Mutual Aid in the Payment of Medical Fees

Acceptance of the National Health Insurance Scheme in Southern Ghana

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1. Introduction

In 2004, the National Health Insurance Scheme (NHIS) was introduced in Ghana, and the scheme has since become widely used. The people concerned can now select a new way of paying medical fees. This paper discusses how this new payment method is related to mutual aid.

1-1 Insurance and Mutual Aid in Sociology

While there has been increasing interest in risk and insurance in the social sciences, studies concerning insurance in sociology and anthropology remain rare [see Baker and Simon 2002]. The sociology of insurance thus primarily builds on the contributions of two exceptional thinkers, Viviana Zelizer and Francois Ewald. They identify several key features of insurance related to mutual aid. First, insurance could undermine face-to-face mutual aid. Second, insurance as individualistic preparation (for an accident, death, illness, etc.) tends to replace face-to-face mutual aid. Finally, insurance can be seen as a system of anonymous mutual aid [Zelizer 1979: 91-117; Ewald 1991, 2002; Dean 1999; Lupton 1999].

Do these features of insurance apply to the NHIS in Ghana? Before examining this question, we should examine the practice of medical fee payment in Sub-Saharan Africa.

1-2 Payment of Medical Fees in Sub-Saharan Africa

In Sub-Saharan Africa, paying medial fees is a comparatively recent practice, as its development began in the 1980s. The inadequacy of the free medical service provided by the states or the states' inability to offer it, created the need

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for people to pay medical fees by themselves [e.g., van der Geest 1982; Turshen 1999]. In this situation, however, people did not necessarily pay medical fees individually, but could also use various types of face-to-face mutual aid such as kinship-based or patron-client based mutual aid [Whyte 1992, 1997].

Ghana provides a good example of this development. In the colonial era, medicine was first limited to the colonizers in the Gold Coast. In the 1920s, the colonial government started to offer medical service for the colonized as well, but the availability of medical service was very low until the 1960s [Addae 1996]. In the period following independence, from the 1950s to the 1970s, medical service was free of charge in Ghana. However, due to an economic crisis and the introduction of structural adjustment policies, the Ghanaian government decided to start charging for medical service in 1985 [Adams 2002].

While there has been little discussion about the relationship between the payment of medical fees and mutual aid, the medical burden has been one of the most important stimuli of face-to-face mutual aid in Southern Ghana, a point that will be discussed later. Since insurance would seem to replace this mutual aid with individualistic preparation, the introduction of the NHIS raises several important questions surrounding this paradox.

1-3 Key Questions

In line with the above-mentioned changes from face-to-face mutual aid to individually secured insurance, we can propose the following hypothesis about health insurance in Ghana: the introduction of the NHIS in Ghana has undermined face-to-face mutual aid for medical fees and evocated self-responsibility for paying medical fees. However, two problems should prevent an acceptance of this type of rationalistic speculation.

First, we should not think of all insurance as either totally individual preparation or anonymous mutual aid. There is some gradation in the strength of insurance's function as individualistic preparation and anonymous mutual aid among different types of insurance. For example, "risk-subdivided" automobile insurance is more individualistic preparation than anonymous mutual aid, while social insurance is more redistributive or anonymous mutual aid than individualistic preparation [Baker 2002; Stone 2002; Omoda 2003].

Second, even if the insurance policy is the same, people could perceive it differently. There is an historical and social diversity of perception regarding insurance [Zelizer 1979; Baker 2002]. Therefore, we have to examine people's perceptions of insurance to discuss the impact of Ghana's NHIS on mutual aid practices.

Through such an examination of people's experiences of taking out insurance, this paper illustrates that the NHIS is not undermining face-to-face mutual aid, but is producing a new domain for this aid in southern Ghana.

1-4 Setting

This study focuses on the Kwaebibirem district Mutual Health Insurance Scheme (KbMHIS) and town "A" in the western part of the Eastern Region, where I conducted fieldwork for twenty months from 2005 to 2010. Approximately 2000 people over the age of eighteen live in town "A," and cacao, oranges, palm, timber and bauxite are its main products. Kwaebibirem district is basically "Akyem land" and most of resident of town "A" are Akyem, though Asante, Fanti, Ewe, and Krobo are also there. As in other areas of southern Ghana, the Christian religion is dominant. In Kwaebibirem district, about 62 percent of the population is registered with the KbMHIS.[2]

2. Features of the NHIS in Ghana

In this section, the details of the policy and its premiums are examined through a discussion of how extending the NHIS in Ghana could be viewed as either individualistic preparation or anonymous mutual aid.

[2] Data provided by the KbMHIS. As will be discussed below, it is important to note that not all those registered necessarily buy insurance every year.

2-1 The NHIS in Ghana as Double Anonymous Mutual Aid

The Ghanaian government first planned the NHIS to enable a correction of the disparities in access to medical service. Three points were emphasized in the health insurance policy proposal: (1) health insurance would "minimize or remove the financial barrier to accessing health care," (2) the design of the health insurance would take into account the principles of equity, cross-subsidization, etc., and (3) all residents of Ghana should be encouraged to participate in the health insurance scheme [GOG 2002].

We should pay special attention to the above "cross-subsidization," which means that premiums differ according to the economic conditions of the insured, not according to risk. This means that the NHIS is not purely a technology of risk equalization or the law of large numbers. From this perspective, we could view the NHIS as a type of redistribution, that is to say, anonymous mutual aid. In fact, the NHIS has from its beginning exempted people over the age of 70 and under 18.

However, this anonymous mutual aid is not simply a nation-wide program like social insurance in France [see Ewald 1991, 2002]. First, not everyone contributes to the NHIS. Thus, it is only the insured that support the medical expenses of the exempted. Second, the administrative agency of the NHIS is district-based and premiums differ between districts. So, redistribution is not nation-wide, but district-wide.

At the same time, the NHIS is funded by the National Health Insurance Fund (NHIF) through taxation, making it a classic redistribution system. In this sense, the NHIS is also a system of nation-wide anonymous mutual aid.

From the above analysis, we can see a perspective-conditional quality of the NHIS as anonymous mutual aid: when we focus on premiums, it is not nation-wide anonymous mutual aid, but when we focus on the NHIF, it is. Thus, we can think of the NHIS as a combination of two types of mutual aid, or a system of double anonymous mutual aid.

2-2 The Prevalence of the KbMHIS and Reasonable Premiums

The number insured through the KbMHIS steadily increased from 2004 to 2007 (see Chart 1). There are several reasons for this success in increasing the number of insured. First of all, NHIS premiums are considered affordable and a good value for the money. Those registered in the KbMHIS can use three hospitals, four health centers and two clinics free of charge. The premiums for the KbMHIS were 10 Ghana Cedi (approximately US$11) in 2004 and gradually increased up to 15 Ghana Cedi (US$12) in 2008.[3] As discussed above, the NHIF funds the NHIS, which enables the NHIS to reduce its premiums.

Chart 1: Number insured by the KbMHIS (2004-2007)[4]

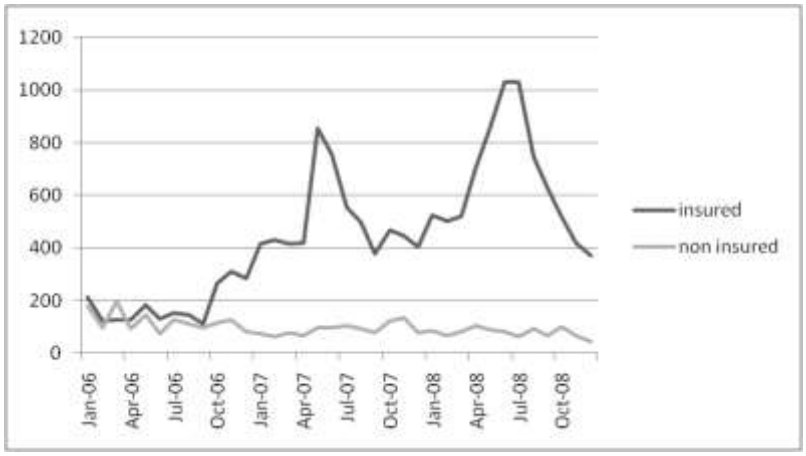
Date	Registrants	Percentage of total population registered[5]
2004.12	2,867	1.5%
2005.12	41,712	22.0%
2006.12	95,976	50.7%
2007.12	117,213	61.9%

This means that the NHIS is both a system of redistribution *and* of individualistic preparation. Ordinarily, redistribution and individualistic preparation are in opposition to each other and cannot coexist. But in this situation, the fact that taxes (one key factor of redistribution) are used to subsidize the NHIS acts as an attractive feature for people considering buying insurance, as they assume that it must offer additional value for their money. This situation,

[3] We should pay attention to the fact that when people buy pharmaceuticals at chemists, the price is substantially lower [Hamada 2008]. Thus, medical services provided by health centers and hospitals are of relatively high cost.
[4] Data from the KbMHIS.
[5] Based on the 2004 population of Kb district, 189,457.

in which the NHIS is subsidized by taxes and in which not all people buy insurance, enables a coexistence of redistribution and individualistic preparation.

Additionally, the most remarkable change with the introduction of the NHIS is the rapid growth of the number of patients seeking medical care. While I cannot discuss this point in detail here, we should interpret this as a positive effect of the NHIS in Ghana.



Graph 1: Number of patients of "A" health center

3. Ways of Taking out Insurance

In this section, methods of taking out insurance in southern Ghana are discussed. This has not been a significant topic in previous studies of insurance in sociology and anthropology. However, as discussed here, this topic is important for the examination of the relationship between insurance and mutual aid.

3-1 Methods of Saving Money

The most popular answer to the question of why people have not gotten insurance is, "I don't have money." So, the most important barrier to getting a policy is typically money. 10 or 15 Ghana Cedi may not be prohibitory prices, but people still have to save money if they want to buy insurance.

In Twi, the *lingua franca* of town "A", the noun *susu* is a blanket term for the practice of saving money. There are three types of *susu* in southern Ghana.

ROSCAs (Rotating Savings and Credit Associations) are the first type of *susu*. An organizer of each *susu* gathers members based on kinship, friendship or church-based ties. He goes around the town and collects money, and then he sends it to one of the members each week. When each member has received money once, the *susu* finishes. Members of the *susu* can then continue for one more cycle or stop participating in the *susu*. The amount of money transacted is decided through negotiation among the participants. The virtue of this type of *susu* is that the early receivers can access a large pool of money without collateral and later receivers can save money [Boatei-Doke and Aryeetey 1995; Nomoto 2005].

Secondly, there is collector *susu*, which was the most popular in town "A" until a few years ago. This type of *susu* is commercialized and focuses on the saving aspect of *susu*. *Susu* collectors visit customers daily and collect a set amount of money. It is the customers who freely determine this amount. When they have paid thirty-one times, customers receive the money equivalent to thirty payments and collectors keep the rest as their fee. If customers want to, they can receive the money they have lodged with the collectors before the thirty-first payment. In that case also,

however, customers have to pay a fee equivalent to one deposit. So the advantages of collector *susu* are its liquidity and convenience, as customers can save money without communicating with or making promises to family or friends.

Finally, bank *susu* is another option. It is virtually the same as collector *susu* and has been widely used in town "A" from 2006. Like in collector *susu*, bankers also visit customers every weekday and gather a certain amount of money. But, unlike collector *susu*, bank *susu* offers interest without fees; the rate is about 0.1% per year.

People said that the main merit of *susu* is that they can keep money out of their hands. If they have money at hand, friends will ask for it; this is something of a "custom" of southern Ghana. Thus, if people want to save money, they have to deposit it where it is out of their immediate access.

3-2 School Fees over Health Insurance

In light of the practice's popularity, we should turn to why people prefer to use *susu* and save money. Aside from merchants' use of *susu* to ensure their ability to make big purchases, people often identify school fees as their main object of consumption and hence their reason for using *susu*.

In Ghana, public primary and junior secondary schools have been free of charge since 2007. Nonetheless, parents still have to buy the required textbooks, notebooks, uniforms, etc. The total cost of the first year of public elementary school has risen to 20 Ghana Cedi. People typically say that if they could afford the school fees, they would send their children for more schooling: to senior high school, training college, polytechnic school, and university. Even the rationale for family planning is often said to be the avoidance of additional school fees in order to concentrate more money on each child.

In this situation, people give priority to school fees, not health insurance. It often occurs that during the period that a child is attending senior high school, all family members stop renewing their insurance. Additionally, there are many families that postpone getting insurance until paying off all school fees. This is related to the fact that while they should ideally pay school fees at the start of each new term, most parents cannot pay at once and use installment plans. This means that many families that rear children (that is, almost all families) take out insurance intermittently.

3-3 Atomizing the Burden of Medical Costs

Monetary gifts are not rare among the Akyem people. People give money to *abusua* (matrilineal clan) members or friends as gifts for funerals, marriages, graduation parties, etc. Even if it is not a special occasion, such as when one encounters friends outside, one should invite them to lunch or for roadside refreshment.

Sickness is another of the most popular occasions for giving money. If someone is ill for a long time, fellow church members conduct a collective gift practice called *kyere odo* (teaching love). Additionally, in the case of an emergency, in order to bring the patient to the health center as soon as possible, those present give money to a family member for transportation and medical fees without request. Faced with the directly observable suffering associated with severe pain or a high fever, the normative power of face-to-face mutual aid exerts its maximum effect.

In contrast, it is not often that people depend on face-to-face mutual aid to get insurance. The key difference is that they have to pay the premium *before* becoming sick because it takes about two months to obtain insurance coverage from the first premium payment. This duration might function as a strategy of avoiding the "adverse select." When one is not sick, one perceives little or no risk of contracting an infection or suffering an injury. So, unlike in the case of the medical burden of the uninsured, people ordinarily pay insurance premiums to save money in a well-planned manner. As described above, the NHIS in Ghana thus undermines face-to-face mutual aid and fosters a calculated management of one's medical burden.

3-4 Face-to-Face Mutual Aid as a Way of Talking

As discussed above (see sections 2-2 and 3-3), we could view the NHIS as individualistic preparation. At least, it seems that we can argue that the NHIS is not face-to-face mutual aid. An insured man in his twenties exemplified this

when he explained that his reason for getting insurance was the avoidance of the danger of high medical fees. According to him, if he became severely sick and required an operation, he would need 200 Ghana Cedi, which is much higher than the 15 Ghana Cedi insurance premium. However, this type of explanation is rare. Most people do not think that insurance is individualistic.

As is generally observed, there is a gambling aspect to insurance. If you do not become sick, your premium is simply lost. When I asked about this, one woman in her thirties replied, "Even if I do not become sick, my mother may become sick. In that situation, my money would help cover her medical burden. So, this is not a problem."

We should note the way she explained this. She did not say that it is not a problem because the money would be spent for the care of an "anonymous other" but for her mother. In fact, most insured people used the same idiom of face-to-face mutual aid.

The difference between the two ways of talking about insurance becomes clearer when regarding attitudes about policy renewal. For a person taking out insurance as individualistic preparation, intermittent renewal is a big problem because people do not become sick only when they are insured. In contrast, if a person buys insurance as face-to-face mutual aid, the drawbacks of intermittent renewal are softer; premiums are not only for oneself, but are like "gifts" for an intimate other.

3-5 A New Mode of Face-to-Face Mutual Aid

At the same time, the importance of face-to-face mutual aid is not only to be found in perceptions of the NHIS, but also is preserved in a new way. To clarify this point, we have to examine how policies are obtained for children.

In Ghana's NHIS, children under the age of 18 can get insurance for 2 Ghana Cedi, rather than the 10 or 15 Ghana Cedi for an adult policy. However, they cannot become insured on their own. They need to get insurance along with one "household head." This situation leads to important questions Who is the "household head" for the child? How can we decide whether this child is a member of household "A" or not?

In Twi, *abusua* means both "extended family" and "clan." However, there are no terms equivalent to "household," meaning people sharing a house and budget. Despite this, there is no definition of "household" provided by the NHIS. When asked about the definition of "household," officers of KbMHIS provided four propositions about "households":

(1) The members of a "household" share a house and budget, basically among parents and their children.
(2) Regardless of whether they are biological children or not, children receiving room and board from the guardian are viewed as the members of a "household."
(3) If their places of sleeping and eating are not the same, children can be viewed as the members of both "households."
(4) When a "household head" pays the premium for the child, the child can get insurance with this person.

From these propositions, we might abstract three types of "household heads":

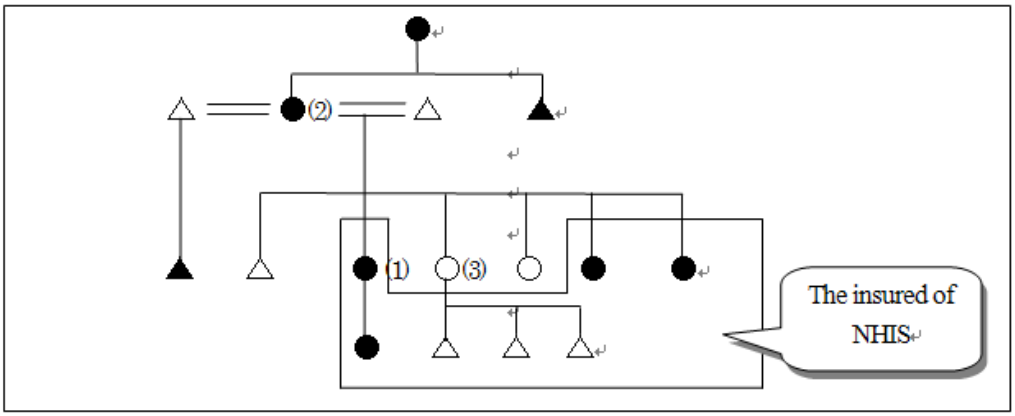
(a) the head of a group comprised of parents and children
(b) the head of group that shares a house *or* food
(c) the person who pays the premium for a child

Among these three types of "household heads," all officers point out type (a) first, while type (c) reflects actual conditions.

There is ambiguity in "household head". Firstly, in this situation, where there are no clear definitions of "household," everyone imagined a meaning easily and plural definitions coexist. Secondly, someone can belong to two

"households" at the same time. Finally, depending on the perspective one takes, or on which individual one focuses, the bounds of "households" differ.

Moreover, the issue is complicated by rearing practices. In the area concerned, it is common for more than two parents to rear children collectively on a conjoint basis and for children to come and go in the home of family members.



Graph 2: the members of the Akosua family and their insured

Graph 2 is the kinship relation of Akosua (1). Akosua is the "household head" of six children. The people indicated by black symbols share the house, while those indicated by white sleep in another house. Akosua got a policy with her biological child, two sisters of under the age of 18, and the three children of another younger sister.

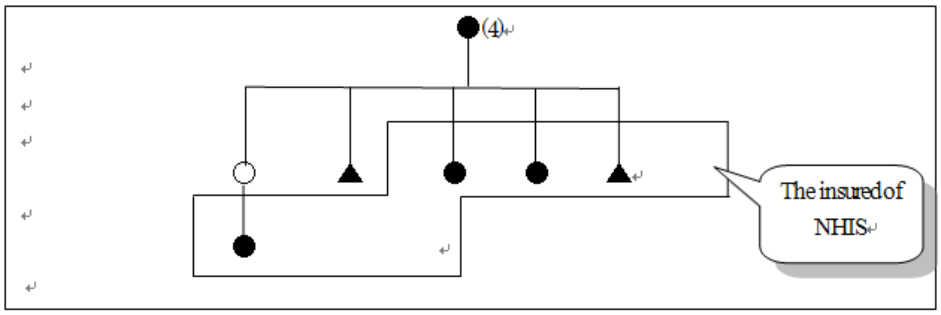
If we apply the generally used definition of "household" of sharing both house *and* burden, the children of Abena (3) are members of another household because they don't share the house with Akosua. And because the burden of Akosua (1) and Adyowa (2) is not completely shared, Akosua (1) and her two sisters are not exactly members of the same household.

On the other hand, if we apply the definition of "household" abstracted from the KbMHIS officers' explanation, the relationship between Akosua and the children is not problematic. Akosua and her sisters share the house, and the three children of Abena also eat with Akosua. So, Akosua and the six children insured are members of the same "household" in the sense of sharing a house *or* burden.

However, we should pay attention to the fact that Akosua is not a "household head" regarding the obligation for paying the premium. The money for buying the Akosua family policy is shared by three women: Akosua, Adyowa and Abena. In this case, like a man paying the premium for only his wife and children and not himself for economic reasons, Adyowa and Abena share the burden with Akosua, but they do not get insurance themselves.

As in the Akosua family, people generally want to get insurance for as many of their children as possible. It is the same when people cannot pay the premium as a "household head." In that case, the parent asks friends or kin to become the "household head" of his or her children.

Graph 3 exemplifies this case. Ama (4) is a woman in her fifties with 10 children, and she has been divorced for five years. She lives with four children and one granddaughter now. While three of these children and the granddaughter are insured, their "household heads" differ: the stepfather of the granddaughter, the pastor of the church to which Ama belongs, a teacher who has kinship ties to Ama, and a neighbor with no other connection to Ama have each gotten insurance with one of the children as his or her "household head."



Graph 3: the members of the Ama family and their insured

To understand this situation, we have to recognize that it is not rare for the guardians of children to change intermittently. In Ama's case, when she was fighting a tuberculosis infection, different "household heads" took the children and reared them on a temporary basis. After six months of medication, Ama gradually regained her vitality and took her children back home again. But Ama cannot afford the premiums for herself and her children. Instead, she has asked each "household head" to not change the register and to send money for the children's premiums.

But the situation of the Ama family is not suitable for KbMHIS. The children do not now share the house and burden of their "household heads." These "household heads" neither are the birth parents nor are they paying the premiums for the children. However, as one can easily imagine, there is great difficulty in deciding the relations between the "household heads" and children here. We could speculate that the officers in charge did not overlook the Ama case as an exception simply because each "household head" registered discretely. Rather, this is the inevitable result of the situation arising from the undefined term "household" and the rearing practices in the area concerned.

In this way, people invent methods of getting insurance for their children. But these strategies require some conditions too. Some may not know about this route to insurance or may not discover alternative "household heads" for their children. Therefore, the provision of insurance for children is not only related to the economic situation and saving practices of the parents, but also to the possibility of their receiving face-to-face mutual aid through a manipulation of the boundaries of "households."

We may then conclude that this strategy of getting insurance for children is a type of resistance against neo-liberalism or pressures toward atomization. But we must also emphasize that this emergent method as a new mode of face-to-face mutual aid is the result of the contingent arrangement of the detailed regulations of the NHIS for children, the flexible translations of "household," and rearing practices in southern Ghana.

4. Conclusion

In this paper, I examined some features of Ghana's NHIS as related to mutual aid. To do so, I articulated three features of the NHIS in Ghana. First, it functions strongly as anonymous mutual aid. Second, in some ways, it has led to the atomization of people in bearing their medical burden. Yet finally, it has also helped create a new mode of face-to-face mutual aid.

Compared with the rationalistic speculation aspect of insurance that previous studies have focused on, the final point is important. Due to that type of speculation, the NHIS in Ghana could be anonymous mutual aid and atomize the medical burden, and also undermine face-to-face mutual aid. But, as discussed in this paper, the NHIS in Ghana does not necessarily break down that aid. Instead, we could say it that changes the form of the aid, rather than eliminate it. This distinction raises important questions for studies in and theories of the anthropology and sociology of insurance.

When Ghana introduced the NHIS in 2004, it thus not only afforded new options for the payment of medical fees and improved access of medical service, but also has created opportunities to look anew at insurance payment in terms of local idioms and to question theories about insurance's impact on mutual aid.

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