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National Health Insurance in Ghana: Improving health and local limits

> «Health Insurance is primarily viewed as a means of offsetting catastrophic financial losses associated with severe illness or injury through risk pooling among many people. Insurance schemes can be compulsory and cover a whole population as through a social insurance fund, or they can be limited to those in the formal employment sector. They may be voluntary, as in the case of private commercial or non-profit coverage; publicly managed; or prepayment scheme» (Beattie, Doherty, Gilson, Lambo & Shaw 1998)

In 2003 the Government of Ghana approved the *National Health Insurance Act 650* and in 2005 it was effectively initiated. The *National Health Insurance Scheme* is one of the most relevant health programs that are changing the Ghanaian health system and Public health.

The first health insurance government proposals dated back under Government of Rawlings. At the end of '80s, the first health insurance pilot project was activated: the experiment was a private insurance in line with the then-neoliberal approach. Notwithstanding, the current *National Health Insurance Scheme* (NHIS) was drafted, organized and applied by the Government of Kufuor. During the 2000 election campaign, the *National Patriotic Party* (Kufuor's political party) proclaimed the *National Health Insurance Scheme* one of the first political aims. NPP defined the *National Health Insurance Scheme* the most relevant democratic health program. After the 2003 and the approval of *Act 650*, the Government of Ghana elaborated the structure and organization of national insurance body modifying health system structure. Actually, the health system administrative organization is changing because no financial reform is likely to be successfully implemented in isolation, and most reforms must be undertaken in combination with other mechanism (Beattie, Doherty, Gilson, Lambo & Shaw 1998). The insurance coverage requires that the government has or provides for an administration system capable of organizing the informal sector and identifying who need subsidies; an efficient banking system to facilitate the flow of funds and information; and a planned implementation process.

The first important step was the establishment of the *National Health Insurance Council*, provided by the *Act 650*. The *National Council* is the most important administrative insurance body, that coordinates and manages the complete government insurance organization and structure. It has the burden to implement the *National Health Insurance Scheme* and guarantee the well-being of Ghanaians within the national territory[1]. The *National Council* is controlled and managed by the

[1] «For the purposes of achieving its object, the Council has the following responsibilities: *(a)* register, license and regulate health insurance schemes; *(b)* supervise the operations of health insurance schemes; *(c)* grant accreditation to healthcare providers and monitor their performance; *(d)* ensure that healthcare services rendered to beneficiaries of schemes by accredited healthcare providers are of good quality; *(e)* determine in consultation with licensed district mutual health

Ministry of Health and depends on government financing, although it is defined an autonomous body by the *Act 650*. The *National Council* is obliged to report the own activities and political choices to the Ministry of Health. In the future, it will probably become independent from the Government economically and politically, aligning itself with the privatization trend and neo-liberal programs with which many scholars tend to interpret this health program.

Besides, in 2004 the *National Health Insurance Regulations (L.I. 1809)* – a legislative appendix of the *Act 650* - was approved and the *National Health Insurance Scheme* was initiated. This legislative appendix imposes specific rules and describes the *National Health Insurance Scheme* organization and functioning from the national to the district level. Then, in 2005 the *National Health Insurance Scheme* program was effectively inaugurated, when the *National Council* started to print and deliver the Membership card or *Passport Insurance Card* to the consumers within the national territory.

Nowadays, in Ghana there are three health insurance programs legally recognized: National Health Insurance Scheme; Private Mutual Health Insurance Scheme; and Private Commercial Health Insurance Scheme. The last two are private insurances that few Ghanaians can afford. The government *National Health Insurance Scheme* is structured to be accessible to all people. Ghanaians are not obliged to be registered and insured to the *National Health Insurance Council*, although the users are increasing year after year – above all in the urban areas. Today, about 70% of Ghanaian people is registered and insured, but the *National Council* hopes to increase the users through training and meetings.

The *National Health Insurance Scheme* covers most of the users' health expenses. The "annual premium" (or payment) guarantees the covering of 95% of diseases and free assistance within health facilities; the last 5% refers to expensive and long treatments diseases, as optical and auditory diseases, orthopedic assistance, dental therapies, drugs and recovers for AIDS patients, renal and cardiac problems, etc. The *National Health Insurance Scheme* is not a free health assistance program, but it is characterized by a prepayment schemes. Ghanaians have to pay an "annual premium" (or payment) to the *National Health Insurance* offices when they want to become insurance consumers. Notwithstanding, young people, under eighteen, and old people, over sixty-nine, are exempt from paying premium, even if they have to register themselves to the *District Mutual Scheme* and receive the *Passport Insurance Card* with which they can use district health facilities freely. The *National Health Insurance Council* imposes a national maximum and minimum "annual premium" (maximum 48 Ghana Cedis – minimum 7 Ghana Cedis) that every consumer has to pay on the bases of own economic status or premium imposed by *District Mutual Schemes*. Actually, the schemes serve as a way to foster decentralization, given its potential to promote community involvement in the provision and financing of health services while maintaining access to free health care at the time of illness. In fact, the registration and payment happen at district level. Every *District Mutual Scheme* – in accord with District Assembly - defines and imposes the annual premium within the proper territory autonomously. The *Scheme Chairman* – the *District Mutual Scheme* representative - communicates the district autonomous decisions to the *National Health Insurance Council*, and the consumers pay the premium to the *District Mutual Scheme*

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insurance schemes, contributions that should be made their members; *(f)* approve health identity cards for members of schemes; *(g)* provide a mechanism for resolving complaints by schemes, members of schemes and healthcare providers; *(h)* make proposals to the Minister for the formulation of policies on health insurance; *(i)* undertake on its own or in collaboration with the other relevant bodies a sustained public education on health insurance; *(j)* devise a mechanism for ensuring that the basic healthcare needs of indigents are adequately provided for; *(k)* maintain a register of licensed health insurance schemes and accredited healthcare providers; *(l)* manage the National Health Insurance Fund established under Part IV; *(m)* monitor compliance with this Act and Regulations made under it and pursue action to secure compliance; and *(n)* perform any other function conferred upon it under this Act or that are ancillary to the object of the Council» (Act 650 2003: 6).

representatives directly. The so-called "collectors", *District Mutual Schemes* employees, play a crucial role at district level. They live in contact with the communities, promote the *National Health Insurance*, register the consumers to the *District Mutual Scheme* office and collect the annual premium. Moreover, some *District Mutual Schemes* allow the consumers to pay in monthly installments. After payment, the collectors give to the users the complete documentation indispensable to use health facilities freely. The consumers receive different documents that they have to deliver to medical personnel within health facilities: *Passport Insurance Card*, which reports user's picture, generality and current job; and three or four "papers" that the user will be obliged to deliver to medical doctors in which they transcribes the user's pathology, therapeutic path and cost of treatment. The consequent economic incomes remain within the *District Mutual Schemes* that manage annual premiums and the three-monthly funding sent by *National Health Insurance Council* to sustain district expenses and employees' salaries. Therefore, the *District Mutual Schemes* are almost autonomous, although they have to respect the national standard imposed by the *National Health Insurance Council*. Besides, the current *National Health Insurance Scheme* is defined "District Health Insurance" by most of Ministerial officers, because the consumers can freely use only health facilities within the own district area.

The management structure of *National Health Insurance Scheme* follows the administrative decentralized system. Decentralization and distribution of decision-making authority and executive powers away from the centers and down to the lower managerial level possible are fundamental components of health system reform. Therefore, *National Health Insurance Scheme* is structured by a branched and decentralized system, characterized by three different administrative levels: national level (represented by *National Health Insurance Council*); regional level (*Regional Offices*); and district level (*District Mutual Schemes*). At the beginning, the *National Health Insurance Council* considered sufficient a unique body at national level to manage the complex entire structure – from the top to the bottom - but in 2007 the *Regional Offices* were initiated. The absence of *Regional Offices* made complex and inefficacious the national system, and underlined the need for an intermediate level among national and local contexts. Therefore, in 2007 the *National Health Insurance Council* initiated ten *Regional Offices*, one for each region, to improve management and economic control of numerous *District Mutual Schemes*. The national territory is divided into 145 *District Mutual Schemes* by the *National Health Insurance Council*. Until 2007, the administrative districts, or District Assemblies were 138 and the *District Mutual Schemes* were more than administrative districts. In fact, the big urban centers (Accra, Kumasi, Takoradi, Tamale, etc.) were divided into more *District Mutual Schemes* because characterized by wide territory. Nowadays, the *District Mutual Schemes* are numerically inferior than District Assemblies, that are 170. The *National Health Insurance Council* declares to not have adequate and sufficient potentialities to develop a conspicuous decentralization in line with national administrative decentralization programs. Economic difficulties, funding scarcity and absence of specialized personnel do not allow to initiate and constitute more *District Mutual Schemes* within the national territory and every administrative district.

The Ghanaian *National Health Insurance Scheme* implements a particular distributive strategy, a differentiation and offshoot of roles, constituting a complex, articulated and autonomous district realities. The *National Council* is responsible for the Schemes, although they have a relevant economic and political autonomy – as above mentioned - criticized by the current Government. In December 2008, the *National Democratic Congress* won the election. The new Government supports and manages the *National Health Insurance* program, even if at the same time underlines its weaknesses and negativities. In particular, the NDC criticizes the current *District Mutual Schemes* decentralization, defined "out of control", unfair and inequitable. In 2008, the NDC proposed

relevant structural changes of *National Health Insurance* system because *National Health Insurance Scheme* implemented by the NPP administration is far from the ideal envisaged by the NDC-in-Government. The NDC Government proposes to implement a "Universal" *Health Insurance Scheme* which will reflect the universal contribution of all Ghanaian residents to the *District Mutual Schemes*. This universal *Health Insurance Scheme* will guarantee access to free health care in all public health institutions. It will be listed in the Health Insurance schedule, will not be district-specific and will allow for a one time premium payment for registration with the scheme. It will also cut down on the health insurance bureaucracy and plough back the savings into health care as well as review the disease and drug categories under the Scheme. The NDC program wants to improve access and efficiency of biomedical institutions within the country changing the current uncontrolled decentralization. The NDC proposes a power centralization to improve the control of *District Mutual Schemes*: *Regional offices* will be divided into different *District Mutual Schemes* that will lose autonomy and will be transformed into simple decentralized offices, called *Branch offices*.

The "universalizing" trend is a political choice. The relevant criticism about extreme decentralization led to interpret NDC program as a power centralization program. However, I do not think NDC wants to impose a centralized trend (also because it would be against international guidelines), but rather a different and controlled decentralization economically and politically, to improve therapeutic assistance within local areas. This kind of decentralization is clearly inspired by the decentralized system of *Ghana Health Service*. The *National Council* is the most important Ghanaian institution that insures the adequate functioning of health system, but the *Ghana Health Service* is the most relevant health services provider. The *Ghana Health Service* and *National Health Insurance Council* are two ministerial institutions highly connected, and the *Ghana Health Service* is defined the most important *National Health Insurance* client because it controls, manages and directs most of national health facilities used by insured patients. These two health bodies have different decentralized systems. The *Ghana Health Service* manages and rules the own district facilities (CHPS) that depend on national and regional decisions. Instead, the current *National Health Insurance* decentralization is described out of control. The Media Relation Manager of *National Health Insurance Council* declares that they would like to inspire the own organization to the *Ghana Health Service* structure. Therefore, it is interesting to observe the thin line between decentralization and centralization trend, autonomy and control, that hide behind health prevention and promotion aid programs, defines indispensable for democratization process by Ministry of health.

The *National Health Insurance* primary aims are to improve availability, accessibility, equity and efficiency in health. It aims to guarantee impartial distribution of human and medical resources, and to establish an equitable health system within the country. The *National Health Insurance Scheme* is defined the most democratic health program and the most important national government "investment" by many health officers, because the first and most relevant instrument against poverty. Nevertheless, is it really a health democratic strategy or an economic and political plan to strengthen transnational political and economical linkages?

The Ghanaian *National Health Insurance Scheme* is a complex policy instrument that requires multiple interactions within and beyond the health system. It is difficult to implement, because requires good managerial, information and accounting capacity, and entails considerable start-up costs. However, it is a national health-financing innovative program, that imposes a new State role within the health sector, and inaugurates a new conception of health assistance. The State loses the function of "unique" actor within the system: it is not more a unique institution that manages and controls health planning, funding and management. The State still manages regulations and

control functions, but funding is managed by "social insurances", and management function are transferred to peripheral authorities: *Regional Offices* and *Districts Mutual Schemes*. The *National Health Insurance* is strongly changing Ghanaian political and economic health system organization. Financial reforms usually require larger changes in the organization and delivery of health system having major effects on incentive and quality of care: such as user fees and insurance require organization and institutional reform to be implemented. Nevertheless, all these health transformations follow the international guidelines clearly. The *National Health Insurance Scheme* is a consequence and, at the same time, the apex of rhetoric and discourses proposed and applied by donors and international health organizations that inaugurated new health financing programs, privatization trend, and persuaded African nations to curtail public services and invest in private services. Indeed, the *National Health Insurance* was one of the health financing programs proposed by the World Bank.

The World Bank and World Health Organization are the most relevant international health organizations, and since '90s the World Bank emerges as the single largest donor agency in the health sector. At the beginning of '80s the World Bank and USAID advanced a competing philosophy that the public sector should be selective in the services and offers, and that most health care is better delivered and financed privately. Afterward, the World Bank and the International Monetary Fund initiated structural adjustment programs, through which inaugurated the privatization, that was subsequently accepted and implemented by the Government of Ghana into the health sector. After structural adjustment programs, the empirical evidence of health care privatization suggested disappointing results, and the collapse of these macroeconomic strategies led the World Bank to change its aims. In fact, the World Bank stepped back from this position in three reports, *Investing in health* (1993), *Worker in an integrating World* (1995) and *The State in a Changing World* (1997). These reports modified the Public health management especially within the development countries. Since this moment, the World Bank proposes no more a complete privatization, but a collaboration between public and private sector and implementation of new economic useful strategies to guarantee incomes and sustenance of national health system: the "user fees", public and private partnership and National Health Insurance Schemes (World Bank 1987; Hill 2002; Baru e Jessani 2000).

Indeed, in Ghana the *National Health Insurance Scheme* substitutes the consolidated health strategy defined as "Cash and Carry". At international level, "Cash and Carry" is generally defined and known as "user fees", that are a common financing mechanism used to increase resources available to health care system and to recover a portion of costs. "Cash and Carry" are fees paid by patients at the point and time of receiving health care services and they are today used by people who are not yet clients of *National Health Insurance Scheme*. In 1989, the "user fees" were approved and introduced within the country by the President Rawlings. He wanted to modify the free health system imposed by Kwame Nkrumah since 1957 (independence of the country). The free health system was effectively negative for national health status and implementation of Public Health. The national health system was failing and collapsing economically because without incomes, then the "Cash and Carry" were an economic health strategy to improve national health services. Notwithstanding, in 2003 the Government of Ghana decided to substitute the previous health financing system with the *National Health Insurance Scheme*. Indeed, "Cash and Carry" started to be expensive and perceived negatively by several Ministerial and political officers, that defined inequitable, undemocratic and inaccessible economically the "user fees". The *National Health Insurance Scheme* is defined by Ministry of Health and *National Health Insurance Council* a "free" system that guarantees equitable and impartial health system. During several interviews, the *Media Relation Manager* of *National Council* underlines how the *National Health Insurance Scheme*

transforms the health system into a more democratic and "free" system: it is free because makes users free from fees and free to choose among different medical resources and health facilities. He defines the *National Health Insurance Scheme* the most relevant government and ministerial health program. In fact, the *Media Relation Manager* declares, during an interview: "*Still today many Ghanaians die because of malaria and other diseases and because they have not enough money for treatments. Instead, National Health Insurance Scheme guarantees free access to health facilities to the people*".

But, is the *National Health Insurance Scheme* improving health standards, accessibility and availability into the country? Does this program improve the quality of health service and reduce the inequalities? How is it perceived within the rural areas?

The Ghana's experience with user fees and *National Health Insurance Scheme* has shown that these two mechanism for financing health care have a negative consequences for equity. By raising new sources of revenue for health, insurance can free up the resources that can be better targeted to subsidize the non-insured or poor population. Nevertheless, the insurance sometimes exacerbates inequity by favoring higher-incomes groups or implementing inequitable and not enough medical distribution. Actually, most of the rural areas are characterized by almost absence of adequate accessibility, availability and distribution of health resources. In the Nzema area (Western Region), where I carry out my research, there are still serious health inequalities and quantitative and qualitative limits. The poor quality of services is not only due to a constant scarcity of basic equipment and drugs and a severe shortage of clinicians, but also to what seems to be increasing indifference among staff towards their patients (van Dijk and Dekker 2010). There are only three medical doctors within the nzema districts for more than 400,000 people, and several villages are without health centers and assistance. Since 2000s, the health status is apparently improved thanks to the *Ghana Health Service* decentralization programs that inaugurated numerous health centers within the rural areas. The *Community Based Health Planning and Service* is the most important Ghanaian decentralization program, that provides for the inauguration of numerous Health centers within the District territories that insurance consumers can use. Just as the quality is important for the user fee scheme, it is also crucial to the success of a prepayment scheme. Thus, many recent health centers are empty of medical and human resources and they are not enough for health local communities' necessities. Drugs distribution does not cover all district territories and many health centers do not interpret their therapeutic role but they affirm only "the presence of the State" (Schirripa 2005; Fassin 1987, 1992). Therefore, there is a hiatus between national and local level, and health insurance, quality and quantity of health facilities that insurance consumers use: insurance consumers pay the annual premium but cannot often use public health centers because they are not adequate numerically and qualitatively. Thus, while insurance can reduce costs to the consumer for each episode of treatment it may also lead to a misallocation of resources, and steps should be taken to guard against adverse selection, moral hazard and cost escalation. The *National Health Insurance Scheme* is clearly a health financial program that does not provide for increasing the number and quality of health centers within the country, because the latter is up to the *Ghana Health Service*.

Beyond accessibility and availability limits, the *National Health Insurance Scheme* does not decrease inequalities also because it is interpreted negatively by some Ghanaians. Above all in the rural areas, there are some interpretation difficulties of this financing health program and interesting interpretative questions that delay the insurance coverage to the total population. Indeed, it is interesting to analyze how individuals, groups, families, and institutions approach the situation of emergent marketization and commercialization of health. At local and rural level, the insurance consumers' percentage is low and a relevant percentage of people underlines a strong reticence toward national health insurance. The most relevant problem is the low diffusion and

penetration of this project within communities that do not comprehend project objectives. In Jomoro District (Nzema area), during numerous interviews and conversations, several patients declare that they do not want to pay the annual premium as a preventive health insurance, and do not understand why they have to pay. "*Why have I to pay the premium if there is a possibility that I will not use any medical institution during this year?*". Many nzema informants do not perceive the *National Health Insurance Scheme* as an instrument to improve health national standards and do not connect the annual premium with possible positive transformations and improvements of national health system and people's health status. This different interpretation and perception of health financing program, health system and public health arise from different factors: in the Nzema area, many local communities perceive the annual premium expensive cost; the biomedicine inefficacious for some nosological categories; health centers useless because are often without drugs and medical personnel; and above all they underline a different economic conception and perception of money and long-term investment. Among Jomoro communities, there is a particular perception of money and economic investment (Pavanello 1992, 1994, 1995, 2000), for which several patients find a relevant difficulty comprehending and sharing the reason why they have to bear the economic expense to obtain a health service of which could not use during the year. Therefore, in Jomoro there is not a perception of long run investment on health, even if it could improve national health status and answer to own and future generation's exigencies. In fact, the *National Health Insurance Sheme* could and should improve the quality and quantity of health facilities, research programs, scientific knowledge and qualification of health personnel that would guarantee a better assistance service. Many people prefer the consolidated "cash and carry", characterized by fees, than a unique and annual premium, although sometimes inferior than the sum of cash and carry fees. Another problem, raised by many people, concerns the exclusive economic insurance cover for biomedical facilities, notwithstanding orthodox medicine is not the unique therapeutic resource within the country, although it is the hegemonic system. Particularly, in the rural context, as Jomoro District, emerges the presence of medical pluralism highlighted by heterogenous nosological categories, traditional healers' behaviors, and patients' therapeutic paths (Pavanello e Schirripa 2008; Vasconi 2008). Most of rural population interprets the biomedicine as one of numerous therapeutic resources within the country, maybe the most efficacious, but not as the unique medical resource. Most of the people do not want to invest only in one medical resource economically, also because the biomedicine is not efficacious for spiritual diseases and other "local nosologies". For this reason in the Jomoro District my informants declare that they are suspicious and unsure to pour money into the *National Health Insurance Scheme* premium, because they perceive to invest most of their economic resources only into one of different efficacious therapeutic traditions that they usually use.

In the rural areas inequalities, economic and health difficulties, and local perception of health, illness and healing induce most of the people to use traditional medicine. In Ghana in 2000, parliament approved the *Traditional Medicine Practice Act 575*, and thus by law recognized traditional medicine. For this reason, in 2010 the *National Health Insurance Council* declared the future coverage of herbal products by the *National Health Insurance*, for instance, and the opening of "Dispensaries" within medical institutions in the country, and the recognition which herbal products will gain through the Council. In 2006 a Commission (comprising of CSRPM of Mampong, Food & Drugs Board, Noguchi Institute, GHAFTRAM) was instituted to write the Essential Herbal Medicine List. The latter is a national list of herbal products that will be shortly recognized by the *National Health Insurance Council* and added to the list of drugs that users of *National Health Insurance* can access. After the list is approved by the *National Health Insurance Council,* the Ministry of Health will set up the "dispensaries" of herbal medicines within medical

institutions in the country. Notwithstanding, all seem to advance the perception that traditional medicine is dichotomous, that it has two different separable aspects, the magico–religio, on one hand, and the herbal on the other hand. Such attempts at splitting traditional medicine into two aspects could devalue its significance and also its therapeutic and symbolic efficacy, which are often what drive its patronage and usage among the larger Ghanaian population. Ghanaian integration of traditional medicine is not coherent with complex heterogeneous panorama of traditional medicine. It favors biomedical practice because it is rooted in the western concepts of health, illness and healing and in the western and biomedical doctor-patient relationship that the code of ethics is trying to impose to every traditional practitioner. In particular, the promotes commercialization and industrialization of traditional and complementary medicines products, and tends to apply the usage and understanding of orthodox drugs to herbal products, and in that way subjecting the herbs to numerous scientific tests and paradigms. In other words, biomedical perceptions of efficacy and treatments are emphasized by the policy makers that are transforming the Ghanaian pharmacological system including new and safety herbal products within the pharmacy market. Thus, at the institutional and legal level, it is possible to observe an attempt of a process of westernizing traditional medicine, reducing its usage and understanding to biomedical conceptions. Such a process can lead to a medicalisation, institutionalisation, and bureaucratization of autochthon medicine – that characterized the post-colonial state - where science is used as a mechanism to control social body and sets itself up as a tutelage where health, illness and healing are regarded as commodities that can be sold for profit. The *National Health Insurance Scheme* is in line with government recognition process: the *National Council* proposes to connect modern and traditional health care systems, even if the current process of integration highlights a relevant reductionism of traditional medicine (Vasconi & Owoahene-Acheampong 2010).

Therefore the inclusion of *National Health Insurance* into the national health delivery system is increasing power relationships, is making complex the "field" of therapy, and is producing a complex field in which many political and economical factors and power relationships unfold. Although the Government of Ghana is trying to change and improve health system financing, health inequalities do not decrease, individual and social tactics of access and usage of health facilities are almost the same, and the problems are both availability and accessibility of health facilities. Therefore, the analysis of "navigation" - the ways people cope with financial constraints and the overall commodification of health and healing - is important to emphasize the way people themselves are aware of the fact that financial reasoning is one mode of though health and to improve the current National Insurance program.

The *National Health Insurance Scheme* leads to analyze structures of inequalities, cultural and social consequences of health financing programs, and the "navigation" of people or how people navigate and negotiate the forces of the market and the process of marketization of practices of health and healing. However, the analysis of *National Health Insurance* allows to debate on health system privatization (Turshen 1999). Is the *National Health Insurance* a privatization program or a welfare program? The ethnography of health system and political anthropology of health system could be useful to examine the current "marketization and commodification of health" that reduce access to health facilities (van Dijk & Dekker 2010); the complex field of therapies; the privatization trend; the current public and private partnership in health; the consequent changes of health system; the new definition of Public health; the changes of the State role into the health sector; but also the complex relationship among Ministry of health, *Ghana Health Service*, *National Health Insurance Council*, donors and international organizations. The *National Health Insurance* highlights both how global, national and local at the same time they are transnational, and how a

"transnational analysis" is more useful than a unidirectional examination of local, national and global level, because they are interconnected highly. First of all, the *National Health Insurance* implements the World Bank and World Health Organization guidelines: decentralization, community empowerment, health insurance scheme and recognition of traditional medicine. Then, in 2010 the World Bank entered in a contractual agreement with the *National Health Insurance Council*: the international health organization will support the *National Council* financially and administratively, strengthening the economic and political health system dependence on donors and stakeholders. Thus, global rhetoric and discourses are acquired and implemented by the Government of Ghana, but they hide several economical and political reasons evidently.

Actually, the *National Health Insurance Scheme* represents an anthropological challenge to analyze health system, and a pervasive way of thinking about the health system and its analytic levels of local, national and global - a way of thinking that rests on what James Ferguson called the "vertical topography of power" (Ferguson 2006: 90). I would like to argue that calling into question this vertical topography of power brings into view the transnational character not only of the "State" but also of the health system. The government health insurance formalizes alliances and entanglements between local, national and international level. The consequences of *National Health Insurance Scheme* and the complex relationships among health providers make indispensable the application of transversal analysis of the new Ghanaian health system organization that shows how the "top" and the "bottom" of this vertical picture operate within a transnational context. The new Ghanaian health system structure and the new Public Health definition, characterized by a different relationships among local, national and global level induce to use a new perspective for "across" and not "from below".

The anthropological analysis of *National Health Insurance* program highlights how a political anthropology of health system could be useful to open new analytic keys and new possibilities of research and political practice into medical anthropology; to debate on the extension of health rights; the development of democratization processes and good governance; the limits of decentralization programs; the consequent changes of borders of "therapeutic citizenship"; the current democratization health programs and definition of democracy in health. Particularly, it could be relevant to debate on re-definition of the current health system in Africa in accordance with "pluralistic health system" and privatization trend.

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