An Assessment of Healthcare Seeking Behaviour in Selected Communities in Ghana

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Summary

BACKGROUND

Health is said to be among the basic capabilities that gives value to life. Unfortunately access to health services and needs is highly skewed in favor of the rich to the neglect of the poor. In Sub-Saharan Africa, the situation is more alarming when it comes to the rural poor. This study investigated the healthcare seeking behaviour in selected communities in the Sunyani metropolis, Ghana.

MATERIALS AND METHODS

We adopted probability sampling, specifically the cluster system, where the selected study communities were put into clusters of households.

RESULTS

The findings of this study suggest that most of the community members tend to seek treatment in modern medical systems when they are sick, with only a few seeking traditional spiritualists and self-medication. Most people patronise government hospitals when they fall sick. Majority attended a healthcare facility because of the need for sophisticated diagnosis of underlining medical conditions. Even though almost all respondents are aware of the National Health Insurance Scheme (NHIS) and the associated benefits of the Scheme, a good number had not registered for the Scheme. They indicated delays in re-imbursements, payment of premiums, delays in issuing NHIS cards, not covering all medicine categories and selective treatment for cardholders and non-card holders, as reasons against the NHIS.

CONCLUSION AND IMPLICATIONS

There is need to embrace a holistic approach to health delivery among the rural poor. Thus, the government should pay more attention to preventive rather than curative measures. A number of useful recommendations are provided in this study aimed at improving healthcare behavior among the rural poor.

ORIGINALITY/VALUE OF PAPER

This paper presents a case for the introduction of more flexible procedures for registration with respect to the premium payment of NHIS to encourage rural community members to register.

Keywords: *Healthcare, Health Seeking Behaviour, Communities, Health insurance, Ghana*

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Introduction

The importance of health and healthcare delivery in the developmental efforts of developing countries cannot be underrated. Evidence suggests that better health results in larger and more equitably distributed wealth by developing social and human capital and improving productivity. Health is said to be among the basic capabilities that gives value to life. Unfortunately access to health services and needs is highly skewed in favor of the rich to the neglect of the poor. In Sub-Saharan Africa the situation is more alarming when it comes to the rural poor. The health delivery system tends to ignore the needs of the poor, thereby generating fewer benefits for them and imposes regressive cost burden on their households (Fabricent, Kamara and Mills, 1999).

Healthcare systems all over the world have strived to make quality healthcare not only available and affordable but also accessible and acceptable to its citizens in line with the World Health Organization (WHO) initiated primary healthcare concept. The interest often times was on the rural poor who were, by virtue of their poor socio-economic status, very vulnerable to preventable diseases. Notwithstanding the giant steps taken by healthcare systems, the health outcomes of most countries, especially those in the Sub-Sahara, are still below the WHO set targets.

Many researchers have therefore set out to find out why health systems were underperforming in the area of public health. Some schools of thought suggest that the approaches by health systems towards achieving health goals were rather truncated because it was not client centered. Wholesale health packages were imposed on individuals especially in deprived areas without assessing their health seeking behaviour before initiating such programmes. This explained why a health programme like the Primary Healthcare concept did not succeed in some African countries.

In Ghana, there is the need to understand factors underlying the health seeking behaviour of the rural poor. With such knowledge, the right policies can be formulated and implemented to enhance the ability to access health resources and improve health status of the rural poor in the country.

The cash and carry system introduced by the People's National Defense Council (PNDC) government in 1985 was associated with a number of challenges which led to its discontinuation when the National Health Insurance Scheme (NHIS) was introduced in 2003. With the introduction of the NHIS throughout the country, the expectation was that healthcare utilisation would improve tremendously because of its affordability. However, this is not the case.

Existing literature suggests that health seeking behavior may be influenced by cultural and socio-demographic as well as socio-economic factors (see Fosu 1994; Addai, 1998); Addai, 2000; Freeman and Payne, 2000; Ngom, Debpuur, Akweongo *et al*, 2003; Abor, Abekah-Nkrumah, Adjasi *et al*, 2011). What determines people's decision to seek health in general is yet to be addressed in rural Ghana. This gap in the literature necessitated this study, which now seeks to investigate how the rural poor perceive orthodox medicine and its utilisation in the

Ghanaian context. Previous studies did not specifically explore the behaviour component of health service consumers regarding health services utilisation. This study, therefore, contributes to the literature in this regard. The study will go a long way to guide future researchers on issues relating to health seeking behaviour of rural dwellers.

Materials and Methods

Research Setting

The area under study is located in the Sunyani Municipality and it is one of the administrative Districts in the Bono East Region of the Republic of Ghana. The municipal capital, Sunyani, is the regional capital of the Bono East Region. Currently, the municipality has an estimated population of about 112,446 with growth rate in population of 3.8 %. The Sunyani district's economy is predominantly agrarian with about 58.5% of the active population engaged in agricultural production. About 19.3% of the population is engaged in service, 11.3% into commerce and 10.9% into industry.

Sample and Data Collection

The sample size for the study was 200 from the selected communities. The respondents were community members from all categories. The respondents were given structured questionnaires at random, but illiterate respondents assisted to answer the questions in the local language through interpreters.

The study adopted probability sampling, specifically the cluster system, where the selected study communities were put into clusters of households. Individuals within each household were then randomly selected for either interviews or administration of questionnaires. The combination of probability and non-probability sampling techniques (triangulation) was intended to provide an exhaustive variety of information on the topic being explored.

Identification of respondents was based on the DHS definition of who the rural poor are. Respondents who fell within this category were either interviewed or asked to answer the questionnaires. The structured questionnaires had both open and closed ended questions.

Casual/unstructured participant observation was also employed to clarify pertinent issues important to the health service utilization question in this area.

Data Analysis

Analysis of data was undertaken using SPSS software. The analysis was built on the key research questions. Thus responses on the demographic, knowledge of the NHIS and its perceived relevance to the respondents were analyzed.

Other components of the analysis were: the health seeking behaviour, and understanding of the role of community members in disease prevention and health promotion.

Results

Demographic and Socio-Economic Characteristics

The return rate for the questionnaire was 92%, thus 184 out of the 200 were filled and returned. The responses from the 184 questionnaires were analyzed and the findings are presented in Tables 1, 2 and3 presented in the appendix.

Table 1 shows the percentage distribution of the respondents by gender. Whereas 97 (52.7%) were males, the remaining 47.3% (87) were females. The distribution of respondents' age indicates that respondents were young and still active in their reproductive years. About 51%, (91) were aged 30 years or younger

29% were 31-50 years and 9.2% 51-60 years old.

Table 1 also reflects the educational attainment of the respondents as well as their occupations. Given the rural nature of the communities, educational attainment among the respondents was impressive. Almost 80% of the respondents had attained some level of education, while those without formal education were only 20%. The results show that 60 (33%) had formal education up to the Junior High School level, 39 (21%) with tertiary level education and 37 (20%) with senior high school level. Eleven (6%) only had primary school education.

Table 1 also indicates that 37 (20%) of the respondents were farmers, 11 (6%) civil servants, 60 (32%) housewives, 39 (21%) traders, 18(9.8%) students and finally 39 (21%) traders. Again the pattern here reflects the deprived nature of this rural communities.

Healthcare Utilisation Pattern

Table 2 shows the health utilisation pattern. It is evident that healthcare seeking behaviour in this population is extremely high.

We found that 169 (92%) of the respondents sought treatment when they fell sick. Only 13 (7%) did not seek treatment. With respect to the type of healthcare facilities utilised by community members, the results show that a significant percentage (87.4%) of the people patronised government hospital when they fell sick. This is suggestive of the fact that in these communities, patronage of private health facilities is minimal. Only 21 (12.6%) attended private hospitals.

The respondents' frequency at utilising the formal health facilities was very low. The results reveal that 69 (37.5%) never utilised healthcare services in past one year. Some 59 (32.1%) people utilised the services once in a year, 20 (10.9%) utilised two times, 4 (2.2%) utilised 3 times, 21 (11.4%) utilised the services 5 times, 2 (1.1%) used ten times, and 7 (3.8%) could not remember. The low utilisation of health services among the community dwellers could be attributed to the limited number of clinics and other healthcare facilities in the community. Community dwellers therefore resorted to alternatively easy and accessible means (traditional medicine) of taking care of their health needs and only turn to the orthodox healthcare system when the disease condition was severe and had deteriorated (Twumasi, 1982)

In terms of the reasons for accessing a particular kind of healthcare facility and services or the other, the results showed that the majority of the respondents 86 (46.7%) attended a healthcare facility because of the need for sophisticated diagnosis of underlining medical conditions. However, 48 (26.1%) also said it was the kind of treatment given them at such facilities that encouraged them to patronise the facilities.

Some 8 (4.3%) also attributed their patronage to the physical environment of the hospital, 16 (8.7%) went to their chosen health facility because of the attitude of health personnel, while 2 (1.1%) went in emergency situations (accident). The response pattern hence gives a convincing clue that these community dwellers made a choice of a healthcare facility based on the confidence they had in it, especially in diagnosing and treating the disease conditions. It was interesting to learn that attitude of healthcare providers and physical environments did not contribute greatly to the decision-making of respondents, a case that is apparent among city dwellers.

Impact of NHIS on Healthcare Utilisation

Respondents' knowledge about the National Health Insurance Scheme (NHIS) is captured in Table 3. Knowledge about NHIS tended to be high in this community. A majority of the respondents (182; 98.9%) reported to have heard of the NHIS. Only 2 (1.1%) of the respondents did not have knowledge of NHIS. This is perhaps due to the rigorous nationwide campaign and advertisement on the NHIS.

Another possible reason for such high knowledge level may be due to the fact that the study setting is part of a region (the Bono East Region) where the NHIS first piloted the Scheme, specifically in Nkoranza. This early introduction to the concept might have influenced this high awareness levels.

The results of the study, however, reveal that knowledge did not translate into participation in the NHIS among the respondents of this study. Although more than half of the respondents (113:61.7%) had actually registered for the NHIS, 69 (37.7%) had not registered, at the time of the study. Financial reasons were cited by most of the respondents as the reason for not registering for NHIS. Some also cited limited time, misunderstanding of the NHIS operations, and being under different health insurance coverage.

Majority of the respondents alluded to the benefits of the NHIS, indicating that they liked the free medical care. However, what they disliked about the Scheme include delays in re-imbursements, payment of premiums, delays in issuing NHIS cards, not covering all medicine categories and selective treatment for cardholders and non-card holders.

Discussion

This study assessed the healthcare seeking behaviour in selected communities in the Sunyani metropolis, Ghana. The findings of this study suggest that most of the community members tended to seek treatment in government facilities and some from private modern medical systems. Only a few visited traditional spiritualists or self-medicated. It is noteworthy, that the rationale behind seeking non-formal healthcare from chemist shops, traditional healers and spiritualists was due to financial constraints and not cultural beliefs. Most of the respondents sought one form of treatment or the other when they were sick.

The most utilised health facilities were the government hospitals with most of the conditions leading to hospital visits being existing chronic conditions reported by the elderly, diarrhoeal diseases by the youth and the pregnancy related conditions by women.

Considering that, the youthful nature of the population, reproductive health needs are likely to be of paramount concern, and since maternal health services tend to be free in the government hospitals, it stands to reason that patronage would no doubt be high in such facilities. Again just like most developing countries, the government hospitals tend to be better resourced with respect to human resource, logistics and equipment. Serious health conditions in private clinics are always referred to such facilities therefore it makes sense for people to make such places their first point of call and maybe to other private clinics for specific treatment.

The findings are supported by findings of some previous studies that reveal that accessibility is an important determinant of the utlisation of health facilities (see Stock, 1983; Okafor, 1984; Mekonnen and Mekonnen, 2003).

The introduction of the NHIS could also be a reason why most members of this community sought treatment from government hospitals. It allows patients to receive treatment in government hospitals without difficulty as compared to private hospitals.

The findings of this study show that most community members are fully informed of the available healthcare facilities but poverty serves as a limitation to accessing the best healthcare services. Again, the limited number of orthodox healthcare facilities compels community members to seek healthcare services that are either accessible by distance or by money.

On the NHIS, most respondents were knowledgeable of the Scheme and indicated that the NHIS was beneficial to community members. This means that policy makers and practitioners of public health have a window of opportunity to cover all people at the community because the community members already know about the benefits of scheme and willingness to comply is evident. With effective educational campaign strategy, the NHIS Scheme can gain total community acceptance and patronage in the near future.

Conclusion

The findings of this study suggest that most of the community members tend to seek treatment from government facilities and some from private modern medical systems when they are sick with only few seeking traditional spiritualists and self-medication. Majority attended a healthcare facility because of the need for sophisticated diagnosis of underlining medical conditions. Even though almost all respondents are aware of the NHIS and the associated benefits of the Scheme, a good number had not registered for the Scheme at the time of the study. They lamented the delays in re-imbursements, payment of premiums, delays in issuing NHIS cards, not covering all medicine categories and selective treatment for cardholders and non-card holders.

Recommendations

Participants not registered to the NHIS insurance cover attributed this to financial constraints. The introduction of more flexible registration and premium payment plans is, therefore, warranted as it will encourage more people to join the NHIS Scheme.

Authorities of the NHIS have to ensure more commitment to fast-tract the registration process especially in issuing the cards since that is a major outcry identified in the study.

The government in ensuring quality health and service utilisation for the community poor need to provide basic social amenities such as portable water, motorable roads, clinics and employment opportunities for the youth, since socioeconomic status of a population is directly related to health outcomes.

Among the majority poor, the government should pay more attention to preventive rather than curative measures.

Members of the community need to see to the maintenance of personal and environmental hygiene, food and water sanitation, community volunteerism, job creation and physical exercises as these are some of the interventions for ensuring good health in the community. These should be highlighted and championed by healthcare providers, opinion leaders, policymakers and researchers.

Each community clinic should establish a health promotion school where community members can be educated about basic hygienic and nutritional practices, basic knowledge about family planning and other reproductive health issues.

Authors' contributions

PAA conceptualised the paper and provided general structure for the paper. She also analysed the results and discussed aspects of the findings. HTG helped with data collection, analysis and also discussed aspects of the results.

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Ethical statement

The authors declare that no ethical approval was required for this study.

Conflict of interest

The authors declare that they have no conflict of interest.

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Appendix

Table 1: Demographic Data

Characteristics	**N (%)**
Gender	
Female	87 (47.3)
Male	97 (52.7)
Age	
18 years or less	19 (10.6)
19-25 years	45 (25)
26-30 years	27 (15)
31-40 years	21 (11.7)
41-50 years	34 (18.9)
51 – 60 years	17 (9.4)
61 years or more	17 (9.4)
Level of Education	
No Schooling	37 (20.1)
Primary	11 (6)
Junior High	60 (32.6)
Senior High	37 (20.1)
University or Higher	39 (21.1)
Occupation	
Farmer	37 (20.1)
Civil Servant	11 (6)
Housewife	60 (32.6)
Trader	39 (21.2)
Student	37 (20.1)

Source: Field Data

Table 2: Healthcare Utilisation Pattern

	N (%)
Seek Treatment when Sick	
No	13 (7%)
Yes	169 (92%)
Type of Healthcare Facility Utilised when Sick	
Government hospital	146 (87.4)
Private hospital	21 (12.6)
Frequency of Service Utilisation within a Year	
Never	69 (37.5)
Once	59 (32.1)
2 times	20 (10.9)
3 times	4 (2.2)
5 times	21 (11.4)
10 times	2 (1.1)
More than 10 times	7 (3.8)
Cannot Remember	2 (1.1)
Reasons for Attending Chosen Health Facility	
Valid Accident	2 (1.1)
Attitude of health personnel	16 (8.7)
Diagnostic purposes	86 (46.7)
None of the above	24 (13)
Physical environment of hospital	8 (4.3)
Treatment given	48 (26.1)

Source: Field Data

Table 3: The Impact of NHIS on Healthcare Utilisation

	N (%)
Heard about the NHIS	
No	2 (1.1)
Yes	182 (98.9)
Registered for the NHIS	
No	69 (37.7)
Yes	113 (61.7)

Source: Field Data