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

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Health insurance and “the poor”

Introduction

From a policy relevance perspective, the primary goal of social health insurance in Africa is to bring together private funds in order to reduce the financial barrier faced by poor individuals, particularly vulnerable groups, to obtain care when they need it (Arhin 1995:2). However, as indicated in the previous chapter, the benefits of insurance are contingent upon the payment of premiums. This raises concerns about the implications for the poor and vulnerable that might not have the means to pay the required premium in order to benefit. Does social health insurance then make health care accessible to the poor? In other words, how effective is health insurance in bridging the access gap faced by the poor and vulnerable to health care? This chapter examines this question using qualitative data from the three districts in this study but mainly from Nkoranza, where it was most practical to explore the issues in-depth in view of the relatively long experience with health insurance in the community. In this chapter, I examine questions relating to:
i) How people in the community conceptualise “the poor” and express the benefits of social health insurance schemes to the poor.

ii) Whether people generally believe and agree that there are some who are truly poor and cannot pay the premiums, and why this is the case.

iii) How, in the community’s perception, those who are poor and cannot pay can be helped.

iv) What the policy context is and what the views of the district policy implementers are on the meaning of being poor in the community.

Since the existing policy framework provides a useful context for discussing “the poor” in relation to social insurance, I begin the analysis with the policy context of access to health care for the poor. I follow that with community perspectives on points dealing with how people conceptualise “the poor”, why they contest the meaning of being poor, how they perceive benefits to the poor and how they think the vulnerable can be helped. I conclude with a discussion of the dilemma of access and equity for the poor and vulnerable in voluntary health insurance. Here I argue that the effectiveness of voluntary insurance in protecting the poor returns to the question of exemption mechanisms, as some writers have already noted. In the case of Ghana, administrative bottlenecks that have plagued the effective application of exemption policies are compounded by problems of identifying who “the poor” are in the community. The exclusion of the poor from social insurance reflects the negative side of reciprocity but the phenomenon is not unique to Ghana; similar trends occurred in Europe in the 19th century.

Policy framework

As I have already indicated, the policy context is a good starting point for discussing what impact social health insurance has on access to health care for the poor. This serves as a useful way of placing the discussion in its proper policy analytical framework. The issue of financial access to health care for the poor has been a perennial problem since the dawn of cost recovery policy in Ghana’s health care system from the mid 1980's. Recognizing that some people cannot afford health services, the introduction of hospital fee regulations
policies of 1972 and 1985 by the government was supported with provisions of exemptions for various categories of patients. However, as a result of widespread problems with and abuse of the implementation of exemption policies for the poor (especially in terms of defining who was poor), the government has had to look for alternatives to user fees at the point of service now dubbed “cash and carry”. The story of the evolution of health insurance in Ghana is thus a story of meeting one of the major challenges of health care financing: ensuring access and equity to all Ghanaians in health care, particularly the poor and vulnerable.

In pursuing the issue of “the poor” and health insurance, one of the preliminary tasks was to understand how “the poor” are defined and what official criteria are used to identify those who are poor. During the span of my fieldwork I took the opportunity to explore the issue in-depth and first hand with policy makers and key ministry of health officials at the national, regional and district levels. At the national level, one of the officials with whom I discussed the subject was Dr. Moses Adibo, who had just stepped down as Deputy Minister of Health and was at one time the Director of Medical Services. In the latter capacity he oversaw the implementation of Ghana’s cost recovery measures from the mid eighties to the mid nineties, and was a strong advocate of community health insurance in Ghana. The ideas that gave birth to the Dodowa health insurance scheme were in fact his brainchild. Our conversation touched on several issues, ranging from user fees to state involvement in health insurance and the failed Eastern region pilot scheme. He explained the official ministry of health policy view in relation to the poor who have difficulty in accessing health care as follows:

The poor exist, so in 1985, when we introduced user fees, I made sure that we introduced exemption for the poor. But I thought the person in charge of the institution should be given the prerogative to determine whether indeed the person was a pauper [emphasis mine]... In the community there are people who are genuinely poor and can be identified so that they could be exempted. But what I have also found out is that, and this is a Ghanaian weakness, people are not willing to take decisions or responsibility. So you hear quite often that somebody has been discharged from the hospital because the person cannot pay the fees and yet they are keeping the person in there. And yet if you go back and see LI [Legislative Instrument] 1313, the thing is there that if the person cannot afford [the costs] declare
him a pauper and let him go, but they wouldn't do it. So our inability or refusal to take decisions is a problem.

A few observations can be made from the above response. First, at the highest policy level, the ministry of health, and for that matter the government, recognises that some citizens are too poor to pay for health services and provisions have to be made for their exemption. Secondly, the details of that exemption policy are well secured by a Legislative Instrument 1313.1 Thirdly, it also emerges from Dr. Adibo's remarks that although the policy theoretically recognises the existence of the poor, it is vague with respect to how a pauper is to be determined. Over the years this has been one of the major sources of problems plaguing the exemption policy law is intended to protect the poor. I will return to this later in the chapter but at this stage of this analysis, further insight into the problem of the poor from a policy perspective is still useful.

Continuing our discussion, Dr. Adibo provided a detailed background insight into health insurance in Ghana, emphasising that government conceived health insurance is a means to mobilise additional funds for the health sector and improve access for the poor. He continued:

When I considered the pros and cons of various health financing mechanisms, insurance appeared to be the best option. But since less than about ten percent of the population are salaried workers, conventional insurance would not be viable. The vast majority of our people in the villages are subsistence farmers with seasonal and small incomes. For most of these, health care often comes as a difficult expenditure. Community based schemes therefore were the next best alternative. It makes it easier to get our rural folks to come together and form smaller groups to evolve some form of insurance, which is peculiar to our environment.

Considering that mutual health schemes are based on the payment of premiums, to what extent can insurance solve the problem of access if the poor still have to pay? In the Brong Ahafo region, which has a lead in community insurance through Nkoranza, I had the opportunity to seek the views of the regional director on the subject. Did he consider
health insurance to be a solution to the problem of access to the poor? How were the “the poor” going to be determined? His response:

I think certainly there will be poor people who will not be able to afford whatever premium is set. But what makes things easier for the government is that there already exists an exemption policy. At the district [assembly] levels, there are programmes like the poverty alleviations funds that are targeting and assisting the poor in the communities. So once these people have been identified, then it’s easier to identify the very poor because we have information on all villages. In all the places we know those who have not been able to pay and we go into their background and find if they are the very poor. When the government gets to know them then it can afford to advance payment for these people in their localities. So, I foresee the government coming in to pay for such people.

These comments raise two pertinent issues. The first relates to exemptions as a solution to the poor who cannot pay. This clearly underscores the fact that health insurance might still not be the answer. The second, and very delicate matter is the means of defining and/or identifying the poor. How easy is that going to be considering what is known from the existing exemption policy for the poor?

At the district level, it was possible to discuss the issue with district health implementers. It provided a good opportunity to situate the discussion at the operational level. I wondered how the problem of access to the poor presented to the policy implementers there and how they deal with it. In Dodowa, one of my key contacts was the senior District Director of Health Services, Dr. Irene Agyepong, who at the time had served in that position for over a decade. At the earliest stage of my fieldwork when I first had a conversation with her, the Dangme West scheme had not yet been implemented but extensive work and preparations had taken place. She was therefore very much abreast of the problems and had ideas about how the district was going to confront them. During our talk, it emerged that the problem of defining the poor was not as simple as the upper hierarchy policy officials portrayed it to me. Indeed, the picture she portrayed to me about determining who “the poor” in the community were when it came to exemptions was a stark contrast to the views of her colleagues at the regional and national levels:

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1 The Hospital Fee Act (Act 387) and LI 1313 of 1985 made provisions for exempting three categories of people on the grounds of economy, age and gender. Section 2 of the Act further identified eight categories of
Although the community members themselves admit that there are poor people, they also say we are all poor and that even if there are poor the gradation is a gentle slope and not a steep one. And there seems to be resentment if you try to classify some people as so poor and deserving of assistance in health care while others are made to pay. But yes, it is an issue we have talked about. What do you do with the poor? On one hand how do we define the poor? And on the other hand who is genuinely poor? Those are the issues. When there is a subsidy, community leaders feel they are the leaders so they should get the subsidy. It's the same situation with the government exemption for those under five, sixty five plus and pregnant women. Most health workers resent the exemption. They keep asking why are you [government] giving some exemption when you [government] are not giving them [health workers] exemption because we are all poor? The idea in the community is that basically we are all poor, so no one needs exemption. The poor problem is there but we do not have an answer to it yet.

Essentially, the import of Irene's remarks is that the issue of determining who is poor in the community is not as simple as policy makers at the centre tend to estimate it to be. The simple message in her remarks is that the way the community perceives its poor is based not only on financial want but also mediated by social features. An intriguing aspect of that is how various groups in the health care cycle express latent self-interest in how the poor are defined or determined. Health staff have as much interest in it as community opinion leaders and the vulnerable poor. The ultimate price is the benefit of exemption. Obviously the extent of group self-interest in how the poor are defined, is not only striking, but gives cause for concern in as much as it can negatively impact the sustainability of insurance schemes. But is it likely that the problem of determining who constitutes the poor are is unique to Irene's district?

Nkoranza offered another opportunity to examine the issue further. I had the privilege to talk to Dr. Ineke Bosman, the Dutch born Ghanaian under whose dual leadership as district director of health services and senior medical officer in charge of the Nkoranza hospital the scheme was set up. Her concern for the plight of the poor is so strong that at the onset of the scheme, she decided against the making of photo identity cards for subscribers. The reason as she told me was her "worry that photographs will

patients for whom "no fee shall be paid" for all services obtained at a public health institution in the country.
increase the fees and anything that increases the fee will create problems because the people have little money". On the basis of the relatively longer experience in Nkoranza, how had the definitional problem of "the poor" manifested in the community? Her view about the issue, based on her long experience in Nkoranza was as follows:

Actually I agree that there is a margin that is "poor poor" but my experience here indicates that "the poor" has a wider meaning. The way it presents in relation to the insurance is either in the mind or money wise or both. "The poor", so to speak, may be about 10 to 20 percent but that includes believers in faith healing who say you can only be healed by prayer, so insurance is not necessary. Some people are also poor only in the mind. It is not poverty in the sense that they cannot pay the money. Rather their attitude is that "I will pay next year" or "I haven’t been sick for three years but I have been paying and so I cannot continue". So it’s not always poverty. That does not mean it does not hurt me that some people who are genuinely poor cannot insure themselves.

Based on her last statement about the genuine poor, does health insurance provide a solution to the vulnerable poor or what she herself referred to as the "poor poor"? Her reaction:

That is the actual problem. We do not actually reach the “poor poor”. It’s the 30% that is the most affluent or the most sensible that is benefitting. The marginal people that you want to benefit cannot join because they do not have the means. The way to achieve that is to keep the premium low. The main goal of this health insurance is to make the hospital accessible to the marginal poor but we have only managed to make the hospital economically self-sufficient. The whole idea of making health care accessible and reaching the poor, I doubt if they [the scheme’s present management] have done that for them.

What can we deduce from the foregoing? Dr. Bosman’s previous remarks about the meaning of the poor provide a useful analytical and practical distinction. Conceptually, it emphasises that being poor is not only about having the monetary resources, but goes beyond conventional poverty profiles. In the context of people committing money for their health in a risk sharing mechanism, “being poor” tends to be very much mediated by social
and mental processes. Irene made reference to the fact that who "the poor" are in the community is contested. The insights suggest a potential source of difficulty in any proposal in that direction. Literally district implementers acknowledge that people are poor and some are indigent and need help because they cannot afford to pay. However, contrary to conventional economic images of the poor, which the written policy issues deal with, representations of the poor in the community are socially constructed and thus make their identification complex. To what extent do the foregoing views of policy implementers reflect the actual situation of the people of the community themselves? I turn to examine this from the perspective of the people themselves.

Community perspectives

How "the people" conceptualise "the poor" and express the benefits of social health insurance scheme to the poor

The way people in the community conceptualise or refer to "the poor" and discuss the benefits of health insurance reflects ambiguities and analytical complexities. In reality the way they perceive "the poor" depicts the problem of definition of "the poor" in the African rural context, about which much has been written. (See for example Iliffe John 1987). The categories they use confirm the view Irene presented to me about the elusive nature of the meaning of "the poor" among community members themselves. Literally, they conceive the poor in two respects. In a wider sense the entire community perceives itself as poor "without exception". However, in a limited sense, people also accept that some are poorer than others within the entire poor community based on certain circumstances such as old age, physical deformity or calamity. I will illustrate this with two cases from the Nkoranza district.

Case 1: Alice
I first met Alice (a pseudonym) on July 18th 1999 when she joined a focus group discussion of mixed subscribers, one of three I organised in Nkoranza. Aged 46 years, she had no formal education and eked out a subsistence existence through farming. She also described herself to me as a Christian and married with two children. She looked quite
reserved but very confident and made very practical and useful contributions during the discussion. A short testimony she gave about the benefits of the Nkoranza scheme aroused my curiosity for a follow up conversation with her.

I was admitted at the hospital two years ago for a long time and after some time I could virtually be mistaken as one of the workers on the ward. When I was eventually discharged, my bill ran into millions of cedis. But I was discharged without paying anything. The only reason why I am still alive is because of the insurance; there was no way that I could have found the money anywhere to pay for treatment.

My follow up conversation with her indicated that Alice was a diabetic who went frequently for insulin injections. Both the medical doctor in charge of the Nkoranza hospital and one of my field assistants who was a coordinator at the insurance office corroborated that. For the managers of the scheme, she was one of their high-risk clients. But since the objective of the scheme was non-profit risk sharing, people like Alice were a good example of how risk sharing makes health care accessible to otherwise poor people who could not have afforded health care without the scheme. In fact her last admission at the hospital lasted about three months. She was discharged just a few days before my arrival in the district. The charges amounted to 2.6 million cedis and the scheme paid every penny from beginning to end.

In terms of outward physical appearance, Alice looked very well without any visible trace of her chronic condition. And she was very appreciative of the insurance scheme:

[It is] the saviour of the poor in the community; you wouldn’t have been talking to me today. My husband and I could not have afforded the cost of my treatment. As for my family members they only visited me at the hospital.

They “try their best to pay” their premiums and that of five other members of their household whenever they were due.

In summary, this is one poor person for whom social health insurance has provided regular access to health care. Without health insurance she had no solution to health care. She is thus a good example of how risk sharing in health care solves the problem of the poor. Alice also typifies the ambiguity of the meaning of the poor in the community. In
one sense, the entire community considers all of their own situations as poor and similar to
that of Alice and her family because economically they face the same problems. They are
all subsistence farmers, have identical family sizes and encounter the same socio economic
problems. This is the wider sense in which people in the community perceive "the poor".
As many of those that manage to pay their premiums, the scheme provides an answer to
their health care needs.

Case 2: Comfort

I met Comfort (a pseudonym) on July 21st 1999 when my field assistant took me to her
house to meet someone, who in his estimation was destitute. Her handicap was clearly
visible. As a leprosy sufferer I was deeply moved by the her physical deformity. Despite
her condition, she had a family of three children and one grandchild but no husband. She
was 56 years old and had her three children with different "partners" she associated with at
various leprosaria across the country where she underwent treatment. The oldest of the
three children appeared to be in her late teens or early twenties and was the mother of
Comfort’s grandchild. Her other two children were a daughter aged about 9 years and a
son aged around 12 years. She lived with all the children in a small house and subsists by
farming.

The other purpose of our meeting was to administer a short semi-structured interview
guide in connection with this research. As soon as she learnt of my mission she started
telling me a story about what in her perception was a recent "unfair treatment" she had
received at Nkoranza hospital. She was a bit upset with Nkoranza hospital because during
the previous year she once sought treatment there and was treated and discharged the same
day. However, she still felt unwell so she visited Techiman Holy Family Catholic hospital,
which was nearer to her village and was admitted for one week before she was discharged.
In her view, Nkoranza did not admit her because of the insurance.

As I later found out, her story was not as simple as she had presented it. In the first
place she was not an insured person who would have been given "free" treatment even if
she had been admitted. Secondly, a tricky dimension of her situation was that although she
was entitled to free treatment for leprosy, the provision of free treatment for conditions not
related to leprosy was ambiguous. It was therefore uncertain whether her situation merited
free treatment or not. She categorically told me that with her physical state, it was not
possible for her to work and save to pay for insurance. However, based on our conversation, it appeared that the exemption privilege she had as a result of her illness did not always make health care access easy. Indeed, the most difficult and pathetic aspect of her personal circumstances was the implication for her four dependants. She was too poor to insure them, so none of her four dependants had regular access to health care.

Comfort is the example of "the poor" in the smaller sense of the meaning in the community. She, and by extension her four dependants, are considered as "needy and less fortunate" because of her health or physical deformity. People like them are the ones at the lowest level of socio economic existence and are the vulnerable poor who are handicapped by reason of gender, age, physical deformity, orphanage or disease. They barely manage an average economic existence. They are a good example of what Dr. Bosman describes as the "poor poor". For such people as Comfort and her four dependants, the scheme does not provide an answer because they still cannot find the money to pay their premiums to entitle them to health care. Ironically these are the ones who often need the insurance most because of their vulnerability to diseases. As one health staff in Dodowa summed up during a conversation, "because of their poor situation the quality of food they take is very poor and the nutrition is equally poor so they easily fall sick. They need something to build them up. It is a vicious cycle of poverty and poor health".

The foregoing two cases illustrate the two senses in which people in the community conceptualise "the poor". In common speak, the entire community considers itself poor because in their perception, the socio-economic context of the rural economy does not only naturally constrain them but in their estimation, the consequences impact them disproportionately. As one local leader described it to me, "for most of them in the villages, its subsistence farming that they are doing and it's just hand to mouth. Whatever they get it's not sufficient to sell to pay for the insurance scheme". Thus in Nkoranza, the typical saying was yen nyinaa ye ahiafoɔ. We are all poor. "We all deserve sympathy because we are all suffering," as one worker in the insurance office at Nkoranza put it when he explained the ambiguity to me. This is more so the case when it involves money or the payment of fees. A brief illustration will bring out the sensitive nature with which this view is carried in the community. I cite a brief excerpt of a conversation with one
participant, John (not his real name), when the issue about why some people who do not pay their premiums came up. Dan refers to me.

John: The whole issue about people being poor or not boils down to what we do and earn for a living. If you ask all of us gathered here what work we do for a living you would understand our poor existence. There are no job opportunities here so we are just struggling with “small” farming. This man is struggling, that one is also struggling, only one of us here is a teacher and the rest of us are just “umbiz” [a popular term meaning not in any gainful employment] people, struggling. Children, adults, men and women in the whole community are all not gainfully employed. If I am a hanging frog, any day you come across me, you will find me hanging. (Enti se meye aponkyereni a mesen h2 a, da bi a wobehu me no na mesen h2 daa.) Do you understand? We are all just there, hanging. [Laughter by the group.]

Dan: So you are all hanging frogs?

John: Some of us are even crabs, both mother and child are crawling so you cannot distinguish which of them is teaching the other how to walk. [Another outburst of laughter by the group.] We have no help.

Dan: Can you explain?

John: That is what I am coming to. We have no help. If you have the time, let us visit some of the villages with a vehicle pretending to be looking for yams to buy. The farmers in the villages will give them to us for free. They will ask us to take whatever we want away without asking for even half a penny. The yam has been in the barn for so long that it has started germinating again. And so if you are a farmer what will be the motivation to farm? Nowadays, we are merely surviving from hand to mouth. There is nothing to fall on in case of emergency. People are so poor that even thieves have become redundant (akrɔmfoɔ koraa a abɔ asesa). If I have ten children, then together with my wife, my family comes up to twelve. Paying six thousand times twelve is a problem. So it is because we have no good jobs in the community that is why we cannot pay the premiums. This is a problem that affects all of us in the community. There is no antelope and there is no tiger, we are all animals. (Ye mnyi twɛ ennyi xebo, yen nyinəa ye mmoa dɔmɔma.) Do you understand?
John's remarks show in a vivid way one sense in which the community abstracts "the poor" in a wider sense. It emphasises the point that structural poverty affects the entire community and so they all consider themselves as poor. That is, however, not to suggest that the community does not recognise indigents among them. In so doing, the distinguishing feature becomes the local concept "ohia buroburoo" which literally means 'abject poverty' although "destitute", "pauper" and "poorest of the poor" convey the meaning very well. That is the sense in which the vulnerable poor is conceptualised by the community. The commonly cited categories are orphans and widows but in general the aged, children and women are cited as deserving support when the community accepts them as "needy and less fortunate".

I should mention that there are quite a number of malnourished children walking around in the communities and the sight of frail looking old people is not uncommon. There are also teenage mothers struggling with life. But when community people are making distinctions about the poor and vulnerable, they might not necessarily refer to these alone because "the poor" is not merely economic or physical want or appearance. Nevertheless, the terms "needy and less fortunate" and the "poorest of the poor" would refer to a few of them. In other words, although the community accepts that there are some who are poor and cannot pay, in practice, "the poor" is highly contested. This is the height of social ambiguity in the way people conceptualise the vulnerable poor when it comes to ability to pay insurance premiums. Why? Based on several discussions and conversations with the people, the following provide some explanations.

Why 'the poor' is contested

In the Nkoranza district, the fundamental reason why many contest the definition of the poor is related to the premium level per annum. Despite the relatively low levels of total subscriptions, the popular view among people in the community is that the premium per se is affordable, particularly when compared with other expenditures that accompany other needs for assistance such as funerals. There is, therefore, a school of thought that believes that with a little effort each individual should be able to pay. This idea was carried across to me in several discussions and conversations. The following statement made by the pastor of a local branch of one of the mainline Christian churches in Ghana typifies the view:
I don't think I will agree entirely with you that people cannot afford to pay €6,000 for the whole year. I know we have poor people but unless you have so many children then if you refuse to pay 6,000 for the whole year for yourself and your children, I don't think I will sympathize with that person if he falls sick. Yes, because you see when someone dies, they spend huge sums of money. That, they are able to do. You see if you are a "responsible" adult and you cannot afford paying a yearly premium for your parents but when it comes to funeral you can contribute more than necessary, then I don't think that person is being reasonable. The €6,000 will cater for any expense that will be made when that person goes to admission.

A counter school of thought exists that believes that the responsibility for paying usually falls on one person, who usually is the breadwinner. With a rather large average family size, payment of any premium collected within three months becomes a problem.

Closely related to the above is a culturally motivated argument that since everybody belongs to a family, "the poor" ought to be catered for by their families. This argument was often made against the background of the hypocritical show of family solidarity during funerals at the expense of the care of the poor and indigents. A local assemblywoman of Nkoranza explained it this to me during a conversation with her:

There is need to help paupers but they should be people who really need help. For example, there are people who have no offspring and are quite sick. For such people the scheme could help. But even the handicapped belong to families and so their families should pay for them.

There is another socially constructed argument that even the so-called indigents are only poor because of their laid-back attitude towards the scheme. A female informant at Nkoranza expressed the following sentiments:

Why should some people be classified as poor? This is wrong. Once they can eat, they are not poor. If you consider what people spend when they go to hospital each time it is nothing. They are not poor. Everybody is doing something and manages to make ends meet so they ought to be able to afford.
Another aspect of the perceived attitudinal problem against "the poor" is that they are prepared to help themselves when efforts are made to help them. In other words, some in the community hold the view that some of those who claim to be too poor to pay have not been challenged to attempt to succeed. Ernest, who used to be a premium collector for the insurance scheme in a suburb of Nkoranza, explained this while in the company of other participants of an all male FGD:

Some are really poor; but the reason why I can also not hold brief for many is that sometime around 1993 the scheme implementers tried some susu scheme to help those who were poor. The people did not patronise it. At the moment, the registration is open but people are not paying till when it is three days to the end, you will see them rushing. So some people can actually not afford; but they would be quite few in the very remote areas of the district. They blame their attitude on being poor; they make no effort to help themselves.

Conventional notions about the poor and vulnerable who do not receive health care due to difficult access to money often include women. This was one reason I took great pains in including a proportionate number of women in my sampling. One of the striking observations in Nkoranza district was that the group of informants who most strongly contested "the poor" argument on the basis of affordability happened to be women. Infact, during a conversation with the Omanhene of Nkoranza at which community female activist and leader was present, he suggested that the economic situation of women was not as bad as I perceived it:

As for women if you need any big loan in the community, they are the ones who can give it to you. The women of today are very resourceful and enterprising so they are not poor. It is the women who buy the yams in the villages and send them to Accra for sale. Some take them to Kumasi while others sell them here. It's the same with maize. So, now, the money is not in the pockets of men but the purse of women. As for the aged, their children look after them. Some children send money from abroad to pay for their aged parents. But as for the women if you need any loan, don't stop at the door of any man. Go to the women.
Depending on how one looks at it, the above perception of the economic power of women could on one hand be taken as an affirmation of the enterprise of women in the community. On the other hand, when I consider it against the strong vocal stance of women that the premium rate in Nkoranza was affordable, the message of women could be a protest against spouses who use non-affordability as an excuse to deny women and children health care. Indeed, in a later interview with the only female representative on the Nkoranza insurance advisory board, she explained to me that many of the men in the district had divorced their wives or separated from them and left the burden of care including health care on the women to struggle to deal with. Accordingly, women are conveying a protest against this irresponsible attitude of some men.

Another ground upon which the definition of the poor is contested is associated with how the community judges the way individuals make choices between the necessities and the pleasures of life. The poor, therefore, lose the support and sympathy of the community if they over indulge in socially disapproved behaviour such as “excessive” or habitual drinking of alcohol at the expense of their expected social responsibilities. One local leader in Kranka put it bluntly:

People still manage as much as 20,000 cedis to buy lotto ticket every week when they have not paid their children’s premium. If tomorrow the child is admitted and he is asked to pay 300,000 cedis then he will start crying. Someone has spent about 1000 cedis drinking alcohol this morning. One year is long enough for people to save towards it [the premium] but they still ignore it.

What the foregoing yet again suggests is that the meaning of “the poor” that is commonly manifested as economic or physical want is highly mediated by social and cultural determinants. Although “the poor” exist, distinguishing them in the rural setting in the context of perceived ability and willingness to pay premiums involves social complexities. One obvious outcome emerges from this ambiguity. The task of identifying the poor must involve processes that do not only take the views of the community at large into consideration but as much as possible include their active involvement. I will take up the issue later in the discussion but I now turn to examine how the community expresses benefits of social health insurance scheme to “the poor” who are able to afford the premiums.
How people perceive benefits of insurance to the wider poor in the community

In the absence of quantitative data (which in all sincerity would require a separate study), I rely on the testimonies and accounts of people in the community to illustrate how they perceive the benefits of the scheme to “the poor”. Discussion of the benefits for the poor here refers to the poor who fall under the wider meaning of the poor in the community who are able to afford and pay their premiums. Given that wider definition, community people perceive the benefits of social health insurance to “the poor” in three mutually exclusive social dimensions, namely the individual, the family and the community.

At the individual level people commonly speak of insurance as being “the saviour” of the poor who previously or otherwise would have found it difficult to afford the cost of hospital care. The case of Alice is a good example of how health insurance benefits the poor who, as a result of insurance, now have regular access to health care. Given the financial cost of the treatment that saved her life, she testified that it would have been impossible for her and her family to have met the cost of health care alone. Apart from her declaration, there are other testimonies about individual benefits were quite common from subscribers as the following from two participants at a male FGD in Nkoranza illustrate.

I have been admitted there for 2 weeks before and that was 2 years ago. My father has also been admitted there before and was operated upon for a “sore in the intestine”. At the time of discharge his medical bill was 880,000 cedis. Fifty-three year-old farmer

My experience is that my mother was hypertensive and became a regular customer at the hospital. Everybody in this room knows about her because she was admitted every month. The doctors did not get fed up with her and anytime they did everything to save her life. Most of the time she spent about 10 to 14 days and it continued for 5 good years. When she died, the receipts that I obtained from the insurance that are on file amounted to 12.2 million. Where would we have obtained that money? So, as for the insurance, chief [a reference to me], it has helped us a lot. Forty-four year-old farmer and sawn miller

On one occasion, during a conversation with a sixty-seven year-old opinion leader, he aptly described the benefit of the Nkoranza scheme as having empowered the poor to be in
control of their own health needs and those of their families. He cited his own personal situation before and after the introduction of the scheme to explain this point to me.

Sometime ago, discharged patients used to knock at my door every now and then asking for a loan to pay their hospital bill before they were allowed to go home. You see when the hospital discharges someone from admission, it detains the person if she or he is unable to pay until the charges are paid. The poor people always had difficulty paying. Before the insurance started people used to knock at my door at dawn for assistance. Sometimes they pledged their maize or cassava and that would be the end. But since the scheme started, that has stopped considerably. Now I would not never mind anyone who comes to me to say that they could not register their child so I should give them money to go and pay their bill. Paying about eight thousand cedis a year to benefit from hundreds of thousands in a year has made the insurance a great benefit for the otherwise poor and deprived who could not afford health care and were just dying.

Significantly, the individual benefit of the scheme was something that virtually every person recognised irrespective of their membership status, whether they were subscribers or non-subscribers. At a FGD with four non-insured men and two non-insured women at Nkoranza, the consensus was that “it is good because when you are a member it takes care of your medical expenses when you are admitted”.

At another level of abstraction, people describe the benefits of insurance to the community-wide poor in relation to the family. Before the introduction of the scheme, many families experienced hospital care as a desperate financial situation. Sometimes loans or credit facilities were sought for urgent conditions at the expense of family assets and reputation. Dora, a native and local assembly representative of one of the electoral zones in Nkoranza described this typical situation in the district to me:

The insurance has been very helpful to families and has improved the health care situation of many families. People are so poor that when the scheme did not exist, it was very common for families to call a meeting to collect contributions before they could discharge relatives who went on admission at the hospital. Now everything has changed. Provided you have paid your premium, you only have to carry your card when you need admission. When you are discharged you walk home without paying
anything. It has brought well being to all of us. It has been very helpful to most families and I know that some communities even wish to have a similar thing as we have here. We are very pleased with it.

Significantly, many recalled with joy the fact that there is now “no cause” for family financial burdens due to health care because of insurance. “People don’t have to sell a family property or mortgage one of them, as was the case in the past, to take care of the sick,” the Omanhene of Nkoranza asserted during one conversation. Indeed in some rural situations either the purse or the decision of a male head of household was required before women and children could seek medical care at the health facility. In such situations, health insurance, as one nurse in Dodowa pointed out to me “has offered a great opportunity for women and children who are the most vulnerable to have access to timely health care”.

At an even wider level of abstraction, the community also acknowledges the benefit of insurance to an entirely poor community. When participants referred to this wider aspect of benefit, the historical context prior to the introduction of the scheme was usually mentioned. A participant at a male focus group discussion in Nkoranza captured this point very well:

One reason why insurance was started at Nkoranza was that the death rate at the hospital was very high. People were just dying like that in the hospital and the doctors became very alarmed. After an investigation by the hospital, they found out that when people fell sick, they stayed at home for so long because they did not have the money to go to hospital. As a result they sought treatment only when the sickness had got to a critical point, which was the stage the family was prepared to contribute money to assist hospital expenses. It was the concern for this that prompted Dr. Bosman and her team to search for assistance to establish the scheme. Due to poverty, people were unable to report early for treatment and it was this that led to the introduction of the scheme. Since the scheme was established, that health profile of the district has changed for the better.

At Kranka, one of the scheme’s field collectors (as the premium collectors are called), characterised the benefit of the scheme to the “entire poor community” to me:
This community is entirely made up of poor farmers. Many people were not able to pay their medical bills and some were detained for weeks. Some run away after undergoing treatment and others even died. It has therefore been very helpful to our poor farming community. I know of a man who lives across the street. He embodies poverty. (Ohio ayi no.) He used to be frequently ill and seeking medication was always a problem for him. When the scheme started I advised him to register and he took my advice. The scheme became the solution to his poor health and since then he has become its disciple, spreading its virtues. He is an example of our poor rural folks who have difficulty attending hospital when they need it. Indeed, because of insurance many poor farmers in the community have had their “parkers” (strangulated hernia) removed.

In talking about the benefits of insurance with reference to the poor, one important qualification that did not escape mention was the clear-cut condition that benefit is only possible “if the poor are able to pay their premiums”. That consideration usually opened a door to discuss ways in which the community feel “the poorest of the poor” or destitute and indigents could be assisted. The next section briefly deals with that.

**How can “the poor” who cannot pay be helped?**

It is the view of people in the community that one way by which the poor who cannot pay can be assisted is through their families. This was a popular idea in various focus groups. In light of their own admission that the family has become less effective in providing support I always challenged this suggestion. But the family support suggestion was always offered as a moral argument on the ground that the family ought to support its indigents just as it supports its dead. At one of the sessions in Nkoranza one participant expressed the view as follows:

Our elders have a saying that the family is one. Although the inheritance system has changed in recent times, some families are still able to help their members who fall into needy situations. However, some families are selective when it comes to providing support. It all depends on the character of the members in the family. As the saying goes the family loves the dead (abusua dɔ fiunu). When it is a matter of death, they will support but giving money to help during sickness does not happen.
Since everyone belongs to a family, I feel in every family those who are capable should help those who are not capable of paying for themselves.

Some in the community would also rather have "the church" take responsibility for the "the poor" by paying for their insurance for both religious and social reasons. Many expect that the church, more than any other social group has a responsibility to look after the sick, orphaned and widowed. "True worship or Christianity is looking after the poor, orphans and widows; this is godliness with contentment," one professional teacher and local church leader at Nkoranza said. Socially, many expect the church to offer assistance as a reciprocal gesture for "such people who fulfil their obligatory church contributions in the form of church collections and tithes". Using church funds for such assistance is perceived as helping the work of God.

For an overwhelming number of informants, the care of "the poor" and indigent in an era of health insurance must be assumed by the state, just as it had been under fee payment at the point of use. Since this is the most pragmatic suggestion among the lot, I discuss it in the concluding section of this chapter.

Discussion

The primary goal of creating a community social health insurance in Ghana is to provide access and equity to health care for the poor and the vulnerable. Because of their voluntary nature, however, benefit from such schemes is contingent on the payment of premiums. Since affordability is a key criterion, those who cannot afford premiums lose out. In this respect, the important lessons learned about mutual insurance in Europe were that insurance did not gather the poor and vulnerable with it. Mutual aid societies in 19th century Europe, according to de Swaan (1988) "represented a form of authentic solidarity and collective care, widely and densely spread, and managed on a small scale by autonomous members". However, the collective arrangements excluded the less privileged because apart from being excluded on the basis of being bad risks, "to these paupers, wretches, lumpen, the pressures of daily survival were often too great for them to afford a penny a week for the burial society, let alone for the sick fund" (De Swaan 1988:147). It took the intervention of state free care policy in the course of time to bring services to the
poor. (De Swaan 1988). Within Africa, Criel (1999:115) has also reported that in Bwamanda, the poor are underrepresented.

This situation cries out for a need to design strategies to take care of the vulnerable poor. Invariably, the effectiveness of insurance in protecting the vulnerable poor returns to the question of effectiveness of exemption mechanisms for the indigent. Exemptions and waivers are seen as strategic design features of most cost recovery programs that are used to ensure access to the poor and medically vulnerable.

In practice, Ghana's experience with exemption has been a dirge of disaster and tremendous abuse. Institutions abused the official policy on exemptions and as one report has noted, "exemptions as provided for the Hospital Fee Act and by the Legislative Instrument was not focused on the socially disadvantaged. Though provisions have been made for paupers and indigents, a lot more have been made available to other categories of people who may be in the position to pay". The less privileged thus lost out (MoH, Ghana 1996:7). Exemption mechanisms have not been effective in achieving the main goal of ensuring access of health care to the poor. One aspect of the problem has been in relation to the definition and processes involved in defining the poor. While the policy set criteria for various groups of patients, including health staff as well as patients with certain conditions, no criteria were made for the poor. That task of determining "the poor" or pauper was conferred on a social welfare officer at health institutions where one was available. Failing that, it was vested in the authority of the head of institution.

However, since many hospitals did not have a social welfare officer and the institutions were more interested in maximising revenue, the pauper privilege was often ignored. The application of the exemption policy had been rather abused to serve the needs and desires of health staff and their relatives and friends. This has often left paupers and the poor without care. For instance, a study of exemption practices in the Volta region involving the 25 main providers of health services, found that the bulk of exemption (72% compared to 6% of paupers) were granted to health staff and their dependants, some of whom had sound financial base to pay for service (Nyonator et al: n.d.). To date, the country still has still not been able to fashion an efficient exemption mechanism that functionally provides ready and easy health care for the exempted class.

The problems of abuse through exemptions are not unique to Ghana. De Swaan has noted that when a government introduces exemptions and subsidies in an attempt to
persuade funds to include the most vulnerable groups, it is the well to do who make the most of these privileges (De Swaan 1996). This was true in nineteenth century England, when Anglican clergymen used their privileges to increase their own pension funds, and it is true today in India, when housewives from the educated classes contrive to obtain governmental loans on favourable terms that are intended for the financially weak, but seldom reach them.

Notwithstanding the problems with exemption mechanisms, they constitute a necessary means for protecting the poor against the problems of access and equity. Indeed, most informants in this study perceive it as a moral responsibility of the state to provide exemptions for those who cannot afford health care in view of their socio-economic deprivations. Mechanisms that can be adapted to local realities through negotiation with community people need to be considered. The strong, socially mediated meaning of the poor in the communities makes such an approach necessary. This is all the more important since exemption plans for the poor have a tendency to create problems of confidence and interest in the health care system. Confidence has a moral connotation but given the strong social dimensions in the meaning of being poor, some amount of community representation in decision-making will be a realistic option.

One sociological consistency that De Swaan emphasises in his analysis of forms of solidarity and collective arrangements in the 19th century is that “a system of small, autonomous, collective provisions always excludes a substratum” (De Swaan 1988:147). This phenomenon accounted for the exclusion of the poor from the mutual funds of the better off workers. In the present analysis, we can explain the relationships of the poor and indigent in social health insurance within a context of balanced reciprocity involving solidarity. The “payment of premium” in insurance is a predetermined balanced transaction. In line with the principle of balance therefore, those who pay their premiums are those who receive support when in need, according to the defined policy. “The poor” and indigent who cannot afford the premium are left out. The importance of the exchange is that it shows the negative side of the concept of reciprocity: that those who are vulnerable and poor and whose circumstances do not permit them to pay are those who also miss out. As much as the reciprocity underlying the solidarity arrangement rewards
those who participate in the exchange agreement, in the case of the poor, it also acts as a mechanism of exclusion.

A lot has been said about the potential of insurance to provide access to the poor. In this chapter, I have shown that two types of poor people exist but typically this is conceived in relation to the wider meaning of the poor. The vulnerable poor are left out. While governments or states (the subject of the next chapter) in sub-Saharan Africa are pursuing ways of developing schemes based on universalistic solidarity, there is also a pressing need to design effective exemption strategies to take care of the indigent if the goal of universal access is to be attained. Although no hard quantitative data has been used here, the testimonies of implementers and community people have provided ample exploration of the existing problem. It will however, require further quantitative, population-based study to know the magnitude of the problem of the poor in order to plan effective exemption policies to tackle it.