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

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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 organise and 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", 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 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 redistributive 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 an 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. He contended that peasants in traditional societies are egoistic 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

1 Polanyi's book is the outcome of an analysis of the work of many anthropologists, economic historians and other historians of thought.
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 insurance schemes, but to procedures that generated and enforced inequality within the village (Popkin 1979: 32-3).
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 affordability. 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 Nobert 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 the 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 of 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 the proposed 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 problem 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, Nyonator & 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 percent 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 percent in 1984 to 43.8 percent 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 percent 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 percent 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 later 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 (Wieseman 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 fieldwork:

- 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.

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

- Semi-structured interviews with 25 members in each research area (15 in each town and 10 in each village to be 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. 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 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

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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.
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 One 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 Two, 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 Three provides relevant background information on the three schemes and localities where the fieldwork was conducted.

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

The fifth chapter 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 Six 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 Seven 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 Eight 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 Nine, 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.