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POLICY TRANSFER AND HEALTH POLICYMAKING PROCESS: THE CASE OF SOCIAL HEALTH INSURANCE IN GHANA

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Abstract: *Since the introduction of the user fee system of healthcare financing in 1969 and its subsequent modifications, the burden of healthcare expenditure on residents of Ghana created health inequality. This system encouraged the poor and vulnerable to have limited access to essential drugs and services. Policy entrepreneurs contributed to raising awareness about the poor and vulnerable people in Ghana not having access to health due to the user fee system as a public policy problem. This awareness began to spread among political leaders, the masses, and professional groups, warranting the attention of policymakers. As significant public dissatisfaction and agitation against the user fee policy continued, the media continued to hold the government responsible for initiating the policy. The democratization process and election period between 1998 and 2000 provided a window of opportunity that led to the idea of health policy change. In 2003, Ghana established the National Social Health Insurance, a form of Social Health Insurance. This study examines the process of establishing the social health insurance scheme through policy transfer framework. First, the paper examines Ghana's health policy after independence, the National Health Service, and the User Fee Policy that was implemented in 1985. Second, the paper accessed the policy transfer framework and applied it to the transfer of social health insurance. Third, the paper explains the radical change from the user fee policy to the social health insurance model. This essay uses time series analysis and comparative analysis to assess the impact of the social health insurance on the under-five mortality ratio, maternal mortality ratio and out-of-pocket expenditure. The assessment results show that the social health insurance scheme has a positive impact on under-five mortality, maternal mortality and out-of-pocket payment compared to Nigeria without social health insurance for the poor and other vulnerable groups. The paper concludes that policy transfer alone cannot be a single variable to explain radical health policy change, but when combined with other complementary perspectives, an empirically grounded account of policy change can be developed.*
Keywords: health insurance; health policy; idea; policy change; user fee.
JEL Classification: I10, I13, I14, I18

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Introduction. We live in the world where change is constant, whether it is in industries, technologies or different sectors such as transportation, healthcare, education or social policies (Cerna, 2013). Several studies have conceptualised and theorised how changes take place in the policy arena. For instance, Dolowitz and Marsh (2000) developed the policy transfer framework, which is linked with the concept of lesson drawing (Rose, 1991) and policy learning (Cerna, 2013) in the explanation of policy change.

One field that has been consistent with policy transfer and policy change is the health sector. For example, the idea of Ghana's Social Health Insurance (SHI) was developed by combining ideas from different countries. Dolowitz and Marsh (2000) refer to this approach of lesson drawing as «combinations», which entail mixtures of several policies. For Rose (1991), it is «synthesis», which is the combination of familiar elements from programs in effect in three or more countries. Ghana borrowed the idea of SHI by drawing lessons from Germany, Thailand, Tunisia, Chile, Zimbabwe and the UK (Wireko, 2015).

Aside from the introduction of SHI in 2003, Ghana has also formulated other health policies to increase healthcare financing and improve the health of its population. For instance, Ghana created the National Health Service (NHS) after gaining independence. As a result of this unsustainable healthcare system, a complete user fee policy was introduced in 1985. The user fee policy constituted a barrier to many Ghanaians accessing healthcare because they had to pay money before services. Policy entrepreneurs framed this policy as a problem, and when the window of opportunity opened in 2001, SHI was used to replace the policy.

Several studies have examined these changes in health policy, but they failed to give comprehensive details of how these changes occurred in policymaking. For example, Agyepong and Adjei (2008), Alatinga (2011), Kipo-Sunyehzi et al. (2019), and Singleton (2006) have examined changes in Ghana's healthcare policy using different theoretical approaches. However, they did not offer in-depth analyses of the procedures and systems used to carry out the policy, from the NHS to the SHI.

Additionally, the literature directly addressing radical policy change in the context of voluntary policy transfer in Ghana is noticeably lacking. This is especially the case of Hall (1993), whose work has proven particularly influential in studying policy change but has not been directly applied to the study of policy transfer except for two studies (Evans, 2006).

Hall's (1993) analysis demonstrates how policy change occurs in three subtypes. These are the first-order change, the second-order change, and the third-other change. In the first-order change, policy is adjusted every year in response to new developments or past experiences. In the second order, policy is amended without radically changing the hierarchy of goals behind it. The third-order change occurs when the set of goals and instruments adopted to guide policy shift radically.

For the purpose of this study, the transition from user fees to SHI will be considered with a radical shift. This is because of the complete discontinuation of the user fee method as well as the stoppage of a capitalist model to a social health insurance scheme «which entailed simultaneous changes in all three components of policy: the instrument settings, the instruments themselves, and the hierarchy of goals behind policy» (Hall, 1993).

Policy transfer is used as an explanation of policy change. It is an essential theoretical approach for understanding policy improvement in developing countries through critical analysis. Policy transfer is «concerned with the process by which knowledge about policies, administrative arrangements, institutions and ideas in one political system (past or present) is used in the development of policies, administrative arrangements, institutions and ideas in another political system» (Dolowitz and Marsh, 2000). It best explains the health policy change from the user fee to SHI in Ghana. In other words, it helped explain and analyse Ghana's process of lessons drawing from other countries' health policies to address its domestic problems.

However, policy transfer analysis alone cannot account for policy change on a general level (Evans and Barakat, 2012), since there are several processes involved in transfer (Stone, 2001). These include:

- attitudes and ideas;
- ideologies or justifications,
- policies,
- institutions,
- negative lessons (Dolowitz, 1997;Stone, 2001).

Because of this, the many dynamics in the policy process cannot be explained by one variable alone (Ouma, 2019).

Hence, this essay adopts what Rhodes (1995) has called «a multi-theoretic approach» or «methodological pluralism» in which complementary theories of policy formulation are synthesised to develop a theory of policy change that explains the role of specific agents of policy transfer in instituting policy change (Evans

and Barakat, 2012). In its simplest form, policy transfer is nothing new (Hulme, 2005). However, it compels «us to examine the origins of «new» knowledge about policy, who supplies such knowledge and the political and practical purposes to which this knowledge is put» (Hulme, 2005). It is against this background that this essay is conceived.

The specific objective of the essay is to use the policy transfer framework to illuminate the processes of policy change, from user fees to the SHI. The remainder of this essay is as follows: in the second section, after this introduction, the essay examines the trends in Ghana's health reforms after independence. Our attention in this section focuses on the National Health Service and the User Fee Policy. Because both policies took incremental reform patterns, we paused a little bit from the reform processes to examine the policy transfer framework in the third section. Then, we applied it in the fourth section to explain the radical change from the user fee policy to social health insurance.

Literature Review.

Trends in Ghana's Health Policy Change since Independence. National Health Service (1957-1983). Before Ghana gained independence in 1957, healthcare provision was managed by the British colonial administration. During this time, the colonial masters adopted the user fee method to finance healthcare services. This was the case where private individuals were charged half a penny, which was the equivalent of two farthings, and those who worked as public or civil servants, such as the police, were given free healthcare (Arhinful, 2003). This situation remained unchanged for a long time. However, as a result of the Great Depression, the user fee was increased by 100 percent (Arhinful, 2003).

In 1957, social approaches concerning healthcare policy underwent a dramatic change after the end of colonialism (Carbone, 2011). The new independent leader of Ghana, Kwame Nkrumah, saw the user fee method imposed on Ghanaians by the colonial administration as arbitrary, despite Ghanaians suffered from a wide array of nutritional, maternal, perinatal and communicable diseases (Aikins and Koram, 2017). For this reason, the Nkrumah administration had to abolish the user fee method in all public hospitals (Kusi-Ampofo et al., 2015) and replaced it with free healthcare for all residents of Ghana (Wireko, 2015).

As a result, Ghana's health system became very similar to the British National Health Service (NHS) system in 1962, which provided universal health care throughout the country (Wireko, 2015). Under the free healthcare system, access to medical care became a fundamental right, thus eliminating the need for individuals to seek services from the market (Wireko, 2015). Additionally, the government became the sole provider of healthcare services (Wireko, 2015), and services were financed through general taxation (Agyepong and Adjei, 2008). Part of this policy initiative can be attributed to President Kwame Nkrumah's socialist ideas (Kusi-Ampofo et al., 2015), as the Nkrumah administration laid a greater focus on preventive health care than on a «hospital-based curative» health system (Carbone, 2011).

The economic effects of Nkrumah's socially-inspired programs did not take long to become apparent (Arhinful, 2003). It caused revenue shortfalls throughout the 1960s (Arhinful, 2003). At this point, Ghana soon discovered that in addition to building up the country, it was struggling to sustain its newly established national health system (Carbone, 2011). As the economy of the country deteriorated, so did the quality and operation of free public health care (Carbone, 2011). It became apparent that measures needed to be taken to sustain the national health system.

Since it was evident that the free healthcare system was not sustainable (Kipo-Sunyehzi et al., 2019), the military overthrow of Nkrumah's government in 1966 altered Ghana's social policy course (Arhinful, 2003; Kipo-Sunyehzi et al., 2019; Kusi-Ampofo et al., 2015). The free healthcare system was replaced with user fees to reduce government spending on healthcare and increase fiscal space for other development projects. This was done through the 1969 enactment of the Hospital Fees Degree, which was subsequently amended to the Hospital Fees Act of 1971 (Carbone, 2011; Kipo-Sunyehzi et al., 2019).

Despite the implementation of a user fee system in 1969 and 1971, the government heavily subsidised healthcare costs (Agyepong and Adjei, 2008; Nyonator and Kutzin, 1999). The heavily subsidised user fee system came to an end in 1985 after external actors demanded through conditionalities that the government cut public spending, leading to the adoption of a complete user fee method without government subsidization.

User Fee Policy with Cash and Carry System (1983/5-2003)

By the middle of the 1970s and the early 1980s, the social services in Ghana had been attacked by a significant lack of resources, and it was in a state of shambles (Carbone, 2011). The worsening of the Ghanaian economy affected the health sector, which led to significant shortages of essential drugs, supplies and equipment. Besides, there was poor quality of care that deteriorated the population's health status, and the

primary health care goal was never met (Agyepong and Adjei, 2008; Arhinful, 2003). The necessity of restoring the healthcare system became a top priority agenda (Carbone, 2011).

It was not surprising that interest groups, such as the Ghana Pharmaceutical Association and the Ghana Medical Association, encountered little opposition when they demanded that out-of-pocket payments be significantly increased to provide the resources that the system required (Carbone, 2011). While the Ghanaian economy continued to wobble, there was a change of government on 31 December 1981. The military struck and took over power, and Flight Lieutenant Jerry Rawlings became the Head of State under the Provisional National Defence Council. To find an immediate solution to the crisis in the health sector, the new government of Rawlings introduced surcharges on foreign drugs and hospital equipment (Arhinful, 2003). The idea of the government was to increase fees for healthcare services (Arhinful, 2003). Non-Ghanaians were charged higher fees for medical services for the first time (Arhinful, 2003). Even so, this was insufficient to save the situation; more pragmatic measures became necessary (Arhinful, 2003).

Recognising the impact of the economic crisis not only on the health care sector, but also on the entire economy, the government implemented the Structural Adjustment Program (SAP) in 1983 as a means of halting further economic decline (Baidoo, 2009). As a result, the Rawlings regime was forced to seek financial assistance from the IMF and the World Bank in order to keep the economy running (Brenya and Adu-Gyamfi, 2014). As a condition of granting financial assistance, the World Bank and IMF demanded that the Ghanaian government reduced public spending (Carbone, 2011), particularly on healthcare. This condition prompted the government to pass the Hospital Fee Regulations Act in 1985, also known as Legislative Instrument 1313 (Arhinful, 2003; Brenya and Adu-Gyamfi, 2014; Carbone, 2011; Kusi-Ampofo et al., 2015).

The purpose of this law was to charge user fees for health care in all public hospitals (Kusi-Ampofo et al., 2015) without government subsidy. Fees for surgery, consultations, laboratory and other diagnostic procedures were mandated by the law (Kusi-Ampofo et al., 2015). In addition, user fees were charged for dental services and hospital accommodation (Kusi-Ampofo et al., 2015). The aim was to recover at least 15% of the government's recurrent expenditure (Agyepong and Adjei, 2008; Carbone, 2011).

This healthcare financing system popularised the phrase «cash and carry», emphasising the importance of Ghanaians paying cash before seeking care at any public health facility (Brenya and Adu-Gyamfi, 2014; Carbone, 2011; Kipo-Sunyehzi et al., 2019; Kusi-Ampofo et al., 2015). Except for immunisations and the treatment of specific diseases like leprosy and tuberculosis, the cash and carry system required patients to pay the full cost of pharmaceutical services and nominal fees for other services (Arhinful, 2003). Certain groups of people, such as children, older people and pregnant women, were exempted from paying for health services (Brenya and Adu-Gyamfi, 2014; Carbone, 2011). However, a few exemptions from the user fee policy were never fully implemented (Ofori-Birikorang, 2009). In fact, the vast majority of people, including those who may be exempted from user fees, were unaware of the existence of fee exemption schemes (Wireko, 2015).

Unfortunately, the user fee system did not achieve its intended goals and instead became a burden for the poor (Brenya and Adu-Gyamfi, 2014). Under the healthcare financing regime, the poorest quintile got only 12.2 percent of total government health spending in 1989, while the richest quintile received 30.4 percent (Aryeetey and Goldstein, 2000). In 1992, the distribution had deteriorated slightly, with the bottom quintile accounting for 11.6 percent of spending and the top quintile accounting for 33 percent (Aryeetey and Goldstein, 2000).

According to Carbone (2011), some empirical investigations by Agyepong (1999), Nyonator and Kutzin (1999), Waddington and Enyimayew (1989; 1990) quickly revealed the extent to which a user-fee-based system effectively excluded all individuals who could not afford to pay for the public healthcare system. This health gap became a problem for the Ghanaian government in the 1990s, and it was concerned about how to address the injustice gap between the rich and poor, rural and urban people effectively (Kipo-Sunyehzi et al., 2019). This health inequality situation prompted policy entrepreneurs to start the search for ideas that have worked elsewhere in enhancing healthcare utilisation and reducing financial hardship. The importation of a workable idea from one jurisdiction to another political setting to solve a problem is called policy transfer (Dolowitz and Marsh, 2000). This essay will examine the framework in the next section with the stages involved in the search for a successful program from one political system to solve a policy problem in another jurisdiction.

Policy Transfer: Theoretical Framework

Dolowitz and Marsh (2000) coined the term of policy transfer and Evans and Barakat defined it as «a generic concept that refers to a process in which knowledge about institutions, policies or delivery systems at one sector or level of governance is used in the development of institutions, policies or delivery systems at another level of governance in a different country» (Evans and Barakat, 2012). As a generic concept, policy

transfer has been used by researchers to explain the processes of policy change within a political system or cross-nationally.

Policy transfer entails lesson drawing and policy learning. Furthermore, transfers can be influenced by political, economic and educational purposes (Eta and Mngo, 2021). Rose (1991) argues that when a problem arises, policymakers in cities, regional governments and nations can learn from how others elsewhere respond. Besides, it offers policymakers the possibility of learning lessons they can apply to their problems. When the lesson is positive, a policy that works is transferred and adapted accordingly (Rose, 1991).

Policy-oriented learning can occur between ministers, civil servants, think tanks, academic experts or practitioners in various nations who are connected by e-mails (Hulme, 2006). There is the possibility for policymakers in country A to travel to country B for learning how to improve the population's health.

Learning through policy transfer can come in two major ways. These are through coercive and voluntary transfers (Boßner et al., 2020; Hulme, 2006). Coercive policy transfers occur when other players, such as states or international or supranational bodies, push political entities to adopt specific policies (Bender et al., 2014). Within the European Union, for example, the Court of Justice can compel member states to follow European policies and directives as part of their responsibilities to the Union (Shapiro, 1992). The question is, however, can any act of the Union be viewed as coercive in terms of policy transfer since individual nations joined the Union voluntarily? (Dolowitz and Marsh, 2000). At the same time, each nation has a say in the direction how EU policies should be taken (Dolowitz and Marsh, 2000). As such, they actively and freely shape and approve the Union's edicts; «for this reason, it is best viewed as obligated and negotiated transfer» (Dolowitz and Marsh, 2000). Negotiated transfer occurs when countries are compelled to adjust their policies in exchange for loans or financial support (Bender et al., 2014). Most of the policy transfers to Africa can be considered coercive or negotiated transfers because of the conditionalities attached to loans that altered domestic policies. As a good example, the Structural Adjustment Programs mandated by the IMF allowed several African countries to embrace privatisation policies.

Unlike coercive transfer, voluntary transfer is based on the notion that policymakers choose policy transfer as a rational response to perceived problems (Dolowitz, 2000). It is considered as a rational and action-oriented mechanism to tackle public policy problems (Evans, 2006). Voluntary policy transfer functions as an aspiration to improve an existing condition when there is no internal/external pressure (Dolowitz, 2009). In the process of policy learning to improve an existing condition, Sacks (1980) asserts «this approach implies that elements within the state, acting in pursuit of the national interest, decide what to do without serious opposition from external actors». Here, the state is considered as an «autonomous actor» (Common, 1999; Hall, 1993). Thus, if governments are looking for policy solutions to new or evolving challenges, they are more prone to turn for «solutions» elsewhere (Dolowitz and Marsh, 2000).

Policy solutions to solve a societal problem through a voluntary policy transfer can be divided into three major stages that involve diverse learning activities. It is demonstrated in Figure 1. According to Evans and Barakat (2012), these stages are pre-decision, decision and post-decision within policy-oriented learning.

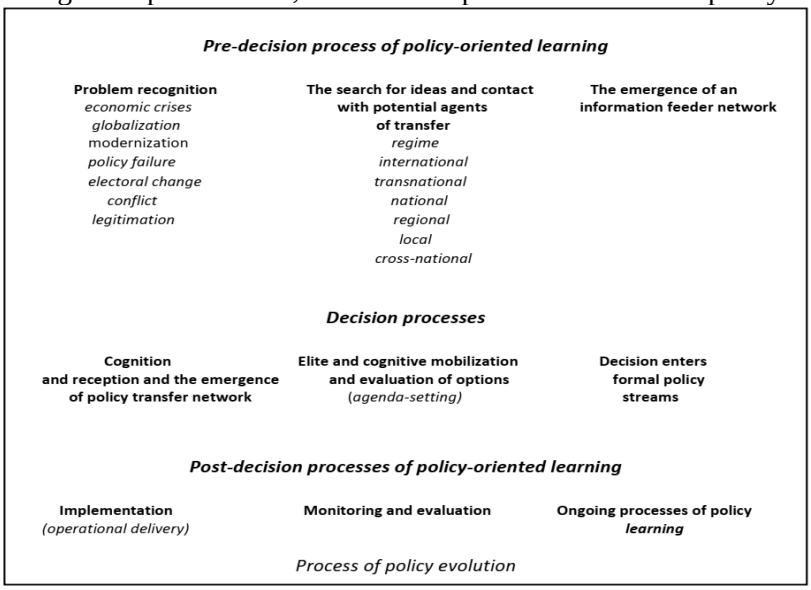

Figure 1. The emergence and development of a voluntary policy transfer network

Sources: developed by the authors based on (Evans and Barakat, 2012).

The first stage entails identifying a public policy problem, searching for ideas, identifying agents of transfer and establishing a policy transfer network. The second stage includes agenda-setting and decision-making processes. The third stage refers to post-decision policy-oriented learning that emerge from the implementation phase. The ability of a policy to progress through these stages depends on environmental circumstances, such as current economic conditions, government changes and transfer agent types (Evans and Barakat, 2012). This voluntary policy transfer network is now applied to the case study of the Ghana's SHI establishment.

Methodology and research methods.

Desk Review. The desk review scope was to examine the existing literature on relationships between policy transfer and adoption of social health insurance in Ghana. To identify relevant documents and materials for our study, we conducted electronic search between April 2021 to July 2022 with the following key terms: social health insurance, policy transfer, lesson drawing, policy change, Ghana, policy implementation and policymaking. Our search included reviews of local and international journals. We also reviewed grey literature that included policy documents, working papers, conference papers, policy briefs, Master's theses, and DSc dissertations in the areas of policy transfer, policymaking and social health insurance.

Historical Analysis. To understand the history and content of social health insurance efforts in Ghana, documents such as academic and grey literature were used to construct a historical account of the dimensions of power, debates, ideas, decision-making, policy formulation, adoption and implementation within social health insurance. This review traced the history of Ghana's healthcare system from independence and identified critical junctures that created institutions to improve healthcare accessibility for Ghanaians.

Document Analysis. The document analysis scope was to examine the policy process related to social health insurance in response to health inequality in Ghana. The objectives were to identify the key themes and trends in health policy formation. The information was collected from the documents, synthesised and organised via a coding system to identify the key issues of policy transfer and social health insurance in Ghana. This included the following categories: pre-decision process, shaping policy discourse, window of opportunity, decision processes, policy formation, policy adoption and policy implementation based on the policy transfer framework by Evans and Barakat (2012).

Results.

The Social Health Insurance Establishment. The Pre-Decision Process of Policy-Oriented Learning. Framing Socio-Economic Conditions as a Rights-Based Problem

This section deals with the problem stream, the window of opportunity, the search for policy ideas and the implementation of a new health policy. Figure 2 gives graphic details of the processes involved in policy learning.

Out-of-pocket payment is known to deny a lot of vulnerable people access to healthcare when needed, especially in developing countries. This was also the case with the user fee system in Ghana. Since the introduction of this system of healthcare financing in 1969 and its subsequent modifications, the burden of healthcare expenditure on residents of Ghana created health inequality. For example, consumers in the user fee system were responsible for the full drug cost, which have been estimated to represent one of the largest proportions of total health care costs in Ghana (Arhinful, 2003).

Even when drugs and medical equipment were available, the exorbitant costs denied citizens the ability to afford them (Arhinful, 2003).This system encouraged the poor and vulnerable to have limited access to essential drugs and services (Agyepong and Adjei, 2008; Aikins and Koram, 2017; Wireko, 2015), thereby creating health inequality (Kipo-Sunyehzi et al., 2019). For example, outpatient attendance fell from 10-11 million in 1973 to around 5 million in 1987, representing roughly 38% of the population at the time (Lavy and Germmain, 1995). In some Ghanaian hospitals, utilisation rates declined by 32.4% (Waddington and Enyimayew, 1989, 1990; Criel, 1998). The greatest impact of user fees was on rural and poor Ghanaians who could not afford healthcare fees (Asenso-Okyere et al., 1997; Senah, 2001; Ofori-Birikornag, 2009).

The problem stream of the Kingdon framework (2014) helps expose how policy entrepreneurs contributed to raising awareness about the poor and vulnerable people in Ghana not having access to health due to the user fee system as a public policy problem. This awareness began to spread among political leaders, the masses and professional groups, warranting the attention of policymakers. However, policy entrepreneurs drew attention to the health inequality among poor Ghanaians in advancing their rights to healthcare as stated in the 1948 Universal Declaration of Human Rights. This attention did not find its way to the policy agenda at that time. Due to this, public discourse became the mouthpiece for pushing for health policy change in Ghana's policy agenda.

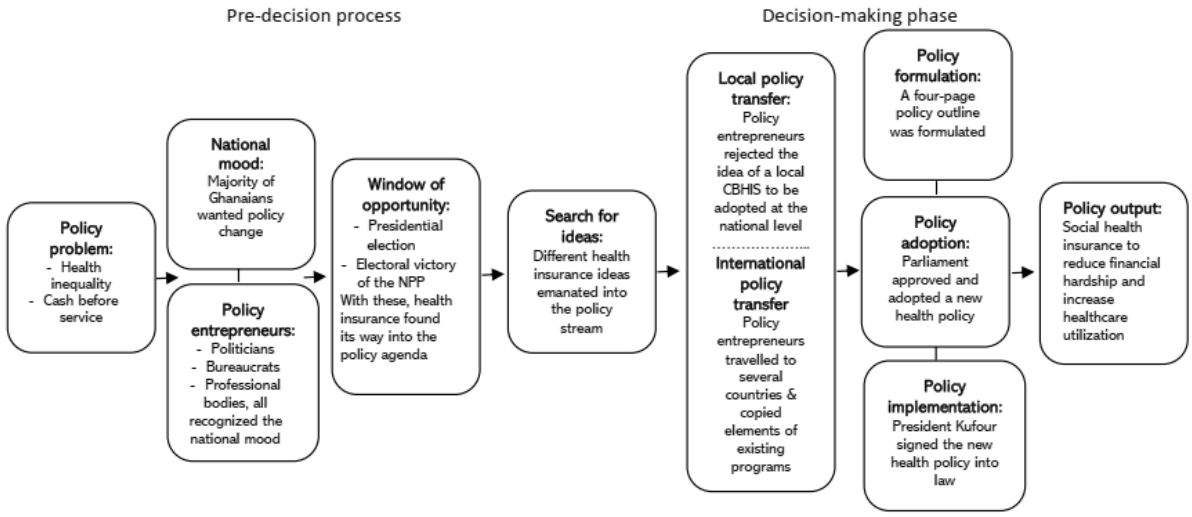

Figure 2. Summary graphic of pre-decision process and decision-making stages of ghana's radical health policy change

Sources: developed by the authors

Shaping the Discourse in Support of Ghanaians' Rights to Healthcare

Article 25 of the United Nations Universal Declaration of Human Rights stipulates that everyone has the right to healthcare (United Nations, 2015). However, the implementation of the user fees in Ghana by successive administrations did not follow the tenets of Article 25. The user fee system became a huge hindrance to healthcare for vulnerable groups. Several attempts were made to push the issue of health inequality onto the policy agenda, but these attempts failed to attract the attention of decision-makers.

As the user fee policy continued to make life difficult for poor Ghanaians, the media, political discourses, academic and grey literature, expert discussions and public opinion began reminding decision-makers of the danger of the user fee system. In the media and public space, how public policies are discussed and portrayed is called the policy image (Baumgartner and Jones, 1991).

As significant public dissatisfaction and agitation against the user fee policy continued, the media continued to hold the government responsible for initiating the policy (Wireko, 2015). Since the media influence health policy development by making health a crucial part of their news agenda (Ofori-Birikorang, 2009), they played a crucial role in framing the user fee policy as a problem that called for policy change. The Graphic, the Ghanaian Times, the Chronicle and the Guide were among the publications that continued to expose the horrors of the user fee policy (Kusi-Ampofo et al., 2015). For instance, in a published article from the New Internationalist with the title "Kill or Cure: Ghana Is Faithfully Following IMF Prescriptions, but Its Health Service Has Fallen Sick as a Result" (Brende, 1997), a medical officer stated the following about user fees (Kusi-Ampofo et al., 2015):

«The system is stinking and dehumanising…. Patients who do not have the ability to pay for medical service are turned away from hospitals only to die at home. The poor, the disabled and accident victims are being asked to pay on the spot before getting medical attention. This system has no human face. Our health service is in confusion» (Brende, 1997).

Besides the media, the situation attracted foreigners who came to Ghana on official assignments. As a case in point, John Kampfner (2002), who was in Ghana to make a film on the impact of IMF and World Bank reforms for the BBC, described the user fees as a misery. According to him:

«In the Tarkwa hospital patients have to pay all surgery costs – gloves, drugs, blood, anaesthetics, gauze, even cotton wool. Betty Krampa, a 20-year-old who has just given birth, is ready to leave. But she cannot until she has paid for her treatment… User fees have to be collected to keep the hospital going» (Kampfner, 2002).

Also, Melissa Taylor, a Volta Regional Hospital (VRH) volunteer and a staff nurse from London King's College Hospital, described the pathetic state of the user fee policy (Taylor, 2007). She put the unpleasant situation as:

«The Ghanaian health system has a cash and carry policy whereby people must pay up front before they are treated or discharged. Many cannot. At the VRH, patients were asked for a deposit before being referred to the relevant department… I met Alimata, a 16-year-old girl who had been in hospital for

three months. Her treatment lasted only a month, but her mother could not pay and stopped visiting» (Taylor, 2007).

As the agitation against the user fee policy continued and policy entrepreneurs were advocating for policy change, it was not until the year 2000 that a window of opportunity arose to consider the issue of health insurance policy in the Ghana's agenda.

The Window of Opportunity

One of the features of military regimes is that citizens are denied access to express their grievances through public discourse or protest. From 1969, when the user fees became the Ghana's health financing system, it was difficult for most Ghanaians to express their dissatisfaction with the policy during the military era. Furthermore, the opportunity to change the user fee policy to health insurance came up twice on the agenda, but it was denied access to the policy space (Wireko, 2015).

However, the democratization process and election period between 1998 and 2000 provided a window of opportunity that led to the idea of health policy change (Wireko, 2015). Also, the conducive environment that characterised the election period created new opportunities for policy entrepreneurs to envisage their choice of health insurance that would lead to reducing health inequality in Ghana. Kingdon asserts that the national mood and how people in government perceive it can bring some items to the public agenda (Kingdon, 2014). National moods do not remain static. They can shift allowing new ideas and approaches to current problems (Dubois and Saunders, 2017).

Besides, there can be efforts of organised political forces, especially if there is a consensus among them as to the most effective course of action. This course of action was taken by the two leading political parties in Ghana: the New Patriotic Party (NPP) and the National Democratic Party (NDC). They promised a change in the healthcare system if given the mandate to govern (Wahab and Aka, 2021).

During the 2000 election campaign, the NPP pledged to replace the current user fee policy, called as cash-and-carry, with a universal healthcare program (NPP, 1996). The NDC promised to review the user fee system «to improve its efficiency and increase access to basic health care services» (NDC, 2000). The above-mentioned offer helped the NPP win the parliamentary and presidential elections in 2000 (Rajkotia, 2009; Carbone, 2011). After the electoral victory, the search for the ideal type of health policy to replace the user fee system began in Ghana.

Entrepreneurial Strategic Action: The Search for Ideas

With the NPP in power and having promised a policy change in the healthcare system, the search for a politically acceptable policy was launched in earnest as a means of solving the problem. According to Rose, this lesson drawing starts with scanning programs in effect elsewhere and with the prospective evaluation of what could happen if a program were transferred in future (Rose, 1991). At this stage, as state Dolowitz and Marsh (2000), policymakers can look at the local, national and international levels for ideas. The continued dissatisfaction with the status quo of user fees made policy entrepreneurs in Ghana more interested in a quick-fix solution to the health policy problem.

The first scan for a suitable program by the policy entrepreneurs was at the local level in Ghana. The Catholic Church had already successfully established Community-Based Health Insurance Schemes (CBHISs) in Nkoranza in 1992 and West Gonja Hospital in Damongo in 1996 (Kipo-Sunyehzi et al., 2019) due to successive government failures to address health inequality caused by the user fee policy (Wireko, 2015). Policy entrepreneurs did a prospective evaluation of these two successful CBHISs to know if the ideas behind them could be transferred to the national level. The results of the evaluation showed that the CBHISs were limited by the fact that most of them concentrated only on hospitalisation. They were few in number, covering 1% of the population (Wireko, 2015).

Furthermore, because the majority of Ghanaians were excluded from CBHISs, they suffered from geographical constraints (Kipo-Sunyehzi et al., 2019). With these constraints in transferring the CBHIS from the local to the national levels, policymakers decided to seek an alternative health policy that would be more accessible to all Ghanaians, regardless of socioeconomic status. The best way to look for an alternative health policy by Ghanaian policymakers was to look for lessons abroad. As national policymakers start searching across international borders, there is potentially no limit as to the distance they can cover (Rose, 1991). In search of a lesson to be drawn, policymakers in Ghana reviewed health policy documents, and they travelled extensively around the world to see how the various models they had read about worked (Wireko, 2015).

According to the study by Wireko (2015) on health policy change from the user fees to the SHI in Ghana, one of the study's respondents claimed that politicians considered the German, Chilean and Thai healthcare models. Another respondent also affirmed that the Minister of Health travelled to Germany, Zimbabwe and

the UK to draw lessons. Responding to why the Ghanaian policymakers had to learn lessons from abroad, a former minister answered:

«In Germany, the health insurance history from Bismarck to now is very instructive… It made me feel confident… It made me feel that this thing has been done somewhere before. If I noticed and took account of our peculiar situation, then it made me feel confident that we could do it. Not that we said that we were going to copy somebody's things» (Wireko, 2015).

The role of Ghanaian policymakers in transferring ideas of some programs from abroad to suit the Ghanaian social, economic and political environment is what Rose (1991) called synthesis. This is the combination of familiar valid elements from programs in three or more countries. Ghana drew lessons from more than three countries. The next section examines the decision processes in the implementation of the ideal health policy.

Decision Processes. The Policy Transfer Window: Aligning SHI with the Political Stream

The previous section described how policymakers reviewed documents and visited some countries to produce ideas for better healthcare access in Ghana. Drawing lessons from Chile, Germany, Thailand, Tunisia, Zimbabwe and the UK (Wireko, 2015), the idea of a social health insurance model was aligned with the political stream.

In Kingdon's view (2014), three streams make up the policy process: the problem, policy and political streams. The problem stream includes issues that are likely to capture policymakers' attention. The policy stream is about policy solutions and the actors who design them. The political stream is about political factors such as swings in the national mood, electoral outcomes and legislation (Catney and Henneberry, 2016; Wireko, 2015).

When the NPP sold the idea of social health insurance to the electorate, it brought them victory in the presidential election. Social health insurance, known as the Bismarckian model (Bohm et al., 2013; Camillo, 2017; Thomson et al., 2009), is a very dynamic method for providing the population with unbiased access to health services (Carrin, 2002). Since Bismarck's Health Insurance Act of 1883 established the first social health insurance scheme (Busse et al., 2017), half of the industrialised world has adopted social health insurance as their primary funding mechanism (Carrin, 2002). Likewise, some developing countries have adopted social health insurance schemes to improve health coverage for their populations (Cotlear et al., 2015).

SHI is a cutting-edge socioeconomic initiative that promotes equity and fosters solidarity (Hsiao et al., 2007). Through it, risks are pooled and income is redistributed between the rich and the poor, the young and the old, the healthy and the less healthy (Hsiao et al., 2007). It was not a surprise that when SHI entered Ghana's policy agenda, it was supported by the majority of Ghanaians, which led to its formulation in the country.

Policy Formulation/Design

The policy community is a wider, more inclusive class of actors and penitential actors interested in policy formulation (Fischer, 2003).The former Ghana's Minister of Health (MOH), Richard Anane, falls into this policy community as he travelled abroad to learn about other countries' health policies. In 2001, he formed a seven-person design team to assist the Ministry of Health in developing an NHIS framework, including the basic benefit package and financing resources to launch the program (Agyepong and Adjei, 2008; Ile and Garr, 2012; Wireko, 2015). The design team was chaired by the MOH director of policy planning, monitoring and evaluation (Ile and Garr, 2012). Among its members, there were bureaucrats from the MOH, Ghana Health Service, Ghana Healthcare Company, the Dangme West District Health Directorate and Research (Agyepong and Adjei, 2008; Wahab and Aka, 2021; Wireko, 2015).

On designing the health policy, progress work was stalled due to vested interests among the team members (Wahab and Aka, 2021; Wireko, 2015). For instance, while the Minister of Health advocated for a centralised, single-payer healthcare system managed by a body other than the Ministry of Health, the design team recommended a healthcare program overseen by the Ministry of Health (Wahab and Aka, 2021). By June 2001, the two sides had reached an agreement on a package that included a centralised single-payer system. It was designed primarily for the organised formal and informal sectors (Agyepong and Adjei, 2008; Seddoh and Akor, 2012). The former was multi-payer semi-autonomous mutual health organisations. The latter was private commercial health insurance.

Having chosen a hybrid scheme, the design team decided on legislation to provide a central coordinating authority known as the National Health Insurance Council (NHIC). Besides, they created the National Health Insurance Fund (NHIF) to finance health policy (Ile and Garr, 2012). In June 2001, the Minister of Health

approved a four-page policy outline formulated by the design team. By January 2002, the team had completed a draft report, which it submitted to the minister for discussion and review with stakeholders from across the country (Wahab and Aka, 2021). In May 2002, the minister presented a final draft report to the cabinet for consideration, and the policy was approved in December 2002 (Agyepong and Adjei, 2008; Ile and Garr, 2012) for adoption.

Policy Adoption

A week before parliament was scheduled to go on recess in July 2003, the final version of the national health insurance bill was brought under a certificate of urgency for passage (Agyepong and Adjei, 2008). Advertisements were placed in national dailies asking for public feedback on the bill before parliament (Agyepong and Adjei, 2008). Professional bodies, such as the Civil Servants Association, Trade Union Congress, Registered Nurse Association and others raised eyebrows on some sections of the bill and questioned the rationale behind the quick passage without adequate consultations (Ile and Garr, 2012). As intense debates, protests and counter-protests accompanied the deliberations on the healthcare bill, parliament went into recess, and the passage of the bill was postponed (Agyepong and Adjei, 2008; Ile and Garr, 2012; Wireko, 2015).

A month after the debate on the bill was postponed, parliament was called back from recess in August 2003 to continue deliberating on its passage (Ile and Garr, 2012). On the resumption of legislative activities, the health bill continued to generate conflicts among stakeholders. For instance, the opposition party (NDC), which felt the debate on the bill was not in the national interest, walked out of parliament, hoping to soften the ruling party's stance so that the bill could be critically examined, but this failed (Ile and Garr, 2012). The Health Finance Bill was signed into law by the ruling party (NPP), which had the required number of votes (Ile and Garr, 2012). Protests by members of the public, stakeholders and interest groups against the bill's passage into law were futile because they accomplished nothing (Ile and Garr, 2012). The new health bill was later sent to the executive arm of the government for assent and implementation.

Policy Implementation

Following the successful health bill passage by parliament, it became Act 650 of 2003, the National Health Insurance Bill (Agyepong and Adjei, 2008; Fusheini et al., 2017; Ile and Garr, 2012; Singleton, 2006; Wahab and Aka, 2021). The bill became law after it was signed by President John Kufour on 5 September 2003, with implementation beginning in March 2005 (Singleton, 2006; Wahab and Aka, 2021).

District mutual, private mutual and private commercial schemes of insurance are all permitted under the health policy (Singleton, 2006). Every Ghanaian citizen must join one of these types of health insurance schemes. Each of them must provide basic healthcare benefits as determined by the National Health Insurance Council (Singleton, 2006).

Under the Act, both formal and informal sectors had to join the government-sponsored Mutual Health Organisations (MHOs) (Ile and Garr, 2012). Government sponsorship is available for district MHOs but not for private non-profit solidarity MHOs. Individual premium payments and a 2.5 percent tax levy known as the «National Health Insurance Levy» would be used to fund the health insurance (Ile and Garr, 2012). A 2.5 percent monthly contribution was to be deducted from the workers' pension. In the policy, risk is pooled across the district schemes, making the policy mandatory (Witter and Garshong, 2009).

Post-Decision Processes of Policy-Oriented Learning

This section utilises the findings of a SHI evaluation conducted by Hsiao et al. (2007), Saleh (2013) and Wang et al. (2017). These studies were published by the World Bank and their terms of reference were coverage rate under the SHI, administrative structure, challenges and utilisation. Other high-quality studies were also used for the SHI assessment in different domains.

This analysis indicates that Ghana's SHI can be viewed as a synthesis policy transfer, which drew lessons from Germany, Chile, Zimbabwe, Thailand, Tunisia and the UK. For example, the SHI financial modalities were largely adapted from Germany's payroll deduction system; Thailand, Chile, Tunisia and Zimbabwe's premium-based system; UK's tax-based system (Wireko, 2015).

With regards to the SHI administrative structure, evaluation findings show that the SHI has the National Insurance Fund, the National Health Insurance Council and the district administrative entities with other administrative setup (Hsiao et al., 2007). However, there appears to be a lack of agreement on which entity is the final authority and what roles the various entities are responsible for. According to the data available, Figure 3 illustrates a rough outline of the administrative structure.

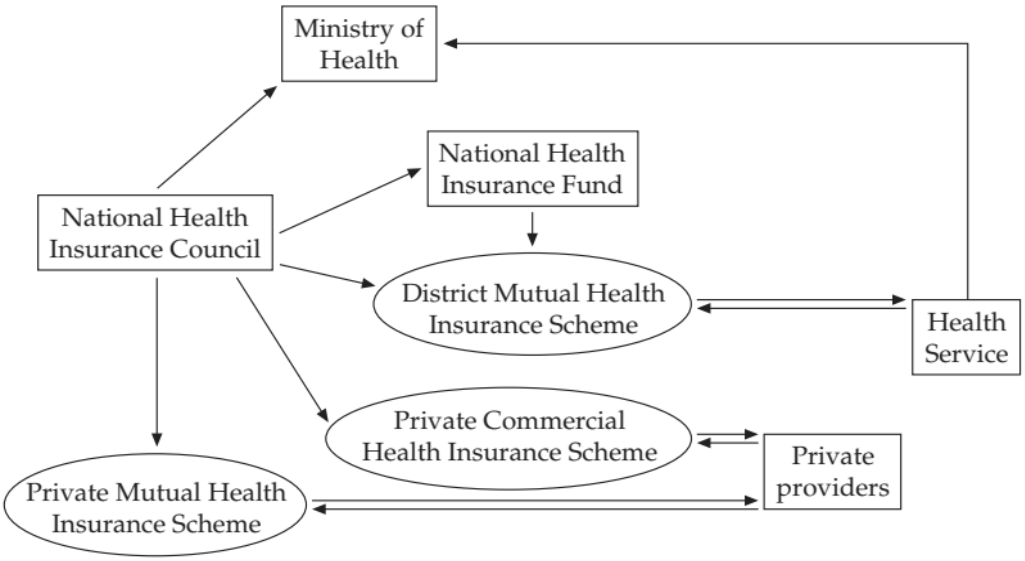

Figure 3. Interaction between Administrative Entities

Sources: developed by the authors based on (Hsiao et al., 2007).

Available data show a significant portion of Ghana's population has enrolled in the NHIS since 2005. Nevertheless, registration figures and valid cardholders differ between household surveys and institutional data (Saleh, 2013). According to NHIS institutional data, as of 2008, at least 55% of the population were enrolled in the NHIS, and 43% had a valid NHIS card (Saleh, 2013).

At the current level of coverage under the SHI, data from the U.S. Department of Commerce show SHI or private health insurance schemes cover 68.6% of Ghana's population, according to the 2021 census (U.S. Department of Commerce, 2022). Females have 72.6% more health insurance coverage than males (64.5%). Health insurance coverage ranges from 51.9% in the Oti Region to 86.2% in the Upper East Region. This represents a significant increase in coverage over 2014-2015 when approximately 40% of the population were enrolled in the NHIS.

See Figure 4 for the membership composition exempted from paying premiums. Figure 5 depicts the revenue composition of the insurance scheme.

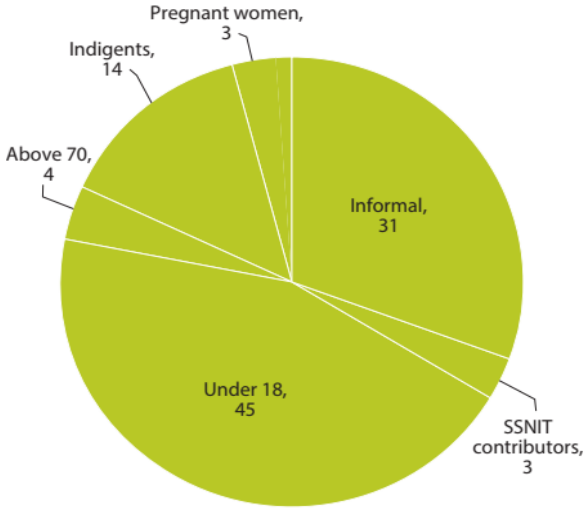

Figure 4. SHI Membership Exempted from Paying Premiums as of 2014

Sources: developed by the authors based on (Wang et al., 2017).

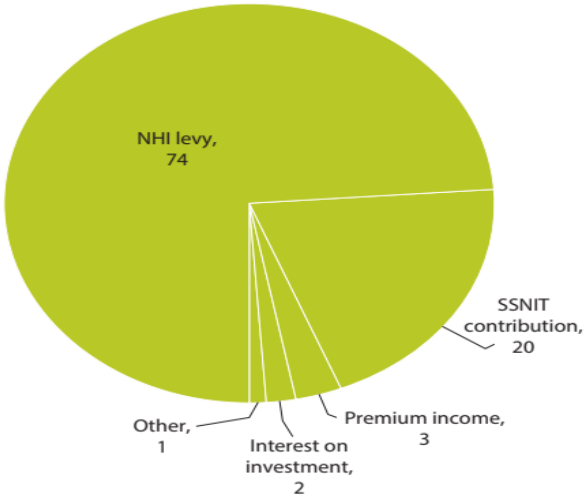

Figure 5. SHI Revenue Composition, 2005-2014

Sources: developed by the authors based on (Wang et al., 2017)**.**

As for the challenges facing the SHI, Figure 6 summarises some of them. It includes funding, engagement with members, enrolment, affordability, claims processing, monitoring.

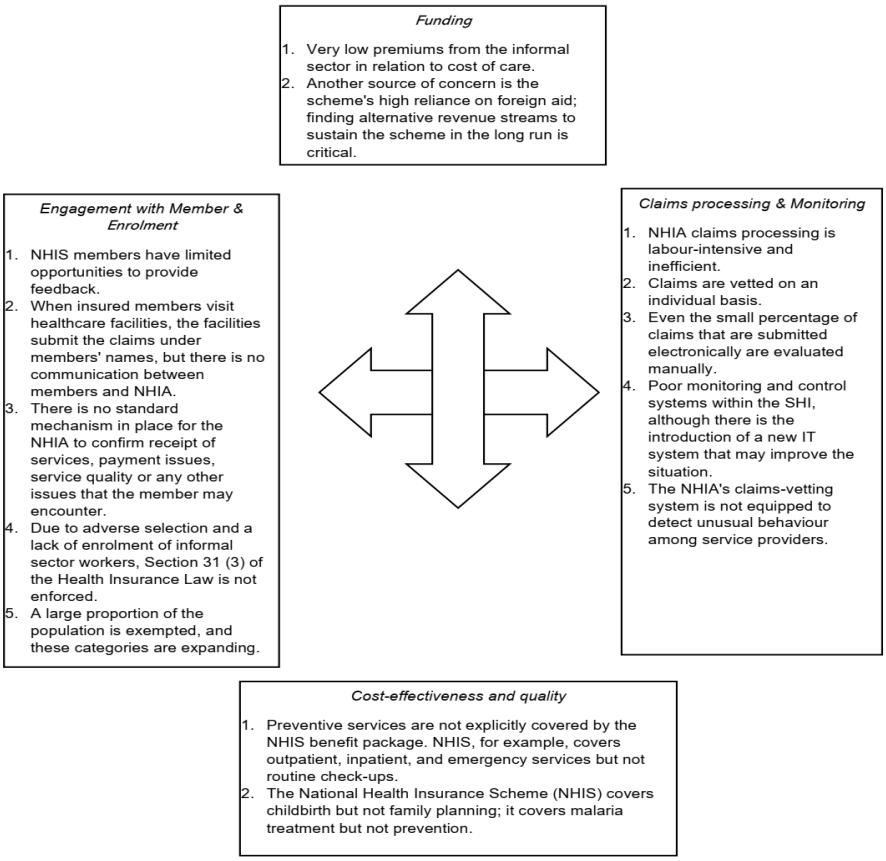

Figure 6. Summary of Challenges Confronting the SHI

Sources: developed by the authors based on (Hsiao et al., 2007; Ile and Garr, 2012; Saleh, 2013; Wang et al., 2017).

Diagram concept courtesy of Evans and Barakat (2012).

Despite these challenges, significant achievements have been made in coverage and membership. In light of this, it is vital to assess the impact of these achievements on the health population outcomes since the health policy inception. Out-of-pocket expenses as well as maternal and child mortality rates will be the main points of emphasis.

Impact Assessment

SHI was designed to reduce healthcare costs and increase access to healthcare (Sarkodie, 2021). This essay uses time series and comparative analysis to assess the intervention impact on the under-five mortality ratio, maternal mortality ratio and out-of-pocket expenditure.

Figure 7 shows that in 2005, when the SHI began functioning, the under-five mortality ratio was 83 and dropped to 45 in 2020. Before that, the mortality ratio moved from 208 in 1960 to 86 in 2004. For the maternal mortality ratio (Figure 8), before the social health insurance intervention, the mortality ratio was 484 and climbed down to 384 in 2004.

With the commencement of the intervention in 2005, the maternity ratio decreased from 371 to 341 in 2016. With regards to out-of-pocket payments, there was a significant drop from 52.61 in 2000 to 37.13 when the new health policy began (Figure 9). The out-of-pocket payments went further down in 2010 to 27.6. By 2014, they increased by 40.05, went down to 35.8 in 2015, went up to 41.41 in 2017 and down to 37.42 in 2018.

To assess the further SHI impact, this essay compares Ghana with Nigeria on three health variables mentioned above. The reason for selecting Nigeria is that both countries are in West Africa and had the same colonial administration. While Ghana gained independence in 1957, Nigeria gained independence in 1960. To improve the health of their populations, Ghana introduced the National Health Insurance Scheme in 2003 in the form of social health insurance, which began operation in 2005. The scheme covered people in the formal and informal sectors as well as some groups of people exempted from paying premiums. On the other hand, Nigeria established its National Health Insurance Scheme in 2004. The health insurance scheme for Nigerians only covers those in the formal sector, leaving the poor and workers in the informal sector unprotected.

Looking at Figures 10, 11 and 12, one can see from the data that the social health insurance scheme in Ghana has a positive impact on under-five mortality, maternal mortality and out-of-pocket payment (compared to Nigeria without social health insurance for the poor and other vulnerable groups). There will be a need for a more comprehensive assessment to determine how the SHI contributes to positive health outcomes in Ghana. While this could be attributed to the radical change from the user fee policy to social health insurance, the following section explains this radical change.

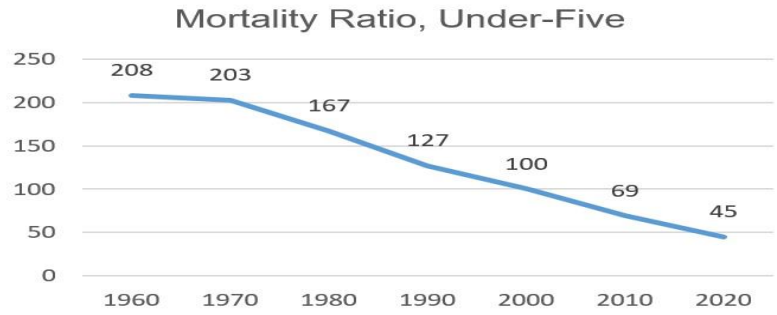

Figure 7. Mortality Rate, Under-Five (per 1,000 Live Births) – Ghana

Sources: developed by the authors based on (World Bank, 2022c).

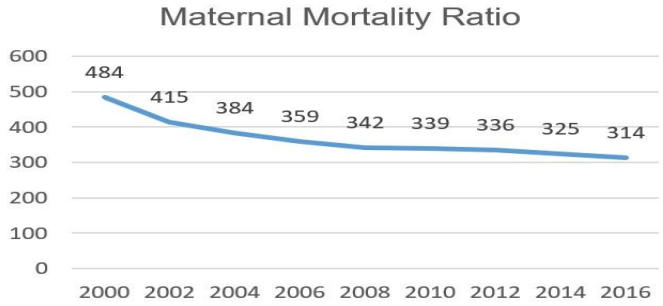

Figure 8. Maternal Mortality Ratio (Modelled Estimate, per 100,000 Live Births) – Ghana

Sources: developed by the authors based on (World Bank, 2022a).

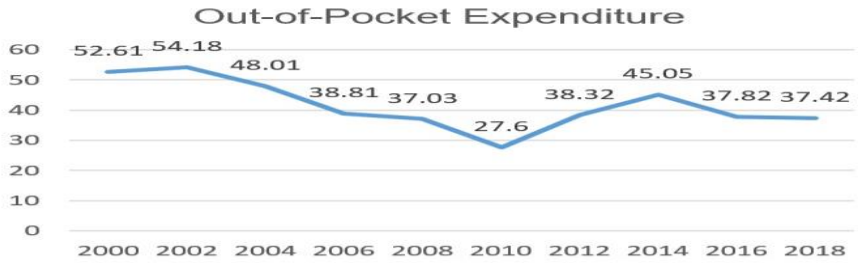

Figure 9. Out-of-Pocket Expenditure (% of Current Health Expenditure) – Ghana
Sources: developed by the authors based on (World Bank, 2022e).

Figure 10. Mortality Rate, Under-Five (per 1,000 Live Births) - Ghana, Nigeria
Sources: developed by the authors based on (World Bank, 2022d).

Figure 11. Maternal Mortality Ratio (Modelled Estimate, per 100,000 Live Births) – Ghana, Nigeria
Sources: developed by the authors based on (World Bank, 2022b).

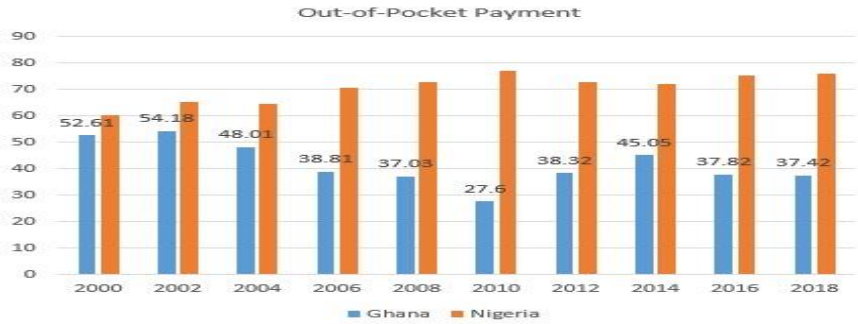

Figure 12. Out-of-Pocket Expenditure (% of Current Health Expenditure) – Ghana, Nigeria
Sources: developed by the authors based on (World Bank, 2022f).

Explaining Radical Policy Change from User Fees to SHI

Policy change is often incremental, but there are times when policy is radically altered in a short period of time (McCarthy-Jones and Turner, 2011). Such radical policy shifts are more common in developing countries where political instability can alter stability. Health policy change in Ghana is suitable to describe radical change after a long time of incrementalism of the user fee system 1969-2003. Hall's typology (1993) of the first-order, second-order and third-order changes will be used to explain shifts in the Ghanaian healthcare system. Table 1 only illustrates the changes from the user fee policy to the SHI. Table 2 demonstrates the types of Ghana's health policy changes, which entail processes and results.

The First-Order Change. The introduction of the NHS system in 1957 offered free healthcare to Ghanaians. With the NHS implementation, government spending on health care increased significantly. For instance, the health care state expenditures doubled between 1960 and 1961 and tripled between 1961 and 1962 (Addae, 1996). Due to the unsustainability of the free healthcare system, the government introduced user fees through the enactment of the following (Carbone, 2011; Nyonator, 2001; Nyonator and Kutzin, 1999):

- Hospital Fees Degree 1969 (NLCD 360);
- Hospital Fees Degree 1969 (Amendments);
- Hospital Fees Act 1970 (Act 325);
- Hospital Fees Act 1971 (Act 387).

The basic instrument settings of Ghana's health policy, such as fee exemption, were altered at frequent intervals during the 1969-1983 period. Simultaneously, the overall goals and instruments of policy remained the same. That can be observed in Table 2: Columns 2, 3 and 4.

For example, the Hospital Fees Degree 1969 (NLCD 360) stated that no fees shall be paid in a hospital by any individuals for antenatal care in any public health facility (Koduah et al., 2015). With the Hospitals Fees Act 1970 (Act 325) amendments, the government made more provision for exemptions in health facilities for some specified categories of patients: those with leprosy or tuberculosis would not be charged any fees (Nyonator et al., 2001). Under the Hospitals Fees Act 1971 (Act 387), for any maternity patient who has had four or more children, no fees other than those prescribed for accommodation and maintenance shall be charged (Koduah et al., 2015).

These adjustments made in the policy instrument settings were based on past experience and projections for economic performance in the future. Despite the policy setting amendments, the overall goals and instruments of the policy remained the same. The overall goal was to increase fiscal space while the instruments were out-of-pocket payments heavily subsidised with some forms of fee exemption. The process whereby policy instrument settings change at frequent intervals in response to past experience and new ideas with stable overall goals and instruments of policy is a process of the first-order change (Hall, 1993).

Table 1. Radical shift from the user fee policy to SHI in 1985-2003

Indicator	Ghana's Use Fee Health Policy 1983/5-2003	Ghana's Social Health Insurance 2003 till date
Policy goal	To increase revenue, which would only cover 15% of the total operating expenses for public healthcare	To guarantee universal access to basic healthcare for all Ghanaians, irrespective of their financial situation
Policy instrument	Legislative Instrument 1313 (1985) Households' out-of-pocket payments	Act 650 of 2003 National Health Insurance Scheme
Policy setting	There will be fees to be charged for each category of service provision	95 percent of all diseases in the nation are covered by health insurance
Method of payment	Out-of-pocket payments	National Health Insurance Fund
Exempted from paying fees	Indigents, pregnant women, babies, health workers (Not implemented)	Indigents, pensioners & dependents, pregnant women, children (under 18) (Fully implemented)
Exemption policy implementation	An exemption not fully implemented 5 out of 23 medical facilities give no exemptions at all Out of 62,755 OPD visits in 1995, only 224 exemptions were granted	For the majority of the marginalized (including children, the elderly, pensioners, pregnant women and nursing mothers), the policy offers a substantial exemption package
Authorized charges	Individual health facility fees were legal, but not supported by the policy instrument, making official fees ineffective	National Health Insurance Levy, contribution, premiums, investment, grants, budget provision
Risk pooling	No risk pooling. Those without money cannot receive healthcare services	Risk is pooled across the district health insurance schemes
Coverage	Exempted group, but providers typically did not implement exemptions. Consequently, 51-56% of the sick gave it up	Universal coverage

Sources: developed by the authors based on (Ile and Garr, 2012; Nyonator, 2002; Singleton, 2006; Wireko, 2015; Witter and Garshong, 2009).

The Second-Order Change. Between 1983 and 2003, the Ghanaian government made a second-order policy change at less frequent junctures through the Hospital Fees Regulation 1983, Legislative Instrument 1277. The government removed subsidies on out-of-pocket payments and abolished the co-payment system (patients have to pay the full cost for health services). Simultaneously, no drastic changes took places in the hierarchy of goals behind the policy.

See Table 2: Row 7. Basic approaches were used to alter the policy instrument settings due to dissatisfaction with the heavily subsidised user fee system. The 1980s economic turmoil and the financial crisis in the health sector (Wireko, 2015) led to the complete removal of subsidies on the user fee system. Amendments in the second order change led to an increase in public health expenditure. By 1987, public spending on healthcare had risen to about 12% of total government spending, though it had fallen to 8.7% in 1994 (Demery et al., 1995).

The majority of the increased spending went to the remuneration of healthcare workers at the expense of enhancing access to healthcare services (Hutchful, 2002; Nyonator and Kutzin, 1999). 67% and 88 % of public spending in the Volta Region proved to focus on staff salaries in their study involving 24 facilities. Changes of this type, in which policy instruments and settings are altered in response to past experience while the overall goals of policy remain unchanged, may be said to reflect a process of the second-order change, according to Hall (1993).

Between 1969 and 2003, changes that occurred in the first-order and second-order changes could be referred to as incremental policymaking (Daigneault, 2014), «where the mode and direction of change are similar» (Thelen, 2009).This entails continuous changes that take small, incremental patterns in a single direction along a single path (North, 1998; Sztompka, 1993) rather than a punctuated equilibrium pattern (Campbell, 2004)

See Figure 13. We can observe that policymakers in Ghana made adjustments to health policy instruments and settings in the first-order and second-order changes without altering the goals behind the policy. Hall (1993) contended that adjustments to instruments, particularly their settings, are normal changes that happen incrementally within an existing policy paradigm. A shift in goals, on the other hand, is rare and more fundamental because it involves a wholesale drift in policymakers' ideas and understandings of the problems they encounter (Campbell, 2004). Here, the third-order change is imminent when policymakers are dissatisfied with an existing policy problem, and the status quo cannot be maintained.

The Third-Order Change. Radical change in the Ghanaian health policy took place in 2003 with the introduction of the National Health Insurance Act (ACT 650). This was when the user fee policy was completely changed to SHI. The policy process disruption that led to a statistically significant change came after John Kufour was elected as President in 2001. All three dimensions of policymaking changed radically within this period: the instruments, their settings and the hierarchy of goals. See the last row in Table 2.

Table 1 provides more details on the radical shift from user fees to the SHI. For example, out-of-pocket payments were replaced with social security funds, and limited coverage was replaced with universal coverage. The SHI goal is to increase healthcare access and reduce financial hardship. At the same time, the user fee entailed everyone having to pay before accessing healthcare to increase government revenue. It denied a lot of people access to healthcare and increased health inequality. Additionally, the responsibility for purchasing health care on behalf of the public was transferred from the Ministry of Health to the newly formed NHIA (Wireko, 2015). Under the SHI, pregnant women, children under 18 years, older people and the indigent were exempted from paying premiums (Wireko, 2015), while in the user fees, the exemption was never implemented for these vulnerable groups.

These paradigm shifts represent a new policymaking logic that entails significant changes in all three types of health policymaking (Campbell, 2004). According to Hall, «this was a clear case of a third-order policy change» (Hall, 1993). In the case of Ghana, the difficulties in accessing healthcare, the national mood and the 2001 presidential election gave the NPP political power to govern. This opened the window of opportunity for a radical policy change (Wireko, 2015). For the policy change to occur, policymakers in Ghana through policy transfer copied some elements of existing programs from abroad and adapted them domestically to suit Ghana's social, economic and political environment.

Table 2. Types of Ghana's Health Policy Change: Processes and Results

Policy amendment / policymaking	Policy goal	Policy instrument	Policy setting	Type of change	Order of change
Hospitals Fees Decree 1969 (NLCD 360)	To increase government finance	Out-of-pocket payment (Subsidised)	Co-payment / Fees exemption	–	–
Hospitals Fees Decree 1969 (Amendments)	To increase finance for healthcare services (Not altered)	Out-of-pocket payment (Subsidised) #	Co-payment / Fees exemption ###	Incremental, reconfigured	First-order change
Hospitals Fees Act 1970 (Act 325)	To increase finance for healthcare services (Not altered)	Out-of-pocket payment (Subsidised) #	Co-payment / Fees exemption ###	Incremental, reconfigured	First-order change
Hospitals Fees Act 1971 (Act 387)	To increase finance for healthcare services (Not altered)	Out-of-pocket payment (Subsidised) #	Co-payment / Fees exemption ###	Incremental, reconfigured	First-order change
Hospital Fees Regulation 1983, Legislative Instrument 1277	To increase government finance (Not altered)	Out-of-pocket payment (Subsidised) #	Co-payment / Fees exemption ###	Incremental. Reproduction by adaptation	First-order change
Hospital Fees Regulation 1985, Legislative Instrument 1313	To increase revenue, which would only cover 15% of the total operating expenses for public health care (Not altered)	Out-of-pocket payment (No subsidy) ##	Co-payment abolished. Patients pay full cost for all drugs ###	Incremental. Reproduction by adaptation	Second-order change
National Health Insurance Act 2003 (ACT 650)	To guarantee universal access to basic healthcare for all Ghanaians, irrespective of their financial situation (Completely altered)	National Health Insurance Fund ##	95% of all diseases in the nation are covered by health insurance ###	Radical shift. Breakdown and replacement. Paradigm shift from user fees to SHI	Third order change

 # Policy instrument remained the same with no alteration in the first-order change. ## Policy instrument altered in response to past experience in the second-order and third-order changes. ### Policy settings were modified during the first-order, second-order and third-order changes.

Sources: developed by the authors.

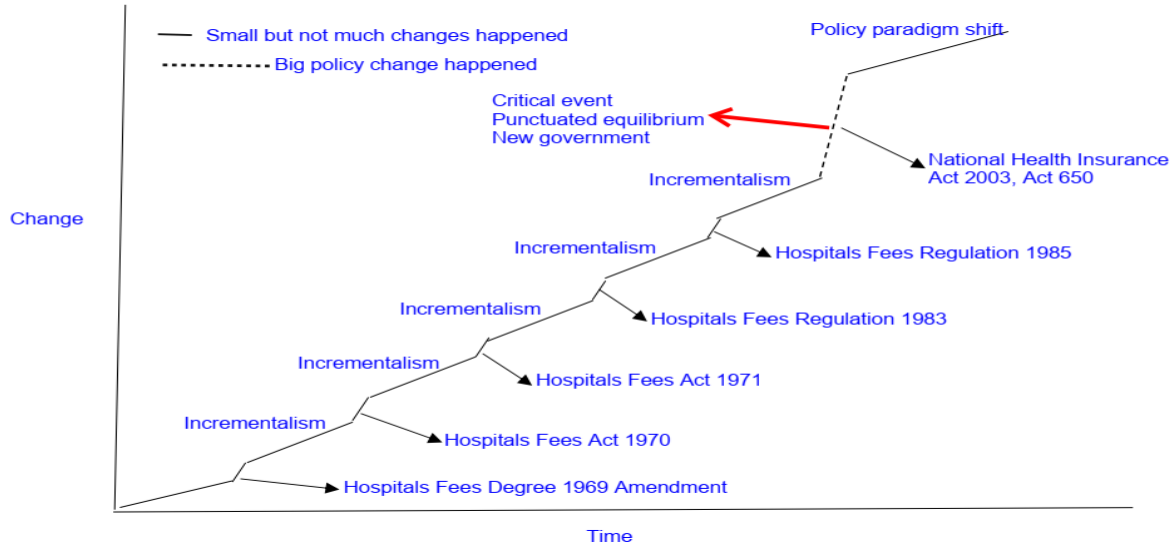

Figure 13. Graphic representation of incremental changes to policy paradigm shift
Sources: developed by the authors.

Conclusions. The major lesson of this essay is that policy transfer alone cannot be a single variable to explain the radical health policy change. According to Evans and Barakat (2012), combined with other complementary perspectives, an empirically grounded account of policy change can be developed. While one policymaking approach may be appropriate in certain situations, it may provide far less insight when those situations change (McCarthy-Jones and Turner, 2011).

For Ghana's SHI implementation, the kingdom's multiple streams, the Rose's lesson-drawing framework (1991) and the impact analysis are reasonably used to deal with the Ghana's health policy change. This approach has resulted in at least six significant observations about policy entrepreneurs' role as voluntary policy transfer agents in a time of rising health inequality.

1) When it was discovered that the user fee policy denied a lot of Ghanaians access to healthcare, decision-makers decided to import the SHI idea to reduce financial hardship and increase access to healthcare. From the implementation analysis of this essay, the SHI has increased the enrolment of Ghana's residents into the scheme.

2) When it comes to solving societal problems and the status quo cannot be maintained, ideas play a crucial role in searching for suitable programs. To solve the policy problem at home, policymakers in Ghana travelled to several countries to copy some elements of workable programs to suit the social, economic, institutional, cultural and political environment of the importing country.

3) The window of opportunity was instrumental in a radical policy change. For two consecutive times, the idea of health insurance entered the policy space, but it was abandoned. With the electoral NPP victory, the policy window opened for a complete change from the user fee policy to a SHI model. This scenario supports the assumption that politicians win elections to formulate policies and not the other way round, i.e. politicians formulate policies to win elections (Hacker and Pierson, 2014).

4) The policy change from the user fees to the SHI was a voluntary policy transfer that involved local actors. Ghana was not under any intense pressure from external actors to implement the SHI. Instead, it followed the national mood that demanded policy change. Here, the transfer of policy can be a progressive learning activity if it is driven by local actors «and culturally assimilated through comprehensive evaluation and piloting, building on current organisational strengths and delivering public value in terms of direct social or economic benefits to the citizenry» (Evans and Barakat, 2012).

5) From 1969 to 2003, the continuous patterns of change were those that characterised changes as small, incremental and gradual processes. There was a discontinuity (punctuated equilibrium) to this process in 2003 that painted a much different scenario. It consisted of a radical shift from the user fees to the SHI (Figure 13).

6) The Ghanaian government has been adjusting the instruments of health policies and the settings without altering the goal hierarchy of these policies to increase fiscal space. However, it became clear that policy entrepreneurs were dissatisfied with the user fee policy. A new government then turned to policy transfer by altering the policy instruments, their settings, and the goal hierarchy behind the policy to establish the National Health Insurance Scheme (a social health insurance model).

Finally, it is hopeful that this essay has provided a compelling explanation to support its core assertion: the voluntary SHI transfer is based on the notion that policymakers chose policy transfer as a rational response to instituting radical change in health policy due to a perceived problem.

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Передача та формування політики охорони здоров'я: приклад соціального медичного страхування в Гані

З моменту запровадження системи фінансування охорони здоров'я на основі медичних зборів у 1969 році та її подальших змін тягар витрат на охорону здоров'я, який лягає на мешканців Гани, створив нерівність у медичній сфері. Ця система змушувала бідні і вразливі верстви населення обходитися з обмеженим доступом до основних ліків і послуг. Підприємці-політики сприяли підвищенню обізнаності про бідні і вразливі верстви населення Гани, які не мають доступу до охорони здоров'я через систему медичних зборів, що є проблемою

державної політики. Це усвідомлення почало поширюватися серед чиновників, громадськості і професійних груп, привертаючи увагу політиків. Оскільки значне громадське невдоволення та агітація проти політики медичних зборів тривали, ЗМІ продовжували вважати уряд відповідальним за ініціювання політики. Процес демократизації та період виборів між 1998 і 2000 роками створили можливість змінити політику охорони здоров'я. У 2003 році Гана заснувала Національне соціальне страхування здоров'я – одну з форм соціального страхування. У цьому дослідженні розглядається процес створення схеми соціального медичного страхування через систему передачі полісів. По-перше, у статті досліджується політика охорони здоров'я Гани після здобуття незалежності. Розглядається Національна служба охорони здоров'я та політика медичних зборів, яка була запроваджена в 1985 році. По-друге, у статті описується структура передачі політики і механізм роботи соціального медичного страхування. По-третє, пояснюється радикальна зміна політики медичних зборів у моделях соціального медичного страхування. Стаття залучає аналіз часових рядів і порівняльний аналіз для оцінки впливу соціального медичного страхування на коефіцієнт смертності дітей у віці до п'яти років, коефіцієнт материнської смертності та витрати з власної кишені. Результати показують, що схема соціального медичного страхування має позитивний вплив, зокрема знижує смертність матерів і дітей до п'яти років. Зіставляється оплата з власної кишені з аналогічним показником в Нігерії без соціального медичного страхування для бідних та інших уразливих груп. У документі зроблено висновок, що суто передача політики не може бути єдиною змінною для пояснення радикальних змін у політиці охорони здоров'я, але в поєднанні з іншими додатковими перспективами можна розробити емпірично обґрунтований звіт про зміну політики.

Ключові слова: страхування здоров'я; політика охорони здоров'я; ідея; зміна політики; медичний збір.