

Interest Groups, Issue Definition and the Politics of Healthcare in Ghana

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Abstract

The provision of healthcare in Ghana from the pre-colonial period to the 4th Republic has been characterized by struggles to maintain dominance. While the politics in the pre-independence period focused on the manner of providing healthcare, the post-independence period encapsulates healthcare financing. Using the interest groups theory, the study examines the manner and motive of healthcare management in Ghana. The study finds that a coalition of healthcare interest groups often comprising healthcare providers, government functionaries, bureaucrats, and the World Bank and IMF etc., (from the 1970s), uses the definition of healthcare management to maintain leverage in the management of healthcare. Healthcare management in the pre-colonial period was defined as interventionism while the colonial administration focused on scientific therapy. The post-colonial period witnessed a shift of focus to healthcare financing and Nkrumah's government adopted free healthcare system financed by the state. The Busia's government focused on sustainability based on payment of small user fee. The Rawling's regime adopted cost recovery featuring cash and carry, and the Kuffour's regime focused on a collective responsibility through the adoption of a national health insurance scheme as financing methods. The paper argues that the way healthcare delivery is defined enables governments and political systems to maintain leverage over its management and subsequently reap direct and indirect benefits of the leverage, which among others include the allegiance and legitimacy of the public. The analysis helps to understand the process of health policymaking in Ghana and perhaps other sub Saharan African countries.

Keywords: Healthcare management, sustainability, healthcare financing, interest groups, issues definition, policy paradigm

1. INTRODUCTION

The management (provision and financing) of healthcare has been a major preoccupation of mankind for several decades because disease is considered deadly with the potential to disrupt the existence of men. Alternatively, being healthy is generally considered a prerequisite for the realization of the full potential and the satisfaction of individuals in life (Adu-Gyamfi, 2010; Twumasi, 1975). Poverty is reduced if the members of society have good health because they are able to attain high levels of education and increase their productivity as well as their levels of income leading to sustainable development. In the pre-colonial era, interested parties including rulers and herbalists in Africa in diverse ways intervened to influence the provision of healthcare. For instance, healthcare providers in Asante during the pre-colonial and colonial periods took measures to manage healthcare in an effort to curtail the harm associated with diseases (ibid). Similarly, healthcare interest groups influenced the post-independence government under the Convention Peoples' Party (CPP) led by President Kwame Nkrumah to adopt a free healthcare system in Ghana.

Subsequently, different policies have been adopted to manage healthcare in Ghana. For instance, the United Party government led by Busia introduced the payment of small user fees towards healthcare in 1971. In addition, a "cash and carry" system was implemented under the Provisional National Defence Council (PNDC) military regime of Fl. Lt. Jerry John Rawlings as a healthcare policy. The "cash and carry" was a system whereby a beneficiary of healthcare paid for the drugs and some medical consumables, at the point of receiving treatment while the government covered the cost of consultation, salaries and emoluments for Doctors, Nurses and other healthcare workers in government hospitals¹. The cash and carry system continued under the two terms of the democratically elected government of the National Democratic Party (NDC) led by President Jerry John Rawlings who became the first President under the Fourth Republican Constitution.

The National Health Insurance Scheme (NHIS) adopted under the democratically elected government of the New Patriotic Party (NPP) led by President John Agyekum Kuffour replaced the cash and carry system in 2004

¹ The information retrieved from the website of the National Health Insurance Scheme (<http://www.nhis.gov.gh/?CategoryID=158&ArticleID=1110>) on 27/3/2013.

and has since been the main system for managing healthcare in this country to date. Interestingly, the preliminary data indicates that the adoption of different systems to manage healthcare were not without political influence from domestic and international actors. Therefore, the study examines the politics that characterize the management of healthcare in this country using the interest groups theory with special focus on issue definition. The study combines the analysis of historical/archival documents and the policies of healthcare adopted under different ruling systems with expert interviews to examine the nature of politics that has characterized healthcare policy adoption in this country. The objectives of this study are three folds: (1) to investigate the politics/struggles over the management of healthcare in this country and motive for the struggle, (2) to examine the individuals, groups and organizations involved in the struggle and the tools to maintain leverage, and (3) to understand how the politics of healthcare management helps to explain the nature of policy process in Ghana and possibly other sub Saharan African countries.

2.1 HEALTHCARE MANAGEMENT IN PRE-COLONIAL GHANA

The effort to resist the adverse effect of disease, which has long been considered as man's enemy of progress has been a major concern of mankind since time immemorial. Ill health and diseases are considered barrier to economic progress and humanity has adopted various measures to manage their healthcare needs to improve the health of society from the pre-colonial to modern period. Good health is generally associated with increased productivity and reduction in poverty. With that in mind, the leaders and rulers of Ghana from the pre-colonial era to the fourth republic have and continue to adopt policies to manage the healthcare needs of the people. Adu-Gyamfi (2010:12) argues that the inhabitants of Kumase and Asante were challenged with providing healthcare from an early period. Therefore, the Asantes managed diseases with indigenous therapies provided by indigenous healers comprising of traditional priests and priestesses prior to the coming of the Europeans.

To situate themselves as the rightful providers of healthcare, the traditional healers who were highly organized and had the *Nsumankwahene* as the head (PRAAD, 1928), portrayed diseases as unnatural occurrences resulting from the wrath of God, ancestors or deities due to sin or immoral behaviour, or the actions of spiritual or mystical demons (Adu-Gyamfi, 2010). With that definition, the right therapies for managing diseases was interventions based on magico-religious beliefs on healings, which situated the traditional priests and priestesses as the rightful actors for providing healthcare (Twumasi, 1975). The priests and priestesses used "incantations, spells, preparation of potions, exorcism, and mostly through the invocation of deities", as intercessory mechanism to cure the sick of their diseases ((Adu-Gyamfi, 2010:64) In that regard, herbs, barks of trees, amulets, and concoctions etc. used in the treatment of diseases were efficacious because of the supernatural powers invoked in them by the gods who have revealed them to the herbalists/priests as the right medicine for curing specific diseases (Personal communication, 2014)¹. Once diseases were attributed to the immoral and personal actions of individuals, the financing of healthcare was borne by the individuals or the immediate family of the person whose action has brought the wrath of the gods to punish him/her. Therefore, the traditional healthcare providers were paid with fowls, sheep, goat or cash after the economy had been monetized² (also captured by Hemmila et al, 2002).

2.2 HEALTHCARE MANAGEMENT IN THE COLONIAL ERA

The coming of the Europeans led to a different definition of healthcare and ultimately the manner of managing healthcare. The traditional notion that attributed disease to the wrath of deities and mystical actions of demons was rejected as being unscientific. Adu-Gyamfi (2010:103) maintains that the Colonial Administration attributed the belief in the wrath of deities, magic and mystical actions of demons such as witchcrafts as the cause of diseases to ignorance that creates fear in the people. The causes of diseases were attributed to biological and environmental factors, which behoved on the Colonial Administration to take over the management of healthcare. Therefore, the provision and finance of healthcare became responsibility of the Colonial government who ordered all cases of contagious diseases to be reported to government doctors to treat them scientifically.

Consequently, the traditional healers took steps to modernize their practices and even called for the scientific verification of the therapeutic efficacies of their herbs and concoctions by the Colonial Administration. In addition, the traditional rulers came up with different organized associations and instituted regulatory measures to ensure that their practices were in conformity with the scientific practices introduced by the Colonial Administration. Simultaneously, the various associations served as interest groups to promote the interest of the

¹ Interviews of five traditional priests/healthcare providers at their shrines at Fumesua, Kwamang, Beposo, and Pepease, Ashanti region on 5th, 9th, 12th and 22nd February, 2014 respectively

² Adopted from Adu-Gyamfi (2010) Interview with Adamu Allah Bar, at his bone setting centre, Allah Bar, Kumase, 9th February, 2008,

traditional healers. For instance, the Society of African Herbalists formed in 12th December, 1931 pushed for official recognition by the Colonial Administration (Patterson, 1900 -1955). The key objective of the Society was to modernize local medical practices to high and advanced standard that will enable its members to practice freely. Even though the Colonial Administration did not officially recognize the Society, its members were allowed to operate unhindered (ibid). The Colonial Administration clamped down on healers who used superstitions and magic to extort money from the people but left those with modernized practice to operate. While the government covered the cost of healthcare at the government hospital and healthcare centres the services provided by the traditional healers were often borne by the individuals.

2.3 HEALTHCARE MANAGEMENT UNDER NKRUMAH'S AND AKUFFO ADDO/BUSIA'S REGIME

The post-independence governments were not confronted with the problem of defining healthcare as scientific or not because modernized medicine has been established as the right way of providing healthcare, even though the traditional healers still operated in the country. However, the main concern was to establish the requisite type of financing healthcare in the country. Therefore, the Convention Peoples' Party (CPP) government of Ghana through the influence of healthcare interest groups defined healthcare as an essential commodity that was to be equitably distributed for all citizens. The definition resulted in the adoption of a free healthcare system in Ghana. Nkrumah's government thought of a universal healthcare system for Ghana whereby everyone had free access to healthcare. The promoters of the free healthcare system perceived healthcare as an essentiality that must be enjoyed by all in society and considered the government as the best actor to produce such service. In that regard, Nkrumah's healthcare was financed through a progressive tax system whereby the rich paid more in taxes but the poor paid less. The service was delivered by the Ghana Health Service and it insulated the poor from shocks of healthcare cost by offering a free delivery of service with no payment of fees at the point of delivery.

However, in 1971, the regime led by Mr Edward Akuffo Addo as President and head of state and Mr Kofi Abrefa Busia as the Prime Minister and head of government and their healthcare interest groups in considering healthcare provision through sustainability, introduced a meagre user fee in healthcare provision. It needs to be noted that the Akuffo Addo/Busia regime did not discard the notion of equitable distribution of healthcare for all that focused on free healthcare system and the government as the key provider in Ghana. However, it adopted a system that government still remained the key provider of healthcare and covered a larger portion of healthcare user fee but the consumer of healthcare were required to pay a small portion of the user fee. The adoption of the user fee was an outcome of a proposal by Dr Felix Konotey for the introduction of a healthcare insurance scheme, which led to enactment of Hospital Fee Act 387 of 1971 under Busia's government (Sodzi-Tettey, 2007; 2013). The user fee is often considered as an important financing mechanism in many developing countries and so the government adopted it to sustain healthcare delivery in Ghana (Cresse 1991; McPake 1993; Gibson 1997; Meessen et al., 2003; Palmer et al., 2004).

2.4 CASH AND CARRY UNDER RAWLINGS

The healthcare policy adopted under the Busia's regime was maintained by all subsequent governments till the 1980s. However, the Nkrumah's post-independence policy, which was maintained by all the subsequent governments led to high inflation, negative GDP growth, trade imbalances, economic hardships and massive poverty, which nearly collapsed the economy in the early 1980s (Brenya, 2013b). Therefore, the Rawlings regime was compelled to seek financial assistance from the IMF and the World Bank to sustain the economy. The first phase of the World Bank's economic stabilization programme - the Economic Recovery Programme (ERP)/ Structural Adjustment Programme (SAP) was implemented in 1983.

The Economic Recovery Programme, which aimed at restoring Ghana's economy to growth through the adoption of macroeconomic policies and programmes to address the weak economy, resulted in the privatization of government entities and removal of subsidies from government programmes (Apusigah, 2002; Ghana, 1995; 1997; World Bank, 2001). The government undertook a massive cut on the budgets of government agencies and introduced a cost recovery programme in the many sectors of the economy (Brenya and Asare, 2011). The cost recovery programme adopted in the healthcare sector was known as the "cash and carry" which entailed a wholesale withdrawal of government subsidies on health delivery. The adoption of the *cash and carry* healthcare delivery system was premised on decentralizing the health sector to facilitate a joint management of the resources generated by health staff and the community through the introduction of user fees in government health facilities.

The Rawlings regime and his international and domestic interest groups defined healthcare delivery in terms of a full cost recovery to improve and sustain the system. Agyepong and Nagai (2011) argue that a full cost recovery

was to increase resources to the health care facilities to allow them expand and upgrade their services, improve access to health care, improve patients' care, and increase efficiency due to adequate revenue from healthcare delivery charges, which was known as internally generated funds. The revenue raised through the provision of service was to enable the facilities to cover other recurrent cost which included new purchases and sometimes payment of incentives of healthcare workers. Additionally, payment of user fee was intended to reduce abuse of the system through unnecessary visits by patients because of free delivery.

Unfortunately, the cash and carry system did not attain its intended objectives but ended up being a *firing squad* for the vulnerable, poor and the disabled. Even though the Hospital Fees Regulation LI 1313 that established the cash and carry system had in-built exemptions for various consumers of healthcare especially the poor and vulnerable such as children, the elderly and pregnant women, it was not effectively implemented (Republic of Ghana, 1985). Ghanaian healthcare is delivered by doctors and nurses who act as street level bureaucrats in the implementation of healthcare policies (Lipsky, 1980). Many of the doctors and nurses abused their discretion in the implementation of the policies by acting according to their dictates instead of the provisions of healthcare policies. The doctors and nurses ignored the exemptions provided for in the healthcare fees regulation LI 1313 and vulnerable patients who could not pay for medical services were sent home to die, even though they were legally covered by the exemptions (Garshong et al, 2001; MOH, 2006; Witter and Adjei, 2007). In addition, accident victims were asked to pay before obtaining critical treatment to save their lives, which often led to massive loss of innocent lives.

What was intended to improve service delivery ended up deteriorating healthcare delivery in Ghana and there was an institution of inequalities in healthcare delivery system whereby the poor- mostly rural women and children - were forced to attend poor hospitals often with no trained staff and medical facilities while the rich attended hospitals with better facilities. Healthcare consumption became a nightmare of many Ghanaians and there was high morbidity and mortality rates especially among women and children and people were compelled to take loans, sell their personal property, go hungry, or stop sending their children to school to obtain healthcare under the cash and carry system.

2.5 KUFFOUR AND THE ADOPTION OF NATIONAL INSURANCE SCHEME

By the late 1990s the healthcare delivery system in Ghana had become a nightmare and majority of people experienced hardships and difficulties under the cash and carry system. Therefore, the national health insurance scheme (NHIS) introduced in 2003 under the John Agyekum Kuffour's government received a resounding welcome. Presidential candidate Kuffour intimated during the 2000 election campaign that he will abolish the healthcare system under President Rawlings to ameliorate the healthcare delivery system and relief Ghanaians of their burden with the cash and carry. Therefore, his government decided to adopt a national health insurance scheme as the healthcare delivery system in 2001 to increase access to healthcare and also cut down on payment of user fees out of pocket (Ekman, 2004). However, it was not until 2003 that Parliament passed the bill into law (Republic of Ghana, 2003; Agyepong and Nagai, 2011).

President Kuffour and his domestic and international healthcare interest groups defined healthcare as an essentially commodity that no strata of society must be denied access because of financial constraints. Therefore, a collective responsibility that centred on a national health insurance scheme was considered a viable means for financing healthcare in Ghana (Sakyi et al, 2012; Carrin et al., 2001; WHO, 2005; Baltussen et al., 2006). The scheme aims at removing "financial barriers to accessing healthcare and to provide quality and affordable healthcare to the Ghanaian population" (Sakyi et al, 2012: 178). It was based on the payment of an annual renewable minimum premium, which gave subscribers access to different minimum healthcare benefits from healthcare providers and organizations in Ghana (National Health Insurance Act, 2003). So far, the health insurance scheme has led to a higher patronization of healthcare facilities for treatment in Ghana (Ministry of Health, 2007).

3.1 INTEREST GROUPS AND ISSUE DEFINITION

One theory that has been extensively analysed in the policy literature is interest group because of the way it impacts policy design, adoption, implementation and evaluation (Brenya, 2013b). The groups who could be highly organized or exist in a looser form of association based on common interest are known to be very influential in the policy process because of their expertise in using tools and strategies to promote policies in the interest of their members (Studlar, 2002). While they may use venue shopping where hospitable venues are sought to introduce their policy issues to gain leverage on specific policy issues, the group can also adopt

definition and redefinition of an old issue to give it a new policy image as a strategy to influence policy adoption (Birkland, 2011). For instance, the redefinition of tobacco issues as second hand smoke gave tobacco control interest groups much leverage in the 1990s (Studlar, 2002; Brenya, 2012b).

Interest groups are generally known to promote issues peculiar to their members but some may promote issues of public interest (Asare, 2009; Ethridge and Handelman, 2004). Generally, the activities of interest groups create a punctuated equilibrium ((Baumgartner and Jones, 2003) or a paradigm shift ((Hall, 1993), which gives policy problems new image and enable them to offer their ideas as new solutions to the policy problem (Brenya, 2013a). The nature of activities of interest groups is determined by the level of organization and the type of political system (Asare, 2009). In that regards, well organized groups tend to be more influential than the less organized groups. Simultaneously, the degree of corporatism determines the involvement of interest groups in the policy process. The three main types of corporatism identified by policy scholars are democratic corporatism, corporatism without labour and the least corporatist systems – (Wilensky, 2002; Lijphart, 1999).

Interest groups/organized labour together with governmental institutions actively deliberate on policy issues in democratic corporatism while organized interest are partially incorporated in the bargaining process for policy decisions in corporatist without labour system and in the final scenario, the least corporatist systems, organized interest are excluded in the decision making process of the political economy (Wilensky, 2002; Author, 2013b). Often no single group has absolute control over policy decision process in the pluralist environment because the various actors involved in the process compete with each other for control over issues of their political interest (Ethridge and Handelman, 2004:163-165).

Asare (2009) observes that the rules of the game in pluralist systems are negotiations, bargaining and compromises to gain leverage with other parties also seeking to influence policy within the system. The competition among the groups in the policy network has led to different description of the activities of interest groups such as iron triangle, issue network, policy community, subsystem, advocacy coalition, and global advocacy network, etc. In spite of the varieties of terms to describe their activities, the essential element of their operation is the promotion of issues that meet the core interest of their members and this cause reciprocal and multiple levels of influences between governmental institutions, bureaucracies and interest groups in the policy process.

3.2 INTEREST GROUPS, ISSUE DEFINITION AND HEALTHCARE MANAGEMENT IN GHANA

The core objective of interest groups is to influence policy to the interest of its members in a specific policy area and the group can exit in a looser form comprising both domestic and international members. The members use issue definition to gain leverage over certain policy decisions in a specific policy subsystem. The definition and redefinition of issues enables interest groups to give favourable image to issues considered as policy problem to create some saliency in addressing the policy issues. Often, issue definition and proper organization enables interest groups to take advantage of window of opportunities to push their policy solutions as public policy (Kingdon, 1995). In that regard, the politics of healthcare delivery of Ghana has been influenced by issue definition and window of opportunity created by change of ruling governments and political system. In addition, the benefit of the interest groups involve in the politics of healthcare has been to maintain dominance over the healthcare delivery so as to gain the allegiance and legitimacy from the public.

In the pre-colonial era, the nature of healthcare delivery system was influenced by the way the illness was defined by healthcare interest groups comprising traditional authorities and healthcare providers - priests and priestess. As custodian of the moral principles and protector of the physical, social and spiritual wellbeing of the society, the traditional authorities had intrinsic interest in the moral and healthy condition for the society. Therefore, the definition of illness was a crucial tool for advancing their objective. In that regard, the definition of illness as punishment resulting from immoral behaviour that had incurred the wrath of the deities or harm from mystical spirits gave the authorities leverage over the people in many regards. The authorities and the priest and priestess were able to demand moral life from their subjects and also maintain their allegiance and legitimacy the way illness and cure was defined.

In much the same way the colonial administration derived benefit from the way healthcare delivery was defined. The administration needed the allegiance and legitimacy of the colonized people and so by defining illness as scientific condition that experts doctors provided by the government need to treat, the administration posited itself to reap the benefit of providing a healthy society to obtain the allegiance of the people. Science became the new *magic* that was used to create allegiance and legitimacy of the people in the struggle for control of the

society between the colonial administration and traditional system. *If illness and cure were no longer the dominion of the gods and the traditional authorities-rulers and healers, then the new gods to worship was the providers of societal health, which was the colonial administration.* It needs to be noted that the definition and implementation of the healthcare policy in both the pre-colonial and colonial era were done by actors who derived direct and indirect benefit from healthcare delivery system.

The healthcare politics in the post-colonial era was devoid of the struggle over maintaining dominance over the best manner of providing healthcare as was the case in the colonial era. Instead, the politics took the form of determining the best way of financing healthcare delivery and this became the tool for obtaining legitimacy from the public. In that regard, a new coalition comprising individuals and groups from healthcare providers, political parties, bureaucrats, government functionaries, and the World Bank and IMF (from the 1970s) emerged as the central actors who influence policy decisions in the policy subsystem. The way the coalitions define/perceive as the proper way for delivering healthcare determines the policy outcome for healthcare in the country. For instance, the Nkrumah's government perceived healthcare delivery as governmental responsibility to ensure equitable distribution and delivery of healthcare, which considered as an essential commodity that all citizens must have free access. This perception led to the adoption of a free healthcare delivery system which provided by the Ghana Health Service and financed by the government.

The coalition of interest with the provision of healthcare under the Akuffo Addo/Busia's regime did not totally reject the idea of state finance of healthcare to promote equitable access to healthcare delivery. However, the coalition thought of sustainability and instituted the payment of small user fee, which was borne by healthcare consumers to sustain the government's ability to provide free delivery of healthcare. However, the healthcare interest groups under Rawlings Provincial National Defence Council (PNDC) and NDC government had different perception on the state role in healthcare delivery. Faced with the realities of the economy by the 1980s, the coalition defined healthcare delivery as cost recovery whereby the consumers of healthcare paid for healthcare out-of-pocket. The money accrued from healthcare delivery was kept by the centres for replacement of consumable and provisions of incentives of staff to promote efficiency. It must be noted that even in defining healthcare delivery as cost recovery, the government was not totally removed from financing healthcare. Exemptions were provided in the healthcare policy for the government to finance the healthcare of the poor and vulnerable such as children, pregnant women and the elderly but the providers ignored the exemptions during the implementation of the policy. In addition, capital intensive projects such as the construction of buildings were financed by the government.

Finally, the government of Kuffour and his coalitions of healthcare interest had an idea for financing healthcare different from the cost recovery stemming from out-of-pocket payment for healthcare by consumers. While reaffirming the importance of equitable access to healthcare by all members of society, the coalitions defined healthcare provision in term of collective responsibility shared by all members of society. In that regard, an insurance scheme whereby individuals paid a small premium was considered the way to finance healthcare delivery. The national health insurance scheme, which was aimed at relieving people of the burden of out - of - pocket payment of healthcare under the cash and carry system, was also intended to increase access to healthcare. The government was to borne the cost of the healthcare of those offered exemptions in the policy such as the elderly, pregnant women and children.

4.1 DISCUSSION AND CONCLUSION

The discussion above generally examines the politics/struggle over the management of healthcare in Ghana. The evidence shows that the management of healthcare in the pre-colonial and colonial era was based on the manner of providing healthcare. However, the politics of management in the postcolonial period focuses on healthcare financing. The interest groups associated with the different government and political systems use the definition of healthcare as the basis to gain leverage, which gave them the benefit in the form of legitimacy from the people, among others. In the pre-colonial period, when the responsibility of the healthcare interest groups was for maintaining the social, economic and spiritual wellbeing of the society, the definition of illness and cure as the wrath of the gods and actions of mystical spirits served the interest of the coalition. This is because it enabled them to control the moral lives of the people and also gain their allegiance.

The core interest of the colonial administration was to receive the legitimacy of the colonized people. Therefore, the focus of the management of healthcare was to provide a new image and understanding of illness and cure in a way that will make the colonial administration relevant. The definition of illness and cure as scientific and physiological condition that needs to be treated by government doctors with scientific knowledge gave the

colonial administration leverage in the politics of healthcare management. Once illness and cure was understood to be scientific, the colonial administration became the right authority to look up to for a healthy society and that came with direct and indirect benefit of some sort of allegiance and legitimacy for the colonial administration. In the postcolonial period when the scientific provision of healthcare had become engrained, the coalition of healthcare interest under different government resorted to healthcare financing as the tool to maintain leverage.

While the government of Nkrumah used the notion of free healthcare delivery and government finance as the basis of maintaining leverage, the Busia government promoted the payment of small user fees to sustain government's ability to provide healthcare. The government of Rawlings focused on a cost recovery that will give care providers control over the management of healthcare. It must be stressed that even when the Rawlings regime was shifting cost of healthcare to consumers, it was packaged as an issue of sustainability and efficiency. The government argued among other things that a cost recovery will not only enable the healthcare centres to purchase drugs and necessary items to provide quality care but it will increase the morale of healthcare staff because of the ability to receive incentives for their work, something the government was no longer able to do.

The adoption of the national health insurance scheme by the government of Kuffour is based on the notion of collective shared responsibility. Even though people are still required to pay a small premium for healthcare consumption, it was packaged as a relief from the burden of out-of-pocket payment under the cash and carry system under Rawlings. The essential finding is that the definition of healthcare management has been the tool used to gain leverage by government and their healthcare interest in Ghana. Issue definition generally is a tool used by interest groups to gain leverage in the policy process. Therefore, its usage in the politics of healthcare management helps to understand the process of health policy making in Ghana and perhaps other sub-Saharan African countries, which complements the literature on the policy process.

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