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The National Health Insurance Scheme in Ghana's Upper West Region: A gendered perspective of insurance acquisition in a resource-poor setting

Jenna Dixon [a, *], Isaac Luginaah [b], Paul Mkandawire [c]

[a] School of Public Health and Health Systems, University of Waterloo, Ontario, Canada
[b] Department of Geography, Western University, Ontario, Canada
[c] The Institute of Interdisciplinary Studies, Carleton University, Ontario, Canada

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ABSTRACT

Ghana's National Health Insurance Scheme (NHIS) was designed as a pro-poor strategy to create wider access to health care. While recent studies have shown that wealth is an important factor in enrolment in the scheme, there is little understanding of its interlinkages with the geographical divisions and deep-seated deprivation in the northern region. In response to the nexus of poverty, gender and access to health care, this research took place in Ghana's Upper West Region (UWR), one of the poorest regions and yet paradoxically touting the highest enrolment rates. Using data from a population survey ($n = 2119$) collected between May to December 2011, we used multinomial regression to examine factors that influence enrolment, controlling for theoretically relevant covariates. Findings reveal that although wealth and desire for health insurance are contributing factors, education was the primary determinant in both never enrolling and in dropping out, and that these factors impact men and women differently. The study also shows that Muslims were less likely to enrol and also women living in non-nuclear households were far more likely to dropout. Our results demonstrate clear gendered divisions in accessing the NHIS, and raised serious equity concerns in the UWR. By focussing on the context of the UWR, we show the importance of understanding intra-household bargaining and resource allocation via the gender dynamics related to health insurance procurement and maintenance, and discuss associated policy implications.

1. Introduction

As governments of developing countries have struggled with financing health care, national health insurance programs have increasingly become a popular mechanism to solve this problem (Hsiaso and Shaw, 2007). This is occurring in the context of what Mills et al. (2012) describe as an international "rallying call" for universal coverage, with specific attention on the poor. Ghana has been a leader in sub-Saharan Africa (SSA), trailblazing the health insurance model with its 2003 parliamentary ascension of the National Health Insurance Scheme (NHIS) – a social health insurance scheme, run at the district level. In principle, the NHIS offers a nationally recognized, heavily subsidized mechanism for the population to obtain health coverage without the risk of catastrophic household health spending. The elderly, children, social security contributors and pensioners, are all exempt from premium payment; the extreme poor (indigents) and expectant mothers are exempt from premiums, card processing fees and renewal fees. Ghana, along with Rwanda, are the only two SSA countries that have achieved what can be regarded as an intermediate stage of development in their health coverage, with Kenya, Mali and Nigeria in the early stages of reform (Lagomarsino et al., 2012). Given Ghana's pioneering position in the development of national health insurance, it stands as a role model for other SSA countries, and insights from Ghana's experience with the NHIS are of considerable interest to architects of both domestic and international health policy.

Since the NHIS' implementation, studies have looked at various facets of the scheme in an attempt to understand how well it is working. While enrolment may lead to utilization (Dixon et al., 2014b), worryingly, studies are building a consensus that the poor are not enrolling in the scheme at the same rates as the more

* Corresponding author. School of Public Health and Health Systems, University of Waterloo, 200 University Ave W., Waterloo, Ontario, Canada N2L 3G1.
E-mail address: jenna.dixon@uwaterloo.ca (J. Dixon).

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wealthy, and thus challenging the fundamental mandate of the NHIS to open up access to the poor (Asante and Aikins, 2008; Jehu-Appiah et al., 2011; Sarpong et al., 2010; Witter and Garshong, 2009). Dixon et al. (2011) have thus far provided the only national level assessment of enrolment using data from the Ghana Demographic and Health Survey. Their findings demonstrate that while enrolment rates are relatively high, wide socioeconomic and geographic variations exist. In particular, while poverty inhibits access to NHIS in the southern part of the country, this problem is even more pronounced in northern Ghana comprising the Upper West Region (UWR), Upper East Region (UER) and the Northern Region. However, the UWR and UER, which have historically been underdeveloped, have much higher poverty prevalence and a far worse availability of health infrastructure and staffing (Al-Hassan and Diao, 2007; Konadu-Agyemang, 2000), also witness the highest rates of enrolment in Ghana (NHIA, 2012).

The UWR provides the most extreme example of this occurrence. Arguably the poorest region, it has over 50% active membership in the NHIS, and remains consistently far above the rest of the country (NHIA, 2012). This result seems paradoxical – how is it that even though poor people in Ghana are generally less likely to enrol in the NHIS, the poorest region of the country also has the highest enrolment rates? More importantly, what does this mean for the NHIS' *pro-poor* mandate and the push towards enabling health care access for Ghanaians? Given Dixon et al.'s (2011) insights, this study focuses specifically on this deprived context to inquire into the factors that guide NHIS enrolment: who is enrolling, who has dropped out, and who has never enrolled into the NHIS? Or more aptly, *how does the 'context' of the UWR influence enrolment status?* The theoretical and policy relevance of these questions should be examined in light of the fact that various studies have consistently shown that enrolment in health insurance in SSA is a highly complex phenomenon, depending on a varied range of contextual factors (see Criel et al., 2004). Through this analysis, we aim to shed light on complex elements that encourage or discourage enrolment in the NHIS in the UWR. The unique conditions of the UWR make this study an important addition to the literature on Ghana's NHIS, with insight into the viability of health insurance schemes in the broader SSA milieu.

The rest of this paper is divided into a number of sections. We start by presenting an overview of the theoretical framework used for the study, followed by an overview the UWR where this study is situated. Next, we present a description of the methods. This is followed by the study findings, discussion and our suggested policy options.

2. Theoretical framework

Many studies that have investigated enrolment in health insurance schemes in SSA have tended to be exploratory in nature and have side-stepped the issue of theoretical models in their research. As De Allegri et al. (2006a) point out, this may be related to the youth of health insurance schemes in SSA. By result, much of the research to date has tended only to focus on characteristics of individuals or households who enrol in schemes, with limited acknowledgement of underlying theoretical assumptions. Some the findings of these studies include: vast differences in enrolment between the poor and the wealthy (Asante and Aikins, 2008; Dixon et al., 2011; Dixon et al. (2014a); Jütting, 2003; Sarpong et al., 2010; Witter and Garshong, 2009), geographic disparities (Dixon et al., 2011), the importance of education (De Allegri et al., 2006a), sociocultural practices and community preferences (De Allegri et al., 2006b), and perceptions of quality (Criel and Waelkens, 2003; Dixon et al., 2013). However, more recently Jehu-Appiah et al. (2011) have made progress on the theoretical front; their investigation into NHIS enrolment in two Ghanaian districts drew on the socio-behavioural theoretical model pioneered by Andersen and subsequently updated (see Andersen, 1968; Andersen, 1995; Gelberg et al., 2000) to conceptualize enrolment outcomes. Taking note of recent progress, our study conceptualizes enrolment in health insurance along four components of Andersen's Behavioural Model (Buor, 2004; Gelberg et al., 2000). These include: *enabling resources* (such as household wealth which may be used to pay for enrolment fees and education), *need factors* (such as perceived health status and self rated desire for enrolment), *predisposing characteristics* (demographic characteristics such as religion and household structure), and *restrictive factors* (such as distance to the nearest health facility or young children which may make travel difficult).

However, while the Behavioural Model may add some clarity to the question of enrolment, there has been a dearth of attention in the literature on the role of gender on influencing access to health insurance. Hence, in this study, we take a feminist theoretical approach to shed light on the influencing gender dynamics. It is essential to understand economic, social, and political mechanisms of prejudice and discrimination that lead to ill-health and poor health care for women and men (Turshen, 2007). Feminist theories recognize gender as a prime component in all social interactions, and a determinant in access to resources. Where previous theories have calculated all resources within the family or household unit to be shared equally and divided up rationally, the feminist theories of intra-household bargaining, as championed by Sen (1990) and Agarwal (1997), critiques this unitary conceptualization of the household. Instead, the relations of power between men and women, especially in a patriarchal society such as our study context, may create asymmetry in economic outcomes, which in turn creates unequal access to and utilization of resources outside of the household. Access and control of resources are negotiated between individuals from relative 'bargaining positions' – which are comprised of many aspects, such as the individual's perceived contribution to household livelihoods or the individual's social and economic position independent of the other household members (Sen, 1990). The household itself is not the focal point of this research, but is only being used as a concept to represent the flows of resources and power between gendered individuals (Carr, 2005).

Cultural norms around gender not only determine who is able to participate in the waged economy, but also what types of labour are considered to be of economic value. As well, once resources have been brought into the household, gender norms stipulate who possesses ownership and the decision making power over how certain resources are to be used. In the non-waged context of subsistence agriculture, as in much of the UWR, this often translates to gendered norms around crop production, where incomes from "male crops" and "female crops" are put to different uses (Haddad and Hoddinott, 1994). Yet men, regarded as the household decision makers, may often take custody of any income from farm proceeds. Even among women engaged in off-farm activities, the husband frequently has access to his wife's financial income (Buor, 2004).

These overarching gendered power structures and asymmetrical relations between men and women guide many decisions within the household. For instance, men largely hold unilateral sexual authority over their wives, including the refusal of sex or of condoms (Dodoo and Frost, 2008). Men also have such power in the decision to have more children that it can even shape his wife's (supposedly) preconceived intentions (DeRose and Ezeh, 2005). Most notable for this study though, Ghanaian women are expected to bargain for their husbands to contribute to household health care payments. When uncooperative, woman may draw on strategies such as withholding cooperation on other tasks or 'reporting' the