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

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The role of the state in the making of community health insurance schemes

Introduction

One of the basic components of any health insurance scheme is fund ownership and management. In any evaluation of the efficiency of community health insurance or protection mechanisms, an essential ingredient is the level of funding that can be generated and the ability of that revenue to sustain the scheme. The continuity of the scheme depends on the extent of people's participation in it. In voluntary health insurance schemes such as those in the informal rural sector, people's participation depends in particular on their acceptance of the concept of risk sharing solidarity that underlies the scheme. But also of crucial importance is how they conceive those who own and manage the funds on their behalf. Fund ownership and management can be run by government (state) organisations or non-governmental (non-state) organisations. Against the background of the emerging context of health insurance schemes in Ghana (particularly
those suited to the rural informal sector), this chapter asks the question: Do people look upon the state as a possible financial caretaker or bursar of their health insurance scheme? If so, how?

In order for community health insurance to be scaled up as a national strategy, the state needs to play a major role. In taking the state as my central focus, I consider the existing context in Ghana in which the state has been at the forefront of ongoing attempts to implement a comprehensive health insurance scheme as an alternative health care financing mechanism to replace the problematic “cash and carry system” in the country. Since comparison is a central focus of this study, I look at the situation of a planned scheme in which funds are (or would be) owned and controlled through a hierarchy of state officials (such as the failed NHIS pilot scheme), together with the decentralised district alternative Dodowa scheme. I compare those with a scheme in which funds are owned and controlled by officials of a non-governmental organisation as is the case with the present Nkoranza scheme.

Although the focus is on community members, in order to place the discussion in a wider policy framework, I begin the analysis with a qualitative examination of the prevailing policy context based on conversations with policy makers, implementers and health staff. This is followed by a qualitative analysis of how the people also perceive the state as a bursar of their health insurance scheme based on prevailing assumptions and previous experiences with local mutual and/or micro finance schemes. Based on data from Nkoranza and Dodowa, I further contrast and discuss quantitative findings in which who the people trust most to be the owner of their insurance scheme, the government or an NGO, is discussed, and why that is. I conclude with a discussion of whether it is possible for the state to exert or inspire the necessary social influence or social capital on the community to make insurance succeed.

Policy, implementers and health staff perspectives

No legislation on health insurance in Ghana exists yet, but since the government accepted the final feasibility report in 1995 to implement a national scheme, several papers, reports and documents have been written, some of them in political party manifestos. For my
present purpose, however, one notable reference is the 1995 final report on the feasibility study for the establishment of national health insurance scheme (NHIS) in Ghana. In its key recommendation for a generic NHIS, the consultants noted that sponsorship ought to be borne by the state in recognition of "certain weakness and problems\(^1\), which will make the establishment of the NHIS in Ghana difficult. In retrospect it is possible to see that the state funding and management of Ghana's NHIS partly explains the function and character that the ill-fated pilot health insurance scheme in the Eastern region assumed. A former Director of Medical Services and later deputy minister of health, Dr. Moses Adibo, explained the background of the aborted plan that the MoH had accepted:

At the time we initiated the implementation, many of those in the ministry (who were mainly medical doctors) who were involved in the implementation had studied in Germany. They therefore only knew about the German social insurance. That system as far as I know is mainly based on contributions from workers. And that unfortunately was how they thought the Eastern region scheme was going to be run. In fact they had done everything and they had even written a memo to cabinet to authorize them to set up a company to run it. But when I was brought back as deputy minister in 1998, and I looked at it, I thought the approach was wrong so I said that government would not be involved in running health insurance schemes.

This is a typical story of state projects that are hastily implemented with enormous resources but which go down the drain. The obvious question to ask here is: What accounted for the change in direction? When and why did policy makers like the former minister begin to feel it was not necessary for the state to be involved in the funding and the running of health insurance?

Primarily, the shift in policy appeared to have started even before the pilot study, after an ill-fated sensitisation programme in the four pilot districts. Overall, the lessons of that abortive pilot, together with the outcome of several activities and reviews undertaken by the ministry of health and other interested parties and organisations in health insurance led to the change. The new orientation appears to be that the state should not be an agent or fund owner in community schemes. This was the overriding consensus conveyed to me.

\(^1\) Among the identified problems and weaknesses are "the unduly large proportion of self-employed which makes premium collection difficult and cumbersome, the state of disrepair of the infrastructure and the
by policy makers and implementers as well as health staff at various levels of the health service headquarters in the present study. Why?

One reason is that the processes involved in having a scheme under state control would entail unnecessary bureaucracy that would make overhead costs relatively too high. Specifically, the view is that when financial administration and management goes under state or parastatal institutions, the scheme carries the brunt of all its administrative features as well as the difficulties and inefficiencies of that bureaucratic organisation. Consistent with his position that the state should not be involved in running health insurance, Dr. Adibo further explained his worries about state ownership:

If the state has to do it then it has to be one huge national one. The overheads would be too much. If you take SSNIT they say that their overheads are 40% and that suggests outright that you should not give it to SSNIT because if you involve them then immediately your overheads are 40%. Health care costs are going up so you will lose. For me that is all the more reason why community based ones centred around the district are more attractive... more so because less than 10% of the population are salaried workers. The best alternative was for us to look at some traditional practices like susu and see if we could not modify or refashion them to suit our circumstances.

Accordingly, current policy and on-going activities tend to stress the development of multi schemes owned by specified groups and communities rather than the ones centrally funded and managed by the state.

It is quite phenomenal that in civic life most citizens rationally pursue what they would get out of the state and community but not what they would contribute to it. This attitude is reflected in several spheres of life in state-citizen relations. People are always quick and proud to exercise their rights to the privileges of what belongs to the state, but reluctant to take up responsibilities to the state. This has become a real problem in the Ghanaian society, and as a result there is some concern that if the state takes centre stage, people would shy away from it. Dr. Adibo reaffirmed his dissenting view on government participation in health insurance as follows:

distribution of health institutions which is skewed in favour of the urban centres" (pp xii-xiii).
The Ghanaian’s concept of government is such that they think it’s some benevolent organisation sitting somewhere who will do everything for them for free. That is the way Ghanaians see government. They don’t see themselves as part of government so they like free things and they expect everything to be free. They don’t know that there is no free lunch. The irony is that usually it is the ‘big men’ who want things free.

You have a friend who is a manager somewhere and walks into your consulting room or office and say I want some ampicillin and they expect you to dish it out free when as a matter of fact by his status he is the one who should pay more. So these are some of our own practices that create problems for us in health care financing. When I look at such things I get more convinced that the government should not be involved in running health insurance schemes.

It is important to recall a similar observation by the manager of the Nkoranza scheme:

Anything that is owned by the government people think is free (bonu). They consider it like elephant meat and so they are not judicious in how they cut it... It is state property (ah aban dea) and that actually spoils everything that belongs to the government".

Probably Ghanaians at large take the paternal role of the state too literally or they just do not care about what happens to an entity like the state. Public apathy towards state property remains a phenomenon too disturbing to ignore in any state plans. Yet this is only one out of many reasons. What are the others?

Although the Eastern region pilot project never concretely began, it taught one important lesson. It acknowledged that state participation in insurance is essential for attaining the necessary legislative, political and to some extent, the economic context for success, even though at the same time state bureaucracy and political clout makes state ownership and control a nuisance. Each step in a community scheme is a new experience that must be learned within each new geographical region. Mistakes are made and corrected in the course of progress, and a lot of learning is gained through experience. The lesson of the defunct pilot scheme, which seems to be evidence against state ownership and control, is that because the state was in the driver’s seat, elaborate legislative processes at every stage slackened the pace because every decision had to be politically agreeable.

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2 An old local expression which is probably appropriated from the English “booty”.
Another aspect of political clout is that when people perceive the state in terms of the political authority in power, then political ideology might unduly influence people’s attitude towards it. At any one time those who are not in favour of the government of the day might not join merely because of political differences. Based on privileged information he acquired through his position, the regional coordinator of the abortive NHIS characterised the problem as follows:

Something that is being done by the government has some political inclinations and that was why they were so cautious about whatever step they took [in the abortive scheme]. I was always convinced that we may not know all the problems before the take off, but here was the other side that let us try to unearth a lot of problems, and so we had to go through meticulous calculations. Someone made an analogy to me the other day that if a child falls to the ground he gets up and brushes off his side and walks off. But when an adult falls, his immediate worry is who is looking at me? In other words, children move on after little slips without worry because society perceives them as learners who pick up lessons along the way. But because adults have to explain their slips they move too slowly. That is the argument for the state and non-state situations. If it is initiated by a group of individuals or community without political undertones, it’s easy to move on. Whether it succeeds or not is known by experiment.

Yet another view from Suhum closely related to the above is that based on previous bad experiences with micro finance schemes in the communities, “people are tired of contributing and their voluntary spirit is exhausted”. As a result any scheme in the community ought to “be the simplest of its type so that if you have to abandon it you do not leave a big building in Suhum”.

It was from the relatively longer existing insurance scheme in Nkoranza district that I picked up on a lot of arguments against state funding and running of schemes from a range of implementers and health staff. A number of those arguments were related to the work culture of public institutions and the behavioural norms of its staff. One of the key worries about state run schemes was associated with financial accountability. By their nature, community health schemes are necessarily non-profit, yet as with all financial activities, accountability is essential for monitoring performance to ensure financial discipline. Most
implementers that I spoke to in Nkoranza, however, did not think highly of the level of accountability and financial discipline in the state sector. The diocesan public health coordinator of Sunyani, who directly oversees the Nkoranza scheme, lamented the lack of efficient accountability in the state sector:

Spending is more strictly controlled in mission than in government hospitals. Then also in mission hospitals, we tend to assign people to jobs and so you are held personally accountable for lapses. In the government sector even though that also ought to be the case, it is an array of staff that normally tends to be blamed so it is easy if you are getting difficulties to move away. In our mission areas that is not the case. For instance, if this scheme [in Nkoranza] collapses, I am going to bear the brunt, the same applies to the manager and the coordinators. You cannot push that to any other person or persons. In government circles that is easy to do and as soon as the thing collapses then I would go on transfer. That kind of informal monitoring process makes people feel secure even when they are doing the wrong thing.

Apart from financial inadequacies, there was also the view that compared to mission institutions, the state system generally lacks an adequate and efficient administrative monitoring of its health staff. There are worries that this may negatively impact the efficiency of any schemes that may come under the control of the state. Inefficient administrative monitoring is acknowledged as having been responsible for undue laxity in the attitudes of health staff which has in turn led to poor discipline and poor work ethic. A 46 year-old nurse midwife at the Nkoranza hospital who was enrolled in the insurance program explained the situation to me this way:

My experience is that although I do not work at a government facility, I have attended Sunyani government hospital before and I have friends working there so I know what is going on. The attitude of the staff working in government institutions is different. In mission hospital the monitoring is strict but in government hospital it is not so. For example in the government hospital, it is possible for two nurses on duty to plan the routine to excuse one from duty so that instead of two people one of them will be working. In mission hospital like here [Nkoranza] it is not like that. The authorities are very strict and serious with monitoring, so two staff members cannot arrange cover for one another without express permission from the head. Indeed, usually it is
not possible and you can cover for someone if you are off duty so that there is no shortage. I am not saying government hospitals are not firm, but when you compare the two places one is stricter than the other.

Related to accountability, implementers from the NGO run insurance scheme had concerns about corruption in the state sector. The problem of corruption is well known in Ghanaian public life. One major cause of corruption is the low wages of staff. In order to survive, it has become a norm typified by a common saying among all shades of salaried workers, but particularly those in the public sector that everybody chops from his job (obiara didi n’adwuma ho). A paramedical male staff of Nkoranza hospital explained it this way:

I have been party to collecting monies for doctors in their consulting rooms before when I was in training in a government hospital. The system there is such that you can’t say “no” because they say every patient that comes for consultation pays it.

However, further conversations revealed a significant irony in the public health service: the practice of bribe taking and corruption has not only become part of expected wages, but it has become entrenched in everyday life. The public has been active accomplices to the point that they sometimes become suspicious or doubtful of health staff or officers who refuse to accept voluntary “cash gifts” from clients. The district director of health services, who also practiced as a clinician at the Nkoranza hospital, narrated to me his own experience as an intern in a teaching hospital:

You see when I was in Komfo Anokye teaching hospital, a patient once told me: “If you refuse to accept money, it means that you are not going to look after my child well”. (Se wo angye sika no a, na ekyert: se wo nnhwe me ba no yie.) That is how the norms in the public sector change, because of the perception of people about that sector.

The reality of the situation in the public sector is that the realisation by citizens that things sometimes do not move as expected without greasing the palms of relevant officials, is not

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3 This word is a Ghanaian slang for eating.
a new phenomenon; but it is worrying since in health care it leads to a vicious cycle of poor care and/or further exclusion of the poor and vulnerable.

I ought to point out these “allegations” from Nkoranza, which is a mission outfit, against the public sector does not rule out some element of bias, nor does it make the “allegations” untrue. Dodowa, with its shorter period of experience but very effective district health management team, however, provided an opportunity for a defence of the public sector. The reactions of entirely public sector implementers and health staff to some of the foregoing issues are interesting.

They do not deny the problems or allegations. Many in that sector feel that the problems are explainable in their total social context. For example, one medical officer briefly explained poor staff attitude as follows:

From the point of view of the client what we always know and hear is that the nurse is being rude and she kept us waiting for two hours and we are dying... It is not an easy problem and we may not have all the resources to solve them. There are very big obstacles and some of the things need systemic change. For example, if you take the issue of staff salary you cannot do anything about it at the district level. And yet that is just one aspect of the problem. In order to look at the problem of staff attitude holistically, we cannot ignore education for their children. Unfortunately people in the system sometimes do not want to hear about new ideas, which seem radically different from the way they do things especially if you meet a proper bureaucrat. That is why the public system remains the way it is.

At a later opportunity, I bluntly asked the district director whether in her view and experience the state could be trusted to be a fund owner and administrator of a community insurance scheme. Her response, while discounting fully state schemes and accounting for the human and social deficiencies of the state sector, justified why in her view the district model that she had been spearheading was a better alternative:

The scheme can be easily mismanaged if the state is in control because it would be too large to control. The administrative, organizational and monitoring systems are so weak that it is in our interest to decentralise to the district. The way things are if there are bad nuts in the system, it can ruin the whole scheme. The only way the good talent can come up is to decentralise at the district level. At worst it is good to keep it
at the region because of lack of manpower and knowledge. The state could then focus on building, handling and processing and thereby creating an even climate for the lower levels to have the freedom to grow.

From the foregoing analysis, we could summarise the key strands of policy implementers’ views on state funding and ownership of insurance. Beyond the well-known technical reasons, pertinent social and contextual factors make state funding and/or management of health insurance schemes in Ghana ill advised. The interesting aspect of the arguments of policy implementers is a view that in order to deal with the myriad of problems “the system first has to deal with the problems of the working staff”. For the present analysis however, it is important to acknowledge that social concerns about staff attitude and credibility based on inadequacies of a system in terms of its ability to deliver services has implications for the trust and confidence that are essential for people’s participation in voluntary schemes.

I will later discuss how trust could influence solidarity towards schemes, but in the meantime I turn to examine the people’s side of the argument for and against state agency in health insurance.

People’s perspectives: Do the people also look up to the state?

In general, people look upon fund ownership by the state with mixed expectations that are usually more pessimistic than optimistic. The mixed expectations are derived from considerable interest in obtaining social protection against an ever increasing cost of medical care, but many are doubtful about the ability of the state to offer such a service. The minimal sense in which people favour state ownership is expressed in two ways. Significantly, both views come from informants in Suhum and Dodowa districts. The first is based on a miscalculated assumption that the nation state more than any other entity is in a better position to provide the financial resources to capitalise and offer the technical capacity needed to get the scheme going. Unfortunately, the reality of the Ghanaian economy does not support such an assumption. As a free market economy, the competing demands of various social sectors simply do not entitle any one service or sector to have more than its essential quota from the national coffers.
A second argument that a few people use in favour of state funding and administration, also a hypothetical one, is that since public health facilities cover the entire length and breadth of the country, state ownership would facilitate a wider geographical coverage. To paraphrase one informant in Suhum, "The government is a big body; it reaches everywhere". A few informants were indifferent about ownership. "What is important is that the nurses will speak nicely to us and the doctor will give us the correct drugs when we join the association. I don't mind whether it belongs to the government or the district assembly," said one informant in Dawa during an FGD session. What is obvious from the remark is that ordinary folks sometimes mix up central government administration and decentralised district administration when such issues are being discussed.

Most of peoples' perceptions of state ownership of insurance schemes were sceptical. Many aspects of this scepticism, stem from lack of trust or faith in public officials and politicians as a result of their failure to deliver on most of past promises. Some of the concerns were morally conceived and derived from what people consider right and wrong or good and bad behaviour and attitudes of officials and politicians. As expected, in the absence of a functional scheme at the time of my first visit in Suhum and Dodowa districts, peoples' views about the state were impressionistic and vague. Their concerns were lack of integrity, the potential for bribery and corruption and the tendency of state officials towards favouritism. On the other hand, informants in Nkoranza, whose opinions are based on eight years of experience, tended to focus more on practical operational issues involved in managing community schemes. Issues that frequently got highlighted were: inefficient administrative and financial monitoring systems, a lack of proper accountability in the public sector and a lack of commitment by state officials and state bureaucracy. In both districts, however, one common concern about state ownership was trustworthiness.

**Suhum and Dodowa district**

The underlying sentiment towards state funded and owned schemes in Suhum district is well captured in the following remark of a participant in a male focus group discussion in Suhum:
The only concern about state ownership is trustworthiness on the part of those who will be in charge. Would they faithfully give 'equal treatment' to clients? When it comes to state schemes such as insurance those in charge rather have a tendency to benefit by living fat on the money and riding in big cars, such as the case of SSNIT.

This message, although short, was too powerful to ignore. For analytical purposes, it is important not to lose sight of the reference to “trustworthiness”. The expression 'equal treatment' in the remark was meant to convey that trust was perceived as the essential ingredient for fair play in office holders' dealings with the people. Most informants were quite suspicious about the character of state officials on the basis of previous experiences in spheres of state organized initiatives. SSNIT was always the common reference point. As the official social security system for the country (that however covers only the formal sector) SSNIT often came under public criticism for several reasons, including the affluent lifestyle of its senior executive and a host of perceived malpractices in the way the fund was managed.

In the context of social or mutual schemes, trust is about assurance that monies paid or premium contributions would be used for the benefit of members. But whether negative public perceptions about SSNIT is justified or not, it is just one cited case. In virtually every community, unfavourable tales about the state were shared. At Dokrochiwa in the Suhum district, for example, one female informant told me a story of how past promises to fix the deplorable road and to provide potable water and electricity to their village were all broken, in spite of the modest financial contribution the community had made towards those projects. In the case of the road, she lamented how a road to another village was shown on television to deceive the entire viewing nation when a minister went to visit their village during a political campaign. She concluded: “I have therefore swore never to contribute money towards state projects in the community”.

To some people, the state is not credible enough to hold their funds because of the alleged indulgence in bribe taking and corrupt practices of state officials. In re-emphasising the well-known problem of shop floor malpractices through the collection of ‘under the table monies’, one participant at a male FGD in Suhum gave his personal experience:
A friend of mine had an electric shock and almost died. He was later referred to Korlebu for further treatment and the hospital here (Suhum) advised him to go very early. He complied and on the day he attended Korlebu he was the seventh person in the cue. But he noticed that others who came later were entering the consulting room ahead of him to receive treatment. It went on until someone hinted that he had to pay “something” if he wanted to go home early. Soon after he had done so he was called into the consulting room.

In this particular story, I probed in order to gain further insight. I asked the speaker if the money was perhaps not paid to the doctor, but possibly to an orderly. But another participant quickly cut in with a fascinating remark. “The doctor also gets his share of the monies collected, unless you have not had the experience of sending a relative to a hospital before”. Indeed in the seeming existential doubt and uncertainty about the integrity of state officials concerning ‘equal treatment’ or fair play, several informants also assume a position most often conveyed in a simple message: “unless we start...we just have to wait”.

Similarly, in Dodowa, concerns about credibility based on honesty, commitment and reliability take centre stage in the way people conceive and describe their impressions about state funding and management of schemes. Some were so distrustful of the state as a result of previous experience with money mismanagement, that they did not even consider the decentralised district administration to be a reliable agent in “money matters” because of fear that they may misapply the funds. Rather, the district health administration was preferred in most cases. The reason given was “because the issue concerns health”. One traditional leader at Dodowa described this view as follows:

These days they talk of decentralisation but if these monies are channelled through the assemblies all may not get to health. What we know is that sometimes when there are disasters like floods, the assembly would take that money and divert it. The Ministry of Health (district health administration) should therefore be solely responsible. That money should not go into the central coffers of the district administration.

Quality of care has been a perennial problem in the health services in Ghana especially in public health institutions. The great hue and cry of people about quality of care in relation to the present issue was mainly about poor staff attitudes. Many are dissatisfied with staff,

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4 Ghana’s foremost and largest teaching hospital in Accra
especially nurses for not working around the clock and because the entire service is not organised around their needs. One female informant and leader in Dodowa explained:

I do not know why a nurse says, "I'm tired". One is a nurse throughout 24 hours. Even after shifts, people will call him/her from the house”. And then the language they use on the patients, they have to polish it up a bit. Sometimes they will insult you because you were late, but they have to be patient, use polite language and seek to improve the service.

Some were also very strongly against what they perceive as staff dishonesty. At Dawa in the Dodowa district, for example, the group consensus at one FGD group discussion was the fear that if management of insurance goes under government control, “health staff will send drugs meant for members to their homes to treat their relatives and friends at our expense”.

**Nkoranza district**

People in this district, speak with pride about ‘our insurance’ being first and foremost a product of the honesty, good work and concern of the diocese and hospital officials for the community on one hand and their own trust and confidence in the implementers on the other hand. Indeed trust was emphasised as the miraculous foundation of the scheme. One informant at Kranka said:

People were prepared to pay and join because they trusted the leadership. Everybody trusted Bosman (the doctor who initiated the scheme) and although it took some convincing, people were saying that since the white lady is involved, it will work (*Oburoni no wɔ mu yi de, ebe ye yie*). They trusted her and the other opinion leaders who got involved in it to sensitise the community. The people were God-fearing and so the only way the government would succeed is to get God-fearing individuals to be in charge.

In contrast to these perceptions of the mission run project, some people in Nkoranza district perceive the state as being unreliable, dishonest and notorious for misapplying, embezzling funds and lacking accountability in ‘the way it conducts business’. Past experiences with state enterprises and public corporations have undoubtedly contributed to this negative image of the way finances are handled by the state. One local leader
illustrated the situation by contrasting the state owned mass public transport companies in Ghana with mission institutions:

The missions control their things such that nobody can manipulate their funds. The state on the other hand has a lackadaisical attitude and approach to the way it conducts its business. One example is the state transport companies. It cannot be trusted, taking the accounting system into consideration. The drivers pick anybody up on the road without issuing tickets to them. Most state companies conduct purchases by buying in bulk yet at very exorbitant prices and people do not buy it. These are some of the things. Sometimes, when it belongs to the state, nobody takes the credit but once it belongs to the mission, the credit goes to the diocese. As for the state there will be lapses here and there.

Another reason for people’s aversion to state ownership and control is that they perceive the state as largely bureaucratic, relatively remote and an institution that is difficult for ordinary folks to establish a close relationship with. Some informants therefore hold the view that this remote feeling leads to a loss of sense of identity, ownership and loyalty for ‘state owned things’. The district chief executive in Nkoranza referred to the phenomenon as breeding “a type of mentality people have towards the state property; whatever is happening, nobody cares”. At a male focus group discussion, one participant who was an officer at the district office of the Ghana Education Service supported suggestions for district-based schemes with the following explanation:

Size is very important when it comes to manageability of many things. Anything that is packaged in the name of the government has problems. Here we are able to check corruption, loopholes and other lapses...and people will have confidence in it. If it’s for Nkoranza district we love it because we believe it is for Nkoranza and Nkoranza alone and we feel close to it. On the other hand if it is owned and managed by the state from Accra my concern for it would probably not be so good... because Accra is too far away for me to identify with it. What belongs to us and what belongs to them are never the same. (**two yen ne ewo won ennse.**)

There is also a strong feeling among some in Nkoranza district that the soul winning ideals of the church that stresses compassion and close identification with the community leads to
a stronger integration and for that matter, better commitment on the part of mission staff to their work and their community. In contrast, the state as personified by its officials, is commonly seen as people who are merely working to earn a living and who are not committed enough to the community to devote the effort and make the sacrifice that is required to run an insurance scheme successfully. To paraphrase a popular opinion leader in Nkoranza who made a reference to the issue:

You know in government hospitals people really do not think much of the community. But in this instance the mission has established churches in even remote villages all over the district. They have fathers and priests who live in the communities and so they are aware of the problems of their members. It is part of their work to help them and therefore if there is something, they have them more at heart than the government people.

The difference in attitudes of the staff employed by the mission and by the state also receives frequent mention. The relative lethargic approach to work that staff in the state sector have does not go unnoticed, nor do people wholly blame the staff of not being more dedicated to their work. Rather, the observation is made that “the missions are able to monitor and control the staff” while the public sector is perceived as having “no time to control the staff”. As one opinion leader in Nkoranza lamented:

They do not think about the job but how they get their money. Whether they work or not they get paid. Some report for work and then go away because the attitude is that the work is not for his or her father but for the government. They tend not to appreciate that we are the government.

The same opinion leader also conceded a commonly held view that Ghanaian citizens are important partners to the problem. “They tend to think that government is just the president in Accra whom they blame for everything wrong with the state. Therefore when it is for the government we do it anyhow”.

In general it is fair to conclude from the views of people that they identify a problem of credibility in how the state conducts its business based on past experience.
Significantly, the human problems of the health sector in terms of the way officials carry themselves reflect the situation of the whole society.

To summarise, the analysis so far, it is important to observe here that both implementers and citizens at large have similar amounts of scepticism about state ownership. The state is no longer perceived as credible on the basis of the trust, honesty and reliability that it has not shown in the past. But is the foregoing evidence that people do not trust the state as a possible caretaker or bursar of their insurance scheme?

In a follow up study to subject some of the preliminary qualitative findings to more rigorous analysis, sampled households in Nkoranza and Dodowa, (chosen on the basis of functional experience) answered a few questions in a survey. A striking finding was that altogether, the relative majority of subscribers and non-subscribers in Nkoranza district (40.8%) favoured the state as the most effective organiser of a health insurance scheme. In Dodowa the relative majority cited the district (35.4%) but the state followed closely (32.0%). This rather high endorsement of the state contrasts the dominant negative outlook of the state in the qualitative study. A brief explanation of that quantitative survey analysis will suffice here.

Altogether, 502 and 518 respondents in Nkoranza and Dodowa districts respectively were interviewed. Respondents were health staff and community members. In Nkoranza 5.8% were health staff compared to 9.3% in Dodowa. While there were more subscribers (55%) than non-subscribers (45%) among the community members interviewed in the survey in Nkoranza district, the opposite was the case in Dodowa where there were twice as many non-subscribers (71.4%) as subscribers (28.6%). This reflects the low level of subscribers and the difficulty in obtaining them for interview in Dodowa district, which is attributable to the young life of that scheme. Specifically, in order to test whether the community trusted the state to be the bursar of their scheme, respondents in the survey were asked to indicate who they “preferred most to organise their health insurance scheme effectively and why” among a choice of alternatives (mainly governmental and non-governmental). Part of the results is presented in Table 8.1 and 8.2 below.
Table 8.1 I believe health insurance can be most effectively organized by...

<table>
<thead>
<tr>
<th>Organiser</th>
<th>Nkoranza Subscribers</th>
<th>Nkoranza Non-Subscribers</th>
<th>Dodowa Subscribers</th>
<th>Dodowa Non-Subscribers</th>
</tr>
</thead>
<tbody>
<tr>
<td>State</td>
<td>23.3</td>
<td>17.5</td>
<td>8.4</td>
<td>23.6</td>
</tr>
<tr>
<td>District</td>
<td>5.4</td>
<td>4.4</td>
<td>11.6</td>
<td>23.8</td>
</tr>
<tr>
<td>NGO</td>
<td>4.8</td>
<td>3.4</td>
<td>3.7</td>
<td>10.4</td>
</tr>
<tr>
<td>Church</td>
<td>14.1</td>
<td>11.4</td>
<td>3.9</td>
<td>10.8</td>
</tr>
<tr>
<td>Village</td>
<td>1.4</td>
<td>1.6</td>
<td>1.4</td>
<td>1.4</td>
</tr>
<tr>
<td>Others</td>
<td>5.6</td>
<td>5.8</td>
<td>-</td>
<td>0.8</td>
</tr>
<tr>
<td>No response</td>
<td>0.4</td>
<td>1.0</td>
<td>-</td>
<td>0.2</td>
</tr>
<tr>
<td>Total</td>
<td>55.0</td>
<td>45.0</td>
<td>29.1</td>
<td>70.9</td>
</tr>
</tbody>
</table>

Table 8.2 Key reasons upon which choices about effective organisation are based

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Nkoranza Subscribers</th>
<th>Nkoranza Non-Subscribers</th>
<th>Dodowa Subscribers</th>
<th>Dodowa Non-Subscribers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better organisational/management capacity</td>
<td>6.0</td>
<td>4.4</td>
<td>2.4</td>
<td>5.6</td>
</tr>
<tr>
<td>Best financial resources</td>
<td>24.2</td>
<td>18.8</td>
<td>9.9</td>
<td>27.9</td>
</tr>
<tr>
<td>Trusted &amp; non-corrupt</td>
<td>6.0</td>
<td>6.8</td>
<td>4.0</td>
<td>12.9</td>
</tr>
<tr>
<td>God fearing</td>
<td>7.4</td>
<td>5.4</td>
<td>1.4</td>
<td>4.2</td>
</tr>
<tr>
<td>More community oriented</td>
<td>4.2</td>
<td>2.4</td>
<td>5.3</td>
<td>8.9</td>
</tr>
<tr>
<td>Experienced in scheme</td>
<td>5.8</td>
<td>5.0</td>
<td>5.9</td>
<td>10.5</td>
</tr>
<tr>
<td>No response</td>
<td>0.4</td>
<td>1.0</td>
<td>0.4</td>
<td>0.8</td>
</tr>
<tr>
<td>Total</td>
<td>55.2</td>
<td>44.8</td>
<td>29.3</td>
<td>70.7</td>
</tr>
</tbody>
</table>

For analytical purposes, the response categories make a distinction between the centralised state administration and the decentralised district administration.

How then do we explain the variation between the qualitative and the survey data? The most likely explanation is offered by the underlying reasons for people's preferences. The dominant indicator upon which people based their choice in the survey was perceived financial ability. Accordingly a majority in each district (43.0% and 37.9% in Nkoranza and Dodowa respectively) cited "best financial capacity" as the most important reason upon which their choice was based. This is further reinforced when various organisers are considered individually in relation to the reasons for selecting them. Among those who
favoured the state, the overwhelming majority of subscribers and non-subscribers together in Nkoranza (83.9%) and Dodowa (93.7%) based their decision on the perceived financial capability of the state to support a scheme.

Furthermore, an interpretation within a broader social context does not suggest a contradiction. First, it is important to acknowledge that apart from financial capability, the other indicators upon which people based their decisions in the survey emphasise social attributes: trust and similar qualities such as perceived fear of God, lack of corruption, orientation to the community and the capacity to organise and manage the scheme based on experience and competence. Significantly, these qualities together outweigh the financial factor and places social attributes at the centre of what people consider important for their preferences for scheme ownership. Accordingly, the ultimate choice might in fact not be the state when all the options and preferences are evaluated. The relative majority preference for the state in the survey ought to be viewed with caution, given the common Ghanaian perception that the state is some benevolent organisation or entity that provides free things. The survey finding might therefore be people's way of saying that they expect the state to provide the necessary financial support if they cannot afford the charges themselves in a social insurance scheme.

A further comment on the other top choice apart from 'the state' in the two districts is worthwhile. In Dodowa, the district was actually the most preferred choice. Practically, this was also the decentralised state, but the difference in emphasis could be explained by the fact that the Dodowa community considers effectiveness more in terms of the district because "district" has been a key concept in the education and mobilization drive of the Dangme West District community health insurance initiative. On the other hand, although all residents and non-residents of Nkoranza are eligible to be members of the scheme in that district, apart from being a single facility based scheme, "district" as a concept per se has not been a key organising principle of the Nkoranza scheme. On the other hand 'the mission' was the next preferred option in Nkoranza district after the state. Again this was consistent with what the community had known and were used to, since they associate the hospital and the scheme with the Catholic mission. In essence, this indicates that familiarity also plays a key role in people's confidence in scheme ownership. Peoples' preference for the church was based on moral grounds such as fear of God (48.8%) and trustworthiness and non-corruption (31.5%). Similarly, when people refer to the district,
they imply the district health management team or health administration in a more narrow sense. People's preference for 'the district' is thus an endorsement of their perceived familiarity with the organisational drive in health insurance by the DHMT in the district. Despite its short period of operation, the important reasons why people chose it as the next in importance after the state was because it was better experienced in organisation (43.3%) and better community oriented (35.0%).

Discussion: Can the state inspire popular collective will in community schemes?

Emerging community health insurance schemes in Africa have either been initiated by health facilities, NGO’s, local communities or cooperatives and owned and run by any of these organisations (Atim 1998; Criel 1998b). It is, however, important to recognise the increasing interest of states in such schemes and attempts by some governments to implement such initiatives on a national scale. State intervention is crucial for a number of reasons. First, it provides a means for achieving the objective of basic health care for all its citizens. Secondly the declining support by the extended family imposes a stronger responsibility on the state to fill the void. Again, there are also practical social reasons that justify state control or administration of non-profit schemes. These include control of cost to consumers, maintenance of quality, provision of a comprehensive package rather than partial coverage and assurance of provision for the poor and indigent.

Furthermore, from a social historical perspective, de Swaan has noted that state intervention in nineteenth century mutual fund societies in Western Europe introduced three unique and novel elements: permanence, national scope and legal compulsion. The state, by virtue of its enormous resources, became the oldest and most creditworthy risk-bearer. It also had the largest encompassing organizational structure. Most important of all, the state could exert effective and legitimate compulsion and thus impose obligatory insurance upon the vast majority of wage earners (de Swaan 1988:149).

However, in the developing country context such as Ghana, state intervention presents its own problems and complexities. First is the problem of a lack of adequate financial resources to implement and support such schemes. Second is that the socie
cultural context of the informal sector makes the application of a generic scheme on a national scope implausible, since communities vary in terms of socio economic and cultural realities. In addition, legal compulsion is untenable because neither the government nor any implementer has control over people’s incomes. Whether people want to pay their premiums, how much they can pay and what type of benefit they want are all issues with the people. Furthermore, state intervention in health care financing through community schemes presents an interesting analytical paradox. While the nation state seeks to implement community insurance schemes as social protection mechanisms, that need has become all the more necessary due to the failure of the state to provide adequate social support for its sick.

Voluntary or mutual co-operation originates from people themselves, and is often informal in nature and intertwined with local culture. In the field of social security, they offer alternatives that compliment what the nation state or bureaucratic formal organisation inadequately provides. Of great significance is that voluntary cooperation is more likely to be accepted, and for that matter effective, where substantial stock of social capital exists. Social capital here can be understood as networks of social relations which are characterised by norms of trust and reciprocity and which lead to outcomes of mutual benefit. In the traditional Ghanaian extended family or village particularly in the past, people trusted those they knew: relatives and neighbours. Society’s social capital was intrinsic in primary social groups in the form of norms of reciprocity and networks of community engagements.

On the basis of the analysis in this chapter, the relevant analytical questions that ought to be asked are: Is whether it is likely or even at all possible for the state to exert, exercise or inspire the necessary social influence or social capital on community members in informal community schemes to achieve a desirable result in the Ghanaian context? Can the state as a formal bureaucratic institution generate loyal feelings of solidarity among its citizens, just as small social units like the family are able to do in informal settings? Furthermore, can the state inspire movement towards the scaling up of informal security mechanisms into formal or market based national schemes?

Views expressed by many community members as well as health staff in the foregoing discussion indicate that they associate public institutions with poor quality services, inefficiency and to a far greater magnitude, corruption. A World Bank study in
June 2000 made a similar observation about public institutions in Africa in general. The problem of corruption, defined simply as the abuse of public office for private gain, deserves some attention here because of its far-reaching social and cultural dimensions. As a concept with wide social, economic and political dimensions, a comprehensive discussion of the subject obviously falls outside the scope of this discussion. A brief reference to relevant aspects will be therefore be made here. First, what are the causes?

As already mentioned, one aspect of the problematic nature of corruption in all public services in Ghana is typified by the common Akan phrase that everybody chops from his job (Obiara didi n'adwuma ho). This association with gastronomy has been found among public institutions elsewhere in Africa. Bayart (1993:242) in his classic comparative study of Africa noted that in Cameroon, they talk of the politics of the belly. "They know that 'the goat eats where it is tethered' and those in power intend to 'eat'". He explains the term "eating" in relation to the concept "politics of the belly" thusly:

> It refers not just to the belly, but to 'politics'.... A man of power who is able to amass and redistribute wealth becomes a 'man of honour'. In this context, material prosperity is one of the chief political virtues rather than being an object of disapproval.

Although Bayart's case referred to the situation of politicians and politics in Africa, it has wider applications for the widespread phenomenon of private gains from public good. Indeed, the fact that the practice finds expression on the shop floor of public health services makes its application here very relevant. Several structural and cultural factors have been identified as encouraging corruption within Africa's public health services and public administrations in general. The relevant ones for our purpose here include the practice of gift giving. Scott (1972) has explained that the survival of the traditional practice of gift giving and granting of services in a society with salaried civil servants constitutes a form of petty corruption. The 'persuasion' of a doctor to take a gift as an assurance for the satisfactory treatment of a client is a case in point.

Again the prevalence of kinship ties, clientilism and other traditional loyalties over modern bureaucratic obligations leads to nepotism and corruption as people in government service allow their family and traditional interests to prevail over those of the state. This situation is worrying to many community members who speak about kinship, friendship and other social ties as the basis of favouritism. They believe these factors will affect how
insurance scheme officials would treat them. Furthermore, the over-centralisation of power in the state also contributes to the phenomenon. In a study of medicine distribution in South Cameroon, Van der Geest also linked the custom of gift giving and most importantly “the overwhelming position of the state as the main source of goods, services and employment” to the socially accepted practices of privately using medicines belonging to the state. Other causes of corruption that have been mentioned by other authors include absence of transparency in public fund management, low salaries and lack of media freedom to expose scandals (Hakeem et al).

How does corruption affect the health services? Or how could it potentially affect financing schemes? Institutionalised or systematic corruption that allows officials or staff of health institutions or health schemes to extort money from patients is socially corrosive. One consequence of the position of the state as the main source of goods, services and employment is the expectation from its citizens that the state should provide them with free services irrespective of their ability to afford the services or not. Ironically, prevailing kinship ties and traditional loyalties nurture the practice in the public sphere and constitutes a major drain on health resources and a potential bottleneck to the social and economic feasibility of community financing schemes. As Van der Geest (1982) observed in relation to the distribution of medicine in South Cameroon, corruption has the tendency to “maintain the status quo in the unequal distribution of health resources and economic resources in general”.

According to a recent Transparency International Report, there are other social consequences of corruption (Global Corruption Report 2001).

[It] adds to poverty as it transfers real resources from official state coffers to a few rich and powerful individuals. Corruption also has a tendency to distort economic factors because those who benefit from it are rewarded for little or no work done, and the costs of projects turns out to be higher than would normally be the case.

To sum up, in the establishment of schemes, public confidence and trust are important in order for them (schemes) to have a strong social and legitimate foundation. However, this legitimacy of the public service in Africa has come under serious challenge due to diminishing public confidence caused by corruption.
When economists and health planners discuss the potential for health insurance in Africa, they commonly ignore or treat these important social issues as piecemeal. For example, in a 1995 World Bank classification by Shaw and Griffin (1995) and later Enser (1997) to explore the potential of social health insurance in Africa, they used a scoring system based solely on supply and demand factors as if the social contexts did not matter. Yet community schemes cannot be seen purely in terms of supply and demand without due regard to the associated social expectations and social environment of those for whom it is planned. Indeed as Criel (1998:78) has rightly noted, a perspective that ignores the social dynamics is ahistorical and incomplete. Yet again where local attitudes and conditions are recognised, there is a tendency to perceive them as static without adequate attention to their dynamic aspects (see Chapter Six).

I wish to emphasise here however that neither the present world nor the formal bureaucratic state meet the social criteria for the functioning of solidarity. In other words, societies today, even the remotest ones in an old indigenous village where economic survival was once based on reciprocity and social capital was central to community engagements are no longer so. Society at present does not stand and fall by the social relationships in the community. Of even greater significance is that in a health insurance scheme, the underlying concept that binds people together is the premiums they pay. The transaction therefore precludes any form of social capital for the individuals involved, although it is probable that where greater stocks of social capital exit in a community the people may be more willing to share risks with others and vice versa. In order for the state to achieve or enhance voluntary cooperation in the community, there must be other ways of building the sense of voluntary cooperation. What the findings in the foregoing analysis suggest is that trust and credibility are very important. Thus, we return to the question: Would people trust the state?

People might be more willing to enter into an insurance arrangement if they are confident they will get the best outcome from the transaction. Hypothetically, a high level of trust is necessary to generate people’s confidence to cooperate voluntarily. Trust might also be necessary for the way people behave in the scheme, such as their tendency towards moral hazard and adverse selection. Under conditions of trust, therefore, people and/or informal social groups are more likely to be co-operative and supportive. A high level of trust is likely to lead to a high level of support, and vice versa. However the corrupt image
of the public service poses problems for confidence and is a critical setback to the ability of the state to scale up informal community insurance schemes to national level schemes. In conclusion, apart from the administrative, institutional, technical and financial limitations, a lack of trust and credibility in the state provides many reasons to not to be too enthusiastic about what the state can achieve through voluntary insurance schemes. The urge or power of solidarity for achieving success rests with the people.