Disparities between Explanatory Models of Health Clients, Healthcare Providers and Health Insurer

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Abstract

Explanatory models (EMs) determine people's perceptions of, expectations of and responses to health problems to a large extent. We compared the EMs of healthcare clients with those of the healthcare providers and the health insurer regarding illness, the need for, the quality of, and the control over healthcare and health insurance services.

We present qualitative data from a study in Ghana (2011), where in 2003 health insurance was introduced to improve access to health care. However, enrollment is stalling. In our comparison we found disparities between the studied EMs of clients, healthcare providers and the health insurer, which were leading to misconceptions and limiting trust. We argue that these disparities influence clients' decisions to enroll in insurance and to access health care. Our findings increase our understanding of clients' behavior and decision making with respect to health care and health insurance. This increased understanding can guide policy makers and managers to improve the effectiveness of communication and training in healthcare and health insurance services.

KEY WORDS:
Explanatory Models, Health communication, Trust, Health Insurance, Ghana
1. Background

In many low-income countries health insurance is being introduced to increase access to health care, in particular for the vulnerable and poor population. This is expected to provide poor households with risk protection. In countries with unfavorable health indicators health insurance has been instrumental to improve this situation (Lu et al. 2003, Werner 2009, Xu et al. 2003). The challenges in reaching out to the full population have been demonstrated by different studies (Asante and Aikins 2008; Jehu-Appiah et al. 2011). A wide range of barriers have been found to influence enrollment in health insurance, such as cost, distance to the facility, quality of care, and timing of premium payment (Osei-Akoto 2003; Jütting 2004; Kamuzora and Gilson 2007; Nketia-Ampomsah 2009; Mensah 2010; Sarpong et al. 2010). It is also believed that socio-cultural factors such as local beliefs and social norms play a significant role in access to care and medical adherence (Vaugh 2009, Horrowitz et al. 2004). We argue that exploration of Explanatory Models (EMs) – a concept from medical anthropology – relating to illness, the need for, quality of, and control over healthcare and health insurance services, might not only help to explain people’s utilization of healthcare services but also of health insurance services. The EM concept and our reasons for adopting it to explain client behavior is presented in the Explanatory Models section of this paper.

Our study context is Ghana, where the government introduced a National Health Insurance Scheme (NHIS) in 2003. This mandatory scheme was to replace the ‘fee for service’ system and ensure better access to quality health care for all citizens in Ghana. Considerable progress has been made and in 2013, at its ten-year anniversary, 34% of the population (over 8.5 million people) was actively using the scheme. This also means that a large segment of Ghana’s population is not benefiting from the scheme and is paying out-of-pocket for services at the point of care. Several studies have identified a variety of factors, such as low education, financial barriers or poor quality of services, as responsible for this low enrollment coverage (NHIA 2010; Aryeetey et al. 2011; Jehu-Appiah et al. 2011). The NHIS is keen to obtain better insights into factors influencing participation in the scheme, with specific interest in aspects at the interface between service providers and clients (Jehu-Appiah et al. 2011).

This paper presents findings on data collected in 2011 in two socio-demographically distinct regions in Ghana: Greater Accra and the Western Regions. We compare EMs of clients with EMs of healthcare providers and of the NHIS staff, with the aim to identify discrepancies in EMs that contribute to barriers to enroll in health insurance. We reason that mismatches or conflicts in EMs can contribute
to discrepancies in expectations and to miscommunications, consequently reducing the clients’ interest and trust in services. In various studies, trust is found to affect participation in insurance schemes (Donfuet et al. 2011, Zangh et al. 2006). There can be mismatches in EMs between clients and NHIS staff with direct consequences for trust in the scheme. Likewise, mismatches between the EMs of clients and the EMs of health providers providing the NHIS healthcare services can have consequences for the clients’ interest in both utilizing healthcare services and enrolling in the scheme. Finally, we also reason that a mismatch between the EMs of a healthcare provider and the NHIS may further affect trust of clients in the scheme. Once differences in EMs have been made explicit, this will allow for the negotiation of best solutions to reduce these and implement improvements that increase interest in utilization of services.

2. Explanatory models
The notions of people’s beliefs about illness, the personal, social and economic meaning they attach to health problems, and the expectations of treatment and risk reduction are believed to be fundamental in explaining health seeking behavior. Kleinman introduces EMs as being ‘the notions about an episode of illness and its treatment that are employed by all those engaged in the clinical process’ (Kleinman 1978, p 88 – see CHAPTERS 2 and 3). He points at the differences in EMs between healthcare experts (the bio-medical trained doctor) and patients.

Brodwin (1998) suggests that different EMs are affected by a number of macro and micro level factors. At the macro level, there are the bureaucratic and economic rules and the systems of the healthcare system (Kleinman 1978; Bakeera 2009; Vaughn 2009). For example, healthcare workers base their EMs on their acquired insights and knowledge obtained during professional training and instruction and on the protocols at their work place. Their concept of illness is found to relate to the bio-medical definition of disease, determining this as a problem of the organ itself (Helman 2007). This contrasts with the term illness in the patient’s EM, which is a more subjective response of an individual and of those around him to his being unwell. These are based on people’s broad understanding and personal beliefs of illness, suffering and the expectations of treatment and risk reduction. At the micro level, it is the face-to-face interaction at the point of service that affects the EMs. Inability to decode each other’s verbal and non-verbal language may easily cause conversational asymmetry that again can lead to mistakes in service provision and reduce reciprocal trust as revealed in various studies (Schouten and Meeuwesen 2006; Haidet et al. 2008).

If a health worker elicits the client’s EM, he acquires insight in the beliefs the client holds about his illness, the personal and social meaning he attaches to his
illness, and the expectations about what will happen. This insight is expected to facilitate bridging the gap between EMs and to build trust.

According to Kleinman (1978), a medical consultation can be seen as a transaction between client and professional EMs. These transactions are featured not only by differences in EMs but also by differences in power (such as social class, professional knowledge, ethnicity, gender) and trade-offs (what do I get out of this interaction). For example, our study results in Ghana reveal that clients bearing a NHIS insurance card do perceive services provided to them (insured) to be poorer than services to clients who can afford paying cash or those who are acquainted with the staff. We found various studies looking at viewpoints of either patients or healthcare providers, while few studies have looked at the intersection between patients and healthcare providers (Kleinman 1978; Horowitz et al. 2004; Schouten and Meeuwesen 2006). In many of these studies effective communication is mentioned as a key problem and believed to risk non-adherence to treatment and low trust. No study has been conducted comparing the EMs of three stakeholders: clients, healthcare providers and the health insurer. We expect the EMs of the health insurer to differ from both the clients and the healthcare provider’s because of the different social role, professional training, and institutional context. Comparisons of clients’ EMs with that of the healthcare providers and the health insurer will enable us to identify discrepancies that influence enrollment in the NHIS. Once differences have been made explicit, it will make it possible to negotiate best solutions to reduce these.

3. Method and data

We aim to explore EMs and identify overlaps and disparities. We used qualitative data from client interviews. In addition, we used qualitative data from two other sub-studies as part of our broader study*, looking at perceptions of healthcare staff (public and private) and of the health insurance provider respectively. Although the topic guides used for clients, healthcare providers and health insurance provider were not completely identical, we defined EMs for our comparison based on Kleinman’s theory of EMs and common inductive themes discussed by all stakeholders. These are described in Table 1 (p. 74).

To obtain an in-depth understanding of the perceptions of clients, healthcare providers and health insurance staff, a participatory action approach (PAA) was

* The study ‘Towards a client-oriented health insurance scheme in Ghana’ started in 2011 and comprises three sub-studies focusing on perspectives of respectively clients, healthcare providers and the health insurance scheme. The three sub-studies were conducted by three, closely collaborating PhD researchers (Fenenga (clients); Kaba-Alhassan (healthcare providers); Duku (health insurance scheme).
employed, using a combination of qualitative methods to elicit the views and opinions of participants to be heard in their own environment and to allow for triangulation and comparison of data. **FIGURE 1** presents the client-healthcare provider-insurer EM tripod.

![Client-Provider-Insurance EMs](image)

**Figure 1** Client-Provider-Insurance EMs

The PAA was chosen for its specific features of awareness raising, exchange of views and mutual learning among participants (See **CHAPTER 4**). We recorded clients' perspectives through twenty two Focus Group Discussions (FGD), with on average nine participants per group, eighteen Individual Health Histories, three key informant interviews and four informal interviews among communities in the two study regions. Clients' interviews were conducted in local languages, using

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**Table 1** Common themes in data of clients, healthcare providers and health insurance

<table>
<thead>
<tr>
<th>Perspectives (EMs) of</th>
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<tbody>
<tr>
<td>Illness and disease <em>(meaning, cause, severity)</em></td>
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<tr>
<td>Need for healthcare services and health insurance services <em>(cultural, belief, awareness, value, severity, financial ability, efficacy)</em></td>
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<tr>
<td>‘Quality’ of healthcare services and health insurance services <em>(definition, expectation, experience, sustainability)</em></td>
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<tr>
<td>Respective roles in healthcare and health insurance services to attain quality services <em>(traditions, expectation, level of influence, power relations)</em></td>
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predefined, translated topic guides. For the providers’ perspective, a total of twenty-two in-depth personal interviews (IDIs) were conducted. Four of the interviews were at the regional level involving Directors of Services. The remaining eighteen interviews involved facility level health personnel (nurses, medical assistants, pharmacists, lab technicians and midwives). For the insurer’s perspective, sixteen IDIs were conducted in the two regions. Four of the interviews were conducted at the National Health Insurance Authority (NHIA) headquarters in Accra, involving departmental directors and senior officers. Six of the interviews were conducted at the regional offices of the NHIA, involving regional managers and monitoring and evaluation officers. The remaining six interviews were conducted at the district scheme offices of the NHIA involving district scheme managers, public relations officers and claims officers. Topic guides were pretested. All interviews were recorded and transcribed verbatim. Data was coded, categorized and analyzed using N-Vivo 9 to interpret their meaning and form well-founded conclusions. Findings were validated and triangulated through two workshops organized for purposively selected clients, healthcare providers and health insurance staff in both study regions. After validation in respective stakeholder groups, results were presented by the stakeholders themselves to the other two respective stakeholder groups, allowing sensitization and mutual learning, while identifying similarities and differences in EMs relating to illness, need for, quality of, and control over healthcare and health insurance services. Based on the discussion, suggestions for solutions to overcome the disparities were sought from the participants and these were incorporated in the design of an intervention.

4. Results

Here we are presenting the findings of our study that have been validated by participants, comparing the EMs of respective stakeholder groups that relate to illness, need for, quality of and control over healthcare and health insurance services (TABLE 1). These were collected in the Western Region (WR) and the Greater Accra Region (GAR), our study area. Table 2 summarizes these findings.

4.1 Perspectives of Healthcare Client

Illness

In Ghana the popular-natural perspective of the clients features different worlds of causation: the individual (that matches with biomedical model); the natural (excessive cold, heat, pollution); the social (witchcraft), the supernatural world (gods, spirits or ancestors), or a combination of these. Their logic, the way they look at illness, shows a variety. 'You see, diseases can be grouped into two, the
physical and the spiritual. So if you go to hospital and it [ref. the illness] does not stop, it means it is spiritual so you should go to prayer camp' (female, GAR). ‘…There are some illnesses that are said to be caused by harm afflicted on you spiritually….you have to remove the harm or curse before doing something else’ (female WR). The believed cause of illness determines to a large extent the drive and place to seek care. Others conceptualize illness as physiological factors: ‘For me, I am pregnant. If anything happens to me, my mother told, I should go to the hospital’ (female WR). These quotes show that the influence of beliefs of close relatives on clients’ perception of illness and health seeking behavior are strong in both regions.

Need for health care and health insurance
First 'emergency' care traditionally is sought from home. ‘When …someone is sick, I first break leaves, cook it and drink it…. If the sickness is not getting better, then you bring it [the sickness] to the hospital’ (female WR). Religion is fundamental in many Ghanaian EMs. Seeking a cure to relieve suffering and removing the harm or curse in prayer camps is common practice. Also, practical factors determine the drive for seeking health care: 'When I have no money and I am sick, I go to the drug-shop. I can tell him that I have three Ghana Cedis. He would look for drugs of low cost. So I decide the cost that I can afford' (male GAR). Others prefer visiting the professionally trained doctor, who uses medical instruments to diagnose a sickness and prescribes the right medicine. Personal relationships influence seeking health care: ‘I know the doctor. He was with me at senior school so….I know he will take care of me fine. So relationship also counts” (female GAR).

Initiated in 2003, everyone knows the NHIS and has some level of understanding of the concept. ‘An illness can occur to you any time. With the insurance you have already paid so when you fall ill I can go to hospital and access care. That motivated me to do it’ (female WR). People appreciate NHIS's effort to meet their needs. ‘Last time someone came to talk extensively about insurance they made clear that even at the local drug shop they made agreements so that if the drug is covered, people can be served here’ (female GAR). We found clients had strong feelings about traditional care currently falling outside the scope of the insurance package. ‘All we are saying is that he [herbalist] is someone who has being helping us a lot here. I will appreciate if they could give him ‘woolo ko’ [referring to certificate/license] so that he can look at us’ (female GAR). In both regions we found that clients experience barriers to enroll in the scheme due to slow administrative procedures (enrollment/renewal) and poor quality of the benefit package at the health facility.
Quality of health care and health insurance

Quality health care through the eyes of clients focuses on comforting the ill body and mind. “When the illness is serious, like my illness…, I would like a nurse around to hold me, put me on a bed and ask me exactly what’s wrong with me and knows what drugs to give me. That is what I expect” (female WR). Inter-relational aspects of quality (respect, responsiveness) are generally valued more than the biomedical aspect. ‘At times you are there, the nurses don’t pay any attention to you. They don’t bother. That is one issue that worries us a lot’ (male GAR).

For some, quality also relates to adequately trained staff, diagnostics and quick services. Our data reveals that people typically find that this is offered by private healthcare providers, a reason for many clients to prefer private clinics above public. Quality health insurance services means an easy registration and renewal process, accessible inquiry facilities and a comprehensive insurance package. Quality in health insurance is also determined by opinions of close relations, just like in health care: ‘Why I realized that it was not good? …most of my siblings and friends that have insurance looked disappointed’ (Male GAR).

Control over healthcare and health insurance services

In Ghana’s health system, clients perceive their position as the ‘receiver of’ care, ‘undergoing’ the services, while the doctor decides and provides. Most clients feel uncomfortable asking questions about or commenting on treatment, fearing negative consequences, though they are conscious about their rights to get quality care. ‘Where can we go? To the police?’ (Male WR). They observe considerable differences in how facility heads manage their operations: ‘As for the private clinics, supervision is good and very intense, more than at government.’ A common complaint concerns the differences in treatments between the non-insured and the insured, with poor treatment for insured. Clients stress that ‘government’ and NHIS should keep their promise to provide quality services to all people. The NHIS needs to continue offering transparent information while supervising facilities to ascertain non-discriminating services for insured and non-insured.

4.2 Perspectives of the healthcare provider

Illness versus disease

Healthcare provider perspectives on disease are largely informed by their predominant professional training in the ‘germ theory’ where there is always a ‘cause-effect’ principle. A client with a health problem is mainly assumed to be sick due to a biological cause. This notion is directly associated with the providers’ logic and handling of clients in the service delivery process (See also CHAPTER 2, Kleinman’s three health sectors). Health providers’ emphasis on ‘disease’ rather than ‘illness’
was summarized by a deputy director of health in GAR ‘…it encompasses the availability of right equipment, functional [medical] equipment… and our responsiveness to emergencies’. A nurse in a private hospital in GAR indicated health care entails ‘…following the due processes… to ensure patients get well without medical complications, making sure the client gets well by treating a particular infection…’ The ‘illness’ notion is overshadowed by the ‘disease’ notion of clinical care, which is also reflected in the providers’ definition of quality health care. The social and psychological aspects of the reporting case often receive minimal attention if any at all.

Need for (professional) health care and health insurance
Based on their bio-medical view of disease, providers stress the importance of clients reporting without delay, to allow early diagnoses and treatment. Data revealed a general ‘blame game’ where healthcare providers attribute undesired treatment outcomes to late reporting and non-adherence to treatment regimen and review dates. A pharmacist in GAR explained ‘these people [clients] will never come on time… they first go in cycles to prayer camps… before coming to hospital in bad state’. Asked why providers think clients adopt this health seeking behavior, none of the health professionals identified a possible lapse on their side. The problem was mainly seen to be a ‘bad behavior of clients’ as mentioned by a nurse in WR.

On the need for health insurance, majority of the health staff acknowledged the importance of health insurance to clients: ‘…the NHIS in particular has come to help the poor people… especially those who cannot afford’ (Lab technician GAR). A deputy director of pharmaceutical services in GAR indicated ‘…it improves accessibility and choice by the client… it makes people have value for their money… ’ A few health workers had some reservations on the benefits of the NHIS but added there is no other option since ‘it is a government policy (Nurse assistant in WR). A nurse in GAR remarked ‘…the NHIS is helping the patients and not the hospitals… due to late payment of claims by the insurance people.…’

Quality of healthcare services and health insurance services
Healthcare providers’ perception of healthcare quality is predominantly influenced by medical technical ascriptions of what constitutes quality. A deputy director of pharmaceutical services in GAR indicated that ‘quality encompasses quality medicine, good storage of medicine and quality dispensing…’ A deputy director of nursing services in GAR stated that ‘quality health care entails providing services that are aimed at achieving our goal… abiding by the protocol or the guidelines that are available’. Responses from national, regional and health facilities were consistently emphasizing medical-technical dimensions over inter-re-
lational components of quality care and indicating health facilities were performing well in these technical areas. Only a few healthcare professionals understood quality care to include tailor-made services that aim to satisfy the patient, as a health administrator in GAR said: ‘quality care includes the attitude of staff towards clients’. He admitted his hospital (like other health facilities) has paid much attention to this, largely due to limited or no active participation of clients and community groups in quality improvement efforts.

**Control over health care and health insurance**

Healthcare providers (especially clinical staff) perceive their role in the service delivery process mainly as trained professionals responsible for disease management. Those in private facilities consider satisfying patients to attract better patronage as another key responsibility. ‘When the clients are happy they [clients] will always come… …and this helps the clinic….’ (Nurse in Greater Accra). A few of the providers also mentioned patient education on rights and responsibilities as their role in contributing to quality healthcare delivery. Their role in health insurance promotion only came up during an interview with one director in the Western region and another in Greater Accra, where they mentioned unprofessional practices such as false claims, provider-induced demand, and avoidance of poly-pharmacy as critical areas in which providers could help sustain the NHIS. Health professionals also indicated that because of the generous nature of the NHIS, (without co-payment for some exceeded visits and services) the majority of clients take advantage of and abuse the system. ‘…some patients even attend the clinic and take medicines and give to their relatives and friends who are not insured….’ (Lab Technician in GAR). A pharmacist also bemoaned the way patients frivolously visit the out-patient department because they have an insurance card. ‘Patients just come to hospital with the least thing… …a small headache….’

**4.3 Perspectives of the health insurer (NHIS)**

**Illness versus disease**

NHIS staff perceives the causes of disease from a socio-economic and the biomedical perspective. They perceive disease as a financial risk for clients losing income. Their objective states ‘this initiative by the government is to secure financial risk protection against the costs of healthcare services for all residents in Ghana’ (NHIA annual report 2011). Treatment of diseases through the administration of drugs is associated with financial cost. The NHIS benefits package covers 95% of diseases, based on the bio-medical diagnosis and treatment. Not included are traditional care and other forms of spiritual treatments.
Need for healthcare and health insurance services
Based on their socio-economic and bio-medical perspective of disease, NHIS staff believes that once an individual falls ill the need to access quality bio-medical care is crucial. The scheme is perceived as very important, in particular for the poor and vulnerable since health insurance coverage protects clients against catastrophic healthcare expenditure and loss of income, hence improving access to health care. Early and effective treatment will control the costs of health care and prevent clients' loss of income.

Quality of healthcare services and health insurance services
The National Health Insurance Authority perceives the quality of healthcare services to clients from both medical-technical and interpersonal perspectives. They defined the determinants of healthcare quality as appropriate diagnostic processes and procedures, dispensing of quality drugs, fair queuing system, short waiting times, friendly attitude of staff and accurate and timely claims processing. However, emphasis was placed on the technical quality of care through effective diagnosis and treatment since in their view the outcome of the treatment is paramount. They indicated that the healthcare providers are therefore monitored against these technical quality determinants: 'The right caliber of people should be there to deliver service. They should be able to provide both clinical and diagnostic services where necessary. The issue of waiting period should be reduced so that clients will not waste too much time at facility. There should also be right attitude of staff to clients' (Scheme Manager, WR).

They, however, perceive the quality of NHIS services to be based entirely on managerial, technical criteria. They define the determinants of NHIS quality services as the ease of registration and registration time, waiting period to acquire NHIS card and the availability of information on the importance and convenience of the NHIS at the time of registration. 'When we talk of the quality of services, one is the time, that is the period of time the person spends when he comes to register, and then the promptness with which we are able to address the concerns of the person’ (monitoring & evaluation officer GAR). They also mentioned information dissemination on the NHIS benefits package, drugs list and accredited facilities and pharmacies in the catchment areas of registered clients as a core component of their mandate.

Control over health care and health insurance
The NHIA believes that their role in health service delivery lies in the area of accreditation of health providers, prompt payment of claims to providers, monitoring of the quality of provider services and providing feedback on results of monitoring process. 'We go into their services such as right machines or equip-
ment, labs, sanitation is good, how they receive patients and whether their waiting area is quality’ (Regional Manager, WR). They indicated that they have performed quite well in the accreditation process. The NHIA inspects, assesses, approves and accredits healthcare providers through the application of an accreditation tool to provide healthcare services to clients of the NHIS. Currently 3,828 healthcare providers are accredited to provide healthcare services under the NHIS. Initially, provisional accreditation was given to all public health facilities and eventually, inspection and accreditation with grading of the facilities was done. They further indicated that their role in health insurance uptake involves ensuring that there is on average a waiting period of thirty minutes for registration and of three months for acquiring a NHIS ID card in most districts. However, they did admit some areas of concern such as inadequate information on the NHIS benefits package at the registration point, long waiting periods of over four months to receive ID cards in some districts and poor attitudes of some staff towards clients.

The NHIS staff also held the view that healthcare providers and clients have equally important roles to play to ensure the effective and efficient functioning of the health insurance scheme. They indicated that healthcare providers have to ensure that NHIS card bearers are provided with the right information about the benefits package, treated and given the appropriate drugs on the NHIS drugs list, without having to make any co-payments for the treatment. They also expect healthcare providers to fill in their claims forms appropriately and file their claims on time to avoid any delays in the payment of reimbursements. They further indicated that they expect clients to show great interest in the NHIS by enrolling and renewing their membership in the NHIS on time and encouraging their friends and family members to also enroll. They also mentioned that abiding by the gate-keeping system is an important role that clients have to play to ensure that they get the greatest benefit out of the schemes, since jumping the gate-keeping system to higher level facilities will mean clients will have to pay out of pocket for their treatment even though they are enrolled.

5. Discussion

Differences in perspectives between patients and their doctor have been described previously in various scientific studies (Kleinman 1978; Schouten and Meeuwesen 2006; Haidet et al. 2008; Vaughn 2009). One prevailing conclusion of these studies is the importance of effective communication to bridge differences in perspectives, leading to a chain of events such as patient trust and adherence (Haidet et al. 2008: p.236). In an effort to reduce barriers to enrollment in the NHIS and enhance access to quality healthcare in Ghana, this study explores...
the difference between four EMs of three stakeholder groups: clients, healthcare providers and NHIS: illness, need for – quality of - and control over healthcare and health insurance services. FIGURE 2 present the key disparities and convergences of the EMs, including macro scale and micro scale factors.

When analyzing the data, we found people's view on 'need for services' logically following their perceptions on 'illness/disease'. Hence we combined 'illness' and 'need for services' in one diagram.

Diagram 1. Clients use different worlds to understand their sickness, often conceptualizing it on the basis of non-physiological factors. In contrast, healthcare providers predominantly use the biomedical model to explain disease. While the 'individual world' matches with the biomedical model, the other worlds do diverge. The generally poor practice of patient-provider dialogue easily leads to misinterpretation of client behavior such as late attendance or non-adherence to treatment. Likewise, it explains why clients are often unhappy because they received little information about the diagnosis or about the prescription and use of drugs. This asymmetric information can explain the persistent dependency position and limited influence (power) of clients in the tripod. Showing more understanding of the client's views and using a language that is more consonant with the client, such as used by traditional healers and the local drug shop owner, will enhance trust.

Our analysis suggests that the socio-economic view of the health insurer is a better match for the client's EM. Reducing the risks of catastrophic health expenditure is a major concern for especially poor and vulnerable people. However, the mismatch in intercultural communication does also exist in the relationship between clients and insurer. This explains clients' call for healers to be acknowledged and contracted by the insurance. Mentioned divergences can be reduced through improving communication, education, and information sharing. This will limit a distorted interpretation of each other's EM and will help lift barriers to enrollment. These communication skills could be emphasized in the professional training of health staff.

Diagram 2. In the analyses of EMs on quality of services we identified an entrenched position by healthcare and health insurance providers, emphasizing medical-technical quality and centered on the availability of good equipment and medicines and adherence to protocols as more important than clients' perceived quality of care. Recognition of inter-relational quality aspects as part of the client's holistic view will influence the experience and satisfaction of clients in particular, which is important for enhancing utilization and enrollment. Another
Divergence relates to non-discriminating services (i.e., prescription of generic versus brand drugs, unexplained differentiation in waiting queues for insured and non-insured). Without providing adequate education to clients (and providers) on the quality of generic drugs, insurance clients may feel misled by the NHIS information. On the other hand, frivolous utilization of services or over-consumption (or over-prescription) of drugs is perceived by providers and NHIS as undermining quality care. Education and appropriate management arrangements can help reduce these divergences of EMs.

**Diagram 3.** Control of services shows fewer divergences in the three EMs, though trust in the scheme is being compromised by imbalanced power positions and by management and implementation challenges (such as slow processing of ID cards for enrollment and renewal, delays in reimbursements). The traditional power dynamic between clients and healthcare providers has changed with the introduction of the insurance as a third actor with considerable (financial) power. This explains some of the critical comments of healthcare providers about the management of the NHIS regarding prices of drugs and reimbursements of claims. These reimbursements are guided by the Ghana Diagnostic Related Grouping list, introduced by the NHIA in 2008. Clients expect the NHIS to establish instant insurance services and control of quality healthcare services.
Healthcare providers find themselves capable of providing the correct treatments to clients, on the condition of timely reimbursements of claims by the NHIS.

Based on the three diagrams we argue that clients’ current ‘passive receiving’ role can be altered into that of active participant if appropriate information and communication is provided. Clients can be encouraged to monitor services. Such a feedback mechanism would enhance communication between the three stakeholders and contribute to eliminating disparities in EMs. A participatory action ‘MyCare’, a monitoring tool, was developed and tested as part of this research. You can read details of this method in CHAPTER 6 (presenting the design) and CHAPTER 7 (presenting the results). The intervention uses aspects of the three diagrams. It stimulates clients to provide feedback on services in their own words, based on their EMs. An important component of MyCare is the stakeholder* dialogues, aimed at enhancing reflection and mutual understanding among the stakeholders with respect to their respective priorities and needs (e.g., attitude of staff, transparency in information, and adherence to treatment). This is expected to improve relationships and trust and can potentially shift power relations.

Implications: Our study suggests that important differences between the EMs (relating to illness, the need for, quality of, and control over healthcare and health insurance services) of clients, healthcare providers and NHIS exist that lead to differences in interpretation, expectations, and behavior. By making these different EMs explicit and analyzing them, we improve the understanding of the different EMs. It emphasizes the strong interdependency of actors in the client-provider-insurer tripod and the consequent need to involve all stakeholders in a comprehensive approach to eliminate disparities and raise the quality of services. This will then lead to client confidence and satisfaction in services, in turn stimulating enrollment and retention in the insurance scheme and access to healthcare.

* Stakeholders are the clients, healthcare providers and health insurance provider.
References


### Appendix Table 2 Comparing Explanatory Models

<table>
<thead>
<tr>
<th>Topics</th>
<th>Perspectives (EMs)</th>
<th>Clients</th>
<th>Healthcare providers</th>
<th>Health Insurance staff</th>
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</thead>
<tbody>
<tr>
<td>2) Need for HCS (belief, efficacy, severity, financial ability)</td>
<td>Causation determines drive to seek relief/ remove harm. Can be formal or informal care. Beliefs vary, and so do level of trust in caregivers and health seeking pathways. Also practical factors play role like distance, timing and available funds. Trust in opinions of close relations</td>
<td>Biomedical perspective based on Western values - Need for early diagnosing and treatment. Blame-game: delays in access, compliance treatment, provider loyalty, poor functional outcome. Challenge to take socially assigned responsibility due to lack of understanding of ‘illness’</td>
<td>From biomedical perspective and socio-economic perspective: loss of income. Early and effective treatment reduces costs</td>
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<td>3) Need for HIS (culture, awareness, value, financial ability, sustainability)</td>
<td>Traditionally strong informal support structure. Changing socio-economic context: increased individualism and self-reliance. NHIS information / service desk key. Some NHIS- managerial constraints + individual financial limitations hamper (re)enrolment.</td>
<td>Increased access to, and choice of services. Reduces financial risks, especially for the poor. NHIS seen as very useful for clients, but not for HCP (late reimbursements)</td>
<td>Driven by main, contractual goal of NHIS. Health system development: marketing view.</td>
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<tr>
<td>4) Quality of HCS (definition, expectation, experience, sustainability)</td>
<td>Mainly holistic view: physical and mental well-being. Vulnerable position make inter-relational aspects valued higher than biomedical. Gender differences in definition quality. More trust in quality service by private providers.</td>
<td>Driven by biomedical perspective and controlled by bio-medical guidelines. Awareness on importance inter-relational aspects. Constraints</td>
<td>Quality seen from NHIS goal and financial sustainability perspective. Poor quality is thus concern. Contractual agreement with providers. Challenges</td>
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<td>5) Quality of HIS (definition, expectation, experience, sustainability)</td>
<td>Relatively new concept, no comparability. Experience should meet expectations (based on information and first experience, incl. that of social networks) and be reliable over time: Reveals to be a problem. Formal + informal networks influence opinions.</td>
<td>Knowledge, expectations, experience: effect on own functioning as HCP</td>
<td>Poor quality is a concern: seen from NHIS goal and financial sustainability perspective. System in development</td>
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<td>Roles in HC &amp; HIS to attain quality services (traditions, expectation, level of influence, power relations)</td>
<td>Culture of receiving: provider in control. Often enforced by mismatch information, leading to dependent position with low influence (power). Consciousness for fairness and rights on quality care. Government/NHIS responsible for enforcement regulations</td>
<td>Expert role in healthcare. (Knowledge = power). For private facilities also: satisfy clients to get business. Control of services by own managers and medical boards to support sustainability of NHIS (false claims, provider-induced demand, avoidance of poly-pharmacy). No role seen for clients other than they should avoid frivolous use of services</td>
<td>Shared responsibility: NHIS, Ministry of Health, Ghana Health Services, Ministry of Finance. Role clients: early attendance and enrolment</td>
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