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

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Summary

This study is about how “the people” for whom social health insurance is planned in rural and informal sectors of Ghana view formal and/or state-based health insurance. The study also intends to determine how likely they are to participate in such a scheme. The central theme is to explore and provide insights into how sustainable community insurance schemes can be implemented in Ghana, taking into account the local traditions of insurance/security. It explores and explains “missing links” between reciprocity and formal health insurance. The purpose is to contribute to the debate by a critical assessment of on-going state plans in pre-payment health care financing in order to offer suggestions for a more culturally sensitive type of health insurance.

In order to relate the outcome of the study to the health insurance policies and plans of the state, health insurance initiatives in three administrative districts in Ghana were studied. The three were all technocratic or provider driven schemes initiated out of the desire to make health care accessible to the rural poor, but also to assure stable revenue for service to the provider. In one district, Nkoranza, a health insurance had been in existence for ten years, in the Dangme West District such an insurance was in the process of being implemented and in the Suhum Kraboa Coaltar District nothing but vague plans had been achieved.

The fieldwork was carried out in two phases. The first was an in-depth qualitative (exploratory) phase; the second a short but wider quantitative (evaluation) survey. The qualitative phase employed a combination of methods involving semi-structured interviews with a sample of community members in each district. There were loosely structured formal and informal in-depth interviews with policy makers and key health officials as well as community informants and focus group discussions with samples of community members. It also included observations of encounters in the health care setting related to insurance, observations of other community solidarity events such as funerals and the study of policy documents and records. During the evaluation phase the most relevant hypotheses from the exploratory phase were integrated into a short questionnaire and applied to a relatively larger sample of a little over 1000 respondents in two of the three districts that had a functional scheme.¹

Altogether, the specific questions explored during the two phases included: What were the principles of the existing traditional forms of support in Ghanaian society, and how do these operate presently in the family? What are the perceptions, values and limitations of a formal voluntary risk sharing health insurance at the different levels of social organisation, both among those who plan and implement insurance and among the community for which it is intended? To what extent can traditional solidarity as it existed in small groups be scaled up in insurance schemes? Can voluntary insurance schemes improve access to the poor in general and vulnerable members of the community? Would people trust the nation state as the bursar of a voluntary health insurance initiative?

¹ 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.
Findings indicate that the opportunity to share risk through solidarity with others is perceived as a noble alternative to the disintegrating traditional system and inadequate state support. However, risk sharing is not easily understood or accepted by people because unlike the logic behind familiar local savings and credit scheme, the return of the investment to individuals in insurance is not always guaranteed. 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 attitude towards patients, favouritism, cheating and other negative misconduct and malpractices by health staff.

Among the key findings, this study challenges the official policy assumption that rural households will participate in risk sharing insurance scheme because of their cultural affinity and past experience with solidarity associations. In reality, instead of solidarity as the organising principle of policy makers, the underlying motive why people join insurance schemes is based on enlightened self-interest. Findings also question common assumptions that tend to associate the potentially positive influence of social capital in rural communities with people's desire or willingness to share risk and thereby enhance health insurance. In practice, the nature and social context of emerging district wide community health insurance schemes do not provide opportunities for the affirmation of social capital. The findings also stress the irony of voluntary prepayment community schemes with regard to the most needy and poor. Paupers and indigents are often the ones least likely to benefit because of their inability to pay insurance premiums to use services at a later period. This attests to the lessons of history that autonomous provisions of care always leave out a substratum of the poorest community members. 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 it as a credible fund holder of insurance in light of perceived negative past experiences with state bureaucracy, wanton official corruption and inadequate administrative and financial monitoring in the public sector.

The lessons of history in the genesis of voluntary mutual insurance in Europe in the 19th century indicate that the propensity for constant self-restrain and the deferral of gratification for the sake of more distant goals were compelled by social constraints towards self-constraint. The obligation to cooperate in case of future adversity 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. In the emerging district wide voluntary insurance schemes studied here and their counterparts in sub-Saharan Africa, however, the social restraint to self-constraint is very weak.

This situation in Ghana 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 use to encourage one another to restrain spending for future adversity. Factors such as structural poverty and the influence of global processes and accompanying “civilisation” (anibue in local parlance) on social relations and local cultural practices even in the rural economy provide some of the explanations for the existing situation.

When policy makers in Ghana plan health insurance they conceptualise it on the principle of solidarity. However, for the individuals whose contribution makes the scheme operational, their primary motivation to participate is the self-interest to cater for themselves and their immediate relatives. Social health insurance as far as the people are concerned is therefore about solidarity of self-interest. The notice that serves is that in order for them to participate, people’s needs as stakeholders must be given the serious
consideration it deserves. This is the lesson for policy makers in Ghana and other sub-Saharan countries desiring to implement health insurance.