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JUSTICE, HUMAN DIGNITY AND THE CAPABILITIES APPROACH:
A MORAL ASSESSMENT ON GHANA'S HEALTH CARE DELIVERY SYSTEM

A Thesis

Submitted to the McAnulty College and Graduate School of Liberal Arts

Duquesne University

In partial fulfillment of the requirements
for the degree of Master of Arts

By

Paul Eliud Esibu

May 2021

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JUSTICE, HUMAN DIGNITY AND THE CAPABILITIES APPROACH:
A MORAL ASSESSMENT ON GHANA'S HEALTH CARE DELIVERY SYSTEM

By

Paul Eliud Esibu

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ABSTRACT

JUSTICE, HUMAN DIGNITY AND THE CAPABILITIES APPROACH: A MORAL ASSESSMENT ON GHANA'S HEALTH CARE DELIVERY SYSTEM

By

Paul Eliud Esibu

May 2021

Thesis supervised by James Patrick Bailey, Ph.D.

Life and quality healthcare delivery are central parts of the well-being of the human person. However, despite the political and socio-economic the successes that Ghana has chalked in pre-colonial, colonial and contemporary times, the quality of healthcare delivery in Ghana could be described as sub-standard. In this a context, the Capabilities Approach, “The Theology of the Body” and the Akan indigenous understanding of the human person emerge as an integrated formidable tool to enhancing life and quality healthcare as central part of the human person. This is because “The capabilities approach – in both its comparative and it’s normative version – brings moral philosophy into development economics, asks questions about ethical norms and standards of justice by asking people to consider what makes for a minimally just society.” According to the capabilities approach, a minimally just society, for example, would be a society in which each individual has the freedom and the ability to choose from the available opportunities of equitable

and accessible quality healthcare delivery in order “to be” and “to do”, that is, the capability to function in a society.

This thesis reinforces the relevance of the above questions by demonstrating the extent to which Ghana can be described as a minimally just society based on the evaluation of the direct bearing that these questions have on the quality of healthcare delivery in Ghana.

These questions of quality healthcare delivery are drawn from the perspectives and roles played by the patients, health workers and government and private institutions who are recognised as the three main players in the giving and receiving of health in Ghana. Such assessments will help expose the weaknesses of the Ghanaian health system in order to suggest theological implications and solutions that aim at making quality, accessible and equitable healthcare delivery a priority for all Ghanaians.

DEDICATION

To the greater glory of God and to Rev. Frs. Daniel Aboagye Adjei, James B. Farnan and Louis F. Vallone. It was by your selfless interactions and subsequent acceptance that made me a resident priest in St. James Parish-Sewickley. This acceptance made my schooling in Duquesne University possible.

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I express my profoundest appreciation to Dr. James Patrick Bailey who supervised this thesis. You went the extra mile to use this supervisory work to guide me into deeper understanding of theology in contemporary times. I appreciate your renowned human virtues of patience, gentleness, sacrifice and dedication that came to bear in our encounters towards the completion of this thesis. I respectfully acknowledge and thank you, Rev. Fr. Peter Ikechukwu Osuji, C.S. Sp Ph. D. for being the second reader of this thesis.

I am ever grateful to Most Rev. John Bonaventure Kwofie, C.S. Sp, Catholic Archbishop of Accra. The success of this project is largely attributed to your prayerful and material support as well as wise counselling.

I am most grateful to the Catholic Diocese of Sekondi-Takoradi. The completion of this thesis is an attestation of the immense human and material resources that you harness towards the growth of the Catholic church. I am happy that you gave me the opportunity and the challenge to give my personal contribution to your hall of fame.

Dear Rev. Fr. Emmanuel Abbey-Quaye, your academic and editorial in-puts into this thesis was a colossus.

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I duly acknowledge all families and friends. I make special reference to my family- the Amoroku and Esibu family of Ghana and to my dearests: Michael Donkor, Joana Blankson and Veronica Amo Ansah. All thanks to the parishioners of St. James Parish, Sewickley, for your countless support. I acknowledge the indefatigable Maribeth Rushe-Rolandi and family, Linda Boord and family, Dan and Ruth-Darragh, Dr. John Moracca and Mr. and Mrs. Beth and Matthew Carol, your various contributions have made this MA in theology program a success. God richly bless you all you all.

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LIST OF ABBREVIATIONS

<i>CA</i>	Capabilities Approach
<i>CHC</i>	Central Human Capabilities
<i>CH</i>	Capability to be Healthy
<i>TOB</i>	Theology of the Body
<i>CMS</i>	Central Medical Stores
<i>CHPS</i>	Community-Based Health Planning and Services
<i>NHIS</i>	National Health Insurance Scheme
<i>NHIA</i>	National Health Insurance Authority
<i>CHAG</i>	The Christian Health Association of Ghana
<i>WHO</i>	World Health Organization
<i>MOH</i>	Ministry of Health
<i>HWs</i>	Health Workers

General Introduction

Background and Purpose

In relation to human dignity, this thesis seeks to establish that Ghanaians must have access to quality, and affordable healthcare. This must be done as a matter of justice and must be a priority because the human person is a sacrament. This can be the context of the Ghanaians' 'capability to be healthy' (CH).¹ The CH is the theory advanced by capability theorists including Sridhar Venkatapuram who explains that access to quality health care is a 'meta-capability.'² Thus, availability of quality health care determines how one functions in all other areas of society and vice versa.

The vulnerability of all mortals is here highlighted as unpredictable, yet needing urgent response as demonstrated in *The Parable of The Good Samaritan* (cf. Lk. 10: 29 – 37). In this parable, compassion is the bridge between mere seeing and action; love is made real through effective action.³ This work seeks to deepen the understanding of 'action' as delivery of just and quality health care in Ghana. This action of delivery is drawn from the perspectives and roles of three main players in the giving and receiving of health in Ghana. These players are the patients, the health workers (HWs), the government and private institutions.⁴

The thesis delves into the perspectives of the patients, the health workers and institutions like government, religious and other bodies play with regard to how quality and just delivery of healthcare is made accessible and functional in Ghana.

¹ Sridhar Venkatapuram, *Health Justice* (Cambridge: Polity Press, 2011), 143-145.

² *Ibid.*, 20 – 23.

³ Economic Justice for All: Pastoral Letter on Catholic Social Teaching and the U.S. Economy 1986 by United States Catholic Bishops 1986.11. para 43.

⁴ Private health providers include individuals and groups such as religious bodies who have been licensed to either partner government or provide health care with their sole financing.

This thesis draws insight from the works of Anita Ago Asare on *Tema Port Clinic*, Nketiah-Amponsah on *National Health Insurance Scheme (NHIS)* and Peter Anabila's work on *The Perception of Patients on the Quality of health delivery in Ghana*. This work agrees with the basic assumption that the results gathered from their works are not significantly different from the situations that the patients encounter in different parts of Ghana, a point this paper affirms in the search towards completing this work.

This important role that quality care health delivery plays in human life and in the Ghanaian context is captured in the Millennium Development Goals (MDGs)⁵ where access to quality health is deemed as a basic right and justice. According to the MDGs, "Universal access to good quality care and optimal patient safety is the goal of health systems and governments all over the world. Even though developed countries have made significant achievements towards attainment of this goal, many developing countries in Africa lag behind due to financial, material and human resource constraints."⁶ "Ghana is one of the sub-Saharan African countries making significant progress towards universal access to quality healthcare. However, it remains a challenge to attain the 2015 targets for the health-related Millennium Development Goals (MDGs)."⁷

In spite of the substantial role that quality health plays in human well-being, quality healthcare delivery in Ghana can be described as underdeveloped. According to Deaton, the reasoning that is most often given to explain the weaknesses in the delivery of quality healthcare in middle-income and Sub-Saharan countries like Ghana is either lack of/or inadequate resources⁸.

⁵ World Bank, "Introduction to the Millennium Development Goals," <https://www.adb.org/sites/default/files/publication/27727/mdg-introduction.pdf> accessed on 02/13/2021.

⁶ Ibid., accessed on 02/13/2021.

⁷ Robert Alhassan, K., Nicole Spieker, Van Ostenberg, P., Alice Ogink, Edward Nketia-Amponsah and Tobias F. Rinke de Wit, "Association between health worker motivation and healthcare quality efforts in Ghana," *Human Resource Health* 11, no. 37 (8/14/2013): 1-2, <https://doi.org/10.1186/1478-4491-11-37> accessed on 02/13/2021.

⁸ Angus Deaton, "Income, health, and well-being around the world: Evidence from the Gallup

However, this thesis agrees with Amartya Sen that lack of availability or inadequate resources cannot be used as convincing grounds to provide or deny access to quality healthcare delivery⁹. Quality health is sacred and intrinsic. It is ‘pre-political’¹⁰ and therefore its thriving should be independent of any negative human or natural influences.

Based on the above argument, this thesis argues that the Ghanaian health system would benefit from adopting and effectively implementing the capability to be healthy theory (CH) proposed by Venkatapuram. Venkatapuram’s CH expands Sen’s assertion of health as a substantial individual freedom¹¹ on one hand and Martha Nussbaum’s use of the ten list of central human capabilities (CHC) to express the dignity of human being on the other.¹² In religious terms, the capabilities approach affirms the dignity of the person as a unique individual and sees the human being as a sacrament holding out the promise that treating human beings as such will become commonplace.¹³

The path that this thesis takes in combining theological ethics with ideas from capabilities theorists is consistent with Bailey’s idea of non-neutrality¹⁴ in pursuing the common good. According to Bailey, “theological ethics must be attuned to developments in the human sciences and other disciplines of human learning and remain open to the insights that these disciplines bring

World Poll,” *The journal of economic perspectives* 22, no.2 (Spring 2008), 53-72.

⁹ Amartya Sen, *Development as Freedom* (New York: Random House Inc, 1999), 21-24.

¹⁰ Sridhar Venkatapuram, *Health Justice* (Cambridge: Polity Press, 2011), 147.

¹¹ Amartya Sen, *Development as Freedom* (New York: Random House Inc, 1999), 18-19.

¹² Martha Nussbaum, *Creating Capabilities; The Human Development Approach* (Harvard: Harvard University Press, 2011), 33-34. The Ten CHC are: 1. Life, 2. Bodily Health, 3. Bodily Integrity, 4. Senses, Imagination and Thought, 5. Emotions, 6. Practical Reason, 7. Affiliation, 8. Other Species, 9. Play, 10. Control of One’s Environment.

¹³ Christopher West, *Theology of the Body Explained: A Commentary on John Paul II’s Man and Woman He Created Them* (Boston: Pauline Books and Media, 2007), 279.

¹⁴ James Patrick Bailey, *Rethinking Poverty: Income, Assets and the Catholic Social Justice Tradition* (Notre Dame, Indiana: University of Notre Dame Press, 2010), 59, 62.

to moral endeavors.”¹⁵ Bailey continues that “the mere fact that an idea originates from within the social sciences does not mean it is any more neutral (or less value-laden) than ideas originating from the religious traditions.”¹⁶ The usefulness of the CA and CH approaches is born out of its features as being in line with post-modern scholarly engagements which integrate several approaches in order to reach a conclusion. The flexibility of the CA, as developed both by Sen’s indeterminate list of capabilities and Nussbaum’s set of central human capabilities leave room for each particular society like Ghana to model her unique CA that responds to her healthcare needs such as the capability to be healthy as proposed by Venkatapuram. In this way, this thesis distinguishes itself by following the methodology of post-modern scholarly discourses where absolutist and universalist approach to attaining knowledge give way to an integral approach that challenges established facts on one hand and is flexible to accept a better theory that emerges on the other.

Scope of the Project

This thesis will be divided into four chapters. Chapter one gives statistics that reveal the internal and external challenges that confront patients, health workers and institutions associated with quality healthcare delivery in Ghana. The focus on the patients will consider four areas: (i) emerging issues on the implementation of the National Health Insurance Scheme (NHIS) and (ii) meeting patients’ expectations in health facilities. (iii) The chapter also treats perceived inequalities that affect health workers. (iv) Lastly, this chapter discusses institutional challenges in the training of personnel and provision of resources needed for quality health care delivery. This work is based partly on the hypothesis that, given the resources of Ghana, if health is deemed

¹⁵ Ibid., 59.

¹⁶ Ibid., 59.

a priority, then Ghana should have a more appreciable response of quality health care than the prevailing situation.

Chapter two addresses the issue of capability to be healthy in Ghana. This chapter will delve deep into the capabilities approach in general and capability to be healthy by Venkatapuram in particular. The chapter will discuss: (i) health deprivation in Ghana as poverty and death, (ii) the dignity of the human being according to Nussbaum and Venkatapuram, (iii) the capability to be healthy by Sridhar Venkatapuram will be discussed as building upon the ideas of Sen and Nussbaum and as offering a better way of answering the challenges that the health system in Ghana poses.

Chapter three will analyze the theological implications of the capability to be healthy in Ghana. The chapter will proceed as follows: (i) biblical exegesis on the capability to be healthy in Ghana, (ii) flowing from the exegesis, this section will offer suggested solutions to achieving quality health care delivery and (iii) the later part of chapter three will discuss the body as a sacrament. The thesis at this point will shift the focus from delivery of health care as spatio-temporal activity to health care delivery as a vocation. Health care will be understood as a vocation that glorifies God through respect for the dignity of the human being as sacrament.

Chapter four is summary, evaluation and conclusion of this thesis. In this chapter, the core points around which this thesis has been developed will be highlighted in the summary. The evaluation will lay bare some of the strengths and weaknesses of the CA and suggest a working paradigm that the capability to be healthy in Ghana can be modelled on. Such a model will be (i) a synthesis that will reflect the religious and the communal inclination of the Ghanaian and (ii) this proposed paradigm will argue for a combination of orthodox and indigenous means of

understanding diseases which will in turn lead to an integral process of assessing the working conditions of HWs, diagnosis and treatment of diseases. It is in the conclusion that this thesis will make its case about how all efforts at enhancing the dignity of the human person through quality healthcare delivery in Ghana ultimately leads to the affirmation of the body as a sacrament.

Chapter One

The Challenges in the State of Healthcare Delivery in Ghana

Introduction

According to Pope Francis,

sickness always has more than one face: it has the face of all the sick, but also those who feel ignored, excluded and prey to social injustices that deny their fundamental rights (cf. *Fratelli Tutti*, 22). The current pandemic has exacerbated inequalities in our healthcare systems and exposed inefficiencies in the care of the sick. Elderly, weak and vulnerable people are not always granted access to care, or in an equitable manner. This is the result of political decisions, resource management and greater or lesser commitment on the part of those holding positions of responsibility. Investing resources in the care and assistance of the sick is a priority linked to the fundamental principle that health is a primary common good. Yet, the pandemic has also highlighted the dedication and generosity of healthcare personnel, volunteers, support staff, priests, men and women religious, all of whom have helped, treated, comforted and served so many of the sick and their families with professionalism, self-giving, responsibility and love of neighbor. A silent multitude of men and women, they chose not to look the other way but to share the suffering of patients, whom they saw as neighbors and members of our one human family.¹

This statement from Pope Francis resonates with other similar assertions by institutions and individuals concerning the indispensable role that health plays in the life of individuals and a nation. The United Nations (UN) defines the right to life as the most fundamental and first of all the human rights.² All other rights spring from the ability to live a healthy life. This assertion of the UN is a re-echoing of Judeo-Christian teaching about life as the prerogative of God to give and to take. This assertion demonstrates the Judeo-Christian tradition's insistence that human beings

¹ Pope Francis' Message for the World Day of the Sick, 2020. http://www.vatican.va/content/francesco/en/messages/sick/documents/papa-francesco_20201220_giornata-malato.html accessed on 02/18/2021.

² Universal Declaration of Human Right by The United Nations General Assembly on December 10, 1948 (article 3 on right to life), <https://www.un.org/en/about-us/universal-declaration-of-human-rights> accessed on 02/15/2021.

have an affirmative responsibility to care for others as for example, in love of neighbor. Thus, health and life have both theological and legal understanding and implications.

Ronald Dworkins adds to the above theoretical basis of the importance of quality healthcare delivery in his idea of “ideal of insulation.” Dworkins explains “ideal insulation” to mean that quality healthcare delivery is indispensable for each individual and each society.³ According to him, the relevance of quality healthcare delivery and its indispensability has three features.

The first argues that healthcare as Rene Descartes put it, chief among all goods: that the most important thing is life and health and everything else is of importance beside it. The second component of the insulation ideal is equality. The ideal supposes that even in a society which is otherwise very inegalitarian- indeed even in society in which equality is despised as a general political goal- medical care should nevertheless be distributed in an egalitarian way so that no one is denied care he needs simply because of inability to pay. The third component (it really flows from the other two) is the old principle of rescue, which holds that it is intolerable when people die, though their lives could have been saved, because the necessary resources were withheld on grounds of economy.⁴

Dworkins continues that achieving healthcare delivery goals of the ideal insulation is based on twin questions of justice based on economics and distribution of resources. These questions are stated as follows. “How much of the overall budget should be devoted to health care instead of other plainly valuable projects like education and infrastructure, for example?” The second question is this: “Once it is established what a society should spend overall on health care, then it must also be decided who should have that care, and on what basis should it be allocated.”⁵ Dworkins further expands these questions into four major areas that bother on economics, administration, medicine and politics, namely (i) on economics, “what are the reliable predictors

³ Ronald Dworkin “Justice in the Distribution of Health Care,” *McGill Law Journal Revue De Droit De McGill Montreal* 38 no. 4 (1993), 885.

⁴ Ibid.

⁵ Ibid.

of how much a particular care structure or plan will cost?”, (ii) on administration, “what is the most efficient organisation for administering any particular plan?”, (iii) on medical, “what is the likely impact of a particular program on morbidity and mortality?” for example, and (iv) on politics, “what particular program will a democracy in fact be willing to accept and pay for?”⁶ For Dworkins, though the ideas on economics, administration, medical and politics may be difficult to understand, the three questions of justice, reflected in the “ideal insulation,” as posted above are not. “That it is clear what the ideal of justice demands in health care, and that our only problem is that we are unwilling to live up to that ideal.” That, Dworkins believes, is a serious mistake.⁷ The ideal insulation states that “a society should spend all it can on healthcare until the next dollar it spends will buy no gain in health or life expectancy at all.”⁸ One could imply from Dworkins’ proposals that it is the integration of all these health indicators that will make attaining quality healthcare delivery achievable in Ghana. This chapter therefore, seeks to give the theoretical and empirical basis that supports Dworkin’s proposal as based on economics, administration, medical and political influences that reflects the challenges of the state of healthcare delivery in Ghana.

In Ghana, the Ministry of Health, considers health care “as a critical sector of the economy and seeks to improve the health status of all people living in Ghana thereby contributing to government’s vision of transforming Ghana into a middle-income country by 2015.”⁹ These goals of the health sector put squarely the successful implementation of health policies and attainment of such goals on effective running of the health institution. This thesis notices that, as stated above, the government is conceptualizing health care not as a human right but as a means to end: a

⁶ Ibid.

⁷ Ibid., 886.

⁸ Ibid.

⁹ Ramatu Umanta, U., *Key Health Challenges in Ghana* (Accra: University Press, 2013),1.

growing economy. Thus, the goals of the health sector seem to be geared more towards economic well-being than the citizens well-being and functioning in society.

The goal of this thesis is to critically assess the health institution in Ghana and its internal and external factors that promote or hinder the delivery of quality, accessible and equitable health needs to citizens and inhabitants of Ghana in line with Ministry of Health's motto, "Your Health Our Concern." The focus of this thesis is also to assess the factors that enable institutions to work beyond individual altruism. The work is based on the hypothesis that, given the resources of Ghana, if health is deemed a priority, then we should have a more appreciable response of quality healthcare than the prevailing situation.

This thesis therefore proceeds from this opening chapter to give statistics that reveal the internal and external challenges that confront patients, health workers and institutions associated with quality healthcare delivery in Ghana. The focus on these three major players of patients, health workers and institutions, will consider five areas: (i) emerging issues on the implementation of the National Health Insurance Scheme (NHIS), (ii) quality of outpatient care. (iii) perceived inequalities that affect health workers (iv) institutional challenges in the training of personnel and provision of resources needed for quality health care delivery in Ghana, and (v) a brief comparative analysis between Ghana and other African countries such as Nigeria, Kenya and South Africa focusing on the Health Insurance schemes of these countries.

The Perceptions of Patients on Quality Healthcare in Ghana: An Assessment on the Emerging Issues on the Implementation of the National Health Insurance Scheme (NHIS)

The purpose of this section of this thesis is to investigate the role of service quality (SQ), customer satisfaction (CS) and customer loyalty (CL)¹⁰ in Ghana's health sector and make a cursory comparative analysis of private and public hospitals concerning SQ in seeking healthcare and particularly in assessing the implementation of the NHIS.

According to Anita Asare Ago, "Patients judge healthcare SQ based on three main parameters, namely, physical environment (tangibles and ambient conditions), interaction quality (attitude and behaviour, expertise and process quality) and outcome quality (waiting time, level of satisfaction and loyalty). These exemplify the significance of patient–doctor relationship in developing patients' trust and confidence in the service delivery chain."¹¹ "These dimensions represent how consumers organize information about SQ in their minds."¹² It could be inferred that what patients perceive and process in their minds inform their preference of one kind of hospitals, clinics and health centers over the other. Such a choice comes with appreciation of economic benefits of their host facility and the contrary will be true for facilities that receive low patronage from patients. Koichiro Otani et al posit that "Patient satisfaction provides greater competitive leverage since it affects patients' willingness to revisit a facility as well as increasing

¹⁰ Anita Asare Ago "Patients' Perceptions of the Quality of Outpatient Care at the Port Medical Center in Tema Community One." (PhD diss., University of Ghana, Legon, 2018), 18-23.
<http://ugspace.ug.edu.gh/handle/123456789/25842> accessed on 02/15/2021.

Service Quality (SQ), Customer Satisfaction (CS) and Customer Loyalty as explained by Anita Asare Ago,

¹¹ Hardeep Chahal and Neetu Chahal, "Service Quality and Performance in the Public Health-Care Centre," *Health Marketing Quarterly* 29, no. 3 (07/2012): 181-207, DOI: [10.1080/07359683.2012.704837](https://doi.org/10.1080/07359683.2012.704837) accessed on 12/14/2019.

¹² See also as conceptualized by Parasuraman et al. (1988, p. 23) the following explanations: • Tangibles: "Physical facilities, equipment and appearance of personnel". • Reliability: "Ability to perform promised service dependably and accurately". • Responsiveness: "Willingness to help customers and provide prompt service". • Assurance: "Knowledge and courtesy of employees and their ability to inspire trust and confidence". • Empathy: "Caring, individualized attention the firm provides its customers".

the level of patient compliance with medical prescriptions and with attendant positive treatment outcomes.”¹³ These attitudes and reactions from patients serve as a source of reliable information for policy formulation.¹⁴ In Ghana, one of such policy formulations that has made inroads is the NHIS.

“The Government of Ghana has, over the past one and a half decades, intensified its quest to achieve universal health coverage. Consequently, Ghana implemented a National Health Insurance Scheme (NHIS) in 2003 as the first of its kind in sub-Saharan Africa. The scheme obligates all Ghanaian citizens and residents of Ghana to subscribe to a health insurance scheme as enshrined in the NHIS Amended Act 852 (2012). This is reinforced by the fact that Ghana has experienced a marked improvement in healthcare accessibility with its concomitant improvement in population health outcomes since the introduction of the NHIS in 2003.”¹⁵ However, According to Nketiah-Amponsah, “only about 50% of the Ghanaian population are currently enrolled in the scheme due largely to poor administrative bottlenecks.” Nketiah-Amponsah avers that this problem is compounded by the limited coverage of payments. In terms of service or benefits coverage, the NHIS also does not pay for all conditions treated at NHIS-accredited health facilities, even though it covers about 95% of the disease burden of Ghana. Cancer and renal (kidney)

¹³ Koichiro Otani, Marie Faulkner, K., Sarah Boslaugh, “How Patient Reaction to Hospital Care Attributes Affect the Evaluation of Overall Quality of Care, Willingness to Recommend and Willingness to Return,” *Journal of Healthcare Management / American College of Healthcare Executives* 55, no. 1(01/2010), 34, DOI: [10.1097/00115514-201001000-00006](https://doi.org/10.1097/00115514-201001000-00006) accessed on 02/18/2021.

¹⁴ Racha Fadlallah, Fadi El-Jardali, Mohamed Nomier, et al “Using narratives to impact health policy-making: a systematic review,” *Health Research Policy Systems* 17,no. 26 (03/05/2019), 15-17, <https://doi.org/10.1186/s12961-019-0423-4> accessed on 01/29/2021.

¹⁵Edward Nketiah-Amponsah, Robert Alhassan, K., Samuel Ampaw, *et al* “Subscribers’ perception of quality of services provided by Ghana’s National Health Insurance Scheme - what are the correlates?” *BMC Health Services Research* 19, no.196 (03/28/2019), 2-3, <https://doi.org/10.1186/s12913-019-4023-3> accessed on 02/15/2021.

diseases which could plunge households into catastrophic health expenditures due to the high cost of treatment are not covered by the Scheme.”¹⁶

Although the benefits of the NHIS are acknowledged by Ghanaians, Nketiah-Amponsah enumerates some inherent challenges that militate against its effectiveness and sustainability as well as the increased patients’ ill-perception about accessing the services that the Scheme provides. For example, NHIS card bearers dread using their cards for perceived fear and actual claims of receiving sub-standard care. The 2011 Annual Report of the Ghana Health Service also give increased pressure on existing health facilities as a result of the introduction of the NHIS. By implication, the Report suggests that that there should have been a corresponding program of increase in infrastructure prior to the introduction of the NHIS. Pressure on health infrastructure relate to pressure on health workers. This preventable inconvenience within the health sector causes staff to charge unapproved fees with the view of helping the patients to access the limited resources out of the health workers ‘benevolence.’¹⁷

Another challenge that the NHIS faces is poverty. According to the Ghana Statistical Service (GSS), 78 % of the poor in Ghana live in rural areas. Also, majority of people living in extreme poverty in Ghana are found in the Northern, Upper East, Upper West and the Central Regions.¹⁸ In a paper assessing the link between poverty and access to the NHIS in two predominantly rural districts of northern Ghana, it came to light that the level of enrollment for the poor and vulnerable populations was low and some factors associated with NHIS membership,

¹⁶ Ibid., accessed on 02/15/2021.

¹⁷ Ibid., 2-3, 5 accessed on 02/15/2021.

¹⁸ Augustine Danso, A., Anthony Zwi, B., and Maria Ho, T., “Equity in Resource Allocation for Health: A Comparative Study of the Ashanti and Northern Regions of Ghana,” *Health Policy* 78. No. 23 (10/2006): 125-148, <https://doi.org/10.1016/j.healthpol.2006.03.013> accessed on 02/15/2021.

after eight years of implementation, that made access of the NHIS difficult was poverty.¹⁹ “Approximately half of the sampled population of 39,262 were registered with a valid NHIS card; 53.2% of these were through voluntary subscriptions by payment of premium whilst the remaining (46.8%) comprising children below the ages of 18 years, elderly of 70 years and above, pregnant women and formal sector workers were exempt from premium payment. Despite an exemption policy to ameliorate the poor and vulnerable households against catastrophic health care expenditures, only 0.5% of NHIS membership representing 1.2% of total exemptions granted on accounts of poverty and other social vulnerabilities was applied for the poor. Yet, cost of premium was the main barrier to NHIS registration (92.6%) and non-renewal (78.8%), with members of the lowest socio-economic status (SES) being worst affected. Children below the ages of 18 years, females, urban residents and those with higher education and SES were significantly more likely to be enrolled with the scheme.”²⁰

This evidence above supports the positive association between poverty and having a better perception of the quality of services provided by Ghana’s NHIS. The positive association between depravity or poverty (wealth status) and perceived quality of NHIS services may be partly explained by the fact that the poor live mostly in communities that lack adequate access to health facilities and health personnel. Given the limited choice of health facilities and qualified health personnel, subscribers tend to be content with the quality of NHIS services provided in such communities. The reverse is true for the relatively rich urban dwellers where both private and

¹⁹ Anthony Kwarteng, James Akazili, Paul Welaga et al., “The State of Enrollment on the National Health Insurance Scheme in Rural Ghana after Eight Years of Implementation,” *International Journal for Equity in Health* 19, no. 4 (12/31/2020), 2-3, 12 DOI<https://doi.org/10.1186/s12939-019-1113-0> accessed on 02/15/2021.

²⁰ Ibid.

public health facilities and health personnel are relatively abundant.²¹ Those defined as poor eventually had to appropriate “adaptive preferences” where they adjust to living in unfavourable conditions because of limited choices.²² For example, the Central, Upper East and Upper West regions that are described as the deprived regions of Ghana have a favorable assessment of the NHIS in Ghana as a social intervention for the poor, while endowed Regions like Ashanti and Greater Accra Regions have an unsatisfactory assessment of the quality of service by the NHIS.

The fact that about 56.30% of the population of Ghanaians are poor²³ and yet only about less than 40% of this category and the whole population is covered under the health insurance²⁴ gives a cause for concern when discussing justice. The blame could be put on the patients’ irresponsibility since the patient is the first person responsible for his or her own health. Yet, this could be interpreted as genuine lack of money to register and enroll in the NHIA or there is the trust in indigenous means of healing over orthodox medicine.

Additionally, there is a difficulty in policy formulations that established the NHIS. It is realized that the policy covers about 95% of all diseases in Ghana, thus not all diseases are covered. If argued correctly, that all people are potential victims of diseases or other discomforts, then the NHIS should be holistic. It should not be partial in covering diseases that could affect all citizens upon whose continuous existence the country defines herself.²⁵

²¹ Caroline Appiah, J., Genevieve Aryeetey, Ernst Span et al., “Equity Aspects of the National Health Insurance: who is enrolling, and who is not and why?” *Social Science and Medicine* 72, no. 2 (01/2011): 157-165.

²² Martha Nussbaum, *Creating Capabilities; The Human Development Approach* (Harvard, Harvard University Press, 2011), 54.

²³ According to Ghana Statistical Service 56.30% Ghanaians are poor as at 2016. <https://www.macrotrends.net/countries/Ghana/GHA/ghana/poverty-rate> accessed on 3/26/2021.

²⁴ Paola Salari, Patricia Akweongo, Moses Aikins, Fabrizio Tediosi, “Determinants of Health Insurance Enrolment in Ghana: Evidence from three National Households Surveys,” *Health Policy and Planning* 34, no 8 (10/8/2019): 582-583, <https://doi.org/10.1093/heapol/czz079> accessed on 3/26/2021.

²⁵ *Ibid.*, 582-584.

In the article, titled “Why are the Poor Less Covered in Ghana’s National Health Insurance A Critical Analysis of Policy and Practice,” Kontoh and Geest address the issues of weak structures and institutions that perpetuate poverty and destroys the aim of the NHIS to make every Ghanaian enroll. For example, not all Ghanaians have enrolled in the NHIS because they cannot pay the premium or they are even not aware of enrollment exemptions for the poor. Coupled with this fact is the difficulty in defining who a poor person is in Ghana since the institutions cannot agree on, and do not have the requisite citizen information to do such determinations²⁶. It shows to some extent that though the NHIS is a good policy, the majority of the population in Ghana that it targeted have not or are not benefitting because they are limited by prevailing weak or non-existing structures coupled with conditions at health facilities and hospitals that could be described as undesirable. An issue worth considering is whether the government can re-design the NHIS to cover all Ghanaians and all diseases in a state where healthcare could be described as free? The obvious answer would be in the negative. The negative answer could be based on the reason of inadequate resources and the need to address other aspects of the country’s budget like Free Compulsory Senior High Schooling Program. Another presumption could be the individual’s responsibility in contributing to their own health needs. The challenge that this thesis poses is how to draw the lines between the extent of universal health coverage and individual responsibility. For example, could there be time lines on the government’s widening of its coverage of diseases so that all citizen would stand to gain equitable access to quality healthcare delivery?

²⁶ Karima Saleh, *The Health Sector in Ghana: A Comprehensive Assessment*. (Washington, DC: World Bank): 152, Doi 10.1596/978-0-8213-9599-8 License: Creative Commons Attribution CC BY 3.0.

Patients' Expectations and Perceptions of the Quality of Outpatient Care

Several factors influence patients' approval or disapproval of particular health facilities. These factors have been classified as *Information, Empathy, Assurance, Reliability and Tangibility*. These qualities that are used to measure patients' expectations of quality healthcare are exemplified in Ago's study of Tema Port Clinic titled "Patients' Perception of the Quality of Outpatient Care at the Port Medical Centre in Tema Community One."

In this study, Ago observes that the priority of patients who visit this clinic is for their information need to be satisfied. Patients seek to know the "treatment and medications to be explained to them. Explanation of diagnosis, ability to express themselves, explanations of test performed, and procedures" that follow from attaining such information.²⁷ We could imply that in healthcare delivery, the right to receive and process authentic information could either be life-saving or could put a patient in harm's way. Information therefore becomes the basis of how both the health worker and the patient react to each other in giving and receiving care, respectively.

The next in prominence in patients' expectation was *Empathy*. Empathy was built from the trust that patients had in their caregivers judging from how the latter had helped them with the quality of information. Such process will help the patient know whether they have been well understood or else misunderstood. In the interaction between patients and caregivers, trust or mistrust in one or more occasions is created. This can have a rippling effect by way of either

²⁷ Anita Asare, A., "Patients' Perceptions of the Quality of Outpatient Care at the Port Medical Center in Tema Community One" (PhD diss., University of Ghana, Legon, 2018), 8, 18-23.
<http://ugspace.ug.edu.gh/handle/123456789/25842>. accessed on 12/15/2019

building trust or developing mistrust that transcends a patient and caregiver to the whole administration of a health facility.²⁸

Assurance came next in the order of expectation. Talking about *Assurance* as patient expectation, one is drawn to focus on “issues involving security, knowledge and skill of staff, staff attitudes and so on.” The attitude that healthcare workers exhibit can form the basis of patients’ revisit or abandoning visit to a facility. Assurance could refer to the level of attention that patients receive as cold, mediocre or excellent which reflect in the patients healing process. According to Ago,

It has been argued that doctors and healthcare personnel working in the private sector tend to have a better attitude toward patients as compared to doctors working in governmental owned health facilities. This may be due to the lower staff to patient ratios in private hospitals which renders them relatively less overworked than healthcare staff in government hospitals. Most of the attendees of Ghana’s hospital’s OPDs may have this assertion from their previous experiences and that may be why this is relatively one of their highest expectations of service quality.²⁹

Ago’s work put *Reliability* as fourth highest in expectation of quality of care (QOC). In explaining reliability, patients’ look out for professionalism and competence on the part of healthcare workers. Such expectations could be implied from a popular Ghanaian phrase, ‘*even when I went to the hospital, the doctor didn’t feel me.*’ The Ghanaian understanding of ‘the doctor to feel’ is the doctor’s physical examination with the hands to check the bodily temperature, for example, and to check the dilation of the eyes. To most or all Ghanaian patients, that will mean acceptance, receptivity, humane and professionalism towards the patient. These initial checks by the doctor tend to give emotional and psychological relief and openness between the doctor and

²⁸ Ibid., accessed on 02/15/2021.

²⁹ Ibid., accessed on 02/15/2021.

the patient in the procedures of consultation that follows. Herein is built information and empathy as complimenting the quality of assurance in quality healthcare delivery. Contrary to expectation of the Ghanaian patient that the doctor does a thorough examination and prognosis of reported ailment, most doctors proceed to write prescriptions for parent after hearing the symptoms that the patient is able to describe about his or her condition. Whereas the doctor's reaction could be based on past experience of the symptoms described and hence greater certainty of giving the right prescription plus the unfavourable doctor – patient ratio which warrants speedy consultation, it is a puzzle to understand how most of these same doctors exhibit much professionalism in private health facilities.

This observation is confirmed by Ago's work when she writes, "in responsiveness, the greatest expectation was for the staff to be quick to attend to patients' needs followed immediately by a reasonably low waiting time with prompt delivery of service." "This may be due to the fact that the mean waiting time in general has been found to be 2.1 minutes: 3.58 minutes in private compared to public hospitals, almost twice difference in Ghana; and the lack of use of the National Health Insurance in our study population as opposed to its use in the public health facilities may influence this and hence, the patients' expectations."³⁰ Effective responsiveness can thus imply speed accompanying the giving of appropriate and accurate remedy at each point of the healing process.

"Tangibility came last in the patients' expectations with a mean percentage score of 84.2%".³¹ "It was more important to the outpatients for the hospital environment to be clean than for it to have modern equipment. This is in keeping with a study done in the northern part of Ghana

³⁰ Ibid., Assessed on 02/16/2021.

³¹ Ibid., accessed on 02/14/2021.

where the cleanliness of the hospital environment was found to be one of the strongest influences of the patients' satisfaction with service quality."³²

It could be surmised that the judgement of patients on the delivery of quality health is largely impacted by the socio-demographic characteristic of patients. Socio-demographic is deemed to be situational and relational for the most part, depending on one's status in life or a particular health related encounter that shapes ones' opinion. These instances are judged to be giving pointers on how perception grows and changes. Thus, one cannot generalize a patients' perception. Such self-evaluation of the quality of healthcare services suffers from bias especially when subscribers are empathized with or treated in a more professional manner or better still receive services from familiar providers.³³

With relative satisfaction of patients who patronize private health facilities, this thesis draws implication from Maia Sieverding, Cynthia Onyango and Lauren Suchman that the country should consider integrating the views of health providers in both the governmental and the private facilities.³⁴ Since "this has the potential to reveal a complex nexus between the two categories of health providers in that most of the private hospitals in Ghana rely to some degree, on health personnel from the public hospitals to fill in gaps and staffing needs especially in areas where specialty services are required. This suggests some level of convergence which should conceivably provide a little room for differences in service quality (SQ)."³⁵ We could imply from Nussbaum's

³² Ibid., accessed on 02/14/2021.

³³ Ibid., accessed on 02/14/ 2021.

³⁴ Maia Sieverding, Cynthia Onyango and Lauren Suchman "Private Healthcare Provider Experiences with Social Health Insurance Schemes: Findings from A Qualitative Study in Ghana and Kenya," *Plos One* 13, no. 2 (02/22/2018): 19, <https://doi.org/10.1371/journal.pone.0192973> accessed on 02/16/2021.

³⁵ A Parsu Parasuraman, Valerie Zeithaml A., Leonard Berry, L. "SERVQUAL: A Multiple Item Scale for Measuring Consumer Perception of Service Quality," in *The Retailing Reader*, ed. John Dawson, Anne Findley and Leigh Sparks (Milton Park, Abingdon: Routledge, 2008), 11-14. <https://www.researchgate.net/publication/225083802> accessed on 02/16/2021.

CA as deepening the truth of this assertion when she points out that the provision of incentives, both in the private and the public sectors facilitate quality health delivery. This is could be achieved through the anticipated reciprocity of sharing of idea and human and material resources that complement both sectors' efforts at reaching the threshold of quality health delivery.³⁶ One could imply from Nussbaum's above assertion that when health workers are motivated and effective and transparent information is shared between the public and the private sectors, quality healthcare delivery could be achieved. "The overriding consensus is that SQ is a multidimensional higher-order construct."³⁷ This thesis attests to this assertion as this claim is also reinforced by the hypotheses that service quality (SQ) significantly affects customer satisfaction (CS) and customer loyalty (CL) in the healthcare industry in Ghana."³⁸

Perspectives of Health Workers on the state of Healthcare Delivery in Ghana

The health workers perspectives are assessed on the enabling environment that facilitates their work as primary agents in ensuring the right to life. This thesis considers the factors of internal and external clients, motivation, procedural justice, distributive justice, interactional justice, interpersonal justice, and the God factor as considerations that measure workers output despite challenging or unfavourable circumstances. One could agree with Cropanzano and theorize that "a frontline health worker's judgement of fairness in policy and organizational processes elicits

³⁶ Martha Nussbaum, *Women and Human Development; The Capabilities Approach* (Cambridge: Cambridge University Press, 2000), 75.

³⁷ A Parsu Parasuraman, Valerie Zeithaml A., Leonard Berry, L., "SERVQUAL: A Multiple Item Scale for Measuring Consumer Perception of Service Quality," *Journal of Retailing* 64, no. 1 (01/1988): 15-17.
https://www.researchgate.net/publication/225083802_y

³⁸ Peter Anabila. Desmond Kumi, K., and Janet Anome, "Patients' Perception of Healthcare Quality in Ghana: A Review of Public and Private Hospitals," *International Journal of Health Care Quality Assurance* 32 no. 1 (2019): 177-180, <https://doi.org/10.1108/IJHCQA-10-2017-0200> accessed on 02/17/2021.

reactions that influence motivation and responses towards work, which in turn affects the worker's desire to perform tasks that contribute to the achievement of organizational goals." This makes organizational justice an appropriate concept for exploring processes that shape health worker motivation and response to clients' needs in a hospital context.³⁹ In this sense, where workers perceive fairness, they are more inclined to be motivated and repay the organization with positive attitudes, including trust and positive response to organizational and client's needs. Justice in the health sector begins with the internal client which refer to the health workers and external clients which refer to the patients.⁴⁰ Kojo Arhinful relates,

a comparison that some health workers make in comparing the health sector in Ghana with other companies like Electricity Company of Ghana (ECG) who pay the health bills of their employees while the Ghanaian health worker's health bill is not paid for by the Health Ministry. The workers therefore question, 'your health our concern, but our health whose concern'? The interaction suggests that health workers perceive that the values they are being asked to uphold for their clients are not the values they feel are being held for them as people in the health system by their employers. The workers perceive that their neglect by management as internal clients is due to a perceived interactional injustice, that health workers mismanage resources and steal health materials to sell them to private health facilities. How could this be true with the code of ethics that punishes such perceived behaviors? For the health workers, this is only a conjecture to downplay the important role that the health ministry should play by being responsible for the health needs of health workers.⁴¹

³⁹ Russell Cropanzano, Cynthia Prehar, A., Peter Chen, Y., "Using Social Exchange Theory to Distinguish Procedural from Interactional Justice: Group and Organization Management," 324–351. As quoted by Matilda Aberese-Ako, Han van Dijk, Trudie Gerrits, Daniel Kojo Arhinful and Irene Akua Agyepong, in "Your Health Our Concern, Our Health Whose Concern?: Perceptions of Injustice in Organizational Relationships and Processes and Frontline Health Worker Motivation in Ghana," in *Health Policy and Planning* 29, no.2 (11/09/2014): 18-19 https://www.researchgate.net/profile/Russell_Cropanzano accessed on 1 02/16/2021.

⁴⁰Irene Agyapong, A., Patricia Anafi, Evelyn Ansah, K., Daniel Ashon, A., Christiana Narh-Dometey, "Health Worker (Internal Customer) Satisfaction and Motivation in the Public Sector in Ghana," *The International Journal of Health Planning and Management* 19, no. 4 (12/07/2004): 332-334, <https://doi.org/10.1002/hpm.770> accessed on 02/16/2021.

⁴¹ Matilda Aberese-Ako, Han Dijk V., Trudie Gerrits, Daniel Arhinful, K., and Irene Agyepong, A., "Your Health Our Concern, Our Health Whose Concern?: Perceptions of Injustice in Organizational Relationships and Processes and Frontline Health Worker Motivation in Ghana," *Health Policy and Planning* 29, no.2 (11/09/2014): 18-19 accessed on 02/17/2021.

Such internal agitations confirm Ntim's point that 'The moment there is a perception of unfairness-that others are having more than their due, (or health workers not being given their due)- these de facto precipitates agitation.'⁴²

These dissatisfactions are heightened in a perceived procedural and distributive injustices within the Health Ministry. Matilda Aberese-Ako reports thus,

Health workers in Ghana complain about distributive injustices in the supply of incentives, transport allowances, poor conditions of service and lack of conducive work environment. This thesis suggests that resources to work with and the quality of hospital infrastructure are significant determining factors of health workers' motivation and retention in district hospitals in Ghana. Other studies equally suggest that health workers' inability to pursue their vocation due to lack of means and supplies is a demotivator.⁴³

The workers also complain about procedural injustice relating to delays of medical supplies. These delays make the health workers improvise on some occasions to supply the health needs of external clients. There are occasions where the materials that management provide are substandard and sometimes some of the drug supply from the Central Medical Stores (CMS) are expired or fake. These issues demotivate the workers in performance.⁴⁴ Also, related to this finding but in a contrary direction, procedural justice has been found to lead to increased job satisfaction, organizational commitment and organizational citizenship behaviour.⁴⁵ Thus, workers' perception of injustice was observed to have contributed to a lack of commitment and anti-citizenship

⁴² Ibid., accessed on 02/16/2021.bracketed mine.

⁴³ Matilda Aberese-Ako, Han Dijk V., Trudie Gerrits, Daniel Arhinful, K., and Irene Agyepong, A., "Your Health Our Concern, Our Health Whose Concern? : Perceptions of Injustice in Organizational Relationships and Processes and Frontline Health Worker Motivation in Ghana" *Health Policy and Planning* 29, no. 2 (9/11/2014):23 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4202923/> accessed on 02/17/2021.

⁴⁴ Ibid., accessed on 02/17/2021.

⁴⁵ Mary Konovsky, A., "Understanding Procedural Justice and its Impact on Business Organizations" *Journal of Management* 26, no. 3 (06/01/2000): 489-491, <https://doi.org/10.1177/014920630002600306> accessed on 02/16/2021.

behaviour that was counterproductive to the achievement of organizational goals.⁴⁶

There is also a perceived distributive injustice related to wider health sector issues at the national level. “When compared with other countries of similar income and health spending, Ghana does not fare too badly in its overall health worker (HW) ratios. Nonetheless, although access to HWs has improved, the distribution is skewed in favour of urban instead of rural areas, and hospitals instead of clinics. As a result, access is uneven. Recruitment of HWs, especially physicians, remains a challenge, although the present situation represents a reversal of an earlier emigration trend. Training of physicians is low relative to the country’s needs, and a shortage of midwives also exists.”⁴⁷ Whereas “Teaching Hospitals in Ghana had about seventy doctors attending to maternity cases, there are less than ten in maternity departments in several other facilities. These inconsistencies in distribution of health workers also point to other factors of low performance of health workers, quality of care, HWs’ competencies and productivity which are rated as low, as a result of these factors. These low performance of HWs in turn deter patient access. Many HWs are not performing up to standard, particularly in rural areas, among the poor, and especially in the Northern Region.”⁴⁸ The low performance could thus be described as multi-faceted. Despite these disparities, the workers of these less endowed facilities are not given additional incentives to compliment the hard work they do in comparison to those in well-endowed facilities.”⁴⁹

⁴⁶ Ibid., 503-504.

⁴⁷ Karima Saleh, *The Health Sector in Ghana: A Comprehensive Assessment* (Washington, DC: World Bank, 2013), 60-61, Doi 10.1596/978-0-8213-9599-8 License: Creative Commons Attribution CC BY 3.0 accessed on 2/14/2021.

⁴⁸ Ibid.

⁴⁹ Matilda Aberese-Ako, Han Dijk V., Trudie Gerrits, Daniel Arhinful, K., and Irene Agyepong, A., “Your Health Our Concern, Our Health Whose Concern?: Perceptions of Injustice in Organizational Relationships and Processes and Frontline Health Worker Motivation in Ghana,” <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4202923/> accessed on 02/17/2021.

The complaints of health workers about inequalities extend beyond their immediate management team to district, regional and national levels. Healthcare workers are of the view that whereas politicians formulate and execute health policies for political expediency, such policies do not normally come with corresponding policies that make room for health workers' incentives and conducive environment of service. For example, "Whereas governments, for political reasons, increase access to health facilities through policies like the National Health Insurance, there are no corresponding policies of training and distribution of personnel as well as acquisition and distribution of standard and advanced health equipment and infrastructure to respond to the growing health needs."⁵⁰ Karima Saleh affirms this when he writes, "While the growth in health facilities is remarkable; however, the scale-up of these facilities has not necessarily always kept up with population growth, nor have they responded to regional needs."⁵¹

Folger suggests that when employees perceive that their organization cares about them as human beings, they are more likely to trust the organization, exhibit greater loyalty and commitment to work and the contrary is true.⁵² Perceived interactional injustice is pointed to healthcare workers allegation against management of health facilities as the latter being insensitive to workers' safety and by extension that of the patients. Perceived interactional injustice contributes to feelings of bitterness, sorrow, and anger, which affects some workers' self-confidence, interest, and desire to perform their duties. Consequently, some workers do not take

⁵⁰ Matilda Aberese-Ako, Han Dijk V., Trudie Gerrits, Daniel Arhinful, K., and Irene Agyepong, A., "Your Health Our Concern, Our Health Whose Concern?: Perceptions of Injustice in Organizational Relationships and Processes and Frontline Health Worker Motivation in Ghana", *Health Policy and Planning* 29, no.2 (11/09/2014): 19-23, accessed on 02/17/2021.

⁵¹ Karima Saleh, *The Health Sector in Ghana: A Comprehensive Assessment* (Washington, DC: World Bank), 6, 43 - 70, Doi 10.1596/978-0-8213-9599-8 License: Creative Commons Attribution CC BY 3.0.

⁵² Robert Folger, G. and Russell Cropanzano *Organisational Justice and Human Resource Management*, (Thousand Oaks London: Sage Publications, 1998), 108.

initiatives to facilitate health service provision to clients while sometimes counterproductive behaviours are also noted within the working environment. Workers' perception of being treated with disrespect and in an insensitive manner contributes to poor organizational climate, lack of job satisfaction and the desire to leave the facility.⁵³

It can be inferred that when health system managers treat workers fairly, respecting their rights, empowering them, and creating conducive work environment, workers become motivated and exhibit positive attitudes towards work. It is also observed from the above analysis that the motivation of Ghanaian health workers is built more on intrinsic and God factor motivations than the nonexistent or ill managed extrinsic factors. Most frontline workers perceive injustice at hospital management and policy levels, which they suggested affect their motivation. However, interestingly some of these workers demonstrate a high sense of motivation and responded positively to clients' needs despite these challenges. The sources of workers' intrinsic motivation include perceiving clients as human beings with rights and the desire to maintain standards and accountability to God for ones' action. Some HWs reckon that successful client recovery would earn them blessings from God for responding positively to clients' needs. These workers conceive of their work as a vocation rather than as a profession. The influence of intrinsic motivation on worker performance is consistent with Lin's finding that workers' attitudes and intentions to perform tasks are strongly associated with their intrinsic motivation.⁵⁴

⁵³ Richard Steers, M., Richard Mowday, T., Debra Shapiro, L., "Introduction to Special Topic Forum: The Future of Work Motivation Theory," *Academy of Management Review* 29, no. 3, (7/2004): 379–387, <https://www.jstor.org/stable/20159049> accessed on 02/14/2021.

⁵⁴ Irum Shahzadi, Ayesha Javed, Syed Shahzaib P., Shagufta Nasreen, Farida Khanam, "Impact of Employee Motivation on Employee Performance," *European Journal of Business and Management* 6, no.23 (2014): 161, <http://www.iiste.org> accessed on 02/16/2021.

A Brief Comparative Analysis of Ghana's NHIS With The Health Insurance Schemes of Nigeria, Kenya and South Africa

This brief comparative analysis is made to evaluate the strengths and weaknesses of Ghana's health system in relation to Nigeria, Kenya and South Africa. The selection of these comparators is both random and purposive, considering the fact that these countries have a stronger economy than Ghana. The comparison is made to reveal how Ghana is faring in quality healthcare delivery and point to indicators that could be used to transform the weaknesses and build upon the strengths of the current healthcare policies and practices aimed at quality healthcare delivery in Ghana. Consideration is given to the National Health Insurance Scheme as the subject of analysis out of other health indicators because this thesis sees health insurance as one of the major key components and a starting point to accessing affordable and equitable quality healthcare delivery. Besides, the Insurance schemes are the policies designed to address the needs primarily of the less privileged and the poor in society whose wellbeing is a matter of justice.

A Comparison of Health Systems: The Case of Ghana and Nigeria

Isaac AO Odeyemi and John Nixon make a comparative assessment of Ghana and Nigeria's health system. In their study, they pointed out that both Ghana and Nigeria have made significant strides since independence to move from Out of Pocket (OOP), otherwise known as "cash and carry" systems respectively. It was a shift from monetised based health system (OOP and "cash and carry") to a universal coverage system. The universal coverage of health delivery regulates and encourages greater enrolment of people who would otherwise be prevented from access to quality healthcare because of lack of money. These paradigm shifts were to enhance

efficient access to healthcare under the universal coverage where all citizens would have the right to equitable, accessible, quality and affordable health care delivery. However, the achievements between the two countries over the years reveal remarkable differences in their progress assessment. For example, as at the time of Odeyemi and Nixon's work, OOP was 65% in Nigeria while it was 45% in Ghana. Also, both Ghana and Nigeria have a private health insurance (PHI) at 1%. Donor Funding (DF) was 14% for Ghana and 4.9% for Nigeria. Ghana has met the 15% of the Abuja Summit Resolution of 2001 which entreated all African countries to spend 15% of their budget on health but Nigeria's budget for health was 3.2%, that is, yet to meet the Abuja Summit recommendation. In Ghana, 70% of funding of the NHIS is funded by tax but Federal funding of health in Nigeria could be said not to be reliable at least, with no clear range of appreciable percentage as mandated by law. According to Odeyemi and Nixon, "Partly because of the phased implementation of the NHIS in Nigeria, enrolment appears to be rather sluggish. As in 2011, there were only 5.3 million Nigerians out of the 158.4 million, representing about 3.5% of the total population. Nay, the principal participants were those in the Formal Sector Health Insurance Programme (FSHIP) element, including 600, 000 pregnant women and children under the Maternal and Child Health Project (MCH). However, about 55% of the population in Ghana have enrolled in the NHIS unlike the 3.5% enrolment in Nigeria. "In Ghana, the benefits package is the same for all members which gives Ghana a clear advantage in equity regarding access and provision."⁵⁵

⁵⁵ Isaac Odeyemi, A.O., John Nixon, "Assessing equity in health care through the national health insurance schemes of Nigeria and Ghana: a review-based comparative analysis," *International Journal for Equity in Health* 12 no. 9 (2013): 10-14, <http://www.equityhealthj.com/content/> accessed on 3/2/2021.

Despite these marked progress of Ghana over their comparators, the Nigerians, Odeyemi and Nixon observe that the Ghanaian enrolment is pro-rich and pro-urban and there is a “squeezing out” of non-members from access to health care.⁵⁶ This could be related to the link the government makes between health care and economic growth where health is used as a means to an end and not as a right. Thus, it can be said that the NHIS has not reached out to most or all the poor in Ghana for whom the NHIS was designed to benefit most. Nearly 40% of the approximately twenty-seven million Ghanaians are enrolled in the NHIS. The NHIS has not reached out to enrol half of Ghanaians since its introduction.⁵⁷ Additionally, the work of Odeyemi and Nixon reveals that “holders of the NHIS experience poor customer care as in long delays for treatment and being made to pay extra unofficial user charges.”⁵⁸ We could assume that the poor customer treatment could be the manifest function of a latent reason which is the delay in payment of premiums by the central government to NHIS private providers. Thus, in order to bear the status of NHIS providers, facilities would devise unapproved means to hold themselves as recognised members while the patients become the victims of these unprofessional conducts by the staff and management of health facilities both in Nigeria and in Ghana.

A Comparison of Health Systems: The Case of Ghana and Kenya

The National Hospital Insurance Fund in Kenya contrasts with the NHIS in Ghana in that it is not a broad-based social health insurance scheme The NHIF was

⁵⁶ Ibid., 14.

⁵⁷ Daniel Ankrah J., Hallas Odei, J., Francis Asenso-Boadi, Lydia Dsane-Selby, Macarius Donneyong “A Review of the Ghana National Health Insurance Scheme Claims Database: possibilities and Limits for Drug Utilization research,” *Basic Clinical and Pharmacology and Toxicology* 124 no. 1 (January 2019): 19, <https://doi.org/10.1111/bcpt.13136> accessed on 3/10/2021.

⁵⁸ Isaac Odeyemi, A.O., John Nixon, “Assessing equity in health care through the national health insurance schemes of Nigeria and Ghana: a review-based comparative analysis” *International Journal for Equity in Health*, 12 no. 9 (2013): 12-14, <http://www.equityhealthj.com/content/> accessed on 3/2/2021.

established in 1966 as mandatory health insurance covering inpatient services for formal sector employees and civil servants. In 1972, voluntary membership in NHIF was opened to the informal sector, or anyone who is not a formal sector employee. Informal sector enrollees pay a flat-rate monthly contribution to cover a nuclear family, but as of 2005 only about half a million people were estimated to be covered through this mechanism. As of 2011, an estimated 20 percent of Kenya's population was covered by the NHIF.

Although various efforts have been made since the early 2000s to transform the NHIF into an SHI scheme for Kenya, these have thus far been unsuccessful. At the same time, NHIF has been introducing changes designed to increase membership and expand the benefits package. Starting in 2004, the previously limited benefits package was expanded to include the majority of inpatient care. NHIF also recently rolled out an outpatient scheme that covers preventative and curative services, including medicines and chronic illness management. NHIF members can access inpatient services at government facilities, as well as private for- or non-profit facilities that are accredited by NHIF. The creation of the outpatient scheme has for the first time opened NHIF accreditation possibilities for facilities that do not offer inpatient services. The provider payment system is also different for the two schemes. For inpatient services, facilities are reimbursed by NHIF after services have been provided and receive a flat daily fee that depends on the facility's accreditation level, which is tied to the range of services offered. The outpatient scheme functions on a capitation basis, in which facilities are paid a flat monthly fee for each NHIF user that has selected the facility as their primary healthcare facility. The NHIF has been less well studied than the NHIS in Ghana, and as noted above, to the best of our knowledge no previous studies have examined providers' perspectives on or experiences with the NHIF. This is a critical gap in the knowledge base as Kenya moves to expand NHIF coverage both in terms of population and services offered.⁵⁹

One could infer that though the NHIF has been less studied in the opinion of Sieverding, Onyango and Suchman, it is also evident that the Kenyan practice or experience challenges that of Ghana in effective integration of private sector and public sector coordination in delivery of healthcare. Thus, in Ghana one ought to envisage an increase in the current 55% enrollment⁶⁰ with

⁵⁹ Maia Sieverding, Cynthia Onyango and Lauren Suchman, "Private Health Care Provider Experiences with Social Health Insurance Schemes: Findings from a Qualitative Study in Ghana and Kenya," *Plos One*, 13 no. 2 (2/22/2018) : 4, <https://doi.org/10.1371/journal.pone.0192973> accessed on 3/3/2021.

⁶⁰ Daniel Ankrah J., Hallas Odei, J., Francis Asenso-Boadi, Lydia Dsane-Selby, Macarius Donneyong "A Review of the Ghana National Health Insurance Scheme Claims Database: possibilities and Limits for Drug Utilization

a corresponding increase in quality care both in the public and private health facilities. Whereas Ghana is ahead of Kenya in enrollment of the NHIS, the Kenyan experience challenges Ghana to look into policy formulation and execution that will give a better and effective response to private-public coordination in healthcare delivery.

A Comparison of Health Systems: The Case of Ghana and South Africa

Shan Naidoo describes the South African Health Care System of moving towards one-tier healthcare delivery as revolutionary. This move replaces the two-tier health care delivery through the public and private sector participation. The propounders of the one-tier system see the current two-tier system of health delivery as not effective to deal with the “quadruple burden of disease made up of HIV/AIDS and TB, maternal and childhood diseases, non-communicable diseases and violence and injury.”⁶¹ According to Naidoo, equity in this system would address directly and forcefully the issues of race and discrimination which South Africa happened to deal with during the apartheid era and still deals with in post-apartheid era.⁶² According to Shan Naidoo, the new move towards one-tier system is based on the Brazilian module of greater emphasis on primary health care as a means of quality healthcare delivery.

One could surmise that the one-tier system could be a development that aims at addressing health issues at the grassroot level. The fact that the policy proposes school health services to be delivered by specialized doctors and nurses to school going children makes the proposal unique

research,” *Basic Clinical and Pharmacology and Toxicology* 124 no. 1 (January 2019): 19, <https://doi.org/10.1111/bcpt.13136> accessed on 3/10/2021.

⁶¹ Shan Naidoo, “The South African National Health Insurance: A Revolution in Health Care Delivery,” *Journal of Public Health* 34, no. 1 (2012):149, doi:10.1093/pubmed/fds008 accessed on 3/3/2021.

⁶²Ibid., accessed on 3/3/2021.

by integrating school health into the larger umbrella of one-tier national health scheme.⁶³ The one-tier system does not rule out private sector participation completely, but seems to suggest a greater responsibility on the central government and hence a greater control by the government in addressing the health needs of South Africans.⁶⁴

We could draw some distinctions between the NHIS of Ghana and the nascent one-tier system of South Africa. Ghana's NHIS seems to focus more on enrollment of all Ghanaians as a means to meeting the health needs of especially the poor and the least privileged in Ghana. However, we could say that the extent to which the NHIS of Ghana addresses social or cultural needs is lower in comparison to the one-tier system of South Africa. The South African one-tier health system addresses the social issue of race and discrimination. Thus, the South African one-tier module appears to be more holistic in addressing societal and formative concerns such as race and discrimination and violence as sicknesses in South Africa and this, I agree that it is quite revealing. Thus, the one-tier system promises to be a broad-based enterprise. Searching for similar policy that will address social and cultural issues such as "Trokosi"⁶⁵ and "Kayaye"⁶⁶ in situations

⁶³ Ibid., 150, accessed on 3/3/2021.

⁶⁴ Ibid., accessed on 3/3/2021.

⁶⁵ Abayie Boaten, B., "The Trokosi System in Ghana: Discrimination Against Women and Children" in *African Women and Children: Crises and Response*, ed. Apollo Rwomire (Westport: Praeger Publishers, 2001), 91-92. *Trokosi* means "slaves of the gods." it is a practice which exist among the Ewe of the north and south Tongu Districts and then the Akatsi and Anlo Districts of the south-eastern part of Ghana. Trokosi is a ritual servitude where traditional religious shrines take human beings usually young virgin girls in payment for services, or religious atonement for alleged misdeeds of a family member. The misdeed is believed to have brought curses of chronic disease, poor crop harvest and numerous deaths. (Trokosi can be a moral, religious and human right subject. The appeal of this thesis is Trokosi's abolishment on the grounds of human right and human dignity). Bracketed mine.

⁶⁶"Kayaye" (Head Porterage) is a work of one who carries headloads for money. This work is highly concentrated in the metropolitans in Ghana. Most of these porters come from the northern parts of Ghana to the south to do this work. The concern of this thesis is the living conditions of these porters and their economic sustenance that turn to create a poverty cycle or social heritage of a family of porters. This thesis believes that the practice of Kayaye could be regulated by the government so that children of school going age for example are prevented by law to be porters and the living and health conditions of these porters factored into NHIS in addressing Kayaye and similar negative

in Ghana seem to be non-existent in the current operations and aims of the NHIS, and the South African module comes in handy for Ghana.

Also, the Ghanaian NHIS seems not to meet timelines in meeting targets that would eventually ensure that all Ghanaians are enrolled onto the system. For example, the NHIS has not met the MDGs that was to be achieved by 2015 where more than 55% of the Ghanaian population would have been registered with the NHIS.

Reflecting on both Ghana and South Africa's systems of health delivery, one can say that there are obvious challenges. For example, timely reimbursement of private providers in respect to their claims is a problem. Nonetheless, we can also have a justifiable fear and skepticism in giving the government the greatest control on the greatest need which is next to life, that is health.

These comparisons between Ghana's health system on one side with separate accounts of health systems of other countries namely, Nigeria, Kenya and South Africa, are not exhaustive of the extent that Ghana's health care system could be challenged to expand progressively in meeting the health needs of Ghanaians. The comparisons are eye-openers or models to what other

health prone economic activities. In this way, Ghana could be dealing with the roots of some social activities that eventually produces negative effects on the health of individuals.

James Akazili et al. and Abdul-Basit Tampuli et al. in the following articles give an expansive understanding of how social issues can be integrated into the formulation of health policies. Both articles used "Kayaye" as a model of this discourse of integration.

James Akazili, Samuel Chatio, John Ele-Ojo Ataguba, Isaiah Agorinya, Edmund Wedam Kanmiki, Osman Sankoh, and Abraham Oduro, "Informal workers' access to health care services: findings from a qualitative study in the Kassena-Nankana districts of Northern Ghana," *BMC International Health and Human Rights* 18, no. 20 (2018): 1-9, <https://doi.org/10.1186/s12914-018-0159-1> accessed on 3/26/2021.

Abdul-Basit Tampuli Abukari and Seidu Al-hassan Agriculture and "Kayaye" (Head Porterage) Menace in Ghana: A Case of Policy or Structural Failure?" (5/18/ 2017): 51-73, doi:10.5296/jas.v5i2.10768 URL: <https://doi.org/10.5296/jas.v5i2.10768>.

researchers could engage in, in making a case for a reliable healthcare delivery system in any country the world over. In particular reference to this thesis, the comparisons are to help put the Ghanaian healthcare delivery system in perspective by assessing it with other nations which fall within Middle- and Low-Income Countries (MLICs). The comparisons point to identifying what the state of quality health delivery is, how it does not measure up to the standard of quality, and what it can be. In other words, this thesis is about the records of poor or under performance of the Ghanaian Healthcare Delivery System which has resulted in the current state of affairs and the potentials for progress and improvement now and in the future.

Putting Them Together: Highlights on the State of Healthcare Delivery in Ghana

Karima Saleh describes the state of healthcare delivery in Ghana as making progressive strides yet needing further boost. He indicates that various indicators in health delivery such as human and material resources appear to be promising especially when compared to some African countries. He suggests a much more greater sustaining policies that would make the health sector capable of responding to the health needs of Ghanaians in quality health care delivery.⁶⁷

⁶⁷ Karima Saleh, *The Health Sector in Ghana: A Comprehensive Assessment*. Washington, DC: World Bank. Doi 10.1596/978-0-8213-9599-8 License: Creative Commons Attribution CC BY 3.0., 4-5, 33-55. Saleh reports as follows: Ghana has a comprehensive health service delivery system. It encompasses community-based programs, such as the Community-based Health Planning and Services (CHPS) initiative (GHS 2002); subdistrict health centers and clinics; district general hospitals; regional general hospitals; and specialized tertiary hospitals. The public sector has the largest share of the market when it comes to health facilities, hospital beds, and health providers. The non-public sector is as important in providing health services as the public sector. The non-public sector includes the for-profit and the not-for-profit health providers. Of the 2,441 health facilities, almost half belong to the non-public sector. At least 34 percent of hospital beds belong to the non-public sector. The Christian Health Association of Ghana (CHAG) represents a significant proportion of beds in the non-public sector with equal representation in urban and rural areas. For-profit facilities are concentrated mostly in urban areas. Rural areas are served by the public sector and under public-private partnership arrangements between missions and the public sector⁶⁷. Ghana's Human Resource for Health (HRH) levels do not meet international benchmarks. The WHO's Joint Learning Initiative (JLI) benchmarks recommend that countries have at least 2.02 to 2.54 (average 2.3) essential health care workers (HWs) per 1,000 population. In contrast, Ghana is estimated to have about 1.24 essential HWs per 1,000

In discussing “The Challenges of the State of Healthcare Delivery in Ghana,” this chapter has sought to establish that the enjoyment of quality healthcare delivery is the right of each Ghanaian. This was established through the empirical data analysis of the state of healthcare delivery in Ghana. In the next chapter this thesis addresses the Ghanaian situation through the lenses of the capabilities approach (CA). This is done to further expose the challenges and weaknesses of the Ghanaian healthcare delivery system and to emphasise the importance of health in society and how health impacts all other areas of life activities. These steps are taken to deal with the factors that renders the delivery of healthcare inefficient.

population (2009). When compared with other countries, Ghana does not fare too badly in its overall HW to patient ratios. But its clinical staff ratios fall short: Ghana has about 1.93 HWs per 1,000 population, whereas Rwanda has 1.22, India has 1.95, and Thailand has 3.0. However, a significant proportion (40 percent) of Ghana’s HWs are nonclinical. Ghana’s clinical staff ratios (60 percent) fall short of other African countries: Zambia (0.59 nurses and 0.23 midwives per 1,000 population) and Côte d’Ivoire (0.13 physicians and 0.34 nurses per 1,000 population).

Furthermore, about 50 percent of Ghana’s clinical HWs are from the nursing cadre (nurses, midwives, community health nurses, or health assistants), and just 3 percent of them are physicians⁶⁷ Physician-to-population ratios have improved but remain low relative to the country’s comparators. Ghana is one of the highest producers of physicians in sub-Saharan Africa, but after having lost its physicians to international demands, the country changed its policy to retain physicians. Ghana’s physician ratio (0.1 per 1,000 population, 2009) has improved over time. Now it lies within the HRH international benchmark (ranging between 0.1 [WHO] and 0.6 [WHO-JLI]), but it remains at the lower end of that benchmark. Ghana’s nurse ratio (0.39 nurses per 1,000 population, 2009) has also improved. The nurse ratio is within the HRH international benchmark (which ranges between 0.2 [WHO] and 1.9 [WHO-JLI]), but on the lower end of that range.⁶⁷ The distribution of HWs is highly concentrated in Ghana’s wealthier, urban areas. The greatest density of HWs per 1,000 population is in the Greater Accra, Ashanti, and Volta regions. Medical officers tend to locate in the Ashanti and Greater Accra regions; professional nurses, midwives, and community health nurses tend to be spread out. The Northern regions had the lowest ratios (MOH 2009a).⁶⁷Critical staff is missing from many facilities. As HWs age and recruitment remains low, many lower-level facilities, including CHPS, face shortages. Retention of HWs, especially in rural and remote areas and in the northern regions, has also been a challenge. The government has offered several incentive packages, including housing, additional allowances, and career opportunities. However, it still faces shortages outside large cities. A more egalitarian distribution exists among nurse–midwives; preservice nurse–midwife training institutions are more widely distributed in the country. However, preservice training for physicians is concentrated in a few cities.

Chapter Two

The Capability to be Healthy in Ghana

This thesis draws largely on the ideas of capabilities approach theorists like Amartya Sen, Martha Nussbaum and Sridhar Venkatapuram. Each of these authors in their own separate approaches expresses their academic views on the idea of justice, health and human dignity in line with the capabilities approach tradition.

Amartya Sen is a philosopher and economist who had taught in some universities including Harvard University. His books, articles and lectures reflect the capability approach tradition. His works and researches have been used by the United Nations (UN) in many developmental projects and interventions all over the world.¹ Sen could be said to be the founder of the capabilities approach. The capabilities approach basically talks about the well-being of people.

Nussbaum is the Ernst Freund Distinguished Service Professor of Law and Ethics in the University of Chicago. A prolific author, having written twenty-four books and numerous articles, Nussbaum's interests are wide ranging.² Her contributions to the capabilities approach is likened to that of Sen. While Sen and Nussbaum have distinguished theoretical and practical application views concerning the capabilities approach, they have similar ideas on the capabilities approach that intersect and converge at enhancing the well-being of the human person.

¹ Amartya Sen (harvard.edu) accessed on 11/18/20.

² <https://www.law.uchicago.edu/faculty/nussbaum> accessed on 11/18/20.

Whereas Sen and Nussbaum teach the general tenets of the capabilities approach, Venkatapuram centers and develops his theory only on the subject of health, from Nussbaum's second item on the Central Human Capabilities as indicated above. Venkatapuram is a senior lecturer in Global Health and Philosophy in Kings Global Health Institute³ as well as a capability theorist who builds his theory of "capability to be healthy" on the ideas of Sen and Nussbaum. He brings capabilities approach to the subject of healthcare and he helps illuminate the capabilities approach and its relevance to health and the capability to be healthy in Ghana. He singles out "the capability to be healthy" as one of the overarching issues that encapsulates and in fact, begins the attainment of all the other capabilities. Venkatapuram's Capability to be Healthy, in most part corroborates the ideas of Sen and Nussbaum on the capabilities approach. However, he points out that Nussbaum and Sen do not explicitly talk about capability to be healthy as the first capability to ensuring human dignity though health is second on the list of the ten CHC.⁴ Venkatapuram's theory, also known as health as a "meta-capability,"⁵ is a subset of the broader views of the mother theory of capabilities approach of Sen and Nussbaum. Venkatapuram posits that one of the things that give dignity to human person's is the capability to be healthy plus the recognition that each individual is an indispensable agent to self and society's wellbeing.⁶

This section of this thesis therefore, tackles the definition of capabilities approach and its tenets. Beside the brief definition and explanation of the capabilities approach, this thesis limits its content to focus on five areas of the capabilities approach. The thesis recognizes that it cannot cover all the tenets of the capabilities approach. Thus, the thesis has selected these five features

³ Sridhar Venkatapuram - Research Portal, King's College, London (kcl.ac.uk): accessed on 1/22/2021.

⁴ Sridhar Venkatapuram, *Health Justice* (Cambridge: Polity Press, 2011), 143.

⁵ *Ibid.*, 168.

⁶ *Ibid.*, 131-133.

because they appropriately speak to the subject of quality healthcare delivery in Ghana. These are the concepts of *freedom, opportunity, ability to choose, functioning and human dignity and agency*. These five areas are assessed based on their impact on how the capabilities approach and capability to be healthy (CH) are relevant to the roles played by the patients, health workers, government, religious institutions and NGOs towards the delivery of quality health care in Ghana. It is the plan of this work that by combining Ghanaian literature and capabilities theories this thesis can reach an appreciable understanding of the theology of the body as a sacrament from a health perspective and as espoused by Christopher West.⁷

Here in chapter two, the thesis addresses the capability to be healthy in Ghana. This chapter will delve deep into the capabilities approach in general by explaining the features of the capabilities approach that serve as measurement of capability to be healthy in Ghana. The chapter will therefore discuss: (i) health deprivation in Ghana as poverty and death. This sub-topic will be analyzed using the ideas of Amartya Sen on ‘freedoms’ and ‘unfreedoms’ and those of Kamm on health deprivation as death. This exposition on deprivation will further expose the weaknesses discussed in chapter one in the light of getting a broader understanding of poverty and death. (ii) The Chapter will also treat the dignity of the human being according to Nussbaum and Venkatapuram. This section will point to the loss or inadequate expression of human dignity in the Ghanaian health care delivery system and how it can be restored. It will point out that the health care delivery that Ghanaians access is one that can best be described as ‘adaptive preference’ by Nussbaum. In summary, Chapter two launches into giving a capability approach’s interpretation

⁷ Christopher West, *Theology of the Body* (Boston: Pauline Books and Media, 2007), 9.

to the weaknesses in the quality of health delivery in Ghana and give pointers to how these challenges can be solved.

The Capabilities Approach: Definition and Some Features Explained

According to Martha Nussbaum, “Human capabilities are what people actually able to do and to be – in a way informed by an intuitive idea of a life that is worthy of the dignity of the human person based on “the principle of each person as an end.””⁸ Nussbaum calls these “ends” of what each person “can be” and “do,” the ten capabilities also known as the “Central Human Capabilities”⁹ (CHC). She groups these ten CHC capabilities into basic, internal and combined capabilities.¹⁰

Firstly, “the *basic capabilities* are the innate equipment of the individual that is the necessary basis for developing the more advanced capabilities and a ground of moral concern.” Examples of these basic capabilities are the ability to see, talk, hear, ability to love and show gratitude, the capability for practical reason and the capacity to work.¹¹

Secondly, “the *internal capabilities* are the developed states of the person herself that are, so far as the person herself is concerned, sufficient conditions for the exercise of the requisite functions. Unlike the basic capabilities, the internal capabilities are states of mature conditions of readiness.” The internal capabilities are nurtured within the person’s environment.¹² For example

⁸ Martha Nussbaum, *Women and Human Development: The Capabilities Approach* (Cambridge: Cambridge University Press, 2000), 5.

⁹ *Ibid.*, 70.

¹⁰ *Ibid.*, 13.

¹¹ *Ibid.*, 84.

¹² *Ibid.*

a person's attraction to the divine could be directed to the object of worship of the person's parent's religion.

Thirdly, "the combined capabilities may be defined as internal capabilities combined with suitable external conditions for the exercise of the function."¹³ These three groupings of capabilities apply to the Ghanaian context where the basic capability, the ability to enjoy life and avoid danger is nurtured by the internal capabilities such as the health institutions. The progress of such a combination of the basic and internal capabilities could then reflect a functional health system in an environment where Ghanaians have the capability to choose from available quality health delivery system that enhances their human dignity.

According to Nussbaum, "practical reason and affiliation are central to the entire project of central human capabilities: the two suffuse all other capabilities making them fully human."¹⁴ Thus, the aspect of practical reason gives individuals and the state the flexibility of improvising and adding to the ten central human capabilities to suit their unique conditions. This is must be done according to the principle of "irreducible plurality" where one is cautioned to avoid taking from them or making any compromises on any of the ten central human capabilities.¹⁵ This because the list is emphatically, a list of separate components. Hence, "we cannot satisfy the need for one of them by giving a larger amount of another one. All are of central importance and all are distinct in quality."¹⁶ It is to be noted that Nussbaum intends the list to be

¹³ Ibid., 84-85.

¹⁴ Ibid., 92.

¹⁵ Ibid., 81.

¹⁶ Ibid.

“facilitative rather than tyrannical.”¹⁷ For her, “the list is emphatically a partial and not a comprehensive conception of the good.”¹⁸

The flexible feature of the central human capabilities is again drawn from the principle of “multiple realizability.” This is where “members can be more concretely specified in accordance with local beliefs and circumstances.” “It is thus designed to leave room for reasonable pluralism in specification.”¹⁹ Nussbaum opines that “the threshold level of each central capabilities will need more precise determination, as citizens work toward a consensus for political purposes. This can be envisaged as taking place within each constitutional tradition, as it evolves through interpretation and deliberation.”²⁰

According to Nussbaum, the aim of the capabilities approach (CA) “is to provide the philosophical underpinning for an account of basic constitutional principles that should be respected and implemented by governments of all nations, as a bare minimum of what respect for human dignity requires.”²¹ She posits that “The capabilities approach is fully universal: the capabilities in question are important for each and every citizen in each and every nation, and each is to be treated as an end.”²² Nussbaum’s CA is grounded in Marxian/Aristotelean idea of truly human functioning²³ that agrees with Christopher Bliss’ assertion that “man, if not the measurement of all things, is at least the measurement of the standard of living.”²⁴

¹⁷ Ibid., 96.

¹⁸ Ibid., 75, 96.

¹⁹ Ibid., 105.

²⁰ Ibid., 77.

²¹ Ibid.

²² Ibid., 6.

²³ Ibid., 13.

²⁴ Ibid., 124.

The flourishing of the CA that has the dignity of the human person as its ultimate aim depends on the space within which the CA operates. Both Sen and Nussbaum agree that the space is a determining factor in what the person is able to be and do. However, Nussbaum goes further and beyond the manifest function of what people describe as satisfaction to the latent function as to whether people are actually aware of having attained the fullest satisfaction they need within their space.²⁵ For it is the capability not the function which is the appropriate political goal that enables an authentic assessment of the well-being of citizens. The capability is the latent or the root cause of well-being while function is the observed or the manifest activities built on a particular presence of a capability.²⁶ In short, thinking in terms of capability gives a benchmark as we think about what it is to secure a right to someone.²⁷ Thus, the absence of capability is the absence of function.²⁸ The basis, strength and clarity of how the CA operates is framed in the following questions as posed by Nussbaum. 1. What is a person actually able to do and be? 2. What are the available resources that can enable the person to be and to do? and 3. What are the available and functional structures or the institutions that administer the resources so that individuals are able to do and be in achieving what they are capable of?²⁹

These questions are geared towards seeking the minimum threshold that each person should have in exercising their capability in what Marx calls “truly human.”³⁰ Being truly human could mean the ability to live in a place and enabling conditions and opportunities that give one

²⁵ Ibid., 12.

²⁶ Ibid., 13, 71, 84, 87.

²⁷ Ibid., 98.

²⁸ Ibid., 93.

²⁹ Martha Nussbaum, *Creating Capabilities: The Human Development Approach* (Harvard, Harvard University Press, 2011), 77. See also Martha Nussbaum, *Creating Capabilities: The Human Development Approach* (Harvard: Harvard University Press, 2011), preface X, 59.

³⁰ Ibid., 73.

the freedom to choose to do and to be in order to achieve what one desires. Asserting oneself in this way is to prevent exploitation of individuals by authorities for example, who would want to use these individuals as a means to an end and not as people who are bearers of value and therefore an end in themselves.³¹

The principle of individuals as end in themselves lays the political foundation of the CA that makes justice the priority of all social reflection.³² Such social reflection should inform the citizen's determination of a just country. In this wise, a country is just to the extent that the country's constitution is built on capabilities and functions that guarantees citizens the freedom to choose to do and to be thereby giving the citizens to choose from their entitlement or opportunities to be who they want to be.³³

Flowing from the idea of a just country, all countries must be concerned with achieving the minimum threshold of all the capabilities. "In short, the capabilities are an interlocking set; they support one another and an impediment in one impedes the others."³⁴ This is what each nation must do for her citizens. According to Nussbaum, this is what each nation must do for her citizens even when attaining these central human capabilities (CHC) do not seem economically feasible and politically pragmatic.³⁵ Endeavouring to achieve the minimum threshold of all the ten CHC will consequently lead to freedom of choice as the appropriate political goal where people choose to function in certain ways not their actual functionings."³⁶

³¹ Ibid.

³² Ibid., 33.

³³ Ibid., 298, 70-71.

³⁴ Ibid., 294.

³⁵ Ibid., 90.

³⁶ Ibid., 101,74.

The political goal of every nation should be the *principle of each person as an end* otherwise known as *the principle of each person's capability*.³⁷ “*The principle of each person as end* entails that the separate person should be the basic unit of political distribution. The basic political principle mandates that society secures a threshold level of the basic goods of life to *each*, seeing each life as deserving of basic life support and of the basic liberties and opportunities; that we do not rest content with a glorious total or average, when some individuals are lacking, whether in liberty or in material well-being.”³⁸ Talking about meeting each individual's need give special attention to the less privileged in society.³⁹

The success of the capabilities approaches and achieving the ten CHC rely to some extent on the availability of resources. Resources such as natural minerals, wealth and facilities like shelter are important opportunities and entitlements that that could enable citizens towards achieving their personal capabilities. However, the capabilities approach is cautious of avoiding the error of the utility approach of social theories that focuses mainly on aggregation of satisfaction of citizen's rather than the satisfaction of each individual, the latter being the stance of the capabilities approach.⁴⁰ Hence, “the capabilities approach directs us to examine real lives in their material and social settings; there is thus reason for hope that it may overcome the difficulty” that the utility approach faces.⁴¹

The capabilities approach supports Kant's idea that “major powers of a human being need material support and cannot be what they are without it.”⁴² The CHC by Nussbaum is designed to

³⁷ Ibid., 188.

³⁸ Ibid., 247.

³⁹ Ibid., 300-301, 5.

⁴⁰ Ibid., 99.

⁴¹ Ibid., 71.

⁴² Ibid., 73.

give the moral basis of the material support that is just for human well-being.⁴³ The list of the ten CHC according to Nussbaum is fixed and applicable everywhere in the world. Each place or space can add to the list but cannot take away or substitute one for the other.⁴⁴ The CHC is partly in line with John Rawls' "natural good" which imply that governments may not be able to meet all the needs and desires of all citizens. Nonetheless, the CHC gives the social basis of these capabilities in the sense of serving as guides for government in helping each citizen attain their capabilities.⁴⁵ This is because according to Nussbaum, "Human beings are creatures such that, provided with the right education and material support, they can become fully capable of all the human functions. That is, they are creatures with certain lower-level capabilities (Nussbaum calls "basic capabilities")⁴⁶ to perform the function in question.⁴⁷ Therefore, "making capabilities the goals entails promoting for all citizens a greater measure of material equality than exists in most societies, since we are unlikely to get all the citizens above the minimum threshold of capability for truly human functioning without some redistributive policies."⁴⁸ Such policies would reflect "the capabilities as being a long list of opportunities and functioning"⁴⁹ that would always draw an individual to want to have more of a said capability or capabilities.

"The delight and satisfaction that make people unwilling to go backward is a very important sign that the conception we are developing is likely to be a stable one, and that regimes

⁴³ Ibid., 74

⁴⁴ Ibid. 74, 75, 81,

⁴⁵ Ibid., 81.

⁴⁶ NFC, with reference to Aristotle's ways of characterizing levels of *dunamis*. As quoted by Martha Nussbaum in Martha Nussbaum, *Women and Human Development: The Capabilities Approach* (Cambridge: Cambridge University Press, 2000), 83.

⁴⁷ Ibid.

⁴⁸ Ibid., 86.

⁴⁹ Ibid., 88.

that thwart central capabilities are likely to prove unstable.”⁵⁰ Once one transitions into enjoying life through the capabilities approach, going back on once former life convictions could be impossible if not difficult.⁵¹ Quality Education, good sanitation and quality health delivery are some of those areas of life whose enjoyment, in the nature prescribed by the capabilities approach attest to the irreversibility aspect of the capabilities approach.⁵²

One could clearly admit the premium that the CA places on the human person as the central subject of policies in a country. Thus, Nussbaum seeks to give a concept that is formidable and applicable to all people in all places and all circumstances including Ghana, that need to respond to the well-being of the person in for example, the provision of quality healthcare as justice requires. This thesis therefore, focuses on health as a central human capability and its relevance to the state of quality healthcare delivery in Ghana.

Health as a Central Human Capability

The preceding sections have given hints that one of Nussbaum’s capabilities approach is to show health as a central human capability. We therefore explore deeper in the foregoing, how health is a central human capability. Nussbaum addresses the critical role of health as an essential aspect of human life by quoting Sextus Empiricus. Empiricus writes thus, “In the person burdened by hunger and thirst, it is impossible to produce by argument the conviction that he is not so burdened.”⁵³ In support of Empiricus’ assertion, Nussbaum indicates that “desires for food, for

⁵⁰ Ibid., 153.

⁵¹ Ibid., 152.

⁵² Ibid.

⁵³ Ibid., 155.

mobility, for security, for health and for the use of reason-these seem to be relatively permanent features of our makeup as humans, which culture can blunt but cannot altogether remove. It is for this reason that regimes that fail to deliver health, or basic security, or liberty, are unstable.”⁵⁴ By this, we can imply that Nussbaum makes the claim that health plus other aspects of life are permanent features of a person’s well-being that cannot be dispensed with. In fact, that quality healthcare is at the foundation of human flourishing.

In discussing quality health, the capability or the opportunity to be healthy must be distinguished from a functioning health delivery. The opportunity to be healthy is where society provides the policies and the structures for health delivery and the actual “healthy functioning” is whether each citizen is enjoying the quality health they desire. According to Nussbaum, most societies could be said to reach the level of providing the structures but one cannot vouchsafe whether each individual has functional health. For Nussbaum, access and enjoyment of quality health should be so embedded in the policies and structures of the health institution that one would not need external agents to make health functional.⁵⁵ Health constitutes one of the core areas of human functioning and therefore, each political regime should provide the minimum capability of citizens to be healthy. In that sense, “if people are systematically falling below the threshold in any of these core areas, this should be seen as a situation both unjust and tragic, in need of urgent attention-even if in other aspects, things are going well.”⁵⁶

Nussbaum makes her argument on health emphatic by stating that health is a “natural good.” This is analogous to John Rawls’s “primary goods” and constitutes the social basis for

⁵⁴ Ibid.

⁵⁵ Ibid., 14.

⁵⁶ Ibid., 71.

which countries must be assessed as just or unjust.⁵⁷ For this reason, “most modern nations treat health and safety as things not to be left out altogether to peoples’ choices. Health and safety are simply so basic to be left entirely to people’s choices. For health is a human good that has value in itself, independent of choice, and that it is not unreasonable for government to take a stand on its importance in a way that to some extent “(though not totally)” bypass choice.”⁵⁸ Nussbaum advances on the centrality of health to human well-being and development by saying that health and bodily integrity are so important to other capabilities that they are legitimate areas of interference with choice up to a point can always be deliberated upon to yield the best result. This makes health as a subject crucial for development.⁵⁹ Venkatapuram agrees with Nussbaum on this point when he coins the term health as meta-capability to show the essential linkage with which health binds all other aspects of human life together.⁶⁰ Health therefore becomes a web that begins and sustains the enterprise of interaction between people in a society.

Insofar as we are establishing that health is the engine behind human interaction, Christopher Bliss could be right in saying that, “the inhabitant of a poor country for example, may not realize how unhealthy they are, and the consequences of that ill health, whereas an expert will know.”⁶¹ Sen, could be agreeing with Bliss when he asserts that “the broadening of the informational base for income to the basic capabilities enriches our understanding about inequality and poverty in quite radical ways.”⁶²

⁵⁷ Ibid., 89.

⁵⁸ Ibid., 91.

⁵⁹ Ibid.

⁶⁰ Sridhar Venkatapuram, *Health Justice* (Cambridge: Polity Press, 2011), 143-145.

⁶¹ Martha Nussbaum, *Women and Human Development: The Capabilities Approach* (Cambridge: Cambridge University Press, 2000), 123.

⁶² Amartya Sen, *Development as Freedom* (New York: Random House Inc, 1999), 97.

From the foregoing, it stands to reason that, authentic information and knowledge about the state of quality health delivery in Ghana requires an extensive inquiry into how the five features of the capabilities approach are reflected in the state of quality healthcare delivery in Ghana, as steps towards achieving the goal of capability to be healthy in Ghana. These five areas are *freedom, opportunity, ability to choose, functioning and human dignity and agency*. These five features will be discussed separately or in combination within the main two areas of this chapter that seeks to lay the features of what could be called the capability to be healthy and the paradigm for measuring the standards of quality healthcare delivery in Ghana.

In this latter part of this Chapter, I shall proceed as follows (i) *freedom, ability to choose, functioning and human dignity and agency*-vis-à-vis deprivation of quality healthcare as poverty and death in Ghana, (ii) *opportunity, ability to choose, functioning and human dignity and agency* - in relation to enhancing the dignity of the human person in equity, access and affordable healthcare geared towards overcoming adaptive preference in quality health delivery.

Deprivation of Quality Healthcare in Ghana as Poverty and Death

According to Sen, *freedom* is the individual's capability to do the things that a person has reason to value.⁶³ These are the substantive things that individuals attach great importance to and for whose violation or denial would negatively affect the existence of the individual.⁶⁴ These substantial freedoms are “escaping avoidable mortality, being well nourished and healthy, being

⁶³ Amartya Sen, *Development as Freedom* (New York: Random House Inc, 1999), 56.

⁶⁴ *Ibid.*, 66.

able to read and write and count and so on.”⁶⁵ For Sen, real freedom is defined precisely in terms of certain human and civil rights that must be guaranteed for all.

Ensuring freedom also includes ‘removal of various types of “unfreedoms.”’⁶⁶ ‘Unfreedoms’ can be described as those things and conditions ‘that leave individuals with little choice and opportunities’ to assert their substantive individual freedoms.⁶⁷ It is in enhancing substantive freedoms that true development really occurs in the society. Real development is the provision of resources through the growth of Gross National Product (GNP) or facilities for education and health that have their main aim of building the substantive freedoms of individuals.⁶⁸ According to Sen, “resources are surely needed to expand public service including healthcare and education.”⁶⁹ Resources therefore, become the means to achieving the end which is freedom of the individual. As a result, “postponing socially important investment”⁷⁰ like health and education with the reason to “*wait* and “*get rich*” *first*” is untenable according to Sen.⁷¹ Sen adds the aspect of urgency to the relevance of quality health delivery when he asserts that there is no time to wait in providing quality healthcare.

It could be inferred from Sen’s argument on freedom that freedom is the foundation upon which the capability approach is built.⁷² Freedom as a foundational concept, answers Sen’s question- ‘equality of what?’⁷³ The answer is equality of freedom. Once the individual has the freedom, she/he can have reason to live and do the things she/he finds important and satisfactory.

⁶⁵ Ibid.

⁶⁶ Ibid., 15, 187.

⁶⁷ Ibid.

⁶⁸ Ibid., 3.

⁶⁹ Ibid., 47.

⁷⁰ Ibid.

⁷¹ Ibid., 49.

⁷² Ibid., 53.

⁷³ Ibid., 20-21.

The exercise of freedom means the instrument for entitlements and opportunities must be present in society.

The CA emphasizes the individual's claim to opportunities and entitlement. The CA thus carries with it a moral obligation that makes its application compelling. For example, Venkatapuram argues that 'every human being has the entitlement or right to the capability to be healthy based on the value of freedom and respect for equal dignity.' He further explains that the enjoyment of these rights should not depend on an institution's readiness to enforce them or deny them to the individual. It is an intrinsic value that the individual possesses as that which is due him on moral grounds.⁷⁴ This gives the individual the ability to function in the society.

The concept of "functioning" as explained by Sen, 'has a distinctly Aristotelean roots that reflects the various things a person may value doing or being.' Hence, 'a person's "capability" refers to the alternative combinations of functionings that are feasible for her to achieve. Capability is thus a kind of freedom: the substantive freedom to achieve alternative functioning combination.'⁷⁵ The following example is given in line with Sen's popular analysis concerning the link between hunger and fasting and how the link explains freedom as a concept. For example, the patriotism of a soldier who enlists in the military can be distinguished as superior to the level of patriotism of another citizen who is forced into the battlefield to fight for his country because of outbreak of war. Discussing "freedom", unfreedoms and entitlements is to point to the situation of what one could have or cannot have as deprivation, poverty and death.

⁷⁴ Sridhar Venkatapuram, *Health Justice* (Cambridge: Polity Press, 2011), 183.

⁷⁵ Amartya Sen, *Development as Freedom* (New York: Random House Inc, 1999), 75.

According to Sen, “poverty is capability inadequacy.” That is inability for one to be or to do in choosing to achieve the kind of life one desires to live.⁷⁶ This understanding ought to be distinguished from the narrow view that poverty is simply the shortage of income.⁷⁷ “The two ideas cannot but be related since income is such an important means to enhancing capabilities and preventing deprivations.”⁷⁸ “What the capability perspective does in poverty analysis is to enhance the understanding of the nature and causes of poverty and deprivation by shifting primary attention away from *means* (and one particular means that is usually given exclusive attention, viz., income) to ends that people have reason to pursue, and correspondingly, to the *freedoms* to be able to satisfy these ends.”⁷⁹

Discussing deprivation of quality health as poverty “entails that “real poverty” (in terms of capability deprivation) may be, in a significant sense, more intense than what appears in the income space. This can be a crucial concern in assessing public action to assist the elderly and other groups with conversion difficulties in addition to lowliness in income.”⁸⁰ One of such policies could be on the delivery of quality healthcare.

Health is considered as one example of public goods. Public goods are the things whose consumption is enjoyed by all and cannot be enjoyed separately. Public goods refer to fields such environmental preservation, epidemiology and public health care. For example, one can contribute to malaria free program but cannot buy her portion of the malaria free program. Whatever contribution anyone make towards this “public good” either benefits or do not benefit all citizens.⁸¹

⁷⁶ Ibid., 90.

⁷⁷ Ibid., 72.

⁷⁸ Ibid., 90.

⁷⁹ Ibid.

⁸⁰ Ibid., 88.

⁸¹ Ibid., 128.

Health is a right⁸² nay “the services that health facilities provide are typically nonshiftable and nonsalable and of not much use to a person unless he or she actually happens to need them.”⁸³

Venkatapuram could be right along this line by defining the capability to be healthy as “a person’s ability to achieve or exercise a cluster of basic capabilities and functionings, and each at a level that constitutes a life worthy of equal human dignity in the modern world.”⁸⁴The deprivation of basic capabilities to be healthy is therefore termed as poverty in this thesis owing to the reasoning that poverty is a lack of something herein understood as lack of capabilities.

The definition of health above could be very broad in relation to various sets of functionings. The set of functionings that this thesis focuses on is the provision of quality healthcare as a capability to be healthy and justice. This thesis agrees with Sen that health is the springboard to developing human capital in a nation.⁸⁵

The freedom or the capability to choose and access health as a “primary good” is of utmost importance to the capability approach since that is the beginning of developments in a nation. Sen considers development in general as a process of expanding the real freedoms that people enjoy. In this, freedom is accessed in the roles that freedom plays in development. Thus, we have “(i) the primary end or the constitutive role and (ii) the principal means of development or the instrumental role of freedom in development.”⁸⁶ “The constitutive freedoms are the abilities that one has to choose substantive freedoms in enriching human life. The substantive freedoms include elementary capabilities to avoid such deprivations such as starvation, under nourishment,

⁸² Ibid., 130.

⁸³ Ibid., 134.

⁸⁴ Sridhar., 143.

⁸⁵ Ibid., 293-294.

⁸⁶ Ibid., 36.

escapable morbidity and premature mortality, as well as freedoms to be educated and participation in politics.”⁸⁷ The instrumental role of freedom is how freedoms interrelate with one another or how one set of freedom is integral to the attaining of other sets of freedoms. For example, the enjoyment of good health can lead to growth in economic or political activities of the state.⁸⁸

It is the objective of this thesis not only to identify and explain the roles that freedoms play in development but also to identify what freedom entails in order to remove what Sen describes as “unfreedoms” that could make one poor because of denial of the capability to be healthy. Sen groups freedoms into five categories. These are (i) *political freedoms* (ii) *economic facilities* (iii) *social opportunities* (iv) *transparency guarantees* (v) *protective security*.⁸⁹ This thesis limits itself to only social opportunities under which health as capability falls.

According to Sen, “Social opportunities refer to the arrangements that society makes for education, health care and so on, which influence individual’s substantive freedom to live better. These facilities are important not only for conduct of private lives such as living a healthy life and avoiding preventable morbidity and premature mortality but also for more effective participation in economic and political activities.”⁹⁰ Such opportunities to be healthy involve what Adam Smith describes as the opportunity to appear in public without shame.⁹¹ Knowing the role and types of freedoms is complemented by addressing the “deprivations” that destroy these freedoms.

⁸⁷ Ibid., 36.

⁸⁸ Ibid., 37.

⁸⁹ Amartya Sen, *Development as Freedom* (New York: Random House Inc, 1999), 38.

⁹⁰ Ibid., 39. These substantive freedoms are things that individuals attach great importance to and for whose violation or denial would negatively affect the existence of the individual. For example, quality health delivery and the Central Human Capabilities of Martha Nussbaum.

⁹¹ Ibid., 73.

Sen identifies three types of deprivations as *premature mortality, under nourishment and illiteracy*.⁹² These deprivations are the elements in society that augment the meaning of poverty as explained above or could be associated with the causes of poverty beyond the view of low income as an instrumental link to poverty. This is because “the instrumental connections, important as they are, cannot replace the need for a basic understanding of the nature and characteristics of poverty.”⁹³ In this, inadequate accessibility to quality health delivery can be described as an intrinsic deprivation Health can be described as “intrinsic deprivation” since that goes to the core or substantive aspect of a person’s well-being.⁹⁴ There could also be relative deprivations where a need at one place may be insignificant at another place and vice versa.⁹⁵ Relative deprivation could also be called variable between different communities or families or individuals on what they consider as important or make value judgement on according to their unique life situations.⁹⁶

Differences in situations of life could result from the inequities that exist in the distribution of utilities and freedoms which could affect one’s substantive freedom.⁹⁷ These inequities in distribution result in inequities in the “space” that one chooses to live.⁹⁸ The location that one lives could be affected by natural or social occurrences that could also make the space less competitive in receiving or accessing the resources of the nation or receiving internal or external aid. Natural or geographic occurrence like famine, drastic weather conditions as well as social conditions such as wars and litigations could render a “space” unstable for projects of developing the capabilities

⁹² Ibid., 103.

⁹³ Ibid., 92.

⁹⁴ Ibid., 87, 88.

⁹⁵ Ibid., 96.

⁹⁶ Ibid., 88.

⁹⁷ Ibid., 119.

⁹⁸ Ibid., 93.

of the citizens of a place.⁹⁹ This could be termed deprivation and iniquities due to space or location deprivation. Giving the challenges that one encounters in the society in enjoying the substantial freedoms to be healthy, an efficient institution is needed to regulate the various valid concerns of all the citizens to enjoy quality health delivery.

“Individuals live and operate in a world of institutions. Our opportunities and prospects depend crucially on what institutions exist and how they function. Not only do institutions contribute to our freedoms, their roles can be sensibly evaluated in the light of their contributions to our freedom. To see development as freedom provides a perspective in which institutional assessment can systematically occur”¹⁰⁰ in ensuring the enhancement of human dignity.

Enhancing Human Dignity: Overcoming Adaptive Preference in Quality Health Delivery in Ghana

Preference could be likened to Sen’s substantive freedoms. Preference can be described as one’s ability to choose the kinds of life he/she values to live. On the contrary, “adaptive preference” can be explained as the situation where one adjusts to fit into a new situation, unsuitable as it may be.¹⁰¹ The clarity of ‘functioning’ as explained above by Sen, is given further clarity by its opposite subject of Nussbaum’s “adaptive preference.”¹⁰² The seriousness of “adaptive preference” as a hindrance to development and freedom is that “habituation shapes desire and aspiration.”¹⁰³ This

⁹⁹ Ibid., 88.

¹⁰⁰ Ibid., 142.

¹⁰¹ Ibid.

¹⁰² Martha Nussbaum, *Creating Capabilities: The Human Development Approach* (Harvard: Harvard University Press, 2011), 81-84. According to Nussbaum, ““adaptive preference” is what people would prefer under conditions of full information”.

¹⁰³ Ibid., 143.

is where a situation can truncate one's search for the higher or ultimate good. Elster supports this view by Nussbaum, when he defines "adaptive preference" in the following. According to Elster, "adaptive preferences" are formed without one's control or awareness, by a causal mechanism that isn't of one's own choosing. For Elster, this is a suspect and bad bases for social choice. Elster contradicts adaptive preference with "autonomous preferences" where the individual reflects, endorses or chooses a preference.¹⁰⁴ The capabilities approach is cautious of individual's preference being controlled by a central authority like the state or other organisations since that can make that authority manipulative of the individuals freedom.¹⁰⁵

Like "autonomous preferences," the concept of 'functioning' seeks to go beyond 'adaptive preference' to giving individuals a wide range of capabilities to choose from as exemplified by Nussbaum's ten set of central human capabilities (CHC).¹⁰⁶ This list of ten CHC by Nussbaum is meant to give individuals the 'minimal threshold' of functioning to realizing their dignities and equality as human beings. Whereas Sen talks about '*functioning vector*' as the ability to choose from alternative opportunities to achieve freedom, Nussbaum uses the ten CHC list as a combination that gives an individual the ability to function.¹⁰⁷

Venkatapuram explains functioning when he talks about health as a 'meta-capability' and 'capability to be healthy' as a cluster of rights.¹⁰⁸ This is similar to Nussbaum's ten CHC. One can observe that Sen, Nussbaum and Venkatapuram agree that 'functioning' needs a combination of

¹⁰⁴ Ibid., 137.

¹⁰⁵ Martha Nussbaum, *Creating Capabilities: The Human Development Approach* (Harvard: Harvard University Press, 2011), 115. See also Martha Nussbaum, *Women and Human Development: The Capabilities Approach* (Cambridge, New York: Cambridge University Press, 2000), 115.

¹⁰⁶ Martha Nussbaum, *Women and Human Development: The Capabilities Approach* (Cambridge, New York: Cambridge University Press, 2000), 70-86. See also Martha Nussbaum, *Creating Capabilities: The Human Development Approach* (Harvard: Harvard University Press, 2011), 69-76.

¹⁰⁷ Amartya Sen, *Development as Freedom* (New York: Random House Inc, 1999), 75.

¹⁰⁸ Sridhar Venkatapuram, *Health Justice* (Cambridge: Polity Press, 2011), 20 – 23, 160, 168.

rights and opportunities either to choose from or be combined to achieve an end. It can be implied that the capability of achieving a functional and quality health care delivery in Ghana requires multiple factors. These factors can be both internal and external to the ministry of health that is entrusted with the mandate of ensuring the health care needs of Ghanaians. Thus, the role of ‘functioning’ in the capabilities approach can be said to lead eventually to the realization of the dignity of each individual in the world and specifically the Ghanaian who is the focus of this thesis.

The dignity of the human person and agency take center stage in the tenets of the capabilities approach. Nussbaum gives an empirical approach to answering what constitutes human dignity by giving the ten Central Human Capabilities (CHC).¹⁰⁹ Sen’s use of *agency* can be interpreted as bringing on board the primary and integral role that the individual plays in ensuring human dignity to oneself and others.¹¹⁰ Sen thinks that the exercise of agency is often dependent on social institutions that enable that agency. What the individual can do must not be relegated to another and there must not be middlemen to presume to perform such subsidiary roles.¹¹¹ Therefore, institutions mandated to ensure the well-being of each person ought to carry out this role to perfection. Sen’s *agency* and Nussbaum’s *human dignity* finds expression in Venkatapuram.

It must be emphasized that Sen, Nussbaum and Venkatapuram do not see health or function as absence of disease or inability. Their broadened view of the healthy person stretches the scope of human dignity to cover disability and mentally ill patients. Sen and Nussbaum for example, criticize Rawls’ theory of ‘*veil of ignorance*’ and ‘*distribution of primary goods*’ as being a mutual

¹⁰⁹ Martha Nussbaum, *Creating Capabilities: The Human Development Approach* (Harvard: Harvard University Press, 2011), 32-35.

¹¹⁰ Amartya Sen, *Development as Freedom* (New York: Random House Inc, 1999), 18-19, 208.

¹¹¹ *Ibid.*

agreement between individuals or groups of equal and mutual expectation.¹¹² This mutual expectation according to Sen and Nussbaum limits the range of the relationship and engagement that exist among people in everyday life. The vulnerable in society need to be catered for by the more abled persons who have access to material resources and have a superior health advantage. Such a gesture is justness and a moral obligation without expecting a return of the same or similar gesture. This is what enhances all individuals 'to be' and 'to do' where all persons are recognized as members of a society with equal dignity. The full recognition of human dignity come from overcoming "adaptive preference" and consequently preventing loss of dignity, functioning and death.

Death, is here understood as an alienation from that which one desires. The absence or the inadequacy of the capability of choice to be healthy in Ghana could be described as death or lifelessness. Consistent with this view, Kamm writes that "death should be viewed in terms of the loss of "goods of life." By goods of life Frances Kamm refers to such things as experiences, achievements, character, wisdom and relationships. Death is a morally bad thing because it deprives individuals of experiential goods (deprivation), is a loss of good for an already existing person (insult) and it forecloses any further possibilities for the person (extinction), Kamm continues that if these kinds of loses happen from death after a normal lifespan, then a premature death must be even a more troublesome thing because it will be the loss of a more experiential goods than would have been lost after a normal lifespan."¹¹³

¹¹² John Rawls, *A Theory of Justice* (Harvard: Harvard University Press, 1971), 90-95.

¹¹³ Frances Kamm as quoted by Sridhar Venkatapuram, in *Health Justice* (Cambridge: Polity Press, 2011), 165.

In the next chapter, this thesis will explore the theological implications of the capability to be healthy in Ghana. This thesis has established in Chapter one, the state of healthcare delivery in Ghana which exposed the weaknesses and the challenges in the current situation. In Chapter two, this thesis has given the measures for assessing quality healthcare delivery according to the capabilities approach. We proceed to chapter three where there will be an assessment of the challenges in the state of healthcare delivery in Ghana through the lenses of the capabilities approach.

Chapter Three

Theological Implications of the Capability to be Healthy in Ghana: A focus on the Theology of the Body as Sacrament

Chapter three analyzes the theological implications of the capability to be healthy in Ghana. In this chapter this thesis reflects on the points of convergence between the capabilities approach, the Theology of the Body (TOB)¹, the Akan² indigenous culture and the Christian scriptures as means of finding solutions to the problems that hinder quality healthcare in Ghana. Precisely building on the immediately preceding chapter of dignity and justice in quality healthcare delivery, the capabilities approach, the TOB and the Akan culture have closest relevance in enriching each other or forming a synthesis in quality healthcare delivery in Ghana. This is drawn from the fact that the Akan culture and the TOB have both transcendental and existential values. This is because

¹Christopher West, *Theology of the Body Explained: A Commentary on John Paul II's Man and Woman He Created Them* (Boston: Pauline Books and Media, 2007), 279, 280, 283

²Kwakye-Nuako, Kwasi, "The Enigma of Life: Death Rites Among the Akans of Ghana and Christian Eschatology" *Journal of Religious Thought; Washington* 56/57, no. 2/1 (Spring 2000-Fall 2001): 2-3. According to Kwakye-Nuako Kwasi, "The Akan ethnic group as described by "The Akan people make up several nations within the existing states of Ghana and Côte d'Ivoire. In Ghana, those nations belong to the Akan group: Asante, Fante, Akyem, Kwahu, Akuapem, Bono, Sefwi, Wassa, Assin, and Nzema. Together with the Ga-Adangbes and Ewes, the Akans belong to the Kwa linguistic group, one of the predominant linguistic classifications in West Africa. Every Akan person belongs to one of the clans that make up each of the Akan nations. There are seven clans: Oyoko/Dako, Bretuo/Agona, Asona, Asakyiri, Asenic, Aduana, and Ekuona/Asokore.

Kinship has remained the bedrock of the social foundation of the Akan people, and as with many African people, when social kinship and biological kinship diverge, the social prevails.³ In addition to the many privileges one enjoys from the kinship system, that kinship lays out the duties and responsibilities required of members within a lineage or clan. A special feature of the Akan kinship is the pivotal role of women in the social structure, which is evident from the fact that among the Akan people the system of tracing descent is matrilineal and matripotestal.⁴ A mother-child relationship is the basis of one's membership of a clan or lineage. It is through this relationship that one derives her or his status and social capital in society."

both the TOB and the Akan culture rely on ascent to the divine's sanctioning of all activities of humankind. Such sanctioning imply a stance of the divine that has bearing and moral implications on how society attends to the just needs of human persons, as for example, in quality healthcare delivery. The link that the capabilities approach has with the Akan culture and the TOB is the aspect of the existential values but not the transcendental values. The capabilities approach insistence on ensuring human dignity and justice, is pursued as not coming from the divine but as a human need and love. Pope Emeritus, Benedict XVI, in his encyclical *Deus Caritas est*, could be affirming both the TOB, the Akan culture and the capabilities approach's pursuit of human dignity and justice. Particularly, in reference to the TOB, Pope Emeritus, Benedict XVI, gives an expansive view of the TOB as built on the theology of the of love God. He explains that love of God and neighbour is the basis of serving one another through care and thereby enhancing the dignity of the human person. He further strengthens the TOB by asserting that the human body is not only a material component of who a human person is, but that the body reveals the spiritual aspect of man's existence. For him, then, "When we live excellently by way of choosing virtuously loving action, we thereby reflect God's glory and fulfill God's desire for the human person, becoming a fragrant and pleasing offering to God Who Is Love, *Deus Caritas est*."³ The fragrance is here understood as reflecting the image and likeness of God.

Consequently, this chapter will proceed to: (i) discuss the body as a sacrament. The thesis at this point will focus on delivery of healthcare as both a spatial and temporal activity and one which points to the divine. As a result, this thesis leads us to locate resemblance of beliefs and

³ Gregory Gresko, "St. Benedict, the Theology of the Human Body and Human Love," <https://www.beliefnet.com/columnist/thebloggingmonk/2011/06/st-benedict-the-theology-of-the-human-body-and-love.html> accessed on 4/2/2021.

ideologies between TOB and the indigenous Akan culture in respect of human life for which quality healthcare delivery is a means of just response to the dignity of the human person. To achieve this, healthcare delivery will be discussed as a vocation. Healthcare will be understood as a vocation that glorifies God through respect for the dignity of the human being as a sacrament.

In furtherance to the idea of the theology of the body as a sacrament, this thesis then advances to (ii) to offer suggested solutions to achieving quality health care delivery in Ghana and (iii) While discussing TOB and the solutions, the thesis is also interlaced with biblical exegesis as it may apply to the TOB and the solutions on the capability to be healthy in Ghana.

In sum, this chapter seeks to give practical applications to the theoretical basis of health as explained and established in chapters one and two.

The Theology of the Body

“The theology of the body” (TOB) was propounded by Pope John Paul II as an ethical anthropology that aims to educate man on being human. It is a “pedagogy that aims at educating man, setting before him the requirements of his own humanity and pointing out the ways that lead to the fulfilment of his own humanity. This is precisely the goal of the TOB.”⁴ John Paul II proposes that “the TOB is the basis and the starting point of the most appropriate method of the pedagogy of the body.”⁵ The TOB covers a wider spectrum than sex and married life. While the truth about sex and marriage provides the key to understanding what it means to be human, the

⁴ Christopher West, *Theology of the Body Explained: A Commentary on John Paul II's Man and Woman He Created Them* (Boston: Pauline Books and Media, 2007), 279.

⁵ *Ibid.*, 280, 283.

TOB talks about “the sacramentality of the human life” itself.⁶ ““The sacramentality of the human life” begins with the realization that *our bodies are sacramental*, that they reveal the mystery of our humanity and also point to the infinitely greater mystery of God’s divinity. Understanding the Body as sacramental is a step towards “knowing who man is and who he is meant to be.”⁷ This in turn reveals the very meaning of life, and this is the first step to take in renewing the world”⁸ with insight into the body as a sacrament.

The sacrament is a visible efficacious sign of grace that points to a divine mystery of truth or reality.⁹ That which we can call a sacrament does not only point to the divine but it accomplishes its effect in humankind. Humankind becomes the greatest beneficiary of anything that admits to be a means to revealing the divine.¹⁰ “The two dimensions essential to the sacrament are the divine dimensions of the covenant and grace and the human dimension of sign.”¹¹ In this thesis, the human body that needs quality health is taken as the means or the sign that points to the divine for which priority must be given the body in ensuring safe and quality health delivery.

“Body” in this sense refers to the whole person in his psychosomatic subjectivity.”¹² “The sacrament as a visible sign, is constituted with man, inasmuch as he is a “body” through his “visible” masculinity and femininity. The body in fact and only the body, is capable of making

⁶ Ibid.

⁷ Ibid., 365

⁸ Ibid 283.

⁹ Ibid., 407-408.

¹⁰ Ibid., 408.

¹¹ Ibid., 376.

¹² Ibid., 331. This is the human person without separation between body and soul as opposed to the separation espoused by Rene Descartes’ *cogito ergo sum* which separates the body from the spirit and soul.

visible what is invisible: the spiritual and the divine. It has been created to transfer into the visible reality of the world the mystery hidden from eternity in God, and thus to be a sign of it.”¹³

In furtherance to this definition of the body, “the Pope indicates that there is more to see when we look at the human body-much more! For the Pope, to look at human body-person is to see not only the human spirit made visible, but also to see something of *the divine* made visible. In fact, to say the theology of the body is another way of saying that the human person is made in God’s image and likeness.”¹⁴ “Understanding the sacramentality of the body as such is the key that opens the door to understanding the body not only as something *biological* but also as something *theological*.”¹⁵ In this sense, the TOB progressively advances the importance of the body by upholding the dignity of the human person through “the ethos of redemption.”¹⁶

The “ethos of redemption” is the respect for the human person in everyday life. The Pope calls this the hope of everyday life.¹⁷ “Humanization and evangelization” are two sides of the same coin in meeting the needs of human persons.¹⁸ The TOB seeks the humanistic meaning of development¹⁹ “by grounding the gospel in the body”. This grounding is “the antidote to theological abstraction. It roots us in what is truly human and by so doing prepares us to receive what is truly divine. In other words, it puts us squarely with the *human question*, thus opening us to the *divine answer*.”²⁰ The human question is “what does some man who lived two thousand years ago have to do with me?”²¹ The divine answer is the incarnation. That God became man and

¹³ Ibid 422.

¹⁴ Ibid., 17.

¹⁵ Ibid., 16.

¹⁶ Ibid., 437.

¹⁷ Ibid., 436.

¹⁸ Ibid., 588.

¹⁹ Ibid.

²⁰ Ibid., 603.

²¹ Ibid., 602.

desires to associate with humankind to better their situation of life.²² One does not need to be a Christian to enjoy well-being. The recognition that the divine wishes to live in communion with humankind and that humankind should live in communion with one another in love is the beginning of the solutions to human plights.

The universal nature and impact of Christ's incarnation and redemption, though it must not be imposed on other cultures and religions or individuals is the common idea of Christ revealing the Father's will of redemption and well-being for all of humanity. Jacque Dupuis intimates that all cultures and religions have remote figures in their history that they associate with a divine intervention into human life to correct an error and show the way to a better life pleasing to the divine and for the satisfaction of the human person. Jesus could be considered as one of those figures who came not only to point humankind to the divine but to bring solutions to existential problems such as healing the sick and feeding the hungry.²³

It could be observed that the TOB and the capabilities approach have a common interest in separately promoting existential theories that give practical solutions to human problems. The content of both approaches such as the body as sacrament, the dignity of the human person, achievements and freedoms resonates with indigenous Ghanaian understanding of the respect for human person for which quality healthcare is a spring board to attending to the various aspects of the needs of the human person as a just call.

²² Ibid., 379, 380, 381.

²³ Jacque Dupuis, *Jesus Christ at the Encounter of World Religions* (Maryknoll, New York 10545: Orbis Books, 1991), 191-192.

The Akan Indigenous Culture, The TOB and the Capabilities Approach: Finding Points of Convergence

The Akan concept of “nyimpa” (the human person), as explained by Dukor Maduabuchi reveals that the person is constituted of body (honam) soul (Okra) and Spirit (Sunsum). These three components are intrinsically bound to each other in such a way that whatever one component experiences affects the other two components and vice versa. The body is mortal but the soul and the spirit are immortal and subsists even when one dies.²⁴ The reverence that the Akans have for the human body is borne, both out of reverence and out of fear.

The aspect of reverence is seen during rites of passage such as birth, puberty rites and marriage. The aspect of both fear and reverence are also observed in the performance of funeral rites. Prior to giving the dead a befitting burial, there is a diligent preparation of the corpse and the place of burial. These rituals that precede the actual interment are done with the belief that the dead or the ancestors who are spirits have the powers to bless or curse the living dependent on how a particular group of people, a family or an individual attended to the former’s need while they were alive, during sickness or at the point of death by providing means of life preservation such as good medication and intensive care for the sick²⁵

During pre-colonial, colonial and post-colonial times, indigenous Ghanaian culture always deemed medicine as a gift of the community. Thus, medicine is to be administered out of benevolence since it is a family or communal asset and never a personal property. Handing on

²⁴ Dukor Maduabuchi, “Comparison of African Concept of Person, Man and Destiny: Across Cultural Study of Ghana, Nigeria and Togo,” *African Psychologist: An International Journal of Psychology and Allied Professions*, (2/9/2010): 9-28. Similar ideas are expressed by some African anthropologists and theologians namely Kwame Gyekye and Peter Akwasi Sarpong.

²⁵ Kwame Gyekye as quoted by Joyce Engmann in “Immortality and the Nature of Man in Ga Thought”

such gifts and practices of healing was part of building structures of the society. The one with the gift of prescribing and administering medicine and healing the sick was deemed to have a special relationship with the spirit world who instruct the indigenous healer on the rituals and medications that bring about the healing. Healing practices were at one and the same time physical, emotional, psychological and spiritual. The medicine woman or man was an intermediary who possessed the vocation of insight into healing both physical and spiritual ailments. The attitudes that indigenous Ghanaian culture exhibits toward the sick and the disabled are attitudes of mercy, love and compassion. The sick is not to be mocked, so also are people suffering from misfortunes such as barrenness, physical deformity, leprosy, epilepsy and mental illness. Any discussion about them is done with circumspection and avoidance of ridicule. The physical or emotional appearance of one who could be described as sick calls for respect and mercy.

These attitudes and approaches towards the sick are borne out of a cultural understanding that there is more to physical appearance of a person than the eyes can see or the senses can perceive. Also, there is the belief that, the one who ridicules the sick, can be punished spiritually by the divine who has the power to transfer the suffering of the one mocked to the one who did the mocking. In addition to the threat of punishment, it is generally unacceptable in Akan culture to show contempt towards the sick. Hence, the steps towards healing the observable signs of sufferings of a person could be the barest minimum that society can do through quality healthcare for the citizens.²⁶

In indigenous Ghanaian culture, respect for the sick and steps taken towards one's healing or that of another is founded on both moral, religious and social understandings of who the human

²⁶ Emmanuel Asante & Raphael Avornyo "Enhancing Healthcare System in Ghana through Integration of Traditional Medicine," *Journal of Sociological Research* 2, no. 4 (10/2013): 259-258.

person is. The idea that the person (nyimpa) is more than the body or the body is more than what society observes of a person, could be an indigenous Ghanaian expression of the human person as a sacrament needing the capabilities to choose and achieve quality healthcare that serves it.

Establishing the link between indigenous Akan culture, capabilities approach and “theology of the body” gives us the background that paves the way for suggesting solutions to the problem of poor and substandard healthcare in Ghana. The theological implication of this thesis, therefore, is to discuss the quality of healthcare delivery in Ghana with regard to the following areas: (i) the gift of life and dignity of the human person, (ii) vocation versus profession in health workers approach to work, (iii) poverty versus financing quality healthcare delivery, (iv) How social institutions sustain health as a “public and social good” and (v) individual responsibility in accessing quality healthcare.

On the Gift of Life and the Dignity of the Human Person

The argument that every person is sacred is made stronger by drawing from a broader range of encyclicals such as *Pax in terra, Deus Caritas est and Humanae Vitae*. The claim that persons are made in God’s image and likeness and therefore are to be treated with reverence and respect is deployed in many different ways and in many different encyclicals as mentioned above.

Pax in terra declares that, “Man has the right to live. He has the right to bodily integrity and to the means necessary for the proper development of life, particularly food, clothing, shelter, medical care, rest, and, finally, the necessary social services. In consequence, he has the right to be looked after in the event of ill health; disability stemming from his work; widowhood; old age;

enforced unemployment; or whenever through no fault of his own he is deprived of the means of livelihood.²⁷

In *Humanae Vitae* (On Human Life), Pope Paul VI's famed 1968 encyclical, the protection of human life is deemed paramount. Pope Paul VI's writings in this encyclical reaffirmed long-held Church teachings about human nature and new life, but also explained how this wisdom was to be applied in a modern cultural context. The Church's message in this document is that God is the Author of Life, and the lives He creates are sacred. God wills into existence every life brought into the world as part of His plan for creation. We are made in God's image and likeness and as the Supreme Creator, it is He who has mastery over life and death.²⁸

Deus Caritas est could be seen to put together the motivation behind the tenets of *Humane Vitae* and *Pacem in Terris* when it states love of God and love of neighbour as the basis of all activities geared towards ensuring respect for human dignity and justice.

The Ghana Health Workers' (GHW) policies acknowledges this truth by referring to persons as internal and external clients. The internal clients are the health workers and the external clients are the patients visiting or admitted in a health facility. The unpredictability of our vulnerability to sickness and the superiority of life at any time is reinforced by the World Health Organization's (WHO) definition of health as "not merely the absence of disease or infirmity, but a state of complete physical, mental, and social well-being". This definition of the WHO has been

²⁷ Pope John XXIII *Pacem in Terris* Encyclical on Establishing Universal Peace In Truth, Justice, Charity, And Liberty (April 11, 1963). www.vatican.va/content/john-xxiii/en/encyclicals/documents/hf_j-xxiii-enc-11041963-pacem.html accessed on 4/22/2021. para 11, related paragraphs of 91 (Justice), Equality (44), Charity, Truth, Justice and Freedom (35) and Essentials of the Common Good (55) all treat subjects related to the respect and dignity of the human person.

²⁸ *Humanae Vitae*, The Second Vatican Document on Human Life. <https://www.hli.org/resources/7-basic-points-humanae-vitae-summary> accessed on 12/13/2019.

challenged over the years to the point that one cannot attain a complete well-being but that well-being, as the capabilities approach and the theology of the body suggests must be a continuous enterprise of meeting the quality health needs of the citizens every day.

This thesis associates with the definition of Venkatapuram on capability to be healthy as a meta-capability when he builds on the WHO definition to define health as follows: “the situation whereby the attainment of quality health leads to achieving other functions of the human person.” Quality health therefore, becomes the foundation and centre for all life activities.²⁹ Wellness has been defined more as the multidimensional action an individual takes to meet the above definition of health, espoused by both by The WHO and Venkatapuram.³⁰ Thus, the ordinary passion of humankind is life preservation for self and the other’s wellbeing since life is both precious and delicate.

The incarnation teaches humanity how God assumed this vulnerable nature and remained dependent on the hospitality of institutions and individuals for survival. Jesus’ passion, death and resurrection redeems life and gives hope that sickness does not have the ultimate determination of life, but God. Thus, the saying that, “If one does not get sick, how can God be healer” is not a fatalistic statement, but one that demonstrates human dependence on each other, whether an internal or external client of the hospital to realizing quality health which we all desire. The multidimensional focus also calls into view the role that priests play in restoring spiritual wholeness to humanity after the model of Jesus in the episode of the healing of the ten lepers (cf. Lk. 17:11-19). The work of healing and restoration of meaning in life tends to evaluate health

²⁹ Sridhar Venkatapuram, *Health Justice* (Cambridge: Polity Press, 2011), 143-145.

³⁰ <https://www.bing.com/search?q=world+health+organisations+definition+of+health&form> accessed on 12/13/2019.

workers as either practicing a profession or responding to the vocation of restoration which Jesus came to establish through the kingdom of God in his life and ministry.

Vocation and Profession vis-à-vis Healthcare Delivery

The idea of vocation is central to the Christian belief that God has created each person with gifts and talents oriented toward specific purposes and a way of life. In the broadest sense, as stated in the Catechism of the Catholic Church, "*Love* is the fundamental and innate vocation of every human being" (CCC 2392). More specifically, in the Orthodox and Catholic Churches, this idea of vocation is especially associated with a divine call to service to the Church and humanity through particular vocational life commitments such as marriage to a particular person, consecration as a religious, ordination to priestly ministry in the Church and even a holy life as a single person.

In the broader sense, Christian vocation includes the use of one's gifts in their profession, family life, church and civic commitments for the sake of the greater common good.³¹ The application of the relationship between profession and vocation is viewed from the understanding of the principle of motivation. Intrinsic motivation characterizes vocation where health workers see full recovery of patients as their ultimate satisfaction and leanings on God's blessings depending on a worker's religious orientation. Extrinsic motivation characterizes a work that is done for material rewards or incentives such as monthly salary and fringe benefits. Vocation does not disregard the tenets of professionalism in their approach to work but does not

³¹ A catholic understanding of vocation according to Catechism of the Catholic Church is explained as follows "The calling or destiny we have in this life and hereafter. God has created the human person to love and serve him; the fulfillment of this vocation is eternal happiness (1, 358, 1700). Christ calls the faithful to the perfection of holiness (825). The vocation of the laity consists in seeking the Kingdom of God by engaging in temporal affairs and directing them according to God's will (898). Priestly and religious vocations are dedicated to the service of the Church as the universal sacrament of salvation (cf. 873; 931)." <https://vocationblog.com/2011/07/the-catechism-on-vocation/> accessed on 3/27/2021.

rely solely on extrinsic motivation as their main drive to helping humanity. Jesus could be affirming both approaches when he says "...the labour deserves his wage..." (cf. Lk. 10:7) and in another context, "... where Jesus teaches people to be selfless and assume servant leadership roles ..." (cf. Lk. 17:10).³²

The incarnation teaches humanity how God assumed vulnerable human nature and remained dependent on the on the hospitality of institutions and individuals for survival. Jesus' passion death and resurrection redeems life and gives hope that sickness does not have the ultimate determination of life, but God. To accomplish this, the incarnation teaches that, Jesus Christ, the eternal word became man and undertook servant leadership role and served humanity. He did this to teach his followers the greatness in service and to love one another. Here, God is represented by priests and health workers who continue this salvific mission.

The multidimensional focus of vocation also calls into view the role that priests and health workers play in restoring spiritual wholeness to humanity after the model of Jesus in the episode of the healing of the ten lepers. Nine of the lepers were Jews and one was a Samaritan (cf. Lk. 17:11-19)³³. In the story, the nine Jews experienced physical healing whereas the Samaritan who returned to Jesus was restored both to physical and spiritual healing as well as complete well-being. This well-being was born out of Jesus' words, "Your faith has made you whole." Holistic healing and restoration to finding meaning in life are the ends that this thesis is emphatic on. We get an understanding of holistic healing by contrasting the healing experience of the Samaritan

³² See also 'man shall not live by bread alone' in Jesus three-fold temptation in the synoptic gospels which could be interpreted as humankind's test on provision or where to get satisfaction. Cf. 4:1-11).

³³ Leprosy is a contagious disease that affects the skin, mucous membranes, and nerves, causing discoloration and lumps on the skin and, in severe cases, disfigurement and deformities. At the time of Jesus leprosy was a forbidden sickness that made people who were infected become outcast by default. Leprosy was considered a taboo, a spiritual curse as a result of one's sin. It took intensive processes of healing or a miracle to restore a leper back to full functioning of the part of the body that had become dysfunctional

with his Jewish counterparts. The Samaritan could be said to have experienced total healing, which is physical, emotional and spiritual while the nine Jews could be described as having experienced only partial or physical healing. Thus, we tend to evaluate healthcare workers as both practicing a profession and responding to Jesus' version of the vocation of restoration which he established through his proclamation of the kingdom of God in his life and ministry. The evaluation of priests and health workers is therefore, done with the background of the extent to which priests and health workers could replicate or reflect in varied ways, Jesus' restoring of holistic healing to humankind. This ministry of restoration of the sick is the endeavour to bring happiness to the human person as a sacrament.

The body as sacrament is espoused as a theory that gives a deeper meaning to the importance of human dignity such as expressed by the capability theorists. The body as sacrament treats the importance of human dignity by establishing the origin and end of the human being. From the beginnings of one's life and activities that one does or does not do, the human being must point to God and help others to do the same by paying attention to the health needs of self and neighbor. This care for self and one another would involve understanding the health of a person, not merely in the absence of disease but also, the attainment of progressively enriching vital goals including: emotional, moral and spiritual well-being of a person.³⁴ The healthcare institution can

³⁴ Lennart Nordenfelt's health as "Vital Goals" as explained and built upon by Sridhar Venkatapuram in the latter's concept of health as "Meta-Capability" in Sridhar Venkatapuram, *Health Justice* (Cambridge: Polity Press, 2011), 43-48. Venkatapuram, Lennart Nordenfelt and contemporary views on quality health agree that quality health cannot be total and static as the WHO definition of health indicate. Rather, attainment of quality health is that aspect of human life that society and individuals keep working at initiating and transforming in the intellect, emotional and spiritual components of the human person. The Vital Goals according to Nordenfelt are the choice one can make to enhance one's dignity as a human person. Venkatapuram's meta-capabilities are capability to achieve a cluster of certain capabilities and functioning.

therefore be referred to as a sacramental³⁵ since it is associated with the giving, protecting and restoration of life which is a gift from God. Albert Williams affirms the sacramentality of a hospital when he observes thus, “A hospital is a unique crossroads for humanity, I see patients as representing the diversity of divinity and divinity of diversity-and the communality of humanity”.³⁶ Albert Williams’ assertion could be understood to mean that hospitals, clinics and all places of healing are places that anyone could be admitted to because the health of a person could be highly unpredictable and that we should see the face of God in the suffering. That is, the stories we gather from these places of healing reveal that all persons are either actual or potential patients. Therefore, this thesis is a contribution to the several workable roadmaps designed to help individuals to deal with suffering to the effect that, in spite of apparent or real human suffering, the Ghanaian and by extension, everyone in the world, will still continue to have a reason to live.

The human being as a sacrament is succinctly put by St. Irenaeus when he said ‘A man fully alive is the glory of God.’ Justice demands that in order to achieve this assertion by St. Irenaeus, the state makes and execute policies that would keep the citizens fully alive and satisfied with prevailing healthcare delivery conditions. This transition from being dead or partially alive to being fully alive can be achieved through efficiency of health workers and due payments of salaries and motivations of Health Workers (HWs). In keeping with moving towards this ideal of their vocation, health workers must be encouraged in the light of being paid their due salaries and incentives which will intend enable them to render quality services to the sick. Such motivations

³⁵ Sacramental as understood here to be an object that has the potential and actual power to bring about healing by its very operation or application and at the same time, it is a sign that points to the divine as the ultimate healer.

³⁶ William E. Alberts, *A Hospital Chaplain at the Crossroads of Humanity* (Oakhill: Alfred Publishing Co., INC.,2012), 17.

will go a long way to making the transition into fullness of life propounded by St. Irenaeus possible. Work therefore, should transcend human motivation to making the utmost satisfaction of the patient a priority, in order to agree with the answer to the following question and related answer, “Can you tell by looking at people whether they are good or bad? I can tell by looking at people that they are human beings.”³⁷ Thus, this thesis advocates with Nussbaum on the centrality of the human person in any approach to any work and policy formulation.³⁸ A focus that defines vocation and profession

Vocation and profession do not compete but complement each other. Vocation and profession should take the turn of pastoral care where it becomes more relevant that we remember patient’s name and give them maximum quality health services. “It is about people getting better not being better.” It is about looking at people and seeing human beings.³⁹ That is, health workers should be well motivated that the maximum satisfaction of the sick in being healed becomes the utmost concern of the health worker. This approach to healthcare delivery strives to give equal attention to all, but especially the poor and the less privileged in society.

Poverty verses Accessibility to Just and Quality Healthcare Delivery in Ghana

Poverty is a fundamental determining factor in Ghana in shaping or describing ones’ perception about the quality of healthcare delivery in Ghana. Poverty is the underlying problem that determines the content of one’s answer to the following two questions from Nussbaum’s

³⁷ Ibid., 31.

³⁸ Martha Nussbaum, *Creating Capabilities; The Human Development Approach* (Harvard, Harvard University Press, 2011), 35.

³⁹ William Alberts E., *A Hospital Chaplain at the Crossroads of Humanity* (Oakhill: Alfred Publishing Co., INC.,2012) 31.

assessment and measure of the level of satisfaction of the citizens in a country. These are: (i) “what are people actually able to do and to be?”⁴⁰ and (ii) “when we look at a society and ask, “is that society minimally just?”⁴¹ When we consider theories of development, and justice then, we are considering what people in every nation are striving for: a decent quality of life.⁴² This is because ‘the real wealth of a nation is its people, and the purpose of development is to create an enabling environment for people to enjoy long, healthy, and creative lives. This simple but powerful truth is too often forgotten in the pursuit of material and financial wealth.”⁴³ “The chase for wealth and satisfaction becomes individualized in a society where communitarian need for all becomes complex. Hence, from the assumption of equal dignity, it does not follow that all the centrally important capabilities are to be equalized. Therefore, treating people as equals may not entail equalizing the living conditions of all.”⁴⁴. While poverty and greed may appear to be hinderances to steps aimed at giving equal opportunity to all, the incarnation becomes a paradigm shift.

Changing the terms of the conversation is what the gift of the incarnation did/does to humankind through the Jesus Christ who became poor so that we can be rich. The incarnation confront poverty on two grounds. That is, poverty can be viewed as one of the “unfreedoms” that must be removed on the one hand and on the other hand, it can be endured as an identification with Christ who identified with our poverty in order to enrich us. Thus, poverty can be eradicated or its effect minimized and made insignificant. This can help promote freedom as a concept in which one’s capability is grounded. Freedom makes each one responsible for their healthcare needs. A

⁴⁰ Martha Nussbaum, *Creating Capabilities; The Human Development Approach* (Harvard, Harvard University Press, 2011), 59. See also the ten Central Capabilities that are the measure for defining the decent life of a society (Ibid.,33-34).

⁴¹ Ibid., 95.

⁴² Ibid.,46.

⁴³ Ibid.,1.

⁴⁴ Ibid.,31.

responsibility that is well expressed by the *concept of Agency* of the CA where individuals are integral contributors to things, they have reasons to value like healthcare in any part of Ghana that they find themselves.⁴⁵

The theology about quality healthcare delivery in Ghana is based on the social demographics to a larger extent as noted above. Sen alludes in keeping with this idea of geographical location in relation to poverty, justice and access to quality healthcare and their impact on human dignity. According to Sen, we need to pay attention to particular needs of people within a particular space when formulating policies.⁴⁶ In Ghana the disparities between the northern part of Ghana and the southern part of Ghana is quite obvious and indicative of the southern part of Ghana having a better healthcare delivery compared to the northern part. Moreover, within the bigger disparities between the north and the south, there are disparities within each division where urban areas have relatively better healthcare delivery than rural folks. Therefore, it is difficult to aggregate on what quality health care is or could be.

In a country with about 56.3 % of the population being poor⁴⁷, peoples' conclusions about health are more that of "adaptive preferences" in relation to quality health delivery. This happens because citizens believe or are made to accept that that government cannot create an egalitarian or utilitarian society of quality health delivery. This understanding in turn affects and limits citizens freedom to choose whichever health provider they could best associate with, public or private health facilities. Even within this practical reality of impossibility of utilitarian or egalitarian society, the just question is, "Whether government officials and the clergy who are the prophets of

⁴⁵ Sridhar Venkatapuram, *Health Justice* (Cambridge: Polity Press, 2011), 131-133, 157- 158. Refer also to Sen's description of *Agency* in Amartya Sen, *Development as Freedom* (New York: Random House Inc, 1999), 18 - 19.

⁴⁶ Amartya Sen, *Development as Freedom* (New York: Random House Inc, 1999), 262.

⁴⁷ According to Ghana Statistical Service 56.30% Ghanaians are poor as at 2016.

society would access a health facility in rural Ghana? How do we address the phenomenon where governmental officials and aristocrats seek medical attention in the West and other countries rather than in Ghana? It is not, therefore, the question of citizens to choose from what is available based on their capabilities, but whether the options of available health facilities are viable to providing the needed responses of healing that could match contemporary standards of quality health delivery. And whether the poor would be able to pay to access quality health delivery as their rich counterparts if such contemporary standards were available in Ghana? We can imply that the deplorable state of quality health delivery in Ghana could largely be blamed on the dereliction of duties of those in charge of policy formulation and execution as well as those who have the power and influence to speak for the poor. The attitudes of these groups of people could be described as callousness, insensitive or uncaring towards the plight of the poor and not taking seriously the dignity of the human person especially the poor.

The question to the CEO of the BOEING 737 aeroplane, Denis A. Muilenburg, after the series of crashes of BOEING planes in 2018, is applicable, “Will you and your family travel in the next available flight of the Boeing?”⁴⁸ It is unfair that the Central, Upper East and Upper West Regions of Ghana are classified as poor regions with their attendant health challenges. To accept this category is not to live with the reality of demographics but to accept that we do not really care whether the next person dies or suffers from a health condition which otherwise could be treated in Accra at Korle Bu Teaching Hospital, Ridge Hospital (Accra), University of Ghana Medical

⁴⁸<https://www.businessinsider.com/faa-administration-chief-meeting-with-boeing-ceo-on-737-max-agency-email-2019-12> accessed on 12/14/2021.

Centre (Accra) or Kumasi at Komfo Anokye Teaching Hospital.⁴⁹ Ghana should aspire to making these referral hospitals within reach to all localities or at least to all the sixteen regions of Ghana. This could be done through formulation and effective execution of a national policy that embarks on a progressive vision of improving the current infrastructural status as well as upgrading and increasing the quality of health workers in Ghana. This internal transformation should be concurrent with national attitudinal and policy change that turn from the idea of continuously providing health facilities in the urban areas where there are already existing or relatively appreciable facilities.

The seemingly lack of will to hear the cry of the poor by successive governments and private providers of health, continues to widen the gap between the poor and the rich in Ghana. This makes health outcomes predictably favorable to the rich and bleak for the poor. The implication is that the majority of talents and human resources are being wasted with the passage of time when the over 56.3% of the populations⁵⁰ health needs are threatened by conformism to prevailing poor health condition and see the shadows as real in Plato's *allegory of the cave*.⁵¹

The irony of the implication is rather true for Ghana's present and future health and wealth when it accepts international aid from organizations like the International Monetary Fund (IMF), World Bank and Western countries which challenges and destroys indigenous cultural healing and moral practices that uphold life and address spiritual aspects of ailments. There seem to be a little

⁴⁹ Korle-Bu Teaching Hospital is located in the capital, Accra. Komfo Anokye Teaching Hospital is located in Kumasi, one of the metropolitans in Ghana. where major medical cases are referred. The Ridge hospital was renovated and recommissioned in 2016 while the University of Ghana Medical Centre was completed in 2017.

⁵⁰ According to Ghana Statistical Service 56.30% Ghanaians are poor as at 2016.

⁵¹ <https://www.studiobinder.com/blog/platos-allegory-of-of-the-cave> accessed on 12/14/2019. In the allegory, humankind is so limited and fixated to the conditions in the cave that they perceive shadows of humans as the real. In the same way due to constraints in the delivery of healthcare, most Ghanaians accept poor delivery as the best delivery and grow to be content with the system no matter how ineffective the health institution is.

effort made at integrating indigenous medical practices with orthodox medicine. In some instances, indigenous practices that are not efficacious in healing certain terminal ailments for example, are denounced as fetish by some medical health workers. This happens especially when orthodox practice proves effective compared to indigenous medicine. One could trace a colonial link to brainwashing of the citizens towards indigenous methods of healing that turns to disregard the space of indigenous Ghanaian medical culture. As a result, such brainwashing creates lack of trust in the efficacy of traditional healing practices in an effort to responding to the Ghanaian health needs especially in cases that could be believed in to be “spiritual.”

What compounds this problem of gap between indigenous and orthodox practice is also the lack or little effort by the Ministry of Health to formulate and execute a progressive and comprehensive health plan that seeks to make this integration a reality in the everyday life of the Ghanaian. The situation of heavy reliance on Western medical practices and principles to some extent undermines “the can-do spirit” of the Ghanaian in being innovative about contemporary healing practices and methods. Some of these Western principles have encroached upon and are growing into the fabric of Ghanaian society as a result of colonization and continued reliance on the West for financial aid in order to execute health policies where she must fulfill conditions attached to foreign aid. Indeed, if health is the life and heart of the nation, and health policies are politicized or are partly controlled by negative external influence, then we could say that the whole nation is at risk and is poor as far as health is concerned. The prophetic voice in Ghana should re-echo Isaiah’s advice to Hezekiah on reliance on foreign military aid for Israel when he says, “...Assyria cannot not save us...” (cf. Isa 37:33). The communitarian Ghanaian spirit should make Ghanaians each other’s keeper by prioritizing health in every Ghanaian’s life through pragmatic policy formulation and effective execution that make individuals more responsible for their health.

Such moves could aim at creating the enabling environment in which such policies aim at financial self-reliance and sustaining health policies that in turn empower the individuals in having the freedom to choose a satisfactory healthcare delivery from available options which meets contemporary standards.

Financing and Sustaining Quality Healthcare Delivery in Ghana: Learning from the Meiji and Karela Models

Sen suggests an answer to the question of how to generate funds to finance quality healthcare delivery in a country.⁵² According to Sen, provision of social services like health and education are cheaper in LMICs. Nonetheless, the profits accrued from such ventures because of high patronage brings in more revenue to sustain and to expand those facilities. Thus, initial and continuous investments in health institutions are self-sustaining and have the potential of accruing more income.⁵³ Sen supports this proposal with the examples of the development model of Meiji and Karela as models to counter the assertion of “get rich first” before development.⁵⁴ He explains that Meiji and Karela made health and education a priority at the initial stages of their nation building, in conditions similar or same to the economic strength of LMICs and the result is the standard quality healthcare they enjoy now. For Sen, this is achievable because the high labor

⁵²Amartya Sen, *Development as Freedom* (New York: Random House Inc, 1999), 47.

⁵³ *Ibid.*, 49.

⁵⁴ *Ibid.*

demands within the health sector and the consequent profits that accumulate from services rendered to clients, make the health sector a viable venture on its own. Thus, the health sector is an internal and self-sustaining enterprise financially. It is observed that while the sector gains profit from payments of services it renders on one hand, the payment of health workers and the maintenance of human and material resources is less expensive compared to the monies that are received by the sector on the other hand. Additionally, payment of workers and the maintenance of human and material resources are less expensive in LMICs compared to that of developed countries.⁵⁵

The persuasiveness of Sen's approach of financing quality health delivery could be an adequate answer to Deaton's observation above that lack of resources has always been given as an excuse to lack or inadequate developments in LMICs⁵⁶ and by inference, Ghana. Progressing upon his solution to poverty, Sen further strengthens his position by radically suggesting that there needs to be no excuse in providing quality health delivery in any nation, Ghana inclusive. Urgency and effectiveness of policy formulation and execution should replace bottlenecks in the current situation of healthcare delivery in Ghana for example.⁵⁷ This position of urgency and no excuse is eloquently supported by Ronald Dworkins who argues that if there should be only one need of the human person, it should be quality healthcare.⁵⁸

⁵⁵ Ibid., 48.

⁵⁶ Angus Deaton, "Income, health, and well-being around the world: Evidence from the Gallup World Poll," *The journal of economic perspectives* 22, no.2, (2008): 53-72.

⁵⁷ Amartya Sen, *Development as Freedom* (New York: Random House Inc, 1999), 143.

⁵⁸ Ronald Dworkin "Justice in the Distribution of Health Care," *McGill Law Journal Revue De Droit De McGill Montreal* 38, no. 4 (1993): 885.

Primary Goods and Social Institutions as Basis for Quality Healthcare Delivery in Ghana

In the article, titled “Why are the Poor Less Covered in Ghana’s National Health Insurance: A Critical Analysis of Policy and Practice,” Kontoh and Geest address the issues of weak structures and institutions that perpetuate poverty and destroys the aim of the NHIS to make every Ghanaian enroll.⁵⁹ The stance of Kontoh and Geest is supported by Sen and Rawls’ argument that policies and institutions respectively are fundamental in ensuring equity in spite of limited resources.⁶⁰ Sen in particular uses the Karela and Meiji Health System as paradigm for all lower Middle-Income Countries (LMICs)⁶¹ and by inference, Ghana. One could predict Nussbaum to be saying that the Ghanaian NHIS implementation takes for granted that individuals should enroll because it is a social intervention programme without taking into consideration other factors that motivate or dissuade any citizen from enrolling, such as the broader motivations of individuals provided in the central human capabilities.⁶² Building on Nussbaum, Sen and Rawls’ views, one could imply from Bailey that the majority of the Ghanaian population who are not enrolling in the Scheme are not doing so because the NHIS policy has not taken into consideration the capabilities and asset building of the patients.

Asset building are the steps taken to end systemic poverty or poverty causing factors in a generation.⁶³ In the Ghanaian situation for example, state policies could be targeted at revamping primary production with machinery, financial and technical support. Additionally, health

⁵⁹ Agnes Kotoh, M, Sjaak Der Geest, V., “Why Are the Poor Less Covered in Ghana’s National Health Insurance?” *International journal of Equity in Health* 15, no. 34 (2/25/2016):6-9, <https://doi.org/10.1186/s12939-016-0320-1> accessed on 3/22/2021.

⁶⁰ Amartya Sen, *Development as Freedom* (New York: Random House Inc, 1999), 120, 130.

⁶¹ *Ibid.*, 49.

⁶² Martha Nussbaum, *Creating Capabilities; The Human Development Approach* (Harvard, Harvard University Press, 2011), 33-34.

⁶³ James Bailey, P., *Rethinking Poverty: Income, Assets and the Catholic Social Justice Tradition* (Notre Dame, Indiana: University of Notre Dame Press, 2010), 5, 15.

capabilities in the sense of provision of functional clinics and health personnel should be provided in rural areas. These would empower the poor whose major work is primary production. The empowerment comes when the labor of these rural folks is rewarded through good production and marketing systems that buy their goods and services. By so doing, the poor will be enabled to build their own capabilities through the exercise of their freedom to choose from existing opportunities in quality health delivery in order to function.

The opportunities should be put in place, so that individuals have the freedom to choose from available options to be healthy in order to enjoy other aspects of life such as building of wealth. For example, not all Ghanaians have enrolled in the NHIS because they cannot pay the premium or they are even not aware of enrollment exemptions for the poor. Coupled with this fact is the difficulty in defining who a poor person is in Ghana since the institutions cannot agree on, and do not have the requisite citizen information to do such determinations.⁶⁴ It shows to some extent that though the NHIS is a good policy, the majority of the population that it targeted have not or are not benefitting because their capabilities of freedom and choice are limited by prevailing weak or non-existing corresponding structures and dysfunctional health conditions in Ghana.

In Ghana, whereas the Free Compulsory Senior High School (FCSHS)⁶⁵ policy introduced by the government in 2017 could be considered as one of the major steps reflecting the capabilities approach, similar or more effective policies should be formulated and executed to complement the

⁶⁴ Karima Saleh, *The Health Sector in Ghana: A Comprehensive Assessment* (Washington, DC: World Bank.) Doi 10.1596/978-0-8213-9599-8 License: Creative Commons Attribution CC BY 3.0., **152**.

⁶⁵ Elona Boateng, “Will the Free Compulsory Senior High School Reduce Poverty in Ghana?” *Ashesi Institutional Repository*, (04/2019).

<http://hdl.handle.net/20.500.11988/512> accessed on 02/16/2021. Elona Boateng explains thus, “Several government policies have been implemented in the quest to enhancing educational access in Ghana. A recent one is the free SHS system that was introduced in 2017. The goal of the free SHS system is to reduce poverty by eliminating household need to pay fees for senior high education, especially for the poor who it had been shown are not accessing education because of the costs”.

NHIS where access to health moves from “adaptive preference” to opportunity and choice based. In this way, the citizens will be empowered beyond the minimal threshold of receiving health care to actually accessing health because the facilities are available and the citizens themselves are capable of choosing from the available well-equipped health facilities that provide quality outpatient care through proficient health workers (HWs).

The analysis on the patients and workers expectation, make John Rawls’ theory on primary goods more relevant to the Ghanaian situation. ““Primary social goods” are rights and liberties, opportunities and powers, income and wealth.” Primary goods are those things that should be regulated and distributed by social institutions to ensure individuals well-being.⁶⁶ According to Bailey, “Rawls tends to evaluate the well-being of societies and persons by focusing on the distribution of resources and commodities. For Bailey, Rawls’ famous “difference principle” which states that inequalities will be tolerated only when such inequalities will be to the benefit of the least advantaged, clearly has in mind disparities in income and wealth distribution.⁶⁷ A just society then would be one in which primary and social goods like health are effectively managed by the state to the benefit of all citizens.

⁶⁶ John Rawls, *A Theory of Justice* (Harvard: Harvard University Press, 1971), 92.

⁶⁷ James Patrick Bailey., *Rethinking Poverty: Income, Assets and the Catholic Social Justice Tradition* (Notre Dame, Indiana: University of Notre Dame Press, 2010), 73-74.

Chapter Four

Evaluation and Conclusion

This chapter brings to the fore the summary of the main points expressed in this thesis. It involves some critique of the capabilities approach and this thesis' reflections and stance on steps that calls on individual and group responsibilities to making attainment of quality healthcare a reality in Ghana. These evaluations and conclusions are outlined thematically as follows.

The Capability to be Healthy as a Gradual and Progressive Process

This thesis agrees with Sen that the achievement of the capability to be healthy in Ghana is both a gradual, progressive and urgent process.¹ This thesis therefore could be right to anchor on Rawls' view on "primary and social goods" to argue that the state of healthcare delivery in Ghana could progress from the effective use of "primary goods" as a prudent course of action towards the success of quality healthcare delivery in Ghana. Provision of social amenities like health facilities and accompanying health workers could fall within Rawls' description of primary social goods. It is realised that achieving these provisions and the competent personnel training and distribution is difficult to achieve at this stage of Ghana's development.

It is true that the capabilities approach, capability to be healthy and asset building theories accept the importance of "primary goods" as a means to developing human capital and individual capabilities of opportunities, freedom, choice and functioning. However, the exposition given by

¹Amartya Sen, *Development as Freedom* (New York: Random House Inc, 1999), 49.

this thesis reveals the inherent weaknesses in the Ghanaian healthcare delivery as not reaching the minimal threshold of provision and access to “primary goods” in quality healthcare delivery.

In this way, this thesis proposes a synopsis of “primary goods” and capability to be healthy in the manner of the MDGs where time limits are set for meeting such goals. The aim is for Ghana to strive to attain the standards of “primary and social goods” as immediate concern and use the success story to project and achieve the capability to be healthy as proposed by Sridhar Venkatapuram.² While Ghana should be optimistic about this transitioning process, the pains and sufferings that the poor quality of health delivery bring could be endured or understood as a redemptive suffering.³ Redemptive suffering is suffering for the sake of the divine. Redemptive suffering is doing everything practically possible to change one’s unfavourable conditions with the passage of time. This is where grace and human effort collaborate to ensure the human person’s well-being

Distinguishing the Theories of Right and the Capabilities Approach Towards the Capability to be Healthy in Ghana

In discussing “The Theological Implications of the Capabilities to be Healthy in Ghana”, this thesis has sought to establish that the enjoyment of quality healthcare delivery is the right of each Ghanaian. Nonetheless, the state of quality healthcare in Ghana strives to meet Rawls’

²Sridhar Venkatapuram, *Health Justice* (Cambridge: Polity Press, 2011), 143-145. Venkatapuram’s theory of meta-capability or capability to be healthy is the situation whereby the attainment of quality health leads to achieving other functions of the human person. Access to equitable and quality healthcare therefore, becomes the foundation and centre for all life activities that all theories such as theories of right and the capabilities approaches that pursue the attainment of human dignity advances towards

³ Redemptive suffering is suffering for the sake of the divine or having a higher motivation to pursue the cause of an action for the greater good of humankind and oneself.

“primary goods” theory with the attainment of capability to be healthy as a cherished but a gradual and progressive enterprise to be attained based on the current state of healthcare delivery in Ghana. In Rawls’ theory, health of human persons is deemed as a “natural good” which should be sustained by “social goods” such as the policies that the government formulates and executes to ensure that there is justice in the delivery of quality healthcare, where patients, HWs, government and private institutions like churches, work hand in hand to meet the just health needs of each Ghanaian.⁴

Ghana’s healthcare situation is one in need of urgent progress. This is because, “if people are systematically falling below the threshold in these core areas (like health and the primary goods of Rawls), this should be seen as a situation both unjust and tragic, in need of urgent attention – even if in other respects things are going well.”⁵ Formidable as the concept of ‘right to quality health’ sounds, it seems not to meet the standards set by the capabilities approach’s content and strength in defining and enhancing human dignity so far as quality healthcare is concerned. This comparison and the subsequent superiority of the capability approach to the concept of ‘right to health’ is affirmed by Bernard Williams when he writes,

I am not very happy with taking rights as starting point. The notion of basic human right seems obscure enough, and I would rather come at it from the perspective of basic human capabilities. I would prefer capabilities to do the work, and if we are going to have a language or rhetoric of rights, to have it delivered from them rather than the other way round.⁶

⁴ Martha Nussbaum, *Women and Human Development; The Capabilities Approach* (Cambridge: Cambridge University Press, 2000), 74, 81-82. The emphasis on each Ghanaian is to explain the direction of the CA in attending to the particular needs of each human person as against utilitarian approach of satisfaction of the many but not necessarily all.

⁵ *Ibid.*, 71 (emphasis in bracket mine).

⁶ Bernard Williams as quoted by Martha Nussbaum, in *Creating Capabilities; The Human Development Approach* (Harvard, Harvard University Press, 2011), 97-98.

In agreement with Bernard William, Nussbaum posits that “When we think of health, for example, we should distinguish between the opportunity to be healthy and actual healthy functioning.” Society might provide the health facilities and personnel but we need more than structures to ensure individuals real experience of health that the structures aim to provide.’⁷ Nussbaum could be understood as saying that provision of health facilities in Ghana for example, should be accompanied by policies of affordability, education on health benefits, explanation of packages for the poor and reliable transportation to access such facilities. If these accompanying capabilities are absent, then, the capability to be healthy had not been fully created and the functioning to be healthy will be questionable, since “functioning” depends, and is built on the presence of capabilities. Proceeding in this way, then, the thesis inquiries into presenting a deeper understanding of the capabilities approach and the capability to be healthy as a better model that builds on Rawls’ primary goods and the human right theory.

Some Identified Limitations/Challenges of the Capabilities Approach

However strong that the capabilities approach promises to be, one could admit of a high level of abstraction and some difficulties in its distinction from theories of right. Yet, the two theories of right and capabilities seem to be two sides of the same coin in expressing views towards upholding of the dignity of the individual as a human person.

Moreover, the capabilities approach is not a fully developed theory. The CA is about forty years since its’ birth. This makes one exercise some hesitations or cautions in applying the approach to resolving problems of life such as the health of a nation without risking further harm

⁷ Martha Nussbaum, *Creating Capabilities; The Human Development Approach* (Harvard, Harvard University Press, 2011), 14.

to a possibly already existing sub-standard situation of health. Drawing the line between the capabilities approach taking credit for success or being blamed becomes somewhat a difficult task. One is justified to question when it will become a fully-fledged theory and whether one has strong justification on academic grounds to use the theory?

Finally, this thesis suggests that the capabilities approach could consider not to use “primary goods” as a means to achieving the goals of the capabilities approach but rather to use “primary goods” as an integral concept to the capabilities approach’s success. This is because I observe that it seems difficult to show the difference between capabilities paving the way for functioning in society on one hand and the evidence of primary goods making life better on the other hand. The reality of both approaches seems the same in real life situations. This is particularly striking in LMICs.

A deeper assessment of the Meiji and Karela models of success in health policies could reveal that while capabilities theorists would consider Meiji and Karela’s success story to be the achievement of the capabilities approach, the people on the ground will most likely describe and trace their well-being to the availability and access to “primary goods” such as functional quality facilities and health workers who in turn deliver quality health. Therefore, the capabilities approach needs to broaden its adherents and would be adherents’ view on the relationship between the capabilities approach and the “primary goods.”

For the capabilities approach, the usefulness of the “primary goods” are basically to enhance the recognition of the individual as a person with dignity, ability, agency and freedom to choose the kind of life that enables him/her to achieve what is best for his or her satisfaction in order to be functional in the society. This thesis suggests that there is more to “primary goods” that seem not to have been fully explored by the capabilities approach, hence the capability approach’s

curtailing of this expansive understanding of the “primary good” and subsequently limiting “primary goods” to being just a means to an end. True as that may be, this thesis does not project the capabilities approach as higher than the primary goods since the primary goods are the concrete realisation of what the theoretical underpinnings of the capabilities approach initiates to achieve. Nussbaum’s assertion is apt attestation to the stance of this thesis when she opines that the capabilities approach is a “both and” and not an “either or” approach⁸ to asserting human freedom and dignity of the human person.

The Theological Understanding of Freedom and the Capabilities Approach

The issues at stake in discussing capabilities approach are functions and freedoms and how these two capabilities combine to enhance the dignity of the human person as a sacrament. The capabilities approach does not use the term sacrament in referring to the dignity of the human person. Nonetheless, the tenets of the capabilities approach as enumerated above, point to this fact without equivocation. This comes out fully when one understands the two faces of freedom that the capabilities approach explicates.

In analyzing freedom in relation to capabilities approach, Robert Sugden refers to Sen as proposing the following. That, there is the “freedom to” (positive) and the “freedom from” (negative). “Freedom to” is the obligation and responsibility that one has, to ensure freedom to self and others. This is comparable to or analogous with “positive liberties.” In positive liberties one takes the initiative to exercise freedom because societies play the positive role in ensuring these

⁸ Martha Nussbaum, *Women and Human Development: The Capabilities Approach* (Cambridge: Cambridge University Press, 2000),48,105. The understanding of the principle “Either or” and “both and” as implied from the principle of *multiple realizability* and “culture of relativism” according to Marth Nussbaum.

freedoms so that people are able to act on their own free will. In like manner, “Freedom to” implies the use of available opportunity to achieve one’s function(s). ‘Freedom from’ is the direct opposite of “freedom to.” “Freedom from” can be compared to “negative liberties.” Negative liberties are the freedoms of the individuals not to be interfered with within a particular space” “Freedom from” and “negative liberties” could be explained as the freedom to do as one pleases.⁹ Sugden’s analysis is further strengthened by Adam Okulicz-Kozaryn’s view on the same topic when he observes, that “Sen proposed freedom as a measure of development, and specifically he meant capabilities and functionings, which are not only about “Freedom From,” but also fundamentally about “Freedom To.” We can therefore, infer that, what the capabilities approach espouses is more of “freedom to” rather than “freedom from.”¹⁰ The capabilities approach does this in order to prevent people from becoming victims of selfishness and the presumption of autonomy without restraint. From the analysis of the capabilities approach, freedom is to choose in accord with the precepts of the space¹¹ and ultimately in accord with the will of the supreme creator as the source and end of life. The latter inclusion about supreme creator is the intention of this thesis. Thus, the significance of freedom is attained when freedom is understood and exercised in accordance with responsibility and respect in the vertical and horizontal sense. Vertical in acknowledging the creator and horizontal in giving respect to the human person as an image and likeness of God and possessing the dignity thereof as intended by the creator.

⁹ Isaiah Berlin, Two Types of Liberty, in *Democracy A Reader(2nd)*, eds. Ricardo Blaugh and John Schwarzmantel (Edinburgh: Edinburgh University Press, 2016),111-115.

¹⁰ Adam Okulicz-Kozaryn, “Freedom From and Freedom To’ Across Countries,” *Social Indic Res* (2014):1010,118, DOI 10.1007/s11205-013-0473-x

¹¹ Robert Sugden, “Welfare, Resources, and Capabilities: A Review on Inequality Reexamined by Amartya Sen”, *Journal of Economic Literature*, 31(December 1993), 1947-1962.

Human Dignity, Personal Responsibility and Justice: A Holistic Assessment of Citizens and Institutions Towards and Freedom Capabilities to be Healthy

The human person that we see, touch, hear, smell and encounter is beautiful, the best gift from the creator. It should be our utmost concern to show respect and love in any condition and especially in deprived situations. For ‘whatsoever you do to the least of my brothers or sisters, that you do unto me’ nay my neighbor is any human person in any condition. (cf. Lk. 10:25-37).

Individual responsibility and authentic data on the demographics in Ghana are the beginnings of attaining the determinants of access to quality health in just institutions such as the MOH, GHS and private health providers. It is worth reiterating that quality health should be timely, safe, effective and patient oriented. The patients’ contributions to these quadrilinear determinants resonate with Jesus’ value for statistics in attending to human needs.

In the episode of the feeding of the five thousand, Jesus made the hungry crowd sit in groups of fifty, asked for the number of bread and fish available and asked the disciples to locate the needed bread and fish and collect the surplus afterwards. The bearing of this episode on this thesis is that, in the face of the desperate situation of conformists’ acceptance of quality of health in Ghana and the needed robust and pragmatic solutions, citizens and the mass media must embark on the campaign of authentic statistics on Ghanaians as the starting point to quality health delivery. Citizens are to cooperate in volunteering the right information that positions policy makers to formulate and execute realistic quality healthcare policies. Such a background should lead to policies that always deal with patients as their foremost priority and act with dispatch to indicate that they genuinely have their patients at heart.

Policies also need to give priority to the “tangibles” by ensuring that the physical environment and ambient conditions in the hospitals are visually pleasing, and medical equipment are up to date. Creating such an enabling environment gives the government and policy makers the just voice to implement measures that will enhance service quality (SQ) in the public hospitals to enable them to compete favorably with private health facilities in terms of *tangibles, reliability, responsiveness, assurance and empathy*.¹²

This could be achieved by instituting a regime of tighter monitoring and evaluation procedures that reward productivity and inherently punish non-performance to deal with the general apathy that often characterizes the public healthcare sector. Hence, beyond qualification and long service, remuneration and promotion should be linked to performance to ensure fairness and equity to drive performance.

Finally, Jesus’ question to the infirm by the Pool of Bethesda, “Do you want to be healed,” (cf. Jn 15:1-15) shows that Jesus puts the responsibility of healing foremost to the sick person’s desire to cooperate or challenge the prevailing conditions and to accept grace of healing as a free gift. If all are deemed patients in the World Health Organization’s definition of health, then both the rich, the poor and stakeholders in health and larger policy formulators should answer this question individually and collectively and make their express ‘yes’ answers reflect the lives of all citizens.

¹² See also as conceptualized by Parasuraman et al. (1988, p. 23) for the following explanations: • Tangibles: “Physical facilities, equipment and appearance of personnel”. • Reliability: “Ability to perform promised service dependably and accurately”. • Responsiveness: “Willingness to help customers and provide prompt service”. • Assurance: “Knowledge and courtesy of employees and their ability to inspire trust and confidence”. • Empathy: “Caring, individualized attention the firm provides its customers”).

The aspect of grace calls on religious denominations that provide private health delivery to proceed on continuous and expansive quality health delivery that challenges public health facilities to live up to standards and to make real and practical God's justice as righteousness and giving the sick their due as a priority. For, 'he was bruised for our sins ... and by his wounds we are healed ...' (cf. Isa 53:5). Health Institutions therefore become the sacraments and the sacramentals that present God's face and love to a wounded people and to wounded Ghanaians.¹³ It must be emphasized that one does not need to have a spiritual or a religious reason in her/his approach to attending to the needs of self or the other as far as health is concerned. The trajectory of this thesis has been to give a broad-based understanding and approach of how and why quality healthcare is essential to the human person.

Conclusion

The above analysis of the quality healthcare delivery is done with the view of using the two subjects - ethics and sacramental theology as implied in the capabilities approach and "theology of the body" respectively. These two areas of study were used to expose the weaknesses in the healthcare delivery system in Ghana, and the same subjects were used to illicit solutions based on scripture and contemporary approaches to answering the problems that Ghana faces in attaining quality healthcare delivery. This thesis finds the capabilities approach a useful tool in support of Nussbaum's assertion that, "The capabilities approach – in both its comparative and its normative version – brings moral philosophy into development economics, asks questions about

¹³ See also John Rawls, *A Theory of Justice*, (Harvard: Harvard University Press, 1971), 56. 'that a well-ordered society, therefore, possesses a publicly understood and effectively regulated shared conception of Justice. Justice as righteousness of God and giving to each what their due.

ethical norms and standards of justice by asking people to consider what makes for a minimally just society.”¹⁴ It is therefore, the aim of this thesis to project the capabilities approach and give it an expansive view as a means for others to discover the capabilities approach as a reliable tool in addressing the health needs of Ghana. This thesis deals with the health sector. Other researches can focus on religion, utilities service providers, the economy and education to address the needs of a particular space. It is observed that most policies in Ghana are framed along the lines of primary goods and utility approach theories. This thesis considers that the time is ripe for increased moves to initiate and pursue the capabilities approach to reflect in pragmatic policy formulations and effective execution in the health sector and all other sectors of the country. Hence, the capabilities approach is an approach that basically seeks a true answer to the question, “What a good life will be like?”¹⁵

In Ghana, the thesis suggests that quality healthcare delivery could be the first and one of the sources of a good life for Ghanaians. This could be achieved by dealing with and overcoming the situation where we notice that the government is conceptualizing health care not as a human right but as a means to end: a growing economy. This is the conclusion we draw from analysis and measurement of the role of the government in quality healthcare delivery in Ghana.

Using the capabilities approach therefore, becomes the tool to expose this latent agenda of the government. We then can move on to assert quality health care as a right and a capability contrary to the posture of the government in handling issues of quality health delivery in Ghana. Doing this assessment of quality healthcare delivery in Ghana through the capabilities approach

¹⁴ Martha Nussbaum, *Creating Capabilities; The Human Development Approach* (Harvard, Harvard University Press, 2011), 77.

¹⁵ Robert Sugden, “Welfare, Resources, and Capabilities: A Review on Inequality Reexamined by Amartya Sen,” *Journal of Economic Literature*, 31(December 1993) 1947-1962.

seems an uphill task or an overly demanding of a country which could be described as struggling to meet the health needs of its citizens even at the level of “public health goods” or “primary goods” as described by John Rawls above. And yet, this thesis puts forth this challenge, radical as it may be, for adoption, execution and achievement of capability to be healthy in Ghana. Taking inspiration from the Meiji and Karela model of advancement in health despite their limited resources.¹⁶ It is the thinking of this thesis that the capability to be healthy in Ghana is doable if quality healthcare is reckoned as a priority by all citizens and state institutions.

¹⁶ Amartya Sen, *Development as Freedom* (New York: Random House Inc, 1999), 5-8.

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