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

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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 nineteen-century to the present. The objective is to offer a brief overview of the antecedents to the present state or 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 Pinteco 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 settlements 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 1870’s 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.

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2 Ofosu-Amaah S. unpublished monograph.
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 1890's, European population shot up to six times what it was in the latter 1880's (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 was established, headed by a physician entitled Principal Medical Officer (PMO), who was designated to administer the department. This remained so until 19233. 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 1890’s, 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. 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 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).

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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.
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 smallpox 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, Ofosu-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 facilities. 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

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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.
the real impetus, before a national health service finally came into being (Eckstein 1958: xvii).

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 1920's
and continued to the independence period in the 1950’s. 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 percent, 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 dispensers were put in charge instead of nurse dispensers. 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. 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 plan 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...

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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 [GGGRMSD (1933/34) P. 44.]
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: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 1940’s 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 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 percent 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 percent 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 percent 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 1800’s, 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 is 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 1950's. 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: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 1960’s, 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 1970’s 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 1980’s 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 1980’s 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, tuberculosis 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 1980’s. 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. 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 free. The

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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.
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 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, 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.