

*Original Research Paper*

# Modes of Using Health Insurance Policies: Lessons from Daakye District, Ghana

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Health insurance policies are regarded as enhancing people's access to healthcare, particularly in developing countries, where poverty remains a barrier to healthcare access and utilisation. As most health insurance policies operate within so-called 'scientific' hospital-based medical systems, it is expected that those who purchase them – particularly the poor – would use them when they are ill. However, drawing on an ethnographic study of Ghana's National Health Insurance Scheme (NHIS) in the Daakye District of the Central Region, this paper argues that joining health insurance schemes does not mean that people necessarily access hospital-based medical care exclusively. In the Ghanaian context, there exists a pluralistic healthcare system consisting of hospital-based treatment, pharmacy/drugstores, traditional medicines and faith healing. Socio-economic factors such as local perceptions of illness, the quality of healthcare provided, distance to healthcare centres and local partisan politics were found to influence people's decisions and modes of NHIS use in the Daakye District. The findings indicate that it is not sufficient to make health insurance policies affordable; rather they also must be accompanied by more medical facilities, with service delivery, that are functionally and qualitatively available, accessible and acceptable.

**Keywords:** Ghana, Health insurance, Health Policy, Health-seeking behaviours.

## INTRODUCTION

Health insurance is often regarded as a panacea for supplementing gaps in healthcare financing, particularly in developing countries, where poverty remains a barrier to healthcare access and utilisation.<sup>1</sup> In line with several academic and political recommendations to replace out-of-pocket fees for health services, the Ghanaian government developed and implemented the National Health Insurance Scheme (NHIS) in 2003. Through the NHIS, the government aimed to provide equitable, universal and essential healthcare access to all Ghanaians.<sup>2</sup>

Health insurance is believed to increase healthcare use and access, and Roetzheim et al. found that health insurance is instrumental in the early detection of illness.<sup>3</sup> Other scholars have argued that most health-insured patients prefer to seek healthcare locally, rather than travel outside their place of residence.<sup>4</sup> Chen and Liu reported that Taiwan's health insurance policy of including hospitals as immunisation providers facilitated access to immunisation services for children born in those facilities.<sup>5</sup> In this way, health planners stimulated greater demand for immunisation. Similarly, Xiaodong argued that health insurance has a strong influence on healthcare utilisation in Vietnam, especially among the

poor.<sup>6</sup> Sekyi and Domanban have made similar assertions regarding Ghana's NHIS, stating that it is 'an effective tool for increasing utilisation of modern healthcare services particularly outpatient care and that membership can protect households from the potentially catastrophic healthcare expenditure'.<sup>7</sup> In a recent study, Blanchet et al also concluded that:

*Individuals enrolled in the insurance scheme are significantly more likely to obtain prescriptions, visit clinics and seek formal health care when sick. These results suggest that the government's objective to increase access to the formal health care sector through health insurance has at least partially been achieved.*<sup>8</sup>

However, such positive conclusions on health insurance are not universal. Bhat and Saha argued that health insurance is not a panacea and that expanding health insurance services without considering whether medical services are available can lead to dysfunction.<sup>9</sup> On 13 November 2008, the Ghana News Agency reported that Dr. Kofi Issah, the then Acting Upper West Regional Director of Ghana Health Services, admitted that although the ultimate goal of Ghana's NHIS was to make people healthy, it was not a remedy for the promotion of quality

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healthcare delivery in the country. Tanahashi has long argued that healthcare systems and initiatives 'do not work' unless the four 'As' are carefully considered: availability, acceptability, accessibility and affordability.<sup>10</sup> Patient satisfaction and quality healthcare are also considered important for healthcare access and use. The quality of healthcare services delivered at health centres depends on how patients are handled and if they feel satisfied with the services rendered.<sup>11</sup> Such satisfaction is believed to produce trust.

Ghana has a pluralistic healthcare system, consisting of hospital-based-treatment, pharmacy/drugstores, traditional medicines and faith healing. However, the NHIS operates only within hospitals, where allopathic or scientific medical cures are provided. In light of the literature on the effects of health insurance schemes on health facility utilisation, we undertook ethnographic fieldwork in Daakyekrom to examine how the NHIS was influencing the use of pharmacy/drugstore facilities, traditional medicines and faith healing. It is important to state while some successes have been chalked to standardise drugstore practices; faith healing and traditional medicinal practice in most rural parts of Ghana are unregulated. Our research explored other factors that influence people's decisions regarding which healthcare option they might use. We observed scenarios that indicated that individuals' situations were perhaps far more complicated than first realised:

*It is 11:40 am in Daakyekrom. A lady in her late thirties is leaning on the arms of two gentlemen as they enter a drugstore at the Daakyekrom car terminal. She is in pain and has caught the attention of everybody around. The drugstore operator asks what the problem is. The men explain that she is having a severe stomachache. 'Has she been to the hospital?' the drugstore operator asks. 'Yes, but even though she has the NHIS, she does not want to be taken there this time,' one of the men replies. 'Why?' the drugstore operator probes. 'I don't want to be insulted, I have been there severally, moreover, it is a market day and the place is too choked, the sick lady manages to retort, writhing in pain'.<sup>12</sup>*

This vignette shows a reality wherein people may join health insurance schemes, but this does not guarantee that they (would) actually access and utilise hospital-based treatment, even if it is 'free of charge', regardless of their socio-economic status. The following sections establish the rationale for this study. First, a description of the research setting is provided as the context for our ethnographic study. The second section briefly reviews the literature regarding the factors that determine people's health-seeking behaviours, and is followed by a description of the methodology and a discussion of the study's key findings.

### DAAKYE DISTRICT<sup>13</sup>

Daakye District ('the District') is in the Central Region of Ghana; Daakyekrom is the District's capital town. In 2009, 150,000 people lived in the District, with 95 per cent living in rural settings and one-third on islands accessible only by boats. At the time of the fieldwork almost 8,000 people lived in the capital.<sup>14</sup> Most people in the District identified as Christians, and 30 per cent of the population was officially recorded as Muslims. Being one of the most poverty-stricken localities in Ghana at the time of data collection, the District had only 1 referral hospital, 3 clinics and 13 Community Health Promotion Services (CHPS).<sup>15</sup> Most of the 240 island settlements had no clinics or CHPS. Diseases treated at the facilities included malaria, hernias, respiratory tract infections and typhoid fever.

Given the paucity of health facilities and the high poverty levels in the Daakye District, it would seem logical for the local people to have joined and reported the greatest use of the NHIS, which makes allopathic cure freely available.<sup>16</sup> However, the research revealed that this was not necessarily the case (data to be provided elsewhere). Individuals chose aspects of the NHIS they needed for treating specific illnesses, after which many deregistered from the scheme.<sup>17</sup>

Invariably, due to such attitudes (behaviours), the scheme was adversely affected in terms of its operational efficiency, with management not assured of consistent membership. This hampered further policy planning and quality health service implementation. It is argued in this paper that the 'selective use' of the NHIS in Daakyekrom reflected the socio-cultural reality that clients were not simply 'individual users' of health services; but rather, viewed themselves to be part of families. However, policymakers appear to have severely underestimated the local cultural (and 'collective') factors that influence health-seeking behaviours in Ghana.

### HEALTH-SEEKING BEHAVIOUR

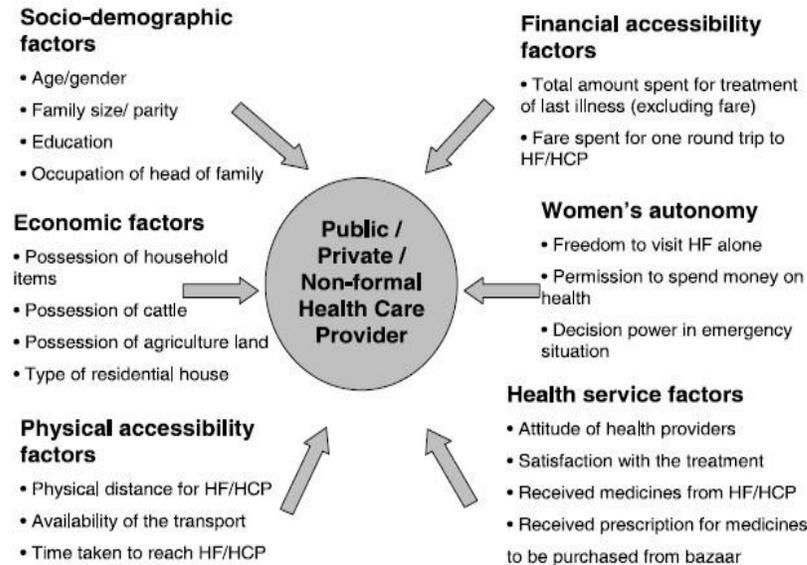
The concept of 'health-seeking behaviour' has evolved as a tool for understanding how and why people use healthcare systems in their respective socio-cultural, economic and demographic circumstances.<sup>18</sup> Several scholars have provided models for studying health-seeking behaviour; however, an in-depth discussion of their work is beyond the scope of this paper.<sup>19</sup> In the context of this paper, Kroeger's model of studying health-seeking behaviour is preferred, not only because the other models draw upon its underlying principles, but because it is an appropriate and detailed framework for examining, analysing and interpreting factors that determine health-seeking behaviours and health services utilisation in developing countries.<sup>20</sup>

As illustrated in Figure 1, Kroeger explained that broad factors – including, 'socio-cultural'; 'economic'; 'physical accessibility'; 'financial accessibility'; 'women's autonomy'; and 'health service factors' influence health-seeking behaviour(s). For the purpose of the ethnographic analysis, we have combined financial accessibility with economic factors, and women's autonomy with social-cultural factors.

### SOCIO-CULTURAL FACTORS

Health-seeking behaviour is not merely dependent on individuals' choices or circumstances, but largely upon the dynamics of communities that influence the wellbeing of local inhabitants.<sup>21</sup> Cultural beliefs and practices can lead to 'self-care', the use of home remedies, and consultation with traditional or faith healers. Although such practices and behaviours are believed to delay individuals' ultimate use of 'more appropriate' formal medical consultations and treatment-seeking behaviours, use of traditional health services in developing countries is commonly observed among women for personal health problems and their children's illnesses.<sup>22</sup>

It is customary in most developing countries – particularly in rural settings – for men to determine 'when', 'where' and 'how' their dependents (spouses) seek healthcare. Generally, their subdued position and limited social mobility affect women's access to the appropriate (formal) health services. In Ghana, Bour argued that even though women generally access healthcare more often than men, they do not necessarily have the 'final say' in deciding which health option(s) they take, particularly in rural locations.<sup>23</sup>



**Figure 1:** Kroeger's model of studying health-seeking behaviour  
**Source:** Kroeger, 1983.

Thus, although a woman may prefer hospital-based treatment (HBT) to cure a particular sickness, whether this option is taken would depend on the consent of her 'head of household' (such as an elderly brother, uncle or husband), who is often responsible for the payment of healthcare costs.<sup>24</sup>

There is minimal agreement as to whether level of education influences access to particular medical services (or healthcare-related choices). Although Acquah's survey in the Accra region of Ghana, suggested that educational level did not influence the use of health services, recent studies have shown that educated people prefer HBT to other healthcare options. For example, in Osei-Akoto's studies in Ghana's Nkoranza region, although people had enrolled in community-based health insurance, they did not always use HBT, instead relying on drugstores and traditional medicines, and reporting to hospitals only if their illnesses (disorders) became severe.<sup>25</sup> Osei-Akoto attributed this dearth in use in health insurance to poor educational attainment.<sup>26</sup>

## ECONOMIC ISSUES

Poverty is viewed as a barrier to healthcare access. If one is 'poor', then 'out-of-pocket' expenditure on consultation fees and public transportation fares are almost certainly a burden. Arhinful and Asenso-Okyere noted that poverty prevented many willing individuals from joining Ghana's NHIS.<sup>27</sup> They argued that in places where the NHIS had been implemented, attempts had been made to help the 'poorest of the poor' to access formal healthcare. At the time of data collection, the socio-economic status of Daakye District was among the lowest in Ghana. Coupled with an apparent lack of health facilities, this made accessing affordable healthcare very difficult. Although the NHIS was conceived to remove 'money' as a barrier to healthcare access, for some people in Daakye District, lack of funds to register remains problematic.

## DISTANCE

For the purposes of this paper, the term 'distance' is used not only in the geographical sense but in terms of the nature, modes and (or) availability of transportation to health facilities, as well as individuals' financial means to make use of such transportation. Kroeger and others have argued that distance is a critical determinant of health-seeking behaviour(s), whereby distance between people's homes and health facilities can affect the decision to use health facilities or not.<sup>28</sup>

Wilson's survey of maternity homes in an urban area of Ghana concluded that distance was the most important factor impeding the use of maternity services.<sup>29</sup> Osei-Akoto also observed that distance affected Ghanaian people's decisions regarding which healthcare options to take. He found that 75 per cent of individuals in Nkoranza and approximately 50 per cent in West Gonja that lived 10km from a NHIS hospital resorted to seeking help from traditional healers, with 89 per cent and 73 per cent respectively resorting to drugstore use instead.<sup>30</sup>

## TRUST

Kroeger's model also considers the attitudes of healthcare professionals towards patients, and patients' satisfaction with regard to treatment received, as determinants of future health-seeking behaviour(s). Specifically, the attitudes of health professionals, who are regarded as 'agents of trust' (or mistrust) towards their patients, can influence individuals' decisions to continue being treated by particular health professionals, or receive care services at certain health facilities.<sup>31</sup> Gilson argued that at the heart of healthcare is 'patient and provider interaction'; thus, effective service delivery requires not only the supply of care by providers but the acceptance of such service by individual patients. Further, a trusting relationship between healthcare providers and patients can have a direct therapeutic effect.<sup>32</sup> In Arhinful's 2003 feasibility study on Ghana's NHIS in Nkoranza, several respondents intimated that they would not join because they

had no trust in HBT.<sup>33</sup> Several studies have also concluded that some patients avoid HBT because of perceived maltreatment meted out to them by health professionals.<sup>34</sup>

### LOCAL PERCEPTION OF ILLNESS

Kroeger's model did not take into account people's perceptions of illness as a determinant of health-seeking behaviour. However, Meyer argued that local cultural conceptions of illness influence prospective patients' choices in accessing healthcare.<sup>35</sup> She observed in Peki (in the Volta region of Ghana) that the violation of accepted (societal) laws of 'mutual respect' – such as two blood relations having sexual intercourse – was deemed to be an abomination or 'gu'. This not only 'polluted' their respective families, but was believed to eventually result in some form of sickness developing for either violator. Meyer found that if a 'gu-related' illness resulted from a violation of local cultural laws, although it could potentially be treated at a hospital, the family generally called upon a priest to perform purification rituals aimed at removing the 'gu'.

Awusabo-Asare and Anarfi argued that in most Ghanaian societies, particularly in rural areas, diseases whose aetiology cannot be readily explained are often given 'supernatural explanations'.<sup>36</sup> Senah made an analogous assertion based on his study in Botianor (in the Greater Accra Region of Ghana) – that the local people did not consider all illnesses to be treatable with 'scientific' medicine (in hospitals).<sup>37</sup> They regarded hospitals as 'emergency medical centres' and frequently gave 'gendered' explanations for their opinions. If men fell sick, their friends often 'teased' them, calling them 'women' and (or) 'children' in a derogatory manner. Consequently, when ill, most men would reportedly try to 'master' the sickness (or symptoms), sometimes pretending not to be ill to avoid being tagged a 'sickler' or 'feeble'; and when critically ill, they would rely on local drugstore operators for treatment rather than hospital services.

### METHODS<sup>38</sup>

The ethnographic fieldwork was conducted over a three-month period in 2009. Participant observation and interviews were the main research instruments used. Participant observation in the Daakyekrom Mission Hospital (DMH), drugstores, and traditional medicine and faith healing outlets provided insights into local knowledge of general conditions and facilities, outpatient day activities and patients' treatment procedures.<sup>39</sup> A total of 30 interviews were also conducted. Formal interviews were conducted with medics, drugstore operators, traditional medicine practitioners and faith healers. Interviews explored the overall health situation in the Daakye District, both before and after the introduction of the NHIS; how the policy had influenced practitioners' experiences; and what the future held for healthcare professionals.

A translator was used for interviews conducted on the Reda Islands; otherwise, interactions with respondents at other sites were in the Buru language. Key informants, such as the directors of two non-government organisations, and district directors of the Ghana Health Services and the NHIS, were also engaged in formal interviews. Informal interviews were conducted with individuals on the Reda Islands, as well as on the streets, homes and workplaces of Daakyekrom. Respondents were asked 'why' they joined the NHIS and explained 'how' they were actually using the scheme.

A further 40 questionnaires were targeted to prospective respondents who had not taken part in interviews, thereby increasing the sample size from which to extrapolate the

findings. These questionnaires were administered at the NHIS Head Office in Daakyekrom, and were aimed at individuals either joining or renewing their membership of the scheme. Similar to interviews, the open-ended questionnaires solicited information pertaining to their use of the NHIS, the benefits they had derived and whether they intended to use or had ever used alternative medical services. Qualitative data were manually transcribed and thematically coded.

### DETERMINANTS OF MODES OF THE NATIONAL HEALTH INSURANCE SCHEME USE IN DAAKYEKROM

In Arhinful's 2003 study, the manager of a local community health insurance scheme remarked that only people, who 'were poor' in the mind would resort to faith healing, suggesting that he could not fathom why people would not pay (what he believed to be) 'a little' NHIS premium to access 'scientific' healthcare.<sup>40</sup> Our research found that the factors that influence decision(s) to access healthcare are complex in nature. Three modes of use pertaining to the NHIS were evident in Daakyekrom, encompassing 'frequent users', 'rare users' and 'non-users'. Frequent users were patients encountered at least twice at the DMH. Most had at least middle school education and (or) lived in (or around) Daakyekrom.

These frequent users were always willing to renew their premiums, even if – as stipulated by local social obligations – those expected to pay for them (such as male 'breadwinners'), would not meet NHIS costs. The cohort of frequent users included women in general (but mainly mothers), children/minors or people who had chronic or terminal illnesses; this encompassed surgical cases that required urgent or regular medical attention.

An interesting feature was that they were driven by the presence of illness. When illness had abated – or conversely, persisted despite biomedical therapies – they often became rare users, sometimes eventually opting out of the NHIS altogether. In most cases, rare users ended up as non-users. These generally included people that lived in locations with no health facilities. The data indicated that rare users and non-users had generally only (personally) registered for the scheme for emergency situations and (or) because of their dependents' healthcare needs. Discussed below are factors that were found in this study to have influenced usage of the NHIS in Daakyekrom.

### LOCAL PERCEPTIONS OF ILLNESS

Local perceptions of illnesses, disorders and injuries in Daakyekrom were often gendered in nature, and faith driven. Daakye District was an androcentric society, which influenced men's relationships with their families, individuals' health-seeking behaviours and subsequent treatment of illnesses. Local cultural norms required that men master illnesses to show that they are 'strong'. If a man visited the hospital often, his male peers mocked him. Consequently, most men would avoid the hospital (as a first option) if they were able to 'contain' or conceal their illness – buying pain relief from drugstores or using traditional herbs, and frequently waiting until their situation worsened before being forced to seek hospital care.

Women were the most frequent users of health facilities in Daakyekrom. Even so, several female respondents considered some health conditions as 'nonhospital' illness types; these ranged from menstrual pains to certain conditions that were dealt with 'over and over' allopathically, but to no avail. This included 'barrenness' (total or post-birth forms) and menstrual disorders. Most women who were rare users or non-users of

the NHIS held a high regard for traditional herbs, which were the most trusted medium for 'curing' these conditions.

Religion also shaped individuals' perspectives of sickness in Daakyekrom. This was particularly evident among devout Christian respondents, many of whom 'blamed Satan' as the source of all chronic illness. Some believers in faith healing claimed that seeking HBT for conditions classified as 'spiritual' – for example, 'asram' (convulsions), barrenness, 'tukpe' (effects of voodoo), mental illness and other sicknesses – would be a waste of time and money.' A pastor at one of the faith healing centres in Daakyekrom posited that we should:

*Tell the government that we need help. We provide hope for the hopeless and deal with cases 'their' hospitals give up on. If they support hospitals, why don't they support us too? If some of us were not around, could you imagine how many mentally ill people would be on the streets?*

The general belief was that spiritual conditions could only be dealt with through 'divine means', such as prayer and fasting. We encountered hundreds of locals seeking treatment in faith healing camps across Daakyekrom. Some recorded anecdotes revealed that many had tried allopathic cures in hospitals to no avail. Obviously disappointed in HBT, such respondents did not find it necessary to renew their NHIS premiums, arguing instead that such funds should be used to support the faith healing churches because they pray and deliver people from the 'albatross' of pain and sickness.

## QUALITY OF HEALTHCARE

The quality of the healthcare played a key role in the decisions of many NHIS holders in Daakyekrom to continue seeking HBT or not. Most individuals would not mind receiving treatment at formal health facilities as long as their illness, disorder or injury as at a 'critical state' and only hospitals could help. However, if they considered an illness to be mild or that drugstores or traditional herbs could better meet their needs, they avoided HBT because of the perception that some medical professionals were 'rude' to patients. This was confirmed in the 2008 Client Satisfaction Survey conducted by the DMH. Table 1 demonstrates that most outpatients and the community were not satisfied with the local DMH's handling of patients. The Daakyekrom District Development Organisation (DDDO) conducted a similar survey in 2008 on this issue and recorded numerous allegations against the medics at the DMH:

*The exercise revealed that access to quality health service in the district, particularly, by the poor is generally very bad in terms of both physical accessibility and quality of service as several factors work against it ... whilst poor attitude of some health personnel and drugs unavailability affect quality health service ... Community members prefer travelling long distances to receive caring treatment to being insulted and shouted at in their own communities.<sup>41</sup>*

Apart from the reportedly poor attitudes of medics, time spent waiting at the hospital was another major concern. Table 1 indicates that patients who were attended to within two hours accounted for less than 50 per cent of the sample. During our own observations at the DMH, we found that on average it took a patient three hours or more to receive medical attention. The first point of contact for patients at the hospital was the NHIS front desk, where patients had to authenticate their health card. This was followed by a visit to the Records Department of the hospital to retrieve the patient's medical history. After these bureaucratic processes were complete patients were often

required to join another long queue before finally being admitted to see either a doctor or medical assistant. For some patients, their situation was compounded with the frustration and anger they experienced as a result of waiting in long queues or dealing with missing cards (records). Generally, they spent less than 30 minutes in the consulting room, with most then being sent to admission, the laboratory, or to X-ray centres for corroboratory checks; ultimately returning to see the doctor, or sometimes joining another queue at the pharmacy department to purchase prescription drugs.

Another point worth noting is that the DMH closed at 1600 hours. Some residents of Daakyekrom and islanders commented that if they had severe illness but did not want to be admitted to a hospital ward after closing time, they had to wait and effectively 'bear their pain' until the following morning. Through impatience and unwillingness to join queues, prospective patients of the DMH would often resort to using pharmaceuticals or traditional herbs instead. I encountered respondents who argued that because the NHIS required no 'out-of-pocket' payments at the DMH, they were usually given inferior drugs and unnecessary injections. Some locals trusted drugstore operators rather than medical professionals at the DMH to prescribe more potent drugs for non-emergency medical conditions. Moreover, some respondents would use their NHIS cards to obtain their laboratory test results and diagnoses at the DMH, but elect not to buy the drugs prescribed by the DMH medical professionals; preferring instead to procure drugs prescribed by drugstore operators.

Finally, some NHIS holders either were unable to (fully) use the scheme and (or) eventually opted out, because DMH staff did not readily provide the medical services they required. Two such services were gynaecology and dentistry. We learned that specialists in these areas of healthcare, from the other parts of Ghana, usually turned down full-time, ongoing employment offers from the DMH, opting to work there on a casual basis instead, partly due to the poor infrastructure in the District.

## DISTANCE

The distance between where locals lived and where NHIS-related services or hospitals were located was a determining factor in the mode of use across Daakyekrom. People living on the islands or other places with no clinics or CHPS were less likely to travel and thus use NHIS (hospital) services in Daakyekrom. A 55-year-old man from the Reda Islands passionately stated that:

*Because of our situation sometimes it takes boldness to register for the NHIS. It will seem as if you are crazy to do so. It does not make sense to register and don't have reliable means to go to hospital when sick.*

We found that many residents in the Reda Islands had not joined the scheme. When asked why this was the case, they would openly respond, 'for what?' Pretending not to know that their location was problematic, the interviewer would prompt them further by saying, 'you need it [the NHIS] for your health'. Generally, they would laugh in response at our lack of understanding about the barriers and distance posed for these Ghanaians. Barriers to healthcare access and the utilisation of formal medical services in the Daakye District were influenced not only by geographical distance, but by the cost and nature of transportation; potentially further compounded by the low availability of vehicles for such travel. If a person fell critically ill in the Reda Islands, they would have to travel by boat to Abor and then find a vehicle that would take them to Atikwa CHPS.

**Table 1:** Abridged version of the DMH Client Satisfaction Survey 2008

	Seen in 2 hours	Attitudes of staff (very good?)	Patients satisfaction	Remarks
Out-Patient Day	32%	18%	14%	Poor
Community	41%	9%	---	Poor

Source: DMH, 2008.

Thus, for these people, utilisation of NHIS-related services depended largely on the availability of a canoe, a canoe driver and then a car to take them to the nearest health facility, as well as money for fares. At the time of data collection, only 10 per cent of the road network in Daakye District was sealed, further compounding ease of access to medical services. Patients could also not be guaranteed that they would find Atikwa-bound commercial cars. Their situation was often compounded if their sickness represented an emergency and they had to be referred to DMH or another hospital outside the District. The issue of distance in Daakyekrom was also identified as a pervasive concern among patients in the DDDO 2008 survey report.

## POLITICS

At the time of data collection, most residents of Daakyekrom identified as supporters of the National Democratic Congress (NDC). This political party won the 2008 election and began governing in 2009, the same year as this ethnographic study. However, the NHIS had been introduced to Ghana by the outgoing New Patriotic Party (NPP) government. Some residents of Daakyekrom initially refused to join the NHIS because they felt they would be 'doing the NPP a favour'; boycotting the scheme was considered to show their support for the new NDC government. In fact, some NDC supporters reported waiting to enrol until they were certain the NHIS was a policy initiative available to all Ghanaians – not just NPP supporters. We also found that a number of people 'opted out' of the scheme because during the election the ruling government had argued the NHIS to be one of 'their' achievements. One female respondent at a healing camp in Daakyekrom confirmed this, stating that:

*The New Patriotic Party argued that they had made Ghana a better place and made a lot of fuss about this NHIS during the last election. Because of this I decided to opt out of the scheme. Now that our government [the NDC] is back in power, I will join again.*

The participant observations, interviews and surveys revealed that there were a number of NDC 'stalwarts' enrolled in and using the policy at the time of data collection. Perhaps unsurprisingly, they generally encompassed rare users; however, this was not necessarily due to politics *per se*, but to other socio-cultural factors such as personal perceptions regarding what causes illness, and issues such as (travel) distance. During the 2008 election, the NDC also pledged to introduce a 'one-time' NHIS premium payment. As a result, respondents who identified as supporters of the NDC were reportedly 'looking forward' to the government fulfilling this promise. However, the government is yet to follow through on this pledge.

## CONCLUSION

The act of joining the NHIS did not mean clients actually used the scheme, and even if they were 'users', they might not (or, elect not to) 'fully' access the services available. Three categories of NHIS users, namely 'frequent users', 'rare users' and 'non-users' were found in the Daakye District. Socio-economic factors such as local perceptions of illness, quality of the healthcare provided, distance, and politics influenced the modes of NHIS use in Daakyekrom.

We conclude that to some extent, healthcare access and utilisation depend on local people's socio-cultural context and networks. Our findings, therefore, support those of Tanahashi who noted that healthcare access does not solely depend on 'affordability' *per se* (which Ghana's NHIS addressed), but on its 'availability', 'acceptability', and 'accessibility' – most of which were found to be inadequate in Daakyekrom. The current findings also echo Bhat and Saha's conclusion that health insurance is not a panacea and that expanding health insurance services without commensurate health services that are readily available and accessible will render the system dysfunctional.

The findings have several important policy implications. First, it is not enough to make health insurance policies 'affordable'; they need to be accompanied by medical facilities (and services) that are 'acceptable', 'available' and 'accessible' to prospective patients. Second, the attitudes of health professionals appear to have consequences for the perceived efficaciousness of public health policies and services. Thus, equal importance needs to be placed on training healthcare professionals to improve their 'handling' of patients and possibly expedite other related medical (administrative) processes.

Third, given the popularity of traditional medicine, faith healing and drugstores in Ghana, it will be critical to regulate and codify such practices. Although inroads have been made in the area of standardising drugstore practices; faith healing and traditional medicinal treatment services in rural areas are yet to receive such attention, with negligible progress in regard to government support for the formalisation of these Ghanaian practices. Finally, given the climate of political divisiveness in Ghana, it is imperative that politicians discuss policies relating to health in a non-partisan manner. Local people who are poor tend to be the ultimate losers when politicians score political points with policies on sensitive national issues such as health. The National Commission for Civic Education has an important role to play in this process.

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## NOTES

<sup>1</sup> Arhin-T 2001, Bour 2004, Xiaodong 2007.

<sup>2</sup> Agyepong & Adjei 2007, p.152.

<sup>3</sup> Roetzheim et al.1999.

<sup>4</sup> Mattoo & Rathindran 2005, Ekman 2005.

<sup>5</sup> Chen & Liu 2005.

<sup>6</sup> Xiaodong 2007.

<sup>7</sup> Sekyi & Domanban, 2012, p.40.

<sup>8</sup> Blanchet et al. 2012, p.46.

<sup>9</sup> Bhat & Saha 2004.

<sup>10</sup> Tanahashi 1978.

<sup>11</sup> Senah 2003, Schneider 2005.

<sup>12</sup> Field notes # 004.

<sup>13</sup> See Adusei-Asante (2009) for a highly detailed profile of the Daakye District.

<sup>14</sup> The organisation has been deidentified.

<sup>15</sup> The Daakyekrom Mission Hospital is a pseudonym.

<sup>16</sup> Hospital-based scientific medical treatment.

<sup>17</sup> Adusei-Asante, forthcoming.

<sup>18</sup> Shaikh 2007.

<sup>19</sup> See Tabi et al. 2006 and Shaikh et al. 2008.

<sup>20</sup> Kroeger's 1983.

<sup>21</sup> Mac Kian 2001.

<sup>22</sup> Mac Kian 2001, Kroeger 2008.

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- <sup>23</sup> Bour 2004.
- <sup>24</sup> Adusei-Asante forthcoming.
- <sup>25</sup> Osei-Akoto's 2004.
- <sup>26</sup> See also Irfan Muhammad et al. 2007, Tabi et al. 2006, Mulder et al. 2007, Renzaho, et al. 2007.
- <sup>27</sup> Arhinful 2003 and Asenso-Okyere 1995.
- <sup>28</sup> Kroeger 1983, Bour 2002, 2004.
- <sup>29</sup> Wilson 1997.
- <sup>30</sup> Osei-Akoto 2004, p.95.
- <sup>31</sup> Gilson 2003.
- <sup>32</sup> Gilson 2003.
- <sup>33</sup> Arhinful 2003, p.135.
- <sup>34</sup> Senah 2003, Schneider 2005, Irfan Muhammad et al. 2007.
- <sup>35</sup> Meyer 1995.
- <sup>36</sup> Awusabo-Asare & Anarfi 1997.
- <sup>37</sup> Senah 1997.
- <sup>38</sup> See Adusei-Asante (2009) for a more detailed description of the research methodology and thematic analyses.
- <sup>39</sup> Patton 2002, Liamputtong 2009.
- <sup>40</sup> Arhinful 2003.
- <sup>41</sup> Daakyekrom District Development Organisation Poverty and Health Monitoring Report, 2005, pp.27–29.