Political Economy of Universal Health Coverage: Ghana Country Experiences

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Objective

- To explore a range of political economy topics in universal health coverage from the context and experience of one country, Ghana.
Methodology

• Qualitative case study of a policy process
• Participant observation from the vantage of being an actor in the health sector in Ghana over two decades.
• Challenge of participant observation is to be able to engage and understand as an insider; and yet step back and clearly describe and provide insights for an outsider.
• Weakness is the possibility of subjectivity, personal bias in observation, analysis and interpretation
• Observer must clearly describe their role and position to enable independent assessment of possible bias
  – District director (LG-DA), Regional director (LG-RCC), researcher, Member of ministerial task force that started the policy and program design, Regional director and researcher, advocate
Analytical Framework

• Borrow from several frameworks and theories in the political economy/policy analysis literature
  – Grindle and Thomas; Walt and Gilson; J.R.A. Aryee; J. Kingdon

• Context

• Actors

• Processes
  – Agenda setting circumstances & processes
  – Policy and program Formulation processes
  – Policy and program Implementation processes

• Content and outcomes
Analytical framework

Content & outcomes

- Agenda Setting Processes
- Policy Formulation Processes
- Implementation Processes
- Actors

Policy Context
Socio-economic context

- 21 million population
- Rapid urbanization and rural urban drift
  - Currently 44% urban.
  - Range from 16% UER to 88% GAR
- GNI per capita US$ 630
- Literacy (CWIQ 2003)
  - Adult (15+ yrs)
    - 66% male 42% female
  - Youth (15-24 yrs)
    - 74% male 63% female
- Large non formal sector
SE context
Historical Context

• Pre-independence (Colonial era)
  – Health financing mostly private out of pocket with some public financing mainly for expatriate civil servants
  – Developing a national health system and financing arrangements does not appear to have been a priority

• Post independence (1957)
  – Socialist ideology of government of 1st republic with declaration of free tax funded public sector health services and attempts to rapidly expand public sector infrastructure and human resource
  – Private sector continued to be user fee financed
  – At independence Ghana had a net budget surplus
  – Adequately financing the public sector through taxes increasingly difficult as economy went into a decline and ever worsening budget deficit
Historical Context (contd)

- Tax base could not support a tax funded system and in 1985: Introduction of policy of significant public sector user fees (LI1313)
- Large World Bank influence (structural adjustment), but also national concerns over public sector under funding
- Aim: Recover at least 15% of health operational costs
- Fees retained at level of collection to replenish medicines stock and pay other recurrent costs
- By 1990 in all public sector facilities 100% cost recovery for medicines & non medicine consumables
- Exemptions for the poor and vulnerable included in the policy but never worked properly
- Objective of recovering 15% recurrent expenditure attained and public sector resource availability improved
Societal pressure: Effect of 1985 user fees

• Fees were clearly regressive and inequitable
  – Steep decline in utilization especially in poorest rural areas
  – Exemption mechanisms did not work properly in practice
  – With time ‘cash and carry’ became increasingly unpopular and there were many ‘horror’ stories and disenchantment

• Everybody (government, civil society and even providers) wanted a viable alternative

• It is important however to note that without the experience of user fees, it might have been harder to get people to embrace the concept of an alternative in the form of health insurance (including premium payments) so enthusiastically
Political Context

- 1957 independence – 1992: Unstable period with predominance of military governments and several failed attempts (3) to establish western style democratic governance
- 1992: 4th republic constitution drawn (4 years cycle, 2 presidential term limit).
  - 4 back to back elections with two hand over to opposition transitions
  - Dec 2000 NPP (opposition) wins elections after 8 years of NDC.
  - Dec 2008 after 8 years of the NPP, the NDC is back and NPP is in opposition again
- Replacing the highly unpopular cash and carry system with an NHIS was a popular campaign trail promise of the NPP in the 2000 elections and part of its manifesto.
- Delivering on this promise appeared to be seen as critical to proving itself and very high profile given to establishing NHI immediately after NPP assumed office in January 2001
- However NHI was not established in a vacuum
Preceding experiences & research

- State and non state provider initiated and supported (CHS, GHS) ‘decentralized’ (district level) experiments
  - Major Danida assistance to MHO development and growth e.g. Okwahuman, Damanago, Ashanti region civil servants scheme etc
  - Ghana Health Service regional coordination with resulting marked MHO growth and enrolment in:
    - Brong Ahafo region
    - Eastern region
  - PHR plus assistance
- Similar designs with benefit package limited to inpatient care (detained for more than 24 hours). Premiums US$ 10 or less per annum
- Failed central government SHI pilot and experiments despite major investment of public funds
  - Eastern Region pilot 1995/1996
  - SSNIT pilot 1998/1999
Pre-Act 650 experiences & experiments with health insurance

• The Dangme West Experiment
  – Request & support of DMS for research to find a way of covering the large non formal sector with insurance as an alternative to user fees. Did not think the Eastern region pilot which was the focus of the insurance unit in the ministry at that time was likely to succeed without answering these questions
  – Delays related to change of actors and funding difficulties
  – This research scheme unlike the already existing provider initiated schemes experimented with outpatient care, a gatekeeper system and contracting with service providers outside the district to provide hospital referral care despite the lack of a hospital in the district

• The results /information coming from of all these decentralized experiments and research as well as the lessons of the failed central government pilot influenced the initial design of the Ghana NHIS
Agenda setting circumstances and processes pre Act 650

• Strong and genuine high level government commitment to successful reform

• ‘Perception’ of crisis among high level (political) decision makers and macro-political decision making concerns
  – High political premium put on successful implementation of NHIS
  – Success seen as important in proving the competence of the government and subsequent re-election
  – Concerns that opposition may capitalize at any opportunity of seeming weakness or inability to deliver
Agenda setting circumstances and processes pre Act 650

- The multi-stakeholder Ministerial task force in early 2001
- The internal conflict over policy design and replacement of director policy with a trusted associate
- The introduction of more trusted political associates and designation as “consultants” and tendency towards a more mono stakeholder task force
- Conflict replaces consensus building
- Dissent and critique was increasingly unwelcome and could easily get labeled as politically motivated opposition to sabotage or slow down a process that need to be completed quickly
- The gradual non dramatic demise of the original task force (plops: resignations and silent drop offs)
- Because of the high premium put by top level decision makers on getting this policy to work, resources were made available to support implementation in a relatively generous way
Agenda setting circumstances and processes

• Act 650 picked a lot from the pre-existing schemes and local research (D/W). However, what was picked was not always the most technically optimal, but rather at the time of picking was perceived as politically optimal – ‘quick and ready to go’/’likely to be popular’

• There was a constant rush to “take a decision and do something quickly. We can always correct mistakes later”

• Selection of ‘trusted associates’ to lead processes without checking ‘technical competence’ to lead

• All further complicated sometimes by trusted associate rent seeking behavior made possible by their high power along with weak accountability and an excess of ‘political faith’ in ‘they are on our side’ e.g. the provider claims forms (Reference Ayee’s: ‘saints, wizards demons and systems’)

• Protests, agitation and latter correction of some of these problems – but some damage had been done
Content: Overview of central basic original design

- **Payer Admin.**
  - Governing body
  - Scheme Manager

- **Registration, licensing and regulation**
  - NHIC

- **Clients**
  - General Assembly

- **Providers**
  - Public
  - Private
Content: Design Evolution

Payer
Regional & District Offices

NHI – national office

Clients

?? “Turning and turning in the widening gyre the falcon cannot find
the falconer ... Things fall apart the centre cannot hold ...”

Providers
• Public
• Private
The Present and the future

• A scheme that has survived so far, in the face of odds and challenges and that nobody wants to go away despite the challenges

• In Dec 2008 the government that introduced NHI lost the elections to the opposition.

• A 2008 election campaign promise of the new government was to continue the reform and replace the non SSNIT non formal sector annual contributions with a “one time premium” as a way of rapidly attaining universal coverage.

• This effectively translates into a promise to move the country closer to a purely tax financed system.
The present and the future

• Tax funding, social insurance or a combination are all effective ways of attaining universal coverage.
• Ghana’s challenge is the practicability of promising universal coverage through tax funding under its current financial circumstances combined with inadequate service availability, quality and equity.
• Attaining universal coverage and improving equity remains high on the agenda but how quickly can that be attained under the current challenges?
• Big bang change is desired but will big bang change mean that the “non workable ideological best” becomes the enemy of the “imperfect but workable good”? 
In Conclusion: Lessons

• There are technical challenges in setting up NHI in a low income sub-Saharan African country and many urgent health policy and systems research questions.
• However, public social policy reform also has political challenges and both technical and political challenges need to be addressed for effective reform.
• Despite this, inadequate attention is generally paid to analyzing, understanding and dealing effectively with the political challenges.
• You cannot get round the politics in trying to make a difference whether you are a researcher, a policy maker or an advocate.
In Conclusion: Lessons

- Indeed the politics has actually driven rapid reform in Ghana despite the fact that the politics has also driven some of the challenges.
- There is a need to promote better understanding of the political economy of reform in developing countries among researchers as well as policy makers and policy advocates.
- This will assist and empower:
  - would be reformers to maneuver more effectively within the challenges of the context, processes and circumstances of reform.
  - researchers to put some of these questions on their agenda.
References

- More information on some of the issues presented here can be found in the following publications:
Thank you for your attention