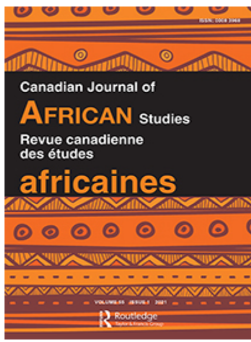

Routledge
Taylor & Francis Group

Canadian Journal of African Studies / Revue canadienne des études africaines

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/rcas20

The politics of healthcare reforms in Ghana under the Fourth Republic since 1993: a critical analysis

Hassan Wahab & Philip C. Aka

To cite this article: Hassan Wahab & Philip C. Aka (2021) The politics of healthcare reforms in Ghana under the Fourth Republic since 1993: a critical analysis, Canadian Journal of African Studies / Revue canadienne des études africaines, 55:1, 203-221, DOI: 10.1080/00083968.2020.1801476

To link to this article: https://doi.org/10.1080/00083968.2020.1801476

Published online: 14 Sep 2020.

Submit your article to this journal

Article views: 971

View related articles

View Crossmark data

Full Terms & Conditions of access and use can be found at
https://www.tandfonline.com/action/journalInformation?journalCode=rcas20

CANADIAN JOURNAL OF AFRICAN STUDIES / REVUE CANADIENNE DES ÉTUDES AFRICAINES
2021, VOL. 55, NO. 1, 203–221
https://doi.org/10.1080/00083968.2020.1801476

The politics of healthcare reforms in Ghana under the Fourth Republic since 1993: a critical analysis

Hassan Wahab[a] and Philip C. Aka[b]

[a]Department of Political Science, University of Ghana, Legon, Accra, Ghana; [b]Faculty of Law, International University of Sarajevo (IUS), Ilidža, Sarajevo, Bosnia and Herzegovina

ABSTRACT
This article analyzes the politics behind the consensus on healthcare by major political parties in Ghana's Fourth Republic since 1993. Using Ghana over the period under review as a case in point, the paper's main argument is that politics matters when it comes to the origination, design and implementation of healthcare programs, including the influence of constitutional design and practice, evidenced in a relative paucity of veto points, in facilitating the enactment of legislation on healthcare reforms; and the extent to which healthcare is defined as a human right. A high point of the paper is a critical assessment of the effectiveness of Ghana's healthcare initiative based on the extent to which it meets the needs of citizens, from a human rights standpoint, in the face of a public health emergency of the type that the world currently faces with the COVID-19 pandemic.

RÉSUMÉ
Cet article examine la politique sous-jacente au consensus sur les soins de santé des principaux partis politiques de la Quatrième République du Ghana depuis 1993. En prenant le Ghana comme exemple pour la période examinée, le principal argument de l'article est que la politique est importante lorsqu'il s'agit de l'origine, de la conception et de la mise en œuvre de programmes des soins de santé, y compris l'influence de la conception et de la pratique constitutionnelles, attestée par une relative rareté des points de veto, dans la facilitation de la promulgation de la réglementation relevant des réformes des soins de santé ; et de la mesure dans laquelle les soins de santé sont définis comme un droit humain. L'un des points forts de cet article est une évaluation critique de l'efficacité de l'initiative des soins de santé du Ghana, basée sur la mesure dans laquelle elle répond aux besoins des citoyens, du point de vue des droits humains, face à une urgence de santé publique du type de celle à laquelle le monde est actuellement confronté avec la pandémie de la COVID-19.

KEYWORDS
Politics; healthcare; human rights; Ghana

MOTS-CLÉS
Politique; soins de santé; droits humains; Ghana

1. Introduction

As the authors observed three years ago in an analysis of Ghana's National Health Insurance Scheme (NHIS), the legislation which established expanded healthcare in Ghana signified a commitment to broadened public healthcare among the country's

CONTACT Hassan Wahab hwahab123@gmail.com
© 2020 Canadian Association of African Studies

major political parties (Aka et al. 2017, 15–16). The legislation replaced the old "cash and carry" system, based on unaffordable user fees at the point of service. We likened the commitment to the consensus on healthcare among major political parties in the United Kingdom (UK) after World War II, and contrasted it with the entrenched opposition to healthcare reforms in the United States of America (US) that dates back a long time. Using Ghana over the period under review as case in point, the main argument of this paper is that politics matters when it comes to the origination, design and implementation of healthcare programs, including the influence of constitutional design and practice, evidenced in a relative paucity of veto points, in facilitating the enactment of legislation on healthcare reforms; and the extent to which healthcare is defined as a human right. Most instructively, the article also critically assesses the effectiveness of Ghana's healthcare initiative based on the extent to which it meets the needs of citizens, from a human rights standpoint, in the face of a public health emergency of the type that the world currently faces with the COVID-19 pandemic.

The practice of democracy under the Fourth Republic in Ghana since 1993 has exerted a noticeably positive effect on governmental provision of access to socioeconomic benefits in the country, particularly healthcare. Drawing on multiple sources related to the topic,[1] this article shows how the experience of democracy in Ghana under the Fourth Republic has facilitated the maintenance of expanded healthcare. As it has evolved in the period under review, Ghana's deepened commitment to democracy, crowned by seven successful general elections and three power transfers between opposition political parties, appears to have produced relatively few veto or gridlock points between the executive and legislative branches of government, beneficial to progressive healthcare policies.

Many studies spanning decades elaborate the theory that democracies are more likely than authoritarian regimes to introduce and pursue redistributive policies, including programs relating to healthcare (see e.g. Avelino, Brown, and Hunter 2005; Brown and Hunter 1999; Carbone 2011, 2012; de Mesquita et al. 2002; Ghobarah, Huth, and Russett 2004; Kaufman and Segura-Ubiergo 2001; Lake and Baum 2001; Nelson 2007; Przeworski et al. 2000).[2] To be sure, there are works that take a contrarian position. For example, Gregory Kasza (2006, 21–22) observed that in Europe before World War I, "constitutional monarchies had a better chance of introducing social insurance [...] than did democracies," and, more relevant to the argument in this paper, suggested that expanded welfare programs encompassing broad sections of a population are rare in states with a gross domestic product (GDP) below 1000–1200 USD per capita (10–11). Emerging evidence from various regions of the world questions this proposition (see e.g. Carbone 2012, 11; Wahab 2019; Wahab 2014). For instance, Giovanni Carbone (2012) compared the healthcare policies of Ghana and Cameroon, the first more democratic than authoritarian, and the latter more authoritarian than democratic, and concluded that democracy was key to the growth of social policies in Ghana, including healthcare. Carbone found that, whereas the vibrancy of democratic life in Ghana created space for voters to press for healthcare benefits that office holders found a need to respond to, the lack of a similar environment in Cameroon impeded healthcare reforms.

Although the debate on the impact of regime type on the introduction and maintenance of socioeconomic rights in political communities helped to inspire this piece, its main focus is the politics behind the consensus on healthcare reforms in Ghana since

1993, including the extent to which the unfolding of partisan political activities between the country's two major political parties meets the stringencies of healthcare as a human right. This article has three main sections, plus this introduction and a conclusion. Section 2 traces the evolution and growth of healthcare as a salient issue in Ghanaian politics under the Fourth Republic. Section 3 discusses the influence of constitutional design and practice, evidenced in a relative paucity of veto points, in facilitating the enactment of legislation on healthcare reforms. Section 4 provides a narrative on the politics behind the consensus on healthcare in Ghana under the Fourth Republic, along with the capacity of that politics to meet the needs of Ghanaians for healthcare from a human rights standpoint.

Overall, this piece seeks to achieve two complementary goals. First, it contributes to, complements and enriches the academic literature on the role of regime type in the origination and maintenance of socioeconomic rights, which before now has focused mainly on consolidated democracies in Europe and the United States to the relative neglect of political communities in the developing world. Second, consistent with the approach in our earlier work built on human rights, the paper adopts an assessment of the effectiveness of the Ghanaian healthcare program tied to the "control knobs" approach of Marc J. Roberts et al. (2008), but also goes beyond that approach.

2. Historical background: origins of healthcare as a salient issue in Ghanaian politics

The return to democratic-civilian rule in 1993 helped bring an end to the culture of silence that characterized Ghanaian politics during the era of authoritarian rule preceding the Fourth Republic. The occurrence galvanized citizens and non-governmental organizations, who pressured politicians to address the issue of healthcare reforms whose salience in the public policy agenda remained unexpressed during the eras of military dictatorship. Consistent with public opinions from African mass publics which singled out healthcare as a most pressing social issue (Bratton 2007), opinion surveys within Ghana showed that nearly nine out of every ten citizens expected their preferences to form the basis for programs initiated by their elected representatives (Afrobarometer 2005).

Ghana's healthcare delivery system was in a shambles by the time of the 2000 general election. Inadequate supply of drugs and other medical supplies led hospitals and clinics to require in-patients to provide their own bedding and drugs (Seddoh and Akor 2012), and, when available, the costs of drugs and medical equipment were so high many citizens could not afford them (Arhinful 2003). Absent affordable healthcare services, many citizens with health problems did everything but see a real doctor: they resorted to self-medication, turned to traditional healers or received medical treatment from quack doctors. The economic deprivations arising from the implementation of the Structural Adjustment Program in the country helped bring the problems associated with user fees to the fore (Aka et al. 2017, 61; Wahab 2019, 95). Given these suboptimal scenarios, it is easy to understand why before 2000, Ghanaians were generally unhappy with their healthcare system (Wahab 2019; Carbone 2012, 2011; Rajkotia 2009; Aryeetey and Goldstein 2000; Seddoh and Akor 2012). Nor is it surprising why political parties in Ghana, including the two major parties, the National Democratic Congress (NDC) and the New Patriotic Party (NPP), promised to reform the country's healthcare system, given

the opportunity to govern. Thus, during the 2000 election campaign, the NPP promised to abolish the existing fee-for-service healthcare arrangement, nicknamed *cash-and-carry*, and replace it with a universal healthcare program (Seddoh, Adjei, and Nazzar 2011; NPP 1996), while, for its part, the NDC pledged a review of the existing system "to improve its efficiency and increase access to basic health care services" (NDC 2000).

Its promise to overhaul the healthcare system, rather than simply mend it, helped the NPP to win the parliamentary and presidential elections of 2000 (Rajkotia 2009, 17; Carbone 2011, 399, 2012, 168). Following that electoral victory, effective January of 2001, the party assumed political control under President J. A. Kufuor. In March 2001, the Minister for Health, Richard Anane, announced a seven-member ministerial task force charged with the responsibility of developing a policy blueprint for the establishment of a National Health Insurance Scheme (NHIS) in Ghana,[3] including applicable laws, insurance and finances for that system (Agyepong and Adjei 2008; Seddoh and Akor 2012). The task force comprised representatives from the Ministry of Health, Ghana Health Service, Ghana Health Company, the Trade Union Congress, and the Dangme West District Health Directorate and Research Center and was chaired by the Director of Policy, Planning, Monitoring, and Evaluation at the Ministry of Health.

The Minister for Health, himself a medical doctor, reportedly clashed with the task force, particularly its chairman, on issues relating to the formation of a national healthcare system, such as the mechanics of the new health insurance program. While the minister advocated a centralized, single-payer health insurance program managed by an entity other than the Ministry of Health, the task force, cognizant of the vastness of Ghana's informal economy, favored a healthcare program controlled by the Ministry of Health. In the end, by June of 2001, the two sides had reached a compromise on a package with multiple features: a centralized single-payer system designed primarily for the organized formal sector, multi-payer semi-autonomous mutual health organizations for the informal sector, and a private commercial health insurance for Ghanaians with the wherewithal to pay for those services (Agyepong and Adjei 2008; Seddoh and Akor 2012). By January 2002, the task force had completed a draft report, which it submitted to the minister for discussion and review with stakeholders across the country. The minister presented a final draft report to the cabinet for deliberation in May, which then approved the policy in December 2002 (Agyepong and Adjei 2008, 154; Seddoh and Akor 2012, 6).[4] During cabinet meetings, President Kufuor gave several signals that underlined his commitment to expanded healthcare. These included personally leading the discussions relating to healthcare, reiterations in those meetings that expanded healthcare was a campaign promise to the electorate that must be kept,[5] timely release of approved funding for the program, and inclusion of a national health insurance policy among the performance indicators for the Minister for Health (Seddoh and Akor 2012).

The NPP and its government intended to enact the law on the national health insurance program during their first term in office, the calculation being that such legislation would improve their reelection chances. Therefore, rather than leave the implementation of the program to bureaucrats in the Ministry of Health and related agencies, the party and its government chose a hands-on approach. They were not going to allow technocrats, be they officials at the Ministry of Health, members of the task force or anyone else, to impede fulfillment of the campaign promise the NPP made to the electorate. After all, it would be the party and its officials, not the unelected officials,

who would face the electorate when, during the next election season, the time came to give account of their stewardship.[6] In short, many NPP politicians and government officials perceived electoral payoffs from the enactment of a national healthcare law. These included Yaw Osafo-Marfo, the NPP MP for Akim Oda and Minister for Finance, who, among other things, accused the opposition of "trying to make it difficult for the Government to do things that the Government said it would do in its electioneering campaign" (Hansard 2003a, 158–160).

3. Paucity of veto points in Ghana's presidential system of government: ramifications for enactment of healthcare policies

Constitutional political systems suffused with veto points tend to have difficulty in enacting legislation and implementing policies (see e.g. Steinmo and Watts 1995; Skocpol and Amenta 1995; Immergut 1990, 1992). This is particularly the case with presidential systems of government. Under its current exposure to civilian rule since 1993, Ghana operates a presidential system of government, an occurrence which instinctively draws comparison with the United States of America. However, unlike the United States, which is renowned for its federal system, Ghana is a unitary state characterized by relative centralization of power in a national government. For instance, the use of the filibuster in the US Senate prevents the passing of bills with otherwise majority support in both houses of Congress. For Steinmo and Watts (1995), this explains the lack of a comprehensive national health insurance program in the United States, given that decision-making institutions in the country give enormous power to intransigent groups, such as insurance companies, to the detriment of healthcare reforms.[7] Similarly, Ellen M. Immergut (1992) has observed that the practice of subjecting nearly every major issue to a referendum in Switzerland makes the passing of bills extremely difficult in that country, even when those bills enjoy majority support in the Swiss Federal Assembly.

Given its possession of a presidential system of government, with the strict separation of powers that marks that system, Ghana is supposed to have many veto or gridlock points capable of impeding the passing of healthcare legislation. However, this is not the case, for various reasons. Consistent with its unitary feature referred to in the previous paragraph – or in spite of it – Ghana's presidential system has several features that call to mind the fused powers characteristic of a parliamentary system that it was used to in the past. Under the Constitution of the Fourth Republic, members of the legislature (instructively, as in Britain, called the Parliament), can serve in the executive branch at the same time. Article 78(1) of the constitution mandates the president to appoint his/her ministers of state "from among members of Parliament or persons qualified to be elected as members of Parliament." Going further, Article 79(2) requires even deputy ministers to be members of parliament (MPs) or "qualified to be elected" as MPs. Add to this mixture Article 108, under which the president initiates all appropriation or budget bills,[8] and the Ghanaian chief executive – whom one Ghanaian political scientist correctly assesses as an "excessively powerful" political figure (Gyimah-Boadi 2009, 146) – looks more like a British prime minister than a United States president.

Collectively, these factors create an environment of reduced veto points that facilitates the enactment and implementation of expanded healthcare. Other auspicious forces include the fortuitousness of united – as opposed to divided – government, indicated

by the fact that in all seven presidential and parliamentary elections in Ghana since 1992, the party that has controlled the legislature has also controlled the presidency. Because MPs who hold cabinet positions are part of the government, these MPs consistently toe the government position, favorable to healthcare reforms (see e.g. Agyepong and Adjei 2008), even as those who are not in the cabinet vote to support the government's position, increasing their chances to be considered for lucrative executive appointments inside or outside the government when the opportunity arises.

4. Influence of politics in Ghana's healthcare reforms

This section continues the discussion in the two preceding sections. Specifically, it does two things. First, it presents a narrative on the political fireworks between Ghana's two leading political parties, behind the origination and maintenance of healthcare reforms. Second, it conducts an examination of the extent to which the politics we describe meet the requirement of "good politics," from a standpoint of healthcare as a human right, especially in the face of a pandemic, signified by COVID-19, that the international community currently confronts.

4.1. Politics in the evolution and denouement of healthcare reforms in Ghana

On 26 August 2003, the Ghanaian government under the NPP passed Act 650, the National Health Insurance Bill. The successful vote followed the introduction of the healthcare bill in parliament by the Minister of Health on 11 July 2003. The measure became law on 5 September 2003, when President John Agyekum Kufuor signed it into law. Act 650 went into effect more than one year later, in 2005. Following its victory in the 2008 presidential and parliamentary elections on 22 March 2012, the NDC introduced its own national health insurance bill, Act 852, taking advantage, like the NPP before it, of its control of the executive and legislative branches of government. The bill did not differ significantly in content from Act 650, enacted a little over eight years before, that the new law repealed and replaced. President John Mahama signed the bill into law on 31 October 2012. By repealing and replacing Act 650, rather than amending it, the NDC earned political credit that it hoped to turn into electoral dividends for healthcare reforms in Ghana, as we elaborate later in this article. From either side of the aisle, politicians appeared to appreciate the importance and saliency of healthcare reforms. Accordingly, they did everything they could to portray themselves and their parties as pro-healthcare reforms, while blaming the opposition for working to undermine healthcare. The ensuing narrative has two parts: first, a discussion on the politics involved in the passing of these two laws, and second, an analysis of the trajectory of politics in the aftermath of each bill's passing.

4.1.1. Politics in the lead-up to the passing of each healthcare law

Following the introduction of the Healthcare Legislation by the NPP in 2003, NDC MPs vehemently opposed it and boycotted floor debate of the bill (Abiiro and McIntyre 2013; Seddoh and Akor 2012; Carbone 2011; Agyepong and Adjei 2008). To counteract the maneuver, the NPP used its majority vote to refer the bill to a joint select committee on health and finance (Hansard 2003b, 2409). Not done yet, the NDC tried to delay passing of

the bill until after the next election in 2004 (Agyepong and Adjei 2008, 158; Carbone 2011, 401), convinced that passing of the bill would give the NPP an electoral advantage. That attempt also failed.

The opposition's displeasure with the legislative process increased when the NPP attempted to pass the healthcare bill using a certificate of urgency, a parliamentary procedure that caps debate time on legislative measures to about a week. For the record, the NDC also used this parliamentary procedure in other settings during its period in office (1993–2000). The NPP backed off after labor unions and other civil society organizations joined the NDC to protest debating the bill under a certificate of urgency. This was the setting in which, on 28–29 July 2003, the joint select committee on health and finance, then working on the bill, postponed debate to enable it to tour the country and solicit public views and comments from a cross-section of the Ghanaian people (Hansard 2003c, 64). The accommodation spelled victory for opponents of the bill, albeit a short-lived one, since – as we show later – NPP leaders managed to pass the bill before the 2004 elections. This was despite a threat in July 2003 to boycott further proceedings of the joint committee purportedly to force broader consultations with stakeholders – a day after the committee, which comprised NDC MPs, unanimously voted to tour the country to secure wider consultations for the bill (Hansard 2003d, 64–65).[9] With the failure of the boycott threat, the NDC fell back on the only available option left to it, namely to make any law that came out of the process unpopular with the public so as to secure the defeat of the NPP in the 2004 elections. Believing that the public would see through and reject the NDC tactics, the NPP-led joint select committee on health and finance proceeded with its plan to consult widely: it advertised for comments on the bill from the public and stakeholders, visited six of Ghana's then ten regional capitals, and held several forums at which numerous stakeholders, including organizations, representatives and members of the general public, participated (Hansard 2003e, 76–103).

Despite the participation of NDC MPs on the joint select committee as it solicited public comments on Act 650, to press its point that the proposed bill was legislation potentially harmful to the public that was being rushed through parliament by the majority without enough debate, the NDC boycotted subsequent floor debate of the bill. The boycott began on 19 August 2003. Not unexpectedly, through the Minister for Finance and Economic Planning, the NPP refuted the NDC allegation that the bill was being rushed through parliament without enough debate (Hansard 2003f, 161). In the end, the NDC did not have the vote to stop the passing of the bill. However, certain consolatory victories attended the failed political maneuver. These include the majority's agreeing on a consultation tour, minority influence on the content of the resultant law, and the fallback option for NDC politicians to use the legislative process to turn public opinion against the NPP at the polls—through boycott of parliamentary proceedings and participating in mass protest.[10]

In sum, while the NPP used its majority to sell the importance of the healthcare bill for Ghanaians, the NDC minority argued that the legislation would be bad for the country. It also accused the NPP of "abusing parliamentary proceedings" and engaging in "illegalities" in the way that it tried to pass the bill (Ghana News Agency 2003). NDC politicians opposed the bill in the hope that their party would win the 2004 election and get the opportunity to pass a healthcare bill and take the credit when it came to power. Accordingly, in public, the party and its officials took the position that their opposition

was a principled one rooted in legitimate matters, such as the funding mechanism and the speed with which the NPP majority was pushing the bill through parliament. Privately, the party opposed the bill because it believed that, if passed, it would boost public support for the NPP that could translate into electoral benefits.[11] For its part, the NPP tagged the NDC the party of cash and carry. The tactic was successful. By tying – and tagging – the party to the detested user fees and promising to fully implement the national healthcare bill in 2005, the NPP won reelection in 2004.

NDC won the presidential and parliamentary elections of 2008 and took office in January of 2009, on a promise to overhaul Act 650. When the NDC's turn in office came, the NPP did not boycott parliamentary debate of the healthcare bill. However, it tried unsuccessfully – just as the NDC had with Act 650 – to delay its passing, using every parliamentary maneuver that it could lay its partisan hands on, including allegations of conflict of interest. Floor debate of the bill began on 12 July 2012. No official listening tour by committee members, to solicit views of the public, took place. Instead, the committee invited written public comments and had some members of the public testify during its sittings (Hansard 2012b, 2915).

Alhaji Mubarak-Muntaka, NDC majority whip and chairman of the health committee, stated in his floor speech during the motion to debate the bill that the implementation of Act 650 had been successful, but several challenges had constrained the realization of its full potential. Those problems, he said, necessitated the complete repeal of Act 650, instead of amending it (Hansard 2012c, 2729–2730). "There is a fundamental difference between the original law and the current one" that justified repeal, claimed Alhaji Mustapha Ahmed, Deputy Minister for Science and Technology and NDC MP for Ayawaso East in the Greater Accra Region (Hansard 2012d, 2935). However, more than a sheer attempt to improve the law, the real reason for the move to repeal was credit claiming. Mending rather than repealing the healthcare bill would have kept the narrative that the NPP was the party that brought expanded healthcare to Ghana, something anathema to the NDC. Understandably, the move to repeal and replace incensed the NPP, which branded it an "act of stealing the legacy of a past government to the good people of Ghana" (Hansard 2012d:2935). However, the party did not have the votes to stop it.

Just as the NDC could not stop the passing of the healthcare legislation in 2003 by the NPP, just before an election, the relatively few veto points provided under the Fourth Republican constitution enabled the NDC to replace the NPP healthcare law with an almost identical bill in 2012, months before the general election. Gifty E. Kusi, the NPP MP for Tarkwa Nsuaem constituency, directed part of her floor speech in opposition to the 2012 health insurance bill at the former minority leader, Alban Bagbin, under whose leadership the NDC had boycotted proceedings in the 2003 bill. Her statement boiled down to the paradox of Bagbin, who had boycotted Act 650, being the one to take credit for enacting a new healthcare bill (Hansard 2012e:2947).[12]

A cornerstone of the NDC campaign in 2008 to overhaul the healthcare system, but one that it did not redeem, was the introduction of a one-time premium payment to facilitate participation of citizens, including the army of workers in the informal economy. In the run-up to the 2012 elections, the NPP heightened its accusations that the NDC had not kept its campaign promise on the one-time premium (Peace 2012; Boateng 2012; Essel 2011; Gyasiwaa 2012). Instead, it was taking detrimental steps capable of bringing

about the "collapse" of the healthcare system (Citifmonline.com 2012, 2013). For its part, the government stuck to its message that the one-time premium policy would be implemented (Ghana News Agency 2012; Essel 2011; Peace 2012). Despite its electioneering energies, the NPP lost the 2012 election. In the aftermath of their defeat, NPP MPs added a new line of attack against the national healthcare plan centered around public distrust of the program, tapping into a public sentiment evidenced in a lack of interest in continued enrollment in the healthcare scheme. Conversely, NDC MPs encouraged their constituents to enroll in the NHIS because it was a good program; this amounted to a 360-degree reversal of their stances when they were the minority in parliament.[13]

4.1.2. Politics in the aftermath of the healthcare bills' enactments

Following the passing of Act 650, the NDC's public stance continued to be determined opposition. One indication of this opposition was NDC MPs' advising their constituents not to enroll in the national healthcare program because the NPP would use their paid premiums and enrollment fees to run their political campaign for the upcoming December 2004 parliamentary and presidential elections.[14] For its part, the NPP used the opportunity of the NDC opposition to the legislation to brand the NDC as pro-cash-and-carry in the campaign. By linking the NDC with the user-fee healthcare system, and promising to vigorously implement the healthcare law in 2005, the NPP won reelection in December of 2004.[15] In some cases, NPP MPs even paid the enrollment fees and the premiums of constituents who claimed they did not have the wherewithal to pay.[16] In contrast, the NDC discouraged its supporters and constituents from enrolling in the program.[17]

Although the NPP seemingly delivered on its promise to reform healthcare in the 2000 and 2004 elections, it did so only nominally, given that the new policy was riddled with flaws, top of which was health insurance premiums out of reach for many workers, particularly those in the informal sector (see e.g. Atinga, Abiiro, and Robert Bella 2014; Abiiro and McIntyre 2013; Jehu-Appiah et al. 2011; Dixon, Tenkorang, and Luginaah 2011; Apoya and Marriott 2011; Agyepong, Orem, and Hercot 2011; Jehu-Appiah et al. 2010). Tapping into these flaws, the NDC based its campaign in 2008 on the theme that the national healthcare program was bad for the country, particularly poor people, and promised to replace it with a "one-time premium" health insurance policy (NDC 2008).[18] For its part, the NPP reminded the public that it was they who had replaced the NDC's "obnoxious" healthcare policy with the "humane" NHIS (NPP 2008). The NPP questioned the feasibility of implementing a one-time premium policy, to which the NDC countered that the NPP did not care about the plight of the poor. But it was too little, too late. The NPP could not successfully shake off the accusation that it was a party for the rich, thereby losing the 2008 election to the NDC (Osei 2013; Nugent 2007; Gyimah-Boadi 2009).

In 2010, two years after the NDC had regained political control in Accra, healthcare service providers complained about unpaid claims, while healthcare workers threatened strikes, or engaged in such work stoppages, over poor conditions of service (Ghana News Agency 6 October 2010; Citifmonline.com 10 December 2010; Ghana News Agency 5 March 2010; Myjoyonline.com 6 October 2010). Yet other problems reared their heads, including inadequate staffing of NHIS claim offices, irregular payment of employee salaries,[19] and mutual finger-pointing between the two major political parties, such as the NPP's accusation that the NDC government aimed to discredit and destroy a

successful "NPP" program, and NDC officials' complaint that the NHIS was in financial distress because the NPP government had dipped its hands into NHIS funds for its election campaigns.[20] In sum, despite the operation of the NHIS going on fifteen years now, user fees remain in Ghana. For example, patients still buy their own drugs, even for common health conditions like headaches and malaria fever, because there are no medications in government pharmacies,[21] while hospitals with dilapidated equipment and few medical supplies hit the headlines of major newspapers.[22] These issues and those recounted in the previous paragraphs are recurring problems that the NDC and NPP governments share, rather than issues limited to any one government.

One key feature in the politics in Phase 2 relating to healthcare reforms was the debate on healthcare financing – the sparring between the parties pertaining to a "one-time premium" in the lead-up to the 2008 elections that the NDC won. This was in contradistinction to Phase 1, when the reference to healthcare financing was nominal.[23] Back to the more substantive second phase, in 2009, the NDC government stressed its determination to implement the one-time premium policy as a way to guarantee access to universal healthcare for Ghanaians. An annual report published that year stated that actuarial work on the sustainability of the policy had been completed, and "the results show that the new policy is feasible" and a "roadmap toward the implementation of [the policy that has] been developed" (NHIA 2009, 22–23). The report and this finding appeared to be a direct response to NPP criticisms of the one-time premium policy as unworkable. Similarly, in its 2010 report, the National Health Insurance Authority (NHIA) disclosed that a task force charged with drafting the policy document for implementing the one-time premium policy had completed its report and submitted it to the Minister of Health for onward submission to the cabinet. Commissioned by the Minister of Health, the task force comprised representatives from the Ghana Health Service, the Ministry of Health and the NHIA. The NHIA indicated that the government expected the policy to become operational in 2011 (NHIA 2010, 10).[24]

4.2. Assessing the extent to which the politics of healthcare reforms in Ghana meets the stringency of *"good politics"* that ranks among the hallmarks of a good healthcare system

Four hallmarks of a good healthcare system necessary for success in healthcare reforms – all four intertwined to the point of being inseparable – are good laws, good funding, pursuit of healthcare as a human right rather than a privilege, and good politics. As a socioeconomic human right, what makes healthcare delivery an onerous (but by no means impossible) proposition is that, for a country to achieve a well-functioning healthcare system, all of these factors must be in place.

A first factor is good laws. Every country has a domestic legal system that includes its constitution (higher law) and the regional and international treaties relating to healthcare that the country ratified, notably the International Covenant on Economic, Social, and Cultural Rights (ICESCR). The next hallmark of a good healthcare system is good funding. Money is "the mother's milk of any healthcare system and key to both access in healthcare and health outcomes" (Aka et al. 2017, 23). The mark of the maturity of a state's healthcare system is the funding that, backed by the masses, its political leaders are willing to devote to healthcare goods. A country can devote a sizable share of its GDP to healthcare and still

get suboptimal healthcare delivery, but financing is the important starting point in the journey toward a good healthcare system. How much a nation is willing to devote to healthcare and the sacrifices it is ready to make to get healthcare for most of its citizens speak to its seriousness about healthcare. Because few countries in the world have all the resources that they need to meet their healthcare needs, achieving expanded healthcare requires the use of creative steps in funding, including reducing waste and efficient management of available resources. Adequate funding is important because financial barriers impede access to healthcare services. Governments have an obligation to protect individuals from impoverishment that could arise from illness, whether due to out-of-pocket payments or loss of income when a household member falls sick. As the then director-general of the World Health Organization (WHO) succinctly put it, "[n]o one in need of health care [. . .] should risk financial ruin as a result" (Chan 2010, vi, vii).

The human rights hallmark stands for the concept of these rights as rights, rather than as a privilege that the government may withdraw when it chooses to. *Human rights* are guarantees of freedom, such as life, liberty, security and subsistence to which people as humans have rights. Because it underpins many human rights, including the right to life (WHO 2014), healthcare is a – if not the – mother of socioeconomic human rights. Expanded healthcare embedded in human rights has several benefits that such a right not anchored in human rights lacks, including an appeal to rights based solely on a person's humanity, and a strategic unity that can force governments to either hold the line on rights or increase those rights, rather than reduce them (Aka et al. 2017, 27–35).

Finally, in regard to good politics as hallmark of a good healthcare system, healthcare is an "intrinsically political" phenomenon "built on principles of fairness and equity that require governments to allocate healthcare benefits according to need, and financial contributions according to ability to pay" (Heymann and Yates 2014). Transition to expanded healthcare is "primarily a political negotiation" between contending interest groups and stakeholders with divergent priorities, with the potential to lead to "dysfunctional processes," if not handled well (Chan 2010, vii). Because "[i]n many countries the health care sector wields little political power or influence [over] decisions about the allocation of public funds[,]" "[e]xpenditure on health care has tended to be viewed simply as a drain on scarce resources, rather than as an investment in the nation's future" (WHO 1995, 91).

The question is whether the politics summarized in Section 4.1 above qualifies as "good politics" in the sense that this paper conceptualizes it, namely healthcare as "who gets what, how, and when" properly attuned to good laws and adequate funding in a manner that takes healthcare away from privilege toward the direction of healthcare as a human right. In other words, good politics, compositely, is a function of progress in the three prior categories. Table 1 presents a recap of our assessment.

On the surface, good laws would be an issue of little or no concern since, in the final analysis, much of this paper is about laws. Also, on this hallmark, more than any other, Ghana appears to make the most progress. However, there are unresolved issues bearing on the constitutional amendment responsible for our assessment of progress on this front as "suboptimal." In our 2017 article, we commented on the solecism signified by the entrenchment of a nominal "right" to healthcare as a "fundamental human right" in Ghana's Fourth Republic Constitution. Particularly, we worried about the tepidness and amorphousness of the provision which reads: "[a] person who by

Table 1. Recap on the progress of Ghana in terms of the four hallmarks.

Hallmark	Progress
Good laws	Suboptimal
Good funding	Suboptimal
Healthcare as a human right	Suboptimal
Good politics	Suboptimal

Source: Table created by the authors.

reason of sickness or any other cause is unable to give his consent shall not be deprived by any other person of medical treatment, education or any other social or economic benefit by reason only of religious or other beliefs" (Aka et al. 2017, 61–62). We advised that the way to correct this anomaly would be a constitutional amendment which guarantees, free of vagueness or tentativeness, the right to healthcare. We cited the language of the ICESCR provision as a good template for such a change. This multilateral treaty, which Ghana ratified in 2000, mandated state parties to create "conditions which would assure to all medical service and medical attention in the event of sickness," among other obligations.

Next is good funding. Ghana still faces many impediments, including undiversified sources of healthcare financing. In April of 2001, African heads of state met in Abuja, the Nigerian capital, where they pledged to set a target of allocating at least 15% of their annual budget to healthcare. As of May 2011, ten years later, Ghana was listed among a set of fifteen countries that the WHO assessed as having made "insufficient progress" in meeting the pledge (WHO 2011). Based on World Bank data, as of 2016, the most recent year for which information is available, Ghana spent a pitifully low 4.45% of its GDP on healthcare. Part of good funding is efficient allocation of what little money a country has – which is where and why good politics comes in. Ghanaian leaders should create a more viable economy that enables citizens to pay their healthcare premium or renewal fees. Good funding mandates the outlay of adequate funding for healthcare, achieved through various means, including diversification of funding sources to avert the vulnerability and uncertainty that can arise from overdependence on one or few sources. This is particularly the case given the vast informal sector of the Ghanaian economy.

Given the various problems that still impede the NHIS, Ghana's fledgling healthcare system does not seem to guarantee access to healthcare as a human right. Finally, on good politics, introduction and implementation of a health-financing system are steps entrusted to the political leadership of a country, who must not only find creative ways to provide resources for healthcare at home but also ensure that external support for healthcare is channeled specifically into healthcare. The politics of expanded healthcare dictates that the government must raise sufficient resources for health, through steps such as increasing the efficiency of revenue collection, reprioritizing government budgets, innovating financing and putting developmental assistance, when available, to good use; removing financial risks and barriers to access, and guaranteeing that those barriers are removed by, for example, providing incentives for people to improve their health through preventive measures; improving efficiency and minimizing waste, and promoting equity in access (WHO 2010, xii–xviii). However, based on the analysis in this article, few of these steps have taken place in Ghana. Neither Act 650 nor Act 852 seriously addressed any of

these funding issues. To the extent that it took place under the Ghana healthcare system, politics was reduced to little more than wrangling between the two major political parties on healthcare matters that, for example, did not lead to improved healthcare funding.[25]

5. Conclusion

Democratic governments afford voters the opportunity to elect representatives to address their needs and preferences. However, for the many decades that Ghanaians were ruled by authoritarian military leaders, citizens lacked the opportunity to choose their government. The situation changed in 1991 when Ghanaians adopted a new constitution that bore their popular input. The return to civilian rule under the Fourth Republic opened the space for voters to demand healthcare reforms. The then ruling NDC party was slow in fully aligning its agenda to voter preferences. Its slowness to address the healthcare issue satisfactorily was a major factor in its defeat by the NPP in the 2000 presidential and parliamentary election. The NPP, after winning that election, took advantage of the limited veto opportunities available to the NDC and used its majority in parliament and control of the executive branch of government to push through its healthcare agenda enshrined in Act 650, despite protestations from the NDC. When the NDC regained political control in 2008, it moved swiftly to replace Act 650 with Act 852 – taking advantage of the limited veto opportunities available to the opposition NPP.

With healthcare now part of the policy agenda in Ghana, the next challenge is to maintain and improve it until it becomes a human right, as we advised in our analysis of the NHIS (see generally Aka et al. 2017). The occurrence calls to mind the memorable story from American national government and politics about how, upon exiting the Constitutional Convention in 1787, Benjamin Franklin was approached by a group of citizens who quizzed him regarding the sort of government the delegates had created. He responded: "A republic, if you can keep it." The same wisdom applies here. The lethargic responses of many governments to the COVID-19 pandemic (caused by the new coronavirus), currently sweeping the world with its mayhem of infections and deaths (Corley 2020), speak to the necessity of a human-rights-oriented healthcare system and the critical role of good politics, in the definition of the term we use in this article, in maintaining that strong healthcare system.

Notes

1. Multiple lines of evidence this article draws upon to support its argument include floor speeches of Members of Parliament (MPs), the public statements and actions of these lawmakers and interviews with stakeholders, such as members of the public, healthcare professionals, lawmakers, heads and workers of government agencies charged with the implementation of healthcare programs (e.g. the Ministry of Health, Ghana Health Service and the National Health Insurance Authority).
2. This is a proposition so intuitive few people would question it. However, not every democratic state pursues progressive policies, and in many political systems, democratic and authoritarian alike, redistributive policies are controversial.
3. Interview by the first author with former Health Minister Richard Anane in Accra, 16 November 2011.

4. Interview by the first author with former Health Minister Richard Anane in Accra, 16 November 2011.
5. Interview by the first author with Alhaji Malik Alhassan Yakubu, former MP, Interior Minister, and second Deputy Speaker in Chicago, 15 June 2013.
6. Interview by the first author with Alhaji Yakubu (see note 5).
7. The situation changed temporarily under President Barack Obama, from 2009 until 2017, giving way to the passing of the Affordable Care Act of 2010, but has returned, arguably with full force, under President Donald J. Trump since 2017.
8. The reality in politics is that the branch of government that controls financial matters essentially dictates lawmaking. Shugart and Carey argue that the power to initiate a bill enables the president to control agenda setting: "If she or he does not want a matter discussed, it will not be discussed" (1992, 151).
9. In an interview with the first author years later, during the research on which this article draws, Alban Bagbin, the then minority leader of the party, disclosed that the boycott threat was merely "political talk" – a ploy to shore up the NDC's base, given that the party lacked the votes to stop the NPP from proceeding. Interview by the first author with Alban Bagbin in Accra, 26 March 2013. The proposition makes sense, given that – contrary to the threat – NDC committee members took part in touring the country to consult stakeholders.
10. Interview by the first author in Accra, 26 March 2013, with an NDC MP, minister, and member of the party's top leadership in the 2000–2004 Parliament. For this interviewee, the threat of boycott was little more than an attempt to energize the party's base in the parliamentary and presidential elections slated for December 2004.
11. One respondent, an NHIS regional manager, told the first author that an NDC MP had told him he opposed Act 650, the initial healthcare bill, because he hoped the NDC would win the 2004 election and, with it, the opportunity to pass a healthcare bill and claim credit when it came to power. Interview by the first author with respondent in Accra, 16 April 2013. Granted, but there were also some NDC tactics that did not smell of fairness. One such tactic was the behavior of NDC MPs who reportedly told their constituents not to enroll in the national healthcare program because the NPP would use their paid premiums and enrollment fees to run for office in December 2004. Interviews by the first author with respondents in Accra on 22 April and 17 May 2013. The NPP did something similar in 2012 after it lost power to the NDC.
12. At the time of the passing of the 2012 health insurance bill, the former minority leader, Alban Bagbin Bagbin, was the Minister for Health.
13. A bureaucrat who closely followed these maneuvers disclosed to the first author during an interview that what surprised him the most about the debate surrounding the NHIS was "the hypocrisy of politicians." Interview by the first author with a respondent in Accra, 22 April 2013.
14. Interview by the first author with a respondent in Accra, 17 May 2012; interview with a respondent in Accra, 22 April 2013.
15. Interviews and conversations with members of the general public by the first author during his fieldwork suggested that NPP won the 2004 election mostly because of progress on healthcare reform, including the passing of Act 650 in 2003.
16. Information obtained by the first author during interviews with some NPP MPs was confirmed by some members of the general public, whom the first author spoke with, who claimed to have benefitted from or knew someone who had benefited from an NPP MP paying their NHIS premium or renewal fee.
17. Interview by the first author with a respondent in Accra, 22 April 2013.
18. The NDC promise of a one-time premium health insurance payment was a huge part of the 2008 election campaign. However, not all stakeholders knew the precise meaning of this premium. See e.g. Abiiro and McIntyre (2013).
19. Interview by the first author with a respondent in Accra, Wednesday, 16 May 2012.
20. Investigation by the first author indicated that it is hard to dismiss this charge out of hand. His finding was that both political parties are guilty of the charge. When the NDC took power in

January 2009, the National Health Insurance Authority was six months behind in paying NHIS bills, even though Act 650 required payment to be made within four weeks. The NDC government paid up the bills and brought them in line with the requirements of Act 650. However, as the country geared up for the 2012 election, payment of NHIS bills got behind again – and for more than six months. Both political parties have failed to deposit revenues for the NHIS into the National Health Insurance Fund as prescribed by the NHIS Act. Instead, NHIS funds have been deposited into a general account (the so-called Consolidated Fund). No finance minister has been willing to deposit NHIS funds in the proper account because of the flexibility it affords the government to use that money for other projects. Interview with respondent in Accra, 17 May 2012.

21. Conversations of the first author with respondents in Accra, 20 April 2013.
22. First author's interview with a respondent in Accra, 25 April 2012.
23. This was within the context of the NDC's move, ultimately successful, to repeal the initial healthcare bill, specifically whether the bill should be referred to the select committee on health and finance (rather than just on health). On a point of order, Anthony Akoto-Osei, the NPP MP for Old Tafo constituency and former Minister for Finance under the previous NPP administration, indicated that since the bill would have financial implications, it should be referred to the select committee on health and finance, just like the 2003 initial bill. However, the NDC presiding officer overruled him (Hansard 2012a:3344-3345) and the bill still went to the health committee only. In an interview with the first author in 2013, after the fact, the former finance minister asserted that the main problem with healthcare in Ghana was insufficient resources; therefore, referring the bill to the health committee to the exclusion of the finance committee indicated that the NDC was not serious about tackling the problem of healthcare reform. Interview by the first author with Mr. Akoto-Osei in Accra, 21 March 2013.
24. *See Daily Graphic* edition of 17 November 2011.
25. After the NDC government assumed office in January 2009, the newly appointed chief executive officer of the NHIA, the agency charged with implementation of the national healthcare scheme, blurted, "I am coming to give the NHIS a political edge." Interview by the first author with one respondent in Accra, 17 May 2012. But this is politics revolving around claiming credit for supposed ownership of healthcare reform, far removed from the healthy politics that we conceptualize in this article.

Acknowledgments

We wish to thank the editors and the anonymous reviewers for their helpful comments.

Disclosure statement

No potential conflict of interest was reported by the authors.

Notes on contributors

Hassan Wahab is a lecturer of political science at the University of Ghana, Legon. He is an affiliated faculty member at the Legon Center for International Affairs and Diplomacy (LECIAD). His current research interests are in politics and state welfare provision, party systems, democracy and democratization. Currently a member of the editorial boards of the *International University of Sarajevo (IUS) Law Journal* and the *Review of Religions* (London), he was previously the managing editor of *Africa Today*. His most recent works include "The Politics of State Welfare Expansion in Africa: Emergence of National Health Insurance in Ghana, 1993–2004" (*Africa Today*, 2019, 65(3): 91–112); "Are Members of Parliament in Ghana Responsive to Their Constituents? Evidence from Parliamentary Debates on Health Care" (in *Ghanaian Politics and Political Communication*, edited by Samuel Obeng Gyasi and Emmanuel Debrah, Rowman & Littlefield 2019); "Democracy, Civil

Society and the Emergence of National Health Insurance in Ghana" (in *Politics, Governance and Development in Ghana*, edited by Joseph A. Ayee, Lexington Books, 2019); an edited volume, *Servant of The Bestower: Maulvi Dr. A. Wahab Adam* (Islam International Publication, 2017); and "Ghana's Health Insurance Scheme (NHIS) and the Evolution of Human Right to Healthcare in Africa" (with Philip C. Aka, Ibrahim J. Gassama, and A. B. Assensoh, *Chicago-Kent Journal of International and Comparative Law*, 2017, 17(2): 1–65). He may be contacted by e-mail at hwahab@ug.edu.gh

Philip C. Aka is a professor of law and former dean of the Faculty of Law at the International University of Sarajevo, as well as a visiting professor at the Southern Illinois University School of Law, Carbondale, Illinois, USA. Aka has published widely on issues related to minority populations in Africa, Europe and the United States, including human rights. His recent publications include "Genetic Counseling and Preventive Medicine in Bosnia and Herzegovina" (*California Western International Law Journal*, 2020, 50(2), 271-340); "Humor as Pedagogy: Evidence from Bosnia and Herzegovina" (*Indonesian Journal of International & Comparative Law*, 2019, 6(4), 539 – with Sencer Yeralan); "The EU in Transition and Its Ramifications for Bosnia and Herzegovina" (*Emory International Law Review*, 34(Fall 2019), 2001); "Precision Medicine in the Era of CRISPR-Cas9: Evidence from Bosnia and Herzegovina" (*Palgrave Communications*, 2019, 5, 1 – with Sabina Semiz); "Ghana's National Health Insurance Scheme (NHIS) and the Evolution of a Human Right to Healthcare in Africa" (*Chicago-Kent Journal of International & Comparative Law*, 2017, 17(2), 1 – with Ibrahim J. Gassama, A.B. Assensoh and Hassan Wahab); and *Human Rights in Nigeria's External Relations: Building the Record of a Moral Superpower* (Lexington, 2017). Aka is Associate Editor of Humanities & Social Sciences Communications, and Corresponding Editor of International Legal Materials (a publication of the American Society of International Law). He may be contacted by email at philip_aka@hotmail.com

References

Abiiro, G. A., and D. McIntyre. 2013. "Universal Financial Protection through National Health Insurance: A Stakeholder Analysis of the Proposed One-time Premium Payment Policy in Ghana." *Health Policy and Planning* 28 (3): 263–278. doi:10.1093/heapol/czs059.

Afrobarometer. 2005. "Parliament of the Fourth Republic of Ghana – Views from the Grassroots." CDD-Ghana, November. Accessed 23 February 2015. http://www.afrobarometer.org/files/documents/briefing_papers/AfrobriefNo20.pdf.

Agyepong, I. A., J. N. Orem, and D. Hercot. 2011. "Viewpoint: When the 'Non-workable Ideological Best' Becomes the Enemy of the 'Imperfect but Workable Good.'" *Tropical Medicine & International Health* 16 (1): 105–109. doi:10.1111/j.1365-3156.2010.02639.x.

Agyepong, I. A., and S. Adjei. 2008. "Public Social Policy Development and Implementation: A Case Study of the Ghana National Health Insurance Scheme." *Health Policy and Planning* 23 (2): 150–160. doi:10.1093/heapol/czn002.

Aka, P. C., I. J. Gassama, A. B. Assensoh, and H. Wahab. 2017. "Ghana's National Health Insurance Scheme (NHIS) and the Evolution of a Human Rights to Healthcare in Africa." *Chicago-Kent Journal of Int'l & Comp. Law* 17 ((2)(Spring)): 1–65.

Apoya, P., and A. Marriott. 2011. *Achieving a Shared Goal: Free Universal Health Care in Ghana*. Oxfam International.

Arhinful, D. K. 2003. *The Solidarity of Self-Interest: Social and Cultural Feasibility of Rural Health Insurance in Ghana*. Leiden, NL: African Studies Center.

Aryeetey, E., and M. Goldstein. 2000. "The Evolution of Social Policy." In *Economic Reforms in Ghana: The Miracle and Mirage*, edited by E. Aryeetey, J. Harrigan, and M. Nissanke, 284–303. Trenton, NJ: Africa World Press.

Atinga, R. A., G. A. Abiiro, and K. Robert Bella. 2014. "Factors Influencing the Decision to Drop Out of Health Insurance Enrolment among Urban Slum Dwellers in Ghana." *Tropical Medicine & International Health* 20 (3): 312–321. doi:10.1111/tmi.12433.

Avelino, G., D. S. Brown, and W. Hunter. 2005. "The Effects of Capital Mobility, Trade Openness, and Democracy on Social Spending in Latin America, 1980–1999." *American Journal of Political Science* 49 (3): 625–641. doi:10.1111/j.1540-5907.2005.00146.x.

Boateng, K. A. 2012. "Implement One Time Premium Policy - Berekum MP Tells NDC Government." June 3. Accessed 23 December 2014. http://www.modernghana.com/news/399337/1/implement-one-time-premium-nhis-policy-berekum-mp-.html.

Bratton, M. 2007. "Are You Being Served? Popular Satisfaction with Health and Education Services in Africa". *Afrobarometer* Working Paper No. 65.

Brown, D. S., and W. Hunter. 1999. "Democracy and Social Spending in Latin America, 1980–1992." *American Political Science Review* 93 (4):779–790.

Carbone, G. 2011. "Democratic Demands and Social Policies: The Politics of Health Reform in Ghana." *Journal of Modern African Studies* 49 (3): 381–408. doi:10.1017/S0022278X11000255.

Carbone, G. 2012. "Do New Democracies Deliver Social Welfare? Political Regimes and Health Policy in Ghana and Cameroon." *Democratization* 19 (2): 157–183. doi:10.1080/13510347.2011.572618.

Chan, M. 2010. "Message from the Director-General." In *World Health Organization, the World Health Report: Health System Financing: The Path to Universal Coverage Vi, Vii*. Geneva: World Health Organization.

Citifmonline.com. 2010. "NHIS Workers Threaten Strike." December 10. Accessed 15 May 2016. http://www.ghanaweb.com/GhanaHomePage/NewsArchive/NHIS-workers-threaten-strike-199241.

Citifmonline.com. 2012. "Former KATH Boss- NDC Has Collapsed NHIS." September 12. Accessed 24 February 2015. http://exposeghana.com/2012/09/former-kath-boss-ndc-has-collapsed-nhis/.

Citifmonline.com. 2013. "Dr Richard Anane: NDC Has Collapsed NHIS." March 13. Accessed 24 February 2015. http://exposeghana.com/2013/03/dr-richard-anane-ndc-has-collapsed-nhis/.

Corley, J. April 10, 2020. "U.S. Government Response to COVID-19 Was Slow. But How Does It Compare to Other Countries?" Forbes. Accessed 10 May 2020. https://www.forbes.com/sites/jacquelyncorley/2020/04/10/us-government-response-to-covid-19-was-slow-but-how-does-it-compare-to-other-countries/.

Daily Graphic. November 17, 2011. "NHIS One-Time Premium to Commence." Daily Graphic. Accessed November 16, 2015. http://www.modernghana.com/news/361447/1/nhis-one-time-premium-to-commence.html.

de Mesquita, B., J. D. Bueno, R. M. S. Morrow, and A. Smith. 2002. "Political Institutions, Policy Choice and the Survival of Leaders." *British Journal of Political Science* 32 (4): 559–590. doi:10.1017/S0007123402000236.

Dixon, J., E.Y. Tenkorang, and I. Luginaah. 2011. "Ghana's National Health Insurance Scheme: Helping the Poor or Leaving Them Behind?" *Environment and Planning-Part C* 29 (6): 1102. doi:10.1068/c1119r.

Essel, I. 2011. "NHIS: One-Time Premium in 2012; but NPP Says It's Nonstarter." Modern Ghana News, November 16. Accessed 23 December 2014. http://www.modernghana.com/news/412053/1/nhis-one-time-premium-to-be-implemented-on-optiona.html.

Ghana News Agency. 2003. "NDC States Its Stand on Health Insurance." September 14. Accessed 15 September 2013. http://www.modernghana.com/news/40956/1/ndc-states-its-stand-on-health-insurance.html.

Ghana News Agency. 2010. "Strike of Junior Nurses Not Affecting Work at KATH." October 6. Accessed 15 May 2016. http://www.ghanaweb.com/GhanaHomePage/health/Strike-of-junior-nurses-not-affecting-work-at-KATH-194713.

Ghana News Agency. 2012. "NHIS 'One Time Premium' to Be Implemented on Optional Basis - Yakubu." Modern Ghana News, August 17. Accessed 23 December 2014. http://www.modernghana.com/news/412053/1/nhis-one-time-premium-to-be-implemented-on-optiona.html.

Ghobarah, H. A., P. Huth, and B. Russett. 2004. "Comparative Public Health: The Political Economy of Human Misery and Well-Being." *International Studies Quarterly* 48 (1): 73–94. doi:10.1111/j.0020-8833.2004.00292.x.

Gyasiwaa, A. 2012. "Onetime Premium Is the Biggest Hoax in Ghana's Political History - Akufo-Addo." Modern Ghana News, October 31. Accessed 23 December 2014. http://www.modernghana.com/news/427051/1/onetime-premium-is-the-biggest-hoax-in-ghanas-poli.html.

Gyimah-Boadi, E. 2009. "Another Step for Ghana. Journal of Democracy." *Journal of Democracy* 20 (2): 138–152. doi:10.1353/jod.0.0065.

Hansard. 2003a:158-160. *Parliamentary Debates*. 19 August. Accra, Ghana: Parliament of Ghana.

Hansard. 2003b:2409. *Parliamentary Debates*. 11 July. Accra: Parliament of Ghana.

Hansard. 2003c:64. *Parliamentary Debates*. 18 August. Accra, Ghana: Republic of Ghana.

Hansard. 2003d:64-65. *Parliamentary Debates*. 18 August. Accra, Ghana: Republic of Ghana.

Hansard. 2003e:76-103. *Parliamentary Debates*. 19 August. Accra, Ghana: Republic of Ghana.

Hansard. 2003f:161. *Parliamentary Debates*. 19 August. Accra, Ghana: Republic of Ghana.

Hansard. 2012a:3344-3345. *Parliamentary Debates*. 22 March. Accra, Ghana: Republic of Ghana.

Hansard. 2012b:2915. *Parliamentary Debates*. 17 July. Accra, Ghana: Republic of Ghana.

Hansard. 2012c:2729-2730. *Parliamentary Debates*. 12 July. Accra, Ghana: Republic of Ghana.

Hansard. 2012d:2935. *Parliamentary Debates*. 17 July. Accra, Ghana: Republic of Ghana.

Hansard. 2012e:2944. *Parliamentary Debates*. 17 July. Accra, Ghana: Republic of Ghana.

Heymann, D., and R. Yates. 2014. "Embracing the Politic of Universal Health Coverage." Chatham House: The Royal Institute of International Affairs. June 25, https://www.chathamhouse.org/expert/comment/14972.

Immergut, E. M. 1990. Institutions, Veto Points, and Policy Results: A Comparative Analysis of Health Care." *Journal of Public Policy* 10(4): 391–416 doi:10.1017/S0143814X00006061.

Immergut, E. M. 1992. *Health Politics: Interests and Institutions in Western Europe*. New York: Cambridge University Press.

Jehu-Appiah, C., G. Aryeetey, E. Spaan, I. Agyepong, and R. Baltussen. 2010. "Efficiency, Equity and Feasibility of Strategies to Identify the Poor: An Application to Premium Exemptions under National Health Insurance in Ghana." *Health Policy* 95 (2–3): 166–173. doi:10.1016/j.healthpol.2009.11.017.

Jehu-Appiah, C., C., G. Aryeetey, E. Spaan, I. Agyepong, and R. Baltussen. 2011. "Equity Aspects of the National Health Insurance Scheme in Ghana: Who Is Enrolling, Who Is Not, and Why?" *Social Science & Medicine* 72 (2): 157–165. DOI:10.1016/j.socscimed.2010.10.025.

Kasza, G. J. 2006. *One World of Welfare: Japan in Comparative Perspective*. Ithaca, NY: Cornell University Press.

Kaufman, R. R., and A. Segura-Ubiergo. 2001. "Globalization, Domestic Politics, and Social Spending in Latin America: A Time-Series Cross-Section Analysis, 1973–97." *World Politics* 53 (4): 553–587. doi:10.1353/wp.2001.0016.

Lake, D. A., and M. A. Baum. 2001. "The Invisible Hand of Democracy: Political Control and the Provision of Public Services." *Comparative Political Studies* 34 (6): 587–621. doi:10.1177/0010414001034006001.

Myjoyonline.com. 2010. "Junior Nurses, Midwives End Nationwide Strike." October 6. Accessed 15 May 2016. http://www.ghanaweb.com/GhanaHomePage/NewsArchive/Junior-nurses-midwives-end-nationwide-strike-194722.

NDC (National Democratic Congress). 2000. "2000 Manifesto: Spreading the Benefits of Development." Accessed 18 December 2014. http://www.ghanareview.com/NDC.html.

NDC (National Democratic Congress). 2008. "A Better Ghana: Investing in People, Jobs and the Economy." Accessed 18 December 2014. http://www.africanelections.org/Userfile/file/NDC%20MANIFESTO.pdf.

Nelson, J. M. 2007. "Elections, Democracy, and Social Services." *Studies in Comparative International Development* 41 (4): 79–97. doi:10.1007/BF02800472.

NHIA (National Health Insurance Authority). 2009. *National Health Insurance Scheme: Annual Report*. Accra: Republic of Ghana.

NHIA (National Health Insurance Authority). 2010. *National Health Insurance Scheme: Annual Report*. Accra, Ghana: Republic of Ghana.

NPP (New Patriotic Party). 1996. *Manifesto of the New Patriotic Party: Development in Freedom Change, and Agenda for Change*. Accra, Ghana: New Patriotic Party.

NPP (New Patriotic Party). 2008. "Manifesto: The NPP's Record - A Promise Delivered." http://www.africanelections.org/Userfile/file/NPP%20MANIFESTO%202008%20ELECTIONS.pdf.

Nugent, P. 2007. "Banknotes and Symbolic Capital: Ghana's Elections under the Fourth Republic." In *Votes, Money and Violence: Political Parties and Elections in Sub-Saharan Africa*, edited by M. Basedau, G. Erdmann, and A. Mehler, 253–275. Uppsala, Sweden: Nordiska Afrikainstitutet.

Osei, A. 2013. "Political Parties in Ghana: Agents of Democracy?" *Journal of Contemporary African Studies* 31 (4): 543–563. doi:10.1080/02589001.2013.839227.

Peace, F. M. 2012. "NHIS One-Time Premium Will Collapse - IMANI." Peacefmonline.com, August 23. Accessed 23 December 2014. http://elections.peacefmonline.com/politics/201208/131012.php.

Przeworski, A., M. E. Alvarez, J. A. Cheibub, and F. Limongi, eds. 2000. *Democracy and Development: Political Institutions and Well-Being in the World, 1950–1990*. Vol. 3. New York: Cambridge University Press.

Rajkotia, Y. 2009. *National Health Insurance in Ghana: Politics, Adverse Selection, and the Use of Child Health Services*. Ph.D. dissert., Johns Hopkins University, Baltimore, MD. April.

Roberts, M. J., W. Hsiao, P. Berman, and M. R. Reich. 2008. *Getting Health Reform Right: A Guide to Improving Performance and Equity*. New York: Oxford University Press.

Seddoh, A., S. Adjei, and A. Nazzar. 2011. *Ghana's National Health Insurance Scheme: Views on Progress, Observations and Commentary*. Accra, Ghana: Centre for Health and Social Services.

Seddoh, A., and S. A. Akor. 2012. "Policy Initiation and Political Levers in Health Policy: Lessons from Ghana's Health Insurance." *BMC Public Health* 12 (S10): S.1. doi:10.1186/1471-2458-12-S1-S10.

Shugart, M. S., and J. M. Carey. 1992. *Presidents and Assemblies: Constitutional Design and Electoral Dynamics*. New York: Cambridge University Press.

Skocpol, T., and E. Amenta. 1995. "Redefining the New Deal: World War II and the Development of Social Provisions in the United States." In *Social Policy in the United States: Future Possibilities in Historical Perspective*, edited by T. Skocpol, 167–208. Princeton, NJ: Princeton University Press.

Steinmo, S., and J. Watts. 1995. "It's the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America." *Journal of Health Politics, Policy and Law* 20 (2): 329–372. doi:10.1215/03616878-20-2-329.

Wahab, H. 2014. "Universal Health-Care Coverage: Assessing the Implementation of Ghana's NHIS Law." In *Intellectual Agent, Mediator and Interlocutor: A. B. Assenssoh and African Politics in Transition*, edited by T. Falola and E. M. Mbah, 188–199. Newcastle, UK: Cambridge Scholars Publishing.

Wahab, H. 2019. "The Politics of State Welfare Expansion in Africa: Emergence of National Health Insurance in Ghana, 1993-2004." *Africa Today* 64 (3): 91–112.

World Health Organization. 1995. *World Health Report 1995: Bridging the Gaps*. Geneva: World Health Organization.

World Health Organization. 2010. *World Health Report: Health System Financing: The Path to Universal Coverage*. Geneva: World Health Organization.

World Health Organization. 2011. "The Abuja Declaration: Ten Years On." https://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf?ua=1.

World Health Organization. 2014. *Health in All Policies: Helsinki Statement Framework for Country Action*. Geneva: World Health Organization.