

## **The Two Sides of Free National Health Insurance Policies: Lessons from Daakye District, Ghana**

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### **Abstract**

The impact of free health insurance policies on healthcare access and utilisation in developing countries, where poverty is endemic, is well documented. However, previous research on the topic seems to have focused on the generic correlation between health insurance policies and increased patronage of hospital-based treatment where most health insurance schemes operate. We seek to contribute to the topic by showing the dynamics of healthcare utilisation in free health insurance contexts and associated unintended impacts. The study draws on an ethnographic study of Ghana's National Health Insurance Scheme in the Daakye district of the Central Region of Ghana. While the findings confirm the theory that free health insurance policies do induce people's health-seeking behaviours, they also unearth issues that result when public policies do not match local infrastructural and human resource capacities.

**Keywords:** *Ghana, health insurance, health-seeking behaviour, hospital-based treatment, public policy, policy impact*

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### **1. Introduction**

A significant body of literature have documented the correlation between free health insurance policies and healthcare access and utilisation in developing countries. Previous studies have variously highlighted the link between increased patronage of hospital-based treatment, improved health-seeking behaviours and health insurance policies. We draw on a research conducted at Daakye district in the Central Region of Ghana to portray the two sides of Ghana's National Health Insurance Scheme (NHIS). We argue that (1) while the initiative significantly influenced people's willingness to access hospital-based treatment, they did so selectively for specific illnesses; and the (2) increased patronage of the NHIS became its bane as the infrastructure of the local medical facility could not support the influx of patients visiting it. Four parts are presented to establish the context of this text. The first segment explains the research context and the methods, followed with a brief overview of Ghana's National Health Insurance Scheme (NHIS) in the second section. A review of the literature on the relationship between national health insurance schemes and health care utilisation is presented in the third. The final section focuses on the analysis and discussion of the research findings.

### **2. Research Setting and Methods**

Daakye is one of the districts in the Central Region of Ghana and Daakye-krom is its capital town. Over ninety per cent of the local people live in rural settings with one-third residing on 240 islands only accessible by boats. At the time of data collection in 2009, 150,000 people lived in the district; almost 8,000 people lived in the capital. Only ten per cent of the entire road network in the district was tarred (Daakye-krom Development Organisation Annual Reports 2006-2009).<sup>1</sup> Most people in the district identified as Christians, although 30 per cent of the population were officially reported to be Muslims. Being one of the poverty-stricken localities in Ghana at the time, the entire district had only one referral hospital (the Daakye-krom Mission Hospital-DMH<sup>2</sup>), three clinics and thirteen Community Health Promotion Services (CHPS). Most of the island settlements had no clinics and CHPS. Malaria, hernia, respiratory tract infections (RTI) and typhoid fever were the prevalent diseases in the district.

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<sup>1</sup> Name of the organisation has been deidentified.

<sup>2</sup> Pseudonym.

The ethnographic fieldwork happened over a three-month period in 2009. Several research tools were used to enhance the credibility of the study and also for triangulation purposes (Liamputtong, 2013), namely participant observation, interviews, review of reports and questionnaire. Participant observation was carried out at the Daakyekrom Mission Hospital (DMH); drugstores; traditional medicine and faith healing outlets. The purpose of the participant observation was to gain local knowledge through observing the general conditions and facilities, outpatient activities as well as the patients' treatment procedures (Patton, 2002, Liamputtong, 2013).

Thirty formal and informal interviews were conducted. Formal interviews were conducted with medical professionals at the DMH, drugstore operators, traditional medicine practitioners and faith healers. The interview questions focused on the health situation in the Daakye district before and after the introduction of the NHIS and how the policy had impacted their work and what the future held for them. Apart from the Reda Islands, where a translator was used, most of the interviews were conducted in the Buru language. Key informants such as Directors of two NGOs and the district Directors of the Ghana Health Services (GHS) and the NHIS were also engaged in formal interviews. The rest of the interviews were informal. Individuals on the Reda Islands as well as on the streets, homes and workplaces of Daakyekrom were engaged and asked about why they joined the NHIS as well as how they were using it.

Annual reports of the DMH and two NGOs working in the district were also obtained to establish the context of the study while informing the design of the research instruments. Forty questionnaires targeted at those who were not included in the interviews to attain a larger data sample. The questionnaires were administered at the NHIS Head Office in Daakyekrom, where people were renewing or joining the scheme afresh. The open-ended questionnaires solicited information on when and why they had joined the scheme; the benefits derived so far and if they intended or had ever used drug stores, traditional herbs or faith healing. The data was manually transcribed and thematically coded, after which they were written into chapters in the thesis proper, one of which is discussed in the current paper.

### **3. Ghana's National Health Insurance Scheme**

Access to adequate healthcare as well as affordable medicines remains a challenge in most developing countries, where poverty is rampant. As a result, several low-income countries have implemented health insurance schemes to enable their citizens' access equitable and essential healthcare. Although Ghana is a signatory to the Abuja Declaration, which requires that the country commit a minimum of 15 per cent of its budget to the health sector, the reality has been that before and after the introduction of the NHIS Ghana's government has only managed an average health expenditure of around 12 per cent (Mamaye 2015). Ghana implemented a National Health Insurance Scheme (NHIS) in 2004 to replace the out-of-pocket payment system that existed in health centres (Arhinful, 2003; Agyepong & Adjei, 2008). The passing of a National Health Insurance Act (Act 650) of 2003 led to the establishment of a National Health Insurance Authority (NHIA). The NHIA was created to implement the new NHIS, a universal health insurance programme intended to provide access to basic healthcare services to all residents in Ghana. The Act (650) made provision for the existence of three parallel health insurance schemes, namely the Private commercial scheme, Private mutual scheme, and the district Mutual Health Insurance Schemes (DMHISs). In exception of the district mutual health schemes, which receive direct financing from the Government, the rest are privately owned and managed. While the DMHISs functioned independently of each other based on the initial design, they currently operate under the NHIA. In 2012, Act 650 was reviewed and under the new Act 852, all DMHISs were classified under a common umbrella called the National Health Insurance Scheme (NHIS). Act 852 made it mandatory for every resident in Ghana to belong to the scheme (Blanchet, Fink, & Osei-Akoto, 2012).

On the provisions of Act 852, there are five funding streams for the NHIS. These include 2.5 per cent tax on selected goods and service from the Value Added Tax (VAT) called the National Health Insurance Levy (NHIL). The NHIL is the largest source of finance for the scheme. It contributes about 60 per cent of total finance of the scheme annually (Kusi, Enemark, Hansen, & Asante, 2015). The rest include 2.5 per cent allocation of formal sector workers contribution to the Social Security and National Insurance Trust (SSNIT) per month, profits on National Health Insurance Fund (NHIF) investments and

premium paid by informal sector workers. In addition to these, being a sub-vented institution, there is an annual Government allocation from the consolidated fund to the NHIA.

Membership of Ghana's health insurance scheme is classified into two main broad groupings. These include the exemption group and those who pay a premium. The exemption group includes formal sector employees and self/private employees who contribute to the national social security scheme (SSNIT). Others include children less than 18 years, persons classified as an indigent group, some categories of persons with disabilities without any productive capacity and persons with mental illness. The rest are pensioners on social security scheme and older people above 70 years old. All informal sector workers (18 years to 69 years) who do not belong to any of these groups were classified as premium payers (National Health Insurance Authority, 2013).

Payment of premium is a graduated scheme depending on the socio-economic group an individual belongs. The category of premium to be paid by a person is determined by the DMHIS now known as NHIS district office. The amount of premium ranges between 7.2 Ghana Cedis (GHC) (US\$1.9) to GHC48.0 (US\$12.6). The graduated payment system notwithstanding many districts pegged flat rates for all categories of people and the rates vary from district to district depending on the socio-economic circumstances of the district. Even though the contribution of formal sector employees is directly from the social security contribution each month, they are expected to register and pay a registration fee of GHC4.00. The indigent groups and pregnant women are by law exempted from the payment of registration fees. The NHIS covers about 95 per cent of disease conditions reported in Ghana. However, it excludes very important diseases such as cancers (except breast and cervical cancers), HIV retroviral drugs, dialysis for chronic renal failure, hormone and organ replacement therapy and some non-communicable diseases (National Health Insurance Authority, 2013).

At present, the NHIS remains an important social protection policy in Ghana with a current national subscription level of 10,145,196 subscribers as at 2013 (see Table 1). This figure only represents about 39 per cent of the current population of Ghana (26 million). There are currently issues about none renewal of memberships and limited new subscriptions (National Health Insurance Authority, 2013).<sup>3</sup>

**Table 1** Subscribers of the NHIS of Ghana

Region	New	Renewals	Active Membership	Percent of Total
Ashanti	472,903	1,242,485	1,715,388	17%
Brong Ahafo	405,088	948,752	1,353,840	13%
Central	382,595	484,341	866,936	9%
Eastern	337,097	773,024	1,110,121	11%
Greater Accra	565,281	714,976	1,280,257	13%
Northern	391,728	488,789	880,517	9%
Upper East	166,538	476,740	643,278	6%
Upper West	99,620	322,797	422,417	4%
Volta	326,243	584,326	910,569	9%
Western	297,477	664,396	961,873	9%
Total (National)	3,444,570	6,700,626	10,145,196	

**Source:** NHIA (2013), Annual Report.

According to NHIA (2013), regarding utilisation of NHIS services, claims payment for outpatient services increased from 580,000 cases in 2005 to 23.9 million in 2012, which represents more than 400 per cent in cases. Similarly, inpatient services increased from 29,000 in 2005 to 1.4million in 2012. Overall claims payment also increased from 7.6 million Ghana Cedis in 2005 to 616 million Ghana Cedis in 2012. The high claim payment is cited as one of the key factors militating against the sustainability of NHIS. This therefore led to the pilot of a new system called the capitation system.

<sup>3</sup> We have argued elsewhere that those who have not joined the NHIS may do out of pocket payments at hospitals, rely on drugstores, traditional medicines faith healing (see Adusei-Asante, in press).

The capitation is based on the Ghana Diagnostic Related Groupings (G-DRG) concept. The G-DRGs are standard groups of diseases related clinically and have comparable treatments under similar healthcare resources. This allows for service providers to be paid for patient's treatment according to his or her diagnostic group irrespective of the cost. This is known as the inclusive flat payment. Although this payment mechanism reduces the cost burden for schemes of having to bear huge claims submission by providers, it brings to the fore the issue of unattractive rates which discourage provider participation. In effect, some service providers have opted out of the scheme and compel members to pay at the point of service delivery.

Currently, the NHIA has introduced some interventions to induce some efficiency in service provision. Some of these include the electronic claims processing system, expansion of the number of claims processing centres across the country, the electronic linkage of diagnosis to treatment and introduction of the instant identity card processing system. Despite these recent developments in NHIS, there are known issues of structural and administrative inefficiencies hence the recent move by the Government to review the entire NHIS and overhaul the system to make it more responsive to the need of the time. The Government constituted a National Review Committee in September 2015 with the review currently underway.

### 3.1 Health Insurance and Healthcare Utilisation

An important feature of health insurance schemes throughout the world is their ability to induce health-seeking behavioural change among people it is intended for. In this respect, it is important to examine how the health insurance policies impact the health-seeking behaviour and health service utilisation. Lichtenberg (2002) found a correlation between health insurance and increased the survival rate of the elderly in the USA by about 13 per cent. Card et al. (2004) evaluated the effects of health insurance coverage on health seeking behaviors and outcomes in the USA. The authors found an apparent impact on self-reported health percentages, with larger gains for groups whose insurance coverage rates increased the most after becoming eligible for Medicare. Hashim et al. (2012) found that many Southeast Asian governments had passed laws to establish national health insurance schemes that allow universal coverage while enhancing healthcare access, and increased financial coverage and affordability for their citizens. Recently, Kondo and Shigeokab (2013) studied the effects of Japan's health insurance coverage on health care utilisation and supply-side responses and found that health care utilisation (about admissions, inpatient days, and outpatient visits to hospitals) increased appreciably.

Meanwhile in Ghana, since the implementation of the NHIS in 2003, several studies have been carried out to ascertain its impact on health service utilisation. In their work on the '*The effect of Ghana's National Health Insurance Scheme on health care utilisation*', Blanchet, Fink, and Osei-Akoto (2012) affirmed that those who enrolled in the scheme were more likely to visit clinics or health facilities to seek formal healthcare, and they were more likely to obtain prescriptions. In effect, this study showed a positive correlation between enrolment in the NHIS and health service utilisation among Ghanaians. In particular, the study found that 76.3 per cent of women with NHIS visited a health facility in the last 12 months preceding the study compared to 50.2 per cent non-NHIS women. Out of these figures, there was 12.7 per cent hospitalisation for women with NHIS and 7.4 per cent hospitalisation for women without NHIS.

Similarly, Sofu and Thompson (2015) in their study on the Fee Free Delivery Policy under the NHIS indicated that both the free delivery policy and the NHIS have significantly impacted the rate of maternal mortality in Ghana. They suggested that their finding is a reflection of how women now seek skilled delivery opportunities by relying on the NHIS. In effect, through the NHIS, pregnant women are now encouraged to seek antenatal care and skilled delivery in accredited healthcare centres (Brugiavini & Pace, 2016; Kotoh, 2013).

In another related study, Gobah and Liang (2011) noted that there is a significant difference between the health-seeking behaviour and healthcare service utilisation between NHIS subscribers and non-subscribers. Their study found that 70.8 per cent of insured than 6.0 per cent of non-insured reported seeking formal care when sick. Some of the healthcare services used by the insured include consultation and treatment (54.7 per cent), medicines/drugs (18.6 per cent), laboratory services (9.8 per cent), delivery (8.8 per cent) and hospitalisation (8.1 per cent). Another significant finding in this study was that about 63

per cent of women insured under the NHIS gave birth in health facilities and were attended by trained health professionals in the last 12 months preceding the study, compared with only 4.7 per cent of women without NHIS. Also, use of post-natal health services was seen to be higher for NHIS members (67.2 per cent & than non-members (7.8 per cent). Similarly, Dzakpasu et al. (2012), found that health facility delivery had increased significantly since the introduction of the NHIS.

In a more recent study, Fenny et al. (2016) affirmed the significant impacts of the NHIS on healthcare utilisation in Ghana. They found that 64 per cent NHIS members more than 50 per cent non-members seek healthcare services. However, they noted that healthcare utilisation was determined by three main factors including insurance (NHIS), education and gender. More educated people used the NHIS to seek healthcare services than non-educated ones. Women were also more likely to use NHIS for health-seeking than men. On the whole, the study concluded that more insured Ghanaians sought care from formal health care service providers. The study further found that geographical location greatly defined healthcare utilisation. They found that 53 per cent of users and 44 per cent of non-users lived in urban areas. In addition, 30 per cent of non-users were more than one hour from the closest district hospital compared to 19 per cent of users.

The impact of NHIS on health-seeking behaviour for the treatment of malaria has also been studied by Fenny *et al.* (2015). The study showed that those who had not enrolled in the NHIS were more likely to choose informal care compared to the NHIS-insured for the treatment of malaria. Also, on malaria care, health insurance and travel time to a health facility were significant determinants of health care demand. The research further acknowledged that participants who were NHIS insured were six times more likely to choose regional/district hospitals; 5 times more likely to choose health centres/clinics and seven times more likely to choose private hospitals/clinics over informal care when compared with the uninsured.

Exclusive impacts of NHIS on health-seeking behaviour alone have further been challenged by Kuuire, Bisung, Rishworth, Dixon, and Luginaah (2015). They found a disparity between the poor and the rich in health-seeking even though both groups are enrolled on the NHIS. In their study, Kuuire et al. (2015) noted that poor and poorest wealth quintiles who are enrolled in the NHIS were less likely to seek treatment in a health facility during their last illness compared with individuals in the richest wealth quintile who are enrolled in the NHIS ( $\beta = 0.41$ ,  $\rho < 0.01$  and  $\beta = 0.45$ ,  $\rho < 0.05$ , respectively). This level of distinctions in health service utilisation in spite of NHIS affirms the possibility several other factors that can explain the impact of NHIS on the health-seeking behaviour of Ghanaians. This notwithstanding, there seems to be some level of consistency among researchers about the overwhelming impact of the NHIS on the health-seeking behaviour of Ghanaians.

#### **4. Findings: NHIS' Impact on Hospital-Based Treatments and Associated Issues**

As alluded to above, Ghana's NHIS operates in hospitals, which provide biomedical treatments, although there also exists traditional medicines, drugstores and faith healing as healthcare options for some Ghanaians. Hospital-based biomedical treatment (HBT) is arguably the most popular and patronised medical system in Ghana. Currently, HBT outlets include hospitals, clinics, polyclinics and Community-based Health Planning and Services (CHPS) operated by the Government (Ghana Health Services), religious organisations and private practitioners. Although HBT's scientific explanation of diseases was initially at loggerheads with local beliefs on the supernatural causes of illness, Twumasi (1975) argued that it has come to stay evidenced by the remarkable improvement in the health of the people. This notwithstanding and aside from being constitutional endorsed, not all Ghanaians (home and abroad) trust HBT (Kim, 2005, Barimah & Teijlingen, 2008) to cure all sicknesses. Arhinful (2003) connected this attitude to culture, but Tsey (1997) argues that it is because HBT is unable to deal effectively with certain diseases that have psychological dimensions. Twumasi argued that HBT does not take into account psychological aspects of illness in its curative process, which is why some believe that traditional herbalists do better than orthodox medical practitioners in Africa, because of the latter's application of psychotherapies in their therapeutic processes (Senah, 2003; Barimah & Teijlingen, 2008). Against this background, below, we show the impact of the NHIS on the use of HBT.

The NHIS brought about an unprecedented awareness about health facilities in the Daakye district. Even though the hospital/CHPS were not always the first healthcare option for some residents of

Daakyekrom, the DMH in particular, became popular for treating sicknesses under the NHIS for free (see Adusei-Asante & Georgiou, forthcoming). The enhanced awareness of the DMH led to high turnouts at the DMH; early reporting of sicknesses; and an increase in the number of surgical cases. The downside of the NHIS, though, was the pressure it brought on the health staff and facilities, resulting in people refusing to visit the DMH although they had enrolled in the NHIS.

#### 4.1 High Outpatients Day Turnouts

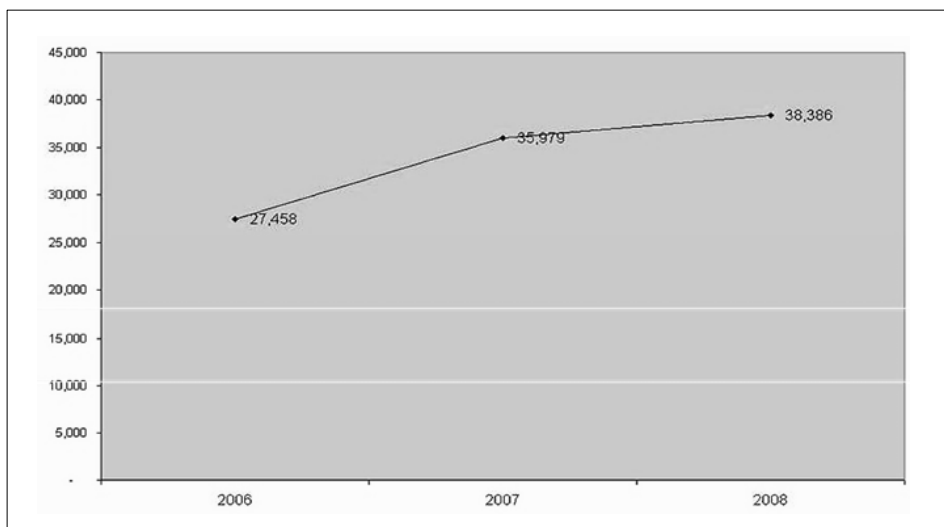
More patients visited the DMH compared to the period before the NHIS. One of the medics confirmed this as:

“We used to beg people to come to the hospital. Before the NHIS was introduced, there were days we recorded ten patients and had the wards virtually empty.”

Before the NHIS was introduced in the Daakye district, most of the local people could not afford the out-of-pocket services offered at the DMH. In 2001, it was reported that 30 patients absconded with their bills unpaid. In 2000, the DMH recorded a total Outpatients day (OPD) attendance of 9,882; 10,490 in 2001 and decreased to 8,869 in 2002 with an average OPD attendance of 28 daily. Bed occupancy rate in 2001 was 33.4 per cent and 38.2 per cent in 2002. The NHIS impacted these figures. The bed occupancy rate in 2006 was 45.12 per cent; 61.23 per cent in 2007 and 69.87 per cent in 2008. DMH was also receiving an average OPD attendance of 150 patients on normal days and 300 on market days (DMH Annual Reports, 2000-2009). Figure 1 and 2 show the steady increase of the OPD attendance at DMH from 2006 to 2008 and the Ghana Medical Service facilities from 2002 to 2008.

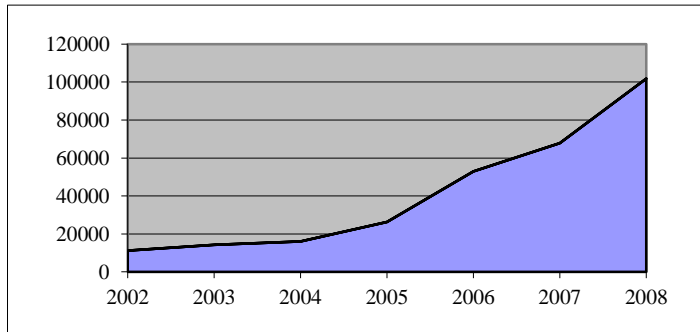
Most of the patients who visited the health facilities had enrolled in the NHIS. During our six weeks observation at the DMH, we recorded 78 adult patients who were health insured as against 22 who were not. It was also recorded that in 2008, 98 per cent of inpatients and 87 per cent of outpatients of the DMH were NHIS insured. For the entire district, the GHS facilities recorded out-patient NHIS status as 9.7 per cent in 2004; 33.4 per cent in 2005; 76.2 per cent in 2006; 84.5 per cent in 2007 and 90.5 in 2008.

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**Figure 1** Total OPD attendance Daakyekrom Mission Hospital 2006-2008

**Source:** DMH Annual Reports 2000-2009



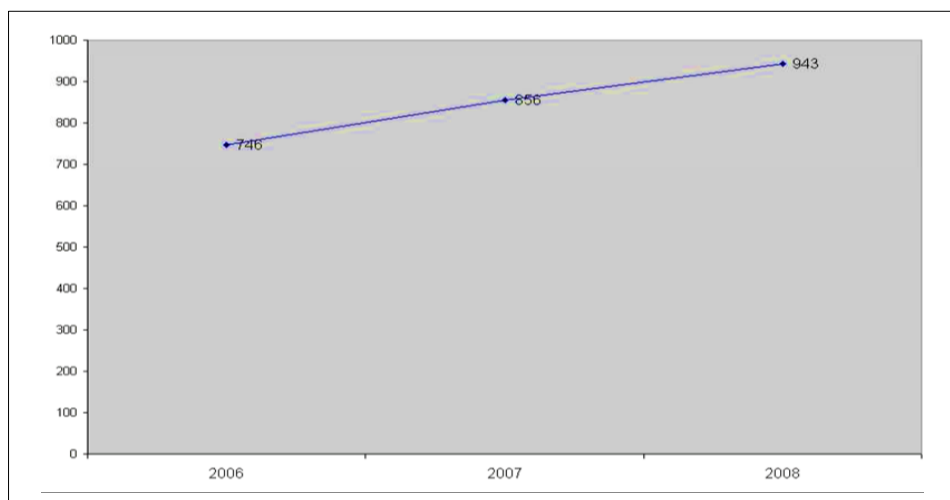
**Figure 2** OPD attendance at Ghana Health facilities-Daakye district  
**Source:** GHS Annual Reports, 2000-2009.

**4.2 Early Reporting**

The NHIS also influenced Daakye district islanders to report early to the HBT facilities. According to the medics, unless in an emergency or exceptional instances, the normal time to report an illness or its symptoms should be within two weeks. In our sample analysis, we observed that most of Islander patients who had enrolled in the NHIS reported early to the DMH. The medics explained that reporting early to the hospital reduced the complication of sicknesses among the health insured and added that complicated cases were common among the non-NHIS insured. We also observed that most patients who came to the DMH were treated for malaria, the topmost prevalent disease in the area. However, we found that most of the malaria cases were uncomplicated. This fact was evidenced in the 2007 and 2008 GHS reports, which indicates that in 2007, 27,350 uncomplicated malaria cases were recorded as against 648 severe and complicated types. In 2008, the uncomplicated types were 51,255 as against 980 complicated types, a finding that corroborates the impact of early reporting of sickness on reducing the complication of illnesses.

**4.3 Increase in Surgical Cases**

The third impact of the NHIS on HBTs in the Daakye district was an unprecedented increase in surgical cases. This relates particularly to a hernia among men and reproductive complications among women. In the year 2000, 642 major and minor surgical operations were recorded and 667 in 2001. In 2008, it shot up to 943, indicating a significant increase (see the chart below).



**Figure 3** Total surgeries at Daakye district 2006-2008  
**Source:** DMH Annual Reports, 2005-2009.

A gentleman we had an open conversation with, shared a joke, which confirmed the impact of the NHIS on surgeries. He said:

“The NHIS is dealing with all hernias in the Daakye district. Some men used to walk as if they had coals under their feet but walk straight now. Hernias are now scarce and even if you wanted one for rituals, it will be difficult and very expensive.”

The quote above corroborates a fact established in the data that, even though the DMH could handle surgical cases before the NHIS, most patients stayed away because of the costs involved. At the time of fieldwork, hernia surgeries topped all surgical cases in the district, thanks to the NHIS, which removed the ‘cost panic’.

#### **4.4 Increase in Health Facilities**

During an interview with the Director of the Ghana Health Services in the Daakye district, she remarked:

“The NHIS had improved healthcare delivery in general and caused more clinics to be built in the Daakye district. Those times, even if you put up clinics, no one would patronise them, because they had to pay. Now it is free, and people come, thus, provides a reason to build more.”

Dr. Atibeh attributed the increasing health facilities in the district from three in 2001 to seventeen in 2008 to the fact that local people were patronising HBTs because of the location of the NHIS, as some are close to their homes.

#### **4.5 Pressure on Health Staff and Facilities**

Although the NHIS led to an increased patronage of HBTs, it also came with some negative views. Most people we spoke to about the DMH raised the issue of time wasting. We gathered in the interviews that the hospital’s under-staffed workers were pressured by the high OPD turnouts resulting in patients having to spend more hours at the hospital, and concerns about less quality healthcare. The Manager of the most influential NGO in the district confirmed this in an interview that:

“Yes, the numbers have increased, but the same numbers could kill the NHIS here. Because of the numbers, the system is quite slow, and people complain.”

Two impacts resulting from the pressure on health staff and facilities were found. First, we found that the situation had led some who had the NHIS to desist from visiting the DMH for fear of being maltreated or chided for reporting illnesses deemed to be mild. The vignette below, discussed elsewhere (Adusei-Asante & Georgiou forthcoming), encapsulates this finding:

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 has 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 do not 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.

(Field notes # 004)

The vignette shows that although people may join health insurance schemes, the attitudes of healthcare professional, in this case, emanating from the pressure imposed by the free NHIS, play a key role in people’s decision to visit hospitals for treatment. This was further complicated by the facts that the DMH closed at 16:00 (which most local residents found acceptable) and the DMH not providing dental and genealogical medical services. Interviews with two senior medics at the DMH revealed that the hospital and the district were not attractive to most existing and prospective healthcare officers due to the lack of adequate incentives and the paucity of social amenities. Tellingly, a 2008 Client Satisfaction Survey done by the



Daakye district Development Organisation on the DMH found that the local people were not satisfied with the hospital's staff handling of clients.

Second, healthcare options such drugstores and traditional medicines were found to be popular in Daakye district because of the pressure on the biomedical staff and facilities. Partly emanating from the need to avoid time wasting at the DMH some of the local people resorted to drugstores or traditional medicines. We found drugstores to be the first point of contact for some NHIS holders until the sickness was no longer bearable. Some NHIS holders tended to visit the DMH only in extreme emergency cases, having unsuccessfully used traditional medicines alongside drugstore-prescribed medicines.

## 5. Conclusion

This paper discussed the dynamics of healthcare utilisation in free health insurance contexts and associated unintended impacts. It was found that Ghana's National Health Insurance Scheme (NHIS) had led to an increased awareness of health facilities in the Daakye district, resulting in high turnouts and early reporting of sicknesses. The high turnouts also gave rise to more surgical cases, a situation that did not use to be the case. On the flipside, however, the study showed that, the high outpatients' day turnouts also exerted pressure on the medics and the limited facilities at the Daakyekrom Mission Hospital, resulting in some local residents who had enrolled in the NHIS to avoid the DMH for fear of being abused for presenting with illnesses deemed to be mild. Such local people resorted to drugstores until the situation became critical.

The key policy implications of this study are twofold. First, there is a need for policymakers to match initiatives with commensurate resources and motivation of key human actors involved in the implementation of the policy. In the case of the Daakye district, the NHIS should have been implemented with establishing an attractive incentive package for healthcare staff, while sustained efforts were made to increase and improve the number of biomedical facilities to accept posting to the locality, given its remoteness and paucity of basic amenities there. This resonates with Kondo and Shigeokab (2013, p.1) suggestion that "countries planning a large expansion in health insurance coverage would need to generate sufficient financial resources to cover the surge in health care expenditures, both in the short and long run." Second, the reality of the popularity of drugstores and traditional medicines in Ghana requires sustained regulation and monitoring of these healthcare options, while public education on their use continues.

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