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Poverty as a Hindrance to Accessing Quality Healthcare in Ghana: A Theological and Pastoral Reflection

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ABSTRACT

Access to quality healthcare is a key requirement in every modern society. In developed countries, majority of the populace has access to quality and affordable healthcare. However, in developing countries such as Ghana, hospitals with quality infrastructure, healthcare equipment, drugs, and well-trained health practitioners are limited and expensive to access. Given the significant number of people living in extreme poverty in Ghana, it is not surprising that many people experience deterioration in their health and eventually die due to the inability to access and/or afford quality healthcare. In the current situation, where economic hardship keeps increasing in the country, there is a need to engage in a discussion on how healthcare can be made available and affordable to people of all economic classes. The purpose of this paper, therefore, is to assess the limitations that poverty places on people in their quest to access healthcare and offer solutions from theological and pastoral perspectives. This paper employed qualitative and historical descriptive research designs to describe the current state of affairs of the impact that poverty has on access to health care in Ghana. The paper used data collected from secondary sources such as books, journal articles and dissertations. After a careful analysis of the subject matter from the Ghanaian and biblical perspectives, the paper made recommendations for the nation (Ghana), the church, and all stakeholders to contribute to the provision of quality, accessible, and affordable healthcare for all irrespective of one's financial background or economic status.

Keywords: *Poverty, Hindrance, Quality Health, Ghana*

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INTRODUCTION

The advancement in technology in the last and present centuries has yielded improvement in healthcare delivery. Today, diseases which used to have no cure in the past can be treated effectively through advanced medical care. While this is good news, many people continue to suffer from minor diseases and die, due to the high cost of healthcare. This is especially so in developing countries where hospitals with quality infrastructure, healthcare equipment, drugs, and well-trained health practitioners are limited and expensive to access. Since better hospitals, drugs, and health practitioners are few in these countries, quality health care is very expensive, and consequently, only a few people who are financially sound are able to access it. In such a context, poverty, therefore, becomes a hindrance to accessingquality health care, and hence poses a great threat to one's existence.

According to the World Health Organization (WHO), health does not merely mean the absence of disease or sickness, but it is also a complete state of mental, social and physical well-being.[1] Health can also be described as the ideal perfect physical, psychological and social condition, not compromising on the absence of sickness.[2] Therefore, a person who is not in sound mind, unable to provide for social needs, and has a deterioration in physical well-being is unhealthy, and can be concluded that a person in extreme poverty is unhealthy.

Ghana (the context of this study) is a West African country where hospitals with quality infrastructure, healthcare equipment, drugs and well-trained health practitioners are limited and unaffordable. Many people die due to their inability to afford quality healthcare. In a predominantly Christian-dominated society like Ghana, such a situation calls for concern, especially against the backdrop of God's concern for the poor and the marginalized evident in the Judeo-Christian Scriptures. This paper, therefore, examines the limitations that poverty places on people in their quest to access quality healthcare and offers theological and pastoral directions to avert the situation.

METHODOLOGY

This study employed a literature-based qualitative research design, to explore how poverty serves as a hindrance to accessing quality healthcare in Ghana. The methodology integrated thematic analysis to systematically review and interpret existing literature, providing a comprehensive understanding of the intersection between poverty, healthcare access, and theological perspectives. The data for this study was derived from both primary and secondary sources including journal articles, theses/dissertations, magazines, books, reports and publications, among other sources. The literature selected for this study focused on Ghana and provided relevant comparisons to similar contexts and addresses the themes of poverty, healthcare access, and theological/pastoral responses.

PRESENTATION OF FINDINGS AND DISCUSSION

Historical Overview of the Health Care System in Ghana

The development of the modern healthcare system in Ghana can be categorized into three phases. The first phase (1471-1844) brought about the establishment of biomedicine. This new development was solely preserved for the colonial masters. They established it to protect themselves against the contraction of infectious diseases from supposed unhygienic conditions of the natives, because of the numerous interactions they had with them.[3] According to Micheal Dummett, it was the sole prerogative of the missionaries in the era before independence to fund healthcare, thus they were much involved in the provision of healthcare in that period.[4]

The second phase of the development of the modern health system in Ghana was pronounced by the 1844 bond, which was signed between the British and some Ghanaian local chiefs. The bond helped in the realization of the colonial masters the need to improve the healthcare of the natives.[5] This development fueled the expansion of some health facilities, equipment and drugs, and increased the employment of health practitioners.

The third phase began in 1868, when hospitals were built in Cape Coast and dispensaries in rural communities. In 1923, the first national hospital; the Korle Bu Teaching Hospital, was built to serve the health needs of Ghanaians.[6] Healthcare services in the colonial days were characterized by massive discrimination against the natives and some health workers in colonialism period. This brought about the prioritization of welfare and social service, as a consequence of the annihilating effect of the colonial era on the health system prior to the independence in 1957.[7] It was the first time the national government

[1] Jacob Novignon et al., "Health and Vulnerability to Poverty in Ghana: Evidence from the Ghana Living Standards Survey Round 5," *Health Economics Review* 2 (2012): 1–9.
[2] Prince Osei-Wusu Adjei, "The Impact of Poverty on the Health of Rural Communities in Ghana: A Case Study of the Amansie West District, Ashanti Region" (Kwame Nkrumah University of Science and Technology, 2008), 48-60, 47.
[3] Prince Boakye Frimpong, "The Quest for Equity in the Provision of Health Care in Ghana," *African Review of Economics and Finance* 4, no. 2 (2013): 254–72, 257.
[4] Frimpong, "The Quest for Equity in the Provision of Health Care in Ghana,"257.
[5] Frimpong, "The Quest for Equity in the Provision of Health Care in Ghana,"257.
[6] Frimpong, "The Quest for Equity in the Provision of Health Care in Ghana,"258.
[7] Frimpong, "The Quest for Equity in the Provision of Health Care in Ghana,"258.

renewed the health sector by training a huge number of health workers, and modernizing health facilities. Unlike before, Ghanaians were able to enjoy state-financed healthcare in government hospitals, health centers, and pharmacies. Between 1957 and 1963, the number of health centers increased from 1.0% to 41% and 31% of the government budget of 144 million pounds catered for social services with much attention to the health sector.[8] These statistics show that the government used a higher proportion of its budget in healthcare, and human resource development compared to other departments.

Since Ghana's independence in 1960, there have been some improvements in the health of Ghanaians. The infant mortality rate dropped from 133 deaths per 1,000 live births in 1957 to 57 deaths per 1,000 live births in 1988, and under the age of 5 mortality rate decreased from 154 deaths per 1,000 live births in 1957 to 110 deaths per 1,000 live births in 1988.[9] Notwithstanding the improvements, the Health Ministry held the view that, rates of change had been slow because the rate that prevailed at that time was far from what was desirable. In February 2003, the Ghana Health Service was launched officially. Although the Ghana Health Service was placed under the administrative supervision of the Ministry of Health (MoH), its staff were and are no longer civil servants; this mode of operation allowed for more flexibility in its management. There was the expansion of the health sector to include government health services; private, traditional, and nongovernmental providers; civil society; and community groups.[10] Between 1990 and 2005, there was a reduction in maternal rate from 740 per 100,000 live births. Again, the WHO reported that maternal mortality in Ghana was reduced from 634 per 100,000 live births in 1990 to 319 per 100,000 live births in 2015.[11] A good account of the history of Ghana's health delivery system cannot be given without the mention of the "Cash and Carry" system that operated in the 1990s and early 2000s.[12] In the "Cash and Carry" system, patients were required to make a deposit of the cost of the medical services before treatment commenced. This system erected obstacles for many vulnerable and extremely poor people to access healthcare, though they needed it the most.

Around 2004 and 2005, about 35 percent of Ghanaians were living in extreme poverty, which as a result limited their access to a formal healthcare system, which increased mortality rates for infectious and parasitic diseases and infant mortality rate of 86 per 1,000 live births.[13] Since many Ghanaians were unable to afford the necessary fees for healthcare services and medical attention, they were not encouraged to go to hospitals, instead, they engaged in self-medication fueling the higher mortality rate and increase in infectious diseases.

The obvious demerits of the "Cash and Carry" system informed the passing into law the National Health Insurance Scheme (NHIS) bill in 2003. Under the National Health Insurance (NHI) Act (in 2003), under which affordable healthcare services were to be provided for all Ghanaian citizens irrespective of their ability to pay.[14] This system helped minimize the financial barriers of Ghanaians who were vulnerable and poor to be able to seek medical attention unlike before. For the less privileged Ghanaian to be able to access quality health services, the government initiated and passed the National Health Insurance Law 2003 (Act 650) and the National Health Insurance Regulation, 2004 (L.I. 1809) which was to abolish the Cash and Carry system at health service delivery.[15] The NHIS system was fully implemented nationwide by 2005 and has been in operation to date (2023). This system requires that all adults in Ghana who are 18 years and above enroll in the NHIS and pay premiums that range from the equivalent of $2.50 to $50.00 annually from 2005, which will depend on each enrollee's financial and employment status. The scheme provides coverage for children under 18 years and younger without paying premiums once the child's parent is fully registered in the NHIS program. Vulnerable, extremely poor pregnant women and

[8] Frimpong, "The Quest for Equity in the Provision of Health Care in Ghana,"258.
[9] Ghana Statistical Service, *Ghana Living Standards Survey (GLSS)* 7 (Accra: Ghana Statistical Service, 2019), 2-15, 7.
[10] Ghana Statistical Service, *Ghana Living Standards Survey (GLSS)* (Accra: Ghana Statistical Service, 2019), 2-15, 7.
[11] University of Ghana, *School of Public Health.* (Accra: University of Ghana, 2018), 1-8.
[12] Abdallah Ibrahim et al., "Perinatal Mortality among Infants Born during Health User-Fees (Cash & Carry) and the National Health Insurance Scheme (NHIS) Eras in Ghana: A Cross-Sectional Study," *BMC Pregnancy and Childbirth* 16, no. 1 (December 8, 2016): 385, https://doi.org/10.1186/s12884-016-1179-2.
[13] Jennifer L Singleton, "Negotiating Change: An Analysis of the Origins of Ghana's National Health Insurance Act," *Sociology Honors Projects* 4 (2006), 3.
[14] Singleton, "Negotiating Change: An Analysis of the Origins of Ghana's National Health Insurance Act," 3.
[15] Frimpong, "The Quest for Equity in the Provision of Health Care in Ghana,"259.

the aged (70 years or above) are also provided free coverage under the NHIS to enable them to enjoy healthcare services.[16]

The NHIS has been in operation in Ghana for two decades now, providing support for those in extreme poverty, vulnerable, and less privileged. It has benefited the citizenry for years, yet without challenges. However, the report from Ghana Living Standards shows that, out of 77.0 percent of the population who have registered in the NHIS scheme, only 44.9 percent are currently covered.[17] Consequently, it is frequently reported in news outlets and social media how hospitals refuse to render services to NHIS card holders. The reason being that, there is a shortage of NHIS premium coverage drugs arias unsettled by the government, and renewal of NHIS card challenges after its validity is exceeded. Obviously, though the NHIS is beneficial, it has not totally irradicated the challenges those in extreme poverty face in accessing quality healthcare.

The historical survey conducted above shows that Ghana's health delivery system has undergone key changes from colonial era through to the post-colonial era, with each change yielding some results and accumulating up to today. Yet (as indicated above), there are still challenges with Ghana's health delivery system and the poor are those who in most cases affected by these challenges. The following section outlines the health effects of poverty on the poor.

Poverty Factors Influencing Health

Poverty influences people's decisions about their health. It actually affects people's well-being. In this section, the paper examines key factors that affect the health of the poor.

Poverty, Nutrition and Health

Many factors influencing the health of an individual include nutritious food, clean water, hygienic disposal of human waste, adequate clothing and shelter. Unfortunately, many developing countries are faced with hunger and malnutrition problems.[18] Nutrition has to do with the organic process of nourishing or being nourished; the process by which an organism assimilates food and uses it for growth and maintenance. A number of epidemiological studies have shown that the human diet is associated with the risk of contracting a number of chronic diseases, such as cardiovascular diseases, cancer, and diabetes, to mention but a few.[19] According to WHO, nearly 800 million people in developing countries are chronically hungry, many of them live in conflict areas, and over 60 percent of them are women.[20] Again, Nutrition and Health Researchers have unveiled that pre-natal and post-natal nutrition influence the risk of developing chronic degenerative diseases, whereas nutritionally-mediated intrauterine growth retardation may permanently impair the development of immune function.[21]

It is estimated that iodine deficiency is the biggest single preventable cause of brain damage and mental retardation, iron deficiency anemia is second among the causes of disability and may be a factor that contributes to 20 percent of maternal deaths, and vitamin A deficiency causes irreversible blindness and deaths among million children every year.[22] Again, sixty percent of annual deaths among children under five are as a result of being underweight, while 161 million children are stunted in their linear growth.[23] All these statistics show how poverty is a hindrance to accessing good health care and good nutrition, a lot of people who are extremely poor are vulnerable to a lot of diseases and health insecurity.

Poverty, Housing, Pollution and Health

One of the crucial factors in developing every economy is housing. In Ghana, about 58 percent of households live in compound houses with 28 percent living in separate houses. For example, in the Greater

[16] Ibrahim et al., "Perinatal Mortality among Infants Born during Health User-Fees (Cash & Carry) and the National Health Insurance Scheme (NHIS) Eras in Ghana: A Cross-Sectional Study," 1-8.
[17] Ghana Statistical Service, *Ghana Living Standards Survey (GLSS)*, 2-15.
[18] World Health Organization, *DAC Guidelines and Reference Series Poverty and Health* (OECD Publishing, 2003), 55.
[19] Jaouad Bouayed and Torsten Bohn, *Nutrition, Well-Being and Health* (BoD–Books on Demand, 2012), 1-5.
[20] World Health Organization, *DAC Guidelines and Reference Series Poverty and Health*, 56.
[21] Osei-Wusu Adjei, "The Impact of Poverty on the Health of Rural Communities in Ghana: A Case Study of the Amansie West District, Ashanti Region," 50-51.
[22] World Health Organization, *DAC Guidelines and Reference Series Poverty and Health*, 57.
[23] World Health Organization, *DAC Guidelines and Reference Series Poverty and Health*, 57.

Accra Region, close to three-quarters of households live in compound houses.[24] Again, just over 3 percent live in flats and apartments,1.2 percent reside in kiosks/containers and 0.5 percent live in huts on different compounds. Some of the relevant health treatments to be found in homes include; lack of hygiene and sanitation equipment, overcrowding, humidity, noise, inadequate ventilation, indoor temperature, asbestos and home safety equipment, all of which affect mental, physical and social health.[25] According to the United Nations Commission on Human Settlement (UNCHS) Global Report on Human Settlements 1996, individuals and households who lack safe water, secure and healthy housing with required infrastructure such as pipe borne water, adequate sanitation, provision of drainage and removal of household waste could have poor health.[26] People residing in poor housing conditions are prone to a wide range of health conditions such as respiratory infections, asthma, lead poisoning, injuries, and mental health.[27]

Over 90 percent of the population in sub-Sahara Africa live in unhygienic areas with a significant risk of contracting malaria and around 75 percent live in high-risk areas.[28] Poor people in their homes are often subjected to the exposure of toxic pollutants from sources including waste disposal sites and incinerators, poor housing and health status increase one's vulnerability to the impact of toxic chemicals.[29] Both indoors and outdoors air pollution is a major problem in relation to the health of poor people. Extreme poverty leads to a dependence on cheap traditional fuels for cooking and heating, for example, the use of stoves fueled by kerosene and the use of charcoal to fuel coal pots which combines with unventilated and overcrowded accommodation to cause indoor pollution. In the urban areas, poor people live close to highly polluting industries and transport networks which worsens air pollution implications and thereby improves ill health.

Poverty, Health Education and Health

The concept of health education has been around since the beginning of humanity. Arguably, in the pre-historic era, a person who ate a particular herb and became ill would then warn (educate) others against eating the same herb. If the herb helped the person too, then the entire community would be encouraged to use it. This is a form of health education which also finds expression in the Pentateuch. God gave the Israelites some specific health education that prevented them from infectious diseases, and protected them from contracting those diseases from their neighbours. For example, in Leviticus 14:1ff, God told Moses to consider people with infectious skin diseases unclean and they should be taken outside the camp by the priest for examination and remain there till the disease is completely healed before coming back into the camp. This idea was to prevent others from contracting the skin disease. Again, in Deuteronomy 23:13 God instructed the Israelites to have digging equipment among their tools so that they may be able to dig a hole to cover up their excretion as a sign of holiness, since God is moving among them. It was not only a sign of holiness but also to improve their health and sign of cleanliness.

To reduce poverty and improve healthy living, health education is very important. Yet, in many developing countries, the lack of investments in education has left the sector in a very weak condition. Again, inadequate infrastructure, lack of learning and teaching materials, inadequate training of teachers, and lack of teachers' motivation have contributed to the failure of the sector.[30] Presumably, a higher level of education potentially has an impact on nutrition, hygiene, and house management which improve health and minimize ill health.[31] Extreme poverty on the other hand leads to limited access to higher-level education which negatively affects the health status of the poor, education can said to be an asset in

[24] Ghana Statistical Service, *Ghana Living Standards Survey (GLSS)*, 2-15.
[25] Xavier Bonnefoy, "Inadequate Housing and Health: An Overview," *International Journal of Environment and Pollution* 30, no. 3–4 (2007): 411–29, 420.
[26] Osei-Wusu Adjei, "The Impact of Poverty on the Health of Rural Communities in Ghana: A Case Study of the Amansie West District, Ashanti Region," 57.
[27] Osei-Wusu Adjei, "The Impact of Poverty on the Health of Rural Communities in Ghana: A Case Study of the Amansie West District, Ashanti Region," 58.
[28] Gerald Bloom, Henry Lucas, and Adebiye Edun, *Health and Poverty in Sub-Saharan Africa*, vol. 103 (Institute of Development Studies, 2000), 10-12, 10.
[29] World Health Organization, *DAC Guidelines and Reference Series Poverty and Health*, 58.
[30] World Health Organization, *DAC Guidelines and Reference Series Poverty and Health*, 54-55.
[31] Osei-Wusu Adjei, "The Impact of Poverty on the Health of Rural Communities in Ghana: A Case Study of the Amansie West District, Ashanti Region," 53.

overcoming poverty, increasing income, and improving health and nutrition which reduces ill health.[32] Health education is very crucial and therefore should be taken to the doorsteps of the people. Seven major settings that are relevant to contemporary health education include; schools, communities, worksites, healthcare centers, homes, marketplaces and communication environments (media outlets).[33]

Poverty, Lifestyle and Health

Extreme poverty has led a lot of people to different categories of lifestyles, with the idea of trying to escape from poverty or minimizing the emotional trauma poverty has caused. These attempts and actions in many instances have resulted in ill health and an increase in the death rate. Extreme poverty may lead to drug abuse. Tobacco and alcohol are legal drugs that cause particular concern. In Ghana, both drugs are widely abused and in worse cases the abuse of marijuana (weed) and tramadol by people attempting to escape their everyday problems. For years, it has been revealed that the use of tobacco, marijuana and alcohol is rife in lower socio-economic societies, compared to higher socio-economic societies with adequate levels of education. The use of these drugs is highly common among the unemployed, uneducated, poor, as well as people living alone.

In Ghana, smoking is common among older people, those with traditional beliefs, those with low educational background, and the unemployed. It is estimated that about 16.6 percent of tobacco smokers and 8.1 percent of no-smokers in the Kassena-Nankana districts of Northern Ghana, died from respiratory diseases, and 10.7 percent of smokers died from cardiovascular disease compared to 10.6 of non-smokers.[34] The adaptation of the lifestyle of an increase in alcoholism and drugs which are negative consequences is driven by the conditions of unemployment. Alcohol and tobacco use may lead to major health risks when used alone or together. In addition to traumatic death and injury, alcohol is associated with chronic liver disease, cancers, cardiovascular disease, acute alcohol poisoning, and fetal alcohol syndrome. Smoking on the other hand is associated with lung disease, cancers, and cardiovascular disease. These substances might be extremely dangerous when they are used together.[35] Another lifestyle that is common among women as a result of extreme poverty is street prostitution. Street prostitution is intrinsically related to poverty. Prostitution is an institutionalized form of the sex industry. Through prostitution, one may contract such diseases and infections as HIV and AIDS.

Poverty, Accessibility and Affordability of Health Care

Lack of financial resources can be a barrier to accessing healthcare services, when healthcare is urgently needed and it is delayed or not delivered, it makes health issues worse and increases healthcare costs.[36] The availability of access and utilization of healthcare facilities minimizes ill health and reduces the level of death rate. For example, nursing mothers who access pre-natal and ante-natal care from health facilities and health professionals stand the chance of improving their health conditions and that of their children. People in extreme poverty living in rural and isolated communities lack quality health care.[37] In addition, factors such as geographical accessibility, availability, financial accessibility, and acceptability may become barriers to the accessibility and affordability of health care.[38] A survey by the Institute of Development Studies (IDS) revealed that in the Jasikan District of Ghana, distance plays a significant role in accessing and utilizing health care services in the district. It was found out in the survey that, ¾ of all registered patients come from approximately four miles before getting access to health care services in the

[32] Osei-Wusu Adjei, "The Impact of Poverty on the Health of Rural Communities in Ghana: A Case Study of the Amansie West District, Ashanti Region," 55.
[33] Catherine A Heaney et al., "Health Behavior and Health Education: Theory, Research, and Practice," *American Psychological Association* (Jossey-Bass, Washington, DC, USA, 2008), 8.
[34] Philip Ayizem Dalinjong et al., "A Retrospective Analysis of the Association between Tobacco Smoking and Deaths from Respiratory and Cardiovascular Diseases in the Kassena-Nankana Districts of Northern Ghana," *Tobacco Induced Diseases* 13, no. 1 (December 26, 2015): 12, https://doi.org/10.1186/s12971-015-0037-8.
[35] United States of America, *Department of Health and Human Services. Alcohol Alert 71* (Washington D.C.: US Department of Health and Human Services, 2007), 1-5, 3.
[36] David H Peters et al., "Poverty and Access to Health Care in Developing Countries," *Annals of the New York Academy of Sciences* 1136, no. 1 (2008): 161.
[37] Osei-Wusu Adjei, "The Impact of Poverty on the Health of Rural Communities in Ghana: A Case Study of the Amansie West District, Ashanti Region," 54-55.
[38] Peters et al., "Poverty and Access to Health Care in Developing Countries," 162.

district.[39] The physical distance or travel time from the location of the patient to the health service delivery point is a great challenge to the poor and results in extreme pain and death.

In Ghana, various strategies were laid down to achieve 'Health for All' in the 1980s. That notwithstanding, in 1990 more than 70 percent of all Ghanaians still lived over 8km from the nearest health care providers, which resulted in a double rate of rural infant mortality.[40] For this reason, other policies were introduced such as the Community-based Health Planning and Services (CHPS) in 1999 and the NHIS in 2003 respectively to help enhance access to health care services irrespective of the geographic and economic conditions of individuals.[41] The use and accessibility of health care services are influenced by availability and means of transport especially the current transport fares and bad roads. These limitations to the poor encourage them to rely on self-medication by the use of traditional medicine and visiting pharmacy shops which can result in severe health implications.[42] The increasing cost of health care, therefore, worsens the plight of the poor.

God's Care and Concern for the Poor

The Bible has sufficient data on God's love, concern, and care for the needy, poor, sick, widow, orphan, and the marginalized. Poor can be defined as, possessing little or no wealth or lack of inadequate financial resources.[43] There are several words that denote poverty in the Old Testament, such words include; *ani*, *ebyon*, *dal*, and *rasj*. *Ani* can be translated as poor (lack of food), as it is implied in Leviticus 19:10 when God instructed the Israelites to leave the fallen grapes in their vineyard for the poor and the traveler. The word *ebyon* is used in the Bible in reference to 'beggars' and also used to describe the 'socially weak' and 'miserable' as Job claimed of helping such people in Job 1:19. Another Hebrew word used is *dal* which is translated as 'low', 'helpless', and 'insignificant'. God, through Moses, gave instruction in Leviticus 14:21 that if a person is poor and cannot offer as much as required for an offering, he should take one male lamb for a guilty offering. The word *rasj* refers to material poverty as 2 Samuel 12:3 gives an account of a narrative Nathan gave to David concerning a poor man who had nothing except a little lamb……[44]

The Bible attests to God's concern for the poor, including the widows, orphans, and strangers. The term 'widow' (Hebrew: *almanah*) denotes a woman whose husband and father-in-law were both dead and without a son in ancient Israel.[45] A woman in this condition has no adult male to support her financial needs especially when she is aged. Widows were not often in possession of the inheritance in the patriarchal Jewish community, their inheritance was usually controlled by the males in the family even if they had. As a result, God gave the people of Israel the command not to abuse any widow or orphan, and the consequences of their cry if they are abused would be death so that the wives of the offenders would be widows, and their children orphans (Ex. 22:23-24).[46] Throughout the Old Testament, Israel had the obligation to take care and ensure the survival of widows and orphans, God considers such acts as befitting a redeemed people who portray the character of their redeemer.

God's provision for the needs of the poor is found in the Mosaic law. Moses made it clear to the Israelites that the poor, the needy, the orphan, and the widow would continuously be with them as neighbors. He, therefore, laid down policies and instructions (Deuteronomic legislation) that would help sustain the vulnerable and the needy, which includes providing food for the poor and systematic debt relief (Deut. 15:11). Norbert Lohfink argued that the Deuteronomic laws categorize two economically deprived groups, the first group are those who own no property (the widow, orphan, alien and Levite), the second

[39] Osei-Wusu Adjei, "The Impact of Poverty on the Health of Rural Communities in Ghana: A Case Study of the Amansie West District, Ashanti Region," 54-55.
[40] Aminu Sulemana and Romanus D Dinye, "Access to Healthcare in Rural Communities in Ghana: A Study of Some Selected Communities in the Pru District," *European Journal of Research in Social Sciences* 2, no. 4 (2014), 121.
[41] Sulemana and Dinye, "Access to Healthcare in Rural Communities in Ghana: A Study of Some Selected Communities in the Pru District,"121.
[42] Osei-Wusu Adjei, "The Impact of Poverty on the Health of Rural Communities in Ghana: A Case Study of the Amansie West District, Ashanti Region," 54-55.
[43] Thomas Nelson, *New Illustrated Bible Dictionary* (Nashville: Thomas Nelson, 1995), 1015.
[44] Eben Scheffler, "Poverty Eradication and the Bible in Context: A Serious Challenge," *Studia Historiae Ecclesiasticae* 39 (2013): 129–53.
[45] Isaac Boaheng and Samuel Boahen, "Theological and Ethical Reflections on Care for Widows from an African Christian Perspective." *E-Journal of Humanities, Arts and Social Sciences*, Issue 4 (2022): 102-114, 113 accessed January 17, 2023, https://doi.org/10.38159/ehass.2022342.
[46] Boaheng and Boahen, "Theological and Ethical Reflections on Care for Widows from an African Christian Perspectiv,"114.

group is poor and needy.[47] These categories of people were subject to hunger and debt servitude. The Israelites were therefore instructed to open their hands to the needy and give them whatever they needed from a pure heart without wickedness. Again, they are to give to the needy and the poor generously without grudging heart (Deut. 15:8-10). Giving generously to the poor is not in vain, rather it attracts the blessings of God into the lives of whoever does that, and their work and everything they torch is Blessed (Deut. 15:10). This reform sought to protect those who have been impoverished.

Another policy that God instituted to help address the needs of the poor was the year of debt remission. This law commands that they should grant a remission (Hebrew: *semitta*) of debt in every seventh year regardless of when the loan was acquired, and debt given to fellow community members is subject to remission (Deut. 15:1-11).[48] God further instructed the people of Israel through Moses to avoid charging interest on either money or food or anything that is loaned (lent) to a neighbour (Deut. 23:19). Again, concerning slaves, God instructed the masters of slaves to release the Hebrew slaves the seventh year after they have served for six years (Deut. 15:12-18). Moreover, the patron is commanded to send out the debt slave with a share of the bounty from his or her labor, which will be a modest foundation for them to build their economic security and enhance their daily living.[49] In respect to the poor and needy, the widow, orphan, alien and Levite who were poor as a condition of their socio-economic status, the Deuteronomic laws require those who have farmlands to provide for them.[50] It was required of those who have farmlands to give the tithe every third year to this impoverished group (Deut. 14:28-29). Since such people did not have lands to provide for their own subsistence, they were given the gleanings of the grain, olive and grape harvests from their neighbours (Deut. 24:19-21) as their source of food.

God gave them these laws as an expression of Israel's covenant with YHWH and a response to God's blessings and prior deliverance of Israel from bondage in Egypt (Deut. 15:12-14). Further, they were not to release a slave who had taken refuge with them back to their master, but to keep them, give them the freedom to choose wherever they wish to stay, and avoid oppressing them, thus showing love to them (Deut. 23:15-16).

God detests the acts of injustice and abuse towards widows and orphans because they have no one to protect them, therefore God has devoted himself to be their protector hence the text cited above.[51] The Psalms frequently reflect on God as one who cares for orphans, widows, and the poor. In Psalm, God is a father to the fatherless, and a defender of widows (Psalm 68:5), he takes up the responsibilities of a father to provide for the orphan and defends the widow from injustice and abuse from wicked people as a husband would do for his wife. He helps the fatherless (10:14) and justifies the weak, afflicted, destitute, and the fatherless, he also rescues the weak and the needy out of the hands of the wicked (140:12).

In the book of Proverbs, Solomon said that whoever despises his/her neighbour sins, but happy are those who show grace to the poor (Prov. 14:21), he also posits that anyone who is gracious to the poor lends it to God, and God will repay such a person with good deed (Prov. 19:17). According to Bonnie Thurston, any wrongful act against orphans, widows and the needy would attract the wrath of God, this instruction helps the people of Israel to adopt the character of the Lord in caring for the oppressed and vulnerable.[52]

In both the prophetic books God did not overlook the oppression, exploitation, injustice, and mistreatment of widows and orphans.[53] God instructed the people of Israel through Isaiah to learn to do what is good, do justice, condemn ruthlessly, defend the orphan and plead on behalf of the widow (Isa. 1:17), he also pronounced a curse on those who formulate evil statutes to deprive the needy of justice and rob the poor of their rights to take advantage of them (10:2). In the book of Amos, he allegedly accused the people of Israel for selling the needy for silver and a pair of sandals. Although the names of the accused

[47] Ronald A Simkins, "Care for the Poor and Needy: The Bible's Contribution to an Economic and Social Safety Net," *Journal of Religion & Society. Supplement* 14 (2017): 4–13, 8.
[48] Simkins, "Care for the Poor and Needy: The Bible's Contribution to an Economic and Social Safety Net, " 9.
[49]Simkins, "Care for the Poor and Needy: The Bible's Contribution to an Economic and Social Safety Net, " 9.
[50] Simkins, "Care for the Poor and Needy: The Bible's Contribution to an Economic and Social Safety Net, " 10.
[51] Boaheng and Boahen, "Theological and Ethical Reflections on Care for Widows from an African Christian Perspective," 102-114.
[52] Millicent Yeboah Asuamah, "Widowhood Care and Empowerment in 1 Timothy 1: 3-16: A Case Study of the Evangelical Methodist Church of Christ as a Paradigm for African Instituted Churches ," *MTH Theses* 2 (2012).
[53] Boaheng and Boahen, "Theological and Ethical Reflections on Care for Widows from an African Christian Perspective," 102-114.

people were not mentioned, he (Amos) categorically stated that for such a crime God would not revoke his punishment on them (Amos 2:6-8). Amos again talked about how the poor were trampled upon and how the elite extorted huge taxes from the poor which became a burden on the poor and the needy (Amos 5:10-13). In Zachariah, God further instructed them to practice true justice and kindness, have compassion on each other and avoid oppressing the widow, orphan, poor and the stranger (Zach. 7:8-10). Again, in Malachi the prophet said, God will come with judgement to those who oppress the poor, the widow and the orphan with wages, and give no attention to the alien (Mal. 3:5).

The New Testament like the Old Testament did not compromise on our relationship with the poor, how those with financial stability can help them, and the precedent the early church left as a way of sustaining the poor, widow, vulnerable and orphan. Jesus gave humanity assurance of how valuable human beings are than all other creatures and therefore it is the will of God to provide all our needs (Matt. 6:26). This is a message of hope to the poor and the needy considering God as their provider. Jesus mentioned the poor in his inaugural speech in Jerusalem synagogue as those to them the Gospel would be proclaimed (Lk. 4:18-19), Jesus was concerned about both physically and spiritually poor. Jesus followed the Old Testament teaching about the concern for the poor and encouraged believers to give and as a result whatever they also want would be given to them (Lk. 6:8). He also encouraged believers to give to the needy in secret and avoid blowing horns on their acts of generosity to avoid embarrassing the poor, with the assumption being that giving to the poor was a common value (Matt. 6:1-4).

Widows in the New Testament were classified among the poor, in Jesus' ministry, anytime he had an encounter with a widow, he was moved with compassion. In Luke 7:11-16, Jesus was moved with compassion to raise the son of a widow from Nain who was on the way to be buried. The woman has supposedly lost all hope because she had lost her husband long ago and now her only son was dead, but when she met Jesus, her hope was restored because, in the biblical times, sons were responsible for taken care of their widowed mothers.[54] Again, Jesus commended the widow who offered two small copper coins of little value because she offered all she had (Mk. 12:41-44).

As a way to battle poverty among the believers, the early church under the leadership of the Apostles maintained unity and those with financial resources sold and shared some of their possessions with the needy among them. There were no needy among them because whatever they got from the sales of their possessions were brought to the apostles and distributed among them (Acts 4:32-37). As the church increased in number, the Hellenistic Jewish widows felt overlooked in food or money distribution, when the issue was brought to the notice of the apostles, they appointed seven men to attend to the issue so that all the widows would have their fair share (Acts 6:1ff). These widows had come from the Diaspora to Jerusalem, their family members were not living in Jerusalem and therefore might have been vulnerable, and their hope of survival would depend on other believers.[55] In the book of Galatians after recounting his defense of his Gospel message to the church in Jerusalem, Paul says that the leaders of the church of Jerusalem ask them to remember the poor which Paul was also eager to do (Gal. 2:10). Paul further encouraged believers to work with their hands so that they will have something to share with the needy (Eph. 4:28). James (1:27) emphatically stated that godly and pure religion is to look after orphans and widows in their time of distress and also to keep oneself from unrighteous life and detestable things.

The above biblical references are clear indications of how God cares, loves, and is concerned about the well-being of the poor, needy, widow, and orphan. It is his delight that no one lives in extreme poverty and vulnerable.

Pastoral and Theological Reflections

In this section, the paper will highlight pastoral and theological reflections on the topic, the role of the church in ensuring the poor have access to quality healthcare services, and the role of the government in providing accessible, quality, and affordable healthcare services for the citizenry.

[54] Boaheng and Boahen, "Theological and Ethical Reflections on Care for Widows from an African Christian Perspective," 102-114.
[55] Boaheng and Boahen, "Theological and Ethical Reflections on Care for Widows from an African Christian Perspective," 102-114.

The Reality of Poverty in Every Generation

From the previous discussions with biblical references both from the Old Testament and New Testament, it has been emphasized that the poor, needy, vulnerable, widow, and orphan have been in existence for centuries. Poverty is not a new thing under the sun from generation to generation there has been some conscious effort to eradicate poverty, for this reason, God in the Old Testament gave laws and regulations (Deuteronomic legislation) to help sustain and improve the undesirable conditions of the poor. In Deuteronomy 15:11, God emphatically said that the poor will always be part of the society and it is therefore the responsibility of the society to cater for their needs.

In Jesus' era, he also acknowledged the fact that the poor and the needy will always be in the communities as our neighbour (Matt. 26:11). In Matthew 19:16-24 when Jesus had an encounter with one rich man who claimed to have fulfill all the commandment of God, Jesus charged him to go sell all his possession and then become his (Jesus) disciple, the man went away sad because it was difficult for him to do such a thing. People from generations have been heartless on the poor and the marginalized, they are identified as burdens to society and no or few people give them attention and help.

The situation in this generation is not different, the poor, needy, widows and orphans still live in society, yet the least attention and help are given to them. One of the greatest challenges facing this generation like past generations is poverty, every country, society, and community is affected by this challenge of poverty especially in developing countries and specifically in Ghana.[56] As a result of this challenge and frustrating circumstances, many people in the society desire to amass wealth through ungodly and unfair means at the expense of the poor. The effect on the country has created poor access to quality health care and a high rate of death. Ghana has engaged and adopted several economic policies over the years in a way of eradicating poverty and restoring the economy. Such policies include; the Structural Adjustment Program (SAP) from 1982-1992, the Economic Recovery Program (ERP) in 1983, and the Highly Indebted Poor Country (HIPC) initiative in 2001 and now in 2023, the takeover of Ghana's economy by the International Monetary Fund (IMF). All these economic policies have been implemented in an attempt to boost the nation's economic growth, and improve the living standard of the citizenry.[57] Although all these policies have been in place the country has not yet achieved its vision, some reasons might be the unchanged characters of the citizenry and political leaders. As this paper seeks to discuss various helpful ways to reduce the poverty rate and provision of quality health for all including the poor and the vulnerable, there is a need to consider change of attitudes on the nation's resource management and attitudes toward the poor and the needy.

The Role of the Church

The church as the body of Christ (Eph. 4:1-8), should be aware of its role in the contemporary life of vulnerability and extreme poverty a lot of people including church members are living in the society, as Jesus demonstrated by feeding five thousand people in the desert where there was no food (Mk. 6:35-44) and has thought the church (Matt. 5:42). There are clear indications of the contemporary church's effort in soul winning, preaching the Gospel and promoting spiritual growth, however, the church should also endeavor to seek and promote the health, physical growth and satisfaction as well as the wellbeing of the poor in the society. The church should be responsible for showing the way of generosity and taking up the torch of poverty reduction, making the necessary effort to provide available and affordable healthcare services to the needy since the church is the light of the world (Mk. 5:4).

In 313 A.D. when Constantine converted the Roman world to a Christian world, most preachers say it was because of great preaching. But the truth is, it was because in the second and third centuries, there were plagues all over Rome. It was literally only the Christians who stood up to help the people, when the people got better, they asked: "Who are you and how can we worship your God?"[58] The church grew as a result of this act, if it worked in the second and third centuries, it will definitely work in this twenty-second century. Health services include all services dealing with diagnosis and treatment of

[56] Isaac Boaheng, *A Contextual Theology of Poverty for Africa* (Cumbria: Hippo Books, 2020).
[57] Godfred Adjei Nyarko, "Poverty in Ghana: Theological Reflection on the Response of Some Churches in Kumasi Metropolitan Area " (Kwame Nkrumah University of Science and Technology, 2012), 45.
[58] Rebekah Tuchscherer, "A Changing Perspective: A Church's Role in Healthcare," October 9, 2019, https://www.sdpb.org/blogs/margins/a-changing-perspective-a-churchs-role-in-healthcare/.

disease, or the promotion, maintenance, and restoration of health which may include personal and non-personal health services. Further, service provision refers to the input of money, staff, equipment, drugs, and infrastructure to enhance the delivery of health intervention.[59]

The church should be commended for doing good work in trying to provide quality and affordable healthcare to Ghanaian citizens in collaboration with the government. The choice of the citizenry in choosing medical centers for health care services usually depends on; proper and excellent medical services, absence of long queues due to raped service and swiftness in solving medical problems of patients, affordability and presence of sophisticated laboratory facilities and convenience and acceptance of NHIS in the medical centers. In Ghana, there are about 71 mission hospitals that are doing well in social activities, providing good health, maintenance and improvement in physical and mental wellbeing, generation of revenue for national development and creating employment through the establishment of these hospitals. The church does this to alleviate poverty, enhance disease treatment, improve the standard of living, and reduce the government's burden in high expenditure on health care provision.[60]

The church is therefore encouraged to continue and improve its good work by expanding and establishing more clinics and hospitals both in rural and urban areas, providing financial support by subsidizing health care charges for extremely poor patients, accepting NHIS cards and assisting the government in addressing NHIS drugs and services payment issues. That not-withstanding, as discussed above, health is not only about the absence of disease therefore, the church should also consider helping people achieve their goal of living by assisting them to have more joy in their life, more love in their lives and get closer to people, especially the poor, needy, widow, orphan and the vulnerable and let them feel part of the society.

The Role of Government

Unemployment is one of the major factors that contribute to poverty in Ghana, it is assumed that every able person should not live without engaging in some kind of productive work, however for people to work, there must be work opportunities available.[61] It is, therefore, the absolute role of the state governed by the government to create and provide job opportunities for the citizenry. There should be laid down policies by the government that support the expansion of the economy, industries, and entrepreneurship. The government should formulate industrial policies that can help Ghana process some of its raw materials into finished products for export, these policies will not only create employment but would also fuel revenue increase for the government.[62]

Government should also work towards improving the road network systems in Ghana, especially in rural communities to enhance easy access to healthcare facilities in remote areas. Again, the availability of quality drinking water is also crucial to improve health, and minimize ill health and sicknesses such as cholera, diarrhoea, dysentery, hepatitis A, typhoid, and polio. One of the health policies initiated by the government that needs commendation is the implementation of the NHIS in 2003 as discussed above, the scheme has helped in taking care of health issues of a huge number of the Ghanaian populace, pregnant women, children, aged, the poor and the needy have all benefited from the scheme. However, the scheme could not totally eliminate the limitations and barriers hindering the poor from accessing quality, accessible and affordable healthcare. The NHIS scheme is unable to cover about 95 percent of Ghanaians and since there are a lot of the populace out there to have a fair share of the national cake, the government is therefore encouraged to expand the scheme to all Ghanaians irrespective of their geographical location, age, health status, severity of sickness, political affiliation and financial background.

Further, the government should also endeavor to build and expand health facilities (clinics, hospitals, laboratories) all over the country especially in the rural and remote communities to provide easy access to health care services. Already established healthcare centers that have inadequate and unfunctional health equipment and resources should be improved. There should also be an increase in employment of health practitioners, provision of at least one ambulance in health centers in remote areas

[59] John Olu Adetoyese, "Church In Health Service," *The American Journal of Biblical Theology* 18, no. 40 (October 1, 2017).
[60] John Kwaku Opoku, Eric Manu, and Victor Selorme Gedzi, "Church and Poverty Alleviation Through Health Care Delivery in the Kumasi Metropolis," *Developing Country Studies* 9, no. 10 (October 2019), https://doi.org/10.7176/DCS/9-10-08.
[61] Boaheng, *A Contextual Theology of Poverty for Africa*,165.
[62] Boaheng, *A Contextual Theology of Poverty for Africa*, 165.

and subsidizing health care charges for patients. Particular attention should be given to the marginalized since they are the most vulnerable people in society in respect to accessing quality healthcare.

CONCLUSION

The poor and the needy should be accepted as part of society, they are people who need the help of the society, therefore the nation, the church, and individuals should be there to attend to their needs. The poor and the needy are the heartbeat of God and he desires that society help bring them out of their unpleasant situation. Providing quality and accessible health care for the poor and battling the barriers and hindrances that prevent the marginalized from accessing quality healthcare services is not the work of one entity, rather it requires the involvement and cooperation of all stakeholders (government, church, NGOs and individuals) to battle these obstacles. Poverty is not a curse, the poor and the needy are not cursed by God, it is rather an unforeseen situation that has brought them to the state of poverty. Each person in the society can find him/herself in their situation therefore society should take it upon itself to show them love and help them enjoy better life.

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