**National level maternal health decisions:
towards an understanding of health policy agenda setting
and formulation in Ghana**

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Thesis

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List of acronyms

AFRC: Armed Forces Revolutionary Council
CHAG: Christian Health Association of Ghana
CHPS: Community Based Health Planning Service Compounds
DFID: United Kingdom Department for International Development
EC: European Commission
EU: European Union
FDA: Food and Drugs Authority
GCNM: Ghana College of Nurses and Midwives
GCP: Ghana College of Pharmacist
GCPS: Ghana College of Physicians and Surgeons
GDHS: Ghana Demographic Health Survey
GDP: Gross Domestic Product
GHS: Ghana Health Service
GMA: Ghana Medical Association
GOG: Government of Ghana
GRMA: Ghana Registered Midwives Association
HEFRA: Health Facilities Regulatory Agency
HIC: High Income Country
HIPC: Heavily Indebted Poor Countries
HRH: Human Resource for Health
IGF: Internally Generated Funds
IMF: International Monetary Fund
LI: Legislative Instrument
LMIC: Low and Middle Income Country
MAF: Maternal Acceleration Framework
MCH: Maternal and Child Health
MDBS: Multi Donor Budget Support
MDC: Medical and Dental Council
MDG: Millennium Development Goal
MOFEP: Ministry of Finance and Economic Planning
MOH: Ministry of Health
NAS: National Ambulance Service
NDC: National Democratic Congress
NDF: Nordic Development Fund
NHIA: National Health Insurance Authority
NHIF: National Health Insurance Fund
NHIS: National Health Insurance Scheme
NLC: National Liberation Council
NLCD: National Liberation Council Decree

NMC: Nurses and Midwives Council
NPP: National Patriotic Party
NRC: National Redemption Council
P&S: Procurement and Supply
PC: Pharmacy Council
PNDC: Provisional National Defence Council
PNP: Private Not-for-Profit
POW: Programme of Work
PPME: Policy Planning Monitoring and Evaluation
PPMED: Policy Planning Monitoring and Evaluation Directorate
PPMTSC: Provider Payment Mechanism Technical Sub Committee
PPP: Preferred Primary Provider
PSGH: Pharmaceutical Society of Ghana
PSP: Private Self-Financing
RDE: Royal Danish Embassy
RNE: Royal Netherlands Embassy
RSIM: Research Statistics and Information Management
SAP: Structural Adjustment Programme
SMC: Supreme Military Council
SPMDP: Society of Private Medical and Dental Practitioners
SSNIT: Social Security and National Insurance Trust
SWAp: Sector-Wide Approach
TAM: Traditional and Alternative Medicine
TH: Teaching Hospital
TMPC: Traditional Medicine Practice Council
UNFPA: United Nations Population Fund
UNICEF: United Nations International Children's Emergency Fund
USAID: U.S Agency for International Development
WHO: World Health Organization

Chapter 1

1 General introduction

1.1 Introduction

Maternal mortality remains high in Ghana, a lower middle income country, although maternal health indicators have improved over the past 20 years. Between 1990 and 2003, the maternal mortality rate decreased from 740 per 100,000 live births to 503 per 100,000, and then to 451 per 100,000 live births in 2008 (Ghana Statistical Service (GSS) et al., 2009). This slow pace reduction of maternal mortality was inadequate for Ghana to attain its Millennium Development Goals (MDGs) target of 185 maternal deaths per 100,000 live births by 2015 (Ministry of Health et al., 2011). As in Ghana maternal mortality also remains high in many other Low and Middle Income Countries (LMICs) with little evidence of progress (Bhutta et al., 2010, Lozano et al., 2011, Waage et al., 2010, 2008).

Over the years, policy makers at national level have formulated a wide range of public policies and programmes to increase financial and geographical access to maternal care; space child birth; provide essential obstetric care; expand midwifery coverage; and make equipment and health facilities available and many more to improve maternal health outcomes and reduce maternal deaths in Ghana (Government of Ghana, 2006, Ministry of Health, 2011b, Ministry of Health, 2007, Ministry of Health et al., 2011, Witter et al., 2009, Ofosu-Amaah, 1981).

These national level policy decisions are of great importance for maternal health because they influence which concrete measures are put in place and how they are implemented to improve maternal health outcomes. This thesis aims to advance our understanding of how maternal health policy decisions are made at national level in Ghana, and present potential lessons for policy actors out of these explanations and understanding to engage in making better informed policy decisions to improve maternal health.

To understand who makes policy and why, one must understand the characteristics of the policy actors, what roles they play, what authority and other powers they hold, and how they deal with and control each other (Lindblom, 1980) and the processes by which they are able to do so. However, the development path of policy decisions whether intent as articulated in policy documents or practice as implemented can be difficult to predict and study because policy making is a complex process and does not follow a particular format.

A simplified framework – the stage heuristic framework - for studying public policy processes separates it into four stages: (1) agenda setting, (2) policy formulation, (3) policy implementation and (4) evaluation (Lindblom, 1980, Sabatier, 2007). Some have justifiably argued that the framework is oversimplified and a rather mechanical representation of a complex and essentially non-linear process (Sabatier, 2007, Nakamura, 1987). Others have argued that policy intent may be

different from what is implemented and are often not connected at all (Mosse, 2005). However, the stage heuristic framework is still useful for purposes of organizing research and ordering the overload of information obtained during data collection. This study will focus on the first two stages of the framework that is agenda setting and policy formulation because as suggested by Kingdon (2003) and Parson (1995) public policy is ultimately made by how policy actors define issues and put them on the policy agenda and subsequently formulate policy contents and alternatives.

Agenda setting refers to how and why some issues come to prominence and receive serious attention from decision makers rather than others. Policy formulation refers to the process of detailing out how to address issues that are on the agenda (Buse et al., 2005). To understand national level maternal health policies through the agenda setting lens I explored policy actors involved in getting, maintaining and removing maternal health issues from the national agenda and the processes by which they were able to influence the agenda. And through the lens of policy formulation explored how and why policy actors influencing each other arrived at and agreed upon policy contents and alternatives. Given the complexity of policy making, exploring how and why some policy issues were considered, maintained or removed from the agenda and the accompanying policy content can give insights into the power dynamics of agenda setting and policy formulation, the powers that policy actors hold and how they deal with and control each other and give answers to questions like who makes policy and the processes by which these policy actors are able to do so.

1.2 Research problem, objective and questions

Despite the importance of understanding how public maternal policies are formulated, and how policy actors within specific context use their power to influence agenda and define policy issues, there is no empirical research on this topic in Ghana. There is, however, limited literature from other LMICs, on national level maternal health agenda setting and formulation and examination of power in health policy (Gilson and Raphaely, 2008). For example, generating political will for safe motherhood in Indonesia (Shiffman, 2003), the state of political priority for safe motherhood in Nigeria (Shiffman and Okonofua, 2007), the emergence of political priority for safe motherhood in Honduras (Shiffman et al., 2004), and actors practise of power in a South African community health programme (Lehmann and Gilson, 2013). Most empirical research on maternal health in Ghana and other LMICs (Travis et al., 2004, Borghi et al., 2006, Adam et al., 2005, Gupta et al., 2011, Asamoah et al., 2011, Phillips et al., December 2006, Witter et al., 2009) focused more on implementation challenges such as scarcity of resources, shortage of skilled health personal, inadequate quality of care, and recommendations of potential policies that should improve maternal health, and less on how the implemented policies came

onto the national agenda and formulated. Studying how those implemented policies were put on the agenda and formulated may give additional insights into why the policies face several implementation challenges. Additionally, there is little guidance available to health practitioners who wish to understand how and why some issues make their way on to policy agendas, get formulated and implemented whilst others languish and some issues do not even get discussed (Buse et al., 2005).

This thesis provides an analysis of national level maternal health agenda setting and formulation in Ghana by exploring the power dynamics in: (1) how and why some policies have long life and are maintained over time despite periodic threats to their existence, (2) why policy agenda items appear and evolve in the framework of the health sector programme of work, (3) why certain problem definitions and policy options can become prominent and endorsed at high level as public policy agenda item and yet fail to subsequently move swiftly into implementation and (4) why certain issues get on to the policy agenda, move into policy formulation and implementation and later drop off in the process. The thesis also contributes to agenda setting and policy formulation literature and the use of power concepts in health policy analysis. Findings from this research will therefore contribute in filling the knowledge gap and provide decision makers and analysts with information on four main issues. First, given the complexity of public policy making, lessons from how policy actors used their power and the processes by which they were able to influence policy decisions can help decision makers to strategize and engage in making better informed policy decisions. Second, the research presents empirically grounded understanding of national level policy actors' decision making processes and their use of power within a dynamic health sector. Third, the research highlights entry points into decision making processes domains, and how policy actors can actively participate in these domains to influence national level decisions. Finally, the research highlights how policy making for maternal health happens in reality instead of what should be.

The research objective is to explore who formulates maternal health policies and the agenda setting and decision making processes through which policy actors operate, in Ghana.

The research objective is further expanded into four main questions.

1. Which policy actors have been involved in maternal health policy agenda setting and formulation and what roles did they play and why?
2. What are the decision making processes related to maternal health policy agenda setting and formulation?
3. How did contextual factors influenced maternal health policy agenda setting and formulation and why?
4. How did policy actors define maternal health issues and why?

1.3 Theoretical perspectives

1.3.1 Public policy and decision making

Public policy refers to government policy. Dye (2001) notes that public policy is whatever governments choose to do or not to do. He argues that government's failure to decide or act on a particular issue also constitutes policy (Dye, 2001). Dye's simple definition of public policy being what governments do, or do not do, contrasts with the assumption that all policy is made to achieve a particular goal or purpose (Buse et al., 2005). Public policy decisions are usually statements or formal positions issued by a government, or a government department, national laws and legislations in order to achieve or containing the intent to achieve certain goals that are deemed desirable for the public good or a specific target population. At the basis of decisions to design such public policies there is always a specific definition of the problem that has to be solved.

In this thesis decision is defined as a specific commitment to action, which is assessed by the factual relationship between decisions (non-decisions) and its final aims – action or inaction (Mintzberg et al., 1976, Simon, 1961). Decision making therefore is the process in which choices are made or preferred option is selected at a point or series of points in time when national level decision makers consider public problems that has to be solved. In the public policy making process, decision making extends throughout the policy stages and the different levels of the health system. For example decisions about what to define as a problem, what knowledge to use in the problem definition, and choice about how to implement policies may be considered at different levels (Parsons, 1995).

1.3.2 Power approaches to decision making

The thesis draws on a pluralist approach to decision making which focuses on the way in which power is distributed and an elitist approach which focuses on the way in which power is concentrated perspectives for interpretation (Parsons, 1995). The pluralist and elitist power approaches to decision making perspectives view decisions as something which is shaped and determined by the structures of power such as, wealth, bureaucratic and political arrangements, pressure groups, and technical and professional knowledge (Parsons, 1995). Its use here is not to establish the validity of these approaches but rather to help explain what happened and as a result develop theoretical understanding of how maternal health policy decisions are made at national level. The thesis draws on elitist and pluralist power approaches, because the Ghanaian health sector is pluralist with many policy actors involved in decision making (Ministry of Health, 2007), and at the same time there are situations where only few policy actors have taken decisions (Agyepong and Adjei, 2008, Seddoh and Akor, 2012).

The elitist approach to decision making presents a hierarchical power structure and argues that power is concentrated in the hands of a few groups and individuals (Rushefsky and Patel, 1998). Decision making according to this approach is a process which works to the advantage of these powerful elites. In the real world there are, it is argued, those at the top with power and the 'mass' without power (Parsons, 1995). On the other hand, the pluralist approach to decision making takes the view that power is dispersed throughout the society and no individual or group holds absolute power and the government arbitrates among competing interest in the development of policy. For the pluralists, policy emerges as the result of conflict and bargaining among large number of group organized to protect the specific interest of their members. According to the pluralist approach the government selects from initiatives and proposals put forward by interest groups according to what is best for society. However, pluralism has been subject to considerable scepticism for its portrayal of the government as a neutral umpire in the distribution of power (Buse et al., 2005). Proponents of the pluralist approach modified their view and according to the revised view decision making therefore is – biased in favour of the powerful, and functions to the disadvantage of the less-powerful and less-well resourced (Parsons, 1995).

1.3.3 Analytical concepts and framework

To understand factors and processes that influence national level maternal policy agenda and formulation decisions, public policy decision making for maternal health is conceptualised as a process predominately influenced by how policy actors within specific context use their power sources to define problems, set the agenda and formulate accompanying policies. Therefore power, problem definition, context and policy actor concepts were explored to analyse the research findings.

Power

Power is relational and a highly contested concept (Parsons, 1995). In analysing how and why policy actors at national level use power in setting maternal health agenda and formulating specific policies, Mintzberg's (1983) concept of organizational power was adopted. Mintzberg (1983) refers to power as the capacity to effect (affect) outcomes – decisions and actions. This concept of power is built on the premise that organizational behaviour is a power game in which various players, called influencers seek to control the organization's actions and decisions. To be an influencer, one essentially requires some source of power, coupled with the will to use the power in a politically skilful way that is to convince those to whom one has access. Mintzberg notes that to understand an organization's decisions and actions, it is necessary to understand which influencers are present, what needs each seeks to fulfil in the organization, and how each is able to use power to fulfil them. Mintzberg

proposes five sources of power: the control of (1) a resource, (2) a technical skill (3) a body of knowledge. To serve as a source of power - the resource, skill or body of knowledge must be essential to the functioning of the organization. The fourth power source stems from legal prerogative, that is exclusive rights or privileges to impose choices. The fifth power source derives simply from access to those who can rely on the other four power sources (Mintzberg, 1983).

To further understand the fifth power source that derives from access to others with power, the Ribot and Peluso (2003) theory of access was adopted. The theory of access facilitates grounded analysis of who actually benefits from things and the processes by which they are able to do so. They define access as the ability to benefit from things including persons, institutions, symbols and material objects (Ribot and Peluso 2003 p, 153). A policy actor's ability to benefit from the powers of others for example funds from a different actor can augment his/her influence and importance to establish networks with others. The established networks can facilitate the spread of a particular problem definition to move a policy agenda and formulation decision in a specific direction.

Problem definition

The concept of problem definition concept is closely linked to policy agenda setting. Hogwood and Gunn (1984 p,109) describe the concept of problem definition as encompassing "the processes by which an issue (problem, opportunity or trend) having been recognized as such and placed on the policy agenda, is perceived by various interested parties, further explored, articulated, and possibly quantified, and in some but not all cases, given an authoritative definition at least provisionally acceptable definition in terms of its likely causes, components, and consequences" (Hogwood and Gunn as cited in Rochefort and Cobb, 1993). The problem definition description relates to issue framing which is the way individuals give meaning to a certain problem situation (Arts and Buizer, 2009).

The problem definition (framing) description relates the way an issue is defined to how it is placed on the agenda, and how policy actors debate and interpret the issue for decision. Hence, knowing how a problem has been defined is essential to understanding the process of agenda setting (Parsons, 1995). There is however no one fixed problem definition for a particular policy issue and as such policy issues are subject to the interpretative manoeuvres and discursive strategies of policy actors who can influence the decision making processes (Mosse, 2005). Problem definitions are not simply 'given' or facts of a situation but crafted out of debates and interpretations of past and current situations (Portz, 1996, Rochefort and Cobb, 1993, Schön and Rein, 1995). Therefore it matters who is defining the problem and when and in which context. A problem definition process is dynamic and sets the stage for policy decision making and the most likely way of policy formulation in defining the

best way to solve the problem, and therefore issue definition and redefinition can serve as tools to gain advantage over the decision making process and what policies to formulate (Peters, 2005, Mosse, 2005, Rochefort and Cobb, 1994). Policy actors therefore can direct decision making by controlling the interpretation of the problem and shaping the final resolution of the problem. The concept of problem definition is therefore useful in analysing how policy actors during discursive discussions define issues to set maternal health agenda and formulate specific policies.

Policy Actor

Policy actors as influencers have power and engage in problem definition processes and there is the need to differentiate between them to analyse the power they hold and how they deal with and influence each other and policy decisions. Differentiating policy actors and their collective or individual influence on national level policy decision is particularly important in the Ghanaian pluralistic and sometimes elitist decision making health sector. Here we draw on Buse et al. (2005) broad description of policy actors as government and non-government to differentiate national level policy actors. In the Ghanaian health sector, government policy actors include the President, the Parliament, political appointees, bureaucrats, public institutions and service providers. On the other hand, non-government actors include the donors (multi-lateral and bilateral), professional bodies and associations of various categories of health workers, private self-financing (for profit) providers, mission based (private not-for-profit) providers, non-governmental organizations, media, interest groups and the general public.

These policy actors - whether as individual, organization or group - do not usually act alone and sometimes depend on each other through consultation, negotiation, consensus building (Hill and Hupe, 2002) and sometimes conflict (Grindle and Thomas, 1991) to take and influence decisions. Policy actors depend on each other not only through formal institutional structures but also through informal structures and relationships such as interpersonal communications (Marin and Mayntz, 1991, Parsons, 1995). Policy actors' interactions within the formal and informal institutional structures create a policy making system with plurality of separate policy actors with separate vested interest, power, goals, and strategies, as a polycentric system of governance and collective action towards problem solving (Ostrom, 2005, Ostrom, 2008). The polycentric system of governance (Ostrom, 2005, Ostrom, 2008) does not take power differences into account, however, power analysis is necessary to understand who influences the agenda and who finally puts the issue onto the agenda given that policy actors hold power. This thesis draws on policy actors' characteristics as government and non-government and the idea of interactions among plurality of policy actors to, firstly identify the policy actors' different roles in specific policy decisions, and as we will see in chapters 3 to 6

distinguish main categories of actors as final decision makers and policy influencers. And secondly explore the linkages and networks among policy actors and power relations that result from their interactions.

Context

To ascertain factors that shape policy actors' actions and decisions, the thesis took into account role of context on policy actors' actions. Policy actors' actions are never fully autonomous but are embedded within the context in which decisions are made. Context confronts policy actors with issues they need to address, set limits on what solutions can be considered and determine what options are politically, economically and administratively feasible (Grindle and Thomas, 1991).

Policy actors relate to context differently and it is important to distinguish between policy actors and their different interaction with context. This thesis draws from Grindle and Thomas (1991) conceptualization of context based on their work on public choice and policy change in developing countries, to study how context shaped policy actors' action and decisions. Grindle and Thomas (1991) categorize context broadly as international, national, institutional and individual factors. International contextual factors include global targets and agendas, and a country's relationship to international economic and political conditions. Domestic economic and political conditions, administrative capacity of the country, historical experiences and conditions, structure of class and interest groups, mobilization in the society – are identified as national context. The institutional context includes administrative capacity of institutions, the impact of prior or similar pursued policies. They also include in individual context: ideological predispositions, professional expertise and training, memories of similar policy situations, position and power resources, political and institutional commitments, loyalties, and personal attributes and goals.

Analytical framework

Figure 1.1: Analytical framework

The interactions among the concepts of - power, problem definition (framing), policy actor, and context form the basis for the thesis analytical framework. Figure 1.1 illustrates the presumed relationship among them. National level maternal health agenda and formulation decisions result from the interactive and connected processes of policy actors' use of power to define issues within a specific context. The agenda and policy formulation decisions made whether implemented or not feedback as a contextual factor of prior or similar pursued policy to inform the ongoing decision making process. A policy actor's ability to consistently rely on power sources from one's resources, knowledge, skills or access to others; and context to define issues and influence decisions is central to this framework.

1.4 Structure of the thesis

Figure 1.2: Structure of the thesis

The thesis is organised into seven chapters as illustrated in figure 1.2. After the general introductory chapter, chapter 2 present the Ghanaian geographical, political, economic and health sector context, and research design, process and data collection methods. Because the empirical chapters (3-6) based on papers published or in the process of being published in international peer reviewed journal contain detailed methodological and context sections, chapter 2 provides a general overview. The research questions are explored through a series of 4 case studies of agenda setting and formulation related to maternal health. Chapter 3 seeks to answer the questions: which policy actors have been involved and how contextual factors influenced maternal health policy agenda setting and formulation and why. This chapter

discusses the role of policy actor's power sources and context in maternal fee exemption policy agenda setting and formulation decisions between 1963 and 2008. The concepts of policy actor, context and power were applied to analyse the maternal fee exemption case. Chapter 4 focuses on policy actors, decision making processes and the evolution of maternal health policies within the institutionalised policy dialogue structures of the Ghanaian health sector. In this case, the concept of problem definition and power were applied to analyse policy actors' influence on the evolution of maternal health policies between 2002 and 2012. Chapter 5 seeks to answer the question: which policy actors have been involved and how policy actors defined maternal health issues and why. This chapter discusses how and why 'free family planning as part of national health insurance scheme' policy appeared on the government agenda and failed to move swiftly into programme formulation and implementation. The concepts of power and problem definition were applied to analyse the case. Chapter 6 discusses how less than three months into the implementation of a pilot per capita provider payment policy prior to upscaling to national level, antenatal, normal delivery and postnatal services those were initially included as part of the basket of services dropped off the policy agenda. The concept of context and the use of power to resist a policy change were applied to analyse the case. Chapter 7 presents the general synthesis and conclusions of the research. The chapter highlights the main findings based on the research questions, discusses theoretical and methodological issues emerging from the study, and policy implications and issues for further research.

Chapter 2

2 Ghana context and research methodology

2.1 Ghana context

Geographical and population context

The Republic of Ghana is situated on the Gulf of Guinea in the south of the West African sub region. It is bordered by Togo in the east, by Ivory Coast in the west and by Burkina Faso in the North. The country covers a land area of 238,533km². Administratively, it is divided in ten regions. Accra, in the Greater Accra region is the capital and seat of Government. The population according to the 2010 national census is 24,658,823 with an average annual growth rate of 2.5 percent between 2000 and 2010. On average 50.9 percent of the population lives in urban areas. However, the level of urbanization varies from region to region. The Greater Accra Region has the highest proportion of urban population (90.5 percent), followed by the Ashanti Region (60.6 percent) while Upper West Region has the lowest proportion of urban population (16.3 percent). The concentration of industries and commercial activities in the Greater Accra and Ashanti Regions may partly account for the relatively high urban population in these regions. The remaining eight regions are predominantly rural, with the level of urbanisation below the national average of 50.9 percent (Ghana Statistical Service, 2012).

Political context

The fifty-nine years of Ghana's independence have been characterised by short-lived governments and frequent instability, the incursion of military in national politics and a recent more stable multiparty democracy. Ghana gained independence on 6th March 1957 from British rule and became a Republic 1st July 1960. After independence, due to the overwhelming majority of the Convention People's Party (CPP) in Parliament, Ghana was made a socialist one-party state in which the CPP became the most dominant and powerful political group. The Nkrumah government initiated several socialist policies in health, education and housing. The National Liberation Council, a military government overthrew Dr Nkrumah in 1966. The National Liberation Council handed power to a democratically elected Prime Minister – Dr Busia in 1969 in the second Republic. Between 1972 and 1979 Ghana experienced a series of military takeovers. In 1979, the People's National Party won the presidential election and Dr Limann became the President of the third Republic. There was a military coup by the Provisional National Defence Council (PNDC) in 1981 that overthrew Dr Limann (Rimmer, 1992). The PNDC military government headed by Flight-Lieutenant Rawlings, reorganise itself into a political party – the National Democratic Congress (NDC) and contested and won the 1992 multiparty presidential and parliamentary elections under the fourth Republican Constitution of

1992. The NDC claims a center left social democratic ideology (National Democratic Congress 2016).

Since then, presidential and parliamentary elections are held every four years. Transitions of power between political parties have taken place smoothly in 2000, 2004, 2008 and 2012 with a handover of government from one political party to another in two instances. Ghana has now twenty seven registered political parties but the NDC and New Patriotic Party (NPP) are the dominant ones, having leadership of governance of the country rotating between them since 1992. The NPP is the new face of the Danquah-Busia tradition which was the party in opposition at independence in 1957 and had briefly ruled the country from 1970 to 1972 before it was ousted in a military coup. The NPP claims a center right liberal democratic / liberal conservative ideology (New Patriotic Party, 2016). In practice the NDC and NPP have tended to support social policies for universal health and education access such as national health insurance, family planning, female education and free universal and compulsory education etc. Responding to the social and economic challenges of Ghana is perhaps more important than strict ideology in Ghana's multiparty democratic politics.

Economic Context

Ghana is a lower middle income country with \$1590 gross national income per capita and a gross domestic product (GDP) per capita growth of 1.6 percent in 2014 (World Bank). The GDP value of Ghana represents 0.06 percent of the world economy. Ghana's has one of the highest GDP per capita in West Africa. The country has a diverse and rich resource base with gold, timber, cocoa, diamond, bauxite, and manganese being the most important source of foreign trade. In 2007, an oil field which may contain up to 3 billion barrels of light oil was discovered. Yet, in spite of abundance of natural resources, a quarter of the population lives below the poverty line (Trading Economics). The health expenditure was 5.4 percent of GDP in 2013 the highest value over the past 18 years while its lowest value was 3.0 percent in 1997 (World Bank). Due to government health sector budget cut, 3.2 percent of the GDP is projected as the total health expenditure for 2016 (GhanaMyjoyonline, 2016).

Maternal and child health context

Antenatal care (ANC) from a skilled provider is important to monitor pregnancy and reduce morbidity and mortality risks for the mother and child during pregnancy, at delivery, and during the postnatal period (within 42 days after delivery). The 2014 Ghana Demographic Health Survey (GDHS) results show that 97 percent of women who gave birth in the five years preceding the survey received ANC from a skilled provider at least once for their last birth. Almost nine in ten women (87 percent) had four or more ANC visits. Urban women are slightly more likely than rural women to

have received ANC from a skilled provider (99 percent and 96 percent, respectively) and notably more likely to have had four or more ANC visits (93 percent and 82 percent, respectively). The percentage of women receiving ANC from a skilled provider has increased steadily over the past two and a half decades, from 82 percent in 1988 to 97 percent in 2014.

Under-five mortality indicators have also improved over the years. The 2014 GDHS documents a pattern of decreasing under-five mortality during the 15 years prior to the survey. Under-five mortality rate decreased from 111 per 1,000 for the five-year period preceding the 2003 GDHS to 60 per 1,000 during the same period prior to the 2014 GDHS (Ghana Statistical Service (GSS) et al., 2015).

Between the mid-1980s and the 1990s total fertility rate (TFR) declined from 6.4 births per woman in 1988 to 4.4 births by 1993. TFR over the past six years increased slightly from 4.0 births per woman in 2008 to 4.2 births in 2014. Over the period the net direction of TFR is downwards from 6.4 to 4.2 (Ghana Statistical Service (GSS) et al., 2015).

National policy making context

In Ghana, the 1992 Constitution Directive Principle of State Policy guides health policy decision making at national level. The Directive Principle of State binds the government to take public policy decisions that promote just and reasonable access by all citizens to public facilities and services for the realization of the right to good health care (Government of Ghana, 1992). Ministry of Health (MOH) a public institution coordinates national level policy decisions and provides overall policy direction for all actors within the health sector (Ministry of Health, 2007, Ministry of Health, 2014). According to the MOH, the health sector is more than health services, and includes all activities, institutions and resources whose primary purpose is to promote, protect, maintain and restore health (Ministry of Health, 2007).

The Ghanaian health sector has had a hierarchical, predominantly publically financed, publically administered and delivered services model since independence in 1957. However, a strong private sector participation in service delivery has always accompanied it. Out-of-pocket payments at point of service have also ensured continuing 'private' financing for the sector. The sector underwent two major reforms in the 1990s. These were the creation of the Ghana Health Service (GHS) under the Ghana Health Service and Teaching Hospitals Act, and the adoption of a sector wide approach in 1997. Prior to passage of the Ghana Health Service and Teaching Hospitals Act in 1996, the MOH was the regulator of public and private sector, the body responsible for health policy direction, coordination, monitoring and evaluation, and the provider of public sector services. The Ghana Health Service and Teaching Hospitals Act 525 created an agency model in the health sector. The MOH became a civil service ministry responsible for overall sector policy making,

coordination, monitoring, and evaluation, with the GHS providing public health and clinical services (Agepong et al., 2012, Mayhew, 2003).

Under the sector-wide approach, dialogue between government and international donors shifted from the planning and management of projects, to the overall policy, institutional, and financial framework within which health care is provided at national level (Cassels and Janovsky, 1998). As part of the sector wide approach, a series of health sector policies dialogues were institutionalised. This includes the biannual review and planning health summits where the MOH and donors jointly agree on national priorities expressed in the programme of work (POW). The POW states the policies, strategies, targets, and resource envelope and allocation for the sector.

The MOH with the authority to coordinate activities within the health sector wields power over the public policy decision process in pursuit of its vested interest and that of others. Policy usually emerges as the result of continuous decision negotiation and compromise through horizontal and vertical coordination between policy actors involved in the policy decision making process (Bevir, 2009, Hill and Hupe, 2002, Buse et al., 2005). For instance, the MOH engages in horizontal discussions and planning with its - service delivery, financing, research and training and regulatory agencies, and vertical discussions and negotiations with non-government actors such as donors (bilateral and multilateral) and the private health providers. The MOH is therefore involved in multilevel discussions and negotiations with government and non-government actors in the development and implementation of maternal health policies.

Ministry of Health

The MOH administratively has eight directorates: Policy Planning Monitoring and Evaluation (PPME), Human Resource for Health (HRH), Research Statistics and Information Management (RSIM), Procurement and Supply (P&S), Traditional and Alternative Medicine (TAM), Finance, Administration and Internal Audit, and four main implementing agencies: regulatory, financing, service delivery, and training. The regulatory agencies are the Food and Drugs Authority (FDA), the Medical and Dental Council (MDC), Pharmacy Council (PC), Nurses and Midwives Council (NMC), Traditional Medicine Practice Council (TMPC) and the Health Facilities Regulatory Agency (HEFRA). The research and training agencies are the Ghana College of Physicians and Surgeons (GCPS), the Ghana College of Pharmacist (GCP) and the Ghana College of Nurses and Midwives (GCNM). There is a single financing agency - the National Health Insurance Authority (NHIA) - which oversees the implementation of the financing aspects of the national health insurance scheme. The service delivery agencies are the Ghana Health Service (GHS), Teaching hospitals (TH) and National Ambulance Service (NAS).

Service delivery is offered through a hierarchy of hospitals, clinics, health centres and community based health planning service compounds (CHPS) and run on a three-tier system of care - from primary through secondary to tertiary services. The three-tier system of care is organized at five levels: community, sub district, district, regional and national. Community and sub-district levels provide primary care, with district and regional hospitals providing secondary healthcare. The teaching hospitals are at the apex providing tertiary services and responsible for the most specialised clinical and maternity care and also provide the highest level of academic and practical training and research in medicine and related health fields (Ministry of Health, 2001, Ministry of Health, 2007).

Service delivery is complemented by mission or faith-based (private not-for-profit (PNP)) and the private self-financing (PSF) providers. The Christian Health Association of Ghana (CHAG) represents nearly all private not-for-profit health care service providers in the country. The private not-for-profit facilities target hard-to-reach rural communities and as a result receive financial support from government in the form of some payment of personnel cost, training and supply of equipment. On the other hand, the private self - financing health providers are concentrated in the urban and peri-urban areas, with low rural penetration and do not receive any financial support from government (Ministry of Health, 2013b). Ghana Living Standards Survey (GLSS 6) 2014 data shows that private health providers nationally produce nearly half (47 percent) of all services used by consumers and this makes them key players in the health sector (Ghana Statistical Service, 2014). Figure 2.1 shows the relationship between the MOH, its agencies and the private service providers.

Figure 2.1: Ministry of Health directorates, agencies and private service providers

2.2 Study design

To investigate context specific maternal policy agenda setting and formulation decisions in-depth, a multiple case study design with qualitative methods of data collection was used. Case studies were considered ideal because of its relevance in investigating a phenomenon in-depth especially when the boundaries between the phenomenon and context are not clearly evident, where ‘how’ and ‘why’ questions are being asked about a set of events over which the researcher has little or no control over in a social and physical setting (Yin, 2009, Robson, 2011). A case study approach allows the use of multiple research methods including flexible and open-ended methods of data collection, interpretation and analysis. The case study approach therefore allowed me to look at maternal health policy decisions not merely as inputs and outputs but as a process to better understand within context the interactions between the policy actors involved and decisions.

Case selection consideration

In this thesis a case is defined as a maternal health policy decision(s) taken at the national level. The four cases are: (1) policy decisions in relation to fee exemption for maternal health care (antenatal, delivery, and postnatal), (2) the health sector programme of work in relation to maternal health policy decisions, (3) free family planning as part of NHIS policy decisions, and (4) policy decisions in relation to the inclusion and subsequent exclusion of primary care maternal health care (antenatal, normal delivery, postnatal) from the per capita provider payment system. These cases were purposively selected during my interactions with several policy actors at the Policy, Planning Monitoring and Evaluation Directorate (PPMED) of the MOH and active participation in health sector meetings and constantly asking 'but why' questions leading me sometimes to the beginning of the policy decisions. The ability to go back to the initial policy decisions or publically made statements was the core guide to the case selection – to be able to study the evolution of policy decisions within different timeframes, actors involved and their problem definitions, and the influence of a fast changing economic, political and international context on the policy decisions.

A number of additional considerations informed the choice of case studies. One consideration was to be able to investigate a maternal health policy that had historical and recent decisions taken in relation to setting the agenda, formulation and implementation. Studying fee exemption decisions for maternal health care was appropriate because the policy agenda was first set in 1963, and had evolved over four and half decades and was never taken off the national health policy agenda. This case allowed investigations into the evolution of decision making processes and policy actors' role over different historical periods and in different political contexts. The second case study was selected to investigate how maternal health policies appeared and evolved on the health sector programme of work between 2002 and 2012. Studying how policy decisions evolved from 2002 to 2012 was appropriate for the research because as argued by Sabatier (2007, p4) a decade is a long enough period to observe policy change. This case allowed investigations into how policy actors used their sources of power to define maternal health problems and influence a policy's fate within the programme of work framework.

Yet another consideration was to be able to study ongoing maternal health policy decisions and draw inferences from my observations of policy actors interactions during these policy discussions to better understand how and why the policy decisions had evolved over time. Studying discussions related to the 2012 'free family planning as part of NHIS' policy agenda and how it was to be implemented allowed investigations into how policy actors since 1970 when the family planning programme was established had framed family planning issues. And how the next focus of free family planning slowly evolved into 'free family planning as part of

NHIS' public policy agenda but failed to subsequently move into implementation. Finally, studying discussions related to the per capita provider payment policy agenda which was first stated in the NHIS regulations (2004) but not implemented until 2012 on a pilot basis allowed a better understanding of how primary care maternal health services were initially included and later dropped from the per capita provider payment system.

2.2.1 Field work process, data collection methods and analysis

Field work for this study was conducted between May 2012 and August 2014. The initial phase involved requesting permission in May 2012, to use the PPMED of the MOH as an entry point for the research. The PPMED director granted the permission and I was assigned to the Policy Analysis Unit to permit official participations in the health sector dialogues as a PhD researcher. The rest of the field work included data collection, analysis and interpretation.

Data collection methods

Multiple data collection methods including document review, interviews and observations were used to collect historical and current information and contribute to the validity and reliability of the research findings.

Documents review

Document review was the initial strategy for data collection to map policy decisions, actors' role, actions and interactions. Document review was also used to corroborate and augment evidence from other data sources. Archival and current documents related to the maternal health both published and grey literatures were thoroughly assessed based on Scott (1990) four criteria on the use of documentary sources in social research. First, authenticity, and this assesses that the evidence is genuine and of unquestionable origin. Second, credibility, and this assesses whether the evidence is free from error and distortion. Third, representativeness, and this assesses whether the evidence is typical of its kind, and, if not, whether the extent of its untypicality is known. Finally, meaning, and this assesses whether the evidence is clear and comprehensible. Documents reviewed (see appendix 1) included government legislatives - Laws and Acts of Parliament, health sector reports, meeting records, letters and memos and media reports. The contents extracted from the reviewed documents were grouped and cross analysed based on the research questions, and as suggested by Robson (2011) to obtain rigorous and valid inferences

Participant and non-participant observations

Observations of ongoing health sector policy discussions including those related to the institutionalised policy dialogue processes, maternal health, family planning and

per capita provider payment system – were used to understand and draw inferences from ongoing decisions making discussions to interpret retrospective data from documents and interviews. During field work, I observed and took notes of policy actors' interactions and discussions as noted by Patton (2002) to better understand and capture the context in which people interact. I also actively participated by summarizing meeting deliberations and joining the MOH and stakeholders on monitoring visits to the Ashanti region. I was asked by the PPMED to join the MOH monitoring team to the Ashanti region (6th-9th November 2012) to assess CHPS performance and supply and availability of Artemisinin-based combination therapy. As a result, I participated in a series of meetings. These included separate meetings with: (1) the regional health directorate team made up of the regional director, deputy directors of pharmaceutical services, public health and institutional care and acting coordinator for community based health planning service compounds (CHPS); (2) the Amansie west district health management team made up of the district health director, health information officer and the public health nurse; (3) service providers of private self-financing health facilities (Kama clinic, Kufuor clinic, County hospital); (4) service providers of public health facilities (Manhyia hospital, Ankam CHPS, Mampong government hospital, Yonso CHPS); (5) service providers of St Martins catholic hospital - a mission based health facility. I used the opportunity to interview them. Again I was asked by the PPMED to take notes and summarise the first two days of the April 29th – 6th May 2013 health summit. This presented the opportunity to observe at first hand direct policy actors discussions and interactions.

During field work, initial findings were presented to policy actors at health sector meetings for discussions, comments and critique. The discussions of findings with policy actors allowed for further clarifications of issues less understood by me and the policy actors and further validation of issues with conflicting findings such specific decisions timelines. Appendix 2 summarizes health sector meetings attended during field work.

Interviews

Respondents were interviewed to obtain varied perspectives and better understand maternal health issues. A flexible questioning format rather than structured queries was used for each case study. Interviews as suggested by Yin (2009) and Kumar (2010) are important source of case study information because it allows a fluid stream of questions and interactions between researcher and respondent. The interviews were conducted with thirty-one government and twenty-one non-government respondents in total (see appendix 3). Detail of specific respondents interviewed per case is presented in the chapters 3 to 6.

The interviews lasting on average 1 hour were conducted face to face, over telephone, by emails and on Skype. Depending on the type of respondents and

context I requested to tape record the interview, where permission was not granted I took notes maintaining as far as possible the respondent's precise words and verifying later with them.

Data analysis

Data from the interviews, observations and document reviews were cleaned up, tabulated and systematically grouped based on individual cases. Through content analysis, patterns of decision making processes, policy actors' role and power sources, problem definition and the effect of context on decisions were identified and mapped. Detailed accounts of conceptual analysis for each case are presented in the chapters 3 to 6. The individual cases were further cross analysed as suggested by Yin (2009) to identify core consistencies, contrasts and meaning. The cross-case analysis not only considered the initial analytic concepts but also identified new patterns of decision making processes domains and core characteristics of policy actors across the four cases.

2.3 Insider and outsider dilemma

During fieldwork I was confronted with the researcher's tag of being an insider and an outsider at the same time. I was considered insider, because I relied on my existing social and professional network for details of potential interviewees and to get access to all kind of information. My affiliation with the MOH as a staff of the drug policy unit (on leave) helped me to quickly blend in when assigned to the PPMED policy analysis unit. I was able to collect and compile an enormous amount of data so much that people came to me for current and past copies of health sector documents. The challenges for me as an insider were: data overload and the perception that I should already have answers to some of the questions I asked of my interviewees. However, since I worked in a different directorate -pharmacy-, I was not privy to national level maternal health policy discussions and interactions.

Using the PPMED as an entry point for my field work and wearing a 'researcher' cap earned me the outsider label. Sometimes during policy dialogue discussions I was referred to as a spy. During health sector meetings some policy actors were uncomfortable having a researcher sitting and constantly taking notes, there was some level of mistrust and a perception that I was there to judge and critique their work. On the contrary, some policy actors saw my participations as an opportunity to obtain detailed meetings records. In the end, being an insider/outsider was an incredible place to be because I was able to benefit from the opportunities and disadvantages of being an insider/outsider presented. As an outsider I moved from self (as a MOH staff) to objectively reflect on my findings and the health sector as a whole. As a result I was able to analytically observe discussions and interactions relevant to my research topic. As an insider I had the opportunities

to partake in high level meetings and access to some unpublished non-confidential policy decisions documents, allowing for gathering of some evidence that only document review of publically available documents will not give.

2.4 Ethical consideration

This study forms part of a larger study – ‘Accelerating progress towards attainment of Millennium Development Goals 4 and 5 in Ghana through basic health systems function strengthening’ – for which ethical approval was granted by the Ghana Health Service Ethical Review Committee and the Wageningen School of Social Science Research Assessment Committee of Wageningen University and Research Centre. Informed consent was obtained from all respondents, and respondent’s anonymity was maintained and protected using codes as labels during the study.

Chapter 3

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3 National level maternal health agenda setting and formulation: the pivotal role of policy actors and context

3.1 Abstract

Background

Development of health policy is a complex process that does not necessarily follow a particular format and a predictable trajectory. Therefore, agenda setting and selecting of alternatives are critical processes of policy development and can give insights into how and why policies are made. Understanding why some policy issues remain and are maintained while others drop off the agenda is an important enquiry. This paper aims to advance understanding of health policy agenda setting and formulation in Ghana, a lower middle-income country, by exploring how and why the maternal (antenatal, delivery and postnatal) fee exemption policy agenda in the health sector has been maintained over the four and half decades since a 'free antenatal care in government facilities' policy was first introduced in October 1963.

Methods

A mix of historical and contemporary qualitative case studies of nine policy agenda setting and formulation processes was used. Data collection methods involved reviews of archival materials, contemporary records, media content, in-depth interviews, and participant observation. Data was analysed drawing on a combination of policy analysis theories and frameworks.

Results

Contextual factors, acting in an interrelating manner, shaped how policy actors acted in a timely manner and closely linked policy content to the intended agenda. Contextual factors that served as bases for the policymaking process were: political ideology, economic crisis, data about health outcomes, historical events, social unrest, change in government, election year, austerity measures, and international agendas. Nkrumah's socialist ideology first set the agenda for free antenatal service in 1963. This policy trajectory taken in 1963 was not reversed by subsequent policy actors because contextual factors and policy actors created a network of influence to maintain this issue on the agenda. Politicians over the years participated in the process to direct and approve the agenda. Donors increasingly gained agenda access within the Ghanaian health sector as they used financial support as leverage.

Conclusion

Influencers of policy agenda setting must recognise that the process is complex and intertwined with a mix of political, evidence-based, finance-based, path-dependent, and donor-driven processes. Therefore, influencers need to pay attention to context and policy actors in any strategy.

Keywords

Context, Fee exemption, Maternal health services, Policy actors, Policy agenda setting, Policy formulation.

3.2 Introduction

The development path of health policy whether as intent or practice can be difficult to predict because it is a complex and intertwined process and does not necessarily follow a particular format. Understanding why some policy issues remain and are maintained while others drop off the agenda (agenda setting and selection of alternatives) is an important field of enquiry since it can give insights into this complex process. This is because getting and maintaining policy issues on the agenda is an essential part of decisions made during policy development.

Green-Pedersen and Wilkerson (2006) argue that the explanations proposed for why some issues make it onto the agenda and others fail are wide ranging. Some are structural, emphasizing how institutions are organized to advantage some alternatives or issues over others. Some are cognitive, emphasizing how individuals or even institutions process information in ways that limit what will be addressed at any given time. Others emphasize the role of external events or public opinions, and how they can combine with political incentives to quickly shift attention to a new direction (Green-Pedersen and Wilkerson, 2006).

Some issues once on the agenda are maintained over time and periodically re-examined to maintain their recurrence (Nelson, 1986). Political attention of vote-seeking politicians for example maintained health policy issues on the national agenda over time in Denmark and the United States (Green-Pedersen and Wilkerson, 2006). There is however very little research related to how and why some policies have a long life and are maintained over time despite periodic threats to their existence, while others cease to exist.

The aim of this paper is to advance understanding of health policy agenda setting and formulation in low- and middle-income country (LMIC) settings by exploring how and why maternal (antenatal, delivery and postnatal) fee exemption policy agendas in the health sector in Ghana have been maintained over the four and half decades since a 'free antenatal care in government facilities' policy was first introduced in October 1963. Specifically we ask: How have maternal user fee exemption policies evolved in Ghana since independence? Which actors have been

involved in the policy agenda setting and formulation and why? What contextual factors influenced the process over time, how and why?

Advancing the understanding of policy agenda setting and formulation process, especially how and why a policy agenda item is maintained over time, is an essential area of analysis to inform public social policy development and implementation. Nevertheless, there is limited research and publications on policy analysis in LMICs (Gilson and Raphaely, 2008) and in particular on processes of agenda setting and formulation (Shiffman and Okonofua, 2007). Our work firstly contributes to the general understanding of policy agenda setting and formulation processes in a LMIC setting. Secondly, it provides insights on how and why maternal fee exemption policies in Ghana were maintained over four and half decades despite the existence of at least eight distinct threats or opportunities for major policy reforms.

Ghana Health Sector

The Ghanaian health sector has had a hierarchical predominantly publically financed, publically administered and delivered services model since independence in 1957. However, alongside has always also been a strong private sector participation in service delivery has always accompanied it. Out of pocket payments at point of service have also ensured continuing private financing. The sector underwent two major reforms in the 1990s. These were the creation of the Ghana Health Service (GHS) under the Ghana Health Service and Teaching Hospitals Act, and the adoption of a sector-wide approach in 1997. Prior to passage of the Ghana Health Service and Teaching Hospitals Act in 1996, the Ministry of Health (MOH) was the regulator of public and private sector, the body responsible for health policy direction, coordination, monitoring and evaluation and the provider of public sector services. The Ghana Health Service and Teaching Hospitals Act 525 created an agency model in the health sector. The MOH became a civil service ministry responsible for overall sector policy making, coordination, monitoring, and evaluation, with the GHS providing public health and clinical services (Agyepong et al., 2012, Mayhew, 2003). Under the sector-wide approach, dialogue between government and international donors shifted up a level: from the planning and management of projects, to the overall policy, institutional, and financial framework within which health care is provided at national level (Cassels and Janovsky, 1998). The Government of Ghana represented by the MOH and international donors jointly agreed to national priorities expressed in the programme of work which states the policies, strategies, targets, and resource envelope and allocation for the sector (Birungi et al., 2006, Mayhew and Adjei, 2004).

In the immediate post-colonial period (March 1957) and several years afterwards, the majority of policy agenda and formulation decisions were undertaken mainly by politicians and a small group of bureaucrats (Kpessa, 2011). The sector-wide approach created a new avenue for policymaking platforms between the MOH, international donors and other actors broadening the scope and range of policy actors. As a result, expertise could be drawn from other actors in or outside the health sector to form groupings to guide the process. Yet, the ultimate policy choice still rested with politicians and a few bureaucrats (Agyepong and Adjei, 2008). A handful of policy elites taking the ultimate decision is not peculiar to Ghana. In their work on developing countries, Grindle and Thomas (1991) noted that small policy elites – government officials and civil servants – strongly influenced the agenda and the nature of adopted policies.

3.3 Methods

A longitudinal mix of historical and contemporary case studies of policy agenda setting and formulation for a specific issue – fee exemptions for maternal health services – was conducted for the period 1957 to 2008. The case study approach was ideal since it allowed collection and analysis of comprehensive, systematic and in-depth information within a real life context (Patton, 2002, Yin, 2009). Nine specific fee exemption policy agendas for maternal health have been set since independence in 1957 and each of these was treated as a separate unit of analysis or case.

To systematically attempt to reconstruct the dynamics surrounding the nine historical maternal fee exemption policy agenda setting and formulation events, we relied on mixed methods, and analysed data in the light of an appropriate conceptual framework. Data was collected between June 2012 and May 2014 using key informant in-depth interviews, a desk review of documents and archival materials including media content from independence (1957) through to 2008, and participant observation during a 20 month period of practical attachment at the Policy Planning Monitoring and Evaluation (PPME) directorate of the MOH by one of the authors (AK)¹. The PPME is responsible for the coordination of policy formulation and strategic planning for the health sector. Participant observation there was therefore ideal for observing and understanding aspects of the processes involved in contemporary policy agenda setting and formulation.

The focus of the in-depth interviews was to obtain real-life experiences of policy agenda setting and formulation processes from respondents. In total, 27 national level respondents were interviewed based on a semi-structured interview guide. Fifteen of these respondents were identified from health sector documents reviewed, while the rest (12) were suggested by other respondents. The in-depth interviews were conducted via face-to-face meetings, e-mails and phone.

¹ PhD candidate

Respondents included actors within government settings such as past and current officials of the MOH (10), the GHS headquarters (3), the National Health Insurance Authority (4) and a former Minister of Health (1). Respondents also included actors outside government settings such as officials of the Christian Health Association of Ghana (1), the Coalition of Non-Governmental Organizations in Health (1), international donors (4) and health professional bodies (3). Interviews were tape-recorded and later transcribed verbatim by a neutral person to maintain the original messages of respondents. Where permission was not granted to tape record an interview, notes were taken and verified later with the respondent. All transcriptions were read and analysed repeatedly and organized into retrievable sections based on the analytical framework.

Document and archival review and analysis were used to map the historical sequence of events, identify policy actors, and further triangulate findings with respondent's information. The study greatly relied on varied documents to trace historical happenings. Documents were assessed based on four criteria developed by Scott (1990). Firstly, authenticity which assesses that the evidence is genuine and of unquestionable origin. Secondly, credibility which assesses whether the evidence is free from error and distortion. Thirdly, representativeness which assesses whether the evidence is typical of its kind, and, if not, whether the extent of its untypicality is known. Finally, meaning which assesses whether the evidence is clear and comprehensible (Scott, 1990). National archives, the National Parliament Library, the George Padmore Research Library, and the Ghana Publishing Corporation were the sources of data for health legislative documents such as National Decrees, Acts of Parliaments and National Regulations, old health related reports and, records of one national newspaper - the Daily Graphic were also used. We obtained access through the policy analysis unit of the MOH to archives of non-confidential official documents including letters, meeting minutes, memoranda, health review reports, health sector programme of work, national strategic plans and agreements related to decisions to provide maternal user fee exemptions. Additionally, the web-based search engine Google Scholar was used to obtain published literature related to maternal fee exemptions. Relevant sections of all reviewed documents were highlighted and coded based on the categories identified in the analytical framework.

Analytical concepts

To guide the analysis of the data we drew on several policy analysis theories, frameworks and concepts in the literature. Grindle and Thomas (1991) conceptualize context as including the structure of class and interest group mobilization in the society, historical experiences and conditions, international economic and political relationships, domestic economic conditions, the administrative capacity of the state,

and the impact of prior or conterminously pursued policies. They also include in context, the individual characteristics of policy actors such as their ideological predispositions, professional expertise and training, memories of similar policy situations, position and power resources, political and institutional commitments, loyalties and personal attributes and goals. They observe that policy actors are never fully autonomous. Instead, they work within several interlocking contexts that confront them with issues and problems they need to address, set limits on what solutions are considered, determine what options are feasible politically, economically and administratively, and respond to efforts to alter existing policies and institutional practices.

Kingdon's framework of agenda setting argues that active participants (policy actors) and the processes by which agenda items and alternatives come into prominence are key factors that affect policy agenda setting and choice. Policy actors in his USA study included the President, the Congress, bureaucrats in the executive branch, and various forces outside of government including the media, interest groups, political parties and the general public. Policy agenda setting and choice processes are embedded within their context and as such influence how policy actors operate within these processes (Kingdon, 2003).

Power is a key factor in health policy processes (Erasmus and Gilson, 2008). Contextual factors may serve as a source of power to influence policy actors' action, inaction and choice. Policy actors therefore can become influencers within a specific context to affect policy agenda setting and formulation processes. As noted by Mintzberg (Mintzberg, 1983), to be an influencer, one requires some source of power defined by control of a resource, a technical skill and body of knowledge or stemming from a legal prerogatives or authority coupled with active involvement in ongoing processes in a politically skilful way.

Drawing on these concepts of context, policy actors and power, we attempted to systematically reconstruct nine historical agenda setting and policy formulation events. Working iteratively on data gathered patterns, themes and categories that emerged were tabulated and further analysed. The analysis process involved mapping to our analytical framework contextual situations, policy actors and their role, linkage among policies, specific policy content, power sources and how these influenced the agenda setting processes and why. We acknowledge the problems involved in mapping the exact sequence of events. To minimise this, varied sources of data were used to reconstruct insofar as possible, the chronology and dynamics of maternal fee exemption policies agenda setting and formulation processes.

3.4 Results

This section contains a historical reconstruction of the dynamics related to the nine maternal fee exemption policy agenda setting and formulation events insofar as

possible. We acknowledge the difficulty in providing a full explanation of events as they unfolded - reconstructing who said what, when, to whom and how it was received. Where such data is available it is duly noted, otherwise the gap is noted, and possible inferences are made from interpretation of data.

3.4.1 Policy actors and agenda setting

Maternal fee exemption policies studied included free healthcare services related to one or more of antenatal, delivery and postnatal services starting from the initial introduction of free antenatal service in 1963. Policies related to maternal fee exemption were maintained and modified – including expansions and contractions, but were never completely dropped over the period studied. Nine specific maternal fee exemption policies were identified along the pathway, as the policies evolved from user fee exemption to national health insurance premium exemption. Table 3.1 summarises the maternal fee exemption policies historical timelines, policy instruments and policy contents between 1963 and 2008.

Over the period studied, we classified policy actors involved in maternal fee exemption policies based on their primary role into four groups. The first group, ‘policy agenda directors’, includes high level politicians such as heads of state who gave directives to either set the maternal fee exemption agenda or modify a previously existing policy. The second group ‘policy agenda approvers’ includes high and middle level politicians such as heads of state and ministers of health who gave approval for existing maternal fee exemption policies to be maintained and/or modified. The third group, ‘policy agenda advisers’, includes government and non-government individuals and organizations who advised agenda directors and approvers. Policy agenda advisers includes the Ministry of Health and its agencies such as the GHS and National Health Insurance Authority (NHIA), as well as those outside the health sector such as the Attorney General Office and National Development Planning Commission. Non-government policy agenda advisers include international bilateral and multilateral donors. Policy agenda advisers provided technical expertise in varying capacities to push/keep particular ideas on or off the agenda. Some have, over the period studied, provided financial resources to support their ideas and in some cases, set the agenda. The fourth group, ‘policy agenda advocates’, includes those who have supported and campaigned directly or indirectly to maintain maternal fee exemption policies. Examples include the general public, the Ghana Medical Association and the Pharmaceutical Society of Ghana.

Table 3.1: Historical timelines and mapping of maternal fee exemption policies in Ghana.

Year	Policy instrument	Policy content
1963	Letter	<i>'The Minister has directed that with immediate effect all antenatal services provided at Government hospitals should be for free'</i>
1969	Hospital Fees Decree. National Liberation Council Decree, 360	<p><i>"Except in respect of accommodation and maintenance fees specified in the Second Schedule to this Decree and subject to any other provision of this Decree, no fees shall be paid in a hospital by</i></p> <ul style="list-style-type: none"> <i>- (b) any persons in respect of antenatal care at a Clinic or Health Centre;</i> <i>- (c) any multiparous patient with a history of five or more pregnancies, or any patient referred to a maternity or other hospital from a clinic or health centre or any patient referred to any such hospital by a registered midwife or registered medical practitioner" .</i>
1971	Hospital Fees Act, 387	<p><i>" No fees other than the fees prescribed for accommodation and maintenance shall be paid in respect of services rendered in a hospital to</i></p> <ul style="list-style-type: none"> <i>- (b) any person other than a non- resident alien in respect of antenatal care at a health post, rural health centre or clinic , or any other hospital specified by the Director of Medical Services by notice published in the Gazette;</i> <i>- (c) any maternity patient who has had four or more child births;</i> <i>- (d) any maternity patient referred to a hospital from a clinic or health centre;</i> <i>- (e) any maternity patient referred to a hospital by a registered midwife or registered medical practitioner" .</i>
1983	Hospital Fees	<i>" No fees other than hospital accommodations and catering services shall be paid in any Government hospital</i>

Year	Policy instrument	Policy content
	Regulation. Legislative Instrument 1277	<i>or clinic in respect of</i> – (i) antenatal and postnatal services
1985	Hospital Fees Regulation. Legislative Instrument 1313	<i>“ No fees other than hospital accommodations and catering services shall be paid in any Government hospital or clinic in respect of</i> – (i) antenatal and post-natal services
1997	November 1997 Ministry of Health Guidelines	<i>‘Exemption for antenatal service (first 4 antenatal care visits) in government health facilities’</i>
2003	Annual Programme of Work, 2004	<i>‘User fee exemption for maternal service in Northern, Upper-West, Upper-East and Central Regions in government, private and mission health facilities’</i>
2005	Annual Programme of Work, 2005.	<i>‘User fee exemption for maternal service in all ten regions in government, private and mission health facilities’</i>
2008	June 2008. Ministry of Health guidelines	<i>‘National Health Insurance Scheme premium exemption for all pregnant women in Ghana’</i>

3.4.2 Contextual factors and agenda setting

Context and policy actors consistently influenced the manner in which policy agenda setting and formulation related to maternal fee exemptions occurred over the period of study (see Table 3.2). Contextual factors that shaped maternal fee exemption policies from 1963 to 2008 included political ideology, economic crises, historical events, change in government, election years, austerity measures, international agendas and country-based health outcomes in the form of health demographic indicators. These contextual factors also served as sources of power that policy actors used to influence the agenda setting and formulation processes, and justify their actions and inactions. They are described below for each of the nine discrete policy change periods we identified.

1963 Free antenatal care in the public sector directive

Prior to independence in March 1957, patients paid charges for hospital services. The existing health law Hospital Fees Ordinance, Regulation Number 56 of 1942, stipulated schedules of fees for hospital services (Konotey-Ahulu et al., 1970). In the context of political emancipation and the euphoria that marked independence, it was evident that charging of fees for services was at odds with the political ideology of free health and education – the Nkrumahism social philosophy – (Rimmer, 1992) promoted by the first head of state, Dr Kwame Nkrumah (Graphic Reporter, 1957). Thus the first financing policy related to maternal health services, the 21st October 1963 directive by the Minister of Health that with immediate effect, all antenatal services should be provided at government hospitals free of charge (Konotey-Ahulu et al., 1970) had as its main contextual agenda driver, ideology.

‘From independence, it was the socialist leaning of the Convention People’s Party that set the agenda’ [Former MOH staff, 22/8/2012].

Public reminders of this popular directive to provide free health services for all were carried in national newspaper with headlines such as; *‘hospital fees, no charge’*; *‘free health service’* and *‘free medical service soon’* (Graphic Reporter, 1957, Graphic Reporter, 1958, Graphic Reporter, 1962). However, the MOH used a piecemeal approach in making free health for all a reality, although it was a political directive. In addition to the free antenatal service, the MOH also made adjustments to reduce existing hospital fees and provided free care for other services. For example, by 9th October 1961, private (professional) fees previously borne by patients were abolished and doctors, dentists and specialists were paid an annual allowance in lieu by government. By November 1961, confinement fees for midwifery services was reduced to about half of the charge stated in the General Orders of 1942. Further adjustments were made at a principal medical officers’

Table 3.2: Summary of policy actors, contextual situations, accompanying power sources and policy outcomes.

Agenda setting events	Precipitating factors	Actors, Forces, Context, Evidence, Narratives and Interest Favoursing Exemptions	Actors, Forces, Context, Evidence, Narratives, and Interest Opposing Exemptions	Outcome
1963	Political	Actors :	Actors :	Free antenatal service and minimal fees for other health services
	Socialist	President-Dr Kwame Nkrumah	Ministry of Health (MOH) bureaucrats	
	Ideology	Forces:	Forces :	
		Political power of government Political ideology at odds with charging fees for social services Context: Euphoria after independence Evidence: Charging fees for health service was at odds with socialist ideology Narrative: Government to provide free health care services for all Interest: Political gains and command of public attention	Health care service expertise and administrative power of MOH Context : MOH adjusting to the 'new' health sector administrative procedures post-independence Evidence : NONE Narrative : Piecemeal effort to make free health for all practical Interest : Provide health care services	
1969	Change in government	Actors :	Actors:	Maternal user fee exemption policy of free antenatal
		1. MOH Bureaucrats	Head of State – Major General Joseph Arthur Ankrah	
		2. General Public		
		3. Head of State – Major General Joseph	Forces:	

Agenda setting events	Precipitating factors	Actors, Forces, Context, Evidence, Narratives and Interest Favouring Exemptions	Actors, Forces, Context, Evidence, Narratives, and Interest Opposing Exemptions	Outcome
	Arthur Ankrah		Political power of the government	services expanded
	Forces :		Government took the evidence of health sector budget deficit	to include free delivery service
	1. Health care service expertise and administrative power of MOH		Context:	for multiparous patient
	2. Power of voice and numbers of the general public		Deteriorating economy and growing health expenditure	
	3. Political interest of military government to consolidate power		Evidence :	Increased fees for other health
	overtook evidence of health sector budget deficit		Health sector budget deficit	services stipulated in the Hospital
	Context:		Narrative :	Fees Decree, 360
	Existing free antenatal policy and minimal fees for other health services.		Reintroduce hospital fee to generate health sector revenue	
	High maternal health related deaths		Interest	
	New military government		Generate health sector revenue to correct budget deficit.	
	Evidence:			
	Popular hospital fees exemption policies and minimal fees for other health services			
	Narrative:			
	Go on with maternal user fee exemption policy			
	Interest :			
	MOH - provide health care services			

Agenda setting events	Precipitating factors	Actors, Forces, Context, Evidence, Narratives and Interest Favouring Exemptions	Actors, Forces, Context, Evidence, Narratives, and Interest Opposing Exemptions	Outcome
	General public - go on with maternal user fee exemption and minimal fees for other health services			
1971	Change in government	<p>Actors :</p> <ol style="list-style-type: none"> 1. Prime Minister - Dr Kofi Abrefa Busia 2. General Public <p>Forces:</p> <ol style="list-style-type: none"> 1. Political power of government 2. Power of voice and numbers of the general public <p>Context :</p> <p>Existing free antenatal policy and minimal fees for other health services.</p> <p>Public outcry about hospital fees</p> <p>New democratic government</p> <p>Evidence:</p> <p>Popular maternal user fee exemption policy.</p> <p>Narrative:</p> <p>Prime Minister - Go on with exemptions and minimal hospital fees awaiting</p> <p>Konotey- Ahulu's recommendations.</p> <p>General Public - No increase in hospital</p>	<p>Actors :</p> <ol style="list-style-type: none"> 1. MOH Bureaucrats 2. Konotey- Ahulu committee <p>Forces :</p> <ol style="list-style-type: none"> 1. Health care service expertise and administrative power of MOH 2. Technical expertise of the Committee <p>Context :</p> <p>Deteriorating economy and growing health expenditure</p> <p>Evidence :</p> <p>Health sector budget deficit</p> <p>Narrative :</p> <p>MOH- Free health service is not the way to go</p> <p>Konotey- Ahulu committee- There could be no health service without fees</p> <p>Interest</p> <p>Generate health sector revenue to correct budget deficit</p>	<p>Existing maternal user fee exemption policy maintained</p> <p>The intent to increase minimal fees for other health services stipulated in the Hospital Fees Act, 387</p>

Agenda setting events	Precipitating factors	Actors, Forces, Context, Evidence, Narratives and Interest Favouring Exemptions	Actors, Forces, Context, Evidence, Narratives, and Interest Opposing Exemptions	Outcome
	<p>fees for health services and maintain ongoing maternal user fee exemption</p> <p>Interest :</p> <p>Prime Minister – Consolidate political power and maintain the status quo</p> <p>General Public - Go on with maternal user fee exemption and minimal fees for other health services</p>			
1983	Under resourced public health services	<p>Actors :</p> <ol style="list-style-type: none"> 1. Military leader - Flight Lieutenant Jerry John Rawlings 2. Multilateral agency: United Nations Children's Fund (UNICEF) <p>Forces:</p> <ol style="list-style-type: none"> 1. Political power of government 2. Medical expertise and financial power of UNICEF <p>Context :</p> <p>Existing free antenatal policy and minimal fees for other health services</p> <p>Evidence :</p> <p>Strong political interest and support of</p>	<p>Actors :</p> <ol style="list-style-type: none"> 1. MOH Bureaucrats 2. Health professional bodies - Ghana Medical Association, Pharmaceutical Society of Ghana <p>Forces :</p> <ol style="list-style-type: none"> 1. Health care service expertise and administrative power of MOH 2. Expertise of professional bodies 3. Evidence of shortage of medicines and consumables overtook political interest to keep the status quo <p>Context :</p> <p>Economic crisis and severe health sector</p>	<p>Existing maternal user fee exemptions policy narrowed to antenatal and postnatal services</p> <p>Fees for other health services stipulated in the Hospital fees Regulation, 1277</p>

Agenda setting events	Precipitating factors	Actors, Forces, Context, Evidence, Narratives and Interest Favouring Exemptions	Actors, Forces, Context, Evidence, Narratives, and Interest Opposing Exemptions	Outcome
		government to keep the status quo	budget deficit	
		Narrative :	Evidence :	
		Go on with maternal user fee exemptions and minimal hospital fee for other health services	Shortage of medicines and consumables	
		Interest :	Narrative :	
		Military leader - Not to distress the general populace with hospital fees during economic crisis	Charge hospital fees to generate health sector revenue	
		UNICEF – Advocate for free maternal health services	Interest :	
			Reintroduce hospital fee for all health services to correct health budget deficit	
1985	Under resourced public health services	Actors : 1. Military leader - Flight Lieutenant Jerry John Rawlings 2. MOH Bureaucrats Forces : 1. Political power of government 2. Health care service expertise and administrative power of MOH Context : Economic crisis Structural Adjustment Programme Existing free antenatal and postnatal	None opposing	Maternal (antenatal and postnatal) user fee exemption policy maintained Increased fees for other health services stipulated in the Hospital fees Regulation, 1313

Agenda setting events	Precipitating factors	Actors, Forces, Context, Evidence, Narratives and Interest Favouring Exemptions services Evidence : Charged hospital fees could not recover full cost. Some health facilities already increased hospital fees to recover cost. Narrative: Increase hospital fees to recover cost and maintain maternal user fee exemption Interest : Generate health sector revenue and go on with maternal user fee exemptions policy	Actors, Forces, Context, Evidence, Narratives, and Interest Opposing Exemptions	Outcome
1997	Worsening national maternal health indicators	Actors : President - Flight Lieutenant Jerry John Rawlings Forces : Political power of government Context : Health sector full cost recovery under structural adjustment programme. Declining maternal health outcomes Evidence: Low maternal supervised delivery in	Actors : MOH Bureaucrats Forces : Health care service expertise and administrative power of MOH Evidence of health sector budget deficit overtook government intent Context : Low health sector budget allocation Evidence : Health sector budget deficit	Existing maternal user fee exemption policy narrowed to four antenatal visits

Agenda setting events	Precipitating factors	Actors, Forces, Context, Evidence, Narratives and Interest Favouring Exemptions	Actors, Forces, Context, Evidence, Narratives, and Interest Opposing Exemptions	Outcome
		health facilities of 44 percent as stated in the Ghana Demographic Health Survey (GHS) and Macro International Inc. (MI). 1994)	Narrative: MOH cannot implement fully maternal user fee exemption policy as per the directive	
		High maternal mortality rate estimate of 214 per 100,000 ² live births as stated in the Ghana Maternal Health Survey (Ghana Statistical Service (GSS) et al., 2009)	Interest	Ensure health service delivery
		Narrative: Pregnant women are not accessing supervised delivery services in health facilities because of inability to pay		
		Interest: Government intends to mitigate social consequence of the structural adjustment programme		
2003	Ghana poverty reduction strategy and	Actors : 1. President: John Agyekum Kufuor 2. Multilateral agency: World Bank group and International Monetary Fund	None opposing	Maternal user fee exemption policy linked to poverty reduction strategy

² Maternal mortality rate estimated at 214 per 100,000 live births was based on Ghana Demographic and Health Survey (1993) data.

Agenda setting events	Precipitating factors	Actors, Forces, Context, Evidence, Narratives and Interest Favouring Exemptions	Actors, Forces, Context, Evidence, Narratives, and Interest Opposing Exemptions	Outcome
	Heavily Indebted Poor Countries grant	<p>Actors, Forces, Context, Evidence, Narratives and Interest Favouring Exemptions</p> <p>3. MOH Bureaucrats</p> <p>Forces:</p> <ol style="list-style-type: none"> 1. Political power of government 2. Financial power of World Bank and International Monetary Fund 3. Health care service expertise and administrative power of MOH <p>Context :</p> <p>Stagnant economic growth</p> <p>Inequitable national poverty levels</p> <p>New democratic government</p> <p>Evidence :</p> <p>Worsening poverty indicators such as maternal mortality rate</p> <p>Narrative :</p> <p>There exist a positive correlation between poverty and health outcomes</p> <p>Interest :</p> <p>Improve poverty related health indicators</p>	<p>Actors, Forces, Context, Evidence, Narratives, and Interest Opposing Exemptions</p>	<p>Maternal user fee exemption policy expanded to included delivery and postnatal services and narrowed to four deprived regions</p>
2005	Worsening national maternal health	<p>Actors :</p> <ol style="list-style-type: none"> 1. Minister of Health: Major Courage Quashigah 2. Multilateral and bilateral agencies - 	<p>None opposing</p>	<p>Maternal user fee exemption policy linked to poverty reduction strategy</p>

Agenda setting events	Precipitating factors	Actors, Forces, Context, Evidence, Narratives and Interest Favouring Exemptions	Actors, Forces, Context, Evidence, Narratives, and Interest Opposing Exemptions	Outcome
	indicators	<p>health sector signatories to 2005 Aide Memoire. (European Commission, Royal Danish Embassy, Royal Netherlands Embassy/Department for International Development³, United Nations Population Fund, UNICEF, USAID, Japan International Cooperation Agency WHO and World Bank)</p> <p>3. MOH Bureaucrats</p> <p>Forces :</p> <ol style="list-style-type: none"> 1. Political and administrative power of the Minister 2. Technical expertise and financial power of the Donors 3. Health care service expertise, administrative power of MOH <p>Context :</p> <p>National poverty reduction strategy Election year</p> <p>High poverty in non-deprived regions</p>	<p>priorities</p> <p>Maternal (antenatal, delivery and postnatal) user fee exemption policy expanded to all regions</p>	

³ The Royal Netherlands Embassy was in charge of Department for International Development health projects in Ghana, in line with the cost containment agreement entered into between the two countries.

Agenda setting events	Precipitating factors	Actors, Forces, Context, Evidence, Narratives and Interest Favouring Exemptions Evidence :	Actors, Forces, Context, Evidence, Narratives, and Interest Opposing Exemptions	Outcome
		High national maternal mortality rate of 503 per 100,000 ^{4b} live birth as stated in the Ghana Millennium Development Goal Acceleration Framework and Country Action Plan (Ministry of Health et al., 2011) Narrative: Poverty and poor maternal health outcome exist in non-deprived regions. Interest : Improve national maternal health indicators		
2008	Maternal health declared a national emergency	Actors : 1. President - John Agyekum Kufuor 2. Minister of Health - Major Courage Quashigah 3. MOH Bureaucrats Forces: 1. Political power of the government	None opposing	Free maternal (antenatal, delivery and postnatal) care directive

⁴ Maternal mortality rate estimated at 503 per 100,000 live births was based on Ghana Demographic and Health Survey (2003) and institutional maternal mortality data.

Agenda setting events	Precipitating factors	Actors, Forces, Context, Evidence, Narratives and Interest Favouring Exemptions	Actors, Forces, Context, Evidence, Narratives, and Interest Opposing Exemptions	Outcome
		Actors, Forces, Context, Evidence, Narratives and Interest Favouring Exemptions		
		2. Political and administrative power of the Minister		
		3. Health care service expertise and administrative power of MOH		
		Context :		
		Election year		
		Suspended maternal user fee exemption policy		
		Evidence :		
		Routine health management information system data from the independent review of the 2007 Programme of Work shows:		
		(a) Increased institutional maternal mortality ratio of 187/100,000 live births in 2006 to 224/100,000 live births in 2007		
		(b) Decreased proportion of maternal supervised deliveries in healthcare facilities from 44.5 percent in 2006 to 35.1 percent in 2007)		
		Narrative :		
		Suspended maternal user fee exemption policy contributed greatly to poor maternal health outcomes		

Agenda setting events	Precipitating factors	Actors, Forces, Context, Evidence, Narratives and Interest Favouring Exemptions	Actors, Forces, Context, Evidence, Narratives, and Interest Opposing Exemptions	Outcome
		Interest : Improve maternal health indicators and consolidate political gains		

conference in May 1962, to treat children of 16 years and under free of charge in government clinics and health centres. In the post-independence context, the MOH may have used this piecemeal approach as it adjusted to the 'new' post-independence administrative procedures.

1969 Hospital Fees Decree 360

Full free health care as envisioned by Kwame Nkrumah's ideology was not realised because he was ousted in 1966 by a military coup. After the coup and during the 1967/1968 budget hearing, the military Head of State decided to reintroduce full hospital fees (Konotey-Ahulu et al., 1970). This decision was partly because the military leaders of the National Liberation Council (NLC) blacklisted anything associated with Kwame Nkrumah and his socialist ideology:

'In order to justify the change, they [NLC government] had to discard all that the previous government did; so many programs were neglected' [Former MOH staff, 15/7/2013]

In addition to blacklisting all existing policies for political reasons, an important contextual factor motivating removal of fee exemptions was the worsening economic situation. The government of Ghana was faced with declining economic indicators and increasing health expenditure. By the mid-1960s, the economy was stagnant. Gross national income per capita was US\$ 200 in 1963 and only slightly increased to US\$ 220 in 1969 (Sowa, 1996, Index Mundi), resulting in a health sector budget deficit in the face of increasing expenditure due to hospital fee exemptions, minimal fees for other health services and an increasing population. Despite these motivations to reintroduce hospital fees, free antenatal service was captured as a user fee exemption policy within the Hospital Fees Decree. Additionally, delivery service for multiparous patients and patients referred to a hospital or clinic by a registered midwife or medical practitioner was made free. How and why did maternal fee exemptions remain on the agenda?

In designing the hospital fees policy content, the MOH bureaucrats collated proposed reasonable fees from all government hospitals. These proposed fees were agreed on in a consultative meeting with regional heads of government health services and submitted to the NLC military government for approval (Graphic Reporter, 1967). Pending approval by the NLC, the MOH sent a circular dated 6th February 1968 to all government health facilities in an attempt to regularise the varying charges that the government's decision to reintroduce hospital fees had caused. The implementation of these new charges brought an uproar from the general public (Konotey-Ahulu et al., 1970). Patients had to pay both dispensary fees and the cost of medicines and some facilities were charging more than stipulated

(Therson-Cofie, 1969, Konotey-Ahulu et al., 1970). The social uproar caused the MOH to issue a press release on 6th July 1968 to suspend the operation of the proposed charges (Konotey-Ahulu et al., 1970). The suspension only delayed rather than altered the government's intention to reintroduce hospital fees. Subsequently, the approved fees were introduced with the Hospital Fees Decree of 18th June 1969, to be implemented from the 1st October 1969 (Government of Ghana, 1969, Konotey-Ahulu et al., 1970, Therson-Cofie, 1969).

During this period however, MOH bureaucrats as policy agenda advisers, advocated for maternal fee exemption in the Hospital Fees Decree, and this was approved by the NLC government. According to the MOH, this was done to pacify the general public and minimise the financial burden of care. Another critical contextual factor that influenced the MOH decision was evidence from the health management information system about the high number of maternal deaths. A former MOH staff stated: *'In 1969, we [MOH] realised that maternal mortality was high and that we had to do something about it...'* [Interview, 15/7/2013]. Furthermore, the NLC military government policy agenda approver did not fully ignore the social unrest against the reintroduction of government hospital fees; and the need to consolidate political power and gain acceptance among the general public in approving the maternal fee exemptions.

The NLC military government handed over to a democratically elected government led by Prime Minister Dr KA Busia on 1st October 1969, the same day the implementation of the Hospital Fees Decree was to start. Although, the Decree was softened to pacify the agitated public, its implementation was still vehemently opposed causing another social unrest. As a result, the Busia led administration suspended implementation of the Decree and set up a five-member committee known as the Konotey-Ahulu committee comprising a medicine and therapeutics lecturer, an industrialist, a health worker unionist, an Arts Council national organiser and a general medical practitioner. The committee was tasked to investigate hospital fees and recommend appropriate charges for health care services in government facilities (Konotey-Ahulu et al., 1970).

1971 Hospital Fees Act 387

With the suspended Hospital Fees Decree, Ghana was back to charging minimal hospital fees much lower than the actual cost of service delivery; although, it was experiencing increasing health care expenditure and a declining economy (Fosu, 2001). Thus, in 1970 the MOH advised Busia's government: *'free health service is not the way to go, with increasing health bill and reduced revenue'* [Former MOH staff, 15/7/2013].

As in the previous reform an important contextual driver was empirical evidence on the performance of the economy. Following the MOH's advice, Busia's

government decided to reintroduce hospital fees (Graphic Reporter, 1970). The new Hospital Fees Act 387 was passed into law by the National Assembly. The Act 387 reflected the repealed Hospital Fees Decree. Existing fee exemptions for maternal health care under the Hospital Fees Decree were maintained by the national assembly and government (Government of Ghana, 1971). However, before the Busia government could develop a Legislative Instrument (LI) to interpret the Act 387 with specific fees, it was ousted on 13th January 1972 in a military coup.

‘The LI was to be based on the committee’s report; however, Busia was overthrown before his government could implement any of the 65 recommendations of the Konotey Ahulu committee report’ [Former MOH staff, 15/07/2013].

The Military Government that replaced the Busia government was known as the National Redemption Council (NRC). The NRC was in a dilemma as to whether to charge hospital fees or abolish them. As a result the NRC commissioner for health invited views from the public on the recommendations of the Konotey-Ahulu Committee (Graphic Reporter, 1973a). The Konotey-Ahulu Committee in 1970 had recommended that there could be no health service without fees. For maternal services, it recommended that antenatal care should no longer be free, and that fees be paid towards the cost of medicines dispensed in government health facilities for maternal services. Also, multiparous patients with a history of five or more pregnancies should bear some cost for their health care services; not everybody agreed with this view. For example, a Daily Graphic newspaper correspondent was of the opinion that charging fees would scare away people and an ignorant expectant mother would totally refuse to attend hospital knowing that she would be charged (A Correspondent, 1974).

There were over 4 months of public debate on whether to charge hospital fees or not (Owusu-Ansah, 1973, Graphic Reporter, 1973b, Nyakey, 1974, A Correspondent, 1974). A review of Daily Graphic newspapers from 1973 to 1974 revealed that the majority of correspondents recommended the government to charge hospital fees and exempt the poor and unemployed. Despite these recommendations, the NRC government did not implement the Hospital Fees Act 387 and the Konotey-Ahulu Committee’s recommendations. Charging hospital user fee was still unpopular with the general public, although their disapproving voices were not expressed greatly by the Daily Graphic correspondents. The NRC military government in order to consolidate political power and gain acceptance did not implement the Hospital Fees Act 387 and the Konotey-Ahulu Committee recommendations.

1983 Hospital Fees Regulation (LI 1277)

Between 1975 and 1981, Ghana experienced a turbulent series of political changes in government structure. The NRC regime changed its name to the Supreme Military Council (SMC) and General Acheampong who was the head of the SMC was replaced by General Fred Akuffo in a palace coup in July 1978. On 4th June 1979, Flight Lieutenant Rawlings led the Armed Forces Revolutionary Council to overthrow the SMC. The Armed Forces Revolutionary Council allowed planned multiparty democratic election to proceed and Dr Hilla Limann's People's National Party came to power on the 24th September 1979. Democratic rule was short lived when Limann was overthrown by Rawlings's second coup on 31st December 1981, and the Provisional National Defence Council (PNDC) was established.

The frequent change in government during this turbulent period was accompanied by the country moving from economic decline to disaster as gross domestic product per capita fell from US\$ 281 in 1970 to US\$ 180 in 1983. State institutions and public services were gravely damaged and under-resourced (Carbone, 2011). The decline in the health budget led to a reduced capacity to procure medicines and consumables. By the early 1980s, deteriorating health care services deterred the general public from using government facilities and some patients only used these facilities when their health conditions were critical. Medical and Pharmaceutical professional bodies advocated for the introduction of hospital fees to revive falling standards of health care and threatened to strike (Graphic Reporter, 1981, Debrah Fynn, 27th February 1981, Waddington and Enyimayew, 1990). Health workers unilaterally introduced de facto hospital fees as a result of the economic crisis and declining availability of health service inputs (Waddington and Enyimayew, 1990). All these contextual factors combined to put hospital fees back on the agenda by the early 1980s. However, once again, fee exemption for maternal health service was maintained on the agenda. How did maternal user fee exemption policy survive the urgent need to reintroduce hospital charges for all services in the face of economic crisis?

To regularise the fees already charged by government health facilities, the MOH conducted a study to propose hospital fees to the PNDC military government. The PNDC government was initially not fully supportive of hospital fees. They reduced the amounts proposed, and later approved them. The reason for the initial reduction was political:

'The PNDC representative for finance said it will be ill politics to introduce user fees when the country had the economic crunch at the time. The proposed fees were reduced by about 90 percent' [Former MOH staff, 22/8/2012].

The reason for the later approval was the further decline in health budget as a result of economic crisis.

To legitimise the approved fees, the MOH drafted the Hospital Fees Regulation with the assistance of the legal department of the Attorney General's office. The initial draft made no exemption for maternal health service. This was contested by the United Nations International Children's Emergency Fund (UNICEF):

'The first time we introduced the regulations, UNICEF was against our fees because for them the policy is that maternal care should be free. We argued that free maternal services would defeat family planning purposes' [Former MOH staff, 22/8/2012].

The MOH, therefore later incorporated fee exemptions for antenatal care, postnatal care and treatment at child health welfare into the new Hospital Fees Regulation, in part, because UNICEF advised against maternal hospital fee charges and demonstrated further interest in free maternal care by providing financial support to procure folic acid for antenatal care. Also, international maternal and child health discourse influenced the decision, in the sense that, in the early 1980s, maternal and child health attention had shifted with more focus on child health and family planning (Rosenfield and Maine, 1985). Some family planning activities were incorporated into postnatal care service (Campbell, 2001, Odoi-Agyarko Henrietta, 2003), making free postnatal care a viable policy. The resulting Hospital Fees Regulation (LI 1277), came into force on 21st April 1983 approved by the PNDC military government (Government of Ghana, 1983).

Up until this point development partners (donors) had not played visible and significant roles in shaping policy agendas related to user fee exemptions in Ghana. The appearance on the scene of UNICEF in a strong role as an agenda influencer was a reflection of the increasing amounts of development partner project aid flowing into Ghana as into many other LMICs because of the economic crisis and international development policies of the seventies and eighties.

1985 Hospital Fees Regulation (LI 1313)

Evidence of Ghana's continuing economic decline drove in part the next agenda. Economic decline still posed a major challenge to Ghana and the PNDC government turned to the International Monetary Fund (IMF) and World Bank. By April 1983, government had introduced a Structural Adjustment Programme under the auspices of the IMF and the World Bank. This economic recovery policy implemented over 3 years from 1983 to 1986, was intended to halt the downward economic spiral and stabilize the economy on a reasonable track (Loxley, 1990, Fosu, 2001).

Hospital fees were substantially increased in July 1985, partly on the recommendation of the IMF and World Bank under the Structural Adjustment Programme (Waddington and Enyimayew, 1990) and partly because the existing fees

could not recover costs and health facilities had already increased their fees to halt further decline of health care services (Graphic Reporter, 1985, Government of Ghana, 1985). Although, hospital fees were increased with the aim of full cost recovery, antenatal and postnatal user fee exemptions were maintained and mentioned in the Hospital Fees Regulation (LI 1313). A key informant explained that with time, user fee exemption policies became a safety net for the poor and so the MOH maintained these.

'Based on experiences within the health service, fee exemptions had become a safe net for the poor so we (MOH) maintained it' [MOH staff, 27/9/2012].

1997 Presidential directive to expand free antenatal and postnatal care to include deliveries

In 1992, the PNDC allowed multiparty democratic election to be held. The PNDC re-organized itself into a political party, the National Democratic Congress (NDC) and won the December 1992 election as well as the December 1996 multiparty election 4 years later with Flight Lieutenant Rawlings as its flag bearer. In January 1997 at the beginning of his second term, the President gave a directive to include delivery service in the existing maternal (antenatal and postnatal) user fee exemption policy (Graphic Reporter, 1997).

The President acted to mitigate the social consequences of the structural adjustment programme as evident by decreasing utilization of maternal health services and worsening health outcomes. Ghana Demographic Health Survey 1993 empirical evidence revealed that national utilisation of free antenatal service was high at 86 percent. The picture was however different for supervised delivery, as national level supervised delivery in health facilities was only 44 percent. About half of the women who received free antenatal care did not return to deliver in those health facilities (Ghana Statistical Service (GSS) and Macro International Inc. (MI). 1994) partly because of their inability to pay at the point of use. Additionally, the MOH 5-year programme of work, attributed a high national maternal mortality rate estimate of 214 per 100,000⁵ live births to the harsh economic recovery policy of the structural adjustment programme (Ministry of Health, 1996). These were major drivers of the agenda to provide free maternal (antenatal, delivery and postnatal) services. Nevertheless, the maternal user fee exemption guideline developed by the MOH to implement the directive in November of the same year provided fee exemption for only four antenatal visits; further visits had to be paid for as well as deliveries and postnatal care. Why did decision makers water down the intent and

⁵ Maternal mortality rate estimated at 214 per 100,000 live births was based on Ghana Demographic and Health Survey (1993) data

miss this opportunity to more radically reform existing maternal user fee exemptions?

Interviews with a key informant explained that policy agenda advisers and formulators in the MOH limited the scope of the policy based on their experience, analysis and judgement of what was contextually feasible and practical to implement at that time.

'Based on our [MOH] experience of reimbursing bills for exemptions, the annual budget allocated was not sufficient to foot the bill; as such we could not have added delivery services' [MOH staff, 27/9/2012].

There was insufficient government financial support to fully implement the directive (Ministry of Health, 2003a). This is because by the mid to late 1990s, Ghana's structural adjustment programme efforts had faded with slowed economic growth (Sowa, 1996) contributing to a reduction in the allocation of government budget to the health sector and hence the subsequent inability to fully implement the directive.

2003 Maternal delivery exemptions in four selected regions

The NDC lost the December 2000 election to the New Patriotic Party led by Mr John Kufuor, the new face of the Danquah-Busia tradition which was the party in opposition at independence in 1957 and had briefly ruled the country from 1970 to 1972 before it was ousted in a military coup (Agyepong and Adjei, 2008). The Kufuor government came to power in a context of stagnant economic and even regressive growth (Sowa, 1996, Bank of Ghana, 2005). For example gross national income per capita for 2002 was US\$ 270; the same as in 1971 (Index Mundi). To address economic stagnation, the government in 2001 opted for debt relief under the Heavily Indebted Poor Countries (HIPC) initiative on the advice of the World Bank and IMF. This initiative was launched by the World Bank and IMF in 1996 (Bank of Ghana, 2005). One of the HIPC austerity measure conditionalities was for Ghana to develop a comprehensive poverty reduction strategy directed towards attainment of anti-poverty objectives consistent with the Millennium Development Goals (MDGs). As a result, relatively poorer regions (Northern, Upper West, Upper East and Central) were set to benefit most from the initiative (Ghana Statistical Service et al., 1999, Ministry of Health, 2001). As per the poverty reduction strategy, health related targets to reduce maternal mortality and under-five mortality proposed by the policy agenda advisers the National Development and Planning Commission with the assistance of the World Bank and IMF favoured these regions. In this regard, the existing maternal fee exemption policy was extended to include delivery and postnatal services and geographically limited to the four deprived regions (National

Development Planning Commission, 2003). In 2004, 27 billion cedis (US\$ 3.1 million) from the HIPC grant were budgeted for this purpose (Ministry of Health, 2004b).

2005 Expansion of maternal delivery exemptions to the whole country

The December 2004 presidential election presented an opportunity for policy actors to modify existing policies putting maternal fee exemption back on the agenda. At the December 2004 health summit meetings, the MOH and stakeholders argued that a national maternal mortality rate of 503 per 100,000⁶ live births was high and there were pockets of extreme poverty across the country and not only in the regions labelled as deprived.

‘The exemption policy and additional resources allocation contributed to the improvement in coverage of health services in the deprived regions. However, concerns emerged about the relatively poor performance of non-deprived regions in 2004 and the apparent worsening of health in urban areas’ [MOH staff, 10/7/2012].

A national user fee exemption for antenatal, delivery and postnatal services was therefore proposed by the MOH and stakeholders to help reduce maternal mortality (Ministry of Health, 2004a, Ministry of Health et al., 2011). Politically, this idea was approved by the government and in 2005, 30 billion cedis (US\$ 3.4 million) from the HIPC grant was budgeted and allocated to implement the policy nationwide (Ministry of Health, 2005a). Empirical evidence of high maternal mortality was thus a major agenda driver.

2008 Integration of maternal fee exemptions into the National Health Insurance Scheme

The New Patriotic Party government won a second term in the December 2004 election. By this time, implementation of their popular promise to replace the health sector ‘cash and carry’ system with a national health insurance scheme and assure access to basic clinical service for all Ghanaian regardless of ability to pay had started (Agyepong and Adjei, 2008).

After 2005, maternal fee exemption policy implementation suffered a major setback. Empirical evidence from evaluation of the maternal user fee exemption policy in 2006 revealed that the policy contributed to a major increase in supervised deliveries, but was significantly under-funded (Witter et al., 2007). Issues of inadequate funds, sustainability and inability to predict when reimbursement would be paid by government were well-known and discussed within the health sector (Garshong et al., 2002, Ministry of Health, 2004c, Nyonator and Kutzin, 1999, Witter

⁶ Maternal mortality rate estimated at 503 per 100,000 live births was based on Ghana Demographic and Health Survey (2003) and institutional maternal mortality data

and Adjei, 2007). Not only was there a problem of inadequate funds, but also health facilities exemptions bills over time exceeded the budget allocated to implement the policy. By 2007, health facilities had to stop providing free maternal health services as unpaid reimbursement bills piled. As a key informant stated:

'Maternal fee exemption became unsustainable because every month the bill was going up and going up, and it got to a point, the facilities were bringing the bill and we [MOH] did not have money to pay, so the exemption policy fizzled out' [MOH staff, 31/8/2012].

Empirical evidence presented at the health sector performance review in 2008 revealed that the suspended maternal user fee exemption policy contributed to worsening maternal health indicators. Specifically with a decrease in the proportion of supervised deliveries from 44.5 percent in 2006 to 35.1 percent in 2007 and an increase in the institutional maternal mortality ratio from 187/100,000 live births in 2006 to 224/100,000 live births in 2007 (Ministry of Health, 2008c). To this end, the Minister of Health at the April 2008 Health summit declared maternal health a national emergency (Ministry of Health, 2008a).

Immediate decisions and actions followed the declaration. A ministerial task force was formed to formulate a timed framework aimed at reducing maternal mortality and the MOH was tasked to estimate the impact and financial implications of subsidising the enrolment of pregnant women onto the National Health Insurance Schemes (NHIS) (Ministry of Health, 2008a). Additionally, the United Kingdom Department for International Development (DFID) submitted a brief to the Presidency through the MOH suggesting that all pregnant women be given functional NHIS membership cards to assure access to maternal health care and improve the performance towards attainment of MDGs 4 and 5. This, they argued, would be an effective, affordable and extremely popular policy with the Ghanaian electorate. The Minister's declaration created a charged atmosphere putting maternal health on the front burner with intense attention from all stakeholders.

The MOH drafted a memo to the Presidency on the status of maternal health and possible interventions. The import of the MOH memo was to inform and prepare the President for his participation in the 'Business Call to Action' meeting hosted by the United Kingdom government and the United Nations Development Programme in London, May 2008.

'We [PPME-MOH] already knew what the British government was supporting; so we only aligned the President's statements to that of the British Government and the British Government said yes' [MOH staff, 31/8/2012].

President Kufuor and Prime Minister Brown met on the side-lines of the Business Call to Action meeting. Their discussions centred on funding for Ghana's 'school feeding' programme and health care delivery.

'The DFID brief submitted to the Ghanaian MOH was also followed up through the British system and given to the British Prime Minister, Gordon Brown. During their meeting, the Prime Minister told President Kufuor that he had heard of the challenges of institutional maternal mortalities. My understanding is that Gordon Brown said it was a good idea to provide free maternal services' [Donor, 27/5/2014].

In London, President Kufuor announced to exempt all pregnant women from paying for maternal health service. However, based on historical experiences and evidence of inadequate financial resources to implement previous maternal fee exemption policies (Witter et al., 2007), availability of funds was the foremost concern of the MOH. According to a former MOH senior official, no specific budget was allocated by the Ministry of Finance and Economic Planning for this policy before it was announced outside Ghana. In an interview with a senior politician for clarification, he said: 'sometimes you need to make the policy and later look for funds to implement it' [Former Minister of Health, 21/12/2012].

With no central government allocated budget to implement the maternal fee exemption directive, the MOH relied on donor health sector budget support for financial commitment.

'DFID's contribution was the obvious choice since maternal health care was tagged as DFID-supported. Although DFID emphasized that their contribution was not for free maternal delivery but to support the whole health sector programme of work, the MOH went ahead and earmarked the funds to implement the directive' [Former MOH staff, 5/11/2012].

With secured funding from DFID through the health sector budget support and the preceding suggestion by the DFID to give pregnant women NHIA cards to assure access to maternal health care, the NHIA lobbied to implement free maternal health care arguing that it was competent in fund management and best positioned to implement the policy. Additionally, it already provided antenatal, delivery and postnatal services under its benefit package and as such, unregistered pregnant women could be issued with cards to enable them access health care without any waiting period. The MOH accepted the arguments.

'The need to incorporate it into the NHIS was realized later, because, when you make the national estimate for the number of expected pregnancies in a year and you look at

the premium level, it would be cheaper to pay the premium for pregnant women than to pay for the services' [Former MOH staff, 5/11/2012].

By 27th June 2008, a guideline accompanying the directive to provide free maternal health care for all pregnant women was designed by the MOH, officials of the GHS, Ghana Registered Midwives Association and the NHIA. The policy implemented through the NHIA started 1st July 2008.

3.5 Discussion and conclusions

Over the four and a half decades since some form of exemption from payment for maternal health services was introduced in 1963, fee exemptions for health service use by pregnant women has managed to remain on the policy agenda. However it has remained on the agenda in a fluid process of ebbs and flows rather than in a static fixed form. Context and policy actors were the major influencers of the ebbs and flows.

Contextual factors that influenced the ebbs and flows were: political such as Nkrumah's ideology, change in government, and election year; economic crises and austerity measures; health and demographic indicators; historical events; social unrest; and international agendas such as the MDGs. These contextual factors served as a source of power for policy actors to influence maternal fee exemption as a policy agenda item. We therefore reason with Erasmus and Gilson (2008) that power is the heart of health policy process as these case studies illustrate how policy actors used contextual factors as power leverage to justify their actions, inactions and choices.

Policy agenda setters (directors, approvers, advisers and advocates) acted within interrelated contextual factors, which sometimes worked as constraints and sometimes opened opportunities. We observed that interrelating context, whether a constraint or an opportunity, is used by specific policy agenda setters to influence the timely manner in which policy content is made and how closely it is linked to the intended agenda. Our observations are in keeping with similar observations by Grindle and Thomas (1991) that contextual factors working in interrelating manner can serve as a constraint and an opportunity within which policy actors manoeuvre to accomplish their goals.

Contextual factors working in an interrelating manner as a constraint, present policy agenda setters with conflicting options shaping the policy content to be made in a less timely manner and less closely linked to the intended agenda. For instance, within the context of high maternal mortality, economic decline, limited government budget allocation, and political authority and will, MOH bureaucrats had to assess options to make practical and feasible choice. Evidence of a health sector budget deficit at times overtook government's intent. This was the case in 1997; there were worsening indicators for supervised delivery as about half of the women who

hitherto attended government health facilities for free antenatal services did not return to deliver in those facilities. To solve this issue, in January 1997 the President within his constitutional power, gave a political directive to provide free healthcare for pregnant women. The directive presented an opportunity to reform existing free antenatal and postnatal policy. However, the government did not allocate adequate resources due to economic decline. To this end, the policy content developed by the MOH bureaucrats in November the same year only partially reflected the intended agenda.

Contextual factors working in an interrelating manner as an opportunity, present policy agenda setters with complementary options in shaping the policy content to be made in a more timely manner and more closely linked to the intended agenda. For instance, within the context of economic decline, inequitable poverty indicators, high maternal mortality, donor financial support, election years, and international agenda, policy agenda setters defined the maternal health problem in relation to a clearly defined solution. This was the case for maternal fee exemption policies in the 2000s. In the early 2000s, the HIPC grant support proposed by international policy agenda advisers the World Bank and IMF to mitigate the effect of economic stagnation provided an opportunity to improve poverty and maternal health outcomes in deprived regions. Policy formulators and international and national policy agenda advisers ensured that the policy content was closely linked to the intended agenda and as a requirement to obtain the HIPC grant, the policy was made in a timely manner. Again in May 2008, President Kufuor announced a 'free maternal health care' policy based on proposed solution from international and national policy agenda advisers. In the light of secured funding from health sector budget support, the policy content was made and disseminated before the end of June 2008, for implementation on July 1st.

In addition to context serving as a source of power to shape policy actors actions, inactions and choices policy actors also wield power by virtue of their political and administrative position, knowledge, experience and financial commitment. Policy agenda setters (directors, approvers, advisers and advocates) acted in varied influencer roles between 1963 and 2008. Politicians (policy agenda directors and approvers) and policy agenda advisers played an active role in maintaining maternal fee exemption policies over a long period. Maternal fee exemption policies therefore survived both military and civilian governments and have become sort of a national legacy. Politician's interest in maintaining the agenda may have varied; however, whether it was out of genuine concern to improve maternal health or to gain political capital and favour, their political support to decisions of maternal fee exemption was critical.

Both national and international policy agenda advisers played an active role in maintaining the policy. Though international policy agenda advisers did not have

official government positions to make and implement public policies, over time they became active agenda setters within the Ghanaian health sector. After the 1990s, international policy agenda advisers – international multilateral and bilateral organisations and officials have increasingly gained agenda access, and sometimes even set the agenda. Donors gained agenda access because they used financial support as leverage of what gets on the agenda and in the policy content.

Policy agenda setters in varied ways and capacities strived to maintain maternal health issues on the agenda. At critical moments of agenda re-set, re-examination, and modification of existing maternal fee exemption policies, policy agenda advisers – acting as policy champions took decisions within boundaries of previous policy content, implementation challenges, such as inadequate funds as well as current demands and expectations. Our finding agrees with the position of Shiffman and Smith (2007), that strong champions are required to shape political priority for a particular policy initiative.

Policy agenda advisers as policy champions mobilised strategies and tactics in the form of commitment and consensus to maintain the maternal fee exemption policy on the agenda over the years. For example the World Bank and IMF committed to reduce poverty and improve MDG-related targets pushed for fee exemptions for maternal health services. They collaborated with the Government of Ghana and other state agencies such as the National Development and Planning Commission for a consensus on the practical details of the Ghana Poverty Reduction Strategy. Also, the MOH over the years built relationships with other policy actors such as donors at institutional level through interactions, consensus building and collaboration towards policy development. These strategies are described as strategy capacity (Pelletier et al., 2011) and include the human and institutional capacity to build commitment and consensus toward a long-term strategy, respond to recurring challenges and opportunities, build relationships among policy actors and undertake strategic communications with varied audiences. Strategic capacity is therefore critical for maintaining policy issues on the agenda over time.

The fee exemption policy for maternal health was maintained over the years in a path-dependent manner. The free antenatal service trajectory taken in 1963 was not reversed, despite varied policy agenda setters and contextual factors. Policy actors relied on context and on each other for financial support, expertise, experience and political resources creating a network of influence to maintain a maternal fee exemption agenda over time. Some scholars argued that a process is path dependent if initial moves in one direction elicit further moves in that same direction (Kay, 2005, Pierson, 2000). Once maternal fee exemption was there, it was difficult to abolish because of wide popular support and later outcry over maternal mortality and international agenda such as the MDGs.

Policy agenda setters also relied on empirical evidence to inform their decisions, however, systematic reviews presumed as a 'gold standard' of evidence-based policy making (Young et al., 2002) were not used. Rather, country based empirical evidence from economic assessments, surveys, research reports and health sector performance reviews were used. Policy agenda setters paid attention to this kind of evidence as one of several important contextual factors rather than the only or even the main one and made use of this evidence to maintain maternal fee exemption policy on the agenda.

Finally, as noted by Shiffman and Smith (2007), the power of actors, the power of ideas, political context and characteristics of the issue are key for setting the global health agenda, these observations are also relevant at national level and evident in these case studies. In addition, a broader contextual environment such as financial allocation arrangements, international agenda and development partner's relationships, data about health outcomes, national administrative capacity to develop and implement policies, historical experience and path dependency are also critical as shown in this paper.

Ghanaian health sector policy agenda setting and formulation is complex and intertwined with a mix of political, evidence-based, finance-based, path dependent, and donor driven processes. The papers by Agyepong and Adjei (2008) and Seddoh and Akor (2012) note this complexity. Actors and stakeholders who want to influence agendas need to pay attention to context and policy actors in any strategy. Efforts to influence policy agenda setting must recognize that empirical evidence is only part of a complexity of factors of which context, path dependency and politics are also very important. Moreover the influence of evidence is dependent on awareness of its availability as well as its use for advocacy in policy agenda setting and formulation in the right window of opportunity.

As policymaking processes are relevant across other LMICs, and national policy actors are likely to confront similar scenarios, we hope this paper contributes to learning beyond Ghana in which this work was conducted to other LMIC in sub-Saharan Africa and beyond.

Chapter 4

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4 *'The one with the purse makes policy': Power, problem definition and maternal health policies and programmes evolution in national level institutionalised policy making processes in Ghana*

4.1 Abstract

This paper seeks to advance our understanding of health policy agenda setting and formulation processes in a lower middle income country, Ghana, by exploring how and why maternal health policies and programmes appeared and evolved on the health sector programme of work agenda between 2002 and 2012. We theorized that the appearance of a policy or programme on the agenda and its fate within the programme of work is predominately influenced by how national level decision makers use their sources of power to define maternal health problems and frame their policy narratives. National level decision makers used their power sources as negotiation tools to frame maternal health issues and design maternal health policies and programmes within the framework of the national health sector programme of work. The power sources identified included legal and structural authority; access to authority by way of political influence; control over and access to resources (mainly financial); access to evidence in the form of health sector performance reviews and demographic health surveys; and knowledge of national plans such as Ghana Poverty Reduction Strategy. Understanding of power sources and their use as negotiation tools in policy development should not be ignored in the pursuit of transformative change and sustained improvement in health systems in low- and middle income countries (LMIC).

Key words

Ghana; Institutionalised policy processes; Maternal health; Policy agenda setting; Policy formulation; Problem definition.

4.2 Highlights

Power relations steer the Ghanaian institutionalised health dialogue.

Use of power to persuade others influences how maternal health agenda issues evolved.

Control of budget allocation is an important source of power to influence decisions.

Understanding of actors' power and how they use them in policy development is vital.

4.3 Introduction

Gaining insights into why some policy issues get on the agenda and move into programme formulation while others disappear is important. This is because part of

the process of transformative change and improvement in health systems and outcomes is getting, formulating and maintaining priority policy issues on the agenda.

Problem definition shapes what issues get on the agenda, and what specific course of action is taken and maintained or not. How policy actors interpret current and past events shape their problem definition (Rochefort and Cobb, 1994) and help to frame and label issues for decisions. Labelling an issue dictates the kind of attention the issue attracts and sets the stage for decision making (Peters, 2005). Therefore, what is usually more urgent and practical in influencing policy agenda setting and formulation is control over the interpretation of events (Mosse, 2005) and subsequent issue labelling. Different policy actors present different explanations for the nature of a particular problem (Portz, 1996) and use different negotiation tools such as the control over a resource or access to information to make a case and persuade others. Despite the importance of understanding agenda setting and the use of power to frame agenda issues, there is still limited literature on the examination of power in health policy in LMICs (Gilson and Raphaely, 2008). There are however papers on political agenda setting for safe motherhood in Nigeria (Shiffman and Okonofua, 2007), and actors practice of power in a South African community health programme (Lehmann and Gilson, 2013).

Reasons proposed for why some issues are considered and specific course of actions formulated and why others fail are wide ranging. Some are structural, emphasizing how institutions are organized to advantage some alternatives or issues over others. Some are cognitive, emphasizing how individuals or even institutions process information in ways that limit the issues to be addressed at any given time. Others emphasize the role of external events or public opinion, and how they can combine with political incentives to quickly shift attention in a new direction (Green-Pedersen and Wilkerson, 2006).

This paper seeks to advance our understanding of health policy agenda setting and formulation processes in a lower middle income country, Ghana, by exploring how and why maternal health policy and programme agenda items appeared and evolved in the framework of the Ghanaian health sector Programme of Work (POW) agenda between 2002 and 2012. Our specific research questions were: Which maternal health policies were prioritised? How did they evolve on the agenda and why? We examined decision maker's problem definition and decision making processes, theorizing that a policy or programme's appearance and fate on the POW agenda is predominantly influenced by how decision makers use their source of power to define problems and frame their policy narratives and accompanying course of actions. This study contributes to still relatively limited literature on policy processes in Low and Middle Income Countries in general and West Africa in particular. It especially provides insights on the power dynamics of how and why

maternal health policies evolved on the Ghanaian health sector programme of work over a decade of time.

Ghana health sector

The Ghana health sector has had a hierarchical predominantly publically financed and publically administered and delivered services model since independence in 1957. It is however accompanied by strong and increasing formal private sector participation in service delivery. It underwent two major reforms in the 1990s with the passage of the Ghana Health Service and Teaching Hospitals Act 525 in 1996; and the adoption of a Sector Wide Approach (SWAp) in 1997.

Prior to passage of the Act 525; the Ministry of Health (MOH), was the regulator of the public and private sector, the body responsible for policy direction, coordination, monitoring and evaluation and the provider of public sector services. With the passage of Act 525, the Ghana Health Service (GHS) was created as the public sector service delivery agency, and MOH became a civil service ministry responsible for sector policy-making, coordination, monitoring, and evaluation (Agyepong et al., 2012).

Under the SWAp, development of national medium term (five year) strategic plans known as five year POW was established in the health sector. The annual POW was developed to progressively ensure the attainment of the five year POW. As part of the SWAp arrangements, international donors gained legal and structural access to national policy making and the authority to join MOH and local actors to negotiate five year and annual POW agendas and priorities during institutionalised policy dialogue processes. These negotiated priorities include specific policies, programmes, targets and financial allocations for implementation (Addai and Gaere, 2001). The institutionalised dialogue process engaged donors within an overall national policy, institutional and financial framework (Cassels, 1997), and promoted the use of POW review findings in decision making. Although, the institutionalised process promotes use of evidence, it is open to external influence and lobbying by interest groups. The institutionalised arrangements include the biannual (review and planning) health summit, health sector working group and several other meetings. Figure 4.1, the schematic outline of national level institutionalised dialogue processes, summarises and illustrates the different levels of the dialogue process, actors involved and routinized sequence of actions. The MOH moderates these meetings and ideas considered are carried through the processes, however, at the business meeting ideas are negotiated and decisions made. The negotiated decisions are detailed in an Aide Memoire. The Aide Memoire generated from the review and planning summits feed into the design of the POW.

Figure 4.1: Schematic outline of national level institutionalised dialogue processes

Also under SWAp, the mechanisms through which donor financial resources were channelled within the health sector were modified. Donors participating in the SWAp moved from specific funding of projects to contributing their funds into a common basket to support the agreed POW. They released funds on the basis of the annual POW to a central account jointly controlled by the MOH and the Controller and Accountant General's Department. The resulting pooled fund was known as "Basket Funding". The UK Department for International Development (DFID) and the Danish International Development Agency (DANIDA) started disbursement to this account in 1997, with the World Bank, the European Union (EU) and the Royal Netherlands Embassy (RNE) joining in 1998-9. Several donors such as United States Agency for International Development (USAID) did not join the pooled fund. They nevertheless still had access to the institutionalized national dialogue processes. Donor funds not channelled through Basket Funding were known as "Earmarked funds". These included MOH managed funds for specific programmes and projects channelled through the MOH as well as direct funding of projects and programmes by donors that were not necessarily in line with the POW (Addai and Gaere, 2001).

As a result of the 2005 Paris Declaration on Aid Effectiveness the 'Basket Funding' was gradually replaced by a Multi-Donor Budget Support (MDBS) fund since the same donors who contributed into the Basket Funding were those who opted to contribute to a MDBS. Under MDBS, donors shifted their financial support a level upwards to a pooled fund at the macro level of the Ministry of Finance and Economic Planning. This was in keeping with the principles of harmonizing donor support with national plans, strategies and budgets agreed upon between donors and developing countries governments (Organisation for Economic Co-operation Development, 2009).

Programme of work's financial resources source and their allocation

The POW draws financial resources from five main sources. First, direct statutory transfers by the Ministry of Finance and Economic Planning (MOFEP) from the Government of Ghana (GOG) consolidated tax funds to the MOH referred to in short as GOG. Second, the National Health Insurance Fund (NHIF) established in 2004 as part of the implementation arrangements of the National Health Insurance Scheme (NHIS). The NHIF is made up of a national health insurance levy of 2.5 percent value added tax on selected goods and services, 2.5 percent of all Social Security and National Insurance Trust (SSNIT) contributions of formal sector workers; and out-of-pocket registration fees from all subscribers and premiums from non SSNIT contributors. Money from the NHIF is transferred periodically by the MOFEP to the National Health Insurance Authority (NHIA) to pay providers for services to subscribers and the administrative expenses of running the NHIS. Third, out-of-pocket payments made by clients at service delivery points. Reimbursements to

service providers from the NHIF and out-of-pocket payments are all retained within the facility and are collectively referred to as Internally Generated Funds (IGF). The fourth source consists of donor budget support and earmarked funding. The fifth source is loans and credits secured by the Ghanaian government for the health sector.

The funds from the above sources are allocated to four categories in the annual POW namely personal emoluments (salaries and allowances), administration, service delivery and investment. Personal emoluments are financed only by GOG. However some health facilities also use IGF to pay temporary staff. The administration category is financed by GOG, IGF and NHIF for administrative expenses incurred in service delivery such as maintenance of vehicles and equipment. The service delivery category financed by GOG, donors, IGF and NHIF provides for operational cost of service delivery. Finally, the investment category financed by GOG, donors, IGF, NHIF and loans and credits pays to procure vehicles and equipment; and construct new facilities and rehabilitate existing ones.

4.4 Methods

Study design and data collection

A longitudinal study of maternal health policies and programmes appearing in the annual health sector POW was conducted for the period 2002 to 2012. The case study approach was appropriate allowing comprehensive and systematic data collection and analysis at different points in a real-life context to trace change over time (Patton, 2002, Yin, 2009). We defined a case as a maternal health policy or programme agenda item appearing in the annual health sector POW over the study period. Twenty-seven maternal health policy and programme items appeared in the annual POW between 2002 and 2012. We traced the fate of these from their first appearance in any of the annual POW documents in the period under study through subsequent years; to understand how they evolved on the POW agenda from year to year. 2002 to 2012 was appropriate for the research because as Sabatier (2007, p.4) argues a decade is a long enough period to observe policy change.

Data were collected between June 2012 and June 2014. Specific methods were in-depth interviews with key informants, a desk review of documents and participant observation during a 20 month period of field work at the MOH Policy Planning Monitoring and Evaluation Directorate (PPMED) by one of the authors (AK)⁷. The PPMED coordinates policy formulation and strategic planning for the health sector. Participant observation in this directorate was chosen, to study and better understand ongoing policy making processes and interactions among policy actors. AK participated in, observed and noted at first-hand ongoing power dynamics and negotiation within the institutionalised dialogue process as a student

⁷ PhD candidate

staff member assigned to the Policy Analysis Unit of the PPMED. The meetings attended, with an average discussion period of 4 hours, are listed in Table 4.1. AK was asked by the PPMED to take notes and summarise the first two days deliberations of the April 29th - 6th May 2013 review summit. Observing and documenting actors interactions and discussions from start to end of these meetings, allowed us to draw inference to support our retrospective data.

Table 4.1 Health sector meetings attended

Meeting	Date
Business meeting	17 August 2012 20 November 2012 2 May 2013
DFID budget support meeting	15 November 2012
Health sector working group	5 July 2012 6 September 2012 7 February 2013 20 March 2014
Inter-agency performance review	4-5 April 2013 16-17 August 2012 12-13 September 2013
MDG Acceleration Framework (MAF) for central and western regions	8-12 October 2012
MAF for teaching hospitals and training institutions	3-5 January 2013
MAF monitoring and evaluation	12 October 2012
MOH budget committee	5 September 2012
MOH budget hearing at Ministry of Finance and Economic Planning	20 September 2012
MOH internal review	7 August 2012 21 March 2013
Health summit	29 April–6 May 2013
PPME general meeting	25 June 2012 30 August 2012
PPME unit heads meeting	10,23 July 2012 13 August 2012 4,10 September 2012 15,22 October 2012 12,19 November 2012
Pre-budget review	12 September 2012
Pre-business meeting	16 November 2012
Pre-health summit	19 April 2013

Key informant in-depth interviews were used to obtain lived experience of maternal health policy dialogues processes from respondents. The interviews were conducted face to face using a semi structured guide investigating how policy actors defined maternal health problems and prioritised policies. Nineteen participants were purposively interviewed. Participants included officials of the: MOH (5), former MOH (1), GHS headquarters (3), and NHIA (4). Respondents outside government include donors (4), coalition of NGOs in health (1), and Christian Health Association of Ghana (1). Where permission was granted the interviews were tape recorded. Otherwise notes were taken and verified later with the participant.

Documents review was conducted to trace and map POW maternal health policy and programme sequence and financial resource allocations; make an inventory of policy actors' definition of maternal health problems and frames of the course of action over time and to triangulate findings with participant's information. Health sector documents reviewed were annual POWs, medium-term development plans, aide memoires, maternal health related evaluation reports, maternal health related meeting minutes, health sector review and study reports.

Analytic concepts

We drew on the concept of power and its use by actors to influence decision making to inform our analysis. Specifically, Mintzberg's conceptualization of power, Ribot and Peluso's theory of access, and Rochefort and Cobb's concept of problem definition as an instrument of power. Mintzberg (1983) defines power as the capacity to effect (or affect) decisions and actions. He labels a policy actor who seeks to control decisions and actions as 'influencer' and argues that influencer's interpretative manoeuvres ability vary as each tries to use his or her own levers of power as means of influence. Mintzberg categorised five general sources of power. These are the control of a resource, a technical skill, or a body of knowledge; authority by virtue of one's legal and structural position; and access to those who can rely on the other four sources of power.

To further understand access to power sources we drew on Ribot and Peluso (2003) theory of access. The concept of access facilitates grounded analyses of who actually benefits from things and through what processes they are able to do so. They define access as the ability to benefit from things – including material objects, persons, institutions, and symbols. They categorised mechanisms of access as right-based; and structural and relational. Right-based access is when the ability to benefit from something derives from rights attributed by law or convention. The structural and relational access mechanisms are the abilities to benefit from resources in the light of constraints established by specific political-economic and cultural context within which access to resources is sought. These include access to finances, knowledge and authority.

Rocheftort and Cobb (1993, 1994) argue that problem definition is a supreme instrument of power since there is no one fixed definition and as such policy issues are subject to the interpretative manoeuvres and discursive strategies of policy actors who influence the process. The defining process is dynamic and occurs in a variety of ways with the function to explain, describe, recommend and above all, to persuade. Once crystallized, some definitions become long-term fixtures of the policy making landscape; while others undergo constant revision or are replaced altogether by competing formulations. They conceptualised problem definition to include some descriptions of the problem origin, dimensions beyond causality such as severity and descriptive qualities of proposed solutions (Rocheftort and Cobb, 1993, Rocheftort and Cobb, 1994).

Data from interviews and documents reviews were systematically grouped based on the research questions. The initial steps of analysis involved mapping out POW maternal health agenda items, financial allocations, maternal health problem definitions, and decision makers' power sources. Further analysis involved iteratively reconstructing links between how decisions makers used their power sources to define maternal health problems and negotiated POW priorities. Due to the difficulty in providing full explanation of events as they unfolded from retrospective data, we drew from the research observation notes and ⁸IAA's experience as a participant in the health sector processes first as a district and then as a regional health director over the decade covered by this study. Further interpretations were therefore made based on our observation and experience of how decision makers lobbied and used their funds, ideas, and empirical evidence to promote specific policy narratives. The analyses were synthesised to reconstruct how POW maternal health policy items appeared and evolved and why.

Study limitation

Data interpretation was limited by the challenge of retrospectively tracing and linking specific policies and programmes to individuals or organizations and financial allocations. Moreover, the negotiated decisions stated in the aide memoires and POW are recorded as collective decisions, masking the details of actual interactions such as who pushed for a particular issue, who said what to whom and how it was received. POW financial allocations are sometimes lumped without stating individual donor's identity and contribution to a specific policy or programme. To get round these challenges we triangulated data from multiple research sources in the effort to reconstruct these interactions and processes. This helped but did not fill in the missing details in all cases.

⁸ Supervisor

4.5 Results

4.5.1 Institutionalised decision making and maternal health policies and programmes evolution

Institutionalised policy decision makers (henceforth decision makers) during meetings used technical skills, legal and structural authority, bodies of knowledge e.g. review reports, access to those with power and control of resources to influence each other and negotiate maternal policies and programmes for implementation. These power sources closely parallel those suggested by Mintzberg (1983). Those able to influence the institutionalised process were not necessarily always active participants in the particular decision making process on hand; but still had power to influence the process when mobilized. For example, the International Monetary Fund (IMF) who controls other financial resources or the President of Ghana who wields political power and influence. The decision makers relied on their power sources primarily to frame maternal health problems from annual POW to POW during the institutionalized policy dialogue processes. The constant revisions of maternal health problem descriptions resulted in some policies and programmes ‘disappearing’ from the POW agenda over time. These items are summarised in Table 4.2 (Data source: Health sector annual POW 2002-2012).

Table 4.2: POW maternal health policy and programme items leaving the institutionalised discussions over time and issues too recent to analyse

Evolution pathway	Policy and programme items
‘Disappearing’ from the POW discussion with time	<ol style="list-style-type: none">1. Assess barriers and develop an investment plan for improving supervised deliveries.(2007)2. Assess the extent to which facilities are designed to respond to maternal and child health services. (2005)3. Conduct a survey on maternal mortality. (2005,2006)4. Conduct baseline needs assessment for basic and comprehensive emergency obstetric and newborn care (EmONC). (2010)5. Continue advocacy for District Assemblies and District Health Management Teams to dedicate a percentage of their resources for maternal and newborn care. (2006)6. Develop national reproductive health strategic plan. (2005, 2006)7. Develop neonatal care guidelines. (2006)8. Disseminate revised reproductive health service policy, standards and protocols. (2004)9. Equip 60 district hospitals to handle maternal health complications. (2010)

Evolution pathway	Policy and programme items
	<ol style="list-style-type: none"> 10. Evaluate impact of high impact rapid delivery strategies. (2011) 11. Finalise and implement recommendations EmONC assessment finding. (2011) 12. Health promotion activities in safe motherhood and family planning. (2004) 13. Implement high impact rapid delivery strategies. (2007,2008) 14. Implement recommendations of consultative meeting on MDG 5. (2009) 15. Improve referral system for reproductive health (2004, 2005, 2006, 2007, 2009) 16. Institutionalise maternal death audits and make maternal mortality a notifiable event. (2004,2005,2006) 17. Introduce new maternal records book with partograph. (2006) 18. Raise awareness on socio-cultural barriers to access to maternal and new-born care. (2011) 19. Review information, education and communication on maternal health. (2003) 20. Revise and pre-test indicators for measuring maternal health. (2005) 21. Support private sector participation in implementation of maternal and child health care programmes. (2010) 22. Train health workers on safe motherhood and Behavioural Change Communications. (2010)
5: <i>The issue is too recent to analyse what happens to it over time.</i>	<ol style="list-style-type: none"> 1. Develop and implement measures to ensure safe blood and blood product transfusion, including the establishment of blood transfusion centres in Accra and Kumasi. (2011) 2. Implement the MDG Acceleration Framework Country Action Plan for improved maternal and newborn care (2011, 2012)

Others became long-term fixtures whose policy narratives remained and sometimes evolved with shifts in issue interpretations during discussions. We classified the evolution pathways of these that remained on the agenda as (1) 'reinterpretation'; (2) 'disappearing and reappearing unchanged at a later date'; and (3) 'expansion'. The accompanying accounts below further explain the processes summarised in Table 4.3 using specific cases to illustrate.

Table 4.3: Summary of long term fixture maternal health policy and programme items, decision makers and their source and use of power.

Evolution pathway	Original item	Final item	Decision makers, source of power and use of power to obtain this outcome
'Reinterpretation'	Provide essential	Provide emergency obstetric	Decision makers
	obstetric care (basic and	care equipment to three	(1) Donors (DFID, EOJ, EU, NDF, RDE, RNE,
	comprehensive) in health	remaining regions namely	UNFPA, UNICEF, USAID, UNAIDS, World Bank and
	centres and clinics (2002)	Upper West, Greater Accra and	WHO
		Volta (2012)	(2) MOH
			Power source and use
			(1) MOH used legal authority and donors structural authority
			(2) MOH and donors relied on evidence
			(3) MOH and donor control financial resource allocation
			(4) MOH control human resources

Evolution pathway	Original item	Final item	Decision makers, source of power and use of power to obtain this outcome
'Disappearing and reappearing unchanged'	Strengthen family	Strengthen family planning	Decision makers
	planning services	services delivery to improve	(1) Donors (DFID, EOJ, EU, NDF, RDE, RNE,
	delivery to improve	unmet needs (2012)	UNFPA, UNICEF, USAID, UNAIDS, World Bank and
	unmet needs (2002)		WHO)
			(2) MOH
'Expansion'			Power source and use
			(1) MOH used legal authority and donors structural authority
			(2) MOH and donors relied on evidence
			(3) MOH and donors allocated funds for contraceptives
'Expansion'	User fee exemption for	Implement free maternal care	Decision makers
	skilled deliveries in four	(2009)	(1) Donors (DFID, EOJ, EU, NDF, RDE, RNE,
	deprived regions (upper		UNFPA, UNICEF, USAID, UNAIDS, World Bank and
	east, upper west, northern		WHO)
	and central regions)		(2) MOH

Evolution pathway	Original item	Final item	Decision makers, source of power and use of power to obtain this outcome
	(2003)		Power source and use
			(1) MOH used legal authority and donors structural authority
			(2) MOH and donors relied on evidence
			(3) MOH and donors relied on a Presidential directive
			(4) Government accessed HIPC grant and DFID health budget support

4.5.2 'Reinterpretation' pathway

The 2002 POW policy item of 'provision of essential obstetric care (basic and comprehensive) in health centre and clinic' evolved in a sequence of interpretative shifts from POW to POW annually and eventually end up as 'provide emergency obstetric care equipment to three remaining regions namely Upper West, Greater Accra and Volta' in 2012 (Ministry of Health, 2002b, Ministry of Health, 2012b).

Initially, decision makers (DFID, EU, MOH, Royal Danish Embassy (RDE), RNE, and World Bank) at the 9-13 June 2003 review summit considered the fact that not all professionals who provide obstetric care obtained in-service training which is a challenge to maternal health service delivery. The health sector medium-term strategy (1997-2001) and the 2002 POW review report informed these considerations. The medium-term strategy regarded essential obstetric care a priority intervention to improve maternal health outcomes (Ministry of Health, 2001). However, the review report noted that in respect to essential obstetric care, only some rather than all doctors and midwives received in-service training for safe motherhood clinical skills and recommended more attention for obstetric care at all levels to improve care (Ministry of Health, 2003b). Decision makers therefore made 'strengthen institutional capacity to provide essential obstetric care in all health facilities through in-service training' a 2004 POW agenda item.

In 2005, however, because of a December 2004 planning summit business meeting decision; 'training of health providers to provide essential obstetric care' became the next framing of this POW agenda item. Decision makers (DFID, EU, MOH, Nordic Development Fund (NDF), RDE, RNE, United National Population Fund (UNFPA) and, World Bank) used the MOH's control of human resource and the 2003 POW review report to support this decision. The MOH controls public sector human resource generation by operating several health training institutions and allocation by virtue of public sector recruitment and government payment of salaries. Although the MOH controls public sector human resource, a gap existed and the review report recommended increase in the numbers of midwives and obstetrician gynaecologists, and the training of community health officers to provide obstetric care (Ministry of Health, 2004d).

Decision makers (DFID, EU, MOH, NDF, RDE, RNE, UNFPA, and, World Bank) in 2005 further reinterpreted the provision of essential obstetric care issue and added obstetric equipment to the discussions. This was mainly influenced by 2004 POW review report and donor financial support. According to the review report many health facilities lacked the numbers and mix of staff and the equipment to provide essential obstetric care (Ministry of Health, 2005b). To which the donors allocated financial resources to fill in the obstetric equipment gap. An analysis of POW financial resource information summarised in Table 4.4 (Data source: Health sector annual POW 2002-2012) shows that donors allocated more financial resources

than Government to procure obstetric equipment. Putting the donor influence into perspective, the DFID specifically, approved an initial contribution of £6.76 million with a first release of £3.38million in March 2009 and the rest (£3.38million) in January 2010; and a further £2.2million in March 2010 to the MOH to procure additional obstetric equipment (Singleton et al., 2010).

Table 4.4: Financial resource allocation and source for obstetric equipment

Year	Amount GHC	Amount US\$	Source	Amount Proportion per source %
2006	900,000	981,000	Earmarked	100 Donor
2008	4,566,000	4,161,452	Earmarked	67.9 Donor
	4,000,000	3,645,600	Budget support	
	1,546,000	1,409,024	IGF	
	2,500,000	2,278,500	NHIF	
	TOTAL=12,612,000	11,494,577		
2009	7,175,000	4,762,765	Earmarked	100 Donor
	1,500,000	995,700	Budget Support	
	TOTAL=8,675,000	5,758,465		
2010	1,068, 000	740,338	Budget Support	100 Donor
2011	3,834,000	2,533,124	Earmarked	100 Donor
	500,000	330,350	Budget Support	
	TOTAL=4,334,000	2,863,474		
2012	1,800,000	927,900	Budget Support	100 Donor

Over the period studied, shifts in discussions were predominantly informed by donor financial support and POW review findings. For example the 2007 POW review noted that investment in essential obstetric care was less systemic and recommended intensification of midwifery training and purchase of additional obstetric equipment (Ministry of Health, 2008c). The decision makers at the November 2008 summit business meeting decided to procure additional obstetric equipment and expand midwifery and nursing training institutions. Although ‘expand midwifery and nursing training institutions’ was made a 2009 POW item,

training of health professionals was an ongoing process. As noted by a policy implementer – *‘the process of increasing the health work force is already in motion. There are always interventions to improve the manpower. For example, we moved from about 98 trained midwives per year in 2000 to about 700 in 2009, with a corresponding increase in training institutions’* [22/08/2012].

By 2012, obstetric equipment was distributed to all regions except three. Decision makers therefore further reframed the POW agenda to; ‘provide obstetric care equipment to three remaining regions – Upper West, Greater Accra and Volta’.

4.5.3 ‘Disappearing and reappearing unchanged at a later date’ pathway

This pathway is illustrated with the policy narrative to strengthening family planning services; which was a 2002 POW item, but did not feature in the discussions and records in 2003, and then reappeared in 2004 and remained on the POW every year after that up to the end of our study period (2012). Our findings suggest that the urgent need to introduce National Health Insurance in 2003 by the Ghanaian Government (fulfilling a political campaign promise) and the focus to participate in the Heavily Indebted Poor Countries (HIPC) initiative contributed to remove family planning from the 2003 POW agenda. However, decision makers consistently regarded family planning a major intervention to reduce maternal and neonatal mortality and morbidity.

‘Family planning has direct effect on reducing maternal and neonatal mortality’ [GHS staff, 14/12/2012]; *‘We continuing invest in family planning to reduce abortions, unsafe deliveries and all associated complications to improve maternal health’* [Donor, 11/ 09/2012].

Decision makers used their knowledge of family planning benefits for maternal health, POW reviews, Ghana Demographic Health Survey (GDHS) indicators, and their control over financial resource to discuss and negotiate decisions to meet unmet demand for family planning. At the 9-13 June 2003 review summit decision makers discussed the increased contraceptive use as reported by the GDHS; from 13 percent in 1988 to 20 percent in 1993 and 22 percent in 1998 (ICF Macro, 2010); and the 2002 POW review findings. The review however reported a decrease in family planning use acceptors indicators from 24.9 percent in 2001 to 21.6percent in 2002 and financial and procurement gaps for contraceptives (Ministry of Health, 2003b). These findings informed the decision to strengthen family planning programme through allocating funds to procure contraceptives; at the 2-4 December 2003 planning summit.

Over the years, family planning indicators had not improved much; according to 2008 GDHS, contraceptive prevalence rate for any method was 24 percent; and 36

percent of married women had an unmet need for family planning (ICF Macro, 2010). Decision makers nevertheless had consistently allocated financial resources for contraceptives making this POW agenda item a long-term fixture. An analysis of the POW financial resource allocation summarised in Table 4.5 (Data source: Health sector annual POW 2002-2012) shows that donors predominately procured contraceptives. Ghana heavily depends on donors to implement the family planning programme since its inception in the 1970s. From 1996 onward notably, USAID and the UNFPA provided strong financial support with further and significant assistance from DFID and the World Bank (Government of Ghana, 2006). Donors filled in funding gaps created by the MOH's insufficient financial commitment. As a donor commented: *'the MOH is not adequately supporting family planning, creating gaps that donors fill by supplying some family planning commodities'* [27/11/2012].

Table 4.5: Financial resource allocation and source for contraceptives.

Year	Amount GHC	Amount US\$	Source	Amount Proportion per source %
2004	2,792,793	3,100,000	Earmarked Basket Funding	100 Donor
	1,351,351	1,500,000		
	Total=4,144,144	4,600,000		
2005	1,355,626	1,500,000	Basket Funding (DFID,USAID,UNFPA)	100 Donor
2006	900,000	981,000	Government of Ghana & Basket Funding (DFID,DANIDA,DUTCH) Earmarked	67 Donor
	1,800,000	1,962,000		
	Total=2,700,000	2,943,000		
2007	1,500,000	1,387,950	Budget Support NHIF	50 Donor 50 NHIF
	1,500,000	1,387,950		
	Total=3,000,000	2,775,900		
2008	600,000	546,840	Earmarked Budget Support GOG	87 Donor 13 GOG
	1,400,000	1,275,960		
	300,000	273,420		
	Total=2,300,000	2,096,220		

Year	Amount GHC	Amount US\$	Source	Amount Proportion per source %
2009	3,200,000	2,124,160	Budget Support GOG	89 Donor 11 GOG
	400,000	265,520		
	Total=3,600,000	2,389,680		
2010	14,842,000	10,288,474	Earmarked Budget Support GOG	98 Donor 2 GOG
	3,200,000	2,218,240		
	400,000	277,280		
2011	Total=18,442,000	12,783,994	Earmarked Budget Support	100 Donor
	18,808,000	12,426,446		
	3,099,000	2,047,509		
2012	Total=21,907,000	14,473,955	Earmarked Budget Support	100 Donor
	22,052,040	11,367,827		
	3,250,000	1,675,375		
2012	Total=25,302,040	13,043,202		

4.5.4 'Expansion' pathway

This pathway is illustrated by policy narratives to provide fee exemption for maternal health services which expanded from user fee exemption for skilled delivery in four regions (2003) to user fee exemption for skilled delivery and antenatal care in all regions (2005), and finally national health insurance premium exemptions for antenatal, delivery and postnatal care for all pregnant women (2009). Decision makers used their access to financial resources, POW review findings, national strategic plan and political authority to negotiate and expand maternal fee exemption policy.

In 2000, for Ghana to access the HIPC programme of IMF and World Bank a Ghana Poverty Reduction Strategy (GPRS), was initiated. The GPRS noted that a positive correlation between income and health indicators such as utilization of health care services and mortality rates exist. Therefore the GPRS health targets aimed at improving core poverty indicators such as under-five mortality rate and maternal mortality rate focused on four regions (Central, Northern, Upper East and Upper West) classified as the most deprived because they had the highest under-five

mortality rates in the country. Three of them (Northern, Upper East and Upper West) had the highest percentage of the population living below the poverty line. The GPRS health priorities included interventions such as fee exemption for obstetric emergencies and life-threatening pregnancy-related conditions (Government of Ghana, 2000, Ministry of Health, 2003a).

In the light of GPRS and its accompanying HIPC grant, and labelling of maternal health a 'poverty issue'; decision makers commissioned a study to review existing fee exemption policies to align with the GPRS (Ministry of Health, 2002a). The study noted that an antenatal care user fee exemption policy existed but health facilities did not implement fully due to inadequate financial resources (Ministry of Health, 2003a). Decision makers at the 2-4 December 2003 planning summit aligned to the GPRS health targets and made user fee exemptions for skilled delivery in the four regions classified as "deprived" a POW item.

At the 31 May-4 June 2004 review summit business meeting, decision makers noted and discussed the worsening maternal health outcomes in the six regions classified as "non-deprived" regions and the gains in the four classified as "deprived".

'The exemption policy contributed to improve coverage of health services and outcomes in the deprived regions. However, concerns emerged about the relatively poor performance of non-deprived regions in 2004 and the apparent worsening of health in urban poor areas' [MOH staff, 10/07/2012].

To address these concerns, the policy was extended to cover the whole country.

The maternal user fee exemption policy suffered a major setback in the late 2005 and by late 2006 health facilities stopped its implementation due to limited financial resources (Ministry of Health, 2008b). In 2005, US\$ 3,319,500 was allocated to implement the policy as noted in Table 4.6. This account was only 10 percent more than what was allocated in 2004 for the four deprived regions with only 25.97 percent of Ghana's population (Ghana Statistical Service, 2013). The 2007 POW review findings discussed at the April 2008 summit noted a decrease in the share of skilled deliveries from 44.5 percent in 2006 to 35.1 percent in 2007 and an increase in the institutional maternal mortality ratio from 187/100,000 live births in 2006 to 224/100,000 live births in 2007 (Ministry of Health, 2008c). Based on these data the Minister of health declared maternal health a national emergency (Ministry of Health, 2008a). In 2009, decision makers relied on a presidential directive to make maternal fee exemption a POW item. However, decision maker's prior discussions and decisions discussed above influenced the presidential directive.

Table 4.6: Financial resource allocation and source for maternal fee exemption policy

Year	Amount GHC	Amount US\$	Source	Amount Proportion per source %
2004	2,700,000	2,997,000	HIPC Grant	100 Donor
2005	3,000,000	3,319,500	HIPC Grant	100 Donor
2006	5,000,000	5,450,000	HIPC Grant	100 Donor
2007	8,000,000	7,402,400	HIPC Grant	8 Donor
	90,000,000	83,277,000	NHIF	92 NHIF
	TOTAL=98,000,000	90,679,400		
2009	10,000,000	6,638,000	Budget support	100 Donor
2010	10,000,000	6,932,000	Budget support	100 Donor

Against the backdrop of these in country discussions, the President at the May 2008 Business Call to Action meeting in the United Kingdom announced a free maternal services for all. According to the MOH, *the government of Ghana negotiated with the UK government and allocated the DFID budget support to implement the directive* [Interview, 5/11/2012]. With secured funding and implementation under NHIS, decision makers made the free maternal health policy a POW item (Ministry of Health, 2008b, Ministry of Health, 2009c).

4.6 Discussion and conclusions

This paper illustrates actors' use of power sources as negotiation tools in interactions to influence the evolution of maternal health policy items in institutionalized decision making processes at national level in Ghana, a LMIC. The MOH and donors used legal and structural authority; access to political authority; control over and access to resources (mainly financial); access to evidence in the form of POW reviews and demographic health surveys; and knowledge of national plans such as Ghana Poverty Reduction Strategy - to negotiate POW policy items. In addition to the use of power as suggested by Mintzberg (1983) to convince others and to use one's resource, information and technical skills in negotiation. Decision makers used their discretion to decipher which evidence, authority and resources to access to support their interest and ideas.

MOH and donors defined, framed and labelled obstetric care, family planning and maternal fee exemption as long-term POW fixtures. They attached labels such as - 'inadequate obstetric care', 'family planning unmet need', 'maternal health poverty issue', and 'poor maternal health a national emergency' - for actions and to ensure the continuous flow of funding.

The MOH and donors used these labels in several ways. One was to promote and sustain specific interventions proven to improve maternal health outcomes and service utilization such as the provision of obstetric care, maternal fee exemption, and family planning programme (World Health Organization et al., 2004, Government of Ghana, 2006). Another was to highlight the magnitude and the crisis aspect to attract and mobilise support from stakeholders within and outside the institutionalised process. The Minister of Health declaring maternal health a national emergency legitimised its severity attracting support from the President. Yet another was to align to international agenda. For example, IMF and World Bank used the poverty label aligning to a broader international perspective directed towards attainment of anti-poverty objectives consistent with the MDGs.

This paper also illustrates the importance of financial resource in agenda setting. The MOH and donors through collective decisions constantly allocated financial resources for obstetric care, family planning and maternal fee exemption policies. How different actors use their power sources to influence others through explanations and persuasions is critical in collective decisions because discursive power lies in the dominant narrative that controls issue interpretation (Mosse, 2005, Shiffman and Smith, 2007) and prioritization. For example, the MOH may have also dominated discussions around public sector human resource generation and allocation because about 90 percent to 93 percent of government's total health sector financial allocation pays public health sector salaries (Ministry of Health, 2009c, Ministry of Health, 2011b). This however leaves very little resources for other health priorities creating opportunities for donors with financial resources to allocate funds to policy issues of interest and sometime set the agenda. Donors' use of their financial control to influence POW agenda reflects an assertion by Mintzberg (1983) that influencers choose and concentrate on issues most important to them.

Donor control of financial resources (control of the purse) has made them particularly powerful. Through the SWAp reforms, donors gained right-based access (Ribot and Peluso, 2003) access to an institutionalised process. As a result, they were allowed to "share" in the decision making process in exchange for "sharing" the decisions regarding the use of the finances they contributed to the sector by contributing to the basket funding. However once the process was institutionalized, they have continued to have the same access even after the demise of the basket funding. However, how decision makers use their negotiation tools to dominate discussions and convince each other raises the question of power relation and the

possible effect on future interactions in the light of changing development and aid context.

The power relation between donors and the MOH reflect what Ribot and Peluso (2003) described when they said that some people and institutions control resource access while others must maintain their access through those who have control. Donors control financial access (earmarked and budget support) and the MOH to benefit from these must maintain relation with donors by investing and continuing with the institutionalised arrangements. However, donor power may have shifted between the control of the purse and discursive power (Rochefort and Cobb, 1993) as they follow up on international agenda such as the MDGs in attempts to direct national agenda.

Ghana's status change from low income to lower middle income means that Ghana is above income limits for grants eligibility (Moss and Majerowicz, 2012) and will eventually move away from aid. With the demise of "basket funding" and reduced total donor support (Ministry of Health, 2013a) there may be little or no shift in donor and MOH future power relations. This is because the health sector processes are path dependent and the processes may move in the same direction as established power relations may not change. However, if the government of Ghana is able to provide complete funding for the health sector minimising or cutting off donor financial support, then the power relations will shift with the government gaining greater control to interpret issues and set agendas.

This paper also illustrates the fact that national agenda setting and formulation processes are enabled within institutionalised dialogue arrangements. The institutionalised arrangements such as the summits create a venue for policy decision making similar to what Baumgartner and Jones (1991) described as a venue of policy action where interaction of ideas concerning a particular policy issue exist within a set of institutional structures. Therefore, interactions within these structures facilitate problem definition and prioritization of policies (Lindblom, 1980); and in this case policies, targets and financial resources allocation are agreed on during business meetings. Active participation in business meeting discussion is primarily restricted to the MOH and donors with authority and control over and access to financial resources. With limited power of private sector actors such as the Christian Health Association of Ghana, the agenda and course of action is greatly skewed to the interest of MOH and donors. We agree with Princen (2011) who in his work on European Union policy agenda setting observes similar pattern, that policy actors control the agenda by controlling participation.

The fact that institutionalised venues restricts participation raise a question – are the relevant people meeting to maintain access to other available resources? For instance, actors who can facilitate potential policy change in terms of budget allocations such the Ministry of Finance and Economic Planning are

underrepresented or sometimes absent at the health summits and other institutionalised arrangements. Additionally, the MOH implementing agencies responsible and accountable for policy implementation such as chief executive officers of teaching hospitals, directors of GHS headquarters directorates, and a large majority of regional health directorate are also underrepresented and sometimes less engaged in these interactions.

Finally, decision makers, researchers and analysts alike - must be mindful of the use of power sources as negotiation tools to carefully define, frame and label issues to attract and mobilise support and the role of institutional structures in agenda setting and formulation. The study and understanding of power sources and use as negotiation tools in policy development should not be ignored in the pursuit of transformative change and sustained improvement in health systems in LMICs.

Chapter 5

An abridged version of this chapter will be submitted to BMC Health Research Policy and Systems

5 The role of agenda setting processes and actors: a case of how free family planning got onto government agenda and not into formulation and implementation, in Ghana

5.1 Abstract

Background:

Understanding how issues attain prominence on public policy agendas in LMICs and then move forward (or not) into successful formulation and implementation can yield important insights as to how to promote adoption and implementation of priority global and national policies and programmes. This paper contributes to this understanding by investigating how and why ‘free family planning as part of the National Health Insurance (NHIS) benefit package’ attained a position on the government policy agenda in 2012; but has not subsequently moved into formulation and implementation in Ghana.

Methods:

A case study approach was employed to systemically reconstruct the policy evolution. Data was collected from June 2012 to May 2014 through interviews, document reviews and observations; and analysed drawing on power concepts; and multiple streams and political priority frameworks.

Results:

Relying on their power sources such as access to bodies of evidence; bureaucrats, donors, reviewers and reproductive health advocates framed inadequate budgetary allocation and disbursement for family planning and exclusion of family planning services from the national health insurance benefits package - as major challenge to maternal health care. Drawing on their legal and structural access to institutionalized public policy processes in Ghana, they proposed including free family planning service in the national health insurance benefits package and increasing government and donor financial support as policy options. Window of opportunity opened when a Minister receptive to these problem definitions and policy options publically voiced support for the policy and therefore pushed it high and visibly onto the public policy agenda and it was also included in the revised the NHIS law. However, the policy has subsequently failed to move rapidly into formulation and implementation. Factors that influenced this failure included lack of stronger, broad actor support and related inability of actors to agree on and develop policy implementation guidelines; and maintain sustained political interest in the issue.

Conclusion

For interest to be sustained and the item to move beyond prominence on the agenda into formulation and implementation it is probably necessary to invest in ensuring a powerful, convinced and persistent broad based supporting coalition at multi-levels of the health system.

Key words:

Agenda setting process, Actors, Power, Framing (Problem Definition), Maternal Health Service, Family Planning

5.2 Key messages

Implications for policy makers

1. As in HIC, bodies of evidence and access to political authority and influence are important for public policy agenda setting in a LMIC like Ghana.
2. Without maintained political interest and implementable policy modalities even when an item is pushed high up the public policy agenda, it can still fail to immediately move on into formulation and implementation.
3. Linking policy item to a high government priority intervention such as maternal health care can influence the policy item's appearance on government agenda.
4. The ability to use issue framing to refocus problem definitions and policy options can influence agenda setting decisions, but it takes more than this to maintain an item high on the agenda and move it into formulation and implementation.

Implications for public

The study of how free family planning as part of the NHIS was raised to prominence on government agenda but then failed to immediately progress into formulation and implementation provides insights into public policy processes in a LMIC setting. The interests of bureaucrats, donors and advocates who influenced the agenda were to eliminate out of pocket payments for family planning service and still sustain the financial needs of the family planning programme through the NHIS. However, the lack of powerful and broad based support within the Ghanaian health sector to agree on implementation guidelines; and sustain political interest in the "free family planning as part of NHIS" policy agenda lead to stalled implementation after three and half years on the government agenda. With this information, the Ghanaian public especially health professions, family planning services users and advocates can demand policy guidelines from bureaucrats and funding from government for implementation.

5.3 Introduction

Why some policy items get onto government agenda and move into formulation and implementation, while others do not is an important field of enquiry to inform public policy development. This is because to improve health outcomes and drive change is not simply enough to get policy items onto government agenda; they must move into formulation and implementation. There are several published studies on how policy items gain prominence and move into policy formulation (Green-Pedersen and Wilkerson, 2006, Kingdon, 2003, Shiffman, 2003, Princen, 2011), and how policy items are periodically maintained on the government agenda and reformulated (Nelson, 1986, Koduah et al., 2015). There is however, limited research and publication from Low and Middle Income Countries (LMICs) (Gilson and Raphaely, 2008) as to why having made it onto the agenda, items fail to move beyond this into formulation and implementation.

The government agenda is the list of policy items that government officials are paying serious attention at any given time (Kingdon, 2003). Problem recognition and definition are critical influences on what policy items occupy the government agenda (Kingdon, 2003, Rochefort and Cobb, 1994). Technical and bureaucratic policy actors label and define issues for the attention of high level decision makers in political systems; who are often political appointees (Kingdon, 2003). Technical and bureaucratic policy actors use their various sources of power (Mintzberg, 1983) such as access to evidence to highlight the magnitude and severity of problems or access to those who hold political power (political authority) to push issues onto the government agenda. They can also build on framings of current and past issues to shape problem recognition and definition. By framing we refer to the way problems are defined, labelled, stated or presented. Building on existing issue framing as suggested by Arts and Buizer (2009), makes arguments for certain problems and policy options to be more prominent than others. Simply getting an item onto the agenda is however no guarantee that it will stay on the agenda or move further forward into policy and programme formulation and implementation. The probability that a policy agenda item moves beyond merely being on the government agenda to formulation and implementation is dramatically increased if policy actors are able to link their problem definitions and possible solutions to a political receptive context in a single package (Kingdon, 2003).

In 1970, Ghana's family planning programme was established to promote and provide family planning education and service (National Population Council, 1994). The family planning service included methods and practices to delay pregnancy, space births, limit family size and prevent unintended pregnancies (Ghana Health Service, 2007). Over the years, the programme has been highly subsidised by government and donors such that clients pay an out of pocket token fee averaging only about 10 percent of the international price (Smith and Fairbank, 2008) at point of

service. In 2012, a policy to completely remove the token out of pocket fees and pay for their replacement through the National Health Insurance Scheme (NHIS) rose to visible prominence on the public policy agenda of the Ministry of Health (MOH). Two public statements by high government officials and the revised NHIS law promoted this agenda. The first high ranking public official statement was when the Minister of Health announced in May 2012 during a hospital refurbishment project launch that government would provide free family planning in public health facilities (Ghana News Agency, 2012b, Dorcas Larbi, 2012). The second public statement was Ghana's communique issued after the London Family Planning Summit in July 2012 that stated - '*Ghana is committed to making family planning free in the public sector and supporting the private sector to provide services...*' (UK Department for International Development and Bill & Melinda Gates Foundation, 2012). This was followed by a section in the National Health Insurance (NHI) Act 852 gazetted November 2012, that stated under the NHIS Benefit section [1]: "*The Minister shall prescribe the healthcare benefits package including any relevant family planning package to be provided under the National Health Insurance Scheme*" (Government of Ghana, 2012) clearly providing a legal framework for this policy. However, three and half years after these announcements and the promulgation of Act 852, this policy item has not moved beyond the agenda into formulation and implementation.

In this paper we seek to advance our understanding of policy processes in a LMIC setting asking questions of how and why certain problem definitions and policy options can become prominent and endorsed at a high level as public policy agenda items; and yet fail to subsequently move swiftly forward into formulation and implementation. Specifically, we investigate how 'free family planning as part of NHIS' appeared on and rose to prominence on government (public policy) agenda in Ghana, a lower middle income country, but failed to move rapidly from there into programme formulation and implementation. We drew from multiple streams and political priority frameworks and power concepts to analyse this case.

Theoretical background

Kingdon (2003) in his influential work on USA health and transport policies notes active participants (policy actors) and processes by which agenda items come into prominence as two factors that affect agenda setting. He argues that the processes made up of - problem, policy and politics - develop and operate in independent streams which can couple randomly to create a window of opportunity for policy actors to push their preferred solutions or attention to special problems. He proposes that governmental agenda can be set solely in either problem or political streams; and solely by policy actors. The problem stream refers to processes through which policy actors use the existence of systematic indicators, focusing events and feedbacks from an existing policy to bring to the attention of government officials

some problems. The policy stream refers to processes where ideas are generated, debated, redrafted and accepted for serious consideration. The politics stream refers activities of interest groups and events such as election results that bring new administrations to power. Policy actors in his study included the President, the Congress, bureaucrats in the executive branch, and various forces outside of government included interest groups, political parties and the public (Kingdon, 2003).

Shiffman and Smith (2007) proposed a framework for determinant of political priority for national and global initiatives. They defined political priority as the degree to which international and national political leaders actively give attention to an issue, and back up that attention with the provision of financial, technical, and human resources that are commensurate with the severity of the issue. Power is core in the political priority framework which is made up of four components. The first component is the strength (power) of the individual and organizations concerned with the issue. The second is ideas; the ways in which those involved with the issue understand and portray it. The third is the political context in which actors operate; and the fourth issue characteristics that are features of the problem.

Power is a key factor in policy process (Erasmus and Gilson, 2008, Weissert and Weissert, 2012) and a highly contested concept (Parsons, 1995). Mintzberg (1983) simply refers to power as the capacity to effect (affect) outcomes – decisions and the actions. He labels a policy actor who seeks to control decisions and actions as ‘influencer’. He notes that the influencer essentially requires some source of power, coupled with the use of the power in a skilful way to effect (affect) outcomes. Mintzberg categorised five general sources of power as the control of (1) a resource, (2) a technical skill, (3) and a body of knowledge; (4) authority by virtue of one’s legal and structural position, and (5) power sources that derives simply from access to those who can rely on the other four. He argues that the influencers’ ability to control decisions and actions vary as each tries to use his or her means of influence effectively – to convince those to whom one has access, to use one’s resources, information and technical skills to their fullest.

5.4 Methods

Study design and data collection

We employed a case study approach to systematically reconstruct how free family planning appeared on and moved through the government agenda over time. Case study approach allows for the collection of comprehensive, systematic and in-depth information within a real-life context to trace policy discussions and change over time (Patton, 2002, Yin, 2009). The case study approach allowed us to look at the policy item as not merely input and output, but to better understand the agenda setting context and how actors used their powers to influence the processes.

Data was collected from June 2012 to May 2014 through interviews, document reviews and observation. One of the authors (AK⁹) undertook a 20 month period of field work at the Policy Planning Monitoring and Evaluation Directorate (PPMED) of the MOH. The PPMED coordinates national policy and strategic planning for the health sector. AK also undertook a two week attachment at the Ghana Health Service (GHS) Reproductive and Child Health (RCH) department. The RCH department coordinates public sector family planning programme implementation. Participant observations at the RCH department and PPMED were chosen to study and better understand ongoing health sector family planning and maternal health policy discussions and actors' interactions. Field notes from observing national level maternal health and family planning related discussions and actors interactions allowed us to draw inference on how policy actors use their power in discussions to support our retrospective data.

The interviews lasting on average 1 hour were conducted face to face using a semi structured guide to explore how policy actors defined family planning problems and proposed solutions; and why the policy item did not move beyond the government agenda. Sixteen respondents involved in free family planning policy discussions were interviewed; six of these were identified from health sector documents, while the rest (10) were suggested by other respondents. The respondents included officials of the: MOH (4), GHS headquarters (2), the National Health Insurance Authority (3); and a politician (1). Respondents outside government included donors (5) and Coalition of Non-Governmental Organizations in Health representative (1). Where permission was granted the interviews were tape recorded. Otherwise notes were taken and verified later with the participant.

Documents review was conducted to trace and map how family planning issues evolved within the health sector at national level; identify policy actors involved and their power sources; make an inventory of policy actors' definition of family planning problems and policy options; and further triangulate findings with field notes and information from interviewees. The health sector documents reviewed were: medium-term development plans (2002-2006, 2007-2011, 2010-2013), annual programme of work (2002-2014), health sector working group 2012 meeting records (12 January, 9 February, 3 May, 7 June, 5 July), reproductive and maternal health reports, briefs, position papers and studies; and family planning related media information from the Ghana News Agency (2008-2014).

Data from interviews, observations and documents reviews were systemically grouped based on the research questions. We systematically mapped out policy actors power sources and use; the way policy actors understood and portrayed family planning issues over time; and the political environment in which policy actors operated. Further analysis involved iteratively reconstructing the agenda

⁹ PhD candidate

setting processes – how policy actors used their power sources to push the ‘free family planning as part of NHIS’ policy onto government agenda and were not able to swiftly move the policy into implementation. Interpretations of how policy actors used their power to influence ongoing health sector decisions from the research observations allowed us to link up retrospective events and explanations. These analyses were synthesised to reconstruct family planning framing evolution and how and why ‘free family planning as part of NHIS’ policy item got onto the government agenda and failed to swiftly move into policy formulation and implementation. We acknowledge the difficulty in reconstructing retrospective events as they unfolded and mapping out who said what, when, to whom and how it was received. Data from multiple sources and methods were triangulated to minimise these challenges.

5.5 Results

5.5.1 ‘Free family planning as part of NHIS’ policy appearance on the government agenda

Policy actors power sources

The policy actors identified for the ‘free family planning as part of NHIS’ policy were MOH and GHS bureaucrats, National Health Insurance Authority (NHIA), National Population Council, non-governmental organizations (NGOs), health sector performance reviewers and donors. These policy actors invested their time and used legal and structural authority, technical skills, access to political authority, control over and access to financial resources and bodies of evidence parallel to those power sources suggested by Mintzberg (1983) to influence each other and the free family planning agenda setting processes. These policy actors power sources are further elaborated below.

The MOH leads and coordinates national level institutionalised policy dialogue processes that set agendas and formulate policies for implementation. The GHS reproductive and child health department coordinates public sector family planning and reproductive health policy implementation. These bureaucrats therefore wield legal and structural authority, experience, technical skills to engage in family planning discussions because of their position within the health sector. They also have access to bodies of evidence e.g. health sector reviews; financial resources from government and donors; and political actors such as the Minister of Health and Parliamentarians.

The NHIA is a body mandated to implement, operate and manage the NHIS that ensures access to basic healthcare services to all residents; and therefore wield legal authority to implement the NHIS policy. The National Population Council also wield legal authority to coordinate population-related programmes including family planning, set targets for programme performance and commission research to inform

policy making. As a result, the NHIA and the Population Council were actively involved in discussions related to the 'free family planning part of NHIS' policy.

The main NGOs involved were Planned Parenthood Association of Ghana (PPAG) and the Alliance for Reproductive Health Rights (ARHR). Lobbying and campaigning abilities; and access to bodies of evidence, bureaucrats and political actors such as the Minister of Health - were their source of power, during discussions related to family planning. The health sector reviewers made up of local and international experts assess the health sector performance based on a clearly defined terms of reference set by the MOH and donors. The review findings form part of evidence that is debated upon during policy dialogues to inform decisions. The reviewers' power sources include their expertise to generate evidence and access to bureaucrats and donors.

Health sector donors [Royal Danish Embassy (RDE); Royal Netherlands Embassy (RNE), UK-Department for International Development (DFID); European Commission (EC); World Bank; United Nations Population Fund (UNFPA); World Health Organisation (WHO); United Nations International Emergency Funds (UNICEF); Embassy of Japan; U.S Agency for International Development (USAID)] were actively involved in agenda setting discussions and decisions related to family planning to which they have structural authority to participate. Some of these discussions were embedded in an institutionalised policy dialogue process which emanated from a sector wide approach to health care adopted in 1997 (Cassels, 1997, Addai and Gaere, 2001). Under the sector wide approach the donors gained rights-base access to national policy making and structural authority to join the MOH and local actors to prioritise health sector policies. The institutionalised policy dialogue therefore promotes a platform for collective action and decisions (Koduah et al., 2016).

Additional donor source of power is their control over financial resources for contraceptives; and our observations show that they use this as leverage and legitimacy to engage in the prioritization of health sector policies to push their preferred ideas through. Ghana has been heavily dependent on donor funding to implement family planning programme since inception in 1970. From 1996 onward, USAID and UNFPA provided strong financial support; with further assistance from DFID and the World Bank (Government of Ghana, 2006). Putting donors financial support into perspective, Graph 5.1 shows Ghana's family planning funding sources for contraceptives between 2003 and 2007 (Smith and Fairbank, 2008).

Graph 5.1: Historical sources of funding for family planning contraceptives, Ghana 2003-2007

Review of health sector annual programme of work revealed that donors over the years have given family planning programme much financial attention and had presented and supported policy options to safe guard it. To quote a policy implementer's view point on donor support. *'Family planning is very, very popular with donors and they have over the years provided funding for contraceptives'* [Interview, 22/08/2012].

Also, donors supported the generation of evidence to influence the 'Free family planning as part of NHIS' policy debates. For example the USAID financially supported studies such as: *'An estimate of potential costs and benefits of adding family planning services to the National Health Insurance Scheme in Ghana, and impact on the private sector'* (Smith and Fairbank, 2008); *'Cost of family planning services in Ghana'* (Felix Ankomah Asante, 2013); and *'How Ghana can save lives and money: the benefits of financing family planning through National Health Insurance'* (Chaitkin, 2015). The donors' power sources combined made them particularly powerful in the 'free family planning as part of NHIS' agenda setting process. As noted by a bureaucrat with a view on donors' intention: *'donors are eager to get family planning to be free and are engaged in several discussions to push it'* [Interview, 22/08/2012].

Family planning framing evolution in Ghana (1970-2006)

The way that the justification for mobilization of resources and other support to subsidize or provide family planning services completely free as a public health good has been framed in Ghana by political and technical actors and donors has evolved over the years in attempts to gain and maintain influence in changing political context.

In 1969, Ghana became the third country in sub-Saharan Africa, after Kenya and Mauritius, to declare a population policy affirming the government's commitment to curbing population growth. The Population Planning for National Progress and Prosperity policy focussed heavily on demographic and other population related targets and the interconnections between population growth and socio-economic development (National Population Council, 1994, Government of Ghana, 2006). Following the adoption of the Population Planning for National Progress and Prosperity policy, a family planning programme was established in 1970 to promote and provide family planning education and service. The Population Planning for National Progress and Prosperity policy provided the conceptual framework within which the family planning programme was framed and conducted with the focus to curb population growth and achieve national demographic targets and socio-economic development goals (Government of Ghana, 2006).

The 1969 population policy was revised in 1994 to correct implementation inadequacies and incorporate emerging issues such as HIV and AIDS. Within the revised policy, the family planning programme was reframed and focused to ensure access to affordable family planning means and services for all couples and individuals to enable them regulate their fertility (National Population Council, 1994).

To rekindle government's interest, the family planning programme was repositioned in 2006 by MOH and GHS bureaucrats and health sector donors. A roadmap for repositioning family planning in Ghana was developed to again highlight family planning's importance to health and socio-economic development as promulgated by the 1969 population policy. The repositioning roadmap initiated a policy shift and frame towards a national strategic plan of combined focus of individual and couple rights to contraceptive use and family planning as a tool to achieve health and socio-economic development objectives (Government of Ghana, 2006, Odoi-Agyarko Henrietta, 2003).

Between 2007 and 2012 the next focus of the family planning programme in Ghana – that is no out of pocket fees slowly evolved and consolidated into the prominent appearance of “free family planning as part of the NHIS” on the public policy agenda.

Issue framing towards a 'free family planning as part of NHIS' agenda

To push the 'free family planning as part of NHIS' agenda, the supporting MOH and GHS bureaucrats and donors considered inadequate budgetary allocation and disbursement for family planning and exclusion of family planning services from the NHIS benefits package - as major challenge to family planning contribution to maternal health care. In April 2008, MOH and donors [RDE, RNE, DFID, EC, World Bank, UNFPA, WHO, UNICEF, Embassy of Japan, USAID] discussed the 2007 health sector review findings and highlighted family planning budgetary disbursement and allocation gap (Ministry of Health, 2008a). According to the report, government and donors in 2007 each allocated US\$1.5million to procure contraceptives; however, only US\$1million was disbursed (actual disbursement by each was not stated). The report also noted contraceptives supplies to the sector did not meet expected demands due to the huge and significant funding gap (Ministry of Health, 2008c). To address the funding gap challenges, the MOH and donors at the meeting agreed as a short term solution the following: (1) the MOH prepares paper on the need for increased government funding and negotiate with the Ministry of Finance and Economic Planning, (2) the donors explore and mobilize additional funds, and (3) commission a cost effectiveness analysis of financing family planning service under NHIS (Ministry of Health, 2008a).

As a result, international consultants were invited by the MOH through USAID Ghana office to provide an analysis of costs and benefits to the NHIS in adding family planning products and services to the benefits package. The consultants conducted from June 29, 2008 to July 11, 2008 a cost benefit analysis of adding coverage of long term and permanent family planning methods, as well as injectable contraceptives, to the benefits package. The analysis revealed that family planning would cause a decrease in fertility and would avert births that otherwise would cost the NHIS considerable expenditures. The report projected a net saving of almost US\$ 11 million by 2011 with an increase to over US\$ 18 million in 2017 if family planning is covered by NHIS in 2009. The consultants therefore recommended inclusion of family planning service onto the NHIS benefit package (Smith and Fairbank, 2008).

In a related development, family planning programme was reframed as part of an appropriate response to persisting high maternal mortality indicators in July 2008. Institutional maternal mortality ratio had increased from 187/100,000 live births in 2006 to 224/100,000 live births in 2007 and the proportion of skilled care at delivery also decreased from 44.5 percent in 2006 to 35.1 percent in 2007 (Ministry of Health, 2008c). The MOH therefore convened a two day (8 & 9 July) consultative meeting of national and international stakeholders to deliberate on Ghana's maternal mortality burden and propose interventions. At the meeting, bureaucrats, reproductive health advocates, international technical advisors, and donors

identified and reframed family planning as a strategic tool to contribute reduce maternal mortality (Ministry of Health, 2008d).

The cost effectiveness analysis findings and the reframing of family planning as a strategic tool for maternal health informed the bureaucrats and donors' consideration of exclusion of family planning from the NHIS a challenge to overall maternal health care, during a policy dialogue meeting in April 2009. In addition, other evidence used to support the position of free family planning as part of the NHIS included inability of some women to pay for family planning and its potential effect on maternal health care (Ministry of Health, 2009b). Another evidence was the fact that other reproductive health services were already covered by the NHIS. Pregnant women registered free onto the NHIS to access free antenatal, delivery and postnatal services from accredited NHIS public and private facilities. This maternal health care policy in the light of family planning contributions to maternal health, created a situation that made the absence of family planning in the benefits package a viable problem.

To safe guard family planning and provide an alternative financing option the bureaucrats and donors supported their problem definitions with narratives of the benefits of family planning for maternal health and the need to continuously invest in family planning.

'Family planning has direct effect on reducing maternal and neonatal mortality' [GHS staff, 14/12/2012]; *'Family planning programme must be financially supported to make contraceptives available and ensure its benefits to maternal health care'* [Donor, 27/11/2012].

The MOH bureaucrats and health sector donors promoted as effective interventions for overall maternal health care the following: including free family planning service in the national health insurance benefits package and increasing government and donor financial support. With the intention to eliminate out of pocket payments for family planning service and still sustain the financial needs of the family planning programme through the National Health Insurance scheme.

Ideas to promote 'free family planning as part of NHIS' agenda

The idea to incorporate free family planning into NHIS floated around and resonated with many within the health sector. For example, according to the November 2009 Aide Memoire Progress Report, the PPAG and UNFPA incorporated the findings of the cost effectiveness analysis into a position paper and submitted to the Minister of Health in October, 2009 for the government's consideration (Ministry of Health, 2009a). The reviewers of the 2009 health sector performance also recommended the inclusion of family planning into the NHIS benefits package, based on the cost

effectiveness analysis (Ministry of Health, 2010). Health sector donors, reproductive health advocates and bureaucrats also lobbied.

The donors are advocating for family planning to be put on the NHIA list, as there is a report that recommends that the NHIA will make saving if family planning services are included in the benefit package. Other partners are involved in the advocacy - the PPAG and Alliance for reproductive Health' [Donor, 27/11/2012]. ' The NHIA has an excellent reimbursement mechanism in place, that is why free family planning should be on its package so facilities could be reimbursed' [GHS staff, 26/11/2012].

By 2011, the idea of adding family planning to the NHIS benefit package was nested within the health sector so much that the GHS Director General in December, 2011 at an international conference in Dakar Senegal, promoted it. He said in an interview that Ghana was committed to family planning programme with negotiations underway to include family planning services onto the NHIS benefit package (Linda Asante Agyei, 2011).

However, there was initial opposition to the idea. One argument used by the NHIA management and other opposing actors was that a 'free family planning as part of the NHIS' policy would financially overburden the NHIS. This was because the National Health Insurance Fund established as part of the implementation arrangement of the NHIS had not increased proportionately to expenditure of running the schemes over the years. Moreover, there had been financial gaps with an excess of expenditure over income; and reimbursement delays to providers (Ghana News Agency, 2013).

'The NHIS is saddled with unpaid claims therefore including family planning services will further over burden the scheme' [GHS staff 26/11/2012].

To put the cost of implementing the policy in perspective, the NHIA estimated commodity and service cost per year based on National Population Council commodity and service cost figures. According to the estimates, it would cost the NHIA nearly US\$13million in 2013 rising to US\$17.02 by 2015 for short and long term contraceptive methods; and for provision of long term methods US\$ 7.4 million in 2013 with an increase to US\$ 10.1 million in 2015. Based on these estimations the NHIA management questioned the sustainability of such a policy under the NHIS and resisted the call to provide family planning (National Health Insurance Authority, 2015). The NHIA management requested for increased financial allocations to the NHIS if the benefit package must include family planning services. To quote an NHIS official with the increase financial resources viewpoint: *'The huge budget for contraceptives from government and donors should be given to the NHIS if family planning is to be included in the benefit package'* [Interview, 26/11/2012].

Upon persistent calls and lobbying by supporting actors, the NHIA management engaged the National Population Council in discussions on the full benefits of family planning and which aspects the NHIS could cover. By 2012, the NHIA had stated in its annual outlook for 2012 the intent to add long term family planning methods to the benefit package (National Health Insurance Authority, 2015, National Health Insurance Authority, 2012a).

Political context surrounding the ‘free family planning as part of NHIS’ agenda

The family planning programme in Ghana has survived as a national intervention through Ghana’s political transitions since it was first introduced in 1970. This includes a series of military and civilian regimes in the unstable period between 1970 and 1992 and the current stable multiparty democratic system since 1992 with presidential and parliamentary elections held every four years in keeping with the 1992 Constitution. Transition of power between political parties has taken place smoothly in 2000, 2004, 2008 and 2012 with a handover from one political tradition to another in two instances. Ghana has over twenty seven registered political parties with the National Democratic Congress (NDC) and New Patriotic Party (NPP) being the dominant ones, between whom leadership of governance of the country has rotated since 1992 (Ghana Electoral Commission, 2015). The NDC claims a center left social democratic ideology (National Democratic Congress 2016) and the NPP a center right liberal democratic / liberal conservative ideology (New Patriotic Party, 2016). In practice both have tended to support social policies for universal health and education access such as national health insurance, family planning, female education and free universal and compulsory education. Responding to the social and economic challenges of Ghana is perhaps more important than strict ideology in Ghana’s multiparty democratic politics.

Window of opportunity

Under the NDC administration and between 2009 and 2013, four different Ministers of Health were appointed by the President as listed in Table 5.1. A new ministerial appointment marks a change in the health sector administration. The Minister represents government and occupies a political authority position and oversees health sector decisions and strategic planning. The frequent turnover of Ministers some with less than a year tenure, was not ideal for continuity as noted by a policy actor – *‘having four Minister of Health in four years is a problem and not good for continuity in strategic planning’* [Donor, 11/09/2012]. But, provided the bureaucrats, donors and reproductive health advocates the opportunity to lobby and push their problem definitions and policy options to the Ministers as they took office.

Table 5.1: Ministers of Health and their office tenure between January 2009 and January 2013

Minister of Health	Start	End
Dr George Sipa-Adjah Yankey	January 2009	October 2009
Dr Benjamin Kunbuor	November 2009	January 2011
Mr Joseph Yieleh Chireh	February 2011	February 2012
Mr Alban Sumana Kingsford Bagbin	February 2012	January 2013

A political window of opportunity for the ‘free family planning as part of NHIS’ policy was opened when the Mr Bagbin became receptive to the problem definitions and policy options promoted through the collective actions of bureaucrats, donors and advocates. Mr Bagbin therefore at a hospital refurbishment launch in May 2012, announced that government will provide free family planning in public health facilities (Ghana News Agency, 2012b, Dorcas Larbi, 2012). The donor community at the April 2012 policy dialogue meeting welcomed the free family planning announcement (Ministry of Health, 2012a).

To further push the ‘free family planning as part of NHIS’ policy agenda after the Minister’s public announcement, the MOH and GHS bureaucrats lobbied the Parliamentary Select Committee on health. The Committee made up of elected parliamentarians from both government and opposition in Parliament deliberate on overall health strategic plans and oversee reviews of health legislations and laws. They are therefore influential in getting ideas onto the government agenda. According to the November 2011 Aide Memoire Progress Report, the MOH and GHS bureaucrats at a Parliamentary Select Committee hearing in July 2011 advocated free family planning under NHIS. The bureaucrats therefore accessed and lobbied this political influence during the NHI Act 650 review process and presented the evidence of financial saving to be made if family planning service was incorporated into the NHIS benefit package to the Committee for consideration.

Mr Bagbin further demonstrated his receptiveness when he agreed for the MOH and GHS to participate in the July 2012 London Family Planning Summit; after a DFID’s invitation and request for government to declare support for family planning programme at the summit. According to a 5th July 2012 policy dialogue record, the MOH prepared a presentation for the Summit. The Summit organised and hosted by the United Kingdom government and the Bill & Melinda Gates Foundation aimed to put increased access to contraception for women in the developing world back on the global health and development agenda (Cohen, 2012).

At the summit, the Ghanaian delegates issued a communique stating - ‘*Ghana is committed to making family planning free in the public sector and supporting the private*

sector to provide services...'(UK Department for International Development and Bill & Melinda Gates Foundation, 2012). As a follow up to Ghana's commitment to family planning, a legal backing was provided for under the revised NHI Act 852. The Act 852 gazetted November 2012, under the Benefits section [1] stated that – *The Minister shall prescribe the healthcare benefits package including any relevant family planning package to be provided under the National Health Insurance Scheme* (Government of Ghana, 2012). The inclusion of family planning in the Act 852 was informed by the Mr Bagbin's receptiveness and the GHS/MOH bureaucrats' use of the cost effectiveness evidence to lobby and convince the Parliamentary Select Committee on health.

5.5.2 'Free family planning as part of NHIS' policy failure to swiftly move into formulation and implementation

The 'free family planning as part of NHIS' policy presence on the government agenda was not openly contested within the health sector, however, it failed to swiftly move into formulation and implementation. One factor contributing to the policy's failure to swiftly move into formulation implementation is partial coupling. Partial coupling occurs when problems come up for decisions without solutions attached (Kingdon, 2003). When the political window of opportunity opened the supporting policy actors failed to fully link the problem definitions and clearly stated policy specifics to the political receptiveness. Months after the summit, implementation modalities were not agreed upon by the GHS, MOH and NHIA. As noted by a donor – *before the summit the DFID asked the GHS/MOH to make a declaration and design modalities for implementation. Before the summit discussion was on how the implementation will be done. It is the same conversation for the past 6 months.* [Interview; 27/11/2012].

The bureaucratic delay in the design of the implementation modalities may also be partly attributed to funding uncertainty and anticipated future implementation constraints. As noted by a policy formulator with a possible implementation constraint viewpoint: *'family planning programme involves contraceptives, implementing a free family planning policy will present a challenge if a clear and agreed guidelines on how to implement is not developed. One needs to make sure that the contraceptives are not taken out of the facilities for private use'* [GHS staff, 26/11/2012].

Funding uncertainty on the other hand is fuelled by: absence of government budget allocation and disbursement for the policy (National Health Insurance Authority, 2015), gradual reduction of health sector donor budget support (Ministry of Health, 2013a, Camp and Musinguzi, 2011) and the fact that the NHIA would have to spend money (that is not available) first to provide free contraceptives before it can recoup the 'saving' over time (National Health Insurance Authority, 2015, Smith and Fairbank, 2008). These uncertainties have resulted in a weak broad base health

sector actor support and related inability to agree on and develop policy implementation guidelines.

Yet another factor contributing to the policy failure to swiftly move into formulation implementation is reduced political access and interest in the issue after it moved up the government agenda. The political window closed when a new Minister took office in February 2013 under the same NDC government. So although, free family planning remained on the government agenda its prominence reduced and faded with the change of a critical and powerful supporting actor like the Minister for health. This may have hampered ongoing free family planning implementation modalities discussions. As noted by a policy actor: *'the family planning implementation modalities discussion may be ongoing. However, I believe the energy is low and there are many other issues on the table now. And this current Minister may have other priorities'* [MOH staff, 14/01/2014].

5.6 Discussion and conclusions

In this study, we have asked: Who are the policy actors involved and how did they use their power sources to define problems and propose solutions? How did free family planning end up on the government agenda and failed to move beyond it? We theorized that the way policy actors used their powers to define problems and propose solutions building on a family planning reframing as a strategic tool to reduce maternal mortality and the cost effectiveness analysis predominately moved free family planning as part of the NHIS, that started being floated around a few years earlier; high onto the government agenda in 2012. However, the actors that moved it high up the policy agenda lacked equal power to move it into formulation and implementation; and at the same time, the actors with more power to move it to formulation and implementation were not completely mobilized and convinced of the financial feasibility and sustainability of the policy.

The policy agenda influencers – supporting MOH/GHS bureaucrats, donors (especially, USAID, DFID, UNFPA, World Bank), reviewers, National Population Council and advocates (PPAG, ARHR) - relied on power sources that closely parallel those suggested by Mintzberg (1983) to influence the agenda setting process. They relied on their expertise, legal and structural authority within the health sector to prioritise issues, control and access to financial resources as leverage and legitimacy to engage in the agenda setting process; access to bodies of evidence and political influence to collectively push 'free family planning as part of NHIS' policy onto government agenda.

But some supporting actors were more influential; particularly the donors with their subtle use of evidence, leverage of financial support and structural authority within the health sector and ability to concentrate their energies and skilfully convinced those to whom they had access. This made the donors

particularly powerful in the agenda setting process influencing others to accept the 'free family planning as part of NHIS' policy issue. However, other influential policy actors such the Ministers of health that came after the 'receptive Minister' were not completely mobilised and convinced of the financial feasibility and sustainability of the policy and this affected the policy's ability to move into formulation and implementation.

The absence of sustained mobilised political support reflected in a low national political priority for the 'free family planning as part of NHIS' policy after it appeared on the government agenda in 2012. The low national political priority led to the policy's failure to swiftly move into formulation and implementation. According to Shiffman and Smith (2007) national political priority is present when: (1) national political leaders publicly and privately express sustained concern for the issue; (2) the government, through an authoritative decision-making process, enacts policies that offer widely embraced strategies to address the problem; and (3) the government allocates and releases public budgets commensurate with the problem's gravity. In our case study, despite national political leaders publicly expressing support and the Parliament including the policy item into the revised NHIS law, the last two political priority indicators i.e. enactment of strategies and release of public budgets were absent; and the initial political access and interest in the policy was not sustained by supporting policy actors.

Sustained political interest and access is particularly important for the timely manner in which policies are enacted and implemented in Ghana (Koduah et al., 2015) as in other LMICs (Shiffman, 2003). For example, to fulfil a political campaign promise made in 2002 to provide universal health coverage through national health insurance ; the Ghanaian government fast-tracked the policy formulation process and ensured that the NHI Act 650 and its accompanying Legislative Instrument (L.I 1809) were developed and gazetted in September 2003, and 2004 respectively for implementation (Agyepong and Adjei, 2008). Heavily indebted poor countries initiative resources were allocated to implement the policy. Again, the free maternal health care policy announced by the President of Ghana in May 2008 had its implementation guidelines developed and implemented July same year with donor funds allocated to jump start implementation (Koduah et al., 2015).

Framing and attraction of the interest of powerful actors can push items high up on public policy agendas. However how they fare once there that is whether they move forward into formulation and implementation or stall depends on the power of the supporting actors including how broad based the support for the agenda item is as well as continuous political interest and resources for policy implementation. For interest to be sustained and the item to move beyond prominence on the agenda into formulation and implementation it is probably necessary to invest in ensuring a

powerful, convinced and persistent broad based supporting coalition at multi-levels of the health system.

Chapter 6

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6 Technical analysis, contestation and politics in policy agenda setting and implementation: the rise and fall of primary care maternal services from Ghana's capitation policy

6.1 Abstract

Background

Why issues get on the policy agenda, move into policy formulation and implementation while others drop off in the process is an important field of enquiry to inform public social policy development and implementation. This paper seeks to advance our understanding of health policy agenda setting, formulation and implementation processes in Ghana, a lower middle income country by exploring how and why less than three months into the implementation of a pilot prior to national scale up; primary care maternal services that were part of the basket of services in a primary care per capita national health insurance scheme provider payment system dropped off the agenda.

Methods

We used a case study design to systematically reconstruct the decisions and actions surrounding the rise and fall of primary care maternal health services from the capitation policy. Data was collected from July 2012 and August 2014 through in-depth interviews, observations and document review. The data was analysed drawing on concepts of policy resistance, power and arenas of conflict.

Results

During the agenda setting and policy formulation stages; predominantly technical policy actors within the bureaucratic arena used their expertise and authority for consensus building to get antenatal, normal delivery and postnatal services included in the primary care per capita payment system. Once policy implementation started, policy makers were faced with unanticipated resistance. Service providers, especially the private self-financing used their professional knowledge and skills, access to political and social power and street level bureaucrat power to contest and resist various aspects of the policy and its implementation arrangements – including the inclusion of primary care maternal health services. Arenas of conflict moved from the bureaucratic to the public as opposing actors presented multiple interpretations of the policy intent and implementation and gained the attention of politicians and the public. The context of intense public arena conflicts and controversy in an election year added to the high level political anxiety generated by the contestation. The

President and Minister of Health responded and removed antenatal, normal delivery and postnatal care from the per capita package.

Conclusion

The tensions and complicated relationships between technical considerations and politics and bureaucratic versus public arenas of conflict are important influences that can cause items to rise and fall on policy agendas.

Key words

Agenda setting, Arenas of conflict, Implementation, Maternal health services, National Health Insurance, Per capita payment

6.2 Introduction

Why some issues get on the policy agenda, move into policy formulation and implementation while others drop off in the process is an important field of enquiry to inform public social policy development and implementation. Despite several published studies on how issues gain prominence (Princen, 2011, Shiffman et al., 2004, Shiffman, 2003, Kingdon, 2003); or are periodically re-examined and maintained on an agenda over time (Nelson, 1986, Green-Pedersen and Wilkerson, 2006, Koduah et al., 2015) there remains a relative dearth of work on these issues from Low and Middle Income Countries (LMICs) (Gilson and Raphaely, 2008).

To advance our understanding in this area of work; the current investigation in Ghana, a lower middle income country explored how in the implementation processes of a pilot prior to national scale up; antenatal, normal delivery and postnatal services that were initially included as part of the basket of services in a primary care per capita National Health Insurance Scheme (NHIS) provider payment system dropped off the agenda.

Under a per capita provider payment system (capitation), accredited health service providers receive in advance, a predetermined lump sum payment to provide a defined package of services for each enrollee with the provider for a fixed period (National Health Insurance Authority, 2011c, Epstein and Cumella, 1988). The predetermined lump is computed to reflect the average cost of providing the defined package of services to the enrolled population. The amount is paid whether or not the enrollees make use of services within the payment period. Providers therefore have strong incentives to minimise their financial cost. Since the compensation package is decided prospectively, providers can maximize the difference between their earnings and costs by simply keeping costs down. There is no limit on the number of times the enrollee can seek services from the provider, and providers therefore have an incentive to limit the quantity of services provided to the patient

per visit as a preferred approach to reducing their operating cost (National Health Insurance Authority, 2010, Jegers et al., 2002, Chawla et al., 1997).

In 2010 the National Health Insurance Authority (NHIA) commenced a process to design and implement a per capita provider payment system in Ghana on a pilot basis. The stated objectives for the introduction of the per capita payment system were to: (1) *improve cost containment, efficiency and effectiveness of health services through more rational resource use.* (2) *share financial risk between schemes, providers and subscribers.* (3) *introduce managed competition for providers and choice for patients to increase the responsiveness of the health system.* (4) *correct some imbalances created by using the Ghana Diagnostic Related Groupings payment system for outpatient care such as outpatient supplier-induced demand.* (5) *simplify claims processing and* (6) *address difficulties in forecasting and budgeting.* The approach of a pilot in one region before nationwide implementation was to “*enable testing of the overall effectiveness of the designed system in achieving the identified objectives, identify key features of implementation that would be essential for success in scale-up after the pilot*” (National Health Insurance Authority, 2010).

Ashanti region where implementation of the capitation was piloted has 19 percent of Ghana’s population – making it the region with the largest proportion of Ghana’s population. It reflects the diversity of Ghana from the complex metropolis of Kumasi the regional capital to deprived remote rural areas like parts of the Afram plains (Ghana Statistical Service, 2012).

The use of per capita provider payment system in health insurance is not new. Health insurance schemes in middle income countries like Argentina, Brazil, Nicaragua and Thailand have adopted capitation payment as a means to remunerate public and private providers (Mills et al., 2000). However, for the lower middle income country in Sub-Saharan Africa that Ghana was in 2010 and currently remains, it was a major innovation. In Ghana, capitation was mentioned in the National Health Insurance law (Act 650) and legislative instrument at the inception of the scheme in 2003 as one of the payment mechanisms to be explored (Government of Ghana, 2003, Government of Ghana, 2004) and thus already on the strategic purchasing agenda. However, it remained dormant, largely because of a sense that the experience to implement it was lacking; until it re-emerged in 2010 with the NHIA decision to reform the provider payment system.

Primary care maternity services were included in the capitation basket of services in the initial design, and implementation started in January 2012 in the Ashanti region. However, by March 16, 2012 after less than three months implementation of the policy amid heavy public arena social and political contestation of the policy; primary care maternal health services were removed from the basket of service. The specific research questions this study tries to answer are: Who were the policy actors involved? How did they include and subsequently exclude primary care maternity services in the capitation policy and why? This

analysis firstly provides insights on how and why primary care maternal health services got onto the capitation policy agenda, implemented and later removed. Secondly, it contributes to the general understanding of policy agenda setting, formulation and implementation in a LMIC setting.

National health insurance provider payment mechanisms in Ghana

In September 2003, Ghana passed a National Health Insurance Law (Act 650) to provide the legal backing for the implementation of a national health insurance scheme that would ensure all residents access to basic healthcare services (Government of Ghana, 2004). Implementation started in January 2004. A National Health Insurance Fund (NHIF) established as part of the implementation arrangements had as its funding sources a national health insurance levy of 2.5 percent value added tax on selected goods and services, 2.5 percent of all Social Security and National Insurance Trust (SSNIT) contributions; registration fees from all enrollees and premiums from non SSNIT contributors.

NHIS provider payment mechanisms have evolved over time. In 2004, NHIA started with itemized billing with no standardized fee schedule for services and medicines. Each of the district schemes negotiated with their providers itemized fee rates for services, consumables, and medicines. In the face of growing concerns over inefficiencies such as random price variations for the same procedures and consumables, cumbersome billing and claim vetting procedures and cost escalation, NHIA in 2008, introduced a case based payment mechanism known as the Ghana – Diagnosis Related Groups (G-DRG) for clinical services and procedures; and standardized itemized fees for medicines based on a periodically revised medicine list. The G-DRG is an adaptation of the DRG approach, in that although it has the patient classification system, it does not have cost weights and severity levels. The G-DRG and itemised fees for medicines are applied nationwide for all levels of care from the lowest (Community Health Planning and Services compounds) to the highest (Teaching hospitals), to pay all accredited providers – public, quasi-government, and private – for inpatient and outpatient services. A study of Ghana’s NHIS provider payment and service supply behaviour and incentives by Agyepong et al (2014) found that financial incentives to service supply were mixed. For example the G-DRG design allows a provider to bill for three visits for outpatient care – the initial visit and two follow-up visits. It could be to the financial advantage of the provider to bill routinely for all three visits regardless of whether the client needed or even made them. On the contrary, the bundled payments of the G-DRG for services were a disincentive to carry out extensive diagnostic investigations whether they were needed or not. Additionally, there was less financial incentive to over prescribe than would be expected under the itemized fee for service billing system, because of

the actuality as well as the perception of too low tariffs that negated, in part, incentives to prescribe and dispense unneeded medicines (Agyepong et al., 2014).

Payment to providers for services and medicines was and remains retrospective. Section 38 of the legislative instrument (LI 1809) recommended schemes to pay claims within four weeks after receipt from a health care facility. In practice, it takes much longer. Providers file claims, which go through a vetting process in the NHIA district scheme offices or for the higher-level facilities such as teaching and regional hospitals in the computerized central claims processing office of the NHIA before final payment. The claims processes of many provider and district scheme offices remain predominantly manual despite increasing computerization (Government of Ghana, 2004, Sodzi-Tetty et al., 2012).

Maternal health is a national priority and reducing financial barriers is one of governments’ interventions to improve outcomes. Related to this, in 2008 Ghana started implementing its free maternal health care policy under the NHIS and reimburses service providers through the G-DRG payment mechanism for these services. Table 6.1 describes the benefits under the free maternal care policy (Twenaboa, 2011).

Table 6.1: Benefits under the free maternal care policy

• No premium for fresh registration or renewal of membership
• No processing fee for registration or renewal
• Antenatal period: free antenatal, general services and medicines
• Delivery: free service and medicines, including caesarean
• Postnatal period: free services and medicines
• Full year cover no matter when pregnant woman registers
• Free care for the baby on mother’s NHIS ticket for 90days
• Alternatively the baby can be treated free on the father or other designated guardian
• After 90 days the child can be registered as an individual under 18 (no premium but processing fee required)

6.3 Methods

Study design and data collection

We used a case study design because it allows collection and analysis of comprehensive and systematic data at different points in a real-life context to trace policy discussions and change over time (Patton, 2002, Yin, 2009). Data was collected between July 2012 and August 2014 using in-depth interviews, document reviews, observations and feedback discussions with respondents. The in-depth interviews

were conducted to obtain real-life experiences from key actors involved in the decision making and pilot implementation of the per capita payment system especially in relation to maternity services. The interviews lasting on average 1 hour were conducted face to face using a semi-structured guide to investigate how policy actors included and later excluded primary care maternal services from the capitation policy. AK¹⁰ (one of the authors) interviewed twenty-eight respondents summarized in Table 6.2. For confidentiality, names and positions are not used. Ten of these were identified from the documents review and the rest (18) were suggested by other respondents.

Table 6.2: List of respondents by agency /role in the health sector in relation to capitation

Respondents	Number
Ministry of Health	4
National Health Insurance Authority	4
Ghana Health Service headquarters	2
Ashanti regional health directorate	2
Provider Payment Mechanism Technical Sub Committee	2
Society of Private Medical and Dental Practitioners	2
Christian Health Association of Ghana head office	1
Public health facility in the Ashanti region	4
Christian Health Association of Ghana health facility in Ashanti region	1
Private self-financing (for profit) health facility in Ashanti Region.	3
Government politician	1
Opposition politician	1
Coalition of non-governmental organizations in Health - Ashanti regional representative	1

Document analysis was used to map the sequence of decisions and actions, identify actors' roles and further triangulate findings with respondent's information. We conducted content analyses of provider payment mechanism technical subcommittee meeting records and reports (2010-2012); press releases and media discussions from the Ghana News Agency archive related to the policy.

To understand decision making dynamics and interactions in the Ghanaian health sector, a 20 month period of practical attachment at the MOH Policy Planning Monitoring and Evaluation Directorate (PPMED) was undertaken by AK (one of the authors) as a participant observer. The PPMED coordinates policy formulation and strategic planning for the health sector. As a result, there were interactions with the

¹⁰ PhD candidate

key regional and district health actors during the MOH joint monitoring team visit to Ashanti region (6th - 9th November 2012). Further interactions with key actors during a December 21-22, 2012 national health insurance stakeholder meeting in Accra and a February 12, 2013 capitation evaluation meeting in the Ashanti region gave insights into the varied opinions on the capitation policy.

The initial findings were validated and further substantiated by a presentation for discussion, comments and critique at an August 29, 2014 provider payment mechanism technical subcommittee meeting.

Analysis concepts

We drew from Mintzberg's power concept to guide the analysis of what powers policy actors used to control decisions and actions related to the rise and fall of primary care maternal health service capitation policy. Mintzberg (1983) defines power as the capacity to effect (or affect) decisions and actions and labels an actor who seek to control decisions and actions as influencer. Mintzberg argues that influencer's interpretative manoeuvres ability vary as each tries to use his or her own source of power as means of influence in a politically skilled way. He proposes the sources of power as the control of a resource, a technical skill, or a body of knowledge; authority by virtue of one's legal and structural position; and access to those who can rely on the other four sources of power (Mintzberg, 1983).

To analyse policy actors' responses and actions related to the rise and fall of the policy; we drew on the concept of arenas of conflict of Grindle and Thomas (1991). Grindle and Thomas (1991) observed that decisions to change existing practice almost always generate conflict. They described two broad scenarios of reactions or response to policy change – conflict in the public arena and bureaucratic arena. Conflict to policy change in the public arena usually occurs during implementation and when the costs or burden of the reform has a direct impact on the public or on politically important groups in society. On the other hand, conflict in the bureaucratic arena is largely determined by bureaucratic agencies and public official's response to the change. This usually occurs during policy formulation especially when the administrative content of the policy is high or it is technically complex and requires coordinated efforts of public officials and agencies through consensus building to design the reform (Grindle and Thomas, 1991).

To understand and analyse how providers were able to resist the policy in addition to their use of power; we drew on Sterman's (2006) concept of policy resistance. Sterman (2006) conceptualises policy resistance as the tendency for a policy to be defeated by a system's response to the policy itself. He argues policy resistance arises because the system is complex made up of separate but interdependent parts that interact with each other in many ways. The system is therefore dynamic, evolving, interconnected and governed by feedback loops. He

further argues that within a system decisions and actions feedback on themselves, triggering others to act thus giving rise to a new situation. Policy actors operate within this complex system and their actions and decisions alter the system and, therefore may trigger unanticipated effects. Others seeking to achieve their goals and acting to restore the balance may also trigger intended and unintended consequences. Policy resistance arises because policy actors are not aware of the full range of feedback surrounding – and created – by their decisions (Sterman, 2006).

Drawing upon these concepts, we systematically attempted to reconstruct the case of decisions and actions surrounding the rise and fall of primary care maternal health service capitation policy in the Ashanti region. The information was analysed first to map events and the power sources of key policy actors. A stakeholder analysis of actors as individuals, groups and institutions was done to further understand their position, interest and use of power to influence. Next the evolution of decisions and actions, the formation of groupings were identified. Finally, the analyses were synthesised to reconstruct insofar as possible the case. We acknowledge the difficulty in providing a full explanation of events as they unfolded within the dynamic health system – reconstructing who said what, where, when, to whom and how it was received. To minimise this multiple research methods and data sources were used. Where such data is available, it is noted; otherwise, the gap is noted and possible inferences are made from data analysis.

6.4 Results

6.4.1 Technical analysis: the rise of primary care health service capitation policy

Capitation provider payment: an active policy option

Health service cost containment was the main driver for the NHIA provider payment reforms. The financial challenge was twofold – increasing claims cost accompanied by a much lower rate of increase of the NHIF (National Health Insurance Authority, 2011a, Ministry of Health, 2013a) as summarized in Graph 6.1: trend of NHIS income and expenditure 2007-2011 (National Health Insurance Authority, 2012b). The NHIA attributed the financial challenge, first to increased number of enrollees. For instance, the number of registered pregnant women more than doubled from 421,234 in 2008 to 1,277,819 in 2010. Second, to overbilling practices such as service providers billing the NHIS for multiple visits that did not occur (Twenaboa, 2011, Acheampong, 2011).

Graph 6.1: Trend of NHIS income and expenditure 2007-2011

Primary care maternal health service capitation policy agenda and formulation

The NHIA with the assistance of the World Bank supported health insurance project established the Provider Payment Mechanism Technical Sub-Committee (henceforth Committee), in June 2010. The Committee with health financing and implementation expertise and authority to design the capitation policy comprised officials of the NHIA, MOH, Ghana Health Service (GHS), Christian Health Association of Ghana (CHAG), Korle Bu Teaching Hospital and a national representative of the Society of Private Medical and Dental Practitioners (SPMDP). The Committee assessed the financial situation of the NHIS and noted that the G-DRG payment system had not contained cost particularly outpatient services claims. Furthermore outpatient claims was accounting for 70 percent of NHIS claims with an increased average claims of 50 percent between 2007 and 2009. To ensure that a routine package of services was paid for by a standard capitation rate across the country, the Committee agreed on a basic basket of service for walk-in outpatient department (OPD) to be paid for by capitation. The original basket of services classified as the primary health care (PHC) bundle is listed in Table 6.3.

Table 6.3: Capitation basket of services (Primary health care bundle)

1. Primary health care outpatient department consultation
2. Maternity consultation and services with a trained midwife or doctor for antenatal, normal delivery and postnatal
3. Medicines for services included in the capitation package
4. Selected laboratory services that can be performed at all levels, namely:
• Routine Urine
• Malaria Test
• Blood Test
• Pregnancy Test
• Venereal Diseases Research Laboratory Test

The Committee's technical consideration of the financial and sustainability challenges of the NHIS alongside what should be essential primary health care in Ghana and therefore what should be included in the per capita basket of services presented a window of opportunity to reform not only health financing but also maternal health service delivery. The NHIS per capita provider payment reform was also needed to address some of the long standing challenges associated with delayed reimbursement to providers. There had been numerous instances where providers suspended services to NHIS enrollees because of delayed payments from the NHIA (Ghana News Agency, 2013, Jafaru, 2015) and this may be due to long vetting processes (Sodzi-Tettey et al., 2012) and the fact that NHIA expenditure is higher than its income (National Health Insurance Authority, 2012a). The adverse effect of services suspension on maternal health was that expectant mothers had to pay out-of-pocket at the point of use to access a 'free' service. The upfront payment to providers that capitation mechanism offers was a potential to reduce if not prevent such happenings. Prompt payments of capitation rate to providers may not be guaranteed, however the delays may be minimal because the amount is predetermined and claims vetting is excluded. Capitation also holds service providers financially responsible for services they deliver and this provides strong incentives for them to integrate activities and reduce cost (Bazzoli et al., 2000). Therefore including antenatal, normal delivery and postnatal services which can be provided at primary care level in the capitation basket of service was to ensure continuity in care because capitation payments mechanism could minimise provider's tendency to suspend services to primary health care.

The Committee also agreed on the following that: (1) a provider must demonstrate the availability of the listed services within the facility to be accredited as a primary care provider to receive a capitation fee. (2) capitation would be limited to this primary health care bundle and all other services would continue to be paid for by the already existing G-DRG for services and itemized fee for medicines

(National Health Insurance Authority, 2010). Review of the committee's reports and meeting records shows decisions including those on per capita rate and enrolment requirement before pilot start were based on consensus building within the Committee; after a back and forth process of discussions. Medicines dropped off the basket of services before it moved into implementation because of stakeholder and technical concerns that it was not clear how best to implement a capitation basket that included medicines in the context of Ghana's health system. It was decided to continue to pay for all medicines under the itemized fee for service.

Primary care maternal health service capitation policy stakeholder education and advocacy

The NHIS is a major health service purchaser and its sustainability is a major national concern. Ways to ensure its sustainability had been discussed at many fora. As a result, at the health sector multi stakeholder November 2011 meeting, participants welcomed the introduction of the capitation policy for primary health care services as a measure to improve efficiency and contain cost (Ministry of Health, 2011a).

During the pre-implementation phase the Committee and officials of the NHIA held series of fora to inform stakeholders from local to national level on key policy principles. Several of these were covered by the media for example forum with the Asante-Akin South District Assembly at Juaso (Ghana News Agency, 2011a). District health insurance schemes and the regional implementation committee; representatives of the MOH, GHS, CHAG and health professional bodies; and private self-financing providers were all participants at these fora (National Health Insurance Authority, 2011d).

The NHIA brought on board politicians to inform and solicit bipartisan support. This included members of the Parliamentary Select Committee on health – elected parliamentarians with the mandate to advise the Parliament on health issues – and members of Parliament representing all constituencies in the Ashanti region. Additionally local government was engaged through the regional coordinating council and the district chief executives in the Ashanti region (Stephen Odoi-Larbi, 2011, National Health Insurance Authority, 2011d). However, the political approval from politicians may have influenced resistance from some stakeholders. As a policy implementer noted – *'involving politicians created the impression that capitation policy was a political issue, putting a political connotation on the policy'* [9/11/2012].

6.4.2 Contestation: the fall of primary care maternal health service capitation policy

Service providers especially the private self-financing (private for profit) contested and resisted the policy intent and implementation in the run up to and during implementation. Service providers wield a lot of power based on multiple sources including their knowledge, skills, authority, social and professional identity and access to other influencers such as the Minister of Health and NHIS enrollees. The access to NHIS enrollees, the discretion required by the nature of their work, public respect and trust for as well as dependence on their skills and knowledge gave them major “street level bureaucrat” (Lipsky, 1980) power. The Minister of Health and NHIS enrollees were not actively involved in the policy design, but had the power to influence the policy process when mobilized. These power sources closely parallel those suggested by Mintzberg (1983).

Service providers’ contestation and resistance created unanticipated effects. There was intense media attention and discussions across the country and not only in the Ashanti region where the pilot was taking place. A mobilized pressure group – Ashanti Development Union - sprung up to oppose the capitation policy. Stakeholders called for the policy to be suspended, and private self – financing providers finally suspended services to NHIS subscribers as part of their protest against the policy. Apart from the contestation by the service providers, the fact that 2012 was an election year fueled the public arenas of contestation and high politics as commentators from both sides of the political divide joined the media discussions and increasing acrimony. All these finally cascaded into a crisis situation and gained the attention of the President and the Minister of Health. We discuss in more detail below these stakeholder’s arguments, unanticipated effects, and the committee’s and government’s responses and actions using specific contested issues to illustrate.

Stakeholder’s arguments

Policy resistance to including maternity services had started to build up even before implementation finally started in January 2012. The main contested issues included: the per capita rate, the enrolment rate, rationale for using the Ashanti region as a pilot site and ‘all or nothing’ choice scenarios that confronted the service providers.

Per capita rate

The per capita rate for the basket of services was computed from a combination of an analysis of historical NHIS annual expenditure on the services in the basket against annual enrolment; and an estimate of the NHIA ability to pay. The per capita rate was then adjusted further for service fixed cost difference between private and public health facilities (National Health Insurance Authority, 2010). The calculation of the per capita rate drew from the G-DRG payment system data. Even in the computation

of the G-DRG rates, there had and continued to be challenges related to data quality and completeness and the need therefore to model and estimate. However this was the best data available and the G-DRG system had been developed with it and accepted by providers (Agyepong et al., 2014).

Providers – public and private – raised several concerns with the per capita rate and its calculation. First, they felt the per capita rate was too low. In response to this the Committee reassessed and increased the rate by 22 percent (National Health Insurance Authority, 2011d). However the SPMDP and providers under the Manhyia health insurance scheme disputed and maintained the revised rate was still inadequate. Discrepancies between provider and scheme data on claims and utilization created a data gap and made it difficult for either the NHIA or providers to be certain about the appropriate rate for the PHC bundle.

Providers also argued that the gains made under the free maternal care policy would be derailed under the capitation policy since there would be incentive to reduce service inputs.

‘Maternity service is a priority for the country and also for the MDGs, maternal mortality will increase if maternity service is put under capitation. Under capitation, there will be restricted services and this will affect the quality of care given - for example the number of antenatal may be reduced by the provider’ [GHS staff, 9/11/2012].

Thirdly the per capita rate was a single flat rate with no risk adjustment. The data quality problems did not make risk adjustment possible. Providers argued that the type of enrollees played an essential role in the nature of the financial risk borne by providers. They anticipated their risk to be much higher with more enrolled pregnant women.

‘The outcome of pregnancy is certain and that is delivery. If maternal service is capitated, we (providers) will bear most of the financial risk [Public Provider, 5/11/2012].

Fourthly and related to the preceding arguments, they anticipated the low rate would ruin their health care business.

‘This capitation policy will collapse health care system and business in the Ashanti region because the per capita rate is too low and we cannot provides services with such small amount’ [SPMDP, 7/11/2012].

Finally, providers claimed to be unable to understand the method of rate computation.

'We (providers) do not understand how the capitated rate was calculated' [SPMDP, 8 /11 /2012].

Table 6.4 shows the per capita rate for implementation as of July 2011 after the 22 percent upward adjustment.

Table 6.4: Per capita rate per health facility ownership for implementation as of July 2011.

Provider Ownership	Capitation Rate (GH¢) (Per Member Per Month)	Capitation Rate (GH¢) (Per Member Per Month)	Total Rate (GH¢) (Per Member Per Month)	Total Rate (USD) (Per Member Per Month)
Private self-financed	1.11	0.64	1.75	1.16
Government	0.59	0.64	1.23	0.81
Mission-based	0.79	0.64	1.43	0.95

Data source: Preferred Primary Provider Group Practice Guidelines, July 2011, National Health Insurance Authority. Conversion from Ghanaian cedis (GH¢) to US dollars; exchange rate at 4.00pm universal time on 31st July 2011 - 1GH¢ = 0.662USD. <http://www.xe.com/currencytables/?from=GHS&date=2011-07-31>

Enrolment rate

Per capita payment systems use the transfer of an average rate per enrollee. This way in any given period, the money of those who do not use the system helps to take care of those who use the system. Under these circumstances it is essential that 100 percent of active enrollees voluntarily chose a preferred primary care provider (PPP) or are administratively assigned to a PPP to avoid short changing providers in the per capita transfers. The method chosen for enrolment to PPP in the Ghana per capita payment system design was voluntary enrolment. It was however acknowledged that it would be impossible to get 100 percent voluntary enrolment. The Committee therefore stipulated that an at least 80 percent voluntary enrolment rate needed to be attained and then the remaining enrollees would be administratively assigned for the implementation start. But, by December, 31 2011, only 46 percent of the active NHIS subscribers had voluntarily enrolled with a PPP. The SPMDP and providers under

the Manhyia health insurance scheme contested the start date given that 80 percent enrolment to PPP had not been attained.

The Committee attributed low enrolment rate to logistics, staffing and financial constraints as well as poor management of the enrolment process. There were also communication challenges such as people considering enrolment information as political propaganda (National Health Insurance Authority, 2011d). Because of the slow progress in enrolment, the Committee had already shifted the start date from August 2011 to October 2011 and again to December 2011 in a quest to attain closer to 80 percent voluntary enrolment. By October 2011, the Committee felt it was no longer appropriate to keep changing the start date. 2012 was an election year and after the first quarter of the year it would be impossible to introduce any reform as major as capitation. A lot of time, money and effort had already been invested in designing the policy and accompanying programmes and trying to move them into implementation. Moreover, some stakeholders perceived the frequent shift in start date as a sign of weakness and a policy that was doomed to failure.

‘The continuous changing of the start date did not help, it fuelled the perception that the NHIS is collapsing’ [GHS staff, 9/11/2012]. ...‘postponing several times the start date contributed to less confidence in the policy implementation’ [Committee member, 29/08/2014].

The Committee felt that given all these issues, the voluntary target of 80 percent should be lowered and other strategies devised to ensure 100 percent of the insured had been assigned to a PPP.

Suspensions about the rationale for the selection of Ashanti region

The mobilized pressure group – Ashanti development union - and providers questioned the rationale for selecting the region for the pilot. Some claimed the region was chosen because NHIA labelled it a ‘fraud region’.

‘NHIA brought capitation to the region because they believe there is fraud and abuse here. So the focus is to fight fraud’ [Private self-financing provider, 8/11/2012].

Others claimed the region was punished for its voting patterns. The region is politically described as a New Patriotic Party (NPP) – the party in opposition at the time of introduction of the pilot – ‘stronghold’. The NPP has consistently won the majority parliamentary seats since the start of multiparty democracy in 1992. For instance in the 2008 election, the NPP won 34 parliament seats while the National Democratic Congress (NDC) that won the national presidential election had only three (Ghana Electoral Commission, 2015). The timing of the pilot in an election year

in addition to placing it in an opposition stronghold also fuelled the suspicions about the intent of the reformers.

'Some people believe this is political, this is to punish the region for voting against the government in power. The timing was also wrong, implementing such a policy in an election year in an opposition dominated region, it's difficult to understand their (NHIA) motive' [GHS staff, 28/8/2012].

'All or nothing' choice scenarios

The policy implementation presented providers with 'all or nothing' choice scenarios. Under the capitation policy developed by the Committee any service beyond a normal delivery for example assisted deliveries and caesareans were to be paid for by the G-DRG. Providers who run primary as well as referral care clinics could not opt out of being NHIS provider for primary care under a per capita system and continue to be provider for referral service care.

'If you do not participate in capitation, you cannot provide services for NHIS subscribers – unless the subscriber pays out-of-pocket. This is not fair.' [Private self-financing health facility, 8/11/2012].

Accredited facilities needed to have the capacity to provide the whole basket of services to qualify as a preferred primary care provider. Maternity homes are private facilities run by nurse midwives. They are licenced purely for the provision of primary maternal care services such as antenatal, delivery, postnatal and family planning. From a legal point of view, Maternity homes could therefore not become preferred primary care providers, since they were not licenced to provide the other components of the primary care per capita package other than antenatal care, normal delivery and postnatal care. Maternity homes accounted for about 12 percent of NHIS accredited providers in the region (National Health Insurance Authority, 2016, National Health Insurance Authority, 2011b). Maternity homes were particularly concerned about this since though they were only licenced in theory to provide maternity services, many provided other primary care services. To date no one had applied the law strictly, but what would happen under a per capita payment system?

Within the package there were other services apart from the maternity services, and as such the maternity homes will not be able to be part of the capitation payment system and they were going to lose out' [NHIA official, 4/10/2012]. 'The position taken by the NHIA that facilities should provide all the primary care bundle will collapse maternity homes' [SPMDP, 7/11/2012].

In response, the Committee recommended Maternity homes could be a PPP if they provided evidence of their capacity to provide the whole basket of services. Such evidence included forming a partnership or group practice with another clinic or a community pharmacy shop with written agreements confirming that all the partners understand and had agreed to group together as a 'primary health care bundle provider' (National Health Insurance Authority, 2011b). This concept of group practice was however new to Ghana. Private providers were unclear how to operationalize it, or even if they wanted to operationalize it. And there were all the other objections to capitation.

Unanticipated effects

Policy redefined by opposing voices

The private self-financing providers made recommendations to promote their desired outcomes, with contestation starting at the bureaucratic level before implementation start in January 2012. In a petition dated October 5, 2011 to the NHIA chief executive officer, the SPMDP suggested the removal of maternal health service from the basket of services. The SPMDP also recommended new per capita rates between 15 – 20 times the rates calculated by the NHIA for the PHC bundle as listed in Table 6.5.

Table 6.5: Per capita rate recommended by the SPMDP in December 2011

Facility	Total Rate (GH¢) Clinical Service & Medicines (Per Member Per Month)	Total Rate (USD) Clinical Service & Medicines (Per Member Per Month)
Hospital	20.57	12.57
Clinic	18.14	11.08
Maternity	9.76	5.96

Data source: Recommendation to the NHIA on pilot implementation of capitation in Ashanti region, December 2011, Society of Private Medical and Dental Practitioners. Conversion from Ghanaian cedis (GH¢) to US dollars; exchange rate at 4.00pm universal time on 31st December 2011 - 1GH¢ = 0.61087USD. <http://www.xe.com/currencytables/?from=GHS&date=2011-12-31>

The SPMDP based their calculation on the rate of encounter with clients and the existing G-DRG payments as estimated by the society. They noted any amount below their request would immensely affect quality of health care and subsequently collapse private self-financing clinics and maternity homes. According to the

SPMDP, increasing cost of general goods and services was making healthcare expensive so primary health care should not be considered as a package of low-cost interventions.

In January 5, 2012 the NHIA therefore organised a meeting to negotiate the basket of service and per capita rate with leaders of the public and private providers, but this ended in chaos with continuing disagreement between the NHIA and the private self-financing providers on the basket of services and the per capita rate. The SPMDP threatened to opt out of capitation. The NHIA also threatened to abrogate all contracts with SPMDP members, stating that private providers that did not implement capitation would not be permitted to provide services under the NHIS (Ghana News Agency, 2012a).

To increase their bargaining power the SPMDP and the Ghana Registered Midwives Association (GRMA) aligned, although they were affected differently by capitation. SPMDP facilities were licensed to provide all the basket of services while Maternity homes were not, despite still providing a broader range of services in practice. SPMDP's focus was to negotiate a higher per capita rate and GRMA focus was to negotiate approval to provide all the basket of services to NHIS enrollees. To register their objection they moved the discussions to the public arena using the media; and issued a press release on the January 11, 2012 stating: *'We shall not start with the pilot capitation under its present form. However, we shall continue to render our services to our Health Insurance Clients using the existing Ghana-Diagnosis Related Groupings (G-DRG) package based on our contract with the National Health Insurance Authority'*.

The unfolding resistance and press release did not deter the NHIA's intent to continue implementation of the per capita payment system despite the strength of private self-financing providers as key health players in the health sector and the Ashanti region. According to the regional health directorate 2010 half year report, the private maternity homes and clinics operated two hundred and seventy-eight (278) out of the five hundred and twenty-seven (527) health facilities (53 percent) in the region (Ashanti Regional Health Directorate, 2010).

Increased media attention and calls for policy suspension

The media with its power to instantly reach thousands of people served as a platform for many stakeholders to convey their messages. Intense media discussions built up as stakeholders discussed multiple interpretations of the policy. Discussants, some with inadequate technical understanding shifted to political interpretations that not only contributed to misinform, but also publicized ideas and influenced others (National Health Insurance Authority, 2011d).

'Some politicians and even some officials of the NHIA misunderstood the technical content of the capitation payment system' [Committee member, 29/08/2014].

For example, a municipal chief executive (a political appointee), stated that the capitation policy was not for '*political witch hunting*' but to check corruption as most providers and some NHIS officials had connived to loot the scheme resources (Stephen Odoi-Larbi, 2012). Such statements influenced political discussions and shifted attention away from the intent and purpose of the policy and the technical issues underlying the disagreements.

Multiple interpretations and the unresolved negotiations ultimately fuelled calls for the capitation policy postponement to allow agreement on contested issues. A range of stakeholders - politicians (mainly opposition), private self-financing providers, health professional bodies (Ghana Medical Association and the Pharmaceutical Society of Ghana), and the Ashanti development union joined the call to suspend the pilot (Ghana News Agency, 2011b, Ghana News Agency, 2012c, Ashanti Development Union, 2012, Ghana News Agency, 2012d). The opposition politicians and supporters took to the streets to register their disapproval (Morgan Owusu, 2012) and the Ashanti development union threatened a demonstration (Ashanti Development Union, 2012).

Private providers suspended their services to NHIS enrollees

The NHIA did not postpone the capitation policy and did not give in to the demands of private self-financing providers. Resistance reached its highest point on February 1, 2012, when the private self-financing clinics and Maternity homes operators suspended their services to NHIS enrollees. They stated the policy was imposed by the NHIA to the detriment of quality care and health facilities in the region (Ghana News Agency, 2012e). The suspension incited further calls to postpone the policy and the opposition parliamentarians perceived it would lead to poor maternal and child health outcomes (Ghana News Agency, 2012f).

6.4.3 Politics: the governments' responses and actions

The resulting crisis escalated to a high politics situation, attracting the attention of the President and the Minister of Health. The President in his February 16, 2012 State of the Nation Address to Parliament acknowledged the crisis and called for urgent dialogue and consensus building on NHIS provider payment mechanisms to ensure sustainability (Ghana News Agency, 2012g). To intervene and build consensus, the Minister of Health met both private and public providers on February 29, 2012. The Minister assured providers of government's commitment to dialogue with all stakeholders to design a comprehensive and sustainable health financing policy for the benefit of all. He reiterated government would not impose any policy to the detriment of any group of people and pledged to convey their issues to the President for immediate action (Ghana News Agency, 2012d).

Parliamentary and presidential elections were due to be held in December 2012. Government stood to gain political points by listening and responding favourably to the opposing voices and to lose if they did not. By March 16, 2012, the government had taken a decision to have primary care maternal health service removed from the basket of service. NHIA was to reimburse accredited health facilities through the G-DRG payment mechanism (Ministry of Health, 2012c).

It is of interest to note that four years on, in 2016, capitation is being scaled up in a step wise fashion with three regions of Ghana set to begin implementation any time soon. The process has been quiet and relatively free of the rancour and contestation of the original pilot to date. The reasons are a story in their own right. However part of it is definitely the organizational learning that occurred from the experiences of the pilot.

6.5 Discussion

This case illustrates the tensions and complicated relationships between technical consideration, contestation and political responsiveness in policy processes that combine to determine the outcomes of policy agenda setting and formulation, with the result of implementation processes sometimes leading backwards to a revision of the policy agenda and formulation.

The capitation payment mechanism was already legitimised by Law (Act 650) but dormant until multiple concern about financial challenges of running NHIS, high outpatient (primary health care) claims and the increased experience and technical skills with provider payment in the country made it just 'right' to implement primary care maternal health care services. We reason with Cook and Skogan (1990) that factors such as policy legitimisation, multiple source concern of an issue and a 'ripe climate' contribute to elevate the issue onto the agenda for implementation (Cook and Skogan, 1990).

Actions and decisions of opposing stakeholders (policy influencers) led to the fall of primary care maternal health services from the capitation policy. Opposing stakeholders in this case, relied on their professional, political and social sources of power to convince those to whom they had access, project their problems and by that reframed the issues to their benefit. They created a system of meaning (Ribot and Peluso, 2003) as they reframed issues from their understanding as well as ideas from others to manipulate revision of the policy. As suggested by Stone (2012 p. 176) policy actors use interpretation as strategic manipulation tool to frame issues to lend legitimacy and attract support to a course of action (Stone, 2012). In our case and also noted by Agyei-Baffour et al. (2013), the media was venue for information and rebuttal; and a breeding ground for multiple policy frames as stakeholders convey their ideas and influenced others. Decision making process related to the policy moved beyond the bureaucracy of the NHIA into the public arena as media

discussants and private self-financing providers reframed the policy issues. In the bureaucratic arena, though there were technical disagreements on what to include in the policy design, decisions were based on consensus. Conversely, in the public arena discussion, decisions were based on the media discussants and private self-financing providers' ability to manipulate interpretations of the policy in a politically skilful way to their benefit (Mintzberg, 1983) than facts. They used frames such as – “derail maternal health”; “political punishment”; “fraud region”; and “collapse health care” to make their arguments and gain political attention.

Within the public arena, not only did opposing stakeholders leverage their professional, political and social power to reframe issues, but also benefited from the context within which the policy was implemented to justify their actions. For instance, the Ashanti development group based on the political context – a ‘stronghold’ of NPP – questioned the rationale for introducing the policy in the region. Also, the private providers gained a high bargaining power and were able to resist the policy because they operated about 53 percent of the health facilities in the region (Ashanti Regional Health Directorate, 2010). The fact is that private providers' resistance imposed limits on the NHIA and the Committee's power on the policy implementation.

Limits on power by resistance contribute to the outcomes of power relations (Barbalet, 1985) and the outcomes at different stages of the policy process. In this case, power relations existed between the NHIA and Committee on one side and the private providers. During the formulation process, the NHIA and Committee with the authority and capacity and upper hand within the bureaucratic arena designed the capitation policy for implementation. On the other hand during the implementation process there was a shift in power; private providers with professional knowledge and skill to implement policies benefited from all the policy contestation within the public arena gained the upper hand and in effect influenced the removal of maternal primary care from the capitation policy.

Despite the recognition of the importance of stakeholder engagement and the use of a multi-stakeholder Committee that included providers; stakeholder identification, analysis and consultation was perhaps inadequate. Contestation is often an inevitable part of policy reform, and reform as major as provider payment with all the incentives inherent in different payment methods holds huge potential for contestation. More careful stakeholder analysis as part of the design and implementation process might have perhaps made some of the problems that precipitated a crisis e.g. selecting an opposition region for pilot of major reform; anticipated and perhaps avoided.

So what started as a seemingly quiet negotiation between the NHIA and private providers resulted in a dispute; and like a ‘snowball’ lead to a series of unanticipated effects. And as noted by Sterman (2006) and others, these

unanticipated effects are spontaneous and difficult to predict, and feeds back on its self - creating new situations (Stermann, 2006, Paina and Peters, 2012). In this case, the new situation – multiple issue reframing - intensified the attention and interest of the President and Minister of Health in the policy. Because, politics is driven by how people interpret and reframe information; and as such political actors strive to control interpretations (Stone, 2012) and debunk any unfavourable ones.

So, the policy with the opportunity to contain NHIA cost and improve continuous access to maternal health care was overturned by high politics and political responsiveness of the government. In a nutshell, a strong competing voice emerged within an enabling environment to dispute the policy through repeated multiple issue reframes. These factors are similar to those proposed by Cook and Skogan (1990) in their work on the fall of criminal victimization of the elderly from government's agenda (Cook and Skogan, 1990).

6.6 Conclusion

Policy formulation and implementation therefore is not only about technical considerations but also how policy influencers' particularly opposing actors frame and reframe issues to generate political attention and response. The tensions and complicated relationships between technical consideration, contestation and political responsiveness in the capitation policy processes raises some questions we pose for policy dialogue and further research. What is the relationship between government policy makers and private service providers in terms of government policy implementation? How is health care service cost determined? The dynamics of this relationship and how health care service delivery cost is calculated are vital for the overall health care system quest to attain universal health coverage and critical for government interventions to improve access to health care services especially in areas dominantly serviced by private providers.

The tensions and complicated relationships between technical considerations and politics and bureaucratic versus public arenas of conflict are important influences that can cause items to rise and fall on policy agendas.

Chapter 7

An abridged version of this chapter will be submitted to Health Policy and Planning as: Koduah A, van Dijk H, Agyepong IA. Power and networks of influence in health sector governance: national level decision making for maternal health policies in Ghana

7 Synthesis and conclusions

7.1 Introduction

The research has had as its objective to explore who formulates maternal health policies and the agenda setting and decision making processes through which policy actors operate in Ghana. Despite some decline, high maternal mortality remains a persistent problem in Ghana. This thesis proposed that a better understanding of conditions under which maternal health policy agenda and formulations are made can serve as lessons for decision makers to strategize and engage in making better informed policy decisions towards improving maternal health outcomes. The research questions specifically asked:

(RQ1) Which policy actors have been involved in maternal health policy agenda setting and formulation and what roles did they play?

(RQ2) What are the decision making processes related to maternal health policy agenda setting and formulation?

(RQ3) How did contextual factors influenced maternal health policy agenda setting and formulation and why?

(RQ4) How did policy actors define maternal health issues and why?

Four cases: maternal (antenatal, skilled delivery, and postnatal) fee exemption policy decisions; health sector programme of work maternal policy decisions; free family planning as part of the NHIS policy agenda; and primary care maternal health service capitation policy decisions were investigated to answer these four main research questions. This final chapter reflects on the research questions, presents theoretical and methodological considerations, policy implication and recommendations for future research.

7.2 Answering the research questions

Maternal and neonatal health is a national priority in Ghana a LMIC country. Maternal health policy agenda at national level is mainly set by political actors and the formulated policy is also mainly approved by political actors whilst bureaucrats, advocates and donors sometimes influence the direction of the policy agenda decisions made by the political actors and draft the accompanying policy guidelines for approval. A maternal health policy issue on the national agenda with or without accompanying policy guidelines does not guarantee implementation. However, as shown in these cases a sustained political and international support and interest in the maternal issue, availability of funds for implementation, and broad base support of health sector actors from national to the peripheral can move the policy agenda into implementation.

At national level, a maternal health policy agenda whether formulated into an accompanying policy guideline and implemented or not has the tendency to evolve in relation to a fast changing national economic and political and international context. These case studies point to three trends: (1) the possibility of a maternal health policy agenda to sustain and remain unchanged even as its accompanying policy guideline is constantly revised and modified along the way (chapter 3); (2) the ability of a maternal health policy agenda to gain political prominence and gradually fade and reduce in prominence with no accompanying policy guideline (chapter 5); and (3) the ability of a maternal health policy to be completely removed from a government agenda along with its accompanying policy guideline (chapter 6). These tendencies at national level agenda setting for maternal health and its evolution are contingent upon the actions of a large variety of policy actors including Presidents, political appointees, bureaucrats, donors, general public and service providers who consistently rely on power sources from one's resources, knowledge, skills or access to others; and context to define issues and influence decisions. The broad categorizations of the policy actors involved, the decision making processes domains in which they operate, the effect of context and problem definitions related to maternal health agenda setting and formulation are further highlighted to reflect on the main research questions.

7.2.1 Policy actors involved in maternal health policy decisions (RQ1)

Looking back on the four cases we can deduce two main overlapping categories of policy actors within the large variety of actors identified: (1) those who took the final decisions to set the agenda and approve policies and (2) those who influenced the agenda setting and formulation decisions and sometimes formulated policies.

We can further subdivide the first category (those who took the final agenda decisions and approved policies) into policy agenda directors and approvers; and these are generally political actors with the political mandate and power to take final

decisions and/or approve decisions made by policy formulators. There were a number of maternal health policy directives and approvals made by political actors. For example, Dr Nkrumah first set the free maternal policy agenda in 1963 and other political actors had over four and half decades sustained and modified the decision but never disapproved it (Koduah et al., 2015). Also, a Minister of Health first put the 'free family planning as part of NHIS' policy on the political (government) agenda in 2012 after several years of lobbying by both national and international policy actors. Again, a Minister of Health reversed a decision to reimburse providers primary maternal health care services delivered through per capita payment system, after less than three months of implementation (Koduah et al., 2016a). However, political actors giving directives or taking final national policy decisions is not peculiar to these cases, others (Green-Pedersen & Wilkerson 2006, Grindle and Thomas, 1991, Kingdon, 2003, Parsons, 1995) have noted similar findings different developing and developed settings.

We can further subdivide the second category (those who influenced agenda setting and formulation processes and sometimes formulate policies) into policy agenda advisers and advocates. The MOH and agencies bureaucrats, bilateral and multilateral donors played the primary role of policy agenda advisers and policy formulators. Whilst health professional bodies, service providers, general public and non-government organizations played the primary role of policy agenda advocates. These policy formulators, agenda advisers and advocates relied on power sources parallel to those suggested by Mintzberg (1983) such as access to knowledge, technical skills and structural and positional authority to influence each other and more importantly political actors. They used several strategies to lobby, bargain and convince those to whom they had access to push their interest and ideas.

One strategy was the use of country based empirical evidence from routine health management information system data and commissioned studies to lobby and bring to the attention of political actors and other policy influencers the causes of maternal deaths and morbidities, and solutions. Another strategy was the use of funding as a leverage and legitimate right to push ideas onto the government agenda; the one with the purse can and did direct the maternal health policy agenda and accompanying policy implementation guidelines. For example the IMF and World Bank directed the agenda and accompanying policy implementation guidelines to fee exemptions for four deprived regions as conditionality for the Ghanaian government to access the HIPC grants. Donors (especially USAID, DFID, UNFPA and World Bank) have largely financed family planning programme and had used their support as leverage to push the free family planning as part of the NHIS agenda. Another strategy was the power of collective action. As shown in these cases and also suggested by Bevir (2009), the policy influencers were able to secure decisions in the direction of their preferred policies when they collaborated

with each other in a collective manner. Policy influencers worked collectively by association and design. For instance the private services providers relied on their professional knowledge and skills, access to political actors, made reference to their professional identities and used their social power and 'street level bureaucrat' power (cf Lipsky, 1980, Ribot and Peluso, 2003, Mintzberg, 1983) and joined forces to contest and boycott the capitation policy. Their collective action led to their desired outcome - a removal of the primary care maternal health service from the capitation policy.

In conclusion, the two main categorisation: those who take the final decisions to set the agenda and approve public policy content (policy agenda directors and approvers) and influencers of agenda setting and formulation decisions (policy agenda advisers and advocates) present another way of policy actor categorisation and contributes to policy analysis knowledge. Some scholars (Kingdon, 2003, Buse et al., 2005, Mintzberg, 1983) categorize policy actors based on their position in the society or organization, but what we see here is another way to categorise and study policy actors based on their actions and use of power and authority without a necessary affiliation to an organization or position in society. Such categorization aids to further understand how policy actors use different power sources during political and technical interactions to effect public policy decisions in specific directions. For instance, a service provider or professional group representative as part of an expert committee can bring to bear his/her professional knowledge to formulate public policies and during a political interaction on the same or different policy issue can draw on their access to social and political power to direct specific decisions to their benefit.

7.2.2 Decision making processes related to maternal health policy decisions (RQ2)

Decision making processes at different periods in four domains - technical, public, institutionalised and political - can be identified as a result of cross-case analysis. Explaining decision making processes within these domains can provide some guidance to health practitioners and analyst who wish to understand national level decision making processes and entry points into the pluralistic (Ministry of Health, 2007) and sometimes elitist (Agyepong and Adjei, 2008, Seddoh and Akor, 2012) Ghanaian health sector. People who want to influence national level decisions can actively participate in one or more of these decision domains. Each has its own peculiarities and subtle rules of who can (or cannot) participate and one must strategize to be able to influence decisions within the domains.

Decision making processes within a technical domain

Looking back, decision making processes within a technical domain occur when policy advisers and formulators mainly with technical expertise and positional authority take decisions on specific policy issues usually based on a set of pre-determined objectives. Decision making usually occurred through consensus building among the experts on the appropriate way to design policy content within a 'closed' membership arrangement. Decision making processes may be temporary as the cases of the provider payment mechanism technical subcommittee (chapter 6) and the Konotey-Ahulu committee (chapter 3), or routine as the case of the MOH bureaucrat's operational activities within the health sector (chapters 3) and the health sector review process (chapter 4&5).

Administrative capacity to design policy content and technical expertise of experts, were some contextual factors associated with the technical domain. Administrative capacity of institutions mandated to design policy content is important because it determines which policies or organizational changes can be pursued effectively as suggested by Grindle and Thomas (1991) and shown in the case studies. For instance, the capitation policy was pursued in part because the administrative capacity of NHIA that existed in 2010 was able to facilitate the design process. Closely related to administrative capacity is the capacity of technical experts and their ability to use their power of knowledge to take decisions particularly irrespective of political directives. For example, the MOH bureaucrats based on their experience and technical expertise had narrowed a political directive to provide free maternal health care and formulated a policy implementation guideline of only four antenatal visits to reflect what was practically possible to implement at that time.

The case studies also point to the fact that decisions made in the technical domain are usually about formulation and not about agenda setting. However, in some instances the repercussions of these technical decisions in terms of policy implementation guidelines and recommendations reset or maintained an existing agenda. For example, the technical decision to include primary maternal health care service in the per capita payment system and implement in a region with more than 50 percent of its health care provided by private service providers lead to resistance and subsequent reset of the policy agenda. In another example, the National Redemption Council government maintained the decision not to implement the 1971 Hospital Fees Act 387 although the Konotey-Ahulu committee recommended that there could be no health services without fees (Konotey-Ahulu et al., 1970). In both cases there was resistance against technical advice, which led to changes and even abolishment of the technical decisions. This also highlights the limited extent to which policy in a LMIC setting can be based on technical advice/evidence. Technical advice/evidence is only part of a complexity of factors of which public opinion and politics are important.

Decision making processes within a public domain

Decision making processes within the public domain occur when people usually non-bureaucrats discuss and recommend and advocate for decisions on government policies in the public. Decision making processes in the public domain result from what Grindle and Thomas (1991) describe as reactions to policies perceived to have a direct impact on broader parts of the society and readily visible to the affected public. Looking back on the findings, people's reactions to government policies were based on their own understanding of how the policy personally affected them and how others interpreted the policy. The main strategy used by people in the public domain is framing and interpretation of issues to one's benefit. Framing and interpretations of issues ranged from people's views and understanding of the policy content, implementation arrangements to personal, political and social implications. The media platform was one of the venues for public discussions where through debates and rebuttals people explained their varied understanding of issues to drive the opinions of an issue. As findings from chapter 6 point out, in the public domain, technical reasoning and facts are of less importance.

The political context in which policies are designed and implemented, change in government, an election year, and the political leaning of a society affected by the policy implementation are some contextual factors associated with decision making processes in the public domain. Political context presents window of opportunities for people to express their views and leverage on the political responsiveness of governments to reset policy agendas. For example as discussed in chapter 3, the reintroduced hospital fee in February 1968 caused a public uproar and the new military government attempting to consolidate its political power and gain acceptance suspended the policy implementation to a later date. Also, as discussed in chapter 6, 2012 as an election year and the fact that Ashanti region is an opposition region contributed to the Minister and President's responsiveness to the capitation policy saga.

Decision making processes within an institutionalised policy dialogue domain

The design of the programme of work which provides strategic direction for the health sector is associated with this domain. Decision making processes within the institutionalised policy dialogue domain allows for structured interactions as illustrated in figure 4.2. The MOH and agencies bureaucrats, donors, POW reviewers and other stakeholders engage in this domain. However as discussed in chapter 4, priorities, programmes and budget allocations decisions rest with the MOH and donors. This is because through the sector wide approach reforms, donors have gained rights-based access (Ribot & Peluso, 2003) to national level agenda setting and formulation and are allowed to partake in decision making in exchange for their financial support (Koduah et al., 2015).

Case studies discussed in chapters 4 and 5 point to alignment to existing national strategic plans such as Ghana poverty reduction strategy, and international agendas such as the MDGs, availability of financial means, and worsening maternal health indicator as some contextual factors influencing decisions within this domain. If we look back on decisions taken within the institutionalised process, the MOH and donors relied on broader national and international policies to inform the programme of work agenda. Although, indicator of maternal health mortality was not the only influencing factor as showed in these cases, the policy formulators and advisers nevertheless used this evidence to support their ideas. Moreover, the availability of financial means whether international support from the World Bank, IMF, donor earmarked and budget support, or government was a major determinant of what appeared on the programme of work agenda.

Decision making processes within a political domain

Decision making processes in the political domain is where politicians (Presidents, Parliamentarians, political appointees, and political party's members) in- and outside government operate to take and approve national level decisions. Decisions taken within the political domain are associated more with maternal policy agenda setting and less with policy content for implementation. At national level decision making in the political domain is an ongoing process because firstly, politicians outside government are in the business of constantly scrutinizing and challenging government policies and secondly the government is mandated (and obliged) under the 1992 Constitution to constantly take public policy decisions to ensure citizen's access to good health care (Government of Ghana, 1992).

Political actors' actions and inactions depend on what is at stake in terms of the public welfare, international recognition, and political gains. This finding is similar to what Grindle and Thomas (1991) noted in their work on political economy of reform in developing countries. In our case, politicians sometimes took decisions based on what policy advisers and advocates drew their attention to, but the politicians were also mindful of their political gains especially in an election year. So though decision making processes within the political domain is ongoing and routine, when the stakes are high, some maternal health policy decisions are put in the public domain to show government's commitment to the populace. For example, when maternal health indicators worsened and the country was off track the MDG 5 target, President Kufuor publically announced a free maternal health care policy as government's commitment to tackle maternal mortality. On the hand, when the stakes are low, it becomes what Grindle and Thomas (1991) described as 'politics-as-usual' where political actors approve decisions of policy agenda advisers as in the case of the institutionalised policy dialogue decisions.

In summary the decision making processes domains are fluid and interconnected to each other, for example processes in the public domain are generally profoundly political and affect the processes in the political domain. Similarly the technical processes sometimes impact the public for instance an expert recommendation and debate can trigger discussions within the public domain. However, the entry points to these decision making processes may vary. The entry point into the technical domain is dependent on one's expertise as well as availability to engage in the decision making process. The public domain entry point is open and as such people who can invest time, advocate and interpret issues publically to their benefit can actively participate. The institutionalised dialogue domain have several entry points but with controlled participation. The multi-stakeholder health summit is open to all stakeholders within and outside the health sector. But participation in the business meeting is controlled and dependent on how much funds one brings to the table. However, the use of empirical evidence from reviews, operational studies and research finding during the institutionalised policy dialogue present a window of opportunity for stakeholders with technical expertise to invest time and generate evidence and advocate for its use in policy development. The political domain is limited to the Presidents, Parliamentarians, political appointees, and political party's members and cronies.

7.2.3 The effect of contextual factors effect on maternal health policy decisions (RQ3)

Policy actors' relationship with different contextual levels (international, national and local) and their ability to operate across these levels to affect a policy decision, and the effect of various contextual factors on the evolution of a policy agenda are the main points of influence of context on national level maternal health policy agenda and formulation decisions.

A variety of policy actors operate in several ways at different contextual levels to influence national level decisions as shown in the case studies. An example is the role of donor staffs representing international organizations and countries who actively participate in global maternal health related meetings, transmit knowledge of global thinking, decisions and funding sources and also operate at national level in close connection with national policy makers. In this way they operate at national level by virtue of the context of their financial support and participation in the sector wide approach to health care promoting global thinking such as the MDGs as they engage with national bureaucrats and political actors. For example, the 2003 maternal health fee exemption for four deprived regions national policy was formulated because of the poverty reduction strategy directed towards attainment of anti-poverty objectives consistent with the MDGs and availability of the HIPC grant which were both international initiatives.

Another example is how policy actors across different contextual levels defined maternal health issues differently. At international level, donors focus primarily on the global maternal health picture and presumed benefits to a country of their presumptive solutions. Whilst at national level, political appointees and bureaucrats focus primarily on national context of politics, sustained financial means for implementation and a broader actor support for the policy within the Ghanaian health sector. Family planning for example has an international focus and support and the USAID, UNFPA and DFID actively promoted the 'free family planning as part of NHIS' policy based on cost and benefits assessment of including contraceptives in the NHIS package. Meanwhile, implementation had stalled because political actors and bureaucrats are not completely convinced of how to continuously fund and implement a policy (of free contraceptives) and avoid future funding constraints and the possibility of the 'free contraceptives' ending on the market in the financial and policy implementation context of Ghana's health sector.

Varied interrelating context whether a constraint or an opportunity influenced the timely manner in which a policy guideline can be formulated and implemented and closely linked to the intended agenda. Our findings are similar to findings by Grindle and Thomas (1991) in their study of public choices and policy change in developing countries that context in interrelating manner can serve as a constraint and an opportunity within which policy actors act to accomplish their goals. For example, within the context of high maternal mortality, political authority and a presidential directive, economic decline, limited financial means from the government for full implementation, the MOH bureaucrats implemented fee exemption policy for only four antenatal visits 11 months after the free maternal health directive. Conversely, contextual factors working in an interrelated manner as an opportunity presented bureaucrats, donors and political actors with complementary options and shaped the 2008 free maternal directive implementation to be made in a timely manner and more closely linked to the intended agenda. Within the context of high maternal mortality, political authority and will, donor health sector budget support, an election year, broader actor support to reduce maternal deaths, and international agenda – MDG 4&5 - the policy guidelines of fee exemption for antenatal, delivery and postnatal was developed and implemented within 2 months after the Presidential directive.

7.2.4 Problem definitions related to maternal health policy decisions (RQ4)

Problem definitions (framing) show how policy actors understood, debated and tried to persuaded others on maternal health issues and influence final decision makers and tried to get policy issues onto the agenda. As noted by Rochefort and Cobb (1993) and shown in the case studies there is not a single fixed maternal problem definition narrative, policy actors therefore related to context and their power

sources parallel to those suggested by Mintzberg (1983) such as access to knowledge and technical skills to define maternal health issues and policy narratives.

The problem definition focused mainly on: (1) highlighting the severity of maternal health problems, (2) connecting with other national and international policies and agendas, (3) promoting specific interventions and programmes and (4) highlighting challenges of maternal policy implementation. First, policy agenda advisers especially relied on empirical evidence to highlight maternal health problems for attention. Inputs from empirical evidence provided information from which comparisons were made and the severity of the issue was underlined. As shown in the case studies and also noted by Grindle and Thomas (1991) policy actors used empirical evidence to advocate and garner support for specific policy decisions. For example, the MOH bureaucrats used the high maternal mortality narrative to advise the National Liberation Council government in 1969 for government to maintain the fee exemption policy for maternal health services.

Ghana has signed on to international agreements and usually develops new policies or aligns to existing ones to achieve them (Campbell, 2001, Ministry of Health, 2007). International agendas do come with conditionalities and funding opportunities. Therefore, political actors and bureaucrats especially tend to connect to the problem definitions and policy narratives of these global agendas and adopt it for national policies. For example as discussed in chapter 3, the user fee exemption policy in 2003 for the four most deprived regions was influenced by policy narratives from the poverty reduction strategy in line with the MDGs targets and the IMF and World Bank HIPC initiative.

Third, policy actors also relied on existing problem definitions and policy narratives from interventions proven to improve maternal health outcomes. Notably are skilled delivery, maternal fee exemptions, provision of emergency obstetric services and contraceptives. Additional, these interventions are usually promoted by agencies such the International Federation of Gynaecology Obstetric and International Midwives Union making them even more important in maternal health care (Government of Ghana, 2006, World Health Organization et al., 2004), and credible to receive financial support from donors. Therefore, policy actors frame maternal health issues and policy narratives to ensure that these interventions became what Rochefort and Cobb (1993) describe as long-term fixtures on the health sector agenda.

Finally, maternal health policies implementation challenges also contributed to the problem defining process. Most challenges that informed the defining process were uncovered from studies and programme evaluations (e.g. Maternal fee exemption policy evaluation, (Witter and Adjei, 2007)), and POW reviews (e.g. Aligning exemption policy and practise with poverty reduction goals (Ministry of Health, 2003a)). The terms of reference of these studies usually contain already a

problem definition about which policy actors such as MOH and donors agree to a certain extent. These studies, programme evaluations and reviews usually highlighted maternal policy implementation challenges due to inadequate financial, human and material resources. But, the case studies point to the importance of the availability of financial resource as the principal solution to maternal health problems whether material, human or financial. Therefore the one with money (a solution) is particularly powerful during the problem definition process and as suggested by Rochefort and Cobb (1993) a problem definition with a solution is likely to garner general support. In our case, the policy narrative promoted by the one with financial resource usually dominates the problem definition process as they persuade others to see the ‘solution’ in their policy narratives. This findings is similar to argument by Mosse (2005), that policy actors have power to control problem definition process and translate their dominate policy narratives into other people’s own solutions.

Surrounding situations that trigger problem definitions of maternal health discussed here and in chapters (3-6) were used by policy actors more in some decision making processes domains than others. Table 7.1 summarises the surrounding situations used in problem definitions in the specific decision making processes domains.

Table 7.1: Surrounding situations that trigger problem definitions of maternal health

Technical domain <ul style="list-style-type: none"> • Empirical evidence from routine health management information system, demographic health surveys, cost effectiveness analysis, and economic and financial situational analysis • Situational analysis of economic and financial context • Policy implementation challenges such as inadequate financial, material and human resources • Prior or similar pursued policies • Interventions proven to improve maternal health outcomes 	Public domain <ul style="list-style-type: none"> • Perceived effect of government policy • Societal political leaning • People’s anticipated risk of policy implementation • Administrative challenge such as unresolved negotiations between policy makers and implementers
Political domain <ul style="list-style-type: none"> • Public perception and interpretation of government policies 	Institutionalised policy dialogue domain <ul style="list-style-type: none"> • Empirical evidence from routine health management information

<ul style="list-style-type: none"> • Worsen maternal health outcomes and indicators • International and national agreements and plans • Societal political leaning • Electoral period • Anticipated political risk • Public mood and opinion 	<p>system, demographic health surveys, cost effectiveness analysis, and economic and financial situational analysis</p> <ul style="list-style-type: none"> • Financial commitment and availability • International and national context, agendas and targets • Interventions proven to improve maternal health outcomes • Inability of some women to pay out of pocket for maternal health care and other reproductive health services such as family planning
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7.3 Theoretical and methodological considerations

Theoretical consideration and contribution

In literature on LMICs health policy analysis is often descriptive with little or no theoretical considerations, however, theoretical considerations and insights can advance the study of health policy and systems research supporting policy learning beyond where the research was conducted and enhancing research rigour and quality (Gilson et al., 2011, Gilson and Raphaely, 2008). The stage heuristic framework (Sabatier, 2007) and power approaches to decision making perspectives (Parsons, 1995) were used to organise the enquiry – an analysis of the maternal health policy process - given the complexity in studying policy and to highlight policy actors’ use of power to influence maternal health agenda setting and the formulation of decisions in relation to the various power sources of policy actors. The interconnectedness and varied effects of actions within the stages (agenda setting, formulation, implementation and evaluation) on each other show the complexity of the policy making process (Sabatier, 2007). However, zooming on agenda setting and formulation allowed unpacking of this complexity and gave insights into the policy making processes (Kingdon, 2003).

Power is the heart of health policy making (Erasmus and Gilson, 2008, Weissert and Weissert, 2012) so drawing on power approaches to decision making, Mintzberg’s conceptualisation of power and Ribot and Peluso’s theory of access that is benefits from access to power emanating from people and institutions was appropriate to unpack the varied power sources of policy actors, how they deal with and control each other and the processes through which they are able to exercise their powers. The empirically grounded case studies point to the importance of

power (control over and access to knowledge, skills, resources and authority) and its use in a skilful way to convince those to whom one has access, to use one's resources, evidence, authority and technical expertise to their fullest in negotiation, to sense what is possible and to organise the necessary alliances and networks – as suggested by Mintzberg (1983). However, the use of power as a means of influence to effect a desired decision and action as argued by Mintzberg can occur around a specific policy issue at multi-levels to impede some policy actors' desired action. As shown in chapter 5 donors, advocates and bureaucrats with means of influence around the family planning decisions by virtue of their evidence of family planning benefits to maternal health care, control over donor budget support, lobbying expertise and positional and structural authority within the health sector could not yet influence the implementation of the free family planning as part of NHIS policy agenda. A possible stronger power source – a combination of sustained political interest, financial means to implement, and broader based actor support – untapped by bureaucrats, advocates and donors resulted in their inability to influence policy implementation – their desired action.

The analytical framework (figure 1.1) and the assumed relationships between – policy actors, power, problem definition and context – allowed the study of how policy actors within specific contexts used their power sources to define maternal problems and framed accompanying course of action in the Ghanaian pluralist and sometimes elitist health sector. The study findings give new theoretical insights to public policy analysis in several ways. First, the results of the empirical analysis of how bureaucrats, donors, advocates, services providers, the general public and political actors within a LMIC setting are able to exercise power, control and maintain access to others under different periods and context to – influence and make maternal health policy agenda and formulation decisions. Second, the categorisation of policy actors based on their actions as policy directors and approvers (those who take final decisions) and policy advisers and advocates (those who influence decisions and formulate policies) and their interactions with the different decision making processes (technical, public, institutionalised and political) domains identified.

Thirdly, we were able to link these categories of policy actors to specific decision making processes domains. The domains as entry points into the policy process present policy actors' unique opportunities to interact and use their power sources and surrounding situations as negotiation tools to control each other and decisions. Decision making processes in the public and technical domains are similar to Grindle and Thomas (1991) public and bureaucratic arena of decision making, what the thesis contribute are examples of decision making processes within the institutionalised and political domains in a LMIC setting and the effect on maternal health policy agenda and formulation. Fourth, is the idea of network of influence.

Network of influence is the collective action of policy actors to effect a policy decision. The case studies point to the important role of network of influence in: (1) maintaining maternal fee exemption policy agenda over time (Koduah et al., 2015); (2) constantly revising and maintaining other policies as long term fixtures on the POW agenda (Koduah et al., 2016); (3) pushing free family planning as part of the NHIS onto the government's agenda (chapter 5); and (4) resisting health financing and maternal health service delivery reforms (Koduah et al., 2016a). A network of influence is steered by power relationships between policy actors. Some actors such as donors had the upper hand in the power relationship because they controlled financial resources access while others for example the MOH simply maintained their access through those who had control. Understanding a network of influence and how policy actors controlled and maintained access to resources can help to explain how they are able to influence policy agenda and formulation decisions in a LMIC setting.

Methodological reflection

One main methodological concern was how to retrospectively piece information together in a systematic way to develop comprehensive case studies acknowledging the difficulty in mapping out the exact sequence of events. However, reviewing various documents (listed in appendix 1), participating in and studying ongoing health sector discussions (listed in appendix 2), following policy actors interactions and the policies evolution over time, and attempts to follow the money – allowed to reconstruct insofar as possible the interactions and processes surrounding the four cases. Additionally being an 'insider/outsider' and participating in high level meeting and analytically observing policy actors interactions, I gained understanding of the thinking behind some decisions recorded as collective decisions in national documents and this understanding complemented interpretations of findings from the documents reviews. However, following the money was difficult, because financial allocations were sometimes lumped without stating the individual donor's identity and contribution to a specific policy, and the actual funds disbursed and spent on the policies investigated were not publically available. Inability to trace actual expenditure was not peculiar to this research, the National Health Account study that tracks the flow of funds through the health system, from their sources through those who control them to their end uses experienced similar difficulties, and reports that financial information obtained from primary and secondary data were aggregated making it difficult to disaggregate the financial information to determine certain sub-classification such as actual expenditure for specific policy implementation (Ministry of Health, 2013a).

Studying who formulates maternal health policies and the agenda setting and decision making processes through which policy actors operate, was not a linear but

a complex iterative process with back and forth refining and modifying the set of research questions, developing understanding, following interesting lines and reviewing cases to study in the light of ongoing policy discussions. Conducting the research also involved studying the non-linear feedback effect of maternal health policy implementation and evaluation on the national level agenda for maternal health and policy formulation. Given the complexity in studying how policies are made, I recommend the following methodological activities for the study of public policies: participate in ongoing policy making processes within context of the study, follow policy actors interactions and discussions, follow the policy issue over time and follow the money – though difficult.

Another methodological concern was related to the generalizability of the study findings. This is a major methodological concern of a case study design (Yin, 2009, Robson, 2011). The problem of generalizability of these cases arises as with many case studies. One may question whether the evidence from studying four cases could provide an understanding of national level maternal health policy decisions in Ghana. However, when you look at the empirically-grounded four cases which investigated different policies at different periods, the findings all point to the same general conclusions. The policy agenda directors, approvers, advisers and advocates reliance on context and use of power sources to frame issues and effect maternal health policy agenda setting and formulation decisions at national level. Additionally, case studies like experiments, are generalizable to formulate theoretical propositions and not to populations or the universe (Yin, 2009). Theoretical propositions entail the development of general conclusions that although derived from limited number of cases, provide theoretical insights that can be put forward for consideration and testing in other similar situations (Gilson Lucy, 2012). Therefore the general conclusions and theoretical insights of this study in terms of power sources, problem definition, policy actors, and context can be tested by applying to other health policy decisions in Ghana and other LMIC setting with similar broader economic, social and political context. Also, the general conclusions and theoretical conclusions can be tested through comparative case studies of maternal health policy agenda setting and formulation across LMIC settings. The general conclusions can be extended to study other policy processes such as implementation and evaluation.

7.4 Policy implication and future research

The case studies highlight how policy making for maternal health happens in reality instead of what should. In reality the national level policy agenda and formulation decision making for maternal health is complex and intertwined with a mix of political, evidence based, varied interpretation of maternal problems, finance-based, path-dependent and donor driven processes, in a LMIC setting - Ghana. Therefore

decision makers and analysts who want to influence national agendas and policy content need to pay attention to the power sources, power relations between final decision makers and policy influencers, the varied decision making processes domains and the effect of context in any strategy.

Public policy actors in Ghana have evolved over the years from predominately government and bureaucrats to include donors and service providers, as shown in the case studies. This shift brings a new power dynamics within the health sector, as donor and service providers seek to push their interest onto the government agenda and influence decisions to their favour. In addition to the shift in power dynamics, national political actors who take final decisions usually rely on international agendas and influence as well as international and national discourse to direct the national policy agenda. All these issues have implications for ongoing and future formulation of maternal health policies designed to reduce maternal deaths.

A first implication is the role and influence of donors in maternal policy agenda and formulation decisions and its consequences for ongoing public policy decision making processes. The donors have sometimes influenced political actors to set national agenda in specific directions and greatly influenced the accompanying policy contents because of their funding to the health sector. This is not peculiar to Ghana, Uganda's national policy development had also followed blueprints drawn by donors (Jeppsson, 2002). Donors may have pushed their ideas out of humanitarian interest or otherwise, but what matters is to understand the relevance of the donor driven policies to avoid a mismatch of donor priorities and practical realities. Findings show that donor blueprints such as the HIPC initiative and their subtle push of ideas during the policy dialogue processes advance their interest onto the government agenda. Because the national agenda tends to follow these donor blueprints and accompanying financial support, a structure of accountability is created where donors demand accountability on policy and programme implementation from government and MOH bureaucrats. This accountability structure existed over the years and was formalised under the SWAp arrangements (Birungi et al., 2006, Addai and Gaere, 2001). The accountability structure signifies the power relation between donors and the MOH bureaucrats and reflects what Ribot and Peluso (2003) described when they distinguish how people and institutions control resources access while others must maintain their access through those who have control. Donors control earmarked and budget support access and the MOH bureaucrats to benefit have maintained relation with donors. But the basis of this relationship under the SWAp had shifted because of the demise of the 'basket funding' and donors' movement back towards vertical programme funding and parallel systems (Ministry of Health, 2013a), however, the government and MOH bureaucrats still periodically account to donors.

Donor's activities within the health sector are institutionalised and they cannot be ignored, however, in the light of Ghana's status as a LMIC, reduced donor funding and the demise of the basket funding (Moss and Majerowicz, 2012, Camp and Musinguzi, 2011, Ministry of Health, 2013a), there is the need for a paradigm shift and urgent reforms in the following ways. One, government and MOH bureaucrats must rethink their relationship and accountability structures with donors, and design new structures that reflect the current relationship. Two, government and MOH must access resources of other stakeholders to improve maternal health outcomes and to maintain sufficient budget. I recommend the government and MOH build extra technical and strategic capacity to engage other actors who can facilitate potential maternal policy change in terms of budget allocation and implementation to minimise policy implementation uncertainties. As argued by others (Aberese-Ako et al., 2014, Kwamie et al., 2014), the Ghanaian maternal policies implementation at district and hospital levels are compromised due to uncertainties about the flow of financial, material and human resources. Therefore to reduce implementation uncertainties, the MOH must develop a coherent and consistent policy making process and decisions such that maternal policies formulated are implementable with the requisite resources. To do this, the MOH must engage more with the Ministry of Finance and Economic Planning and lobby for increased GOG allocation and disbursement. The MOH also needs to develop their human and institutional capacities to build commitment and consensus with health services providers on maternal health ideas relevant to actual needs and practical realities, and create and maintain access to service providers' expertise and experience to build collective support for policy design and implementation towards reducing maternal deaths.

A third implication is that the national level policy makers need to rethink the role and influence of private (self-financing and not-for-profit) service providers in public maternal health policy agenda and the formulation of decisions for implementation. The case studies gave an example of how private (self-financing) service providers' resisted a policy reform and implementation because of their disagreement with the policy implementation arrangements and misunderstandings between them and the policy formulators. The private self-financing and not-for-profit service providers are key stakeholders in service delivery in the urban and rural areas respectively (Ministry of Health, 2013b, Ghana Statistical Service, 2014) and are potential ally in the government's quest to increase access to health care services across the country (Ministry of Health, 2007). However, the involvement of private sector actors in national policy design appears limited, for example within the institutionalised dialogue process where decisions are greatly skewed to the interest of MOH and donors, the private service providers have limited ability to influence national decisions unless they publicly resist and contest a policy reform

and implementation and gain political and social attention. The MOH must therefore engage and negotiate more with private sector actors in policy decisions at national level and address conflicting issues early to avoid resistance to public policies as in the case of the private self-financing providers, and support the private not-for-profit providers in implementing the policies in rural and hard-to-reach communities. The MOH and private sector must compromise and find a common ground for the delivery of public health care (public goods). This is particularly important because the private (self-financing) service providers' primary interest is to make profit and may oppose any public policy that threatens their business.

A fourth implication is the effect of the interconnectedness of the different decision making processes domains identified and its possible consequence. Decisions made in the technical, public, institutionalised and political domains are interrelated and fluid in that maternal health policy issues can be discussed and decisions taken in more than one domain. As the case studies point to actions in one domain can lead to unintended (or intended) and unpredictable (or predictable) decisions taken in another domain. Policy actors working in these domains on different aspects of public policies to reduce maternal deaths are not only involved in formulating and influencing policies but are also involved in the national efforts to reduce maternal deaths. There is a potential for decisions taken on the same maternal health policy issue in different domains to contradict each other as was the case of primary care maternal health service under the per capita payment system (Koduah et al., 2016a). Such occurrences can lead to power clashes and impede policy implementation and reset or modify the policy agenda and accompanying policy contents. The ability of public policy decisions related to maternal health to contradict in these domains shows the complexity in formulating, sustaining and implementing policies that can work together to reduce maternal deaths. As a leader and coordinator of the health sector policies, the MOH needs to especially appreciate such happenings and build strategies to mitigate any unforeseen outcomes and actively scout for possible opportunities or threats within these different domains to formulate sustainable public policies for implementation to reduce maternal deaths.

Recommendations for further research

The dynamics of power relations among policy actors are less understood and require further investigation. The degree of control by policy actors within their collective influence to affect a decision is less clear. Political actors and policy influencers bring different forms of power to the network of influence, what is less understood is the relative weight and the ability of different power sources to control decisions and actions. For example the power relation between the donors and MOH is such that donor use financial resources and the MOH authority to control and maintain their relationship. What is less understood is how other sources of power

such as knowledge, experience and interpretation of facts weigh on either the donors or the MOH's ability to control decisions and actions within their relationship, and access to other influencers within the Ghanaian health sector and beyond. I recommend further research to explain the policy actors' power relations in light of the issues raised.

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Appendix

Appendix 1: Documents reviewed

Document	Year
Laws	
Ghana Health Service and Teaching Hospital Act 525	1996
Hospital Fees Act 387 - 1971	1971
Hospital Fees Ordinance CAP 82 (1897)	1942
Hospital Fees Decree, NLCD 360	1969
Hospital Fees Regulations, Legislative Instrument 1277,1313	1983,1985
National Health Insurance Act (650,852)	2003, 2012
National Health Insurance Regulations, Legislative Instrument 1809	2004
The 1992 Constitution of Ghana- Act 527	1992
Reports	
Health sector Aide memoire	2001-2013
Aligning exemption policy and practice with poverty reduction goals	2003
Annual programme of work	2002-2014
Independent review of the annual programme of work	2001-2013
Inter-Agency Leadership Committee report (April 2009)	2009
Health sector medium term development plan	[2002-2006,2007-2011, 2010-2013]
Pro-poor Agenda	2004
Report of the committee appointed to investigate hospital fees	1970
Review of the Exemption Policy	2006
The Health Sector response to Maternal Mortality	2004
Meeting records	
Health sector working group meetings	[12 January 2012, 9 February 2012, 3 May 2012, 7 June 2012, 5 July 2012]
Inter-agency leadership committee meeting	[9 March 2011, 1 Dec 2011, 10 April 2012]
Provider Payment Mechanism Technical Subcommittee	[2010-2012]

Media	
Ghana News Agency website	2008-2014
Ghanaian Daily Graphic	1957- 2014

Appendix 2: Meetings attended during field work

Meetings	Dates
Business meeting	17 August 2012 20 November 2012 2 May 2013 20-21 November 2014
Capitation evaluation meeting	12 February 2012
DFID meeting on health sector budget support	15 November 2012
Free family planning committee meeting	13 December 2012
Health sector working group meetings	5 July 2012 6 September 2012 7 February 2013 20 March 2014
Inter-agency performance review meeting	16-17 August 2012 12-13 September 2013 4-5 April 2013 20-21 August 2014
MDG Acceleration Framework (MAF) regional (Central & Western) planning meetings	8-12 October 2012
MAF teaching hospitals and training institutions planning meeting	3-5 January 2013
MAF national monitoring and evaluation meeting	12 October 2012
MOH budget committee meeting	5 September 2012
MOH budget hearing at the Ministry of Finance and Economic Planning	20 September 2012
MOH internal review meeting	7 August 2012 21 March 2013
Monitoring visit to Ashanti region; series of meetings	6th-9th November 2012
Multi-stakeholder health summit	29-30 April 2013
National workshop with accountability framework with special reference towards women and	3-4 October 2012

Meetings	Dates
children's health meeting	
NHIA stakeholder meeting	21 – 22 December 2012
PPME general meeting	25 June 2012 30 August 2012
PPME unit heads meeting	10, 23 July 2012 13 August 2012 4, 10 September 2012 15, 22 October 2012 12,19 November 2012
Pre budget review meeting	12 September 2012
Pre business meeting	16 November 2012
Pre health summit meeting	19 th April 2013
Provider Payment Mechanism Technical Subcommittee	29 August 2014
Stakeholder meeting on institutional mortality	27-28 March 2014

Appendix 3: List of respondents

Respondent type	Number
Government	
Ashanti regional health directorate	2
Ghana health service headquarters	5
Minister of Health	1
Ministry of health former staff	3
Ministry of Health	10
National Health Insurance Authority	4
Provider payment mechanism technical sub-committee	2
Public health facility service provider in Ashanti region	4
Non-government	
Christian Health Association of Ghana	1
Coalition of non-government organization in health (National and Ashanti region representative)	2
Donors	8
Health professional bodies	5
Opposition politician (former Minister of Health)	1
Private not-for-profit service provider	1
Private self-financing service providers	3

Summary

Maternal and neonatal deaths and morbidity still pose an enormous challenge for health authorities in Ghana, a lower middle income country. Despite massive investments in maternal and neonatal health and special attention through Millennium Development Goals (MDG) 4 and 5, Ghana still have high mortality rates. At national level, policy decision makers to improve maternal outcomes have over the years developed several public policies to increase financial and geographical access to maternal care; space child birth; provide essential obstetric care; expand midwifery coverage; make equipment available and many more.

The problem of maternal mortality persist and this raises the question of what essentially goes into public policy making given the failure to achieve targets despite several maternal health policies developed for implementation. This thesis thus aims to advance our understanding of who makes maternal health policies and the agenda setting and formulation decision making processes through which they operate, in Ghana; and out of these understanding present potential lessons for policy actors to engage in making better informed policy decisions to improve maternal health.

To understand factors and processes that influence national level maternal policy agenda and formulation decisions; we conceptualised that maternal policy decision making is predominately influenced by how policy actors within specific context use their power sources to define issues and frame accompanying course of action. The main research questions are:

1. Which policy actors have been involved in maternal health policy agenda setting and formulation and what roles did they play and why?
2. What are the decision making processes related to maternal health policy agenda setting and formulation?
3. How did contextual factors influenced maternal health policy agenda setting and formulation and why?
4. How did policy actors define maternal health issues and why?

To investigate maternal policy agenda setting and formulation decision making in-depth, a multiple case study design with qualitative methods of data collection was used. The case study approach allowed me to look at maternal health policy decisions not merely as inputs and outputs but to better understand within context the processes and policy actors involved. Field work in the Ghanaian health sector, through observation and participation in the work of the Ministry of Health, steered the selection of the cases. Four cases: maternal (antenatal, delivery, and postnatal) fee exemption policy decisions, health sector programme of work maternal health policy decisions, free family planning as part of NHIS policy decision, and primary care maternal health service capitation policy decisions were investigated.

The field work was conducted between May 2012 and August 2014. Multiple data collection methods including document review, interviews and observations were used to collect historical and current information and contribute to the validity and reliability of the research findings. Data were analysed drawing on an analytical framework in which concepts of organizational power, context, policy actors and problem definition were central elements.

Case 1

Historical and contemporary fee exemption policies for maternal (antenatal, skilled delivery and postnatal) health services were explored. Specifically we ask: How have maternal user fee exemption policies evolved in Ghana since independence? Which actors have been involved in the policy agenda setting and formulation and why? What contextual factors influenced the process over time, how and why? Nine specific policies were identified along the pathway as, the policies evolved from user fee exemptions to national health insurance premium exemption. The policy was first introduced in 1963 and has remained on the government agenda over four and over decades in a fluid process of ebbs and flows rather than in a static fixed form. Contextual factors and various policy actors were the major influencers of the ebbs and flows. Contextual factors that influenced the ebbs and flows were: political such as Nkrumah's ideology of free access to health care and education, changes in government, and presidential election year; economic crises and development partners' austerity measures; worsening health and demographic indicators; historical events; social unrest; and international agendas such as the MDGs. These contextual factors served as a source of power for policy actors to sustain maternal fee exemption agenda over time. The case study showed that various categories of policy influencers (policy agenda advisers and advocates) and final decision makers (policy agenda directors and approvers) operated within these interrelated contextual factors, which sometimes worked as constraints and sometimes opened opportunities. These contextual factors shaped the timely manner in which policy content was formulated and level of deviation from the intended agenda at each specific decision period. For instance, contextual factors such as declined health budget allocation and high maternal mortality presented the ministry of health bureaucrats with an option to formulate the policy content in a less timely manner and away from the intended agenda of 1997 free maternal care presidential directive. Whilst, within the context of austerity measure and Ghana poverty reduction strategy, maternal fee exemption policy for four deprived regions was formulated in a timely manner and closely linked to the poverty strategy.

Case 2

The case explored how and why maternal health policy and programme agenda items appeared and evolved in the framework of the Ghanaian health sector programme of work agenda between 2002 and 2012. Our specific research questions

were: Which maternal health policies were prioritised? How did they evolve on the agenda and why? We examined decision maker's problem definition and decision making processes, theorizing that a policy or programme's appearance and fate on the POW agenda is predominantly influenced by how decision makers use their source of power to define problems and frame their policy narratives and accompanying course of actions.

Ministry of health bureaucrats and donors used their power sources as negotiation tools to frame maternal health issues and design maternal health policies and programmes within the framework of the national health sector programme of work. The power sources identified included legal and structural authority; access to authority by way of political influence; control over and access to resources (mainly financial); access to evidence in the form of health sector performance reviews and demographic health surveys; and knowledge of national plans such as Ghana Poverty Reduction Strategy. Bureaucrats and donors used their power sources to define, frame and label issues for attention making some policies such as family planning long term fixtures on the agenda. They used labels such as 'inadequate obstetric care', 'family planning unmet needs', 'maternal health a poverty issue', and 'poor maternal health a national emergency' – for actions and to ensure the continuous flow of donor and government funding.

Case 3

The case investigated how and why 'free family planning as part of the NHIS' policy attained a position on government agenda in 2012 but has not subsequently moved into formulation and implementation in Ghana. Relying on their power sources such as access to bodies of evidence; bureaucrats, donors, reviewers and reproductive health advocates framed inadequate budgetary allocation and disbursement for family planning and exclusion of family planning services from the national health insurance benefits package - as a major challenge to family planning contribution to maternal health care; and free family planning as potential life and cost saving. Drawing on their legal and structural access to institutionalized public policy processes in Ghana, they proposed the following policy options: include family planning service in the national health insurance benefits package and increase government and donor financial support. The interests of the supporting actors were two fold to eliminate out of pocket payments for family planning service and still sustain the financial needs of the family planning programme through the National Health Insurance Scheme. A window of opportunity opened when a Minister of Health receptive to these problem definitions and policy options publically voiced support for 'free family planning as part of the NHIS; policy and therefore pushed it high and visibly onto the public policy /government agenda. However, the policy failed to move into formulation and implementation. Factors that influenced this failure included the lack of a stronger, broad based health sector actor support and

related inability to agree on and develop policy implementation guidelines; and maintain political access and interest in the issue after it was moved up the agenda.

Case 4

This case explored how and why less than three months into the implementation of a pilot prior to national scale up; primary care maternal services that were part of the basket of services in a primary care per capita national health insurance scheme provider payment system dropped off the agenda. During the agenda setting and policy formulation stages; predominantly technical policy actors within the bureaucratic arena used their expertise and authority for consensus building to get antenatal, normal delivery and postnatal services included in the primary care per capita payment system. Once policy implementation started, policy makers were faced with unanticipated resistance. Service providers, especially the private self-financing used their professional knowledge and skills, access to political and social power and street level bureaucrat power to contest and resist various aspects of the policy and its implementation arrangements – including the inclusion of primary care maternal health services. Arenas of conflict moved from the bureaucratic to the public as opposing actors presented multiple interpretations of the policy intent and implementation and gained the attention of politicians and the public. The context of intense public arena conflicts and controversy in an election year added to the high level political anxiety generated by the contestation. The President and Minister of Health responded and removed antenatal, normal delivery and postnatal care from the per capita package.

Conclusions

The general findings of the thesis are: (1) policy influencers (donors and bureaucrats) and final decision makers (Minister and President) used their power sources and contextual factors to define problems, promote their vested interest and justify actions and inactions; through technical, institutionalised, public and political decision making domains. (2) Policy influencers and final decision makers' collective actions and inactions through interactions and power relations influenced decisions to their benefit at different levels. They used their control over and access to knowledge, authority and financial, material and human resources to push their interest and influence decisions. Therefore, this thesis concludes that the findings can serve as lessons for policy actors to strategize and make better informed policy decisions. We are in need of a health sector that pays more attention to context, power sources and power relations of final decision makers and influencers and the varied decision making domains in any maternal health policy decision.

About the Author

Augustina Koduah was born December 29, 1975 in Accra, Ghana. In 2002, she obtained a Bachelor of Pharmacy from the Kwame Nkrumah University of Science and Technology, Kumasi, Ghana. She worked in the Korle-bu Teaching Hospital, Accra for two years, as a Pharmacist. In 2005, she obtained a Master's degree in Health, Population and Society from the London School of Economics and Political Science (LSE), London, United Kingdom. After which, she worked as a researcher at the Centre for Tropical Clinical Pharmacology & Therapeutics, University of Ghana; and later as a programme officer at the Ghana National Drugs Programme, Ministry of Health. In 2011, she obtained, a sandwich scholarship through the WOTRO funded Accelerate project to pursue her PhD with the Sociology of Development and Change group at the Wageningen University. Augustina is a fellow of the Ghana College of Pharmacists and has a passion for health systems and policy research and teaching.

Completed Training and Supervision Plan
Wageningen School of Social Sciences (WASS)
Augustina Koduah

Wageningen School
of Social Sciences

Name of the learning activity	Department/Institute	Year	ECTS*
A) Project related competences			
Qualitative Data Analysis: Procedures and Strategies (YRM 60806)	WUR	2011	6
Research Methodology: From topic to proposal	WASS	2011	4
Short course on Health Policy	Institute of Tropical Medicine, Belgium	2012	10
Seminar Zooming in and out on Multi stakeholders Processes	Centre for Development innovation	2011	0.3
Participatory approaches in planning, policy and development	WASS	2011	2
Writing Research Proposal	WUR	2012	6
Information literacy including Endnotes	WUR Library	2012	0.3
B) General research related competences			
Introduction course	WASS	2011	1
<i>'Actors, framing, context and decisions to provide user fee exemption for maternal and neonatal care, in Ghana'</i>	Conference on Exemption policies for maternal health services evaluations, experiences and knowledge, Burkina Faso	2013	1
<i>'Capitation in the era of Universal Health Coverage; an opportunity to improve health service provision in lower level health facilities in Ghana'</i>	National Health Insurance Scheme 10th Anniversary , Accra Ghana	2013	1
<i>'Complex interplay of institutional arrangement, international and local contextual factors; rise and fall of programmes and policies for maternal and new-born health in Ghana'</i>	Third Scientific Conference of the African Health Economics and Policy Association (AfHEA), Nairobi, Kenya	2014	1
<i>'Rise and Fall of Policy Issues: The Case of Maternity Services in Capitation Benefit Package in Ghana'</i>	Third Global Symposium on Health System Research. Cape Town, South Africa	2014	1
<i>'Agenda Setting Processes and Policy Actors in Low-Middle Income Countries: A Case of Free Family Planning Service Policy Agenda in Ghana'</i>	Population Association of America annual meeting, San Diego, USA.	2015	1
C) Career related competences/personal development			
Emerging Leaders Programme in Health Policy & Systems Research	The University of Western Cape. South Africa	2013-2014	4
Accelerate project workshop	WUR	2012-2016	2
Total			40.6

*One credit according to ECTS is on average equivalent to 28 hours of study load

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