

DEVELOPMENT POLICY PLANNING IN GHANA: THE CASE OF HEALTH CARE PROVISION

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Abstract

This paper examines the historical development of health policy in Ghana within the framework of financial, geographical accessibility and the availability of health care. We find that historically, health policy has been urban biased, and largely focused on financial accessibility. Even Nkrumah's free health care policy could not adequately address the problem of inadequate health professionals and facilities in the rural areas. The study also established that poverty is also largely a rural phenomenon. The poor benefit less from the National Health Insurance Scheme (NHIS). This situation makes the NHIS lack social equity, the very reason for its being. We recommend that government should expand health facilities in the rural areas, and introduce attractive incentive packages to attract and retain health professionals in such areas. And, there is an urgent need for rigorous criteria to be developed by the NHIS to identify the very poor for health insurance premium exemptions.

Keywords: Health policy, development, colonial, user-fees, poverty reduction, health insurance, Ghana

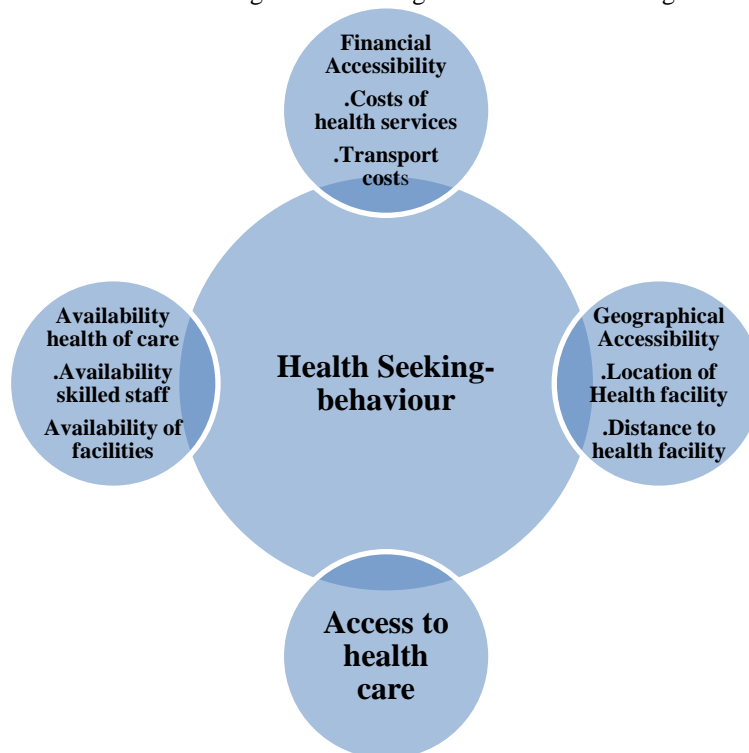
Introduction

This paper examines the history of health policy development and health care provision from the colonial days to the present, with a special focus on the poor in Ghana. Examining the history of health policy development and health care provision is predicated on the recognition that access to health care is a key strategy for poverty reduction. This examination is based on an interaction of both demand and supply side factors that may determine an individual or household's access to health care. These factors include: financial accessibility, geographical accessibility and the availability of health care. Financial accessibility speaks to the ability and

willingness of individuals or households to pay for the costs of health care. Availability of health care refers to the availability of skilled health professionals, facilities as well as the availability of supplies, such as beds and medication. For example, the doctor/nurse to patient ratio is very crucial in determining the quality of care patients at the health facility. The third factor, geographical accessibility refers to the physical location of the health facility with respect to the location of the users.

Examining these factors is essential because literature suggests that they influence population's health-seeking behaviour and impact health outcomes (Ensor and Cooper, 2004; Kerber et al., 2007; Peters et al., 2008; Arthur, 2012). For instance, Kerber et al. (2007) argue that long distances, financial constraints, poor transport, and poor quality care in health facilities are serious barriers limiting access to care for those who need it most. In other words, the distance to the health facility and associated transportation costs may further limit poor household's access to health services. Supporting this claim, Arthur (2012) suggests that access to health care services such as antenatal care (ANC), may be much easier for urban dwellers than rural dwellers in Ghana because urban dwellers live relatively closer to health facilities than rural dwellers. Conceptually, these factors are presented in figure 1 below.

Figure 1: Factors influencing health-seeking behaviour in accessing health care



source: Authors' Construct, 2014

This triad of factors— financial accessibility, geographical accessibility and availability of health care shown in figure 1, determine individual's health-seeking behaviour, and ultimately access to health care. These factors require attention because they are amenable to policy intervention with respect to health care provisioning—for example, with political commitment, societies may not necessarily achieve equality in health, but they may at least create equal opportunities for health care, thereby promoting social justice. As Young (1990:47) argues, "social justice... requires not the melting away of differences, but institutions that promote reproduction of and respect for group differences without oppression". Resource limitations and budget constraints call for participatory health policy planning to ensure equitable and balanced distribution of health facilities, projects and interventions.

Perhaps, an equally important justification for the historical account of health policy development is, to unpack the nexus between it (health policy development) and poverty. Very few contemporary research studies examined the genesis of health policy development preceding the period of independence in Ghana (Senah, 2001; Arhinful, 2003). Most of the studies begin their examination of this important issue from the independence period in Ghana (Addae-Korankye, 2013; Nguyen, Rajkotia, and Wang, 2011; Mensah, Opong, and Schmidt, 2010; Durairaj, D'Almeida, and Kirigia, 2010). The inadequate attention paid to the nature of health policy development during the colonial period in contemporary research studies creates a wide knowledge gap between the pre-independence and post-independence periods. For this reason, this paper adopts an historical analysis and aims to bridge this knowledge gap. In particular, the paper aims to contribute to, and increase the existing body of knowledge on health policy development in Ghana because we believe present health care decisions must be informed by past decisions in order to guide future decisions.

The paper is divided into six sections structured around the themes of: colonial health policy, free health care policy in Ghana from 1957 to 1966, the re-introduction of user-fee policy in Ghana from 1967 to 1979, the institutionalisation of user-fees in Ghana from 1983 to 1999 and the implementation of the National Health Insurance Scheme (NHIS) and access to health care from 2003 to the present. The paper concludes with a summary of the discussion.

Colonial health policy and access to health care

The historical development of modern health care policy in Ghana (formerly, the Gold Coast) dates back to the 1920s. According to Anyinam (1989), formal planning of health care services in Ghana started in the 1920s under the leadership of Governor Gordon Guggisberg when the colonial

government established an effective medical policy which instituted free health care for European officials. The provision of health care services was initially limited to colonial administrators, officials of mining companies, merchants and other Europeans. Health services were later extended to only 0.02% of the African Population (Anyinam, 1989) and most of this population worked in the civil and public services such as the police (Arhinful, 2003).

Consistent with the concept of financial accessibility, in 1930, a proportional user-fee system was introduced in the Gold Coast for people seeking health care in public facilities. In this direction, lower fees were charged for the lower income groups, mainly formal sector employees. This proportional user-fee system however, did not clearly address informal sector workers and how their incomes were assessed for the proportional user-fee policy to be applied appropriately. It is also interesting to note that, under the colonial health policy, medical practitioners were allowed to charge private professional fees despite the fact that they worked in government health facilities (Konotey-Ahulu et al., 1970). Because of user-fee policy, by 1954, patients seeking health care at government facilities were required to pay dispensary fees and the cost of any drugs dispensed as well as professional fees, thus creating financial barriers to access health care (Konotey-Ahulu et al., 1970).

However, it is important to note that the colonial health policy did exempt the very poor from paying any forms of user-fees at all government health facilities (Konotey-Ahulu et al., 1970). However, the policy of free health care for the very poor was never accompanied by any clear criteria for the identification of these very poor people for effective implementation of the policy. The determination of who were very poor and who were not was left to the personal interpretations of colonial medical staff. For instance, Konotey-Ahulu et al. (1970) indicate that the decision as to whether any charges were made or not was left to the discretion of the medical officer in charge of the dispensary, subject to the discretion of the Director of Medical Services. This practice of giving interpretative leverage to medical officers remained till 1957 when Ghana gained independence from Britain (Konotey-Ahulu et al., 1970).

Geographically, the colonial health policy was biased toward those living in urban areas. According to Twumasi (1981), colonial health was simply urban-oriented. Twumasi argues that even though the colonial health policy discouraged the use of traditional medicine, formal health facilities were concentrated in a few urban towns, where the colonialists were engaged in commercial and mining activities whereas the rural areas were without modern health facilities. Anyinam, (1989:532) points out that the “colonial health policy was characterised by a gross regional maldistribution of health

facilities.”For example, out of 39 hospitals in the country in 1927/28, 87% (or 34 of 39) were located in the more urban and resource rich southern parts of the country leaving only 13% in the more rural, resource-poor northern regions of the country. (Anyanim, 1989)

The third factor determining access to health—the availability of health care — appears to follow the same trend.Anyinam (1989:532) again asserts that by 1953, about 90% of hospital beds were in the south. For example, the population to bed ratios ranged from 478:1 in the south to 35000:1 in the north. Building on this argument, Arhin (2003) points out that even the few health facilities established in the urban towns routinely experienced overcrowding at hospitals and dispensaries plus inadequacy of medical staff and deterioration of sanitary conditions.

Christian missionaries contributed immensely to the historical development of health care policy in Ghana. Arhin (2003) argues that unlike the colonialists, the missionaries established their health facilities in the rural areas in their desire to win converts to Christianity. To this end, the contribution of missionaries to health care delivery in Ghana started in 1931 when the Basel Missionaries established the Agogo hospital in Ashanti Akim in the south. In 1943, the Catholic Missionaries also built the BremanAsikuma hospital also in the south, and in 1951 the Jirapa hospital in the north, and the Worawora hospital in the south respectively were added. These mission health facilities operated on cost recovery, and as such, the full cost of drugs was passed on to users but exemptions were granted to the very poor. Because the missionaries operated in rural settings, their ability to identify the very poor was enhanced by the fact that at rural level, people were likely to know one another.

The maldistribution of health resources by the colonialists created a kind of spatial injustice between the urban and rural areas of the north, in particular. As Soja(2010) argues, unjust geographies arise endogenously or internally from the distributional inequalities created through discriminatory decision making by individuals. These policies appear to have impacted adversely on the overall health of the people of the Gold Coast. The United Nations (UN, 1995) for example, report that at the dawn of independence in 1957, life expectancy at birth in the Gold Coast was just 44 years.

Free health care policy for all, 1957-1966

Soon after independence in 1957, Dr. Kwame Nkrumah, the first President of Ghana made it a priority to improve health services in the country as borne out by the following statement: “my first objective is to abolish from Ghana poverty, ignorance and disease. We shall measure our progress by the improvement in the health of our people. The welfare of our

people is our chief pride, and it is by this that my government will ask to be judged” (Rooney, 2007:123).

Encouraged by his vision to create a prosperous society for all, Nkrumah radically transformed the Ghanaian economy based on socialist ideals and egalitarian principles. To this end, his first major policy action in the health sector was to immediately abolish private practice in government health facilities especially hospitals, where the practice was common. On September 1st 1958, Nkrumah’s government withdrew “the privilege of private practice from all medical doctors and dentists” (Konotey-Ahulu et al., 1970:12). Consequently, for the first time in the country, patients whether Ghanaian or non-Ghanaian, stopped paying professional fees in government health facilities (Konotey-Ahulu et al., 1970).

With the abolition of private fees in government health facilities, financial access to health care was improved because hospital charges were drastically revised downwards. For instance, with respect to midwifery services, women delivering in government hospitals, spending ten days and beyond, were charged only £1 as daily maintenance charges; children of 16 years and below were treated free of charge; government official employees, public and civil servants and all workers were entitled to free medical care at out-patients clinics (Konotey-Ahulu et al., 1970).

Subsequently, Nkrumah essentially instituted a free health care policy for all persons living in Ghana at all public health facilities by 1965. This free health care policy was financed mainly from the state’s tax revenue (Arhinful, 2003) thanks to flourishing cocoa prices on the international market and huge \$481 million foreign reserves (Rooney, 2007). The objective of the free health care policy was to prevent households or individuals from falling into poverty as a result of paying out-of-pocket for health care. As a result, hospital fees and all charges were abolished at all government health facilities, allowing even the poor to access formal health care.

Nkrumah's free health care policy aimed to address the problem of urban bias in the distribution of health resources geographically. For this reason, there was a massive expansion of health facilities across the country with a focus on the rural areas. For instance, between 1960 and 1966, 35 new rural health centres were established (Senah, 1989 cited in Arhinful, 2003: 44).

Despite these attempts, Twumasi(1981) is emphatic that the problem of unbalanced distribution of health resources was insignificantly addressed because health care was not readily available for those who needed it in most rural areas. Twumasi (1981:150) argues that though 23% of the population lived in the urban areas then, 76% of doctors practiced there. Twumasi claims that the cadre of health professionals who emerged in the newly

independent country was very powerful because of their prestige, scarcity, and social contacts with political decision-makers to determine where to work. Anyinam(1989:536) substantiate this claim, indicating that by 1960 there was one physician to every 21,600 patients while the ratio of nurses to patients was one nurse to every 5,430 patients in the rural areas. Most rural dwellers thus relied on the use of traditional medicines, herbs and concoctions to treat their ailments.

It may be argued that the gains of free financial access to health care were negated by the still unbalanced geographical distribution of health facilities and the unavailability of health staff at the rural areas to administer to the rural people. Twumasi (1981) argues that infant and maternal mortality rates were very high in the rural areas. The World Bank(2012:17) argues that in 1960 under-5 child mortality was as high as 218 per 1,000 live births. Consequently, life expectancy only marginally increased to 46 years from the base year of 44 years in 1957.

Despite these short-comings and criticisms that the policy was “over-generous” and led to financial drain on tax revenue, (Konotey-Ahulu et al., 1970:13), Nkrumah’s free health care policy remained in force until 1966 when Nkrumah’s government was toppled in the first military coup in the country ushering in the military government of the National Liberation Council (NLC) led by Lt. General Ankrah (Konotey-Ahulu et al., 1970).

Reintroduction of user-fees and access to health care, 1967-1979

In what appears to be a sharp contrast to Nkrumah’s free health care policy, Ankrah’s military government reintroduced user-fees for drugs and prescriptions dispensed at public health facilities akin to the colonial health policy. In the 1967/68 Budget Statement, the government’s policy on hospital charges declared that any patient who visited a government hospital was required to pay a small fee for his prescription, and that in-patients who received treatment in luxurious wards were required to pay higher fees (Konotey-Ahulu et al., 1970).

As would be expected, the reintroduction of user-fees was greeted with public uproar but the public outcry did not stop the military government from implementing the policy. In 1969, a civilian government under the tutelage of Dr. Kofi Busia took the reins of power. In a dramatic fashion, Busia’s government immediately suspended the collection of hospital fees through a circular dated 16th October 1969 until further notice (Konotey-Ahulu et al., 1970:19) following the public outcry that characterised the reintroduction of user-fees under the previous government.

Paradoxically, two years later, user-fees were re-introduced again by the government through a Hospital Fee Act of 1971, making hospital fees in public health facilities official, albeit small, for the cost of drugs. The aim

for re-introducing user-fees was to "reduce excessive demand and contribute to recovering part of the costs of curative and essential services" (Arhin, 2003:45).

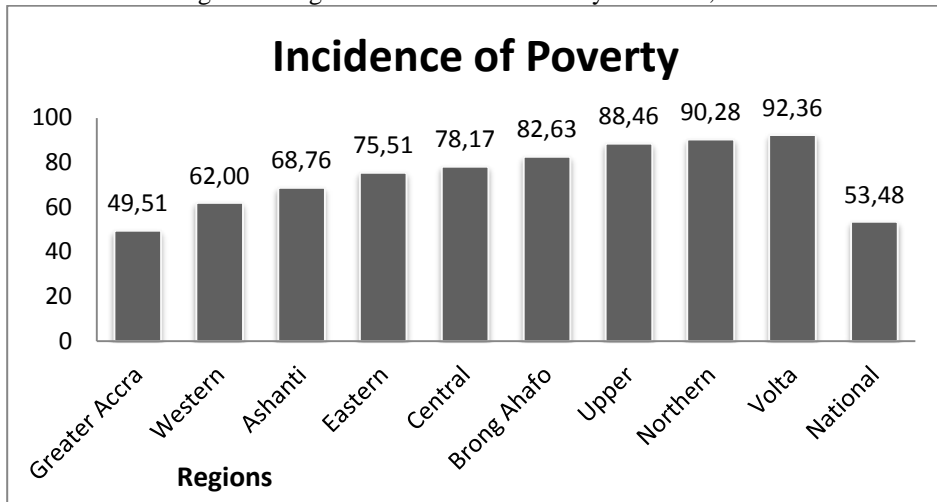
The official introduction of user-fees in public facilities in 1971 appears to have been ill-timed because the Ghanaian economy was, at this time, less economically robust in terms of foreign reserves as compared to its economic success in the 1960s. General tax revenue shrank significantly and per capita Gross Domestic Product (GDP) declined by a total of 19.7% between 1970 and 1980 (Hutchful, 2002:6). In addition, tax collection dropped from 18.6% of GDP in 1970-71 to 6.5% in 1984, one of the lowest ratios in Africa. Also, the collection of domestic sales tax fell from 1.7% of GDP in 1970-71 to 0.4% in 1982 (Hutchful, 2002:6).

Most importantly, the health budget declined from 7.8% to 6.1% and the overall size of the state budget dwindled from 18.3% to merely 10.1% of the Gross National Product (GNP) between 1972 and 1982 (Hutchful: 29 & 128). These figures are not only alarming but also have serious implications on poverty reduction efforts in the country and access to health care. A feeble economy with a dwindling tax-base suggests a situation where social safety-net interventions for the poor and the less privileged in society will also be reduced and, will negatively impact the indigence and poverty levels in the country.

Precisely so—in 1975, it was estimated that about 75% of the Ghanaian population was poor, with poverty concentrated in the rural areas—85% of the rural population was poor compared with 53% of the urban population (The World Bank, 1990). During the same period, regional poverty levels were 92.36%, 90.28% and 88.46% in the less resource endowed and more rural regions of the Volta, Northern and ³Upper Regions compared to 49.51%, 62% and 68.76% in the more resource endowed and more urbanised regions of Greater Accra, the national capital; Western and Ashanti regions in the South respectively as shown in figure 2.

³ Upper Region was the name given to the Upper East and West Regions prior to their separation in 1983

Figure 2: Regional Incidence of Poverty in Ghana, 1975



Source: World Bank, (1990)

These economic "hard times" as depicted in figure 2, certainly impacted on the state's ability to provide adequate health care to the population and on the health-seeking behaviour of the population as well as on health outcomes. The state simply lacked the needed foreign exchange to procure essential supplies for health facilities, resulting in acute shortages of drug, medical supplies and equipment and widespread poor quality of health care. The situation about the availability of health facilities and personnel was not different, as there were only 118 health posts and centres in the country. There were also only 667 physicians in the country, with more than 80% of them based in the urban areas. For instance, Accra, the national capital alone had 37% of the physicians, and communities within Accra with a population of 20,000 got a further 30% of the physicians population while only 33% served the remaining 82% of the country's health needs (Anyinam,1989:532). To worsen matters, the poor economic conditions lead to an exodus of doctors and other professionals from the country (Arhin, 2003).

Consequently, the use of traditional medicine and self-medication was rife, especially in the rural areas. Some rural dwellers, simply did not seek care when ill. Over 30% of children in the Northern, Upper East and Upper West Regions who had diarrhea did not seek treatment at all while less than 10% children did not seek care in the more urbanised regions of the south (Ghana Statistical Service, 1988a:75; Anyinam,1989). Mortality rates, though better than the 1960 figures, were still significantly high. Over all infant mortality was estimated at 100 per 1000 live births between 1973-1977. Under-5 mortality for the period 1978-1987 was 24% higher in rural

areas than in urban areas. Infant mortality was also 103 per 1000 live births in the Upper East, West and Northern regions whereas it was 58 per 1000 live births in Accra. During the same period, the percentage of physician-assisted deliveries for women in Accra was 16%, 10% in Kumasi and negligibly 0.9% in all the three regions of the north (Ghana Statistical Service, 1988a: 69)

The huge regional disparities in access to health care coupled with high poverty levels were addressed tactfully to lessen the burden of drug costs on patients. The government paid 70% of the cost of drugs for patients in towns and cities in Accra, Ashanti and Western regions; the government also paid 90% of the cost of drugs for patients in towns and cities in the Upper, Northern and Volta regions while also paying 80% of the cost of drugs for patients in the rest of the country.

Significantly, government reiterated its commitment to provide free health for the poor and vulnerable. As a result, very poor people, children under 18 years old who constituted 50% of the population, and pregnant women were exempted from paying any form of fees at all public facilities. However, the medical officers in charge of public facilities, again had discretionary powers to decide who should or should not be exempted from user-fees (Konotey-Ahulu et al., 1970).

While these subsidies or fee waivers and exemptions sound like benefits to the already poverty stricken population, there is no evidence in the literature to show how effective the implementation of these subsidies were in order to inform current policy decisions with respect to subsidising the cost of health care services. Proceeding speculatively however, they may have worked to some extent, given that by 1977, life expectancy increased to 53 years (UN, 1995). The general economic stagnation of the Ghanaian economy however, continued throughout the 1970s and, by 1979, this situation prompted yet another coup d'Etat, headed by Ft. Lt Jerry John Rawlings on the 31st December, 1981. This coup d'Etat ushered in the government of the Provisional National Defence Council (PNDC) (Arhin, 2003).

Institutionalisation of user-fees and access to health care, 1983-1999

Rawlings' PNDC government took over the reins of power with a zealous commitment to salvaging the stagnating economy from the abyss in which it had found itself. Consequently, the government heeded to the World Bank and International Monetary Fund (IMF) economic reforms, known as Structural Adjustment Programmes (SAPs) in 1983 in an attempt to revitalise the weak economy and to establish a sound macroeconomic framework for stabilising the economy. SAPs required the liberalisation of the economy and reduced spending on social sectors— education and health. Under the

auspices of the World Bank and the IMF, the first major reform in the health sector was cost recovery, with the introduction of nominal user-fees and other charges in public health facilities in 1983 (Hutchful, 2002).

By 1985, the economic situation in Ghana had worsened, and the Ministry of Health (MOH) could hardly import medical supplies for the various health facilities in the country. In the midst of these socio-economic difficulties, about one million Ghanaians were deported from Nigeria in 1983, which caused severe food shortages (Senah, 2001). The price of a gallon of petrol which was ¢12.5 in 1981 skyrocketed to ¢235 in 1988; a gallon of Kerosene shot from ¢5.00 to ¢170 during the same period and the cost of a minimum nutritious diet was estimated to be ¢168 while the daily minimum wage was ¢112⁴ (Anyinam, 1989:539).

This situation affected health care policy significantly in Ghana's history. User-fees, known as “cash and carry” were effectively introduced and institutionalised in public health care facilities on a full cost recovery basis for drugs and other services. The institutionalisation of the user-fee policy was backed by the enactment of the Hospital Fee Law, Legislative Instrument (LI) 1313 in the same year (Arhin 2003:45-46). Beneficiaries of health care now had to pay out-of pocket at the point of using health services. The major objective of the cash and carry system was to recover at least 15% of recurrent expenditure for quality improvement, provide essential medicines and medical supplies, and improve staff efficiency and to deter frivolous use of scarce health resources (Arhin, 2003).

The official introduction of user-fees significantly increased the cost of health care in the midst of high poverty levels. For instance, specialist consultation fee which was ¢25 in 1983 increased to ¢200, around 88% increase; adult patients at wards with catering services paid ¢100 instead of ¢10, a 90% increase; and casualty wards and polyclinics which had been rendering free services now charged ¢5 for adults and ¢2.5 for children of up to 12 years in 1985 (Anyinam, 1989:539). Anyinam (1989) argues that the implementation of the SAPs did not give consideration to the poor and the vulnerable in society as evidenced by high levels of poverty in the country— 56% of the total population was estimated to be poor in 1987/88 and this figure increased to 61% in 1988/89 (Ghana Statistical Service, 1988b, 1989).

As the cost or price of health care increased, so did the demand and use modern health services reduce drastically among the poor and average households. Waddington and Enyimayew, (1989, 1990) argue that increases in user charges in 1985 led to a sharp decline in health care utilisation during the second half of 1985; from 4,581 consultations in the second quarter of 1985 to 1,095 for the final quarter. Similarly, Nyongator and

⁴ The figures/prices are in the old Ghana cedis

Kutzin(1999:337)assert that“health facilities in the Volta region of Ghana have achieved a kind of ‘sustainable inequality’, with fees enabling service provision to continue, while concurrently preventing part of the population from using these services”. Another adverse effect of user-fees was that malnourished children who had been on regular treatment stopped attending clinics because their mothers could not afford the new fees (Anyinam, 1989). Perhaps, the worst consequence of use-fees was that at the maternity ward at Korle-Bu Hospital, the nation’s premier teaching hospital, “some women absconded, leaving their babies behind” due to the inability to pay (Senah, 2001:87).

Reacting to the decreased utilisation of health services imposed by financial barriers, exemptions were given to pregnant women, children under five years old, those aged 70 years and above, the very poor and other vulnerable form paying user-fees(Anyinam, 1989). Nevertheless, the exemption policy in practice, hardly worked because it lacked consistency in the interpretations of the exemption guidelines. The determination ofwho was poor enough to be exempted was not clearly defined by the exemption policy (Britwum et al., 2001). Consequently, most of the people who should have been exempted were not (Waddington and Enyimayew, 1990).

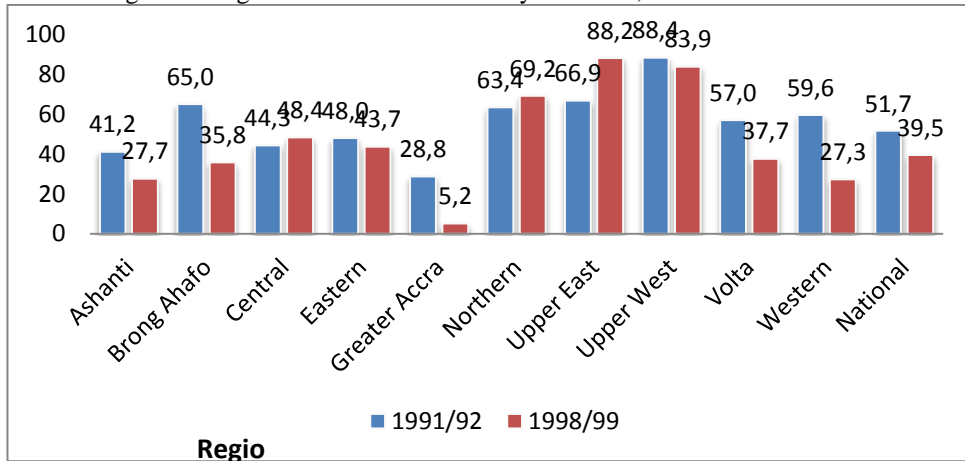
Granted that the government exempted the very poor and other vulnerable groups from paying user-fees, the problems of geographical accessibility of health services and the availability of health care caused roadblocks limiting access to health care. In term of health facilities, by 1985, Accra had 12 hospitals, 9 health centres and 10 health posts. The Upper East Region had 3 hospitals, 2 health centres while the Upper West Region had 4 hospitals, 1 health centre and 8 health posts respectively. During the same period the physician to patient ratio was one physician to every 6,355 patients in Accra, one physician to every 107,840 patients in both the Upper East and West Regions (Anyinam, 1989:534). Overall infant mortality rate (IMR) however, reduced from 100 per 1000 live births in 1977 to 77 per 1000 live births in 1988 but the IMR remained at 103 per 1000 live births in 1988 for both the Upper East and West Regions.

By 1992, the Rawlings-led military government of the Provisional National Defence Council (PNDC) came under intense pressure both locally and internationally to return the country to civilian rule. The PNDC metamorphosed into a political party, the National Democratic Congress (NDC). And, multiparty elections under the parliamentary system were held in 1992, which the NDC contested and won in December 1992.

Perhaps, the implementation of SAPs began yielding fruits in terms of economic stability and growth at the macro-level during the NDC’s early days in office. For instance, by 1991/92, national poverty levels declined to 51.7% and by 1998/99, the estimated poor population in Ghana was 39.5%

(Ghana Statistical Service, 2007:13). These national statistical averages, however, tend to mask the true picture of the poverty situation in Ghana. An examination of the poverty levels between the north and the south is not significantly different from those of 1975 as shown in figure 3.

Figure 3: Regional Incidence of Poverty in Ghana, 1991/92 and 1998/99



Source: Patterns and Trends of Poverty in Ghana 1991-2006, Ghana Statistical Service

Figure 3 illustrates that in some cases, in the Northern and Upper East Regions, poverty levels worsened, increasing from 63.4% to 69.2% and 66.9% to 88.2% respectively.

Against the odds, the NDC government embarked on a Medium-Term Health Strategy (MTHS) to improve the health status of the population centred on three levels of health care delivery– primary, secondary and tertiary levels of health. By 1995, health policy was based on MTHS to promote greater equity in access to health and outcomes. To this end, the MTHS promoted community participation in the delivery of health services (Canagarajah and Ye, 2001). Between 1992-98, the number of district and others hospitals increased to 215 and health centres/clinics increased to 1,758; bringing the total number of health facilities in the country to 1,973. Out this number, 80% facilities were located in the urban areas whereas the rural areas had 37%. Accra had 22 hospitals and 271 health centres/clinics. Upper East had 5 hospitals and 75 healthcentres/clinic while the Upper West had 4 hospitals and 51 health centres/clinics respectively (Canagarajah and Ye, 2001:26). As a result, among the 10 regions of Ghana, over 75% of the urban population live relatively close to the nearest health facility—defined as people who walk between 30 minutes or less to get to the nearest health facility. In the Upper East, West and Northern, only 15% of the rural population lives less than 30 minutes away from the nearest health facility (Canagarajah and Ye, 2001:25-26).

Consistent with our conceptual framework, one other key measure of the availability of health care is to measure the population per health professionals. In 1998, out of a total of 1,204 physicians, Accra had one physician to every 14,482 patients; Upper East had one physician to every 57,591 patients. One Nurse attended to 734 patients on average in Accra, 1,868 patients in Upper East and 1,507 patients in the Upper West regions respectively (Canagarajah and Ye, 2001:25-26). Asenso-Okyere et al.(1998) argue these developments also affected the health-seeking behaviour of the population in three ways. Firstly, because of long distances, self-medication was pervasive among all classes of people; secondly people generally delayed in seeking care at the health facility until illness was considered severe. And thirdly, the use of herbal medicine was also widespread because people felt that the herbal practitioners had patience to treat them, claiming that at the hospital, as soon as the patient starts talking about his/her sickness, the doctor starts writing the prescription, and the herbal practitioners also accepted payments in-kind or in installments. Yet still, the population that did not seek care at the formal health facility during illness or injury generally was 56% and 63% for the poor (World Bank, 2012:21). How did these developments translate into health outputs and outcomes?

According to Asenso-Okyere et al.(1998), the collection of user-fees appeared to have led to improvements in the quality of services, including the availability of drugs, resulting in increased out-patient attendance. For this reason, health outputs measured by the number of out-patient visits were estimated to be 15,616,488 nationally, while out-patient visits were 2,965,816, 555,390 and 402,704 for Accra, Upper East and Upper West Regions respectively. IMR declined from 77 per 1000 live births in 1988 to 66 in 1993 and to 57 per 1000 live births in 1998. Under-5 mortality also took a downward trend; decreasing from 155 in 1988 to 119 in 1993 and to 108 per 1000 live births in 1998 (Ghana Health Service, 2010:10).

Despite these relatively modest health improvements, the user-fee policy, spanning the 15 years of the implementation of the SAPs and the 18 years of the PNDC/NDC regime, 1981-1999 became unpopular among the Ghanaian populace by the year 2000. Consequently, campaigning on the promise of affordable health care, a leading opposition party the New Patriotic Party (NPP), hyped the issue of affordable health care as its flagship message, and promised to abolish user-fees if it annexed the reins of power. The NPP did win the keenly contested elections in a runoff in December 2000 and took over the reins of power in January, 2001. Fulfilling its campaign promise, the NPP implemented a set of health reforms that aimed to replace the user-fee system with a National Health Insurance Scheme (NHIS).

The implementation of National Health Insurance Scheme (NHIS) and access to health care

The political importance given to the issue of user-fees in the 2000 general elections makes the implementation of the NHIS an important home grown policy initiative worth examining. The NHIS was established by an Act of parliament (Act 650) in 2003, and, passed into law, legislative instrument, LI 1809 in 2004 (Government of Ghana, 2004). The NHIS, which aims to attain universal health insurance coverage to persons resident in the country, ensure equity in health care coverage, is celebrated as a promising model for social protection. It is currently the most prominent public social intervention policy in the country, increasing access of the poor to health care services and protecting them against financial risk (Government of Ghana, 2012:7). The NHIS operates through community/district wide mutual health insurance schemes (DWMHIS) in all districts across the country. By focusing on community or district insurance schemes, the NHIS aims to promote community participation and local ownership in the management of the schemes. Perhaps, community participation may not only give voice to the local population but may also, enhance the sustainability of the schemes. Arhinful (2003) argues that community participation and local ownership potentially give members a sense of responsibility that is necessary for curbing abuse or over use.

NHIS funding, benefit package, premium payment and exemption policy

The NHIS is funded publicly by a national health insurance fund (NHIF) from three major sources. The first source of funding constituting about 70% of the fund is a 2.5% value added tax (VAT) known as the National Health Insurance Levy. The second source of funding, which constitutes about 20-25% of the fund, is also a 2.5% contribution from the Social Security and National Insurance Trust (SSNIT) for mainly public formal sector employees, apart from University lecturers. The third source of funding is an annual premium paid by informal sector workers to the scheme (Aryeetey et al., 2013).

The NHIS has quite a generous benefit package. It covers 95% of disease conditions that afflict people in Ghana, including general and specialist consultations, general and specialist diagnostic testing such as laboratory investigation, X-rays, ultrasound scanning, medicines on the NHIS medicines list, surgical operation such as hernia repair, and physiotherapy and in-patient services general ward and feeding. In terms of oral health, services such as tooth extraction, temporary incision and drainage, and dental restoration, comprising simple amalgam filling and temporary dressing are covered by the NHIS. In 2008 free maternal care

(FMC) was added as well as HIV/AIDS symptomatic treatment for opportunistic infection in 2012 (Act 852, 2012). The NHIS benefit package does not include appliances, prostheses, rehabilitation, dentures, organ and cosmetics surgery and assisted reproduction, heart and brain surgery other than accident, diagnosis and treatment abroad, dialysis for chronic renal failure and cancers (Government of Ghana, 2003).

To benefit from NHIS, members pay annual health insurance premiums and these premiums must be renewed annually. Typically, formal sector employees under Social Security and National Insurance Trust (SSNIT) pay 2.5% of their SSNIT contributions as insurance premiums directly to the scheme through the national health insurance authority (NHIA). But SSNIT contributors must still pay an annual registration fee determined by local health insurance scheme in order to access health care. Informal sector employees between the ages of 18 and 69 years are required to pay an out-of-pocket annual insurance premium to the district schemes. The premiums range from Gh¢7.20 (\$3) to Gh¢48 (\$20), and in principle are supposed to be paid based on individual or household incomes. However, due to the challenge of assessing the incomes of informal sector workers, each district charges flat rate premiums (Abihiro & McIntyre, 2013). Like previous health policies, the NHIS exempts children under 18 years of age, pregnant women, persons with mental disorder, SSNIT pensioners (60 years and above), and the aged 70 years and above, pregnant women and the indigent (very poor). There is a two months processing or waiting period before members can access the services of the scheme.

Even so, the NHIS exemption policy is beset with the same problem of how to identify the very poor, making this policy not different from previous exemption policies dating back from the colonial health policy.

NHIS coverage, poverty, health care utilisation and health outcomes

On the 4th of November, 2013, the NHIS celebrated its 10th anniversary of implementation and boast of a national coverage rate of 33% (National Health Insurance Authority NHIA, 2011:16), an unprecedented success story in the history of the development of health insurance in sub-Saharan Africa (SSA).

The NHIS 10 year's journey also coincides with a robust economy achieving a 7.1% GDP growth rate in 2012 and a projected GDP of 8.5% for 2013; inflation declined from about 18% in 2008 to 8.8% in 2012; and food inflation declined from 5.5% in July 2012 to 3.9% in December 2012 (Ministry of Finance, 2013:45). The latest poverty figures put out by Ghana Living Standards Survey (GLSS 5) under the auspices of the Ghana Statistical Service indicate significant decline in poverty levels in Ghana from the 1998/99 figure of 39.5% to 28.5% in 2005/06, with absolute

poverty falling from 36% in 1991/92 to 27% in 1998/99 and now to 18% in 2005/06 (Ghana Statistical Service, 2007:10-14). More so, in 2013 government increased its total expenditure on poverty reduction from 26% in 2012 to 30.35% in 2013 (Ministry of Finance, 2012, 2013). With these robust macro-economic outlook, Ghana is on track to meeting the first MDG, which is to halve, between 1990 and 2015, the proportion of people whose income is less than \$1.25 a day. These macro level achievements place Ghana on a pedestal as one of the fastest growing economies in the world.

In this seemingly robust economy, research indicates that the NHIS enhances access to health care for those who would have otherwise not had access to health care (Derbile and Geest, 2013; Barimah and Mensah, 2013; Dixon, Tenkorang, and Luginaah, 2013; Amporfu, 2013; Boateng and Awunyor-Vito, 2013). The National Health Insurance Authority (NHIA, 2011:19-20) shows that between 2005 and 2011, both out-patient and in-patient utilisation of health services have skyrocketed. Out-patient utilisation is reported to increased forty-fold from 0.6 million in 2005 to 25.5 million in 2011, while in-patient utilisation shot from 28,906 in 2005 to 1,451,596 in 2011 nationally. An important question to ask is: which categories of people are enrolled in the NHIS and use the health facilities?

Answering this question, the National Development Planning Commission (NDPC, 2009:25) reports that 64% of the richest are enrolled whereas only 29% of the poorest people are enrolled in the NHIS. In fact, only 2.3%, 1.4% and 4.2% of the very poor were enrolled by the NHIS in 2009, 2010 and 2011 respectively (NHIA, 2009:28, 2010:18, & 2011:17). At the same time, the Ghana Statistical Service (GSS, 2007:9) estimates the very poor or absolute poverty in Ghana to be about 18.2%. This trend suggests that the benefits of the NHIS are accruing disproportionately to the rich than the poor, hence does not address the problem of equity in health financing. The point is that 72% of insured people consulted a medical doctor/assistant when ill and 39% of those without health insurance consulted drugstores or traditional birth attendants (NDPC, 2009:31). Substantiating this assertion, the World Bank (2012:24) reports that 32% of insured pregnant women in the poorest quintile delivered at a government hospital while only 11.45% uninsured women in the same quintile delivered at a government hospital. Compared to the richest quintile, 66% insured and 77% uninsured women delivered at a government hospital. In addition, 7% insured and 1.2 uninsured % pregnant women in the poorest quintile sought a physician's assistance during delivery compared to the richest quintile, 28% insured and 36.46% women sought a physician assistance during delivery. Following these trends, Oxfam International (2011) claims that the poor who are uninsured treat their ailments at home including visiting unqualified drug dealers and risk childbirth at home without professional health care. The

World Bank (2012) supports this claim, reporting that about 20% of the very poor who are not insured forgo treatment when they are ill.

These results look paradoxical given the buoyant macroeconomic performance of the economy in general. However, available regional level data appears to support this story as shown in table 1.

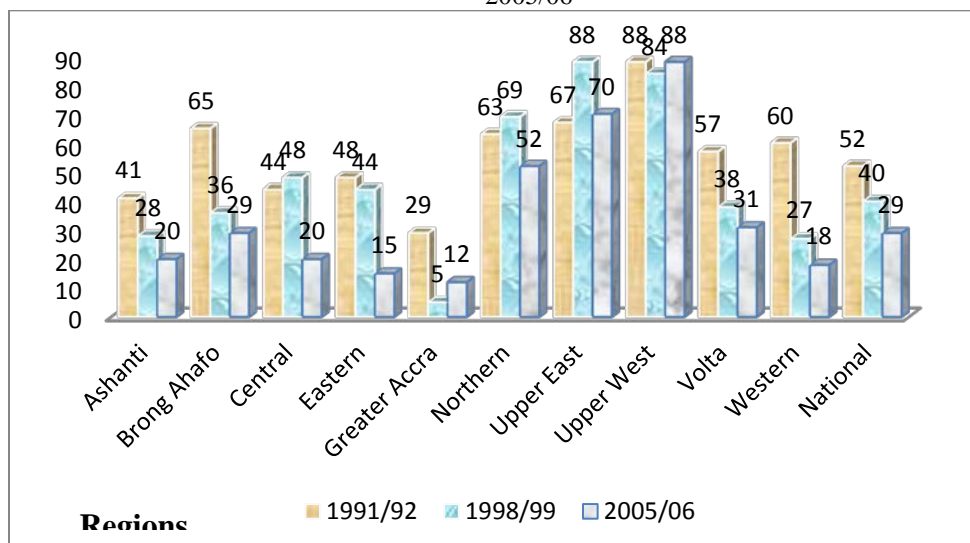
Table 1: Regional Incidence of Poverty in Ghana, 2005/06

Region	Incidence of poverty
Ashanti	20.0%
BrongAhafo	29.0%
Central	20.0%
Eastern	15.0%
Greater Accra	12.0%
Northern	52.0%
Upper East	70.0%
Upper West	88%
Volta	31
Western	18.0%
National	28.5

Source: Patterns and Trends of Poverty in Ghana 1991-2006, Ghana Statistical Service

As shown in table 1, poverty reduction was more significant in the urban areas than in the more rural regions of the north. In fact, in table 1, poverty figures for the Upper West for example, even worsened. To better appreciate the trend in national and regional poverty levels in the country, the poverty results for 1991/92, 1998/99 and 2005/06 are presented together for easier comparison as shown in figure 4.

Figure 4: Regional and National Incidence of Poverty in Ghana, 1991/92, 1998/99 and 2005/06



Source: Patterns and Trends of Poverty in Ghana 1991-2006, Ghana Statistical Service

Figure 4 shows that poverty is still a rural phenomenon, disproportionately concentrated in the three regions (Northern, Upper East and West) of northern Ghana. This trend seems to be a colonial legacy because the colonial government concentrated most of its development efforts in the resource endowed regions in the south of the country to the neglect of less resource endowed regions of the north. Poverty in the Upper West Region appears to be endemic, reducing only slightly from 88% in 1991/92 to 84% in 1998/1999 and rose again to 88% in 2005/05.

Nonetheless, government, since the implementation of the national health insurance policy focused on expanding health facilities and the training of more health professionals to ensure the success and sustainability of the policy. For instance, by 2009 health facilities were expanded to 3,217, out which Accra had 466, Upper East and West Regions had 144 and 135 respectively. Likewise, the number of health professional also increased; physician increased to 2,033 and that of nurses increased to 24,974 nationally. Out of these, Accra had 837; Upper East and West Regions had 29 and 14 respectively. This brings the physician to patient ratio in Accra to one physician to every 5,103 patients, one physician to every 35,010 in the Upper East and one physician to every 47,932 patients in the Upper West Region. The nurse to patient ratios are appreciably reasonable for the three regions: in Accra, one nurse attended to 874 patients, one nurse attended to 805 and 750 patients in the Upper East and West Regions respectively (Ghana Health Service, 2010:14-19). In 2012, 911 trained midwives passed out to help address the country's maternal health challenges while 209 new functional Community-Based Health Planning Services (CHPS) zones were created to enhance access to Primary Health Care (Ministry of Finance, 2013:165-166)

In General, locality of residence is a crucial factor in determining access to health care. Whereas about 91% of urban women deliver in health care facilities, only 57% of rural women deliver in health care facilities. For instance, 52% of women deliver in health care facilities while 48% women deliver at home in the Upper East Region, but in Accra 100% of women deliver in health care facilities (NDPC, 2009:34). This trend is logical from the preceding discourses because urban dwellers have relatively easier access to health facilities than rural dwellers. However, given the modest expansions in health facilities and increase in the number of health professionals, particularly nurses, health outcomes have also been generally, positively impacted. Particularly, maternal mortality decreased from 630 in 1990 to 350 per 100,000 live births in 2008 (World Bank, 2012:17). IMR reduced from 57 in 1998 to 50 per 1000 live births in 2008. In Accra, IMR decreased from about 41 to 36 per 1000 live births during the same period. In the Upper East and West Regions, IMR decreased from 103 in 1988 to 46

and 97 per 1000 live births respectively (Ghana Health Service, 2010:10), while the United Nations Development Programme (UNDP), estimates life expectancy at birth in 2013 to be about 65 years (UNDP, 2013).

Given these trends, it is not surprising that in 2008, when the National Development Planning Commission (NDPC) conducted a nationwide citizen's assessment of the National Health Insurance Scheme (NHIS), 92% of those insured with the NHIS were either satisfied or very satisfied with its performance. It is significant to point out that 82% of the lowest 20% income group and 75% of the upper 20% income groups were either satisfied or very satisfied with the performance of the NHIS (NDPC, 2009:52). This outcome sounds like good news, and perhaps the NHIS may probably be the last destination in Ghana's health policy development trajectory.

Conclusion

Health policy development has travelled a long and bumpy road to reach its current state in Ghana. In this paper, we have examined the historical development of health policy in Ghana within a tripod framework of financial, geographical accessibility and the availability of health care. Primacy is given to these factors because they are amenable to policy intervention with respect to health care provisioning. Based on this framework, key policy issues emerge. Firstly, throughout the colonial period to the present, health policy has largely focused on financial accessibility to the neglect of the other two factors. The colonial government, and subsequent ones, apart from Nkrumah's government, which implemented a free health care policy, implemented fee exemptions for the very poor but never developed any robust criteria to identify the very poor. Secondly, health policy has been urban biased right from the colonial era, and even Nkrumah's free health care policy could not adequately address this problem. For this reason, health facilities and professionals are largely concentrated in the urban areas, especially in Accra to the detriment of the rural areas. Unsurprisingly, these rural areas of the north are also the poorest in the country because poor health leads to poverty and poverty leads to poor health. Because of these reasons, the NHIS currently lacks social equity, the very reason for its implementation as the rich disproportionately benefit more than the poor. We therefore recommend that the three dimension of access to health care—financial accessibility, geographical accessibility and health care availability – need to be addressed holistically to ensure the sustainability of the NHIS. The government should expand the number of health facilities in the rural areas, and introduce attractive incentives packages to attract and retain health professional in the rural areas. And finally, there is an urgent need for rigorous criteria to be developed by the

NHIS to identify the very poor in order to achieve its ambitious aim of universal health coverage for all.

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