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# Contextual Dynamics of Health Insurance Use: Case Study of Faith Healing and Ghana's National Health Insurance Scheme

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## Abstract
Health insurance is believed to enhance poor people's access to healthcare. Thus, one would expect that, in contexts where poverty is endemic, health insurance policies would encourage people to use hospital-based healthcare when they fall sick. However, an ethnographic study of Ghana's National Health Insurance Scheme (NHIS) in the Daakye District of the Central Region provides evidence to the contrary. Our research found that in a pluralistic healthcare context such as Ghana's, socio-economic factors such as local perceptions of illness and distance to healthcare centres are key predictors of why and how people use health insurance policies. This paper presents a brief discussion of the manner in which those who enrolled in the NHIS have related to faith healing and hospital-based treatment in Daakye District. Our study shows that faith healing remains popular in Ghana, despite the introduction of the NHIS, and puts forward the case for public education and a national regulatory framework for controlling dangerous forms of the practice.

## Introduction
Ghana's National Health Insurance Scheme (NHIS) was introduced in 2004. The NHIS replaced the existing system, known as "cash and carry", under which patients paid for their medical expenses out-of-pocket (Adusei-Asante & Doh 2016; Agyepong & Adjei 2008). The NHIS was implemented as a pro-poor policy that provides Ghanaians with essential, equitable and universal healthcare access (Agyepong & Adjei 2008). The National Health Insurance Act (2003) established Ghana's NHIS, and made it compulsory for all Ghanaians to join the scheme, although in practice, this is not enforced. The NHIS operates as an indemnity policy, requiring that those who join only pay a fixed amount for specific illnesses (Aryeetey *et al* 2016). Ghanaians working in the civil service, contributors to the country's Social Security and National Insurance Trust, pensioners, and an exempt group (comprising indigents, children and minors below 18[1] and those aged above 70 years) are not required to pay premiums, although in some jurisdictions, they pay little sums as administrative costs (Agyepong & Adjei 2008; NHIA 2016).

The NHIS operates biomedical facilities, hospitals, clinics and community-based health planning and services (CHPS). The benefits package includes primary care and hospital care consisting of outpatient and inpatient care, oral health services, eye care services,

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[1] The legislative instrument states that before a child or a minor under 18 years is registered, at least one of his or her parents must join the NHIS.

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maternity care and all emergencies. The NHIS was formulated to ensure that the policy covered 95% of the diseases in Ghana and 80% of the country's disease burden. While no ceiling is provided on the number of instances clients are able to visit health facilities, a gatekeeper system prevents abuse of the policy (Blanchet et al., 2012; Kotoh, 2013; Sekyi & Domanban 2012).

It is generally acknowledged that there are four medical options in Ghana: hospital-based treatment, pharmacies (drugstores), traditional medicines and faith healing (Ae-Ngibise *et al* 2010; Senah 1997; Twumasi 1978). According to Twumasi (1978), the cultural characteristics of a society influence the manner in which people use existing medical options. Twumasi (1978) further argued that subtle competition among various medical options is a feature of pluralistic healthcare, and people, depending on their particular situation, may vacillate between options. The choice of a particular healthcare option (or a combination of two) is also influenced by the health-seeking behaviour of the person in question. Health-seeking behaviour drives the reasons for which and the manner in which the community patronises available healthcare options (Kroeger 1983; Shaikh 2007). According to Musoke *et al* (2014), factors that influence health-seeking behaviour can be categorised as physical, socio-economic, cultural or political, and include educational levels, environmental conditions, socio-demographic factors, knowledge about facilities, gender issues, political environment and the health care system itself (Kian 2001; Musoke *et al* 2004; Ogunlesi & Olanrewaju 2010; Prosser 2007; Ukwaja *et al* 2013).

The factors relating to cultural beliefs are particularly relevant for this study. According to Meyer (1995), local and cultural perceptions of sickness influence choices in accessing healthcare. In observing the Peki in the Volta Region of Ghana, Meyer (1995) found that the violation of accepted (societal) laws—such as two blood relations having sexual intercourse—was regarded an abomination or "gu". For the local people, "gu" defiled families, and would result in violators falling ill. While supposedly "gu-related" illnesses were theoretically often treatable at hospitals, families generally called on local traditional priests to perform purification rituals to remove "gu" from their affected relatives. Similarly, Awusabo-Asare and Anarfi (1997) argued that in most Ghanaian rural societies, diseases whose aetiology could not be readily explained were often given "supernatural explanations"—a belief system Senah (1997) confirmed in researching the Botianor area in the Greater Accra Region of Ghana.

Since its introduction, little has been written on how the NHIS has influenced the use of faith healing in Ghana,[2] which is a gap this paper attempts to fill. In recent times, given the lack of medical facilities for mental health patients in Ghana, there have been calls for 'inter sectoral partnership between biomedical care providers and faith healers to deal with treatment gaps' (Arial *et al* 2016, p. 2; see also Ae-Ngibise *et al* 2010; and Patel 2011). Thus, the focus on faith healing in the context of an affordable pro-poor NHIS is timely. As discussed below, it is critical for Ghana to develop a national policy regulatory framework for streamlining and educating the public on dangerous forms of faith healing.

[2] Elsewhere we have discussed the impact of the NHIS on hospital-based treatment, traditional medicines and drugstores (see Adusei-Asante, 2017).

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**Methods**

An ethnographic study was conducted over a three-month period in 2009 in the Daakye District of the Central Region of Ghana. Most residents live in rural settings; nearly one-third live on 240 islands reachable only by boat. In 2009, 150,000 people lived in the district, with nearly 8,000 living in Daakyekrom, the district capital. At the time of data collection, just 10% of the district road network was tarred (Daakyekrom Development Organisation Annual Reports 2006–2009).[3] Tali and Buru were the main languages spoken, with ethnic groups comprised of Tali, Buru, Northerners and others. Seventy per cent of residents identified as Christians, while 30% identified as Muslims. As a locality experiencing extreme poverty, the entire Daakye District had only one referral hospital (Daakyekrom Mission Hospital [DMH]), three clinics and 13 CHPS. Most parts of the 240 islands in Daakye District had no clinics or CHPS. Prevalent diseases in the district included malaria, hernia, respiratory tract infections and typhoid fever (Daakye District Development Organisation Annual Reports 2006–2009).

This research formed part of a Master of Anthropology programme at the Vrije University of Amsterdam. As the study was driven mainly by ethnography, review of reports, participant observation and interviews were the main research tools. Annual reports of the DMH and two non-governmental organisations (NGOs) that work in the district were obtained to establish the research context. Observation was carried out at the DMH and two faith-healing outlets, mainly in Daakyekrom, to obtain local knowledge of the general conditions and facilities, in- and outpatient activities and treatment procedures (Liamputtong 2009). Thirty formal and informal interviews were conducted for the study proper. Formal interviews were conducted with DMH medical professionals and faith healers. The interview questions focused on the health situation in the Daakye District before and after the introduction of the NHIS, and how the policy had influenced the practice and use of faith healing in the district. Apart from the Reda Islands, where a translator was used, most of the interviews were conducted in the Buru language. Key stakeholders, such as the directors of two NGOs operating in the district and the district directors of the Ghana Health Services (GHS) and the NHIS, were also engaged in formal interviews. Individuals on the Reda Islands as well as on the streets and in homes and workplaces of Daakyekrom were informally engaged in the study and asked if they had enrolled in the NHIS, and if and why they still patronised faith-healing outlets (see Adusei-Asante 2017). The data were coded and analysed manually after several rounds of immersion.

**Faith Healing in Ghana**

Faith healing is discussed here within the contexts of Christianity and Islam, the two most common religions in Ghana. The practice of Christian faith healing in Ghana goes back to the days of Peter Anim, who started the Faith Tabernacle Church in the 1920s, associated with the founding of Ghanaian Pentecostalism (Larbi 2001). Faith healing involves an invocation of the divine (through all-night prayer sessions, fasting, anointing oil, prayer cloths and soaps, usually in prayer camps, healing crusades and church services) to heal the sick and deliver a person purported to be suffering spiritual bondage (Gifford 2004). The practice of faith healing is rooted in the cultural belief that evil spirits are responsible for sickness (Meyer 1995; Senah 1997), a belief system Onyina (2008) repudiates.

[3] The research locality, languages and the name of the organisation have been de-identified.

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Faith healing used to be considered an option mainly for the mentally ill or those suffering from "demonic oppression". This has changed, especially with the advent and popularity of (neo) Pentecostal/Charismatic churches (Asamoah-Gyadu 2004; Sackey 1991). Ghana's airwaves are fraught with faith-healer broadcasts and advertisements, campaigning for people to visit their faith-healing services. While some do not provide an exact timeframe for healing those who attend their services, others boast of having the ability to heal instantly. Although the practice is criticised for its unorthodox healing processes, some of which are deemed to infringe on the rights of patients, faith healing continues to thrive, particularly in rural Ghana (Ae-Ngibise *et al* 2010; Arias *et al* 2016; Human Rights Watch 2012). Sackey (1991) has noted that not all churches agree on the best method of faith healing. Some believe in sole reliance on the Holy Spirit for healing, while others believe this should be combined with biomedicine and traditional herbs, and still others argue it should be blended with hospital-based treatment only (Asamoah-Gyadu 2004; Onyina 2008). Unless otherwise specified, faith healing in this research study refers to all three approaches.

Islamic faith encourages followers to seek appropriate medical attention, yet posits that no medicine will work if God does not want it to work. Therefore, Muslims visiting a medical doctor for treatment must also pray to God to cure the illness. There are specific Quranic verses that Islamic scholars consider to offer help for common conditions such as headaches and fevers. In the case of serious illnesses, scholars may make the patient wear written verses on the body, a practice known as Taweez (Alavi 2008). It is a part of the Islamic faith to be cured (as well as to learn how to cure), so if Muslims become ill and seek medical attention, they are deemed to have done a good deed (Alavi 2008; Tarmahomed 2013).

**Findings: The NHIS and Faith Healing**

Faith healing takes place in churches, in mosques and at healing crusades. Compared with other parts of the country, healing crusades in the Daakye District were rare at the time of data collection.[4] In the absence of such crusades, residents of the Daakye District relied on local churches for divine healing. I visited and interacted with the pastors and members of two churches that had held healing prayer camps in Daakyekrom; both pastors claimed no sick person had ever died in their healing camps.

Maame Tass, a member and a trained catechist of the Abrabopa Church in Daakyekrom, ran one of the faith-healing centres. Maame Tass was married with three children and ran a bread-baking business alongside her healing ministry. She had a commercial school educational background. Maame Tass preferred her camp to be called the Abrabopa Prayer Centre, where she served as one of the leaders of the women's wings. At her services, the members took turns to share numerous testimonies of miraculous healing they had received. Maame Tass preached about God's grace and ability to heal, which endeared her to the members. She shared her three-bedroom house with her patients, including the mentally ill. Although she participated in the NHIS, Maame Tass claimed that she had never used it. Her continual membership in the scheme, she said in an interview, stemmed from her desire to help the poor. Maame Tass debarred her patients

[4] Evangelist Lapeewa of the Fine House Chapel held the most well-known healing crusade in the Daakye District, in 2007

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from taking biomedicines in the camp. Uncharacteristically for a Ghanaian prayer camp, she did not use any spiritual water or anointing oil when praying for the sick in her services, but instructed them to engage in fasting and midnight prayers.

The other church, the Glorious International Church, belonged to the Pentecostal denomination. The leader, Pastor Peter, used anointing oil, and also managed a prayer camp where the mentally ill were housed and prayed for. Pastor Peter was married, had three children and lived in the camp in a separate apartment. Pastor Peter believed in medicine, but stressed its limitations in curing spiritual illnesses. He owned a small herbal medicine shop, which he depended on to support his family and church. During my several visits to his services, I found Pastor Peter to be a charismatic figure who preached healing and deliverance as the rights of the Christian. On Sundays, the service numbered about 100, without children, and on Fridays, when he held his healing services, about 80 (mostly women). He was a member of the NHIS, but many of his church were not—some considered it too expensive, while others stated they would not renew their NHIS because their sickness was beyond scientific medicines and hospitals. The church lined up for prayers, and the touch of the man of God was believed to heal and deliver people from satanic oppression. After the prayers, the church shared porridge together.

While most people I interacted with at Pastor Peter's church had little education, I talked to a 48-year-old man visiting Maame Tass' healing camp who was the headmaster of a junior secondary school in the district. He had been sick for a year, and claimed to have gone to the hospital several times. When asked what had brought him there, he replied –

> Doctors at Cape and Korle Bu [the biggest hospital in Ghana] have done their best, but I am still not OK. They have conducted one test after the other and done numerous scans. Sometimes after three days of being discharged, the sickness comes back, so I heard about Maame Tass and came to try God too.

When I probed as to why he concluded the sickness had spiritual undercurrents, he said, 'I suspect someone wants to take my position in the school. My sickness comes whenever I go to the school to resume work. It is not normal, there is more to it'. Before the NHIS was introduced in the Daakye District, people visited faith healers with diseases that could have been cured at the hospital, because of the high cost of medical care. However, the NHIS appeared to have changed the kind of sicknesses that faith healers handled in the district. Although faith-healing camps were being patronised, as shown above, people first visited hospitals, and if they were not cured, sought help from the prayer camps. As a result of the NHIS, faith healers tended to handle sicknesses deemed to be untreatable in hospitals, believed to be orchestrated by demons, witches, evil forces or Satan, or a punishment for sins committed, including asram[5], tukpe[6], barrenness and mental problems. Even though it was usually the last (but not the least) of the medical options, faith healers assured their followers of protection from forces that inflict pain and suffering. In both churches, Satan is rejected as an enemy who is

[5] Disease believed to cause stunted growth in children.
[6] A medical condition believed to have resulted from satanic attack.

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whipped, jeered at and bound in prayers.

With regard to Islam, the Imam in Daakyekrom explained that their faith also believed in faith healing, but because he did not personally have the gift of healing, he did not promise nor encourage it in his mosques. During an interview, he explained that in Islam, people are trained specially to deal with sicknesses regarded as untreatable with scientific medicine. The Imam ridiculed churches and mosques that prayed for sicknesses deemed to be treatable at hospitals. I found out in my interaction with Muslims in Daakyekrom that most of them had joined the NHIS. During an observation of a Muslim service, I heard the Imam encourage the people to shun visiting "spiritual healers" for healing and go instead to the hospitals.

Nevertheless, most islanders from localities with no or limited health facilities had high regard for faith healing. The coping mechanism of some islanders when sick was to self-medicate with medicines obtained from drugstores. If that failed, they would apply traditional medicines. If none of these worked, they would visit the hospital or resort to prayer camps, depending on their financial status. This pattern was repeated if they fell sick again.

Conclusion

This study found that faith healing continues to thrive in Ghana, in spite of the introduction of the free NHIS. The popularity of faith healing is attributed to the culturally embedded belief that the devil is to blame for so-called "biomedically untreatable sicknesses", the advent of Pentecostalism and the lack of medical facilities in rural areas for Ghanaians who have enrolled in the NHIS. The continuous growth of Pentecostalism in Ghana suggests that faith healing may persist. While some churches are beginning to modernise the practice to make it attractive, others continue to engage in forms that are dangerous, such as forbidding patients from taking their medication while in their care. In the wake of discussions exploring some form of collaboration between biomedical care providers and faith healers to deal with treatment gaps in mental health in Ghana, it is recommended that the peak bodies of the various religions in Ghana, such as the Christian Council of Ghana, the Association of Pentecostal Churches and the Islamic Council of Ghana, establish enforceable codes of conduct for regulating the practice of faith healing and controlling extreme and dangerous forms. At the same time, the establishment of a national campaign championed by the National Commission for Civic Education on safe faith-healing practices is critical. While the Ministry of Health and the GHS continue to engage with faith healers for mutual grounds of collaboration, the Government of Ghana also needs to expand biomedical care to areas in which it is currently lacking, to reduce the need for people to unnecessarily rely on faith healing.

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