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

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Overview of the three case studies

Introduction

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

This is the most established and frequently cited health insurance scheme in Ghana. It was inaugurated in February 1992 by the Sunyani diocesan health administration of the Catholic Church. Before I describe its origin, I will provide a brief profile of the Nkoranza district.

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

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

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

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

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

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

When we came back, we held further meetings with the staff of the hospital and health centres in the district to discuss the problem of hospital fee until everybody became convinced that a prepayment scheme would be the most sustainable and practical way to deal with the health care payment crises in the community. From then on we started to talk to other ‘big shots’ and groups in town: opinion leaders, church leaders, teachers’ association and education officers. After they had all given their blessing we constituted four teams in threes and fours and started a crusade into the communities to convince the people. We went to the villages early in the mornings with public address systems. Usually we sent messages ahead of our arrival and organised durbars to explain the problem, introduced the idea to them to find out their reactions and answered their questions. We spent about three hours in a village and we could do about three or four villages in a day. After visiting virtually all the villages the reaction was overwhelmingly, ‘YES we like it’, especially among heads of families and households who had responsibility for shouldering medical bills. It was very tiring and at some point I fell ill with malaria but I liked the idea so I persevered because I knew I was going to succeed.

As part of our plans we also formed a strong advisory board team that was basically a facilitators group with responsibility for dealing with practical decisions involving the scheme and the community. It met every week and it included the DS and the chief and all the church leaders. So in short, this is how we basically did it. After the awareness campaign, we appointed fieldworkers in every village and divided Nkoranza township into several sectors because of its bigger size and assigned fieldworkers. Altogether we had over a hundred fieldworkers and instituted a bonus system to them for hard work. The fieldworkers went from door to door in their communities and ensured that households registered their whole families because if you only had the man with the hernia registering

2 One of the common testimonies about the scheme is the solution of hernia cases in the district. The medical doctor in charge of the hospital explained to me that high incidence of hernia in farming communities like Nkoranza district was not unusual. It results from repeated strain or pressure exerted on the abdomen
then that was not good. Our policy was to do the whole family and to keep it simple we said everyone should pay the same fee.

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

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

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

**Design features**

**Membership, benefits and exemptions**

Figure 3.1 provides the organisational chart of the scheme. Membership of the scheme is open to all residents and native non-residents of the Nkoranza district. It is voluntary and subscribers are obliged to pay an annual fixed premium per head, which is determined at through intense farm labour. The bending posture that people commonly adopt in farming activities also contributes to it.
the beginning of every year. Entire family registration is required in order for individuals to receive benefits.

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

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

**Administration and financial matters**

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

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

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

**Figure 3.1: Organisational chart of the Nkoranza community financing scheme**

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BISHOP OF SUNYANI

DHC OFFICE

EXECUTIVE SECRETARY

DIOCESAN PHC CO-ORDINATOR

INSURANCE MANAGEMENT TEAM

INSURANCE ADVISORY BOARD

CONTRACTED FIELD WORKERS
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*Financial administration*

The scheme is entirely funded through premiums paid by subscribers. Its accounts are kept separate from that of the hospital. All premiums collected are sent to the bank the same day or the following day and deposited in a savings account. Only a quarter of the funds are however left in the savings accounts for payment of expenses and administrative charges. The rest is invested in treasury bills and fixed deposits, which yield substantial interest and generate revenue for the scheme. It also receives donations in kind from MEMISA, such as the stamps that are used as receipts and identification for yearly registrations. Occasionally it receives assistance from NGO’s. Payment to the hospital is made when members are treated under the conditions specified by the policy on a monthly basis. Three signatories comprising the manager, a co-ordinator and an advisory board
chairman have to sign all payments to the hospital. For daily routine expenses the staff keeps an accountable impress which at the time of this fieldwork amounted to 200,000 cedis.

*How do the parties involve look upon the scheme?*

Undoubtedly the Nkoranza scheme has brought some relief to its clients and made hospital admissions accessible and affordable to subscribers who otherwise would have found it difficult to access health care. The scheme is a source of pride particularly for implementers for its pioneering work in community health care financing in the informal sector in Ghana. My observation in this research indicated that the community endorses the scheme particularly as a great health security and help to the rural poor. Ordinary community members value it as having provided the means for many in the community to have their “parker”\(^3\) (hernia) removed. At the end of 1999, average annual enrolment stood at 27.11% or 39,288 clients from an estimated (or rather over-estimated) district population of 144,900\(^4\). Five percent of these were admitted and made use of 77 percent of the annual revenue as hospital admission bills. In 2000, the total registration was 43,688 clients. Based on the official 2000 population and housing census report figure of 128,960 residents, the proportion of actual residents in the district comes to 33.88 percent. This however is deceptive since it does not include non-resident citizens of Nkoranza. One of its important solidarity aspects is that high and expensive health risk factors of chronic nature such as diabetes and cardiovascular conditions are all covered by the scheme.

But the scheme has not been without its problems and challenges. Its annual average population coverage at 26.6% to date remains low, while annual registration figures show no tendency towards significant increase in coverage. The scheme's implementers and managers attribute this partly to negative community perceptions such as the community view that the insured receives inferior drugs and that doctors are reluctant to admit them. On the other hand, there is also a perception in the community that hospital staff have negative attitudes towards patients. In a way, the accusations and counter accusations show the expected changes in power relations during health insurance. The view of the

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

\(^4\) Source 1999 Annual report on the Nkoranzaman community financing health insurance scheme, page 4
implementers about the community’s negative perceptions about the scheme could be explained as an indication of the community’s desire for better service not only in terms of technical but also social status in a health insurance regime. On the other hand, it shows the reluctance of providers to remain at the pedestal of their prescribing power.

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

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

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

The government of Ghana’s attempts to implement a health insurance scheme in the country dates back to the mid-eighties with the commissioning of several research projects

5 For February 1998 to December 1999, income over expenditure in Nkoranza registered a deficit of 10,486,944, while that of Yefri was also a deficit of 1,771,379. Similarly, for February 1999 to December 2000, income over expenditure in Nkoranza registered a deficit of 14,941,562 while that of Yefri was also a deficit of 2,946,034. Source: Annual reports of the Nkoronzaman community financing health insurance scheme, 1998 and 1999.
and consultancies to assist the formulation of its policy in that direction⁶. However it was not until 1997 that an attempt by the government to pilot a health insurance scheme was initiated. The Ministry of Health selected four districts in the Eastern Region for a pilot initiative. Speculative reasoning⁷ for selecting the Eastern Region is that as one of the largest regions in the country, it has a lot of health facilities (143 health centres and about 18 hospitals) and health workers to test the initiative. These facilities are categorized in a way that cuts across mission, government and private facilities, which reflect different situations of health care. The population structure also appears to be quite representative of the socio economic background of people from all sources and cultural groupings in the country. It is also believed that the region’s proximity to the national headquarters in Accra might have influenced the decision. The Suhum Kraboa Coaltar district, which was selected as the case study in this research, was one of those that were chosen in the Eastern Region by MOH Ghana to implement the pilot national health insurance scheme. The remaining three districts are New Juabeng (Koforidua), Birim South District (Akim Oda) and Kwahu South (Mpraeso).

**Brief profile of Suhum Kraboa Coaltar district**

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

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

⁷ These were reasons suggested by the Eastern region national coordinator of the scheme during a conversation.
The district has a relatively good road network which boosts trade and commerce in the area. It is connected to the national electricity grid, which ensures constant electricity supply for both domestic and industrial purposes, but the main sources of water supply are boreholes, rivers, ponds, wells and rainwater. It has one government hospital located in Suhum, 10 health centres, three private clinics and one maternity home. Prevalent diseases in the area include malaria, diarrhoea, onchocerciasis, yaws and schistosomiasis.

**Why a pilot project?**

This NHIS pilot project was planned to be a trial scheme to assist MoH–Ghana to formulate a policy on “rural-based community-financed schemes meant to cover all the members of the rural community” in Ghana (Addo et al. 1995: VIII). The purpose was to ensure that suitable systems were developed for the various aspects of the scheme, including premium levels, premium collection systems, provider payment systems and the type of benefit package. In order to implement the project, a national health insurance secretariat was set up in the national capital, Accra, to lead the implementation activities. A regional secretariat was also established under the regional director of health services at the regional capital, Koforidua, to co-ordinate the activities in the region.

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

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

Proposed policy package

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

Public education programme

The most elaborate activity that was carried out as part of the implementation of the scheme was a public education programme in the four pilot districts. As was characteristic of most of the activities in connection with the implementation of the scheme, this (educational) component was also contracted to a private consultant, the Centre for Development and Intercultural Communication (CEDIC)\(^9\) based on a proposal submitted to and accepted by the Ministry of Health. The project began in August 1997.\(^10\) The so-called communication objectives of the pilot project upon which CEDIC embarked are provided in Figure 3.1 below.

CEDIC developed a plan using national service personnel who were trained for three days and sent to three districts\(^11\) to work. Fieldworkers were expected to work closely with existing district structures like District Health Management Teams (DHMT), District Assemblies, National Commission for Civic Education (NCCE) and the Non-Formal Education Division (NFED) of the Ministry of Education. Communication strategies that

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\(^8\) Eastern Health News, Dr. Brookman-Amissah on health insurance, pp 8-10
\(^9\) CEDIC later changed its name to Strategic Communication Limited (StratComm)
\(^10\) The original consultancy period for this activity was supposed to be from July to December 1997, but actual work only began in August. Before the term was over, CEDIC informed the ministry about the need and its intention to extend the period to April 1998.
were used to create public awareness and sensitisation in the districts included posters, handbills, billboards, audiocassettes messages, newsletters and radio programmes.

Fig. 3.2 Communication objectives of the NHIS pilot project implemented by CEDIC

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<tr>
<td>a)</td>
<td>Create general awareness about the health insurance scheme.</td>
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<td>b)</td>
<td>Educate the general public about how health care could be improved through the health insurance scheme by persuading people to join the scheme, motivate the non-formal sector to join the scheme, educate the public about how to join the scheme and pay premiums and educating the public about how to ease the burden of paying premiums.</td>
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<td>c)</td>
<td>Create a sense of national as well as traditional pride in those who join the scheme.</td>
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<td>d)</td>
<td>Explain the scheme to the public.</td>
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<td>e)</td>
<td>Create the sensitivity, support and excitement about the scheme so that policy makers will make available the necessary facilities and logistics for implementing the scheme.</td>
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<td>f)</td>
<td>Help the public to see the links between the scheme and traditional social support systems.</td>
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<td>g)</td>
<td>Change the widespread attitude, belief and expectation that health care is solely the responsibility of the government.</td>
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As fate would have it the public education programme was the furthest the pilot scheme could go. The project stalled in 1998 although this was not officially admitted\(^{12}\). Rather, the state maintained a deceptive public image that the scheme was progressing well and results were being studied, when in fact there was no intention of actual implementation taking place. It took a change in government for the MOH to publicly announce the failure of the pilot scheme. In one such public admission, the official reasons for the failure were attributed to already known challenges of rural informal schemes such as devising appropriate scheme designs, determining premium levels, developing a collection mechanism and setting up a company appropriate to manage the scheme that was suitable for the informal sector.\(^{13}\)

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

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

\(^{13}\) Reasons attributed to Dr. Aaron Offei, Regional Director of Health Services, Eastern region, reported in *The Ghanaian Chronicle on the Web* "We’re no longer each other’s keeper due to harsh economic trends" written by Eric Boateng Sampon, Koforidua, Volume 10, No 13 Monday October 1, 2001.
A number of other reasons could also be assigned as explanations for the failure. One of these is the over-ambitious decision to set up a centralised national insurance scheme based in Accra to manage the operations in various districts in another region. Again most of the predictions upon which the feasibility of the NHIS was made were quid pro quo economic assumptions that ignored the socio economic and cultural realities of the economy and society. For example, it was projected that the economic measures introduced in the early 1990’s such as trade liberalisation, incentives to attract private investment and measures aimed at encouraging domestic production were going to increase job opportunities and incomes, thereby creating an enabling environment for the NHIS (Addo et al. 1995: 102-103). Furthermore, despite the limited technical knowledge on rural health insurance, the planned pilot scheme descended on the communities with very inadequate preparation and typically ended up as another unsuccessful government programme. Indeed the education programme was not effective because it was hastily implemented, handled by unskilled field personnel and in most cases prior notice was not given before community visits.

How do various parties involved look upon insurance?

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

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

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

The Dangme West District Health Insurance Project (hereafter called Dodowa) is the fruitful culmination of the community based insurance vision of a former director of medical services and later deputy minister of health, Dr. Moses Adibo. It is the end result of Dr. Dyna Arhin's PhD research work in health economics. In principle, however, it was implemented as a MoH operational research activity that partially fulfilled the government's desire to test the feasibility of rural health insurance schemes in Ghana. The primary goal was to make modern health care accessible to the rural poor through prepayment community health insurance schemes. In May 1993 the first fieldwork was conducted to examine the demand and financial feasibility; the scheme was finally launched in October 2000.15

Brief profile of Dodowa district

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

Physical features

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

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

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

Health indicators
For purposes of health administration, the district is divided into four sub-districts: Dodowa (Shai), Prampram, Great Ningo (previously called Old Ningo) and Osudoku. Each sub-district is served by one main health centre headed by a medical assistant and in addition has one or two community clinics. They are supported by two private clinics in Prampram and Dawhenya as well as two private maternity homes also in Prampram and Dodowa. There are several licensed chemical sellers shops in the larger communities. In addition, there exist a number of untrained, unlicensed and unregistered providers of biomedical care who practice their trade in the markets and on tabletops in front of their homes. There are also drug peddlers, injectionsists and other varieties of quacks. Public health care delivery system in the district is hampered by poor infrastructure, lack of staff accommodation as well as transport facilities and motorable roads. At the moment, the

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13 I was encouraged and motivated to cover the district extensively by the district director of health services. He had expressed demand for such a study as a means of understanding the experiences, problems and challenges the district was facing in its implementation.
district has no in-patient facility, but expansion work is on going to upgrade the Dodowa health centre to a hospital.

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

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

Who took the initiative?

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

If you go back it does not really come from the district. Somewhere in the eighties Dr. Adibo had this idea that community based health insurance might be a possibility to help solve the acute health care payment problems of the rural poor. So he actually looked for someone who was interested in the issue. And that was Dinah. She got a scholarship to study health economics in Leeds and went further on to do a PhD in the London School for Hygiene and Tropical Medicine focussing on Health Insurance. Dinah’s PhD thesis looked at the willingness to pay for health insurance in rural communities and whether the ideas of health insurance already existed and how people would react to it. And when she was deciding where to work, I was doing my Masters in Liverpool and people suggested she talk to me to find out the possibility of starting her work in Dangme West. In short she ended up
doing the fieldwork in this district in 1993. When she finished her PhD and published one or two papers there was interest in following it up.

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

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

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

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

Prior to the actual implementation, a number of elaborate activities were carried out including the following:¹⁶

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

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

distribution was targeted at entire communities. A nine-page flip chart was designed for the use of trained community volunteers in the communities.

Community health educator training and home visits. These were done jointly with the planning unit of the district assembly. The initiative brought together existing groups of men and women including chiefs, community development officers, opinion leaders and teachers who had received extensive training in community education on various issues. Forty selected volunteers were oriented in various aspects of the scheme, in order for them to carry out house-to-house education and the organisation of radio listenership groups in the community. The listenership group listened to educational programmes on the radio and discussed the issues that arose from them. Each volunteer signed a promise to endeavour to reach every person in communities assigned to him/her after the training.

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

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

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

Membership and benefit package

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

a. All primary outpatient clinical care
b. Basic laboratory tests requested as part of primary outpatient clinical care namely: haemoglobin, sickling, full blood count, stool R/E, urine R/E, widal test and blood grouping
c. Antenatal care
d. Delivery and postnatal care
e. Family planning
f. Child welfare and immunization. This is in theory free currently, but in practice in most clinics mothers pay a “voluntary contribution” to cover costs for items such as cotton wool and transportation for nurses.
g. Referral to a participating hospital provided the patient consulted a primary outpatient clinical care providing facility first and was referred by the prescriber there. Clients who self refer to hospital are not reimbursed. This system of gate keeping is intended to prevent the administrative and financial complications that are likely to be associated with allowing patients to self refer to hospitals outside the district.

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

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

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

The administration of the scheme also incorporates a District Advisory Board (DAB) that is yet to be set up. It is planned to be composed of representatives of traditional, political, religious and administrative leaders in the community and district. Regional health leaders (MoH, NGO) and other persons considered to have expertise as well as the interest in the welfare of the scheme are also planned to be incorporated. The board is expected to meet twice yearly to offer advice in policy related issues such as contribution schedules, exemptions, credit facilities, assuring equity and disciplinary matters.

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

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

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

Poor physical access to the nearest clinic is also a disincentive for some communities to register. Some are also of the view that the services they are receiving still fall short of what was promised them. Most are uncertain about it and have therefore adopted a wait and see attitude to monitor how it would fare before committing their resources. For a scheme in its first year of practical implementation, this situation is not surprising, but raises doubts about the open enthusiasm people express about it. On the other hand, hospital staff involved in the scheme also complain of increasing workload as a result of the additional services insurance has added to their clinical routines.
Brief appraisal of the three schemes in terms of their socio-cultural challenges

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

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

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

Another issue of social significance is the underlying risk sharing solidarity upon which the schemes are based. The initiatives represent an attempt to institutionalise solidarity between the healthy and sick in the communities. It is important to emphasise, however, that although risk sharing may not be a new concept (since it has been part of traditional support arrangements), the mode of organisation and the total context in which

17 Regarding voluntary health insurance pursuing a public or social objective, Criel (2000) makes a distinction between mutualistic or participatory model and "provider driven" or technocratic model. The mutualistic model often involves a "larger social dynamic where solidarity or self-governance is important concerns". There is usually an intermediary structure between the source (households) and the destination (health care providers) of funds. In the provider driven or technocratic model, the health care provider is also the insurer.
it worked varied. For instance, in the traditional system the features of the group in which solidarity and risk sharing mainly took place were homogenous, small and varied with the type of situation i.e. sickness, old age or death. Health insurance, on the other hand, thrives better on a wider level of solidarity in the sense that the more people that are involved on a broader scale the better. Schemes therefore face the important social challenge of how to secure culturally appropriate ways of creating or attaining larger risk pools beyond familial and other small homogenous groups among community members to cover entire districts.

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

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

Concluding remarks
In dealing with the subject of social and cultural feasibility of rural health insurance in Ghana, it is important to keep in mind the official cultural propaganda that traditional systems of support such as kinship and friendship in Ghanaian society that are supportive of people’s willingness to join solidarity insurance systems.
Table 3.1 Comparison of distinct features of three initiatives

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

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

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

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

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