

The ethnographic fieldwork happened over a three-month period in 2009. Several research tools were used to enhance the credibility of the study and also for triangulation purposes (Liamputtong, 2013), namely participant observation, interviews, review of reports and questionnaire. Participant observation was carried out at the Daakyekrom Mission Hospital (DMH); drugstores; traditional medicine and faith healing outlets. The purpose of the participant observation was to gain local knowledge through observing the general conditions and facilities, outpatient activities as well as the patients' treatment procedures (Patton, 2002, Liamputtong, 2013).

Thirty formal and informal interviews were conducted. Formal interviews were conducted with medical professionals at the DMH, drugstore operators, traditional medicine practitioners 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 impacted their work and what the future held for them. Apart from the Reda Islands, where a translator was used, most of the interviews were conducted in the Buru language. Key informants such as Directors of two NGOs and the district Directors of the Ghana Health Services (GHS) and the NHIS were also engaged in formal interviews. The rest of the interviews were informal. Individuals on the Reda Islands as well as on the streets, homes and workplaces of Daakyekrom were engaged and asked about why they joined the NHIS as well as how they were using it.

Annual reports of the DMH and two NGOs working in the district were also obtained to establish the context of the study while informing the design of the research instruments. Forty questionnaires targeted at those who were not included in the interviews to attain a larger data sample. The questionnaires were administered at the NHIS Head Office in Daakyekrom, where people were renewing or joining the scheme afresh. The open-ended questionnaires solicited information on when and why they had joined the scheme; the benefits derived so far and if they intended or had ever used drug stores, traditional herbs or faith healing. The data was manually transcribed and thematically coded, after which they were written into chapters in the thesis proper, one of which is discussed in the current paper.

### **3. Ghana's National Health Insurance Scheme**

Access to adequate healthcare as well as affordable medicines remains a challenge in most developing countries, where poverty is rampant. As a result, several low-income countries have implemented health insurance schemes to enable their citizens' access equitable and essential healthcare. Although Ghana is a signatory to the Abuja Declaration, which requires that the country commit a minimum of 15 per cent of its budget to the health sector, the reality has been that before and after the introduction of the NHIS Ghana's government has only managed an average health expenditure of around 12 per cent (Mamaye 2015). Ghana implemented a National Health Insurance Scheme (NHIS) in 2004 to replace the out-of-pocket payment system that existed in health centres (Arhinful, 2003; Agyepong & Adjei, 2008). The passing of a National Health Insurance Act (Act 650) of 2003 led to the establishment of a National Health Insurance Authority (NHIA). The NHIA was created to implement the new NHIS, a universal health insurance programme intended to provide access to basic healthcare services to all residents in Ghana. The Act (650) made provision for the existence of three parallel health insurance schemes, namely the Private commercial scheme, Private mutual scheme, and the district Mutual Health Insurance Schemes (DMHISs). In exception of the district mutual health schemes, which receive direct financing from the Government, the rest are privately owned and managed. While the DMHISs functioned independently of each other based on the initial design, they currently operate under the NHIA. In 2012, Act 650 was reviewed and under the new Act 852, all DMHISs were classified under a common umbrella called the National Health Insurance Scheme (NHIS). Act 852 made it mandatory for every resident in Ghana to belong to the scheme (Blanchet, Fink, & Osei-Akoto, 2012).

On the provisions of Act 852, there are five funding streams for the NHIS. These include 2.5 per cent tax on selected goods and service from the Value Added Tax (VAT) called the National Health Insurance Levy (NHIL). The NHIL is the largest source of finance for the scheme. It contributes about 60 per cent of total finance of the scheme annually (Kusi, Enemark, Hansen, & Asante, 2015). The rest include 2.5 per cent allocation of formal sector workers contribution to the Social Security and National Insurance Trust (SSNIT) per month, profits on National Health Insurance Fund (NHIF) investments and