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Dynamics Shaping Health Care Policy Adoption And Implementation In Ghana

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Abstract
The paper examined the health care policies implemented in Ghana from the pre-colonial era to the current Fourth Republic of Ghana. The study was based on a desktop review of literature and official government publications. The study found that pre-colonial health care was championed by traditional healers and leaders and the strategies took the form of communal labour, taboos and herbal medicines as well as amulets. The colonial era witnessed the introduction of medicine into the Gold Coast. However, this strategy was mostly selective in favour of the Europeans. When the selective application or implementation failed, the medication was extended to the indigenes with European affinity. Health care policy during the post-colonial era was aimed at ensuring access, affordability and equity for the citizenry. As such, successive governments implemented a three-prone health care policy: financing, infrastructure and human resource. However, lack of policy continuity due to unstable and punctuated political leadership derailed the fruition of these policies. Nevertheless, the Fourth Republic has experienced some level of policy stability in health care financing with the implementation of the National Health Insurance Scheme. However, the scheme is also plagued with diverse hiccups like excessive politicization of appointments, delay in reimbursing accredited service providers etc. The study also revealed that health care policies were shaped by multiple dynamics; key among them were ideology, demography, partisan politics, external factors and global public health issues. The study concludes and recommends that health care policy have been on the front burner since the pre-colonial era until date. But selectivity, lack of continuity and politicization have denied the country of its fruits as such the paper recommends fine tuning the current National Health Insurance Scheme to suit the exigency of the time and politicization should be minimized if it cannot be neutralized.
Keywords: Ghana; public policy; health care financing; National Health Insurance Scheme; Cash and Carry.
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Section 1: Introduction

Public health issues are highly political and therefore calls for public policy interventions to deal with them. Hence, the governmental actions to produce outcomes (injury and disease prevention or health promotion) that individuals are unlikely or unable to produce by themselves (Oliver, 2006). Nation-states are plagued with varieties of public health issues which needs to be addressed. In the words of Oliver (2006), science helps with the diagnosis and prescriptions for public health challenges, however, politics through the rudiments of public policy translates the diagnosis and prescriptions into reality. Ghana since time immemorial (pre-colonial, colonial and post-colonial) have taken several steps to deal with her public health issues. The task of this study is to chronologically examine the various health care policies adopted and implemented in Ghana from the pre-colonial era to date, the factors that influenced the adoption of the policies and finally do an assessment of the health care policies in the context of their objectives and proffer recommendations. Methodology wise, the paper is a desktop study that relied on secondary data as well as literature from official government publications..

The paper is structured as follows: section two discusses pre-colonial health care strategies in Ghana. Section three is devoted to colonial health care policies in Ghana, section four addresses post-colonial health care policies to date. Sections 5 and 6 are committed to the discussion and conclusion respectively.

Section 2: Pre-colonial health care strategies in Ghana

Prior to the arrival of the first Europeans at the shores of the Gold Coast in 1471, strategies were in place to safeguard and secure the health needs of the indigenes. Traditional rulers were the champions or lead agents in the implementation of these strategies. The strategies were in the form of organizing communal labour, taboos and the adherence to strict rules and regulations to ensure cleanliness to avert the outbreak of diseases. These

measures took the form of norms, conventions and practices because they were not documented as we have in modern day public policy making. In addition, medicine at the time was controlled by traditional healers or rulers who used herbs and other traditional means such as the wearing of amulets to cure and prevent diseases (Brenya et al, 2014).

Section 3: Colonial era health care policy

Health care policy during the colonial period could be classified into three phases. These were

(i) Phase one from 1471 to 1844

(ii) Phase two from 1844 to 1900

(iii) Phase three from 1901 to 1957

Phase one from 1471 to 1844: This covers the period 1471 to 1844 when the British under Commander Hill signed a peace pact with the coastal chiefs. Medical service at this time was to safeguard the health of European residents through prompt diagnosis and treatment as well as physical separation from the local population (Senah, 1989).

Phase two from 1844 to 1900: Failure of phase one policy of separation resulted in few Africans in the colonial administration receiving medical care. Potable water and other sanitary facilities were provided for communities with sizeable European population and political significance. This was aimed at reducing infections of the Africans and transfer of diseases to the Europeans. A legislation was passed in 1878 to neutralize the influence of traditional healers' practices. The legislation also liquidated traditional medicine and ensured the distribution of anti-malaria tablets free of charge (Senah, 1989).

Phase three from 1901 to 1957: This phase is considered as the period of colonial health care policy consolidation. Efforts were made to extend health facilities to the entire colony following the defeat of the Asantes in 1901 and the acquisition of the Northern Territories. It was also the highest point of colonial public health delivery as Governor Gordon Guggisberg built the Korle Bu Teaching Hospital in 1923 (Senah, 1989). There was partnership in health care provision as missionary bodies, mining companies and private individuals participated in health care provision. The period witnessed some level of cost sharing in health care financing as civil servants paid dispensary fees ranging between 5s and 6s but received free medical attention. Other categories aside, paupers paid professional fees at government hospitals (Senah, 1989). The cost sharing resulted in most people not availing themselves for health facilities when sick due to the general poverty level. However, there was a marginal income to health facilities because of the payments made by patients.

Following the attainment of internal self-rule in 1951, which made Kwame Nkrumah the leader of government business, the Ministry of Health and a Commission were established to investigate the health care system of the colony. The Commission recommended the abolition of hospital fee regime. This recommendation had effect on subsequent health care (financing) policies in post-independence Ghana.

Section 4: Post-colonial era health care policies

This section of the paper is divided into two sub-headings, health care policies before the Fourth Republic (civilian and military regimes) and health care policy in the Fourth Republic.

Section 4.1: Health care policies before the Fourth Republic

Ghana attained independence on March 6, 1957. Since then, the governance of the state has been in the hands of her leaders. Generally, post-independence health care policy is underpinned by the following strategies:

(i) To increase geographical and financial access to basic services
(ii) To provide better quality of care in all health facilities
(iii) To improve efficiency in the health sector
(iv) To foster closer collaboration and partnership between the health sector and communities, other sectors, private providers both allopathic and traditional
(v) To increase overall resources in the health sector, equitably and efficiently distributed
(vi) To bridge inequality gap in access to quality health services with emphasis on deprived areas

(vii) To ensure sustainable financial arrangements that protect the deprived and vulnerable (Ministry of Health, 2004). The ensuing sub-sections discusses the various health care policies.

Health care policy under the Convention Peoples' Party (CPP)

At independence, Ghana was faced with plethora of challenges with health care inclusive. To solve the health care problem, Nkrumah remarked, "***We shall measure our progress by the improvement in the health of our people***" (Axioms of Kwame Nkrumah, 1969). To achieve the declaration, the CPP government adopted free health care financing policy in its early years. Free health care financing is a policy where the citizenry are provided with health care without paying for the cost of treatment and other related services. The cost is always borne by the government.

Between 1963 and 1966, the CPP government had a marginal shift in health care financing policy to embrace citizens paying for the cost of their health care whenever they sought the service from private practitioners whilst those from the public facilities were still free. The rationale for this policy was to endear the government to the Western Bloc as part of the strategies to attract funding for the construction of the Akosombo Dam (Senah, 1987).

Factors that influenced the choice of the policy

The adoption and implementation of the free health care financing policy under Nkrumah's CPP was influenced by five key factors. These were:

First, the socialist ideology of Kwame Nkrumah. This is captured as "*the CPP is a nationalist, democratic socialist movement in which all men and women shall have equal opportunity and where there shall be no capitalist exploitation*" (Boahene, 2000). Second, at the time of independence thus between 1957 and 1960, Ghana's population was 6,726,815. The government at the time thought it worthwhile to finance the health care needs of the citizenry. The third factor that influenced the adoption of the free health care policy was the foreign reserve of £ 200 million. The fourth factor was the high level of unemployment at the time. The unemployed population could not afford the cost of their health care hence government shouldering the burden. The free health care financing policy was also adopted for the purposes of political patronage. Under the CPP government, praise singers of the government were treated free of charge. As a way of bolstering its popularity, government exempted the Workers Brigade, the teaching service, members of the armed forces and government employees from paying for health care services (Senah, 1989).

Health care policy under the National Liberation Council (NLC) government

The NLC ousted the CPP government and appointed the Easmon Committee to investigate the existing health care financing policy. The Committee recommended that hospital fees should be raised and collection strictly enforced. The pro-west oriented nature of the NLC resulted in the adoption of the recommendation (Senah, 1989). To ensure effective implementation, the government on February 6, 1968 introduced a statutory dispensing fee of 30NP (new pesewas). This was contained in a gazette as NLC Decree 360 on January 20, 1969.

Health care policy under the Progress Party (PP) government

Following the landslide victory of the PP in the 1969 elections and the subsequent formation of government, the Konotey-Ahulu Committee was inaugurated to investigate health care financing. The Committee observed and recommended "***considering the cost to the government that these drugs dispensed free must bring, the generality of patients including civil servants, out-patients care and treatment should no longer be free, and that something be paid towards the cost of drugs dispensed in government hospitals and clinics***". The government implemented a discriminatory health care financing policy because attendance at the rural health centers and posts were free while urban centers attracted a fee. Attendance at the former was free because the party had a strong rural base. In affirming the government's commitment to the health care of the rural areas, diverse health care projects were undertaken and 64 of these were commissioned as at the time of the overthrow of the government (Okyere, 2000:215-216). The fee paying was also implemented because of the market-oriented ideology of Busia.

Health care policies of the National Redemption Council, Supreme Military Council 1 and 2 the Armed Forces Revolutionary Council (AFRC) and the People's National Party (PNP)

These military governments (1972-1979) did not do much pertaining to health care policy because their basic preoccupation was to clear the mess created by the predecessor regimes (Okyere, 2000:246). However, the NRC contributed to beefing up the health infrastructure and the human resource capacity of the health sector. For instance, the government established the School of Medical Sciences at the Kwame Nkrumah University of Science and Technology to train more doctors, constructed the Mamprobi Urban Health Center and renovated the Okomfo Anokye Teaching Hospital and Mampong District Hospital (Okyere, 2000:229). The PNP maintained the status quo.

Health care policy under the Provisional National Defence Council (PNDC)

The PNP government was toppled by the military on December 31, 1981 partly because of the inability of the Limann administration to sustain the "house-cleaning" exercise initiated by the AFRC to rid the country of bribery and corruption.

The government adopted the "cash and carry system of health care financing on July 15, 1985 as part of the Economic Recovery Programme (ERP) and Structural Adjustment Programme (SAP) prescriptions of the Bretton Wood Institutions. The policy involved the wholesale withdrawal of government subsidies on health care delivery. The system had different fee structures for adults, children and non-Ghanaians. There were varying fees for facilities as depicted in Table 1 below.

Table 1: Fee structure under the "Cash and Carry" system

Teaching Hospitals	Adults	Children	Non-Ghanaians
a. Specialist consultants (First visit)	200	100	400
Follow up visits	50	25	100
b. General consultation	75	40	200
Regional Hospitals	75	40	100
District Hospitals	50	30	80
Urban Health Centres	50	30	80
Rural Health Centres	30	20	80

Source: Republic of Ghana, Hospital Fee Regulation, 1985

In defense of the astronomical increase in fees, Kwesi Botchway, the Secretary of Finance had this to say "***If we continue to saddle the government budget indefinitely with high cost for social services without a programme for generating revenues to sustain these costs into the future, we will simply initiate a self-destructive future***" (Botchway,1987).

Effects of the cash and carry system of health care financing

The cash and carry system of health care financing negatively impacted the citizenry in seeking health care treatment and services. Below are some of the effects.

1. People who could not pay for their health care were turned away from hospitals only to die at home.
2. People no longer went to orthodox health care facilities; they rather patronized the services of drug peddlers and drug stores (Asenso-Okyere, 1998).
3. Majority of Ghanaians resorted to self-medication, healing crusades, prayers or resigned themselves to their fate (Akosa, 2001)
4. Most people died before the retirement age of 60 (Akosa, 2001).
5. Most patients absconded from hospitals before they were discharged.
6. Reduction in attendance at health care facilities (Waddington and Enyimayaw, 1989).
7. Production and consumption were affected in the rural areas (Asenso-Okyere, 1993).

Though the policy negatively affected the health care seeking behaviour and pattern of the populace, it helped the health facilities to generate some appreciable amount of internally generated funds (IGFs) that they used to support their operations when government subventions delayed.

Section 4.2: Health care policy under the Fourth Republic

Ghana returned to multiparty democracy on January 7, 1993 following the founding elections of November and December, 1992. The National Democratic Congress (NDC) succeeded the PNDC from 1993 to 2000. There was no significant change in the health care policy during the period aside the piloting of a health insurance scheme in some parts of the country following the outcry of the citizenry in accessing health care due to the challenges of point of service payment associated with the cash and carry system of health care delivery.

The emergence of the National Health Insurance Scheme in Ghana

During the 2000 electioneering campaign, health care financing was a major campaign issue. The New Patriotic Party (NPP) then in opposition indicated that when elected to form government, they would implement a national health insurance scheme to make health care services affordable and accessible to the populace whereas the NDC was promising the expansion of the same scheme to other parts of the country following a successful piloting.

Following the victory of the NPP in the 2000 general elections and the subsequent formation of government, the requisite steps were taken for the passage of the National Health Insurance Bill into an Act of Parliament. The National Health Insurance Bill was laid in Parliament on July 11, 2003 and passed on August, 26, 2003 (Agbevade, 2018). It had Presidential Assent on September 5, 2003. It is called The National Health Insurance Act, 2003, (Act 650). Health insurance is a risk pooling arrangement by which the cost of health care to pay any single individual in the society whether rich or poor becomes a collective responsibility of all the people in the society (Ministry of Health, 2003).

The basic objective of the NHIS is to ensure equitable universal access to quality health services for all Ghanaians (Ministry of Health, 2004). Under the NHIS, health care is financed by individuals belonging to a health insurance scheme contributing money regularly to a scheme regardless of whether they were sick or not. This contribution is called premium. A member's cost of treatment and services are paid for from the premium anytime health care service was sought.

In Ghana, formal sector workers contribute two and half (2½) percent of their Social Security and National Trust (SSNIT) per month while non-formal sector workers initially contributed Gh¢6.00. This amount has seen reviews over the years to the present premium of Gh¢28.00 per annum.

From the onset, the scheme covered all health care services except the following: rehabilitation other than physiotherapy, appliances and prostheses, cosmetic surgeries and aesthetic treatment, HIV retroviral drugs, assisted reproduction, echocardiography, angiography, orthotics, dialysis for chronic renal failure, organ transplantation, heart and brain surgery, mortuary services, diagnosis and treatment abroad (Ministry of Health, 2004). With time, the coverage of treatments were expanded to include maternity care, childhood cancers etc. The scheme also has exemption for the poor to access health care without payment (see NHIS Membership Handbook).

For effective implementation of the scheme, the National Health Insurance Act, 2003, established The National Health Insurance Council (NHIC) charged with the responsibility of securing the implementation of a national health insurance policy that ensures access to basic healthcare services to all residents (Republic of Ghana, 2003). The NHIC is decentralized. A National Health Insurance Fund is established for financing the scheme (Section 78(1)). A levy is imposed under Section 86(1) of the Act.

The Act 650 provided for the establishment of three types of health insurance schemes, namely; District Mutual Health Insurance schemes, Private Commercial Health Insurance schemes and Private Mutual Health. Since the passage and implementation of the NHIS, there have been tremendous increase in accessing health care services in Ghana, however, the quality of services have been doubted.

The NHIS like any other public policy have been bedeviled with challenges, some of which are the excessive partisan politicization in terms of personnel appointment. The offices of the scheme are battleground for political party foot soldiers whenever there is alternation in political power. This has resulted in high rate of labour turnover mostly at the top echelon while party supporters were employed at the lower levels. Another challenge is the delay in the reimbursement of accredited service providers. This delay has culminated into shortage of

drugs in some of the accredited service providers and feet dragging by some to continue rendering services under the scheme.

Aside the financing policies, successive governments in the Fourth Republic have been consistent in improving and expanding access to health care through various interventions such as the CHPS compound, upgrading of polyclinics to General Hospitals, building of Metropolitan, Municipal and District Hospitals and Regional Hospitals. The development of the human resource capacity to implement the health policies among others have also engaged the attention of governments in the Fourth Republic.

Section 5: Discussions

The aim of this paper is to discuss the dynamics that shaped the adoption and implementation of health care policies in Ghana. The paper traced the emergence of health care policy from the precolonial era to the present Fourth Republic.

Generally, it could be argued that the penchant to provide quality and access to health care fundamentally influenced the choice of policy options and strategies in health care delivery even during the precolonial era. The specific dynamics are espoused below.

The colonial era health care strategies and policies were selfish and parochial in nature, as the colonial authorities were selective and discriminatory in the implementation of the policies. This is because they focused on the diagnosis and treatment of the Europeans while neglecting the local population. When these failed, the services were then extended to the local population who came into regular contact with the Europeans. This give credence to the rationality of policy makers, as they are always concerned with the benefits that they stand to gain in any policy initiative.

The foremost dynamic that informed the choice of health care policy is political ideology of the government. Ideology, an action-oriented phenomenon is associated with emotional connotations because it is related to certain motivating principles of change within a social and political system usually brought about by agents that are uncomfortable with the status quo (Bamikole, 2012:69; Arendt, 1966). In the words of Mannheim (1960), they are thought systems that defend a particular social order and broadly expresses the interests of its dominant or ruling class. It is therefore seen as a terminology of approbation in the sense that it is applied by the dominant ruling class (Bamikole, 2012:69). Nkrumah practiced the socialist ideology (coined as African Socialist principle) which is characterized by a state-led development strategy based on planning, land reform, industrialization and the nationalization of the economy. The socialist ideology is characterized with equity and egalitarianism while frowning on discrimination. Through the ideology, the state took center stage by absorbing the cost of health care of the citizenry. The NLC and the PP governments on the other hand were driven by the capitalist/pro-west ideology. Under this ideology, the private sector owns and controls resources and property. The forces of demand and supply sets market prices. This ideology is influenced purely by profit motive. This compelled the governments to scrap the free health care policy implemented by the CPP government. With this approach of health care financing, the citizenry paid for the cost of their health care at the point of receiving service.

Aside ideology, health care financing policy was also influenced by the demographic appeal of the government. For instance, the PP government had a strong rural base support. As a result, aside the influence of the capitalist ideology, the government also varied the cost of health care for the rural communities. This was because the party had a strong support from these areas. In the case of the CPP, free health care financing was pursued due to the high rate of unemployment that characterized the country immediately after independence. At independence, the colonial masters were occupying most of the positions in the public sector hence most nationals remained unemployed because they lacked the requisite capacity to be employed. At the same time, their basic needs must be met hence the government's resort to providing free health care.

The high level of foreign reserve at independence partly influenced the choice of health care (financing) policy. The foreign reserve of Ghana at independence was £200 million coupled with relatively small population size of 6,726,815. This the Nkrumah led government felt could finance the health care for free.

Health care financing policy was also shaped by external/donor agencies. The harsh economic conditions of the 1980s brought about the involvement of international donor agencies like the International Monetary Fund (IMF)

and the International Bank for Reconstruction and Development (World Bank) jointly called the Bretton Wood Institutions or modern day Washington Consensus. Through the structural adjustment programme/economic recovery programme, conditionalities such as the withdrawal of subsidies were prescribed. The Ghanaian experience resulted in wholesale withdrawal of government subsidy in health care financing and the transfer of the cost of health care to the citizenry christened "cash and carry". This policy brought about difficulties in seeking for health care most especially among the poor.

Partisan politics also influenced health care (financing) policy in Ghana. In the run-up to the 2000 general elections, the NPP had the introduction of a health insurance scheme as parts of its campaign message (NPP Manifesto, 2000). On winning political power in the same year and forming government, the National Health Insurance Bill was formulated and initiated into Ghana's parliament. The bill was subsequently passed into law and implementation started in 2003.

Public health issues such as the emergence of the Ebola and COVID-19 viruses also shaped health care policy in Ghana with respect to infrastructure provision. The responses to these health crises were reactionary and knee-jet. These situations exposed the deficit in the country's health care infrastructure hence government(s) had to take steps to deal with the ensuing challenge. For instance, at the height of the COVID-19 pandemic in 2020, the government through the president announced the construction of 111 health (Agenda 111) care facilities across the country. The period also witnessed the establishment of infectious disease centres in the Ga-East Municipal Assembly. This was a public private partnership arrangement.

Section 6: Conclusion

The paper interrogated health care policies in Ghana dating back to the pre-colonial era through to the Fourth Republic of Ghana. It emerged that there existed health care policies in Ghana since time immemorial some documented others not. All these policy measures or strategies were aimed at securing the health care needs of the citizenry. However, the strategies adopted by the colonial masters had some element of selfishness imbedded because of the selective nature of implementing the strategy in settlements of the Europeans aimed at preventing them from being infected by malaria and when it failed, the strategy was extend to include indigenes with close affiliation with the Europeans.

The health care policies implemented in Ghana were aimed at three key issues, namely; infrastructure, human resource and health care financing. The policies adopted and implemented in attaining these policy objectives were significantly influenced by factors such as ideology, demography, external factors such as the Washington Consensus, partisan politics, and global public health issues among others.

In fine, the paper revealed that Ghana lacked continuity in the implementation of health care policies especially before the Fourth Republic. Intermittent punctuation in the political leadership (military and civil regimes) chiefly accounts for this hence punctuated equilibrium in health care policy. However, the Fourth Republic have witnessed some element of stability with regards to health care financing since 2003 when the National Health Insurance Scheme was implemented as an alternative to the fee paying system. In spite of this, the NHIS is also bedeviled with challenges such as excessive partisanship, delays in reimbursing accredited service providers, limited coverage of ailments and drugs under the scheme and the political chess that feature whenever political power alternates. This has seen party supporters of the incoming government takeover the offices of the scheme and the removal of the chief executive officer, top management members and the board of directors. Because of the acrimonious nature of Ghana's electoral politics, the succeeding management in most cases is suspicious of the predecessor hence strategic hiatus as the former tries to audit and acclimatize itself with operations of the scheme.

With respect to infrastructure, all governments have demonstrated commitment to providing the needed infrastructure (regional and district hospitals and agenda 111). Again, lack of continuity in building projects initiated by predecessor governments since independence has been a bane.

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