

## **Do new democracies deliver social welfare? Political regimes and health policy in Ghana and Cameroon**

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Democratic reform processes often go hand in hand with expectations of social welfare improvements. While the connection between the emergence of democracy and the development of welfare states in the West has been the object of several studies, however, there is a scant empirical literature on the effects of recent democratization processes on welfare policies in developing countries. This is particularly true for Africa. In a dramatically poor environment, Africans often anticipated that the democratic reforms many sub-Saharan states undertook during the early 1990s would deliver welfare dividends. This article investigates whether and how the advent of democracy affected social policies – focusing, in particular, on health policy – by examining one of the continent's most successful cases of recent democratization (Ghana) and comparing it with developments in a country of enduring authoritarian rule (Cameroon). Evidence shows that democracy can indeed be instrumental to the expansion and strengthening of social policies. In Ghana, new participatory and competitive pressures pushed the government towards devising and adopting an ambitious health reform. Despite façade elections, no similar pressures could be detected in undemocratic Cameroon and health policy remained almost entirely dictated by foreign donors.

**Keywords:** democratization; welfare state; consequences of democratization; Ghana; Cameroon

### **Democratic reforms and welfare policies: what connection?**

Democratic reform processes are often supplemented by expectations of tangible improvements in social welfare. The development of social welfare was a key motive behind demands for democratization in Western Europe in the late nineteenth and the early twentieth century. Without political reforms, it was thought, social needs would never receive proper attention. Changing the way collective decisions were made, on the other hand, was expected to critically affect the very

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content of such decisions. Because previously excluded social strata would most likely demand a better share of the country's material resources and wealth, political democracy – the reasoning went – was bound to change social outcomes.<sup>1</sup>

The theoretical literature highlights a number of causal mechanisms that supposedly link the introduction of democratic politics to efforts at improving the social welfare of a population. In a democratic environment, the needs of the poor can be openly voiced in public debates and the media. They can be systematically expressed and articulated in an organized way by advocacy and pressure groups, political parties and social movements, as well as through the vote. Competitive elections, in particular, maximize voters' capacity to influence policy-makers by holding them accountable for the outcomes of their decisions. Elected rulers concerned with being re-elected have greater interest in providing public goods to large constituencies rather than in distributing private rents and other benefits to narrow groups. In contrast, non-democratic regimes that are shielded from direct pressures and supported by a smaller constituency of beneficiaries may find ways of being resilient to the disastrous consequences of the bad policies they adopt.<sup>2</sup>

Yet, the assumption that the many and the needy will benefit from democratic change has not gone without challenges. The most classic objection is that some authoritarian developmental states – particularly in East Asia – often achieved impressive results in tackling social problems. In these cases, leaders who were largely insulated from bottom-up demands nevertheless introduced policies that addressed issues such as poverty or inequality. At a more general level, it is claimed that the notion that democracy means inclusive politics may be misleading. Democratic elections normally imply that there are winners as well as losers, and the latter may suffer marginalization. Even when the poor are more numerous, in particular, they may not be able to turn this into real political influence and counter the substantial impact that the middle classes typically have on decision-making processes.<sup>3</sup> A further question is whether opening up the political system is enough to raise the political saliency of issues such as famine, poverty, education, or health. If this does not happen, then electoral processes are unlikely to make much difference.<sup>4</sup> Similarly, if neopatrimonialism and clientelist distributions remain the core business of politics even after elections are introduced, the assumption that voters are in a position to demand and obtain responses to their social-welfare needs may be misplaced.<sup>5</sup>

At least up until recently, empirically-oriented scholars also largely failed to find evidence 'that democracy matters for the material conditions of everyday life'.<sup>6</sup> Many studies that tried to test the democracy-welfare link, in particular, hint at a more complex relationship.<sup>7</sup> Democracies, for example, seem to be instrumental to improving the survival chances of the deprived,<sup>8</sup> but poverty alleviation appears to be orthogonal to regime type.<sup>9</sup> Democratic change may also help narrow the gap between the wealthy and the poor, but such an effect may be smaller than predicted and may only occur after the initial worsening of inequality.<sup>10</sup> Democratic regimes do normally produce higher social spending when compared to

authoritarian governments,<sup>11</sup> but such increased spending is often not much to the benefit of the worse-off.<sup>12</sup>

Besides conflicting theoretical and empirical claims, the relatively scant 'democracy-promotes-welfare' literature suffers from at least two specific lacunae. One is a relative lack of in-depth country investigations. By focusing and shedding light on the specific political and policy processes at play, such investigations are crucially needed to enrich our understanding of the relationship under scrutiny by complementing existing quantitative studies. The other lacuna concerns the limited coverage of developing areas. While the connection between the emergence of democracy and the development of welfare states in the West has been the object of a number of studies, some 35 years after the beginning of the Third Wave very little is known about the democracy-welfare link in certain developing regions.

This article contributes to filling these gaps. First, and most broadly, the article provides new evidence on an emerging and yet understudied subject, that is that of the consequences of democratization on social welfare. Secondly, it does so by closely investigating and comparing two country cases – a recently democratized nation and a country of stable undemocratic rule – so to uncover the specific causal channels through which democratic transformations are linked to policy changes. Thirdly, it examines the validity of theoretical arguments for a developing region – Africa – for which the policy consequences of democratization have hardly been studied as yet. The driving hypothesis is that the advent of democracy fosters the introduction or extension of social policy measures. The underlying conjecture is quite straightforward: granting voting rights to the citizenry and liberty to compete to alternative political parties allows the former to advance demands for social protection, while incentivizing the latter to pledge and implement policies that respond to such demands. The key mechanism is thus competition for votes at election time. Where elections are competitive, incumbent leaders looking for re-election, and facing potentially serious electoral challenges from oppositionists, are more likely to adopt social policies that provide public goods, as a way to distribute benefits among their large electoral constituencies, rather than focusing on handing out private goods to a more limited circle of supporters.

### **A comparative test**

A vast majority of sub-Saharan states undertook democratic reforms during the early 1990s. While many authoritarian regimes were simply adapting their institutional façade in an attempt to gain international respectability, or to placate domestic protests, a few countries achieved truly democratic progress. In a dramatically poor environment, Africans often anticipated that democratic reforms would deliver a number of additional goods.<sup>13</sup> Social welfare was among them.

The notion that African electorates may be in a position to demand and obtain social policies from their elected leaders challenges much common wisdom about the politics of the continent, and notably those interpretations that stress

the prevalence of predatory and neopatrimonial logics as well as those that emphasize the role of foreign actors in shaping key policy decisions in poor and aid-dependent developing countries. Yet very limited research has been conducted into whether recent democratic changes actually delivered social dividends to African countries.<sup>14</sup>

At the end of the 1980s, both Ghana and Cameroon were governed by authoritarian regimes. Observers' assessments of the repression and constraints that these states posed on individual freedoms and political equality tended to agree (Figure 1). Early in the next decade, however, the political trajectories of the two countries began to diverge dramatically. At that time, Ghana embarked on a process of gradual but steady democratic progress, starting with a controversial election and slowly improving its credentials up to the point where, today, many observers consider it a shining star on the continent's poorly-performing democratic scoreboard.<sup>15</sup> Cameroonian politics followed a rather different path. The country's authoritarian leaders diverted pressures for reform by remodelling a single-party regime into a hegemonic party system in which multiparty elections were all but a window-dressing exercise. In spite of a formal adoption of democratic arrangements, the ruling elite retained unchallenged control over the political process, never really opening the latter to inputs and challenges from alternative domestic actors.<sup>16</sup>

Aside from their opposite political trajectories, Ghana and Cameroon share a number of similarities that make them a good choice for comparison. Equally belonging to western sub-Saharan Africa, for example, they are medium-sized countries in terms of territory and population. Both states are ethnically diverse colonial creations in which more densely-populated and fertile southern regions

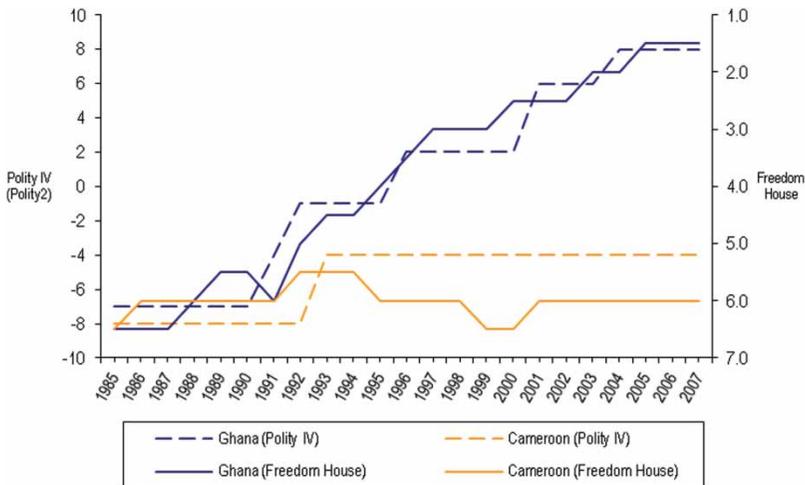


Figure 1. Democratic trends in Ghana and Cameroon, 1985–2007.

Source: Author's compilation based on Freedom House and Polity IV data.

were joined with less densely-populated, predominantly Islamized northern regions. When compared to the rest of Africa, the two countries also share features such as relatively functioning state bureaucracies and infrastructures, as well as similar levels of development. Both nations went through economic ups and downs, with Ghana experiencing its most difficult time between the late 1970s and early 1980s, and Cameroon facing recession between the late-1980s and early 1990s. Each reacted by introducing World Bank- and IMF-sponsored structural reforms. Today, Ghana and Cameroon are low-human development countries, taking, respectively, 130th and 131st position in the United Nations Development Programme's (UNDP's) human development world rankings for 2010.<sup>17</sup>

In these two relatively similar African contexts, did different political regimes produce different public policies? Besides a synchronic comparison in which democratized Ghana is set against non-reformed Cameroon as a control case, the comparative strategy of the article also implicitly includes diachronic comparisons through which pre-reform, nondemocratic Ghana (1981–1992) is weighed against post-reform, democratic Ghana (1992–2008), with pre-1992 Cameroon measured up to post-1992 Cameroon. This double comparative approach is aimed at maximizing checks on variables other than democratic change. Focusing on just two cases provides us with the chance of looking somewhat closer at the causal processes at play, but also demands caution when drawing all-too easy generalizations from our findings.

For the dependent variable, the focus is on health as a crucial policy sector. Given the particular implications that this area of social policy bears upon the life conditions of ordinary individuals – notably, by directly affecting their survival possibilities or their capacity to sustain the economic costs of ill-health – it can be reasonably expected not only that, where Africans are in a position to demand something from their leaders, demands will likely touch upon health issues, but also that the more African leaders depend upon the consent of their citizens, the more they will be concerned by their countries' health policies.

To the author's knowledge, no work has so far been published that examines the effects of Africa's democratization processes on health policies. In focusing on the politics of health reform, the article places particular emphasis on institutional reforms and resource reallocations. These are critical aspects of welfare policies that can prove more relevant than social spending increases in bringing about performance improvements in outputs (such as immunisation rates or education enrolment) or outcomes (for example, infant mortality or literacy rates).<sup>18</sup> The next two sections, therefore, empirically examine changes and continuities in the financial and organizational arrangements of the health systems of Ghana and Cameroon, respectively. Two further sections provide an analysis of the causal processes at play, the first one by comparing the different political contexts and policy processes of the two states, and the second one by gauging the influence of external actors and international health agendas on domestic policy-making patterns.

The main findings of this two-country comparison highlight a contrast that could not be starker: while pressures stemming from newly-introduced competitive

politics in Ghana were the main factor behind the decision to introduce key policy changes in the health sector, Cameroon's non-competitive political setting displays a total lack of any comparable political and policy-making dynamics, and health policy remains virtually dictated by foreign donors.

Empirical evidence was largely gathered through fieldwork research carried out in both countries during 2008. Interviews were conducted with policy-makers that had been involved in the health policy processes, including parliamentarians and top ministerial officials, as well as with privileged observers such as health specialists working for local non-governmental organizations (NGOs), for the local units of international organizations and for research institutions. The primary documentation the article relies upon also consists of ministerial, other institutional and research reports, health legislation and party election manifestos. Auxiliary sources were the local media, development-related quantitative databases and secondary literature.

### **Developments and change in Ghana's health policy**

When Ghana became independent, in 1957, Kwame Nkrumah's government immediately set to make health and education services vastly more available and accessible than had previously been the case under British colonial rule. In health policy, in particular, a new emphasis was placed on preventive and community-based health care, as opposed to a hospital-based curative system, and the relatively low user charges that had been introduced during colonial times were abolished, as all services came to be entirely financed through general taxation.

A gradual decline in the quality of free services and growing financial difficulties, however, led post-Nkrumah governments to adopt a number of measures aimed at cutting social spending and reintroducing a degree of cost recovery. A dispensing fee was first established with the 1969 Hospital Fees Decree by the National Liberation Council, the military junta that governed the country after Nkrumah was toppled. When the Progress Party elected government took over, the latter measure was amended by the Hospital Fees Acts of 1970 and 1971, which were meant to make fees broader, so that they would also cover, for example, out-patient care and treatment.<sup>19</sup> As in the rest of the public sector, however, out-of-pocket fees at point of service remained very low and were largely meant to discourage unnecessary use.<sup>20</sup>

By the time Ghanaians had become used to expecting a public provision of health and education services, the country's economy was entering its most difficult period. The economic decline of the 1970s gravely damaged the functioning of state institutions, which were dramatically hit by a growing dearth of resources. By the middle of the decade and the early 1980s, the social services system had weakened to the point of virtual collapse.

The health system was thus in a dismal situation when Jerry Rawlings took over as a military leader at the end of 1981. To restore service provision, as well as because of donors' prevailing thinking and pressures with regard to health

financing strategies, the Hospital Fees Regulation of 1985 was adopted by a government that was otherwise often deemed to be populist.<sup>21</sup> The Regulation substantially increased the level of out-of-pocket payments by patients with the aim of recovering 15% of recurrent costs. The new arrangement was popularly labelled 'cash and carry', particularly after, in 1992, a revolving fund scheme was introduced that directly linked user fees to drug purchase. As the envisaged exemption of certain categories of people, such as pregnant women, ran into practical difficulties, virtually everyone in Ghana had to pay, in practice, for public health services at point of use. By the end of the 1980s, well-documented studies began to expose the way the new cost-recovery system tended to exclude many people from accessing health facilities and services,<sup>22</sup> and the cash-and-carry system became increasingly infamous and resented among Ghanaians.

When the Rawlings regime opened to multipartyism in the early 1990s, health care and user fees thus became a major political issue. Reverting to a Nkrumah-style tax-based health system was hardly an option, given its past failure. The idea of addressing health financing in an entirely new manner, that is, by pooling resources through prepayment schemes, had meanwhile begun to be explored by some private health insurance schemes. But these arrangements only covered about 1% of the population.<sup>23</sup> By the mid-1990s, plans for replacing the cash-and-carry system with some form of public health insurance were also examined at the Ministry of Health, but lack of consensus soon stalled the pilot projects.

It was only after the New Patriotic Party (NPP) government came to office in 2000 that the issue of a nation-wide insurance plan was forcefully pursued by the new government. As the end of John Kufuor's first presidential term loomed, a National Health Insurance Act was passed by parliament in mid-2003, resulting in the launch of the National Health Insurance Scheme (NHIS) in March the following year, with implementation beginning in early 2005. The scheme was financed through the payment of individual premiums, a health tax on commercial transactions, and the transfer of a small percentage of formal sector workers' contributions towards retirement benefits. Measured against the experience of other countries, rather than against the overoptimistic goal of actually achieving universal enrolment within five years, coverage was extended at a surprisingly impressive pace: by 2008, over 10.4 million or 45% of Ghanaians had health insurance.<sup>24</sup>

The left side of Table 1 sums up the key steps in the evolution of Ghana's health policy. For the purpose of this article, what appears to be crucial is the shift from a policy based on substantial fees charged to users – an arrangement established and developed since 1985 – to the system based on universal health insurance that was introduced in 2003.

### **Reforms and continuity in Cameroon's health policy**

The gradual development of a nation-wide health sector was undertaken by Cameroon's new independent government during the 1960s. The creation of

Table 1. Key developments in health policy in Ghana and Cameroon.

Ghana				Cameroon			
Year	Policy	Main features	Financing	Year	Policy	Main features	Financing
1957	UK-type national health service	Creation and expansion of territorial health services Universal coverage Free provision	General revenues	1960	Zones DASP	Experimentation Introduction of territorial health services <i>De facto</i> free services	General revenues User fees (low)
1969– 1971	Hospital Fees Decree/Acts	Containment of health care costs Cost recovery (minimal) <i>De facto</i> free provision	General revenues User fees (low)	1982	<i>Soins de Santé Primaires</i> (Primary Health Care)	Local, essential, universal health care National system for integration and continuity of health services Involvement of local communities Free services	General revenues
1985	Hospital Fees Regulation	Cost recovery (substantial: partial to full) Decentralization: health facilities retain 25–50% of fees charged to patients Exemptions (not implemented)	General revenues User fees (substantial)	1989– 1992	<i>Réorientation des Soins de Santé Primaires</i>	Cost recovery Decentralization	General revenues User fees (substantial)
1992	Drugs revolving fund (cash & carry)	Full cost recovery for drugs Decentralization: 100% of fees retained by health facilities Exemptions (not implemented)	General revenues User fees (substantial)	1990– 1992	<i>Dérogation . . . en matière financière (Loi 90/062) e legge 1992</i>	Cost recovery (substantial) Decentralization: 50% of fee revenues retained at district level	General revenues User fees (substantial)

1996	Medium term health strategy	Sector-wide planning Aligning national policy and partners' agendas Harmonizing donors' procedures Health fund at MoH for pooling donors' resources	General revenues User fees (substantial) Donors	1998	<i>Plan National de Développement Sanitaire</i>	Cost recovery Decentralization Private providers included Fighting HIV/AIDS Minimum benefits package	General revenues User fees (substantial)
2003	National Health Insurance Act	Health insurance (mandatory) Universal coverage (within 5 years) Decentralized, district-based mutual schemes plus private (commercial or mutual) schemes Minimum benefits package Exemptions	General revenues Premiums (graduated) Sales levy Social security contributions Donors User fees (for the uninsured)	2002	<i>Strategie Sectorielle de Santé</i>	Sector-wide planning Aligning national policy and partners' agendas Harmonizing donors' procedures Cost recovery Decentralization Reducing morbidity and mortality in vulnerable groups	General revenues User fees (substantial) Donors

Source: Author's compilation.

four *Zones de Démonstration des Actions de Santé Publique*, in particular, aimed at gradually starting a network of health facilities at the local level. In spite of the payments prescribed by the law, the Zones DASP introduced *de facto* free health care, albeit they never quite took off beyond a piloting stage.

The early 1980s marked the beginning of a new period of reforms, largely inspired by the internationally-agreed recommendations of the 1978 Alma Ata Declaration on local-level, essential and universally accessible health care. In 1982, a Presidential Decree officially made the *Soins de Santé Primaires* (primary health care) government policy. While consultations, treatments and drugs were in principle freely provided by the state, however, quite a different *modus operandi* actually emerged within the health system. With declining amounts of the health budget spent on drugs, inefficiency and diversion in the centrally-managed distribution of pharmaceutical supplies, and frequent illegal appropriations at the local level, health centres, particularly in rural areas, became more often than not short of medicines and thus underutilized.<sup>25</sup>

The long recession the country suffered between 1986 and 1994 hit hard on the Cameroonian state. By the late 1980s, the country had to bow to external pressures for structural reforms and resources became ever scarcer. By 1989, government health spending no longer covered drugs and the latter thus virtually disappeared from health structures, leading to a further drop in the use of public health facilities.

During the early 1990s, President Paul Biya's one-party regime had to face domestic and external pressures for the establishment of multipartism. The cosmetic political changes that were introduced, however, had little impact on a process of health reform that had already begun in the late 1980s under the auspices of foreign donors.

In 1988, a report by the Ministry of Health had outlined a number of problems in the way the Primary Health Care approach had been implemented.<sup>26</sup> In line with both the recommendations of the international health conferences held at Harare and Bamako in 1987 and the structural adjustment programmes the country was undertaking, the government then announced a new PHC implementation strategy, officially adopted in 1992 as *Réorientation des Soins de Santé Primaires* (Reorientation of Primary Health Care).

Hailed as a 'radical reform', the Reorientation policy reorganized the health system with significant decentralization to the districts.<sup>27</sup> The reform was then further spelt out through a series of measures introduced during the better part of the 1990s. Key among them was a 1990 law establishing cost recovery mechanisms that would restore the actual provision – if paid for – of cheap, essential drugs. User fees for health services and drugs were thus gradually phased in with support from donors such as USAID, while local health facilities were allowed to retain half the revenues thus generated.<sup>28</sup>

By the end of the decade, the notions of decentralization and cost recovery were again placed at the core of a new strategic document launched by the government for 1999–2008, the *Plan National de Développement Sanitaire*, inspired by the World Health Organization and supported by the World Bank. A full fledged

sector-wide policy document – the *Strategie Sectorielle de Santé* worked out between 1999 and 2002 – essentially re-stated the same organizing principles articulated by previous policy documents.<sup>29</sup>

As summarized in Table 1, the ‘re-orientation’ of Cameroon’s health system was thus a process that began in the late 1980s and continued for at least 15 years. After the initial decision was taken to embrace the decentralization and cost recovery recipes, however, subsequent policy measures largely re-stated these guiding principles and detailed the way they would be implemented. The country’s move from one-partism to a system of multipartism without democracy, in the early 1990s, had no effect on a long wave of health reforms whose roots lay in the previous decade.

### Political regimes, party platforms and policy strategies

Divergent political developments in Accra and Yaoundé, as shown above, were paralleled by an equally different evolution of their health policies. But were the two phenomena actually related? And if so, how? To empirically investigate the existence of a causal connection, the article looks at the way and the extent in which, in each of the two countries, the nature of electoral competition and of the public arena affected the politicians’ choice to favour programmatic politics and public-good-oriented policies over the appropriation and distribution of private goods and rents.

At a broad political level, in Ghana, the emergence of a domestic public sphere in which political issues could be openly and vigorously debated was crucial to the creation of a context where voters’ demands could be articulated and voiced in such a way that politicians would feel pressurized to provide policy responses. As observers have repeatedly pointed out, the country displays ‘the continent’s greatest media freedom’, the media are ‘free to criticize the authorities without fear of reprisals’<sup>30</sup> and citizens enjoy *de facto* ‘unfettered freedom of expression’.<sup>31</sup> The role of a free press as a key democratic mechanism making leaders better aware of and more likely to respond to social needs has long been noted.<sup>32</sup>

The constant scrutiny and open debates on health issues in the free media coupled with the mobilization of political organizations and interest groups. The Trade Unions Congress and the Ghana National Association of Teachers, for example, loudly proclaimed their unhappiness at the forced use of retirement contributions for funding the health insurance scheme.<sup>33</sup> The development of a public sphere and the emergence of democratic politics thus created new incentives for politicians to pay growing – if certainly not exclusive – attention to policies oriented towards large sections of the electorate. It is in this context that the process of health policy-making ceased to be the exclusive preserve of government and donors’ agencies, rapidly politicizing to become an ever more prominent public matter and, ultimately, a major electoral issue:

in the 1990s, because of party politics, people had to sell their ideas to win votes...and the cash-and-carry was a particularly big election issue in 2000 and 2004.<sup>34</sup>

health is invariably in the manifestos of the political parties...voters are very concerned, and no issue has received greater attention than the NHIS.<sup>35</sup>

A content analysis of the election manifestos of Ghana's major parties is revealing of how health developed into a key focus of electoral contestation. Over the eight years (1992–2000) during which it ruled the country, Rawlings' National Democratic Congress appeared too slow in answering to a 'public outcry' and the 'steady calls' for discontinuing the cash-and-carry system.<sup>36</sup> In the mid-1990s, the insurance schemes option was being explored but the party was cautious about it.<sup>37</sup> Four years later, the party did anticipate 'a major strategy' based on a new 'mix of insurance schemes', yet the latter was meant to work side-by-side with a 'reviewed' and 'improved' cash-and-carry system, rather than the latter being fully phased out.<sup>38</sup> The fact of being an offspring of the authoritarian regime that had introduced the existing cost-recovery arrangements during the 1980s somehow held the National Democratic Congress (NDC) back from reforming them. It was only after it lost power that the party tried to catch up with the NHIS reform adopted by the New Patriotic Party government.<sup>39</sup>

The health reform brought in by the NPP, on the other hand, was the result of the party leadership's long standing effort to capitalize on the unpopularity of the cash-and-carry system. While in the opposition, the party had attacked the latter as 'notoriously callous and inhuman', promising to reform it 'with a view to evolving a more equitable system including health insurance and other repayment schemes'.<sup>40</sup> By 2000, the NPP platform was even clearer in pledging that the party would 'abolish the iniquitous cash-and-carry system', albeit it still only envisaged a regulatory and monitoring role for the government.<sup>41</sup>

Once it won power, President Kufuor's party felt the urge to go beyond its own election pledges. As the 2004 electoral deadline approached, in particular, the NPP government was on the look for highly visible measures it could showcase in seeking a new mandate. Health reform required to by-pass the top bureaucrats at the Ministry of Health, who were in favour of a slower, step-by-step, more technical and sustainable approach.<sup>42</sup> To speed up the NHIS reform, therefore, the health minister made a series of new appointments aimed at realigning the position of key ministerial personnel with the political imperatives and the policy goals of the executive. With political nominees rapidly taking a decisive role in the policy-making process, the traditionally strong role played by the technocrats at the Ministry of Health was *de facto* downsized, and their preferences overshadowed by the voter-conscious agenda of the government.<sup>43</sup> To minimize the risk that the passing of the National Health Insurance bill would be slowed down – or even halted – and the political objective of having it enacted prior to the election undermined, the government then made sure that the proposed law would be rushed through

parliament with very limited time for debate.<sup>44</sup> The NDC accused the executive of too hastily introducing the new policy only to fulfil a campaign promise,<sup>45</sup> thus acknowledging a connection between elections and the reform. Electoral pressures and the need to court the vote of the masses prevailed over the ideological principles of a supposedly centre-right party historically rooted in Ghana's liberal tradition.

At the exact time Ghana did, in the early 1990s, Cameroon also allowed domestic oppositions to organize and contest national elections. Yet, after an initial moment when Biya's regime appeared to be on the brink of collapse, the president was able to win the close election of 1992 and re-establish the essentially monopolistic role of his *Rassemblement Démocratique du Peuple Camerounais (RDPC)*. With decisive support from the civil service, the army and France, the ruling party quickly learnt how to neutralize the electoral process through a skilful use of patronage, control over the media, electoral manipulation and repression. The RDPC did not just comfortably carry subsequent elections, but it increased its share of parliamentary seats from 88 in 1992 to 153 in 2007, out of a total 180, while Biya's presidential vote grew from 40% in 1992 to 71% in 2004. While it was formally no longer a single party, the RDPC had become an unchallenged, *de facto* hegemonic actor under a façade multiparty system.

It was this broader political context that, in Cameroon, prevented the development of a lively public sphere similar to Ghana's. Policy issues were not the object of genuine public debates in the media nor of political competition, as the room for discussions remained limited and controlled. In Yaoundé, the government and its security forces continuously intimidated, physically harassed and even jailed journalists covering oversensitive political issues or high-profile corruption cases.<sup>46</sup> Despite some timid improvements, journalists remained the 'targets of over-zealous police and military, corrupt judges and score-settling between politicians', with media offences continuing to be 'heavily-punished crimes' and the government so 'aggressively' monitoring newspapers, radios and television stations that they could 'not freely discuss numerous topics'.<sup>47</sup> In 2008, the country was the second-ranked jailer of journalists in Africa.<sup>48</sup>

The stark difference with Ghana is further apparent if we turn to party policy manifestos. In a country that lacked a tradition of political participation, civic and political organizations remained very weak. The Social Democratic Front (SDF), which had emerged as the main new political force in the course of the transition, did initially make an effort to raise and address policy issues in the scant political documents it produced. Its original 1990 manifesto, for example, mentioned the need to 'provide free health care for children, students, the unemployed, elderly and handicapped people', and, notably, to introduce a national health insurance scheme.<sup>49</sup> In 1997, the party further pledged to reform the country's 'disastrous' health system, 'ensure fundamental health care to the most needy', 'create a minimum health solidarity tax payable by Cameroonians according to their means', 'cut prices of drugs and health equipment', and 'encourage health insurance not only by para-statal but also by private companies and

village cooperatives'.<sup>50</sup> Yet the main opposition largely failed to fully articulate a political and economic policy programme, while its leadership became increasingly divided and controversial, even facing accusations of having been bought off by the ruling elite.<sup>51</sup> Ultimately, the attention of opposition groups and self-censured media focused almost exclusively on reforming the main rules of the political game – such as the conditions under which elections were being contested – rather than on any specific policy issues. The health care cost recovery approach, for example, was never challenged in any open and substantial manner. The government itself prevented public discussions from indulging in potentially contentious issues. As a high-level official at the Ministry of Health put it:

the government did not really make health a political priority. We have elections, but there is no real political competition. So, for those in government, there is no need to make much effort to make your way. Elections and votes are not really a concern for the government. Minor parties are part of the system, except for the SDF. They do not know how things could be done differently. There is not really public debate – debate is led by one person, there is no game. The government certainly does not promote discussions like these ones [i.e. on health reform], discussions that would let them down.<sup>52</sup>

The ruling RDPC, in other words, never felt the urge to move beyond some very general political slogans and articulate an explicit policy platform, a manifesto. The party simply did not develop any positions on social policies – or, for that matter, on policies as such – except for what may be gathered from the government's actual initiatives. When, in early 2008, rather unique social demonstrations took place in the country's major cities, protesters were simply repressed with a violent crackdown. Such was the nature of Cameroon's electoral authoritarianism.

Overall, the regime appeared to remain much more concerned with the appropriation and distribution of private benefits to its core constituency, rather than with the provision of public goods to wider segments of the populace. To the extent that the prevalence of corruption can be taken as a proxy for the politics of rents and private goods, the comparison with Ghana is once again telling. On a  $-2.5$  (most corrupt) to  $+2.5$  (least corrupt) scale, the 'control of corruption' indicator elaborated by the World Bank ranked Cameroon in 19th place with a  $-0.90$  score for 2008, that is, a position almost twice as bad as the average for sub-Saharan Africa. Ghana, with a moderate difference in absolute terms ( $-0.06$ ), made it to 57th place, a position almost twice as high as the regional average.<sup>53</sup> Corruption data by Transparency International fully corroborate the stark difference between the two countries.<sup>54</sup> Neither did the adoption of donor-induced anti-corruption initiatives, such as *Opération Epervier*, launched in 2004, significantly change Cameroon's bad performance.<sup>55</sup>

In a context of severely limited media freedom, virtually inexistent programmatic election platforms, and predominantly private-gain oriented politics, health policy in Cameroon was no more of a public issue after 1990 than it had been before.

A comparison of politics and policy-making in the two countries, therefore, reveals a close link between the very different political dynamics of the two regimes and the equally dissimilar policy processes that characterize a social welfare sector such as health. Ghanaian political leaders were held sufficiently accountable through an electoral process and a free press that incentivized them to pay increasing attention to the provision of public goods. Cameroonian rulers, on the contrary, kept their hands free from the constraints of real electoral competition and media scrutiny, and thus felt little domestic pressure to modify the country's predominantly clientelistic politics.

### **International influences in health policy-making**

A key consequence of the profoundly different political arenas of Ghana and Cameroon is a fundamental disparity in the balance of influence over health policy-making processes between domestic and external pressures. External actors often play a significant part in the policy decisions of the governments of developing countries. The health policies of many African countries are a case in point, as they have long been shaped by developments in an international public health agenda that emerged during the second half of the twentieth century. Since the late 1970s, in particular, the notions of health for all and primary health care helped consolidate the prominence of this agenda and the role of international actors such as the World Health Organization and Unicef. In the 1980s, the Harare and Bamako initiatives further articulated an internationally-shared vision by placing emphasis, respectively, on the decentralization of health care and on the adoption of cost-recovery mechanisms as key organizational principles for re-structuring health systems in developing nations.<sup>56</sup> Virtually all African states soon embraced the new approach. By the mid- and late 1990s, as the World Bank had meanwhile acquired a major role in this area of policy, new ideas gained ground which largely concerned the need for sector-wide strategic planning and financing. For over three decades, the global health agenda had a very significant influence over the evolution of public health systems in Ghana and Cameroon. While such an influence remains a relevant factor in the policy-making practices of both countries, recent years have seen international actors and ideas weighting somewhat differently upon the development of their health policies.

For a country like Ghana, the NHIS policy represented a bold and ambitious step to say the least. As of today, it is in just above two dozen countries worldwide that the principle of insurance for universal coverage has been established, and, except for Ghana and Rwanda, no other low-development country is on the list.<sup>57</sup> As a matter of fact, up until recently universal insurance was far from a core international health policy prescription, that is, it was not a policy donors would actively push for. The World Bank, for example, cautioned that this could hardly be a feasible strategy for most developing countries.<sup>58</sup>

Compulsory social health insurance has only recently begun to emerge as an increasingly legitimate and fashionable approach for health financing.<sup>59</sup> It was in 2005, in particular, that the World Health Organization (WHO) adopted a resolution recommending this strategy for poor countries, with a subsequent report noting that 'there is now widespread consensus that providing such coverage is simply part of the package of core obligations that any legitimate government must fulfil'.<sup>60</sup> This emerging thinking likely contributed to the direction health reform took in Ghana. Key donors that had initially been sceptical of the reform plans of the government gradually became more supportive and eventually gave their green light.<sup>61</sup> But these developments only followed *after* the health insurance law was enacted in Accra. In the words of a policy official, pressure for 'health reform was most political and was coming from a domestic agenda rather than from the donors, who only later became favourable'.<sup>62</sup> The influence of external actors was thus a secondary, if supplementary factor. Rather than explaining why the country opted for changing its health financing policy, it partly helps understand the solution that was chosen to replace existing arrangements.<sup>63</sup> In Ghana's NHIS reform process, the emergence and primacy of the election concerns of a democratically-elected government resulted in a strongly reduced room for external inputs: as elected leaders knew that voters would hold them accountable, the policy-making process was principally aimed at aligning the government's decisions to domestic rather than foreign demands.

In the virtual absence of domestic pressures, international actors were much more prominent in the health policy-making process in Cameroon. The World Bank and the World Health Organization, in particular, played pivotal roles. The World Bank had become a major donor in international public health between the late 1980s and the early 1990s, as it took on emerging concerns about the social costs of adjustment while also realizing the relevance of health for development. In Yaoundé as much as elsewhere, the Bank, and partly the International Monetary Fund (IMF), came to play an ever more influential role by linking reforms to the disbursement of aid and other financial support. Most notably for Cameroon, eligibility to the Heavily Indebted Poor Countries initiative for debt relief was made conditional upon the elaboration not only of a Poverty Reduction Strategy Paper, but also of health and education sector-wide strategies. The country had neither the capacity nor the political will to resist these conditions.

A critical, if different, kind of influence was also exerted by the World Health Organization. The latter's officials, for example, sat with other 'development partners' in the committee charged by the Ministry with the task of elaborating a health sector strategy. Ultimately, the world health body was at the origin of many of the ideas contained in the *Strategie Sectorielle de Santé*.

The extent to which the Bank and the WHO played a crucial part in health policy-making in Cameroon, however, was most evident, in the late 1990s, when a highly-qualified minister for health who had tried to resist the World Bank's request for a partial change of strategy in health policy was replaced by president Biya with a more reliable representative of donors' visions and interests

Table 2. External aid in Ghana and Cameroon.

	Net ODA received (% of GNI)		Net ODA received (% of central government expense)*		Aid per capita (Net ODA received, current US\$)		Aid for social infrastructure and services, per capita (constant 2008 US\$)**		Aid for health, per capita (constant 2008 US\$)**	
	CAM	GHA	CAM	GHA	CAM	GHA	CAM	GHA	CAM	GHA
1980–1992	3.2	7.4	–	–	27.0	27.8	–	–	–	–
1980–2008	4.5	9.1	–	–	35.6	35.2	–	–	–	–
1993–2008	5.5	10.4	41.4	47.0	42.7	41.3	11.3	22.9	1.7	5.6
2000–2008	5.7	11.2	–	–	48.2	46.5	–	–	–	–

*Sources:* Author's compilation based on data from World dataBank (World Bank) and QWIDS database (OECD).

*Notes:* \*Data cover 1990 to 1994 and 1998 to 1999 for Cameroon, and 2000 to 2008 (2001 missing) for Ghana; \*\*Based on World Bank data on population and OECD data on ODA commitments to the sectors. Data cover 1995 to 2009.

at the Ministry. Through the mediation of the country's leadership, therefore, the international actors proved able to influence the crucial choice of who could or could not be in charge in the health sector. In Cameroon, elected leaders proved unmistakably that they felt accountable not to voters, but to international agencies.

Besides the international health agendas that foreign actors pursue, there is a further way in which they might have affected policy processes in Accra and Yaoundé, potentially watering down any direct connection between democratic politics and social policy: if, say, Ghana received significantly higher external resources for health care than Cameroon, its health reform might have been favoured by a looser budget constraint, rather than by electoral incentives. Table 2 shows some aid data for the two countries and suggests two main points. First, aid as a percentage of GNI is, on average, twice as high in Ghana. Yet, not only had this also been true before the multiparty transition of 1992, but it was in Cameroon that the relative weight of aid increased the most after 1992. It thus becomes difficult to argue that the volume of aid explains health policy change in Accra and the lack of any such change in Yaoundé. At a more general level, the very notion that higher levels of aid imply looser budget constraints is questionable. Indeed, aid as a percentage of national income (or, for that matter, of government expenditure, also in Table 2) is often considered an indicator of 'aid dependency'.<sup>64</sup> The assumption is that the larger the role of aid, the more influence foreign donors will bear on a country's decision-making processes. Compared to Cameroon, one may thus argue that Ghana had actually less rather than more room for manoeuvre in adopting a domestically-driven reform.

Secondly, the level of aid for social services (relative to the size of the population that the public sector has to serve) is also almost twice as high in Ghana as in Cameroon. The same goes for per capita aid for health. Yet, when decisions such as the introduction of a health insurance scheme are made, budget constraints are more likely to depend on a country's overall budget rather than on the budget for the specific sector. We therefore need to look at total aid rather than aid targeting the social sectors. Total aid per capita was lower in Ghana than in Cameroon, and one may thus claim that the former country had relatively less resources available, and therefore stronger budget constraints, rather than the other way round.

Ultimately, however, the above differences in the aid received by the two countries are relatively limited. A gap of five percentage points in Official Development Assistance (ODA) as a share of government expenditure, for example, does not seem enough to claim that this created two significantly diverse budgetary situations. Aid levels thus essentially turn out to be another reason why Ghana and Cameroon make for a good comparative analysis.

## Conclusions

Does the advent of democracy affect social policies in developing countries? This article addressed the question by examining two cases from sub-Saharan Africa, a region for which the consequences of recent democratization processes are only

beginning to be explored. Ghana and Cameroon make a good choice for comparison since they are reasonably similar countries, except that, from the early 1990s, their political trajectories followed dramatically divergent paths: while democracy gradually took hold in Accra, Yaoundé remained tenaciously nondemocratic. Health policy was chosen as the testing ground for observing the effects of political regimes.

Over the past two decades, Ghanaian politics developed into a highly competitive political game. Two parties consistently challenged each other in five successive electoral rounds, one winning two and the other one three. Besides an elected and electorally accountable executive, a parliament was established and developed as well as independent courts of justice. Hundreds of civic associations sprung up, fostering rights' advocacy, open debates and political mobilization, while free media multiplied, providing ample coverage of public affairs and fierce debates on political issues. The overall result was a vibrant democratic life that generated strong pressures for governing parties to answer to the social concerns of the voters. A key social demand, in particular, related to the health sector and to the limited and unequal access to drugs, services and facilities under the so-called cash-and-carry system. The opposition was quick in exploiting health issues to challenge the ruling party, to articulate an electoral platform that would win it power, and, once in office, to adopt health policy changes that would help it gain a second mandate. It is difficult to overestimate the relevance of electoral competition in Ghana's politics of health reform.<sup>65</sup>

Despite the introduction of multipartism, Biya's enduring regime in Cameroon prevented the development of any of the features displayed by Ghana's flourishing democracy. Political room for the opposition was constrained and individual freedoms curtailed, the media were kept under close scrutiny and censure, no public debates on political issues were allowed to emerge, most political parties hardly developed explicit policy platforms, electoral procedures and, ultimately, election outcomes were closely controlled by the regime. It is therefore not surprising that hardly any bottom-up pressures for the government to adopt this or that policy emerged. When they did, as with the demonstrations of early 2008, they met fierce repression from the government. In this political context, combined with domestic economic difficulties, international donors continued to dominate a health policy agenda centred on cost-recovery in the 1990s as much as they had done in the previous decade. The main directions followed by health policy developments were established prior to the introduction of multiparty elections in the early 1990s, and they were continued after the latter. Multipartism without democracy had no effect whatsoever on health policy-making.

A comparative analysis of Ghana and Cameroon thus shows that democracy can be instrumental to the development of welfare policies in poor countries. While further research is needed to fully understand the extent to which this finding may be generalized, the latter is in line with anecdotal evidence from other parts of the continent. As out-of-pocket payments have come under strong criticisms, in recent years, on grounds of both equity and efficiency, a few countries

have started to phase them out. In Africa, elected governments have been particularly sensitive to this public concern: South Africa in 1994 and again in 1997, Uganda in 2001, Madagascar in 2002, Kenya in 2004, Zambia and Burundi in 2006, all acted to reform user fees, whether by reducing or removing them, permanently or temporarily, entirely or partially.<sup>66</sup>

Besides the above crucial point, there are at least five broader lessons to be learned from our comparative investigation. The first is that, domestic policy-making processes can retain a significant degree of autonomy even in developing countries where foreign aid is often an important, if not critical, source of funding. A second, related point is that not all developing countries are dismantling their often weak welfare systems in favour of more limited and privatized forms of protection. The third lesson is that electoral accountability mechanisms can favour a redistributive policy, rather than, or at least in addition to, the patron-client exchanges and distributive policies that are found all-too-often in Africa's neopatrimonial regimes. Furthermore, democratically elected politicians, contrary to what Nelson suggests,<sup>67</sup> may receive bottom-up signals that favour reallocation or reform of social services, rather than (or in addition to) spending and expansion. Finally, socially-oriented policies do not necessarily materialize as a result of mobilization by left-wing political forces and parties. Indeed, a right-wing versus left-wing distinction may not always prove useful in predicting social policy choices.

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### Notes

1. The classic argument about the redistributive properties of democratic politics is formalized in Meltzer and Richard, 'A Rational Theory of the Size of Government'.
2. See, for example, Lake and Baum, 'The Invisible Hand of Democracy'; Bueno de Mesquita et al., 'Political Institutions, Policy Choice and the Survival of Leaders'; Gerring, Thacker, and Alfaro, *Democracy and Human Development*; Brown and Mobarak, 'The Transforming Power of Democracy'.
3. Bollen and Jackman, 'Political Democracy and the Size Distribution of Income'; Ross, 'Is Democracy Good For the Poor?', 861.
4. Cf. de Waal, 'Democratic Political Processes and the Fight against Famine', 13; Varshney, 'Why Have Poor Democracies Not Eliminated Poverty?', 729.
5. Lindberg, "'It's Our Time To «Chop»'".
6. Lake and Baum, 'The Invisible Hand of Democracy', 588.
7. Carbone, 'The Consequences of Democratization'.

8. Sen, 'An Argument on the Primacy of Political Rights'; de Waal, 'Democratic Political Processes and the Fight against Famine'.
9. Varshney, 'Why Have Poor Democracies Not Eliminated Poverty?'.
10. Harms and Zink, 'Limits to Redistribution in a Democracy'; Chong, 'Inequality, Democracy, and Persistence'; Bollen and Jackman, 'Political Democracy and the Size Distribution of Income'.
11. Brown, 'Reading, Writing and Regime Types'; Brown and Hunter, 'Democracy and Human Capital Formation'; Stasavage, 'Democracy and Education Spending in Africa'.
12. Nelson, 'Elections, Democracy and Social Services'; Ross, 'Is Democracy Good For the Poor?'.
13. Bratton and Mattes, 'Support for Democracy in Africa'.
14. Such works include Hickey, 'Conceptualising the Politics of Social Protection in Africa' and 'The Politics of Staying Poor'; Stasavage, 'Democracy and Education Spending in Africa' and 'The Role of Democracy in Uganda's Move to Universal Primary Education'; Natrass and Seekings, 'Democracy and Distribution in Highly Unequal Economies'; and Kosack, *Do Democracies Serve the Poor?*
15. See, for example, 'Democracy in Africa. A Good Example', *The Economist*, October 22, 2009; 'Obama: Time to End Tyranny in Africa', *The Guardian*, July 11, 2009; Freedom House, *Freedom in the World 2011. The Authoritarian Challenge to Democracy*.
16. See, for example, Gros, 'The Hard Lessons from Cameroon', and van de Walle, 'Africa's Range of Regimes'.
17. UNDP, *Human Development Report 2010*, 145.
18. Nelson, 'Elections, Democracy and Social Services', 80ff. Cf. Ross, 'Is Democracy Good for the Poor?'.
19. SEND-Ghana, *Balancing Access with Quality Health Care*, 13.
20. Badasu, 'Implementation of Ghana's Health User Fee Policy', 290; Nyongator and Kutzin, 'Health For Some?', 330; Agyepong and Adjei, 'Public Social Policy Development and Implementation', 154.
21. See, for example, Nugent, *Big Men, Small Boys and Politics in Ghana*.
22. Waddington and Enyimayew, 'A Price to Pay'; and Waddington and Enyimayew, 'A Price to Pay, Part 2'; Aryeetey and Goldstein, 'Ghana. Social Policy Reform in Africa'.
23. Sulzbach, Garshong, and Owusu-Banahene, *Evaluating the Effects of the National Health Insurance Act in Ghana*, 3.
24. Ministry of Health, *Pulling Together, Achieving More*.
25. van der Geest, 'The Efficiency of Inefficiency', 2148.
26. Essomba, Bryant, and Bodart, 'The Reorientation of Primary Health care in Cameroon', 233.
27. *Ibid.*, 235.
28. Litvack and Bodart, 'User Fees Plus Quality Equals Improved Access to Health Care', 374; Essomba, Bryant, and Bodart, 'The Reorientation of Primary Health Care in Cameroon'.
29. Cf. Médard, 'Décentralization du système de santé publique et ressources humaines au Cameroun', 1–2.
30. Reporters Without Borders, *Ghana Report*, 2010.
31. Freedom House, *Freedom of the Press. Ghana Country Report*, 2009.
32. Cf. Sen, 'An Argument on the Primacy of Political Rights'.
33. National Democratic Congress, *Manifesto 2004*, 49.
34. Interview, Isaac Adams, Director of Research, Information and Statistics, Ministry of Health, Accra, November 25, 2008.

35. Interview, Sam Adjei, former deputy Director of Ghana Health Service, interview, Accra, November 25, 2008.
36. Aryeetey and Goldstein, 'Ghana. Social Policy Reform in Africa'.
37. National Democratic Congress, *Manifesto 1996*.
38. National Democratic Congress, *Manifesto 2000*.
39. National Democratic Congress, *Manifesto 2004* and *Manifesto 2008*.
40. New Patriotic Party, *Manifesto 1996*.
41. New Patriotic Party, *Manifesto 2000*.
42. Cf. Rajkotia, *The Political Development of the Ghanaian National Health Insurance System*, 8–10; Agyepong and Adjei, 'Public Social Policy Development and Implementation', 155.
43. *Ibid.*, 155–6.
44. Cf. Rajkotia, *The Political Development of the Ghanaian National Health Insurance System*; Agyepong and Adjei, 'Public Social Policy Development and Implementation', 155–6.
45. UN, *Integrated Regional Information Network*.
46. Freedom House, *Freedom of the Press. Cameroon Country Report*.
47. Reporters Without Borders, *Cameroon Report*.
48. See Freedom House, *Freedom of the Press. Cameroon Country Report*; Committee to Protect Journalists, 'Attacks on the Press 2009: Africa Developments' (February 16, 2010), 'CPJ Alarmed by Harassment of Journalists in Cameroon' (March 9, 2010) and 'Cameroon Must Investigate Jailed Editor's Death' (April 25, 2010). In its 2009 appraisal of media freedom, Reporters Without Borders ranked Ghana 27th out of 175 nations, with Cameroon in 109th place. Out of a slightly more numerous total number of states (195), Freedom House similarly positions Ghana in 53rd place and Cameroon in 143rd. For the complete rankings, see <http://www.rsf.org> and <http://www.freedomhouse.org>.
49. Social Democratic Front, *SDF Manifesto 1990*.
50. Social Democratic Front, *SDF Election Platform 1997*.
51. See, for example, Konings, 'Opposition and Social-democratic Change in Africa', 308; 'Cameroun: fin de partie pour John Fru Ndi', *Jeune Afrique*, October 27, 2009.
52. Basile Kollo, Directeur des Ressources Humaines, Ministère de la Santé Publique, Interview, Yaoundé, February 29, 2008.
53. For World Bank data on 'control of corruption', see Kaufmann, Kraay, and Mastruzzi, 'Governance Matters VIII', 6.
54. See <http://www.transparency.org> for data by Transparency International.
55. See 'Just'ou ira Paul Biya?', *Jeune Afrique*, May 5, 2008, and 'Paul Biya accuse d'instrumentaliser "Epervier"', *Jeune Afrique*, January 25, 2010.
56. Gruénais, 'L'État à la conquête de son territoire national', 2.
57. Cf. Hsiao and Shaw, 'Introduction, Context and Theory', 11–14. In Rwanda, the principle of compulsory health insurance for universal coverage was only established by Law no. 62/2007 of December 2007, a law that was implemented from 2008. Previously, since 1999 Kigali had introduced and promoted a system of community-based insurance schemes (besides other schemes covering the formal sector), but so-called *mutuelles* had remained voluntary schemes.
58. Health insurance had been part of the World Bank's broad health reform agenda for developing countries since the late 1980s and early 1990s, but it never quite developed into a central theme in debates and reform practice at that time. Moreover, insurance schemes were neither meant to be arranged directly by the government, nor to be universal, nor comprehensive (World Bank, *Financing Health Services in Developing Countries*): universal coverage was considered a feasible strategy for 'only a few middle-income countries' (World Bank, *World Development Report. Investing in*

*Health*, 161). It was only in 2005 that the World Bank explicitly put some distance between itself and the adoption of user fees for the ‘basic health services for poor people’ (Yates, *International Experiences in Removing User Fees for Health Services*, 14).

59. Wagstaff, ‘Social Health Insurance Reexamined’; Hsiao and Shaw, ‘Introduction, Context and Theory’.
60. World Health Organization, *World Health Report 2008*, 25–7.
61. Cf. Rajkotia, *The Political Development of the Ghanaian National Health Insurance System*, 7.
62. Sam Adjei, former deputy Director of Ghana Health Service, interview, Accra, 25 November 2008.
63. Interviews with top-level officials involved in the reform process confirmed the primary role of domestic politics and the relative marginalization of external inputs – including, in particular, the World Bank – in making key decisions about the direction of reform (Sam Adjei, quoted above; Isaac Adams, Director of Research, Information and Statistics at Ministry of Health, interview, 25 November 2008). The same point is found in Rajkotia (*The Political Development of the Ghanaian National Health Insurance System*, 7, 10), who refers to donors as ‘neutral/opponents’ with respect to the NHI Act. By 2009, a few other countries had abolished or limited user fees as a result of domestically-driven processes in which donors such as the WB, ECHO, WHO, DFID, DANIDA and several NGOs essentially followed suit, rather than taking a leading role (Morestin and Ridde, *The Abolition of User Fees for Health Services in Africa*, 1). Whether reform processes in these countries were also spurred by democratic change is beyond the scope of this study.
64. World Bank, *World Development Indicators 2009*.
65. As a policy ‘input’, health insurance may be regarded as little relevant to voters that normally judge governments on the basis of outputs. Yet insurance had a very direct impact on output, that is on the provision of and access to health services, since it addressed the problem of exclusion caused by the cash and carry system. For many Ghanaians, the difference was between access to health services (through insurance) and no access to health services (because of barriers created by the cash and carry). This is what made insurance something voters could associate very tangible prospective effects to. More specifically, the common view among Ghanaian politicians as well as voters was that insurance would be more favourable to the average Ghanaian poor than the cash and carry system. Whether this assumption turned out to be true is not of direct relevance to this article. Yet what little evidence is available on the implementation phases seems to show that the NHIS was relatively effective and the country’s vulnerable groups benefited from the reform. The scheme proved quite successful in enrolling a growing part of the population, in removing financial barriers for households to access health care, and thus in increasing utilization of services as well as users’ satisfaction (SEND-Ghana, *Balancing Access with Quality Health Care*, 6; Witter and Garshong, ‘Something Old or Something New?’, 7, 13–14; Rajkotia, *The Political Development of the Ghanaian National Health Insurance System*; Asante and Aikins, *Does the NHIS Cover the Poor?*, 4; Durairaj, D’Almeida, and Kirigia, *Obstacles in the Process of Establishing Sustainable National Health Insurance Scheme*, 2). The structure of insurance premiums did go some way towards the establishment of a more equitable access by (1) differentiating between core poor, very poor, poor, middle income, rich and very rich, and (2) by exempting the extreme poor. All the same, obstacles to accessing the health system for the most vulnerable groups remain, particularly with regard to the urban-rural divide (Durairaj, D’Almeida, and Kirigia, *Obstacles in the Process of Establishing Sustainable National Health Insurance Scheme*, 2).

As implementation only started in 2005, health indicators will likely take some time to show the expected improvements (if ever). This is likely true also for Human Development Index trends, for which one may predict stronger improvements in democratic Ghana rather than in nondemocratic Cameroon. As Table 3 shows, while Cameroon achieved better progress and overtook Ghana in HDI scores and rankings during the 1980s – that is, prior to the multiparty reforms – Ghana was back ahead by the mid-1990s, and has been ever since. To the extent that the index measures social progress, HDI trends would thus be consistent with the notion that a democratic regime (that is, Ghana since the 1990s) is better than a nondemocratic regime at improving social conditions. Moreover, as pointed out, one may expect HDI progress to be further strengthened as the NHIS reform gradually produces its effects. The HDI, however, is not necessarily a valid indicator because, besides its education-based and health-based components, it is also based on GDP per capita data. Economic growth per se, in other words, could be enough to change – for good or for worse – the HDI trend of a country regardless of social policies and outcomes.

Table 3. Human Development Index in Ghana and Cameroon (1975–2010).

	HDI*		HDI**	
	Ghana	Cameroon	Ghana	Cameroon
1975	–	–	0.442	0.422
1980	0.363	0.354	0.471	0.468
1985	–	–	0.486	0.523
1990	0.399	0.418	0.517	0.529
1995	0.421	0.408	0.542	0.513
2000	0.431	0.415	0.568	0.525
2005	0.443	0.437	0.553	0.532
2010	0.467	0.460	–	–

Sources: \*HDI author's compilation based on data from UNDP, *Human Development Report 2010*.

\*\*HDI author's compilation based on data as revised estimates 'not strictly comparable with those in earlier Human Development Reports' (UNDP, *Human Development Report 2007–08*).

66. Yates, *International Experiences in Removing User Fees for Health Services*.

67. Nelson, 'Elections, Democracy and Social Services', 82[0].

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