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The solidarity of self-interest : social and cultural feasibility of rural health insurance in Ghana

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The solidarity of self-interest

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Social and cultural feasibility of rural health
insurance in Ghana

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To Angie and our children



The Ghanaian *adinkra* symbol *NKONSONKONSON* (chain links) is used to signify solidarity. It is used to remind citizens that in unity lies strength and entreats them to contribute to the community. It was the rallying symbol of the 1997 abortive NHIS pilot scheme in the Eastern Region.

Foreword

When African states gained their independence in the late 1950s and early 1960s, free health care at the time and point of use was a constitutional right. Health care delivery systems were supposed to be entirely financed by the taxpayer, a state of affairs that rapidly proved to be an illusion. The international economic crisis in the 1970s had a dramatic effect on government budgets allocated to health. This eventually resulted in many African countries having a public health service that was free at the point of use but that had increasingly less equipment, fewer drugs and supplies available, and poorly paid and demoralised staff. 'Free care' had become a myth.

The myriad of small health projects that were established during the 1970s and 1980s pointed to the potential of community financing in the form of user fees. The rationale behind the introduction of user fees in the public sector was pragmatic: to try to mobilise additional resources for an under-funded health care sector. At the end of the 1980s most African governments were openly shifting to more formal policies of direct 'out-of-pocket' payments. These policies were increasingly being legitimised by international organisations such as UNICEF and the World Health Organisation, for instance in the framework of the Bamako Initiative launched in 1987. User fees have now become a fact of life in virtually all African countries but their limitations have also become common knowledge. Today there is a wealth of empirical evidence accumulated in Africa that indicates that user fees reduce access to health care for the poor who, in many instances, are finding themselves excluded from the system.

It is in the light of this evolution that the current interest in health insurance in Africa – with its potential to overcome the problem of access created by user fees – has developed over the last decade. Insurance is a technique that requires the pre-payment of a premium at a time of the year when the household has the necessary income to do so. Eventually, this will mean that no payment has to be made at the time and point of use of health care services. In addition, health insurance, when it is organised in a social perspective, implies a level of risk sharing between the healthy and the sick, and between rich and poor.

There is currently huge interest in the development in Sub-Saharan Africa of community health insurance schemes implemented on the periphery of the health system, organised on a voluntary basis and co-managed by the beneficiaries. But one has the impression that for many international development organisations, and even for African governments, community health insurance has become a new magic bullet – which of course it is not. Community health insurance will never be a quick technical fix.

A certain naivety sometimes surrounds health planners' enthusiastic pleas for community health insurance. Community health insurance is being reduced to a particular financial arrangement but, at the same time, its complex social and cultural dimensions are being underestimated. One could say, rather provocatively, that community health insurance has become too much the exclusive study domain of health economists, whereas there is need to study and unravel, in a systematic way and in a variety of settings, people's expectations and fears in these innovative but complex forms of health care financing. There is, therefore, a need for more qualitative research by sociologists and anthropologists.

It is precisely here that the merits of Daniel Kojo Arhinful's study lie. He critically analyses the gap between the official rhetoric concerning community health insurance and the reality of people's views and expectations. He further investigates the links to be made, if any, between community health insurance and existing traditional solidarity systems in rural Ghana. His study findings point to the crucial importance of trust in the institutions in charge of the management of the scheme, and the need for an acceptable level of quality of care – and certainly relational quality – to be provided by health care workers. And last but not least, Arhinful shows that the Ghanaian community insurance schemes he studied do not constitute an option for the destitute in society.

This study will definitely lead to a better understanding of the complexities of developing community health insurance in Ghana. Daniel Arhinful's work constitutes, in my view, an important contribution to more evidence-based policies with regard to the promotion and organisation of community health insurance in Sub-Saharan Africa.

Bart Criel
Institute of Tropical Medicine, Antwerp
November 2003

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I wish to emphasise however, that I am entirely responsible for any errors, substantial or marginal, which may be found in the following pages.

PART I

GENERAL, HISTORICAL AND SOCIAL
CONTEXT

Introduction

Why did Emmanuel Boadi die? An epitome of Ghana's health care crises

Brother, village life is war. We have to struggle to survive. Farm work is not good. The prices of everything have gone up and they continue to rise. We are surviving by the day on cassava. When you need financial help, no one will mind you. And woe betides you if any bad illness afflicts you. You will be marched to your grave. There is no security here for the youth so if you hear of any job opportunities in big city, remember me.

This is a paraphrase of a statement by Emmanuel Boadi, or Emma, as he was commonly called at Sikakrom village. Those were his words when he spoke to me briefly in a short encounter during my visit a month earlier in connection with the funeral of my maternal grandmother. As is the practice in this small village at such occasions, the young men assist with various small tasks such as the raising up canopies at the funeral ground and the digging of the grave. The service is reciprocal. Those who help others on such occasions receive help when they find themselves in similar circumstances. On the other hand, those who do not help always have to pay in kind or cash for such services. Emma caught my attention when I saw him busily working on a small canopy alone. I walked to him to express my appreciation and he asked a few questions about a senior cousin who happened to be his peer and classmate in primary school and who was then out of the country. Of course I could not say otherwise to his request than assure him that I would try just to rest matters there.

Barely four weeks later, I returned to Sikakrom to meet a procession of mourners conveying a coffin to the cemetery in a typical Roman Catholic fashion accompanied by solemn hymns. My enquiries revealed to my greatest shock and dismay that the body on its last journey through the lone street of Sikakrom was none other than Emmanuel Boadi. Death is unpredictable and inevitable during our transient earthly existence but the pain it strikes and the sorrow it leaves behind is unbearable if it happens so prematurely and unexpectedly in potentially preventable situations like the case of Emma.

The circumstances of Emma's death, as narrated to me by one of his closest friends, was that two weeks before his death, he was still the vivacious, energetic postal agent's assistant at Sikakrom. When he started feeling unwell, with the symptoms of fever and cough, his immediate intervention was the common first line therapy of resort in the village as indeed would be the situation in most rural parts of the third world: self medication. Two days later when his condition was not improving, he managed to travel to the district capital, which was only ten kilometres away, to seek treatment at a mission hospital. Then the agony that led to his demise began.

He was asked to deposit the equivalent of US\$15 in order to be put on admission for a suspected condition of enteric fever. Since he did not have the money himself he returned to the village to try to raise it by approaching a few family members and friends, but he could not get the needed financial assistance. I learnt that one family member he approached was surprised that he went to him because as a postal agent, Emma was considered one of the few privileged in the village with a regular income.

Unable to find the much-needed assistance, Emma stayed at home and his condition deteriorated. Only then did close family members become concerned; but their intervention was to send him to a spiritual healer in a local healing church. He remained there and died after three days. Ironically, when he died, the family was able to mobilise resources running into the equivalent of hundreds of dollars to organise a 'fitting and deserving' funeral for him.

As I reflected on the circumstances leading to his death, my mind went back to the previous four weeks and Emma's exact words concerning the difficult economic life in the village and his worry about falling ill and dying due to financial difficulties. "Coming events cast their shadows," as the saying goes, but little did I suspect that Emma was already sounding his funeral dirge in advance. Suddenly, I felt pity and anger well up within me. My pity was for his poor soul and his last battle with life due to his inability to raise a mere US\$15, which could have enabled him to live longer. My anger was directed in part at a health care system that has deprived a young man of his life, leaving behind three orphans comprising a young widow and two children to battle the harsh life alone. Part of the anger was at the family and friends who could not provide

US\$15 for his treatment, yet managed to give him a fitting burial. May his soul rest in peace.

Emmanuel, however, features as just one example of a phenomenally common problem in most of rural Ghana. It seems that people are just dying, but when you find out more about their deaths you get to know that initially all they required was just 15,000 cedis (US\$2) to pay for needed medication. When they are sick they find it hard to go to the health facility because of difficulties with paying for the cost of medical care. At the funeral of Emma, a teacher in the village told me that a young expectant mother died the previous week because she could not afford delivery at the health centre and therefore went to see an old birth attendant when she started feeling contractions. Unfortunately, the delivery developed complications. A last rally to get her the needed health care in a medical facility was too late to save her. Another young woman had a simple boil but her family ignored the advice to send her to the hospital when it became critical and she needed surgery due to financial reasons. Instead, they confined her to home treatments. She passed away under miserable circumstances. The stories go on and on; it is the reality of the majority of people who eke out a subsistence existence in most rural parts of Ghana.

Health care crises

Emma's case represents the user fee (popularly dubbed 'cash and carry') misery of health care in Ghana. Nothing comes for free. At health facilities, patients have to pay for the cost of treatment from recording cards through laboratory investigations to drugs and medical supplies such as syringes, needles and cotton wool. The user fees have to be collected to keep revenue for such items coming in and thus the institutions financially afloat. In these circumstances, the majority of the people are denied access to health care due to their inability to pay. In particular, it is the poor like Emma who are less likely to report illness and seek treatment. Although this is influenced by perceptions of choice and preference, a lot of it is related to the impact of health cost on household expenditure relative to income. For example, according to the Ghana Living Standards Survey 3, the poorest quintile in 1992 spent 12% of their income on health, compared to a national average of 9%.

The financing crises of health care in Ghana, as indeed for most of sub-Saharan Africa, is a recognised fact. Scarcity of resources for government health services is the major factor hindering access to health care for the majority of the rural poor. Consequently, one of the challenges facing these countries has been how to organise community financing in a manner that does not deter the poor and vulnerable groups from seeking health care in time of illness. This has, however, been a difficult task in view of the generalised level of poverty in these countries. Most existing and planned community financing

schemes are however based on fee-for-service and only a few schemes provide risk sharing through the payment of premiums. One of the earliest reviews of community financing schemes in Africa carried out by Carrin (1987) involving twenty schemes, for example, found out that only one involved prepayment, although two others combined prepayment with fee for service at the time of receiving service.

Social health insurance is thus one of the cost recovery options that has been proposed to promote community involvement in health financing while maintaining access to free, or virtually free, health care at the time of illness (Arhin 1994). Social health insurance in the present context is an arrangement designed to provide risk sharing for illness-related events and which is accessible to households in the informal and rural sectors of developing countries regardless of the orthodoxy of its operational modalities. Indeed since the 1990's, a number of African countries, such as Burundi, Guinea Bissau and Congo have experimented with rural health insurance schemes that cater to rural communities. The schemes they have adopted have taken a number of forms, which include providing benefits at a central facility such as a district hospital or other lower levels of health care such as a health post. The administrations of these schemes have also been varied. Some are managed by central government organizations together with local officials, while others have been organized by community solidarity groups that are autonomous from the government. The experiences to date, however, indicate that their effectiveness has been limited because of lack of economies of scale, as well as the lack of the necessary managerial skill (Criel 1998), and also the lack of the essential knowledge about people's perceptions of how a pre-payment scheme should operate to suit their cultural needs.

Ghana presently finds itself on the eve of the introduction of a national health insurance scheme. Like the situation in many low-income countries, the problems surrounding this scheme are enormous and include such uncertain factors as financial viability, as well as management and political will. This study investigates another aspect of health insurance, which has received insufficient attention from planners: How do "the people" view a state-based and/or formal health insurance? And how likely are they to participate in such a scheme? A state-based and/or formal insurance program is radically different from the traditional reciprocity-based support mechanisms and it is highly unlikely that members of local communities will grant a state or formal organisation the same measure of trust, which they used to grant their close relatives. It explores and explains the "missing links" between reciprocity and formal or state-based health insurance. The purpose is to critically assess the government's present plans in order to provide recommendations for a more culturally sensitive type of health insurance.

Theoretical framework: Social security, past and present

Social security encompasses a broad array of academic disciplines that include sociology, political science, economics and anthropology. Similarly, several theoretical frameworks have been presented to analyse the phenomenon. For the individual researcher, this leaves the daunting task of making a choice that has meaning for the question of his study. Nevertheless, most debates on the study of social security mechanisms involving traditional welfare mechanisms — as is the case in my present study — revolve around Polanyi's (1977) three basic "principles of social organisation" which are comprised of: the principle of reciprocity (solidarity networks), the principle of (state) authority (command networks) and the principle of the market (exchange networks).

After Polanyi, the analysis of face-to-face solidarity into a collective system of risk insurance based on reciprocity has been the topic of extensive anthropological, sociological, political economy and historical research. Much of the discussion has focused on the conceptual, ethical and practical problems and issues of deprivation and fragility associated with the lives of so many people in so-called non-capitalist societies. Indeed, the ILO's definition of insurance does apply to both micro and macro concepts of risk prevention: "The reduction or elimination of the uncertain risk of loss for the individual or household by combining a large number of similarly exposed individuals or households who are included in a common fund that makes good the loss caused to any one member" (ILO 1996). The dominant theoretical question has been the rationale for such provision; how and why do people come together into collective action to help one another through mutual insurance? A greater degree of altruism between related or proximate individuals has traditionally been put forward as an explanation (Cox 1987; Platteau 1991). This has been countered by the argument that exchange behaviour is motivated by self-interest values in a risky environment on the basis of long-term reciprocity (Coate & Ravallion 1989). The concept of self-interest also takes a central place in De Swaan's (1988) theory of collective action, as employed in his study of the rise of state-organised care in four West European countries and the United States. I will now provide a brief review of some of these views.

In the original exposition of "The Great Transformation"¹, Polanyi argued that all economic systems up to the end of feudalism in Western Europe and in most societies were organised on the principles of reciprocity or redistribution or a combination of both. The organization of production and distribution in many societies, he stated, had been accomplished through social relationships of

¹ Polanyi's book is the outcome of an analysis of the work of many anthropologists, economic historians and other historians of thought.

kin or community obligations and counter obligations (reciprocity) and that other societies, on scales as small as a band of the !Kung or even as large as the planned economy of the former Soviet Union, employed re-distributive systems. This was characterized by “the absence of motive of gain; the absence of the principle of labouring for remuneration; the absence of the principle of the least effort; and, especially, the absence of any separate and distinct institution based on economic motives” (47). According to him, in much of Western Europe, these systems of distribution came to be increasingly supplemented and then replaced by market trading at the end of the feudal and manorial era, the control and encouragement of which was a major focus of medieval municipal and mercantilist national governments. Since I will be dealing with informal and mainly rural communities, his concept of reciprocity and how it has been applied is of particular significance for my present purpose.

Until the late 1970's, the dominant explanation to the underlying rationale of traditional mutual insurance in so called pre-capitalist societies which went unchallenged particularly in anthropology was the ‘moral economy approach’. The premise of the approach, which derived its name from the title of the seminal book by James C. Scott (1976) in which he echoes Polanyi's views that solidarity mechanisms of peasants reflected two high ethical values: the right to subsistence and the principle of reciprocity. Therefore, for Scott, a model applicable to most peasants was that although constrained by the vagaries of the weather and the claim of outsiders, they commit themselves to the moral good of their society rather than seeking to maximise the well being of themselves and their families. Reciprocity thus serves as a central moral formula for interpersonal conduct. The right to subsistence also defines the minimal needs that must be met for members of the community within the context of reciprocity (Scott 1976:167). But the moral economy approach of Scott was not without its problems.

Its strongest critic was Popkin (1979) who attacked the orthodox view of Scott and those before him by showing that opportunistic behaviour also exists among pre-capitalist peasants. In his ‘rational’ or ‘political economy approach’ expounded in “The Rational Peasant”, Popkin emphasised that traditional village institutions, arrangements and norms had not been as effective in guaranteeing of the subsistence needs of community members. He therefore found fault with the explanation that peasants are either altruistic actors or passive subjects willing to respect social norms of conduct and moral principles of reciprocity.² He contended that peasants in traditional societies are egoistic

² Popkin emphasised that ‘insurance, welfare and subsistence guarantees within pre-capitalist villages are limited’ and ‘the calculations of peasants driven by motives of survival in a risky environment led to subsistence flaws and extensive village wide

and hard calculating agents who seek by intent to maximise personal advantages from all actions. His pessimism about collective action led him to dismiss its success in even small communities. His critique however, failed to account for the well-documented existence of solidarity networks.

In a paper in which he used economic theory to explain some of the characteristics of so called primitive or pre-literate societies, Posner (1980) reconciled the two opposing traditions by arguing that mutual solidarity can be sustained in the long run by the existence of a lasting relationship between its self-interested members. He explained that opportunistic behaviour is prevented as long as short-term benefits from deviation are smaller than long run punishments.

Following Posner, Platteau (1991) synthesised the views of Scott and Popkin. He faults Scott for confusing social security arrangements with altruistic behaviour. While agreeing with Popkin's challenge of the idealised view of traditional mutual insurance, which many anthropologists were inclined to accept, he also levels two basic criticisms against him. The first is that he overdoes his approach to the moralist tradition to the point of even ignoring qualifying statements such as the limitations that mutual suspicions create for collective action. Secondly he lashes out at Popkin's for having views of the traditional village societies that are equally as partial and incomplete as those he criticises. He specified his "most important conclusion" as that both Scott and Popkin have "somewhat gone astray by seeing the problem of the 'moral economy' as concerned only with the motivations of people in traditional village societies". He shows rather that mutual insurance can take a variety of forms such as grain transfers, credit, access to land and labour assistance. He thereby patches up the two viewpoints by noting "since these mechanisms have proven to be workable, their success ought to be ascribed *both* to self-interested behaviour on the part of the individuals and to the ruling customs and norms that are designed to ensure continuity" (emphasis in original). He also cautions the continued usefulness of the traditional system as a major source of social protection against the background of numerous constraints arising from the joint impact of the market penetration, population growth and the rise of the modern state that have led to their gradual erosion or weakness.

In a recent article, Fafchamps (1992) revisits many of the arguments of Posner and Platteau and conducts an analysis focussing on the key features of solidarity systems (rather than particular institutions). He explained solidarity networks "in the light of recent developments in the theory of repeated games". He argues that solidarity systems are usually organised as a form of mutual insurance on the basis of delayed reciprocity contingent upon need and afford-

insurance schemes, but to procedures that generated and enforced inequality within the village (Popkin 1979: 32-3).

bility. Recipients of aid are not expected to give back the equivalent of what they receive but help others in return. How much help a recipient returns depends on his own circumstances at the time as well as the situation of those calling for help. He concludes by reasserting Posner's view that people in pre-industrial societies pursue their long-term self-interest as well as the ethical values of their society. This emphasises solidarity as a moral obligation and subsistence as a right. He thus reconciles the arguments of Scott and Popkins.

How does Fafchamp, accommodate the two bodies of thought in his explanation? According to him, without formal enforcements, the existence of solidarity mechanisms, and for that matter risk pooling, is achieved through the theory of infinitely repeated games, which is another illustration of the prisoner's dilemma principle. All prisoners realise that they can benefit from cooperation although they all find opportunistic behaviour in their short-term interest. People who breach their promise can be 'punished' by being treated less well afterwards. The mutual insurance agreement thus becomes self-enforcing based on voluntary participation but not coercion. The benefit of the cooperation according to Fafchamp comes over a long period of time.

The idea of self-enforcing agreement without coercion resonates more profoundly in De Swaan's (1988) theory of collective action, as employed in his study of the rise of state-organised care in four West European countries and the United States. He uses two processes to explain how and why people come to develop collective, nationwide and compulsory arrangements to cope with deficiencies and adversities that appeared to affect them separately and requiring individual remedy with two processes. One relates to external effects, which refers to the indirect consequences of one person's deficiency or adversity for others not immediately afflicted themselves. He cites the example of the outbreak of cholera in 19th century Europe as an object lesson in the external effects of individual deficiencies. Linked to this, according to him, is the second process of chains of human interdependence in the course of time to foster group interest. He traces a link of this explanation to the historical sociology of Nibert Elias and his classical predecessors. Using the concept of 'figuration' as a reference to the "structured and changing pattern of interdependent human beings" he states that the changing attitudes towards the poor of those established in society were the result of shifts in the balance of mutual dependency which are the results of the emergence of nation states and the rise of capitalism.

The application of the theory to explain the emergence of friendly societies and workers' mutualism at the early period of industrial capitalism in Europe is particularly relevant for this study. The theory is chiefly useful in the sense that it deals further with the processes from small voluntary to large compulsory state schemes. He explains that participants in these voluntary co-operations were able to achieve a measure of solidarity through self-coercion by exerting pressure on

one another to contribute a small but fixed part of their income. Mutual funds were therefore able to achieve cooperation because participants were under social constraints towards self-constraint. This form of coercion that de Swaan indicates could also be applied to societies “where sharing *en famille* is taken for granted, the obligation to make deposits at set intervals provides a good excuse for withholding income from kinsmen who appeal to one’s moral obligation”.

Overall, the analyses and explanations of solidarity institutions and networks have not been without their oversights and shortcomings. One significant shortcoming is that where the focus has been on so-called developing or Third World societies, the analyses have consistently been undertaken and pursued as mere ‘objects of curiosity’ in pre-industrial societies (Atim 1999). This focus has invariably left a gap in the empirical study of how traditional solidarity systems function as mutual insurance mechanisms for solving the problems of health care financing in, for example, sub-Saharan Africa. In other words they have not been problematised in specific contexts. Such analysis is all the more important because although the well-documented experience of mutual insurance in Europe and the study of economic systems of the so called pre-industrial societies provide important material for comparison and for testing generalizations, they certainly cannot be applied wholesale to today’s developing countries.

In Ghana, as in most developing countries of Africa, traditional social security is still the major source of social protection for a large section of the population. However, as some of the cited authors above have called attention to, the processes of socio-economic changes in transitional societies tend to undermine the effectiveness of the existing cultural mechanisms of social security (although informal reciprocal obligations cannot be ignored). One of the pertinent questions that needs to be answered therefore is: Would the principles of traditional social security mechanisms within formal health insurance schemes be functional or feasible? And if so, how is that practicable in the situation of the increasing recognition of self-interest in such group dynamics? It is aspects of these social relations that I have set out to investigate in this study. In order to place the discussion in its proper contextual framework, it is appropriate to provide some background.

Background: Social security in Ghana

The traditional system of social security in Ghana, as in most African societies, is based on reciprocity. It was first and foremost the (extended) family, which provided the social and juridical framework for long-term reciprocity. Its members were supposed to assist one another in times of hardship and misfortune

and the entire lineage was held responsible for the (mis) behaviour of one of its members (see e.g. Fortes 1969, Assimeng 1981, Nukunya 1992). Lineage solidarity showed itself for example during sickness, old age and death. The principle of reciprocity worked most prominently in the organisation of funerals. Significantly, among the Akan, the largest ethnic group in Ghana, people considered themselves members of one *abusua* (lineage) if they shared funeral debts.

With the advent of colonial rule, a Western style of social security system was added to the existing one (Darkwa 1997). It was based on the principles of the market and the state. However, this form of social security arrangement was limited to the formal sector of the economy and left out the largest proportion of the population: those who earned their livelihood in the 'informal' (including the traditional) sector. People suffering the greatest insecurity, such as the aged, the young, women, children and particularly the ill or handicapped were often excluded from this new form of social protection.

Both systems, but the traditional one in particular, are now under severe stress. Due to education, migration, urban employment, economic and environmental crisis and changing values, the old solidarity network is tearing apart. Recent research among elderly people in a rural community shows that 'reciprocity' no longer provides adequate security for the old (Van der Geest 1997). The introduction of economic cut backs in the form of Structural Adjustment Programmes (SAP) and environmental degradation (leading to a diminished agricultural output) has hit women and elderly in particular and those in need of medical care very hard (Apt 1996; Senah 1989, 1997).

The problem: Health insurance in Ghana

Despite considerable progress in health care since the 1970's, the health status of most Ghanaians remains poor as evidenced by high infant and maternal mortality, high prevalence of preventable infectious and parasitic diseases and poor nutritional standards (Asenso-Okyere 1995). Apart from inadequate government allocation of resources to the public health sector, there is also great inequality between urban and rural areas in access to health care. Since 1981 however, the government has tried several cost recovery measures as part of health sector reforms in the context of structural adjustment programmes to reduce increasing public expenditure on health care.

One of the recent economic reforms that the state is implementing is the transformation of traditional social welfare mechanisms into a new form of social insurance. The new system is to assure health security for the most needy and at the same time reduce social expenditure in the state budget. The final report for the feasibility studies of a national health insurance scheme in Ghana summarises some of the long-term goals of the proposed scheme. These

include: achieving universal coverage of primary health care, making health care economically and geographically accessible to all Ghanaians, ensuring an acceptable minimum standard of health care at the primary level and generating additional sources of health care funding. The driving forces behind the scheme are the principles of equity and solidarity. It is thus proposed that the scheme will in the first instance concentrate on increasing access and raising the quality of primary care.

There are, however, numerous obstacles to overcome. Among the complexities and problems of implementing a scheme of insurance which the government recognises include: the background of Ghana's low economic base, a relatively poor population, unplanned spending on health care, and a lack of expertise on socialised health insurance. Accordingly, it has initiated and carried out a number of feasibility studies that deal with the technical and financial aspects of the scheme to obtain the needed information to enable the scheme to take off smoothly. But Ghana, like many other low-income countries confronted with similar problems, finds itself at a difficult crossroad. On the one hand it needs to transcend to a more encompassing system of health financing, preferably one based on prepayment and on the other, it should ask itself whether it has to copy foreign systems of insurance which have proved their viability in relatively well-off countries but may prove less suitable for a low-income population such as the Ghanaian one. There are also other crucial issues of social and cultural nature that need to be considered in the design and implementation of such a system, but which have not yet received adequate attention. While the underlying principle of exchange in the dominant traditional arrangements is reciprocity, the proposed insurance system, however, is based on an entirely different principle: that of state authority.

Lack of financial means and the unanimous relationship between citizen and nation-state entail an uneasy start for health insurance in Ghana. Scott (1972) notes in this regard that, "in new nations, values attached to the state bureaucracy tend to remain fairly formalistic and tenuous". In a typical developing country context like Ghana, the prevalence of kinship ties, clientelism and the priority of other traditional loyalties over modern bureaucratic obligations (among others) lead to nepotism and corruption, as people in government service allow their family and traditional interests to prevail over those of the state. Nugent (1995), for example, has described the state in Ghana as commonly regarded as an enemy, a kind of vampire, which tries to extort resources from its subjects. Bayart (1993) writing about African states in general, speaks of "politics of the belly" while Ellis et al. (1997) view the affairs of African states as legalised crime. Citizens, therefore, mistrust state claims concerning "equity" and "solidarity".

A state organised insurance thus becomes a highly ambiguous institution, which seems extremely vulnerable to two perennial constraints of any insurance system, both of which derive from self-interest and lack of solidarity among its individual members: adverse selection and moral hazard. The former is the tendency of people at risk to join the insurance more than those who are healthy and without risk. Moral hazard refers to the over consumption of health care by those who join the insurance. The latter in particular seems a formidable threat to health insurance in a low-income country such as Ghana (Criel 1995: 66-67). Methods of counteracting moral hazard are a major point in any health policy. The state, therefore, has good reasons to doubt the willingness of its citizens to fully participate in its insurance scheme and the citizens have equally good reasons to mistrust state claims concerning “equality and solidarity” (MoH 1996: 2). This research intends to look into this political and moral stalemate.

The question that needs to be answered is how the traditional mechanisms of reciprocal moral obligation can be “scaled up” or extended to an anonymous, more formalised state centred social insurance scheme. Particularly crucial is the question of how the concept of ‘family solidarity’ translates in the behaviour of the population towards the scheme in the light of their past experiences with traditional social security mechanisms. Given the strong family bonds in traditional reciprocal exchange, what are the guarantees that people are willing to pay to help others who are not their relatives, if the traditional force of moral obligation — reciprocity — is absent and an untrustworthy treasurer — the state — will administer their contributions? Indeed, as the findings of a recent study indicate, people are likely to provide assistance for close relatives because they feel morally obliged as a result of what they had done for them in the past (Arhinful 1998). To date, it is not clear to what extent the policy objectives of increasing the provision of and raising the quality of primary health care can be reconciled with what individuals and informal groups such as the *abusua* (family) know, do and want in health insurance. The conflict or uneasy relationship between ‘the people’ and state interests will be a central issue in this study on social security.

Objective and research questions

In light of the foregoing, this study seeks to provide insights into how a sustainable insurance system can be implemented in Ghana, taking into account the local traditions of insurance/security. It was envisaged therefore that the research will provide information on how to marry traditional forms of assistance to modern health insurance. This objective translates into a number of specific research questions:

What are the principles of the existing traditional forms of support and how do these operate presently in the family?

What are the perceptions, values and limitations of a state-organised solidarity risk-sharing scheme at the different levels of social organisation, both among those who plan and implement insurance and among the community for which it is intended?

Can traditional rules of reciprocity and solidarity be scaled up to or transformed into a modern state-organised insurance system?

Can a state-centred health insurance scheme improve access to the poor and vulnerable members of the community such as women, children and increasingly elderly people and paupers?

Brief overview of community health care financing problems in Africa

Since the beginning of the 1990's the relevant literature on community financing schemes in Africa has been growing with increasing interest in academic, policy and development spheres. Undoubtedly this growing interest has been fostered by the financial crises affecting public health care services in the region. Health sector reforms introduced to assure quality of care and improve access and efficiency from the 1980's saw the introduction of user fees at the point of use. Although this led to some improvement such as the availability of essential drugs, it also led to untoward effects of decreasing access to the poor particularly rural populations (Waddington & Enyimayew 1990, Nyongator & Kutzin 1999).

Most rural based populations experience total exclusion from whatever benefits cost recovery may offer, due to their inability to pay for services at the time of need because of their low income. Lipton (1976), writing in the late seventies in support of his 'urban biased' theory, thus noted in relation to health care in rural Africa that "the townsman has nine times as good a prospect of medical attention as the villager in India, eleven times in Ghana, thirty-three times in Ethiopia". In terms of access to health care, about 40 % of the population of Ghana is estimated to live more than 15 kilometres from a health facility but rural communities are worse off since most of the facilities are located mainly in towns and villages along main roads (MoH-Ghana 1996). The 2000 population census report of Ghana recorded a substantial increase in urbanisation from 32 % in 1984 to 43.8 % in terms of population based in localities with more than 5000 persons (GSS 2002). The reality, however, is that the provision of health care has not kept pace with this growth in population. User fees among rural households have therefore "contributed significantly to increasing the exposure of poor households to financial risks associated with illness" (Arhin-Tenkorang 2001).

This situation has led to a greater interest in insurance systems as alternative and complementary options for sub-Saharan Africa. Indeed, the grim reality of user fees has led some people to rather overenthusiastically describe health insurance as “virtually the only practical instrument through which African governments can get out of the expensive business of across the board subsidies for hospital care, and thus release funds for public health, preventive and primary services that benefit the poor” (Griffen & Shaw 1996: 143).

In contrast to user fees, health insurance encompasses risk sharing through pooling of calculable, pre-paid contributions to reduce unforeseeable or even unaffordable health care costs. However, public and private health insurance in Africa cover the formal sector almost exclusively, and therefore achieve a coverage rate of no more than 10 % of the population. The majority of African citizens comprising a dominant rural population and informal sector workers have no access to this kind of social protection (World Bank 1994).

For example, a survey of 23 countries in sub-Saharan Africa covering the period 1971-1987 by Vogel (1990) found out that only seven countries had formal health insurance schemes. The insured as a percentage of the total population ranged between 1 % in Ethiopia to 14.4% in Kenya. Vogel’s definition of health insurance included arrangements involving a formal pool of funds held by a third party or provider as in the case of a mutual health organization. The third party relies on prepayment by the *insurees* and excludes, for instance, employer provided health care.

Partly as a response to this lack of formal social security and partly to the negative side effects of user fees in the face of persistent problems with health care financing, the analysis of non-profit, voluntary insurance schemes for rural and the urban self-employed and informal sector workers is gaining increasing prominence in sub-Saharan Africa (Jütting 2000, Atim 1998). These schemes are characterised by an ethic of mutual aid, solidarity and the collective pooling of health risks.

But rural health insurance in Africa creates its own problems. In an extensive review of 82 health insurance schemes in the informal sector worldwide, Bennet et al. (1998: 11) mention that, “people outside formal sector employment create a much thornier problem for health planners because of frequent fluctuations in and the fact that their income is often untaxed and therefore it is difficult to collect premium payments at source”. The bigger problem is that widespread poverty among potential members is a serious obstacle to the implementation of community or rural insurance. If people are struggling for every day survival, they are less willing to pay insurance premiums in advance to use services at a latter point in time for an illness that may never happen. This has often put affordability at the forefront of such schemes.

Cultural habits also influence how people deal with the risk of illness and could also be a source of problem (Wieseaman et al. 2000). People might traditionally save money for unpredictable events like funerals and marriages as well as the education of their children, but where a belief exists that saving money for eventual health care costs meant “wishing oneself the disease” they may be reluctant in joining community health insurance schemes (Garba et al. 1998). The prevailing concepts of illness and risk are also relevant to the decision of communities to purchase health insurance or not. If people see illness as a somewhat random event that can hit anyone, they are surely more willing to purchase insurance than if they perceive it as punishment for misbehaviour by magical powers. Furthermore, past experience with other community based initiatives with different logic such as savings and credit might induce misperceptions and unwillingness to join schemes. For example, people might harbour the wrong perception that the money paid into a common fund accumulates over time and that the benefits will correspond to the contributions made (Batusa 1999).

The lessons to date indicate that actual implementation of rural or community based health insurance schemes has had mixed results. Success and viability have largely depended on factors such as design and management of the scheme, community participation, regulations at the level of the health care provider, quality of services and in particular on the socio-economic and cultural context. As Bennet et al. indicate, many schemes had encountered substantial problems of adverse selection, were dependent on continuing access to some form of external support and still very few succeeded in reaching the very poorest. Nonetheless, their potential in enabling marginally poor individuals and households to regularise their access to health care remains quite attractive (Bennet et al. 1998: 3)

Despite the growing interest in rural community schemes, traditional solidarity networks have not received the necessary attention in the health care financing debate, at least not from anthropology and sociology. Bennet et al. (1998) have pointed out another significant pitfall of most reviews; they have tended to focus predominantly upon the schemes themselves rather than the relationship between them and the broader health care context. In joining the ongoing debate about the potential of community-based health insurance to improve access to health care and social protection, this empirical study is aimed at filling out some of these gaps.

The fieldwork

Study approach

In its efforts to implement health insurance in Ghana, the Ministry of Health (MOH) has undertaken a number of activities. In order to relate the outcome of this study to the health insurance policies and plans of the Ministry, the following three local administrative districts in Ghana where voluntary health insurance activities had been initiated and/or were being carried out were selected for the fieldwork³:

- Nkoranza district, which operates a provider driven, private, not for profit health insurance scheme;
- Dangme-West district where previous baseline economic feasibility studies on rural health insurance were conducted and which is presently also implementing a non profit, provider driven district community scheme;
- Suhum Kraboa Coaltar district, which was one of four districts in the eastern region of Ghana, selected to pilot Ghana's ill-fated national health insurance scheme (NHIS) in 1997. This scheme was initiated by the state and sought to create new structures within the ministry of health to implement it.

Policy makers and implementers involved or connected to the three initiatives in both public and private not for profit sector in Ghana were included in the research at the Ministry of Health headquarters, as well as the regional and/or district administrative centres. Formal approval, notification and support to conduct the fieldwork in the three districts were granted by the ministry of health through its national Director of Policy, Planning, Monitoring and Evaluation. The fieldwork in each district was preceded by prior notification to the relevant regional and district health officials through correspondence. This was followed up with a familiarization visit to communicate the general objectives and the necessary details and expected logistics assistance necessary for the fieldwork. The fieldwork was carried out in two phases comprising a longer qualitative (exploratory) phase and a short quantitative (evaluation) phase as follows.

Exploratory phase:

During this phase of the project, I selected two sites in each of the three districts; one was the capital of the district in which the scheme is situated and the other was one other rural village further away from the district capital. I then applied the following research techniques:

³ A detailed discussion of the three schemes is the subject of Chapter 3.

- Semi-structured interviews with 25 members in each research area (15 in each town and 10 in each village were covered comprising men and women, young and old. This mainly served as a pilot activity to obtain preliminary knowledge about the communities.
- Formal and informal interviews with key informants (community leaders-including female group leaders, elders, health workers and administrators);
- Observation of activities taking place in specific situations or during events which require community solidarity: sickness, funerals and old age;
- Focus group discussions with various members of the community (men and women, young and old) on security and insecurity in the past, the present and the future;
- In-depth interviews with policy makers and health planners at the national and district levels;
- Study of policy documents and records.

To facilitate rapport, conversation, interviews and focus group discussion with community members as well as a cross section of health staff were conducted in the local languages. In all three districts, I was provided with accommodation on the premises of the district hospital or health centre during my initial visit and throughout my subsequent fieldwork at the district. At my request, two district health staff were released from their routine duties to assist me. In Nkoranza and Suhum, a motorbike was also placed at my disposal to facilitate movement to the accessibly difficult remote areas in the district. One of my assistants was usually the driver. I also engaged one field assistant in the distant rural village. Field assistants provided guidance in recruiting informants as well as arranging interviews and discussions. The exploratory phase resulted in an intermediary report and provided hypotheses and specific questions that were followed up in the second evaluation research phase.

Evaluation phase:

During this phase the most relevant hypotheses from the exploratory phase were integrated into a short questionnaire and applied to larger samples in the Nkoranza and Dodowa districts.⁴ The purpose of the second phase was to validate the insights acquired through qualitative methods in small groups during the first phase with a bigger sample using a quantitative questionnaire. Suhum was excluded because the survey focussed on practical issues that could not be investigated there.

The selection of study areas and sample sizes in the survey was done to cover all the administrative health zones or sub-districts in the two districts. In

⁴ The original proposal planned to carry out the survey in all three districts with the assistance of interviewers based on a targeted systematic random sample of +333 persons from the three districts, making a total of 1000 respondents.

each district, six field workers were selected, in consultation with the district health director and insurance managers or personnel concerned. Apart from their knowledge about the community, another criterion used was participation in similar community research in the past. They were then trained and oriented in two days. The orientation also included a pilot study during which survey instruments were revised based on the outcome of the pilot test.

In each district the questionnaire was finalised and then translated into the local language after a second role-play session. Although the instrument used in both districts were the same, it was conveniently adapted to suit particular characteristics and needs. For example, in Dodowa this involved inserting two additional sub-questions on awareness in view of the relatively shorter existence of the scheme. Adequate numbers of the English version were duplicated and given to the interviewers. Each interviewer also carried a copy of the vernacular version as a source of reference. At the end of the training, fieldworkers drew up a work plan that I used to monitor and supervise the fieldwork, which was conducted over a two-week duration.

During the survey phase, further qualitative research was also considered useful and therefore carried out in all three locations to gain more in-depth insights into the issues that were investigated. The selection of informants for qualitative study during the evaluation phase was done in consultation with district health managers and insurance officers concerned in each district, just as it was in the previous phase. In Nkoranza district my arrival coincided with a training workshop for community stakeholders in the Nkoranza community to inculcate the sense of community ownership in the scheme. These included policy makers at the district administration, health staff, traditional and local leaders as well as fieldworkers who collect annual premiums in the communities. The event provided me with a direct opportunity to update my knowledge on the state of affairs of the scheme since my last visit the previous year. In view of the relatively shorter operational period of the scheme in Dodowa, the qualitative interviews in that district were limited to fewer stakeholders who had been associated with the scheme either directly or indirectly from its planning stages, thus a few health officials and key district administration functionaries and local leaders. The qualitative investigation also took me to the Eastern regional capital of Koforidua where I took advantage of a training workshop for promoters and initiators of mutual health initiatives in that region. Apart from the regional coordinator of the ill-fated NHIS who actively coordinates health insurance activities in the Eastern region (and who also hosted me), I had extensive conversations with leaders of some of those emerging mutual groups in the region as well as other targeted participants. The latter included health officials from Suhum district and a facilitator at the workshop.

Data analysis

Data involving all conversation and interviews as well as focus group discussions in the qualitative phase were recorded, transcribed and manually analysed. Quantitative data coding and entry were carried out in Ghana with the assistance of data collectors and a professional data entry clerk respectively. I carefully edited this in the Netherlands. Analysis was carried out using SPSS and Epi Info statistical analysis programmes. The results of the two studies have been integrated in various chapters of the thesis.

Study limitations

The limitations of this study must be noted. I set out with the aims of exploring how “the people” look upon health insurance and how they are likely to participate in it based on their own traditions of social support in the family. The case studies selected were, however, all formal, top-down initiated insurance schemes thereby theoretically overlooking other alternative, community inspired and bottom up community approaches. Good considerations, however, justify my choices. In the first place, my focus was on heterogeneous, district wide schemes that serve a wide section of rural populations and that in fact are representative of the emerging and preferred trend in sub-Saharan Africa. Diversity also influenced my selection. Nkoranza was chosen because it offers Ghana’s first experience in community health insurance scheme and represented the mission or private not for profit variant. Most of the economic studies for the feasibility of health insurance in Ghana were conducted in Dangme West district. Apart from the availability of existing data, which provide a buffer for comparison, the district also stands out as the only wholly public sector functional health insurance initiative in Ghana although nurtured and operated by the district health management team. Suhum represented a fully central state inspired health insurance scheme and the experience of its failure is considered a useful lesson. Together the three schemes, though far from being selective examples, therefore provided a range of experience that informs the health insurance debate in Ghana and sub-Saharan Africa. Their rural demographic features are a good reflection of the practical situation in most of the sub-region.

Fieldwork limitations

In general, the fieldwork proceeded well, but was not without difficulties and limitations. Enlisting people who meet the overall criteria for various interviews defined by the methodology was not easy. One aspect of it related to the selection of “the few” from a wide target population. Another aspect however, was the practical issue of enlisted respondents who turned out to be “inappropriate” or reluctant informants for various reasons, although they had previously agreed whole-heartedly to the appointment. For example, I cancelled my first

interview in Dodowa because the interviewee honestly told me that he suffers from partial forgetfulness. I was pleased that my interviewee was very honest with me because he looked very frail and ill. I wondered how I could have coped with an interview with him. There was a lady in Dodowa who agreed to be interviewed when my field assistant met her to inform her about the study. However, when we arrived for the actual interview, she behaved as though she was uninformed about the subject completely. I later learnt through my assistant that she thought that talking freely on the subject might bring tax consequences for her *chop bar* business.

Again I spoke to an opinion leader in an in-depth interview who decided to be rather speculative on some of the issues that I tried to probe into. For instance, at one point when the issue of premiums came up I asked him what he considered to be a reasonable rate and he told me 5,000 cedis per person per year. Later, I learnt through my assistant that he told him he deliberately quoted a lower figure to me. He considered 10,000 to be more realistic but he felt if he said that to me it might influence the decision. What was most interesting about this incident was that he indicated to my assistant that he could not confide in me because I could not speak his native Dangme language — call it language identity. Altogether, interesting but sometimes unfortunate issues such as these represent the practicalities one ought to expect in fieldwork of this nature.

Focus group discussions were typically difficult and tiring to organise but interesting to conduct. The difficulty had to do with punctuality. Despite the fact that reminders were given about the time and place of discussions, the time interval between the average first reporting participant and the last one was often about an hour.

The second phase of fieldwork was prolonged by nearly a month due primarily to electioneering campaigns in Ghana towards the end of 2000 and other public holidays in December. The anticipation and enthusiasm of elections in the country during that period was such that slowed down the fieldwork considerably. One observation about the elections though, is that as far as the data collection was concerned, the euphoria surrounding it gave a psychological boost to people's confidence and resulted in open expressions on the research topic. Also, the travels to Nkoranza, for example had had its dramatic moments. On three occasions, the State Transport coach on which I travelled suffered mechanical problems and in each case we had to wait for hours before a new one arrived to pick us up to continue the journey. The dry harmattan season was at its peak during this time, compounding the problems and risks involved in travelling the dusty roads within the Nkoranza district.

One problem encountered by data collectors in the quantitative survey was the reluctance of some respondents to be interviewed. In most cases they were sometimes persuaded to do so and those who refused outright were replaced. An

interesting incident reported by one interviewer was that in one village the community mistook him for a sanitary inspector and did not want to be interviewed at first, but the problem was resolved with the assistance of the insurance field collector in the village. Getting transport to travel to some of the locations within the Nkoranza district as well as finding food to eat was sometimes problematic for fieldworkers. They did learn their lesson, though, and carried their food with them to villages where they were uncertain about availability of food. In one village in Nkoranza district, the interviewer had to solicit the assistance of an interpreter to interview a few people who did not speak the local language who live in that village. An interesting observation in both districts was that some in the community felt “farming” was not an occupation because it did not bring them any substantial income.

Ethical considerations

This study took utmost care to protect the interest of informants as well as stakeholders in the field of health insurance.

In order to ensure that no physical or psychological harm was suffered by any of the informants, the highest level of ethical conduct was observed in the process of data collection, analysis and publication of the research results.

Informed consent was sought from participants before they were included in the study. In doing this, adequate information about study objectives, purpose and importance was provided to give them the option to voluntarily decide whether or not to take part. The provision of such information was however, limited or delayed in observation situations or activities where informed consent was considered counter-productive to the validity of the data and/or the interest of subjects or the public good.

In order to secure valid and good quality data, the researcher sought to establish a good relationship with communities and informants before topics and particularly sensitive issues were investigated.

Informants in the study have been protected through confidentiality and anonymity. In this regard, the personal identities of those interviewed have been concealed except where it is officially prudent to reveal their identity. Such cases have been reported with the consent of the officials involved.

In order to ensure that the various parties, groups, communities, individuals and stakeholders that took part in the study, get the maximum benefit of participation, the findings have been circulated as much as practicable. The means of communication to various parties has been determined and guided by their level of literacy, the comprehension of the material and the pertinence of the information to their benefit and to the expediency of communication.

In reporting the findings of the study, the individual autonomy as well as the health and well being of all subjects and parties has been respected. I have ultimately sought to provide a fair account of the phenomenon studied.

Plan of the book

This dissertation is organised in two main parts. Part one provides the general, historical and social context of the study. This constitutes the first four chapters of the book. Part two provides the empirical findings of the primary fieldwork in the subsequent four chapters.

Chapter 1 sets the agenda for the entire study and specifies the objectives and purpose as well as the theoretical underpinnings of the problem of organising a formal health insurance scheme based on traditional principles of solidarity and reciprocity.

In Chapter 2, I continue with the historical background of health care financing since the pre-colonial period. This background is necessary for an appreciation of the current problems in relation to people's attitudes towards prepayment health care.

Chapter 3 provides relevant background information on the three schemes and localities where the fieldwork was conducted.

Chapter 4 concludes the material on the relevant contextual background with a focus on the traditional social security system in Ghana.

Chapter 5 opens part two with empirical findings dealing with community perceptions, values and limitations of health insurance. It explains the dichotomies of attitudes towards different forms of insecure situations with a particular focus on sickness and organisations of funerals in Ghanaian society.

Chapter 6 is the core conceptual chapter of the book and deals with the subject of why people join health insurance. I explore whether the rationale is based on solidarity or self interest and explain why people pay lip service to solidarity in how they speak about and practice health insurance.

In Chapter 7, I discuss whether risk sharing health insurance solves the problem of access to the poor and vulnerable by arguing this is still problematic partly because the poor who cannot afford to pay premiums are left out. Ironically government exemption policies in the past have not been effective.

Chapter 8 deals with how people perceive the state as a bursar of health insurance schemes against the background of the expected leading role of the state in Africa to use community financing schemes based on risk sharing solidarity to solve the problems of access to health care for the poor. I point out that people do not trust the state because it is perceived as corrupt and unaccountable.

In Chapter 9, I conclude with a summary and a discussion of the scientific importance of the study and offer suggestions by way of policy implications for a social and culturally sensitive health insurance for Ghana with implications for sub-Saharan Africa.

Health care in Ghana and how it was paid for: An historical perspective (1850-2001)

Introduction

Financing of health care delivery in Ghana has had a chequered history. In the search for appropriate ways of raising revenue to supplement government allocation to the sector, various options have been tried. The strategies have shifted from the era of nominal fees to fee free health system and then back to user fees, all in an attempt to provide and guarantee universal access to adequate health care for all of Ghana's people. This chapter focuses on an examination of the history of modern health care in Ghana and how it was financed over the years from the mid nineteenth-century to the present. The objective is to offer a brief overview of the antecedents to the present state of public health services as well as to the financing problems they have had in their efforts to make health care accessible to the people of Ghana, particularly the rural poor. It is useful to start discussing the development of modern health care and how it was financed from 1850 because that is the period the colonial power, Britain, gained an enduring foothold in the Gold Coast. Data from that period is available and reliable. Indeed, an underlying theme of this presentation is that the health services available today developed directly from, and still to a large extent reflect, the character of the legacy bequeathed by colonial Britain.

For analytical purposes, the review is organized into two broad phases: colonial and postcolonial health services. After a brief introduction to the pre-

colonial period situation, the discussion turns to what policies and developments were pursued to offer health and medical care to Ghanaians under various colonial and post colonial administrations and how those policies influenced the health care status of the population over the years. The examination particularly emphasises how various governments sought to generate revenue to finance health care and development, and the response and impact those policies have had on coverage and accessibility of health care to Ghanaians. The discussion offers the appropriate framework for understanding the problems and challenges of implementing health insurance in Ghana with implications for other sub-Saharan African countries.

Historical foundations of public health services

Pre-colonial period before 1850

The people inhabiting the area that was to become modern Ghana were not isolated from the rest of the world before European discovery. Some accounts have it that as far back as the AD 1200, Western Sudan Mande gold traders started to penetrate the country to establish small commercial colonies. Contacts with Hausa merchants through trade in cola nuts also date back to the mid fifteenth centuries. It is certain that these early, pre-European contacts for trade purposes were also accompanied by some of the major infections of the Eurasian landmass such as small pox, measles, and perhaps gonorrhoea (Patterson 1981: 3). On the basis of present knowledge about disease causation and immunity, it is probable that some serious epidemics took place from these early contacts, but their magnitude was curtailed by low population densities and limited mobility at the time.

The early beginnings of modern health care can, however, be traced to the time of organised European presence in Ghana. It dates back to the 15th century when the Portuguese built a fort at Elmina in the central region of present day Ghana in 1481 under the expedition of Don Diego D'Azambuja. Subsequently, the Dutch, British, Danes and others arrived on the coast to build forts and castles for the purpose of trade in spices, gold and, later, slaves. Historical accounts of merchant activities along the West African Coast indicate that European ships and castles became centres for the spread of diseases like small pox, syphilis and yellow fever (Patterson 1981: 3). Anecdotal accounts of the havoc Europeans suffered from the fevers in West Africa earned the area the reputation of "white man's grave" in colonial history. Some writers indicate that the Portuguese found the region so inhospitable that they vacated their posts when the Dutch challenged them in 1595. Mary Kingsley (1897: 681) captured

the health situation along the West Coast of Africa very well in her *West Africa Travels*:

Great as is the delay and difficulty placed in the way of the development of the immense natural resources of West Africa by the labour problem, there is another cause of delay to this development greater and more terrible by far – namely, the deadliness of the climate.

In his book, *In the Niger Country*, Harold Bindloss (1898: 57) even provides a more vivid picture of the situation he observed at Cape Coast:

It is by no means an attractive place... Malaria fever is always there, dysentery and cholera strike the white man down, small pox is generally at work among the swarming natives, and a few years ago a scourge which was generally believed to be yellow fever, though the authorities said it was not, swept most of the Europeans away.

An example of the low rate of survivorship could be found in the earliest documented English trade expedition to the west coast of Africa, which was organised by a group of London merchants in 1553. It was a two-ship expedition, led by Captain Thomas Windham, who intended to buy gold at Elmina and pepper from Benin (Blake 1977: 143). About one hundred of the 140-man crew died, including the captains of the two ships, Windham and Pinteado, a Portuguese man. Nevertheless, the survivors returned with valuable cargo to England.

Malaria was the chief killer on the West African Coast and this contributed to the reluctance of European traders to venture inland. In spite of the heavy losses in human lives, however, the trade continued mainly because of the high profitability of the slave trade. The profitability was determined by the delivery of healthy slaves to their destination in the Americas and the Caribbean. That need also necessitated the employment of ship's surgeons whose duty was to ensure not only that healthy slaves were bought but also that they remained in good health until the delivery point on the other side. In a way, these processes led to the unplanned introduction of Western medicine to the West African Coast, albeit on slaves ready for shipment. However, it goes without saying that those surgeons who accompanied visiting European ships would have only serviced inhabitants who lived close to those settlements (Addae 1996: 9).

The colonial period

The early beginnings of modern health care under British colonial administration: 1843-1870

The significant historical landmark in the history of the Crown in what was the then Gold Coast was the arrival of George Maclean, an officer of the Royal African Colonial Corps, who took up duties on the Gold Coast in 1830 for the Committee of Merchants of London. His splendid administrative abilities and success led to the creation of what became the “Gold Coast Protectorate” which persuaded the British to resume control of the trading forts from 1843 on. The coastal Fanti states signed a bond in 1844 and came under direct British protection and justice administration. The Danes negotiated all their forts to the British in 1850 at a cost of 10,000 British pounds and left. By Letters Patent dated the 24th January, 1850, the British Forts and Settlement on the Gold Coast were separated from Sierra Leone and became a distinct dependency of the Crown, with their own Governor and Executive and Legislative Councils (Kimble 1963: 168, Claridge et al. 1915: 474).

When officials replaced merchants as rulers, they undertook the construction of roads and railroads, provided sanitation, recorded scientific observations and introduce health measures. British government subsidies was four thousand pounds per annum and was limited to exceptional ventures such as the construction of port facilities and railroads or grants for pacification. In order to carry out the social programmes the colony needed, the money had to be found from within the colony. At that time, there was no official national health system in Britain and the service was provided mainly through voluntary or charitable hospitals, which were tax financed. Meanwhile in 1850's England customs and excise taxes provided almost two thirds of the revenue of the government (Clapman 1932: 423). The natural tendency then was for British administration to pursue a policy in the colonies similar to what prevailed in Britain. Since all the money needed for development could not be found through indirect tax mainly because of Merchants constant opposition to that and the fear of smuggling to nearby ports that such an increase could lead to, they resorted to direct taxation. The decision therefore was that if Gold Coasters (Ghanaians) needed health care they would have to pay for it.

In 1850 therefore, the Colonial Secretary of the Gold Coast, Earl Grey proposed direct taxation to supplement custom duties to generate additional revenue for social infrastructure and services like road extension, establishment of schools and hospitals and sanitation. He also realised, however, that direct taxation without a regular government for the whole territory would be an imposition so he decided to do so only with the general consent of chiefs and their people at the coast (Knoll 1967: 434). As it was, Governor Stephen J. Hill

(1851-53) succeeded in 1852 in getting some Fanti chiefs around the British settlements to agree to form a Legislative Assembly and to a Poll Tax of one shilling for every person in the towns and districts under British protection. Some of the proceeds of the Poll Tax were to be used for medical work.

From the very beginning of Crown jurisdiction, however, the socio-political background of the Gold Coast through the impact of pre-colonial merchant control experience brought mixed blessings to taxation policies. Local chiefs were involved in the indirect rule as road construction supervisors, tax collectors and sanitary inspectors in spite of the opposition of some British governors such as Governor H.T. Ussher (1879-80) because they perceived the chiefs to be superstitious and ignorant. On the other hand, the creation of an experienced ruling class through informal British rule also created its own problems for the colonial office. African and European elites and merchants became a community of interest that resisted fiscal levies of the government and exerted concerted pressure for tariff education using the chamber of mines in England. African chiefs also adopted petitions to impede the enforcement of direct tax measures. The Fanti chiefs and elite in particular adeptly used democratic devices of petition and remonstrance to relieve themselves of taxation, an unwanted responsibility of local self-government. As a result of the persistent opposition, the poll tax had to be abandoned after a few years. Kimble (1963: 189-191) reports that the poll tax failed after a few initial successes because of the failure to eradicate abuses of the system. These included dishonesty on the part of officials appointed to assist in the collection, improper keeping of receipts and an irregular system of auditing. While chiefs were paid stipends, benefits that were stipulated for medical officers and hospitals were not honoured and there was scarcely any expenditure for the public good. Persistent opposition to the poll tax therefore led to its total abandonment after a few years of operation.

The attack on direct taxation was pursued with so much vigour that successive poll, hut, municipal and maintenance taxes had to be abandoned and with it the opportunity for developing social services, including health related ones. Nevertheless, in the few years that it lasted, health care was free because Gold Coasters were paying poll tax (Ofosu-Amaah, personal communication).¹ From the beginning, the administration established posts for the Poll Tax Doctors or "Doctors to the natives". The first two such doctors were Dr. J. Jenkins and Dr. R. Clarke. Others were soon appointed to the various British forts and settle-

¹ Professor S. Ofosu-Amaah is a distinguished Ghanaian public health practitioner with a long career in public health practice and education in Ghana. He was a key architect in the founding of the Post-graduate School of Public Health at the University of Ghana, which was set up with core funding from the Rockefeller Foundation. He became its first director and has also worked with UNICEF in New York.

ments with the instructions that the natives were entitled to gratuitous medical treatment from the physicians (Blue book 1955). Army doctors were also appointed to undertake part time duties. For example, in 1857, Dr. Martin was appointed to the office of colonial surgeon on a salary of hundred pounds per annum with the understanding his duties included attending to the natives. His decline of the position upset the Governor so much that he wrote to the colonial secretary in London complaining about how Dr. Martin expected to be paid five pounds a day for merely attending to the civil servants in Accra who happened to be only one person, Mr. Bannerman, a native and his son.² Part of the expenditures, such as the salaries of doctors, would have been financed from the 4000 pounds grant from Britain. However, by the 1870s the poll tax had stopped and the colonial administration started charging small sums for those who used the system. In any case by that time only a few people would have been using the new health system because the alternative medicine was very strong.

Essential foundations of the Gold Coast Medical Department: 1872-1920

The essentials that finally led to the creation of a colonial medical service started in the last quarter of the 19th century. Britain became the sole European power of the Gold Coast in 1872. This followed the Dutch cessation of their Gold Coast territory to the British in April of that year. From 1874, British power began to spread beyond the coast following the defeat of Ashanti. Then by letters Patent issued on 24th July 1874, the Gold Coast Forts and Settlements (with Lagos) were separated from the government of Sierra Leone, and were 'erected into' a Colony (Kimble 1963: 302). Rapid expansion of the administration, necessitated by additional responsibility to keep the law and peace beyond the coastal settlements and forts, was accompanied by a rapid expansion of British business in commercial and mining areas as well as missionary activities. By the late 1890s, European population shot up to six times what it was in the latter 1880s (Addae 1997: 29).

The population increase, however, created constant concerns for European health as a result of high death rates among them. This concern prompted the need to channel resources of the colony into securing their health. This led to the build up of a civil medical infrastructure, virtually from scratch, in the colony from 1890. An effective medical policy therefore became necessary from 1890 for two reasons: consolidation of British power and influence and concern for European health with the principal aim of reducing the abnormally high mortality of Europeans resident in colonial tropical climates, principally due to malaria. During that period (the 1880s), a Gold Coast Medical department

² Ofosu-Amaah S., unpublished monograph.

was established, headed by a physician entitled Principal Medical Officer (PMO), who was designated to administer the department. This remained so until 1923.³ He reported to the Governor through the Colonial Secretary, just as all departments did at the time.

The primary mission of the colonial medical services during the early decades of colonial rule was first and foremost to protect the health of European officials and then other Europeans. Their next duty was to look after African civil servants, the military and police, inmates of gaols and asylums. Although little attention was paid to the native population, they were not completely ignored. Apart from self-interest however, there were genuine reasons for the European bias, such as “lack of resources and public (native) response” (Patterson 1981: 12). A medical officer travelled constantly under difficult conditions, as it were, to cover the wide area allotted to him. In between a doctor’s visit, a dispenser remained in charge of the health outpost.

The emphasis on European health however, led to the provision of affordable medical resources at centres where there was an appreciable concentration of Europeans, while purely African towns had none. The effect was that in the 1890s, hospitals and health facilities were spread along the major towns on the coast and in the south of the country to the disadvantage of the inland and northern parts of the country.⁴ As a result between 1878 and 1915, a European had about 300 times greater chance of admission into a hospital bed than an African, while one bed was available to 70 Europeans, the ratio for the African was 1 to 22,000 (Addae 1997: 30).

As far as cost of health care was concerned, the system that was arranged during the time by the British was that private people would pay some money whereas people who worked in the civil and public services such as the police were given free health care. The fee charged to private people was half a penny, which was equivalent to two farthings. For a long time this situation remained the same until 1930-31 when, as a result of the great depression, the Gold Coast medical department decided that they would raise the fees charged private people from half a penny to one penny. One of the remarkable things about hospital charges during the period was its equity. Higher income workers were

³ At the Crown level the concern for the high death rates of Europeans led to a campaign led by the then Secretary of State, Joseph Chamberlain for the establishment of Schools of Tropical Medicine in London and Liverpool in 1898. Their principal aim was reducing the abnormally high mortality of Europeans resident in colonial tropical climates.

⁴ For example, in 1878, army medical facilities located along coastal towns such as Keta, Accra, Cape Coast and Elmina were turned into civilian facilities. A civil hospital with admission facilities was also built in Accra. In 1890, four more health facilities were built Dixcove, Saltpond, Winneba and Ada.

expected to pay more when they exceeded their limit within which free care was provided. For example, in “The General Orders of the Gold Coast Colony 1907 – revised up to 31st December, 1907”, it was stated that Government Officers with salaries of 250 pounds and over and their wives and children were charged 3 shillings and 6 pence while those with salaries under 50 pounds were charged 6 pence per diem on native wards. For persons not in the Government Service, natives other than labourers and paupers such as clerks, auctioneers, goldsmiths and their wives and children paid a per diem of 2 shillings and 6 pence while labourers and their families paid 1 shilling for the same facility. Service was free for paupers (Konotey-Ahulu 1973: 1-2).

African reception to modern health care

One issue that is worth considering in the present context is the African reception to modern medical care. As it were, the initial official neglect of Africans began to change and Africans who were not in the Government service were granted some limited attention and those who had access were even encouraged to use the service. This change in official attitude must have been stimulated by a sense of responsibility for African welfare. However, the initial response of natives, especially non-officials, to hospital admissions in particular was near boycott. A number of factors accounted for it.

Before the advent of colonial rule, the native Gold Coaster was used to indigenous medicine provided by the traditional healer whose cosmology was based on physical as well as social causation of illness (Twumasi 1975). Their services included consultations, treatment of ills and prevention through protective charms. Experienced healers passed on their skills through apprenticeship training. However, due to lack of appreciation and understanding of their practice, the British administration sought to eliminate the activities of traditional healers during the colonial period. The administration thus devised a method to neutralise the influence of healers through a so called “enlightenment” campaign directed at educated Africans, urban dwellers and opinion leaders, which characterised traditional healers “to be insincere, to be quacks who lived on the neurosis of their illiterate folks” (Twumasi 1981). Indeed, without any mandate or legal backing for their practice, they could only practice in secrecy and isolation. In their own way, missionaries contributed to the denigration of the practice of traditional healers and Christian followers were encouraged to shun them. These negative campaigns notwithstanding, the ordinary local African was so used to the native healer and his social and spiritual theories of disease causation and the remedies provided that the

modern physician and his remedy were considered alien and something they found difficult to relate to. As Patterson (1981: 15) describes it:

The colonial physician was often a puzzling figure for Africans. He was usually a white male stranger who had to use an interpreter. He often asked impolite questions, demanded (for reasons unknown to patients), samples of blood, urine and faeces; and sometimes cut open the bodies of the dead. On the other hand, he frequently had great power over sickness and injury.

At the beginning, therefore, most Africans preferred indigenous traditional medicine to modern medicine and their prejudice towards the latter and its practitioners kept them from seeking help from them.

Another reason that accounts for the attitude of ordinary Africans towards modern health care was that many of those who were admitted died for the simple reason that they often reported late for treatment. They attended a doctor only after everything else that they had known and experimented with had failed. This did make them somewhat prejudiced towards the new service without any suspicion on their part that they were partly or fully responsible for the deaths. Their prejudice was particularly strong in cases of chronic diseases, which required long periods of hospitalisation. Even when threatened by an outbreak of epidemics or death, they were reluctant to submit themselves to hospital treatment (Addae 1997: 58). For example, in 1899-1902, when there was a severe outbreak of small pox along the coast, attempts by the government to isolate victims and vaccinate the general public was unsuccessful and so the government resorted to a system of giving the chiefs monetary incentive of a farthing or half a penny for every person that was vaccinated before people came for it (Patterson 1981: 70, Ofose-Amaah 2001).

Furthermore, another significant factor that accounted for the initial rejection of modern medicine must have been related to the payment arrangements. Before the inception of modern medicine in the Gold Coast, most elders knew what readily available herbs might be used for the cure of certain common ailments. If a family member fell ill, one of these remedies would be tried. However when that remedy failed, a traditional healer would be called in. If a healer decided to treat a patient, the sick person's kinsfolk would appoint one from among themselves as the *okyiginafo* or supporter or representative. This representative discussed the details of the treatment with the healer and took responsibility for any fees to be paid or for procuring any supplies the healer would require. Before the healer prescribed any medicine to the patient, he discussed with the representative the *ntoase* or deposit that ought to be paid (Busia 1962: 14). Traditional medical care therefore was not free per se but the payment arrangement was reasonably flexible and negotiable. The cost of

treatment varied (and still varies), depending upon several factors including the type of practitioner, reputation and client's financial status. The mode of charges and payment also vary. The sick person might be asked to provide money but also things such as eggs, fowls or sheep. Payment might be made in advance or after the treatment, but significantly, a client was not denied treatment for inability to honour immediate charges. Credit arrangements would be made when necessary and in some instances treatment might be given for free, but the service was not free per se (Asenso-Okyere 1995). The modern medical care that the British were offering did not involve or allow negotiation in price, nor were they made to understand the need for the amount of money that they were being asked to pay.

Given the foregoing reasons, it was not surprising that when the first Hospital and Dispensary Fee Ordinance was enacted in 1898, the first response of Africans was to stay away from health facilities⁵. The fees prescribed for government officials and their dependants was a small per diem only in the case of admissions while non official Africans paid between six pence to three shillings and sixpence per day depending upon the type of occupation and status (Konotey-Ahulu FID 1973). Paupers were exempted. However, although the fee was small, it was still expensive for ordinary Africans. It must be said though that this negative attitude to fees was not peculiar to Africans. Non-official Europeans who were also required to pay a small fee to the hospital and the medical officer when they sought treatment often complained that hospitalisation fees were excessive and preferred, when ill, to remain in their quarters rather than incur the hospital admission fees.

The point that needs to be emphasised here is that the system of health care that the colonial government introduced in the Gold Coast was that private people paid for health care in the government system while civil servants were exempted. That this was the case was not surprising because at that time there was no national health system in Britain. Hospitals in Britain at the time charged for services, though poorer people were sometimes reimbursed, but even so it meant paying for the service in the first place. The need for a national health service was widely recognised in Britain throughout the 19th century but it took the experiences of World War I, the great depression, and World War II which was the real impetus, before a national health service finally came into being (Eckstein 1958: xvii).

⁵ Addae also cites Dr. B. W. Quartey-Papafio's report of 1899 on African reluctance to use dispensaries serving Saltpond on account of fees in GCGRMSD (1899: 261) as well as several colonial documents of despatches to the Secretary of State for the Colonies regarding complaints about fees. See especially Addae, *ibid.* page 98.

A significant health care development that took place around the end of the first decade of the 20th century followed a major outbreak of yellow fever in 1910-11, when the Colonial office sent a “Yellow Peril” team under Sir Rupert Boyle to the Gold Coast to investigate. By the time the team arrived in the Gold Coast, the epidemic had ceased, but the team went ahead to make recommendations for combating future epidemics. The most contentious proposal of their recommendation was to segregate Europeans from native dwellings with at least 400 yards of no man’s land. As expected, there was great resentment, particularly from European merchants who lived near their stores and warehouses for trade purposes and from educated Africans and politicians who read a racist meaning into it. Some disagreements even came from Governors in other colonies of the West Coast for fear of potential political effects. Nevertheless, the Colonial Office was firm about their decision and carried it out.

When Governor Hugh Clifford assumed office in 1912, he was dismayed by “the conservatism, racism and complacency of much of his medical staff” and made it a priority “to afford to the native population of the colony a larger share in the benefits of European medical science than they enjoyed” (Gale 1973). European mortality rates had been reduced considerably by then, and there was a growing awareness of the “trusteeship” role of the colonial government. However, due to wartime pressures and the limited European medical staff at his disposal, he could not do much. Nevertheless, he tried to draw on his previous experience from Ceylon (present day Sri Lanka) where he was previously the governor, to establish dispensary schemes involving the employment of great numbers of African medical auxiliaries: nurses, midwives, dispensers, vaccinators and other subordinate staff. He left office in 1919, with a legacy of 28 dispensers and 64 nurses in the major hospitals of the colony. It was also he who prepared the ground for the social and infrastructural landmarks undertaken by his successor Governor Guggisberg, which included the first African Hospital for the Gold Coast: Korle Bu Hospital.

The firm foundations of medical services in Ghana: 1920-1930

The construction of the firm foundations for medical services during the colonial period in Ghana is, however, credited to Governor F.G. Guggisberg. Construction began the 1920s and continued to the independence period in the 1950s. The period saw the transformation of the medical service and facilities into a modern state. The general medical policy of the Guggisberg government was to deal with diseases in the order in which they most affected the general life of the people. The Gold Coast Hospital, Korle Bu, that he commissioned in 1923, was in the following next year equipped with the most modern and latest technology of the time, and for many years judged to be the most sophisticated hospital in Africa. Its success derived not only from the treatment of diseases; it

also became a teaching centre for nurses, midwives, dispensers and sanitary inspectors. This was in keeping with the fact that as early as 1923, the general African appreciation of government health facilities was rapidly increasing, thereby made it necessary for the government to progressively increase hospital accommodation in existing hospitals or build new ones.

In 1924, Guggisberg introduced the first ten-year development plan for Ghana. It involved a £25 million expenditure which had far reaching implications for economic, educational and health development in what was still called the Gold Coast. For this, he went into the history books of Ghana as the untiring person whose foresight, hard work and devotion to duty was responsible for the initiation of a basic infrastructural network for socio-economic development. His administration was the first to enunciate, in clear terms, a public health policy, that was both comprehensive and largely executed. This public health policy was organised under eight headings that included care of the sick, professional training of African medical and public health officers, sanitation and improvement of towns and villages and medical research. The care of the sick was no longer exclusively confined to Europeans. The majority of the hitherto ill-designed hospitals and dispensaries were re-designed and built in larger towns. Throughout his administration, expenditure on public health and services ranged between 16 and 18%, the highest ever (Addae 1997: 66).

Despite his genuine concern for public health and the advancement of Africans in government service, Guggisberg refused to appoint African doctors to a common list with Europeans. In a speech in Britain, he argued that half of the Africans with MD degrees were incompetent. Africans hit back at the discriminatory policy against them; he was able to find very few among the handful of Gold Coast physicians who would accept appointment under terms inferior to those of Europeans. The number of African physicians in the service grew very slowly throughout the twenties and the thirties. One of his more liberating innovations was the hiring of female physicians, variously titled Women Medical Officer (WMO) or Lady Medical Officers (LMO). They had inferior status and, like their African male counterparts, were not members of the WAMS. But whereas African Medical Officers (AMOs) had rights to private practice and MOHs had an extra stipend of 150 pounds in lieu of private practice, WMOs had none. The WMOs were nevertheless very effectively engaged in work at infant welfare centres and his new children's hospital and maternity hospital (Patterson 1981: 14). His passion for native education also led to plans to the establishment of the University of Ghana and a Medical School at Korle Bu, although the latter had to wait to be implemented by an African government.

Latter stages of colonial medical services: 1931-50

Like the situation in Britain, the nature of the health policies adopted during the thirties and the forties were shaped by the depression of the 1930s, and the outbreak of the Second World War in 1939. Together these factors laid bare the weaknesses, shortfalls and problems of the health system. The first problem was related to finance. As a result of the depression and the war, revenue to the public health sector was highly curtailed and this halted any further expansion. A number of already existing hospitals and dispensaries were closed down or downgraded (Addae 1996: 74). Ironically, hospitals had by that time become the basic health care unit in colonial Ghana with one or more resident medical officers. Africans' confidence in modern medicine had by then been won and people went to outpatient clinics for most complaints; those who had serious conditions and would agree to hospitalisation were admitted to the wards. However, although the number of hospitals and beds had increased, the number of African hospitals and African hospital beds remained small and static, even though the annual number of African patients rose astronomically (Patterson 1981: 17). The cumulative effect was overcrowding at hospitals and dispensaries, inadequacy of the medical staff and deterioration of sanitary conditions.

In order to deal with the health care problems of the time, one measure the colonial government took was the replacement of the West African Medical Service with the Colonial Medical Service in 1934. This transformation was done in an effort to Africanise the service personnel and doing away with the British bias in the service. Another way the government dealt with the problems was to extend the responsibilities of medical officers beyond the districts they were originally assigned. Similarly, responsibilities of junior personnel such as dispensers, nurses and nurse-dispensers were also extended while new nurses in training and new dispensers were engaged. Village dispensaries were put in charge instead of nurse dispensaries. Hospitals were complemented by dispensaries, which were usually located in rural areas and supervised by African dispensers who were periodically visited by a medical officer. These were geared towards outpatient care; bed space was limited and serious cases were referred to hospitals. The foregoing measures, while solving one problem, undoubtedly over-stretched the facilities and compromised the quality of care.

The government also sought to solve the problems of revenue shortages at the period by encouraging Native Authorities to build their own village dispensaries for which Africans' preference for outpatient treatment would support. Local or regional administrations provided subsidies in the form of building materials, drugs, dressings, equipment as well as trained medical personnel to

communities that built their own dispensaries according to approved plans.⁶ These measures, though, were cosmetic responses to the deep-seated problems that plagued the service at the time.

The desired major policy changes that the health service needed were initiated when Sir Alan Burns became Governor of the Gold Coast in 1941. Having served under Lord Luggard in Nigeria, Governor Burns was sympathetic and well in tune with African opinions. Against strong opposition of the medical department, he advocated and obtained the abolition of the segregated hospitals and the gesture freed additional hospital accommodation for Africans. In a five year development plan⁷ that he published, Sir Burns sought, among other things, the immediate and long-term remedy of the appalling overcrowding, the upgrading and extension of existing hospitals and construction of several new ones. This position of Burns which privileged cure over prevention was however opposed by his DMS, Dr. Balfour Kirk, who rather preferred to place emphasis on preventive work to curative work. Burns countered that Kirk's position would provoke a storm of indignation and gravely imperil the reputation of government in the eyes of Africans. The Secretary of State provided a truce to support immediate long-term measures to improve hospital accommodation and also promote preventive medicine based on a suitable balance between the two approaches (Addae 1997: 77).

In August 26, 1942, the Governor made a 13-point Regulation under the Hospital Fee Ordinance in which outpatient charges were increased for the first time from their 1907 levels. One important aspect in the new pronouncement was that within the limits permitted, the amounts charged in any particular case were subjected to "the discretion of the medical officer concerned, and the approval of the Director of Medical Services" (Konotey-Ahulu 1973: 5). This left a gap for financial abuse of the system. What the 1940s is best remembered for is that it became a period of grand plans and proposals for new hospitals and health centres, including a ten year hospital development plan, which could not be implemented as a result of shortages of building materials, delayed implementation and revenue shortages. Dr. Kirk's grand proposal embodied the establishment of a network of several rural health centres in small communities around major hospitals. To date, the rural visionary plans of Kirk remain the means by which health services reach the majority of rural people in Ghana.

Another element that is worth mentioning is that until 1946, the Colonial government allowed specialists to have private practices so ordinary private

⁶ This scheme first took root in the Northern territories in the mid-1930s, to be followed by others in other parts of the country in later years. pp76 [GCGRMSD (1933/34) P. 44.]

⁷ Sir Alan Burns (1944) Five-Year Development Plan, Government Paper on Development for the Gold Coast, Accra: Government Printer.

Ghanaians paid them directly, even in the government hospitals. From 1946, however, although the Secretary of State had issued a clause in their letters of appointment prohibiting them, no regulations were issued to stop them. Naturally, it could not be stopped since not all received the notice in their appointment letters. In effect, some patients paid more while others paid less. Some of the professional fees paid ranged between 2 shillings and 5 shillings for brief outpatient visits to medical officers, while outpatient visits to a physician or surgical specialist cost two pounds two shillings. The Gold Coast had actually the cheapest fees for such services.

The period before independence: 1951-1957

When the first African government assumed internal self-rule in 1951, it inherited a medical service that was tremendously curative with several inherent weaknesses. The success of vaccination campaigns and modern treatments against previous outbreak of yaws, *trypanosomiasis* and small pox as well as other diseases such as leprosy, venereal diseases and pneumonia, had led to public confidence in the medical services. However, the success of modern medicine also became a source of limitation since it could not meet all demands and expectations. At the beginning of 1951, rural health had only three health centres and virtually nothing to show in terms of preventive medicine, yet rural populations were the ones that needed them most. By and large, colonial medicine had ignored the rural communities due to its highly biased primary policy of securing European health. When the new African government assumed power, one of the things it sought to do was to develop a policy framework for the development of health services in the country.

The most important change in the early fifties was the incorporation of the Medical Department into a Ministry of Health headed by an African with the administrative machinery also headed by an African. Furthermore, it sought the services of Sir John Maude, a former permanent Secretary of the Ministry of Health in the United Kingdom to head a commission to review the health needs of the country. Its terms of reference were defined as:

To review the measures taken and projected in the Gold Coast, either by government or by enterprise; for the development of preventive and social medicine, including health education; for the development of curative medicine, including the provisions for hospitals, health centres and dressing stations and for the training of personnel; for medical research; to examine the adequacy of the administrative structure and organisation of the Medical Department in relation to such development; and to make recommendations (Maude 1952: 5).

Among its significant recommendations were:

- i. Hospital fees and all charges were to be abolished;

- ii. The building of more health centres and dressing stations;
- iii. Hospital and health centres were to be under the control of the central government, but dressing stations and maternity homes were to be the responsibility of local government;
- iv. Large municipalities employ their own MOH's and should operate school health services; and
- v. Urban and district councils were to be responsible for sanitation in rural and urban areas.

Although the recommendations of Maude were far reaching, some were misjudged. For example, the separation of hospitals from public health units under two authorities created confusion. One of the greatest aberrations was the recommendation regarding hospital fees. Throughout the colonial period until that recommendation in 1954, medical charges were levied. Minor modifications were sometimes made in the grading of hospital per diem, but the principle of fee charging did not change. In general the private patient seeking treatment in a government hospital was liable to pay: a private professional fees, a statutory dispensary fee, and the cost of any medication prescribed.

The statutory dispensing fee actually did include the cost of any medicine prescribed although where the patient was able to pay, a charge was made and credited to government revenue (Konotey Ahulu 1973: 5).

The regulations were interpreted literally and so "patients in the Gold Coast were made to pay the cost of drugs dispensed rather than pay something towards the cost". Whether deliberate or inadvertent, a circular from the chief medical officer in 1955 confirmed that prices fixed were "carefully calculated to equate actual cost price to ourselves from Crown Agent sources plus a 15% marginal charge for overheads". Maude's recommendation that abolished it placed successive governments in great difficulty in terms of raising revenue to finance the health sector.

The best way to appreciate the far-reaching recommendations of Maude, particularly regarding fee charging, is to place them in the context of overall British politics at the time. Significantly, in 1951, the British Labour Party was in power in Britain and as a matter of policy, the party saw all health care as socialised. The Labour Government of 1945-51, led by Clement Attlee, in its first majority in parliament, introduced substantial reforms that created the National Health Service (NHS), established a universal state welfare and nationalised 20% of British industry (Fielding Stephen 1995). Among the key principles of the NHS in Britain that might have influenced Maude's commission were that everyone was eligible for care, including those who were temporarily resident or visiting and such care was entirely free at the point of use. The British service however, also *clearly indicated that the service was financed*

almost 100% from central taxation and the rich paid more than the poor for comparable benefits. Yet Maude prescribed a free health care service for Ghanaians *but failed to analyse how the government of the Gold Coast, (later Ghana) was going to get the money to finance their health system.* That created an everlasting problem for health financing in Ghana, one that has plagued them to date.

It must also be emphasised that user fees at the point of use are merely a small amount that supplements or reduces the recurrent expenditure of the service provided. The major financial burden of providing health services such as capital cost was borne by the colonial government. Apart from the government, missionary bodies shared some of the work of providing health care in Ghana. Therefore, it is important to take a brief look at the missionary contribution.

The contribution of the missionaries to health care

The introduction of Western medicine and public health in colonial Africa was in most cases, pioneered by Christian missionary societies during the last quarter of the nineteenth century and the early decades of the twentieth century. Initially, most of the missionaries sought to propagate the gospel without a commitment to the health needs of their potential converts. However, the realities of the appalling endemic and epidemic diseases compelled them to pioneer medical services to their host populations (Goody 1988: 14). In many territories, missionary hospitals and dispensaries were in place several decades before the colonial government accepted any general responsibility for African health care. Unlike Medical Missionary work in other British colonies, such as Nigeria or East and Central Africa which were begun in the late 1800s, missionary hospitals were not started in the Gold Coast until 1931, when the Basel Mission started the Agogo hospital in Asante Akim. This was followed by the Catholic hospital at Breman Asikuma in 1943. By 1951 there were two more at Jirapa (maternity) and Worawora. Before hospitals were started though, medical missions in the Gold Coast had taken off as small dispensaries, aid posts and clinics. The unique feature of the spread of missionary health services in Ghana was the fact that unlike the government facilities, they developed in the rural or least accessible parts of the country.

Between 1951 and 1960, the growth of mission hospitals jumped from 3 to 27, which were distributed all over the country, particularly in the Northern Territories, Ashanti and the Volta Regions. This growth in mission hospitals was facilitated by the government's acceptance of the policy, advocated by the Maude commission, of enlisting the aid of missionary societies and other

voluntary agencies in the provision of health facilities. Although the missions built and ran the hospitals, the government provided grants-in-aid to them to facilitate their work.

One remarkable aspect about the mission facilities, as far as health financing is concerned, has been that the collection of user fees had always been part of their operations. No common fee schedule exists as such, and user prices might vary from mission to mission and from Church denomination to denomination; but some mechanism exists by which fees are matched with the costs of the services provided. Such charges usually covered recurrent expenditures; the full cost of drugs was passed on to users. They nevertheless granted exemptions to the poor. Their ability to do this has likely been helped by the fact that since they operate mainly in the rural settings where people are likely to know one another, identification problems are not difficult to deal with.

The government recognizes the significant contribution of mission health facilities and makes a budgetary provision for subsidizing their operations. This is channelled through the Christian Health Association of Ghana (CHAG). CHAG was started in 1967 with the help of the World Council of Churches, the Catholic Bishops Conference of Ghana and the Christian Council of Ghana and duly registered under the Trustees (incorporation) Act of 1962. Its mission is “to provide holistic, affordable and quality health care in fulfilment of Christ’ mandate to go and heal the sick” (CHAG 2000). In order to achieve this mission, CHAG collaborates with the government and its stakeholders. The missions, represented by CHAG, are presently the largest single provider of health services after the government with 128 health institutions, 49 of which are hospitals. The government now provides about 80% of the salaries of health staff.

CHAG meets periodically to discuss pricing policies and to compare ranges of prices charged for specific forms of care and procedures. Price revisions are carried out based on changes or increases in the average prices of supplies and equipment that they buy from the free market. Since 1979, most of the drugs and pharmaceuticals that they use have come from foreign donor sources. These donations are channelled through the Christian Medical Commission of the World Council of Churches in Geneva. It depends upon its own resources to import any pharmaceuticals that its members desire over and above those received from donors.

One significant observation about mission institutions is that there is a public perception that the quality of the service they provide is superior to that of government-run health care facilities in the sense that staff are more dedicated to their work and provide a friendlier interpersonal environment. One fundamental problem that they experience is finance. As a non-profit organization devoted to serving the poor, CHAG operates mostly in the remotest parts of the

country where user charges are far below the cost of the services rendered. Although they implement their own exemption policy, their financial situation has been made worse by the government's wholesale exemption policy for certain categories of patients. Those exempt are children less than five years, pregnant women and those aged seventy years and above. The source of the problem relates to the government's inability to refund institutions the exemptions that are provided on a *timely* basis. Given that mission facilities receive higher patronage by such exempted patients as compared to alternate government facilities, the revenues from these exemptions are quite substantial.

Apart from the missions, other quasi-government concerns, mining companies and private individuals also made modest but important contributions to the growth of non-governmental health facilities from the 1950s. In the early stages of their inception in Ghana, most of them were situated in the colony and South because of the location of mines in those areas. Educational institutions in the colony and Ashanti areas ensured that quasi-government hospitals were built there. Nowadays, most private modern health care practitioners are mainly found in urban areas. Since they thrive on full cost recovery and profits, users pay for all the services they receive. Their charges, however, vary from facility to facility depending upon location, services, reputation, amenities and the goodwill that the provider(s) commands in the population. User fees in private facilities tend to be beyond the means of ordinary people since there does not appear to be any regulation on price setting.

Postcolonial health care and its financing: 1957 to date

When Ghana eventually attained internal self-rule, the Nkrumah government launched a 10-year development plan in which a huge investment in the social development of the country was sought. The health component of this included the expansion of the number of existing health facilities, while cost to users of these facilities was made either very low, or in most cases, completely free. Private practice was abolished in government hospitals in September of that year to forestall the policy on free health care. This was followed in 1961 by the banning of private professional fees charged by government doctors, dentists and specialists. In lieu of those fees, the government paid an annual allowance.

Further concessions were offered to various categories of Ghanaians in May 1962. This included free outpatient care for Ghanaian and non-Ghanaian children and adults resident in Ghana. Civil servants and members of the security services were charged a token fee for in-patient treatment and drugs. Mission hospitals that were charging fees for their services were reimbursed for services provided to the various categories of people. Pragmatic measures were

also introduced for the rural areas. Thirty-five new rural health centres were established between 1960 and 1966 (Senah 1989: 250). In line with Nkrumah's 'African personality' agenda, steps were initiated to study and organise traditional healers to form an association for the advancement of their techniques in the delivery of health care.

It did not take long for the impact of the socially inspired programme of Nkrumah to take its toll on the economy. It led to shortfalls in revenue for most parts of the 1960s, which eventually compelled the government to impose foreign exchange and import restrictions in 1965. In the area of health, the restrictions affected capital-intensive equipment, essential drugs and supplies with attendant shortages and inadequacies in service delivery. Ghanaian doctors, who had inherited the elite and conservative disposition of their colonial forebears, became aggrieved and critical, and vented their frustrations on the Nkrumah government.

The military regime of the National Liberation Council (NLC) that toppled Nkrumah's government in 1966 was ideologically pro-Western and introduced policies that sought to divest the state from the socialist programmes pursued under Nkrumah. It appointed a committee headed by Dr. Easmon to investigate the health needs of Ghana. Among many suggestions, the report of the committee recommended not only the raising of hospital fees but also the strict enforcement of their collection. Because of these recommendations, a statutory dispensing fee (30 new pesewas) was introduced in February 1968, but the directive was withdrawn following public outcry. It was, however, re-introduced through an official gazette to be effective from October 1969 when the military junta would have handed over power to the new government of Dr. K.A. Busia. It was again suspended after public protest.

When the civilian government of Dr. Busia's Progress Party took office, the issue of health financing had become so sensitive that immediate measures had to be taken to resolve it. The Konotey-Ahulu committee was set up to investigate all issues relating to hospital fees in the country. In its far-reaching report, it recommended that outpatient treatment, including antenatal care, should no longer be free and that a nominal amount had to be charged for drugs dispensed. On the basis of those recommendations, the government introduced the Hospital Fee Act of 1971 in government health facilities with the aim of reducing excessive demand and contributing to recovering part of the costs of curative services. However, the charges imposed were so low that only a minimal percentage of total costs were recovered (Waddington et al. 1989). Other fees were instituted for referrals from lower to higher levels of the health care ladder. Again, apart from charges for private patients, fees for inpatient services were raised. Significantly, in the spirit of its vigorously pursued rural development programme for the country, attendance at rural health facilities was made free.

In addition twelve new health centres were established and electricity, feeder roads and piped-borne water supply were extended to the rural areas in the relatively short time the administration lasted.

The National Redemption Council/Supreme Military Council (NRC/SMC) overthrew the Busia government in a military coup after (twenty-seven months) in 1972 and ruled Ghana until 1979. During its term of office, hospital fees remained the same as they were during the Busia era, but moderate budgetary allocations were made to the health sector.

Things did not change much with respect to health financing during the Limann administration (an Nkrumah offshoot) that assumed power in 1979 after the stopgap administration of the Armed Forces Revolutionary Council (AFRC) regime. An important landmark in Ghana's health policy took place in the late 1970s when the Government of Ghana (GOG) adopted the primary health care strategy as the vehicle for achieving Health for all by the year 2000. But as a result of the economic crisis that drastically reduced resources available to the health sector in the early 1980s that resulted in the deterioration of the population's health status, the primary health care goal was never achieved.

The Provisional National Defence Council (PNDC) seized power from Limann at a time when the economic conditions and in particular the drug and medical supply situation were in bad shape. In order to prop up the situation, the PNDC introduced surcharges on imported drugs and hospital equipment, but this merely worsened the situation. The prevailing general poor economic conditions in the country at the time led to a mass exodus of doctors and other professionals. Patients did not only have to "scavenge" for their drugs from private sources, but they, in addition, had to carry their bedding, food requirements and sometimes even stationary with them when attending some public facilities. The response of the PNDC to the crises was to increase fees for hospital services. For the first time non-Ghanaians were asked to pay higher fees for medical services. Even this could still not salvage the situation; the need for more pragmatic measures became apparent.

In the mid 1980s when World Bank and International Monetary Fund structural adjustment programmes became a major feature of Ghana's economic policy, reforms in the health sector led to the introduction of user fees in public health care facilities in 1985 and full cost recovery for drugs. This was institutionalised as the Hospital Fee Law, otherwise known as Legislative Instrument 1313. From the point of view of the World Bank, user fees are a precondition for self-financing as otherwise the public would lack an incentive to participate when no- or low-cost health care is available through government facilities. Again user fees (together with self financing health insurance) is perceived as a measure that allow governments i) to allocate scarce funds from curative services to preventative measures to combat such epidemics as HIV, tuberculo-

sis and malaria and ii) to reallocate resources to needed subsidies for the poorest segments of the population with the worst access to health facilities (World Bank 1996).

The objective for the introduction of user fees in Ghana was to raise revenue and to deter frivolous use of scarce health resources. The regulation stipulated that patients were to pay the full cost of drugs and nominal fees for other services, except for vaccinations and the treatment of certain diseases such as leprosy and tuberculosis. Health institutions were to retain the fees collected in order to establish a revolving drug fund, even though these institutions continued to collect drugs free of charge from the central and regional medical stores. Consultation fees were charged according to the level of institution visited. Ministry of Health staff and their immediate dependents were exempt from all charges.

Although the measures led to some improvement in the drug supply situation in the public health sector, the attempt to recover part of the overall government health expenditures through user fees produced less revenue than expected. One serious setback was that it resulted in mixed effects on the demand for health care; some potential patients were precluded from health care because of their inability to pay for services. One of its internal handicaps was that although it stipulated that paupers and indigents were exempted, it did not say who was to pay when someone was exempted. Ignoring the lessons of history, people were thus exempted without knowing where the money to pay for them was to come from. Additionally, no controls were set up to monitor the monies collected and some health care staff took advantage of the situation to abuse the system through illegal charges and the proliferation of local charging practices.

In 1987, Ghana embraced the Bamako initiative programme as a means of solving some of its problems of access to health care by rural, deprived areas. The initiative was a programme adopted by African Health Ministers at a meeting in Bamako in 1987. The basis of the initiative was that UNICEF and WHO purchased drugs and sold them to communities at an affordable price. In turn, the community could use the savings to upgrade its basic health care system. Conceived to guarantee access to primary health care by all populations, the Bamako Initiative was considered one of the most important strategies in the area of health promotion. At one point it was implemented in 33 countries in Africa, Asia and Latin America, based on four components, namely:

- Revitalisation and extension of peripheral public health systems in order to provide a package of essential health care — training, equipment, micro planning, follow-up and supervision — through a policy of decentralisation of decision-making to the district;
- Adequate supply of basic drugs to ensure access to medical care at a reasonable cost;

- Introduction and enhancement of co-financing systems by the community in order to ensure their sustainability;
- Involvement of communities in the management of health care centres.

Ghana could, however, not make any progress with the initiative and virtually abandoned it after three years.

In order to deal with the problems of cost recovery system introduced in 1985, the regulation was restructured in 1992 under a scheme dubbed “Cash and Carry”. From that time, health institutions were made to pay for drugs they collected from the medical stores. The rationale behind the programme was to make health institutions more efficient in the management of drugs at the sub district level (MOH 1996). Although the scheme led to some improvement in the drug supply situation, there were problems with the way it was implemented, particularly in relation to issues involving availability and affordability for low-income patients, paupers and indigents as well as for emergency treatments. Other problems related to operational pressures, which made its capacity to revolve a difficult exercise for managers and the consequent negative impact on quality of care. To date, the problems of user fees for most households as Akosa (2001) summarises it, have been:

A gradual diminution in uses of health facilities because of affordability, resulting in 69% of the population unable to attend/use the health service. The majority have resorted to self-medication, herbal or traditional medicine, or healing crusades or prayers or resigned themselves to their fate not by choice but purely because they cannot afford health care.

Accordingly, one of the critical health care challenges for Ghana has been the obtainment of additional resources for the financing of health care without deterring the poor and vulnerable from seeking care when they need it. Other struggles have been to improve quality and access as well as manage resources efficiently. The search for alternative and/or supplementary means for health care financing became focussed on health insurance. It has been regarded with hope and enthusiasm as far back as the mid 1980s. The main thrust of the government for a social health insurance in Ghana is that Ghanaian social and cultural systems has an built in social insurance scheme through the extended family system whereby the family members have collective responsibility for the welfare of members of the family (Addo 1995). Most government officials (past and present) and many outside the government seem to believe that social insurance will help solve the government’s health financing problem, and that its introduction will release substantial resources from government revenue for preventive services. Indeed in 1997, the idea was taken a step further with an attempt by the then government to implement a national health insurance

scheme particularly suited to the rural informal sectors on a pilot basis in four districts in Ghana. Laudable as the idea is, the social and cultural problems and challenges of an insurance system that may prohibit a feasible implementation are empirically pursued by this research.

Concluding remarks

Colonial rule has always been intended to be profitable for the colonizer. Likewise, in the institutionalisation of modern health care in Ghana, it had a direct relation to the situation and interests of its bearers. British colonial administrators, with a monopoly over the governance of the state, used their position and privilege to set up a health service that enhanced their status and interests; i.e. protected the health and interests of European officials and merchants. The system they set up was therefore self serving and the legacy became an urban biased health care service. The service was curative oriented with hospitals located mainly in cities and major towns where European officials settled. At the dawn of independence, a vacuum was created in the manpower resource when many of the expatriate doctors resigned. Although the immediate post-independence government stepped up the training of local health professionals and provided facilities for their practice, with the building of additional health centres, it still maintained the curative emphasis of the health services.⁸ The number of health centres increased from 10 in 1957 to 41 by 1963. Indeed, it became more politically expedient for Nkrumah's nationalist oriented government to build modern hospitals and clinics than to promote public health.

Regarding the financing of health care, colonial health services were financed mainly through general taxation, apart from the small fees charged to non-civil servants. This, however, did not create a public problem because the service was at its early stages where public interest and patronage in alternative traditional medical service was rather high in the society. By the time of independence, when the use of modern health care services had picked up among ordinary Ghanaians, government policy on health was influenced by social considerations to provide basic health and medical care that was nearly

⁸ In 1964, the training of pharmacist and dispensary technicians was instituted in the new University of Science and Technology, which was opened in Kumasi. Also in the same year a medical school was opened in the University of Ghana and located at the facilities of the Korle Bu teaching hospital in Accra. Nursing training was also stepped up with the opening of new colleges and a new post, basic nursing, at the University of Ghana.

free. The cost of providing free health services, however, soon became a major problematic expenditure item for government. In a matter of time, free care became a myth. Drugs shortages in the public sector left patients with no choice other than to pay for more expensive drugs in the private sector or report at health facilities rather late and moribund. The solution to this was the introduction of user fees in the late sixties with the passage of the hospital decree of 1969 (NLCD 360) as a means of partial recovery from patients. Although user fees led to some improvement in the drug supply situation, it also resulted in limited access to health care for the poor, particularly the rural poor whose income were marginal and seasonal.

The pattern of the public health service financing has not changed from what was obtained in the past. The bulk of the expenditure is provided by the government and covers the services infrastructure, salaries and wages of health care personnel in both government institutions and non-governmental (mainly mission) institutions, running costs, training expenses and health education and promotional programmes. Significantly, a considerable portion (about 85% of the total annual expenditure), goes into recurrent expenditure, with little spent on maintenance and development of infrastructure. Donor assistance also constitutes a substantial source of funding. For example, when capital expenditures are excluded, donor pooled funds in 2000 constituted 20% of public health expenditure. This is significantly lower than the contribution in 1992, which constituted 28% of government expenditure on the health sector (Sudharshan et al. 2001: 31). These donations have mainly been in the form of supplies and equipment, drug donations, rehabilitation of health care facilities, training of human resources, as well as technical assistance in the area of disease prevention, organisational reform and institutional building. Overall, although government funding to the sector has been increasing over the years, health care delivery in the public sector has been deteriorating in quality and quantity mainly due to under-funding.

The lesson from history, therefore, is that the continued reliance on general taxation revenue and donor assistance to finance health services delivery in Ghana has created problems and thwarted the development of the service. Similar to the situation in other sub-Saharan African countries, it is this financial crisis in the public health sector that has brought into focus the need for additional financing methods and led to heightened interest in the development of social health insurance. In particular, solidarity based social insurance schemes have emerged in discussions as favoured options because of the peculiar socio economic and socio cultural nature of the Ghanaian setting. As in other sub-Saharan African countries, it has a low economic base, unplanned spending on health care, limited capacity of the ministry of health in terms of workload and lack of expertise on socialized insurance. Additionally, such a

scheme would entail a relatively poor and large rural informal population whose incomes are low and seasonal. Given such a socio- economic profile, it is questionable whether centralised state or large commercial schemes like those in rich industrialised countries would be feasible in the Ghanaian context (Arhin 1995; Criel 1998; Criel 2000). This is in spite of the factors such as a strong demand from the public for an alternative to a user fee system of “cash and carry”, an on-going decentralization process, which is steadily increasing management capacity at the district and sub-district level (MOH 1995).

The policy relevance of health insurance to the Ghanaian context therefore suggests the innovation of a “risk sharing mechanism employed to harness private funds for the health care and reduce the financial barrier faced by vulnerable groups to obtaining care” (Arhin 1995: 2). The organisation of such a scheme must of necessity become an action that must take the form of a social security programme, which takes into consideration the peculiar historical, and socio cultural imperatives of the population. It must also involve dialogue and negotiation with them in order to ensure that the package is socially and culturally acceptable to them. The foregoing lessons from history obviously provide some insights, but at the same time invite further questions and discussion about the context of existing social health insurance schemes as well as traditional mechanisms in Ghanaian society. These are tackled in subsequent chapters.

Overview of the three case studies

Introduction

The three community initiatives that constitute the subject matter of this research have different origins but a similar historical background. They were all conceived within the context of a need to make health care accessible to poor families in rural communities, but were initiated by different actors in the health care milieu. This chapter provides the background information of the three initiatives. It traces how each of them developed and how they survived or faded away. They are chronologically presented on the basis of when they emerged. Each section begins with a brief profile of the district. This is followed by a description of design features relating to membership and coverage as well as management and financial administration. I then examine how in each case study the parties involved in each scheme look upon insurance in terms of success and failure. The chapter concludes with a brief synthesis and questions of the socio-cultural challenges pertaining to the feasibility of community schemes in the Ghanaian context.

The Nkoranza Community Health Insurance Scheme

This is the most established and frequently cited health insurance scheme in Ghana. It was inaugurated in February 1992 by the Sunyani diocesan health

administration of the Catholic Church. Before I describe its origin, I will provide a brief profile of the Nkoranza district.

Brief profile of Nkoranza District

Nkoranza District is one of the 13 administrative districts in the Brong Ahafo region of Ghana. It covers an area of 2300 square kilometres and is made up of about 120 settlements. According to the 2000 census provisional report, the population of the district is 127,519 comprising 64,123 male and 63,396 females. It is ethnically diverse and hosts a large number of migrants from other regions, particularly those from Northern Ghana, who constitute about 65% of all inhabitants in the district. It is mainly rural and about 95% of the economically active labour force are subsistence agricultural workers. Forty-five percent of the people are below the poverty line with 17% being under the margin of hardcore poverty.

Infrastructure and social services in the district are inadequate and the conditions of roads, especially feeder roads, are poor. Only 6% of the population has access to electricity and the majority of them (90%) depend on firewood and kerosene for energy. About three quarters of the population depend on stream water for drinking, making the incidence of water-borne diseases very high. The district has one hospital, which hosts the insurance scheme. Poor sanitation and nutrition constitute some of the public health problems in the area. Similar to most parts of Ghana, malaria constitutes the major medical problem in the area with others being stomach disorders, rheumatism, boils, eye problems and hernias.

How did the scheme originate?

The story behind the formation of the Nkoranza Health Insurance Scheme dates back to the late 1980s. Following the introduction of user fees at 1985 in health facilities by the government of Ghana, Nkoranza hospital, like most others in the country, began to experience rising costs and unpaid medical bills particularly in relation to in-patient bills. The impact of the high bills was two fold, one a consequent of the other. First the effect of the rising costs on patients and their families as well as potential patients was such that many reported too late or could not afford the services of the hospital and so there was a significant rise in reported deaths from treatable clinical conditions. As a consequence, the stability of revenue accruing from patient attendance to the hospital suffered considerably. In 1989, the concerns of the policy makers of the Nkoranza hospital, the Catholic Diocesan Health Administration at the regional capital, Sunyani and the policy implementers at the hospital in Nkoranza led to discussions on alternative ways of financing health care.

Based on a first hand experience of what the diocesan secretary at the time, a reverend sister, had previously witnessed in Bwamanda in the Republic of Congo (Zaire), she suggested the setting up of a similar insurance scheme for in-patients in Nkoranza. A project proposal was written in 1989. In 1990 experts were consulted and MEMISA, a non-governmental organisation of the Netherlands was approached for technical and financial assistance to set up the scheme. Preparation of legal and other regulatory documents as well as consultation with traditional and opinion leaders in the district and the district health management team followed suit. The scheme was finally inaugurated in February 1992. Dr. Ineke Bosman, the Dutch-born Ghanaian district director of medical services and medical officer in charge of the Nkoranza hospital at the time, was responsible for coordinating the insurance activities. In a conversation with me, she narrated the details of the formation as follows:

First of all we had this new hospital building, which was completed from scratch in the late eighties, but was not accessible to the people even though it was relatively cheaper compared to other places like Korle Bu¹ in Accra. So we thought a community health insurance, something that the whole community pays together would help. The diocesan secretary at the time, Sister Marianne, had seen Bwamanda in Zaire and I had also done my Master's in public health at Antwerp so I had heard about it. Thus when she mentioned it I became interested and first discussed it with Madame Dora, the District Secretary at the time and the doctors and we all became totally enthusiastic about it. Call it luck but once you have all the people who mattered interested, it did not become a burden but an inspiration to do it. The Bishop and Marianne agreed that if we wanted to do it we could go ahead.

We therefore studied the original papers of Bwamanda in Zaire and travelled to Holland to visit MEMISA who upon consultation agreed to shore it up for three years. We read from the Zaire programme that they used printed stamps to identify those who pay their premiums at each renewal period so we made a request to MEMISA for similar assistance and they agreed to do it. Madame Dora was very supportive and I travelled with her to Holland for those negotiations.

When we came back, we held further meetings with the staff of the hospital and health centres in the district to discuss the problem of hospital fee until everybody became convinced that a prepayment scheme would be the most sustainable and practical way to deal with the health care payment crises in the community. From then on we started to talk to other 'big shots' and groups in town: opinion leaders, church leaders, teachers' association and education officers. After they had all given their blessing we constituted four teams in threes and fours and started a crusade into the communities to convince the people. We went to the villages early in the mornings with public address systems. Usually we sent messages ahead of our

¹ Ghana's first and largest teaching hospital in Accra.

arrival and organised durbars to explain the problem, introduced the idea to them to find out their reactions and answered their questions. We spent about three hours in a village and we could do about three or four villages in a day. After visiting virtually all the villages the reaction was overwhelmingly, 'YES we like it', especially among heads of families and households who had responsibility for shouldering medical bills. It was very tiring and at some point I fell ill with malaria but I liked the idea so I persevered because I knew I was going to succeed.

As part of our plans we also formed a strong advisory board team that was basically a facilitators group with responsibility for dealing with practical decisions involving the scheme and the community. It met every week and it included the DS and the chief and all the church leaders. So in short, this is how we basically did it. After the awareness campaign, we appointed fieldworkers in every village and divided Nkoranza township into several sectors because of its bigger size and assigned fieldworkers. Altogether we had over a hundred fieldworkers and instituted a bonus system to them for hard work. The fieldworkers went from door to door in their communities and ensured that households registered their whole families because if you only had the man with the hernia² registering then that was not good. Our policy was to do the whole family and to keep it simple we said everyone should pay the same fee.

From an operational point of view, teamwork was one of the most essential features that got it off the ground. Again, Dr. Bosman continued:

Our ability to get it started was much enhanced by teamwork. We had a team of dedicated people who had the patience and exuded power and respect in the community and that made a lot of difference to our success. It was a mix of all the community leaders including the chiefs and religious leaders because that is where the power is and we worked on humanitarian grounds without thinking about economic incentives. So basically the community did it. We, as health implementers, were partners. There was a young Catholic priest who was different from the old conservative type and was very supportive. Madame Dora was also a very creative person and together with the others picked up the idea and knew much better than I how to approach the community and keep them on their toes and that was very wonderful.

Before the inauguration of the scheme, workshops were organised to orient various stakeholders in relevant aspects of it. These included communication

² One of the common testimonies about the scheme is the solution of hernia cases in the district. The medical doctor in charge of the hospital explained to me that high incidence of hernia in farming communities like Nkoranza district was not unusual. It results from repeated strain or pressure exerted on the abdomen through intense farm labour. The bending posture that people commonly adopt in farming activities also contributes to it.

skills for district and sub-district health management teams and hospital staff, education for members of the advisory board to be educators and durbars for chiefs and the community at large to explain the policies and benefits of the scheme to them. Final preparations for the scheme involved the production of identity cards (ID cards) for subscribers as well as family cards, registers, receipts and other such paraphernalia for record keeping purposes. The scheme was finally launched in February 1992.

Design features

Membership, benefits and exemptions. Figure 3.1 provides the organisational chart of the scheme. Membership of the scheme is open to all residents and native non-residents of the Nkoranza district. It is voluntary and subscribers are obliged to pay an annual fixed premium per head, which is determined at the beginning of every year. Entire family registration is required in order for individuals to receive benefits.

The policy covers admissions to the Nkoranza hospital, in which case the total admissions bill is paid as well as snake and dog bites. In addition, members referred from the hospital to other hospitals are also reimbursed with a sum equal to the average monthly bills of Nkoranza hospital during the particular month in which the referral was made. Bills of drug prescribed that are not stocked or out of stock by the hospital are fully reimbursed to insured patients. As much as possible, doctors of the hospital are obliged to prescribe only from the ministry of health approved essential drug list (EDL).

Apart from outpatient cases, various criteria for what was exempt from coverage have been defined on the basis of what the owners perceive and the community accepts as good health and what is morally acceptable and unacceptable behaviour. Thus, the policy of the scheme exempts cases of normal deliveries of babies, complications associated with self-induced abortions, retention of patients for less than 24 hours on observation and cases involving alcoholism and alcohol related injuries.

Administration and financial matters. At the time I conducted this study in 2000, as indeed had been the case for most of its existence, the organisational structure of the scheme comprised the Bishop of the diocese of Sunyani as the ceremonial head who also symbolises ownership of the scheme. Under him is a hierarchy of officers, but the actual management team was made up of all four members of the hospital management team: the senior medical officer in charge, the administrator, the matron or principal nursing officer of the hospital and the accounts officer. Others are the district director of health services, the manager, coordinator and the assistant coordinator of the scheme and the chairperson of the insurance advisory board.

The insurance advisory board was made up of prominent members of the community and had no designated authority other than a moral one to influence community participation and interest in the scheme and the resolution of matters and complaints that crop up between the management and the community.

Contracted field workers complete the organisational structure of the scheme. These are mainly community personnel who collect premiums from the communities. They are usually contracted for two months during the premium collection period and receive commission on the basis of how much they collect.

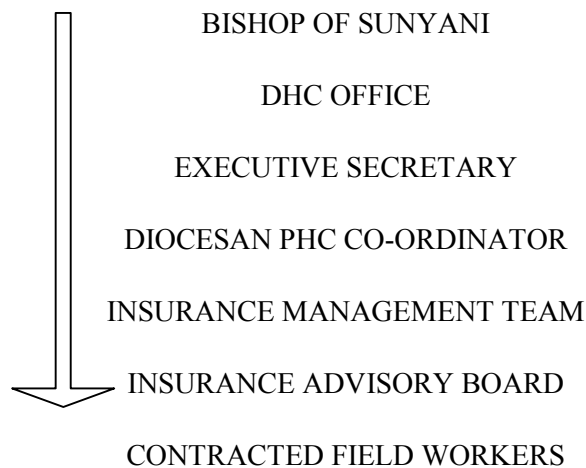


Figure 3.1: Organisational chart of the Nkoranza community financing scheme

Financial administration. The scheme is entirely funded through premiums paid by subscribers. Its accounts are kept separate from that of the hospital. All premiums collected are sent to the bank the same day or the following day and deposited in a savings account. Only a quarter of the funds are however left in the savings accounts for payment of expenses and administrative charges. The rest is invested in treasury bills and fixed deposits, which yield substantial interest and generate revenue for the scheme. It also receives donations in kind from MEMISA, such as the stamps that are used as receipts and identification for yearly registrations. Occasionally it receives assistance from NGO's. Payment to the hospital is made when members are treated under the conditions specified by the policy on a monthly basis. Three signatories comprising the manager, a co-ordinator and an advisory board chairman have to sign all

payments to the hospital. For daily routine expenses the staff keeps an accountable impress which at the time of this fieldwork amounted to 200,000 cedis.

How do the parties involved look upon the scheme?

Undoubtedly the Nkoranza scheme has brought some relief to its clients and made hospital admissions accessible and affordable to subscribers who otherwise would have found it difficult to access health care. The scheme is a source of pride particularly for implementers for its pioneering work in community health care financing in the informal sector in Ghana. My observation in this research indicated that the community endorses the scheme particularly as a great health security and help to the rural poor. Ordinary community members value it as having provided the means for many in the community to have their “parker”³ (hernia) removed. At the end of 1999, average annual enrolment stood at 27.11% or 39,288 clients from an estimated (or rather over-estimated) district population of 144,900.⁴ Five percent of these were admitted and made use of 77% of the annual revenue as hospital admission bills. In 2000, the total registration was 43,688 clients. Based on the official 2000 population and housing census report figure of 128,960 residents, the proportion of actual residents in the district comes to 33.88%. This however is deceptive since it does not include non-resident citizens of Nkoranza. One of its important solidarity aspects is that high and expensive health risk factors of chronic nature such as diabetes and cardiovascular conditions are all covered by the scheme.

But the scheme has not been without its problems and challenges. Its annual average population coverage at 26.6% to date remains low, while annual registration figures show no tendency towards significant increase in coverage. The scheme’s implementers and managers attribute this partly to negative community perceptions such as the community view that the insured receives inferior drugs and that doctors are reluctant to admit them. On the other hand, there is also a perception in the community that hospital staff have negative attitudes towards patients. In a way, the accusations and counter accusations show the expected changes in power relations during health insurance. The view of the implementers about the community’s negative perceptions about the scheme could be explained as an indication of the community’s desire for better service not only in terms of technical but also social status in a health insurance regime. On the other hand, it shows the reluctance of providers to remain at the pedestal of their prescribing power.

³ When I tried to find out how “parker” emerged as a name for a hernia, I received a speculative explanation that the name is probably a description of the way the condition “packs” at the lower end of the abdomen.

⁴ Source: 1999 Annual report on the Nkoranzaman Community Financing Health Insurance Scheme, page 4.

Most clients in the scheme live closer to Nkoranza and existing records indicate that, for example, in the successive financial years of February 1998 to January 1999 and of February 1999 to January 2000, nearby locations such as Nkoranza township and Yefri exceeded their revenue from premiums over expenditure through admission costs.⁵ Adverse selection and patient moral hazard are also quite widespread (examples of these are provided in Chapter Six). Provider moral hazard is, however, not a problem in Nkoranza since staff salaries do not depend upon revenue from patient attendance. The scheme “has not been able” to integrate health centre services into its benefits package yet. One of the scheme’s perennial challenges has been how to inculcate the sense of ownership within the community. According to its managers most associate it more with the hospital or the Catholic Church sometimes symbolised as the Bishop. They sometimes hold the view that subscribing to the scheme means providing revenue for the upkeep of the diocese, if one does not fall ill.

These problems obviously lead to a number of questions. What are the underlying reasons for the so-called misconceptions about the scheme? Given that adverse selection and moral hazard are high in the scheme, how does the community perceive the scheme? Do they understand and accept the concept of risk sharing underlying the scheme? Why or why not? These are the issues that the subsequent chapters in this study will examine.

The National Health Insurance Scheme (NHIS) pilot project in the Eastern Region

The government of Ghana’s attempts to implement a health insurance scheme in the country dates back to the mid-eighties with the commissioning of several research projects and consultancies to assist the formulation of its policy in that direction⁶. However it was not until 1997 that an attempt by the government to pilot a health insurance scheme was initiated. The Ministry of Health selected four districts in the Eastern Region for a pilot initiative. Speculative reasoning⁷

⁵ For February 1998 to December 1999, income over expenditure in Nkoranza registered a deficit of 10,486,944 cedis, while that of Yefri was also a deficit of 1,771,379 cedis. Similarly, for February 1999 to December 2000, income over expenditure in Nkoranza registered a deficit of 14,941,562 cedis while that of Yefri was also a deficit of 2,946,034 cedis. Source: Annual reports of the Nkoranzaman Community Financing Health Insurance Scheme, 1998 and 1999.

⁶ Addo et al. (1995) mentions one of the earliest citations as pre-feasibility report prepared by Joseph Amenyah in August 1985.

⁷ These were reasons suggested by the Eastern region national coordinator of the scheme during a conversation.

for selecting the Eastern Region is that as one of the largest regions in the country, it has a lot of health facilities (143 health centres and about 18 hospitals) and health workers to test the initiative. These facilities are categorized in a way that cuts across mission, government and private facilities, which reflect different situations of health care. The population structure also appears to be quite representative of the socio economic background of people from all sources and cultural groupings in the country. It is also believed that the region's proximity to the national headquarters in Accra might have influenced the decision. The Suhum Kraboa Coaltar District, which was selected as the case study in this research, was one of those that were chosen in the Eastern Region by MOH Ghana to implement the pilot national health insurance scheme. The remaining three districts are New Juabeng (Koforidua), Birim South District (Akim Oda) and Kwahu South (Mpraeso).

Brief profile of Suhum Kraboa Coaltar District

Suhum-Kraboa-Coaltar District (hereinafter called Suhum District) is one of the fifteen administrative districts in the Eastern Region of Ghana. It is located in the southern part of the region to the east of the New Juaben district in which the regional capital, Koforidua is situated. It has a total number of 415 settlements and the official 2000 population census put the existing population at 166,472 of which 82,244 are males and 84,228 are females. About 78% of the district is categorized under rural. Climatic conditions in the district are similar to those of the forest zone of Ghana, with high temperatures ranging between 75 to 80 degrees Fahrenheit. The bedrock of economic activity in the district is agriculture, providing income for about 70% of the population. Major cash crops cultivated are cocoa, palm oil, cassava and plantains. Land is mostly individually owned through outright acquisition. It is noted for its vibrant commercial farming activities and serviced by three banking institutions.

The district has a relatively good road network which boosts trade and commerce in the area. It is connected to the national electricity grid, which ensures constant electricity supply for both domestic and industrial purposes, but the main sources of water supply are boreholes, rivers, ponds, wells and rainwater. It has one government hospital located in Suhum, 10 health centres, three private clinics and one maternity home. Prevalent diseases in the area include malaria, diarrhoea, onchocerciasis, yaws and schistosomiasis.

Why a pilot project?

This NHIS pilot project was planned to be a trial scheme to assist MoH-Ghana to formulate a policy on "rural-based community-financed schemes meant to cover all the members of the rural community" in Ghana (Addo et al. 1995: viii). The purpose was to ensure that suitable systems were developed for the

various aspects of the scheme, including premium levels, premium collection systems, provider payment systems and the type of benefit package. In order to implement the project, a national health insurance secretariat was set up in the national capital, Accra, to lead the implementation activities. A regional secretariat was also established under the regional director of health services at the regional capital, Koforidua, to co-ordinate the activities in the region.

In preparation for the pilot, various consultancies were also engaged to carry out a number of key activities, which included the following:

- Baseline Studies (Affordability and Willingness to Pay) carried out by the Institute of Social, Statistical and Economic Research (ISSER) in 1995;
- A study on implementation of National Health Insurance Scheme — Eastern Regional Project, conducted by W.K. Siaw of SSNIT in September 1997;
- Accreditation Exercise in the four Pilot Districts in October 1997;
- Cost and utilization study for the determination of premiums, conducted by Tri-star Actuarial and Management Consultants in February 1998;
- Development of benefit package and provider guidelines by the National Secretariat; and
- Seminars and Workshops for providers with different stakeholders to obtain their input for the design of the scheme.

Design features

Proposed policy package. The initial position of the NHIS Secretariat was that a central agency, a National Insurance Company would be set up to run the scheme. It was proposed that the scheme was to be operated on the principles of solidarity, equity and non-profitability. Its basic tenets were to share cost of health services, share care for the sick and thereby make health care affordable to all the people of Ghana in the event of illness. These services were expected to “be possible for a small premium to be paid either on a monthly, quarterly, half yearly or yearly basis”.⁸ Clients joining the scheme were to be entitled to a benefit package of outpatient and in-patient services including ancillary services at the district level. Providers were to be selected through accreditation and were to include hospitals, private clinics, polyclinics, health centres, clinics and maternity homes as well as pharmacies, medical laboratories and X-ray units in the private sector.

Public education programme. The most elaborate activity that was carried out as part of the implementation of the scheme was a public education programme in the four pilot districts. As was characteristic of most of the activities in connection with the implementation of the scheme, this (educational) component was

⁸ Eastern Health News, Dr. Brookman-Amisshah on health insurance, pp. 8-10.

also contracted to a private consultant, the Centre for Development and Intercultural Communication (CEDIC)⁹ based on a proposal submitted to and accepted by the Ministry of Health. The project began in August 1997.¹⁰ The so-called communication objectives of the pilot project upon which CEDIC embarked are provided in Figure 3.1 below.

CEDIC developed a plan using national service personnel who were trained for three days and sent to three districts¹¹ to work. Fieldworkers were expected to work closely with existing district structures like District Health Management Teams (DHMT), District Assemblies, National Commission for Civic Education (NCCE) and the Non-Formal Education Division (NFED) of the Ministry of Education. Communication strategies that were used to create public awareness and sensitisation in the districts included posters, handbills, billboards, audiocassettes messages, newsletters and radio programmes.

As fate would have it the public education programme was the furthest the pilot scheme could go. The project stalled in 1998 although this was not officially admitted.¹² Rather, the state maintained a deceptive public image that the scheme was progressing well and results were being studied, when in fact there was no intention of actual implementation taking place. It took a change in government for the MOH to publicly announce the failure of the pilot scheme. In one such public admission, the official reasons for the failure were attributed to already known challenges of rural informal schemes such as devising appropriate scheme designs, determining premium levels, developing a collection mechanism and setting up a company appropriate to manage the scheme that was suitable for the informal sector.¹³

A number of other reasons could also be assigned as explanations for the failure. One of these is the over-ambitious decision to set up a centralised national insurance scheme based in Accra to manage the operations in various districts in another region. Again most of the predictions upon which the

⁹ CEDIC later changed its name to Strategic Communication Limited (StratComm).

¹⁰ The original consultancy period for this activity was supposed to be from July to December 1997, but actual work only began in August. Before the term was over, CEDIC informed the ministry about the need and its intention to extend the period to April 1998.

¹¹ Originally eight field staff were trained for the four districts involved in the pilot scheme but two did not return for posting when they were asked.

¹² In 1999, when the first phase exploratory fieldwork was carried out, a pilot scheme was officially on going. In reality there was nothing to show for it.

¹³ Reasons attributed to Dr. Aaron Offei, Regional Director of Health Services, Eastern region, reported in *The Ghanaian Chronicle on the Web* "We're no longer each other's keeper due to harsh economic trends" written by Eric Boateng Sampon, Koforidua, Volume 10, No 13, Monday, October 1, 2001.

- a) Create general awareness about the health insurance scheme.
- b) Educate the general public about how health care could be improved through the health insurance scheme by persuading people to join the scheme, motivate the non-formal sector to join the scheme, educate the public about how to join the scheme and pay premiums and educating the public about how to ease the burden of paying premiums.
- c) Create a sense of national as well as traditional pride in those who join the scheme.
- d) Explain the scheme to the public.
- e) Create the sensitivity, support and excitement about the scheme so that policy makers will make available the necessary facilities and logistics for implementing the scheme.
- f) Help the public to see the links between the scheme and traditional social support systems.
- g) Change the widespread attitude, belief and expectation that health care is solely the responsibility of the government.

Figure 3.2: Communication objectives of the NHIS pilot project implemented by CEDIC

feasibility of the NHIS was made were quid pro quo economic assumptions that ignored the socio economic and cultural realities of the economy and society. For example, it was projected that the economic measures introduced in the early 1990s such as trade liberalisation, incentives to attract private investment and measures aimed at encouraging domestic production were going to increase job opportunities and incomes, thereby creating an enabling environment for the NHIS (Addo et al. 1995: 102-103). Furthermore, despite the limited technical knowledge on rural health insurance, the planned pilot scheme descended on the communities with very inadequate preparation and typically ended up as another unsuccessful government programme.¹⁶ Indeed the education pro-

¹⁴ In 1999, when the first phase exploratory fieldwork was carried out, a pilot scheme was officially on going. In reality there was nothing to show for it.

¹⁵ Reasons attributed to Dr. Aaron Offei, Regional Director of Health Services, Eastern region, reported in *The Ghanaian Chronicle on the Web* "We're no longer each other's keeper due to harsh economic trends" written by Eric Boateng Sampon, Koforidua, Volume 10, No 13, Monday, October 1, 2001.

¹⁶ Various examples abound of state initiated programmes that soon became defunct after take off due to the approach and attitude of state officials. In health care these include the community clinic attendant initiative and the Bamako initiative, which were targeted at improving primary health care at the community level.

gramme *was not effective* because it was hastily implemented, handled by unskilled field personnel and in most cases prior notice was not given before community visits.

How do various parties involved look upon insurance?

One issue that became a subject of concern during my data collection in Suhum was trust in the implementers. There was scepticism based on previous bad experiences with community credit and savings schemes. Many believed that such ventures are only a means of exploitation by “smart officials” to take advantage of “innocent and ignorant poor rural folks”. Many people therefore, do not trust or are very sceptical of officials or any group of people who come with pen and paper to collect money from them.

Notwithstanding the failure of the NHIS pilot scheme, the need for the government to provide accessible health care has never been so strong. This is a result of increasing economic hardships and the consequent difficulties in paying for health care at the point of use. It is against this background that the desire, search and attempt to implement a feasible health insurance scheme in Ghana that is particularly suited to its unique socio- economic environment presents a problem of great social scientific importance and of interest to health policy and planning.

The Dangme West District Health Insurance Project

The Dangme West District Health Insurance Project (hereafter called Dodowa) is the fruitful culmination of the community based insurance vision of a former director of medical services and later deputy minister of health, Dr. Moses Adibo. It is the end result of Dr. Dyna Arhin’s PhD research work in health economics. In principle, however, it was implemented as a MoH operational research activity that partially fulfilled the government’s desire to test the feasibility of rural health insurance schemes in Ghana. The primary goal was to make modern health care accessible to the rural poor through prepayment community health insurance schemes. In May 1993 the first fieldwork was conducted to examine the demand and financial feasibility; the scheme was finally launched in October 2000.¹⁷

¹⁷ I was encouraged and motivated to cover the district extensively by the district director of health services. He had expressed demand for such a study as a means of understanding the experiences, problems and challenges the district was facing in its implementation.

Brief profile of Dodowa District

The Dangme West District is one of forty-five districts created in 1988 as part of the government's decentralisation reforms. It is also one of two rural districts among the five in the Greater Accra Region that is yet to experience the rapid urbanization that has besieged the peripheral areas surrounding Accra city. Dodowa is the district capital.

It has the largest surface land area (about 1,700 square kilometres) in the Greater Accra region, constituting about 41.5% of the entire regional land area. The land is flat and at sea level with isolated hills. It is bounded on the east by the Volta River in the Osudoku sub-district, to the west by Ga District, to the north by the Akwapim Ranges of the Eastern region and to the south by Prampram and Tema in the Greater Accra region. It is home to the ancient Shai Hills tourist site. The vegetation is predominantly coastal savannah but dense forest commonly known as the "Dodowa Forest" exists in the Dodowa sub-district part.

The 2000 population census put the number of people in the district at 96,809, 46,550 males and 50,259 females. The district has a slightly lower population density than the average for the country (55.3 persons per square kilometre against the national average of 63) and far lower than the regional average (which is 441 persons per square kilometre) mainly as a result of migration to Accra and Tema, which fall within the region. The population is concentrated along coastal settlements mainly in Prampram, Old Ningo and Lekponunor due to fishing activities, and in the western parts at Dodowa and Asutuare, due to farming and commercial activities. The large, central portion, which is inhabited by pastoralists is very sparsely populated. The population structure of the district reflects a typical developing country rural region with a predominant youthful population with an average of 21.5 years. This implies a high dependency rate.

In spite of the presence of the wide ocean mass and the Volta River, farming, rather than fishing, is the main occupation of the majority (about 60%) of households in the district. This is due to the fact that fishing (only 6.4%) in the area still uses old and rather crude labour intensive methods. Trading (about 22%) is the next major occupation after farming and it is significant to note that some of the main towns in the district such as Dodowa, Prampram, Old Ningo and Osuwem used to be dynamic trading and commercial centres in the region but this has declined over the years due to shifts to Accra and Tema.

Health indicators

For purposes of health administration, the district is divided into four sub-districts: Dodowa (Shai), Prampram, Great Ningo (previously called Old Ningo) and Osudoku. Each sub-district is served by one main health centre headed by a

medical assistant and in addition has one or two community clinics. They are supported by two private clinics in Prampram and Dawhenya as well as two private maternity homes also in Prampram and Dodowa. There are several licensed chemical sellers shops in the larger communities. In addition, there exist a number of untrained, unlicensed and unregistered providers of biomedical care who practice their trade in the markets and on tabletops in front of their homes. There are also drug peddlers, injectionsists and other varieties of quacks. Public health care delivery system in the district is hampered by poor infrastructure, lack of staff accommodation as well as transport facilities and motorable roads. At the moment, the district has no in-patient facility, but - expansion work is on going to upgrade the Dodowa health centre to a hospital.

The prevalent diseases in the district include malaria, diarrhoeal diseases, anaemia and upper respiratory tract infections. In 1999 for example, malarial diseases made up about 47% of all reported conditions. Other commonly reported diseases included accidents including fractures and burns, and diseases of the skin and ulcers.

Supply of potable water is inadequate, and nearly half of the 124 settlements are without access to clean water. Only a small proportion (20) has regular supply of pipe- borne water. The majority of the people depend upon surface ponds, rainwater, rivers and shallow wells for water. This has implications for health in the spread of water borne diseases such as guinea worm, bilharzias and river blindness as well as typhoid and cholera, particularly in communities situated along the river. Sanitation facilities are also poor. In the urban areas of the district there are no designated sewage and refuse disposal systems; only 26% of houses have toilet facilities.

Who took the initiative?

The background of the Dodowa scheme was recounted to me by the district director of health services, Dr. Irene Agyepong, and corroborated by other sources including Dr. Moses Adibo, the man whose vision led to the location of the scheme in that district is as follows:

If you go back it does not really come from the district. Somewhere in the eighties Dr. Adibo had this idea that community based health insurance might be a possibility to help solve the acute health care payment problems of the rural poor. So he actually looked for someone who was interested in the issue. And that was Dinah. She got a scholarship to study health economics in Leeds and went further on to do a PhD in the London School for Hygiene and Tropical Medicine focussing on Health Insurance. Dinah's PhD thesis looked at the willingness to pay for health insurance in rural communities and whether the ideas of health insurance already existed and how people would react to it. And when she was deciding where to work, I was doing my Masters in Liverpool and people suggested she talk to me to find out the

possibility of starting her work in Dangme West. In short she ended up doing the fieldwork in this district in 1993. When she finished her PhD and published one or two papers there was interest in following it up.

The EU, through the University of Heidelberg, decided to fund a collaborative research between the London School of Hygiene and Tropical Medicine (LSHTM) and MoH-Ghana on one hand and then Heidelberg and MoH-Burkina Faso on the other hand. Heidelberg was actually not interested in insurance but prepayment in Burkina Faso but the EU felt it would be good if, apart from the north-south cooperation, there is also a south-south cooperation so they linked these issues and a proposal was developed in which Heidelberg was made the coordinator. The funds went to Heidelberg then they passed some to the London School, then to Burkina and Ghana. The entire project was thus actually bigger than the Dangme West scheme. There were however, problems somewhere along the line with the coordination issue. The links between Ghana and Burkina Faso hardly worked as envisaged while the relationship with Heidelberg almost became a matter of just transferring money.

The other issue is that there were delays. For such a huge project there are always problems when it comes to translating the theory into practice. In our case I think the original thing was that all kinds of things changed in the MoH. Dr. Adibo retired, and then his successor Dr. Adamafo who came in also retired shortly. Then Dr. Otoo, who followed also stayed in office for a short time so we changed directors about three times in a year. The Minister of Health also changed several times and they all affected the project. In short there were delays so we took off finally in 1996 with discussions and planning but the funds were transferred in 1997. On the other hand, the long planning phase was not an entirely bad thing because it helped us to identify a lot of issues although many of these issues were quite obvious to us from the start. For example, quality of care is a problem that we have always known but how to get the funds to bring it under par is still problematic.

Again when the project took off, instead of having a short planning period we had a long planning session. Part of the problem was that when the project was originally conceived, the EU was going to fund research and evaluation while the MoH was supposed to fund intervention. So basically all the issues to do with design and implementation was going to be funded by MoH. However, because of the changes in the MoH top hierarchy, that part from the MoH did not materialise and we ended up with further problems. We had money to evaluate the project but did not have money to implement it. So what did we do? We looked at several issues and decided to implement something from the little money that the district had. But then we were not very happy with that because as we planned the scheme the things that we felt were very necessary to have a viable insurance project we could not do just because of funding difficulties. We could not carry out certain things such as capitation and community sensitisation.

So we spent the whole of 1996 and part of 1997 looking and begging for money to implement the project. The irony with that was sometimes the issues were not understandable for some of the people and donors we approached, because to them we had EU funds so why were we asking for more money? In the end we had to take a second look at the EU budget to see how flexible it was and if it was possible to reinterpret evaluation into implementation. We did manage to reinterpret some of the things. For instance the budget included equipment for research and evaluation but you could use the same equipment for implementation activities so we just used the same equipment. Then we got some help along the line. The district poverty reduction programme helped a bit, MoH helped a bit and we also got little bit from our donor funding and then our financial emoluments (FE) and that is the history of the scheme. And then because the project officially ended, part of the salary for principal investigator that was being paid by the EU fund also went to finance the project directly.

Prior to the actual implementation, a number of elaborate activities were carried out including the following:¹⁸

Social mobilisation and the raising of awareness. The channels through which this was effected included house to house education using community volunteers, information vans and community drama. Public address systems were mounted on seven vans as part of the education campaign. This was reinforced by community drama using a mix of health workers and community members.

Information booklets and flipcharts. These were produced jointly by the DHMT and the planning unit of the district assembly in consultation with people at various levels in the community to educate people in the district as well as those in other regions (and eventually the entire nation) about the scheme. The content of the books was based on frequently asked questions during the sensitisation and awareness campaigns; other issues in it dealt with what people needed to know about the scheme in order to be prepared. The distribution was targeted at entire communities. A nine-page flip chart was designed for the use of trained community volunteers in the communities.

Community health educator training and home visits. These were done jointly with the planning unit of the district assembly. The initiative brought together existing groups of men and women including chiefs, community development officers, opinion leaders and teachers who had received extensive training in community education on various issues. Forty selected volunteers were oriented in various aspects of the scheme, in order for them to carry out

¹⁸ Excerpts from 2000 Annual Report of the Dangme West District compiled by the DHMT, January 2001.

house-to-house education and the organisation of radio listenership groups in the community. The listenership group listened to educational programmes on the radio and discussed the issues that arose from them. Each volunteer signed a promise to endeavour to reach every person in communities assigned to him/her after the training.

Health worker orientation meetings. This involved a two-day orientation to educate and outline the role of health workers in the scheme. Community health educators and field staff were trained to educate the community while clinical staff were also trained to educate their clients in the consulting room.

The scheme was formally launched on October 10, 2000 at Dodowa by the Deputy Minister of Health at the time, Dr. Moses Adibo. Several MoH officials in the region, the donor community, local leaders and organisations and the community at large attended the launching. A pilot registration was organised in Dodowa one week prior to the actual launching. Actual registration of the scheme started a day after the official launching in Dodowa. A registration team made up of a photographer, a registrar and a community mobiliser toured the various communities. They were armed with notebooks, registration forms, receipt books, a wooden money box, a census listing all people in area councils and a wooden photo frame. Families had an option to pay in full or in instalments within a period of three months. Pictures of subscribers were taken only after families had fulfilled their premium obligations in full for ID card to be issued to them.

Although the first registration was scheduled to end in December 31, 2000, this was extended for about three weeks into January 2001 “due to several holidays in December and other health activities” (Dangme West Annual Report 2001).

Design features

Membership and benefit package. Membership is voluntary and open to all residents of the Dangme West district. Residents of adjoining districts who are interested and desire to join are accepted on the condition that they agree to use one of the primary health care clinics in the district as their first point of service use. Benefits cover the use of health services in the public sector. Presently, the following benefit package is offered:

- a. All primary outpatient clinical care.
- b. Basic laboratory tests requested as part of primary outpatient clinical care namely: haemoglobin, sickling, full blood count, stool R/E, urine R/E, widal test and blood grouping.
- c. Antenatal care.
- d. Delivery and postnatal care.

- e. Family planning.
- f. Child welfare and immunization. This is in theory free currently, but in practice in most clinics mothers pay a “voluntary contribution” to cover costs for items such as cotton wool and transportation for nurses.
- g. Referral to a participating hospital provided the patient consulted a primary outpatient clinical care providing facility first and was referred by the prescriber there. Clients who self refer to hospital are not reimbursed. This system of gate keeping is intended to prevent the administrative and financial complications that are likely to be associated with allowing patients to self refer to hospitals outside the district.

If a client is so referred (as in (g) above), all fees are paid up to a maximum of two hundred thousand cedis. Any additional fees are the responsibility of the client. Cases that are referred as acute emergencies, e.g., convulsions; ruptured ectopic pregnancy and other obstetric emergencies are provided transport under the scheme if an ambulance is available. If not, private transport such as taxis and buses has to be hired by relatives. Currently only Dodowa and Prampram have ambulances.

Management and financial administration. In theory, registered households who collectively form the *Dangme Hewanminami Kpee (DHK)* (translated as Dangme Good Health Group or District Health Maintenance Association), are considered the actual owners of the scheme. In practice, however, a District Health Insurance Management Team (DHIMT) administers the scheme on behalf of its members. The District Health Management Team (DHMT) and appointed staff from the office of the District Director of Health Services (DDHS) are members. District assembly representatives, including the head and a member of staff of the District Planning Coordinating Office, make up the rest of the membership of the DHIMT.

Responsibilities of the DHIMT include the monitoring of performance to ensure that paid up members of the association have access to good quality health care at hospitals and clinics. It also reimburses health centres and hospitals for services based on an approved formula and/or agreed rates. It is also charged with the compilation and analysis of routine health management information system data related to the scheme.

The administration of the scheme also incorporates a District Advisory Board (DAB) that is yet to be set up. It is planned to be composed of representatives of traditional, political, religious and administrative leaders in the community and district. Regional health leaders (MoH, NGO) and other persons considered to have expertise as well as the interest in the welfare of the scheme are also planned to be incorporated. The board is expected to meet twice yearly

to offer advice in policy related issues such as contribution schedules, exemptions, credit facilities, assuring equity and disciplinary matters.

The premium for the first insurance year was 12,000 cedis (or about US\$ 2) per adult and 6,000 cedis per child or elderly person (70 years and above) per annum if the whole family registered as required by the scheme. At the initial stage, monies collected were acknowledged with MOH general counterfoil receipt books and then deposited in the District Director of Health Services (DDHS) account for convenience. Subsequently a separate specific account for the scheme was opened with Standard Chartered Bank, Legon branch and all monies transferred there. A total of thirty five million and seventy five thousand cedis (35,075,000 cedis) from 775 households was collected in premiums during the registration of the first insurance year.

How do the various actors view the scheme?

In all fairness, the time span within which Dodowa has been in existence is too short to make a constructive assessment. One unique feature of the Dangme West district health insurance scheme that poses a critical challenge is the absence of hospital in the district. Accordingly, in-patient care for insured patients is presently provided by hospitals in adjacent districts. While this might be a source of concern, the scheme's implementers perceive it as a challenge that may end up to be one of its strengths if it works out successfully. Within the district, both health service staff and community people acknowledge the scheme for what it is intended to do, particularly its potential "to do away with the distressed 'cash and carry' system". Virtually every health service worker in the district considers health insurance as the panacea to the accessibility problems that the majority of the people in the district face. Most subscribers find the scheme helpful because it is cheaper and treatment is accessible. Some of those who have already benefited from it testified that medical care is literally free under the scheme.

There are, however, several complaints against aspects and operations of the scheme by the community. One common complaint is staff attitude at the clinics. Complaints about staff rudeness are very common and some claim that it is a disincentive for them to register. Indeed, some think that even in the era when they were holding money the staff did not treat them well and therefore harbour the fear that things could get worse if they only have to attend clinic with just a card in hand. There are already allegations that health service staff treat those with cash in hand first.

Poor physical access to the nearest clinic is also a disincentive for some communities to register. Some are also of the view that the services they are receiving still fall short of what was promised them. Most are uncertain about it and have therefore adopted a wait and see attitude to monitor how it would fare

before committing their resources. For a scheme in its first year of practical implementation, this situation is not surprising, but raises doubts about the open enthusiasm people express about it. On the other hand, hospital staff involved in the scheme also complain of increasing workload as a result of the additional services insurance has added to their clinical routines.

Brief appraisal of the three schemes in terms of their socio-cultural challenges

What relevant socio-cultural challenges emerge from the foregoing background knowledge about the three initiatives? The following are worthy of note.

Historically, the ideas emerged as a social reaction to the consequences of cost recovery measures introduced by the state as part of structural adjustment policies. Characteristically, they are voluntary health insurance initiatives or ideas with a public or social objective: to make health care accessible to all, particularly the poor and vulnerable. Significantly, the two functional schemes are predominantly provider-driven schemes¹⁹; the health care provider is also the insurer (for a detailed discussion of the two models, see Chapter 1 of Criel 2000). Socially this has the effect of limiting administrative costs and checking excesses such as overuse through provider moral hazard. Theoretically, its technocratic feature also has the potential of keeping premiums low and within affordable limits for the barely subsisting poor.

On the other hand, the technocratic feature of the schemes theoretically make them external to the community in the sense that they represent innovative ideas that originated from policy makers and implementers rather than the community itself. Practically, although this feature does not always create an acceptability problem, the situation has created a lack of sense of ownership in Nkoranza. The Dangme West district scheme is still too early in its existence to make an objective assessment in this regard. Indeed, one of the present challenges of Dangme West is how to foster communication links and understanding of the principles underlying the scheme in order to make it socially and culturally acceptable to the communities.

¹⁹ Regarding voluntary health insurance pursuing a public or social objective, Criel (2000) makes a distinction between mutualistic or participatory model and “provider driven” or technocratic model. The mutualistic model often involves a “larger social dynamic where solidarity or self-governance is important concerns”. There is usually an intermediary structure between the source (households) and the destination (health care providers) of funds. In the provider driven or technocratic model, the health care provider is also the insurer.

Another issue of social significance is the underlying risk sharing solidarity upon which the schemes are based. The initiatives represent an attempt to institutionalise solidarity between the healthy and sick in the communities. It is important to emphasise, however, that although risk sharing may not be a new concept (since it has been part of traditional support arrangements), the mode of organisation and the total context in which it worked varied. For instance, in the traditional system the features of the group in which solidarity and risk sharing mainly took place were homogenous, small and varied with the type of situation i.e. sickness, old age or death. Health insurance, on the other hand, thrives better on a wider level of solidarity in the sense that the more people that are involved on a broader scale the better. Schemes therefore face the important social challenge of how to secure culturally appropriate ways of creating or attaining larger risk pools beyond familial and other small homogenous groups among community members to cover entire districts.

Furthermore, from a rather narrow health economics point of view, the key issues in insurance are willingness and ability to pay. It is, however, important to recognise on the basis of the above that a community's preparedness and individual preference (and for that matter decision to participate in a health insurance) go beyond economic considerations to include the total social context. Issues about quality of care, for example, are a major social challenge since they constitute an item upon which people base their decisions to participate or not. As a matter of fact, people will not participate when quality of care is below their expectation. Complaints about and dissatisfaction with poor staff attitudes and low quality of service in general on the part of health care consumers on one hand, and counter-charges of health staff that such complaints are based on community members misconceptions of the service reflect a social problem relating to varied perceptions of providers and consumers. It is therefore necessary to have a good appreciation of the type of quality of care people expect from insurance and health care service in general. This would involve the need for constant dialogue and negotiation of implementers with the community to appreciate each other's needs and difficulties in relation to the total socio economic context of the service.

By way of comparison, the distinguishing features of the three cases in Table 3.1 below present notable challenges for performance and sustainability.

Concluding remarks

In dealing with the subject of social and cultural feasibility of rural health insurance in Ghana, it is important to keep in mind the official cultural propa

Table 3.1

Comparison of distinct features of three initiatives

Feature	Cases		
	Nkoranza	Dodowa	NHIS
Initiator/Owner	Mission oriented/ non-profit provider	Public/ DHMT provider	Public / RHA provider
Purpose	Improve access/ revenue	Improve access/ revenue	Improve access/ revenue
Type	Provider driven	Provider driven	Provider driven
Subscription basis	Voluntary	Voluntary	Voluntary
Scale	District	District	Region
Benefit package	In-patient	In-and out- patient	-
Coverage	Single facility based	District wide facilities	-
Premiums	Cash	Cash	Cash
Exemptions	None	None	-
Measures to control adverse selection	Household mandatory benefit	Household mandatory benefit	Household
Benefit cost ceiling	Unlimited	Limited	-

ganda traditional systems of support such as kinship and friendship in Ghanaian society that are supportive of people's willingness to join solidarity insurance systems.

Accordingly, it is important to underscore the fact that any effort or attempt at implementing community health insurance initiatives must of necessity deal with a number of socially and culturally relevant questions. They include the following, which set the agenda for discussions in subsequent chapters.

- What are the principles of the existing traditional forms of support and how do these operate presently in the family?
- What are the perceptions, values and limitations of a formal and/or state-organised solidarity risk sharing at the different levels of social organisation: among those who plan and implement insurance and among the community for which it is intended? Or would communities accept the principles of solidarity in insurance beyond their traditionally known homogenous and small groups?
- How can traditional rules of reciprocity and solidarity be scaled up to or transformed into a modern state-organised insurance system? Would people trust and have confidence in health planners and implementers, particularly the state, when it is the bursar of their health insurance scheme? Why or why not?

- How will a state-centred insurance affect the well being of the weakest members of the community: women, children and increasingly elderly people? Or would solidarity based community schemes really assure access to the poor and vulnerable in the community?

Traditional social security mechanisms in Ghana

Introduction

From time immemorial, social and economic insecurity have been endemic to human societies. Correspondingly, societies have evolved provisions to guarantee its members certain minimum standards of help or assistance during times of insecurity. These mechanisms are products of the historical and cultural development of the societies concerned, reflecting their specific cultural values. Traditional social security, therefore, has been a simple, collective, indigenous social institution whereby members of a society or community afflicted with social and economic contingencies such as sickness, disability, old age, famine, widowhood or orphanage, are protected, based on customary reciprocity. What are the essential features of the social security organisation of traditional Ghanaian society and how did they function? This chapter examines that question based on the writings of published authors and my own research material. Specifically, I focus on what the forms and principles of traditional social security support in Ghanaian society were, how they operated in the past and how they still function at present in the family and welfare groups. The underlying theme of the discussion is that as a result of social and economic changes in the Ghanaian society, aspects of traditional social security arrangements are disintegrating.

Factors that are contributory to the disintegration of traditional social security include modernising factors such as increasing education, aspirations

for better economic conditions, higher standards of living, increased urbanisation, westernisation, globalisation, changes in attitudes, different patterns of consumption and radical changes in work roles and social stratification. I begin the discussion by tracing the patterns and important principles upon which traditional social security was based. This will be followed by a description of how support was given during times of insecurity in the past and the present based on three examples: sickness, death and old age. This is done in order to show how the principle of reciprocity worked and is still working. I then follow it up with a discussion of the limits of past support against the background of their common romanticism and conclude with a reflection on the effectiveness of traditional support within its historical perspective. Where necessary, examples focus on the Akan¹ of Southern Ghana, because of their predominance in terms of population and the fact that they constitute the bulk of my targeted population in this study. Indeed, their rich culture and traditions of social security may bear semblance to other societies in Africa south of the Sahara.

Social framework of traditional social security in Ghana

Kinship based family system

The basic unit of social organisation around which traditional social security revolves is the family, based on kinship. According to Rattray (1956: 62), “the family unit was a corporation; action and even thought were corporate affairs”. The kinship organisation, particularly in the past, constituted the basis for formal political and religious organisation and influenced the social stratification in many Ghanaian ethnic groups. Social relations, defined by the kinship system, served among other purposes to determine in advance the rights and duties of members in case of emergencies. Others rules relating to property, inheritance, ownership of land and collection of family contributions became the customary laws governing the larger group. Thus, the group bore the moral

¹ The Akan ethnic group is the largest in Ghana and constitutes 49.1% of the entire population (2000 Population and Housing Census, GSS, 2000: 5). They occupy most of the southern half of the country namely Western, Central, Eastern, Asante and Brong Ahafo regions as well as the northern parts of the Volta region. They can also be found in various occupations in the remaining five regions of Ghana. The sub-groups who speak variants of a common language of Fanti/Twi are the Asante, Ahanta, Akuapim, Akyem, Aowin, Brong, Fanti, Kwahu, Nzema, Sefwi, Twifo and Wassa. Although they were never politically united until they came under the rule of the British colonial government, they have a common culture (Arhin 1994: 307-308, Okali 1987).

and social responsibility for the welfare of its members such as maintenance, housing, health and other problems when they emerged.

Most ethnic groups in Ghana limit kinship descent through a single line of male or female ancestry (unilineal descent). The typical family thus consists of a group of people related by blood who trace their past to a common past ancestor or ancestress. Among the Akan, the principle of matrilineal descent is followed and forms the foundation for social order. Every person is by birth a member of his mother's lineage and a member of the chiefdom in which this lineage is located. The localised lineage, referred to as the *abusua*, is generalised throughout the society by an organisation of dispersed clans. Dispersal of members of a (matri) lineage through marriage or migration does not deprive them of their lineage rights and status since they still find their real home in their natal homes.

Every lineage or extended family has a leader, whom the Akan refer to as the *abusuapanyin* (family head). Leadership usually falls to an elderly male member (from the mother's side) of the extended family who is selected because of his superior wisdom, personal qualities and experience. The *abusuapanyin* is ordinarily responsible for the general well being of the group. He is also the administrator of the family property, the custodian of its traditions, the arbitrator of disputes among lineage members and their representative to the chief's council. Such authority is supported by the spiritual order; the *abusuapanyin* is seen as the intermediary between the living and the lineage ancestors. He undertakes his functions with the support and advice of the 'elders' who are accorded honour in Ghanaian society as the transmitters of myth and custom and arbiters of proper conduct. The respect accorded to the aged, as with that due to those in authority and the mysterious, is conceived out of a belief that they are in close proximity to the ancestors and for that matter the sacred. Thus, there is an expectation that something evil will result from its negation (Sarpong 1974, Twumasi 1975).

The marriage institution

Marriage is the fundamental building block of the society. The practices that are followed are patterned to sustain and foster kinship or lineage alliance and internal integration. In its ideal form, marriage was not left in the hands of the boy and girl who desired to get married but brokered as a social contract between the two families. Potential in-laws or representatives of the potential couple first investigate each other and come to an agreement to establish new obligations of mutual respect and aid between the two families. Both families are active counsellors during the courting and their wholehearted endorsement is essential for the success of the marriage. One underlying reason for the interest of potential in-laws in the marriage of their children is to ensure that

the future social security of both families is guaranteed. They thus probe the background of the potential bride to know whether she “*came from a good, prided and wealthy home; free from indebtedness; will work hard and; be able to bear and raise her children well*” (Twumasi 1975: 18, emphasis mine). Marriage was thus an integral part of the extended family or kinship structure, and marriage between two people imposes new reciprocal obligations and duties on the families.

Economic institution

In the economic sphere, the traditional system of production was mainly subsistence and the important pre-condition through which the traditional family fulfilled its obligatory social security responsibilities was through land assets. Land was held as property for the use of an entire family and was not for sale. Members were entitled to a small portion of family land for their own support. The subsistence system of farming ensured that all adults had a small piece for farming and an inherent right to settlement on it if needed be. Members of the family therefore enjoyed the profits and advantages of such property without altering or damaging the substance. In situations where a member was not able to undertake his own farming due to incapacity such as illness, the social network provided a safety net through the principle of reciprocal obligation. Food and economic security was therefore guaranteed for every member if they worked with reasonable diligence on family lands and conformed to the expectations of the group.

The individual's economic interest in that traditional system was, however, subordinate to the demands for the welfare of the entire group of which he or she was a part. The obligation to provide assistance for the needy did not depend on the altruistic feelings and inclinations of individuals, but was fixed by definite social norms determining who was responsible for the care of whom. To check abuses, norms for proper conduct were designed to protect the social order by acceding custodianship of the land to the ancestors through the *abusuapanyin* whose orders they are obliged to obey. The ancestors were believed to watch the living to monitor their conduct and insure the land was used in a manner that benefits the entire lineage. Violation of those rules of conduct laid down to govern property was said to bring illness or accident to the individual or disaster to the lineage members (Twumasi 1975: 20).

As a consequence, the traditional system of production and distribution was based on reciprocities, which were derived from the complex web of ties that link kin. This was fostered by the interrelations between the kinship, marriage and economic institutions. The reciprocal obligation enjoined both the family and the individual to work together and cooperate to ensure the welfare of the family and its members. The ideal set before him was that of mutual helpful-

ness and co-operation within the group of kinsfolk. Each member therefore helped the others, in health or sickness, in success or failure, and in poverty or plenty. How these worked in the past and how they have changed through time is discussed in the subsequent sections.

How did the traditional support system function in the past?

In order to appreciate the practice by which the lineage group provided assistance to a needy member in the ideal sense, I shall illustrate it with three common insecure situations: old age, sickness and death. The main objective here is not so much to give a description of a society's methods of caring for the aged or curing disease or burying the dead, but to illustrate how the traditional social security system worked based on the principle of reciprocity. I use the past tense to emphasise the past ideal situation.

Old age support

In Ghana, the aged were traditionally perceived as an integral part of the family unit, holding definite and high ranking position. The aged were the people of wisdom whose advice the young sought eagerly. He or she was the repository of knowledge who settled social disputes, officiated at marriages, births and funeral ceremonies. He or she was a *Nana* an elder to the young and youth, both inside and outside his compound. An affront to him or her was considered displeasure to the ancestral gods. Sarpong (1974: 65) describes this ideal position as follows:

Old age is sacred as the person is thought to be in closer proximity to the ancestors. He is likely to die before the others — than the young... Hence it is in relation to the sacred that a respectful attitude should be shown towards authority, old, the mysterious and the spiritual.

The aged, both female and male, resided with their families, and played very important roles in the kinship and social affairs of the communities.

Old women were regarded as endowed with great wisdom; successful rulers consulted and depended upon their astuteness and experience. For example, the wisdom of old women was depicted in difficult dispute settlements when the council of elders would retire to consult with the remark that “we are going to consult with the Old Woman” (*yɛ rekɔ̃ susu ho akyerɛ Nana Aberewa*). When an elderly woman was widowed, she usually returned to reside with her family where she played an active role in their social affairs. This role usually included counselling of young women and girls about their moral and social development.

Old men or elders were also generally responsible for the administration of the affairs of the family. They met often to deliberate and make decisions about diverse matters that affected the entire family or just individual members. They administered the family property under the leadership of the *abusuapanyin*. The elders also settled many disputes affecting members of the family and other relations. Old people, therefore, played the roles of priests, teachers, disciplinarians, marriage counsellors, psychiatrists, legal experts, administrators and more. The Akan, for example, capture this sentiment with the saying that a family is accursed if it has no old person (*abusua bɔne na panyin nni mu*).

In the light of their importance to society, there was an informal support for the aged. Members of the family assumed collective responsibility through children and grandchildren. Accommodation was provided in a family or relative's house, if the old person did not have his or her own house. Socially, the bond between parents and children did not weaken after the marriage of the "child". Instead, there was a continuity of relationship with the extended family throughout life, which guaranteed some form of security in old age. One important benefit derived from links with the extended family was that, apart from actual material assistance to the aged, it provided social support through replacement for intimate members of the family lost by death or migration so that the old person did not have to stay alone. When the system worked normally and perfectly, it was not a burden on any particular individual. Each person contributed his or her bit freely, knowing that in his own old age, he or she could depend on similar support from the younger family members and relations. Through this process, traditional social security was maintained for older members of society.

Help during sickness

Before the advent of colonial rule, indigenous health care systems provided the main means of remedy and relief when health care was needed. Significantly, in traditional Akan society, most elders were expected to know what herbs might be used for the cure of certain common ailments. Typically, the first action that the family took when a member fell ill was to try one of those known remedies. Consultation with a professional healer was sought only if the self-remedy failed. Traditional healers held consultations, treated ailments and offered protective charms to people who sought their assistance. Four main types of traditional healers are identified: traditional birth attendants, faith healers, spiritualists (diviners or traditional priests) and herbalists.² Herbalists, who constitute the largest group of traditional healers, approach healing through the use of herbal medicine and had knowledge of plants, their roots and leaves and the diseases

² For more information on this, see Twumasi 1989.

they are expected to cure. Traditional birth attendants specialised in pregnancy and pregnancy related problems, while faith healers were mainly leaders and representatives of sectarian religious movements. Spiritualists included fetish priests and priestesses, diviners and ritual leaders. Analytically, faith healers operate as a religious movement while spiritualists operate as intermediaries of a god or spirit. Healers usually had an attendant who ran errands for them, collected herbs and other remedies or assisted the healer in various aspects of the healing ritual.

A disease was the concern of the entire family, which took responsibility and supported the person throughout it, both financially and emotionally. In the past, if and when a healer decided to treat a patient, the sick person's kinsfolk would appoint one from among their number as the *okyigyinafo* or supporter or representative. This representative discussed the details of the treatment with the healer and took responsibility for any fees to be paid or for procuring any supplies the healer would require. Of this Busia (1962: 14) notes:

The appointment of such a representative was enjoined by custom. Everyone looked to his kinsfolk for support and security; their failure to name an *Okyigyinafo* would amount to disowning the patient. No Akan family would fail a relative in this way, for it would be a standing reproach to the family

If the illness was a serious and protracted one, there would be a blood relation attending to him as well. If it were a married man, his wife or wives would nurse him. Field (1961: 127) has noted in her study of ethno-psychiatry among the Akan that the number of clients who sought assistance at shrines of traditional healers included "other vicarious supplicants who appeared to be well-disposed people, wishing to leave no stone unturned to help a sick parent, uncle, sister, husband or wife but not possessing any authority to bring the patient away from home".

Before the healer prescribed any medicine to the patient, he discussed the *ntoase* or deposit that ought to be paid with the representative. This usually consisted of a fowl, alcohol (usually a bottle or half of a bottle of local rum) or money. When medicines were handed out, the family representative and attendants were given detailed instructions regarding their usage with the accompanying taboos and observances. Similarly, when food taboos were prescribed, those attending to the patient also observed them, for by eating what was forbidden to the patient, they might defile the medicines and so destroy their potency. The healers' fee was sometimes settled after the commencement of the treatment. More often, the patient himself or his family promised in advance what they would give if the patient got better. A rite of purification, which was believed to wash away any 'uncleanliness' that may have caused the illness,

marked recovery from serious illness. The members of his family also joined that ceremony. The peak of the celebration is the presentation of gifts such as eggs, money, fowls and other food items, some of which is sent to friends to inform them of the recovery and sanctification.

Support during death

In spite of all efforts to heal a patient, he or she may die. According to an old Akan belief, death is a return to the world of the spirits or *asaman*. Once death has occurred, the subsequent funeral rites passed through elaborate phases in which the family's role was outstanding. This involved preparation of the body for its journey to the spirit world, mourning before the burial, putting the body into the coffin and committing it into the grave (burial), and continued mourning after the burial.

Death was a separation and to those who were closest to the deceased, it was a painful one. The sense of loss and the value placed on group solidarity was given expression in various phases of the funeral rites. Frantic outbursts of wailing publicly announced the death and drew neighbours to the scene to join in a stunning pandemonium of wailing and lamentation. Those attending the burial also gave drinks, donations of money or cloth, pillows, or mats for burying the dead to the bereaved relatives. These gifts were publicly announced and shown to all present. Another aspect that indicated that the death of a member was the concern of an entire community was symbolised in their participation. People stopped their usual activities and joined the mourning in spite of the immense cost in time. More importantly, death was a matter of great concern to the *abusua*, such that they would go to great lengths to pay their last respects and give a decent burial to their departed. They adorn the body with as much jewellery as possible, depending upon the status and economic position of the deceased and his close relations.

Furthermore, before the body was put into a coffin for burial, rites were performed at which burial things were presented by close lineage members of the deceased. This (called the *adesiedee*) may include pieces of cloth, rings, sums of money tied in handkerchiefs, mats, pillows and toiletries. While it is believed that such paraphernalia are required by the deceased for the journey to, and residence in, the land of the dead, and the living are morally obliged to provide them, the quality and quantity of the gifts enhanced or diminished the social standing of the lineage. During the funeral, the whole community and the *abusua* in particular gather to sympathise with the bereaved and give donations, which might be in the form of money or drinks to help with the funeral expenses. Arhin (1974: 312) has beautifully captured the entire attention and public display by the family as follows:

The duty of performing the funeral rites enjoined the family to spare no pains in making the performance ‘a memorable event’, so that it could be said that it was well attended, *εbae*, and exciting, *εsoe*.

To sum up, the enthusiasm and dedication with which funeral rites were conceived and carried out depicted an important mechanism of traditional social security. The burial gifts and exchange of gifts, drinks and money were both obligatory and reciprocal. In the past these were performed with economy but varied according to the political rank of the deceased.

Welfare groups support

As with all human institutions, traditional family support mechanisms based on family was not always functional. Accordingly, society evolved other welfare or cooperative mechanisms through which the individual obtained or sought assistance, as it was needed. These included both small and bigger welfare groups such as community and neighbourhood groups. The most common of this was the labour partnership system, which the Akan refer to as *nnoboa*. Essentially it was a collective self-help group that may be comprised of age-mates and friends who assisted each other for a number of days in farming activities such as clearing bush, planting or harvesting crops, hunting (referred to as *atwee*), building a house or some marketing venture. At an opportune time, the individual who had received help reciprocated the support he received from others by offering a similar form of assistance to a group effort. Indeed, the nature of the arrangement ensured that the need for money to hire labour did not become necessary or problematic.

Like all indigenous support systems, *nnoboa* was purely based on reciprocity and a moral obligation to help one another. Tradition imposed a restraining influence on members not to default on their honour and obligation. A member would lose membership of the group if he did not live up to expectation. Since that would mean living outside the society, each member tried to fulfil his responsibility in a creditable manner.

Another old indigenous practice involved the mutual financing assistance called *Susu* by the Akan. As with *nnoboa* or ROSCAs (rotating credit savings and credit associations or *tontines* in francophone Africa) it is an arrangement by which a limited number of people, friends or professionals, contribute money daily, weekly or monthly for the use of one of the group members. Each member of the group is entitled in turn to the entire collection of the week or month. In areas where *Susu* are popular, someone collects the money everyday or weekly, depending on the agreement the members had entered into with the collector. Money was paid out to members less a day’s savings, which was considered an allowance for the person who collects the money daily.

Present-day changes in the traditional system of social security

In the course of time, changes have occurred. In present times the traditional social security system has been limited in several respects by the socio-economic transformations of society. Evidence of this change is very visible in the way and magnitude the system provides its traditional social support functions both within the family and welfare groups.

Aged support at present

Although most Ghanaians would want to believe that their family ties are still very strong and doubt that there are citizens without a home to go to, the neglect of parents by their children is becoming common. As far back as the mid 1960s annual hospital services reports in Ghana raised concerns over the number of old people (aged between 60 and 90 years) who had difficulty in going home after they had been discharged. This was because their relatives were reluctant to take home an aged patient whose condition had not much improved or was not going to improve in health. Even in rural district capitals like Nkoranza, a pastor of a local church indicated that “for some old people, what to put on is a problem and what to eat is a problem”. A typical case is the story of an 80-year-old woman, which was narrated to me. It was indicated that although all her children were living outside the town and she was surrounded by several of her grandchildren, she was being fed by church members who lived near her. Some opinions in the community suggested that “some people felt there is no need bothering about those who are already old and getting near to their graves”. Other writers have also noted the situation of the aged in present day Ghanaian society. Some have reported increasing abandonment or “dumping” of old sick relatives in hospitals due to difficult home situations (Apt 1975: 178). Others have also noted that the loneliness, marginalisation, the dire poverty and lack of adequate help that the elderly suffer in rural communities. The situation is partly attributed to reciprocity and sometimes “blaming the elderly for having neglected their children when they were young” (Van der Geest 1997: 24).

Help in sickness at present

A critical examination of the traditional support system also reveals a similar stressful situation concerning sickness in present times. Indeed the role of the family in providing emotional support during illness is still quite prevalent, but nowadays where the support involves herbal treatment, members with knowledge of particular remedies may provide this only if it means getting them free or at very minimal cost. For most treatments that require hospitalisation or high cost, the trend is that responsibility for health care has shifted more and more

towards the nuclear family. In exceptional cases, some individual members of the family (if they have the means), would assume the responsibility for the cure of sick relatives. But in general the help that one receives from family members has predominantly become “merely visiting the person at his or her sick bed or in the hospital” (*fa w’ani kɔhwɛ no wɔ baabi a ɔda wɔ ayaresabea*). The following contribution of a participant in a male focus group discussion in Suhum clearly summarised the present day scenario regarding family help towards sickness as was commonly described to me in most conversations.

The way the family used to help its members through nephews and uncles, as was the case in the past, has changed. In modern times what is happening is that help in the family when it is needed is offered within the nuclear family. I can testify with my own experience. My father fell ill but the family looked up to me as the son to look after him. I actually struggled financially and took him to several places until my resources ran out. In fact it was only when my father died that the family came in to help.

In summary, the section of the family that nowadays carry the tangible responsibility of a member is typically the immediate family members.

Help during death

Although the essential aspects of funerals are still carried out, much has changed in present times to what they used to be. At present, the responsibility for organising funeral is increasingly falling on the immediate family members. However, contrary to the situation with old age and sickness, extravagant funerals have become more fashionable among Ghanaians in general and the Akan in particular, with expenditure having in most cases no relation to the deceased’s estate. During a male FGD session at Dawa in the Dangme West district, a participant emphasised this point as follows:

In the olden days it was not so expensive to organise funerals. Now, in times of bereavement, a lot of debt is incurred. Now, when there is a funeral unlike the past when they used just the cultural groups that were available locally, they go in for bands men and spinners, which are very expensive. Others expenditures involve refreshments, ‘take-aways’ [packed meals] and a whole lot of things. These things add up to make the cost of funerals very high these days.

The items that require the most expenditure nowadays include mortuary charges (because people keep the body of the deceased for longer periods), invitation cards, and advertisements on radio, newspapers and public places, with details of all the close relatives of the deceased at home and abroad. Of

course these serve the purpose of emphasising the social status of the deceased and informing the world at large of the programme, and at the same time inviting them to support the family in kind and cash. To obtain the money to undertake these activities, families now go to the extent of obtaining a loan from a bank or individuals to cover the cost of the funeral. Significantly, funerals add an interesting dimension to the operations of rural banks in Ghana. They are the only insecure situation that they grant families loans to undertake, which seems to suggest the notion that funerals are, after all, viable activities worthy of loans. The expenditure is later defrayed through the *nsawa*, donations that sympathisers provide based on reciprocity. A person's contributions at other people's death will determine how much he or she gets when he or she is bereaved. It may also depend on the social status and prestige in society of the person who is contributing. In some communities, there is a fixed sum that every adult ought to pay at the death of a resident of a town, but the tendency is for people to exceed that in expectation of reciprocity. Indeed, in Nkoranza district, attempts to keep the amount small were flouted and have become unenforceable. Receipts are given when donations are made and individuals and families faithfully keep records in a notebook for reference purposes. The system ensures that those who do not contribute to other people's funeral expenses do not get any donations when they are bereaved.

Welfare groups nowadays

The striking thing about the origin and/or major function of most existing help and welfare groups in several Ghanaian communities is the importance of the provision of mutual aid during the death of a family member or an immediate relative of a member. My interactions with leaders of some of these community groups indicated that quite a number actually came into being through circumstances related to death; some become dormant for most of the time and are resuscitated only when a member dies. The composition or membership criteria are diverse and include ethnic origin, common town, village or community, tribal occupation and age groups. Significantly, most of them have written rules and regulations and their main objectives include fostering unity among its members; but in practice, funeral benefits take precedence over all of their other activities. Monetary assistance other than help during funerals is strikingly rare. They usually have a funeral sub-committee that sees to the organisation of funerals in the group. Sickness benefit, on the other hand, is often handled in footnotes and the typical pattern is a token support from the group or what members provide individually from their own free will when they visit the sick.

During my conversations with leaders of some of these organisations, one reason given for the undue attention placed on death was the emotional sentiments attached to it and its public dimensions.

Help during death is the foundation of our group. Our culture places more emphasis on death or funerals and you see this in the number of visitors one receives when someone is dead compared to when the person was sick. The essence is to help the person overcome the pain and grief and, since it is a public affair, to assist him/her entertain the visitors who would attend the funeral. If we start providing assistance for other things like sickness then we would have to increase the dues. That would be difficult for us because it means that people would turn to the group when they have any difficulty, some genuine, some not. Death, however, comes unexpectedly and there is no argument about it when it happens. Financially, many people experience difficulty. When that happens and you receive support, it strengthens you to meet the burden and that is why funerals are the centre of our activities. That does not mean that we are placing emphasis on death. It is part of our history.

To date, *Susu* groups are quite common but their primary function involves savings and/or rotating credit financing for its members.

Based on the foregoing information, it seems the current pattern regarding traditional social security support in Ghana appears to be that while the help offered by the extended family is increasingly diminishing, one thing that the family never ignores is death. The issue becomes more interesting considering that more is spent on funerals with each successive one. People commonly refer to this as “cultural and part of our history” but why an aspect of a culture that seemingly serves a similar end is disintegrating (care for the aging) while an aspect of it is gaining strength (expenditure on funerals) is a problem of great social scientific importance. It appears that the return in investment from funeral expenditure through donations and the social prestige from extravagant public display are factors that have strengthened the social patronage and support of funerals as compared to support during sickness and old age. The remaining section takes a look at the factors that have contributed to the general disintegration of traditional support mechanism nowadays.

Appraisal of traditional support in historical perspective

Without asserting that traditional social security arrangements were perfect ways of supporting one another, they were nevertheless relatively effective ways of assisting members in the society. However, there is a tendency to romanticise the effectiveness of the old system when it is being discussed relative to the situation at present. Thus in reference to its moral obligatory role

of supporting its members, it is common for people to describe the family symbolically not only as effective and very good, but as loving (*onuad*) and compassionate (*te-ma*) in the past, but nowadays selfish (*pɛsɛmenkomenya*) and wicked (*atrimoden*). The view of a participant in a female FGD at Dodowa captures this sentiment:

In the past there was brotherly love and as a result when your child or sister's child is sick, others in the family did not mind looking after the person but now they pretend they have not seen what is going on. The only help they may give you is to ask whether you have taken the sick person to hospital. In the past however, the entire family felt responsible. There is no brotherly/sisterly love (*onua d*).

Another participant at the same discussion group reinforced the point with the following observation:

The love we are talking about was such that when someone bought a piece of land to build a house and another brother also later decided to do a similar thing, the former would encourage the latter to build the house next to his on the same plot. But nowadays people put up bungalows for only their wives and children and they fence it and put a dog there to protect their property and separate themselves from the rest of the family. The underlying reason is that, nowadays, people look after their personal interests. There is no love. People have become "too wise" and selfish and that is what has led to the present situation.

Although a family's generosity might have been much better, in terms of the solidarity and its capacity and ability to help, it is an overstatement to assume that society in the past was much more generously gratuitous in the manner in which it dished out support to those who needed it than what it is now. My findings from the field indicate that within traditional memory the magnitude and quality of traditional support is commonly romanticized when people compare it to the past.

As one opinion leader at Nkoranza, who has been effectively involved in the scheme from the beginning told me, past support usually originated from the nuclear unit of the family of the sick person. Accordingly he disagreed with the view that the extended family always had a ready-made solution to people's problems:

It's never true. If they were helping, I think it would not be difficult for them to help in the insurance if somebody could not pay the premium. When there was a problem in the family, the solution started from the *tso tso mu tso*, the inner circle (but more appropriately the nuclear family), which comprises the father, mother and children. Then it moved to uncles and nephews and grandchildren. So when there was a problem, the family looked up first and foremost to the immediate family. When the

immediate family could not provide the support alone then they turned to other members of the family till it got to the head of the family. It sometimes even went beyond the *abusuapanyin* (family head) to the chief of the town. In all this, one thing that the family never ignored was death.

In effect, it can be said that in the past, it was only if and when the resources of the nuclear family were not enough to meet the problem at hand that the family head or the extended family members were approached for assistance. What the head of the family would do under such circumstances would be to convene a family meeting of elders to solicit their support. The effectiveness of the family in providing support at any given situation and at any given time depended on the resources of the family, the status of the person in the family and above all, the type of contingency. Sometimes the presence of 'resourceful' and 'kind' individuals in the family was very helpful in many respects.

Again, when people commonly speak about traditional support in the past they say nothing or at least very little about its exclusions and checks and balances that ensured that the family was not helped in every case. People who were perceived as not conducting themselves well were denied support. Those who engaged in sanctioned behaviour such as adultery, murder or stealing, for example, did not receive help but those who suffered from 'natural ailments' like leprosy did receive help. A contributor at a male FGD at Nkoranza explained it as follows:

They (meaning the family) were selective. For example, the society abhorred taking or going after other people's wives and those who ventured into such a thing were usually warned. If they did not heed the warning and they contracted any disease from the relationship they were not helped. But where the illness involved an accident or some natural communicable disease unrelated to any social offence, the family was quite supportive. For example, the family was supportive when a member was affected by leprosy. They would go to every extent to find a cure for the victim.

Reciprocity was also very important in that system of support. Another participant in the same male FGD group gave his view:

Before the family provided help, they considered what the person has offered to the family in the past. If he was someone capable but who did not provide any assistance to the family himself, they may also not help him. As the saying goes, one only reaps where one has sown. It is when you cast your bread upon the waters that it multiplies. I know someone who was rich in the past but because he neither respected the family nor offered any help to the family in the past, the family also refused to help him when he fell ill and needed help. It was only when he died that the family buried him.

In the opinion of a health staff member at Dodowa, the family's attitude towards health care has always been inadequate relative to that towards funerals:

Since time immemorial what and how I have known it is that we support funerals more than death. Only a few people provide assistance when a relative is sick. It is considered that people are capable of making all the money when they are healthy and alive so when they become ill they are not helped.

As a last resort, when the needed money was not available, family property such as a cocoa farm or land might be offered as a guarantee for a loan to finance the funeral. The property was not sold but merely used as a collateral for a loan. In extreme cases, however, such property may be sold outright. Indeed in older times, if the family did not have property, human beings were sometimes used as collateral security (*awowa*) to work for the creditor for a period of time agreed upon to defray the cost.

From a rational perspective, two hypotheses support the greater assistance funerals attract relative to that which sickness and aging attract. One of these relates to the asymmetry of information in relation to the two. Whereas feeling unwell is deductively non-objective or relative to the person reporting the condition, when death happens, it is an objective, undisputed phenomenon. Secondly, except in situations of disasters, the incidence of sickness is statistically and phenomenally more common, so there is a tendency for people to take it for granted or feel too taxed to commit their resources to it unless it involves people closely related to them.

On the basis of the forgoing it is possible to give a few general characteristics of traditional Ghanaian social support:

- It was organised on a family basis and operated within the extended family.
- Members of the extended family considered themselves as 'one people' because they traced their origin to a common unknown ancestor.
- The extended family members are enjoined by a strong feeling of solidarity.
- Being essentially a 'solidarity group', there was a shared feeling and consequently a moral obligation to help one another for their common good.
- Help was offered during stressful situations such as funerals, sickness and old age, but also during secure and happy occasions such as the naming ceremonies of children and marriage. Help was also offered for future security in terms of education and trading (setting up a business).
- The organisation of help or assistance is based on values and governed by norms imposed by tradition that the entire group respects.
- Such values and norms were validated by magico-religious beliefs and practices; it was believed that the ancestors punished those who violated them.

- Help, when it was needed, originated from the nuclear unit of the extended family.
- Typically, it was the head of family, *abusuapanyin*, who was ideally responsible for making sure that help was organised and provided when it was needed.
- Help or support was however not automatic. Exceptions were made when the situation involved a person who had engaged in a socially sanctioned or deviant behaviour such as sexual offence or stealing.
- Provision of support at any given time depended on resources of the family and the “standing” of the person in the family.

Context of socio economic changes

In spite of the romanticism that is commonly associated with traditional support mechanisms, their effectiveness nowadays seems to be diminishing. In order to appreciate this near disintegration however, it is important to place the changes within their proper historical perspective. My view is that to a great extent the present day ineffectiveness is attributable to social changes, which have led to the adoption of new values. It is deducible from statements of ordinary people that the family nowadays has sacrificed its unity of purpose for ‘personal interest’. Logically that seems plausible, considering the emphasis that people now place on themselves and their individual interests. What is happening must be understood in terms of the fact that people are merely behaving rationally by placing their prime sense of moral obligation where they can best optimise their socio economic needs.

Compared to the present, family solidarity was strong in the past because at that time members in a given social system needed one another for their economic survival. The important unit of that solidarity support mechanism was the extended family because of the need for interdependence in the system. The need for one another also guaranteed a strong bond of love and unity which in consequence morally enjoined members to help or assist one another when the need arose. Each person became one another’s keeper. That kinship or extended family unity was also facilitated by the close pattern of settlements and living arrangements. Support, when it was needed, was therefore easier to find in the past since the close living arrangements ensured that other family members were already aware of what was happening without necessarily having to be informed.

The most important precondition for the functioning of that economic unit and its survival in the traditional subsistence economy, land, was readily available. That land belonged to the entire family, and ownership was vested in the family head. Such land for farming or other economic activities was virtually free when it was needed. Family members who needed a piece of land for farming or any other economic activity had to approach the head of the family to make their request. All things being well, such requests were honoured.

Indeed within the framework of the prevailing arrangements regarding family lands and property such as cocoa farms, individual members had no individual rights to the resources except with the consent of the family head and elders. When situations demanded it, the family could negotiate some of its assets or property as collateral or sell them outright in order to help provide assistance for a member in a stressful situation. As I have already indicated, family members were sometimes even used as sureties to redeem the problems of others.

However in the course of time, population increases led to increased pressure on land resources. Excessive use caused the depletion of the economic viability of the land, due to the continued dependence on the indigenous means of cultivation. This has been in spite of the fact that people have adopted modern ways of living in other areas of social life. Growing individualism also created division of family lands and an era of sale to private hands began. More people also meant scarcity of the limited land and less economic opportunities at home. It did not take long for some of the active population to look for favourable opportunities for existence elsewhere. Land therefore virtually lost its importance as the main source of sustainable economic activity on which most families depended for total economic and social security. With this change, the family's position as an effective traditional social security mechanism dwindled in importance.

Closely related to land ownership and acquisition is the issue of inheritance systems and succession to property and positions in the traditional kinship system. This was primarily based on family decent and was well accepted, respected and followed. In the old system, there was no discrimination. (*Saa bre no, eye a na nyiyi mu nni mu.*) In the Akan matrilineal system for example, nephews (sisters'-sons) inherited their uncles' (mothers' brothers) property. The inheritance system and the existence of family property therefore ensured that family assets and privileges were maintained within the extended family. In effect, that bolstered family solidarity. At present, however inheritance has shifted in favour of children. State legislation on interstate succession has shifted succession to spouse and children, that is, the nuclear family, as opposed to the extended family.

The unique characteristic of traditional political authority in Ghanaian society was its sacred origin and basic commitment to the past. What was legitimate and the best way to act in society was conceived as "the way our fathers have ordained" (Apter 1972: 83). Accordingly, anything that threatened the sacred sources threatened the continuity and legitimacy of traditional authority. Nowadays, modernisation and education and new faiths such as Christianity have provided people with values outside the traditional organisation of society. For example, education has now replaced the knowledge that

the elderly provided and, together with money, offered new ways of defining the acquisition of social status. Indeed, many elderly people in present times would be quick to complain that the youth are no longer ready to listen to them and take their advice. They refuse to take part in certain traditional practices and rituals. Interestingly, although Christianity is supposed to have inculcated into society the principles of love, compassion and sharing, many adherents tend to pay only lip service to such values. One participant in a female focus group discussion in Dodowa explained the moral context of this ambiguity to me as follows:

Yes, our forefather's worshipped gods but they also cared for one another more than the present generation. We now worship and make a lot of noise about God but we do not practice love for one another. Rather we love money more than our fellow human beings.

On the other hand, Christian values have also equipped society to defy ancestral beliefs on which respect for the aged in the past thrived. A consequence of this change is the weakened traditional belief in the sanctions meted out by supernatural agencies such as the ancestors and the gods, against those who violated the norms of society.

Furthermore, a *sine qua non* of the seemingly weakened traditional support at present is the modern economic order which has put money at the centre stage of survival and the reality that cost of living has become very high and difficult for many ordinary people to obtain. More than ever before, people need and use money to do almost everything rather than family members or family lands. That makes it seem as if people in the family now love money than their own kin relations which some informants perceive and describe as "fetish love for money" (*wɔdo sika kyɛn wɔnho*). This contrasts with the situation in the past where there was limited need and use of money. As one traditional ruler explained:

Those days, there was nothing like sending someone to the hospital to see the doctor, but there was a way to help them against diseases. They were helping each other by way of communal labour, keeping their environments clean and free of disease. In times of sickness, they used their herbal medicine and the family helped one another in this aspect. At times, we³ asked for sheep and fowl to be used to treat the person. In the end if the person recovered, we paid the one who provided the things either in cash or kind. The help we are talking about was our own manpower and not money. Nowadays money is the problem.

³ The speaker here uses "we" to emphasise what was traditional or "our culture".

Money is the problem. Due to the difficult economic conditions people have become thrifty and are selective about those they spend on. As most informants describe it, it is as if there is no *onuad* □ *ne tema* (love and compassion) in the family anymore or the family has become ‘too wise’ or ‘too civilised’ (*anibue*) or selfish (*pesemenkomeya*).

Together, these factors have de-emphasised the principles of solidarity and reciprocity that were so important for survival in the past and the social logic upon which the traditional system was based. From a social analytical point of view, the present changes can be situated within the general idea in development literature that as society develops from a traditional society toward a more modern economy, extended families develop towards nuclear families (Murray 1981; UN 1986). When that happens, there is less need for interdependence because there is no need to rely on land as the economic backbone of the society. Indeed the creation of new economic opportunities and new forms of social stratification and reward systems other than those based on kinship have provided alternatives that have enabled people to gain a livelihood outside the traditional system. That does not presuppose that people have lost their sense of moral obligation; but in the context of such social changes, the fulfilment of those social obligations is likely to be placed where the individual’s, rather than the groups’ self-interest are optimised.

One of the key themes of the official propaganda for the implementation plans of health insurance in Ghana is that Ghanaian social and cultural system has a built in social insurance system through the extended family system whereby family members have collective responsibility for the welfare of members of the family.

The discussion so far, suggests a very important dilemma to the Ghana programme. How can the disintegrating system of traditional social support mechanisms serve as a social foundation or even facilitate a new system of social insurance involving a more heterogeneous membership? Although indigenous mutual aid systems exist, they tend to have a strong focus on the dead rather than the living. That partly explains why the organisation of funerals on the basis of traditional principles still commands a lot of support in Ghanaian society. The important question to address is: How Ghana can then transform some of the principles of funeral organisations into a sickness support risk sharing mechanism. What are the opportunities for grafting the scale of solidarity in the organisation of funerals into health insurance activities? These are issues that subsequent chapters will help to unravel on the basis of data from the field.

PART II

EMPIRICAL FINDINGS

Perceptions and cultural complexities of health insurance and traditional family support

Introduction

This chapter examines the question of how consumers or potential subscribers, the people for whom insurance is planned, perceive health insurance in the context of their particular socio-economic and socio-cultural circumstances. Specifically, the chapter attempts to tease out popular perceptions that “the people” hold about social or mutual health insurance and how those affect or could affect their attitudes and behaviour in the scheme. An insight into what health insurance means to those it is planned for in relation to how the planners conceptualised it is essential for determining potential areas of difficulty and misunderstanding and strategies for minimising, avoiding or rectifying those problems.

The presentation is organised in two main parts. In order to put the discussion in its proper analytical framework, the first part begins with policy and the implementers’ perspectives followed by lay or popular notions or perceptions of the people, both positive and negative, about health insurance. This will set the scene for the second part which analyses how both policy implementers and the people who would be affected by said policies perceive relationships between health insurance and traditional family support mechanisms in order to identify generalisations that explain those relationships.

Perceptions about health insurance

Policy perspectives

Although the idea to implement health insurance was conceived in the mid-nineteen eighties, an official policy framework is still being developed. There is therefore no published official policy document on health insurance in Ghana as of yet. Nevertheless, several research efforts on health insurance have been carried out and documented including background papers, feasibility studies and reports, and several official and ministerial statements. Some of these have been on political platforms that underscore the Ghanaian government's belief in health insurance as a preferred alternative to the existing fee for service regime, which is popularly dubbed a "cash and carry" system.

This official policy commitment to health insurance is motivated by concerns that many Ghanaians, particularly people in the large informal rural sector where incomes are marginal and occupations are seasonal, are not able to access health care when they need it because of problems with cash. Policy makers therefore perceive health insurance as a potentially efficient health care option that will make health care delivery more accessible to the people of Ghana. The potential efficiency of health insurance is derived from the principles of prepayment and risk sharing that underlies it. A solidarity based prepayment scheme is thought to be able to bring together the resources of several poor people who are individually unable to afford it, but can share the cost of health care when one of them needs it. A second main short-term goal of the policy is to use insurance to mobilise funds from communities to improve health care delivery in the country (Assenso-Okyereh et al. 1997; Arhin 1995; Addo et al. 1995).

The government's original key health insurance policy plan, as adopted by the Ministry of Health and based on the recommendations of feasibility studies, was to set up a centralized or generic national health insurance for the entire country under a statutory body with the responsibility for the development and operation of the following:

- i. A mainstream Social Health Insurance Scheme whose membership is compulsory for (a) all contributors to the Social Security and National Insurance Trust (SSNIT) and (b) all registered cocoa farmers;
- ii. A family of rural-based community-financed schemes meant to ultimately cover all members of the rural community. Membership would be voluntary. This can be developed on a pilot basis; and to serve as a catalyst for the creation of an enabling environment;
- iii. Profit or non-profit private schemes for the urban self-employed. Membership will be voluntary.

The first efforts to give meaning to the above led to the initiation of the pilot NHIS in the Eastern region by the then government of the National Democratic Congress (NDC).

Significantly, however, at the time of my fieldwork in 2000, the official policy framework had shifted from the idea of centralised national health insurance scheme to multi-scheme systems. The new government of the New Patriotic Party (NPP) that came into power in January 2001 also had health insurance strongly enshrined in its party manifesto and was very determined to get rid of the existing “cash and carry system” and replace it with health insurance. Surprisingly, however, the period during which this shift in policy thinking occurred, pre-dated the new government that assumed political power in January 2001, as I discovered during my fieldwork.

Dr. E.K. Adibo was the immediate past Deputy Minister of Health in the previous NDC government and also a former Director of Medical Services. He was also one of the instrumental proponents of the health insurance concept in Ghana. When I sought an opportunity to have a conversation about health insurance with him, he promptly agreed. We met during one Friday afternoon in an office within the Ministry of Health, which incidentally happened to be very familiar to the two of us. At the time I spoke to him, the reasons for the official shift in policy from generic to multi-schemes were common knowledge, but what he said about the timing of the conceptualisation of the multi-scheme idea within the ministry came as a surprise to me. In his words, “From the very outset the policy of the ministry was that multi-schemes should be encouraged and that the ministry would work with communities to establish community based schemes”. In spite of this, when the ministry decided to pilot a scheme for the informal sector, it chose a centralised approach and as he himself described it, “The whole experiment became a fiasco”. This subject, which is more related to the role of the nation state in health insurance, belongs to another chapter, and is discussed in Chapter 8.

The Brong Ahafo region of Ghana is the pace setter in community health financing scheme in the country because of the Nkoranza experience. Although Nkoranza itself is a mission facility and therefore administered as a non-governmental scheme, it had had a demonstrable effect on ideas and policy thinking regarding health insurance at the regional health administration. At the time of my first fieldwork in the latter part of 1999, the regional director of health services had assembled a regional health insurance team whose objectives were to study and encourage the formation of insurance schemes in all the districts in the region. I actually got the opportunity to sit in one of their meetings. It became very obvious to me that the Regional Director of Health Services, who was the ministry’s highest ranking policy person at that level, had become a committed apostle of community health insurance.

During my second phase of fieldwork in Nkoranza, I arranged a formal interview with him, but when I made the two-hour or so long journey to Sunyani on the appointed day and time, he was not in his office. Tracking him was frustrating, especially in the midst of a gathering rainstorm in an unfamiliar territory; but when I did locate him on his mobile phone, I was not disappointed. He had travelled to another district under his administration to join district MoH officials and various stakeholders in that community to dialogue on community health insurance scheme that was in its final preparatory stage. During our conversation, I asked him about reasons behind the “shift” (so to speak) in policy by the ministry to multi-schemes in the policy of the ministry. His response was:

Experiences with the Social Security and National Insurance Trust (SSNIT) and such other big bodies do not encourage us to go for a universal national scheme. My belief is in community and small schemes, which can later on be amalgamated when they are properly set up. The reason is that the population under formal employment is about 23% and that may be the only group that can meaningfully make their monthly contribution. When we go that way, we leave out those who are most vulnerable to sickness and do not have the financial access. And once we start a national scheme it will be very difficult to organise these informal sectors and villages that are the most disadvantaged.

In summary, the policy conception of the MoH regarding health insurance in Ghana is driven by the assumption that a prepayment health insurance scheme appears to be a better and more humane option of health care financing, particularly for the vast numbers of rural poor. There is also an assumption that implicit demand for it exists as some economic feasibility studies suggest. For example, Asenso-Okyere et al. (1997: 236), in a pilot study of the willingness to pay for health insurance in the informal sector of Ghana covering three districts in the Eastern Region and using contingent valuation reported that an overwhelming 98.7% of respondents were prepared to participate in the scheme while 63.6% were willing to contribute 5000 cedis (\$3.03) a month for a household of five persons. Prior to that, Arhin also reported in a feasibility study of rural schemes in Dangme West based on contingent valuations that 98% of household heads were willing to pay a premium to obtain health insurance coverage for all persons in their households (Arhin 1995: 104-105). These views are central issues of discussion in later sections of this chapter.

Implementers' perceptions

Implementers are the group of officials who are responsible for implementing desired policies. This gives them a very unique position. Among other factors, both technical and social, their perception of issues and principles have a bearing on their motivations and ability to bring about the expected policy change. I therefore had a series of interviews and conversations with a cross section of health implementers in the various districts that I visited to ascertain how they also perceive health insurance within the framework of the official policy perspective. The general view conveyed to me indicated that virtually every health staff has a strong sense of attachment and responsibility towards health insurance. Consistent with the policy ideals, implementers perceived health insurance as the potential alternative solution to the problem of financial access to health care for the rural poor. In Suhum for example, the Principal Nursing Officer in charge of nursing administration conveyed this view to me:

I think it would be of great help to all of us because at times when patients come here they encounter so many problems. I feel insurance is a laudable idea. People who come on admission sometimes claim that their relatives have gone home to bring money to pay their bills and medical cost. But those relatives never come back to pay the bills. The reality is that they do not have the money to pay. Sometimes we have five to six patients in the wards who cannot afford paying the bills. On some occasions we even have to follow them to their homes. All this makes the work difficult and it does not give a good impression about the institution of health care. It looks as if we are not considerate but that is not the case. And it also causes delay in the sense that chasing them takes some of the time away from nursing care.

The potential benefits of community schemes to both service provision and community, as put across in the above is well demonstrated in Nkoranza. The district director of health services who also practiced as a clinician at the Nkoranza hospital endorsed the view to me during a conversation.

It has made a lot of difference to the service and the community. To us, the service providers, it has offered an easier way of getting paid for the service because it assures us that the returns are already available so it makes it possible for the service run smoothly. The people also benefit a lot in the sense that when they are sick, they do not have to look for money to pay for the service. Subscribers can just walk in and get the service they need without bothering about how to pay for it.

In Dodowa the health implementers I spoke to were also supportive of insurance because of what one female nursing officer aptly described as 'money famine and people's inability to pay for health care'. But there were deep-seated

concerns about the attitudes people are likely to develop towards insurance. The medical assistant of the Dodowa health centre expressed his views in the following comment when I spoke with him:

I think there should be something like this. We know that eventually it is going to assist them. Even today somebody came to me with a child and she was to pay only 2,000 cedis for the service. She went up and came down to say that he cannot afford it and the child was suffering. So she asked me if I could help in any way and the only thing I could do was to pull out 2,000 cedis from my pocket for her to pay. The situation is a bit complicated. If there is no emergency people feel they are healthy so they spend their monies on other things. Yet the same people are saying that the insurance is good. The future means very little to them. Some may also say what will be the outcome if I deposit 50,000 cedis for my family and I do not fall ill the whole year? Eventually they may be having negative thoughts and this is the area I know our policy would run into difficulty.

In summary, most health implementers were also quite enthusiastic about the potential benefits of community health insurance to enhance access and improve service provision. Many were also pessimistic about the centralised approach the ministry of health originally planned to implement a nationwide insurance scheme as well as the decision to start from the informal sector. In Suhum the District Director of Health Services observed the following in relation to this pessimism:

Well, in my opinion, the idea to start from the informal sector is wrong because most of these people are not organised. They have some form of arrangements like clubs and they contribute money weekly. When somebody dies they help the family, but I do not think that is what they want to do. Look at the poor farmer. If you ask him to pay some money every month it's going to be a problem because he doesn't see himself as likely to fall ill. We even hear such things from our staff here sometimes. I think they should rather start from the formal sector because they are already organised, and we can learn from that experience and then move to the informal sector.

Certainly there are several concerns about community health that are related to the context of their implementation. Before I venture into any discussion however, I will first examine how the people also perceive health insurance.

Community perceptions

Lay or popular notions, both positive and negative about health insurance are highly pervasive in all studied communities but prevailing ideas vary in

accuracy and detail in relation to the level of contact communities have had with health insurance initiatives. Basically, people conceive health insurance as an arrangement in which they contribute towards sickness in advance, something similar to vehicle insurance. In general, however, popular notions and reception to health insurance are shaped and coloured by several identifiable social factors or patterns which include:

- Ideas floating around about other forms of insurance such as vehicle accident and fire insurance;
- Past experiences with local credit and mutual schemes;
- Perceived level of credibility and confidence in ownership of health scheme/proposed initiative;
- Prevailing quality of health care services/care provided at the facility;
- General economic hardships and level of poverty in society;
- Distressed traditional social support mechanism in Ghanaian society; and
- Expectations and nuances about community initiatives based on past experience.

I now examine these patterns in detail as people relate to them in day-to-day conversations.

Prevailing ideas about conventional insurance feed into how people perceive and/or what they expect from community social health insurance. Perceptions in general tend to be positive or negative depending upon the nature or experience people have had with insurance. Commonly, however, what stands out is that most informants appreciate community health insurance on the basis of its potential to solve their financial problems when they need health care. A seventy-year-old opinion leader and the owner of a successful retail pharmacy at Suhum captured this positive image and people's common expectations of health insurance as follows:

It is good because not all people are financially sound; they cannot make ends meet [expressed figuratively as *wɔ̃n nsa nhyia wɔ̃n ho*]. Some cannot even pay ₵2000 and others run away from the hospital when they are admitted. Insurance will take care of them.

Positive perceptions

Economic difficulties and the ever-increasing cost of medical care are fundamental reasons why people are favourably disposed to an initiative that promises to take away the burden of medical care cost. In the practical case of Nkoranza, where the community had had experience with a community scheme for nearly a decade, the perception of the overwhelming number of them focussed on the idea that insurance has made health care accessible to the

otherwise financially poor in the community. A female FGD participant at Dodowa had this to say:

What we like so much about it is that when you are a member and you are admitted, it pays for all your medications. Even when the drugs prescribed for you are not available, the insurance reimburses you the cost for prescribed drugs that you purchase from other pharmacy/drug stores.

In most focus group discussions, participants enthusiastically conveyed the view that possessing an insurance card (as the community commonly referred to it) provides both financial and psychological benefits to the holder. The following set of comments at a discussion involving six male subscribers from Nkoranza who were aged between 43 and 72 years typifies the observation. In particular, they stressed that psychologically, it reduces the anxiety people have about being sick and how to deal with the sick role.

Since I joined the scheme from its inception, I have never fallen ill. I have used the seven thousand to buy off my illness. Mentally, our health is better than the non-insured because we are not afraid to go the hospital. *A 43-year-old farmer and sawn miller from Nkoranza, with six years basic primary education, married with five children and a Christian.*

If you are a member, even if you fall ill you are still mentally sound unlike the one who has no insurance. When the non-insured is admitted, he is worried about the cost of the drugs and the money to pay for the number of days he is kept there. But if you are insured, you are not bothered about these things. Even if you are admitted for two months you are a happy person despite being sick. *A 53-year-old farmer with 10 years of elementary education, married with seven children and a Christian.* Anyone who has insurance does not think about when he is going to fall ill. As soon as you begin to get symptoms of illness you are eager to go to hospital because you know that when the sickness becomes serious there is no financial problem. You report early and the sickness does not get out of hand so you maintain good health. *A 45-year-old professional teacher, married with 3 children and a Christian.*

When you are insured, sickness avoids you and has no power over you. So gentleman, the insurance is a very good thing. The last time I was admitted, my bill was 550,000 cedis; my family could not have paid that money if I were not a subscriber. *A 62-year-old male of Nkoranza, with eight years elementary education, married with six children and a follower of indigenous religion.*

Significantly, the non-insured also attested to the benefits of health insurance as a group of them indicated at a mixed (male and female as well as subscribers and non-subscribers) focus group discussion at Kranka, a distant rural villages within Nkoranza district noted for a low rate of subscription to the scheme.

It is good because when you are a member it takes care of your medical expenses when you are admitted. *A 29-year-old female petty trader of Kranka with 10 years elementary education, married with 2 children and a Christian.*

It is good in the sense that if I join and I do not fall sick, at least a member of my family may fall sick and the money will be used to look after him or her. That is helpful to all of us. The problem I have with it is the timing of the collection of the premium. If they leave it open throughout the year it will enable me to pay. *A 54-year-old female farmer of Kranka, no formal education, with eight children, widowed and a Christian.*

Those who are insured are better than us because anytime they fall sick and need admission they are assured of health care. *A 45-year-old male physical education instructor, married with seven children and a Moslem.*

Obviously without the benefit of a functional scheme, community people in Suhum and Dodowa did not have much to say by way of positive perceptions. Indeed they had more concerns and questions about how health insurance would operate based on previous experience and perceptions of public initiatives. In general, positive impressions about insurance in terms of its potential to make health care accessible when needed were not lost on people in those two districts. The general view was that because of poverty and high hospital fees, people have difficulty paying so “it is better to pay something small now to cover you in future”. Again there was particular stress on the fact that the weakening traditional family support system makes community health insurance a favourable idea to encourage. At rural Dawa in the Dangme West district, one female FGD participant emphasised this point:

Now the family is not able to help very well. If you fall sick you can see that you need to seek medical treatment but you may not have the money. Looking around, you might not find help from anywhere. You may easily die from preventable conditions because of the inability to pay. So by the grace of God, if we join this scheme, it would make it easier for us to seek treatment. When we are sick, the only thing you need to think of will be your transportation. So I think it will be of help to us.

People thus evaluate health insurance as being very beneficial, particularly for the rural poor who are unable to save towards health contingencies in view of their marginal subsistence. They recognise the economic, social and psychological benefits of health insurance.

Negative perceptions

There were some negative perceptions; some based on ‘rumours’, some on misunderstandings, and others on misgivings and ‘ignorance’. Particular perceptions depended upon the community in which one finds oneself, the stage of actual implementation of the insurance program, the experience the community has had with insurance and the type or group of persons one was speaking to. Thus negative perceptions in Nkoranza tended to be complaints, misrepresentation or what some blame on ignorance. In Dodowa and Suhum, negative perceptions were embedded in doubts, misgivings and misapprehension. In some respect, part of the negative feelings that people from Suhum and Dodowa district harboured about health insurance stemmed from previous bad experiences with other forms of community mutual arrangements, in most cases savings and credit schemes. People who had previously suffered a loss of savings or income through local savings and credit schemes (as a result of financial misappropriation) were completely unenthusiastic and doubtful about community financing initiatives in general. One of those that I spoke to was Madame Adepam (not her real name) of Suhum, a 57-year-old dressmaker, divorced with five children. She had a dressmaking business with twelve trainees. She lamented a local credit scheme that went bankrupt after a few years of operation. Many of its clients sustained heavy losses. Her comments:

About ten years ago, something came to this town called BAMAX¹ to which people contributed all their life savings because of a promise of fifty percent interest per annum. It received a high patronage but after a while it became bankrupt and people lost everything. Some even developed heart and mental problems. Yet the man behind it is still walking round without any punishment. Such an incidents make me and I suppose others who have gone through similar experience, quite apprehensive about anything that involves the payment of money with a promise of future benefits a difficult thing to accept.

She was not alone. Just across the street from where I spoke to Madame Adepam was a 63-year-old retailer of alcoholic and non-alcoholic drinks. When I called on him for a similar conversation he stated that he would not have

¹ Around 1993 a number of non-bank financial institutions started operating savings and loan schemes without authorization from the central bank. These included R5, Pyram and Bamax. These phoney institutions succeeded in luring unsuspecting members of the public to deposit millions of cedis with them. In return, depositors were promised interest rates above the prevailing market rate offered by commercial banks. Huge interest rates of 30-40% attracted many people to the point that some investors withdrew their money from the recognised commercial banks and deposited them with these institutions. Before long they became bankrupt and many lost their entire lifetime savings.

anything to do with insurance because of the loss of cash he suffered through BAMAX. Memories of such situations were common in virtually any community, as I discovered when I moved into the Dangme West district. There were genuine fears that ‘things’ like insurance “might turn out to be a trick by which some individuals use to rob poor people” of their hard earned money. This was the consensus at a female focus group discussion in rural Dawa. A twenty-five-year-old participant’s comment captured this sentiment:

Some time ago, some people came to this town and claimed they were going to establish a bank here. Our elders gathered all their monies and opened an account with them but we have since not seen any of them. So although I like the idea behind the new scheme, because of what happened I am entertaining some fears about it.

Part of the negative perceptions were traced to misgivings about official bureaucracy based on experience with conventional insurance schemes, such as car accident and pension insurance. A 38-year-old male photographer at Suhum explained it in the following words:

When you are going into it they bring a sheet of paper. When you are entitled to a benefit they bring twenty sheets. We do our things in such a way that those who do not invest rather benefit and those who suffer don’t benefit. When you invest your money into insurance it is the staff of the company that rather benefit. Look at SSNIT.²

Indeed, mistrust of officialdom was also cited at the district and local levels, for the way they sometimes collect fees or dues from communities in return for promises for improved social amenities, but nothing happens. One participant in a female focus group discussion at Dokrochiwa, a distant rural village in Suhum district, made the point emphatically clear citing a local example.

There are several cases where we have paid monies and nothing came out of them. One case is the road to this town. There is also the case of water. They promised us a borehole and we all paid; but that never happened. The most recent one was street-lights. I vowed I’ll never pay and I lived up to my word. It all boils down to our leaders in this town. I will still say it even if they are here because it bothers me. Similarly if you take the Eastern Regional Minister, she has never set foot in this

² SSNIT is the acronym for the Social Security and National Insurance Trust. It is the official social security system in Ghana, but is limited to only the formal sector employees. Among others benefits, it provides cash payments to contributors after retirement or to their dependents in the event of death, but the manner in which the contributions and payments are conducted have attracted a lot of criticism, especially in recent years.

town. How can she say anything about this town in parliament or cabinet? I remember our road, we heard that they came and took a picture of the Owirem road (a nearby village) and presented it that they have constructed the entire road to Dokrochiwa. These are the reasons why people might be reluctant to embrace the insurance scheme.

Some negative perceptions are also against the government for its inability to deliver on some or most of its promises (the subject of another chapter). In theory, the idea that a community pays a premium to entitle them to free treatment during illness sounds nice and good. However, many are sceptical about it because of “such sweet official promises that were never fulfilled”. A participant, at a female FGD at Dodowa explained it this way:

Some time ago it was announced that pensioners would be treated free when they went to hospital but when I sent my father to the health centre they asked me to pay 2,500 cedis. So I feel that they are telling us lies. At some time they might even tell us not only to pay for drugs but for thermometer and speedometer readings... I do not believe what they say. In Ghana things move sideways and backwards too often.

The credibility of the health care system in relation to quality of care factors and ownership of schemes were also decisive factors in the way people perceive insurance. Concerns about poor staff attitude towards patients, favouritism, cheating and other misconduct and malpractice by health staff and/or implementers and/or administrators were often voiced. These tended to cloud any merits that people perceive health insurance to have, as these two views from Suhum district indicate. First, a 39-year-old professional photographer’s contribution during a male focus group discussion at Suhum:

It is an open secret that nurses collect “under the table fees” from patients. When the insurance becomes operational, the chances are that people may no more pay such monies if they know they are fully covered and entitled to treatment. But the non-insured may still pay such bribes and get preferential treatment from the nurses. If you do not take care you may sit in the wheel chair and die.

A 34-year-old single mother of one and a petty trader also from Suhum expressed her view on the issue during a female FGD as follows:

The only concern about it is trustworthiness on the part of those who will be in charge. Would they faithfully give equal treatment to clients when they report ill? Sometimes those in charge of such schemes live fat on the money and ride in big cars. The money is there but instead of using it for good purpose they would buy big cars and ride in them.

In Nkoranza the most common misrepresentation of the insurance scheme was symbolised in “gossip” about the casualty ward. The gossip began when the casualty ward was created for the purpose of observation and emergency, just as all other casualty wards are. Detention at the casualty ward is technically not considered as in-patient admission. However, since it became the transit point for admitting patients onto the ward where they could then benefit from the scheme if they were insured, some in the community started associating it with cheating. The common claim therefore is that doctors are often reluctant to admit those who are insured to the main ward but rather prefer to put them on observation at the casualty ward. In the view of those community members, the casualty ward has been created as a watershed to deprive people from benefiting from the scheme and a way to cheat them by the hospital authorities. This misrepresentation even goes beyond the casualty ward to another misperception: that the insured do not receive good quality drugs when they are admitted because the hospital wants to economise on the premiums paid in order to break even or make profits. However, one participant at a male subscriber’s FGD at Nkoranza disagreed with this negative perception. He gave this vivid descriptive assessment of the issue as follows:

Some claim that when you are a member of the scheme and you go on admission, you are discharged early, or the doctor does not take good care of you or even when your condition is serious the hospital does not want to admit you. But some people are sometimes rushed to the hospital on emergency during odd times such as the night. You see in such situations, the appropriate thing for the hospital to do is to admit them at the casualty ward to study the situation. But when such people are discharged after observation because they do not require admission, they begin to grumble that they were not admitted to the ward because the hospital did not want them to benefit from their insurance. For that reason they think it is useless to have health insurance. This is an erroneous impression and such utterances come from illiteracy; it is lack of education.

Significantly, during a conversation with the *Omanhene* of Nkoranza, he also dismissed the charge of ‘cheating’ against the scheme as “rumours” that ought not to be taken seriously. However, he advised about the need for sustained education to disabuse the minds of those who harbour such notions.

Some people claim that when you pay and you are admitted they don’t look after you well. They give you inferior medication and they discharge you early. But this is not true. There is no doctor who will discharge a patient if the patient has not fully recovered. There is also no doctor who will keep away a good drug that will make his patient well. It does not happen because that doctor will lose the confidence of his or her patients so it is never true. In every community, *sebe* (excuse me to say),

where the literacy rate is low, or where too much superstition thrives, rumours and misconceptions are very high. What we need is education to change those attitudes.

In summary, the views from the community indicate that the encounters that people experience with the health care service and its financing leads to diverse reactions. Some are favourable while others are prejudiced. Altogether, these perceptions are therefore a function of contextually deep-seated social, cultural and economic factors.

One general observation from the foregoing is that apart from the problems of economic poverty, historical and social factors play a dominant role in shaping people's ideas about health insurance. Concerns about weakening traditional social security arrangements, credibility of local and state officials in relation to ownership, prevailing notions about the health care service and previous experiences with local micro finance initiatives are all factors that make the problem of mutual health insurance both important and difficult for social analysis. Since my purpose in this thesis is to help understand how to translate some of the social features of traditional support into insurance systems, I turn to examine how implementers and other people further perceive some of the relationships between the two i.e. insurance and traditional support mechanisms.

How do implementers and 'the people' perceive the relationship between insurance and traditional family support?

One basic assumption of the official policy of Ghana's health insurance plans is that the underlying principles of risk sharing and 'resource pooling' or solidarity in insurance are synonymous with traditional Ghanaian mechanisms of social support. Planners view the Ghanaian socio-cultural system as already having in-built sophisticated and time-tested support mechanisms that can accommodate elements of a solidarity based health insurance scheme. The policy perspective therefore is that designing a scheme with "a rich blend of the traditional and modern" would appeal to people, for they would already understand what the scheme is about and the role they have to play to access its benefits. The ministry of health thus conceptualised health insurance as a means to formalise traditional risk management mechanisms by "pooling of resources from friends and family to take care of our health" as is traditionally done "in times of trouble and ill health" (NHIS 1998). Because of this perceived parallel, in this study it was important to ascertain how implementers and the community at large actually perceive the relationship between health insurance and traditional

social support arrangements in order to understand how both groups draw social lines or levels between traditional family support and health insurance.

Implementers' perspective

Health implementers hold the view that traditional social security mechanisms and mutual health insurance based on the principle of solidarity are synonymous. The coordinator of the abortive NHIS in the Eastern region succinctly conveyed the view during one of our meetings:

In the old traditional system, we supported one another on the basis of solidarity. Family members went to the assistance of one another in times of difficulty and sometimes in times of joy, such as marriage celebrations. It took different forms, but food was shared and the sick and bereaved were supported based on reciprocity. So this culture of assistance already exists and people help one another already. This thing has been there and people think about each other so that we will bear one another's burden. We are picking on this to build the insurance programme. It is just another way of conscientising the people about reciprocity so that we will bear one another's burden.

The difference however is that instead of waiting for the family member to fall dead before we assist, we want to get organised and provide support as soon as the need arises. We want to give a new dimension to social support. It is the same solidarity principle but I do not want to compare the strength of this solidarity with what used to prevail some time back because things are changing.

Apart from citing solidarity as being common to both, the prepayment feature and the wider scope of insurance were also emphasised by implementers. A health manager of Nkoranza emphasised the level of social inclusiveness in particular in insurance. He made this remark during one of our conversations:

The concept of solidarity is common to both but the difference is just a matter of degree. The difference is that the whole community or other communities are involved in insurance. Traditional family support for sickness was never on such a large scale. Rather, it was and still is during funerals that the whole community become involved.

Despite the common view about solidarity among implementers, some were unsure about how it was going to work in the new scheme, in view of the increasing social differentiation in society. In particular, there were doubts about the sincerity of community members when accepting the basic underlying risk sharing mechanism. The principal medical officer in charge of Suhum Government Hospital hinted at this when he made the following (excerpted) remarks about the program's feasibility as conceptualised by the ministry.

It will be very difficult to achieve what they [the policy makers and planners in the ministry] are talking about. By solidarity I think planners mean that everybody will act as his/her brother's keeper, so if you do not fall sick and your brother falls sick your money will be used in treating him. You see, this kind of thing, before you can ask people to contribute willingly you must make them see the need and this is where the difficulty lies. Some people feel that they do not fall sick so how can they feel that need? They will feel that they are being cheated. You may have a system where people will feel that at the end of the year, if they do not fall sick, you should pay them some money.

Community perspectives

The community also shared the general view that solidarity is the building block of both traditional support and insurance. However, the concept of risk sharing was hardly used by the community who tended to describe it simply as sharing or helping one another. One community member illustrated the perceived similarity of solidarity underlying the two support systems at a focus group discussion as follows:

In traditional support, which was quite effective in the past, when something happened to a family member, other members would come together to assist. For example, if someone becomes seriously ill and needed assistance, the family will mobilise resources and either send the person to hospital or call on someone who could cure him. At present, as insured people, we all contribute and if someone falls ill, the money contributed takes care of the admission at the Nkoranza hospital. The two are therefore the same because they are both based on unity. Since the scheme started, I have been paying every year together with my wife and children but none of us has ever been on admission. However, I think that the small money I have paid is helping somebody. *Participant in male FGD, Kranka, Nkoranza district*

In addition, there was agreement among community people that mutual insurance is literally wider in terms of scale of social participation. Two views from different locations illustrate this point. First, a female informant at Dawa in Dodowa district:

The big difference I see is that, in the new insurance scheme, so many people are involved so the support base is bigger than the traditional family support.

Then at a male FGD participant at Nkoranza expressed his view on the issue:

In the past if someone was sick in the family, the family pooled resources together to look after the person. The present Nkoranza scheme is a larger family in the sense that the whole district is pooling resources together. We are all pooling resources together so that if one person is in difficulty we help to pay the debt, if another

person gets ill, we pool resources to assist him and so on and so on. This is the sense in which the insurance has become a bigger family, pooling resource together to assist in time of sickness.

In addition, the common view that in sickness the level of social participation in mutual insurance is wider than the situation in the traditional support system (since it goes beyond the family), they also cited distinctions in two functional dimensions between insurance and traditional support. The first was recognition of the prepayment feature of mutual insurance compared to the traditional system and its associative consequential security potential when there is a need for assistance. Again two contributions from focus group discussions summarise the viewpoints. A female FGD participant from Kranka in Nkoranza district:

In insurance you prepare for the problem but in the traditional support you look for help after the problem has occurred. Sometimes, the expected help might come too late or may not come at all. This makes insurance better.

Another view from a male participant during a male FGD at Dodowa:

The security in family support is not always guaranteed because sometimes the family has to borrow money, which has to be refunded anyway, and this may become a burden on the family or the sick person after treatment. That does not happen in insurance and the entire community shares the risk so if it is one million it is spread across.

The fact that the community recognises that health insurance is relatively more secure in terms of its promptness and reliability when there is need for assistance is quite reassuring. At the same time, the point about traditional support that it was (and still is) organised after the event has happened and only when the need was critical and the evidence for the assistance was without doubt, is quite revealing. The latter situation in fact could partly explain the unenthusiastic or lackadaisical attitude of people when it comes to fulfilling prepayment premium obligations in insurance. They are used to waiting for events to happen before they react.

Another distinction perceived by the community was that insurance is more proactive since it avoids the problems of occasional conflict among family members and the social stigma that sometimes accompanies traditional support. A participant in a male FGD in Suhum illustrated this disadvantage to traditional support as follows:

They are almost the same but there is one “cross” [negative aspect] about the traditional support system. The cross is that when the entire family comes together and looks after me, they could cast insinuations at me when for instance a quarrel breaks out later in the family. But in the insurance it is like buying my own food to eat so no one can remind and/or insult me about it at a later time under any circumstance. It is like using my own money to buy land. I have not cultivated family land, its rather buying my own land and cultivating to feed myself from the harvest; that is insurance. On the other hand the former [traditional support] is like farming on family land, the family head [*Abusuapanyin*] can take it back or say something about it against me.

Despite the common view in all communities that social participation in mutual health insurance is wider and for that matter “better” in terms of risk pooling, one point that was also frequently brought to my attention was the unique situation of funerals. Some even compared the solidarity logic behind insurance to ‘the way Ghanaians organise their funerals’. In view of the interest and concern the issue attracts, I enquired with the *Omanhene* of Nkoranza, Nana Okatakyie Agyeman Kodom IV, when I had the opportunity to interview him. I asked whether the popular support that funerals receive was a recent phenomenon or “culturally Ghanaian” from the past. Indeed, such an enquiry was necessary and relevant, since the case of funerals is sometimes cited by health policy officials as an example of how Ghanaian society share risks beyond the family. One news report cites a former minister of health as saying that, “Ghanaians are familiar with the principles of pooling community resources for funerals, for example, and that could be applied to a health insurance scheme” (Adu-Asare 2001). In responding to my enquiry the *Omanhene* of Nkoranza provided a brief historical view of traditional sickness and funeral support:

In the past, when a member of the family fell ill, it was the responsibility of the family to either send the person for treatment or bring someone to treat the person. The cost involved was basically borne by just the family. Assistance outside the family may be sought only when it became necessary. Family support during funerals followed a similar pattern. When there was death in the family, everything in connection with it was the responsibility of the family but there was a little but significant variation with sickness support. The difference was that, although the family was responsible for the cost involved, during the funeral the family would invite the entire community through the palace or chief. The community would offer donations to the bereaved family. The fundamental difference of community participation between sickness and funerals is therefore an old phenomenon although there are wide variations in modern times. Traditional support for sick relatives has diminished while support for funerals has been taken to uncontrollable limits.

For analytical purposes, two general remarks could be drawn from the foregoing observations of implementers and the community regarding the relationship between traditional family support and health insurance. Both make the point that traditional family support for sickness, when it was provided was confined to the family. Secondly, the principle of solidarity or pooling of resources from the whole community was well associated with the organisation of funerals in traditional support system. One obvious question can be posed in relation to the two remarks. Why did (and still does) the whole community get involved only in funerals and not in sickness? The same question could be asked in another way to find out why traditional support for sickness did not transcend the family to become a community activity, as has been the case with funerals. An attempt to find answers to the question is a fruitful way of explaining beyond economic factors, the cultural antecedents to people's attitudes and behaviour towards health insurance.

Is it possible to transform 'family solidarity' exhibited during funerals to community health insurance?

This question is important for two reasons. In the attempt to implement risk-sharing schemes in the sub-Saharan African context, any risk sharing mechanisms beyond the family are useful for providing lessons. Secondly, in the attempt to implement community health insurance in Ghana, funeral support, as I have already pointed out, is sometimes cited as an example by proponents of community health schemes to show that people's willingness to share risk beyond the family was socially and culturally acceptable and feasible. However, when I posed the above question to informants in the community, it often evoked vague or elusive responses. Some found it a difficult question to answer.

Indeed when I seized the opportunity during my meeting with the *Omanhene* of Nkoranza to ask for his opinion, his immediate reaction was a smile followed by a remark that "this question of yours is a difficult one". He then rendered a comprehensive response that did not only reinforce the delicate nature of the matter and the Ghanaian sentiment towards funerals but also explained previous unsuccessful attempts by his traditional council to regulate and scale down the organisation of funerals in areas under his jurisdiction. Moved by a great concern about expensive funerals in the community, the traditional council made bylaws to stipulate how much people could contribute, both in terms of donations during funerals and on the type of alcoholic drinks served during such occasions. The rules were abused repeatedly, and after just two years it soon became ineffective because, as Nana explained it, "we do not have state enforcement power to punish offenders". He ended a long discourse by pointing

out that society's uncompromising attitudes towards expenditure during funerals weighed against their citing poverty as a reason for ignoring the payment of insurance premiums as "an attitudinal problem that requires a long sustained education and attitudinal change on the part of people".

Considering that the Nkoranza scheme had run for eight years at the time this conversation was held, the observations were a sad reflection on the society's double standards towards health care and funerals. Indeed, observations about Ghanaian funerals never miss the large-scale social participation and financial expenditure involved. If it is ever possible to learn and transfer some of funerals' organisational principles into mutual health insurance, we need to understand why the desire to spend and support them is so compelling. In a number of FGDs when the issue came up, the dominant explanation was emotional sentiments. In Dodowa, one participant echoed such a view:

No one likes death but we need to help one another. Even if an animal dies, it has to be disposed of. How much more a human being created in the image of God! No matter the character or nature of the person, God created him. People sympathise because they will not see the dead person any more and they feel the pain. When I attend someone's funeral, therefore, I use it to reflect on my own funeral one day.

What the above remarks suggest is that death generates an elevated degree of emotional sentiment that compels people to respond the way they do at funerals. Apart from that economic appropriation and affirmation of family prestige in the public sphere through funerals greatly contribute to its relatively unique scope of support in contemporary Ghanaian society. This view was succinctly brought home during a conversation between Paul (not his real name) and I. Paul is a native of Nkoranza, and one of the coordinators at the insurance office. Excerpts:

Paul Everybody knows that a lot of friends and well wishers will attend a funeral. If they attend the funeral of someone related to me and I don't perform well, I disgrace myself. Besides when you need a loan to pay medical bills and you approach people they will not help you, but if the person dies, and you need a loan of one million cedis for the funeral, you will get it in five minutes because they know that one you can repay.

Dan: How?

Paul: Because those who attend the funeral give cash donations which you can use to pay off the loan. On the other hand, how do you go and explain to someone that you need money to pay your mother's hospital bill when there is no guarantee that you can pay it within a reasonable time? If you tell them that you are going to pay such monies after you have harvested and sold your maize they won't give it to you. Nobody will give you the loan. In fact, in the case of funerals, even if the donations are not sufficient to cover the loan, any remain-

ing debt will be shared among the family members and they will pay. So there is increased security for the person to get his money back.

Dan: You are saying that the family members will be willing to pay the debt in this case?

Paul: Yes, because it's a disgrace to them if they do not pay the debt. Supposing I lose my mother and after the funeral there is a debt of 200,000 cedis to be paid to somebody who gave me a loan. If I am not able to fulfil the loan obligation the whole town will hear about it and all sorts of insinuations will be cast against the family. So to protect the public image the family, we will do everything to pay off any remaining debt. There is a proverb that says *Abusua dɔ funu* [the family loves the dead]; it is true.

Dan: What does that mean?

Paul: That means that every family or clan wants to maintain a certain level of respect or protect its name and maintain some fame. One way they achieve that is through funerals. It sounds great for people to acknowledge which musical band they brought to town to play at their funeral. When that happens people will comment that the funeral was grand but nobody will commend you for sending your mother to Korle Bu (Ghana's number one teaching hospital in Accra) when she was sick before her death. The family will buy the big and expensive shroud to dress the body in and get the most popular band in town to come and perform. That is death; but never when the person is sick.

In summary, the views conveyed in this brief excerpt reinforces a point that economic appropriation and affirmation of social prestige or capital is at the centre of Ghanaian's willingness to spend extravagantly during funerals. People are able to afford heavy expenditure because they look to donations to recoup what they spend. Donations offered at someone's funeral are an investment that will be reciprocated in the future when they become bereaved. A very revealing aspect of this economic appropriation in the organisation of support for funerals is that when the need arises, expected donations also provide a form of security to obtain a loan from potential lenders to pre-finance funerals. In Nkoranza, for example, I learnt that it was very easy for people to obtain loans from rural banks to organise funerals but difficult for farmers to get loans to improve their farms due to lack of the collateral.

I need to point out that any economic considerations in support of funerals cannot be divorced from their social dimensions. During a debriefing session, one of my field assistants summarised the nature of the public manifestation of the social aspects of funerals:

People use the donations to show off their magnanimity to the gathering. When this happens, they receive public acknowledgement for what and how much they have given. But when someone is sick there is no gathering for people to show off.

In other words, funerals are occasions that offer opportunities for collective action to strengthen social identities and prestige through *generalised reciprocity* in the public sphere. The adaptive function of this is that those who donate will also receive donations themselves when they are bereaved.

On the other hand, social insurance involves some aspects that are more akin to *balanced reciprocity*. It involves a clear obligation to make a premium contribution usually within a specified time or be counted out for any future benefit. The concept of risk sharing emphasises its social purpose but it is the payment of premiums that establishes an alliance of equality between subscribers. The benefit is, however, conditioned only on being sick, which is the aspect that underscores its social importance. The fact that the opportunities for “social rewards” such as prestige and public acknowledgement, when premium obligations are fulfilled do not exist, as they do for funerals probably impacts the tendency of people to participate in them.

Concluding remarks

The foregoing analysis of perceptions about health insurance and its relationship with traditional social support provides useful social cultural insights. In general, popular perceptions in the community about social or mutual health insurance are influenced by factors that include prevailing ideas about other forms of insurance, past experiences with similar and often local savings and credit schemes, perceived credibility of the ownership, prevailing context of health care services, general level of poverty and the nature of traditional support mechanisms.

Both health implementers and community people perceive health insurance as a useful option and solution to the problem of financial access to health care for the rural poor. Community people conceptualise the *value* of health insurance in terms of its economic, psychological and social support attributes. Its prepayment feature and regulation through a set of written rules and bylaws are perceived as socially appropriate. On the other hand, implementers harbour the fear that achieving solidarity through insurance is going to be difficult. Indeed the *concerns* of community people about insurance schemes attest to such a fear of the difficulty of getting people to participate in schemes. People’s legitimate concerns about what happens to their monies are based on a catalogue of complaints, including but not limited to: previous experience with similar micro finance schemes, lack of confidence in public and local officials, perceived favouritism on the part of health staff and dissatisfaction with quality of health care services in general.

There is a common assumption made by health planners in Ghana that existing traditions of social support in the rural context ought to make the implementation of community insurance schemes readily achievable. I wish to emphasise that although resource pooling or risk sharing traditions abound, the data here also indicate that people's willingness to participate in insurance is also influenced by a complex mix of socio economic and cultural factors that make the past or traditional affinity argument pale in insignificance. My analysis of how implementers and particularly community people perceive social relationships between health insurance and traditional social security arrangements has revealed some of the underlying social and economic factors that explain the differential social attitudes towards social support in the Ghanaian society. In particular, I have cited the wider level of social inclusiveness in support of funerals compared to the lack of such support in times of sickness in Ghanaian society. I have explained the difference in terms of economic appropriation and social affirmation or accumulation as well as their emotional aspects.

The effect of economic appropriation involved in the organisation of funerals does not escape any observer of Ghana. Apart from donations, which are meticulously recorded in notebooks with a view to cross checking and a pointer to the family's future obligations towards others, there are other items of economic appropriation, as noted by Arhin (1994: 318):

The increase in the quality and scale of the funeral rites has stimulated the carpentry (coffin and seats), brewing, distilling and paint trades, and has promoted such service industries as those of the mortician (a Ghanaian version of the undertaker), the suppliers of canopies and seats, and music and dance or cultural groups.

In the final analysis, the heavy expenditure would usually be recouped through donations from well wishers and friends as a demonstration of sympathy and affection on the basis of generalised reciprocity. Funerals therefore serve an economic purpose.

The economic appropriation of the heavy economic investment involved in funerals also serves an important social purpose. The scale and quality of the funeral is first and foremost an exercise in self-glorification that enhances the prestige of the bereaved family in the public sphere. At the same time, well wishers and friends who demonstrate their sympathy and affection through high donations receive acknowledgement and gain prestige and reputation in the public sphere through announcements on loud speakers and through intangible rewards such as where they are seated, the drinks they are served and even the glasses in which they are served. Such social accumulation opportunities that

keep funerals on the economic pedestal of traditional social support do not exist in the mutual insurance setting.

Other writers have also made observations about the wider scale of funerals in Ghanaian society when compared to other forms of assistance. According to Manuh, who analysed the changes in marriage and funeral exchanges among the Asante, funerals are occasions where “the fullest expression is given to the reciprocal relationships and obligations established between kinfolk of a man and a woman” (Manuh 1995: 188). Van der Geest interprets a similar situation in which social pressure effectively insures proper family care in the organisation of funerals while it was often defective in the provision of moral and material support to the elderly in the small town of Kwahu Tafo in Southern Ghana. He explains that “they saw the responsibility of looking after the elderly people as a house affair that is not seen by many. Funerals however are public celebrations and participation — by attendance and financial contribution — is visible to the entire community” (Van der Geest 2000: 120). Witte (2001: 69-70) has also made observations about the relationship of funerals and sickness to marriage, in her study of the changing funeral celebration of the Ashantis. She reports that marriage ceremonies are small compared to funerals because “marriage is considered more a private matter, whereas death is regarded as a matter of public concern”.

It has been noted in the existing literature on mutual health organizations in Africa that the reason promoters attribute to the lack of interest in such schemes or organizations is related to the notion of a lesser degree of risk beyond the family (Criel & Walkins: forthcoming). I have pointed out that the example of funeral support as an indication of risk sharing beyond the family has indeed existed for a very long time. I have used the case of funerals here because it is a common reference point for planners when they refer to the use of solidarity as an organising principle in insurance. I wish to stress that in any analysis of the capacity to appropriate some of the social and cultural ethics of traditional support, particularly funerals, into a mutual health insurance, the following observations ought to be taken into account. In the Ghanaian context:

- The levels or expanse of family or group involvement at which support was offered has always differed by situation in the traditional support system.
- The differences reflect cultural meanings or importance that society attaches to various situations.
- Accordingly, generalisations that put the capacity of risk sharing at par with different situations are culturally illogical and socially inaccurate.
- Furthermore, cultural traditions are constantly changing and such changes influence traditional systems and their effectiveness.

In developing or planning community schemes, imaginations about the existing culture do not provide a sufficient guarantee of success. Developing a deeper understanding of the perceptions of the social group or people and their cultural preferences and meanings more than anything else would potentially yield new insights and clues about dealing with potential misunderstandings and misconceptions between planners and the community. Practically, what it means is that in designing community schemes, assumptions that people will join because of altruistic risk sharing or solidarity reasons are not enough. A complex mix of social factors influences the ultimate motivation to join or not to join. These are the subject of the next chapter.



The picture shows how subscribers are put together for registration photographs in the Nkoranza scheme. The objective of this photographing arrangement is to minimize cost. The picture however, portrays the principle of solidarity of self-interest. The unity of members make risk-sharing possible but invariably, individual identity of subscribers in good standing counts when it comes to benefits. Policy makers conceptualize health insurance on the principle of solidarity. The primary motive of these seated here to participate is however, the self-interest to cater for themselves and their immediate relatives.

6

Solidarity, self-interest and social health insurance

Introduction

What leads a community to participate in a voluntary health insurance scheme? The previous chapter highlighted various factors that influence lay perceptions about community health insurance. Perceptions ultimately play a determining role in people's readiness to participate. In this chapter I focus on the driving force behind the concrete decisions people make to join or not to join health insurance; decisions that to a far extent determine how successful or unsuccessful a scheme could become. In discussing the factors that drive people's decisions, my analysis looks beyond economic determinants in which the prime focus is on latent demand. I look beyond people's assertions or contingent declarations of willingness to join and ability to pay when there is no scheme, to interpret how they actually behave when there is a scheme. I therefore examine the relationships that explain people's underlying motivations to join or not join community financing or insurance schemes. In particular, I stress the dynamic effects of social and cultural factors and the part they play on the collective or solidarity motive underlying schemes in the context of present realities. These issues are often not given adequate attention in the existing literature on social health insurance, which is dominated by economics and health economics literature.

The chapter begins with a brief explanation of the concepts of solidarity and self interest as they apply to social health insurance and how and why policy

makers in Ghana conceptualise solidarity as an organising principle of health insurance in the country. This introduction provides a useful background to the analysis of why people join or do not join health insurance, based on assertions when there is no scheme followed by the situation where a scheme exists. Data from various locations is used. The material on which these are based is derived from the first exploratory fieldwork in Suhum and Dodowa districts. I continue by showing what happens in practice and how people actually behave towards risk sharing solidarity arrangements when there is a functional scheme. This is based mainly on qualitative data from Nkoranza but also includes a little supporting data from a quantitative survey from Nkoranza and Dodowa districts¹. I use case studies to illustrate the fact that instead of the underlying solidarity principle that planners conceptualise, self-interest is rather the strong motive of people for joining voluntary insurance. In the discussion that follows I use the theoretical notions of social capital to explain the dilemma between solidarity and self interest in health insurance. I pursue my argument from the previous chapter and explain further that the strong self-interest serves to give credence to the absence or low opportunities for social capital in the voluntary context of health insurance.

Solidarity

Community health financing and/or social insurance schemes aim to protect or improve health through the concept of risk sharing by pooling resources together. Through the payment of contributions, those who are very healthy and rarely become ill help those who are less healthy and/or frequently fall ill. This is the concept of solidarity. Dunning et al. (1992: 56) have described it as “an awareness of unity and a willingness to bear its consequences”. Solidarity therefore implies that people accept that the size of the return may not match the resources (financial or others) they have put *ex ante* in the system (Criel 1998: 60)

Characteristically, health insurance is linked to the principles of group solidarity because it is a group activity. In the history of health insurance in Europe, which began in the 19th century, group solidarity played a prominent role and many schemes originated from it. Solidarity in health insurance may come in the form of risk solidarity or income solidarity². Income solidarity is when the financially able pay for the less financially or incapable or when the

¹ The data for Nkoranza was collected at both the exploratory and follow-up evaluation stages, while that of Dodowa was collected at the second evaluation study.

² Dunning et al (1992) also distinguish humanitarian solidarity, which is based on the intrinsic value of human life. Those who need protection because of disease or handicap must be offered it. It does not leave these other people to their fate but gives them the chance to participate in society.

rich pay more and the poor pay less for equal care. Risk solidarity is when the healthy pay for the ill or the good risks pay for the bad risks. It is therefore right to say that evolving schemes in Africa are characterised by risk solidarity and based on the payment of a fixed premium for unequal care.

From policy perspectives, solidarity-based risk sharing mechanisms potentially facilitate the harnessing of private funds for health care, thereby reducing the financial barriers faced by poor rural individuals, particularly the vulnerable groups, to obtain care when they need it (Arhin 1995: 2-3). On the part of consumers, payment of contributions in times of good health guarantees that they receive health care when ill. In order for a scheme to be viable, it requires a reasonably large membership of a cross section of the targeted community or group. Solidarity is therefore of critical importance to the design of a social health insurance scheme, in as much as it can impact how people in a society accept and join this type of mutual support.

Self-interest

Enlightened self-interest, to paraphrase Tocqueville (1840) who popularised the concept³ as “self-interest rightly understood”, simply implies that it is in the best interest of the individual to attend to the interests of the group at large because the needs of the group serve those of the individual. In other words, by securing the interest of the group, the individual protects his or her own interest. According to Sheridan (1996), that works in two ways. First, people are less likely to get caught up in individual pursuits when they contribute to society at large. Secondly, when people *see* (my emphasis) that their own interests are better achieved by meeting the interest of the community, they are more likely to promote and perpetuate the practice. Self-interest, like solidarity, thus requires people to sacrifice a little of their own resources to the benefit of the whole which in turn benefits them. The principle is a natural way of achieving individual and societal goals. However, in contrast to solidarity where the motive is what someone does for the group, the motive of self-interest is what someone gets from the group. It has to do more with the greater benefit that individuals get from being part of a solidarity group as a result of the little they themselves have also contributed to the group. In this sense, at the core of giving or being part of solidarity is personal motive.

In voluntary insurance, people come together to insure themselves against certain risks on the basis of reciprocity because of an underlying rationale of self-interest. Voluntary health insurance thus builds on self-interest (Criel 1999:

³ Tocqueville (1840) suggested the term “self interest rightly understood” or enlightened self interest as an alternative to individualism described as too much concern for one’s own agenda or interest.

60). The desire to avert risk is motivated by self-interest. Dunning et al. (1992) depict this phenomenon at the bottom of most voluntary insurance schemes as solidarity of interest. The voluntary character however, often constitutes a major limitation in the sense that those who perceive the potential return to be too low may decide to opt out or not engage in it at all. From the individual point of view, such a decision might be rational but in societal terms it is counterproductive since it limits the financial base of the scheme. In view of this, some authors have argued that in order to be effective and successful, mutual aid schemes must of necessity be rooted in both solidarity (based on broader cultural and emotional grounds) and in self-interest (see Elchardus 1994).

Solidarity in Ghana's health insurance plans

In the attempts to implement health insurance in Ghana, one of the basic assumptions that planners have emphasised is that a solidarity-based scheme is a suitable option because the Ghanaian social and cultural system has a built in social insurance or solidarity mechanism conventionally centred around the extended family. The family, it is conceived, has collective responsibility for the welfare of its members. A national health insurance scheme based "on the principles of solidarity, equity and non-profitability" is therefore officially perceived as "very much like our [Ghanaian] traditional support system in which resources of a family, clan, business, etc. are pooled together for the support of the group."⁴ Health planners conceive the philosophy behind such an idea to be "a rich blend of tradition and modern".⁵

This conception of Ghana's health insurance plans, raises a number of pertinent questions. The primary one, which will be dealt with in this chapter, is whether the motive of the people or community for joining an insurance scheme in the social context nowadays is based on the collective principle of solidarity or on an individualistic purpose. Granted that solidarity was/is effective in the traditional support system would people then accept or embrace the concept of risk sharing in a new social insurance dispensation because of historical or cultural affinity? And if so under what circumstances will they accept it in the present socio economic and cultural context? The discussion highlights the importance of social dynamics in the decision-making to join or not to join an insurance scheme.

⁴ National Health Insurance Scheme: Handbill (Undated) All About the NHIS.

⁵ National Health Insurance Scheme: Handbill (Undated) Questions and Answers, Accra.

Why people do or do not join insurance: A case of self-interest?

Why people join

In order to answer the above question I first turn to examine how people are likely to participate in a health insurance scheme based on their declarations of what they imagine and expect from it when the scheme does not yet exist. This is a credible and useful way of examining the subject in view of the fact that evidence to justify health insurance in Africa by several authors of predominantly health economics orientation is usually derived from household or aggregate expenditure surveys using contingent valuations (Yoder 1989). Similar studies have been reported from Ghana. Arhin (1995), who studied households in the Dangme West district using contingent valuation to ascertain their willingness to participate in solidarity based schemes, concluded that 98% were willing to join such a scheme. Assenso-Okyere et al. (1997), in a study of three districts in the Eastern region using a similar approach, also reported very high willingness rates of 98.7%. For my present purpose I focus on Suhum and Dodowa districts⁶ at the first stage of my fieldwork when the community's experience with health insurance was merely at the level of sensitised stages.

As an introductory remark, it is worth recalling that at the onset of my fieldwork in those two districts, one of the striking observations I made was the strong desire for and high expectations that people generally had for health insurance. In one sense, this was surprising considering the fact that at the time people knew little about the details of health insurance. Indeed, as the previous chapter indicated, people's concerns and worries about health insurance at the time far outweighed their positive perceptions. So why were they so enthusiastic about it and indicated they would join?

One reason is that due to the problems of poor and seasonal income coupled with the burden of unforeseen health expenditures, many in the community have difficulty coping with fee for service at the point of use. People are therefore enthusiastic about any new or alternate plan that promises to mitigate their financial difficulties in access to health care. And so, despite concerns about what monster health insurance would look like, people yearned for it in the hope that its introduction would change their existing precarious health care financing situation. In one of my interactions with a community leader, a 73-year-old divisional chief and retired educationist of Dodowa, explained this community desire to me as follows:

⁶ Arhin's study was also carried out in Dangme West District, while Assenso-Okyereh et al.'s was also undertaken in the Eastern region.

Health insurance is a new thing but we look up to it. I think it will help because in the villages the people don't have money, they are poor and many times it is finance or poverty that kills them. I say so because somebody may be sick with simple malaria and because he has no money to attend the hospital he would die. So I think they just have to be educated for them to grasp it. When each person pays a little money, it will help everybody in the community.

The dominant health care problem of rural folks as the above statement stresses is financial accessibility. Access to health care is difficult because money is a problem. Due to poor earnings, welfare needs and contingencies become problematic for most rural dwellers. It was therefore not surprisingly that the dominant reasons for joining were presented in terms of economic or financial advantage. A participant at a male FGD session in Dodowa explained it this way:

It is not always that man has money in his pocket. But sickness does not wait for one to have money in one's pocket, so if I join it will help me. Another teacher who used to work at the same place where I work had a surgical operation sometime ago. His condition did not improve so his family wanted to send him to the hospital again. But they needed 100,000 cedis for that. Because they could not raise the money he died. If there were something like the health association at the time, the insurance would have taken care of him. Sickness has no timetable. It comes anytime. Insurance is something good so I will join.

Indeed the uncertainty about illness vividly conveys to many informants the need for a safety valve. Many therefore value joining a health insurance scheme for the health security it provides. A female FGD participant at Dokrochiwa said:

I will join due to the present hardships in life and my future health security. No one knows tomorrow. (*Obi nnim □kyena asem*). You may think you do not fall ill but tomorrow may be different. Even if you do not fall ill your wife or child may fall ill.

Financial accessibility and a desire for health security constitute the most commonly cited reasons. In addition, some informants also conceive the motivation to join insurance in terms of social and/or cultural appeals. One of these was related to the failing traditional support system. Some perceived insurance as a way of reviving family support to achieve reciprocity. At an FGD discussion at Dawa involving female participants one of them observed:

Since the old family [support] system is no longer effective, this group⁷ when established will bring us together. We will be our brothers' keepers so that we will come together again as a family.

At rural Dokrochiwa, a participant in a female FGD session indicated to me that having an insurance scheme in their village would help enhance the image of their community.

I have to help because it is good to have something like that here so that we can also claim credit for having such a new thing in this town.

Insurance was therefore sometimes conceptualised as an object for community improvement. One observation was that, in situations in which the reasons for joining insurance schemes were related to social and cultural factors, the sources were mainly traced to the relatively remote parts of the districts. This might partially be explained by the fact that the average rural dweller has perceived a formal health insurance as a means by which their locality could become part of the "modern society". Another explanation could be that it is in the more remote rural areas where family and other mutual traditional solidarity based support mechanisms were stronger and so that is where the desire for similar mechanisms is also more likely to be felt. One would expect that where people know each other better in the "rural-rural" setting compared to the "rural-urban", it enhances the sense of belonging and for that matter, heightens the desire for a similar institution in the remotely rural. People also mentioned health security and financial access frequently in conversations. When listening to people explain their desire for health insurance, it was tempting not to disagree with what health economists hurriedly concluded based on latent demand. In virtually every case, the underlying stated motive for joining often pointed to the speakers themselves.

Not everyone was enthusiastic about insurance. Why? I discuss the reasons in the next section.

Why people are not willing to join

In the imaginary situation where the views of informants must be considered as contemplations because the insurance scheme did not yet exist, one striking observation I made was that there was a tendency for most informants to portray themselves as potential subscribers and conceive of "others" as the non-subscribers. In other words, individuals in principle almost always try to cast

⁷ In the case above, the speaker's reference to health insurance as "this group" reflects the conception of how the scheme was marketed to the community as a "health welfare group".

their own relationship to health insurance in a favourable light while associating negative attitudes towards insurance with others. In a way this attitude was not surprising. I understood it as logically consistent with their lay expectations and cognitions about insurance, particularly in relation to the existing fee for service system.⁸ But in a way that attitude also had the effect of biasing their self-appraisal of insurance.

Accordingly, in order to deal with the preconceived bias when discussing attitudes towards health insurance, I had to frame my inquiry in order to have them talk about why *others* would not want to join insurance. In that context, people freely opened up and showed a depth of knowledge that made it seem like they had already experienced health insurance. During a FGD with females in Dodowa, for example, all seven participants present indicated that they would join. When I asked them why others might not join one quickly gave a brief catalogue of reasons.

Money problems. Lack of understanding; if education is inadequate and *anibue* [literally meaning civilisation but apparent reference to social change or modernisation]; some may also feel they have been deceived for so long in the past.

I will elaborate further on these factors alongside the analysis. As expected, financial incapability or non-affordability was cited as the most likely reason why some may not join. The problem was variously described as “money problem” or “poverty” or “hardships”. The common meaning attributed to non-affordability was lack of cash but when people talk about it in this context, they relate it not only to poor incomes but also to large family or household size. A female informant at Dokrochiwa added:

Well many people in this community are poor. Some will like it but they do not have a good job that generates enough income to enable them to join such a scheme. People here usually have six children or more. This is one reason why it may be difficult to do it here.

How much people will get for their money also tends to occupy a central position in their contemplation to join or not to join. They wonder about what will happen to the money they will pay and whether it will really be used to provide the health care they need or whether the quality of care will meet their expectations. This comes out very distinctly in a few cases where informants

⁸ According to the theory of cognitive dissonance by Festinger, human beings have a tendency to seek consistency among their cognitions (Festinger 1962).

did declare that they would not join. For example at a male FGD in Suhum, the only participant out of eight who dissented stated his concern about what could become of the investment in insurance:

As of now, we do not know the benefit package and until I have seen the full benefits and the policy and become convinced about it, I cannot make up my mind. Quite recently some people came here and started campaigning for people to grow sunflowers. Many people responded but when the sunflowers were harvested there was no buyer and some even burnt their harvest. So for something that you do not know the head and tail of it how do you do it? As for me, I have to wait and see to make my decision (*patuo gye se m'ani*)⁹.

Behind the uncertainty of some people there was the fear that if something went wrong, they would lose their investment. Incidentally, there was always some negative reference event in their recent past that informed that notion. Indeed, based on previous experience with community savings and credit schemes (*susu*), there was also some suspicion and fears that those into whose custody the finances of the scheme would be entrusted could embezzle the funds. There was conjecture that those who harbour such fears might not commit their resources to the scheme. A male participant in a FGD at Dawa shared these thoughts:

Some officials came to this village and informed the community that they were setting up a savings and credit scheme. People responded, but after a few months they bolted away with the money and we never saw them again. Some people might think that this is just another means to cheat them. It will be difficult to convince such people to join anything that involve money. Because of the previous experience they take such things very personal and will see it as another ploy to cheat them. For this reason they will not join until it takes off. In fact because of such suspicions many will adopt a 'wait and see' attitude before they make their decision. So it all depends on how it progresses.

For some people, the type and manner of education that they would receive is an important determinant of how they make up their mind about insurance. In this respect, many informants envisioned poor education as an important potential determinant for non-subscribing behaviour. During a male FGD at Suhum, for example, not only did the group emphasise the importance of education but also they went further to illustrate what was perceived as a good example of poor education. In an apparent reference to the NHIS public educa-

⁹ *Patuo* is an owl, which is known for its big eyes. The speaker therefore implies proverbially that unless he observes with big eyes he could not make up his mind.

tion campaign in the district a year before, one participant lamented the experience as follows:

The way people are educated about new things go a long way to influence acceptance. At the time [apparent reference to NHIS education campaign period] I came across a batch of leaflets in the GPRTU¹⁰ kiosk when I went to the lorry station to purchase a ticket. I had no previous knowledge about the scheme but the leaflets were just lying in the kiosk for those who wanted to pick them. What was the guarantee that people will read them and understand? How could anyone educate people on a new programme that way in a community such as ours?

In fairness to the programme implementers and the educators, this way of spreading the message and sensitising people about the scheme was just one of a number of approaches that was used to reach out to the community. That is however, not to absolve a bad dissemination approach involving handbills, which was not only potentially limited in scope but also inappropriate for a community that had a very low literacy rate. In the same group discussion, some suggested that inadequate education also had the potential to become ammunition in the hands of those who would not understand the concept and that they would spread misconceptions about it.

Another set of reasons for unwillingness was related to systemic problems people encounter with the health care services. The complaints related to attitudes of nurses, long waiting times at health facilities, the collection of dubious fees and poor diagnostic materials. An opinion leader in Dodowa said:

Insurance is good but it will only work if the health staff treat people humanely when they go there. Nurses are human beings like all others but it's about time they accepted the challenges of their profession. You see, people are such that even a touch can sometimes reassure them; but some nurses reprimand patients just because they go to clinic late. The other time someone complained to me that he was referred without a referral note. Such attitudes create confidence crises and leads to mistrust in the service. And if upon all that people have to buy drugs and do laboratory tests outside then we have a problem to deal with. I don't foresee an enthusiastic response if these don't change in our health service.

Further reasons why, in the view of respondents, many in the community might keep away from a health insurance scheme were similar to those for joining: mainly out of self-interest. Predominant among them was the perceived 'risk

¹⁰ GPRTU is the acronym for Ghana Private Road Transport Union, and is umbrella trade union of most private commercial vehicle operators. In cities, towns and villages where they exist, they operate a small office, which sometimes is a kiosk in lorry stations.

averse' attitudes towards insurance. This attitude is a feeling commonly held by some that they were healthy and therefore underestimating future risks of illness. As a female informant at Dodowa briefly explained, "Some people have the feeling that they do not fall sick so they may not benefit from joining such a group".

Related to the risk averse notion is another view: that the relatively well to do who might consider themselves capable of paying when they need health care might also not join the scheme. Sometimes these people are portrayed as being selfish. A participant, in a female FGD in Dawa said:

Some people are rich and they will not need anything from the association. They will therefore not want to join. Anytime they are sick, they can just get up and go to the hospital because they have the means. They even have private doctors because they are financially sound. But someone who is not financially sound will join.

State or governmental support for community insurance is potentially useful since it offers opportunities for logistical and technical support and the political goodwill necessary to operate it. However, there are also genuine concerns that if politicians are allowed to play centre stage in rural insurance initiatives, wrong signals may be sent to those in the opposition party, who may reject it. A male FGD participant in Dawa said:

Others may not join because of their political alliance. During the recent census, someone told me that he was not going to register because he did not like the government in power. So, some may feel that it is for the government and therefore may not join.

Furthermore, the value and individual preference for traditional or indigenous health care, which is quite pervasive in the rural setting, is also recognised as a factor that could keep some people away. One male FGD participant in Dodowa explained:

In the rural areas people think most sicknesses are the result of a curse, so when they fall sick, they prefer to visit native healers and spiritualists. Even when you do not believe in such supernatural causes, those around you will tell you to see a healer because the condition is a not a clinical but spiritual ailment. People who believe in supernatural causes simply ignore the clinic and it might probably take a generation to appreciate a health insurance scheme.

It is obvious from the foregoing that people's drive towards social health insurance is highly influenced by social and cultural constructions and motivated by enlightened self interest. That assertion immediately leads to one

question. Can we merely depend on people's declarations to join or not to join insurance to determine their concrete attitudes towards it or their commitment to the solidarity motive behind it? Certainly, any critical assessment cannot be made based merely on statements people make about why they will join or not. We need to go beyond that in order to get to the bottom of how people genuinely feel about the redistribution effect of solidarity.

How do people feel about the redistribution effect of solidarity?

In order to dig deeper, I posed a question to ascertain from informants their feelings about the redistribution arrangement or effect of solidarity in health insurance. The concept relates to how potential subscribers or real subscribers feel in a typical situation in health insurance where their fellow insured people, who are more prone to illness, benefit more from the scheme as a result of frequent illness. Interestingly, the immediate reactions were typically coloured to sound socially appealing and convey good impressions about the speakers. But in general, the reasons for accepting the consequences of investment without return in solidarity were related to uncertainty about what could happen to themselves, concern about depressed traditional support mechanism and most predominantly moral and religious reasons. Frequent use was not considered a problem if sickness was perceived genuine because the essence of insurance, as one informant described it is to help one another (*eyε mmoa a yede reboa yen ho*). Again, being sick was also not considered a privilege but rather a disadvantage. A participant at a male FGD in Suhum explained it this way:

We understand the situation and it does not bother us. Even in car insurance it is only third parties that get the benefit. Calamity does not affect one individual. (*enyε baako fo□ na asem to no*). If it does not benefit me, it may benefit my brother. If your contribution is used to look after someone else, others contribution will also be used to look after you at another time in the future. After all, we make donations when someone dies in the community so it is not a problem.

There was nevertheless some feeling that a wholesale benefit package ought to be prevented. For example one view was that the package ought not to cover HIV/AIDS because of the long-term implications it may have on the financial sustainability of the scheme. In response to a question by another participant whether the scheme should cover cases such as HIV/AIDS, a male FGD participant in Suhum said:

The policy should not cover cases such as AIDS because there is no cure for it and so if the money is used on them it will run out. We cannot afford to use the money on that because it will be a waste.

Considering the implications of HIV/AIDS for public health, this remark that people ought to be responsible for their own problems clearly stretches the issue of self-interest to elastic limits. However, the common statements people made about their preparedness to participate in any utilitarian co-operation or solidarity arrangement were predominantly gratuitous expressions emphasising religious reasons. Most reactions were based on the biblical edict that “those who have money should look after the poor”. A 70-year-old Presbyterian pharmacist from Suhum explained it this way:

No one knows tomorrow. You may be strong today but you need your heart to carry you into the next day. The Bible says it is not within the power of man to map and plan his course. [He then referred me to Proverbs 20:24¹¹].

Other reactions to the redistribution effect of solidarity follow a similar trend. The following are further remarks made by participants from various FGD sessions in the two districts.

The Bible says we should help our neighbours so if I pay that little money and I do not fall ill, God will bless me for helping to cure someone. *Female FGD participant, Dokrochiwa.*

I will be grateful to God for not getting ill. *Female FGD participant, Dokrochiwa.*

It would not bother us at all. What we need is good health so if my contribution is used to look after someone why should I get worried? I should rather be happy because it brightens my chances for heaven. *Male FGD participant, Suhum.*

Not all people fall ill frequently so if I am not sick and I contribute to help those who fall ill then in a way I am performing my Christian duty. The objective for joining is not to fall ill but to help those in need of health care who may not have the means of their own. *Male FGD participant, Suhum*

Ascriptions to divine benefits as justification of the unequal redistribution effect of solidarity were so pervasive in peoples’ reasoning that even those who considered it “cheating and painful”, were still prepared to accept it as the will of God. What does that tell us?

In a Christian dominated and widely religion conscious country like Ghana,¹² such remarks about sacrifices for the benefit of divine rewards are not

¹¹ “A man’s steps are directed by the Lord. How then can anyone understand his own way?” NIV

unexpected. Such statements certainly have their social appeal but what is important is that even when explaining their solidarity links through religious passions, they were laced with expressions of self-interest; they expect personal reward in heaven. In any case, the common thread in pious religious sentiments about solidarity in the Ghanaian context is that they indicate one potential avenue — churches and religious groups — for fostering solidarity about insurance schemes in communities.

The important question to ask here is: Should we take these pious statements about people's attitude towards solidarity seriously or take them with a pinch of salt? In essence, talk is cheap or ambitious depending on where you stand; people have the tendency to sound socially desirable in a social research situation when the actual event has not happened. Indeed, if we have to attach any meaning to people's preparedness to accept risk sharing in insurance, a reliable barometer is the widespread evidence of neglect of poor families by relatives in the present day Ghanaian society of today, which is easily excused by economic hardship. Even if people decide to join, how reliable are their assurances that they will overlook the unequal redistribution of benefits in insurance and keep their subscription in good standing? Once again the view of my 70-year-old Presbyterian informant in Suhum was moralistic but nevertheless served as good food for thought:

Our character has changed. In the past when we farmed we did not demarcate boundaries but we were honest because we shared and exchanged what we had. We needed and loved one another. Now things have changed. Now there is no longer love for one another. We don't fear God, although we worship and make a lot of noise about God. But the people in the past were not like that. Unless we change our morality, unless we change our moral weakness, it will be difficult. Nevertheless, we still have to start from somewhere and we can start gradually with the few people who are prepared to start.

Asking people how they feel about the behaviour of others in a hypothetical situation provides some indications about what attitudes to expect in the practical situation. Imaginary statements or contemplations however, still do not give an accurate picture, particularly when they involve informants' responses that are a reflection on themselves. In order to get to the heart of the matter as far as attitudes towards risk sharing or solidarity is concerned, we need to look elsewhere for a practical illustration. In this study, Nkoranza provided an ideal setting for this.

¹² The most current (2000) population census of Ghana indicates that Christians constitute approximately 70%. Others comprise 15.9% Islam, 8.5% traditional, 0.7% others and 6.1% no religion.

People's motive behind insurance: Concrete lessons from Nkoranza District

In order to assess people's concrete motives for participating in a health insurance scheme, the case of Nkoranza and, to some extent, Dodowa, present a useful means of validation. For the owners or organisers of the Nkoranza scheme, solidarity is important because it is the organising principle for bringing the community together in a non-profit risk-sharing scheme to make health care accessible to them. Residents and non-resident natives of the district are therefore required to invest in a common pool so that those who fall ill will be catered for on the basis of pre-determined conditions and benefits. In one of my conversations with the manager of the Nkoranza scheme, he elaborately explained the mechanism by which solidarity works in the scheme as follows:

We, the initiators of the scheme, want to foster unity through the insurance scheme because if you look at it, one person pays a small amount, falls sick and then a "huge" amount is paid for his bill. If it were not for the sake of solidarity that person would not have had the benefit of getting other people's money to pay his bill. I think that is the solidarity aspect of it in the sense that the monies that are collected from the various health zones [within the district] are not kept independent of the other zones. They are brought together into a common pool so that anybody who falls sick in any of the zones can benefit from that common pool. What we wanted people to understand is that it is not a matter of paying the money and falling sick to benefit but paying it for a risk tomorrow. That is, you can pay for many years without falling sick but there may be a day that you will also fall sick. Meanwhile either a family member or a friend or a church member would have benefited from the scheme. Without the scheme one of these people would have had to come to you to solicit funds to pay his hospital bill. But once you are all contributors it tends to foster unity and solidarity. It takes care of the unfortunate ones who fall sick. This is our message but *I do not think that is what actually people see in it* [my emphasis].

Two main strands are embedded in the long statement above. First, solidarity in the scheme is about connecting diverse individuals across the district to share health care through a system of reciprocity. The second strand is that this has been a difficult task because the expected understanding, cooperation and commitment to the risk sharing principle on the part of the community has been lacking. Indeed, the benefit of nearly ten years of operation and several evaluations on reasons why people join in Nkoranza indicate that they join because for their own sake and that of their closest relatives. Interviews with various stakeholders in this study, (i.e. implementers, health staff, community opinion leaders, subscribers and non-subscribers) attest to this view. One case will suffice here.

Steve

Steve is 54 years old, a native of the district and had been part of the accounting staff of the Nkoranza hospital for 11 years when we met. He had married twice. He had a total of 13 children, 10 of whom were with his present wife. In our conversation below, I sought his view about aspects of the scheme by asking him what, in his opinion, drives people to join the scheme. Excerpts:

Steve: Some people have foresight about future health security so they are prepared to make the present sacrifice. Instead of waiting to be sick before they look for assistance from family members, they do their best to join the scheme. Some of such people are of the notion that even if they do not fall ill, they are secure or others may benefit or they would receive blessings from God. Some have such thoughts for their fellows.

Dan: So is concern for others the motive that people have for joining the scheme?

Steve: That is not the primary objective why they join, but rather they join so that when they fall ill, it does not become a burden for them or their close family members. These days unless it is a matter of death, the family would not help you so it is important for individuals to secure their health to avoid access problems when they are suddenly taken ill. So people join to avert the burden of health insecurity.

The literal interpretation of Steve's statement indicates that to date, the primary motivation of many in the community is not so much the underlying principle of solidarity but their enlightened self-interest. In Nkoranza, some even considered it cheating if after paying there are no direct benefits for remaining healthy and as a result discontinued their subscription after a few years of subscribing. In some cases, they made a claim that they found it difficult to raise the needed money to remain subscribers of the scheme. Others also maintained they have no need to join since they do not fall sick. Actual evidence of such situations were not difficult to find in the community. One such example was Opanyin Nkrumah, a 56-year-old elder and a non-subscriber at Kranka:

I was a member but when you pay and you do not fall ill for even three or five years you do not benefit. Since the benefit covers only selected cases, it is possible that some of us will never benefit because by our constitution we are very strong and we do not fall ill. This is cheating to me. So they should probably build in a mechanism where those of us who do not fall sick can be given say a 30% discount for the subsequent year.

It is obvious from the above statement made by Opanyin Nkrumah (and many others he represents) that enlightened self-interest is at the core of people's desires and actions to join and leave the scheme. The informant practically demonstrates this individualistic value by pulling out after a few years without

personal benefit. It is implied in his words and deeds that the motive for joining was that by sacrificing a small part of his resources he or probably a close relative would benefit. He pulled out when that objective became too remote. It appears that people are more likely to continue with the scheme when they are able to relate their membership to situations or benefits involving them or someone they know. A participant who was certainly a subscriber, conveyed this attitude to me during a male FGD discussion at Nkoranza.

Some say it is cheating but it is not. It is not cheating because you pay the money for those who get sick. So the motive for paying is to help those who will fall ill. Next time when I also fall ill, someone's contribution will help me. Someone's father has been there while another's mother has been there so it is the same thing. When I was last admitted there, my bill amounted to 398,800 cedis. Where would I have obtained this money to pay my bill? So left to me, if it were not because of poverty I would have said paying even 50,000 cedis as a premium would have been reasonable. And even if any of those here or I do not fall ill we have to pay our premiums to take care of the poor. The insurance scheme is a very good thing.

Let me explain the situation of the above informant whom I shall call Kwame in relation to the argument he raised. I understood Kwame's point from his personal and poor health circumstances. He was sixty-one and a father of six when I had the above discussion with him; his main source of income was farming. He did not have to fend for his six children who were all adults living on their own, but he was not receiving any subsistence support from them either. Significantly, his general health had not been good during the three years prior to our meeting and he had therefore been a regular client at the Nkoranza hospital. Indeed his poor health was manifested by a persistent cough throughout the duration of the discussion, something he did not waste time to draw my attention. In one of his contributions, he clearly pointed out "I wish I could exchange my poor health with those who consider frequent use of the scheme by people like us as cheating". Obviously therefore this was someone whose belief in risk sharing is inspired to a great extent by his personal circumstances and a strong underlying enlightened self interest.

Adverse selection

In the community, people's self-interest motives in the solidarity arrangement are generally conveyed, in their attitudes towards the payment of premiums and where they are insured in their health seeking behaviour. I recall an encounter I witnessed in Nkoranza during one of my observational visits to the insurance office. It involved someone who was going on admission to the hospital. I will call him John.

John's case of adverse selection

On July 26th, 1999, while sitting and conversing with the coordinators at the insurance office, John, who was due for admission for a hernia operation, walked into the office. He was personally insured and had already managed to collect some medicines from the pharmacy with his insurance identity card when he walked into the insurance office to collect his family records card to take to the ward. The family card contains updated information about the premium payment status of all the household or family members of every insured individual. The scheme's implementers employ that as one way of containing adverse selection. When someone is asked to go on admission, getting the family card from the insurance office was always the last process to confirm that the scheme would cover the cost of the admission. That was why John had to walk there to finish his pre-admission ritual.

When the insurance office coordinator checked the data on John's family card he noticed that the premiums of four members of John's household had not been paid. The coordinator then quoted the relevant portions of the insurance policy and informed John that the conditions for benefit enjoined him to pay for the four unpaid cases before his hospital charges would be covered. John however maintained that he did not have the money to pay for the four members and besides he did not see the logic for such a condition since he had paid faithfully in previous years without any benefit. The coordinator therefore asked John to follow him to the cashier's office to sort out the problem.

I followed them to the cashier's office where the coordinator simply repeated to John that he had to pay up for the four defaulters on his family card. But John was persistent in his previous arguments. The coordinator then informed the cashier that under the circumstances, John was not eligible to be covered by the insurance office so the cashier ought to deal privately with him. In short, John was declared ineligible to be covered by the scheme in view of his refusal to pay for the arrears of four members of his household as required. Someone at the cashier's office then quickly took back the drugs that John had already taken from the dispensary and demanded the deposit for his admission. There and then, John dipped his hands into his pocket and brought out 28,000 cedis to pay for the four family members that was demanded. Money, which he originally claimed he did not have suddenly popped out from his pocket and the matter ended there. He got back his drugs and the process for his admission and operation was finalised.

On reflection, John was not prepared to pay for four members of his household because as he indicated, he had paid in previous years without any benefit. From an analytical perspective, we could explain John's behaviour and that of many others whose attitudes obviates the principle of solidarity underlying the scheme to enlightened self interest. The lesson here is that although theoretic-

cally self-interest is not conceived as being fundamental to planners compared to the choice for unity in solidarity, the former is an instrumental influence on the latter.

Yaw's experience about adverse selection

Another common way by which self-interest manifests itself in the scheme is the way the community selects themselves to join as new subscribers or to renew their premiums during registration periods. This takes the form of what is technically referred to as adverse selection. I will illustrate this with a narrative from one of my informants whom I refer to here as Yaw. Yaw was a 34-year-old schoolteacher, married with two children and a founding fieldworker of the insurance scheme at Kranka. He was quite popular in the village as a community focal person and became an effective field assistant. During one of the several conversations sessions I had with him, he gave me a vivid illustration of the depth of the problem of adverse selection that underscores the strong self-interest motive of people as against the solidarity concept of the planners of the scheme does:

At the early stages of the scheme, people were very selective and registered only those members in their family who were high risk. Unfortunately our system was not tight enough to detect them. Last year, a certain man came to inform me that he has not been well for some time but when he sought treatment at Holy Family hospital, he was asked to deposit 300,000 cedis against his admission. When he sought assistance from his family, no one was prepared to help him so he came to inform me that he wanted to register for the insurance. To be honest with you, if he had not told me that story, I would have registered him but he started by betraying himself. Well, I told him that in that case he had to register 20 people before I would admit him. I arrived at that decision because I realised that even if he registered 20 people as I requested, it would have still amounted to 140,000 cedis¹³ which was still less than what he was asked to pay at Holy Family. In short I refused to register him so he reported me to the Chief of the town. I answered the Chief's call and explained everything to him, which he understood. I did not register him because I felt it was not fair for those of us who have been with the scheme for seven years. And I did that because of an experience I had with a teacher colleague. He had a hernia so when the scheme started he registered and managed to get an operation to remove it. After that he did not renew his registration again during the second year. However, he brought his sick mother from the North to register her and got treatment for her. He never renewed his premium again. Two years ago he came to me with another tribesman to register him but by then I had detected his tricks so I told him bluntly that I was not going to do it.

¹³ The premium per person at the time was 7,000 per person for new subscribers and 6,000 for continuing subscribers.

You may ask why I am so protective of the scheme. Since the scheme started my family and I have faithfully been paying the yearly premium but none of us has ever utilised it. It is not in the interest of the scheme to have only people who know they are sick and therefore only join to get treatment and walk away. If I allow such people to do that then the scheme would collapse and my family and I would have toiled in vain. So as a member, it is in my interest to make sure that the scheme is sustainable.

This long account shows how self-interest is in people's motive to join an insurance scheme. Interestingly, Yaw ended his narrative by emphasising his own self-interest in the scheme as a reason for ensuring that others do not abuse it. Those who cheat do so in their self-interest; those who protect or secure also do so in their self-interest. When planners estimate people's sense of solidarity and loyalty to health insurance on the basis of historical and cultural assumptions, they are oblivious to these intricacies or take them for granted. The individuals enter into the solidarity arrangement because of their self-interest.

Further evidence from Nkoranza underscores the prominence of people's self interest or non-solidarity reasons. These can be gleaned from statements of non-subscribers during conversations I had with them. Although affordability, and for that matter economic reasons are issues, the common strand in most of the reasons why people do not join were socially and culturally determined. They were sometimes bothered about how individuals conceptualised the risk to their health or that of someone close to them, may be at risk. Sometimes their discontent is found in the service offered by the insurance scheme. Two cases from Nkoranza district from separate FGDs will suffice here. A female FGD participant in Nkoranza relates:

The reason why I did not join is because I have observed that whether you would be admitted or not depends on the judgement of the doctor although you are the one that is ill. We know that the doctors are professionals but sometimes they also make errors because they are human, and not God. There is a case when a friend of mine went to the hospital very sick but the doctor felt he was not sick enough to be admitted. So he was given out patient (OPD) treatment. When he came home he did not recover and so he had to seek treatment elsewhere after three days. When you think about these things it makes it difficult for you to join.

A male FGD participant from Kranka:

Recently my grandmother became ill and was very sick. When she was admitted at the hospital, she was discharged the next day even though she was not well. In my view, they discharged her early because they did not want the insurance to spend too much on her. Besides, when my wife delivered, they asked me to pay because they said normal delivery was not covered; but that is the main reason why I registered

my wife. So when you are insured and you are admitted, they do not want to spend so much on you because when they do that the scheme would overspend its resources and that is why I am not a member. I feel that they are just using the insurance to make money for the hospital.

In Nkoranza, subscription records of the scheme statistically exemplify the community's self-interest. Since it was established nearly a decade ago, low patronage has been a chronic problem. Available records indicate that it has managed to achieve a 40% mark just once. For all the remaining years that it has been in operation, the entire district coverage has been below 30% and most of the subscribers have been from the Nkoranza township and its immediate surroundings. Indeed, people's egocentric motives for joining are so strong that they sometimes want compensation if they contribute but do not fall ill for some years. A public health coordinator of the Regional Catholic Diocesan Health Services who is the overseer of the scheme explained it as follows:

After nearly ten years of operation, people have still not grasped or accepted the concept of insurance that once you pay you do not necessarily have to benefit personally. Previous evaluations indicate that people want compensation if they contribute but do not fall ill for some years. There is also a high level of adverse selection and this further attests to people's self interest motive for joining.

Moral hazard

The depth of people's strong self-interest does not end with adverse selection. The phenomena whereby subscribers abuse an insurance scheme through excessive use and moral hazard also looms large in the Nkoranza scheme, as insured patients play all sorts of tricks to over-utilize the benefit of the scheme. The medical doctor in charge at the time illustrated the situation for me:

Among the funny things that happen in the ward is that insured patients will always try to give complaints to stay longer on the ward because they are 'not paying'. They always pretend so that at the end of the day they stay longer than the patients who are not insured. For non-insured patients, after 2-3 days when they think that they are OK, as soon as they see the doctor enter the ward they will be sitting on the bed and smiling. Displaying it on the bed, telling you that they want to go home. Sometimes they even come out to say it that "today I feel fine and I want to go home". The insured on the other hand will tell you that they feel worse and pretend that if you do not administer oxygen to them in the next second they would die within one minute.

That sounds comic, but moral hazard in the scheme, as another medical doctor of the hospital narrated to me, even goes beyond patient behaviour in the ward in a more striking manner. Once they are insured, they do not just plead with

doctors at consulting rooms to be admitted in order to benefit, they sometimes start the lobbying for admission at a doctor's home. Medical doctor:

People come to knock on my door at home at 6 AM and say that they want to bring a sick person to the clinic. They come to see you because they cannot pay at the OPD so they want assistance to have the patient admitted to the ward. If you assure them of "assistance" in that line of direction, they will then go home and bring the patient. As a doctor the reasonable and ethical thing to do when such situations arise is to ask them to bring the patient to the consulting room for examination. A few times however, when they come with the sick person and you examine him/her, you realise that the patient is still fit to go back home. But when you don't admit them then they get pissed off. Occasionally they also keep the patient at home deliberately to worsen the condition to the state that all you can do is to keep the patient on the ward. Yet that kind of "trick" can have serious health consequences for them.

The outcome of interviews I had with several informants suggests that to the community, the ability to go to hospital and be treated for "free", when they have paid their premium is very attractive. Subscribers are willing to register with the insurance scheme because they first and foremost know that if they register and they fall sick they will be taken care of and that is their prime motive for registering with the scheme. To the people who make solidarity in social insurance functional through their patronage, the essential risk sharing purpose is 'first unto myself before all others'. And they conceptualise insurance in terms of the tangible direct benefits that they obtain from being members.

Knowledge about main idea behind insurance: Survey finding

Peoples' conception of health insurance comes out clearly in the results of a follow up evaluation survey in Nkoranza and Dodowa districts, where I employed a short household survey to further explore a few issues in a relatively wider spectrum of the community.¹⁴ I asked household respondents to indicate what in their view they "think is the main idea behind health insurance". The findings affirmed that to the average rural person, it is the immediate personal benefits of insurance that preoccupies their thoughts more than the solidarity principle. The reasons were mainly related to accessibility (78.6% in Nkoranza and 59.8% in Dodowa), health security (8.0% in Nkoranza and 25.7% in Dodowa), improvement of health care in the district (8.5% in Nkoranza and 8.2% in Dodowa) and replacement of the 'cash and carry' system (0.4% in Nkoranza and 4.8% in Dodowa).¹⁵ Responses relating to solidarity

¹⁴ It is important to recall here that by the period of that second study, the Dodowa scheme was in its first year of implementation.

¹⁵ Altogether, the response rate was about 98% of the total cases.

(conceptualised as help one another) and/or unity constituted a mere fraction of the total responses.¹⁶

In summary, when the discussion is situated in the total socio-economic and socio-cultural context, the picture that we get is that the motivation to join the insurance scheme is *not* the solidarity concept as portrayed by the implementers; but their personal benefit. Is solidarity then only a mental construct for organising a social health insurance? What is its use then relative to the overbearing self-interest motive that people bring into insurance? The Catholic diocesan public health coordinator of Sunyani who oversees the Nkoranza scheme explained it in the following way during one of my final interview sessions:

The way solidarity works in this era in community health insurance is like the ripple when a stone is thrown into a pool of water. It is stronger where the stone falls but as it gets further it gets weaker. So for instance I have more solidarity to my wife and children than my extended family. It gets weaker across the village and might not even work when stretched across the district. But there is the need to promote solidarity to help people to get health because if you leave it that way then things like insurance would never work.

That this is the reality about solidarity support mechanisms is a fact that ought not to be surprising in the present social context. There is rarely a society in this age where social differentiation has not led to obvious tendencies towards decreased interdependence. The effect of decreased interdependence is that people now put more emphasis on the self-fulfilment of themselves and their immediate relatives. One reason for this is the weakening effectiveness of traditional social support institutions, such as the family. Unlike in the past, people no longer depend solely on one another and the goodwill of the society; they rely more on achieved positions for their daily economic survival. Therefore, as far as the organisation of solidarity support is concerned, the important unit is no longer the extended family or the community, but the individual and his or her immediate relatives or nuclear family. What is surprising is that planners do not seem to realise that this is the way people behave, that despite the latent demand and seeming enthusiasm and anticipation, people pragmatically fancy their self-interest as the primary reason for joining a social insurance scheme more than the risk sharing motive that the solidarity principle seeks to foster among the group. Where then does this take the analysis? How can we explain the progression of self-interest as a primary motivating reason for participation in social health insurance?

¹⁶ See Table A1 in Appendix 2.

Discussion: The interplay between solidarity and self-interest

The framework for understanding the relationship between solidarity and self-interest in social health insurance rests on the concept of social capital — the idea that sociability has positive consequences for the individual and the group. The origins of the concept lie in 19th century classical sociology of Durkheim, but it owes its currency chiefly to the more contemporary works of Pierre Bourdieu followed by that of Glen Loury and James Coleman (Portes 1988). In the analysis of social capital, these authors and several others following them, grounded their theory in relationships between actors or between an individual actor and a group. Bourdieu in particular focuses on the benefits that accrue to individuals by virtue of participating in groups and on the deliberate construction of sociability for the purpose of creating this resource. He stresses, “the profits which accrue from membership in a group are the basis of the solidarity which makes them possible” (Bourdieu 1985: 249).

In the sense in which I intend to apply the concept here however, I lean more on the persuasive twist introduced by Robert Putnam in his classic piece *Bowling Alone, America's declining social capital*. In it Putnam goes beyond individual actors to conceptualise social capital as a feature of the “connectivity” of communities and nations. Through an analogy with notions of physical and human capital, he explains that social capital means “features of social organisations, such as networks, norms and trust, that facilitate action and cooperation for mutual benefit” (Putnam 1995: 67). Putnam notes that when conceptualised this way, life is easier in a community blessed with a substantial stock of social capital for a number of reasons. He lists the benefits of social capital as follows:

In the first place, networks of civic engagement foster sturdy norms of generalized reciprocity and encourage the emergence of social trust. Such networks facilitate coordination and communication, amplify reputations, and thus allow dilemmas of collective action to be resolved. When economic and political negotiation is embedded in dense networks of social interaction, incentives for opportunism are reduced. At the same time, networks of civic engagement embody past success at collaboration, which can serve as a cultural template for future collaboration. Finally, dense networks of interaction probably broaden the participants' sense of self, developing the “I” into the “we,” or (in the language of rational-choice theorists) enhancing the participants' “taste” for collective benefits (Putnam 1995: 67).

In practice, stocks of social capital account for the level of associational involvement and participatory behaviour in a community and constitute the basis of their solidarity

Based on this sociological argument about the importance of social capital to group cohesion and mutual support, several writers with backgrounds predominantly in economics and health economics have emphasised that community prepayment schemes benefit from a community's willingness to cooperate with each other. The common strand in the argument is that a greater degree of social capital in a community would enhance people's preference or desire to prepay. Hsiao (2001: 5), for example, explains that social cohesion and mutual concern or solidarity shapes people's preference for prepayment, and hypothesises that "the greater the social capital, the more people are willing to prepare". Preker et al. (2001: 7) also refer to the benefit of social capital, citing that "it is not what you know but whom you know" that counts. They, however, also point out the downside of social capital in situations when communities and networks become isolated or parochial and operate for example as gangs and cartels that work against the collective interest. Wiesmann et al. (2000: 14) have also noted that if solidarity is strong, people will not worry so much if the benefits of the premiums will accrue to themselves or other community members. Actual studies also support the claim. Based on empirical findings, Criel (1999: 51) reported that in Bwamanda, Zaire, members of the insurance scheme expressed the opinion that if their premiums would not benefit themselves, they would do so for the entire community.

In Ghana, an implicit assumption of the social feasibility of health insurance has also been made in relation to the benefits of social capital in a number of statements and background papers. Arhin concluded in the precursor study to the Dangme West District health insurance scheme that the reason why 98% of household heads were willing to pay a premium to obtain health insurance cover for their members was that they conceptualised it as a solidarity association to deal with health risk and that they had previous experience of it (Arhin 1995: 104-105).

It is without doubt that a high degree of solidarity or social capital in a community is likely to influence the quality of cooperation or support for one another. I wish to point out here that, it is precisely what social capital is not able to achieve, contrary to the popular conventional arguments about it, that explains the overbearing self-interest motivation of people's willingness to join an insurance scheme. What do I mean? A careful appraisal will show that the conditions that facilitate the building or realisation of social capital scarcely exist in the social setting of the emerging top down voluntary insurance schemes like those in this study. In other words: They do not provide the opportunities for social capital to accumulate.

In order for social capital to accumulate, social conditions from the point of view of social connectedness must exist. These include social trust through obligations based on emotional ties and generalised reciprocity accompanied by

social benefits such as respect, prestige and reputation. In the emerging mutual insurance setting, a contract that asserts payment of a fixed voluntary premium is the only social tie that binds members together. For most of these people there is no sense of emotional attachment to other members of the group, apart from the few that they probably know and live with. The absence of opportunities for the accumulation of social capital thus diminishes the binding feeling of solidarity and for that matter the binding force of reciprocity underlying such schemes.

The analogy of the ripple of the pool of water when a stone is thrown into it is a useful illustration for the strong self-interest motive with which people participate in the schemes. The vast pool of water depicts the wide community. The ripple effect indicates that people have a stronger sense of solidarity to the small unit closer to them. Their relationship with the wider community is negotiated by rational self-interest.

People's motive for participating in an insurance scheme in the present social context is therefore based first and foremost on what they believe would best advance their own self-interested goal of averting a risk or securing a gain for themselves. They are therefore more likely to insure themselves against common risks on the basis of clearly perceived self-interest. The motive is served by the voluntary nature of schemes, which gives people a discretionary choice. In practice, a lot of solidarity in voluntary health insurance is enlightened self-interest in the sense that people come together to insure themselves against certain risks on the basis of reciprocity because of clearly perceived self-interest. This would explain why Dunning et al. (1992) characterise the relationship as solidarity of interest.

Health insurance and “the poor”

Introduction

From a policy relevance perspective, the primary goal of social health insurance in Africa is to bring together private funds in order to reduce the financial barrier faced by poor individuals, particularly vulnerable groups, to obtain care when they need it (Arhin 1995: 2). However, as indicated in the previous chapter, the benefits of insurance are contingent upon the payment of premiums. This raises concerns about the implications for the poor and vulnerable that might not have the means to pay the required premium in order to benefit. Does social health insurance then make health care accessible to the poor? In other words, how effective is health insurance in bridging the access gap faced by the poor and vulnerable to health care? This chapter examines this question using qualitative data from the three districts in this study but mainly from Nkoranza, where it was most practical to explore the issues in-depth in view of the relatively long experience with health insurance in the community. In this chapter, I examine questions relating to:

- i) How people in the community conceptualise “the poor” and express the benefits of social health insurance schemes to the poor.
- ii) Whether people generally believe and agree that there are some who are truly poor and cannot pay the premiums, and why this is the case.
- iii) How, in the community’s perception, those who are poor and cannot pay can be helped.
- iv) What the policy context is and what the views of the district policy implementers are on the meaning of being poor in the community.

Since the existing policy framework provides a useful context for discussing “the poor” in relation to social insurance, I begin the analysis with the policy context of access to health care for the poor. I follow that with community perspectives on points dealing with how people conceptualise “the poor”, why they contest the meaning of being poor, how they perceive benefits to the poor and how they think the vulnerable can be helped. I conclude with a discussion of the dilemma of access and equity for the poor and vulnerable in voluntary health insurance. Here I argue that the effectiveness of voluntary insurance in protecting the poor returns to the question of exemption mechanisms, as some writers have already noted. In the case of Ghana, administrative bottlenecks that have plagued the effective application of exemption policies are compounded by problems of identifying who “the poor” are in the community. The exclusion of the poor from social insurance reflects the negative side of reciprocity but the phenomenon is not unique to Ghana; similar trends occurred in Europe in the 19th century.

Policy framework

As I have already indicated, the policy context is a good starting point for discussing what impact social health insurance has on access to health care for the poor. This serves as a useful way of placing the discussion in its proper policy analytical framework. The issue of financial access to health care for the poor has been a perennial problem since the dawn of cost recovery policy in Ghana’s health care system from the mid 1980s. Recognizing that some people cannot afford health services, the introduction of hospital fee regulations policies of 1972 and 1985 by the government was supported with provisions of exemptions for various categories of patients. However, as a result of widespread problems with and abuse of the implementation of exemption policies for the poor (especially in terms of defining who was poor), the government has had to look for alternatives to user fees at the point of service now dubbed “cash and carry”. The story of the evolution of health insurance in Ghana is thus a story of meeting one of the major challenges of health care financing: ensuring access and equity to all Ghanaians in health care, particularly the poor and vulnerable.

In pursuing the issue of “the poor” and health insurance, one of the preliminary tasks was to understand how “the poor” are defined and what official criteria are used to identify those who are poor. During the span of my fieldwork I took the opportunity to explore the issue in-depth and first hand with policy makers and key ministry of health officials at the national, regional and

district levels. At the national level, one of the officials with whom I discussed the subject was Dr. Moses Adibo, who had just stepped down as Deputy Minister of Health and was at one time the Director of Medical Services. In the latter capacity he oversaw the implementation of Ghana's cost recovery measures from the mid eighties to the mid nineties, and was a strong advocate of community health insurance in Ghana. The ideas that gave birth to the Dodowa health insurance scheme were in fact his brainchild. Our conversation touched on several issues, ranging from user fees to state involvement in health insurance and the failed Eastern region pilot scheme. He explained the official ministry of health policy view in relation to the poor who have difficulty in accessing health care as follows:

The poor exist, so in 1985, when we introduced user fees, I made sure that we introduced exemption for the poor. But I thought *the person in charge of the institution should be given the prerogative to determine whether indeed the person was a pauper* [emphasis mine]... In the community there are people who are genuinely poor and can be identified so that they could be exempted. But what I have also found out is that, and this is a Ghanaian weakness, people are not willing to take decisions or responsibility. So you hear quite often that somebody has been discharged from the hospital but the person cannot pay the fees so they are keeping the person in there. And yet if you go back and see LI [Legislative Instrument] 1313, the thing is there that if the person cannot afford [the costs] declare him a pauper and let him go, but they wouldn't do it. So our inability or refusal to take decisions is a problem.

A few observations can be made from the above response. First, at the highest policy level, the ministry of health, and for that matter the government, recognises that some citizens are too poor to pay for health services and provisions have to be made for their exemption. Secondly, the details of that exemption policy are well secured by a Legislative Instrument 1313.¹ Thirdly, it also emerges from Dr. Adibo's remarks that although the policy theoretically recognises the existence of the poor, it is vague with respect to how a pauper is to be determined. Over the years this has been one of the major sources of problems plaguing the exemption policy law intended to protect the poor. I will return to this later in the chapter but at this stage of this analysis, further insight into the problem of the poor from a policy perspective is still useful.

Continuing our discussion, Dr. Adibo provided a detailed background insight into health insurance in Ghana, emphasising that government conceived health

¹ The Hospital Fee Act (Act 387) and LI 1313 of 1985 made provisions for exempting three categories of people on the grounds of economy, age and gender. Section 2 of the Act further identified eight categories of patients for whom "no fee shall be paid" for all services obtained at a public health institution in the country.

insurance is a means to mobilise additional funds for the health sector and improve access for the poor. He continued:

When I considered the pros and cons of various health financing mechanisms, insurance appeared to be the best option. But since less than about ten percent of the population are salaried workers, conventional insurance would not be viable. The vast majority of our people in the villages are subsistence farmers with seasonal and small incomes. For most of these, health care often comes as a difficult expenditure. Community based schemes therefore were the next best alternative. It makes it easier to get our rural folks to come together and form smaller groups to evolve some form of insurance, which is peculiar to our environment.

Considering that mutual health schemes are based on the payment of premiums, to what extent can insurance solve the problem of access if the poor still have to pay? In the Brong Ahafo region, which has a lead in community insurance through Nkoranza, I had the opportunity to seek the views of the regional director on the subject. Did he consider health insurance to be a solution to the problem of access to the poor? How were the “the poor” going to be determined? His response:

I think certainly there will be poor people who will not be able to afford whatever premium is set. But what makes things easier for the government is that there already exists an exemption policy. At the district [assembly] levels, there are programmes like the poverty alleviations funds that are targeting and assisting the poor in the communities. So once these people have been identified, then it's easier to identify the very poor because we have information on all villages. In all the places we know those who have not been able to pay and we go into their background and find if they are the very poor. When the government gets to know them then it can afford to advance payment for these people in their localities. So, I foresee the government coming in to pay for such people.

These comments raise two pertinent issues. The first relates to exemptions as a solution to the poor who cannot pay. This clearly underscores the fact that health insurance might still not be the answer. The second, and very delicate matter is the means of defining and/or identifying the poor. How easy is that going to be considering what is known from the existing exemption policy for the poor?

At the district level, it was possible to discuss the issue with district health implementers. It provided a good opportunity to situate the discussion at the service delivery level. I wondered how the problem of access to the poor presented to the policy implementers there and how they deal with it. In Dodowa, one of my key contacts was the senior District Director of Health Services, Dr. Irene Agyepong, who at the time had served in that position for

over a decade. At the earliest stage of my fieldwork when I first had a conversation with her, the Dangme West scheme had not yet been implemented but extensive work and preparations had taken place. She was therefore very much abreast of the problems and had ideas about how the district was going to confront them. During our talk, it emerged that the problem of defining the poor was not as simple as the upper hierarchy policy officials portrayed it to me. Indeed, the picture she portrayed to me about determining who “the poor” in the community were when it came to exemptions was a stark contrast to the views of her colleagues at the regional and national levels:

Although the community members themselves admit that there are poor people, they also say we are all poor and that even if there are poor the gradation is a gentle slope and not a steep one. And there seems to be resentment if you try to classify some people as so poor and deserving of assistance in health care while others are made to pay. But yes, it is an issue we have talked about. What do you do with the poor? On one hand how do we define the poor? And on the other hand who is genuinely poor? Those are the issues. When there is a subsidy, community leaders feel they are the leaders so they should get the subsidy. It's the same situation with the government exemption for those under five, sixty five plus and pregnant women. Most health workers resent the exemption. They keep asking why are you [government] giving some exemption when you [government] are not giving them [health workers] exemption because we are all poor? The idea in the community is that basically we are all poor, so no one needs exemption. The poor problem is there but we do not have an answer to it yet.

Essentially, the import of Irene's remarks is that the issue of determining who is poor in the community is not as simple as policy makers at the centre tend to estimate it to be. The simple message in her remarks is that the way the community perceives its poor is based not only on financial want but also mediated by social features. An intriguing aspect of that is how various groups in the health care cycle express latent self-interest in how the poor are defined or determined. Health staff have as much interest in it as community opinion leaders and the vulnerable poor. The ultimate price is the benefit of exemption. Obviously the extent of group self interest in how the poor are defined, is not only striking, but gives cause for concern in as much as it can negatively impact the sustainability of insurance schemes. But is it likely that the problem of determining who constitutes the poor are is unique to Irene's district?

Nkoranza offered another opportunity to examine the issue further. I had the privilege to talk to Dr. Ineke Bosman, the Dutch born Ghanaian under whose dual leadership as district director of health services and senior medical officer in charge of the Nkoranza hospital the scheme was set up. Her concern for the plight of the poor is so strong that at the onset of the scheme, she decided

against the making of photo identity cards for subscribers. The reason as she told me was her “worry that photographs will increase the fees and anything that increases the fee will create problems because the people have little money”. On the basis of the relatively longer experience in Nkoranza, how had the definitional problem of “the poor” manifested in the community? Her view about the issue, based on her long experience in Nkoranza was as follows:

Actually I agree that there is a margin that is “poor poor” but my experience here indicates that “the poor” has a wider meaning. The way it presents in relation to the insurance is either in the mind or money wise or both. “The poor”, so to speak, may be about 10 to 20 percent but that includes believers in faith healing who say you can only be healed by prayer, so insurance is not necessary. Some people are also poor only in the mind. It is not poverty in the sense that they cannot pay the money. Rather their attitude is that “I will pay next year” or “I haven’t been sick for three years but I have been paying and so I cannot continue”. So it’s not always poverty. That does not mean it does not hurt me that some people who are *genuinely poor* cannot insure themselves.

Based on her last statement about the genuine poor, does health insurance provide a solution to the vulnerable poor or what she herself referred to as the “poor poor”? Her reaction:

That is the actual problem. We do not actually reach the “poor poor”. It’s the 30% that is the most affluent or the most sensible that is benefiting. The marginal people that you want to benefit cannot join because they do not have the means. The way to achieve that is to keep the premium low. The main goal of this health insurance is to make the hospital accessible to the marginal poor but we have only managed to make the hospital economically self-sufficient. The whole idea of making health care accessible and reaching the poor, I doubt if they [the scheme’s present management] have done that for them.

What can we deduce from the foregoing? Dr. Bosman’s previous remarks about the meaning of the poor provide a useful analytical and practical distinction. Conceptually, it emphasises that being poor is not only about having the monetary resources, but goes beyond conventional poverty profiles. In the context of people committing money for their health in a risk sharing mechanism, “being poor” tends to be very much mediated by social and mental processes. Irene made reference to the fact that who “the poor” are in the community is contested. The insights suggest a potential source of difficulty in any proposal in that direction. Literally district implementers acknowledge that people are poor and some are indigent and need help because they cannot afford to pay. However, contrary to conventional economic images of the poor, which the written policy issues deal with, representations of the poor in the community

are socially constructed and thus make their identification complex. To what extent do the foregoing views of policy implementers reflect the actual situation of the people of the community themselves? I turn to examine this from the perspective of the people themselves.

Community perspectives

How “the people” conceptualise “the poor” and express the benefits of social health insurance scheme to the poor?

The way people in the community conceptualise or refer to “the poor” and discuss the benefits of health insurance reflects ambiguities and analytical complexities. In reality the way they perceive “the poor” depicts the problem of definition of “the poor” in the African rural context, about which much has been written. (See for example Iliffe John 1987). The categories they use confirm the view Irene presented to me about the elusive nature of the meaning of “the poor” among community members themselves. Literally, they conceive the poor in two respects. In a wider sense the entire community perceives itself as poor “without exception”. However, in a limited sense, people also accept that some are poorer than others within the entire poor community based on certain circumstances such as old age, physical deformity or calamity. I will illustrate this with two cases from the Nkoranza district.

Case 1: Alice

I first met Alice (a pseudonym) on July 18th 1999 when she joined a focus group discussion of mixed subscribers, one of three I organised in Nkoranza. Aged 46 years, she had no formal education and eked out a subsistence existence through farming. She also described herself to me as a Christian and married with two children. She looked quite reserved but very confident and made very practical and useful contributions during the discussion. A short testimony she gave about the benefits of the Nkoranza scheme aroused my curiosity for a follow up conversation with her.

I was admitted at the hospital two years ago for a long time and after some time I could virtually be mistaken as one of the workers on the ward. When I was eventually discharged, my bill ran into millions of cedis. But I was discharged without paying anything. The only reason why I am still alive is because of the insurance; there was no way that I could have found the money anywhere to pay for treatment.

My follow up conversation with her indicated that Alice was a diabetic who went frequently for insulin injections. Both the medical doctor in charge of the

Nkoranza hospital and one of my field assistants who was a coordinator at the insurance office corroborated that. For the managers of the scheme, she was one of their high-risk clients. But since the objective of the scheme was non-profit risk sharing, people like Alice were a good example of how risk sharing makes health care accessible to otherwise poor people who could not have afforded health care without the scheme. In fact her last admission at the hospital lasted about three months. She was discharged just a few days before my arrival in the district. The charges amounted to 2.6 million cedis and the scheme paid every penny from beginning to end.

In terms of outward physical appearance, Alice looked very well without any visible trace of her chronic condition. And she was very appreciative of the insurance scheme:

[It is] the saviour of the poor in the community; you wouldn't have been talking to me today. My husband and I could not have afforded the cost of my treatment. As for my family members they only visited me at the hospital.

They “try their best to pay” their premiums and that of five other members of their household whenever they were due.

In summary, this is one poor person for whom social health insurance has provided regular access to health care. Without health insurance she had no solution to health care. She is thus a good example of how risk sharing in health care solves the problem of the poor. Alice also typifies the ambiguity of the meaning of the poor in the community. In one sense, the entire community considers all of their own situations as poor and similar to that of Alice and her family because economically they face the same problems. They are all subsistence farmers, have identical family sizes and encounter the same socio economic problems. This is the wider sense in which people in the community perceive “the poor”. As many of those that manage to pay their premiums, the scheme provides an answer to their health care needs.

Case 2: Comfort

I met Comfort (a pseudonym) on July 21st 1999 when my field assistant took me to her house to meet someone, who in his estimation was destitute. Her handicap was clearly visible. As a leprosy sufferer I was deeply moved by her physical deformity. Despite her condition, she had a family of three children and one grandchild but no husband. She was 56 years old and had her three children with different “partners” she associated with at various leprosaria across the country where she underwent treatment. The oldest of the three children appeared to be in her late teens or early twenties and was the mother of Comfort's grandchild. Her other two children were a daughter aged about 9

years and a son aged around 12 years. She lived with all the children in a small house and subsists by farming.

The other purpose of our meeting was to administer a short semi-structured interview guide in connection with this research. As soon as she learnt of my mission she started telling me a story about what in her perception was a recent “unfair treatment” she had received at Nkoranza hospital. She was a bit upset with Nkoranza hospital because during the previous year she once sought treatment there and was treated and discharged the same day. However, she still felt unwell so she visited Techiman Holy Family Catholic hospital, which was nearer to her village and was admitted for one week before she was discharged. In her view, Nkoranza did not admit her because of the insurance.

As I later found out, her story was not as simple as she had presented it. In the first place she was not an insured person who would have been given “free” treatment even if she had been admitted. Secondly, a tricky dimension of her situation was that although she was entitled to free treatment for leprosy, the provision of free treatment for conditions not related to leprosy was ambiguous. It was therefore uncertain whether her situation merited free treatment or not. She categorically told me that with her physical state, it was not possible for her to work and save to pay for insurance. However, based on our conversation, it appeared that the exemption privilege she had as a result of her illness did not always make health care access easy. Indeed, the most difficult and pathetic aspect of her personal circumstances was the implication for her four dependants. She was too poor to insure them, so none of her four dependants had regular access to health care.

Comfort is the example of “the poor” in the smaller sense of the meaning in the community. She, and by extension her four dependants, are considered as “needy and less fortunate” because of her health or physical deformity. People like them are the ones at the lowest level of socio economic existence and are the vulnerable poor who are handicapped by reason of gender, age, physical deformity, orphanage or disease. They barely manage an average economic existence. They are a good example of what Dr. Bosman describes as the “poor poor”. For such people as Comfort and her four dependants, the scheme does not provide an answer because they still cannot find the money to pay their premiums to entitle them to health care. Ironically these are the ones who often need the insurance most because of their vulnerability to diseases. As one health staff in Dodowa summed up during a conversation, “because of their poor situation the quality of food they take is very poor and the nutrition is equally poor so they easily fall sick. They need something to build them up. It is a vicious cycle of poverty and poor health.”

The foregoing two cases illustrate the two senses in which people in the community conceptualise “the poor”. In common speak, the entire community

considers itself poor because in their perception, the socio-economic context of the rural economy does not only naturally constrain them but in their estimation, the consequences impact them disproportionately. As one local leader described it to me, “for most of them in the villages, its subsistence farming that they are doing and it’s just hand to mouth. Whatever they get it’s not sufficient to sell to pay for the insurance scheme”. Thus in Nkoranza, the typical saying was *yɛn nyinaa yɛ ahiafo* □. We are all poor. “We all deserve sympathy because we are all suffering;” as one worker in the insurance office at Nkoranza put it when he explained the ambiguity to me. This is more so the case when it involves money or the payment of fees. A brief illustration will bring out the sensitive nature with which this view is carried in the community. I cite a brief excerpt of a conversation with one participant, John (not his real name), when the issue about why some people who do not pay their premiums came up. Dan refers to me.

- John: The whole issue about people being poor or not boils down to what we do and earn for a living. If you ask all of us gathered here what work we do for a living you would understand our poor existence. There are no job opportunities here so we are just struggling with “small” farming. This man is struggling, that one is also struggling, only one of us here is a teacher and the rest of us are just “unbiz” [a popular term meaning not in any gainful employment] people, struggling. Children, adults, men and women in the whole community are all not gainfully employed. If I am a hanging frog, any day you come across me, you will find me hanging. (*ɛnti sɛ meyɛ aponkyerɛni a mesɛn h□ a, da bi a wobehu me no na mesɛn h□ daa.*) Do you understand? We are all just there, hanging. [Laughter by the group.]
- Dan: So you are all hanging frogs?
- John: Some of us are even crabs, both mother and child are crawling so you cannot distinguish which of them is teaching the other how to walk. [Another outburst of laughter by the group.] We have no help.
- Dan: Can you explain?
- John: That is what I am coming to. We have no help. If you have the time, let us visit some of the villages with a vehicle pretending to be looking for yams to buy. The farmers in the villages will give them to us for free. They will ask us to take whatever we want away without asking for even half a penny. The yam has been in the barn for so long that it has started germinating again. And so if you are a farmer what will be the motivation to farm? Nowadays, we are merely surviving from hand to mouth. There is nothing to fall on in case of emergency. People are so poor that even thieves have become redundant (*akr□mf□ koraaa ab□ asesa*). If I have ten children, then together with my wife, my family comes up to twelve. Paying six thousand times twelve is a problem. So it is because we have no good jobs in the community that is why we cannot pay the premiums. This is a problem that affects all of us in the community. There is no antelope

and there is no tiger, we are all animals. (*Ye nnyi □twe ennyi □sebo, yen nyinaa ye mmoa d□mma.*) Do you understand?

John's remarks show in a vivid way one sense in which the community abstracts "the poor" in a wider sense. It emphasises the point that structural poverty affects the entire community and so they all consider themselves as poor. That is, however, not to suggest that the community does not recognise indigents among them. In so doing, the distinguishing feature becomes the local concept "*ohia buroburoo*" which literally means 'abject poverty' although "destitute", "pauper" and "poorest of the poor" convey the meaning very well. That is the sense in which the vulnerable poor is conceptualised by the community. The commonly cited categories are orphans and widows but in general the aged, children and women are cited as deserving support when the community accepts them as "needy and less fortunate".

I should mention that there are quite a number of malnourished children walking around in the communities and the sight of frail looking old people is not uncommon. There are also teenage mothers struggling with life. But when community people are making distinctions about the poor and vulnerable, they might not necessarily refer to these alone because "the poor" is not merely economic or physical want or appearance. Nevertheless, the terms "needy and less fortunate" and the "poorest of the poor" would refer to a few of them. In other words, although the community accepts that there are some who are poor and cannot pay, in practice, "the poor" is highly contested. This is the height of social ambiguity in the way people conceptualise the vulnerable poor when it comes to ability to pay insurance premiums. Why? Based on several discussions and conversations with the people, the following provide some explanations.

Why 'the poor' is contested

In the Nkoranza district, the fundamental reason why many contest the definition of the poor is related to the premium level per annum. Despite the relatively low levels of total subscriptions, the popular view among people in the community is that the premium per se is affordable, particularly when compared with other expenditures that accompany other needs for assistance such as funerals. There is, therefore, a school of thought that believes that with a little effort each individual should be able to pay. This idea was carried across to me in several discussions and conversations. The following statement made by the pastor of a local branch of one of the mainline Christian churches in Ghana typifies the view:

I don't think I will agree entirely with you that people cannot afford to pay ₵6,000 for the whole year. I know we have poor people but unless you have so many

children then if you refuse to pay 6,000 for the whole year for yourself and your children, I don't think I will sympathize with that person if he falls sick. Yes, because you see when someone dies, they spend huge sums of money. That, they are able to do. You see if you are a “responsible” adult and you cannot afford paying a yearly premium for your parents but when it comes to funeral you can contribute more than necessary, then I don't think that person is being reasonable. The 6,000 will cater for any expense that will be made when that person goes to admission.

A counter school of thought exists that believes that the responsibility for paying usually falls on one person, who usually is the breadwinner. With a rather large average family size, payment of any premium collected within three months becomes a problem.

Closely related to the above is a culturally motivated argument that since everybody belongs to a family, “the poor” ought to be catered for by their families. This argument was often made against the background of the hypocritical show of family solidarity during funerals at the expense of the care of the poor and indigents. A local assemblywoman of Nkoranza explained it this to me during a conversation with her:

There is need to help paupers but they should be people who really need help. For example, there are people who have no offspring and are quite sick. For such people the scheme could help. But even the handicapped belong to families and so their families should pay for them.

There is another socially constructed argument that even the so-called indigents are only poor because of their laid-back attitude towards the scheme. A female informant at Nkoranza expressed the following sentiments:

Why should some people be classified as poor? This is wrong. Once they can eat, they are not poor. If you consider what people spend when they go to hospital each time it is nothing. They are not poor. Everybody is doing something and manages to make ends meet so they ought to be able to afford.

Another aspect of the perceived attitudinal problem against “the poor” is that they are prepared to help themselves when efforts are made to help them. In other words, some in the community hold the view that some of those who claim to be too poor to pay have not been challenged to attempt to succeed. Ernest, who used to be a premium collector for the insurance scheme in a suburb of Nkoranza, explained this while in the company of other participants of an all male FGD:

Some are really poor; but the reason why I can also not hold brief for many is that sometime around 1993 the scheme implementers tried some *susu* scheme to help

those who were poor. The people did not patronise it. At the moment, the registration is open but people are not paying till when it is three days to the end, you will see them rushing. So some people can actually not afford; but they would be quite few in the very remote areas of the district. They blame their attitude on being poor; they make no effort to help themselves.

Conventional notions about the poor and vulnerable who do not receive health care due to difficult access to money often include women. This was one reason I took great pains in including a proportionate number of women in my sampling. One of the striking observations in Nkoranza district was that the group of informants who most strongly contested “the poor” argument on the basis of affordability happened to be women. Infact, during a conversation with the *Omanhene* of Nkoranza at which community female activist and leader was present, he suggested that the economic situation of women was not as bad as I perceived it:

As for women if you need any big loan in the community, they are the ones who can give it to you. The women of today are very resourceful and enterprising so they are not poor. It is the women who buy the yams in the villages and send them to Accra for sale. Some take them to Kumasi while others sell them here. It’s the same with maize. So, now, the money is not in the pockets of men but the purse of women. As for the aged, their children look after them. Some children send money from abroad to pay for their aged parents. But as for the women if you need any loan, don’t stop at the door of any man. Go to the women.

Depending on how one looks at it, the above perception of the economic power of women could on one hand be taken as an affirmation of the enterprise of women in the community. On the other hand, when I consider it against the strong vocal stance of women that the premium rate in Nkoranza was affordable, the message of women could be a protest against spouses who use non-affordability as an excuse to deny women and children health care. Indeed, in a later interview with the only female representative on the Nkoranza insurance advisory board, she explained to me that many of the men in the district had divorced their wives or separated from them and left the burden of care including health care on the women to struggle to deal with. Accordingly, women are conveying a protest against this irresponsible attitude of some men.

Another ground upon which the definition of the poor is contested is associated with how the community judges the way individuals make choices between the necessities and the pleasures of life. The poor, therefore, lose the support and sympathy of the community if they over indulge in socially disapproved behaviour such as “excessive” or habitual drinking of alcohol at the expense of their expected social responsibilities. One local leader in Kranka put it bluntly:

People still manage as much as 20,000 cedis to buy lotto ticket every week when they have not paid their children's premium. If tomorrow the child is admitted and he is asked to pay 300,000 cedis then he will start crying. Someone has spent about 1000 cedis drinking alcohol this morning. One year is long enough for people to save towards it [the premium] but they still ignore it.

What the foregoing yet again suggests is that the meaning of "the poor" that is commonly manifested as economic or physical want is highly mediated by social and cultural determinants. Although "the poor" exist, distinguishing them in the rural setting in the context of perceived ability and willingness to pay premiums involves social complexities. One obvious outcome emerges from this ambiguity. The task of identifying the poor must involve processes that do not only take the views of the community at large into consideration but as much as possible include their active involvement. I will take up the issue later in the discussion but I now turn to examine how the community expresses benefits of social health insurance scheme to "the poor" who are able to afford the premiums.

How people perceive benefits of insurance to the wider poor in the community

In the absence of quantitative data (which in all sincerity would require a separate study), I rely on the testimonies and accounts of people in the community to illustrate how they perceive the benefits of the scheme to "the poor". Discussion of the benefits for the poor here refers to the poor who fall under the wider meaning of the poor in the community who are able to afford and pay their premiums. Given that wider definition, community people perceive the benefits of social health insurance to "the poor" in three mutually exclusive social dimensions, namely the individual, the family and the community.

At the individual level people commonly speak of insurance as being "the saviour" of the poor who previously or otherwise would have found it difficult to afford the cost of hospital care. The case of Alice is a good example of how health insurance benefits the poor who, as a result of insurance, now have regular access to health care. Given the financial cost of the treatment that saved her life, she testified that it would have been impossible for her and her family to have met the cost of health care alone. Apart from her declaration, there are other testimonies about individual benefits were quite common from subscribers as the following from two participants at a male FGD in Nkoranza illustrate.

I have been admitted there for 2 weeks before and that was 2 years ago. My father has also been admitted there before and was operated upon for a "sore in the intestine". At the time of discharge his medical bill was 880,000 cedis. *Fifty-three year-old farmer*

My experience is that my mother was hypertensive and became a regular customer at the hospital. Everybody in this room knows about her because she was admitted every month. The doctors did not get fed up with her and anytime they did everything to save her life. Most of the time she spent about 10 to 14 days and it continued for 5 good years. When she died, the receipts that I obtained from the insurance that are on file amounted to 12.2 million. Where would we have obtained that money? So, as for the insurance, chief [a reference to me], it has helped us a lot.

Forty-four year-old farmer and saw miller

On one occasion, during a conversation with a sixty-seven year-old opinion leader, he aptly described the benefit of the Nkoranza scheme as having empowered the poor to be in control of their own health needs and those of their families. He cited his own personal situation before and after the introduction of the scheme to explain this point to me.

Sometime ago, discharged patients used to knock at my door every now and then asking for a loan to pay their hospital bill before they were allowed to go home. You see when the hospital discharges someone from admission, it detains the person if she or he is unable to pay until the charges are paid. The poor people always had difficulty paying. Before the insurance started people used to knock at my door at dawn for assistance. Sometimes they pledged their maize or cassava and that would be the end. But since the scheme started, that has stopped considerably. Now I would not mind anyone who comes to me to say that they could not register their child so I should give them money to go and pay their bill. Paying about eight thousand cedis a year to benefit from hundreds of thousands in a year has made the insurance a great benefit for the otherwise poor and deprived who could not afford health care and were just dying.

Significantly, the individual benefit of the scheme was something that virtually every person recognised irrespective of their membership status, whether they were subscribers or non-subscribers. At a FGD with four non-insured men and two non-insured women at Nkoranza, the consensus was that “it is good because when you are a member it takes care of your medical expenses when you are admitted”.

At another level of abstraction, people describe the benefits of insurance to the community-wide poor in relation to the family. Before the introduction of the scheme, many families experienced hospital care as a desperate financial situation. Sometimes loans or credit facilities were sought for urgent conditions at the expense of family assets and reputation. Dora, a native and local assembly representative of one of the electoral zones in Nkoranza described this typical situation in the district to me:

The insurance has been very helpful to families and has improved the health care situation of many families. People are so poor that when the scheme did not exist, it was very common for families to call a meeting to collect contributions before they could discharge relatives who went on admission at the hospital. Now everything has changed. Provided you have paid your premium, you only have to carry your card when you need admission. When you are discharged you walk home without paying anything. It has brought well being to all of us. It has been very helpful to most families and I know that some communities even wish to have a similar thing as we have here. We are very pleased with it.

Significantly, many recalled with joy the fact that there is now “no cause” for family financial burdens due to health care because of insurance. “People don’t have to sell a family property or mortgage one of them, as was the case in the past, to take care of the sick,” the *Omanhene* of Nkoranza asserted during one conversation. Indeed in some rural situations either the purse or the decision of a male head of household was required before women and children could seek medical care at the health facility. In such situations, health insurance, as one nurse in Dodowa pointed out to me “has offered a great opportunity for women and children who are the most vulnerable to have access to timely health care”.

At an even wider level of abstraction, the community also acknowledges the benefit of insurance to an entirely poor community. When participants referred to this wider aspect of benefit, the historical context prior to the introduction of the scheme was usually mentioned. A participant at a male focus group discussion in Nkoranza captured this point very well:

One reason why insurance was started at Nkoranza was that the death rate at the hospital was very high. People were just dying like that in the hospital and the doctors became very alarmed. After an investigation by the hospital, they found out that when people fell sick, they stayed at home for so long because they did not have the money to go to hospital. As a result they sought treatment only when the sickness had got to a critical point, which was the stage the family was prepared to contribute money to assist hospital expenses. It was the concern for this that prompted Dr. Bosman and her team to search for assistance to establish the scheme. Due to poverty, people were unable to report early for treatment and it was this that led to the introduction of the scheme. Since the scheme was established, that health profile of the district has changed for the better.

At Kranka, one of the scheme’s field collectors (as the premium collectors are called), characterised the benefit of the scheme to the “entire poor community” to me:

This community is entirely made up of poor farmers. Many people were not able to pay their medical bills and some were detained for weeks. Some run away after

undergoing treatment and others even died. It has therefore been very helpful to our poor farming community. I know of a man who lives across the street. He embodies poverty. (*Ohia ayi no.*) He used to be frequently ill and seeking medication was always a problem for him. When the scheme started I advised him to register and he took my advice. The scheme became the solution to his poor health and since then he has become its disciple, spreading its virtues. He is an example of our poor rural folks who have difficulty attending hospital when they need it. Indeed, because of insurance many poor farmers in the community have had their “parkers” (strangulated hernia) removed.

In talking about the benefits of insurance with reference to the poor, one important qualification that did not escape mention was the clear-cut condition that benefit is only possible “if the poor are able to pay their premiums”. That consideration usually opened a door to discuss ways in which the community feel “the poorest of the poor” or destitute and indigents could be assisted. The next section briefly deals with that.

How can “the poor” who cannot pay be helped?

It is the view of people in the community that one way by which the poor who cannot pay can be assisted is through their families. This was a popular idea in various focus groups. In light of their own admission that the family has become less effective in providing support I always challenged this suggestion. But the family support suggestion was always offered as a moral argument on the ground that the family ought to support its indigents just as it supports its dead. At one of the sessions in Nkoranza one participant expressed the view as follows:

Our elders have a saying that the family is one. Although the inheritance system has changed in recent times, some families are still able to help their members who fall into needy situations. However, some families are selective when it comes to providing support. It all depends on the character of the members in the family. As the saying goes the family loves the dead (*abusua d□ funu*). When it is a matter of death, they will support but giving money to help during sickness does not happen. Since everyone belongs to a family, I feel in every family those who are capable should help those who are not capable of paying for themselves.

Some in the community would also rather have “the church” take responsibility for the “the poor” by paying for their insurance for both religious and social reasons. Many expect that the church, more than any other social group has a responsibility to look after the sick, orphaned and widowed. “True worship or Christianity is looking after the poor, orphans and widows; this is godliness with contentment,” one professional teacher and local church leader at Nkoranza said. Socially, many expect the church to offer assistance as a recipro-

cal gesture for “such people who fulfil their obligatory church contributions in the form of church collections and tithes”. Using church funds for such assistance is perceived as helping the work of God.

For an overwhelming number of informants, the care of “the poor” and indigent in an era of health insurance must be assumed by the state, just as it had been under fee payment at the point of use. Since this is the most pragmatic suggestion among the lot, I discuss it in the concluding section of this chapter.

Discussion

The primary goal of creating a community social health insurance in Ghana is to provide access and equity to health care for the poor and the vulnerable. Because of their voluntary nature, however, benefit from such schemes is contingent on the payment of premiums. Since affordability is a key criterion, those who cannot afford premiums lose out. In this respect, the important lessons learned about mutual insurance in Europe were that insurance did not gather the poor and vulnerable with it. Mutual aid societies in 19th century Europe, according to de Swaan (1988) “represented a form of authentic solidarity and collective care, widely and densely spread, and managed on a small scale by autonomous members”. However, the collective arrangements excluded the less privileged because apart from being excluded on the basis of being bad risks, “to these paupers, wretches, *lumpen*, the pressures of daily survival were often too great for them to afford a penny a week for the burial society, let alone for the sick fund” (De Swaan 1988: 147). It took the intervention of state free care policy in the course of time to bring services to the poor (De Swaan 1988). Within Africa, Criel (1999: 115) has also reported that in Bwamanda, the poor are underrepresented.

This situation cries out for a need to design strategies to take care of the vulnerable poor. Invariably, the effectiveness of insurance in protecting the vulnerable poor returns to the question of effectiveness of exemption mechanisms for the indigent. Exemptions and waivers are seen as strategic design features of most cost recovery programs that are used to ensure access to the poor and medically vulnerable.

In practice, Ghana’s experience with exemption has been a dirge of disaster and tremendous abuse. Institutions abused the official policy on exemptions and as one report has noted, “exemptions as provided for the Hospital Fee Act and by the Legislative Instrument was not focused on the socially disadvantaged. Though provisions have been made for paupers and indigents, a lot more have been made available to other categories of people who may be in the position to pay”. The less privileged thus lost out (MoH, Ghana 1996:7). Exemption

mechanisms have not been effective in achieving the main goal of ensuring access of health care to the poor. One aspect of the problem has been in relation to the definition and processes involved in defining the poor. While the policy set criteria for various groups of patients, including health staff as well as patients with certain conditions, no criteria were made for the poor. That task of determining “the poor” or pauper was conferred on a social welfare officer at health institutions where one was available. Failing that, it was vested in the authority of the head of institution.

However, since many hospitals did not have a social welfare officer and the institutions were more interested in maximising revenue, the pauper privilege was often ignored. The application of the exemption policy had been rather abused to serve the needs and desires of health staff and their relatives and friends. This has often left paupers and the poor without care. For instance, a study of exemption practices in the Volta region involving the 25 main providers of health services, found that the bulk of exemption (72% compared to 6% of paupers) were granted to health staff and their dependants, some of whom had sound financial base to pay for service (Nyonator et al. n.d.). To date, the country still has still not been able to fashion an efficient exemption mechanism that functionally provides ready and easy health care for the exempted class.

The problems of abuse through exemptions are not unique to Ghana. De Swaan has noted that when a government introduces exemptions and subsidies in an attempt to persuade funds to include the most vulnerable groups, it is the well to do who make the most of these privileges (De Swaan 1996). This was true in nineteenth century England, when Anglican clergymen used their privileges to increase their own pension funds, and it is true today in India, when housewives from the educated classes contrive to obtain governmental loans on favourable terms that are intended for the financially weak, but seldom reach them.

Notwithstanding the problems with exemption mechanisms, they constitute a necessary means for protecting the poor against the problems of access and equity. Indeed, most informants in this study perceive it as a moral responsibility of the state to provide exemptions for those who cannot afford health care in view of their socio-economic deprivations. Mechanisms that can be adapted to local realities through negotiation with community people need to be considered. The strong, socially mediated meaning of the poor in the communities makes such an approach necessary. This is all the more important since exemption plans for the poor have a tendency to create problems of confidence and interest in the health care system. Confidence has a moral connotation but given the strong social dimensions in the meaning of being poor, some amount of community representation in decision-making will be a realistic option.

One sociological consistency that De Swaan emphasises in his analysis of forms of solidarity and collective arrangements in the 19th century is that “a system of small, autonomous, collective provisions always excludes a substratum” (De Swaan 1988: 147). This phenomenon accounted for the exclusion of the poor from the mutual funds of the better off workers. In the present analysis, we can explain the relationships of the poor and indigent in social health insurance within a context of balanced reciprocity involving solidarity. The “payment of premium” in insurance is a predetermined balanced transaction. In line with the principle of balance therefore, those who pay their premiums are those who receive support when in need, according to the defined policy. “The poor” and indigent who cannot afford the premium are left out. The importance of the exchange is that it shows the negative side of the concept of reciprocity: that those who are vulnerable and poor and whose circumstances do not permit them to pay are those who also miss out. As much as the reciprocity underlying the solidarity arrangement rewards those who participate in the exchange agreement, in the case of the poor, it also acts as a mechanism of exclusion.

A lot has been said about the potential of insurance to provide access to the poor. In this chapter, I have shown that two types of poor people exist but typically this is conceived in relation to the wider meaning of the poor. The vulnerable poor are left out. While governments or states (the subject of the next chapter) in sub-Saharan Africa are pursuing ways of developing schemes based on universalistic solidarity, there is also a pressing need to design effective exemption strategies to take care of the indigent if the goal of universal access is to be attained. Although no hard quantitative data has been used here, the testimonies of implementers and community people have provided ample exploration of the existing problem. It will however, require further quantitative, population-based study to know the magnitude of the problem of the poor in order to plan effective exemption policies to tackle it.

The role of the state in the making of community health insurance schemes

Introduction

One of the basic components of any health insurance scheme is fund ownership and management. In any evaluation of the efficiency of community health insurance or protection mechanisms, an essential ingredient is the level of funding that can be generated and the ability of that revenue to sustain the scheme. The continuity of the scheme depends on the extent of people's participation in it. In voluntary health insurance schemes such as those in the informal rural sector, people's participation depends in particular on their acceptance of the concept of risk sharing solidarity that underlies the scheme. But also of crucial importance is how they conceive those who own and manage the funds on their behalf. Fund ownership and management can be run by government (state) organisations or non-governmental (non-state) organisations. Against the background of the emerging context of health insurance schemes in Ghana (particularly those suited to the rural informal sector), this chapter asks the question: Do people look upon the state as a possible financial caretaker or bursar of their health insurance scheme? If so, how?

In order for community health insurance to be scaled up as a national strategy, the state needs to play a major role. In taking the state as my central focus, I consider the existing context in Ghana in which the state has been at the

forefront of on-going attempts to implement a comprehensive health insurance scheme as an alternative health care financing mechanism to replace the problematic “cash and carry system” in the country. Since comparison is a central focus of this study, I look at the situation of a planned scheme in which funds are (or would be) owned and controlled through a hierarchy of state officials (such as the failed NHIS pilot scheme), together with the decentralised district alternative Dodowa scheme. I compare those with a scheme in which funds are owned and controlled by officials of a non-governmental organisation as is the case with the present Nkoranza scheme.

Although the focus is on community members, in order to place the discussion in a wider policy framework, I begin the analysis with a qualitative examination of the prevailing policy context based on conversations with policy makers, implementers and health staff. This is followed by a qualitative analysis of how the people also perceive the state as a bursar of *their* health insurance scheme based on prevailing assumptions and previous experiences with local mutual and/or micro finance schemes. Based on data from Nkoranza and Dodowa, I further contrast and discuss quantitative findings in which who the people trust most to be the owner of their insurance scheme, the government or an NGO, is discussed, and why that is. I conclude with a discussion of whether it is possible for the state to exert or inspire the necessary social influence or social capital on the community to make insurance succeed.

Policy, implementers and health staff perspectives

No legislation on health insurance in Ghana exists yet, but since the government accepted the final feasibility report in 1995 to implement a national scheme, several papers, reports and documents have been written, some of them in political party manifestos. For my present purpose, however, one notable reference is the 1995 final report on the feasibility study for the establishment of national health insurance scheme (NHIS) in Ghana. In its key recommendation for a generic NHIS, the consultants noted that sponsorship ought to be borne by the state in recognition of “certain weakness and problems¹, which will make the establishment of the NHIS in Ghana difficult”. In retrospect it is possible to see that the state funding and management of Ghana’s NHIS partly explains the function and character that the ill-fated pilot health insurance scheme in the

¹ Among the identified problems and weaknesses are “the unduly large proportion of self-employed which makes premium collection difficult and cumbersome, the state of disrepair of the infrastructure and the distribution of health institutions which is skewed in favour of the urban centres” (pp. xii-xiii).

Eastern region assumed. A former Director of Medical Services and later deputy minister of health, Dr. Moses Adibo, explained the background of the aborted plan that the MoH had accepted:

At the time we initiated the implementation, many of those in the ministry (who were mainly medical doctors) who were involved in the implementation had studied in Germany. They therefore only knew about the German social insurance. That system as far as I know is mainly based on contributions from workers. And that unfortunately was how they thought the Eastern region scheme was going to be run. In fact they had done everything and they had even written a memo to cabinet to authorize them to set up a company to run it. But when I was brought back as deputy minister in 1998, and I looked at it, I thought the approach was wrong so I said that government would not be involved in running health insurance schemes.

This is a typical story of state projects that are hastily implemented with enormous resources but which go down the drain. The obvious question to ask here is: What accounted for the change in direction? When and why did policy makers like the former minister begin to feel it was not necessary for the state to be involved in the funding and the running of health insurance?

Primarily, the shift in policy appeared to have started even before the pilot study, after an ill-fated sensitisation programme in the four pilot districts. Overall, the lessons of that abortive pilot, together with the outcome of several activities and reviews undertaken by the ministry of health and other interested parties and organisations in health insurance led to the change. The new orientation appears to be that the state should not be an agent or fund owner in community schemes. This was the overriding consensus conveyed to me by policy makers and implementers as well as health staff at various levels of the health service headquarters in the present study. Why?

One reason is that the processes involved in having a scheme under state control would entail unnecessary bureaucracy that would make overhead costs relatively too high. Specifically, the view is that when financial administration and management goes under state or parastatal institutions, the scheme carries the brunt of all its administrative features as well as the difficulties and inefficiencies of that bureaucratic organisation. Consistent with his position that the state should not be involved in running health insurance, Dr. Adibo further explained his worries about state ownership:

If the state has to do it then it has to be one huge national one. The overheads would be too much. If you take SSNIT they say that their overheads are 40% and that suggests outright that you should not give it to SSNIT because if you involve them then immediately your overheads are 40%. Health care costs are going up so you will lose. For me that is all the more reason why community based ones centred around the district are more attractive... more so because less than 10% of the

population are salaried workers. The best alternative was for us to look at some traditional practices like *susu* and see if we could not modify or refashion them to suit our circumstances.

Accordingly, current policy and on-going activities tend to stress the development of multi schemes owned by specified groups and communities rather than the ones centrally funded and managed by the state.

It is quite phenomenal that in civic life most citizens rationally pursue what they would get out of the state and community but not what they would contribute to it. This attitude is reflected in several spheres of life in state-citizen relations. People are always quick and proud to exercise their rights to the privileges of what belongs to the state, but reluctant to take up responsibilities to the state. This has become a real problem in the Ghanaian society, and as a result there is some concern that if the state takes centre stage, people would shy away from it. Dr. Adibo reaffirmed his dissenting view on government participation in health insurance as follows:

The Ghanaian's concept of government is such that they think it's some benevolent organisation sitting somewhere who will do everything for them for free. That is the way Ghanaians see government. They don't see themselves as part of government so they like free things and they expect everything to be free. They don't know that there is no free lunch. The irony is that usually it is the 'big men' who want things free. You have a friend who is a manager somewhere and walks into your consulting room or office and say I want some *ampicillin* and they expect you to dish it out free when as a matter of fact by his status he is the one who should pay more. So these are some of our own practices that create problems for us in health care financing. When I look at such things I get more convinced that the government should not be involved in running health insurance schemes.

It is important to recall a similar observation by the manager of the Nkoranza scheme:

Anything that is owned by the government people think is free (*bontu*²). They consider it like elephant meat and so they are not judicious in how they cut it... It is state property (*ah aban dea*) and that actually spoils everything that belongs to the government".

Probably Ghanaians at large take the paternal role of the state too literally or they just do not care about what happens to an entity like the state. Public apathy towards state property remains a phenomenon too disturbing to ignore in any state plans. Yet this is only one out of many reasons. What are the others?

² An old local expression which is probably appropriated from the English "booty".

Although the Eastern region pilot project never concretely began, it taught one important lesson. It acknowledged that state participation in insurance is essential for attaining the necessary legislative, political and to some extent, the economic context for success, even though at the same time state bureaucracy and political clout makes state ownership and control a nuisance. Each step in a community scheme is a new experience that must be learned within each new geographical region. Mistakes are made and corrected in the course of progress, and a lot of learning is gained through experience. The lesson of the defunct pilot scheme, which seems to be evidence against state ownership and control, is that because the state was in the driver's seat, elaborate legislative processes at every stage slackened the pace because every decision had to be politically agreeable. Another aspect of political clout is that when people perceive the state in terms of the political authority in power, then political ideology might unduly influence people's attitude towards it. At any one time those who are not in favour of the government of the day might not join merely because of political differences. Based on privileged information he acquired through his position, the regional coordinator of the abortive NHIS characterised the problem as follows:

Something that is being done by the government has some political inclinations and that was why they were so cautious about whatever step they took [in the abortive scheme]. I was always convinced that we may not know all the problems before the take off, but here was the other side that let us try to unearth a lot of problems, and so we had to go through meticulous calculations. Someone made an analogy to me the other day that if a child falls to the ground he gets up and brushes off his side and walks off. But when an adult falls, his immediate worry is who is looking at me? In other words, children move on after little slips without worry because society perceives them as learners who pick up lessons along the way. But because adults have to explain their slips they move too slowly. That is the argument for the state and non-state situations. If it is initiated by a group of individuals or community without political undertones, it's easy to move on. Whether it succeeds or not is known by experiment.

Yet another view from Suhum closely related to the above is that based on previous bad experiences with micro finance schemes in the communities, "people are tired of contributing and their voluntary spirit is exhausted". As a result any scheme in the community ought to "be the simplest of its type so that if you have to abandon it you do not leave a big building in Suhum".

It was from the relatively longer existing insurance scheme in Nkoranza district that I picked up on a lot of arguments against state funding and running of schemes from a range of implementers and health staff. A number of those arguments were related to the work culture of public institutions and the

behavioural norms of its staff. One of the key worries about state run schemes was associated with financial accountability. By their nature, community health schemes are necessarily non-profit, yet as with all financial activities, accountability is essential for monitoring performance to ensure financial discipline. Most implementers that I spoke to in Nkoranza, however, did not think highly of the level of accountability and financial discipline in the state sector. The diocesan public health coordinator of Sunyani, who directly oversees the Nkoranza scheme, lamented the lack of efficient accountability in the state sector:

Spending is more strictly controlled in mission than in government hospitals. Then also in mission hospitals, we tend to assign people to jobs and so you are held personally accountable for lapses. In the government sector even though that also ought to be the case, it is an array of staff that normally tends to be blamed so it is easy if you are getting difficulties to move away. In our mission areas that is not the case. For instance, if this scheme [in Nkoranza] collapses, I am going to bear the brunt, the same applies to the manager and the coordinators. You cannot push that to any other person or persons. In government circles that is easy to do and as soon as the thing collapses then I would go on transfer. That kind of informal monitoring process makes people feel secure even when they are doing the wrong thing.

Apart from financial inadequacies, there was also the view that compared to mission institutions, the state system generally lacks an adequate and efficient administrative monitoring of its health staff. There are worries that this may negatively impact the efficiency of any schemes that may come under the control of the state. Inefficient administrative monitoring is acknowledged as having been responsible for undue laxity in the attitudes of health staff which has in turn led to poor discipline and poor work ethic. A 46-year-old nurse midwife at the Nkoranza hospital who was enrolled in the insurance program explained the situation to me this way:

My experience is that although I do not work at a government facility, I have attended Sunyani government hospital before and I have friends working there so I know what is going on. The attitude of the staff working in government institutions is different. In mission hospital the monitoring is strict but in government hospital it is not so. For example in the government hospital, it is possible for two nurses on duty to plan the routine to excuse one from duty so that instead of two people one of them will be working. In mission hospital like here [Nkoranza] it is not like that. The authorities are very strict and serious with monitoring, so two staff members cannot arrange cover for one another without express permission from the head. Indeed, usually it is not possible and you can cover for someone if you are off duty so that there is no shortage. I am not saying government hospitals are not firm, but when you compare the two places one is stricter than the other.

Related to accountability, implementers from the NGO run insurance scheme had concerns about corruption in the state sector. The problem of corruption is well known in Ghanaian public life. One major cause of corruption is the low wages of staff. In order to survive, it has become a norm typified by a common saying among all shades of salaried workers, but particularly those in the public sector that everybody chops³ from his job (*obiara didi n'adwuma ho*). A para-medical male staff of Nkoranza hospital explained it this way:

I have been party to collecting monies for doctors in their consulting rooms before when I was in training in a government hospital. The system there is such that you can't say "no" because they say every patient that comes for consultation pays it.

However, further conversations revealed a significant irony in the public health service: the practice of bribe taking and corruption has not only become part of expected wages, but it has become entrenched in everyday life. The public has been active accomplices to the point that they sometimes become suspicious or doubtful of health staff or officers who refuse to accept voluntary "cash gifts" from clients. The district director of health services, who also practiced as a clinician at the Nkoranza hospital, narrated to me his own experience as an intern in a teaching hospital:

You see when I was in Komfo Anokye teaching hospital, a patient once told me: "If you refuse to accept money, it means that you are not going to look after my child well". (*Sɛ wo angye sika no a, na ekyerɛ sɛ wo nnhwɛ me ba no yie.*) That is how the norms in the public sector change, because of the perception of people about that sector.

The reality of the situation in the public sector is that the realisation by citizens that things sometimes do not move as expected without greasing the palms of relevant officials, is not a new phenomenon; but it is worrying since in health care it leads to a vicious cycle of poor care and/or further exclusion of the poor and vulnerable.

I ought to point out these "allegations" from Nkoranza, which is a mission outfit, against the public sector does not rule out some element of bias, nor does it make the "allegations" untrue. Dodowa, with its shorter period of experience but very effective district health management team, however, provided an opportunity for a defence of the public sector. The reactions of entirely public sector implementers and health staff to some of the foregoing issues are interesting.

³ This word is Ghanaian slang for eating.

They do not deny the problems or allegations. Many in that sector feel that the problems are explainable in their total social context. For example, one medical officer briefly explained poor staff attitude as follows:

From the point of view of the client what we always know and hear is that the nurse is being rude and she kept us waiting for two hours and we are dying... It is not an easy problem and we may not have all the resources to solve them. There are very big obstacles and some of the things need systemic change. For example, if you take the issue of staff salary you cannot do anything about it at the district level. And yet that is just one aspect of the problem. In order to look at the problem of staff attitude holistically, we cannot ignore education for their children. Unfortunately people in the system sometimes do not want to hear about new ideas, which seem radically different from the way they do things especially if you meet a proper bureaucrat. That is why the public system remains the way it is.

At a later opportunity, I bluntly asked the district director whether in her view and experience the state could be trusted to be a fund owner and administrator of a community insurance scheme. Her response, while discounting fully state schemes and accounting for the human and social deficiencies of the state sector, justified why in her view the district model that she had been spear-heading was a better alternative:

The scheme can be easily mismanaged if the state is in control because it would be too large to control. The administrative, organizational and monitoring systems are so weak that it is in our interest to decentralise to the district. The way things are if there are bad nuts in the system, it can ruin the whole scheme. The only way the good talent can come up is to decentralise at the district level. At worst it is good to keep it at the region because of lack of manpower and knowledge. The state could then focus on building, handling and processing and thereby creating an even climate for the lower levels to have the freedom to grow.

From the foregoing analysis, we could summarise the key strands of policy implementers' views on state funding and ownership of insurance. Beyond the well-known technical reasons, pertinent social and contextual factors make state funding and/or management of health insurance schemes in Ghana ill advised. The interesting aspect of the arguments of policy implementers is a view that in order to deal with the myriad of problems "the system first has to deal with the problems of the working staff". For the present analysis however, it is important to acknowledge that social concerns about staff attitude and credibility based on inadequacies of a system in terms of its ability to deliver services has implications for the trust and confidence that are essential for people's participation in voluntary schemes.

I will later discuss how trust could influence solidarity towards schemes, but in the meantime I turn to examine the people's side of the argument for and against state agency in health insurance.

People's perspectives: Do the people also look up to the state?

In general, people look upon fund ownership by the state with mixed expectations that are usually more pessimistic than optimistic. The mixed expectations are derived from considerable interest in obtaining social protection against an ever increasing cost of medical care, but many are doubtful about the ability of the state to offer such a service. The minimal sense in which people favour state ownership is expressed in two ways. Significantly, both views come from informants in Suhum and Dodowa Districts. The first is based on a miscalculated assumption that the nation state more than any other entity is in a better position to provide the financial resources to capitalise and offer the technical capacity needed to get the scheme going. Unfortunately, the reality of the Ghanaian economy does not support such an assumption. As a free market economy, the competing demands of various social sectors simply do not entitle any one service or sector to have more than its essential quota from the national coffers.

A second argument that a few people use in favour of state funding and administration, also a hypothetical one, is that since public health facilities cover the entire length and breadth of the country, state ownership would facilitate a wider geographical coverage. To paraphrase one informant in Suhum, "The government is a big body; it reaches everywhere". A few informants were indifferent about ownership. "What is important is that the nurses will speak nicely to us and the doctor will give us the correct drugs when we join the association. I don't mind whether it belongs to the government or the district assembly," said one informant in Dawa during an FGD session. What is obvious from the remark is that ordinary folks sometimes mix up central government administration and decentralised district administration when such issues are being discussed.

Most of peoples' perceptions of state ownership of insurance schemes were sceptical. Many aspects of this scepticism, stem from lack of trust or faith in public officials and politicians as a result of their failure to deliver on most of past promises. Some of the concerns were morally conceived and derived from what people consider right and wrong or good and bad behaviour and attitudes of officials and politicians. As expected, in the absence of a functional scheme at the time of my first visit in Suhum and Dodowa Districts, peoples' views about the state were impressionistic and vague. Their concerns were lack of

integrity, the potential for bribery and corruption and the tendency of state officials towards favouritism. On the other hand, informants in Nkoranza, whose opinions are based on eight years of experience, tended to focus more on practical operational issues involved in managing community schemes. Issues that frequently got highlighted were: inefficient administrative and financial monitoring systems, a lack of proper accountability in the public sector and a lack of commitment by state officials and state bureaucracy. In both districts, however, one common concern about state ownership was trustworthiness.

Suhum and Dodowa District

The underlying sentiment towards state funded and owned schemes in Suhum District is well captured in the following remark of a participant in a male focus group discussion in Suhum:

The only concern about state ownership is trustworthiness on the part of those who will be in charge. Would they faithfully give 'equal treatment' to clients? When it comes to state schemes such as insurance those in charge rather have a tendency to benefit by living fat on the money and riding in big cars, such as the case of SSNIT.

This message, although short, was too powerful to ignore. For analytical purposes, it is important not to lose sight of the reference to "trustworthiness". The expression 'equal treatment' in the remark was meant to convey that trust was perceived as the essential ingredient for fair play in office holders' dealings with the people. Most informants were quite suspicious about the character of state officials on the basis of previous experiences in spheres of state organized initiatives. SSNIT was always the common reference point. As the official social security system for the country (that however covers only the formal sector) SSNIT often came under public criticism for several reasons, including the affluent lifestyle of its senior executive and a host of perceived malpractices in the way the fund was managed.

In the context of social or mutual schemes, trust is about assurance that monies paid or premium contributions would be used for the benefit of members. But whether negative public perceptions about SSNIT is justified or not, it is just one cited case. In virtually every community, unfavourable tales about the state were shared. At Dokrochiwa in Suhum District, for example, one female informant told me a story of how past promises to fix the deplorable road and to provide potable water and electricity to their village were all broken, in spite of the modest financial contribution the community had made towards those projects. In the case of the road, she lamented how a road to another village was shown on television to deceive the entire viewing nation when a minister went to visit their village during a political campaign. She

concluded: “I have therefore sworn never to contribute money towards state projects in the community”.

To some people, the state is not credible enough to hold their funds because of the alleged indulgence in bribe taking and corrupt practices of state officials. In re-emphasising the well-known problem of shop floor malpractices through the collection of ‘under the table monies’, one participant at a male FGD in Suhum gave his personal experience:

A friend of mine had an electric shock and almost died. He was later referred to Korlebu⁴ for further treatment and the hospital here (Suhum) advised him to go very early. He complied and on the day he attended Korlebu he was the seventh person in the cue. But he noticed that others who came later were entering the consulting room ahead of him to receive treatment. It went on until someone hinted him that he had to pay “something” if he wanted to go home early. Soon after he had done so he was called into the consulting room.

In this particular story, I probed in order to gain further insight. I asked the speaker if the money was perhaps not paid to the doctor, but possibly to an orderly. But another participant quickly cut in with a fascinating remark. “The doctor also gets his share of the monies collected, unless you have not had the experience of sending a relative to a hospital before”. Indeed in the seeming existential doubt and uncertainty about the integrity of state officials concerning ‘equal treatment’ or fair play, several informants also assume a position most often conveyed in a simple message: “unless we start...we just have to wait”.

Similarly, in Dodowa, concerns about credibility based on honesty, commitment and reliability take centre stage in the way people conceive and describe their impressions about state funding and management of schemes. Some were so distrustful of the state as a result of previous experience with money mismanagement, that they did not even consider the decentralised district administration to be a reliable agent in “money matters” because of fear that they may misapply the funds. Rather, the district health administration was preferred in most cases. The reason given was “because the issue concerns health”. One traditional leader at Dodowa described this view as follows:

These days they talk of decentralisation but if these monies are channelled through the assemblies all may not get to health. What we know is that sometimes when there are disasters like floods, the assembly would take that money and divert it. The Ministry of Health (district health administration) should therefore be solely responsible. That money should not go into the central coffers of the district administration.

⁴ Ghana’s foremost and largest teaching hospital in Accra.

Quality of care has been a perennial problem in the health services in Ghana especially in public health institutions. The great hue and cry of people about quality of care in relation to the present issue was mainly about poor staff attitudes. Many are dissatisfied with staff, especially nurses for not working around the clock and because the entire service is not organised around their needs. One female informant and leader in Dodowa explained:

I do not know why a nurse says, "I'm tired". One is a nurse throughout 24 hours. Even after shifts, people will call him/her from the house". And then the language they use on the patients, they have to polish it up a bit. Sometimes they will insult you because you were late, but they have to be patient, use polite language and seek to improve the service.

Some were also very strongly against what they perceive as staff dishonesty. At Dawa in Dodowa District, for example, the group consensus at one FGD group discussion was the fear that if management of insurance goes under government control, "health staff will send drugs meant for members to their homes to treat their relatives and friends at our expense".

Nkoranza District

People in this district, speak with pride about 'our insurance' being first and foremost a product of the honesty, good work and concern of the diocese and hospital officials for the community on one hand and their own trust and confidence in the implementers on the other hand. Indeed trust was emphasised as the miraculous foundation of the scheme. One informant at Kranka said:

People were prepared to pay and join because they trusted the leadership. Everybody trusted Bosman (the doctor who initiated the scheme) and although it took some convincing, people were saying that since the white lady is involved, it will work (*Oburoni no wɔ mu yi deɛ, ɛbɛ yɛ yie*). They trusted her and the other opinion leaders who got involved in it to sensitise the community. The people were God-fearing and so the only way the government would succeed is to get God-fearing individuals to be in charge.

In contrast to these perceptions of the mission run project, some people in Nkoranza District perceive the state as being unreliable, dishonest and notorious for misapplying, embezzling funds and lacking accountability in 'the way it conducts business'. Past experiences with state enterprises and public corporations have undoubtedly contributed to this negative image of the way finances are handled by the state. One local leader illustrated the situation by contrasting the state owned mass public transport companies in Ghana with mission institutions:

The missions control their things such that nobody can manipulate their funds. The state on the other hand has a lackadaisical attitude and approach to the way it conducts its business. One example is the state transport companies. They cannot be trusted, taking the accounting system into consideration. The drivers pick anybody up on the road without issuing tickets to them. Most state companies conduct purchases by buying in bulk yet at very exorbitant prices and people do not buy it. These are some of the things. Sometimes, when it belongs to the state, nobody takes the credit but once it belongs to the mission, the credit goes to the diocese. As for the state there will be lapses here and there.

Another reason for people's aversion to state ownership and control is that they perceive the state as largely bureaucratic, relatively remote and an institution that is difficult for ordinary folks to establish a close relationship with. Some informants therefore hold the view that this remote feeling leads to a loss of sense of identity, ownership and loyalty for 'state owned things'. The district chief executive in Nkoranza referred to the phenomenon as breeding "a type of mentality people have towards the state property; whatever is happening, nobody cares". At a male focus group discussion, one participant who was an officer at the district office of the Ghana Education Service supported suggestions for district-based schemes with the following explanation:

Size is very important when it comes to manageability of many things. Anything that is packaged in the name of the government has problems. Here we are able to check corruption, loopholes and other lapses...and people will have confidence in it. If it's for Nkoranza district we love it because we believe it is for Nkoranza and Nkoranza alone and we feel close to it. On the other hand if it is owned and managed by the state from Accra my concern for it would probably not be so good... because Accra is too far away for me to identify with it. What belongs to us and what belongs to them are never the same. (*εwo yen ne εwo w□n ennse.*)

There is also a strong feeling among some in Nkoranza district that the soul winning ideals of the church that stresses compassion and close identification with the community leads to a stronger integration and for that matter, better commitment on the part of mission staff to their work and their community. In contrast, the state as personified by its officials, is commonly seen as people who are merely working to earn a living and who are not committed enough to the community to devote the effort and make the sacrifice that is required to run an insurance scheme successfully. To paraphrase a popular opinion leader in Nkoranza who made a reference to the issue:

You know in government hospitals people really do not think much of the community. But in this instance the mission has established churches in even remote villages all over the district. They have fathers and priests who live in the communi-

ties and so they are aware of the problems of their members. It is part of their work to help them and therefore if there is something, they have them more at heart than the government people.

The difference in attitudes of the staff employed by the mission and by the state also receives frequent mention. The relative lethargic approach to work that staff in the state sector have does not go unnoticed, nor do people wholly blame the staff of not being more dedicated to their work. Rather, the observation is made that “the missions are able to monitor and control the staff” while the public sector is perceived as having “no time to control the staff”. As one opinion leader in Nkoranza lamented:

They do not think about the job but how they get their money. Whether they work or not they get paid. Some report for work and then go away because the attitude is that the work is not for his or her father but for the government. They tend not to appreciate that we are the government.

The same opinion leader also conceded a commonly held view that Ghanaian citizens are important partners to the problem. “They tend to think that government is just the president in Accra whom they blame for everything wrong with the state. Therefore when it is for the government we do it anyhow.”

In general it is fair to conclude from the views of people that they identify a problem of credibility in how the state conducts its business based on past experience. Significantly, the human problems of the health sector in terms of the way officials carry themselves reflect the situation of the whole society.

To summarise, the analysis so far, it is important to observe here that both implementers and citizens at large have similar amounts of scepticism about state ownership. The state is no longer perceived as credible on the basis of the trust, honesty and reliability that it has not shown in the past. But is the foregoing evidence that people do not trust the state as a possible caretaker or bursar of their insurance scheme?

In a follow up study to subject some of the preliminary qualitative findings to more rigorous analysis, sampled households in Nkoranza and Dodowa, (chosen on the basis of functional experience) answered a few questions in a survey. A striking finding was that altogether, the relative majority of subscribers and non-subscribers in Nkoranza District (40.8%) favoured the state as the most effective organiser of a health insurance scheme. In Dodowa the relative majority cited the district (35.4%) but the state followed closely (32.0%). This rather high endorsement of the state contrasts the dominant negative outlook of the state in the qualitative study. A brief explanation of that quantitative survey analysis will suffice here.

Altogether, 502 and 518 respondents in Nkoranza and Dodowa Districts respectively were interviewed. Respondents were health staff and community members. In Nkoranza 5.8% were health staff compared to 9.3% in Dodowa. While there were more subscribers (55%) than non-subscribers (45%) among the community members interviewed in the survey in Nkoranza district, the opposite was the case in Dodowa where there were twice as many non-subscribers (71.4%) as subscribers (28.6%). This reflects the low level of subscribers and the difficulty in obtaining them for interview in Dodowa district, which is attributable to the young life of that scheme. Specifically, in order to test whether the community trusted the state to be the bursar of their scheme, respondents in the survey were asked to indicate who they “preferred most to organise their health insurance scheme effectively and why” among a choice of alternatives (mainly governmental and non-governmental). Part of the results is presented in Tables 8.1 and 8.2 below.

Table 8.1

Believe health insurance can be most effectively organized by....

<i>Organiser</i>	<i>Nkoranza</i>		<i>Dodowa</i>	
	Subscribers	Non-Subscribers	Subscribers	Non-Subscribers
State	23.3	17.5	8.4	23.6
District	5.4	4.4	11.6	23.8
NGO	4.8	3.4	3.7	10.4
Church	14.1	11.4	3.9	10.8
Village	1.4	1.6	1.4	1.4
Others	5.6	5.8	-	0.8
No response	0.4	1.0	-	0.2
Total	55.0	45.0	29.1	70.9

For analytical purposes, the response categories make a distinction between the centralised state administration and the decentralised district administration.

How then do we explain the variation between the qualitative and the survey data? The most likely explanation is offered by the underlying reasons for people’s preferences. The dominant indicator upon which people based their choice in the survey was perceived financial ability. Accordingly a majority in each district (43.0% and 37.9% in Nkoranza and Dodowa respectively) cited “best financial capacity” as the most important reason upon which their choice was based. This is further reinforced when various organisers are considered individually in relation to the reasons for selecting them. Among those who favoured the state, the overwhelming majority of subscribers and non-subscrib-

ers together in Nkoranza (83.9%) and Dodowa (93.7%) based their decision on the perceived financial capability of the state to support a scheme.

Table 8.2

Key reasons upon which choices about effective organisation are based

Reasons	<i>Nkoranza</i>		<i>Dodowa</i>	
	Subscribers	Non-Subscribers	Subscribers	Non-Subscribers
Better organisational/ management capacity	6.0	4.4	2.4	5.6
Best financial resources	24.2	18.8	9.9	27.9
Trusted & non-corrupt	6.0	6.8	4.0	12.9
God fearing	7.4	5.4	1.4	4.2
More community oriented	4.2	2.4	5.3	8.9
Experienced in scheme	5.8	5.0	5.9	10.5
No response	0.4	1.0	0.4	0.8
Total	55.2	44.8	29.3	70.7

Furthermore, an interpretation within a broader social context does not suggest a contradiction. First, it is important to acknowledge that apart from financial capability, the other indicators upon which people based their decisions in the survey emphasise social attributes: trust and similar qualities such as perceived fear of God, lack of corruption, orientation to the community and the capacity to organise and manage the scheme based on experience and competence. Significantly, these qualities together outweigh the financial factor and places social attributes at the centre of what people consider important for their preferences for scheme ownership. Accordingly, the ultimate choice might in fact not be the state when all the options and preferences are evaluated. The relative majority preference for the state in the survey ought to be viewed with caution, given the common Ghanaian perception that the state is some benevolent organisation or entity that provides free things. The survey finding might therefore be people's way of saying that they expect the state to provide the necessary financial support if they cannot afford the charges themselves in a social insurance scheme.

A further comment on the other top choice apart from 'the state' in the two districts is worthwhile. In Dodowa, the district was actually the most preferred choice. Practically, this was also the decentralised state, but the difference in emphasis could be explained by the fact that the Dodowa community considers effectiveness more in terms of the district because "district" has been a key concept in the education and mobilization drive of the Dangme West District

community health insurance initiative. On the other hand, although all residents and non-residents of Nkoranza are eligible to be members of the scheme in that district, apart from being a single facility based scheme, “district” as a concept per se has not been a key organising principle of the Nkoranza scheme. On the other hand ‘the mission’ was the next preferred option in Nkoranza district after the state. Again this was consistent with what the community had known and were used to, since they associate the hospital and the scheme with the Catholic mission. In essence, this indicates that familiarity also plays a key role in people’s confidence in scheme ownership. Peoples’ preference for the church was based on moral grounds such as fear of God (48.8%) and trustworthiness and non-corruption (31.5%). Similarly, when people refer to the district, they imply the district health management team or health administration in a more narrow sense. People’s preference for ‘the district’ is thus an endorsement of their perceived familiarity with the organisational drive in health insurance by the DHMT in the district. Despite its short period of operation, the important reasons why people chose it as the next in importance after the state was because it was better experienced in organisation (43.3%) and better community oriented (35.0%).

Discussion: Can the state inspire popular collective will in community schemes?

Emerging community health insurance schemes in Africa have either been initiated by health facilities, NGO’s, local communities or cooperatives and owned and run by any of these organisations (Atim 1998; Criel 1998b). It is, however, important to recognise the increasing interest of states in such schemes and attempts by some governments to implement such initiatives on a national scale. State intervention is crucial for a number of reasons. First, it provides a means for achieving the objective of basic health care for all its citizens. Secondly the declining support by the extended family imposes a stronger responsibility on the state to fill the void. Again, there are also practical social reasons that justify state control or administration of non-profit schemes. These include control of cost to consumers, maintenance of quality, provision of a comprehensive package rather than partial coverage and assurance of provision for the poor and indigent.

Furthermore, from a social historical perspective, de Swaan has noted that state intervention in nineteenth century mutual fund societies in Western Europe introduced three unique and novel elements: permanence, national scope and legal compulsion. The state, by virtue of its enormous resources, became the oldest and most creditworthy risk-bearer. It also had the largest encompassing

organizational structure. Most important of all, the state could exert effective and legitimate compulsion and thus impose obligatory insurance upon the vast majority of wage earners (de Swaan 1988: 149).

However, in the developing country context such as Ghana, state intervention presents its own problems and complexities. First is the problem of a lack of adequate financial resources to implement and support such schemes. Second is that the socio cultural context of the informal sector makes the application of a generic scheme on a national scope implausible, since communities vary in terms of socio economic and cultural realities. In addition, legal compulsion is untenable because neither the government nor any implementer has control over people's incomes. Whether people want to pay their premiums, how much they can pay and what type of benefit they want are all issues with the people. Furthermore, state intervention in health care financing through community schemes presents an interesting analytical paradox. While the nation state seeks to implement community insurance schemes as social protection mechanisms, that need has become all the more necessary due to the failure of the state to provide adequate social support for its sick.

Voluntary or mutual co-operation originates from people themselves, and is often informal in nature and intertwined with local culture. In the field of social security, they offer alternatives that compliment what the nation state or bureaucratic formal organisation inadequately provides. Of great significance is that voluntary cooperation is more likely to be accepted, and for that matter effective, where substantial stock of *social capital* exists. Social capital here can be understood as networks of social relations which are characterised by norms of trust and reciprocity and which lead to outcomes of mutual benefit. In the traditional Ghanaian extended family or village particularly in the past, people trusted those they knew: relatives and neighbours. Society's social capital was intrinsic in primary social groups in the form of norms of reciprocity and networks of community engagements.

On the basis of the analysis in this chapter, the relevant analytical questions that ought to be asked are: Is whether it is likely or even at all possible for the state to exert, exercise or inspire the necessary social influence or social capital on community members in informal community schemes to achieve a desirable result in the Ghanaian context? Can the state as a formal bureaucratic institution generate loyal feelings of solidarity among its citizens, just as small social units like the family are able to do in informal settings? Furthermore, can the state inspire movement towards the scaling up of informal security mechanisms into formal or market based national schemes?

Views expressed by many community members as well as health staff in the foregoing discussion indicate that they associate public institutions with poor quality services, inefficiency and to a far greater magnitude, corruption. A

World Bank study in June 2000 made a similar observation about public institutions in Africa in general. The problem of corruption, defined simply as the abuse of public office for private gain, deserves some attention here because of its far-reaching social and cultural dimensions. As a concept with wide social, economic and political dimensions, a comprehensive discussion of the subject obviously falls outside the scope of this discussion. A brief reference to relevant aspects will be therefore be made here. First, what are the causes?

As already mentioned, one aspect of the problematic nature of corruption in all public services in Ghana is typified by the common Akan phrase that everybody chops from his job (*Obiara didi n'adwuma ho*). This association with gastronomy has been found among public institutions elsewhere in Africa. Bayart (1993: 242) in his classic comparative study of Africa noted that in Cameroon, they talk of the politics of the belly. "They know that 'the goat eats where it is tethered' and those in power intend to 'eat'". He explains the term "eating" in relation to the concept "politics of the belly" thusly:

It refers not just to the belly, but to 'politics'.... A man of power who is able to amass and redistribute wealth becomes a 'man of honour'. In this context, material prosperity is one of the chief political virtues rather than being an object of disapproval.

Although Bayart's case referred to the situation of politicians and politics in Africa, it has wider applications for the widespread phenomenon of private gains from public good. Indeed, the fact that the practice finds expression on the shop floor of public health services makes its application here very relevant. Several structural and cultural factors have been identified as encouraging corruption within Africa's public health services and public administrations in general. The relevant ones for our purpose here include the practice of gift giving. Scott (1972) has explained that the survival of the traditional practice of gift giving and granting of services in a society with salaried civil servants constitutes a form of petty corruption. The 'persuasion' of a doctor to take a gift as an assurance for the satisfactory treatment of a client is a case in point.

Again the prevalence of kinship ties, clientilism and other traditional loyalties over modern bureaucratic obligations leads to nepotism and corruption as people in government service allow their family and traditional interests to prevail over those of the state. This situation is worrying to many community members who speak about kinship, friendship and other social ties as the basis of favouritism. They believe these factors will affect how insurance scheme officials would treat them. Furthermore, the over-centralisation of power in the state also contributes to the phenomenon. In a study of medicine distribution in South Cameroon, Van der Geest also linked the custom of gift giving and most

importantly “the overwhelming position of the state as the main source of goods, services and employment” to the socially accepted practices of privately using medicines belonging to the state. Other causes of corruption that have been mentioned by other authors include absence of transparency in public fund management, low salaries and lack of media freedom to expose scandals (Hakeem et al. 2001).

How does corruption affect the health services? Or how could it potentially affect financing schemes? Institutionalised or systematic corruption that allows officials or staff of health institutions or health schemes to extort money from patients is socially corrosive. One consequence of the position of the state as the main source of goods, services and employment is the expectation from its citizens that the state should provide them with free services irrespective of their ability to afford the services or not. Ironically, prevailing kinship ties and traditional loyalties nurture the practice in the public sphere and constitutes a major drain on health resources and a potential bottleneck to the social and economic feasibility of community financing schemes. As Van der Geest (1982) observed in relation to the distribution of medicine in South Cameroon, corruption has the tendency to “maintain the status quo in the unequal distribution of health resources and economic resources in general”.

According to a recent Transparency International Report, there are other social consequences of corruption (Global Corruption Report 2001).

[It] adds to poverty as it transfers real resources from official state coffers to a few rich and powerful individuals. Corruption also has a tendency to distort economic factors because those who benefit from it are rewarded for little or no work done, and the costs of projects turns out to be higher than would normally be the case.

To sum up, in the establishment of schemes, public confidence and trust are important in order for them (schemes) to have a strong social and legitimate foundation. However, this legitimacy of the public service in Africa has come under serious challenge due to diminishing public confidence caused by corruption.

When economists and health planners discuss the potential for health insurance in Africa, they commonly ignore or treat these important social issues as piecemeal. For example, in a 1995 World Bank classification by Shaw and Griffin (1995) and later Ensor (1997) to explore the potential of social health insurance in Africa, they used a scoring system based solely on supply and demand factors as if the social contexts did not matter. Yet community schemes cannot be seen purely in terms of supply and demand without due regard to the associated social expectations and social environment of those for whom it is planned. Indeed as Criel (1998: 78) has rightly noted, a perspective that ignores

the social dynamics is ahistorical and incomplete. Yet again where local attitudes and conditions are recognised, there is a tendency to perceive them as static without adequate attention to their dynamic aspects (see Chapter 6).

I wish to emphasise here however that neither the present world nor the formal bureaucratic state meet the social criteria for the functioning of solidarity. In other words, societies today, even the remotest ones in an old indigenous village where economic survival was once based on reciprocity and social capital was central to community engagements are no longer so. Society at present does not stand and fall by the social relationships in the community. Of even greater significance is that in a health insurance scheme, the underlying concept that binds people together is the premiums they pay. The transaction therefore precludes any form of social capital for the individuals involved, although it is probable that where greater stocks of social capital exist in a community the people may be more willing to share risks with others and vice versa. In order for the state to achieve or enhance voluntary cooperation in the community, there must be other ways of building the sense of voluntary cooperation. What the findings in the foregoing analysis suggest is that trust and credibility are very important. Thus, we return to the question: Would people trust the state?

People might be more willing to enter into an insurance arrangement if they are confident they will get the best outcome from the transaction. Hypothetically, a high level of trust is necessary to generate people's confidence to cooperate voluntarily. Trust might also be necessary for the way people behave in the scheme, such as their tendency towards moral hazard and adverse selection. Under conditions of trust, therefore, people and/or informal social groups are more likely to be co-operative and supportive. A high level of trust is likely to lead to a high level of support, and vice versa. However the corrupt image of the public service poses problems for confidence and is a critical setback to the ability of the state to scale up informal community insurance schemes to national level schemes. In conclusion, apart from the administrative, institutional, technical and financial limitations, a lack of trust and credibility in the state provides many reasons to not to be too enthusiastic about what the state can achieve through voluntary insurance schemes. The urge or power of solidarity for achieving success rests with the people.

Summary and conclusion

Summing up

This study set out to investigate how “the people” for whom health insurance is planned view a formal or state-based health insurance and how they are likely to participate in such a scheme. The purpose has been to provide insights into how a sustainable insurance system can be implemented in Ghana by taking into account the local traditions of mutual insurance or social security. The focus has therefore been kept on the dynamics of both traditional social security arrangements in the Ghanaian society and the emerging health insurance schemes since the driving force behind the ‘new’ insurance schemes are the similar principles of equity and solidarity.

Contrary to official policy assumption and existing empirical propositions that rural households will participate in risk sharing insurance schemes because of their cultural affinity and past experience with solidarity associations, this study has as one of its main findings that the overriding motivation of people to participate is based on enlightened self-interest. Again, the common assumption that tends to associate potential positive influence of social capital in a community with people’s desire or willingness to share risk and thereby enhance health insurance is questioned. In practice, the nature and social context of community wide or district wide health insurance schemes do not provide opportunities for the accumulation of social capital. Another key finding is that, although people perceive the state as more capable of providing the resources for setting up insurance schemes, they literally do not trust the state as a credible fund holder

in view of perceived official corruption, bureaucracy and inadequate monitoring and accounting systems in the public sector.

Polanyi's analysis of the rise and influence of "the socially embedded market" in *The Great Transformation* provides a useful starting point for my theoretical perspective. His three basic "principles of social organisation" which are the principle of reciprocity (solidarity networks), the principle of (state) authority (command networks) and principle of the market (exchange networks) explains how the needs of society determine economic behaviour in pre-industrial and primitive economies, whereas in modern market economies the needs of the market determine social behaviour. Following Polanyi, the moral economy theory of James Scott and the political or rational economy theory of Popkin provide the basic arguments for my conceptual framework. Scott embodies the thoughts of Polanyi and argues that the peasant life is geared towards altruistic motives. In Popkin's rational economy approach, he opposes Scott. He believed that the actions of the pre capitalist peasant were directed towards individual, self-interested values. Writers after them joined the debate as proponents and opponents reconciled the two viewpoints. De Swaan's theory of collective action explains the collectivisation process as a result of self-interested behaviour that arises from the realisation of interdependence and external effects of people on one another's actions. In Chapter 1, I provided an overview of the community health care financing problems in sub-Saharan Africa by emphasising the point that health insurance there owes its increasing popularity to the problems of health care financing. Community based health insurance schemes are conceived of as a response to the negative side effects of user fees on access to health care for the poor and socially disadvantaged.

In order to situate the discussion in its proper historical context, Chapter 2 dealt with the historical developments of public health in Ghana and how it was paid for from the pre-colonial period. That history reminded us to not lose our perspective on the social and political forces that have shaped the service and people's attitude towards health care and its payment. It revealed that the public health services available today developed directly from, and are to a large extent reflective of, the curative biased character of the legacy bequeathed by colonial Britain. The financing of that service has gone through a chequered history from nominal fees to fee free health system and back to user fees. That chapter also pointed out that colonial health services were financed mainly through general taxation, with the exception of small fees charged to non-civil servants. Financing the service became a chronic problem after the immediate post independence government of Nkrumah in the late 1950s introduced the free health care policy. In general though, the pattern of public health financing did not change significantly after Nkrumah. The problems of health care financing became compounded after the economic problems of the seventies and the entry

of nominal fees into the realm of public health services during the time. The pragmatic introduction of user fees in public health care facilities started in the mid-1980s, with full cost recovery for drugs when World Bank and International Monetary Fund structural adjustment programmes became a major feature of Ghana's economic policy reforms in the health sector.

The background information in Chapter 3 pointed out that the three community initiatives that constitute the subject matter of this study were all conceived against the backdrop of the foregoing contextual problems. They were initiated or planned with the intention of making health care accessible to poor households, particularly in rural communities, who face chronic payment problems. They thus represent attempts to inject and institutionalise traditional reciprocal solidarity principles into innovative insurance schemes in rural communities. They share certain common features. They are all planned as voluntary but household mandatory schemes, they are based on prepayment of contributions to an identifiable fund and they offer a clearly specified benefit package. The pioneer community health insurance scheme in Ghana, Nkoranza, has never really met its projected membership target since its inception, but it has been able to survive the challenges of an innovative community scheme for a decade. The Dangme West district scheme, which is in a very infant stage, offers another experience in community schemes. It is the first district wide and also public sector scheme that offers both in- and out- patient services from all public health facilities in one district. Its greatest challenge remains how it will be able to meet its in-patient obligations by relying on hospitals in adjacent districts. The NHIS pilot scheme became a stillborn highhanded social engineering programme, but understanding the path it treaded while the idea lasted fills a useful information gap on what is known about community health insurance schemes planned by the state.

Overall, the critical challenge for the emerging community health insurance schemes is how to secure culturally appropriate ways of creating or attaining larger risk pools beyond familial and small homogenous groups and transforming them into more anonymous mutual insurance schemes. Understanding the dynamics at work in such a process is what the study set out to investigate. In-depth insight into the traditional social security arrangements in Ghanaian society in Chapter 4 therefore provided the necessary socio-cultural background for situating the discussion. In the Ghanaian traditional support system, the extended family was the basic unit of social organisation. The system revolved around it and provided the social and juridical framework for long-term reciprocity. Social relations, defined by kinship served, among other functions, the purpose of determining in advance the rights and duties of members during times of emergencies. These relations became customary laws governing

groups; they decided social norms relating to property, inheritance, ownership of land and collection of family contributions.

Although it had its limitations, the traditional system was a relatively effective way of assisting the members of society who adjusted their norms to insure their daily survival. There is, however, a common tendency to idealise the past in relation to the present when it is discussed. More significantly, traditional arrangements are disintegrating as a result of the common processes of social transformations discussed by several authors and mentioned in previous chapters that are also taking place in Ghanaian society. Factors that contribute to social disintegration include modernising features of state formation, education, new economic opportunities and aspirations, urbanisation, westernisation, globalisation as well as concomitant changes in attitudes and patterns of consumption as well as radical changes in work roles and social stratification. For example, education and Christianity have provided people with values that fall outside of the traditional organisation of society, while the new economic order has put money at the centre of economic survival. The processes of state formation also led to the addition of a new Western style of social security system to the existing one, which was based on the principles of the market and the state. The continued importance of traditional social security is explained by the fact that the formal social security arrangement has been limited to the formal sector of the economy, thereby leaving out the largest proportion of the population who earn their livelihood in the 'informal' sector. People suffering the greatest insecurity, such as the aged, the young, women, children and particularly the handicapped are often excluded from this new form of social protection.

Chapter 5 opened with the primary empirical findings that a range of contextual factors shape lay perceptions of health insurance in Ghana. Key factors among them are the weakening traditional social security mechanisms, past experience with other community micro-finance schemes, financial and social problems that individuals encounter with the public health system and existing beliefs in the efficacy of alternative medicines. Significantly, both implementers and community people conceptualise and share the *value* of community-based health insurance in terms of its social protection ability. The prepayment feature is perceived as immensely helpful in enabling rural households to gain regular access to health care. Community people also credit insurance with psychological benefits, as once they are insured, they do not have to worry about money when they need health care. The scheme's contractual nature (composed of a set of formal rules and regulations) is also regarded as more secure and reliable compared to traditional support mechanisms. Altogether, the opportunity to share risk through solidarity with others is perceived as a noble alternative to the disintegrating traditional system.

There are however, popular concerns and worries about community schemes. The different logic of local savings and credit schemes make people sometimes question the redistributive effect of risk sharing in health insurance in which the return of the investment to an individual is not always guaranteed. Some feel it is 'cheating' when 'nothing is offered' for conditions or situations that in their own estimation ought to be covered or when they do not get anything after a long period of not falling ill. This finding suggests that risk sharing is not always understood or accepted by people in the community. The most far reaching concerns that people have about community schemes are related to poor quality of health care and services, which are manifested in poor staff attitudes towards patients, favouritism, cheating and other negative misconduct and malpractice by health staff.

In discussing the relationship between traditional solidarity and mutual health insurance, one question that comes out strongly is whether it is possible to transfer the solidarity as exhibited for example in funerals into mutual insurance. A careful understanding of the social context and dynamics of the organisation of funerals and how they differ from mutual insurance reveals that the economic appropriation and social accumulation or affirmation of prestige involved in funerals explains why such a transfer is difficult. An important item of economic appropriation is donations offered during funerals. Moreover, the social setting of funerals and donations provide opportunities for collective action to strengthen social identities and prestige through *generalised reciprocity* in the public sphere. On the other hand, the payment of premiums in insurance only provides an opportunity for *balanced reciprocity* where social ties might never be experienced between the individuals involved. This fundamental social difference between funeral support and insurance schemes is an important finding in light of the widespread tendency to cite community support during funerals as an example of the solidarity that could be achieved with health insurance. Another culturally complex difference between funerals and insurance is the emotional aspect of the former. Funerals instantly revive solidarity and mutual assistance, not only among family members, but among the entire community because the emotional sentiment to assist is influenced by the level of precariousness. This is the context within which I interpret Ghanaian people's differential attitude towards situations such as old age and sickness on the one hand and funerals on the other hand.

Chapter 6 took the analysis further and examined the reasons why people join or do not join insurance. Most of what we know about the feasibility of community insurance schemes in sub-Saharan Africa comes from economic studies. One of the dominant themes in those studies is that community members' willingness to participate and pay into an insurance scheme is based on household or aggregate expenditure surveys or from attitude surveys using

contingent valuation analysis. The findings in this study caution against the reliability of findings or predictions derived through such approaches. I produced qualitative evidence, especially in Nkoranza, that shows that the pious and favourable statements people make about their willingness to join community schemes that do not yet exist must be taken with a pinch of salt. They are likely to behave otherwise when the scheme becomes operational. If people know and feel strongly that a certain behaviour or phenomenon is desirable, they are likely to endorse it in the theoretical social research situation but in practice they might reject it. The views of Maame Akosua, a 44-year-old businesswoman from Dodowa, in the Greater Accra region, during one of my field visits regarding the need to look beyond rhetorical flourishes of people on the field was very incisive:

I live and mingle with people in this community so I can confidently attest that I know them very well. When they first hear about something new, they will tell you that it is good, they like it and they will do it. But I can assure you that when the time comes for them to do it, they will behave as if they were not the same people who previously said they would do it. It does not matter how well you try they will ignore you. That is their attitude and you will see it when the insurance starts. Mark my words.

What then is the rationale for some people to join insurance schemes while others do not? Instead of solidarity being the organising principle of policy makers, the key finding of this study is that the underlying motive for people to join insurance schemes is based on enlightened self-interest. This finding questions the common health policy assumption in Ghana that households will join community insurance schemes because of past traditions of solidarity. It is quite ironic that while every Ghanaian accepts the fact that traditional support networks have weakened because of *anibue* (the Akan word which literally means ‘civilisation’), in the context of the discussions of this study, claim is still made on traditions without recourse to the dynamics of change. It is important to underscore the point on the basis of the evidence in this study that the effectiveness of solidarity in the traditional support system was occasioned by social attributes such as the homogeneity, the small size of group and networking within that group. These attributes are lacking or at best are overlooked in the new insurance schemes.

One of the key objectives in the development of community financing schemes is to reduce health inequalities and improve financial access to health care for the poor. I emphasised in Chapter 7 that attempts to focus on the poor began with a problem of conceptualising ‘the poor’. There are at least two levels of poorness: economic and social. In the first sense, the whole of the rural community considers themselves as poor. In their perception, the socio-

economic consequences of the rural economy affect them equally; incomes are seasonal but they survive. In the second sense, the poor comprise a relatively smaller group of people who are consistently in physical want due to disability, gender or social want. These are often referred to as the poorest of the poor, indigents or paupers. Beyond these economic meaning of the poor, 'the poor' in the context of community schemes has other relative social dimensions. Most people consider themselves poor and unable to afford the premiums not because the premiums are unaffordable per se but due to large family size and the timing of the collection. Even though these arguments are sometimes circumstantial. There are also others who are "poor in mind"; these include all those who do not join because of highly self-interested reasons such as faith that they will not fall sick or belief in indigenous medicine.

Overall, the irony of community voluntary schemes is that the people in greatest need, people like paupers and indigents who struggle for everyday survival, whom the schemes seek to assist, are often the ones least likely to benefit from them. This is because of their inability to pay insurance premiums, which would entitle them to use services at a later period. This attests to the lessons of history that the autonomous provision of care always leaves out the poorest substratum. In 19th century Europe, it took the intervention of the state to create a free health care policy, and bring services to the poor in the course of time. From a policy relevance point of view, the issue of insurance for the poor returns to exemption policies for the poor. The implementation of exemption policies for the poor in Ghana has however, been fraught with problems that include unclear guidelines, a varying social definition of the poor, inadequate funding and delays in reimbursement.

Such problems with the poor lead this analysis to the role of the state in insurance schemes. In a developing country such as Ghana, the role of the state in community health insurance is necessary for providing the political, legal and infrastructure back up for its implementation. In the Ghanaian rural context, policy makers and health planners consider the key role of the state as particularly critical in view of the particular social setting which makes health insurance difficult to implement. Chapter Eight therefore analyses people's reception to the state as a bursar or fund owner of insurance schemes. The striking findings showed that people look upon state controlled insurance funds with mixed expectations; most were pessimistic. On one hand people perceive the state as having more resources than any other entity to support insurance schemes. They also thought it offered opportunities for a wider coverage in the entire country. On the other hand, there is greater scepticism about the state, which is related to a lack of trust and faith in public officials and politicians concerning "the way things are done in the public sector". This negative public perception comes out of dissatisfaction and disillusionment with the past performance of state enterprises and public corporations. One of the most

frequently cited examples is the formal social security institution in Ghana, SSNIT. Images of state institutions commonly convey notions of dishonesty, misapplication and embezzlement of funds and a total lack of a culture of accountability. In short, people do not consider the state as credible to hold their funds. In their view even on the shop floor of health care, the collection of illegal fees, bribes and other corrupt activities take place. People therefore attribute their scepticism about state initiatives as due to fears that they might not work. The ill-fated NHIS pilot scheme is a monumental example of those worst fears. In essence, people's attitudes towards public health institutions are ones of protest against lethargic health staff attitude and poor quality of service.

Interestingly, implementers sometimes conceive the problem of people's lack of confidence in the state as a phenomenally Ghanaian apathetic attitude towards state owned institutions or initiatives. But significantly, health implementers deride the work culture in the public sector as generally lacking adequate and effective monitoring and systems for accountability. There is some consensus among them that if schemes are run by the state they could inherit bureaucratic encumbrances, inefficiencies, financial mismanagement and corruption from the state. Implementers also explain away the problems as being the consequences of poor remuneration and logistics, a lack of good social amenities particularly in rural areas and the conservative posture of some key policy makers who ought to effect necessary changes to improve the health service.

Is health insurance socially and culturally feasible?

Theoretical implications of findings

It has not been the purpose of this study to test any grand theory about people's rationale for collective action to solve individual health problems. It is, nevertheless, necessary to situate the findings alongside existing knowledge. How do existing explanations of mutual schemes in sub-Saharan Africa and other places in the developing world help us to explain the findings here?

Analytically, any attempt to understand what impels individuals towards collective action and whether family solidarity could translate or be scaled up into a modern mutual health insurance must of necessity be based on an understanding of the comparative and functional dynamics of both the traditional (past and present) and the emerging health insurance systems.

To recall some of the issues already discussed in the previous chapters, the effectiveness of reciprocity in the traditional Ghanaian social support system was clearly facilitated by the homogenous nature of the kinship based system. Members of exchange systems knew each other and functionally interacted with

one another. The sense of belonging and trust served as a check on one another and prevented abuses. The obligation to share was also supported by existing social sanctions. Thus, those who refused to share did not only stand the risk of not benefiting from similar or alternate provisions themselves, but in the perception of the community risked incurring the displeasure of the social group. People were willing to share in order to avoid tainting their reputation (*dinsee*) or bringing disgrace (*aninguasee*) upon themselves and their families. This is forcefully conveyed by the Akan proverb that the death of a family member is considered as the death of an individual while the disgrace of a member was seen as shame that infested the whole family. (*Wo busua ni wu a na wo nwo bi, na mmom, se fere a na wo nso wo afere bi*). The urge to share and give to other members rather than keeping ones resources for oneself was a highly valued trait, because the ideal set in that reciprocal system was that of mutual helpfulness and co-operation for the common good of the group of kinsfolk.

Clearly, in the Ghanaian traditional system, the conditions in which people lived and worked would have compelled them to seek cooperation and share what they had with others. Indeed, the economic as well as the inheritance system ensured that family assets were shared among members and remained within the group. Family and community thus relied on each other and shared with each other in order to satisfy their social and material needs. As a consequence, such a system provided an effective motivation to seek cooperation with others. It is significant to observe however, that on the whole, the collective arrangements of the traditional Ghanaian social security system have gone in the direction of decreasing efficiency as the involvement of the scope of social networks has become increasingly weaker. As a result, the internal mechanisms or dynamics of the solidarity networks in the traditional system is not as strong as it used to be. In the area of health care this weakened process has had more untoward consequences for the poor and indigent in society in their ability to access health care when the need arises.

I have emphasized the historical processes involved in the emergence of the schemes analysed in this study. Like most similar schemes in sub-Saharan Africa, they represent an attempt by the state to secure additional revenue in health care for its citizens. In other words, it is a subtle way by which the state seeks to mobilize revenue it cannot directly raise by taxation. It cannot raise this money through taxation because of the highly informal nature of occupations in the vastly rural economy. In this context, health insurance is one way of what Scott (writing in another context) refers to as the “state’s attempt to make a society legible... in ways that simplified the classic function of taxation” (Scott 1998: 2).

Secondly, the goal of planners is based on the principle of solidarity. However, unlike the traditional system, which was based on generalised reciprocity, the emerging schemes are based on balanced reciprocity. Members voluntarily contribute at a certain point in time in order to benefit when sick. Sickness is therefore a precondition for benefit. Not all will have their turn, but once sick, help is assured. The main finding in this study however indicates that for the people for whom insurance is planned, the over-bearing motivation to seek cooperation with others is based on enlightened self-interest. This has implications not only for the desire of members to participate, but also for how they behave within the scheme. The idea of a higher self-interested motive therefore implies that people only want to pay premiums or are willing to join the insurance scheme if they feel that it will benefit them rather than cause them to share risk with others. This partly explains the high levels of adverse selection and moral hazard, factors that bear on the feasibility and long term sustainability of such schemes. How do we explain this?

As I pointed out in Chapter One, Polanyi's thoughts on economy and society in *The Great Transformation* (1940) provide the lead that has influenced the debates on interpreting the rationale for collective behaviour. His analysis of reciprocity and redistribution shows that other modes of social exchanges with concurrent motives exist in society apart from market exchange. He thus provides a tool for identifying and explaining traditional social protection or security arrangements and the importance of social networks in mutual health insurance schemes. One of Polanyi's key points regarding the motive for exchange in traditional society is that such traditional systems were altruistic in the sense that they ensured a living out of the resources of the group. Some of Polanyi's allies have emphasised this point. Among these, Scott, writing about risk insurance in a South East Asian village, notes:

It is above all within the village — in the patterns of social control and reciprocity that structure daily conduct — where the subsistence ethic finds social expression... All village families will be guaranteed a minimal subsistence niche insofar as the resources controlled by villagers make this possible (Scott 1976: 40).

He insisted that although the desire for subsistence security grew out of the needs of individuals, it was thus socially experienced as a pattern of moral rights and expectations.

Romantic as the moral explanations of collective behaviour were, they make sense if considered against the background that they represented cultural solutions to inherent problems in the objective social conditions of their occurrence. Indeed Scott was careful to note, "where they worked... they were not so much a product of altruism as of necessity" (Scott 1976: 6). Platteau

(1991) has made reference to Evans-Pritchard (1940) who wrote at about the same time as Polanyi. Of his study of the Nuer, he remarked that, "it is scarcity not sufficiency that makes people generous". Other writers such as Posner (1981) and Fafchamps (1992) have also explained that extreme precariousness in life in pre-industrial societies often aroused solidarity. How then does the moral economy approach accommodate self-interested behaviour? Like his forebear Polanyi, Scott concluded that two major transformations, capitalism and the related development of the modern state under a colonial aegis radically led to processes that served to undermine the pre-existing insurance system. The transformation of land and labour into commodities for sale brought a profound impact on pre-existing social insurance in pre-capitalist societies.

The fundamental assumption of Popkin (1979), gives much credence to the self-interest motives frequently observed in this study. As Popkin points out, the individual is forever calculating about how to improve his well being or at least maintain his own standard of living, rather than that of the village. In his view, therefore, such an assumption is more powerful than the 'romantic' notion of 'communal man' who is an altruistic actor or passive subject willing to respect social norms of conduct and moral principles of reciprocity employed by Scott and his moral economy followers. Rather, he argues, transfer behaviour may result from repeated interactions of self-interested individuals or households who share risk or generosity for the sake of future reciprocity.

It is significant to point out that later contributions to the debate have tended to see the two approaches not as being in opposition but when taken together permit an adequate understanding of the rationale for collective action. For example, Posner's (1980: 4) contribution to the debate, which he wrote from an economic theory perspective, stated that much of the 'moral' behaviour in so called pre-capitalist societies including gift-giving and reciprocal exchange were "adaptations to the pervasive uncertainty and high information costs" that prevail in such a system. Both explanatory approaches are therefore contextually and historically situated.

An attempt to understand the over-bearing presence of self-interest provides insight into the dilemma of solidarity in insurance. The reason for a bigger group to make the scheme more effective through the benefits of economies of scale is also the reason that makes self-interest more prominent than the solidarity principle. How does this happen? An adequate risk pool of health insurance even at the community level must go beyond the family or proximate individuals in order to become a viable 'mutual insurance company'. The propensity therefore is that the widening process in a community or district wide 'mutual insurance company' also has the effect of loosening or weakening the bonds of the web of social connectedness as the group widens and becomes more heterogeneous. The tendency is that people in the heterogeneous group

become freer of social group pressure to conform to group norms, as they would do in traditional morally obligated associations. Accordingly, the social solidarity networks that compel conformity do not in practice exist, or function to obligate members merely to share in written legal contracts for the insurance. In effect achieving a higher level of integration in a wider insurance arrangement as de Swaan has noted involves a higher level of dilemmas. On one hand a larger and more heterogeneous membership potentially enhances the risks sharing capacity and costs across the group. On the other hand, the processes of expansion impede mutual control and diminish common solidarity (De Swaan 1988: 7-8).

I have also argued that the character of the widening insurance group has consequences for the influence of social capital. The potential for social capital in the group diminishes because from the point of view of social connectedness, it does not enhance solidarity since it is the premium people pay more than anything else that connects them. Paying the premium through third parties does not provide the opportunity for group interaction nor accumulation of social rewards such as prestige, recognition and patronage. The social ties in insurance through premiums collected by a third party in this sense are merely synonymous with what Putnam (1995) calls 'tertiary associations'.

The overbearing significance of self-interest as a motivation for collective action has well been expounded by De Swaan in his analysis of the processes of how and why people come together in collectivised arrangements to deal with deficiency and adversity that appeared to affect them separately. Based on a case study of Europe and the United States in the 19th century, he shows how in these societies the collectivisation process extended from the bourgeois to the working class and then to the entire society. Using the theory of the civilising process of Norbert Elias, he explains that this was achieved as a result of the realisation of the growing interdependence of people and the external effects of their actions upon others. He points out that:

The constraints upon affective and impulsive behaviour were not imposed from outside, but adopted.... They became social constraints to self constraint... as part and parcel of one's person" (De Swaan 1988: 248).

About workers' mutual societies in which these processes were highly visibly exemplified, he observes that "the propensity to save epitomises the tendency to subordinate momentary affects to more distant goals, the orientation to more distant future, constant self constraint and the deferral of gratification" (De Swaan 1988: 249-250). He points out that one underlying development essential to the process is the acceptance of risk aversion, which implies the subordina-

tion of momentary affects for the sake of more distant goals. People accept this by their reliance on their capacity for self-constraint to restrain spending.

By way of analogy, the process described by De Swaan is synonymous to that which takes place in the traditional, morally obligated, Ghanaian social security system. People's desire for future cooperation in that system was compelled by social constraints to cooperate in case of future adversity. The obligation to cooperate was achieved through the pressure people exerted on one another, by self-restraint based on the recognition of their interdependence and the external effect of their actions on others. The unwritten code of that system was, in the parlance of a common Ghanaian Akan saying: "Those who offer help to their neighbours in need also receive help when they need it". (*Se wo ye ma obi a, na se asem to wo a, yeye ma wo so.*) Social constraints in insurance schemes do not possess the same force of moral obligation. This situation may be attributed to the fact that it is practically less easy for autonomous public and/or voluntary institutions to exert the specific type of social pressure that members of families or traditional mutual associations used to encourage one another to refrain from spending in case of future adversity.

Applying the same explanatory model here, the process could be described as one of self-constraint to cooperate. In this respect, the emerging voluntary insurance schemes studied here and their counterparts in other countries in sub-Saharan Africa introduce another theoretical paradigm to the collective process in mutual insurance: In the social context of contemporary health insurance schemes, participants are under *self-restraint towards self-constraint*. Typically the immediate and most frequent reason for incapacity for self-constraint to restrain spending is lack of adequate resources. In the midst of too much poverty, people would naturally pay less heed to *unforeseen* risk aversion because under such circumstances, the *necessity* to survive *here and now* becomes more pressing and leaves little room to put aside money for a future event. But a more socially poignant argument based on the evidence adduced in this study is the lack of an effective moral binding force to impel coercion, or what Atim (1999) describes as the 'social movement dynamic'. In the light of the foregoing, the clear challenge to emerging insurance schemes is to identify conditions under which bonding social forces and self-interest can be harnessed to the benefit of schemes.

In summary, Polanyi's theory about the three forms of integration, reciprocity, redistribution and market, provides a tool to situate the analysis in an appropriate historical framework to reveal the dynamics of the past and present in the social security arrangements in Ghanaian society. By emphasising that reciprocity and redistribution are institutionalised with the help of a social organisation disciplined by general principles of behaviour, the theory also enables us to highlight the centrality of culture and society in human concerns.

It also endeavours to pay attention to them when looking at social security or health insurance arrangements. His emphasis on cooperation and reciprocity as a function of custom, law, magic and religion gives us a sense of the tendency to romanticise traditional social security arrangements. His attention to the effects of the emergence of the market on the ability of traditional arrangements to remain functional helps us to explain increasing self-interested behaviour in mutual insurance.

When we consider the range of insecure situations in Ghanaian society, such as funerals and sickness, we see that people cling to the moral economy or engage themselves in rational attitudes according to the context and general situation in which they find themselves. Scott and Popkin and those following them also reinforce the tools that permit an adequate consideration of how people order their social needs in the practical situation. By emphasising self-interest as the sole motive for collective behaviour, de Swaan's theory of collective action provided a tool for interpreting the dynamics of increasing self-interest in mutual insurance with a social face. An important utility of the theory for our analysis is that it helps us to understand the dilemmas of voluntary insurance provisions. The fact remains that autonomous provisions do not necessarily provide a complete answer to the problems with health care access of the entire society, and especially not to the rural poor. The theory also enlightens us about why intra family solidarity does not transform into inter family solidarity in a society like Ghana. What then are the policy implications from the foregoing discussion?

Policy implications of findings

Social context of insurance

Traditional social support mechanisms might have been efficient and were the only means by which Ghanaian society met its social security needs in the past. Indeed for a vast proportion of the population it remains the only source of social security. In implementing any new schemes it is expedient and necessary to take cognisance of the operating principles by which they work in order to learn from them. However, any attempt to apply the principles in the formal context must take into account the dynamics of the context in which they worked. In this respect, it is important to remember that traditional social protection arrangements functioned better as small groups and communities. The good counsel of a former Deputy minister of health, Dr. Adibo, is worthy of recollection here:

Let's start small and expand. By our nature we are good at looking after small things. Our towns are small, buildings are small and we look after small things better than big ones.

Another contextual issue related to the above is that population growth, market penetration and state formation are factors that limit the functioning of traditional social security. This has come about as a result of the opening of new and varied avenues for social and economic mobility and the growth of the market that tends to encourage the overt expression of individualistic propensities and aspirations. This further dissolves cooperative ties and disentangles individuals' interest from those of the social group. The penetration of market values has also had the effect of loosening the web of traditional social ties so people are at liberty to conform to the pressure of the group to which they were previously closely bonded.

Popular participation

In setting up community health insurance schemes, I believe there is no challenge more important than the building up of trust and confidence of people in it. A lot of this depends on the extent to which people believe that the implementers or officials involved are honest and trustworthy. One way to build confidence is through effective community participation.

One of the preconditions to bear in mind in the design is that contexts differ. The attitudes even within one district towards insurance in village A might run opposite to those of community B because of deep seated beliefs about the efficacy of indigenous healing and practices. The diverse and transitional nature of Ghanaian society therefore makes multiple approaches to the provision of health insurance essential for achieving a near-universal or at least wider coverage of the population. In order to increase the potential for the success schemes, and particularly those in the rural informal settings, there is a need to pay heed to the particular social setting with due regard to what is feasible in each specific locality. In light of this, the design ought to take into account not only the social characteristics of the locality but also the expectation and fears of various stakeholders. Stakeholders who need to be brought into the picture from the beginning include traditional authorities, the churches, various trades and professional associations as well as the health staff. It is important to remember that health insurance is not socially neutral. The interests of the private not for profit sector as stakeholders must also be of prime concern, particularly against the background of the important role they play in health care in rural communities. It is also prudent to ensure that the input of ministries of other sectors such as local government, employment and manpower development and youth is brought to bear on any plans for optimum benefits.

Most of all, community structures such as traditional and local authorities and church leaders as well as bodies and associations including teachers and other 'professional' groups ought to be involved. It is important to appreciate and make explicit what the respective expectations and fears of all shades of opinion and representations in the community are and take these into consideration.

Solidarity, risk sharing and self-interest

The dominant self-interest motive in peoples' decisions to join health insurance suggests that the concept of risk sharing and its financial implications need to be well addressed. The discussion indicates that people are not sufficiently aware that there is an element of self interest in participating in insurance for a period of time even if one does not get sick. There is therefore the need to begin the dissemination of information that will make people appreciate, understand and accept the collective meaning of risk sharing. When people think of insurance in terms of its short-term benefits they will stay away because they might consider themselves as low risk or low priority relative to other household demands. Insurance should be better explained by planners in terms of its merits given the needs and circumstances of the present, instead of the pious statements about solidarity and the past.

Practically, what the dominant self interest motive in people's attitude towards insurance schemes means is that it is very essential not to underestimate the expectations of people for whom the scheme is planned in the design and implementation. Other researchers have noted the importance of paying attention to acceptable quality of care to motivate people to participate in community health financing schemes such as availability of prescribed drugs and medical supplies, friendly and expedient staff and the provision of expected laboratory investigations¹. I wish to add here that because the concept of risk sharing is not well-understood or accepted, community participation by local leaders in the decision making of the scheme from its very outset could motivate community interest. Regular consultations and dialogue with them must take place in order to be able to take into account their point of view of the various stages of implementation. This would assure that important policy and operational decisions are based on a compromise acceptable to the community and the operations are transparent to them. In the rural context this is of critical importance inasmuch as it may increase people's preparedness to patronise the schemes, ensure more openness and build trust and confidence.

¹ See in particular Arhin, D.C. 1995: 87.

The poor and insurance

It is common knowledge that in mutual insurance schemes the poor are better off if everyone contributes to the fund. In reality however, the poor stand the greater disadvantage of not benefiting, in view of their inability to pay the premiums. The critical policy issue in insurance remains: how to extend the provision to the poor and needy? The effectiveness of the schemes in protecting the poor must therefore factor into them the effectiveness of exemption mechanisms. In Ghana there is already an exemption policy for certain categories of patients. One way of securing and strengthening the policy is through channelling funds meant to subsidise indigents directly to insurance schemes to strengthen their financial base and their fund management. This begins to address the issue of the implementation of exemption policies in a manner that will benefit the poor. There is need to integrate the existing exemption policies into insurance but before then there is a need to study exemption practices in the past in order to design effective means of factoring them into insurance schemes to provide support for the poor.

The role of the state

The main purpose of insurance in Ghana, is to improve access to otherwise deprived and vulnerable populations. Politicians also know that one way to court public goodwill is by influencing initiatives aimed at improving health infrastructure and access by the people. High profile political clout is therefore usually part of the rules of the game in ongoing efforts to implement community schemes. Two unintended negative consequences are likely to emanate from this. Political propaganda about insurance tends to send wrong signals to people about their own responsibility in insurance with respect to payment of premium. Some people live in the false expectation that health insurance, particularly in the present context, which is targeted at removing an existing ineffective payment system, is perceived as a 'free lunch'. Secondly, politicised messages about health insurance tend to send different signals to people across the political divide. People who do not support an existing government in power that is championing insurance might stay away from it. I emphasise that it is important for governments to be aware of this in order to maintain a reasonable distance about what statements and promises they make about health insurance to the people.

Monitoring systems

The need for comprehensive monitoring systems from the onset cannot be overemphasised. Monitoring should be targeted not only at the technical aspects such as coverage and financial data; social impact should also be tracked. Indeed, carefully designed schemes may even have a greater potential in

improving not only access to health care but also quality of care and ultimately the efficiency of the health service. Issues such as kinds of people for whom access has improved and to what extent the quality of care issues such as staff attitude and clinical interactions have improved in the perception of consumers are all important for the sustainability of any scheme and therefore need to be monitored. Measuring social impact is better done through observations of routine clinical and pharmacy encounters than rigid quantitative procedures.

Concluding remarks

Community health insurance is seen as the answer to the problems of health care exclusion suffered by the vast numbers of poor in rural Ghana. From people's perspective this view is often based on two main assumptions. In the first place, it is believed that the prepayment principle of risk sharing will make it easier for poor families to pool funds together during favourable times when they are more capable and more likely to afford the required premium. Secondly, the principles of solidarity and risk sharing are considered familiar and in tune with time tested traditional support mechanisms of Ghanaians. But will people really participate and give health insurance the same attention and loyalty as they use to do in family support arrangements on the basis of the foregoing assumptions? The exploration of the issue in this study has unearthed a number of challenges about such official optimism.

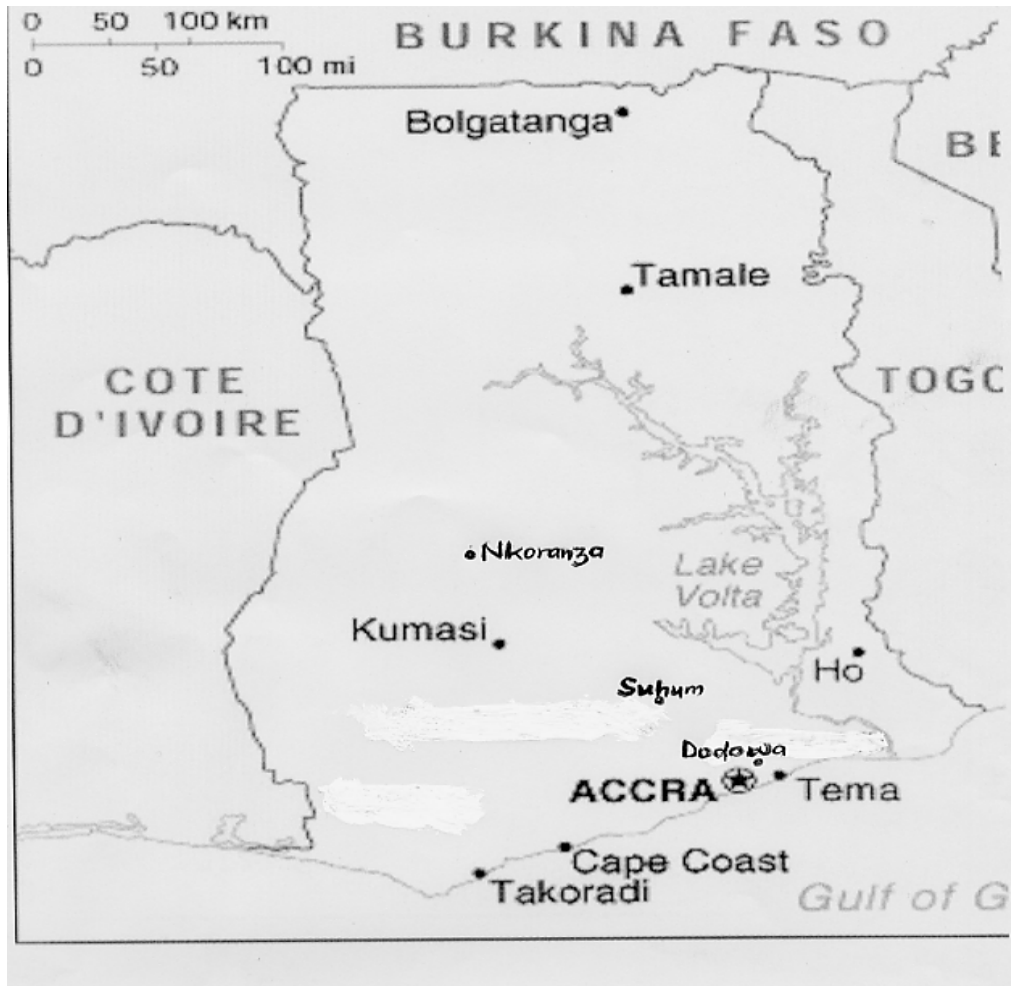
The idea of community insurance schemes appears quite popular and its potential tends to be over-romanticised. In my view, these high expectations and romanticisation is the result of the fact that when policy makers discuss health insurance, they tend to look only at the benefit of the underlying solidarity principle while ignoring its dynamic aspects. Those dynamic aspects that I have focused on in this study reveal that the dilemma of the collective process is highly present in community financing schemes in the Ghanaian rural context, just as they were in 19th century Western European and American attempts to provide health care for all. It should be obvious that irrespective of the cultural antecedents of rural households to solidarity, their links in insurance become weaker as the group becomes more and more heterogeneous. This actually limits the romanticised benefits of solidarity in community insurance schemes, a fact that policy makers are overlooking.

Without suggesting that the contexts are similar, the social dynamic lessons of history in the genesis of social health insurance in Western Europe and the United States again indicate that voluntary solidarity took on other features when it involved people who did not have common social ties such as kinship or convictions. When that happens, solidarity is 'reduced' to solidarity of

interests because as far as the members are concerned, the motive for sharing risks in a group whose members have no common ties in the conventional sense is driven by enlightened self-interest. This view is consistent with those of Dunning et al. (1992). Writing about choices in health care in the Netherlands, they believed that that 'solidarity of interests lies at the bottom of most voluntary insurance schemes'. It explains the dominant self-interest rationale of people in the present Ghanaian context, which in the decade old Nkoranza scheme is typified by the high degree of adverse selection, moral hazard and the generally low subscription rates.

To conclude, issues of contextual importance need to be taken into account in the socio-cultural feasibility of schemes. The findings in this study have shown that no matter how culturally sensitive schemes are perceived, people tend to be ambivalent towards the state as a fund holder because it is not seen to be accountable to society at large. Again insurance still does not provide a remedy for the poor who cannot afford any premiums that are charged. Certainly the magnitude of the problem of poverty actually suggests that only an integrated approach that also improves rural incomes would be the most adequate solution to the problem of social exclusion in health care. But in the light of the foregoing, a response to what is socially and culturally feasibility could be that effective initiatives are likely to be those in which the state plays only a facilitating role. An appropriate response would also have to consider that the greater part of the operational matters should be fostered through support and mediation with preferred organizations and stakeholders from within communities. The message should also emphasise that it is in the self-interest of people to join insurance schemes even if they do not see the immediate benefit because the long-term benefit would accrue to someone they know. In summary, by focussing on micro level practices, this study has given some insight into issues of socio-cultural dynamics and feasibility of community health insurance in Ghana as a contribution to the intellectual search that is needed to deal with the problems of health care financing in sub-Saharan Africa.

Appendix 1: Map of Ghana showing study areas



Appendix 2: Tables of selected survey results

Table A1

What people think is the main idea behind health insurance

Main idea	Nkoranza		Dodowa	
	Subscribers	Non-Subscribers	Subscribers	Non-Subscribers
Provide access to poor	45.4	34.2	18.8	41.0
Provide health security	3.7	4.3	6.4	19.3
Improve health care in the district	5.4	3.1	2.1	6.1
Replace cash and carry	0.4	0.2	1.0	3.7
To make profit	-	0.8	-	-
Can't tell	0.4	0.8	-	1.2
Others	0.6	0.6	-	0.4
Total	55.9	44.1	28.3	71.7

SOCIO-DEMOGRAPHIC BACKGROUND CHARACTERISTICS OF RESPONDENTS IN SURVEY

Table A2

Respondents involved in the study

Type of respondent	Nkoranza		Dodowa	
	Male	Female	Male	Female
Community member	237 (47.7)	231 (49.4%)	12 (2.3%)	36 (6.9%)
Health staff	8 (1.6%)	21 (4.2%)	206 (39.8%)	264 (51.0%)
Total within district	245 (49.3%)	252 (50.7%)	218 (42.1%)	300 (57.9%)
Overall district total	502 (49.2%)		518 (50.8%)	

Table A3

Age of respondents

Age variable	Nkoranza			Dodowa		
	Subscribers	Non-Subscribers	Both	Subscribers	Non-Subscribers	Both
Mean	44.935	40.813	43.084	40.662	37.147	38.151
Median	42	39	40	39.5	35	36
Variance	267.142	223.992	251.495	224.905	178.011	193.529
Std. Dev.	16.344	14.996	15.859	14.997	13.342	13.911
Minimum	18	18	18	18	18	18
Maximum	100	90	100	99	84	99

Table A4

Education

Level of education	Nkoranza		Dodowa	
	Subscribers	Non-Subscribers	Subscribers	Non-Subscribers
No formal education	19.4	18.2	7.1	20.1
Primary	6.6	5.2	2.3	11.2
Middle	21.4	17.0	10.0	25.5
Secondary	3.0	2.4	4.6	7.3
University	-	0.2	0.2	0.8
Polytechnic/Other tertiary	3.6	1.4	3.9	6.2
Other	1.0	0.6	0.4	0.4
Total	55.0	45.0	28.6	71.4

Table A5

Occupation

Type of occupation	Nkoranza		Dodowa	
	Subscribers	Non-Subscribers	Subscribers	Non-Subscribers
Farming/Fishing	35.0	31.4	6.0	18.5
Trading/Services	6.4	5.6	8.3	19.7
Artisans	3.4	2.2	3.5	12.5
Teaching/Clerical	4.6	2.6	3.1	6.9
Nurse/Health staff	3.2	1.0	4.6	4.4
Labourer	0	0.2	0.4	1.4
Unemployed	2.2	1.4	1.7	6.6
Student/Other	0.2	0.6	1.0	1.4
Total	55.0	45.0	28.6	71.4

Table A6
Marital Status

Status	Nkoranza		Dodowa	
	Subscribers	Non-Subscribers	Subscribers	Non-Subscribers
Married	43.6	31.5	19.3	48.7
Single	7.0	9.6	4.4	14.1
Widowed	3.0	2.0	1.7	1.9
Divorced	1.4	1.4	0.4	1.2
Separated	-	0.4	2.5	5.6
Total	55.0	45.0	28.4	71.6

Table A7
Ethnic background

Ethnicity	Nkoranza		Dodowa	
	Subscribers	Non-Subscribers	Subscribers	Non-Subscribers
Akan	45.5	34.7	1.9	4.1
Ewe	0.4	0.2	2.1	7.2
Ga Adangbe	-	-	23.2	58.6
Northerner	9.0	10.0	0.6	1.2
Guans/Buem	0.2	0.2	0.6	0.4
Non Ghanaian	-	-	-	0.2
Total	55.1	44.1	28.4	71.6

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