Full Length Research Paper

Financing health care and policy issues in developing countries: Decision making in Ghana’s health insurance policy process

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Health care financing is a major challenge in developing countries. Ghana happens to be the first country in Africa to implement universal health insurance coverage. In view of the challenges of policy development in developing countries, the paper sought to analyse the policy making process of Ghana’s health finance policy, applying theoretically robust and well structured approaches to policy process analysis. The paper argues that policy is not only about the intentions or the content, but, also the policy making process. A policy may have the best of intentions but failure to pay attention to the processes that the policy go through, the institutional arrangements, rules of decision making, the political context, the interest and the participation of key actors and stakeholders in the policy making process may stifle a brilliant policy. The paper brings out lessons of experience that can be useful to other developing countries considering a health finance policy, as well as serve as a guide for future policy developments.

Key words: Developing countries, Ghana, out of pocket payment, health costs, health insurance, health finance policy, policy making process, actors, institutional arrangements.

INTRODUCTION

In developing countries, the average person spends between 5 to 10% of their income on health care costs. The poorest spend about a third of their income paying health bills (EQUINET, 2005). The WHO (2005) (EQUINET, 2005) estimates that in each year, about 100 million people become poor as a result paying health costs, and an additional 150 million people face severe hardships as their resources are expended on health care cost payment. Most households have to take loans, sell their assets, or cut down on their basic needs to meet their health care costs. The catastrophic health care costs have left millions of people incapacitated, resulting in preventable deaths and reduced life expectancy for poor households. These have made health care financing a major issue of concern in developing countries.

The citizens of every nation are its priceless assets. A country with sick and unhealthy citizens is doomed to collapse as its social and economic functions cannot be achieved. The wealth of a country depends on the well-being of the citizens (Sen, 1987), and it is when health care is made accessible to residents of the country that development can be sustainable (Baidoo, 2009). In the notable words of Ghana’s first president and Africa’s inspirational leader, Kwame (1969), “We shall measure our progress by the improvement in the health of our people... The welfare of our people is our chief pride, and it is by this that we ask to be judged”. Since independence in 1957, Ghana has not had any steady health finance policy. In 2001, the country started a policy process that sort to finance her health needs. Until the introduction of the National Health Insurance Scheme (NHIS) in 2004, the Government funded 80% of public health budget through taxes and donor support, and patients funded the remaining 20% through out-of-pocket payment. The out-of-pocket payment had serious

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consequences on access to health care, and the wellbeing of many poor Ghanaians. Many households postponed medical care, took to self-medication and uncertified healers, which often presented them with worst consequences. To address the problems of out of pocket payment and to ensure equal access to health care, the NHIS was introduced, where the 20% share of individuals’ public health bill is covered through the pooling of funds. Under the NHIS, residents of Ghana pay premiums into a pool of funds which allow them to access health services without having to pay at the counter or point of service. To make it accessible to all Ghanaians, some categories of people, including indigents (the very poor), are exempted from premium payment. Ghana has since become the first African country to implement a social health insurance scheme nation-wide.

Obviously, the case for a health finance policy is laudable and long overdue, however, in appreciating the nation-wide.

Objectives

The paper seeks to analyse the policy making process of Ghana’s health finance phases, and the focus is on the decision making phases. In doing this, the paper will illustrate available theoretical frameworks in the area of public policy process, draw lessons, and provide recommendations for policy development. The objective of the paper is parallel to the concern expressed by Walt to deepen and to extend health policy analysis in low and middle income countries (Gilson et al., 2008). Health care financing is a major challenge in many countries. Because Ghana happens to be one of very few countries implementing universal health insurance coverage aside few high income countries (Agyepong and Adjei, 2008), bringing-out lessons of experience from the policy making process can be useful to other countries considering a health finance policy. It would also serve as a guide for future policy developments.

METHODOLOGY

The policy making process has variously been described as complex, obscured or a “black box”. To simplify the policy making process, concepts and models in policy studies will be used to analyse the case. The paper uses qualitative approach which makes for in-depth analyses of the policy process, the context, actors, and institutional arrangements (Garr, 2011). Exploring detailed and contextual matters that may be considered and applied to other contexts are best analysed and understood qualitatively (Baidoo, 2009). Also as a novelty in the developing world, a qualitative approach is more informative. Data for the analysis was gathered through primary (interview with key stakeholders) and secondary sources (NHIS and public health reports, public health policy papers, and news reports).

Key indicators of health finance policy

Socio-economic characteristics of Ghana

A country’s choice of health finance policy is affected by socio-economic factors. Ghana’s 2010 gross domestic product (GDP) is estimated at US$44.8 billion, an increase over the 2009 figure of US$ 36.9 billion. The growth rate is 6.6% (Ghana Statistical Service, 2010). The country’s per capita income is US$ 1300. The 2006 Ghana Living Standard Survey indicates a decline in poverty (population living on less than US$2 per day) from 51.7% in 1991/1992 to 28.5% in 2005/2006. Extreme poverty (population living on less than US$1 per day) also declined from 36.5% to 18.2% (Garr, 2011).

Population demographics and health status characteristics of Ghana

Population demographics and health status characteristics are important determinants of what should constitute the content of health care policies. Though Ghana’s population continues to increase (from 6,700,000 in 1960 to about 23,887,812 in 2010), the population growth rate has declined from the height of 2.7% in 2000 to 1.90% in 2010 (MOH, 2007). Females are marginally more, 53%, than males who form 47% of the population.

The disease profile of Ghana is characterised by mainly preventable diseases. Communicable diseases are the leading causes of morbidity and mortality in Ghana, followed by pregnancy related diseases. Non-communicable diseases are gradually on the increase. Malaria is the leading cause of death in Ghana, followed by Anaemia, Pneumonia, Cerebrovascular accidents, Typhoid fever, Diarrhoea, Hypertension, Hepatitis, Meningitis and Sepsis (MOH, 2007). The paper now proceeds to apply the body of knowledge in public policy to the case understudy.

THEORETICAL PERSPECTIVES ON POLICY MAKING PROCESSES

Public policies are to promote the welfare of society. It should also be noted that policy decisions affect an entire country in diverse ways, good or bad. It is in view of this that studies into the policy making process are important so as to share the useful experiences and to help shape ongoing and future policy processes (Garr, 2009). Generally, policies arise as a result of the need to solve a problem or address an issue, meet certain needs or improve upon the service delivery or management. Often, the Government leads the process by deciding or setting the tone for the formulation of the policy. Civil society groups and members of the public (stakeholders) participate by advising or making inputs into the policy based on their interest. Political actors, experts and civil servants develop the content, administrative guidelines and procedures. Parliament then approves the bill into law. Walt and Gilson (1994), in their work “Reforming the
health sector in developing countries”, outline a framework for policy analysis where emphasis is put on the role of actors, context, content and process. De Coning and Sherwill (2004), note that in young democracies like the case in most developing counties, the focus of policy analysis is increasingly in process terms - “the institutional arrangements, and the ability to plan and facilitate policy processes.” Dror (1990) also distinguishes between content analysis and process analysis. While content analysis examines the substance and intentions of the policy and tries to improve policy decisions, the process focuses on the entire policy process and how policy decisions are shaped by each phase in the process. It is therefore clear that policy is not only about the intentions or content, but also about a process consisting of phases. The process analysis as indicated earlier is very important because the content of a policy can be outstanding in addressing the needs of the people, however, the processes and the phases that the policy goes through can have serious repercussions on the policy and consequently on its impact.

There are many policy process models, each outlining various stages of the policy process and advancing reasons why each stage in the process is important. However, some stages are com-mon to the various process models. These include agenda setting, deciding how to decide, issue definition or forecasting, setting objectives and priorities, option analysis, policy implementation, monitoring and evaluation, and policy succession or termination (De Coning and Sherwell, 2004). The study will proceed to highlight some process models.

**The Dunn's model**

Reputed as the most internationally recognised policy process model, the Dunn’s policy process has a common outline (Dunn, 1994). The model outlines five policy process stages, namely, Agenda setting, policy formulation, policy adoption, policy implementation and impact assessment. Like the vicious cycle, Dunn notes that policy process is marked by interdependent activities that are political and arranged to consequently follow each other, and the decisions taken at a stage affects the next stage of the process. It continues to affect subsequent stages and eventually the whole process is affected. Dunn (1994) writes:

> Each phase is related to the next, and the last phase (policy assessment) is linked to the first (agenda setting) as well as intermediate phases, in a non-linear cycle or round of activities. The application of policy analytic procedures may yield policy relevant knowledge that directly affects assumptions, judgements and actions in one phase, which in turn indirectly affects performance in subsequent phases.

**Wissink's stage model**

Another important policy process model is that developed by Henry Wissink. The Wissink stage model departs from the models that outline few policy process stages and identifies eight detailed policy process stages. These are initiation, agenda setting, processing the issue, considering the options, implementation, adjudication, impact evaluation, and feedback (Fox et al., 1991). The model emphasizes the break-down of policy making process into descriptive stages, and it provides detailed guidelines and process requirements that aid in developing the policy content and a coherent policy. The model allows for consultation with stakeholders and for their input to be factored into every stage of the policy making process. This is critical and made for policies to be successful, as when people feel they are involved in decisions on matters that affect them, they support and help to make it work.

**Generic model**

The Generic model was developed by Christo de Coning. The model was developed to address the policy process inadequacies, especially, the public policy process needs of South Africa. The Generic model consists of the following stages: Policy initiation and review, policy process design, policy analysis, policy formulation, decision making, statutory stage, policy dialogue, implementation, monitoring and evaluation (De Coning, 2006). The model does not leave the policy process to chance or for easy manipulation; it provides clear guidelines that direct the policy. As De Coning (2006) writes, “the generic process model provides for both a comprehensive set of phases as well as proposing specific requirements and key issues to be addressed during each of the phases”. The model also pays more attention to institutional arrangements at the various stages of the process; this is made for the deployment of the appropriate expertise and participation of stakeholders at each stage of the process. De Coning (2006) recounts various specific experiences in South Africa that prompted the need for a unique policy process, culminating in the generic model:

> ... The South African context of simultaneously introducing large scale public transformation and mega policy making endeavours, required that special attention be given to institutional arrangements.

> ...The last specific ... consideration ... was more to single out the process facilitation element from the analysis actions on content, so as to be able to focus on the management arrangement as a distinct project.

Another model is one developed by Mutahaba et al. (1993). They follow a macro approach, and concentrate a
great deal on institutional determinants. The trio simplified the entire policy process into three comprehensive stages: the policy formulation stage, the implementation stage, and the monitoring and evaluation stage. Their argument that there are too many policy processes, which obscure the policy process, but in effect are just three stages, is worthy of note.

Among the various models discussed and other useful ones that have not been mentioned, Dunn’s model will be applied to the case study. Ghana has not developed any policy making process model of her own, and as the Dunn’s model is reputed as the most used internationally, it is assumed that it would provide a better analysis of Ghana’s health finance policy process.

POLICY MAKING PROCESS OF THE GHANA HEALTH FINANCE POLICY

Using Dunn’s policy process model, the paper focuses on the decision making stages of the process model. The decision making stages to be examined are, structuring the problem at the agenda setting stage, forecasting at policy formulation stage, and recommendations at the policy adoption stage of Ghana’s health finance policy or the National Health Insurance Scheme. Information on the chronicle of events in the policy making process of the Ghana Health Finance Policy is credited to the work of Agyepong and Adjei (2008).

In the 1990s, when the National Democratic Congress (NDC) was in government, many community based health insurance schemes emerged in attempts to mitigate the challenges of out-of-pocket payment. Some of the schemes made marginal gains and others failed. Most worthy of note is the fact that some important lessons were learned (data gathered). The New Patriotic Party (NPP), which was in opposition by then, made a campaign promise to introduce a national health insurance when voted into office. The NPP won the 2000 elections, and provided the political leadership for the development of a national health insurance policy.

Agenda setting (2001)

In 2001, the Minister of health set up a seven member ministerial health finance taskforce, charged with helping the Ministry of Health (MOH) come out with a NHIS. The specific terms of reference, according to Agyepong and Adjei (2008), were “to support and advise the MOH on the development of a NHIS, the building up of systems and capacity for regulation of health insurance in Ghana, the development of appropriate health insurance legislation, and the mobilization of extra resources to support national health insurance.” The taskforce was chaired by the director for policy planning, monitoring and evaluation in the MOH. One major source of disagreements was the choice of health insurance scheme. The minister preferred a centralised social health insurance, while the chairman of the taskforce and majority of the members preferred a community health insurance scheme also known as Mutual Health Organisation (MHO) scheme, based on their reasoning that there were large number of people in the informal sector that have to be catered for, and also from their experience, the centralised single payer pilot projects did not work. Misunderstanding and conflict over the choice of scheme continued between the chairman and minister, and later the chairman had to quit the taskforce. The impasse over the choice of scheme was resolved with a decision to have a hybrid, which consisted of a centralised single payer scheme for the formal sector and a multiple payer scheme for the informal sector.

Analysis of the National Health Insurance Scheme (NHIS) agenda setting

Agenda setting refers to problem structuring or identifying the main issues for consideration. Before 2001, pilot studies were conducted on a number of health insurance projects with the aim of coming out with a national health insurance and therefore there were some data. As a good starting point, the taskforce was constituted by experts from the Ministry of Health who have worked on the pilot projects. Agenda setting is often characterised by competition among issue proponents, and disagreements should not necessary lead to replacements, but instead, an opportunity to do optional analysis and consultation, considering the fact that the chairman’s position is based on experience with pilot projects that have failed. The taskforce did well by settling on a compromise - a hybrid, which was the best. Health reforms are inherently political as the government leads the agenda. Often, they generate tension between political actors and experts. Gilson et al. (2003) reports similar experiences in their work on health policy reforms in South Africa and Zambia. Glassman et al. (1999) also make the same observation in a study on health reform in the Dominican Republic. There is the need for strong institutional arrangements to ensure that such tensions have no adverse effects on the quality of policy decisions.

Policy formulation (2001 to 2003)

Having reached a decision to work with a hybrid scheme, the task force decided there should be legislation on a central coordinating authority to be known as the National Health Insurance Council (NHIC), and also a fund to finance the health policy, known as National Health Insurance Fund (NHIF). In June 2001, the minister endorsed a four page policy outline formulated by the task force. The minister also appointed a trusted political
associate to chair the task force. Consultation with stakeholders started; this took place at the national and sub-national levels. The chairman appointed more political associates to join the task force. Discussions on the content of the policy proposal generated disagreements between the political associates and the experts. The political associates who had increased in number dominated the decision making process and concerns of the experts on content development were ignored. The one-sided decision making process continued, and most experts quit the task force. By the end of 2002, the task force was made up of only one original member and many political associates.

In February 2003, funds from highly indebted poor countries (HIPC) initiative were allocated to the MOH for the creation of MHOs in all districts. The political associates became consultants who saw to the disbursement of the funds and the creation of the MHOs.

Analysis of the National Health Insurance Scheme (NHIS) policy formulation

In this phase, it is expected that information and views would be collected and drafted into a framework that addresses the main issue. Consultation with stakeholders was said to have taken place at the national and the sub-national levels, and this is very vital. But, interestingly, none of the problems that were raised later (in the adoption stage) came up or were they ignored? The effect of having party associates dominate the taskforce of such an important national policy was that the political associates hijacked all decisions, ignoring the experts, who were accused of being anti-government. Clearly, party interest had priority over national interest. One wonders why when the HIPC fund was allocated for the creation of MHOs, external consultants were not engaged, but instead, the same group of political associates became the consultants overseeing the creation of the MHOs. The diagnosis here suggests weak institutional arrangements to check or support critical decision making, which saw the political associates taking advantage of the process. Political pressure cannot be ignored, but strong institutional arrangements could have made adequate provisions for experts to effectively participate in the decision making process.

Policy adoption (2003 to 2004)

In July 2003, just a week before parliament went on recess, the final draft of the Health Insurance Bill was laid before parliament under a certificate of urgency to be passed into law that week. Advertisements were published in the national newspapers inviting comments from the public. Stakeholders, including labour groups such as Ghana National Association of Teachers, Ghana Registered Nurses Association, Trade Union Congress, Civil Servants Association of Ghana, etc., raised concerns about sections of the bill, and strongly questioned why the rush to pass the bill into law without adequate consultation with stakeholders. The interest groups subsequently called for deferment of the bill to allow for consultation with stakeholders. The opposition disagreed on sections of the bill and they also requested the deferment of the bill to allow for deliberation on the content of the bill. The bill was deferred and parliament went on recess.

In August 2003, a month after the bill was deferred, parliament was called back from recess to pass the bill into law. The bill remained the same, and it generated heated and hostile debates on the floor of parliament with the opposition (NDC) calling on parliament not to rush the bill through but to allow time for deliberation since they have seen many anomalies in the bill. The ruling party (NPP) accused the opposition of attempts to sabotage national interest. The content of the bill was no more the matter under discussion, but accusations and counter accusations. The opposition party (NDC) who felt the debate was not in the national interest, walked-out of parliament, hoping that their action will soften the stance of the ruling party so that the bill could be critically looked at, but that failed. The ruling party (NPP), who had the numbers required by law to pass the bill into law, passed the Health Finance Bill into law. Sections of the public, stakeholders and interest groups went on demonstrations, protesting the passage of the bill into law, but that was an exercise in futility as it changed nothing.

The bill became known as the National Health Insurance Act 650 of 2003. The Act required that the formal and the informal sectors be enrolled into the government district sponsored MHOs. Government was going to sponsor district MHOs; all other private non-profit solidarity MHOs will not receive any sponsorship from the government. Funding of the health insurance was going to be through individual premium payment and 2.5% tax levy known as the National Health Insurance Levy. A monthly contribution of 2.5% was to be taken from workers' pension. Workers protested against the decision to take 2.5% of their pensions and vehemently criticised the mode and manner in which government gets up and deeps its 'long' hands into their pension contribution any time it wishes without due consultation with them. For them, this was the cause of low pension payments and the poor management of pension funds. A National Health Insurance Council was to implement the NHIS (Republic of Ghana, 2003). Its responsibilities included registration, licensing, regulation and supervision of health schemes, granting accreditation to health providers, monitoring their activities to ensure that they deliver quality health services. The opposition party (NDC) criticised the increase in value added tax from 12.5 to 15% which they considered too much a burden on the tax payer when there were other sources of funding for the NHIS. The existing MHOs that were exempted from
state funding challenged the basis for their illegibility. They argued that they were rural community based schemes that serve the health needs of the poor who could not afford to pay out of their pockets, and for every reason they form a critical target of the policy. They also pointed out that they were left out of the policy making process which was done in the towns and cities.

Following the passage of the National Health Insurance Act, a taskforce made up of experts and the political associates was setup to provide recommendations on the implementation and to finalise all other legislations that come with the implementation of the Act. Again, the political associates dominated decisions making process, usurping technical issues. The NHIS was made to cover about 95% of all treatments. The minimum benefit package covers all outpatient care services, in-patient services, including hospital admission and feeding, oral health and eye care services, supply of drugs on the NHIS list, and emergency care. Some categories of people were exempted from premium payment. These include all Ghanaians under 18 years, indigents, people aged 70 years and above and pensioners. In the calculation of the premium, the political associates chose estimates in the range of what existing schemes were using. They decided on an annual premium of GhC 7.2, about $8 by then. The experts on the taskforce disagreed with the manner in which the taskforce was taking decisions in haste based on assumptions, and asked that decisions should take into consideration demographic data and financial resources available. The strategy adopted by the trusted political associates was to label any member on the taskforce who disagreed with them as an anti government element who wanted to sabotage government policy. On the service providers' claims format, the concerns of the health service providers and the experts that it be made easy and convenient to facilitate the process were ignored. The decision making process is best described in the words of Acheampong and Adjei (2005): “…it was better to cut a few procedural corners and get things moving rapidly.”

Before the elections in December 2004, the NHIS came into operation. The chairman of the task force became the Chief Executive Officer of the NHIC, and members of the council were subsequently appointed. The political associates continued as implementation consultants. Soon, the December 2004 elections were held and the ruling government retained power.

**Analysis of National Health Insurance Scheme (NHIS) policy adoption**

Under Policy Adoption, the policy draft was expected to be debated, recommendations effected and approved into law. The bill was passed but the recommendations that were to precede the approval were lacking. It was wrong for the government to rush the bill into law under a certificate of urgency. The conduct of the ruling party, to a large extent, supports speculations that the government was using the NHIS as a campaign tool to win the next election which was few months away, and not necessarily to deliver to the people a sustainable health insurance scheme.

In the midst of the abnormalities, the media focused on sensationalism rather than discuss the issues, thereby denying the public the much needed information and education on the health finance bill - they could have served the nation better. The media can help enhance the policy making process and participation of the public by reporting on such issues of national interest.

Consultation should have been held with workers before the decision to take 2.5% of workers’ social security contributions. You do not go about taking people’s money because you are the government. On the decision of the minimum benefit package, exempt groups and the fixing of the annual premium, there should have been due consultation into the health reports of the country, the demographic characteristics and the financial resources available as more diligent financial and demographic assessments could even lead to lower premiums, more exemptions and provide strong empirical basis for evaluation. It is no surprise that the political actors ‘raided’ the decision-making processes. Health reforms are political and most political actors prefer short-term actions that would keep them in power and not necessarily long-term solutions. It becomes important to develop strong institutional arrangements that provide for consultation and participation of the requisite stakeholders, and also active civil societies to help hold the ambitions of politicians in check.

**Outcomes in the implementation phase**

The implementation phase is not the issue under discussion here, but a review of some implementation outcomes would give impetus to the discussion on the decision making phases above. As indicated by Dunn (1994), actions in one stage of the policy process affect the other stages in the process. The NHIS faced enormous challenges and problems at the start. Most of the schemes did not start operation as expected (MOH, 2005). There were misconceptions and misinformation in the public domain about the entire NHIS. There were legislative and operational challenges. The NHIS Act makes it difficult for the NHIA (the implementing authority) to supervise the District Mutual Health Insurance Schemes (DMHIS) as the DMHIS were made autonomous. This is counter-productive, to say the least, and a critical factor undermining the implementation of the scheme. Similarly, the relationship between the various stakeholders and institutions in the health sector (ministry of health, Ghana health service, ministry of finance and economic planning, NHIS, DMHIS) were not
clearly demarcated (Atuguba and Associate, 2009). Another problem, which the experts raised, but was ignored, which later affected the NHIS badly was the claims format for health service providers. Because the process was complicated, it became very difficult for health care providers to make their claims. Another serious threat to the NHIS is the fraudulent activities of health service providers, which is rippling the NHIS of huge sums of money. The NHIS reports that about 30% of claims issued were fraudulent (Myjoyonline, 2010). Patients who pay out-of-pocket received preferential treatments at health centres as those who registered under the NHIS were made to wait for long periods. There was also miss information suggesting that the NHIS was made for only members of the ruling party. These and many other challenges at the start of the NHIS fuelled scepticism about the success of the NHIS and peoples’ willingness to join the scheme. Later in 2005, the political associates were suspended, and an audit into their operations, according to the Auditor General’s report indicated malfeasance and mismanagement on their part. In the same year, the Chief Executive Officer was also dismissed by the council for incompetence (Agyepong and Adjei, 2008).

It should however be noted that over the years, there have been significant improvements in the operation of the NHIS in terms of, insurance coverage, equitable access to professional health care, high utilisation of health care services and improvement in maternal health outcomes. However, there are many other challenges threatening the sustainability of the NHIS. As indicated earlier, the focus is on the decision making phases. The inclusion of implementation outcomes is to give impetus to the discussion on the decision making phases.

**Lessons for the policy making process**

The analysis consistently demonstrates that the policy planning process did not take due cognisance of the challenges of the policy process and its elements - the political interest (marauding), the institutional arrangements (weak), decision making mechanisms (lacking), and stakeholders’ participation (limited). There were many institutional challenges that the Dunn policy process model could not address. It did not provide detailed guidelines for decision making in the various stages: agenda setting, policy formulation, policy adoption or the other stages of the process. The decision making process was left to chance, allowing political actors to use the policy for their parochial interest. The participation of stakeholders was cosmetic rather than effective. Subsequently, the content analysis was poor. Dunn’s model only provides a general outline which does not respond to the development needs of Ghana.

Most often, we pay all attention to the goals of the policy and less attention is given to the policy making process (a blind spot that is often manipulated by politicians). We do not foresee the importance of the process: the process that the policy goes through can make or unmake the most laudable intentions. The over-emphasis on the goal of a health policy suited the interest of the political actors. Instead of developing a sustainable health insurance for the country, the government promoted its political interest to get the NHIS into operation before the 2004 election. In pursuit of their interest, the policy was hastily developed. Also, “the system was crafted to suit persons and institutions who became implementers after it was created” (Atuguba and Associate, 2009). As a result, the policy process was characterised by corner-cuttings and political manipulations. Little attention was paid to institutional arrangements, rules of decision making, and participation of stakeholders – experts, civil society groups and the public. These led to the legislative and operational challenges which resulted in implementation difficulties. Similarly, because of the haste to get the NHIS into operation, the public was not properly informed on the scheme prior to its operation. More so, the political manipulation and disregard for stakeholders in the decision making process fuelled the misconception and misinformation on the NHIS. Most of these problems could have been avoided or minimised if adequate institutional provisions were made for decision making and the participation of stakeholders.

The Generic model mentioned earlier is illustrated in Figure 1. It shows institutional arrangements and key considerations that are made for effective decision making and participation of stakeholders.

**Conclusion**

Health care financing is a major challenge in developing countries. However, in recent times, owing to some positive experiences, health insurance is becoming the attractive solution to the problem. The objective of the paper has been to share lessons of experience from countries that are implementing health insurance. After decades of out-of-pocket payments for health service and its terrible health outcomes for majority of Ghanaians, Ghana took a bold step to implement a health financing policy known as the NHIS, making it the first country in Africa to implement a mutual health insurance scheme. The NHIS faced enormous challenges at the start of its implementation. However, as the policy muddled through implementation, the flaws are being identified and resolved. Though, some challenges still exist, Ghana’s health insurance scheme is achieving considerable success.

The focus of the paper has been on the decision making process of Ghana’s health insurance policy, initiation or agenda setting, policy formulation and policy adoption. Though, the health finance policy is a laudable
Policy process initiation and review
- Mandate and legitimacy
- Consultation with key stakeholders
- Preliminary objective setting
- Consider rules of the game

Policy process design
- Agreement on process
- Objective and agenda setting
- Institutional arrangements
- Policy project planning
- Monitoring arrangements

Policy analysis
- Issue filtration and prioritization
- Option analysis
- Consequences and predictions
- Set of value judgments

Policy implementation
- Translation to operational policy
- Planning, programming, and budgeting of prioritized programmes and projects
- Management and monitoring

Policy evaluation
- Management arrangements
- Objective, criteria, indicators, and information
- Evaluation
- Report and follow-up

Policy formulation
- Report format
- Confirmation
- Preparation of proposals

Policy decision
- Decision making processes
- Consultation
- Mandated decision

Policy dialogue
- Communication Strategy
- Dialogue
- Ensure feedback
- Implementation

Statutory phase
- Legal drafting
- Bill/Act
- Guidelines
- Debrief and negotiate

Figure 1. Generic model of the policy making process.

initiative, the policy making process was carried out in the form of a "pork-barrel" – using the phrase of Klein (1982), and because the policy was hastily developed for political gains, the NHIS faced enormous challenges and problems at the start of its implementation. The lesson here is that, a policy may have the best of intentions but failure to pay attention to the institutional arrangements, rules of decision making, and the participation of key actors and stakeholders in the policy making process may stifle any such brilliant policy. There is a high level of decision making imbalance in developing countries, where dominant political actors in the face of weak institutional arrangements and weak civil society involvement resort to the use of indiscriminate political power and the skipping of essential policy making processes. It is true that politics cannot be divorced from the policy making process, but we also have to recognise the fact that policy decisions have ramifying effects on all sectors of the country, and if we want to make meaningful progress, then we should establish the requisite institutions and support them to function.

RECOMMENDATIONS

In view of the short falls in the NHIS policy, lessons and experiences drawn from the policy process, the following are recommended to help improve the policy making process: There is the need to promote a better understanding of the policy making process and use analytical frameworks to enable actors (political actors, and other stakeholders) working at all levels of policy process or reforms to understand the challenges and complexities of the process and be equipped with the knowledge and skills to discharge their functions effectively.

In response to Ghana’s development aspirations, its flying democracy, and the willingness of the citizenry to be part of the governance process, it requires policy process models that have a transparent outline that provides for the participation of all stakeholders, and has
appropriate institutional arrangements to see the process through. Until Ghana develops such a process model, the Generic model is recommended, as it provides a framework that is similar to the aspirations of the country. This would check the abuse of the policy process by political actors.

There is a need for a meta policy on decision making - a policy on how decisions are to be made in the policy process. This meta policy should state clearly the various procedures to arrive at decisions, participation and representation of stakeholders, institutional channels for collecting the positions of interest groups into each stage of the process, how the work of each stage should receive approval before it is allowed to the next stage. The Meta policy should be one that enables the process to function systematically. The rush and the many mistakes that were evident in the policy making process of the NHIS could have been avoided if there was a policy on decision making. Similarly, it is very important to consolidate the role and participation of experts, civil societies and the public in policy making.

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