

RESEARCH BRIEFING  
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MAKING ALL  
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WHEN DOES THE STATE LISTEN?

A GRAND CHALLENGE  
FOR DEVELOPMENT



**How does government  
responsiveness come about?  
The politics of accountability  
in Ghana's National Health  
Insurance Scheme**

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## Further reading

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Cassim, A. (2016) *What happens to policy when policy champions move on? The case of welfare in South Africa*, Brighton: IDS

Katera, L. (2016) *Why is it so hard for non-state actors to be heard? Inside Tanzania's education policies*, Brighton: IDS

Loureiro, M; Cassim, A; Darko, T; Katera, L; and Salome, N. (2016) 'When Does the State Listen?' *IDS Bulletin Vol 47 No. 1: 'Opening Governance' 55-68*, Brighton: IDS, <http://opendocs.ids.ac.uk/opendocs/handle/123456789/7690#.Vx5yMMdRXn2>

Salome, N. (2016) *Has Kenya's ICT revolution triggered more citizen participation?*, Brighton: IDS

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## When does the state listen?

Communication between the state and citizens is an essential element for an equal and just society. Growing social inequalities, lack of proper public services, and denial of basic human rights all act to widen existing communication gaps. Key to bridging these gaps is ensuring not only that citizen voices are heard, but also that states have the capacity and incentive to listen and respond. As much of the literature on accountability focuses on citizen voices, a group of researchers from Ghana, Kenya, South Africa and Tanzania – in collaboration with the Institute of Development Studies – decided to look at state responsiveness. Trying to find instances of accountable governance, when the state is responsive to citizen voice, this team of researchers interviewed key actors across the state–citizen spectrum who had been involved in landmark social justice policy processes during major junctures of democratisation in

these four countries. Calling their research project *When Does the State Listen?* (Loureiro et al. 2016), they examined when and how the state listened, and to which actors; and why, at times, it chose not to listen.

The researchers identified three types of juncture when the state listened: (1) 'hearing' moments, when the state engaged with citizen voices but did not change the way it acted; (2) 'consultation' moments, when it engaged with citizen voices through two-way dialogue, resulting in one-sided action; and (3) 'concertation' moments, when coalitions between reform-minded officials and politicians and organised citizen voices engaged in two-way dialogue and action for accountable governance. They witnessed concertation moments when state and non-state actors shared a sense of urgency and a common goal, despite different understandings of accountable governance.



Midwives and nurses at a hospital in Accra, Ghana.

ABBIE TRAYLER-SMITH/PANOS PICTURES

But they also found that states often reverted to consulting or hearing, as concertation moments are arduous and temporary, and part of larger, ever-changing policy processes.

In this brief, Terence Darko looks at the development of Ghana's National Health Insurance Scheme (NHIS) and examines the extent to which urgency contributed to an increase in political accountability. He notices that during democratic consolidation in Ghana, when the government had an urgent goal without a clearly defined plan, it was more open to engagement with non-state actors to consult and even concert. As the policy progressed and the government changed, the state felt less of a need to concert but still consulted with non-state actors, as the country's free, dynamic and relatively autonomous political society kept on pushing for its voice to be heard.

## Introduction

The creation of Ghana's NHIS was a major health policy reform. Its implementation was influenced by both internal and external factors. Internally, the government's need for a national health insurance policy was influenced by democratic developments, which were evident in the successful transition of governments following a peaceful presidential and parliamentary election in 2000 (Morrison 2004; Cheeseman 2010), and a massive media campaign against the ill effects of existing structures of healthcare for the masses. Externally, the ratification of the Millennium Development Goals, coupled with the adoption of a Poverty Reduction Strategy Paper to access debt relief during the pre-policy and design phase, also influenced the government's decision to enact a national health insurance policy.

By the early 2000s, it was becoming obvious that democratic development, coupled with pressure from Ghana's donors, was bringing about a political transformation in the relationship between the state and citizens. These developments provided a basis for an improvement in the process of political accountability, and were clearly played out in the policy design phase that led to the adoption of the NHIS in Ghana.

In the application of accountability mechanisms in the health sector, Brinkerhoff (2004) highlights three types of accountability: financial, performance and political. This briefing focuses on political accountability and establishes its connection with the policy processes of Ghana's health insurance scheme. Political accountability refers to the responsibility or obligation of government officials to act in the best interest of the people or face the consequences. The political process and elections are the main avenues for this type of accountability, but it also plays out in the policy process (Brinkerhoff 2004). Regarding the making of a health policy, political accountability also relates to the government's stewardship over the entire healthcare system. This can be understood as a function of a government that is responsible for the welfare of its citizens, and also concerned about the trust and legitimacy of governance as perceived by the citizenry (Saltman and Ferroussier-Davies 2000).

One vital feature of the government's stewardship discussed in this briefing is how a multitude of state and non-state actors had a voice in the design, implementation and revision processes of the NHIS. The case of the NHIS is used to track state responsiveness to citizen demands for access to public

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services. The research sought to establish the extent to which citizens cooperated with the government throughout the design, implementation and revision stages of the scheme, and how this cooperation offered citizens an opportunity to hold the government accountable. This briefing shows that the health insurance policy process, to a great extent, offered political accountability to citizens because state and non-state actors within the health sector shared the same urgency and a common goal, even if they did not agree on the course of action to reach that goal. This case shows not only that the government responded directly to citizens' health concerns in order to stay in power democratically, but also that beyond elections, the government listened to the demands of non-state actors for the accountability of the scheme.

### **Ghana's political context and the structure of the health system**

Since 1992 Ghana has been under constitutional rule, with democratic governance that sanctions checks and balances through the three arms of government. Under the 1992 constitution, an institutional framework for popular participation and programmes for a more direct interface between government

and people were created in the areas of economic planning and local government-level development and democracy, with District Assemblies providing administrative leadership. The District Assemblies have become a key political mechanism for ensuring popular participation in decision-making at the local level (Government of Ghana 1992; Government of Ghana 1994; Government of Ghana 2003).

Beyond participation, the Ghanaian constitution also contains provisions for transparency and accountability mechanisms. For instance, in ensuring financial discipline and effective management of resources and economic governance to meet the needs of citizenry, it provides for institutions that exercise stringent control on the use of public resources. The political ambience further promotes civil liberties, and government cooperation with civil society organisations (CSOs) in national policy design and implementation via sector working groups. The country runs a presidential government with an executive president elected for a term between four and eight years, complemented by the legislature, judiciary, and a vibrant media and civil society (Arthur 2010). Although the constitution permits a multiparty political system, elections over the years have been dominated by two political parties: the National Democratic Congress

(NDC) and the New Patriotic Party (NPP) (Gyimah-Boadi 2008). These two parties currently control the 275 parliamentary seats of the legislature.

Ghana has a multi-level and integrated health system distributed throughout the country. It comprises community-based health planning and services zones; health centres; district, regional and teaching hospitals; private health providers (mainly the Christian Health Association of Ghana, CHAG), and health-related non-governmental organisations (NGOs). The Ministry of Health (MoH) oversees this decentralised health system and other governmental and regulatory entities. There is also a vibrant private sector offering both hospital and non-hospital care in several districts, especially in urban areas; this sector provides more than half the services in every category of the health sector (Sealy, Makinen and Bitran 2010).

### **Pre-design phase of the National Health Insurance Scheme (1990–2000)**

Health insurance as a policy option became necessary when the ill effects of paying for health services at the point of delivery (also known as 'cash and carry') reached a tipping point in Ghana. There were specific instances of the mothers of new-born babies and patients in government hospitals being detained for not having the money to pay medical bills (Nyonator and Kutzin 1999; Atuguba 2013). Between 1995 and 2000, these situations on the health front rendered the ruling NDC government unpopular (Adedeji 2001). Although in 1999 the government, in partnership with the Ghana Health Care Company, had attempted to pilot a tax-funded health insurance scheme,

not a single person was registered. At the same time, however, several community-based mutual health insurance schemes – implemented by different actors including the St Theresa's Catholic Mission Hospital at Nkoranza, the bilateral donors Danida (the Danish International Development Agency) and the United States Agency for International Development (USAID), and faith-based organisations and other NGOs – were working successfully.

Against this background, some bureaucrats from the MoH and civil society actors had been involved in feasibility studies and health insurance pilots in some districts (interview with Irene Agyepong, member of the Ministerial Task Force on Health Insurance (2001–02), 7 July 2015). Following several public debates, and amplified by the media, a national health insurance scheme became a key issue during the 2000 presidential and parliamentary elections. According to Irene Agyepong, the efforts of all these actors during the 1990s served as a catalyst for the development of the NHIS, as well as providing useful lessons for what was to become the legal structure of health insurance.

### **The design phase (2001–03)**

When the NPP government came to power in 2001, they had no clear road map on the structure and funding of the health insurance policy in their election manifesto. By March 2001, they had commissioned a Ministerial Task Force to support and advise the MoH on the development of a national health insurance scheme, the establishment of systems and capacity for health insurance regulation, the development of health insurance legislation, and the mobilisation of extra resources to support national health





TERENCE DARKO

A Ghana NHIS identification card.

insurance (Agyepong and Adjei 2008). Task Force members were selected on the grounds of having technical knowledge on health insurance, or because they were perceived to be important stakeholders. Most of the members were bureaucrats from the MoH and the Ghana Health Service (GHS). The remainder were representatives from the Trades Union Congress (TUC) and the now-defunct Ghana Health Care Company. After debating whether the scheme should take a centralised single-payer approach or a decentralised community-based approach, the Task Force eventually settled on a hybrid arrangement that became a draft policy which was put out for broad public consultation.

In June 2001, as the draft policy proceeded to stakeholder consultations at both national and local government levels, the Chair of the Task Force – Samuel Akor, the Director for Policy, Planning, Monitoring and Evaluation in the MoH – was replaced. A new Minister of Health was also appointed just after the Task Force drafted the policy (Agyepong

and Adjei 2008). The new chair continued to coordinate design activities for the NHIS prior to its passage through Parliament, and with the new minister brought new members onto the Task Force, including other bureaucrats from the MoH and the GHS, and consultants. Some of the original Task Force members resigned, sensing a deviation from the proposed hybrid arrangement, and political differences with Akor.

After reviewing the concerns and proposals raised in various stakeholder consultation forums, the Task Force updated the zero draft. The revised policy that was debated in Parliament included the possibility of using a proportion of value-added tax (VAT) as a funding option for the scheme, inspired by the Minister of Finance, who had already increased VAT to raise revenue for education without any public opposition. However, this proposal proved contentious, as did other aspects of the basic structures of the scheme. Nonetheless, by the last quarter of 2003, the NHIS Act (Act 650) was passed into law.

## Implementation phase I: the NPP era (2004–08)

NHIS implementation began in 2004 before the presidential and parliamentary elections of that year. The ruling NPP government won the election and vigorously continued the implementation of the scheme. Between 2004 and 2008, the NHIS became well accepted among the population. According to a citizens assessment survey on the NHIS, conducted in 2008 by the National Development Planning Commission, the number of people registered for the scheme increased from 1,797,140 in 2005 to 12,518,560 at the end of 2008, representing about 61.3% of the country's population. The report indicates that about 30% of subscribers to the scheme worked in the informal sector, and 7% worked in the formal sector. 'Vulnerable' people – including pregnant women, children, those aged 70 and above, and the homeless – constituted 63.2% of those registered (NDPC 2009; NHIA 2010).

Getting people to subscribe to the scheme was not all that easy. According to some district health insurance fund managers, one of the biggest constraints to the success of their enrolment drives was the perception that enrolling in the NHIS meant siding with the NPP (Alatinga 2011). This perception gradually waned after a public campaign by the National Health Insurance Authority (NHIA) highlighted the benefits of the scheme. During the first implementation phase, there were complaints from the public and board members of district health insurance schemes about the operations of scheme managers and start-up consultants (Agyepong and Adjei 2008; NHIA 2008). This led the new Minister of Health to suspend all the

scheme's services to enable an operational audit, which exposed malfeasance in some districts. As implementation continued, the main challenges that affected the smooth operation of the scheme included losses incurred from claim settlements as a result of fraud, inflation of prices of medicines supplied to subscribers, irrational prescription of medicines, overbilling, provision of services above the accredited levels, delays in claim payments, and district schemes not being held accountable for their operations (Gobah and Zhang 2011; NHIA 2008, 2010, 2011 and 2012).

## Implementation phase II: the NDC era (2009–15)

During the campaign for the 2008 elections, the opposition NDC included in its platform pledges to fix the problems with the NHIS and reform the scheme so that it provided basic healthcare coverage for all. On winning the elections and coming into power, the NDC government appointed a new director for the NHIA to begin work on resolving the challenges of the NHIS and to review Act 650. Measures to reform the scheme included a financial audit of the NHIA and all the district health schemes commissioned by the government. There was also the disbanding of the local boards of the district schemes due to perceived political leanings and influence in selecting the members, and the practice whereby board members outnumbered official staff. This was reported to burden government coffers heavily (NHIA 2010; Seddoh, Adjei and Nazzar 2011).

A legislative process was set in place by the NHIA that culminated in the review of Act 650, which was duly superseded by



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Act 852 in 2012. This process was led by Law and Development Associates (LADA), a consulting firm commissioned by the NHIA to examine the policy and legislative review of the scheme. LADA held a series of high-level strategic meetings with the Minister of Health, the Chief Executive Officer of the NHIA and other directors of the NHIS to present a progress report on the outcome of the legislative review. An interview with the lead consultant, Dr Atuguba, showed that these meetings focused on the major components of the legislative review, namely the new bill and legislative instruments, and an operational manual. The firm also consulted with service providers and health insurance beneficiaries in all of Ghana's ten administrative regions, using surveys and focus group discussions to learn about challenges of the scheme.

After developing the proposed legislation, the consultants conducted three validation meetings across the country to further deliberate on the legislative proposals, and for actors who had made an input to the proposal to validate its content. The workshops also sought to elicit participants' views on the most effective and efficient ways to operationalise the proposals in the form of regulations and manuals to guide implementing officers. There were a total of 236 participants from the National Health Insurance Council (NHIC), the NHIA and its regional offices, the district mutual health

insurance schemes and their beneficiaries, the MoH, the GHS, the Ghana Medical Association (GMA), the Ghana Employers Association, academia, various service providers, and CSOs operating in the health sector (LADA 2012).

The NDC government was silent about funding arrangements during the review of Act 650, due to its inability to fulfil one of its 2008 election promises – to ensure a one-time premium payment for all. By the 2012 general elections, it was clear that it was not practical to fulfil this promise due to the financial challenges that faced the scheme. The NHIA has constantly delayed payments to service providers – a situation that was hotly discussed in the 2012 general election and will be again in the 2016 general election. Delays in payment have been a cause for concern in the implementation and revision phases of the scheme. The TUC, the GMA, the GHS, the CHAG, the Society of Private Medical and Dental Practitioners, the Ghana Registered Midwives Association, the Pharmaceutical Society of Ghana, the Ghana Catholic Bishops Conference, the Christian Council of Ghana, academics and CSOs in the health sector are all beseeching the government to fix the payment delay problem, alongside other challenges associated with the scheme.

In short, despite the passage of Act 852 and the review of the health insurance policy, challenges in creating universal access

to public health still linger. Barely a year before the 2016 general election, a new Minister of Health commissioned a seven-member technical committee to review the implementation of the NHIS and recommend ways of improving the scheme (MoH 2015), in response to growing pressure among the electorate and civil society actors that the scheme is collapsing under the NDC administration. As Ghanaians approach the polls once again, the NHIS will be a hot topic, so the government must be seen to be doing

something to stave off the perceived collapse of the scheme. It is interesting to note that two members of this new review committee were heavily involved during the design phase.

## A typology of actors involved in the NHIS policy process

Broadly, those involved in the NHIS policy processes can be categorised into state and non-state actors. Table 1 presents a typology of actors to explore the extent to which

**Table 1. Actors involved in the NHIS policy process**

Actor	Who did they engage with?	How did they engage?
<b>Organised labour</b>	Members of the Task Force; consultants; Health Committee of Parliament; NHIA; Ministries of Health and Finance; President	Deliberative workshops; public hearings; advisory forums; focus group discussions
<b>Development partners</b>	Ministry of Health; Ghana Health Service; NHIA	One-on-one conversations; consultative meetings; lobbying
<b>Health service providers</b>	Ministries of Health and Finance; NHIA	Consultative meetings
<b>Media</b>	Ministries of Health and Finance; NHIA; Committees of Parliament	Internet and radio discussions; articles and opinion pieces in the press
<b>NGOs and policy experts</b>	Ministries of Health and Finance; NHIA; Committees of Parliament; President	Advisory forums; consultative meetings; internet and radio discussions; articles and opinion pieces in the press
<b>The electorate</b>	Elected officials and state bureaucrats	Radio call-ins; text messaging to radio programmes; surveys and polls; elections; public hearings
<b>State bureaucrats</b>	Organised labour; donors; service providers; CSOs; citizens; elected officials	Deliberative workshops; public hearings; advisory forums; consultative meetings; house meetings
<b>Politicians</b>	Organised labour; donors; service providers; CSOs; electorate; bureaucrats	Public hearings; consultative meetings; election campaigns



citizens engaged with the state during the design, implementation and revision phases of the NHIS, and how this engagement in the policy processes offered them an opportunity to make the state more accountable. The subsequent narrative focuses on how each type of actor was influential at different stages of the policy process.

### **Organised labour**

The category of organised labour comprises workers' unions, including the Civil Servants Association, the Ghana National Association of Teachers, the Ghana Registered Nurses Association, the Judicial Services Workers Union and the TUC. During the NHIS design phase, the leadership of these groups convened a meeting, studied the bill and submitted a formal resolution to Parliament protesting that the proposed 2.5% of their social security pension contributions should not be used to finance the scheme. They also protested the haste with which the bill was to be passed, and requested a deferment of passage, further consultations and amendments.

In response to these concerns, the debate and passage of the bill was deferred, after which Parliament went on recess. According to the Health Insurance Officer at the MoH, the leadership of these groups was then invited to a meeting by the President, who appealed to them on the need to use their pension contributions as a funding source for the scheme. At this meeting, the agreement reached was that the 2.5% would comprise a loan to the scheme, which would be refunded to workers when they reached pension age. This is why formal sector workers became non-contributory members of the scheme. In the meantime, the GMA

and the TUC played instrumental roles in making suggestions during the stakeholder consultation forums organised by the Task Force.

During the implementation phase, the voice of organised labour was one of those calling on the government to account for the delay in payments to service providers and to provide proper accounting of allocations to the national health insurance fund. Most engagements with the government took the form of deliberative workshops, public hearings, advisory forums and focus group discussions, and the government both consulted with and cooperated with organised labour to hear their views.

### **Development partners**

Development partners are the external partners and donor agencies that support Ghana's development agenda. Briefly silent during the initial design phase of the NHIS, at the 2001 health summit – an annual meeting bringing together all key health sector stakeholders – they cautioned against migrating too quickly from existing community mutual health insurance schemes to a national social health scheme (Seddoh, Adjei and Nazzar 2011). Nonetheless, during the implementation phase, the World Bank, the International Labour Organization, Danida, USAID, the World Health Organization, Unicef, the UK Department for International Development and the Korea Foundation for International Healthcare all provided either financial support for the scheme, or technical support in the form of implementation strategy and advice. The government's engagements with development partners on health insurance proposals took the form

of one-on-one conversations, consultative meetings and lobbying. In Ghana, donor funding to health is channelled through a sector-wide approach, whereby all donor funds within the health sector are pooled in support of various health programmes. Throughout the different phases of the policy, the government has come up with proposals for development partners, such as NHIA staff training on various processes and some reform measures for the scheme, and partners have responded to some of these with funding through the sector-wide approach. Beyond this, development partners also fund civil society programmes within the health sector.

### **Health service providers**

Health service providers comprise community-based health centres; district, regional and teaching hospitals; private hospitals (represented by the CHAG); and pharmaceutical firms. During the implementation phase, they complained vehemently about the delay of payments due to them for services rendered to NHIS enrollees. They have been instrumental in sustaining the scheme, although the private hospitals intermittently revert to patient user fees until the government pays the arrears owed to them. Some public hospitals have also sometimes reverted to user fees, and suppliers of pharmaceutical materials have halted their services until receiving payment from the government. All these health providers on average operate for at least four months before they receive payment. Sometimes, even after a long delay, the government will make payment for only a month or two.

During the revision phase, health service providers also complained strongly about

the gradual introduction of capitation grants, a form of service-provider payments provided for in the now-defunct Act 650 and the new Act 852. Service providers normally engage with the government through consultative meetings, but despite these consultations, the government does not usually take their views on board, instead forcing proposals on them under the pretext of ensuring quality of service for health insurance beneficiaries.

### **Media**

The media has been active at all phases of the policy process. Prior to the legislation of the NHIS, the media shed light on the ill effects of the 'cash and carry' system and government inaction on a policy within the old system that exempted the poor and vulnerable from payments for accessing healthcare. Since the NHIS legislation was passed, the media has been active in calling on the government to account for the delay in payments to service providers and the funding allocations to the national insurance fund. The media is always engaging with the government through its reportage, radio and internet discussions on the challenges that confront the NHIS.

### **NGOs and policy experts**

Experts specialised in drafting legislation, health policy and budgeting were included in the design and revision phases of the NHIS policy. As well as offering technical inputs, they also drafted the different legislations (interview, Nana Amo, 19 July 2015; interview, Raymond Atuguba, 9 August 2015). During the implementation and revision phases, NGOs in the health sector also added their voices to the situation of delayed payments, because of the adverse



impact on the poor and vulnerable among their constituencies. These NGOs have been pushing for the NHIS to deliver universal healthcare coverage, maintaining that it could be achieved if the main challenges of the scheme are attended to. They are also pushing for strategies that the NHIA could adopt to facilitate the enrolment of the poor and vulnerable. Policy experts and NGOs have engaged with the government through advisory forums and consultative meetings. The government has in most cases collaborated with these actors on recommendations to improve the NHIS, but refused to listen to critical research findings that they have presented.

### **The electorate**

Health insurance in Ghana is mainly about the welfare of the people. High unemployment, low income levels and poverty mean that the masses see national health insurance as a priceless social protection option for the majority of people. Since the 1996 general election, health insurance has become one of the core social issues that influence people to vote for a particular political party. For instance, the NPP's zeal to win the 2004 general election nudged them into passing Act 650 into law. Similarly, the NDC's zeal to win the 2012 general election led to the revision of the old law into Act 852.

However, the citizenry continues to lament the impact of delayed payment to service providers. Some citizens have engaged with the government on the NHIS by expressing their frustrations through radio call-ins, text messaging to radio programmes, surveys and public hearings. But on the whole, elections have been the main accountability

mechanism for the electorate on the health insurance scheme.

### **State bureaucrats**

State bureaucrats comprise senior members of the civil service and public servants at the MoH, the Ministry of Finance, the GHS and the NHIA. According to a member of the Task Force, Irene Agyepong, the early planning of the NHIS was led by technocrats from the MoH. State bureaucrats wanted reforms in the health sector, and they utilised the window of opportunity created by the NPP during their 2000 election campaign to advocate for them. During the revision of the NHIS, they also utilised the opportunity to advocate for a wider range of types of sickness to be included in the scheme's benefit package. State bureaucrats, on behalf of the government, engaged with organised labour, development partners and civil society actors in deliberative workshops, public hearings, advisory forums, consultative meetings and in-house meetings. In such instances these bureaucrats consulted and cooperated with diverse stakeholders on government proposals.

### **Politicians**

Politicians comprise the elected and appointed political officers of the state. The two Ministers of Health appointed during the design phase were instrumental in providing support for the first Planning Task Force, and the two subsequent planning teams. According to Kofi Aduesi, Health Insurance Officer at the MoH, the Minister of Health from 2002 until 2004, Dr Kwaku Afriyie, held several weekly meetings with the Task Force and planning teams to listen to all sides of the debates on structure and funding arrangements. His leadership in this regard created opportunity for bureaucrats and

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consultants to make inputs into the draft policy. Most importantly, the President was able to persuade a large section of organised labour to accept the proposal of using 2.5% of their pension deductions as a funding source for the scheme. Strong NPP control of the Presidency and Parliament in this phase limited the ability of the NDC, then in opposition, to stop the NHIA legislation, which was passed in August 2003. Most engagements on health insurance by politicians took the form of public hearings, consultative meetings and election campaigns. In most instances, politicians cooperated with key stakeholders on health insurance at different phases of the policy.

## Implications for policy and practice

As countries go through democratic consolidation, having a vibrant political society – including an independent media, vocal CSOs and strong political opposition – can make governments more responsive to citizens' demands. When democratic governments have urgent goals without necessarily having a clear road map on how to reach them, they are more open to listen – to concert and consult – with non-state actors. This briefing uses the case of Ghana's NHIS to track state responsiveness to citizen demands for access to public services and examines the extent to which

urgency contributed to an increase in political accountability. The policy process offered political accountability to citizens because state and non-state actors shared the same urgency and common goal, despite not agreeing on the course of action to reach it. As the policy process progressed and the sense of urgency subsided, the state felt less of a need to concert with non-state actors, but still consulted them.

This case provides insights into the opportunities presented by the creation and implementation of Ghana's NHIS to hold the state accountable, through social and political mechanisms, for citizens' rights to basic health services. As the process continues to unfold, elections, media exposure and deliberative meetings through sector working groups will continue to be effective tools for holding the state accountable on the health front. In the medium term, the passage of a freedom of information bill would deepen transparency of the state which, donors hope, would complement the push for social accountability.



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## About Making All Voices Count

Making All Voices Count is a programme working towards a world in which open, effective and participatory governance is the norm and not the exception. This Grand Challenge focuses global attention on creative and cutting-edge solutions to transform the relationship between citizens and their governments. The field of technology for Open Government is relatively young and the consortium partners, Hivos, the Institute of Development Studies (IDS) and Ushahidi, are a part of this rapidly developing domain. These institutions have extensive and complementary skills and experience in the field of citizen engagement, government accountability, private sector entrepreneurs, (technical) innovation and research.

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## Research, Evidence and Learning component

The programme's research, evidence and learning contributes to improving performance and practice, and builds an evidence base in the field of citizen voice, government responsiveness, transparency and accountability (T&A) and technology for T&A (Tech4T&A). This component is managed by IDS, a leading global organisation for research, teaching and communication with over 30 years' experience of developing knowledge on governance and citizen participation

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