Original Article

Health Research

An Assessment of the Health Reform Policy Process In Ghana: The Case of the National Health Insurance Policy Process

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ABSTRACT [ENGLISH/ANGLAIS]

This study provides a critical assessment of the health reform policy process culminating in the implementation of the National Health Insurance Scheme (NHIS) in Ghana. It is opportune to examine the health reform policy process now because most policy makers and analysts have focused most of their attention on the technical design and content of the NHIS while inadequate attention has been paid to the process by which the technical design and content of the policy came into being. Using the generic and institutional policy process models as the main theoretical guide, the study provides a comprehensive, vivid and systematic understanding of the health reform policy process in Ghana bringing to light the historical and constitutional context of the policyThe study establishes that the NHIS was plagued by design flaws and questions of sustainability due to the fact that public participation in the policy decision-making process was very low. This led to many implementation problems including weak institutional capacities of the novel scheme. Nevertheless, 38 percent of the Ghanaian population was enrolled into the insurance programme within the first two years of implementation. In conclusion, the health reform policy process in Ghana provides broad lessons for public policy reform as it demonstrates the importance of politics in the formulation of public policy in general.

Keywords: Assessment, national health insurance, policy process models, policy analysis, generic, institutional, Ghana

RÉSUMÉ [FRANÇAIS/FRENCH]

Cette étude fournit une évaluation critique du processus de réforme de la politique de santé aboutissant à la mise en œuvre du National Health Insurance Scheme (SNIS) au Ghana. Il est opportun d'examiner le processus de réforme de la politique de santé maintenant, parce que la plupart des décideurs et des analystes se sont concentrés la plupart de leurs attention sur la conception technique et le contenu du SNIS alors attention insuffisante a été accordée au processus par lequel la conception technique et le contenu du la politique a vu le jour. En utilisant les modèles génériques et institutionnels processus politique comme le principal guide théorique, l'étude fournit une approche globale, la compréhension vivante et systématique du processus de réforme de la politique de santé au Ghana de mettre en lumière le contexte historique et constitutionnelle de l'étude établit que le Politique de l'NHIS a souffert par des défauts de conception et les questions de durabilité en raison du fait que la participation publique dans la politique de processus de décision a été très faible. Cela a conduit à la mise en œuvre de nombreux problèmes dont la faiblesse des capacités institutionnelles du système de roman. Néanmoins, 38 pour cent de la population ghanéenne a été inscrit dans le programme d'assurance dans les deux premières années de mise en œuvre. En conclusion, le processus de réforme politique de santé au Ghana fournit enseignements généraux pour la réforme des politiques publiques, car elle démontre l'importance du politique dans la formulation des politiques publiques en général.

Mots-clés: Évaluation, l'assurance santé nationale, les modèles de processus politique, l'analyse des politiques, génériques, institutionnel, le Ghana

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Accepted/Accepté: October, 2011

Full Citation: Alatinga KA. An Assessment of the Health Reform Policy Process In Ghana: The Case of the National Health Insurance Policy Process. World Journal of Young Researchers 2011;1(4):45-53.

INTRODUCTION

The Government of Ghana in 2001 embarked on a process of developing and implementing a set of health reforms that aimed to replace out-of-pocket fees at the point of service use in favour of a National Health Insurance Scheme (NHIS) as a more equitable and pro-poor health financing policy.

.This study provides a critical assessment of the health reform policy process culminating in the implementation of the NHIS in Ghana. My motivation to dissect the policy process stems from the fact that so far, policymakers and analysts have focused most of their attention on the technical design and content of the NHIS. Inadequate attention has been paid to the process by which the technical design and content came to being despite the fact that political scientists have over the years pointed out that the formation of successful public policy fundamentally depends on the political

environment as well as the checks and balances that hold this environment together. Walt and Gilson [1] also posit that the traditional focus on the content of policy neglects the other dimensions of process, actors and context which can make the difference between effective and ineffective policy choice and implementation [2]. In the words of Reich, 'economists and health policy analysts tend to provide detailed prescriptions on what should be done, but without clear instructions on how to do it and without good explanations of why things go wrong' [3]. Thus, the study provides a detailed analysis of the health reform policy process in Ghana in order to identify gaps and make recommendations.

MATERIALS AND METHODS

This paper is a descriptive case study of the health reform policy process in Ghana. It examines the history and policy context of National health insurance scheme in Ghana between 2001 and 2006. The study is located in context using the generic and institutional policy process models as the main theoretical guide to the analysis.

RESULTS

Theoretical Perspectives on Policy Process

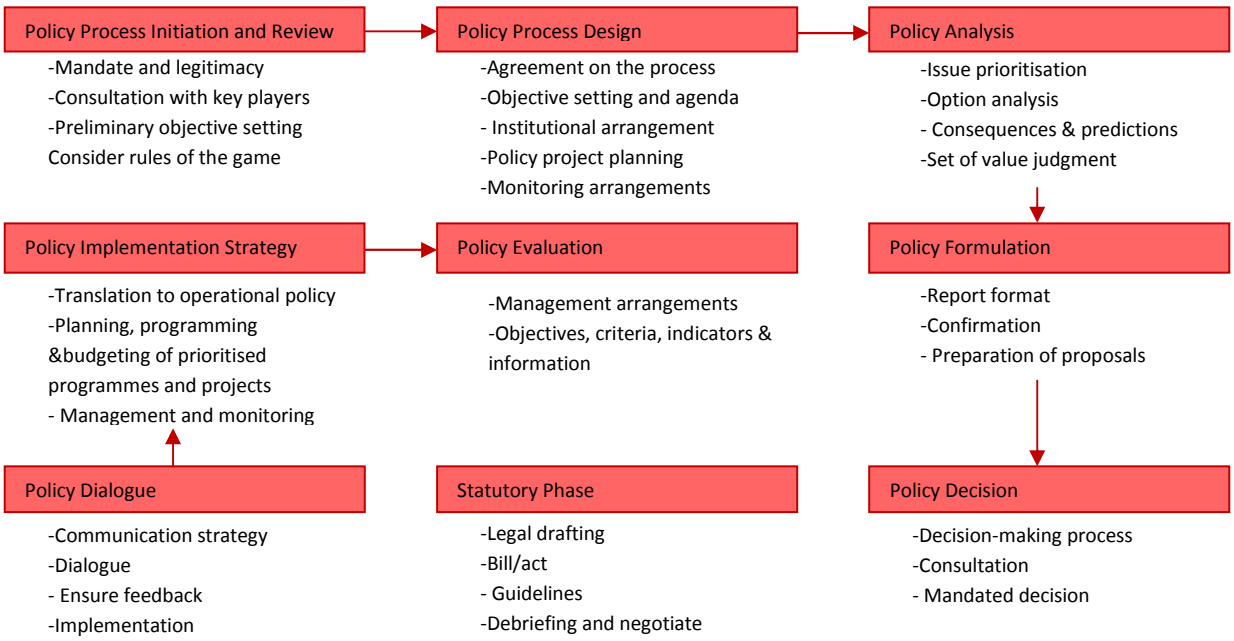
The policy-making process refers to the systematic and coherent phases or steps that are or should be followed in the development of public policy. Various scholars have found it useful to analyse the policy process in terms of a number of stages through which a policy issue may pass. These stages may include the initiation, design, analysis, formulation, dialogue and advocacy, implementation and evaluation among others. The generic and institutional policy process models are invoked upon in this paper as the main theoretical guide.

The generic policy process model is mainly a redefinition of existing process models consisting of several phases and principles. The generic policy process model is appropriate in analysing the health reform policy process in Ghana because it provides a comprehensive set of phases and proposes specific requirements and key policy process issues to be addressed during each phases. I therefore, find it appropriate and easy to use because its phases can be systematically followed and its principles applied. The advantage of this model is that it identifies the major stages and considerations of the various stages through which a policy is developed. A demerit of the model is that it does not provide details on all the activities that should be attended to during a particular stage such as policy analysis techniques during policy analysis or the usefulness of decision-making and negotiating models during policy adoption. Another short coming of the model is that it does not provide guidance on the use of institutional capacities during the policy phases and where the use of analytical teams, leadership quality and managerial effectiveness are important considerations [4].

These weaknesses of the generic process model will however, be complemented with the institutional policy process model because the short space of time within which the macro- level health reform policy was implemented in Ghana makes it imperative to look at the institutional capacity of the country to perform good quality policy analysis and to facilitate participatory policy processes. It is argued that essentially, institutional features determine the capacity of societal actors to influence policy as well as policymakers' ability to act autonomously [5]. Again, it is posited that the importance of the institutional dimension in the policy-making process is underscored by the fact that 'the effectiveness of the policy is highly dependent upon the interrelationship between functions, organisation and capacities' [6]. Therefore, a critical intercourse with both the generic policy process model and that of the institutional model will enhance our understanding of the health reform policy in its totality in Ghana. A rigorous analysis of the policy process through the lens of these models is important for two practical reasons. First, understanding the policy process can help technical analysts frame their intervention-specific recommendations in a way that is appropriate to the political environment. Reich argues that a narrow focus on the technical aspect of policy reform can leave technical analysts less effective throughout the reform process [7]. Second, a clear understanding of the policy process can help countries to better design strong governance structures that will protect the integrity of their policymaking process. This entails understanding what dynamics exist among stakeholders, where power is concentrated, and what structures and processes are in place to keep these powers from overtaking the policy process [8]. (Understanding the policy-making process in its entirety will allow us to identify at an early stage people or groups of people (Demons) who may sabotage the policy process. Aryee argues that Demons are a very small set of public officials and individuals who engage in corruption or rent seeking activities [9]. Therefore, a thorough understanding of the policy process and adequate participation of the public in these processes

will make such Demons accountable. Brinkerhoff, suggests two aspects of accountability— answerability and sanctions [1]. Actors need to be answerable in terms of provision of information on their actions and justification for their actions to someone or some groups who have available sanctions they are empowered to apply for illegal or inappropriate actions and behaviour uncovered through answerability. Based on the above exposition, it is my considered opinion that the Generic and the institutional policy process models are appropriate for enhancing our understanding of the health reform policy process in Ghana. Below is an illustration of the Generic policy process model.

Figure 1: Figure 1 shows the Generic Policy Process Model



Source: *Adopted from DeConin [4]*

The Case of the Health Insurance Policy Process in Ghana

History and Policy Context

The Republic of Ghana gained its independence from Britain, in 1957. It was the first country in Sub-Saharan Africa to emancipate itself from the shackles of colonial rule. Upon independence, Ghana implemented a system of free health care. However, economic deterioration in the mid 1960s led to a gradual phase-in of user charges. Economic deterioration also contributed to a string of military coups, of which the longest was that of the Provisional National Defence Council (PNDC) headed by Jerry John Rawlings in 1981. Jerry John Rawlings and his PNDC government were chastised by by both internal and external bodies to return the country to civilian and democratic rule. Consequently, the PNDC re-organised itself into a political party, the National Democratic Congress (NDC), and multiparty elections under the parliamentary system were held in 1992. The National Democratic Congress (NDC) contested and won the December 1992 election as well as the December 1996 multiparty elections. The NDC's second term in office was characterised by a continuous economic distress leading the country to implement a system of full cost recovery (known as cash-and-carry), in which users were charged the full procurement cost for drugs and a partial cost for most services [10]. The system of cash-and-carry resulted in dramatic reductions in utilisation of health services and service providers began forming their own insurance mechanisms to mitigate against non-payment [11]. By the late 1990s, user charges were recognised as a key national and political issue. Campaigning on the promise of affordable health care, a leading opposition party in Ghana, the New Patriotic Party (NPP), touted the issue of user fees, and promised the abolition of cash-and-carry as a key campaign promise during the 2000 elections. The NPP won the keenly contested elections in a runoff in December 2000. Thereafter, the party quickly

embarked on an aggressive path towards fulfilling its campaign promise.

Policy Initiation: Health Insurance Policy and Constitutional Context

The New Patriotic Party took over the reigns of government in January 2001 with strong political will and support to fulfil its campaign promise of eliminating user fees through a system of national health insurance. The 1992 constitution of Ghana guarantees every citizen the right to affordable and quality health care. Thus the NPP government saw itself with the mandate and legitimacy for the initiation of the health insurance policy. Consultations were done with major stakeholders including ministry of health, labour unions, donors, private sector, sections of civil society, insurance experts, and health planners. In August 2003, the government of Ghana passed National Health Insurance Act (Act 650) providing the legal framework for the National Health Insurance Scheme (NHIS).

Policy Design and Objective Setting

In January 2001, the NPP government appointed a Minister of Health whose top priority was to translate the campaign vision into reality. As a result, in March 2001 the Minister for Health inaugurated a seven member ministerial health financing task team of technical experts to develop broad framework and financing strategies for health insurance. The task team was chaired by the Director for Policy, Planning, Monitoring and Evaluation (PPME) in the Ministry of Health [12]. In April 2001, the task team presented its recommendations to the minister, who disagreed with the team both on political and ideological grounds. The minister then replaced the chair of the task team with close and trusted associates to develop new recommendations [13]. In June 2001, there was a Cabinet reshuffled and a new Minister of Health was appointed who was strongly committed to the success of the task team. Again, in August 2001, consultants with political ties were brought into the task team. The Core technical members of the team felt that the task team had been hijacked by political motives because there was no longer transparency in the whole design process and many of the team members resigned.

Policy Analysis

The policy analysis process started in 2002 with the consideration of different policy options that the insurance scheme should adopt. The Minister for Health was keen on a centralised single payer social health insurance scheme but the task team saw the creation of district-level Mutual Health Insurance Schemes (MHIS) in all districts as a viable policy option. Conflict developed between the Minister and the Chair of the task team over this and other issues, and the Chair disengaged from the process. The impasse was resolved by the introduction of a hybrid system that comprised a classical single payer scheme for the organised formal sector, and multiple payer semi-autonomous MHIS for the non-formal sector. Private commercial health insurance was also allowed for those who felt they could afford it and preferred it. The task team, together with the consultants, concluded that a community initiative could reach rural populations better than a central-only initiative and proposed the establishment of a centrally regulated district scheme in every district of Ghana. With this community-based initiative, the consultants developed an exemption policy option to exempt everyone under the age of 18 years, over 70 years and the indigent. They also proposed an annual premium payment of $8 for informal sector employees and a 2.5% deduction from the social security contributions of formal sector employees. The technical members of the team felt that actuarial studies needed to be conducted to estimate a sustainable premium. However, this figure resonated well with the political actors, as they believed that setting premiums any higher would be unpalatable to the general public. Sustainability, they felt, was an issue that could be dealt with later, after the insurance system had developed some legitimacy and permanence.

Policy Formulation

In order to ensure a speedy process that was free from the regular bureaucratic channels for intersectoral policy formulation, the NPP government formed and empowered a task team to formulate a national health insurance policy for Ghana. The policy formulation process began with the drafting of the health insurance policy document by the MOH. The draft policy was sent to Cabinet for review after which it was again sent to the Attorney General for review and confirmation. Rajkotia indicates that all consultants who were involved in the policy formulation were ordered to cease activities and have been removed from the process. He further asserts that the policy had three major criteria:

1. The policy had to result in the establishment of a national system that could quickly be scaled up to cover the majority of the population.

2. The policy had to be publicly perceived as an NPP initiative, not as a continuation of the previous government's efforts.
3. The policy had to be formulated and passed through Parliament before the next elections in 2004

Satisfied with the final version of the draft policy document, the minister of health in July 2003, placed the national health insurance bill before parliament under a certificate of urgency to be passed into law, one week before parliament was due to go on recess.

Policy Decision, Policy Dialogue, Statutory Phase

Having placed the bill before parliament, a one-week timetable was given for deliberation, review, vote and the passage of the bill into an act but very few people outside the policy elite group had seen the full text of the bill that finally appeared before parliament. Adverts were then placed in the national dailies requesting comments from the general public on the bill before parliament.

The leadership of organised labour groups convened a meeting in Accra, the national capital, studied the bill and submitted a formal resolution to parliament protesting aspects of the content of the bill and the rushed passage, and requesting a deferment of passage, deeper consultations and amendments. The minority in parliament also raised concerns about the inadequate time given for deliberation and review of the bill. In response to these concerns, the debate and passage of the bill was deferred and parliament went on recess.

In August 2003, parliament was recalled and the bill was once more laid before it. The protests of organised labour groups and the minority in parliament were ignored by the majority. The minority NDC therefore, refused to be part of the passage of the bill and walked out of parliament in protest. The majority NPP went ahead and passed the bill into an Act-the national health insurance Act, (Act 650) since they had the numbers to do so under the requirements of the 1992 constitution. The President of the Republic of Ghana then signed it on 5th September 2003 giving birth to ACT 650 and LI 1809, and Act 650 and LI 1809 gazette on 12th September 2003. Consequently, NHIS was formally launched in December 2004. Organised labour groups went on a street demonstration in protest at the passage of the bill into law in spite of their concerns. The acrimonious debates that erupted around the passage of the bill were widely covered by the media. However, most of the civil society engagement in the extensive media debates was in the larger urban areas, with higher literacy levels and a bigger formal sector) [13].

Policy Implementation

After the passage of Act 650, the MOH organised stakeholder meetings and set up task forces, with membership from technical actors in the health sector as well as the trusted political associates, to provide recommendations on implementation and to finalise the legislative instrument to accompany Act 650. In line with Act 650, MOH allocated $2.15 million for the rapid setting up of mutual health insurance schemes in all districts and managers were appointed to manage them with little regards for the institutional capacities of schemes. Each district was to be divided into Health Insurance Communities so that Health Insurance could be brought to the door step of all Ghanaians. A Health Insurance Committee was formed in each Health Insurance Community to oversee the collection of contributions and supervise their deposit in the District Health Insurance Fund.

The trusted political associates continued their role as implementation consultants in many of these districts. A National Health Insurance Council was set (NHIC) in July 2004 as an independent body that will monitor the operations of the district-level mutual health insurance schemes. The team also proposed that all Ghanaians pay a 2.5% Health Insurance Levy on selected goods and services to be put into a National Health Insurance Fund to provide direct subsidy to the district mutual health insurance schemes. Following the political promise to abolish user fees, the government implemented a generous benefit package under the National Health Insurance Scheme covering 95 percent of all illnesses in Ghana with a large exempt group without a careful analysis of the medium to long term financial viability and sustainability of the schemes.

Policy Monitoring and Evaluation

After barely less than two years of implementation, the National Health Insurance Scheme covered a significant proportion of the Ghanaian population. According to the National Health Insurance Council as of December 2006, 37.6 percent of the population had enrolled into the program since early 2005 [14]. Such increases in coverage have been unprecedented on the African continent. Many schemes however, reported that they were unable to issue ID cards to all of their members. Again, insurance fund managers claim that one of the biggest constraints

in their enrolment drives was the perception that enrolling in insurance means siding with the NPP.

Interestingly, after two years of implementation, there has been a clear rebalancing of the political landscape. All actors interviewed, even those who were once strong opponents of the policy, agree that the National Health Insurance Scheme is important for Ghana. Most importantly, interviews with the various actors revealed that there is a marked shift in the dialogue from political toward technical issues. Even those actors who felt that political issues were more important than technical design issues (such as sustainability and public cost) cited mostly technical issues when asked to list the top 10 most critical policy needs.

Along with this shift in thinking has come an unravelling of the close alliance between political actors and the private sector consultants. In October 2005, the National Health Insurance Council board unanimously voted to remove their executive director on alleged issues of mismanagement. With broad political support and a new wave of consensus building, in January 2006, an interagency oversight committee was formulated consisting of technical actors, many of whom were marginalised during the policy formulation stage to review key technical aspects of National Health Insurance Scheme design.

DISCUSSION

Findings on Policy Initiation and Review

The National Health Insurance policy initiation process was politically motivated and driven by political agenda. The Policy process was legitimate, mandated and appropriate within the political context. The process was however, over politicised, making political faithfuls and party loyalists to hijack the process.

Findings on Policy Design

The policy design process was marked by disagreements between members of the technical team and the minister of health on both political and ideological grounds leading to the resignation of some members of the task team who felt that the process was no longer transparent. In this regard, there was not a clear balance between technical realities and the political ideals. Indeed, technical and bureaucratic actors who want to effectively inform public policy need to understand political actors and create a relationship of mutual trust and respect between technical, bureaucratic and political actors without compromising scientific integrity. It is observed that

'. . . The relationship between research and policy making often involves a more fundamental relationship between researchers and policy makers. Increasingly, research evidence points to the importance of trust and ongoing commitment between parties when research is successfully translated into action' [12].

This relationship of mutual trust and respect was conspicuously missing in the policy design and objective setting process [12].

Findings on Policy Analysis and Formulation

Within the theoretical lens of the generic policy process model, the policy analysis and formulation stage was merely symbolic as many policy options were not considered due to political expediency. For instance, actuarial analysis to estimate a sustainable premium and to determine the long term viability and sustainability of the insurance scheme was discarded by the political actors who had their political motives high on the agenda. The policy formulation process was thus fast-tracked with a lot of short-cuts taken to ensure that the policy was formulated and passed through Parliament before the next elections in 2004. Consequently, the consultants who were involved in the policy formulation were fired from the process with the excuse that they were slowing down the formulation of an important national policy that needed to be formulated within the shortest possible time. One senior NPP official involved at the time is reported to have said that "the political leadership was deeply suspicious of the consultants' motives. Some questioned their party loyalty, while others questioned their political savvy" [13]. This amply demonstrates that the other stakeholders involved in the policy analysis and formulation processes were merely acting as 'rubber stamps' because their views were really not considered in the entire exercise, thus undermining the democratic nature of the policy process.

Findings on Policy Decision-Making

Based on the strong political will of the ruling government to get the health insurance policy implemented at all costs, little time (one week) was given to the statutory phase of the process. The consultative process was very limited as the views of the minority in parliament and those of organised labour were ignored. Participation in the policy decision-making process was

again limited because media publication and education about the policy was only limited to the urban towns with higher literate populations who could easily read the news papers. The rural poor for whom the policy is of crucial importance hardly knew what was happening. From practical experience, I was involved in a research work in 2006 funded by Grassroots Africa, a Non-governmental Organisation in Ghana to find out the perceptions of the rural people regarding the national health insurance policy in Northern Ghana. Surprisingly, about 60% of the interviewees indicated that they did not know anything about the national health insurance policy.

Furthermore, the limited time given for parliamentary deliberation on the bill and for consultation with other intersectoral agencies and departments made the process at this stage less transparent and democratic. In this manner, civil society will find it difficult to hold policy-makers accountable for policy failure as the full content of the white paper was not known publicly. It will therefore, be difficult to set benchmarks with which to judge the policy makers and measure their performance. It is against this background that public policy experts have proposed a variety of approaches to improve governance, most of which ultimately aim to create a system of checks and balances, promote greater civil society participation, improve transparency, and increase overall organisational capacity [22]. A lack of these checks and balances may impede the implementation of the policy in the long term.

Findings on Policy Implementation

With a burning desire to accomplish their campaign promise of abolishing user fees, the white paper on Health Insurance was implemented in December 2004 with the setting up of mutual health insurance schemes throughout the country with a very generous benefit package covering 95 percent of all illnesses in Ghana with a large exempt group. This generous benefit package and the annual premiums were implemented without prior actuarial studies and projections to determine the long term financial viability and sustainability of the schemes.

In addition, the institutional capacities of the districts to manage these novel schemes were down played. Managers with political affiliations to the ruling NPP government were mainly appointed to manage the schemes without prior training on health insurance and how insurance works generally. The schemes' managers simply lacked the technical ability and competence to manager the schemes. Not surprising then, in 2005, many schemes all over the country reported that they were unable to issue ID cards to all their members. It is against this background that the importance of the institutional policy process model which focuses on the institutional dimension in the policy-making process is underscored. Mutahaba et al opine that 'the effectiveness of the policy is highly dependent upon the interrelationship between functions, organisation and capacities' [23]. To this end, many of the implementation problems could have been avoided or at least minimised if the institutional arrangements and capacities of the schemes were taken into serious account by appointing managers with the requisite technical skills, undertaking actuarial studies and projections to ascertain the viability of the schemes and by providing adequate training for the support staff. Also, a thorough involvement of all stakeholders right from the policy initiation and review process could help curb implementation problems.

Findings on Policy Monitoring and Evaluation

Despite various dissenting views and fierce political exchanges between the ruling NPP government and the opposition NDC party regarding the health insurance policy, the policy ultimately offered financial protection to millions of people – 38 percent of the Ghanaian population was enrolled into the insurance program within the first two years of implementation. Politics is a natural part of any policy development process hence the adverse effects of over-politicisation can be reduced by carefully understanding the dynamics of the vertical, horizontal, and state-society networks, and building strong governance structures around these networks. It is the balancing of these dynamics that has resulted in consensus building between the major stakeholders in policy process, giving birth to the interagency committee to review key technical aspects of the policy design and formulation as a way of improving the National Health Insurance Scheme to ensure affordable and quality health care for the good of all Ghanaians

CONCLUSION

Generally, this analysis of the policy process of the Ghanaian NHIS provides broad lessons for public policy reform. First, this study demonstrates the importance of politics in the formulation of public policy.

The specific application of the generic and institutional policy process models elucidates our understanding of

the health reform policy process in Ghana by allowing us to identify gaps during the process. By systematically following the phases of the generic model, it can be seen that most of the phases were not dully followed. For instance, it is crystal clear that the policy-making process lacked transparency. To maintain electoral popularity, the NPP made a series of technical tradeoffs that undermined the fiscal health of the National Health Insurance Scheme. For example, there were no politically neutral, technical intermediary organisations that helped to guide the policy debate and disseminate objective information to the citizenry especially those at the rural areas. Thus, it is important for countries to carefully identify and empower information channels, so that more actors can be enfranchised in the policy process.

Within the lens of the institutional policy process model, it is evident that the implementation of the policy was fraught with a myriad of institutional inadequacies. Despite the fact that Health Insurance was meant to be community based, inadequate institutional arrangements were actually put in place to facilitate the participation of the communities in the implementation and management of the schemes.

RECOMMENDATION

Based on the above discussion and within the frameworks of the generic and institutional policy process models, issues of technical sustainability of the policy were compromised with political expediency. It is recommended that a macro level policy like a health insurance policy should be thoroughly and dispassionately deliberated and discussed in parliament for a genuine consensus to be reached before being passed into law. In the development of macro level public policies, a proper balance of power can help attain a desired policy goal as demonstrated in the Ghanaian case where the various actors involved in the policy process had to bury their initial political differences and concentrate on addressing key technical gaps in the policy for the overall benefit of the country. This scenario highlights the fact that peace can be made out of conflict.

Furthermore, there must be an unequivocal strategy for the dissemination of information on the policy and an opportunity for all relevant stakeholders to fully and fairly participate in all the stages of the policy process so as to allow policy makers to be held accountable for their actions and inactions

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ACKNOWLEDGEMENT / SOURCE OF SUPPORT
Nil

CONFLICT OF INTEREST
No conflict of interest was declared by authors.