Social Science & Medicine 167 (2016) 79–87

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

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

Augustina Koduah [a, d, *], Irene Akua Agyepong [b, c], Han van Dijk [d]

[a] Ministry of Health, P.O. Box MB 44, Ministries, Accra, Ghana
[b] Julius Global Health, P.O. Box 85500, 3508 GA, Utrecht, The Netherlands
[c] Ghana Health Service, Research and Development Division, Dodowa Health Research Center, Dodowa, Ghana
[d] Wageningen UR (University & Research Centre), Sociology of Development and Change, The Netherlands

ARTICLE INFO

Article history:
Received 25 July 2015
Received in revised form
27 August 2016
Accepted 30 August 2016
Available online 31 August 2016

Keywords:
Ghana
Institutionalised policy processes
Maternal health
Policy agenda setting
Policy formulation
Problem definition

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).

1. 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

* Corresponding author. Wageningen University, Sociology of Development and Change, Leeuwenborch, Building 201, Hollandseweg 1, 6706KN, Wageningen, The Netherlands.
E-mail address: augustina.koduah@wur.nl (A. Koduah).

http://dx.doi.org/10.1016/j.socscimed.2016.08.051
0277-9536/

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.

1.1. 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. Fig. 1 summarises and illustrates the different levels of the dialogue process, venues, 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.

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 programmes 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 institutionalised 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 (MOFEP). 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 (Organization for Economic Cooperation and Development, 2009).

1.2. 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 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.