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Universal financial protection through National Health Insurance: a stakeholder analysis of the proposed one-time premium payment policy in Ghana

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Extending coverage to the informal sector is a key challenge to achieving universal coverage through contributory health insurance schemes. Ghana introduced a mandatory National Health Insurance system in 2004 to provide financial protection for both the formal and informal sectors through a combination of taxes and annual premium payments. As part of its election promise in 2008, the current government (then in opposition) promised to make the payment of premiums 'one-time'. This has been a very controversial policy issue in Ghana. This study sought to contribute to assessing the feasibility of the proposed policy by exploring the understandings of various stakeholders on the policy, their interests or concerns, potential positions, power and influences on it, as well as the general prospects and challenges for its implementation. Data were gathered from a review of relevant documents in the public domain, 28 key informant interviews and six focus group discussions with key stakeholders in Accra and two other districts. The results show that there is a lot of confusion in stakeholders' understanding of the policy issue, and, because of the uncertainties surrounding it, most powerful stakeholders are yet to take clear positions on it. However, stakeholders raised concerns that revolved around issues such as: the meaning of a one-time premium within an insurance scheme context, the affordability of the one-time premium, financing sources and sustainability of the policy, as well as the likely impact of the policy on equity in access to health care. Policy-makers need to clearly explain the meaning of the one-time premium policy and how it will be funded, and critically consider the concerns raised by stakeholders before proceeding with further attempts to implement it. For other countries planning universal coverage reforms, it is important that the terminology of their reforms clearly reflects policy objectives.

Keywords Universal coverage, universal financial protection, national health insurance, stakeholder analysis

KEY MESSAGES

- Depending on the interpretation of its meaning and the design of its implementation arrangements, stakeholders believe a one-time premium payment policy can have potential for increased population coverage (especially within the informal sector), equity in health care financing and universal financial protection.
- Due to the uncertainties surrounding the policy issue, many powerful stakeholders who participated in the study are yet to take clear positions on it, thereby making it difficult to conclude on the feasibility of implementing this policy.
- Lack of stakeholder understanding of the policy concept, uncertainty about the mechanism for financing and the sustainability of the policy, and excessive politicization will be the main challenges to its successful implementation, and hence, these issues need to be addressed before its implementation.

Introduction

Universal coverage (UC) has globally been recognized as a high priority goal for every health care financing system (WHO 2005b; WHO 2010). It entails universal financial protection and universal access to needed health services (McIntyre and Kutzin 2011). Prepaid contributory systems such as taxes and insurance, which involve fund and risk pooling, are widely accepted as the key instruments for moving towards universal financial protection (WHO 2005b; McIntyre *et al*. 2008). Few countries, mostly those with large formal sectors, have been able to achieve universal financial protection through direct contributory health insurance systems (Carrin and James 2004; WHO 2005a; Evans 2007; McIntyre 2007). A key challenge of contributory health insurance systems in low- and middle-income countries (LMICs) is how to extend coverage to those populations outside the formal sector (WHO 2005a; Hsiao 2007; McIntyre *et al*. 2008; Samson 2009).

Ghana, a lower-middle-income country, took a bold step towards universal financial protection in 2004 when, in an attempt to fulfil its 2000 election promise, the New Patriotic Party (NPP) government introduced a mandatory National Health Insurance Scheme (NHIS) to replace out-of-pocket payments for health care called the 'cash-and-carry' system (Government of Ghana 2003; Ministry of Health 2004). It was designed to cover both formal and informal sector workers concurrently through a combination of insurance premiums and taxes, but with exemptions for children, the aged and indigents (Ministry of Health 2004). The main sources of funds for the NHIS are: a National Health Insurance (NHI) levy, which is an additional 2.5% value-added tax (VAT); a monthly equivalent deduction of 2.5% of the payroll from each formal sector worker's contribution to the Social Security and National Insurance Trust (SSNIT) pension fund; interest from investments made by the scheme; an annual premium contribution from all informal sector workers and those formal sector workers who are not covered by the SSNIT pension scheme; and a registration fee paid by all NHIS subscribers to their respective District Mutual Health Insurance Schemes (DMHIS) with which they register. The premiums are supposed to be structured according to ability-to-pay (NHIA 2009), but due to difficulties in assessing the income levels of households outside the formal sector, a flat rate is charged by many DMHIS (McIntyre *et al*. 2008; Jehu-Appiah *et al*. 2010). Services are accessed via a valid NHIS membership identification card.

It is reported by Agyepong and Adjei (2008) and Rajkotia (2007) that all key stakeholders supported the NHI policy *idea*, but some [the National Democratic Congress (NDC)—then the main opposition party—and organized labour] opposed the policy process and certain aspects of its content. The Ministry of Health (MOH) (political), the then incumbent political party (New Patriotic Party, or NPP) and politically connected consultants were very strong proponents of the formulation of the NHIS. The position of the private sector was between neutral and proponents, while the position of civil servants of the MOH and donors was between neutral and opponents. The main opposition party (then NDC) and labour unions strongly opposed it (Rajkotia 2007). The opponents raised three main concerns: the NHI levy would increase the burden of taxes on Ghanaians; the SSNIT deductions could affect the sustainability of the pension scheme; and health facilities and personnel were not adequate to ensure equitable access to services under the system (Abbey 2003; Rajkotia 2007; Agyepong and Adjei 2008). However, the majority of the intended beneficiaries, especially those within the rural informal sector, had very little knowledge of what was going on with regard to the policy development (Agyepong and Adjei 2008).

Currently, the registered membership population is about 66% (NHIA 2010a; NHIA 2010c), though the population with valid NHIS cards is 50% (Ministry of Health 2010). The tax component (NHI levy) contributes almost 70% of the total funding to the NHIS, SSNIT deductions 23%, informal sector premiums only 5% and other income constitutes 2% of the total funds for the NHIS (Results for Development Institute and Adjei 2010). Studies show that many of those who are not yet covered under the NHIS are the poor and informal sector workers who have been reported to have problems affording the annual premium payment (Gyapong *et al*. 2007; Asante and Aikins 2008; Ansah *et al*. 2009; Ministry of Health 2009; Akazili 2010; Jehu-Appiah *et al*. 2011; Oxfam *et al*. 2011).

It is perhaps against the above background that in 2008, the NDC (then in opposition) in its election Manifesto promised to *''implement a Universal Health Insurance Scheme which will reflect the universal contribution of all Ghanaian residents to the Scheme. Our Universal Health Insurance Scheme will guarantee access to free health care in all public health institutions. It will be listed in the health insurance schedule, will not be district-specific and will allow for* ***one-time premium payment*** *for registration with the scheme . . .''* (NDC 2008: 68). Since coming to power in January 2009, the government has consistently indicated its commitment to implementing the one-time premium payment (OTPP) system, though there is currently no policy document in the public domain on it (Ministry of Health 2009; NHIA 2010b; NHIA 2010c).

The one-time premium has attracted considerable debate in the Ghanaian media as regards its feasibility. This study seeks to contribute to assessing the feasibility of formulating and implementing the policy by exploring the perceptions (understandings) of various stakeholders about the proposed policy and assessing their interest/concerns, potential positions, power relations and influences on the implementation of the proposed policy through a stakeholder analysis. The study also highlights the potential prospects and challenges for the formulation and/or implementation of the policy, and hence, its potential impact on extending NHI cover to all those outside the formal sector, thereby achieving universal coverage. Key lessons from this Ghanaian experience are provided.

Conceptual framework

In this paper, it is postulated that stakeholders' understanding of the policy issue affects what they perceive as its impact on them (stakeholders' interest), their interest influences their positions on the policy and drawing on the power they possess, stakeholders will seek to defend their interest by influencing the policy based on the nature of their position (see Figure 1). The interest of a stakeholder refers to the perception of the stakeholder about the likely impact of a policy on it, which could either be positive or negative (Thomas and Gilson 2004; Roberts *et al*. 2008), or the advantages and disadvantages for the stakeholder as a result of the implementation of the policy (Schmeer 2000). Stakeholders' position refers to their potential support for or opposition to the policy issue (Brugha and Varvasovszky 2000; Thomas and Gilson 2004), while stakeholders' power is their ability to influence a policy (Thomas and Gilson 2004) either at the level of policy formulation and/or implementation. This study is not a full policy analysis and hence the policy content, context and process have been de-emphasised in the conceptual framework.

Methods

The proposed OTPP was seen as a case of universal coverage reforms; thus, a case-study approach was adopted to allow for flexibility and a detailed exploration of the proposed OTPP policy (Yin 1994; Stake 1995; Bowling 2002). The data were gathered from three main sources to allow for triangulation as a way of improving upon the reliability of the study (Mack *et al*. 2005; Silverman 2006). These were: face-to-face key informant interviews, focus group discussions (FGDs) and a review of media reports (from 2008 to February 2011) and other relevant documents. The data were collected between November 2010 and February 2011 in Accra, the national capital, Akuapim South district, an urban district in the southern part of Ghana, and Kassena-Nankana West District, a relatively rural district in the northern part of Ghana. The key informant interviews were successfully administered to national-level policy actors such as:

- politicians of the ruling party: the chairman of the Parliamentary Select Committee on Health and a leading member of the NDC who is also a board member of the NHIA;
- opposition politicians: ranking member on health (NPP) and an opposition member of parliament;
- technocrats: staff of the Ghana Health Service;
- academics: lecturers and health researchers;
- labour unions: leaders of the Trade Union Congress (TUC) and Ghana Registered Nurses Association; and
- district-level front-line policy implementers: staff of DMHIS (a scheme manager, public relation officers and claims managers), and health workers (a medical assistant, nurses, pharmacists, hospital administrator and accountants).

The FGDs were conducted with NHIS (or potential) beneficiaries at the community level in the two districts. Stakeholders were selected through purposive and snowball sampling techniques due to the nature of the study and difficulty in easily identifying and getting access to the most

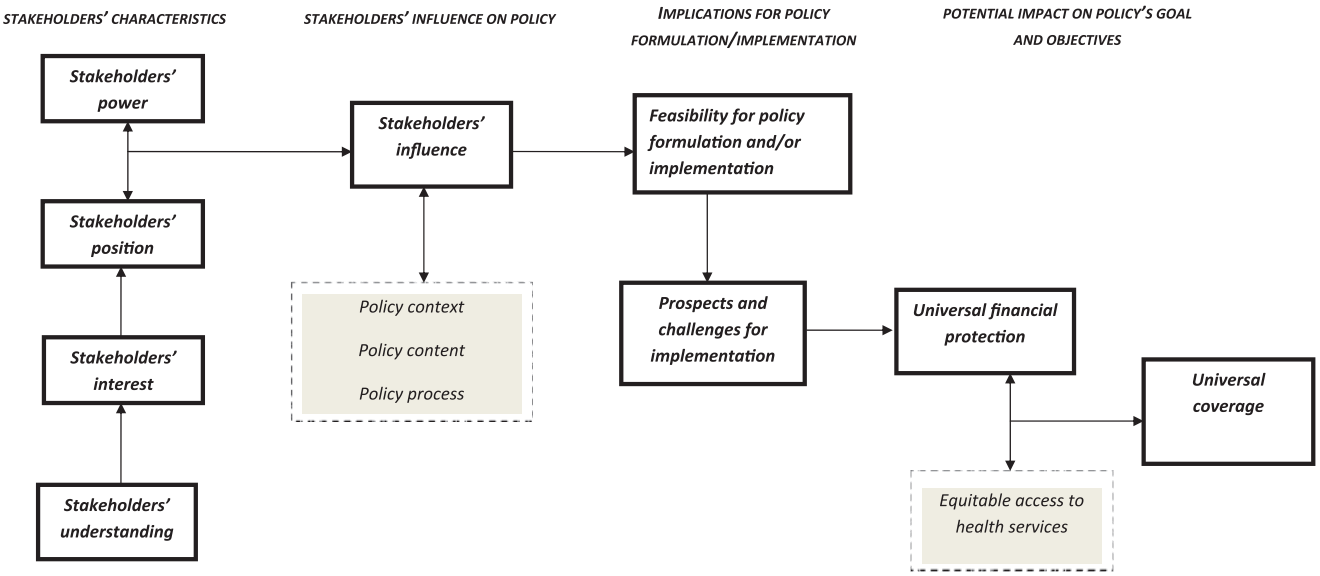

Figure 1 Conceptual framework for analysing the potential influence of stakeholders on the formulation/implementation of the proposed one-time premium payment (OTPP)

important stakeholders, respectively (Mack *et al*. 2005). However, because of the political sensitivity of the topic, some stakeholders [all staff of the ministries and the NHI Authority (NHIA) and one DMHIS manager] did not consent to the interviews and hence their opinions were not obtained. Other national-level policy actors such as former directors of the Ghana Health Service, staff of the Ghana Medical Association and sampled medical doctors were willing to participate but were too busy to make time for the interviews. Notwithstanding the above, the views of such policy actors as the ministers (and deputies) of health, former directors of health services, and civil society organizations (CSOs), among others that could not be obtained through interviews, were captured from media reports.

In all, 28 key informant interviews and six FGDs were carried out. Three FGDs—one for formal sector workers, one informal sector men and another informal sector women—were organized in each district. All FGD participants were above 18 years of age, some were registered members of the NHIS and others were not. The size of each FGD ranged from 9 to 11. Three separate interview guides (for policy-drivers, other national-level policy actors and front-line implementers, respectively), a FGD guide and a data extraction sheet, with questions/topics around stakeholders' understanding, interest, positions, power and potential ability to influence the proposed policy were used as instruments for data collection. Stakeholders were asked to give their own opinion and what they think will be the position/opinion of other stakeholders on the policy issue. All interviews and FGDs were tape recorded, transcribed and analysed using thematic analysis with major themes derived from the conceptual framework of the study. The results are presented in tables, diagrams, boxes and on a force-field analysis map. A draft report of the findings was sent to key respondents for review. The study was given ethical approval by the University of Cape Town Human Research Ethics Committee, Cape Town, South Africa (HREC REF: 464/2010), and the Ghana Health Service Ethical Review Committee, Accra, Ghana (GHS-ERC: 12/11/10).

Results

Stakeholders' awareness and understanding of OTPP policy

The results show that there is a very high level of stakeholder awareness on the proposed OTPP policy. The 2008 NDC manifesto and the electioneering campaigns, public statements by politicians and key staff of the NHIA, and radio discussions were reported as the main sources of information on the OTPP. The respondents in the urban district were more aware of the policy issue than those in the rural area. This could be due to the intense political activities and better access to modern communication networks such as radio broadcasting in urban areas.

There was a lot of confusion in stakeholders' understanding of the proposed policy. This confusion was more intense among potential beneficiaries at the community level. Though almost all stakeholders reported not having a clear understanding of the proposed policy, a range of possible meanings as illustrated in Figure 2 were revealed from the explanations stakeholders gave on what they anticipate it to be.

Though the manifesto did not clearly state whether the OTPP entails a single life-time payment [either a token registration payment or a payment to cover the net present value (NPV) of life-time health care costs] or periodic payments, what is often captured in the press and was reported by all the national-level policy actors, many front-line policy implementers and some potential beneficiaries is that of a once-off life-time payment. Only a few health workers in the rural district and some potential beneficiaries felt it could entail paying every 5 years. A majority of those who reported the 5-year cycles thought the new national NHIS identity card system, which is valid for 5 years but renewable every year, was the same as the proposed OTPP. Others were aware of the difference but still argued as follows:

> *"I don't understand the whole idea of the one-time. If you pay once and not pay again, then what will they use to buy drugs for us since we would not pay again? My understanding is that you pay again in 5 years time otherwise they won't get money to buy drugs*

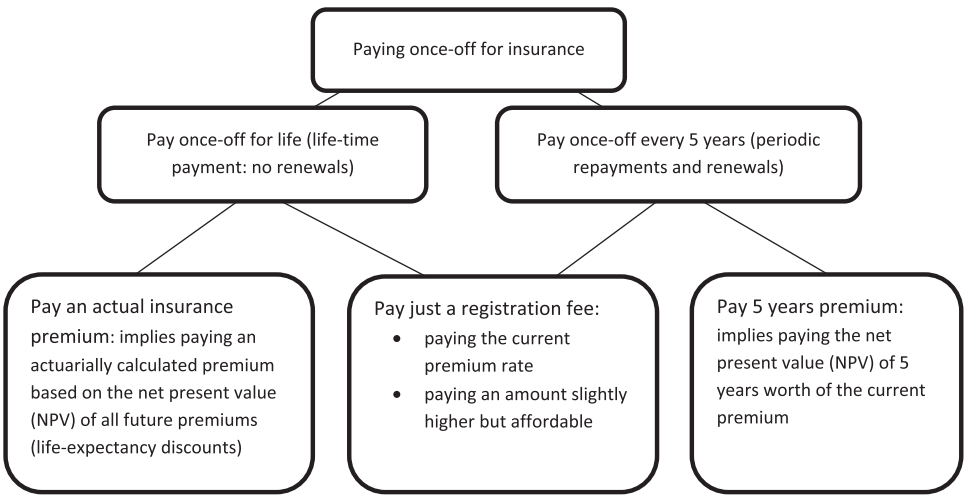

Figure 2 Different interpretations of the meaning of the proposed one-time premium payment (OTPP) based on stakeholders' understanding

Box 1 Illustrations of forms of life-time one-time premium payment based on stakeholders' perceptions

Paying just a registration fee	Paying an actual insurance premium
A complete removal of informal sector premiums.	Means premium payment will be maintained but paid for once to cover entire life time.
Minimal (nominal) initial payment from the informal sector as a registration fee.	Implies substantial single premium payment.
Health care in all accredited health facilities becomes free as existed in the 1960s.	Those who can pay the accumulated amount will be covered and the rest will have to continue with the cash-and-carry system.
No longer an insurance scheme but a publicly funded system (tax-based system).	The system will continue to operate as a life-time premium based insurance scheme.
Government will have to raise additional funding elsewhere for the running of the National Health Insurance Scheme.	Premiums will be relied upon for the running of the scheme.
The role of the National Health Insurance Authority (NHIA) becomes that of a third party payer.	The NHIA maintains it current role.

to treat us or the government will buy the drugs for us free?'' (Woman, FGD, rural)

As a form of life-time payment, Box 1 illustrates the understandings of stakeholders on what the OTPP system may look like.

The notion of paying the NPV of all future premiums was held mainly by opposition politicians, technocrats and some academics. Politicians of the ruling party, CSOs, most front-line implementers and potential beneficiaries expect that as a campaign promise, the OTPP will involve low payments (paying just a once-off registration fee). Though the manifesto stated that the OTPP will provide free health care to all residents, neither the manifesto nor the policy makers have clearly indicated how it will be financed. The policy idea also seems to put an emphasis on an insurance premium as it is called a one-time 'premium' payment. There are, therefore, currently a lot of uncertainties with regard to how it will be financed. This confusion is compounded by the recent statement by the Chief Executive Officer of the NHIA that they are considering running a parallel system of OTPP alongside annual premiums and individuals will be allowed to choose between these options (Gadugah 2011). The technocrats, academics and opposition politicians who participated in the study were therefore of the opinion that even the policy drivers are confused, or at least have different views, about the policy concept and argue that it is the name 'one-time premium' that makes the policy issue unclear.

''From what the government is saying, the meaning is not clear but from my personal understanding, one-time premium payment is really not insurance, if it is just about paying a registration fee then that becomes like a National Health Service like akin to the British, but if it is about paying the premium one-time, then it means that they would have done the actuarial studies to be able to calculate how much you are supposed to pay till you die.'' (Opposition politician)

''I don't understand it . . . it is a political nonsense. It doesn't conform to any health insurance, if it is a tax-based system, I would understand it but not under the National Health Insurance System.'' (Academic)

Stakeholders' interest and potential positions on the proposed OTPP policy

Stakeholders' interest and potential positions varied in relation to the two main meanings of the OTPP that were derived from their understanding of the policy issue.

Box 2 Stakeholders' reasons for their potential non-acceptance of a one-time premium payment rate that is significantly higher than the current premium rate

It will be unaffordable to most Ghanaians, reduce the number of people on insurance, and make the NHIS pro-rich and inequitable.

The electorate will feel deceived since they were promised free health care.

It will be catastrophic and further impoverish many potential beneficiaries.

It involves high risk as potential beneficiaries feel they may lose a lot if one pays and suddenly dies or a different government comes to change it.

It is strange in insurance policy and not practiced anywhere in the world.

Paying a huge amount is not a guarantee that the quality of services received from providers will be improved.

The amount that will be generated from the premiums alone will not be enough to run the scheme without subsidies from taxes.

The NHIS have no capacity to efficiently manage the money over time.

OTPP as paying the net present value of all future premiums as a single payment

Stakeholders tended to have similar interests or concerns and positions on this option. They generally felt this option would be unaffordable for many Ghanaians. It was clear that there is unlikely to be any significant stakeholder support for an OTPP if it results in amounts (premiums) that are significantly higher than the current premium. The reasons given by stakeholders for their potential non-support for an OTPP in this form are illustrated in Box 2.

It is important to note that since this option was regarded by stakeholders as the least feasible option, the rest of the analysis in this section is based on the interpretation that the OTPP involves low payments.

OTPP as paying just a registration fee (low payments)

In relation to this interpretation of the policy, stakeholders showed varied interests in the OTPP. The positive issues that stakeholders raised related to its potential impact on population coverage and equity in access to health care. What stakeholders had doubts about was how it would be financed, sustained and operated efficiently. In general, those stakeholders, such as the opposition politicians, technocrats, accredited private pharmacists, the NHIS premium collectors and a few academics and formal sector workers, who had negative concerns about it were more likely to be opponents, those (politicians of the ruling political party, CSOs and informal sector workers) who had positive views proponents, and those (labour unions, most academics and formal sector workers, health workers and DMHIS staff) who were not certain about its possible impact had conditional positions or were non-mobilized, as illustrated in Table 1 and the force-field analysis presented in the next section.

Table 1 Overall perceived impact of the one-time premium payment (OTPP) on stakeholders and their potential position on the policy (if amount is low)

Stakeholder	Overall perceived impact (interest)	Potential position	Key interest/concerns of stakeholders motivating stakeholder's overall perceived impact of policy and their potential positions
Politicians of the ruling party	Strongly positive	Very high support	They are the originators, initiators and drivers of the policy issue and implementing it will help them fulfil their campaign promise and make the NHIS more equitable and pro-poor.
Opposition political parties	Strongly negative	Very high opposition	Feel it is politically motivated, strange in insurance parlance and will only lead to an increase in taxes and the collapse of the NHIS because it will be economically unsustainable since the 1960s tax-funded public health care collapsed.
Technocrats	Not direct Slightly negative	Neutral – opponents	A few clearly maintain the civil service code of conduct of neutrality but a clear majority are opponents because they are concerned about its feasibility, efficiency and sustainability.
Academics	Not direct	Opponents and non-mobilized	A few are opponents because they feel the concept is strange in insurance policy parlance and may be unsustainable, but a clear majority are non-mobilized because they feel, depending on how it is designed, it can bring equity in health care financing.
Labour unions	Not direct/uncertain	Non-mobilized	They were not sure if it can be sustained and operated efficiently without increasing the burden of indirect taxes.
Civil society organizations	Strongly positive	High support	It will relieve the poor of the financial burden of health care and promote equity in access to health care under the NHIS.
Staff of DMHIS (permanent)	Uncertain	Non-mobilized	They all feel it will increase NHIS coverage and may not necessarily affect the running of DMHIS if additional revenue can be mobilized to support it, but they are also not sure of how it will be financed and whether there will be prompt transfer of centrally pooled funds to the scheme, and a few were also concerned about their job security if the NHIS does not survive under an OTPP system.
Premium collectors	Strongly negative	Very high opposition	The premium collectors feel they will lose their jobs when renewal of premiums is taken away.
Health workers (clinical)	Slightly positive	Support	They all reported some support for the OTPP because it will enhance the welfare of their clients, but their support may not be very strong because it may increase their workload and occupational stress.
Health workers (administrative)	Not direct/uncertain	Non-mobilized	They are not sure of its potential impact on claims payment, and hence, internally generated funds.
Private pharmacist	Negative	Opponent	Opponents because it may collapse their business or delay claims payment, but their opposition may not be very strong because they are accredited to the NHIS and they also stand to benefit in terms of claims payment if the system works very well.
(SSNIT contributors)-teachers	Not direct/uncertain	Highly divided	Some may support it because it will relieve them of annual payments for their relatives; a clear majority are non-mobilized because they are not sure of its effect on tax burden; but others are opponents because they feel their contributions will continue to be deducted while those in the informal sector will not be paying.
Informal sector premium contributors	Strongly positive	High support	It will offer them unlimited financial access to health care and relieve them of the physical and psychological stress associated with yearly renewal of payments, but their support may not be extremely high because of fears that it can lead to poor quality of care and they also do not trust its continuation by subsequent governments because of the excessive politicization of it.

Box 3 contains key quotations from stakeholders' responses that illustrate their interest and potential positions on the OTPP as captured in Table 1.

Stakeholders' power and potential influence over OTPP

Assessment and mapping of stakeholders' power

An assessment of the power of stakeholders in relation to their ability to influence the formulation, implementation and/or overall success of the OTPP is illustrated in Table 2. The assessment was based on information gathered from stakeholders' opinions and secondary data from published studies (Rajkotia 2007; Agyepong and Adjei 2008). A mapping of the overall estimated power of each category of stakeholder in relation to their positions, to give an indication of their potential influence on the policy, is presented in the force-field analysis (Figure 3). This is done from the perspective that the OTPP will not translate into paying amounts that are significantly higher than the current premium. It must be noted that, in general, national-level policy actors have greater potential power and influence over the formulation, front-line implementers over the implementation and potential beneficiaries over the success and survival of the policy.

Box 3 Key quotations from stakeholders' responses that illustrate their interest and potential position on one-time premium payment

''In as much as my re-imbursement will come regularly, I don't think it will affect my work.'' (Administrator, health facility)

''For us we do not think it is going to impact directly on us because we don't go out there to collect the money from the clients. We pick it from the insurance authority, so long as they have done their mathematics and they know that it is workable, we will always take our money from them. We don't crack our heads about how you want to raise the money, we take it.'' (Accountant, health facility)

''It is going to close down community pharmacies because doctors and nurses are saying that they must generate their internal fund (IGF) to support the health sector, and because pharmacists are not prescribers and since every hospital has its own pharmacy, the clinicians would prescribe drugs that can be obtained from the public pharmacies and since with one-time premium many people may be under insurance, the business of community pharmacists will collapse.'' (Private pharmacist, urban)

''We give a condition and we are not strongly against it, we only raise concerns about whether it will be sustainable. If it will be sustainable and we have means of ensuring that we don't bother Ghanaians with extra indirect taxes then of course we are in for it.'' (Trade Union Congress)

''Nurses need to have a clear understanding of the policy before taking a position on it. We are not sure whether it will work or not but if it will work we will support it.'' (Nurses Association)

Description of potential influence of stakeholders

From the force-field analysis, the party in government (politicians) is the main proponent of the OTPP and possesses very high power. It has political and constitutional legitimacy to initiate the policy, a parliamentary majority to secure parliamentary approval, and control over the economic resources of the state needed for policy implementation. It may be limited by a lack of technical knowledge to design and enforce its implementation. It will therefore have to directly involve technocrats who possess the technical expertise required for the design of the policy. These technocrats are, however, opponents of the policy issue, but their influence may not be visible because of limitations imposed by the civil service code of conduct. They can still covertly influence the content of the policy. Hence, the policy drivers may have to act cautiously when involving technocrats in the design of the policy.

If the policy makers choose to act in the interest of informal sector workers, who constitute the majority of the Ghanaian voters, by setting a nominal amount for the OTPP, they may obtain widespread public support and the support of CSOs for the policy. By virtue of the fact that this policy issue is a political initiative and has been highly politicized, it will be the voting power of the electorate and their acceptance of it that will determine its ultimate survival. The informal sector, therefore, possesses a potentially very high level of power in relation to the survival and success of the policy, since informal sector workers constitute the largest population of voters in Ghana and the direct beneficiaries of the OTPP. However, informal sector beneficiaries in reality have not had much influence over social policy formulation in Ghana in the past (e.g. with the establishment of the NHIS) (Agyepong and Adjei 2008). While this may have changed recently, their actual influence at the formulation stage of the policy is unlikely to be high. A possible opportunity exists for an alliance between informal sector beneficiaries and CSOs, as both may be supporters of the policy if the OTPP does not involve substantial payments. This alliance can give a voice to beneficiaries, increase their awareness level on the policy issue and be able to influence the policy through an informed exercise of their political franchise, and also strengthen the power level of CSOs, which is currently judged to be medium. The two can come together to strongly demand that government adheres to the social contract of providing free health care for all. Also, some CSOs have technical expertise, financial resources and international connections to support policy implementation. They can therefore rally behind the government through advocacy and research or use their international connections to attract international funds to support the implementation of the policy.

As potential supporters, health workers (clinical) may be a key source of education on the OTPP to potential beneficiaries and may also encourage their patients to register with the scheme. But since they are not strong proponents of the policy, if nothing is done to mitigate the increased workload and stress the policy will bring to them, they may behave rudely to insured clients (such as deliberately delaying seeing patients, shouting at them, going on long breaks etc.) (Erasmus and Gilson 2008). Local-level health workers generally possess professional knowledge and interact directly with patients and are therefore at the centre of the successful implementation of a policy. With their discretionary powers, they can undermine or

Table 2 Procedural assessment of stakeholders' power and ability to influence the formulation and/or implementation of the one-time premium payment (OTPP)

Source of power/ influence	Legal mandate to initiate the policy	Voting power/ influence over voters	Legislative power for policy approval	Control over state resources	Technical/ professional knowledge/ skills	Involvement in policy formulation/ NHIA Board	Ability to influence public opinion	Ability to organize members	Past influence over state policy (NHIS)	Control over policy implementation at the local level	Determine policy success and continuity[1]	Overall estimated potential level of power
Ruling party politicians	✓✓✓✓		✓✓✓	✓✓✓✓		✓✓✓✓	✓✓✓	✓✓✓	✓✓✓✓		✓✓✓	Very high
Opposition parties			✓✓				✓✓✓	✓✓✓	✓✓		✓✓	Medium/high
Technocrats					✓✓✓✓	✓✓✓			✓✓	✓	✓✓	Medium/high
Academics					✓✓✓✓		✓✓					Low/medium
Labour unions		✓✓				✓✓	✓✓✓	✓✓✓✓	✓✓✓			High
Civil society organizations		✓			✓✓		✓✓✓	✓✓	✓			medium
Staff of DMHIs (permanent)					✓✓✓		✓			✓✓✓✓	✓✓	Medium/high
Premium collectors										✓		Very low
Health workers (clinical)					✓✓✓✓		✓✓✓	✓✓✓	✓✓✓	✓✓✓✓	✓✓✓	High
Health workers (administrative)					✓✓✓✓		✓	✓✓✓	✓	✓✓✓	✓✓	High
Private pharmacists					✓✓✓✓		✓✓	✓✓	✓✓	✓✓✓	✓✓	High
Informal sector workers		✓✓✓✓					✓				✓✓✓✓	Very high[2]
SSNIT contributors		✓✓✓					✓✓	✓			✓	Higher medium

Notes: The number of ticks implies level of power and potential ability to influence the policy. ✓✓✓✓ implies very high; ✓✓✓ implies high; ✓✓ implies medium; ✓ implies low and no tick implies no recognized power (potential limitation on the ability of the stakeholder to influence the policy).

[1] Though the other sources of stakeholder power are self explanatory, ability to determine policy success and continuity refers to how a stakeholder's acceptance or rejection of the policy can directly affect policy sustainability and the realization of policy goals.

[2] Though informal sector workers do not have many ticks relative to some other stakeholders, their power mainly serves as a limitation to the power of other powerful stakeholders and is very key in the survival of the policy.

NHIA = National Health Insurance Authority; NHIS = National Health Insurance Scheme; DMHI = District Mutual Health Insurance Scheme; SSNIT = Social Security and National Insurance Trust.

STAKEHOLDERS' POSITION		Proponents						Opponents
		Very high support	<<<<		Non-mobilized/ conditional/ neutral	>>>>		Very high opposition
POTENTIAL STAKEHOLDERS' POWER	Very high ^ ^	Political party in government	Informal sector workers					
				Health workers (Clinical)	Labour unions Health workers – administrative Staff of DMHIS (permanent)	Technocrats	Accredited private pharmacist	Opposition parties
	Medium			(SSNIT contributors)	(SSNIT contributors) (majority)	(SSNIT contributors)		
			Civil society organizations		Academics (majority)	Academics (few)		
	^ ^ Very Low							Temporary staff of DMHIS (Premium collectors)

Figure 3 Force field analysis: the potential power and positions of stakeholders (if OTPP is not significantly higher than current premium rate)

facilitate the implementation of the policy by their behaviour towards insured clients (Hudson and Lowe 2009; Lipsky 2010), and hence they have high power to influence the policy.

Apart from technocrats, potential opposition to the proposed policy may come from the opposition political parties, accredited NHIS private pharmacists and the NHIS premium collectors. The premium collectors may have very little influence over the policy because their power is very low. As the main opponents, the opposition politicians may try to block its passage into a law and its subsequent implementation, but their power may be limited by their lack of a parliamentary majority, and they must also act in the interests of the electorate. However, as a vibrant opposition in parliament, they can influence public opinion, especially that of their supporters, against the policy and may strongly resist and delay its passage into law. The policy may finally be passed without parliamentary consensus. However, the opposition party may not continue with its implementation if they win the next election, which is due in 2012. With their potentially high power, if the NHIS accredited private pharmacists feel that the OTPP will result in delays in payment of their claims (if there is no secure funding for universal coverage under an OTPP), they may withdraw their accreditation with the NHIS and encourage insured clients to continue to buy drugs out-of-pocket from them, since they are located close to clients and interact regularly with them.

Stakeholders such as the labour unions, health workers, DMHIS staff, some academics and SSNIT contributors who have potentially medium to high power currently have no clear (certain) positions on the policy, and their influence may therefore be conditional on the content or design of the policy. If the labour unions perceive that the policy will not be sustainable without an increased burden of taxes, they may organize their members to demonstrate against it or form an alliance with other opponents to oppose it. Their power is high because they are well organized, have control over their members in formal sector employment and the Trade Union Congress (TUC) is represented on the NHIA board.

The permanent staff of the DMHIS can influence the implementation of the OTPP at the district level. If it is clearly proven that implementing it will not affect the sustainability of the DMHIS, a clear majority of them are likely to become strong proponents of it and hence will facilitate its implementation by giving effective client education on the policy, preventing fraud and ensuring that clients and providers are fully satisfied with the services received from them. However, if they perceive that its implementation will negatively affect the operations of the DMHIS, although they may not be able to openly oppose it because they are civil servants, they may undermine its implementation by deliberately delaying claims processing and payment and issuance of membership cards or by providing poor treatment to clients. Also, the influence of health workers (administrative) will depend on how promptly their claims will be paid under the OTPP. Health facility administrators have control over health facilities and hence can withdraw services provided to insured clients and demand out-of-pocket payments from clients if the scheme is unable to pay their claims.

Table 3 Stakeholders' perceived prospects and challenges for formulating and/or implementing one-time premium payment (OTPP) idea and hence universal coverage

Issue	Prospects	Challenges	Recommendation[1]
The policy idea	• It is in line with international calls for efforts to extend financial protection to the poor and informal sector workers.	• Lack of clarity on the policy concept has led to confusion among stakeholders and hence uncertain stakeholder positions on the policy issue.	• Policy-makers should be clear on the definition of the OTPP. If it is to be implemented there must be effective public education on the policy.
Sources of funds for implementation	• Can rely on proceeds from oil revenue. • Can increase National Health Insurance (NHI) levy, increase sin taxes on alcohol and tobacco, let corporate bodies pay NHI levy. • Seek support from donors. • Increase budgetary allocations to the National Health Insurance Scheme (NHIS).	• Oil revenue is not reliable because it is a finite resource and oil prices are not stable. • Introduction of new taxes may be resisted. • The donor community does not contribute much to the current NHIS, and hence, cannot be relied upon to support an OTPP. • Government has a limited ability to raise additional revenue.	• Government should be honest and tell Ghanaians that it will be tax-funded. Hence, fund it from (earmarked) indirect taxes.
Feasibility for implementation	• Premium constitutes a small proportion of NHIS revenue (about 5%) and hence removing it may not negatively affect the NHIS.	• It will be difficult to determine an affordable one-time premium. • There is inadequate technical and administrative capacity to run it. • Difficult to obtain the support of all stakeholders for the policy. • Poor identification system and database on population and disease burden makes it difficult to predict future health care cost.	• Results of feasibility studies on it should be released for public assessment. • The national identification exercise should be completed and birth and death registration improved before its implementation.
Impact on population coverage	• If the premium is affordable, more people will be enrolled into the NHIS.	• If the premium rate is high, it will reduce the number of people under NHIS.	• The OTPP must not be significantly higher than the current premium.
Impact on financial protection	• Can reduce the level of out-of-pocket payments (OOP) if many are able to enrol.	• If the number of people on insurance reduces, the cash-and-carry system may re-emerge or if there are delays in claims payment, providers will charge informal fees.	• Ensure that claims under the OTPP are paid promptly.
Impact on equity	• If it is tax-funded, it will improve progressivity in health care financing as informal sector premiums are currently regressive while VAT and direct taxes are progressive in Ghana (Akazili 2010); the poor will enrol and also benefit from the tax subsidy to the NHIS.	• If the initial payment is substantial, the NHIS will become more regressive and pro-rich in enrolment.	• Make the premium rate affordable and ensure that exemption from the OTPP for the poor and vulnerable is effectively implemented.

(continued)

Table 3 Continued

Issue	Prospects	Challenges	Recommendation[1]
Politics and political commitments	• Because it is a political campaign promise, the current government will be committed to its implementation.	• People do not trust that subsequent governments will be committed to its sustainability since it has been highly politicized.	• Its implementation should not be rushed. Depoliticize it. The public must be adequately informed about the policy design and informed public debates should be fostered.
Financial sustainability	• Generally doubted by stakeholders.	• It may be difficult to sustain in the event of economic difficulties since the Ghanaian population grows faster than the economy. • A tax-based system was previously introduced in Ghana but could not be sustained. • Actuarial studies reveal that even without the OTPP, the NHIS reserves will be depleted by 2016 (Adu-Gyamerah 2010).	• Carry out more independent studies to establish its long-term financially viability. • or • Maintain the current system and only identify the poor and indigents to make a one-time registration with continued payment for this group from tax revenue.
Impact on access to health care	• If affordable, it can increase financial access to health care and hence increase utilization of health services.	• Limited health facilities and personnel can lead to overcrowding, poor attitude of health personnel and a general poor quality of services. There will still be spatial inequities in access to health services since facilities are not evenly distributed.	• Before implementing the OTPP, more health personnel need to be trained and out-migration checked. Health facilities should also be expanded and more established in underserved areas.
Impact on efficiency in the use of health services	• Can check demand-side moral hazard since it can prevent people from seeking health care just because their cards are near expiring and hence they feel their money will go to waste if they do not use the card within the year.	• If tax-funded, it can lead to 'unnecessary use' on the demand side and supply-induced demand (SID) on the supply side, and a loss of ownership of the scheme by clients; clients may not value the services received under the OTPP.	• Capitation should be implemented to limit SID. • Proper primary care gate-keeping should be enforced under the OTPP. • Introduce periodic renewals with minimal payments to give a sense of ownership.

Note: [1]The recommendations are based on stakeholders' views. Not all are therefore necessarily in line with the personal opinions of the authors on the policy issue.

Academics and formal sector employees are the groups that appeared to be divided on the policy issue. While academics generally possess academic and technical knowledge, they are not organized and often not directly involved in the policy process, and hence, they usually have low influence over health care financing policy (Gilson *et al*. 2003; Rajkotia 2007; Agyepong and Adjei 2008). Notwithstanding this, the few academics who are currently clear opponents can influence public opinion against it through their writings or public discussions in the media. The majority who are currently non-mobilized may become supporters depending on how the policy is designed. Though formal sector workers are a more organized and educated population than informal sector premium contributors, their power may not be as high as that of the informal sector workers (as illustrated on the force-field analysis map) in determining the success of the policy since they may not be the direct target of the policy. If their leadership accepts the policy, they may not individually be able to influence it. However, they could be key sources of education on the policy at the local level (especially teachers).

Stakeholders' perceived prospects and challenges for the OTPP's formulation and/or implementation and hence universal coverage

Table 3 summarizes the opinions of stakeholders on the prospects and challenges for the formulation and/or implementation of the proposed OTPP and hence universal coverage, and the recommendations stakeholders made for consideration.

Discussion

It must be noted that the views captured in this study may not be the universal views of all stakeholders since the sample size is relatively small and, because of the political sensitivity of the topic, key staff of the NHIA and the Ministry of Health refused to give their opinion on the policy issue. Also, the opinions of an individual stakeholder may be different from the general opinion of the group to which s/he belongs. Furthermore, the debate on the OTPP is ongoing, so the opinions of stakeholders may change as fresh information on the policy issue is released to the public. The findings of this study may therefore not hold beyond the timeframe of the data collection period. Besides, because of the absence of a policy document at the time of the study, and since the policy issue has been ill-defined, the views captured in this study could have been misinformed. Also, since stakeholder analysis requires greater clarity on the focus of the analysis, a limitation of this study is that information on potential policy formulation and on implementation have been combined. These are, however, problems peculiar to prospective stakeholder analysis of this nature (Brugha and Varvasovszky 2000; Varavasovszky and Brugha 2000; Thomas and Gilson 2004). Despite the above limitations, there are important findings in relation to the study objectives and conceptual framework that can inform policy makers on the opinions of a wide range of stakeholders on the proposed OTPP, and lessons from this experience can inform future universal coverage reforms within Ghana and other LMICs.

One of the key findings of this study is that although stakeholders are highly aware of the proposed policy, there is currently lots of confusion in their understanding of it. This is perhaps because the policy issue was not made very clear in the NDC election manifesto and has not been well communicated subsequently to the public. Also, some stakeholders cannot understand how an insurance scheme will be run on a one-time premium basis.

This confusion in stakeholder understanding has led to several interpretations, and likely misinterpretations, of the meaning of the concept OTPP. The varied understandings of stakeholders offer some policy options for an OTPP. These include: an OTPP which involves paying an actual life-time premium calculated as the net present value of all future premiums; an OTPP based on a free health care model (tax-funded) requiring only nominal direct payments for registration; and an OTPP that takes the form of either the first or second options but renewable every 5 years. The third option is not a mutually exclusive policy option but it raises an issue for policy consideration as regards whether there is the need for periodic renewals of the insurance membership ID card within an OTPP. While some may argue that due to the absence of an effective national database and system of identification, periodic renewals may be necessary for updating the membership status of the NHIS under the OTPP, others may argue that if there are no regular payments of premiums, incurring an extra cost to renew the membership ID card may not be necessary.

The first two forms of stakeholder understandings had great influence over the interests and positions of various stakeholders on the policy issue. Stakeholders generally view the first option as *'a non-starter'* because it will be unaffordable and a departure from the campaign promise which put emphasis on access to free health care in all public facilities. Most stakeholders will, therefore, not support its implementation and it is unlikely that it will be feasible to implement the policy if it results in premiums that are significantly higher than current premium rates. This policy option may therefore have an overall negative impact on universal financial protection since it may shift many people out of insurance, increase out-of-pocket expenditure on health care and widen inequities in access to health care.

The second option was considered more realistic but stakeholders still had various concerns about a solely tax-funded OTPP. For the politicians, their interest seems to be more on how it will affect their political fortunes; for the technocrats, it is how it will affect sustainability and efficiency in the operation of the DMHIS; for academics, it is contrary to their understanding of the concept 'insurance' but it is favourable in terms of equity in health care financing; for frontline implementers, the concern is its effects on their occupational and/or professional stability; and for CSOs and beneficiaries, its effects on affordability of NHI membership and equity in access to health care. The positions of stakeholders on this option therefore vary according to what they perceive as its likely overall impact on their interest. Those stakeholders in the political stream seem to have clear perceptions of its impacts on their interest and hence have clearer positions on it. This perhaps is a reflection of the general politicization of the policy

issue. But, due to the uncertainties surrounding the policy issue, most powerful stakeholders included in the study were generally not sure of how it will be financed (what taxes or public funds would be used) and sustained. Hence, stakeholders such as labour unions and front-line implementers (the staff of the DMHIS and health workers), with high discretionary powers and whose behaviour can facilitate or undermine the successful implementation of the policy (Erasmus and Gilson 2008; Hudson and Lowe 2009; Lipsky 2010), have not yet taken a clear stance on it.

This makes it very difficult to conclude whether it will be feasible to implement the OTTP or not, even if it takes the form of a tax-funded system. It is, however, clear that the positions of most of those stakeholders are conditional on the amount that will be fixed as a one-time premium, the sources of funds to support it and evidence on its financial sustainability. These are therefore issues that should be given critical attention in the preparation of the policy as they will be key in determining the feasibility of a tax-funded OTPP and its overall prospects for achieving universal financial protection.

Stakeholder dynamics with regard to the OTPP (especially at the level of policy formulation) may therefore not differ so much from what was reported during the introduction of the NHIS, since political figures are still likely to have the greatest influence over the policy process (Howlett and Ramesh 2003; Rajkotia 2007; Agyepong and Adjei 2008). The main difference may be that potential beneficiaries appear to be more aware of the OTPP debate, based on the high level of awareness of FGD participants, than is reported for the debates with regard to the introduction of the NHIS (Agyepong and Adjei 2008), and are very interested in the policy issue because of its potential impact on the benefits they currently enjoy from the NHIS. Also, unlike the NHIS policy idea, which was widely accepted by stakeholders, some key stakeholders such as opposition politicians, technocrats and academics are strongly opposed to the OTPP policy idea/concept. Besides, the private sector, which supported the introduction of the NHIS, is likely to be opposed to the OTPP.

In general, the following implications can be drawn from the findings of this study for future universal coverage reforms in Ghana and other LMICs. Firstly, though political campaign promises offer windows of opportunity for moving towards universal coverage as happened in Thailand (Hanvoravongchai and Hsiao 2007; Jongudomsuk 2007; Tangcharoensathein *et al*. 2011), those campaign promises in themselves are potential sources of actor opposition to intended policy reforms, if the policy process is not managed well. A considerable part of the debate about the OTPP is perhaps due to the fact that it was a campaign promise that may bring political advantage to a particular political party if implemented or not. This rivalry between the two main political parties, NDC and NPP, was reported in 2003 with the introduction of the NHIS, which was also a campaign promise by the NPP (Agyepong and Adjei 2008). It may therefore not be surprising that, as the OTPP was also as a campaign promise by the NDC, members of the NPP may oppose it on political grounds. On the other hand, it also implies that the policy initiators may tend to consider the concerns of the opponents as mere political propaganda without critically looking at the substance of their arguments. The broader implication of this is a lack of consensus on the initiation of universal coverage reforms, which becomes a threat to the continued existence of political will for policy sustainability in the event of a change in government.

Also, the terminology of universal coverage reforms is a potential source of confusion about intended reforms. The name 'one-time premium' is central to the confusion on the policy issue. Reforms bearing unfamiliar titles like one-time premium usually do not capture clearly the objectives of the reform and hence lend themselves to misinterpretation. This confusion with concepts used in universal coverage reforms was also reported in South Africa, with the term NHI being used in their recently proposed health care financing reforms for a system that will be largely tax-funded (McIntyre 2010). This is because people usually understand the concept of insurance to mean a system that is operated on the basis of renewable premium payments (Kutzin 2007), and hence, any system that challenges this belief system of stakeholders will generally be resisted (Weible 2006). Other scholars, however, argue that insurance does not necessarily mean the existence of an insurance scheme that people make direct payments to, but as indicated by Gupta can refer to any financing arrangement that *''can help defer, delay, reduce or altogether avoid payment for health care incurred by individuals and households''* (Gupta 2007: 111). This implies that even a fully tax-funded or what is often called a 'free' health care system also serves as an instrument for achieving the insurance objective (Kutzin 2007).

In reality, if the OTPP is intended to be a single payment of net present value of all future premiums, it is a strange concept as there is no evidence of any country that has successfully implemented such a system. However, using tax revenue to fully fund the contributions of the informal sector is not strange as countries like Thailand have achieved universal coverage under such a system (Jongudomsuk 2007; Tangcharoensathien *et al*. 2007; Tangcharoensathein *et al*. 2011). Other countries such as Kyrgyzstan and Moldova have also adopted this strategy for universal coverage (Yang and Holst 2007; Kutzin *et al*. 2009). The South African NHI proposal is also similar to this option (McIntyre 2010). What is more important is that the tax-funded approach is currently viewed as the fastest way to achieve universal coverage because of the international recognition that enforcing premium contributions in the informal sector is often not effective (WHO 2005a; Samson 2009; WHO 2010). The fruitless debate about terminology should be ended by the government clearly stating its policy design intentions and the substance of the policy can then be debated.

The Ghanaian historical experience of health care financing has an influence on stakeholders' perceptions about the merits of the intended OTPP. Stakeholders were generally afraid that if the OTPP entails paying just a nominal registration fee, the country may be taken back to the free health care system of the 1960s, which some stakeholders' argued was abandoned because it could not be sustained (Ramachandra and Hsiao 2007; Agyepong *et al*. 2011). On the other hand, if the OTPP policy is not affordable then the 'cash-and-carry system' may become even more widespread in Ghana. The desire to do away with out-of-pocket payments in Ghana is seen as a major motivation for moving towards universal financial protection,

which is in line with international perspectives on the need for universal coverage (Evans 2007; Mathauer 2009; WHO 2010). This is because empirical evidence has shown that out-of-pocket payments negatively affect utilization of health services and have led to inequities in financial protection and the impoverishment of many households in countries where they exist (Asenso-Okyere *et al*. 1998; Waddington and Enyimayew 1989; McIntyre 2006; van Doorslaer *et al*. 2006; Xu *et al*. 2006; Lagarde and Palmer 2008). The claimed failure of tax-funded systems requires further debate as there is no documented empirical evidence that such systems really failed. Instead, they were abandoned in favour of user fees and health sector privatization as a conditionality of the World Bank and the International Monetary Fund (IMF) under a Structural Adjustment Programme (World Bank 1993; Gilson and Mill 1995; Sahn and Bernier 1995; Russell *et al*. 1999).

Conclusion

Though an OTPP potentially can lead to increases in NHIS coverage, especially within the informal sector, if it does not involve substantial initial direct payments, the feasibility of its implementation and sustainability will largely depend on how it is designed. Lack of stakeholder understanding of the policy concept and excessive politicization will be the main challenges to its implementation. It is therefore not possible to conclude whether it is currently feasible to implement the policy or not since many powerful stakeholders, whose views are captured in this study, are very uncertain about its impact and hence have not taken clear positions on it. The government and the policy drivers need to clearly communicate to stakeholders what form the OTPP will take to enable Ghanaians to engage in an informed debate on it. Also, the policy issue needs to be depoliticized and independent studies and public debates organized on it to examine its feasibility and long-term sustainability within the current Ghanaian economic context and historical experience of health care financing. The stakeholders' concerns captured in this study need to be critically considered before proceeding with further attempts to implement the policy. Those LMICs considering universal coverage reforms should be aware that terminology of reforms that does not directly reflect policy objectives can lead to confusion among stakeholders, and opposition to a policy may result from such misunderstandings. Successful health policies have clear objectives and explicit guidance on how these objectives will be met; it is only on this basis that stakeholder support for a policy issue can be built.

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None declared.

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