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

Arhinful, D.

Citation for published version (APA):
Summary and Conclusion

Summing up

This study set out to investigate how “the people” for whom health insurance is planned view a formal or state-based health insurance and how they are likely to participate in such a scheme. The purpose has been to provide insights into how a sustainable insurance system can be implemented in Ghana by taking into account the local traditions of mutual insurance or social security. The focus has therefore been kept on the dynamics of both traditional social security arrangements in the Ghanaian society and the emerging health insurance schemes since the driving force behind the ‘new’ insurance schemes are the similar principles of equity and solidarity.

Contrary to official policy assumption and existing empirical propositions that rural households will participate in risk sharing insurance schemes because of their cultural affinity and past experience with solidarity associations, this study has as one of its main findings that the overriding motivation of people to participate is based on enlightened self-interest. Again, the common assumption that tends to associate potential positive
influence of social capital in a community with people’s desire or willingness to share risk and thereby enhance health insurance is questioned. In practice, the nature and social context of community wide or district wide health insurance schemes do not provide opportunities for the accumulation of social capital. Another key finding is that, although people perceive the state as more capable of providing the resources for setting up insurance schemes, they literally do not trust the state as a credible fund holder in view of perceived official corruption, bureaucracy and inadequate monitoring and accounting systems in the public sector.

Polanyi’s analysis of the rise and influence of “the socially embedded market” in The Great Transformation provides a useful starting point for my theoretical perspective. His three basic "principles of social organisation" which are the principle of reciprocity (solidarity networks), the principle of (state) authority (command networks) and principle of the market (exchange networks) explains how the needs of society determine economic behaviour in pre-industrial and primitive economies, whereas in modern market economies the needs of the market determine social behaviour. Following Polanyi, the moral economy theory of James Scott and the political or rational economy theory of Popkin provide the basic arguments for my conceptual framework. Scott embodies the thoughts of Polanyi and argues that the peasant life is geared towards altruistic motives. In Popkin’s rational economy approach, he opposes Scott. He believed that the actions of the pre-capitalist peasant were directed towards individual, self-interested values. Writers after them joined the debate as proponents and opponents reconciled the two viewpoints. De Swaan’s theory of collective action explains the collectivisation process as a result of self-interested behaviour that arises from the realisation of interdependence and external effects of people on one another’s actions. In Chapter One I provided an overview of the community health care financing problems in sub-Saharan Africa by emphasising the point that health insurance there owes its increasing popularity to the problems of health care financing. Community based health insurance schemes are conceived of as a response to the negative side effects of user fees on access to health care for the poor and socially disadvantaged.

In order to situate the discussion in its proper historical context, Chapter Two dealt with the historical developments of public health in Ghana and how it was paid for from the pre-colonial period. That history reminded us to not lose our perspective on the social and political forces that have shaped the service and people’s attitude towards health care
and its payment. It revealed that the public health services available today developed directly from, and are to a large extent reflective of, the curative biased character of the legacy bequeathed by colonial Britain. The financing of that service has gone through a chequered history from nominal fees to fee free health system and back to user fees. That chapter also pointed out that colonial health services were financed mainly through general taxation, with the exception of small fees charged to non-civil servants. Financing the service became a chronic problem after the immediate post independence government of Nkrumah in the late 1950s introduced the free health care policy. In general though, the pattern of public health financing did not change significantly after Nkrumah. The problems of health care financing became compounded after the economic problems of the seventies and the entry of nominal fees into the realm of public health services during the time. The pragmatic introduction of user fees in public health care facilities started in the mid 1980’s, when full cost recovery for drugs when World Bank and International Monetary Fund structural adjustment programmes became a major feature of Ghana’s economic policy reforms in the health sector.

The background information in Chapter Three pointed out that the three community initiatives that constitute the subject matter of this study were all conceived against the backdrop of the foregoing contextual problems. They were initiated or planned with the intention of making health care accessible to poor households, particularly in rural communities, who face chronic payment problems. They thus represent attempts to inject and institutionalise traditional reciprocal solidarity principles into innovative insurance schemes in rural communities. They share certain common features. They are all planned as voluntary but household mandatory schemes, they are based on prepayment of contributions to an identifiable fund and they offer a clearly specified benefit package. The pioneer community health insurance scheme in Ghana, Nkoranza, has never really met its projected membership target since its inception, but it has been able to survive the challenges of an innovative community scheme for a decade. The Dangme West district scheme, which is in a very infant stage, offers another experience in community schemes. It is the first district wide and also public sector scheme that offers both in- and out-patient services from all public health facilities in one district. Its greatest challenge remains how it will be able to meet its in-patient obligations by relying on hospitals in adjacent districts. The NHIS pilot scheme became a stillborn highhanded social engineering programme, but
understanding the path it treaded while the idea lasted fills a useful information gap on what is known about community health insurance schemes planned by the state.

Overall, the critical challenge for the emerging community health insurance schemes is how to secure culturally appropriate ways of creating or attaining larger risk pools beyond familial and small homogenous groups and transforming them into more anonymous mutual insurance schemes. Understanding the dynamics at work in such a process is what the study set out to investigate. In-depth insight into the traditional social security arrangements in Ghanaian society in Chapter Four therefore provided the necessary socio-cultural background for situating the discussion. In the Ghanaian traditional support system, the extended family was the basic unit of social organisation. The system revolved around it and provided the social and juridical framework for long-term reciprocity. Social relations, defined by kinship served, among other functions, the purpose of determining in advance the rights and duties of members during times of emergencies. These relations became customary laws governing groups; they decided social norms relating to property, inheritance, ownership of land and collection of family contributions.

Although it had its limitations, the traditional system was a relatively effective way of assisting the members of society who adjusted their norms to insure their daily survival. There is, however, a common tendency to idealise the past in relation to the present when it is discussed. More significantly, traditional arrangements are disintegrating as a result of the common processes of social transformations discussed by several authors and mentioned in previous chapters that are also taking place in Ghanaian society. Factors that contribute to social disintegration include modernising features of state formation, education, new economic opportunities and aspirations, urbanisation, westernisation, globalisation as well as concomitant changes in attitudes and patterns of consumption as well as radical changes in work roles and social stratification. For example, education and Christianity have provided people with values that fall outside of the traditional organisation of society, while the new economic order has put money at the centre of economic survival. The processes of state formation also led to the addition of a new Western style of social security system to the existing one, which was based on the principles of the market and the state. The continued importance of traditional social security is explained by the fact that the formal social security arrangement has been limited to the formal sector of the economy, thereby leaving out the largest proportion of the population
who earn their livelihood in the 'informal' sector. People suffering the greatest insecurity, such as the aged, the young, women, children and particularly the handicapped are often excluded from this new form of social protection.

Chapter Five opened with the primary empirical findings that a range of contextual factors shape lay perceptions of health insurance in Ghana. Key factors among them are the weakening traditional social security mechanisms, past experience with other community micro-finance schemes, financial and social problems that individuals encounter with the public health system and existing beliefs in the efficacy of alternative medicines. Significantly, both implementers and community people conceptualise and share the value of community-based health insurance in terms of its social protection ability. The prepayment feature is perceived as immensely helpful in enabling rural households to gain regular access to health care. Community people also credit insurance with psychological benefits, as once they are insured, they do not have to worry about money when they need health care. The scheme's contractual nature (composed of a set of formal rules and regulations) is also regarded as more secure and reliable compared to traditional support mechanisms. Altogether, the opportunity to share risk through solidarity with others is perceived as a noble alternative to the disintegrating traditional system.

There are however, popular concerns and worries about community schemes. The different logic of local savings and credit schemes make people sometimes question the redistributive effect of risk sharing in health insurance in which the return of the investment to an individual is not always guaranteed. Some feel it is 'cheating' when 'nothing is offered' for conditions or situations that in their own estimation ought to be covered or when they do not get anything after a long period of not falling ill. This finding suggests that risk sharing is not always understood or accepted by people in the community. The most far reaching concerns that people have about community schemes are related to poor quality of health care and services, which are manifested in poor staff attitudes towards patients, favouritism, cheating and other negative misconduct and malpractice by health staff.

In discussing the relationship between traditional solidarity and mutual health insurance, one question that comes out strongly is whether it is possible to transfer the solidarity as exhibited for example in funerals into mutual insurance. A careful
understanding of the social context and dynamics of the organisation of funerals and how they differ from mutual insurance reveals that the economic appropriation and social accumulation or affirmation of prestige involved in funerals explains why such a transfer is difficult. An important item of economic appropriation is donations offered during funerals. Moreover, the social setting of funerals and donations provide opportunities for collective action to strengthen social identities and prestige through *generalised reciprocity* in the public sphere. On the other hand, the payment of premiums in insurance only provides an opportunity for *balanced reciprocity* where social ties might never be experienced between the individuals involved. This fundamental social difference between funeral support and insurance schemes is an important finding in light of the widespread tendency to cite community support during funerals as an example of the solidarity that could be achieved with health insurance. Another culturally complex difference between funerals and insurance is the emotional aspect of the former. Funerals instantly revive solidarity and mutual assistance, not only among family members, but among the entire community because the emotional sentiment to assist is influenced by the level of precariousness. This is the context within which I interpret Ghanaian people’s differential attitude towards situations such as old age and sickness on the one hand and funerals on the other hand.

Chapter Six took the analysis further and examined the reasons why people join or do not join insurance. Most of what we know about the feasibility of community insurance schemes in sub-Saharan Africa comes from economic studies. One of the dominant themes in those studies is that community members’ willingness to participate and pay into an insurance scheme is based on household or aggregate expenditure surveys or from attitude surveys using contingent valuation analysis. The findings in this study caution against the reliability of findings or predictions derived through such approaches. I produced qualitative evidence, especially in Nkoranza, that shows that the pious and favourable statements people make about their willingness to join community schemes that do not yet exist must be taken with a pinch of salt. They are likely to behave otherwise when the scheme becomes operational. If people know and feel strongly that a certain behaviour or phenomenon is desirable, they are likely to endorse it in the theoretical social research situation but in practice they might reject it. The views of Maame Akosua, a 44 year-old businesswoman from Dodowa, in the Greater Accra region, during one of my
field visits regarding the need to look beyond rhetorical flourishes of people on the field was very incisive:

I live and mingle with people in this community so I can confidently attest that I know them very well. When they first hear about something new, they will tell you that it is good, they like it and they will do it. But I can assure you that when the time comes for them to do it, they will behave as if they were not the same people who previously said they would do it. It does not matter how well you try they will ignore you. That is their attitude and you will see it when the insurance starts. Mark my words.

What then is the rationale for some people to join insurance schemes while others do not? Instead of solidarity being the organising principle of policy makers, the key finding of this study is that the underlying motive for people to join insurance schemes is based on enlightened self-interest. This finding questions the common health policy assumption in Ghana that households will join community insurance schemes because of past traditions of solidarity. It is quite ironic that while every Ghanaian accepts the fact that traditional support networks have weakened because of anibue, (the Akan word which literally means ‘civilisation’), in the context of the discussions of this study, claim is still made on traditions without recourse to the dynamics of change. It is important to underscore the point on the basis of the evidence in this study that the effectiveness of solidarity in the traditional support system was occasioned by social attributes such as the homogeneity, the small size of group and networking within that group. These attributes are lacking or at best are overlooked in the new insurance schemes.

One of the key objectives in the development of community financing schemes is to reduce health inequalities and improve financial access to health care for the poor. I emphasised in Chapter Seven that attempts to focus on the poor began with a problem of conceptualising ‘the poor’. There are at least two levels of poorness: economic and social. In the first sense, the whole of the rural community considers themselves as poor. In their perception, the socio economic consequences of the rural economy affect them equally; incomes are seasonal but they survive. In the second sense, the poor comprise a relatively smaller group of people who are consistently in physical want due to disability, gender or social want. These are often referred to as the poorest of the poor, indigents or paupers. Beyond these economic meaning of the poor, ‘the poor’ in the context of community
schemes has other relative social dimensions. Most people consider themselves poor and unable to afford the premiums not because the premiums are unaffordable per se but due to large family size and the timing of the collection. Even though these arguments are sometimes circumstantial. There are also others who are “poor in mind”; these include all those who do not join because of highly self-interested reasons such as faith that they will not fall sick or belief in indigenous medicine.

Overall, the irony of community voluntary schemes is that the people in greatest need, people like paupers and indigents who struggle for everyday survival, whom the schemes seek to assist, are often the ones least likely to benefit from them. This is because of their inability to pay insurance premiums, which would entitle them to use services at a later period. This attests to the lessons of history that the autonomous provision of care always leaves out the poorest substratum. In 19th century Europe, it took the intervention of the state to create a free health care policy, and bring services to the poor in the course of time. From a policy relevance point of view, the issue of insurance for the poor returns to exemption policies for the poor. The implementation of exemption policies for the poor in Ghana has however, been fraught with problems that include unclear guidelines, a varying social definition of the poor, inadequate funding and delays in reimbursement.

Such problems with the poor lead this analysis to the role of the state in insurance schemes. In a developing country such as Ghana, the role of the state in community health insurance is necessary for providing the political, legal and infrastructure back up for its implementation. In the Ghanaian rural context, policy makers and health planners consider the key role of the state as particularly critical in view of the particular social setting which makes health insurance difficult to implement. Chapter Eight therefore analyses people’s reception to the state as a bursar or fund owner of insurance schemes. The striking findings showed that people look upon state controlled insurance funds with mixed expectations; most were pessimistic. On one hand people perceive the state as having more resources than any other entity to support insurance schemes. They also thought it offered opportunities for a wider coverage in the entire country. On the other hand, there is greater scepticism about the state, which is related to a lack of trust and faith in public officials and politicians concerning “the way things are done in the public sector”. This negative public perception comes out of dissatisfaction and disillusionment with the past performance of state enterprises and public corporations. One of the most frequently cited
examples is the formal social security institution in Ghana, SSNIT. Images of state institutions commonly convey notions of dishonesty, misapplication and embezzlement of funds and a total lack of a culture of accountability. In short, people do not consider the state as credible to hold their funds. In their view even on the shop floor of health care, the collection of illegal fees, bribes and other corrupt activities take place. People therefore attribute their scepticism about state initiatives as due to fears that they might not work. The ill-fated NHIS pilot scheme is a monumental example of those worst fears. In essence, people’s attitudes towards public health institutions are ones of protest against lethargic health staff attitude and poor quality of service.

Interestingly, implementers sometimes conceive the problem of people’s lack of confidence in the state as a phenomenally Ghanaian apathetic attitude towards state owned institutions or initiatives. But significantly, health implementers deride the work culture in the public sector as generally lacking adequate and effective monitoring and systems for accountability. There is some consensus among them that if schemes are run by the state they could inherit bureaucratic encumbrances, inefficiencies, financial mismanagement and corruption from the state. Implementers also explain away the problems as being the consequences of poor remuneration and logistics, a lack of good social amenities particularly in rural areas and the conservative posture of some key policy makers who ought to effect necessary changes to improve the health service.

Is health insurance socially and culturally feasible?

Theoretical implications of findings

It has not been the purpose of this study to test any grand theory about people’s rationale for collective action to solve individual health problems. It is, nevertheless, necessary to situate the findings alongside existing knowledge. How do existing explanations of mutual schemes in sub-Saharan Africa and other places in the developing world help us to explain the findings here?

Analytically, any attempt to understand what impels individuals towards collective action and whether family solidarity could translate or be scaled up into a modern mutual health insurance must of necessity be based on an understanding of the comparative and
functional dynamics of both the traditional (past and present) and the emerging health insurance systems.

To recall some of the issues already discussed in the previous chapters, the effectiveness of reciprocity in the traditional Ghanaian social support system was clearly facilitated by the homogenous nature of the kinship based system. Members of exchange systems knew each other and functionally interacted with one another. The sense of belonging and trust served as a check on one another and prevented abuses. The obligation to share was also supported by existing social sanctions. Thus, those who refused to share did not only stand the risk of not benefiting from similar or alternate provisions themselves, but in the perception of the community risked incurring the displeasure of the social group. People were willing to share in order to avoid tainting their reputation (dinsee) or bringing disgrace (animguasee) upon themselves and their families. This is forcefully conveyed by the Akan proverb that the death of a family member is considered as the death of an individual while the disgrace of a member was seen as shame that infested the whole family. (*Wo busua ni wu a na wo nnew bi, na mmom, se afere a na wo nso wo afere bi*). The urge to share and give to other members rather than keeping ones resources for oneself was a highly valued trait, because the ideal set in that reciprocal system was that of mutual helpfulness and co-operation for the common good of the group of kinsfolk.

Clearly, in the Ghanaian traditional system, the conditions in which people lived and worked would have compelled them to seek cooperation and share what they had with others. Indeed, the economic as well as the inheritance system ensured that family assets were shared among members and remained within the group. Family and community thus relied on each other and shared with each other in order to satisfy their social and material needs. As a consequence, such a system provided an effective motivation to seek cooperation with others. It is significant to observe however, that on the whole, the collective arrangements of the traditional Ghanaian social security system have gone in the direction of decreasing efficiency as the involvement of the scope of social networks has become increasingly weaker. As a result, the internal mechanisms or dynamics of the solidarity networks in the traditional system is not as strong as it used to be. In the area of health care this weakened process has had more untoward consequences for the poor and indigent in society in their ability to access health care when the need arises.
I have emphasized the historical processes involved in the emergence of the schemes analysed in this study. Like most similar schemes in sub-Saharan Africa, they represent an attempt by the state to secure additional revenue in health care for its citizens. In other words, it is a subtle way by which the state seeks to mobilize revenue it cannot directly raise by taxation. It cannot raise this money through taxation because of the highly informal nature of occupations in the vastly rural economy. In this context, health insurance is one way of what Scott (writing in another context) refers to as the ‘state’s attempt to make a society legible... in ways that simplified the classic function of taxation’ (Scott 1998:2).

Secondly, the goal of planners is based on the principle of solidarity. However, unlike the traditional system, which was based on generalised reciprocity, the emerging schemes are based on balanced reciprocity. Members voluntarily contribute at a certain point in time in order to benefit when sick. Sickness is therefore a precondition for benefit. Not all will have their turn, but once sick, help is assured. The main finding in this study however indicates that for the people for whom insurance is planned, the over-bearing motivation to seek cooperation with others is based on enlightened self-interest. This has implications not only for the desire of members to participate, but also for how they behave within the scheme. The idea of a higher self-interested motive therefore implies that people only want to pay premiums or are willing to join the insurance scheme if they feel that it will benefit them rather than cause them to share risk with others. This partly explains the high levels of adverse selection and moral hazard, factors that bear on the feasibility and long term sustainability of such schemes. How do we explain this?

As I pointed out in Chapter One, Polanyi’s thoughts on economy and society in The Great Transformation (1940) provide the lead that has influenced the debates on interpreting the rationale for collective behaviour. His analysis of reciprocity and redistribution shows that other modes of social exchanges with concurrent motives exist in society apart from market exchange. He thus provides a tool for identifying and explaining traditional social protection or security arrangements and the importance of social networks in mutual health insurance schemes. One of Polanyi’s key points regarding the motive for exchange in traditional society is that such traditional systems were altruistic in the sense that they ensured a living out of the resources of the group. Some of Polanyi’s
allies have emphasised this point. Among these, Scott, writing about risk insurance in a South East Asian village, notes:

> It is above all within the village -- in the patterns of social control and reciprocity that structure daily conduct -- where the subsistence ethic finds social expression...All village families will be guaranteed a minimal subsistence niche insofar as the resources controlled by villagers make this possible (Scott 1976:40).

He insisted that although the desire for subsistence security grew out of the needs of individuals, it was thus socially experienced as a pattern of moral rights and expectations.

Romantic as the moral explanations of collective behaviour were, they make sense if considered against the background that they represented cultural solutions to inherent problems in the objective social conditions of their occurrence. Indeed Scott was careful to note, “where they worked... they were not so much a product of altruism as of necessity” (Scott 1976: 6). Platteau (1991) has made reference to Evans-Pritchard (1940) who wrote at about the same time as Polanyi. Of his study of the Nuer, he remarked that, “it is scarcity not sufficiency that makes people generous”. Other writers such as Posner (1981) and Fafchamps (1992) have also explained that extreme precariousness in life in pre-industrial societies often aroused solidarity. How then does the moral economy approach accommodate self-interested behaviour? Like his forebear Polanyi, Scott concluded that two major transformations, capitalism and the related development of the modern state under a colonial aegis radically led to processes that served to undermine the pre-existing insurance system. The transformation of land and labour into commodities for sale brought a profound impact on pre-existing social insurance in pre-capitalist societies.

The fundamental assumption of Popkin (1979), gives much credence to the self-interest motives frequently observed in this study. As Popkin points out, the individual is forever calculating about how to improve his well being or at least maintain his own standard of living, rather than that of the village. In his view, therefore, such an assumption is more powerful than the ‘romantic’ notion of ‘communal man’ who is an altruistic actor or passive subject willing to respect social norms of conduct and moral principles of reciprocity employed by Scott and his moral economy followers. Rather, he argues, transfer behaviour may result from repeated interactions of self-interested individuals or households who share risk or generosity for the sake of future reciprocity.
It is significant to point out that later contributions to the debate have tended to see the two approaches not as being in opposition but when taken together permit an adequate understanding of the rationale for collective action. For example, Posner's (1980:4) contribution to the debate, which he wrote from an economic theory perspective, stated in that much of the 'moral' behaviour in so called pre-capitalist societies including gift-giving and reciprocal exchange were "adaptations to the pervasive uncertainty and high information costs" that prevail in such a system. Both explanatory approaches are therefore contextually and historically situated.

An attempt to understand the over-bearing presence of self-interest provides insight into the dilemma of solidarity in insurance. The reason for a bigger group to make the scheme more effective through the benefits of economies of scale is also the reason that makes self-interest more prominent than the solidarity principle. How does this happen? An adequate risk pool of health insurance even at the community level must go beyond the family or proximate individuals in order to become a viable 'mutual insurance company'. The propensity therefore is that the widening process in a community or district wide "mutual insurance company" also has the effect of loosening or weakening the bonds of the web of social connectedness as the group widens and becomes more heterogeneous. The tendency is that people in the heterogeneous group become freer of social group pressure to conform to group norms, as they would do in traditional morally obligated associations. Accordingly, the social solidarity networks that compel conformity do not in practice exist, or function to obligate members merely to share in written legal contracts for the insurance. In effect achieving a higher level of integration in a wider insurance arrangement as de Swaan has noted involves a higher level of dilemmas. On one hand a larger and more heterogeneous membership potentially enhances the risks sharing capacity and costs across the group. On the other hand, the processes of expansion impede mutual control and diminish common solidarity (De Swaan 1988:7-8).

I have also argued that the character of the widening insurance group has consequences for the influence of social capital. The potential for social capital in the group diminishes because from the point of view of social connectedness, it does not enhance solidarity since it is the premium people pay more than anything else that connects them. Paying the premium through third parties does not provide the opportunity for group interaction nor accumulation of social rewards such as prestige, recognition and patronage.
The social ties in insurance through premiums collected by a third party in this sense are merely synonymous with what Putnam (1995) calls ‘tertiary associations’.

The overbearing significance of self-interest as a motivation for collective action has well been expounded by De Swaan in his analysis of the processes of how and why people come together in collectivised arrangements to deal with deficiency and adversity that appeared to affect them separately. Based on a case study of Europe and the United States in the 19th century, he shows how in these societies the collectivisation process extended from the bourgeois to the working class and then to the entire society. Using the theory of the civilising process of Norbert Elias, he explains that this was achieved as a result of the realisation of the growing interdependence of people and the external effects of their actions upon others. He points out that:

The constraints upon affective and impulsive behaviour were not imposed from outside, but adopted.... They became social constraints to self constraint... as part and parcel of one’s person” (De Swaan 1988:248).

About workers’ mutual societies in which these processes were highly visibly exemplified, he observes that “the propensity to save epitomises the tendency to subordinate momentary affects to more distant goals, the orientation to more distant future, constant self constraint and the deferral of gratification” (De Swaan 1988: 249-250). He points out that one underlying development essential to the process is the acceptance of risk aversion, which implies the subordination of momentary affects for the sake of more distant goals. People accept this by their reliance on their capacity for self-constraint to restrain spending.

By way of analogy, the process described by de Swaan is synonymous to that which takes place in the traditional, morally obligated, Ghanaian social security system. People’s desire for future cooperation in that system was compelled by social constraints to cooperate in case of future adversity. The obligation to cooperate was achieved through the pressure people exerted on one another, by self restraint based on the recognition of their interdependence and the external effect of their actions on others. The unwritten code of that system was, in the parlance of a common Ghanaian Akan saying: “Those who offer help to their neighbours in need also receive help when they need it”. (Se wo ye ma obi a, na se asem to wo a, yeye ma wo so.) Social constraints in insurance schemes do not possess the same force of moral obligation. This situation may be attributed to the fact that
it is practically less easy for autonomous public and/or voluntary institutions to exert the specific type of social pressure that members of families or traditional mutual associations used to encourage one another to refrain from spending in case of future adversity.

Applying the same explanatory model here, the process could be described as one of self-constraint to cooperate. In this respect, the emerging voluntary insurance schemes studied here and their counterparts in other countries in sub-Saharan Africa introduce another theoretical paradigm to the collective process in mutual insurance: In the social context of contemporary health insurance schemes, participants are under *self-restraint towards self-constraint*. Typically the immediate and most frequent reason for incapacity for self-constraint to restrain spending is lack of adequate resources. In the midst of too much poverty, people would naturally pay less heed to unforeseen risk aversion because under such circumstances, the *necessity* to survive *here and now* becomes more pressing and leaves little room to put aside money for a future event. But a more socially poignant argument based on the evidence adduced in this study is the lack of an effective moral binding force to impel coercion, or what Atim (1999) describes as the ‘social movement dynamic’. In the light of the foregoing, the clear challenge to emerging insurance schemes is to identify conditions under which bonding social forces and self interest can be harnessed to the benefit of schemes.

In summary, Polanyi's theory about the three forms of integration, reciprocity, redistribution and market, provides a tool to situate the analysis in an appropriate historical framework to reveal the dynamics of the past and present in the social security arrangements in Ghanaian society. By emphasising that reciprocity and redistribution are institutionalised with the help of a social organisation disciplined by general principles of behaviour, the theory also enables us to highlight the centrality of culture and society in human concerns. It also endeavours to pay attention to them when looking at social security or health insurance arrangements. His emphasis on cooperation and reciprocity as a function of custom, law, magic and religion gives us a sense of the tendency to romanticise traditional social security arrangements. His attention to the effects of the emergence of the market on the ability of traditional arrangements to remain functional helps us to explain increasing self-interested behaviour in mutual insurance.

When we consider the range of insecure situations in Ghanaian society, such as funerals and sickness, we see that people clinging to the moral economy or engage themselves
in rational attitudes according to the context and general situation in which they find themselves. Scott and Popkin and those following them also reinforce the tools that permit an adequate consideration of how people order their social needs in the practical situation. By emphasising self-interest as the sole motive for collective behaviour, de Swaan’s theory of collective action provided a tool for interpreting the dynamics of increasing self-interest in mutual insurance with a social face. An important utility of the theory for our analysis is that it helps us to understand the dilemmas of voluntary insurance provisions. The fact remains that autonomous provisions do not necessarily provide a complete answer to the problems with health care access of the entire society, and especially not to the rural poor. The theory also enlightens us about why intra family solidarity does not transform into intra family solidarity in a society like Ghana. What then are the policy implications from the foregoing discussion?

Policy implications of findings

Social context of insurance:

Traditional social support mechanisms might have been efficient and were the only means by which Ghanaian society met its social security needs in the past. Indeed for a vast proportion of the population it remains the only source of social security. In implementing any new schemes it is expedient and necessary to take cognisance of the operating principles by which they work in order to learn from them. However, any attempt to apply the principles in the formal context must take into account the dynamics of the context in which they worked. In this respect, it is important to remember that traditional social protection arrangements functioned better as small groups and communities. The good counsel of a former Deputy minister of health, Dr. Adibo, is worthy of recollection here:

Let’s start small and expand. By our nature we are good at looking after small things.
Our towns are small, buildings are small and we look after small things better than big ones.

Another contextual issue related to the above is that population growth, market penetration and state formation are factors that limit the functioning of traditional social security. This has come about as a result of the opening of new and varied avenues for social and economic mobility and the growth of the market that tends to encourage the overt
expression of individualistic propensities and aspirations. This further dissolves cooperative ties and disentangles individuals’ interest from those of the social group. The penetration of market values has also had the effect of loosening the web of traditional social ties so people are at liberty to conform to the pressure of the group to which they were previously closely bonded.

*Popular participation*

In setting up community health insurance schemes, I believe there is no challenge more important than the building up of trust and confidence of people in it. A lot of this depends on the extent to which people believe that the implementers or officials involved are honest and trustworthy. One way to build confidence is through effective community participation.

One of the preconditions to bear in mind in the design is that contexts differ. The attitudes even within one district towards insurance in village A might run opposite to those of community B because of deep seated beliefs about the efficacy of indigenous healing and practices. The diverse and transitional nature of Ghanaian society therefore makes multiple approaches to the provision of health insurance essential for achieving a near-universal or at least wider coverage of the population. In order to increase the potential for the success schemes, and particularly those in the rural informal settings, there is a need to pay heed to the particular social setting with due regard to what is feasible in each specific locality. In light of this, the design ought to take into account not only the social characteristics of the locality but also the expectation and fears of various stakeholders. Stakeholders who need to be brought into the picture from the beginning include traditional authorities, the churches, various trades and professional associations as well as the health staff. It is important to remember that health insurance is not socially neutral. The interests of the private not for profit sector as stakeholders must also be of prime concern, particularly against the background of the important role they play in health care in rural communities. It is also prudent to ensure that the input of ministries of other sectors such as local government, employment and manpower development and youth is brought to bear on any plans for optimum benefits. Most of all, community structures such as traditional and local authorities and church leaders as well as bodies and associations including teachers and other ‘professional’ groups ought to be involved. It is important to
appreciate and make explicit what the respective expectations and fears of all shades of opinion and representations in the community are and take these into consideration.

*Solidarity, risk sharing and self-interest*

The dominant self-interest motive in peoples' decisions to join health insurance suggests that the concept of risk sharing and its financial implications need to be well addressed. The discussion indicates that people are not sufficiently aware that there is an element of self interest in participating in insurance for a period of time even if one does not get sick. There is therefore the need to begin the dissemination of information that will make people appreciate, understand and accept the collective meaning of risk sharing. When people think of insurance in terms of its short-term benefits they will stay away because they might consider themselves as low risk or low priority relative to other household demands. Insurance should be better explained by planners in terms of its merits given the needs and circumstances of the present, instead of the pious statements about solidarity and the past.

Practically, what the dominant self interest motive in people's attitude towards insurance schemes means is that it is very essential not to underestimate the expectations of people for whom the scheme is planned in the design and implementation. Other researchers have noted the importance of paying attention to acceptable quality of care to motivate people to participate in community health financing schemes such as availability of prescribed drugs and medical supplies, friendly and expedient staff and the provision of expected laboratory investigations\(^1\). I wish to add here that because the concept of risk sharing is not well-understood or accepted, community participation by local leaders in the decision making of the scheme from its very outset could motivate community interest. Regular consultations and dialogue with them must take place in order to be able to take into account their point of view of the various stages of implementation. This would assure that important policy and operational decisions are based on a compromise acceptable to the community and the operations are transparent to them. In the rural context this is of critical importance inasmuch as it may increase people's preparedness to patronise the schemes, ensure more openness and build trust and confidence.

\(^1\) See in particular Arhin, D.C. 1995: 87.
The poor and insurance

It is common knowledge that in mutual insurance schemes the poor are better off if everyone contributes to the fund. In reality however, the poor stand the greater disadvantage of not benefiting, in view of their inability to pay the premiums. The critical policy issue in insurance remains: how to extend the provision to the poor and needy? The effectiveness of the schemes in protecting the poor must therefore factor into them the effectiveness of exemption mechanisms. In Ghana there is already an exemption policy for certain categories of patients. One way of securing and strengthening the policy is through channelling funds meant to subsidise indigents directly to insurance schemes to strengthen their financial base and their fund management. This begins to address the issue of the implementation of exemption policies in a manner that will benefit the poor. There is need to integrate the existing exemption policies into insurance but before then there is a need to study exemption practices in the past in order to design effective means of factoring them into insurance schemes to provide support for the poor.

The role of the state

The main purpose of insurance in Ghana, is to improve access to otherwise deprived and vulnerable populations. Politicians also know that one way to court public goodwill is by influencing initiatives aimed at improving health infrastructure and access by the people. High profile political clout is therefore usually part of the rules of the game in ongoing efforts to implement community schemes. Two unintended negative consequences are likely to emanate from this. Political propaganda about insurance tends to send wrong signals to people about their own responsibility in insurance with respect to payment of premium. Some people live in the false expectation that health insurance, particularly in the present context, which is targeted at removing an existing ineffective payment system, is perceived as a ‘free lunch’. Secondly, politicised messages about health insurance tend to send different signals to people across the political divide. People who do not support an existing government in power that is championing insurance might stay away from it. I emphasise that it is important for governments to be aware of this in order to maintain a reasonable distance about what statements and promises they make about health insurance to the people.
Monitoring systems

The need for comprehensive monitoring systems from the onset cannot be overemphasised. Monitoring should be targeted not only at the technical aspects such as coverage and financial data; social impact should also be tracked. Indeed, carefully designed schemes may even have a greater potential in improving not only access to health care but also quality of care and ultimately the efficiency of the health service. Issues such as kinds of people for whom access has improved and to what extent the quality of care issues such as staff attitude and clinical interactions have improved in the perception of consumers are all important for the sustainability of any scheme and therefore need to be monitored. Measuring social impact is better done through observations of routine clinical and pharmacy encounters than rigid quantitative procedures.

Concluding remarks

Community health insurance is seen as the answer to the problems of health care exclusion suffered by the vast numbers of poor in rural Ghana. From people’s perspective this view is often based on two main assumptions. In the first place, it is believed that the prepayment principle of risk sharing will make it easier for poor families to pool funds together during favourable times when they are more capable and more likely to afford the required premium. Secondly, the principles of solidarity and risk sharing are considered familiar and in tune with time tested traditional support mechanisms of Ghanaians. But will people really participate and give health insurance the same attention and loyalty as they use to do in family support arrangements on the basis of the foregoing assumptions?

The exploration of the issue in this study has unearthed a number of challenges about such official optimism.

The idea of community insurance schemes appears quite popular and its potential tends to be over-romanticised. In my view, these high expectations and romanticisation is the result of the fact that when policy makers discuss health insurance, they tend to look only at the benefit of the underlying solidarity principle while ignoring its dynamic aspects. Those dynamic aspects that I have focused on in this study reveal that the dilemma of the collective process is highly present in community financing schemes in the Ghanaian rural
context, just as they were in 19th century Western European and American attempts to provide health care for all. It should be obvious that irrespective of the cultural antecedents of rural households to solidarity, their links in insurance become weaker as the group becomes more and more heterogeneous. This actually limits the romanticised benefits of solidarity in community insurance schemes, a fact that policy makers are overlooking.

Without suggesting that the contexts are similar, the social dynamic lessons of history in the genesis of social health insurance in Western Europe and the United States again indicate that voluntary solidarity took on other features when it involved people who did not have common social ties such as kinship or convictions. When that happens, solidarity is ‘reduced’ to solidarity of interests because as far as the members are concerned, the motive for sharing risks in a group whose members have no common ties in the conventional sense is driven by enlightened self-interest. This view is consistent with those of Dunning et al. (1992). Writing about choices in health care in the Netherlands, they believed that that ‘solidarity of interests lies at the bottom of most voluntary insurance schemes’. It explains the dominant self-interest rationale of people in the present Ghanaian context, which in the decade old Nkoranza scheme is typified by the high degree of adverse selection, moral hazard and the generally low subscription rates.

To conclude, issues of contextual importance need to be taken into account in the socio-cultural feasibility of schemes. The findings in this study have shown that no matter how culturally sensitive schemes are perceived, people tend to be ambivalent towards the state as a fund holder because it is not seen to be accountable to society at large. Again insurance still does not provide a remedy for the poor who cannot afford any premiums that are charged. Certainly the magnitude of the problem of poverty actually suggests that only an integrated approach that also improves rural incomes would be the most adequate solution to the problem of social exclusion in health care. But in the light of the foregoing, a response to what is socially and culturally feasibility could be that effective initiatives are likely to be those in which the state plays only a facilitating role. An appropriate response would also have to consider that the greater part of the operational matters should be fostered through support and mediation with preferred organizations and stakeholders from within communities. The message should also emphasise that it is in the self-interest of people to join insurance schemes even if they do not see the immediate benefit because the
long-term benefit would accrue to someone they know. In summary, by focusing on micro level practices, this study has given some insight into issues of socio-cultural dynamics and feasibility of community health insurance in Ghana as a contribution to the intellectual search that is needed to deal with the problems of health care financing in sub-Saharan Africa.