Education and Health Care Policies in Ghana: Examining the Prospects and Challenges of Recent Provisions

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Abstract

Education and health care policies in Ghana since independence have been universalist in approach providing free universal health care and free basic and tertiary education until the early 1980s. Precipitated primarily by a severe drought, stagnant economic growth, mismanagement, and political instability, Ghana undertook major economic reforms with prodding from the World Bank and International Monetary Fund in a bid to salvage the economy. These economic measures included cost recovery and cutback spending in education and health sectors. However, in recent years, purposive targeted interventions have been pursued to address inequalities in education and health care. These new programs include the Education Capitation Grant, school feeding program, and the National Health Insurance Scheme (NHIS), which are propelling Ghana toward the achievement of the Millennium Development Goals. The prospects of these programs in addressing disparities in access to education and health care in the country and recommendations for improved delivery are discussed.

Keywords

health care, structural adjustment programs, Ghana, school feeding program, Capitation Grant

Introduction

Ghana is located in West Africa with Accra as its capital. With a population of approximately 25 million (Ghana Statistical Service [GSS], 2012), the country is divided into 10 administrative regions. Its neighbors are Togo to the East, Ivory Coast to the West, and Burkina Faso to the North. The southern part of Ghana is bordered by the Gulf of Guinea. In 1957, Ghana became the first country in sub-Saharan Africa to gain independence from colonial rule. Since the nascent years of the republic, government has been very proactive in recognizing the important benefits of education and health care in the lives of its citizens. The country has a large youthful population with the proportion of youth 15 years and younger constituting 38% of the population (GSS, 2012).

Education and health care policies in Ghana since independence have been universalist in approach providing free universal health care and free basic and tertiary education until the early 1980s. Precipitated primarily by a severe drought, stagnant economic growth, mismanagement, and political instability, Ghana undertook major economic reforms with prodding from the World Bank and International Monetary Fund (IMF) in a bid to salvage the economy. These economic measures included cost recovery and cutback spending in social programs, including education and health care and resulted in severe hardships and declines in education and health outcomes. However, in recent years, purposive targeted interventions such as the Capitation Grant, school feeding program, and the National Health Insurance Scheme (NHIS) have been pursued to address inequalities in access to education and health care (Government of Ghana, 2007).

The predominantly socialist welfare climate in Ghana immediately after independence resulted in the provision of fully funded public health services and universal primary and free tertiary education. Under these arrangements, pre-tertiary education was free in northern Ghana at all levels while there was limited cost bearing for parents in southern Ghana. Citizens also received free medical care for every medical condition. For this reason, very few private medical facilities operating a fee-paying regime were in service in the

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country. This arrangement inculcated into Ghanaians the notion of government as burden bearer. It is worth noting that such universal provisions provided protection against naturally occurring structural inequalities that create extreme disadvantage and marginalization. The other aspect of these universal provisions was that service seekers were not means tested, which meant that both rich and poor alike could access the same services. Such a non-discriminatory approach stands the risk of being overwhelmed with increases in population and demand for services.

Not surprisingly, as Ghana’s population increased from about 4 million in the 1960s to about 8 million in the 1980s, and economic progress began to decline, it became obvious that the system was not sustainable, because government revenue was lagging unacceptably far behind expenditure (Dzorgbo, 2001). This scenario of population growth and economic decline led to sweeping changes in the welfare provisions in 1980s, largely due to a decade of declining economic growth, endemic economic mismanagement, and rapid population growth. The government was forced to negotiate a way out with the IMF and the World Bank (White, 2004). Within the framework of the IMF/World Bank-supported Economic Recovery Program (ERP), Ghana agreed on structural adjustment program (SAP), which severely affected the existing universal welfare policy including those of education and health care.

The purpose of this article is to review education and health care policies in Ghana within the context of policy reforms in these areas that were precipitated by SAPs in the past two decades. A second objective is to critically examine the renewed effort by government to re-introduce pro-poor social protection measures in education and health care to increase access and make these programs more affordable to all citizens. Finally, we examine the prospects and challenges of these new welfare provisions as well as policy recommendations. The next section presents a brief discussion of the negative effects of the SAP on health and educational outcomes in Ghana.

Effects of SAPs on Health and Educational Outcomes

Central to the structural adjustment philosophy was the World Bank’s idea that developing countries should rethink the role of the state; that is, to steer away from the state as sole provider of welfare, including health and education, to one of enabler and quality assurer with a focus on strengthening labor market linkages (Konadu-Agyemang, 2000; Kuyini, 2013). Applying such a market-oriented approach to health and educational development meant privatization of these services in a fragile economy. A common and yet inevitable outcome of this policy position in Ghana and other developing countries such as Uganda was that structural adjustment led to the deepening of existing inequalities in access to education, health care, and other basic social services (Alexander, 2001; Konadu-Agyemang, 2000; Kraus, 1991). Rolling back the frontiers of welfare as part of the SAPs entailed cutback on government expenditure, especially on social spending and the introduction of user charges for public services like health and education. As noted earlier, Ghana’s health care system from independence was founded on the basis of a “free health care” model, and although token user fees were introduced in the 1970s, a full-fledged user-fee scheme backed by a decree came into effect in 1985 as part of the structural adjustment conditionalities (Durairaj, D’Almeida, & Kirigia, 2010). This infamous cash for health system, known as “Cash and Carry,” required out-of-pocket payment before any treatment could be received at any public health facility with the only exemptions for children, indigent, pregnant women, and treatment of certain diseases of public interest (Durairaj et al., 2010). The effect of these measures on health was poor-quality health outcomes for the majority of people who could not pay for health care. There were signs of decline of quality of life in the country prior to the implementation of SAPs. For example, life expectancy at birth in Ghana fell from 55 years in 1970 to 53 years in 1979, and at the same time, daily calorie intake as a percentage of requirement fell from 88% in 1979 to 68% in 1983 (Kuyini, 2013; Sowa, 1993). Sowa (1993) further noted other consequences of the SAPs, including the erosion of real wages of Ghanaians and shortage of essential commodities. In the area of education, a significant number of redepolyment affected access, quality, and outcomes. For example, government subsidies on textbooks and boarding school feedings were replaced by a cost-recovery measure known as “cost-sharing” with a requirement for parents to pay part of the cost of education for their children (Sowa, 1993). Similarly, although primary pupils were charged 120 Ghana cedis for textbooks, the fee for secondary school students increased from 24 to 1,500 Ghana cedis (Sowa, 1993; Tsikata, 1995). As a result, Ghana witnessed a decline in school enrollments and participation among poor families and communities. According to a World Bank report cited by Trading Economics (2012), primary school enrollments in Ghana fell from about 74% in 1980 to 71% between 1988 and 1991 and rose slightly to 78% in 1992 and again declined to 75% in 1995-1996. These developments in the education sector exacerbated existing structural inequality and coincided with the first 6 years of the implementation of the IMF/World Bank structural adjustment policies.

Problems of Public Policy Making and Implementation in Ghana

Public policy making in Ghana is bedeviled by considerable challenges, including its exclusionary and elitist character. There are also inconsistencies in the selection and prosecution of policy priorities as government alternates between political parties of different ideologies and unstable political environment in which the authoritative allocation of values for society is made. Policy-making decisions are further undermined by
an erosion of policy ownership due to donor influences and the lack of political will to translate broad intents in the constitution into actual policy frameworks that can inform service provision in a way that meets objectives. This often results in a gap between policy intentions and actual practice. In a developing country such as Ghana, such a scenario can have severe consequences for service delivery and negatively affect service users.

There are benefits as well as limitations to both elitist or top–down and participatory decision-making approaches. The justifications for adopting an elite model is predicated on the belief in the technocrat’s competence, trust in the expert’s ability to choose, confidence in the ruler’s capacity to offer leadership and direction, and the bureaucrat’s possession of information and technical expertise (Dye & Zeigler, 2000; Steelman, 2001). Implied in this approach is the skepticism of the public’s ability to express and articulate their preferences, contribute useful knowledge to the process, and influence the policy meaningfully (Steelman, 2001). Thus, proponents of the elite approach insist that involving the public can be disruptive, costly, time-consuming, and inefficient, owing to the fact that they are not capable of participating effectively.

This line of thinking might have influenced the approach to policy making in the one-party system and military regimes in Ghana prior to 1992. For example, the ERP and the Education Reform Program (EDRP) formulated under the Rawlings’ military rule were enacted with little, if any, public involvement (Gyimah-Boadi, 2001; Vordzorgbe & Caiquo, 2001).

The outcomes of these examples of exclusionary policy making in Ghana point to the fact that the elite decision-making model has considerable drawbacks, including limiting societal diverse views and limiting public in-depth knowledge of policy and capacity to contribute to its effective implementation and evaluation. A more participatory approach enables the public to contribute to decisions by providing pragmatic support and substantive information to professional managers as well as enhancing social goals (Barnes, Newman, Knops, & Sullivan, 2003; Fiorino, 1990; McAvoy, 1999) and thereby supporting effective implementation.

With regard to the erosion of policy ownership, although the literature on citizen participation has been discussed as if governments around the world have complete ownership over their affairs (e.g., Fishkin, 2009; Fung, 2006), policy makers in developing nations face the dilemma of responding to both internal and external constituencies, who often fund new programs. A wide gap can therefore exist between the preferences that are domestically desired and the proposals that are externally imposed by the donor community to the detriment of the developmental aspirations of the developing country concerned. For example, the fears of Ghanaian policy makers that the privatization and commercialization prescriptions of the World Bank and the IMF would crowd out the provision of social welfare services such as free education and subsidized health care could not be allayed following the implementation of the SAP. This means that the ideological preferences of donors are prioritized over citizens’ desires.

It is in the light of these that the new education and health care policy initiatives formulated within the last two decades seem to hold more promise because they were enacted in a climate of participatory democracy with relatively less external influence. The new initiatives are discussed in the next sections.

**Re-Introduction of Semi-Universal Provisions**

Following the implementation of the SAPs and their negative consequences on education and health care, attempts were made to re-introduce universal policies albeit on a much smaller scale in education and health care. Beginning in 1988, the Government began to implement a program called Program of Action to Mitigate the Social Cost of Adjustment (PAMSCAD) to reduce the negative effects of structural adjustments. PAMSCAD was an irrefutable admission as well as recognition that the IMF and World Bank’s market-oriented policies of allowing the unfettered rule of market forces and cutting public spending was not appropriate for a developing country such as Ghana.

In 1995, with assistance from the IMF, the Ghana government introduced a new policy framework dubbed “Ghana Vision 2020” as a blue print for sustainable development. The government and the IMF envisaged that the new development framework would foster stronger economic growth and better living standards for the people of Ghana (IMF, 1999). The primary objective of Vision 2020 was to streamline fiscal, monetary, and social policies that will encourage private-sector involvement, export expansion, and balanced social and regional development (IMF, 1999). Such an agenda reflected a need for economic growth that also provided social protection measures that aligned with principles of recognitive and distributive justice. However, although the government and its development partners viewed this as the foundation for Ghana’s strategy for raising living standards and reducing poverty (IMF, 1999), some critics condemn it as a mere collection of policy statements that lacked consistency and implementation focus (e.g., Thompson, 2003). Consequently, the Ghana Vision 2020 was replaced by two interrelated medium-term development plans known as the Ghana Poverty Reduction Strategy Papers (GPRS I and GPRS II). GPRSP I (2003-2005) with a theme “An agenda for growth and prosperity” focused on macro-economic stability and was designed to enable Ghana benefit from significant debt relief under the Highly Indebted Poor Countries’ Initiative (HIPC; Government of Ghana, 2003). Under the GPRSP II (2006-2009), focus was on “Growth and poverty reduction strategy” and sought to utilize the debt relief funds from HIPC to increase access to and participation in all level of education
and training and to bridge the equity gap in access to quality health care and nutrition services (Government of Ghana, 2005). These policy documents laid the foundation for many recent social policies in Ghana, including the education and health care policies described in this article. Thus, in line with the focus of this article, we will highlight some of the social policies that emerged from these policy frameworks with a specific focus on education and health care.

**Free Compulsory Universal Basic Education (FCUBE)**

The first form of formal education in Ghana was introduced by Christian missionaries to teach literacy and propagate the teachings of the Bible. These early education programs, apart from focusing on the parochial interests of commerce and spirituality of the colonialists, were only accessible to a small section of the population, and no attempts were made at instituting broad access to education. After independence from colonial rule in 1957, Ghana enacted the first free compulsory universal primary education policy in sub-Saharan Africa to cover 6 years of primary education (Ghana Education Service [GES], 2004), and since then, educational policy has been guided by the Education Act of 1961. This legislation established the right to education for every Ghanaian child of school age (Foster, 1965; GES, 2004). Driven by the Accelerated Development Plan of 1951, the Education Act of 1961 provided free, universal, and compulsory basic education (6 years duration) for all children from 6 years of age. The Act also empowered local authority councils to manage the schools in their localities (Foster, 1965).

The Education Act of 1961 also made pre-university education at all levels free in northern Ghana. Despite these provisions, access to education was still limited, and the quality of education was beginning to decline in the 1970s and 1980s, necessitating educational reforms in 1987.

The first phase of education reforms began in 1987 as part of the SAP cost-cutting recommendations and was designed to restructure the entire pre-tertiary education system and improve access through provision of infrastructure and make the curriculum more relevant to the social and economic needs of the country (Ministry of Education [MOE], 1998; Yamada, 2006). According to the MOE (1998), the new reforms were designed to salvage the educational system and to make it more relevant to the individual and national development needs. As part of the reforms, pre-university education was reduced from 17 to 12 years. The government policy priority in education as outlined in the Vision 2020 and later in the GPRS I and II were to achieve universal primary education, adult literacy, and increased access to secondary and tertiary education, as well as foster skills development through vocational training (Government of Ghana, 2003, 2006; IMF, 1999).

Following the successful implementation of the 1987 reforms and the subsequent transition to constitutional rule in 1992, the government re-enacted the FCUBE policy in 1996 as mandated by the 1992 Constitution of the Fourth Republic of Ghana. FCUBE is different from the policies that preceded it in that the new policy guaranteed 9 years of free basic education for all children of school-going age with emphasis on quality teaching and learning, efficient management and sustainability, increased access, and decentralization of education management (GES, 2004; MOE, 1996). As we note later in the article, the goals of FCUBE were not fully achieved because of auxiliary fees that were not completely absorbed by the reforms in addition to lack of enforcement of enrollment. This has necessitated the institution of the education Capitation Grant to absorb the user fees as discussed later in this article.

In 2003, the government renewed the FCUBE as part of GPRS I with a goal to achieving the following: (a) increase universal basic education from 9 to 11 years comprising of 2 years of kindergarten, 6 years of primary school, and 3 years of junior high school; (b) focus basic education on literacy, creative arts, numeracy, and problem-solving skills; (c) technical and vocational training; (d) upgrade teacher training colleges and offer incentives to teachers in rural areas; and (e) introduce information and communications technology into the curriculum and provide special education needs at all levels (Government of Ghana, 2003). This constitutes a more innovative and inclusive education policy in that FCUBE led to the policy goal of making basic education free and the expansion of school infrastructure in many deprived rural areas that hitherto had no schools. Thus, the FCUBE policy held more promise for vulnerable children in terms of meeting their educational needs. Notwithstanding, FCUBE was still limited in terms of increasing access for vulnerable and marginalized groups such as girls, children from low-income families, children with disabilities, and rural youth. For example, for children with disabilities, the additional resources required for their education were not covered by the provisions under FCUBE. Thus, special schools for children with disabilities did not receive additional supports than under previous policies. These problems had the potential to hinder the goals of the FCUBE and led to the introduction of new programs aimed at filling the gap between the urban and rural, impoverished, and marginalized populations. Two of the new policies under the FCUBE and the GPRS I and II discussed below are the Education Capitation Grant and school feeding program.

**The Education Capitation Grant**

Access to and the right to basic education has been taken for granted in wealthy higher-income nations as governments make every effort to provide opportunities for children to receive an education irrespective of their social, economic, physical ability, or cultural background. In lower-income countries such as Ghana, providing access to quality basic education for all children of school age remains a daunting challenge due to high cost and limited resources. Under the
FCUBE policy, basic education is supposed to be free, but students are still required to pay a number of user-fees, including uniforms, books, and parent–teacher association (PTA) dues, which constitute a barrier to basic education for many children from impoverished households (Akyeampong, 2011). To resolve this problem, the Capitation Grant was introduced in 2005 as part of the new education reforms under GPRS I and II to absorb these auxiliary school fees. However, it must be noted that the program only absorbs the user-fees at the elementary but not at secondary level to increase access, retention, and completion of primary education (Adu, 2006; Jones, Ahadzie, & Doh, 2009). The premise underlying the Capitation Grant is that it would remove the burden on households to pay fees for basic education, especially poor children whose access to education has been constricted by these fees (Akyeampong, 2011). These changes were informed by findings that suggest that 25% of children between ages 6 and 17 dropped out of school in 2003 because of these ancillary costs (Ghana National Education Campaign Coalition [GNECC], 2005). The introduction of the Capitation Grant is considered profoundly important because it not only increases demand for education but also makes education more accessible to the most disadvantaged.

A 2009 review of the program by Jones and colleagues (2009) revealed that net primary school enrollment increased from 59% to 69% in school districts where the program was first piloted with the largest increase among girls, and the country achieved the gross enrollment target at the primary level in 2013 (MOE, 2013). Proponents of school fee abolishment hail the Capitation Grant and point to high school-enrollment numbers and a near parity in enrollments of boys and girls in other African countries who have implemented similar school fee abolishing policies such as Uganda, Tanzania, Zambia, and Malawi (Osei, Owusu, Asem, & Afutu-Kotey, 2009). However, critics warn that the increased enrollment, if not matched by increased classrooms, trained teachers, and textbooks, could reverse the gains. The existing educational system and culture in Ghana has inherent weaknesses that may not be alleviated immediately by the Capitation Grant unless a more pragmatic approach is adopted. For example, due to inadequate teachers and insufficient school supplies, a fee-free education would be meaningless to a rural child who only sees a teacher once a week or in some instances once a month or not at all. For example, a recent report by the Ghana News Agency (2012) quoted an official of GES that a whopping 113 primary classrooms and 83 kindergartens in the West Mamprusi district of the northern region do not have teachers. Even more alarming, the official revealed that the pupil–teacher ratio is 101 to 1 and 90 to 1, respectively, for kindergarten and primary schools.

These concerns are similar to earlier findings that identified low quality as one of the challenges facing basic education in Ghana (e.g., Glewwe & Ilias, 1996; White, 2004). Specifically, the reports note that in many schools, learning achievement is so low that after several years of schooling, students still have not mastered basic competency in reading and math (GSS, 1989; White, 2004). Similarly, a recent publication by the Education for All Global Monitoring Report 2012 by United Nations Educational, Scientific and Cultural Organization paints a dismal picture for educational achievement in sub-Saharan Africa. Specifically for Ghana, the report note that girls still lag behind boys in terms of an opportunity to enroll in school with 53% of girls in the northern regions that never attended school. In essence, the Capitation Grant has a potential to promote primary education that would give more Ghanaians at least literacy and numeracy, which are not adequate for employable skills but have other benefits, particularly, in the areas of child and maternal health (e.g., Govender, 2004).

School Feeding Program

As a lower-income country with fewer social safety net programs, Ghanaian children are vulnerable to many crises, including diseases, child labor, and malnutrition. In 2009, the United Nations (UN) World Food Program (WFP) estimated that 60 million children in developing countries go to school without food every day, and 40% of these children live in Africa. It is not exactly known how many children in Ghana go to school hungry every day, but these staggering statistics raise serious concerns about the prospect of meeting the UN Millennium Development Goals (MDGs) of universal primary education by 2015. Studies show that children who are hungry, malnourished, or sick are not capable of learning skills needed for a successful future (Jones et al., 2009).

Background of school feeding programs in Ghana.

Ghana was 1 of 10 countries in sub-Saharan Africa selected to implement a pilot school feeding program under the auspices of the New Partnership for Africa Development (NEPAD) as described in the Comprehensive Africa Agricultural Development Programme (CAADP) Pillar 3 (WFP, 2007). And consistent with the Growth and Poverty Reduction Strategy (GPRS II), the Ghana school feeding program was launched in 2005 as a pilot program in one district each of the 10 administrative regions to provide at least one hot nutritious meal a day in the poorest areas of the country (Jones et al., 2009). The program’s long-term goal, according to Jones and colleagues, is to reduce poverty and promote food security by feeding children with locally produced food that will generate wealth for the local farmers. However, it is important to point out that various forms of school feeding programs existed in Ghana prior to 2005. According to the WFP (2007), since the 1950s, a few nongovernmental organizations including the Catholic Relief Services (CRS) and the WFP have implemented school feeding programs in small scales primarily targeting poor and marginalized communities in the northern regions. For example, each child in the CRS program-sponsored school received a hot lunch, and girls who maintained a monthly attendance of 85% received a take-home food ration.
was free for all Ghanaians immediately after independence. According to USAID-EQUIP, the program resulted in school enrollment increase of 33%, and girls attendance increased by 85%. Although these programs made positive impacts, the food was imported from foreign countries with limited coverage. As a result, the government of Ghana launched its own school feeding program in 2005 using the concept of home-grown school feeding program (Ghana School Feeding Program, 2015; WFP, 2007).

The Ghana school feeding program seeks to increase enrollment and attendance, especially for girls and children in deprived and economically marginalized communities and regions of the country including the northern regions, which has the lowest enrollment rates in the country (GSS, 2014). According to the Ghana School Feeding Program (2015), consumption of locally grown food is an added impetus of the school feeding program, which also aims to reduce hunger and malnutrition. Results of a mid-year review of the program in 2006 suggested that the program was achieving its objectives. For example, enrollment increased by 20.3% in pilot beneficiary schools compared with observable declined enrollments in non-beneficiary schools (WFP, 2007). A follow-up field study by the WFP in 2007 in selected schools in Greater Accra and northern regions revealed that enrollment in two deprived schools in the northern region increased by 29% and 50%, respectively, and by 16% in one rural school in Greater Accra region. The results further showed that none of the schools had experienced dropout in the preceding 2 years and observed that the children looked healthier and nourished, an indication of decline in hunger in these schools.

As the examples above illustrate, school feeding programs have several benefits and can be used to successfully target vulnerable groups such as girls and children from poor and rural communities. A more recent study by Akyeampong (2011) on the impact of the Capitation Grant and the school feeding program in two districts in Ghana—one each from the southern and northern regions of the country—revealed that the full benefits of these programs will likely take time to take hold. Akyeampong observed that although there has been an observable increase in enrollment, the dropout rate remains high for both districts. The author further observes a higher dropout rate for girls, particularly in the Savelugu-Nanton district in the northern region. Although these are encouraging signs, the government and the MOE will need to tackle the perennial issue of absentee teachers in rural areas if the full benefits of these programs are to be realized. As we will discuss later, though a laudable policy initiative, the sustainability of the program is being threatened by scandals including allegations of corruption and embezzlement (Jones et al., 2009).

**NHIS**

As noted earlier, health care, similar to many social services, was free for all Ghanaians immediately after independence with no out-of-pocket expenses to individuals and financed solely by the government through taxes. As the economic situation began to deteriorate from the early 1970s, with increasing government deficit, it became obvious that the system was unsustainable. In the newly independent country that had no physical infrastructure, fewer skilled labor, and a weak institutional framework to implement, monitor, and assess these programs, the health care system eventually collapsed in the early 1980s. This led to the introduction of the now infamous “cash-and-carry” system, a fee-for-service system mandated by the structural adjustment policies, thereby reducing access to health care for many Ghanaians, particularly the poor and the vulnerable. According to Sowa (1993), the introduction of hospital fees in 1985 discouraged many Ghanaians, particularly the poor, from using health services with outpatient attendance falling nearly 50% in 1986. Another consequence of this was self-prescription and the flight of skilled health personnel from Ghana to other countries, which further worsened health outcomes of Ghanaians.

The NHIS represents a near universal system similar to the immediate postcolonial provisions initiated by the government in 2004. NHIS was established by the National Health Insurance Act of 2003 to provide equitable health insurance for all Ghanaians (Jones et al., 2009). The program is funded by Ghanaian taxpayers through payroll deductions and value added tax (VAT) and was estimated to cover about 54% of the population by the end of 2008. This broader national coverage of health care services is attributed to a large extent to the emergence of community mutual health organizations (HMOs) that grew from 47 in 2001 to 168 by 2003 (Sulzbach, Garshong, & Banahene, 2005). The emergence of district-wide community HMOs mandated by the NHIS law is a departure from the structural adjustment era health care reform where hospitals and physicians demanded payment before treatment. Under this scheme, the Ghana government sought to mitigate the negative effect of structural adjustment on health services. People who pay the minimum membership fee or premium to join the NHIS are entitled to government-supported medical services relating to various health issues. Several reports show that the NHIS has enabled many poor people to access health services (Jones et al., 2009; Sulzbach et al., 2005), and this has resulted in better health outcomes/well-being. Recent reports reveal a 67.6% nation-wide coverage as at 2014 with 99.1% of those covered through the district mutual-health insurance schemes (GSS, 2014). The report also suggests a higher coverage in rural areas (71.5%) than urban areas (63.9%) and indication of increasing access by rural and poor people.

However, the NHIS imposes insurance premiums as a requirement for accessing health care, and this remains an obstacle for poor people’s access to health care. According to the GSS (2014), among the 33% of the population not presently covered by the health insurance scheme, the majority (56%) cited economic reasons for not enrolling in the scheme. It has also been observed that although a substantial percentage of
Prospects and Challenges

The prospects and challenges of the recent policy initiatives discussed above are rooted in the first post-independence policies such as the Education Act of 1961, free health care prior to 1983 that provided unfettered access to education, and health care for all Ghanaians regardless of socioeconomic and cultural background. However, as noted earlier, adverse economic circumstances and mismanagement led to the introduction of user-fee regimes in health, education, and other social services imposed by the IMF/World Bank’s structural adjustment policies that resulted in serious hardships for vulnerable populations. Reversing or mitigating these negative outcomes was at the heart of recent government policy reforms in education and health care. In this section, we briefly evaluate the extent to which past and current policies in education and health provide protections to Ghanaians, particularly vulnerable populations. While our analysis will take the form of broad strokes, it will also delve into each of the policy areas with a focus on current achievements as well as prospects and challenges that remain as well as policy recommendations.

Policies such as the Education Act of 1961 and FCUBE under the GPRS I and II have provided broader access to education for all children. This is particularly true for those at risk of school dropout or not enrolling in school such as girls, rural children, and children whose parents are uneducated and unmotivated to enroll their children in school. Similarly, the Capitation Grant relieves parents from low-socioeconomic backgrounds of the burden of paying the ancillary school fees that they could not otherwise afford and ensures continuous attendance of many children regardless of socioeconomic background. These programs have largely contributed to improvement in school outcomes in the last two decades. One quantifiable measure of the progress Ghana is making on the education front is within the context of the MDGs. Although poverty reduction (MDG1) is not the focus of this article, it has both direct and indirect consequences on educational outcomes, and evidence shows that despite spatial inequalities, particularly in the three savannah regions, Ghana has achieved the MDG1 target of reducing the proportion of people living in extreme poverty by half as at 2014 (GSS, 2014). The direct consequence of this is a slow but steady decline in childhood malnutrition, and children born with low birth weight, which studies show, have a direct effect on children’s cognitive development and learning outcomes (Del Rosso, 1999; Hutchison, 2013).

Recent data further suggest that the country is on track to achieving both gross and net primary school enrollment targets by 2015, which is attributed to government’s renewed push in education in the areas of the Capitation Grant, school feeding program, and free school uniforms (United Nations Development Programme [UNDP], 2012). These data further indicate that four regions in the country, namely, Central, Western, Brong Ahafo, and Upper West Regions, have already achieved 100% of the gross enrollment ratio (GER) target. Although gender parity in enrollment at both primary and junior high levels have stagnated in the past 5 years, these data show that the target of ensuring gender parity is on track to be achieved by 2015. This means that the Capitation Grant and school feeding program, although they have not covered the entire country yet, have made a profound impact on educational outcomes. This suggests that a political will supported by goal-directed planning can produce real results and positive school outcomes.

It has also been revealed that the school feeding program provides schoolchildren healthy and nutritious food that is important for their learning and development. Evidence suggests that health factors are important determinants of when a child is enrolled in school (Akyeampong, Djangmah, Oduro, Seidu, & Hunt, 2007) and that health status has important implications for attendance, retention, and dropout, with hunger, malaria, headache, and poor vision noted as major causes of absenteeism and dropping out of school in Ghana (Fentiman, Hall, & Bundy, 2001). This program, therefore, provides important protection against hunger and malnutrition, which diminishes school-age children’s cognitive development through psychological changes and their ability to participate effectively in learning experiences (Del Rosso, 1999). These positive benefits of school feeding program suggest that efforts should be made to expand the program to all parts of the country not just poor and marginalized communities. As it is done in other parts of the world such as the United States, government needs to establish eligibility criteria that require nonpoor families to pay for the feeding of their children.

Despite these achievements, significant challenges remain. As noted earlier, even though the country has cut the proportion of people living in extreme poverty by half ahead of the target date of 2015, performance has been mixed across indicators, regions, and localities. This is particularly true for the endemic poverty-stricken regions of northern Ghana and rural areas. This is worrisome, because poverty has been identified as one of the major obstacles to educational access in Ghana and pushes many children into child labor (Akyeampong et al., 2007). A large number of children in the country experience inadequate access to education, poor-quality teaching
and learning, and inefficient management (Government of Ghana, 2007; World Bank, 2010). Thus, although the education Capitation Grant and the school feeding program are profoundly important in supporting the learning of students and increasing access and retention, more needs to be done to expand access and improve supervision and management through school management committees and PTAs. Despite the good intentions and contributions of FCUBE, many children of school-going age either fail to enroll or drop out of school for reasons of parental poverty and lack of teachers (GES, 2010; Kuyini, 2013). Even with increased educational spending (currently more than 10% of the GDP), the World Bank (2010) observes that the gains made from the recent initiatives are under constant pressure from expectations that exceed outcomes. The World Bank also raised concerns communities and parents have regarding sub-standard schools, absentee teachers, botched exams, and poor facilities. The Bank notes that many qualified children are turned away from institutions of higher learning due to lack of space and poor facilities or job opportunities after their training.

Akyeampong (2011; Kuyini & Desai, 2008) made similar observations suggesting that programs such as the school feeding and Capitation Grants are not enough to secure better educational outcomes unless they are accompanied by increased teacher–student time and instructional quality in schools and classrooms. Moreover, in a situation where the program still largely depends on foreign donor funding, the long-term sustainability of the program is in jeopardy. Government must make efforts to broaden local revenue base by expanding the tax net beyond the formal sector and VAT to reign in more revenue from the informal sector.

Furthermore, the current reforms do not include secondary and tertiary education and therefore diminish poor children’s access to secondary and tertiary education. The cost-sharing regime in secondary education is a further blow to girls’ education as many female students dropout at this level when they reach puberty (Dunne et al., 2005). As a matter of fact, the compulsory school attendance component of the FCUBE and its predecessor, Education Act of 1961, has never been enforced thereby undermining their effectiveness. As a lower-income country, establishing a primary school in every village would be ideal but unattainable in Ghana. However, evidence suggests a high correlation between school dropout and distance from home to school (Akyeampong et al., 2007; United Nations Educational, Scientific and Cultural Organization–Food and Agriculture Organization of the United Nations, 2006). In that regard, children may lack the physical strength to commute long distances daily in rural, sparsely populated areas. Traveling alone in these areas also poses significant risk for girls who are often targeted for rape (Dunne, 2007; Hyde, 1989). A more realistic policy strategy is to increase the number of feeder schools to cater for children from cluster communities as part of a broader policy envisioned in the Education Strategic Plan 2010-2020 (MOE, 2010). This will not only bolster enrollment and attendance but also enhance community involvement and encourage teachers to stay in the communities. Also, teachers need to be re-oriented to be gender sensitive and promote student participation in the classroom. These measures will go a long way to increasing school completion of at risk youth.

Regarding health care, the NHIS by far is the most important welfare scheme for many poor people in the country. Payment of the insurance premium eliminates out-of-pocket cost for most basic health conditions thereby eliminating the fear of going to the hospital when needed. A review of specific national health indicators shows a slow but steady improvement in many areas over the years. According to the Ministry of Health (2010, 2014), national under-five mortality rate (per 1,000 live births) continues to decline, dropping from 155 per 1,000 in 1998 to 80 in 2008 and dropped further to 60 in 2014. However, spatial differences are prevalent suggesting an uneven coverage of the scheme. For example, in the more urbanized and prosperous regions of Greater Accra and Ashanti, under-five mortality rate dropped from 103.8 and 142.2, respectively, in 1988 to 50.0 and 80.0, respectively, in 2008. During the same period, under-five mortality rates in the northern and Upper West Regions, two of the most deprived in the country, saw a decline of 221.8 each in 1988 to 137.0 and 142.0, respectively, in 2008. Although the percentage drop in the northern regions is larger, it is evident that under-five mortality rate is still almost twice the national average. These data suggest that health care coverage is still low among the poor in the poorest regions of the country suggesting the need for more education in these areas to encourage more people to enroll in the program.

Not surprisingly, recent data suggest that despite the significant reductions in both infant mortality and under-five mortality rates in Ghana, the country is unlikely to achieve the 2015 MDG4 target of reducing the child mortality rate unless there is an expansion of coverage of child survival interventions (UNDP, 2012). The Ghana government appears to have heeded this warning as recent data suggest that 98.3% of children under 5 years have received preventive vaccination against measles and other childhood diseases (GSS, 2014), a 10.6% increase from 2010. Similar challenges pervade the other health indicators and targets across the country. For example, Ghana has made remarkable progress toward achieving the MDG5 of reducing maternal mortality, which declined from 216 per 100,000 live births in 1990 to 164 per 100,000 live births in 2010 (UNDP, 2012). The maternal mortality rate declined further to 144 per 100,000 births in 2014 (Ministry of Health, 2014). However, this is still far away from the target of 54 per 100,000 births by 2015. On MDG6 target of HIV/AIDS and other infectious diseases, the infection rate has remained relatively stable and has declined from its peak of 3.2% in 2006 to 2.0% in 2010 (UNDP, 2012).

Although NHIS is popular among the general population and a vast improvement over its predecessor—cash-and-carry system—its structure and how it is being implemented may be contributing to Ghana’s struggles to meet her health
targets. Ghana’s experience in health insurance is similar to China where many poor rural residents have been squeezed out of health services because they are unable to afford the high user charges and direct costs. In many cases, the high costs have caused financial catastrophe for many rural families (Liu et al., 2000, in Li et al., 2014; Liu, 2004). Such a scenario has been reported in Ghana (Jones et al., 2009). For Ghana, the recent proposition that the one-off payments should be changed to multiple payments could result in increased catastrophic health expenditure and medical impoverishment for the very poor. Indeed, the experience with health insurance affordability for the poor in China and Ghana, speaks to the reality of the impact of structural inequality on access to health care. In the case of Ghana, structural poverty that manifests in demographic, gender, and regional/geographic inequalities are visible impediments to health care affordability and overall well-being. The government needs to increase the public spending as well as expand the exceptionality bracket to cover many more marginalized groups. However, as a recent report by Send Foundation (2014) notes, the government’s yearly allocation to the health sector is still below the 15% of the national budget as recommended in the Abuja Declaration of 2001.

Recent reports also suggest that effective implementation of the NHIS is blighted by poor implementation and mismanagement, which could lead to a complete collapse of the program. The World Bank recommends that more public resources are needed in addition to reforms in areas such as provider payment systems, and the effective use of payment mechanisms, which will facilitate service delivery. The report highlights the important fact that any calls for more public resources should hold in mind the reality that Ghana’s fragile macro-economic/fiscal situation may be unable to support substantial increases in such funding from government. Recently, the Integrated Social Development Centre (ISODEC, 2012) suggested a tax-based financing of health care by broadening the tax net, but the fact that the majority of Ghanaians work in the informal sector and are not covered by the tax system makes this problematic and unlikely.

**Conclusion**

Welfare policies are fundamental to the well-being of the citizenry and more so critical to the protection of the most vulnerable citizens. In the past decade, the Ghana government instituted new reforms to ameliorate structural adjustment era problems in education and health care to promote citizens well-being and reduce vulnerability. It is clear from our analysis that significant improvements have been made in the past two decades in education and health sectors, which offer some hope that Ghana could meet some of the MDG targets on poverty reduction, education, and health by 2015. At the same time, resource constraints, contradictions in policy formulations, and implementation inefficiencies are palpable impediments to sustaining these programs.

These challenges notwithstanding, these programs provide useful lessons for the government of Ghana as well as other governments in the region. Education and health care programs in the form of school fee abolition, school feeding programs, and universal health care have been implemented in varying forms in many countries in sub-Saharan Africa, some as cash transfer programs. Cash transfer programs have emerged as important social protection strategies that aim at reducing vulnerabilities and marginalization among the poorest segment of the population. The more-than-decade long cash transfer programs in Ghana have produced a wealth of evidence on their positive impact on educational and health outcomes as well as poverty reduction in general as indicated in this study. Potential challenges in their implementation and design have also been documented, and all these can serve as useful lessons for other countries in the region who have introduced or plan to introduce similar programs. The evidence presented in the study further suggests the need for adjusting the program design to the heterogeneous living conditions of the poor in different regions and localities of the country. This has become more imperative as many countries in the region strive to achieve the MDG targets by the target date of 2015.

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