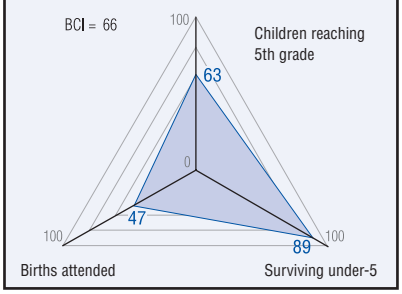
GHANA

No hope for the poor

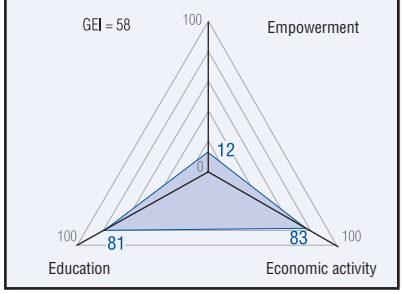
While foreign aid has increased significantly in recent years, it has been erratic and has largely fallen short of expectations. Nevertheless, dependence on this aid has been growing, as the domestic share in development spending becomes ever smaller. At the same time, domestic resource mobilization has largely focused on taxation, leading to a disproportionate burden on women and the poor.

Ghana Social Watch Coalition

Basic Capabilities Index (BCI)



Gender Equity Index (GEI)



Every country must commit to the disadvantaged by having a social development policy that promotes universal and equitable access to a minimum set of social services and resources. This ensures long-term improvements in the living standards of both women and men in the society.

In Ghana, there is a recognized basket of social provision. This includes access to water and sanitation, universal tuition-free basic education for all citizens, and primary health care. Other basic social services are food security, social security (such as pensions), housing, and economic services such as energy and transport infrastructure. A more comprehensive approach to social security must include access to a minimum level of income for all citizens of working age and all families (The Women's Manifesto for Ghana, 2004). Thus a good social security system must provide protection against basic income loss in cases of illness and injury, old age and retirement, invalidity, and family responsibilities such as pregnancy and child care. Such benefits are important especially for women, given the particular inequalities and disadvantages they experience. This paper attempts to examine Ghana's social security system from a historical and gender analytical perspective to identify challenges and options. It traces the system's historical development and addresses the current attempts at privatizing the sector and its implications for women.

Women, a majority of the informal sector

The country has a working population of nine million, with women accounting for 51% of the total. The formal economy employs about 13.7% of the labour force aged between 15 and 64, while the remaining 86.3% work in the informal economy – divided between 52% in agriculture and 34.3% in non-agricultural activities (ILO, 2003). Women constitute 77% of the informal sector, and engage in both agricultural and non-agricultural activities. Informal trading is a major source of employment for many Ghanaians, especially those in the urban centres: there are 1.9 million households operating 2.3 million small businesses, and women operate over 66% of these small businesses. Over 56% of all non-farm enterprises are engaged in some trading activity, 24% in manufacturing, and the remainder in other activities (ILO, 2003).

Clearly, the vast majority of workers in Ghana are in the informal economy. Yet only 10% of the workforce, mainly those in the formal sector, benefit from social security (SSNIT, 2005). As a result, workers in the informal economy, most of whom are women, have no social security coverage. This is in spite of the fact that membership in the Social Security and National Insurance Trust (SSNIT) is supposed to be open to all who work in the informal economy, on a voluntary basis.

The history of social security

Before the introduction of a formal social security system in Ghana, the extended family system served as a source of social protection and a cohesive unit that provided security for vulnerable groups. But as Kumado and Gockel (2003) have noted, the advent of colonization changed this traditional system as men moved into employment centres to work in the mines, cocoa farms or the civil service. Women were virtually left on their own to engage in food production to sustain household members. The government and some private sector operators then introduced private social security schemes aimed at providing wage earners who were mainly men with some form of social protection.

The Compulsory Savings Act of 1961 sought to provide pensions for formal sector workers. The scheme created, however, collapsed through gross mismanagement. A more comprehensive social security system was subsequently introduced through the Social Security Act (Act 279) passed by the First Republican Parliament in 1965. The Act fixed the retirement age at 60 years for men and 55 years for women. It further established a Social Security Fund for the provision of superannuation, invalidity, death/survivors, emigration and unemployment benefits. It also provided for the payment of lump sums or what is known as the 'Provident Fund'. In terms of contributions to financing the scheme, workers were to contribute 5% of their monthly basic income while employers were to add 12.5%.

Weaknesses in the social security scheme adopted in 1965 were rectified through National Redemption Council Decree (NRCD) 127 of 1972. Under it, the SSNIT was established as an independent corporate body to administer the scheme. The retirement age was reduced from 60 to 55 years for men and 55 to 50 for women. The lump sum payment to retired workers was retained. The scheme also provided for coverage for up to five employees.

In 1991, the government of the Provisional National Defence Council (PNDC) repealed the 1972 social security decree, NRCD 127, and replaced the scheme then in place through PNDC Law 247 which was an attempt to redress the major defects of the provident fund scheme. Therefore, the main thrust was the conversion of the system from the payment of lump sum benefits into a pension scheme under which monthly payments would be made to members until death. Benefits enjoyed under this law are superannuation/old age pension, death/survivors benefits and invalidity benefits. The scheme is supposed to be open to all classes of employees in both the formal and informal economy.

As a result of the inadequacies in the social security system's coverage of the working population, the majority of Ghanaians have continued to rely on informal social security schemes such as social networks, trades associations, credit unions and remittances to meet their social security needs. These schemes oblige individuals, groups and

communities to offer mutual support through the pooling of resources based on their own principles of insurance to extend help to each other within certain basic regulatory conditions. Such self-financed initiatives are essentially based on trust and the capacity of the group to manage the scheme. Informal social security schemes are the main sources of security for the poor, allowing them to continue to meet contingencies such as care and support for children, the aged and the disabled. However, there have been major changes in the form of mutual aid based on social networks, resulting in low well-being outcomes for the poor across all age groups. This is evidenced by health-related problems like malnutrition, livelihood stress, and the detention of newborns in maternity wards pending the payment of hospital bills.

TABLE 1. Contributions payable by social groups in the informal sector

Name of group		Who they are	Minimum contributions payable annually (USD 1 = GHC 9,000)
Core poor	A	Unemployed adults without any identifiable support for survival	Free
Very poor	B	Unemployed but with identifiable financial support from sources of low income	GHC 72,000
Poor	C	Employed adults with low income and unable to meet their basic needs	GHC 72,000
Middle income	D	Employed adults who are able to meet their basic needs	GHC 180,000
Rich	E	Adults who are able to meet their basic needs and some of their wants	GHC 480,000
Very rich	F	Adults who are able to meet their needs and most of their wants	GHC 480,000

Source: Government of Ghana, <www.ghanaweb.com/GhanaHomePage/documents/NHIS.pdf>

The National Health Insurance Scheme

In 2004 the government unilaterally decided to use 2.5% of workers' SSNIT contributions to establish what it called the National Health Insurance Scheme (NHIS).[1] The NHIS was created to replace the 'cash and carry' system, based on the principle that the inability to pay the costs incurred at the point of service should not prevent access to health care services. While three types of insurance schemes were available under the law – district-wide mutual health insurance, private mutual health insurance and private commercial health insurance – the government opted for a district mutual health insurance scheme throughout all 138 districts in Ghana. Contributions are based on the ability to pay, and workers in the informal economy have been categorized into social groups to enable individuals within each category to pay according to what they can afford.

Women who were interviewed for a recent study (Akakpo, 2006) fell within categories B and C, which means they are either 'poor' or 'very poor' and are only able to pay the lowest premiums (see Table 1). It is the right of every citizen to have equal access to good health care, but there are reports of differential treatment given to NHIS card-holding patients and non-card-holding patients at hospitals. For example, because the women sampled fell within the category with the lowest paid premium, they were hardly ever given medicines, and instead were given prescriptions to buy them on their own.

Privatization of social security

Women have largely not benefited from Ghana's social security system because of the large proportion of them employed in the informal sector, which is mostly not covered by the system. Yet even beneficiaries in the formal sector have complained about the inadequacy of monthly pensions and their inability to meet the basic necessities of life. Such concerns prompted the government to set up a Presidential Commission on Pensions in 2004. The Commission was to examine existing pension arrangements and to make appropriate recommendations for a sustainable pension scheme to ensure retirement income security for workers, especially those in the public sector.

The Commission proposed a three-tier pension structure, comprising two mandatory schemes and a voluntary scheme. They suggested that the SSNIT should be restructured to implement a mandatory State Social Security Pension Scheme, which would pay only periodic monthly and other pension benefits. With regard to the second tier, the commission recommended a mandatory privately managed occupational pension scheme, preferably a defined contribution pension scheme with payments mainly in the form of lump sum benefits. Finally the commission suggested a third tier which would be a voluntary, privately managed personal pension scheme offering attractive tax incentives (Government of Ghana, 2006).

The government issued a White Paper on 25 August 2006, virtually accepting all the recommendations made by the Commission without questioning any aspect of the report.

The challenge: higher pensions and inclusion

A recent study by the Research and Policy Department of the Ghana Trades Union Congress (GTUC, 2006) revealed that salaries in Ghana are lower than those in numerous countries in Sub-Saharan Africa with the same level of economic development.

One of the implications of the low salaries in Ghana is the poor pensions paid to retirees. Currently, the lowest pension that SSNIT pays is GHC 182,000 (USD 20.50) per month, while the highest is GHC 14.9 million (USD 1,675) per month.[2] Thus pensions are not only low, but their distribution also favours very few people, primarily men in the formal economy. The proposed 'multi-pillar system' will not address these shortcomings; on the contrary, it will worsen disparities and exclude many more, especially women, from enjoying social security.

In terms of the distribution of pensioners by gender, of the 66,971 SSNIT pensioners at the end of 2004, only 7,326 (11%) were women (SSNIT, 2005). Furthermore, despite the launching of an informal sector retirement scheme in June 2005, by the end of the year only 13,577 informal economy workers were registered with the SSNIT (6,577 who had signed on under the new scheme, together with roughly 7,000 volunteer contributors), as compared to 898,368 formal sector contributors (SSNIT, 2005). This underscores the need for a more comprehensive scheme to address the needs of both men and women in both the formal and informal sectors.

The three-tier approach which the Pensions' Commission has recommended to the government is basically the World Bank's template for managing pensions through scaling down public schemes. The privatization of pensions will create an opportunity for a very few private individuals to access cheap funds at the expense of the majority of citizens. Already a number of US firms are advertising their private pension schemes in Ghana. This approach has failed in Latin America (Bakvis, 2005) and is unlikely to work here. Once the money goes into private funds, the government would be deprived of resources to invest in social services. Women's socioeconomic well-being in particular would be sacrificed, especially in terms of their ability to access affordable health care, safe drinking water and improved energy technologies.

Research by the International Confederation of Free Trade Unions (ICFTU) has shown that the 'multi-pillar' system results in lower benefits for retirees, partly due to the extremely high administrative costs for private accounts encouraged by banks. Also, the fiscal cost of diverting contributions away from public pensions into mandatory private funds puts pressure on governments to reduce spending on other public services.

Clearly, a different national social security system that addresses issues of inequality, and specifically targets women and other disadvantaged groups, is what is needed to ensure a minimum lifeline provision for the poor and marginalized in rural and urban communities in Ghana. ■

1 <www.ghanaweb.com/GhanaHomePage/education/artikel.php?ID=41469>

2 Figures as of April 2007. <www.ssnit.com/Details_news_ssnit.cfm?EmpID=146&departmentId=1>

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The Committee underlined many of the reforms which Canadian groups have long sought including: social assistance at levels adequate for a decent standard of living, increases in minimum wages, assured access to employment insurance benefits and measures addressing food insecurity, hunger, homelessness and inadequate housing (NAPO, 2006).

A national anti-poverty strategy might embody these steps. Twelve years after Copenhagen, Canadians still await it. ■

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CANADA

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The Ontario provincial government recently introduced an Ontario Child Benefit.

It is not yet possible to tell whether the Newfoundland and Quebec initiatives will lead either to a cross-country provincial competition at raising the bar of social support and/or to a national anti-poverty strategy.

When Canada appeared before the ICESCR Committee in 2006, the Committee expressed particular concern that amid such a prosperous country, 11.2% of Canadians remained in poverty, including many First Nations, immigrants, women, single mothers and disabled Canadians. Clearly Canada had continued to fail to fulfil its obligations to adequacy of social supports.

Most worrying was the Committee's assessment that Canadian governments treated rights such as the right to adequate social assistance and the right to adequate health care as "principles and programmatic objectives rather than legal obligations." It noted that enforcement mechanisms for these rights were lacking and that governments argue before courts against including Covenant rights among those protected by the Constitution's Charter of Rights and Freedoms.

FRANCE

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In March 2007, the Conference on Social Security in Health in Developing Countries took place in Paris. This event, which was organized as a French initiative, developed on the reflections of the eight wealthiest countries in the world (G8) from St. Petersburg in 2006 which called for "an acceleration in international discussions on the practical approaches that permit public, private and community based health insurance coverage in developing countries." We hope that this French initiative is a first step towards rebalancing multilateral and bilateral aid in the health sector, and the benefit of the reinforcement of French actions in the improvement of health systems. ■

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KENYA

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The National Food Policy of 1980 built on the need for prudent and focused land reform policy as a requisite for achieving a food-secure nation. Sessional Paper No. 1 of 1986 on Economic Management for Renewed Growth, the Household Food Security and Nutrition Policy of 1988, as well as the National Development Plan 1984-1988, all recognized the need to limit the misuse of land. Through Sessional Paper No. 1 of 1986, the government expressed its intention to establish a National Land Commission to review land tenure, land-use practices and legislation. This came to naught.

The government came to recognize that although food may be available nationally, it may not be accessible at the household level (GoK, 1988).[2] Many factors were acknowledged to be responsible for this situation, not least among them the fact that a significant proportion of the Kenyan population is malnourished as a consequence of inequalities in the distribution of land resources, income inequalities, seasonal food shortages and lack of education and awareness.

2 See also Sessional Paper No. 1 of 1986.