

Does democratisation deliver social welfare?

Political regimes and health policy in Ghana and Cameroon

Giovanni Carbone*
Università degli Studi di Milano

1. Introduction: democratic reforms and welfare policies

Democratic reform processes are often supplemented by expectations of tangible improvements in social welfare. 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. Beyond this basic mechanism of electoral accountability, the theoretical literature highlights a number of more specific causal processes – such as the emergence of a diverse media system, the activities of civic associations and advocacy groups, the development of a public sphere and discourse, etc. – that supposedly link the introduction of democratic politics to efforts at improving the social welfare of the population.

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, the empirical literature on the effects of recent democratisation processes on social welfare in developing countries is rather scant. This is particularly true for Africa. 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 (cf. Bratton – Mattes 2001). Social welfare was among them. Yet very limited research has been conducted into whether recent democratic changes actually delivered social dividends to African countries¹.

A proper understanding of whether and how democratic transformations in Africa may be linked in a causal manner to social policy changes requires an examination of specific political processes. This, in turn, entails selecting particular countries and an appropriate social policy sector for closer investigation. This paper focuses on social policy developments in one of the continent's most prominent cases of democratisation and compares such developments with the evolution of welfare measures in a country of stable undemocratic rule. The methodological approach adopted thus implies a double comparative strategy. First, a diachronic comparison in which pre-reform, nondemocratic Ghana (1981-1992) is weighed against post-reform, democratic Ghana (1992-2008),

* First draft. Paper presented at the Annual Congress of the Società Italiana di Scienza Politica (SISP), 17-19 September 2009, Rome. I would like to thank Fred Eboko, Armand Leka, Laurent Mbassi, Matteo Jessoula, Antonio Fiori, Rocco Ronza, Elisa Giunchi, Federico Battera and Davide Grassi for helpful comments on issues the paper deals with.

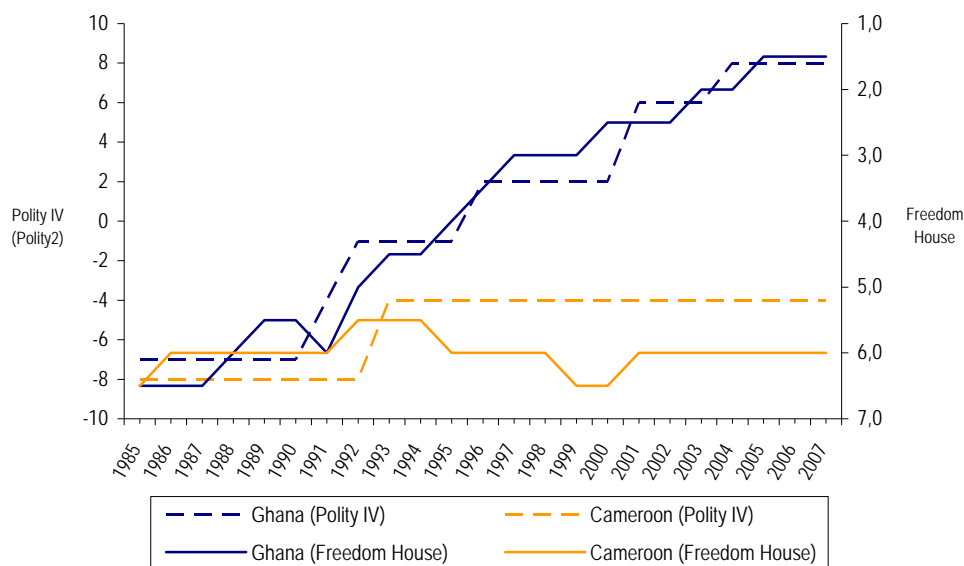
¹ What little research exists only made its appearance in very recent years, as analyses of democratic transitions in Africa began to evolve into questions concerning the broader effects of multiparty reforms. The few works that focus comprehensively on African countries include Hickey (2007) on the politics of social protection and Stasavage (2005) on democracy's positive impact on education spending. The effects of regime types in individual countries, on the other hand, have been studied by Hickey (2005), who focuses on political inclusion and pro-poor policies in Uganda; Nattrass and Seekings (2001), dealing with the limited impact of South Africa's post-apartheid democracy on inequality; and Kosack (2007) and Stasavage (2005), who reach opposite findings on democracy and education policies in Ghana and Uganda.

thus essentially holding constant country-specific variables such as culture or demographics. Secondly, a synchronic comparison through which democratic Ghana is set against non-reformed Cameroon as a control case in which no transition to democracy took place. The latter comparison helps further isolate the relationship we are investigating by controlling for the effect of additional variables that the longitudinal comparison cannot hold constant (notably those concerning the international context: economic growth in Africa, for example, was significantly weaker during the 1980s than it was during the 1990s; the Cold war represented an entirely different geopolitical setting from the post-1989 global environment; etc.).

Besides selecting two specific countries, the paper narrows down its attention to a crucial social policy sector, namely health. No published work has so far examined the effects of Africa's democratisation processes on health policies. Yet given the particular implications that this policy sector 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.

At the end of the 1980s, both Ghana and Cameroon were under authoritarian rule. Outsiders' assessments of the repression and constraints that these states posed on individual freedoms tended to agree (see Figure 1, based on Polity IV and Freedom House data). 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. 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.

Figure 1. Democratic trends in Ghana and Cameroon (1985-2007)



Except for these recent political developments, Ghana and Cameroon appear to be similar enough to make a good choice for comparison. Equally located in western sub-Saharan Africa, they are medium-sized countries in terms of territory and population (see Table 1). Both states are colonial creations in which more densely-populated and fertile southern regions were joined with less densely-populated, predominantly Islamized northern regions. Even by African standards, the two countries remain very ethnically diverse, albeit one is more so than the other: while 40-50% of Ghanaians belong to the Akan peoples, no single group in Cameroon accounts for more than 20% of the populace, the largest being the Bamileke.

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. Their economies are dominated by few agricultural and mineral productions (cocoa and gold for Ghana; cocoa, coffee, cotton and oil in Cameroon) and have not-so-different levels of per capita income. Both 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, starting with an Economic Recovery Programme (1983 in Ghana, 1988 in Cameroon). Today, Ghana and Cameroon are medium-human development countries, taking, respectively, 142nd and 150th positions in Human Development Index world rankings for 2008.

Of course, the two countries also have important distinctive traits. Cameroon, for example, was initially colonised by the Germans and later shared out between France and Britain – leaving an enduring division between a French-speaking majority and English-speaking regions – while the Gold Coast, as Ghana was formerly known, was ruled by the British for the entirety of the colonial period. At independence, in addition, the two countries opted for opposite development strategies, at least in principle: a socialist path as against a conservative liberal approach (over time, however, socialist initiatives alternated with rule by liberal elites in Accra, while ample room was left for state planning and interventions in Yaoundé). Finally, while Cameroon has historically been a politically stable if undemocratic country, Ghana went through diverse and often unstable political regimes.

Table 1. Context in Ghana and Cameroon: economy, land and population

	Ghana	Cameroon
Surface area (sq. km)	238,540	475,440
Population, total	23,461,523	18,532,799
Ethnic fractionalization	0.67	0.86
GDP (current US\$, bn)	15.1	20.7
GNI per capita, Atlas method (current US\$)	590	1,050
Poverty headcount ratio at national poverty line (% of population)	28.5	39.9
Human Development Index (2007)	0.514	0.533
Agriculture, value added (% of GDP)	33.6	19.5
Industry, value added (% of GDP)	25.8	30.6
Services, etc., value added (% of GDP)	40.6	49.9
Exports of goods and services (% of GDP)	33.4	22.1
Roads, paved (% of total roads)	14.9	8.4

Sources: World Development Indicators Online (2009) and UNDP/Human Development Index.
Note: data refer to 2007 except: data on poverty refer to 2006 (Ghana) and 2007 (Cameroon), data on paved roads refer to 2005 (Ghana) and 2004 (Cameroon). Data for ethnic fractionalization are based on Alesina et al. (2003).

The paper focuses on the politics of health reform by investigating continuities and changes in the financial and organisational arrangements of the health systems of the two countries. Institutional reforms or resource reallocations are critical aspects of welfare policies and can prove more relevant than social spending increases in bringing about performance improvements in outputs (such as

immunisation rates or education enrolment) or outcomes (e.g. infant mortality or literacy rates) (Nelson 2007:80ff.; cf. Tsai 2006, Ross 2006).

The paper contends that 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, as is also evidenced by the lack of comparable dynamics in Cameroon's still largely monopolized political setting.

Before digging into the politics of health reform, however, a brief overview of health spending and health performance is in order: neither of the two is the object of this paper (spending is not logically connected to institutional reform, while performance may take time to reflect the impact of recent policy changes), yet they are both part of the broader picture of any national health system.

Public expenditure on health as a share of GDP has long been quite modest both in Ghana and Cameroon, amounting, respectively, to a meagre 1.7% and 1.0% in 2006, that is, below the 2.4% average for sub-Saharan Africa (WDI Online 2009). In both countries, health spending as a percentage of total government expenditure has gone through ups and downs. If we take comparable data for the period 1995-2006, Ghana does appear to record a slightly higher 8.8% average, with a peak of 11.6% in 1999, as against Cameroon's 7.7%, with a 11.0% peak in 2005 (see Table 2). Yet not only Ghana's moderately higher levels of spending actually predate its political transition (cf. World Bank 1987:61), but, for different reasons, the reliability of available data seems to be questionable², rendering evidence essentially unhelpful in supporting or disproving the notion that democratic governments tend to channel more resources towards social sectors.

Government welfare interventions are meant to improve the life conditions of ordinary citizens. Health policy, in particular, is supposed to affect the general health of a population. With the notable exception of life expectancy – for which a 3.3 year difference in favour of Ghana in 1992 grew to a 9.6 year gap in 2007 – the performance of Ghana's health indicators since 1990 is not any better than Cameroon's, in spite of both the fact that the former started with better health indicators at independence and that the economic crisis the latter suffered was more recent (see Table 3). Indeed, if we take 1995 as a baseline (the first post-transition year covered by available data), figures for Cameroon show some marginal (children's mortality) to substantial progress (immunization), while Ghana's do show some substantial progress (immunization) but also some slight regress (children's mortality). While it may come as a surprise that Ghana's health indicators actually came under stress since the 1990s – a time when democratic politics should have made politicians and, indirectly, administrators, ever more accountable to the general population for the delivery and quality of social services – it will take a few more years before this kind of data will tell us something about the impact of the country's all-too-recent health reform (see below). Indeed, the disappointing results achieved by the Ghanaian health system over the 1990s likely contributed to the emergence of pressures towards a change in health policy.

² For Ghana, entirely contradictory trends emerge, with regard to certain given periods, when comparing different datasets (see, for example, NDPC 2005:57-58, WHO, *World Health Reports*, 1995 to 2006, and WHO Statistical Information System at www.who.int/whosis). For Cameroon, any figurative amount may have to be reduced by as much as 30-60% because of transaction costs that public health structures incur in to obtain the actual disbursement of health money (Ntangsi 1998:8,14).

Table 2. Health spending as a percentage of total government expenditure

	Ghana	Cameroon
1995	8.1	5.9
1996	8.2	5.2
1997	9.1	4.2
1998	10.2	4.6
1999	11.6	7.2
2000	10.9	9.5
2001	8.7	7.4
2002	9.3	8.7
2003	9.0	10.2
2004	6.9	10.5
2005	6.9	11.0
2006	6.8	8.6

Source: WHO Statistical Information System (www.who.int).

Table 3. Health performance in Ghana and Cameroon, 1960-2007

	Ghana					Cameroon				
	Life expectancy at birth (years)	Mortality rate, under-5 (per 1,000)	Mortality rate, infant (per 1,000 live births)	Immun., DPT (% children 12-23 months)	Immun., measles (% children 12-23 months)	Life expectancy at birth (years)	Mortality rate, under-5 (per 1,000)	Mortality rate, infant (per 1,000 live births)	Immun., DPT (% children 12-23 months)	Immun., measles (% children 12-23 months)
1960	45.8	212.4	125.9	..	..	41.7	255.0	151.0	..	..
1970	49.2	183.0	110.1	..	..	46.2	215.0	127.0	..	..
1980	53.0	149.7	92.3	7.0	16.0	51.5	173.0	105.0	..	..
1985	55.0	141.6	87.9	22.0	21.0	54.2	147.0	91.0	33.0	39.0
1990	56.9	119.7	75.7	58.0	61.0	54.6	139.0	85.0	48.0	56.0
1995	58.2	110.9	70.8	70.0	70.0	53.0	151.0	89.0	46.0	46.0
2000	58.5	111.5	71.1	84.0	84.0	50.8	151.0	88.0	53.0	49.0
2005	59.4	114.2	72.6	84.0	83.0	50.2	149.0	87.0	80.0	68.0
2006	59.7	114.7	72.9	84.0	85.0	50.3	148.6	86.8	81.0	73.0
2007	60.0	115.2	73.2	94.0	95.0	50.4	148.2	86.6	82.0	74.0

Source: World Development Indicators Online (2009).

2. Developments and change in Ghana's health policy

Ghana's move from authoritarianism to democratic politics is a recent development in a post-independence political history that can be divided in four main phases. After the British left, the country's leader Kwame Nkrumah tried to entrench his own rule (1957-1966) by establishing a single party regime. A fifteen-year period of instability began, however, when Nkrumah himself was ousted by a military takeover. During this time, different regimes – military and civil – alternated in power, including two short-lived attempts (1969-1972 and 1979-1981) at reintroducing pluralist politics. It was only in 1981 that a third phase was ushered in by Flt.Lt. Jerry Rawlings' coup, which brought about a clear process of political stabilisation in the country. The fourth phase opened with the 1992 multiparty elections that, in spite of their pitfalls and of the fact that Rawlings himself initially remained at the helm, created the conditions for the country's gradual but so far steady democratic development.

When Ghana became independent, in 1957, the new government immediately set to make health and education services vastly more available and accessible than had previously been the case under British colonial rule (MacLean 2002:75; Aryeetey – Goldstein 2000). 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, while the relatively low user fees that had been introduced during colonial times were abolished, as 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 (1969 *Hospitals Fees Decree*, 1970 *Hospitals Fees Act* and 1971 *Hospitals Fees Act*). But, as in the rest of the public sector, out-of-pocket fees at point of service remained very low and were largely meant to discourage unnecessary use (cf. Sulzbach et al. 2005:3; Ramachandra – Hsiao 2007).

By the time Ghanaians had become used to expect a public provision of health and education services, the country's economy went through its most difficult period and the public sector was dramatically hit by a growing dearth of resources. Greeted during the early post-independence period as one of Africa's economies with great developmental potential, Ghana's promise of affluence worsened over the late 1960s and 1970s, with GDP per capita falling from \$281 in 1970 to \$180 in 1983. This time of economic disaster gravely damaged the functioning of state institutions and public services. By the mid-1970s and the early 1980s, the social services system, like many other state institutions and services, had weakened to the point of virtual collapse.

The health system was thus in a dismal situation when the Rawlings regime took over at the beginning of the 1980s. The official fees that were being charged were so low that health services were nearly free. Yet the health infrastructure was so deteriorated it could hardly deliver any such services at all. Even basic drugs were missing from health points. Thus, while health services were virtually free, they were *de facto* almost inexistent. In a similar situation, many people became concerned about how to restore service provision, rather than how to lower the costs of accessing health. There was thus little opposition when the Ghana Medical Association and the Ghana Pharmaceutical Association – the voices of professional and business interests – demanded that more substantial fees be charged to revive the functioning and improve the quality of the country's health system.

The legitimacy of the new military regime could not but benefit from the reestablishment of basic services. It was on this ground, as well as because of donors' pressures, that a populist government adopted the *Hospital Fees Regulation* of 1985. The Regulation substantially increased the level of fees with the aim of recovering 15% of recurrent costs – particularly those relating to drugs – which would in turn expand available resources and thus help restore Ghana's public health system. Meanwhile, the country as a whole was undergoing an impressive economic turnaround, rapidly recovering from collapse and inaugurating a sustained period of economic growth (Tsikata 2001:47).

While the new cost-recovery measures raised health care fees from token to real, certain categories of people – such as pregnant women – were officially exempted. Nor was any payment required for selected services deemed to be of public interest, such as immunisation or health care for leprosy and tuberculosis. During subsequent years official exemptions were further broadened, and by 2001 the guidelines of the Ministry of Health explicitly exempted indigents, although who belonged to the latter group was never clearly defined (Atim et al 2001: 9n, 63). The implementation of the exemption policy, however, run into a number of practical difficulties, partly due to a poor capacity of the Ghanaian state for targeting social services (Aryeetey – Goldstein 2000). As a result, virtually everyone in Ghana had to pay, in practice, for public health services at point of use (cf. Sulzbach et al. 2005:3; Atim et al. 2001:10, 17).

By the end of the 1980s, well-documented studies began to expose the way the new system tended to exclude many people from accessing health facilities and services (Waddington – Enyimayew 1989, 1990; Nyongator – Kutzin 1999; Agyepong 1999). This was hardly surprising, given that, under the logic of economic reforms, social objectives had been subordinated to growth and stability goals. Not only user fees had reduced access, but the specific intrasectoral allocation of funding had crucial implications, as personnel costs came to represent an increasing share of the health budget, at the expense of resources for drugs and services, with serious negative effects for community-level primary health care. Overall, the system resulted in “a significantly regressive spending regime” in which, between the late 1980s and early 1990s, the poorest quintile in Ghana

received only about 11-12% of government health spending, whereas the top quintile received 30-33% (Aryeetey – Goldstein 2000). Yet it was not just the poor who were being left out. The middle classes also bore substantial costs as they found it increasingly difficult to cater for the health of their extended families. Infamously known as the “cash and carry system”, the cost-recovery health policy came to be increasingly resented by Ghanaians.

With the multiparty openings of the 1990s, health care became a major political issue. It was first the National Democratic Congress (NDC) government that tried to respond to public concerns. Rawlings’ 1997 presidential address, in particular, announced an expansion of exemptions from health fees. These and other measures, however, had relatively little impact. Between the end of the decade and the early 2000s, for example, infrastructural improvements raised the percentage of Ghanaians with proper geographical access to a health facility (i.e. living within 30 minutes of it) from 37% to 58%. Yet overall use of health structures over the same period fell from 22% to 18%, pointing at the fact that obstacles other than distance still hindered access. Prominent among such obstacles was inability to pay for health services under the existing arrangements (Agyepong – Adjei 2008:153-154).

The idea of addressing the health financing needs of Ghanaians in an entirely new manner, that is, by pooling resources through insurance schemes, had meanwhile begun to be explored. Under the initiative of Catholic missions and hospitals, a number of private health insurance schemes had begun operating in some areas, normally based on joint management by a health facility and the community, to relieve individuals from the payment of fees at the moment and point of use. Yet these arrangements only covered about 1% of the population (Sulzbach et al. 2005:3).

By the mid-1990s, plans and pilot projects for replacing the cash-and-carry system with some form of public health insurance were also being discussed and examined at the Ministry of Health (Agyepong – Adjei 2008:154; Atim et al. 2001:5). In 1997, a pilot project covering four districts in the Eastern region was launched, with the aim of testing the terrain for the establishment of a nation-wide scheme. But lack of consensus within the Ministry about the best health financing strategy – particularly about the prospect of the government directly running an insurance scheme – stalled the piloting.

It was only after the New Patriotic Party (NPP) came to office in 2000 that the issue of a nation-wide scheme 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.

Through a decentralised structure that combined the coverage offered by private commercial schemes, private mutual schemes, and newly-established public schemes in each of Ghana’s 138 districts, the NHIS aimed at achieving universal coverage within 5 years. That is, to insure and offer a minimum but comprehensive package of services to all Ghanaians, independently of their capacity to contribute to the scheme. Besides the payment of individual premiums (from a minimum of \$8-10 per year up, according to income), the scheme was financed through a 2.5% National Health Insurance Levy (a tax on commercial transactions collected through the same mechanisms as VAT) and the transfer of 2.5% of formal sector workers’ contributions to the Social Security and National Insurance Trust (SSNIT) towards retirement benefits.

While the original plan was to have 50% of the entire population enrolled under the NHIS within 15 years, coverage was extended at an impressive pace, growing from 3.2 million or 15% of Ghanaians in 2005, to 8.2m or 38% in 2007, to 10.4 million or 45% in 2008 (Ministry of Health 2009). About two-thirds of members belonged to the relatively broad categories identified as vulnerable groups and were therefore exempted from paying the premium, including the poor, the elderly (over 70) and the youth (under 18 with two premium-paying parents, or kids of a single parent³). Some early

³ Since 2007, under-18 are included even when their parents are not registered (Adams 251108).

evidence found that a large majority of card holders were satisfied with the benefits they received – particularly in terms of money saved – and were willing to continue their membership (Asante – Aikins 2007:4).

While the scheme seemed relatively effective and the country’s health policy as a whole appeared to benefit from the reform, the cost of the NHIS escalated from \$13m in 2005 to \$23m in 2008 as enrolment expanded, raising questions about its sustainability. Moreover, the implementation stage did not go without problems. The scheme raised particular concerns with regard to its limited impact on making access to health services actually more equitable. Not only indigence had been defined in too much a stringent manner, but verification procedures were introduced to discourage district lists of exempted poor from exceeding a pathetically low 0.5% of each health scheme membership (National Health Insurance Regulations, L.I. 1809, 2004)⁴. Thus, only about 2.3% of NHIS members were subsidised as indigents, in spite of the fact that between a quarter and a half of all Ghanaians – depending on which standard measure of poverty is adopted – are usually deemed poor. As a result, according to a survey conducted in two rural districts in the Eastern and Brong-Ahafo regions, people belonging to the poorest quintile appeared to be much less likely to register than the rest, largely due to premiums perceived to be too expensive (Asante – Aikins 2007:1). Medium and higher quintiles also complained about subscription costs, but it was these social strata that benefited the most. Under the NHIS, the poor continued to suffer significant exclusion (Ramachandra – Hsiao 2007:74; UNDP 2007:92,4; cf. Wahab 2008:8,17).

3. Reforms and continuity in Cameroon’s health policy

In almost fifty years since independence, Cameroonians have only known two presidents, namely Ahmadou Ahidjo (1960-1982) and Paul Biya (1982 to date). For the better part of this period (1966-1990), stability was granted by a single-party regime in which the incumbent president and his party regularly won elections for executive and legislative offices unopposed. A comparatively good economic performance, sustained by the export of oil, which began in the late 1970s and peaked at the beginning of the next decade, favoured the consolidation of the regime. The country grew at an annual rate of 5.4% (1960-1986), with a strong 8.5% yearly progress for the period between 1974 and 1986 (WDI Online 2009). Ethnic diversity was also managed more successfully than elsewhere on the continent, as demonstrated by a northern Muslim Fulani peacefully handing over the presidency to a southern Christian Beti. While Cameroon never suffered a military coup, the army had established itself as a key political player since it fought a long and violent civil war in the country’s south-western region, during the early post-independence era. Efforts to curb the rebellion also increased the country’s dependency from its former colonial patron, France. The war allegedly contributed to imbue the state of a “security ethos”, leaving a general legacy of contempt for any form of political dissent (Gros 1995:113; 2003:5-7; Konings 1996:247). This helped the elite in Yaoundé build what became “perhaps the most effectively centralised state in Africa” (Gros 2003:20), and, notably, a state concerned that autonomist claims in English-speaking areas could develop into centrifugal and secessionist tendencies, leading to the political marginalisation of the communities inhabiting these regions.

⁴ According to the NHI Act of 2003, “a person who has no visible or adequate means of income or who has nobody to support him or her and by the means test qualifies as an indigent” (art. 104). As Ramachandra and Hsiao point out, “this is a stringent test that will qualify only the poorest of the poor. According to Regulation 58, people cannot be classified as indigent unless they meet each of the following four criteria: (a) they are unemployed and have no visible source of income, (b) they do not have a fixed place of residence, (c) they do not live with a person who is employed and who has a fixed place of residence, and (d) they do not receive any identifiable and consistent support from another person. ... Clearly, the number of indigents in each district will be limited, which could mean that many of the poor and needy who deserve a subsidy may be excluded. ... many poor people would be uninsured and would be denied access to care. Thus the scheme could end up hurting the very people it was intended to benefit” (Ramachandra – Hsiao 2007:74).

The gradual development of a nation-wide health sector was undertaken by Cameroon's new independent government during the 1960s. Colonial authorities had established health services in some urban areas only, to the benefit of colonial staff and expatriates, with Africans having separate and limited access to them. Rural areas, where most of the poor lived, had long been largely neglected, and their partial coverage had only begun after WWI. A prominent initiative in this direction was the establishment, by the French doctor Eugene Jamot, of a mobile unit to fight sleeping sickness and other endemic diseases such as malaria.

Soon after independence, the government experimented the creation of four *Zones de Démonstration des Actions de Santé Publique* (Zone DASP), aimed at gradually starting a network of health facilities at the community level. At the end of the decade, a Centre Universitaire des Sciences de la Santé was also set up for the training of health workers. The Zones DASP, which never quite took off beyond a piloting stage, introduced forms of community participation and, in spite of the payments envisaged by the law, provided *de facto* free health care (MSP 2002:20).

Cameroon's ratification of the *Charte de développement sanitaire de l'Afrique*, in 1980, marked the beginning of a new period of reforms. The latter were largely inspired by the recommendations of the 1978 Alma Ata Declaration on Health for All (HFA), the internationally agreed target for the year 2000, and Primary Health Care (PHC), that is, the approach – based on local-level, essential and universally accessible health care with community participation – that was meant to lead developing countries towards achieving that target.

In 1982, a Presidential Decree officially made PHC government policy. The main objectives included moving from an intermittent provision of health services to their continuity and integrating village-level health care activities into a national strategy. Accordingly, the expansion of non-hospital, local-level facilities – i.e. health posts and health units, only staffed by a nurse or midwife, a medical assistant, and one non-medical assistant, and normally visited weekly by a physician – was strongly accelerated, from a rate of 4% a year in the late 1970s to rates of 13% and 7% in the early and late 1980s, respectively (Ogbu – Gallagher 1992:618). Mechanisms for community involvement were also envisaged. Further initiatives, during the 1980s, included the adoption and implementation of the Unicef-led global “Expanded Programme on Immunization” (EPI) and initiatives aimed at integrating health services against malaria, against diarrhoea and immunization programmes (Essomba et al. 1993:232-233).

Cameroon's health policy was thus centred around the notion of village-based primary health care. In principle, health consultations, treatments and drugs were freely provided by the state. The country's health infrastructure was relatively well developed and had a real potential for responding effectively enough to the needs of the populace (Médard 2001:5; Ntangsi 1998:3). In reality, however, quite a different *modus operandi* gradually developed within the health system. For a start, only a very limited and declining part of the health budget was spent on drugs – in the early 1980s this was about 12%, versus an average of about 25% in rich countries (van der Geest 1982:2150; cf. Ogbu – Gallagher 1992:618) – so that the annually fixed amount of medicines allocated to health centres was typically inferior to actual needs. Moreover, inefficiency and diversion in the centrally-managed distribution of drugs meant that only about two-thirds of official allocations actually reached local facilities. Finally, what pharmaceutical supplies did reach the local level were dramatically reduced by the illegal appropriation by health workers for either free distribution among relatives and friends or for private sale. Health centres, particularly in rural areas, were thus more often than not short of medicines, and this chronic lack of drugs led to their underutilization, as people sought alternative solutions (van der Geest 1982:2148).

This state of affairs was compounded by the effects of the long recession suffered by Cameroon between 1986 and 1994, a period during which the country's economy contracted by about 3.8% a year (WDI Online 2009). The crisis was largely due to the combination of three external shocks: worsening terms of trade for the country's major exports (cocoa, coffee and oil), a decline in oil output, and a real exchange appreciation. The related fall in public revenues and the growing weight of the external debt hit hard on the Cameroonian state. Its service provision capacity was seriously

affected, particularly in the social sectors. By the late 1980s, the country had to bow to external pressures from the international financial institutions and embarked upon a programme of structural reforms. Resources became ever scarcer, and the public health infrastructure deteriorated at an even faster pace. With the national budget shrinking from \$3.1 bn (1987) to \$2.2 bn (1992), health expenditure was not only reduced in absolute terms, but also as a share of the national budget, declining from 5.2% (1989) to 4.4% (1991). Overall per capita health expenditure almost halved from \$15.3 (1985-86) to \$7.9 (1991-92) (Sauerborn et al. 1995:1731; Essomba et al. 1993:232). Because salaries, which accounted for over 85% of recurrent budget, were politically difficult to reduce, non-salary recurrent expenditures – particularly drugs – were hit the hardest by spending cuts. As a matter of fact, from 1989 government health spending no longer covered drugs, and the latter thus virtually disappeared from health structures. Here, patients now “received a consultation and usually only a prescription to purchase drugs at the pharmacy in the regional or provincial capital” (Litvack – Bodart 1993:373). This inevitably resulted in a further drop in the use of public health facilities, at a time when the effects of the crisis on households incomes and the increased cost of imports implied by the 1994 devaluation had reduced the number of Cameroonians who could afford to buy drugs (Médard 2001:8; Sauerborn et al. 1995:1731-1732; cf. Ogbu – Gallagher 1992:618).

By the early 1990s, as most African countries embarked in political reform processes, the Biya regime also had to face domestic and external pressures for the establishment of multipartism. The cosmetic changes that were introduced, however, had little impact on a process of health reform that had already begun in the late 1980s.

In 1988, a report by the Ministry of Health had outlined a number of problems in the way the PHC approach had been implemented, including the fact that “all community and health activities had completely halted in 30% of the 1913 villages surveyed between 1982-1988” (Essomba et al. 1993:232; cf. MSP 2002:4,31). Thus, a number of steps were undertaken – largely influenced by the 1987 Harare and Bamako international health initiatives and in line with the structural adjustment programmes the country was embarking upon – which restated the Health for All goal while introducing a decentralised new policy framework and cost recovery principles.

First, the government announced in 1989 a new PHC implementation strategy that was in fact a “radical reform” (Essomba et al. 1993:235), officially adopted in 1992 as Reorientation of Primary Health Care in Cameroon (*Réorientation des Soins de Santé Primaires*). The new policy, claimed to be a response to the changing economic climate and aimed at making primary health care and health for all a reality, reorganised the health system in three levels (ministerial, provincial and district), with significant decentralisation to the districts, while integrating all PHC activities in health centres (each one responsible for a health area of 5,000-10,000 people) and creating local-level health committees meant to empower communities for the management and financing of primary health services (Essomba et al. 1993:232ff., Molem 2008:65).

The reform process was then further spelled out, and its implementation provided for, through a series of measures introduced throughout the 1990s (Médard 2001:23n). Key among them was a 1990 act that introduced cost recovery (*Loi 90/062, Dérogation spéciale aux formations sanitaires en matière financière*). The aim was to sacrifice the officially free provision of expensive medicines – something that was there in name but not in fact – in favour of making cheap, essential drugs actually available to Cameroonians, if paid for (cf. van der Geest 1982:2152). This, as pointed out, was in agreement with the Bamako initiative and the underlying assumption that changing prices would not substantially affect the demand for health care (Sauerborn et al. 1995:1732). User fees for drugs and services were thus gradually phased in, starting in January 1991 in the Adamaoua and South provinces, with support from donors such as USAID. From 1992, local health facilities were allowed to retain fifty per cent of the revenues thus generated. Such revenues (including a price surplus on the actual cost of drugs) were meant to be used by local facilities to support other PHC

activities, such as community outreach, as well as for other managerial and general expenditures (Litvack – Bodart 1993:374; Essomba et al. 1993:235-236; cf. Sauerborn et al. 1995:1731-1732).

By the end of the decade, the notions of decentralisation and cost recovery were again placed at the core of a new strategic document that the government launched for 1999-2008, the *Plan National de Développement Sanitaire* (PNDS, 1998). The plan, inspired by the World Health Organisation and supported by the World Bank, aimed at pushing decentralisation forward by making health districts fully up and running while further defining their financial mechanisms based on cost recovery. The need to better control the diffusion of Hiv/Aids was also emphasised. A significant innovation introduced by the PNDS was the integration in the national health system of private providers, meaning mainly confessionnal structures – accounting for 95% of private health facilities – but also commercial clinics and traditional healers. This would further extend health care coverage and help make a minimum package of activities (*paquet minimum d'activités*) accessible within one-hour walk to at least 90% of Cameroonians (Okalla – Le Vigouroux 2001:3).

Finally, a further, full fledged sector-wide policy document – the *Strategie Sectorielle de Santé* (2002) – was worked out between 1999 and 2002 with the alleged aim of reducing the fragmentation of health programmes. In truth, however, the sector-wide strategy was a formal response to the conditionalities imposed by donors: in continuity with previous policy documents, it essentially re-stated the same health system organising principles that the latter had articulated (cf. Médard 2001:1-2). The primary objectives thus included the implementation of the *paquet minimum d'activités*, the effectiveness and efficiency of the management of health resources, and a one-third reduction of overall morbidity and of mortality among vulnerable groups as its key objectives (MSP 2002).

In Cameroon, therefore, the recent wave of health reforms – notably, the adoption of decentralisation and cost recovery schemes – began prior to the move from one-partism to formal multipartism. Subsequent policy measures were largely in continuity with these previous initiatives. The introduction of cost recovery, in particular, was never challenged in any substantial manner⁵. One possible reason is that user fees were accompanied by “quality improvements” (notably, making drugs actually available at health centres) that made health facilities more attractive, thus increasing overall use as well as access for the poor (Litvack – Bodart 1993:374). But Ghana, which set user fees at virtually the same level as Cameroon, also achieved a similarly dramatic change in drugs availability⁶. Quality improvements are thus hardly a difference that helps explaining why Ghanaians expressed their frustration with the fee-based system while Cameroonians did not.

4. Regime transitions, party platforms and political constituencies

Multiparty transitions in Ghana and Cameroon formally opened politics to political parties and electoral competition, establishing, at least in principle, accountability mechanisms aimed at linking political leaders to the voters. Yet, as pointed out, a key difference distinguishes the two “reformed” regimes: while Ghana truly achieved democratic progress – as testified, primarily, by an incumbent party being voted out of office twice, in 2000 and 2008 – Cameroonian politics looked much the same on either side of the transition, i.e. essentially authoritarian and non-competitive.

As soon as democratic politics took hold in Ghana, health policy rapidly became a key electoral issue. As the process of health policy-making was politicised, this policy area ceased to be the

⁵ In 2006, a forum gathered health sector actors from state, civil society, unions and development partners in Yaoundé to discuss the elaboration of a strategic plan for the promotion and development of health insurance schemes (*mutuelles*) in Cameroon. Between late 2008 and 2009, pilot projects were launched for community-based, voluntary insurance schemes (PANA 010206; Cameroonlinknews.blogspot.com 010109).

⁶ In Cameroon, in the early 1990s, a consultation fee at health centres was about \$0.80, while a fee for drugs averaged \$4, depending on prescription (Litvack – Bodart 1993:374). In Ghana, where consultation fees at district hospitals had been established at about \$0.90 in 1985, what patients said they paid in 1996 was much higher in nominal terms, but, taking inflation into account, much lower in real terms (Nyonator – Kutzin 1999:332).

exclusive preserve of government and donors' agencies and became increasingly subject to direct inputs by political and social actors. The development of a vigorous system of free media provided a critical tool for constant scrutiny and open debates on health issues. Interest groups mobilised to influence public discussions and have their voices heard in the policy process. The Trade Unions Congress (TUC) and the Ghana National Association of Teachers (GNAT), for example, were unhappy about a number of provisions in the NHIS bill. In particular, they resented the use of retirement contributions to fund the new health scheme. In practice, however, their protests against a rushed approval of the draft bill only managed to have it deferred by a month.

A content analysis of the election manifestos of Ghana's major parties is revealing of how health became an ever more prominent public matter and a key focus of political competition. Over the eight years (1992-2000) during which it ruled the country, the National Democratic Congress appeared to be too slow in answering to a growing "public outcry" and to the "steady calls" for discontinuing the cash-and-carry system (Aryeetey – Goldstein 2000). In the mid-1990s, the insurance schemes option was being explored but the party was cautious about it: "feasibility studies on the proposed Health Insurance Scheme have been completed, and the scheme will be tested on a pilot basis. If successful, it will be introduced on a national scale as part of the NDC's health policy" (NDC Manifesto 1996). 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 (NDC Manifesto 2000). Since Rawlings' party had unchallenged control of executive and parliamentary institutions for two consecutive mandates, it may appear striking that it did not haste to replace the widely detested cash-and-carry with some alternative arrangement. Particularly since the NDC was always perceived as the major political force on the left-of-centre, more socially-oriented side of Ghana's political spectrum (cf. Wahab 2008:13). The party's direct links to the authoritarian regime that introduced the existing cost-recovery mechanisms during the 1980s, however, may have held back the NDC government from reforming health financing arrangements. It was only after the party lost power that the NDC tried to catch up with the NHIS reform adopted by the NPP government. It did so by criticising the way in which the new scheme had been rushed in (Rawlings' party walked out of parliament when the bill was being passed) and by suggesting that, were it to win office, the NDC would abolish both the SSNIT contribution deductions and the NHI Levy, while also limiting the premium paid by individuals to a one-off registration fee (thus moving from a contribution-based "social health insurance" to a tax-financed "national health insurance") and transforming the NHIS into a "Universal Health Insurance Scheme" that would no longer be district-based (NDC Manifestos 2004 and 2008)⁷.

The reform brought in by the NPP was the result of the party's long standing effort to capitalize on the unpopularity of the cash-and-carry system. In 1996, the opposition had attacked the arrangement 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" (NPP Manifesto 1996:36-37, quoted in Singleton 2006:20). By 2000, the NPP platform was even clearer in pledging that the party would "abolish the iniquitous cash-and-carry system" (NPP Manifesto 2000). At the time, however, the NPP believed that a single national health insurance scheme was not a feasible solution due to a variety of reasons, including the low percentage (10-15%) of people employed in the formal sector, the seasonal income of farmers, and the high levels of unemployment and poverty (*Evening News*, 26 April 2000). In its election programme, the party did not go beyond the idea of encouraging a variety of collectivities (workers, employers, local communities, religious bodies, private health companies, etc.) to establish "their own" insurance schemes, while the government would retain a regulatory and monitoring role and support the provision of health "quality service at

⁷ Soon after the NDC came back to power, in early 2009, both president John Atta Mills and his Minister of Health, Dr George Sipa Yankey, confirmed that, to further increase equal access, the one-off premium payment would become operational by the end of the presidential term, and possibly in 2010 (*Daily Graphic*, 30 April 2009; *Ghanaian Times*, 16 June 2009).

affordable cost even to those not covered by any insurance scheme” (NPP Manifesto 2000). Once it won power, however, the New Patriotic Party felt the urge to go beyond its own election pledges and strongly accelerated its health reform plans. As the 2004 election loomed, in particular, the NPP government was on the look for highly visible measures it could showcase in seeking a new mandate. To better shape and speed up the NHIS reform, for example, the health minister made a series of new appointments aimed at realigning the position of key ministerial personnel with the policy goals of the executive. The traditionally strong role played by the technocrats at the Ministry of Health was thus downsized, while political nominees increasingly came to dominate the policy process, with a direct hand on the final drafting and a key influence on the implementation of the reform (Agyepong – Adjei 2008:155,156). Not only the ruling party “wanted an NHIS here and now” (Agyepong – Adjei 2008:158), but the scheme had to “ensure that the poor and destitute are covered” (NPP Manifesto 2004). The rapid achievement of high rates of enrolment once the scheme was launched may be an *ex post* confirmation that there was a strong demand for replacing the cash and carry. Electoral pressures had prevailed over the ideological principles of a supposedly right-wing party historically rooted in Ghana’s liberal tradition: the very success in the 2000 election allegedly proved that the NPP had been “able to transform itself as a party perceived as one for educated middle class and urban dwellers to one which appealed to rural dwellers” (Aye 2001:52; cf. Nugent 1995:223).

At the exact time Ghana did, Cameroon also allowed domestic oppositions to organise and contest national elections in the early 1990s. Yet after an initial moment when the regime appeared to be on the brink of collapse, the president was able to win a close election, in 1992, to regain control and re-establish the essentially monopolistic role of his Rassemblement Démocratique du Peuple Camerounais (RDPC). With the support of key sectors and actors, including 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. By early 2008, the president felt secure enough to have parliament approve a constitutional amendment that would allow him to stand for further mandates. If the RDPC was no longer formally a single party, it had become an unchallenged, *de facto* hegemonic actor under a façade multiparty system. Cameroon’s was thus a “soft” failure in democratic reforms: the country did avoid the dreadful scenario of a full fledged military coup or a civil war, but few would question that the regime merely transformed itself into an “electoral authoritarianism” (cf. Schedler 2006). Opposition forces bear significant responsibility for this failure. The pro-democracy movement initially succeeded in forcing the regime towards holding multiparty elections. Yet, in 1991, the country counted 70 political parties, many of them the expression of personal ambitions. The following year, in the first multiparty presidential election, the opposition vote was crucially split between two candidates. While many opposition politicians were gradually co-opted by the RDPC government, the Social Democratic Front, which had emerged as the main new political force, proved inept at building up or at least maintaining the momentum for challenging the ruling elite. It is important to keep this political context in mind to understand why public debates and political competition on policy issues could hardly flourish in Cameroon. Participation was never really part of Cameroonian political culture and civic organisations remained very weak. When a consultative exercise was set up in view of producing a Poverty Reduction Strategy Paper (inclusive of health issues), for example, the whole thing proved little more than a top-down exercise (Lagarde 2003). The Social Democratic Front 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 “ensure the provision of basic medical care and services, free medical consultation”, “to provide free health care for children, students, the unemployed, elderly and handicapped people”, and, notably, to introduce a national health insurance scheme (SDF Manifesto 1990). 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", "promote a primary health care approach that emphasises community participation", "cut prices of drugs and health equipment", "encourage health insurance not only by para-statal but also by private companies and village cooperatives" (SDF Election Platform 1997). Ultimately, however, the attention of opposition groups and self-censored 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. This was compounded by a government that graciously prevented public discussions from indulging on potentially contentious issues. As a high level official at the Ministry of Health put it, "the government certainly does not promote discussions that would let them down. Health was never an important issue" (Basile Kollo, Director, Direction des Ressources Humaines, Ministère de la Santé Publique, interview, 29 February 2008). The ruling RDPC, after all, never felt the urge to move beyond some very general political slogans and articulate anything similar to an explicit policy platform. The party simply did not develop any positions on social policies – or, for that matter, on policies as such – except for what may appear in government documents or policies. The result was that, in Cameroon, open debates on such themes as public health remained virtually inexistent, after 1990 as much as before.

5. External actors and health policy-making

Since the late 1970s, the health policies of African countries have been strongly influenced by an international public health agenda that originally revolved around notions such as Health For All (HFA) and Primary Health Care (PHC). During the 1980s, the Bamako initiative launched by Unicef and the Harare initiative led by the World Health Organisation (WHO) further articulated an internationally shared vision by prescribing organisational principles for structuring health systems in developing nations, particularly with regard to the decentralisation of health care and the adoption of cost-recovery mechanisms. Accordingly, the new approach that virtually all African states soon embraced implied moving preventive care to the background, as primacy was given to the delivery of quality curative health care by local health centres, each one in a position to refer patients to a higher, district level hospital when necessary. Effective and quality health care was thus provided through local health systems, organised around vertical linkages and financially autonomous thanks to revenues generated by user fees (Gruénais 2001:2-3). By the mid- and late 1990s, new ideas developed which largely concerned the need for sector-wide strategic planning and financing.

For over three decades, this international or "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 of both countries – health sector-wide strategic plans were adopted, for example, by both Ghana (the first one in 1996) and Cameroon (2002) – recent years have seen international actors weighting somewhat differently upon the development of the two countries' health policies.

The emergence and primacy of domestic demands resulted in a strongly reduced role for external actors in Ghana's NHIS reform process. The dynamics of electoral competition, as pointed out, were the crucial factor leading to the introduction of the scheme. For a country like Ghana, the latter represented a bold and ambitious policy to say the least. As of today, it is only in 27 countries worldwide that the principle of insurance for universal coverage has been established (Hsiao – Shaw 2007:1), and, except for Ghana, no low-development country is among them. Until recently, universal insurance was far from a core international health policy prescription. In the early 1990s, for example, a World Bank report focussing on health issues cautiously suggested that "only a few middle-income countries that have adequate financial resources, political resolve, and administrative capacity will be able to achieve ... universal insurance coverage" (World Bank

1993:161). Yet compulsory social health insurance aimed at universal coverage has become an increasingly fashionable strategy for health financing in developing countries (Hsiao – Shaw 2007:1). In 2005 – that is, shortly after the NHI Act was enacted in Accra – the WHO assembly adopted a resolution recommending this strategy for developing countries, and a subsequent report noted 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” (World Health Organisation 2008:25-27). This suggests that the case of Ghana may lay at the forefront of a process of policy diffusion and, by granting additional support to the government’s health reform plans, the influence of external actors turned out to be a supplementary, if secondary, factor in explaining why the country opted for changing its health financing policy.

International actors were much more prominent in the health policy-making process of Cameroon. The World Bank and the World Health Organisation, 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 realising the relevance of health for development. In Yaoundé as much as elsewhere, the Bank (and partly the IMF) came to play an instrumental role by linking reforms to the disbursement of aid. Eligibility to the Heavily Indebted Poor Countries (HIPC) 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 (Médard 2001:1-2, Lagarde 2003). Funding deriving from debt relief would go to structural reforms and social sectors. Cameroon bowed to these conditions, albeit the government ultimately diverted part of the funding away from the health sector, reflecting the fact that this policy area was not high on the list of government priorities (Basile Kollo, interview, 29 February 2008).

The World Health Organisation, which sat with other development partners in the committee charged by the Ministry with the task of elaborating a health sector strategy, was at the origin of many of the ideas contained in the *Strategie Sectorielle de Santé* (Médard 2001:1-2). In the late 1990s, a former WHO regional director for Africa, Gottlieb Monekosso, was named minister for health (1997-2000). The new minister mastered all the dominant directions in international public health and tried to implement a reform model based on the Harare and Bamako prescriptions for the rationalisation of national health systems through district decentralisation and cost-recovery (Gruénais 2001:3). This was the aim of the Plan National de Développement Sanitaire (PNDS) he adopted. But when the WB made new funding for fighting Aids available on the condition that the government introduced a multisectorial approach (whereby all sectors set up a unit devoted to fighting Aids: in agriculture, in education, in the army, etc.), the ministry opposed the proposed change of strategy, pointing that the Ministry already had a different policy. It did not take long before the president sacked him and replaced him with Urbain Olanguena Awono (2001-2007). The latter proved to be the best possible representative for the international agencies at the Ministry, particularly as he implemented the anti-Aids policies requested by donors such as UNAIDS and the Global Fund, also successfully raising the funds necessary to make anti-retroviral drugs free. The donors were so happy with his work that Awono led the Ministry for six consecutive years as president Biya, who is known for playing ministers around to avoid them build their own clienteles, left him at his place as a guarantee for the international community. In Cameroon, elected leaders proved unmistakably that they felt accountable not to voters, but to international agencies⁸.

6. Conclusions

Does democracy affect social policies in developing countries? This paper addressed this question by examining two cases from sub-Saharan Africa, a region for which the consequences of

⁸ This paragraph is partly based on discussions with Fred Eboko, Fondation Paul Ango Ela (FPAE). See also Eboko (2005:721).

democratization have been rarely if ever studied. 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. Thus, to investigate whether and how democracy affects social policies, the paper compared democratic Ghana (post-1992) both with non-democratic Cameroon (post-1992) and with non-democratic Ghana (pre-1992). 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 mobilisation, while the private media sprouted and 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. While neither spending data nor health performance indicators tell us much about a possible difference between Africa's democratic and non-democratic regimes, it is difficult to overestimate the relevance of electoral competition in Ghana's recent politics of health reform.

Besides the dynamics of democratic politics, however, two additional factors were at play, namely a domestic policy-feedback process and a dynamic of international policy diffusion. The first one accounts for the centrality that health reform acquired as a political issue, a centrality largely due to strong popular feelings against the existing cash-and-carry arrangement. It also helps understanding the government's choice of a solution based on insurance schemes, as community-based mutual insurance had been experimented for some time in certain local areas. The second factor is the relative support that Ghana's health reform received from donors, as the proposed solution (social health insurance) went in the same direction as a WHO-led emerging global policy agenda.

Despite the introduction of multipartism, Paul Biya's 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. The only type of pressures that did materialise – in the 1990s as much as in the previous decade – largely came from foreign donors and agencies. The WHO and the World Bank continued to play dominant roles in defining the country's health policy agenda; the Bank, in particular, kept conditioning financial disbursements upon the government's adoption of certain specific initiatives. The government itself was in a vulnerable position since the country had been hit hard by an economic crisis between the late 1980s and the early 1990s. External pressures and domestic economic difficulties thus combined in favour of the adoption and perpetuation of cost-recovery policies in the health sector. What health reforms were introduced in the country had begun prior to the introduction of multipartism in the early 1990s, and they were continued after the latter. Façade multipartism 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. This finding is in line with anecdotal evidence from other parts of the continent. In recent years, user fees have come under strong criticisms on grounds of both equity and efficiency, and a few countries have started to phasing

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 (Yates 2006).

Besides this general 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 a confirmation that “welfare states in developing countries have not unilaterally evolved towards a neo-liberal, residualistic model of social protection characterized by limited coverage and a private provision of benefits” (Carnes – Mares 2007:869). 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 (cf. Lindberg 2003). Moreover, contrary to what Nelson (2007:82) suggests, democratically elected politicians 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 materialise as a result of mobilisation by left-wing political forces and parties. Indeed, a right-wing versus left-wing distinction may not always prove a useful tool in predicting social policy choices.

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