Do prevailing theories sufficiently explain perceptions and health seeking behavior of Ghanaians?

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Abstract

The challenges faced by African countries that have pioneered a national health insurance scheme (NHIS) and the lessons learned can be of great value to other countries contemplating the introduction of such a health financing system. In 2003, Ghana initiated the NHIS to provide access to health care for people in both the formal and informal sectors. The paper assesses the applicability of four theoretical models to explain the perceptions and decisions of Ghanaians to participate in the NHIS. To contextualize these models, qualitative data from individual and group interviews of Ghanaians are used. These interviews form part of the study towards a client-oriented health insurance system in Ghana to explain the uptake of the Ghanaian social health insurance. The paper argues for a new integrated model to provide a better understanding of clients' perceptions on illness, health care and health insurance. Such a model should highlight trust as a fundamental factor that influences the decision of Ghanaians to enroll in the NHIS.

KEY WORDS:
Perceptions; health insurance; trust; Ghana; theoretical models
Background
Ghana is one of the countries in Africa with a relatively high per capita expenditure on health, nearly 15% of GDP (IFC/WB 2009). Ghana launched its National Health Insurance Scheme (NHIS) in 2003 offering health insurance to people working in the formal and informal sectors. The NHIS is a mechanism for healthcare financing that offers a risk sharing system and intends to reduce clients’ financial barriers to accessing health care by lowering out-of-pocket payments at the point of service use. The NHIS Policy framework mandates the District Mutual Health Insurance Schemes to charge a premium between 7.2 and 48 Ghana Cedis (1 GHC = 0.6 USD) per adult. Formal sector workers are exempted from paying premium because 2.5% of their monthly salary is transferred by their employers to the NHIS fund. In order to promote access to health care amongst certain vulnerable groups, some people (the very poor; children under 18 years of age; people above 70 years of age; and from July 2008 all pregnant women) are exempted from paying insurance premium. TABLE 1 provides an overview of enrollment in the scheme. The drop in 2010 is attributed to a new reporting methodology introduced in that year.

Participation in the social insurance scheme is compulsory. NHIS-accredited public and private healthcare providers are contracted by the DMHIS to provide services to enrollees. Providers are required to offer a minimum package of services – outpatient and inpatient care – covering about 95% of the common illnesses in Ghana (Ghana Ministry of Health, 2004a and 2004b). The drugs provided are listed on the National Health Insurance Drug List. Providers are reimbursed on a fee-for-service basis according to agreed tariffs (the Ghana-Diagnosis Related Group Tariffs) after submitting claims for services provided.

<table>
<thead>
<tr>
<th>Year</th>
<th>Estimated population in Ghana</th>
<th>Total active members</th>
<th>Active members as % of population</th>
<th>Claims payment to providers (mll. GHC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>21,876,031</td>
<td>2,521,372</td>
<td>11</td>
<td>35.48</td>
</tr>
<tr>
<td>2007</td>
<td>22,378,911</td>
<td>6,643,371</td>
<td>30</td>
<td>79.26</td>
</tr>
<tr>
<td>2008</td>
<td>22,876,031</td>
<td>9,914,256</td>
<td>44</td>
<td>198.11</td>
</tr>
<tr>
<td>2009</td>
<td>23,416,518</td>
<td>10,638,119</td>
<td>48</td>
<td>322.91</td>
</tr>
<tr>
<td>2010</td>
<td>24,223,431</td>
<td>8,163,714</td>
<td>34</td>
<td>394.27</td>
</tr>
</tbody>
</table>
The NHIS has so far contributed to reducing financial barriers to accessing health care (Mahamud 2010; Brugiavini & Pace 2010). However, the NHIS faces various challenges such as enrolling and retaining clients in the insurance scheme; reaching the vulnerable and very poor people; ensuring a sustained quality of health care; managing claims; and reducing cost of service delivery. All these challenges pose potential risks to ensuring the delivery of affordable and accessible quality health care for the population of Ghana on a long term basis.

The paper assesses the relevance of prevailing models to help understand clients' perceptions on health, health care and health insurance. How do traditions, norms, relationships in groups and networks influence decision-making and health-seeking behavior? What is the role of informal and formal institutions in influencing clients' trust and involvement in the NHIS? To contextualize and assess the models, qualitative data obtained from a research conducted in August 2011 is used to explain the rationality behind Ghanaians enrolling or not in the NHIS. The paper subsequently suggests ways of improving upon these models.

**Methods**

Client perceptions on illness, health and health care were studied through 22 focus group discussions, 18 individual health histories and some key-informant interviews in rural and urban communities in seven districts of the Greater Accra and Western Regions of Ghana. Discussions were guided by the following issues: clients' beliefs regarding illness and health; status in the family, social groups and networks and the support derived from these social relationships; and their perceptions of and experiences with insurance services and health care. Interviews were continued up to a saturation level. Information was recorded and transcribed verbatim. In both regions, findings were validated and shared with healthcare providers and health insurance staff.

**Exploring four theoretical models**

In this paper, the following four theoretical models are described and reflected upon: the socio-anthropological model on healthcare systems (Kleinman, 1978), the sociological model (Granovetter, 1983; Granovetter, 1985; Coleman, 1988; Putman, 1993; Flynn et al, 1995; Woolcock, 2000; Woolcock and Harper, 2001), with specific focus on the social capital theory (Woolcock and Harper 2001) and the new institutional economics theory (North 1990, Klein 1998). Each of these theories on its own does not provide an adequate framework for explaining clients' perceptions and decision making with regards to illness and health care. Trust is an important component that links social behavior and economics. Thus, Mechanic's three-dimensional trust model (Mechanic 1998) is also used
to explain the dynamics of trust between clients, healthcare providers, health insurance and the government as regulator.

**The socio-anthropological explanatory model on healthcare systems**

Kleinman defines the client as an individual, being part of the community in a specific socio-cultural context (Kleinman 1978). He defines health, illness and healthcare-related aspects of societies as cultural systems, and divides the healthcare system into a popular, folk and professional arena or sector (FIGURE 1). The popular sector comprises the family context of sickness and care and the social network and community services linked to the individual. The size of the circles representing the three sectors and the overlap may vary according to the context. The folk sector (traditional sector) consists of the non-professional healing specialists and the professional sector involves western medicine (Kleinman 1978; Helman 2007). Between 70-90% of illnesses and health care is managed solely within the popular domain (Helman 2007). Most decisions on when to seek help, whom to consult and how to comply with treatments are made in the popular sector. In the Ghanaian context, this is illustrated by the following remark by a client: 'I don’t like all these medicines prescribed by the drug store, it’s usually the herbal preparations – the “ground” medicines that I drink. That’s all... then it’s gone. When I feel pains in my joints, I use the “neem” tree and orange leaves, boil them and pour them into a bowl, sit around it and cover myself with a thick cloth. Then I inhale the heat'.
According to Kleinman, the folk and professional domains help to organize particular subsystems of socially legitimate beliefs, expectations, roles and relationships called clinical realities (Kleinman 1978). These subsystems differ across societies. In some homogeneous Ghanaian societies, especially in rural areas, we found strong traditional beliefs and trust in spiritual healers, while in other societies, community members feel more reassured by the presence of a professional hospital.

Recognizing the differences between realities in these three sectors and attempting to collaborate, helps understand how people make decisions regarding different health sectors. We found that many clients use a combination of sectors in seeking health care. Kleinman presents explanatory models consisting of these five issues: etiology; onset of symptoms; patho-physiology; cause of sickness and treatment. Explanatory models are tied to specific systems of knowledge and values from the different sectors of the healthcare system. Healthcare relationships (i.e., patient-healthcare worker) can be studied as transactions between different explanatory models. Communication between professional explanatory models and popular explanatory models may easily lead to culturally construed conflicts. Professional practitioners commonly talk about sickness in a sector-specific language of biological functions and behavior, viewing treatment as a technical product whereas patients and families talk about sickness in a culturally-situated context. Folk healers use the language of their clients, which is probably one of the reasons why they are commonly consulted. Thus, in order to understand the perceptions of the Ghanaians interviewed, insights into their clinical realities are essential.

In discussions with community members, we learned that the introduction of the NHIS has made certain people change their choice and timing of seeking care. Since the NHIS only contracts healthcare providers in the professional sector, this has led to increased consultations in this sector. People who predominantly seek care from the folk sector are not likely to benefit from the NHIS. People pointed out that the NHIS should consider expanding collaboration to formally trained herbalists, considering that these folk healers are trusted for the support that they offer to the community. The socio-anthropological theory is useful in explaining perceptions and health-seeking behavior of clients based on the existence of different clinical realities. The focus is on processes at an individual level. However, the theory does not help explain the dynamics within and between social groups and networks and its impact on health care. Also, it does not explain the influence of a political decision, such as the launch of the NHIS, on people’s motives and choice to access health care.
Social theory
Social theories interpret social phenomena and draw ideas from various disciplines. The notion that social relations, networks, norms and values matter in the functioning and development of societies has long been recognized in sociology, economics, anthropology and political science (Gauntlett, 2011; Woolcock and Harper, 2001; Williamson, 2000; Putman, 1993; Coleman, 1988; Bourdieu, 1986; Granovetter, 1983 and 1985;). Granovetter describes the influence of social relations as the ‘social embeddedness’, where behavior of people and institutions are constrained by ongoing social relations (Granovetter, 1985; Polanyi, 1957). These networks of community relationships facilitate trust and motivate action called social capital (Coleman, 1988; Grootaert and Bastelaer, 2002). Social capital can be seen as an accumulated stock which requires investment and generates a stream of benefits (Grootaert and Bastelaer, 2002). It is also characterized by levels of trust, civic engagement and norms of reciprocity (Putman, 1993; Mechanic, 1998; Mechanic and Rosenthal 1999; Fukuyama, 2000; Brewster, 1998).

In Ghana, clients generally perceive membership of a group to be important because it is a source of sharing information and knowledge for different purposes, for example to help raise children, save money or improve crop production. Also, membership of a group offers the possibility to share beliefs and norms. It is considered as a form of insurance to get moral or financial support in times of need, which is expected to be reciprocal. During the fieldwork, we found that most people are affiliated to one or more groups, particularly the religious groups as described here: ‘… the strongest and most influential are the (church) women’s fellowships because they are able to mobilize their members to engage in many activities and they also last long.’ Their stories indicate the importance of a strong and fair leadership that promotes trust among the members, and strengthening leadership is perceived as a worthwhile investment.

Woolcock has explained the scope of social capital through bonding relationships at micro, meso and macro level (Woolcock and Harper 2001). At the micro level, social capital encompasses networks of individuals or households and the associated norms and values that create benefits for the community as a whole (FIGURE 2). At the meso level, it comprises horizontal as well as vertical associations and behavior within and among other group entities whereby vertical associations are characterized by hierarchical relationships and unequal power distribution among members. Social capital at the macro level shapes social structure and enables norms to develop. It is often about formal institutional relationships and structures such as rule of law and political regulations.
Individuals can use various channels to generate social capital that can influence their decision making and actions (Grootaert and Bastelaer 2002). The first channel constitutes the participation of individuals in a social network such as women and religious groups in the case of Ghana, which increases the availability of information and lowers transaction costs. This can be critical in the decision and behavior of women, for example, the timely utilization of professional antenatal care to avoid complications during pregnancy. A second channel involves mutual trust derived from the participation in social networks which makes it easier for any group to reach a collective decision and implement a collective action. For example, in Ghana, when information on entitlement to treatment covered by the NHIS is not well understood among clients, community or client platforms could serve as a suitable channel to access information and raise awareness within the community. The third channel entails attitudes and norms that reduce opportunistic behaviors by community members. In Ghana, community health committees can stimulate communities to adhere to malaria control measures, preventing the break-out of a malaria epidemic. Social control can serve to pressure individuals who do not adhere to these preventive measures to adopt these community standards.

Strong leadership in a group or social network enhances social capital (Ahern and Hendryx 2003; Hendryx, Ahern et al. 2002; Fukuyama 2000; Kilpatrick and Abbott-Chapman 2005). Loss of social capital appears when norms and sanctions that support the system are weakening, resulting in diminished trust and fragmentation. Kilpatrick states that the quantity and quality of a community’s social capital not only depend on the leadership but also on the diversity or in-

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Figure 2 Social capital framework (Source Woolcock 2001)

1. Bonding social capital at micro-level: relations within communities
2. Bridging social capital at meso-level: relations across communities
3. Linking social capital at macro-level: relations between communities and formal institutions
4. Bonding social capital at macro level: organizational integrity within institutions
equalities in opportunities within societies. When communities become more heterogeneous, the features of solidarity and the positive effects of social capital tend to weaken (Arhinful 2003), which was also observed during our fieldwork.

Since health insurance requires very formal and costly monitoring mechanisms, social capital can contribute to the reduction of the transaction costs associated with coordination and monitoring mechanisms (Ahern and Hendryx 2003; Hendryx, Ahern et al. 2002; Fukuyama 2000; Hughes et al. 2011). In a recent study in England and Wales, a strong influence of ‘relationality’ (i.e., strong relational component) was observed on contracting (Hughes et al. 2011; Vincent Jones 2006). It is, therefore, important for the leadership of the NHIS to build a strong embedded scheme, where clients and healthcare providers feel involved and support the efforts of the NHIS to implement and manage the insurance program for the benefit of the community and the population at large.

Social capital theory helps to understand clients’ perceptions on health and health care by offering a framework that describes the scope and channels along which information, relations and social support can be fostered. It helps explain how community relations can affect intrinsic motivation and facilitate trust, solidarity, social exchange and civic engagement. However, the social theory does not adequately incorporate the impact of political decisions, legislations, regulations and self-interest on clients’ behavior.

New institutional economics theory
Where political scientists, sociologists and anthropologists tend to approach the concept of social capital through analysis of norms, networks and organizations, new institutional economics tends to approach the concept through analysis of contracts and institutions, and their impact on the incentives for rational actors to engage in investments and transaction (Grootaert and Bastelaer 2002; Williamson, 2000; North, 2010 and 1990). The complexity of exchange relations was earlier proposed by Macneil (1980), who introduced the relational contract theory and pointed out the inaccuracy of the ‘classical’ and ‘neoclassical’ contracts.

Informal institutions are, for instance, rules of conduct, social norms and religious beliefs and can be compared with social capital at micro and meso level that is embedded in social groups and networks (Fukuyama 1996). Formal institutions can be described as property rights, common laws, contract enforcements, financial institutions and registries, and can be compared with social capital at the macro level (formal institutional relationships and structures). Institutions create order and reduce uncertainty by providing structure in everyday life (North 1990). In some communities with strong community feeling, well-rooted traditions and multiple associations and informal institutions are strong and can
outweigh the effect of formal institutions (North 1990; Klein 1998). Also, it has been observed in the socio-legal studies that the social relations in which formal contracting is embedded affect the success of contractual exchanges. It is vital to maintain an effective balance between the so-called discrete and relational contractual norms (Hughes et al. 2011). Thus, when introducing new policies and regulations, contractual partners must observe the relational norms required to foster trust and cooperation, which in the long run will generate mutual benefits (Macneil 2000; Hughes et al. 2011).

Traditional arrangements can disintegrate as a result of common processes of social transformations (Klein, 1998; Williamson, 2000) such as in the Western Region where rapid economic developments are taking place: ‘At first the oneness was here. Now that the mines have come it has made some people move forward and others not. So the oneness is not as before.’ Social transformation can weaken informal institutions but our field study revealed that where certain groups and associations dissolve, new ones arise.

Lack of formal institutions can lead to unfavorable behavioral effects and a limited system (North 1990; James 2007). People do not invest due to high risk and transaction costs (cost for information, bargaining and enforcement of the agreement). In relation to health care, clients perceiving a professional health system as poorly organized without delivering quality care are less likely to have trust in the system and thus less likely to pay for it. Likewise, people who perceive an insurance scheme as disorganized and non-performing, see no benefits in enrolment. Poor people, particularly, have a short planning horizon (high discount rate) and are unlikely to invest in national health insurance with uncertain benefits.

Arhinful observed that at the start of the NHIS in Ghana, people looked upon a state controlled health insurance fund with mixed expectations (Arhinful 2003). On the one hand, they perceived the state as having more resources than any other entity to support the health insurance scheme but on the other hand, there was a great skepticism towards the state due to a lack of trust and faith in public officials and politicians based on past performance of state enterprises and public corporations. Almost ten years later, the majority of the Ghanaian population has had a direct or indirect experience with health insurance. During our fieldwork, we learned that over time, many people have enrolled in the NHIS, which suggests a certain level of trust in the system. Some people have changed their health seeking behavior by visiting a professional healthcare facility more often. Trust in the NHIS has changed over time. Clients believe that the NHIS-affiliated healthcare providers are not meeting the quality standards and benefit package that were initially promised. Several respondents feel increasingly un-
certain about what to expect from the healthcare providers when they show
their insurance card. The people interviewed cited lack of control and supervi-
sion of services as an important factor. This supports an important feature of the
new institutional economics: enforcement of contracts and agreements, whether
through informal or formal institutions, raises the level of trust (North 1990).

Some clients explained that they would like to return to the old fee-for-ser-
vice system since they perceived the quality of care there to be better and more
reliable. According to clients, the policy makers and leaders of the NHIS are
believed to show limited concern for quality control and the training of health
professionals. Nurses are thought to lack empathy and devotion in assisting
patients. Lohlein who studied the relation between clients’ access to health-
care and the efficiency of formal institutions in Russia, also confirmed the impor-
tance of policy makers in creating formal systems, which are compatible with
the existing informal institutions (Lohlein et al. 2003).

New institutional economics provides a framework to analyze clients’ percep-
tions and decisions to participate in the NHIS by taking into account the dy-
namics, governance and efficiency of both informal and formal institutions. The
effect of formal institutions depends strongly on the level of enforcement and the
extent to which these formal institutions are compatible with existing informal
institutions, which in the social capital theory can be translated as bridging social
capital at the macro level. Nevertheless, in most developing countries, imma-
ture and weak formal institutions affect the relevance of new institutional eco-
nomics in explaining transactions, for example, health care which is usually or-
organized within the informal, non-professional sector. The importance of new
institutional economics is also determined by the extent to which the NHIA is
able to nurture a formal system that capitalizes on social and cultural conditions
and norms of the communities.

Three-dimensional trust model
Perceptions on health and health care are based on a broad range of factors.
Trust is an important factor in the decision making with regards to adopting inno-
vations, making investments, negotiating contracts or using health care (Polanyi
1957, Greenwood and Buren 2010, Mechanic 1998, Granovetter 1983, 1985, Mac-
neil 1980, 2000, Nooteboom 2002; Hughes et. al 2011). Trust has been defined
as the expectation that a counterpart will not engage in opportunistic behavior
even in the face of countervailing short-term incentives (Nooteboom 2002).
Although most of the empirical work on trust is conducted in the field of busi-
ness and law, considerable work is also done on trust in purchaser-provider sys-
tems, including the United Kingdom (Palmer 2000; Broomberg 1994; Flynn et
al. 1996; Hughes 2011). **FIGURE 3** describes clients’ trust in health insurance, which emphasizes the three-dimensional aspects of trust in the following model (Mechanic 1998; Mechanic and Rosenthal 1999).

The above model illustrates that client’s choice to enroll in health insurance is based on:

- their trust in *providers*’ technical and interpersonal competence and the judgment whether providers advocate on patients’ behalf;
- their trust in *insurance* management, based on the reputation of improved and consistent access to care and demonstrating expertise in financial management;
- and finally client’s trust is related to *regulations and control mechanisms* for legal enforcement of commitments. These can be compared with the so called “formal institutions of the new institutional economics” (North 1990; 2010; Easterly 2008)

Clients in Ghana perceive these trust dimensions as important in their decision-making, whereby dimension 1 (provider trust) and 2 (Insurance trust) are mentioned more frequently than dimension 3 (regulator). This can be explained by the fact that the clients’ contact with the health system is at provider and insurance level so their perceptions are more articulated at these two levels. It is remarkable though that in the model of Mechanic, the immediate environment of clients and social groups and networks are not considered.

According to Mechanic (1998), clients’ trust is primarily influenced by these
three factors: assurance of competence; advocacy for the client's welfare; and appropriate control over the healthcare process. Hall in his work in the United States adds two other sub-dimensions: management of confidential information and disclosure of information (Hall, Dugan et al. 2001). Trust should be considered as a process (Meyer, Ward et al. 2008), which means that the dimensional model introduced by Mechanic should include the social context in which trust relationships are continuously affected by changing social relations.

**Trust in the provider**

One of the sub-dimensions of trust about providers is the expectations about the health workers' technical competence, which is usually difficult to assess by lay people due to information asymmetry. Lay people would like to be reassured that they can trust health workers because of their (academic) training and professional regulations. “What I know is that doctors are people who have studied and learned all about the body. That is why they can help me”. Not everyone shared this opinion: “Some are qualified to work in the hospital but are just not patient. Some nurses are working out of devotion to help people. It is something they learn when they grow up at home and use in their work with patients”.

Some clients base their decisions on suggestions by relatives and friends whom they trust. “It is my mother who decides because she knows what the condition is and the best place (health facility) to take the child to” according to a woman during a focus group discussion in Greater Accra Region. Education will enhance clients’ ability to compare and contrast information provided by the doctor. Access to sufficient quality information contributes to increased knowledge and understanding on illness and healthcare. The rapid growth of internet, at least to a part of Ghana’s population, primarily the youth will contribute towards accessing information about medical conditions and treatments.

Competence includes not only knowledge and skills but also interpersonal skills, for example helping patients feel at ease, interviewing sensitively and providing meaningful responses (Mechanic 1998; Donabedian 2001). Patients are sensitive to this aspect of interaction. Poor interpersonal competence may well undermine the patients' trust in the health workers' competence, resulting in unwillingness to adhere to advice and treatment. Poor attitude of healthcare staff is found to be a major problem in Ghana: “Those nurses, especially the young ones are very lazy. They will sit down and chat while they should be working”. The doctor, the nurse and the health institution are expected to create a trustworthy, service-oriented relationship with the client. Failing to do so has the potential to undermine the clients' overall trust in the health system (Rhodes et al. 2000). In Ghana, it is a common phenomenon for clients at public healthcare facility to complain about the services rendered: “Mostly when you go to some of these govern-
ment hospitals with your insurance card, they will not take care of you but just leave you sitting and waiting there the whole day. They would never mind you”.

To be deemed trustworthy, healthcare providers should make efforts to improve safety and provide information about the treatment (Entwistle and Quick 2006). This helps increase the trust of clients and contributes to their desire to seek health care. A woman in Western Region described it as follows: *When you go to some of the clinics, the nurses will talk to us about our sickness and advise us not to wait too long before bringing conditions to the hospital – observing the situation for two to three days without seeing improvement means we should go to the hospital*.

Entwistle describes the reciprocity of trust where healthcare providers may feel vulnerable to their clients because of reputation risk. From providers’ perspective, trustworthy clients acting responsible should adhere to treatment advice to optimize the outcomes of their treatment and to preserve healthcare providers’ good reputation. During a meeting with Ghanaian healthcare providers, nurses mention non-compliance as a major problem.

A second sub-dimension of trust in healthcare providers is the advocacy of clients’ welfare. This is believed to be fundamental in the provision of quality services. One example mentioned by several clients was the advice given to them by nurses to enroll or renew their membership in health insurance in order to reduce health costs. Clients appreciate doctors and nurses, who spend time to discuss with them issues such as the need of the NHIS to include certain drugs in the health insurance benefit package or to speed-up renewal processes for NHIS members.

Healthcare is sometimes seen as a selfless endeavor in which health workers would suffer inconvenience to assist and be loyal to their patient (Mechanic 1998, p. 667). However, economic incentives are seen as a threat, which may motivate health-workers to prescribe unnecessary medicines. The third sub-dimension is the healthcare providers’ level of control over decision making in healthcare processes. To which extend can health care providers make sure that the treatment needed can be made available. “During previous visits, they gave us medicines but now they tell us that this particular drug does not fall under the insurance. These are new developments, which bother us”. Also, providers are forced into positions where they face tangible conflicts between serving their patient needs and ensuring their own economic survival. “Those not insured are promptly taken care of and provided with large amount of drugs, because they are willing to make direct payment” several people explained. “They will prescribe drugs for you and then say that you should go and buy…what if do not find it elsewhere, what then is the point of them writing it?”
The fourth sub-dimension of trust is the capacity of healthcare provider to manage confidential information. In most countries, protection of confidentiality has made it possible for clients to communicate freely with healthcare providers without fear that the information would be used against them. The final sub-dimension is trust related to disclosure, i.e. the need that the healthcare provider will share information with the client necessary for his or her to make informed decision about the treatment. Earlier studies indicate that doctors underestimate patient's desire for information (Hall 2002), which was also reflected in the interviews we conducted in Ghana. Doctors and nurses do sometimes provide incomplete information partly due to neglect and in cases when an effective treatment is unavailable. Full disclosure of treatment options is a requirement for the maintenance of trust. Both confidentiality and disclosure were not revealing from the discussions as much as the other sub-dimensions.

Trust in the Insurance Scheme

Compared to the United States and Europe, not many studies have been conducted in Africa exploring the relationship between clients, insurers and providers (Flynn et al 1996; Straten et al, 2002; Balkrishnan et al, 2004; Goudge and Gilson 2005, Gilson 2005).

Balkrishnan describes health plan-related behaviors that are associated with trust in the US, measuring changes in trust in an insurer over time (Balkrishnan et al. 2004). He observed that the trust in a physician is less susceptible to change compared to the trust in an insurer. This can be explained by the fact people who are ill (patients) are more vulnerable to submit themselves to physician's advice and care. This is quite different from people who after an episode of illness contact the insurer for claim issues (Balkrishnan et al. 2004). Trust in health plans is strongest when patients can make their own choice and are not restricted by either employer's decisions or health plan constraints. Insured clients with high trust in their health plan are significantly less likely to seek care from someone other than their own healthcare provider.

In our study, low coverage of healthcare providers in certain areas result in some people not having a choice. We did not find clear differences in trust levels between clients in rural and urban areas. With respect to healthcare services available through the insurance scheme people responded: “When I first delivered, the insurance was not there but it has helped me a lot especially to have safe delivery of my third and fourth child”. The exemption policy for free maternal care was mentioned as important benefit that the NHIS offers. “With the introduction of the insurance, no matter your position in society, whether poor or rich, once you have the card, you can get up and go straight to the doctor; and you know the scheme is there to help”.

DO PREVAILING THEORIES SUFFICIENTLY EXPLAIN PERCEPTIONS AND HEALTH SEEKING BEHAVIOR OF GHANAIANS?
In particular with respect to the enrolment and renewal procedures of the NHIS there are negative feelings among clients: “At times when they say three months, even after five months the card is not ready, so they should be clear on when we can expect the cards”.

“To be frank I have not registered. The weakness I see is that someone attending the hospital with his card at the end of the day pays the same amount of money than the person without a card”. The inconstancy in services available to clients is seen as threat to the reliability of the scheme.

Schneider (2005) conducted one of the few studies on trust in micro-health insurance in Africa. In Rwanda she identifies three important factors affecting trust: the management of the insurance scheme; the capacity of the scheme to respond to consumers’ needs and patient concerns; and the mechanism the NHIS uses to ensure quality care for clients. Through focus group discussions, she observed some key factors that promote trust in the insurance: clients’ ability to influence appointment of management, accounting systems ensuring sound financial management, timely provider reimbursement and negotiations with providers for better quality care. These are typical factors applicable to small scale community initiatives. Whether these factors also apply to a nation-wide social insurance program is doubtful because the management of the NHIS is more distant. In Ghana despite the presence of District Mutual Health Insurance Scheme offices at local level many clients perceive the scheme as not being visible. Clients do not understand the procedures of the scheme, which affects the trust in the scheme. Our findings reveal that trust in the Ghana NHIS is related to information provision, consistency of services, equity and fairness at healthcare provider level and the ability of clients to file complaints.

**Trust in the health system**

Clients develop trust in a healthcare system when the system is able to deliver good quality care and promote institutional guarantees. These guarantees include government’s capacity to regulate training and certification healthcare providers, the protection of patient rights and quality controls of healthcare services. These institutional guarantees do also affect the relationship between provider and client. Some respondents suggested ways to strengthen institutional guarantees, especially related to staffing: “if the government is to provide sufficient staffing, they also have to guarantee that they are well trained before sending them to us such that they know how to help us”.

System trust is the trust placed by a group or a person in a societal institution or system (Straten et al 2002). It is influenced by people’s experience with those working for these institutions or systems and societal values and the media (Mechanic 1998). The legislative framework of the health sector includes the rights
of patients. Laws and policies can be seen as a highly sophisticated normative system, and are defined to regulate the developments and as such influence the way the client, the provider and the health insurance operate (Friele 2010). Information and awareness-raising is ‘key’ to realizing these regulative developments. We observed in Ghana that the awareness of clients about these laws and regulations is insufficient.

The extent to which laws and policies are effective and binding varies greatly across countries. In low-income countries the capacity for enforcement is often weak. Laws must offer reliable social protection in order to contribute to clients trust. Enforcement should motivate providers and health insurance organizations to adhere to the required laws. High transaction costs, caused by complex administrative procedures, requirement of highly specialized workers, high administrative costs or registration fees (or a combination of this) can eventually discourage providers and users using the system. Clients depending on non- or semi-regulated systems are likely to develop limited trust. In Ghana, the problems related to enrolment and renewal of membership, inconsistency in delivering of insurance services and low competence of staff hamper trust in the system. Also the delay in re-imbursement – i.e. a problem between the healthcare provider and insurer – does indirectly threaten clients’ trust in the scheme. In Ghana, some of the insurance laws are under review to help reduce bureaucracy and complex regulations that hamper operations.

The three dimensional trust model of Mechanic limits the trust-model to relationships between the client and healthcare provider, insurer and regulator. It does not incorporate the exchanges among the service providers nor the cultural and social relations outside the formal health sector that affect the choices clients ultimately make. Understanding the choices that people make requires a critical appraisal of their trust in formal and informal service providers as well as the relations among the service providers which affect the quality of service.

Conclusion
We have demonstrated that each of the four theories has its own strengths and limitations in explaining clients’ perceptions on illness, healthcare and health insurance. Each discipline – the socio-anthropological model, the sociological model and the new institutional economics – has contributed to the scientific understanding on health systems decision-making, but from mainly a mono-dimensional perspective. Since each discipline has insufficiently integrated its work beyond its own domain, the explanatory value of the models has been limited, especially in developing countries where due to institutional failure and limited trust, informal relations and socio-cultural processes hugely determine the value that people attach to formal institutions and the quality of services that they render.
In order to avoid fragmentation and help framing the factors that influence decisions and ultimately determine health-seeking behavior in developing countries, a new integrated model should be defined. Some studies such as the social embeddedness of economic action (Granovetter, 1985), the ecological perspectives in health research (McLaren and Hawe, 2005) and the research program, REFGOV (the Centre for Philosophy of Law at the Catholic University of Louvain, Belgium) on emerging institutional mechanisms, governance and collective action have shown promise to situate public good in an intrapersonal, socio-economic and institutional context. Also, Hughes (2011) elaborates on the importance of relations in contracting mechanisms in the formal health sector.

The paper has shown that decisions on health, healthcare and participation in national health insurance in Ghana are influenced by a dynamic and complex interaction of intrapersonal, interpersonal, community, institutional and larger socio-cultural and policy factors. Research into health-seeking behavior and participation in national health insurance should not only focus on improving greater capacity for providing quality care but also on understanding the aspirations of low-income people to invest in health care. Improving technical competence in the delivery of health care and insurance services is vital but it has not always led to increased participation in health insurance. Trust and cooperation cannot be enhanced primarily by rules and performance management. Thus, future research should also emphasize the inter-relationships, exchanges and reciprocities among the diverse health actors, namely the community, the health care provider, the health insurer and the regulator. An integrated model offers a framework to assess the critical elements which account for health decisions and care, especially in developing countries, where complementarity of formal and informal relations and mechanisms influence transactions in healthcare more than in developed countries.
References


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