# GHANA'S NATIONAL HEALTH INSURANCE SCHEME (NHIS) AND THE EVOLUTION OF A HUMAN RIGHT TO HEALTHCARE IN AFRICA

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"If the introduction of 'Cash and Carry' health care was stage one, and the NHIS stage two, it is now time for stage three[.]" – Oxfam International[1]

## I. INTRODUCTION

In August of 2003, the Ghanaian government, under President John A. Kufuor,[2] unveiled a healthcare plan, the National Health Insurance Scheme (NHIS),[3] designed to provide every Ghanaian citizen with access to quality healthcare unimpeded by the constraints of user fees. The program became fully effective beginning 2005 when benefits under the scheme kicked in.[4] Since its introduction, the NHIS has been the object of academic and public policy attention.[5] It

[1] ACHIEVING A SHARED GOAL: FREE UNIVERSAL HEALTH CARE IN GHANA 10 (Oxfam Int'l, 2011), https://www.oxfam.org/sites/www.oxfam.org/files/rr-achieving-shared-goal-healthcare-ghana-090311-en.pdf Oxfam is an international confederation of eighteen affiliate organizations from across the world, working together with partners and local communities in more than 90 countries. *Who We Are*, OXFAM INT'L, https://www.oxfam.org/en/about. The confederation works to combat poverty in the world by various means, including "mobilizing the power of people against poverty," and "end[ing] the injustices that cause poverty." *Id*. Oxfam was formed in 1995 by a group of non-governmental organizations with the aim of working together for greater global impact to reduce poverty and injustice. *History of Oxfam Int'l*, OXFAM INT'L, https://www.oxfam.org/en/countries/history-oxfam-international. The name Oxfam comes from the Oxford Committee for Famine Relief founded in Britain in 1942. *Id.* During World War II, the Committee campaigned for food supplies to be sent to starving women and children in enemy-occupied Greece. *Id*. Oxfam Intl.'s approach to combating poverty is human rights-oriented. *See Our Commitment to Human Rights*, OXFAM INT'L, https://www.oxfam.org/en/our-commitment-human-rights (voicing its belief "that respect for human rights will help lift people out of poverty and injustice, allow them to assert their dignity and guarantee sustainable development.").

[2] *See infra* note 36, and Table 1.

[3] *See infra* Part III below for more details on the program.

[4] Kavita Singh et al., *Ghana's National Health Insurance Scheme and Maternal and Child Health: A Mixed Methods Study*, 15 BMC HEALTH SERVICES RESEARCH (Mar. 17, 2015) (scroll down to discussion on "Background.").

[5] *See, e.g.*, Nathan J. Blanchet et a., *The Effect of Ghana's National Health Insurance Scheme on Health Care Utilization*, 46 GHANA MED. J. 76-84 (Jun. 2012); Freeman F.K. Gobah & Zhang Liang, *The National*

is a deserved treatment that this article joins. Thanks to the plan, Ghana is ranked among countries viewed as leaders in healthcare reforms in Africa.[6] Praise came, notably, from the International Bank for Reconstruction and Development, more popularly known as the World Bank, which is mostly impressed with the expanded coverage in healthcare access that the plan signifies.[7]

Because of the existence of a plenitude of published scholarship on the political forces culminating in the passage and implementation of the NHIS,[8] that angle will not be the focus of

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*Health Insurance Scheme in Ghana: Prospects and Challenges: a Cross-Sectional Evidence*, 3 GLOBAL J. HEALTH SCI. 90 (Oct. 2011); ACHIEVING A SHARED GOAL, *supra* note 1, *passim*; Rhodaline Baidoo, Toward a Comprehensive Healthcare System in Ghana. M.A. Thesis, Center for Int'l Studies, Ohio University (Mar. 2009), https://etd.ohiolink.edu/!etd.send_file?accession=ohiou1237304137&disposition=inline; Jennifer L. Singleton, Negotiating Change: An Analysis of the Origins of Ghana's National Health Insurance Act, Honors Project, Paper 4, Macalester College (May 1, 2006), http://digitalcommons.macalester.edu/soci_honors/4. *See also* K.B. Barimah, *Traditional Healers as Service Providers in Ghana's National Health Insurance Scheme: The Way Forward*, 8 GLOB. PUBLIC HEALTH 202-8 (2013) (zeroing in on the relationship between the NHIS and traditional medicine in Ghana).

[6] African countries placed low in overall performance in a 2000 study by the World Health Organization which ranked 191 healthcare systems in the globe. *See* WORLD HEALTH ORGANIZATION, THE WORLD HEALTH REPORT 2000: HEALTH SYSTEMS: IMPROVING PERFORMANCE 152-55 (WHO, 2000) (Annex Table 1, healthcare attainment and performance based on eight indicators, including generation and distribution of health services, responsiveness of the healthcare system, and healthcare funding). Except for Senegal which ranked 59 and Benin 97, all Black African states scored in the triple digits with Sierra Leone placing last (191) in a rating that had France being No. 1 in the world and the United States No. 37. *Id*. It is within this landscape of general low ranking that some African countries have been viewed as leaders in healthcare reforms. Along with Ghana, these states include Botswana, Ethiopia, Rwanda, and South Africa. *See The Future of Healthcare in Africa*, ECONOMIST INTELLIGENCE UNIT 10 (London) (2014), http://www.economistinsights.com/sites/default/files/downloads/EIU-Janssen_HealthcareAfrica_Report_Web.pdf. (providing a profile of African countries that include Ghana, Ethiopia, and South Africa). Ghana, Botswana, Ethiopia, Rwanda, and South Africa placed 135, 169, 180, 172, and 175, respectively, in overall performance in the WHO study. *Id*. However, what these countries have in common is that they have taken important steps toward universal healthcare, which concept we elaborate shortly in this discussion.

[7] ACHIEVING A SHARED GOAL, *supra* note 1, at 23 (specifically that because of its "rapid expansion in coverage […] ahead of its own targets and faster than health insurance schemes attempted in other low-income countries," to use the language of Oxfam Int'l, rather than the words of the World Bank). The World Bank cites a coverage rate for the program of over half of the population and at times close to 60% that Oxfam Int'l, argues is "hugely exaggerated," insisting that the actual coverage "could be as low as 18%" for the reasons that it outlined in its report. *Id*. at 7. In light of these observations, Oxfam Int'l advised donors to "[s]top presenting Ghana as a health insurance success story or use inaccurate accounts of Ghana's progress to promote the introduction of health insurance in other low-income countries." *Id.* at 54.

[8] Emblematic studies include: Hassan Wahab, "The Politics of State Welfare in Africa: Ghana's National Health Insurance Scheme in Comparative Perspective," Ph.D. dissertation, Indiana University Bloomington (Sept. 2015); and A.B. Assensoh & Hassan Wahab, *A Historical-Cum-Political Overview of Ghana's National Health Insurance Law*, 7 J. AFRICAN & ASIAN STUD. 289-306 (2008).

this Article. Instead, our main thrust will be on the human rights ramifications, or lack thereof, of the plan; this is a side of the literature that "remains significantly unexplored"[9] both with respect to Ghana and other African countries committed to expanded healthcare coverage.

The implementation of Ghana's healthcare initiative coincides with the global movement for universal healthcare, spearheaded by the World Health Organization (WHO),[10] and other intergovernmental organization. Universal healthcare means affordable healthcare for all, free of all unnecessary impediments by whatever name, whether copays, deductibles, or user fees that could lead to medical bankruptcy. [11] In shorthand, "[f]inancial barriers are a key predictor of poor access to and quality of health care[,]" that also constitute "a leading cause of debt and impoverishment."[12] More elaborately, the goals of universal healthcare include equity in access to health services, which exists when any individual who needs healthcare services gets access to those services, without regard to employment status or ability to pay; extension of healthcare services good enough to improve the health of individuals receiving those services; and

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[9] Ernest Owusu-Dapaah, *Empowering Patients in Ghana: Is There a Case for a Human Rights-Based Health Care Law?*, 1 LANCASTER UNIVERSITY GHANA L.J. 91, 91 (2015), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2821895 (copy on file with author).

[10] Founded on Apr. 7, 1948, the day set aside as World Health Day, the WHO directs and coordinates international health within the United Nations system.

[11] *See* UNIVERSAL HEALTH COVERAGE: WHY HEALTH INSURANCE SCHEMES ARE LEAVING THE POOR BEHIND 3 (Oxfam, Oct. 9, 2013), https://www.oxfam.org/sites/www.oxfam.org/files/bp176-universal-health-coverage-091013-en_.pdf. (abstract) (defining universal health care as meaning "that all people get the treatment they need without fear of falling into poverty," specifically that "everyone has the same financial protection and access to the same range of high[-]quality health services, regardless of their employment status or ability to pay."). The concept of universal healthcare seems too obvious to form the basis for any extended analysis: isn't healthcare for all what government should be about? However, many governments do a poor job of *distributing* what scarce resources they have, whether in healthcare or any other field. Otherwise we would not be talking about the "who gets what, when, and how?" that hallmarks politics. *See generally* HAROLD D. LASSWELL, POLITICS: WHO GETS WHAT, WHEN, AND HOW? (Peter Smith Pub. Inc., 1990) (colloquially defining politics as "who gets what, when, and how"). In some developed countries, such as the United States, governments generate plentiful healthcare resources that they distribute inequitably. In many developing countries, governments generate non-plentiful healthcare resources that they distribute inequitably.

[12] Anja Rudiger, *Human Rights and the Political Economy of Universal Health Care: Designing Equitable Financing*, 18 HEALTH & HUM. RTS. J. 67, 69 (2016).

protection of individuals from impoverishment arising from illness, whether due to out-of-pocket payments or loss of income when a household member falls sick.[13]

The concept of universal healthcare is embedded in WHO instruments, including the Constitution of 1948,[14] the Alma Ata Declaration of 1978,[15] and Resolution 58.33 adopted by the World Health Assembly in 2005.[16] WHO's 1948 Constitution stipulates that "[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[17] The Alma Ata Declaration, notable for its message of "healthcare for all," affirmed that health, defined to include "physical, mental, and social wellbeing," rather than absence of disease or infirmity, is "a fundamental human right" whose attainment at "the highest possible level" "is a most important world-wide social goal[.]"[18] Finally, Resolution 58.33 defines *universal coverage* to mean "access to key promotive, preventive, curative, and rehabilitative health interventions for all at an affordable cost," consistent with the principles of equity in access *and* equity in financing.[19]

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[13] *What is Universal Coverage?*, WORLD HEALTH ORGANIZATION, http://www.who.int/health_financing/universal_coverage_definition/en/.

[14] Constitution of the World Health Organization, *entered into force* on Apr. 7, 1948, http://www.who.int/governance/eb/who_constitution_en.pdf.

[15] Declaration of Alma-Ata, Int'l Conference on Primary Health Care, Alma-Ata, USSR (Sept. 6-12, 1978), http://www.euro.who.int/__data/assets/pdf_file/0009/113877/E93944.pdf

[16] *See* Social Health Insurance, World Health Organization, 58th World Health Assembly, Provisional Agenda Item 13.16, *passim* (2005).

[17] Constitution of the World Health Organization, *supra* note 14, preamble.

[18] Declaration of Alma-Ata, *supra* note 15, Art. I.

[19] Social Health Insurance, *supra* note 16, ¶ 2. The Resolution indicates that equity in access exists when "the cost of care does not put people at risk of financial catastrophe" and equity in financing exists when "households contribute to the health system on the basis of ability to pay." *Id*., ¶ 2. The risk of financial catastrophe is real, not academic. In Nov. of 2004, WHO conducted a preliminary global estimates on the population subjected to catastrophic expenditure and impoverishment. Estimates showed that as many as 178 million people suffered financial catastrophe as a result of out-of-pocket health payments each year, and that 104 million could be forced into poverty simply because of health payments. *Id.*, ¶ 8.

Peradventure inspired by the worldview that "[h]ealth care is a human right, not a privilege[,]"[20] through the NHIS, Ghanaian governments seek to realize the vision "of a national health system free at the point of delivery for all—a service based on need and rights and not ability to pay[,]" where, "[e]very citizen of Ghana [is] able to access and use the same range of good-quality health services within easy reach of his or her home."[21] To what *extent* is increased access to healthcare in Ghana informed by the doctrine of human rights?[22] More broadly, what are the prospects for the right to health in a still poverty-ridden region like Africa.[23]

Using Ghana as window into the world, this Article explores these questions. We argue that, although the adoption of the NHIS is an important step in the movement toward universal healthcare in Ghana and a model for many African countries, Ghana still has a long way to go in the journey to full realization of healthcare as a human right. To complete the Oxfam International epigraph preceding this introduction, stage three of Ghana's healthcare system is realization of a vision of healthcare for all free at the point of use,[24] embedded in human rights.

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[20] Ruth Rosen, *Time for Single Payer?*, SAN FRANCISCO CHRONICLE (Dec. 29, 2003), http://www.sfgate.com/opinion/article/Time-for-single-payer-2544505.php. This author added poignantly: "If you don't believe this now, you might change your mind if and when you find yourself in need of life-saving care in a hospital emergency room." *Id.*

[21] ACHIEVING A SHARED GOAL, *supra* note 1, at 8. This is the language of Oxfam Int'l, not the Ghanaian government's.

[22] For the definition of human rights, *see infra* notes 138-39.

[23] For more on this line of argument, *see infra* Part V.E. (commenting on the still inadequate government spending on healthcare in Ghana and other African countries).

[24] ACHIEVING A SHARED GOAL, *supr*a note 1, at 32-39.

Development takes disciplined hard work.[25] Similarly, transition from inspiration to impact in realizing human rights[26] requires action beyond verbal invocation of human rights ideals.

This Article is organized into five key sections. The first sketches a historical background on healthcare in Ghana focused around the country's mixed experience with user fees. The second consists of an unpacking of Ghana's NHIS, focused on the legal framework of the program, services accessible to registrants under the program, the principle of exemptions that hallmarks the scheme, and three models of healthcare financing vis-à-vis the location of the NHIS within the typology. The third section analyzes the benefits of a human rights approach to healthcare in Ghana and other African countries, vis-à-vis the dominant economics-based approach. The fourth marshals various reasons why, for its bellwether features, Ghana's healthcare initiative still falls below the requirements of healthcare as a human right, along with the implications of that occurrence for Africa as a whole. The fifth and final section is a suggestion, building on insights from the preceding sections, for Ghana to move to a single-payer, tax-funded healthcare system, in place of its present hybrid public-private healthcare financing model.

## II. HISTORICAL BACKGROUND: GHANA'S MIXED EXPERIENCES WITH OUT-OF-POCKET USER FEES

[25] *See* WILLIAM EDGETT SMITH, WE MUST RUN WHILE THEY WALK: A PORTRAIT OF AFRICA'S JULIUS NYERERE 3, 5 (Random House, 1971). Julius Nyerere, president of Tanzania from 1960 until 1985, was known to carp relentlessly on Tanzanians and Africans in general. Nyerere taught that economic development requires the "discipline" of hard work. "Clean water requires piping. That pond must be drained. Work! … Germany was virtually razed, and Japan, but they had the necessary attitudes and skills for reconstruction." *Id*. at 5. For Nyerere, the role of an inspirational leader is "to build these attitudes" of hard work that are necessary for development. *Id*.

[26] *See* REALIZING HUMAN RIGHTS: MOVING FROM INSPIRATION TO IMPACT xiii, xiv (Samantha Power & Graham Allison, eds., St. Martin's Press, 2000) (positing that "if a key challenge of the second half of the twentieth century was gaining universal acceptance of the idea that human rights existed or mattered, *the* key challenge for the decades ahead is to identify the policies and actions that most effectively realize human rights.") (emphasis in original).

Overlooking the Gulf of Guinea, Ghana is bounded on the east by Togo, west by Côte d'Ivoire, north by Burkina Faso, and south by the Atlantic Ocean.[27] Modern-day Ghana is a merger of two territories, old Ashanti, later the Gold Coast, and German Togo (the Volta Region)[28] that at independence took on the name *Ghana.*[29] The country gained independence from the United Kingdom in March of 1957,[30] after nearly 60 years of British colonial rule.[31] It

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[27] *Ghana Country Profile—Overview,* BBC NEWS (May 5, 2015), http://www.bbc.com/news/world-africa-13433790.

[28] After World War I (1914-18), the victorious Allies, under the auspices of the League of Nations (1920-1946) divided Germany's colonies in Africa (to be held and prepared for independence as "mandates") among themselves. Togoland, formerly held by Germany, was split longitudinally, to be held as mandates by Britain and France. Britain received the Transvolta-Togoland territory which it administered along with the Gold Coast until May 9, 1956, when, in a plebiscite supervised by the United Nations, , inhabitants of the territory voted to integrate with the Gold Coast, paving way for the union of British Togoland with the Cold Coast upon the latter's independence in 1957. *See Ghana: History*, THE COMMONWEALTH, http://thecommonwealth.org/our-member-countries/ghana/history. For its part, French Togo became Togo, later achieving independence in April of 1960. *Togo*, INFOPLEASE, http://www.infoplease.com/country/togo.html.

[29] *Ghana*, INFOPLEASE, http://www.infoplease.com/country/ghana.html; *Kingdom of Ghana*, USHISTORY.ORG, http://www.ushistory.org/civ/7a.asp. The name came from an ancient empire, located 500 miles northwest of the contemporary state, which reigned until the thirteenth century. *Id*. Residents of present-day Ghana believe themselves to be descendants of the inhabitants of the old Ghana Empire. *Ghana,* WORLDMARK ENCYCLOPEDIA OF NATIONS (2007), http://www.encyclopedia.com/topic/Ghana.aspx.
Colonial authorities in Africa had a knack for assigning bland and uncreative names to their colonial estates. Many names were assigned based on landmarks like rivers or just the natural resources or trade item found there when the affected European colonizers met the society in question. Thus, Ghana was called the Gold Coast to memorialize the trade in gold that was found there in commercial quantity. Similarly, the Ivory Coast (Cote d'Ivoire in French) was named so because of the existence of ivory there and Nigeria at first as Slave Coast because of the enormous slave activities there. Sometimes two countries confusedly got the same name. That was the case with Nigeria and Niger Republic, its neighbor to the North, both of which took their common names from the River Niger that ran through their territories.

[30] GHANA INDEPENDENCE ACT *1957*, 1957 CH. 6 (Feb. 7, 1957), www.legislation.gov.uk/ukpga/Eliz2/5-6/6/enacted?view=plain (granting the country "fully responsible status within the British Commonwealth of Nations," effective Mar. 6, 1957, under the name of Ghana). *See also A New Nation: Gold Coast Becomes Ghana in Ceremony, 1957/03/07*, https://archive.org/details/1957-03-07_A_New_Nation (newsreel video of independence festivities, published Jul. 3, 2006).

[31] This is counting from 1900 when the British government proclaimed the colony of the Gold Coast. *See* DAVID OWUSU-ANSAH, HISTORICAL DICTIONARY OF GHANA 92-3 (Rowman & Littlefield, 2014). Ghana's first interaction with Whites came in 1471 when Portuguese traders landed on the coast in search of gold, ivory, and spices. Kent Mensah, *Ghana's Successful but Unpopular Healthcare,* AL JAZEERA (Aug. 6, 2014 09:52 GMT), http://www.aljazeera.com/news/africa/2014/07/ghana-successful-but-unpopular-healthcare-20147221016518281 27.html. Portuguese navigators built a fortress at Elmina in 1482, a transit point for slaves exported to the New World that, till today, remains a monument of the slave activities that took place in the area. Subsequently, other Europeans came, including the Dutch, the Danes, the Swedes, the Prussians, and the British. Among these European powers, Britain colonized the Gold Coast. British colonialism in the country dates back to Jan. of 1902 when the British government declared Ashanti a British crown colony with the regions further north becoming the Protectorate of the Northern Territories of the Gold Coast. *History of Ghana*, HISTORYWORLD, http://www.historyworld.net/wrldhis/PlainTextHistories.asp?historyid=ad43.

became a republic three years later, in a move designed to eliminate lingering residues of British colonialism and consolidate its newly-won "political kingdom,"[32] to use the famed expression of Kwame Nkrumah, Ghana's first indigenous leader.[33] Until recently, Ghana has been a state and society rife with military rule. Under its current Fourth Republic, or period of civilian rule, since April of 1992, Ghana operates a presidential system of government modelled on the United States of America.[34] However, unlike the United States, Ghana is a unitary state.[35] Three previous republics preceded the Fourth Republic, each like it marked by the adoption of a new constitution: the First Republic from 1960 to 1966; the Second Republic from 1969 to 1972; and the Third Republic from 1979 to 1981.[36] These previous republics involved a combination of parliamentary and presidential rules. Years in-between these eras of civilian rule were periods of military dictatorship.[37] Ghana is a country of 10 regions (up from 5 at independence) of 275

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[32] *See History of Ghana*, WORLD HISTORY, http://www.historyworld.net/wrldhis/PlainTextHistories.asp?historyid=ad43 (scroll down to section on "Independence: from 1957."). A famous saying from Kwame Nkrumah, who led the country from 1951 until 1966, was "give us first the political kingdom and all other things would be added unto it." This statement, a parody of Matthew 6:33 underscored Nkrumah's belief in self-rule as the key to Ghana's economic transformation. See Robert Anthony Waters Jr., *How Socialism Underdeveloped Africa*, 34(1) POL. SCI. REVIEWER (Fall 2005), https://home.isi.org/how-socialism-underdeveloped-africa (positing on how "Nkrumah's political kingdom was independence and socialism[,]" given that, for him "Capitalism [was] a system of exploitation not in keeping with traditional African values of cooperation and caring […]").

[33] Nkrumah led the country from 1951 until 1966, when he was overthrown in a military coup. *See Kwame Nkrumah, President of Ghana,* ENCYCLOPEDIA BRITANNICA, https://www.britannica.com/biography/Kwame-Nkrumah

[34] *See Ghana: Constitution and Politics*, THE COMMONWEALTH, http://thecommonwealth.org/our-member-countries/ghana/constitution-politics. *See also Ghana: The Fourth Republic*, http://www.photius.com/countries/ghana/government/ghana_government_the_fourth_republic.html.

[35] In 1955, in response to demands for a federal government in the country, British colonial authorities set up a commission of inquiry, headed by Sir Frederick Bourne, to look into the matter. The commission recommended, and the colonial government accepted, that federalism was an inappropriate constitutional arrangement for a small country like the Gold Coast. *See* Alexander K.D. Frempong, Constitution-Making and Constitutional Rule in Ghana, Paper Presented at a Colloquium by the Dept. of Political Science, University of Ghana (Mar. 1-2, 2007) (stating that "[t]he Bourne Report recommended a compromise formula of a unitary system with devolutionary powers to regional assemblies, which formed the basis of the 1957 Constitution.").

[36] Although also a period of democratic experiment, the period 1957 to 1960 when Ghana had a governor-general who represented the Queen of England, is not usually included among these eras of Republic.

[37] *See e.g.*, *The Role of the Military in the Development of Ghana (Critical Analysis)* (Mar. 3, 2015), http://chrisdonasco.blogspot.com/2015/03/the-role-of-military-in-development-of.html; YOURY PETCHENKINE, GHANA: IN SEARCH OF STABILITY, 1957-1992 (ABC-CLIO, 1993).

administrative districts.[38] The regions, alphabetically, are: Ashanti, Brong Ahafo, Central, Eastern, Greater Accra, Northern, Upper East, Upper West, Volta, and Western.[39]

The NHIS replaced a user fee system colloquially known as "cash and carry."[40] Instituted in 1985, cash and carry required potential patients to pay upfront at the point of service delivery before they could receive treatment—even when faced with a medical emergency. It benefitted the few well-off individuals who had the means to pay for expensive healthcare services for themselves and their families at the point of service—and left out the many poor citizens who lacked the wherewithal for badly-needed medical attention. Under cash and carry, when they received services at all, poor citizens had to buy their own medication because government pharmacies lacked many items of basic medical supplies. This was the setting when in 1996, the National Patriotic Party, one of Ghana's major political parties, assessed the user fee system as "notoriously callous and inhuman," and pledged to "thoroughly overhaul[]" it to make it "more equitable" if it came to power.[41] In a word, the NHIS emerged within the broader context of "general acknowledgment that the cash and carry system was ineffective and encouraged inequality."[42]

To start the story of Ghana's healthcare system from its proverbial beginning, the country's experience with user fees is mixed. During the pre-colonial and even colonial eras,

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[38] *Regions of Ghana*, STATOIDS, http://www.statoids.com/ugh.html. For the identity of some of these districts, *see Ghana Presidential Election Result Updates Live 2016 By Region*, WIKIELECTIONS, http://wikielections.com/africa/ghana-presidential-elections-results-live-2016-by-region-constituencies/ The original five were Ashanti, Eastern, Northern, Trans-Volta Togoland, and Western. *Regions of Ghana*, *supra*.

[39] *Regions of Ghana, supra* note 38.

[40] *See, e.g.*, Wahab, *supra* note 8, *passim*.

[41] National Patriotic Party, Manifesto for 1996, *quoted in* Giovanni Carbone, *Do New Democracies Deliver Social Welfare: Political Regimes and Health Policy in Ghana and Cameroon*, 19(2) DEMOCRATIZATION 157, 168 (2012), https://pascal.iseg.ulisboa.pt/~cesa/files/Comunicacoes/carbone2.pdf.

[42] Singleton, *supra* note 5, at 18.

many residents depended on traditional medicine,[43] rather than Western medicine, for their physical and mental wholeness. Although such services remained cash and carry, user fees were nominal, where medical attention was not free, nothing compared to Western medicine, usually linked with such fees. After the Gold Coast became independent as Ghana in 1957, the new indigenous government under Kwame Nkrumah took on responsibility for healthcare. However, the government pursued socialist-oriented policies that viewed expanded healthcare as part of the nation-building process,[44] and more specifically linked healthcare to economic development.[45] The orientation meant no user fees. It is possible too that "large-scale popular support for free healthcare[,]" most likely inspired by Nkrumah's socialist-oriented policies, "deterred any serious attempt to introduce user fees."[46] At any rate, the outcome remained absence of user fees.

Although Nkrumah's successors did not share his passion for socialism, they unveiled national development plans that included free education and healthcare for citizens. So, to this point, user fees did not become much of an issue. The situation changed, beginning in the 1970s, as Ghana came under economic hard times, leading to severe cuts in government funding for healthcare and other social programs.[47] This was a period marked "by shortages of essential

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[43] Ali Arazeem Abdullahi, *Trends and Challenges of Traditional Medicine in Africa*, 8 AFR. J. TRADITIONAL, COMPLEMENTARY, AND ALTERNATIVE MED. 115, 123 (2011), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3252714/ (pointing out that before colonialism, traditional medicine formed "the dominant health care system in Africa."). For a variety of reasons that includes lack of access to Western medicine, till today, traditional medicine still serves as alternative medicine in many rural communities in Ghana and other African countries. Testimony to the continuing vitality of herbal native medicine, Ghana, like many other African countries, has traditional healers' associations which aim to preserve the integrity of traditional medicinal practice and whose members seek to assure the government regarding the important role that traditional herbal medicine plays in modern medical practice. LA VERLE BERRY, GHANA: A COUNTRY STUDY 110 (3d ed. 1995). Ghana's Traditional Healers' Association was formed in the 1960s with its headquarters at Nsawam in Greater Accra Region. *Id*.

[44] ACHIEVING A SHARED GOAL, *supra* note 1, at 17.

[45] Nkrumah once stated that Ghana's progress toward economic development will be measured "by the improvement in the health of our people." Quoted in Baidoo, *supra* note 5, at 13.

[46] ACHIEVING A SHARED GOAL, *supra* note 1, at 17.

[47] For example, in the 1990s, per capita health expenditure amounted to between $5-$6, compared to $10 in 1970. Frank Nyonator & Joseph Kutzin, *Health for Some?: The Effects of User Fees in the Volta Region of Ghana*, 14(4) HEALTH POLICY & PLANNING 329, 330 (1999),

medicines and other supplies, badly paid and demoralized staff, illegal under the table payments by patients for care, and an effective freeze on building new [healthcare] facilities for those without access."[48]

To stem the decline in its economic fortunes, Ghana, under Jerry J. Rawlings, sought the assistance of the World Bank and the International Monetary Fund (IMF). As condition for its loan, these international monetary agencies placed the Ghanaian economy under their structural adjustment program (SAP). The program requires recipient countries to recover costs by way of user fees for social services, such as healthcare and education.[49] For example, "In return for its assistance, the World Bank required the [Ghanaian] Ministry of Health to generate at least 15 percent of its recurrent expenditure from such fees."[50] The result was that the full burden for healthcare services became laid on Ghanaian citizens who sought these services. In short, the practice of cash and carry in Ghana coincided with SAP implementation in that land.

The introduction of user fees had a dire negative effect on healthcare in Ghana. To save money that they did not have, many patients resorted to traditional medicine or self-medication.[51] Given the fact that many Ghanaians were poor or unemployed, conditioning services upon payment of out-of-pocket user fees "further impoverished them[,]" in that "patients were denied treatment because they were unable to pay prior to their treatment," and, "In cases whe[re] patients [were] able to get the money, there were little, if any, hope for treatment as delayed

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https://www.researchgate.net/publication/12529006_TitleHealth_for_Some_The_Effects_of_User_Fees_in_the_Volta_Region_of_Ghana. By 1997, government spending on healthcare reached an all-time low of 1.3%. Kwadwo Konadu-Agyemang, *The Best of Times and the Worst of Times: Structural Adjustment Programs and Uneven Development in Africa: The Case of Ghana*, 52(3) PROFESSIONAL GEOGRAPHER 469, 476 (2004).

[48] Konadu-Agyemang, *supra* note 47.

[49] Konadu-Agyeman, *supra* note 47.

[50] ACHIEVING A SHARED GOAL, *supra* note 1, at 17.

[51] W. Asenso-Okyere et al., *Cost Recovery in Ghana: Are There Any Changes in Health Care Seeking Behavior?*, 13 HEALTH & PLANNING 181, 187 (1998). *See also* Konadu-Agyemang, *supra* note 47. Within nearly three decades after introduction of these fees, more than half of patients turned to traditional medicine or self-medication. *Id.*

diagnosis and treatment" worsened their health conditions.[52] Within two and a half decades after the introduction of user fees, more than 50 percent of patients in Ghana "turned to traditional [medicine] and self-medication."[53] Moreover, cash and carry disproportionally affected vulnerable sectors of the Ghanaian population, such as women and children and the rural poor, who bore the brunt of the program.[54]

To ameliorate some of the effects coming from user fees, the Ghanaian government enacted partial exemptions in its healthcare system.[55] However, these exemptions militated against access to healthcare for poor people for a variety of reasons that, as the antipoverty group Oxfam International[56] recounts, includes "non-uniform application across regions, difficulties in identifying poor people," and problems related to reimbursement of service providers.[57] And, at any rate, these exemptions also remained unworkable because they "went largely unfunded[.]"[58]

## III. GHANA'S NATIONAL HEALTH INSURANCE SCHEME (NHIS) OF 2003

The goal of Ghana's National Health Insurance Scheme (NHIS) is to assure a specified minimum healthcare benefit package for all Ghanaians at the point of service.[59] Its objectives are manifold, including: equity, risk equalization, quality of care, solidarity, efficiency, partnership, and sustainability.[60] Four issues around which this section is organized are: the legal framework of the NHIS, quantum of services registrants can access under the scheme, the principle of

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[52] Baidoo, *supra* note 5, at 28.

[53] ACHIEVING A SHARED GOAL, *supra* note 1, at 17.

[54] Baidoo, *supra* note 5, at 28. Oxfam Int'l notes ruefully that "despite the instrumental role of the World Bank in pushing for cost recovery in the form of user fees in Ghana, its subsequent loans throughout the 1980s and 1990s did nothing to address their catastrophic impact." ACHIEVING A SHARED GOAL, *supra* note 1, at 17.

[55] ACHIEVING A SHARED GOAL, *supra* note 1, at 17.

[56] *See supra* note 1.

[57] ACHIEVING A SHARED GOAL, *supra* note 1, at 17.

[58] *Id.*

[59] Hassan Wahab, Assessing the Implementation of Ghana's NHIS Law, Paper Prepared for Workshop in Political Theory and Policy Analysis Mini-Conference 1, 4 (2008), http://fliphtml5.com/auhu/hwhn

[60] *Id.* at 1, citing Kwaku Afriyie, National Health Insurance Framework for Ghana 7-10 (Ministry of Health Accra, 2004).

exemptions that is a hallmark of the NHIS, and three models of healthcare financing and the location of the NHIS within those models. We will return to some of these four topics later in the conclusion of the Article.

### *A. Legal Framework of the NHIS*

The legal framework of the NHIS comprises the constitution, Ghana's charter document; the National Health Insurance Act (NHIA); and the National Health Insurance Fund (NHIF or the "Fund"). Beginning with the charter document, Ghana's 1992 Constitution,[61] the closest to a right to healthcare is found in Article 30 which stipulates that "[a] person who by reason of sickness or any other cause is unable to give his consent shall not be deprived by any other person of medical treatment, education or any other social or economic benefit by reason only of religious or other beliefs."[62] Instructively, the provision is part of the "fundamental human rights and freedoms" for all Ghanaians under Chapter Five of the Constitution.[63] The document mandates that these fundamental human rights and freedoms "be respected and upheld by" all government officials and enforced by the courts.[64] The legal framework of the NHIS also encompasses relevant treaties Ghana ratified, such as the International Covenant on Economic, Social, and Cultural Rights (ICESCR), and the African Charter on Human and Peoples' Rights (ACHPR), discussed in Part IV.A, below. The ICESCR, in pertinent part, mandates state parties to create "conditions which would assure to all medical service and medical attention in the

[61] Ghana's Constitution of 1992 with Amendments through 1996 (Apr. 18, 2016), https://www.constituteproject.org/constitution/Ghana_1996.pdf?lang=en [hereinafter referred to as Ghana's 1992 Constitution]. The constitution came into effect on Jan. 7, 1993. It has 26 chapters and 5 appendices under two "schedules." *Id.* These chapters encompass a variety of topics, including "fundamental human rights and freedom" at issue in this study, as well as the power of the courts to protect these rights.

[62] *Id.* at Art. 30.

[63] *See id.* at Chap. 5, Arts. 12-34.

[64] Ghana's 1992 Constitution, *supra* note 61, at Art. 12(1). *See also id.* at Art. 33(1) (allowing individuals whose fundamental human rights are violated access to the court to redress the violation).

event of sickness." Similarly, the ACHPR, in pertinent part, enjoined state parties to "ensure that [their residents] receive medical attention when they are sick."

Next to the NHIA, the law provided access to healthcare for all Ghanaians, irrespective of ability to pay.[65] It was signed into law by John A. Kufuor, president from 2001 until 2009. In October of 2012, the law was replaced with a new one, Act 852, designed to revamp the NHIS.[66] The new law aimed to promote accountability, enhance transparency, and increase the effectiveness of the scheme, among other objectives.[67]

Passage of Act 650, the initial law, was made possible through the strong support of a legislature dominated by the New Patriotic Party (NPP).[68] The party was founded on a set of beliefs that includes "development in freedom," the duty of the government to provide "affordable, quality healthcare to every citizen," and the responsibility of the government to provide "a level of support, a safety net" for poor citizens who are unable to fend for themselves."[69] The same support for healthcare continued after control of the government shifted to the National Democratic Congress (NDC);[70] the NDC made affordable healthcare part of its development plan to transform the country into a middle-income country by 2015.[71]

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[65] Nat'l Health Insurance Act, 2003, Act 650 (Ghana). http://asgmresearch.weebly.com/uploads/3/0/1/6/30160743/national_health_insurance_act_2003.pdf.

[66] Republic of Ghana, Nat'l Health Insurance Act, 2012, Act 852 (Ghana), https://s3.amazonaws.com/ndpc-static/CACHES/NEWS/2015/07/22//NHIS+Act+2012+Act+852.pdf

[67] *Id.*

[68] Founded in 1992, the NPP is a right-of-center conservative party. The party touts itself as a "liberal democratic political party" with "direct ancestral links to the oldest democratic traditions of Ghanaian politics." *Who We Are*, NEW PATRIOTIC PARTY, http://www.newpatrioticparty.org/index.php/the-party/who-we-are/who-we-are.

[69] *Our Beliefs*, New Patriotic Party, http://www.newpatrioticparty.org/index.php/the-party/who-we-are/our-beliefs.

[70] Founded by Jerry J. Rawlings, military dictator from 1981 to 1993 and civilian leader from 1993 to 2001, the NDC is a left-of-center social democratic party.

[71] ACHIEVING A SHARED GOAL, *supra* note 1, at 8.

This occurrence betrays a commitment to expanded healthcare among Ghana's major political parties (see Table 1).[72] It is a commitment reminiscent of the consensus on healthcare among major political parties in the United Kingdom after World War II,[73] but a marked contrast to the entrenched opposition to healthcare reform in the United States that goes back a long time.[74]

**Table 1: Leaders of Ghana's Fourth Republic since 1993**[75]

| Serial No. | Leader's Name | Political Party | Years in Office | How term ended |
|---|---|---|---|---|
| 1. | Jerry J. Rawlings | National Democratic Congress (NDC) | 1993-2001 | Term limited |
| 2. | John A. Kufuor | New Patriotic Party (NPP) | 2001-2009 | Term limited |
| 3. | John A. Mills | NDC | 2009-2012 | Died in office |
| 4. | John D. Mahama | NDC | 2012-2016 | lost election for 2nd term |
| 5. | Nana Akufo-Addo | NPP | 2017-present | Still in office |

Finally on the NHIF, the Fund is the tool for subsidizing the District Mutual Insurance (DMI) plans and "reinsuring them against random fluctuations and shortfalls in financing."[76] It

[72] *See also id*. at 33 (observing that the Ghana "health sector enjoys a high level of political commitment.").

[73] *See* MICHAEL J. SODARO, COMPARATIVE POLITICS: A GLOBAL INTRODUCTION 408-9 (McGraw-Hill, 3d ed., 2008) (commenting on the acceptance by Conservative and Liberal politicians of the welfare programs, including health insurance, initiated by the Labor Party after World War II).

[74] *See, e.g.,* President Harry S. Truman (1945-53) faced stringent opposition from the medical lobby when he sought to unveil affordable healthcare. His opponents dubbed his program "socialized medicine." *See* MONTE M. POEN, HARRY S. TRUMAN VERSUS THE MEDICAL LOBBY: THE GENESIS OF MEDICARE 113-14 (University of Missouri Press, 1996) (discussing President Harry S. Truman, 1945-53 vis-à-vis his opponents, including the medical lobby, who dubbed his program "socialized medicine."); KENNETH JANDA ET AL., THE CHALLENGE OF DEMOCRACY: GOVERNMENT IN AMERICA 329 (Houghton Mifflin, 6th ed. 1999) (commenting on how advertising campaigns of interest groups, such as the Health Insurance Association of America, contributed to help defeat the healthcare plan of William J. Clinton, 1993-2001); STEVEN BRILL, AMERICA'S BITTER PILL: MONEY, POLITICS, BACK-ROOM DEALS, AND THE FIGHT TO FIX OUR BROKEN HEALTHCARE SYSTEM (Random House, 2015) (analyzing the opposition to the Affordable Care Act under Barack Obama, 2009-2017), .

[75] Table created by authors.

[76] ACHIEVING A SHARED GOAL, *supra* note 1, at 8. For more on DMI plans, *see infra* notes 83-4.

also covers healthcare costs for all exempt patients and supports programs aimed at improving access to health services.[77] Contributions to the Fund come from four main sources:

- a 2.5 percent value-added tax (VAT) on goods and services;[78]
- an earmarked portion of social security taxes (2.5 percent of the 17.5 percent) from workers in the formal sector;
- premium payments from informal sector adults;
- miscellaneous funds from various sources, including investment returns, allocations by Parliament, gifts from donors, and voluntary contributions.[79]

The establishment of the Fund is borne out of the recognition by the government "that universal access could not be financed by individual premium payments alone, but instead would require subsidy with public funds."[80] The body charged with implementation of the healthcare initiative is the National Health Insurance Authority.[81] The Authority registers, licenses, supervises, accredits providers, and manages the NHIF.[82]

Under the NHIS, all residents must join one of three plans: District Mutual Insurance (DMI), Private Mutual Insurance (PMI), or Private Commercial Health Insurance (PCHI).[83] The first, DMI is operational in all of Ghana's administrative district.[84] It is a non-commercial program available to every member of the public who registers as a beneficiary.[85] Registrants

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[77] ACHIEVING A SHARED GOAL, *supra* note 1, at 8.

[78] VAT is a consumption tax "placed on a product whenever value is added at a stage of production and at final sale." *Value-Added Tax—VAT*, INVESTOPEDIA, http://www.investopedia.com/terms/v/valueaddedtax.asp. Under this arrangement, "[t]he amount of VAT that the user pays is the cost of the product, less any of the costs of materials used in the product that have already been taxed." *Id*.

[79] ACHIEVING A SHARED GOAL, *supra* note 1, at 8.

[80] *Id*.

[81] National Health Insurance Scheme, http://www.nhis.gov.gh/nhia.aspx (scroll down to "N.H.I.A.")

[82] *Id*. (section on "functions of the authority").

[83] *See Health Insurance in Ghana*, GHANAWEB, http://www.ghanaweb.com/GhanaHomePage/health/national_health_insurance_scheme.php.

[84] *Id*.

[85] This sentence and the material in the rest of this paragraph draw from *id*.

under the program can transfer their policy when they move to a new district. The program is available to residents of small means unable to afford insurance premiums, such as poor citizens and individuals without a job. In addition to any premium paid by registrants, the DMI is funded by the national government, the source of which subsidy is the National Health Insurance Fund, into which every Ghanaian worker pays 2.5 percent of his or her social security contributions. Other sources of funding include the value-added tax of the same percentage.

Under the PMI, any group of people, say members of a church or any secular group, can come together and make contributions to cater for their health needs, providing such services under the plan that the governing council approves.[86] PMI plans are *not* eligible for subsidy from the government.[87]

The PCHI plan is, as its name implies, a plan operated by companies approved by the government. Individuals who have the means can purchase these plans for themselves and their dependents, just as they would buy a car. Like PMIs and unlike DMIs, PCHI plans are not subsidized by the government. Instead, individuals may be required to pay a security deposit by the approved companies as a condition for registration or enrolment.[88] The co-existence of the last two plans with the first effectively means that the Ghanaian government unveiled a "model of universal coverage through district mutual schemes from which individuals can opt out so long as they are covered by a private insurer."[89]

Individuals registered under any of these plans are given a card which they then use to seek and access treatment in any hospital or related healthcare facility in the country—without having to pay for anything, unless they ask for extra service, such as a private ward. Following

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[86] *Health Insurance in Ghana, supra* note 83.
[87] *Id*.
[88] *Id.*
[89] Singleton, *supra* note 5, at 17.

treatment, their bills are sent to their healthcare provider—which then pays the money to their healthcare giver. Individuals can also use their card to buy prescribed drugs at accredited pharmacies without paying at the point of service delivery. Instead, like with the healthcare giver or hospital, the pharmacy contacts the individual's healthcare provider for payment.[90]

### *B. Quantum of Services Available to Registrants under the NHIS*

The NHIS entitles registrants to minimum services. Therefore, in the scheme of things, whichever plan an individual signs up for does *not* cover all services. Services covered under the NHIS are:

- *outpatient services*, including consultations; requested investigations; medications, especially drugs on NHIS drugs list and approved traditional medicines; outpatients/day surgical operations, such as repair of hernia; and outpatient physiotherapy;
- *inpatient services*, including general and specialist inpatient care; requested investigations; medications, especially prescription drugs on NHIS drug list; cervical and breast cancer treatment; surgical operations; inpatient physiotherapy; general ward accommodation; and feeding, where available;
- *other specific services,* including oral health services, pain relief, and dental restoration;
- *eye care services*, including refraction, visual fields, A-scan, cataract removal, and eye lid surgery;

[90] *See generally* Sodzi Sodzi-Tettey et al., *Challenges in Provider Payment under the Ghana National Health Insurance Scheme: A Case Study of Claims Management in Two Districts*, 46(4) GHANA MED. J. 189-99 (2012), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3645172/.

- *maternity care services*, including antenatal care, normal and assisted deliveries, Caesarean section, and post-natal care;
- emergencies of every kind, defined as crisis health situations demanding urgent intervention, whether medical, surgical, pediatric, obstetric and gynecological; road traffic accidents; and dialysis for acute renal (kidney) failure; and
- public health services, including immunization, family planning, inpatient and outpatient treatment of mental illness; treatment of tuberculosis and related conditions; and confirmatory HIV test for AIDS patients.[91]

But there is also a long list of excluded services that beneficiaries are *not* entitled to for which services they must pay more to receive benefits. These excluded services include: rehabilitation other than physiotherapy; appliance and prostheses, including optical aids, heart aids, orthopedic aids, and dentures; cosmetic surgeries and aesthetic treatment; anti-retroviral drugs for HIV; assisted reproduction; echocardiography, photography, angiography, dialysis for chronic renal (kidney) failure; organ transplants; all drugs not listed on the NHIS list; heart and brain surgery, other than those resulting from accidents; cancer treatment, other than breast and cervical; mortuary services; diagnosis and treatment abroad; medical examinations for purposes other than treatment in accredited health facilities (e.g., visa application, driving licenses, etc.); and accommodation in Very Important Persons (VIP) ward.[92]

### *C. Operation through the Principle of Exemptions*

Various pilot initiatives, several that were unveiled by the Ministry of Health, preceded the introduction of the NHIS in 2003. One of these was Community Health Insurance (CHI).

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[91] SARA SULZBACH ET AL., EVALUATING THE EFFECTS OF THE NATIONAL HEALTH INSURANCE ACT IN GHANA: BASELINE REPORT, USAID 63 ( 2005), http://pdf.usaid.gov/pdf_docs/Pnadg454.pdf.

[92] *Health Insurance in Ghana*, *supra* note 83.

These schemes are "voluntary health insurance, organized at the level of the community[.]"[93] The first of these pilot schemes by the Ministry of Health was unveiled in 1993.[94] This was followed by another in 1997 in four districts of the Eastern Region of the country with dire need for healthcare services.[95] None of these efforts metamorphosed into a national plan at this stage because of lack of political will.[96] Another set of initiatives was the Mutual Health Organization (MHO). These are "voluntary organizations[…]usually owned, designed, and managed by the communities they service[,]" which "provide health insurance services to their members."[97] They are organizations "based on ethical principles of mutual aid and social solidarity[,]" whose popularity "reflects a need in communities to address the difficulty of paying for health care when care is required."[98] The number of these MHOs grew from just three in 1999 to 258 four years later.[99] However, just like CHI schemes, MHOs were only able to provide healthcare access for a small percentage (not more than 2 percent) of the Ghanaian population.[100]

The NHIS operates through what we might, for lack of a better term, call the principle of exemptions. Workers in the formal sector are, in principle, exempt from paying premiums, since their 2.5 percent contributions into the Social Security and National Insurance Trust (SSNIT) are accepted in lieu of a premium.[101] Other groups exempted from paying premiums under the law

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[93] GUY CARRIN, WORLD HEALTH ORGANIZATION, COMMUNITY-BASED HEALTH INSURANCE SCHEMES IN DEVELOPING COUNTRIES: FACTS, PROBLEMS, AND PERSPECTIVES, Discussion Paper No. 1, 3 (2003).

[94] ACHIEVING A SHARED GOAL, *supra* note 1, at 18.

[95] *Id.* In 2004, under the NHIS, the Ghanaian government implemented a free maternal healthcare program in these four most deprived regions. *Id*. at 17.

[96] *Id.* at 18.

[97] Lynne Miller Franco et al., *Effects of Mutual Health Organizations on Use of Priority Health-Care Services in Urban and Rural Mali: A Case-Control Study*, BULLETIN OF THE WORLD HEALTH ORGANIZATION (2008), http://www.who.int/bulletin/volumes/86/11/08-051045/en/.

[98] *Id*.

[99] ACHIEVING A SHARED GOAL, *supra* note 1, at 18.

[100] *Id.*

[101] *Id.* at 21. The government initially proposed that formal sector workers pay an annual premium, in addition to the Social Security and National Insurance Trust contribution, to enroll in the NHIS. However, the government backed off when workers and their union threatened a mass protest. *Id*.

include: self-employed who contribute to the SSNIT;[102] pregnant women (whether in need of ante-natal, delivery, or post-natal health care services);[103] persons under 18 years of age whose parents have enrolled in the scheme;[104] persons determined by the Minister for Social Welfare to be indigent;[105] persons determined by the Minister for Social Welfare to be "differently-abled," meaning disabled;[106] senior citizens aged 70 years and above;[107] pensioners under the Social Security Pension Scheme;[108] persons with mental disorder;[109] and other categories prescribed by the Minister of Social Welfare.[110]

Many groups are exempted from paying premium under the scheme that, as Oxfam International deadpanned in its report, practically "the only non-exempt group in Ghana required to pay a regular out-of-pocket premium payment are informally employed adults."[111] As of the time of the Oxfam report in 2011, these workers paid a premium of 7.20 Ghana cedis, denoted GHc 7.20 (approximately $4.60 USD) to GHc 48.00, assessed based on income and capacity to pay.[112] In contrast, the NHIF paid a flat rate of premium into the scheme on behalf of each exempt member, which as of 2008 amounted to GHc 14.[113] Regarding the exemption of all

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[102] *About Us*, National Health Insurance Scheme Official Website, http://www.nhis.gov.gh/about.aspx (last visited Apr. 10, 2017).

[103] *Id.*

[104] *Id.* During a meeting of world leaders at the U.N. General Assembly at New York in 2009, President John A. Mills (2009-2012) announced his government's commitment to provide free healthcare for all people under 18 years of age, whether or not their parents were enrolled under the scheme. ACHIEVING A SHARED GOAL, *supra* note 1, at 18. The hard part is implementation, regarding which Oxfam Int'l observed that "[d]isappointingly[,] the government has been slow to implement the commitment to free care for all people under 18." *Id.*

[105] National Health Insurance Scheme Official Website, *supra* note 102.

[106] *Id*.

[107] *Id*.

[108] *Id*.

[109] *Id*.

[110] *Id.*

[111] ACHIEVING A SHARED GOAL, *supra* note 1, at 21.

[112] *Id.*

[113] *Id.* As of this writing in July of 2016, the exchange rate of the Cedis vis-à-vis the U.S. dollar is about 4 Cedis to $1 USD.

pregnant women, introduced in 2008, Oxfam International observed that "[i]n just one year of implementation 433,000 additional women had access to health care."[114] But, realizing healthcare goes beyond mere announcement of how many more women enroll in healthcare, Oxfam advised, "bolder changes are now urgently required to accelerate progress."[115] In addition to the premium, beneficiaries under the scheme are also required to pay a processing fee or renewal fee for their identification cards.[116] The only exceptions are pregnant women and indigents who are exempted from this registration fee.[117]

### *D. Three Models of Healthcare Financing and the Location of the NHIS Within These Models*

Financing is central to the definition of universal health coverage.[118] It is the mother's milk of any healthcare system,[119] and key to both access in healthcare and health outcomes. Four possibilities of healthcare financing exist: out-of-pocket, user-fee healthcare arrangement; tax-funded healthcare financing; social health insurance; and mixtures of the last two approaches (or hybrid).[120] Because it prevents people from seeking medical attention, and can exacerbate poverty, user-fee arrangement is the least efficient and most inequitable means of financing health care.[121] The NHIS is traceable to experiments with alternative financing models in the

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[114] ACHIEVING A SHARED GOAL, *supra* note 1, at 21. *Id.* .

[115] *Id.*

[116] National Health Insurance Scheme Official Website, *supra* note 102.

[117] *Id*.

[118] *See* Rudiger, *supra* note 12, at 68 (arguing for "a human rights approach to financing health care, along with the design of a financing mechanism for a sub-national universal system in the United States[.]").

[119] The expression is a parlance from United States politics that invokes Jesse Unruh, Speaker of the California Assembly from 1961 to 1968, who used the phrase in the context of the influence of money in United States politics. Unruh famously called money "the mother's milk of politics." Mark A. Unlig, *Jesse Unruh, a California Political Power, Dies*, N.Y. TIMES (Aug. 6, 1987), http://www.nytimes.com/1987/08/06/obituaries/jesse-unruh-a-california-political-power-dies.html.

[120] *See* Social Health Insurance, *supra* note 16, at ¶¶ 58.33(1)(6), (7).

[121] *See* Peter Waiswa, *The Impact of User fees on Access to Health Services in Low- and Middle-Income Countries*, RHL: THE WHO REPRODUCTIVE HEALTH LIBRARY (May 1, 2012), https://extranet.who.int/rhl/topics/improving-clinical-practice/impact-user-fees-access-health-services-low-and-middle-income-countries (finding that "limited evidence suggests that introduction of user fees for healthcare has little public benefit, especially with regard to improving access to services in an equitable and efficient way, or to

1990s that evolved "against the background of high user fees, inability to pay, and exemptions failure."[122] These are probably among the reasons why, as one study points out, "As a share of the total value of global health spending," the out-of-pocket, user fee system "is eclipsed by" the other categories of funding.[123] The occurrence leaves us with the last three options—which categories other studies track—[124] as viable social insurance possibilities for Ghana and other African countries.

*Tax-funded healthcare financing* involves the use of general tax revenue as the main source of finance for risk pooling. By definition, it is a prepaid financing arrangement in which "more than half of public expenditure is financed through revenues other than earmarked payroll taxes […] and in which access to publicly-financed services is, at least formally, open to all citizens."[125] It is a widespread approach to healthcare financing for many countries, evident in the fact that, as one source disclosed in 2004, it is "the predominant source for health care expenditure in 106 out of 191 W[orld] H[ealth] O[organization] countries."[126]

Tax-funded healthcare financing has certain advantages, which rival approaches lack, emanating from their political tax-and-spend nature; these include "[large]-scale economies in administration, risk management, and purchasing power."[127] However, there are also several

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improving healthcare outcomes.") (abstract); UNIVERSAL HEALTH COVERAGE, *supra* note 11, at 3 (observing that "[e]very second, three people are pushed into poverty because they have to pay out-of-pocket for health care.").

[122] ACHIEVING A SHARED GOAL, *supra* note 1, at 18.

[123] William Savedoff, Tax-Based Financing for Health Systems: Options and Experiences 2 (World Health Organization, 2004).

[124] *See, e.g.,* THE RIGHT TO HEALTH AT THE PUBLIC/PRIVATE DIVIDE: A GLOBAL COMPARATIVE STUDY (Colleen M. Floyd & Aegal Gross, eds., Cambridge University Press, 2014) [hereinafter referred to as Floyd & Gross], *passim* (case study of 16 national healthcare systems, excluding Ghana). These three categories were healthcare programs based on: *tax-financed* or national public health system, exemplified by Canada, Sweden, New Zealand, and the United Kingdom; *social health insurance* systems, exemplified by Israel and the Netherlands among others; and *mixed private/public systems*, exemplified by Brazil, China, India, South Africa, and the United States, among others. *Id*.

[125] Savedoff, *supra* note 123, at 3.

[126] *Id.*

[127] *Id.*

drawbacks traceable to that tax-and-spent attribute, notably "inefficiencies that emerge from serving multiple objectives, political pressures to serve privileged groups, the normal challenges of effective management in public services, and problems associated with weak accountability and instability."[128]

Under the *social health insurance model*, specific contributions for health are collected from workers, self-employed people, enterprises and the government, and then pooled into a single or multiple social health insurance Fund, as the case may be. This model evolved in response to the deficiencies of some political systems lacking in "robust tax base," marked by "a low institutional capacity to collect taxes and weak tax compliance."[129] Social health insurance may be managed in various ways, including through a single government insurance fund or through multiple non-governmental funds.[130] Whereas under tax-funded healthcare financing, coverage is automatically universal in the sense that all citizens or residents are typically entitled to services. Under social health insurance, "Entitlement is linked to a contribution made by, or on behalf of, specific individuals in the population" and universality is "achieved only if contributions are made on behalf of each member of the population."[131] This explains why "most social health insurance schemes combine different sources of funds, with government often contributing on behalf of people who cannot afford to pay themselves."[132] As a corollary, resource constraint may have been the reason why the Ghanaian government has been slow to implement free care for persons under 18:[133] because for Ghana as for many African countries,

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[128] *Id.* at 2-3.
[129] CARRIN, *supra* note 93 at 3.
[130] Social Health Insurance: Report by the Secretariat, World Health Organization, Executive Board, 115th Session, Provisional Agenda Item 4.5, EB115/8, ¶ 6 (Dec. 2004), ,
[131] *Id.*
[132] *Id.*
[133] ACHIEVING A SHARED GOAL, *supra* note 1, at 18.

persons in this age category form the bulk of the population, the budgetary implications of extending healthcare to this group are enormous to the point of being unaffordable.

Last, but not least, is the *hybrid model* involving a mixture of tax-funded healthcare financing, and social health insurance financing. Each of the last three categories encompasses some of the four key actions for financing universal healthcare—minimizing direct payments and maximizing mandatory pre-payment, establishing large risk pools, and using general government revenue to cover those who cannot afford to contribute—that the World Health Organization advises countries pursuing expanded healthcare to prioritize.[134] In contrast, user fee arrangements lack all of these four features.

Which of these three categories does Ghana's NHIS scheme fall into? Based on the preceding section's description of the program's features, Ghana is neither fully tax-funded nor fully social insurance. Instead, it appears to straddle both approaches, an occurrence that therefore makes it a little bit of both or, in the terminology of Floyd and Gross, mixed private/public systems.[135] According to one study, about 70-75 percent of total revenue of the NHIS comes from tax monies, about 20-25 percent from formal sectorcontributions, and about 5 percent from the informal sector.[136] As Oxfam International observed, "The NHIS's heavy reliance on tax funding" contradicts its image "as social health insurance" of a manner that realistically makes it "more akin to a tax-funded national health care system[.]"[137]

## IV. SEVERAL BENEFITS OF A HUMAN RIGHTS APPROACH TO HEALTHCARE IN GHANA AND OTHER AFRICAN COUNTRIES

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[134] UNIVERSAL HEALTH COVERAGE, *supra* note 11, at 3.

[135] Floyd & Gross, *supra* note 124.

[136] Sophie Witter & Bertha Garshong, *Something Old or Something New?: Social Health Insurance in Ghana*, 9 BMC INT'L HEALTH & HUM. RTS. 4 (Aug. 2009), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2739838/ (based on data for 2008).

[137] ACHIEVING A SHARED GOAL, *supra* note 1, at 8.

Human rights are guarantees of freedom, such as life, liberty, security, and subsistence to which people as humans have rights.[138] They are "the rights that distinguish men and women from the other creatures who inhabit the earth, the rights that make for the 'humanness' of human beings."[139] Along with good health outcomes, access to good healthcare occupies a central place among these rights, as the ensuing discussion makes obvious. There are three interrelated aspects to the conversation in this section: human rights instruments on the right to healthcare that Ghana is linked with, social determinants of good health in the country, and the right

to healthcare as a tool of social struggle in Ghana and other African countries alike.

### *A. Global and Regional Human Rights Instruments on the Right to Healthcare Linked to Ghana*

Global human rights instruments recognizing the right to healthcare that Ghana is associated with include the Universal Declaration of Human Rights (UDHR)[140] and the International Covenant on Economic, Social, and Cultural Rights (ICESCR).[141] Beginning with the UDHR, the instrument proclaims that "[a]ll human beings are born free and equal in dignity and rights."[142] Good health and equal access to healthcare services are essential for the

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[138] JACK DONNELLY, INTERNATIONAL HUMAN RIGHTS 19 (Westview Press, 4th ed., 2013). *See also* Jack Donnelly, *An Overview, in* HUMAN RIGHTS AND COMPARATIVE FOREIGN POLICY 310, 315 (David P. Forsythe, ed., United Nations University Press, 2000) (stating that "[h]uman rights are held by all human beings, regardless of who or where they are" and that, consequently, "[t]o identify with human rights is to identify with all human beings, regardless of nationality or other status") (internal parentheses omitted)

[139] SAMUEL EDWARD CORWIN & JACK W. PELTASON, CROWIN & PELTASON'S UNDERSTANDING THE CONSTITUTION 4 (Dryden Press, 7th ed. 1976). *See also* Donnelly *supra* note 138 (stating that "[t]o identify with human rights is to deny […] fundamental moral differences between ourselves and others.").

[140] Universal Declaration of Human Rights (UDHR), G.A. Res. 217 A (III), U.N. GAOR, 3d Sess., U.N. Doc. A/810 (1948).

[141] International Covenant on Economic, Social, and Cultural Rights, G.A. Res. 2200, U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A16316, 993 U.N.T.S. 3, 6 I.L.M. 360 (1966).

[142] UDHR, Art. 1.

consummation of the "dignity and worth of the human person[.]"[143] More specifically, the UDHR stipulates that "[e]veryone has the right to a standard of living adequate for the *health* and well-being of himself and of his family, including food, clothing, housing and *medical care* and necessary social services."[144] To be sure, the Universal Declaration is *not* a multilateral treaty. However, it embodies a model of a "common standard of achievement" in human rights[145] embraced by all members of the United Nations that is antecedent to the ICESCR and other multilateral human rights instruments.

As for the ICESCR, the multilateral treaty stipulates that "[t]he States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of *physical and mental health*."[146] It lays down several specific steps that signatories of the instrument could use "to achieve the full realization of this right[,]" including provisions to reduce stillbirth-rate, infant mortality, and the healthy development of children; improving "all aspects of environmental and industrial hygiene"; preventing, treating, and controlling epidemic, endemic, occupational and other diseases; and creating "conditions which would assure to all medical service and medical attention in the event of sickness."[147] Ghana became a State Party of the ICESCR on September 7, 2000.[148]

Regional instruments recognizing the right to healthcare that Ghana is linked with include the African Charter on Human and Peoples' Rights (ACHPR, also known as the "Banjul

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[143] UDHR, preamble.
[144] *Id*. at Art. 25, ¶ 1 (emphasis added).
[145] UDHR, preamble.
[146] ICESCR, Art. 12, ¶ 1 (emphasis added).
[147] *Id*. at Art. 12, ¶2 (a)-(d).
[148] Claiming Human Rights—in Ghana, CLAIMING HUMAN RIGHTS ORGANIZATION, http://www.claiminghumanrights.org/ghana.html

Charter"),[149] and African Charter on the Rights and Welfare of the Child (ACRWC).[150] The ACHPR stipulates that "[e]very individual shall have the right to enjoy the best attainable state of physical and mental health."[151] Going further, the Charter enjoined state parties to "take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick."[152] Ghana ratified the Banjul Charter in January 1989.[153]

The ACRWC provides that "[e]very child shall have the right to enjoy the best attainable state of physical, mental, and spiritual health."[154] It also specifies ten measures that state parties to the treaty could undertake to realize this right, including: reducing infant and child mortality rate; providing adequate nutrition and safe drinking water; ensuring appropriate health care for expectant and nursing mothers; and integrating basic health service programs in national development plans, among others.[155] Ghana ratified this instrument in June of 2005, two years after the passage of the NHIS.[156]

### *B. Social Determinants of Health in Ghana*

[149] African Charter on Human and Peoples Rights (ACHPR or Banjul Charter), June 27, 1981, OAU Doc. CAB/LEG/67/3/Rev. 5, 21 I.L.M. 58 (entered into force Oct. 21, 1986). The document is sometimes referred to as the Banjul Charter, after the city in The Gambia where it was adopted. The body charged with oversight and interpretation of the ACHPR is the African Commission on Human and Peoples' Rights, set up in 1987 and headquartered in Banjul. In 1998, the OAU adopted a protocol to the ACHPR creating an African Court on Human and Peoples' Right. *See* Protocol to the African Charter on Human and Peoples' Rights on the Establishment of an African Court on Human and Peoples' Rights (1998), OAU Doc. OAU/LEG/EXP/AFCHPR/PROT (III) (Jun. 9, 1998) (entered into force Jan. 25, 2004). The Court complements the protective mandate of the African Commission on Human and Peoples' Rights. *See id.*, Art. 2 (explaining the relationship between the court and the commission). Its power includes the authority to issue advisory opinion "on any legal matter relating to the Charter or any other relevant human rights instruments […]" *Id.*, Art. 4.

[150] African Charter on the Rights and Welfare of the Child (ACRWC), OAU Doc. CAB/LEG/24.9/49 (1990) (entered into force Nov. 29, 1999).

[151] ACHPR, *supra* note 149, at Art. 16(1).

[152] *Id*. at Art. 16(2).

[153] African Commission on Human and Peoples' Rights, *Ratification Table: African Charter on Human and Peoples' Rights*, http://www.achpr.org/instruments/achpr/ratification/

[154] ACRWC, *supra* note 150, at Art. 14.

[155] *Id.* at Art. 14, ¶ 2 (a)-(j).

[156] African Commission on Human and Peoples' Rights, *Ratification Table: African Charter on the Rights and Welfare of the Child*, http://www.achpr.org/instruments/child/ratification/.

Few things stand by themselves in life. The same is true of health. Good health spells more than just the absence of illness or disability,[157] and is dependent on a number of social determinants without which it is hard to realize this condition. These social determinants include the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, as well as the freedoms of association, assembly and movement.[158] The condition of good health by these social determinants syncs with the definition of *health* by the World Health Organization as "[a] state of complete physical, mental and social well-being."[159] Put differently, individuals exposed to physical, mental, and social conditions that minimize their well-being *lack* good health.[160] To elaborate on the WHO definition, persons vulnerable to communicable or non-communicable diseases, or exposed to injury or related risks, lack *physical well-being*.[161] Similarly, persons with mental illnesses or who live in poverty or in fear of crime, sexual abuse or victimization lack *mental well-being*.[162] Finally, persons who lack access to healthcare services, water, sufficient food or jobs, lack *social well-being*.[163]

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[157] *See* Declaration of Alma-Ata, *supra* note 15 (citing the Alma Ata Declaration with its proposition of healthcare for all); *see also* Const. of the World Health Organization, *supra* note 14.

[158] Committee on Economic, Social, and Cultural Rights, General Comments No. 14 on the Right to the Highest Attainable Standard of Health, E/C.12/2000/4 ¶ 3 (Aug. 11, 2000), http://www.nesri.org/sites/default/files/Right_to_health_Comment_14.pdf. (tying the right to a number of other rights, including the rights to life, food, housing, education, work, prohibition against torture, privacy, access to information, as well as freedoms of association, assembly, and movement). The comment also assigns responsibility for realizing this right to actors other than state parties, such as the World Health Organization, the U.N. International Children's Fund, the International Labor Organization, the International Monetary Fund, the World Bank, and the International Committee of the Red Cross/Red Crescent. *Id*. at ¶¶ 63-65.

[159] Const. of the World Health Organization, *supra* note 14 (preamble). The document added instructively, "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic[,] or social condition."

[160] *A Background to Health Law and Human Rights in South Africa*, HEALTH AND DEMOCRACY (Jun. 1, 2007), www.section27.org.za/wp-content/uploads/2010/04/Chapter1.pdf.

[161] *Id*.

[162] *Id*.

[163] *Id*.

Living with dignity, having the right to make choices and the ability to control our own bodies may on the surface seem like factors unconnected to health, but can have a big effect on good health. Good health and access to good healthcare services are essential for people's right to dignity.[164] Concededly, health is also influenced by the choices we make about how persons live their lives, such as whether to smoke tobacco or drink alcohol.[165] Nevertheless, more often than not, these choices are influenced by whether people have access to education or information.[166]

Applying the WHO's holistic concept of health to Ghana, "A broad range of [social] factors determine good health, many of which are not necessarily under the direct management of the Ministry of Health or other health sector actors[,]" as Oxfam International observes in its recommendation on improving healthcare services in Ghana under the NHIS.[167] According to the antipoverty coalition, these social forces that heavily influence health "include infrastructure, especially roads, water and sanitation, working and living conditions, nutrition and education[,] as well as the overall distribution of money, power and resources."[168] Stated differently, "Low levels of literacy, gender inequality, poor sanitation, under-nutrition, alcohol abuse, sedentary life styles and unhealthy diets all also contribute to ill health and high mortality rates."[169] Using the access to healthcare services for pregnant women under the NHIS as example, Oxfam International noted that "[u]nfortunately, the impact on assisted deliveries has been less than expected[,]" for a variety of non-financial reasons that includes "distant health facilities, poor

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[164] *Id.*
[165] *Id.*
[166] *Id.*
[167] ACHIEVING A SHARED GOAL, *supra* note 1, at 42.
[168] *Id*.
[169] *Id*. at 43. Regarding sanitation, as of the time of the report, only about 13% of Ghanaians have access to basic sanitation. With respect to environment sanitation, in 2008, this lack was found to have accounted for 70% of out-patient attendances in Ghana hospitals.

road conditions, lack of easily available transport, some social traditions" and even the role of skilled traditional birth attendants, access to whose services are "most unevenly distributed across regions and ethnicities" in the country.[170]

Given this and other occurrences, it stands to reason that "[t]he Ministry of Health acting alone cannot hope to tackle all" the social determinants that impede healthcare in Ghana.[171] Instead, "A coordinated approach" by all government agencies is needed to promote healthcare in the country.[172] Finally, to be meaningful, the right to health requires that medical products and services be available, accessible, acceptable (i.e., respectful of medical ethics and culturally appropriate), and of good quality.[173]

### *C. Right to Health(care) as a Tool of Social Struggle in Ghana and Other African Countries Alike*

Human rights instruments on the right to healthcare with respect to Ghana, and social determinants of good health are key in a discussion on the importance of a human rights approach to healthcare in Ghana. But so too, is a comment on the right to healthcare as a tool of social struggle, without which the discussion remains incomplete. Healthcare as a tool of social struggle occurs when ordinary citizens frame or lace their political and economic aspirations using the human rights framework.[174] Although "global institutions and norms have increasingly recognized and supported expanded access to palliative care as a human right,"[175] individuals and groups still have to act to claim this right. Yet, as the Nigerian human rights expert Chidi

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[170] *Id*.
[171] *Id*.
[172] *Id*.
[173] Gen. Comments No. 14 on the Right to the Highest Attainable Standard of Health, *supra* note 158, at ¶ 12.
[174] Donnelly, *supra* note 138, at 314.
[175] Paul Hunt et al., *Editorial: Making the Case: What Is the Evidence of Impact of Applying Human Rights-Based Approaches to Health*, 17 HEALTH & HUM. RTS. J. (Nov. 2, 2015), https://www.hhrjournal.org/2015/11/editorial-making-the-case-what-is-the-evidence-of-impact-of-applying-human-rights-based-approaches-to-health/.

Odinkalu once observed, many Africans don't use the language of human rights in their social struggle.[176] What then are the benefits of a human rights approach to healthcare, embedded in international standards, vis-à-vis the traditional (and still dominant) economics-based approach devoid of that feature?

First, framing healthcare as a human right (or public good) can provide an alternative to the dominant economics-based discourse. While economics can continue to dominate discussions among political leaders, legislative committees on healthcare can use human rights principles as guiding norms for healthcare reform. Thus, in the U.S. in 2010, the State of Vermont adopted a new law embracing human rights principles as guidelines for healthcare reform.[177] The human rights approach also gets "people to think about economic inequality differently, in terms of rights."[178] It "act[s] as a counter to society's unceasing attempt to make poor people think it's their fault that they can't make it."[179] Lawmakers can internalize human rights principles as part of their democratic principles of governance, as they did in Vermont in the United States.[180]

Second, building on the first point, because it incorporates an appeal to rights based solely on a person's humanity, the human rights approach is superior.[181] Placing economic and social needs, such as access to life-sustaining healthcare "within an international human-rights

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[176] Chidi A. Odinkalu, Why More Africans Don't Use Human Rights Language, Carnegie Council for Ethics in Int'l Affairs (Dec. 5, 1999), http://www.carnegiecouncil.org/publications/archive/dialogue/2_01/articles/602.html (noting that "[w]hile Africa's human rights problems are immense, even ubiquitous, most of our people do not describe these problems in human rights terms.").

[177] Gillian MacNaughton et al., *The Impact of Human Rights on Universalizing Health Care in Vermont, USA*, 17 HEALTH & HUM. RTS. J. 83 (Dec. 2015).

[178] Philip C. Aka, *Analyzing U.S. Commitment to Socioeconomic Human Rights*, 39 AKRON L. REV. 417, 431 (2006).

[179] *Id*. at 431 (quoting Ethel Long-Scott of the Women's Economic Agenda Project in Oakland, California).

[180] MacNaughton et al., *supra* note 177, at 83.

[181] Aka, *supra* note 178, at 425.

framework would allow them to be seen […] as falling squarely within the categories of rights."[182] More specifically, phrasing one's work in human rights terms "takes you back to the primacy of equality and dignity[,] no matter what the circumstance."[183] And because it is embedded in international law, the human rights approach affords a ready "another place to go" outside "the chokehold of domestic law."[184]

Third, the human rights approach has a *strategic utility* that a system not based on human rights lacks. "You cannot reduce rights. You either have to hold the line or increase them."[185] There is also evidence that "a human rights framework changes the discussion … and opens the door to different outcomes. 'A human rights framework helps us see and think about issues in a new light, helps us to determine what is ours by right. And when we talk in those terms, the discussion changes.'"[186] By contrast, "Keeping a human rights awareness *out* of public discussion can make it easier for governments to deny responsibilities and evade accountability."[187] Little wonder that U.S. "activists dealing with issues relating to immigrants, prisoners, the poor, and other minorities are now increasingly using human rights as a tool of advocacy[,]"[188] steeped in the belief that "[h]uman rights as a framework has the power to transform [their] activism."[189]

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[182] *Id*.

[183] *Id*. at 426 (citing FORD FOUDATION, CLOSE TO HOME: CASE STUDIES OF HUMAN RIGHTS WORK IN THE UNITED STATES 9 (2004)).

[184] Cited in Aka, *supra* note 178, at 431.

[185] Aka, *supra* note 178, at 431.

[186] *Id*. at 432.

[187] *Id*. at 432-33 (quoting Loretta Ross, a human rights administrator and veteran activist). Like in the U.S., there may be a likelihood political leaders probably "don't want [people] to know this stuff, for fear that [they] might use it." *Id*.

[188] *Id*. at 431.

[189] *Id*. at 432 (quoting Libra Foundation President Susan Pritzker's keynote address at a human rights gathering in Chicago in July 2005 ).

Fourth, human rights principles can empower the citizenry by giving them more voice in policymaking.[190] Specifically, framing healthcare as a human right empowers citizens as right holders to demand accountability from their government.[191] As one writer explained this, drawing on her study of South Africa, "Rarely do public servants and governments welcome being held to account—after all, who would want to be viewed as a human rights violator?"[192]

In sum, a human rights approach to healthcare embodies a potential for social transformation that an approach not based on this orientation lacks. Given the generally poor state of health and healthcare in Africa,[193] applying human rights principles to healthcare has many benefits that the traditional economic approach lacks. Human rights can serve as a tool to mobilize and employ communities to demand healthcare for all. Many Ghanaians are still unaware of their rights to healthcare. Instead, many patients, especially beneficiaries of plans subsidized by the government, "tend to see such institutions as doing them a favor and are thus reluctant to complain about any disregard for their rights during their clinical encounters."[194] Given this occurrence, Owusu-Dapaah makes several recommendations for promoting the development of a human rights-based healthcare law to empower patients in Ghana, including creation of a patient rights ombudsman; and integrating healthcare law in the curriculum in law, medical, and nursing schools.[195]

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[190] *Id.*

[191] Owusu-Dapaah, *supra* note 9, at 91 (abstract).

[192] Leslie London, *What is a Human-Rights Based Approach to Health and Does it Matter?*, 10 HEALTH & HUM. RTS. J. (Jun. 2008), http://www.hhrjournal.org/2013/09/what-is-a-human-rights-based-approach-to-health-and-does-it-matter/.

[193] *See, e.g.,* Angus S. Deaton & Robert Tortora, *People In Sub-Saharan Africa Rate Their Health and Healthcare Among the Lowest in the World*, 34(3) HEALTH AFF. 3519-27 (Mar. 2015); B. Rose Huber, *Sub-Saharan Africans Rate Their Health and Health Care Among the Lowest in the World*, Woodrow Wilson School of Public & Int'l Affairs, Princeton University, Feb. 25, 2015 (news story on the Deaton & Tortora research).

[194] Owusu-Dapaah, *supra* note 9, at 92.

[195] *Id.*

Our using certain activist groups as example in discussion of some of the four categories in the application of human rights in social struggle can leave the appearance that these groups use one of these approaches rather than the others. Such an interpretation would be erroneous since nothing prevents these groups from using *all* those instances in their advocacy work. The story is similar with an entity like Oxfam International. As indicated earlier in this Article, the antipoverty confederation spots an approach to combating poverty that is embedded in human rights, an approach anchored in its belief that "respect for human rights will help lift people out of poverty and injustice."[196] Surely, the orientation is a child of strategy, but it is also simultaneously an alternative to the dominant economics-based discourse, an appeal to rights based solely on a person's humanity, and a tool of empowerment that gives citizens more voice in policymaking.

## V. GHANA'S NHIS AND THE EVOLUTION OF A HUMAN RIGHT TO HEALTHCARE IN AFRICA: NINE REASONS WHY THE NHIS IS *NOT YET UHURU* WHEN IT COMES TO HEALTHCARE AS A HUMAN RIGHT IN GHANA

Ghana's healthcare program marks a refreshing departure from the "cash and carry," user fee, system, that preceded it. The NHIS is a monument in universal healthcare whose introduction in 2003 "was a bold progressive step that recognized the detrimental impact of user fees, the limitations and low coverage of" the incomprehensive pilot initiatives that preceded it, and "the fundamental role of public financing in" achieving universal healthcare.[197] As of 2008, "findings suggest that there has been an increase in access to formal care amongst members, as well as a significant decrease in out-of-pocket expenditures[,]"[198] such that, "[w]hile user fees

[196] *See supra* note 1.
[197] ACHIEVING A SHARED GOAL, *supra* note 1, at 18.
[198] Witter & Garshong, *supra* note 136, at 6. There are hiccups, indicated by surges in informal payments, such as charges for out-of-hours services and advisement for patients to pay for drugs supposedly out of stock. *Id.*

only constituted around 12-14 [percent] of the overall resource envelope in the first half of the decade," as of 2009, the NHIS contributed about 41 percent of overall revenue.[199]

There is no question regarding the huge impact of the program. Available empirical "evidence suggests that access and quality of services have improved."[200] More specifically, government spending on healthcare has grown from one into two digits;[201] there are important advances registered in the number and distribution of medical personnel, particularly nurses, across the country;[202] commendable gains have taken place in health outcomes;[203] and the concept of universal healthcare "is now a shared vision across civil society and government" in Ghana.[204] Moreover, the impact goes beyond Ghana: the program arguably serves as a model for developing countries in Africa and beyond.[205]

This said, the Ghanaian government still has long ways to go in access and health outcomes to realize its touted vision of "health care for all, free at the point of use."[206] For example, the country lags behind the United Nations Millennium Development Goals (MDGs)

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However, these may be developments part of the normal transition to a new system that at this point may not be major cause for concern.

[199] ACHIEVING A SHARED GOAL, *supra* note 1, at 9.

[200] *Id.* at 8. For example, "average OPD [out-patient department] attendance […] increased considerably from 0.49 in 2000 to 0.81 in 2009."

[201] According to Oxfam International's estimate, government spending on healthcare in the country rose from 8.2% in 2004 to 14.6% in 2009. *Id.* at 33.

[202] *Id*.

[203] For example, between 2002 and 2009, death from malaria reduced by 50% for children under five, treatment success rate for tuberculosis reached 85% in 2009, child mortality declined by 27% by 2009, and infant mortality by 32% by 2009. *Id*. at 33.

[204] ACHIEVING A SHARED GOAL, *supra* note 1, at 34.

[205] *Id*. at 18. The range of countries from Africa and abroad understudying the program for its supposed cost-effectiveness include Bangladesh, Benin, Democratic Republic of Congo, Ethiopia, Liberia, Mali, and Senegal. Mensah, *supra* note 31. The attention was probably spurred by the NHIS's winning in 2010 of a United Nations award. The prize in question was the South-South Cooperation Excellence Award, issued by the United Nations Development Program and the World Health Organization. *See Ghana's NHIS Wins Major World War*, THE PRESIDENCY, http://www.presidency.gov/gh/node/55.

[206] ACHIEVING A SHARED GOAL, *supra* note 1, at 8.

targets in health;[207] despite improvement in out-patient department attendance, averages lag behind the "generally accepted minimum of 3 per person per year for basic universal coverage";[208] and there is little progress registered in family planning,[209] to name these downsides. The net result is that many years after implementation of the NHIS, many Ghanaians still rely on the cash and carry user fee system for their healthcare needs, "or resort to unqualified drug peddlers and home treatment due to lack of funds."[210]

In sum, on the right to healthcare in Ghana, it is not yet *uhuru* (freedom), as East Africans would put it in Swahili.[211] Instead, as Witter and Garshong pointed out in their 2009 study, still relevant here, for Ghana and other supposed healthcare bellwether countries in Africa, little evidence exists regarding the argument that social health insurance "increases the responsiveness of services," allegedly due to the "stronger entitlement" rising beyond the status of "tax-paying consumers" that this model of healthcare financing symbolizes.[212] Some of the numerous interconnected factors analysed in this section which add up to place Ghana's otherwise commendable healthcare initiative below the standard of a human right to healthcare include that it is less than free, less than comprehensive, inequitable, inefficient, not adequately funded, lacking in accountability, privileges curative medicine over preventive care, is dependent on external assistance with the vulnerabilities that come from such dependence, all of which factors

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[207] *Id*. at 33. For example, there is slow progress on communicable diseases (such as malaria, HIV and AIDS, tuberculosis, meningitis, cholera, and guinea worm) as it faces new challenges in non-communicable illnesses, such as diabetes, cancers, and heart diseases. *Id*. at 33-4.

[208] *Id*. at 34.

[209] *Id.*

[210] *Id.* at 8.

[211] Swahili, short for Kiswahili, is a language widely spoken in East Africa. Broadly speaking, the idea for this statement was inspired by OGINGA ODINGA, NOT YET UHURU: THE AUTOBIOGRAPHY OF OGINDA ODINGA (Heinemann, 1968) (drawing from his personal experiences of persecution, Odinga, a former vice president of Kenya, indicates that the freedom in Kenya was a mere appearance with little basis in reality).

[212] Witter & Garshong, *supra* note 136, at 12.

are then compounded by a rapid population growth out of sync with economic growth. We take these factors in turn and return to some of these variables in the conclusion of the Article.

### *A. Less than Free*

The first reason why the NHIS falls below the international and ethical standard of human rights is that in its present condition the program is less than free. Ghanaian governments promised free healthcare for all citizens at the point of access that the NHIS, as currently designed and implemented, did not meet. An issue here is exactly what we mean by unfree healthcare. There is a popular saying in the United States to the effect that there's no free lunch in that everything costs something, even if sometimes indirectly or hidden.[213] This is a viewpoint the WHO itself seems to share regarding healthcare. Elaborating on the concept of Universal Health Coverage, the international agency indicated that protection against financial risk is not absolute. This is because "[n]o health system meets the full cost of health services out of the prepaid and pooled funds collected by tax or insurance contributions."[214] Instead, many health systems "require some form of co-payment, sometimes of an informal nature, at the time of use[,]" aimed at "restrain[ing] demand and/or limit[ing] the cost to the government or insurance fund."[215] For WHO, insulation against financial risk or hardship is still met if "the relative contribution made by out-of-pocket payments from patients at the time of service provision is not so high that it reduces access to care."[216] User fee may be all right "if it is administratively more accessible than general government allocations[,]" but is a problem when "revenue collection

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[213] *There Ain't No Such Thing as a Free Lunch*—TANSTAAFL, INVESTOPEDIA, http://www.investopedia.com/terms/t/tanstaafl.asp. (explaining that the saying "expresses the idea that even if something seems like it is free, there is always a cost, no matter how indirect or hidden."). The phrase is believed to have originated from the practice of some saloons in the U.S. who provided free lunches to their patrons but required them to purchase drinks in order to get those lunches. *Id.*

[214] Social Health Insurance, *supra* note 16, ¶ 8.

[215] *Id*.

[216] *Id.*

becomes a disproportionately important evaluative criterion in a system which is, after all, ultimately intended to improve health status."[217]

This said, the NHIS in its present form is not free. For one thing, despite the scheme, many drugs and services are not included and must be covered by out-of-pocket payments.[218] To make the program more free, as Oxfam International indicated in its recommendations on how to strengthen the NHIS, the Ghanaian government may have to take a number of steps that include introducing a single lifetime payment in place of regular premium payments and abolishing user fees in the parallel system.[219]

### *B. Less than Comprehensive*

In addition to not being really free, as currently designed and implemented, the NHIS is also less comprehensive than it appears at first sight. Because of a range of problems that includes long hours spent on "unmoving queues," as of 2014, about 15 million Ghanaians have not registered to use the benefits of the NHIS.[220] This is especially the case with richer citizens who can afford service in the user-fee system. In no area is this lack of access more evident than in mental health services. In June of 2012, the Ghanaian national government unveiled a mental health program under the Mental Health Act, designed to complement the NHIS.[221] Among other features, the law allows people with disabilities to challenge their detention in psychiatric

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[217] C.J. Waddington & K.A. Enyimayew, *A Price to Pay, Part 2: The Impact of User Charges in the Volta Region of Ghana*, 5 INT'L J. HEALTH PLANNING & MGT. 287, 287 (1990).

[218] *See supra* Part III.B (commenting on the quantum of services available to registrants under the NHIS).

[219] ACHIEVING A SHARED GOAL, *supra* note 1, at 34-5.

[220] Mensah, *supra* note 31.

[221] Mental Health Act, 2012, Act 846, https://ijmhs.biomedcentral.com/articles/10.1186/1752-4458-8-16. For an analysis on the law, *see* Mark Roberts et al., An Overview of Ghana's Mental System: Results from an Assessment Using the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS), 8 INT'L J. MENTAL HEALTH SYSTEMS (May 4, 2014), https://ijmhs.biomedcentral.com/articles/10.1186/1752-4458-8-16.

hospitals.[222] Before the law, the "practice is that family members deliver individuals to a psychiatric hospital or prayer camp, or police remove individuals off the street when they exhibit confused or aggressive behavior."[223] Not so any longer, thanks to the Mental Health Act.

However, an early assessment of the law published October 2, 2012 by Human Rights Watch revealed that many mental patients hospitalized under the program faced physical and verbal abuse, including being chained to trees.[224] Accordingly, administrators of the NHIS still have long ways to go to promote improved mental health services. Mental well-ness and integrity is critical to the WHO's definition of good health;[225] therefore, people without access to proper mental treatment lack the mental well-being and integrity that epitomize good health.[226] It should be noted that the National Health Insurance Act exempts persons with mental disorder from paying premiums,[227] but this by itself does not cure the problem of incomprehensiveness.

There are also services excluded under the NHIS that warrant coverage. One such service that comes to mind is dialysis for *chronic* kidney failure, even though the scheme covers *acute* kidney failure.[228] The fact of the matter is that the distinction between the two illnesses is not too obvious to the naked eyes that it would be a good idea to cover both.

### *C. Inequitable*

In addition to not being entirely free and possessing features of incomprehensiveness most indicated by inadequate attention to mental treatment, as currently designed and

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[222] Hum. Rts. Watch, Ghana: People with Mental Disabilities Face Serious Abuse (Oct. 2, 2012 4:30 AM EDT), https://www.hrw.org/news/2012/10/02/ghana-people-mental-disabilities-face-serious-abuse.

[223] Juan E. Méndez , Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Human Rights Council Twenty-Fifth session, Agenda item 3, A/HRC/25/60/Add.1 (Mar. 5, 2014).

[224] Hum. Rts. Watch, *supra* note 222; Méndez, *supra* note 223, *passim*.

[225] *Supra* note 159 and corresponding text.

[226] *Supra* note 162and corresponding text.

[227] *See supra* note 109.

[228] *See supra* Part III.B. (enumerating the quantum of services available to registrants under the NHIS).

implemented, the NHIS is also inequitable in access as well as in financing. *Inequity* refers to lack of basic fairness or justice. "Who pays how much for what, when?" is a major element in the design and implementation of any healthcare system.[229]

One element, out of several, which makes the NHIS inequitable—a concern anchored on both access and funding—is that it limits healthcare benefits funded mostly from tax revenue to a small section of the public. As Oxfam International colloquially put it in its seminal report, practically everybody pays for healthcare but only a minority benefits.[230] To put things in a more practical perspective, about 70 percent of the NHIS's funding, representing more than two-thirds, came from tax revenue made up of 2.5 percent health insurance levy plus a sales value-added tax that every Ghanaian citizen pays each time he or she buys goods and services.[231] Given this funding reality, "All Ghanaians, rich and poor, are contributing financial[ly] to the health system[.]"[232] However, according to Oxfam International's estimate, only about 18 percent benefit from the scheme.[233] The antipoverty group reached this number through its assessment that "[c]overage of the [scheme] has been hugely exaggerated, and could be as low as 18 [percent]," an occurrence that leaves about 82 percent excluded.[234] Oxfam International maintains that the NHIS delivers healthcare for a "lucky few at the expense of the many[,]"[235] and it assesses "[t]his large-scale exclusion" to be the most damning flaw of the NHIS.[236]

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[229] EDWARD BAKER ET AL., MANAGING THE PUBLIC HEALTH ENTERPRISE 170 (Jones Barlett Learning, 2010).

[230] *See* ACHIEVING A SHARED GOAL, *supra* note 1, at 7, 26.

[231] *Id.* at 26. The figure of 70% is based on available data for 2008 provided by Oxfam Int'l.

[232] *Id*. at 26.

[233] *Id*. at 7, 26.

[234] *Id*. at 7.

[235] ACHIEVING A SHARED GOAL, *supra* note 1, at 7. *See also id*. at 8 (positing that the design in the funding of the NIHS rooted largely on tax funding "is flawed and unfair—every citizen pays for the NHIS but only some get to join.").

[236] *Id*. at 26.

Besides benefitting relatively few people at the expense of many, another feature which makes the NHIS inequitable is that it discriminates against abjectly poor persons.[237] These are persons defined by the World Bank as living on less than one U.S. dollar per day.[238] Despite their material poverty, based on Oxfam International's estimate, 20 percent of this group "pay[s] 6 [percent] of their expenditure as tax and of this nearly 15 [percent] goes into the government health budget."[239] Though the matter of financing inequity is so obvious, like the first feature (benefitting the few at the expense of the many), this problem is also equally an issue of access, given that under the scheme, 64 percent of the richest are registered, compared to 29 percent of the poorest.[240] The progressive nature of taxation in Ghana, simply meaning that "the rich pay a higher proportion of their expenditure as tax than the poor," minimizes but does not take away this badge of inequity.[241] The result is that "[p]oor people are left with no choice but to resort to home treatment[,]" including "risk[ing] childbirth at home without qualified care."[242]

Just like abjectly poor individuals, the NHIS discriminates against workers in the informal sector. The informal sector consists of economic activities outside the formal economy that elude or are not amenable to government regulation.[243] It is a sector "characterized by underemployment, bad working conditions, uncertain work relationship, and low wages,"[244] where about eight out of every ten workers in Ghana derive their source of livelihood.[245]

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[237] *Id*. at 8.
[238] *Id.* at 26.
[239] *Id*.
[240] *Id.* at 7.
[241] *Id*. at 26 (stating that despite the progressive nature of Ghana's tax system, "financial contribution from the poor could well be diverting already scarce resources away from other goods and services essential for their health and well-being.").
[242] *Id.* at 28. Vis-à-vis richer persons, abjectly poor women in Ghana "are more than three times more likely to deliver at home," often the only "private" health services available to these poor women. *Id.*
[243] *See* Clara Osei-Boateng & Edward Ampratwun, The Informal Sector in Ghana, Friedrick Ebert Stiftung 4 (Oct. 2011), http://library.fes.de/pdf-files/bueros/ghana/10496.pdf. (reviewing definitions of the term).
[244] *Id*. (abstract)
[245] *Id*.

Informal sector workers, most of whom "liv[e] with high income insecurity," include "self-employed persons, such as farmers, traders, food processors, artisans, and craft-workers," among numerous occupations in the rural and urban areas.[246] Discrimination against this large group of workers is marked under the NHIS by the "principle of exemptions";[247] they "are the only population group required to pay premiums individually and in cash to benefit from the" scheme.[248] It is an inequity rooted in funding given that, as Oxfam International observes, "despite their low incomes, informal economy workers are unfairly paying significantly more per head than any other members [under] the scheme."[249] The inequity is equally embedded in access given that it also "leads to the large-scale exclusion of informally employed adults and their children."[250] To get a sense of the magnitude of this exclusion, "As of June 2010, only 29 [percent] of those registered for NHIS were employed in the informal economy."[251]

A fourth and final badge building on and reinforcing the previous three elements of inequity is insurance financing, particularly reimbursement payments, which favor high-level facilities, such as hospitals and districts/regions with higher levels of infrastructure to facilitate access. It is in light of the foregoing problems of inequity that Oxfam International predicted that the NHIS, as currently implemented, "fail[s] to deliver the scale of change promised"[252] and advised the Ghanaian government to enact "bolder changes," including "overhaul[ing] the health insurance bureaucracy."[253]

### *D. Inefficient*

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[246] *Id*.
[247] *See supra* Part III.C.
[248] ACHIEVING A SHARED GOAL, *supra* note 1, at 29.
[249] *Id*.
[250] *Id*.
[251] *Id*.
[252] *Id.* at 15.
[253] *Id*.

A fourth factor why the NHIS falls below the international and ethical standard of human rights is because it is inefficient. *Efficiency* denotes the relationship between input and output, specifically "the ability to do something or produce something without wasting materials, time, or energy."[254] Inefficiency is a problem of execution, rather than design, that afflicts many healthcare systems, rather than unique to Ghana.[255] One feature which notably makes the NHIS inefficient is registration. To access supposedly free healthcare under the system, beneficiaries need a card which they do not get unless they register. However, the registration process can be arduously slow, leaving individuals to stand in line for many hours in long queues that sometimes barely move.[256] As Oxfam International pointed out in its report, "[m]any Ghanaians simply do not have access to an NHIS agent near where they live."[257] Individuals who manage to register can wait months for their membership cards to arrive before they can access the healthcare system.[258]

Another badge of inefficiency under the NHIS consists of major delays in reimbursing hospitals, pharmacists, and other healthcare providers for services, sometimes running into millions of U.S. dollars.[259] It takes three to four months on average for the government to reimburse health facilities within which time-lag some health facilities reportedly turn away insured patients or demand payment before rendering services.[260] A third badge of inefficiency is cost escalation which occurs when healthcare providers "gam[e] the system to maximize

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[254] MERRIAM-WEBSTER DICT., http://www.merriam-webster.com/dictionary/efficiency.

[255] *Id*. at 46. For example, Oxfam Int'l cites a WHO report which estimates that "between 20% and 30% if existing health resources are being wasted due to inefficient and inequitable use." *Id*.

[256] Mensah, *supra* note 31. This news story deadpanned that "Would-be beneficiaries must meet one unofficial requirement - be physically fit or forget about it," because, for example, "In Accra, the capital, people queue as early as 3a.m. at the National Health Insurance offices to register."

[257] ACHIEVING A SHARED GOAL, *supra* note 1, at 29.

[258] *Id*.

[259] *Id.* at 29 (stating that the Ghanaian government owed health facilities about $34 million USD as of the end of 2008).

[260] *Id.*

reimbursement payments."[261] Regarding this matter, Oxfam International averred in its report that "[i]n certain respects[,] the NHIS could be seen as a provider's dream: 95 [percent] of health conditions covered with payment methods that offer few or no incentives to contain costs."[262] A fourth and final badge of inefficiency is the waste which arises when the National Health Insurance Authority, which runs the scheme, "set[s] its provider reimbursement price levels too high so providers can make profits by procuring medicines at lower prices[,]"[263] rather than pay them the same rate as public providers.[264]

Oxfam International estimates that about 36 percent of healthcare spending in Ghana is waste due to inefficiencies and poor investment.[265] Collectively, these inefficiencies cost the Ghanaian government millions of Cedis each year,[266] impeding the sustainability of the still fledgling system. On the other hand, plugging these holes of inefficiency "will bring significant gains […] by generating savings that can be ploughed back into improving and expanding service delivery" in the country.[267] Revamp of health insurance administration alone could save the country $83 million USD a year, an amount enough to pay for about 23,000 more nurses.[268]

Several sources of savings for Ghana's healthcare system that Oxfam International points up include: a shift away from annual premium payments that eliminates the need for much of the current insurance bureaucracy, slimming down the National Health Insurance Authority and incorporating relevant portions of its responsibility to the Ministry of Health, plugging avenues

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[261] *Id.*
[262] *Id.*
[263] *Id.* at 29.
[264] On this, Oxfam Int'l determined, based on an analysis of NHIS data, that "the average reimbursement rate per health facility attendance claim for insured patients is 50% higher than non-insured patients paying for themselves in the cash and carry system." *Id*. at 30.
[265] *Id.* at 7, 11.
[266] *See id*. at 30, 46.
[267] *Id*. at 46.
[268] *Id*. at 7.

for fraud and leakages in the healthcare system, and reducing the cost of medicines through better negotiations with suppliers and reducing unnecessary cost escalation along the supply chain.[269] Others are: paying private providers at the same rate as public providers; incorporating family planning services as part of the current package of benefits under the NHIS; and investing in preventive measures, such as increased bed net distribution to prevent malaria, as well as potable water and increased sanitation to reduce diarrhea and typhoid.[270]

### *E. Not Adequately Funded*

As indicated in Part III. above, funding is critical to the design and maintenance of any healthcare system. This is a criterion that, just like other healthcare systems in Africa, the NHIS does not rank well on—and a fifth factor why, for all the important advances it signifies, Ghana's healthcare program falls below the high standard of a human right. The NHIS's problem of inadequate funding stems from a decoupling of revenue from growing membership that questions the sustainability of the scheme.[271] To put the matter in a broad perspective, government spending on healthcare in many African countries are inadequate to scratch the surface of healthcare delivery, a situation then compounded by corruption which leaves even less money available for health services.[272] In 2005, 192 members of WHO endorsed a resolution on "sustainable health financing, universal coverage, and social health insurance."[273] Earlier on, in September of 2000, 189 heads of state met and adopted the Millennium Development Goals

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[269] *Id*. at 47 (distilled from Table 5, "potential savings that could contribute toward financing universal health care.").

[270] *Id.*

[271] This statement is based on Witter & Garshong, *supra* note 136, at 4, in turn based on figures for 2008 showing that card holders under the program increased from nearly 7% of the population in 2005 to 45% in 2008, of which only about one-third were contributing to the scheme financially. *Id*. Keep in mind that the membership is unevenly spread—from 13% in Central Region to 70% in Upper West. *Id.*

[272] *See Future of Healthcare in Africa, supra* note 6, at 13.

[273] Sustainable Health Financing, Universal Coverage and Social Health Insurance, WHA58.33, 9th Plenary Meetg., May 25, 2005, Committee A, 8th Rept., http://apps.who.int/iris/bitstream/10665/20383/1/WHA58_33-en.pdf?ua=1.

(MDGs), time-bound targets for combating extreme poverty.[274] Three of the eight MDGs—reducing child mortality rates, improving maternal health, as well as combating HIV/AIDS, malaria, and other diseases—relate directly to healthcare.[275] To make progress on the MDGs, African leaders met in April 2001 in Abuja, Nigeria, and pledged to commit 15 percent of their national budgets to healthcare spending.[276] However, ten years later, only two countries—Rwanda, and South Africa—met the pledge[277] and Ghana was not on the list,[278] although at 14.6 percent in 2009,[279] it came close to meeting the pledge. The expectation is that Ghana stands the chance of meeting the minimum standard necessary for progress on the MDGs if it reduces wastes from inefficiencies in the administration of the NHIS.[280]

Black Africa makes up 11 percent of the world's population and accounts for 24 percent of global disease burden,[281] but commands less than 1 percent of global health expenditure.[282] For some countries in the region, the only way around this inadequate funding of healthcare is external assistance. Inadequate funding militated against implementation of the early phase of the free maternal healthcare exemption Ghana unveiled in 2004. Because of shortfall in funding, "Facilities became increasingly indebted and many reverted to charging. The number of facility based deliveries declined as a result."[283] Partly financed by debt relief, the exemption became reactivated in 2008 and expanded to six more regions following financial support from the

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[274] *What They Are*, MILLENNIUM PROJECT, http://www.unmillenniumproject.org/goals/.

[275] *Id.*

[276] *See Future of Healthcare in Africa, supra* note 6, at 13; WHO, *The Abuja Declaration: Ten Years On,* http://www.who.int/healthsystems/publications/Abuja10.pdf.

[277] WHO, *The Abuja Declaration, supra* note

[278] *Id.*

[279] ACHIEVING A SHARED GOAL, *supra* note 1, at 33.

[280] *See id*. at 7 (stating that "[t]hrough savings," from some sources of waste, and other means, "the government could afford to increase spending on health by 200%, to U.S. $54 per capita, by 2015.").

[281] *Future of Healthcare in Africa, supra* note 6, at 13.

[282] *Id*.

[283] ACHIEVING A SHARED GOAL, *supra* note 1, at 18.

British government that year.[284] But a right to healthcare means little if not backed with funding to realize it.[285] This matter of financing is obviously one reason why, while acknowledging the important advances in expanded healthcare the NHIS embodied, Oxfam International nevertheless posited that holding Ghana up as a model "is misleading."[286]

Given the importance of financing, it is not surprising that the bulk of the suggestions of Oxfam International for strengthening the NHIS focused largely on this variable: what it will cost to finance the vision;[287] and how to pay for financing the vision by 2015.[288] Our focus here will be on the *how* while we come to *what* it will cost later in Part V.I, below, related to Ghana's rapid population growth. Regarding how to pay for universal healthcare, Oxfam International estimated that "under the current financing arrangements, the NHIS would enter into a deficit situation within the first 4 to 5 years of scheme operation, and especially as population coverage rises beyond a certain point."[289] It averred that financing universal healthcare in Ghana can be achieved from three sources, comprised of: "Savings generated from reduced inefficiencies in the health sector, additional revenue from improved economic growth and progressive taxation, and improved external development aid."[290] The first two sources are appropriate, but not the third for reasons we provide shortly in V.H. below regarding the dependence of the NHIS on the vagaries of external assistance.

As one Kikuyu proverb goes, when two elephants fight, the grass suffers.[291] As the

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[284] *Id*.

[285] *See e.g.* Charles Ngwena, *The Recognition of Access to Health Care as a Human Right in South Africa: Is it Enough*, 5 HEALTH & HUM. RTS. 26 (2000).

[286] ACHIEVING A SHARED GOAL, *supra* note 1, at 15.

[287] *Id*. at 45.

[288] *Id*. at 45-47.

[289] *Id*. at 45 (quoting the Int'l Labor Organization (ILO)).

[290] *Id.* at 46. For more on the first source (savings from reduced inefficiencies), *see supra* note 280and corresponding text.

[291] *African Proverb of the Month, November 2001*, AFRICAN PROVERBS, SAYINGS, AND STORIES, http://www.afriprov.org/african-proverb-of-the-month/27-2001proverbs/172-nov2001.html. (explaining that "the

theatre of many conflicts, Africa was the proverbial grass in the ideological Cold War struggle between the socialist East and the capitalist West.[292] Yet, in the aftermath of the Cold War in 1991, governmental expenditure, as a share of the gross domestic product (GDP), still favored military spending in the region (proverbial guns) at the expense of social service (proverbial butter), including healthcare. Four African countries—Eritrea, Burundi, Liberia, and Ethiopia—are among the 20 countries in the world with the highest military burdens as a share of GDP.[293] Their shares are Eritrea 23.5 percent, Burundi 7.6 percent, Liberia 7.5 percent, and Ethiopia 5.2 percent.[294] Liberia may be understandable, given the crisis in its land until recently, but the others are more difficult to justify.

High military spending militates against social welfare needs, given that implementing "basic economic and social rights depends upon a shift in scarce resources away from militarism and towards these areas of human need[,]"[295] whereas military spending "divert[s] invaluable human, material, and financial resources" to social needs.[296] As Zeleza elaborates, for about "every 1 percent of G[ross] N[ational] P[roduct] devoted to military spending," overall economic growth reduces by about 0.5 percent, a state of affairs that results in a diversion "of resources away from the collective human rights of education, health care and subsistence."[297]

*F. Lacking in Accountability*

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proverb is used regularly to describe local officials and leaders whose disputes and divisions end up hurting innocent and powerless" third parties.).

[292] *See id*.

[293] P.T. Zeleza, The Struggle for Human Rights in Africa," Keynote Address to the Annual Meeting of the Association of African Studies, University of Toronto, May 17, 2007, at 1, http://www.zeleza.com/node/162/print. at 5. *Reprinted in* 41(3) CANADIAN J. AFRICAN STUD./LA REVUE CANADIENNE DES ÉTUDES AFRICAINES 474-506 (2007)

[294] *Id.*

[295] *Id*., at 5 quoting William Felice.

[296] *Id*. at 5.

[297] *Id*.

In addition to the foregoing issues of deficiency in human rights, Ghana's healthcare program lacks needed accountability. Accountability is a cardinal principle of democracy and a concept ineluctably tied to transparency.[298] *Accountability* stands for the proposition that government officials, both those elected and those appointed by elected officials, "are responsible to the citizenry for their decisions and actions."[299] *Transparency* mandates "that the decisions and actions of those in government are open to public scrutiny and that the public has a right to access such information."[300] Both concepts are so central to the "very idea of democratic governance that" without them, "democracy is impossible."[301] Absent them, "elections and the notion of the will of the people have no meaning, and government has the potential to become arbitrary and self-serving."[302] Though less obviously, accountability and transparency are also an issue of human rights. Under international law, individuals have the right to take part in the government of their country and the will of the people, expressed in free and fair elections, forms the basis for the authority of government.[303]

As of the date of publication of the Oxfam International report in 2011, the NHIS failed to publish reports on the performance of healthcare in the country that would help Ghanaians and non-government groups in the country to hold accountable their government and officials of agencies charged with implementing the NHIS, including the Ministry of Health and the Ministry of Finance, for their decisions and actions.[304] In its report on the Ghana healthcare

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[298] *See Accountability and Transparency: Essential Principles*, DEMOCRACY WEB: COMPARATIVE STUDIES IN FREEDOM, http://democracyweb.org/node/42.

[299] *Id*.

[300] *Id*.

[301] *Id*.

[302] *Id*.

[303] *Universal Declaration of Human Rights*, *supra* note 140, Art. 21(1) and (3). For an extensive analysis on this right, *see* Thomas M. Franck, *The Emerging Right to Democratic Governance*, 86 AM. J. INT'L L. 46 (Jan. 1992).

[304] *See* ACHIEVING A SHARED GOAL, *supra* note 1, at 36.

initiative, Oxfam International made suggestions Ghanaian authorities could take to promote accountability and transparency with respect to the NHIS. These include: placing the management of the National Health Insurance Fund (NHIF) under the jurisdiction of the Ministry of Health "with a clear legal responsibility to publish timely and comprehensive accounts of both income and expenditure, including regular tracking surveys to monitor spending at all levels of the system";[305] and enforcing regular published accounts from the Ministry of Finance, "indicating disbursements to the health sector against commitments made."[306]

### *G. Privileging Curative Medicine over Preventive Care*

A seventh factor accounting for the ranking of Ghana's healthcare program as less than human rights is its privileging of curative care over preventive medicine. "An ounce of prevention is better than a pound of cure," as one famed adage goes.[307] Consistent with this saying, progressive healthcare systems today stress primary healthcare, i.e., keeping people healthy, over curative medicine. They "make disease unacceptable instead of building ever larger infrastructure to accommodate it."[308] Preventive medicine counsels holistic well-ness campaigns that "involve not only medical staff, but also officials dealing with agriculture, transportation, law enforcement, water and sanitation, food security and housing."[309] It also encompasses well-targeted education designed "to prevent [people] from developing chronic diseases in the first place[,]" and to "teach[] those with chronic conditions to manage their health[.]"[310]

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[305] *Id.* at 36. It is not clear whether the structure Oxfam Int'l is proposing here (under the heading 4.1.2 titled "Establish a National Health Fund," is a new one, given that the NHIS already has a Fund that we described in *supra* Part III.A., dealing with the legal framework of the NHIS.

[306] *Id.* (under 4.1.3 focused on "transparency and accountability").

[307] The saying is attributed to the U.S. founding father, Benjamin Franklin (1705/6-1790).

[308] *Future of Healthcare in Africa, supra* note 6, at 17 (quoting Dr. Ernest Darkoh, founding partner of BroadReach Healthcare, a healthcare services company). According to Dr. Darkoh, most successful outcome for a healthcare system in Africa should be defined as never needing to see the inside of a hospital. For him, the continuous need to build more hospitals and clinics should be considered a sign of failure. *Id*.

[309] *Id.*

[310] *Id.*

Unfortunately, this preventive approach to medicine has yet to reach the shores of Africa where, instead, in many countries, the healthcare system "remain[s] focused on acute, short-term treatment, and on fighting the traditional battles against infectious and tropical diseases, diarrhea, and maternal and child mortality."[311] To compound an already bad situation, foreign donors also unwittingly promote this curative approach with their assistance when they "focus[] overwhelmingly on high-profile causes like HIV/AIDS or malaria, and neglect[] other health issues, like child and maternal health, nutrition and the spending necessary to build up health systems."[312]

The NHIS is guilty of this stress of curative medicine over preventive care, when the emphasis should be in the opposite direction. Two indicators point to this orientation. The first is the failure of the Ghanaian governments to address many of the social determinants of health discussed in IV.B. above, such as bad roads, inadequate access to clean water, poor sanitation, low literacy levels, and gender inequality, among other problems. The second is signified by the processing of claims under the NHIS in a manner that shifts resources away from preventive to curative care. As Oxfam International points out, "[f]rom 2006 to 2008, while claims payments for curative health were sky-rocketing, the government subsidy to the District Health Administration responsible for preventative health levelled off in real terms in 2006 and 2007 and fell in 2008."[313] However, "[b]y only reimbursing curative care," at the expense of investments that keep people healthy, "the NHIS presents no incentive to facilities to incorporate preventative health into their services."[314] Oxfam International advanced capitation payments as

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[311] THE STATE OF HEALTHCARE IN AFRICA: FULL SECTOR REPORT 17 (KPMH Africa Ltd., 2012),

[312] *Id*. at 4-5.

[313] ACHIEVING A SHARED GOAL, *supra* note 1, at 30.

[314] *Id*.

a tool that the Ghanaian government could use to promote preventive healthcare.[315] "Capitation requires that the government negotiate a fixed price per citizen to be paid upfront to a given health care provider to cover their health costs over a given period."[316] These payments "[give[] providers a predic[t]able amount of income and an inherent incentive to invest in preventative health."[317]

### *H. Dependent on External Assistance*

An eighth factor that renders Ghana's healthcare initiative not yet *uhuru* on the human right to health is its dependence on external assistance. As the implementation of the pregnancy exemption in 2008 made clear, external aid plays a critical role in the NHIS's work. The successful implementation of the exemption was made possible only with debt relief from external sources and the financial support from the British government, without which that expansion of access would have been difficult if not impossible.[318] Although on the surface this does not seem like a problem, it *is* a problem for the reasons that this Article shall spell out shortly.

First, generally speaking, in the wisdom of one African proverb, no serious traveler depends wholly or even largely on the legs of another person for his own journey.[319] Depending on the legs of another person for one's own journey engenders vulnerabilities that is inconsistent with a good travel. Second, more practically or specifically, excessive dependence on foreign aid constraints the decision making options of an aid-dependent state—and it leaves it vulnerable to

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[315] *Id.* at 36 (box 5).
[316] *Id*.
[317] *Id*.
[318] *Id.* at 18.
[319] *See Africa: The Struggle for Development, in* GLOBAL STUD.: AFRICA, 3, 9 (F. Jeffress Ramsay ed., McGraw-Hill, 8th ed. 1999)

fits of withdrawal syndromes when external aid is withdrawn.[320] These possibilities counsel that these donor-dependent countries "prepare for this eventuality by weaning themselves off aid voluntarily and gradually."[321] The terms *voluntarily* and *gradually* are instructive for Ghana and for other African countries. The first is self-explanatory. With respect to the second, *gradually*, as one health expert advised, "If we are at 90% donor funding now, let's create a plan that in 2022 we will move to 50-50."[322]

This is a piece of advice Ghana should keep in mind. In 2007, the country struck oil in commercial quantity[323] and has been exporting the black gold since 2010.[324] Because of this economic good fortune, Ghana which is already the world's second-largest producer of cocoa and a major gold producer, posted double digit economic growth in 2011.[325] Therefore, well managed, the country can afford more revenue from oil that could replace dependence on foreign aid. Oxfam International identified "improved external development aid" as one of three key main sources Ghana could use to achieve universal healthcare.[326] For Ghana, external should no longer be a viable option in its ultimate plan to develop a healthcare system, unimpeded by the constraints of user fees, a healthcare system that is the envy of many countries in Africa. Dependence on donor assistance runs contrary to the advice for the country and other aid-

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[320] *See Future of Healthcare in Africa, supra* note 6, at 29 (observing that countries heavily dependent on donor financing "are likely to see their health systems overwhelmed and their economic development stunted when aid is withdrawn" or "forced to make difficult decisions about the care that they can offer.").

[321] *Id*.

[322] *Id*.

[323] Francis Kokutse (Associated Press), *Ghana Leader: Oil Reserves at 3b Barrels*, INTERNET ARCHIVES (Dec. 22, 2007, 8.55 AM ET) http://web.archive.org/web/20071226200944/http://news.yahoo.com/s/ap/20071222/ap_on_re_af/ghana_oil_discovery_3.

[324] Jason McLure, *Ghana Oil Reserves to be 5 Billion Barrels in 5 Years*, BLOOMBERG (Dec. 1, 2010, 9:48 AM CST), http://www.bloomberg.com/news/articles/2010-12-01/ghana-oil-reserves-to-be-5-billion-barrels-in-5-years-as-fields-develop; Chuck Neubauer, *Ghana Discovery Sparks Fight Over Oil*, WASH. TIMES (Mar. 26, 2010), http://www.washingtontimes.com/news/2010/mar/26/ghana-discovery-sparks-fight-over-oil/?page=all.

[325] *Ghana Swears in Mahama as New President*, AL JAZEERA (Jul. 25, 2012), http://www.aljazeera.com/news/africa/2012/07/20127259518486684.html.

[326] *See supra* note 290.

dependent countries in Africa to gird their loins for the eventuality that comes from unanticipated withdrawal of foreign aid "by weaning themselves off aid voluntarily-and gradually."[327]

### *I. Rapid Population Growth Out of Sync with Economic Growth*

Compounding the preceding eight factors and keeping the Ghana's healthcare project below the international and ethical standard of human rights is the factor of rapid population growth, estimated at an annual birth rate of 2.18 percent.[328] This means that the country's population is projected to double about every 32 years.[329] Testimony to this rapid growth in population, from about 6 million persons in 1957, Ghana's population has ballooned to nearly 28 million people as of May 2016 with a landmass that remains unchanged at 92,456 square miles.[330] To use a U.S. state for comparison, Ghana is about the size of Oregon, where two of the authors of this Article are resident, but with a much larger population compared to Oregon's less than 4 million people as of 2014.[331] To use Norway as another measuring rod, at independence in 1957, Ghana had a population "about the same as [the country]."[332] Fifty-eight years later,

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[327] *See supra* note 320.

[328] *Ghana*, in CIA FACTBOOK (2014) (estimate as of 2014).

[329] This doubling period is arrived at by taking the number 70 and dividing it by the country's population growth rate, here 2.19, consistent for the formula in determining doubling time. *See* Population Growth: Friend or Foe?, ECONEDLINK, http://www.econedlink.org/lessons/projector.php?lid=32&type=educator.

[330] *Ghana Population (Live)*, WORLDOMETERS, http://www.worldometers.info/world-population/ghana-population/. *See also* Ken Ntiamoa, *Ghana Needs a Population Control Policy*, MODERN GHANA (Jan. 18, 2005), https://www.modernghana.com/news/116094/1/ghana-needs-a-population-control-policy.html; Arjun Adlakha, Population Trends: Ghana, U.S. Bureau of the Census, Int'l Brief No. 96-1 (Jul. 1996) (providing country data that include the country's 1957 population), https://www.census.gov/population/international/files/ib96_01.pdf; *Ghana*, INFOPLEASE, *supra* note 29 (providing country data, including landmass and population as of 2014). Ghana's population is spread unevenly within its area, with almost 80% of the population residing in the south or in the far northeast and northwest. *Ghana*, WORLDMARK ENCYCLOPEDIA OF NATIONS, *supra* note 29.

[331] *Oregon*, QUICKFACTS (U.S. Census Bureau), https://www.census.gov/quickfacts/table/PST045216/41.

[332] Elizabeth Ohene, *Letters from Africa: What Can Ghana Learn from Norway*, BBC NEWS (Dec. 22, 2015), http://www.bbc.com/news/world-africa-34710175.

"Norway still has a population of just over five million," while Ghana's has jumped to "almost 28 million."[333]

The high fertility rate is out of sync with the rate of economic growth averaging 1.98 percent in the past 10 years from 2006-2016.[334] If unchecked, Ghana's fertility rate vis-à-vis economic growth rate could pose problem for any socioeconomic venture like expanded healthcare. To be sure, only humans develop an economy. Therefore, a healthy population is the greatest resource of Ghana or any other country.[335] But too much of a good thing sometimes can be a problem. As one Nigerian demographer stated, commenting on Nigeria in a wisdom that also applies here, "[p]opulation is key. If you don't take care of population, schools can't cope, hospitals can't cope, there's not enough housing—there's nothing you can do to have economic development."[336] Given a choice between population control and achievement of high economic growth, population control seems much less arduous and achievable. However, Ghana's leaders appear not to take population control seriously. Instead, as Oxfam International disclosed in its 2011 report on the Ghana healthcare program, "[f]amily planning coverage is […] unacceptably low at 31 [percentage]."[337]

Finally, unchecked population could have negative consequences for food production.[338] As one study noted, rapid population growth ranks among factors that undermine efforts "to

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[333] *Id*.

[334] Ghana GDP Growth Rate 2006-2016, TRADINGECONOMICS, http://www.tradingeconomics.com/ghana/gdp-growth. Over this period, GDP growth rate in the country reached an all-time high of 8.10% in the first quarter of 2012 and a record low of -2.20% in the fourth quarter of 2008. *Id*.

[335] *See supra,* note 45 and corresponding text (Nkrumah's statement directly tying economic development in Ghana to improvement in the health of the people.).

[336] Quoted in Elisabeth Rosenthal, *Nigeria Tested by Rapid Rise in Population*, N.Y. TIMES (Apr. 14, 2012), http://www.nytimes.com/2012/04/15/world/africa/in-nigeria-a-preview-of-an-overcrowded-planet.html?pagewanted=all&_r=0.

[337] ACHIEVING A SHARED GOAL, *supra* note 1, at 34.

[338] Nafis Sadik, *Population Growth and the Food Crisis*, FAO CORPORATE DOC. REPOSITORY, http://www.fao.org/docrep/U3550t/u3550t02.htm.

increase food production."[339] Specifically, "lower birth rates, along with better management of land and water resources, are necessary to avert chronic food shortages."[340]

## VI. SEVERAL REASONS WHY GHANA SHOULD MOVE TO A SINGLE-PAYER, TAX-FUNDED HEALTHCARE SYSTEM

Consider the following. The NHIS is a healthcare system that is mostly funded by tax revenues.[341] It is a system built on the principle of exemptions where the only group not exempted from annual premium payments are informally employed adults.[342] It is also a system of Universal Health Coverage embedded in social insurance "from which individuals can opt out so long as they are covered by a private insurer."[343] And under the NHIS, everyone pays registration fees, except for indigents and pregnant women who are the only groups exempted from payment of these fees.[344] One way to achieve some harmonization of these moving parts would be a single-payer, tax-funded system, based on single lifetime payments premiums, and free of all registration fees (an accommodation under the NHIS now extended only to indigents and pregnant women).

Although seemingly starkly different from the United States', Ghana's healthcare system still calls to mind the U.S.'s system which, before the Affordable Care Act of 2010, some commentators likened to "a fragmented hodge-podge of private and public plans" that left tens of millions uninsured;[345] and since 2010, "a maze of private and public health insurance, including employer-supported private health insurance schemes, public health insurance programs for people over 65 years of age (Medicare) and poor people (Medicaid), and several smaller public

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[339] *Id*.
[340] *Id*.
[341] *See supra* note 231and corresponding text.
[342] ACHIEVING A SHARED GOAL, *supra* note 1, at 21.
[343] *See* Singleton, *supra* note 5, at 17.
[344] *See* Official Website of the NHIS, *supra* note 102.
[345] Rosen, *supra* note 20.

programs, including the Indian Health Service and the Veterans Health Administration" which leaves "millions uninsured and millions more underinsured and unable to access healthcare due to high deductibles and co-payment."[346]

Although our proposal for a single-payer, tax-funded arrangement may sound radical or sweeping, it does not depart substantially from the present supposedly hybrid system which is mostly funded by tax revenues. In the apt language of Oxfam International, the NHIS's "heavy reliance on tax funding erodes the notion that it can accurately be described as social health insurance and in reality is more akin to a tax-funded national health care system[.]"[347] A single-payer, public-funded system conduces with "the fundamental role of public financing in" universal healthcare that the NHIS symbolizes,[348] would resolve the inequities of the current system, retain healthcare workers who otherwise would prefer to work in the private sector with the more favourable conditions of service this sector affords,[349] and cut down on administrative overheads.[350] A single-payer system anchored on general taxation will do away with the current three plans under the NHIS that registrants must join.[351] It will also draw Ghana closer to the imperatives of universal healthcage built around provision of access to the same range of high-quality health services for individuals, regardless of their employment status or ability to pay[352]—in marked contrast to the current system where informal workers, the only group not exempted from payment of premium under the NHIS, are charged premium avowedly based on

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[346] MacNaughton et al., *supra* note 177.

[347] ACHIEVING A SHARED GOAL, *supra* note 1, at 8.

[348] *Id*. at 18.

[349] *See Background to Health Law and Human Rights in South Africa*, *supra* note 160, at 25 (commenting on South Africa where, according to the author, "[t]he private system provides better conditions to health workers[,]" resulting in "many doctors and nurses leav[ing] the underfunded public system.").

[350] Olga Oksman, *"We Need Fundamental Changes": U.S. Doctors Call for Universal Healthcare*, GUARDIAN (May 5, 2016), https://www.theguardian.com/us-news/2016/may/05/us-doctors-calling-universal-healthcare-system-affordable-care-act.

[351] *See Health Insurance in Ghana*, *supra* note 31.

[352] UNIVERSAL HEALTH COVERAGE, *supra* note 11, at 3.

income and capacity to pay.[353] Under the system, access to private health could still be available for individuals who choose that option and are willing to pay for it, but that option should not be part of the public health scheme the way it is now under the NHIS. This proposal is not inconsistent with Oxfam International's recommendation that Ghana "prioritize investment in the expansion of *public* health care services whilst also continuing to improve regulation of the *private* health care sector."[354]

Ghana can adopt this formula while keeping a watchful eye on problems like rationing and long lines associated with single-payer system, of the kind that occurs in countries like the United Kingdom.[355] It can discover more efficient and equitable ways of raising revenue for health from tax reform, while ensuring that adequate proportions of national budgets are allocated to health, in compliance with the Abuja target advising commitment of at least 15 per cent of government spending on healthcare.[356] A single-payer, tax-funded healthcare financing is today the arrangement of choice for many WHO members committed to universal healthcare.[357]

## VII. CONCLUSION

After more than one decade of courageous implementation, Ghana's healthcare program still leaves capacious room for improvement. In the beautiful imagery of the epigraph prefacing this piece, the program is poised for a Stage 3 of healthcare reform—after the cash and carry of user fees and the NHIS regime[358]—that in this Article we choose to denominate a human right to

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[353] ACHIEVING A SHARED GOAL, *supra* note 1, at 21.
[354] *Id.* at 40 (emphasis added).
[355] *See* Sally C. Pipes, *The Many Failures of Single Payer*, NAT'L REV. (Dec. 1, 2014, 4:00 AM), http://www.nationalreview.com/article/393679/many-failures-single-payer-sally-c-pipes (conversation on the British healthcare system that also integrates discussion on Canada and portions of the United States, such as Vermont).
[356] UNIVERSAL HEALTH COVERAGE, *supra* note 11, at 29.
[357] *See* Savedoff, *supra* note 123, at 3.
[358] ACHIEVING A SHARED GOAL, *supra* note 1, at 10, 34.

healthcare in due cognizance of the transformational advantage this approach embodies vis-à-vis any other reform arrangement. To assess the progress of the country toward this critical phase and its ramifications for Africa, the Article took four steps, crowned in the penultimate section of the piece with a suggestion for Ghana to move toward a single-payer, tax-funded system for the various reasons marshalled therein, building on insights from the preceding sections, particularly Part III. focusing on the NHIS.

The first was a sketch of a historical background of healthcare in Ghana embedded in the country's mixed experiences with user fees. These fees had always been present in Ghana but their effects, notably the dangers they pose to public health, became full-blown, too close for comfort, during the severe cuts in government spending on social programs that came with the implementation of Structural Adjustment Program in the country. These programs stressed cost recovery on all social programs, including healthcare, an occurrence which for Ghana and other countries which came under these programs, translated into imposition of user fees on these social services.

The second step this Article took toward assessing the progress of Ghana on healthcare as human right involved a chronicle of the NHIS, focusing on the four key issues of the scheme's legal framework, the services afforded to registrants under the scheme, the principles of exemptions that mark the scheme, and the location of the NHIS within the three models of healthcare financing. Several lessons emerged from that discussion that we call to the reader's attention. The first, bearing on the legal framework governing the NHIS, is the solecism signified by the entrenchment of a nominal "right" to healthcare as a "fundamental human right" in Ghana's 1992 Constitution. Stated differently, although included as a fundamental human right, there is little substance in human right to the right itself given the tepidness and amorphousness

of the provision which reads: "[a] person who by reason of sickness or any other cause is unable to give his consent shall not be deprived by any other person of medical treatment, education or any other social or economic benefit by reason only of religious or other beliefs." The way to correct this anomaly would be a constitutional amendment which un-vaguely and un-tentatively guarantees the right to healthcare. A good template for such a change could be the language of the ICESCR, which multilateral treaty Ghana ratified in 2000, mandating states to create "conditions which would assure to all medical service and medical attention in the event of sickness," among other obligations.

Still on legal framework, Act 852 of 2012 revamping the NHIS instructively included promoting accountability and transparency among its objectives. The law was enacted in the aftermath of Oxfam International seminal report of 2011 which criticized the NHIS for its lack of accountability and made recommendations for change. The extent to which such promotion has occurred is an issue beyond the scope of this study that future studies must carefully explore. Finally regarding the other issues in Part III, particularly the principle of exemptions that hallmark the NHIS and its possible location within the three models of healthcare financing, the lesson to be drawn from that presentation is the necessity for Ghana to adopt a single-payer system funded on tax revenue, a position we later elaborated in Part VI. of this Article. Such an arrangement will do away with the discriminations and badges of inequities that contribute to keep the NHIS below the international and ethical standards of human rights.

The third step this Article took toward assessing the progress of Ghana on healthcare as human right involves an enumeration of the several benefits of a human rights approach to healthcare in Ghana and Africa vis-à-vis the dominant economics-based approach. The

discussion encompassed three topics germane to the conversation, crowned by the presentation on the right to health(care) as a handy tool of social struggle.

The fourth and final step this Article took toward evaluating the progress of Ghana on healthcare as human right consists of an identification and discussion of nine reasons why, for its bellwether features, Ghana's healthcare program falls below the standards of human rights. Another way to look at the discussion would be to see the nine factors as impediments that, if removed or even minimized, would bring the NHIS closer to the human rights standard that Ghana's Fourth Republic leaders (see Table 1) appeared to envision when they rolled out the program. To these factors should be added some of the changes touched upon or not covered in sufficient details in the foregoing discussion that Oxfam International recommended for improving Ghana's healthcare program. These changes include stemming the shortage of healthcare workers,[359] developing more reliable information systems as foundation for effective decision-making in healthcare,[360] and affording patients, non-governmental sectors of Ghanaian society (civil society), and even healthcare workers, opportunity to participate in the healthcare system through full access to information, including financial data, and channels to ventilate their concerns and experiences and demand improvements.[361]

More on the knotty issue of healthcare worker shortage, particularly doctors and nurses, the problem revolves around inadequate numbers, inequitable distribution, low motivation, and levels of attrition (brain drain caused by external migration) involving these workers.[362] As Oxfam International observed in its 2011 report, "Ghana produces an estimated 400 new doctors

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[359] *Id*. at 40.

[360] *Id.* at 42. During the research for its 2011 report, Oxfam International beheld "fragmented, duplicative, confused and contradictory" information systems, complete "with different institutions presenting differing records of progress." Regarding membership data, the antipoverty group also found that NHIS officials "collect[ed] data using different methodologies and presenting wildly differing pictures of progress made."

[361] *Id.*

[362] *Id*. at 40.

each year and while efforts have been made to expand existing health training institutions and set up new institutions, capacity remains inadequate in terms of infrastructure, teaching staff, and funding."[363] On doctor shortage, the report advised Ghana to learn from other countries, like Malawi and Ethiopia, which have responded to this problem successfully[364] and for other health workers, including pharmacists and midwives, to evolve a new and fully costed human resource strategy.

Africa has made important strides in human rights in the post-Cold War period, monuments of which include the transition of the Organization of African Unity (OAU) into the African Union (AU) in 2000.[365] The Constitutive Act creating the African Union stipulates that one of the objectives of the revamped organization shall be to "promote and protect human and peoples' rights in accordance with the African Charter on Human and Peoples Rights and other relevant human rights instruments."[366] Some of the provisions germane to these objectives, enumerated under Article 4 on the "principles" of the new organization, include: "promotion of gender equality; respect for democratic principles, human rights, the rule of law and good governance; and promotion of social justice to ensure balanced economic development."[367] Going further, the AU created a number of organs that are critical for safeguarding and promoting human rights, including the African Court of Justice.[368] Still the constraints against

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[363] *Id*. at 41.

[364] In Malawi, pooled funding derived from external aid helped increase the number of doctors by 516% between 2004 and 2009. In Ethiopia, the government trained and deployed 32,000 community health workers. *Id*. at 41. Malawi would not be a good example here because of the argument we made in this study for Ghana and other African countries to voluntarily and gradually wean themselves from foreign assistance because of its uncertainty for aid-dependent countries, including the withdrawal syndrome it creates when donors suddenly cut assistance.

[365] Organization of African Unity (OAU), Constitutive Act of the African Union (Jul. 1, 2000), http://www.refworld.org/docid/4937e0142.html.

[366] *Id.* at Art. 3(h).

[367] *Id*. at Art. 4.

[368] *See Id.*at Art. 5 (spelling out the organs of the AU) and Art. 18 (establishing the Court of Justice).

realization of these rights remain "daunt[ing]."[369] Notwithstanding these impediments, national discourses on healthcare should continue to stress the link between health and human rights.[370] Using Ghana as case study, this Article contributes to the emerging "global movement for health and human rights," including the intricacies of "health as an issue of fundamental human rights and social justice."[371]

[369] Zeleza, *supra* note 293, at 10.

[370] *See* ISIDORE BONABOM, HEALTH AND HUMAN RIGHTS IN GHANA: THE POLITICAL AND ECONOMIC ASPECTS OF HEALTH *passim* (Common Ground Publishing, 2014) (suggesting that national discourses sometimes overlook that inevitable link).

[371] About HHR, http://www.hhrjournal.org/about-hhr/ (mission statement of the Health and Human Rights Journal, sponsored by the Harvard School of Public Health and published by Harvard University Press).