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

Arhinful, D.

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Introduction

What leads a community to participate in a voluntary health insurance scheme? The previous chapter highlighted various factors that influence lay perceptions about community health insurance. Perceptions ultimately play a determining role in people’s readiness to participate. In this chapter I focus on the driving force behind the concrete decisions people make to join or not to join health insurance; decisions that to a far extent determine how successful or unsuccessful a scheme could become. In discussing the factors that drive people’s decisions, my analysis looks beyond economic determinants in which the prime focus is on latent demand. I look beyond people’s assertions or contingent declarations of willingness to join and ability to pay when there is no scheme, to interpret how they actually behave when there is a scheme. I therefore examine the relationships that explain people’s underlying motivations to join or not join community
financing or insurance schemes. In particular, I stress the dynamic effects of social and cultural factors and the part they play on the collective or solidarity motive underlying schemes in the context of present realities. These issues are often not given adequate attention in the existing literature on social health insurance, which is dominated by economics and health economics literature.

The chapter begins with a brief explanation of the concepts of solidarity and self interest as they apply to social health insurance and how and why policy makers in Ghana conceptualise solidarity as an organising principle of health insurance in the country. This introduction provides a useful background to the analysis of why people join or do not join health insurance, based on assertions when there is no scheme followed by the situation where a scheme exists. Data from various locations is used. The material on which these are based is derived from the first exploratory fieldwork in Suhum and Dodowa districts. I continue by showing what happens in practice and how people actually behave towards risk sharing solidarity arrangements when there is a functional scheme. This is based mainly on qualitative data from Nkoranza but also includes a little supporting data from a quantitative survey from Nkoranza and Dodowa districts. I use case studies to illustrate the fact that instead of the underlying solidarity principle that planners conceptualise, self-interest is rather the strong motive of people for joining voluntary insurance. In the discussion that follows I use the theoretical notions of social capital to explain the dilemma between solidarity and self interest in health insurance. I pursue my argument from the previous chapter and explain further that the strong self-interest serves to give credence to the absence or low opportunities for social capital in the voluntary context of health insurance.

**Solidarity**

Community health financing and/or social insurance schemes aim to protect or improve health through the concept of risk sharing by pooling resources together. Through the payment of contributions, those who are very healthy and rarely become ill help those who are less healthy and/or frequently fall ill. This is the concept of solidarity. Dunning et al. (1992: 56) have described it as "an awareness of unity and a willingness to bear its consequences". Solidarity therefore implies that people accept that the size of the return
may not match the resources (financial or others) they have put ex ante in the system (Criel 1998:60)

Characteristically, health insurance is linked to the principles of group solidarity because it is a group activity. In the history of health insurance in Europe, which began in the 19th century, group solidarity played a prominent role and many schemes originated from it. Solidarity in health insurance may come in the form of risk solidarity or income solidarity. Income solidarity is when the financially able pay for the less financially or incapable or when the rich pay more and the poor pay less for equal care. Risk solidarity is when the healthy pay for the ill or the good risks pay for the bad risks. It is therefore right to say that evolving schemes in Africa are characterised by risk solidarity and based on the payment of a fixed premium for unequal care.

From policy perspectives, solidarity-based risk sharing mechanisms potentially facilitate the harnessing of private funds for health care, thereby reducing the financial barriers faced by poor rural individuals, particularly the vulnerable groups, to obtain care when they need it (Arhin 1995:2-3). On the part of consumers, payment of contributions in times of good health guarantees that they receive health care when ill. In order for a scheme to be viable, it requires a reasonably large membership of a cross section of the targeted community or group. Solidarity is therefore of critical importance to the design of a social health insurance scheme, in as much as it can impact how people in a society accept and join this type of mutual support.

**Self-interest**

Enlightened self-interest, to paraphrase Tocqueville (1840) who popularised the concept as self-interest, rightly understood simply implies that it is in the best interest of the individual to attend to the interests of the group at large because the needs of the group serve those of the individual. In other words, by securing the interest of the group, the individual protects his or her own interest. According to Sheridan (1996), that works in two ways. First, people are less likely to get caught up in individual pursuits when they

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1 The data for Nkoranza was collected at both the exploratory and follow-up evaluation stages, while that of Dodowa was collected at the second evaluation study.

2 Dunning et al (1992) also distinguish humanitarian solidarity, which is based on the intrinsic value of human life. Those who need protection because of disease or handicap must be offered it. It does not leave these other people to their fate but gives them the chance to participate in society.
contribute to society at large. Secondly, when people see (my emphasis) that their own interests are better achieved by meeting the interest of the community, they are more likely to promote and perpetuate the practice. Self-interest, like solidarity, thus requires people to sacrifice a little of their own resources to the benefit of the whole which in turn benefits them. The principle is a natural way of achieving individual and societal goals. However, in contrast to solidarity where the motive is what someone does for the group, the motive of self-interest is what someone gets from the group. It has to do more with the greater benefit that individuals get from being part of a solidarity group as a result of the little they themselves have also contributed to the group. In this sense, at the core of giving or being part of solidarity is personal motive.

In voluntary insurance, people come together to insure themselves against certain risks on the basis of reciprocity because of an underlying rationale have self-interest. Voluntary health insurance thus builds on self-interest (Criel 1999:60). The desire to avert risk is motivated by self-interest. Dunning et al. (1992) depict this phenomenon at the bottom of most voluntary insurance schemes as solidarity of interest. The voluntary character however, often constitutes a major limitation in the sense that those who perceive the potential return to be too low may decide to opt out or not engage in it at all. From the individual point of view, such a decision might be rational but in societal terms it is counter productive since it limits the financial base of the scheme. In view of this, some authors have argued that in order to be effective and successful, mutual aid schemes must of necessity be rooted in both solidarity (based on broader cultural and emotional grounds) and in self-interest (see Elchardus 1994).

**Solidarity in Ghana's health insurance plans**

In the attempts to implement health insurance in Ghana, one of the basic assumptions that planners have emphasised is that a solidarity-based scheme is a suitable option because the Ghanaian social and cultural system has a built in social insurance or solidarity mechanism conventionally centred around the extended family. The family, it is conceived, has collective responsibility for the welfare of its members. A national health insurance scheme based “on the principles of solidarity, equity and non-profitability” is therefore officially perceived as “very much like our [Ghanaian] traditional support system in which

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3 Tocqueville (1840) suggested the term “self interest rightly understood” or enlightened self interest as an
resources of a family, clan, business, etc. are pooled together for the support of the group." Health planners conceive the philosophy behind such an idea to be "a rich blend of tradition and modern".

This conception of Ghana's health insurance plans, raises a number of pertinent questions. The primary one, which will be dealt with in this chapter, is whether the motive of the people or community for joining an insurance scheme in the social context nowadays is based on the collective principle of solidarity or on an individualistic purpose. Granted that solidarity was/is effective in the traditional support system would people then accept or embrace the concept of risk sharing in a new social insurance dispensation because of historical or cultural affinity? And if so under what circumstances will they accept it in the present socio economic and cultural context? The discussion highlights the importance of social dynamics in the decision-making to join or not to join an insurance scheme.

Why people do or do not join insurance: a case of self-interest?

*Why people join*

In order to answer the above question I first turn to examine how people are likely to participate in a health insurance scheme based on their declarations of what they imagine and expect from it when the scheme does not yet exist. This is a credible and useful way of examining the subject in view of the fact that evidence to justify health insurance in Africa by several authors of predominantly health economics orientation is usually derived from household or aggregate expenditure surveys using contingent valuations (Yoder 1989). Similar studies have been reported from Ghana. Arhin (1995), who studied households in the Dangme West district using contingent valuation to ascertain their willingness to participate in solidarity based schemes, concluded that 98 percent were willing to join such a scheme. Asenso-Okyere et al. (1997), in a study of three districts in the Eastern region using a similar approach, also reported very high willingness rates of 98.7%. For my present purpose I focus on Suhum and Dodowa districts at the first stage
of my fieldwork when the community’s experience with health insurance was merely at the level of sensitised stages.

As an introductory remark, it is worth recalling that at the onset of my fieldwork in those two districts, one of the striking observations I made was the strong desire for and high expectations that people generally had for health insurance. In one sense, this was surprising considering the fact that at the time people knew little about the details of health insurance. Indeed, as the previous chapter indicated, people’s concerns and worries about health insurance at the time far outweighed their positive perceptions. So why were they so enthusiastic about it and indicated they would join?

One reason is that due to the problems of poor and seasonal income coupled with the burden of unforeseen health expenditures, many in the community have difficulty coping with fee for service at the point of use. People are therefore enthusiastic about any new or alternate plan that promises to mitigate their financial difficulties in access to health care. And so, despite concerns about what monster health insurance would look like, people yearned for it in the hope that its introduction would change their existing precarious health care financing situation. In one of my interactions with a community leader, a 73-year-old divisional chief and retired educationist of Dodowa, explained this community desire to me as follows:

Health insurance is a new thing but we look up to it. I think it will help because in the villages the people don’t have money, they are poor and many times it is finance or poverty that kills them. I say so because somebody may be sick with simple malaria and because he has no money to attend the hospital he would die. So I think they just have to be educated for them to grasp it. When each person pays a little money, it will help everybody in the community.

The dominant health care problem of rural folks as the above statement stresses is financial accessibility. Access to health care is difficult because money is a problem. Due to poor earnings, welfare needs and contingencies become problematic for most rural dwellers. It was therefore not surprisingly that the dominant reasons for joining were presented in

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"Arhin’s study was also carried out in Dangme West district, while Assenso-Okyereh et al.’s was also undertaken in the Eastern region."
terms of economic or financial advantage. A participant at a male FGD session in Dodowa explained it this way:

It is not always that man has money in his pocket. But sickness does not wait for one to have money in one’s pocket, so if I join it will help me. Another teacher who used to work at the same place where I work had a surgical operation sometime ago. His condition did not improve so his family wanted to send him to the hospital again. But they needed 100,000 cedis for that. Because they could not raise the money he died. If there were something like the health association at the time, the insurance would have taken care of him. Sickness has no timetable. It comes anytime. Insurance is something good so I will join.

Indeed the uncertainty about illness vividly conveys to many informants the need for a safety valve. Many therefore value joining a health insurance scheme for the health security it provides. A female FGD participant at Dokrochiwa said:

I will join due to the present hardships in life and my future health security. No one knows tomorrow. (Obi nim zkyena asem). You may think you do not fall ill but tomorrow may be different. Even if you do not fall ill your wife or child may fall ill.

Financial accessibility and a desire for health security constitute the most commonly cited reasons. In addition, some informants also conceive the motivation to join insurance in terms of social and/or cultural appeals. One of these was related to the failing traditional support system. Some perceived insurance as a way of reviving family support to achieve reciprocity. At an FGD discussion at Dawa involving female participants one of them observed:

Since the old family [support] system is no longer effective, this group when established will bring us together. We will be our brothers’ keepers so that we will come together again as a family.

In the case above, the speaker’s reference to health insurance as “this group” reflects the conception of how the scheme was marketed to the community as a “health welfare group”.

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At rural Dokrochiwa, a participant in a female FGD session indicated to me that having an insurance scheme in their village would help enhance the image of their community.

I have to help because it is good to have something like that here so that we can also claim credit for having such a new thing in this town.

Insurance was therefore sometimes conceptualised as an object for community improvement. One observation was that, in situations in which the reasons for joining insurance schemes were related to social and cultural factors, the sources were mainly traced to the relatively remote parts of the districts. This might partially be explained by the fact that the average rural dweller has perceived a formal health insurance as a means by which their locality could become part of the "modern society". Another explanation could be that it is in the more remote rural areas where family and other mutual traditional solidarity based support mechanisms were stronger and so that is where the desire for similar mechanisms is also more likely to be felt. One would expect that where people know each other better in the "rural-rural" setting compared to the "rural-urban", it enhances the sense of belonging and for that matter, heightens the desire for a similar institution in the remotely rural. People also mentioned health security and financial access frequently in conversations. When listening to people explain their desire for health insurance, it was tempting not to disagree with what health economists hurriedly concluded based on latent demand. In virtually every case, the underlying stated motive for joining often pointed to the speakers themselves.

Not everyone was enthusiastic about insurance. Why? I discuss the reasons in the next section.

*Why people are not willing to join*

In the imaginary situation where the views of informants must be considered as contemplations because the insurance scheme did not yet exist, one striking observation I made was that there was a tendency for most informants to portray themselves as potential subscribers and conceive of "others" as the non-subscribers. In other words, individuals in principle almost always try to cast their own relationship to health insurance in a favourable light while associating negative attitudes towards insurance with others. In a
way this attitude was not surprising. I understood it as logically consistent with their lay expectations and cognitions about insurance, particularly in relation to the existing fee for service system. But in a way that attitude also had the effect of biasing their self-appraisal of insurance.

Accordingly, in order to deal with the preconceived bias when discussing attitudes towards health insurance, I had to frame my inquiry in order to have them talk about why others would not want to join insurance. In that context, people freely opened up and showed a depth of knowledge that made it seem like they had already experienced health insurance. During a FGD with females in Dodowa, for example, all seven participants present indicated that they would join. When I asked them why others might not join one quickly gave a brief catalogue of reasons.

Money problems. Lack of understanding; if education is inadequate and *anibue* [literally meaning civilisation but apparent reference to social change or modernisation]; some may also feel they have been deceived for so long in the past.

I will elaborate further on these factors alongside the analysis. As expected, financial incapability or non-affordability was cited as the most likely reason why some may not join. The problem was variously described as “money problem” or “poverty” or “hardships”. The common meaning attributed to non-affordability was lack of cash but when people talk about it in this context, they relate it not only to poor incomes but also to large family or household size. A female informant at Dokrochiwa added:

Well many people in this community are poor. Some will like it but they do not have a good job that generates enough income to enable them to join such a scheme. People here usually have six children or more. This is one reason why it may be difficult to do it here.

How much people will get for their money also tends to occupy a central position in their contemplation to join or not to join. They wonder about what will happen to the money

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8 According to the theory of cognitive dissonance by Festinger, human beings have a tendency to seek consistency among their cognitions (Festinger 1962).
they will pay and whether it will really be used to provide the health care they need or whether the quality of care will meet their expectations. This comes out very distinctly in a few cases where informants did declare that they would not join. For example at a male FGD in Suhum, the only participant out of eight who dissented stated his concern about what could become of the investment in insurance:

As of now, we do not know the benefit package and until I have seen the full benefits and the policy and become convinced about it, I cannot make up my mind. Quite recently some people came here and started campaigning for people to grow sunflowers. Many people responded but when the sunflowers were harvested there was no buyer and some even burnt their harvest. So for something that you do not know the head and tail of it how do you do it? As for me, I have to wait and see to make my decision (*patuo gye se m'ani*).

Behind the uncertainty of some people there was the fear that if something went wrong, they would lose their investment. Incidentally, there was always some negative reference event in their recent past that informed that notion. Indeed, based on previous experience with community savings and credit schemes (*susu*), there was also some suspicion and fears that those into whose custody the finances of the scheme would be entrusted could embezzle the funds. There was conjecture that those who harbour such fears might not commit their resources to the scheme. A male participant in a FGD is Dawas shared these thoughts:

Some officials came to this village and informed the community that they were setting up a savings and credit scheme. People responded, but after a few months they bolted away with the money and we never saw them again. Some people might think that this is just another means to cheat them. It will be difficult to convince such people to join anything that involve money. Because of the previous experience they take such things very personal and will see it as another ploy to cheat them. For this reason they will not join until it takes off. In fact because of such suspicions many will adopt a 'wait and see' attitude before they make their decision. So it all depends on how it progresses.

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9 *Patuo* is an owl, which is known for its big eyes. The speaker therefore implies proverbially that unless he observes with big eyes he could not make up his mind.
For some people, the type and manner of education that they would receive is an important determinant of how they make up their mind about insurance. In this respect, many informants envisioned poor education as an important potential determinant for non-subscribing behaviour. During a male FGD at Suhum, for example, not only did the group emphasise the importance of education but also they went further to illustrate what was perceived as a good example of poor education. In an apparent reference to the NHIS public education campaign in the district a year before, one participant lamented the experience as follows:

The way people are educated about new things go a long way to influence acceptance. At the time [apparent reference to NHIS education campaign period] I came across a batch of leaflets in the GPRTU\(^{10}\) kiosk when I went to the lorry station to purchase a ticket. I had no previous knowledge about the scheme but the leaflets were just lying in the kiosk for those who wanted to pick them. What was the guarantee that people will read them and understand? How could anyone educate people on a new programme that way in a community such as ours?

In fairness to the programme implementers and the educators, this way of spreading the message and sensitising people about the scheme was just one of a number of approaches that was used to reach out to the community. That is however, not to absolve a bad dissemination approach involving handbills, which was not only potentially limited in scope but also inappropriate for a community that had a very low literacy rate. In the same group discussion, some suggested that inadequate education also had the potential to become ammunition in the hands of those who would not understand the concept and that they would spread misconceptions about it.

Another set of reasons for unwillingness was related to systemic problems people encounter with the health care services. The complaints related to attitudes of nurses, long waiting times at health facilities, the collection of dubious fees and poor diagnostic materials. An opinion leader in Dodowa said:

\(^{10}\) GPRTU is the acronym for Ghana Private Road Transport Union, and is umbrella trade union of most private commercial vehicle operators. In cities, towns and villages where they exist, they operate a small office, which sometimes is a kiosk in lorry stations.
Insurance is good but it will only work if the health staff treat people humanely when they go there. Nurses are human beings like all others but it's about time they accepted the challenges of their profession. You see, people are such that even a touch can sometimes reassure them; but some nurses reprimand patients just because they go to clinic late. The other time someone complained to me that he was referred without a referral note. Such attitudes create confidence crises and leads to mistrust in the service. And if upon all that people have to buy drugs and do laboratory tests outside then we have a problem to deal with. I don't foresee an enthusiastic response if these don't change in our health service.

Further reasons why, in the view of respondents, many in the community might keep away from a health insurance scheme were similar to those for joining: mainly out of self-interest. Predominant among them was the perceived 'risk averse' attitudes towards insurance. This attitude is a feeling commonly held by some that they were healthy and therefore underestimating future risks of illness. As a female informant at Dodowa briefly explained, “Some people have the feeling that they do not fall sick so they may not benefit from joining such a group”.

Related to the risk averse notion is another view: that the relatively well to do who might consider themselves capable of paying when they need health care might also not join the scheme. Sometimes these people are portrayed as being selfish. A participant, in a female FGD in Dawa said:

Some people are rich and they will not need anything from the association. They will therefore not want to join. Anytime they are sick, they can just get up and go to the hospital because they have the means. They even have private doctors because they are financially sound. But someone who is not financially sound will join.

State or governmental support for community insurance is potentially useful since it offers opportunities for logistical and technical support and the political goodwill necessary to operate it. However, there are also genuine concerns that if politicians are allowed to play centre stage in rural insurance initiatives, wrong signals may be sent to those in the opposition party, who may reject it. A male FGD participant in Dawa said:
Others may not join because of their political alliance. During the recent census, someone told me that he was not going to register because he did not like the government in power. So, some may feel that it is for the government and therefore may not join.

Furthermore, the value and individual preference for traditional or indigenous health care, which is quite pervasive in the rural setting, is also recognised as a factor that could keep some people away. One male FGD participant in Dodowa explained:

In the rural areas people think most sicknesses are the result of a curse, so when they fall sick, they prefer to visit native healers and spiritualists. Even when you do not believe in such supernatural causes, those around you will tell you to see a healer because the condition is a not a clinical but spiritual ailment. People who believe in supernatural causes simply ignore the clinic and it might probably take a generation to appreciate a health insurance scheme.

It is obvious from the foregoing that people’s drive towards social health insurance is highly influenced by social and cultural constructions and motivated by enlightened self interest. That assertion immediately leads to one question. Can we merely depend on people’s declarations to join or not to join insurance to determine their concrete attitudes towards it or their commitment to the solidarity motive behind it? Certainly, any critical assessment cannot be made based merely on statements people make about why they will join or not. We need to go beyond that in order to get to the bottom of how people genuinely feel about the redistribution effect of solidarity.

How do people feel about the redistribution effect of solidarity?

In order to dig deeper, I posed a question to ascertain from informants their feelings about the redistribution arrangement or effect of solidarity in health insurance. The concept relates to how potential subscribers or real subscribers feel in a typical situation in health insurance where their fellow insured people, who are more prone to illness, benefit more from the scheme as a result of frequent illness. Interestingly, the immediate reactions were
typically coloured to sound socially appealing and convey good impressions about the speakers. But in general, the reasons for accepting the consequences of investment without return in solidarity were related to uncertainty about what could happen to themselves, concern about depressed traditional support mechanism and most predominantly moral and religious reasons. Frequent use was not considered a problem if sickness was perceived genuine because the essence of insurance, as one informant described it is to help one another (eye mmoa a yede reboa yen ho). Again, being sick was also not considered a privilege but rather a disadvantage. A participant at a male FGD in Suhum explained it this way:

We understand the situation and it does not bother us. Even in car insurance it is only third parties that get the benefit. Calamity does not affect one individual. (enye baako foɔ na asem to no). If it does not benefit me, it may benefit my brother. If your contribution is used to look after someone else, others contribution will also be used to look after you at another time in the future. After all, we make donations when someone dies in the community so it is not a problem.

There was nevertheless some feeling that a wholesale benefit package ought to be prevented. For example one view was that the package ought not to cover HIV/AIDS because of the long-term implications it may have on the financial sustainability of the scheme. In response to a question by another participant whether the scheme should cover cases such as HIV/AIDS, a male FGD participant in Suhum said:

The policy should not cover cases such as AIDS because there is no cure for it and so if the money is used on them it will run out. We cannot afford to use the money on that because it will be a waste.

Considering the implications of HIV/AIDS for public health, this remark that people ought to be responsible for their own problems clearly stretches the issue of self-interest to elastic limits. However, the common statements people made about their preparedness to participate in any utilitarian co-operation or solidarity arrangement were predominantly gratuitous expressions emphasising religious reasons. Most reactions were based on the
biblical edict that “those who have money should look after the poor”. A 70-year-old Presbyterian pharmacist from Suhum explained it this way:

No one knows tomorrow. You may be strong today but you need your heart to carry you into the next day. The Bible says it is not within the power of man to map and plan his course. [He then referred me to Proverbs 20:24].

Other reactions to the redistribution effect of solidarity follow a similar trend. The following are further remarks made by participants from various FGD sessions in the two districts.

The Bible says we should help our neighbours so if I pay that little money and I do not fall ill, God will bless me for helping to cure someone. *Female FGD participant, Dokrochiwa.*

I will be grateful to God for not getting ill. *Female FGD participant, Dokrochiwa.*

It would not bother us at all. What we need is good health so if my contribution is used to look after someone why should I get worried? I should rather be happy because it brightens my chances for heaven. *Male FGD participant, Suhum.*

Not all people fall ill frequently so if I am not sick and I contribute to help those who fall ill then in a way I am performing my Christian duty. The objective for joining is not to fall ill but to help those in need of health care who may not have the means of their own. *Male FGD participant, Suhum*

Ascriptions to divine benefits as justification of the unequal redistribution effect of solidarity were so pervasive in peoples’ reasoning that even those who considered it “cheating and painful”, were still prepared to accept it as the will of God. What does that tell us?

In a Christian dominated and widely religion conscious country like Ghana, such remarks about sacrifices for the benefit of divine rewards are not unexpected. Such

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11“-A man’s steps are directed by the Lord. How then can anyone understand his own way?” NIv
statements certainly have their social appeal but what is important is that even when
explaining their solidarity links through religious passions, they were laced with
expressions of self-interest; they expect personal reward in heaven. In any case, the
common thread in pious religious sentiments about solidarity in the Ghanaian context is
that they indicate one potential avenue - churches and religious groups -- for fostering
solidarity about insurance schemes in communities.

The important question to ask here is: Should we take these pious statements about
people's attitude towards solidarity seriously or take them with a pinch of salt? In essence,
talk is cheap or ambitious depending on where you stand; people have the tendency to
sound socially desirable in a social research situation when the actual event has not
happened. Indeed, if we have to attach any meaning to people's preparedness to accept
risk sharing in insurance, a reliable barometer is the widespread evidence of neglect of
poor families by relatives in the present day Ghanaian society of today, which is easily
excused by economic hardship. Even if people decide to join, how reliable are their
assurances that they will overlook the unequal redistribution of benefits in insurance and
keep their subscription in good standing? Once again the view of my 70- year old
Presbyterian informant in Suhum was moralistic but nevertheless served as good food for
thought:

Our character has changed. In the past when we farmed we did not demarcate
boundaries but we were honest because we shared and exchanged what we had. We
needed and loved one another. Now things have changed. Now there is no longer
love for one another. We don't fear God, although we worship and make a lot of
noise about God. But the people in the past were not like that. Unless we change our
morality, unless we change our moral weakness, it will be difficult. Nevertheless, we
still have to start from somewhere and we can start gradually with the few people who
are prepared to start.

Asking people how they feel about the behaviour of others in a hypothetical situation
provides some indications about what attitudes to expect in the practical situation.
Imaginary statements or contemplations however, still do not give an accurate picture,

12 The most current (2000) population census of Ghana indicates that Christians constitute approximately
70%. Others comprise 15.9% Islam, 8.5% traditional, 0.7 Others and 6.1 No religion.
particularly when they involve informants' responses that are a reflection on themselves. In order to get to the heart of the matter as far as attitudes towards risk sharing or solidarity is concerned, we need to look elsewhere for a practical illustration. In this study, Nkoranza provided an ideal setting for this.

People's motive behind insurance: concrete lessons from Nkoranza district.

In order to assess people's concrete motives for participating in a health insurance scheme, the case of Nkoranza and, to some extent, Dodowa, present a useful means of validation. For the owners or organisers of the Nkoranza scheme, solidarity is important because it is the organising principle for bringing the community together in a non-profit risk-sharing scheme to make health care accessible to them. Residents and non-resident natives of the district are therefore required to invest in a common pool so that those who fall ill will be catered for on the basis of pre-determined conditions and benefits. In one of my conversations with the manager of the Nkoranza scheme, he elaborately explained the mechanism by which solidarity works in the scheme as follows:

We, the initiators of the scheme, want to foster unity through the insurance scheme because if you look at it, one person pays a small amount, falls sick and then a "huge" amount is paid for his bill. If it were not for the sake of solidarity that person would not have had the benefit of getting other people's money to pay his bill. I think that is the solidarity aspect of it in the sense that the monies that are collected from the various health zones [within the district] are not kept independent of the other zones. They are brought together into a common pool so that anybody who falls sick in any of the zones can benefit from that common pool. What we wanted people to understand is that it is not a matter of paying the money and falling sick to benefit but paying it for a risk tomorrow. That is, you can pay for many years without falling sick but there may be a day that you will also fall sick. Meanwhile either a family member or a friend or a church member would have benefited from the scheme. Without the scheme one of these people would have had come to you to solicit funds to pay his hospital bill. But once you are all contributors it, tends to foster unity and solidarity.
It takes care of the unfortunate ones who fall sick. This is our message but *I do not think that is what actually people see in it* [my emphasis].

Two main strands are embedded in the long statement above. First, solidarity in the scheme is about connecting diverse individuals across the district to share health care through a system of reciprocity. The second strand is that this has been a difficult task because the expected understanding, cooperation and commitment to the risk sharing principle on the part of the community has been lacking. Indeed, the benefit of nearly ten years of operation and several evaluations on reasons why people join in Nkoranza indicate that they join because for their own sake and that of their closest relatives. Interviews with various stakeholders in this study, (i.e. implementers, health staff, community opinion leaders, subscribers and non-subscribers) attest to this view. One case will suffice here.

**Steve**

Steve is 54 years old, a native of the district and had been part of the accounting staff of the Nkoranza hospital for 11 years when we met. He had married twice. He had a total of 13 children, 10 of whom were with his present wife. In our conversation below, I sought his view about aspects of the scheme by asking him what, in his opinion, drives people to join the scheme. Excerpts:

Steve: Some people have foresight about future health security so they are prepared to make the present sacrifice. Instead of waiting to be sick before they look for assistance from family members, they do their best to join the scheme. Some of such people are of the notion that even if they do not fall ill, they are secure or others may benefit or they would receive blessings from God. Some have such thoughts for their fellows.

Dan: So is concern for others the motive that people have for joining the scheme?

Steve: That is the not the primary objective why they join, but rather they join so that when they fall ill, it does not become a burden for them or their close family members. These days unless it is a matter of death, the family would not help you so it is important for individuals to secure their health to avoid access problems when they are suddenly taken ill. So people join to avert the burden of health insecurity.
The literal interpretation of Steve’s statement indicates that to date, the primary motivation of many in the community is not so much the underlying principle of solidarity but their enlightened self-interest. In Nkoranza, some even considered it cheating if after paying there are no direct benefits for remaining healthy and as a result discontinued their subscription after a few years of subscribing. In some cases, they made a claim that they found it difficult to raise the needed money to remain subscribers of the scheme. Others also maintained they have no need to join since they do not fall sick. Actual evidence of such situations were not difficult to find in the community. One such example was Opanyin Nkrumah, a fifty-six-year-old elder and a non-subscriber at Kranka:

I was a member but when you pay and you do not fall ill for even three or five years you do not benefit. Since the benefit covers only selected cases, it is possible that some of us will never benefit because by our constitution we are very strong and we do not fall ill. This is cheating to me. So they should probably build in a mechanism where those of us who do not fall sick can be given say a 30% discount for the subsequent year.

It is obvious from the above statement made by Opanyin Nkrumah (and many others he represents) that enlightened self-interest is at the core of people’s desires and actions to join and leave the scheme. The informant practically demonstrates this individualistic value by pulling out after a few years without personal benefit. It is implied in his words and deeds that the motive for joining was that by sacrificing a small part of his resources he or probably a close relative would benefit. He pulled out when that objective became too remote. It appears that people are more likely to continue with the scheme when they are able to relate their membership to situations or benefits involving them or someone they know. A participant who was certainly a subscriber, conveyed this attitude to me during a male FGD discussion at Nkoranza.

Some say it is cheating but it is not. It is not cheating because you pay the money for those who get sick. So the motive for paying is to help those who will fall ill. Next time when I also fall ill, someone’s contribution will help me. Someone’s father has been there while another’s mother has been there so it is the same thing. When I was last admitted there, my bill amounted to 398,800 cedis. Where would I have obtained
this money to pay my bill? So left to me, if it were not because of poverty I would have said paying even 50,000 cedis as a premium would have been reasonable. And even if any of those here or I do not fall ill we have to pay our premiums to take care of the poor. The insurance scheme is a very good thing.

Let me explain the situation of the above informant whom I shall call Kwame in relation to the argument he raised. I understood Kwame’s point from his personal and poor health circumstances. He was sixty-one and a father of six when I had the above discussion with him; his main source of income was farming. He did not have to fend for his six children who were all adults living on their own, but he was not receiving any subsistence support from them either. Significantly, his general health had not been good during the three years prior to our meeting and he had therefore been a regular client at the Nkoranza hospital. Indeed his poor health was manifested by a persistent cough throughout the duration of the discussion, something he did not waste time to draw my attention. In one of his contributions, he clearly pointed out “I wish I could exchange my poor health with those who consider frequent use of the scheme by people like us as cheating”. Obviously therefore this was someone whose belief in risk sharing is inspired to a great extent by his personal circumstances and a strong underlying enlightened self interest.

**Adverse selection**

In the community, people’s self-interest motives in the solidarity arrangement are generally conveyed, in their attitudes towards the payment of premiums and where they are insured in their health seeking behaviour. I recall an encounter I witnessed in Nkoranza during one of my observational visits to the insurance office. It involved someone who was going on admission to the hospital. I will call him John.

**John’s case of adverse selection**

On July 26th, 1999, while sitting and conversing with the coordinators at the insurance office, John, who was due for admission for a hernia operation, walked into the office. He was personally insured and had already managed to collect some medicines from the pharmacy with his insurance identity card when he walked into the insurance office to collect his family records card to take to the ward. The family card contains updated information about the premium payment status of all the household or family members of
every insured individual. The scheme’s implementers employ that as one way of containing adverse selection. When someone is asked to go on admission, getting the family card from the insurance office was always the last process to confirm that the scheme would cover the cost of the admission. That was why John had to walk there to finish his pre-admission ritual.

When the insurance office coordinator checked the data on John’s family card he noticed that the premiums of four members of John’s household had not been paid. The coordinator then quoted the relevant portions of the insurance policy and informed John that the conditions for benefit enjoined him to pay for the four unpaid cases before his hospital charges would be covered. John however maintained that he did not have the money to pay for the four members and besides he did not see the logic for such a condition since he had paid faithfully in previous years without any benefit. The coordinator therefore asked John to follow him to the cashier’s office to sort out the problem.

I followed them to the cashier’s office where the coordinator simply repeated to John that he had to pay up for the four defaulters on his family card. But John was persistent in his previous arguments. The coordinator then informed the cashier that under the circumstances, John was not eligible to be covered by the insurance office so the cashier ought to deal privately with him. In short, John was declared ineligible to be covered by the scheme in view of his refusal to pay for the arrears of four members of his household as required. Someone at the cashier’s office then quickly took back the drugs that John had already taken from the dispensary and demanded the deposit for his admission. There and then, John dipped his hands into his pocket and brought out 28,000 cedis to pay for the four family members that was demanded. Money, which he originally claimed he did not have suddenly popped out from his pocket and the matter ended there. He got back his drugs and the process for his admission and operation was finalised.

On reflection, John was not prepared to pay for four members of his household because as he indicated, he had paid in previous years without any benefit. From an analytical perspective, we could explain John’s behaviour and that of many others whose attitudes obviates the principle of solidarity underlying the scheme to enlightened self interest. The lesson here is that although theoretically self-interest is not conceived as
being fundamental to planners compared to the choice for unity in solidarity, the former is an instrumental influence on the latter.

_Yaw's experience about adverse selection_

Another common way by which self-interest manifests itself in the scheme is the way the community selects themselves to join as new subscribers or to renew their premiums during registration periods. This takes the form of what is technically referred to as adverse selection. I will illustrate this with a narrative from one of my informants whom I refer to here as Yaw. Yaw was a 34-year-old schoolteacher, married with two children and a founding fieldworker of the insurance scheme at Kranka. He was quite popular in the village as a community focal person and became an effective field assistant. During one of the several conversations sessions I had with him, he gave me a vivid illustration of the depth of the problem of adverse selection that underscores the strong self-interest motive of people as against the solidarity concept of the planners of the scheme does:

At the early stages of the scheme, people were very selective and registered only those members in their family who were high risk. Unfortunately our system was not tight enough to detect them. Last year, a certain man came to inform me that he has not been well for some time but when he sought treatment at Holy Family hospital, he was asked to deposit 300,000 cedis against his admission. When he sought assistance from his family, no one was prepared to help him so he came to inform me that he wanted to register for the insurance. To be honest with you, if he had not told me that story, I would have registered him but he started by betraying himself. Well, I told him that in that case he had to register 20 people before I would admit him. I arrived at that decision because I realised that even if he registered 20 people as I requested, it would have still amounted to 140,000 cedis\(^{13}\) which was still less than what he was asked to pay at Holy Family. In short I refused to register him so he reported me to the Chief of the town. I answered the Chief's call and explained everything to him, which he understood. I did not register him because I felt it was not fair for those of us who have been with the scheme for seven years. And I did that because of an experience I had with a teacher colleague. He had a hernia so when the scheme started he registered and managed to get an operation to remove it. After that he did

\(^{13}\) The premium per person at the time was 7,000 per person for new subscribers and 6,000 for continuing subscribers.
not renew his registration again during the second year. However, he brought his sick mother from the North to register her and got treatment for her. He never renewed his premium again. Two years ago he came to me with another tribesman to register him but by then I had detected his tricks so I told him bluntly that I was not going to do it.

You may ask why I am so protective of the scheme. Since the scheme started my family and I have faithfully been paying the yearly premium but none of us has ever utilised it. It is not in the interest of the scheme to have only people who know they are sick and therefore only join to get treatment and walk away. If I allow such people to do that then the scheme would collapse and my family and I would have toiled in vain. So as a member, it is in my interest to make sure that the scheme is sustainable.

This long account shows how self-interest is in people's motive to join an insurance scheme. Interestingly, Yaw ended his narrative by emphasising his own self-interest in the scheme as a reason for ensuring that others do not abuse it. Those who cheat do so in their self-interest; those who protect or secure also do so in their self-interest. When planners estimate people's sense of solidarity and loyalty to health insurance on the basis of historical and cultural assumptions, they are oblivious to these intricacies or take them for granted. The individuals enter into the solidarity arrangement because of their self-interest.

Further evidence from Nkoranza underscores the prominence of people's self interest or non-solidarity reasons. These can be gleaned from statements of non-subscribers during conversations I had with them. Although affordability, and for that matter economic reasons are issues, the common strand in most of the reasons why people do not join were socially and culturally determined. They were sometimes bothered about how individuals conceptualised the risk to their health or that of someone close to them, may be at risk. Sometimes their discontent is found in the service offered by the insurance scheme. Two cases from Nkoranza district from separate FGDs will suffice here. A female FGD participant in Nkoranza relates:

The reason why I did not join is because I have observed that whether you would be admitted or not depends on the judgement of the doctor although you are the one that is ill. We know that the doctors are professionals but sometimes they also make errors because they are human, and not God. There is a case when a friend of mine went to
the hospital very sick but the doctor felt he was not sick enough to be admitted. So he was given out patient (OPD) treatment. When he came home he did not recover and so he had to seek treatment elsewhere after three days. When you think about these things it makes it difficult for you to join.

A male FGD participant from Kranka:

Recently my grandmother became ill and was very sick. When she was admitted at the hospital, she was discharged the next day even though she was not well. In my view, they discharged her early because they did not want the insurance to spend too much on her. Besides, when my wife delivered, they asked me to pay because they said normal delivery was not covered; but that is the main reason why I registered my wife. So when you are insured and you are admitted, they do not want to spend so much on you because when they do that the scheme would overspend its resources and that is why I am not a member. I feel that they are just using the insurance to make money for the hospital.

In Nkoranza, subscription records of the scheme statistically exemplify the community’s self-interest. Since it was established nearly a decade ago, low patronage has been a chronic problem. Available records indicate that it has managed to achieve a 40 percent mark just once. For all the remaining years that it has been in operation, the entire district coverage has been below 30 percent and most of the subscribers have been from the Nkoranza township and its immediate surroundings. Indeed, people’s egocentric motives for joining are so strong that they sometimes want compensation if they contribute but do not fall ill for some years. A public health coordinator of the Regional Catholic Diocesan Health Services who is the overseer of the scheme explained it as follows:

After nearly ten years of operation, people have still not grasped or accepted the concept of insurance that once you pay you do not necessarily have to benefit personally. Previous evaluations indicate that people want compensation if they contribute but do not fall ill for some years. There is also a high level of adverse selection and this further attests to peoples self interest motive for joining.
Moral hazard

The depth of people’s strong self-interest does not end with adverse selection. The phenomena whereby subscribers abuse an insurance scheme through excessive use and moral hazard also looms large in the Nkoranza scheme, as insured patients play all sorts of tricks to over-utilize the benefit of the scheme. The medical doctor in charge at the time illustrated the situation for me:

Among the funny things that happen in the ward is that insured patients will always try to give complaints to stay longer on the ward because they are ‘not paying’. They always pretend so that at the end of the day they stay longer than the patients who are not insured. For non-insured patients, after 2-3 days when they think that they are OK, as soon as they see the doctor enter the ward they will be sitting on the bed and smiling. Displaying it on the bed, telling you that they want to go home. Sometimes they even come out to say it that “today I feel fine and I want to go home”. The insured on the other hand will tell you that they feel worse and pretend that if you do not administer oxygen to them in the next second they would die within one minute.

That sounds comic, but moral hazard in the scheme, as another medical doctor of the hospital narrated to me, even goes beyond patient behaviour in the ward in a more striking manner. Once they are insured, they do not just plead with doctors at consulting rooms to be admitted in order to benefit, they sometimes start the lobbying for admission at a doctor’s home. Medical doctor:

People come to knock on my door at home at 6 AM and say that they want to bring a sick person to the clinic. They come to see you because they cannot pay at the OPD so they want assistance to have the patient admitted to the ward. If you assure them of “assistance” in that line of direction, they will then go home and bring the patient. As a doctor the reasonable and ethical thing to do when such situations arise is to ask them to bring the patient to the consulting room for examination. A few times however, when they come with the sick person and you examine him/her, you realise that the patient is still fit to go back home. But when you don’t admit them then they get pissed off. Occasionally they also keep the patient at home deliberately to worsen the condition to the state that all you can do is to keep the patient on the ward. Yet that kind of “trick” can have serious health consequences for them.
The outcome of interviews I had with several informants suggests that to the community, the ability to go to hospital and be treated for “free”, when they have paid their premium is very attractive. Subscribers are willing to register with the insurance scheme because they first and foremost know that if they register and they fall sick they will be taken care of and that is their prime motive for registering with the scheme. To the people who make solidarity in social insurance functional through their patronage, the essential risk sharing purpose is ‘first unto myself before all others’. And they conceptualise insurance in terms of the tangible direct benefits that they obtain from being members.

Knowledge about main idea behind insurance: Survey finding
Peoples’ conception of health insurance comes out clearly in the results of a follow up evaluation survey in Nkoranza and Dodowa districts, where I employed a short household survey to further explore a few issues in a relatively wider spectrum of the community. I asked household respondents to indicate what in their view they “think is the main idea behind health insurance”. The findings affirmed that to the average rural person, it is the immediate personal benefits of insurance that preoccupies their thoughts more than the solidarity principle. The reasons were mainly related to accessibility (78.6% in Nkoranza and 59.8% in Dodowa), health security (8.0% in Nkoranza and 25.7% in Dodowa), improvement of health care in the district (8.5% in Nkoranza and 8.2% in Dodowa) and replacement of the ‘cash and carry’ system (0.4% in Nkoranza and 4.8% in Dodowa). Responses relating to solidarity (conceptualised as help one another) and/or unity constituted a mere fraction of the total responses.

In summary, when the discussion is situated in the total socio-economic and socio-cultural context, the picture that we get is that the motivation to join the insurance scheme is not the solidarity concept as portrayed by the implementers; but their personal benefit. Is solidarity then only a mental construct for organising a social health insurance? What is its use then relative to the overbearing self-interest motive that people bring into insurance? The Catholic diocesan public health coordinator of Sunyani who oversees the

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14 It is important to recall here that by the period of that second study, the Dodowa scheme was in its first year of implementation.
15 Altogether, the response rate was about 98% of the total cases.
16 See Table A1 in the Appendix 2.
Nkoranza scheme explained it in the following way during one of my final interview sessions:

The way solidarity works in this era in community health insurance is like the ripple when a stone is thrown into a pool of water. It is stronger where the stone falls but as it gets further it gets weaker. So for instance I have more solidarity to my wife and children than my extended family. It gets weaker across the village and might not even work when stretched across the district. But there is the need to promote solidarity to help people to get health because if you leave it that way then things like insurance would never work.

That this is the reality about solidarity support mechanisms is a fact that ought not to be surprising in the present social context. There is rarely a society in this age where social differentiation has not led to obvious tendencies towards decreased interdependence. The effect of decreased interdependence is that people now put more emphasis on the self-fulfilment of themselves and their immediate relatives. One reason for this is the weakening effectiveness of traditional social support institutions, such as the family. Unlike in the past, people no longer depend solely on one another and the goodwill of the society; they rely more on achieved positions for their daily economic survival. Therefore, as far as the organisation of solidarity support is concerned, the important unit is no longer the extended family or the community, but the individual and his or her immediate relatives or nuclear family. What is surprising is that planners do not seem to realise that this is the way people behave, that despite the latent demand and seeming enthusiasm and anticipation, people pragmatically fancy their self-interest as the primary reason for joining a social insurance scheme more than the risk sharing motive that the solidarity principle seeks to foster among the group. Where then does this take the analysis? How can we explain the progression of self-interest as a primary motivating reason for participation in social health insurance?

Discussion: The interplay between solidarity and self-interest

The framework for understanding the relationship between solidarity and self-interest in social health insurance rests on the concept of social capital -- the idea that sociability has positive consequences for the individual and the group. The origins of the concept lie in
19th century classical sociology of Durkheim, but it owes its currency chiefly to the more contemporary works of Pierre Bourdieu followed by that of Glen Loury and James Coleman (Portes 1988). In the analysis of social capital, these authors and several others following them, grounded their theory in relationships between actors or between an individual actor and a group. Bourdieu in particular focuses on the benefits that accrue to individuals by virtue of participating in groups and on the deliberate construction of sociability for the purpose of creating this resource. He stresses, "the profits which accrue from membership in a group are the basis of the solidarity which makes them possible" (Bourdieu 1985: 249).

In the sense in which I intend to apply the concept here however, I lean more on the persuasive twist introduced by Robert Putnam in his classic piece Bowling Alone, America's declining social capital. In it Putman goes beyond individual actors to conceptualise social capital as a feature of the “connectivity” of communities and nations. Through an analogy with notions of physical and human capital, he explains that social capital means “features of social organisations, such as networks, norms and trust, that facilitate action and cooperation for mutual benefit” (Putnam 1995:67). Putnam notes that when conceptualised this way, life is easier in a community blessed with a substantial stock of social capital for a number of reason. He lists the benefits of social capital as follows:

In the first place, networks of civic engagement foster sturdy norms of generalized reciprocity and encourage the emergence of social trust. Such networks facilitate coordination and communication, amplify reputations, and thus allow dilemmas of collective action to be resolved. When economic and political negotiation is embedded in dense networks of social interaction, incentives for opportunism are reduced. At the same time, networks of civic engagement embody past success at collaboration, which can serve as a cultural template for future collaboration. Finally, dense networks of interaction probably broaden the participants’ sense of self, developing the "I" into the "we," or (in the language of rational-choice theorists) enhancing the participants' "taste" for collective benefits (Putnam 1995:67).

In practice, stocks of social capital account for the level of associational involvement and participatory behaviour in a community and constitute the basis of their solidarity.
Based on this sociological argument about the importance of social capital to group cohesion and mutual support, several writers with backgrounds predominantly in economics and health economics have emphasised that community prepayment schemes benefit from a community’s willingness to cooperate with each other. The common strand in the argument is that a greater degree of social capital in a community would enhance people’s preference or desire to prepay. Hsiao (2001:5), for example, explains that social cohesion and mutual concern or solidarity shapes people’s preference for prepayment, and hypothesises that “the greater the social capital, the more people are willing to prepare”. Preker et al. (2001:7) also refer to the benefit of social capital, citing that “it is not what you know but whom you know” that counts. They, however, also point out the downside of social capital in situations when communities and networks become isolated or parochial and operate for example as gangs and cartels that work against the collective interest. Wiesmann et al. (2000:14) have also noted that if solidarity is strong, people will not worry so much if the benefits of the premiums will accrue to themselves or other community members. Actual studies also support the claim. Based on empirical findings, Criel (1999:51) reported that in Bwamanda, Zaire, members of the insurance scheme expressed the opinion that if their premiums would not benefit themselves, they would do so for the entire community.

In Ghana, an implicit assumption of the social feasibility of health insurance has also been made in relation to the benefits of social capital in a number of statements and background papers. Arhin concluded in the precursor study to the Dangme West District health insurance scheme that the reason why 98 percent of household heads were willing to pay a premium to obtain health insurance cover for their members was that they conceptualised it as a solidarity association to deal with health risk and that they had previous experience of it (Arhin 1995:104-105).

It is without doubt that a high degree of solidarity or social capital in a community is likely to influence the quality of cooperation or support for one another. I wish to point out here that, it is precisely what social capital is not able to achieve, contrary to the popular conventional arguments about it, that explains the overbearing self-interest motivation of people’s willingness to join an insurance scheme. What do I mean? A careful appraisal will show that the conditions that facilitate the building or realisation of social capital scarcely exist in the social setting of the emerging top down voluntary
insurance schemes like those in this study. In other words: They do not provide the opportunities for social capital to accumulate.

In order for social capital to accumulate, social conditions from the point of view of social connectedness must exist. These include social trust through obligations based on emotional ties and generalised reciprocity accompanied by social benefits such as respect, prestige and reputation. In the emerging mutual insurance setting, a contract that asserts payment of a fixed voluntary premium is the only social tie that binds members together. For most of these people there is no sense of emotional attachment to other members of the group, apart from the few that they probably know and live with. The absence of opportunities for the accumulation of social capital thus diminishes the binding feeling of solidarity and for that matter the binding force of reciprocity underlying such schemes.

The analogy of the ripple of the pool of water when a stone is thrown into it is a useful illustration for the strong self-interest motive with which people participate in the schemes. The vast pool of water depicts the wide community. The ripple effect indicates that people have a stronger sense of solidarity to the small unit closer to them. Their relationship with the wider community is negotiated by rational self-interest.

People’s motive for participating in an insurance scheme in the present social context is therefore based first and foremost on what they believe would best advance their own self-interested goal of averting a risk or securing a gain for themselves. They are therefore more likely to insure themselves against common risks on the basis of clearly perceived self-interest. The motive is served by the voluntary nature of schemes, which gives people a discretionary choice. In practice, a lot of solidarity in voluntary health insurance is enlightened self-interest in the sense that people come together to insure themselves against certain risks on the basis of reciprocity because of clearly perceived self-interest. This would explain why Dunning et al. (1992) characterise the relationship as solidarity of interest.