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

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Perceptions and cultural complexities of health insurance and traditional family support

Introduction

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

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

Perceptions about health insurance

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

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

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

i. A mainstream Social Health Insurance Scheme whose membership is compulsory for (a) all contributors to the Social Security and National Insurance Trust (SSNIT) and (b) all registered cocoa farmers;

ii. A family of rural-based community-financed schemes meant to ultimately cover all members of the rural community. Membership would be voluntary. This can be developed on a pilot basis; and to serve as a catalyst for the creation of an enabling environment;

iii. Profit or non-profit private schemes for the urban self-employed. Membership will be voluntary.

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

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

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

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

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

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

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

**Implementers' perceptions**

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

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

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

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

In Dodowa the health implementers I spoke to were also supportive of insurance because of what one female nursing officer aptly described as ‘money famine and people’s inability to pay for health care’. But there were deep-seated concerns about the attitudes people are likely to develop towards insurance. The medical assistant of the Dodowa health centre expressed his views in the following comment when I spoke with him:

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

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

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

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

**Community perceptions**

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

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

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

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

It is good because not all people are financially sound; wɔn nsa nhyia wɔn hu [figuratively meaning: they cannot make ends meet]. Some cannot even pay €2000 and others run away from the hospital when they are admitted. Insurance will take care of them.
Positive perceptions

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

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

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

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

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

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

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

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

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

Those who are insured are better than us because anytime they fall sick and need admission they are assured of health care. *A 45-year-old male physical education instructor, married with seven children and a Moslem.*
Obviously without the benefit of a functional scheme, community people in Suhum and Dodowa did not have much to say by way of positive perceptions. Indeed they had more concerns and questions about how health insurance would operate based on previous experience and perceptions of public initiatives. In general, positive impressions about insurance in terms of its potential to make health care accessible when needed were not lost on people in those two districts. The general view was that because of poverty and high hospital fees, people have difficulty paying so “it is better to pay something small now to cover you in future”. Again there was particular stress on the fact that the weakening traditional family support system makes community health insurance a favourable idea to encourage. At rural Dawa in the Dangme West district, one female FGD participant emphasised this point:

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

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

**Negative perceptions**

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

About ten years ago, something came to this town called BAMAX\(^1\) to which people contributed all their life savings because of a promise of fifty percent interest per annum. It received a high patronage but after a while it became bankrupt and people lost everything. Some even developed heart and mental problems. Yet the man behind it is still walking round without any punishment. Such an incidents make me and I suppose others who have gone through similar experience, quite apprehensive about anything that involves the payment of money with a promise of future benefits a difficult thing to accept.

She was not alone. Just across the street from where I spoke to Madame Adepam was a sixty-three-year-old retailer of alcoholic and non-alcoholic drinks. When I called on him for a similar conversation he stated that he would not have anything to do with insurance because of the loss of cash he suffered through BAMAX. Memories of such situations were common in virtually any community, as I discovered when I moved into the Dangme West district. There were genuine fears that ‘things’ like insurance “might turn out to be a trick by which some individuals use to rob poor people” of their hard earned money. This

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\(^{1}\) Around 1993 a number of non-bank financial institutions started operating savings and loan schemes without authorization from the central bank. These included R5, Pyram and Bamax. These phoney institutions succeeded in luring unsuspecting members of the public to deposit millions of cedis with them. In return, depositors were promised interest rates above the prevailing market rate offered by commercial banks. Huge interest rates of 30-40% attracted many people to the point that some investors withdrew their money from the recognised commercial banks and deposited them with these institutions. Before long they became bankrupt and many lost their entire lifetime savings.
was the consensus at a female focus group discussion in rural Dawa. A twenty-five-year-old participant’s comment captured this sentiment:

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

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

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

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

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

\[1\] SSNIT is the acronym for the Social Security and National Insurance Trust. It is the official social security system in Ghana, but is limited to only the formal sector employees. Among others benefits, it provides cash payments to contributors after retirement or to their dependents in the event of death, but the manner in
remember our road, we heard that they came and took a picture of the Owirem road (a nearby village) and presented it that they have constructed the entire road to Dokrochiwa. These are the reasons why people might be reluctant to embrace the insurance scheme.

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

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

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

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

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

which the contributions and payments are conducted have attracted a lot of criticism, especially in recent
The only concern about it is trustworthiness on the part of those who will be in charge. Would they faithfully give equal treatment to clients when they report ill? Sometimes those in charge of such schemes live fat on the money and ride in big cars. The money is there but instead of using it for good purpose they would buy big cars and ride in them.

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

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

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

Some people claim that when you pay and you are admitted they don’t look after you well. They give you inferior medication and they discharge you early. But this is not true. There is no doctor who will discharge a patient if the patient has not fully recovered. There is also no doctor who will keep away a good drug that will make his patient well. It does not happen because that doctor will lose the confidence of his or her patients so it is never true. In every community, sebe (excuse me to say), where the literacy rate is low, or where too much superstition thrives, rumours and misconceptions are very high. What we need is education to change those attitudes.

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

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

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

Implementers’ perspective

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

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

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

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

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

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

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

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

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

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

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

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

In the past if someone was sick in the family, the family pooled resources together to look after the person. The present Nkoranza scheme is a larger family in the sense that the whole district is pooling resources together. We are all pooling resources
together so that if one person is in difficulty we help to pay the debt, if another person gets ill, we pool resources to assist him and so on and so on. This is the sense in which the insurance has become a bigger family, pooling resource together to assist in time of sickness.

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

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

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

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

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

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

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

Despite the common view in all communities that social participation in mutual health insurance is wider and for that matter “better” in terms of risk pooling, one point that was also frequently brought to my attention was the unique situation of funerals. Some even compared the solidarity logic behind insurance to ‘the way Ghanaians organise their funerals’. In view of the interest and concern the issue attracts, I enquired with the Omanhene of Nkoranza, Nana Okatakyie Agyeman Kodom IV, when I had the opportunity to interview him. I asked whether the popular support that funerals receive was a recent phenomenon or “culturally Ghanaian” from the past. Indeed, such an enquiry was necessary and relevant, since the case of funerals is sometimes cited by health policy officials as an example of how Ghanaian society share risks beyond the family. One news report cites a former minister of health as saying that, “Ghanaians are familiar with the principles of pooling community resources for funerals, for example, and that could be applied to a health insurance scheme” (Adu-Asare 2001). In responding to my enquiry the Omanhene of Nkoranza provided a brief historical view of traditional sickness and funeral support:
In the past, when a member of the family fell ill, it was the responsibility of the family to either send the person for treatment or bring someone to treat the person. The cost involved was basically borne by just the family. Assistance outside the family may be sought only when it became necessary. Family support during funerals followed a similar pattern. When there was death in the family, everything in connection with it was the responsibility of the family but there was a little but significant variation with sickness support. The difference was that, although the family was responsible for the cost involved, during the funeral the family would invite the entire community through the palace or chief. The community would offer donations to the bereaved family. The fundamental difference of community participation between sickness and funerals is therefore an old phenomenon although there are wide variations in modern times. Traditional support for sick relatives has diminished while support for funerals has been taken to uncontrollable limits.

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

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

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

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

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

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

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

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

Dan: How?

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

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

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

Dan: What does that mean?

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

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

I need to point out that any economic considerations in support of funerals cannot be divorced from their social dimensions. During a debriefing session, one of my field assistants summarised the nature of the public manifestation of the social aspects of funerals:
People use the donations to show off their magnanimity to the gathering. When this happens, they receive public acknowledgement for what and how much they have given. But when someone is sick there is no gathering for people to show off.

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

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

**Concluding remarks**

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

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

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

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

The increase in the quality and scale of the funeral rites has stimulated the carpentry (coffin and seats), brewing, distilling and paint trades, and has promoted such service industries as those of the mortician (a Ghanaian version of the undertaker), the suppliers of canopies and seats, and music and dance or cultural groups.
In the final analysis, the heavy expenditure would usually be recouped through donations from well wishers and friends as a demonstration of sympathy and affection on the basis of generalised reciprocity. Funerals therefore serve an economic purpose.

The economic appropriation of the heavy economic investment involved in funerals also serves an important social purpose. The scale and quality of the funeral is first and foremost an exercise in self-glorification that enhances the prestige of the bereaved family in the public sphere. At the same time, well wishers and friends who demonstrate their sympathy and affection through high donations receive acknowledgement and gain prestige and reputation in the public sphere through announcements on loud speakers and through intangible rewards such as where they are seated, the drinks they are served and even the glasses in which they are served. Such social accumulation opportunities that keep funerals on the economic pedestal of traditional social support do not exist in the mutual insurance setting.

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

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

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

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