UNIVERSITE DE LILLE
Faculte des Sciences Economiques et Sociales
Centre Lillois D'etudes et de Recherches Sociologiques et Economiques (CLERSE)

Sciences économiques, sociales, de l'aménagement et du managemant (SESAM-ED 73)

THE PATHWAY OF ACHIEVING THE UNIVERSAL HEALTH COVERAGE IN GHANA: THE ROLE OF SOCIAL DETERMINANTS OF HEALTH AND 'HEALTH IN ALL POLICIES'

THESE

Pour obtenir le grade de

Docteur en Sciences Economiques

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Abena Asomaning Antwi

29th Mars, 2019

Sous la direction de **Bruno Boidin, Professeur d'économie**

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“Bend the arc of history to ensure that everyone in the world has access to affordable, quality health services in a generation.”

World Bank Group President, Jim Yong Kim

(The 66th session of the World Health Assembly in May, 2013)

Abstract

The Universal Health Coverage (UHC) has become a globally accepted concept and medium of providing healthcare to populations equitably. This goal, which stems from the third Sustainable Development Goals (SDG), has been embraced by many governments across the globe and witnessed many different steps taken in achieving it by the 2030 deadline. Regardless of the potential challenges envisaged, viewed as a policy tool, it has been described as one of the most forward-looking concepts with the power to transform lives in terms of health and also, emancipate people from poverty. Ghana, a lower-middle-income country in the Sub-Saharan Western African region in 2003 initiated its own form of the UHC through the establishment of the National Health Insurance Scheme (NHIS) and the continuation of the Community Health-Based Planning and Services (CHPS) implementation. This was an amalgamation of efforts by all successive governments in the country of more than three decades. It was a political decision which brought together different interest groups into the policy-making space - legislators, policy-makers, unions, civil society, development partners and the entire citizenry in pursuant of this policy choice. The implementation of this decision saw healthcare expenditure shoot up to 10.6 percent as a share of Gross Domestic Product (GDP) in 2007 and galvanized efforts by all in seeing to its successful implementation. After more than a decade's implementation, however, the UHC in Ghana, seen primarily through the lenses of the NHIS in this study has stagnated in growth with concerns of equity and sustainability raised.

In order to find out the reasons contributing to this phenomenon, this study looks at the NHIS' implementation from the point of view of the Social Determinants of Health (SDH) and what it could mean for growth (in terms of enrollment and renewals) if it's complimentary Health in All Policies (HiAP) concept was applied as a national development strategy. The HiAP is a science-based approach to implementing the SDH in a logical manner. Through the use of Kingdon's theoretical framework in terms of multiple-streams framework and agendas, alternatives and public policies, the policy process and environment are looked at. The research method used was qualitative case study with a small reliance on quantitative data using key informant interviews, participant observation and questionnaire administration. Through the analysis of data, bases for empirical arguments were found in support of the adoption of the SDH tools in Ghana. Some of the research outcomes were that there are undercurrents of tensions existing between a purely

voluntary approach to the implementation of the UHC policy and the quasi-compulsory approach adopted by the country which among others have stagnated growth, in terms of coverage. In conclusion, the research finds that financially, it is not feasible to carry on with the current strategy that Ghana's NHIS has adopted, catering to about 95 percent of all diseases in the country compounded by the quasi-compulsory approach to enrollment. Also, there is the need to seek better institutional complementarities in pursuant of the UHC and potential adoption of the SDH especially in light of resource scarcity, especially with financial, in ensuring equity in health and also judicious utilization of resources.

Key Words: Universal Health Coverage, Ghana, Policy, National Health Insurance Scheme, Social Determinants of Health, Health in All Policies

Résumé

Le concept de Couverture Santé Universelle (CSU) est désormais mondialement accepté comme un moyen de fournir équitablement des soins de santé aux populations. Découlant du troisième Objectif de développement durable des Nations Unies (ODD), il a été adopté par de nombreux gouvernements à travers le monde et fait l'objet de différentes mesures pour y parvenir d'ici à 2030. Indépendamment des défis potentiels, il a, en tant qu'outil de politique publique, été considéré comme un concept d'avenir, capable non seulement d'améliorer la santé des individus, mais plus largement de les affranchir de la pauvreté. Le Ghana, pays à revenu intermédiaire de la région subsaharienne de l'Afrique de l'Ouest, a lancé en 2003 sa propre forme de couverture sanitaire universelle en créant un Régime national d'assurance maladie et en développant la mise en œuvre de services de santé extrahospitaliers de proximité (*community-based*). Il résulte de l'ensemble des efforts déployés par les gouvernements successifs dans le pays pendant plus de trois décennies et a réuni différents groupes d'intérêt au sein de l'espace politique – législateurs, décideurs politiques, syndicats, société civile, partenaires engagés dans le développement et plus largement l'ensemble des citoyens. La mise en œuvre de cette décision a fait augmenter les dépenses en soins de santé pour atteindre 10,6 % du Produit intérieur brut (PIB) en 2007 et galvanisé les efforts de tous pour en assurer la réussite. Cependant, après plus d'une décennie de mise en œuvre, la CSU ghanéenne (ici envisagée principalement sous l'angle du Régime national d'assurance maladie) a stagné, suscitant des inquiétudes en termes d'équité comme de soutenabilité.

Afin de comprendre et d'expliquer ce phénomène, cette recherche examine la mise en œuvre du Régime national d'assurance maladie ghanéen du point de vue des déterminants sociaux de la santé. Il étudie en particulier ses implications pour la croissance (en termes d'inscription et de renouvellement) dans le cas où le principe complémentaire de promotion de la santé dans toutes les politiques publiques ("*Health in All Policies*"), une approche scientifiquement fondée pour prendre en compte plus systématiquement le rôle des déterminants sociaux de santé, était appliqué en tant que stratégie nationale de développement. Le cadre théorique proposé par John Kingdon concernant la mise sur l'agenda des problèmes publics est ici mis à profit pour saisir le processus d'élaboration des politiques publiques et l'environnement dans lequel il prend place. L'étude repose sur une méthode essentiellement qualitative, complétée par des données

quantitatives. L'analyse permet de soutenir empiriquement l'argument d'une meilleure prise en compte des déterminants sociaux de santé au Ghana. La recherche montre également que l'existence d'une tension entre une approche purement volontaire de la mise en œuvre de la Couverture Santé Universelle et l'approche quasi obligatoire adoptée au Ghana a, entre autres, contribué à la stagnation du processus. En conclusion, la recherche montre que la stratégie actuelle adoptée par le Ghana, qui concerne environ 95% des maladies dans le pays, n'est pas financièrement soutenable, surtout étant donné le caractère contraignant de l'inscription. Il importe aussi de rechercher de meilleures complémentarités institutionnelles dans l'application de la CSU et la prise en compte des déterminants sociaux de la santé, particulièrement compte tenu de la rareté des ressources, financières en particulier, pour assurer l'équité sanitaire tout en utilisant judicieusement les ressources disponibles.

Mots-clés: Couverture Santé Universelle, Couverture Sanitaire Universelle, Ghana, Santé, Politique publique, Déterminants sociaux de la santé

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Abbreviations

AAAQ	Availability ,Accessibility,Affordability and Quality
ADPs	Accelerated Development Plans
AfDB	African Development Bank
AfDF	African Development Fund
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARIs	Acute Respiratory Infections
ASM	Artisanal and small scale mining
AU	African Union
B&FT	Business and Financial Times
BGL	Bogoso Gold Limited/Golden Star Resources
BI	Bamako Initiative
CAGD	Controller and Accountant General's Department
CBHI	Community-based Health Insurance
CCM	Central Coordinating Mechanism
CD	Communicable Diseases
CEDEAO	Communaute Economique des Etats de L'Afrique de l'Ouest
CEO	Chief Executive Officer
CHAG	Christian Health Association of Ghana
CHIs	Community Health Insurance schemes
CHMCs	Community Health Management Committees
CHN	Community Health Nurse
CHO	Community Health Officer
CHPS	Community Health-Based Planning and Services
CHVs	Community Health Volunteers
CHWs	Community Health Workers
CMH	Commission on Macroeconomics and Health
CPC	Claims Processing Centres
CRC	Convention on the Rights of the Child
CSDH	Commission on Social Determinants of Health
DA	District Assembly
DAC	Development Assistance Committee
DANIDA	Danish International Develpoment Agency
DHMT	District Health Management Team
DMHIS	District Mutual Health Insurance Schemes
DPS	Deputy Permanent Secretary
DRC	Democratic Republic of Congo
DRG	Diagnosis-Related-Grouping
DVLA	Driver and Vehicle Licensing Agency
ECA	Extended Credit Agreement
ECD	Early Childhood Development
ECF	Extended Credit Facility

ECOWAS	Economic Community of West African States
EPA	Environmental Protection Agency
ERP	Economic Recovery Programme
EU	European Union
FAO	United Nations Food and Agriculture Organization
FBOs	Faith-Based Organizations
FCUBE	Free Compulsory Universal Basic Education
FDI	Foreign Direct Investment
FFS	Fee-For-Service
FGD	Focus Group Discussion
FP	Family Planning
FSHS	Free Senior High School
FSV	Facilitative Supervision
GAVI	Global Alliance for Vaccine and Immunization
GCPH	A Global Charter for the Public's Health
GDP	Gross Domestic Product
GHA	Global Health Actors
GHS	Ghana Health Service
GII	Ghana Integrity Initiative
GLICO	Gemini Life Insurance Company
GLSS6	Ghana Living Standards Survey 6
GMHI	Ghana Macroeconomics and Health Initiative
GNP	Gross National Product
GoG	Government of Ghana
GRA	Ghana Revenue Authority
GSGDA	Ghana Shared Growth And Development Agenda
GSS	Ghana Statistical Service
HFRA	Health Facilities Regulatory Agencies
HiAP	Health in All Policies
HIPC	Highly Indebted Poor Countries
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HPP	Healthy Public Policies
ICESCR	International Covenant on Economic, Social, and Cultural Rights
ICTs	Information and Communication Technologies
IDA	International Development Association
IEA	Institute of Economic Affairs
IFIs	International Financial Institutions
IGF	Internally Generated Fund
ILO	International Labour Organization
IMF	International Monetary Fund
IMMR	Institutional Maternal Mortality Ratio
IPC	Infection Prevention Control
IQ	Intelligence Quotient
ISODEC	Integrated Social Development Centre

JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
JICA	Japanese International Co-operation Agency
JLN	Joint Learning Network
KATH	Komfo Anokye Teaching Hospital
KOICA	Korea International Cooperation Agency
LEAP	Livelihood Empowerment Against Poverty
LGs	Local governments
LI	Legislative Instrument
LMICs	Lower-Middle Income Countries
LSM	Large-Scale Mining
MCH	Maternal and Child Health
MCSP	Maternal and Child Survival Program
MDGs	Millennium Development Goals
MDRI	Multilateral Debt Relief Initiative
MESTI	Ministry of Science,Technology and Innovation
MESW	Ministry of Employment and Social Welfare
METCARE	Metropolitan Health Insurance Scheme
MHO	Mutual Health Organization
MLRD	Ministry of Local Government and Rural Development
MMDAs	Metropolitan, Municipal and District Assemblies
MMR	Mixed Methods Research
MoF	Ministry of Finance
MoFEP	Ministry of Finance and Economic Planning
MoGCSP	Ministry of Gender, Children and Social Protection
MoH	Ministry of Health
MP	Members of Parliament
NCCE	National Commission for Civic Education
NCDs	Non-Communicable Diseases
NDC	National Democratic Congress
NDPC	National Development Planning Commission
NEPAD	New Economic Partnership for Africa's Development
NGOs	Non-Governmental Organizations
NHIA	National Health Insurance Authority
NHIC	National Health Insurance Council
NHIF	National Health Insurance Fund
NHIL	National Health Insurance Levy
NHIS	National Health Insurance Scheme
NHRC	Navrongo Health Research Centre
NPP	New Patriotic Party
O&M	Operational and Maintenance
ODA	Official Development Assistance
OECD	Organization for Economic Co-operation and Development
OOP	Out-of-Pocket Payments
Oxfam	Oxford Committee for Famine Relief
PCHIS	Private Commercial Health Insurance Scheme
PFM	Public Financial Management Law

PHC	Primary Health Care
PhD	Doctor of Philosophy
PHI	Private Health Insurance
PM	Particulate Matter
PMHIS	Private Mutual Health Insurance Scheme
PNC	Postnatal Care
PNDC	Provisional National Defence Council
PNDCL	Provisional National Defence Council Law
PPP	Public Private Partnerships
PRS	Poverty Reduction Strategy
PTSDs	Prevalence of anxiety and post-Traumatic Stress Disorders
RC67	Sixty –Seventh Regional Committee
RHA	Regional Health Administration
RHO	Regional Hospitals
RPMED	Research,Policy Monitoring and Evaluation Directorate
SAPRIN	Structural Adjustment Participatory Review Initiative Network
SAPs	Structural Adjustment Programmes
SDGs	Sustainable Development Goals
SDH	Social Determinants of Health
SDR	Special Drawing Rights
SHI	Social Health Insurance
SHS	Senior High School
SPSS	Statistical Package for Social Sciences
SSA	Sub-Saharan African
SSM	Small Scale Mining
SSNIT	Social Security and National Trust
SSPP	Single Spine Pay Policy
SSSS	Single Spine Salary Structure
SV	Sexual violence
TFR	Total Fertility Rate
TIN	Tax Identification Number
TSDF	Transport SectorDevelopment Project
TUC	Trades Unions Congress
TV	Television
TVET	Technical and Vocational Education and Training
UHC	Universal Health Coverage
UK	United Kingdom
UN	United Nations
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHWs	Village Health Workers
VSAT	very small aperture terminal
WATTFP	West African Transport and Transit Project

WB	World Bank
WEEE	Waste Electrical and Electronic Equipment
WFPHA	the World Federation of Public Health Associations
WHA	World Health Assembly
WHO	World Health Organization

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This dissertation has been the work of contributions from many professionals of diverse backgrounds. The motivation to pursue this research work has been born out of the increasing health needs of not only my country Ghana but also, the African continent, which would require a paradigm shift in some of the existing approaches being implemented.

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It is my hope that the research outcome would serve as input into policy discussions on-going and yet to be held in Ghana and elsewhere on a refocus of governments' efforts at achieving key milestones in health and in development, generally.

GENERAL INTRODUCTION

The need to make the promotion of health in all endeavors of life most prominent has been realized universally. The age-old statistic of three score years and ten life expectancy, also underscored by the World Health Organization (WHO) no longer holds true for many reasons both progressive and otherwise – the differential spread has been observed in countries like China with over seventy years life expectancy and those with less than that statistic. Such countries as Japan with an eighty year life expectancy (eighty-six for women) and that of forty-six in Sierra Leone depict the stark reality of national differences in health and life expectancy (Marmot, 2015: 15-17). **There are also in-country inequalities** observed in health and life expectancy (Marmot, 2004: 2-8). Indeed, the Commission on Macroeconomics and Health (CMH) established by the WHO made a positive connection between investment in health and economic growth at the end of the millennium (Marmot, 2004: 17) and this serves as an impetus for many countries to take a second look at the health of their populations. The ideology behind the provision of healthcare for all, equally, and by all, started more than 50 years ago with the call by Halfdan T. Mahler , the then Director General of the WHO, for the 1977[1] **"Health for All"** goal to be achieved by year 2000. Also, the momentous Alma Ata Declaration of 1978[2] gave some impetus to focus on Primary Health Care (PHC) as a universal goal. The **1978 Alma Ata Declaration** provided a platform to **"exert moral pressure"** on participant countries to embrace the implementation of Primary Health Care (PHC) in their countries (Cueto, 2004: 1866). Certainly, the Universal Health Coverage (UHC) which emanates from the Sustainable Development Goals (SDGs 3) carries on from the ideals expressed by the "Health for All" and also the Alma Ata Declaration. The UHC's implementation in the various countries is undertaken through the adoption of policies. To introduce the concept of policy, a basic

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[1] The 1977 Health for All initiative is the main social (health) target recommendation by the World Health Assembly to participant governments, to be attained by the year 2000 as a minimum acceptable health level for their populations which would enable them "to work productively and to participate actively in the social life of community in which they live" Barroy 2014: 23).

[2] The Alma Ata Declaration of 1978 represents a landmark event, the International Primary Health Care conference which happened in the capital of the Soviet Republic of Kazakhstan on the 12 of September, 1978. At the conference, the significance of primary healthcare being an "essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community" was impressed upon all countries (Barroy, 2014: 23; Cueto, 2004: 1866).

definition of it as described in the work of Wallace (1972) is given as **"the conduct of public affairs e.g. government policy."** It is within this mindset that policy in this dissertation would be addressed - in the conduct of public policy within government.

The general introduction of this dissertation is organized in six subsections under the following themes: presentation and rationale of the study; three key elements of the quest for health with a view of the universal health coverge, the social determinants of health and the health in all policies; the theoretical framework of the study; relevance and features of the case of Ghana; empirical methods; and finally, an outline of the entire dissertation.

1. Presentation and rationale of the study

The different tenets of the UHC has been extensively researched and widely published. In as much as the UHC is generally accepted for implementation by countries, its form of adoption has taken on many dimensions as per local contexts. Its actualization is saddled with many challenges and hence, the need to learn and 'unlearn' some of the lessons of implementation from countries which have achieved successes, and also tailor useful reforms to countries implementing the goal with difficulty.

In light of this, the objectives of the dissertation are two-fold - first is **to understand and present the UHC as it is being implemented in Ghana**, one of the trailblazers of the UHC implementation in Africa and second, **to improve the links between different literature/theories about the Social Determinants of Health (SDH)** and also, the policy process. It also lays to bare the issue of **institutional complementarities[3] and its place in helping achieve the UHC**. This research outcome adds on to the existing body of knowledge on the National Health Insurance Scheme's (NHIS) implementation including that of Agyepong et

[3] The concept of institutional complementarities acknowledges the strengths of the different institutions that may be required to successfully implement policies and programmes. With the complementarity stemming from the contributions of one institute to the quality and quantity of services rendered and its consequent positive effect on the ability of other institutions such that their contributions then become beneficial to all involved. According to Boidin (2017) there is not a 'one best way' approach to achieving desired outcomes from policies but instead, there exists a web of 'comprehensive, coherent policies that link the various actors and programmes together or, conversely, incoherent policies that simply stack programmes on top of each other'. According to him, health policy studies have proven that there is indeed the presence of low institutional complementarities associated with government institutions acting as silos, individually striving to implement policies which should ideally incorporate the input of other institutions (Boidin, 2017).

al. (2016) and Ridde et al. (2018) which point to an observed tension between the seeming voluntary approach of Ghana and the compulsory approach (elsewhere proven to be more reliable in promoting expanded coverage, equity and growth). But the uniqueness of this dissertation lies in its introduction of both the Social Determinants of Health (SDH) and the Health in All Policies (HiAP) as tools in assessing the various constituents under the framework in the context of Ghana and also by considering potential for adoption into the governance system. This could present a paradigm shift in the policy discourse of the country on its journey to achieving the UHC.

2 Three key elements of the quest for health and well-being through the Universal Health Coverage (UHC), Social Determinants of Health (SDH), and the Health in All Policies (HiAP)

Achieving the Universal Health Coverage at all cost

Universal health coverage (UHC) is defined as ensuring that all **people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services do not expose the user to financial hardship** (WHO, 2015: 41, 61 & 157; Maeda et al., 2014: 1). UHC comprises two main components being first, health service coverage and second, financial protection coverage. These aspects have to be equally assessed for the entire population. Effectively, three dimensions concerning the UHC have to work together to achieve the expected health outcomes - **health services, finance and population** which are represented figuratively in the "coverage box" (Figure 1). Through the health systems of participating countries, efforts have to be made to fill the coverage box (i.e. in essence, the extension of coverage should provide both quality health services with financial protection). This is not exclusive to only poor or middle-income countries but also high-income countries with well-established institutional health systems. A combination of factors such as epidemiological, demographical and technological advancements has gone a long way in altering the patterns of people's demand and utilization of health services. Some of these reasons are assigned for the reference to the achievement of **the UHC as a journey instead of a destination**. The journey is intended to be a progressive process, one that has the potential to absolve modifications and not 'a once-and-for-all' solution that can be

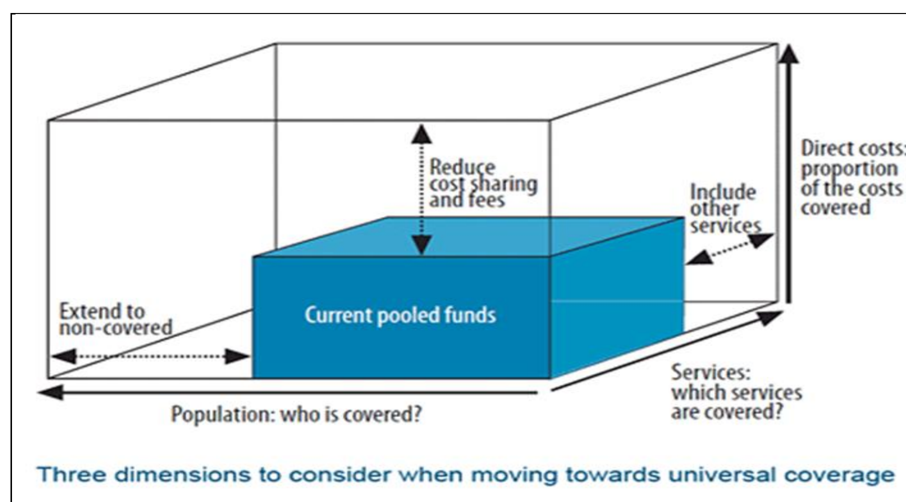
“achieved”’. Thus, the UHC has a **focus to equitably distribute access to healthcare services** with an expectation of such a responsibility on all participating countries (Vega, 2013: Cotlear et al., 2015: 19).

Achieving universal health coverage (UHC) has long been **a social aspiration of most nations and is currently a top health policy priority around the developing world**. Low- and middle-income countries as diverse as **Ghana, Rwanda**, Peru, and Vietnam are striving to expand health insurance coverage for their populations. Upper-middle-income nations, such as Brazil, France, Japan, Thailand, Turkey Colombia, Costa Rica, and Thailand have already claimed success and showed over time, the significance of the UHC as influential in promoting economic growth and health and welfare of populations. The quest for UHC has also been promoted by international development organizations, which have recently embraced UHC. The Director General of the World Health Organization (WHO) has stated that UHC **“is the single most powerful concept that public health has to offer.”** The World Health Report 2010 focused exclusively on this question (Lagomarsino et al., 2012; Maeda et al., 2014: 1). There is no known agreed definition of UHC, but the ones available tend to overlap somewhat but maintain that the UHC comprises the extension of health insurance to all citizens, improvement in health service accessibility by all, while **providing financial protection against the costs of health shocks, catastrophic health expenditures and impoverishment** (Abiiro and De Allegri, 2015). There is therefore some room for interpretation of the concept of UHC, particularly as regards the breadth of the benefits package delivered by the insurer, but also in relation to the extent of financial coverage conferred by the health system.

Efforts to achieve the UHC are characterized by **increased public spending**. Some countries which experienced increased expenditure on healthcare geared towards the establishment of the UHC include Colombia with a total health expenditure (expressed as a percentage of gross domestic product (GDP) during the 1994 reform moved from 7.4 percent in 1995 to about 10.0 percent in 1997. Vietnam experienced a three-fold increase in real per capita total expenditure in health within the period of 1995 and 2009. In **Ghana**, the implementation of the National Health Insurance Scheme (NHIS) in 2005 saw **healthcare expenditure as a share of GDP, shot up to 10.6 percent in 2007** (Bitrán, 2012: 9, 13, 18).

For many countries especially those in the Lower-Middle Income Countries (LMICs) group however, **galvanizing public funding for the health sector is not as straight forward and easy as may seem**. Countries that reach high levels of income are known to typically have **stronger institutions, largely urbanized populations and have the majority of their workforce in formal employment**. These countries' experiences were somewhat different with efforts of expansion of coverage and legal backing for Social Health Insurance (SHI) being far apart. **The increased revenues required for the UHC implementation often pose formidable to governments. Dependence on user payments alone to bridge the financing gaps through public financing is not an advisable option. Admittedly, user fees help in raising the needed revenues to improve health workers' remuneration and improve quality of care but act as a deterrent to access, especially for the poor and vulnerable** and thereby render the UHC infeasible. Due to targeting difficulties, implementing pro-poor systems of providing waivers for the poor has been shown not to be administratively easy in low-income settings, and therefore implementing a system of charging user fees solely for the non-poor population is hard to implement (Bitrán 2014: 1, 40). Additional public revenue for health is essential, and may be obtained from reallocations to the health sector away from other sectors. Governments have used the tax system to raise additional revenues when required or, in some other countries through social health insurance (SHI), where extra revenues are raised from social security contributions of formal workers (Bitrán, 2014: 31 – 34, 41). Regardless of the intended source of funding for the UHC implementation, developing countries usually are confronted by the challenge of raising such needed funds especially as their economies have large informal sectors.

FIGURE 1: THE THREE DIMENSIONS OF UNIVERSAL HEALTH COVERAGE (UHC)



Source: Cotlear et al. (2015: 22, 213)

The path to universal coverage involves important policy choices and inevitable trade-offs. These dimensions of coverage reflect a set of policy choices about the benefits and their potential rationing that are among the critical decisions facing countries in their reform of health financing systems towards the attainment of universal coverage. Choices need to be made by governments about proceeding along each of the three dimensions, in many combinations, in a way that best fits their objectives as well as the financial, organizational and political contexts (Cotlear et al., 2015: 22).

Social Determinants of Health (SDH)

To achieve the absolute health status that is required for a people to be productive and contribute meaningfully to the communities and countries they reside in, the **conditions in which they are born, grow, live, work and age** need to be looked at (Marmot, 2015: 3). To some, this represents human rights and social justice that maximizes freedom, thus if one considers **the right to a healthy life, productivity and longevity** (Marmot, 2015: 105). Social justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death. Within countries there are dramatic differences in health that are directly linked with degrees of social disadvantage. The **differences observed in health are**

avoidable, within and between countries, and should not be made to fester. In 2005 the Director-General of the WHO, J. W. Lee set up the Commission on Social Determinants of Health (CSDH) in a bid to galvanize global efforts in refocusing attention to this dimension of healthcare ideology and to create a movement to achieve it (Marmot, 2015: 19).

Social, economic and environmental factors are embedded in development practice as the three interlinking pillars of sustainable human development. They also, to a large extent, determine population health and the distribution of health. Yet, there is a common perception that health is the responsibility of individuals, and the realm solely of the healthcare sector. Overturning this misconception, the WHO Commission on Social Determinants of Health (CSDH) concluded that **health inequities** (that is: systematic differences in health between groups that are avoidable by reasonable means) **are caused by inequalities in conditions in which people are born, grow, live, work and age and the inequities in money, power and resources that create these unequal conditions**. This unequal distribution of health-damaging experiences is not in any sense a 'natural' phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics. Together, the structural determinants and conditions of daily life constitute the social determinants of health are responsible for a major part of health inequities between and within countries. **'These social inequalities in health – the social gradient – are not a footnote to the 'real' causes of ill-health in countries that are no longer poor; they are the heart of the matter'** (Marmot, 2004: 2). These social, economic and political environments are all situated within policy envrionments which lend themselves to change (Kickbusch, 2010: 1).

In conclusion, the CSDH laid to bare three principles of action:

1. Improve the conditions of daily life – the circumstances in which people are born, grow, live, work, and age.
2. Tackle the inequitable distribution of power, money, and resources – the structural drivers of those conditions of daily life – globally, nationally, and locally.
3. Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

These three principles of action are embodied in the three overarching recommendations in the Commission's Final Report 2008 - Closing the gap in a generation: health equity through action on the social determinants of health.

Health in All Policies (HiAP)

Due to increased public health challenges, the health sector has worked evolved to the point of embracing the awareness and need to address the fundamental determinants of health in a more holistic, what some would refer to as **"whole-of-governments' approach in achieving better health outcomes**. This whole-of-government approach involves an awareness and implementation of a system of addressing issues (in this case health issues) that take on board the input of different sectoral portfolios in achieving shared and desired outcomes within a government (Kickbusch, 2010: 11, 12). A strict **single dimensional focus on tackling healthcare challenges is inadequate** to meet the demands of modern populations. As intimated by the SDH, health and its associated implications stem from a myriad of circumstances rooted in economics, social policies and governance (Marmot, 2015: 2-3, 105) and addressing these should ideally be through multidimensional lenses. Kenneth W. Newell, a WHO staff member from 1967, explains this idea succinctly concerning developing countries in *Health by the People*, that **"a strict health sectorial approach is ineffective"** (Cueto, 2004: 1864). Kickbusch (2010: 27) points out that the choices of healthy public policies have a long history premised on epidemiological, historical and social science analysis of which the HiAP has been derived.

Based on this, Health in All Policies (HiAP), which is essentially a development approach which supports measures taken to address prevailing inequities in health and the social determinants of health, is focused on in this study in an attempt to assess its presence or absence in this case study. This approach also helps governments in prioritizing key sectors in promoting population health and development. It has been successfully implemented in at least sixteen countries, albeit under different models.

3 The dissertation and SDH frameworks guiding the study

To discuss the UHC in the context of policy involves a look at the process, the various actors, their unique strategies, the various approaches and the different modes of implementation. This is important as it serves as the framework within which the UHC as a policy will be looked at in the dissertation. However complex the issues surrounding policy-making and implementation are, the attainment of the UHC would prove inevitable without it. It is important that government policies are based on sound evidence, of what works and what does not to make informed decisions (Parsons, 2002). The policy-making process is often not linear and could be 'muddled up' with one stage preceding another (Ridde, 2009). Some of those policies when introduced to address specific needs, such as those of economic policies, could have unintended consequences for health (Marmot, 2004: 19; Leppo et al., 2013) and should be observed.

Three main frameworks are relied on in this dissertation – first is the conceptual framework designed for data collection which takes on board the actors and policy interactions in Ghana and based on this framework, respondents and institutions are selected for the empirical aspect of the study. The design of the framework is based theoretically on a combination of issues raised by Kingdon's multiple-streams approach observed through Ridde (2009) and his view of agendas, alternatives and public policies. This framework is found in the political science. This framework is not used exclusively in this study, it is used collaboratively with other views of the policy process such as those of Lindblom[4] (1968), Olivier de Sardan and Ridde, (2015) and Agyepong and Adjei (2008). The work of Kingdon (2011) and Ridde (2009) extension of Kingdon's multiple-streams approach forms the main basis for discussion on issues of policy in this dissertation. The agenda, as perceived by Kingdon (2011) can best be described as the selection of issues that attracts and holds the attention of a variety of stakeholders within and out of governmental business (Pg. 3). The issues as placed on the agenda list may differ from one part of government to another and even within a particular sector; the issues of concern may vary in terms of magnitude and may be called the alternatives for many reasons including lack of acceptance, cost implications and others (Kingdon, 2011: 3, 17 - 18) – this aspect of the policy analysis features prominently in this study concerning the National Health Insurance and the

[4] Charles Lindblom's (1968) ***The Policy-Making Process*** is also used in analyzing the policy-making process aspects of this study. It is of the political science discipline.

Community Health-Based Planning and Services (CHPS). For many reasons, some agenda items never find themselves as priority despite how long they may have been presented - such reasons as absence of public interest and acceptance, inadequate fiscal space to accommodate their implementation, resistance by interests of "actors" more powerful in the policy space and others are noted in that stead (Kingdon, 2011: 18). The second framework used in this study is the Dahlgren and Whitehead (1991) framework on the SDH – it is used extensively for the selection of sectors under consideration in the case of Ghana and relevant to health and the specific health policies discussed. This framework is also relied on as a guide in the discussion of key findings and the pathways in achieving the UHC in Ghana. The third and final framework is the institutional complementarity concept which was used in the analyzing how cohesive the different institutions work in achieving health outcomes and the UHC specifically. This framework guides the workings of institutions both in and out of the health sector. Section two of chapter 2 explains the conceptual framework that guided the data collection and also, section one of chapter three explains in detail how the two frameworks are used in the study. The third subtle framework of institutional complementarity can be found under section two of chapter 2 and section 2 of chapter 4.

4 Relevance and features of the case of Ghana

The selection of Ghana as a case study stemmed from the fact the pursuit of the UHC on the African continent has been observed as more compelling in the country, providing avenues for learning for other countries in the sub-region and elsewhere. Ghana has many characteristics which make it worth studying such its demographical changes, its economic policy history and it's democratic and governance structure, aspects of which pertain in many other developing countries but the contexts and outcomes related to health remain different. According to the literature, Ghana and Rwanda are often mentioned internationally as countries making remarkable strides in the journey to achieving the UHC but these two find themselves at different points on the journey. Locally, with the context of the author being closely linked to the country under study, the choice of the country as a case study was made in order to provide insights into the pathways by which a developing country was pursuing the UHC (see section one of chapter five for a description of the context of the author).

General features of Ghana

Ghana is a West African sub-regional country with land area of about 238, 533 square kilometres and about 750 km north of the equator on the Gulf of Guinea. Ghana is a known politically stable country bordered on the north by the Republic of Burkina Faso, with the Atlantic Ocean to the south, bordered on the east is Togo and Cote d'Ivoire to the west. The land area in Ghana can best be described as fairly flat with an altitude registered as below 500m but with good land area being below 200m. There are two main seasons in the country - the rainy and dry seasons (Asenso-Boadi, 2010: 147).

The era after independence on 6th March 1957 from the British saw Ghana renamed the Gold Coast by the early Europeans, a name given to it as a result of the predominance of gold trade along the shores of the country and with the belief of ties between the people of modern day Ghana and the prehistoric Ghana empire with descent from the Sahelian region of Senegal, Mauritania and Mali. It became a republic in the British Commonwealth of Nations on 1st July 1960 (Asenso-Boadi, 2010: 147). Administratively, Ghana has been demarcated into 10 regions namely Western, Central, Greater Accra, Volta, Eastern, Ashanti, Brong Ahafo, Northern, Upper East, and Upper West (Saleh, 2012a: 1; Saleh, 2012b: 22) with a further sub division into 216 districts. The districts represent the last and most basic level of public and political administration of the governance structure (Asenso-Boadi, 2010: 148). The governance system of decentralization being operated in the country is progressing, however, with some implications on public sector healthcare. Although the foundational tenets of a well-functioning decentralization system has been put in place through the administrative structures of Ministry of Health (MoH) and implemented through the Ghana Health Service (GHS), the actual manifestation of its benefits still faces challenges (Saleh, 2012a: 11 – 12; Saleh, 2012b: 22, 32 - 35). Boidin et al. (2013) point out the difficulties in infusing decentralization into countries and systems which are centralized, non-democratic states or poor economies and how it thrives best in rich, democratic and pacified societies. Although Ghana is a democratic country, it faces challenges with its economy.

A recorded 51 percent of Ghana's population was registered as living in urban areas in 2009, a speculation of two scenarios – firstly, that Ghanaian cities are developing exponentially, and

secondly, that people are possibly moving to cities out of economic hardships and possibly indicative of a lack of economic opportunities in the rural areas (Saleh, 2012a: 2). The Greater Accra region is host to the capital city of Ghana - Accra, also one of the country's ten administrative regions. With an estimated population size of 1.7 million in 2000 (a 70 percent representation of the total population of the Greater Accra Region and also, 30 percent of all urban population in Ghana), it has a land coverage area of about 420 km2 (Agyei-Mensah and de-Graft Aikins, 2010: 882). By 1998, 98.5 of inhabitants in the country were black with 1.5 representing other races. Religious groupings are segmented into 63 percent of Christians, 16 percent Muslims and 21 percent representing other indigenous beliefs. Of the major tribes in Ghana, those of the Akans (44 percent of the entire population) represent the majority with the Moshi-Dagaomba (16 percent) following, the Ewe (13 percent), Ga (on the land resides the capital city, Accra with 8 percent), Gurma (3 percent), and finally the Yoruba (1 percent). The official language spoken is English (Hsiao and Shaw, 2007).

Ghana, its demography and related health challenges

At the time of independence, Ghana's population was just about 6 million. The first population census conducted after independence in 1960 registered an estimated number of people of 6.7 million, indicative of an intercensal growth rate of 4.2 percent within the period of 1948 - 1960 (Asenso-Boadi, 2010: 151). Ghana's population growth was captured in the 2000 population census as 18.9 million, indicative of a tripling in the period of 1957 – 2000 (Asenso-Boadi, 2010: 151). Over time though, Saleh (2012a: 3) reports that, Ghana has sturdily declined in its population growth rate. The population of Ghana was recorded at 24.3 million (2010), with a corresponding growth rate of 2.1 percent captured in the period of 2005-2010. The decline in population growth registered over the years is likely due chiefly to the dropping total fertility rate (TFR) (a registered decline from 5.34 children per woman (1990-95) to 4.34 (2005-10) (Saleh, 2012: 3). The country experienced a slowdown in the trend of TFR for many years but the rate of decline in terms of outcomes has been rather remarkable, especially among girls in the 19 and below age cohort which can be attributed mainly to the increased school enrollment rate and changing economic circumstances of the people. Also notable are the fertility declines of women in the 45-49 and 20-30 age cohorts primarily due to the use of contraceptives and abstinence

modes of birth control. The rate of declines in TFR has not however been experienced among rural women, the lower income quintiles and people living in the Northern region of Ghana, one of the poorest regions in the country. Asenso-Boadi (2010) points out that majority of the Ghanaian population lives in the rural areas (Pg. 152).

In the estimation of Saleh (2012b: 25), Ghana can best be described as going through a demographic transition (with lower population growth and lower fertility rates occurring concurrently) thus there may be challenges ahead (by a projected period of 2030) for the country if certain interventions are not put in place. This is explained as, with a recorded crude birth rate of 32.6, and that of crude death rate of 8.3 (captured within a 5-year period of 2005-2010), it is projected that the population of the country would be at 33.8 million in 2030 (an increase from the 24.3 million registered in 2010), a 39 percent increment. In addition to the declining birth rate, the increasing life expectancy of over 64 years, would combine to see the population below 14 years decrease from 38.1 percent in 2010 to 30.8 percent in 2030 thereby eventually leaving an aged population (by the projections, there will be 90 percent more elderly people in the country in 2030 as compared to 2010) (Saleh, 2012b: 4). In essence, the existing health system and social protection programs must mature fast enough to support the demographic transition in the country.

Observing from the earlier discussion, the population growth of the country with the aforementioned factors and more, would predictably present challenges to the healthcare delivery system which would require strategic investment (Asenso-Boadi, 2010: 151). This demographic transition has a potential telling effect on the sustainability of the National Health Insurance Scheme (NHIS) eventually – due to the past high population growth rates. The number of people within the age range of 14-64 that would be entering the productive labour force is expected to be high while those born will reduce and yet more would enter the 64 plus range (for the retired). This occurrence could affect Ghana's dependency ratio, decreasing from 0.72 dependents per productive member as at 2010 to 0.56 by year 2013 and by projection, a further reduction to 0.51 by 2050 (Saleh, 2012a: 5). It is said that the 'demographic benefit' of this fall in dependency ratio phenomenon can only be derived if and when Ghana is able to productively absolve the population in that age cohort but with the current trend of a saturation of the employment sector with many small firms (about 70 percent) whose capacity to engage labour is for only about five

or less employees at a time, about 70 – 90 percent of the labour force may find themselves in the informal sector where the challenge of low revenues (in the form of taxes) to be accrued to government remains formidable and the issue of enrollment and premium collection for the NHIS has been evasive. The country's inability to absolve the labour force amassed in that age cohorts could spell doom for the country as there could be lower economic growth, decreasing tax base, challenges with the financial sustainability of the NHIS and eventually, political unrest (Saleh, 2012a: 6; Saleh, 2012b: 1, 25). Ortiz and Cummins (2012) point out that many developing countries which are facing high youth unemployment rates may be facing precarious situations as this could lead to a myriad of occurrences such as child labour, unsupervised and abandoned children, lower educational outcomes, domestic violence and even civil unrest.

Agenda-setting in Ghana's political space

Ghana in December 2016 went to the polls again to elect its next president for the 4th republic. In conformity with the country's multiparty structure, 7 political candidates were presented on the ballot with the real contest witnessed between the two biggest political parties - the National Democratic Congress (NDC) and the New Patriotic Party (NPP). The election campaign period was noted in the history of the country as being one which saw the electorate voting largely based on issues of major concern to their welfare. Albeit issues based, it saw on a limited basis (as in previous elections), the electorate voting on tribal, religious and political ideological basis also. All the presidential candidates went round the country campaigning with messages they thought would resonate with the citizenry. As Lindblom (1968: 61) asserts that, **"Party does not merely aggregate the opinions of groups, it goes a long way toward creating these opinions by fixing the framework of public thinking about policy and the voters' sense of the alternatives and the possibilities…….the parties themselves, backed by research staff, equipped with nationwide organizations, and enjoying the continuous attention of the mass media, have themselves in great part framed and elicited the very demands to which they then respond."** The parties, on different platforms (campaign rallies, print and electronic media etc.) presented to the electorate and citizens the policy direction their four-year mandate would take should they be voted into power and those policies on various development issues were debated, justified, modified, accepted and sometimes rejected by the public who through their experiences seemed interested in which development agenda suited their sense of well-being.

The sitting president of the National Democratic Congress (NDC) party, H.E. John Dramani Mahama was voted out, a first in Ghana's electoral history - traditionally; the electorate gives each sitting president and party a two-term mandate to govern. But not this time as a resounding statement of rejection was made with about one million plus votes' difference to unseat the incumbent government.

Policy emanates from politics and in the many processes involved in the policy reform process, the presence of politics is undeniable (Fox and Reich, 2015: 1021). And the agenda-setting stage of the policy-making process experienced an interesting dynamic as the electorate in Ghana voted based on issues of concern for the next four-year term. Some of the top priority issues dwelt on by the electorate as surveyed by some media houses were the rejuvenation of the economy, education (free education for senior high students - as promised during the campaign), health - a revamping of the "ailing" National Health Insurance Scheme (NHIS), infrastructure development (road transport and electricity) and finally, creation of employment avenues (www.ghanaweb.com[5]). In a sense, the citizenry had set out the agenda with the policy direction they wanted the new government to pursue resonating with Lindblom's (1968: 45) assertion that, "some political scientists speculate that voting in genuine elections may be an important method of citizen influence on policy not so much because it actually permits citizens to choose their officials and to some degree instruct these officials on policy but because the existence of genuine elections put a stamp of approval on citizen participation."

Using Kingdon's multiple-streams model (Ridde, 2009: 339 - 340) where the four stages are described as agenda-setting, determination of possible choices, authoritarian selection of choices and implementation of decisions. The author of this study shares in the position taken in the Ridde (2009: 339) study that, **"there are three recurring sub-processes: agenda-setting, formulation and implementation, with evaluation being more of a meta-process"**. The agenda-setting stage came with the electoral period in Ghana and the presentations of manifestos by candidates. The alternatives stage came along as the electorate debated the country's development trajectories and better ways to achieve desired outcomes based on the proposals made by the presidential candidates and finally, the decision making stage was in two-fold first,

[5] www.ghanaweb.com Articles on the NHIS, its prominence in the 2016 election from different stakeholders including the presidential aspirants (Dates of articles: 9th July, 2016; 17th July, 2016; 26th July, 2016)

the decision on the preferred areas of focus as dictated by the electorate to all candidates and the decision of who to lead the development decisions made. All in all, a new set of developmental policy agenda was set for Ghana in the elections and the winning party would be careful to implement the agenda set as it represents the voice of the people. (Lindblom, 1968: 59) states that elections in democratic dispensations afford citizens the opportunity to show their preferences for certain policies in their countries. Although not all policies can be selected, the voter exerts powerful influence on some specific policies. The 'window of opportunity' (Kingdon (2011: 165 - 170) was presented then for implementation with the arrival of a new government. On the issue of honoring political promises made to the electorate, Lindblom (1968: 55) holds the view that it would be "suicidal not to satisfy them" and as the NHIS' policy efficiency, effectiveness and sustainability were placed rather high on the agenda of the citizenry and electorate in the 2016 elections, it is imperative that the government takes the operations of the National Health Authority (NHIA) seriously.

5 Empirical methods

Research on the UHC in Ghana is not new, however, this dissertation, in utilizing diverse qualitative research methods including a combined approach of primary data collection, participant observation, secondary data analysis, comparative analysis with some previous studies captured in different time periods and on different aspects of the UHC and a limited use of quantitative analysis, presents a research with a refined knowledge that adds value to the already existing repository of knowledge of the UHC in academia.

Literature Review

The literature review, captured predominantly under this study, took a look at the Universal Health Coverage (UHC) under which the two main health policies namely the NHIS and the CHPS are implemented in Ghana. It also covered theoretical basis for the discussion of the Universal Health Coverage (UHC, captured under the Sustainable Development Goal 3), the Social Determinants of Health (an academic concept applied in the research as a measure for health outcomes) and the Health in All Policies (as a concept that aims to stimulate action towards the achievement of the SDH (Baum et al., 2014). There was research undertaken on

policy-making and with Kingdon's **multiple-streams framework** and Kingdon's **agendas, alternatives and public policies**, both of which emerged in the 1980s, the policy dimensions are explored generally and in relation to the African continent as seen through the study of Ridde (2009) and Kingdon's perspectives of the policy-making process (2011). The guiding principles espoused by Walt and Gilson (1994) that ***'The traditional focus on the content of policy neglects the other dimensions of process, actors and context which can make the difference between effective and ineffective policy choice and implementation'*** (Agyepong and Adjei, 2008) are deliberately used in the entire research. These principles guided the selection of all the stakeholders/or actors with differing influences on the policy options related to the UHC's implementation (NHIS and CHPS), the processes and the context described in the discussions of the two policies.

The search strategy for dissertation

Based on the focal areas of the UHC under study, the key areas looked at in information search covered the following – the SDGs, UHC, SDH, HiAP, Policy, health policy, WHO, Sub-Saharan Africa, Ghana, SHI, NHIS, CHPS, public health, IMF, World Bank, SAPs, poverty, poverty reduction, User fees, Out-of-Pocket payments, Bamako Initiative, economic growth and other relevant areas.

The strategy for the search for information for the literature review was to gather general information on the selected areas from well-known electronic sites and books, and then narrow the search down to more specific areas, closer to the research area. Such sources as Pubmed, Elsevier, BioMed, Pubmed, Google scholar and others were used in searching for information on the focus area.

Admittedly, due to the limited time within which to undertake such a research, the various dimensions of the SDH such as extensive focus on education, employment, agriculture and food production and their impact on the NHIS could not be done in this research and remain in the shadows to be explored further. And while this study focused on only three out of the 10 administrative regions of the country, the results are not a reflection of what pertains in all the other regions and cannot be extrapolated to the other regions due to potential contextual

differences. Albeit, characteristics of the results may well guide future attempts of a national study.

Results from the empirical study

Results from this study indicate that, although the NHIS' policy implementation started on a strong footing, with time, interest and commitment to enroll has waned. Some of the features of respondents under this study include 150 respondents from three regions in Ghana, of both male and female gender. In terms of age of the respondents, most of the respondents were young and fall within the age range of 14 to 35 years (77.3 percent). This study also sought for information on whether they are subscribers or non-subscribers – out of this, the group with majority of dependents of 1-2 (57.6 percent) was found in the subscribers' group. Of this, 54.7 percent indicated their dissatisfaction with the services received as card bearers of the scheme. The results of the syudy are presented in the following categories: perception of the NHIS, enrollment issues, performance and sustainability of the health system, and awareness of and implementation or the lack thereof the Social Derminants of Health (SDH) and the Health in All Policies (HiAP).

Perception: Relatively more subscribers under the study carried the perception that the scheme was not effective (52.0 percent) while 42.7 percent of non-subscribers shared same opinions. Of interest also are the perceptions of respondents under the "don't know" category from the non-subscribers with 18.7 percent who intimate their lack of knowledge of the effectiveness or otherwise of the operations of the scheme.

Enrollment issues: The study discovered the main reasons for which respondents refused to enroll on the scheme. Some of the reasons assigned were: respondents not finding it necessary to enroll on any form of health insurance scheme, lack of money to afford the subscription fees, lack of interest, the scheme not covering the required services and others. Other studies conducted on the NHIS corroborate these findings and espouse various reasons, some of which resonate with this current study. Some of the reasons assigned to the stagnated enrollment rates for the NHIS are similar to those under the study (Agyepong et al. 2016: 7-11; Amu and Dickson 2016: 5-7; Asamoah et al. 2014: 11). All the aforementioned issues notwithstanding, if the law

concerning compulsory enrollment in Ghana was enforced, the journey then to the UHC could enjoy increased participation and the sustainability challenge could be addressed. Agyepong et al. (2016) and Ridde et al. (2018) have pointed to the tension between the compulsory and voluntary approaches of enrollment with the latter making the suggestion 'to abandon the ideal of volunteer involvement in CBHI' based on which the NHIS was built. There are also detected inequalities in the system that the NHIS operates. For instance, even though pregnant women are part of the exempt categories, due to the informal payments which necessitates Out-of-Pocket Payments (OOP), the cost of accessing and utilizing the services at the point of delivery is costly, especially for the poor (Asamoah et al., 2014: 11-12).

Performance and sustainability of the health system: Findings of the research indicate that although the NHIS and the CHPS are the main vehicles chosen by the country in its efforts to achieve the UHC, the coverage of both leaves much to be desired – the NHIS' coverage has been reported at about 40 percent and the CHPS at 5 percent. There is demand for healthcare – the uptake of health insurance is not at optimal capacity especially among the population found in the informal sector and also, quality service delivery is lacking in the system. One reason assigned to the latter being that there is an absence of adequate supervision of staff conduct which falls under the mandate of the Ghana Health Service (Code of Ethics and Patients' Charter). There is also the existence of the Health Facilities Regulatory Agency (HFRA) under the MoH which has since 2015 been mandated to license and monitor the activities of both public and private sector health facilities. While there is demand for healthcare and an overproduction of trained healthcare personnel (under the CHPS), the infrastructure available is not commensurate with the number of staff produced. It was observed through this study that the position of the NHIA concerning enforcement of the law on compulsory enrollment remains weak and thus, with an over-generous benefit package and low premium rates, the NHIS' performance border on financial vulnerability.

Awareness of and implementation or the lack thereof the Social Derminants of Health (SDH) and the Health in All Policies (HiAP): With stagnated enrollment rates and reduced interest in fresh enrollments and renewals, the issue of sustainability is raised. The study additionally sought to find out whether there was a conscious effort by policy makers in the application of HiAP. From interviews held with key informants, majority indicated a subtle

presence of HiAP at the policy making and sometimes at the implementation levels involving government, development partners, and private sector. But the health system took cognizance of the need for a multisectoral approach decades ago for better health outcomes (MoH First Five-Year Health Sector Programme of Work, 1997-2001: 26-30[6]), progress towards an overt commitment to such an approach seems to be slow. For some of the sectors, the presence of a HiAP approach is stronger than others but generally a deliberate attempt to incorporate such a concept and a focus on the SDH is lacking. Whilst government's annual budget allocation to the health sector seems to be on the ascendency (refer to Figure 2 below), much more is required to achieve key milestones in health in general but also with the UHC's achievement.

Over all, the expansion of the UHC has been found to be dependent on a number of factors such as enforcement of the law, education, perceptions of subscribers and non-subscribers, gender, financial management/funding (through resource mobilization and judicious use of available resources), continued multisectoral involvement of stakeholders, political will and good governance (not only in the health sector but all others) particularly the ones that fall in the domain of the SDH. Indeed, to achieve the UHC within the period allotted, by 2030, there must be political commitment which has the power to transform the health fortunes of the country. After all, it is said that **'Health is political'** (Marmot, 2015: 20).

In summary, the efforts made by Ghana in pursuant of the achievement of the UHC are commendable and has been hailed on the continent. The successes achieved have not been without challenges but these challenges are not alien to any of the countries which are striving for the UHC and those who have already done so. Indeed, countries such as South Korea and Thailand attained near Universal Population coverage while categorized as lower middle income countries (Agyepong et al., 2016) and they did so surmounting challenges until eventually succeeding. In reality, some countries and continents are currently battling ideologically, politically, socially and economically with the idea of the UHC, such as Europe and the United States of America (Borgonovi and Compagni, 2013) but in Ghana, successive governments have embraced the ideals of the UHC and backed it with political power. One of the challenges faced by the country is with coordination of policies among the different sectors which sometimes act as silos in their approach to national development. Abudu (2016: 40-43) has pointed **a gap in**

[6] http://www.moh.gov.gh/wp-content/uploads/2016/02/5yr-POW-1997-2001.pdf

coordination since independence of over sixty years with no one government being successful at establishing one key institution to firstly, coordinate all policies, programmes and projects under the various ministries and secondly, to ensure that all such government initiatives produce the expected outcomes that would be beneficial to all citizens. This observation, also articulated by key informants during the data collection should be addressed through the HiAP approach which would inadvertently address all the concerns identified in connection with the Social Determinants for Health (SDH) in Ghana.

Finally, Borgonovi and Compagni (2013) have argued that despite the fact that healthcare is often portrayed as a cost centre and a drain on countries' resources, there is evidence to prove that investment in health and healthcare are sure strategies to reduce poverty, promote economic growth through increased productivity and higher household incomes. It is perhaps for this reason that has propelled Ghana's commitment to the promotion of healthcare in general but the unflinching pursuit of the UHC as a lower-middle income country in the West African sub region. The working hypothesis for this dissertation is ***"The Universal Health Coverage (UHC) objective - the National Health Insurance Scheme (NHIS) in Ghana cannot be achieved as it is, without an inter-sectoral approach"*** and the findings have proven the hypothesis true. The seeming tension between the optional/compulsory enrollment on the NHIS as pertains in Ghana currently (emanating from the foundations on which the NHIS was built – CBHI) and which is affecting the growth and potential sustainability of the scheme needs to be addressed. This has the potential to affect the country's attainment of the UHC within the stipulated time of 2030. Part of the recommendations made in this study is that government should rouse the latent enforcement aspect of the law on NHIS to allow for the entire population to enroll and there should be continued civic education (this mandate lies with another ministry for which the application of the HiAP has been recommended as well).

6 Dissertation Outline

This dissertation has been divided into three main parts namely the UHC goal and conceptual framework, the case of Ghana - general elements and the UHC journey and the final part, the empirical study. The objective of part 1 is to present the UHC goal in Africa and the conceptual and theoretical frameworks used in the dissertation. The second chapter of the Part 1 focuses on

themes covering the Soial Determinants of Health (SDH) and other institutional intiatives for health around the globe and the policy-making process.

Part 2 is a presentation of the case of Ghana, focusing on the health goal, the SDH and the UHC journey. The Social Determinants of Health is introduced in the chapter 3 – using the Dahlgren and Whitehead (1991) framework, a selection of key areas is made and issues of Ghana in that context are discussed. In the same chapter, the health goals, objectives and the general health system of the country are highlighted. The UHC journey of Ghana is raised for discussion under chapter 4 with the NHIS considered the primary policy under consideration with the alternative policy being the CHPS also mentioned.

The third and final part of the dissertation is focused on the empirical study and perspectives. Here, the chapter 5 is placed which focuses on the various methods – from the qualitative to the various frameworks used. Also, the context of the research is described here. The chapter 6 discusses the data collected and feedback from both the key informants and the subscriber- non-subscriber categories. A comparative analysis of the dissertation and that of a notable researcher is made to add value to the research findings. Chapter 7 which is the final chapter of part 3 discusses outcomes of the research – from both literature and empirical evidence and presents what is titled "perspectives" based some selected aspects of the Social Determinants of Health in the case of Ghana. There is a conclusion to the entire dissertation at the end of the presentation of the results and discussions.

PART 1: THE UHC GOAL AND CONCEPTUAL FRAMEWORK

PART 1: UHC GOAL AND CONCEPTUAL FRAMEWORK

Introduction

The objective of this part is to discuss the UHC in detail - how it's being implemented globally and subsequently, in Africa. It also discusses the Conceptual Framework for this dissertation and captures two main chapters – 'The global goal of UHC and its main challenges' and the 'Conceptual framework'. The goal of this first chapter is to present the UHC goal in the African context. The second chapter focuses on the conceptual and theoretical framework for this research covering the Social Determinants of Health (SDH) and other institutional intiatives for health around the globe. It also addresses the ultimate bedrock on which the UHC goal, concept and initiatives interact and through which the UHC is implemented in this dissertation being the policy-making process.

CHAPTER 1: THE GLOBAL GOAL OF UHC AND ITS MAIN CHALLENGES

Introduction

This chapter deals with general elements of health systems in African countries. Since over forty countries rely on donor support or have had relations with the International Monetary Fund (IMF) and World Bank (known for approaching developing and ailing economies with market-oriented prescriptions) but with a changed institutional dogma of expectations of what development should look like, it is important to pay attention to what it has translated into, in terms of development for the continent. Its importance is discussed with respect to policy decisions dependent on public expenditure in the Sub-Saharan Africa (SSA). Other development challenges which have a relationship with the broader issues of growth and health such as availability of a policy window, corruption and conflict are highlighted in this chapter. Developing countries are in much need for reinforced health financing policies. Inability to undertake sustained efforts at such policies have been the limitation at realizing expected outcomes from investments made. According to Rowden (2009), "where developing countries have put in place effective policies, they have been able to achieve universal coverage, effective risk protection and sustained improvements in health outcomes, and often do so at below-average levels of expenditure" (Rowden, 2009: 40).

Any effort at achieving strengthened health financing policies and systems require not only political will but also fiscal space. This chapter creates room for discussion of impacts of conditionalities emanating from Structural Adjustment Programmes (SAPs) associated with healthcare. This chapter presents a preamble to issues to be discussed in detail in part 2 in the context of Ghana which has had SAPs since the 1980s culminating in substantial somewhat poor social determinants of health (SDH) conditions prevailing in the country. It lays bare issues of whether the Sustainable Development Goals (SDGs) could realize significant gains (post the Millennium Development Goals - MDGs) and whether the UHC could attain appreciable levels especially in the context of fiscal space for capital expenditure in infrastructure, human resource development etc. which are contingent factors for access, and also an important aspect of the UHC. Under this chapter, the health system in Africa is discussed including a history of the user-fee removal policy, the disease burden with its healthcare financing approaches touched on.

Subsequent to this, corruption and conflict (1.2, 1.2.1 and 1.2.2) with their implications on health are discussed. Here, it must be stated that while the country under study is not a conflict-prone one, it is surrounded by countries which have had civil wars in the not-too-distant past which may have implications on the healthcare system of the case study. Under this chapter, Structural Adjustment Programmes (SAPs) and their impact on health are discussed in 1.3, 1.3.1 and 1.3.2. The chapter 1 then shifts to a discussion of the Universal Health Coverage (UHC) – the UHC in African countries (2), its definition and history (2.1), the different perspectives of the goal (2.1.2), challenges of implementation (2.1.3), measurement of progress towards the goal's achievement (2.1.4) and the progress made by different countries are captured under 2.2.

CHAPTER 1 NAVIGATION CHART

CHAPTER ONE The GLOBAL GOAL OF UHC AND ITS MAIN CHALLENGES	
Section 1: Health systems in African countries and main challenges	Section 2: The UHC in African countries: origin, definition and challenges
1.1 Africa's health care systems	2.1 Origin and historical background of the UHC
1.1.1 Africa's health care profile – the user-fees removal history	2.1.1 Definition and historical antecedence of the UHC goal
1.1.2 Africa's health care profile – the disease burden, support systems and the health care financing predicament	2.1.2 Different perspectives/conceptions of the UHC
1.2 Corruption, conflict and health care	2.1.3 Challenges regarding implementation
1.2.1 Corruption and its effects on health	2.1.4 Measurement of progress towards the UHC
1.2.2 Conflict and its effects on health	2.2 The progress by different countries towards achieving the UHC
1.3 Structural Adjustment Programs (SAPs)	
1.3.1 SAPs, Africa and impact on health	
Key words: UHC, Africa, Health care in Africa, UHC implementation	

Section 1: Health Systems in African countries and main health challenges

This section captures issues of concern in the environmental context of Africa, issues affecting development in general and health, specifically. In order to understand the challenges faced by Ghana, which is the country in focus in this dissertation, the sub regional context should be known. This dissertation is important in addressing the prevailing challenge of sustainability of the NHIS in Ghana and proffers some implementable views to addressing it. The working hypothesis was **"The Universal Health Coverage (UHC) objective - the National Health Insurance Scheme (NHIS) in Ghana cannot be achieved as it is, without an inter-sectoral approach".** Some of the challenges being faced in Ghana mirror similar happenings in other countries within the sub-region. In this section, the objective is to discuss the issues related to health that have a relationship with development and the efforts being made to address them in Sub-Saharan Africa (SSA) hence the discussion of such issues as the history of user-fee removal, disease burden of the continent, conflict and corruption and the influence of market-oriented policies on healthcare decisions. In this section, Africa's healthcare system is discussed (1.1) with issues such the history of the user-fees removal and the disease burden of the continent (1.1.2) raised. In 1.2, corruption, conflict and their effects on health are described and although conflicts do not occur often in Ghana, the former is prevalent in the country. Sub-section 1.3 raises the issue of Structural Adjustment Programmes (SAPs) and its impact on health. This was worthy of note because Ghana, the country under study has a long history with this programme and has since 2015 being implementing policies under its latest agreement. This has potential effect on the ease or otherwise of implementing new health initiatives in the country.

1.1. Africa's healthcare system

1.1.1 Africa's healthcare profile - the user-fee removal history

The post-independence era of the 1950s and beyond, many of the African countries at the time made efforts to offer free medical care to their people. In the face of harsh economic realities in the 1970s and their effects on social spending self - financing of healthcare options emerged in countries in the West and Central parts of Africa. Examples are cited in countries such as Zaire's Kasongo project and Nigeria's Shomulu clinic located in Lagos. Aid had started trickling in, in

support of social services which by the late 1970s and early 80s had seen a shift in focus towards projects in social services (aid inched up to 50 percent from a low 10 percent in the previous decade) but aid does not come cheap - it "costs money" and certainly some of the aid that had been secured from the international development community had to be paid back albeit with interest and hence the introduction of cost recovery schemes, examples such as revolving drug funds' establishment (Soucat et al., 1997: 1; Moyo, 2009[7]: 20). This cost recovery movement had hit several African countries by the mid-1980s, and community-level healthcare financing systems had started operations in earnest in more than 50 percent of health districts in Zaire, Benin and Guinea. The adoption of such cost recovery schemes in the latter two countries however took a different approach with shared responsibility of quotas among three main stakeholders namely the community, government and donors (Soucat et al., 1997: 1). The joint introduction of the Bamako Initiative (BI) in 1987 was stimulated by these health financing events happening on the continent by the African Ministries of Health. Two notable components of the BI were the "community financing based on selling of essential drugs" and "community management". With the main objective of sustaining efforts at increasing population health coverage through strengthened health systems and improved cost of care, the user fees had come to stay in African countries' health systems (Soucat et al., 1997: S112).

For decades, user fees prompted long drawn debates in the international health arena with a stalemate observed among those in support who promoted it in the 1980s as a means of financing healthcare in low-income countries and those who have reservations about its impact on the poorest sect of society (Meessen et al., 2011). The instance of the Sierra Leone office of UNICEF reporting of the practice of the collection of user fees at health clinics serving as an important barrier to healthcare access and a call for its abolishment in 2008 is cited by Rowden (2009: 162). The discussion rages on with strong cogent points and evidence made for both sides of the debate. It is debated that user fees, may serve as a barrier to users, but it possesses its merits as a means of providing a continuous and sustained resource base for expenditure in light of deprivation of any other source (Meessen et al., 2011). Another positive angle is taken with the introduction of evidence gathered from studies that indicate that positive results on service utilization have been recorded when user fees have run alongside with supply-side improvements

[7] It must however be stated here that Moyo's work, **'Dead Aid: Why aid is not working and how there is a better way for Africa'** represents the opinions of a liberal economist and was not considered as an economic theory.

in the system relative to periods of no user fees (Barroy, 2014: 68). Some other studies have gathered some more positive aspects of the collection of user fees in areas of improved service delivery and staff motivation emanating from the autonomy enjoyed in retaining aspects of the user fees in Mauritiania, Niger, Cameroon (Barroy, 2014: 68). It is noted that retaining facility-based user fees creates room for staff to make payments for recurrent and or variable costs at the health facility in the absence or infrequent substantial transfers of financial and material support from the central level (Barroy, 2014: 68).

A definitive stance on the user fees debate is not easy for countries and their development partners in light of limited resources and ever-increasing demand for healthcare (Meesen et al. 2011). A study conducted in 2013 on Global Health Actors (GHA) on their perspectives of user fees as a means of health systems financing was insightful. The research findings give an indication of the position held by some GHAs on the subject of user fees as indicating that there is indeed a non-verbal acceptance of it being on one side as an inequitable way of financing health system and additionally, promoting inaccessibility to healthcare. This consensus is evidenced in the rhetoric but not translated in deed. While some GHAs are of the opinion that health services should be made free, others (including the intergovernmental sub sector) hold the pristine position that the alternative social-protection focused or risk pooling means of financing should be sought and endeavor to avoid the discussion of "free healthcare" (Robert and Ridde, 2013). The mixed research outcome does not seem surprising; while some international non-governmental organizations have been focused on their agenda of promoting free healthcare, some GHAs are reported as directly and indirectly influencing the implementation of user fees. Two organizations' that inspired the user fees implementation in LMICs are noted as the UNICEF and WHO (openly supporting the Bamako Initiative which underpinned the user fees mode of healthcare financing in LMICs) (Robert and Ridde, 2013). The World Bank's indirect promotion of user fees implementation in the sub-region is captured in their efforts of the 1980s with the introduction of SAPs into many of the African economies with their attendant conditions of a reduction of public expenditure in the social sector compelling many to seek alternative sources of financing for healthcare. By influencing the power relations among countries and insisting on fiscal discipline and an adherence to conditionalities, they covertly promoted the expansion of the ideals of the BI in many developing countries (Robert and Ridde, 2013; Moyo, 2009: 20-23). The themed "cost recovery" healthcare financing policies introduced

into health systems have been implemented in SSA countries as captured under the BI (Stierle et al., 1999). Ridde et al., 2018 wade into the debate with insights collected from Rwanda, Ghana, Mali and Senegal and have drawn the conclusion that 'User fees exemption policies, while often beneficial in terms of increasing people's use of care and reducing inequalities in access [......] is perhaps no longer the concept in which to invest if we are aiming for UHC'. This commentary while acknowledging the benefits of user fee exemptions, contrasts it with more participatory and sustainability-ladden approach which could ensure a more-encompassing approach of compulsory premium-paying approach. The shift in the focus on user fees as a means of healthcare financing, has been largely blamed on evidence that contradicted its impact especially on the poor – Rowden (2009: 156) cites examples of declines in access to healthcare when user fees were introduced in Zambia (by one-third), Tanzania (50 percent), Niger (41 percent) and Ghana experienced a decline in outpatient attendance by 40 percent.

1.1.2 Africa's healthcare profile - the disease burden, support systems and the healthcare financing predicament

Of importance is the matter of life expectancy and according to the WHO (2018: xi), the healthy life expectancy (this represents the measure of life expectancy adjusted for years spent with disability) has been observed to increase from 50.9 to 53.8 over a three-year period (2012 – 2015) and despite this, the African continent is reported as having the lowest levels of healthy life relative to other regions (it is the only WHO region with expectancy under 60 years). The previous paragraph's indication of health financing issues associated with Africa indicates a one-sided view of the healthcare challenges facing the continent. Of essence also is that the disease burden that these financing mechanisms were and are meant to address. Generally, the continent has recorded reduced rates of morbidity and mortality with noncommunicable diseases (NCDs) not showing any signs of slowing down with people identified in the the age cohorts of 30 – 70 years having the propensity of dying from one of the major NCDs being alcohol abuse, unhealthy diets, substance abuse and inadequate physical activity (WHO, 2018: xii, 15). The disease burden, as captured of the SSA region is on a heightened level with continual influences of demographic and epidemiological changes occurring on the continent on the existent burden of disease of infectious diseases, injuries and others. The situation of healthcare in the public

sector is that it is saddled with poor infrastructure and overburdened limited human resource base. Government healthcare is poorly resourced in general, with poor health system infrastructure and limited human resources. The influence of the private sector on the health sector is gradually becoming prominent in the provision of better-perceived services in comparison to the public sector (Young et al., 2016). Of grave concern is the incidence and management of HIV/AIDS which in 2007 claimed over 2.7 million lives globally out of which three-quarters came from Africa. Despite efforts made internationally, there are an overwhelming number of reported cases of young people and women living with the disease in the SSA (Rowden, 2009: 9 - 12).

According to Rowden (2009: 166 - 169), the current trend in financing health needs of people in developing countries is social health insurance or tax-based systems. By this approach, taxes collected as revenue are directly used in financing public healthcare services aimed at reducing catastrophic health spending on the populace. This approach acknowledges the failures of user fees as a means of financing healthcare, that there is broad concensus on this trend of a shift from out-of-pocket to SHI.

Evidence gathered in the early 2000s, indicated that higher income groups in developing countries enjoyed the benefits of publicly financed health services, to the detriment of lower-income earners - 15 countries emerging out of a study for 21 gave credence to the earlier finding while only 4 out of the lot favored the poor through subsidies (Cotlear et al., 2015: 35). Another study capturing the situation of some 56 developing countries discovered that Millennium Development Goals' (MDGs) programs aimed at expanding coverage tended to favor about 20 percent of the richest upper quintile than the lowest 20 (Cotlear et al., 2015: 35). Thus, there is inequity in healthcare in developing countries.

With the potential for the phenomenon above where most impoverished sections of society are left untended, countries seeking to provide healthcare using the UHC approach have devised mechanisms within their systems to address access to healthcare (financially and geographically) with a focus on lower-income populations. Rowden (2009: 162 - 165) explains that this emphasis on SHI is considered critical not only to local governments' efforts at addressing healthcare access but remains a concern for the international development partners. He cites efforts by the

WHO in making the call for universal coverage and that of the European Union (EU) emphasizing the call for universal social health protection. Cotler et al. (2015: 18 - 46) call these as the "bottom-up approach" health coverage expansion. Fundamentally, this approach takes cognizance of the fact that the different strata of society require different strategies to meet their health needs and with this in sight, the bottom-up approach has seen prospects for implementation. The implementation of this approach has been made possible in developing countries also because such countries have developed enhanced capacities aimed at enhancing healthcare coverage (Cotler et al., 2015: 18 - 46).

While there is a place for the private sector in operating health insurance schemes, there have been reports of poor service delivery. But the argument is made for an acknowledgement and promotion of their services, as the World Bank has explained that 'almost two thirds of total health expenditure and at least half of health-care provision in Africa are accounted for by the private sector' (Rowden, 2009: 158). There are known challenges associated with healthcare financing by developing countries and since the context of countries participating in the UHC implementation remain different, an appreciable level of innovation is called for. Rowden (2009: 166 - 167) states that for some countries in the middle-income bracket, the SHI has been successful in implementation while not so much in countries with low-income status. He states that a mixed approach is needed in specific cases based on benchmarks, that "making public health services work is the only proven route to achieving universal and equitable healthcare". He emphsises the difficulty in achieving success in low-income countries lies in first the large informal sector and second, the technical and administrative capacity of those governments in collecting premiums which are key to the expansion of SHI coverage (Rowden, 2009: 43).

According to Cotlear et al. (2015: 30) any well-designed UHC program should address issues of both the "financing gap" and the "provision gap" within whatever resource allocated with a focus on a "pro-poor" approach and innovative ways of providing wide-ranging incentive packages that meet the health needs of the poor - this position seem to be a consensus agreed among policy-makers on UHC investment approaches settled on with emphasis on an equity-focus on health system.

1.2 Corruption, conflict and healthcare

Among some of the noteworthy issues affecting Africa's healthcare system is the issue of corruption and conflict. Corruption here will be addressed as that which affects service quality and accessibility in the health sector. The aim of this sub section is to discuss one of the most debated over issues in Africa's development. The corruption and conflict issues are important as they saddle the healthcare system and its potential to make fiscal space to accommodate new and innovative health policies. As indicated in the previous sub section, there is a challenge of an ever-bulging disease burden accompanied by weak healthcare support systems which require attention and fiscal space.

1.2.1 Corruption and its effects on health

The incidences of corruption are not new, it has been around for a while (Tanzi, 1998: 564). It is explained that while corruption has been defined severally (with each robbing the phenomenon of a valuable characteristic in definition) and has many faces, like the proverbial elephant, it is not difficult to detect upon close inspection by different observers however, its detection is not easy as corruption tends not to occur in the full glare of the public (Tanzi, 1998: 564). The most widespread definition given by the World Bank of corruption is "*the abuse of public power for private benefit"*. From this definition, Tanzi (1998: 564) adds that it should not be misconstrued that corruption happens in the public sector alone but also within private sector activities (especially in procurement and employment), corruption is very much prevalent.

BOX 1: DIMENSIONS OF CORRUPTION

Corruption has several dimensions and can be categorized into various types namely; bribery, illegal payments, theft (which is a common form of "petty corruption" includes absenteeism from paid work and embezzlement), state capture and political corruption. They define bribery as referring to the propositioning of a person in a position of (such as a civil servant) with a "reward", or the requesting for same from a private citizen with the promise to offer a favor or provide a service which ideally should not attract any such "reward" – a persuasive

reward. A further explanation by them reveals that bribes by themselves suggests some type of enticement either in material or financial benefit to a person in power and that they do not always fall into the category of the earlier two but could be in the form of sexual favours or the promise of a reciprocal future exchange of favors. Simply, bribery connotes corruption and as explained earlier, it is difficult to detect and also sometimes not so easy to differentiate from extortion and illegal payments (Seppanen and Virtanen, 2008). The definition of extortion is given as, "the unlawful demand of property or money through the use of force or threat" and also falls under a category of corruption (Seppanen and Virtanen, 2008).

Source: Seppanen and Virtanen (2008)

According to Sappanen and Virtanen (2008), Transparency International's definition of illegal payment makes an attempt to distinguish the various types of bribes in that the former could easily resemble legitimate payment for a service, such as the request for consultation fees at a health facility under circumstances where such fees have been waived free of charge by law but for which even some form of formal documentation is made such as the issuance of an official receipt but the destination of such collected fees may be unknown. They continue to explain that in the best case scenarios, such payments received at the facility level are used as stop-gap expenditures at facilities where due to delayed or non-receipt of adequate resources from the central government but since there is not definite effort assigned to such fee collections, accountability issues for such still leave much to be desired and thus, contributes to the declined transparent practices in public administration. They add that, in some cases these illegal payments/fees prevent access to the poor for basic public services.

Some pertinent examples of such phenomena can be cited in the health systems at the district level in African countries where due to the introduction of decentralization as part of health sector reforms, decision-making powers have been ceded off to staff at the district level. But whilst the intent of the decentralization approach is relevant and has empowered district level managers and granted them more autonomy in matters concerning budgetary resources, the allocation and release of funds remains at the central level of government where due to perpetual inadequacy of resources and somewhat irrationalized systems are unable to release funds for

utilization at the district level where primary healthcare is domiciled (Asante et al., 2006: Saleh, 2012a: 11 - 12).

First, due to the decentralization approach to governance in the public sector in many African countries, Ghana included, such practices as "coping mechanisms" in health systems is not uncommon. In a research conducted by Asante et al. (2006) of eight districts (four districts each from two regions in Ghana) revealed that funds for non-salary related expenditures were budgeted for and released on a quarterly basis, with expenditures for service and donor funds issued by cheques. Evidence gathered indicated that funds for administrative expenses were often delayed (with some delays as worrisome as non-arrival of two quarters of the year's funds). This challenge encouraged such practices as unauthorized "borrowing of cash" from the internally generated fund (IGF); purchasing of supplies (leaving room for the purchase of "ghost" supplies – supplies not formally recorded and whose demand may not be existent) on credit with the view to make payments in subsequent year with funds carried over from previous year (the law prohibits this practice as all funds allocated and released are expected to be either spent or returned to government chest, waiting another round of complicated allocations and releases from the central level) (Asante et al., 2006). **A similar situation is cited in a study by Boidin, Laidet and Manier (2013: 2) in Mali** where due to the decentralized system of healthcare administration, some community health centres (also known as CSCOMs) have been observed as diverting funds for various purposes by the community health associations (ASACO). Notably, the authors indicate that this phenomenon may not necessarily be the "fault of the current staff". These practices, unlawful in nature but necessitated by flaws in the health systems in both Ghana and Mali, are examples of **"coping mechanisms"** which reveal a wider challenge of several ways in which government funds could be misappropriated and the weaknesses persistent in a weak **decentralization system**. Rowden (2009: 159) has however argued that, decentralizing the health systems in developing countries in the true sense of the concept without corresponding strengthening of local capacities will prove futile and lead to potential devastating health outcomes. He states that, 'Overly premature decentralization has created a process by which certain decision-making powers over planning and management responsibilitiesand money are taken away from the central line ministries in the capitals and transferred to the lower levels of government n the provinces, many of which are ill equipped and lack the trained personnel to effectively handle the new duties, and in the end the cumulative

result is an overall weakened public health sector – weakened both at the centre and at its lower levels'.

Second is the example of the NHIS in Ghana, in 2009, which experienced a change in management consistent with the political norms of the country since the onset of democratic rule (after a change in government, all public sector related institutions replace top management with new to pursue the development agenda for that particular political party/regime). The NHIS in that period was fraught with issues of lack of accountability, corruption by scheme staff and service providers, falsification of records of subscribers, over-prescription of medicines and over billing of patients, just to mention a few (details of the challenges of the NHIS are captured in Chapter 4). The system lacked transparency and inadvertently affected the fiscal space for delivery of quality care for subscribers and the payment of debt owed service providers running into millions of cedis (Ghana Health Insurance Review, 2011: 7 - 8). The corruption in the NHIS system perpetuated by internal staff in collusion with service providers and sometimes patients themselves left the scheme financially hemorrhaging and negatively affecting the poor as most service providers who had not been paid for months started turning away the sick simply because the reimbursement of the costly healthcare services could not be assured (Ghana Health Insurance Review, 2011: 7-8). According to Witter and Garshong (2009), "reports of informal payments were rare in the years before the NHIS, with user fee collection closely controlled at health facility level". "In the past year, reports of informal payments to health workers have grown. Examples of reported informal payments by clients include: charging for services out-of-hours; asking patients to pay for drugs which are said not to be in stock and; asking patients to pay for 'better' drugs, said not to be provided under the NHIS."

Theft is another category of the corruption discourse and as explained by Seppanen and Virtanen (2008), public servants at all levels of employment have been known to **steal government supplies (from stationery, vehicles to equipment)**. Other aspects of corruption are absenteeism (theft of paid working time) and embezzlement which represents the misappropriation of funds or property belonging to the state for personal profit. Corresponding with such activities is the falsification of official documents with personal gain as intent, legally called fraud. In 2009, it was uncovered that falsification of documents was one of the critical challenges facing the NHIS for which the system was left not working to optimum potential.

Political corruption is the last of the categories to be described here. According Seppanen and Virtanen (2008), it is manifested in favouritism, including clientelism, cronyism and nepotism. Cronyism is defined as giving preferential treatment to friends and associates such as offering government contracts, employment opportunities to members of same political party whilst in a position of power regardless of their merits in terms of qualification etc. Tanzi (1998: 565) cites an example of one president of a country who built an airport in his small hometown regardless of demand for its use in that particular location, this is a form of corruption which may not elicit direct payment of a bribe but could facilitate his reelection.

Tanzi (1998) explains that there are **two causes of corruption - the direct and indirect forms**. According to him, direct forms of corruption can be demonstrated through the roles played by the state in terms of regulations and authorizations for licenses, permits and the authorizations of all manner of tax collection and management and the decision-making for all expenditure (capital investment projects, procurement spending etc.) and also with the sole responsibility of the provision of goods and certain services with other discretionary decisions, all these he considers as rather monopolistic (Pgs. 565 – 571). As part of the indirect causes of corruption Tanzi (1998: 565, 571) cites the quality of internal bureaucracy (which can affect the cost of doing business in terms of delays); how high or low public sector wages are (the higher the wage level, the lower is corruption); penalty system (the penalty structures for offenses serve as a vital deterrent to corruption in that country); institutional controls; transparency of rules, laws and processes; and finally, the type of leadership displayed (when the top political leaders provide good examples). Some examples are given as, in an African country, a president refused to fire ministers widely reputed to be corrupt. In an Asian country, a minister that was accused of corruption was simply moved to head another ministry. In a Latin American country, a president who was planning to create an anticorruption commission proposed to appoint as head of this commission an individual widely reported to be corrupt. Examples such as these do not help create the climate for a corruption - free society (Tanzi, 1998: 571 – 576).

The problem of corruption as pertains to the NHIS and its operations; affecting beneficiaries have been reported over time in the country. In 2011, Oxfam of UK in research collaboration with three Ghanaian NGOs (ISODEC, Essential Services Platform of Ghana and Alliance for Reproductive Rights) made some startling allegations against the NHIA which saw subsequent

rebuttals in the form of a publication. The Reports' revelations of lack of transparency, mismanagement and misappropriation of 45 percent of the NHIS Fund was called inaccurate and even "laughable" indicating that the National Health Insurance Fund (NHIF) and all other such financial records were subject to public audit (Ghana Health Insurance Review, 2011: 44 - 52). In 2016, Ghana Integrity Initiative (GII), the local representation of the Transparency International released a press statement talking about the global perception of corruption. The press release also cited Ghana as scoring below the 50 percent pass mark for countries concerning the prevalence of corruption in the public sector[8]. These and many more are the reports over the years that are received concerning corruption that affects the public sector including health that affects the developmental growth of Ghana.

The persistent corruption problem in Africa can best be described as a development concern (Lawal, 2007). It is pointed out that, the level of development in any country can be measured against such indicators as the type of leadership, its political culture and corruption (Lawal, 2007). Tanzi (1998: 559, 585, 590) observes that the ways in which corruption affects economic growth and by extension, development are several. In the 2005 Human Development Report indicates that 30 out of the 32 countries in the "low human development" category are in SSA. Of the 38 severely indebted low income countries, 32 are alarmingly in the sub-region (Lawal, 2007). The expenditure of the majority of these same countries on health and education are on a declining slope as they in spite of promises of debt relief and increased aid flows, sometimes, never translate into actual aid (Ndikumana, 2006; Moyo, 2009: 74). The impact of corruption on the health and education sectors have been noted (Tanzi, 1998: 559, 569, 585). Within the health sector itself and in the provision of health services specifically, corruption happens in the form of the collection of bribes by doctors and other health professionals with the promise of providing better and faster services to patients (Tanzi, 1998: 585).

Since the post-independence era for most African countries, a large amount of aid, several SAPs and borrowed monies have found their way into the economies of many African countries aimed at development but due to corruption and abject waste (through conflicts and others), there has not been commensurate social development for the continent. A respectable portion of all such

[8] The corruption perception of Ghana and its ranking globally: https://www.tighana.org/assets/Uploads/GII-Press-Statement-on-the-CPI-2015.pdf

funds have been embezzled and have served to build the private investment bases for many public officials and politicians. Interestingly, research indicates that "Africa is a "net creditor" to the rest of the world in the sense that outflows of funds vastly exceed inflows and private assets held abroad which exceed the continent's liabilities to the rest of the world" (Ndikumana, 2006). Meanwhile, domestically, petty theft and embezzlement among politicians and career bureaucrats and civil servants have additionally robbed countries of natural resources and other assets (Ndikumana, 2006; Moyo, 2009: 50).

Corruption has the potential to reduce government revenues in the areas of tax evasion, improper tax exemptions and weak tax administration, massive "looting" of state resources by politicians, private sector, bureaucrats, civil servants etc. The stolen wealth and personal fortunes of some heads of state in Africa were published by French weekly in May, 1997 (Lawal, 2007) and the revelations are telling: President Henri Bedie of Ivory Coast - $300 million; General Sani Abacha of Nigeria - $20 billion; President Denis N'gnesso of Congo - $200 million; President Mobutu of Zaire - $4 billion; President H. Boigny of Ivory Coast - $6 billion; General Ibrahim Babangida of Nigeria - $5 billion and a lot more others. The effects of these in the long term on African countries' social development would be devastating (Lawal, 2007). Corruption's impact on development is massive, as it can reduce government resources for current expenditure and capital investments geared towards building of hospitals, rehabilitation of dilapidated health facilities (and increased operational level operational and maintenance (O&M) expenditure), building roads to help improve access to healthcare in "unreachable" rural communities, increase investment in the training of health personnel etc. (Tanzi and Davoodi, 1998: 3, 10). Regrettably, corruption is known to be most prominent in the infrastructure sub sector of the economy (Tanzi and Davoodi, 1998: 9 -10, 18 -19) where the ripple effects on public health are felt the most due to the effects of infrastructure on social determinants of health (using the Dahlgren and Whitehead (1991) framework, areas such as agriculture and food production, education, healthcare services, housing and others can be cited). One of the issues that emerged in the 2016 election as a priority for citizens was the issue of corruption. Kusi (2015) gives an apt description of the corruption situation in Ghana which has a direct impact on availability of resources to implement social protection policies/interventions including those associated with healthcare. According to him, there is the perception by some Ghanaians of a corrupt public sector with an added view that government has failed to address this prevailing problem. Evidence in support of

this view has emerged over the years with reports of several misappropriated public funds intended for social projects and programmes. According to Transparency International's 2014 Corruption Perception Index, Ghana is ranked 61 out of 175 countries, with the government attempting to rectify the situation.

1.2.2 Conflict and its effects on health

Although **Ghana is not known as a conflict - prone country, it has served as a safe haven for refugees from neighboring countries - Cote D'Ivoire, Sierra Leone, Togo and Liberia. With refugees come the overburdening of the health facilities available for use by both citizens and refugees and other health related issues.** The discussion of conflict in this sub section is therefore for the benefit of putting the UHC journey of Africa in general in perspective and what conflict has contributed to the dwindling fortunes of infrastructure and financial resources, and their bearing on healthcare.

Child health is dramatically affected by armed conflict around the globe. The last decade has witnessed between 14 and 21 major armed conflicts annually (Rieder and Choonara, 2011). Out of every six children, one is recorded as being resident in an area of armed conflict and with such conflict occurrences, are the deaths of civilians (Rieder and Choonara, 2011). Sexual violence (SV) is a common feature during conflicts (Watts et al., 2010). SV represents an abuse of human rights with lingering lifetime health effects. According to Rieder and Choonara (2011), despite the fact that globally, recorded incidences of armed conflicts in and among countries may pale in significance in number, their impact on humanity, especially children is staggering. They observe how troubling it is to note that over the last century the ratio of civilian to military deaths has risen progressively (Rieder and Choonara, 2011).

In a short paper that investigated the socio-demographic distribution of excess mortality in four African countries that have experienced an episode of heightened violence and conflict and which illustrate a variety of conflict profiles, de Walque and Filmer (2012) made interesting revelations about the relationship between the conflicts and demographic structures of the lives that were lost. The focus of the investigations was on the Democratic Republic of Congo (DRC) which, since the late 1990s (i.e. in the 1995 - 2000 and 2000 - 2004 periods) saw an onslaught of

a civil war with sporadic bouts of violence; the second, Ethiopia's recorded in the late 1980s, and a border war with its neighbor Eritrea lasted for two ghastly years (1998 to 2000); the third was Rwanda's ethnic violence – with international recognition as a genocide in 1994; and lastly was Sierra Leone's civil war which ran from 1991 to 2001. According to the research, in each case of conflict, the concern most apparent was the mortality rates – even though the impact on the various socioeconomic groupings were different in terms of mortality figures. Rwanda's cases of recorded mortality was rather shocking with high mortality rates recorded within a short space of time – the mortality spikes in the 1990 - 1994 and 1995 - 2000 periods were sharp. While mortality increased for both men and women, it was rather prominent among men, more especially the educated urban men. And within the period of conflict (in the mid – 1990s especially) for DRC, in terms of mortality, there was a marked increase in mortality among men in rural areas and those with less education at the primary level – with mortality rising from an estimated 2 to 4 percent by 2000-2004 (de Walque and Filmer, 2012). Ethiopia registered an interesting dichotomy in the mortality rates between male and female mortality rates with adult men being a third higher than women. In Eritrea, the period of the mid to late 1980s witnessed mortality "spikes" among urban and more educated. Lastly, with Sierra Leone's decade long civil war, there were recorded adult mortality increases across all groupings. De Walque and Filmer (2012) conclude that understanding how conflicts have affected different socio-demographic groups is crucial to inform policy during reconstruction and reconciliation efforts, and by extension development efforts.

A return to the focus of impact of conflict on children through the work of Rieder and Choonara (2011) reveals that the effects of the different types of conflict with, 'Terrorist attacks on civilians have resulted in significant numbers of children being killed or injured. Internal conflicts are usually associated with even higher ratios of civilian to military casualties than the conflicts between nation states'. They emphasize the importance of recognizing that an end of violence in a country does not necessarily result in an automatic end to its effects on child health. Recognizably, the psychological trauma alone following a period of conflict is a significant health problem in children and additionally, the residual landmines in such conflict-ridden areas tend to cause severe injuries and death, several years after the conflict.

The relationship between conflicts and health are varied. According to Watts et al. (2010) the SV categorized under forced marriages, gang rape (for both men and women) and sexual slavery are some of the cruelties experienced during conflict which sets the stage for many health-related challenges such as malnutrition, sexually transmitted diseases, unwanted pregnancies etc. but unfortunately, reportage on some of these focus mainly on mass rape (Wakabi, 2008; Plisik, 2009). In the example of Rwanda the incidences of HIV infections recorded among rape survivors post - the genocide period was a staggering 70 percent high, with 0.2 percent percent of women in Cote d'Ivoire being survivors of sexual violence and that of Liberia being, 35.3 percent (Watts et al., 2010).

Rieder and Choonara (2011) present in their article, **Armed Conflict and Child Health**, rather worrisome dimensions of effects of conflict. The lives and the economic potential lost to conflicts in Africa remain a concern, a concern that can only be understood and appreciated in the rebuilding and redevelopment stage of the countries. The children who, but for the period of conflicts, should be in school earning an education in preparation to contribute to the development of their countries and continent, become witnesses and participants in wars that leave them scarred for life with the prevalence of anxiety and post-traumatic stress disorders (PTSDs). For instance, the Rwandan genocide is on record as the most violent conflict recorded in modern history registering more than half a million civilians murdered within the space of a few months. A study conducted of 1,500 children and adolescents in Rwanda a year after the conflict period reveals that incidences of possible PTSDs among them were as high as 54 percent to 62 percent (Neugebauer et al., 2009).

1.3 Structural Adjustment Programmes (SAPs)

1.3.1 Structural Adjustment Programmes, Africa and impact on health

The era between 1950s and 1960s saw many African countries - over thirty-one of them break out of the mold of colonial rule to exert control over their own development agendas - Ghana in 1957, Kenya in 1963, and Malawi and Zambia in 1964, just to cite a few. This independence however did not seem to have emancipated the continent from dependence on their colonial masters and the West generally from aid. This dependence on aid however has not been peculiar

to countries on the African continent alone but to most countries categorized as developing or low-middle income. The aid that has often been given themed as development-oriented have often had dire consequences, sometimes not directly, on the same people in the long-term due to conditions attached (Moyo, 2009: 13). The history of market-orientation and its impact on the development of LMICs leave many questions unanswered about the ability of Sub-Saharan African (SSA) countries in the achievement of the UHC goal. The historic perspective would render much meaning to the current state of developmental affairs in some SSA countries and their readiness to fully respond to the call for the adoption of the global health goal of UHC and make logic of why some developing countries pursue SAPs. Indeed an interesting connection is made by Amartya Sen (1999: 619) in an effort to position health in development, between economic wealth and that of the quality of life that a people can lead. It is explained that the relevance of wealth is found in the basic freedoms that it can afford including good health and longetivity (in addition to some other influences). Also, the connection between health and wealth which has been established is said to be much more appreciable when viewed from the lower ranks of affluence, that the healthier a population, the easier and better their contribution to economic growth (Bloom et al., 2004), noted is the difficulty faced by countries which do not have strong health systems in achieving such sustained growth (Sta°hl et al., 2006). According to Loewenson (1993), the World Bank/IMF SAPs have been introduced in over 40 countries of Africa but Rowden (2009) points to the disastrous consequences of market-oriented policies on social expenditure including healthcare systems in developing countries and adds that "….the effect of adjustment policies on poverty is more difficult to judge" (Rowden, 2009: 79).

Loewenson (1993) provides evidence that indicates that SAPs have been associated with increasing food insecurity and undernutrition, rising spate of ill-health, and increased inequities in healthcare access in two-thirds or more of populations found in African countries that already live below acceptable poverty levels. The effects of SAPs have been wide-spread, affecting health policy implementation where they exist, and where there is a non-existent effective health policy framework, there has been an inadvertent disparity created between the affected communities and policy makers. This has also in a way formed a basis of supplanting the underlying principles of equity in and social responsibility for healthcare by policies which place

the responsibility of healthcare access right at the door-step of the individual when health is promoted a commodity.

Both the direct and indirect impacts of these SAPs in Africa can be traced to several health factors such as the declines in life expectancy witnessed in some African countries which can be described, at best, as most catastrophic: from age range declines from 62 to 46 in South Africa; 58 to 37 in Lesotho; 45 to 38 in Malawi; 56 to 39 in Zimbabwe; 49 to 36 in Zambia; and 57 to 38 in Botswana (Rowden, 2009: 153). The connection of health to all sectors was established in the Alma Ata Declaration in (1978). The number of preventable deaths in Africa is rather disastrous and calls for attention; a 74 percent rate of deaths recorded in Africa which has been traced to communicable diseases, maternal related causes and perinatal conditions and nutritional deficiencies. In sum, these deaths are traceable to poverty and underdevelopment but could have been prevented, with malaria playing a major role in the demise of populations, especially children. These are largely preventable diseases and are directly related to poverty and underdevelopment. In the meantime, malnutrition as a key factor rendering African populations susceptible to diseases and infections is on an increasing trajectory. As reported by an FAO report on the State of Food Insecurity in 2005, there has been a substantial upsurge in the percentage of underweight children from the periods 1994 to 2004 in some countries on the continent, and a related increased rate of more than a recorded 20 percent undernourished populations in countries such as Chad, Mali, Senegal, Sudan, Angola, Burundi, Zambia and Zimbabwe. Additionally, a strong association has been made between hunger and the populations living under the poverty line (FAO, 2015 Regional Overview of Food Insecurity, Africa report). Forward-looking in a decade however, contained in a United Nations Food and Agriculture Organization (FAO) 2015 Regional Overview of Food Insecurity, Africa report indicates that, the SSA region is still faced with the formidable challenge of rapid population growth which does not correspond with the capacities of countries in the region to consistently supply and provide access to food. An annual population growth rate of 2.7 has been recorded (a rather significant increase from 507 million to 936 million) in 2013 alone (FAO, 2015 Regional Overview of Food Insecurity, Africa report).

BOX 2: INDIRECT CONSQUENCES OF SAPS AND IMPACT ON HEALTH

Some of the indirect consequences have been on a slashing of healthcare expenditure and other related sectors which have a bearing on health, and for these reasons, this sub-section remain relevant. These consequences often affect the levels of poverty of the people who sometimes find it difficult to afford healthcare (for which the call for UHC must be heeded to) and other basic necessities like good nutrition, sanitary environments, education and others. Ghana has had a long lasting relationship with aid. A look at aid here in the context of the International Monetary Fund (IMF) and World Bank is critical to SDH in the policy framework of development and also, critical to the discussion of UHC. The discussion here is contextualized not only to African countries dependent on aid but by extension to Ghana.

Source: Author

In the past two decades (1990 – 92 and 2012 - 14), food availability in the SSA region has witnessed an increase by 12 percent, and additionally, those countries in the sub-region which have experienced economic growth, have also had increased food availability. For instance in the case of South Africa, there has been radical reduction in the rates of poverty from 26 percent in 2000 to 9 percent in 2011, a marked 64 percent decline recorded; Niger has had poverty rates reduced by 48 percent within the periods 1994 – 2011; and Ethiopia has recorded a 33 percent decline in poverty rates in the periods 1999 - 2011. Rwanda and Mali also have witnessed declines of 21 and 17 percent in poverty rates for the periods 2000 to 2011 and 2001 to 2010, respectively (Rowden, 2009). Five countries are recorded as being on course to meeting two World Health Assembly (WHA) targets, with 20 countries on course for meeting one target while 20 more countries are experiencing difficulties and are off course for attaining any of the targets, according to the 2014 Global Nutrition Report (Rowden, 2009). A chronological relationship is made between the onslaught of poverty and population's susceptibility to diseases explaining that to the fundamental understanding of the Alma Ata consensus, poverty tends to exacerbate the effects of malnutrition, which subsequently increases population's susceptibility to HIV/AIDS and other sexually transmitted diseases, and further, access to basic social amenities, especially the access to healthcare is greatly influenced by an individual's social gradient, resulting in poor people's less access to healthcare and treatments. He cites that poverty, for instance, is known to increase people's likelihood of taking up high-risk occupations

such as prostitution, and in the example of Ghana, illegal mining and e-waste scavenging (to be discussed in detail in sub section 1.2.7) are some high-risk-health impacting occupations engaged in by a significant number of Ghanaians. Marmot (2004: 1 -3) also makes a connection between levels of affluence for both individuals and nations, and susceptibility to diseases and eventual life expectancy.

Rowden (2009: 30-37, 79, 138, 193) asserts that in the midst of a financial crunch, investment expenditure in such settings as in Africa see the first cuts in areas of consumption even in healthcare delivery. It is explained that **governments find it difficult to increase expenditure on its absorptive capacity for employment creation avenues for all sectors including healthcare**, and adding on to the influence of conditionalities often imposed by the IMF and World Bank, **lay-offs** are experienced leading the discussion to another sensitive burden of the continent - the brain drain challenge. Moyo (2009) cites the examples of **six African countries (Benin, the Central African Republic, Guinea, Madagascar, Mali and Uganda) that between the periods of 1986 - 1996, were compelled to downsize the civil service workforce by a 10 percent margin**. This brain drain phenomenon has been recognized as one of the devastating attempts by the IMF in imposing **wage bill ceilings** and minimizing the role of the state in developing and transition countries (Pg. 20).

According to Rowden (2009: 192 -196), one thorny subject that has managed to attract many education and health advocates to the discussion table is the issue of wage bill ceiling impositions and the limits placed on the utilization of national budgets expenditure on public sector employees' wages. This policy found its way into IMF adjustment programmes when countries perpetually failed to meet agreed targets relating to their deficit reducing efforts - observed in many developing countries' budgets is the continual presence of large proportions of public sector wages burdening already inadequate national budgets which form a rather significant portion of overall public expenditure. It was therefore the belief of the IMF that, in constraining the expenditure patterns on public sector wage bills, larger budget deficits could be reduced. The experience of Ghana in relation to wage bill ceilings is captured in the ensuing chapter. This is an example of **a well-intended policy having unintended negative consequences (Leppo et al., 2013) – this policy, inadvertently, resulted in a rather**

unfortunate situation of pushing out well-trained workforce, badly needed in critical sectors, into unemployment and emigration abroad due to the wage bill restrictions.

Hilary (2010) paints a rather vivid picture of the impacts of the IMF and World Bank's trade liberalization policies and conditionalities resulting in some consequential outcomes such as huge employment losses and the incapacitation of industries' growth in the *War on Want's recent report Trading Away Our Jobs*. **A consequence of this is quandary of conditionalities for the health sector is emigration and brain drain**. Rowden (2009: 33 - 34) points out the **difficulty in gauging the actual numbers of healthcare workers in flight from African countries to find work abroad, and sadly adds that, many do not necessarily end up in jobs in the medical field**. It must however, be added that the 'push factors' involved in this brain drain phenomenon is **not restricted to only the unemployment situation but also, low pay and poor working conditions under which healthcare workers find themselves**. In essence, this condition whereby developing countries have spent hard-to-come-by investment in educating their healthcare workers and by their eventual flight to developed countries in search of jobs results in a waste of effort if such developed skills are not used in these developing countries' settings. Conversly, wealthier nations' investment in those absorptive sectors are being subsidized as noted by the International Organization for Migration (Rowden, 2009: 35). **Much remain to be said and done about the conditionalities attached to the SAPs which are entered into by African countries.** Hilary (2010) indicates the **IMF's admission of misgivings concerning their earlier insistence on trade liberalization policy implementation in developing countries**. In a 2009 internal evaluation, the conclusion was drawn that in the era of 1980s -1990s, in relation to the promotion of trade liberation as a conditionality, actions taken were untenable and 'went beyond staff's technical competence', whereas the IMF's underlining market - oriented philosophy was implemented without regard for the unique nature of each participating country creating a situation of **'an insufficient basis for a constructive trade policy dialogue between country authorities and the IMF'**. In a rather well-known case of **one of the biggest economic blows to hit Ghana, the IMF is recorded as compelling the government of Ghana to reverse a decision by parliament to raise tariffs on imported poultry. Subsequently, it was discovered through internal evaluation that the IMF staff involved lacked the requisite sectoral knowledge to facilitate this course of action** (Hilary, 2010) and to date the poultry industry has not fully recovered. Sadly, the brain drain situation

resultimg from SAPs is real in Ghana as within three years of qualification for young doctors in the country, they abandon the shores of the country in search of jobs abroad (Rowden, 2009: 37). Sen (1999: 622) points out that while poor counries have a need for resources to expand their public services (including the health and education sectors), the pertinent question of focus **should be the cost-benefit analysis and balance which takes consideration of the human dimension of these so-called economic reforms**. He admits that **"financial prudence is not the enemy here"** but that **a situation where professionals in the health** and education sectors **are more "threatened by financial conservatism" than other professionals** in other sectors must be reconsidered.

Conclusion

While aid may have a role to play in the discourse of economic growth and development of developing countries, especially those in the SSA region, there would always be conditions attached to SAPs which have had mixed outcomes in terms of the economies they have sought to reform. The real concern is the relationship between the economic policy reforms and the social dimensions of development with emphasis here on healthcare. As pointed out by Sen (1999: 619, 623), health remains a "constitutive part of development" and cannot be overlooked in the pursuit of economic growth. Inarguably, good health is not cheap and comes at a cost – a healthy population is thus needed to undertake income generating activities which can help foster the desired growth in any economy (employment, tax, patronage of servces etc.) but also, this same population require better nutrition to support their sustainance and help continue with the income-generating activities. Rowden (2009) posits that liberation and adjustment programmes in developing countries put social expenditure under strong pressure. The focus, for African countries including Ghana in pursuing economic growth through SAPs, should be to seek a balance between the policies which promote 'economic progress and health achievement' (Sen, 1999: 623) and the UHC goal is one such initiative that promises to liberate African countries by way of health. A study by the Commission on the Social Determinants of Health (CSDH) which span three years sums up the need the for bridging the gap between economic policy reforms and healthcare needs of countries, "Ceilings on public expenditure associated with the need to secure IMF approval of national macroeconomic policies may limit the ability of governments to pay

badly-needed health professionals, although the relative contribution of IMF demands and other factors must be assessed on a country-specific basis" (Rowden, 2009: 200).

Section 2: The UHC in African countries: origin, definition and challenges

The context of the main health goal under scrutiny is placed under section two of Chapter 1 - a definition of the UHC is given, a background to its current structure and the journey to this current apex of prominence as expounded in the literature are presented. It aims to shed light on the different perspectives in literature and in practice, and also explain its aims and objectives. It demonstrates the various mechanisms of application and gives an indication of how it could be measured for success. The issue of context (derived from the discussion of policy by various authors such as (Kingdon, 2011; Savedoff et al., 2012a; Savedoff et al., 2012b; Gilson and Raphaely, 2008; Stuckler et al., 2010; Abiiro and Allegri, 2015; Lindblom, 1968; Carey and Crammond, 2015; Ridde, 2009; Olivier de Sardan and Ridde, 2015) within which the UHC is implemented across the globe and in the Sub-Saharan African context in light of all the environmental issues (disease burden, financial challenges, conflict etc.) are discussed here in order to place Ghana's UHC journey in context of challenges and successes - a fuller discussion of policy and the conceptual framework for the dissertation are captured under the second section. This health goal is not looked at in isolation but the concurrent demand for its implementation globally by nation states. The required conditions under which this goal can be achieved are discussed all through this first chapter and the point is made of the fact that it's ultimate achievement can only be witnessed with respect to the concept and initiatives through policy mechanisms which are discussed in the third section of the chapter. The Social Determinants of Health (SDH) is an academic notion, while the Sustainable Development Goals (SDGs) and Health in All Policies (HiAP) are institutional initiatives, all captured under section three of Chapter 2.

2.1 Origin and historical background of the UHC

2.1.1 Definition and historical antecedence of the UHC goal

Globally, countries with diverse health systems are going universal and taking the UHC seriously (Cotlear et al., 2015: 19). The UHC is defined as — **"the availability of quality, affordable health services for all when needed without financial impoverishment—can be a vehicle for improving equity, health outcomes, and financial wellbeing"** (Jamison et al., 2013). Inherent in the UHC goal is its ability to contribute to economic development as well and the reduction of poverty. The countries embarking on health system reforms with the UHC theme, in many cases have an underlying pro-poor focus (Jamison et al., 2013). The genesis of health system reforms targeted at the UHC dates back to the 19th century, when organized labor unrest called for the implementation of social security systems. These labour agitations which have their roots in Germany under the leadership of Otto von Bismarck, later spread throughout other parts of Europe such as Britain, France and Sweden. Subsequently in 1948, the UHC model became an implicit part of the WHO constitution, acknowledging that **"the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, and political belief, economic or social condition"** - WHO, 1948. The then accepted human rights found its way again as a bedrock in the "Health for all" declaration of the Alma Ata conference with primary health care as its focus in 1978 (Abiiro & De Allegri, 2015).

Subsequent efforts have been made globally to put the UHC goal on the health agenda. The UN General Assembly's resolution on this health goal in December, 2012, underlines the UHC as a critical health objective. Its adoption at the General Assembly was by consensus, the resolution urged member states to develop health systems aimed at avoiding the payment of substantial direct payments at the point of service delivery and encouraged the pooling of risks "to avoid catastrophic health-care spending and impoverishment." By this, the General Assembly's resolution recognized the UHC as a coalescing central health goal in the post - 2015 Millennium Development Goal framework. The WHO's 2010 World Health Report (WHR), **"Health Financing: The Path to Universal Coverage"**, created a milestone in the global movement towards the achievement of the UHC. The momentum to galvanize support for the UHC has

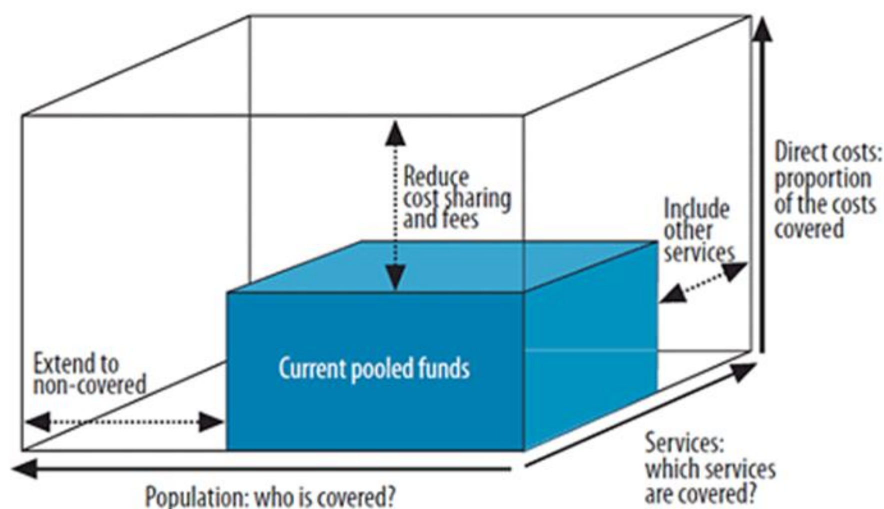
been gradual and evidenced in the amalgam of many important meetings, statements, resolutions, and publications since WHR 2010. Examples as seen in the past 3 years include but not limited to the Global Health 2035; a special collection of 19 papers in PLOS Medicine on monitoring UHC; a 2014 World Health Assembly resolution on health intervention and technology assessment in support of UHC; the June, 2015, publication by WHO and the World Bank of the first UHC global monitoring report, **"Tracking Universal Health Coverage"**; and a guide for policy makers on delivering UHC, published by the World Innovation Summit for Health. It is noteworthy that "all 194 WHO member countries endorsed UHC as a guiding principle in 2011 and more than 100 are actively seeking this goal. Many are also trying to ensure that they do not move backwards as a result of recent financial and economic crises" (WHO, 2015; Jamison et al., 2013).

The journey towards the achievement of the UHC is diverse, thus the pathways chosen to achieve the goal has been based on local circumstances and as Savedoff et al. (2012a) observe, international support for the promotion of it in the past has taken note of this.

The concern for attaining the UHC goal can be addressed severally by countries. Foreseeably, some of the possible areas of concern would be the sources of funding for this initiative, which organizations would be assigned the responsibility of managing the funds if allocated, and how the resources through policies could translate into healthcare services on the ground to benefit beneficiaries. The issues raised bring to the fore the three main priority health financing functions of revenue generation, pooling, and purchasing. They reflect the core areas of the discussion of "health system design, including sources of tax, third-party payers, public provision", exemptions policies and so on. Alternatively, the implementation path to achieving the UHC could be through the framework of the "UHC cube" which has been made popular in the **World Health Report 2010** (WHO, 2010). "This depicts three dimensions of coverage—the population (who is covered?), services (which are covered?), and cost sharing (what proportion of costs are covered?). It conceptualizes the journey toward UHC as a task of making progress along each of these dimensions to help "fill" the cube (Figure 2) below. The UHC cube represents the implementation hurdles of choice of which aspect of the cube to prioritize, and where and what trade-offs to make in achieving the goal in the face of limited resources. For

instance, during implementation questions of what benefit package to give and to which category of beneficiaries would be contemplated on (Jamison et al., 2013; Cotlear et al., 2015: 9, 68).

FIGURE 2: THE THREE DIMENSIONS OF UHC



Source : Jamison et al. (2013 : 35) ; Cotlear et al. (2015: 22)

The UHC has two components – "health service coverage on the one hand and financial protection coverage on the other – both of which need to be assessed at the level of the whole population. Thus, three dimensions – health services, finance and population – are typically represented in what has come to be known as the 'coverage box'" (Figure 2). It remains a challenge for many countries to simultaneously extend coverage of quality healthcare services and provide financial protection to its populace. This is difficult for participating countries as in light of the rising costs of healthcare provision and demographical (e.g. population ageing, bulging youth populations in some African countries) and epidemiological (e.g. rising chronic diseases) transitions (Cotlear et al., 2015: 21).

2.1.2 Different perspectives/conceptions of the UHC

The approaches to the adoption of UHC can be seen from multi-dimensional conceptual perspectives. The literatures on the various perspectives are seen as political, social, policy and legal. In the estimation of Savedoff et al. (2012a), the pathways for achieving the UHC have

often fallen into three categories namely, political, social and financial. The first being political concerns the process by which different social forces interact to produce regulation and public programs aimed at expanding access, equity in healthcare and the pooling of financial risks to achieve desired outcomes. The second has to do with increase in incomes and health spending and finally, the third is connected to governments increase in health spending in avoidance of Out-of-Pocket payments by households. Some these efforts by governments are seen through taxes, compulsory enrollment on insurance schemes and other modalities with these implemented through policy-making processes.

The first is a political process with interrelationships with a range of social factors aimed at simplifying access to healthcare. "Countries have responded to these social forces by creating public programmes or regulations that expand access to care, improve equity, and pool the financial risks of care across populations" (Savedoff et al., 2012a). The role of politics as a key determinant of health and development outcomes must be noted - Kickbusch (2016) adds "health is to a large extent a political choice", this point is also emphasized by Marmot (2015: 20). According to Stuckler et al. (2010), "fundamentally, the decision to implement UHC is a political one; its implementation is a political process". Within the policy process is the political economy analysis and discourse. This as pointed out by Savedoff et al. (2012a) is "broadly rooted in historical and institutional analysis, focuses on the structural forces driving movement towards UHC. This approach acknowledges the important role of actors but aims to understand the forces that empower or disempower competing groups in the political process. When examined in a historical context, almost every country shows a consistent drive towards the provision of universal health coverage. The trajectory is not smooth or free of conflict, but the general pattern of political action to mobilize funds, mandate participation in health financing schemes, and expand access to care is widespread" (Savedoff et al., 2012a).

This is reminiscent of the political play of actors in the 19th century Germany, and Chancellor Otto von Bismarck's compromise in establishing a compulsory health insurance system financed purely from a fund for employers and employees. This was due to the efforts made by the political opposition. Another example is that of the United Kingdom's NHIS which deviated from its original design based on payroll taxes due to high demand; as a result government rather utilized general revenues eventually making it tax-based. Some more recent healthcare reforms,

in Chile and Thailand also give a strong indication of the political forces that are at play in the pathways to achieve the UHC by diverse countries and according to Savedoff et al. (2012b), these "show a similar tendency for political process to alter health system designs in unpredictable ways". Another example of the political dimension of the UHC is given by Rowden (2009: 161) of Zambia, explaining that the abolishment of user fees by the president in April 2006 witnessed an increase in healthcare utilization especially in outpatient attendance by 40 percent by mid-2006. "Despite recurrent problems with inadequate supplies of medicine, the policy change proved exceedingly popular and was a factor in the re-election of the president" (Rowden, 2009: 161). Other interesting examples of politics at play in the UHC agenda are those of the "Obamacare" in the United States of America and its political debates since 2000 and which seems to have been an important electioneering factor for the President D. Trump's victory in 2016 (interesting political dynamics observed in the healthcare system of Americans as a previous government supported a policy "Obamacare" which is the country's version of the UHC but the current President opposes its implementation) and and also the politics preceding the establishment of the National Health Insurance Scheme (NHIS) in Ghana in 2000 and the pivotal role it played in the 2016 reelection of the opposition NPP.

Kickbusch (2016) elaborates the power of politics in healthcare priority setting with the point that, health has become key on the political and development agenda for a number of reasons not exclusive to economics and security, "but also because it plays an increasing role in relation to the legitimacy of the state and the values and expectations of citizens, both in developed and developing countries. It also plays a key role in establishing relations between states either as an entry to collaboration in other areas or as an integral component to an overall foreign policy strategy. The 2014, Ebola outbreak provides ample illustration for involvement in health at the highest political level of states as well as the United Nations (UN). The 2015 Johannesburg Summit on China-Africa Cooperation identified public health as one of the cornerstones for foreign policy action in "opening a new era of China-Africa cooperation" (Kickbusch, 2016). The many actors in the political arena who set the health agenda are varied and each has a relevant role in setting the agenda- researchers with different health focus, policy-makers, donor community, lobbyists, ministers of health, ministers of finance, advocacy groups representing the different healthcare needs, pharmaceutical companies, civil society, the media and many others.

To the extent that the UHC is considered as a legal obligation entreats all sovereign nations who were part of the ratification of the convention on the right to health to take up not only the responsibility of making the UHC a reality but also creating legal privileges to healthcare for all their residents. “To guarantee a comprehensive right to health, the legal obligation of the state needs to reach beyond mere health service provision to include deliberate efforts to advance improvements in structures which are recognized to act as important social determinants of health such as, education, housing, sanitation and portable water as well as equitable gender and power relations”. Principally, efforts towards the achievement of the UHC goal need to be backed by national laws (Abiiro and De Allegri, 2015). “All countries have ratified International Covenant on Economic, Social, and Cultural Rights (ICESCR) and the Convention on the Rights of the Child (CRC), which legally and morally bind their leaders to ensure the “highest attainable standard of health, encompassing medical care, access to safe drinking water, adequate sanitation, education, health-related information, and other underlying determinants of health” (Stuckler et al., 2010). It is explained further that this right to health has inherent negative and positive freedoms covering areas like the ‘right to be free from discrimination and involuntary medical treatment’, and ‘the right to essential primary health care’ (Stuckler et al., 2010). Cotlear et al. (2015: 21) posits that the human rights view of UHC is consistent with Article 25 of the Universal Declaration of Human Rights (1948).The multi-sectoral and interactive characteristic of the UHC speaks to the social nature of the goal.

The perspective of UHC as a policy issue can be gleaned from the fact that the intent of UHC can be materialized through the design, promulgation and application of policies relevant to specific countries’ policies. The importance of public policy in the achievement of the UHC has basis theoretically and empirically (Savedoff et al., 2012a). According to them, theoretically and empirically, it is difficult to make logic of the effectiveness in providing impactful health insurance based on competitive markets and the inability for public action to provide better quality of care and protect consumers at the same time (Savedoff et al., 2012a). Despite the fact that the development and execution of public policies are problematic and complex in nature, policy remains the only strategy through which UHC implementation can see the light of day.

2.1.3 Challenges regarding implementation

While the UHC goal is a laudable and progressive one, it is not bereft of challenges. There seems to be many challenging aspects of it, some with possible solutions in the long term, others not so. As with other goals previously adopted, the magnitude of the challenges associated with the UHC may become eminent with time within countries and as pertains to their peculiar circumstances.

That the foremost organization calling for the adoption of the UHC, "the WHO, while passing resolutions about UHC (2005) and writing reports about PHC (2008), has intentionally sidestepped complex political issues that are implicitly necessary to address within countries to promote UHC and action on the social determinants of health" is worth noting. This subtle action by the WHO presents a portrait of total focus on the achievement of the health goal without interest in exerting any control over the political processes of sovereign states in arriving at the implementation modalities. This absolves the WHO from potential in-country tensions emanating from the political processes to be faced in setting the agenda for attaining the UHC (Stuckler et al., 2010) but with the process of UHC achievement being inherently political, how does its dissociation from the internal processes help further the course of speedy achievement of the goal?

The definitional framework, intended meaning, and scope of UHC for implementation since inception seem to be elusive not withstanding the extensive consultations undertaken prior to its formal call (Abiiro and De Allegri, 2015). Stuckler et al. (2010) contends that "**the definition of UHC is nebulous"** which renders its implementation difficult. It is difficult to cite, for instance a list of countries which specifically address which of those countries have or have not got the UHC. The ambiguity associated with the conceptual definition of UHC has left room for various elucidations, emanating from different disciplinary perspectives (Abiiro and De Allegri, 2015). Definitional ambiguity with the use of words synonymous with the UHC has a bearing on the framework for implementation in the end. Stuckler et al. (2010) point out that in the literature terms like '"Universal Coverage", "Universal Health Care" are used interchangeably without reference to the exact framework within which the concepts were being applied. They explain that "an aim of Universal Health Coverage is to provide every citizen or

resident access to insurance or a particular (albeit not necessarily universal or comprehensive) set of services. Usage included "Everyone can get insurance", as well as certain services, such as "Access to essential medicines" and outcomes, "Access to care with financial risk protection". A broad range of organizations equated UHC with Universal Access, including the Organisation for Economic Co-operation and Development (OECD) and American medical associations". A concern has been raised that "persons may achieve the financial, geographic, and legal means of access to health service and protection, but face cultural or social barriers to care' (Stuckler et al., 2010).

For the purposes of this dissertation and in line with the WHO, the applicable definition is that of the WHO which states; **"Universal health coverage (UHC) is defined as ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship"** (WHO, 2015). The choice of UHC to mean "universal health coverage" is supported by Behera and Behera (2015) who assert that, "this clear meaning of UHC stands as an important landmark for a global understanding that would entail and provide a diverse, well-maintained framework to guide planners and policymakers in the achievement of equity in healthcare services and outcomes".

Fundamental to the health financing policy is the issue of **equity** which levels the play field by allowing households to make payments based on their financial strengths and their "ability to pay". The guiding principles of the UHC identify with same for the Health for All and Primary Health Care under the WHO. As earlier indicated, the WHO's **definition** is what will be applicable here, however, it has been recognized as **having 'several limitations'** (Stuckler et al., 2010). Despite the acceptance of and commitment to the provision of healthcare for all, especially for those with limited resources, some proponents believe that healthcare should be an individual responsibility and not a corporate one with reliance on solidarity in pooling risks together (as can be gleaned from aspects of the seemingly never ending debate about the US' healthcare reforms). Underlying the belief and practice by some is the decision to provide selective healthcare packages in support of avoidable diseases by providing lean and "cost-effective interventions" for beneficiaries (Stuckler et al., 2010). In effect, with the WHO proposing such **an "aspirational definition" of the UHC**, its implementation bottlenecks are

exposed due to the different connotations assigned to it. Agreeably, even though an explicit definition of the UHC does not ideally provide a clear-cut pathway for implementation; it would have made the pathways for implementation for countries more unified had the definition been more explicit. But had the current definition being as explicit as alluded to, Stuckler et al. (2010) adds that "……. they may impede implementation by setting lofty, intractable and unmeasurable goals".

After the **political process of adopting the UHC** (discussed earlier), the burden of implementation ensues. According to Rowden (2009: 166 - 167), the critical discussion among health specialists and development agencies in relation to the UHC goal is that it represents a generally accepted trajectory for under-resourced poor countries to depend on public financing to expand coverage of health services, to address the issue of equity and the reduction of the financial burden on the poor (Rowden, 2009: 166 - 167). In the estimation of Xu Y. et al. (2015), **due to the technical complexity involved in designing a UHC program that is locally-suitable and relatively easily implementable, a methodical and piece-meal approach is called for** to avoid the danger of leaving any aspect behind. From experience they explain the risk of leaving the very poor and vulnerable out if a strategy to addressing different segments is adopted such as the distinct collection of funds from the formal sector is adopted. Although collection of funds from the formal sector is often deemed easier, it presents the issue of *inequity* as the poor and vulnerable are left out. It is expounded that "once separate pools are created and unequal benefits are prescribed for different schemes, it proves challenging to integrate them". China's institution and management of three different social health insurance schemes with funds pooled at the municipal level is cited as one such scheme which proved daunting and has "led to a de facto of more than 300 different health insurance plans with better benefit packages for the urban employees" (Xu Y. et al., 2015). The Chinese are currently finding it difficult to integrate all three schemes with a focus on equity. The lesson here is that, any "health insurance reform" would be careful to commence with the poor and vulnerable as focus, 'creating a financial floor for them' and gradually integrating other segments of the society. Rwanda, a low-income country, is cited as a beacon of Africa in this regard (Xu Y. et al., 2015).

In conclusion, the call to cater for the health of populations (through financial protection and expanded geographical access has been made) through **health system reforms** by the WHO. The

UHC is criticized as been ambiguous in definition yet it **provides the freedom for countries to implement as deemed suitable to local settings but not undermining the equity principle of the goal.** Seen in the different lenses as political, social, policy and legal, the UHC remains a landmark call **"to ensure that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship"** (WHO, 2015).

2.1.4 Measurements of progress towards the UHC

Some perceptible measures of countries' performance towards the achievement of the universal health coverage are captured as basic rights, use of healthcare and financial protection through enrolment in health insurance. The **rights approach** gives an indication of whether a country professing to have adapted the UHC has made legal room for entitlements for healthcare services for its citizens, and this is usually achieved through provisions made under the law. The instances of "19 countries in Latin America" are cited for creating legal rights in their constitutions in order to provide surety to access to healthcare for their people. It is explained that the "use of a rights definition of universal health coverage distinguishes countries whose political systems have reached a consensus on aims but not necessarily on implementation. Many countries legally establish a right to health care without having policies or resources in place to guarantee that people who need care can obtain it without financial hardship" (Savedoff et al., 2012). Thus as Kingdon (2011: 43) intimate, making laws do not always translate into implementation as the laws may desire.

The second distinguishing approach is to **use health-care utilization** as a measure of progress towards universal health coverage. This measure is touted as a better means of measure among the three, albeit saddled with its own unique limitations. It is known to sometimes overvalue and underestimate coverage. It overvalues coverage in terms of "unnecessary services" together with "necessary ones". It is known to underestimate coverage in places where there are infrequent reported cases of illness stemming from available preventive measures and/or better environmental conditions and it is sensitive to individual cost of care upon access. It is however explained that **"utilization does not fully address concerns about financial protection**

because people who utilize care might still be impoverished as a consequence" (Savedoff et al., 2012a).

The "**share of the population with financial protection through enrolment in health insurance schemes is another common measure** for universal health coverage". This is a measure of coverage and performance of in-country UHC programs that are designed for individual beneficiaries and/or groups to access healthcare services by enrolling in a scheme, with prearranged payment plans. Nevertheless enrollment as a measure could be misleading (exaggerated even) in relation to healthcare delivery if disproportionately stagnated in certain places and where copayments have a rather grievous impact on households. It can also not be used accurately to measure coverage in countries which provide healthcare access to citizens through "publicly provided or publicly subsidized services". This is because the public institution is deemed to be providing the functions of insurance even if it has not been legally instituted as such. Another measure is that of "the share of households who are impoverished by health expenditures", seen as a lopsided view of measure as it does not give a clear indication of foregone care due to lack of ability to pay. It is explained that **"rights establish legal entitlements and insurance enrolment establishes a contractual promise, but neither one indicates whether people are effectively using the health-care services that they need"** (Savedoff et al., 2012a).

While the earlier forms of measure for progressivity towards the UHC goal's achievement have been explained, another dimension to measuring such is seen in the targets (160) and indicators (230) set by the Sustainable Development Goals (SDGs) (Union A, 2016: 115 – 133). It has been noted that accurate data is critical to this process, the African Union (2016) has pointed out the need for a data revolution in the form of investments in national statistics systems (and databases) for the continent in order to avoid such deficits which have the potential to hamper efforts of establishing baselines, track performance and reinforce evidence-based policy-making (Pg. vii – viii). One of the targets for measuring progress of the SDG 3: "**Ensure healthy lives and promote well-being for all at all ages"** is observed under target for the UHC (SDG 3.8): "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all." It has the 3.8.1 and 3.8.2 as its indicators which state firstly,

"Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population), and secondly, **"Number of people covered by health insurance or a public health system per 1,000 population"** respectively (Union A., 2016: 117 – 118).

In the case of Ghana, measurements towards progress are made using features all the earlier stated, some are embedded. The main measures are seen through in and out-patient rates of utilization, claims management (this is used in checking for how effective systems in place for managing and verifying claims by service providers and acts also acts as an avenue for information on rates of utilization), and how equity concerns are addressed (this can be seen as embedded in the rights approach where poor and vulnerable people are also given their entitlements to healthcare access). The 2013 Annual Report of the NHIS[9] reports of an increasing trend in the out-patient utilization rate from 16.63 million – 27.35 million people in the country. Also, for in-patient utlisation, it witnessed an ascending trend from 0.97 million – 1.61 million people in the periods 2009 - 2013 with an observed decline in 2010 (0.72 million). For **health equity concerns, measurement is made through health insurance coverage (enrollment), access by the poor and vulnerable to healthcare services, protection of the poor and vulnerable against financial risk and premium contribution and the National Health Insurance Levy (NHIL).** The latter, the premium contribution and the NHIL aspect ensures that provision is made for those who can afford healthcare to do so in view of supporting those you cannot. With emphasis on the NHIL, it is **inherently infused into the NHIS design and its source is guaranteed by law to ensure care for the poor and vulnerable by the rich, thus, the NHIL is placed on selected number of luxurious goods and services** frequently patronized to ensure the vertical equity feature is safeguarded in the system (Pg. 17).

[9] The annual reports give an overview of performance by the National Health Insurance Authority in terms with the 2013 Annual Report capturing the performances of the scheme between the periods 2009 – 2013. See pages 13 – 18 for details on the measures used to measure progress in the case of Ghana. Access to report - http://www.nhis.gov.gh/files/2013%20Annual%20Report-Final%20ver%2029.09.14.pdf

2.2 The Progress by different countries towards achieving the UHC

Progress on the pathways and performance of countries implementing UHC are reported as diverse, unique to circumstances peculiar to each (Behera and Behera, 2015) and with mixed outcomes in terms of the financial protection aspect (Cotlear et al., 2015: 224). According to a World Bank review of how 24 developing countries are implementing universal health coverage reforms from bottom up published in 2015, UHC can be achieved through a wide range of approaches (Cotlear et al., 2015). Similarly in the Global health 2035, **'A world converging within a Generation Report'**, Lancet Commission endorses **two pro-poor pathways to achieving UHC within a generation. In the first, publicly financed insurance would cover essential health-care interventions to achieve convergence and tackle Non-Communicable Diseases (NCDs) and injuries (Jamison et al., 2013)**. This pathway would directly benefit the poor because they are disproportionately affected by these problems. This approach takes into consideration the basic human rights indicator identified under 1.2 of Chapter 2, that despite the cost of care and because access to healthcare is a human right, using this approach (risk-pooling) allows for equity and coverage for people who could ideally not afford. **The second pathway provides a larger benefit package, funded through a range of financing mechanisms, with poor people exempted from payments.** Implementation of a UHC pathway that equitably covers the poor will require greater commitment to public spending on healthcare from resources which are increasingly dwindling with competing demands. The indicator of health care-utilization and also the basic human rights feature have been assumed under this pathway – that this ensures fair opportunity for all, including the poor for both access and utilization Cotlear et al. (2015: 22). It also inadvertently addresses financial protection for as many people that would enroll. Xu Y. et al. (2015) assert in support of previous statements that covering the poor under UHC programs requires governments' increased public financing coupled with commitment for funding from partners. They explain that, such as Rwanda, China, Vietnam and many others have shown commitment to the expansion of health insurance coverage through the use "massive public subsidies for insurance"[10] (Xu Y. et al., 2015).

[10] The example is cited of the Chinese government's provision of 85 percent of the premiums under the "New Cooperative Medical Insurance for rural residents and 60 percent of the premiums of the Urban Resident Basic Medical Insurance, on average" indicating the commitment needed from government via the expansion of public

At a time like this in the 21st century, an estimated 1 billion people globally, are yet to access quality health services (Behera and Behera, 2015). An additional close to a 100 million is placed in the “below poverty line” segment due to crippling healthcare expenditures (Behera and Behera, 2015). As earlier indicated, in using the definition of the WHO, there has been interpretational ambiguity of the UHC which has left much room for misinterpretation by countries. Since to them, the fundamental principle of the definition is equity, the UHC policy implementation is being implemented based on the exclusive interpretation of different countries. In light of this, they posit the question **“is this due to confusion or is UHC an aspirational slogan for local reality?”** Examples are given for different countries to illustrate the diversity in implementation of the goal - in China; their version of the UHC is the “Quanmin Jiankang Fugai ("health coverage for all")” whiles in Portugal it is referred to as the “Cobertura universal emsaude” operating as a type of UHC specializing in “narrowing health inequalities”. The Philippines’ version of the UHC is the “Kalusugan Pangkalahatan ("health for all")” designed “to improve access to services for the poor”. In France, the UHC is synonymous with “Coverture Maladie Universelle ("universal disease coverage")”, highlighting “the burden of disease in that country, mainly human immunodeficiency virus (HIV), tuberculosis, and malaria” (Behera and Behera, 2015). What is more, the international community’s view and definition of various aspects of the UHC to address issues of inclusiveness and appropriateness leave many questions unanswered. A study in the Lancet on 14 countries and a province (Punjab) in Pakistan, reports of how “inequity in a particular country is possible” during the UHC implementation. The discussion herein assigned reasons for the observed poor service utilization, quality coverage, poor access, and proposed how key national and subnational actors in development could better comprehend the intricacies inherent in the UHC’s implementation, calling for contextualization of local circumstances for effective delivery (Behera and Behera, 2015).

In Africa, the countries identified as attempting to implement the UHC since the 2000s are doing so through either the CBHI or a metamorphosis of CBHI, in line with the Alma Ata declaration and generally employing two main means of financing being user fee exemption and results-based methods (RBF) (Ridde et al., 2018). Countries such as Rwanda, Ghana, Senegal and Mali have all approached the CBHI using their own unique local contexts and capacities with Rwanda

funding of subsidies for the poor on health insurance. Vietnam is also known to have funded its expansion plans under the health insurance with 70 percent of premium subsides coming from public financing (Xu et al., 2015).

adopting a purely CBHI approach at the inception stages and transforming it into a participation by compulsion approach. Ghana on the other (and as can be read in more detail in other sections) designed its NHIS based on already existing CBHIs and made it compulsory by law but that has not translated into practice. While Mali built its journey to the UHC on three pillars of financing (a compulsory contributory, a non-contributory and revival of CBHI systems), the results have not been as desired with a reversal made to voluntary mode of enrollment. Senegal also runs its system on a similar approach as Mali and with current coverage rate of 47 percent, a disappointing turnout compared to the 75 percent estimated by 2017 (Ridde et al., 2018). **While each country has approached the UHC based on local contexts, progress has not been easy and a suggestion to make enrollment mandatory has been made.**

Conclusion of Chapter One

This chapter has captured the environmental context in Africa within which the global goal of the UHC is situated and has presented a prelude to the context of Ghana. In discussing the history of the user-fee removal policy, the country under review has a similar narrative. The question of whether a policy like that which swept over the continent decades ago still holds relevance in the face of timelines for the achievement of the UHC, challenging financial landscape, conflict, corruption, weak health systems and somewhat evasive public sector reforms, remain. Indeed, the WHO in the period 2017 – 2018 has undertaken various efforts including the convening of a multidisciplinary group meeting for its first advisory group on health governance in a bid to gather evidence and technical support for the continent. It has also made efforts at addressing the determinants of health (which represents one of the priority areas for the achievement of the UHC and the health targets emcompassing the SDGs), the Africa regional office has supported three countries (Guinea, Zambia and Lesotho) in conducting health inequities assessments at the heels of the agreement by Member States at Sixty-seventh Regional Committee (RC67) aimed at reducing health inequities at country level through intersectoral action on the SDH. According to the Africa regional office report, the findings of this initiative are being as input into decision-making and policy-making, especially in the development of the implementation framework for HiAP. Additionally, the WHO has institutionalized National Health Accounts (NHAs) with the provision of technical and financial NHAs in 25 countries

which entails the collection, analysis and reporting of health related expenditure at country level and other laudable initiatives aimed at strengthening health systems on the continent (WHO 2017 -2018 Annual – The Work of the WHO Report in the African Region[11]: 31 – 33).

These efforts have profound impact on health outcomes of the continent. Despite the challenges identified, the chapter shed light on the progress made by some countries across the globe as diverse as Rwanda, Ghana, Senegal, Mali, France, China, Vietname, Phillipines and others, and the ways in which each has approached the implementation of the UHC based on unique local circumstances and with improved health systems, countries on the African continent may just be able to meet the 2030 timeframe for the achievement of the UHC.

[11] https://afro.who.int/publications/work-who-african-region-report-regional-director-2017-2018 Accessed on 17th November, 2018

CHAPTER 2: CONCEPTUAL AND THEORITICAL FRAMEWORK

Introduction

Under this chapter, the concepts related to the focus of this dissertation are discussed. Chapter 2 relates to the Social Determinants of Health (SDH) which is an academic concept, and the two global initiatives - the Sustainable Development Goals (SDGs), and the Health in All Polices (HiAP), all of which reinforce each other and the challenges inherent in the efforts to achieve them. Each of these is given special focus generally and subsequently looked at in their connectivity to each other and their bearing on the UHC and also in relation to the Sub-Saharan African (SSA) context. For instance, the performance of African countries on the SDGs and in specific relation to Ghana is mentioned to give an indication of the status quo on various health performances and the work that remains to be done. This chapter looks at how all the goal, concepts and initiatives earlier mentioned are considered as policies worth implementing due to their fundamental principles, and their relevance in various ways to the achievement of the UHC which leads to the discussion in section two of this chapter being policy-making - key to the entire dissertation.

The chapter forms the fundamental basis for all analysis in this dissertation and is captured in the Conceptual Framework for all discussions here – in the context of Policy-Making and Implementation in Africa. It presents the main framework for this dissertation. Detailed here is the policy-making process as identified in the sub region with regards to health - in its simplicity in concept yet complexity in application, with the literature revealing the need to strengthen policies, systems and institutions in general. The section 2 under Chapter 2 is critical to the UHC health goal's implementation – the process, actors and context as proffered by Walt and Gilson (2008) but largely based on aspects of the Kingdon (2011) multiple-streams framework (Ridde, 2009) and Kingdon (2011) agendas, alternatives and public policies approach. The theory of policy would be observed more closely in here in its implementation stages (through outcomes captured in the Ghanaian context).

CHAPTER 2 NAVIGATION CHART

CHAPTER TWO CONCEPTUAL AND THEORITICAL FRAMEWORK	
Section 1: The Social Determinants of Health (SDH) and other international initiatives for health	Section 2: Conceptual framework and policy-making in Africa
1.1 SDH and inequality issues affecting health	2.1 Policy-making in Africa
1.2 The human rights feature of the SDH	2.2 Global framework – agenda-setting, alternatives, decisions, actors and implementation
1.3 Transition to the Sustainable Development Goals (SDGs)	2.2.1 Agenda-setting and alternative discourse phase of policy-making
1.3.1 The Sustainable Development Goals defined	2.2.2 Decision-making phase
1.3.2 Africa's performance on the MDGs and its transition to the SDGs related to health	2.3 Coupling and actors involved in the process
1.4 The Health in All Policies (HiAP)	2.4 The use of Kindgon's framework for comparison with other African countries
1.4.1 Health in All Policies (HiAP) definition as a concept	2.4.1 The implementation phase of the UHC concept captured within the policy-making process of African countries
1.4.2 Justification for the adoption of the HiAP	
1.4.3 The connectivity among the UHC, SDH and HiAP	
Key words: UHC, SDH, HiAP, SDGs, Policy-making, Kingdon's multiple-streams	

Section 1: The Social Determinants of Health (SDH) and other international initiatives for health

Globally, people considered destitute are known to have limited access to health and yet are prone to other related conditions which invariably affect their health status, and may send them to their early graves as compared to the more privileged in society. Known as the Social Determinants of Health (SDH), much attribution of the causes of ill-health are made to the social conditions under which people live and work. Unfortunately, inequities in health have grown over the years regardless of progress made towards economic growth and technological advancement. Notably, **"good medical care is vital to the well-being of populations, but improved clinical care is not enough to meet today's major health challenges and overcome health inequities"** (Irwin et al., 2006). Research and evidence gathered over time give an indication of the connections among health status, vulnerabilities to ill-health and social conditions under which people live and work (Irwin et al. 2006; Marmot 2005; Marmot 2015). Developing countries seem to bear the brunt of the disease burden which appears to be transitioning from the already difficult-to-solve problem of chronic communicable diseases to non-communicable diseases (NCDs). The examples cited of developing countries such as "Brazil, China, India, and Pakistan —death rates from chronic diseases already far exceed the combined death rates from communicable diseases, maternal and perinatal conditions, and nutritional deficiencies". These NCDs resulting in conditions such as overweight, poor diets, alcohol abuse and others, which are often referred to as "individual lifestyle choices" are precipitated on poverty and social exclusion (Irwin et al. 2006). It is explained that all these "health-compromising behaviors" are invariably found among the destitute and marginalized groups in "both in developed and in developing countries" (Irwin et al. 2006). Section one of this chapter touches on various issues such as the Social Determinants of Health and inequality issues which affect health (1.1). Under this, unequal economic opportunities and their reflections on health in different countries is also deliberated on. Sub-sections 1.2 and 1.3 raises the subjects of the human rights feature of the SDH and the transition to the SDGs respectively. 1.4 delves into the Health in All Policies, as a concept and what principles establish it. Finally, a connection among the UHC, SDH and the HiAP is made under 1.4.3.

1.1 SDH and inequality issues affecting health

The disparities in health are observed not only among countries but also contained in countries. For instance, as a singular measure to emphasis the point of inequalities in health is life expectancy at birth. Comparing countries, life expectancy may record 34 years in Sierra Leone with Japan witnessing 81·9 years for its populace. With same measure but for in-country assessment, there seem to be observed inequities with the example of the USA cited with “a 20 - year gap” among populations in different states (Marmot, 2005: 2; Marmot, 2015: 16). Marmot (2005) estimates that, further work towards the effective management of “major diseases” through reformed systems and an effort at dealing with the issue of poverty should substantially address the challenge of inequity in health. Marmot (2005) makes yet another analogous suggestion in support of the earlier two - a call to commit to the SDH. He asserts that such a poverty reducing strategy should be adopted with an inherent focus on making the conditions of living and work better for populations, thereby addressing both communicable diseases (associated with prevalent poverty) and NCDs, the world over but especially in Sub-Saharan African countries (Marmot, 2005). By extension, he explains that attention needs to be paid to the social conditions under which people live and work should the health of such people begin to take a downward trend.

Marmot (2015) points out that poverty and the various degrees of inequality are interconnected, expounding that the levels of absolute poverty with connections with child mortality in any developing country is also associated with “national incomes and life expectancy”. The higher the level of affluence of a people, the easier it is for them to afford the basic necessities of life. He cites an example to explain his point on poverty - the absolute and relative dimensions of it (Marmot, 2015: 42 – 48). The position one finds him or herself in life, be it affluent or destitute affects the quality of life lived and its corresponding longevity, these differences (as observed in health) abound (Marmot, 2004: vii; 36).

BOX 3: AN ILLUSTRATION OF RELATIVE AND ABSOLUTE POVERTY ON DIFFERENT POPULATIONS AND ITS IMPACT ON LIFE EXPECTANCY

Marmot (2015: 24 -30; 42 – 44) explains the subject of relativity and absolutes in poverty and its impact on health using a small city in Glasgow called Carlton who on the surface could be called poor (by Glasgow standards) and nonetheless, is not by India's standard of poverty - while Indians would live on a daily minimum of $1.25, same cannot be said for a poor person in Carlton. Explaining that the average income for each person is $3,300 (as per purchasing power), in Scotland, it would be considered unacceptable as it is under the poverty line. Albeit, recorded men's average life expectancy in Carlton was "eight years shorter than the Indian average". He further emphasizes that differences and magnitude of poverty need to be put in context, simply, what may be considered as destitution would not be same by another. Undeniably, health inequalities do exist among countries and in-country and according to Marmot (2005), the "differences in adult mortality among countries are large and growing". A particularly telling example of health inequalities in-country is the 20-year gap in life expectancy between Australian Aboriginal and Torres Strait Islander peoples where life expectancy is 56·3 years for men and 62·8 years for women, and the Australian average (Marmot, 2005).

Source: Marmot (2015: 24 -30; 42 – 44; Marmot, 2005)

Social determinants should be inherent in efforts geared towards poverty reduction and the effective management of communicable diseases. The conditions under which people live and work are as critical to both communicable and non-communicable diseases (NCDs) as well as the beginnings and management of such, be they fatal or otherwise (Marmot, 2005: 10, 30).

Unequal economic opportunities and their reflections on health in different societies

Eckersley (2015) recalls a period of income inequality focused research more than two decades ago, when research findings gave an indication of "unequal societies" which yielded more unequal health and showed that the more unequal a society, the deeper disparities in health existed (Eckersley, 2015). That period and the unveiling of two landmark publications - **"Report of the WHO Commission on Social Determinants of Health"** (2008), headed by Michael

Marmot; and the 2009 best-selling book, "The spirit level", by Richard Wilkinson and Kate Pickett (2010a), introduced outside the field and made popular the science of health inequalities. The inconclusiveness of the direct relationship between income inequality and health gradient is brought to bare as Marmot (2005) cites the instances (replete of comparison between gross national product and life expectancy) of Greece with a Gross National Product (GNP) at "purchasing power" of $17, 000 with corresponding life expectancy of 78.1 years and the USA with a GNP of $34, 000 and a 76.9 years. There is an incoherent correspondence between GNP and life expectancy and hence a call for further research (Marmot, 2005: 1102).

The knowledge of the relationship between health and poverty is not enough to achieve results but systemic action to tackle the negative effects requires a fuller understanding of **"health effects of social and economic policies"** (Marmot, 2005: 1101). Eckersley (2015) throws light on the different dimensions of understanding the complexities associated with the SDH, causal factors and the fact that **focus on the socio-economic factors alone may be flawed**. He points out that, "The research emphasis on socio-economic status and inequality can be challenged on both empirical and theoretical grounds. This argument applies especially to the income inequality hypothesis, on which current research focuses, but also, by extension, to health inequalities research more broadly and to the research on the social determinants of health, given its dominant theme has been health inequality". Eckersley's paper draws on, in his own words, "transdisciplinary analysis of progress and wellbeing, which includes social determinants of health and, in particular, cultural influences and young people's health and wellbeing". In theory however, **the importance laid on just the one causality to inequality is somewhat flawed because such an analytic does not take into consideration the myriad of issues present in non-static "human societies"** (Eckersley, 2015). He explains that instead of approaching the discussion of health inequality with a narrow view of single causative factor resulting in a correspondent outcome, it is fairly prudent to approach it with several factors and possible pathways among them, hence a need for the Health in All Policies (HiAP) approach (Eckersley, 2015).

The emergence of simple to complex health systems: the quest for better

Eckersley (2015) further explains how "complex systems" metamorphosed into a whole network of complex yet related sub systems, working sometimes concurrently together to achieve an ultimate goal and that these "complex systems show emergence" thus, their inherent features are able to bud out of sometimes one organized system working in concert to achieve the whole. It is explained that the inability to grasp how the various components work will make it difficult to understand how the whole system is supposed to work and that due to the potential problems that could develop, "they have to be constantly monitored and managed" (Eckersley, 2015). An example of the analogy can be cited in how the UHC's metamorphosis from the Ottawa Declaration in 1978 to its current eminence in 2015 seems to have treaded the complex path being described by Eckersley (2015), where previously the policy call was on Primary Health Care (PHC) but now merged with various - health goal, initiatives and concepts (HiAP, SDG and of course the SDH) that must be worked together somehow to achieve the expected positive long-term health outcomes. Another such instance can be cited in relation to how the Universal Health Coverage (UHC) goal can find itself on the top of a country's development agenda – the various stages (complex and interwoven stages) of the policy process that the various actors go through to arrive at the policy implementation stage and even after that, effective monitoring is called for to manage the "UHC emergence" from the complex process for effectiveness (refer to the policy-making sub section 2.1 under Chapter 2) (Kingdon, 2011: 230).

BOX 4: HEALTH OUTCOMES' RELATIONSHIP WITH COMPLEX EXTERNAL ENVIRONMENT

Complexity science suggests that leaning heavily on just one or few factors in appreciation of the "patterns and trends in population health" is not only narrow but problematic. Additionally, the suggestion is made that, as in accordance with 'the concept of emergence" systems must be looked at as a whole and not in distinct constituents. The UK Government's Foresight Programme is cited as a rather prominent example on obesity which recognized the many, interrelated and sometimes messy factors which cause obesity; these factors were described as "resembling a bowl of spaghetti – that lies behind rising rates of obesity" (Eckersley, 2015). Although the "complexity" inherent in social determinants of health is not

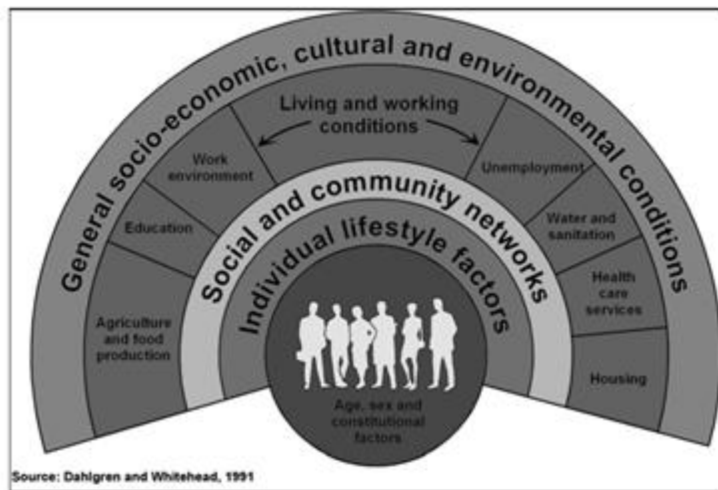
denied as a possible causality, it remains a characteristic in the literature that is disputed in the "nature of the science". In an instance cited of a study conducted in 2001, it was established that "population health" emerged out of the complex interactive maze woven by "history, culture, politics, economics and the status of women and ethnic groups" (Eckersley, 2015). It is noted that in the "health and medical sociology", studies of 'fundamental causality' establishes "complexity" right at the centre, not giving prominence to any single sub system as superiority - that all health outcomes are a result of 'the potential for a massive multiplicity of connections' with others (Eckersley, 2015). There is also acknowledgement in the literature of the dogma of politics that belies inequality, more specifically, income inequality[12].

Source: Eckersley (2015)

In order to logically explain the application of the SDH in the context of Ghana, the Dahlgren and Whitehead grid of 1991 will be adapted for use (find below). As may be observed subsequently (in Chapter 3) of this dissertation, the SDH grid which is adapted from Bambra C. et al. (2009) is applied in the choice of key sectors in Ghana for discussion and this dovetails into the HiAP concept. By this, the SDH and HiAP are seen as a rational implementation unit which if applied in Ghana has the potential of transforming efforts leading to the achievement of the UHC but much remains to be evidenced from the empirical study.

[12] Eckersley (2015) points to the deliberate oversight of some scholars in the political science space in acknowledging income inequality as the fundamental challenge leading up to the phenomenon of the gaping gap between the wealthy and the destitute. 'According to this view, the mal-distribution of income is a by-product, or an epi-phenomenon, resulting from broader adversarial class relations.' Eckersley (2015) includes in his analysis of the need not to focus research on only inequality as a dominant factor in the SDH but as part of a complex system of relevant contributors, the aspects of psychosocial and cultural perspectives. It is explained that there are constant exchanges between social conditions and individual natural predispositions which have a bearing on value systems and responses to social situations (Eckersley, 2015).

FIGURE 3: SOCIAL DETERMINANTS OF HEALTH BY DAHLGREN AND WHITEHEAD (1991) FRAMEWORK



Source: Bambra et al. (2009)

1.2 The human rights feature of the SDH

In an address by Paul Hunt (the UN Special Rapporteur on the right to the highest attainable standard of health (2002–8), on the theme: “Missed opportunities: human rights and the Commission on Social Determinants of Health” he begins by giving credit to all the those who contributed to the “Closing the Gap in a generation” report on the Commission on the Social Determinants of Health (CSDH). He raises the numerous issues associated with the relationship between human rights and poverty - “the rights to basic shelter, food, education and health - related services, as well as classic civil and political rights, such as freedoms of expression, assembly and association”. The report is awash with other equally significant human rights issues such as the right to safe environment, safe working conditions, just to mention a few. He narrates the journey of how momentously they became part of the objectives of the United Nations, and how the international human rights became established as the Universal Declaration of Human Rights (1948) and subsequently, unleashing a barrage of other international human rights instruments such as the Convention on the Rights of the Child and others which contain cultural, political, social, economic, civil liberties, not excluding the “right to development” (Hunt, 2003).

The Chairman of the Commission on Social Determinants of Health (CSDH), Michael Marmot also contributes to the dialogue on SDH as a human right. In Marmot's (2015: 94) estimation, 'Basic Freedoms' - attributable to the work of Amartya Sen epitomizes the personal liberty to living a life considered of "value". Sen's perspective on the human rights discourse is that, they are full of liberties considered basic. Within the human rights context is the promotion of the social determinants of health and so is it in the reverse of the SDH (a fundamentally human rights - promoting concept). Marmot simplifies its context that **"in other words, if I claim that people have rights to health, there is the implication that they have rights to the social determinants of health – pre-school education, good education, housing, a decent paid job, social protection"**. Studies in the last "four decades" give an indication of the different conduits through "which social, economic, political and cultural environments" influence health outcomes (Marmot, 2015: 94). These well-documented research findings have sought to influence the global call for the adoption of the SDH by sovereign states (CSDH 2008) although largely accepted as a trajectory to addressing health concerns, "causal mechanisms and pathways to change remain elusive" (Carey and Crammond, 2015).

Not only has the call to SDH been descriptive, it has made it binding on national governments to tackle the issues of "discrimination and inequality" head on. Inherent in the call for the adoption of "the highest attainable standard of health" is the recognition of the need to embrace the social justice component to development by governments. This calls also for public policy reforms that would enhance the information dissemination to aspects of the population affected by such. The "right to the highest attainable standard of health" however makes room for incremental progress towards its full attainment. In that case, measurable indicators for progress are then called for and cautions that such progressivity is required due to the possible resource constraints that could be faced by implementing countries. Additionally, the realization of the SDH with infused bedrock of the right to the highest attainable standard of health would also require a constant stream of "monitoring and accountability" activities to keep it on track (Hunt, 2003). Issues addressed earlier on the SDH relate directly to the UHC as a global call for governments to ensure accessible healthcare to its citizens at a cost that does not become burdensome to them, thus bridging the inequity gap and also heeding to the SGD goal 3 - ensuring healthy lives and promoting well-being for all.

Conclusion

In the afore, it is clear that the issues associated with the SDH are not so simple and easy for implementation, however if various angles of the concept are attended to, progress can be made in addressing health inequalities and improved life expectancy levels for different populations. In addition, it would help in tackling the progressively challenging development issues of the world in general but specific to countries, with a lens of the myriad of complex interactions among the different dimensions of development such health's relatedness to education and income inequality, cultural influences on addressing income inequality issues which have a bearing on economic growth and social cohesion and others, but altogether with the well-being of populations in focus (Eckersley, 2015). In essence, and as Irwin et al. (2006) postulate, the discussion of the social determinants of health remains a commonsensical one - "one hardly needs sophisticated epidemiological models to see that it is inefficient to treat children for diarrhea or respiratory ailments, and then send them back to slum - like living conditions that virtually guarantee new bouts of infection". That the problem is found at the level of conversion of "such common sense into public policy" at the implementation level to realize results (Irwin et al., 2006).

In the ensuing sub sections, there will be a focused discussion of the Sustainable Development Goals (SDGs) in 1.3; a discussion of the transition of the Millennium Development Goals (MDGs) to the SGDs is made under 1.3 in connection with the performance of the African continent based on various indicators. Also, the Health in All Policies (HiAP) concept is brought into focus in 1.4 and finally, there are connectivities made among the health goal and the global initiatives on health. These discussions and interactions are relevant to the ultimate area of study, being the different pathways of achieving the UHC in the case of Ghana and the role of the SDH. An understanding of these key concepts is needed at this stage before moving to Part 2 of the dissertation where the specific case of Ghana is brought into focus.

1.3 Transition to the Sustainable Development Goals (SDGs)

The number of people who lose their lives prematurely to diseases in developing countries is rather daunting. The death of an alarming 11 million under five children was recorded with 99

percent of them traced to developing countries, of this, Sub-Saharan Africa alone accounted for 4.5 million. Another projected 140 million children under five have been found to be underweight, South Asia accounting for a half of the number. Lives lost to Tuberculosis alone is estimated around 2 million. 3 million deaths were recorded in 2001 resulting from HIV/AIDS, with almost a 100 percent from developing countries. Majority of maternal deaths recorded in developing countries in 1995 was 515,000. Such needless deaths and disease with their productivity and economic growth implications should be of concern to all. The genesis of health as a prominent theme in the 2001 call for the MDGs stemmed from such issues of deaths and disease in developing countries which needed to be addressed. Thus, "in September 2001 at the Millennium Summit, 147 heads of states endorsed the Millennium Development Goals (MDGs). Later, it is noted that at the UN General Assembly, the heads of states of all 189 UN member states adopted the goals" (Wagstaff and Claeson, 2014).

It is said that almost half of the targets of the MDGs were centered on either health or related to health, and a priority placed on achieving all the goals, although the one said to have been most ambitious to achieve was "the maternal mortality goal of a three-quarters reduction between 1990 and 2015". The measure of performance for all the goals tell a different story of the levels of ambition that was attached to them, not surprising though as the MDGs were said to have a leaning towards the health sector on outcomes (Wagstaff and Claeson, 2014).

As a continuum to the MDGs, the SGDs were introduced in December 2015 to guide pathways to development for the foreseeable 15 years (ending in 2030). Even though considered as yet another ambitious agenda, the SDGs is focused on social, economic and environmental aspects of development. With 17 goals and 169 targets they are deemed exhaustive enough to provide sustainable development for the world with a leaning towards addressing environmental sustainability, ending poverty and ensuring inclusiveness. As a guide, the SDGs entreat nation states to adopt and prioritize them to address the thematic areas to suite local conditions to bring about expected results (Gable et al., 2015). In the MDG era, development seemed to have seen significant progress with such observations as "development has advanced more rapidly over the 15-year MDG era than at any other time in human history". Despite the positive outcomes experienced in many lives due to differential levels of impact, the "development agenda" remains an ongoing preoccupation (Winthrop et al., 2015: 21).

With the demography of the world changing, the development agenda is set to be impacted severely, a more diversified and exhaustive approach to addressing development challenges is needed and that is what the SDGs epitomizes. In the estimation of the World Bank, **"the SDGs seek to accelerate progress with a strong focus on implementation and reflect learning from the MDG experience"**. The SDG era is projected to assist in improved ways of translating the goals into workable policies at the country level and in addition enhance partnerships aimed at "resource mobilization" intended to achieve the expected outcomes for the goals all within the fifteen year window (World Bank, 2016). It is with this view that the UHC implementation at the country level is considered critical, not only for the sake of the health of populations but as bedrock to the achievement of all the other SDGs especially with poverty reduction and equity as a concern. The multisectoral representation under the SDG framework and the emphasis on cooperation and sustained partnership in achieving the various targets mirrors that of the SDH framework which also lays emphasis on the causes of ill-health as being rooted in the workings of different sectors. This mirroring of ideals of both concepts is important to the view of the SDH and its application in Ghana – a country which was very much involved in the implementation of the MDGs (but failed to achieve some targets) and committed to overcome all such challenges in an era of SDGs. Indeed, the success of both frameworks relies on harnessing the potentials of all sectors with equity as the bedrock.

1.3.1 The Sustainable Development Goals defined

The MDGs and SDGs are in many ways not too different except that the latter is more expansive and thematically interconnected, and as earlier mentioned, more focused on the implementation of the goals - the MDGs had 8 goals, 21 targets and 60 indicators as compared to the SDGs which projects 17 goals with corresponding 169 targets and 304 indicators (World Bank, 2016: 103; WHO, 2018; 2). The SDGs' unique strengths stem from the intersectorialism mode of addressing all the themed development goals yet they do not compromise the underlying promotion of good health and total well-being (mental health included under Goal 3) with a suggested mechanism for achieving them such as its emphasis on inclusive and sustainable infrastructure, institutions and partnerships to implement. Unlike the MDGs, its focus is broader, and does not overemphasis issues such as child and maternal health with little mention of Non-

Communicable diseases (NCDs). The SDGs have been described as improved and **'being more universal in scope, with a focus on local adaptation, an emphasis on sustainability, while seeking to magnify integration across actors and domains for results'** (WHO, 2018: xi). This integrative nature takes on board the strengths of all identified key areas and the need to achieve all set targets seamlessly. It has been observed that the SDGs are in keeping with the "epidemiological transitions" of the 21st century's disease burden (Hawkes and Buse, 2016). As a continuum of the MDGs, the SDGs remain committed to addressing similar issues before but with a detailed outlook of the changes going on in the world today and responding accordingly with expected better outcomes (Gable et al., 2015) and indicators with which to measure progress.

Inherent in the SDGs is the human rights characteristic. This feature is also prominent at the core of the UHC (reference to 2.1.1) and embedded in the human rights discussion with this goal are both the 1948 WHO constitution and the 1978 "Health for all" Declaration of the Alma Ata conference. The SDH's feature as a human right is seen in detail under (1.2) with Marmot's (2015: 94) consideration as part of 'basic freedoms'. Hawkes and Buse (2016) observed in an SDG process and outcome documents that while the four major documents from the global goals process are cognizant of human rights language, there is variation in the construction and expression of the right to health. They continued, in line with how the human rights aspect, made fundamental in the SDGs could be sought and offered, "Realizing the right to health within the SDG framework will mean **utilizing the full range of commitments, conventions and covenants** already in existence that **promote, protect and ultimately realize rights in relation to the determinants of health**." For instance the International Covenant on Economic, Social and Cultural Rights entreats all countries to guarantee the rights to education, employment and its commensurate pay, sanitation, provision of potable water and others which all fall within the ambit of some of the thematic areas covered by the SDGs (UN 1976). Inarguably, the observation made by the Commission on Social Determinants of Health (CSDH) about the observance of the rights approach to "healthy environments" with a focus on determinants of health has the potential to yield positive results for populations in a sustained manner and holds true (Marmot et al., 2008). As much as these are descriptive of the presence of SDH, they also call for the application of Health in All Policies (HiAP) as an approach to achieving the SDGs, as

all the goals have a contribution to make to development but cannot achieve appreciable levels independently.

The SDG 3 on health pulls together several related MDGs but is expanded to cover additional dimensions of healthy living. It seeks to **“ensure healthy lives and promote well-being for all at all ages”** addressing MDGs 4, 5, and 6 on maternal and child health, as well as the key communicable diseases of malaria, tuberculosis, and HIV/AIDS. Both the MDGs and the SDGs include targets on universal access to reproductive health (SDG 3, target 3.1 and 3.7), which play a key role in shaping demographic trajectories. The expansions center on efforts to seek more investment in neglected tropical diseases, address the increasingly important issue of non-communicable diseases, ensure universal health coverage, reduce the number of deaths and illnesses from environmental degradation, and lower global deaths and injuries from road traffic accidents (World Bank, 2016). As a continuum of the MDGs, there is a significant place for the UHC in the SDGs (Borgonovi and Compagni, 2013) which has been further expanded under the Goal 3 “Ensure healthy lives and promote well-being for all at all ages”.

BOX 5: THE SUSTAINABLE DEVELOPMENT GOALS (SDGS)

The Sustainable Development Goals

Goal 1	End poverty in all its forms everywhere	GOAL 11	Make cities and human settlements inclusive, safe, resilient, and sustainable
Goal 2	End hunger, achieve food security and improved nutrition, and promote sustainable agriculture	GOAL 12	Ensure sustainable consumption and production patterns
Goal 3	**Ensure healthy lives and promote well-being for all at all ages**	GOAL 13	Take urgent action to combat climate change and its impacts
Goal 4	Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all	GOAL 14	Conserve and sustainably use the oceans, seas, and marine resources for sustainable development
Goal 5	Achieve gender equality and empower all women and girls	GOAL 15	Protect, restore, and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss
Goal 6	Ensure availability and sustainable management of water and sanitation for all	GOAL 16	Promote peaceful and inclusive societies for sustainable development, provide access to justice for all, and build effective, accountable, and inclusive institutions at all levels
Goal 7	Ensure access to affordable, reliable, sustainable, and modern energy for all	GOAL 17	Strengthen the means of implementation and revitalize the global partnership for sustainable development
Goal 8	Promote sustained, inclusive, and sustainable economic growth, full and productive employment, and decent work for all		
Goal 9	Build resilient infrastructure, promote inclusive and sustainable industrialization, and foster innovation		
Goal 10	Reduce inequality within and among countries		

Source: Author's adaptation from Borgonovi and Compagni (2013)

Hill et al. (2014) observe that, "While some may be concerned that health has seemingly lost prominence since it has "dropped" from 3 out of 8 goals in the MDGs, to 1 out of 17 in the SDGs, we believe that this is an unwarranted concern". It is important to acknowledge that health is the central theme for the achievement of all the other SDGs for without a healthy population, all efforts to achieve the rest of the goals remain in futility and that is why the UHC must be pursued in all earnest as a set of unifying policies for countries especially those in the LMIC bracket. Find below information on the targets of the Goal 3 (for health) and its targets.

BOX 6: THE HEALTH GOAL (GOAL 3) AND ITS TARGETS

The Goal: Ensure healthy lives and promote well-being for all at all ages	
Targets	
3.1. By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births	**3.8**. Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
3.2. By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births	**3.9.** By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination
3.3. By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	**3.a** Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate
3.4. By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being	**3.b**. Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the

	provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all
3.5. Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol	**3.c**. Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States
3.6. By 2020, halve the number of global deaths and injuries from road traffic accidents	3.d. Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks
3.7. By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes	

Source: Author, (adapted from Union A., 2016: 117 – 118)

1.3.2 Africa's performance on the MDGs and its transition to the SDGs related to health

The year 2016 witnessed a remarkable transition period from the MDGs to the more progressive era of the 2030 Agenda for Sustainable Development. On the African continent, countries have also committed to a transition from the New Economic Partnership for Africa's Development (NEPAD) to Agenda 2063, a new development agenda with the focus of hastening the development of the continent (Puplampu and Hanson, 2016). At best though, the achievements of Africa recorded in the MDGs era can be described as "patchy" (Puplampu and Hanson, 2016; Boidin, 2017). According to the report "MDGs to Agenda 2063/SDGs - Transition Report 2016" which explains Africa's performance (Union, 2016), on the health related MDGs, the period 1995 – 2015 witnessed mixed levels of outcomes on the various health related targets. Child mortality is reported as witnessing exceptional declines with the under-five mortality rate declining from 180 deaths per every 1,000 live births (1990) to 83 per every 1,000 (2015) (this progress however does not include progress recorded in North Africa); 2000-2010 was the period with the greatest declines. Exceptional was the decline reported in North Africa within the period between 1990 and 2015 with 73 per every 1,000, additionally, infant mortality rates experienced remarkable decline in the same period. Factors accounting for improved coverage for immunization for children, decreased incidences of death related to malaria can be traced to progressively expanded preventative programmes and greater access to treatments to NCDs and a closer attention paid to the utilization of community health workers in distant and rural communities in African countries. Regrettably and despite all the progress made, Africa is known to still carry the biggest "burden of child mortality" worldwide. Almost all African countries have seen a reduction in MMR (1990 – 2015) but for Zimbabwe and South Africa. Remarkably between 1990 and 2015, Cabo Verde, Rwanda and Libya achieved the target of reducing the maternal mortality ratio with a reduction observed for other 15 countries in the MMR by half. On a down side, there have been observed increases in the incidences of MMR in the same period by Zimbabwe and South Africa due to widespread HIV/AIDS (Union, 2016). The report by Pupulampu and Hanson (2016) accounts that despite the progress made so far, MMR remains high in many African countries. There were reports of nineteen countries in the sub-region having had reports in 2015 of MMR above 500 deaths per every 100,000 live births (Pupulampu and Hanson, 2016). Ghana continues to have challenges with MMR; the country's

performance on the MDGs was not as impressive as expected despite initiatives introduced in the health sector.

The final MDG target's performance for the African continent which is not health-related but that gives an indication of great possibilities for further development is the number of mobile-cellular subscriptions which is recorded as having grown exponentially with 80 percent of the entire continent using a mobile phone. Conversely, 84 percent of Africans are on record as not being presently "linked to a global network of content and application, while more than half of the world's population are connected to the Internet" (Puplampu and Hanson, 2016). This situation is blamed on Africa's disproportionate reliance on "satellites and very small aperture terminal (VSAT) earth stations for connectivity". The reason of high cost has been cited for the problem of inaccessibility to better internet usage on the continent ("the price for 100 kilobytes per second in Africa is the highest in the world"). In 2014, the Seychelles recorded internet use for more than 50 percent of every 100 inhabitants, the only country to have achieved such feat. On the continent, there were marked disparities in recorded levels of internet usage among countries - as per every 100 inhabitants, Eritrea recorded less than 1 percent with some twenty-four other countries showing some improvement in this area with 10 per 100 inhabitants. Countries such as Ghana, Mauritania, Cameroon, Liberia, Lesotho, Mali, Côte d'Ivoire, Lesotho and Mali made remarkable stride in performance with growth in internet usage per 100 inhabitants growing by more than 50 percent in 2014 (Pupulampu and Hanson, 2016). See Chapter 7, sub sections 1.3 'SDH – Healthcare services and impact on the UHC' and 2.1 'Health in All Polcies and the empirical evidence' (Pgs. 312 – 314) for specific details of progress made and potential held by Ghana in relation to internet usage, Information and Communication Technology (ICT), e-health and Health Information Systems (HIS). The SDGs focus on health (Goal 3) is laudable and broad – covering indicators which as defined by Lim et al. (2016), include 'health services, health outcomes, and environmental, occupational, behavioural, and metabolic risks with well established causal connections to health' with effective monitoring spreading to areas such as immuinsation coverage, antenatal coverage, coverage of antiretroviral therapy for HIV patients, coverage of skilled birth attendance and others. The WHO (2018: 2) further divides the SDGs into two main categories – the environmental and political determinants of the SDG 3 which explains the influences of all the other SDGs on health and its outcomes.

Provisional conclusion of the links between the SDH and the SDGs in Africa

Although the MDGs' performance has been described as patchy earlier (Boidin, 2017), it sets the precedence for how the SDGs should be approached. In the estimation of Griggs (2013), 'The MDGs have shown that a goal-setting approach raises both public and policy support and channels funds effectively towards urgent global problems'. As the SDGs remain a continuum of the performance of the MDGs post - 2015, it is expected that African countries would strive to improve on gains made during the MDG era to make the transition to the targets set in the SDGs smoother and rely on the proven modalities by which aspects of the MDGs were achieved. The **SDGs have slight modifications in targets with emphasis on health**. According to Boidin (2017), the uniqueness of the SDGs is in its fundamental awareness of the need for each goal to work in cohesion with others in achieving expected outcomes, thus, thus, the SDGs seek a multisectoral approach for impact. Due to the reinforcing nature of the SDGs, it additionally incorporates the principles of the SDH in application (Boidin, 2017). Indeed, the SDGs act as a set of better-interacted set of goals than the MDGs, influencing policy cohesion across various sectors (Le Blanc, 2015: Kieny et al., 2017) and reinforcing each other in achieving development for all.

1.4 The Health in All Policies (HiAP)

As discussed earlier, the social conditions within which people are born, grow, live and work are determinants of health, universally. These conditions have a relationship with their health status and invariably determine whether they are productive or not and whether die old or young. There are issues of inequity involved in access to healthcare emanating from these social determinants of health for which the global call for UHC has been made. The UHC cannot be addressed holistically as its success is dependent not only on the health sector but others, consequently a call for all the other sectors to perform in unison as the SDGs endorses, with a focus to maintain the ultimate objectives of health as a goal. As seen in Box 5 (the SDGs) , the sphere of influence of intersectoral impact for health is vast and as such calls for a mechanism to address all areas of coverage being socio-economic, cultural and environmental conditions as recognized under the SDH discussion and the SDGs. The SDGs that have a bearing on health are categorized as social, economic, environmental and political as per their influence on health (WHO, 2018: 2, 38, 83).

Due to the multidimensional contribution made to all aspects of life, great "value" is placed on health - physiological, social and economic environments. Not only are both adults and children able to be productive whether learning or working, health is said to be "good for business" as its influence can be felt not only at the micro (individual) level but also at the macro (national) level where healthy populations can effectively contribute to economic growth (Leppo et al., 2013). The definition of health inequities is given as **"avoidable, unfair and unjust differences in health status within and between countries"** can be traced to the SDH. It is believed that public policies have a role to play in bridging the gap in health and health inequity by positively influencing "healthy choices" among populations. Relying on the application of public policies that are reinforcing of each other has fascinated much of the global discourse on development and seems to be the way to addressing the many evolving challenges especially in health (Leppo et al*.,* 2013). Health in All Policies (HiAP) as a concept has emerged as an approach aimed at stimulating decisive action towards the achievement of the SDH with a focus on imbibing into the fabrics of other non - health sectors, health concerns (Baum et al*.,* 2014).

Health in All Policies (HiAP) strategy is not new in the development arena, hitherto tagged differently but has been around for decades. However, its prominence came to be globally, with the Finnish EU President's (2006) deliberate acknowledgement as Healthy Public Policies (HPP). Albeit, the fundamental meaning attached to it remains same with pathways to achieving it slightly divergent. The HiAP is science-based, approaching the SDH in a logical manner so as to incorporate health concerns in other sectors (Bacigalupe et al*.,* 2010). According to Baum et al. (2014), the recognition of the social, economic and political influences on health is not new and can be traced back to the "Alma Ata Primary Health Care Strategy (World Health Organization, 1978)" and also, it formed an important part of the Ottawa Charter (Baum et al., 2014). Bacigalupe et al. (2010) considered that the Charter's refocusing on the social determinants of health away from individual-based causative factors to health introduced a more fundamental collective viewpoint to the issues of health and also tended to incorporate a participatory and empowering dimension to the broader subject of health (Bacigalupe et al., 2010). The Helsinki Statement on Health in All Policies (2014) indicates that, the HiAP approach has been reinforced in the more recent 2011 Rio Political Declaration on Social Determinants of Health, and the UN General Assembly Resolution on the Prevention and Control of Non-Communicable Diseases (Tang et al., 2014).

1.4.1 Health in All Policies (HiAP) definition as a concept

With the way development issues are taking place globally and locally, there is no one particular sector that stands the chance of success as a standalone – policies derived and intended for one sector almost always cascade into others to see smooth implementation and impact. There is also an aspect of the same policy implementation discourse that could have unintended and yet catastrophic impacts from one sector onto other sectors (Leppo et al., 2013).

The description by Baum et al. (2014) of the HiAP is that it is a logical methodology that affords public policies on health to infuse itself into those of other sectors in unearthing the health implications (in decisions and actions) in those directly unrelated sectors and invariably averting the detrimental impacts of them on the health of those populations (Baum et al., 2014). It provides a foundation for policy makers from the health sector to work with those in other government sectors to consider the potential health impacts of policies as they are developed and implemented. This type of approach provides assurance to policy makers of at best, positivity of impact on population health and at worst, a zero effect of other sectors' policies leading to total well-being (Baum et al., 2014).

The concept of HiAP is grounded in the tenets of the Universal Declaration of Human Rights (especially Articles 21, 22, 24 and 26), the United Nations Millennium Declaration, and accepted principles of good governance and under sustainable development under the UN which are all intersectoral in nature with a policy-making tilt (Leppo et al., 2013).

Essentially, the HiAP embodies the following guiding principles (Tang et al., 2014):

- legitimacy grounded in the rights and obligations conferred by national and international law
- accountability of governments towards their people
- transparency of policy-making and access to information
- participation of wider society in the development and implementation of government policies and programmes
- sustainability in order that policies aimed at meeting the needs of present generations do not compromise the needs of future generations.

- collaboration across sectors and levels of government in support of policies that promote health, equity, and sustainability.

1.4.2 Justification for the adoption of the HiAP

The relevance for the use of the HiAP by governments in public policies cannot be underestimated. Its adoption promises to have trickledown effects into all sectors - social, economic and political, to reinforce the policy-making process in participating countries. The synergy it seeks among the different sectors lends support to the presence of the SDH which addresses issues of inequities in health and by extension in other non-health related sectors. The importance for adopting the HiAP approach is first, in its ability to help find links among relevant sectors and second, for its strength in providing avenues for sustainability of initiatives related to health due to the dependence on the strengths of all collaborating sectors. Thus, it gives a win-win outcome (Leppo et al., 2013) to all participating sectors' initiatives which inadvertently reinforce each other, creating a platform for accountability and better understanding of expected outcomes. This raises the level of confidence in the partnerships formed through HiAP and forms the basis for commitment for parties to see initiatives under HiAP through. Although the multisectoral approach is present in for instance in the governance structure of the NHIA where at the board level and as enshrined in the law establishing the NHIA (the section 3 of the National Health Insurance Act 2003, Act 650), there is representation from the Ministry of Finance and Economic Planning, the Ministry of Health, the Ministry of Gender, Children and Social Protection, the National Insurance Commission, the Social Security and National Insurance Trust (SSNIT), organized labour and others, same cannot be said for the HiAP's place. An overt health policy-infusion is not present in the individual sectors represented.

1.4.3 The connectivity among the Universal Health Coverage (UHC), the Social Determinants of Health (SDH) and the Health in All Policies (HiAP)

The UHC with its strong connection with the SDH is touted as a revolutionary goal that has the potential to reduce poverty, promote economic growth and ensure equity in health and its deemed as a pivotal goal in the "post-2015 global development agenda", with progress towards its achievement projected in 2035 as gradual by reports from the "Lancet Commission on

Investing in Health" (Abiiro and Allegri, 2015). The UHC as a target, captured under the SDG 3 (and target 3.8, specifically), derives its importance from being the one goal that has the ability to affect the well-being of populations through the provision of access to healthcare (geographically) and the prevention of same by averting its catastrophic financial impacts. It has been echoed as the single most significant and impactful concept of this generation to help reduce the negative effects of both communicable and NCDs on populations with a focus on equity. And with Dr. Margaret Chan's (WHO Director- General) resounding support of its relevance to development in 2012 that the *"universal coverage is the single most powerful concept that public health has to offer"* and also mirrored prominently in the 2012 United Nations General Assembly Resolution, it was repositioned high on the global development agenda (Tangcharoensathien et al., 2015; Schmidt et al., 2015). It is also one goal that has been able to galvanize all the other goals around it in terms of influence (WHO, 2018: 2).

Abiiro and Allegri (2015) clarify that the achievement of the UHC with its effects translated in the SDH, and the SDGs are not the sole obligation of governments neither is it that of the private sector. Even within government, it cannot be placed in the sole ambit of only the health sector. Their integrative nature recognizes the potential of all sectors' contribution to their achievement through the lens of HiAP. Wagstaff and Claeson (2014) point out that the relevance of roads and transport are relevant to the SDGs targets on maternal health and child mortality but can they be said to be the only targets relevant to reducing maternal health? What about the contribution of water and sanitation (SDG 6) and what of the promotion of well-being under the SDG 2 responsible for ending hunger, achieving food security and improving nutrition? All the other SDGs are complementary lifelines to the provision of healthcare and eventually evidenced in the way in which people live and work (the SDH). They cite an example of a 10-year study in Rajasthan, India, that reports of the role better constructed road networks and transport played in hastening women in reaching referral facilities but many of who sadly died as a result of a lack of correspondent improvements at the households and facilities' levels. In their estimation, "improved hygiene (hand-washing) and sanitation (using latrines, safely disposing of children's stools) are at least as important as drinking water quality in shaping health outcomes, specifically on reducing diarrhea and associated child mortality" (Wagstaff and Claeson, 2014).

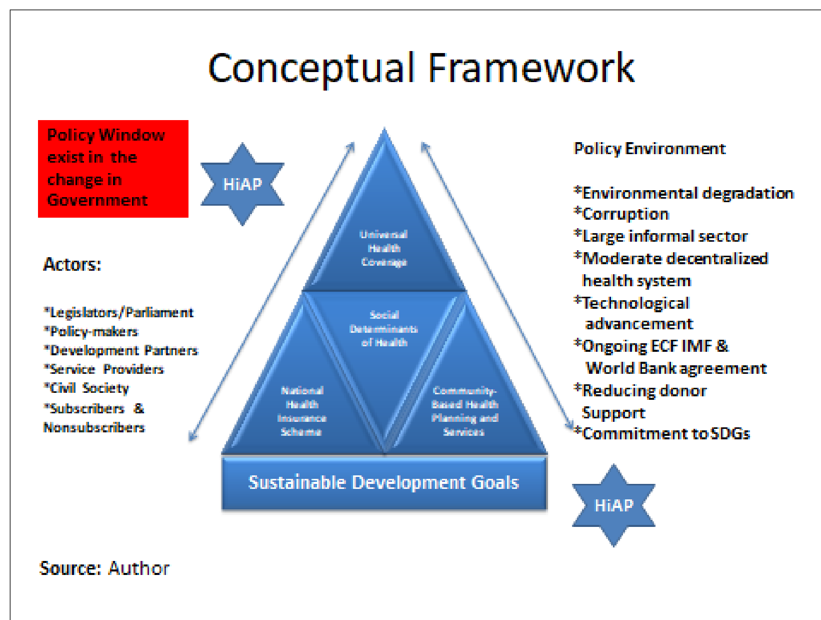
Investment in infrastructure development should be complemented with education and promotion of health-seeking behaviours for desired health outcomes - this is at the heart of the intersectorialism ideal behind the UHC, HiAP and SDH. Kieny et al. (2017) make a link of the health goal and the health sector in general in promoting economic growth (SDG 8). They emphasis the role the UHC could play in promoting the achievement of four specific SDGs – that the UHC in seeking to improve health would render a healthy working population and support the 'end poverty in all its forms everywhere' (SDG 1). The SDG 4 is enhanced when the health of children and adolescents are secured leading to better outcomes in education. They point out that due to the high presence of women (more than 75 percent) in the health workforce; a well-functioning health system for the UHC could contribute to the SDG 5 (achieving gender equality and empowering all women and girls). Finally, they submit that by the strengthening of health systems towards the achievement of the UHC, the SDG 16 that emphasizes the promotion of inclusive societies for sustainable development, provision of access to justice for all and the building of effective, accountable and inclusive institutions for all, would be improved (Kieny et al., 2017). Tangcharoensathien et al. (2015) further iterate that the critique of the number of SDGs being 17 goals with corresponding 169 targets, their interconnectedness reflects the unifying fashion by which they can all be achieved by countries. Thus by seeking to achieve all the key areas that the goals address, equity and health concerns would be correspondingly secured (Tangcharoensathien et al., 2015). A supporting example is given by Xu et al. (2015) of a not easily forgotten pandemic that hit the West African sub region - the Ebola. They explain how through the Ebola crisis weaknesses in the healthcare system were exposed which threatened not only individual health security but the collective of an entire continent. This was a classic health sector concern which in no time moved to endanger not only in-country security but cross border security and sub regional tranquility.

Section 2: Conceptual framework and policy-making in Africa

This dissertation has its foundation based on three main concepts from which analysis are made in relation to the country in focus – the UHC (as embedded in the SDGs), the SDH (as relayed in the HiAP) and the Kingdon's multiple-streams (Ridde, 2009) and Kingdon's (2011) agendas, alternatives and public policies. Their interaction is captured within a framework which allows for discussion individually and as a working unit. The conceptual framework designed below explains the environment within which the concepts, policies and actors interact (emanating from Kingdon's (2011) agendas, alternatives and public policies on policy making). It is also based on this framework that respondents for the empirical study were selected (Kingdon, 2011: 46 - 70) on **interest groups**.

The health goal, concept and initiatives - with the achievement of the UHC as the ultimate goal for this dissertation would be looked at as policies which have to work in line with each other. The UHC which seeks to address the problem of inequity in access in Ghana's healthcare system through the NHIS and the CHPS would be given an exploratory focus on what could be achieved if the two health policies were implemented not as silos. The policy vehicle for the exploration would be the HiAP which would look at in terms of its possible contributory role of an intersectoral approach in improving the lot of the two policies in translating the effectiveness of the policies in the lives of the Ghanaian people and related SDH. The SDGs which are goals already set for all the sectors would be used in the conceptual framework as a means to measure progress and explore possibilities for a HiAP approach to development in general. The achievement of the UHC are already in operation in the country and would not be explored in detailed here but mentioned when related to any of the aforementioned goal or concepts.

FIGURE 4: CONCEPTUAL FRAMEWORK FOR DISSERTATION - POLICIES, CONTEXT AND ACTORS



In reference to Agyepong and Adjei (2008), the environmental context of policy-making is relevant to its eventual success or not. In light of this, Ghana's current environment (as indicated in the diagram) in terms of the economic policies (IMF/World Bank with the market-oriented prescriptions, attempt at fiscal discipline, dwindling donor support), corruption (as seen in terms of both institutional and political here with its consequent effect on investment in the health sector), and technological advancement (innovations in the telecommunications space would be explored in relation to the NHIS and the CHPS which often serve populations in the rural areas). The actors' and their unique roles and possible power play are also situated in the environmental context. They would act as source of data collection and a means of validation for the hypothesis of this dissertation.

There is of course a policy window (Kingdon, 2011: 15 - 170) presented with the election of the NPP into government again in the 2016 election (they previously passed the NHIS into law in 2001). It would be interesting to observe what new policy innovations would be reintroduced to the NHIS. This change in power and its potential influence on policy lends credence to what (Fox and Reich, 2015) posit about policy being an output of a political process and that at each stage of the policy reform, politics is located.

Finally, this study takes note of observations made by Carrey and Crammond (2015) about the complexity in the policy process and; Boidin (2017), in the difficulty in implementation of an SDH-based approach and a comprehensive health policy. And also as indicated by Gilson and Raphaely (2008), about possible contestations in proposing a policy change and with the myriad of actors cited in the diagram, resistance or otherwise could be detected during data collection and analysis in Part three.

In the ensuing sub sections, the general policy-making environment in Africa (2.1), the global framework with which agenda-setting, alternatives, decisions and policy implementation (2.2) are made, come into focus. Also, different aspects of the policy-making process are delved into such as the agenda-setting and alternatives discourse phase (2.2.1), followed by the decision making phase (2.2.2) and a view of the actors involved in the policy-making process (2.3). Finally by using Kingdon's framework, comparisons are made among African countries and their pathways to pursuing the UHC goal implementation (2.4 and 2.4.1).

2.1 Policy-making in Africa

All the health goals, concepts and initiatives described earlier fall in the categorization of policy when viewed with implementation as focus. The Conptual Framework for the entire dissertation puts into focus the various actors which interact with the different concepts in the research (discussed in the earlier sub section). It brings into focus the processes yet to be undertaken or have already been undertaken by countries interested in the implementation of UHC.

To introduce the concept of policy, a basic definition of it as described in the work of Wallace (1972) is given as "the conduct of public affairs e.g. government policy" is considered. It is within this mindset that policy in this dissertation would be addressed - in the conduct of public policy within government. To discuss the UHC in the context of policy involves a look at the process, the various actors, their unique strategies, the various approaches and the different modes of implementation. This is important as it serves as the framework within which the UHC as a policy will be looked at in subsequent chapters of the dissertation. However complex the issues surrounding policy-making and implementation are, the attainment of the UHC would prove inevitable without it.

In the words of Savedoff et al. (2012a), the important role of public policy in the attainment of the UHC has a theoretical and empirical basis - thus, in the theory it has been proven that efficiency in the administration of social health insurance is difficult when undertaken within competitive markets. Empirical studies conducted also prove that such market failures as identified by the theory in relation to health insurance and inherent in healthcare systems can be addressed through public action with ultimate outcomes of better care delivery (Savedoff et al., 2012a). The public policy-making process and implementation are known to be challenging but they are the only known strategy through which countries have managed to implement the UHC (Savedoff et al., 2012a). As earlier intimated, none of the laudable and much-discussed global health goal, concepts and initiatives have the ability to impact population health of countries unless through the adoption and implementation as policies. Gilson and Raphaely's (2008) article focused on a first ever review of literature analyzing the health policy processes of LMICs, the empirical analyses based on 164 articles show that policy is the sum total of the social interactions among the various actors in the process and that what is pursued is the outcome of the connotations assigned (Gilson and Raphaely, 2008). As has already been mentioned in association with the UHC's implementation, there is subjectivity in the interpretation of the definition of the goal (Abiiro and Allegri, 2015; Stuckler et al., 2010), and hence, the successful implementation and eventual achievement of the health goal (earlier described) depend much on the efficacy of interpretations that the various actors would render it in their various constituencies, leaving its attainment or otherwise at the mercy of the policy - making process.

For the discussion about policy as pertains to this dissertation, the policy-making process which include agenda-setting and decision-making, the actors and context and finally, implementation will be looked at. Lindblom and Woodhouse (1993) have suggested that the best way to understand and explain policy is to break it into its various constituent parts for analysis and that such a systematic approach commences with a view of how issues arise and find themselves on the agenda (Pg. 10). It should not however be assumed that this stated systemic approach to policy-making has a logical flow to how it proceeds but that, it is seen as "increasing in complexity" (Carey and Crammond, 2015) and bears a resemblance to a "primeval soup" with ideas and actions interacting with each in an incoherent manner (Kingdon, 2011: 116 - 144). The primary level author's work for the policy part of this dissertation is aspects of John W.

Kingdon's multiple-streams framework and his agendas, alternatives and public policies (2011). Both of which have been in existence since the 1980s and possesses embedded experiential logic which have been used in the study of policy not only in the health sector but also in international aid and education. Kingdon's multiple-streams framework and agendas, alternatives and public policies are used in the analysis of policies related to this study, not exclusively though, as sometimes some other concepts are applied jointly and liberally (Rawat and Morris, 2016; Riddde, 2009; Kingdon, 2011). Critiques levelled against the Kingdon's multiple-streams framework notwithstanding, (Ridde, 2009) notes that this framework is noted for its prominence in health policy research, analysis and especially, implementation. There is an appreciation of this framework's scientific relevance in literature and actual implementation, as witnessed in the Bamako Initiative's roll-out in Burkina Faso, a West African contextual policy environment (Ridde, 2009) and for the Kingdon's agendas, alternatives and public policies (2011), its use in the healthcare system reform efforts of the United States of America including the eras of former presidents, Clinton and Obama administrations.

Although mentioned here as a linear, almost simple process, public policy-making is not deemed as such (Ridde, 2009). The identified set of interconnected processes is: (1) the agenda-setting phase; (2) alternatives' discourse (from which some choices may be made instead of a substantive choice made); (3) decision-making from alternatives and; (4) implementation (Kingdon, 2011: 2 - 18). As intimated earlier, aspects agreed for use in this study are based on the three processes preferred by Ridde (2009) – agenda-setting, formulation and implementation. Several discussants of public policy are known and a great many debates held over the preference of Kingdon's work over others in the area of health. For instance, the chronological approach to public policy process analysis by deLeon's stages heuristic has been criticized by Olivier de Sardan and Ridde (2015) for being too linear (Ridde, 2009). This policy-making framework would be used in this dissertation in explaining Ghana's choices of policies leading to its current policy choices for the UHC; how the National Health Insurance Scheme (NHIS) appeared on the agenda, how its ultimate selection was made and its implementation. Policy is understood as a creation of diverse interactions between political and social processes (Gilson and Raphaely, 2008). Indeed, public policy in Africa is believed to be molded by the many influences of international institutions and development partners, who sometimes use 'one-size-fits-all' models and approaches to development and by this promote the incoherence in the policy

framework and thus, present many of the challenges experienced at the implementation stage of the process - this was experienced in the adoption and implementation of user fee exemptions in health in some francophone African countries - Burkina Faso, Mali and Niger (Olivier de Sardan and Ridde, 2015).

It is critical to acknowledge the international political antecedence which forms part of the inception of the UHC's current eminence as an international health goal and how its choice as a model worthy of adoption and implementation is also captured prominently in the same political economy, even at the country level (Kickbusch, 2016; Stuckler et al., 2010; Savedoff et al., 2012; Rowden, 2009: 166 - 167; Marmot, 2015). Despite the potential challenges inherent in the policy-making process, there should be observed coherence and effectiveness, which are the ultimate aim of every public policy (Olivier de Sardan and Ridde, 2015). Some four variables (which act independently and yet interdependently) have been cited as being influential on health policy outcomes - interests, institutions, ideas, and ideology, the four I's (Fox and Reich, 2015: 1022). This position is shared by Kingdon (2011: 45 - 70) where the grave importance of the various interest groups with divergent opinions, interests, resource base and levels of influence on the policy-making process is expressed. Indeed, Kingdon (2011: 49) notes that while these interest groups may be promoting ideas which may be new or encouraging the maintenance of others, the issues that eventually emerge in the spotlight for governmental consideration do so based on a myriad of complex issues, not necessarily from the interest groups. For the Fox and Reich's (2015) four I's, the first being interest, represents the interests harbored by the actors (these may be policy makers as individuals or representatives of institutions or sectors) in the political process which may be expressed in their preferences of the different policy options. The ideas expressed in support of such options and their placement as primary or secondary policy options are often fueled by the belief system which make such individuals or representatives of institutions choose and defend their positions held concerning the policy choices.

2.2 Global framework - agenda-setting, alternatives, decisions, actors and implementation

The agenda, as perceived by Kingdon (2011) can best be described as the selection of issues that attracts and holds the attention of a variety of stakeholders within and out of governmental business (Pg. 3). The issues as placed on a list may differ from one part of government to another

and even within a particular sector; the issues of concern may vary in terms of magnitude and may be called the alternatives (Kingdon, 2011: 3). For many reasons, some agenda items never find themselves as priority despite how long they may have been presented - such reasons as absence of public interest and acceptance, inadequate fiscal space to accommodate their implementation, resistance by interests of "actors" more powerful in the policy space and others are noted in that stead (Kingdon, 2011: 18). The Kingdon's multiple-streams would be used subsequently in explaining the process of policy-making for the NHIS and the CHPS (in relation to the UHC) however; the last phase being implementation is discussed in detail under in the specific case of Ghana's implementation of the NHIS policy captured in 1.1 of Chapter 4. And iterative as the policy process is, it would be realized that in the case of Ghana, even at the implementation stage, a review of the approaches for implementation has been called for.

2.2.1 Agenda-setting and alternatives discourse phase of policy-making

The agenda-setting and decision-making stage is often necessitated by three main factors – firstly, the emergence of a problem in the public domain for which a solution must be sought (Kingdon, 2011: 16; Olivier de Sardan and Ridde, 2015), and the ways in which those solutions are brought about in making the most potent choice for the problem, have generated a great deal of literature. The second source of government agenda (and alternatives) is cited as the repository of knowledge or information gathered over time on a particular issue or subject among stakeholders, for example, researchers, bureaucrats, civil society groups etc. And the third and final, which is more populace in nature is how politics impacts policy agendas with such influences as election outcomes, "swings of national mood", and whims of public opinion (Kingdon, 2011: 16 - 18). How the free healthcare model as applied in public health administration gained international prominence after its neglect for some time is documented as such and how it "suddenly" got adopted by heads of African states has been researched (Olivier de Sardan and Ridde, 2015) reflects the above notion. But the journey and the debates surrounding user-fees for service in the health sector and the discussion of the introduction of a form of health insurance in Ghana and many other African countries was not sudden, many have gone through various policy and political processes from the 1980s to date (see Table 1 for current status of some African countries journey on the UHC), reflecting a mixture of the three

factors described above (Olivier de Sardan and Ridde, 2015; Agyepong and Adjei, 2008). In Ghana, debates surrounding the “cash and carry” system which had been introduced as an alternative to the Free-for-Service (FFS) had been replaced in an era of Structural Adjustment Programmes (SAPs) and Economic Recovery Programmes (ERPs) which demanded cost recovery for aspects of healthcare. But due to the challenges presented by the Out-of-Pocket payments (OOP) also known as the “cash and carry”, the mood of the country was to seek a more sustained method of healthcare financing that did not have catastrophic impact on the population especially the poor. See Box 7: Political and institutional policy-making and implementation transitional process for Ghana’s NHIS (2.3) for the history of the NHIS since the 1970s in Ghana under different themes and governments. This is intended to add value to the discussion of policy-making and to reflect the notions expressed earlier that the current state of healthcare in African countries, and Ghana in particular has not happened ‘suddenly’.

Issues on the agenda are “pushed to prominence” after many phases of proposals, discussions, debates, workshops, media coverage and public discussions - a form of “natural selection” (Kingdon, 2011: 116) where ideas are strewn around in hopes of the logic of such ideas prevailing to the many “actors” or interest groups who have their own issues of concern and interests on the agenda. Ridde (2009) points out the three origination sources of policy according to Kingdon’s multiple-streams as – the problem, political and policy streams. Kingdon (2011: 116) submits that some of the debates at this stage can often take years. Many of such debates were witnessed in countries such as Mali, Niger, Ghana and others concerning the financing of healthcare in those countries. In Ghana and still at the discussion phase (also known as the ‘garbage can model’, this approach of decision-making by organizations is also emphasized by Cohen et al., 1972[13]) of decision-making for a critical healthcare reform, there was even a debacle between the government and the Trades Union Congress (TUC) - the largest organized labour group in the country at the time concerning the government’s proposal to use part of labour’s social security contributions as part of funding sources for the NHIS which sparked

[13] The ‘garbage can model’ describes the decision-making situations of organizations emphasizing three characteristics – the problematic preferrences, unclear technology (the how) and the third and final, fluid participation. The process has been described as being synonymous with organized anarchies with two concepts for better comprehension expressed as first, the way in which organizations are able to make decisions in the absence of coherent shared goals. The second is the conduct of members of the decision-making organization – the attention patterns of these member, the drivers of their focus on particular issues (Cohen, March and Olsen, 1972). Similar positions on the ‘garbage can model’ have been described by Kingdon (2011: 85 – 86) and Ridde (2009).

controversy in the policy-making process (Dovlo, 2005; Olivier de Sardan and Ridde, 2015). These processes, referred to by Olivier de Sardan and Ridde (2015) as the "Deliberative process"- incorporates a diagnosis of the problems to be addressed with differing views proffered by the actors in the agenda space such as subject matter specialists/experts on health, legislators on health committees in parliament, development partners, and other interest groups. Such interest groups include entities captured in business and industry - healthcare providers, organized labour, academics, researchers, consultants, media etc. seek to find coherence and effectiveness in the policy decisions and outcomes in order to avoid policy gaps during implementation, which would be a recipe for failure (Kingdon, 2011: 46 - 60; Olivier de Sardan and Ridde, 2015).

The "Deliberative process" is necessary to bring out the eventual best solution or priority on the agenda and, Woodhouse and Lindblom (1993) and Lindblom (1968:6 - 10) hold a measured opinion (after reviewing the analysis phase of different institutions in their policy-making efforts) that the usefulness of intellectual and well-researched information debates is not to be undermined but then due to the fact that inherent in the policy-making process is the simmering influence of politics, its actual effect remains somewhat contentious and questions why policy-making remains poor despite the great asset that analyses and deliberations present to the process. The author of this study after assessing the different intricate deliberations and analysis in the studies of Lindblom (1968) and Kingdon (2011) prior to embracing what remains in the 'garbage cans' begs the question that should the real attention of the agenda-setting phase of policy then not be pinned on the conflict between the lure of logic-scientific-reasoned evidence and the power of persuasion through politics among the interest groups or actors over the ultimate choice of what becomes the agenda, what becomes alternatives and what is thrown out (Lindblom, 1993: 6 - 20; Kingdon 2011: 4 - 44)? In response to the UHC call, Ghana after much policy and political deliberations, settled on the NHIS as top on the **agenda** with all other health interventions such as the Community-Based Health Planning and Services (CHPS) (by virtue of attention and resource allocation), playing **alternative roles**. It is also important to note that under the agenda- setting phase, perception is a major driver to first, prioritizing an issue on the agenda and secondly, due to same, either maintaining it on the agenda or reintroducing it at a later date. In line with the three streams earlier mentioned, there must be a 'coupling' among them to realise specific outcomes – policy entrepreneurs usually 'couple' a problem stream with

that of a political stream for policies to emerge. Thus, there are windows of opportunity that appear unannounced or announced in any of the streams; nevertheless, these opportunities must be taken advantage of for preferred policies. The chances of other windows of opportunities appearing in an area related to the current remains high and this is what is referred to as 'spillovers' (Ridde, 2009; Kingdon, 2011: 165). Kingdon (2011) emphases that, "policy entrepreneurs must be prepared, their pet proposal at the ready, their special problem well-documented, lest the opportunity pass them by." The coupling is a condition precedent for the emergence of a policy (Ridde, 2009) and the contention remains with the problem and political streams and not the policy stream[14] (Kingdon, 2011: 173 – 174). There is also the matter of the national mood which Ridde (2009) points out that without easily recognizable problems or solutions, one cannot take advantage of.

2.2.2 Decision-making phase

Agyepong and Adjei (2008) point out that if the context in which an issue is introduced is perceived as one of a crisis situation, often it attracts attention and pressure from actors for urgent action and its importance on the agenda gets pushed to the top as stakes may be considered high for reform and the burden for change, eminent. Conversely, issues perceived as not in the crisis category are treated as "business as usual" and do not get the urgency assigned to the others based on the perception factor. Such issues in this category would usually be attended to in an incremental manner by the actors in the agenda-setting space including politicians, bureaucrats, interests groups, lobbyists etc. (Agyepong and Adjei, 2008). They observe how the NHIS in Ghana got to be prioritized in the 2000 presidential elections, that as part of the campaign promises, the then opposition party New Patriotic Party (NPP) won power based on their promise to abolish the "cash and carry" (OOP) system of healthcare financing which the electorates had perceived as burdensome and pressing. Here is an example of how Ghana's NHIS is apt in describing the adoption and implementation of the policy decision that was considered critical in a political space and one which which commanded the backing of an act of parliament with appropriate fiscal space made for its implementation. It can also be said that

[14] The policy stream could potentially enjoy a 'coupling' in the event that policy makers become convinced that a problem is in need of a solution. Also, when politicians begin setting themselves up for reelection, they may scout around for proposals in the policy stream (Kingdon, 2011: 174).

continuous perception and public discourse about healthcare and its importance has managed to keep the NHIS on the national agenda over a decade down the line into 2018, and through another cycle of general election. It can then be surmised that "generally, then, the lower the partisanship, ideological cast, and campaign visibility of the issues in a policy domain, the greater the importance of interest groups" (Kingdon, 2011: 47), and hence the perception attached to political promises made and how they form the basis for placing issues on the agenda. On the other hand and in connection with the UHC, the CHPS, which has gone through thorough research and has spent many years at the piloting phase, only recently got as much public and government attention, and even so, not at the same level as the NHIS.

2.3 Coupling and actors involved in the process

The contexts within which the health goal, concept and initiatives are translated into policies and applied are significant in this study. **Even though the Kingdon's multiple-streams framework (Ridde, 2009) and Kingdon's agendas, alternatives and public policies are the first level authors in use for the policy analysis for this dissertation, they are not used fully in a systematic manner as in the case of Ghana, the emphasis on the roles and interaction of actors (institutional and policy makers) is considered more salient.** Agyepong and Adjei (2008) posits that **'The traditional focus on the content of policy neglects the other dimensions of process, actors and context which can make the difference between effective and ineffective policy choice and implementation'**. For this, all the interest groups/or actors with differing influences on the policy options related to the UHC's implementation are discussed. The 'coupling'[15] in Kingdon's multiple-streams is also looked at in combination with the actual role of the actors in the emergence of the National Health Insurance Scheme (NHIS) in Ghana. These categories of actors are sometimes described as 'governing elites', 'street bureaucrats' and 'demons' in the case of public officials and individuals who may wield such negative influences on the policy process bordering on accountability issues (Agyepong and Adjei, 2008).

[15] Coupling is explained as a confluence of items floating in and around government in search of recognition, analysis and debating in hopes of an adoption in the event of a shift in the political space. The coming together of the different items which may be in either the problem or politics stream would allow policies to emerge. In the absence of this process of coupling, no policy can emerge (Kingdon, 2011: 172 – 173; Ridde, 2009).

The natural offshoot of the earlier discussion on the agenda-setting process is that of the emergence of the NHIS and the CHPS as the key policies for the UHC journey and the interactions among the actors in the policy framework. It is important to note that in the discussion of actors, the weighting of power (not only in resources availed to them by virtue of position) domiciled in each in influencing the policy, differs – for some, they seemingly wield a lot of power but in actual fact do not while others remain powerful all through the process, from setting the agenda to implementation of policies (Kingdon, 2011: 42 - 59). Gilson and Raphaely (2008) describe these policy actors as simply not only the participants in the policy-making process alone but inclusive of all parties with interest in what developments may emanate from the outcomes of such policies, examples such as civil society organizations, actors in the private sector, beneficiaries etc. Boidin (2017) maintains the view that without taking consideration for the context within which policy is placed; expected outcomes may not be realized. He cites the example of the SDH-based approach's failure to have made progress in the development arena and the SDGs' implementation within weakened local public authorities in light of economic crisis and the dictates of development partners and its effects on their ability to embark on holistic health policy reforms. He indicates that the oversight of the implementation of health policies is tasking enough, even for developed countries, how much more for LMICs with weak health systems (Boidin, 2017). The complexity of the dynamics connected to the policy process to eventually reach implementation cannot be underestimated. The breadth of its importance is far-reaching, all through to the beneficiaries and degree of health outcomes hoped for.

Political stream: The roles of political institutions and public bureaucracies in policy-making are important aspects of this analysis, but it also acknowledges and considers the influence of non-state actors, including private sector and civil society organizations, as well as, in low and middle income countries (LMICs), international agencies (Gilson and Raphaely, 2008). In the case of Ghana, for example the development partners and other non-state actors such as the the Trades Union Congress (TUC) played key but divergent roles in the establishment of the NHIS – the former rendered technical assistance and funding. In the context of Ghana and for a policy to emerge, politics plays a key role. Thus, the political stream places high on the agenda in the policy environment of the country (Kindgon, 2011: 198). Agyepong and Adjei (2008) observe that the effective selection and implementation of a particular policy depends very much on whether a holistic view is taken in looking at the process itself, the actors involved and the

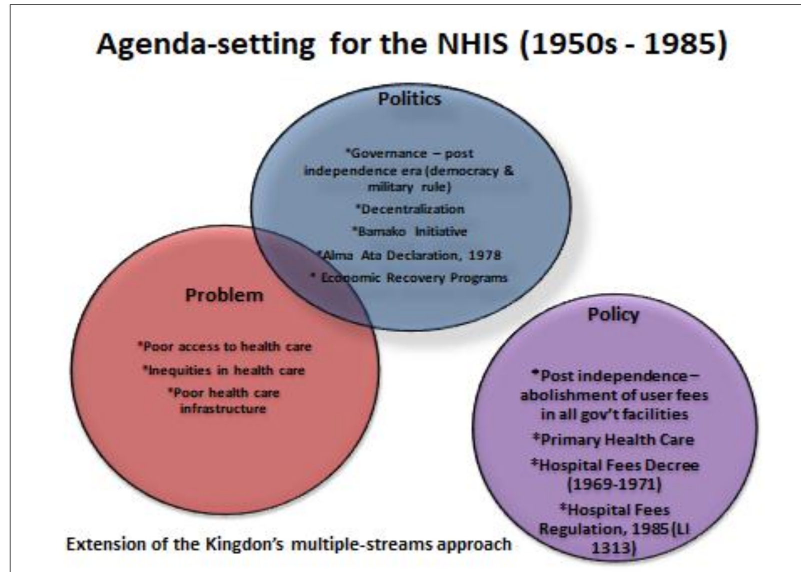
context. The actors representing the various interest groups in the process interact in ways that allow the policy to become prominent or get discarded.

Glassman et al. (1999), in a political analysis of health reform in the Dominican Republic indicate that there is a perpetual strain in the relationship between technocrats and politicians in the space of health reforms (Glassman et al., 1999). This is also observed in another paper on actor management in health financing in South Africa which concluded with similar observations (Agyepong and Adjei, 2008). In the case of Ghana's initiation of the UHC with the NHIS as the lead on the agenda, the discussion started under different political regimes, bureaucrats and technocrats decades before a particular political actor (the New Patriotic Party - NPP) reformed and legalized it in 2000 via the electoral campaign process. Thus, between the periods of 1970 – 1985, various efforts had been made at both the international level (with initiatives such as Bamako Initiative (BI), the Alma Ata Declaration and others) and the local level witnessed a number of policies including the abolishment of the user-fees, reintroduction of it for specific services, the introduction of the Community Clinic Attendants and Traditional Attendants in 1977 and others (MoH, 2016, CHPS Policy: 8). Thus at this stage, and with the country going through its own changing phases of governance (prominent for a time was military rule), there was a coupling of the persistent healthcare problems with the politics of the time and this formed part of the agenda-setting phase without the emergence of a concrete policy to eliminate catastrophic health expenditures (see Figure 5) for the case of Ghana at the agenda-setting stage, before the emergence of the NHIS.

The main influential actor in 2000, since power had changed with a new administration in place and by promising the NHIS to the Ghanaian people, and the agenda set, was clear. Thus, the context within which the formal NHIS was birthed was a political one which called for commitment in honoring a promise made to the electorate (another interest group). The president at the time, President J. A. Kufuor as an actor, who after the election championed the course of the NHIS on behalf of his political party (also another interest group) could be described as wielding much more power than others in setting the agenda but not in totality. It is not surprising that the presidency is accorded much respect, it is said that **"No other single actor in the political system has quite the capability of the president to set agendas in a given policy area………"** And he became a policy entrepreneur who coupled the problem stream of poor

healthcare with the political stream of a new administration in birthing the NHIS policy (Kingdon, 2011: 23). But the president could not have wielded all the power within the policy space as many other related events, some of which are deemed beyond his control, could have prevented the realization of the NHIS. Agyepong and Adjei (2008) observe some **tension between the political actors and the technocrats during the agenda-setting and formulation phases** of the NHIS policy-making process and state that, "the power of the politically powerful was used to sieve out undesirable inputs from the technical experts which do not add to their intended outcome" (Seddoh and Akor, 2012). But Kingdon (2011: 159) insists that **the political stream's consensus building approach is through bargaining while conversely, the policy stream emphasizes persuasion. Such issues as the fiscal space and capability of the country at the time, the availability of information/evidence ready for use in implementing the NHIS, the availability of trained personnel, the debate and passing to law of the NHIS law (powers of which lie with the legislature, a separate arm of government) and the contributions of other actor groups to the NHIS' establishment must have then been bargained for**. This bargaining approach is deemed important to ensure that the NHIS did not only come as a political promise to a people holding the new administration to account but also to ensure its sustainability beyond different political terms, because as as Kingdon (2011: 33) points out, **"Political appointees come and go, but the bureaucracy endures"**. To state that the bureaucrats' resources and power in the policy-making process is highly prominent (especially at the formulation stage) would not be an exaggeration. Lindblom (1968) adds that with all the interactions among the interest groups, one should not disregard the biases of analysts and their incompetences which could have a telling effect on the outcomes of policies during the agenda-setting phase of policy-making (Pg. 19). Going by Kingdon's ideals, there is a place for each actor and their roles in turning policies into reality but each category has varying degrees of influence on the process and this must be put in context in considering the NHIS' establishment and implementation, and the aptitude of each interest group in further influencing the achievement of the UHC by 2030.

FIGURE 5: AGENDA-SETTING FOR THE NHIS (1950s – 1985)



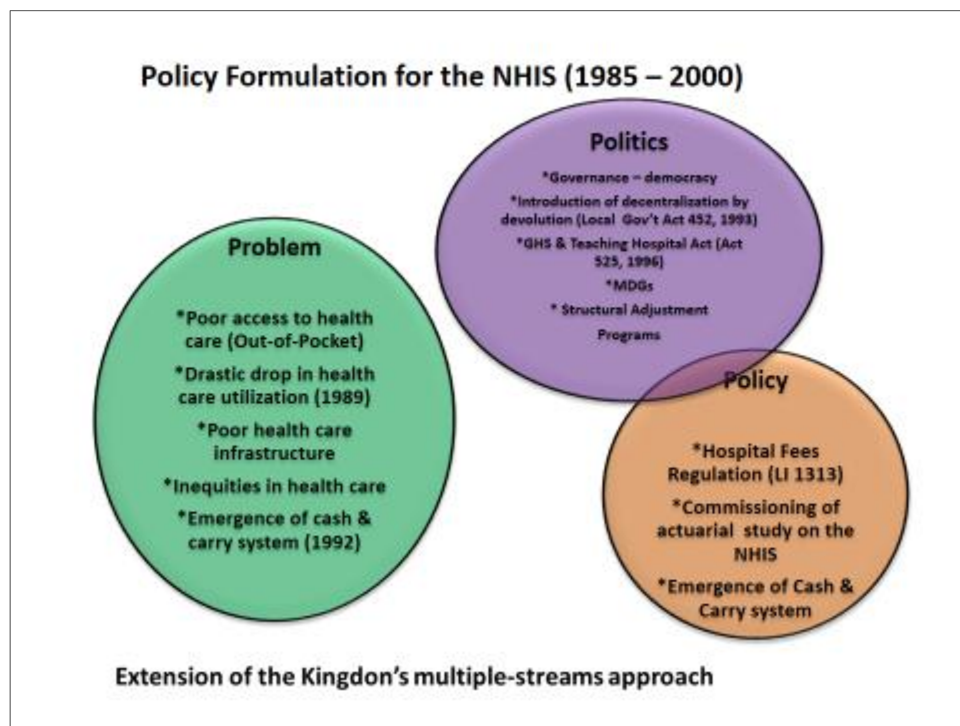
Source: Author

The figure above represents an extension of the Kingdon's multiple-streams framework as presented by Ridde (2009) who analyses policy-making in the context of the Bamako Initiatve, a first of its kind on policy-making in Africa. By the extension, using the different streams, the policy-making process leading to the establishment of the NHIS in Ghana is analysed. As Ridde (2009) asserts, the process is non-linear and consists of several sub-processes, which are sometimes complicated. And Ridde's (2009) caution that **"for the extension of the multiple-streams framework to be relevant to implementation, a coupling of streams must be shown to have occurred in the preceding stages"** and hence the demonstration of the case of Ghana from when the coupling of the different streams started.

The post-independence era saw the abolishment of user fees in all government health facilities. There was a reintroduction of same legally, the Hospital Fees Decree in 1969 – 1971 and subsequently, the Hospital Fees Regulation (LI 1313, 1985) (Nyonator and Kutzin, 1999). On the international level, the period under consideration witnessed some policy waves concerning health – some of the notable ones are the Bamako Initiative (which ushered in primary health care) formulated in Mali in 1987 at a gathering of the United Nations Children's Fund (UNICEF), the World Health Organization (WHO) and health ministers from the African continent (Ridde, 2009). It was in this period that the Alm Ata Declaration also happened (1978).

The political climate for paying attention to health concerns especially at the Primary Health Care (PHC) level was rife and Ghana's policies and strategies at the time also followed in line with the country introducing in 1977, Community Health Workers called Community Clinic Attendants and Traditional Birth Attendants. PHC has been designed at the district level, in connection with the decentralization efforts of the country (MoH, 2016, National CHPS Policy: 8). Despite the coupling of the governance structure and political decisions of the era, no concrete policy had been arrived at that presented a solution to the problem of catastrophic expenditures incurred by healthcare users – a look at the policies introduced at those times (the Hospital Fees Decree of 1969 – 1971) and the Hospital Regulation (LI 1313, 1985) all presented a deepening of the problem of OOP.

FIGURE 6: POLICY FORMULATION PRIOR TO THE NHIS' ESTABLISHMENT (1985 – 2000)



Source: Author

The year 2000 ushered in the Millennium Development Goals which presented a set of goals under different sectors and themes for adoption by 147 heads of states. The period prior to this, Ghana had also been going through different phases of governance and initiating laws that shaped its politics, governance structures and healthcare. In 1985, the Hospital Fees Regulation came on board (LI 1313) which introduced fees for specific services such as consultations, surgical and dental services, hospital accommodation and others. It also emphasized the pricing of drugs to be linked with the level of inflation that pertained in the country (Nyonator and Kutzin, 1999). **Government health budget was low in the 1990s**. Recurrent expenditure for the Ministry of Health fell between 6.9 – 11.1 percent of total government recurrent expenditure; this situation propelled many health facilities' managers to adopt their **own coping mechanisms called 'local charging practices' to ensure that basic recurrent expenditures at the facilities level were covered** (Nyonator and Kutzin, 1999). The government had initiated structural adjustment and economic recovery programs which had conditionalities attached that constrained expenditures. In terms of decentralization which had seen snippets of operationalization since independence, it gained legal backing for its formal adoption by way of devolution of powers to the districts by the Local Government Act 452, 1993. This included devolution also to all social sectors. Not long after, Saleh (2012a: 11) observes some interesting developments under the decentralization in the country - there was the introduction of the the Ghana Health Service (GHS) and Teaching Hospital Act (Act 525, 1996). **While the Act 452 for decentralization was intended to transfer powers to the lower levels of governance, it did not support the devolution of same in the health sector**. Saleh (2012a: 11) explains that the law only promoted delegation from the Ministry of Health (MoH) to the GHS and the GHS, which is an implementing agency under the MoH was left with deconcentration. In essence, **the Acts 452 of the local government ministry was in conflict with the Act 525 – a clear case of weak institutional complementarity.** There was an introduction of a subsequent law, the Local Government Service Act[16] (Act 656, 2003) but that left out devolution of staff of the social sectors. According to Nyonator and Kutzin (1999), the "cash and carry" program for drugs[17]

[16] According to Saleh (2012: 11), even after the ensuing Local Government Service Act (Act 656, 2003), the structures concerning staff of the health and education sectors remained same albeit under the Ghana Health Service and the Ghan Education Service respectively.

[17] The "cash and carry" drug program was essentially constituted as a revolving fund that supported the system of payment for fees paid by users as per the procurement cost of the particular drug purchased with price mark ups by

came on the health sector scene in 1992. With the changing phases in the governance and healthcare system, the problem of poor access to healthcare, poor infrastructure and the problem of high out-of-pocket payments for services and many others persisted but formed part of the policy formulation journey towards the establishment of the NHS. Thus, the coupling of the politics stream (through the passage of laws) with the policies stream still left the problem stream unattended supporting the notion that the passage of laws does not necessarily guarantee their implementation as per the intent for which they were passed (Kingdon, 2011: 43).

Problems, Politics and Policies coupling – While the three different streams are unique and play key roles – problem definition is quite different from the processes leading to policy formulation and also, the place of politics and how it unfolds in the policy-making process. But it has been pointed out that there comes a time when they inevitably meet (Kingdon, 2011: 201). This was the case of Ghana - in going down memory lane of how the UHC/NHIS in Ghana came to be. Seddoh and Akor (2012) indicate that **the first proposal for a national health insurance scheme was made in 1970 as part of a comprehensive plan to introduce cost recovery** and protect the poor. Though Fee-for-Service (FFS) was introduced in 1971 nothing was done for insurance, thus the impact of catastrophic household expenditures on health persisted despite efforts that had been made over the period under different political regimes. The Fee-for-Service (FFS) was implemented in a limited form as token fees in the absence of a Legislative Instrument. It was not until 1985 when the Legislative Instrument, LI 1313 was promulgated. According to Seddoh and Akor (2012) due to the fact that exemptions were granted for selected public health diseases and services including leprosy and yaws, hospital accommodation and antenatal and postnatal care with no provision made for the poor, indigent and emergency care, there was a resultant decline in healthcare service utilization.

The journey of Ghana's NHIS to have reached this crescendo has been through **a complex web of interactions between politicians, technocrats of diverse backgrounds, development partners and citizens with the persistence of the problem of poor healthcare delivery** remaing unabated. Seddoh and Akor (2012) explain the various transitions as the Ministry of Health (MoH), in 1997, under the National Democratic Congress (NDC)-led government,

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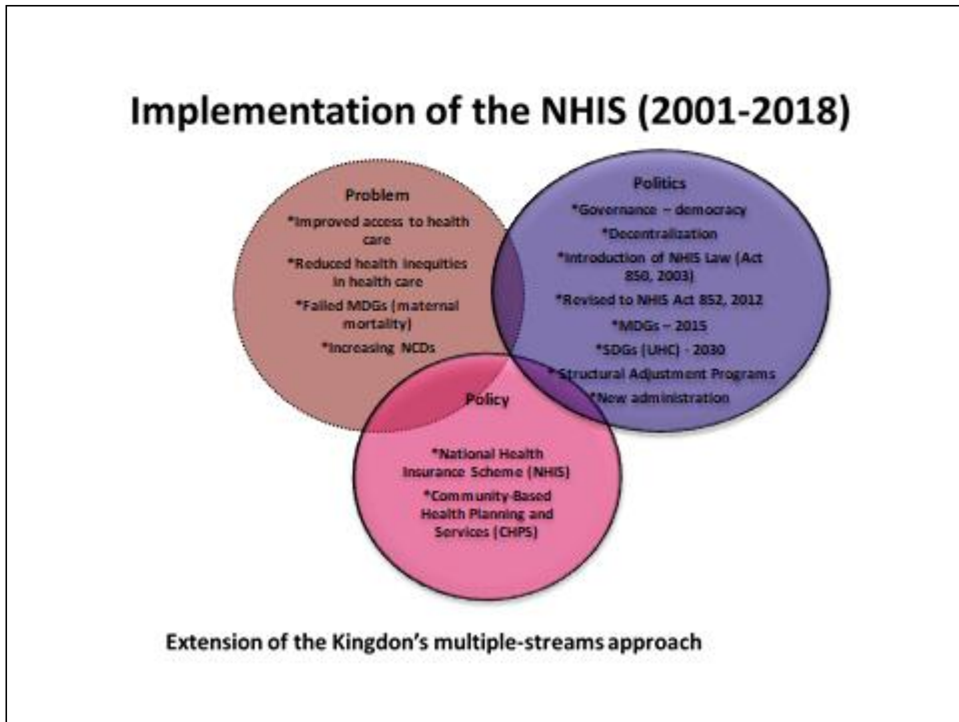
the central and regional medical stores under the Ministry of Health. This system was introduced in 1992, and was implemented nationwide (Nyonator and Kutzin, 1999).

established a task force to facilitate a national health insurance scheme. Preparatory efforts were made by commissioning an actuarial study by technocrats. Seddoh and Akor (2012) explain that however, not much was done in actualizing the dream at the time of handing over to the NPP - led government in 2001. At this point, political efforts had been made concerning the problem of FFS or what is commonly referred to as the "cash and carry" system of healthcare financing but no definite policy had emerged. Finally, in 2001, **the newly elected NPP government established the NHIS with the support of all interests groups** earlier mentioned in addition to the development partners whose support through the enhanced Highly Indebted Poor Countries (HIPC initiative) coupled with the Multilateral Debt Relief Initiative (MDRI) created the fiscal space for funding this policy's implementation. As stated by Gilson and Raphaely (2008) above and in the case of Ghana's NHIS, the policy was formulated by one political party/government and re-formulated and implemented by the NPP and new policy reforms were introduced by the NDC-led government, giving credence to the fact of governance is a continuum and the messy nature of policy-making and implementation cannot be avoided. Refer to the Political and Institutional Policy-making and Implementation Transitional Process framework for Ghana (Box 7) for the various transitions and manoevres made concerning the NHIS to date. Finally, the place of one interest group in the policy-making process must be stated – the media. Kingdon (2011: 58 – 59) mentions that the media's influence on the policy-making process is not as powerful as expected, that their penchant for giving attention to most dramatic or newsworthy stories tends to dilute their impact on the agenda-setting phase of the process because at the stage of reporting a policy, the agenda would have already been set. Albeit, the role as an interest group and one for disseminating information is noted.

FIGURE 7: THE COUPLING OF PROBLEM, POLITICS AND POLICY STREAMS



Source: Author

The three streams intersected at the point of implementation in the context of Ghana where efforts at eliminating the problem of catastrophic healthcare expenditures have been ushered in by politics to birth a policy (refer to Figure 7 for the coupling of the three streams). This coupling for implementation is seen as both a mirroring and a deviation from the extension of the Kingdon's multiple-streams framework as seen in Ridde (2009) in the sense that in the case of the BI implementation in Burkina Faso as per the analysis of the three streams, there was no coupling of the three. From the 1970s the idea of an equitable and sustainable financing scheme for healthcare in Ghana had been conceived but saw implementation only in the latter part of 2000s. This mirrors what occurred in the case of the Bamako Initiative (BI) implementation, that in Africa its official adoption was in 1987 but actual implementation in Burkina Faso happened in 1993. In the policy stream's situational analysis by Ridde (2009), it is explained that there was an exclusion of indigents (this term's definition which suffered "verbal gymnastics") by many stakeholders despite efforts made. The policy stream also concerns the challenge of addressing equity - that after all the deliberations about indigents; no solutions were proffered that addressed inclusion of this sub group. Mirroring the case of Ghana, Ridde (2009) states that, "While the BI

policy envisioned that exemption of the poorest would be financed through services paid for by other members of the community, central health officials gave no clear directives about allocating a percentage of user fee revenues to exemptions." Until the introduction of the NHIS, no decisive and measurable considerations to cater for the needs of the poor and vulnerable that were most affected by the OOP for healthcare services that had resulted from the various policies and laws, had been made. This is now catered for under the Livelihood Empowerment Against Poverty (LEAP), a project managed under the Ministry of Employment and Social Welfare (MESW) and remains part of the NHIS' performance indicators annually (see NHIS Annual Report for 2013[18]).

In the political stream discussion which concludes Ridde (2009) analysis of the BI's adoption, he states that "according to all the stakeholders interviewed, the state endeavours to meet the demands of loan/donor agencies, without really believing in equity or taking serious measures to ensure its actualization". This mirrors the discussions under 1.3 in Chapter 1 where the SAPs are discussed; in the same vein, Ghana also endeavours to meet the demands of conditionalities of loans signed and the dictates of donor partners in the country which often affect implementation of certain decisions related to health and healthcare in the country (refer to 1.1.3 – 1.2.7 which look at the specific case of the SAPs, their links with the SDH and impact on health). Finally, regarding the window of opportunities, unlike the Burkina Faso case where research findings were ill-prepared and promoted in such a fashion that could not propel the Prime Minister to fully implement the BI, Ghana was different. In the case of the latter, the over two decades of research, experiments and passage of laws coupled with a conduicive national mood adequately prepared the new administration to bring about the NHIS policy. This represents a superficial comparison of two health policies in the local contexts of Africa through an extension of Kingdon's multiple-streams framework of policy-making. Admittedly for deeper insights, further research should be undertaken. But the query of whether policies emerge or are planned has been considered by Seddoh and Akor (2012), and in the instance of Ghana, it would be answered that the NHIS policy has experienced both – the planning started from the 1970s with the coupling of aspects of the different streams which still left the problem unaddressed but with a coupling of

[18] See pages 17 for details on coverage of indigents used in measuring progress towards the UHC achievement in Ghana. Access to report - http://www.nhis.gov.gh/files/2013%20Annual%20Report-Final%20ver%2029.09.14.pdf

all three streams, a policy emerged capable of addressing the problem of inequity and catastrophic healthcare expenditures. In this figure, all the three streams merge – a possibility described by Kingdon's (2011: 201) agendas, alternatives and public policies (details of the NHIS implementation is captured under 1.1 of Chapter 4). **Until the emergence of the NHIS, an insignificant proportion of the population (less than 5 percent) were insured** and these were mainly from mutual health insurance schemes and individual employers (Bitran, 2014: 39).

BOX 7: POLITICAL AND INSTITUTIONAL POLICY-MAKING AND IMPLEMENTATION TRANSITIONAL PROCESS FOR GHANA'S NHIS

Political and Institutional Policy-Making and Implementation Transitional Process for Ghana's NHIS						
1970s	1985	1985 - 1993	1993 - 1997	1997 - 2004	2005 - 2012	2013 - 2018
*Agenda Setting *Formulation	*Agenda Setting *Formulation	*Agenda Setting *Implementation *Evaluation	*Agenda Setting *Implementation *Evaluation	*Agenda Setting *Implementation *Evaluation	*Agenda Setting *Implementation *Evaluation *Re-evaluation	*Agenda Setting *Implementation *Evaluation *Re-evaluation
*Alma Ata Declaration (1978) *Adaption of the Bamako Initiative(1987) in Africa *The introduction of Hospital Fees Decree (1969- 1971)	*Hospital Fees Regulation (LI 1313) promulgated	*Facility-based Health Insurance introduced in Nkoranza	*The Society of Private Medical Practitioners established the 1st Mutual Health Insurance * 1996 Health Sector Reform launched	*MoH creates Task Force & Directorate for NHIS *Commissioning of Actuarial Study & Gh. Health Company (under SSNIT) *Scale-up of the CHPS policy in 2000	*Change in Political Power: NPP-NDC (2008) *Claims Processing Centre est. *Clinical Audits introduced	*Capitation scale up in 3 regions Project 1000 introduced & piloted *Multi-year Renewal of Membership of Cards, piloting
*Introduction of Community Clinic Attendants and Traditional Birth Attendants (1977)		Cash & Carry system (1992)	*Emergence of new district schemes	*Regional Secretariat est. in Eastern Region *Negotiations with TUC for NHIS	*Introduction of Free Maternal Healthcare (MDG 4&5) *2009 Institutional Reforms	*ClaimIt introduced *NDC Government institutes Presidential Task Force for Review
				*Change in political power: NDC-NPP *Funds from HIPC available	*Formal Accreditation system introduced	*Change in Political Power: NDC-NPP (2016)
				*NHIS est. (Act 650), LI 1809, 2004	*Act 650 replaced with Act 852, 2012	*NPP Government * SDGs made prominent in dev't agenda
				*Est. DMHIS, PMHIS & PCHIS	*Introduction of Capitation *G-DRG *Piloting of Capitation	*IMF/World Bank EFC agreement
Policy Actors	Policy Actors	Policy Actors	Policy Actors	Policy Actors	Policy Actors	Policy Actors
*International Development partners *Political Party *Policy Makers *Citizens	*Political Parties *Policy Makers *Parliament *Citizens	*Political Parties *Catholic Dioceses of Sunyani (Private) *DMOH (Govt) *Policy Makers *Parliament *Community	*Devt. Partners *GoG *Policy Makers *Communities - Damango, Drobo, Duayaw Nkwanta, Berekum, Dangme West Districts	*Political Parties *GoG/NHIA *Policy Makers MoH/GHS *Devt. Partners (HIPC Funds) *CHAG *Private Sector Service Providers *Citizens	*Political Parties *Parliament *GoG/NHIA *Policy Makers MoH/GHS *CHAG *Private Sector Service Providers	*Political Parties *GoG/NHIA *Policy Makers MoH/GHS *CHAG *Private Sector Service Providers *Private Sector Consultants *IMF/World Bank

Source: Author (adapted from Seddoh & Akor (2012), Ghana Health Insurance Review (2011), Otoo et al. (2014), Research Department, NHIA), MoH CHPS Policy (2016)

2.4 The use of Kingdon's framework for comparison with other African countries

A description of the various approaches employed in achieving desired health outcomes is important to understand in context, and to position Ghana's choice among other African countries. First, the context of the population heterogeneity and the fragmented health systems within which the UHC operates is worthy of note - the salaried workers in the formal sector and their dependents (known to be easily taxable); the non-poor informal sector (non-salaried workers and their dependents with incomes, their families with incomes directly above the vulnerability line but relatively harder to tax and sometimes trace); and lastly, the poor and vulnerable group in society (who are generally susceptible to the harsh effects of healthcare expenditures) all operate within the health systems and the economies of the African continent (Cotlear et al., 2015: 36 – 38, 44). According to the World Bank[19], the population living under the extreme poverty line (living on less than $1.90) in Africa is 389 million in 2013, even after a 41 percent decline rate, the SSA accounts for one half of the world's extreme poor (113 million more people since 1990). Hence, there is the need to discuss the UHC within the context of attainable and affordable healthcare for a large and impoverished population on the continent with possible repercussions on productivity and economic growth.

Putting into context the efforts of some African countries courageously embracing the challenge of the UHC's implementation in their countries, the legal framework as a context described as a pre-requisite to the implementation of the UHC in countries (Abiiro and De Allegri, 2015); Stuckler et al., 2010) has been established in many African countries such as Morocco (in their Constitution under Article 31 and 154, it makes mention of universal access to health and provision of financial-risk protection for its citizens - Tinasti (2015); Senegal (first attempt at legality was in 2003 without much enforcement and a second in 2008 under the Communaute Economique des Etats de L'Afrique de l'Ouest (CEDEAO) with progressive enforcement Alenda-Demoutiez (2016), Ridde et al. (2018); Rwanda's Community-based Health Insurance (CBHI) schemes piloted in 1999 with nationwide rollout in 2004; Tanzania with mandatory enrollment attached to them (Ndiaye et al., 2007; Ridde et al., 2018); Kenya (the choice of UHC program run - the Health Sector Services Fund and the National Hospital Insurance Fund), the

[19] www.datatopics.worldbank.org. For information on poverty in Sub-Saharan Africa (SSA)

latter which provides healthcare to 18 percent of the people but both of which depend on government and donor funds —allocates government- and mandatory resource mobilization from labour in the formal sector (Cotlear et al., 2015: 124 - 125) and Mali, with the Decree of 4th June 2002 (Boidin et al., 2013: 1).

2.4.1 Community-based and solidarity-driven health systems in Africa

A peculiar trend among African countries practicing the UHC is the understanding of the concept of solidarity (communal way of doing things) which underlies the principle of risk-pooling captured under the UHC concept - this should be placed in the context within which the UHC in these countries is implemented. This risk-pooling or communal way of living and providing support to each other is over a century-old tradition which permeates areas such as communal savings schemes operated on a rotational basis and credit associations (known in Ghana as "susu"), the burying of the dead etc. (Ndiaye et al., 2007). Community-based approaches to insurance have been implemented in African countries since the 1990s, aimed at pooling risks together in the "purchase" of health services from selected facilities and maintaining a common interest for welfare, especially at the PHC level (Barroy, 2014: 47). The actors identified in these efforts, be they community members, government officials, development partners and others, all contribute to social protection of the larger population than when individually-focused. With a good number of countries practicing the Community-Based Health Insurance schemes (CBHI), one key actor group is the community/traditional leaders, for example, in Kenya's UHC program; the community committees play a critical role in the administration of funds expenditure (Cotlear et al., 2015: 169, 180; Ndiaye et al., 2007; Alenda- Demoutiez, 2016; Ridde et al., 2018). But the effectiveness of these communal, voluntary and quasi-voluntary-laiden approaches to healthcare financing has been questioned. Admittedly, due to the diversity of CBHIs, their contribution to the ultimate healthcare financing remains valuable and diverse but not much can be said for their professionalism, equity concerns, financing sustainability and revenue raising capacities (Bennet, 2004; Ridde et al., 2018). While there has been evidence of tension between the objectives of the various CBHIs (Bennet, 2004), there is also observed tension between the voluntary and compulsory approaches to enrollment undertaken by many

African countries (Ridde et al., 2018). Indeed, the implementation of the universal health coverage for many African countries has been built on community health systems.

Countries such as Ghana, Mali and Senegal can be cited in a bid to provide healthcare to their populations on the continent based on community health-based insurance schemes. As earlier indicated, some of these countries have attempted to elevate the profile and coverage of their operations by involving the state (sometimes through legal frameworks) and changes to the governance structure aimed at improved systems of delivery, accountability, efficiency and others. With the involvement of the state in these CBHIs, there is a shift towards "marketization of healthcare alongside a state that has itself adopted private-sector management practices and international performance criteria" (Alenda-Demoutiez and Boidin, 2018 working paper: 3) aimed at achieving expanded coverage and efficiency in the delivery of services. But with these challenges have come challenges in connection with reach as the systems established no longer rely on the traditional methods of participation in these systems as pertains to the norms of a small population or community. For instance, the case of Senegal can be cited for challenges with growth and expansion of coverage in a country that has coverage for only about 12 percent of formal sector employees while the majority of the population can be found in the informal sector, with a history of the Mutual Health Organisations (MHOs) established decades before by local civil society (Alenda-Demoutiez and Boidin, 2018 working paper: 3). A similar situation pertains in Ghana where the NHIS (one of the avenues for pursuing the UHC) which was built on existing CBHIs has legal backing but has stagnated at 40 percent coverage with majority of enrollment in the formal sector and under exempt categories and yet, the rest of the population can be found in the informal sector. Boidin et al. (2013: 1 and 2) point to the case in Mali, where the community health centres (also known as the CSCOMs) are non-profit health centres and have since the Decree of 4th June 2002 had the involment of the state and regulation. This has brought on changing phases to the operations of the CSCOMs - firstly, the renumeration of the workers called ASACOs are not mainstreamed enough to be competitive in order to afford the social security deductions, secondly there is sometimes a lack of contract to guarantee the employment of these community health workers. Thirdly, there are challenges with financial management including the collection of taxes, diversion of funds and others. Generally, the CSCOMs are attempting to provide healthcare to communities within a system that is being

modernized using the decentralization process, somewhat appropriate financial management practices but as the authors point out, "……the employers, most of whom are members of the community and farmers, have an informal approach to life" (Boidin et al., 2013: 2). Similar challenges are faced under the Community-Based Health Planning and Services (CHPS), one of the policies adopted by Ghana to achieve the UHC but which has also stagnated in growth at 5 percent and has a number of problems including, the absence of regularly trained community health volunteers (CHVs) in about 55 percent of the CHPS zones (the CHPS zones cover a population of five thousand people or 750 households), financing of the CHPS implementation not clear as development partners do not seem to have any coordination among themselves, there is a problem with the reimbursement of CHPS services as situated in the decentralization framework of the country whereby services rendered under the NHIS at the community level are only reimbursed through the Health Centres which cause delays and challenges in operations for the CHPS and others (National CHPS Policy, 2016: 20 – 22).

Agyepong and Adjei (2008) observe the significant role of such actors considered as "policy elites" through the entire policy framework, to ensure effective implementation of public policies aimed at reforms. The reference to "policy elites" connotes 'those who have official positions in government and whose responsibilities include making or participating in making and implementing authoritative decisions for society'. In the case of African countries' efforts towards healthcare reforms in providing access to healthcare whether through governmental framework or the private sector, because the intended beneficiaries are citizens and due to the "monopolistic" role of government over the welfare of citizens (Tanzi, 1998: 565 -571), there is the strong presence of government as a major actor either through regulation, authorization, funding, monitoring of standards etc. In the case of Ghana, while the state has the sole responsibility for the welfare of citizens, the players in the health sector are mixed with an estimated 65 percent ownership of all health facilities by the state, 26.4 percent by private for-profit interests, not-for-profit facilities with ownership by religious groups representing 6.6 percent and 2.1 percent ownership of quasi-government facilities by the security services and the universities (Asante et al., 2014: 2).

2.4.2 The implementation phase of the UHC concept captured within the policy-making process for African countries

According to Olivier de Sardan and Ridde (2015), in Africa, health policies do not receive as much attention as health systems. They emphasis the one thing that should be made clear from the outset: any feature of public policy-making and health systems in Sahelian Africa (and, in our own experience, in West Africa generally) could also be found in some way or another in Europe or North America, but variations remain. Bureaucracy in the health system is a case in point. For African countries, a dominant and persistent challenge in the health systems has been that of health financing systems which have seen prominence of OOP spending even after the introduction of such initiatives as the removal of user fees, mandatory insurance schemes, sometimes piloted, community-based insurance programmes (Barroy, 2014: 46 - 47).

On the African continent, country-level progress made towards the attainment of the UHC has been rather slow with the exception of Ghana and a few other countries. This progress is however not surprising as, according to the WHO (2013), in 22 of 45 countries in the sub-region, observed funding for healthcare is seen below the recommended threshold minimum of US$44 per capita (Barroy, 2014: 47). Thus, a visible context within which to understand the UHC's ease or otherwise of implementation is that of financial capability or willingness to create the fiscal space for its implementation.

Another of the context for consideration under the adoption and implementation of the UHC is in the characteristics of the countries pursuing the UHC policy, as being captured as heterogeneous but very much similar in some aspects to the pathways chosen to attain the UHC. This is due to the difference in healthcare needs in each country in the sub-region (Drechsler and Jütting, 2007). Central to the UHC implementation's history is the introduction of user fees policies in the 1980s, the review and modifications period and the abolishment of such policies and or maintenance of a mix of approaches for some African countries, albeit, at different paces (Robert and Ridde, 2013; Rowden, 2009: 162 -167; Yates, 2007; Sekabaraga et al., 2011; Meessen et al., 2011; Barroy, 2014: 64 – 73; Brugiavini and Pace, 2016). The seeming tension between some African countries' choices of the policy of mandatory and voluntary contributions as a means of financing healthcare and their consequent impact on coverage, as explained by Ridde et al.

(2018) sheds more light on the divergent contexts of the UHC implementation. The sequential perspective adopted for public policy process analysis by Olivier de Sardan and Ridde (2015) which indicates that the logical sequence proffered by some theorists such as deLeon's stages heuristic have been criticized and that, some stages in the sequence are known to precede others which resonates with the complexity and non-linear nature of the policy-making process (Carey and Crammond, 2015). In their analysis, the distinction in the process was made in two parts; first, with the shaping of policies, in other words agenda-setting, decision-making, legitimation and formulation at which stage the example of the contradictions in free healthcare policies was observed – in the cases of Mali and Niger, legitimization preceded formulation and secondly, same anomalies were found at the implementation stage. Thus, the non-linear and sometimes integrative nature of public policy can be observed more deeply in some African countries than others in the implementation of policies and in that the environmental contexts in those specific countries may render the policy implementation process easy or otherwise, eventually affecting the efficacy of the outcomes of such policies (Agyepong and Adjei, 2008).

It is further explained that the environmental context is inclusive of such factors as the historical antecedence of such policies, the experience of the actors involved, their ideological and political leanings, personal motivations and others (Agyepong and Adjei, 2008). Based on the divergent policy environmental contexts for African countries, addressing issues of healthcare financing, user fee removal and progressive approaches towards the attainment of the UHC have tended to take on varied forms across countries (Barroy, 2014: 71; Meessen et al., 2011) with some countries removing user fees incrementally for certain services and sub-groups, and for others, user fees on PHC have been terminated indefinitely but with most of them providing exemption policies in line with the MDGs (Barroy, 2014: 71). Examples of the user fee policy implementation approaches adopted are given of different countries such as Lesotho, Liberia and Uganda which offer PHC for its entire population; Niger and Burundi which offer ANC, PNC, delivery (C-Section included) and child care for pregnant women, and children under five; Ghana, Tanzania, Malawi and South Africa providing exemptions for women and children under five with respect to services such as ANC, PNC, and curative child care; Kenya providing exemptions for only deliveries; and Zambia providing exempt services for only rural populations in terms of PHC (Barroy, 2014: 73).

Different sides to the implementation perspectives have been documented - the top-down approach and the bottom-up approach, both of which have distinct challenges for implementation (Cotlear et al., 2015: 1 – 6, 17 - 18; Nielsen et al., 2013). As noted by Cotlear et al. (2015) study of 24 developing countries and as is characteristic of the UHC's definition, there is freedom given to countries to implement as per own definition (even though criticized as a flaw). Most of the countries attempting to implement the UHC have tended to articulate the implementation based on their own local and unique circumstances in defining benefit packages, exemptions if any, and it has been observed that due to the observed weaknesses in priority setting, there are issues with prioritization criteria and decision-making. As discussed under the UHC sub section, the WHO allows for such freedoms in the interpretation of the goal and its implementation.

The UHC's implementation has been observed in many pathways; some using the approach of Community Health Insurance schemes (CHIs) or innovative versions of the CHI which sometimes operate within the nomenclature of nonprofit (Drechsler and Jütting, 2007) and have been observed among countries such as Ghana, Togo, Benin, Burkina Faso, Cameroon, Côte d'Ivoire, Guinea, Mali, Nigeria, Senegal, Tanzania, and finally, Uganda (Drechsler and Jütting, 2007) and also, through Private Health Insurance (PHI) with varying coverage in such countries as Namibia with (22.4 percent), Zimbabwe (18.8 percent), Botswana (7.6 percent), South Africa (46.2 percent), Nigeria (5 percent) (Drechsler and Jütting, 2007). The approaches are uniquely themed and have unique pathways towards implementation; Kenya (Health Sector Services Fund), Ghana (National Health Insurance Scheme (NHIS), Nigeria (National Health Insurance Scheme), Ethiopia (Health Extension Program), Tunisia (Free Medical Assistance for the Poor), and South Africa (Antiretroviral Treatment Program), and the list goes on. Among some of the pathways to healthcare financing are supply-side programs, demand-side programs, private health insurance, community health insurance and some, still depend on OOP (Cotlear et al., 2015: 10 – 16, 28 – 30, 78, 222 - 223). In the sub region, only Rwanda is reported to have successfully established a mandatory form of insurance which is predominantly subsidized, developed as an offshoot of the initial community-based insurance scheme (Barroy, 2014: 47;

Sekabaranga et al., 2011) and with this approach, the country is reported to have achieved the UHC with over 90 percent of Rwandans covered on the Mutuelle de Sante[20].

The CHI, which has been around since the latter part of the 1980s and early 1990s (Ndiaye et al., 2007), has been greatly influenced by the Social Health Insurance (SHI) model and has its implementation roots by actors in the policy space as the non-profit organizations and religious groups and non-governmental organizations (NGOs) (founded as part of church activities as observed in the cases of Ghana and Senegal, and Democratic Republic of Congo in the latter) (Ndiaye et al., 2007). Voluntarily, beneficiaries agree to join the financial risk-pooling approach to healthcare provision with an agreed understanding of what contributions to be made and the services entitled. The raging obsession of this model on the continent culminated in a meeting of many African countries and their local representatives and also, interested international partners in Abidjan, Ivory Coast where the La Concertation (formerly known as the Concertation entre les acteurs du de´veloppement des mutuelles de sante´ en Afrique) was birthed, aiming to act as the support and monitoring nerve centre for all African countries developing the CHI (Ndiaye et al., 2007).

Many African countries are practicing voluntary health insurance however, Cotlear et al. (2015: 5 - 9, 16) submit that such programs' ability to provide the much needed equity in healthcare provision and ability for speedy expansion of coverage for a wider population health is weak, that evidence has proven over time of their unsustainability in addressing the object of the UHC - it remains useful for providing financial protection for a smaller but more vocal sect of the society. They however, credit it as a worthwhile stop - gap approach to be taken by countries in transition to formally instituting mandatory contributory models and/or non-contributory tax supported health insurance system, in the view of political economists (Cotlear et al., 2015: 5, 16). Ridde et al. (2018) draw similar conclusions after an analysis of the operationalization of CBHI in four Rwanda, Ghana, Mali and Senegal.

As equity concerns form part of the fundamental principles of the UHC goal which many countries in the sub region are pursuing, greater public participation is called for in the financial risk-pooling and organization of healthcare especially for the poor. In furtherance of this

[20] https://www.theeastafrican.co.ke/scienceandhealth/Rwanda-has-achieved-universal-healthcare/3073694-4896906-r24j1i/index.html

approach to involve more public participation in providing healthcare, is the salient view to address the issue of revenues from general taxation and/or health insurance contributions. The advantage attributable to this approach is first, that it addresses the health needs of many people than community-based approaches and secondly, they present avenues of distinguishing payment from utilization which indirectly ensures greater access, with the poor and vulnerable also in sight (Carrin, 2002).

The Social Health Insurance (SHI) concept is described as a mechanism of pooling the health risks and contributions of subscribers and those of households, companies and the state together. Whereas contributions from the state are from revenues from general taxes, those from households and companies are from income (Carrin, 2002). SHI is said to be explicit, characteristically, as it provides healthcare to people who remain inherently aware of their entitlement to healthcare based on their contributions, on the other hand, with the contributions made through the tax system, contributions are made indirectly to a pooled fund against pooled risks. Albeit, both forms - taxation and income-based contributions rely on contributions, and by these, a set of healthcare options are availed to all regardless of status. Essentially, the SHI smacks of mandatory membership (Carrin, 2002).

The table below (Table 1) enlists a number of countries on the African continent who are attempting to implement the UHC goal. It is a comparative table of African countries at different stages of implementation of the UHC. It points also to the performance of Ghana, the country under study in terms of its stage of implementation and coverage.

TABLE 1 : AFRICAN COUNTRIES PURSUING UHC

Name Of Country	Stage Of Implementation	Comments
Benin	Piloting	Population and service coverage and financial protection below 40%.
Burkina Faso	Agenda setting	Limited access and coverage of health services and prevalence of OOP (above 50%)
Chad	Agenda setting	Limited access and coverage of health services and prevalence of OOP (above 50%)
DRC	Agenda setting	Limited access and coverage of health services and prevalence of OOP (above 50%)
Gabon	Piloting	Population and service coverage and financial protection below 40%.
Ghana	Initial reform in place but need for further development to address remaining uncovered population	Significant (above 40%) share of population gains access to services, but generally high OOP spending
Guinea	Agenda setting	Limited access and coverage of health services and prevalence of OOP (above 50%)
Kenya	Piloting	Population and service coverage and financial protection below 40%.
Mali	Agenda setting	Limited access and coverage of health services and prevalence of OOP (above 50%)
Morocco	Initial reform in place but need for further development to address remaining uncovered population	Significant (above 40%) share of population gains access to services, but generally high OOP spending
Niger	Agenda setting	Limited access and coverage of health services and prevalence of OOP (above 50%)
Rwanda	Initial reform in place but need for further development to address remaining uncovered population	Significant (above 40%) share of population gains access to services, but generally high OOP spending
Senegal	Piloting	Population and service coverage and financial protection below 40%.
South Africa	Initial reform in place but need for further development to address remaining uncovered population	Significant (above 40%) share of population gains access to services, but generally high OOP spending
Tanzania	Piloting	Population and service coverage and financial protection below 40%.
Uganda	Piloting	Population and service coverage and financial protection below 40%.

Source: Barroy (2014: 50)

Table 1 contains an overview of the progress made by sixteen countries in Africa. Out of the sixteen countries, four (Ghana, Morocco, Rwanda and South Africa) countries have coverage surpassing a 40 percentage share of their populations. Six of the sixteen countries are still at the agenda-setting stage of policy-making and the rest at the piloting stage. Despite the progress made, high OOP spending is noted in each of the four countries. Many of the health insurance schemes introduced on the African continent in the last four decades have been observed as having the challenge of reducing out-of-pocket expenditures for their populations. Indeed, in a study covering 15 African countries and how their populations coped with OOP, it was realized that OOP as a share of total health expenditure ranged from 6 percent in the case of Namibia to 60 percent in Cote d'Ivoire and Chad, and an average of an estimated 40 percent for all 15 countries surveyed. Over 30 percent of households financed these OOP expenditures by borrowing and selling assets. This phenomenon of borrowing and selling of assets to support healthcare expenses was observed more for inpatient care with the most severe of instances occurring in Congo, Ethiopia and Ghana with incidences of households' inpatient expenditure representing 38 percent, 39 percent and 40 percent respectively. The situation is more pronounced in the Congo, Cote d'Ivoire, Burkina Faso and Senegal with 50 percent total health expenditure made (Amu and Dickson, 2016: 2; Leive and Xu, 2008: 850 - 852). Ghana, the country under study in this dissertation is no exception as several studies (Asante et al., 2014; Amu and Dickson, 2016: 2, 6; Nguyen et al., 2011: 1, 10) have noted the prevalence of OOP in the healthcare system despite the progress made with the National Health Insurance Scheme (NHIS).

Conclusion of Chapter Two

Regardless of the approach taken in achieving the UHC, it must be appreciated that the fundamental comprehension of the need to fill both the financing and provision gap is present, that policy makers and implementers have to continually keep equity concerns for the poor in focus and a shift in how health systems utilize resources (Cotlear et al., 2015: 14, 30). As noted from the varied approaches taken, some exploring mandatory means of "pulling" everyone along the UHC path, others expanding coverage using age old solidarity mode to canvass support at the community level in the case of Senegal, others practicing similar approaches as Senegal but

improving upon them such as in the case of Ghana, and even more others, legally creating space for the UHC but with an infusion of Private Health Insurance (PHI) and other methods. In essence, public policy-making processes are non-linear and irrational; they are also not systematic (Ridde, 2009). Kingdon (2011) suggests that any such models prescribing such logic do not reflect reality. That the idea that human beings are that strategic and organized is not tenable, suggesting that the different actors' roles and ideas "drift in and out of the process", robbing the process and implementation of any chronology and strict adherence to structure (Pg. 77 -79). Ridde (2009) suggests that public policy process can be understood as consisting of several sub-processes.

Indeed, the conceptual framework designed for this dissertation is based on the realities of the fluidity of the policy environment and different influences of the varying roles of the different actors in the process. First, the Kingdon (2011) multiple-streams framework's application has proven that the policy-making process followed by many African countries and especially Ghana has not been linear (Ridde, 2009) but the basic tenents have been present – agenda-setting, alternative discourse, decision on choice and implementation. For some of these countries, some of the stages in the framework have been mixed, for others they have stayed on one stage for a longer period than others – Ghana can be cited for this part (commencing the agenda-setting from the 1970s) and for others, implementation has been on a somewhat piecemeal form and, while others still like in the case of Ghana's latter, bold, decisive and financial resource-consuming scale of implementation was undertaken (10.6 percent of GDP and the support of development partners). The contexts have been different, proving that when it comes to policy-making especially for the health sector, there is no one-size-fits-all approach required. The pyramid-shaped conceptual framework which comprises the UHC, as translated through the NHIS and the CHPS, the SDGs and SDH which has the proposed HiAP encassing them in a dual directional manner also talks about the various actors involved in the policy environment in Ghana. This implies that there is continuous interaction among the policies, culture, institutions and the various actors. The interactions do not remain static and the landscape within which the UHC would be achieved by year 2030 also keeps changing. For instance, even though corruption is captured as part of the policy environment has influence on health outcomes in Ghana, its impact looks to be waning as new policies have been introduced to curb its incidences in the

country. Another feature in the conceptual framework's environment is technological advancement which keeps progressing in support of the health demands and supply methods of the population – this will be evidenced further under the sub section 1.1 in Chapter 4 on the specific case of the NHIS in Ghana.

In addition to the above, implementation of public policies often do not follow the agreed plan (Ridde, 2009). Gilson and Raphaely (2008) in an article show that policy decisions (or non-decisions) often result in unintended and unwanted consequences. Ridde (2009) cites an example that explains some unintended consequences, a deviation from the original objectives and aspirations of the policy directive. According to him equity in access to healthcare was among the original objectives of the Bamako Initiative (BI) policy; nothing, however, came of it. It is therefore necessary to focus, not on the first stages of the process, but rather on the implementation phase. Adding that, specification of policy objectives and means is one of the factors influencing successful implementation (Ridde, 2009). As observed from the earlier discussions in the chapter, the UHC and the challenges indicated with respect to definitional difficulties lending its mode of implementation to diverse interpretations with the degree of implementation is also subject to the whims of development partners. These development partners sometimes dictate what policies and to what extent those policies of local governments would receive support from them to implement, thus the context of the power-play among the actors in the policy space must be noted. Boidin (2017) in pointing out why the SDH-based approach has stalled in Africa posits this same issue of politics and unequal power-play among the actors with sovereignty and yet aid dependent, with African countries on the one hand and the donors and development partners on the other (Boidin, 2017; Laverack, 2007; Moyo, 2009: 35 - 38). Countries within the sub-region have been subject to considerable pressure from development partners. Policy preference favoured by the donors and technical partners have often trumped those of aid recipients who may be in need for support in undertaking health interventions such as the UHC (Moyo, 2009).

In addition to the issues earlier discussed, a lack of appreciable levels of institutional complementarities relating to government silos defeat the harmonized ways in which public health policies could work effectively to achieve expected impact (Marmot, 2010: 23; Boidin, 2017). Perhaps it is for issues of accountability that the operations of such policy silos may suit

the preference of some actors in the policy environment. As described by Aryee (2000), the 'demons' related to issues of accountability could prevent the implementation of public policies on health even if a 'win-win' strategy as cited by Ollila (2011) in association with HiAP approach is adopted in addressing the status quo of disjoint government silos (sectors).

Finally, another aspect of the policy discourse of relevant mention is the possible contestation that could arise at the point of policy change (Gilson and Raphaely, 2008). It is pointed out that contestation around some policies occur within the public arena, for example, the debate on abortion, and in some other instances, inaction on policies of HIV/AIDS could also generate public outcry. This policy-making aspect of the dissertation brings to the fore an observed dynamic worth noting by Brugha and Zvarvasovszky (2000) that considerations should be given to both the political and technical aspects of health sector reform and hence, the political dimension of the UHC implementation. It inherently presents possible challenges that could be faced in the achievement of the UHC with a true reflection in the lives of the people of Ghana (as observed through the SDH) and through the implementation possibility lenses of the HiAP. In this chapter also, the choice of the National Health Insurance Scheme (NHIS) in Ghana as a priority item on the agenda has been explained and how the Community Health-Based Planning and Services (CHPS) became an alternative health goal is also hinted at in the narrative, based on Kingdon's policy-making framework (2011). This chapter cements the fundamental basis for this thesis, as all the concepts, goal and initiatives are seen specifically actualized through policy options. The conceptual framework covers the issues of concern in the policy environment. The SSA's efforts at achieving the global health indicators are looked at extensively with regards to its present health disease burden, institutional challenges and financing difficulties which could affect the attainment of the health goal and the SDGs.

PART 2: THE CASE OF GHANA: GENERAL ELEMENTS AND THE UHC JOURNEY

Introduction

This part focuses on Ghana – its established health goals and socio-economic conditions reflected in light of the SDH. Specific areas are selected for discussion based on the Dahlgren and Whitehead (1991) framework. As would be seen in this part, many of Ghana's social policy outcomes have been influenced by the economic policy choices made, spanning decades under different governments. This part gives an indication of sectors which have been prioritized by successive governments. It sheds light on strategic partnerships sought through the development partners including the International Monetary Fund (IMF) and the World Bank. Issues of some sub sectors such as the informal mining sector and others which create employment for thousands of people but have negative consequencies on health and the environment are raised. These are considered important due to the influence of the outcomes on the potential effect on subscriptions on the NHIS which is one of the key policy options chosen by the country in the achievement of the UHC and also, the environmental determinants which have an effect on health (see SGD3 6, 11, 12, 13, 14 and also, 15) (WHO, 2018: 2).

This part further focuses on the NHIS and the CHPS, the two main health policies chosen to achieve the UHC by 2030. The NHIS is looked at through the legal framework which establishes it, organizational structure, coverage, equity concerns and sustainability issues. The CHPS on the other hand is looked at in terms of historical antecedent, its underlying principles, coverage, implementation and challenges. Part 2 of this dissertation has two chapters, the Chapter 3, *Health in Ghana, the social determinants and health goals* and Chapter 4, *Ghana and the Universal Health Coverage journey with a look at the National Health Insurance Scheme (NHIS) and the Community-Based Health Planning and Services (CHPS)*. The Chapter 3 focuses on the SDH and health as contextualized in Ghana and also covers the Structural Adjustment Programmes (SAPs) and their impact on health in the country. There is a view of the diverse sectoral presence under the Dahlgren and Whitehead (1991) SDH framework as pertains in the country.

Chapter 4 is focused on Ghana's journey to the achievement of the Universal Health Coverage (UHC) through the National Health Insurance Scheme (NHIS) and the Community-Based Health Planning and Services (CHPS). It looks at issues such as the legal framework for the two policies, exemption policies under the NHIS, the governance structure and operations, coverage,

equity concerns, impact and sustainability of the two policies in Ghana. There is also a section for challenges and a comparative analysis of both the NHIS and the CHPS implementation.

CHAPTER 3: HEALTH IN GHANA: SOCIAL DETERMINANTS AND HEALTH GOALS

Introduction

Social Determinants of Health (SDH), as explained in detail under section 1.1 of Chapter 2, underscores the importance of understanding the causes of ill-health and attributes much of it to the social conditions under which people live and work (Irwin et al., 2006; Marmot 2005; Marmot, 2015). Relying on the Dahlgren and Whitehead (1991) SDH framework, various aspects of the conditions under which people live and work such as unemployment, water and sanitation, housing, education, work environment, agriculture and food production, are encapsulated under the umbrella of general socio-economic, cultural and environmental conditions which dictates their well-being. The ensuing issues identified in Ghana's case are categorized using the Dahlgren and Whitehead framework (1991) on the SDH. While this framework explains the conditions under which the people of Ghana live and work, it also depicts the connectivities among the different sectors represented and sheds light on synergies among their performances and what social benefits can be derived should they work in unison. The issues raised under each specific area in the framework bring to the fore the need to address health, which is central to all the areas, with a multisectoral approach without fail.

The Chapter 3 has two main sections – the first being the SDH and health in Ghana which describes the economic decisions of the country and their impact on health. It runs through several budgets of successive governments and their contribution to the health sector. It moves to issues of Structural Adjustment Programmes which the country has entered into since the 1980s. The section shifts to the SDH's focus on the different sectors as spelt out in the Dahlgren and Whitehead (1991) framework in mirroring the circumstances in the country. The section 2 which is themed 'Ghana's health sector: challenges in organization and financing' explains in different sub sections the healthcare sector focusing on the institutional arrangements and then the two health policies selected to champion the UHC journey in the country.

CHAPTER 3 NAVIGATION CHART

CHAPTER THREE THE CASE OF GHANA: GENERAL ELEMENTS AND THE UHC JOURNEY	
Section 1: SDH and health in Ghana	Section 2: Ghana's health sector: challenges in organization and financing
1.1 General socioeconomic outlook – Ghana's economic outlook and links with health	2.1 Ghana's health care sector
1.1.1 Background	2.1.2 The public sector and the decentralization process
1.1.2 Trends in Government of Ghana (GoG) annual budgets and links with health	2.1.1 Actors in the health sector in Ghana
1.1.3 Ghana's longstanding relationship with Structural Adjustment Programs, outcomes and effects on health issues	2.1.2 The public sector and the decentralization process
1.2 SDH – General socioeconomic, cultural and environmental issues in Ghana	2.2 Using health insurance as a meaning of financing health care in Ghana
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1.2.2 SDH – Agriculture, food production and impact on health conditions	2.2.2 Different sources of health care financing
1.2.3 SDH – Work environment and unemployment and its effects on health	
1.2.4 SDH – Water and sanitation (environmental conditions) and impact on health	2.3 The advantages and disadvantages of Private Health Insurance (PHI)
1.2.5 SDH – Housing and its impact on health	
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1.2.7 SDH (Work environment) – The informal mining sector	
Key words: SDH, Health Insurance, Health care financing, SAPs	

Section 1: SDH and health in Ghana

This section focuses on the SDH and health in Ghana (section 1) which details the general socioeconomic outlook, Ghana's economic outlook and its links with health (1.1). There is a connection made with the trends in Government of Ghana (GoG) annual budgets and links to health (1.1.2). Sub section 1.1.3 is an overview of Ghana's longstanding relationship with the Structural Adjustment Programmes, outcomes and the effects on health issues. The Social Determinants of Health (SDH) bordering on the general socioeconomic, cultural and environmental context of Ghana are captured under 1.2. From 1.2.1 to 1.3.7, there is a view of the specific sector representations under the Dahlgren and Whitehead (1991) SDH framework. Here details of the different sectors and their influences on health as pertain to Ghana are explained.

1.1 General socioeconomic outlook - Ghana's economic outlook and links with health

In addressing health and well-being issues, the WHO has described the determinants of health in the following categories - social, economic, political and environmental capturing the SDG targets which are not directly health-focused with the most critical being the economic dimension for the African continent. Indeed the WHO has made one of its strategic priorities as **'Tackling the social and economic determinants of health'** in supporting the continent's journey to achieving the UHC. The journey towards the achievement of the UHC is said be highly dependent on integration among others (WHO, 2018: xii, 5) and the fact that Ghana has shown commitment to the SDGs and the UHC in particular suggests that all relevant aspects need to be looked especially the economic dimensions. In light of this, the economic policies and performance of the country under study is taken into consideration in this section through the lenses of the determinants of health.

1.1.1 Background

The dominant sector (also referred to as the primary sector) in Ghana's economy contributes the highest in output, employment, revenue and foreign exchange earnings (Asenso-Boadi, 2010: 148). This sector being agriculture, produces the food basket of the country from different

regions, with the food basket comprising cassava, yam, sorghum, coconut and also milk (Darko et al., 2013: 1) which in turn produces the nutritional requirements of the population. The country's economy is dominated by agriculture, which has been known to have contributed as much as half of the total GDP in 1993 and provided income to an estimated 60 percent of the population in that same year. The year 2000 saw agriculture dominate with contributions to the economy (36 percent of total real GDP). However, the contribution of the tourism sector seemed to be catching up as a significant foreign exchange earner (Asenso-Boadi, 2010: 148).

Bawumia (2010: 68) captures the economic performance of Ghana in two distinct eras – the era of relative macroeconomic stability witnessed in the period 1984 -1991 and the 1992 - 2000 era, epitomizing an era of relative macroeconomic instability. Asenso-Boadi (2010: 148) also describes the era of the decade before 1984 as the worst performing decade in the economy of Ghana but through the World Bank (WB) and International Monetary Fund (IMF) designed assistance, the Economic Recovery Programme (ERP) and Structural Adjustment Programme (SAPs) were introduced in 1983, and the country made a come-back. At the onset of the SAP/ERP, priority was given to infrastructure development namely, roads (under the highway rehabilitation programme giving priority to roads that linked regions that produced export-oriented products), highways, water, sanitation and electrification projects. This was because at that time, most of the serviceable roads which could support the transportation of cocoa and other export-oriented products from the rural communities were not passable (Bawumia, 2010: 68 - 69) and the vehicles meant to ply those bad roads were also in disrepair, additionally, the rail system had not seen any improvement since their establishment (Bawumia, 2010: 68). These are the same roads that transported food from mainly the rural areas to the urban areas to feed the populations there. Bawumia (2010: 70) points out that the aftermath of the 1983 interventions, saw the country's economy making progress, among others the following - policies introduced in the agricultural sector in concerted patterns with good rainfall resulted in improved output for cocoa, staple foods and cereals; an average GDP growth of 5 percent per annum witnessed within the period of 1984 and 1991; there was a decline in inflation from a severe 122 percent in 1983 to 10 percent by 1991; foreign exchange markets experienced an appreciable level of stability with exchange rate depreciation declines from 40 percent to 11.7 percent by 1991 and others.

The seasonality of the dominant agricultural sector mainly due to its dependence on rain affects the income levels of the majority of people who depend on this sector for sustenance and also affects the ability of such persons to afford good nutrition and healthcare when the need arises. Under such circumstances, the people in need of healthcare may have no choice than to borrow from friends and family, sell productive assets which in the long run affects their income earning potential, plunging them further into poverty with its attendant problems (Asenso-Boadi, 2010: 109, 148-149). This predicament is the very same that the UHC is set to eradicate or at worst minimize. According to the IMF African Department[21] however, the year 2013 saw mining and agriculture together dominating Ghana's exports with construction and services representing more than half of the country's output and a majority of jobs remained in the informal sector. This is worth noting as the mining sector continues to make relevant contributions to the Gross Domestic Product (GDP) of the country, there is inherent health issues associated with their operations and their presence as informal sector as well.

BOX 8: SOME TRENDS IN ECONOMIC PERFORMANCE IN GHANA

As already indicated, the economic profile of Ghana is masked with episodes of both stability and instability. The period leading to the 1992 elections saw the government's expenditure rise exponentially with noticeable weakened tax administration regime (Bawumia 2010: 71). There were obvious declines in revenue and grants to the country (from 16.7 percent of GDP in 1991 to 15.2 percent of GDP in 1992) and tax revenues also seeing a decline from 12.4 percent of GDP to 10.8 percent of GDP. These notwithstanding, government increased total expenditure from 18 percent of GDP to 24.6 percent in the same period (Bawumia 2010: 71). The onslaught of fiscal indiscipline continued to the extent of creating a budget deficit (from 1.3 percent of GDP in 1991 to an ascent of 9.4 percent in 1992 and a domestic debt stock increase from a 4 percent of GDP level in 1991 to a quadruple 16 percentage level of GDP in 1993. The outcome was a shortfall in donor support which the IMF/World Bank refused to support, propelling the government to borrow on a non-concessionary terms in 1992. The two

21 www.imf.org/external/ns/search.aspx?hdCountrypage=&NewQuery=mining+and+Agriculture%2C+Ghana&search=Search&filter_val=N&col=SITENG&collection=SITENG&lan=eng&iso=&requestfrom=&countryname=&f=

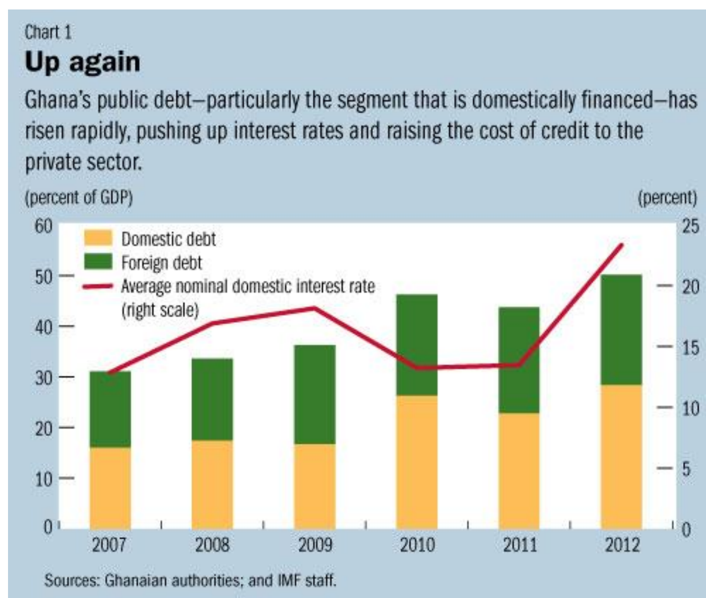
institutions ceased all financing arrangements with the Government of Ghana in the period 1992 – 1994 (Bawumia 2010: 71). Due to an increase in crude oil prices on the global market which propelled a domestic upward adjustment increase in inflation to 10.5 percent by October 2006, and this translated in a disappointing fall in gains made in March (9.9 percent declining further to 9.5 percent) in April same year (GoG Budget, 2007).

Source: Bawumia (2010) and GoG Budget (2007)

1.1.2 Trends in Government of Ghana (GoG) annual budgets and links with health

There has been a prominent place for the role of development partners in Ghana. The Government of Ghana (GoG)'s annual budgets have always seen support in the area of the fiscal deficits by the donors and multilateral partners, although inflows from them sometimes delay (GoG Budget 2014) (refer to Figure 8 for Ghana's Public Debt for 2007-2012 and Table 2 for top 10 Donors). For example, in the 2007-2008 periods, the operationalization of and contributions from the enhanced Highly Indebted Poor Countries (HIPC initiative) coupled with the Multilateral Debt Relief Initiative (MDRI) helped create fiscal space for funding the social sector, and helped execute poverty - reduction projects and growth oriented expenditures in the country (GoG Annual Budget, 2008: 22, 171). The 2010 Budget reported that the planned HIPC Funds for 2009 totaling GH¢261.64 million (equivalent of $59.46 million at the rate of $1 - Ghc4.4), comprising GH¢52.33 million (equivalent of $11.89 million at the rate of $1 - Ghc4.4) for domestic interest payments, and representing 20 percent of the total being GH¢168.9 million (equivalent of $38.39 million at the rate of $1 - Ghc4.4) was set aside for sectoral programmes reflecting 66 percent of the total. Out of this, for the health sector, the focus was to provide funding for the Community-based Health Planning and Services (CHPS) concept and the expansion of ambulance services was provided with GH¢5 million (equivalent of $1.14 million at the rate of $1 - Ghc4.4). In 2010, the government listed as one of its priority social sector programmes, the scaling up of the CHPS concept (GoG Budget, 2010). In addition, the HIPC Funds in 2003, as allocated by the Ministry of Health (MoH) funded the creation of government - owned and sponsored Mutual Health Organizations (MHOs) in all districts in Ghana, eventually leading to the realization of the NHIS' establishment (Agyepong and Adjei, 2008).

FIGURE 8: GHANA'S PUBLIC DEBT FOR 2007-2012



Source: IMF Survey Report of June 28, 2013 (accessed on 10th January, 2017)

TABLE 2: GHANA'S TOP 10 DONORS

Table 1: Ghana's top 10 donors	
Donor	**Average Annual ODA 2006-10 (USD$)**
IDA	268.6
United Kingdom	158.1
United States of America	115.4
European Union (EU) institutions	107.6
Netherlands	106.1
African Development Fund (AfDF)	95.3
Canada	84.1
Denmark	80.7
IMF	69.0
Germany	60.7

Source: Adapted from Moss and Majerowicz, 2012

TABLE 3: SOURCES OF FINANCING FOR GOVERNMENT OF GHANA (GOG)

Subject Descriptor	2006	2007	2008	2009	2010
	(Millions USD)				
Total ODA (DAC reported)	1,213	1,164	1,305	1,583	1,692
(Percent of GDP)	5.9	4.7	4.6	6.1	5.2
FDI Net Inflows	639	855	1,220	1,685	2,527
(Percent of GDP)	3.1	3.5	4.3	6.5	7.8
Remittances	105	117	126	114	120
(Percent of GDP)	0.5	0.5	0.4	0.4	0.4

Source: Adapted from Moss and Majerowicz, 2012

BOX 9: GHANA'S TRANSITION TO LOWER-MIDDLE-INCOME STATUS

The country was moved into a lower-middle income status in 2010 after a rebasing and revision of the national accounts exercise which raised Ghana's national income by more than 60 percent (GoG Budget, 2012). By this, a significant milestone had been reached as the desire for such had been encapsulated in a plan launched in 1995 called the Government's Vision 2020 with the aim "to transform Ghana from a low-income to a middle-income country within one generation" (GoG 1995). Through a somewhat unconventional and unpredictable means - a technical statistical adjustment was used in the recalculation in reaching this status in November 2010. Although, according to the World Bank, three decades before the real GDP growth rates

had witnessed steady growth (from 1.4 percent in the 1970s to 5.5 percent for the past decade), the sudden leap placed Ghana's official GDP per capita at $1,363, from a previous under $800 level. Overnight, the country found itself in a different income category – these income categories are often used by many international organizations to classify countries and they usually come with differential treatment when approached for economic/financial agreements (Moss and Majerowicz, 2012). Within the same space of time as being elevated to middle-income status, the country officially became an oil producer (in June 2007, an offshore oil discovery triggered commercial production by December 2010), however, such oil revenues often come classified as "unearned income" in the assessment of potential recipients by donors, and it's likely to affect donor allocation decisions (Moss and Majerowicz, 2012).

Source: Moss and Majerowicz, 2012

1.1.3 Ghana's longstanding relationship with the Structural Adjustment Programmes (SAPs), outcomes and the effects on health issues

Ghana has been focused on economic growth and poverty reduction for decades through various national strategies namely the Ghana Vision 2020 (which commenced with The First Step (1996 -2000); the First Medium-Term Plan (1997-2000); Ghana Poverty Reduction Strategy (2003-2005); and the Growth and Poverty Reduction Strategy (2006-2009); Medium-Term National Development Policy Framework: Ghana Shared Growth and Development Agenda (GSGDA), (2010-2013); and Medium-Term National Development Policy Framework: Ghana Shared Growth and Development Agenda (GSGDA II), (2014-2017)[22]. Issues of poverty are important to the policy discourse in all the sectors in Ghana. It is important to look at poverty in Ghana in general and the various attempts the GoG has made to ameliorate it, with a focus on health in assessing the potential ease or difficulty for citizens to afford costs associated with healthcare expenditure. Healthcare is known not to be free and inexpensive the world over. As observed by Cotlear et al. (2015), the introduction of the UHC is a policy of relief to many, as **the burden of**

[22] www.ndpc.gov.gh All the development plans and strategies on Ghana are supposed to be found at the National Development Planning Commission where all development plans from the different sectors among others are properly monitored, evaluate and coordinate policies, programmes and projects. It was established by Articles 86 and 87 of the 1992 Constitution.

cost of healthcare is often heaviest on the on the poor and vulnerable in society. In essence, they summarize that "achieving more rapid progress toward UHC is important for the broader global goals of ending extreme poverty and boosting shared prosperity. Making progress on this front is one of today's most important public policy imperatives." According to Saleh (2012a), the rate of poverty in the country has witnessed a decline from 51.7 - 28.5 percent in the periods 1992 – 2006 but with persisting inequality observed in **the south-north gradient**. **This is also noticeable in the the country's population dynamics and health conditions**.

A historical overview of the country's relationship with the SAPs could shed light on some **socioeconomic conditions**. The efforts of the government to adhere to the Washington Consensus became apparent and was formalized by the then Finance Secretary (1983) Dr. Kwesi Botchwey in the PNDC budget reading for that year. Contained in it was the devaluation of the cedi and an increase in prices of foodstuff which negatively affected the population. Thus, instead of improving the living conditions of Ghanaians at the time, they were made worse off. As Bresciani and Valdés (2007: 23) note '…………thus **lower food prices result in an increase in real income' for poor households in an economy**. An antecedent to Ghana's unbridled entry into the market-oriented SAPs (Bawumia, 2010: 44 - 45). At the macro-level, it has been speculated that the SAPs saved Ghana's economy from absolute collapse and stimulated growth (Bawumia, 2010: 44- 45; Loxley, 1990). For instance, the negative GDP growth experienced in the 1970s was reversed with a drop in inflation from 123 percent to 32 percent in the period of the early 1980s to 1991 and previously ailing industries in the 1980s witnessing improved production capacities. Public finances saw appreciable improvement in the era of 1984 – 1991 when government budget deficit declined from a 2.9 percentage point of GDP in 1983 to a surplus of 0.1 percent of GDP in 1986 (Bawumia, 2010: 70). Ghana's performance in terms of compliance with IMF and World Bank prescriptions over the period can be described as inconsistent with two notable financial support suspensions from the programs with the first in the period 1992 - 1994 and the second registered in 1996 (Bawumia, 2010: 70 - 73).

Albeit, the long lasting Structural Adjustment Programmes (SAPs) and Economic Recovery Programmes (ERPs) impact at the micro - level have not been altogether impressive (Loxley,

1990; Peabody, 1996; Rowden, 2009: 109 - 140, 153 – 169). Some perspectives in economics hold the view that **such programs are "present pain for future gain"** (Peabody, 1996) **but for some key sectors of the economy like the health, such notions cannot hold true** (Peabody, 1996). As a result of directives from the Structural Adjustment Programmes/Economic Recovery Programmes in the period 1984 -1991 with regards to cutbacks in the health, education sectors and general welfare expenditures in those periods, there were notable negative repercussions on the health and livelihoods of many people in the country, but especially on the rural poor. The situation got exacerbated with the **employee downsizing** exercise which resulted in the eventual retrenchment of more than 300,000 public sector workers (Bawumia, 2010) propelling many into much deeper socio-economic hardships and poverty. Accra the capital city for instance, experienced a heightened **increase in the migration of individuals from the three northern regions (noted to be most impoverished in the country)** and poor regions of the south such as Central and Volta regions to some regional capitals of Ghana such as Kumasi and Takoradi, with a sizeable number of people from the rural communities becoming slum dwellers on lands demarcated for schools, institutions, other public services, and with their unplanned, overcrowded and unsanitary structures putting enormous pressure on water courses (Agyei-Mensah and de-Graft Aikins, 2010: 888). The **post-adjustment era of the 1970s has witnessed an exponential increase in the chronic disease burden of the country with epidemiological studies providing evidence of increased prevalence rate in chronic diseases such as hypertension and diabetes and a definite increased mortality** rate emanating from these (Agyei-Mensah and de-Graft Aikins, 2010: 891). Over the period of having Structural Adjustment and Economic Recovery Programmes in the country, healthcare expenditure has not been consistent and is reported to have suffered a steady decline from 11.6 to 5.5 percent in the years 1999 to 2007 (Alfers, 2013: 5). Marmot (2010: 19) suggests that there is evidence of that economic downturns have negative effects on population health and that with these effects, "health inequalities are likely to widen".

1.2 SDH – General socioeconomic, cultural and environmental issues in Ghana

Based on the Dahlgren and Whitehead (1991) framework, the environment within which people live and work in Ghana is going to be discussed subsequently. The framework has been used in

guiding the key sectors of choice for discussion below, reference to Figure 3 – the Dahlgren and Whitehead (1991) SDH framework. The country since the 1980's has somewhat implemented successive neoliberal policies (Mawuko-Yevugah, 2014) under Structural Adjustment Programs (SAPs) and some indigenously-infused Economic Recovery Programs (ERPs) introduced by the IMF and World Bank (Bawumia, 2010). The programs introduced in Ghana were and have not been different from those in other developing countries with similar economic circumstances. The programs could best be described as "a package of actions that included currency devaluation, reducing inflation, downsizing the public service, drastic cutbacks on government expenditure on education, health and welfare, financial reforms, privatization of public enterprises, export promotion, and other policies geared to enhancing economic growth" (Konadu-Agyemang, 2000; Agyei-Mensah and de-Graft Aikins, 2010).

1.2.1 SDH - Unemployment

The Ghanaian economy experienced a declined growth rate of 3.7 percent in 2015, from a 4 percent rate in the previous year resulting from a number of challenges faced in the economy which prevailed also in 2014 - a three-year power crisis, unplanned - for low world market prices for oil and gold exports, rising fiscal deficit and public debt levels leaving the services sector as the main sector of growth in the economy and also, the industrial sector making a positive growth showing with a rate of 9.1 percent (AfDB, OECD and UNDP, 2016: 291). The population that lived in urban areas in 2010 was more than 50 percent of the population, a vast difference from the 30 percent that registered in 1957 at independence with urbanization projected at a 72 percent rate by 2035 (AfDB, OECD and UNDP, 2016: 291).

Ghana's economy took a nosedive in 2012 and had to seek another round of an IMF/World Bank intervention. **The latest arrangement (also known as the Extended Credit Facility (ECF) arrangement stipulated that "the ECF is a lending arrangement that provides sustained program engagement over the medium to long term in case of protracted balance of payments problems") and was approved on April 3, 2015** and estimated at SDR 664.20 million (about US$918 million), was meant to span over a period of 3 years. The arrangement which is intended for the country to restore its macroeconomic stability and ensure its debt

sustainability will also be expected to propel high economic growth, create jobs while protecting social spending (IMF, see Press Release No.15/159). A number of reasons have been cited for the economic deterioration in the country by the IMF, not limited to - the public sector employee wage policy bill popularly called the Single Spine Pay Policy (SSPP), which was passed in 2012, and by this a large expansion of fiscal deficit was created (IMF, see Press Release No.15/159).

Some of the conditionalities of the latest IMF/World Bank support to Ghana with mixed impact but which formed key part of the policy discussions of the IMF and GoG agreement, specifically in line with the expenditure restraint in 2015, was **the freeze on employment into the public sector (except for the health and education sectors)**. The government also removed the long-standing subsidies enjoyed on petroleum products by citizens and liberalized petroleum prices by 1st July, 2015 (IMF Country Report No. 15/245). In addition to these, the government set up the EXIM Bank which would support growth in the agricultural sector and also introduced initiatives towards public sector reforms such as the biometric registration exercise of all employees on government payroll aimed at validating existing employees with the biometric database on all employees domiciled at the Controller and Accountant General's Department (CAGD) (IMF Country Report No. 15/245). This was in order to sanitize the existing corrupt system whereby names (popularly tagged 'ghost names') of people who are not employees of government are fraudulently paid each month, syphoning state resources.

At a press briefing in Washington D.C. in 2015 and in a response to a question posed about the deficit reduction rate "pressure" of 9.5 percent in 2014 expected to be reduced to about 3.7 percent in 2017 imposed by the IMF on Ghana, the response given was in line with the standard practice of the IMF on adherence to conditionalities[23]. With this said the stringent economic adjustment agreement remained. Indeed, the country has in the past not lived up to expectation

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[23] The following response was given by Ms. Antoinette Sayeh, Director, African Department at the IMF: *"No, we don't think it's overly ambitious. It's certainly a considerable fiscal adjustment. Ghana needs a considerable fiscal adjustment and needs to frontload that adjustment to deal with the very dire situation it's been in over the course of the last 2 to 3 years as a result of very large fiscal and current account deficits that have really reduced growth, led to significant inflation, and undermined its ability to pay attention to the issues that Ghana needs to in the way of financing and making room for different spending needs to support sustainable growth in Ghana. The adjustment effort is frontloaded given, of course, Ghana's track record in fiscal adjustment has not been the best in the past*" (www.imf.org/en/news/articles/2015/09/14/01/49/pr09386 and accessed on 8th January 2017.

under such agreements, as cited by Bawumia (2010: 71-73), and with Ghana having had two rounds of suspensions from such programs, the first being in the period 1992- 1994 and the second in 1996, the conditionalities were to be strictly adhered to. At a time when the World Bank had revealed that 48 percent of **Ghanaian youth were unemployed**, in a 51 - page Letter of Intent from the GoG, signed by the Minister for MoFEP and governor of the Bank of Ghana and addressed to the Managing Director of the IMF, **the government reiterated its commitment to strict compliance to the net freeze on recruitment into the public sector under the Extended Credit Facility (ECF) arrangement agreement**[24]. The expected achievement of the fiscal deficit reduction exercise has implications on public expenditure and on critical sectors such as health, education, agriculture, commerce, energy, environment and others. Although indicated in the initial agreement that the health and education sectors would not be affected, that was not the case as several fall outs have been recorded as a result of this policy. As pointed out in the literature regarding policy implementation, **there is an aspect of the policy implementation that could have unintended and yet catastrophic impacts on other sectors** (Leppo et al., 2013). As indicated under the living and working conditions in the Dahlgren and Whitehead (1991) framework for the SDH, many people were affected by these policies - apart from some demonstrations from unemployed graduates, mainly from the health and education sectors, there were also agitations from those already recruited within the system concerning poor remuneration and unsatisfactory conditions of service under GoG's Single Spine Salary Structure (SSSS) combined with the high cost of living[25].

Impact of past conditionalities imposed upon Ghana with dire consequences at the micro level were similar - unemployment, high utility prices, removal of subsidies on a range of things which used to act as buffer for many underemployed households, many retrenchment exercises in the private sector and other austere measures. The SAPs, between the period of 1987 – 2000 ushered in the privatization of 300 state-owned enterprises at different stages of the Economic Recovery Programme (ERPs) resulting in the loss of an estimated 70, 000 jobs and 147, 000 people in the formal sector with recorded reduction in the rate of employment from 18 percent in 1989 to 13 percent in 1999 (Jorgensen, 2012: 55; Bawumia, 2010: 45- 47). Nationally, between

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[24] Extended Credit Facility (ECF) agreement accessed from the Ministry of Finance and Economic Planning

[25] www.ghanaweb.com posted on 17th November, 2016 and accessed on 29th September 2017

the periods 1999 – 2000 and 2006 -2008, the country experienced declines in the unemployment rate from 8.2 percent to 3.6 percent and with a notable decline in unemployment of 12.0 percent to 6.3 percent in urban areas, within the same period (Jorgensen, 2012: 55). The current unemployment rate stands at 10.9 percent for populations in the age cohorts of 15 - 25 and children between the age cohorts of 7 – 14 years are active in the labour force below the minimum 15 - years standard set by the International Labour Organization (ILO's Convention 138 - Minimum age convention 1973) is at 28.8 percent (cited in Ghana Child Labour Survey, 2003 by Ghana Living Standards Survey 6 (GLSS6)). With difficult economic conditions and resultant unemployment come conflicts, community violence and crime – 61.5 percent of the population surveyed under the GLSS6 responded positively to either being part or witnessing violence in their neighbourhoods and 10.7 percent of people expressed concerns about safety at home (GLSS6 refer to Tables 12. 17 and 12. 16 respectively).

According to a July 4th 2014 edition of the Daily Guide newspaper (a national newpaper in Ghana), the General Secretary of the Trades Union Congress (TUC), one of the most powerful labour unions in Ghana (same that negotiated with government concerning the use of part of their earnings to support the NHIS' establishment) made an appeal to government to continue to subsidize the cost of utilities for consumers in the country, complaining of the deteriorating social and economic conditions in the country. At the heels of the IMF/World Bank negotiations, critical sectors such as the **energy, petroleum and water had been part of the economic reforms' recommendations which urged government to remove subsidies and let market forces work**. These subsidies represented **safety nets for workers/consumers who had for decades come to rely on them in the face of poor remuneration in the labour market especially in the public sector**. In a statement which read "The government continues to withdraw subsidies and abolish long-established allowances, either to teacher trainees or nursing trainees. Yet, the budget deficit remains unacceptably high" (July 4th 2014 edition of the Daily Guide newspaper), the labour unions sought an end to the **poor socio-economic conditions** which had befallen the country. An even worst prospect for the government was the non-achievement of the performance indicators set for the country which could lead to a cessation of the programme (known to have happened in the past). While the evidence of negative effects of economic upheavals have been cited, Marmot (2010: 19, 14) has pointed out that "employment"

or the lack of, in addition to “working conditions have powerful effects on helth and health equity”.

1.2.2 SDH – Agriculture, food production and impact on health conditions

Some of the macroeconomic decisions made have had a significant impact on the loss of employment from the agricultural sector (considered relevant to the SDH framework – agriculture and food production) which as earlier indicated was the main economic activity in Ghana accounting for 50 percent of Ghana’s GDP in 1993. Agriculture as a source of economic activity has seen the worst decline in the last decade or so (2006 – 2015) from 30.4 – 21.0 percent. Agriculture can support poverty reduction efforts through its trickle down effects on the poor and its overall contribution to GDP. More importantly, it has the ability to increase employment rate for unskilled labour relative other sectors – providing incomes to households in both rural and urban populations. This goes a long way in reducing poverty (Bresciani and Valdés, 2007: 7) and increasing the purchasing power of households. Still in relation to the significant contribution of agriculture, Bresciani and Valdés (2007: 23) intimate that ‘For poor households which are net buyers of food, food expenditures usually represent a relatively high share of total expenditures…..’ and also to the overall GDP, as earlier indicated. Generally, Ghana’s agricultural sector is described as having an abundance of unskilled labour coupled with low productivity (Bresciani and Valdés, 2007: 11). There is marked reduction in the gains previously made in the agricultural sector with Ghana becoming a net importer of food emanating from the reduced incentives for farmers to produce various food items to feed the population (Abudu, 2016: 128). The lack of effective agricultural policies have been blamed for the prevailing conditions of low farm yields, land degradation, reduced food production and rural unemployment leading up to food and nutrition insecurity closely connected to malnutrition and malnourishment. There is negative impacts of these latter two on child growth and development, including their educational development (Tutu, 2011: xxii). There are fortunately two other sub sectors in the economy which have also contributed notably to economic growth and recorded double digits growth rates. These are the Information and Communication (13.4 percent) and the Health and Social Work sub sector (11.5 percent) (GSS, 2016). Table 4 below shows the distribution of non-oil GDP across some sectors. In the opinion of Oteng-Ababio (2012), the

neglect and subsequent decline in growth in the agricultural sector could be attributable to the "un-remunerative commodity prices". However, this marked decline in the agricultural sector seems not to be a Ghanaian economic and social phenomenon alone. According to the World Economic Forum's Africa Competitiveness Report (2015), an estimated 50 percent of all employment in the SSA sub region emanate from the agricultural sector, with recent movement of labour into the service sector and surpassing the gains made in the manufacturing sector. In the year 1998, an independent utilities and regulatory commission was established and agricultural price subsidies were removed (Seddoh and Akor, 2012). While government subsidies are being removed from key goods and services in the economy, the cost of living keeps increasing for the poor. In relation to agriculture and food production, **another dimension to the economic policies and its adherence to conditionalities and relevance to the SDH framework and is "economic livelihood is largely dependent on nutrition"** (Darko et al., 2013: 1). While **malnutrition is very much prevalent** in Ghana with 14.3 percent of children underweight (Darko et al., 2013: 1), there is conversely the presence of **obesity** (21.9 percent of Ghanaian women and 6.0 percent of men are reported as obese) which has been linked with many non-communicable diseases. Indeed it is reported that in the past twelve years, **malnutrition has been the primary cause of "disability-adjusted-life-years" in Ghana** (Nykanen et al., 2018: 1). The other aspect of the agriculture and food production discussion is that of **affordability of nutritional foods in support of the health requirements of households**. It is important to note the significant link made in earlier discussion on the impact of the economic policies on incomes of Ghanaians and their ability to afford basic necessities of life including food. Nykanen et al. (2018: 1) point out that, **while "cost of food is considered a barrier to achieving a health-promoting diet", Ghanaians are said to be suffering from "a double burden of malnutrition" and sadly, the population residing in the rural areas where majority of Ghanaians live are said to be more disadvantaged in relation to the high cost of food** (Nykanen et al., 2018) even though the production of a greater percentage of the food basket in the country emantes from there.

In the view of Agyei-Mensah and de-Graft Aikins (2010), in adhering to the policy directives of the earlier SAPs and poverty reduction, **the emphasis on trade liberation caused changes to Ghana's food production and supply policies**. It is explained that in the period before 2000,

the IMF/World Bank's policy nudges for poor countries to focus on export-orientation of their agricultural sectors for growth led to a de-emphasis on basic food crops for local consumption and a rather transformed taste for imported and processed foods (Agyei-Mensah and de-Graft Aikins, 2010: 890). One notable effect of trade liberation which has very much been part of the conditionalities embedded in the SAPs for Ghana and other low-income countries over the period is the **removal of subsidies for farming inputs**. This is a direct deviation from what still pertains in rich/developed countries, leading to the artificial inflation of some international food prices, stifling local food producers out of business. For instance, **Ghana's efforts to increase tariffs on imported EU poultry products was interfered with by the IMF who succeeded in making the Ghana government reverse its decision**, inadvertently killing the local poultry industry (Agyei-Mensah and de-Graft Aikins, 2010: 890). This situation has been made far worst with **the proliferation of multinational companies in the country** with their aggressive and impressive marketing strategies promoting various processed foods and chains of fast-food eateries (Agyei-Mensah and de-Graft Aikins, 2010: 890). This **adds to the sorry story to tell on the increased number of people with NCDs in Ghana with many lives lost each year** but preventative methods are currently not supported by the NHIS entirely (which has a package for a number of curative conditions). The other side of the challenge of agriculture and food production is the loss of farmlands and fish stock in water bodies through "galamsey" activities, thus, the problem is not only of quantum but also of quality of food production locally, leading to the gnawing problem of malnutrition in Ghana.

1.2.3 SDH – Work environment and unemployment and its effects on health

A consequent economic interplay in the various sectors is the increased level of activity in the informal employment sector. The Ghana Living Standards Survey (GLSS) reports of that **42 percent of all employed persons in the country, of 15 years and over can be found in the informal sector, with 46 percent in agri-business** (Kusi, 2015). Unfortunately for the revenue mobilization agencies in the country, despite this marked number of people in the informal sector, **economic activities are not well-documented and taxed with a resultant loss of revenue to the state**. These may be due to unreliable information (statistical), ineffective regulation and inability of authorities to monitor this part of the economy (Kusi, 2015). There are ongoing attempts being made to streamline activities of this sector in a bid to mobilize much

needed resources for development. Bawumia (2010) hints of **efforts made under the SAPs which resulted in the restructuring of the tax regime in Ghana culminating in an increased rate of 16.9 percent in 1993 from a low rate of 4.6 percent in a decade** (Pgs. 44 -45). Without the support of significant taxes from the informal sector, **the burden to financially support the NHIS falls mainly on the minority in the formal sector** (who are compulsorily taxed).

The noticeable decline in the absorption of labour into the formal economy, with a thrust from the neo-liberal policies culminating in an incapacitated government machinery to absolve and create jobs for its people has plunged many deeper into poverty (Oteng-Ababio, 2012). The social sector has had development at different periods slowed down due to **significant cuts in budgets and the introduction of various service charges on healthcare, utilities and others** (Oteng-Ababio, 2012). With these realities **have emerged some "nouvelle" enterprises into the informal economy calling for attention on all fronts, health included - e-waste scavenging**. The emergence happened in the last three to four years, until then, it was virtually unknown. This phenomenon in the informal sector is often blamed on the inability of the formal sector to absorb the ever-increasing urban job seekers, some of whom are well-trained and qualified and the others, without employable skills (Oteng-Ababio, 2012).

Apparently, **these "survival industries" have been employing more than 50 percent of the urban workforce in SSA, according to the ILO** (Oteng-Ababio, 2012). E-waste scavenging[26] seems to be a reaction to the unbridled flooding of the Ghanaian market with used computers (in 2004, there was a zero rating on import duties attached to their importation by government) and of course, to the high unemployment situation in the country. It is estimated that, there is a 300 – 400 arrival of shipping containers at the ports each month, with no definite end-of-life management plan for this activity. Albeit, this activity is reported to **directly employ about 4,500 – 6,000 people in Accra alone, 30,000 people along the chain of activities and 200,000**

[26] E-waste (also known as waste electrical and electronic equipment [WEEE]) refers to discarded electrical and electronic materials that enter the waste stream and are destined for reuse, resale, recycling, or disposal. It contains secondary raw materials such as copper, steel, plastic, etc. The term scavenging is used in this context to describe the act of: (i) Picking recyclable elements from mixed waste wherever it may be temporarily accessible or disposed of; and (ii) Manually dismantling computers monitors and TV sets for resalable items at numerous small workshops. The extraction of the components is done through burning and the dumping of residue in one of the prominent water bodies which leads to the sea, rendering all marine species lifeless and the place (Agbogbloshie) perpetually engulfed in smoke and ash.

nationwide with revenues ranging from $105 – 268 million yearly (Oteng-Ababio, 2012). As part of the **burning and extraction of lead, mercury and other substances which are known to contain high levels of neurotoxins (known to have negative effects on children leading to low IQ and developmental abnormalities** (BAN/SVTC, 2002), there are also other long-term health risks on the general population. It is therefore not surprising that, as cited in a World Bank report (2007), a medical doctor interviewed from the Ghana Health Service noted that **"in Ghana, about five million children die annually from illness caused by poor environment [……] poor resource management costs the country about 10 percent of GDP, with 40 percent attributed to water and air pollution".** It was further added that, without any evidence from epidemiological studies, **there has been observed increases in the number of convulsive cases from the areas where these metals are extracted** (Oteng-Ababio, 2012). Agyei-Mensah and de-Graft Aikins (2010) in support of the health concerns add that the operations of this "survival industry" are linked to health conditions such as cancers of the lymph system, central nervous system damage, asthma, and silicosis and others. According to them the Abglogbloshie slum area in the capital Accra is now a known repository of e-waste items from Europe and America (Oteng-Ababio, 2010). Another offshoot challenge from Ghana's longstanding relationship with SAPs/ERPs is the problem of street hawking as a means of livelihood among the youth in Ghana. The situation of **street hawking[27] in Ghana is seen in almost all the big towns and cities** (Jorgensen, 2012: 53). They explain that this informal economic activity and by extension the informal economy is a mix of all transactions between two parties which take place on a personal level, of all unregistered and not legally-backed income-earning activities.

As earlier explained, conditions pertaining to urban slum dwellers in Ghana are unsanitary with several associated health hazards. Therefore, many of the rural migrants to the urban cities in search of unavailable economic opportunities and better living conditions end up disappointed as they inadvertently get caught up in a poverty web of social exclusion, unavailable and restricted job conditions, unsanitary living conditions, among others. This risk-taking in selling wares of any kind in traffic also causes vehicular traffic (Jorgensen, 2012). There are known health problems associated with vehicular traffic - air pollution and with reference to solid particulate

[27] "Street hawking is an important source of livelihood in the developing world and has been seen to absorb many unemployed persons often youth who move to urban centres for better economic opportunities" (Jorgensen, 2012).

matter (PM) which have toxic health effects (Jones et al., 2016). In addition, the presence of hawkers on the streets for hours cause filth and waste (Jorgensen, 2012: 72 -77, 83). Hawkers sometimes lose their lives from being knocked down by moving vehicles and other accidents caused by many reasons not limited to only drivers' recklessness (Jones et al., 2016). The combined effects of all the activities of the 'survival industry' and the others described above have serious consequencies on health (Marmot, 2010: 14).

1.2.4 SDH – Water and sanitation (environmental conditions) and impact on health

Ghana is experiencing urbanization which has brought on concerns on a number of sustainable development challenges including but not limited to sanitation and transportation (Osei, Duker and Stein, 2012) and its consequences for the environment, poverty and health (considering the environmental determinants of health under the SDGs). Agyei-Mensah and de-Graft Aikins (2010) explain how urbanization and urban poverty are intricately linked. They cite the example of Accra's population growth from a low 18, 574 in 1911 to 1.7 million in 2000 representing a 90 - fold upsurge in less than a century. Increasing migration from the poor from the Northern, Central and Volta regions to the city can be traced to have tremendous ramifications on sanitation and environmental health – there are recorded perennial cholera outbreaks in the capital city occurring especially in the poorest of neighborhoods. Osei, Duker and Stein (2012) explain the phenomenon of rural migrants and the urban poor's health status mergence as the "epidemiological polarization". They explain that persons finding themselves under such situations are risk-prone to death emanating from chronic non-communicable diseases and acute infections. Their vulnerabilities persist in the rather delicate combined outcomes of environmental degradation, poor sanitation, and overcrowding, as well as in poor lifestyles. The **perennial outbreak of cholera**[28] earlier mentioned continues to recur to today. It is a disease of public health concern which emerged in the 1970s (Osei, Duker and Stein, 2012). Its **worst occurrence happened in 2014 when within five months (May – September) 40,000 cases had been recorded in all ten regions** of the country with Accra bearing the brunt of them all and registering an overwhelming 300,000 incidences and 200 fatalities surpassing the 1982

[28] The perennial cholera disease pandemic is associated with unsanitary living conditions. The World Health Organization (WHO) has explained the disease as *"is an acute intestinal infection caused by the waterborne bacteria Vibrio cholera O1 or O139 (V. cholerae)*" (Bagah et al., 2015).

catastrophic outbreak of 12, 000 (Bagah et al., 2015). The problem has been traced **predominantly to inappropriate liquid and solid waste disposal system in the country**, a stubborn problem being dealt with currently (Bagah et al., 2015). The second largest city in Ghana, Kumasi Metropolis also experiences these **cholera incidences, recurrence observed between 1997 - 2001** (Osei, Duker and Stein, 2012). The two main reasons being expounded for these patterns are - demographic status and the geographic location of the city - it is the central nodal district of Ghana, attracting both human and vehicular traffic from both the northern and southern parts of Ghana. Not being a Ghana occurrence alone, the African continent has chronicled over **2.4 million cases with 120,000 deaths within the period 1970 - 2005**, with this record representing over 90 percent rates of cases and deaths globally (Bagah et al., 2015).

1.2.5 SDH – Housing and its impact on health in Ghana

One other area of consideration under the SDH is the housing situation in Ghana. The rapid uncontrolled urbanization situation in Ghana coupled with factors such as low incomes and the withdrawal of the government's investment in housing have brought on the current state of reduced housing stock (Fiadzo, Houston & Godwin, 2001). A survey by the government of Ghana in partnership with the World Bank revealed that about 40 percent of the population lived in plastered or mud brick houses and 60 percent had no access to electricity with almost without indoor plumbing system (Fiadzo, Houston & Godwin, 2001). Some determinants of poverty (Tutu 2011: 15) and health include housing. There has been in recent years the invasion of slum communities in many urban settings in the country, created by rural-urban migration (people in search of non-existent jobs), inadequate housing stock, high cost of rent for accommodation facilities (even though there are laws for rent control), virtually non-existent social services and others leading to the creation of unsanitary living conditions and havens for criminals. There is also the challenge of low income areas turning into slums due to overcrowding (Tutu, 2011: 15-16). There are direct and indirect consequances of poor or lack of housing on health. Shaw (2004) explain that housing is a basic human right as enshrined by the United Nations in its many dimensions not limited to the provision of shelter. Firstly, the socioeconomic status of an individual or a household can be determined by the ownership of their housing facility, additionally, the location of such a housing facility serves as determinants of health – the

proximity to services, the conditions pertaining to the surrounding built and natural environment, the sense of community among residents or neighbors and others, contribute to the indirect benefits of housing to health. Shaw (2004) refers to the direct bearing of housing on health to include both the psychological and social aspects of poor housing effects on health and considers **housing as a major determinant of health**. **Some diseases associated with deplorable housing conditions include whooping cough, cholera, tuberculosis, diarrhea** (Shaw, 2004) with cholera being the infamous one that caught the attention of public health authorities in Ghana in the 1980s and manages to emerge annually although fatalities have reduced over the years (refer to previous sub section, 1.2.4 for detailed discussion). Shaw (2004) reiterates the point that public health and housing are intricately linked – some previous studies have made the connection between childhood exposures to some unwholesome housing conditions (such as risk of infections, pollutants, allergens and others) and their eventual adult mortality rates.

1.2.6 SDH – Education in Ghana and health

Another key aspect of the SDH is education. The education aspect of the SDH is significant in diverse ways, most importantly health. Currently, there is an estimated 70 percent illiterate population in Ghana (Abudu, 2016: 73 – 75) with the scale skewed in favour of the urban population. The low level of investment in educational infrastructure by successive governments is betrayed by the high prevalence level of illiteracy in the country – even more excercebated by the rural-urban divide in the development in the country. Even though investment seems to be improving, children in several towns and villages can be seen attending schools under trees or dilapidated structures. This phenomenon is compounded by the resistance of teachers to teach under those deplorable conditions (Tutu, 2011: 114 -115). In the sixty years post independence, Ghana has undergone several educational reforms. Prior to the 1980s, the country's educational system was recognised for its high development and effectiveness, and post this era witnessed a decline in support for teachers, quality of school buildings, academic standards of pupils and others, all due to inadequate financing and management (Kadingdi, 2006). Against the background of these negative developments in the educational sector, the government of Ghana in 1996 embarked on a number of reforms starting with the Free Compulsory Universal Basic Education (known also as the FCUBE) programme which sought to reform all levels concerning

the provision of physical structures, retention, teacher training issues, the perennial challenge of access and financing (Kadingdi, 2006). Just as observed in the other sectors, the educational policy initiatives introduced over time in the country have also been influenced by the different political regimes and the ideologies therewith – the Accelerated Development Plans (ADPs) for Education in the period between 1951 – 1961; the 1973 Dzobo Committee's recommendation of 1973 which led to the New Structure and Content of Educational Plan in 1974; the military government of the Provisional National Defence Council (PNDC); the FCUBE which emerged from the 'the military to the rescue' phase of governance in 1996 (and which was informed by Ghana's endorsement of international agreements such as Education for All, the Beijing Declaration on Women's Rights, the Declaration on the Rights of the Child and the Lome Declaration) (Kadingdi, 2006); and in 2017, the New Patriotic Party (NPP) introduced the Free Senior High School (SHS) policy underpinned by the mantra, 'Access, Equity and Quality' and at the heels of the country's failure to achieve the Education for All (championed by the United Nations Education, Scientific and Cultural Organization - UNESCO) by 2015. While the country recognizes that through education the inequality gap can be bridged (Anti, 2017), it is costing the country a sizeable part of its GDP to implement this policy with the UNESCO envisaging that the achievement of the SDGs depend on education (Anti, 2017). One challenge of this sector is the flight of professionals (including those in the health sector) in search of better jobs after investments have been made in preparing them to support the development agenda of the country. World Bank, WHO et al. (2016: 19) report of the challenge of the brain drain phenomenon of the Sub-Saharan Africa sub region, which sadly carries 24 percent of the global disease burden. With this, the continent maintains only about 3 percent of trained global health workers with an estimated shortfall of midwives, nurses and doctors in African countries falling below the SDG acceptable threshold. While all health worker categories are included, there is a shortfall of 4.2 million, expected to escalate to 6.1 million by the year 2030. While progress has been made generally in improving health outcomes in the world, Frenk et al., (2010) perceive that **professional education in health has not kept abreast with the dynamics of health system challenges mainly due to the fragmentation and outdated curricula that ill-prepares health professionals**. They have pointed out the other side of the challenge as being the general inadequacy and inter and intra-country imbalances of educational institutions for training health professionals with a global presence of 2,420 medical schools or departments of public health,

with intermediate number of post-secondary nursing educational facilities aimed at training about a million doctors, nurses, midwives and public health professionals annually (in the case of Ghana, an estimated 70 percent of young doctors emigrate each year – Rowden, 2009:37). Frenk et al. (2010) cite the gross maldistribution of these facilities across the globe with 26 countries in the SSA region having such imbalaces as well. 36 countries across the globe do not have any medical school at all. With these imbalances, the health professionals produced remain incommensurate with the respective population sizes and disease burdens in each region. They emphasis the need for **educational reforms that take due consideration for the place and importance of health professionals** who are the intermediate between people in need of care and information, knowledge and technology, and these health professionals come in such forms as caregivers, policy makers, educators, communicators and others. They stress the point that while drastic **educational reforms have been catalysts in realizing incremental positive health outcomes in the past century**, political will on all levels (local, national and international) is required to foster greater health gains in the future (Frenk et al., 2010).

1.2.7 The SDH (work environment) - the informal mining sector

This aspect is an extended discussion of some of the consequent outcomes of Ghana's relationship with SAPs overtime affecting the environmental conditions within which a section of the population works. Its important to place it here due to first, its place under the SDH, second, the **devastation its causing to the environment in Ghana** and finally, its influence on health outcomes considering the **environmental determinants of health as observed in the SDGs 6, 8, 11, 12, 13, 14 and 15** (WHO, 2018: 2). Some of these risky "survival industries" as referred to by the ILO (2012) being undertaken by the unemployed and underemployed are sometimes considered unlawful but certainly reactionary. Oteng-Ababio (2012) explains that the micro level schemes propelled by macro level economic strategies adopted can be traced to the economic upheavals of the 1970s, 1980s and the 2000s which have neo-liberal inscriptions all over them. Afriyie et al. (2016) explain **the genesis of one of the recently turned prominent national issues that has a serious bearing on health - Small-scale mining (SSM) or the Artisanal and small-scale mining (ASM)** (Tschakert and Singha, 2007) or more informally, '**galamsey**'. The terms would be used interchangeably here, to avoid confusion.

ASM is defined by Tschakert and Singha (2007) as a practice of using the most basic of methods in extracting minerals often manually which poses risks to human existence and has negative environmental impact. Globally, this practice directly and indirectly engages between 80 – 100 million people as a source livelihood (Tschakert and Singha, 2007). According to Afriyie et al. (2016), **the government after 1957 enacted a law (the Minerals Act of 1962) which in effect vested all forms of mineral deposits in Ghana into the custody of the state to the exclusion of local communities**. The merits of this law was mirrored in subsequent pieces of legislation, which included the Constitution even after 1969 (the Minerals and Mining Law (PNDCL 153(2) of 1986), with amendments made later to the Minerals and Mining Amendment Act 475 in 1993 and 2006. The import of these laws, in essence was that despite ownership of land with mineral deposits, upon discovery of such, the right to own, trade and exploit remained the prerogative of government to mine legally and trade due to the state's sole right and responsibility to grant mineral rights to future miners (Afriyie et al., 2016). The Small-scale Mining Law (PNDCL 218) was passed in 1989 after local community agitations (Akabzaa & Darimani, 2001). A further enactment of the PNDCL 218 returned some legitimacy to the small-scale mining sector (SSM) but with compulsory acquisition of mining licenses.

It was in **this same era of SAPs/ERPs which conditioned the government to open up its sectors for free market-entry by foreign companies. In the course of promoting a liberal economy and attracting foreign, large-scale mining companies into the country under the mining sector reforms with oversight of the World Bank and IMF, the needs of the local communities were totally ignored**, making licensing and operations of artisanal miners complex and difficult (Akabzaa & Darimani, 2001). This was a major setback for the implementation of the PNDCL 218 in its promotion of local **Small-scale mining (SSM)**. Ghana is Africa's second largest gold producer, following South Africa attracting about 40 large-scale mining companies (Tschakert, 2009) including AngloGold Ashanti, Newmont, Gold Fields, and Bogoso Gold Limited/Golden Star Resources (BGL). The market-oriented induced policies from the SAPs/ERPs in the 1980s were in flight with the privatization of state-owned gold mining concessions. Tschakert and Singha (2007) posits that although the **SSM makes a contribution to poverty reduction, it also perpetuates a vicious cycle of poverty and continuous**

vulnerability through the hazardous methods used in extraction plunging individuals into illnesses, accidents and environmental degradation. This often illegal activity with its profound impact on health's contribution to the Ghanaian economy is undeniable - since 1989, gold extraction from this sub-sector alone has made a contribution of $461.1 million to the economy and **employs about half a million people, however, its catastrophic repercussions on health and the number of lives lost is not justifiable** (Tschakert and Singha, 2007).

As to what has driven many people into this venture, Afriyie et al. (2016) give the following description in their research study on Tarkwa Nsuaem Municipality in the Western Region of Ghana, one of the sites of the SSM activities - **"Many of the accounts we heard suggest that local community members became engaged in SSM partly because they have systematically been dispossessed of their traditional sources of livelihoods (i.e. farming) due to the state's policy of awarding large mining concessions to Large-Scale Mining (LSM) companies."** According to them, this situation in Ghana goes to reinforce a view held on **'agricultural poverty'** being a cause of the rapid expansion of the SSM phenomena in SSA and the argument that this activity has robbed thousands of rural dwellers of farmlands which used to be their main source of livelihood (Afriyie et al., 2016). For reasons of **loss of biodiversity, chemical contamination, massive air and water pollution**, due to its migratory nature of this venture, it is saddled with problems such as **prostitution, abuse of alcohol and drugs, the rapid spread of communicable diseases (e.g., HIV/AIDS), massive school drop-outs (many children are also involved as are the cases of their parents), rising community tensions, rivalries and armed conflicts** (sometimes among locals and multinational companies with legal rights to gold concessions) and others, there has been a call on its ban by both local and international actors (Afriyie et al., 2016). This is currently a national crisis in Ghana, post the 2016 election. There are almost daily reports of negative incidences in the communities/regions where galamsey activities are being undertaken.

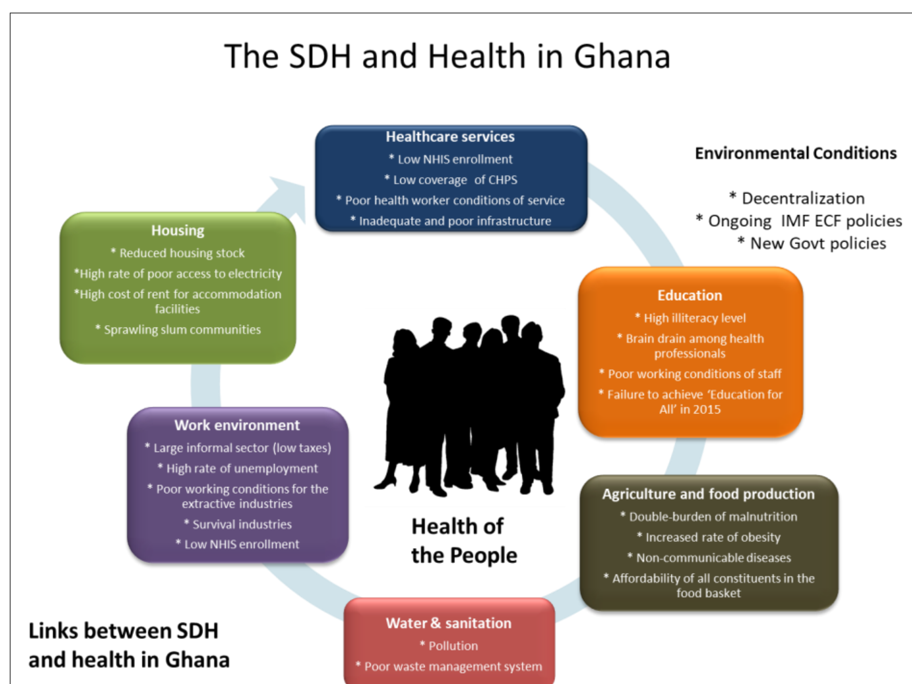
Below are tables representing the growth rate of the various sectors in Ghana for 2010 – 2015:

TABLE 4: DISTRIBUTION OF NON-OIL GDP (AT BASIC PRICES) BY ECONOMIC ACTIVITY (PERCENT)

Table 5: Distribution of Non-Oil GDP (at Basic Prices) by Economic Activity (percent)											
		2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
1.	**Agriculture**	30.4	29.1	31.0	31.8	29.9	27.2	24.8	24.4	23.2	21.0
2.	**Industry**	20.8	20.7	20.4	19.0	18.8	20.2	22.0	21.3	20.9	23.5
3.	**Services**	48.8	50.2	48.6	49.2	51.3	52.6	53.3	54.3	56.0	55.5
4.	**GDP at Basic Prices**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Source: Author (adapted from GSS Revised 2015 Annual Gross Domestic Product - September 2016 Edition)

FIGURE 9: THE SDH AND HEALTH IN GHANA



Source: Author's adaptation of the Dahlgren and Whitehead (1991) SDH framework in the context of Ghana

The figure above depicts the determinants of health (based on the Dahlgren and Whitehead (1991) framework) as pertains in the case of Ghana. From the text on the contextualized SDH in

Ghana (1.2 – 1.2.7) where the specific discussions of the different aspects of the framework are discussed, the realities of the country are demonstrated. The prevalence of challenges described fall under different sectors but a commonality is in their influences on health which begs for a serious look at and an application of the Health in All Policies (HiAP) concept. Undeniably, the narrative of Ghana (with the country's inability to meet the MDG 5.1 target of reducing maternal mortality ratio (MMR) by three quarters and achieving the universal access to reproductive health for women under the health sector and also, its failure to achieve education for all by 2015 under the educational sector[29] (The 2019 Budget Statement and Economic Policy of GoG[30]: 156) can change within this period of efforts being made towards the achievement of the Universal Health Coverage (UHC) by year 2030. The "window of opportunity" (Kingdon, 2011: 165 – 170) exists for the HiAP approach to be adopted as Kingdon (2011: 165) points out "……a political change makes it the right time for policy change, and potential constraints are not severe". This awareness is depicted in the figure above under the environmental conditions (new government policies). The pursuit of the UHC promises to promote gains in many key SDGs, thus it has the ability to pull together the benefits of many other sectors (refer to Chapter 2, section and sub section 1.4.3 for the connectivities among the UHC, SDH and the HiAP concept).

Even though the GoG's current policy direction can be gleaned from the 2019 budget reading in Parliament of Ghana (November, 2018), it does not make specific mention of the government's focus on the health sector in specific (see Figure 10 below), but some of the ripple effects of the sectors mentioned in the priority areas for year 2019 have the potential to positively affect health outcomes and change the narrative in the Figure 9 on the SDH and health in Ghana, also refer to sub section 1.4.3 under Chapter 2 for the linkages among the UHC, SDH and the HiAP concept. Presentations of annual budgets for ensuing years are important to Ghanaians (all interest groups) not only for the policy direction of the government but because as Kingdon (2011: 105) cites, "…..the budget is a central part of governmental activity. Programs, agencies, and professional careers wax and wane according to their budget share. A budget pinch very directly affects both bureaucrats and legislators since the programs in which they have a personal career

[29] **Sources of data:** Global Health Observatory May 2017 http://apps.who.int/gho/data/node.cco

[30] https://www.mofep.gov.gh/sites/default/files/budget-statements/2019-Budget-Statement-and-Economic-Policy_.pdf

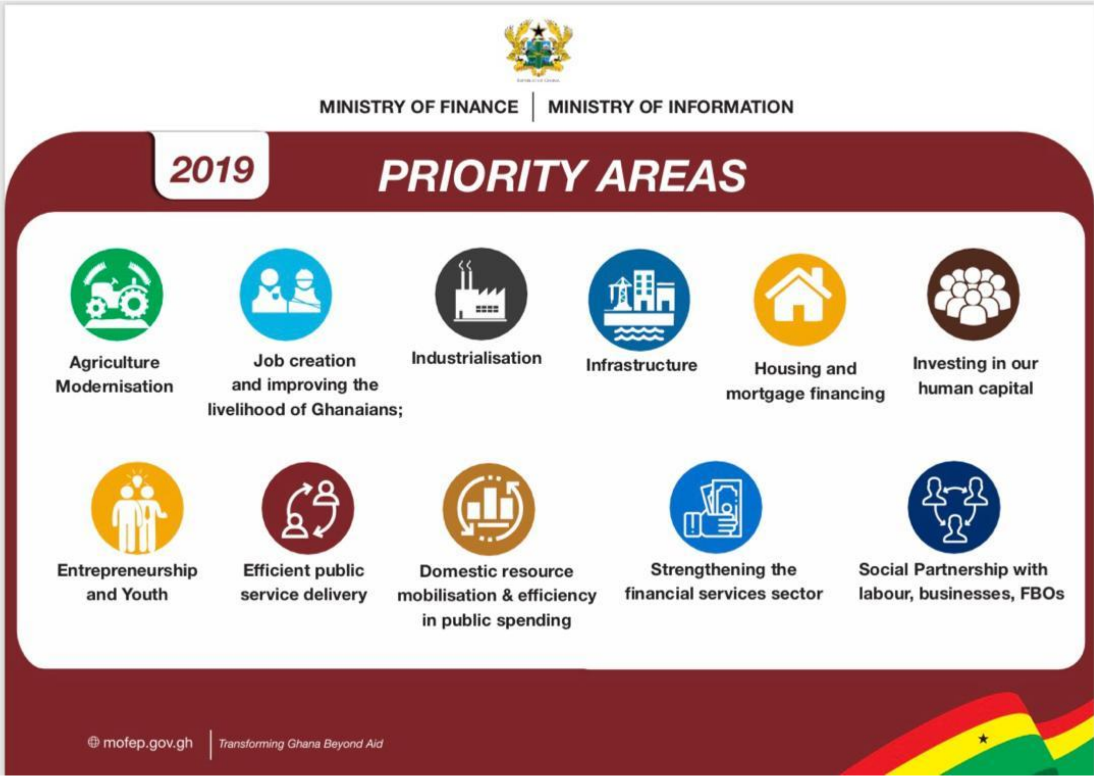
stake are affected." The share of the budget towards the social development, particularly the health sector indicates the government's dedication to the well-being of the people in the country. Indeed, commitment to the UHC has been made through the payment of debt owed service providers which had greatly stalled service delivery and affected the confidence of subscibers in the NHIS (for the first time, it was mentioned that an annual budget had been made in the country with a vivid display of government's commitment to the Sustainable Development Goals (SDGs), "This will be the first budget in Africa and second in the world, after Mexico to fully integrate the SDGs framework, enabling us to track our financial performance in order to ensure progress on these important targets that affect lives of our fellow Ghanaians" (The 2019 Budget Statement and Economic Policy of GoG[31]: 20). This is progressive for the country as the previous years' budget had hints of the SDG infusion also under food and agriculture and energy (The 2019 Budget Statement and Economic Policy of GoG[32]: 14 - 15). Such progressivity is reminiscent of an example cited by Kingdon (2011: 170 - 171) of the Carter administration and the national health insurance proposals made in the period of 1977- 1978 in the United States of America, to depict when a window of opportunity opens for policies. Under that regime, one of the proponents of health insurance stated "You have a president in office who is strongly and publicly committed to national health insurance [.....] You just don't see these opportunities come along very often." These sentiments concerning the opened window of opportunity for a policy adoption can be assumed for the new government in Ghana which is being innovative in policy formulations with a world view, and thus, despite the social determinants of health that currently exist (as shown in Figure 9: SDH and health in Ghana), there is a policy window for the HiAP to be incorporated into the system in Ghana. In reference to budgets and priorities of the GoG, in Annex 2 (SDH-based selected budgets and policies in Ghana 2007 – 2017), there seems to be a trend in making efforts in improving the conditions under the various sectors in the framework through the policies introduced over the years through successive governments' budget allocations to those sectors. Some of the issues raised earlier in terms of nutrition, non-communicable diseases, infrastructure development, addressing the equity gaps in health and others can be cited in the budgetary allocations and corresponding policies introduced but most

[31] https://www.mofep.gov.gh/sites/default/files/budget-statements/2019-Budget-Statement-and-Economic-Policy_.pdf

[32] https://www.mofep.gov.gh/sites/default/files/budget-statements/2019-Budget-Statement-and-Economic-Policy_.pdf

notable is the focusing of most policies on primary healthcare for the health sector. In the agriculture sector for instance, there is an observed trend of ensuring food security using modern methods and a focus on poverty reduction, and in 2017, the sector was allocated the highest budget since 2007. In some sectors such as the Minstry of Environment, Science, Technology and Innovation (MESTI), Minsitry of Water and Sanitation and the Ministry of Education, there were observed recurring themes in policies over the years for lack of implementation. This situation is plausible because there is a difference in the budget allocation process annually and actual release of funds for implementation, powers of which do not necessarily lie with those particular sectors – the Ministry of Finance and Economic Planning (MoFEP) administers all such. That notwithstanding, while impact of policies implemented is best felt when there is consistency, the position of the particular sector on the agenda list of the government of that period commands the needed resources.

FIGURE 10: PRIORITY AREAS FOR DEVELOPMENT IN GHANA FOR YEAR 2019



Source: Ministry of Finance and Economic Planning (MoFEP), 2018

Section 2: Ghana's health sector: challenges in organising and financing

Introduction

The declining death rate in Ghana can be traced to a number of reasons such as improvement in educational levels, public health, sanitation, increased number of medical facilities and a generally modernized country, according to information gathered from the GSS and the MoH (Asenso-Boadi, 2010: 152). From 45 years life expectancy in 1960, the country has made significant improvement to its current 61 and 57 years life expectancy for women and men respectively as recorded in 1998 (Asenso-Boadi, 2010: 153).

Ghana is said to be carrying a dual disease burden and going through a epidemiological transition with 53 percent of deaths being communicable diseases (CD) related and 39 percent emanating from Non-Communicable Diseases (NCDs) - comparing information in the SSA region, Ghana is reported to have higher incidence of NCDs (by 2008, the country had started showing progressive incidences at 39 percent rate). A worrisome trend with implications for productivity and economic growth are the reports of cases in the 15 – 59 age cohorts' with causes of death being reported as 45 percent from NCDs, injuries (10 percent) – generally, infectious diseases, cardiovascular diseases, and injuries leading in the causes of death. Some of the leading causes of death for children under 14 years, include infectious and parasitic diseases and malaria and pneumonia feature prominently in the leading causes of death among children under-5 years (Saleh, 2012a: 6). For the 60 plus year age range, 67 percent deaths are also from NCDs with infectious diseases leading. Looking at the discussion of the demography of the country, there is obviously a need to focus on preventive measures but nothing substantive has been implemented. The quagmire is that the management and treatment of NCDs is costly but the **NHIS'** benefit package covers only partly (Saleh, 2012a: 7 - 8).

2.1 Ghana's healthcare sector

2.1.1 Actors in the health sector in Ghana

There are various actors in the health sector playing different roles aimed at achieving the set objectives for the sector. The following represent the key actors and their specified roles:

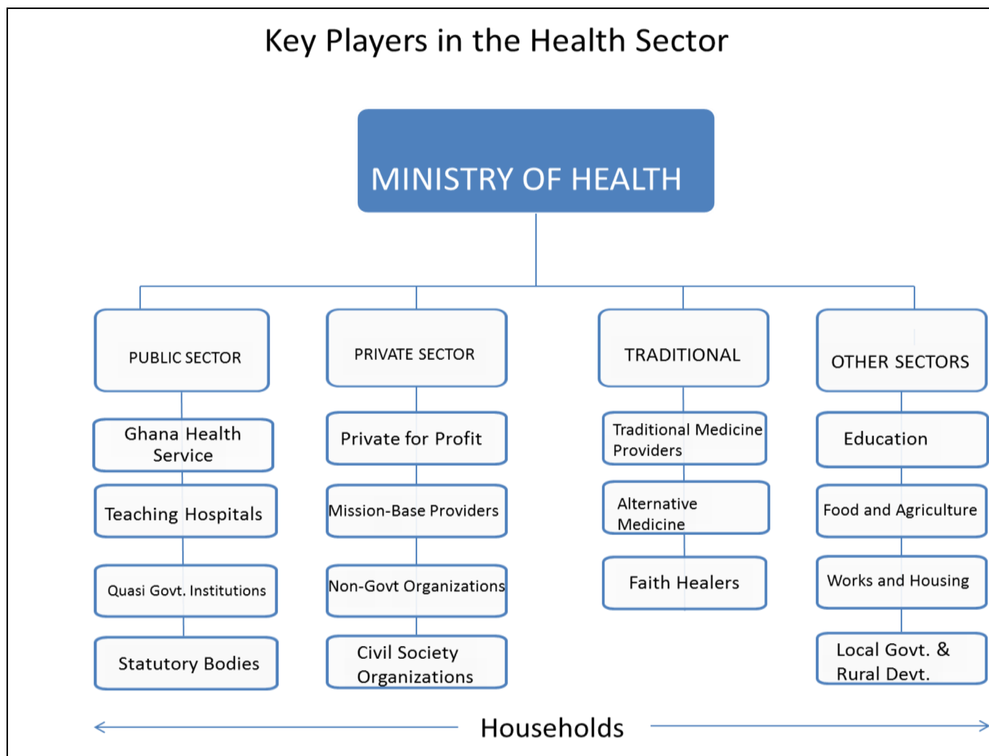
Couttolenc (2012: 2-3) describes the health sector in Ghana as encompassing six interrelated ecosystems;

- The Ghana Health Service (GHS) is established under the Act 525 (Ghana Health Service and Teaching Hospitals Act). Under Act 525 (Ghana Health Service and Teaching Hospitals Act), the Ministry of Health has transferred to GHS the responsibility of managing and operating nearly all public facilities. The GHS is a semi-autonomous agency with the mandate to "ensure access to health services at the community, sub-district, district, and regional levels." This subsystem manages most health facilities and the largest part of the public financial resources in the sector.
- The Ministry of Health (MOH) is responsible for carrying out central-level activities - such as policy-making, regulation, and planning coordination - and several vertical programs (mostly focused on specific diseases and public health). It also manages the three teaching hospitals - the largest in the country.
- CHAG. This is a para-public group of organizations (private, non-profit/mission health facilities) which receives significant funding from the MoH, called the Christian Health Association of Ghana (CHAG). They are said to be the second largest healthcare provider group in Ghana which has taken the form of quasi-government institutions owned by 21 Christian religious organizations. There are currently 183 healthcare facilities and training institutions under this group, providing care to poor and vulnerable people in all the 10 regions of Ghana, most especially in the remote areas. As at 2010, 90 of the 183 facilities under this group had received accreditation from the NHIS to provide care to subscribed members (Aryeetey et al., 2016).
- Local governments (LGs). The Metropolitan, Municipal and District Assemblies (MMDAs), although do not directly operate or manage healthcare facilities, are involved

in rendering health-related support to the MoH and GHS as part of the decentralized system being run in Ghana.

- Private sector. The private sector plays a key role in healthcare provision in Ghana through ownership and service delivery (covering about one-third of all facilities, especially maternity homes and clinics). Notable is the role they play sometimes at the district hospital level.
- Quasi-public. Such institutions in the security sector such as the Armed Forces, Prisons Service, the Police and some universities also own and operate health facilities attending to populations within their membership, and not necessarily opened to the general public.

FIGURE 11: PLAYERS IN THE HEALTHCARE SYSTEM

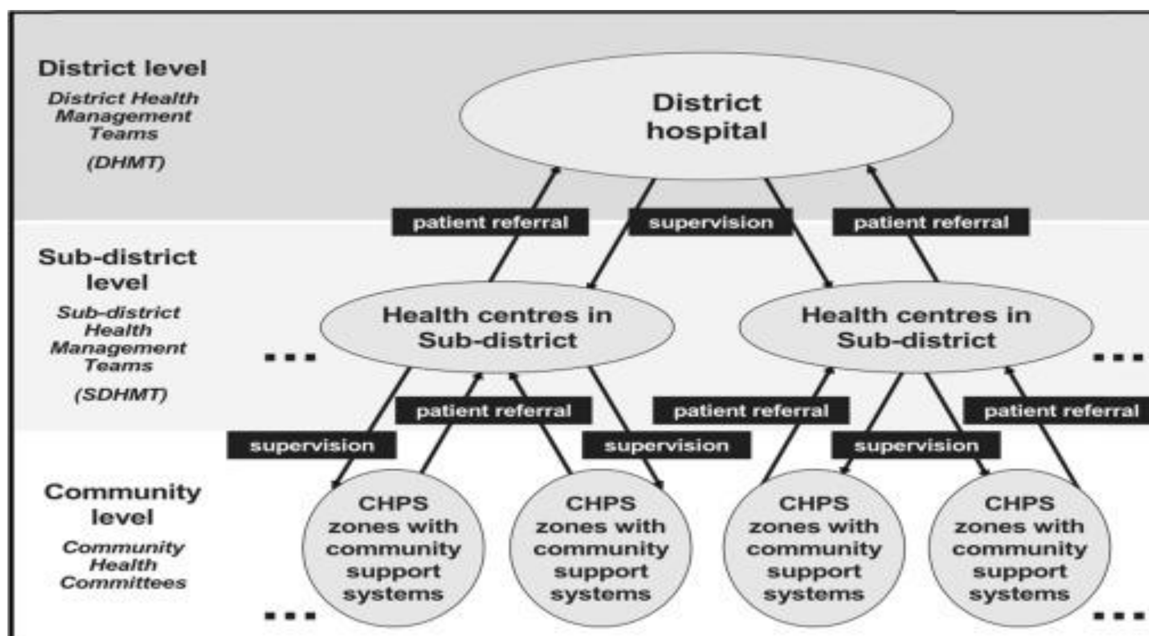


Source: Author (adapted from First Five-Year Programme of Work 1997-2001: 31)

The distribution of health infrastructure across the length and breadth of the country reveals important variations across regions (Couttolenc, 2012:3-5, 48). The MoH and GHS operate at five main levels:

1. But for three teaching hospitals in the country, the MOH has delegated all implementation/operational roles to the GHS;
2. The GHS administers health through the Regional Health Administration (RHA) offices which are represented in all the 10 regions in the country, undertaking coordination of the districts' health activities and planning and also, providing secondary hospital care through the Regional Hospitals (RHO);
3. The DHAs and district hospitals manage district-level health facilities which include most health centres and other primary care facilities. At present are 124 districts and 46 Metropolitan and Municipal administrations (up from the original 62 District Councils established in 1974);
4. There are about 1,500 sub-districts which are intended to provide primary healthcare with the next lever of reporting to the DHAs but are saddled with limited autonomy and capacity; and
5. The Community-Based Health Planning and Services (CHPS) supposed to provide care at the community; level is the lowest in rank in hierarchy as per the decentralized structure.

FIGURE 12: LEVELS OF THE PRIMARY HEALTH CARE SYSTEM IN GHANA



Source: MoH, National CHPS Policy (2016: 10)

2.1.2 The public sector and the decentralization process

Ghana has been implementing a decentralization policy and system from the 1980s which got a further boost with the enactment of the Local Government Act of 1993. But the road to a totally decentralized system has not been smooth and fully integrated into all aspects of the different sectors. One such sector is the public health sector which still maintains some functions and roles decentralized but others very much a mirror of the old system (Couttolenc, 2012: 33, 37). By an act of parliament, the Ghana Health Service (GHS) was established in 1996 as the implementation arm or agency of the MoH with the responsible for setting service standards for and the regulation of all service providers in the country, definition and monitoring of health needs, ensuring equitable access to health facilities and finally, ensuring the efficient and effective use of public resources in the health sector (Asenso – Boadi, 2010: 154). The MoH however, remains at the apex of the central structure of the decentralized health system playing a key role in policy- making, regulation, and planning coordination and oversight over specific health programs (Couttolenc, 2012: 3). Additionally, the MoH works with other agencies and departments in achieving its mandate such as the Teaching Hospitals, Regulatory Agencies, Psychiatric Hospitals, Sub-vented Organizations, Training Institutions, Christian Health Association of Ghana and Ghana College of Physicians and Surgeons (GoG Budget, 2012).

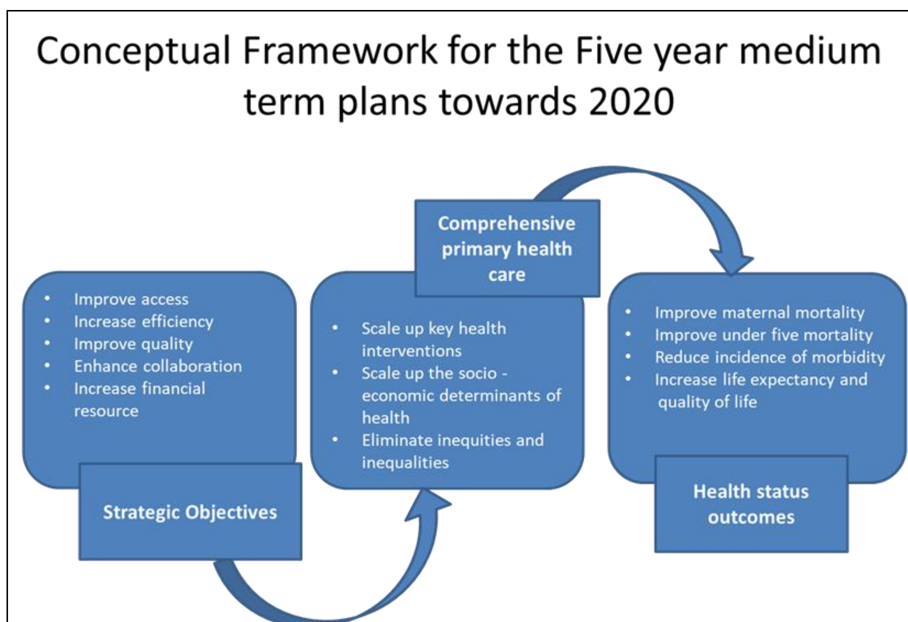
According to the WHO a health system is ‘more than a pyramid of public-owned facilities that deliver personal health services’ including such other actors as state and non-state actors such as non-governmental organizations, civil society organizations, and the private sector (Senkubuge et al., 2014). The Ghana health system is made of 1832 facilities, 49 percent of which (897) are government-owned (Service Availability Mapping 2006). There are also 509 private facilities that have been accredited by the NHIS with an additional 626 providers of diagnostic and other services (Couttolenc, 2012:2).

In the few years past, through policies introduced, public health management has experienced institutional restructuring leading to the separation of powers and well-defined roles in the areas of policy-making, service delivery, financing, regulation among the earlier stated institutions (Saleh, 2012a: 10). Citizens have been made to expect better service delivery through the state’s continuous healthcare financing mechanisms aimed at eliminating out of pocket payments and

expanded health coverage focused on curative and preventive services (Saleh, 2012a: 10), the effect of these interventions remain to be seen.

As part of the separation of powers and the decentralization approach introduced into the healthcare system, services delivered at the district level are seen as the decentralized unit allowing for more autonomy at the level of hospitals and the infusion of primary healthcare through the Community-based Health Planning and Service (CHPS). Through Public Private Partnerships (PPPs) with the GHS and the NHIA (through accreditation of privately-owned health facilities such as maternity homes, clinics, hospitals etc.), attempts are being made to realize the objective of healthcare expansion (Saleh, 2012a: 10). However, the full extent of a decentralized health system has yet to be realized as with the exception of teaching hospitals, the human resource management component has still not devolved and remains centralized under the MoH and the GHS with some flexibility observed for the Internally Generated Funds (IGF) and in the procurement of some goods and services (Saleh, 2012a: 10 - 12). Both the NHIS and the CHPS are captured within the national strategic context namely the Medium Term Health Strategy: Towards Vision 2020 (see Figure 13 for conceptual framework for this vision).

FIGURE 13: CONCEPTUAL FRAMEWORK FOR THE FIVE YEAR MEDIUM-TERM PLANS TOWARDS 2020



Source: MoH, National CHPS Policy (2016: 11)

2.2 Using health insurance as a means of financing healthcare in Ghana

2.2.1 From Out-of-Pocket (OOP) to alternative financing systems

Ghana has for decades now implemented healthcare reforms aimed at reducing the catastrophic impacts of Out-Of-Pocket (OOP) payments for services on its people; in an effort at reducing impoverishment stemming from healthcare expenditure at the micro level (Box 7 in Chapter 1 explains the different political and institutional transitions of the NHIS). According to Xu et al. (2015), if the health system is designed well enough to eliminate reliance on OOP, households could be protected against financial risk due to the fact that OOP represents **"the single most important cause of catastrophic health spending"** (Xu et al., 2015). One of the ways of providing such financial risk protection for health is through health insurance. The response to the global consensus for countries to institute measures for protecting its citizens from the catastrophic consequences of perpetual OOP on household budgets has been for Ghana, through the introduction of the NHIS (see 1.1 of Chapter 4 for details). This consensus has prompted interest in investigating alternative healthcare financing systems such as tax-based financing, social health insurance and community-based health insurance (Akazili et al., 2014). Ichoku et al. (2013) explain that in spite of its well-known consequences, OOP payments remain the dominant method of financing health services in many developing countries particularly in SSA. In 15 of 46 African countries, OOP expenditures constitute more than 50 percent of total health expenditure, and in 31, it constitutes more than 30 percent of total health expenditure. In 2000, user charges (OOP) formed 46.5 percent of total expenditure on health in Ghana (Asenso-Boadi, 2010: 84). This is a not-so new phenomenon for SSA countries, Ichoku et al. (2013) point out that, a review of the literature indicates that poorer countries, on average, rely more on OOP to finance healthcare than richer countries (Ichoku et al., 2013). Also, poorer countries bear greater burden of financial catastrophe and impoverishment than richer countries. They explain that within countries; the poor, relative to the rich, are more prone to incurring catastrophic and impoverishing costs. Countries with some broader form of risk-sharing arrangement such as social or national health insurance schemes or universal coverage system have recorded lower levels of impoverishment and catastrophic costs than those with little or no cover. It is for the potential relief that the UHC could give that it is deemed as not only life-saving but a significant

health goal due to its potential impact. In an article, Fox and Reich (2015: 1020) make the assertion that, the UHC has been described as **“the single most powerful concept that public health has to offer”** by World Health Organization Director General Margaret Chan and presented as the third global health transition, thus, after the demographic and epidemiologic transitions (Rodin and de Ferranti, 2012). The UHC has been promoted as a solution that can strengthen health systems, raise revenue for healthcare, and improve social risk protection in low- and middle-income countries (Rodin and de Ferranti, 2012; Carrin et al., 2013).

2.2.2 Different sources of healthcare financing

The various sources of financing for healthcare were until recently acknowledged as government annual budgetary allocation and OOP, the latter was often critical but deemphasized in developing countries (Hsiao and Shaw, 2007). The contribution of OOP to healthcare financing represents a rather significant portion and even more crucial is its impact on more deprived populations. In the SSA region, OOP has represented on average 41 percent of total national health expenditures in countries with per capita income of about $546 in the period 2002-2004 (Hsiao and Shaw, 2007). With the negative impact of OOP well-documented, many countries have introduced a number of other healthcare financing mechanisms including, social health insurance (SHI), taxation, private health insurance, user-fee charges and others (Doherty et al., 2000). For most developing countries, a mix-bag approach is adopted for financing healthcare using the various mechanisms (Asenso-Boadi, 2004: 30 -57).

The following are the various healthcare financing mechanisms:

BOX 10: PRINCIPAL FINANCING MECHANISMS

Principal financing mechanisms

Tax-based financing: health services are paid for out of general government revenue such as income tax, corporate tax, value added tax, import duties etc. There may be special earmarked taxes (e.g. cigarette taxes) for **health care**.

Social insurance financing: health services are paid for through contributions to a health fund. The most common basis for contributions is the payroll, with both employer and employee commonly paying a percentage of salary. The health fund is usually independent of government but works within a tight framework of regulations. Premiums are linked to the average cost of treatment for the group as a whole, not to the expected cost of care for the individual. Hence there are explicit cross-subsidies from the healthy to the less healthy. In general, membership of social health insurance schemes is mandatory, although for certain groups (such as the self-employed) it might be voluntary.

Private insurance: people pay premiums related to the expected cost of providing services to them. Thus, people who are in high health risk groups pay more, and those at low risk pay less. Cross-subsidy between people with different risks of ill health is limited. Membership of a private insurance scheme is usually voluntary. The insurance fund is held by a private (frequently for-profit) company.

User fees: patients pay directly, according to a set tariff, for the health care services they use. There is no insurance element or mutual support. This is the most common way of paying for privately provided services in developing countries, and is also used as a component of financing for public sector services.

Community-based health insurance: as for social health insurance, premiums are commonly set according to the risk faced by the average member of the community i.e. there is no distinction in premiums between high and low risk groups. However, unlike social health insurance schemes enrolment is generally voluntary and not linked to employment status. Funds are held by a private non-profit entity.

Source: Author (an adaptation from Asenso-Boadi, 2004: 42 - 50)

Social Health Insurance (SHI)

SHI takes on different forms for different populations but it holds consistent certain features such as the following which distinguish it from other resource-mobilizing efforts (Asenso-Boadi, 2004):

1. Members’ contributions are usually compulsory and backed by law;
2. Individual exit and exclusion from the insurance scheme is difficult;

3. One’s ability to pay determines premium payment; and
4. There are standardized benefit packages for healthcare spending.

Asenso-Boadi (2004: 43) posits that two main generic forms of health insurance exists, thus, the private health insurance and that of government – the national/social health insurance scheme. Ghana currently has both but the means to achieving the UHC is that of the national/social health insurance (SHI).

Private Health Insurance (PHI)

There have been several attempts to diversify the mode of accessing healthcare payments to infuse an element of security, but many people in developing countries’ reliance on OOP seems not have waned. Organized, Community-based Health Insurance (CHI) and other group and individual voluntary programs have been in existence for some time, an indication of possibilities for PHI. There is however inadequate information on the role PHIs play in the broader national health strategies in developing countries (Drechsler and Jutting, 2007). The uptake of private health insurance is known to be voluntary and premiums to be paid are charged based on individual risks’ assessment and exposure. As is with all other insurance practices, there are a range of benefit packages available for subscription and selection based on one’s ability to pay and preference. In principle, the choice of insurance policies are based on whether applicants are of higher risk profiles and based on this, corresponding policies are selected. The services for this type of health insurance are provided by medical societies, insurance companies, unions, mutual associations and community groups (Asenso-Boadi, 2010: 43).

Choosing health insurance is one of the most complex, costly and yet critical decisions consumers may have to make in their lifetime (Paez et al., 2014). The following factors have been cited as being the determinants of choice and use of insurance policies/benefits: (1) state regulation which either enhance or inhibit the promotion of health insurance products and services; (2) how simple or complicated the benefit package is; (3) the support system available to consumers at the point of purchase and use of health insurance; and 4) the knowledge base of consumer in selecting relevant insurance package for self (Paez et al., 2014). But there seems to be a stalemate in the theory supporting the possible uptake of health insurance and the empirical

evidence of what actually occurs. In the theory on health insurance (Ruger, 2007), the neo-classical economic perspective assumes the posture that individuals who are rational and should be risk-averse would make logical decisions in maximizing their preferred outcomes thereby taking on health insurance covers in order to be assured of medical care in the periods in between good health and ill-health (Ruger, 2007), and rational profit-making decisions would be made also by businesses (here represented by insurance companies). In contrast though, the empirical evidence have proven that individuals do not always make the rational decision that the theory postulates, not taking steps to know their actual health risks and assessing the corresponding insurance thus needed (Ruger, 2007). This explains if not regulated by law, the uptake of insurance would remain low, even for populations that can afford.

In a revenue mobilizing mode, the uptake of private insurance is considered either as a main approach or as supplemental. Insurance companies may work as for-profit or not-for profit entities with focus on different segments of the market. With private insurance, consumers are afforded greater influence on the range of services provided in markets where there is efficiency and the number of service providers scramble for the business of consumers (Asenso-Boadi, 2010). The influencing factors behind the existence and growth of private health insurance schemes in different territories are carved in reasons of economics as well as culture and history. The dynamics of operations and incentives for growth of private insurance in different countries remain unique, for instance, in the United Kingdom, the government offers, in some cases tax relief for senior citizens upon the payment of premia and also in the United States of America where employers contribute to insurance programmes (Asenso-Boadi, 2010).

2.3 The Advantages and Disadvantages of Private Health Insurance (PHI)

There is debate in the literature over the advantages and disadvantages of a shift from public insurance to that of private in developing countries (Drechsler and Jutting, 2007). The advantages of private health insurance schemes include (Asenso-Boadi, 2010: 45):

1. Private health insurance is accommodative of possible changes to be made in benefit packages due to the fact that it works within competitive markets where consumers can exercise their right of choice upon dissatisfied service delivery;

2. Efficiency in the delivery of services; and
3. The risk assessed corresponds to the premiums paid and hence, there is equity.

The main disadvantage of the PHI by design is that, it encourages the subscription of certain segments of society leaving behind others, as it does not support the concept of mutuality thus making it difficult and expensive to insure such segments. By this design, it covers relatively affluent individuals or groups (Asenso-Boadi, 2010). PHI has been criticized that it unnecessarily escalates costs associated with healthcare, not pro-poor, allows for adverse selection and does not make focal the social aspects of health protection (Drechsler, and Jutting, 2007). There is also the matter of 'job lock' which explains the situation with employer-based private insurance provided for employees but which could be lost should the employee switch jobs or decide to quit, thus compelling them to remain with same employer over time (Asenso-Boadi 2010: 46).

The growth of private health insurance in Ghana has been gradual. Asenso-Boadi (2010: 45) draws attention to the fact that the proportion of PHI's coverage of healthcare expenditure in Ghana is below 1 percent (in the year 2000, it was zero) and in many developing countries also, high numbers of uninsured segments of the population have been noted (Pauly et al., 2006). The fundamental basis for the uptake of PHI has been the need to fill the gaps created in the failure of public systems in providing health insurance coverage and financial protection to the satisfaction of all citizens in developing countries (Pauly et al., 2006). Some reasons assigned for the low uptake of private health insurance in Ghana include - the perception of PHI being a luxury for the affluent and a lack of affordability; the funding of healthcare being perceived as the sole responsibility of government emanating from historic antecedence but in actuality remains false; and government's inability to encourage the uptake of PHI because healthcare is considered a public good and any government seen as promoting PHI could possibly suffer a political backlash (Asenso-Boadi, 2010: 45). The individual uptake of health insurance is saddled with many barriers such as incomprehension, difficulty in making a choice, affordability and others (Barnes et al., 2015; Paez et al., 2014; Pauly et al., 2006). Paez et al. (2014) explain the intricacies in the health insurance space when at the point of choice, much work must be done in enhancing clarity, accessibility and usability of insurance policies and benefits for consumers.

A logic associated with the need for PHI is that due to the uptake of insurance by high income individuals and groups, the public healthcare system resources are freed to absorb greater numbers of people in the lower income earning bracket. But this logic holds true only when the freed resources are utilized fully to the benefit of the poor. PHI thus spreads risk for an individual or group but does not pool large-scale risk mainly because of its limited coverage. Additionally, the high 'transaction costs' which sometimes range between 10 - 50 percent compared with that of 5-10 percent of SHI (in-built administration, marketing, processing fees and other costs) which are offloaded on the consumer cannot be overlooked (Asenso-Boadi, 2010: 45 - 46).

Some of the PHI schemes operating in Ghana currently are the Metropolitan Health Insurance Scheme (METCARE), Provident Xpress Medical Insurance Scheme (Asenso-Boadi, 2010: 75), GLICO Healthcare Limited, Vanguard Assurance, Liberty Medical Health Scheme Limited, Nationwide Mutual Health care (Nationwide) and others, addressing diverse medical needs for various segments of society.

Conclusion of Chapter Three

Chapter 3 has presented a reflection of the SDH in the context of Ghana. There seem to be an intermingling and sometimes tension between social and economic policies which have effects on health, healthcare and the prospects of affordability for the population. While it is not a new phenomenon to see well-intended policies having negative effects on others (Leppo et al., 2013), it is best to keep such effects at a minimum. For instance, while the SAPs and ERPs had sought to put Ghana's economy on a growth path, some of the conditions attached to the support renderd thousands of people unemployed from the formal sector. Although the economy experienced stability and sometimes growth, with many job losses, people were propelled into the 'survival industries' (ILO, 2012). The rebasing and revision of the country's accounts leading to a change in its status to a lower-middle income country has witnessed the departure of many donors, many of who supported the budget deficit and projects in the health sector. Other examples include the government's efforts to comply with the Washington Consensus in 1983 by devaluing the currency as part of the conditionalities led to an increase in the prices of foodstuffs

in the country. In correspondence with the high unemployment rate and increased urbanization, poor living conditions became prevalent. It is of no wonder that for decades, there is perennial outbreak of cholera in major cities in Ghana, with one source identified as the vast development of slums. With the current Extended Credit Facility (ECF) lending arrangement with the IMF/World Bank which started in 2015, there are still restrictions on the expenditure patterns of government specifically and general high rate of unemployment, massive uncontrolled rural-urban migration, poor state of infrastructure particularly in the health sector and many others. The issues arising from the influences of policies on each other call for an inter-sectoral approach to development. That while economic growth tied to SAPs is often tauted as necessary and a major indicator for development, its effects have not always been positive on social outcomes. All the policies mentioned earlier have a place in the SDH framework and have an impact on the health of the population.

CHAPTER 4: GHANA AND THE UHC JOURNEY: THE NATIONAL HEALTH INSURANCE SCHEME (NHIS) AND THE COMMUNITY-BASED HEALTH PLANNING AND SERVICES (CHPS)

Introduction

The two main health policies of Ghana for achieving the UHC by 2030 are discussed in chapter 4. This discussion represents the implementation discussion that started under the policy-making section of 2. The importance of healthcare in general and health insurance specifically has not been lost on successive governments in Ghana for decades. The establishment of the NHIS emerged from a political process and was built on already existing community-based mutual health insurance schemes. The scheme has gone through various transitions to get to its current state – experiencing a speedy growth at inception and stagnating at 40 percent. Conversely, the CHPS began as an experiment which gained relevance and popularity over time calling for national recognition among health practitioners and replication. It is based on a number of principles and has a coverage rate of 5 percent. Both of these policies face implementation challenges which need attention if the UHC is to be achieved within the stipulated time.

The Chapter 4 under the theme **Ghana and the Universal Health Coverage journey with a look at the National Health Insurance Scheme (NHIS and the Community-Based Health Planning and Services (CHPS)**, has two sub sections. The first section discusses the Universal Health Coverage (UHC) as implemented as the NHIS and CHPS and the second, emphasizes the workings of the CHPS as another avenue for achieving the UHC in Ghana.

CHAPTER 4 NAVIGATION CHART

CHAPTER FOUR GHANA AND THE UHC JOURNEY: THE NATIONAL HEALTH INSURANCE SCHEME (NHIS) AND THE COMMUNITY-BASED HEALTH PLANNING AND SERVICES (CHPS)	
Section 1: The Universal Health Coverage (UHC) journey in Ghana	Section 2: The Community-Based Health Planning and Services (CHPS)
1.1 Ghana and the UHC journey – the National Health Insurance Scheme (NHIS)	2.1 Presentation of the Community-Based Health Planning and Services (CHPS)
1.2 Legal framework for the NHIS/NHIA	2.2 The implementation of the CHPS policy
1.3 Exemption policies under the NHIS	2.3 Implementation challenges of the CHPS
1.4 Governance structure and operations	2.4 Comparative analysis of the NHIS and the CHPS implementation
1.5 Financing, claims and reimbursement issues of the NHIS	2.5 Analysis of the UHC in Ghana through the conceptual grid
1.6 Coverage, equity and impact of the scheme	
1.7 Sustainability challenges of the NHIS	
Key words: UHC, NHIS, CHPS, Coverage, Sustainability, Institutional complementarities	

Section 1: The Universal Health Coverage (UHC) journey in Ghana

This section focuses on the Universal Health Coverage (UHC) in its implementation as the NHIS and CHPS under the different sub sections, there is a focus on the legal framework for the two policies (1.2), the exemption policies under the NHIS (1.3), the governance structure and operations (1.4) and financing issues (1.5). The coverage, equity concerns and impact of the scheme are looked at under 1.6 and finally, there is an overview of the sustainability challenges of the NHIS under 1.7. Section 2 under Chapter 4 emphasizes the CHPS as another avenue for achieving the UHC in Ghana. There is a presentation of an overview of the CHPS, its implementation (2.2), implementation challenges (2.3), a comparative analysis of both the NHIS and the CHPS implementation (2.4) and finally, there is an analysis of the UHC using the conceptual grid (2.5).

1.1 Ghana and the UHC journey - the National Health Insurance Scheme (NHIS)

In the SSA region, Ghana has been noted as a trailblazer in the implementation of the National Health Insurance Scheme (NHIS) (Aryeetey et al., 2016) and the Government of Ghana's (GoG) commitment to the health sector through its expenditure (in 2013, the country's total expenditure on health expressed as a percentage of its GDP was 5.4 percent, exceeding those of Nigeria, Kenya, Benin with 3.9 percent, 4.5 percent and 4.6 percent respectfully). Additionally, through the GoG's 10.6 percent health budget allocation of the total government expenditure, the country was put in a positive light in bringing it closer to the Abuja target of 15 percent – found in The Abuja Declaration [33] (Jehu-Appiah et al., 2011). According to Otoo et al. (2014: 1), by the introduction of the National Health Insurance Scheme (NHIS) and the enactment of its corresponding legal backing the National Health Insurance Scheme (NHIS) Law, Act 650, the government's commitment to achieving the UHC was displayed in the year 2003. The period before the introduction of the NHIS had witnessed a number of health financing reforms, some of which included exemption policies - general tax revenues and user fees, with user fees dominating the financing options in the period from the 1970s until 2003 (Fusheini et al., 2012).

[33] The Abuja Declaration of 2001 sought the commitment of African Union (AU) governments in giving substantial weight to the health sector of their respect countries through the allocation of revenues and also impressed on the donor partners to increase their funds (www.who.int/healthsystems/publications/abuja_declaration/en/)

The new NHIS which drew public debate and much stakeholder involvement also brought forth a major controversy in relation to the use of part of workers' pensions - social security contributions in funding part of the initiative (Dovlo, 2005).

The fundamentals of Ghana's move to a social health insurance system emanated from its existing system of community-based health insurance (CBHI), which started operating from 1995 (Otoo et al., 2014). The voluntary enrollment feature of the National Health Insurance (NHIS) is said to emanate from the CBHI concept regardless of such infused innovative features as the support of the single-pooled national funding source, the devolution of authority through the presence of district NHIS offices as purchasers and institutionalized tax funding (Agyepong et al., 2016). With the enactment of the Act 650 in 2003, most of the operating CBHIs folded up into the district mutual health insurance schemes (DMHISs), with a certain level of autonmy in management and governance structure. By the year 2012, the country had managed to register a total number of 145 DMHISs registered by gurantee and under the regulation of the National Health Insurance Authority (NHIA) (Otoo et al., 2014: 3). Existing community-based mutual health insurance schemes continue to function, but each of such schemes is now required to be licensed by the National Health Insurance Council (NHIC) and through the National Health Insurance Fund (NHIF) receives subsidy from the government. However, private schemes can seek to be incorporated into the district schemes created under the law. The law also makes provision for the licensing, regulation, and operation of private commercial schemes that do not receive government subsidies (Akazili et al., 2014).

1.2 Legal Framework for the National Health Insurance Scheme (NHIS) and the National Health Insurance Authority (NHIA)

With the enactment of the NHIA Act (650), the establishment of three kinds of health insurance schemes in Ghana came to be namely, District Mutual Health Insurance Schemes (DMHIS), Private Mutual Health Insurance Scheme (PMHIS) and Private Commercial Health Insurance Schemes (PCHIS) (Ghana Health Insurance Review, 2011). It allowed for the creation of DHMIS as companies limited by guarantee. This arrangement created real difficulties for governance and accountability of these schemes evidenced by non-compliance with directives

and corruption in the operations of these schemes. The DMHIS are to a large extent funded from the National Health Insurance Fund, a public fund set up under Act (650), and in small proportion from premiums collected by the schemes from their subscribers (Ghana Health Insurance Review, 2011). The revision of the law in 2012 (Act 852), as posited by Otoo et al. (2014: 1) brought into a single pooled fund the district insurance schemes. The Act 650 makes it compulsory for all residents in Ghana to enroll with one accredited insurance scheme; it also made way for the establishment of the National Health Insurance Authority (NHIA) to oversee the implementation of the NHIS. Interestingly in practice, enrollment has taken on the nature of a voluntary scheme despite the compulsory tone of the law, this is because the law does not seem to have prescribed any penalty for failing to enroll neither are there mechanisms to ensure automatic enrollment of residents (Otoo et al., 2014: 1).

1.3 Exemption Policies under the NHIS

Under the NHIS, some categories of people have been identified as indigents and other specialized groups who enjoy exemptions from the payment of premiums. Among the people who are **exempt from paying premiums are pregnant women (introduced in 2008), people under 18 years or 70+ years, indigents and Social Security and National Insurance Trust (SSNIT) contributors from the formal sector** whose 2.5 percent portion of their incomes go to the National Health Insurance Fund (NHIF) (Alhassan et al., 2016; Chankova, Atim, & Hatt, 2010: 60). The NHIS has its own unique means test for indigents, which has been described as restrictive and reads as "that the person be unemployed with no visible source of income, be homeless, and have no identifiable support from another person" (Chankova, Atim, & Hatt, 2010: 62). **But the definition of an indigent is amorphous** and has been subjected to persistent "verbal gymnastics" (Ridde, 2009). The definition of indigent, as proffered by the NHIS has been said to pose its own challenges for scheme managers in identifying all such people [34] and this has resulted in excluding many poor people (Chankova, Atim & Hatt, 2010: 62). In 2011, to ensure **inclusiveness of the poor in the NHIS and adequate coverage for them, the Ministry**

[34] By this definition, it is doubtful that any but the homeless beggars in Accra and other major urban centers could qualify to receive benefits, and it rules out many of the poor in the rural areas where taboos, family pride, and social solidarity systems prevent even poor relatives from being cast out to the streets (Chankova, Atim, & Hatt, (2010), Pg. 60).

of Health (MoH) collaborated with the Ministry of Employment and Social Welfare (MESW) on a project - the Livelihood Empowerment Against Poverty (LEAP) and identified the very poor in society for registration under the National Health Insurance Scheme. This reflects an application of one of Ollila's strategies of HiAP application (refer to sub section 3.8 for details), where in this case a ministry established with a focus on gender issues and social protection (Ministry of Gender, Children and Social Protection (MoGCSP), through a collaborative effort with the MoH provides cash transfers and healthcare packages to vulnerable households.

Prior to the 2003 enactment of the NHIS law, similar policies had been introduced in 1997 by the government for similar exempt groups but inclusive of people suffering from certain types of communicable diseases (Chankova, Atim, & Hatt, 2010: 60). Thus the modality for ability to pay for services was determined by the outcome of a doctor's examination, theoretically under the policy. But **in practice though, patients were made to pay for "consultation fee"** (Chankova, Atim, & Hatt, 2010: 60), propagating a culture of corruption. Refer to 1.2.1 of Chapter 1 **Corruption and its effects on health** for detailed discussion. At the time, the policies for exempt coverage for under 5, pregnant women and the elderly presented several problems due to the ambiguous guidelines, inadequate resource allocation to embrace such a policy, inequity in application of the policy leading to poor patronage of healthcare services with its attendant complications (Chankova, Atim, & Hatt, 2010: 60).

In sum, currently a sizeable percent of active subscribers are found in the exempt category but the NHIS does not cover all ailments of insured members except for the general ones such as diarrhoea, malaria and upper respiratory tract infections and others (Alhassan et al. 2016; Chankova, Atim, & Hatt, 2010: 62-63). According to Akazili et al. (2014), a relatively comprehensive NHI benefit package for outpatient and inpatient health services has been assembled that includes maternal care services and covers over **90 percent** of the disease burden. These have consequences for **sustainability**, to be discussed subsequently. Within the period of inception to about the year 2012, the scheme was hailed as the flagship social protection initiative in Ghana, striving to abolish the '"cash and carry" system of payment (OOP) and removing barriers to access to healthcare especially for the poor. Its import became such an

attraction to other countries in the sub-region that many aspiring to emulate the initiative have sought to learn from the management of the NHIA (Kuusaalesuo, March 2017 www.graphic.com.gh). The NHIS has membership from the following categories – adults in the informal sector, the aged (70+), children of age 18 and below, Social Security and National Trust (SSNIT) contributors, SSNIT pensioners, pregnant women and indigents. Children under age 18 were initially exempt only if their parents or guardians were scheme contributors. Since 1 September 2008, however, children under age 18 have been exempt in their own right (known as "decoupling"). The exemption for pregnant women became effective on 1 July 2008 for up to four prenatal visits, delivery care and one postnatal visit, as well as all other minimum medical benefits needed during the 12 months following initial registration (Chankova, Atim & Hatt, 2010).

1.4 Governance structure and operations

In terms of governance, the Act (650) established the National Health Insurance Council as the overall body to oversee the implementation of health insurance schemes in the country. The day-to-day functions are performed by the National Health Insurance Authority (NHIA) (Ghana Health Insurance Review, 2011). There is a governing board at the apex of the organization with representatives from Ministries of Health, Ministry of Finance and Economic Planning (MoFEP), Ministry of Gender, Children and Social Protection (MoGCSP), the NHIA itself, the Ghana Health Service (GHS), National Insurance Commission, the Social Security and National Insurance Trust (SSNIT), Medical and Dental Council, Pharmacy Profession, Legal practitioners, organized labour and the President's nominees (www.nhis.gov.gh). The composition of the board reflects an attempt of a multisectoral approach but not the same as HiAP. Next to the board is the management of the NHIS at the head office, followed by regional directors and district directors. Across the country, there are about three thousand six hundred employees (NHIA, 2017).

With the establishment of NHIS Act 2003, also came three distinguishing types of health insurance schemes – district mutual health insurance, private commercial health insurance and private mutual health insurance. All such schemes are by law expected to apply to the NHIA for inclusion through registration, licensing. All public health facilities are automatically enlisted

and accredited. For inclusion also, all private health facilities have to apply – as at December 2008, 1,551 private healthcare service providers had been accredited (Chankova, Atim, & Hatt, 2010: 61). From 2009 to 2013, 3,828 health facilities had received their accreditation from the NHIA with 1 percent, 6 percent mission facilities, 40 percent private-for-profit facilities and 54 percent were government-owned. Also, of the facilities accredited 1,203 (31 percent) were clinics and health centres (Alhassan et al., 2015: 2).

To be included in the scheme as an individual member, one must either register with a district mutual scheme or an agent. After the registration, there is a waiting time of one month (used to be six months but with the introduction of the biometric system in 2012, the waiting time has been shortened) before utilization of service. Premiums are set differently by the district scheme offices, as by law, premiums should be paid according to income/wealth levels of the population being served. Premiums usually range from $5 – 32 (Chankova, Atim, & Hatt, 2010: 62). But with a weak national data system interspersed with high unemployment rate and high informal sector employment population, how can the system determine who is wealthy enough to pay which levels of premiums?

1.5 Financing, claims and reimbursement issues of the NHIS

A National Health Insurance Fund (NHIF) has been set up and is financed through a payroll tax contribution, whereby 2.5 percent of the 17.5 percent of formal sector workers' Social Security Scheme (SSNIT) contributions is directed towards health insurance. This is augmented by a 2.5 percent value added tax on selected goods and services as well as an annual allocation of central government funds (Akazili et al., 2014; Alhassan et al., 2016). The NHIF transfers funds to each District Health Insurance Scheme (DHIS) based on the number of SSNIT contributors and indigents in the district (Akazili et al., 2014; Alhassan et al., 2016).

In 2009, it was realized by management of the NHIA that many corrupt practices were being perpetrated through the claims process at scheme offices, nationwide. Some of the corrupt practices included: falsification of subscribers' records to depict an increase in attendance based on which claims were made; over prescription of medicines for patients; abuse of the healthcare exempt programme for pregnant women with operations being used to replace assisted deliveries

which demands higher reimbursement for service providers; and overbilling of patients by service providers. Hence major reforms (including clinical audits) were introduced to control the fraud in the system (Ghana Health Insurance Review, 2011). Major achievements in the area of claims management were made and this included auditing of 28,925,293 claims and the recovery of GH¢471,215 and GH¢755,582 from services and medicines respectively (GoG Budget, 2012). The reimbursement of NHIS claims by the NHIA to facilities takes between 1 to 4 months after submission of claims (Aryeetey, 2016). The law provides for a 90 day processing period of which 30 should be used by the service provider to generate and submit claims documents to the Authority and a 60 day period for the NHIA to vet and make payment. In recent times, the government has delayed reimbursable payment for service providers culminating in a backlog of 8 eight months.

In its bid to restructure the claims processing for accredited service providers and also curtail the abuse of the system, the NHIA made a shift from the Fee-For-Service (FFS) system to that of the Diagnosis-Related-Grouping (DRG) and a piloting of the capitation payment system (although the capitation is designed for a different level of care – the primary walk-in outpatient level of care while the DRG caters to the needs of Itemized Fee for medicines and services, the higher levels of care) (Sackey and Amponsah, 2017). The law, LI 1809 makes specific mention of capitation as one of the provider payment methods and makes room for the use of multiple payment methods in recognition of international best practice and also due to the fact that no one provider payment method is void of flaws. This is a healthy approach as the DRG has been noted for not being wholly successful in containing costs, especially for outpatient claims meanwhile, outpatient claims amount to 70 percent of all claims under the NHIS and 30 percent of cost (Sackey and Amponsah, 2017).

The delay in payment for services provided and the corrupt practices related to claims seem to have been dealt with as some of the benefits of the provider payment system reforms and the introduction of the capitation payment system include but not limited to: (1) a reduction in the massive costs emanating from man-hours spent by administrative and staff on the claims preparation, submission, vetting and final reimbursement; (2) improve the Authority's ability to make financial forecasting and commensurate budgeting; (3) elimination of delays in claims

payment (due to the fact that, with this system monies are extended to service providers ahead of service delivery); (4) improvement in clarity of roles and responsibilities for stakeholders; (5) the creation of a better information management system which helps in monitoring and evaluation, quality data analysis and utilization (Sackey and Amponsah, 2017). All these have a positive link with quality of care and access to healthcare – the previous system during which reimbursement to service providers delayed, subscribers were inadvertently affected adversely, as in times of non-payment of claims, service providers have in the past turned away sick patients (card bearers).

1.6 Coverage, equity and impact of the scheme

While the official rate of coverage for people enrolled on the scheme has been given as 10,145, 196, which translates into 38 percent of the total population according to 2013 annual report[35], Bitran[36] (2012: 7) cautions that information concerning such rates may not necessarily reflect the actual numbers enrolled. Jehu-Appiah et al. (2011) avers that the promise of protection against catastrophic financial burden on the poor and better access to healthcare seems to have been made by the concept of pooling of risks and resources to the poor. **But at the policy implementation stage, is this promise delivered in relation to the NHIS?** Different reports of the impact of the scheme in almost fifteen years of existence and coverage reveal diverse levels of impact. A research undertaken by Akazili et al. (2014) in one of the northern regions of Ghana gives an interesting report of challenges of inequity for the vulnerable. The Upper East Region of Ghana is the poorest and most remote region of the country. A successful poverty amelioration policy would be expected to have a high coverage in such circumstances. However, not only is the insured coverage rate of 40 percent in the region unacceptably low, pronounced variations in coverage based on socioeconomic status are evident. The insurance coverage rate for women in

[35] Source of official coverage rateof the NHIS - http://nhis.gov.gh/files/2013%20Annual%20Report-Final%20ver%2029.09.14.pdf

[36] Bitran's (2012: 7) take on the reliability on information on population covered in developing countries is that, "information about these three dimensions of coverage is seldom readily available in developing countries and there are often multiple and conflicting sources of information. For example, government health insurance agencies hand out health insurance cards to beneficiaries, but holding a card does not necessarily imply that the holder and his or her family are insured. Sometimes cards expire, or their validity is contingent on the timely payment of premiums, or the periodic re-establishment of eligibility. Thus, the officially- reported number of beneficiaries covered by public health insurance may not always be a good reflection of the number of actually covered beneficiaries."

the lowest quintile is only 33.9 percent compared to 58.3 percent among respondents from households in the highest quintile, according to the research (Akazili et al., 2014). This finding corroborates with results obtained elsewhere in Ghana and Africa showing that the relatively prosperous are more likely to join the National Health Insurance than the relatively poor. The reasons for these differences vary and range from financial or economic to social, demographic, political or policy implementation reasons, but in general, results are consistent with the conclusion that equity problems persist (Akazili et al., 2014) despite being in existence for over a decade. In the research there is compelling evidence that the Ghana's NHIS, rather than being pro-poor as was originally formulated, tends instead to differentially benefit the relatively prosperous respondents – this is based on a survey conducted in one of Ghana's most impoverished regions, the Upper West region (Akazili et al., 2014). **Could this be as a result of the absence of considerations of SDH at the design stage of the initiative?** It has been discovered that people living in urban areas have a higher likelihood to enroll than those in the rural areas. With the introduction of the FSHS policy aimed at increasing educational coverage for all (both rural and urban populations) leading to economic growth for many, the middle to long term solution to low enrollment on the NHIS could be a thing of the past. Thus, an overt HiAP implementation could be achieved in the long run, seeing the multisectoral linkages of policies existent in the country at the moment (captured under the SDH in 1.2 under Chapter 3). A conclusion to the research on the scheme's impact in the poorest region in the country was given as, **"characterizing the scheme as a "pro-poor" program, at least in Ghana's Upper East Region, is a misnomer"** (Akazili et al., 2014). The inequity concerns about the NHIS has been widely researched and the outcomes have usually been mixed – described in part as favouring the wealthy in terms of propensity to enroll (Jehu-Appiah et al., 2010) and then being positive for the poor in the area of financial protection and utilization (Otoo et al., 2014: 5-6). On the matter of coverage, by the end of 2008, about 145 district mutual schemes were in operation and covering an estimated 12.5 million of the population. This number of registered members surpassed the NHIS targeted coverage of 40 (Chankova, Atim, & Hatt 2010: 62-63). Quality of service delivery for NHIS subscribers has also been noted as poor (Alhassan et al., 2016; Agyepong and Nagai, 2011). Social equity indicators such as geographical, educational, cultural barriers, in addition to operational inefficiencies must be addressed if the UHC is to be achieved in Ghana (Akazili et al., 2014).

1.7 Sustainability challenges of the NHIS

A report by a Technical Committee set up the president of the Republic of Ghana to review and restructure the NHIS in 2016 revealed that there are issues of sustainability existing with the current design and operations of the scheme. The report states that, **'It is important to note upfront that in the design decisions around the NHIS in 2003 there is no evidence that the capacity of the country to pay for the benefit package was ever explicitly taken into account and explained to Ghanaians'** (MoH 2016, Proposed Redesign and Restructuring of the National Health Insurance Scheme Main Report: 33). These design oversights have had implications on the sustainability of the scheme. Also according to Alhassan et al. (2016), the challenges saddling the NHIS can be found in three categories – political, financial and operational. The rapid growth in number of subscribers has stagnated at about 40 percent of the population, much more worrisome is the fact that enrollment and renewal rate for even exempt categories is not improving (Agyepong et al., 2016). In a study by Agyepong et al. (2016), three main categorizations were assigned to the **reasons why people were not enrolling on the NHIS - purchaser, provider, client and context**, with the first two factors being further disaggregated under a theme **"national policy" and the latter 'program arrangements and those more influenced by peripheral implementation arrangements of frontline (mainly district level) purchaser and provider staff'.** Those factors captured under national policy are the issues which are part of legislative and administrative provisions and which border on the very design of the scheme and its mandate (Agyepong et al., 2016). The financial factors threatening the sustainability of the scheme can be seen as: low premiums from a narrow population size eligible to enroll and the additional burden of broad benefit package without co-payment [37](Chankova, Atim, & Hatt, 2010: 60 - 61; Alhassan et al., 2016; Witter & Garshong, 2009). In addition is an abuse of the gatekeeping system which should ideally encourage an adherence to the referral system of access to healthcare in the country (Alhassan et al., 2016). There is also the matter of collection of premiums from the informal sector considered as regressive due to the fact that 45

[37] With an estimated 40 percent of the total population of Ghana living below the national poverty line, indigents account for only 2.4 percent of members. The means test for the NHIS for indigents is strict, and requires that an indigent be unemployed with no traceable source of income, known to be homeless, and have no identifiable support from another person (cited in Republic of Ghana 2004). This narrow definition poses challenges for scheme managers whose responsibility it is to identify all such persons (Chankova, Atim & Hatt, (2010). This raises equity concerns for the poor who may be existent in communities but the system si unable to identify them.

percent of total health expenditure emanated from there (Odeyemi and Nixon, 2013) perpetuating the OOP culture that the NHIS and by extension the UHC seeks to abolish. Under the operational category of issues which have negative influences on the sustainability of the scheme are fraud and corruption, delayed reimbursement of service providers (as at mid-year 2017, the government owed service providers Ghc1.2 billion (translated into $270 million at the rate of $1= Ghc4.4 www.graphic.co.gh), unfavorable spatial distribution of health facilities and staff causing subscribers to consider opportunity cost to accessing healthcare, weak human resource capacity of the NHIS district offices and poor quality of healthcare services at facilities accredited by the NHIS causing longer waiting times, poor staff attitude etc. (Alhassan et al., 2016; Agyepong et al., 2016). But in a study by Fenny et al. (2014) using the Donabedian[38] model on 'structure-process-outcome' to ascertain differential treatment between insured and uninsured patients, no significant differential treatment was discovered between the two except for some complaints from the uninsured patients about waiting time and service levels at the pharmacies/dispensaries. Some studies have revealed the inequities prevalent under the NHIS, posing major disincentives for the poor and very poor to join. Some of the reasons assigned to the issue of inequity in benefits include, cultural, economic, geographic and organizational, making the ability of marginalized groups to join difficult. Even though expected premiums slated for the informal sector hovers around $5 per person per year with the additional fee of $1.5 for enrollment (except for expectant mothers), this poses as a deterrent for many poor people (Odeyemi and Nixon 2013; Witter & Garshong 2009).

Table 5 below gives a summary of the NHIS with all the dimensions of its existence and operations discussed earlier. This is an added value to this study as it presents a one-stop view of all the disaggregated information that pertain to the scheme, the health status of the country, challenges and its position on the ladder to achieving the UHC by 2030.

[38] The Donabedian model assesses quality of care by dividing factors of care that affect quality into structures, processes and outcomes (Fenny et al., 2014).

TABLE 5: SUMMARIZED PROFILE OF THE NHIS IN 2017

Summarized Profile of the NHIS in 2017				
Population Dynamics	Health Indicators	Financing Mechanisms	Legal Provisions	Sustainability Concerns
*Total Population: 26.9m (51% Female/49% Male)	*Total NHIS coverage: 40% of population	*GDP of Ghana: 7.5% (2017)	*NHIS Act, 2003 (650) established the NHIS. -Allows for the concurrent operation of DMHIS, PMHIS and PCHIS.	*Over 60% of active members in the exempt category (without co-payment)
*Population Density: 124 persons per Sq. Km of land area (2016, World Development Indicators Database)	*Life expectancy at birth (as at 2013): 62.4 years Fertility Rate, total (births per woman): 4.0	*GDP (current US$) (Billions): 42.69 (2016, World Development Indicators Database)		F*raud & Corruption at some health insurance scheme offices *Abuse of gatekeeping system (a system that encourages members to access health care using the referral system starting from the primary level)
*Population in the Informal Sector: 67%	*Doctor: population ratio (as at 2012): 1:10,452	*GoG Budget allocation to health (2013): 10.6%	*Passage of NHIA law, Act 852 (2012). -Benefit package reviewed to include other exempt groups such as mental patients and relevant family planning options for subscribers -Enjoins the NHIA to collaborate with relevant agencies to ensuring quality health care and to also carry out clinical audits	Low premium payments (propelled by the dissatisfaction with services delivered and decreasing the renewal rate for subscription)
*Active Membership Category for the NHIS (%):	*Nurse: population ratio (as at 2012): 1:1,251	*Sources of NHIS Funding: NHIL- approx. 70%		*Political interference (observed in the reappointment of CEOs of the NHIS whenever a new government assumes office)
*Aged (70+): 4.5	*No. of health care facilities (public and private): 5,000+	*SSNIT Contributions - 17% Premium Payment - 4%		*Delayed reimbursement of services rendered by providers
*Indigents: 4.4 *Informal Sector Workers: 35.5 *SSNIT Contributors: 4.2 *SSNIT Pensioners: 0.3 *Population under 18 years: 51.2 *Dependency Ratio: 0.72 per productive member	*Disease burden: Top 10 Causes of Out-patient Morbidity in Ghana including malaria, diarrhoeal diseases, skin diseases, accidents, pregnancy related complications etc. The NHIS covers 95% of all diseases.	*Other Sources (include donor funding & returns on investments)- 8% Financing for the scheme is considered progressive (taxes), mildly progressive (NHIL payroll deduction) & regressive (informal sector)		*Unfavorable spatial distribution of health facilities causing subscribers to consider opportunity costs of accessing health care *Poor service delivery at accredited facilities
		*By 2017 mid-year, GoG owed service providers- Ghc1.2 b (equiv. $270 m) @$1=4.4		*Weak human resource capacity of NHIS district offices

Source: Author's aggregated information based on Asenso-Boadi (2010); Alhassan et al. (2016); Odeyemi & Nixon (2013); Witter & Garshong (2009)); www.graphis.co.gh ; www.worldbank.org (2017)

Section 2: The Community-based Health Planning and Services (CHPS) and its contribution to the UHC journey

2.1 Presentation of the Community-Based Health Planning and Services (CHPS)

In 1977, prior to the Alma Ata Declaration of 1978 which focused on Primary Health Care (PHC), Ghana embarked on a number of decentralized health strategies which acknowledged the input of Community Health Workers (CHWs) known as Community Clinic Attendants and Traditional Birth Attendants at the grassroots level (MoH, National CHPS Policy, 2016: 8). The design of Ghana's health system is modeled on the various interconnectivities and dependencies of a host of health-seeking touch points such as health posts and dispensaries located at the lowest points linked to health centres, moving onto polyclinics and finally at the apex are hospitals. The PHC operates on 3-tier interconnected levels - Levels A, B and C. Level C is situated at the very top comprising the District Hospital and District Health Administration, responsible for planning, supervision, monitoring and coordination of health service delivery and also working with local government institutions and decentralized agencies. Level B which represents the sub-district level has the responsibility for planning, developing, monitoring and evaluating community-based service delivery. At the most basic level, at the community, Level A is designed to draw healthcare services closer to the community through the work of the Community Health Officer (CHO) (MoH, National CHPS Policy, 2016: 8). See Figure 12 for the interactions existing among the 3 levels of the primary health care system.

1996 saw another health sector attempt at reforms at the district level - the launch of the Medium Term Health Strategy dubbed 'Towards vision 2020 and the first in a series of Five Year Program of Work and Common Management', this concept still holds relevance to the health sector (MoH, National CHPS Policy, 2016). The Community-based Health Planning and Services (CHPS) concept has been in existence for over a decade. Its emergence came after much reform efforts by the MoH and as part of lessons gathered from Bangladesh. It was initially called Community Health and Family Planning (CHFP) project and launched in Navrongo (in the Upper East region of Ghana) as a pilot project in 1994 aimed at helping to redefine the appropriate modalities for the design of community based health services. The pilot

project fell under four sub-districts also called Cells (MoH, National CHPS Policy, 2016; Nyonator, 2002). This initiative was an offshoot of an experimental study from the Navrongo Health Research Centre (NHRC) which became accepted and rolled out as a national health policy intended to improve access, efficiency and quality of healthcare and family planning (Nyonator, 2002). After several attempts at health policy reforms in the country, it was realized through research in 1990 that, an outstanding 70 percent of all Ghanaians still lived distant (more than 8km) from the nearest healthcare provider (Nyonator, 2002). The dichotomy of this reality between rural and urban residents in terms of mortality rates was disproportionately skewed in favour of the latter. Hence, the Navrongo experiment and the CHPS emerged as a policy response to the 1978 "Health for All" global call (Nyonator et al., 2005).

A long history of program/project successes (the Danfa Comprehensive Rural Health and Family Planning project and the WHO-sponsored Brong Ahafo Regional Development Project) and failures (some domiciled in the PHC Strategy paper of 1977/78) associated with the achievement of community health coverage, informed the policy direction to involve community participation in promoting access which had become a central notion to healthcare (Nyonator et al., 2005). The evidence-based policy direction was to use Village Health Workers (VHWs) as a key medium to achieving the PHC strategy. However, due to organizational, resource, capacity building, monitoring and supervision challenges, the VHWs system became a failure and was abandoned in the 1980s (Nyonator et al., 2005). The United Nations Children's Fund (UNICEF) with the World Bank, in an effort to resuscitate the then controversial subject of volunteers, recommended another approach to volunteer service – the Bamako Initiative, aimed at addressing the weaknesses in previous systems but with continuous reliance on volunteer health providers (Nyonator et al., 2005). With the introduction of the CHPS (based on the final selection of the model in the experiment Cell 3), deliberate modifications to existing service delivery approaches at the district level were adopted. The differences in the various approaches offered during the experiment are captured in Table 6.

TABLE 6: CONCEPTUAL FRAMEWORK OF THE NAVRONGO COMMUNITY HEALTH AND FAMILY PLANNING PROJECT (CHFP) AND THE DIFFERENT APPROACHES OFFERED BY THE EXPERIMENTAL CELLS

Conceptual Framework of the Navrongo Community Health and Family Planning Project (CHFP) and the different approaches offered by the experimental Cells		
Constant: Health Centres in all cells upgraded equally	Traditional community not mobilised	Traditional Community Mobilized – entry, Community Health Management Committee (CHMC) formed and volunteers engaged
No nurses trained and deployed for home visits	**Cell 4:** Upgraded Health Centre	**Cell 1:** Upgraded Health Centre with community mobilized
Nurses trained and deployed – residency with basic services (including motorcycles and backstopping logistics) available to make 24-hour home visits and in emergency cases	**Cell 2:** Upgraded Health Centre with Community Health Nurse (CHN) trained and deployed in communities	**Cell 3:** Upgraded Health Centre with communities mobilized and Community Health Nurse (CHN) trained and deployed

Source: Author's adaptation of Nazzar et al. (1994) model in MoH CHPS Policy (2016: 14)

The CHPS, based on the Cell 3 model was settled on in 1999, to be a means to achieving the national strategy to improve access, efficiency and quality of healthcare (MoH CHPS Policy, 2016). A key feature of the CHPS' introduction into communities and districts is the ownership and acceptance of the concept by the traditional leaders of the participating communities. Critical to the success of the implementation of the CHPS is the support of the leadership and entire community out of which Community Health Management Committees (CHMCs) would be composed – thus, the concept thrives on community participation, volunteerism and mobilization (MoH CHPS Policy, 2016; Nyonator et al., 2005). According to Aldous (1962), strong and stable group solidarities formed elicit communal spirit which in turn often engage in welfare activities for its members and could substitute, in cases where absent, for non-existent social welfare

programs for the public. Ayé et al. (2002) also point to similar observed relevance of social networks at the community level through which effective ways have been shown for the poor to access modern healthcare in Africa.

After the selection of the appropriate model (Cell 3) in 1999, the year after saw the commencement of the scale-up exercises of the CHPS at the community level – the CHPS with the objective of reducing challenges with geographical access to healthcare (Nyonator et al., 2005) become a national health policy. This was facilitated by some funding from the HIPC Program under the World Bank and also, the Ghana Macroeconomics and Health Initiative (GMHI, 2005) (MoH National CHPS Strategy, 2016). Upon selection of the model to be used for implementation, fifteen implementation steps were identified as guide to the process with training provided to Community Health Nurses (CHNs) and a further upgrading to Community Health Officers (CHOs) with designated CHPS Zones (GHS CHPS National Implementation Guidelines, 2016). It should also be noted that the CHPS forms part of the GoG's Poverty Reduction Strategy (PRS) aimed at placing nurses in rural communities to increase access to the poor and ultimately increase community participation (Dovlo, 2005).

2.2 The implementation of the CHPS policy

The CHPS is a national health policy strategy designed to deliver basic and essential healthcare services to communities aimed at bridging the access and inequity gaps towards the attainment of the UHC by 2030 (MoH National CHPS Policy, 2016). Nyonator et al. (2005) posit that the CHPS is designed to **"reduce barriers to geographical access to health care"**. The different levels of healthcare provision are captured adequately in the GHS and Teaching Hospitals ACT, 1996 (ACT 525) (GHS CHPS National Implementation Guidelines, 2016). There are various components of the CHPS which make its implementation feasible and unique such as the CHPS Zones, CHPS Compound, Community Health Officers (CHOs), Community Health Volunteers (CHVs) and the Community Health Management Committees (CHMCs), all defined in Table 7. The funding of the various activities (including but not limited to infrastructure development, training, equipping etc.) under this initiative seem a shared responsibility among government, donor partners and the communities within which the CHPS are situated. The GoG's

commitment towards the realization of the objectives of this strategy has been shown in diverse ways over time. Through the establishment of appropriate institutional arrangements, the funding of the construction of CHPS, efforts at resource mobilization at all levels, equipping the facilities, training of health workers and deployment by the GHS and supervisory roles at all stages form part of the decentralized healthcare system. The Ministry of Health (MoH) established 276 new functional Community-based Health Planning and Services (CHPS) Zones (GoG Budget, 2012). Different donors contribute in different ways to the expansion of coverage of the CHPS – the Japanese International Co-operation Agency (JICA), Korea International Cooperation Agency (KOICA), United States Agency for International Development (USAID) and others; give support in the areas of funding and technical assistance. The traditional leaders and members of the communities form a significant component of the CHPS initiative – the planning of infrastructure development in the communities require planning and resource mobilization with some leaders offering free parcels of land and labour by community members for the construction of the CHPS compounds (Nyonator et al., 2005).

As two health initiatives under the Ministry of Health, the NHIS is deemed as the social protection program designed to address the challenges with financial barriers to access to healthcare while the CHPS addresses the geographical barriers to access (by drawing PHC closer to the people), with both attempting to address issues of inequities (MoH National CHPS Policy, 2016: 11, 13 & 16).

TABLE 7: DEFINITIONS AND ROLES OF CONSTITUENTS OF THE CHPS POLICY

Table 8: Definitions and Roles of Constituents of the CHPS Policy

Name of Implementation Constituent of CHPS	**Definition and Role**
CHPS Zone	A geographical area demarcated for healthcare outreach/service delivery with a population of about 5,000 people or 750 households (for densely populated areas).
Functional CHPS Zone	This terminology emerged in 2008 to mean *"where all the milestones have not been completed……but a CHO has been assigned and provides a defined package of services to the catchment population, from house to house and reporting on the unit area"*. This terminology has been assigned different meanings by different actors. With the different interpretations come different understanding and approaches to the initiative. The definition of the functionality does not lie in whether there is an existing structure referred to as the CHPS Compound (although this is the ideal case), but lies in a catchment area that is either underserved or devoid of any health centre or hospital.
	Completed Functional CHPS Zone: defines an area with all milestones completed including the residency of a CHO assigned, equipped to render the basic package of services to the catchment area.
	Uncompleted Functional CHPS Zone: defined as a CHPS zone where certain protocols have been completed (such as community entry process with sensitized community members, CHMC selected and introduced through durbars and fully engaged in the health planning and service delivery aspects of the CHPS strategy). With such a zone, it is normal to see a deployed CHO and several other milestones completed yet not fully equipped to achieve full functionality.

CHPS Compound	This is a building with a demarcated living area for CHO and another for healthcare delivery.
Community Health Officer (CHO)	A trained and oriented CHN with a designated CHPS Zone and assigned roles as: Provide reproductive, maternal, and child health services; Manage diarrhea; Treat malaria, acute respiratory infections (ARIs), and childhood illness; and provide comprehensive family planning (FP) and childhood immunization outreach.
Community Health Nurse (CHN)	Is one that has undergone the prescribed in-service training and orientation and is a classified and licensed cadre by the Nurses and Midwives Council.
Community Health Volunteers (CHVs)	These are community members specially selected and trained as support staff to the CHOs within the CHPS Zones. They are usually not remunerated monthly.
Community Health Management Committees (CHMCs)	This group represents a selection of community leaders with diverse expertise and volunteering from the CHPS communities with focus on providing guidance, mobilizing for health planning ad service delivery activities and with general oversight of the welfare of the community.

Source: Author's adaptation of GHS CHPS National Implementation Guidelines (2016) and MoH National CHPS Policy (2016: 22)

General Principles and Policy Directives for the CHPS

There are six general principles and five key policy directives guiding the implementation of the CHPS policy. Below are the General Principles guiding the CHPS (GHS CHPS National Implementation Guidelines (2016) and MoH National CHPS Policy (2016) :

1. Community participation, empowerment, ownership, gender considerations, and volunteerism
2. Focus on community health needs to determine the package of CHPS services
3. Task shifting to achieve universal access
4. Communities as social and human capital for health system development and delivery
5. Health services delivered using a systems approach
6. CHO as a leader and community mobiliser

The Key Policy Directives for the CHPS policy implementation

There are five key policy directives which guide the implementation of the CHPS policy (GHS CHPS National Implementation Guidelines (2016) and MoH National CHPS Policy (2016). The following cover the critical aspects of the policy implementation in Ghana:

BOX 11: KEY POLICY DIRECTIVES FOR THE CHPS IMPLEMENTATION

1. Duty of care and minimum package: defines the core package of services to be provided within the CHPS zone by the CHO and Community Health Volunteer (CHV). The package focuses predominantly on maternal and child health (MCH) and nutrition services. It also incorporates health education, sanitation and counseling on healthy lifestyles. Additionally, information and surveillance on disease patterns are also to be undertaken. Coordination and linkages with private health facilities in the CHPS zone is emphasized.
2. Human resources for CHPS: This defines who a CHN is and their grading. It also clarifies who a CHO is and determines the CHO-to-population ratio. It directs that a system for career progression be developed and incentive schemes instituted for both the CHNs and CHOs. It also identifies the essential role of the CHVs and reward system for such this category of human resource.
3. Infrastructure and equipment for CHPS: defines standards for a CHPS compound and the accompanying list of equipment and furnishings, and direct that all CHPS compound construction will comply with standards. Guidance for completing ongoing projects is provided. Establishment of CHPS zones and location of CHPS compounds will be determined by District Assembly (DA) emanating from the District Health Strategic Development Plan and all land for construction will be documented and sealed at the Land Title Registry. Rural and underserved areas will be prioritized for CHPS construction and guidance is provided for urban CHPS.
4. Financing: Directs that all services delivered in a CHPS compound shall be free and assigns government the primary responsibility for financing.
5. Supervision, monitoring, and evaluation: The main policy provides for the hierarchy of supervision, monitoring, and evaluation. It indicates that the Officer in charge of the sub-district shall supervise the work of the CHO, with technical support from the District Health Management Team (DHMT).

Source: MoH National CHPS Policy (2016)

2.3 Implementation challenges of the CHPS

Many challenges have been identified as hindering the smooth and speedy nation-wide implementation of the CHPS policy after more than 10 years of scale-up, a policy which is intended to contribute to the country's achievement of the UHC by year 2030.

Some challenges of the CHPS are (MoH, National CHPS Policy 2016):

1. There are ambiguities associated with definitions of key themes and also, a long-strung conceptual debate with the CHPS policy – these include the 'functional CHPS zone' definition supposed to be implicit in the implementation of the policy leave its interpretation confusing to many. A lack of effective leadership and technical know-how compounded by poor community, district, regional and national planning have also been cited;
2. Some commissioned CHPS compounds in districts have after several years not started operations. About 60 percent of compounds are partially equipped and without accommodation for Community Health Officers (CHOs) and without provision for recurrent operational budgets;
3. After all the investment made over the years, the current population covered by the CHPS policy is 5 percent (Pg. 20). This raises concerns over return on investment and also, whether the policy is being implemented optimally and whether the performance indicators assigned should be reviewed;
4. There seems to be an oversupply of Community Health Nurses (CHNs) for the limited number of CHPS zones available (the current rate stands at 1 CHPS Zone: 11 CHNs). This presents logistical challenges in relation to accommodation leading to many Community Health Officers (CHOs) not residing in the communities but which defeats the purpose for the CHPS strategy. There is also the matter of the absence of career progression for Community Health Nurses (CHNs) which frustrates many;
5. There is the challenge of inappropriate siting of CHPS compounds in areas such as cemeteries, sacred groves, places with insanitary conditions etc. which offend the cultural sensibilities of the people who have to patronize services of the CHPS in such areas;
6. The modalities concerning the financing of the CHPS remain unclear with different development partners funding different aspects of the policy implementation. This causes disharmony and a lack of coordination for efforts geared towards the policy's implementation. Also, the CHPS compounds which have accreditation from the National Health Insurance Authority (NHIA) do not get reimbursed directly but are rather claimed from Health Centres extending the period for reimbursement and affecting available resources for recurrent expenditures; and

7. The Community Health Management Committees (CHMCs) which act as a local institutional support to the work of the CHOs currently are formed in most of the zones where the CHPS is existent but 65 percent of members remain untrained and inactive;
8. There has been low investment in the recruitment, training and deployment of the Community Health Volunteers (CHVs) which forms a fundamentally significant component to the CHPS concept. About 55 percent of CHPS Zones have no well-trained and active volunteers bridging the gap between patients and CHNs at present. Meanwhile the work of these volunteers does not add to the national wage bill which has been frozen due to the conditionalities imposed on the country by the IMF/WB agreement. Apart from this, there seems to be volunteer-fatigue for the few who are available for work and other actors with unrelated activities drawing on their time and the lure of cash incentives from all those other activities – payment is not by design part of the CHPS concept. To avoid high turnover of the Community Health Volunteers (CHVs), the Ministry of Health (MoH) has proposed, however, plans to retool existing volunteers and offer a more consistent monetary payment system.

In the implementation of the two policies being the NHIS and CHPS, there are complementarities and divergence and uniqueness in how they exist and operate and their contributions to the health sector and the UHC. Tables 8 –15 below present these dimensions of the two health policies.

2.4 Comparative analysis of the NHIS and CHPS implementation

The two chosen policies for the achievement of the UHC are found under two separate agencies under the MoH. This table represents the institutional complementarities or the lack thereof between the two agencies, policies and implementation modes. There are interactions between the two policies some of which occur at the point of service delivery. Below are the overlaps and differences between the two policies' implementation presented under different themes and in a series of related tables:

TABLES 8 – 15: POLICY INTERACTION BETWEEN THE NHIS AND CHPS

TABLE 8: INSTITUTIONAL AND LEGAL FRAMEWORK OF THE NHIS AND CHPS				
Subject	**NHIS**	**CHPS**	**Level of synergies and/ or Challenges**	**Comments**
Instit./Legal Framework	Domiciled at the MoH, its implementation is under one of the agencies under the ministry. Its establishment saw the enactment of the law NHIA Act (650) and subsequently, its revision to in 2012 (Act 852).	*Domiciled at the MoH but implemented under the Ghana Health Service (another agency under the ministry). It has no legal backing, although considered as a priority health policy.	NHIS: *Although the law states that it is compulsory for all Ghanaians to enroll on the NHIS, enforcement of that part of the law seems to be lacking. * Based on the decentralization approach, the CHPS is incorporated into the NHIS implementation at the point of service for subscribers and reimbursement of services to the CHPS are done at the health centres. There are delays with the processes involved at the NHIS-Health Centre extending to the CHPS. *Communication of the compulsory nature of the law seems to be lacking as well, as not all citizens seem aware of their obligation. CHPS: *Policy and system level challenges identified - unclear policy direction and ambiguous definition	*It is imperative now to encourage more people to enroll on the NHIS to ensure firstly, sustainability of the scheme, coverage and ascertain the benefits that the UHC promises. The delays in reimbursements to the CHPS affects service delivery and defeats the Primary Health Care (PHC) focus of the country since 1977 and Ghana's adoption of the Alma Ata Declaration in 1978, the first Medium Term Health Strategy and the Sector-wide Approach (1995).

			for key aspects of implementation and continued conceptual debate. *Lack of strong leadership and planning at all stages of the decentralized structure in making the policy prominent.	

Source: Author (based on MoH, National CHPS Policy (2016: 2, 10 -11), Chankova, Atim & Hatt (2010), Nyonator et al (2005), NHIS Annual Report (2013), and Official NHIA website)

The institutional framework for the NHIS and the CHPS are similar by way of where both are domiciled, under the Ministry of Health (MoH). While both are intended to address the UHC, the NHIS has legal backing as a policy but the CHPS does not but is considered a priority. The NHIS may seem, based on successive governments' commitment in terms of investments made into its incremental institutional improvements and national campaigns on it, as the primary health policy driving the UHC and has since inception gained popularity and patronage in the form of 40 percent enrollment nationwide. The CHPS on the other hand, has been saddled with finding its place in the national health discourse with challenges of definition, funding, incoherence in policy framework for implementation, a lack of leadership and others. Sometimes, the policy has suffered from a lack of institutional complementarities from within with for instance, the MoH assigning a national CHPS coordinator (at the policy level) and another national CHPS coordinator at the agency and implementation level of the Ghana Health Service (GHS) as per the decenetralization system being implemented nationally. This situation causes undue conflict and also, has impact on resource utilization.

TABLE 9: POLICY GOALS AND OBJECTIVES OF THE NHIS AND CHPS				
Subject	NHIS	CHPS	Level of synergies and/ or challenges	Comments
Policy Goals/ Objectives	*Attainment of financial sustainability of the NHIS. *Achievement of universal financial access to basic healthcare services. *Securing stakeholders' satisfaction. *Provision of support to increase access to quality basic healthcare services in all districts. *Increase of coverage for the vulnerable (poor & indigents).	*To attain the goal of reaching every community with a basic package of essential health services towards attaining UHC and bridging the access inequity gap by 2030.	There is policy convergence where both seek to provide both geographical and financial access and quality to basic healthcare services to all – UHC.	Although both are geared towards the UHC, the NHIS seems to be the prominent policy driving the UHC agenda in Ghana.

Source: Author (based on MoH, National CHPS Policy (2016: 13, 16), Chankova, Atim & Hatt (2010), Nyonator et al (2005), NHIS Annual Report (2013), and Official NHIA website)

The goals and objectives of both policies are geared towards the achievement of the universal health coverage with the NHIS positioned as the policy to address the financial access to healthcare by the population and the CHPS, as the policy to provide geographical access to the population (MoH, National CHPS Policy, 2016: 16) with both expected to address equity concerns.

TABLE 10: COVERAGE OF THE NHIS AND CHPS				
Subject	**NHIS**	**CHPS**	**Level of synergies and/or challenges**	**Comments**
Coverage	Facilities - All public health	5 percent of total population	CHPS compounds are also accredited by	Although, the sector's

	facilities in the country are automatically accredited. Private health facilities have to apply for accreditation and participation. Population - 40 percent of total population. Disease – coverage of 95 percent of all diseases in Ghana.	covered. Nationwide coverage, predominantly in rural areas.	the NHIS for inclusion and based on the decentralized approach, reimbursement of services are made from the NHIS through the health centres at the sub-district level.	approach to attaining the UHC is financially through the NHIS and geographically through the CHPS, no special concessions are made for the latter in order to improve spread.

Source: Author (based on MoH, National CHPS Policy (2016: 10), Chankova, Atim & Hatt (2010), Nyonator et al (2005), NHIS Annual Report (2013), and Official NHIA website)

In reference to **Figure 12 (Levels of the Primary Health Care System in Ghana),** the CHPS is placed under the health centres in the sub-districts according the decentralization structure being operated in the system. Here not only more complicated patient cases are escalated to the next/higher level of care based on the gatekeeping system but also it is run as key parts of the PHC system. The health centres apart from being the next referral point for patients, also play the role of reimbursement points for costs of services delivered at the CHPS level from the NHIS/NHIA. The NHIA has no special arrangements made for the CHPS implementation, thus, the same accreditation and reimbursement arrangements made with and for all service providers remain same for the CHPS, even though the CHPS operates widely in rural and often hard-to-reach locations and also, its positioned as the only other health policy working in partnership with the NHIS in pursuit of the UHC. The low coverage rate by the CHPS leaves much to be desired in relation to return on investment after more than ten years of implementation. While the legal and institutional framework may present a challenge, as both policies are not on an equal footing, coverage of the CHPS remains low due to infrastructure challenges among others which may be covered in the ensuing tables.

TABLE 11: INNOVATIONS AND SYSTEMS IN THE NHIS AND CHPS				
Subject	**NHIS**	**CHPS**	**Level of synergies and/or challenges**	**Comments**
Innovations & Systems Improvement	Multiple provider payment systems have been introduced – the Fee-for Service, the DRG and the Capitation. *The Scheme also uses the biometric identification card as process of registration.	Even though the CHPS receives accreditation by the NHIA, its reimbursement model creates delays such that card bearers of the NHIS still have to make out of pocket payments at the CHPS level since the NHIA does not reimburse all expenses (patients are asked to pay for folders).	*The Capitation which was piloted in the Ashanti region has been suspended. This was a political promise and piloting of it started under one leading party but now in opposition, the policy has been suspended. *The OOP at the CHPS level could promote corruption as CHOs and CHNs are perpetually exposed to cash in remote areas which may lack external financial services.	*An observed political interference in the capitation roll-out. *Efforts should be made to eliminate the OOP at the CHPS level as it defeats the strides being made to achieve the UHC. A specialized system of payment should be designed solely for the CHPS to expediate action on the system of reimbursement.
Source: Author (based on MoH, National CHPS Policy (2016), Chankova, Atim & Hatt (2010), Nyonator et al (2005), NHIA, NHIS Annual Report (2013), and Official NHIA website)				

Over time, the NHIS has introduced a number of technology and innovations in its system by way of enrollment, claims, payments, audits and others. For instance, for claims management, e-claims and the ClaimIT have been introduced. The E-claims is only in about one hundred facilities while the ClaimIT has not taken off since the pilot ended more than a year ago with the claims management proposed to be privatized. This electronic submission of claims is designed for all big facilities in the country, with the smaller ones to submit to Claims Processing Centres (CPCs) for efficiency in claims management. There will not be claims processing at the district offices any further. To increase coverage for the entire population, the National Health Insurance Authority (NHIA) has introduced the electronic renewal of membership system which is being

piloted in three districts currently. For enrollment under this project as well, and in collaboration with the Ministry of Employment and Social Welfare (MESW) on the project - the Livelihood Empowerment Against Poverty (LEAP), this initiative also applies. This is to forestall the waiting times experienced by subscribers at the district offices. The NHIA projects that membership would increase by 50 percent in the few months to follow, there will be full implementation. This digital renewal platform has been introduced with expected commencement in December 2018. This innovation is being implemented in partnership with the National Commission on Civic Education[39] and the Information Services Department (under the Ministry of Information) to disseminate these new improvements in the system and to help people utilize it so that the objective of Ghana attaining the UHC by 2030 is achieved by the NHIA.[40] This is a multisectoral approach to addressing issues of healthcare – and not a representation of HiAP. Still under the NHIS, the audit and accreditation functions also have the support of technology to improve efficiency. Within the system, the CHPS' delayed reimbursements associated with the decentralized form of payment at the health centres threaten to encourage corruption and/or induce coping mechanisms as the CHNs and CHOs would continuously need to provide restocking of health supplies, pay utility bills and others. At the service providers' facilities, there has been the introduction of Biometric Authentication system installed to help verify all active or otherwise members before service delivery. Finally, for subscribers and enrollees, a new system is yet to be introduced that will empower them to manage their own membership on the scheme by dialing an access code which allows the individual to access how much the provider is claiming for the services accessed – verification for the patient for the amount and number of attendances made at that facility. These are innovations aimed to improve both end of service provider efficiency and accountability, and also patients' confidence in the system and provide value for money.

TABLE 12: HUMAN RESOURCE CONSIDERATIONS UNDER THE NHIS AND CHPS				
Subject	**NHIS**	**CHPS**	**Level of synergies and/or challenges**	**Comments**

[39] This is an independent non-partisan governance institution established in 1993 under Article 231 (Act 452) of the constitution to promote the ideals of democracy, awareness of citizens' rights and obligations through civic education. It has nationwide presence in all 216 districts in the country. http://nccegh.org/site/index.php

[40] http://www.ghanaweb.com/GhanaHomePage/health/NHIA-to-scale-up-electronic-membership-renewal-by-end-of-year-703884?channel=D1

Human Resource	There are staff in all 10 regions of the country in the regional and district offices.	*The current ratio of CHPS Zone to CHN is 1:11 (an over-production of CHNs for fewer positions to be occupied. The ideal ratio is one CHO per a zone (which covers a population of 1,500 people) and one CHN per zone. But now, there are two per zone. *The selection, training and retention of volunteers and CHMCs have been poor.	*This poses many logistical challenges in terms of accommodation and other supportive amenities under the CHPS. *It also presents challenges to the implementation design of the policy; that nurses would be resident in the distant communities and be ready to provide 24-hour healthcare service to the inhabitants. *Career progression is absent for CHNs, who are sometimes left in deprived communities indefinitely.	The CHOs and CHNs are unique to only the CHPS implementation. But they fall in the same category as other health workers whose work are generally supervised for quality assurance. The place and function of the CHMCs needs to be looked at as its integral to design and effectiveness of the CHPS.
Source: Author (based on MoH, National CHPS Policy (2016: 20 - 22), Nyonator et al (2005), NHIS Annual Report (2013), and Official NHIA website)				

The observations made concerning the human resource dimension of the CHPS implementation present both challenges and opportunities. The situation of more-available trained nurses-than spaces to occupy is a result of the inadequate and under-equipped CHPS compounds that exist for the operalization of the policy. Efforts towards the quantity and quality of infrastructure under this policy's implementation need to improve, with corresponding logistical support for the health workers who will be deployed to live in the communities assigned and with supervision of such staff. The other aspect of the human resource challenge is that, the initial design of the policy (regarding the Community Health Nurse's (CHN) training specifically) took no cognizance of career progression resulting in dissatisfaction among CHNs after being deployed and left to stay in one location for extended periods. Thus, the policy did not contain any strategy for the duration of stay for a deployed CHN serving in deprived communities neither did it specify any reward or motivation for extended stay (MoH, National CHPS Policy (2016: 20). The matter of a decline in the availability of Community Health Volunteers (CHVs) must also be addressed. These CHVs form a relevant conduit between patients living within the

communities and the Community Health Nurses (CHNs) in such a manner that does not burden the national wage bill. The services of these CHVs were designed to be voluntary with some basic incentive packages but the absence of such incentives has brought on volunteer fatigue. The Community Health Management Committees (CHMCs)[41], also an important component of the CHPS implementation framework, have the challenge of not being formed in all communities where the CHPS exist and where they are formed, there is inadequate training – an estimated 65 percent of such CHMCs are not trained and/or remain idle (MoH, National CHPS Policy (2016: 21). The introduction of the CHPS Implementation Guidelines (2016) embodies renewed lifeline into the policy implementation as it spells out guidelines into all aspects of the policy implementation to provide structure and ensure the sustainability of the CHPS. For instance, the difficulty in clarity and form of supervision is covered under such guidelines under Facilitative Supervision (FSV)[42] which defines the supervisor, who to be supervised and at what level, approaches to the supervision and others (CHPS Implementation Guidelines, 2016: 59). The National Health Insurance Authority (NHIA) does all recruitments for the NHIS staff with remuneration and career progression determined by same, despite the proclaimed stance of the country and health sector on decentralization.

TABLE 13: DONOR SUPPORT

Subject	**NHIS**	**CHPS**	**Level of synergies and/or challenges**	**Comments**
Donor Support	*Part of the initial funding came from the Highly Indebted Poor Countries (HIPC) support from the World Bank. Other support	*Many donors have focused on technical training (upgrading of skills) but fail to change work systems. *An	There seems to be some effort by the Ghana Health Service/MoH (with support from the USAID under the Maternal and Child Survival Program and JICA) at streamlining	*The NHIA still receives donor support in various aspects of implementation. *Released in August 2016 and March

[41] The Community Health Management Committees (CHMCs) represents an important component of the CHPS governance structure which involves the recruitment of community leaders with diverse competencies and responsibilties from the various communities where the CHPS exists who volunteer their time and skills in providing guidance by way of health planning and service delivery (including oversight of the welfare of CHOs) in their communities (MoH, National CHPS Policy (2016: 22).

[42] Facilitative supervision (FSV) is a system of management whereby supervisors at all levels in an institution focus on the needs of the staff they oversee. This approach emphasises monitoring, joint problem solving, and two-way communication to strengthen the learning process between the supervisor and those being supervised (CHPS Implementation Guidelines (2016: 59).

	received have come from DANIDA, Joint Learning Network (JLN); KOFIH, ILO, DFID offering both financial and technical assistance.	uncoordinated way of funding preferred portions of the initiative by donors leaves many aspects untended e.g. infrastructure gaps, equipping etc.	all development partners' efforts at promoting the CHPS.	2016, the CHPS Implementation Guidelines and National CHPS Policy respectively, have both benefitted from donor support.
Source: Author (information from Government of Ghana (GoG Annual Budget, 2008: 171); Nyonator et al. 2005; National CHPS Policy MoH, 2016: 37-39; the CHPS Implementation Guidelines (2016); NHIA, NHIS Annual Report, 2013; and Official NHIA website)				

The health sector of Ghana has benefitted from donor support for long periods in the development of the country with a few exiting in recent times due to the elevated middle-income status of the country. While the NHIS had support from the HIPC funds during its establishment, it has over its existence benefitted from both technical and financial support from a number of development partners including the IMF/World Bank, WHO, the International Labour Organization (ILO) and others. Indeed, the ILO is currently giving support with the Digital Renewal Project, and the Korean Foundation for Internal Healthcare (KOFIH) is also supporting research to improve enrollment and capacity building for claims management. The CHPS Implementation Guidelines (2016) which touches on key areas such as the CHPS policy directives, definitions, community engagement strategies, management responsibilities (using the decentralized governance structure in Ghana), resource management, performance evaluation methods and others, has brought structure to the CHPS policy which had remained *a policy without identity*. With this as a guide and the National CHPS Policy (MoH, March 2016) all efforts could be aligned properly such that no aspect of implementation is left unaddressed. Both policy documents under the CHPS have benefitted from the enjoined contributions from the likes of the United States Agency for International Development (USAID) and the Maternal and Child Survival Program, Japan International Cooperation Agency (JICA), Korea International Cooperation Agency (KOICA), the United Nations Children's Fund (UNICEF), World Health Organization (WHO) and others.

TABLE 14: FUNDING				
Subject	**NHIS**	**CHPS**	**Level of synergies and/or challenges**	**Comments**
Funding	National Health Insurance Fund (NHIF) comprising of a sales tax levy (a 2.5 percent earmarked added to the value added tax) and 2.5 percent of formal sector workers' contributions under the Social Security and National Insurance Trust Fund (SSNIT).	*The primary source of funding comes from government. *Uncoordinated funding mechanisms for different aspects of the policy implementation leaves some aspects underfunded. Donor contributions from: JICA, KOICA, USAID, DFID, KOFIH, World Bank, ENI Foundation, Grameen Foundation, DANIDA.	There are financial sustainability challenges currently being experienced by both policies for different reasons. *The NHIA does not reimburse services made at the CHPS directly; costs associated with services rendered are claimed at Health Centres (the next referral level under the gatekeeping system). This leaves the CHPS perpetually cash strapped and unable to maintain quality of care for patients. *The unclear funding arrangements under the CHPS leave many CHPS compounds uncompleted and those completed remain without equipment for operations.	*NHIS - efforts must be made to address the combined problems of sustainability through the rapidly rising enrollment rates for indigents, the generous benefit package of the scheme, and the fairly constant insurance revenue base. *CHPS – seamless coordination of funding streams must be undertaken (especially among donors) to ensure that the various facets of implementation have been covered.
Source: Author (information from Chankova, Atim & Hatt, 2010; Nyonator et al. 2005; National CHPS Policy MoH, 2016; Agyepong et al (2016: 7); NHIS Annual Report, 2013; Official NHIA website)				

Both policies receive funding for implementation. The NHIS receives has its main funding sources from the government with support from its legal backing, premiums and the development partners, and the CHPS, also receive support from government through the MoH and the development partners/donors. With the NHIS, through subscriptions, the non-exempt categories contribute through premiums upon registration and statutory arrangements through the Social Security and National Insurance Trust (SSNIT) where compulsory deductions are made from employees' earnings. Also, the National Health Insurance Fund (NHIF) has an arrangement

to give subsidies to the district mutual health schemes to cover costs associated with healthcare for indigents who fall in the exempt categories under the NHIS (Chankova, Atim & Hatt, 2010: 61). The CHPS, under the Ghana Health Service (GHS) has support from the MoH and also, has support from the donors for different aspects of its implementation. The challenge has been the uncoordinated nature of donors' support which is based on interest for areas such as health system strengthening, infrastructure, capacity building and others. Based on such arrangements which allow preferences to prevail, relevant aspects of the implementation (of both policy design and geographical locations) are sometimes left unattended affecting not only the coverage but also, the quality of services delivered across the regions. The CHPS Implementation Guidelines (2016) document promises to streamline all aspects of the policy including the efforts of the development partners and thus, attention should be paid to its incorporation into the CHPS implementation.

TABLE 15: QUALITY OF CARE AND EQUITY CONSIDERATIONS				
Subject	NHIS	CHPS	Level of synergies and/or challenges	Comments
Quality of Care/Equity Considerations	*There have been negative reported cases of provider attitudes and practices, bordering on illegal fee collections and deliberate delays in seeing insured patients. * Healthcare supply has not matched increased demand for services resulting from NHIS coverage. *There have been cases of	*Not all persons are able to access healthcare in the remote areas because of the cumbersome reimbursement system, delays in reimbursement which inadvertently promotes OOP. * Continuous change in the definition in aspects of implementation affects service delivery by trained staff.	*Quality of care for insured people is compromised under both policies. *Prevalent corrupt practices in the payment system of the NHIA also affect the quality of care. *When service providers are not reimbursed in a timely manner, patients end up receiving bad treatment and paying out of pocket.	The introduction of the multiple service provider payment system instituted by the NHIA to address all such occurrences should eventually address the problem.

	misapplication of tariffs and spurious reimbursement claims by providers. *Performance incentives for NHIS - accredited service providers are considered weak negatively affecting the quality care delivered to patients.			
Source: Author (information from Agyepong et al, (2016); Nyonator et al. 2005; National CHPS Policy MoH, (2016); NHIA; NHIS Annual Report, 2013; Official NHIA website, Alfers (2013)				

While there is an over-production of CHNs under the CHPS, the quality of services delivered by all cadres of health workers has been brought to question with many reported cases of poor service delivery at point of service at health facilities which fall under the NHIS including the CHPS. This situation of over-production of CHNs could be connected to the challenge of conditionalities imposed on the government through agreements signed with the IMF/World Bank. In the view of Rowden (2009: 200), 'Ceilings on public expenditure associated with need to secure IMF approval of national macroeconomic policies may limit the ability of governments to pay badly-needed health professionals, although the relative contribution of the IMF demands and other factors' (such as Ghana's preoccupation with health access has been laden in the PHC policies since the 1970s) 'must be on a country-specific basis' – this observation was contained in a report of a 3-year study by the WHO Commission on Social Determinants of Health released in August 2008 but that bears the reality of Ghana.

Access to quality to healthcare is hampered by reported corrupt practices by health professionals by way of demands for Out-of-Pocket payments (OOP) including staff of the NHIS, cumbersome payment procedures and others (Alfers, 2013: 18; Agyepong et al., 2016: 6). The continuous definitional changes of the CHPS concerning standard basic health package of interventions per CHPS zone, for instance affected service delivery with confusion on the part of both CHOs and reciepient communities (MoH, National CHPS Policy, 2016: 20). With commitment to the usage of the CHPS Implementation Guidelines (2016) and further capacity building efforts, the standard of service delivery and monitoring systems should be improved for better health outcomes. To ensure provision of quality care and compliance with the standards set for service providers, the NHIA's Quality Assurance Department (QAD) which has two departments in one being the Credentialing and Clinical Audits, has increased its frequency of audits and improved its processes for checking for adherence to standards and to ensure that quality of care is given to subscribers. The NHIA has also improved the human resource base of its legal department to help in cases of fraud reported both internally and externally.

2.5 Analysis of UHC in Ghana through the conceptual grid

Agyepong and Adjei's (2008) admonishment to put into perspective the need to give due consideration to context in relation to the complex interaction between actors and processes (including the political dimensions) in the discourse of policy analysis and change, has been adhered to. The issue of context in policy analysis is grounded in the literature by many other authors (Kingdon, 2011; Savedoff et al., 2012a; Savedoff et al., 2012b; Gilson and Raphaely, 2008; Stuckler et al., 2010; Abiiro and Allegri, 2015; Carey and Crammond, 2015; Ridde, 2009). Issues raised in this chapter have exposed Ghana's fiscal, political and institutional context and capacity to undertake health sector reforms to achieve the UHC by 2030. As has been depicted in Figure 3 (diagram by Dahlgren and Whitehead (1991) Pg. 75 and adapted by Bambra et al. (2009), almost all aspects of the issues of SDH (such as employment/unemployment, work environment, agriculture and food production, water and sanitation, housing and healthcare services) have been theoretically represented and practically contextualized through the narrative of Ghana. This is in line with view of the SDH as human rights as expressed by Paul Hunt (see sub section 1.2 of Chapter 2, Pg. 76).

Economic policy decisions affect national income and health spending and inadvertently affect the cost of universal health coverage in several ways. According to Savedoff et al. (2012a), **"although political trends drive the key reforms necessary to achieve universal health coverage, economic trends also play a substantial part. In particular, economic growth generates both resources and demand for expanded health-care provision. As a result, when countries dedicate increasing shares of national income to health-care services, more services are provided, and this contributes to better health".** Thus while Ghana has strived to make socioeconomic progress through economic policy decisions, the social outcomes have sometimes not been commensurate. A redirection of health in this chapter focused on the social determinants of health with a guide from the Dahlgren and Whitehead (1991) model of SDH which shed light on the key areas - not only social and economic, that determine the well-being or health of the Ghanaian population. A key concern flagged by the Extended Credit Facility (ECF) arrangement with the IMF/World Bank and evidenced at firsthand is the matter of government's wage bill (which had to be frozen in relation to further recruitment of labour into the public sector). Although the agreement stipulated that key sectors such as health and education would not be affected, this policy recommendation associated with the economic reforms does not seem to have translated well during the implementation as reports of job freezes have been made in both sectors. Indeed, with more trained CHWs, CHOs and CHNs than available spaces to occupy under the CHPS, there is much to reconsider in the face of higher demand for healthcare services especially in the rural areas where majority of the population reside. This is a case of unintended policy implementation outcomes from the economic reforms having unplanned and negative repercussions on one of the two key sectors, initially exempt from all conditionalities (Leppo et al., 2013). This trend is noted in the discussion on policy. Albeit, how can the UHC be achieved without a sustained flow of well-trained labour (CHWs, CHOs, CHNs, CHVs) to ensure expansion?

To further explain the issues raised in this chapter, the analysis will be made from two perspectives being institutional complementarities from internal and external perspectives. This is esteemed necessary as, Boidin (2018 working paper: 17) points out, **"health needs are not simply natural data. They are shaped by the historical context, the policy framework, the level of welfare state provision and so on.**" With this logic, Chapter 4 looked at Ghana's journey to the UHC through the lenses of both the NHIS and CHPS policies with consideration

from historical perspectives, legal and institutional frameworks establishing them, operations and others. By this, and as cited by Boidin (2018 working paper: 18 - 19) again, such analyses provide the ability to identify the institutional silos pertaining in the health sector itself and exposes how unstructured and messy policy-making can be. Marmot (2010: 13) calls for an 'integrated approach across the social determinants' in such a manner that greater impact of such policies can be manifested.

The literature on institutional complementarity places emphasis on the leverage that can be gained by obtaining a desired outcome based on the utility of working in partnership with and on the reliance on the strength of more than one institution. Höpner (2005) explains that the term complementarity stems from the Latin word 'complementum' which translates into "that which completes'. That for desired outcomes, the functionality of one institution is that "the performance of a configuration increases when its elements assume specific properties". Deeg (2005) echoes same idea saying "the co-existence of two or more institutions enhances the functioning of each" and makes a disclaimer that although the notion of complementarity seems alluring to the workings of organizations, its use and effectiveness in producing change remains complicated. Höpner (2005) cites the example of complementarity observed in the imposition of higher tariffs on goods such as alcohol and cigarettes that have the combined benefit of good health and revenue generation. Deeg (2005) suggests that "A better understanding requires that we embed complementarities within a more general theory of institutional change which takes a broader view of the ways in which institutions interconnect and change." Boidin (2017) explains that the application of such concepts in expectation of achieving health objectives can be particularly difficult if generalized and applied to the context of health systems in Africa for many reasons not limited to the fact that 'deficiencies are particularly significant in Africa' and "health policy making tends to proceed very much by trial and error". Complementarities could exist within and outside of institutions aiming for similar objectives. For instance, complementarities may be sought for within a government ministry such as the Ministry of Finance and Economic Planning that manages the finances of Ghana and one of its agencies, the Ghana Revenue Agency, responsible for collecting taxes and others – both seeking to mobilize and manage finances on behalf of the state. External complementarity among institutions in different agencies or ministries may be seen for example, in efforts by the Ministry of Health pursuing projects aimed at improving the living conditions of women (through exemption

policies under NHIS) and similar programmes under the Minsitry of Gender, Children and Social Protection (MoGCSP) which focuses on improving the living standards of women and children including health.

The capacity of health systems in low-income countries has been noted as one of the critical healthcare challenges – that the absence of functioning infrastructure remains the bane of poor quality healthcare delivery. In connection with the Dahlgren and Whitehead's (1991) framework, healthcare services play a crucial role in determining the health of a people and for the Ghanaian situation, **the absence of point-of-entry primary health care delivery resources such as adequate number of doctors, nurses, Community Health Workers (CHWs) equipped with access to requisite reliable supply of medical implements including appropriate infrastructure such as road networks, electricity etc. make the work of policy makers and health practitioners to implement effective policy difficult** (Stuckler et al., 2010). Rowden (2009: 45, 165 - 169) is cited as indicating a critical call made by the health donors such as the Global Fund, World Health Organization (WHO) and others on the need to assist in strengthening countries' public health systems in order to mainstream the health goals. **In relation to internal complementarity, the NHIS and the CHPS seem have two perspectives**, first is the unique manner in which they both **exist under the same ministry but operate under two separate implementing agencies** and yet **manage to work together in providing health services** (this occurring through the decentralized healthcare system that exists). The **second perspective** which is dissimilar to the first, is **how within the same health sector, under the same ministry and working towards a common goal of the UHC, one policy seems to have been made primary with legal backing and a sustained funding route** but the other, being **the CHPS without any legal backing** and although with financial support (with heavy reliance on donor partners for implementation), this route cannot be said to be reliable in terms of sustainability as donors tend to change priority in terms of years spent in a particular country and also, the quantum of support to give each year. With this the issue of the CHPS (which addresses more extensively the PHC) being saddled with the challenge of about 60 percent of the compounds being partially equipped and without accommodation for CHOs with the added challenge of a lack of recurrent operational budgets presents a health system with weak capacity to expand further its operations and impact. Within the **internal complementarity perspective, there is also the challenge of uncoordinated funding objectives by donors within the same**

sector which is affecting the operations of the CHPS as some key aspects of implementation are left untended. Is it then surprising that after over a decade of the CHPS scale-up, coverage remains at only 5 percent? Stuckler et al., (2010) point out that some of the underlying factors to the logistical challenges of healthcare systems are recurrent political and **economic crises**, with the latter **evidenced in the Ghana case**, as evidenced in Chapter 3. They note that many countries under SAPs in the 1980s made little to no investment in their public sectors.

The challenges facing the entire Ghanaian health system have been summarized as **"limited access to health care (geographical, financial and physical); inadequate service quality; inadequate funding of health services; inefficient allocation of resources; poor community, inter-sectoral and private sector linkages"** with these compounded further by the issue of brain drain among health workers with low remuneration (Asenso-Boadi, 2010: 155). For many of the Community Health Workers (CHWs), living and working conditions have been complained about and which as represented in the SDH framework (under working conditions) affects a broad spectrum of issues not limited to the poor quality of care delivered but also, the brain drain issue mentioned under Chapter 3. The lack of institutional complementarity and a poor reflection of the health system is revealed with a look at the fact that donors who operate within the same sector have uncoordinated efforts towards achieving the implementation of the CHPS policy. While the two health policies being implemented in pursuant of the UHC goal are similar in so many ways, they remain distinct in their approach to addressing the different aspects of the UHC. A relevant distinction which Xu et al. (2015) make and insists could be ignored is the fact that UHC is not synonymous with universal insurance coverage, that an implied component is that the availability of basic health services which are delivered and made accessible translates into effective coverage. This is what the CHPS seeks to achieve through the provision of the basic package of services[43] to a CHPS zone but which due to capacity constraint has not fully materialized to considerably increase in coverage over the years. Xu et al. (2015) emphasis that, effective coverage means that basic health services are available and accessible, and delivered with high quality and this dimension of UHC should not disregarded during implementation.

[43] The basic package of services rendered to a CHPS zone by the Community Health Officer and Community Health Volunteers include community linkage and outreach services; basic clinical services; and management of activities, logistics, and services (CHPS Implementation Guidelines, 2016: 20).

The second perspective of the issues raised which do not fall within the purview of the health sector but which have influence over it under this chapter can be seen in several ways. In order to achieve the delivery of high quality health services in a bid to attain appreciable levels of the health goal, there is need for sustained financial resources and economic stability that can spur on the policies initiated in the health sector and all others as dictated by the SDH. The economic policy in Ghana fall under the Ministry of Finance and Economic Planning (MoFEP) but a glance at the current economic situation and the fact that the usual support system that comes from external sources to the health sector has experienced and could see a further decline, present mixed feelings about how quick and consistent actions towards the health goal would be and also, how future economic policies could affect the health sector. The structure of the economy has not changed significantly over the years with overdependence on the commodities' export sector. This will have dire consequences on fiscal space for the social sector under which health falls and where the SDGs gather. But there is, as Manheimmer et al. (2007) explain, a policy window that has been opened with all the challenges confronting a new government which desires to fulfill the electoral promises of its people (Lindblom, 1968; 55) and an opportunity for the full and explicit adoption of the HiAP with signs of hope in the Government of Ghana's 2019 annual budget which took into consideration all the SDGs in budgeting for each sector, a first on the continent. It also made a shift in favour of the social sector. The relevance of budgets and their impact on the place of policy items on the agenda of government is explained by Kingdon (2011: 105), that budgets act as either promoters or constraints. This has potential influence on the education sector where health workers are trained, influencing the quality and number that can be produced each year. It has potential for the infrastructure development which as described under the CHPS is lacking in number and the quality in terms of equipment for already constructed ones. The infrastructure development also presents opportunities for agriculture and food production (especially in the rural areas where bad roads often prevent the transportation of food), for job creation for the labour in the informal sector and others.

Conclusion of Chapter Four

This chapter took special interest in the two healthcare initiatives charged with the mandate to help the country achieve the UHC goal - the NHIS and CHPS. This decision was premised on the

logic proposed by Sackey and Amponsah (2017) that, **“the wealth of every nation is partly dependent on the health of its people”,** a subtle acknowledgement of the need for HiAP approach as captured by the National CHPS Policy (MoH, 2016: 12) that **“……up to 80 percent of illnesses could be prevented by the combination of improved nutrition, adequate clean water supplies, education on personal hygiene, family planning, vaccination services, treatment of common ailments and injuries”** and also because, as explained by Bitran (2014: 1**), “efforts to achieve UHC are characterized by increasing needs for public financing…..”** and goes on to cite the initial capital outlay that was required to start the implementation of the NHIS.

Both initiatives looked at under Chapter 4 are in the same health sector with similar yet divergent actors (Agyepong and Adjei, 2008). **The histories behind both are different and yet they both seek to achieve the same goal of the UHC**. The context of the actors, while in the same sector, may seek different outcomes with health financing approaches for the NHIS and expansion of healthcare, infrastructure development, human resource management for the CHPS. The chapter covered issues of the SDH in connection with the socioeconomic, cultural and environmental conditions under which Ghanaians live and work with influences on health outcomes. These would be of relevance to the discourse of the UHC, in theory and in practice with the support of primary and secondary data analysis in section two of part 3. It is important to acknowledge the strong presence and contribution of the informal sector/economy in Ghana at this point (considered under the SDH earlier) because of its potential connection to the NHIS’ subscriptions, fiscal sustainability, linkage to the CHPS and the UHC and the other concepts and initiatives such the HiAP, SDH and the SDG, under consideration in this dissertation.

In Ghana, the informal sector is an important component of the economy; employing many people and contributing to economic growth and development (Grant and Oteng-Ababio, 2012). Grant and Yankson (2003) are of the opinion that about 40 percent of the population of Accra in 2000 was engaged in the informal sector. Similarly, Appiah-Kubi (2007) contends that the informal sector contributes within the range of 20 – 40 percent to the economy of Ghana and indeed experienced an increase in labour force participation from 79 percent to 86 percent between 1987 and 1999. In spite of its importance to the economy of Ghana, the informal sector does not have a singular positive depiction in public policy. Bitran (2014: ii) observes a

challenging pattern with enrollment and financing associated with developing countries' efforts towards the expansion of health insurance coverage – **that there is an initial coverage for formal-sector workers, followed by coverage for the poor with the "missing middle" being the informal sector workers who are left behind.** As earlier explained in Chapter 3, there is the challenge of increased unemployment in Ghana exacerbated by the economic stability and growth policy choices. It is explained that by the informality of informal sector workers' activities which are often not bound by formal contracts, the population found in this category may be able to evade income taxes mainly because local tax institutions are unable to assess, and tax them (Bitran, 2014: 2). They are also known not to belong or contribute to a social health insurance (SHI) and for tax purposes may misrepresent their actual incomes. Economic reforms have been blamed for the ballooning size of informal employment, in particular the impact of stabilization and structural adjustment policies' contribution to the negative socio-economic conditions including a rise in the rate of poverty (Bitran, 2014: 2, 11 – 12, 17). For all employment in Ghana, 80 percent are said to be traced to the informal sector. As earlier stated, the enforceability of the law compelling all citizens to enroll on the NHIS is weak and thus, the equivalent $10 premium per household remains uncollected. It is a known fact that the government is having challenges in enrolling the population found in the informal sector with only 22 percent of workers in the informal sector enrolled as at 2006 (Bitran, 2014: 39).

A **key concern for the UHC in Ghana is the sustainability threat** of the NHIS which has been highlighted as a main challenge plaguing the initiative (Alhassan et al., 2016; Odeyemi and Nixon, 2013; Bitran 2012: 26; MoH, 2016: Proposed Redesign and Restructuring of the National Health Insurance Scheme Main Report: 33). Some of the reasons for this include the seemingly wide exemption base (more than 60 percent of active members of the scheme) granted to different categories of the population with coverage for about 95 percent of all diseases in the country (Odeyemi and Nixon, 2013; Bitran, 2014: 6; Chankova, Atim and Hatt, 2010) and without expectation of co-payment. Some authors and health professionals have criticized the implementation mode of the scheme as being **"overly generous and financially unsustainable"**. In a report of a Committee established by the President of Ghana to resdesign and restructure the NHIS in 2016, it reports that 'It is important to note upfront that in the design decisions around the NHIS in 2003 there is no evidence that the capacity of the country to pay for the benefit package was ever explicitly taken into account and explained to Ghanaians. In that

connection, it is important to note also that when Ghana launched the NHIS in 2003, no other country at that level of income per capita (then well below $1000 per capita) or health spending per capita (even now still at about $60 per capita), had ever attempted such a sweeping and highly ambitious social health insurance reform with such a benefit package, acclaimed all over as very generous, without any cost controls of any kind to moderate the foreseeable expenditure growth'.

This calls into focus the concerns raised by Cotlear et al. (2015: 20 - 23) on the UHC Cube (explained in detail in section 2.1 of Chapter 1) and some of the implementation questions that may need to be asked, that "should more people get smaller benefit package or fewer people a larger package?" But is it not for the benefit of the poor and vulnerable in society that an initiative such as the NHIS and by extension the UHC would be deemed relevant? That the factor that allows many poor people access to healthcare, with its increasing financial burden, is through solidarity which is a key formative component of the risk pooling quality of the UHC (Ayé et al., 2002). The soundness of the mutuality/solidarity dimension to both the NHIS and the CHPS is theoretically and empirically grounded. Indeed, it has been pointed out that countries found in the Sub-Saharan African sub-region tend to depend on the third system of social regulation of solidarity, donations and mutual aid for survival due to the inability of the state to assume all of its responsibilities (Ayé et al., 2002). The usefulness of traditional institutions in providing innovative apparatuses for "indemnifying community members against the costs of unforeseen ill-health……" is known and these institutions hold much promise for Africa (Ichoku et al., 2013) and ultimately, the timely achievement of the UHC. The NHIS emerged from existing mutual health organizations at the community level in 2003 (Fusheini et al., 2012). The successes of the NHIS have been well-documented – the swift and considerable population coverage of 67.5 percent by June 2009 although disputed by an Oxfam publication in March 2011 (Fusheini et al., 2012); its impact on declined Institutional Maternal Mortality Ratio (IMMR) from 224 per a 100,000 live births to 144 per 100,000 live births within the period (2008 – 2014); and infant mortality rates also witnessed a decline from 64 per 1000 live births to 41 per 1000 live births within the period (2003 – 2014) (Alhassan et al., 2016). And despite all the observed health outcomes, Odeyemi and Nixon (2013) discovered evidence of **"strong inequalities" in the NHIS implementation** in Ghana.

The issues are myriad and complex with different mandates and interests of the actors involved and all the global demands emanating from the expectations of attainment of the UHC and also, the SDGs with an agreed time frame within which to work. The expectations are high as Ghana remains a trailblazer on the African continent. There is some evidence of the HiAP at play among some notable sectors, namely, the Ministry of Finance and Economic Planning (which allocates resources for the activities of the two health initiatives and even during negotiations for Extended Credit Facility (ECF) arrangement (ECF) made an effort to protect the health sector from some of the conditionalities imposed), the MoH, the Ministry of Gender, Children and Social Protection (MoGCSP) (where a key cash transfer program for the poor and vulnerable incorporates the exemption policy of the NHIS) and the Ministry of Education, where two agencies under two different sectors (the Ghana Education Service and the Ghana Health Service) are collaborating to prevent a health epidemic in educational institutions. Efforts at intersectoral approach to development towards economic development has been cited by Bawumia (2010: 68 – 69) but this does not necessarily reflect a strong presence of HiAP.

BOX 12: RELATIONSHIP OF CHAPTER TO HYPOTHESIS OF STUDY

To a great extent, the hypothesis for this chapter being ***"The Universal Health Coverage (UHC) objective, the National Health Insurance Scheme (NHIS) in Ghana cannot be achieved as it is, without an inter-sectoral approach"*** has been substantiated (but requires further studies) due to the results of the UHC journey so far covered being mixed and there seems to be congruence between this limited results and the deficiencies of public action in terms of the HiAP.

PART 3: EMPIRICAL STUDY: INSIGHTS FROM THE FIELD AND ANALYSIS OF HEALTH INITIATIVES

Introduction

The third and final part of this dissertation focuses on the detailed empirical study. Presented here are chapters 5, 6 and 7. Chapter 5 focuses on a description of the research methods, highlight of the researcher's background. Chapter 5 also focuses on the sources of data and explanation of the conceptual framework used in the selection of the key informants for primary data collection. Chapter 6 discusses the various key informants, their responses and those of subscribers and non-subscribers. A comparison of this dissertation to one other study conducted

on a similar subject area is made. Chapter 6 additionally presents main results of the comparative analysis and discussions are made of the findings.

Chapter 7 presents perspectives of data collected from the field and the literature. Using the Dahlgren and Whitehead (1991) SDH framework, some selected sectors are given emphasis and discussed using the information from the empirical study, the comparative analysis of the other study and the literature. The second section of Chapter 7 presents perspectives of the possibility of adoption of the SDH and the HiAP and concludes with assessing progress of Ghana's UHC journey based on the Framework for Action on the UHC in Africa.

CHAPTER 5: FRAMEWORK AND RESEARCH TOOLS FOR THE EMPIRICAL DATA COLLECTION OF THE UHC IMPLEMENTATION IN GHANA

Introduction

This research is predominantly qualitative case study of a national policy which depends on triangulation (the use of various techniques in accessing and assessing the different aspects of a social phenomenon) (Agyepong and Adjei, 2008; Olsen, 2004). The objectives of this study are

to analyze the ways by which the universal health coverage is being implemented in Ghana and to establish the presence or otherwise of the HiAP approach using the SDH concept. The present study aims to make a modest contribution to the already existing repository of knowledge on the UHC implementation but more specifically, the place of the SDH in the health system of a developing country and how it can support its quest for the UHC's attainment. It does this by contextualizing the SDH in the case of Ghana and ascertaining the presence or absence of the HiAP in the policies of the country. It takes a multisectoral view to assessing the presence of the SDH.

The methodology was based partly on Agyepong et al. (2016)'s article on the **"Universal" in UHC and Ghana's National Health Insurance Scheme: policy and implementation challenges and dilemmas of a lower middle income country**. In their study, the aim was to seek comprehension of the reasons why the enrollment figures under the NHIS has stagnated and what the outcome means for the policy implementation, its design and import for UHC. It was set in one of the ten regions of Ghana (Volta Region). There are common areas in their approach in relation to this dissertation; however, this dissertation deviates from it in a number of ways (see Tables 31 - 35 for similarities and differences between the two studies).

In the ensuing sections 1 and 2, there is a presentation of all approaches used in undertaking the research. The first section (1) describes the context of the research and the author, where an explanation of the background of the author is given which has a bearing on the manner the research was conducted. Second, the research methods (2) – here, the qualitative and quantitative methods used, the mixed methods research (MMR), and an indication of the data collected and their sources (3) are provided. In 2.3, there is a presentation of the interview topics and guides and data analysis, discussed in 3. And finally, there is a description of the conceptual framework under 4.

CHAPTER 5 NAVIGATION CHART

CHAPTER FIVE FRAMEWORK AND RESEARCH TOOLS FOR THE EMPIRICAL DATA COLLECTION OF THE UHC IMPLEMENTATION IN GHANA	
Section 1: Contextual considerations of research and methods used	Section 2: Mode of data collection and conceptual framework
1.1 The context of the author undertaking the research	2.1 Data collection and sources
1.2 Research methods	2.2 Data analysis
1.2.1 Qualitative and quantitative research methods	2.3 Selection of actors relating to the conceptual grid
1.2.2 Triangulation/Mixed Methods Research (MMR)	
Key words: Data, research methods, conceptual framework	

Section 1: Contextual considerations of research and methods used

This section places the author in context (1.1), thus her prior and current relationship with the case study and the policies under consideration. The various research methods and reasons for such preferrences are described in 1.2, 1.2.1 and 1.2.2 respectively.

1.1 The context of the author undertaking the research

The context of the research is described as the implementation of a global health goal (UHC), translated as a national policy in a Sub-Saharan African setting. The national health policy, as implemented in a developing country, is observed through the lenses of the SDH (which is an academic concept which sets the parameters for how health outcomes can be achieved), seeking to establish the existence or otherwise of a progressive approach which has been proven to be of significant use in facilitating the promotion of health in states' or governments' policies in many settings. Part of the **Explication of context and purpose** principle is the dimension of disclosing the background of the researcher (this often happens in sociology and psychology) (Barker & Pistrang, 2005) but encourages better comprehension of the context of all research, appropriateness of methods used, transparency in data collection, appreciation of and application of ethical guidelines used and other research protocols. The Figure 14 explains the context of the author of this dissertation.

Due to the background of the author, the data collection methods and the subject area were familiar and the impact of the field challenges that a researcher without such a context would have faced were limited. Also, due to familiarity with the health sector, the two policies and the terrain, key informants were contacted with much ease than if the researcher were not familiar. Due to same contextual factor, the snowball sampling method was effective and easily applied as first line key informants felt confident and comfortable in referencing subsequent key informants.

FIGURE 14: CONTEXT OF AUTHOR

Source: Author

Explanation of the Figure 14: The author is a Ghanaian, born, educated and lives in the country under study. She has had prior exposure to the phenomena under study - the NHIS and CHPS, through work as an independent Consultant to the National Health Insurance Authority (NHIA) and the Ministry of Health (MoH) respectively. The author has previously had firthand experience with the exempt category of the free maternal care policy under the NHIS. Finally, due to the nature of her study (co-tutelle) which allows her to spend part of her study time in both France and country under study, she had first-hand information (all through the research period) with regards to on-going national policy shifts across all relevant sectors, insights of which were incorporated into the research. Under this study, the author could be considered as a "research instrument" when the author spent time in 2016 as an intern with the NHIA, gathering data as a participant observer. This approach[44] served to enhance validity of data collected from primary (author's perspective and others) and secondary sources.

[44] For similar approaches used in previous studies refer to Mechanic D. (1989).

1.2 Research Methods

This research was undertaken using multidisciplinary approaches with a focus on the framework method, observational methods, qualitative and quantitative methods. The use of the Framework Method is not new, its use dates back to the 1980s (Gale et al., 2013). They explain that although previously used in large-scale social policy research it has become a popular approach in medical and health research. The choice of the framework method was based on its strength in allowing the researcher to interrogate different themes (a common feature of qualitative data analysis) concurrently. It is not a known affiliate of any particular "epistemological, philosophical, or theoretical approach" but rather works well to incorporate them if need be. The different frameworks used in the dissertation are the Dahlgren and Whitehead (1991) SDH framework, the Kingdon multiple-streams and agendas, alternatives and public policies (2011) and the Conceptual Framework developed by the author, with all these guided by the concept of complementarity. The application of the SDH framework was used in explaining the social determinants of health as pertains in Ghana. This framework helped in first, the selection of key sectors which needed focus in the discussion of the UHC specifically, and health in general in Ghana. Secondly, the selection of the key sectors and their subsequent discussion under the SDH, helped in exploring the presence and/or application or otherwise of the HiAP in the country and also the presence of complementarities among the various actors/institutions in the possibility for change.

The aspect of the literature review in section 2 of Chapter 2 which delved into policy-making and was captured in the Conceptual Framework for the dissertation, allowed for the research to: (1) contextualize the implementation of the UHC, NHIS and CHPS in light of policy discussions as pertains to the Ghanaian situation; (2) select the policies, constituents in the policy environment (such as the economic policies related to the IMF/World Bank, corruption - as seen in the implementation of the NHIS/CHPS, technological advancement - also found under the SDH/HiAP etc.). The actors defined in the conceptual framework guided the respondent categories for the data collection for the dissertation, discussed in this and the subsequent chapter.

It was deemed necessary to use triangulation for the research as being holistic in nature and allowing for the strengths of both the qualitative research part and reliance on the numerical strengths of quantitative method – it helped establish the relationships among the variables in the data set and links among the numbers from the data collected from the field.

1.2.1 Qualitative and quantitative research methods

The choice of the qualitative research method helped to incorporate aspects of participant observation, interviewing (key informants interviewed were 17 and the beneficiaries of the NHIS were 150), review of public policy documents, media reports and historical records on the social phenomenon under study (Agyepong and Adjei, 2008; Bryman et al., 1996). There are merits to the choice of qualitative research approach for this dissertation. One of the main strengths of this research method is that it is able to generate information not existent elsewhere – with unique combinations of methods such as questionnaire administration, the author being an observant, use of other similar research works, key informants and others. This method is known to have an appreciation of the inherently subjective nature of social interactions (Olsen, 2004).

Some criticisms leveled against this research method is that, firstly, it represents an assembling of anecdotal personal impressions gathered over a particular phenomenon and which are subjective due to the researcher's biases, secondly, it lacks reproductibility that due to the its closeness to a researcher, no assurances can be given that similar work or outcomes can be achieved should another researcher undertake same research endeavour. Another criticism is that it tends to render detailed information about rather smaller number of settings and magnifies outcomes unnecessarily (Mays and Pope, 1995). While in this research respondent opinions were sought on different variables predetermined in the questionnaire, a simple tally was kept of the frequencies of responds which resonated with those of other respondents, thus, making an appreciation of the numbers/frequencies of similarities or differences in responds to variables in the qualitative data. Thus, the study allowed the numbers to also tell a story. But such an approach has been criticized and also justified, as cited by Bryman, Stephens and Campo (1996: 357), **"While this quantification of qualitative data is not liked by many exponents of qualitative research and seems to erode the differences between quantitative and**

qualitative research, as Silverman (1984) has observed, simple counting can be very helpful in determining how far a set of results is representative of a whole data set".

Data collection under this study occurred at different times and in phases. The year 2015 was used in defining the topic for study which involved reading different materials and refocusing. The researcher, as part of the qualitative data collection opted for an internship position with the NHIA for a period not less than six weeks – this occurred in 2016. By this, the author also became part of the research as a participant observer - relying on daily interactions with staff, internal processes and systems, participation in meetings and events and exposure to information and culture, to gather important information which an outsider would not be privy to (see Annex 6 for Account of Internship with NHIA and refer to Mechanic D. (1989) for relevance of this approach). Based on insights gathered, an exposure to a wide network of professionals (in the health sector and others) and a better structuring of the research problem, the initial data collection instrument was designed. After a pre-testing of the instrument on selected key informants in the sector including members of the Parliamentary Select Committee on Health, service providers and some key policy makers who were part of the initial set-up of the NHIS, the Conceptual Framework for the Dissertation was designed which spelt out the various relevant actor categories in the implementation of the UHC in Ghana (see figure 4 of section 2 in Chapter 2 for detailed explanation of the framework). Based on this framework, the earlier research instrument was redesigned to cover the different actor categories in the framework and subsequently, administered. There were two types of qualitative data collection at this point – an interview guide for key informants and a questionnaire for subscriber/non-subscriber categories. In 2017, the data collection commenced with first acquiring a list from the NHIA of key stakeholders (obtained from a broad stakeholders' event which occurred during the internship period), scheduling appointments and attending interview sessions. The three regions which were selected for the data collection were the Greater Accra, the Eastern and Central regions. The choice of these regions was based on proximity to the capital. During the analysis and composition of this dissertation, continuous updates on activities and policies of the NHIA were collected and infused from the research department. Cessation of that process occurred upon submission of the final draft of the dissertation. Data collection, documentation and analysis of data occurred concurrently from 2015 – 2019 with modifications made based on direction of the Professor.

Quantitative research method

From the responds to the questionnaire administration, interviews with key informants and institutional representatives, tables were generated to collate the information gathered. Frequencies in responses were collated with the help of Microsoft Excel and used in generating graphs which served to indicate trends. In total 250 people responded to the questionnaires but only 150 (fifty for each of the three regions) were deemed useful due to the non-response rate for the bio data component of the questionnaire rendering it difficult to categorize responses.

1.2.2 Triangulation/ Mixed Methods Research (MMR)

"There is some truth in the quip that quantitative methods are reliable but not valid and that qualitative methods are valid but not reliable." Britten and Fisher (1993)

The term Mixed Methods Research (MMR) (Fielding, 2009), is explained as the approach of mixing different methods of research in such a manner that there is an eventual reflection of diverse viewpoints on the subject under consideration (Olsen, 2004; Mays and Pope, 1995; Fielding, 2009). There are strengths and weaknesses in both the qualitative and quantitative methods and hence to gain better insights into the research, both methods were adopted, albeit on a limited basis for the latter method. Barker and Pistrang (2005) point out that it is of no use pitting one approach against another, that a strategy of collaboration could be sought.

The use of mixed methods of qualitative and quantitative methods for this research was considered relevant because both act complementary to each other - here, due to the need to rely on response to key variables in both the questionnaire and interview guide, synergies had to be sought using the Microsoft Excel.

TABLE 16: RESPONDENTS IN DATA COLLECTION

Category of respondents	Number of respondents
Policy makers	3
Service providers	2
Development partners	6
Legislators	2
Academia	3
Trade Union's Congress (TUC), Social Protection section – workers' union	1
Subscriber/ Non-subscribers	250

Source: Author

Respondents' disaggregation

The data collection was viewed from two angles - urban and peri-urban segments in terms of subscribers/non-subscribers. This logic of this disaggregation emanated from the work of Galbraith et al. (2005) revealing that in an effort to access healthcare, socio-economic disparities exists for both children and adults, with consequent health outcomes. In his work, the point is made for the need to disaggregate the demographic constituents in any research discussing access to healthcare due to the fact that the different constituent have unique needs and require different attention. Hence, the research made room for also sex, age, employment status, and subscriber and non-subscriber disaggregations among respondents.

With all these categories in Table 16 guided by open and close ended questions, some responses fell under common and different themes which were categorized and inferences made. Also, there was reliance on some national surveys and other fairly recent studies undertaken with similar themes (GLSS6; GSGDA II 2014-2017; HSMTDP 2014-2017; Agyepong et al., 2016; Amu and Dickson, 2016; Asamoah et al., 2014) on the NHIS in previous years with similar

variables as in the dissertation – results from these studies were also used in the discussion. This added not only validity to the research but also, presented a widespread view of the research of the UHC in Ghana. With the combined outcome of the analysis, seen in both qualitative and quantitative, added much value to the research outcome.

TABLE 17: OTHER STUDIES ADAPTED IN SUPPORT OF ANALYSIS

Title of Study	**Authors**	**Type of Study/ Document**	**Date of Publication**
GLSS6	Ghana Statistical Service	Nationwide household survey	2014
GSGDA II (2014-2017)	National Development Planning Commission (NDPC)	Fifth in a series of Medium-term national development policy frameworks' document.	2014
Health Sector Medium-Term Development Plan 2014 -2017	Ministry of Health, Ghana	A national development plan for the health sector	2014
Ghana Demographic and Health Survey 2014	Ghana Statistical Service, Accra-Ghana	Population and health survey	2014
The "Universal" in UHC and Ghana's National Health Insurance Scheme: policy and implementation challenges and	Agyepong et al.	Cross sectional case study using mixed methods	2016

dilemmas of a lower middle income country.			
Health insurance subscription among women in reproductive age in Ghana: do socio - demographics matter?	Amu and Dickson	Case study using bivariate descriptive analysis and binary logistic regression	2016

Source: Author

Section 2: Mode of data collection and conceptual framework

This section presents information on the sources of data (2.1 and 2.4), the interview topics and guides in 2.3 (with full details in Annex 4). The section also presents how data was analysed in 3 and gives a description of the conceptual framework based on which the actors in the policy framework pertaining to the NHIS were selected in 4.

2.1 Data collection and sources

Data collection used was a mixed approach, through the use of primary and secondary data - conducting interviews and the use of published data and working papers also. Mixed methods research (MMR) has been a subject for much debate within the academic arena, especially with regards to qualitative research. Objections have been raised about its combination of varying methods with somewhat different epistemological leanings (Fielding, 2010). The combined use of MMR and other forms of data is considered “a practical necessity” because as it’s explained, the contexts of the questions for inquiry and the policy evidence tend to require different methods (Fielding, 2010). See Annex 4 (Pgs. 357-366) for interview guides.

2.1.1 Primary source of data collection

As part of the observation approach, the researcher spent an internship period of six weeks in the NHIA, with the research department. Semi-structured interviews were used in collecting information from actors in the Conceptual Framework for the dissertation (Figure 4). Using Kingdon's (2011) **Agendas, Alternatives, and Public Policies** as a basis for identifying and selecting the themes and the "actors" within the policy-making process, key informants were selected for the data collection. This approach afforded the policy-making process (of the UHC - the NHIS and the CHPS, as an agenda) to be dissected with respect to the distinct roles of each actor in the process. From the Conceptual Framework for the dissertation, the actors were identified as: legislators/parliamentarians, policy makers (MoH, MoFEP, NHIS, and GHS), development partners, service providers, traditional leaders, civil society, subscribers (beneficiaries)/non-subscribers and consultants (who may be institutionally independent but have a stake in the policy-making process).

A pre-testing exercise was conducted at the end of the second year of the research for some key informants in the categories of legislators/parliamentarians, policy makers and service providers. Questions remained on the research focus of the NHIS and the CHPS as health policies. Information gathered served to enrich the final interview guides for the actual data collection.

A list of stakeholders was obtained from the NHIA (the list of attendees for the stakeholders' conference attended during the internship period) from which purposive sampling method was used in selecting a minimum of twenty from each category (with the aim to interview a minimum of five). From the selected, and also using the snowball approach, after the interviews more informants were gathered representing the various predetermined categorizations. This approach is due to the fact that at the end of the day, the number of informants whose interviews would be successfully undertaken was very much dependent on, in the words of Smith (2015) **"one's sample will in part be defined by who is prepared to be included in it!"** From the experience gathered at the pre-testing stage, experienced informants sometimes agreed to an interview but due to time constraints and other personal reasons, the scheduled interviews fell through. In essence, the greater the initial number of the sample size, the better the opportunity to obtain the eventual desired number of interviews secured and granted. Informants were communicated with

(through direct delivery of introduction letters from the university, emails and telephone calls). Meetings were scheduled and interviews conducted by author. During data collection, the traditional leaders' category of actors could not be accessed due to problems of scheduling within the period.

2.1.2 Presentation of interview topics and guides

The topics for inquisitions were on the general health sector of Ghana (successes and challenges), the performance of the National Health Insurance Scheme (NHIS), policies introduced, successes and challenges. This trend also went for the Community-Based Health Planning and Services (CHPS). The questions covered areas such as coverage, actors and responsibilities in the Universal Health Coverage (UHC) journey in Ghana, shortfalls and recommendations (in the case of subject matter experts). The questions stretched to the connections between the NHIS and the CHPS and how they could work seamlessly together in achieving the UHC by 2030. The Health in All Policies was introduced, thus, for the development partners and policy makers' categories. Based on the conceptual framework, these 'actors' were found in the environment within which the SDGs, UHC, SDH and HiAP interact. Also based on the conceptual framework where the economic policies were present, contact with the Ministry of Finance and Economic Planning (where economic policies are derived for the country) was made for information concerning that main sector and others – official documents that could not be found on the website and interpretations of some national economic policies were sought as input into the study.

There were four main categorizations of the guides – questions for the National Health Insurance Authority (NHIA), those for the development partners, subscribers/non-subscribers, and other stakeholders in academia, service provision and legislation. But for the NHIA where only information about the departments were required, the rest of the key informants (institutional and individuals) had to present profiles of themselves as subject matter experts and also when it pertained to institutions, a profile of the institution, the duration of stay in the country, the contributions made so far to the health sector, areas of specialization and finally, a discussion of the topics above (see Annex 4 for details).

2.1.3 Secondary source of data collection

Since the NHIS and the CHPS were being looked at as policies with a long history and key roles played by diverse actors over time, there was no cut-off point/year for the secondary data collection. A review of published and grey literature consisting of annual reports, annual budgets from the government of Ghana sites, published online articles, editorials, journals, discussion and working papers, books on the subject of policy-making, economics, UHC, SDGs, SDH, HiAP, NHIS, CHPS, social and economic development have been gathered and analyzed.

Articles, journals, editorials, Policy research papers and books were gathered from a number of sources including Pubmed, The Lancet Public Health, Google Scholar, Health Policy and Planning, International Journal of Health Planning and Management and others. Newspapers used as part of the dissertation include, the Daily Graphic (Ghana), Business & Financial Times (Ghana), Daily Guide (Ghana), Goldstreet Business (Ghana) – these represent politically unbiased newspapers.

The search for published and unpublished studies, research papers, abstracts, press clippings and others from institutions were gathered from websites of: UNDP, WHO, UNICEF, Oxfam, IMF, World Bank and NDPC.

2.2 Data analysis

The qualitative aspect of the data collected was manually undertaken in line with the themes. Some aspects of the data collection were done in an overlapping manner. The data collection began in 2016 with a six (6) weeks term spent with the NHIA as a research intern and also as a participant observer. Notes of observations during the time spent were recorded and stored for subsequent use. A participants' list obtained from involvement in a stakeholders' forum organized by the NHIA for the review of the sustainability of the NHIS was used in determining the institutions/subject matter experts to include in respondents' list for the dissertation. Some respondents (policy makers, legislators and subject matter experts who were part of the establishment of the NHIS and a service provider) were interviewed in 2016. In 2017, a participant list obtained from the stakeholders' forum was used as basis to identify some

institutions and individuals and official letters were drawn up and delivered to them for data collection in 2017 and 2018.

All in-depth interviews and participant observations were undertaken by author (see Fig. 14) to understand the context of the author in order for readers to better understand the research questions, methods adopted and to make sense of the interpretations of findings of the research as recommended by Barker and Pistrang (2005). All transcriptions of the in-depth interviews recorded were manually contextualized based on 'policy actor' category they belonged to and synergies and contrasts were found in the responses received using Microsoft Excel, using coded variables assigned to respondents' themes which were based on the interview guide.

BOX 13: ETHICAL APPROVAL AND CONSENT

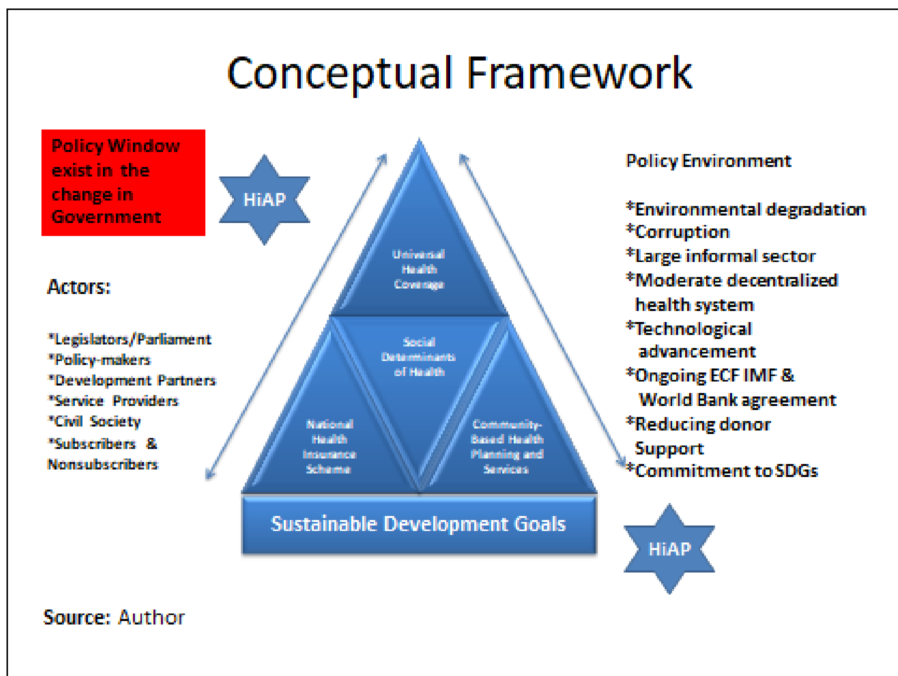
Ethical approval and consent
Formal approval was sought from all the institutions in Ghana where data was required for this study. A letter of introduction was presented to the National Health Insurance Authority (NHIA) for an "internship" period of three months - in the first year and during the pre-testing phase, and also, permission for data collection sought in 2017. Permission was granted at both times. Verbal consents were obtained from selected key informants in the various actor categories in the Conceptual Framework of the Dissertation before interviews and data collection exercises commenced.

2.3 Selection of actors relating to the conceptual framework

Presented under this sub section is the conceptual framework that guided the selection of the 'actors' in the policy environment in Ghana for data collection. The Figure 15 is same as the Figure 4 under section 2 of Part 1 (Pg. 94) in principle but it has been repeated here to explain how the actors in the framework guided the selection of key informants and institutions for the data collection, and as part of the approach for this study. Based on Kingdon's (2011) agendas,

alternatives and public policies, the different constituents in the policy-making process were identified and used in designing this framework based on the conext of Ghana.

FIGURE 15: CONCEPTUAL FRAMEWORK FOR DISSERTATION – POLICIES, CONTEXT AND ACTORS



The figure above depicts Ghana's current environment with economic policies being structured under the Extended Credit Facility (ECF) with the International Monetary Fund (the IMF and World Bank) with corresponding market-oriented prescriptions and an attempt at fiscal discipline. This environment within which the pyramid of a structure (amidst the Social Determinants of Health, the Universal Health Coverage as represented by the National Health Insurance Scheme and the Community-Based Health Planning and Services, at the apex which is the focus of this study with the timeline of 2030 exists, has dwindling donor support (which has been occasioned by the country's elevation into middle-income status), corruption (as seen in terms of both institutional and political here with its consequent effects on investment in the health sector), environmental degradation and technological advancement (innovations in the telecommunications space are explored in relation to the NHIS and the CHPS which often serve populations in the rural areas). Within this environment is the new government's commitment to achieving the the Sustainable Development Goals (SDGs). As advanced by Kingdon (2011:

165), there exists a policy window for the adoption of new and innovative policy ideas. The actors' and their unique roles are also placed in the environmental context. They are used as source of data collection and a means of validation.

Conclusion of Chapter Five

In this chapter, the modalities for undertaking the research have been presented in terms of the context of the author and the methods used in collecting the data. The context of the author was that, the author had been exposed to the two policies under consideration for achieving the UHC in Ghana as a consultant to both the MoH and the NHIA. The benefits of this context was experienced during the contacts with key informant for interviews and enhanced the snowball sampling method used in selecting some more key informants. The conceptual framework which is based on the Kingdon (2011) agendas, alternatives and public policies, was used as a guide in selecting the different categories of actors for the data collection. The different phases of the data collection (primary) were useful for filling in gaps in information gathered over time.

CHAPTER 6: FEEDBACK FROM THE KEY INFORMANTS

Introduction

This chapter examines the empirical results of the study. The aim of the chapter is to contextualize the responses of the various actors selected based on the conceptual framework. The outlook of each actor in the policy-making and implementation of the UHC as seen through the NHIS and CHPS is taken on board here in the form of perspectives. In total, seventeen key informants were interviewed with diverse professional and specialist backgrounds and influences on how the UHC is implemented in Ghana – essentially, their viewpoints (sometimes embodied as institutional representatives) would help shape the narrative concerning the UHC journey to success. It presents a synthesis of both the empirical and literature study. While the empirical study focuses on three regions (Greater Accra, Central and Eastern), the comparative aspect draws insights from the Volta region.

CHAPTER 6 NAVIGATION CHART

CHAPTER SIX FIELD DATA, ANALYSIS AND PERSPECTIVES		
Section 1: Results about the NHIS, CHPS and impact on the achievement of the UHC	Section 2: Disincentives for subscription on the NHIS	Section 3: Analysis of field data
1.1 Overview of key informants and institutions interviewed	2.1 Reasons for NHIS non-subscription	3.1 Basis for selection of the study of Agyepong et al. (2016) for comparison
1.2 Key informants' responses (policy makers, legislators and institutions)	2.2 Other relevant results	3.2 Main results of the study of Agyepong et al (2016)
1.3 Feedback from institutional representatives	2.3 Length of NHIS subscription	3.3 Graphical representation of findings
1.4 Subscribers and non-subscribers' responses to questionnaires	2.4 Alternative means of accessing healthcare (non-subscribers)	3.4 Comparative analysis of findings of the empirical and Agyepong et al. (2016) studies
Key words: Field data, NHIS, CHPS, key informants, enrollment		

Section 1: Results about the NHIS, CHPS and impact on the achievement of the UHC

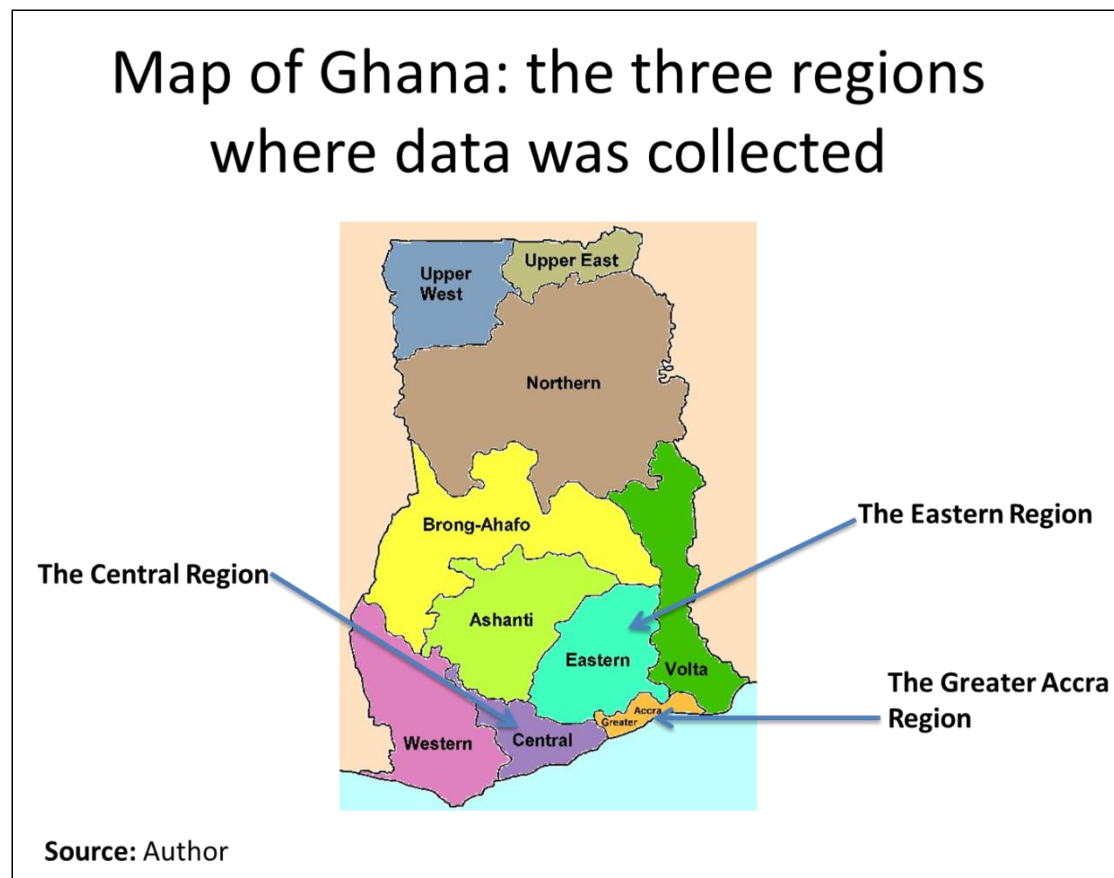
Introduction

This section of the study focuses on the presentation and discussions of results from the questionnaire administered to the different categories of actors found in the conceptual framework of the dissertation. These consist of individual subscribers and non-subscribers of the National Health Insurance Scheme (NHIS), legislators, development partners, service providers, policy makers and staff of NHIA. This section presents responses from key informants (section 1.2), feedback from institutional representatives (section 1.3) and feedback from subscribers and non-subscribers (section 1.4).

The data in this section represents data collected from subscribers and non-subscribers from three regions in Ghana – Greater Accra, Eastern and Central. A map of Ghana[45] showing the specific locations of the regions is presented below:

[45] Source of the original map modified for use: https://7e0b1a84-a-62cb3a1a-s-sites.googlegroups.com/site/ghanaplacenames/database/Ghana_regions.jpg?attachauth=ANoY7cqHN6kPNLekiSZeOBD3MxdFQqD6zCz_0tuldyBPnJz87F4q7BAZs_7yRqM4QCEnQkVPtdk-KSGkZEjXwQSmv2no_JODoN7d6up09UmBCD_V4t6aAlRys863u0oy9Lu9u9fkJUQOlehmxD3o4ztEm-m2_k7JqcGgqGF9uWg5SXkdOxAC3_Z5pn5VYqWsXbly9gO4Z97_Rqz6lpCwGwIyE2HcHY8hv9WHjYWRs8fG_m-Xcb1VVAI%3D&attredirects=1

FIGURE 16: MAP OF GHANA



1.1 Overview of key informants and institutions interviewed

There were a total of 17 interviews conducted for key informants and institutions in and associated with the health sector in Ghana. The specific categories of key informants are captured in the Table 18. The interview guides were different for the different categories but there were a few interviews that had cross-cutting themes (see annex for detailed interview guides and synopsis of some transcribed interviews on Pgs. 356-366 and 367 respectively).

TABLE 18: CATEGORIES OF KEY INFORMANTS AND INSTITUTIONAL INTERVIEWS

Development Partners	Local Institutions	Individuals
European Union (EU)	National Identification Authority (NIA)	President, College of Nurses and Midwives
World Health Organization (WHO)	National Health Insurance Authority (NHIA)	Medical doctor and Service Provider to NHIA
International Monetary Fund (IMF)	Trade Union's Congress (TUC), Social Protection section	Current Director-General to the Ghana Health Service/ Former Chief Executive Officer (CEO) of the Komfo Anokye Teaching Hospital (KATH)
Japanese International Cooperation Agency (JICA)	School of Public Health, University of Ghana, Legon	One of the technical advisors for the initial set-up of the NHIS and the first Chief Executive Officer (CEO)
United States Agency for International Development (USAID)	Parliament of Ghana – Parliamentary Select Committee on Health	

Source: Author

1.2 Key informants' responses (policy makers, legislators and institutions)

State of the health sector in Ghana - on the issue of current state of the healthcare delivery system in Ghana, majority of respondents conceded that for a lower-middle income country, the state can be described as not the best but not the very worst. Considering efforts made by successive governments, the state of healthcare delivery was considered progressive but with

much more left to be done. Some of the areas of concern expressed in relation to the healthcare system include macro-economic challenges combined with socio-political changes which did not bring continuity in some policy directions; the observed gap between policies introduced and their implementation; the increasing disease burden with heightened non-communicable diseases leading; poor ambulance system; poor working conditions for trained healthcare staff including doctors (with doctor-patient ratio of 1:13,000 and nurse-patient ratio of 1:6,000) perpetuating high migration; leadership and governance challenges; inadequate and poor state of infrastructure of health facilities; maternal and child health and care for the aged; and finally and the most emphasized, poor attitude of health professionals. Another frustration expressed by key informants was with the seeming lack of capacity or lack of right skills set of personnel in the system. But with observed increased health sector staff (of over 40 percent) in the last 8 years, without corresponding improvement in quality of service, much needs to be done. To one key informant, the challenge is that of the lack of supervision in the system. To this particular key informant, the appraisal system is that of a gentleman's agreement or matter of course.

> *"Well, I would say that it is difficult to appreciate the current situation without knowing where we came from, because it may not seem like a perfect situation now but you should know that it was worse. Today, I would say that access to healthcare delivery in our country has improved drastically but it is still a major challenge because where you have a disproportionate ratio for patient – doctor nationally with populations in Greater Accra having a little more than the Ashanti region and the Northern region having fewer than the two big regions, then it tells you that access to healthcare is a skewed one between the urban and rural and then between the north and the south. But in all, you will be tempted to think that it is improving and its better and it is getting better. Especially, now in the north, you have the Tamale teaching hospital now running fully. You have the Wa regional hospital almost being completed. And then you have the Bolgatanga regional hospital also coming up. So, in the nut shell, I would say that the healthcare delivery is improving even though we are not there yet……"* **Legislator, member of the Parliamentary Select Committee on Health**

- in a response to the question of the general state of healthcare in the country

The reasons for the health outcomes in the country have been blamed on capacity gaps in addition to others such as attitudinal problems of health professionals, political interference, data gaps and others. Below are responses that reflect some of the reasons for the health outcomes:

> *"It affects it a lot - for instance……when you take this maternal health support program, we were envisaging that before the program ends, we should have some strong capacity built in Ghanaians in the ministry of health who are able to deal with maternal health related issues. So for them, the idea was that, they receive the best capacity building as possible, they have an office set up, so that even for the sake of the SDGs you have someone with the idea, if you have another donor coming in with support, you have somebody to guide the process and say that, this is the data available, these are the areas I think we need support…… so we need the people, not in silos. I mean they'll tell you; well we have a PPME unit - that's a PPME unit, fine. But we do not have people - if you go to the MInistry of Health now and you ask ……..to see five staff who are good at data collection, you will not have them……. five staff when it comes to maternal health related issues - you can't have it. So we sit, and all we want to do is to form projects. We form projects, the projects end, oh we have bought cars, we've bought computers and then we start looking for the next person to give us. Yes, so I think that for us, it's more about commitment, it's more about…….making use of the resources that we have. For me, I keep saying that if there's a sector that has received more funding ever, it's the health sector. From everywhere - left, right - they receive it. So, they really have to make a change. Enough training in Ghana. People have gone for trainings over and over again. We need those kinds of fresh ideas just to be brought on board. And then we have too many political interferences. All that institutional is gone - records are not right".* **Representative from the European Union**
>
> - in response to a question on the effect of the lack of institutional complementarities observed but a response that reflected capacity of the health institutions and their effect on health outcomes.

Still on areas of concerns in the health sector, some of the respondents gave the following in order of priority:

> *"Number one is quality of care; getting value for money. If a person goes to a healthcare facility he or she must be able to access quality healthcare at the right time and with the right medication. Number two is data quality. We collect a lot of data but ours is outcome data and so you are not able to focus on processed data. So our focus should be on processed data that would help improve the health process. Number three will be maternal and new born health. It's still a challenge, our women and children are dying and it shouldn't be so."* **-USAID Representative 2**

> *"Funding for the health sector is not adequate and donor funding has gone down since we attained middle-income status. We have to pay for vaccines now. We need to get private partners and enterprises in Ghana to take up more of the work but we also need to work around issues of leadership and governance"* - **Representative 1, School of Public Health (University of Ghana)**

> *"There is a problem with the provision of quality healthcare in Ghana affecting the UHC. There are a lot of challenges pertaining to health outcomes which are attributable sometimes to not having the right equipment, lack of funding…….but for me, the bottom-line is the issue of personality traits. Generally, Ghanaians have very bad customer relations such that wherever we are we think that we are providing great service to people. And that happens a lot in the health sector. Even though it is across board, in the health sector it can be seen immediately when a person is sick and does not get the right type of care and there are consequences. The other issue is that there is no punishment for such acts which negatively affect health outcomes……this issue features annually at the health summit in Ghana (an annual affair for health sector stakeholders to review performance. Luckily, the MoH has produced a National Health Quality Strategy. And even the CHPS which is supposed to be the service delivery arm of the UHC is not being delivered as it should. The MoH should have been fully decentralized*

by now in order to empower healthcare delivery at the peripheral but it seems there is a problem with political will" - **WHO Representative**

Issues concerning the NHIS implementation in the country - all respondents agreed that the intent for setting the NHIS is laudable; however, the scheme has not been able to achieve fully the objectives for which it was set. Majority agree that at the onset of the policy implementation, the scheme performed creditably. Some respondents made reference to the previous system of healthcare financing, being the "cash and carry" and submit that it did not work for majority of Ghanaians. While the new system of NHIS has been applauded for taking off the financial burden from subscribers, the difficulty faced by government in adequately resourcing the scheme which delays payment to service providers often allows for the old system to resurface sometimes (when patients with the NHIS cards are rejected by health facilities unless they make upfront cash payments before they are treated). For both the NHIS and the CHPS, government's commitment has been cited as problematic. This has contributed to the state of the NHIS, and when asked whether the NHIS is considered top on the development agenda for the country, one respondent opined that 'The NHIS is on top of the agenda because they receive a lot of media attention and it is also because if it is done and done well, it's going to contribute to Universal Health Coverage. And if we are talking of UHC then we are looking at "AAAQ", it talks about Availability, Accessibility, Affordability and Quality. And without these we cannot talk about Universal Health Coverage.' The poor quality of service delivery surfaced in almost all respondents' answers. On the matter of whether voluntary or compulsory, the legislature interviewed indicated 'I want to believe that it is just because of the challenges of funding gap that the National Health Insurance is not enforcing the law, because the law makes it mandatory for every resident in Ghana to be on the National Health Insurance. It is in the law. It is mandatory.' Additionally, premium collection seems to be a problem as the scheme looks to depend on few Social Security and National Insurance Trust (SSNIT) formal sector deductible taxes, leaving the large informal sector unattended. One development partner observed that people are not keen to complete tasks on time - even though the sector has developed a management arrangement which has agreed on all protocols between government and partners.

The following responses were given by different respondents concerning the objectives for the set up of the National Health Insurance Scheme (NHIS) and its current level of coverage and plausible reasons for it:

> *"It was established to eliminate the struggle of patients and people in Ghana in accessing healthcare. So that people will have no difficulty accessing quality healthscare. The rationale has been met thus everybody is supposed to be rolled on, just walk in and access health. It was supposed to make quality healthcare accessible which is far beyond the "cash and carry" system. People at the remotest part of the country too can access healthcare"* - **Service Provider, 2016**

> *"The scheme has not been able to achieve 100 percent of its set objectives. The objective for setting up was to look at least basic health services. Initially when it was started, about 90 percent of diseases were taken care of, which was also problematic because the people were few. But what I believe is that the scheme should be able to take care of all accidents and accident emergencies - that is where we need health insurance the most. Secondly, the scheme should take care of all primary health cases for both maternal and child health. For instance, when someone wants to remove her fibroid and then the scheme says the private mutual should to put in measures to handle that, it is known as the reinsurance system (that's a top up of the insurance)"* - **Former CEO, KATH and current Director-General of the Ghana Health Service**

> *"It was simple. It was designed to provide financial access to healthcare. Secondly, the law also mandated the NHIS fund which is part of the scheme to help finance health system developments. If you look at the rationale behind the creation of this program we have not achieved our social purposes completely yet. Of course no system in the world can claim to be perfect but I think, from where the system was in 2008 or even middle 2009 versus now, there's been deterioration …………. Now all the reserve has been dissipated to such an extent that in 2011, the scheme which was the net lender to national institutions in Ghana has become a net borrower to pay for claims and so claim payments are*

always delayed and providers are agitated because they aren't getting paid for the services they are providing. I think by 2008-2009 the system had come to a point where it was well recognized not only in Ghana. Countries like the Netherlands, France and others invited us to come and talk about our system. Michael Moore, the TV actor in the US was in a discussion about Obama Care and he stated; "Why can't the wealthiest country on earth afford healthcare for its citizens when a tiny country called Ghana in Africa is doing it' That to me, is the peak of recognition because to feature in US presidential debate was amazing" - **Former CEO of the NHIS**

The performance and place of the Community-Based Health Planning and Services (CHPS) in the UHC journey - The CHPS which has been the alternate health policy for the attainment of the UHC was lauded by respondents on its practicality and reach into the rural areas of the country. It has been described as that health policy which can assist the country in expanding coverage nationwide. One of the challenges facing this policy as identified is the poor communication of government and other stakeholders and the poor prioritization (in terms of resourcing) on key aspects of the policy implementation. The implementation of the CHPS has been recognized as a problem – that regarding the geographical access, it has been progressive in performance. The challenge observed under the CHPS has to do with the financial access – even in the remote areas, it has come to rely on the NHIS and despite its laudable principles, except for the free maternal care component, if a patient does not carry a valid NHIS card, they will be made to pay cash. Better collaboration is required between the leadership of the GHS and the NHIA in making the two policies work in achieving the UHC. It was also observed that another challenge is that, although the the policy is technically sound and that it has been piloted over time, the resourcing in terms of staffing and equipment provision must be addressed. This observation of the reliance of one policy on the other reflects a weakness in the HiAP implementation, thus, while the ideals of one policy may be strong and sound, its collaboration with another in hopes of effectiveness and impact may not translate.

Responses concerning the CHPS elicited the following responses:

> *"When the CHPS policy was first pronounced, I sincerely believe that some government officials were even sceptical whether that was the right way to go. And it took them several years to recognize that yes, for it to reach out to everybody, that the community health concept CHPS, was the right way to go. You know, Ghana is using CHPS to address UHC, so once the CHPS concept was passed, the first - initial problem was that people were very sceptical. Some regions were very sceptical. The other issue had to do with this* ***conceptual debate*** *about "how do we go about it?", "how do we explain the terms?" So the conceptual debate went on for a very long time"* – **USAID Representative 1**

> *"The CHPS is a fantastic idea. You know when you are a poor nation like ours and completely underdeveloped, I think it is the* ***single best policy implementation*** *by President Kuffour (President of 2000-2008). You can't build hospitals for every hamlet but if we have about eight CHPS compounds across the nation, even if they don't have the most qualified nurses, the nurse's aid can provide first aid and that alone can improve mortality rate. I think the CHPS is an absolute necessity looking at our current state"* - **Former CEO of the NHIS**

> *"I mean the CHPS is high on the agenda now or it is better than it used to be. On a policy agenda scale of 1 to 10 I think it is placed more than 5.* ***You can't take politics out of anything in Ghana.*** *We can still do better on issues of human resource. I think the communities themselves are beginning to understand the fact that the future of healthcare as far as they are concerned is better with the CHPS"* – **Representative 2 from School Of Public Health**

Opinions of the efforts being made towards the achievement of the Universal Health Coverage (UHC) were asked and the following responses were given to depict the current position of the country, challenges and some of these responses were recommendations for the country to better align with the vision of the 2030 goal:

"To have a very resilient UHC, you need the needed human resource, logistics and all that. The first frontline service provider is the one that I call the community health officer or the community health worker. So if government can have access to resources to provide for volunteers in large numbers for more than two weeks, what makes government not capable of training these frontline service providers who are even the direct service providers that will supervise volunteers. You know, the previous regime, we had this (community health volunteers - they're part of the design of the CHPS). You know, their training is even more expensive than the training of a community health officer. ***But the community health officers as we speak, several of them have not been trained.*** *And you know, you pick a young community health nurse who has lived all their life in the cities and you're sending them into the community, you need to train them to understand the sensitivities of the communities, but that has not been done. In Ghana we have less than 7,000 community CHPS zones, and less than 4,000 are functioning. Less than the 4,000, you're talking about less than 1,000 with trained nurses - well the nurses are trained professionally but not trained to work in a community. So for me, if the commitment was there, that budget cannot be compared to the budget that is used to train even the volunteers. So what should happen is that, you look at training the community health officer who is the leader, to provide the technical service. Then you come to the volunteers"* – **USAID Representative 1**

Whilst there is an appreciation for Ghana's UHC journey, the concern expressed about 'the how' was raised consistently by key informants during data collection with the merits and demerits of both the CHPS and NHIS brought to the fore:

"For me, it would have been very good if we had continued with district-wide mutual health insurance. The fact is that, ***the district-wide mutual health insurance allows the community to participate*** *because we have a general assembly where we have the communities participate in the decision-making and I think that we all have the right to say that this particular doctor or these nurses are not giving the right care, or they show us disrespect and other such*

> *complaints. And that would have given information to national level to act on because Accra cannot do everything. We should let decision-making about care be at the peripheral level - it's too heavy at the top. But I think there's a problem of political will so how will the people own the process?"* - **WHO Representative**

The above opinion from the key informant is not only telling on the NHIS design but also very much on the decentralization approach in the healthcare system and the roles of the various actors in the policy implementation process (including politics).

> *"We should be talking about UHC as a country. I will clap hands for the CHPS concept.* ***We have to address the implementation problem.*** *Let's build the CHO's capacity. Lets' get data at that level right. Preventive healthcare has to be cared for and cost for. So it has to be enrolled in NHIS in a way to be catered for. There should be a way to pay for home visits. The fourth is standardizing functionally, lets' improve the referral system don't let us bring in any big idea. Convert a lot of people to make sure zones have increased and the numbers as well. And* ***capacity building and quality healthcare. We also have to stop issues of fraud and corruption.*** *We also have to prioritize as a government"* **USAID Representative 2**

> *"For coverage, WHO was an advocate for what is being implemented now as CHPS. You might have heard something they call the Bamako initiative in 1978, and then you might have heard of the Danfa Project, which even came on board before the Alma Ata Declaration. You might have also heard of the Ouagadougou Declaration which had nine areas, and one of them is community ownership. So those are some of WHO's contribution towards the UHC process.* ***But in Ghana we're fond of starting projects very well, developing the various documents, piloting them and then we become laid back.*** *If the government had implemented all the recommendations in all those documents I've mentioned to you earlier on the CHPS, I think we would have had over 90 percent coverage now.* ***The policy of national health insurance is a good one but let's take a second look at its***

implementation. ***The way it is now, it's not right - because we provide over 90 percent of the care*** *that is required at the district hospital level. And there's no co-payment from anywhere. Meanwhile, the National health insurance fund is not solely for the NHIS. It does other things as well, so we have to look at that. So, the principle of national health insurance is good for UHC. That's the finance bit. The CHPS concept and the improvement in the referral system will also help in achieving the UHC on time"* – **WHO Representative**

1.3 Feedback from institutional representatives

Responds from the development partners except for the IMF, on health was mixed. All of them by their mandate support different aspects of the health sector - the USAID/JHPIEGO supports maternal and child health, family planning, early childhood development, ensuring quality of training of nurses, midwives etc. and the CHPS. JICA has been in the country for over fifty years, supporting with funding, infrastructure development and others especially in the rural settings and very much focused on the CHPS. The WHO supports with the provision of technical support, advice on policy development, information dissemination and its usage and limited financing, while the EU supports in diverse ways (recent funding of 52 million euros which ends in December 2018) was for health sector budget support and maternal health monitoring. From the development partners, coordination is not a problem but rather with identified agencies under the Ministry of health and also, sometimes among the development partners which sometimes causes duplication of efforts. This is evidence of lack of institutional complementarities (as explained under 2.4 of Chapter 4 taking a look at the CHPS and the NHIS in terms of internal and external complementarities in the health sector). But for effective implementation and impact of health policies, Marmot (2010: 13, 23) has called for an "intergrated approach to the social determinants" such that policy strategies that are effective and impact on health take on a "whole of society – whole of government" approach, thus essentially insisting on the adoption of the HiAP approach in the case of Ghana.

On the question of health in all sectors, this is the response that was given by one of the respondents in academia (public health):

"I don't really know if there is something like that but some actions have been taken towards that. I'm looking at "one health" which is mainly about animal and human health, so that we don't have the animal health under Ministry of Agric but animal and human health would be under ministry of health because what affects the animal affects human. As it stands now I don't see health at the center of all the sectors. Yeah it's a big challenge but we also have to understand that there are too many actors; sometimes they are located under different umbrellas. Locating the specific actors has been a major challenge." – **Representative 1, School Of Public Health**

To some of the development partners, there is 'waste' in the system and difficulty in mobilizing interministerial efforts for projects and programs if the primary ministry does not see the benefits exclusively as theirs. Others believe that for some ministries, there is good working relationships in pursuing development but not necessarily health. For instance, while the Ministry of Gender, Children and Social Protection (MoGCSP), Ministry of Health (MoH) and Ministry of Finance and Economic Planning (MoFEP) work together in making the objectives of the NHIS get achieved, each of them still maintains their core mandate and health is not at the core except for MoH. Among development partners, there exist good working relations and collaboration – since 1996, there has been a collaborative group now called Development Partners' Group for the health sector with another group which meets with the MoH called the to Health Sector Working Group. Additionally, all development partners in the health sector meet at the Health Summit. To forestall the tendency for the different development partners from talking at cross purposes (which happens at times at meetings), the Development Partners' Group was formed. The current lead for this group is the UNICEF the USAID as the co-lead. Some development partners believe there are still cases of fraud in the NHIS system which needs to be dealt with by management. The challenge of delays in payment to service providers by the NHIA was identified as one of the problems which inadvertently affect the quality of care delivered to subscribers. But some key informants have challenged this assertion as untrue that poor service quality and poor attitude seem to be a cultural problem, not found in the health sector alone but at all service delivery points.

> *"There are a lot challenges pertaining to health outcomes emanating from* ***poor service quality.*** *But most people will blame it on not having the right equipment or appropriate funding. For me, I don't think that is right. The bottom-line is the issue of personality traits. Ghanaians generally have* ***very bad customer relations****, such that wherever we are, we think that we are delivering great service to people……….. That happens a lot in the health sector. And I will* ***not*** *say that it's* ***limited to the health sector alone****, it's across board".* - **WHO Representative**

The parliamentarian interviewed narrated a first-hand experience he encountered at a public hospital in an urban area to emphasis his point on poor health worker attitude. To check this phenomenon, the MoH is reported as producing a National Health Quality Strategy. To also check the financial malfeasance in the health sector, the Public Financial Management Law has been introduced which now puts the onus on each individual staff. Formerly it put the financial loss responsibility on only the head of an agency. Some of the development partners indicated that **if the lack of urgency in getting things done in the health sector, prioritization of resources especially financing and accountability issues are not addressed**, the **achievement of the UHC would be difficult**. Also the low investment in the CHPS - that many people are focused on the number of CHPS compounds that can be built but quantity is not the problem alone but the quality of service provision which the UHC also talks about. To achieve the UHC, the current mistrust for the NHIS system and the fact that even people who can afford the premiums are not enrolling must be addressed.

1.4 Subscribers and non-subscribers' responses to questionnaires

A total number of 250 questionnaires were shared among respondents in the categories of subscribers and non-subscribers. Upon receipt of filled out questionnaires, 150 were usable for our study since due to gaps in the bio data areas of the questionnaire, categorization was difficult and hence a rejection of 100. Below are results of the analysis of the questionnaires that were deemed useful.

1.4.1 Demography of respondents

The overall demographic characteristics of the respondents (subscribers and non-subscribers) have been presented in Table 19. This is in terms of age group, gender and employment status as follows:

TABLE 19: DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

Variable	Frequency	Percentage
Age Group		
14-35	116	77.3
36-55	29	19.3
56-71	5	3.3
Total	150	100.0
Gender		
Male	79	52.7
Female	71	47.3
Total	150	100.0
Employment status		
Employed	92	61.3
Unemployed	58	38.7
Total	150	100.0
Subscription status		

Subscriber	75	50.0
Non-subscriber	75	50.0
Total	**150**	**100.0**
Regional Distribution		
Greater Accra	50	33.3
Eastern	50	33.3
Central	50	33.3
Total	**150**	**100.0**

Source: Author

In terms of age of the respondents, the results show that most of the respondents are young and they are within the age range of 14 to 35 years (77.3 percent). This is followed by those within the 35 to 55 years age cohort (19.3 percent). Again, the gender distribution of the respondents show that males account for more than half (52.7 percent) while their female counterparts represent (47.3 percent). Regarding, employment status of the respondents, the results show that majority of respondents are employed (61.3 percent) while those unemployed represent 38.7 percent.

1.4.2 Cross-tabulation of key results

Under this section of the discussion of field results, cross-tabulation was conducted on key results to identify whether the demographic attributes and other variables vary across the respondent types (subscribers and non-subscribers). This is shown in Table 20 as follows:

TABLE 20: DISTRIBUTION OF RESPONDENTS BY GENDER AND SUBSCRIPTION STATUS

	Subscriber	Non-Subscriber	Total
Male	39 (52.0 percent)	40 (53.3 percent)	79 (52.7 percent)
Female	36 (48.0 percent)	35 (46.7 percent)	71 (47.3 percent)
Total	75 (100.0 percent)	75 (100.0 percent)	150 (100.0 percent)

Source: Author

From Table 20 it is obvious that male respondents account for the highest proportion both among the NHIS subscribers (52.0 percent) and non-subscribers (53.3 percent). But in percentage terms, the difference between the male and female subscribers is not significant; indeed, the female subscriber population is more than that of the males (50.7: 49.3). That is, relatively more females than males randomly selected for this part of the study benefit from the NHIS policy.

TABLE 21: DISTRIBUTION OF RESPONDENTS BY EMPLOYMENT AND SUBSCRIPTION STATUS

	Subscriber	Non-Subscriber	Total
Employed	50 (66.7percent)	42 (56.0percent)	92 (61.3percent)
Unemployed	25 (33.3percent)	33 (44.0percent)	58 (38.7percent)
Total	75 (100.0percent)	75 (100.0percent)	150 (100.0percent)

Source: Author

Employment status is relevant in the discussion of NHIS subscription (affordability or otherwise) and sustainability thereof of the scheme as shown in Table 21. The results indicate that most of the respondents are employed (61.3 percent) while those unemployed constitute 38.7 percent. A further, analysis of the results into respondent type shows that being "employed" accounts for the highest share among subscribers (66.7 percent) as well as non-subscribers (56.0 percent). However, it is observed that relatively more subscribers are employed than the case of non-

subscribers (56.0 percent). A possible explanation of this result is that being employed increases the propensity of people to earn income making it easier to subscribe on the NHIS.

1.4.3 Number of dependents and NHIS usage

Number of dependents cannot be ignored in the discussion of National Health Insurance Scheme's subscription and utilization. Its importance is echoed in the fact that exemption provision has been made under the scheme for under 18 - year olds. Dependents of both subscribers and non-subscribers are presented in Table 22.

TABLE 22: DISTRIBUTION OF NUMBER OF DEPENDENTS BY RESPONDENT TYPE

Dependents	Subscriber	Non-Subscriber	Total
1-2	23 (56.1 percent)	11 (61.1 percent)	34 (57.6 percent)
3-4	14 (34.1 percent)	6 (33.3 percent)	20 (33.9 percent)
5+	4 (9.8 percent)	1(5.6 percent)	5 (8.5 percent)
Total	41 (100.0 percent)	18 (100.0 percent)	59 (100.0 percent)

Source: Author

The results show that among respondents with dependents (dependents here understood as children of respondent), most of them had 1-2 dependents (57.6 percent) followed by those with 3-4 dependents (33.9 percent). Those with 5 or more dependents account for the least share (8.5 percent). A further analysis of the results indicate that out of a total number of 59 respondents with dependents, a larger number of them were subscribers (41) while only 18 of them were non-subscribers. A possible explanation for this result could be that having dependents imposed higher responsibility on the individual to cater for their welfare of which healthcare (and by extension the uptake of health insurance) played a key role.

1.4.4 Subscriber satisfaction of NHIS card usage

Satisfaction of subscribers is considered significant to the discussion of NHIS card utilization, yearly renewal and sustainability of the scheme. This study sought to find out whether subscribers were satisfied with the services experienced while using NHIS cards at the point of access to healthcare and the results obtained have been presented in Table 23 as follows:

TABLE 23: SUBSCRIBER SATISFACTION OF NHIS CARD USAGE BY GENDER

	Male	**Female**	**Total**
Satisfied	20 (51.3 percent)	14 (38.9 percent)	34 (45.3 percent)
Not satisfied	19 (48.7 percent)	22 (61.1 percent)	41(54.7 percent)
Total	39 (100.0 percent)	36 (100.0 percent)	75 (100.0 percent)

Source: Author

As shown in Table 23, most of the respondents who used the NHIS card said they were not satisfied with the services offered (54.7 percent) under the scheme. In terms of gender distribution of the results, it is observed that more males indicated they are satisfied with NHIS (51.3 percent) as compared to the case of their female counterparts (38.9 percent). A higher proportion of females indicated their dissatisfaction with the services received with the use of NHIS card (61.1 percent) while 48.7 percent accounted for responds among the male respondents.

1.4.5 Distance covered to access healthcare

Distance covered to healthcare provider is relevant in the discussion of geographical access to universal health coverage. The results obtained are depicted in Table 24.

TABLE 24: DISTANCE COVERED BY SUBSCRIBERS TO ACCESS HEALTHCARE BY GENDER

	Male	**Female**	**Total**
0 to 1 km	19 (48.7 percent)	16 (44.4 percent)	35 (46.7 percent)
2 to 3km	13 (33.3 percent)	13 (36.1 percent)	26 (34.7 percent)
4 km or more	7 (17.9 percent)	7 (19.4 percent)	14 (18.7 percent)
Total	39 (100.0 percent)	36 (100.0 percent)	75 (100.0 percent)

Source: Author

The results reveal that most of the respondents travel for shorter distances to access healthcare thus 0 to 1 kilometer (km), followed by those who cover within 2 to 3 km to access healthcare delivery while 4 km or more account for the least share (7 percent). The distribution of the results among gender did not reveal any significant difference except that relatively higher proportion of males cover shorter distances to access healthcare (48.7 percent) than those for females (44.4 percent).

1.4.6 Perception of NHIS' effectiveness

For the purpose of subscriptions to the scheme, patronage of healthcare and sustainability of the NHIS, it is relevant to discuss subscriber/customer perception regarding the effectiveness of the NHIS. Table 25 provides the results obtained from the opinion poll of the respondents perceptions of effectiveness.

TABLE 25: PERCEPTION OF NHIS' EFFECTIVENESS

Opinions	Subscriber	Non-subscriber	Total
Effective	35 (46.7 percent)	29 (38.7 percent)	64 (42.7 percent)
Not effective	39 (52.0 percent)	32 (42.7 percent)	71 (47.3 percent)
Don't know	1(1.3 percent)	14 (18.7 percent)	15 (10.0 percent)
Total	75 (100.0 percent)	75 (100.0 percent)	150 (100.0 percent)

Source: Author

Based on the results in the Table above, it was realized that almost half of the respondents in the survey were of the opinion that the NHIS is not effective (47.3 percent) with 42.7 percent considering it as effective and 10 percent respondents were of the view of "don't know". Relatively more subscribers indicated that the scheme was not effective (52.0 percent) than 42.7 percent of non-subscribers who shared same opinions. Also noticeable is the "don't know" responds from the non-subscribers with 18.7 percent than the subscribers (1.3 percent) who intimate their lack of knowledge of the effectiveness of the scheme based on not ever subscribing. In view of this result, it can be inferred that the opinions of respondents may have an effect on fresh subscriptions, renewals and eventual sustainability of the NHIS based on respondents' opinions of effectiveness. Perhaps this can be seen in the various reasons cited for non-subscription to the schemes as a result of the challenges that confronts subscribers in Table 26.

Section 2: Disincentives for subscription on the NHIS

From the field data, some reasons were assigned by respondents for not subscribing on the NHIS. The reasons are captured under 2.1 with its accompanying table, Table 26. Other aspects such as Out-of-Pocket payments and the specific services that demand such payments are described under 2.2.1 and 2.2.2 takes on the issue of differential treatment of subscribers at health facilities. Under sub sections 3.1, 3.2 and 3.4, a presentation of discussions of the results, the main analysis of the Agyepong et al. (2016) study and the comparative analysis of both the empirical and the Agyepong et al. (2016) studies are made respectively.

2.1 Reasons for NHIS non-subscription

Various reasons were cited by respondents for not subscribing to the NHIS. The main reasons include "not needed", "lack of money" and "lack of interest". Most of the respondents cited the fact that they do not need the NHIS (24.0 percent) because they do not fall sick often. Subsequent to this is the number that cited lack of money as the reason for not subscribing (20.0 percent), followed by lack of interest in the service (17.3 percent). 13.3 percent cite the reason of preferred service not being covered under the scheme. The next two reasons (Slow registration process and Lack of effectiveness) are captured as 10.7 percent and 8 percent respectively and other reasons which were not specified from 6.7 percent of respondents.

TABLE 26: REASONS FOR NOT SUBSCRIBING ON THE NHIS (BY GENDER)

Reason	Male	Female	Total
Not needed	9 (22.5 percent)	9 (25.7 percent)	18 (24.0 percent)
Lack of money	5 (12.5 percent)	10 (28.6 percent)	15 (20.0 percent)
Lack of interest	8 (20.0 percent)	5 (14.3 percent)	13 (17.3 percent)
Preferred service not covered	7 (17.5 percent)	3 (8.6 percent)	10 (13.3 percent)
Slow registration process	5 (12.5 percent)	3 (8.6 percent)	8 (10.7 percent)
Lack of effectiveness	4 (10 percent)	2 (5.7 percent)	6 (8 percent)
Others	2 (5 percent)	3 (8.6 percent)	5 (6.7 percent)
Total	40 (100 percent)	35 (100 percent)	75 (100 percent)

Source: Author

The gender dimension of the reasons for non-subscription did not show any significant variation. This point correlates with the earlier noted "not needed" reason which dominates the entire survey and is represented almost equally among the male and female gender. Relatively higher proportions of the female population also cited lack of money as a reason for non-subscription to

the NHIS with more males citing lack of interest, preferred service not covered and slow registration process as other reasons for not subscribing. A plausible explanation to this finding could be that the males are breadwinners of their families and work to cater for all the families' needs including healthcare. As a result, most males tend to register their wives and children on the NHIS, securing healthcare access for them and not making resources including time available to register for themselves. Albeit, the small number of respondents under this study first of all limits the importance of this interesting finding and also, unless further studies are conducted for this, this finding cannot be general generalized.

2.2 Other relevant results

There were other results which shed light on the operations of the NHIS and the benefit package given to subscribers. These other aspects include the additional payments they are made to make at the point of service, differential or otherwise treatment they receive as subscribers of the scheme, duration of being a subscriber (which can give better insights to improvements or otherwise in service delivery) of the scheme and other means of accessing healthcare.

2.2.1 Other services requiring OOP from NHIS users (top-ups)

Most of the NHIS subscribers interviewed revealed the fact that they are made to make out-of-pocket payments (OOP) for other services at the point of accessing service from healthcare providers with their NHIS cards. The service cited as demanding OOP from subscribers the most was for expensive medicines (51.2 percent) which were not on the NHIS Medicine's list, followed by laboratory tests (30.2 percent) while blood transfusion accounted for 18.6 percent.

TABLE 27: NHIS SERVICES REQUIRING (OOP)

Service	Frequency	Percent
Drugs not on the NHIS Medicine's List	22	51.2
Laboratory	13	30.2

Blood transfusion	8	18.6
Total	43	100.0

Source: Author

A total number of 43 out of the 150 respondents indicated that they are made to make out-of-pocket payments (OOP) at the point of service. This represents almost 30 percent of the total population interviewed who are financially not protected despite being registered on the scheme.

2.2.2 NHIS cardholder comparative treatment with other patients

Subscribers of NHIS under the survey were asked to express their view on how fair they thought they were treated by service providers as compared to non-subscribers of the scheme shown in Table 28. A slight majority of respondents claim they are not treated fairly (where fairness in treatment to these respondents is defined here as extended waiting times, OOP, condescending attitude of staff and others) as compared to other patients (48.0 percent). This result may have implication on subscriptions, renewals and by extension, the financial sustainability of the scheme. That is, if this trend remains unchecked, it may lead to people preferring the “cash and carry” system of accessing healthcare to using the NHIS card to access healthcare.

TABLE 28: NHIS CARDHOLDER COMPARATIVE TREATMENT FEEDBACK

Opinion	Frequency	Percent
Not Fair	36	48.0
Fair	34	45.3
Don’t know	5	6.7
Total	75	100.0

Source: Author

2.3 Length of NHIS subscription

Most of the respondents who use the NHIS have had more years of use of the card, from 3 to four years subscription (56.9 percent). This is followed by those who have used the NHIS for 5 years or more (24.1 percent). This implies more years of subscription onto the scheme implies more years of renewals and reliance on the scheme for accessing healthcare.

TABLE 29: LENGTH OF NHIS SUBSCRIPTION

No. of years	Frequency	Percent
1 to 2 years	11	19.0
3 to 4 years	33	56.9
5 years ≤	14	24.1
Total	58	100.0

Source: Author

2.4 Alternative means of accessing healthcare (non-subscribers)

There are alternative means of accessing healthcare other than by the usage of the NHIS card in addressing health needs by non-subscribers presented in Table 30. The most dominant means cited by respondents is through the purchase of medicines from sources such as chemical sellers, drugs stores and pharmaceutical shops (28.0 percent). There are others who rely on private health insurance schemes provided by their employers (20.0 percent) in accessing healthcare. Others rely on OOP when they visit hospitals or clinics for healthcare (20 percent). Another category of respondents rely mainly on traditional health methods (the use of herbs) in curing their ailments. 10 percent indicated none of the healthcare measures.

TABLE 30: MAIN MEANS OF HEALTHCARE SERVICE USED BY NON-SUBSCRIBERS

	Frequency	Percent
Buying medicines	21	28.0
Use of private health	15	20.0
Use of herbs	14	18.7
Visits clinic/hospital (cash)	15	20.0
None	10	13.3
Total	75	100.0

Source: Author

Section 3: Analysis of field data

This section presents a discussion of the comparative analysis made between the two studies – the empirical and the Agyepong et al. (2016) in 3.1. It also presents the main findings after the analysis has been made and finally the comparative analysis of the two captured under 3.2 and 3.4 respectively.

3.1 Basis for selection of the study of Agyepong et al. (2016) for comparison

The discussion here is based on a comparison between the empirical study and the study by Agyepong et al. (2016) on the **"The Universal" in UHC and Ghana's National Health Insurance Scheme: policy and implementation challenges and dilemmas of a lower middle income country'.** Indeed the Agyepong et al. (2016) study while it addressed questions on the NHIS which reflected similar ones under this study it was captured under different regional context.

The article's selection for the comparative analysis aspect of this dissertation is based on the following:

1. Focus on another region, different from the three from where data was collected for the dissertation. This presents an opportunity to assess bottlenecks in enrollment on the NHIS from another part of Ghana;
2. The research shares one common goal with the dissertation – assessing barriers to the achievement of the UHC in Ghana;
3. The research captured enrollment of the NHIS over a period of three years (2010 - 2013) – a feature not present in this dissertation but relevant to demonstrate a pattern of behavior and trend of patronage of the services the scheme offers at a district and municipal mutual health insurance schemes. While the respondents under the dissertation were selected based on random and snowball sampling methods from three regions, this research selected its respondents based on purposive and snowball sampling methods from two districts within the region. It is considered useful in supporting pronouncements that may be made from the data analysis of the dissertation;
4. The authors' context, led by Prof. Agyepong (a well-known health professional in the health sector of Ghana and a prolific researcher on policy and health, especially the NHIS in Ghana. She is known for many research works in the field of health particularly on health policy, health insurance, the NHIS' implementation, the UHC and others. She was also part of the committee that was established by the former president of Ghana to review the operations of the NHIS). The authors' composition is varied with some identifiable staff of the NHIA including a former Chief Executive Officer of the Authority. This is important for the 'truth value' of the research (see Krefting, 1991) on Guba's model of Trustworthiness of Qualitative Research (1981) concerning confidence gained from a research outcome due to the research design, quality of informants and context; and
5. The variables used – why people enrolled or not on the NHIS; perceptions of benefit package; issues of OOP; enrollment and renewal issues and others. These are similar to variables considered in the dissertation.

3.2 Main results of the study of Agyepong et al. (2016)

Against the background of the SDG vision statement on health, the UHC has come to represent a formidable force to usher all into good health by removing financial barriers which usually face people at the point of access. With Ghana's journey to the achievement of the UHC commencing in 2003 by an act of parliament (the National Health Insurance Act 650) and the policy objective stated as "to assure equitable and universal access for all residents of Ghana to an acceptable quality package of essential healthcare", the Agyepong et al (2016) study sought to understand the enrollment patterns (who was enolling and renewing or not) and why the NHIS had stagnated at its current level of 40 percent – what this means for the policy design and implementation towards the achievement of the UHC. It sought for reasons for barriers and facilitators in support of observations made. As per the design of the NHIS, its supposed to be a single payer model with a designated fund comprising diverse funding sources including tax, contributions from pensiors and out of pocket contributions by way of premium payments. The scheme has various exempt categories. Inequities have been observed in enrollment on the NHIS. The scheme was built on an already existing model of the community based health insurance (CBHI) which has voluntary enrollment as a design feature. Several studies cited in the research concerning CBHIs' performance in lower-middle income countries (LMIC) pointed to the low enrollment with factors such as institutional rigidities, socio-cultural practices (in the cases of rural West Africa and Uganda), poor quality of healthcare delivery, long waiting times, poor health worker attitudes, subscribers' socio-economic status (including education, gender, income etc.) among others.

The Agyepong et al. (2016) study was based in the Volta region, one of the ten administrative regions of the country. According to the national population census of 2010, the region had a population of over two million and represented about 8.6 percent of the population of Ghana. The region's demography mirrored the same as the country's – with a relatively young population with 43 percent under 18 years. A municipality and a rural district were purposively selected for the study with populations of about 300,000 and 64,404 respectively. The Municipality had 45 health facilities including a regional and municipal hospital with various economic activities while the rural district lacked many social and economic infrastructure

including road network with a problem with accessing healthcare. The predominant economic activities in the rural setting were farming and kente weaving.

The study employed an exploratory, mixed methods cross-sectional case study design with data collection being a combination of focus group discussions, key informant interviews, review of various related documents such as annual reports, legislative instruments, documents from parliament and the extraction of routine management information system data.

Findings of the research have been summarized into four main themes as assigned reasons why people are enrolling or not on the scheme. The four main categories were national policy, program arrangements, implementation arrangements and context related reasons. The multiplicity of factors which prevent people from enrolling and renewing the health insurance subscriptions include: perceptions of who pays and who benefits; national policy implications; annual enrollment and renewals; SSNIT contributor and pensioner disinterest; non-SSNIT subscribers out of pocket premiums; opportunity costs; claims reimbursement; identity card processing and issuing; district NHIS office staff and logistics; health facility availability and resources; frontline purchaser implementation arrangements; formal out of pocket payments in scheme offices; informal out of pocket payments in scheme offices; district scheme office responsiveness to clients; interpretation of rules; frontline provider implementation arrangements (health service provider responsiveness); formal out of pocket payment in provider facilitaties; informal (under the table) charges; and contextual factors such as high poverty levels (some of which emanated from the seasonality of farmers' incomes based the farming practices used), dependency ratios (large family size), bad road networks affecting access to scheme offices to enroll and also, to healthcare facilities (complicating travel time and imposing extra costs). Politics associated with the NHIS and its management was cited as also a finding which sometimes affected both negatively and positively enrollment depending on the context of use.

A combined effect of all the afore-mentioned factors produced client experiences which were mixed – some reported satisfaction upon utilization of the NHIS card while others' negative experiences left them disinterested in enrolling on the scheme. There seemed to be some communication gap concerning the official statements made about the object and intent of the NHIS to mean absolutely free so when clients encounter situations which necessitate co-

payments, balance billing and under the table charges in a health facility, there is great disappointment and mistrust created. In the research, it was frequently mentioned that decision-makers often announced in the public space that the NHIS policy covered about 90 – 95 percent of all common diseases in the country making it one that provided a rather generous benefit package. At the heels of this, when service providers communicated the unavailability of certain medicines and co-payment of certain services, clients became unhappy.

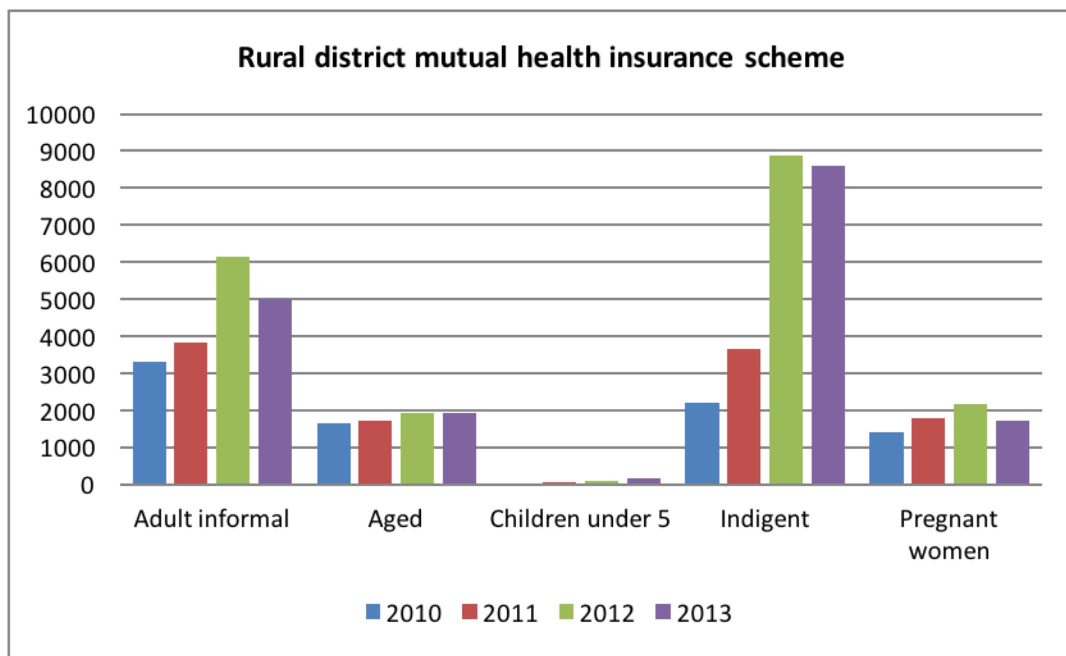
> *"The reason I enrolled is that we were promised that when you are able to enrol you have access to everything when you attend the hospital. But there have been times when you go to the hospital you are told that certain conditions are not covered by the card or we don't have this or that drug"* - Insured community member, rural district - **Opinion of a subscriber in a rural setting in the Volta region**

The research concluded that the attainment of universal population coverage with health insurance could take decades, that even with countries such as Germany and Japan who are known to have started classical health insurance, it took sometime. Germany is known to have achieved the UHC some twelve decades after the inception of its first sickness fund and Japan, who based its operations on the German model, achieved the UHC some four decades after. And in relation to recent achievers, countries such as South Korea (1989, a little after a decade of commencement), Taiwan and Thailand (after two decades achieved the UHC in 2002) were cited. Although the NHIS has been called a trailblazer on the continent, there are continued challenges – it has the opportunity to learn from the experiences of both South Korea and Thailand both of who achieved the UHC while classified as LMIC. Also experiences from the CBHI have shown that increased enrollment and the eventual attainment of the UHC would prove difficult with a predominantly voluntary model and that there must be ways to ensure compulsory enrollment, especially for the country's large informal sector. The situation of the voluntary enrollment is exacerbated by the non-existence of 'a universal citizen registration database'. There are many lessons to be learned from countries in the LMIC category who have achieved the UHC and many insights to be gained from this article hence the choice to use it for the comparative analysis.

3.3 Graphical representation of findings

Aspects of data presented in the Agyepong et al. (2016) study were used here in capturing the trends in enrollment and renewals in both the rural and municipal areas under the study. Find below graphs and narratives derived from aspects of tables generated in the study in the Volta region in the period 2010 - 2013:

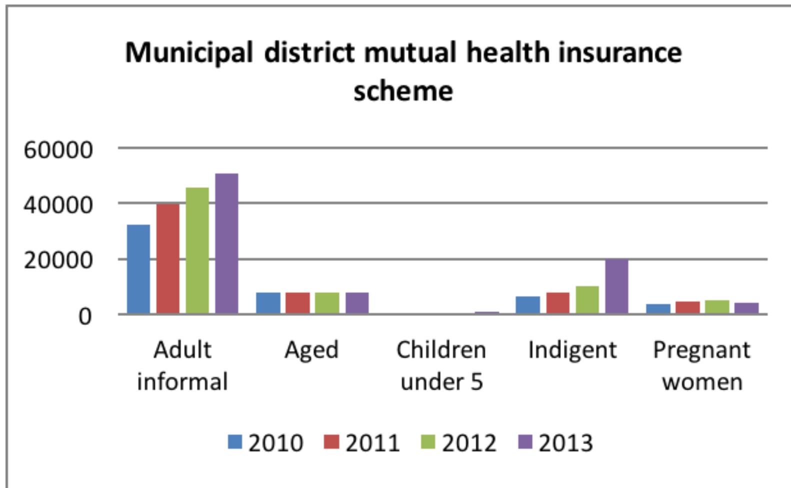
FIGURE 17: ENROLLMENT ON RURAL DISTRICT - MUTUAL HEALTH INSURANCE SCHEME



Source: Author (an adaptation from Agyepong et al., 2016)

Taken from the Table 3 in their study (Registration by category in the two districts from 2010 – 2013), this table represents enrollment (both new and renewal) in a rural District Mutual Health Insurance Scheme (DMHIS). From the graph, the enrollment captured for the categories of adult from the informal sector, aged, under five children, indigent and pregnant women, all experienced a growth from 2010 – 2012 and declined in 2013, except for the under-five category which seemed to continue on an ascending trajectory. This is captured at the rural level.

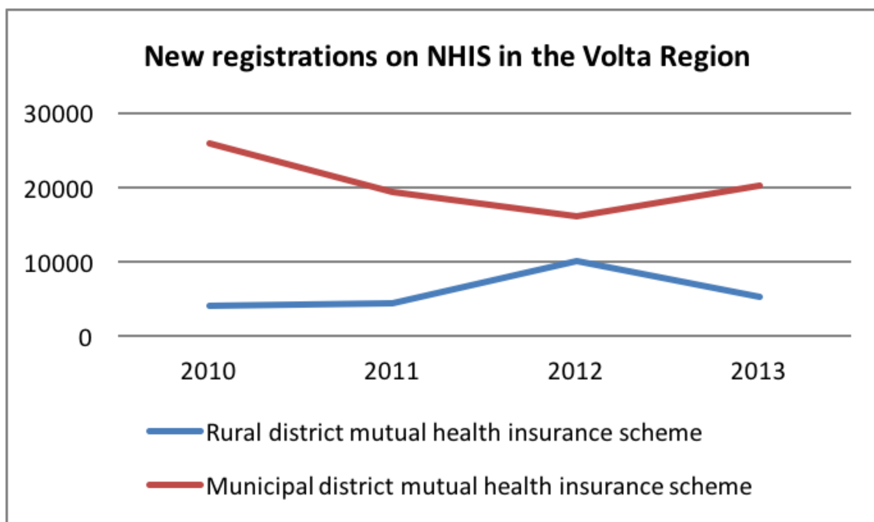
FIGURE 18: ENROLLMENT ON MUNICIPAL DISTRICT MUTUAL HEALTH INSURANCE SCHEME



Source: Author (an adaptation of Agyepong et al., 2016)

The new enrollments at the municipal level (although captured with greater numerical values), as observed from the graph shows growth over the years for the adult informal, under-five and indigent categories, and a plateauing for the aged. For the pregnant women category, growth was observed between 2010 – 2012 periods and a decline in 2013.

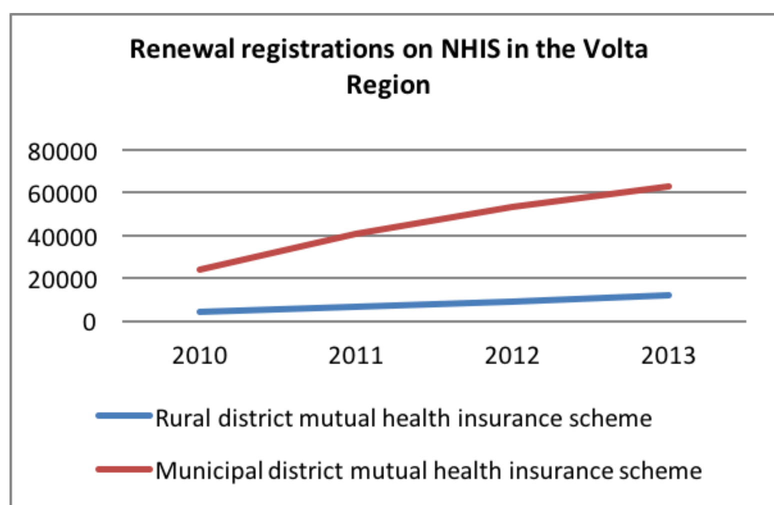
FIGURE 19: NEW REGISTRATIONS ON NHIS IN THE VOLTA REGION



Source: Author (an adaptation of Agyepong et al., 2016)

This line graph allows for comparison of same variables earlier depicted, between the rural and municipal populations. There was no significant growth in new registrations between 2010 – 2011 periods. Enrollment grew steadily between 2011 – 2012 periods. It peaked in 2012 and started a decline from 2012 to 2013. The new enrollment for the municipal population started on a high in 2010 but experienced a decline from through 2011 and hit the lowest point in 2012. In the same year, 2012, it started experiencing positive growth towards 2013.

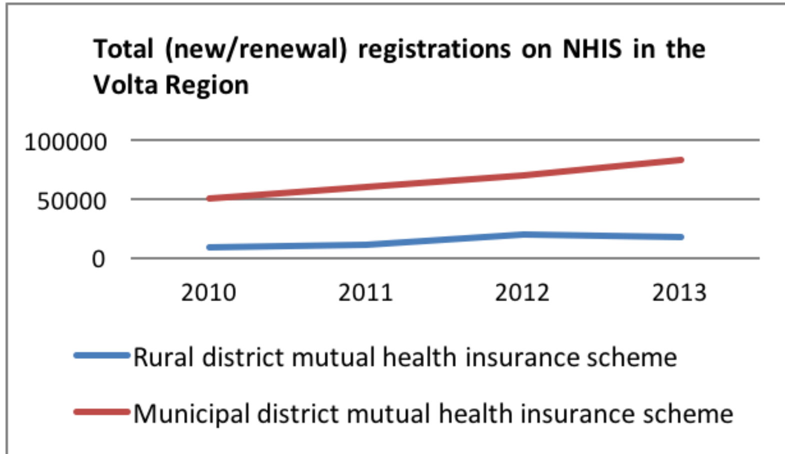
FIGURE 20: RENEWAL OF REGISTRATIONS ON NHIS IN THE VOLTA REGION



Source: Author (an adaptation of Agyepong et al., 2016)

For renewal of registration of subscribers in both the rural and municipal areas, the graph shows an ascent, with the municipal renewals growing speedily and the rural, being almost stagnant.

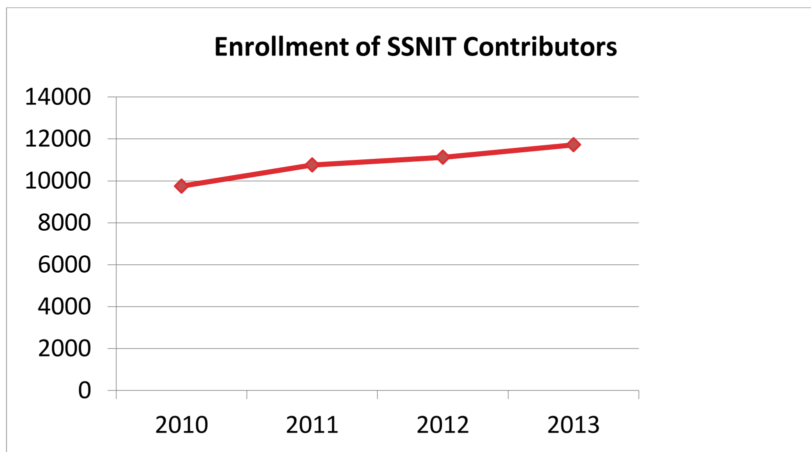
FIGURE 21: TOTAL (NEW/RENEWAL) REGISTRATIONS ON NHIS IN THE VOLTA REGION



Source: Author (an adaptation of Agyepong et al., 2016)

This graph represents the total enrollment (new registrations and renewals) over the period under consideration. For the rural population in the two districts, from 2010 enrollment witnessed a gradual growth and peaked in 2012. From 2012 – 2013, there is a decline in enrollment. In contrast however, 2010 – 2013 shows progression in enrollment figures for the population in the municipal area.

FIGURE 22: ENROLLMENT OF SSNIT CONTRIBUTORS



Source: Author (an adaptation of Agyepong et al., 2016)

From 2010 – 2013, the enrollment (both new and renewals) continued to be on the ascendency for the entire population covered in the research. This is not surprising as formal sector

employees are automatically enrolled and deductions made from employers, be they public or private sector.

3.4 Comparative analysis of findings of the empirical and Agyepong et al (2016) studies

The table below shows the results of the dissertation and the article by Agyepong et al. (2016). From the comparison, similar approaches were used in collecting data albeit from different regions in the country. The results however have similar findings.

TABLE 31: COMPARATIVE ANALYSIS OF FINDINGS OF BOTH STUDIES – OBJECTIVES

Areas of Comparison	**Empirical study**	**Agyepong et al., 2016**	**Comments**
Objectives	• To understand the implementation of the NHIS policy and its efforts towards the attainment of the UHC; • To understand and improve the links between the different literatures and theories about the SDH, Kingdon's (policy process) and institutional complementarities and how they can support Ghana in attaining the UHC.	To understand why enrollment within the NHIS has stagnated at the current levels and the implications for NHIS policy and program design and implementation towards universal population coverage.	Both studies have the UHC in focus but the emphasis is on the different views of the approaches being used towards its achievement. While the empirical study emphasized the adaption of some international health concepts, the Agyepong et al. (2016) study focused on the enablers and barriers to enrollment on the NHIS based on policy and program design.

Source: Author

Both the empirical and the Agyepong et al. (2016) studies are focused on the achievement of the Universal Health Coverage (UHC) and its achievement in Ghana. While the empirical study has the objective of studying the modalities of achieving the UHC through considerations of some international initiatives, the Agyepong et al. (2016) study takes on the angle of policy and

program design and its reflection on enrollment. Both avenues are impact focused on what the NHIS could offer by the end of 2030.

TABLE 32: COMPARATIVE ANALYSIS OF FINDINGS OF BOTH STUDIES – STUDY METHODS, LITERATURE REVIEW AND REGIONS COVERED

Areas of Comparison	Empirical study	Agyepong et al., 2016	Comments
Study methods & data collection	Case study using mixed methods of data collection. Purposive sampling method used in the selection of regions, key informants and to ensure gender balance. Similar approach adapted under empirical study with all interviews conducted and recordings made with informed consent of the respondents and later transcribed. Seventeen in-depth interviews were held lasting within 45 - 120 minutes. Total respondents for the Subscribers/Non-subscribers category for the empirical study were 150.	Exploratory cross-sectional case study using mixed methods. Use of purposive sampling method for the region and also to ensure the rural-urban differential. In total, 35 in-depth interviews were held, lasting between 30-70 minutes (with incidents of some interviews held in respondents' homes for convenience).	Similar methods except for the participant observation approach (during the internship) added to the empirical study and the Focus-group discussion (FGD) used for the Agyepong et al. (2016) study.
Literature review	Review on related themes such UHC, SDGs, SDH, HiAP, SAPs, Policy, Policy implementation and others.	Review of studies on various related themes such as enrollment factors,	Both studies looked the operations of the NHIS and

	Similar approach of drawing on literature reviewed and the application of theories in the design of data collection instruments and selection of "actors" as respondents.	enrollment in CBHI schemes, socio-demographic, economic factors and other factors such as education, gender etc. Literature used drew on theoretical factors affecting enrollment of the NHIS classified as Purchaser, Provider, Client and Context.	similar attempts in Africa however, the empirical study used SDH framework to add value to the analysis of the Ghana situation in the achievement of the UHC.
Regions covered & sample size	Greater Accra, Eastern and Central regions. With sample size of 150 respondents for the NHIS beneficiaries/non-beneficiary category and 17 key informants.	Volta region. Sample size was 35 for the key informants and 12 FGDs consisting of 8 – 11 persons per group.	Empirical study was on a smaller scale as compared to the Agyepong et al. (2016) study.

Source: Author

Both studies used the case study and mixed methods approach to data collection with similarities in the data collection methods (thus the use of in-depth interviews) and observed differences in the sample size, the use of FGDs and the participant observation through internship. Another difference is in the choice of geographical locations – the empirical study selected three regions (Greater Accra, Central and Eastern), predominantly urban and peri-urban while the Agyepong et al. (2016) study focused on one region (the Volta region) when a look at both urban and rural settings. The literature for the empirical study was based on the international health related

initiatives (such as the Sustainable Development Goals (SDGs), the Social Determinants of Health (SDH), the Health in All Policies (HiAP), the determinants of health in Ghana using the Dahlgren and Whitehead (1991) framework (socio-economic dimensions) and policy-making processes in Africa and Ghana. The empirical study also looked at institutional complementarities in and outside the health sector and the two health policies (National Health Insurance Scheme and Community-based Health Planning and Services) selected for the achievement of the UHC in the country. The Agyepong et al. (2016) study also looked one of the international health initiatives, the SDGs, factors that influence enrollment in Africa and Ghana, and finally settled on issues that bordered on enrollment on the NHIS.

TABLE 33: COMPARATIVE ANALYSIS OF FINDINGS OF STUDIES – POLICY STATUS, POLITICS AND OOP

Areas of Comparison	**Empirical study**	**Agyepong et al., 2016**	**Comments**
Findings			
Status and implementation of national policy	Same effect of national policy of the NHIS but a few innovations introduced to the CHPS (the alternative policy under the study) during the study period.	National policy for the establishment of the NHIS, its operations, the rules guiding it, financing structure, exempt categories, enrollment guidelines etc. did not change in the period of the study.	The NHIS policy as is implemented remained same during the period of data collection for both studies. No differences observed in policy.
Effect of politics	Key informants all agreed that politics played a role in the state of the NHIS.	Politics was cited in the operations and state of the NHIS.	The effect of politics was considered both positive and negative for both

			studies.
Formal and informal out of pocket payments (OOP)	OOP were cited under the empirical study. Subscriber respondents indicated OOP at health facilities.	OOP were cited under this study. Observed formal and informal OOP (fraud) at both health facilities and scheme offices.	For both studies, formal OOP were mentioned as a factor in perceptions formed about the scheme. Some of these OOPs could either be formal, informal and/or fraudulent but both studies flagged it as an issue.

Source: Author

At the time of both studies, no new changes had been made to the policy by way of the law establishing the NHIS, its operations, financing, exempt policies and basic guiding principles. This was same under the Agyepong et al. (2016) study period. But in the case of the CHPS, two significant documents were introduced, both in 2016 – the MoH, National CHPS policy (March, 2016) and CHPS National Implementation Guidelines (August, 2016). Politics was cited as an influencing factor in both studies.

TABLE 34: COMPARATIVE ANALYSIS OF FINDINGS OF BOTH STUDIES – DISCRIMINATORY TREATMENT, HEALTH WORKER ATTITUDES AND INEFFICIENCIES

Areas of Comparison	Empirical study	Agyepong et al., 2016	Comments
Findings			
Discriminatory treatment	A slight majority of subscribers described the treatment they received at health facilities as unfair as compared to patients who used other forms of payment for healthcare services.	There was no perceived exceptional treatment for indigents.	A notable difference in the categories considered under the two studies. The empirical study considered subscribed and non-subscribed respondents, service providers, legislators, policy administrators and development partners while the Agyepong et al. study considered policy administrators (NHIA staff), district assembly, subscribers, and service providers' categories.
Poor health worker attitude	Poor health worker attitude was cited more at the health facilities level under this	There were unmet expectations of skills and capabilities of staff at health facilities, poor attitude of scheme office staff.	While poor health worker attitude was mentioned at the implementation level (hospitals, NHIS scheme office etc.), the empirical study indicates both policy-making and implementation levels as having

	survey.		challenges of poor attitude.
Inefficiencies of NHIS	A slight majority of all respondents in the subscriber/non subscriber and key informant survey considered the NHIS as inefficient.	Several observations of inefficient management were cited in this study ranging from scheme's inability to assess premium rates for non-exempt categories thus all subscribers had to pay flat rates despite income levels, delays in processing and card issuance, delay in provider reimbursements, inadequate staffing and logistics at district offices, poor attitude of scheme office staff.	Inefficient practices were noted by both studies.

Source: Author

The empirical study using the conceptual framework as guide considered subscribed and non-subscribed respondents, service providers, legislators, policy administrators and development partners while the Agyepong et al. (2016) study considered policy administrators (NHIA staff), (including those involved in the decentralization system of governance at the district level), subscribers and service providers categories. In both studies, poor health worker attitudes were registered. In both studies, inefficiencies in the operations of the NHIS were recorded.

TABLE 35: COMPARATIVE ANALYSIS OF FINDINGS OF STUDIES – OPPORTUNITY COST OF ENROLLMENT, COMMUNICATION GAP AND CONTEXTUAL FACTORS

Areas of Comparison	Empirical study	Agyepong et al., 2016	Comments
Findings			
Opportunity cost of enrollment	Distances traveled to scheme offices were not a problem for respondents.	Time and transport cost of enrolling contributed to disinterest in the scheme.	Respondents in the empirical study did not consider travel time and transportation as a decision-making factor for enrollment but it was a decider for the Agyepong et al. (2016) study.
Communication and education gap	While majority of non-subscribed respondents indicated that they have no need for the NHIS, others indicated disinterest for various reasons.	Perceived no need for health insurance (among people of 18-40 years) due to perceived low risk of ailment. Perceptions of benefit package for beneficiaries to include everything medical without co-payment of any kind.	Both absence of need and disinterest have been cited in both studies and reflects a lack of education on first the civil obligation to enroll on the NHIS and second, the need for protection against catastrophic financial expenditures on healthcare.

Contextual factors	While 61 percent of respondents were employed, 20 percent indicated that they could not afford the premiums charged. 91.5 percent had dependents of 1-4 years and 8.5 percent had 5 or more.	Poverty levels and dependency ratios were considered.	The contextual variable was considered by both studies. Subscribers had more dependents under the empirical study than non-subscribers. Affordablity of healthcare expenditures was observed in both studies.

Source: Author

There were records of respondents who expressed disinterest and no or little value for enrollment on the NHIS for various reasons including travel time and cost of transportation. The empirical study did not record issues of travel time as a deterrent to enrollment but those under the Agyepong et al. (2016) did. There seemed to be a miscommunication about benefit package and co-payment for subscribers. For both studies, the issue of affordability of enrollment on the NHIS was raised.

Conclusion of Chapter Six

The Chapter 6 presents both raw and analysed empirical results of the study in two forms. The first is the reponses taken from the key informants with some verbatim responses documented to emphasis areas of concern. The second part is the presentation of information gathered from the subscriber and non-subscriber categories of respondents. The data collected from these categories of actors in the policy-making space in Ghana represented three regions. The Agyepong et al. (2016) study which was used to make a comparison of the empirical helped to add other perpectives on the NHIS' implementation in another region, the Volta Region.

CHAPTER 7: PERSPECTIVES

Introduction

Relevant aspects of the Dahlgren and Whitehead (1991) framework of the SDH (refer to Figure 3) are used as guide in the discussion here, focusing on education, health services, employment, unemployment and a mix of the housing and agricultural aspects. There are two main sections under Chapter 7 namely, the SDH-based perspectives of Ghana; and the applicability of the international concepts in the case of Ghana. The discussion of HiAP (2.1) follows on from the SDH component in section 2. This chapter presents analysis and deeper insights gained in the data collected, compared and analysed so far, thus, a combination of the literature and the empirical. The perspectives under this chapter are categorized under institutional complementarities between the health sector and that of other sectors (2.4 and 2.5 under chapter 4), and the institutional complementarities within the health sector. Perspectives on the Health in All Policies (HiAP) approach are also given under 2.1. This chapter makes links with section 1.2 in Chapter 3 (Health in Ghana: social determinants and health goals) under which the social determinants of health in the case of Ghana are discussed in detail in section one. Sub section 2.2 takes a look at the feasibility of adopting the SDH in Ghana and finally, Ghana's progress based on the Framework for Action on the UHC is observed in 2.3. Find below the navigation chart for the chapter.

CHAPTER 7 NAVIGATION CHART

CHAPTER SEVEN PERSPECTIVES	
Section 1: The SDH-based perspectives of Ghana	Section 2: The applicability of the international initiatives to the case of Ghana
1.1 SDH- Education and its impact on participation in the UHC program in Ghana	2.1 Health in All Policies and the empirical evidence
1.2 SDH – Employment, unemployment and equity	2.2 Feasibility of the Social Determinants of Health's adaption in Ghana
1.3 SDH – Healthcare services and impact on the UHC	2.3 Ghana's progress based on the Framework for Action on the UHC in Africa
1.4 Sustainability concerns of the NHIS	
Key words: SDH, Institutional complementarities, HiAP, Ghana	

Section 1: SDH-based perspectives of Ghana

The section 1 of Chapter 7 presents a bridge between the empirical results and the literature regarding issues bordering on education, employment and unemployment, a superficial incorporation of the housing and agriculture and food production aspects but with greater emphasis on healthcare services and the workings of the NHIS. These perspectives are based on facets of the Dahlgren and Whitehead (1991) framework of the SDH.

1.1 SDH – Education and its impact on participation in the UHC program in Ghana

The first indication of hindrance to access to healthcare as indicated from the results of the study is observed in feedback from respondents concerning reasons why they are not enrolling. It was recorded that (24.0 percent) of respondents believe they do not need the NHIS because they do not fall sick often. **The significance of health and healthcare seems to be lost on respondents**. In the nationwide survey which covered 18,000 households with a response rate of 93.2 percent, the GLSS6 also recorded a similar outcome with one in ten (10.9 percent) respondents indicating their lack of need for health insurance (GLSS6, Pg. 39). This can be attributable to a lack of education. Under Chapter 3 (specifically 1.2.6) education as a social determinant of health is discussed in detail and there it was established that Ghana was unable to achieve the MDG target of 'Education for All' by 2015. The finding in the national survey indicating the lack of need of health insurance by households has potentially severe consequences for the females, 25.7 percent of who responded under this empirical study that they have no need for health insurance. This is important to note as in a representative nationwide survey covering sample size of 18,000 and conducted by the Ghana Statistical Service (GSS) within the period 2012-2013, the results indicate **a higher propensity among women** (15.6 percent as compared to 13 percent of men) to **fall ill** (based on rate of illness recorded two weeks preceding the study). This discrepancy is also prevalent in the rural-urban dichotomy with more women (16.2 percent) being more ill than their male counterparts (14.8 percent) (GLSS6, Pg. 44). Nationwide, females are slightly more likely to be sick (15.6 percent) than males (13.0 percent) (GLSS6, Pg. 44). These findings also coupled with the fact that **Ghana was unable to meet the MDG 5.1 target of reducing maternal mortality ratio (MMR) by three quarters** and achieving the universal access to reproductive health for women under the health sector, calls for attention to the need for education which is

the domain of an entirely different sector in the country. The ability of people to subscribe to the NHIS is captured under the study when respondents indicate their willingness to subscribe but express their inability to do so. This point also proves the relevance of the wealth in accessing healthcare.

In a study by Amu and Dickson (2016), the research sought to find out the effects of socio-demographics on health insurance subscription among women in Ghana, the research outcome pointed to the fact that education played a key role in health insurance subscriptions. According to the authors, 'people with high levels of education may have a higher outlook with regards to the necessity of being ready for any unforeseen health challenges and as such decide to own health insurance, as opposed to those with lower or no level of education who may not realize the level of threat that will be posed to their health and life if they are not prepared financially for any unforeseen health challenges but they eventually occur' (Amu and Dickson, 2016). The **significance of education is not only critical in enrollment** on the NHIS but as Aseweh Abor et al. (2011) assert, also in **maternal health services utilization**. In the case of this research, with the highest percentage (24 percent) being the response to not needing health insurance and another 17.3 percent pointing to a lack of interest, close to half of all respondents (41.3 percent) displayed the need for education on the NHIS subscription and its benefits. The need for education also features in the study by Boateng and Awunyor-Vitor (2013) who posit in their findings that there has been an increase in enrollment on the scheme over the years which is a consequence of increased education on the benefit package of the health insurance scheme among the population. The significance of education in general and education on the benefits of the scheme in particular is critical for the growth and sustainability of the NHIS and the UHC. The literature and empirical aspects of this **study has brought into focus the need for better institutional complementarities.** Abudu (2016: 73 – 75) indicate a need for education for the estimated 70 percent illiterate population in Ghana. The need for education in promoting health among citizens is also realized in a finding in the GLSS nationwide survey which discovered that about 4 percent of people living in Ghana have no knowledge that a healthy looking person could be HIV/AIDS positive (GLSS6: xvii, 37-38). In line with the connection of education to health and by extension health insurance subscription, the results of this empirical study and the work of Agyepong et al. (2016) also found that one of the reasons cited by people within the age cohorts of 18 - 40 years for not subscribing was that they considered themselves strong,

insusceptible to ill-health and at low risk. In their study, a former scheme manager was quoted as **"The informal sectors are not enrolling because they happen to be the strong group in the age brackets (above 18 to mid-40s) where they hardly fall sick, so they don't see the reason why they should come for an insurance card"** (Agyepong et al., 2016).

The need for education in Ghana has not only been realized in healthcare but also being considered relevant in governance. The relevance of education has been called to play a major role in politics and leadership of the country, particularly in relation to legislation. A survey conducted by the Institute of Economic Affairs (IEA) a think-tank and research outfit in Ghana, conducted a study on the perception about Members of Parliament (MPs), revealed that 60 percent of the population of 1,500 respondents in the 10 regions of the country considered a tertiary level educational background of their Members of Parliament (MPs) as critical to voting for them into power. Interestingly however, at the moment, the 1992 Constitution is silent on educational attainment as one of the criteria for aspiring MPs. The respondents therefore called for a national debate which could lead to a review of the constitution on the matter (Daily Graphic, Monday December 4th 2017 – www.graphic.com.gh Political Desk, Pg. 17). This is important as progressive national development in general, needs both the health and education sectors for growth but critical also, is the factor of decentralization. Since the governance of Ghana is based on the decentralization approach, it plays a key role in the healthcare system, first, the education about the need to enroll on the NHIS may reside in the structures that exist at the districts and community levels. Second, the effectiveness of reimbursement of services delivered on the CHPS (which has been infused in the decentralized system whereby reimbursement is made to the CHPS zones via the health centres at the sub-district levels) lies in better education of the actors at the lower hierarchy of the decentralized system for better administration of processes such as claims processing and others. Third and final point on the decentralization of the healthcare system is that, the mainstreaming of decentralization is domiciled in another ministry – the Ministry of Local Government and Rural Development. But Ghana is said to have had a long history of decentralization in the country Couttolenc (2012: 31). In 2009, parliament of Ghana passed the Local Government Instrument 1961 aimed at devolving powers from key sectors[46] and their functions to the Metropolitan, Municipal and District

[46] http://www.ifpri.org/blog/ghana-serious-about-decentralization for impact of decentralization on agriculture

Assemblies (MMDAs), away from the central government. The institutionalization was completed in 2012 however, from this process many sectors have not fully experienced the full actualization of this policy direction with such sectors as health, agriculture and others still suffering from the poor implementation of the decentralization approach. Indeed, Couttolenc (2012: 21) points out that **"inspite of the progress accomplished since independence and the several waves of decentralization reforms, Ghana's public sector remains less decentralized than comparable countries"**. The connectivities of education to health need to be made, especially in the Ghanaian context for various reasons, not exclusive to health. This is significant because in Ghana about 70 percent of the population are illiterates (Abudu 2016: 74) and the more educated the population becomes, the better the understanding citizens would have of first, the relevance of health insurance subscription, and secondly, the importance of compliance with the law on compulsory subscriptions and renewals especially among the population found in the informal sector. Thus, this should be complementary to the enforcement of the law on the enrollment on the NHIS.

1.2 SDH – Employment, unemployment and equity

Employment status is relevant in the discussion of NHIS subscription (affordability or otherwise) and sustainability thereof of the scheme as shown in Table 21. The results indicate that most of the respondents under the study are employed 61.3 percent while those unemployed constitute 38.7 percent. A further, analysis of the results into respondent type shows that being "employed" accounts for the highest share among subscribers (66.7 percent) as well as non-subscribers (56.0 percent). The connection of health insurance subscription costs associated with premiums and wealth status has been made (Amu and Dickson, 2016: 5; Boateng and Awunyor-Vitor, 2013: 7; Agyepong and Adjei, 2008). The second reason given by non-subscriber respondents was a lack of money and this could be emanating from the fact that workers' earnings remain low in the country in comparison to costs of living (Agyepong and Nagai, 2011). Also, women's healthcare service utilization has been connected with levels of family income (Aseweh Abor et al., 2011). Theoretically, the premiums allotted for payment should be based on a formula designed to assess one's ability to pay, however, in practice, there has not been such a formula to assess people's ability to pay based on which premiums would be determined hence a flat rate has been

used for all subscribers despite income levels (Agyepong et al., 2016: 7). This could act as a deterrent for enrollment for many people whose incomes are not sufficient enough to afford healthcare and also, the premium may also be too low for those who could easily afford it – the equity factor. But in an analysis made by the ILO, a review of the benefit package, premiums and the exemption criteria used for determining who pays and who does not has been recommended in view of inflows to the scheme and also, the sustainability of the NHIS fund (Agyepong and Adjei, 2008: 157). As earlier mentioned, the majority of employed people are found in the informal sector that is known not to voluntarily enroll on health insurance schemes. **But as pointed out under section 1.2.7 in citing some of the occupations in the informal sector engaging thousands of people, the nature of their occupations can best be described as precarious. There is need for healthcare for all, and the prevention of catastrophic healthcare expenditures especially for workers in the informal sector cannot be overemphasized.**

The laws promulgated in support of the establishment of the NHIS (the National Health Insurance Scheme (NHIS) Act 650 of 2003), the subsequent legal framework in 2004 through the National Health Insurance Regulations (L.I. 1809) by the Government and National Health Insurance Act 2012 (Act 852) are clear on the population to be covered, the governance, administrative and operational structure for the scheme (Otoo et al., 2014: 1, 5 & 9). **But the enforcement of the law in ensuring that all residents in Ghana are enrolled remains weak.** However, even if enforcement was not weak, with an unemployment rate of (5.8 percent as at 2017- https://data.worldbank.org/indicator) and youth unemployment rate of (4.6 percent as at 2013 - https://data.worldbank.org/indicator) compounded by the restrictions of the agreement signed with the IMF and the World Bank (which has limited government's capacity to absorb more labour into the various sectors), how can many people enroll on the NHIS? The nationwide household survey GLSS6 reports of a similar unemployment rate of (5.2 percent as at 2014) which is considered relatively low among countries in the sub region (Nigeria - 5.5 percent; Mali - 9.7 percent; Guinea - 6.3; Ivory Coast - 9.2 percent - https://data.worldbank.org/indicator) but of essence is the fact that more than one-third of the population said to be working are described as underemployed (thus, people who work less than 35 hours a week) (GLSS6: xviii).

In the survey of Amu and Dickson (2016), it was realized that health insurance subscription was higher among women who were working than those who were not. Out of the underemployed persons in Ghana, (61.5 percent) of them are involved in agricultural activities compared with those in non-agricultural activities (38.5 percent) (GLSS6: xviii). Thus, productivity for those responsible for food production and nutrition for the country is not at full capacity. And if their healthcare cannot be guaranteed through health insurance subscription, because of affordability, then not only is sustainability of the NHIS at risk but also, the health of the majority of Ghanaians is not secured as the issue of food insecurity and improper nutrition could in the long term rear its head. Earnings from employment, whether in the formal or informal sectors affords people the opportunity to improve their quality of life, contribute to productivity and economic growth in the long ran and alleviates poverty. **'Poverty, both conceptually and practically, is the lack of or absence of adequate endowment, assets and/or cash to provide oneself with adequate food, decent clothing and decent housing and not only that but also the inability to access or pay for basic social infrastructure services such as health care, education, water, electricity, markets, entertainment and recreation'** (Tutu, 2011: xxi - xxii). Poverty levels in Ghana experienced different phases – with the Ghana Statistical Service (GSS) recording a halving of rates within the period 1999 and 2006 (Tutu, 2011: xxi). But the poverty characteristics in Ghana are not unique – it takes the forms of socio-economic, sociocultural and environmental, which also pertains in other countries in the SSA region (Tutu, 2011: xxi). The plight of millions of poor people is exacerbated by poverty and OOP because financial protection is generally low on the continent (World Bank; WHO; JICA et al., 2016: 4). The obsession of many governments including Ghana, on the continent with economic growth and development is fueled by the understanding that many forms of poverty could be eradicated by sound policies which could inadvertently create wealth. This could however occur only when the wealth generated is equitably distributed across all sectors and people in all regions. This issue of equitable distribution of wealth in Ghana needs to be addressed consciously as the country, like some other SSA countries was rated extremely poor with over 25 percent living under extreme conditions and those living under moderately poor conditions being at least 40 percent. This notwithstanding, **some regions in the country have poverty levels of over 80 percent** (Tutu 2011: 4). One key informant (with JICA and working on the CHPS in Ghana) during the data collection mentioned that, **'By the design, equity concerns are addressed by the NHIS but it**

must balance with the finances.' But is the policy design adequate to address the issues surrounding equity by the NHIS during the implementation? By placing the aged, under 18 year olds, indigents, the infirmed, and pregnant women (also referred to as welfare clients by Tutu, 2011: 8) under the exemption category of the NHIS, attempts at addressing the equity concerns of the UHC are being addressed. But how impactful is the equity dimension of the NHIS policy for the different categories of subscribers in terms of, as Ward (2009) points out, access, utilsation, treatment and outcomes, if the southern-northern disparities pertain, even in the distribution of health facilities and personnel? **At the inception stage of the NHIS implementation, certain challenges were faced such as the reimbursement of service providers** (Agyepong and Nagai, 2011) and more than **a decade after, this problem persists**. As explained under 2.5, while the NHIS and CHPS may fall within the purview of the Ministry of Health (MoH), its implementation calls for deliberate efforts by all sectors, critically the education ministry, and the ministry that is supposed to champion the decentralization efforts – the Ministry of Local Governmant and Rural Development (MLGRD). Thus, to attain the Universal Health Coverage by 2030, better institutional complementarities should be sought in paving the way for easier adaption of the Health in All Policies approach, should the government choose this path.

1.3 SDH – Healthcare services and impact on the UHC

Behera and Behera (2015) point to the relevance of a borader definition of health that the UN General Assembly has given indicating that the UHC journey and the choice of SHI in particular has the potential to render populations the benefit of equitable access to health in gaining "the highest attainable standard of physical and mental health" and this includes **"the work on social determinants of health"** (Behera and Behera, 2015). The place of healthcare services (and by extension health systems) in the Dahlgren and Whitehead (1991) framework on the SDH is considered important to the discussion of health outcomes and the social determinants in Ghana. According to the WHO, healthcare services represent the culmination of all services which exists for the population and must be related to the well-being and health needs of a people. It also represents 'the forgotten arm of UHC' (WHO, 2018: 23). Indeed, healthcare is positioned at middle level as the other SDH by the WHO CSDH and its appreciation is believed to contribute

to equity in the distribution of health to a population (Ward, 2009). By definition, healthcare services refer to **'activities whose primary purpose is to promote, restore or maintain health'** (Ward, 2009) for a population and in considering the various networks under this definition, it should be the healthcare system in genral and how all the different dimensions of it work together to achieve the objective of good health. Ward (2009) posits that due to the continual interactions between the various networks mentioned earlier, healthcare services must be considered social – that it is not 'a given state' but thrives on communication and interaction between patients and practitioners making it susceptible to amendments through practice and policy. By this definition, an efficient healthcare system should seek to have strong internal institutional complementarities that deliver effective services to patients when the need arises.

Consideration of the healthcare services under the SDH in this study took a view of the state of the current healthcare system in Ghana with emphasis on the chosen trajectories for achieving the UHC being the NHIS as the primary policy under consideration and the CHPS as the alternate policy (Kingdon, 2011: 4 - 18). From the data collected, there is concensus among key informants that the state of the healthcare system in Ghana has been progressive but not at the level deserving of a LMIC and one that has gone through so many reforms with corresponding financial investments. For a country of over 28 million people, the NHIS policy which started in earnest in 2003 and with a share of GDP being 10.6 percent, the current coverage of 40 percent has been described as woeful. The alternative policy selected for partnership of the NHIS in attaining the UHC (the CHPS) has achieved coverage of only about 5 percent with glaring challenges. The challenges facing the NHIS have been cited as many, not exclusive to the following – formal and informal OOPs often creating inaccessibility for many who cannot afford, poor health worker attitude (for those at the scheme offices and also at health facilities), inadequate medical equipment and logistics for the CHPS (this has affected the deployment of many trained Community Health Nurses (CHNs) and Community Health Officers (CHOs) to the rural areas where much of the population resides), high turn over of trained health workers especially medical doctors and nurses (due to poor working conditions and low remunerations), reported cases of discriminatory treatment towards subscribers of the NHIS, delays in the reimbursement to service providers, inefficiencies observed and experienced in the management of the NHIS, a seeming lack of education and/or communication on the objectives and principles

of the NHIS and the presence of politics which is seen in both a negative and a positive light but which is considered relevant in bringing about change in the health sector.

Focusing on the issue of **responsiveness of health workers to people who go to seek healthcare**, the WHO through its World Health Report of 2000 considered this area as one of the critical goals of any health system (WHO, 2018: 34) but as is evidenced from the empirical study, the country does not seem to be achieving this goal. Responsiveness as considered by the WHO include dignity, confidentiality, prompt attention, autonomy, access to social support and quality of basic amenities (WHO, 2018: 34 - 36). One other problem identified with the CHPS in particular and the entire health system is **the poor implementation of the decentralization concept in governance and the health system,** with all decision-making reverting to Accra, the capital. This is what Ridde et al. (2018) term **'recentralisation or verticalisation of decision-making'** which has left the potential impact of the decentralization elusive to many African countries. Couttolenc (2012) also points to the challenges of a not fully decentralized healthcare system in Ghana which affects health delivery. The stagnant coverage of the NHIS cannot be fully blamed on the healthcare services issues enlisted earlier, but also the absence of enforcement of the law concerning compulsory enrollment by residents in Ghana. Thus, there is an observed tension between the compulsory and voluntary approach to Community-Based Health Insurance (CBHI) and health insurance at large which has negatively affected the coverage rate of the scheme, especially for those in the informal sector (Ridde et al., 2018). The challenge of the decentralization that exists within the NHIS' implementation that tends to affect the CHPS can best be viewed as a presence of low level internal institutional complementarity within the health sector (Boidin, 2018 working paper: 19).

Some of the healthcare system challenges gathered from both the literature review and the empirical study points to issues of capacity of the human resource in the health sector to deliver on objectives set for the different aspects of the system. The lack of capacity and commitment as identified by key informants under the empirical study affects not only coverage but planning, quality delivery, resource mobilization and utilization, data collection and management and a host of others. From the representative of the EU, the challenges in the health planning system can be summarized as **"Our health planning process needs the right people to think right. It needs people to not just think about the planning but costing also, and how to achieve it.**

Because it is not all the plans that we make that need money; some need just the human resource, some need the commitment, some just need some discussions around the table and it's done. So we need proper people to do a proper planning". In addition to the capacity gap in existing health professional is the problem of inadequacy of health professionals with a documented doctor-to-patient ratio standing at 1:13,000 (Yusif and Soar, 2014) for a population of over 28 million people.

1.3.1 Enrollment and renewals

Enrollment rates on the NHIS have since inception been uneven - rose from 6 to 20 percent of the population between 2005 and 2006 (Agyepong and Nagai, 2011) and then doubled and stagnated at 42 percent in 2007 (Agyepong et al., 2016). For the past three years (2015 – 2017), the national enrollment numbers have been declining - 11,342,450 in 2015, 11,029,058 in 2016 and 10,656,951 in 2017, respectively (NHIA, 2018). Using the research outcome on enrollment rate in one of the regions in Ghana – the Volta Region, the periods between 2010 -2013 experienced different trends in growth between the rural district mutual health insurance scheme and that of a municipal district mutual health insurance scheme. **Enrollment in the rural setting saw a decline in the period. Meanwhile majority of the Ghanaian population reside in rural areas and also represent the source of produce for the urban markets.** Amu and Dickson (2016) observed conversely that women in the rural setting had a higher likelihood of subscribing on health insurance than their counterparts in urban areas. In this current study, the respondents who were subscribers had enrolled on the scheme from one year to five years and more. Majority of subscribers had enrolled for between 3 to 4 years (56.9 percent) (Table 29) and had knowledge of the changes they had experienced over that period which informed their perceptions of quality of services delivered to them - these were predominantly peri-urban and urban respondents. The motivation to enroll stemmed from many factors not limited to service quality. In Ghana, majority of the population is women who need healthcare services due to biological reasons, economic and the traditional social roles which border on caregiving. From the empirical data (reference to Table 20, Distribution of respondents by gender and subscription status), less than 50 percent of the subscribed respondents were women which is not encouraging as the estimation of majority of **women and children who die annually are over 130,000 from**

preventable causes - mostly related to maternal and child mortality (Aseweh Abor et al., 2011). Even though the exemption policy under the NHIS covers pregnant women, maternal healthcare, utilization should also be encouraged. The NHIA's work should not end with providing coverage for this exempt group but should ensure utilization, thus, with reliance on other sectors such as education, this challenge could be overcome. Aseweh Abor et al. (2011) point to lack of education as one of the deterrents of maternal healthcare services utilization. But to ensure gender parity, all other concerns such as no need for registration/renewal, issues of lack of interest and others (refer to Table 26, **Reasons for not subscribing on the NHIS by gender**) should be addressed in the expansion of the UHC in Ghana in partnership with other ministries and state agencies who's core mandate some of these concerns may fall under. Thus, there is need for the HiAP approach.

1.3.2 Service quality and effectiveness of the NHIS

According to 48 percent of respondents in this study, as NHIS cardholders they are treated differently (poorly) as compared to other patients with other forms of payments like cash, private health insurance and others. Interestingly, Agyepong and Nagai (2011) also documented a similar report of stigmatization and poor service at point of healthcare access by cardholders in 2005. One of the plausible reasons assigned to this behaviour of frontline workers towards cardholders was that it could be a form of sabotage of the system in rebellion to a system that has now tend to prevent the collection of illegal fees (Agyepong and Nagai, 2011). Holding a card translated into a cashless form of transaction which prevented corruption. The GLSS6 survey also reported that 9.6 percent of respondents in all the ten regions in the country expressed a lack of confidence in the in NHIS (Pg. 39). In a paper by Boateng and Awunyor-Vitor (2013), the perceptions of quality of healthcare delivery under the NHIS and its impacts on subscription rates in Ghana are discussed – the research outcome showed a strong linkage between perception of either good or poor quality service delivery and enrollment and renewals in the Volta region and the conclusion that quality of services delivered had a positive influence on voluntary enrollment and renewal. In another research, Ameyaw et al. (2016), a link between subscription and perception of quality of service delivery was found in the three most poorest regions in Ghana (the Northern, Upper East and Upper West regions where enrollment rates on the NHIS

were high and the perception of good quality recorded same positivity) with assigned plausible reasons being that first, due to the pro-poor nature of the scheme and the indigent category (where in practice, the MoH and NHIA is in partnership with the Ministry of Gender, Children and Social Protection (MoGCSP) under the LEAP programme provided indigents with free healthcare as part of the cash transfer and social welfare programme) seemed like a benevolent gesture. In relation to this, the equity goal of access to healthcare by all embedded in the design of the scheme seem enhanced. Secondly, there were also regional - level heterogeneity in perception of quality of health services provided under the NHIS with enrolment rates lower in regions where poverty levels were lower – this perception is based on the fact that people who were not in the poorest regions have the financial capacity to afford different healthcare options such as private health insurance, and other healthcare service providers which may even require OOP (Ameyaw et al., 2016). Perception of poor quality service delivered to subscribers and its consequent influence on interest and willingness to enroll and renew subscriptions have also been linked to non-subscription and declining membership in a mutual health organization (MHO) and a community health insurance (CHI) in Guinea Conakry and Uganda (Ameyaw et al., 2016). In this research, 36 percent of respondents cited responses which border on perception (lack of interest, preferred service not covered, slow registration process and lack of effectiveness) for non-subscription on the NHIS. The national survey indicated that due to inefficiencies in the system, 78.2 percent had not enrolled on the insurance scheme. This is important in understanding the potential challenges that the UHC faces in Ghana if the policy continues to be implemented as has been. With continued perception of poor service, few people would be interested in subscribing and renewing their subscriptions.

Under this study, respondents indicated that they are made to make OOP for a number of services upon accessing healthcare using the NHIS card (refer to Table 27) and collaborated by the comparative analysis between the dissertation and the work of Agyepong et al. (2016) (Table 33). This finding has implication for the rationalization and communication of the NHIS Medicines list which is periodically reviewed, and potential fraud on the part of the service providers and consequent sustainability of the scheme. Thus, if NHIS was focused on the elimination of the "cash and carry" system and the promotion of access to quality healthcare without financial hardships on households and yet card bearers still have to make OOP for some services, then the objective of the UHC in Ghana is not being achieved. With subscribers not

made aware of what benefit package they are entitled to, unsuspecting ones could easily be taken advantage of by service providers who are aware of the information gap for subscribers. There is also the challenge faced on the service provider side whereby after months of providing services to subscribers, the government delays in reimbursing them. This phenomenon of delayed payments to service providers has persisted for years in the country at the different implementation stages of the policy causing service providers to be indebted to the suppliers of inputs into their health facilities. This also affects the quality of care delivered to subscribers during those periods – some subscribers at point of accessing healthcare have been asked to make OOP or are turned away without care.

1.4 Sustainability concerns of the National Health Insurance Scheme (NHIS)

In government's annual budgetary allocation to the health sector, there have years when the allocation to the sector was woefully inadequate. The place and influence of budgets on policies and their implementation cannot be overemphsised – Kingdon (2011: 105 – 106) explains this influence that without due appreciation for budgets, policy makers cannot afford to contemplate policy proposals, alternatives, initiatives. Consequences of budget constraints can render a blow not only to the place of a policy on government's agenda but can ensure that nothing gets done. He describes **the effect of budget constraints as "…..so severe that it virtually paralyzes people."** For instance, in a particular year, the allocation to the sector was so low that the NHIS struggled to reimburse service providers meanwhile the scheme contributes significantly to the resource envelopes of many activities in the sector and with delays in reimbursing service providers, the quality of services rendered to subscribers would be compromised. While this funding challenge affects service delivery, from the respondents of the survey, it also inadvertently affects perception of people and influences their decision to either enroll or renew. There is also the matter of the enforcement of the law concerning compulsory enrollment which is lacking in the country but health insurance thrives on the pooling of risks. And of course, **health concerns** are known to **receive attention when there is a strong political will** (Marmot, 2015: 20). All the key informants interviewed indicated the importance of politics in health. The success and sustainability of the scheme is dependent on increased number of people who patronize its services as well as political will to make necessary changes required to inform the

attainment of the UHC by 2030. The coverage of over 90 percent of all illnesses without expectation of co-payment in the country with a significant number of exempted people also draws attention to funding issues.

The sustainability challenges facing the NHIS reveal inherent design flaws which have been with the scheme from the onset – due consideration was not given to the capacity of the country to perpetually handle the benefit package to subscribers and corresponding communication about this fact was absent to potential subscribers at the time and there were no cost control mechanisms to moderate projected growth demands as well (MoH, 2016: Proposed Redesign and Restructuring of the National Health Insurance Scheme Main Report).

BOX 14: DEVELOPMENT PARTNERS' OPINIONS OF POLICY IMPLEMENTATION APPROACHES IN GHANA

"The current institutional arrangement with the decentralization concept not fully incorporated into the health system and everything concentrated in Accra is a problem that would affect the UHC, especially at the district level." **- WHO Representative**

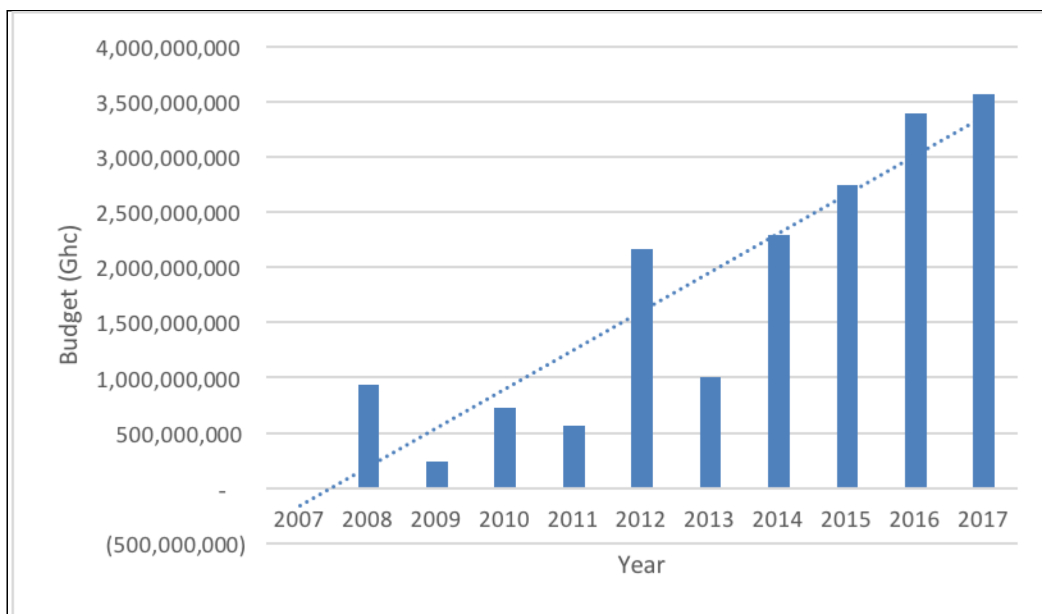
"This is typical of Ghana - there are a lot of policies in this country, frankly. In the stage of planning the policies' implementation, people don't include the planning of the budget to implement or materialize the policy". - **JICA Representative**

There seems to be a challenge with implementation across board with key development concepts adopted for the country's growth not being fully implemented such as the decentralization approach to devolving decision-making power to the grassroots level where as per the gatekeeping system, primary health care is accessed. If this system was properly implemented, it could ensure better financial planning and better the care given to subscribers, majority of who reside in the rural areas.

In terms of the human resource base to support the expansion drive towards the achievement of the UHC, there seem to be an over produced number of public sector health workers without

corresponding infrastructure to allow for deployment especially under the CHPS and mostly to the rural settings where most the agricultural activities in the country happen. The WHO key informant indicated that over the last seven to eight years, whilst the health sector workers have increased to over 40 percent, there is still a capacity gap to address the many health challenges in the sector. This serves as a frustrating challenge to the sector which allows health sector workers to work not to standards set – this has been attributed to the lack of supervision and an appraisal system. **"The appraisal system is a gentleman's agreement or a matter of course"** the WHO Representative stated during data collection of this study. But addressing the supervision of staff conduct is part of the mandate of the Ghana Health Service (Code of Ethics and Patients' Charter) and there also exists the Health Facilities Regulatory Agency (HFRA) under the MoH which has since 2015 been mandated to license and monitor the activities of both public and private sector health facilities. This lack of capacity to adequately supervise performance of staff in the health sector translates into poor service quality across the entire sector which affects not only perceptions about service delivery, but which has been attributed solely and possibly wrongly to the fact of bearing an NHIS card. This is another reflection of poor internal institutional complementarities within the health sector.

FIGURE 23: 10-YEAR ANNUAL GOG BUDGET ALLOCATION TO MINISTRY OF HEALTH



Source: Author's computation based on Government of Ghana Budgets (2007 – 2017)

The graph above illustrates the GoG's financial commitment to the health sector through its annual budget allocation from 2007 to 2017. In the ten-year period, government budget allocation to the sector has witnessed a few dips but since 2014-2017, it has been increasing. As compared to other sectors (selection based on the SDH framework), the sector places second, next to the allocations given to the educational sector. Over the ten-year period, there have a general ascending trajectory but some pitfalls noted in the years of 2007 to 2008, a slight rise in 2008 and a significant fall in 2009. The period 2010 to 2013 also witnessed uneven annual budget allocations but a steady rise from 2014 to 2017. The 2007 and 2017 show the lowest and highest budget allocation respectively across the years reviewed. The World Bank/IMF agreement started in the 1980s and adherence to conditionalities under different governments have had mixed effects on GoG's borrowing patterns. Figure 8 on Ghana's Public Debt for 2007-2012 showed that it had risen and cost of borrowing for the private sector was high. This has implication on spending by the private sector which among others employs a significant number of labour. Also, with government borrowing 'crowding-out' the private sector, the private sector is left to borrow at steep rates making expansion of business activities illogical and unsustainable hence reducing the intake of labour, job cuts, limited spending on activities that would have ideally put money in the pockets of people who work along the supply chain. This leaves disposable incomes at the household level reduced. With this, spending on healthcare – subscriptions and renewals could also reduce. This could account for the low subscription figures witnessed in the subscriptions in the period of 2010 – 2013 in the Volta Region (refer to figure 19 used as an example in the discussion) and this also corroborates the enrollment rate reported in the 2013 annual report of the NHIS for that year.

Section 2: The applicability of the international intiatives to the case of Ghana

This section introduces the SDH and the HiAP initiatives and based on the empirical study, considers the plausibility of their adoption in Ghana. The 2.1 addresses the HiAP approach while 2.2 focuses on the SDH and its different facets which make it either easy or difficult to implement in the case of Ghana. Finally, using the Framework for Action on the UHC in Africa, Ghana's progress towards the achievement of the UHC is made based on the framework in 2.3.

2.1 Health in All Policies and the empirical evidence

Through an understanding of the SDH, health is not the preserve of only the health ministry or sector but rather, due to the fact that all sectors have implications on health outcomes emanating from economic, social and governance, the multidimensional lenses through which the HiAP operates must be paid attention to. From the data collected (literature review and empirical data), there is confirmation of collaboration between the Gender ministry (MoGCSP) where the LEAP is domiciled, the MoH and the NHIS, which helps in incorporating health into a cash transfer programme for indigents. However, a full awareness and implementation of the HiAP concept is lacking. Majority of the key informants under the study agree that healthcare issues are important in the country however, they have not been prioritized across all the sectors. And **the knowledge of HiAP for most of the key informants was low to absent and these are actors who are fully active in the health sector in the country. Once the concept of HiAP was explained and connected to the SDH, they could relate and explain in context what an adoption of it in the Ghana context could mean**. This is not a new development in the context of LMICs, as Exworthy (2008) has noted **'Knowing and understanding causal pathways is a first step in devising appropriate policies but many gaps in knowledge remain, especially in LMIC contexts'**. With this, how and where should the discussion of the SDH be proposed for adoption?

BOX 15: OPINION ON THE NEED FOR HiAP

"There is an issue of governance, not leadership. In the past 13 years, many people pointed out some challenges of the NHIS and proposed the idea of the improvement through the 10-year review of the NHIS. Now the review has been conducted by many persons but decisions are not taken and there has not been any significant change of the system. It's not an issue of the NHIA alone. Maybe the primary responsibility is the MoH because it is the sole actor to design the system, administratively. Although decisions should be taken by other actors – NHIA, Ghana Health Service, MoH is governed by Cabinet; there is also the Ministry of Finance, government in general. Each party has a role to play because a single party cannot provide the NHIS…….but each agency does not take responsibility" - **JICA Representative**

What it means for the UHC

While 50 percent of the non-subscriber category of respondents under the study seeks healthcare through sources which are predominantly reliant on OOP, the subscriber category which was supposed to depend on the NHIS in accessing care still gave room for OOP for many aspects of healthcare under the NHIS. These OOPs were registered when respondents accessed the following services: expensive medicines (51.2 percent) which service providers claimed were not on the NHIS Medicine's list, laboratory tests (30.2 percent) and 18.6 percent of respondents cited blood transfusion as demanding OOP at the point of accessing healthcare using the NHIS card.

Ghana can be described as a country with a relatively young population. Ghana's demographic structure has a youth bulge which should be considered in planning and projecting investments towards healthcare in the future. While the country is saddled with a youth bulge, life expectancy has gone up with a reducing fertility rate and also, increased incidences of non-communicable diseases (NCDs). Soon, the population available in the labour force to support the NHIS through contributions would be reduced if the rapid growth in NCDs is not curtailed. The issue of investing in specialized care with regards to the CHPS and other healthcare interventions is critical. Investment in the CHPS, for instance is going to guarantee a wider coverage of healthcare for more people in the country especially those in deprived communities to address the issue of health inequalities. For the adoption of the HiAP, there is the need for an assessment of the various aspects of the healthcare system, planning and making necessary investments which can enahance the performance of the UHC. One area that can support the application of the HiAP in Ghana includes the strengthening of Health Information System (HIS). With the reliance on progress made by Ghana in terms of the recent positive developments on access to internet usage, with penetration said to have increased appreciably from 5.2 percent in 2010 to about 10 percent in 2011, there is opportunity for adaption. For total mobile voice subscription, coverage is at 98 percent of the total population (Yusif and Soar, 2014). Despite the introduction of the NHIS, there are still equity concerns among citizens who live in the southern and northern parts of the country. And there is still the nagging problem of maternal mortality ratio (the country's failure to meet the MDG 5.1 target of reducing maternal mortality ratio) which hangs

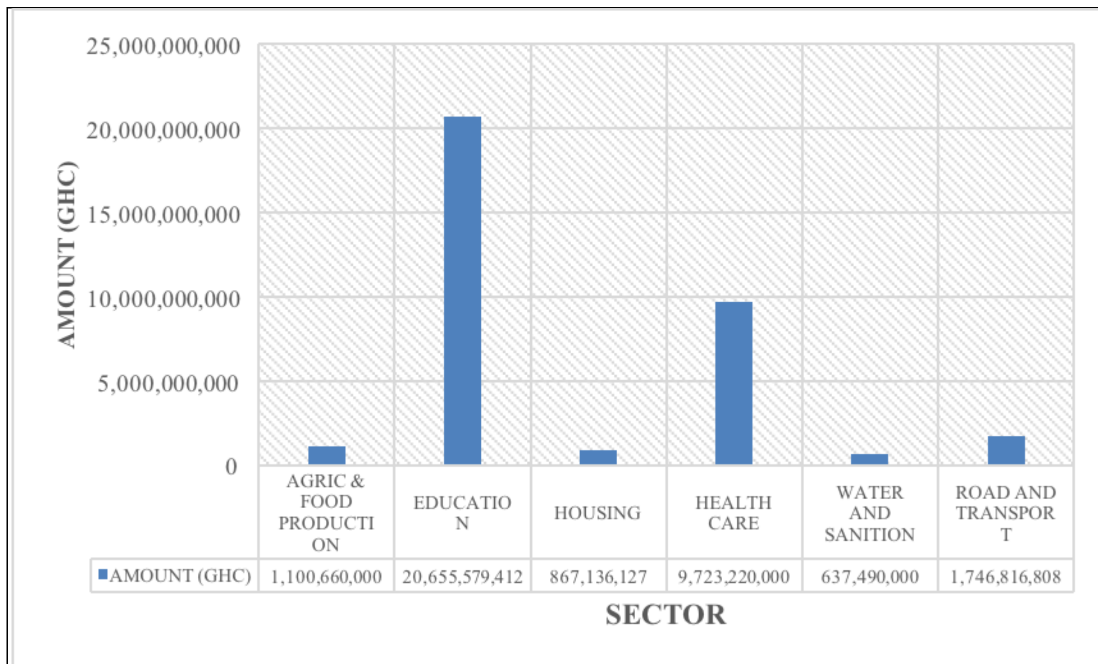
over the country's health performance. But by relying on e-Health[47] in Ghana, this inequity challenge and MMR could be overcome. This effort however calls for the efforts of many different sectors such as the Ministry of Health, Ministry of Communication, Ministry of Information, Ministry of Education and the Ministry of Local Government and Rural Development (where the decentralization governance policy implementation resides). This holds great promise for the geographical expansion of the UHC in Ghana and the improvement of healthcare services in general. While this is promising, the challenge of the readiness of the country has been questioned in terms of first, the observed difficulty of achieving sustained growth of new technologies stemming from systematic inefficiencies of institutions, and secondly, a gap in the education of Information and Communication Technologies (ICTs) professionals (Yusif and Soar, 2014). Fortunately, there is precedence for the adaption of a HiAP approach in a project using e-Health by the Novertis Foundation for Sustainable Development (NFSD) which collaborated with the Ministry of Health and the Ministry of Communication in addressing the medical staff shortage problem in the country with doctor-to-patient ratio at 1:13,000 nationally, a far cry from the world standard of 1:5,000. There are other similar initiatives such as this (Yusif and Soar, 2014). Developing countries such as Rwanda which is said to have attained the UHC, made nationwide investment in ICT as part of monitoring service quality, evidence-based policy-making and innovation in their healthcare system (Binagwaho and Scott, 2015).

BOX 16: OPINION ON REDESIGN OF THE NHIS FROM THE EMPIRICAL STUDY

"The concerns of the health sector, especially the NHIS has to do with financing. The NHIS must be redesigned – there are a lot of inefficiencies leading to the deficits. When Ghana introduced the system, it was very pro-poor, soft, not strict design with a lot of benefits. Many countries try to start from the small-scale but Ghana's case, it started from the biggest part. There are a lot of people who are exempt and a lot of categories of diseases to be covered. The initial design was ambitious. If it is not reviewed, it will be difficult to control the financing aspect" - **JICA Representative**

[47] "E-health" is described as an emerging filed which incorporates medical informatics, public health and business, addressing to health services and information given to the public which are enhanced by the use of the Internet and other such related technologies including mobile phone, computers, satellite communication and others(Yusif and Soar, 2014).

FIGURE 24: CUMULATIVE BUDGET ALLOCATION FOR SOME SECTORS IN GHANA (2014 -2017)



Source: Ministry of Finance and Economic Planning, Ghana

The graph above is the cumulative representation of government's annual financial allocations to the various sectors (selection based on the SDH) for the period 2014 - 2017. From the graph, the two sectors prioritized were education and health, however, the health sector's budgetary allocation in the period is second to the education.

2.2 Feasibility of the Social Determinants of health's adaption in Ghana

In relying on the SDH (based on the theoritical framework of the Dahlgren and Whitehead, 1991) in the selection and explanation of key sectors in the Ghana context, there have been synergies and gaps identified which have an influence on how the UHC in Ghana can be achieved. The SDH as a concept and the HiAP (as an enabling tool to ensure implementation of the former) seem like a novel concept at the policy-making level (evidenced through responses gathered under the empirical aspect of this study) and in line with the position of Exworthy (2008) on the knowledge gap existing on the causal pathways as a first step in developing appropriate policies in addressing challenges of SDH, especially in a LMIC context such as

Ghana. As evidenced from both the literature review and empirical outcomes of this study, there exist both health issues and health disparitives in Ghana, especially under the SDH in education and healthcare services where implementation of the NHIS and the CHPS were positioned. From the implementation of the two health policies, although there are different levels of working relationships among the institutions responsible and supporting implementation, there also pertains lack of sufficient institutional complementarities among key stakeholders within the health sector to ensure growth, expanded coverage and the needed quality of care for the attainment of the UHC in a timely manner. Therefore, policies to be developed to firstly, introduce the SDH/HiAP into the governance system should not only be by the MoH, as health is not the preserve of only the health ministry. Secondly, to see to the implementation of such policies in the Ghana context especially with the current policy window (Kingdon, 2011: 165) is opened with a newly elected government. As Deaton (2002) posits 'Policy cannot be intelligently conducted without an understanding of mechanisms; correlations are not enough'. The current mechanism of the state institutions is to work as silos or chimneys (Boidin 2017; Exworthy, 2008) and this, as evidenced in the empirical study, poses a threat to the attainment of the UHC. As pointed out by the European Union (EU) representative during the empirical study when asked about how the HiAP could work and how all the ministries are collaborating, her response was, "That is not that easy. It's not easy for the normal civil servant because - I've worked at the Ministry of Women, Children and Social Protection before and the situation there is that when somebody identifies a project, **they think that because it's a project they should be the one in charge but as far as they don't really need it in their specific ministry, they don't care"**. This 'territorialism' attitude among different ministries could pose a challenge to the discussion of the SDH because an absence of institutional complementarities is required for the progressivity of the UHC.

The current mode of implementation of the different pathways chosen for the attainment of the UHC presents its own sets of challenges, however the different perspectives of the SDH (intended under this study to support the implementation of the UHC through the HiAP) could also prove problematic. For the SDH to be infused into the governance system of Ghana for implementation, there must be a translation of the concept into a policy, and thus, an attempt to view the SDH through different lenses is required. The SDH as seen **as a 'life-course' phenomenon presents a contrasting view to the duration within which outcomes of an SDH**

policy can be manifested and evidenced for all to witness as pitched against the known tenure of elected/appointed institutions/offices such as presidential, parliamentary or even electoral tenures which can be concretely measured. Unlike these terms, the life-course perspective of the SDH sheds light on how difficult it is to measure the timescale associated with the impact of lack of education, poor nutrition or even environmental degradation on the health of a population. The time frame for the manifestation of such effects is difficult to measure and may present a challenge to a range of necessary constituents including budgetary cycles (measured annually) needed to ensure its translation into workable policies. It is thus difficult to integrate short-term approaches such as earlier mentioned cycles with those that have long-term effects or outcomes such as the SDH presents. Appreciation for such a merger would be rare. This **perspective would inadvertently affect the needed commitment that should correspond with the introduction and implementation of such an initiative** (Exworthy, 2008) in the case of Ghana. For instance, the NHIS policy implementation seems to be characterized by both positive and negative feedback loops (Exworthy, 2008) and could benefit from an injection of change (not alien to the policy process as its known to be 'messy' and could be iterative (Exworthy, 2008; Kingdon, 2011). This injection of change could come at the heels of the sustained interest and commitment to the policy which has presented traceable results in a period that has not taken a life-course. This change could take 'advantage' of the 'window of opportunity' (Kingdon, 2011: 165 - 167) that has been presented within this current governance cycle.

The next perspective of **the SDH** is that, its **implementation demands action from different organizations and sectors** (Exworthy, 2008) but as earlier indicated, **these collaborations are difficult to muster. This perspective is in line with that of the SDGs 3, that its implementation demands 'not a sectorial delegation of responsibilities'** according to the WHO (2018: 2). Another perspective worth mentioning of the SDH is that, it requires resources to implement – resources here explained as both human and financial. Firstly, as the empirical study pointed out, **there is a gap in knowledge about the concept of the HiAP approach and its implementation**. There must therefore be personnel trained in understanding the approach and exposed to its implementation to aid ease of infusion into the Ghanaian setting. Secondly, **there are competing prioritized projects and programmes already calling for financial resources to implement** and these priorities are across different sectors and even worst, there

would be competition in the same health sector which remain at its core (Exworthy, 2008). With the current agreement with the IMF and World Bank and the support from other development partners on decline, issues of **funding for a novel concept such as this would depend on prioritization of the government and of course, political will** (which is considered both positive and negative according to outcomes of the empirical study) with all key informants agreeing that it gets policies on the agenda of the country. One other critical perspective of the challenge that could be posed is the ability of the proposed policy and policy makers' in 'overcoming the inclination to conceptualise SDH as mere barriers to health behavior to be modified by lifestyle interventions by addressing them as structural factors instead' (Krumeich and Meershoek, 2014). If this happens, the SDH would have lost it focus and may as well be placed under only the MoH, this is important because such conceptual definitional challenges have happened in the case of the CHPS where misunderstandings and redefinitions of aspects of the concept overtime delayed its full adoption and nationwide scale up efforts. Finally, in the adoption of the SDH framework via the HiAP approach, there are aspects of such a novel concept that need to be rechecked for alignment in the case of Ghana such as **technical feasibility, value acceptability (by the specialists/professionals in and out of the sector who would work on the policy specificities) and anticipation of potential constraints** in order to ensure its survival (Kingdon, 2011: 131 – 138).

2.3 Ghana's progress based on the Framework for Action on the UHC in Africa

Table 36 below represents recommendations to the UHC implementation in Africa and an apt framework that describes some of the efforts currently being undertaken by Ghana in its bid to achieve the UHC (adopted from World Bank, WHO et al., 2016: 6). The framework spells out five key areas for action which need to be considered while implementing the UHC and adds the disclaimer of "there is no one-size-fits-all" approach to implementation strategies for each country. The areas include, services, financing, governance, equity and preparedness (World Bank, WHO et al., 2016: 19). Using this framework, aspects of the case of Ghana can be described in terms of efforts being made on the UHC journey.

TABLE 36: THE FRAMEWORK FOR ACTION ON THE UHC IN AFRICA

Financing	Services	Equity	Preparedness	Governance
More and Better Spending and Effective Financial Protection	People - Centered Services, Quality and Multisectoral Action	Targeting the Poor and Marginalized and Leaving No One Behind	Strengthening Health Security	Political and Institutional Foundations for the UHC Agenda
Improve efficiency of public and private health spending for better outcomes and resource expansion – with the introduction of the Public Financial Law, public servants are held accountable for financial misappropriations.	Establish people-centered health services to improve quality of services and patient safety – this is lacking in the health system currently but HEFRAH has been established to check for service delivery standards at the facilities' level.	Target vulnerable populations and design programs tailored to their needs – some of the social programs tailor-made for poor and vulnerable populations can be cited as the LEAP which is a combination of cash transfer and healthcare.	Improve national preparedness plans including organizational structure of the government-collaborations among different ministries and agencies such as the pre-screening exercise for senior school students between the MoH and MoE. There is a health screening exercise at the various ports of entry for Ebola-this is between the Ministry of	Establish platforms and processes to foster societal dialogue – there is an instituted program for all ministries called 'Meet the Press' which allows for information dissemination on government policies and programs and public education for all. Also, the Right to Information Bill has been placed in parliament and if passed into law, there

			Aviation and the MoH.	will be easy access to information and foster better dialogue among differents segements of society.
Increase government spending on health through budget re-allocation and increased domestic resource mobilization – from Figure 10 on priority areas for development in Ghana based on 2019 budget allocation to the various sectors and the, government has increased spending in the health and educational	Prioritize investments in community and primary health care services within the framework of viable local governance systems – the CHPS has been prioritized, scaled up but requires further investment in order to fulfill the expansion of the geographic access of UHC.	Expand service delivery to marginalized groups and settings – further efforts have to be made in reaching out to marginalized groups beyond the LEAP programme.	Promote adherence to the International Health Regulations (IHR) – better enforcement of the Code of Ethics and Patients' Charter under the GHS and also the Health Facilities Regulatory Agency (HFRA) should help Ghana perform under this guideline.	Enhance effective mechanisms for inter-sectoral dialogue and action – at the highest level of governance is cabinet where key sectors deliberate on the country's development is the MoH.

sectors. The introduction of the TIN serves as an avenue for better resource mobilization which would positively affect GoG's expenditure on health.				
Use budget resources to reduce financial barriers to care and make services affordable to everyone – the MoFEP's efforts to mobilize resources through enforcement of tax laws (a percentage which is allotted to the NHIS) is in the right direction.	Partner with civil society and non-state providers to expand access to key services and interventions – government has partnered and continues to partner with all such actors through the annual health summit and through the workings of the Development Partners Group,	Scale-up pro-poor interventions such as demand-side incentives, including vouchers and conditional Cash - transfers – this happens under the LEAP programme however, for expansion to occur, the programme needs to be further looked at, especially	Utilize international framework for monitoring and evaluation of IHR – through the Health Facilities Regulatory Agency (HFRA) such standards are monitored in the country.	Establish transparent monitoring and reporting on progress toward UHC – the MoH has established its own monitoring and evaluation mechanisms for checking for progress and reporting on the UHC. It has also had support from the USAID Health Finance and Governance

	mechanisms for discussion of the UHC have been created.	with the definition of indigents.		(HFG) project[48] in developing effective measurement of progress towards the UHCin the country.
Ensure that the poor, and people working in the informal sector benefit from pre-payment, and that Providers get a fair deal – enforcement of the law concerning compulsory enrollment will ensure that people in the informal sector are covered under the UHC. Also, the introduction of the capitation mode of payment under	Invest in pre - service education, particularly in underserved areas – the NHIS' efforts at drawing the registration and renewal of membership through the electronic renewal service efforts by the NHIA in partnership with the NCCE and the Information Services Department are	Ensure the rights and entitlements of women, children and minorities, particularly during vulnerable parts of the life course.	Enhance relevant partners' and across countries' collaboration to prepare for and respond to public health emergencies – this is done through the Annual Health Summit, Development Partners' Group and the Health Sector Working Group meetings.	Strengthen national institutions and organizations to lead implementation of reforms for UHC – the steps to this can be seen in the government's commitment to SDGs and the resource mobilization efforts.

[48] https://www.hfgproject.org/universal-health-coverage-monitoring-framework/ for information on the Health Finace and Governance Project in Ghana.

the NHIS would ensure that service providers get fair payment for services rendered. This effort should match the swift reimbursement of services provided by the NHIA.	concrete staeps being taken render pre-service education for the UHC.			
Improve the effectiveness of development assistance for health through improved coordination and use of country systems – this already happens through the Health sector Working Group meeting which started before 1997under different names	Engage in multisectoral action to address determinants of health – this as seen is on course in various areas but further efforts at SDH must need to be done.			Ensure that all citizens have access to data and information on UHC, as part of societal dialogue and participatory processes – this can be done between the NHIA and NCCE.

Source: Author's adaptation of World Bank; WHO et al. (2016: 6, 47 - 57)

In order to achieve milestones in the health sector generally, and towards the UHC, the government has increased its budget allocation for the health sector and also, in line with domestic resource mobilization especially in the area of taxation. To improve traceability of people's activities in relation to the various state institutions and especially to tax collection, the National Identification Authority (NIA) has started registering residents in the country on a single database supposed to be connected nationwide to all major institutions including the NHIS, drivers' licensing, tax offices and others. There has also been public education on the registration of the Tax Identification Number (TIN) and the enforcement of this resource mobilization effort by an agency under the Ministry of Finance and Economic Planning (MoFEP), the Ghana Revenue Authority (GRA). The TIN has been made a mandatory for official transactions with public institutions such as the registration of land titles (which falls under the Ministry of Lands and Natural Resources), registration of businesses, transactions at the ports, transactions at the district assemblies (under the Ministry of Local Government and Rural Development) and others. Thus, there is a hint of (both internal and external) institutional complementarities at play in revenue mobilization in the country. Commendable is the response of government to the public outcry against corruption of public officials who use national resources for their personal gains – with the establishment of the special prosecuter's office (intended to prosecute and imprison state officials who misuse state funds). It is recommended that these efforts be sustained combined with an overt approach to the incorporation of the HiAP concept towards making the SDH one of the key drivers to achieving the UHC and generally for development in the country.

In terms of financing, enforcement of the law to make it compulsory for every Ghanaian to subscribe is needed to increase the subscription numbers and improve the financial might of the policy – indeed, taking a queue from the efforts of the MoFEP on the enforcement of the directive on the TIN registration, a precedent has been set for same to be done for the NHIS. Health insurance thrives on increased number of subscriptions and additionally, health insurance schemes built on CBHI and established without compulsory enrollment remain weak and slow in growth in terms of coverage (Agyepong et al., 2016; Ridde et al., 2018). In addition to this, judicious use of available resources is recommended. This would involve reducing the financial hemorrhage in the system through corruption, the elimination of duplication of efforts by different actors in the health sector and by punishing public officials who are caught as culprits

in financial malfeasance in the health system as a deterrent to others. The government's commitment to the sector, as shown through the Figure 24 for the 3 year budget seems to be on the ascendency although as compared to the education sector, it places second. This is encouraging and the momentum must be continued especially as the study made a link between health insurance subscription and educational background (other studies also support this finding).

The provision of quality of service in the health sector must be seen as playing a dual role - first, as a catalyst for inciting the interest of non-subscribers to enroll on the scheme (as part of the resource mobilization drive) and secondly, that subscribers deserve value for money and also that, good quality service delivery is a key driver to keeping subscribers committed to renewing their subscriptions yearly. It makes financial sense to ultimately provide quality service to all. Under service delivery, the communication about benefit package and whether for some services a top-up (OOP) may be required must be made to subscribers. This communication gap fuels the perceptions about the value to be obtained from subscribing on the NHIS. Thus establishing a people-centred health system in Ghana, in practice, is not fully realized even though the aspiration remains but in line with service delivery, the NHIA has introduced innovations into the system aimed at first, getting more people to enroll and secondly, delivering efficient services (reference to Tables 8 – 15).

Equity as expressed in the NHIS' policies is laudable but should be looked at again. In planning the equity aspects of the policy, corresponding funding for such should be considered. First the targeting of indigents, who do not only reside in rural areas (considering the current problem of rural-urban migration) must be reconsidered, neither do they also reside only in the three most impoverished regions in the country (where the LEAP is most prominent) and the targeting of the indigents should be looked at so that first, many in that category are not overlooked.

Additionally, a mechanism to identify and re-categorize people who may fall out of the exempt category must be introduced otherwise people previously considered poor and vulnerable may stay on the scheme for life which would financially make it unrealistic to keep adding on to lessen the financial burden of the NHIS on the country. The health sector collaborates with other sectors in pursuing some health goals including its preparedness for outbreaks of diseases and

other unexpected health concerns seem to be in place. Examples can be cited for the partnership of the sector with the Ministry of Education (where two agencies under two different sectors - the Ghana Education Service and the Ghana Health Service) have collaborated to prevent a health epidemic in educational institutions at the senior high school level for screening during student registration period is laudable. Another that can be cited (which started with the outbreak of Ebola in the sub-region) is the erection of screening equipment at the ports of entry into the country. These are laudable signs of preparedness to fight diseases within the country with efforts between the MoH and the Ministry of Interior - Immigration. Governance, there is an established working structure under the MoH which incorporates the efforts of many bodies both within and outside of the sector in the governance and management of the health in the country. This can be seen through the workings of the Annual Health Summit, Development Partners' Group and the Health Sector Working Group and others. Also, at the highest level of the governance structure in the country, at Cabinet, the Minister for health is present – this represents the priority given the sector. This is commendable as not all ministries have a presence there but this prioritization must be felt in a deliberate HiAP approach where health concerns are made paramount to all policies of the other sectors and not only when there is a national crisis. Decentralization in the health system which has many benefits including resource mobilization and speedy decision-making powers allotment to the healthcare administrators at the grass root level from the CHPS, Community Health Centres and others must be fully implemented.

Conclusion of Chapter Seven

The Chapter 7 was conceived as a conduit between the theoretical and empirical analysis of the study. The aim was to make a presentation of the Universal Health Coverage journey more relevant in the case of Ghana based on the conceptual and theoretical frameworks.

From an empirical viewpoint, the UHC goal implementation has been examined based on the responses from the actors and the insights gained from the time spent at the NHIA. The place and contributions of the actors in terms of the policy design, mode of implementation, impact and challenges have been established. The empirical study has revealed the presence, although sometimes subtle and weak, institutional complementarities within and outside the health sector.

Theoritically, this chapter has enriched the understanding of the UHC implementation in Ghana, a developing country surrounded by policies that sometimes act as enablers and other times, not so much. These policies in the country, as juxtaposed by the SDH concept have revealed the potential for growth, expansion as well as inhibitions for the attainment of the UHC by year 2030. The perspectives under the different sectors which were based on the empirical study have made known the feasibility of adapting the SDH concept in the case of Ghana in light of the revelations of the empirical study and the literature of the determinants of health that exist. From both the empirical and theoretical, the chapter has proven that there is need for further work to be done and thus, the health concerns and the attainment of the UHC cannot remain in the armbit of the health sector alone and hence an adaption of the Health in Policies approach is needed. From Chapter 4, it is obvious that such a novel concept in the case of Ghana can be overtly adapted and applied in the UHC journey as the window of opportunity (Kingdon, 2011: 165 – 166) exist in two ways with the first being the new government and the second in the prioritization of the Sustainable Development Goals (SDGs) in the 2019 annual budget for all the sectors.

GENERAL CONCLUSION

This study has shed insights on the performance of the UHC in the case of Ghana. The general conclusion sums up the issues raised in the entire thesis, thus, both the literature and the empirical study. This part is organized in three parts, namely, reminder of the main lessons of the thesis, weaknesses and perspectives of the thesis.

Reminder of the main lessons of the thesis: for the purposes of expansion of coverage for the non-poor informal sector and sustainability, it may be best to heed to the call by Cotlear et al. (2015: 50) to review the NHIS' benefit package to make it narrower and uniform for all, and not as is done for the poor. That if made equally broad (such that all subscribers/enrollees enjoy equal benefit packages), "achieving UHC may become infeasible". Focusing on the the three dimensions for consideration (population covered; services and financial protection) (refer to Figure 1) towards the achievement of the UHC, Saleh (2012a: 88) indicate that Ghana, firstly, 37 percent of the population in Ghana are covered with a basic benefit package under the NHIS; secondly to address the issue of services covered, the NHIS offered coverage of 95 percent of all curative treatment under the scheme (absorbing about 20 percent of total health expenditure). Thirdly on the dimension of financial protection and to answer the question of whether people make Out-of-Pocket (OOP) payments for services, Saleh (2012b: 6, 151, 168) indicate that about 40 percent of total health expenditure is made Out-of-Pocket (OOP). This corresponds with results of this study (refer to Table 27: NHIS services requiring OOP) where about 27 percent of respondents (43 respondents out of 150) indicated that they make out-of-pocket payments and specified which services such payments were made for. Despite the smallness of the overall sample size under the study, the results remain significant and points to the predicament of poor households who have no financial protection. Asante et al. (2014), in a study point to a statement which draw similar conclusions as those in this study, that there is "an indication that many households in Ghana are making out-of-pocket payments for health" with the household OOP for health to total health expenditure reduced from 47 percent in 2000 to 37 percent and yet remaining high as compared to recommendations of the World Health Organization (WHO) for thresholds of 15 – 20 percent for such expenditures.

Observed weaknesses: financially, it is not feasible to carry on with the strategy that Ghana's NHIS has adopted, catering to about 95 percent of all diseases in the country with the current exempt category of persons. For the exempt categories, indigents should be assessed to understand the dynamism of their poverty - whether they are transient poor or chronically poor. Such classification would enable better national planning for all safety net programmes under the government and support financial planning in the medium to long term (Grosh et al., 2008: 373 - 377). It has been argued that while healthcare can be draining to the resources of a country, there has been progressive evidence gathered to prove that on the contrary investments made into healthcare is one of the most effective ways of reducing poverty and increasing economic growth (Borgonovi and Compagni, 2013). But since any insurance scheme thrives on the patronage of increasing number of people, the weak enforcement of the law in Ghana concerning the compulsory enrollment of all citizens if not addressed could eventually lead to total disinterest in the scheme and invariably, low patronage, and a return to OOP for all healthcare needs. This can only spell doom for many, especially the poor and vulnerable.

Preceding the enforcement is the required effort and investment in education in creating first, the awareness of the need for health insurance and second, the benefit package for enrollees. As already indicated from the earlier discussions, the UHC cannot be achieved without the influence of all the non-health sectors in the development of the country. From the research findings, one of the key issues raised by a number of the key informants was the lack of coordination among sectors but even more glaring was that of the major players in the health sector. While the country strives for economic development based on judicious utilization own resources, building the human capital of the country, reducing and eventually eliminating the incidences of corruption at all levels under the current President's mantra of 'Ghana Beyond Aid', the interrelations among the various sectors must be looked at. Chankova et al. (2008) posit that employment and education have the power to increase people's propensity to enroll on insurance schemes due to the fact that they both contribute to the acquisition of knowledge of the benefits of health insurance and the provision of opportunities to earn incomes to afford the premiums (Chankova et al., 2008). In essence, higher incomes increase the inclination of people to afford health insurance premiums (Dong et al., 2008).

The **need for education**, as has been stated through the discussion on the research findings and the comparative analysis made based on all the other studies. From the Table 36 (Framework for Action on the UHC in Africa), the recommendation is made for **investment in pre-service education** – the education, if based on the HiAP, would address relevant aspects such as good nutrition, sanitized work and living environments, work-life balance, all of which could be preventative of ill-health. In addition to the education based on the SDH, the **NHIA must embark on education campaign targeted at the general populace - both subscribers and non-subscribers, on the compulsory nature of the law concerning enrollment on the NHIS**, the benefit package of subscription, the exemption policy and others. This effort would go a long way to incite confidence in this health policy and its benefits which would translate into increased enrollment and continued renewals, ensuring that the UHC gets expanded in the entire country and also, the eventual sustainability of the NHIS. The government agency responsible for this role in addition to the NHIA itself is the National Commission for Civic Education and the Information Services Department. This agency has one of its functions as implementing programmes which inculcates in citizens their rights and obligations as pertains to matters of the law and constitution. It is an agency established by an act of parliament and committed to matters of education of the citizenry. This would represent a deliberate effort at implementing a HiAP approach in policy implementation.

Coordination among the various sectors has been cited as lacking cohesion in the empirical study, this is present even in the health sector itself **but the need for better coordination and a multisectoral approach has been recognized in the health system for decades** (MoH First Five Year Health Sector Programme of Work, 1997-2001: 26 – 30). As cited by the WHO representative during the data collection, the UHC in Ghana suffers from a challenge with decentralization whereby the people who are affected by the health policy of NHIS do not own the process. He explains that every decision seems to be centred in Accra, the capital city and the administrative city for governance. 'If we want to achieve any success with the UHC, we should emphasis more the work at the primary healthcare level. Let's decentralize the system, and make the local people the owner of the process. Perhaps because of political expediency, Accra dominates such that the local people who should own the process…..' While the issue of ensuring decentralization falls under the mandate of the Ministry of Local Government and Rural Development (MLRD) for all ministries and with institutional complementarities lacking, the

challenge of making decentralization work better in the health sector is formidable, especially as an LMIC struggling to position its economy right but the case of Rwanda can be cited for inspiration, if need be. According to Sekabaraga et al. (2011), the country in 2007 took a bold step towards **political and fiscal decentralization reform** which saw the healthcare delivery system fully decentralized led by the President. As part of this reform, the president set performance indicators for the health sector and also, signed **multi-sectoral performance contracts** with all district mayors to hold them accountable. The display of political will towards healthcare has in 2018 reaped positive results with Rwanda reported as achieving the UHC with **over 90 percent of Rwandans registered on the Mutuelle de Sante**[49].

Perspectives of the thesis: the need to be deliberate about the application of HiAP in Ghana is critical if the UHC goal is to be attained by year 2030. But Abudu (2016) points out that since independence some sixty plus years ago, none of the governments has been successful at establishing one key institution to firstly, coordinate the implementation of all policies, programmes and projects under the various ministries and secondly, to ensure that all such government initiatives produce the expected outcomes that would be beneficial to all citizens. This level of cohesion among policies has been lacking for so long and to address it, successive governments have attempted by appointing either a super minister or a de facto prime minister with such a responsibility but the task of ensuring that the age old lack of coherence and divergence of policies and programmes is too much for a single minister (Abudu, 2016: 40 - 43). Savedoff et al. (2012b) point out that while 'insurance coverage is associated with greater utilization of healthcare services, by itself it does not account for observed increases in aggregate health spending', income and technology have been identified as the key drivers of increasing health spending, as subscribers tend to demand more sophisticated advances in healthcare services which require increased expenditure (Savedoff et al., 2012b) but how cohesive are the health policies of the MoH with the Ministry of Communications where technological advancements in the government sector reside? Subsequent to the coordination issue is the challenge of prioritization which is considered critical to change and improvements in the healthcare system. The lack of prioritization has led to gross waste of resources which could otherwise be invested in improving the health system. The key areas of focus for investment if

[49] https://www.theeastafrican.co.ke/scienceandhealth/Rwanda-has-achieved-universal-healthcare/3073694-4896906-r24j1i/index.html

the UHC is to be attained within the stipulated time include health workforce, health financing, health information, medical products, service delivery and health governance WHO (2018: xiv) – all of these have been captured under the empirical study as problematic in the Ghana context.

The **effort at making HiAP engrained in the policies of all sectors to ensure that the SDH is addressed starts with leadership and political will** – the influence of political will was greatly appreciated by key informants during the study. It was concluded that politics and policy formulation and effective implementation go hand in hand. Indeed, health has become an important political issue in most countries across the world (World Bank; WHO; JICA et al. 2016: 10) with citizens holding their governments accountable for targets unmet. Indeed the recognition for the place of resilient public health systems across the globe – that while the term 'public health' has its own challenges in terms of the different connotations assigned to it, it remains relevant in a globalized world. The World Federation of Public Health Associations (WFPHA) has made a proposal to the WHO to position A Global Charter for Public's Health (GCPH) in the schema of the SDGs[50]. This happening on the international front gives an indication of the prioritization of health by all actors in recognition of the need to speak a common language in taking steps to address health concerns for populations. Through political will, a country that was neck-to-neck with Ghana for the attainment of the UHC, Rwanda has attained the UHC[51] (Xu et al., 2015).

Locally, it would take yet another political decision as was done to establish the NHIS (2003) by the NPP government, to conduct a review to ensure sustainability by the NDC administration in 2016 and an incorporation of the SDH into the governance system of the country by either the current or subsequent government because as Kickbusch (2016) stresses, **"health is to a large extent a political choice"**. Some steps have been started by the current government – with the President Nana Akufo-Addo appointed as co-Chair of the Advocates Group of Eminent Personalities on the SDGs and also, the African Union (AU) Gender Champion on the African continent, he has mobilsed the support of prominent personalities (intended as primary promoters

[50] To read more on the Global Charter for the Public's Health (GCPH) and its ideals - https://academic.oup.com/eurpub/article/26/2/210/2570439

[51] https://www.theeastafrican.co.ke/scienceandhealth/Rwanda-has-achieved-universal-healthcare/3073694-4896906-r24j1i/index.html

of social and economic transformation and of his vision of successfully implementing the SDGs) in Ghana. In his bid, he has stressed the importance of gender equity due to the fact that 52 percent of the Ghanaian population are female and education (www.presidency.gov.gh) with the latter being the flagship sector with the Free Senior High School policy. On agriculture and food production, some initiatives introduced include the Planting for Food and Jobs and the One-Village-one-Dam projects aimed at improving food production, reducing rural urban migration and generally improving economic and social circumstances of people in the country. On agriculture, the occupational mainstay of the majority of Ghanaians, President Akufo-Addo indicated that initiatives such as the programme for Planting for Food and Jobs, and the one-Village-one-Dam project in the three regions of the North, are the answers to the twin-problem of the migration of youth to city centres in search of non-existent jobs, as well as ending the disgraceful spectacle of Ghana importing food stuffs from neighbouring countries. From the above, there is a refocusing of the leadership of the country on the SDGs (as evidenced in the The 2019 Budget Statement and Economic Policy of GoG52 (Pgs. 6, 85 – 89, 99) states the GoG's commitment towards the SDGs, however, even within this attempt some sectors have been emphasized more than others. But this effort at infusing the SDGs into all sectors presents an opportunity for new international initiatives, highlighting the point that policies can emanate from multiple sources and as Lindblom (1968: 4) suggests, 'A policy is sometimes the outcome of a political compromise among policy makers, none of whom had in mind quite the problem to which the agreed policy is the solution. Sometimes policies spring from new opportunities, not from "problems" at all. And sometimes policies are not decided upon but nevertheless "happen".' With the mainstreaming of international initiatives into major policy and budget document, there seems to be a conduicive national mood for more initiatives that could further the development of the country. Historically, the country has been preoccupied with poverty alleviation and economic growth (evidenced through national policy documents - Ghana Vision 2020 (1996 -2000); the First Medium-Term Plan (1997-2000); Ghana Poverty Reduction Strategy (2003-2005); and the Growth and Poverty Reduction Strategy (2006-2009); Medium-Term National Development Policy Framework: Ghana Shared Growth and Development Agenda (GSGDA), (2010-2013); and Medium-Term National Development Policy Framework:

[52] https://www.mofep.gov.gh/sites/default/files/budget-statements/2019-Budget-Statement-and-Economic-Policy_.pdf

Ghana Shared Growth And Development Agenda (GSGDA II), (2014-2017) (www.ndpc.gov.gh). Obviously, issues of poverty are important to the policy discourse in all the sectors in Ghana, however, without a healthy population none of the strategies can be pursued. But health and its many dimensions and consequent policy requirements are complex and demand resources to keep the discourse of change in the health sector going. Lindblom (1968: 14) stresses that "…..for complex policy problems, analysis can never be finished…."

While the period between 1990 and 2015 saw the SSA and North Africa sub regions witness reductions in child mortality, many other African countries including Ghana were unable to meet all of the Millennium Development Goals (MDG) targets. Impliedly, building up on the unmet targets to achieve the SDG targets would seem overwhelmingly challenging (World Bank; WHO; JICA et al., 2016: 9). Some of the emerging challenges are being observed in health, economic, social, geographic, gender disparities World Bank; WHO; JICA et al., 2016: 10) and the UHC represents an avenue to ensure equity. The motivation for investment in the UHC is justified not only economically but morally – that regardless of one's economic circumstances, people should not have to die before their time or live poorly because they cannot afford basic healthcare. Marmot (2015: 105) points out that poor people's focus tend to be on short-term survival maneuverings than taking strategic decisions, such as healthcare and health insurance. While Ghana's UHC journey may be a beacon on the continent, it is still saddled with design flaws and implementation gaps bordering on the legal environment, institutional complementarities or sometimes the lack thereof, subscribers, non-subscribers and service providers, and there is much more to learn from countries that have already attained the UHC such as 'South Korea and Thailand in the Asian region who have attained near Universal Population coverage and did so while they were still in the category of lower middle income countries' (Agyepong et al., 2016). All the countries which have achieved the UHC did so surmounting one challenge after another until eventually succeeding. Indeed, some countries and continents are currently battling ideologically, politically, socially and economically with the idea of the UHC. Presently and politically, the United States is faced with uncertainty about the place and nature of the UHC in its welfare system, while in Europe, the UHC is under attack due to persisting economic crisis which is challenging the ideology of the UHC and central to the healthcare discourse - regarding the vast range of benefits of the health system over time and

whether they should be considered priviledges guaranteed for all (Borgonovi and Compagni, 2013).

This study's findings have proven the hypothesis of this dissertation valid. With the working hypothesis being, **"The Universal Health Coverage (UHC) objective - the National Health Insurance Scheme (NHIS) in Ghana cannot be achieved as it is, without an inter-sectoral approach"**, it is obvious from the findings that there is urgent need to incorporate the HiAP in addressing the SDH issues in Ghana. With the country experiencing a demographic transition, the MoH alone cannot be relied on to achieve the UHC by the year 2030. The challenges identified in the SDH and confronting the potential achievement of the UHC are not found within the domain of the health ministry alone – it has the footprints of both the public and private sectors, for the government owes citizens the provision of many things as their rights including a good healthcare system. Thus, on the side of government, the government of Ghana's efforts at mainstreaming the SDGs in its multisectoral annual budget is considered laudable and gives hope for the adaption of other progressive international initiatives such as the Social Determinants of Health (SDH) and the Health in All Policies (HiAP). Stating that the adoption of the SDH and HiAP into the governance system is likely may not be a stretch of the imagination as the evidence of the SDG-mainstreamed annual budget, the HiAP could be gradually introduced as Lindblom (1968: 26 – 27) points out that "drastically different policies fall beyond the pale" in analysis, acceptance and possible implementation. Indeed, with there is a high possibility to witness a policy 'spillover' because the SDGs represent a multisectoral approach to development and inherent in the SDGs is health – the HiAP approach falls within the same arena of multisectorialism. Judging from the national mood (Kingdon, 2011: 146 – 149) on this SDGs-infused budgeting strategy of the new government, the susceptibility and acceptance of another international initiative based on health is likely but should be done incrementally. Politically and theoretically, this incremental approach may be the only chance for such a policy as SDH and HiAP to see adoption in pursuit of the UHC, in a country that is said to involve politics in everything (from the empirical study). Cotlear et al. (2015: xiii) points out that governments that pursue the UHC are presented with **"a triple win: it improves people's health, reduces poverty, and fuels economic growth."** While the government introduces health policies aimed at improving livelihoods, there must be a manifestation of the benefits of such policies in the lives of the people. But as posited by Marmot (2015: 95), for the rights owed citizens to be fully

manifested, there are corresponding responsibilities for citizens as well. Thus, efforts by all are needed to put health at the fore of the country's development agenda. In essence, the existing health system and social protection programs must mature fast enough to support the demographical and epidemiological transition of the country and the ultimate realization of the UHC by 2030.

ANNEXES

Annex 1: Profile and history of Ghana

Annex 1: History of Ghana

Ghana is a West African sub-regional country with land area of about 238, 533 square kilometres and about 750 km north of the equator on the Gulf of Guinea. Ghana is a known politically stable country bordered on the north by the Republic of Burkina Faso, with the Atlantic Ocean to the south, bordered on the east is Togo and Cote d'Ivoire to the west. The land area in Ghana can best be described as fairly flat with an altitude registered as below 500m but with a good land area being below 200m. There are two main seasons in the country- the rainy and the dry seasons (Asenso-Boadi (2010) Pg. 147).

The era after independence of 6th March 1957 from the British saw Ghana renamed the Gold Coast by the early Europeans, a name given to it as a result of the predominance of gold trade along the shores of the country and with the belief of ties between the people of modern day Ghana and the prehistoric Ghana empire with descent from the Sahelian region of Senegal, Mauritania and Mali. It became a republic in the British Commonwealth of Nations on 1st July 1960 (ibid). Administratively, Ghana has been demarcated into 10 regions namely Western, Central, Greater Accra, Volta, Eastern, Ashanti, Brong Ahafo, Northern, Upper East, and Upper West (Saleh K. 2012) with a further sub division into 216 districts. The districts represent the last and most basic level of public and political administration of the governance structure (Asenso-Boadi, 2010, Pg. 148). The governance system of decentralization being operated in the country is progressing, however, with some implications on public sector healthcare. Although the foundational tenets of a well-functioning decentralization system has been put in place through the administrative structures of Ministry of Health (MoH) and implemented through the Ghana Health Service (GHS), the actual manifestation of its benefits still faces challenges (Couttolenc (2010) cited by Saleh (2012)).

A recorded 51 percent of Ghana's population was registered as living in urban areas in 2009, a speculation of two scenarios- firstly, that Ghanaian cities are developing exponentially, and secondly, that people are possibly moving to cities out of economic hardships and possibly indicative of a lack of economic opportunities in the rural areas (ibid). The Greater Accra region is host to the capital city of Ghana - Accra, also one of the country's ten administrative regions. With an estimated population size of 1.7 million in 2000 (a 70 percent representation of the total population of the Greater Accra Region and also, 30 percent of all urban population in Ghana), it has a land coverage area of about 420 km2 (Agyei-Mensah and de-Graft Aikins (2010)). By 1998, 98.5 of inhabitants in the country were black with 1.5 representing other races. Religious groupings are segmented into 63 percent of Christians, 16 percent Muslims and 21 percent representing other indigenous beliefs. Of the major tribes in Ghana, those of the Akans (44 percent of the entire population) represent the majority with the Moshi-Dagaomba (16 percent) following, the Ewe (13 percent), Ga (on the land resides the capital city, Accra with 8 percent), Gurma (3 percent), and finally the Yoruba (1 percent). The official language spoken is English (Hsiao and Shaw, 2007).

Annex 2: SDH-based selected budgets and policies in Ghana (2007-2017)

Environment, Science and Technology Sector and Policies introduced to improve conditions

Year under Review	Rate of Unemployment	Annual Budget Allocation (GHc)	Policies introduced	Linkage with other sectors
2007		11,322,257,000,000	- To ensure the promotion of science, technology and research.	_
2008	5.59	1,264,902,043	- Support for CSIR to commercialize its activities and thereby transfer technology and application of new knowledge.	_
2009	8.43	1,693,735,829	- Embracing science and technology efforts in other sectors to synergize the implementation of programmes and activities. - Review of the implementation status of environmental legislation and facilitate the enactment of a legislation to ensure the implementation of legislation on the environmental.	_
2010	4.2	131,529,124	- Re-launch of the National Environmental Fund. - Development of a national sustainable Development strategy. - Revamp the science	_

			and technology endowment fund to support research activities.	
2011	3.98	177,443,578	- Implementation of action plan for the utilization of local building materials in the construction industry and plastic waste Action Plan.	_
2012	4.09	123,247,875	- Implementation of programs and project that on diversity, reduction of the impact of climate variability change, application of science and technology and enhancing environmental quality.	_
2013	5.2	139,995,861	- Implementation of programmes and projects that focus on biodiversity reduction of the impact of climate variability and change, application of science and technology enhancing environmental quality and ensuring proper spatial organization for sustainable development.	_
2014	5.14	245,955,307	- Monitoring and analyzing air quality indicators from industries for effective compliance.	_
2015	5.54	243,399,833	- Development of a register of pesticide, industrial and	_

			consumer chemicals to enhance monitoring and prevention of imports of unregistered and banned chemicals. - Spatial planning and human settlement programmes.	
2016	5.77	274,215,152	- Support efforts of rural electrification through the use of lesser known wood species for electric poles, bio-fuel for generators etc.	_
2017		349,152,142	- GAEC will conduct safety assessments and monitoring telecommunication base stations to ensure public safety. - National Bio-safety Authority (NBA) will create public awareness and educate stakeholders on bio-safety management.	_
Observed differences			- Policies are not fully implemented and so keep on recurring over the years.	_

Source: Author's compilation based on information from the Ministry of Finance and Economic Planning (Official website[53])

Health Sector and Policies introduced to improve conditions (2007-2017)

[53] For budgets annual budgets of Ghana: https://www.mofep.gov.gh/publications/budget-statements

Year under Review	Rate of Unemployment	Annual Budget Allocation (GHc)	Policies introduced	Linkage with other sectors
2007		5,637,564	- Ensuring that children survive and grow to become healthy adults. - Reducing access risk and burden of morbidity, disability and mortality. - Reducing inequality in access to health population and nutrition services.	_
2008	5.59	934,205,026	- High impact and rapid service delivery and also consolidate weak and fragmented health system.	_
2009	8.43	243,265,009	- Expansion of midwifery and nursing training institutions.	_
2010	4.2	726,871,440	- Improving health outcomes by targeting resources to malnutrition, emergency service, private sector collaboration, NHIS, etc.	_
2011	3.98	558,625,890	- Improving health outcomes by targeting resource towards the health of women and children, prevention and control of communicable and non-communicable diseases.	_
2012	4.09	2,170,962,917	- Bridging equity gaps in access to healthcare and nutrition services to ensure sustainable financing arrangements that proofed the poor.	_

2013	5.2	1,010,000,000	- Bridging equity gaps in access to healthcare and ensure sustainable financing arrangement that protects the poor. - Strengthen governance and improve efficiency and effectiveness of the health system. - Improve access to quality material, neonatal child and adolescent health and nutrition services.	_
2014	5.14	2,288,700,000	- Strengthen public financial management of the sector as well as health data collection, analysis and management. - Increase the member of functional infant incubators.	_
2015	5.54	2,749,260,000	- Expansion of NHIL and allocations from the central budget. - Expansion of access to healthcare by vigorously embarking on infrastructure.	_
2016	5.77	3,402,150,000	- Establishing an infectious disease control centre. - Increase the number of ambulance stations across the country to 370.	_
2017		3,571,810,000	- Improve the efficiency in the procurement process and timely delivery of essential medicines to all health facilities and service delivery points.	_
Observed differences			- Most established policies were focused on Primary	_

			Health Care.	

Source: Author's compilation based on information from the Ministry of Finance and Economic Planning (Official website[54])

Food and Agriculture Sector and Policies introduced to improve conditions (2007-2017)

Year under Review	Rate of Unemployment	Annual Budget Allocation (GHc)	Policies introduced	Linkage with other sectors
2007		1,206,050	- Promoting selective crop development - Modernizing livestock development - Improving access to mechanized Agriculture. - Increasing access to extension services.	_
2008	5.59	95,323,383	- Sustainable Agric and thriving agri-business, through research and technology development.	_
2009	8.43	1,731,669,239	- Increase income. - Tree crop development. - Livestock development. - Implementation of Agricultural land management strategy to address the sustainable use of land for Agricultural purpose. - Promoting quality planting material.	_
2010	4.2	256,886,465	- Food security and emergency preparedness	_

[54] For budgets annual budgets of Ghana: https://www.mofep.gov.gh/publications/budget-statements

			programme. - Increase competitiveness, improve growth in incomes and reduced income variability.	
2011	3.98	221,550,587	- Modernizing agriculture for strong economy to create job opportunities.	_
2012	4.09	318,170,483	- Review of all existing supply agreement with processing companies. - Promotion of Cocoa consumption. - Continuation of CODAPTEC Programme.	_
2013	5.2	184,000,000	- Continuation to implement programs and projects in the medium Term Agricultural Sector Investment Plan (METASIP).	_
2014	5.14	226,300,000	- Continuation of the food security and emergency preparedness programme.	_
2015	5.54	395,190,000	- Marketing of Agric produce and product programmes. - Increasing growth in income programme.	_
2016	5.77	355,140,000	- A total of 3057mt of certified seed made up of rice sorghum, cowpea, soybean and groundnut and produced. - Boasting local production of poultry, commercial poultry (broiler) farmer will be supported.	_
2017		450,330,000	- "Planting for food and jobs" campaign. - Small to medium scale irrigation schemes be	_

			identified and rehabilitated. - Setting up of Ghana Incentive – Based Risk Sharing System for Agricultural Lending (GIRSAL)	
Observed differences			- Implementation of policies was focused on poverty related areas like subsidy on fertilizers.	–

Source: Author's compilation based on information from the Ministry of Finance and Economic Planning (Official website[55])

[55] For budgets annual budgets of Ghana: https://www.mofep.gov.gh/publications/budget-statements

Water and Sanitation Sector and Policies introduced to improve conditions (2007-2017)

Year under Review	Rate of Unemployment	Annual Budget Allocation (GHc)	Policies introduced	Linkage with other sectors
2007		1,869,568	- Promote urban infrastructure development and the provision of basic services.	_
2008	5.59	99,769,017	- Provision of basic services including increased access to potable water as well as to safe, decent and affordable shelter.	_
2009	8.43	243,265,009	- Increase the provision of safe and portable water in the country.	_
2010	4.2	178,008,902	- Construction of primary storm water drainage and sanitation systems in all regional capitals.	_
2011	3.98	558,625,890	- Setting up of natural Dams safety units to regulate and coordinate all activities related to dam designs, construction, operations, maintenance and decommissioning.	_
2012	4.09	329,625,342	- 68 percent access to safe water.	_
2013	5.2	143,200,000	- Renew the national water policy document to incorporate new ideas. - Development of rain water harvesting strategy. - Reduce perennial flooding and safeguard life and property.	_
2014	5.14	90,900,000	- Continuation of the water and sanitation management	_

			programme	
2015	5.54	230,470,000	- Develop more buffer zones in degraded river basins and institute measures to enforce its implementation.	_
2016	5.77	143,990,000	- Development and management of buffers in dehydrated river basins will be intensified. - Completion of the water treatment plant.	_
2017		263,030,000	- Consolidate various policies and programme into a comprehensive National Sanitation Programme and Action Plan that will facilitate the implementation of the clean Ghana campaign.	
Observed differences			- Policies that were not fully established in previous years were continued in 2014. Some of the established policies were reviewed.	_

Source: Author's compilation based on information from the Ministry of Finance and Economic Planning (Official website[56])

[56] For budgets annual budgets of Ghana: https://www.mofep.gov.gh/publications/budget-statements

Educational Sector and Policies introduced to improve conditions (2007-2017)

Year under Review	Rate of Unemployment	Annual Budget Allocation (GHc)	Policies introduced	Linkage with other sectors
2007		1,196,327,000,000	- Attainment of targets set under the Education Strategic Plan, the GPRS II and Education Reform.	_
2008	5.59	133,240,720	- Implementation of the education reforms programme which took off in September 2007	_
2009	8.43	113,045,554	- Conveying an all party conference on education reform. - Implementation of equitable access to and participate in quality education and training.	_
2010	4.2	1,729,450,088	- Implementation of the Education Strategic Plan as the GPRS II which has identified new areas for the accelerator, effectiveness and efficiency in delivery of education in the country.	_
2011	3.98	1,983,217,447	- Addressing the managerial and structural challenges confronting education to assist in achievement of the benchmarks contained in the strategic plans to accelerate the growth and development of education.	_

2012	4.09	2,871,680,218	- Providing infrastructural facilities, human resources and other auxiliary facilities to support, improve and increase quality education delivery to all Ghanaians of school going age.	_
2013	5.2	4,412,695,383	- Continuation in achieving the objective in the Education strategic Plan and National medium Term Development Framework.	_
2014	5.14	5,816,315,034	- Increase the number of youth and prison inmates' participation in the open school system.	_
2015	5.54	6,740,437,383	- Collaborate with NCTE, CENDLOS, Open University of UK and commonwealth of learning to finalize the policy on open and Distance Learning (ODL).	_
2016	5.77	6,532,352029	- Intensify school supervision and inspection. - Review of language policy and be streamlined as part of the learning project.	_
2017		7,382,790,000	- Review of Basic level curriculum. - Increase the student loan by 50%. - Conduct national Skills and competency audit to align skill training with	_

			needs of industry and the large economy.	
Observed differences			- Projects that were not established in previous (2007-2012) were continued in 2013.	_

Source: Author's compilation based on information from the Ministry of Finance and Economic Planning (Official website[57])

Roads and Transport Sector and Policies introduced to improve conditions (2007-2017)

Year under Review	Rate of Unemployment	Annual Budget Allocation (GHc)	Policies introduced	Linkage with other sectors
2007		3,852,574,000,000	- Ensure the provision, expansion and maintenance of road transport infrastructure of all kinds. - Provision of affordable, safe and accessible transportation system.	_
2008	5.59	503,287,051	- Ensure effective linkage between the transport sector programmes and promote private sector competitiveness.	_
2009	8.43	386,370,228	- Implementation of Transport Sector Development Programme (TSDP), West African Transport and Transit facilitation Project (WATTFP) and Urban Transport Project.	_

[57] For budgets annual budgets of Ghana: https://www.mofep.gov.gh/publications/budget-statements

			-	
2010	4.2	381,467,645	- Prohibition of usage of mobile phone while driving. - Maintenance of road assets.	_
2011	3.98	18,173,336	- Ghana Railway Authority will strengthened and appropriate regulatory framework	_
2012	4.09	99,463,777	- Election of a new load traffic regulation to operationalize the Road Traffic Act 2004, Act 683. - Improve access through better distribution and integration of the road network system.	_
2013	5.2	187,086,535	- To achieve a preferable road condition mix in line with GSGDA. - New Ready traffic regulations and road safety strategy III Action Plan implementation.	_
2014	5.14	89,949,128	- Construction of 300 km of trunk roads, 90 km of rural road and 150km of urban roads. - Expansion of KIA terminal building.	_
2015	5.54	361,652,706	- Routine maintenance on 11,199 km, 22, 500 km and 8200 km of trunk, feeder and urban road respectively. - Collaborate with ECOWAS on the	_

			development of ECOWAS and the Trans-African Highways which includes Ghana’s Coastal and Central corridors.	
2016	5.77	126,317,102	- Periodic maintenance of roads. - Construction of more trunk and urban road	
2017		1,258,850,000	- Periodic maintenance of roads. - Expansion of the DVLA computerized Based Theory Test System.	–
Observed differences			- Poverty eradication related road projects were implemented.	–

Source: Author’s compilation based on information from the Ministry of Finance and Economic Planning (Official website[58])

Annex 3: CHPS and NHIS budget allocations and policies introduced to improve conditions of health (2007-2017)

Year under Review	Policies introduced		
	NHIA/NHIS	CHPS	NHIS/NHIA
2007	1,759, 097	- Continue with programmes to	- Continuous public education to

[58] For budgets annual budgets of Ghana: https://www.mofep.gov.gh/publications/budget-statements

		increase access to health facilities with emphasis on construction CHPS compounds.	increase awareness of benefits and reduce misconceptions surrounding the NHIS. - Improving systems for legislation and claims management. - Establishment of zonal office.
2008	235,429, 513	- Increasing coverage of community based services in the management of childhood disease.	- Introduction of New Universal Health Insurance Card, revise the tariff medicine list and operationalize M and E systems in all regions
2009	375,209, 162	- Equip and staff the CHPS compounds to cater for maternal health services.	- NHIS to be restructured to respond to the need of the population and improve upon the issue of claims management. - Payment of insurance premium under NHIS
2010		- Focusing on more of the CHPS concept which is very close to the client, while at same time strengthening the referral	Improving the operations of NHIS, particularly claims management, communications and coverage of the poor and linking LEAP and NHIS

		system.	
2011		- Completion of 30 ongoing CHPS compounds while an additional 30 will be constructed and equipped to be functional.	- Provide financial risk protection against the cost of basic quality healthcare for all citizens in Ghana. - The implementation of the integrated ICT platform project with MInistry of Employment and social welfare to identify the very poor for subsidized NHIS membership.
2012		- Provide orientation to regional and local government staff on the revised CHIPS policy and strategy to support its implementation.	–
2013	917, 858, 409	- Refrain the existing staff and collaborate with local Government to develop an additional 450 function CHPS zones based on population community	- Instant issuance of biometric ID Cards. - Piloting electronic claims submission and vetting to allow for country-wide roll-out for high volume facilities.

		Health Nursing Office (CHO) ratio.	
2014		- Construction of CHPS compounds to upscale maternal and child healthcare service.	–
2015		- Pursue the expansion and construction of CHPS zones and compounds nationwide to bring basic healthcare to the doorsteps of the people.	- Expansion of NHIL and budget allocations from the central budget.
2016		- The first 250 compounds will be constructed.	- Ensuring a sustainable healthcare financing arrangements focusing on strenthening the NHIS.
2017		- Revised CHPS policy and implementation plan to be launched. - More CHPS compounds to be constructed and equip existing ones.	- Improving access to quality healthcare delivery through NHIS. - Review and strenghten NHIS to ensure it is fit for purpose.

Source: Author's compilation based on information from the Ministry of Finance and Economic Planning (Official website[59])

[59] For budgets annual budgets of Ghana: https://www.mofep.gov.gh/publications/budget-statements

Annex 4: Interview Guides for data collection

Annex 4a: Interview Guide for the NHIA and NHIS Stakeholders

This interview schedule has been prepared to guide the interview on the NHIS (as the Universal Health Coverage (UHC) approach for Ghana) and Community-Based Health Planning Services (CHPS) as two health interventions in addressing the expansion of health coverage in Ghana. As an identified stakeholder in the policy process, your views are needed to inform how the two health policies can work to effectively contribute to the UHC in Ghana.

The NHIS and the CHPS

Technical Context

1. What is the current coverage for the NHIS?
2. How is coverage calculated?
3. The NHIA employs how many staff and in how many offices across the country?
4. What are the current bottlenecks saddling the NHIS? Mention according to priority
5. How many indigents does the Scheme cover nationwide, and by region?
6. How are indigents identified, processed for inclusion and what packages are provided for them?
7. Are indigents monitored for when they are no longer in that indigent bracket? How is this done?
8. Since the amendment of the NHI Act 852, what major policies have been introduced to the scheme?

- Insurance packages
- Payment Systems
- Indigent categorization
- Medicines List
- Technology

9. How are subscribers identified and accredited?
10. How many CHPS are accredited as service provided? And what incentives are given to the CHPS in rural communities?
11. What measures have been put in place to cover the informal sector? Potential, challenges

Organizational Context

12. What arrangement does the NHIA have with the GHS in accrediting the CHPS compounds?
13. In order for the NHIS to achieve its ultimate goal of the UHC (both financial and geographical access), could the NHIS and CHPS be merged into one health policy? If yes next question, if no skip to Question 16
14. What would it require for such a policy to work in providing healthcare to all citizens?
15. How would service payment arrangements to the NHIS be, if the policies are merged?
16. Why is it not possible? What could prevent such a policy merger proposal from being a priority for the health sector?

17. In the last couple of years, the CHPS has attracted some attention; how do you think it is placed high on the development agenda for Ghana now? And what informed its position on the agenda?
18. In your opinion, what is your assessment of the NHIS in terms of performance?
19. What recommendations would you give for efficient service delivery and increased coverage?

Other Perceptions

- Is Ghana practicing the Health in All Policies (HiAP) approach? If yes, how is it being implemented? If no, why?
- How can this approach be used to improve access to healthcare in an equitable manner?
- The difficulties of coordinating the various actors involved in the health system are often pointed out as a weakness of this system. Do you agree with this analysis? Explain

Annex 4b: Interview Guide for Policy Makers/Legislators/ Consultants

This interview schedule has been prepared to guide the interview on the NHIS (as the Universal Health Coverage (UHC) approach for Ghana) and Community-Based Health Planning Services (CHPS) as two health interventions in addressing the expansion of health coverage in Ghana. As an identified stakeholder in the policy process, your views are needed to inform how the two health policies can work to effectively contribute to the UHC in Ghana.

Policy Makers/Legislators/ Consultants

1. What are the areas of much concern in the health sector at present? State 4 (according to priority)

2. The National Health Insurance Scheme (NHIS) seems to be attracting a lot of attention. Do you think it is top on the development agenda for Ghana? And what has informed its position on the agenda?
3. In the area of access, how has the NHIS fared? Financial access? Geographical access?
4. What, in your estimation are the challenges facing the NHIS? State and discuss 4
5. What are the policy gaps identified in the NHIS' implementation which have still not been addressed since inception?
6. Has the Scheme achieved its set objectives?
7. Tell me, in which period did the scheme achieve the most impact and what reasons could account for this?
8. Do you think the NHIS' challenges can be traced to the fact that it has been politicized?
9. In your opinion, what is your assessment of the NHIS in terms of performance?
10. Can the NHIS be sustained in the long-term? Explain
11. In the last couple of years, the CHPS has attracted some attention; do you think it is placed high on the development agenda for Ghana now? And what has informed its position on the agenda?
12. What are your impressions of the Community-based Health Planning and Services (CHPS) initiative?
13. Has this health policy been implemented as should? Reasons for response
14. In the area of access, how has the CHPS fared? Financial access? Geographical access?
15. What are the challenges facing the implementation of the CHPS?
16. Can the CHPS be sustained in the long-term? Is there need for any intervention? If yes, what interventions would be recommended?
17. Will it be possible to combine the NHIS & CHPS health policies in order to achieve the Universal Health Coverage in Ghana?
18. If the possibility exists, what are the factors to consider for such a policy merger to be successful?
19. How will such a policy merger proposal find its way on the development agenda?
20. How would service payment arrangements to the NHIS be, if the policies are merged?
21. If such a merger is not possible, please give reasons.
22. Discuss current bottlenecks for Ghana's achievement of the UHC.

Other Perceptions

- Is Ghana practicing the Health in All Policies (HiAP) approach? If yes, how is it being implemented? If no, why?
- How can this approach be used to improve access to healthcare in an equitable manner?
- The difficulties of coordinating the various actors involved in the health system are often pointed out as a weakness of this system. Do you agree with this analysis? Explain

Annex 4c: Interview Guide for Service Providers

This interview schedule has been prepared to guide the interview on the NHIS (as the Universal Health Coverage (UHC) approach for Ghana) and Community-Based Health Planning Services (CHPS) as two health interventions in addressing the expansion of health coverage in Ghana. As an identified stakeholder in the policy process, your views are needed to inform how the two health policies can work to effectively contribute to the UHC in Ghana.

Service Providers

1. What category of service do you render to subscribers?
2. How long have you been a service provider to the NHIA?
3. Averagely, how many people do you provide healthcare to in a month?

4. Of the people you provide healthcare to, what percentage is male/female; adult/children?
5. Do you receive training from the NHIA on standards of operation? If yes, how often
6. What challenges do you face in being a service provider? Enumerate based on priority
7. Have you had to turn away patients due to the challenges faced with the NHIA?
8. Do you treat NHIS cardholders differently from those using other modes of payment, including cash? If yes, why?
9. Suggest how the NHIS can register/cover as many Ghanaians as possible, especially those in the informal sector?
10. In your opinion, is the NHIS working effectively? Please give an explanation for your response
11. What could be done to improve efficiency in delivery? (Operational)
12. What do you think about the CHPS and its implementation so far?
13. What do you think about an NHIS – CHPS policy merger? Possibilities and Challenges
14. What can be done to increase coverage for both urban and rural populations? (Coverage)

Other Perceptions

- Is Ghana practicing the Health in All Policies (HiAP) approach? If yes, how is it being implemented? If no, why?
- How can this approach be used to improve access to healthcare in an equitable manner?
- The difficulties of coordinating the various actors involved in the health system are often pointed out as a weakness of this system. Do you agree with this analysis? Explain

Annex 4d: Interview Guide for Development Partners

This interview schedule has been prepared to guide the interview on the NHIS (as the Universal Health Coverage (UHC) approach for Ghana) and Community-Based Health Planning Services (CHPS) as two health interventions in addressing the expansion of health coverage in Ghana. As an identified stakeholder in the policy process, your views are needed to inform how the two health policies can work to effectively contribute to the UHC in Ghana.

Development Partners

1. What are the objectives of your organization in Ghana?
2. For how long have you been involved in the health sector in Ghana?
3. What has been your organization's contribution to the health sector in Ghana?
4. What are the concerns you have about Ghana's efforts towards achieving the UHC?
5. In what way have you contributed to health coverage in general and the UHC in particular in Ghana?
6. In what way have you contributed to the NHIS in expanding health coverage in Ghana?
7. What is your view of the roles of the actors in the policy process in the achievement of the UHC so far? Any gaps?
8. Do you collaborate with other development partners in working to improve healthcare in Ghana? In what ways have you collaborated?
9. What challenges do you face in your work in the health sector in Ghana in general and with the NHIS in particular?
10. What policy recommendations can you give to the country in its bid to achieving the UHC?
11. In what ways could your organization partner with the government of Ghana towards the achievement of the UHC?
12. What are the policy gaps identified in the NHIS' implementation which have still not been addressed since inception?
13. Has the Scheme achieved its set objectives?
14. Do you think the NHIS' challenges can be traced to the fact that it has been politicized?
15. In your opinion, what is your assessment of the NHIS in terms of performance?
16. Can the NHIS be sustained in the long-term? Explain

17. In the last couple of years, the CHPS has attracted some attention; how do you think it is placed on the development agenda for Ghana now? And what informed its position on the agenda?
18. What are your impressions of the Community-based Health Planning and Services (CHPS) initiative?
19. Has this health policy been implemented as should? Reasons for response
20. In the area of access, how has the CHPS fared? Financial access? Geographical access?
21. What are the challenges facing the implementation of the CHPS?
22. Can the CHPS be sustained in the long-term? Is there need for any intervention? If yes, what interventions would be recommended?
23. Will it be possible to combine the NHIS & CHPS in order to achieve the Universal Health Coverage in Ghana?

Other Perceptions

- Is Ghana practicing the Health in All Policies (HiAP) approach? If yes, how is it being implemented? If no, why?
- How can this approach be used to improve access to healthcare in an equitable manner?
- The difficulties of coordinating the various actors involved in the health system are often pointed out as a weakness of this system. Do you agree with this analysis? Explain

Annex 4e: Interview Guide for Beneficiaries

This interview schedule has been prepared to guide the interview on the NHIS (as the Universal Health Coverage (UHC) approach for Ghana) and Community-Based Health Planning Services (CHPS) as two health interventions in addressing the expansion of health coverage in Ghana. As an identified stakeholder in the policy process, your views are needed to inform how the two health policies can work to effectively contribute to the UHC in Ghana.

Beneficiaries

1. How old are you?
2. Are you employed? Yes ☐ No ☐ Informal ☐ Formal ☐
3. Male ☐ Female ☐
4. Do you have dependents? How many and how old are they?
5. Are you enrolled on the NHIS? If yes, for how long now and do you renew your subscription?

FOR SUBSCRIBERS ONLY

1. Are you able to access healthcare anytime and anywhere using your NHIS card?
2. Have you been asked to make additional payments for healthcare even after showing your NHIS card? If yes, follow with next question, if not skip to the next
3. For what services were you asked to make additional payments?
4. Were you able to make those additional payments?
5. With the NHIS card, are you treated the same way in the health facility as all other patients?
6. Are you satisfied with the service you receive using the NHIS card?
7. How far did you have to travel to access healthcare?
8. If you had a community health nurse in your community to attend to you 24 hours, would you like it?
9. In your opinion, is the NHIS working effectively?

FOR NON-SUBSCRIBERS

1. Have you ever subscribed to the NHIS?
2. If yes, for how long did you subscribe and why did you stop subscribing?
3. When sick, how do you seek medical care at a health facility?
4. How do you pay for the medical care?
5. Why have you not subscribed to the NHIS?
6. If you could pay for medical care through mobile money, would you find it easier than the NHIS subscription process?
7. In your opinion, is the NHIS working effectively?

Anne 4f: Interview Guide for Traditional Leaders

This interview schedule has been prepared to guide the interview on the NHIS (as the Universal Health Coverage (UHC) approach for Ghana) and Community-Based Health Planning Services (CHPS) as two health interventions in addressing the expansion of health coverage in Ghana. As an identified stakeholder in the policy process, your views are needed to inform how the two health policies can work to effectively contribute to the UHC in Ghana.

Traditional Leaders

1. Are you enrolled on the NHIS? If yes, (second question), if no, why?
2. For how long have you been enrolled?
3. Do you have a CHPS compound in your community? If yes, for how long have you had it?
4. If yes, what was the community's contribution towards the construction and equipping of the CHPS compound?
5. (If answer to the previous question is yes) What are some of the challenges facing the CHPS' operations in the community?
6. Are there Community Health Management Teams established in your community?
7. If yes, how do they work and how are they motivated?
8. Do you have any other health facility in your community?
9. Do you have indigents in your community enrolled on the NHIS?
10. Do you know how indigents are selected from this community for "free NHIS" enrollment?
11. If asked to provide land and labour as your contribution to building a CHPS compound in your community, would you be happy to?
12. In your opinion, is the NHIS working effectively to provide healthcare in your community?

Annex 5: Some Transcribed Interviews (summarized)

Annex 5A: European Union

Interviewer: Which part of the health sector has the EU in Ghana being involved in?
Respondent: Maternal and child health. Okay, so we're not directly involved in health sector support alone. Budget support - It's not like a project based approach that we use. So we have funds directly sent to the Ministry of health, and then they manage it as a sector. But ours is geared towards maternal and child health. So our support was worth 50 million Euros.
Interviewer: When? Which period?
Respondent: 50 million spanning between 2011 and support will end in December 2018.
Interviewer: After which, that's it for us?
Respondent: We have funded. The money is paid and gone. So for us implementation ends and all the funds have been transferred.
Interviewer: But what went into your choice? The choice of the maternal and child health?
Respondent: It was not really a choice, it was just that in 2012, Ghana had an emergency - even it's still an emergency. But then, as at 2012, it was much more urgent- we had many more women and children dying, so we had triggers. We had three triggers - we have one on newborn care, we have one on antenatal plus four visits (antenatal plus four visits means that every pregnant woman should be able to go for four or more antenatal visits), we have one on couple years of protection (that has to do with family planning). So those were the three triggers that were formed. But the three triggers, we didn't set them up. It was together with the Ministry of health - so the government of Ghana.
Interviewer: So it was needs-based?
Respondent: It was needs-based because Ghana already had an action plan. There was already a country action plan, so the funding gap between what was supposed to be achieved was 50 million Euros, which the EU came in to support. Unfortunately, the GOG contribution that was supposed to cover that funding gap never came, so DANIDA came in at a point. So you have DANIDA also supporting. Currently, they have exited…
Interviewer: But how much did they give towards that?
Respondent: I cannot really be specific about that. But then, finally, we came up with a maternal development - I have this document, and this is like a country action plan for Ghana. So it's just an extract of what was supposed to be achieved in 2012. It took a look at the various implementing agencies in Ghana. So you have the National Ambulance Service, the Blood Service, the Ghana Health Service located in all ten regions, and then you have the Ministry of Health. Then there is the Christian Health Association of Ghana (CHAG). So you have all those agencies expected to benefit from the support.
Interviewer: Did you do anything in connection with the CHPS? The help that went to the Ghana Health Service - or you didn't choose any specific area for them - you just gave the grant?
Respondent: Yes, we just gave the grant. Ours was based on the triggers. Anytime we did disbursement it was based on the triggers. So we do the first triggers, they meet A-B-C-D, we do the next disbursement. So if the target is not met, we don't disburse. But the total amount was 50 million - but we did not disburse all the 50 million (of course it's disbursed at different stages).
Interviewer: But the final disbursement has been done?
Respondent: Yes, done.

Interviewer: Of course you'll await some kind of feedback towards the end of project completion?
Respondent: Yes, we will. But also, there is one component of it - the value of the funds itself was 52 million. So the 50 million was like a sector budget support. The 2 million was an institutional support, and Ghana was expected to decide presumably, what to do with the money. Talking about the institutional support - so Ministry of Health decided that the last maternal health survey was done in 2007. So between 2007 and 2017 or 2016 at the time, there had not been any clear cut data that Ghana had as evidence, so they decided to undertake a maternal health survey. So currently, there's a maternal health survey on-going by the Ghana Statistical Service. They're on the field - they should leave the field like somewhere end July or early part of August - I'm not so sure. But they're on the field now. And then we can have a database of real maternal health related issues in Ghana.
Interviewer: But whichever way, whatever the results are, you've given the support, and so you may not continue with any intervention?
Respondent: No. It depends. Because health is not like a priority area for the EU so……
Interviewer: What is the priority area for you?
Respondent: We have a lot actually. There is governance because (there's a governance section here), we do trade so Environmental Protection Agency (EPA) - we have these labs on these vegetable bans, we have social protection, employment, there's Technical and Vocational Education and Training (TVET), agriculture, there's infrastructure - so there are roads, there is education, migration and gender. So it's a lot.
Interviewer: But what triggered your leaving Ghana?
Respondent: No, it's not exactly "leaving". It's just that we have signed a financing agreement so we have agreed the time frame for implementation and that's it. And we even did an extension, because at a point there was some macro-economic instability in the country, so we didn't disburse for two years. So we had to take into account the two years, and then do an extension, that's how come we are ending in December 2018, otherwise we would have ended in October 2017 - this year.
Interviewer: But, so this means it is across board to all sectors. EU ceases to support to Ghana?
Respondent: No, it's just for health - only for the health sector.
Interviewer: Why is that?
Respondent: It's because it's a sector budget support and it's specific. The program has ended. No, it's like we've signed an agreement. If it ends, that's it.
Interviewer: So to be clear, the EU is in Ghana to stay except that its focusing on other areas but for health?
Respondent: Sure.
Interviewer: Because I got information of your withdrawal from the sector from another development partner - I think from WHO.
Respondent: It's just withdrawal from health - it's just the health sector. If there is another lobbying done again or there's another program and the EU comes in to support, then we may revise the situation. So it could come in again, but not necessarily maternal health. It could even come in again with another sector, because I have a colleague who works with smaller NGOs on this maternal health related issues - but those are programs that have ended. They've also ended. They're smaller programs so they're based with NGOs and all that - in the Upper West, Upper East and the northern part of the country.

Interviewer: I want to dwell my next question on this Health-in-all policies concept which is part of my Phd. And it's that, I'm seeing that the EU has a good spread. I still didn't get your explanation properly of the health sector part but I would say that with that kind of Health-in-all policies concept, basically, it means you're contributing one way or the other to it. What is the focus, or how are you focusing on universal health coverage somewhat?
Respondent: Hmm, it's tricky one. It's tricky for universal health coverage for us. But there's something under the social protection program that we have that is a bit delayed, because we signed off somewhere in February 2016 and we've not yet initiated any contracts. So what it is, is to have a good social protection system, but taking into account that the health sector is also part of the social protection intervention. Our support is to have something like a monitoring and evaluation framework for social protection in Ghana. So that, when you have that framework and you need to assess who is benefitting for which social protection intervention and then we could help, so that we can easily assess the beneficiaries. So directly under universal health coverage, we don't have plans - we don't have a specifically designed program yet. But like I said, I mean, it's still up to the hierarchy to decide and it's still up to the government of Ghana to make it a priority. It's a corporation so anything is possible…..
Interviewer: Do you deal directly with all the ministries?
Respondent: No. We have an office at the Ministry of Finance, which is the national authorizing office. But they're Ghanaians and staff of the Ministry of Finance. So, we discuss issues with them - we discuss with the Ministry of Finance, then they go ahead to discuss with the sector ministries. So they're like a link between us and all other ministries.
Interviewer: So prioritization of projects or of key health areas all come from there?
Respondent: For the health sector, for instance, for the maternal health support program, you will not really say that it's a prioritization. I mean it was the EU that saw it as a top priority. Because Ghana was declared as a country that was not going to be able to achieve the MDG 4. So they saw it as a priority, and then from headquarters, they felt that okay, this has to go on. We had colleagues who worked on it, and then it went through the system.
Interviewer: I'm asking this because there's a gap….. Do you see the gap as well?
Respondent: The gap is there - the systems are not right, that is the problem. You see, the systems are not right. The way we prioritize in Ghana is not right - I'm Ghanaian so I can tell you this...
Interviewer: Exactly, and so, are your decisions based on any data for instance that informs you to go in this direction or that direction? You understand what I am saying?
Respondent: The Ministry of Health should have it. We don't have it. That is the unfortunate and the tricky part. Because, when we want to do a program, we will do an assessment of the system before we do the program.
Interviewer: And your assessment is based on which institution's data?
Respondent: The assessment is based on the institution we want to work with. So we have technical assistants coming in to help us gather the information that we need. But for Ministry of Health, I mean, even though it's a very critical sector, I don't know if it is the commitment that is not there, or the urgency they don't feel, because we have lots of funds that go into the Ministry of Health but they go to waste. They waste the resources....
Interviewer: Why is that? Is it because we don't prioritize?
Respondent: Because they don't see the value - I'm a Ghanaian, so I can tell you - they don't see the value of things. I mean that is a ministry that you'd think that every dime that goes there

should be taken seriously, but they don't care and you would be surprised at the waste in the health system.
Interviewer: I want to talk about how the institutions you work with, work together. I'm happy talking to you because; one other area that I'm working on is Health-in-all policies which involves all the sectors. Such that, for instance, monies that may come in, if we went to agric, there would be a health component to the agricultural sector's plan, but such that, the benefits of health can actually be achieved in another sector - not necessarily because the money went to the health sector. How are they coordinating? Are they working well together?
Respondent: It is not that easy. It's not easy for the normal civil servant because - I've worked at the Ministry of Women, Children and Social Protection before and the situation there is that when somebody identifies a project, they think that because it's a project they should be the one in charge but as far as they don't really need it in their specific ministry, they don't care.
Interviewer: So then, that the reason why the ministries are working as silos? You know everybody on their own turf?
Respondent: They'll do the document and tell you well, there's a health component. But you look for the health people in there, and you don't find them. And even in the ministry itself, it happens. Because you need someone, if you're doing something on data, ideally you should have someone who has an idea of data collection on the team, and you don't find the person, you will only see medical doctors sitting there.
Interviewer: How does this affect your work - because for an EU, I believe it's not only for development - it's for all other sectors to have their fair share? That you want to see growth across board. My understanding is that, right. How does it work for you?
Respondent: Abena, you see, this is cooperation - Ghana-EU cooperation so the part that is receiving the help should be able to dictate the pace. If the part receiving help is not right, then there is a problem. It's cooperation - if somebody tells you there is funds for you, and you're not able to tell the person that you want to find a nice way of using it, there is a problem. And after you tell the person what you want to use it for, the person can decide to support you or not. So it's our systems. If our systems are right and we make them understand that look, we need you to link this program to that program, and then it's easier for us all to work towards achieving that. But if the person needing the help does not create that impression that they need to create the links…… and until we have those kind of very technical and very committed people, success will be difficult. I think that as for the educational sector, we have the best human resource we need. But it is the commitment that is lacking.
Interviewer: But the commitment will come from where?
Respondent: The commitment should come from the sectors.
Interviewer: Sector ministers?
Respondent: Not the ministers as such. The ministers, they're political appointees - I mean they'll come and go. The problem is with the civil servants sitting in the office.
Interviewer: How does this not-so cohesive system you work in affect the cooperation? The EU-Ghana cooperation
Respondent: It affects it a lot. For instance, when you take this maternal health support program, we were envisaging that before the program ends, we should have some strong capacity for Ghanaians in the ministry of health who are able to deal with maternal health-related issues. So for them, the idea was that, they would receive the best capacity building possible. There is an office set up, so that even for the sake of the SDGs they can have someone with an idea for even when another donor comes in with support, they would have somebody to guide the process and

provide the needed data. And say these are the areas we need support. For example, if it's the ambulance service, I think it's an emergency sector… so we need the people, not the people in silos. I mean they'll tell us; well we have a PPME unit - that's a PPME unit, fine. But we do not have people with clear cut capacity. If you go to the Ministry of Health now and you ask to see five staff that are good at data collection, you will not have any. If you want to see five staff who are good when it comes to maternal health - related issues - you can't have them. When it comes to cholera policy specialists, they can't be found. How can such an institution just walk to a donor and say they need to link this to that when they don't have the people to assess those needs? So they sit, and all they want to do is to form projects concepts. They form the projects, by the time the projects ends they would have bought cars, computers and then the donor starts looking for the next person to recommend for projects. Yes, so I think that for us Ghanaians, it's more about commitment and making use of the resources that we have. For me, I keep saying that if there's a sector that has received more funding ever, it's the health sector. From everywhere - left, right - they receive it. So, they really have to make a change.
Interviewer: From a development partner's point of view, what can be done, or what should be done?
Respondent: Just commitment is enough.
Interviewer: And commitment will translate into what?
Respondent: Enough training in Ghana. People have gone for trainings over and over again. Hands-on and all, it's time for people to really be committed to what they do. Because for instance, we have people who have ideas from school. We need those kinds of fresh ideas just to be brought on board and all of us can be on the same page and then we know that this is where we're heading. And then there's too much political interference. So we have one political party coming in, after some time there's this change of minister or this minister has changed all these ranked people in the sector that used to work on a particular project so they start to reselect new people… And we have many postings even in the public sector with saying they don't want this or that ministry. With these all gathered institutional memory is gone - records are not right. When we go looking for files or documents, they are not there. Usually, somebody has been transferred so the files also follow such people - some of them are just on pen-drives or their personal laptops. And this is because the ministries do not have the system to store them. We do not have the database to keep them so the person thinks that, "I have done the ministry a favor by storing the information, so when I am leaving, I carry it along and when you need it, you call me".
Interviewer: What's wrong with our health planning process?
Respondent: Our health planning process needs the right people to think right. It needs people to not just think about the planning but costing also, and how to achieve it. Because it is not all the plans that we make that need money. Some need just the human resource, some need the commitment, some just need some discussions around the table and it's done. So we need proper people to do a proper planning - not the numbers. So that's the only problem with our health planning. Apart from that, I think that development partners have done their best. Because, around the table they have provided the expertise that Ghana will need to discuss on issues as far as health is concerned so if we're taking those ideas on board and we're making a change, then it's easier for us all to move on. But until we take those ideas, nothing would happen.
Interviewer: Would you say that HiAP is being practiced in Ghana somewhat, because we have the LEAP which is connected to NHIS, other sectors.
Respondent: Everything is in a mess with the LEAP. It's a mess.

Interviewer: What do you even say about how they get the indigenes - how they do the classification. Is it very subjective?
Respondent: No it's not subjective. It's just a gathering of data. I think...supported that. Yeah, it's a gathering of data - that's partly what we're going to do but we're not supporting any intervention actually. We'll rather want to strengthen the system than to support an intervention.
Interviewer: How are you strengthening the system?
Respondent: So ours is more on capacity building at the district level, not the national level. The poor people are in the district, not here in Accra.
Interviewer: So you're building the competency of people that… But that means a lot of workshops, right?
Respondent: Not workshops. So there's going to be a team of experts - it's a four-year program about to be rolled out. We've delayed actually. We signed off in 2016 but because capacity issues from the ministries, we are delayed in implementing. We signed off somewhere in February 2016 and we've still not taken off. We've been going back and forth, but we're hoping that at least, by the end of the year, we'll have them together.
Interviewer: At the district level, what exactly are you going to be doing for them? You know there are challenges of infrastructure, challenges with stationery even sometimes, all sorts - the human resource, you have issues, and you have all sorts. Which area are you building the capacity?
Respondent: So it's more of human resource, and for us, we want to create a link between social protection, employment, TVET and business development. So the program has four components.
Interviewer: Who determined these components?
Respondent: The EU, the Ministry of Finance, and then the ministries involved. The government of Ghana saw the need for the capacity building training, the funds were available, we agreed together and then we'll proceed.
Interviewer: I want you to give me an idea - just two more questions - of your perception of the health sector in Ghana, generally. I know you've talked about maternal healt.
Respondent: Health sector, hmm...our emergency systems are not right.
Interviewer: Okay, if you had to prioritize, give me four or five key areas of priority
Respondent: Emergency systems first, the blood service, capacity might come in… Capacity in terms of the technical areas that the ministry deals in, and then trying to separate some kind of political phases when it comes to health related issues.
Interviewer: Will you say, so that's governance? Institutional governance of some sort - separation of powers?
Respondent: I see it as institutional governance, but I see it more as the willingness of the people at the helm of affairs to really deal with all the issues so that they are not politicized. If I come and there's a political party already doing something, as far as health is concerned, let me just continue and it doesn't matter who is doing it because that is an emergency area. If our health systems fail as a country we have failed - no matter what we have. Because if the average Ghanaian can walk to the hospital and his or her NHIS card is not working, then it doesn't make sense.
Interviewer: What are your thoughts, generally? If you had to recommend three key areas that if there was need to jump in to help the system become better and biased towards health, but generally the UHC. I'm working also a bit on sustainable development - and the sustainable development goals. So in terms of all these, keeping them all in mind, and like I said, EU is very well positioned. You have an eye over everything. What can be done to help them?

Respondent: For us, hmm… I don't want to say health because we don't know whether we'll go to health again. Health is a priority, health is key but I think that our social protection system is also key. **Interviewer:** Which falls under gender ministry?
Respondent: Yes.
Interviewer: And which areas do you look out for when you talk about social protection?
Respondent: You know, for us in Ghana, it's like giving people fish and not teaching them to fish, and that's what we have failed to do. I don't know for how long the government of Ghana will be able to support this LEAP program. But I think that if people have the skill to work with to raise funds to take care of themselves and our systems works well. And the little funds that they're able to raise, or the little income they have, when they access maybe healthcare system, it should work. If for instance, the NHIS works well, I don't need so much money to go to the hospital. But at the moment the system doesn't work well, so when I'm sick, I need to think of what to do, and even though the system is working, how well it's working is another issue.
Interviewer: So employment under Social Protection is what you're talking about. And then what else?
Respondent: Employment is key. Agriculture. is key.
Interviewer: Why is agriculture important?
Respondent: So, for instance I have another program that has to do with civil societies and agriculture. It's quite a new program, and you see that agriculture is one sector that Ghana can really make resource from if really we manage our systems very well. But why we chose civil society is because, civil societies are able to tell people about their needs. So our program is in two folds; we have a Ghana Employment and Social Protection Program that supports a bigger aspects of the ministries, the all the sectors involved. Then we have the civil society side that tells people, you know, you have access to this, demand this. So it's the demand and supply kind of strengthening system. So agriculture is key, and one aspect we might have ignored is TVET (under education ministry). This is because for us in Ghana, I think our minds are that books are all that matters. We've lost a lot of very knowledgeable and brilliant people because we've not made use of TVET, and I think it's key.
Interviewer: So, with all these, are there connectivities amongst the ministries you've selected to work with?
Respondent: Yes.
Interviewer: How do they work under this thing - how are they going to be working together? Obviously you must have some set of objectives for the project, so, how will they be working together?
Respondent: Sure. So there's going to be a steering committee and we've worked together - for us it's a process, it's quite a long process. We have prepared terms of reference together with all the partners. So they have ideas on what this person is doing, but then we're yet to get to the point where we need to agree amongst ourselves that this is what we want to do, their roles and then we can come together to do it. And that has been the challenge. Because everybody believes that "I think that you should give me the money so that….." I guess that's the system. It will work one day.

Juliet, thank you very much.

Annex 5B: United States Agency for International Development (USAID)

Interview on 3rd May, 2017 with Mr. Zachi Sabogo

Development Partners

Interviewer: What are the objectives of your organization in Ghana?
Respondent: It's an organization with many parts, in the sense that we have the MCSP project, the Gates project, the Early Childhood Development project (ECD), which is a new project that we are just developing. So we have Jhpiego as the umbrella organization with smaller projects under it. But the mother company is from US and most of our activities are all sponsorships from the US government. So USAID, right?
Respondent: Perfect.
Interviewer: For how long have you been involved in the health sector in Ghana?
Respondent: 17 years as a professional.
Interviewer: What has been your organization's contribution to the health sector in Ghana? What is Jhpiego? What's the contribution? Which part of the health sector is it really involved in?
Respondent: If you talk of Jhpiego generally, you must put it this way; that we are supposed to support the government of Ghana to improve the health status of Ghanaians, generally. But then, we work specifically in several areas. If you come to pick most of the output areas, we have nutrition, WASH family planning, maternal health and child health. Then, it depends on the project that you're working on. Under IPC we're just looking at infection prevention, under the MCSP we have two broad objectives. One of them is to look at pre-service education, where we'll have a better prepared health service provider. You know, those at the training school, Ghana nursing, midwives, committee of nurses need to have quality training. What we do is that, we support the schools, set up skills labs, and train tutors so that they'll train the students very well to fit into the job market. Then we have the community health component. So there are two broad objectives; one is the pre-service education and one is the community health component. And the community health component, we have the national level where we help them to standardize the processes, and at the regional level we help them with actual implementation.
Interviewer: What processes do you focus on?
Respondent: One, policy development, standard guidelines, training materials development, all that.
Interviewer: What are the concerns you have about Ghana's efforts towards achieving the UHC?
Respondent: One of them has to do with - when the policy was first pronounced, I sincerely believe that some government officials were even skeptical whether that was the right way to go, and it took them several years to recognize that yes, for it to reach out to everybody, that community health concept CHPS, was the right way to go.
Interviewer: I'm talking about the UHC, Universal Health Coverage.
Respondent: Yes, you know, Ghana is using CHPS to address UHC, so once the CHPS concept was passed, the first - initial problem was people were very skeptical. Some regions were very skeptical. The other issue had to do with this conceptual debate of "how do we go about it?", "how do we explain the terms?" So conceptual debate went for a very long time.

Interviewer: Like how long?

Respondent: Oh, we can talk about more than 5 years - for me, when I talk about a community health level facility, we need to place a staff there, a staff must do A-B-C-D. Another person will have a different thinking. So in order to clarify all this conceptual debate, that was the essence of them revising the CHPS policy. But even I can go back into it. You know, we used to have a CHPS operational policy, meaning it was both a policy and then an implementation guideline. So along the line, it was difficult to understand it clearly. So to put clarity to it and end this conceptual debate that I'm talking about, we decided to have a CHPS policy, and now we have translated that CHPS policy into the implementation guideline. So, the conceptual debate has to some level come to an end. The other concern has to do with dissemination. We have very good materials that are developed, but sometimes, they are not disseminated to the lower level.

Interviewer: How come they are not disseminated properly?

Respondent: Alright, let me put it - maybe probably due to funding, or issues of priority. Because the fact is that, if you develop a policy and the policy never get to even the district where they are even closer to the communities, they don't get the issues clearly - you know, if somebody reads it, they'll interpret it the way they understand it. So likewise the implementation guidelines; so for me, dissemination is very important.

Interviewer: So these are the two concerns you have concerning Ghana's efforts towards the UHC?

Respondent: When I talk about concept normally, I hide a lot of things under it. One of them has to do with the cadre of staff, their progression within the service, are all issues that needed to be clarified. Should the community health system or CHPS be managed by whom? An enrolled nurse, a community health nurse, a midwife or a combination of all of them? If it is a community health nurse, how should a community health nurse grow? And one of the things is that most of the community health nurses that are very experienced in community health systems will rather think that there is no future progression in that area, so they will divert to medicine, to do general nursing. So the experienced ones divert to other areas. So if we have a clear progression, what it means is that if I become a community health nurse and become experienced, I can do a diploma in it, I can do a degree in it, and I can be promoted along that line up to the highest level. Career progression is then clear. It has to be clear. They were all part of the conceptual issues.

Interviewer: So that is an HR issue towards the UHC. What other issue?

Respondent: Issues of even the service package; what services should we provide? (Who determines that)? That should be determined by Ghana Health Service, together with the Ministry of Health. So because of this issue of conceptual issues, some people will say they should provide maternal health service, others will say no, what level of maternal health services can they provide? Emergency delivery? Others will say they deliver somebody, it's normal. Others will say no. So, but I think for now, with the policy guidelines, we have been able to iron out all these ones.

Interviewer: In what way have you contributed to health coverage in general and the UHC in particular in Ghana?

Respondent: Personally, I worked first with Ghana Health Service, but I was leading a project in JICA which was essentially community health, before I came in to join this one. So, I rather brought a lot of experience from JICA to this organization. But for MCSP or Jhpiego or USAID, what I can say confidently is that, we have been able to start national level, to standardize or develop the national CHPS communication advice which played a crucial role. I was a member of the team that wrote a number of the chapters. So that is one. The second one is that, we're

doing a CHPS costing study. The first question is that how much does it cost to establish a CHPS zone in terms of construction, in terms of human resource, in terms of medical logistics? These were not known. So even when you want to advocate for resources, one does not have the requisite basis for it. Then, the training material that we're harmonizing, it's a very important element. So what happened is that, JICA in Upper West, we modified it and reduced the number of days to 12 days, and other regions were using different approaches because of the cost of the initial package. So what we're trying to do is that, what can we do to unify all these things - standardize it such that, a CHO that is trained in Upper East is the same CHO in Greater Accra region - that is all we're doing. So we have been able to come to come up with the framework, the number of modules that are required, the number of days, the theory and practical component. We're just about finalizing that. We have also helped Ghana Health Service to develop the CHPS web page although it's not functioning to our expectation. We also helped them to organize national CHPS seminar or forum; bring all the regions together.

Interviewer: In what way have you contributed to the NHIS in expanding health coverage in Ghana?

Respondent: With the NHIS, one of the things we wanted to do was with the capitation area but it's something that we're a bit silent on. We wanted to use a costing tool, repackage it in such a way that we could build the capacity of community health nurses or community health workers to be able to use the capitation appropriately. In the absence of that, what we want to do is that, you know they generate funding from their services they provide, and about 90 percent of it could come from NHIS. What we want to do is to train them on financial management. The other part which is an indirect effect of the community health system that I can say not directly from MCSP or any of the organization workers, the CHOs who live in the community, they provide the necessary education for the community members to enroll onto NHIS. In terms of health education, health promotion and all that.

Interviewer: But so your organization has had partnerships with NHIS? The capitation, did you even start?

Respondent: We didn't start you know, because of political issues. Because you're recording this, some of the things I cannot say.

Interviewer: But I have spoken to some professionals in the field. And they are from the previous government, and the understanding is that, the capitation has been piloted in the Ashanti region. Yes, so it became political and stuff. But you were involved in the technicalities of it?

Respondent: Technicalities, yes. My former country director and other team members were involved.

Interviewer: But your organization contributed to the concept.

Respondent: Yes.

Interviewer: What is your view of the roles of the actors in the policy process in the achievement of the UHC so far? Any gaps?

Respondent: The gaps normally I see first of all has to do with commitment from the government side.

Interviewer: But they accept the UHC concept?

Respondent: Yes, they accept it. But the quality in terms of pushing the resources to be able to realize that, sometimes I don't see it. It's because you are recording, otherwise one of the clear things is that

Interviewer: Okay the part that you'd say that you're not sure, off record, we'll take it out. I'll transcribe myself so.

Respondent: Off record, because to have a very resilient UHC, you need the needed human resource logistics and all that. The first frontline service provider is the one that I call the community health officer or the community health worker. So if government can have access to resources to provide for volunteers in large numbers for more than two weeks, what makes government not capable of training these frontline service providers who are even the direct service providers that will supervise volunteers. You know, the previous regime, we had this community health volunteers - they're part of the design of the CHPS. You know, their training is even more expensive than the training of a community health officer. But the community health officers as we speak, several of them have not been trained. And you know, you pick a young community health nurse who has lived all their life in the cities and you're sending them into the community, you need to train them to understand the sensitivities of the communities, but that has not been done. So when you do it, Ghana we just have less than 7000 community CHPS zones, and less than 4000 are functioning. Less than the 4000, you're talking about less than 1000 with trained nurses - well they the nurses trained professionally but not trained to work in a community. So for me, if the commitment was there, that budget cannot be compared to the budget that is used to train even the volunteers.
Interviewer: Which brings the gaps in the entire process. So what other gaps have you seen?
Respondent: I've also seen that the communication to the government probably is not right - communication from the Ghana Health Service, the Ministry, given to the government. We just had a meeting. We were talking on the sidelines, and then Global Fund - I went to South Africa for a meeting. They have huge funding for community health, otherwise known as the UHC, two windows. But Ghana, they're just about developing a proposal. The young man was telling me that their emphasis is on e-tracker. No prioritization. Yes, e-tracker is just to tell you that what are they doing in the CHPS zone, so you track it, and so what? But you know, we have the gaps in terms of equipment, basic equipment, basic logistics are not there, capacity of the CHOs, the community health systems are weak, the structures that you need to have a functional community health management committee, functional volunteer system, then the technical workers, all of them working together with the community leadership. All these things are not very strengthened.
Interviewer: Do you collaborate with other development partners in working to improve healthcare in Ghana? In what ways have you collaborated?
Respondent: Yes, several. Our intention is to bring all the development partners, come and tell us what you have in your work plan that addresses UHC or the CHPS concept so that Ghana Health Service will be aware that this development partner is in this area, these are the services they provide, and all that. So that they begin to know the quantum of work that the government can. So it is a very good intention for the higher level to know where the gaps are, avoid duplications. You can have more than four development partners doing almost the same thing in one region.
Interviewer: What challenges do you face in your work in the health sector in Ghana in general and with the NHIS in particular?
Respondent: NHIS, the only challenge will just be their payment issues.
Interviewer: What policy recommendations can you give to the country in its bid to achieving the UHC?
Respondent: We have an implementation guideline, we now have a costing tool, and we have a business plan that talks about now to 2030. What we don't have is actually a strategic plan that for each region. That is actually what is lacking. The level of commitment of government in

terms of financing. I just gave you a typical example where Global Fund, World Bank, UNICEF and so many others have money. But Ghana, we're not able to access it because; we do not have one framework we're working with. Many people are doing things in their own way.

Interviewer: In what ways could your organization partner with the government of Ghana towards the achievement of the UHC?

Respondent: We have the ideas. We talk to them, but we don't have that muscle to push.

Interviewer: Has the Scheme achieved its set objectives?

Respondent: They need improvement. They might have achieved but they need a lot of improvement. I think they need to do a lot of work to be able to determine their financial viability.

Interviewer: Do you think the NHIS' challenges can be traced to the fact that it has been politicized?

Respondent: Partly. You need political support but you need the right technocrats to carry out the jobs. We need political support to succeed, but not for everything.

Interviewer: Can the NHIS be sustained in the long-term? Explain

Respondent: It can, we have ideas. Ghana, we can do it. And one of the things I believe is that the premium we pay in the first place is too low to survive. So one thing for them to do is that, they should look at the premium payment, structure it in such a way that - I believe in other countries, it is structured depending on the wealth quintile you fall in.

Interviewer: In the last couple of years, the CHPS has attracted some attention; how do you think it is placed on the development agenda for Ghana now?

Respondent: High. That's the only way to reach the communities or reach everybody. Apart from the commitment issue of government, it would place 8. CHPS is very high. It was based on the research and has scientific basis and globally because it addresses the primary health care concept. There are a number of factors that made CHPS to reach the apex within the shortest possible time. I think it's a good concept but needs to improve. Supervision is very weak.

Interviewer: Has this health policy been implemented as should? Reasons for response

Respondent: No, because of weakness in the health system. The health system weakness is affecting it. The caliber of staff we have there is enough. It is one of the challenges we have is an issue of communication.

Interviewer: What are the challenges facing the implementation of the CHPS?

Respondent: One of them is weak supervision which I have spoken about. The other one has to do with poor community entering and community engagement. Logistics, capacity building, community level structures - poor community entry in fact leads to a number of them. Even referral is an issue.

Interviewer: Why is referral an issue?

Respondent: Referral, there are two things, transport - communication, effective transfer - documentation. You might have documentation that has gaps. Transportation could be a major factor in some areas. You know, some areas, they do not have vehicles that go there on a daily basis. If they have this tricycle, sometimes there are also issues of even the maintenance and a number of things.

Interviewer: But in terms of - I know that at the primary health care level, a lot of the services are supposed to be free.

Respondent: Well, you've used the right word. They're supposed to be free but they're services that should be paid for by somebody.

Interviewer: So that assumption of the free, such that people are not paying or people are paying? If you're paying it basically means it's out of pocket, right? So we're going back to the '80s. But that is what UHC is trying to prevent, isn't it?
Respondent: And they can do that if they strengthen NHIS.
Interviewer: But is that what is happening at the CHPS level, for those who are not on NHIS?
Respondent: Those who are not on NHIS at the CHPS level, they're normally not many, unless the CHO is not doing their work well. So once they're not many, that one should not be a big problem. The free part is the primary, like immunization, the output services. But you know, to provide it you need fuel and other things to do it. So there should be a way of paying for it.
Interviewer: But who should be paying for it? That's what I'm asking.
Respondent: In the new policy, the agreement is that primary health care at least to some extent will be costed for in the NHIS. But I saw it to be a good idea. Only that NHIS is not even able to pay for what they have already agreed on and they are taking on more issues
Interviewer: Can the CHPS be sustained in the long-term? Is there need for any intervention? If yes, what interventions would be recommended?
Respondent: It can, once again it's the commitment problem of government.
Interviewer: Will it be possible to combine the NHIS & CHPS in order to achieve the Universal Health Coverage in Ghana?
Respondent: But that is the way to go. Is it not financial access and geographical access?
Interviewer: So if that is possible, how in your estimation can it be achieved?
Respondent: One of the ways is that first of all, NHIS and Ghana Health Service are both under Ministry of Health, but I think they see themselves differently. The community health workers or CHOs are aligned to Ghana Health Service and just assume that they only get payment from NHIA. One of the ways for me to ensure is appropriate education of the populace, appropriate service package. So, they should have a service delivery package at the community level that probably will fit well into NHIS, and the CHO should also have that capacity that can even educate community members on the need for all of them to enroll. So once there's about 90 to 100 percent enrollment in a community with the basic package of services that are provided in that community, then it means that UHC in terms of financial access and geographical access will be achieved.
Interviewer: Institutionally, how would this work? Who will take the lead in such a merger if you call it?
Respondent: Ministry of Health.
Interviewer: And are we going to get one institution being absorbed by the other or it's just on paper?
Respondent: Not necessarily. Ministry of Health should play their role where people need to work together. They can force it and it would need legal backing, even for CHPS - community health. People who are working there, when something happens, they are on their own. In other countries - in South Korea, community health systems there - nurses there are backed by law on what they can do, what they should not do, and all that. Here, even I tell you, general nurses I don't know how they are backed by law. Then, come to think about the need for these two organizations to work together closely, you might need a bit of legal backing, but I think it will take leadership. We should have the right leadership. NHIS has issues - the way we cost services, the submission of claims - claims to management actually, is a serious issue. In other countries, people will submit genuine claims, but in Ghana, because of fraud we need a lot of supervision. I think it is one of the things that is affecting the service.

Other Perceptions

Interviewer: Is Ghana practicing the Health in All Policies (HiAP) approach? If yes, how is it being implemented? If no, why?

Respondent: To some extent but probably not entirely. I know Ghana Health Service or the Ministry of Health collaborates with a lot of the agencies, especially during epidemics. But you probably might expect a higher level collaboration than just when there is an issue, you need to bring them on board, you need to plan together and then execute. But there's some level of collaboration - when it comes to health. I know during the annual reviews, they bring most of these departments on board, and then they're able to pronounce what they should do. What Health doesn't know is what each of those departments have on their work plan that is concerning health. But if we want to strengthen that window, it is possible. I even mentioned that coordination is an issue when it comes to the community health system. Then coordination and practically you go on the ground. Ghana Health Service, even the divisions are fighting over who should be the lead person to coordinate the CHPS. So the PPME wants it, Institutional Healthcare Division wants it and then Family Health Division equally want it. And between Ministry of Health and Ghana Health Service, you have the roles - I believe very soon they might even have conflict. In Ministry of Health, they have appointed a national CHPS coordinator and Ghana Health Service also has a CHPS coordinator.

Annex 5c: World Health Organization (WHO)

This is an interview on 23rd of May 2016 with Mr. Selassie Daumeda of the WHO.

Interviewer: What are the objectives of your organization in Ghana?
Respondent: WHO's role is across board it is a secretariat of member nations in each country. So, because WHO is formed by member nations, and when you see the office, we're just a secretariat to support the country, to provide technical support, advice on policy development, information and its usage and limited financing.
Interviewer: For how long have you been involved in the health sector in Ghana?
Respondent: WHO came just, I think a few months after our independence specifically for the health sector in Ghana.
Interviewer: What has been your organization's contribution to the health sector in Ghana?
Respondent: In a similar role as the Ministry of Health - policy formulation, resource mobilization, monitoring and evaluation. Those are broadly the three areas. In those areas, WHO is heavily involved. For example, for policy development, there is no policy that will be developed by Ministry of Health or its agencies without the participation of WHO. We talk about system wide policies for example for human resources, health financing, technology, leadership. Then to the service delivery area; for example something like communicable diseases, non-communicable diseases and all those things, we support the country with the tools that they should use, and aside that we participate in the process itself. Also involved in the resource mobilization which the ministry undertakes like the GAVI support. GAVI used to be Global Alliance for Vaccine and Immunization. But they've changed the name now, they just call it GAVI. For example, there's going to be called MAF, MDG Accelerated Framework for maternal health or the MDG… Actually it was WHO who initiated the process because the money was allocated by EU for group 7 which was for environment - environmental sustainability but, by then we thought that the health system had a very good case for maternal health so we logged it both in country and globally that the money which almost 84 million dollars, should passed on to health, so that money was passed on because we have the policy, we have the strategy, and even the plan
Interviewer: So you do a bit of lobbying also for the health sector, basically?
Respondent: Yes, I remember when Rawlings was in power and we wanted to put up the regional hospitals, most of the development partners were against the idea, they said "most of your health needs are preventive", so why not concentrate on the primary level and end up at district level? But the Jerry Rawlings government was also not paying attention because, he thought it was necessary for them to have regional hospitals. And the WHO came in to play the role of the arbiter with the other partners, and because the partners were saying that look, your physical space is so limited, you do not have enough funds, you cannot pay your salaries. And when you put up the regional hospital, it means that you have train and recruit more specialists; even you don't have the means. So, they had a good case, but we came in with some best practices in other parts of developing countries to support.
Interviewer: What are the concerns you have about Ghana's efforts towards achieving the UHC?
Respondent: Okay, let me put it this way. You know, for most people, when they talk about UHC - I'm sure if you even go to the health center, they'll say yes, we're doing UHC but for me UHC is not a one step, it's a journey. And the concern is that, you know we have the national

health insurance which is talking about financial access, and we have the CHPS which you've already addressed, for the physical service provision. But the area of concern is, we're trying as much as possible to cover a lot but we're forgetting about the people who actually need the services. You know, if you look at national health insurance, almost about over 10 percent of the population are pro poor, yet national health insurance has never ever covered more than 5 percent of people for their indigents. So it means that there's a large mass of people who are not covered. And for me, if you ask me, I can go to hospital and pay. A lot of civil servants can go to hospital and pay, but they rather appear to be benefitting more than those who are poor.

Interviewer: So neglect of indigents. Is that not being addressed somehow by the LEAP?

Respondent: It's been addressed but what is number of LEAPs? LEAP till recently, I think last year, prior to the election, one or two things were done to increase the number but it was, for me, it was at an experimental stage for a very long time, and I know MOH struggled to get the numbers there. But, it's not the problem of the ministry per say because the name, you know the tag on the pro poor is a factor. Because nobody wants to be a poor person. So once you start to give the name poor, you are sure you won't get a lot of people coming in. so even the categorization is a problem and even the mean test that you have to use is very very difficult. I know few of my friends did some studies even up to PhD level, but yet it's still a problem. So there are a lot of issues there, not only in the NHIA, even Ministry of Gender which taking the social protection, and even Health.

Interviewer: So the indigents component is a problem. Now the issue of even if the LEAP is supposed to be for the indigents is domiciled in one ministry, and there's another ministry concerning health.

Respondent: But at least, there's a certain level of interaction among them, yes. The gender ministry and MOH, there's a certain level of talking… But you know what, health is produced at the primary level - health is produced as a community. So for me if you want to achieve any success, you should emphasize more on districtalization. Let's district-alize the system. Let's make the people the owner of the process and the output. But, I don't know. Maybe because of political expediency, Accra usually dominates, such that, the local people who should own the process, may not own the process. And for me that's one of the problems. The third one is the problem with UHC. You know we're supposed to provide quality care but that is not forthcoming. There are a lot challenges pertaining to health outcomes, and most people will tell you that "oh, because we do not have the right equipment, we do not have the right funding" and all those things. For me, I don't think that is right. The bottomline is the issue of personality traits. You know Ghanaians generally, we have very bad customer relations, such that wherever we are, we think that we are doing great service to people that we're providing service to, and that happens a lot in the health sector. And I will not say that it's limited to the health sector. It's across board, but because health sector - you can see it immediately - somebody is sick. If the person doesn't get the right type of care, there are consequences. And aside that, there's issues - nobody wants to talk about punishment, or maybe punishment is too harsh a word. You know because, just last month we held what we call health summit. It's an annual affair to review our performances. And it's very clear that we're still lacking in quality. It's always on the discussion board - what can we do? But luckily enough for us, the ministry was able to produce a national health quality strategy, just last year it was out-doored and they're working very hard with. Even the CHPS concept as we have it which is supposed to provide the service delivery… It's not happening as planned; we're always behind time - with the CHPS.

Interviewer: So now, apart from these three, the neglect of the core beneficiaries, the indigents, the ineffective decentralized system, and when you say that, are you talking about the fact that it's a referral system which the decentralization has been infused into the...or that's not what you mean?

Respondent: No, that's not what I mean. You see, what I mean is that, we should let decision-making about care be at the peripheral level - it's too heavy at the top. By government directives, MOH should have been fully decentralized by now, but it's not. We go round, we do a lot of but, I mean ground zero. The previous government was, I think, by September 2016 - the setup should have been fully decentralized. Efforts were made. We had a lot of meetings, a lot of writings and all those things. But I think there's a problem of political will, and it could be - you know, it's very difficult for people to hand over whatever they have, and the resource is also an issue, so efforts were made - I mean serious efforts but it still… So even at our health summit it's still an issue. Decentralization; when are you going to decentralize? And even when CHPS - the idea, was for the community to decide where to place, they're supposed to contribute, but all those things have been taken away from them, it's now with Accra. So how will the people own the process?

Interviewer: In what way have you contributed to health coverage in general and the UHC in particular in Ghana?

Respondent: For coverage, WHO was an advocate for what is being implemented now as CHPS. You might have heard something they call the Bamako initiative in 1978, then you might have heard of the Danfa Project, which even came on board before the Alma Ata declaration, and you might have heard of the Ouagadougou declaration which has 9 areas, and one of them is community ownership. So those are WHO's… Ghana even piloted some of them with success stories, and for us to run with but, Ghana we're fond of starting very well, developing the various documents, piloting then we lay back. And i think it's because, when government accept the ideas and they see it as a good process or good tool or whatever, they're usually in the mode of, "we should get support - funding from donors to do something", but you know, the funding outlay for such investments is huge. And no development partner can do it. It's the country who should do that. So those are the challenges with coverage. I'm telling you that those are the things which are talking about coverage. You see, all those documents I've mentioned to you, if Ghana was able to implement any of them fully, I think we would have had over 90 percent coverage now. But we do not. That's number one. Then number 2, when the policies are being developed, when CHPS was - the idea came on board, WHO was seriously involved and even paid part of the research which was undertaken in Navrongo. You know, CHPS is a researched and well tested policy. WHO participated in paying some of the research funding request, and even when the actual piloting came on, WHO was there and we supported by even bringing in experts at certain times to support the system.

Interviewer: Yes, but did they not have a summit on it, last year for the proper launch in the northern region?

Respondent: Yes. Before that, that document, it was WHO which paid for the final workup. It's WHO who did that, and when it was launched at Wa, WHO, I think among the main funding aids WHO was the only one which was, apart from JICA. Because JICA, that's their - Upper West region, that's their region, and they put a lot of the CHPS compounds so this was easy for them to do. But apart from that, we share best practices all over with the country. And we even do capacity building in terms of how coverage could be expanded, and what we do is, we take people to meetings. And even aside that, at times, WHO goes to Ministry of Finance to negotiate

for funding. We do that, because at times when the MOH goes, you know it's minister to minister, you know, familiarity. But we go with different face, different approach, and at times, we do have success but not all the time. The last one, I even presented, on the Ouagadougou declaration. When we presented, the emphasis was on community ownership, and that was done when Ghana Health Service was developing its new strategy. I'll tell you the history. We have what we call the Nkoranza community-based health insurance scheme. That scheme was started in a hospital, St. Theresa's hospital in 1995 and when I joined WHO in 1996, the first task I did, was to go and review that particular scheme and write a paper on it. And I remember when we came, we sold the idea to the ministry. Even though because it was in a CHAG facility and by then, the relationship - even though government was paying the salary of CHAG members, there was no MOU like now. So, there's a bit of distance between the two. District directors used to hold congress, and each time WHO supports them, so it was during one of the meetings that we presented on findings on Nkoranza and asked that they can take it on, and few of them took it on and in a short time it started moving, because I mean there was no money for most of the health facilities. They were almost in red. But with that, they were able to get some funding from the people, and people were enthusiastic to participate in the scheme, and that was NDC 1's regime. The idea was there and when there was a change in government when NPP 1 came, the same idea was brought on and fortunately, president Kuffour accepted the deal and took it as one of his key priorities, and we immediately rushed in. We brought in consultants from Congo Brazzaville and Geneva, and even at one point, we have to liaise with ILO because they also have something on healthcare under their social protection. So we brought people in, they did quite a number of studies just to support the institutionalization of national health insurance. So that's the role we've played. And then we gave little - when national health insurance was being established, they were having district offices. I remember we gave computers - the first one was 20, another one was 30 and even I remember Dodowa health research, was trying to pilot the community base before they start and I remember Dr. Irene Agyapong was there. I remember our regional director came here, we went personally to Dodowa and he made personal donation of 10,000 dollars and we supplied some equipment to them.

Interviewer: What is your view of the roles of the actors in the policy process in the achievement of the UHC so far? Any gaps?

Respondent: If I understand your actors, maybe yes, we have the development partners, we have government, which is MOH and its agencies, then we have the Ministry of Finance, then the community or the people. You know, for most of the partners, it's participating in the policy development or the strategic direction - supporting the - and capacity building, and provision of limited funding. For example if you take the funding agencies like World Bank, they provided grants and loans. I think the last one was 25 million dollars about 3 or 4 years; those are what they would do. But for WHO, ours is mainly technical. Most I've already talked about. Then I know some of the - like DANIDA, JICA, they also provided funding and technical support; technical support in various fields. Then if you look at Ministry of Finance, theirs is just the resource mobilization and release of the funds, and for the community, some of them participated in the discussion. I remember when president Kuffour made the establishment of district-wide mutual health insurance schemes a target - oh it's a KPI, for the district assemblies, that enabled - in a very short time, we saw the schemes moving from 70 to 148 district mutual and we were in the process of increasing them before the IGI said no, we'll not have the district-wide mutual health insurance, we'll have the national health insurance alone. So that stopped the process. And for me, it would have been very good if we continued with district-wide mutual health insurance.

The fact is that, the district-wide mutual health insurance allows the community to participate because we have a general assembly where we have the communities participate in the decision-making and I think that we all have the right to say that this particular doctor or these nurses are not giving the right care, or they show us disrespect. And that would have given information to national level to add. But Accra cannot do everything. They gave an excuse of expenditure and I don't believe that.

Interviewer: Was it not at that level that there was fraud - so much fraud? When it was at that level, especially with the review in 2009, a lot of fraudulent activities were picked up.

Respondent: We still have - health insurance all over the world, even in America, is full of fraud, and even in your own country. It's all over. So it's now left to the authorities to make sure that they put mechanisms in place to stop that. There should be punitive measures, don't arrest people and just use the usual network in Ghana to hand off people. We still have serious malfeasance in national health insurance at the national level. And finally, MOH, they as the service providers - I think they are the biggest service providers followed by CHAG and the private entities. They were doing well providing the care that they're supposed to provide. But just as I've said, all over the world, care providers try to increase cost. Because when we started, we started with fee for service, and you know what goes with fee for service, out of pocket. So that was not good for the scheme and the population so that was stopped and now we moved to the DRJ, and now DRJ and capitation. They all have their challenges but we're tagging on so that's the roles that the various stakeholders play.

Interviewer: Do you collaborate with other development partners in working to improve healthcare in Ghana? In what ways have you collaborated?

Respondent: Yes, you know first, we have what they call the donor's meeting. And that was on till I think 1997 - 98 when we changed the name to Ministry of Health DPs meeting and around 2010, we change the name to Health Sector working group meeting, and those ideas all came from WHO because of best practices in other countries and the health sector working group meeting is ideal - because the ministry meets different stakeholders at different times and at times, there is not cross specialization of ideas and what is happening so we suggest. We meet all those people, we struggle to let people have what is happening, and we push all those things during the health summit, perhaps so we as per the health sector working group meeting where everybody who matters in the health sector attends that meeting - it's the first Thursday of every month. And when we even started, we realized that we the DPs, at times when we go to the meeting, we have to struggle to - we talk at cross purposes. So we formed what we call development partners' group for the health sector. So what we do is, the group meets last Tuesdays before...so as we can harvest ideas, agree on points of execution and all those things, before we go to the health sector working group on Thursday, and it's a group that is well recognized by government such that whenever there's going to be any event, the development partners' group is consulted through our lead. And currently, we have UNICEF leading. Now we have a bilateral, the USAID as the co-lead, and we have the multilateral as the lead. After a year, then a bilateral will be the lead, and a multilateral will be the co-lead. But we're suggesting a new thing, that WHO, in actual fact, we're not a development partner because, we are a secretariat for government so no matter what, we should always be in a leadership position. Because if any issue comes up, all the donors can decide to leave government, but WHO cannot leave government because our main stakeholder, or if it's the corporate world, our shareholders are governments. We are just the clerks and office in the company, so we cannot be seen to be doing away with our shareholders.

Interviewer: But so it means that if you led, you're going to lead forever? You want to own that process?
Respondent: Yes, because first the idea was, it was WHO's idea, and so when we brought that the first time, we led for 2 years. Even though the person who was leading said oh, let me hand over because the idea was one year. They said no, continue leading. When he left, they went to...nominated WHO leaders. WHO led for another 18 months, so the design is there for WHO to lead and it seems we're being too benevolent. Yes, because do you know how WHO's leadership is chosen? It's chosen by countries. All the development partners, UNICEF, UNFPA, their leadership is chosen from New York. Currently, they're choosing the director general, it's happening this week. Do you know the people who are doing that? It's Ministry of Health, they are doing it - from the 149 member countries. So, WHO is actually owned by countries. But apart from that, no other organization. The nearest is food and agriculture, but they are not in the health sector. So we think that we are workers of the health sector. The others are not.
Interviewer: How long has the development partners' group been in existence?
Respondent: Oh I told you that we as at 1996 when I joined. Yes, the first one they were calling it donors' meeting. But the health sector working group and this one just 2010. We have donors' meeting - that 1996, '97 thereabouts. Then we changed it to health sector working group meeting in 2010. And the same period, we formed the development partners' group.
Interviewer: What challenges do you face in your work in the health sector in Ghana in general and with the NHIS in particular?
Respondent: Some of the problems are, at times maybe we don't get things done on time. I can give you an example; since - in 2015, we had a health summit. That is the biggest meeting of the ministry, and after the meeting we hold what we call business meeting. That is like, sort of cross training between Ministry of Health and its partners, and there issues are identified. During the 2015 one, the ministry said oh, we're having efficiency problems so WHO can you help us? So that decision was taken. Now, when this decision was taken, it's left for the ministry to send us a formal letter that this agreed in a aide memoire, so can you help us - come and do this for us? They did not do that. We keep reminding them, till last year, yes. And even with this one, a lot of persuasion from us before the letter came, and when the letter even came, they are still dilly dallying. But we think that, you know, most of the people who give money to Ministry of Health, they are moving away because we are now lower middle income now. So we're no longer a poor country or we're no longer an underdeveloped country. So most of the grants are going away and so the next aim is to increase domestic resource mobilization and try to introduce efficiency measures into how we spend our resources. And we think it's a very big opportunity for us to do the programmatic efficiency system so as the results will be there to be fed into the next medium term strategy, but dilly dallying.
Interviewer: Why do you think that's happening?
Respondent: I think it's individual - you know, equal benefits from the...you know people like the status quo, and we all know that if the results come out, it's going to change a lot of things, the way business is done, the ways funds are managed, and people don't want that, and luckily for us, we have the new PFM law - the Public Financial Management Law which now puts the onus on each individual staff. Formerly it's put on the head of agency. For example, if I do something wrong, any financial malfeasant, the law will not hold me responsible. It'll hold my boss responsible. But the law now holds the individual, and we think the efficiency study, will even help them. But they don't want because people are still in the various… So that is one of them, things not being done in a timely manner. Number 2, you develop strategies and plans,

spend so much energy and resources, and it's not implemented too, but it should. (Why is that)? They will give the usual cry; there is no money, which for me is not true. That where they even implemented, you can only know the outcome or your output when you review, and that's another problem. People are not keen even though the sector has developed what we call common management arrangement which has agreed on all those steps between government and partners. At times we have to be urgent; let's do this, let's do that before we do that. And another frustration too is lack of capacity or lack of right skill set. But the issue is that, over the past 7, 8 years, the health sector staff has increased by over 40 percent.
Interviewer: So increased in numbers or increased in quality?
Respondent: I won't talk about quality. You know, quality does not come by itself. There are certain things that will produce quality goods and services. But if those things are lacking, you don't expect to see quality. And it's supervision. Supervision doesn't exist. The appraisal system is a gentleman's agreement or matter of course. You know, there are certain issues, certain people do not even - a story I heard just last weekend, I was mad. There's somebody I know. I've not been seeing that person. Oh, he's there. That person comes to work, in a whole year what? One month. Yet, that person is getting promotion. He doesn't come to work but he's getting promotion. So, those are some of the things. Because, that person immediately, it means that person should not be working. But that person is at post. And even the most annoying part is that, there are some hardworking ones who are always dying, I mean, hurting their back, are not being promoted like that person. So, you know, quality comes with… But apart from that, we have the funding issue. I think the last two years, it was really really bad, pretty pretty bad, for MOH. and you need money to provide your service. You know, the ministry has, or government has three items. Compensation - that's for salary. Then we have goods and services. We have capital expenditure. In 2014, we were given 55 million cedis for goods and services, and in 2015, we were given 35 million, in 2016, we were given 2.6 million. So if you were even drawing graph, normal graph you have...how? From 55 to 35 to 2.6. So when we saw the 2.6, immediately, i called - I have a friend among the parliamentary staff committee. And I said sir, you've made a mistake. He said "what mistake"? I said sir, you've left out one zero. At least if 35 you're even going to reduce it, not to 2.6 million. I thought it was 26, but even when the budget was being developed, we were sort of lobbying for increase, and we were assured that we'd get that increase, so when we saw the 2.6, most of us thought that it was a terrible error, and they said no, that's the allocation. And when this was going on, national health insurance was not reimbursing most of the facilities. And meanwhile, national health insurance contributes between 60 to 70 percent of the resource of most facilities. So, where are they going to get the money from? So, if they don't have money, you don't expect quality service. And that was even bringing it around that issue of what we're trying to prevent, i.e. out of pocket expenses which we were trying to reduce or minimize has been on the rise, because if I'm producing care and you're coming to me and I don't get the supplies for a while, I have to buy it and they were buying on credit. Their capital has been thrown off and now most of them were not even getting supplies to give them. So funding is also a major problem. But the good thing is that the current government has increased the goods and services to over 550 million cedis...so if you're writing the story, I don't know how you'll write it, of you're trying to analyze - over 10,000 percent. It doesn't make sense.
Interviewer: But something you mentioned earlier - in line with also same resources and funding, which I want to ask. You know, with the - first, can you tell me which of the development partners has left?

Respondent: First, EU left. They were the first to leave, then they came back again with the MAF funding in 2010, '11. Because the MAF funding was supposed to end by 2015 so they came back. (When did they leave, the EU, the first leaving was when)? They left around 2007, '08 and they came back again. When they came back it was just to the money for the funding until the end of it. Now, they don't come for the meetings. Then the Dutch embassy left. They left but they appear once a while. Their portfolio has changed. They've left the health sector, but they've not left health completely. Their focus is now on the private sector, and since MOH isn't strong in the private health sector, they decide to give it. Then DANIDA left just last year.
Interviewer: Why? Since we got to be middle income?
Respondent: Yes, apart from that, they've been here for a very long time and they're not seeing the progress that they expected. DFID has given signals
Interviewer: Given what kind of timelines?
Respondent: Oh by I think 2020 - 2021. So those are those who have left the big ones who have left. But whilst they're leaving, we have new ones coming in. We have Koica, the Korean… Then we… Israel has come, but because they do not have capacity, they are not very big but because they support some building of - you know, the military is putting up a hospital in the Ashanti region. And University of Ghana is putting up their medical school from the jewish - Israel. Then France, in developing the global fund, the said they're there, but France is your country. They're not straightforward because France came to see us that they're interested, we spent so much time, so much energy, but at the end of the day - apparently, it was a health project they're running in a lot of countries and they were thinking of bringing Ghana in, but they were not straightforward. When all this was going on we said ah, what is happening? Go onto the net to read, that was when we realized that. But currently, France is supporting the consultant who is leading my proposal. They have...what they call the 5 percent something. This is from France, so they are paying that person. And aside that, they are supporting a study on malaria, with WHO. But if you go to the health sector and ask for France, nobody will mention them. They're not known. So if they want to help, that will be nice. So that's it.
Interviewer: But so the challenge of financing is a big problem?
Oh it's a big problem.
Interviewer: What policy recommendations can you give to the country in its bid to achieving the UHC?
Respondent: Oh, you know, we're on the right track, we have the right policies. The first policy of national health insurance is a good policy but let's take a second look at its implementation. The way it is now, it's not right. Because we provide almost over 90 percent of the care that is required at the district hospital level. And there's no co-payment from anywhere. For me I don't think - it does not happen, and more so what comes to dedicating - the National health insurance fund is not solely for National insurance. It does other things as well, so we have to look at that. So, the principle of national health insurance is good for UHC. that's the finance bit. The CHPS concept and the improvement in referral, because we have… The CHPS led with the - let's say the referral system from CHPS to the health center district, regional, and to tertiary level, is wonderful. Then the third one, it's across - it's everywhere so it doesn't matter your background, your religion, all those things. So that's supposed to be population wide, that is also good for UHC. And finally, I will always talk about the quality issue. So in principle, all that we planned to do, are the advise that I would give to any country that wants to do UHC. but the issue is, the way we're going about it, is that the right way? It's another issue.

Interviewer: In what ways could your organization partner with the government of Ghana towards the achievement of the UHC? What are the policy gaps identified in the NHIS' implementation which have still not been addressed since inception?
Respondent: The main policy gaps is, for me, the current institutional arrangement where everything is constrained in Accra, I don't like it. Even the regional offices, if you go, their troubles are even more than what the regional health insurance office will be talking about. So for me, they should go back to the roots. You know Rwanda had over 96 percent coverage, and what they are doing is what Ghana started, the community-based. That's what Ghana started, and the management of the scheme, is in the hands of the people - the local people. So they know who is not an indigent. So they recommend that okay, household is indigent so government should pay the premium on their behalf, and if the premium is not even paid, you just go to the healthcare center. There's a guarantee from the committee for you. Those are the things we should be doing. So that's the first policy gap. Then if you talk about the service provision wing, the CHPS concept is interpreted differently by different individuals. Some people think that without a compound, we do not have CHPS, but the principle is to have somebody to provide the care that is required, that is the CHPS. So, when we were in the Ashanti region, the director there - Ashanti was one of the poorly performing regions in CHPS, but when they brought in a new director from Upper West region, in less than a year, the face of CHPS had changed. Because he said look, in Kumasi, I don't need a CHPS compound. All that I need are the personnel and the tools. So they are what we call CHPS in bag. So they just need a community health officer, a bag; the person should go to a community regional service and have information. That's all, once you do that, it's working.
Interviewer: Has the Scheme achieved its set objectives?
Respondent: It has to some extent, but not as - because we're still roaming around 39, 40 percent so we're far behind, and the indigent population cover is so small, and those who are exempt form 78 percent - all these under 18, maternal - pregnant women, pensioners, those on the SSNIT. Why should those on SSNIT be exempted?
Interviewer: But I interviewed TUC, their argument is also very different. It's their funds; it's their retirement monies that was used in setting up NHIS. but like you said earlier, they can afford healthcare even without an NHIS, yet every month deductions are made to support the scheme.
Respondent: I understand that, but I can educate you a bit. You know, most of them do not even understand what is happening. The deduction that is made, is not made from their salaries. If your salary is 100 cedis, nobody takes any percentage from your 100 cedis, you'll still receive your 100. But, we have the pension fund which is guaranteed by government, and government takes that 3(½) percent from there. But if let's say on pension, because you're earning 100 cedis, and at pension you're supposed to earn 50, they'll not say because government has taken 3.5 percent, they are going to give you 3.5 percent less your 50 cedis. You'll still get your 50 cedis. Because government has guaranteed that particular fund. And they keep on making that argument. They do not lose anything.
Interviewer: Do you think the NHIS' challenges can be traced to the fact that it has been politicized?
Respondent: That's one. The fact is that you know, when the scheme came to being, NDC claimed that oh they started it, then NPP said no, we took it to scale when NDC was in power there was nothing called national health insurance, but community-based health insurance. But it's actually the NPP one which promoted and took it to scale. And since then, it has been very

political. In any case, health financing all over the world is a political issue, and what usually happens is that, change of government see change in leadership position in the NHIA. And so, that's one. (So is it a bad thing? The first one you said - with the politics of it, is it bad)? No, it's not bad. All over the world - when Trump became president - go and check the names of the people - even your new president, go and check if he'll maintain most of the guys. He'll change them, because the person has an agenda, and these are the people I can deliver that agenda with, so I don't see anything wrong with it. Because you cannot have the status quo running forever. There should be a change, but as to whether the change is managed appropriately, is another thing altogether. That's number one. Number two, the politicization has become so indemnified that at certain points, people do not want to register with the scheme. When NDC came, people said no, they'll not register - they'll not renew their registration. And I think it's the level of education. And what even destroyed everything was when the capitation pilot was sent to the Ashanti region. And you know, that is not supposed to be a political decision because it's a technical decision. I was part of the initial meetings. It was professor Irene and co. who suggested Ashanti region. (Why did they select the Ashanti region)? Yes, because you know Ashanti is at the central point of the...and in the Ashanti region, you could see almost all tribes over there. (So it's a good test case). Yes, it was a good test case without politics. But unfortunately, because Ashanti happens to be the odd bet for the NPP, and it was NDC which selling that in the… so immediately, they started painting capitation bad. But when - a time came, nobody wanted to discuss capitation in Ashanti. I think it was a year or two… Before we hold our business meeting, we take a test case to look at - nobody wants to go to Ashanti - I said let's go to Ashanti. We're listening to politicians say their own story. We go, let us go independent minded and go and look at what's up. When we went, the story was different. All the facilities we spoke to, they were all happy with the capitation because it brings money in lump sum.
Interviewer: I need you to educate me on the capitation. Please tell me, what is the capitation?
What capitation does, is that, it takes the number of people that you're supposed to see.
Interviewer: How do you determine that. By the catchment area?
Respondent: Yes, by the catchment area. But it depends upon the individual too. Please come and register with hospital A or health facility A. So once you are able to go and register there, when you are sick you go there and receive care. And at the end of the period, hospital A registers 100 people. Okay, for the primary care, we're paying for each person 10 cedis. 10 times 100 is 1,000. So, quarterly, we give 1,000 to hospital A. Whether you're sick of not, the hospitals has the money. But if you get ill often, then hospital A will be spending so much money on you. So what most of the facilities just - that's why some good passes we heard, was that there was one hospital too that they used to receive a lot of malaria cases. So what they did was that they went to the areas and realized that the environment was not sanitary. So they sprayed the area, and spent so much on community education and personal hygiene. In less than three months, the malaria cases dropped down to zero. They were not sick, so it means that the money they were making became theirs even though they did initiate - because the gave… So after that, it's minor cases they were seeing. That's one. But two, because they had their money in bulk, they were able to make strategic purchasing, unlike the DRJ, if you don't come, I don't give you the money. So, the hospitals were using the capitation process to do mobilization. I remember I went to one of the villages, and we saw a lot of people at a very big park - we bypassed, and when we were coming we saw the people so we went in there and said oh, what are they doing? They said oh, there was a CHAG facility which has called the people to come. The following day will be a

market day and most of the people come to the market in the evening. So they've asked that they should come, when they should come to a particular school for them to have their registration done free. So the hospitals are responsible for mobilizing the people, registering them. And once they do that, that means that they have customer base. So if they haven't reached a thousand, that's good for them. I remember one facility was telling me that they were given 197,000 cedis a quarter. And I said, is it too small? He said oh, Selassie, that money is too huge because we've never received that money before but when we receive that money, immediately we plan and we'll make sure that we never get out of stock of things, etc. So it was good for some of them, but the politicians played the hell. Some also said they withdrew because they thought the amount of money they were paying was not good for them. But most of them that we spoke to - private, government, CHAG, I think that they were on board. (But, so if the institution doesn't use the money? If people don't come and patronize, still the money remains)? Yes, it's yours. Unless the people do not come to register. So that's why they will go out to mobilize. But it's good. It's helping coverage.

Interviewer: In your opinion, what is your assessment of the NHIS in terms of performance? If you were a beneficiary, your assessment would be?

Respondent: Poor.

Interviewer: Why?

Respondent: If you're a cardholder, most of them will tell you, because I'm a cardholder, before I go I'm delayed, those who are paying are treated. Normally too, when I'm looked after, I'm given prescription - where I'll not be given prescription, I'm given the low quality drugs, maybe the analgesic, and I'm asked to go and buy the other medicine. Those who are paying cash, they are attended to very fast, they're given quality drugs, and waiting time in our facilities is getting worse and worse. That's from the point of the client, and from the point of the service provider, it's worse. Most of them are have been now for about a year.

Interviewer: Is it yesterday in the morning that they said they're clearing 2 months arrears?

Respondent: The minister said in April when we went for the meeting that he will clear the debts. But I'm sure we didn't hear the specifics so people were happy. Apparently, it was one month debt. But the fact is that, the annual allocation from Ministry of Finance for this year, for 2017 cannot even pay the whole last year's bill let alone this year. So people do not understand, but I don't know why people are not going to court. You know, litigation is good - I want the providers to go to court to test the system. Somebody must sit up. And that should bring a change. National health insurance was reviewed since last year; the report is not out for anybody, yes. It's reviewed but it's not out.

Interviewer: Can the NHIS be sustained in the long-term? Explain. But they don't have money, donors are moving out. So the health sector hasn't got money or?

Respondent: Of course, yeah. Anything can be sustained if you're committed. No, who said the health sector hasn't got money? It can be sustained. Sustainability means the resource inflow and outflow, and control measures. Currently, the leakage is huge. The inflow is limited. So what we have to do is that let's increase the inflow, let's control the leakage. Let's introduce more control measures. Health insurance has done that. They've instituted a directory of claim and all those things. They should do more. And, let's increase the flow by increasing other sources of funding.

Interviewer: But is that not worrisome when we have - because of our middle income status - we have donors moving out as is expected really. How do we sustain all these?

Respondent: Yes, if you gain 1 euro from every 10 euros spent, is that good? No, it's bad. If I spend 10 euros, I expect to see at least, making 10 euros from that. That's what I said. But that's not...because the leakage is too much.

Interviewer: Where do you find the leakage? Is the system corrupt? Because you know in the past, we've talked about service providers trying to rip off the system, insiders ripping off the system, even beneficiaries ripping off the system.

Respondent: It's still same. Some people were caught, and they said they will be sent to court, we've never heard the end of it.

Interviewer: In the last couple of years, the CHPS has attracted some attention; how do you think it is placed on the development agenda for Ghana now? And what informed its position on the agenda?

Respondent: First because it's one of the few researched policies. And number two, its objective is ideal. Number three, it's pro human or pro poor. Number four, its capital outlay is supposed to be manageable, and number five, it's supposed to be managed by the people themselves. So when you have all those things, then it means that it's a good system, or it's laudable.

Interviewer: So what propelled it? Because yes, it's been going on. It's gone through the pilot stage, and it's gone through over a period. But like in the last three years or so, it's become more visible, it's gained national attention…

Respondent: No, CHPS had national attention long ago, but what has made it more visible is that the previous government for example, made it more of their targeted programs to the extent that the presidency and the executive decided they'll commit 10 percent of their remuneration to that. As to whether that was done or not, we don't know. Then, the next idea is that, for politicians, small small things matter. For example, if let's say I have about 25,000 cedis, I could establish a CHPS compound. And it's visible for everybody to see - Selassie's CHPS compound. So it's easier for politicians to cite those as achievements. So you see it coming up, and in actual fact most of the politicians actually contributed to the construction or refurbishing of the equipment. Because we went round to look at CHPS and when we used to have power outage, most parliamentarians bought gen sets and fuel and all those things, motorbike...etc. So, it's at political visibility because of its small capital, the political prominence, number 3, you know people want to use it win votes.

Interviewer: What are your impressions of the Community-based Health Planning and Services (CHPS) initiative?

Respondent: It's extremely good.

Interviewer: Has this health policy been implemented as should? Reasons for response

Respondent: Yeah, it has but there is a challenge. I'll tell you the challenge. You know, CHPS was originally supposed to be considered on provisions of limited care. Their main objective was supposed to be outreach and referral. But unfortunately, government doesn't provide - doesn't give them money to run the care, and they don't have money to go for outreach and all those things. And they realized that, when they provide service, they can get some small money from national health insurance through their health centers so most of them have become like clinics. You render service, you get money. So most of them have become institutes instead of concentrating on their outreach and referrals. So national health insurance has brought a problem and we have suggested that there should be dedicated allocation of funds either for national health insurance because, if national health insurance wants to reduce its cost, that means that they want less people being sick and going to the hospital. And if CHPS can provide the outreach, the health education to limit people going to the hospital, then they should be

reimbursed. (That's a good point, but then from some of the interviews I've had, the question has been that was the CHPS designed for that? You know, the CHPS, if for instance - I mean sorry, the national health insurance is more curative than preventive, so if that is the situation, at which point should they compensate for that part which is not part of the original design)? Yes, it's not part of the original design but national health insurance scheme gives money to MPs. Quarterly, they give them 50,000 or 25,000 - it's 25,000 because in a year they get 100,000. They give them to do… so if you give to politicians in all the 230 constituencies, why not give to the CHPS?

Interviewer: In the area of access, how has the CHPS fared? Financial access? Geographical access? Then in terms of financial access, for who? (For the CHPS, because I know that even though it's supposed to be primary healthcare at a certain level, certain services have been added, maybe by default. But they do have to pay

Respondent: CHPS has completed at least 8 percent of the OPD last year. It was 6.5 in 2015, and 2016 it's 8.01, so at least, it riled patience. That's what I was alluding to that the curative part was good for them in the sense that it will make them get money because national health insurance will give them money, once they enrolled patients, and once they do that, they're covered - they'll get some money. And I was saying that it will be good for us to concentrate - later concentrate more on the preventive side, and they can only do that if let's you say you get 1000 cedis every month from the national health insurance clients. National health insurance should give you that 1000

Interviewer: What are the challenges facing the implementation of the CHPS?

Respondent: Money is one of them, then we spoke about human resources, but the human resource is that - you know CHPS is supposed to be manned by someone we call community health officer and those community health officers who are professional community health nurses who have taken extra courses to be officers. But of you go round, I think currently, I can say that less than 20 percent of community health - people who are manning are only community health nurses, they are not community health officers because they've not gotten the extra training. But the question is that, if you're training me to go and work at the CHPS compound, you want me to come and continue for officer. What stops the curriculum to be revised to include that component such that by the time I'm complete, I've become community health officer, so that when you take me to the CHPS, I'll be a community health officer. If I go somewhere else, I'll be my community health nurse. You'll be a CHO when you're on a CHPS program. If you're outside, you're CHN. Why don't we do that?

Interviewer: Where is the problem coming from with this kind of money? But if we're training them is it not the same curriculum?

Respondent: No, they have extra, I think 4 to 6 weeks training to make them officers. And initially, they were being funded by partners, but now we're mature so government should take over. So that's the issue - most of them are not officers.

Interviewer: So you have HR, you have funding as challenges of the CHPS? What's that affecting?

Respondent: Yes, and the final one is the rollout is not going as expected and personally I think the community ownership part is not going as it should. The community mobilization - the community should be able to identify their need. If the community knows they know the type of illness or the people who are ill, they'll help you but, they're still detached. It's just like the normal…..the hospital is there, the district is there. If you like come, if you don't like stay, but it's not supposed to be like that.

Interviewer: But is it not an issue of globally, the absence of volunteerism? Because you know, with the design of the CHPS, you have the community volunteers.
Respondent: No I'm not talking about that, I'm not talking about that. When I want to put up this structure, I have the resources, I am government. I want to put this structure in your area. First and foremost, I have to call you, your parents, your folks. Oh you people, what's your problem? Oh we want water, we want this. Oh is that so? What about clinic? Oh yes, we need it. So where should we put it? Okay, so who should put it for us? So I will just provide the resources. But now, people are there, government goes there, go to district assemblies which is another government structure - even though they claim they're...participation, it's...that they get few vocal people who are there, immediately they get to the assembly, they see themselves different from them. Okay, we have land here. Okay, we'll give you the land. Government brings its structure, they bring people from outside, they come and build. Community A has built a CHPS compound. You've limited input. The nurses sent to the CHPS, and even though the CHPS is inside the community, the CHPS is another class. So at the end of the day, the facility is there, but…. So you'll go you'll maybe see one or two people. Do you liaise the community? Oh yes, we have somebody, when the place is weedy, we tell the assemblyman then they come to weed or just somebody from the community who is the watchman.
Interviewer: So what's the way forward with what we've said? Can the CHPS be sustained in the long-term? Is there need for any intervention? If yes, what interventions would be recommended?
Respondent: We should let the community be more involved. Accra should I mean be delivering themselves. We've done that all through and almost 60 years. At least we should trust the community. For once, let's trust them.
Interviewer: Will it be possible to combine the NHIS & CHPS in order to achieve the Universal Health Coverage in Ghana?
Respondent: You see if you take the MOH as the main ministry for the establishment in charge of CHPS, and the establishment in charge of NHIS, then that should be positive. But the unfortunate thing is that, when the CHPS policy is being developed, you don't see national health insurance heavily there. When national health insurance is discussed, you see limited participation of CHPS. the people you will see are the big guns from the government service delivery wing i.e. Ghana Health Service who will be participating there. But whilst they are participating there, their intention is about the whole Ghana Health Service, and Ghana Health Service have the regional level, the district, the sub-district before the CHPS, and the CHPS is the minutest in terms of the service links, whereas it's supposed to be the strongest. So that is missing. Till that is reversed, and the revision could be that when national health insurance should have a substantive debt for communities, and those who have designed the CHPS should also have a substantive debt for financing. So that such two roles will meet. And that thing will not work when the CHPS is run as it is being done now. Because CHPS is still being run at the national level. We have the CHPS coordinator at GHS, MOH said they also have a CHPS committee. So how will you know the problems of the CHPS? They'll not understand. Somebody will be at Accra and maybe hear one or two stories and think that that's the issue, but in actual fact, the real issue might have been different.
Interviewer: So what is the way forward? How can they work, because now, they're working as silos. Is there a policy merger that can be suggested?
Respondent: Yeah, it's possible. (Who'll champion it)? It's MOF. MOH owns those two agencies. Policy can be to say that look, henceforth, national health insurance, put about 5

percent of your money down for CHPS. at the end of every quarter, CHPS submit your request. Health insurance gives money for a lot of things. Now they're even going to give money for vaccine procurement. So what stops them from doing for CHPS? It's just a matter of policy directives. (So is it a leadership thing that we need now)? It's not a matter of leadership, maybe the idea, people have not thought about that idea. I told you that when they talk about UHC, people think that national health insurance is UHC. because people don't remember that coverage talks about the geographic and the financial. People don't think about - it doesn't go far. Unless...but we have CHPS before the idea… But to come naturally to them, that oh CHPS is part of the...is not there.

Other Perceptions

Interviewer: Is Ghana practicing the Health in All Policies (HiAP) approach? If yes, how is it being implemented? If no, why?

Respondent: You know as far back as 2000-2001, I went to a meeting in Geneva, and I saw a flyer on the HIAP, then when I came back, by then we were trying to do what we call intersectoral collaboration for health, and I thought HIAP answered my question. So when I came, I sold the idea to the ministry, and as usual, they liked it but no further… So I took it national development planning commission because they have the mandate for intersectoral collaboration. MOH cannot call other ministries but NDPC can do that. They can command all those ministries. So I went to them, they said it's a good idea but you know what, we cannot do it till health tells us that we should do it. Because, even though we have the mandate, health is not our core business. So if health says that this is what they want to do. If the write to us, we'll call the meeting and all those things. So a meeting was called, so we have intersectoral. I can show you, we have to reports - and that was the end. You know, the bottom-line is resource. NDPC said oh, we don't have money to continue that process. And the other agencies too, if you call them, they say but that's MOH's mandate - health is for them, so why are you bothering us? So that's the challenge, but a new thing which has come on board is global health security agenda being promoted by USAID, and international health regulation 2005. And in that, they expect all agencies to work together. So we were trying to use that window to develop the HIAP. it was on my work plan I think last two or three years. But my schedule has changed so there's a new officer now for health promotion. You know, WHO, the nomenclature can change. Initially, that was part of policy, but now they moved it to health promotion. So, that's the lady who is handling it. But I know there's something on the HIAP. And we even discussed it I think last - when we were planning for the health summit, we discussed it. When we came to issues relating to non-communicable diseases and lifestyle, they said look, the health sector cannot do it well. There are a lot of things, for example a lot of people will like to jog because usually, Saturdays and Sundays, if you go to Aburi, you'll see the nurse on the hill. We started that thing about 4 or 5 years. But now, it has become something else. So that means that in the mind of the people, people will like to exercise. But the road network is so poor… still there's no proper planning or if there is, the other elements of human needs are not taken care of. It's only business, business. The HIAP, it was well discussed and all those things, but people should accept the fact that...because we could do the policy and nobody will use it. It'll be there.

Interviewer: How can this approach be used to improve access to healthcare in an equitable manner? The difficulties of coordinating the various actors involved in the health system are often pointed out as a weakness of this system. Do you agree with this analysis? Explain

Respondent: I agree. You know, the health sector working group is one of the products to address the coordination issues, and I told you we have what we call the common management

arrangement. I think we're the voluntary now. And in that particular one, we sort of tried to bring out the various coordination mechanisms because different coordination with different intentions and results. So you'll see something we call interagency leadership committee. So that is the various agencies' heads - they meet to discuss, then we have something we call the CCM, Central Coordinating Mechanism for the diseased specifics. We have different coordinating groups, but all of them are supposed to converge at the health sector working group. But it's still a challenge. We have overcome that several years ago. But the issue is that, at times some of them do not meet and let someone remind them. But the good thing is that, the health sector working group, it has become a statutory event, or statutory establishment within the health sector. We all know. Coming Thursday, 8 o'clock, we're all at MOH. We know the conference room, the time, we'll get there by 9. Initially it was 7 we were getting there so we'' make it 9. 9 to 11:30 to 12. The agenda has already come out. So that is for the larger… So coordination at that level is fine. And the diseased specifics also have their coordination mechanisms. So for the health sector, you cannot talk - coordination is not a big problem in other countries. It's not.

Annex 6: Report on Author's internship

Report: Internship at the National Health Insurance Authority

Duration: 6 weeks (May – June, 2016)

Department Attached to: Research, Policy, Monitoring and Evaluation (RPME)

Activities undertaken:

1. Review of reports; internal reports, annual reports

2. Interaction with different departments but worked in the Research, Policy, Monitoring and Evaluation Directorate (RPMED).

3. Introduction to the use of the SPSS tool used for data analysis

4. Interaction with different department heads where new policies have been introduced

5. I participated in a Stakeholders forum for the discussion of the report by the 7-Member Technical Committee for the review of the National Health Insurance Scheme established by the President. At the forum, I joined the Finance Sub-Committee which was a Focused Group Discussion comprising of professionals of diverse backgrounds in both the private and public sectors who deliberated on issues concerning recommendations by the Review Committee concerning the financial standing and other ways of sourcing further funding for the sustainability of the scheme. The dates for the forum were 21st and 22nd June 2016 at La Palm Hotel.

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