Access to health services by ethnic minorities in the Kumasi metropolis, Ghana: Does insurance cardholding matter?

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Abstract

Background:

Ethnic minorities find difficulty in accessing healthcare and other services due to their vulnerable socio-economic conditions. The study explores the effectiveness of access to healthcare by insurance cardholding ethnic minorities in the Kumasi Metropolis, Ghana.

Methods

It was a qualitative study that used convenience and snowballing approaches in data collection. The study objects were ethnic minorities. Both primary and secondary data were used to explore access to health services in the Kumasi Metropolis of Ghana with data collected within a six-week time frame. The outcome variable was access to and use of health services and the key independent variable was insurance cardholding. The Andersen access and utilisation framework and WHO (2018) quality standards guidelines guided the study. Data were collected using unstructured focus group and interview guides from the community participants, both male and female, who were not below age 18, the legal age of adulthood. Appropriate variables were exhausted until theoretical saturation was reached. Data were analysed manually by coding and categorising the responses to derive the themes.

Results

It was observed that ethnic minority cardholders who bear insurance cards have better access to health services than none cardholders. The constraints to their effective use are inadequate and sometimes lack of medicine supply by the health facilities, low coverage of services given the low premiums they pay, poor communication by medical staff, stigmatisation and poor attitude of medical staff, among others. The conceptual framework has largely been justified.

Conclusions

Ethnic minorities generally face problems in accessing healthcare. Efforts must be made to facilitate their accessing national health insurance facility to improve their access. Besides, medical staff must improve their relationship with patients whilst services covered by low premium cardholders should improve.

Background

The plight of ethnic minorities especially in developing countries is near deplorable. They live in uncomfortable conditions which call for the attention of policymakers to design policy frameworks to improve them. Among the problems, they face in their areas of destination is access to healthcare which can partially be addressed by insurance registration. Health insurance coverage is an important
determinant of access to healthcare\textsuperscript{1,2}. This study is to assess whether insurance cardholding of ethnic minorities in the Kumasi Metropolis, an expanding metropolis in Ghana, improves their access to efficient healthcare. The results will help structure a policy framework for insurance cardholding as an efficient tool for accessing health care by ethnic minorities who are a vulnerable group.

The term ethnic minority generally refers to “ethnic or racial groups in a given country in which they are in a non-dominant position vis-à-vis the dominant ethnic population”\textsuperscript{3}. The characteristics of ethnic minorities include: being smaller than the rest of the population; being not in a dominant position; having a culture or language or religion or race that is distinct from that of the majority and its members having the will to preserve such characteristics. The marginalisation of such minorities is the norm. The ethnic minorities in the areas of study bear such characteristics.

Goal three of the sustainable development goals (SDGs) centres on ensuring healthy lives and the promotion of well-being for all at all ages\textsuperscript{4} yet migrants to some countries face difficult living conditions including access to health care\textsuperscript{5}. The issue of health and migration in most developed countries is highly considered in healthcare policy formulation\textsuperscript{6}. This is in line with WHO's objective of “Health for all” which recommends that ethnic minorities have equal access to healthcare services irrespective of their place in society\textsuperscript{5}; hence, emphasizing the fact that equitable access to healthcare services is a fundamental human right\textsuperscript{7–9}. Healthcare policy gives ethnic minorities an assurance regarding accessing quality healthcare in the host country\textsuperscript{10,6}. Access to and use of healthcare by ethnic minorities in the United Kingdom (UK) for instance, is enhanced by the National Health Scheme (NHS)\textsuperscript{11}. Despite the efforts by governments of various countries to enhance the utilization of health services by ethnic minorities, it appears ethnic minority patients are confronted with several challenges when using healthcare services, especially in developing countries. Therefore, their (ethnic minorities) use of healthcare services is lower than their non-migrant colleagues\textsuperscript{12}. Inequalities in access to healthcare exist in several countries\textsuperscript{13–15} and ethnic minorities are affected.

Studies show that there is a positive relationship between insurance cardholding and access and use of healthcare. \textsuperscript{16,17} in a study on NHIS promotion in Ghana observed that the better the quality of healthcare the more the enrolment into the scheme whilst \textsuperscript{18} observed similarly that perceived poor quality of healthcare would detract attention from registering with the scheme. Factors such as extra payment for expensive drugs/medicines, and shortage of drugs, among others, discourage people from enrolling on the scheme to access healthcare. In the United States, uninsured children and non-elderly adults are substantially less likely to have a usual source of health care than their insured counterparts\textsuperscript{1}.

The government of Ghana has made efforts in the past years to promote healthcare access and use among its citizens. Despite the government's efforts to make healthcare accessible, there are still inequalities in terms of access to healthcare. Ethnic minorities (specifically, the newly arrived migrants) are faced with several challenges which hinder their use of health facilities and these challenges make them very vulnerable in their community compared to their non-migrant colleagues yet there is very
limited research on their access to healthcare through the instrument of insurance. The holding of health insurance cards is deemed to open easy doors to access healthcare by vulnerable groups but there are very limited studies on the extent to which insurance cardholding can facilitate access to health services by ethnic minorities in an expanding metropolis such as Kumasi where ethnic minorities constitute a significant proportion of its population. Similarly, in developing countries, research on access to health services by ethnic minorities is rare. Further, little work is done on the role health insurance plays in accessing healthcare by vulnerable ethnic minorities. It is against this backdrop that there was a need to carry out this research. Specifically, this study sought to examine the role health insurance plays in accessing health care by ethnic minorities in the Kumasi metropolis.

The key research question is: What impact does national health insurance cardholding by ethnic minorities have on their access and utilization of healthcare in the study area? The related questions are as follows: How regularly do ethnic minority cardholders access healthcare? What challenges do they face in accessing healthcare with their insurance cards? What is the level of satisfaction with healthcare by ethnic minority cardholders? What alternatives do they resort to in taking care of their health? The study is exploratory, using the qualitative approach to answering the research questions. The access and utilisation framework is the underpinning model.

**Conceptual Framework**

The study justified the application of the Andersen (1995)[19] framework to the study of the effectiveness of insurance cardholding in accessing healthcare. Accordingly, the[19] behavioural model of health service usage (Fig. 1) was used as the conceptual framework.

[Figure 1 is Here]

This model has four components namely the environment, population characteristics, health behaviour and then outcomes. The environment is made up of the health care system: facilities, personnel, infrastructure, etc and the external environment which are external factors that can affect the system. The population characteristics entail the predisposing, enabling and need factors, while health behaviour refers to the activities performed by the individual concerning healthy lives and the use of health facilities. The use will largely depend upon the level of access and population characteristics. The personal health practice and use of health services will predict outcomes which refer to the effect of the interaction between the environment, population characteristics and health behaviour. The numerous variables captured in this model reflect the true situation in developing countries.

**National Health Insurance Scheme (NHIS) in Ghana**

The National Health Insurance Scheme is a system of insurance benefits established by a government to cover all or almost all of the citizens of the country. These systems are entirely or partially funded with the taxpayer’s money[20]. Health insurance is a mechanism for spreading the risks of incurring healthcare costs over a group of individuals or households[21].
Ghana's National Health Insurance Scheme (NHIS) was created by the National Health Insurance Act of August 2003, and it is one of the very few attempts by a sub-Saharan African country to implement a national-level, universal health insurance programme. The scheme focuses mainly on addressing the needs of the poor and the provision of social health protection based on the principles of equity, subsidization, client and community ownership, value for money, solidarity, risk sharing, reinsurance, good governance and transparency in the healthcare delivery.

**Methods**

**Profile of Study Area**

The Kumasi Metropolitan area (Fig. 2) is one of the 43 administrative districts in the Ashanti Region. The population of Kumasi Metropolis (1,730,249) represents 36.2 per cent of the total population of the Ashanti Region (4,780,380). It comprises 826,479 males (47.8%) and 903,779 females (52.2%). The 2010 Population and Housing Census revealed that there are 929,203 migrants, constituting 53.7 per cent of the population in the Kumasi Metropolis. This implies that the present population of Kumasi Metropolis comprises less than half of the persons born within the Metropolis. Among the 929,203 migrants, 576,373 or 62.0 per cent were born elsewhere in Ashanti Region. The remaining 335,458 migrants (36.1%) are persons born in other regions.

[Figure 2 is Here]

**Study Design and Variables**

The study made use of a descriptive cross-sectional design. Also, the study employed the quantitative approach to provide data for the study. The dependent or outcome variable was 'access to healthcare'. The independent variable was 'insurance cardholding'. These variables were derived from the characteristics in the Andersen framework (Fig. 1) as well as from the related literature. The quality health care standards were used in the determination of the quality assessment of quality health care by the respondents. They are effective service, efficient service, patient-centeredness, integration and equity and safety. These factors or part of them were the benchmarks used for assessing the quality of service which motivated utilisation.

**Sampling**

Three communities in the metropolis, Adum, Asafo and Bantama (Fig. 2) were selected for the study. These were selected because the ethnic minorities operate at the centre and immediate periphery of the metropolis where business activities dominate. The study participants were selected from ethnic minorities aged 18 years and above, because at age 18, the legal age of adulthood, they were expected
to be able to make decisions concerning their healthcare. Accordingly, persons below age 18 were excluded. Both male and female participants were included in the sample. Accidental and snowball sampling techniques were employed in selecting thirty-two respondents for the focus group discussion (FGD). There were two focus groups for each community, with six per group. For each group, there were on average two males and three females. Of the health personnel, seven were accidentally selected from Suntresu Government Hospital; two were from Komfo Anokye Teaching Hospital and three were from Heritage Natural Clinic, a private health facility. These sampling techniques were used because getting respondents for the study was difficult. Convenient places in the metropolis were used for the discussions.

**Data Collection and Analysis**

The study made use of both primary and secondary data. Primary data were obtained from the respondents in the selected study areas. A Focus group discussion guide was used for the community respondents whilst an unstructured interview guide was used for the health workers. Questions for the focus group discussion included: Do you hold an insurance card? For how long have you been an insurance cardholder? Have you been using your card regularly? Are you diagnosed with your disease at the hospital? Are you served with the prescribed medication? Are you satisfied with the communication from the doctor? What is the attitude of health workers towards you? What is the effectiveness of the medication? Do you have access to health education at the hospital? For the health workers some of the questions posed in the interview guide were as follows: Do ethnic minorities utilise healthcare? How often do they? On average what distance do they cover to access healthcare? Does the holding of insurance cards by ethnic minorities influence their use of healthcare? What challenges do insurance cardholders face in utilising healthcare? Apart from the government insurance scheme do any of them subscribe to a private insurance scheme?

The questions were asked in the local language (Twi) which they all could speak. The instruments were edited by two Doctor of Philosophy (PhD) personnel who were versed in quantitative research. A pilot study was conducted (pre-testing) in Ejisu, an area in the Ejisu Municipality to find out how realistic and applicable these tools were. Two trained undergraduate personnel assisted in the data collection. Each FGD on average lasted for 45 minutes whilst an interview lasted for 30 minutes. The data collection exercise lasted for six weeks. Permission to collect data was granted by the Committee on Human Research, Publication and Ethics, School of Medical Sciences, KNUST/Komfo Anokye Teaching Hospital, Ghana, Ref. No: CHRPE/AP/074/21.

Interviews and FGDs were tape-recorded and transcribed. Data were analysed thematically. Themes derived from the literature were linked with the responses to acknowledge widespread trends in data similarities and contrasts. It was ensured that the theoretical saturation level was reached where no new concepts were available for further coding. The themes that emerged from the coding are indicated in Table 1.
Table 1
Themes emerging from the Interviews/FGDs

<table>
<thead>
<tr>
<th>Themes</th>
<th>Description/Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Regularity of Use of health services</td>
<td>Mixed responses on constraints</td>
</tr>
<tr>
<td>2. Quality of Services</td>
<td>Diagnoses; communication; potency of medication, attitude of medical staff, etc.</td>
</tr>
<tr>
<td>3. Challenges in accessing health services</td>
<td>Inadequate medication; additional costs; attitude of staff; communication barriers, etc.</td>
</tr>
<tr>
<td>4. Use of alternative healthcare devices</td>
<td>Self-medication</td>
</tr>
<tr>
<td>5. Satisfaction with service delivery</td>
<td>Wellness. Desire to continue patronising services</td>
</tr>
</tbody>
</table>

Source: Field Data, 2020

Results

Characteristics of Respondents

The characteristics of the participants are indicated in Table 2. Most of the respondents fall within the economically active age group whilst there are more females than males, reflecting the sex ratio of Ghana. A significant proportion of the respondents have never been to school whilst over 33% have just basic education with tertiary education constituting just over 13%, implying that they have very little opportunity to be employed in the formal sector. Over 27% earn less than GhC100 ($14.00) a month whilst an additional over 55% earn within GhC100 and GhC500.00 ($14-$70.00) a month implying that most of them live below the poverty line. Regarding housing conditions, over 38% live in kiosks or the streets whilst one-half of them rent their rooms with 11% living in their own houses. Over 80% work in the informal sector which is unstable and income opportunities are uncertain. Over 88% are national health insurance cardholders subscribing to a lower premium. Only 7(19.4%) use the services of clinics and hospitals whilst over 80% use unscientific medicine together with other health services including traditional medicine. By their characteristics, ethnic minorities are a vulnerable group in terms of educational attainment, income levels and housing conditions.

Table 2: Characteristics of Respondents
<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>2</td>
<td>5.6</td>
</tr>
<tr>
<td>19-64</td>
<td>30</td>
<td>83.3</td>
</tr>
<tr>
<td>65+</td>
<td>4</td>
<td>11.1</td>
</tr>
<tr>
<td>Total</td>
<td>36</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Formal</td>
<td>11</td>
<td>30.6</td>
</tr>
<tr>
<td>Basic</td>
<td>12</td>
<td>33.3</td>
</tr>
<tr>
<td>Secondary</td>
<td>8</td>
<td>22.2</td>
</tr>
<tr>
<td>Tertiary</td>
<td>5</td>
<td>13.9</td>
</tr>
<tr>
<td><strong>Income (In GhC)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;100</td>
<td>10</td>
<td>27.8</td>
</tr>
<tr>
<td>100-499</td>
<td>20</td>
<td>55.6</td>
</tr>
<tr>
<td>500-999</td>
<td>4</td>
<td>11.1</td>
</tr>
<tr>
<td>1000+</td>
<td>2</td>
<td>5.5</td>
</tr>
<tr>
<td><strong>Housing Structure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kiosk</td>
<td>7</td>
<td>19.4</td>
</tr>
<tr>
<td>On Street</td>
<td>7</td>
<td>19.4</td>
</tr>
<tr>
<td>Rented Room</td>
<td>18</td>
<td>50.0</td>
</tr>
<tr>
<td>Own House</td>
<td>4</td>
<td>11.1</td>
</tr>
<tr>
<td><strong>Employment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formal</td>
<td>3</td>
<td>8.3</td>
</tr>
<tr>
<td>Informal</td>
<td>29</td>
<td>80.6</td>
</tr>
<tr>
<td>Unemployed</td>
<td>4</td>
<td>11.1</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ewe</td>
<td>11</td>
<td>30.6</td>
</tr>
<tr>
<td>Fante</td>
<td>4</td>
<td>11.1</td>
</tr>
<tr>
<td>Mole Dagbon</td>
<td>5</td>
<td>13.9</td>
</tr>
</tbody>
</table>
Use of Health Services

Whilst insurance cardholders access health facilities regularly with their insurance cards, non-cardholders have a problem accessing health care. The responses are indicated below:

Well, most of the people that have enrolled in the national health insurance scheme access healthcare often. They see the importance of healthcare accessibility so most of them have enrolled and they use it frequently. Thus, those without health insurance do not come to health centres frequently as compared to those who have active NHIS cards. [Male Health Worker, In-depth Interview (II)]

The NHI card has actually facilitated my access to healthcare centres. Because, with the NHI card I pay little or no fees at the healthcare centre. Therefore, the NHI card has proven to aid me access healthcare services regularly. [Female, with no formal education, FGD].

I do not visit healthcare services regularly because I do not have the NHI card. Hence, anytime I visit the hospital I pay huge sums of money for my bills and this normally prevents me from using the hospital regularly as I do not have the means to be paying huge medical bills regularly. But I do believe that with the NHI card my bills will be reduced and so that will help me to use the hospital often when the need
arises. Therefore, I appeal to the government to help us register for the NHI card [Male with basic education FGD].

**Quality of Service Delivery**

The quality of services delivered by the health facilities was explored. Diagnosis of patients, the attitude of medical staff, health education services, clarity of communication and availability of medicines were the indicators used. It is clear that, whereas patients are diagnosed with their health condition, they have a problem securing prescribed medication and are not satisfied with the attitude of some medical staff and the clarity of communication by the staff. The responses are indicated below:

We do take the health records of ethnic minorities whenever they access healthcare. This is a routine practice for us to be able to reconcile with existing data on them so we can offer proper diagnosis and treatment of their health problems. This is a standard everywhere and we enforce it vigorously [Female Nursing Officer, II].

I am diagnosed by a nurse anytime I visit the hospital and my records taken as well. It is the first process I go through whenever I visit the hospital. [Male with secondary education, FGD]

We the staff treat all patients as our siblings. Thus, we show them love hence we have established a very good relationship with them. And this has actually proven to speed up the healing of patients throughout my years of service [Male Staff Nurse, II]

Some of the staff are nice and relate very nicely with me when I go to the hospital. Others too have a very bad human relationship and as such do not relate well with me especially, the young and newly enrolled staff. But overall, I think I have a good relationship with the healthcare workers. [Male with basic education, FGD]

I actually do not like how the nurses relate with me when I go to the hospital. They talk to me in a disrespectful manner and this mostly prevents me from going to the hospital. So, my relationship with health services workers is very poor. [Female with basic education, FGD]

Oftentimes, I am educated on my health-related issues at the hospital by the doctor. He also advises me on the food to eat and the right exercise to do in order to ensure healthy living. I must say that, I am well educated on health issues at the hospital. [Male with tertiary education, FGD]

They find it difficult communicating with us. When we ask them to narrate their problem to us, they find it difficult telling us their health problems due to the language barrier. Most of them cannot speak Akan or English. Last time, there was a scenario of that nature that almost resulted in a misdiagnosis had it not been the timely intervention of someone who understood and interpreted the language of the patient. [Male Healthcare Worker II]

**Use of Unorthodox Medical Services**
The use of unorthodox medical devices due to the inability to access healthcare through insurance cardholding and the ability to purchase healthcare through cash and carry was explored. Statements below indicate that some have been resorting to self-medication and traditional medicine.

I do not remember when I used the hospital. My grandmother happens to be a traditional medicine practitioner and so she taught me some herbs for the treatment of some illnesses. Hence, anytime I am not well, I prepare the drugs myself and drink it. That is how I have been treating my illnesses all these years [Female with no formal education, FGD].

I have been self-medicating ever since I gave birth to my firstborn and I am okay. I feel strong and energetic besides the drugs I have been using seem to be ideal for my illnesses. I personally do not see the need to visit the hospital and pay monies while I can self-medicate and get healed of my illness [Female with Basic Education, FGD].

**Challenges facing minority ethnic group cardholders in accessing healthcare**

The challenges minority ethnic groups face in accessing health care were explored. The challenges included additional costs to pay, communication barriers (as indicated in the section on the use of health services), unavailability of drugs, the attitude of medical staff, inability to go by dosage instructions, stigmatisation etc. The narratives by participants and medical staff are indicated below.

Most of them cannot get all medications with NHIS. This is highlighted in the difficulty they face when they have to pay top-ups to access other services. They are unable to afford drugs and other consumables, thus the health insurance membership influences their healthcare use strongly [Female Nurse, II].

The NHI card facilitates my use of healthcare services regularly however, it does not cover all of my medical charges therefore, I pay additional charges at the healthcare centre and it is very worrying [Male with basic education, FGD].

I personally do not feel the impact of the NHI card on my access to healthcare. Because I pay huge amount of money for my health conditions even though I have the NHI card. The NHI card does not cover much of my medications and so going to the hospital with the NHI card is like going without any insurance cover [Female with No Formal Education, FGD].

I actually do not like how the nurses relate with me when I go to the hospital. They talk to me in a disrespectful manner and this mostly prevents me from going to the hospital. So, my relationship with health services workers is very poor [Female with Basic Education, FGD].

Some staff mock them and there is also stigmatization. This mockery and stigmatization are rampant among the ethnic minorities that cannot communicate effectively in either Akan or the English language. This sometimes makes them furious and less inclined to visit health facilities [Female Nurse, II].
Satisfaction with Service Delivery

Whereas health personnel report that most of the patients are satisfied with the services rendered to them, the respondents say otherwise. In such a stalemate credibility shall be given to the respondents who are the recipients of care so will be better assessors. The narratives below are respondents’ statements.

Most of them are satisfied with the services we render them since they get healed by following the directives and the prescriptions we give to them. Also, they are satisfied because consumables are always readily available [Female Nurse, Periphery, Il].

I am always asked to pay extra charges when I go to the hospital even though I have the NHI card. This honestly displeases me from going to the hospital oftentimes because I do not have money to be paying extra charges. I am generally not satisfied with the services [Female, 20 years, no formal education, FGD].

Discussion

The study focused on accessibility to and use of health services by ethnic minorities in an expanding metropolis in Ghana. Whereas accessibility and use of health services generally have received research attention that of ethnic minorities, a vulnerable group, has received limited attention. Findings show that insurance cardholders among ethnic minorities in the Kumasi Metropolis access healthcare more than non-holders. Secondly, cardholders are frustrated with their accessing health care by inadequate medication they have to buy. Thirdly, the absence of numerous basic medications from the list of medicines covered by the insurance scheme makes the cardholders not enjoy the full benefits of insurance. Other problems they face include communication barriers and poor attitude of medical staff and stigmatisation.

Improved access to and use of healthcare through insurance cardholding is evident in the literature. The National Centre for Health Statistics 1 observes that uninsured children and non-elderly access healthcare less than the insured whilst 16, 17 in similar studies conclude the same. On the other hand, poor quality delivery services including shortage of drugs, extra payments, bad attitude of medical staff, communication inefficiencies, etc. discourage the use of healthcare. These are general factors that affect the use of healthcare services by insurance cardholders. In the current study extra payments by insurance cardholders, poor attitude of medical staff and communication barriers and stigmatisation are factors that discourage their use of healthcare services. In the current study involving ethnic minorities who are a vulnerable group, the situation becomes more serious and requires urgent attention. The additional problem, the stigmatisation issue is a serious canker that requires urgent attention. Even though participants are satisfied with some aspects of the service delivery including diagnosis and health education primarily, quality is generally compromised given 26 standards of healthcare quality assessment.

The conceptual framework has been substantially justified by the findings. The healthcare system (institution) influences the evaluated or perceived need of ethnic minorities which results in access to and
use of health services. The enabling factor of insurance has a positive effect on the use of healthcare. Ethnic minorities holding insurance cards use health services more regularly than those who do not. Further, the use of health services predicts the outcomes which are perceived health status, evaluated health status and assessment of health services. The insurance cardholders have assessed the efficacy of the services, accordingly. The WHO standards of assessment have also been justified. The framework could be used for research on access and use of healthcare services by ethnic minorities in urban areas in developing countries in Africa. It is recommended however that, based upon the findings of this study, some modifications be made to the conceptual framework. The healthcare systems must have direct links with health behaviour and outcomes.

**Limitations**

The study had some limitations. Firstly, it should have covered more than an urban community in the country to ensure adequate spatial spread. This restricted spatial coverage would however not affect the credibility of the results since the characteristics of the ethnic minorities in this study are similar to those in the country. The second limitation is the use of the qualitative approach which depicts the ‘how’ and ‘why’ of events but not of ‘what’ of an event. Although the mixed method approach gives a better picture of the status of a phenomenon, the use of the qualitative approach gives a strong basis for hypothesising, hence, preparing a foundation for the use of a pragmatic (mixed methods) philosophy. Lastly, there was the possibility of an interviewee bias since there must have been the expectation that their responses might result in some financial relief from the government to assist in their access to healthcare. This suspicion might be far-fetched since the objectives of the research were made clear to them.

**Policy Implications**

The results bring to light the need for the implementation of some policies to improve access to healthcare by vulnerable insurance cardholders. Firstly, the premium of cardholders who receive very low incomes must be upped so that there will be more coverage of the services, including medicines. Secondly, basic services coverage of the health insurance scheme must be improved. Thirdly, in health institutions, there must be orientation programmes for health personnel on staff-patient relationships and effective communication between health personnel and patients. Moreover, there must be a mechanism to assess patient satisfaction with service delivery in health institutions. For improvement in healthcare for ethnic minorities, the recommends a health system approach employing preventive measures and community involvement.

**Conclusions**

Using the qualitative approach to explore the effect of insurance cardholding on accessing healthcare by ethnic minorities in an expanding urban area in Ghana, we established that those holding insurance cards accessed healthcare more than their counterparts who do not. Among factors which discourage them
from regularly accessing healthcare, stigmatisation, marginalisation, inadequate medicines and sometimes lack of them, non-statutory payments and poor attitude of medical staff rank high. Recommendations for policies to address the problem have been made.

Declarations

Ethics approval and consent to participate

All experimental protocols were approved by the Committee on Human Research, Publication and Ethics, School of Medical Sciences, KNUST/Komfo Anokye Teaching Hospital, Ghana, Ref. No. CHRPE/AP/074/21. The informed consent method was approved by the same Committee. All methods were carried out following relevant guidelines and regulations.

Participants signed informed consent to participate forms. Those who could not sign were made to thumbprint after details of the study had been made read out to them. They were further informed that they could opt out of the activity anytime they felt like doing so.

Consent for publication

Not Applicable

Availability of Data Materials

Data would be made available upon reasonable request from the corresponding author.

Competing Interests

There were no competing interests.

Funding

The study did not receive funding from any organisation.

Authors’ Contributions

a. Daniel Buor: Conception, study design, execution, data analysis and interpretation.
b. Peter Boakye Ansah: Conception, study design, acquisition of data, data analysis
c. Seth Agyemang: Conception, study design, data analysis and interpretation

Acknowledgements

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References

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Footnotes

1. The sub-metropolitan areas of the Metropolis have been elevated to municipalities. The study however cover the former area of the metropolis since the municipalities had not been created at the time of data collection for the study.

2. The 2021 Population and Housing Census (PHC) had not been conducted at the time of data collection for this research. The 2010 PHC data were thus used.

Figures
Figure 1

Anderson behavioural model

Source: Anderson (1995)
Figure 2

Map of Kumasi Metropolis showing Study Communities

Cartographic Office, Department of Geodetic Engineering, KNUST-Kumasi, Ghana, 2020