



Facilitators of and barriers to the use of healthcare services from a user and provider perspective in Ejisu-Juaben municipality, Ghana

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Abstract

Objective Knowledge about the use of formal healthcare services is an important aspect of public health policy. However, there is a paucity of empirical studies on facilitators of and barriers to formal healthcare use in Ghana from the health user and provider points of view, a gap this qualitative study aims to fill.

Methods In-depth interviews were conducted with 20 healthcare users and 15 formal healthcare providers in Ejisu-Juaben Municipality in the Ashanti Region of Ghana. A thematic analytical framework was used to analyse the data, which were then presented based on an a posteriori inductive reduction approach.

Results Four major facilitators of healthcare use were identified: acceptance of the health insurance card, having a good relationship with the healthcare providers, quality of the service offered/professionalism and proximity to healthcare facilities. The barriers to formal healthcare use established in this study were of an economic, social, cultural and institutional nature.

Conclusion The study findings highlight the need to address barriers to the utilisation of formal healthcare by reviewing the national health insurance scheme, recruiting language interpreters at health facilities and integrating the formal and traditional systems into the mainstream national health system in Ghana. This move would help make headway toward meeting UN Sustainable Development Goal 3 of ensuring healthy lives and promoting well-being for all at all ages by 2030.

Keywords Barriers · Facilitators · Healthcare · Access · Ejisu-Juaben · Ghana

Introduction

Good health status is considered one of the most important elements of national development. To ensure a population's good health status, widespread accessibility to and frequent use of healthcare services are required. This makes it an important consideration for the various governments of the world, as reflected by all the policies implemented, medical professionals trained and infrastructure established, to ensure that the citizens of a country have access to quality healthcare.

Globally, there have been more advancements in the fields of health, science and technology in the last 50 years than in the preceding 500 years (WHO 2007). Progress has been made in the areas of health infrastructure, policies, education and income, amongst others. According to Cook et al. (2009), healthcare accounts for about one-third of government expenditure globally. For instance, the US government spends the most on healthcare per capita and has the highest health expenditure as a percentage of its gross domestic product (GDP), namely 17.2%, of any country in the world.

Nevertheless, the gains made by humanity in the area of healthcare delivery have not been universal. In Africa, formal healthcare is the lowest ranked sector considered for national development because many countries in sub-Saharan Africa (SSA) are restricted by a scarcity of resources, which is a major hindrance to healthcare delivery (Kaseje 2006; Kasil 2003). Compared with countries like the US, as stated above, healthcare expenditure in most SSA countries does not exceed 5% of their GDP, with some even spending less than \$10 per person on healthcare delivery (Stanfield 2009). Kirigia and Barry (2008) stated that Africa is confronted with a heavy

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burden of issues concerning communicable and non-communicable diseases, mostly because healthcare coverage is too low as a result of health system weaknesses.

In Ghana, healthcare provision is mostly the responsibility of the government and is supervised by the Ministry of Health and the Ghana Health Services (Kirby 2007). Mayo (2009) stated that the government funds the healthcare system using internally generated funds and through donors. Statistics show that Ghana spends about 5.2% of its GDP on healthcare, which is about 40% of all government expenditure. According to Blanchet et al. (2013), Ghana has made giant strides in trying to enhance healthcare use in the country, taking measures such as implementation of a national health insurance system, building of hospitals and training of health professionals. This shows the commitment of the government to ensuring that healthcare use in Ghana is improved.

However, in the midst of recent advancements in healthcare financing and provision, it has been perceived that the decision to use health services is down to individual preference, and these choices are mostly framed in a social context characterised by cultural, social and family ties (Tidermalm et al. 2008). Thus, certain facilitators exist that promote formal healthcare use as well as barriers to the process of seeking professional healthcare and submitting oneself to the application of regular health services, with the purpose of preventing or treating health problems (Ratnasingham et al. 2013). Healthcare is a means to an end, whereby the ultimate target is the restoration or preservation of health. Facilitators of formal healthcare use are influenced by both internal and external components that make access to formal healthcare easier for people (Heaman et al. 2015). Elements supporting the use of healthcare systems and ensuring that both users and providers are satisfied may vary from social and physical to psychological aspects. Considerations such as quality of healthcare, high level of professionalism, culturally sensitivity, health insurance and accessibility of health facilities have been identified as enabling factors of formal healthcare use (DiClemente et al. 2011; Ross et al. 2015; Waiswa et al. 2010; Beekman et al. 2013; Vickers et al. 2006; Buor 2003).

However, many aspects have also been regarded as barriers to the use of formal healthcare (Sword 2003), ranging from socio-economic to cultural (Buor 2003). Obstacles can be seen from two perspectives: those of the users and providers. Sword (2003) argued, for example, that seeking the experiential knowledge of healthcare providers and administrators is a key factor to determining the potential hindrances and facilitators underlying the accessibility of formal healthcare services. Over the years, healthcare providers have been faced with various stumbling blocks that prevent them from delivering the services that they have been trained to offer, including lack of professional staff, inadequate basic equipment and infrastructural deficits (Sword 2003). On the part of the users, issues such as poverty make them unable to pay for medical

services and drugs. Language difficulties whereby health providers are unable to communicate in the local language of health seekers and health users are unable to convey how they feel or describe the symptoms of diseases (Chadwick et al. 2013; Hassali et al. 2012) are also hurdles to be overcome, as well as poor attitudes of health professionals, societal cultural norms and practices, geographical distance and lack of health insurance (Buor 2003).

Other studies that have looked at barriers and enabling factors only considered the views of either the user or provider, an approach that has created a one-sided picture. However, facilitators and inhibitors must be critically assessed and addressed from both sides if Ghana is to make headway in its quest to achieve Sustainable Development Goal 3. The objective of this study was therefore to explore the promoters of and impediments to formal healthcare use from both a user and provider perspective using Ejisu-Juaben Municipality as the study example.

Methods

Study setting and design

This study was conducted in three purposively selected healthcare facilities (Paradise Clinic, Ejisu and Onwe health facilities) and three communities (Onwe, Akyeremanda and Asuminya) in Ejisu-Juaben Municipality. Ejisu-Juaben Municipality has two major hospitals, the Municipal Hospital in Ejisu and Juaben Hospital. These two hospitals serve as referral points for other health delivery facilities. This is because most health centres and maternity homes providing healthcare to the population are not adequately resourced and also lack qualified health professionals to treat and diagnose specific diseases. Access to and use of health facilities in this area is challenged by poor road networks although diseases such as malaria and respiratory tract infections continue to afflict the residents in the municipality, necessitating the use of healthcare services. The multi-ethnic nature and cultural diversity of this population also made it suitable for conducting our study. We employed a qualitative research design. This approach is useful as it helps to tap deep into complex and dynamic issues such as health. It is a way to explore and understand the meaning individuals or groups ascribe to a social or human problem (Creswell 2003, 2009, 2012, 2014) to obtain a holistic view (Denscombe 2010). In our case, it provided a detailed description of facilitators of and barriers to healthcare use in Ejisu-Juaben Municipality, Ghana.

Sampling and recruitment procedures

We purposively selected three health facilities comprising one private health facility (Paradise Clinic) and two government

health facilities (Ejisu Government Hospital and Onwe Health Centre) to obtain a mix of ideas, experiences and opinions on the facilitators of and barriers to formal healthcare use in three communities (Onwe, Akyeremanda and Asuminya) in Ejisu Municipality. The recruitment of multiple health facilities was also appropriate because the researchers wanted to capture a diversity of health experiences from different health stakeholders (such as users and providers) to draw meaningful conclusions. In this study, we conceptualised facilitators as factors that make access to and use of formal healthcare services easier for health service users (Heaman et al. 2015), whereas barriers were defined as factors that make access to and use of formal healthcare services more difficult or impossible for service users (UNICEF 2011). Generally, formal healthcare is defined as a system whereby medical doctors, nurses, midwives and pharmacists treat symptoms of various diseases using surgery, drugs or radiation (National Cancer Institute 2014). The World Health Organization (2016) defined formal healthcare systems as various activities that have the primary purpose of promoting, restoring or maintaining the health of an individual or group of people. For the purpose of this study, formal healthcare was defined as a mechanism or process whereby healthcare professionals provide treatment to people with the purpose of disease prevention and health promotion. Formal healthcare use was defined as the seeking of professional healthcare and submitting of oneself to the application of regular health services, with the purpose of preventing or treating health problems (Ratnasingham et al. 2013). Non-probability techniques, such as purposive and convenience sampling, were used to recruit 35 study participants comprising 20 health service users and 15 formal healthcare providers. Healthcare users were selected subject to their availability, readiness and willingness to provide information about formal healthcare use facilitators/barriers.

We considered healthcare users as individuals seeking health treatment from formal healthcare facilities, while healthcare providers were defined as health professionals such as doctors, nurses and midwives that had knowledge about the diagnosis or treatment of diseases afflicting people and who had worked in the area for at least 3 years preceding the study. Following Barbour (2001), the selection procedure was an arbitrary one in that it did not consider the size of the target and the accessible populations of the study regions. The sample size was grounded on the principle that in a phenomenological study, it must comprise at least six participants (Morse 1994 cited in Mason 2010). Since qualitative research seeks to examine attitudes, behaviours and experiences, fewer people participate in such studies, but the contact with them normally lasts for longer periods of time (Dawson 2002). Our purpose was to obtain high quality information on the complex normative views and experiences concerning facilitators of and barriers to formal healthcare use. To take part in this study, participants had to be at least 18 years of age, have some

knowledge regarding healthcare use and have used a health facility for at least 1 year or more prior to the study. Healthcare providers were selected based on the purposive sampling technique.

Data collection instrument and procedure

The data collection instrument used in this study was in-depth interview guides, designed to ensure that similar themes and questions were covered in each discussion session. Since this study sought to gain an understanding of the experiences, opinions, feelings and emotions of the study participants, personal interviews were highly recommendable (Denscombe 2010), enabling us to probe the study participants and gain valuable insights into the data provided. To ensure validity and quality control, the research instrument was first tested in one of the study communities, which helped us to rephrase questions and clarify and use more appropriate concepts for easy comprehension by the study participants. The interviews were supported with informal and personal conversations conducted by the second author who had in-depth knowledge of medical geography, health policy and health development. Healthcare users were interviewed at home, free of interference from any third party. Health professionals were interviewed in free consulting rooms after the end of their usual daily activities. The research instrument comprised three sections. The first considered the background information of the study participants such as age and education. The second component dealt with the perspectives of study participants on facilitators of formal healthcare use, and the last part focused on the views of study participants on barriers to formal healthcare use.

Interviews were audio-recorded with informed consent from the study participants and handwritten field notes were made according to Denscombe (2010). This procedure enabled us to cross reference or check with what was actually discussed. Interviews were carried out in two languages—Twi (the local dialect of the study participants) and English. The average interview length was 50 min.

Ethics

The purpose of the study was first explained to the study participants before their informed written and verbal consents were obtained. Further, interviewees were assured of the strict confidentiality and anonymity of the data they provided. To minimise any potential negative effects, their identities, such as names, were not given to the interviewers and no personal identifying details were audio-recorded or handwritten in the course of the interviews. They were assured that their participation in the study was voluntary and that the data provided would only be used for the purposes of the study. In addition, they were informed that they were free to opt out at any time.

Data analysis

Audio records were transcribed into the Twi dialect and later translated into English. Translations were then cross-checked with the audio records and handwritten field notes to ensure validity, reliability and quality control. All authors read the transcripts and handwritten field notes for general understanding. We performed back-to-back translation on selected transcripts to check the accuracy of the translations. The data coding then started until theoretical saturation was reached and an a posteriori inductive method applied (Glaser and Strauss 1967). This approach helped the authors to develop broad and consistent themes and enabled them to derive true experiences after engaging with the study participants instead of relying on their prior knowledge of the issue under investigation. The authors then read and reviewed the transcripts and interview notes several times, and topics were extrapolated and compared to responses for the purpose of identifying similar trends and differences. The essence of the thematic analysis was that it helped to identify, analyse and report patterns within data and also aided in organising and describing the data in rich detail (Braun and Clark 2006). The study results were presented based on themes, and the normative views of the study participants were presented using quotes and excerpts.

Results

The findings encompassed the views of the two sample groups recruited for the study, namely service users and healthcare providers. The first part of the analysis dealt with the background characteristics of the respondents. The second part evaluated the various facilitators of healthcare use. The final section examined the barriers to healthcare use. The findings were further categorised into theme clusters.

Background characteristics of participants

Thirty-five study participants took part in the study, with 20 being users and 15 providers. Regarding the users, 12 were female and 8 male, indicating a higher use of formal healthcare by females. Also, it could be inferred that the users were relatively illiterate since a total of 15 had no kind of formal education and only 5 had basic education. Most respondents were in the 41–50-year age group. Health providers who took part in the study were also predominantly female (10), with only five males, as indicated in Table 1. It could also be deduced that providers were highly educated, with all participants having attained tertiary education. Most respondents in this group were aged 20–40 years, suggesting active labour forces within the facilities visited.

Table 1 Sample characteristics of respondents

Type of respondent	N = 35
User	20
Provider	15
Gender (users)	
Male	8
Female	12
Gender (providers)	
Male	5
Female	10
Education (users)	
None	15
Basic	5
Education (providers)	
Tertiary	15
Age in years (users)	
20–30	4
31–40	5
41–50	10
Above 50	1
Age in years (providers)	
20–30	8
31–40	5
41–50	1
Above 50	1

Facilitators of formal healthcare use

Discussion with study participants revealed acceptance of the health insurance card, attitudes of formal healthcare providers, quality of service/professionalism and proximity to healthcare centres as the major facilitators of formal healthcare use.

Acceptance of health insurance card

All participants mentioned the acceptance of the national health insurance card by most formal health centres in Ejisu-Juaben Municipality as the main facilitator of formal healthcare use. They explained that the insurance covers most healthcare costs once you have it. All participants observed that those who had the insurance used formal healthcare more than their counterparts who did not have the insurance. A user from Onwe had this to say:

‘I think what makes me use hospitals is the health insurance’ [Healthcare user].

Similarly, another user from Asuminya noted that:

‘The health insurance that most hospitals accept is what makes most of us use formal healthcare. This is because

I have observed that those who have it use healthcare more than those who do not have it [Healthcare user].

Most of the providers also believed that the number one facilitator to the use of formal healthcare was the health insurance, which allows holders to access healthcare for no or reduced charges. They also observed that holders of the national health insurance card in the municipality visited and used formal healthcare more than those who did not have it. A provider from Paradise Clinic explained this further:

‘Generally, I believe it is the health insurance which is the major facilitator of formal healthcare use. This is because, as a healthcare professional, I have observed that those with the insurance use formal healthcare more than their counterparts who do not have it’ [Healthcare provider].

The endorsement of the national health insurance card as a key facilitator of formal healthcare use by both users and providers showed how crucial the scheme is in enabling formal healthcare use.

Good relationship with healthcare providers

Study participants also highlighted having a good relationship with healthcare providers as another factor promoting healthcare use. Some of them expressed their general satisfaction with the expertise of most healthcare staff. Some also mentioned a positive and cordial relationship between them and the healthcare providers as a facilitator. They explained that the friendly and approachable nature of most nurses in the formal healthcare centres influenced their decision to use formal healthcare. This is what participants from Asuminya and Akyeremade said:

‘There are a lot of experts there that I can rely on’ [Healthcare user].

‘I believe the doctors and nurses can take care of me when I visit. The doctors get time to take good care of you when you visit’ [Healthcare user].

‘The nurses too are friendly and they ask important questions that can help you be cured’ [Healthcare user].

These findings indicate a positive relationship between healthcare providers and users.

Quality of service/professionalism

The quality of service provided by healthcare staff was also named as a facilitator by users who explained that client satisfaction with health services encourages them to use formal

healthcare. The majority of study participants, especially users, explained that quality of service is synonymous with better treatment and care. They further expressed that the quality of treatment or services given by health providers is assessed by how quickly they are healed or cured of a particular illness, often with a given medication. By using this indicator, the majority of study participants generally judged that the service of healthcare providers in the municipality was of high quality.

Elaborating further was a provider from Akyeremade who said:

‘I think our attitudes towards the users, how we relate to them, make them use our facility’ [Healthcare provider].

A provider from Onwe Health Centre also remarked:

‘I believe the availability of equipment and the quality of care we provide encourages people to use our services’ [Healthcare provider].

Adding more evidence to this was another provider from Ejisu Hospital who felt:

‘Most users really like the way the providers treat them. We always make sure they are given the needed attention and care whenever they visit’ [Healthcare provider].

A pinnacle statement was made by a user from Akyeremade who said:

‘I must say the healthcare providers treat us very well. This is because you feel very good after visiting’ [Healthcare user].

Proximity of healthcare centres

One distinctive facilitator mentioned by providers was the location of most healthcare centres in the municipality close to the users; as a result, their visits did not involve transportation costs that could act as a barrier to accessibility. One provider said:

‘Our health centre, the hospital, has a certain proximity to the citizenry of the town’ [Healthcare provider].

Another user also added:

‘From our places to the healthcare centres in this community is not far, which I think is good’ [Healthcare user].

Also, explaining the economic importance of proximity was a user from Onwe who commented;

‘The distance from our residence to most of the healthcare centres is not far which helps to reduce the cost of accessing healthcare’ [Healthcare user].

This finding confirms that the closer healthcare centres are to users, the lower the cost of healthcare for them.

Barriers to formal healthcare use

Study participants disclosed that key barriers to formal healthcare use in Ejisu-Juaben Municipality included those of an economic (low income coupled with high hospital charges), social (language issues), cultural (traditions, norms and practices) and institutional/internal (health insurance problems) nature.

Economic barriers

Participants explained that the costs involved in using formal healthcare were very high in the municipality and most people could not afford them. This study confirmed that most users were relatively poor in terms of income and as a result unable to pay for any services involving higher charges. The study also discovered that most of the users who used formal healthcare, specifically those in rural areas, did not have valid health insurance and were therefore required to pay the full bill whenever they visited the hospital. Nearly all study participants expressed a willingness and readiness to use formal healthcare, but poverty and high healthcare charges served as barriers preventing them from doing so.

One participant from Asuminya criticised:

‘The cost involved in accessing formal healthcare is too high. Looking at my income status, I cannot afford it. So what I have to do is to stay at home even when I am seriously sick’ [Healthcare user].

Another user from Onwe complained:

‘Due to poverty I am unable to use formal healthcare. This is because I cannot afford the charges. Even if I am seriously ill and I feel that I need treatment’ [Healthcare user].

And a provider from Paradise Clinic concluded:

‘Almost all of our clients, especially those from the rural areas, complain of high cost involved in accessing our services. Due to this reason, they are unable to afford them. Patients are mostly given different days to come

for check-ups and additional medication as well as treatment, but they often only come once, largely because a lack of money to cover travel expenses and medical services costs’ [Healthcare provider].

Social barriers

Some study participants also mentioned language as a barrier to formal healthcare use in the municipality. They emphasised that most of the professionals do not understand the local dialect (Twi), which makes effective communication difficult. Users further elaborated that most of the medical staff only spoke English, which they cannot understand. In a similar vein, most of the providers found it difficult to talk with and understand patients who could not speak English, especially when all the healthcare professionals present were non-natives or non-speakers of the local language.

A user from Onwe explained:

‘Most of the nurses do not understand our local language and we also do not comprehend the English that they mostly speak. This often prevents me from visiting the hospital because I believe that if the nurse does not understand you, it will be very difficult to get the right treatment’ [Healthcare user].

A user from Akyeremade commented:

‘Personally I know some people in this community who do not use formal healthcare because of language differences. Most of the nurses and doctors do not understand the local dialect and we do not understand English either. So it has made it difficult for some of us to discuss our health issues with them. I think the nurses should try their best to communicate effectively with us in the local language. We can then explain our problems to them and get the treatment we need’ [Healthcare user].

Another provider from Ejisu Hospital noted:

‘When it comes to language, most of the users who come to our hospital from rural areas do not understand English which makes it difficult for them to express themselves well when they meet professionals who in turn cannot speak the local language. I think most of the rural inhabitants do not come here because of the communication problem’ [Healthcare provider].

Another provider from Onwe Health Centre endorsed this view:

‘I believe language is a big issue here which is serving as a barrier to formal healthcare use in this community. This is because, from my experience, I can see that most of the patients who come here feel victimised and stigmatised when they are unable to express themselves well in English, especially when the health assistants do not comprehend the local language either’ [Healthcare provider].

Cultural barriers

Study participants also revealed certain cultural and religious factors that act as barriers to formal healthcare use by many residents in the municipality. They explained that some residents’ strict adherence to certain societal norms and practices prevent them from using formal healthcare.

A provider from Paradise Clinic confirmed:

‘I am aware that some norms and practices in this community do not allow certain groups of people to take orthodox drugs which prevents them from using formal healthcare’ [Healthcare provider].

Another provider from Ejisu Hospital explained:

‘Some people in this community trust conventional methods of healing more than formal healthcare. Their strong belief in the use of traditional herbs does not allow them to use most formal healthcare’ [Healthcare provider].

Another user from Akyeremade added:

‘I believe most people do not use formal healthcare in this community because of the drugs which are alien to our cultural systems. Most prefer the use of traditional medicines which are part of our culture. Also, we still request traditional medicines when we are given the western drugs’ [Healthcare user].

Institutional/internal barriers

Study participants generally lamented the challenges faced by the national health insurance scheme. They explained that current issues plaguing the insurance policy were compelling most of the hospitals in the municipality to withhold acceptance of the insurance card. It transpired that the insurance scheme was no longer functioning properly since users were not receiving the medication that they used to get with the card. Providers also explained that they were not being given the money allocated to them by the government after treating

patients with insurance. As a result, some specific drugs that the insurance used to cover were being removed, which was negatively affecting patients who primarily used the insurance for accessing healthcare.

One provider from Onwe Health Centre explained:

‘I genuinely think the health insurance scheme is facing serious challenges. Now the monies for the hospitals are not coming. You can provide services to patients with the card for more than a year without receiving money from the government for repayment. As a result we are also re-strategising to keep the hospital running by taking some medicines out of the scheme’ [Healthcare provider].

A user from Onwe also regretted:

‘The cost involved in accessing formal healthcare is too high. Now the healthcare insurance too, which reduces the cost for us, is also not really working. One has to pay for almost the full cost’ [Healthcare user].

Another user from Akyeremade described his ordeal:

‘Though I have a valid insurance card, the amount of money I paid for drugs and other charges at the hospital the last time I visited was still too high’ [Healthcare user].

Certain other internal factors were also discussed, with providers generally mentioning the issue of inadequate staff and other logistics needed for an effective and efficient healthcare system.

One provider from Paradise Clinic noted:

‘The hospital lacks a lot of staff and there is always overcrowding and it makes the patients frustrated. This often prevents them from coming to the hospital’ [Healthcare provider].

Another participant from Onwe also said:

‘There are basic things that we lack internally, like thermometers and drugs, which I think also discourages people from using formal healthcare. We could also do with more staff to help with the nurse-patient ratio’ [Healthcare provider].

Another provider from Ejisu Hospital remarked:

‘There are not enough nurses to treat the teeming number of persons that visit the hospital on a daily basis. The longer they wait at the hospital premises, the more

they become frustrated. This I believe influences their decision not to use formal healthcare' [Healthcare provider].

These findings imply that facilitators of formal healthcare use are complex and the barriers are multifaceted in nature, comprising financial, social and cultural dimensions.

Discussion

This study explored the facilitators of and barriers to healthcare use from the user and provider perspective in Ejisu-Juaben Municipality in the Ashanti Region of Ghana. The findings largely concur with a number of related previous studies (Ross et al. 2015; Buor 2003; Sword 2003), whereas in some instances, certain differences could be observed. The study generally found that the main facilitators to formal healthcare use were availability of health insurance, attitudes of health professionals and proximity of health centres. These facilitators have also been reported by others (Buor 2003; Griffiths and Stephenson 2001; Vickers et al. 2006). The positive relationship between health insurance and formal healthcare use has also been established in the literature (Buor 2003; Griffiths and Stephenson 2001; Vickers et al. 2006). The availability of health insurance allows holders to use formal healthcare at a reduced or no cost and in some communities serves as an incentive promoting the use of formal healthcare since the cost burden is diminished. This was evidenced in our study by the number of health insurance holders who used formal healthcare compared with non-holders. Since health insurance makes such a tremendous contribution to formal healthcare use, Buor (2003) recommended the implementation of effective health insurance schemes in Ghana to substitute the cash and carry system.

Another facilitator was the attitude and competence of the health professionals. This finding is also in line with previous studies (Griffiths and Stephenson 2001; Vickers et al. 2006; Ross et al. 2015; Beekman et al. 2013; Waiswa et al. 2010). Our study maintains that professionalism is one of the major facilitators of formal healthcare use by healthcare seekers. When providers ensure that they engage with patients in a skillful way, users are eager to use formal healthcare services. Professionalism includes ensuring confidentiality of user information and interacting with patients in the most appropriate way. It also makes certain that the rights of the users are protected. In addition, a respectful attitude and approachable interaction style while taking care of the needs of users always promote health-seeking behaviour. Health professionals are trained to adhere to certain work ethics that ensure they deliver health services in an empathetic and person-centred manner (Ross et al. 2015; Vickers et al. 2006).

Moreover, the physical location of medical facilities can be a major facilitator of formal healthcare use as mentioned by our study participants and as has been reported elsewhere (Diclemente et al. 2011; Ross et al. 2015). When a health centre can be easily accessed, it promotes formal healthcare-seeking behaviour amongst users. This facilitator has an indirect link to the issue of mobility and reduces the total healthcare cost. The closer the health centre, the more people use it because of the absence of transport costs coupled with no or little difficulty involved in reaching the centre. This is in line with a finding by Ross et al. (2015) who stated that when transportation facilities were made available by the health authorities in Kenya, there was an increase in formal healthcare patronage. This is a very important aspect of the healthcare system since users may want to attend clinics, but cannot always access them.

On the other hand, the study also found a number of factors acting as barriers to formal healthcare use in the study area. Predominant among them were issues of poverty (financial problems), challenges in the national health insurance policy, social issues such as language differences, cultural and religious beliefs, and institutional and other internal formal healthcare sector issues such as lack of staff, inadequate basic equipment and infrastructural deficits. Most of these obstacles were no different from the previous findings of other studies, in both Ghana and beyond (Ross et al. 2015; Buor 2003; Sword 2003; Bryman and Bell 2007; Tidermalm et al. 2008; Ratnasingham et al. 2013; Kusi et al. 2015; Barimah and Mensah 2013; Alhassan et al. 2016). Poverty and financial issues as major complications have been mentioned across almost all studies relating to barriers to healthcare use. This monetary hindrance to formal healthcare use was reduced by the introduction of the national health insurance scheme in Ghana, with the ultimate aim of serving as part of a poverty reduction strategy to enhance healthcare and make it affordable to citizens (Barimah and Mensah 2013). The implementers were of the view that an effective health insurance scheme can remove the issue of poverty as a barrier to formal healthcare use in Ghana. However, Bryman and Bell (2007) indicated that many of the national health insurance schemes implemented in Africa have been mismanaged and now actually present major barriers to healthcare use, as currently being experienced in Ghana. After rendering services, health providers are not reimbursed with the funds that are needed to restock their centres, purchase equipment and hire the professionals required to ensure quality healthcare delivery (Tidermalm et al. 2008). Ratnasingham et al. (2013) added that when healthcare providers are left to finance their operations, they are forced to revert back to the cash-and-carry system. This creates a mismatch because the health seekers expect benefits based on the insurance paid (Kusi et al. 2015), whereas the health providers do not receive the funds allocated for such services. There is, therefore, a conflict of interest

that acts as a barrier to formal healthcare use. Users are unable to seek medical attention because of a lack of finances, and providers are no longer in a position to provide healthcare services because of the lack of resources.

Additionally, social issues such as language differences have featured in many healthcare studies related to barriers (Hassali et al. 2012; Chadwick et al. 2013; Scheppers et al. 2006). The inability of health providers and users to communicate in a single language affects the healthcare process and system (Hassali et al. 2012; Chadwick et al. 2013). This is because it is difficult for the users to express themselves and the providers to understand them (Hassali et al. 2012). Hence, health users feel discriminated against when providers use English (Griffiths and Stephenson 2001) and the providers also feel restricted because of the inability of the users to speak English. The net effect of these potential barriers is the decision to stay away from formal healthcare centres. However, for the health system to be effective, both users and providers should compromise; the users should learn to speak at least basic English, while the providers should also learn some of the local dialects (Hassali et al. 2012; Scheppers et al. 2006). The combination of the two languages can help both parties to communicate effectively for quality healthcare service and ensure a two-way information flow.

Cultural, societal and faith-based factors also constitute hindrances to formal healthcare use, with certain cultural values, norms and practices not allowing some groups to use these services. Most of the study participants stated that formal healthcare was not culturally sensitive, with methods, drugs and equipment being used that are alien to them. As a result, they frequently patronised the services of traditional health providers, an outcome that agrees with the findings of studies by Griffiths and Stephenson (2001), Waiswa et al. (2010) and Beekman et al. (2013). This suggests that provision of high-quality interpersonal care processes should be culture-based since such an attitude makes the users more relaxed and allows them to easily adapt to the formal health setting. In a similar approach, Beekman et al. (2013) recommended that formal healthcare providers should consider and reflect the culture and belief systems of the healthcare seekers.

Some strengths of this study deserve comment. To the best of our knowledge, this is one of the first studies in Ghana examining the facilitators of and barriers to formal healthcare utilisation from both a user and provider perspective. Further, the current study depicts a detailed analysis of the views of a multicultural and ethnically diverse population from the study prefecture. It could contribute to the attainment of Sustainable Development Goal 3 in addition to helping policymakers design and formulate policies that aim to address the existing barriers to healthcare use in Ghana. However, the interpretation and generalisation of these findings must be undertaken with caution since the study selected respondents using non-probability sampling techniques. The limited sample size used

could compromise the generalisation of the findings. However, the authors were interested in providing a detailed description and in-depth knowledge of providers and users and the facilitators of and barriers to formal healthcare use. In addition, the study does not provide detailed information on and analysis of the socio-economic background of users of formal healthcare. Further rigorous research is needed to shed more light on this relationship.

Conclusion

The purpose of this study was to examine the facilitators of and barriers to the use of formal healthcare services from the health user and provider perspective. Four major facilitators of healthcare use were identified: acceptance of the health insurance card, a good relationship with healthcare providers, quality of the service offered/professionalism and proximity to healthcare facilities. Barriers to formal healthcare use identified in this study were of an economic, social, cultural and institutional nature. Recommendations for addressing these obstacles include a review of the national health insurance scheme, recruiting language interpreters at the health facilities, and integration of the formal healthcare and traditional healthcare systems into the mainstream national health system. Our study findings highlight the need to address barriers to formal healthcare use so that Ghana can achieve Sustainable Development Goal 3, which seeks to ensure healthy lives and promote well-being for all at all ages by 2030.

Compliance with ethical standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical approval All procedures performed in this study involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.

Informed consent Informed consent was obtained from all individual participants included in the study.

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