POVERTY AND ACCESS TO HEALTH CARE IN GHANA: THE CHALLENGE OF BRIDGING THE EQUITY GAP WITH HEALTH INSURANCE

PhD THESIS SUBMITTED TO THE SCHOOL OF GOVERNMENT, FACULTY OF ECONOMIC AND MANAGEMENT SCIENCES, UNIVERSITY OF THE WESTERN CAPE

In fulfilment of the requirements for the degree, Doctor of Philosophy in Public Policy and Administration

by

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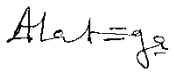
DECLARATION

I, Kennedy Alatinga, declare that, apart from the normal guidance provided by my supervisor and the literature that has been duly referenced, this work represents my own independent research and it has not been submitted to any other university in the world.



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Kennedy Alatinga Prof. John J Williams

(Student) (Supervisor)

DEDICATION

Dedicated to the Alatinga family

ACKNOWLEDGMENTS

I thank God Almighty for the health, wisdom and strength He has bestowed on me and for having brought me to this level. May His name be glorified forever and ever, Amen.

I am highly indebted to my dear parents, Mr and Mrs Alatinga, for the selfless sacrifices they have made to bring me up, and the wonderful love and support they have shown to me throughout my years of schooling. May God grant them long life to enjoy the fruits of their labour. To all my siblings, I say, thank you very much for your kind support. May the good Lord keep us united, in love, always.

I thank my wife sincerely for all her support. You are the most hardworking woman in the world. Thank you for keeping the family together while I was on this academic journey. I also thank my little daughters for all the support I received from them. Their enquiring minds and continuous questioning as to when I was coming home, or when I was going to bring them to South Africa, kept me focused on finishing the work as quickly as possible in order to be reunited with them. Thank you so much, Webonga, Wetoga-amo and Awedoba. I thank Wisdom, my nephew and dear friend for your caring and love. You have always called to find out how I was doing with my studies. You also updated me on your academic progress, and that challenged me, as your role model, to work harder.

I am highly indebted to my supervisor, Professor John J Williams, for the exceedingly thorough and rigorous guidance I have received from him during the course of preparing and writing up this thesis. His comments, suggestions and criticisms have always been illuminating and these suggestions and criticism greatly improved the quality of this thesis. Thank you very much, my dear Professor, friend and brother.

Finally, I thank DAAD for the scholarship they awarded me and that enabled me to pursue my Ph.D. Without this funding it would have been difficult to come this far. I

thank the staff of the School of Government and ISD for all the support throughout my stay in UWC. To you all, I say; “God bless”.

LIST OF ABBREVIATIONS

CBD – Central business district

CMEPSP – Commission on the Measurement of Economic Performance and Social Progress

CSDH – Commission on Social Determinants of Health

DFID – Department for International Development

FGDs – Focus group discussions

FMC – Free maternal care

GDP – Gross domestic product

GLSS – Ghana Living Standards Survey

GNP – Gross national product

GSS – Ghana Statistical Service

IFAD – International Fund for Agricultural Development

IMF – International Monetary Fund

KMO – Kaiser-Meyer-Olkin measure of sampling adequacy

KND – Kassena-Nankana District

KNMHIS – Kassena-Nankana Mutual Health Insurance Scheme

MDGs – Millennium Development Goals

MMR – Mixed methods research

MT – Means test

NDC – National Democratic Congress

NDPC – National Development Planning Commission

NDSS – Navrongo Demographic Surveillance System

NHIA – National Health Insurance Authority

NHIF – National Health Insurance Fund

NHIS – National Health Insurance Scheme

NLC – National Liberation Council

NPP – New Patriotic Party

PCA – Principal components analysis

PMT – Proxy means test

PNDC – Provisional National Defence Council

PPAs – Participatory Poverty Assessments

PWR – Participatory Wealth Ranking

SAPS – Structural Adjustments Programmes

SES – Socioeconomic status

SSA – Sub-Saharan Africa

SSNIT – Social Security and National Insurance Trust

UER – Upper East Region

UHC – Universal health coverage

UK – United Kingdom

UNDP – United Nations Development Programme

USA – United States of America

VAT – Value added tax

WHO – World Health Organization

ABSTRACT

This study addresses the issue of the low participation in or enrolment of the poor in Ghana's National Health Insurance Scheme (NHIS). The low enrolment of the poor in the NHIS is attributed to the difficulty in identifying who qualifies for exemptions from paying health insurance premiums. In an attempt to address this problem, the purpose of this study was, therefore, to develop a model for identifying very poor households for health insurance premium exemptions in the Kassena-Nankana District of Northern Ghana in an effort to increase their access to equitable health care.

In order to achieve this purpose the study adopted a mixed methods research design. Twenty-four focus group discussions (FGDs) were conducted with key informants and poor people to gather the data required for the study. These FGDs were recorded, transcribed and analysed. In addition, 417 interviews were conducted with household heads. The analysis of the data provided the following information: The FGDs provided a rich understanding of the communities' perceptions of poverty. The communities then suggested criteria in terms of which very poor households could be identified for the purpose of insurance premium exemptions. Some of the suggested criteria included, among others, the lack of own seeds to sow during the rainy season, insufficient food and unemployed widows with children. Even so, the FGDs highlighted the problem of identifying very poor households, as the village elite hijacks this exercise. On the other hand, the household survey established that demand and supply side factors, including the unavailability of health facilities, distance to the nearest health facility and affordability, constituted obstacles to the accessing of equitable health care. A logistic regression model estimated that income, marital status, educational status, the number of times without food and gender are very good predictors of household poverty status. The model accurately predicted that 12.5% (52 households) were very poor and qualified for insurance premium exemptions. These results are very useful as regards understanding poverty

from the perspectives of the communities themselves, thus facilitating the development of a model that is both relevant and acceptable to the communities.

It is important to note that the results also shed light on existing inequities in access to the NHIS. Based on the results of this study, very poor households could be identified and granted insurance exemptions. The results of the study do not only contribute to bridging the inequity gap in terms of access to health care but also make a significant contribution to the achievement of the objectives of the NHIS and, ultimately, contribute to sustainable development in Ghana. By logical extrapolation, this study proffers significant insights to the rest of Africa and beyond.

KEY WORDS

Poverty, equity gap, access to health, health insurance, health policy, Kassena-Nankana District, Navrongo, Ghana

Chapter One

Health Insurance Policy in Ghana: The Challenge of Identifying the Very Poor

1.0 Introduction and Background

Identifying the indigent or very poor in an effort to increase their access to health care is a key objective of Ghana's flagship social protection policy – the National Health Insurance Scheme (NHIS). However, since the implementation of the NHIS in 2003, the scheme has struggled to increase the participation or enrolment of the very poor in an effort to increase their access to equitable health care. The NHIS aim of increasing the access of the very poor to health care is consistent with the achievement of the Millennium Development Goals (MDGs), particularly in view of the fact that good health, as has been argued, is associated with the socio-economic development of nations (Sen, 1999; Bloom, Canning, & Sevilla, 2001; Gyimah-Brempong, & Wilson, 2004). In fact this contribution of good health to development is so important that both professionals and academics are exploring it. Nevertheless, access to health care is not automatic for all and particularly not for the poor and very poor people who need health care the most.

Relevant literature indicates that socio-economic status (SES) is an important determinant of access to health care and of health status (Peters, Garg, Bloom, Walker, Brieger, & Hafizur Rahman, 2008; Ezeoke, Onwujekwe, & Uzochukwu, 2012; Odeyemi & Nixon, 2013; Etim & Edet, 2014). For example, Peters et al. (2008) argue that one effect of poverty is that poor people have less access to health care as compared to those who are better-off, with this resulting in growing disparities in access to health care in society. According to the UNDP (2013), health service provision has been heavily skewed in the favour of the better-off who are, in any case, more likely to have good access to the public as well as private health care services as compared to the poor.

In order to eliminate these disparities and inequities in access to health care and health status, nations at all stages of development have renewed their efforts to

extend universal health coverage (UHC). UHC may be defined as extending access to adequate health care for the entire population at an affordable price (Carrin & James, 2004; WHO, 2013). It may be that the efforts to extend UHC are in pursuance of the *right* to health (WHO, 2006).

Health insurance has been widely recognised as a potential tool for bridging the equity gap in access to health and attaining UHC (Durairaj, D'Almeida, & Kirigi, 2010; Akazili, Gyapong, & McIntyre. 2011; The World Bank, 2012; Amporfu, 2013). It is argued that the attainment of UHC is possible in all countries on the basis of just social relations of power because the achievement of universal and equitable health coverage is socially determined (Commission on Social Determnants of Health (CSDH), 2008; Navarro, 2009). For example, Thailand's success in extending UHC to its poor and disadvantaged population is largely attributed to both strong political commitment and to active civil society engagement (Oxfam International, 2013).

In the pursuit of bridging the equity gap in access to health care, eliminating disparities in the access to health care and attaining UHC, Ghana implemented the National Health Insurance Scheme (NHIS) in 2003. The NHIS aims to attain UHC for all persons resident in the country, ensure equity in the access to health care for the poor and vulnerable groups and protect these groups against financial risk (Government of Ghana, 2012). In particular, the NHIS exempts the very poor from paying the annual health insurance premiums by providing them with government subsidies.

1.1 Problem Statement

The problem or challenge of identifying the poor has been well documented in the relevant literature (Nolan & Whelan, 1996). Nolan and Whelan (1996) argue that the major challenge facing poverty research is how best to identify the very poor, especially in the informal sector. The UNDP (2013) suggests that the people with the

greatest access to health care are formal sector workers, who are able to finance their health care needs from their annual salary contributions. Stierle, Kaddar, Tchicaya, and Schmidt-Ehry (1999) argue that the assessment of poverty is extremely difficult for conceptual and technical reasons. Stierle et al. (1999) further suggest that research results as regards adequately identifying the very poor and devising mechanisms in terms of which to improve their access to health care have tended to be somewhat misleading. This may be because the research methodologies used to identify the very poor have either not been based on the poor's own definitions of poverty or are simply not clear. In support of these views, Morestin, Grant, and Ridde (2009) argue that several exemption experiences have had ambivalent results in terms of the access to health care services of the poorest. Morestin et al. (2009) claim that several evaluations of these exemptions experiences have noted a lack of clarity in both the criteria and the processes used to identify the very poor. Thus, this study represents an example of an attempt to deconstruct poverty based on the existential experiences of people in the Kassena-Nankana District in Ghana and, therefore, to identify the very poor.

In the specific case of Ghana, for example, notwithstanding the health insurance premium exemption policy for the very poor, the commitment to fighting poverty and addressing health inequities has not been matched by relevant community informed criteria for identifying the very poor. For example, Act 650, which established the NHIS, stipulates a set of four criteria with which the very poor (indigent) may be identified.

A person shall not be classified as very poor or as an indigent under a district health insurance scheme unless that person

- is unemployed and has no visible source of income
- does not have a fixed place of residence according to standards determined by the scheme
- does not live with a person who is employed and who has a fixed place of residence and

- does not have any identifiable consistent support from another person (Government of Ghana, 2003, Act 650).

A close examination of these criteria reveals that they appear to be too exclusionary. For example, apart from the first criterion, which appears both practicable and relevant, the second and third criteria may apply only to "homeless" people who wander about on the streets without a fixed place of residence. In addition, within the rural context, it is extremely common to find very poor people living together as a household. It is in this regard that Dixon, Tenkorang, and Luginaah (2011) describe the criteria as too stringent and as excluding too many people in need. Similarly, Aryeetey et al. (2013) argue that, a decade after the implementation of the NHIS, these criteria rarely succeed in identifying the very poor because practically nobody qualifies for exemption because of the strict nature of the criteria. Thus, these criteria could best be described as 'dead on arrival' as there is certainly a disjuncture between development policy planning and policy implementation in relation to the NHIS.

Against this background, the National Development Planning Commission (NDPC, 2009) called for an improvement in the exemption policy in a bid to cater adequately for the health needs of the very poor in Ghana. In this vein, Dixon et al.(2011) argue that ensuring that the pro-poor agenda of NHIS is met would depend on the ability of the poor to participate easily and equitably in the national health insurance scheme. The World Bank holds the same view, advocating a reassessment of the indigent or very poor exemption policy in order to ensure the enrolment of the indigent in the NHIS (The World Bank, 2012).

The issue of exempting the very poor from paying insurance premiums gives rise to the following questions: Who really are the very poor? Who identifies them? How many of the very poor are covered by the NHIS? By what criterion or model are the very poor identified? Addressing these questions is precisely the focus of this research study. Available data suggests that 64% of the richest are enrolled (insured) in the NHIS whereas 29% of the poorest people only are enrolled in the NHIS

(NDPC, 2009). In particular, the available evidence further indicates that only 2.3%, 1.4% and 4.2% of the very poor were covered by the NHIS in 2009, 2010 and 2011 respectively (National Health Insurance Authority, 2009, p. 28; 2010, p. 18; 2011, p. 17). The extremely low coverage of the very poor by the NHIS is a matter of grave concern because the Ghana Statistical Service (2007, p. 11) estimates extreme poverty to be approximately 18% in Ghana.

The NDPC (2009, p. 31) further indicates that 72% of insured people consulted a medical doctor/assistant when ill, while 39% of those without health insurance consulted either pharmacies or traditional birth attendants. Similarly, whereas approximately 91% of urban women gave birth in health care facilities, 57% of rural women only gave birth in health care facilities. For example, 52% of women gave birth in health care facilities while 48% women gave birth at home in the Upper East Region while, in Accra, 100% of women gave birth in health care facilities (NDPC, 2009, p. 34).

In support of these views, Oxfam International (2011) claims that the poor who are uninsured in Ghana treat their ailments at home, including visiting unqualified drug dealers and risking childbirth at home without professional health care. These inequities in access to health care are depicted in table 1.1.

Table 1.1: Percentage of Women who Delivered either at Home or in Hospital, were/were not Assisted by a Doctor and their Insurance Status in 2008

	Home		Government hospital		Doctor-assisted delivery		Forgo treatment	
Wealth Quintile	Insured	Uninsured	Insured	Uninsured	Insured	Uninsured	Insured	Uninsured
Lowest	65%	88%	32%	11%	7%	1%	3%	20%
Second	43%	65%	38%	21%	3%	8%	5%	10%
Third	28%	50%	57%	35%	12%	12%	2%	7%
Fourth	13%	24%	74%	54%	18%	13%	3%	3%
Highest	5%	5%	66%	72%	28%	36%	Nil	5%

Source: World Bank (2012, pp. 22–24)

As depicted in table 1.1, alarmingly, 88% of uninsured women in the lowest quintile gave birth at home, whereas 5% only of uninsured women in the highest quintile gave birth at home. Similarly, whereas 32% of insured women in the lowest quintile gave birth at a government hospital, 66% of their counterparts in the highest quintile gave birth at a government hospital. The table also shows that 11% only of uninsured women gave birth at the government hospital. In addition, while a doctor assisted 7% of insured women and 1% of uninsured women in the lowest quintile to give birth, a doctor assisted the deliveries of 28% of insured women and 36% of uninsured women in the highest quintile. Above all and perhaps, more terrifying, is the fact that, whereas approximately 20% of the very poor who are not insured forgo treatment when they are ill, a mere 5% of the richest forgo treatment when they are ill. Even more revealing is the fact that not one of the people in the richest quintile forgo treatment when ill (The World Bank, 2012, pp. 22–24). In light of these statistics, it is patently clear that a huge inequity gap exists with respect to the access

to health care of the poor in Ghana. It is therefore essential that the very poor be identified to ensure that the state provides health services for them. This is the rationale underpinning this study.

1.2 Research Objectives

Based on the discussion above, this study seeks to achieve a number of objectives. Firstly, the study seeks to contextually define the very poor based on the communities' perceptions of poverty. Secondly, the study seeks to explore the reasons motivating households or individuals either to enrol or not to enrol in the National Health Insurance Scheme (NHIS). Accordingly, the study seeks to analyse how the NHIS is promoting equity in the access to health of the very poor after a decade of existence. Finally, the study seeks to develop a model for identifying very poor households for the purpose of health insurance premium exemptions in Ghana.

1.3 Definition of Key Concepts

Before proceeding it is important to deconstruct the major concepts that underpin the study. The major concepts considered include poverty, the very poor or indigent, health equity ad health access. Deconstructing these concepts will, I believe, more clearly and logically enhance the understanding of the relationship between poverty and access to health care. This is imperative as these issues are of topical research and policy importance.

1.3.1 Poverty

Definitions of poverty abound, depending on the socio-cultural context, the person or institution defining the concept and the rationale for the definition. Arthur and Shaw (1978) argue that basic needs such as access to adequate food, shelter (housing), health care, education and security are of primary importance for human survival in all societies. Arthur and Shaw, therefore, argue that, if any or a combination of these needs is not met, this is an indication of poverty.

In the same vein, Peters et al. (2008) argue that poverty is multidimensional and extends beyond just the concept of deprivation of income. Peters et al. further suggest that public health and access to clinical health services, in addition to food, water, sanitation, assets, and access to knowledge and education are necessary conditions for both good health and poverty reduction. Despite the fact that income is an important determinant of poverty and is considered in this study, income alone is insufficient to define poverty in the context of this study. People's perceptions and definitions of poverty may result from multiplicities of interlocking factors. For example, Sen (1999, 2009) argues that, quintessentially, poverty comprises a deprivation of basic capabilities – defined as the basic opportunities and freedoms at the disposal of individuals to live the kind of life they have reason to value. These capabilities are proxied and measured by either access to or a lack of access to health and education. Sen (1999) argues that access to good education and health care directly improves the quality of life of an individual as well as increasing the individual's ability to earn income and be free from income-poverty.

In support of the multidimensional view of poverty, the United Nations Development Programme (UNDP, 2013) asserts that poverty includes the following three dimensions, namely, health, education and living standards. For example, the UNDP (2013) contends that a mother's education level is more important to child survival than is household income. The multidimensional view of poverty highlights access to the basic needs, which are of prime importance for human survival in all societies. This study used this multidimensional concept of poverty. This conceptualisation of poverty makes sense, as the ultimate aim of the study is to develop a model for identifying very poor households in an effort to increase their access to health care.

1.3.2 The Very Poor

Consistent with the multidimensional nature of poverty as discussed above, Peffer (2003, pp. 1–2) defines very poor households or individuals as those who live in extreme poverty, namely, "poverty so severe that their basic needs for adequate nutrition, potable water, minimally decent housing and clothing, and basic health

care and sanitation are not met on a continuing basis". Peffer (2003, pp. 1–2) asserts that, globally, 1.2 billion people are very poor. Sachs (2005) concurs with Peffer's view when he states that extreme poverty means that households are not able to meet their basic needs for survival. Sachs further argues that very poor households are chronically hungry and are unable to access health care. Similarly, the Ghana Statistical Service (2007, p. 11) defines the very poor as "those whose standard of living is insufficient to meet their basic nutritional requirements even if they devoted their entire consumption budget to food". In light of these views, Ridde et al. (2010, p. 1) defines the very poor as those people with a "sustained incapacity to pay for minimum health care". It is this category of poor households or individuals that this study seeks to identify.

1.3.3 Health Equity

While attaining health equity is a key objective of many health systems, the concept of equity may mean different things to different people (Goddard & Smith, 2001). The construct of equity evokes an idea of fairness and social justice (Rawls, 1971, 1999). The use of the term *social justice* is likely to evoke the following questions: Justice of what? Justice from whose perspective? For example, the neo-liberalists (advocates of the free market mechanism of the invisible hand of supply and demand) may see social justice as the benefits or profits delivered by the market (Harvey, 1996). More explicitly, to the neo-liberals, social justice is best arrived at through competitively organised, price-fixing markets in which entrepreneurs are entitled to the profit produced by their endeavours (Harvey, 1996). Thus, according to the neo-liberal school, the developmental state, defined as a state which is proactive and responsible, develops policies and priorities in line with the needs of the people, and promotes equality of opportunity while protecting the less advantaged from social and economic risks, should be rolled back. According to the (UNDP, 2013, p. 4), the character of the developmental state, as explained above, is based on "long-term vision and leadership, shared norms and values, and rules and institutions that build trust and cohesion". In other words, neo-liberalism, as an

ideology, calls for rolling back the developmental state in the provision of health care and is often promoted by the international financial institutions (IFIs), notably, the International Monetary Fund (IMF) and the World Bank. The policy implication is that the state should leave the provision of essential primary or basic goods such as health and education to the free-market mechanisms based on the forces of demand and supply. However, the neo-liberal concept of social justice may also appear unjust to the poor and the less disadvantaged in society who may be unable to access health care as a result of their poverty.

This study draws on Rawls's construction of social justice (Rawls, 1971). In relation to equity, the Rawlsian (1971) philosophy of social justice argues that justice is the first virtue of social institutions. Thus, Rawls's theory of social justice aims to achieve equality of access to resources, including health care, and to ensure that each person in society has a voice in deciding the distribution of resources according to need and irrespective of a person's social status. Rawls makes particular reference to fair and equal access to primary goods: "those goods that anyone would want, regardless of whatever else they wanted" (Robeyns & Brighouse, 2010, p. 1). Equal access, as used here, implies the elimination of differences, marginalisation or discrimination as a result of either socio-economic status or geographical locations (Nussbaum, 2011).

An illustrative example of a state of inequality within the context of this study is the degree to which health policies have been urban-biased over time in Ghana (Twumasi, 1981). The overconcentration of health resources in the urban areas to the neglect of the rural areas provides an example of inequality because these rural areas have been marginalised. I hasten to add, however, that inequality may, under certain circumstances, be considered just, but only if this inequality was created to benefit either the less advantaged or the very poor in society. For example, Rawls's Difference Principle states that social and economic inequalities should be tolerated only when they are expected to benefit the disadvantaged in society (Rawls, 1999). In other words, given the already urban-biased nature of health policy in Ghana, if

the government strategically redistributed health resources to the rural areas of the country, especially in northern Ghana, then the inequality which would be created by the distribution of these resources to the already poor areas would be considered socially just. The application of this notion of social justice to equity in access to health care suggests that individuals or groups of individuals should have both equal opportunity to as well as equal access to health care, irrespective of their socio-economic status. Anything contrary to this ideal translates into a state of injustice. This is the interpretation of justice or injustice as adopted in this study.

Based on the Rawlsian conception of justice as explained above, Sen (2002) argues that health is a social consideration and, for that reason, health equity is a consequential feature of the justice of the social arrangements in society. Sen further suggests that health equity is not concerned only with health but that it also relates to the broader issues of fairness and justice in social arrangements, including economic allocations, focusing appropriate attention on the role of health in human life and freedom. Equity in the achievement and distribution of health is, therefore, embedded in the broader understanding of social justice (Sen, 2002). Thus, in the context of this study, health equity is interpreted as the fair distribution and use of health care services by all segments of the population, irrespective of socio-economic status (SES). In other words, "equity in health implies that, ideally, everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided" (Whitehead, 1991, p. 220). This is the notion of equity implored throughout in this study.

1.3.4 Health Access

According to Thiede, Akweongo, and McIntyre (2007), access to health care is a multifaceted construct which, essentially, entails the freedom to use the health care services without any barriers. Thiede et al. argue that health access may be operationally defined using three dimesions, namely, availability, affordability and acceptability of health care. In this study, health access is broken down into demand

and supply side factors. Demand side access factors refer to individual or houshold demographic, economic and socio-cultural characteristics that either enhance or constrain access to health care. On the other hand, supply side access factors relate to the provision of health care by the heath delivery system with reference to the distribution of health care facilities, availability of health care, including adequate and skillful health staff, and the quality of health care, amongst others. Based on these demand and supply dichotomies, access to health care may be examined in terms of four dimensions, namely, financial accessibility or affordability, availability of information, availability or geographical accessibility and quality of health care. These dimenstions of health access are elaborated upon in the next chapter.

Having operationalised the major concepts, and having also established the existence of inequities in the access to health care in Ghana in the preceding section 1.2, it is important at this stage to examine the origin of these health inequities in the health care delivery system. Accordingly, the next section discusses the origin of both poverty and the existing inequities in access to health care, how the health care needs of the very poor have been addressed in the context of health policy planning and health care provision in Ghana.

1.4 The Origins of Poverty and the Existing Inequities in Access to Health Care in Ghana

In order to appreciate the origins of poverty and the existing inequities in access to health care in the current health care regime, this section examines the history of health policy development and health care provision in Ghana from the colonial days to the present. This historical account of health policy development is, I believe, extremely important for understanding present human conditions with respect to access to health care. Present human conditions of life are, invariably, reflections of the human past, based on interactions and experiences; that is, the human past is in the present. In other words, it is not possible to understand where we are in the quest for an equitable and just health care system unless we first understand where we

have been in the quest for such a system. Based on her notion that justice warrants the need for historical engagement, Young (1990, 2009) argues that there is a need to contextualise justice in a more dynamic, historical and institutional terms in order to focus on the structural forces that generate inequalities and injustice. Supporting these views, Soja (2010) argues that social action in life is contingent on a spatio-temporal sociality of human existence. I should hasten to add that, even though history is extremely important in enhancing our understanding of the past, history is not destiny and, thus, public policies are able to transform bad history into good history and vice versa. In other words, history and initial conditions are surmountable. According to the UNDP, "no country remains a prisoner of history for long if it wants to break out" (UNDP, 2013, p. 65).

In an attempt to proceed both systematically and coherently, I first examine the colonial health policy and how it catered for the health care needs of the very poor. I then discuss Nkrumah's free health care policy from 1957 to 1966. In addition, the reintroduction of the user-fee policy in Ghana between the periods 1967 and1979 is examined. The institutionalisation of user-fees in Ghana from 1983 to1999 is also discussed in this section. The section ends with an investigation into the implementation of the National Health Insurance Scheme (NHIS) in 2003 and how it enhances access to health care in the current health care trajectory. The colonial health policy is now examined.

1.4.1 Colonial Health Policy and Access to Health Care

The historical development of modern health care policy in Ghana (formerly, the Gold Coast) dates back to the 1920s. According to Anyinam (1989), the formal planning of the health care services in Ghana started in the 1920s under the leadership of Governor Gordon Guggisberg and when the colonial government established an effective medical policy which instituted free health care for the European officials. The provision of health care services was initially limited to colonial administrators, officials of mining companies, merchants and other

Europeans. According to Anyinam (1989), the health services were later extended to include 0.02% only of the African population of which the majority worked in the civil and public services, for example, the police (Arhinful, 2003).

In 1930, a proportional user-fee system was introduced in the Gold Coast for people seeking health care in the public facilities. In terms of this system, lower fees were charged for the lower income groups, mainly formal sector employees. This proportional user-fee system, however, did not clearly address informal sector workers and how their incomes were assessed for the application of the proportional user-fee policy.

It is also interesting to note that, under the colonial health policy, medical officers were allowed to charge private professional fees despite the fact that they worked in government health facilities (Konotey-Ahulu, Ocloo, Addy, Bamford, & Ennin, 1970). Because of this system, by 1954, patients seeking health care at government facilities were required to pay dispensary fees and the cost of any drugs dispensed as well as professional fees, thus creating financial barriers to access health care for the poor (Konotey-Ahulu et al., 1970).

However, in an effort to increase the access of the very poor to health care, the colonial health policy did exempt the very poor from paying any forms of user fees at all at the government health facilities (Konotey-Ahulu et al., 1970). However, the policy of free health care for the very poor was never accompanied by any clear criteria for identifying these very poor people in the interest of the effective implementation of the policy. The determination of who were very poor and who were not was left to the personal interpretations of the colonial medical staff. For example, Konotey-Ahulu et al. (1970) indicate that the decision as to whether any charges were either made or not made was left to the discretion of the medical officer in charge of the dispensary, subject to the discretion of the Director of Medical Services. This practice of according interpretative leverage to medical officers remained in force until 1957 when Ghana gained independence from Britain (Konotey-Ahulu et al., 1970).

Geographically, the colonial health policy was urban biased. According to Twumasi (1981), the colonial health policy was, in essence, urban-oriented. Twumasi argues that, despite the fact that the colonial health policy discouraged the use of traditional medicine, the formal health facilities were concentrated in a few urban towns only, where the colonialists were engaged in commercial and mining activities whereas the rural areas were without modern health facilities. In support of this claim, Anyinam (1989, p. 532) points out that the "colonial health policy was characterised by a gross regional maldistribution of health facilities". Substantiating his claim, Anyiman indicates that, for example, of the 39 hospitals in the country in 1927/28, 34 (87%) were located in the more urban and resource-rich, southern parts of the country, leaving 13% only in the more rural, resource poor, northern parts of the country.

It would appear that the availability of health care followed the same trend. Anyinam (1989, p. 532) asserts that, by 1953, approximately 90% of hospital beds were in the south, with population:bed ratios ranging from 478:1 in the south to 35000:1 in the north. However, Arhinful (2003) points out that even the few health facilities in the urban towns routinely experienced overcrowding at hospitals and dispensaries, inadequate medical staff and a deterioration in the sanitary conditions.

In addition, missionary activities also contributed to the historical development of health care policy in Ghana. For example, Arhinful (2003) points out that, unlike the colonialists, the missionaries established their facilities in the rural areas in their desire to win converts to Christianity. To this end, the contribution of the missionaries to health care delivery in Ghana started in 1931 when the Basel missionaries established the Agogo hospital in Ashanti Akim in the south. In 1943, the Catholic missionaries built the Breman Asikuma hospital, also in the south and, in 1951, the Jirapa hospital in the north and the Worawora hospital in the south. These mission health facilities operated on a cost recovery basis. For this reason, the full cost of drugs was passed on to the users although exemptions were granted to the very poor. In view of the fact that the missionaries operated in the rural settings, their

ability to identify the very poor was enhanced by the fact that, at the rural level, people were likely to know one another.

It is important to point out that it was not only the colonial health policy that was urban-biased but also the colonial economic development policy framework in general. The unjust and uneven development created by the colonial economic development policy heralded structural forces, which were linked to the demand for capitalist accumulation. For example, the colonialists forcibly recruited the young labour force from the northern areas of Ghana to work in the mines, harbours, and railways in the southern parts of the country in order to facilitate the exploitation and export of the natural resources, such as gold, to the west (Konadu-Agyemang, 2000). This forced labour recruitment was facilitated by the local community leaders who were financially compensated by the colonial administration (Akurang-Parry, 2000).

It is worth noting that the practice of recruiting the young labour force from the north suggests that no attention was being paid to the development of educational and health facilities in these areas. This situation, I think, had far-reaching economic and socio-cultural development implications for both poverty and access to health care for the people in the north of the country. From the economic perspective, forcibly removing the economically vibrant labour force meant that only the weak, and the old women and men remained of the families affected. It is, thus, logical to assume that removing the productive labour to work in the south resulted in poverty for the affected families in the north because the unproductive labour force left behind would have found it difficult to engage in any viable economic activities in order to provide for the family needs. Socio-culturally, the young labour force which had forcibly moved to the south may have suffered from a sense of anomie or alienation in their new environment as a result of which they may have been unable to accumulate the assets which are crucial in helping people to build up livelihoods and reduce household vulnerability to poverty (Moser, 1998).

In short, the colonial economic and health policies both created a type of spatial injustice between the urban and rural areas of the north, in particular. These policies

appear to have impacted adversely on the overall health of the people of the Gold Coast. For example, the United Nations (1995) reported that, at the dawn of independence in 1957, life expectancy at birth in the Gold Coast was a mere 44 years.

1.4.2 Free Health Care Policy for All, 1957–1966

Soon after independence in 1957, Dr Kwame Nkrumah, the first President of Ghana, made it a priority both to eliminate poverty and to improve the health service delivery in the country. This is borne out by the following statement:

> "My first objective is to abolish from Ghana poverty, ignorance and disease. We shall measure our progress by the improvement in the health of our people. The welfare of our people is our chief pride, and it is by this that my government will ask to be judged" (Rooney, 2007, p. 123).

Based on his vision to create a prosperous society for all, Nkrumah sought to radically transform the Ghanaian economy based on socialist ideals and egalitarian principles. To this end, his first major policy action in the health sector was to immediately abolish private practice in the government health facilities, especially in hospitals where the practice was common. Accordingly, on 1 September 1958, Nkrumah's government withdrew "the privilege of private practice from all medical officers and dentists" (Konotey-Ahulu et al., 1970, p. 12). Consequently, for the first time in the country, patients, whether Ghanaian or non-Ghanaian, stopped paying professional fees in the government health facilities (Konotey-Ahulu et al., 1970).

With the abolition of private fees in the government health facilities, financial access to health care was improved because the hospital charges were drastically revised downwards. For example, as regards midwifery services, women giving birth in government hospitals and who spent ten days and more in hospital, were charged £1 only as a daily maintenance charge. In addition, children aged 16 years and below were treated free of charge while government employees, public and civil servants

and all workers were entitled to free medical care at the out-patients clinics (Konotey-Ahulu et al., 1970).

By 1965 Nkrumah had instituted a policy of virtual free health care for all persons living in Ghana at all public health facilities. According to Arhinful (2003), this free health care policy was financed mainly from the state's substantial tax revenue as a result of the flourishing cocoa prices on the international market and huge $481 million foreign reserves (Rooney, 2007). The main objective of the free health care policy was to prevent households or individuals from falling into poverty as a result of paying out of pocket for health care. Accordingly, hospital fees and all charges were abolished at all government health facilities, thus enabling even the very poor to access care at the formal health facilities.

Nkrumah's free health care policy was also aimed at addressing the problem of urban bias in the geographic distribution of health resources and, thus, there was a massive expansion of health facilities across the country with a focus on the rural areas. For example, between 1960 and 1966, thirty-five new rural health centres were established (Senah, 1989, cited in Arhinful, 2003, p. 44).

However, despite these attempts, Twumasi (1981) is emphatic that the problem of the unbalanced distribution of health resources was not resolved because health care was still not readily available to those who needed it in the most rural areas. Twumasi (1981, p. 150) argues that, despite the fact that 23% only of the population lived in the urban areas then, but 76% of all doctors practised in the urban areas. Twumasi also claims that the health professionals who emerged in the newly independent country wielded considerable power as regards where they would work as a result of their prestige, scarcity, and their social contacts with the political decision-makers. Anyinam (1989, p. 536) substantiates this claim, indicating that, by 1960, there was one physician to every 21,600 patients in the rural areas while the ratio of nurses to patients was one nurse to every 5,430 patients. Thus, most rural dwellers relied on the use of traditional medicines, herbs and concoctions in order to treat their ailments.

Deductively it may, thus, be argued that the gains arising from free financial access to health care were negated by the ongoing unbalanced geographical distribution of health facilities and also the unavailability of health staff in the rural areas to administer to the rural people. Twumasi (1981) argues that infant and maternal mortality rates were very high in the rural areas. The World Bank (2012, p. 17) argues that, in 1960, under-5 child mortality was as high as 218 per 1,000 live births. Consequently, life expectancy had increased only marginally to 46 years from the base year of 44 years in 1957.

However, despite these short-comings, together with the criticisms that Nkrumah's free health care policy was "over-generous" and was leading to a financial drain on the tax revenue (Konotey-Ahulu et al., 1970, p. 13), the policy remained in force until 1966 when Nkrumah's government was toppled in the first military coup in the country. This coup ushered in the military government of the National Liberation Council (NLC) led by Lt. General Ankrah (Konotey-Ahulu et al., 1970).

1.4.3 Reintroduction of User Fees and Access to Health Care, 1967–1979

In what appears to be a sharp contrast to Nkrumah's free health care policy, Ankrah's military government reintroduced user fees for both drugs and prescriptions dispensed at public health facilities. This was akin to the colonial health policy. In the 1967/68 Budget Statement, the government's policy on hospital charges declared that any patient who visited a government hospital would be required to pay a small fee for his/her prescription, and that in-patients who received treatment in luxurious wards would be required to pay higher fees (Konotey-Ahulu et al.,1970).

As was to be expected, the reintroduction of user fees was greeted with a public outcry. However, this outcry did not stop the military government from implementing the policy. In 1969, a civilian government, under Dr Kofi Busia, took over the reins of power. In a dramatic fashion, Busia's government immediately

suspended the collection of hospital fees in terms of a circular dated 16 October 1969 until further notice. This directive was clearly in response to the public outcry that had characterised the reintroduction of user fees under the previous government (Konotey-Ahulu et al., 1970, p. 19).

Ironically, two years later, user fees were reintroduced by Busia's government through the Hospital Fee Act of 1971, making the payment of hospital fees, albeit a small amount, in public health facilities official to cover the cost of drugs. The aim of reintroducing user fees was to "reduce excessive demand and contribute to recovering part of the costs of curative and essential services" (Arhinful, 2003, p. 45).

The official introduction of user fees in public facilities in 1971 appears to have been ill-timed because the Ghanaian economy was, at that time, less economically robust in terms of its foreign reserves as compared to the economic success of the 1960s. General tax revenue had shrunk significantly while per capita gross domestic product (GDP) declined by a total of 19.7% from 1970 to 1980 (Hutchful, 2002, p. 6). In addition, tax collection dropped from 18.6% of GDP in 1970/71 to 6.5% in 1984, one of the lowest ratios in Africa (Hutchful, 2002), while the collection of domestic sales tax fell from 1.7% of GDP in 1970/71 to 0.4% in 1982.

Most importantly, however, the health budget declined from 7.8 to 6.1%, while the overall size of the state budget dwindled from 18.3% to a mere 10.1% of the gross national product (GNP) between 1972 and 1982 (Hutchful, 2002, pp. 29, 128). These figures were not only alarming but they also had serious implications for both poverty reduction efforts in the country and access to health care. A feeble economy with a dwindling tax base suggested a situation where social safety-net interventions for the poor and the less privileged in society would also be reduced and this, in turn, would impact negatively on the indigence and poverty levels in the country.

This was, in fact, the case in Ghana. In 1975, it was estimated that approximately 75% of the Ghanaian population was poor, with poverty concentrated in the rural

areas – 85% of the rural population was poor compared with 53% of the urban population (The World Bank, 1990). In 1975, regional poverty levels were 92.36, 90.28 and 88.46% in the less resource endowed and more rural regions of the Volta, Northern and [1]Upper Regions respectively as compared to 49.51, 62 and 68.76 in the more resource endowed and more urbanised regions of Greater Accra (the national capital) and the Western and Ashanti regions in the South respectively (see fig. 1).

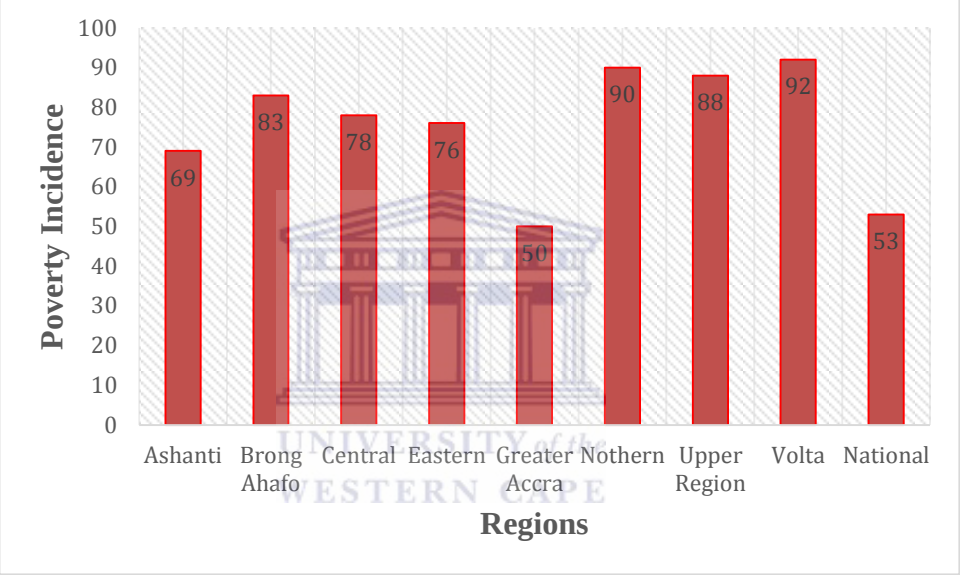

Figure 1.1: Regional Incidence of Poverty in Ghana, 1975

Source: World Bank (1990)

There is no doubt that the economic "hard times", as depicted in figure 1, impacted on the state's ability to provide adequate health care to the population, on the health-seeking behaviour of the population as well as on the health outcomes. The state lacked the foreign exchange required to procure essential supplies for the health facilities and this resulted, in turn, in acute shortages of drugs, medical supplies and equipment and the widespread poor quality of health care. The situation regarding the availability of health facilities and personnel was no different, as there were only

[1] Upper Region was the name given to the Upper East and West Regions prior to their separation in 1983

118 health posts and centres in the country. In addition, there were also 667 physicians only in the country, with more than 80% of them being based in the urban areas. For example, Accra, the national capital, was served by 37% of the physicians, communities within Accra with a population of 20,000 were served by a further 30% of the physicians, while only 33% of doctors only served the remaining 82% of the country's health needs (Anyinam, 1989, p. 532). The situation was exacerbated when the poor economic conditions led to an exodus of doctors and other professionals from the country (Arhinful, 2003).

Consequently, the use of traditional medicine and self-medication was common, especially in the rural areas, with some rural dwellers simply not seeking care when they were ill. Over 30% of the children in the Northern, Upper East and Upper West regions who had contracted malaria did not seek treatment at all, while less than 10% of children with malaria did not seek care in the more urbanised regions of the south (Ghana Statistical Service, 1988, p. 75; Anyinam, 1989). In addition, mortality rates, though better than the 1960 figures, were still significantly high. Overall infant mortality was estimated at 100 per 1000 live births during the period 1973 to 1977 while under-5 mortality for the period 1978 to 1987 was 24% higher in the rural areas than in the urban areas. Infant mortality was also 103 per 1000 live births in the Upper East, West and Northern regions, whereas it was 58 per 1000 live births in Accra. During the period under review, the percentage of physician-assisted deliveries for women in Accra was 16%, 10% in Kumasi and a negligible 0.9% in all the three regions of the north (Ghana Statistical Service, 1988, p. 69).

The government attempted to address the issue of these huge regional disparities in access to health care together with the high poverty levels in order to lessen the burden of drug costs on patients. Accordingly, the government paid 70% of the cost of drugs for patients in towns and cities in the Accra, Ashanti and Western regions, 90% of the cost of drugs for patients in towns and cities in the Upper, Northern and Volta regions, and 80% of the cost of drugs for patients in the rest of the country.

Significantly, the government reiterated its commitment to providing free health care for the poor and vulnerable. As a result, very poor people, children under 18 years old (50% of the population), and pregnant women were exempted from paying any form of fees at all public facilities. However, the medical officers in charge of public facilities again had discretionary powers to decide who should or should not be exempted from user fees (Konotey-Ahulu et al., 1970).

While these subsidies or fee waivers and exemptions appear to be benefits for the already poverty-stricken population, there is however, no evidence in the literature to indicate how effective the implementation of these subsidies was in order to inform current policy decisions with respect to subsidising the cost of health care services. It is, nevertheless, possible that they may have worked to some extent as, by 1977, life expectancy had increased to 53 years (UN, 1995). However, the general economic stagnation of the Ghanaian economy continued throughout the 1970s and, by 1979, this situation had prompted yet another coup d'état, headed by Ft Lt Jerry John Rawlings, on 31 December 1981. This coup d'état ushered in the government of the Provisional National Defence Council (PNDC) (Arhinful, 2003).

1.4.4 Institutionalisation of User fees and Access to Health Care, 1983–1999

The PNDC government of Rawlings took over the reins of power with a zealous commitment to salvaging the stagnating economy from the abyss in which it had found itself. Consequently, under the auspices of the World Bank and the IMF, the government instituted economic reforms, known as structural adjustment programmes (SAPs), in 1983 in an attempt both to revitalise the weak economy and to establish a sound macroeconomic framework for stabilising the economy. As pointed out in the previous section (section 1.3.3), both the World Bank and the IMF are enthusiastic promoters of the neo-liberalism, which is driven primarily by profit seeking motives. Accordingly, both the World Bank and the IMF seek to privatise essential goods and services, such as health, education and water. Consequently, the SAPs sought both the liberalisation of the Ghanaian economy and also the reduction

in spending on the social sectors – education and health. It is, thus, not surprising that, under the auspices of the World Bank and the IMF, the first major reform in the health sector involved cost recovery, with the introduction of nominal user fees and other charges in public health facilities in 1983 (Hutchful, 2002).

However, by 1985, the economic situation in Ghana had worsened, and the Ministry of Health (MOH) was barely able to import medical supplies for the various health facilities in the country. In the midst of these socio-economic difficulties, approximately one million Ghanaians were deported from Nigeria in 1983. This, in turn, caused severe food shortages (Senah, 2001). The price of a gallon of petrol, which had been ¢12.5 (old Ghana Cedis) in 1981, skyrocketed to ¢235 a gallon in 1988, while the price of a gallon of kerosene increased from ¢5.00 to ¢170 during the same period. The cost of a minimum nutritious diet was estimated to be ¢168 while the daily minimum wage was ¢112 (Anyinam, 1989, p. 539).

This situation significantly affected health care policy in Ghana. User fees, known as "cash and carry", were effectively introduced and institutionalised in 1985 in public health care facilities on a full cost recovery basis for drugs and other services. The institutionalisation of the user fee policy was backed by the enactment of the Hospital Fee Law, Legislative Instrument (LI) 1313 in the same year (Arhinful 2003, pp. 45–46). The beneficiaries of health care were now forced to pay themselves at the point of use of the health services. The major objective of the cash and carry system was to recover at least 15% of the recurrent expenditure with the aim of improving quality, providing essential medicines and medical supplies, improving staff efficiency and deterring the wasteful use of scarce health resources (Arhinful, 2003).

Despite the high poverty levels, the official introduction of user fees significantly increased the cost of health care. For example, a specialist consultation fee, which had been ¢25 in 1983, increased to ¢200 – an increase of approximately 88%. In addition, adult patients in wards with catering services paid ¢100 instead of ¢10 – a 90% increase – while, in 1985, casualty wards and polyclinics, which had been

offering free services, now charged ¢5 for adults and ¢2.5 for children of up to 12 years (Anyinam, 1989, p. 539). Anyinam (1989) argues that the implementation of the SAPs did not focus sufficiently on the poor and the vulnerable in society, despite the high levels of poverty in the country. Of the total population, 56% was estimated to be poor in 1987/88 with this figure increasing to 61% in 1988/89 (Ghana Statistical Service, 1988, 1989).

The increased cost of health care led to a drastic decline in the demand for and use of modern health services among the poor and average households. Waddington and Enyimayew (1989, 1990) argue that the increases in user charges in 1985 led to a sharp decline in health care utilisation during the second half of 1985 – from 4,581 consultations in the second quarter of 1985 to 1,095 for the final quarter. Similarly, Nyonator and Kutzin (1999, p. 337) assert that "health facilities in the Volta region of Ghana had achieved a kind of 'sustainable inequality', with fees enabling service provision to continue, while concurrently preventing part of the population from using these services". Another adverse effect of user fees was that malnourished children, who had been receiving regular medical treatment, stopped attending the clinics because their mothers could not afford the new fees (Anyinam, 1989). However, perhaps the worst consequence of the user fees was the fact that, in the maternity ward at Korle-Bu Hospital, the nation's premier teaching hospital, "some women absconded, leaving their babies behind" as a result of their inability to pay for the cost of care (Senah, 2001, p. 87).

In response to the decreased utilisation of health services imposed by the financial barriers, exemptions from paying user fees were granted to pregnant women, children under five years old, people aged 70 years and above, the very poor and other vulnerable groups (Anyinam, 1989). However, in practice, the exemption policy hardly worked because there was no consistency in the interpretations of the exemption guidelines. The determination of who was poor enough to be exempted was not clearly defined by the exemption policy (Britwum, Jonah, & Tay, 2001).

Consequently, most of the people who should have been exempted were, in fact, not exempted (Waddington & Enyimayew, 1990).

However, despite the fact that the government had exempted the very poor and other vulnerable groups from paying user fees, the problems of the geographical accessibility of health services and the availability of health care continued to play a role in limiting access to health care. In terms of health facilities, by 1985, there were 12 hospitals, nine health centres and ten health posts in Accra, three hospitals and two health centres in the Upper East region, and four hospitals, one health centre and eight health posts in the Upper West region. During the same period, the physician–patient ratio was one physician to every 6,355 patients in Accra, one physician to every 142,801 patients in Kumasi and one physician to every 107,840 patients in both the Upper East and West regions (Anyinam, 1989, p. 534). However, the overall infant mortality rate (IMR) had reduced from 100 per 1000 live births in 1977 to 77 per 1000 live births in 1988, although it remained at 103 per 1000 for the Upper East and West Regions in 1988.

By 1992, the military government of the Provisional National Defence Council (PNDC) led by Jerry Rawlings came under intense pressure, both locally and internationally, to return the country to civilian rule. Accordingly, the PNDC metamorphosed into a political party – the National Democratic Congress (NDC). Multiparty elections under the parliamentary system were held in 1992. The NDC contested the elections and won in December 1992.

It may be that the implementation of the SAPs began to bear fruits in terms of economic stability and growth at the macro-level during the NDC's early days in office. For example, by 1991/92, the national poverty levels had declined from 61% to 51.7% and, by 1998/99, the estimated poor population in Ghana was 39.5% (Ghana Statistical Service, 2007). However, these national statistical averages tend to mask the true picture of the poverty situation in Ghana. As depicted in figure 2, an examination of the poverty levels in the North and the South does not show any significant differences as compared to 1975.

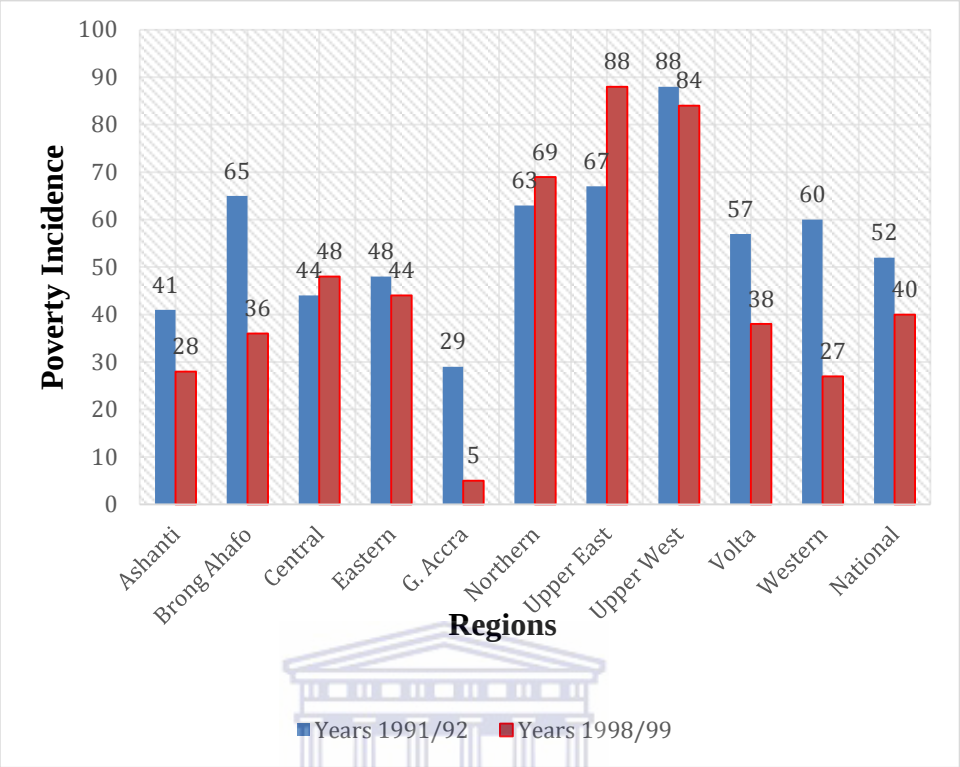

Figure 1.2: Poverty Trends in Ghana, 1991/92 and 1998/99

Source: Patterns and Trends of Poverty in Ghana 1991–2006, Ghana Statistical Service

Figure 1.2 reveals that the highest incidences of poverty were still concentrated in the three regions in the North – similar to the situation in 1975 as shown earlier. In fact, in the Northern and Upper East regions poverty levels had even worsened, increasing from 63.4 to 69.2% and 66.9 to 88.2% respectively.

The NDC government embarked on a Medium-Term Health Strategy (MTHS) in an attempt to improve the health status of the population. The MTHS centred on three levels of health care delivery – the primary, secondary and tertiary levels of health. By 1995, the health policy had been based on the MTHS to promote greater equity in access to health. To this end, the MTHS promoted community participation in the delivery of health services (Canagarajah & Ye, 2001). During the period, 1992 to

1998, the number of district and others hospitals increased to 215 and the health centres/clinics increased to 1,758, bringing the total number of health facilities in the country to 1,973. Of this number, 80% of the facilities were located in the urban areas and 37% in the rural areas. There were 22 hospitals and 271 health centres/clinics in Accra, five hospitals and 75 health centres/clinic in the Upper East Region and four hospitals and 51 health centres/clinics in the Upper West Region (Canagarajah & Ye, 2001, p. 26). The urban facilities were also more likely to be better equipped than the facilities in the rural areas. In the ten regions of Ghana, more than 75% of the urban population lived relatively close to the nearest health facility – defined as people who have to walk for 30 minutes or less to reach the nearest health facility. However, in the Upper East, West and Northern Regions, 15% only of the rural population lived less than 30 minutes away from the nearest health facility (Canagarajah & Ye, 2001, pp. 25–26).

Canagarajah and Ye (2001, pp. 25–26) further report that, in 1998, of a total of 1,204 physicians in the country there was one physician to every 14,482 patients in Accra and one physician to every 57,591 patients in the Upper East Region. On average, one nurse attended to 734 patients in Accra while, in the Upper East Region, one nurse attended to 1,868 patients and one nurse to 1,507 patients in the Upper West region. Asenso-Okyere et al. (1998) argue that these developments affected the health-seeking behaviour of the population in three ways. Firstly, because of the long distances they needed to travel, the use of self-medication was pervasive among all classes of people. Secondly, people generally delayed in seeking care at a health facility, often waiting until the illness was considered severe. Thirdly, the use of herbal medicine was also widespread because patients felt that the herbal practitioners possessed the patience required to treat them. Patients claimed that, at the hospital, as soon as a patient started talking about his/her sickness, the doctor started writing out the prescription. In addition, the herbal practitioners accepted payments in kind or in instalments (Asenso-Okyere et al., 1998). It is reported that,

of the 56% of population that did not seek care for illness or injury, the poor constituted 63% of that population (The World Bank, 2012, p. 21).

How do these developments translate into health outputs and outcomes? According to Asenso-Okyere et al. (1998), it would appear that the collection of user fees led to improvements in the quality of services, including the availability of drugs, and this resulted in increased outpatient attendance. For this reason, health outputs as measured by the number of outpatient visits were estimated to be 15,616,488 nationally. Regionally, outpatient visits were 2,965,816, 555,390 and 402,704 for Accra, the Upper East Region and the Upper West Region respectively. The IMR declined from 77 per 1000 live births in 1988 to 66 per 1000 in 1993 and to 57 per 1000 in 1998, while the under-5 mortality also showed a downward trend; decreasing from 155 in 1988 to 119 in 1993 and to 108 per 1000 in 1998.

However, despite these relatively modest health indicators, the user-fee policy, which spanned the 15 years during which the SAPs were implemented and the 18 years of the PNDC/NDC regime, namely, 1981 to 1999, became notoriously unpopular among the Ghanaian populace. The user-fee policy was perceived as extremely inequitable as it was based on the individual's SES (ability to pay). Consequently, campaigning on the promise of affordable and equitable health care in 2000, a leading opposition party, the New Patriotic Party (NPP), used the issue of affordable health care as its flagship message, and promised to abolish user fees if it came into power. The NPP did win the keenly contested elections in a runoff in December 2000 and took over the reins of power in January 2001. In fulfilment of its campaign promise, the NPP then implemented a set of health reforms that replaced the user fee system with a National Health Insurance Scheme (NHIS) in Ghana.

1.4.5 The Implementation of the National Health Insurance Scheme (NHIS) and Access to Health Care

The political importance accorded the issue of user fees in the 2000 general elections implies that the implementation of the NHIS, an important, home-grown policy initiative, merits attention. The NHIS was established by an Act of Parliament (Act 650) in 2003, and it passed into law as legislative instrument, LI 1809, in 2004 (Government of Ghana, 2004). The NHIS, which aims to extend universal health insurance coverage to all persons resident in the country and to ensure equity in health care coverage, is celebrated as a promising model for social protection. The NHIS is currently Ghana's flagship public social intervention policy, increasing the access of the poor to the health care services and protecting them against financial risk (Government of Ghana, 2012, p. 7).The NHIS gives prominence to community/district mutual health insurance schemes in an effort to promote community participation in and local ownership of the management of the schemes. It is possible that community participation may not only give voice to the local population but, also, increase the sustainability of the schemes. Arhinful (2003) argues that community participation and local ownership potentially give members the sense of responsibility that is necessary for either curbing abuse or over use.

1.4.5.1 NHIS Funding, Benefit Package, Premium Payment and Exemption Policy

The NHIS is funded publicly by a national health insurance fund (NHIF) from three major sources. The first source of funding, which constitutes approximately 70% of the fund, is a 2.5% value-added tax (VAT), and is known as the National Health Insurance Levy. The second source of funding, which constitutes approximately 20 to 25% of the fund, is also a 2.5% contribution from the Social Security and National Insurance Trust (SSNIT) and is mainly for public and private formal sector employees. The third source of funding is an annual premium which is paid by informal sector workers to the scheme, and it constitutes approximately 5% of funding to the scheme (Aryeetey et al., 2013).

The NHIS offers a fairly generous benefit package. The package covers 95% of the diseases that afflict people in Ghana, and includes general and specialist consultations reviews, general and specialist diagnostic testing such as laboratory investigations, X-rays and ultrasound scanning, and medicines on the NHIS medicines list. Surgical operation such as hernia repair, as well as physiotherapy and inpatient services, such as beds in a general ward and food, are also covered by the scheme. In terms of oral health, services such as tooth extraction, temporary incision and drainage, as well as dental restoration, including simple amalgam filling and temporary dressings, are covered by the NHIS. In 2008, free maternal care (FMC) was added as well as HIV/AIDS symptomatic treatment for opportunistic infections in 2012 (Act 852, 2012). However, the NHIS benefit package does not include appliances, prostheses, rehabilitation, dentures, organ and cosmetic surgery, assisted reproduction, heart and brain surgery other than accident, diagnosis and treatment abroad, dialysis for chronic renal failure and cancer (Government of Ghana, 2003).

In order to benefit from the NHIS, members pay annual health insurance premiums. These premiums must be renewed annually. Typically, formal sector employees under the Social Security and National Insurance Trust (SSNIT) pay 2.5% of their SSNIT contributions as an insurance premium directly to the scheme through the National Health Insurance Authority (NHIA). However, in order to access health care, these SSNIT contributors are still obliged to pay an annual registration fee, which is determined by the local health insurance scheme. Informal sector employees and other formal sector employees who do not contribute to the SSNIT and who are between the ages of 18 and 69 years are required to pay an annual insurance premium as determined by the local health insurance scheme. Similar to previous health policies, the NHIS exempts children under 18 years of age, pregnant women, persons with mental disorders, SSNIT pensioners (60 years and above), those aged 70 years and above, and the indigent (very poor). There is a two-month processing or waiting period before members may access the services of the scheme. However, the NHIS exemption policy is beset with the same problem of how to

identify the very poor. This means that this policy is no different from the previous exemption policies dating back to the colonial health policy.

1.4.5.2 NHIS Coverage, Poverty, Health Care Utilisation and Health Outcomes

On 4 November 2013, the NHIS celebrated the tenth anniversary of its implementation. On that date it boasted a national coverage rate of 33% (National Health Insurance Authority, NHIA, 2011, p. 16), an unprecedented success story in the history of the development of health insurance in sub-Saharan Africa (SSA).

The NHIS ten-year history coincided with a robust economy, which achieved a 7.1% GDP growth rate in 2012 with a projected GDP of 8.5% for 2013. Inflation declined from approximately 18% in 2008 to 8.8% in 2012, while food inflation declined from 5.5% in July 2012 to 3.9% in December 2012 (Ministry of Finance, 2013). The latest poverty figures published by the Ghana Living Standards Survey (GLSS 5), under the auspices of the Ghana Statistical Service, indicate a significant decline in poverty levels in Ghana from the 1998/99 figure of 39.5 to 28.5% in 2005/06, with absolute poverty falling from 36% in 1991/92 to 27% in 1998/99 and now to 18% in 2005/06 (Ghana Statistical Service, 2007). In addition, in 2013, the government increased its total expenditure on poverty reduction from 26% in 2012 to 30.35% in 2013 (Ministry of Finance, 2012, 2013).With this robust macroeconomic outlook, Ghana is likely to attain the first MDG, which is to halve, between 1990 and 2015, the proportion of people whose income is less than $1.25 a day.

In this seemingly robust economy, research indicates that the NHIS enhances access to health care for those who would, otherwise, not have had access to health care (Derbile & Geest, 2013; Barimah & Mensah, 2013; Dixon, Tenkorang, & Luginaah, 2013; Amporfu, 2013; Boateng & Awunyor-Vito, 2013). The National Health Insurance Authority (NHIA, 2011, pp. 19–20) indicates that, between 2005 and 2011, both outpatient and inpatient utilisation of health services skyrocketed. Outpatient utilisation was reported to have increased forty-fold from 0.6 million in

2005 to 25.5 million in 2011, while inpatient utilisation increased from 28,906 in 2005 to 1,451,596 in 2011 nationally (see fig. 1.3).

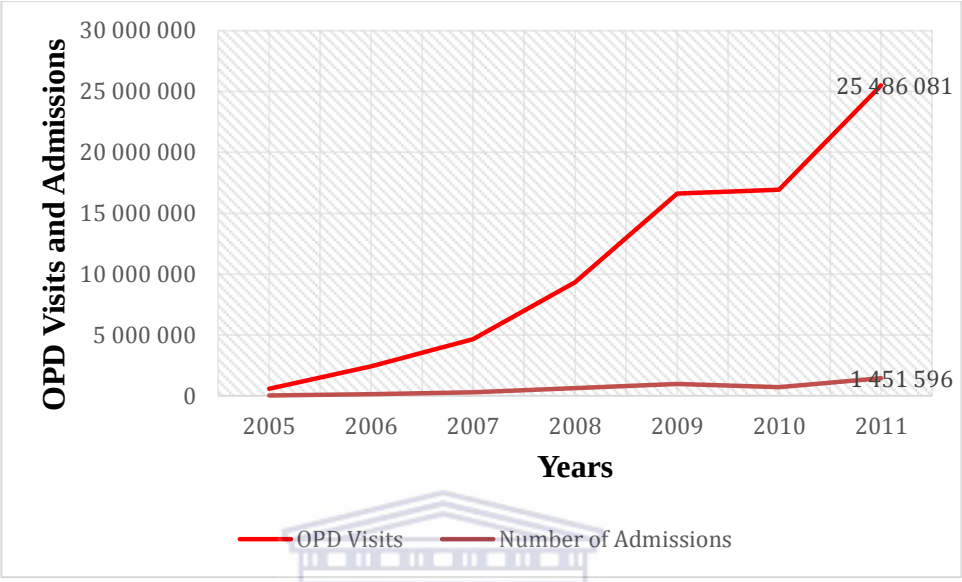

Figure 1.3: Health Care Utilisation under the NHIS

Source: National Health Insurance Authority, 2011

However, despite the increased utilisation of health care under the auspices of the NHIS, as indicated above, this increased usage, as emphasised in section 1.2 earlier, disproportionately benefits the better-off in society. This is because, despite the buoyant economic outlook discussed above, the various governments since independence have not made any concrete efforts to bridge the poverty and inequality gap between the north and south of the country. In addition, poverty reduction in the urban areas has received more attention than in the more rural regions of the north. The implication of this situation is that these urban populations benefit more disproportionately from the NHIS as compared to the poorer populations in the rural areas. In order to substantiate this claim, I compare the trends in the national and regional poverty levels in the country for the periods 1991/92, 1998/99 and 2005/06 (see fig. 1.4).

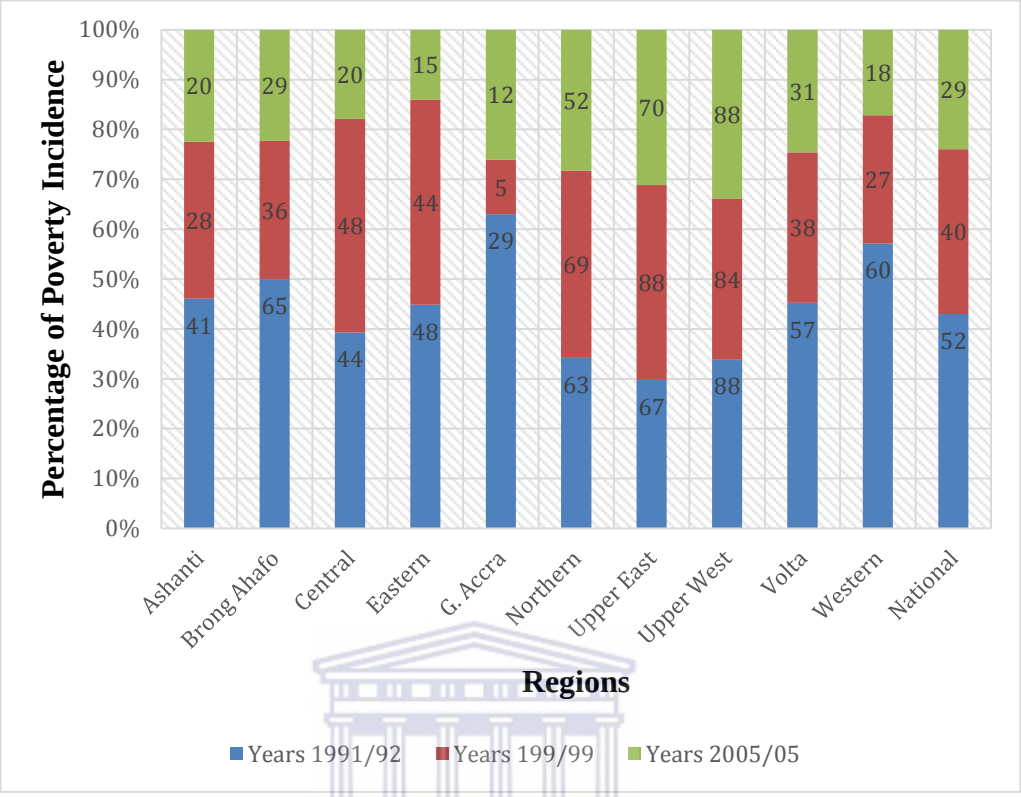

Figure 1.4: Trends of Poverty Incidence in Ghana, 1991/92, 1998/99, and 2005/06

Source: Patterns and Trends of Poverty in Ghana 1991-2006, Ghana Statistical Service

Figure 1.4 shows that, even in 2005/06, poverty was still disproportionately concentrated in the Upper East and West Regions of northern Ghana. The figures shown above are approximately the same as those recorded in 1975 and presented earlier, thus suggesting that, in the space of three decades, the poverty situation in the three regions in the north has not change significantly. In fact, poverty in the Upper West Region even worsened, reducing only slightly from 88% in 1991/92 to 84% in 1998/1999 and then rising again to 88% in 2005/05. It appears that these trends are in accordance with the colonial legacy because the colonial government had concentrated most of its development efforts in the resource endowed regions in the south of the country to the neglect of the less resource endowed regions of the north.

Nevertheless, since the implementation of the national health insurance policy, the government has started expanding the health facilities and training more health professionals in order to ensure the success and sustainability of the policy. For example, by 2009, the number of health facilities had expanded to 3,217 in the country. Of this figure, 466 health facilities were situated in Accra and 144 and 135 in the Upper East and West Regions respectively. The number of health professionals also increased, with the number of physicians increasing to 2,033 and the number of nurses increasing to 24,974 nationally. Of the total number of physicians 837 were in Accra and 29 and 14 in the Upper East and West Regions respectively. Thus, the physician to patient ratio was one physician to every 5,103 patients in Accra, one physician to every 35,010 in the Upper East Region and one physician to every 47,932 patients in the Upper West Region. The nurse to patient ratios were approximately equal for the three regions: in Accra, one nurse attended to 874 patients, while one nurse attended to 805 in the Upper East Region and one nurse to 750 patients in the West Region (Ghana Health Service, 2010, pp. 14–19).

Despite the modest expansions in the number of health facilities and the increase in the number of health professionals, particularly nurses, the impact on the health outcomes has, in general, been positive. In particular, maternal mortality decreased from 630 per 100,000 live births in 1990 to 350 per 100,000 live births in 2008 (The World Bank, 2012, p. 17). The IMR reduced from 57 per 1000 live births in 1998 to 50 per 1000 live births in 2008 nationally. In Accra, the IMR decreased from approximately 41 per 1000 live births to 36 per 1000 live births during the same period, while in the Upper East and West Regions IMR decreased from 103 per 1000 live births in 1988 to 46 and 97 per 1000 live births respectively (Ghana Health Service, 2010, p. 10). The United Nations Development Programme (UNDP) estimated life expectancy at birth in 2013 to be approximately 65 years (UNDP, 2013).

Based on these trends, it is not surprising that, in 2008, when the National Development Planning Commission (NDPC) conducted a nationwide citizen's

assessment of the National Health Insurance Scheme (NHIS), 92% of those insured with the NHIS were either satisfied or very satisfied with its performance. It is significant to point out that 82% of the lowest 20% income group and 75% of the upper 20% income group were either satisfied or very satisfied with the performance of the NHIS (NDPC, 2009, p. 52). This outcome appears to be extremely positive and it is possible that the NHIS may be the final destination in Ghana's health policy development trajectory.

1.5 Summary

Health policy development has travelled a long and difficult road to reach its current state in Ghana. This chapter examined the issue of access to equitable health care for the very poor in Ghana. The chapter identified the difficulty in identifying the very poor for health insurance premium exemptions. In addition, an examination of the historical development of health policy revealed that the challenge of identifying the very poor has persisted since the colonial days. This historical account reinforced the clear need for the very poor to be identified if their access to health care is to improve. Despite the fact that the colonial government and subsequent governments, with the exception of the government of Nkrumah, which implemented a free health care policy, instituted exemption policies for the very poor, clear criteria, in terms of which the very poor may be identified, have never been formulated. In terms of access to health care, Nkrumah's free health care policy remains of historical importance because it increased the very poor's access to formal care facilities. Thus, Nkrumah's free health care policy is an indication that history matters although it is not a destiny.

The historical account of health policy development also highlighted a number of key policy issues. Firstly, throughout the colonial period to the present day, health policy has focused primarily on financial accessibility to the neglect of geographical accessibility, particularly in view of the uneven distribution of health resources across the country. Thus, health policy has been urban biased from the colonial era,

and even Nkrumah's free health care policy was not able to address this issue adequately. Thus, in Ghana, and to the detriment of the rural areas, health facilities and health professionals are concentrated mainly in the urban areas, especially in Accra. Thus, it is not surprising that the rural areas in the north are also the poorest in the country because poor health leads to poverty and poverty leads to poor health. Secondly, because of the reasons mentioned above, the NHIS currently lacks social equity, the very reason for its being, because the rich benefit disproportionately more than the poor from the scheme. It is suggested that the government expand the number of health facilities in the rural areas, and also introduce attractive incentives packages to attract and retain the services of health professionals in the rural areas. Finally, there is an urgent need for the NHIS to develop clear criteria to identify the very poor in an effort to achieve equity as regards the access to health care of all the people in the country.

1.6 Research Significance and Justification

This study fills a demand side void by seeking to develop a model for the purpose of identifying very poor household for health insurance premium exemptions. The NHIS has consistently admitted that the extremely low coverage rate of the very poor is as a result of the lack of clear guidelines for identifying them (NHIA, 2009, 2010, 2011). As Burnham, Lutz, Grant, and Layton-Henry (2008, p. 306) point out, "decision-makers want solutions". This study seeks to offer a solution to the policy makers. Burnham et al. (2008) also suggest that research should not only help us to understand society, but it must offer some guidance on how to improve society better. Burnham et al. (2008) further contend that research represents the voice of citizens in the policy-making process. This study represents the voices of the citizens in the Kassena-Nankana District in Ghana.

Accordingly, while some studies have been conducted on the NHIS and access to health care in Ghana, no study has systematically attempted to develop a model for identifying the very poor for insurance premium exemptions. This study is thus

original and innovative as it aims, ultimately, to develop a model for the purpose of identifying the very poor for health insurance premium exemptions. Consequently, the results of this study will also serve as a guide to other social sectors, such as education, because the problem of identifying the poor transcends the health sector. In particular, in view of the fact that the NHIS is Ghana's flagship social protection policy and is integral to Ghana's poverty reduction efforts, this research study will provide data of critical policy value on health insurance status and access to health care services. This data will, in turn, empower policy-makers and enable them to design specific measures to enhance the participation of vulnerable groups in the NHIS in an effort to achieve equitable universal health care for the citizenry of the country.

1.7 Organisation of the Study

The remainder of the study is organised as follows. Chapter two presents the conceptual framework of the study. Particular attention is paid to the concepts of equity, social justice and the social relations of power in explaining poverty and equity in access to health care. Whitehead's concept of health equity and Rawls' concept of social justice were used extensively in this respect. One of the most significant aspects of the chapter is that it hypothesises that the provision of equitable health is a function of the social relations of power. The chapter then moves on to present empirical evidence to support this hypothesis. The chapter highlights the fact that just social relations of power in the Kerala state in India have enabled the state to develop a decisive policy framework to provide health insurance to all its poor and underprivileged citizens. Chapter three describes the research setting and the methodology used in the study. The chapter opens with a brief background of the Kassena-Nankana District, where the study took place, as well as a brief background of the Kassena-Nankana Mutual Health Insurance Scheme (KNMHIS). In addition, the chapter discusses the research design, sampling procedure, sample size, data collection instruments as well as the data analysis procedure. Chapters four and five

shift the attention from theory to practice by discussing the research findings in detail. Thus, chapter four details the qualitative research results. The chapter highlights the communities' perceptions of poverty and their suggested indicators in terms of which very poor households or individuals may be identified for health insurance premium exemptions. Chapter five discusses the results of the quantitative analysis. The chapter also presents and evaluates the reasons that motivate households either to enrol or not to enrol in the NHIS with reference to relevant literature. The discussion in this chapter provides the methodological grounding for the proposed model for identifying very poor households. Chapter six is the final chapter of the study and, as such, presents the conclusions and policy recommendations. In other words, chapter six coalesces the discussion of the qualitative and quantitative findings of the study by synthesising and summarising the qualitative and quantitative results in an integrated manner, consistent with a mixed methods research design.

Having established the research problem and provided a clear understanding of the historical development of health policy in Ghana, the next chapter will situate the study within a more elaborate and detailed conceptual framework of equity, social justice and social relations of power.

Chapter Two

Equity in Access to Health Care: Towards a Conceptual Framework and the Literature Review

2.0 Introduction

This chapter aims to develop a conceptual framework for equity in access to health care within a coherent framework of social relations of power. In order to achieve this aim, the chapter is divided into two major sections. The first section discusses both poverty and inequities in health care, arguing that poverty and the existing health inequities are linked to historical materialism, colonialism and capitalism. The second section briefly reviews the common notion of poverty as lack of income. In addition, expanding on the notions of health equity and access, as discussed in chapter one, the second section presents a more elaborate explanation of health equity and access by drawing on Rawls's concept of social justice (Rawls, 1971, 1999). The section also presents and explains in detail the dimensions of access to health care. This explanation is of particular importance as it serves as a benchmark with which to evaluate the extent to which the Ghanaian National Health Insurance Scheme (NHIS) is equitable in terms of access to health care for the poor. I then embed the study in a framework of the social relations of power, and then link equity theory and social relations of power. In this regard, it is my conviction that the social determinants that give rise both to poverty and to the disparities and inequities in access to health care are actionable by public policy within the context of the right social relations of power in society. To this end, addressing the issues of socio-economic status (SES) and access to health care requires, in my view, a conscious public policy intervention which is a function of the social relations of power. The next section discusses poverty and inequities in health care in light of historical materialism.

2.1 History and its Link to Poverty and Inequities in Health Care

This section draws on existing empirical literature to hypothesise that the existing social relations of power in society are correlated with the problems of both poverty and health inequities. The reason for this hypothesis is that I believe that the demand and supply factors that drive and maintain poverty and health inequities are, perhaps, not peculiar to Ghana alone but that these problems permeate the globe across space and time. From this perspective, this section examines the concept of historical materialism[2] and its links with poverty and health inequities in contemporary times. Following the discussion of this materialistic view of society, the section then proceeds to examine colonialism and capitalist exploitation and their contribution to poverty and health inequities. Firstly, historical materialism.

2.1.1 Historical Materialism, Poverty and Inequities in Access to Health Care

Marx and Engels are known for their materialistic explanation of the history of human development in contemporary society. Historical materialism examines the primacy of economic forces in shaping the history of humanity as social classes interact on a daily basis. In explaining the history of human existence, Marx and Engels (1983) argue that matter takes precedence over everything and that the material world precedes all consciousness. Marx explicitly points out that "it is not the consciousness of men that determines their being but, on the contrary, their social being that determines their consciousness" (Marx & Engels, 1983, p. 160). In other words, the material or economic conditions in society shape the social structure of society, including the survival of the people who live in the society. Marx and Engels further argue that "men must be in a position to live in order to be able to make history" (Marx & Engels, 1983, p. 171).

[2] Historical materialism describes the view of Marx and Engels (1983) that human history or existence is characterised by the transformation of nature (material) into finished goods to satisfy human wants or needs. The transformation process is facilitated by the presence of raw material, tools, technological knowledge and labour power.

Perceiving and understanding both the world and humanity materialistically, Marx and Engels argue that, just as material causes underlie all natural phenomena, so is the development of human society conditioned by the development of material forces – the *productive forces* (Marx & Engels, 1991). The productive forces suggest the material tools and instruments, which are used in facilitating the production process. The productive forces relate to the *productive powers* in the production process. Marx and Engels (1991) argue that these relations between the productive powers and the productive forces determine social life, human aspirations, ideas and laws and the basis of social class struggle.

According to historical materialism, the productive powers thus determine the material production in society. The important point is that the productive powers determine the division of labour in society, bearing in mind that man must labour in order to survive. Therefore, it follows that labour physically changes the world, causing economic forces or materialism to develop. In support of these views, Wood (2004) argues that the main premise of historical materialism is that the economic behaviour of human beings, namely, their mode of production in material life, shapes their social interaction and life. Wood points out that the productive powers mentioned by Marx and Engels refer to "the capacities or abilities of human beings, whether individual or collective, which they manifest and exercise in their productive activity" (Wood, 2004, p. 67). The relationship between the productive forces and the productive powers are vital in social development as human beings attempt to gain more and more control over their environment. I argue that the materialistic and insatiable quest of humanity to gain control over the resources of the environment have consequences. One such consequence was the trans-Atlantic slave trade, which in turn, impacted negatively on poverty in Africa and, for that matter, on access to health care in Africa.

Writing on the impact of the slave trade on Africa, Manning (1990) argues that the slave trade had depopulated Africa by half by 1850. In summarising the impact of slavery on African life, Manning (1990, p. 124), writes "Slavery was corruption: it

involved theft, bribery, and exercise of brute force as well as ruses. Slavery, thus, may be seen as one source of pre-colonial origins for modern corruption." Nunn (2008, p. 142) echoes Manning, estimating that, during the trans-Atlantic slave trade, approximately 12 million slaves were exported from Africa. However, Nunn argues that this figure did not include those who were killed during the raids or died during their journey to the coast. Specifically with reference to Ghana, it is estimated that 1,614,793 slaves were exported from Ghana between 1400 and 1900 (Nunn, 2008, p. 152). In examining the effects of slavery on African development, Nunn (2008) estimates that a negative relationship exists between slave exports and per capita income and this has contributed to the poverty and health inequities in Africa.

Based on the preceding arguments, Acemoglu and Robinson (2012) contend that slavery created poverty in Africa because the contact with Europeans introduced Africans to certain practices that did not encourage investment and productivity. For example, Acemoglu and Robinson (2012) assert that the Kongolese (now the people of the Democratic Republic of Congo) were quick to adopt the Western innovation of the gun between 1491 and 1512. The gun was a new and powerful tool with which to respond to the market incentives of capturing and exporting slaves to the West. The potential danger of being captured and sold as a slave, no doubt created an environment of insecurity and this discouraged investment in increased long-term productivity. Thus, it may be said that the slave trade undermined human and property rights in Africa, and disrupted all forms of economic and political activity on the continent (Acemoglu & Robinson, 2012). Accordingly, it stands to reason that, once economic and political activity had been disoriented by the banditry of the slave trade, Africa lagged behind in the processes of production and industrialisation and this led to low incomes. In other words, the slavery in the past directly affects the present level of poverty in Africa and it is this level of poverty that, ultimately, impedes access to health care. However, the ending of the slave trade did not bring to a close the unequal power relations between the West and the developing countries, particularly, in Africa, as slavery was then replaced by colonialism.

2.1.2 Colonialism and the Creation of Poverty and Health Inequities

In line with the materialistic nature of human beings, between the 17th and 18th centuries, the European colonialists plundered the greater share of the mineral resources and products of the plantations, for example sugar, leaving Africa with little resources for its own development. It is argued that African gold was the main source of gold for the Dutch gold coins which were minted in the 17th century; thus helping Amsterdam to become the financial capital of Europe during that period (Rodney, 1973). Iliffe (1987) makes an impelling case that, before the advent of slavery and colonialism, there were no poor in Africa. In support of this assertion, black South Africans often agree:

> "There were no poor and rich; the haves helped those who were in want. No man starved because he had no food; no child cried for milk because its parents had no milk cows; no orphan and old person starved because there was nobody to look after them. No, these things were unknown in ancient Bantu society" (Iliffe, 1987, p. 3).

As late as 1972, the United Nations' Regional Adviser on Social Welfare Policy and Training, Economic Commission for Africa observed that:

> "In rural Africa, the extended family and the clan assumed the responsibility for all services for their members, whether social or economic. People live in closely organised groups and willingly accept communal obligations for mutual support. Individuals satisfy their need for social and economic security merely by being attached to one of these groups. The sick, the aged and children are all cared for by the extended family. In this type of community, nobody can be labeled as poor because the group usually shares what they have. There is no competition, no insecurity, no big ambition, and no unemployment and, thus, people are mentally healthy. Deviation or abnormal behaviour is almost absent" (Iliffe, 1987, p. 3).

It is my opinion that, because the colonisers were economically powerful, the economic and social structure of Africa was deliberately altered to generate inequalities and social injustice. In this regard, Young (1990) suggested five interdependent notions of the injustice that could cause poverty, namely, exploitation, marginalisation, powerlessness, cultural imperialism, and violence. Exploitation has to do with class struggle, in which structural relations, social

processes and institutional practices enable the powerful to accumulate economic wealth while constraining such accumulation by others through action. Marginalisation, as a form of injustice, involves curtailing the full participation of certain groups or individuals in social life and accessibility to societal resources while powerlessness refers to the inability to exercise political power, participation, representation and a lack of capacity for self-expression, whether based on gender, class or race. As with colonial dominance, cultural imperialism represents a form of dominance in which one group or another loses the distinctive differences in its beliefs and behaviour, and becomes subordinates to a different culture.

In line with Young's classification above, it may be said that the colonists exploited Africa in the sense that the colonisers used physical or economic force to coerce the local people into growing cash crops instead of food crops on their own lands and to give these cash crops to the colonisers for export. This was precisely the case in both Northern Ghana and Liberia (Broad, 2002). Invariably, the establishment of plantations involved the separation of agriculture from nourishment, as the notion of food value was lost to the overriding claim of "market value" (Broad, 2002, p. 83). This, of course, had obvious consequences, including the stagnation and impoverishment of the peasant and the food-producing sector thus leading to insufficient food for the indigenous people. As a result of the fact that the indigenous people were not able to meet their basic subsistence needs for, among other things, food, they were forced to sell their labour cheaply to the colonisers by working on the plantations. In addition, Broad (2002) argues that the most insidious tactic to seduce the indigenous peasants away from food production and a tactic with profound historical consequences was the policy of keeping the prices of imported food low through the removal of tariffs and subsidies. This policy was double-edged. In the first place, the indigenous farmers were persuaded that they did not need to grow food because they could always buy it cheaply with their plantation wages and, secondly, the cheap food imports destroyed the market for domestic food, thereby impoverishing the local food producers (Broad, 2002). Once the local Africans had

been impoverished, there is no doubt that their access to health care will be adversely affected.

Still in line with Young's classification, Africans were marginalised as the land was taken over directly by the large-scale plantations, which were growing crops for export. For example, during the apartheid government in South Africa, more than 80% of the land was forcibly taken away from the black majority by the white minority. Williams (2005) argues that 2% of the land only has been redistributed and 80% of the land is still owned by white commercial farmers, thus depriving between 13 and 14 million black South Africans of access to land and exacerbating the rural poverty of the historically marginalised and excluded poor black people of South Africa. The marginalisation of the majority black population in South Africa is an insidious manifestation of the injustice perpetrated on this segment of the population. Poverty exacerbated by the fact that the indigenous people were not able to invest in any productive ventures because the land in which they could have invested, no longer belonged to them. Thus, it is clear that the processes of exploitation and marginalisation were both responsible for and fostered the poverty in Africa, which, in turn, limits the access of the poor to health care.

I also argue that the colonial policy of seizing land from indigenous Africans for plantation agriculture not only impoverished the Africans economically, but also culturally and spiritually. It is important to note that land represents both the spiritual and the cultural identity of Africans. It is the resting place of the ancestors where the living are united with the spirits of the dead. The land is also the abode of the spirits of deities that provide supernatural protection to the living. Thus, land is an embodiment of tradition for the Africa people. Accordingly, land dispossession through acts of colonialism had led to immeasurable cultural poverty, as the Africans are alienated from their very traditions.

The effects of the colonial exploitation on the indigenous people of Asia are no different from those in Africa. In India, for example, McMichael (2012) argues that the colonialists favoured the production of commercial cash crops. Consequently,

between the 1890s and the 1940s, the production of commercial crops, such as cotton, jute, peanuts and sugar cane, increased by 85% whereas local food crop production declined by 7% although the population grew by 40%. This shift from local food production ushered in hunger, famine and social unrest, all of which also impacted adversely on the access to health care of the poor.

To return to Africa, McMichael (2012) further argues that the colonialists' system of export agriculture interrupted the African pattern of diet and cultivation, creating a commercial food economy in terms of which what was being grown became disconnected from what was being eaten. For the first time in African history, money was determining what people ate and even if they ate at all. In short, both the transformation of Africa into a commercial centre for the hunting of black skins and the colonial exploitation of Africa led to the emergence of a capitalist and monetised economy which, in turn, ushered in the era of capitalist production.

2.1.3 Capitalism and the Creation of Poverty and Health Inequities

The unequal power relations between the West and developing countries did not, however, end with slavery and colonialism. The ending of slavery and colonialism marked the beginning of capitalism. According to Dunleavy and O'Leary (1987), capitalism is an economic system in terms of which private ownership of the means of production and the full use of money exchange enables the owners of the capital to exploit the masses – the people who must sell their labour in order to survive. Karl Marx is known as the first intellectual in history who identified capitalism, how it arose and the laws in terms of which it worked (Marx & Engels, 1991). Marx is also known as the bitterest critic of the capitalist mode of production. There are two preconditions that must be present for capitalism to materialise. Firstly, there are the *capitalists* – the owners of the means of production – and, secondly, there are the *workers*– the people who do not possess any material goods that they are able to sell and who do not also have the material means of producing the things they need for themselves. Thus, their only asset is their labour (Lebowitz, 2002). In other words, in

the capitalist mode of production, capital, in the form of money and credit, machinery, stocks of goods and labour, is privately owned (Harriss-White, 2006). In other words, this means that, under capitalism, everything, including production and labour, is for sale with this sale being made possible through the medium of money.

In view of this background, I argue that poverty and the inequities in health care are created by the dynamics of capitalism. However, I should hasten to point out that despite the fact that capitalism creates wealth it creates wealth only for the owners of the means of production (capitalists) and the middle class and not for the poor in society. This argument is based on the fact that, under capitalism, the owners of the means of production/employers control the hiring and firing of the labour force as well the working conditions while also deciding on the choice of technology to be used, the commodities to be produced and the exchange of goods and services (Marx & Engels, 1983). Thus, because the capitalists hire and fire the labour (workers), they determine the wages to the paid to the working class and these wages may be extremely low. In view of the fact that the workers have no other assets to sell to raise the money required for their survival, they are forced to accept the pittance offered by the capitalists. Therefore, because the workers have no choice but to accept the low wages offered by the capitalists, they may have to live in dehumanising conditions of poverty and misery and this, in turn, ultimately reduces their access to quality health care (Bourdieu et al., 1999). In this sense, it may be said that capitalism creates inequities in the access to health because everything is based on money and, therefore, only the rich and middle classes are able to afford the cost of health care.

Algeria provides an excellent example of the dehumanising conditions under which helpless labourers are forced to work and their experiences under capitalism (Bourdieu et al., 1999). According to Bourdieu et al. (1999, p. 8), not only was it difficult for poor Algerians to find jobs but those who did finally manage to do so were treated with disdain. For example, Algerian workers were not supposed to fall sick without permission. The capitalists are quoted as issuing the following warning

to the African workers: “You aren’t supposed to get sick, there’s no one to replace you”; “Now you have to get permission to be sick” and “Count yourself lucky you’ve got a job” (Bourdieu et al., 1999, p. 8). According to Wood (2004), the workers have no choice other than to work under such dehumanising conditions because capitalism creates a reserve army of unemployed proletarians, thus giving the capitalists a decisive bargaining advantage over the workers. Thus, these people live in poverty, they work under dehumanising conditions and they have no or few opportunities to escape from the misery in which they find themselves. This scenario clearly illustrates the workers’ vulnerability, which, in turn, gives the profit-seeking capitalists the opportunity to exploit the workers because they depend on the capitalists for their daily bread – a clear expression of unequal and unjust social relations of power.

In addition, capitalism has impoverished both individuals and households because it has abysmally failed to translate the wealth, which it created into expanded opportunities for individual self-actualisation. Wood (2004) asserts that capitalism has diminished, rather than increased, the extent to which individual labourers, their intelligence, skills and powers participate in the potentialities of social production, as well as limiting the extent to which the labouring masses share in life empowering capabilities such as access to health care and education.

In light of these views, I argue that, even in the United States of America, one of the most established capitalist powers in the world, the “benefits” of capitalism have been poverty and misery for the majority of America’s working class in the 21st century. In support of this claim, the US Census Bureau (2009) report indicates that, between 2007 and 2008, the poverty rate in the United States increased from 12.5% in 2007 to 13.2% in 2008. The official 2008 poverty rate, that is, 13.2%, indicates that 39.8 million people were living in poverty as compared to the 37.3 million people in 2007. This poverty rate is reported to be the highest in the history of the United States of America since 1997.

Based on these statistics, Petras (2010) argues that the present configuration of the economic, political and social structures of capitalism include the extremely high pillaging of the public treasury in order to prop up insolvent banks and factories, involving unprecedented transfers of income from wage and salaried taxpayers to non-productive rent earners and to failed industrial capitalist, dividend collectors and creditors. Petras (2010, p. 111) further asserts that the rate and levels of appropriation and reduction of savings, pensions and health plans, all without compensation, have led to the most "rapid and widespread reduction of living standards and mass impoverishment in recent US history". Petras (2010) maintains that 600,000 Americans have lost their jobs on a monthly basis from 2010.

These statistics show that capitalism reinforces both poverty and social inequality because the top 10% of adults worldwide own 84% of the wealth while the bottom half owns barely 1% (Chossudovsky, 2010). Thus, capitalism creates two parallel worlds in which some people are meant to be poor and some are meant to be rich (Freeman, 2010). The impoverishing effects of capitalism are even more significant in Africa, Latin America and Southeast Africa.

In this respect, it is important to note that the problem of food security in Africa, Latin America and Southeast Asia is fuelled by the free market in grain imposed by the Bretton Wood Institutions – the IMF and the World Bank and their allies – the United States and the European Union, thus destroying the peasantry economy and undermining food security. For example, Chossudovsky (2010) contends that Malawi and Zimbabwe were once prosperous grain surplus countries while Rwanda was virtually self-sufficient in terms of food production until 1990 when the IMF ordered the dumping of EU and US grain surpluses on the domestic markets of these countries, thus precipitating the bankruptcy of the small farmers in these countries. Chossudovsky argues further that one of the conditions for the rescheduling of Kenya's external debt was the IMF supervised deregulation of Kenya's grain market. The deregulation process resulted in low local food production because of the influx of imported food, such as rice and wheat, and ushered in famine and poverty in

Kenya, East Africa's most successful break-basket economy, in 1991 and 1992 (Chossudovsky, 2010).

In the name of the "free market" (capitalism) the global phenomenon of poverty has become frightening with people in various countries around the world becoming impoverished as a result of a global market mechanism. This global market mechanism confers on a handful of financial institutions and corporations only the ability to determine the prices of basic staples, such as rice, wheat and corn, on the New York and Chicago mercantile exchanges, thereby directly affecting the standard of living of millions of people around the world (Chossudovsky, 2010). The inevitable result is dramatic hikes in the food, water and fuel prices – the three essential commodities, which determine the level of economic and social life on earth. For example, food prices in Haiti have, on average, risen by 40% in less than a year, with the cost of rice doubling in 2008. In the same year, in Bangladesh, approximately 20,000 textile workers took to the streets to denounce soaring food prices, while, in Egypt, protests by workers over food prices rocked the textile centre of Mahalla al-Kobra. In Ivory Coast thousands of people marched on the home of former President Laurent Gbagbo, chanting "We are hungry" and "Life is too expensive, you are going to kill us" (Chossudovsky, 2010, p. 154).

Thus, because the prices of the essential commodities (food, fuel and water) are under the control of a small number of global financial institutions and corporations, the fate of millions of human beings is determined behind closed doors in corporate boardrooms as part of a profit driven agenda under the auspices of capitalism (Chossudovsky, 2010). Thus, capitalism causes and reinforces injustice although, as Martin Luther King pointed out, "[i]njustice anywhere is a threat to justice everywhere" (Soja, 2010, p. vii).

It is worth pointing out that the food, fuel and water "crises" facing the world are not separate and distinct but are, instead, part of a global process of economic and social restructuring and relations. It is interesting to note that the provision of water, food and fuel is no longer the subject of governmental or intergovernmental regulations or

interventions aimed at alleviating poverty or averting the outbreak of famine (Chossudovsky, 2010). According to Chossudovsky, "[b]oth the state and the international community serve the unfettered interests of global capitalism" (Chossudovsky, 2010, p. 158). It is for this reason that the dramatic price hikes of these essential commodities (food, water and oil) are not haphazard, but are the result of a process of deliberate and simultaneous market manipulation. The price of grain staples increased by 88% from March 2007 to May 2008, while the price of wheat increased by 181% over a three-year period (Chossudovsky, 2010, p. 158). These price hikes force millions of people around the world into starvation and chronic deprivation with people no longer having the means to purchase the food required survival and, thereby, contributing in a real sense to "eliminating the poor through starvation deaths" (Chossudovsky, 2010, p. 160). Even water, which is a natural resource, is being appropriated and sold. Water is not only essential for agricultural and industrial production but also for social infrastructure, public sanitation and household consumption. However, its price has increased dramatically because of a global movement to privatise water resources (Chossudovsky, 2010). Privatisation is one of the best ways of keeping capitalism alive.

The World Bank favours the privatisation of water as it (World Bank) serves the interests of water companies and its regular loan programmes in developing countries often require the privatisation of water provision. However, this requirement breaks down the system of the public distribution of safe tap drinking water, forcing the poor to resort to unsafe drinking water. For example, approximately one billion people worldwide, representing 15% of the world's population, have no access to clean water with 6,000 people dying every day because of infections linked to unclean water (BBC News, 2005). Despite the fact that, at present, water is not an internationally traded commodity such as food staples and oil, it is, however, the object of market manipulation through the privatisation of water. "The tendency is towards the commodification of water" (Chossudovsky, 2010, p. 157) because water giants, including Suez and Veolia, control

approximately 70% of the privatised water systems worldwide as a result of the fact that profit is a passion that dominates the lives of capitalists (Hunt & Lautzenheiser, 2011).

Capitalism has dramatically accentuated inequality, poverty and health inequities the world over, particularly in the developing countries and especially in Africa. For example, in the 21st century during which humanity is witnessing the greatest prosperity created by capitalism in history, billions of people are still living in abject destitution. Between 2003 and 2011, the number of people in the world living in extreme poverty increased from 1.2 billion to 1.4 billion people (Peffer, 2003, pp. 1–2; IFAD, 2011, p. 9). Eagleton (2011, p. 8) asserts that "the income of a single Mexican billionaire is equivalent to the earnings of the poorest seventeen million of his compatriots". It is on this basis that Eagleton (2011) describes capitalism as being antisocial as regards the entire human raced. Under capitalism, the hunger prevalence in sub-Saharan Africa is the highest in the world and, in 2006 to 2008, more than one in four Africans, that is, almost 218 million people were undernourished and experiencing precarious food security and a lack of access to the requisite health care (UNDP, 2012).

The adverse effects of capitalism are felt the most by Africans because capitalism breeds avarice that is alien to the African ethical culture of community life. According to Mangena and Chitando (2011), the African ethical culture is best explained by the philosophy of "Ubuntu". According to Mangena and Chitando (2011, p. 234), "Ubuntu refers to the process of becoming a human being which calls for a particular mode of being in the world, which mode of being requires each person to maintain social justice, to be empathetic to others, to be respectful and to have a conscience. Failure to observe these guidelines disrupts communal unity leading to disequilibrium".

> "Ubuntu is a powerful manifestation of the African humanity. This involves, in turn, not only the physical mode of existence but also the entire array of values – moral, legal, aesthetic – and all other norms. These values are pegged in the collective consciousness of specific groups and are expected to

> vary in accordance with history and the experience of the collective. These values, in turn, are transmitted to the progeny through the process of socialisation" (Mangena & Chitando, 2011, p. 234).

Mangena and Chitando further add that Ubuntu has become a key concept, which evokes the unadulterated forms of African social life before the European conquest. The following question immediately arises: Are the younger generations of Africans still socialised in these values and morals of Ubuntu? The answer is an emphatic no. The reason for this that capitalism has broken down that ethical culture that once held the African community in place. Younger Africans are born into capitalism and, hence, are socialised in capitalist ideals and, for this reason, they are deprived of the communal life and, indeed, the spirit of Ubuntu. Thus, the younger generation tend to perpetuate poverty, inequality and injustice in a once, just and communal society because of the desire to amass wealth.

In addition, under capitalism, the world has become a "global village" with increased operations on the part of the Multinational Corporations (MNCs) in the developing countries, particularly in Africa, as a result of the age of information and the communication technological revolution. The power of the mobile telephone and the Internet has virtually bridged the barriers of physical distances between countries. Proponents of the MNCs argue that they inject financial flow into the host nations by providing jobs, transferring technology and helping to train the youth of the host developing countries to acquire employable skills (Chukwuemeka, Anazodo, & Nzewi, 2011). This assertion has, however, been refuted in no uncertain terms by opponents to the operations of the MNCs in Africa. Notable among these opponents variants are Chukwuemeka et al. (2011, p. 102) who argue that the MNCs tend to bring down the economies in the host developing countries overnight because of their superior technical knowledge. For example, "[a] few clicks of a computer mouse can devalue a nation's currency very quickly, wasting away the life savings of millions of breadwinners".

The large size of the MNCs tend to result in their being used as instruments of exploitation by the imperialist western countries and to intensify the poverty and

underdevelopment in Africa and in other third world countries (Chukwuemeka et al., 2011). Chukwuemeka et al. further argue that the MNCs use their size to undermine the sovereignty of states through political manipulations. In addition, they may be used as the foreign policy instruments of their home governments. A telling example is that of the International Telephone and Telegraph Corporation (ITT), an American private business company. According to Harvey (2007), the ITT was threatened by the late President Salvador Allende Gossens's drive towards socialism in Chile and, thus, the company campaigned against his election in the 1970s. Despite the fact that Allende was democratically elected president, the ITT, with the support of the CIA, masterminded the overthrow and murder of Allende on 11 September 1973. With the help of the CIA, the ITT then replaced Allende with their ally, Augusto Pinochet, who allowed the United States of America a "free" hand in Chilean business and economic management. Similar coups in developing countries, including the coup that ousted General Murtala Mohammed of Nigeria and the coups of Jerry John Rawlings in Ghana in 1979 and 1981, are the handiwork of the multinational corporations (Chukwuemeka et al., 2011).

The transfer of technology to the developing countries by the MNCs is a myth and simply does not exist. It is asserted that the "technology transfer is obsolete, overpriced, inappropriate and inconsistent with the factor endowment of host states" and is, thus, illusive (Chukwuemeka et al., 2011, p. 103). In terms of job creation in the host developing countries, the MNCs in fact take jobs away from the indigenous inhabitants because the majority of foreign direct investment by MNCs is focused on the exploitative or extractive sectors such as oil, gas and the minerals industries with minimal investment in the productive and manufacturing sectors. The indigenous inhabitants often do not possess the requisite skills to compete favourably with the expatriates for jobs in the extractive sectors. For example, foreign investment by MNCs in Swaziland in the mining and quarrying sector was 46.2% and 20% in the manufacturing and processing sectors respectively, in 2005, and in 2006 investment in the mining and quarrying sector surged to 50.2% while investment in the

manufacturing and processing sector declined to 19.1% (Chukwuemeka et al., 2011, p. 107).

Based on the discussion it may often be inferred that the underdevelopment and poverty in Africa and the subsequent inadequate access to health care of the poor may be attributed to Africa's ongoing interaction and unequal relationship with international capitalism. In light of the preceding discourses on capitalism and poverty, it would appear that a relevant question to ask at this juncture would be: Does capitalism bring into being social transformation or new changes that benefit the ordinary people in particular in society, especially in the wake of the worldwide financial crisis of 2008? Horton and Lo (2014) argue that the financial crisis of the 21st century raised serious questions about capitalism's ability to protect and sustain the wellbeing of populations in both rich and poor countries. As a result of the human being's quest to make profits and accumulate material wealth, "[w]e have created an unjust global economic system that favours a small, wealthy elite over the many who have so little" (Horton, Beaglehole, Bonita, Raeburn, Mckee, & Wall, 2014, p. 847).

In his work, *Rebel cities: From the Right to the City to the Urban Revolutio*n", Harvey (2012, pp. 109–110) articulates clearly that, in view of the fact that capitalism benefits only the capitalists and since everything inclusive of health care is "commodified, commercialised and monetised" under capitalism, opposition movements are bound to come into being with the aim of overthrowing the existing power. The overthrow of capitalist rule may help to reverse the social order to the advantage of the suffering masses in society because, collectively, organised social movements (opposition movements) may acquire both power and legitimacy (UNDP, 2013). According to the UNDP, these social movements are particularly crucial for the poorer people who, without such revolutions, may remain trapped in poverty and inequities as regards their access to health care. These views of Harvey and the UNDP, as cited above, are distinctly illuminating in the context of this study because they speak precisely to the events that led to the implementation of the

NHIS in Ghana (Section 1.4.4). AS mentioned earlier, following the imposition of the IMF/World Bank neo-liberal policies, user fees were institutionalised and, thus, access to health care was based on the ability to pay. Indeed, user fees benefited the wealthy and middle class people only while, at the same time, greatly impeding the access to health care of the poor. This, in turn, resulted in the coalescing of the voices of opposition political parties, civil society organisations and the suffering poor and which, in turn, led to the revolt against the IMF/World Bank imposed user-fee policy and its replacement with a more pro-poor health care system, the NHIS.

Having established the correlation between historical materialism, colonialism and capitalism and poverty and inequities in access to health care, it is logical at this point to review the notions of poverty, health equity and health access in more detail. This, thus, is the focus of the next section, beginning with the income notion of poverty.

2.2 The Income Notion of Poverty

Income or consumption expenditure is the most popular way of conceptualising and assessing poverty. This income notion of poverty is, perhaps, inspired by the earlier work of Booth (1889) and Rowntree (1901) which defined poverty using income levels based on poverty lines. The definition of poverty based on income or using poverty lines suggests that poverty may be conceived of in absolute terms. For example, Sen (1985, p. 670) asserts that poverty is not a matter of being relatively poorer than others in society, but of not having some basic opportunities of material wellbeing – the failure to have certain minimum capabilities. "The criteria of minimum capabilities are "absolute", not in the sense that they must not vary from society to society, but people's deprivations are judged absolutely and not simply in comparison with the deprivations of others in that society". Like Sen, Nussbaum (2011) describes capabilities as the opportunities, such as education, health and access to adequate information, that empower individuals to choose and act upon their daily activities in society. For example, Nussbaum makes an impelling claim

that education nourishes the development of the power of the mind of individuals in society (Nussbaum, 2011).

The income notion of poverty employs income as a 'means' indicator and used as a proxy for poverty. Income poverty assumes that individuals and households are poor if their incomes or consumptions fall below a certain threshold, which is usually defined as a minimum, socially acceptable level of wellbeing and which is referred to as the poverty line (Falkingham & Namazie, 2002).

Using this income conceptualisation, the Ghana Statistical Service (2007), in the fifth (latest) round of the Ghana Living Standards Survey (GLSS), established two absolute poverty lines, namely, a lower poverty line and an upper poverty line. The lower poverty line is pegged at nutritional intake; that is, such a lower poverty line focuses on what is required in order to meet the nutritional requirements of household members and is equivalent to GH¢288 (US$113) per adult per year. On the other hand, the upper poverty line incorporates both essential food and non-food consumption and is equivalent to GH¢370 (US$145) per adult per year.

As pointed out in the previous chapter, despite the importance of the income variable is, the income notion alone is not sufficient as regards the understanding of poverty in an effort to identify the very poor. In support of this claim, Sen (1999) asserts that, even though income is an important determinant of poverty, income, in itself, has an instrumental value only. In other words, income is needed, not for its own sake, but to enhance the achievement of basic capabilities. In my view, the absolutist notion of poverty abstracts it from class and power relations, and presents it as a tangible entity rather than a consequence of the social relations of power through which people identify with others and act in the social world (Harriss, 2007). Young (2009) argues that social groups are relationally constituted through interactions that make categorical distinctions among people in a hierarchy of status or privilege. Young (2009, p. 363) continues that these interactions tend both to produce and reproduce "durable inequality" processes in terms of which people produce and maintain advantages for themselves and disadvantages for others as regards access to

resources, power, autonomy and honour. Accordingly, I argue that the income notion of poverty distracts the focus of public policy from the provision of the basic necessities of life, such as health and education, to the ordinary citizens of society. It may be that, poverty "experts" continuously conceptualise poverty as a lack of income because this enables them to quickly offer technical solutions to poverty, including doling out hand-outs to the poor, in such a manner that these poverty "experts" benefit from the existing social structures while ensuring that their powerful relationships are not threatened (Harriss, 2007).

2.3 Equity as Applied to Health Care

As pointed out in chapter one the notion of equity is linked with the notion of fairness and the just distribution of resources, including health care, in society (Rawls 1971, 1999; Sen, 2009). Operationalising the concept of *justice as fairness*, Rawls (1999, p. 3) proposes that, as a type of social ideal, social institutions ought to maximise the life prospects of the less advantage in society. Rawls suggests the following two principles of social justice. The first principle is equality in basic rights and duties. This principle underlines the *right* to both health care and education. In other words, this principle upholds the equality of fair opportunity for all in society with respect to the health care. The second principle demands that social and economic inequalities, such as inequalities of wealth and authority, be governed in terms of securing benefits for everyone and, particularly, for the least advantaged members of society (Rawls, 1999).

In his exposition on justice as fairness, Rawls (1999) argues that people born into different positions have different expectations of life which are determined, in part, by the prevailing political system as well as by economic and social circumstances. Rawls (1999) contends that social institutions favour certain social positions over others, resulting in deep inequalities. Thus, Rawls argues that it is to these inequalities, which are, presumably, inevitable in any society that the principles of social justice must, in the first instance, apply. In addition, Rawls maintains that it is essential that political and legal institutions preserve the social conditions, which are

necessary for the fair equality of opportunity. According to Rawls, these institutions have the important duty of preventing the excessive accumulation of property and wealth and of maintaining equal opportunities of education and health care for all. He argues that the opportunities to acquire skills and knowledge and to access health care "should not depend upon one's class position" in society (Rawls, 1999, p. 63).

According to Whitehead (1991, p. 221), the notion of equity, as applied to health care, is multi-dimensional, comprising the following essential themes, namely, "Equal access to available care for equal need, equal utilisation for equal need, equal quality of care for all". Explaining these three themes of health equity, Whitehead argues that *equal access to available care for equal need* means equal entitlement to the available health services for everyone, a fair distribution of the services throughout the country based on health care needs and ease of access in each geographical area.

With regards to *equal utilisation for equal need*, Whitehead suggests that, where the use of the health service is limited by individual socio-demographic characteristics such as age, sex, and religion or by social or economic disadvantage in general, it is essential to aim for equal utilisation rates for equal need. The last theme, *equal quality of care for all,* speaks to the fact that everyone in need of health care should have an equal opportunity of being treated fairly and that health care is not based on either SES or social influence (Whitehead, 1991). Starfield (2007, p. 1356) elaborates on the concept of equity in health care, defining it as the "absence of systematic and potentially remediable differences in one or more aspects of health between groups of people characterized socially, geographically, or demographically".

On the other hand, Whitehead (1991, p. 219) explains inequity as follows: "Inequity refers to differences which are unnecessary and avoidable but, in addition, are also considered unfair and unjust". Whitehead explains further that, in order to describe a situation as inequitable, the cause of the situation has to be examined and judged to be unfair in the context of what is happening in the rest of the society.

Whitehead uses four key terms, namely, *unnecessary*, *avoidable*, *unfair* and *unjust.* These terms are all worth highlighting. In the context of this study, if the members of a section of the Ghanaian population are excluded from access to health care because they do not have health insurance, or because of physical distance and the unavailability of health facilities, this, in turn, represents an apt example of unfairness and injustice. In this regard, Whitehead (1991) argues that inequities in access to health care arise when health resources and health facilities are unevenly distributed around a country, clustered in the urban and more prosperous areas and scarce in the deprived and rural settings. Elaborating on Whitehead's view of health equity, Sen (2002) argues that injustice refers to the lack of opportunity of some sections of society to achieve good health because of inadequate social arrangements as opposed to their personal choice or decision not to seek health care.

Sen's use or introduction of the issue of *choice or personal decision* in explaining health equity represents a key indicator which society may use to evaluate whether or not a given state of affairs is equitable. For example, Whitehead (1991, p. 219) suggests that ill health resulting from "health-damaging behaviour if freely chosen, such as participation in certain sports and pastimes, would not normally be classified as inequities in health". On the other hand, if ill health is the result of poverty, then this may be interpreted as inequities in health because poverty is both preventable and unjust. This explanation offers an appropriate index with which to measure whether or not a prevailing situation is equitable. In order words, whether the situation is the result of choice or whether it is beyond the control of an individual or group of individuals. This exposition further justifies the application of the equity theory in this study because, as already demonstrated in chapter one, the people living in the northern parts of Ghana, through no choice of their own, have been historically and systematically marginalised in terms of the allocation of health resources. One of the consequences of this historical marginalisation of the north is the high level of poverty with its corollary of inequities as regards access to health care. Developing the notion of equity as fairness further, Marmot (2007, p. 1153)

argues that "the development of society, rich or poor, can be judged by the quality of its population's health, how fairly health is distributed across the social spectrum and the degree of protection provided from disadvantage due to ill-health".

Relating these views of health equity to Ghana's NHIS, I argue that, as pointed out in chapter one, the design and content of the NHIS, are indicative of a pro-poor approach. In other words, the NHIS aims to achieve a kind of social reform in terms of which the most vulnerable members of the society are empowered through the principles of equity, solidarity, and client and community ownership in the delivery of health care (Durairaj et al., 2010). For example, Durairaj et al. (2010, p. 5) argue that the key design principles of the NHIS include "*equity*" – defined as equal access to benefit package, irrespective of one's socio-economic status – and "*risk equalisation*" – defined as the financial risk of illness being equally shared by all. These principles of *equity and risk equalisation* highlight the fact that the Rawlsian concept of justice as fairness is particularly relevant to this study because the it does not simply assume a 'blanket' notion of social justice but, in a very distinct manner, it advocates for "equality as equality of fair opportunity" for all in society, irrespective of their social status (Rawls, 1999, p. 57).

It may be that Harvey's (2009) notion of social justice offers more practical and relevant explanation of the concept of equity as it applies specifically to health care. In his work, *Social justice and the city*, Harvey (2009) suggests that social justice is a normative concept, which should be regarded as a principle in resolving conflicts with respect to the production and distribution of limited societal resources. Similar to Sen's (2002) notion of social justice as explained earlier, Harvey further suggests that this principle of justice relates also to the social and institutional arrangements associated with the production and distribution of the health care service. In order to render this notion of social justice more relevant and practical in society, Harvey suggests that social justice should not be conceived of merely in an aggregate form but that it should rather be deconstructed in terms of territorial, group and individual forms of justice. I am of the opinion that Harvey's three-tier social justice system

suggests that, in the provision and distribution of health care services, different locations (territories), groups (e.g. households) and individuals should receive a fair share of these services to the extent that the available resources allow. Harvey (2009) argues that the provision of social services, such as access to health care, should be in sufficient quantity and quality at the correct locations if a socially just, distributive objective is to be achieved. Harvey argues that, essentially, the concept of social justice speaks to "a just distribution justly arrived at" (Harvey, 2009, p. 98). In the context of this study it would appear that Harvey's contention suggests that it is essential that the allocation of health services throughout the ten regions in Ghana reflect the needs for the services and that the allocation is not merely based on population size (Soja, 2010).

In short, the notion of equity as applied to health care implies fairness in the distribution of health care. It entails three interrelated themes, namely, equal access to the available care for equal need, equal utilisation for equal need, and equal quality of care for all. Thus, any inequalities in the distribution of health care, which could be avoided, are inequitable. In general, socio-cultural, geographical and demographical differences that constrain people's access to health care are inequitable because these differences are amenable to decisive policy interventions. However, differences in access to health care that occur as a result of an individual's own choice of life-style cannot be considered as inequitable. These last two arguments lead us to the issue of access to health care, which is discussed below.

2.4 Access to Health Care

Elaborating on the notion of health access as the freedom to use health care services without any barriers, and as presented in chapter one, Goddard and Smith (2001, p. 1151) operationalise access to health care to mean "the ability to secure a specified range of services, at a specified level of quality, subject to a specified maximum level of personal inconvenience and cost, while in possession of a specified level of information". In terms of this explanation of Goddard and Smith, access is

quintessentially a demand and supply sided concept. This will be explained below. In simple terms, the availability of health care services, the quality of the service, and the costs of the service as well as the population's awareness of the existence of the services determine the access to health care. Citing the United States of America as an example, Goddard and Smith argue that, in the United States, access to health care is often considered in terms of whether or not the individual is insured. Thus, as in the United States, the possession of a valid health insurance card is literally the "visa" to quality health care in Ghana. Without health insurance, the cost of health care may be too high for poor households or poor individuals, depending on the type of illness and this, in turn, may force poor people to seek health care from unqualified persons. As Goddard and Smith have pointed out, access to health care is often understood to mean the level of service which either the health care system or the state makes available to the citizens. However, this notion of access is limited to the supply side of health services only.

On the demand side, Goddard and Smith (2001) argue that factors such as travel costs, cost of care, and cost of insurance premiums greatly influence people's access to health care in almost all societies. Ensor and Cooper (2004) are in agreement with Goddard and Smith when they argue that demand side factors, such as the costs of access, lack of information and cultural barriers, are likely to be more important to the poor and vulnerable as regards preventing them from benefiting from public spending on health services.

These views affirm the fact that access to health is both a fundamental universal human right and a basic human need (Marmot, 2007). The right to health is clearly spelled out in the forty-fifth edition of the World Health Organisation's (WHO, 2006, p. 1) constitution, and reads as follows:

> "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition".

In support of these views, Evans, Marten, and Etienne (2012) argue that a lack of access to health care may impoverish people because they will be unable to work, while at the same time, using health care services may impoverish others poor because they are not able to the payments for these services. It is in light of these views that the provision of equitable health care to the entire population, irrespective of SES, is crucial in the reduction of poverty. It is important to note that equity in access to health care is a prerequisite for the achievement of quality health in a population (Marmot, 2007).

In support of the right to universal health care (UHC), Oxfam International (2013) argues that citizens must be entitled to receive equitable health benefits by virtue of their citizenship because, above all else, they are people and not because they have the ability to pay to be enrolled in a health insurance scheme. For Oxfam, radical reforms are a prerequisite to reducing inequities in access to health care, so that all the citizenry will enjoy the same financial protection and access to the same health services based on need and not on their ability to pay.

In order to make the application of the concepts of equity and universal access to health coverage more relevant in various contexts, the World Health Organization (2013) cautions that, in pursuance of UHC, health systems should not record only the absolute numbers of people who either have or do not have access to health care and that it is, perhaps, most important to conduct a critical examination of the socio-demographics of the people in more detail. In other words, in an effort to achieve equity in the demand and supply of health care services, it is essential that the data on these health care services is disaggregated by, for example, gender, age, income and location of residence. The World Health Organization (2013) suggests that this aggregation is important to ensure that coverage is truly universal, that is, everyone has access to health care, in order to avoid partial coverage in terms of which coverage may benefit certain groups at the expense of others. This issue of UHC coverage highlights the importance of any endeavour to identify the very poor, such as this study. In an effort to enhance equity in access to health care, it is essential that

the dimensions of access to health be clearly understood. Accordingly, a discussion of the dimensions of access to health care now follows.

2.5 Dimensions of Access to Health Care

It is clear from the discussion above that access is a multidimensional concept although there is no consensus on the number and nature of its dimensions (Thiede et al., 2007). It is, therefore, important to break the concept down into its constituent dimensions, as applied to this study, not only for the purposes of evaluating access in a systematic and inclusive manner but also for comprehensively defining an equity-oriented health policy agenda (Thiede et al., 2007). According to Thiede et al. (2007), a wide range of health system and individual or household factors influence access. Exploring these factors systematically requires that these factors be categorised into identifiable groups for easy evaluation. As indicated earlier, access may be deconstructed into both demand and supply side factors with their accompanying dimensions (see fig. 2.1).

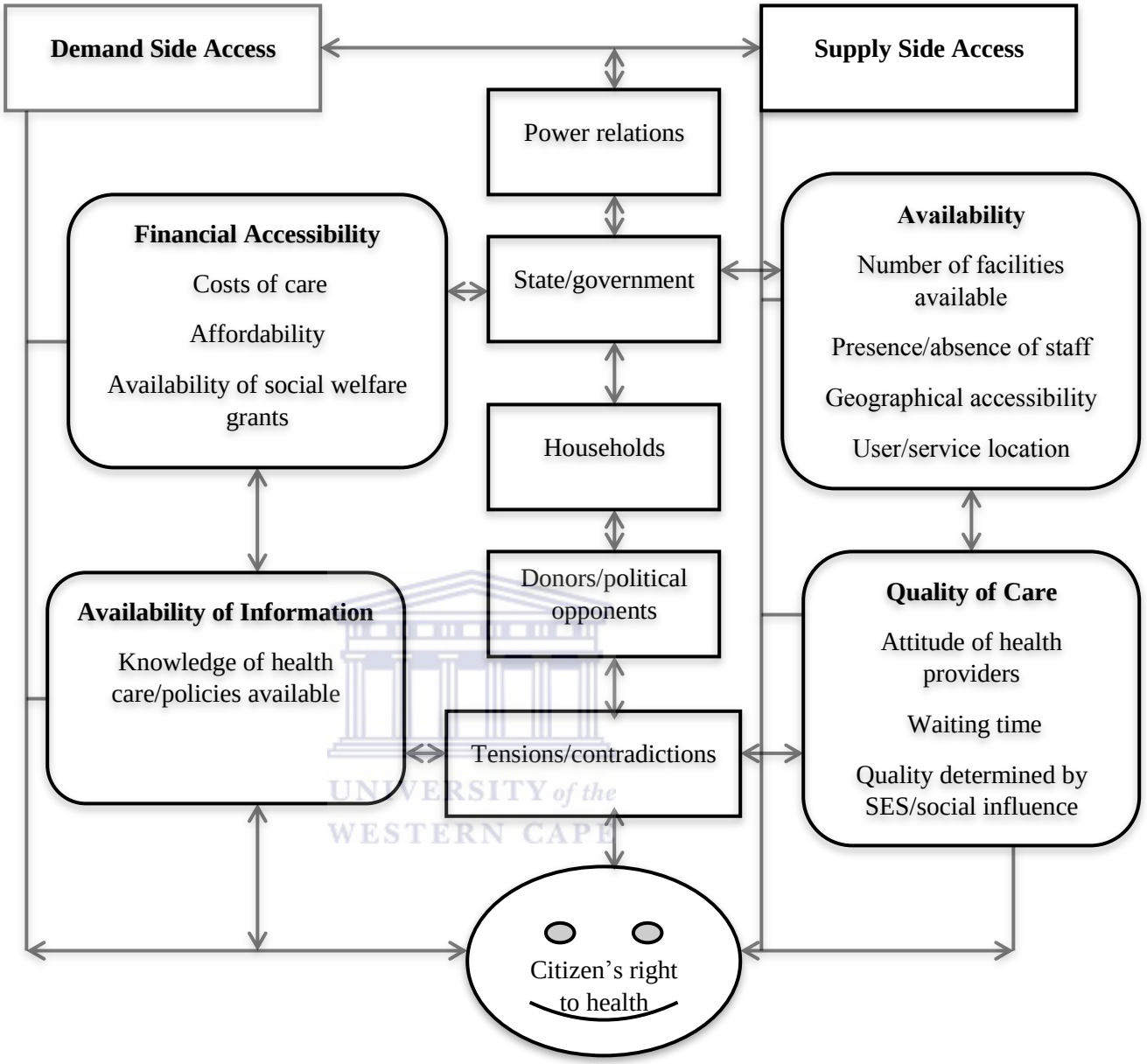

Figure 2.1: Institutional Relations of Power and Dimensions of Access to Health Care from Demand and Supply Sides (Author's Construct, 2014)

As illustrated in figure 2.1, demand side factors generally include household or individual level factors that either impede or enhance access to health care. On the other hand, supply side factors have to do with the health system as regards the distribution and delivery of health care. As figure 2.1 shows, it is important to note that the interaction of demand and supply factors does not take place in a vacuum but is embedded in an institutional framework of social relations of power. It is worth

noting that citizens depend on the health care provided by the state. However, the provision of health care takes place within a web of competing interests on the part of the state, households/individuals, political opponents and donor agencies, to mention just four. This competition between these powers culminates in tensions and contradictions that either enhance or impede the citizens' access to health care. For example, policy change is often the outcome of a political struggle in which different groups either seek or oppose specific changes (UNDP, 2013). According to Harvey (1996), the provision of social services such as equitable health care services by the state is not merely a linear process of demand and supply. Instead, as shown in figure 2.1, the state's provision of health care services is contingent on the institutional relations between the state and various actors in society. In addition, society is dynamic and social institutions change over time. However, these changes may be accompanied by social tension if they compromise the interests of some groups while favouring others. In this perspective, the nature and quality of these social relations of power, whether democratic and inclusive or otherwise, determine the extent to which health care services are provided, and whether or not citizens have the freedom and choice to decide on the type of health care they need (Harvey, 1996; UNDP, 2013).

Sen (2002) is in agreement with these when he argues that it is essential to go beyond just the delivery and distribution of health care in order to obtain an adequate understanding of the way in which social arrangements in society either enhance or impede access to health care. In other words, the interactions between the health system and household or individual factors within each of the dimensions are functions of the social relations of power in society. It is within this institutional framework which interrogates power relations that the dimensions of access to health care – financial accessibility, availability of information, geographical accessibility and quality of care – must be appreciated. These dimensions are discussed further in the next section.

2.5.1 Financial Accessibility

Financial access to health care is perhaps the most common demand side factor and it has attracted the attention of both policy analysts and decision-makers. This dimension relates to health financing in general and it details the financial access of individuals or households to health care services. This dimension has raised questions about the health financing mechanisms and their affordability for the poor and vulnerable in society (Peters et al., 2008). Peters et al. argue that user fees in the form of out-of-pocket payments have generally been recognised as an inequitable way of financing health because they affect the already poor segments of the population most out of all the segments of the population. For this reason, financial access or affordability is considered as one of the most important determinants of access and it is associated directly with poverty (Peters et al., 2008). In addition to the direct costs of treatment, the indirect costs may also impede household or individual access to health care. These indirect costs include transport costs and the opportunity cost of the patient's time as well as that of accompanying relatives, particularly during peak periods of economic activity such as harvest time (Ensor & Cooper, 2004). Peters et al. (2008) argue that, in addition to these financial barriers to accessing health care, it is essential that policy focus on the economic consequences of paying for health services. These economic consequences include spending high proportions of household finances on health, borrowing money or selling assets. These may, in turn, propel households or individuals into even deeper poverty (Peters et al., 2008).

In light of these views, the implementation of the NHIS in Ghana is a response by the state aimed at eliminating financial barriers to access to health care, particularly for the poor. In addition, as highlighted in the previous chapter, the implementation of the NHIS did increase the utilisation of the health care services. Peters et al. (2008) also argue that the abolition of user fees led to an increase in the utilisation of curative, preventative and promotive health services in the developing countries, although this increased utilisation benefited the poor disproportionately.

2.5.2 Availability of Information

The awareness of the citizens about the existence of particular health services or policies is an important factor that determines both the demand for and access to health care (Goddard & Smith, 2001; Ensor & Cooper, 2004; Peters et al., 2008). Goddard and Smith (2001) argue that it is essential that the availability of health services is clearly communicated to all population groups in society. In the event of the health services existing but people are not aware of their existence, the access of even financially sound individuals or households may be limited. Ensor and Cooper (2004) assert that a lack of information about the availability of health services impedes access to health care in the following ways, namely, delays in the decision to seek health care; delays in getting to the health facility, and delays in receiving the appropriate care once at the health facility. Ensor and Cooper (2004) further argue that the citizens' knowledge about the availability or existence of health services is a function of education.

According to Ensor and Cooper, education provides individuals with the knowledge they require to evaluate whether or not they need health care. Thus, knowledge impacts on information about health and care because education and information are correlated. The ability to understand a health message is determined partly by an individual's level of education while the impact of information on health care options and desirable health seeking behaviour is equally important in determining demand (Ensor & Cooper, 2004). The quality and amount of information available are, therefore, critical factors in determining the confidence and/or trust of the health seekers in the health system because people need to have a clear understanding of how the health system works in order to develop confidence and trust in the system. Thiede et al. (2007) go on to suggest that information is crucially important for understanding access as the freedom to use health care. In particular, information on patients' rights may empower patients them to demand accountability from the health care providers with respect to the provision of health care.

2.5.3 Availability of Health Services

The availability of health care is one of the most important supply side factors that has attracted policy action in both the developing and the developed countries (Goddard & Smith, 2001; Peters et al., 2008). The availability of health care may be measured either in terms of the opportunity to access health care as and when needed or in terms of geographical accessibility. According to Sen (2002), it is important to distinguish between achievement and capability, and the facilities socially offered for the achievement of health care. Sen argues that health equity cannot be about demand alone but, also importantly, about how health care is distributed. For example, specialist care may not readily be available to the poor as compared to wealthier families who may be able to travel to tertiary levels of care or private health providers to receive such specialist care. Similarly, the degree of fit between the opening hours of health care facilities, and the presence or absence of health staff at their posts are crucial in determining access to health care when needed (Thiede et al., 2007; Banerjee & Duflo, 2012). For example, Banerjee and Duflo (2012) report that public health facilities in the Udaipur Municipality in India were closed for 56% of the time. Banerjee and Duflo (2012) also argue that the absence of health workers was also extremely unpredictable and this, in turn, made it very difficult for the poor to rely on these public health facilities.

In terms of geographical accessibility, Kerber, De Graft-Johnson, Bhutta, Okong, Starrs, and Lawn (2007) argue that long distances and poor transport networks pose serious barriers which limit the access to care of those who need it most. In other words, the distance to the health facility and the associated transportation costs may further limit the access of poor households to the health services. Peters et al. (2008) concur with this view, arguing that there is an inverse relationship between distance or travel time to health facilities and the use of health facilities. The problem of geographical access becomes extremely pertinent in the rural areas where communications are often cut off during the rainy season. In this regard, Arthur (2012) argues that access to health care services, such as antenatal care (ANC), is

much easier for the urban dwellers than the rural dwellers in Ghana because the urban dwellers live relatively closer to the health facilities as compared to the rural dwellers.

2.5.4 Quality of Care

An equally important determinant of access to health care is the perceived quality of health care, which the health seekers receive. Quality health care is understood in terms of whether or not the health system provides satisfactory services to patients. This, in turn, involves the way in which patients are treated, for example, with decency and respect, and also whether or not patients are accorded a different quality of health care based on either SES or social influence.

Sofaer and Firminger (2005) define and measure quality health care in terms of patient satisfaction with the services they receive and based on expectation theories. Sofaer and Firminger (2005) point out that satisfaction is based on the difference between what one expects from the health providers and what one actually receives. In other words, satisfaction is determined by the difference between a patient's standard of expectations, ideals or norms and the same patient's perceptions of his/her experiences of care, with satisfaction arising from either confirming positive expectation or disconfirming negative expectations (Sofaer & Firminger, 2005). According to Zineldin, "good quality of care is considered the right of all patients and the responsibility of all staff within the hospital" (Zineldin, 2006, p. 61).

When seeking health care, patients enter into a dialogue with the health care providers. This entry into a dialogue presumes the equality of both parties predicated on mutual trust while there must be equal and mutual respect, care, and commitment from both parties. In support of this claim, Thiede et al. (2007) argue that health providers expect patients to respect their professional status and to comply with the prescribed treatment. Similarly, patients expect health providers to treat them with respect, carry out a thorough examination, explain their illness and discuss treatment

options. Decrying the perceived poor quality of health care in Udaipur, India, Banerjee and Duflo (2012, p. 55) claim that the treatment of patients in public health facilities follows a 3-3-3 rule – the interactions between the patient and health provider last three minutes, the provider asks three questions, and the patient is then provided with three medicines. Summing up these views, Arries and Newman (2008) describe quality health care as services that meet set standards involving excellence, and which satisfy the needs of both the health seekers and the health professionals in a way that adds significant meaning to the health care experiences of both parties.

The four dimensions of access presented above are all equally important. I maintain that it is important to policy that that both the demand and supply side access be fairly balanced in an effort to achieve total (T) or universal access. I propose a total access (TA) equation, which must be balanced, based on both demand (D) and supply (S) side access factors across time and space:

$$TA = \sum \left(\frac{TD}{C}\right) N$$

Where TA = total access (D+S), D = distance (Access to health requires movement or displacement from one location or geographical area to another), T = time (The displacement or movement of individuals over space to seek health care takes up a certain about of time, depending on the location of the health facility), C = cost (movement involves both the direct cost of paying for health care and the opportunity cost of lost income from work), and N = number of people/patients served (distance, time and costs of care determine the number of people served).

I justify this proposed formula on Harvey's (2009) three-tier – territorial, group and individual – form of social justice. Territorially, let us assume that the government is the sole provider of health care in a set of territories or regions and that the health care is provided in such a way that social justice is maximised. In this regard, the type and categories of health services or needs that the government will provide in the different territories or regions may vary because health needs are not constant over time (primary, secondary or tertiary health care services). In the words of

Harvey, "[n]eeds are not constant for they are categories of human consciousness and, as society is transformed, so the consciousness of need is transformed" (2009, p. 101).

In a similar manner, health problems may relate to local environmental conditions, local ecology, water quality as well as age, poverty and the number of migrations. These variables all change over time. Consequently, the government's ability to understand the relationships between these variables in a constantly changing environment will provide the government with an objective method for measuring the potential demand for health services. This potential demand will then form the basis for providing (supplying) equitable health care services in the set of regions in a given period of time in an effort to achieve social justice (Harvey, 2009). According to Harvey (2009), the health care needs of individuals or households (groups) are also not static but are, instead, dynamic. Harvey, thus, suggests that these health needs of the individual or groups may explored through demand and supply analysis based on consultation with health planners, community groups, individuals, social workers and rights groups in an effort to achieve socially just and total access (TA) to the health care services.

It is clear from the conceptual illumination above that either demand or supply side access alone will connote partial access. For example, all other things being equal, an increased availability of health care without corresponding effective and well-targeted subsidies for the poor may not automatically increase the demand for and access of the poor to the existing services. The opposite scenario is also possible, namely, even if there are subsidies for the poor without the corresponding supply or availability of health care services, the poor may not be able to access the existing services as a result of long distances to travel and the costs of transportation. The point is that variations in the socio-economic status of different population subgroups at different locations and at different times may lead to inequities in the access to health care. It is for this reason that, by using the analytical framework presented above, this study examines equity in the form of equal access to health care for equal

people in need from the perspective of total access based on territorial, individual and group views of social justice (Goddard & Smith, 2001; Harvey, 2009). This analytical framework will be used to evaluate the empirical findings of the study.

The application of the institutional relations of power framework is particularly relevant for understanding the determinants of access to health care because these relations may either enhance or limit human agency – defined as the capacity of agents (individuals) to make their own life choices with respect to health care (Elder, 1994; Kabeer, 1996). In other words, the demand for health on the one hand, and the supply of health care on the other are mediated by a constantly changing social structure. Kabeer (1996) argues that, for example, unequal gender relations constrain women's agency at the household level because of women's limited access to household resources historically. According to Elder (1994), the issues of time and human agency identify the key mechanisms by which environmental change and pathways influence health-seekers' access to health care. Elder continues that, in rapidly changing societies, differences in birth years expose individuals to different historical worlds, with their opportunities and constraints. For example, in terms of health policy development and access to health care in Ghana, an individual born during the period of the IMF/World Bank superimposed user-fees and another born during the era of the NHIS would have clearly different experiences with respect to access to health care.

Mészáros (2011, p. 10) supports Elder's views, suggesting that it is essential that access to health care be understood in light of the existing social structure because social structure and the state (government) are constantly evolving out of the "life-process of definite individuals". Thus, social structure and history are intertwined because, according to Mészáros, there can be no structural relevance abstracted from either history in "its dynamic course of unfolding in any conceivable social formation, nor history as such without the associated structure" (Mészáros, 2011, p. 12). Mészáros makes a strong claim that ignoring the substantive, dialectical interrelatedness of social structure and history with respect to the provision of, and

access to health care, risks building an incomplete theory of power relations. He writes:

> "For an undialectical approach can only result either in a philosophically irrelevant anecdotal depiction of historical events and personalities by representing some chronological sequence of "before and after" as its assumed self-justification for "story-telling" or in a mechanical cult of structuralism"[3] (Mészáros, 2011, p. 12).

This thesis gives prominence to this social structure and history dialectics as explained by Mészáros, which is the reason why chapter one of the thesis succinctly detailed the historical evolution of health policy development in Ghana. This, in turn, provided the foundation upon which the remainder of the thesis rests.

Mészáros justifies this social structure and history dialectic. He contends that, because the demand and supply side dimensions of access to health care are embedded in the social structure, the social structure and history dialectic renders them amenable to empirical observation and rational assessment in an effort to enhance the provision of the correct quantity and quality of health care to the locations where it is most urgently needed and at the right time.

In taking the discourse on the institutional relations of power framework a step further, Chilvers (2013) argues that assessing any social system in terms of power relations, such as the health system in this case, enables us to determine the level of reflexivity (the extent to which the health system either enhances or constrains human agency in the pursuit of health care) of the system. In other words, to what extent do the dimensions of access to health care – geographical accessibility, availability of information, quality of care and financial accessibility – ultimately affect the citizens' access to health care? According to Tsekeris and Katrivesis (2008), reflexive engagement refers to the unfolding of actions and interactions, beginning in the present and orientating to the future, through the study of the relations between the various actors (e.g. state, individuals, households, opposition

[3] In general, structuralism describes the notion of trying to understand human society by examining the relationship between the constituent elements and the broader social structure.

political parties) within the existing social structure. Thus, in this sense, reflexivity may be regarded as an essential capacity enabling the actors to adjust to situations or to the specific contexts of social phenomena (e.g. access to health care). Consequently, the level of reflexivity of the social systems, ultimately, determines the extent or the degree of human agency within the system (Tsekeris & Katrivesis, 2008).

Thus, a social system with high levels of reflexivity may greatly enhance human agency. In other words, this type of social system enables people to plan effectively and to make free choices from the human development opportunities available (e.g. access to health) in order to to construct their lives (Elder, 1994; Tsekeris & Katrivesis, 2008; Chilvers, 2013). The reverse situation is also valid, that is, a social system with low levels of reflexivity may greatly constrain human agency.

At this point I will use insights from both the ideas presented in the discussion above and the historical account of health policy development, as presented in chapter one, to propose a conceptual model that may be used to rank the degree or levels of reflexivity of a health system or of a social system in general. For the sake of clarity and simplicity, I shall employ a scale of 1 to 3 – 1 representing low levels of reflexivity, 2 representing medium levels, and 3 representing high levels respectively (see fig. 2.2).

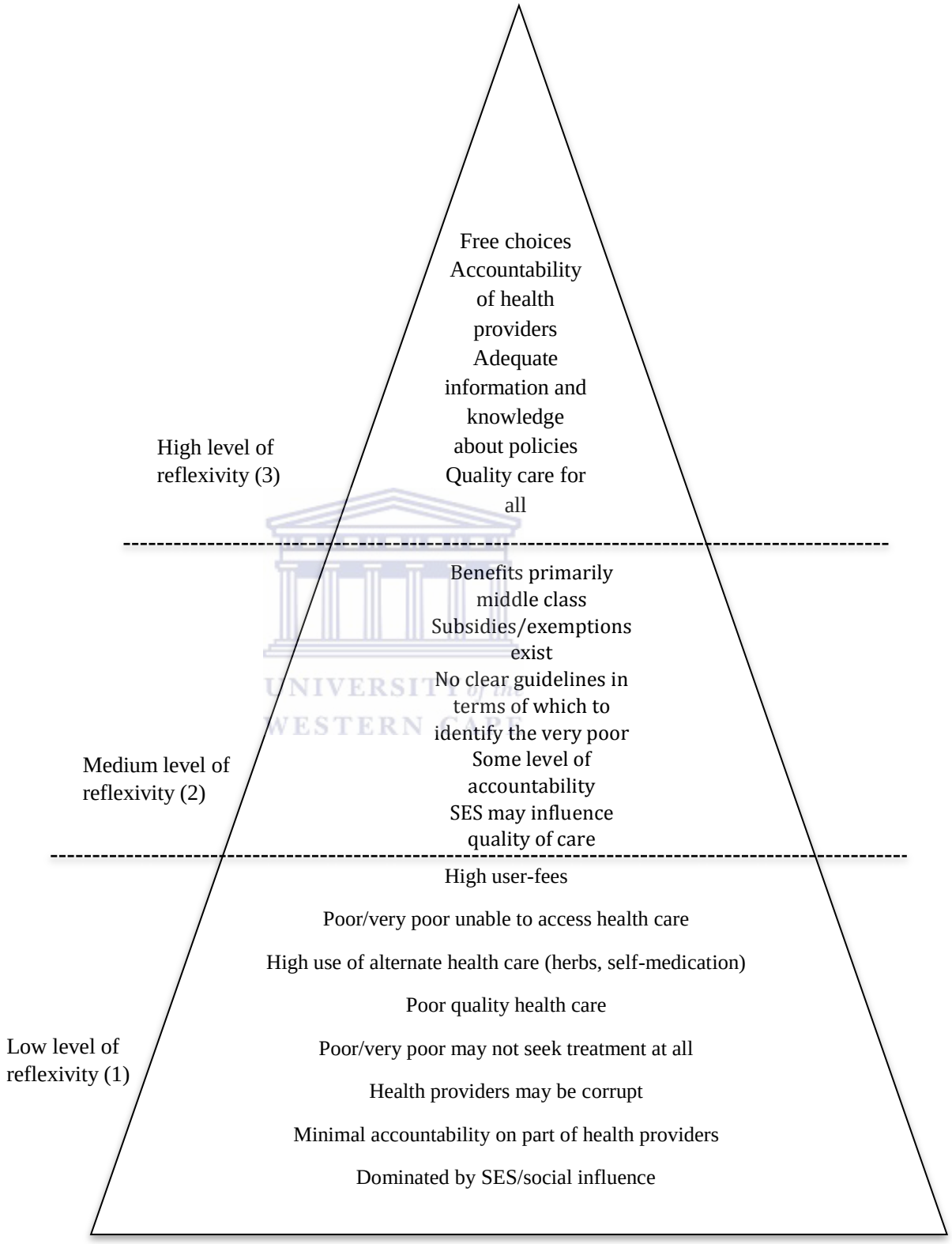

Figure 2.2: Levels of Reflexivity of Health Systems (Author's Construct, 2014)

As illustrated in figure 2.2, a health system with high levels of reflexivity enhances human agency and, thus, enables people to make free choices with respect to access to quality health care. As a result of the fact that the social actors' agency is enhanced in this type of health system, they are able to hold the health providers accountable for the type of health care they receive because they possess adequate information and knowledge about existing public health services. Ultimately, therefore, the people receive quality health care.

As figure 2.2 shows, health systems may also exhibit low levels of reflexivity. In this case, the cost of health care may be so high as to block the access of the poor to health care. Thus, in this type of system access to health care is generally premised on the SES and social influence of the individual. Health providers may even be involved in corrupt practices and, yet, they may not be accountable to the health-seekers. In this case, the quality of the health care is often poor and this, in turn, may frustrate the poor people, who may then resort to alternative forms of health care such as the use of herbs and self-medication. At the very worse, some of the poor/very poor may not seek health care at all.

Health systems with medium levels of reflexivity lie between these two extremes. Health systems with medium levels of reflexivity make provision for subsidies or exemptions policies for the very poor. However, these benefits may not necessarily reach the target population as a result of unclear guidelines for identifying the less advantaged. SES may still, to some extent, influence access to health and, thus, the benefits of health care may accrue disproportionately to both the middle class and the wealthy in society. In the pursuit of health equity and social justice, it is essential that all health systems aspire to high levels of reflexivity in order to enhance the mutual engagement of the various actors in the social structure in an effort to enhance human agency across time and space.

I hope that the discussions above will help to draw attention to the shared contours of the concepts of equity and access to health care and their guiding dimension and that this will lead to an evaluation of the NHIS in Ghana. However, based on the

preceding discussions, I argue that, if health inequities are to be eliminated, it is essential that the economics of health inequities be integrated with the political economy of social relations of power/knowledge in society, as illustrated in figure 2.1. The concept of social relations of power will be discussed in the next section.

2.6 Social Relations of Power and Knowledge (SRPK)

The decision to provide or distribute health resources and facilities equitably throughout the regions or districts in a country is a political decision. In support of this assertion, Guba and Lincoln (1989, p. 118) argue that "every act of science is a political act, one that structures power relationships in a particular way and serves to maintain the *status quo*". Senah (2001, p. 85) goes on to argue that, as a result of the resource constraints in developing countries such as Ghana, "policy makers are constantly faced with the task of making choices which are not only economically, socially, and morally defensible but also politically expedient". Senah (2001) further argues that, as regards public policy making, the implementation of the notion of universal and equitable health care stems from the morality and political economy, which are rooted in the social relations of power in the society concerned. The social relations of power and knowledge become more pronounced when the availability of sufficient economic resources to provide equitable universal access to health care services is limited.

Marx and Engels (2005) emphasised the concept of social relations of power in the history of human existence. They argued that human beings are, by nature, social and, thus, they can neither live without interacting with their fellow human beings nor be isolated from society. In fact, in the first sentence of their *Communist Manifesto*, Marx and Engels (2005, p. 7) write that "the history of all hitherto existing society is the history of class struggles".

Based on these views, I argue that society is a structure of *social relations*, which impinge on every sphere of human activity, including access to equitable health care. Thus, in justification of the overarching social relations of power framework used in

this study, it is my considered opinion that it is not possible to address poverty and the disparities in access to health care without addressing the social, economic, cultural and political factors that shape the conditions of poverty and the disparities in the access to health care. As regards the economic dimension, the structure of the economic relations is an important determinant of access to health care because the material resources, for example, assets, at the disposal of the individuals or households determine the ease or difficulty with which individuals/households are able to access health care. Politically, the distribution of power is manifest in all spheres of life. For example, at work and in politics itself people occupy differentiated hierarchies based on their positions, and the powerful are able to their positions of power as leverage to access health care. This, in turn, implies that those at the very bottom of the hierarchy may have difficulty in accessing health care. Socio-culturally the social networks within which a person is embedded may enhance his/her capabilities as regards accessing health care (Barnes, Hall, & Taylor, 2008). In this light, Hall and Taylor (2009) contend that, in public policy making, the politico-economic and socio-cultural resources are essential in terms of the population's access to health care. Hall and Taylor further suggest that social relations are, in fact, social resources, which individuals or groups draw on in order to advance their own welfare.

In addition, Hall and Taylor (2009) suggest that the structure of the social relations in which people are embedded in society condition both their poverty status and their access to health care. Navarro (2009) supports these views when he argues that the achievement of universal and equitable health coverage is socially determined. I wish, at this point, to emphasise that both the provision of and access to equitable health care do not occur in a vacuum but are, instead, shaped by the existing social relations of power, which are, in turn, shaped either directly or indirectly by institutions. Thus, to a marked extent, institutions embody the content of the principles of justice because the achievement of fair equality of opportunity is predicated on just social relations. Thus, within this context, the social relations of

power encompass the multiply ways in which people are connected to one another in society and are structured by institutions (Hall & Lamont, 2013). Institutions are, therefore, central to social relations by virtue of how they guide both social and political interactions (Hall & Lamont, 2013).

North (1981, pp. 201–202) defines social institutions as the rules, compliance procedures, and moral and ethical behavioural norms which are designed to *constrain* the behaviour of individuals in the interests of maximising the wealth of the ordinary people in society. Elaborating on North's view, Andras (2011) argues that institutions are effective instruments with which to achieve social justice because social justice may be promoted by creating and maintaining just institutions which are likely to result in the just provision and distribution of health resources. According to Acemoglu and Robinson (2012), in view of the fact that institutions are supposed to regulate or constrain behaviour, especially the behaviour of political leaders, they may be said to be like the rules, both formal and informal, that govern economic and political life in society.

Acemoglu and Robinson (2012) distinguish between inclusive and extractive institutions. According to Acemoglu and Robinson, inclusive economic institutions both allow and encourage the participation of the great mass of people in the economic activities that make the best use of their talents and skills and also enable individuals to make choices based on the expanded opportunities available to them. In addition, inclusive economic institutions ensure secure property rights and enforcement of contracts while also creating incentives for investment and innovation, especially in health and education. Inclusive institutions also enable the citizenry to hold their political leaders accountable. On the other hand, extractive institutions do not promote security of property rights, and, as such, they do not provide a socio-political environment, which is conducive to creating and enhancing the capabilities of individuals. In fact, extractive institutions are designed by the politically powerful to extract resources from the mass of society for the benefit of a small, elite group.

Acemoglu and Robinson (2012) further suggest that, in most cases, corrupt political leadership is the outcome of extractive institutions. In Egypt, for example, the protesters who gathered at Tahrir Square in Cairo cited a corrupt government, the absence of social justice, the state's inability to deliver public services such as health care, the lack of equal opportunity and poor education as the reasons for the ousting of Hosni Mubarak on 11 February 2011 (Acemoglu & Robinson, 2012). Acemoglu and Robinson (2012) also argue that Egypt's poverty is the result of the fact that the country has been ruled by a small, elite group that has organised the society for its own benefit at the expense of providing basic social services to the vast majority of the people. Acemoglu and Robinson further report that, while 20% of the population were living in extreme poverty as at February 2011, ex-President Mubarak had accumulated approximately $70 billion for himself and family. In fact, the Africa Union Report (AU, 2013) estimates that as much as $148 billion dollars is lost to corruption in Africa annually. These colossal sums of money accumulated by ex-President Mubarak could have been used to provide health care and education for millions of the Egyptian people. Thus, because extractive political institutions concentrate power and opportunity in the hands of a small elite group, this elite group often promotes its own welfare to the neglect of the provision of basic necessities, such as health and sanitation and education, for the ordinary people.

In light of the preceding discussions the social relations of power framework was deemed appropriate, for the purposes of this study because, as explained in section 2.2, the inequities in access to health care are socially governed, and are, therefore, actionable under socially just or fair social relations of power (Rawls, 1971). In fact, the report of the Commission on Social Determinants of Health of the World Health Organisation (CSDH) (2008) argues that health equity requires fairness as regards both the voice and the inclusion of all groups in society in the decision-making process. The report points out that such fairness in voice and inclusion depends on social structures, which are supported by responsible governments, and which guarantee a comprehensive set of rights and also ensure fair access to health care of

all groups, irrespective of social status. To this end, Navarro (2009, p. 423) observes that it is not *inequalities* that kill people, it is *those who are responsible for these inequalities* who kill people. Thus, the social relations of power framework enables us to challenge the unequal social relations of power in society, and also to answer the "how and why" questions about poverty and access to health care. Drawing on the work of Harriss (2007, p. i) to support my claim, I contend that these "questions refer to the political economy of contemporary capitalism and cultural politics".

I argue that, historically, a theory of social relations of power may encompass knowledge. Foucault (1977, p. 27) acknowledges the vital relationship between power and knowledge when he argues that knowledge is power, and that "power and knowledge directly imply one another, there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations". Foucault (1979) goes on to state that power is intrinsic in all social relations in society and, thus, that power is a "multiplicity of force relations" that constitute social relations (Foucault, 1979, p. 92). Foucault's view leads on to Freire's (1981) rationalisation of the manner in which knowledge is internalised to create a culture of silence among the oppressed. In his contribution to the analysis of power and knowledge, Chambers (1997, p. 58) uses the analogy of "uppers" and "lowers" in his examination of "hierarchies of power and weakness, of dominance and subordination" in society. In Chamber's view "uppers" are people who occupy positions of dominance, whereas "lowers" are those who occupy positions of subordination or weakness. Thus, in Chamber's exposition on "uppers" and "lowers", power is less fixed in persons than in the positions they occupy.

Chambers also speaks to the ways in which the "taken for granted" practices, which are associated with professions – the "normal professionalism" –, create and reproduce power relations (Chambers, 1997). Chambers contends that "uppers", such as professionals with power, tend to impose their "realities on the lowers" and this, in turn, devalues the knowledge and experience of the "lowers". The imposition of

the "realities on the lowers" by powerful professionals is akin to Foucault's description of the ways in which "regimes of truth" are sustained through discourses, institutions and practices (Foucault, 1977).

Using the views of Foucault, Freire and Chambers, Hayward (1998, p. 2) argues that power is "a network of social boundaries that constrain and enable action for all actors" – powerful and powerless alike. Hayward explains social boundaries as the laws, rules, norms, institutional arrangements, and social identities and exclusions that both constrain and enable the actions of all the actors. Thus, if the views of Freire, Chambers and Hayward are combined, it emerges that the oppressed or "lowers", in this context, may comprise very poor households or individuals whose access to health care may be constrained by both unjust institutional arrangements and social barriers such as, inter alia, the costs of health care, geographic location of health facilities, and gender. Nevertheless, the proponents of participatory development advocate giving everyone who has a stake in a development intervention both a "voice and a choice" (Cornwall, 2003, p. 1325).

Thus, knowledge is a resource, which determines the definition of "what is conceived as important, as possible, for and by whom" (Gaventa & Cornwall, 2008, p. 176). Through access to knowledge, and participation in its production, use and dissemination, actors may affect the boundaries and definition of the possible. In other words, the asymmetrical control of power/knowledge may either enable or limit action by individuals or groups in society through the definition of what is possible or right and also what is impossible or not right in policy decisions. In this regard, the ability to influence policy decisions is a function of countering expertise with other expertise. In other words, the ability of individuals to exert greater influence on policy decisions depends on their "superior or better" knowledge. Expertise may take the form of policy analysis or advocacy, both of which involve speaking "for" others and which is based not on the lived experiences of a given problem, but on a study that claims to be "objective" (Gaventa & Cornwall, 2008, p. 173). Gaventa and Cornwall (2008) suggest that power exists through action only

and is present in all spheres of life in society. Thus, based on the above, I maintain that the social relations of power framework underpin the provision of equitable and universal access to health care. I will substantiate this claim by linking social relations and equity in the access to health care in the next section.

2.7 Linking Equity in Access to Health Care and Social relations of Power/Knowledge

As stated above, the social relations of power/knowledge, advertently or inadvertently, tend to order or stratify society into different classes of socio-economic statuses and these, in turn, affect the citizens' access to health care differently. Thus, individuals in society are affected by the asymmetries in their relations with others with these asymmetries being construed in terms of class, status and power (Hall & Taylor, 2009).

In terms of the structure of social relations in society, I argue that it is possible to distinguish the following two forms of social relations of power. The first refers to just, equitable and democratic social relations – those that promote equality of fair opportunity (Rawls, 1999). The second form of social relations of power is socially unjust and stifles the equality of fair opportunity. Based on this dichotomy, I term the socially just relations of power as *ideal* relations of power while the unjust relations are termed the *de facto* relations of power.

I argue that, in the ideal situation, socially just social relations of power may enhance the realisation of the goal of equitable and universal health coverage (UHC) because, despite resource constraints, ideal social relations of power enhance investments in education and health. In this sense, the ideal social relations create opportunities for the ordinary people to participate in the decision-making that affects their lives. With respect to the National Health Insurance Scheme (NHIS) in Ghana, the very poor will have an important role to play with regard to developing criteria for identifying them. It is against this background that Hall and Lamont (2013) suggest that

governments concerned about the wellbeing of their people have to be attentive to social relations because public policies may have significant effects on social relations, in the sense that, as social resources, social relations have to be conserved in the same way in which natural resources are conserved. This, in turn, implies that governments are able to mitigate the effects of demand and supply side inequalities and inequities in health care. These inequalities and inequities may, indeed, be mitigated by providing public services, including health insurance and access to health care, and also promoting education in order to enhance the marketable skills of individuals but only if governments have the political will to do so (Hall & Taylor, 2009).

In addition, under the ideal type of social relations of power, equity in health care is possible because of the enhanced investments in education and health. Green (2008) maintains that, because "knowledge is power" investments in quality education are emancipatory, such investments constitute a path to greater freedom and choices as well as opening the door to improved health, earning opportunities and material wellbeing. In other words, access to quality education unlocks the individual's professional potential and, thus, increases the individual's ability to secure well paid employment. Well-paid employment in turn, increases the disposal income of individuals and households with this increased income enhancing the ability to purchase health insurance. This, in turn, results in increased access to health care coverage for the population on a consistent basis (Liburd, Giles, & Mensah, 2006; Marmot, 2007; Navarro, 2009). However, the opposite is also true as the lack of education may perpetuate social inequalities and also exacerbate poverty.

Goldin and Reinert (2012) argue that education and health are key dimensions of poverty. Access to education and health empowers individuals as regards increasing the opportunities available to them. Thus, both the citizens' ability to realise their rights to education and health and the state's capacity to grant these rights are a function of their relative power relations. Finally, under the ideal type of social relations, the citizens, including the poor, are empowered by their access to

information and knowledge. Both knowledge and power are integral in enabling poor people to address the deeply rooted inequalities of power and voice that pervade local level politics in most countries (Green, 2008). In line with this view, the CSDH (2008) argues that access to health care depends on the empowerment of both individuals and groups and that this empowerment, in turn, enables them to represent their health needs in an effort to question the distribution of health resources. Enhanced access to health care ultimately results in equitable access to health care.

In light of the concept of capabilities approach, as proposed by both Amartya Sen's (1999) and Nussbaum's (2011) and as explained in the preceding sections, I argue that increasing the very poor's access to health care unleashes their human potential or capabilities. The unleashing of this potential, in turn, empowers the poor to engage in new patterns of participation in an effort to question the status quo of the socio-economic and political spheres of society. In this regard, Peters et al. (2008) argue that empowering citizens to lead healthy lives is both a means of overcoming poverty and also an end in itself. This claim of Peters et al. is premised on the fact that the relationship between poverty and access to health is part of a larger cycle in terms of which poverty leads to ill health while ill health maintains and exacerbates poverty. Thus, the capability approach emphasises the collective, social responsibility of the state to protect this potential by removing the societal constraints such as the poverty that inhibit an individual's capabilities and, subsequently, his/her access to health care (Gopinathan et al., 2014).

In contrast, I argue that the de facto relations of power are vertical (or unequal) and may deliver health care only to those who are able to afford the cost of health care, the powerful and the knowledgeable – the "uppers". Unlike the ideal social relations, the delivery of health care by the state is guided by economic and political returns. According to the Commission on Social Determinants of Health (CSDH, 2008), these relations of power are shaped by deeper and systematic social structures and processes which produce and reproduce policies that either tolerate or enforce the unfair distribution of power and wealth as well the access to power and wealth. This,

in turn, results in inequities in access to health care. Under these circumstances, as in the case of other commodities, which are distributed and sold in the market, the forces of demand and supply also determine access to health care. In other words, health becomes a commodity which is marketed and sold in such a way that access to health care is essentially determined by the individual's SES, with the better-off in society benefiting while the poor and vulnerable, who are in desperate need of health care, lose out (Liburd et al., 2006).

This explanation resonates with Hart's (1971) inverse care law. Writing over three decades ago, Hart proposed the inverse care law, which states those who most need health care are less likely to receive it. Hart further explains that the factor driving and maintaining the inverse care law is the free market mechanisms – the forces of demand and supply – because no market will ever shift investment from where it is most profitable to where it is most needed. Watt (2002) agrees with Hart's views when he argues that the inverse care law remains relevant in the 21st century. Substantiating his claim, Watt argues that the commodification of health care remains a major threat to public health equity, especially in the developing countries. In Watt's view, in every society in which market forces determine who gets what in health care, inequalities and inequities abound because the free market does not distribute resources fairly, based on need, but on the ability to pay. This view aptly describes the Ghanaian situation with respect to the participation or enrolment of the very poor in the national health insurance scheme. The view is also appropriate to the Ghanaian situation because, as detailed in chapter one, resources, including health staff and health facilities, are not fairly distributed throughout the country, particularly in the northern regions of the country. However, effective political will is required to effect a fair distribution of these resources to the deprived regions of the North in an effort to reduce the poverty and increase the access to equitable health care.

Watt (2002, pp. 253–254) writes:

> "We need more from our politicians and policy advisers than wholehearted commitment to reduce inequalities in health. Intellectual opposition to injustice is only the beginning of social understanding. We need policies that will make a difference and resources to ensure that good medical care is provided where it is most needed".

It is, however, important to acknowledge that social relations of power at the global level may affect a state's commitment to providing equitable health care to its citizens. In this respect, the CSDH (2008) notes that, even where national governments may be committed to providing equitable health care, policies at the global and national levels may act as obstacles to the creation of the conditions necessary for equitable health care at the national and local levels (Chukwuemeka et al., 2011; Goldin & Reinert, 2012; McMichael, 2012).

2.7.1 Impact of Relations of Power at the International Level on Health Inequities

At the global level, Navarro (1984) argues that even the WHO, which claims to be a neutral and classless technical agency for international health policy, is also part of the international structure, representing the interest of certain classes and states, such as the United States of America, because the actions and ideas of the WHO neither threaten the interests of those in power nor challenge the structures and power relations themselves. To substantiate his claim, Navarro (1984, p. 470) writes:

> "There is a great need to question two dichotomies: politics/technology and ideology/science ... science and technology are not neutral; they carry with them a set of values and ideologies that reflect and reproduce power relations. In that respect, WHO, while being, a technical agency of the United Nations, is also a political agency, which reproduces and distributes political positions through its technological discourse and practices. Thus, it is important to question the prevalent vision of WHO as merely a technical agency committed to the eradication of disease in today's world. This vision belongs to the realm of appearance than reality. Like any other international apparatus, WHO is the synthesis of power relations (each with its own ideology, discourse, and practice) in which one set of relations is dominant. The dominant powers are the dominant classes in the developed capitalist countries".

Navarro's analysis of the unequal power relations at the international level suggests a possible reason for the virtual non-achievement of the health related Millennium Development Goals (MDGs). The MDGs were adopted in 2000 as the next generation of the "health for all goals" in most of the developing countries (Walley et al., 2008, p. 1001).

These unequal social relations of power at the international level also contribute to health inequity in the sense that health has been commodified. According to Nichter (1989, p. 236), the commodification of health portrays health as a state in terms of which one is able obtain health through the consumption of commodities, "medicine". Nichter (1989) further argues that this health commodification is a process, which is responsive to the particular health concerns that are elaborated by the marketing strategies of multinational pharmaceutical companies from the capitalist western world. The rise in the consumption of western medicine is a clear manifestation of health commodification with western medicine increasingly appealing to the public as it claims to offer quick fixes to life's immediate health problems (Nichter, 1989). In order to strengthen the developing countries' dependency on western medicines western pharmaceutical companies consciously engage in the consumerist advertising of medicines which overstate the efficacy of the drugs (Nichter, 1989). This situation, in turn, promotes a process of "pharmaceuticalisation" – a term designating the appropriation of human health problems by western medicines (Nichter, 1989, p. 239). According to Nichter, the overdependence on western medicine tends to weaken the body while enriching the western pharmaceutical companies.

From a policy perspective, the discussions above have two interrelated implications for the health of the populations in the developing countries, including Ghana. Firstly, it may be suggested that the fetishisation of western medicines is, perhaps, a capitalist strategy to siphon money from the burgeoning middle class occupying privileged positions in the developing countries at the expense of the ordinary citizens.

Thus, the consumerist advertisements of the western drug companies try to make indigenous medicines appear both unattractive and ineffective with the result that the practitioners of traditional or indigenous medicine may become redundant as their clients start using western medicines. The second important policy implication is that this fetishisation of western medicines may lead to the objectification of the body, that is, the body becoming an object surviving on western medicine. The logic in this claim is that, in the craze for western medicine, people fail to recognise that one's health is determined by one's "physical environment and socio-moral relations as well as the qualitative state of the changing cosmos; all of which are interactive and multidimensional" (Nichter, 1989, p. 236). In other words, the citizens are not educated to understand their relationship with the physical environment and to appreciate that poor and insanitary environmental conditions are breeding grounds for diseases such as malaria. Instead of socialising citizens to understand the need to live in clean and healthy environments in order to promote preventive health, which is cheaper than curative health, the citizens are, instead, socialised to regard western medicines as a panacea for all their health problems. Finally, the people in the developing countries may have borrow money to pay for the cost of drugs and this, in turn, may make them even poorer, thus resulting in even greater inequity as regards access to health care while the western drug companies become richer and more global.

2.7.2 Impact of Relations of Power at the National Level on Health Inequities

At the national level, the global reach of western companies is linked to institutions such as the IMF and World Bank which, according to McMichael (2012), also contribute to the health inequity in the developing countries. The hegemony of the IMF and World Bank may contribute to the health inequity in the developing countries because most of the governments of these countries, particularly those in sub-Saharan Africa, accept and implement IMF/World Bank prescribed 'textbook' economic policies instead of pursuing their own social and economic development policies which would be relevant to the needs of the ordinary citizens (McMichael,

2012). McMichael (2012) further argues that the World Bank and the IMF also contribute to the health inequity in the developing countries through material supports such as foreign aid, technology transfer and loans. McMichael explains that these material supports from the World Bank and the IMF require the developing countries to reduce their investments in the social services such as education, health services, water and sanitation facilities and housing – all basic needs of the poor. Instead the developing countries are encouraged by the World Bank and the IMF to invest heavily in energy, export agriculture and highways. Clearly, the reduced investment in health care translates into reduced access to health care for the ordinary citizen.

With specific reference to Ghana, the IMF/World Bank hailed Ghana as a success story in the implementation of structural adjustment programmes (SAPs) in Africa. However, available evidence suggests that SAPs was widespread in Ghana between 1987 and 1992 with 31% of all Ghanaians living below the poverty line (Konadu-Agyemang, 2000, p. 457). Investments in the social services stalled as the SAPs were linked to a reduction in budgetary allocation in terms of the provision of education and health. For this reason, less than 5% of the national budget was allocated to health and education. Specifically, 1.16% and 1.3% only of the national budget was allocated to health in 1996 and 1997, whereas the allocation for health was 7% and 10% of the national budget in 1980 and 1982 respectively. Education fared even worse under the SAPs as its share of the national budget allocation fell from 4.3% in 1982 to less than 1% in both 1996 and 1997 (Konadu-Agyemang, 2000, p. 456).

With regards to the commodification of health, Senah (2001, p. 88) argues that "drugs are sold literally by any person in Ghana. And they are used for the wrong conditions, in wrong combinations and with wrong or sub-therapeutic dosages". Senah (2001) further contends that the process of pharmaceuticalisation has become so wide spread that the level of the drug supply has become an important barometer for assessing the political stability of the country.

In addition, the unequal relations of power also contribute to the health inequity at the national level as a result of the uneven distribution of health facilities across space (geographically) and time (historically). As pointed out in the previous chapter, various health policies in Ghana focused on the urban areas as regards the distribution of health facilities. This uneven distribution of health facilities has created a type of spatial injustice. In his work, *Seeking spatial justice*, Soja (2010) argues that unjust geographies arise endogenously or internally from the distributional inequalities which are created by the discriminatory decision making on the part of individuals or institutions. According to Soja (2010), distributional inequality is the most basic and obvious expression of the spatial injustice which is caused by differential wealth and social power, creating locationally biased and discriminatory geographies of accessibility to health services as well as to all basic needs such as education, food, housing and employment.

2.7.3 Impact of Relations of Power at the Local Level on Health Inequities

The unequal social relations of power at the local or community level is, perhaps, exemplified in the policy implementation process of the National Health Insurance Scheme (NHIS) in Ghana (see table 2.1).

Table 2.1: Key Actors, their Levels and Sources of Influence in the NHIS Policy Implementation Process

Actors	Position on National Health Insurance Act 650	Level of Influence	Source of Influence
Ministry of Health	Strong proponents empowered with political mandate to develop NHIS	High	Political status, technical mandate
Incumbent Political Party	Strong proponents empowered with political mandate to develop NHIS	High	Political status
Opposition Political Party	Strong opponents. Felt that 2.5% levy does not encompass adequate accountability controls. Also felt NHIS requires deeper technical analysis	Medium	Political status
Labour Unions	Strong opponents. Felt that 2.5% deduction from their social security contribution was unjustified	Medium/high	Civil society, Economic status
Donors	Neutral/opponents. Felt that design of NHIS was not technically sound. Felt that more time was needed to discuss options	Medium	Financial leverage, Technical knowledge

Politically Connected Consultants	Strong proponents. Empowered with political support. Profit motive to set up schemes	High	Political status derived from MoH
Local Communities/ Ordinary People	Inadequate consultation	No influence	No influence

Source: Modified from Rajkotia (2007, p. 7)

Table 2.1 illustrates the arguments of Rajkotia (2007) and Agyepong and Adjei (2008) that the NHIS implementation process had been dominated by powerful interest groups such as politicians, Ministry of Health (MOH) technocrats, civil society organisations, labour unions, and donors, whereas the ordinary people has not been adequately consulted. This apparent neglect of the local communities and the ordinary people in the NHIS implementation process appears paradoxical in view of the fact that it was the expressed aim of the NHIS is to enhance access of the poor to health care. Interestingly, as table 2.1 shows, opposition political parties, labour unions and donors had recommended more discussions on the design options of the NHIS as well as a deeper technical analysis to explore adequate accountability control mechanisms for the scheme.

However, because the incumbent political party and its politically connected consultants had both political and profit reasons for promoting the scheme, they hastened to implement the scheme. In fact, Rajkotia (2007) argues that, even despite the fact that the concerns of the labour unions, donors and the oppositions parties appear to have been technically credible, they were ignored because of political considerations as the incumbent government wanted to fulfil its campaign promise as quickly as possible in an effort to win votes during the next election. For this reason, the NHIS consultants comprised trusted political allies of the incumbent government and they were entrusted with the "ultimate responsibility for ensuring that the policy

was politically sound and passed quickly and decisively" (Rajkotia, 2007, p. 8). Agyepong and Adjei (2008) also assert that civil society engagement in the media on the implementation of the NHIS took place in the larger urban areas with their higher literacy levels and larger formal sector, and not in the more rural areas and with their larger informal sector.

I argue that the greater financial burden placed on the poor or very poor in the form of flat rate insurance premiums will increase inequity in the NHIS, and that the inability of the NHIS to develop models or criteria in terms of which to identify the very poor is attributable to the neglect of the ordinary citizens as regards their involvement in the decision-making and implementation processes. Decrying the limited opportunities accorded to ordinary citizens to participate in decision making that affects their lives, Banerjee and Duflo (2012) argue that, in policy implementation at the national level, there is rarely space for the average poor man or woman. In fact, if the poor appear at all, it is usually as the "dramatis personae of some uplifting anecdote or tragic episode, to be admired or pitied, but not as a source of knowledge, not as people to be consulted about what they think or want or do" (Banerjee & Duflo, 2012, p. viii).

The WHO (2013) admonishes that strong political leadership and commitment are both crucial in achieving equitable and universal health care (UHC) for the citizenry. This admonition from the WHO clearly describes the relationship between relations of power and the provision of equitable health care in society while underscoring the fact that just social relations of power are crucial for ensuring the requisite investments in health and education in an effort to expand the citizens' capabilities which will, in turn, increase their access to health care.

I will now make use of an empirical example from the Kerala state in India to substantiate my claim that socially just relations of power result in the provision of equitable health care for the ordinary citizens. The literature suggests that Kerala succeeded in providing equitable health care for its ordinary citizens because of inclusive institutions and just social relations of power.

Social justice advocates argue that the developmental state is capable of providing equitable health care to the poor and less advantaged in society (Harvey, 1996, 2009, 2012; Chossudovsky, 2010; Acemoglu & Robinson, 2012; McMichael, 2012; Banerjee & Duflo, 2012; UNDP, 2013; Horton et al., 2014). These writers all agree that social change (positive) is possible if prioritised planning for the social services is supported by inclusive institutions and ideal (socially just) power relations.- At this juncture it seems appropriate to examine briefly how the Kerala state in India has succeeded in providing health care to poor and less advantaged in society.

2.8 State and Health Care Provision for the Poor: The Kerala Model

I maintain that health is the poor's greatest asset. For this reason, it is essential that states make a conscious effort to identify the very poor in an effort to provide for their health needs. A healthy and vibrant population is a prerequisite for both national development and poverty reduction. For example, the Department for International Development (DFID, 2000, p. 11) argues that better health reduces poverty while reduced poverty improves health.

Recognising the importance of good health in the overall socio-economic development process, the Kerala state in India adopted inclusive and participatory policy initiatives that led to the improved access to health care services for the poor in the Kerala. It is argued that the success of the Kerala state in increasing access to health care for the poor was the result of a consistent policy agenda on the part of all the elected governments in Kerala, whatever their political leaning, to invest in both education and health infrastructure (Kutty, 2000). Kutty (2000, p. 103) further points out that "the tradition of government support for health development has been a catalyst for the advancement of health care in the state". Comparing Kerala state to Uttar Pradesh state, also in India, the World Bank (2003, p. 44) describes the two states as "worlds apart" because Kerala is far ahead of Uttar Pradesh in terms of human development. For example, the World Bank (2003, p. 44) points out that the literacy rates for women in Kerala are extremely high, with a 90.8% female school

enrolment rate for girls aged between 6 and 17 years. In the same vein, in Kerala, the proportion of rural girls aged between 10 and 12 years and who have never attended school is 0.0%, while 1.6% of the rural women aged between 15 and 19 years have never attended school. On the other hand, in Uttar Pradesh, the female school enrolment rate for girls aged between 6 and 17 years is 61.4%, the proportion of rural girls aged between 10 and 12 years and who have never attended school is 31.7% and the proportion of rural women aged between 15 and 19 years who have never attended school 49.3% respectively. In addition, 55.7% of the poorest 20% of households in Kerala prefer to use a public health facility when ill as compared to 9.5% only of the poorest 20% of households in Uttar Pradesh.

This evidence from Kerala suggests that, as compared to Uttar Pradesh, the public health care system in Kerala is fair and just and that health-seekers are accorded equality of fair opportunity. The World Bank attributes the achievements of Kerala to its culture of political competition, which is supported by an informed citizen action and political activism. On the other hand, Uttar Pradesh's failures are attributed to its clientelist politics. The World Bank further argues that Kerala's success is as a result of public action that has promoted extensive social opportunities as well as the widespread, equitable provision of schooling, health and other basic services. In contrast, Uttar Pradesh's failures are attributable to the public neglect of these opportunities.

Oommen (2004) supports this claim when he argues that, since mid-1996, Kerala has, launched a unique, decentralised planning experiment to enhance both participatory democracy and the quality of life of the local people. This participatory democracy may be said to be reasonable because, as Oommen argues, in view of the fact that politics is about power, democratic politics is and should be about bringing power down to the people or empowering them. Using the Kerala's Municipal Act 1994 Committee on the Decentralisation of Powers, Oommen (2004, p. 8) substantiates his claims as follows:

> "Local self-government is essentially the empowerment of the people by giving them not only the voice, but the power of choice as well, in order to shape the development they feel is appropriate to their situation. It implies maximum decentralisation of powers to the elected bodies to function as autonomous units with adequate power, authority and resources to discharge the basic responsibility of bringing about economic development and social justice".

According to Oommen (2004), this participatory democracy and local planning framework involves a multi-stage process, which broadens the avenues for people's participation, including the right to information. The right to information, Oommen argues, is a statutory right, and not only enhances the ability of local people to hold their leaders accountable, but is also a powerful step against corruption. In other words, the culture of competitive politics in Kerala widens the opportunities provided for people's participation and reduces the power and domination of entrenched bureaucracy which usually supports rent-seeking interests rather than improving the welfare of society in general.

Comparing Kerala to developed countries, such as Germany and the United Kingdom, Thomas (2009) asserts that the state of Kerala in southern India has achieved health indices comparable to those of the western world, especially as regards providing access to health care services to the poor. Thomas (2009, p. 2) asserts that the "government of Kerala took a decisive policy to provide health insurance to all its underprivileged citizens". In this vein, Acemoglu and Robinson (2012) contend that consistency in policy direction is the hallmark of inclusive political institutions because wealth creation goes beyond simple economics to the understanding of how decisions are made, who makes them and why those people decided to make those decisions. However, these issues are within the realm of politics and the political processes that govern society. Acemoglu and Robinson further suggest that governments in power must work to reduce poverty, claiming that poverty persists because those who have the power make the type of choices that create poverty, instead of getting institutions 'right' in order to create wealth. This argument resonates with that of Navarro's (2009) when he argues that it is not

inequalities do not kill people but, rather, those who create these inequalities who kill people.

The state of Kerala focused on ensuring that institutions functioned properly so that they created wealth and met the health needs of the poor. Kerala's consistent public policy and also its consistent people-centred development, in general, resonates with the UNDP's (2013) description of a developmental state, as described earlier in chapter one. In terms of the three-level reflexivity conceptual model of health systems proposed in section 2.5 earlier, the health system in Kerala may be classified as exhibiting high levels of reflexivity.

According to Thomas (2009), Kerala's success in providing equitable health care and other social services to the poor was predicated on an effective mix of methodologies. Thomas (2009, p. 239) argues that, since 1992, the governemnt of India has been using a below poverty line (BPL) method to identify poor households for targeted subsidies. However, Thomas describes this BPL method as top-down and based on the views of experts. This method is similar to the general income and expenditure methods used in order to identify the poor, also known as the means test (MT) (Thomas, 2009). According to Thomas, people were generally not satisfied with the MT method of identifying poor households because it did not take into account the local or contextual understanding of poverty.

However, since the late 1990s, the government of Kerala has been using a multidimensional method oriented to the socio-cultural settings of the region and known as the "Kerala method" in order to identify poor households. According to Thomas (2009), the Kerala method includes 17 indicators related to, inter alia, housing, presence of alcohol, water, sanitation and health, income sources, food, literacy (Thomas, 2009, p. 240). Thomas further points out that the Kerala method identifies poor households through neighbourhood groups and assumes that perfect knowlegde of each other at the neighbourhood level ensures transparency in identifying poor households. In particular, Thomas argues that the Kerala method is bottom-up and also emphasises the socio-cultural dimensions of poverty (e.g. caste)

within the context of the social relations of power (Thomas, 2009). The Kerala method of identifying poor households appears to resonate with a relatively large body of methodologies, including the proxy means tests (PMT) and participatory wealth ranking (PWR) tha, according to the literature, was generally used to identify poor households Africa, Asia and Latin America (Simanowitz, Nkuna, & Kasim, 2000; Falkingham & Namazie, 2001; Zeller, Sharma, Henry, & Lapenu, 2003).

The following section briefly review the three methodologies highlighted above, noting their respective potential strengths and weaknesses. This review helped me to select the appropriate methodologies as regards identifying very poor households within the context of this study.

2.9 Methodologies to Identify the Very Poor

As pointed out above, this section briefly reviews MT, PMT and PWR as common methodologies for assessing poverty in an effort to identify the very poor.

2.9.1 Means Testing (MT)

In line with the popular notion of poverty being considered as a lack of income, Baulch (1996) argues that income is the most objective and also the best single proxy for poverty (MT). Baulch further argues that data on incomes is readily available. On the other hand, Zeller et al. (2003) indicate that MT involves obtaining detailed information about household average incomes across various socio-economic groups. Zeller et al. (2003) further suggest that it is easy to measure income data directly. This, in turn, offers the advantage of a monetary definition of poverty – a definition that is easily understood by the wider public. Other proponents of MT, such as Lines (2008), suggest that means testing is used by several international agencies because of its clarity and its simplicity.

Variations on this position soon appeared because, as Hulme and McKay (2005), amongst others, assert, income and consumption are complex variables to measure in view of the variety of different types of consumption or sources of income that exist while illiterate populations may find it extremely difficult to recall their past consumption expenditures. Thus, given the detailed and extensive data requirement for MT, it may have limited application, particularly in contexts in which the majority of the people are informal sector workers, and who do not receive regular incomes. MT may also require advanced skills in statistical data analysis in order to analysis the income and expenditure data. In addition, the focus of MT is primarily on material wellbeing, while overlooking other aspects of poverty. In this regard, Bourdieu et al. (1999) argue that using material poverty as the sole measure of all suffering prevents us from seeing and understanding poverty and suffering in society. Bourdieu et al. (1999) further contend that the ongoing reliance on MT to identify the poor has multiplied the social spaces of poverty and also set up the conditions for the occurrence of all types of suffering. In addition, it is argued that poverty is multidimensional and that a lack of assets may offer a better explanation of poverty than income alone (Lakwo, 2009). For example, Lakwo (2009, p. 1) reports that, in Uganda, 98.7% of rural households were asset poor as opposed to the national headcount income poverty of 46.2%. Thus, in the face of these limitations, proxy means testing (PMT) may be a better alternative to MT within the context of this study.

2.9.2 Proxy Means Testing (PMT)

PMT describes the situation in which household or individual characteristics are used as proxy indicators for household or individual wealth or poverty status (Grosh & Baker, 1995). Filmer and Pritchett (2001) argue that PMT identifies poor households on the basis of criteria that relate to income, including education, housing characteristics and asset ownership. The PMT strategy attempts to identify the poor by constructing a poverty index based on a range of household indicators such as health, education, and housing, amongst others, which describe the various

dimensions of poverty. Zeller et al. (2003) suggest that obtaining credible information on these household characteristics is both quick and inexpensive, and that the characteristics also correlate with or are good predictors of either poverty or wellbeing (Jehu-Appiah, Aryeetey, Spaan, Agyepong, & Baltussen, 2010).

One of the most common PMT proxy indicators used in identifying poor households, especially in Asia, is the CASHPOR[4] Housing Index (CHI). The CHI uses external housing conditions as a proxy for poverty and is said to be extremely effective in conditions in which there is a consistent relationship between poverty and housing conditions (Simanowitz et al., 2000). In such a context, by understanding local conditions and the characteristics of poverty, it is possible to select one or more indicators or proxies for poverty that will be visible during a short visit to a person's house. PMT appears to be of practical relevance to this study because it resonates well with the conceptual framework used in the study. It also allows for the easy collection of identifiable information on relevant aspects of household or individual poverty within an informal economy setting. In addition, household or individual assets and demographic characteristics may be more difficult to hide from field surveyors than it would be to hide income.

Nevertheless, PMT may have some limitations. Jehu-Appiah et al. (2010) contend that PMTs are prone to both inclusion and exclusion errors, where the non-poor are included and the 'real' poor are excluded. Jehu-Appiah et al. (2010) suggest that experiences with proxy means testing have shown an exclusion of 16% to 20% of the poor as well as considerable leakages to the non-poor. However, it may be that, in the context of this study, inclusion and exclusion errors may be minimised because the selection of the indicators used as the proxies for poverty would be based on the communities' perceptions on poverty as they emerged during the focus group discussions (FGDs). A second limitation of PMT involves data aggregation. According to Zeller et al. (2003) data aggregation is an issue in proxy means testing because the mix and weights of the indicators reflecting the various dimensions of

[4] CASHPOR is a network of the Grameen Bank in Bangladesh

poverty, such as food insecurity, education, and assets, would necessarily vary between different socio-cultural, economic and agro-ecological contexts. However, the aggregation challenge is often overcome by using a statistical method, known as principal components analysis (PCA).[5] This method is discussed later in the methodology section. Participatory wealth ranking (PWR), which is another strategy for assessing poverty and identifying the poor, and which may complement PMT within the context of this study is now discussed.

2.9.3 Participatory Wealth Ranking (PWR)

PWR is a participatory poverty assessment (PPA) tool for including the views of poor people in the analysis of poverty. It appears the rise of PPAs followed Chambers' (1995, p. 191) assertion that poor people are the "only experts on their life experiences and priorities". In support of this view, Falkingham and Namazie (2001) suggest that an important function of this methodology is the empowerment of the community with the primacy of local knowledge being asserted over externally determined measurement criteria. The technique emphasises the ability of poor people to understand and analyse their own reality. The community itself sets defined criteria for identifying the poor, usually during focus group discussions (FGDs).

Similarly, in their work, *Voices of the poor from many lands,* Narayan and Petesch (2002, p. 2) maintain that "the poor are the true poverty experts". Narayan and Petesch (2002) further suggest that PPA tools, such as PWR, are usually open-ended and interactive in design and, as such, they enable an exploration of issues and shared learning between local people and outsiders. It would, thus, appear that PPAs provide poor people with the opportunity to define poverty in their own terms and based on their perceptions and understanding of the phenomenon. Consistent with

[5] PCA is a variable reduction procedure which is used to obtain data on a large number of variables believed to contain some redundancies. Redundancy means that some of the variables are correlated with one another, perhaps because they are measuring the same thing. In view of the redundancies, PCA is used to reduce the observed variables into a smaller number of principal components.

the preceding discussions, Laderchi et al. (2003) assert that PWR attempts to understand the poverty dimensions within the social, cultural, economic and political environment of a specific locality. In other words, PWR identifies poor households or individuals on the basis of a community's own definitions and perceptions of poverty (Thomas, 2009).

Accordingly, Chambers (2007) suggests that the views of the poor need to be addressed in the formulation of strategies aimed at reducing poverty through public policy. The publication of the report of the Commission on the Measurement of Economic Performance and Social Progress (CMEPSP, 2009) also supports the use of PPAs and, for that matter, PWR in poverty research. According to the report:

> "The time is ripe for our measurement system to shift emphasis from measuring economic production to measuring people's wellbeing. Emphasising wellbeing is important because there appears to be an increasing gap between the information contained in aggregate GDP data, and what counts for common people's wellbeing" (CMEPSP, 2009, p. 12).

Chambers (2010) supports this claim when he argues that based on their experiences, poor people bring to the fore a myriad of dimensions of deprivation, ill-being and wellbeing as well as the values and priorities of these poor people themselves. There are certain advantages to the use of PWR. Souares, Savadogo, Dong, Parmar, Sié, and Sauerborn (2010) suggest that PWR is not only extremely effective in identifying the poor but it is also time efficient. Souares et al. further argue that PWR is also less expensive as compared to MT and PMT while it is also generally well accepted by the local population.

However, it is argued that, as a participatory technique, PWR is useful at the community level or in specific locations only and, hence, it is not possible to use PWR in order to assess poverty across regional, national and international levels for the purposes of comparisons (Zeller et al., 2003). The reason for this shortcoming derives from the fact that it is difficult to verify the results of PWR as they emanate from the subjective ratings of community members. While this weakness of PWR may be genuine, it may not apply to the context of this study because the National

Health Insurance Scheme (NHIS) in Ghana is decentralised. In other words, all districts/municipalities/metropolis are mandated to operate Mutual Health Insurance Schemes (MHIS) autonomously. For this reason, PWR within the context of this study may be a strength rather than a weakness because each district/municipality may be able to harness the potential of PWR in identifying the very poor in their respective catchment areas of operation for the purpose of health insurance premium exemptions.

PWR has significant implications for this study. Firstly, in view of the fact that one of the objectives of this study is to define the very poor contextually and to establish criteria for identifying them, PWR may shed invaluable light on the identification process because the perceptions of the local people of poverty will be brought to bear in the discussions during the focus groups. Secondly, this study also seeks to examine the specific dynamics of the very poor and PWR, as a participatory poverty assessment tool, may be suited to this purpose because the ultimate object of participatory poverty assessments is to enable the poor people to participate in a democratic and dynamic manner in designing the measurement criteria for poverty from an insider's perspective.

2.10 Summary

This chapter examined the concepts of equity and access to health care. Both equity and access are multidimensional concepts. Equity, as applied to health care, implies fairness in the distribution of health care. Essentially it entails three interrelated themes, namely, equal access to available care for equal need, equal utilisation for equal need, and equal quality of care for all. Avoidable inequalities in the distribution of health care are inequitable. In general, the socio-cultural, geographical and demographical differences that constrain people's access to health care are inequitable because these differences are amenable to decisive policy interventions. Social justice should not be conceived of as an aggregate concept but should be appreciated territorially and in both the individual and the group context.

Access to health care entails the freedom to use the health care services without any barriers. This thesis deconstructed access into four main dimensions, namely, financial accessibility, availability of information, availability of health care and quality of care, within a framework of institutional relations of power. These dimensions were categorised into demand and supply side factors, and were examined within the context of an institutional framework of power relations. Thus, this institutional framework enhances our understanding of the supply and demand side factors because these factors are embedded in the social structure which is mediated by the history of human existence. The social structure and history dialectic are, therefore, particularly illuminating because they enable the evaluation of human agency in the light of the constantly changing human need for health care territorially, individually and in groups.

The health needs of both individuals and are not constant for they are categories of human consciousness and, as society is transformed, so is the consciousness of need transformed (Harvey, 2009). A three-level reflexivity framework is proposed for assessing health systems or, more generally, social systems. This framework was extremely useful in the context of this study because it enables various actors within the social structure to reflexively engage with each other while drawing on the method of dialectics in the pursuit of achieving greater human agency with respect to equitable access to health care and social justice.

An extensive literature review suggested that equity as regards access to health care is attainable because the issues of poverty, health inequities and the social relations of power are mutually interdependent. In other words, it is possible for both poverty and the inequities in access to health care to be either eliminated or, at least, minimised under just social relations of power. The Kerala state of India provides an example of how just social relations of power have enabled the state to develop decisive policies which have ensured the provision of health insurance to all the poor and underprivileged citizens of Kerala. Thus, the Kerala state represents high levels of reflexivity. It, therefore, stands to reason that other developing countries could

emulate the Kerala example through effective and inclusive policies based on pro-poor planning and an investment in health.

A set of methodologies, including means testing, proxy means testing and participatory wealth ranking, had been used to identify poor households in Kerala. Accordingly, the chapter reviewed these methodologies in an effort to decide on the selection of appropriate methodologies for identifying the very poor in context of this study. The methodology used in the study is discussed in the next chapter.

Chapter Three

Research Setting and Methodology

3.0 Introduction

This chapter describes the methodology which was used to realise the objectives of the study, namely, to define contextually the very poor based on the communities' perception of poverty, to explore the reasons that motivated households either to enrol or not to enrol in Ghana's National Health Insurance Scheme (NHIS), and to develop a model for identifying very poor households for the purpose of health insurance premium exemptions.

Before discussing the methodology used it was deemed appropriate to contextualise the study by presenting a brief background of the study area – the Kassena-Nankana District in Ghana where the study was conducted. According to Geertz (1993), context is important because most of what we need to understand about a particular social phenomenon is situated as background information before the phenomenon itself is directly examined. Geertz further contends that it is not possible to understand the social phenomenon in which we are interested without first knowing it. In other words, to know it is to understand the context in which it occurs.

Soja (2010) concurs with Geertz's view. According to Soja, context is extremely important as regards enhancing our understanding of social phenomena because humans are spatial beings from birth and, in addition, human beings are integral actors within social contexts. Thus, Soja argues that human existence "is not solitary but always embedded in social contexts and relations" (Soja, 2010, p. 69). Soja goes on to say that human existence is "interactively social, historical and spatial" (Soja, 2010, p. 71) and, hence, to gain knowledge about specific aspects of human existence is first to understand the context in which these aspects occur. Translating these notions to the context of this study suggests that it is not possible to abstract the issues of poverty and access to health care from the context in which they occur. In other words, identifying the very poor means understanding the interpretation of

poverty from the natives' perspective because poverty is related to culture (Geertz, 1993). Accordingly, to understand these phenomena – poverty and access to health care – is also to understand the context in which they occur, because the study context serves as the 'social laboratory' in which the empirical analysis will occur. The background of the Kassena-Nankana District is now discussed.

3.1 Background to the Kassena-Nankana District

The Kassena-Nankana District is located in the north-western region of the Upper East Region of Ghana, as depicted in figure 3.1.

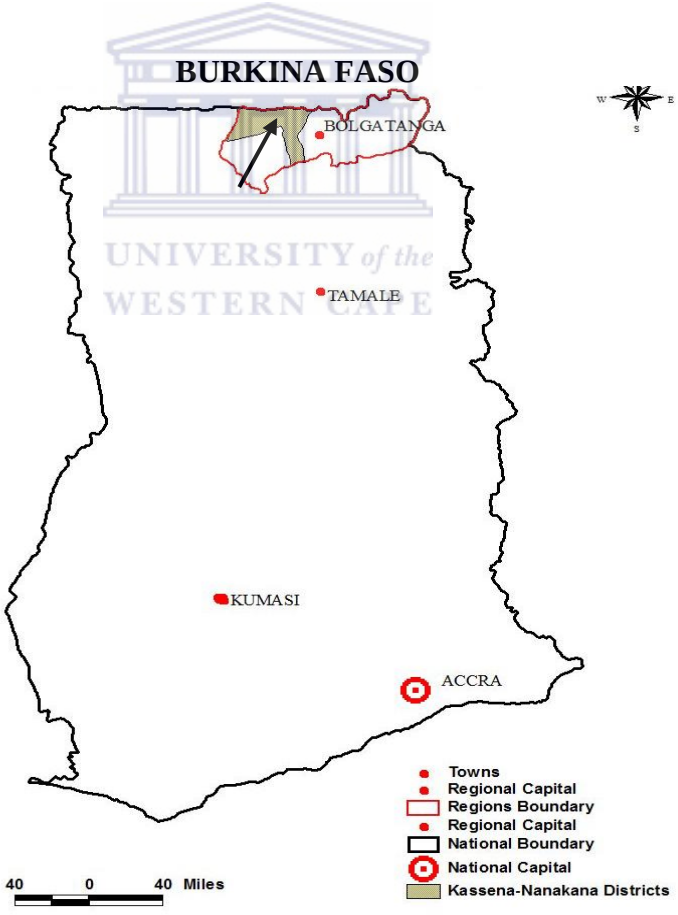

Figure 3.1: Map of Ghana showing the Study Area (Author's Construct, 2014)

The capital of the district is Navrongo. The district lies roughly between latitudes 10°30' and 11°00' north and longitudes 0°55' and 1°30' west (UNDP, 2010). The district covers a total area of approximately 1,674 sq. km and stretches, – approximately 55 km from north to south and 53 km from east to west. It is bordered to the north by the Republic of Burkina Faso, to the east by the Bolgatanga, Bongo and Talensi-Nabdam districts, to the west by the Builsa district and the Sissala East District (in the Upper West Region) and south by the West Mamprusi districts (in the Northern Region). The district has an estimated population of 149,491 (UNDP, 2010, p. 12). Of this figure, the female population is estimated to be 77,575, representing 51.9% of the total population, while the male population is estimated to be 71,916, representing 48% of the population. The district is populated by two main ethnic groups – the Kassenas and the Nankanas. The Kassena ethnic group speak Kasem while the Nankana ethnic group speak Nankam. Agriculture is the major economic activity of the Kassena-Nankana District, providing employment for approximately 70% of the active labour force, while the private informal sector employs approximately 88% of the population (UNDP, 2010, p. 12, 24).

The district experiences two main seasons – a dry season from October to May and a rainy season from June to September. The short rainy season, coupled with erratic rainfall pattern, means that the crop yields are poor. This, in turn, results in the major problems of shortages and poverty in the district. Specifically, households have no food security during the months of April, May, and June. This period marks the onset of the rainy seasons for the cultivation of crops (UNDP, 2010, p. 29). The district is, however, is home to a large irrigation dam – the Tono irrigation dam – which provides water for dry season farming. In the main cereals such as rice and vegetables such as tomatoes and peppers, amongst others, are cultivated in the area irrigated by the Tono Dam.

The unemployment rate in the district is approximately 23% (UNDP, 2010, p. 28.) Child labour, defined as children aged between 7 and 14 who are engaged in paid work, is estimated to be approximately 3.4%. While the adult illiteracy rate in Ghana

is estimated to be 31%, the adult illiteracy rate in the Kassena-Nankana District is 43%. It is worth noting that, while 39% of the population in Ghana is without access to health care services, the corresponding figure for the Kassena-Nankana District correspondingly is 56% (UNDP, 2010, p. 28).

In addition, the doctor to patient ratio in the district deteriorated from 1:31579 in 2005 to 1:31927 in 2007 although, the nurse to patient ratio improved from 1:1700 to 1:1071 during the same period. In 2008, 45% of the health facilities in the district were located in the rural areas while 72% of the health facilities were located in the urban areas. On average, it takes 22% of the urban population between 15 and 30 minutes to get to the nearest health facility whereas the corresponding figure for the rural population is only 10% (UNDP, 2010, p. 40–42).

Road infrastructure in the district is generally poor, especially in the rural areas. Inaccessible roads, particularly in the rainy season, mean that bicycles are the most popular means of transport. On average, 63% of rural dwellers walk for approximately 30 minutes or more in order to access public transport (UNDP, 2010, p. 78).

The Kassena-Nankana District is divided into five zones, namely, the central, east, north, south and west zones respectively by the Navrongo Demographic Surveillance System (NDSS)[6] because of its vast and dispersed settlement patterns. These zones are further divided into clusters, each cluster containing between 29 and 99 compounds. As shown in figure 3.2 the central, north and south zones were randomly selected for the purposes of this study. The central zone comprises the Central Business District (CBD) and is, thus, an urbanised area. The north zone has peri-urban characteristics while the south zone is more rural in nature. The Kassena-Nankana Mutual Health Insurance Scheme (KNMHIS) is briefly described in the next section.

[6] NDSS is a unit of the Navrongo Health Research Centre that collects and updates demographic data in the Kassena-Nankana Municipality in Ghana.

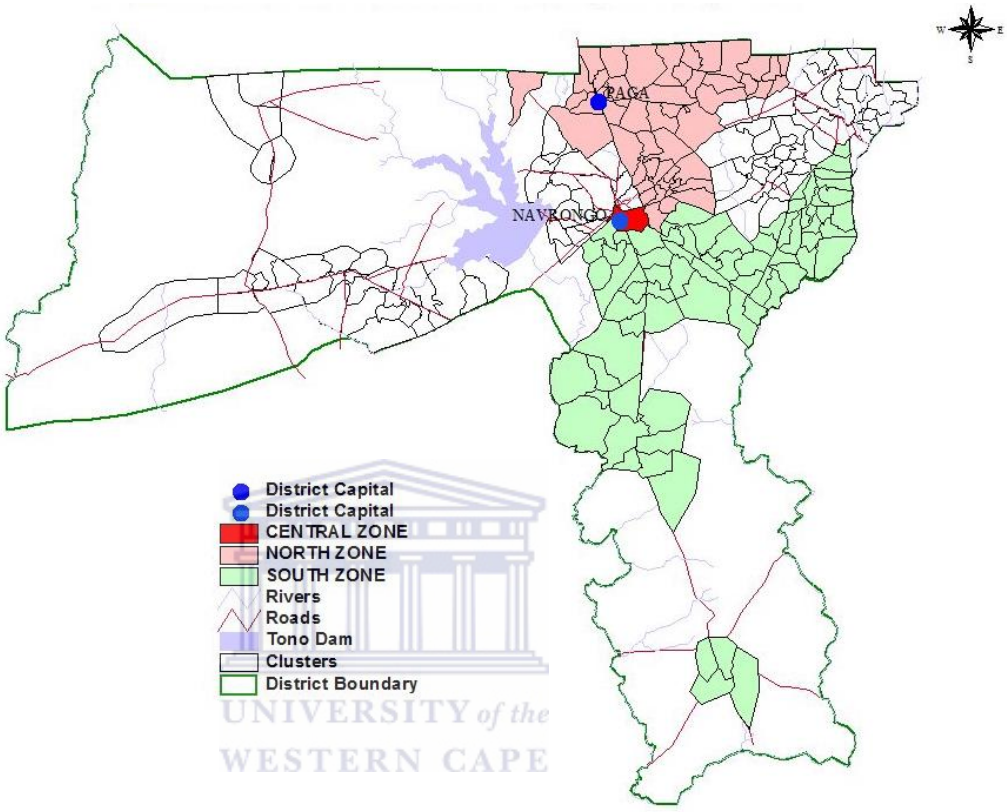

Figure 3.2: Map of the Kassena-Nankana Districts showing the Study Sites (Author's Sketch, 2013)

3.2 The Kassena-Nankana Mutual Health Scheme (KNMHIS)

The Kassena-Nankana Mutual Health Insurance Scheme (KNMHIS) is one of the 145 district health insurance schemes nationwide. It became operational in November 2005 following the nationwide implementation of the National Health Insurance Scheme (NHIS). In December 2012, the KNMHIS had a total registered membership of 15,549. It must, however, be noted that registered members are not necessarily active members in the KNMHIS. Active membership refers to registered

members who have renewed their membership with KMHIS. The active members generally have a valid NHIS membership card, which indicates that they are eligible to receive treatment or medication at NHIS accredited health facilities. The possession of the NHIS membership card means that health seekers do not have to pay cash at the time of receiving health care, provided the treatment or medication demanded is available and covered by the NHIS (Author's interview with staff of KNMHIS, February, 2013). At the time of the fieldwork for the study, the active membership of the KNMHIS was 93, 252. This, in turn, implies that 77,703 people had not renewed their membership with the KNMHIS as at February 2013 and, hence, were not eligible for the benefits of the scheme. Active NHIS members are generally referred to as the "*insured*" while the non-active members are referred to as the "*uninsured*". The active members or insured members also include the exempt categories of people such as the SSNIT pensioners, and those aged 70 years and above, children under 18 years of age, pregnant women and the very poor people. Of the active membership, men constitute 43,521 thus representing 46.67%, whereas women constitute 49,731, representing 53.33%.

The initial or first-time annual registration fee or insurance premium is Gh¢12 ($5) for informal sector workers. Similarly, the initial or first-time annual registration fee for SSNIT contributors is Gh¢4 ($1.6). On the other hand, the annual premium renewal fees for already existing NHIS subscribers is Gh¢10 ($3.9) for informal sector workers and for SSNIT contributors Gh¢2 ($0.8). This renewal fee of ($0.8) also applies to SSNIT pensioners, children under 18 years and those aged 70 years and above. However, both enrolment and renewals are completely free for pregnant women and the very poor. The breakdown of the various categories of people constituting the active membership of the KNMHIS is depicted in figure 3.2.

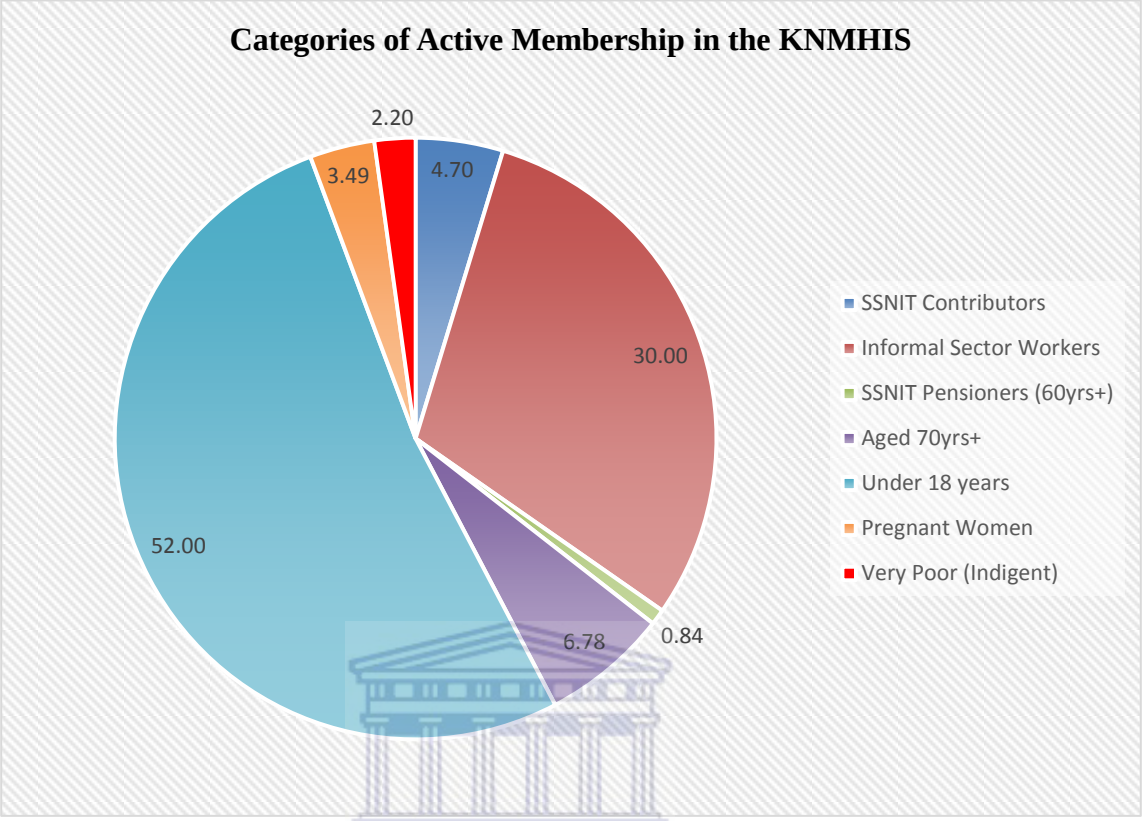

Figure 3.3: Categories of Active Membership in the KNMHIS as at December, 2012

(Source: Author's construct based on interview with staff of KNMHIS, February 2013)

It has become clear that poverty and equitable access to health care are both multidimensional and complex in nature. Thus, in view of the complexity and multidimensionality of these variables, they have to be understood with historical, social and spatial contexts. From this perspective, the multidimensionality and complexity of these variables demand a rigorous research design capable of capturing the various strands of the variables. Thus, what type of research design would be appropriate to capture the various strands of the variables accurately? The following section contains a detail description of the study methodology, which was employed to give meaning to the conceptual issues raised in the preceding chapters.

3. 3 Research Methodology

This section details the research design used in the study. It discusses the sampling procedure and research instruments that were used to collect the empirical data as well as the techniques used in the data analysis. In addition, the section also indicates the time frame within which the research was carried out.

3.3.1 Research Design

Bryman (2008) describes a research design as the general orientation to social research. In view of the multidimensionality of poverty and access to health care as pointed out earlier, a mixed methods research (MMR) design was adopted for the purposes of this study. Definitions of MMR abound. In their work, *Designing and conducting mixed methods research*, Creswell and Plano Clark (2007, p. 5) define MMR as follows:

> "Mixed methods research is a research design with philosophical assumptions as well as methods of inquiry. As a methodology, it involves philosophical assumptions that guide the direction of the collection and analysis of data and the mixture of qualitative and quantitative approaches in many phases in the research process. As a method, it focuses on collecting, analysing, and mixing both quantitative and qualitative data in a single study or series of studies. Its central premise is that the use of quantitative and qualitative approaches in combination provides a better understanding of the research problem than either approach alone".

In the same vein, Johnson, Onwuegbuzie, and Turner (2007, p. 123) define MMR as follows:

> "Mixed methods research is the type of research in which a researcher or team of researchers combines elements of qualitative and quantitative research approaches (e.g., use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the broad purposes of breadth and depth of understanding and corroboration".

With these key definitions in mind the next section contains a justification for the rationale behind adopting a MMR design for the purposes of the study.

3.3.2 Rationale for MMR

A number of reasons motivated the choice of MMR for this study. In the first place, the choice of adopting a MMR design was guided by the fundamental assumption that MMR would provide a broader understanding of the research problem than either qualitative or quantitative approach alone (Teddlie & Tashakkori, 2011). In addition, the issues of poverty and inequity in access to health care comprise multiple constructions and interpretations of reality and MMR offers a tool for understanding complex problems, such as poverty and equity in access to health care in general (Merriam, 2002). Furthermore, both qualitative and quantitative methods have their own strengths and weaknesses and it was felt that MMR would mean that their strengths would be combined. This, in turn, would help with the development of a more comprehensive understanding of the research problem or research questions (Creswell, 2014). For example, it is argued that the use of qualitative methods alone may make it difficult to establish the *extent* of the research problem while the use of quantitative methods alone may make it difficult to ascertain the *whys, hows* and so *whats* of the research problem (Weaver-Hightower, 2013, p. 6).

In this study, the combination of the methods was sequentially phased. During the first phase, qualitative interviews were conducted in selected communities. Specifically, participatory wealth ranking (PWR) exercises were held in the selected communities using focus group discussions (FGDs) in order to explore the perceptions of the community of poverty and its dynamics. These FGDs also elicited reasons for either enrolling or not enrolling in the health insurance scheme. After the qualitative phase, the variables or indicators, which had been suggested by the communities as sound descriptors of poverty or wealth, were thematised. These thematic areas were then used in order to formulate a structured, close-ended questionnaire for the household survey, which was conducted in the selected communities during quantitative phase.

The qualitative phase explored two of the research objectives. This phase contextually defined the very poor and examined their specific dynamics of poverty.

It also suggested criteria with which the very poor may be identified. The perceptions and dynamics of poverty are social constructs and hence my motivation for using qualitative techniques in order to explore these constructs. As further support for the use of qualitative techniques during this phase, Geertz (1993) suggests that qualitative techniques help researchers to interpret the meaning of the social phenomena under investigation from the natives' worldview because people and their institutions are both historically and materially intertwined. Denzin and Lincoln (2011) support this view of Geertz, arguing that qualitative techniques enable researchers to understand the processes and dynamics of a social reality, such as poverty, because qualitative techniques generally involve open-ended questions which provide participants with the opportunity to express their view freely and openly.

In context of this study, the qualitative techniques enabled me to interpret poverty based on the natives' own understanding of it because poverty is culture-related. It is for reason that I deemed qualitative techniques to be more appropriate because these qualitative methods enabled the participants to express both their perceptions and experiences of poverty freely.

During the quantitative phase the reasons that motivated households or individuals either to enrol or not to enrol in the NHIS were examined. The aim of this phase was to quantify or examine the extent to which the NHIS had enhanced equity in the access to health care of the very poor. It was also during the quantitative phase that a model for identifying the poor for the purposes of health insurance premium exemptions in Ghana was developed. As regards the MMR data analysis, I used the convergent, parallel, mixed methods design. In terms of this design, both quantitative and qualitative data are collected, analysed separately and the results then compared to ascertain whether the findings either confirm or do not confirm each other (Creswell, 2014).

Thus, in view of the complexity of both the data sources and data analyses, the use of MMR provided the opportunity to assess divergent views in the conclusions and

inferences made by the study (Teddlie & Tashakkori, 2011). It is important to note that MMR does not necessarily seek convergence in the research results. In fact, according to Teddlie and Tashakkori (2011), an important result of combining information from different sources is divergence or dissimilarity and this, in turn, may provide greater insights into the complex aspect of the same phenomenon and/or the design of a new study or phase for investigation.

In short, the use of both qualitative and quantitative techniques simultaneously is complementary. In addition, the combination of these methods increases confidence in the research findings when the data is consistent (Luyt, 2012). Bryman (2008, p. 621) argues that MMR is "very useful in generating data that are suitable for policy-makers" while Guest (2013, p. 144) argues that "a study gains legitimacy from the strength of the research design, the use of cogent argument and the transparency of the research process". Translating these ideas into a template for this study, I argue that neither quantitative nor qualitative methodology alone is inherently superior but that they both play a role in the production of knowledge, contingent upon the form of knowledge that is being sought. Having justified the rationale for adopting a MMR design for the purposes of the study, the next sections will the rest of the research process, beginning with the qualitative research design.

3.4 Qualitative Research Design

3.4.1 Sampling of Participants for the FGDS

Purposive sampling was used to select the participants for the FGDs. The participants included key informants/opinion leaders as well as people who were perceived as either poor or very poor. The key informants/opinion leaders were selected because they were deemed to possess expert knowledge about the area, including knowledge of the poverty in the area, or they were gatekeepers to a specific segment of the populations (McKenna & Main, 2013). Similarly, the poor or

very poor were selected because of their status as it is believed that the poor are the people who have the best understanding of poverty.

I relied on the key informants in the various zones to recruit people they perceived to be poor or very poor to participate in the FGDs. The FGDS were conducted separately for males and females. The rationale for holding separate FGDs for the key informants/opinion leaders and the poor/very poor groups was based on the notion that the key informants' ideas about and priorities for communities may not necessarily have reflected and may even have conflicted with those of the ordinary community members, particularly the poor or very poor (McKenna & Main, 2013). In addition, in engaging the different groups, a diversity of knowledge and learning may arise from the ongoing collaboration while participation different groups increases the relevance, reach and impact of the research findings (McKenna & Main, 2013).

A total of 24 FGDs were conducted – eight FGDs in each zone. Of the eight FGDs conducted in each zone, four were held with the key informants/opinions and the other four with the poor or very poor people in the zone. The justification for FGDs of this size was informed by the principle of the saturation of information. Saturation describes a situation in which the research, after listening to a range of ideas, reaches a point where he/she is not acquiring any new information (Krueger & Casey, 2009). In other words, as regards FGDs, the new information gained from conducting another session typically decreases as more sessions are held (Teddlie & Yu, 2007). In this case, after the twenty-fourth FGD had been conducted, virtually no new information was being provided by the participants about to the perceptions of poverty and the suggested criteria for identifying the very poor. At this point, the information was deemed to be saturated and the FGDs ended.

Sherraden et al. (1995, p. 62) suggest that, in FGDs, the social interaction within the group yields freer and more complex responses as a result of the interactive synergy, snowballing, spontaneity, and security of the participants within the group. This, in turn, implies that the participants tend to express views that they may not have

expressed in other settings or if they were interviewed individually. Sherraden et al. maintain that, in FGDs, the responses have high face validity as a result of the clarity of the context and the detail of the discussion. Similarly, Bryman (2008) asserts that FGDs offer the researcher the opportunity to study the ways in which individuals collectively make sense of a phenomenon and construct meanings around the phenomenon. In short, the qualitative phase of this study enhanced the exploration of the non-financial dimensions of poverty.

Despite the advantages of FGDs as discussed above, they may also have some limitations. Notable among these disadvantages include the fact that participants in FGDs are not usually randomly sampled from the population and, thus, the results are not generalisable. However, as noted earlier, the chief objective of qualitative studies is to understand the way in which individuals perceive, organise, give meaning to and express their understanding of themselves, their experiences and their own worlds within a particular context – something which quantitative techniques are not able to offer (Mishler, 1986). In addition, FGDs usually deliver a significant great deal of information, some of which may be extremely tangential to the main topic. This, in turn, may render the analysis and summarisation of the results challenging. In addition, it is also often difficult to assemble participants for the discussions while the transcription of interviews may be time consuming.

3.4.2 Participatory Wealth Ranking (PWR) Process

The qualitative phase off the study involved participatory wealth ranking (PWR) exercises during which between eight and 15 selected community members were brought together in focus groups in order to explore perceptions of poverty and, then, to suggest criteria for identifying the very poor. The PWR process involved five stages. During the first stage, the participants were asked to share their experiences or understanding of poverty. Based on these descriptions or definitions of poverty, the second stage required the participants to identify different wealth categories within their communities. The participants were then asked to develop a set of

indicators or criteria for each wealth category, for example, the characteristics of the poorest and the richest? In the third stage the participants were asked to give each wealth category or social class a name, for example, very rich, rich, average, poor and very poor. The participants were then asked to list the various characteristics of these social classes, for example, their assets and possessions. While the participants listed the characteristics of the various social classes, the researcher entered the characteristics of the various social classes on flip charts in the form of a table. In the fourth stage the participants were asked to select five of the criteria listed in the table and to rank and score the criteria that they considered essential that households should fulfil in order to be exempted from paying health insurance premiums. Five baskets representing each of the five criteria were placed before the participants. Each participant was given a set of five cards and asked to distribute their cards by dropping the cards into the baskets. The more cards placed in a particular basket meant that that the criterion which was represented by that particular basket was deemed to be key in predicting poverty. When everyone in the group had distributed their cards, the number of cards in each basket was then counted and ranked. The more cards there were in a particular basket relative to the others, the higher the ranking. The final stage of the PWR process involved validation meetings in all three of the zones with respect to the five selected criteria. The validation meeting brought together all the groups to reach consensus on the selected criteria. The quantitative research design is discussed briefly in the next section.

3.5 Quantitative Research Design

The quantitative phase of the study involved a cross-sectional, household-based survey conducted in the study area. A multi-stage sampling procedure was adopted for the purposes of the study.

3.5.1 Multi-stage Sampling

Consistent with the multidimensional nature of poverty and access to health care, as discussed earlier, a multi-stage sampling procedure was followed in select households for the purposes of the study. The rationale for adopting this sampling procedure was to ensure that a representative sample was selected in an effort to enhance the trustworthiness of the research results.

In the first stage, three out of the five zones in the Kassena-Nankana District, namely, central, north and south, were randomly selected for the study. Secondly, three clusters in each of the zones were randomly selected and households were then drawn randomly from these clusters. In the third stage, simple random sampling was used to draw households for the purposes of the interviews. The NDSS has a database containing all the households in the Kassena-Nankana District. This database of households served as the sampling frame and, thus, I liaised with NDSS to generate the list of households from their database in an effort to arrive at a representative sample size.

3.5.2 Sample Size

In order to ensure the representativeness of the sample, the sample selection process for the household survey was guided by standard statistical procedures. It is argued that the sample size or population parameters in general are important in quantitative research design because the population parameters help to enhance the reliability of the research findings (Leedy & Ormrod, 2010). According to Creswell (2014, p. 159), there are three factors, which often guide the selection of a representative sample. These factors include the following: (i) the estimated prevalence of the variable of interest – the variable of interest in this case was poverty, (ii) the desired level of confidence and (iii) the acceptable margin of error. Thus, based on these three factors, the required sample size was calculated according to the following formula:

$N = t^2 * p\ (1-p)/m^2$

Where

***N** = required sample size*

***T** = confidence level at 95% (standards value of 1.96)*

***P** = estimated prevalence of poverty in the research area – 70% (0.7)*

***M** = margin of error at 5% (standard value of 0.05)*

The required sample size was then obtained as follows:

N = 1.96^2*0.7(1-0.7)/0.05^2 = 3.8416*0.21/0.0025 = 0.806736/0.005 = **322.6944 or 323**

This figure was increased to 437 in order to take into account the issue of non-responses. In view of the fact that the clusters in each of the zones were of equal sizes, this figure (437), was divided equally among the clusters and, thus, approximately 146 households from each cluster were randomly selected to participate in the study. At the end of the survey, 417 questionnaires had been completed or answered, representing a 95% response rate and 5% non-response rate respectively. The households included a total population of 2,173 individuals.

3.5 MMR Data Collection Techniques

Having calculated the desired sample size, the data collection was conducted in two stages, namely, the pre-data collection procedure and the actual data collection.

3.5.1 Pre-Data Collection Procedure

Data collection was preceded by two weeks of training sessions for the field assistants. These field assistants were graduate students who assisted the researcher to collect the requisite data. The purpose of the study was explained to the field assistants and, together with the researcher, common terms and the meanings of the

variables used in the questionnaire and in the FGD guide were agreed upon. Following the training sessions the questionnaire and the FGD guide were both pre-tested. This afforded the research team the opportunity to revise and make appropriate adjustments to the questionnaire and the FGD guide. This pre-field work helped to minimise response bias in the data collection process. Response bias describes a situation in which the responses do not reflect the 'true' opinions or behaviours of the respondents because the respondents misunderstood the questions.

It was recommended that field assistants administer the questionnaire to household heads only. Household heads were considered as appropriate persons to respond to the questionnaire because the questions related both to household possessions and assets and to the reasons that motivated households either to enrol or not to enrol in the NHIS. The questionnaire was administered to the household heads on a face to face basis until all the household heads had completed the questionnaire. The field assistants were encouraged to make repeated visits to households should the household head not have been present at the first visit.

3.5.2 Actual Data Collection

The actual data collection process started in February 2013 and ended in July 2013. FGDs were conducted in order to collect the qualitative data from the key informants, opinion leaders and poor or very poor people in the zones or communities. The FGDs explored the communities' understandings of poverty and distinguished between the very poor, poor, average, rich and very rich social classes in the communities. The FGDs enhanced the examination of the dynamics of these social classes of people by highlighting the assets or possessions associated with these categories of people or households. The FGDs then suggested criteria in terms of which very poor households may be identified (see chapter four). The FGD guide is contained in Appendix I.

The quantitative phase of the study involved structured, closed ended questionnaires (Appendix II) being administered to the household heads. The questionnaire covered a number of issues, including health insurance status of households, the reasons for either enrolling or not enrolling in the health insurance scheme and household expenditure on health. The questionnaire also explored, inter alia, the self-rated health status of the households, the socio-demographics of the households, the assets and possessions of the households and housing quality.

3.6 Data Validity and Reliability

"All research is concerned with producing valid and reliable knowledge in an ethical manner" (Merriam, 2009, p. 209). Validity and reliability are also referred to as trustworthiness, credibility, transferability, dependability, conformability and consistency, especially with regards to qualitative research design (Merriam, 2009; Leedy & Ormrod, 2010; Creswell, 2014). This study used the definitions of validity and reliability as formulated by Leedy and Ormrod (2010). According to Leedy and Ormrod (2010), validity and reliability refer to the accuracy, meaningfulness and credibility of the research results. Leedy and Ormrod suggest that the validity of a study refers to whether or not the study has sufficient controls in place to ensure that the conclusions drawn from the data are truly warranted. It is clearly of the utmost importance that policy decision-makers are able to trust research results because they (policy decision-makers) may rely on the research results to effect policy interventions in the lives of citizens.

Accordingly, for the purposes of this study a number of controls were put in the place to ensure the validity and reliability of the research in general, and the research findings in particular. The first control mechanism involved the two week training sessions organised for the field assistants. These training sessions clarified the concepts used in the questionnaire and the focus group guide and ensured that the research team had a uniform or consistent understanding of the concepts used in these instruments. In addition, the pre-testing or piloting of both the questionnaire

and the FGD guide enhanced the validity and reliability of the research findings because this process – the pre-test or pilot exercise – enabled the research team to identify problem areas in the data collection instruments, for example, the appropriate translations of the concepts "poor and very poor". Such issues were then addressed and adjusted appropriately. In support of the pilot testing or pre-testing exercises as a validity control mechanism, Creswell (2014) suggests that this pre-testing is important in order to establish the content validity of the study.

Secondly, triangulation – the use of multiple methods of data collection – was used to enhance the validity of the study (Merriam, 2009). Thus, the use of both FGDs and household surveys to collate similar information enhanced the validity and reliability of the study. Leedy and Ormrod (2010) argue that triangulation is a key feature of mixed method research designs, and serves to increase the validity and reliability of the research findings.

The use of *thick description* – sufficiently verbatim and detailed representation of the facts as presented by the natives on a particular subject matter (Geertz, 1993) – has been found to be an effective control for validity and reliability, especially with respect to the qualitative phase of an MMR design. Leedy and Ormrod (2010) and Creswell (2014) agree with Geertz (1993) when they point out that thick description refers to a situation in which the research problem is described in sufficiently rich, "thick" detail that may transport the readers to the setting and also give to the discussion an element of shared experiences. Within the context of this study, the communities' perceptions or explanations of poverty, and their views on the criteria with which the very poor may be identified are, indeed, thick and rich (see chapter four).

Finally, I controlled the quality of the quantitative interviews on a daily basis in the sense that, when the field assistants returned the completed questionnaires, I reviewed the questionnaires in an effort to verify and ensure consistency in all the completed questionnaires. Questionnaires that were incomplete and contained inconsistencies were returned to the field assistants for verification. In some

instances, I requested the field assistants to go back to the field to complete the questionnaires or to correct the inconsistencies. In addition, the quantitative data was entered twice as part of the quality control measures. In order to ensure the credibility of the qualitative interviews, I conducted the FGDs myself and was assisted by one field assistant. I acted as the moderator of the FGDs while the field assistant took notes. The note taker occasionally prompted me to investigate further certain issues that needed further clarification. As a validation process, I recapitulated the main issues discussed during the FGDs to allow for feedback from the participants. In order to ensure the accuracy of the information, all the FGDs were recorded using a tape recorder and then transcribed to enable visual scrutiny. Throughout the FGDs I remained conscious of the fact that there is no one objective reality and that reality is a value-laden concept which has implications for power relations (Butler-Kisber, 2010). The transcriptions were then translated from the local languages, Kasem and Nankam, into English.

3.7 Data Analysis

According to Bernard and Ryan (2010, p. 109), "analysis is the search for patterns in data and for ideas that help explain those patterns, interpreting those patterns, deciding what they mean and linking your findings to those of other research". In order to search for patterns and ideas in the data the data analysis process was both qualitative and quantitative.

3.7.1 Qualitative Data Analysis

The qualitative data generated from the FGDs in the study was initially categorised into themes in order to facilitate the data analysis (Riessman, 2008). I then made systematic comparisons between the themes to establish similarities or commonalities. After this categorisation, I validated the themes by listening to the audio recordings several times and comparing them with the visual transcripts to

ensure that the recordings and the visual transcripts were consistent. After this validation process, the analysis then took the narrative form, based on the experiential accounts of the participants. In view of the fact that the aim in this context was to explore the communities' perceptions of poverty and to solicit the communities' own suggested criteria for identifying the very poor, the narrative analysis was consider appropriate because the narratives directly allowed the voices of the natives to be represented accurately. Since the communities' views were directly captured in the narratives and their voices echoed in the narratives, the research findings are original and should appeal to policy-makers. Thus, the results have the potential to ignite the desired social action and change in an effort to identify the very poor for insurance exemptions.

Geertz (1993, p. 6), points out that an attempt to understand culture-related phenomenon, such as poverty, no matter what the analysis the researcher carries out in the form of taxonomies, tables, statistics or econometric models, it is essential that the analysis "reflect what the natives really say" the phenomenon is. Geertz argues that this understanding may be enhanced only through an intellectual effort, an elaborate venture of *thick description*, and this, in turn, is made possible by a narrative.

Similarly, Butler-Kisber (2010, p. 4) argues that narrative analysis is essential because "narrative is a legitimate and natural way of doing and knowing" while it helps both to challenge the thinking about the nature of reality and to examine the local as a political site where inequities exist that may be challenged and changed with action. Finally, narrative analysis gives the researcher "the ability to enter the lived experience and perspective of the other person, [the narrator emphasis mine] to stand not only in their shoes, but also in the emotional body – to see the world with their eyes" (Hawkins, 1988, p. 63, cited in Butler-Kisber, 2010, p. 52).

3.7.2 Quantitative Data Analysis

The household data was captured into a database using Epidata and then analysed using STATA version 12.0. A poverty index was generated using principal

component analysis (PCA) to determine the SES of the households. Using the poverty (SES) index generated by the PCA, the sampled population was dichotomised into *poor* and *not poor* categories, based on the household possessions and assets. The reason for dividing the population into two instead of quintiles was to allow for heterogeneity between the two groups because dividing the population into quintiles may not have revealed any variability between the different categories, given the sample size. The dichotomisation would also allow for a logistic model specification. This was deemed important because the ultimate aim of the study was to be able to predict the number of very poor households from among the poor households, based on the poverty index generated by the PCA.

PCA is a statistical procedure which is used to determine weights for a linear index of a set of variables (Filmer & Pritchett, 2001). According to Zeller et al. (2003, p. 1491), PCA is a statistical procedure that could be used to isolate and measure the poverty component embedded in various indicators and, thus, create a household-specific poverty status score or index in relation to all the other households in the sample. The lower the poverty status score, the poorer the household relative to other households with higher scores. The assets and possessions that were used for the PCA included bicycles, motor bikes, vehicles, beds, radios, mobile telephones, cooking fuel, cattle, sheep, goats, pigs and donkeys and, as regards the dwellings,, number of rooms, type of material used for walls, roofing material, toilet material and sources of drinking water. The reason why all these 17 items were included in a single PCA is that PCA identifies meaningful factors of items. In other words, PCA includes items that are interrelated while excluding items that are not related and/or overlap significantly with other items (Jehu-Appiah, Aryeetey, Agyepong, Spaan, & Baltussen, 2012). Ownership of these assets and possession were perceived as an important proxy of the household economic status. Thus, households with all these possessions and assets were perceived as the "better off" in the study setting as compared to households that had either very few or none of these possessions.

Before proceeding with the PCA, the Kaiser-Meyer-Olkin measure (KMO) of sampling adequacy and the Bartlett test of sphericity were applied to determine whether or not the set of 17 items contained sufficient collinearity to warrant the use of PCA. The KMO value ranges between 0 and 1 – a value of zero or close to zero suggests that the data set is not amenable to PCA while a value of close to 1 or exactly 1 suggests that the data set is perfect for PCA. In this study, the KMO was 0.805 while the Bartlett test was significant with a p-value of ($p = 0.001$), thus indicating that the data was amenable to PCA.

Following the PCA, a bivariate analysis was conducted to establish the correlation between insurance status, income and monthly household health expenditure. The Cramer's V correlation coefficient was also used to evaluate the relationship between income and insurance status; to establish whether there was any relationship and, if indeed, there was a relationship, the strength of the relationship between income and insurance status. The Cramer's V correlation coefficient was deemed appropriate because it allows for a comparison between ordered/ranked variables and dichotomous/categorical variables. In this case, income brackets were ranked in order of magnitude, while the outcome variable, insurance status, was dichotomous (insured or uninsured). The decision rule is that the coefficient ranges in value from 0.0 to 1.0. The closer a coefficient is to 1.0 the stronger the association, while the closer a coefficient is to 0.0 the weaker the relationship. In addition, the coefficient is either positive or negative with this indicating the direction of the relationship. Generally, the Cramer's V coefficient is given by the following formula:

Cramer's V coefficient = $\sqrt{\mathbf{x^2/N\,(k-1)}}$ where,

X^2 = the computed chi square value
N = total frequency (sample size)
K = the smaller of R (the number of Rows) or C (the number of columns)
1 = a constant

In addition, a cross-tabulation of self-rated health status and insurance status was conducted to establish the relationship between the two variables while a chi-square test was conducted to test the following hypothesis "*There is no*

relationship between self-rated health status and insurance status". The results of the chi-square test are discussed in detail in chapter five.

The third and final section of the analysis focused on developing a model for identifying very poor households. A logistic regression model was used for this section of the analysis. Based on the SES index generated by the PCA, the aim of the logistic regression at this point was to predict the number of households among the poor households that were very poor and, thus, deserved to be exempted from paying health insurance premiums. In order to predict or identify these very poor households, the predicted probabilities of being poor were used, based on the fitted logistic model. In view of the fact that different probabilities of being poor were generated for different households, coupled with the fact that there had not been any prior statistical guide in terms of which to identify very poor households, a cut-off point had to be decided upon, that is, the threshold at which households be should be considered very poor. It was decided that households would be considered as very poor if their predicted probabilities of being poor were 75% and above. Such households would qualify for exemption from paying health insurance premiums. The 75% and above probabilities cut-off point was intuitively chosen because the poor households were divided into quartiles with the upper quartile (75%) representing the poorest among the poor. Based on this cut-off point, a new variable "exempt" was generated in an effort to determine the number of households, which should or should not be exempted from paying insurance premiums. The number of households that were predicted as being very poor and the unique characteristics of these households are presented in Appendix V.

3.8 Research Scope and Limitations

This study examined the NHIS with the aim of bridging the equity gap in access to health based on field research conducted in the Kassena-Nankana District in Ghana.

Despite the fact that the research was not carried out on a national scale, the research findings do provide valuable insights with respect to the extent of the inequities that exist in the NHIS. In addition, the research procedure adopted in this study may be applied to other contexts for the purpose of identifying the poor generally.

Finally, because the questionnaire was administered to household heads only, it was, in some cases, challenging to meet the household heads at home for the interviews. In order to overcome this problem, the field assistants often made several follow up visits to households in an effort to meet the household heads. However, these follow up visits paid off because, in the end, adequate data was collected to allow the analysis to proceed because a high response rate of 95% was obtained.

3.9 Ethics Statement

Research involves collecting data from and about people. For this reason, it is important to observe high ethical standards if credible and trustworthy research findings are to be produced. According to Creswell (2014), it is essential that researchers protect their research participants, develop a relationship of trust with them, promote the integrity of research, and guard against misconduct and impropriety. Consistent with these views, ethical protocols for this study were followed during the three stages of the study, namely, the pre-fieldwork, fieldwork or data collection and the data analysis stages.

During the pre-fieldwork stage, the research proposal for the study was submitted to the Faculty of Economic and Management Sciences and the Senate High Degrees Committee for review. Subsequently, permission to carry out the study was granted by both the Faculty of Economic and Management Sciences and Senate High Degrees Committee in June 2012. Similarly, permission to conduct the study was also sought from the chiefs and people of the study communities in Navrongo, Ghana.

During the fieldwork stage, the purpose of the study was explained to the participants and their consent was sought. In addition, the participants were informed that their participation in the study was voluntary and, thus, they were at liberty to withdraw from the study anytime they so wished. The confidentiality and privacy of the participants were also assured. Accordingly, during the third (analysis) stage, the participants' names were not mentioned in the analysis. For example, the participants in the focus group discussions (FGDs) were given numbers, participant 1, participant 2, etc.

Chapter Four

Contextualising Poverty: Towards an Interpretative Inquiry

4.0 Introduction

The chapter presents the qualitative results of the study. The objectives addressed in this chapter are twofold. The first objective was to define contextually the very poor by eliciting the community perceptions of poverty and the dynamics of poverty. Having contextualised poverty, the second objective of the study discussed in this chapter was to solicit the communities' own criteria for identifying the very poor for the purpose of health insurance premium exemptions. The communities' perceptions of poverty are discussed next.

4.1 Understanding Poverty: The Communities' Perspectives

In an attempt to assess the socio-economic status (SES) of the households in the study communities, definitions of both the poor and very poor were solicited in the two major languages used in the study areas, namely, Kasem and Nankam. In Kasem, the very poor are referred to as '*Yinigretu*' while the poor are referred to as '*Yinigatu*' whereas in Nankam, the very poor are referred to as '*Namsa Piadaana'* while the poor are simply referred to as *Namsa*. It emerged from the communities' perception of the poor that, according to the communities, their status is not a permanent condition. They are poor because they have a weak assets base and may easily be plunged into very poor status in the difficult seasons of either drought or flood. On the on the other hand, the very poor were perceived as being permanently stuck in that position, seeking merely to survive. In the focus group discussions (FGD), the poor people themselves defined poverty as follows:

> *"Poverty is like fire. Every day, the fire burns you but you won't die. You know when you die; it is better than when you are suffering. Poverty is when you are sick and you cannot afford the cost of treatment. As you have seen me, you have seen poverty. It is not hidden* (FGD with poor/very poor people at Pindaa, North zone).

The following perception of poverty emerged from another FGD held with a group of poor or very poor people aged 40 years and above:

> *For me, I think that there is no definition for poverty because poverty is not natural. People create poverty. Even in the land of the White man, there is poverty. Poverty occurs as a result of the refusal of the rich in society to help the poor because of their desire to amass more things [wealth] and money. Money has spoiled everything because everyone wants to have more money. In those days, when you entered a house, everything belonged to the landlord and so things in the house belonged to everyone. It was not easy for you to know who was poor and who was rich. When we help one another, there will not be poverty on earth* (FGD with key informants/opinion leaders in Kologo, South zone).

The testimonies quoted above reveal the communities' realities about poverty as well as their understandings of poverty. When these narratives are interpreted in terms of the conceptual and theoretical framework, the narratives support the dialectical interrelatedness of the social structure and history as suggested by Mészáros (2011). It is important to note that the one narrator compared human existence or life as it is now to how it was in before ("in those days"). The narrator appears to be suggesting that life in those days was better than it is now because the society was more supportive and offered more help to the poor than it does now. This supportive nature of society or lack thereof suggests that the level of reflexivity in society today is low because the sense of reflexive engagement between the poor and the rich is minimal or even, perhaps, non-existence (Tsekeris & Katrivesis, 2008). The narrator alludes to the fact that people are poor now because there is no commonal social support given to the needy in society today as compared to the previously.

A further critical analysis of the narrative also seems to reveal that the low level of social support for the needy in society in contemporary times is probably associated with the exploitative nature of capitalism. Thus, the narrative reflects the global reach of capitalism even at the rural community level because, as the narrator claims, the rich are always wanting to accumulate more wealth, a key feature of capitalism, while the poor are left with few or no resources. In addition, this desire of the rich to

accumulate more wealth is indicative of the unequal social relations of power at the community level. For this reason, the credibility of capitalism's ability to protect and sustain the wellbeing of the poor, especially in developing countries, is in doubt.

As regards the communities' understanding of poverty, one participant described poverty as follows:

> *Poverty has so many colours, which make it difficult for people to know it [poverty]. Here, we wait for the rains to fall before we can do anything. So, it means that when there are not sufficient rains, our crops will not do well, hence poverty. Also, our land has become so infertile that, when we farm, we don't get anything. We did not know money in the past because when we farm we get good yield. All this is poverty* (FGD with key informants/opinion leaders, 40 years and above in Naaga, South zone).

It emerged from the above narrative that poverty is synonymous with insufficient rains or the presence of drought because farming is the main economic activity in the study area and people depend heavily on the rains in order to sow their crops. The assertion that "poverty has so many colours" emphasises the multi-dimensional nature of poverty. The narrative suggests that the study communities were vulnerable to the effects of climate change because, with the erratic rainfall and infertile lands, crop yields are low. This, in turn, raises the question as to the extent to which the communities are food secure. In view of the fact that is already a large irrigation dam in the study area it is possible that subsidies in the form of fertiliser may be given to poor farmers to increase their crop yields.

Another interesting revelation was that some of participants perceived poverty to be caused by the excessive drinking of alcohol. The narrative below attests to this claim:

> *I want to add that Akpeteshi*[7] *is also a major cause of poverty in our homes. If you take the little money that you have to drink Akpeteshi and forget of what you should do to help you tomorrow, you will definitely become poor. So, if you can include this in your paper for them [government] to ban Akpeteship*

[7] Akpeteshi is a locally brewed gin in Ghana.

in the system, I will be happy (FGD with poor/very poor women in Pungu-Nyangua, North zone).

One striking characteristic of the very poor is that they do not borrow anything, especially money, from their neighbours because they lack both the capacity and the ability to pay back. *"I don't borrow anything from anybody because I cannot pay back"*, a participant lamented (FGD with poor/very poor women in Pindaa, North zone).

On the other hand, the communities perceived the rich and very rich as people who "*touch money every day*", live in extremely comfortable houses, often have more than one wife and several children as well a huge asset base, including goats, sheep, cows, donkeys and even vehicles while they also "*drink beer*" (FGD with key informants/opinion leaders in Nogsenia, Central zone). Based on this general understanding of poverty, the communities further suggested some indicators which they considered to good descriptors of poverty. These indicators are tabulated and discussed in the next section.

4.2 Indicators of Poverty

During the FGDs, eleven key indicators were suggested as key descriptors of poverty and which may be used to identify the very poor. The indicators suggested by the communities sought to provide a thick description of poverty and of the very poor, in particular, while noting the dynamics which distinguish the very poor from the other socio-economic groups or classes. These eleven indicators which emerged from the communities' perceptions of poverty are summarised in the table below, according to the zones studied and discussed.

Table 4.1A: Communities' Views of Indicators for Identifying the Very Poor

Indicators by Zones	SES	Central Zone (Urban)	North Zone (Peri-urban)	South Zone (Rural)
1. Food sufficiency	Very poor	Live on the largesse of the Catholic Church	Beg for food/depend on wild fruits/honey	Beg for food/skip meals
	Poor	Inability to feed during bad harvest seasons	Do not have enough food to eat	Do not have enough food to eat
	Average	Adequate food supply	Adequate food supply	Adequate food supply
	Rich	Food surplus	Food surplus	Food surplus
	Very rich	Food surplus, eat meat and drink beer	Food surplus, eat meat	Food surplus, eat meat
2. Employment/financial security	Very poor	Daily farm labourers/no money	Daily farm-labourers/ Gardening	Children used as daily farm-labourers at the irrigation site
	Poor	Daily labourers	Daily labourers	Daily labourers
	Average	Most formal sector employees	Engaged in small businesses, retail trade	Own sizeable farms, harvest about 6 bags of rice yearly
	Rich	Traders, harvest over 50 bags of rice yearly	Large tracts of farms/Hire labour	Large tracts of farms/Hire labour
	Very rich	Engaged in commercial farms, have a lot of money (savings)	Engaged in commercial farms, have money (savings)	Engaged in commercial farms, have money

Table 4.1B: Communities' Views of Indicators for Identifying the Very Poor

Indicators by Zones	SES	Central Zone (Urban)	North Zone (Peri-urban)	South Zone (Rural)
3. Physical appearance/respect	Very poor	Appear unkempt/not respected	Patched clothing/ not respected	Wear dirty rags/not respected
	Poor	Mainly wear slippers/worn out clothes/not respected	Mainly wear slippers/worn out clothes/not respected	Mainly wear slippers/worn out clothes
	Average	Decent/accorded some respect	Accorded some respect	Accorded some respect
	Rich	Respected/wear nice dresses	Respected/wear nice dresses	Respected/wear nice dresses
	Very rich	Highly respected/ decently dressed	Highly respected	Highly respected
4. Burial of Dead Relatives	Poor/very poor	Buried quickly in mats and no ceremonies	Unable to perform final funeral rites of dead relatives	Buried quickly in mats and no ceremonies
	Rich/very rich	Well planned, buried in nice coffins and friends invited	Well planned, buried in nice coffins and friends invited	Well planned, buried in nice coffins and friends invited

Table 4.1C: Communities' Views of Indicators Identifying the Very Poor

Indicators by Zones	SES	Central Zone (Urban)	North Zone (Peri-urban)	South Zone (Rural)
5. Health-seeking Behaviour	Very poor	No health insurance/use herbs/do not seek any treatment at all	No health insurance/use herbs, consult traditional healer/gods	No health insurance/use herbs, consult traditional healer/gods
	Poor	Self-medication/obtain Paracetamol from drug store	Use herbs, consult traditional healers	Use herbs, consult traditional healers
	Average	Most have health insurance, able to meet OPD expenses	Most have HI, able to meet OPD expenses	Most have HI, able to meet OPD expenses
	Rich	Able to meet health care cos	Able to meet health care cost, have HI	Able to meet health care cost, have HI
	Very rich	Use private hospitals/have personal doctors	Attend hospital frequently when sick	Attend hospital frequently when sick
6. Education	Very poor	Mostly illiterates	Children do no attend school	Children do no attend school
	Poor	Children do not go beyond primary class 6	No school uniform	No school uniform
	Average	Children public schools	Children public schools	Children public schools
	Rich	Mainly literate parents	Children become teachers/nurses	Children become teachers/nurses
	Very rich	Mainly literate parents/Children attain university levels	Mainly literate parents/Children attain university levels	Mainly literate parents/Children attain university levels

Table 4.1D: Communities' Views of Indicators for Identifying the Very Poor

Indicators by Zones	SES	Central Zone (Urban)	North Zone (Peri-urban)	South Zone (Rural)
7. Ownership of Assets	Very poor	No assets	No tangible assets, some degree of social capital	No tangible assets, some degree of social capital
	Poor	A radio set, 1-2 acres of farm land	Small area of farm land	Small area of farm land
	Average	Motor bike, mobile phone, TV, donkey cart	Approximately 6-10 goats and sheep /plough	Several fowls, have goats and sheep
	Rich	Own cars, farm tractors	Large herd of cattle, has a wife and children	Large herd of cattle, has a wife and children
	Very rich	Own cars, tractors and large tracts of farm lands	Has more than one wife and children, big farms	Has more than one wife and children, big farms, lack nothing
8. Housing conditions	Very poor	Mud houses	Mud houses/sleep on rags	Mud houses/sleep on rags
	Poor	Poor housing and walls not plastered	Mud house, sleep on mats	Mud house, sleep on mats
	Average	Mud house, zinc roof/ sleep on beds	Mud house, zinc roof/ sleep on beds	Mud house, zinc roof/ sleep on beds
	Rich	Decent house, zinc roof and well furnished	Decent house, zinc roof and well furnished	Decent house, zinc roof and well furnished
	Very rich	Cement built house, zinc roof and well furnished	Cement built house, zinc roof and well furnished	Cement built house, zinc roof and well furnished

Table 4.1E: Communities' Views of Indicators for Identifying the Very Poor

Indicators by Zones	SES	Central Zone (Urban)	North Zone (Peri-urban)	South Zone (Rural)
9. Seeds to sow during rainy season	Very poor	No seeds to sow	No seeds to sow	No seeds to sow
	Poor	Borrow seeds to sow	Borrow seeds to sow	Borrow seeds to sow
	Average	Adequate seeds to sow	Adequate seeds to sow	Adequate seeds to sow
	Rich/ very rich	Abundance of seeds to sow	Abundance of seeds to sow	Abundance of seeds to sow
10. Unemployed Widows with children/incapacitated	Poor/very poor	-	-	-
11. Participation in Decision-making	Very poor	Marginalised in decision-making at the family level	Views are not valued	Often not invited for family meetings.
	Poor	Concerns and views not addressed	Concerns and views not addressed	Concerns and views not addressed
	Average	Participate in church activities	Participate in decision-making	Participate in decision-making
	Rich	Control the Decision-making process	Control the Decision-making process	Control the decision-making process
	Very rich	Control the decision-making process	Control the decision-making process	Control the decision-making process

Source: Author's fieldwork, based on FGDs with Communities (2013)

The list of indicators presented in the table above validates the choice of qualitative methodology in terms of which to explore the communities' perception of poverty because the findings resonate with Geertz's (1993) concept of thick description. In addition, the findings are also consistent with the literature in that they lend credence to the multidimensional nature of poverty. Similarly, the findings also support Chambers' (2010) assertion that participatory poverty assessment methodologies enable communities to freely present the different dimensions of deprivations, ill-being and wellbeing as well as the values and priorities of the poor people based on their lived experiences. These indicators are discussed briefly below.

4.2.1 Food Insufficiency

Food insufficiency appeared to be the most consistent descriptor of poverty in almost all the communities surveyed. Both the key informants/opinion leaders and the poor groups of people highlighted hunger as a classic experience of poverty with an individual's life being threatened by starvation on a daily basis. It would, thus, appear that hunger is the norm for the very poor people. The very poor people are needy throughout the year and depend primarily on the benevolence of others and their families, while struggling to eat one decent meal a day. Most of the very poor literally beg to survive. Adults in very poor households, often skip meals in order to cater for their children. The participants in the rural areas indicated that the very poor people also depend on wild fruits and honey for survival while most of the very poor in the urban areas depend on the largesse of the Catholic Church for survival. They indicated that the church gave them a bowl of grain, for example, maize, rice or wheat, from time to time, thus helping them to eat. The very poor households in the urban area (Central zone) often boiled "Kanzaga" (vegetable leaves) because they could not afford to buy millet in order to prepare the local staple food (TouZaafi, TZ). It was both revealing and interesting to note that, when the "Kanzaga" was boiled, only salt was added in order to make it tasty because the very poor could not afford to buy ingredients such as "Amani" (fish). Even if the very poor received rice

from the church they cooked it and usually added only salt, with a few of them begging for ingredients such as "dawadawa" (spice) and pepper from their neighbours to add to their food. By inference, the discussions seem to suggest that most of the diets of the very poor are probably not balanced as they consist primarily of carbohydrates. From a public health policy perspective, these unbalanced diets may cause malnutrition in young children and general poor health in the population at large.

One woman decried the huge responsibility she had to provide food for her children. She narrated her experience as follows:

> *For poverty, it is we women who suffer a lot. As I talk, I don't have anything but my children are many. When my husband wakes up, he doesn't care whether the children have eaten or not, that's my responsibility* (FGD with poor/very poor women in Pungu Nyangua, North zone).

This narrative echoes the socio-cultural structures in society that appear to perpetuate the inequality and injustice which women have to suffer. Thus, the narrative above supports the conceptual framework of social relations of power because, as Kabeer (1996) pointed out, unequal relations of power between men and women historically have constrained women's agency and yet women are responsible for carrying out most of the household's socio-economic activities – a heavy burden in their lives. In general, the narrative above also supports the literature with respect to gender power relations. For example, Isangula (2012, p. 76) and Naidoo (2011) argue that, of the 1.2 billion people who live in poverty in the world, women constitute 70% of this figure while, of the 774 million illiterate adults, women account for a third of this number. Isangula further argues that women work more than men, contributing 67% of the world's working hours but earning 10% only of the income and owning 1% of the property of the world.

It is likely that this situation adversely affects women's access to health as compared to men as access to health care is largely predicated on the ability to pay for the health care. Naidoo (2011) suggests that, in view of the major role which gender plays in shaping peoples' relations with each other, especially at the household level,

it is imperative that discourses on poverty and access to health care focus on ways in which the unequal position of women in society relates directly to the position of men and also on the power relationships between men and women in society. It is against this background that Soja (2010) argues that the failure to appreciate society as a network of social interactions of power not only results in internal differences of outlook being ignored but also draws the attention away from significant forms of oppression such as racial, gender, class and other forms of injustice that permeate society. Hence, examining the causes of poverty also means examining the dynamics of social forces.

Finally, the participants also indicated that the very poor people are often forced either to sell or to exchange their personal effects such as "jogo" (traditional trousers) for money in order to buy food. Clearly, the discussion above has established that food insufficiency is a huge challenge to the very poor. The question then arises as to whether the very poor are also challenged with respect to employment/financial security. This issue is explored next.

4.2.2 Unemployment/Financial Insecurity

The communities highlighted unemployment and financial insecurity as key indicators of poverty. The World Bank (2013) reports that jobs are generally the cornerstone of economic and social development and that people are able to work their way out of poverty and hardship through better livelihoods. Thus, jobs provide earning opportunities, which raise people out of poverty, increase their consumption, and contribute to individual or household wellbeing. However, very poor often miss out of employment and, thus, they lack financial security. The following narrative summarises the employment situation of the very poor.

> *Poverty is when there is no work or job for you to do and get money. We don't have work. That is why the poverty is worrying us here* (FGD with key informants/opinion leaders men 40 years and above in Kologo, South zone).

The participants indicated that, as a way of coping with their financial insecurity, the very poor are often engaged by the better-off classes in the community as farm labourers, albeit for a pittance, and sometimes, for a few cedis or a meal. Some of the very poor work at the Tono irrigation site as daily labourers and take their children out of school to work for those who are better-off for a small wage. However, such earnings are usually so meagre that they cannot lift the poor out of their misery. This finding supports the findings of the UNDP (2010), which reported that the rate of child of child labour in the Kassena-Nankana District in Ghana was 3.4%. The finding is also consistent with the World Bank's (2013) report that 21 million children are the victims of children labour worldwide.

One interesting finding worth mentioning is that, during a FGD with key informants/opinion leaders in Kologo in the South zone, the participants portrayed the very poor as lazy people who are not willing to work. A participant remarked that *"They [the very poor] are very lazy people and that is why nobody respects them. In this community we cherish and respect hardworking people"*. (FGD, with men aged 40 years and above). This narrative reinforces the importance of conducting separate FGDs with the key informants/opinion leaders and the poor/very poor people. If based on the perception of this particular group of key informants that the very poor were simply very lazy people, there would be very little effort made to support them. Nevertheless, this finding supports the claim of McKenna and Main (2013) that the key informants' ideas about and priorities for communities may not necessarily reflect and may even conflict with those of the ordinary community members, particularly the poor or very poor. The remark about respect for the very poor in society leads on to the next indicator – physical appearance and respect, and also the way in which the very poor bury their dead relatives in society.

4.2.3. Physical Appearance, Respect in Society and Burial of Dead Relatives

As regards physical appearance and respect in society, the participants indicated that the very poor, characteristically, always appeared to be dirty and shabbily dressed.

"*Look at what I am wearing, these are 'rags'. I can't wear these rags and attend any function because I will be laughed at*", said a participant (FGD with poor/very poor women in Pindaa, in the North zone). The children of the very poor are almost always bare foot with no decent clothes to wear. As a result, these already disadvantaged groups of people are often discriminated against and not respected in several spheres of life, including access to health care – a fundamental human right. The narrative below supports this claim.

> *Even when somebody offers to pay my health insurance premium for me free of charge, I will not go to the hospital because the workers there don't respect poor people and I do not know anyone to help me see the doctor. There is also no hospital near here and the roads are too bad during the rainy season* (*Ibid*).

The narrative above brings to the fore two important key policy issues. Firstly, apart from the inability to afford the cost of treatment, a lack of respect for the very poor is also a major barrier to their accessing health care at the formal health care facilities. The narrative suggests that the very poor are treated with disdain because of their physical appearance The narrative is also consistent with Cleaver's (2005) claim that the derogatory perceptions of the poor leave them with little room in which to manoeuvre in both their family and their wider social relations. The narrative also reveals that one of the themes of equity, namely, equal quality of care for all, is often violated. In this vein, Whitehead (1991) points out that it is unfair if one social group consistently obtains preferential health service over less favoured groups. It is against this backdrop of the unjust and discriminatory practices of health systems that the World Health Organization (2000) enjoins responsive health care systems which treat all patients equally and without discriminations.

The narrative above also supports the conceptual framework, as Hall and Taylor (2009) pointed out that social relations are essential social resources on which individuals or groups draw in order to advance their own welfare. The narrator claims that when even she visits the health facility in times of ill health, she does not have a social influence or network that would help her see the doctor. In terms of the

conceptual framework, this particular narrative appears to suggest that the health system in the study area has low levels of reflexivity because it does not enhance mutual reflexive engagement between the poor patients and the health providers (Tsekeris & Katrivesis, 2008).

As highlighted in the preceding narrative, it is important to note that the discriminatory attitude of health service providers towards the very poor further discourages them from enrolling in the national health insurance even if the opportunity to do so presents itself. Thus, this situation furthers widens the inequity and access to health care gap between the poor and the non-poor. In addition, this discriminatory attitude on the part of health workers towards the poor not only undermines the achievement of the MDGs, but it also defeats the actual objective of establishing the national health insurance scheme (NHIS) in Ghana as a pro-poor health policy. These findings are similar to the earlier findings in Ghana by Turkson (2009, p. 68), which suggest that "some health workers were perceived as rude, unfriendly, unapproachable or impatient, or did not respect patients, and favouritism was sometimes practised to the chagrin of poor patients".

In addition, by inference, the preceding narrative questions the quality of the health services delivered at the formal health facilities, particularly to the poor and very poor people in society. The point to note here is that patients' satisfaction with the health care services they receive at health facilities is a key proxy measure of quality health care. For example, Downey-Ennis and Harrington (2002) suggest that it is essential that health systems become more people-centred with the interests of the public and patients being accordance greater prominence and influence in decision-making at all levels. Supporting this claim, Arries and Newman suggest that "healthcare institutions ought to create a people-centred and people-driven service that is characterised by equity, quality, timeliness and strong code of ethics" (Arries & Newman, 2008, p. 42). Comparing the standards suggested by Downey and Harrington and Arries and Newman with the narrative above in terms of the

provision of quality health, it is logical to conclude that the poor or very poor are not satisfied with the quality of the health care they receive at the formal health facilities. Still within the domain of respect for the poor, the participants indicated that, even in death, the poor are not respected because the dead relatives of very poor households are not buried decently. The participants revealed that the very poor are often unable to perform the final funeral rites of their dead relatives. In a somewhat biblical manner, the participants pointed out that death is the end of man's life on earth and when man returns to God. For this reason, it is proper for the dead to be given a decent burial. However, when very poor people die, they are not given fitting burials because of their socio-economic status. One participant pointed out sadly that "*A very poor man has no funeral. When he dies, he is quickly thrown into a very shallow grave without ceremonies*" (*Ibid*).

The second policy issue raised in the narratives was the issue of geographical inequity, especially in the rural areas. The participants revealed that there were no health facilities closer to them and also that they were not often able to access health care in the more urban areas because of bad roads, especially in the rainy season. This finding resonates with earlier research findings that suggested that, in the Upper East, West and Northern regions of Ghana, 15% only of the rural population live less than 30 minutes away from the nearest health facility (Canagarajah & Ye, 2001, pp. 25–26). In support of these views, Arcury, Gesler, Preisser, Sherman, Spencer, and Perin (2005, p. 137) argue that rural populations experience great difficulty in gaining access to health care because of what they referred to as *distance decay* – "increasingly smaller proportions of populations use health services at greater distances from them". This distance decay often results from poor transportation infrastructure as well as a lack of public transportation options in the rural areas. The effect of the poor transportation infrastructure for the rural poor is increased travel times and increased costs when seeking health care. Similarly, Delamater, Messina, Shortridge, and Grady (2012) argue that the extent to which inequalities in accessibility to health care are manifest is a product of the unique spatial

arrangement of the health care delivery system, the location and distribution of the population within a region, and the characteristics of the transportation infrastructure. Delamater et al. (2012) further argue that geographical inequities result from large distances between the people and the health care facilities.

These findings are consistent with the conceptual framework because the issue of geographical inequity is a supply side problem and is actionable by public policy. In other words, the provision of adequate health infrastructure and health care staff by government for the rural areas, such as Pindaa, would help bridge the geographical inequity gap. Likewise, the ethical issue of disrespect for the poor people in general at the formal health facilities is also actionable by public policy. Health staff members who engage in discriminatory practices against the poor should be sanctioned. This, in turn would also as a deterrent to others in the future. It is thus clear that the issues of the lack of respect for the very poor and geographical inequity may invariably impact on the health seeking behaviour of the very poor.

4.2.4 Health-seeking Behaviour of the Very Poor

It has emerged from the preceding discussions that ethical issues such as respect for the very poor and also geographical access may influence the health-seeking behaviour of the very poor. These challenges (geographical and ethical), in turn, may impact adversely on the health status of the very poor people as they may deter them from using the formal health facilities. Most of them then resort to the local 'jujumen'[h] to intercede for them by offering prayers of supplication to the ancestors and the gods to heal them and to save them from ill-health and poverty. This claim is supported in the following quotation.

> *Because we cannot afford to go to the hospital, we turn to our ancestors, the gods, to give us good health. But often, our health does not improve because the gods do not know the modern diseases and medicines* (FGD with poor/very poor men in Pindaa, North zone).

[h] A jujumen is someone with supernatural power that makes impossible things happen or gives somebody control over the forces of nature.

In addition, some of the very poor people also resort to self-medication, for example, they buy Paracetamol over the counter at the local drug store for all their ailments without any professional medical advice, they use herbs or they simply do not seek health care at all. *"I boil the leaves of the neem tree to treat 'paa' (malaria) and the bark of the mahogany tree to treat 'wozuru' (dysentery) for my children"*, a participant revealed (FGD with poor/very poor women at Pindaa, North zone). The preceding narratives again emphasises the dialectical interrelatedness of social structure and history (Mészáros, 2011). The narrator reveals how the social structures in which people are embedded influence their health seeking behaviour as they turn to their ancestors for supernatural healing. The reliance on herbs also underlines the historical materialistic nature of human existence.

The preceding narrative supports earlier research findings in Ghana which reported that approximately 94% of very poor households tend not to seek treatment at formal health facilities but, instead, treat their illnesses at home (Alatinga & Fielmua, 2011, p. 135). In the same vein, the World Bank (2012, p. 22) reports that approximately 31% of the very poor in Ghana without health insurance seek health care at local drug stores as compared to 5% of the insured. Also, approximately 7.40% of the uninsured seek health care from traditional herbal healers while only about 3% of the insured seek health care from the traditional herbal healers in Ghana. The World Bank further indicates that, in Ghana, while approximately 20% of the uninsured forgo treatment altogether, only about 3% of the insured forgo treatment altogether (World Bank, 2012, p. 22).

Consistent with the conceptual framework, the discussion above paints a picture of growing inequities in access to health care for the very poor people and, this, in turn, may prevent them from accessing other life enhancing capabilities and opportunities, including education.

4.2.5 Educational Levels of the Very Poor

Education determines social stratification in two ways. Firstly, as pointed in chapter two, high levels of quality educational attainment unleash the individual's human potential or capabilities, which, in turn, empower them to engage in new patterns of participation in the socio-economic, and political spheres of society. Socio-economically, well-educated people are able to engage in the science, innovation and technology, which, I believe, are the key drivers for the transformation of any society. The attainment of higher education levels leads to better paid jobs and this, in turn, enables families and individuals to earn the necessary income to take care of their health needs. Politically, well-educated and well paid people are able to transform society socially because this category of people have both power and prestige, and they are able to participate in politics by contributing to the decision-making process at the community level. Secondly, an individual's social status in society also determines the type and amount of education an individual receives. This point resonates with the research findings of this study.

The research results reveal that achieving high levels of education is the preserve of the rich and very rich people in the community while the very poor are scarcely to afford to keep their children in school beyond primary level six (class 6). However, parents who do manage to keep their children at the public local authority school until primary six are often not able to afford the local school uniform. These parents then clothe their children in patched dresses of variegated textiles, ironically modish enough to be used as models in any modern designer boutique. Unfortunately, these children are often driven away from school because they are not wearing the prescribed local school uniform.

As discussed in the conceptual framework, knowledge is power. Power, as derived from education, would enable the very poor people to question or challenge the *status quo*. Paulo Freire (1970) contends that education is a requisite tool which to liberate the very poor (oppressed) from the socio-economic quagmire in which they find themselves. Freire maintains further that it is essential that the oppressed be

made aware of their living conditions, become conscious of their rights as citizens and mobilise communities to unite in order to find a way to improve their living conditions. As Freire suggests, this awareness and self-consciousness may, to a very large extent, be created through education, which the very people in the study area lack. The fact that the very poor are not socially empowered and lack vital ingredients such as skills, knowledge and experience is evidence of a capability failure (Sen, 1999). The very poor may, thus, find it challenging to acquire and build up assets.

4.2.6 Ownership of Assets in Managing Household Poverty

Productive assets, such as land, have long been recognised as important insurance mechanisms for poor households, especially in the rural areas (Moser, 1998). In most of the focus group discussions it was stated that ownership of cattle, sheep, goats, ploughs, television sets, large tracts of farms and motorbikes were a sign of wealth. The following narrative from one of the participants lends credence to this point.

> *As I sit here, I am a very poor widow. I have no land, no fowl, let alone to talk of a goat or sheep that I can sell to get money and register for health insurance. But, if you have all these things with children, you like a king* (FGD with poor/very women in Pungu-Nyangua, North zone, Author's fieldwork, 2013).

The testimony above highlights the importance of asset ownership in managing household or individual poverty. The narrative seems to suggest that assets such as land may easily be converted into the cash required to manage poverty. However, as stated in the above narrative, very poor households or individuals lack these assets. This finding is consistent with the literature. For example, IFAD (2011) argues that a lack of assets, limited economic opportunities, a lack of education and socio-political inequalities are the major causes of rural poverty. Etim and Edet (2014) support this viewpoint. They found that, in Southern Nigerian, the incidence as well as the depth and severity of poverty were lower for households who owned assets such as land, cars, motorcycles and sewing machines as compared to those households who owned

none of these assets. Like assets, housing conditions were also pointed out as a major indicator in terms of which very poor households or individuals may be identified.

4.2.7 Housing Conditions of the Very Poor

The participants suggested that the very poor are incapable of building their own houses and, thus, they live in family or lineage owned houses while others live either in huts made from wild grass or in mud houses roofed with thatch. The participants also indicated that members of very poor households do not only often crowd into one room, but they also spread rags or sacks on the floor and sleep on these. For those who live in mud houses, their walls are often either not plastered or full of cracks, to the extent that a passer-by is able to see into the room from the outside. The narrative below attests to this claim.

> *You don't need to be shown the house of a very poor man. The walls are not plastered and the cracks on the walls are so wide that he does not need to look through the window to know what is happening in his vicinity* (FGD with key informants/opinion leaders, men 40 years and above in Naaga, South zone).

The above narration is consistent with earlier research findings in Asia which suggest that external housing conditions are sound proxies for poverty, especially where household characteristics have a strong relationship to poverty (Falkingham & Namazie, 2001).

4.2.8 The Very Poor lack Seeds to sow during the Rainy Season

One of the most revealing indicators of very poor households is the fact that that they lack seeds to sow during the rainy season. Consequently, some of the very poor beg for seeds from their neighbours while others just watch helplessly while their neighbours busy themselves on their farms during the rainy season. "*When the rains set in, everybody gets busy on his/her farm and I just sit and watch, not because I am lazy but because I don't have the seeds*", one of the participants revealed (FGD with poor/very poor men in Pindaa, North zone). The participants explained that the very poor lack seeds to sow during the rainy season because they consume everything at

their disposal. The very poor consider their present survival as of prime importance and are not able to preserve seeds until the next rainy season when their children are dying of hunger. The penultimate indicator which the participants suggested is crucial for identifying very poor households or individual is the issue of unemployed widows with children.

4.2.9 Unemployed Widows or Widowers with Children/the Incapacitated

According to the participants the very poor categories of people typically include, amongst others, unemployed widows with children, lepers, the blind and the aged. In addition, able-bodied adults who are very poor are often unable to find spouses.

One participant rhetorically asked, "*As I sit, I can't see, I don't have a husband, I don't have a child, am I not very poor?*" Another participant, in a rather emotional manner, asked the research team the following question:

> *I want to ask a question. My parents died very early and left my brother and me. My wife died in 2004. My brother and the wife have also died and now I have eight children to take care of. None of us has health insurance. I can't even get food for them, let alone talking of their school fees. So I don't know whether you people can help us or not* (FGD with poor/very poor men in Pungu-Nyangua, North zone).

The above narrative provides compelling evidence that unemployed widows or widowers with children should be exempted from paying health insurance premiums in an effort to increase their access to health care. The way in which all the indicators discussed above either support or constrain the participation of the very poor in decision-making at the community level will be discussed next.

4.2.10 The Very Poor and Participation in decision-making at the Community Level

It was deemed insightful and informative to unpack the theme above using the following testimony from a participant during the FGDs in one of the communities:

We know who the very poor are. They live with us and we can identify them but we don't have the power to. Usually, when the church asks for the names of very poor

people, it's the assemblyman[i] *and the chief who decide who the very poor are, sometimes their favourite people who may not be as poor as we are. Let me tell you, you are the first person to come here and ask us (poor people) to identify among ourselves who the very poor are* (FGD with poor/very poor men in Pungu-Nyangua, North zone).

The narrative cited above clearly indicates how the unequal relations of power constrain the poor from active participation in the decision-making process at the community level. This finding is consistent with a relatively large body of existing knowledge that suggests that the poor are generally excluded from decision-making (Cleaver, 2005; Williams, 2006; Green & Labonte, 2008). Cleaver (2005), for example, argues that the very poor are largely excluded from effective access to the decision-making process with respect to the provision of basic social services such as education and health, even at the most local level, because of their fragile and thin institutional network. In other words, the decision-making process with respect to health care is dominated by the powerful while the poor's presence is merely ceremonial. This argument resonates with Williams (2006), as he points out that community participation is often seen as the mere ceremonial presence of participants in local institutions without their active involvement in any decision-making process while the power relations in institutions impact on the participatory processes.

Similarly, Green and Labonté (2008) argue that most national health policies such as the NHIS in Ghana seek to reduce poverty, address inequities in the access to health care and enhance the participation of the ordinary citizen in public policy-making. Green and Labonte, however, argue that these policies often fail to address the underlying causes of social inequality, poverty and health inequities precisely because the poor are excluded from the initial stages of the policy implementation process. Green and Labonté (2008) further argue that the poor are often asked only to

[i] In the local government system in Ghana, the assemblyman wields a lot of power and influence at the community level because the local communities elect him as liaison officer between the communities and the local assembly. One of his key roles is to lobby the local assembly for development projects in his communities.

comment on an agenda which has already been defined by professionals, and to contribute to the individualistic health interventions that attempt to ameliorate the effects of inequalities, rather than being genuinely included in the participatory processes that would challenge the political processes that result in both poverty and health inequities. This observation precisely describes the situation with respect to the NHIS in Ghana. As the narrative above suggests and also as pointed out in chapter one, the poor at the community level have not been involved by the bureaucrats, planners and managers in the process of developing community relevant and acceptable indicators for identifying the very poor for the purpose of insurance premium exemptions.

In fact, this narrative above not only reveals that the very poor do not participate in the decision-making that affect their very wellbeing but, importantly, it also reveals a political critique of the exploitative social relations in terms of which the very poor are victims of injustice and neglect (Riessman, 2008). In addition, it portrays in the narrator a sense of reaction which may be considered "a consciousness of being less powerful in relationship of power and a consciousness of opportunity to challenge the powerful" (Riessman, 2008, p. 60). Thus, the narrative reinforces the dynamics of social relations of power and the ordinary citizens' beliefs about the perceived unjust workings of the world. It is in light of the above views that I hypothesise that '*the voice of the powerless is useless*' because the concept of community participation is often oversimplified without due attention being paid to the interplay of power relations at the community level.

In this vein, Weaver-Hightower (2008, p. 158) argues that participatory development policies "are created and implemented within complex ecologies involving intricate relationships of actors, environments, and processes". For this reason, the oversimplification of the notion of participation takes for granted the fact that the space for participation is premised on power and social relations, on the power distributions in policy processes, and on the influences or weight that each actor has in shaping the focal policy (Weaver-Hightower, 2008).

Indeed, as pointed out in the narrative, the implication of these power and social relations configurations is that the poorest of the poor are overwhelmed by the local elites and, thus, do not participate in the decision-making process. The narration above communicates unequivocally that very poor people seldom participate in the decision-making that affects their very wellbeing with regards to identifying the very poor for health insurance premium exemptions. In this respect, one of the participants rhetorically asked, *"When you talk about health insurance premiums, who fixes the premiums, do they consider our socio-economic status before fixing them?" [premiums]* (FGD with key informants/opinion leaders, men 40 years above, in Kologo, South zone).

In line with the above, Tapscott and Thompson (2013) argue that participatory development advocates often underestimate the impacts of local power relations and the fact that the poorest of the poor seldom benefit from the participatory programmes which are frequently subject to capture by local elites. Indeed, policy analysts suggest that a small group of elites control the policy and governance processes at the local level (Weaver-Hightower, 2013).

The testimonies of the participants also refer to the issue of corrupt or nepotic practices in relation to the identification of the very poor at the community level. The narrator alluded to the fact that the assemblyman and the chief often submit the names of their 'favourites' only to the church for support, to the chagrin of the *real very poor* people.

Corruption marginalises the very poor and excludes them socially from access to health care, thus widening the inequity gap. The marginalisation and exclusion of the very poor from the decision-making process is, however, are contrary to the principles of social justice as the very poor are not given fair equality of opportunity. Even at the family level, the marginalisation and exclusion of the very poor is often manifested during family meetings or social functions such as marriage ceremonies (see table 4.1E above).

During such meetings and events individuals make financial contributions but, because the very poor are not able to afford these contributions, their views and concerns are often ignored. These findings are consistent with earlier studies conducted in Tanzania (Cleaver, 2005). Based on his empirical research in Tanzania, Cleaver (2005, p. 902) argues that the very poor are not able to join even formal clubs and societies because they are not able to afford the "entry fees", while even those who manage to pay these fees initially are soon excluded because of their inability to make regular contributions or to attend meetings regularly. Cleaver further suggests that the voices of the poorest are not heard in public and, even where their voices are heard, they are accorded little weight and they exert negligible influence. Cleaver argues that most of the poor people who attend meetings at the local community level attend just to listen and to be informed but not to speak.

Finally, the narrative also fits perfectly with Chambers' (1997) analogy of "uppers" and "lowers". In this context, the chief and assemblyman represent the "uppers" while the poor people represent the "lowers". The "uppers with power then act as social boundaries that constrain the "lowers" from participating in the process of identifying the very poor for support from the church" (Hayward, 1998).

In short, the preceding discussions suggest that it is unlikely that equitable access to universal health care for the very poor will be attained unless concerted efforts and arrangements are directed at uprooting the root causes of poverty – unjust institutions and the unequal relations of power.

It is, however, essential that these efforts and arrangements be directed at the elites. In this regard, Horton and Lo (2014) suggest that these efforts and arrangements must effectively address the rigid consensus among the powerful elites that prevents most attempts to question the norms based on which political decisions are made. Horton and Lo (2014) argue that the elites are only as powerful as the systems that support the status quo. In order to transform society socially for the benefit of all, especially the ordinary people, I suggest that institutions should perform three interrelated functions. Firstly, we need the courage to question the norms based on

which political decisions are made. However, it is essential that this courage to question the status quo be supported by legislation that guarantees freedom of speech. Secondly, we need to examine the depth of our answers to these questions and, finally, we must examine the consistency of the actions we take and that are aimed at overturning the status quo to ensure that the desired results are achieved. With these expositions in mind, the communities' suggested indicators for identifying the very poor are now discussed.

4.3 Communities' Suggested Indicators for Identifying the Very Poor

The eleven indicators suggested by the communities for the purposes of identifying the very poor for health insurance premium exemptions are too many. It would not be feasible for the staff of the health insurance scheme to use such a large number of these indicators in order to identify, for example, one household or one individual. The purpose of these indicators is to serve as a heuristic device with which to assess the SES of either households or individuals at the community level in an effort to identify the very poor for health insurance premium exemptions. For this reason, I asked the participants to narrow down the indicators to a maximum of five. This "narrowing down" process was based on the indicators, which the communities considered or perceived as core in identifying very poor households. It is envisaged that this set of five indicators will enable the staff of the health insurance scheme or anyone mandated by the scheme to conduct poverty assessment to effectively carry out the assessment with relative ease. The suggested indicators are presented in table 4.2.

Table 4.2: Communities' Suggested Indicators for Identifying the Very Poor

Indicators	Central Zone (Rankings)	North Zone (Rankings)	South Zone (Rankings)	All Zones (Rankings)
Food insufficiency	1st	1st	1st	1st
Lack of seeds to sow	5th	2nd	2nd	2nd
Educational status	3rd	3rd	3nd	3rd
Financial insecurity/income	2nd	4th	4th	4th
Unemployed widows/widowers with children	4th	5th	5th	5th

Source: Author's Fieldwork, 2013

As indicated in table 4.2 above, all the participants in the various communities selected food insufficiency, lack of seeds to sow during the rainy season, educational status, financial insecurity/income and unemployed widows/widowers with children as well the incapacitated without support as the prime indicators for identifying the very poor. A close examination of the criteria above revealed that some issues warranted highlighting. Firstly, food insufficiency stood out forcefully in all three zones, with all the zones ranking it as the prime indicator of poverty.

The second issue worth highlighting is that, while the North and South zones ranked lack of seeds to sow during the rainy as the second key descriptor of poverty, the Central zone ranked financial/income insecurity as the second most pressing indicator. However, this divergence does make logical sense because the Central zone is the Central Business District (CBD) of the study area and, as such, the

participants from this zone considered finance/income as an important variable in their daily transactions. On the other hand, financial insecurity/income was ranked as number 4 in both the North and South zones, perhaps as a result of their peri-urban and rural characteristics respectively.

However, a further examination of the five indicators revealed that something was clearly missing – the issue of the health status of individuals or households had not been mentioned as one of the prime indicators for identifying the poor. One would have expected, logically, that, as the aim of the identification exercise was to enhance the access of the very poor people to health care, health issues would, at least, have featured among the final indicators selected. However, as revealed by the following dialogue between the researcher (moderator of the discussion) and the participants the participants thought otherwise:

Researcher: The purpose of this exercise is to identify the very poor and enhance their access to health care but health is not selected as one of the five indicators. Any reasons for that?

Participant1: "Yes, when you have all the others, you have good health. Remember, the pain of starvation and the mental trauma of not having money to register for health insurance, and to pay the school fees of your children, the pain of having to go and beg for seeds when everyone is busy sowing, not having a decent place to rest your head in the night, is more deadly than physical illness". These indicators, therefore, represent the views and voices of the communities surveyed in the Kassena-Nankana District, Ghana. Gaventa and Cornwall (2001, p. 71) argue that, when the public policy process is opened up to include new voices and new perspectives, "policy deliberations will be more democratic, less skewed by the resources and knowledge of the more powerful.

4.4 Summary

The preceding discussions focused on the community perceptions of poverty and their suggested indicators for identifying the very poor. Five indicators, namely, food

insufficiency, lack of seeds to sow during the rainy season, educational status, financial insecurity/income, and unemployed widows/widowers with children were selected by all the study communities as core indicators in terms of which the very poor may be identified. The analysis qualitative data brought to the fore key issues of public policy relevance, which are worth discussing. Firstly, the analysis revealed a continuing inequity in the access to health care of the very poor, especially in the rural areas, which are characterised by the inadequate provision of health facilities. The very poor are further barred from adequate access to health care because they are often treated with disrespect at the formal health facilities. The combined effect of the distance to the nearest health facility and the unethical manner in which poor patients are treated at the formal health facilities is that most of the very poor people rely on "jujumen" for health care while others resort to self-medication. Others simply themselves resign to their fate by not seeking health care at all.

Secondly, the analysis also strongly suggests that the continuing inequity in access to health care of the very poor is partly as a result of the neglect of the poor in the very process of identifying the poor. The reality is that policy-makers at the community level have not engaged the poor people themselves in the process of identifying the very poor for the purposes of health insurance premium exemptions. As suggested by the participants the identification process is sometimes even hijacked by local elites – the assemblymen and chiefs.

Finally, in an effort to enhance equity in access to health of the poor at the community level, the process of identifying the very poor needs to be considered as a public policy process. It is, thus, essential that the identification process be opened up to the local communities in order to include new voices and perspectives from the poor themselves – the 'professors' of poverty assessment. The policy process thus, needs to include balanced and democratic deliberation in an effort to ensure that the process is not hijacked by the local elites. Above all, the poor need to be empowered to challenge the status quo in an effort to create a socially just society in which

everyone has the freedom to unleash their God given potential. The next chapter, chapter five, contains the quantitative results of the study.

Chapter Five

Health Insurance and Access to Health Care in Ghana

5.0 Introduction

The objectives of this chapter are twofold. The first objective is to establish the reasons that motivate households either to enrol or not enrol in the health insurance scheme in Ghana while the second objective involves developing a model for identifying very poor household for the purpose of health premium exemptions.

In order to achieve these objectives, the analysis proceeds as follows. Firstly, the descriptive summary statistics of the data are presented. These include household income, health expenditure and insurance status. Following these descriptive statistics, the reasons for either enrolling or not enrolling in the health insurance scheme are then presented and evaluated with reference to existing literature. The self-rated health status of households against their insurance status is then presented. The final section of the analysis presents the model for identifying very poor households. The weaknesses and strengths of the model are also discussed. The chapter concludes with a summary of the research findings.

5.1 Descriptive Summary Characteristics of Respondents

Males and females constituted 72% and 28% respectively of the household heads in the study population. The mean age in the sample was 51 years. The mean household size was 5 while the minimum and maximum household sizes were one and 13 respectively. In addition, 74% of the study population was married while 19% had been widowed. In terms of education, the majority (55%) of the study population had never been to school while 8% only had reached the tertiary level of education. With respect to employment, 60% were farmers while 7% were unemployed. These characteristics of the respondents are presented below.

Table 5.1: Descriptive Summary Statistics of Respondents

Characteristics of respondents (N = 417)	Mean (SD)		
Age of household head (years)	51 (16)		
Household size	5 (2)		
Sex of household head	**Frequency (%)**	**Insured (%)**	**Uninsured (%)**
Male	301 (72.0)	199 (71.3)	102 (74.0)
Female	116 (28.0)	80 (28.7)	36 (26.0)
Marital status of household heads			
Married	310 (74.0)	210 (75.3)	99 (71.7)
Never married	11 (3.0)	9 (3.2)	2 (1.5)
Divorced	19 (4.0)	12 (4.3)	7 (5.1)
Widow	78 (19)	48 (17.2)	30 (21.7)
Ethnicity of household heads			
Kasem	251 (60.2)	172 (61.6)	79 (57.3)
Nankam	143 (34.3)	87 (31.2)	46 (40.5)
Buli	12 (2.9)	10 (3.6)	2 (1.5)
Other	11 (2.6)	10 (3.6)	1 (0.7)
Educational level of household head			
Never been to school	231 (55.4)	130 (46.6)	101 (73.1)
Primary	70 (16.8)	47 (16.8)	23 (16.7)
Junior high school	45 (10.8)	37 (13.3)	8 (5.8)
Senior high school	39 (9.4)	33 (11.8)	6 (4.4)
Tertiary	32 (7.6)	32 (11.5)	0 (0.0)
Occupation of household head			
Farmer	250 (59.9)	145 (52.7)	101 (73.2)
Trader	75 (18.0)	53 (19.3)	22 (15.9)
Employed in the formal sector	53 (12.8)	50 (18.2)	3 (2.2)
Retired/Pensioner	6 (1.4)	5 (1.8)	1 (0.7)
Student	4 (0.9)	4 (1.4)	0 (0.0)
Unemployed	29 (7.0)	18 (6.6)	11 (8.0)

Source: Author's fieldwork, 2013

5.2 Insurance Status, Socio-Economic Status (SES), Income, and Health Expenditure of Households

It is worth noting that insured households are those who have registered with the national health insurance (NHIS). Thus, insured households possess a valid NHIS membership card, which renders them eligible to receive treatment at NHIS, accredited health facilities. On the other hand, uninsured households or individuals are those who do not possess a valid NHIS membership card and generally pay cash when receiving health care.

In this regard, this study found a health insurance cover rate of 67% among the sampled population, twice that of the national coverage rate of 33%. Thus, 33% of the sampled households were not covered by or enrolled in the national health insurance scheme. It is possible that the high health insurance coverage among the sampled population is as a result of the presence of the Navrongo Health Research Centre (NHRC). The NHRC has been conducting health research in the study area over the past 25 years. Hence, the population of the study area is exposed to public health issues, including the importance of access to health care. In addition, the Kassena-Nankana Mutual Health Insurance Scheme has on periodic basis, organised educational campaigns to educate the population on the benefits of enrolling in the health insurance scheme.

As indicated earlier in chapter four, the sampled population was dichotomised into *poor* and *not poor* SES categories. Based on this dichotomisation, I found that 51% of households were not poor whereas 49% were poor. Given the sample size, the 49% poverty rate found among the study population is consistent with earlier studies. In addition, this figure of 49% is consistent with the figure given by the Ghana Statistical Service (GSS, 2007, p. 13) because the GSS estimated that 70% of the population in the Upper East Region was poor.

In addition, a cross-tabulation of the SES of households against their insurance status showed that 68% of the households that were not poor were insured while 32% of the households in the same category were not insured. On the other hand, 65.37% of

poor household were uninsured while 34.63% of poor households were insured. These results indicate that the uninsured households were generally the poor households while the insured were the better-off households in the study area. These results clearly illustrate the inequities in access to health insurance and the subsequent inequities in the access to health care of the poor and the non-poor households.

Similarly, using the Cramer's V correlation coefficient, the study established that insurance status and income are strongly and positively correlated with the results of the correlation analysis showing a Cramer's V = 0.682. Table 5.2 below depicts a cross tabulation of household monthly income, health expenditure and insurance status.

Table 5.2: Household Monthly Income, Health Expenditure and Insurance Status

Monthly Household Income	**Insurance Status**	
	Insured (%)	**Uninsured (%)**
Between GH¢10& GH¢30	54 (19.0)	58 (42.0)
Between GH¢40& GH¢60	75 (28.0)	40 (29.0)
Between GH¢70& GH¢100	149 (53.0)	40 (29.0)
Total	**278[j] (100)**	**138 (100)**
Monthly Household Health Expenditure	Insurance Status	
	Insured (%)	**Uninsured (%)**
Between GH¢10& GH¢30	167 (60.0)	33(24.0)
Between GH¢40& GH¢60	84 (30.0)	91 (66.0)
Between GH¢70& GH¢100	28(10.0)	13 (10.0)
Total	**279 (100)**	**137 (100)**

Source: Author field survey, 2013

[j] Indicates one missing response for the insured and uninsured

The positive relationship between household income and health insurance status is further revealed in table 5.2. As shown, as income increased, so did the enrolment levels in health insurance – 53% of the households with a monthly income of between GH¢70 and GH¢100 ($27–$38) were enrolled in health insurance.

The evidence presented in table 5.2 also suggests the inverse situation, namely, low levels of income were inversely correlated with household enrolment in health insurance. As shown above, 42% of household earning between GH¢10 and GH¢30 ($4–$12) were not enrolled in the health insurance scheme.

In terms of health expenditure, the evidence presented in table 5.2 is clear with insured households spending less on health as compared to uninsured households. Approximately 60% of insured households spent an average of between GH¢10 and GH¢30 ($4–$12) on health. This evidence, in turn, suggests that, in general, access to health insurance reduces the out-of-pocket payments of those who have health insurance. On the other hand, 66% of uninsured households spent a monthly average of between GH¢40 and GH¢60 ($16–$23). At the same time, as indicated earlier, the incomes of the uninsured households were generally lower as compared to the incomes of insured households. This evidence suggests that, at this level of expenditure, the uninsured households spend more on health monthly than they earn. Thus, since the expenditure of these uninsured households exceeds their income, these households probably have to borrow money to pay for health care and this, in turn, may plunge them into deeper poverty. Significantly, even without health insurance, these households still rely on direct out-of-pocket payments to finance their health needs. It is argued that direct out-of-pocket payment is extremely inequitable in terms of health financing and that, globally, 150 million people incur huge out-of-pocket payments for health care costs while 100 million people are plunged into poverty because of these direct payments (Xu, Evans, Carrin, Aguilar-Rivera, Musgrove, & Evans, 2007, p. 979; Oxfam International, 2013).

These findings support earlier findings as Nguyen, Rajkotia, and Wang (2011) argue that the NHIS has not eliminated out-of-pocket payments for health care in Ghana. In

support of this point of view, Akazili, Garshong, Aikins, Gyapong, and McIntyre (2012, p. 14) suggested that, in spite of the NHIS, out-of-pocket payments, which are an extremely regressive way of financing health care, account for 45% of the total health care expenditure in Ghana. The World Bank (2012) validates these views, asserting specifically that the poorest in Ghana spend more out-of-pocket on health care as compared to the better-off. For example, the World Bank (2012, p. 25) indicates that, whereas the poorest spend approximately 3.2% of their total household out-of-pocket expenditure on health care, the better-off spend only 0.5% on health care.

I ran a logistic regression model to find out which variables determine household participation in the NHIS. A logistic regression allows for correctly predicting the category of outcome for individual cases using the most parsimonious model (Berman & Wang, 2012). The logistic regression uses a statistic known as the *odds ratio*. The odds ratio compares the probability of an even occurring (success) as compared to it not occurring (failure). In other words, the odds ratio shows how much more likely it is that an event will occur than it will not occur (Berman & Wang, 2012). In this context, the odds ratio compared the likelihood of households being insured as compared to their being uninsured. The odds ratio ranges between 0 and 1 – an odds ratio of 1 implies that the event is equally likely in both groups while an odds ratio of less than 1 indicates that the event is less likely in the first group and vice versa. For the purpose of the logistic regression, household income was recoded as a binary variable. The results of the regression model are presented in table 5.3.

Table 5.3: Logistic Regression of Determinants of Participation in NHIS

Insurance status	Response	Odds Ratio	95% CI	P-value
House income	$32–46	1		
	$4–27	0.47	0.28, 0.75	0.002
Age	< 40 years	1		
	40–59 years	1.18	0.66, 2.11	0.570
	60 years +	2.04	1.04, 3.99	0.038
Education of household head	Never	1		
	Basic	2.31	1.32, 4.03	0.003
	Post-secondary	4.28	1.43, 12.8	0.009
Gender of household head	Female	1		
	Male	2.53	1.24, 5.14	0.011
Occupation of household head	Informal	1		
	Formal	3.70	0.93, 14.7	0.063
	Retired	1.70	0.61, 15.9	0.690
Household size	Small	1		
	Medium	1.17	0.63, 2.17	0.617
	Large	0.91	0.44, 1.87	0.804
Marital status of household head	Married	1		
	Divorced	0.99	0.32, 3.05	0.992
	Widow	0.47	0.20, 1.08	0.074
	Other	1.02	0.22, 4.67	0.980
Ethnicity	Kasem	1		
	Nankam	0.84	0.51, 1.37	0.487
	Builsa	4.72	0.93, 24.1	0.062
	Other	2.91	0.33, 26.0	0.339

Source: Author's fieldwork, 2013

The results of the logistic regression above show that four variables, namely, income, age, educational level of household head and the gender of household head – significantly influence household participation in the NHIS. Household that earn a monthly income of between $4 and $27 are 53% less likely to enrol in the NHIS as compared to households that earn between $32and $46. The results are statistically significant with a p-value of (p = 0.002). Male-headed households are almost three times more likely to enrol in the NHIS as compared to the female-headed households with a significant p-value of (p = 0.011). Similarly, household heads that have attained post-secondary levels of education are 4 times more likely to participate in the NHIS as compared to those who have never attended school.

The results are also statistically significant with a p-value of (p = 0.009). Finally, age is an important determinant of participation in the NHIS. As illustrated in table 5.3, people aged 60 years and above are twice as likely to participate or enrol in the NHIS as compared to people who are less than 40 years, with a p-value of (p = 0.038). These results make intuitive sense in view of the fact that the NHIS grants exemptions to the SSNIT pensioners (60 years) and those aged 70 years and above. In addition, the people aged 60 years and above are theoretically more vulnerable to illnesses and, thus, they require medical care more often as compared to younger people in the household. These results are generally consistent with earlier findings. For example, Kimani, Ettarh, Kyobutungi, Mberu, and Muindi (2012) found that participation in the health insurance in Kenya was significantly higher for men than for women as also for those who had attained secondary school education or higher as compared to those who had attained lower levels of education The next section will examine the reasons that motivate households either to enrol or not enrol in the health insurance scheme.

5.3 NHIS – Reasons for enrolling or not enrolling

All the respondents were asked to indicate the reasons that had motivated their decision to enrol/not to enrol in the National Health Insurance Scheme (NHIS). As high as 74% of the respondents who had enrolled in the NHIS indicated that they had enrolled in the NHIS because of the easy access to health care and because the NHIS offered them protection against the financial costs of illness. This finding is logical and is largely consistent with the relatively large body of literature documenting the NHIS and access to health care in Ghana. For example, Jehu-Appiah et al. (2012, p. 226) found that 76% of households cited financial protection against the cost of illness as the main reason for enrolling in the NHIS. Studies conducted by Aryeetey et al. (2012, 2013) corroborate this claim, suggesting that, in general, the NHIS improves access to health care. Similarly, a study of a community health insurance scheme in Burkina Faso and a comparative study of the NHIS in Ghana and Nigeria both confirm the fact that health insurance is an effective tool for protecting the poor against the financial costs of illness (Hounton, Byass, & Kouyat, 2012; Odeyemi & Nixon, 2013). Figure 5.1 depicts the reasons motivating households to enrol in the NHIS.

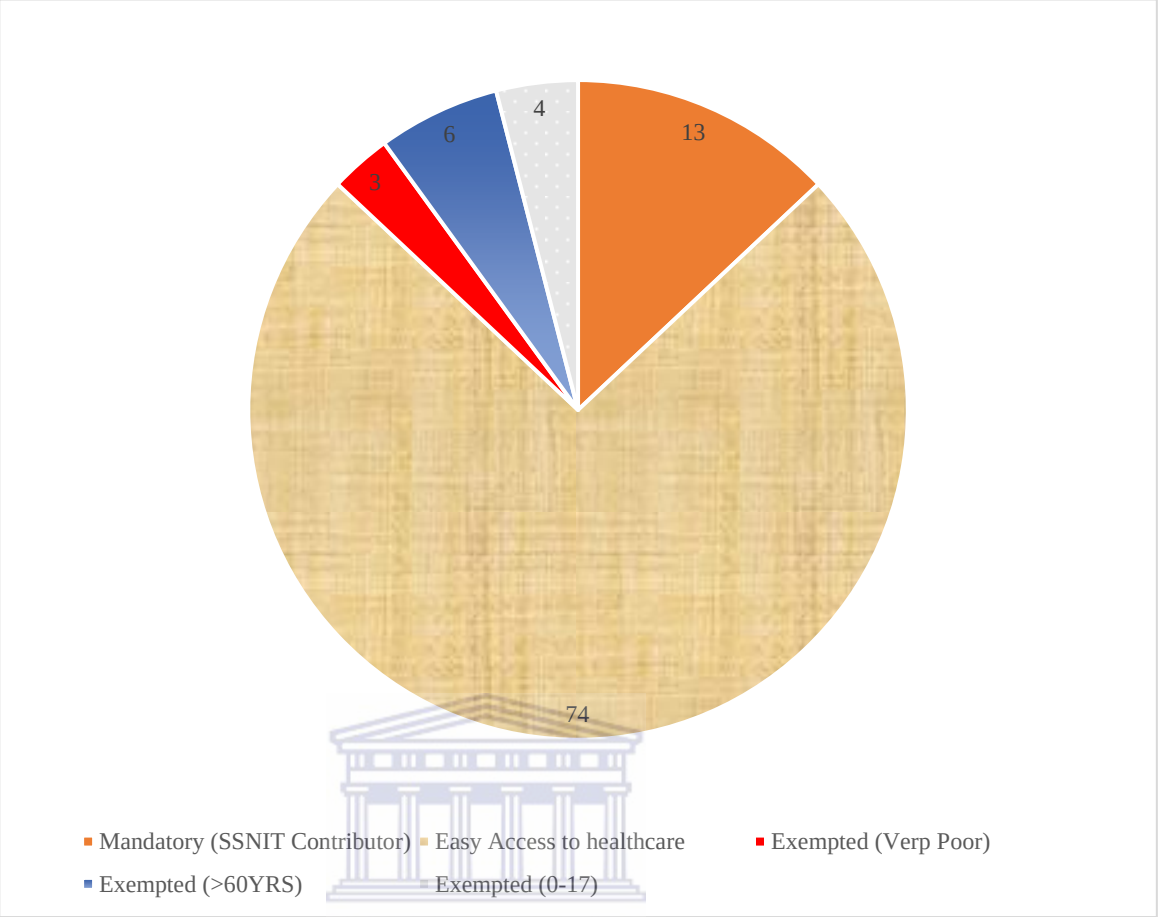

Figure 5. 1: Reasons for Enrolling in the NHIS (Author's Field Survey, 2013)

It is worth noting that this study found that 3% only of households were mandatorily enrolled in the NHIS because of their status of very poor. This figure (3%) is very close to the percentage of households covered by the Kassena-Nankana mutual health insurance scheme (KNMHIS) in 2012. It is worth noting that, as illustrated in figure 5.1 above, the KNMHIS had enrolled 2.20% only of very poor people in 2012. This finding highlights the fact that the very poor are disproportionately represented in the NHIS and, therefore, reinforces the need for them to be identified to enable state intervention. This finding is consistent with existing literature as Jutting (2005) found that in Senegal that 8% only of very poor households were enrolled in community health insurance. However, the finding supports those of the National Health Insurance Authority (NHIA, 2009, p. 28, 2010, p. 18, 2011, p. 17) which reported the national NHIS coverage rates for the very poor to be 2.3%, 1.4% and 4.2% respectively.

On the other hand, the participants suggested a number of reasons that had discouraged households from enrolling in the NHIS. These reasons are depicted in figure 5.2.

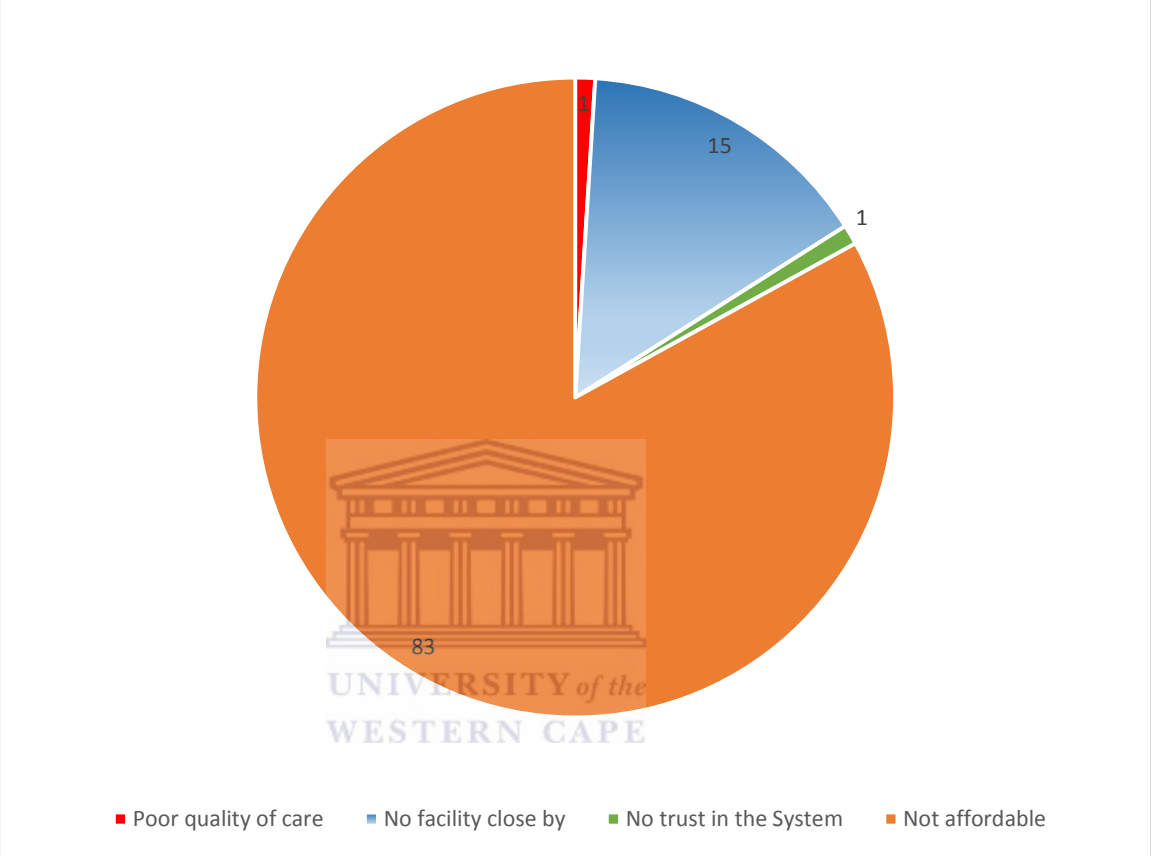

Figure 5.2: Reasons for not Enrolling in the NHIS (Author's Field Survey, 2013)

As illustrated above, it would appear that it is the affordability of insurance premiums followed by the geographical accessibility that comprise the dominant reasons constraining households from enrolling in the NHIS. These reasons are briefly discussed in the next section.

5.3.1 Affordability

The evidence presented in figure 5.2 clearly reveals that the affordability of insurance premium constitutes the cardinal barrier preventing households from enrolling in the NHIS. In fact, 83% of the households indicated that they had not

enrolled in the NHIS because they could not afford the inflexible premiums. This evidence corroborates the earlier correlation analysis that suggested that household income is positively correlated with health insurance status. It also supports the qualitative results that suggested that the SES of communities is often not duly considered when the annual insurance premiums are fixed. It is worth noting that this finding also supports existing literature on Burkina Faso, Ghana and Vietnam. Dong, De Allegri, Gnawali, Souares, and Sauerborn (2009) found that, in Burkina Faso, the affordability of the premiums was cited as the major reason for the low enrolment in community health insurance while, in Ghana, the World Bank (2012) and Amporfu (2013) also found affordability of the insurance premiums was the major barrier to accessing health care. In Vietnam, a study of a sample of 3500 households reported that health insurance uptake was low as a result of the inability of households to pay insurance premiums (Acharya, Vellakkal, Taylor, Masset, Satija, & Ebrahim, 2012, p. 47).

In the same vein, Oxfam International (2013) cite high insurance premiums as the major reason for nonparticipation in health insurance. The premiums are usually charged at a flat rate, thus making them highly regressive as, in general, the poor people contribute a higher proportion of their income as compared to the wealthier people in the developing countries. This finding is also consistent with the theoretical framework. Goddard and Smith (2001) pointed out that demand side factors such as cost of care, cost of insurance premiums and travel costs significantly influence people's access to health care in many societies.

However, in addition to the issue of ability to pay for health care, the problem of affordability also raises the critical issues of equity in access to health care and social justice, as indicated in the conceptual framework. In particular, this finding is at variance with the second theme of equity theory in terms of which all sections of the population should be entitled to equal utilisation for equal need with regards to health care (Whitehead, 1991). The finding clearly highlights the issue of unequal access because affordability (income) constrains the majority of households from participating in the NHIS, thus reducing their access to health care. Indeed, the finding is at variance with the theories of equity and social

justice (Whitehead, 1991; Rawls, 1999). Thus, apart from the fact that 3% only of the very poor are covered by the NHIS in the study area, this study shows that there is continuing inequity as regards access to health care, despite the existence of the NHIS.

This inequity is even more marked when the data is further disaggregated by gender and insurance status (see table 5.1, pg. 168). The evidence in table 5.1 reveals that, while 71% of the male-headed households were insured, 29% only of the female-headed households were insured. However, more serious is the fact that 17% only of widows were insured as compared to the 30% of widows who were not insured. Disaggregating the data was an extremely important exercise as it highlighted the differentials with respect to gender, income and insurance status. For this reason, relying on the absolute insurance coverage rate, in this case 66% in the study are, may not be helpful as these policy relevant differentials are masked. It is against this background that the UNDP (2013) argues that greater equity in health between men and women is crucial, not only because it is essential in itself, but it is also important for promoting human development in general. These findings lend further credence to the issue of social relations as the findings highlight the fact that the benefits of the NHIS are accruing disproportionately to the wealthier households as compared to the poorer households who are in the most need of health care.

These findings are in accordance with the findings of previous studies. For example, Akazili et al. (2012) argue that, in order to improve the equity in both health financing and access to health care, it is essential to ascertain who benefits from the health care delivery relative to the need for such care in Ghana. Akazili et al. argue that equity requires that health care be financed according to the ability-to-pay and that services are accessible according to need. Based on these views, it may be concluded that the NHIS is not equitable because the majority of the citizens are not enrolled in the NHIS because they are not able to afford the insurance premiums. Similar studies conducted by Schieber, Cashin, Saleh, and Lavado (2012), Dixon et al. (2013), and Frimpong (2013) have all questioned the extent to which the NHIS enhances equity in access to health care in Ghana.

5.3.2 Geographical Accessibility

Another important factor that prevents households from enrolling in the NHIS is proximity to health facilities. As figure 5.2 illustrates, a significant proportion (15%) of households are not enrolled in the NHIS because there are no health facilities close to them. This finding makes logical sense in that, in the rural areas, people may find it difficult to access health care even if they are enrolled in the NHIS because of the distance to the health facilities. As noted in the earlier qualitative analysis, the problem of distance is particularly challenging in the rural areas in the rainy season when most of the roads become impassable. This claim was confirmed by the UNDP (2010, p. 78) when it pointed out that the road infrastructure in the study area was generally poor and that, on average, 63% of rural dwellers are forced to walk for approximately 30 minutes or more to access public transport. The UNDP (2010, pp. 40–42) further reported that, on average, 22% of the urban population take between 15 and 30 minutes to reach the nearest health facility whereas 10% only of the rural population take that time to reach the nearest health facility in the Kassena-Nankana District (UNDP, 2010, 40–42).

This finding is consistent with earlier research findings in Ghana. For example, Jehu-Appiah et al. (2012, p. 226) also found in their study in the Eastern and Central Regions of Ghana that proximity to health facilities is an important reason why households do not enrol in the NHIS. They found this to be the case for 1.1% of their population. It may be that the small proportion of 1.1% found in Jehu-Appiah et al.'s study and the 15% found in my study could be as a result of differences in the study settings. The Eastern and Central Regions are generally more urbanised as compared to the study area in this study and, given the historically urban biased nature of health policy, the 15% found in my study appears reasonable. In addition, this figure of 15% supports earlier research findings in Ghana as Canagarajah and Ye (2001) indicated that 15% of the rural population in the north lived less than 30 minutes away from the nearest health facility. Similarly, studies in Burkina Faso by Hounton et al. (2012) and in Nigeria by Ezeoke et al. (2012) reported that distance to the nearest health facility and transportation costs were crucial factors that impeded the access of households to health care.

Here again, the first theme of equity, which is, equal access to available care for equal need, as promoted by Whitehead (1991), is violated. As Whitehead pointed out, inequities in access arise when resources are unevenly distributed across the country and also clustered in the urban and more prosperous areas but scarce in the deprived and more rural settings. Whitehead (1991) claims that deprived communities tend to suffer the worst health. Such unequal distribution of health resources and facilities is a clear example of Hart's (1971) *inverse care law, which states that* those who most need health care are less likely to receive it.

5.3.3 Quality of Health Care and Trust in the NHIS

It is interesting to point out that 1% of the households indicated poor quality of health care as the reason why they were not enrolled in the NHIS. Despite the fact that this statistic of 1% is not too alarming, it is still indicative of the fact that some sections of the population are not satisfied with the quality of care they receive at the formal health facilities. Nevertheless, as one of the key determinants of supply side access, quality of health care is a right of all patients and a right which all health staff are mandated to ensure (Zineldin, 2006, p. 61). In fact, as indicated earlier in chapter four, the results from the FGDs highlighted the problem of quality health. In an earlier study in Ghana, Jehu-Appiah et al. (2012, p. 226) also reported that 0.7% of households which had previously enrolled in the NHIS had not renewed their membership when it had expired because of the poor quality of health care.

In this study another 1% reported that they did not have trust in the system and that this lack of trust was the reason why they had not enrolled in the NHIS. It is possible that this lack of trust in the NHIS suggests that people may not have adequate information about the concept of insurance, the NHIS and its benefits. This argument is reasonable in view of the fact that the majority of the sampled population (55%) had never attended school. As indicated in the conceptual framework, people require quality information if they are to access health care, and education plays a critical role in this regards. Education empowers citizens to be able to evaluate the quality of care or to decide whether to seek health care.

As compared to the 1% reported in this study Jehu-Appiah et al. (2012, p. 226) found that a rather higher proportion (7%) of households had not enrolled in the NHIS because they did not have confidence in the scheme. These findings suggest the existence of inequities in the access to health care in the NHIS. It is worth noting that these findings violate the third theme of health equity – equal quality of care for all (Whitehead, 1991). The issues of quality and trust in the NHIS are moral and ethical issues. Everyone in the population should have an equal opportunity of being treated fairly and that this should not be based on either SES or social influence (Whitehead, 1991).

These barriers to equitable access to health care, namely, affordability, distance, poor quality of care and lack of trust in the NHIS, are all in line with the conceptual framework. These barriers are primarily demand and supply side problems, which are unjust, unfair, unnecessary and avoidable because it is possible for these factors to be addressed with decisive policy action; provided the government is willing and committed to providing equitable health care to all the citizens irrespective of SES. As Starfield (2007) points out, these social, geographical and demographical differences in access to health between the various subsections of the population are *remediable differences*. For example, the problem of affordability, as a demand side problem, could be addressed if the very poor are identified and exempted from paying insurance premiums. The local communities could play a critical role in the process of identifying the very poor. In addition, trust in the NHIS would be increased if people were educated to understand the concept of insurance and the operations of the NHIS in general.

In the same way, the problems of distance and poor quality of health care are both supply side problems. The issue of distance could be addressed if the government built more health facilities, especially in the rural areas, and improved the road network to these peripheral locations. The key issue is that affordability and distance to the nearest health facility are not divorced from each other but, rather, they are mutually interdependent in the sense that there may be a health facility in a particular area but its proximity to the beneficiary population may affect the access to the facility. On the other hand, a health facility could be within the reach of the population it serves but it may be financially inaccessible.

These findings highlight the fact that the equity and risk equalisation principles of the NHIS, as discussed in chapter two, are not being realised. Access to health is still determined largely by the ability to pay the insurance premiums while the very poor continue to bear a disproportionate share of the health risks.

These barriers to the access to health care are extremely relevant to notion of equity because they are unfair, unjust, and above all, are actionable by public policy in the presence of transparent and accountable relations of power. In interpreting all these results in light of the literature review and the conceptual framework discussed in chapter two, I would rank the NHIS's level of reflexivity as medium. I would rank it as medium because, despite the fact that the NHIS has increased access to health care (see chapter one and section 5.3), this increase in access to health care benefits mainly the middle class and the wealthy in Ghana. These results mean that Hart's (1971) inverse care law, which was propounded over three decades ago, is even more relevant in the 21st century with the expansion of global capitalism.

In view of the fact that enrolment in the NHIS is the 'visa' to accessing health care in Ghana, it is highly likely that either enrolment or non-enrolment in the NHIS may have affected the health status of the sampled population in different ways. In an effort to establish the link between enrolment or non-enrolment in the NHIS and the health status of the sampled population, the self-rated health status of households and their insurance status are examined in the next section.

5.4 Self-rated Health Status of Households and Insurance Status

According to Onadja, Bignami, Rossier, and Zunzunegu (2013), self-rated health invites respondents to provide an overall assessment of their health using some form of a five-point scale, for example, very good, good, fair, poor and very poor, in an effort to assess the health status of adult populations.

In line with Onadja et al.'s (2013) suggestion, the household heads were asked the following question: How would you describe the health status of this household? The following choice of responses accompanied the question namely, very poor, poor, fair, good and very good. The results are presented in figure 5.3.

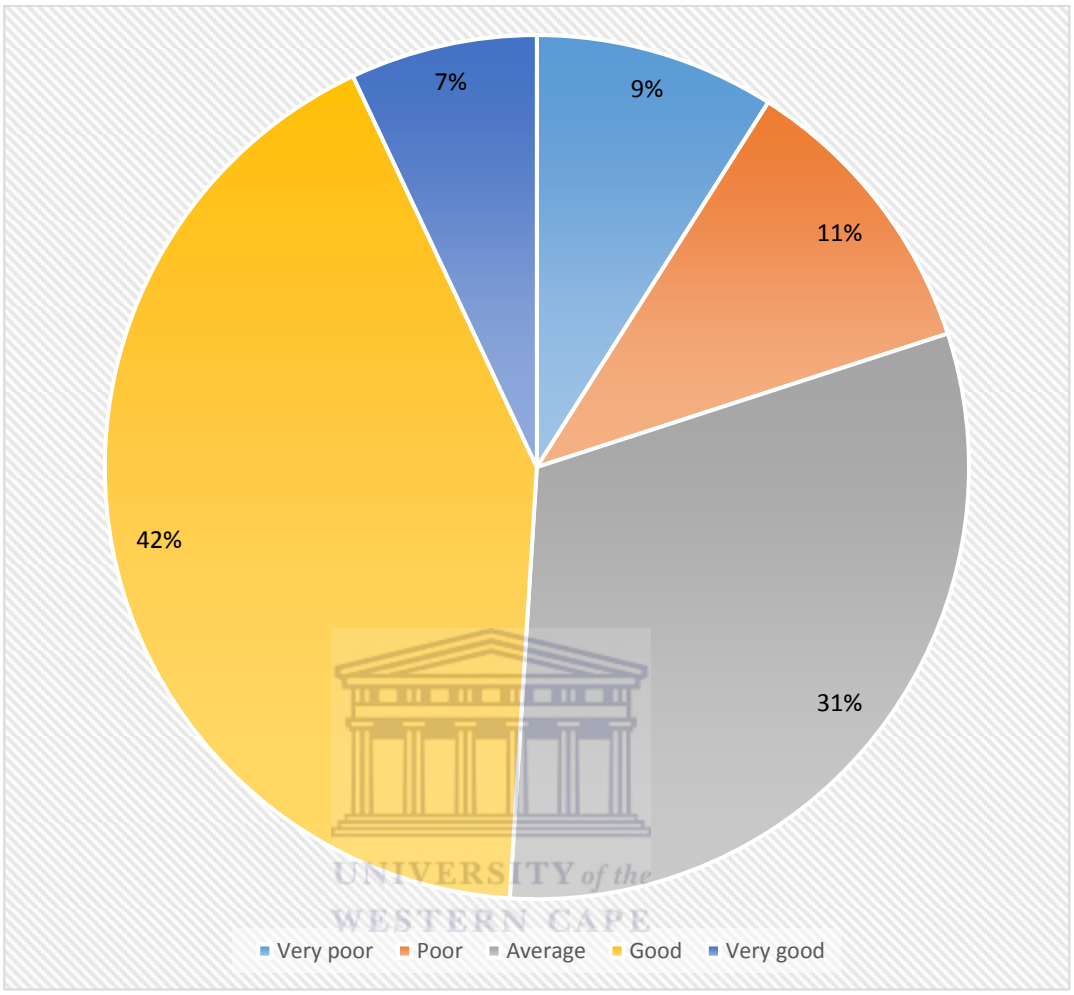

Figure 5.1: Self-rated Health Status of Households (Author's Field Survey, 2013)

Figure 5.3 reveals that the majority (42%) of households rated their health as good while 11% rated their health as poor. A cross-tabulation of self-rated health status and insurance status was conducted to establish whether there was a relationship between self-rated health and insurance status. The following hypothesis was tested: "*No relationship exists between self-rated health and insurance status.*" A chi-square test was performed to test this hypothesis. The results of the cross-tabulation are presented in table 5.4.

Table 5.4: Self-rated Health Status and Insurance Status

Self-rated health status	Insurance status	
	Insured (%)	**Uninsured (%)**
Very poor	0 (0.0)	38 (28.0)
Poor	0 (0.0)	47 (34.0)
Average	100 (36.0)	31 (22.0)
Good	151 (54.0)	22 (16.0)
Very good	28 (10.0)	0 (0.0)
Total	279 (100)	138 (100)

Source: Author's fieldwork, 2013 **Pearson chi-square (0.001)**

The results presented in table 5.4 reveal that 54% and 10% of the insured households rated their health as good and very good respectively, whereas significant proportions of the uninsured households, namely, 34% and 28%, rated their health status as poor and very poor respectively. The chi-square test showed a chi-square value of $\chi^2 = 233$ ($p < 0.001$) at a 5% level of significance and 4 degrees of freedom respectively. The chi-square results indicate that there is a statistically significant positive relationship between self-rated health status and insurance status. In other words, the null hypothesis that assumed that there was no relationship between self-rated health and insurance status is rejected as, indeed, the two variables are highly correlated. These results are logical because, comparing them to the qualitative results, the very poor, who are generally the uninsured, rarely have balanced diets.

The relationship between good health and being insured is, thus, consistent with the discussions above, and in fact, emphasises the crucial importance of identifying the very poor for the purpose of insurance premium exemptions in an effort to increase their access to health care. It is worth noting that, as indicated in table 5.4, not one (0%) of the uninsured households reported that their health was very good. These findings are also consistent with the results of the FGDs

because it emerged explicitly from the FGDs that the majority of the very poor resort to seeking health care from traditional healers although, in most cases, the traditional healers do not succeed in curing them of their ailments. Nevertheless, some of the very poor do not seek health care from the formal health facilities because they are not able to afford the cost of treatment at these facilities. The FGDs also brought to light the fact that very poor households or people have poor diets. Thus, the poor health of the uninsured, who are also generally the poor, may probably be attributed to the interplay of the factors highlighted above. Therefore, these findings also exemplify Hart's (1971) inverse care law, as explained in the preceding discussions.

Despite the fact that this study did not investigate the frequency of use of health facilities by the insured and uninsured, it is likely that the insured would use health facilities more frequently for preventative health care as compared to the uninsured and, hence, the significant disparities in the self-rated health status between the two groups. In fact, earlier studies suggest that the insured in Ghana are three times more likely to use health facilities than the uninsured (Alatinga & Fielmua, 2011, p. 136). With this background analysis in mind, the proposed model for identifying the very poor is now presented in the next section.

5.5 Model for Identifying the Very Poor: A Logistic Model Specification

In order to determine the variables that are of the most theoretical and also the most practical relevance in explaining the dependent variable (household poverty status – SES), a logistic regression model was employed. In the fitted model, the outcome or dependable variable was treated as a binary variable, that is, *poor* and *not poor*. The results of the logistic regression are presented in table 5.5.

Table 5.5: Logistic Regression Model of Predictors of Household SES

SES	Response	Odds Ratio	95% CI	P-value
Income	$32–46	1		
	$4–27	1.64	1.01, 2.66	0.045
Education	Never	1		
	Primary	0.62	0.35,1.10	0.105
	JHS	0.59	0.29,1.18	0.137
	SHS	0.25	0.11,0.54	0.001
	Tertiary	0.09	0.03,0.28	0.001
Gender of household head	Male	1		
	Female	0.56	0.29,1.08	0.085
Marital status of household head	Married	1		
	Single	0.13	0.02,1.10	0.061
	Divorced	0.17	0.05,0.55	0.062
	Widowed	1.50	0.24,1.04	0.003
Times without food	No	1		
	Yes	1.65	1.02,2.67	0.042

Source: Author's Field Survey, 2013

The results in table 5.5 show that income, education, gender of household head, marital status of household head and the number of times without food, are good predictors of household poverty or SES. These variables are briefly discussed below.

5.5.1 Income

As shown in table 5.5, income is a good predictor of household SES. Households that earn a monthly income of between $4 and $27 are more likely to be poor as compared to households that earn between $32 and $46. The odds ratio of 1.64 indicates that households that earn between $4 and $27 a month are 64% more likely to be poor as compared to households that earn $32 and $46. The odds are also statistically significant (p = 0.045). This finding supports earlier findings, as Sen (1999) asserted that low income contributes to poverty in the form of hunger and undernourishment. The finding is also akin to the lower poverty line set by the Ghana Statistical Service (GSS). In its latest publication of the Ghana Living Standards Survey (GLSS) report of 2005/2006, the GSS (2007) set a lower poverty line of GH¢288 (US$113) per adult per year. Dividing $113 by 12 we obtain $9 per month and this falls neatly within the range of $4–$27 found in this study.

5.5.2 Education

The explanatory power of education as a predictor of household poverty status is phenomenal. As illustrated in table 5.5, as the level of education of the household heads increased, so the odds of being poor decreased greatly. The odds of being poor for household heads with tertiary levels of education were only 9%, as compared to that of household heads with no education at all. The odds ratio is statistically significant (p = 0.001). This finding is in line with the theoretical framework, as Foucault (1977) postulated that "knowledge is power". In other words, knowledge in the form of education acts as a catalyst for both individual civic participation and for higher levels of household wellbeing. In this context, education leverages knowledge to households in the form of acquired skills and innovative ideas while the heads of households with tertiary levels of education are more employable in better paid jobs as compared to the heads of households with no such education. In support of this claim, Sen (1999) argues that both better education and better health help in earning higher incomes, while Adams (2011) is unequivocal, pointing out that postsecondary education improves the chances of both households and individuals of finding employment and earning

higher incomes. The finding is also consistent with the preceding analysis, because, as (table 5.1, p.168) illustrates, all the households with tertiary level of education were insured. This, in turn, suggests two possibilities. Firstly, it may be that the household heads with tertiary level of education earn sufficiently high incomes to be able to afford to pay the annual insurance premiums while, secondly, it may be that the household heads who have tertiary levels of education are more enlightened and understand the purpose and benefits of health insurance. In conclusion, the UNDP (2013) argues that education is the most important instrument for promoting human development because it boosts the citizens' self-confidence, thus encouraging them to scrutinise government health policy and, consequently, hold government accountable for the provision of health care.

5.5.3 Gender of Household Head

Another interesting finding from the logistic regression depicted in table 5.5 is that female-headed households were 44% less likely to be poor as compared to their male-headed households. There is, however, mixed evidence in the literature relating to the poverty status of female-headed households relative to that of male-headed households. For example, a study conducted by IFAD (2001) in Western and Central Africa found that the poverty incidence among female-headed households was lower than among male-headed households. Specifically, the IFAD study (2001, p. 17) found that, in Niger, 55% of female-headed household were poor as compared to 64% of the male-headed households. Similarly, in Ghana, the GSS (2007, p. 15) found that female-headed households were, on average, less poor than male-headed households. In the case of Ghana, the GSS (2007, p. 15) indicated that, between 2005/06, while 31% of male-headed households were poor, 19% of female-headed households were poor.

It could, perhaps, be argued that, in general, women are better managers of the household resources as compared to men. In fact, the qualitative results support this logical deduction, as it emerged that it was the women who generally took responsibility for catering for the food needs of their children while the men were

indifferent. This viewpoint is further supported by evidence from La Côte d'Ivoire. For example, IFAD (2001, p. 17) found that when women were in control of households, the household cash resources doubled while the household expenditure on cigarettes and alcohol dropped by 26% and 14% respectively.

Nevertheless, these study findings and the supporting evidences discussed above are contrary to conventional wisdom. In fact, Matsa (2011) suggests that poverty in Africa is feminised because female-headed households lack access to and control over resources, such as land, as compared to their male counterparts. Isangula (2012) concurs with this viewpoint, claiming that women are naturally disadvantaged in Africa while more women live in poverty in Africa than men. Even in the developed countries, such as the United States of America, research has shown that the poverty rates for all groups of women are higher than for their male counterparts (National Women's Law Center, 2012). However, the mixed evidence from this study appears to be a positive development as the findings provides an incentive for further research to ascertain whether the female-headed household are, indeed, less likely to be poorer than the male headed households in the study area. If so, what reasons would account for this trend?

5.5.4 Marital Status

It is also worth noting that, as reported in table 5.5, the study found that households headed by widows were 50% more likely to be poor as compared to households where the household heads were married. This result was highly statistically significant ($p = 0.003$). However, this finding makes intuitive sense because a couple is able to pool resources to manage household poverty as compared to a widow or widower, especially should either the widow or widower be unemployed. This finding is also consistent with the results of the qualitative analysis, which highlighted that unemployed widows with children were a good predictor of poverty.

5.5.5 Times without Food

Another interesting and important finding from the logistic regression was that households that had been without food at least three times in the thirty days preceding the survey were more likely to be poorer as compared to households that had not been without food for the corresponding period. The odds ratio of 1.65, as reported in table 5.5, suggests that households that had been without food were 65% more likely to be poorer than those that had not. This odds ratio is also statistically significant (p = 0.042). This finding is in accordance with the literature. For example, Ezeoke et al. (2012) argue that, apart from selling household assets and borrowing, one critical way in which poor households manage their poverty is reducing household consumption although this impacts negatively on their health status. The number of times without food, therefore, underlines the finding that income is significantly correlated with insurance status.

A further examination of those households that had indicated that they went without food and those that had not gone without food by insurance status supports this finding (see table 5.6).

Table 5.6: Times without Food in the Last 30 Days and Insurance Status

Times without Food	**Insurance Status**	
	Insured (%)	**Uninsured (%)**
Yes	38 (14.0)	85 (62)
No	241(86.0)	53 (38)
Total	**279 (100)**	**138 (100)**

Source: Author's field survey, 2013. Pearson chi-square (0.001)

Table 5.6 is self-explanatory. The proportion of insured households that had not gone without food in the previous 30 days was more than twice (86%) that of uninsured households (38%) while 14% of insured households only had gone without food in the preceding 30 days. Correspondingly, 62% of uninsured

households had gone without food at least three times in the 30 days preceding the survey. It is possible that the results from the logistic regression and presented in table 5.6 support the evidence presented earlier in table 5.2 and that suggested that uninsured households spent more on health care as compared to insured households. It may, therefore, be a coping strategy adopted by poor households to spend more on their health and reduce household food consumption – type of opportunity cost. These findings generally support the multidimensional concept of poverty as comprising education, health and living standards as reported in this study (UNDP, 2013).

The logistic regression model presented in table 5.6 allowed for analysing the variables that significantly predicted household poverty status (SES) using the odds ratio. However, the results in table 5.6 do not allow us to determine the number of households among the poor households that were very poor and, thus, merited exemption from paying health insurance premiums because the focus is on very poor households. For this reason, by using the 75% probability of being poor cut-off point, as explained in chapter three, the logistic regression model predicted that 52 (12.5% of the household as shown in table 5.7) in the sampled population were very poor. Thus, these 52 households should be exempted from paying health insurance premiums.

Table 5.7: Exempt Households and Insurance Status

Insurance Premium Exemption	**Insurance Status**		**Total**
	Insured	**Uninsured**	
Not exempt	248 (89.0)	117 (85.0)	365 (87.5)
Consider for exemption	31 (11%)	21 (15)	**52 (12.5)**
Total	279 (100)	138 (100)	417 (100)

Authors' field survey, 2013

Given the sample size for this study, this finding of 12.5% is within the range of the very poor population in Ghana because the GSS (2007) indicated that 18% of the population in Ghana was very poor.

In examining the major characteristics of these 52 very poor households, it is interesting to note that males headed all 52 households. This finding also supports the finding that male-headed households were more likely to be poorer as compared to female-headed households. In particular, all of these 52 households had gone without food at least three times in the 30 days preceding the survey. This finding supports the IFAD's (2011, p. 16) claim that approximately one billion people are suffering from hunger globally. This finding further resonates with the qualitative results, which revealed that food insufficiency was ranked as the most important descriptor of poverty. Thus, these findings suggest that the 75% cut-off point criterion used for the prediction of very poor households was fairly robust because the logistic regression model predicted that female-headed households were 44% less likely to be poorer as compared to their male counterparts. The 52 households contained 278 people. I also found that 30 households, representing 58% of the 52 households, were located in the south zone, 14, representing 27% of the households, were located in the north zone while the remaining eight, representing 15% of the households, were located in the central zone. These results suggest that, in the main, poverty among the study population was a rural phenomenon. These results are consistent with earlier research findings. For example, IFAD (2011, p. 16) reported that 70% of the world's very poor people are live in rural areas.

In short, it emerged from the logistic regression model that household income, marital status, level of education, and food insufficiency significantly predict household poverty status. In the next section, I briefly critique the model presented in the study, paying attention to its weaknesses and strengths.

5.6 Limitations and Strengths of the Logistic Regression Model

One possible limitation of the model presented above is that its use may be limited to the study area because of the various socio-economic backgrounds in

Ghana. In other words, the model may not be applicable nationally as a result of differences in the socio-economic backgrounds as the country is ethnically diverse. However, the procedure followed in this study may be replicable in other contexts for the purposes of identifying the very poor for the purposes of health insurance premium exemptions, given that each district in Ghana operates the NHIS or for other social support programmes meant for the poor autonomously.

However, the model does have a number of strengths. Firstly, the model is simple and nomothetic, that is, the model isolated only the most important explanatory variables that significantly predicted household poverty status (Berman & Wang, 2012). Secondly, the model is theoretically and conceptually driven. According to Berman and Wang (2012), theory-driven explanations usually result in models with approximately five to 12 variables, but seldom resulting in less than five variables. This model contained five important variables only.

5.7 Summary

The study found high health insurance coverage in the study area, with 67% of the sampled population being enrolled in the NHIS. In addition, 49% of the sampled population was found to be poor as compared to the 51% that was not. Despite the fact that uninsured households spent more out of pocket for health care as compared to insured households, there was a positive relationship between self-rated health and insurance status. In other words, insured households generally rated their health status to be good as compared to uninsured households. This situation may perhaps be explained by the possibility that insured household are able to visit the health facilities frequently to seek preventative health care.

The most significant reason that motivated households to enrol in the NHIS was the easy access to health care afforded by insurance. The majority (74%) of households indicated that the NHIS protected them against the costs of illness. On the other hand, the affordability of health insurance premiums as well as the geographical location of health facilities constituted the major reasons why households do not sign up for the NHIS. Significantly, 3% of households only

were exempted from paying insurance premiums because of their status of being very poor. This situation raises questions about the extent to which the NHIS promotes equity in the access to health care for the entire population. In addition to the ability to pay the insurance premiums, disaggregating the data revealed that the percentage of male-headed households (71%) enrolled in the NHIS was disproportionate as compared to the percentage of female-headed households (29%). Of more concern, however, is the fact that households headed by widows were further marginally represented (17%) in the NHIS. These findings are at variance with equity and social justice theories because generally highlight demand and supply factors that are remediable if government takes decisive public policy action.

Using a logistic regression model, household income, education level, marital status and food insufficiency significantly predicted household poverty status. Interestingly, the model suggested that female-headed households were 44% less likely to be poor as compared to male-headed households, although the finding was statistically insignificant. However, this finding provides a definite incentive for further research into this issue. Based on the household predicted probabilities, the model predicted that 12.5% of households were very poor and, as such, deserved to be exempted from paying health insurance premiums. However, in general, these findings suggest continuing inequities with respect to access to health care in Ghana.

Like all models, the model presented has some limitations and some strengths. One possible limitation of the model is that it may not be applicable nationally because of the differences in the socio-economic backgrounds arising from the fact that Ghana is an ethnically diverse country. However, the procedure followed may be replicable in other contexts for the purposes of identifying the very poor for health insurance premium exemptions or for other social support programmes aimed at the poor. Among its key strengths; the model is simple, intuitive and, above all, theoretically-driven. In this vein, Burnham et al. (2008) argue that social science research should be able to provide clear accounts of complex problems that assist in understanding the problems and the dynamics at work.

In conclusion, synthesising the analysis above, one issue stands out, namely, that the NHIS, as it is now, is extremely inequitable. An equitable health system seeks to minimise the differences in health which occur on the basis of wealth, education, gender, and place (Horton et al., 2014). For this reason radical reforms are needed to reduce the inequities in the access to health care so that all citizens of the country are able to enjoy the same financial protection and access to the same health services based on need and not on their ability to pay. One such reform would involve a conscious and committed effort aimed at identifying the very poor for the purpose of health insurance premium exemptions in order to enhance their access to health care. The next chapter present the conclusions and policy implications of the study.

Chapter Six

Conclusions and Policy Recommendations

6.0 Introduction

This study set out to achieve a number of objectives. The first objective was to contextually define the very poor and to solicit community criteria for identifying very poor households for the purpose of health insurance premium exemptions. Participatory wealth ranking exercises were carried out in selected communities using focus group discussions (FGDs) to attain this objective. Community members participated in these discussions and discussed their experiences and perceptions of poverty. The participants in the discussions distinguished between the very poor, poor, average, rich and very rich individuals or households based on their assets and possessions. The perceptions of the communities about poverty, as presented in chapter four, mirrored the multidimensional nature of poverty. An interesting perception about the poor people that is worth highlighting is that some of the community members perceived the very poor as lazy people who are not willingly to work. The FGDs also revealed a number of barriers that impede enrolment in the NHIS or access to health care in general. These barriers included the attitude of unfriendly health providers toward poor patients, geographical inequity and affordability. One key finding from the FGDs was that the very poor have no voice in the process of identifying the very poor at the community level because village or local elites often hijack the process of identifying the very poor.

The second objective of the study was to examine the reasons why households either enrol or do not enrol in the NHIS. Household surveys were conducted to achieve this objective. The results of the survey revealed that, despite the fact that the health insurance coverage in the study area was extremely high, SES was the major determinant of participation or enrolment in the NHIS. In particular, the survey results revealed that 83% of households had indicated that they were not enrolled in the NHIS because they could not afford the annual insurance premiums while 15% of households reported that they were not enrolled because there were no health facilities close to them. The quality of the health care

received and trust in the NHIS were also highlighted as reasons for households failing to sign up with the scheme. On the other hand, 74% of the households enrolled in the NHIS cited financial protection as the most significant reason for enrolling in the NHIS. Nevertheless, it also emerged that 3% only of households were mandatorily enrolled in the NHIS because of their status of being very poor.

The third objective of the study was to develop a model for identifying very poor households for the purposes of health insurance premium exemptions. A logistic regression model specification was used to achieve this objective. PCA was used to generate a poverty index of household SES based on the assets and possessions of households. Based on this poverty index, and using a 75% probability of households being poor, the model accurately predicted that 52 households (12.5%) were very poor and deserved to be exempted from paying health insurance premiums.

6.1 Integrating the Qualitative and Quantitative Results

A synthesis of the qualitative and quantitative results showed that the findings were complementary. Both the qualitative and the quantitative results revealed that demand and supply side factors such as the availability of the health care services, the quality of the health care services and affordability (cost of care) were the major barriers restricting the access to equitable health care in the Kassena-Nankana District. As regards the quality of care, the qualitative results were more revealing than the quantitative results as the FGDs enabled the participants to freely express their satisfaction as regard the quality of health care they received. Some of the participants were so appalled by the quality of the services received by poor patients that they expressed worry about their future use of the formal health facilities even if they were offered free health insurance. In the terms of the two dimensions of access – availability of health services or facilities and affordability – the household surveys proved to be extremely useful in highlighting the extent or the number of households that were restricted from access to health care because of these factors. The fact that the qualitative and the quantitative results largely complemented each other with respect to these

demand and supply side factors enhanced the credibility of the findings while also signifying that the research design adopted for the study was both valid and reliable. This complementarity of the research findings also lent credence to the research strategy adopted. Teddlie and Tashakkori (2011) point out that a mixed methods research design provides a broader understanding of the research problem than either the qualitative or quantitative approach alone.

In terms of the criteria for exempting very poor households from paying health insurance premiums, the results were again complementary. The community suggested indicators for identifying very poor households and the predicted criteria from the logistic regression model are presented for easy comparison in table 5.8. These criteria were also compared with those that were stipulated in the Act that established the NHIS, Act 650 (chapter one), in the same table 6.1.

Table 6.1: Comparison of Criteria for Identifying the Very Poor

Community Suggested Indicators for Identifying Very Poor Households	Logistic Model Predictors of Very Poor Households	Criteria Set by Act 650 for Identifying the Very Poor
1. **Food insufficiency**	Times without food	Unemployed and no visible source of income
2. **Lack of own seeds to sow during the rainy season**	Gender of household head	No fixed place of residence
3. **Educational status**	Educational status	Does not live with a person who is employed and who has a fixed place of residence
4. **Financial/income insecurity**	Lack of income	Does not have any identifiable, consistent support from another person
5. **Unemployed widows with children**	Marital status of household head (widows)	

Source: Author's construct 2013, based on FGDs, Logistic Regression Model and Act 650

Table 6.1 clearly illustrates that four of the indicators suggested by the communities and the predictors arising from the logistic regression model are basically the same. These indicators include food insufficiency, educational status, income and unemployed widows with children. The similarities between the indicators that emerged from the FGDs and those from the logistic model reflect a high degree of credibility in the research design. As indicated in chapter 3, one of the major reasons for selecting a mixed methods research design is the

fact that both qualitative and quantitative methods have their own strengths and weaknesses and these strengths may be combined to enable a more comprehensive understanding of the research problem or research questions (Creswell, 2014). The FGDs were extremely about the issue of marital status, by indicating that unemployed widows with children deserved exemptions. Another very revealing descriptor, also shown in table 5.6, is the lack of own seeds to sow during the rainy season. I found this criterion to be revealing because I had not come across it in the literature and, hence, it is an issue merits further investigation. With respect to the gender of households, the logistic regression model indicated that households headed by females were 44% less likely to be poor as compared to those male-headed households.

However, when comparing these indicators from the FGDs and the logistic regression model to those that were set by Act 650, significant differences emerge. Apart from the first indicator (unemployment or lack of income), the rest of the indicators, as stipulated in Act 650, appear to be far removed from the realities of poverty on the ground. In addition, the criteria contained in Act 650 do not reflect the communities' views on poverty, at least not those of the communities in the Kassena-Nankana District and as demonstrated in this study. When integrating the criteria from the FGDs and the logistic regression model, the final proposed model or criteria for identifying the very poor contained the following variables:

- Number of times without food in the last 30 days (food insufficiency)
- Unemployed widows with children
- Lack of own seeds to sow during the rainy
- Educational status
- Financial/income insecurity

This proposed model was both relevant and acceptable to the study communities. The model is also very parsimonious and would enable the staff of the health insurance scheme to make a rapid assessment of the poverty situation of a household during a short visit. In particular, the criteria are verifiable at the community level. It is important also to point out that, because society is dynamic

and in constant flux, it is essential that these criteria be updated or revised periodically so as to ensure that they reflect the realities of poverty based on societal changes and dynamics. Based on the study objectives summarised above I will now draw the main conclusions of the study.

6.2 Conclusions

The evidence presented in the preceding chapters clearly depicts the continuing inequities in the access to health care of the poor, despite the existence of the NHIS. In particular, both demand and supply side factors, such as the availability of health care services, the quality of health care, affordability and the cost of care, continue to constitute obstacles to the access to health care of the poor. Differences in access to health care are clearly based primarily on individual or household SES because higher income households and household heads who have attained post-secondary levels of education are more likely to enrol in the NHIS compared to low income households and household heads who have never attended school. The quality dimension of access to health care highlights the reality that poorer patients are not treated with respect as compared to the wealthier patients.

Geographical inequity emerged specifically as a rural problem in the study area because of the poor road infrastructure. Geographical inequity encompasses the physical location of the health facilities as well as transport costs. Geographical inequity appears to be a colonial legacy because the colonial government failed to distribute health resources and health facilities fairly across the country, with the more urbanised and resources rich southern parts of the country benefitting disproportionately from investments in the health sector. Even Nkrumah's free health care policy did not adequately address this problem of geographical inequity while subsequent governments have also not done enough to address the problem. Geographical access and affordability are not mutually exclusive but are rather intrinsically linked. Health services may be available to the population but access to these health services may be restricted because people are not able to afford the cost of treatment. In the same vein, people's access to health may be

constrained because of travel or transport costs. In addition, the problem of access to health care for the very poor is compounded when they are confronted with both geographical inaccessibility and the cost (affordability) of health care.

These dimensions of access to health care were examined within the framework of institutional relations of power. These demand and supply factors do not occur in vacuum but are integrally embedded in the social structure of society mediated by history. This social structure and history dialectic render the dimensions of access to health care amenable to empirical observation and rational assessment in an effort to enhance the provision of the right quantity and quality of health care to the locations where it is needed the most and at the right time (Harvey, 2009; Mészáros, 2011)

Nevertheless, the existence of differences in access to health is indicative of the fact that the health system is inequitable, thus suggesting a medium level of reflexivity as all the citizens do not have a fair equal opportunity to access health care. This inequity was even clearer when the data was further disaggregated by sex and insurance status. While 71% of the male-headed households were insured, only 29% of female-headed households were insured. However, of more concern is the fact that 17% of widows only were insured as compared to 30% of widows who were not insured.

These differences in access to health care between the various socio-economic sub-groups from the demand and supply side are unnecessary, unjust, unfair and avoidable. It is important to note that these differences are remediable by public policy action, given committed political will and decisive policy direction. The research findings are, therefore, at odds with the theories of equity and social justice.

The disparities in access to health care between the different population sub-groups invariably affect both their health seeking behaviour and their health status as the possession of a health insurance card is, literally, a ‘visa’ with which to access health care at the formal health facilities. Consequently, the majority of the very poor people who are uninsured resort to the use of herbs while others rely on *jujumen* to seek the help of supernatural powers for their ailments.

Unfortunately, in most cases, these *jujumen* are not able to address the health needs of the health-seekers adequately. Thus, the study established that, in general, the uninsured have poorer health as compared to the insured. For example, 54% and 10% of the insured households rated their health as being good and very good respectively, while 34% and 28% of the uninsured households rated their health status as being poor and very poor respectively – a substantial difference. It is worth noting that not one (0%) of the uninsured households rated that their health status as very good. These findings are in keeping with Hart's (1971) inverse care law because the poor who live in risky environments are in the most urgent need of health care and, yet, they receive very little of it.

The popularity of the NHIS in Ghana offers a unique, generational opportunity for the health inequity gap to be bridged. Nevertheless, even health insurance may not be able to bridge the inequity gap in the access to health care unless conscious efforts are made to address the demand and supply side barriers to health care, as discussed above. Addressing the supply side problems by increasing the availability of health service alone will not bridge the inequity gap. On the demand side, there is now more than ever an urgent need for the very poor to be identified in an effort to increase their demand for and access to health. It is in the spirit of addressing the demand side inequity gap that the model proposed in this study for identifying very poor households for the purposes of health insurance premiums exemptions is uniquely opportune.

6.3 Policy Recommendations

It has emerged from the preceding discussions that access to equitable health care is limited by demand and supply side factors. This limited access to health care, especially for the poor, has forced many of them to resort to the use of alternative medicines, such as the use of *neem* leaves and the bark of the mahogany tree to treat malaria and dysentery respectively. The limitation in access to health care as a result of these avoidable factors defeats the principle of universal access to health care as both a fundamental human right and a basic need. In addition, it

also defeats the NHIS equity and risk equalisation principles because the benefits of the NHIS accrue disproportionately to the better-off in society.

Accordingly, it is essential that development policy focus on addressing these demand and supply side factors. As regards the theme of the availability of health care services, there is an urgent need for the number of health facilities throughout the country to be increased and, especially, in the Kassena-Nankana District equitably. The policy priority should focus on expanding these health facilities in the rural and deprived areas of this district. There is also an urgent need to develop and improve the road infrastructure.

As regards the theme of affordability (cost of health care), there is a need for special social policy interventions in the north in an effort to bridge the poverty gap between the north and south of the country in general. With respect to the Kassena-Nankana District, in particular, health policy should focus on addressing the socio-economic demographics that influence the population's access to health care. In this respect, the issue of identifying needy households or individuals for state intervention is extremely important. The communities' perceptions of poverty and the communities' own criteria for identifying the very poor are key to addressing this demand side problem.

As regards the theme of equal quality of care for all, there is a need for public health education for the population to enhance everyone's understanding of their right to health care. This education will empower the populace both to challenge and to hold the health providers who treat patient disrespectfully based on SES or social influence accountable for their actions. The issue of providing quality health care to those in need is an ethical issue and must be further investigated. If it is found that some health providers are indulging in this unethical practice of not providing providing the required quality care for patients, these health providers should be appropriately sanctioned in an effort to curb the problem in the future. The implementation of these recommendations by policy-makers will make a significant contribution to bridging the health equity gap in the country as a whole and in the Kassena-Nankana District in particular. The role of socially just relations of power and political commitment in bridging the equity gap is a

reality, which is exemplified by the Kerala model in India. Politicians and policy advisers have a unique generational opportunity to reduce the huge disparities in the health access to health care. It is essential that development policies make a difference and that resources are distributed equitably to ensure that good health care is provided where it is most needed. Anything short of these policies will render the attainment of universal access to health care and the bridging of the equity gap in health insurance in Ghana elusive.

6.4 Contributions to Knowledge

The results of this study contribute to existing knowledge methodologically and theoretically and also in terms of development policy and practice. Methodologically, the procedure adopted for identifying very poor households is original and innovative and, as such, may be applied in contexts other than Ghana. Thus, this procedure contributes to the existing methodologies that aim to identify the poor. Theoretically, the extensive review of the concepts of equity and social justice and the way in which they relate to access to health care contributes to existing and ongoing discourses on how to provide equitable social interventions to the less advantaged in society in a socially just manner. In particular, the institutional relations of power framework adopted for the purposes of this study have illuminated our understanding of the dimensions of access to health care. In this way the institutional relations of power framework has, thus, advanced our understanding beyond the traditional economics of demand and supply as the framework embeds these within the dialectics of the social structure and history. In this regard, the analytical framework is equally relevant to other social sectors or countries seeking to examine equity of access as regards social interventions. In terms of academic contribution, researchers and students will find the effective application of the theories of social justice and equity illuminating.

Finally, the study has successfully shed light on the factors that constrain citizens' access to health care. The constrains highlighted in the study are extremely relevant to both development policy and practice because they

highlight specific issues that need to be addressed if the inequities and disparities as regards access to health care for the population at large are to be eliminated.

6.5 Suggestions for Further Research

It is clear from the research findings that one of the key issues that merit further research is the finding that female-headed households are less likely to be poor as compared to male-headed households. Given the high rate of poverty in the study area, it is important that this trend be further investigated. Such further research should try to establish the reasons or factors why female-headed households are more resilient to poverty as compared to male-headed households. The experiences and successes of these female-headed households could be made public for all households to emulate in their efforts to manage poverty.

Despite the fact that this study established the demand and supply factors that block access to health care, detailed research is still needed to find out which supply side factors, in particular, are more prevalent, and in what communities? In other words, an inventory of the health facilities in the various communities is required in order to ascertain which communities are in dire need of what facilities in an effort to inform policy. Such an inventory is important as it should help to avoid the waste and/or duplication of resources and also to ensure that additional health resources or facilities are sited at where they are needed in the face of scarce resources.

It is also essential that periodic research be undertaken to update or revise the proposed model or criteria for identifying very poor households. For example, should the 52 households identified continue to receive health insurance premium exemptions *ad infinitum*? Thus, further research should be conducted in this regard to determine the SES of these households after, for example, five years, and to endeavour to predict a timeframe within which these households should move out of poverty.

It is also imperative that further research investigates the issue of the quality of the health care being delivered to health-seekers based on their SES or social influence in order to ascertain the veracity of the claim.

Finally, and, perhaps, most importantly, this study established that many people, especially the poor, continue to rely on herbs in order to treat ailments such as malaria and dysentery. For this reason, it is recommended that further research be conducted into the efficacy of such herbs by collecting samples and analysing their chemical properties in a scientific laboratory. If found to be efficacious, these herbs could be integrated into the formal health care system and appropriate doses prescribed by pharmacists to the population in an effort to avoid the danger of overdosing. The integration of herbs into the formal health care system would help maintain a balance between the religious cosmologies of the people while ensuring that formal health care is more acceptable to all.

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APPENDICES

Appendix I: FGD Guide

Section 1

Community Perceptions on Poverty

1. What is poverty? Probe for the perceptions of participants on poverty. As much as possible, allow participants to describe all their experience or understanding of poverty
2. Ask Participants to list as many as possible the descriptors or indicators of poverty

Section 2

Distinguishing the Poor from the Very Poor

3. What distinguishes the poor/very poor, rich/very rich?
4. Who are the poor and the very poor? (Probe for characteristics of the poor and very poor)
5. Who are the rich/very rich? (Wealth ranking)

Section 3

Criteria for Identifying the Very Poor

6. What criteria should a household or individual meet in order to be exempted from paying health insurance premiums?
7. List five major/key criteria that should be used to exempt households or individuals from paying health insurance premiums (**Note**: This list must be validated at all the zones in an effort to have a unified and acceptable criteria from the communities concerned)

Section 3

Causes of poverty

8. What do you think are the causes of poverty? (Probe for slave trade, colonialism, poor social relations (breakdown of the extended family system) weak institutions (corruption).
9. (Probe for how each of these cause poverty)

Appendix II: Household Questionnaire

SECTION 1: IDENTIFICATION

DATE OF INTERVIEW		DINT
COMPOUND NAME/ID		COMPNAM
HOUSEHOLD NAME/ID		HHNAME
NAME OF FIELD ASSISTANT		NFA
NAME OF COMMUNITY		COMTYNAM

SECTION 2: SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF RESPONDENT

	For the household head	Coding Categories	Codes
1	How old is the household head? **(Age in completed years)**	☐☐	Q1HHAGE
2	Sex of household head	Male……1 Female…….....2	Q2HHSEX
3	Marital status of household head	Married……...….....1 Never married…….....2	Q3HHMAR

		Divorced……..….....3 Widow….…….....4 Other (specify)...…….....5	
4	Ethnic origin of household head	Kasem……..….....…1 Nankam…….…….....2 Buli…….…….....3 Other(specify)……...….....4	Q4HETHIC
5	What is educational level of the household head?	Never been to school……...1 Primary……...…….....2 JSS…….....…….3 Secondary……..….....….4 Tertiary……..….....5	Q5HEDUC
6	What is the occupation of the household head	Farmer…….....…….1 Trader……...……...……2 Employed in the formal sect.3 Retired/Pensioner……..…...4 Student…….…….....5 Unemployed....……..….....6	Q6HOCCUP
7.	Apart from the household head, are there other members of the household who are employed?	Yes……. .1 No…… …2	Q7OCCUPOHM ➔**SKIPQ8**
8	If yes, What type of occupations are they engaged in?	Farming…….. 1 Retail Trading……2 Rice processing……..3 Shea butter processing……4	Q8TOCCUPOHM

		Day-labourer (Canal)…….....5 Tailor/Seamstress……6 Hairdresser/Barber…….7 Other (specify)……8	
9a	How many people live in this household?		Q9HHSIZ
9b	**Write down sex, age and education of each household member**		

Household member	Age	Sex Male…..1 Female...2	Educational level Never been to school……..1 Primary.....2 JSS.....3 Secondary..... 4 Tertiary.....5	
Person 1				PERS1ASE
Person 2				PERS2ASE
Person 3				PERS3ASE
Person 4				PERS4ASE
Person 5				PERS5ASE
Person 6				PERS6ASE
Person 7				PERS7ASE
Person 8				PERS8ASE
Person 9				PERS9ASE

Person 10				PERS10ASE
SECTION 3: HOUSEHOLD INCOME AND EXPENDITURE				
10	On average, what is the monthly income of the household?	Less than GH¢10……1 Between GH¢10 & 20……2 Between GH¢20 &30…….3 Between GH¢30 &40…….4 Between GH¢ 40 & 50……..5 Between GH¢50 &60……6 Between GH¢60 &70……7 Between GH¢70 &80……8 Between GH¢90&100……9 Above GH¢100……10		Q10AVMI
11	On average, how much is the monthly expenditure of the household?	Less than GH¢10……1 Between GH¢10 & 20……2 Between GH¢20 &30…….3 Between GH¢30 &40…….4 Between GH¢ 40 & 50……..5 Between GH¢50 &60……6 Between GH¢60 &70……7 Between GH¢70 &80……8 Between GH¢90&100……9 Above GH¢100……10		Q11EXP
12	How much do you spend, per month, on average on each of the following:	Less than GH¢10……1 Between GH¢10 & 20……2 Between GH¢20 &30…….3		Q12MEXPHLT

	Health?	Between GH¢30 &40…….4 Between GH¢ 40 & 50……..5 Between GH¢50 &60……6 Between GH¢60 &70……7 Between GH¢70 &80……8 Between GH¢90&100……9 Above GH¢100……10	
13	Clothing (including shoes)?	Less than GH¢10……1 Between GH¢10 & 20……2 Between GH¢20 &30…….3 Between GH¢30 &40…….4 Between GH¢ 40 & 50……..5 Between GH¢50 &60……6 Between GH¢60 &70……7 Between GH¢70 &80……8 Between GH¢90&100……9 Above GH¢100……10	Q13 MEXPCL
14	Education?	Less than GH¢10……1 Between GH¢10 & 20……2 Between GH¢20 &30…….3 Between GH¢30 &40…….4 Between GH¢ 40 & 50……..5 Between GH¢50 &60……6 Between GH¢60 &70……7 Between GH¢70 &80……8 Between GH¢90&100……9 Above GH¢100……10	Q14MEXPEDU

15	Food?	Less than GH¢10……1 Between GH¢10 & 20……2 Between GH¢20 &30…….3 Between GH¢30 &40…….4 Between GH¢ 40 & 50……..5 Between GH¢50 &60……6 Between GH¢60 &70……7 Between GH¢70 &80……8 Between GH¢90&100……9 Above GH¢100……10	Q15MEXPFO
16	How many meals does this household usually serve in a day?	1……1 2……2 3……3 Other (specify)……..4	Q16MEALPD
17	How many meals were served in the last two days?	1……1 2……2 3……3 Other (specify)……..4	Q17MEALTD
18	Are there days when the household goes without food?	Yes……1 No……..2	Q18NDWFOOD ➔**SKIPQ19**
19	If Yes, how many times in the last 30 days did the household	8	Q19NTWFOOD

	go without food?	Times…….1 5 Times…….. 2 3 Times…….3 Twice……. ….4 Once……. ..5 Other (specify)……...6	
20	Does this household receive remittances from elsewhere?	Yes…… …1 No…… ..2	Q20REMITTANCES ➔**SKIPQ21**
21	If yes, how much do you receive in a month?	Less than GH¢10……1 Between GH¢10 & 20……2 Between GH¢20 &30…….3 Between GH¢30 &40…….4 Between GH¢ 40 & 50……..5 Between GH¢50 &60……6 Between GH¢60 &70……7 Between GH¢70 &80……8 Between GH¢90&100……9 Above GH¢100……10	Q22MONREM
SECTION 4 HEALTH INSURANCE AND HEALTH INFORMATION			
22	Is your household head enrolled in the MHI scheme?	Yes……1 No…….2	Q22HMHI ➔**SKIPQ23**

23	If yes, why	Mandatory (formal worker...1 Easy health access ….……..2 Exempted (poor)……..3 Exempted (> 60 yrs)…….4 Exempted (0–17 years).....5 Others Please specify……..6 Na……...88	Q23YSHMH
24	If No, why have you not enrolled in the MHI	Poor quality of care……...1 No facility close by……...2 No trust in the system……...3 Too Expensive……..4 Not Affordable…….5 Na……...88	Q24NOHMH
25	How many members of your household are enrolled in the KNDMHIS?	☐☐	Q25HHMHI
26	How much do you pay for enrolling all the members in the scheme?	☐☐	Q26AMTEN
27	How would you describe the health status of this household?	Very poor……1 Poor……2 Average……..3 Good……..4 Very good……..5	Q27HEALTH

SECTION 5: HOUSING AND SANITATION CHARACTERISTICS			
28	How many rooms are in the house?	☐☐	Q28ROOMS

29	What is the **main** material for the wall?	Concrete…….....1 Mud…….....2 Bricks…….....3	Q29MODD
30	Type of **main** roofing material?	Zinc……...1 Concrete……2 Mud……..3 Thatch……...4 Concrete tiles……5 Other…….6	Q30WLMAT
31	What are the toilet facilities in your household?	Free range……1 Pit latrine……..2 KVIP……3 Pan latrine……4 WC.....……5 Others……...6	Q31TOLET
32	How do you dispose of refuse in this household?	Open refuse dump……..1 Bury……...2 Incinerator……3 Other (specify)……....…...4	Q32REFUSE
33	What is the **main** source of drinking water does your household have?	Pipe borne water……...1 Borehole…….……..2 Stream…….....3 Well……..…….....4 Other…….5	Q33WATER
SECTION 6: ASSETS AND OTHER POSSESSIONS			
34	Does this household own land?	1. Yes……1	Q34LAND ➔

		2. No……2	**SKIPQ35**
35	If yes, how many acres of land do you own?	1–3……1 3–5……2 5–7……3 7 and above……4	Q35ACRESL
36	Does this household own a bullock plough?	1. Yes……1 2. No……2	Q36PLOUGH
37	Does this household own a donkey cart?	1. Yes……1 2. No……2	Q37DCART
38	How many functioning bicycles do members in your household own?	None……1 One……2 Two……3 Three……4 More than three……5	Q38BIKE
39	How many functioning motor bikes do members in your household own?	None……1 One……2 Two……3 Three……4 More than three……5	Q39MOTOR
40	How many functioning cars/vehicles do household members own?	None……1 One……2 Two……3 Three……4 More than three……5	Q40VEHIC
41	How many wooden/iron beds are in your household?	None……1 One……2 Two……3 Three……4 More than three……5	Q41BEDS

42	How many functioning radio sets are in your household?	None……1 One……...2 Two……..3 Three……4 More than three…….....5	Q42RADIO
43	How many functioning mobile phones are in your household?	None……1 One……...2 Two……..3 Three……4 More than three…….....5	Q43MOBIL
44	What is the **main** type of cooking fuel used in your household?	Gas…….....1 Electricity..……...2 Wood…….....3 Charcoal……...4 Stalks……..……..5 Other……6	Q44CFUE
45	How many cattle do you have in your household?	None……1 One……...2 Two……..3 Three……4 More than three…….....5	Q45CATLE
46	How many sheep do you have in your household?	None……1 One……...2 Two……..3 Three……4 More than three…….....5	Q46SHEEP

47	How many goats do you have in your household?	None……1 One……...2 Two……..3 Three……4 More than three…….....5	Q47GOAT
48	How many pigs do you have in your household?	None……1 One……..2 Two…….3 Three……4 More than three…….....5	Q48PIGS
49	How many donkeys do you have in your household?	None……1 One……...2 Two……..3 Three……4 More than three…….....5	Q49DONKY
SECTION 7: SOCIAL AND POLITICAL WELLBEING			
50	Does any member of this household belong to any social organisation? (Church group, women's group, farmers' group, trade union, etc.)	1. Yes……1 2. No……2	Q50SOCOR ➔**SKIPQ51**
51	If yes, state the specific Organisation.		Q51TYPOR
52	Does any member of this household belong to any credit union?	1. Yes……..1 2. No…….2	Q52CREDUN
53	Does any member of this	1. Yes……..1	Q53SUSU

	household belong to any Susu group?	2. No…….2	
54	Do members of this household participate in community meetings?	1. Yes……..1 2. No…….2	Q54COMMEET
55	Do members of this household belong/campaign for a particular political party?	1. Yes……..1 2. No…….2	Q55POLPART
56	How would you evaluate the social relations within this household?	Very low conflict…….1 Low conflict…….2 Moderate conflict……3 High conflict……4 Very high conflict……...5	Q56SOREHH

Thank you very much for your time.

Appendix III: Introductory Letter for Fieldwork

UNIVERSITY of the WESTERN CAPE

FACULTY OF ECONOMIC AND MANAGEMENT SCIENCES

SCHOOL OF GOVERNMENT

TO WHOM IT MAY CONCERN **24 JANUARY 2013**

LETTER OF INTRODUCTION: KENNEDY A ALATINGA

This letter confirms that Mr Kennedy A Alatinga is a *bona fide* Doctoral Student in the School of Government, University of the Western Cape and that he is conducting research in Ghana for his PhD thesis on **IDENTIFYING THE POOR IN THE INFORMAL SECTOR FOR SUSTAINABLE STATE SUPPORT: THE CASE OF INDIGENTS COVERAGE IN THE HEALTH INSURANCE POLICY OF GHANA.**

Based on Mr Kennedy's academic progress and research requirements, I hereby wish to kindly request the appropriate authorities in Ghana to grant Mr Kennedy access to all the requisite areas and sources of information that would enable him to complete his research for his PhD thesis successfully.

Should you require any additional information with regard to Mr Kennedy's academic endeavours, kindly do not hesitate to contact me, please.

Your kind assistance would be duly appreciated and acknowledged with regard to Mr Kennedy's research.

Faithfully yours

Prof John J Williams, Ph D, MUP (Illinois, USA); MA (UCT Supervised); HED,BAHONS,BA(UWC)
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Appendix IV: Copy of Consent Form

25 January 2013

Consent Form

My name is Kennedy Alatinga. I am a PhD student in the School of Government, University of the Western Cape, South Africa. I am conducting research on the National Health Insurance Scheme (NHIS) and access to health care in the Kassena-Nankana District. The purpose of this research study is to develop a model for identifying very poor households or individuals for health insurance premium exemptions. The information that will be gathered from this study will be for academic purposes only.

I will very much appreciate it if you agree to participate in the study. Your participation in this study is voluntary. If you do agree to participate in the study, the information you provide will be treated very confidentially and your identity will also be kept anonymous. Nowhere in the data collection, processing, or writing stages will your name be mentioned. If you also do wish to withdraw from the study at any time, you are at liberty to do so.

Please, do not hesitate to raise any concerns about this study now or after the interview. I can be reached on phone on: 0205649944 or by email at: kalatinga@gmail.com.

Thank you very much for you time.

Appendix V: Major Characteristics of the 52 Very Poor Households

		Times without food (3x)		**Assets and Possessions**						**Household Size**	**Gender**
Households	Zone	yes	No	Bicycle	Goat	Sheep	Pigs	Donkey	Cattle		
1	South	yes		0	1	0	0	0	0	2	M
2	South	yes		0	1	0	0	0	0	6	M
3	South	yes		1	1	1	0	0	0	8	M
4	South	yes		1	0	0	0	0	0	6	M
5	South	yes		0	0	0	0	0	0	5	M
6	South	yes		1	1	0	1	0	0	4	M
7	Central	yes		1	1	0	0	0	0	8	M
8	North	yes		1	0	0	0	0	0	3	M
9	South	yes		1	1	0	0	0	0	7	M
10	North	yes		1	1	1	1	1	1	6	M

11	Central	yes	1	1	1	0	0	0	5	M
12	North	yes	1	1	1	1	1	0	3	M
13	South	yes	1	1	1	1	1	1	6	M
14	South	yes	1	1	0	0	0	0	6	M
15	North	yes	1	1	1	0	1	0	11	M
16	North	yes	1	1	1	1	1	1	2	M
17	North	yes	1	1	1	1	0	1	5	M
18	North	yes	1	1	1	0	0	1	5	M
19	North	yes	1	0	0	0	0	1	4	M
20	Central	yes	1	1	1	0	1	1	4	M
21	South	yes	1	1	1	0	0	1	10	M
22	South	yes	1	1	0	0	0	1	6	M
23	South	yes	1	1	1	0	0	0	4	M
24	North	yes	1	1	0	0	1	1	2	M
25	North	yes	1	1	0	0	1	0	6	M

26	South	yes	1	1	0	0	0	0	8	M
27	North	yes	1	1	1	1	0	1	5	M
28	South	yes	1	1	1	1	1	1	8	M
29	North	yes	1	1	1	0	0	1	4	M
30	South	yes	1	1	0	0	0	0	7	M
31	South	yes	1	1	1	1	0	0	4	M
32	South	yes	0	1	1	1	0	1	8	M
33	South	yes	0	1	1	1	1	1	5	M
34	Central	yes	1	1	0	1	0	0	5	M
35	South	yes	0	1	1	0	0	1	7	M
36	South	yes	1	1	0	0	0	1	4	M
37	South	yes	1	1	1	0	1	1	5	M
38	Central	yes	1	1	1	1	1	1	6	M
39	South	yes	1	1	1	1	1	0	4	M
40	South	yes	1	1	1	1	0	0	3	M

41	South	yes	1	1	1	1	1	1	6	M
42	Central	yes	0	0	1	0	0	0	2	M
43	South	yes	1	1	0	0	0	0	7	M
44	North	yes	1	1	0	0	1	1	4	M
45	Central	yes	0	1	1	1	0	1	9	M
46	South	yes	1	1	0	0	1	1	4	M
47	Central	yes	1	1	1	0	1	0	6	M
48	North	yes	1	1	1	1	0	0	4	M
49	South	yes	1	1	0	0	0	0	6	M
50	South	yes	0	1	0	0	0	0	3	M
51	South	yes	1	1	1	0	0	0	1	M
52	South	yes	1	1	1	0	0	0	9	M