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UNIVERSITY OF GHANA, LEGON

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CENTRE FOR SOCIAL POLICY STUDIES (CSPS)

PATTERNS OF ENROLMENT AND USE OF NHIS BY LEAP BENEFICIARIES IN THE NEW JUABEN MUNICIPALITY

BY

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THIS DISSERTATION IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN PARTIAL FULFILLMENT OF REQUIREMENT FOR AN AWARD OF MA SOCIAL POLICY STUDIES DEGREE

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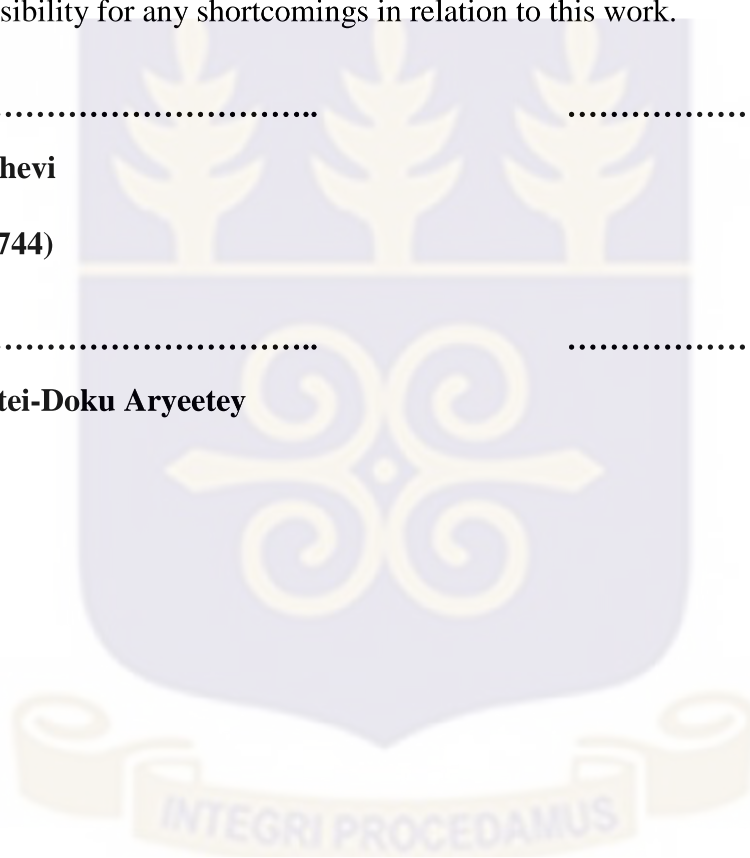
DECLARATION

This dissertation, "*Patterns of enrolment and use of NHIS by LEAP beneficiaries in the New Juaben Municipality*" is a study submitted to the Centre for Social Policy Studies (University of Ghana, Legon) for the award of a Master of Arts Degree in Social Policy. I, John Awuku-Ahevi hereby declare that apart from references cited which have been duly acknowledged, this research was conducted under the supervision of Professor Ellen Bortei-Doku Aryeetey during the 2016/2017 academic year. This work has never been submitted in whole or part for the award of any Degree in the University of Ghana or elsewhere. Henceforth, I do take complete responsibility for any shortcomings in relation to this work.



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DEDICATION

With phenomenal gratitude and affection, I dedicate this dissertation to my wife Esther Awuku for her enormous sacrifices, prayers and tireless efforts that have brought me this far in my life and profession. This is also to the memory of my late Mother Daavi Adugba Ama Tsibge.

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I express my immense appreciation to my affable and benevolent supervisor, Prof. Ellen Bortei-Doku Aryeetey for her astounding insights, rigour and intellectual support that helped me to develop a better understanding of the issues under study. I also thank the Director and staff of the Centre for Social Policy Studies.

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ABSTRACT

The study focused on Patterns of enrolment and use of National Health Insurance Scheme (NHIS) by extremely poor households who are beneficiaries of a national cash transfer programme in Ghana known as Livelihood Empowerment Against Poverty (LEAP). The New-Juaben Municipality of the Eastern Region was selected as a case study because it has a high incidence of extremely poor people and a relatively low enrolment onto NHIS as compared to other districts in the Eastern Region. (NHIA 2014 Membership Report). The main objectives were to examine the patterns of enrolment and use of NHIS by LEAP beneficiaries, as well as administrative and operational challenges associated with enrolment. The study adopted a mixed method approach using both quantitative and qualitative methods. By means of a multi-stage sampling technique, primary data was collected through questionnaires for the quantitative aspect (N = 96) while the qualitative aspect included semi-structured interviews with 48 LEAP beneficiary household heads who have a total of 168 dependents. In addition, expert interviews were held with five staff of the National Health Insurance Authority (NHIA) in the New-Juaben Municipality. The main finding was that most of the LEAP beneficiary household heads and their dependents were enrolled on the LEAP in 2012 and 2013 with 91.7% enrolment onto the National Health Insurance Scheme. Yet, only 72.9% have been able to renew their NHIS cards. More than half of those whose cards were not renewed were children under 18 years. Although, all LEAP beneficiaries agreed that the NHIS had reduced their out-of pocket expenses, they were compelled to pay for some health services included in the minimum healthcare package that NHIS offered. On their part, the staff were challenged with inadequate logistics and network problems to facilitate the registration process. It is therefore essential for NHIA, the Ghana Health Service and the Ministry of Gender, Children and Social Protection to work together at addressing these logistics and practical challenges since countries with the highest enrolment onto the NHIS have resolved most of these challenges.

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LIST OF ABBREVIATIONS

LEAP	Livelihood Empowerment Against Poverty
MDGs	Millennium Development Goals
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
UNSDGs	United Nations Sustainable Development Goals
PWD	Persons with Disability
OVC	Orphans and Vulnerable Children

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CHAPTER One

INTRODUCTION

1.1 Background of the Study

Without a doubt health care financing is of critical importance to both the rich and the poor. But the approach that has been adopted by different countries for meeting this need varies considerably from social risk pooling for social insurance to private risk pooling for privately funded insurance. Scholars continue to debate this issue, focusing not only on the costs involved in health insurance but also the ideology of social responsibility (Witter & Garshong, 2009). In a multi-level analyses, Mensah et al., Oppong, Bobi-Barimah, Frempong and Sabi (2010) emphasized that health is and should be important at the individual level, micro level, and macro levels of the society. This suggests that, health improvement is not the responsibility of one person, it should be an interplay of the individual, family, institutions in society, government and even international organizations.

In view of the above, the United Nations Millennium Development Goals (2000-2015) adopted health as one prime area of growth for all nations (United Nations, 2004). This was especially captured in a UN report in 2013 which stated, "Although, advances in science and technology have helped to minimize a lot of communicable disease, we still suffer from a number of sicknesses."[p.12]. This led to a reformulation of health-related issues in United Nations Sustainable Development Goals (UNSDGs) covering the period, 2015 to 2030. Goal three of the UNSDGs, which is to ensure healthy lives and promote wellbeing for all at all ages (United Nations, 2013) focuses primarily on the health needs of developing countries.

Many nations including Ghana responded to the UN goal to promote healthy living by creating health policies and reforms. In Ghana, such health policies included the enactment of the NHIS law in 2003 (NHIS Act 650, 2003) and its subsequent roll-out from late 2005 (Brugiavini & Pace,

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2010). This was followed by the establishment of the National Health Insurance Authority (NHIA) and the National Health Insurance Scheme (NHIS). NHIS was introduced "in Ghana to ensure equity and financial access to healthcare in a period that was characterized by user-fee regimes" (Kotoh & Van der Geest, 2016, p.39).

In 2012, NHIS Act 650, 2003 was replaced with NHIS Act 852 where a number of reforms were made to give the Ghana National Health Insurance Scheme a national character. A remarkable feature of the NHIS is the relatively large number of social groups generally seen to be vulnerable on the basis of their poverty, age or infirmity who are exempted from premium payment. Among the reforms introduced in the Act 852, 2012 was the inclusion of the Persons With Disabilities (PWD) in the exemption basket. The age for older persons to qualify for premium payment exemption was also reduced from 70 years to 65 years to enable older people qualify (exemption from payment of premium and processing fees granted to poor categories). This brings it in line with the qualifying age for old age support under the LEAP in Ghana. The NHIS was also made a unitary scheme with the NHIA as the body corporate and a single centralized payer of claims to the credentialed service providers of the scheme.

1.1.1 Livelihood Empowerment Against Poverty (LEAP)

One of the strategies under the Ghana National Social Protection Policy is a cash transfer programme known as the Livelihood Empowerment Against Poverty (LEAP) programme.

The LEAP programme was started in 2008 to specifically provide a safety net for the poorest and most marginalized groups in Ghanaian society, especially the bottom 20% of the extreme poor in Ghana. Gbedemah, Jones and Pereznieto (2010) noted that, of the 28.5% of Ghana's population who were poor at the time, LEAP targeted the 18.2% 'extremely poor'. But poverty rates have

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improved since 2010. According to the GLSS6, the extremely poor rate has reduced from 15.9% in 2014 to 8.2% as at 2016.

The Ghana Living Standards Survey Round Six (GLSS 6) reports indicate that Ghana has about 27.89% of its extremely poor people enrolled unto the LEAP. The programme therefore seeks to protect and empower extremely poor households with elderly (aged 65 and above), the Persons With Disability (PWD) who are unable to work, Orphans and Vulnerable Children (OVC) by providing them financial support (cash grants), as well as access to complementary services such as the national health insurance. Some of the grants are unconditional (e.g. elderly support) while others are conditional (OVC support).

Like other conditional cash transfer programmes, LEAP sets positive conditionalities which promote synergies with complementary social services, including advancing children's school enrolment and retention, registration at birth, uptake of post-natal care and immunisations for young children."(NHIS, 2015. P.14). It also includes a number of behaviour change messages, such as ensuring children are neither trafficked nor engaged in the worst forms of child labour, for example as domestic workers, to which girls are especially vulnerable. Gbedema et al (2010) have argued that, these objectives of the LEAP are not binding because "there are few means and resources to assess compliance" when it comes to enrolling the right people who qualify. (p.6).

Since its inception in 2008 the programme has made some gains. As at the last quarter of 2016, the programme had covered over 77,000 households (Nsiah-Boateng et al., 2016). According to the Ministry of Gender, Children and Social protection, the LEAP cash programme has impacted on beneficiaries and families in areas such as food security, health, education, savings and investments, as well as on their wider communities particularly in terms of community development and economic growth (MGSP, 2013). For instance in 2013, enrolment of the LEAP

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beneficiaries from the ages 0-5 and 6-17 onto the National Health Insurance Scheme had seen some increases (Ministry of Gender and Social Protection, 2013).

As part of Ghana's Poverty Reduction Strategy, all members of LEAP households are afforded with some complimentary services aimed at further reducing their financial burden and elevating them from a status of marginalisation. The LEAP Management Secretariat (LMS) believes that the cash grant alone cannot address extreme poverty, rather there is the need to adopt a holistic approach, which involves the coordination of other interventions. To facilitate the complimentary healthcare and as a conditionality for LEAP membership, all household members of LEAP are to enrol on NHIS free without any payment .The free NHIS registration factored into the LEAP Programme ensures that members of the LEAP households receive better healthcare and to enable them to live healthier and more fulfilled lives.

1.1.2 Overview of the NHIS Policy

By establishing a social insurance scheme, Ghana chose universal health insurance over voluntary private insurance, though the latter remains an option for those who want it. The Social Health Insurance Scheme was established to create a health financing fund to support equitable access to affordable healthcare for all Ghanaians. It replaced the cash and carry (C&C) cost-sharing system that had been introduced under the Structural Adjustment Programme (SAP). With the C&C everyone was required to pay for health services upfront before healthcare would be provided.

The NHIS forms part of the health insurance policy under which three types of health insurance schemes were set up. These are (1) the District-wide Mutual Health Insurance Scheme, (2) the Private Mutual Health Insurance Scheme, and (3) the Private Commercial Health Insurance Scheme. As a matter of convenience, the NHIA adopted the District Mutual Health Insurance

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Scheme leaving the private mutual and commercial health insurance schemes for interested companies to manage at the individual and commercial level (Mensah et al, 2010). This District Mutual Health Insurance Scheme covers all 212 Districts, Municipal and Metropolitans Assemblies in Ghana.

In order for the health system to function well, the District Mutual Health Insurance Scheme is to ensure that, "opportunity is provided for all Ghanaian citizens to have equal access to the functional structures of health insurance" (NHIS, 2015, p.8). It is also to ensure that the citizens move from an unaffordable 'cash and carry' regime to "an affordable health insurance for all" (NHIS, 2015, p.8). Again, it is to ensure that the quality of healthcare provision in Ghana is not compromised under the health insurance scheme.

For the provision of the quality healthcare to be realized, premiums are levied to be paid yearly according to the individual's level of income. The rationale behind this is that, the socio-economic standing of contributors is not equal among contributors but the scheme aims to ensure that no one remains in the 'cash and carry' system. This therefore means that, the premiums payable varies from district to district in Ghana as the disease burden is not the same in all districts. To ensure that all Ghanaian citizens make some contributions to the scheme, a 2.5% health insurance levy on some selected goods and services has been passed into law and incorporated into the VAT regime, which is then channelled into a National Health Insurance fund to subsidize access by the poor (Abekah-Nkrumah, Dinklo & Abor, 2009). Again, Nsiah-Boateng and Jousten (2014) have posited that while most private health insurance service providers in Ghana charge a premium of about GHc1,000 ($225) a year, the NHIS premium ranges from GH¢7.2 to Gh¢48. ($1.62 to $10.8)

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According to Wagstaff and Garshong (2009), the NHIA has a minimum benefit package of diseases which every district-wide scheme covers for Ghanaians. This package covers about 95% of diseases in Ghana including malaria, diarrhoea, skin disease, hypertension, asthma, and diabetes, among others. However, the NHIA considers certain diseases and services too expensive to treat or provide. Examples of such diseases and services which are considered too expensive to treat and as a result not covered under the NHIS include optical aids, hearing aids, orthopaedic aids, dentures, beautification surgery, supply of AIDS drugs, treatment of chronic renal failure, heart and brain surgery, among others (Wagstaff & Garshong, 2009).

Enrolment onto the NHIS has been slower than anticipated. As at 2016 the scheme had registered only 11 million (42%) out of about 26 million Ghanaians in the country (Nsiah-Boateng et al, Aikins, Asenso-Boadi & Andoh-Adjei, 2016). This includes a large proportion of vulnerable and poor people who qualify for premium payment exemption, made up of pregnant women, children under 18, people over 65years, Social Security and National Insurance trust (SSNIT) contributors and pensioners, as well as destitute people. Despite these efforts Kotoh and van der Geest (2016) as already mentioned have argued that the poor are still not well covered in Ghana's National Health Insurance. The Ghana Living Standards Survey Round Six (GLSS 6) reports that Ghana has about 2.2 million extremely poor people. Out of this proportion, there are about 1.2 million registered LEAP beneficiaries. From the NHIA database 749,035 of LEAP beneficiaries have been enrolled as indigents onto the NHIS. Ghana took a major step to provide social support for the extremely poor with the establishment of a cash transfer programme known as the LEAP whose members are enjoined to enjoy free healthcare under the NHIS.

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1.2 Statement of Problem

The NHIS was established to provide equitable and financial access to basic healthcare services to the Ghanaian citizenry especially the poor and the vulnerable. The scheme is heavily subsidised in its exemption from payment of premium and processing fees provided for the poorest in society, yet studies reveal that only a few LEAP beneficiaries have been enrolled onto the scheme (Kotoh & Van der Geest, 2016) even though they are required to do so. This suggests that, the poor and vulnerable find it difficult to enrol given the existing conditions of enrolment. A two-year trend analysis of the enrolment of the LEAP beneficiaries in the Eastern and other regions of Ghana shows that enrolment among beneficiaries is declining each year (Atulley, 2015). In the Eastern Region, a total of 18,113 and 20,566 were identified as LEAP beneficiaries in 2014 and 2015 respectively. Out of these 6,488 and 7,273 beneficiaries were enrolled onto the NHIS for the two years. This means that, 35.82% and 35.36% of the extremely poor were enrolled in the Eastern Region in 2014 and 2015.

According to the Ghana Statistical Service (2014) the population of New-Juaben Municipality is 183,727. Furthermore, the population of LEAP beneficiaries in the Municipality which is the population of the study is 4,291 from 33 towns, according to the LEAP secretariat of New-Juaben Municipal Assembly. Of these 2,984 (constituting 69.5%) enrolled as at their time of LEAP registration but only 1,562 (constituting 36.4%) have been able to renew their NHIS cards.

Sanuade and Boatemaa (2015) in discussing the health intervention programmes for acute non-communicable disease among children and affected caregivers in Ghana revealed that National Health Insurance in Ghana has had low coverage among LEAP beneficiaries and other vulnerable groups. It is against this background that this study investigates the causes of the low enrolment of

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the LEAP beneficiaries and low use of NHIS. Further, the study aims to establish the patterns of use by different categories of beneficiaries.

1.3 Research Questions

1. What knowledge do the LEAP beneficiaries have about NHIS and its importance to their eligibility?
2. What are the practical challenges of the LEAP beneficiaries in enrolling onto the NHIS
3. What are the administrative challenges in the enrolment of the LEAP beneficiaries in the NHIS
4. What are the patterns in enrolment and use of NHIS by the LEAP beneficiaries?

1.4 Objectives

This study was conducted to achieve the general aim of analysing patterns of enrolment and use of NHIS by the extremely poor on LEAP, as well as administrative and practical challenges associated with the enrolment and use of NHIS by LEAP beneficiaries.

Specific Objectives

1. Assess the knowledge LEAP beneficiaries of the New-Juaben Municipality have about the NHIS
2. Identify the patterns of enrolment among LEAP beneficiaries and their use of the NHIS.
3. Identify administrative constraints facing LEAP officials and practical challenges of the LEAP beneficiaries in enrolling onto the NHIA.

1.5 Relevance of the Study

Studies on health insurance schemes face a critique that they solely rely on qualitative methods of investigation and sometimes small sample sizes (Walters, 1999; Perker & Carrin, 2004).

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According to Creswell (2008), "small sample sizes reduces the predictive power of the socio-demographic factors" of a study. Again, a study meant to inform policy making must involve some sort of statistical backings. This is so essential because social policies hinge on well-established facts in other to be effective (Harvey & Yoshino, 2006). For that matter, qualitative studies alone that are tantamount to the researchers own idiosyncrasies or biases may need further exploration; a gap for which this study would use mixed methods to fill.

Moreover, this research would provide stronger basis for improvement in the NHIA's operations on enrolment of the poor in Ghana. It would provide insights into the factors militating against the enrolment of the poor from their point of view of the LEAP beneficiaries as well as from the point of view of the duty bearers (staff of NHIA in the New-Juaben District Office). The perspectives from both the beneficiaries and the duty bearers have shown to be very fruitful in social policy formation and implementation (Harvey & Yoshino, 2006). By this, it is hoped that, findings from this research would help in awareness creation and policy making to help in the realization of the UNSDGs which aims at better health and development for all.

1.6 Purpose of the study

The purpose of this study is to investigate the factors militating against the enrolment of LEAP beneficiaries and their use of NHIS. The free healthcare is part of the package of complementary services in the social protection strategy for the poor and the vulnerable. It is expected that greater use of health services among the poor will improve the general health status of Ghanaians and facilitate the attainment of the sustainable development goals (SDGs).

Studies on LEAP enrolment in the NHIS indicate a number of challenges that subscribers face in renewing their membership in the scheme (see Joha, 2012; Abbey, Odonkor, & Boateng, 2014;

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Jaha & Sika-Bright, 2015; Atulley, 2015). Joha (2012) reported that "LEAP in Yama in the Northern Region of Ghana does not give the intended benefits to beneficiary households and there was a general lack of knowledge of the programme by beneficiaries". However, this study failed to consider LEAP beneficiaries and health. This heightens the need to investigate the LEAP from the health sector angle. The only research on healthcare by Kotoh and Van der Geest (2016) investigated, "why the poor are less covered in Ghana's national health insurance." This study pointed to the lack of equity in healthcare access. For that matter, it is highly imperative that research about LEAP should look at its patterns of enrolment and use of NHIS.

1.7 Scope and Limitations of the Study

This study specifically targets the LEAP beneficiaries in the New-Juaben Municipality which has 4,291 LEAP beneficiaries distributed across 33 towns in Ghana (Ghana Statistical Service, 2014). Data was collected from both LEAP beneficiaries of the New-Juaben Municipality and the NHIA staff of the municipal Office since it was practically based on an ethic-emic perspective to social policy formation and implementation.

1.8 Organization of the Dissertation

Chapter One of the dissertation includes a background of the study in relation to the subject matter about patterns in enrolment and use of NHIS by LEAP beneficiaries in Ghana, as well as overview of NHIS policies in that regard. It also includes statement of the problem, aims and objectives of the study, scope of the study to the health profession, stakeholders of healthcare for policy formation and the country as a whole.

Chapter Two of the dissertation includes the literature review of the theoretical perspectives underlying the study, as well as review of empirical studies on national health insurance in Ghana and enrolment of LEAP beneficiaries in the NHIS.

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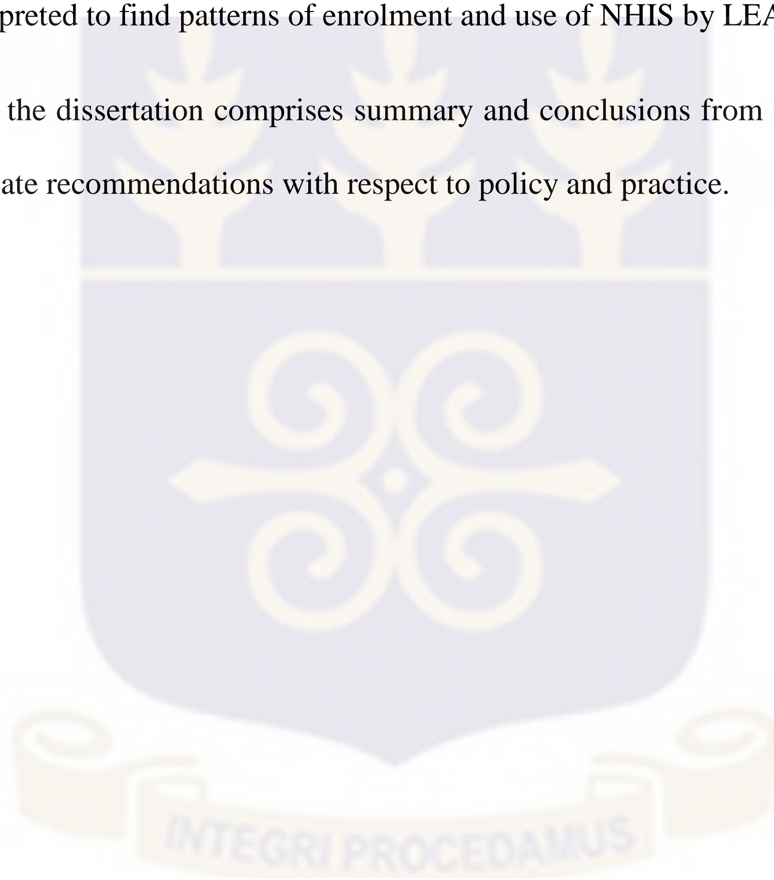
Chapter Three of the dissertation contains information about the research design, population of study, sample, sample size, and sample size technique, inclusion and exclusion criteria. Moreover, this section highlights the instruments and data collection procedures, as well as procedure and data analysis techniques, including descriptive statistics, multivariate analysis and thematic analysis.

Chapter Four of the dissertation comprises research findings and discussion of the results. The results were interpreted to find patterns of enrolment and use of NHIS by LEAP beneficiaries.

Chapter Five of the dissertation comprises summary and conclusions from the findings. It also includes appropriate recommendations with respect to policy and practice.



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CHAPTER Two

LITERATURE REVIEW

2.1 Introduction

This chapter of the dissertation includes a theoretical background of the study, as well as empirical literature review with regards to enrolment and use of NHIS.

2.2 Theoretical Background

The principle of Social Health Insurance (SHI) is very vital in the success of NHIS. SHI's are managed by government with benefits and eligibility requirement predefined by statute. Usually, SHI is funded by taxes or premiums which is paid by or on behalf of participants. Sometimes, additional funds may be obtained from proceeds and grants to the government or scheme (WHO, 2003). WHO defined SHI as a form of financing and managing health care based on risk pooling. It protects people against financial and health burden and is a relatively fair method of financing health care. However, the WHO report on SHI remarked that, "desirable though it is, not many least-developed and low-middle-income countries have succeeded in adequately expanding coverage of SHI." A number of theories such as the standard economic theory and the rational choice theory come into play to explain its effectiveness more fully.

2.2.1 Standard Economic Theory

The standard economic theory suggests that as prices of goods or facilities decreases, the quantity demanded increases. It therefore suggests a negative correlation for cost of goods and demand from both a policy and individual perspective. This means that, in terms of health, if the cost of NHIS registration should be zero or free to LEAP beneficiaries, then their demand for enrolment onto the NHIS would be very high. Hatt et al, Makinen, Madhavan & Conlon (2013) emphasized

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that the relationship between price and demand forms the basis for user fee exemption policies. This means that, if enrolment on the NHIS is made free for LEAP beneficiaries, then virtually all LEAP beneficiaries should enrol onto the NHIS and make use of it. Harvey and Yoshino (2006) reported that, most individuals turn to self-medication because of the rise in cost of health. This means that, using the standard economic theory from a policy perspective, making health insurance free would see a rise in registration for health insurance which would put a virtual end to self-medication/treatment.

Hatt et al. (2013) emphasized however that, the relationship between price and demand is not a straightforward one. This is because, the interaction between price and the quality of services provided strongly affects the price-demand relationship. This means that, from an individual perspective, making health insurance free might not be all that is needed to inform high demand for enrolment but also some other factors which may include ease of access to enrolment, quality of health services provided for the poor and vulnerable with free health insurance, among others.

Hatt et al. (2013) critiqued the standard economic theory as used in health policies that, the theory is unable to explain what happens then in cases where both the price of the health product and quality of health services drops. This suggests the possibility of a positive correlation in price and demand characteristics when it comes to health in the mist of other variables. For example, Hatt et al.2013 admitted that, the presence of alternative providers of affordable health care such as traditional healers in the Ghanaian setting as well as proximity of such alternative health care to the individual may bring a disparity access to health expectations from the policy and individual perspective.

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2.2.2 Rational Choice Theory (Scott, 2000)

The rational choice theory views "all human actions as fundamentally rational in character and that people calculate the likely cost and benefits of any actions before deciding what to do" (Scott, 2000, p.9). With this theory one would assume that as the costs are lowered the consumption of goods and services would increase.

In the rational choice theory, "individuals are seen as motivated by the wants or goals that express their preferences. They act within a certain time and space based on their knowledge of the conditions under which they are acting" (Aratuo, 2012, p.11). The rewards or benefits and cost or punishment, gained from an action, serve as source of motivation for people. People are generally motivated by the profit that they can make in pursuing a particular course of action" (Collier & Hoeffler, 2004). Rational action is therefore seen as "psychological conditioning." Imobighe (2004, p.113) argued that, "human behaviour is determined and shaped by rewards and punishments encountered.

The relevance of this theory to this research is the fact that health insurance and reforms, policy makers such as the government and health insurance authority rely on a rational choice. Again, this cost-benefit analyses includes the gains and challenges associated with pursuing the NHIS. Factors such as its availability, affordability and extent of perseverance required to gain it are all important factors. For example, with respect to rational choice theory, Stangeland, Dhillion and Reksten (2008) identified that most rural folks in Tanzania first wish to pursue traditional treatment because of its easily available nature, cost and convenience before they later pursue conventional health when physical health continues to deteriorate despite traditional treatment. This is based on a rational choice by the people. Similarly, if LEAP beneficiaries perceive the costs of national health enrolment to be more than its benefit, they would refuse to enrol and this would prevent the

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realization of the health policy of providing financial risk protection for basic healthcare. On the other hand by offering the beneficiaries exemptions from direct fees payment it is expected that they will increase their use of health care services.

2.3 Review of Empirical Literature

Joha (2012) investigated the "effects of Livelihood Empowerment Against Poverty Programme in reducing poverty of beneficiary households in Yama in the Northern of Ghana". Specific objectives of the researcher was to "examine the targeting mechanisms of the LEAP, how direct cash transfer affects livelihoods of beneficiaries, and the challenges LEAP faces in its implementation in Yama District." Through qualitative research approaches, Joha combined primary and secondary data.

For the Primary Data, Joha (2012) sampled 15 beneficiaries of the LEAP programme in Yama District, one district focal person of the programme as well as the chairperson of the community LEAP implementing committee. Findings from this study indicated that, "LEAP in Yama does not give the intended benefits to beneficiary households and there was general lack of knowledge of the programme by beneficiaries;" for that matter, it was marked with fraud and "operational difficulties including lack of human and financial resources." It was reported that beneficiaries only saw it as some sought of charity work, for that matter, they did not live up to its expectations. The factors necessitating the fraudulent practices of the LEAP officials was attributed to the fact that the beneficiaries do not know about their rights.

Abbey, Odonkor and Boateng (2014) did a beneficiary assessment of the LEAP. Objectives of the researchers were to investigate the perspective of LEAP beneficiaries about how the programme is benefiting them, their knowledge about it, and issues of service providers and their general overview of the programme. By way of methods, "two (2) districts were studied during the

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nationwide payment period (April, 2014) to enable inter-district comparison." These districts were purposively selected and they included: "Ga East Municipality in the Greater Accra Region and Amansie West Municipality in the Ashanti Region." Moreover, sample size included 5% of beneficiary households in these districts; that is, 741 LEAP beneficiaries from Ga West Municipality and 977 LEAP beneficiaries from Greater Accra Region were randomly selected and studied.

Interviews and observations were used as the means of data gathering. Findings from their study showed that, 71.6% of the LEAP beneficiaries are females with the majority being aged, caregivers of orphans and the disabled. It was also found that, 80% of the LEAP beneficiaries did not know about the amount due them and the time intervals to receive payment. Again, they found that, the key feature of regularity and reliability required of cash transfer delivery was weak. Majority of LEAP beneficiaries used their benefit for food, healthcare and education. It was reported that most of these beneficiaries requested for increment in benefit to enable them meet high cost of living and healthcare.

Analytically, the policy on LEAP include the fact that, LEAP beneficiaries are not required to pay for health services because funds are channelled directly through NHIS. In this regard, it is now momentarily essential to investigate the patterns of enrolment of LEAP beneficiaries in the NHIS. This would help to unravel the truth behind how they are being enrolled to grant them health benefits.

Jaha and Sika-Bright (2015) researched the "challenges of the LEAP programme in the Upper West Region of Ghana" using the institutional perspective. These researchers focused on the LEAP programme and how it is functioning in the Upper West Region of Ghana since its inception in 2008. They also examined its perculiar challenges in meeting its goals. By way of methodology,

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Jaha and Sika-Bright interviewed nine LEAP officers from various districts in the Upper West region of Ghana. Afterward, they proceeded to use secondary data which included "the 2010 population and housing census, government publications on the LEAP programme, district statistics on the LEAP as well as relevant publications on LEAP in Ghana. Findings from the research indicated that, the LEAP programme has made some efforts to alleviate poverty in the district and improve the living conditions of the local people in the Upper West region of Ghana. However, the programme was marked with several adminitrative difficulties, irregular inflow of funds as well as "perceived political interferences." In relation to this, it was found that, there is no official means of transportation for programme officails of LEAP despite their varied and numerous work responsibilities.Another administrative challenges was the "difficulty eliminating deceased beneficiaries and swapping of beneficiary's names and pictures." On the side of beneficiaries, Jaha and Sika-Bright found from the pespective of the LEAP officials that, delay in payment of monies served as a major challenge for beneficiaries. Again, most of the LEAP beneficiaries did not know about what to do with beneficits.

A critical analysis of the work of Jaha and Sika-Bright (2015) suggests that research done in the area of LEAP should focus on two aspects, the administrative aspects in rendering LEAP services and the beneficiaries aspect of accessing and using LEAP services. Jaha and Sika-Bright have unearthed a number of challenges which needs to be considered in implimentation policies. However, a major challenge with this work is about the methodological aspects of arriving at these findings. For a fact, the LEAP is supposed to benefit the local people in Ghana and not to create jobs for officals of the programme. A major weakness of the study by Jaha and Sika-Bright was that they failed to investigate beneficiaries of LEAP and instead relied on information from nine officials. According to Creswell (2008) such approach could lead to what is known as social

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desirability effect and deception. This is where the interviewees tell the researcher what is socially desirable to know rather than the real socially unfavourable factors. Besides, Jaha and Sika-Bright failed to consider LEAP from a health perspective.

Atulley (2015) did an "assessment of the Livelihood Empowerment against Poverty programme in the Bongo district" of Ghana. Objectives of Atulley's study was to (a) "examine whether beneficiaries use cash transfers from the beginning to engage in small scale businesses," (b) "find out whether the programme has enhanced the basic necessities of beneficiaries such as food, shelter and health," and (c) to "determine the extent to which beneficiaries comply with the conditionalities of the programme." . In the study, Atulley sampled 145 LEAP beneficiaries. It was found that, "57% of the LEAP beneficiaries interviewed are above sixty years and 66.3% of these are females." Again, 83.4% were farmers and 60.7% are widows. Among these 44.5% used their benefits to do small scale business such as weaving, rearing animals and selling. According to Atulley, profits from the business then helps them to take care of their basic needs such as payment of fees, health and food.

Kotoh and Van der Geest (2016) investigated, 'why the poor are less covered in Ghana's national health insurance.' The main objective of these researchers was to use "a multi-level perspective as conceptual and methodological tool to examine why the NHIS is not reaching the poor as envisaged "by the NHIA. They conducted their study in 15 communities in the Central and Eastern Regions of Ghana, after implementing a 20 months intervention programme on NHIS had been completed. They also made use of observation and in-depth interviews to gather information about the effects of the intervention in seven selected communities, health facilities and district health insurance schemes in the Central Region. Results from Kotoh and Van der Geest's research indicated that of the 6,790 individuals covered in the survey, less than half (40.3 %) of the

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population were currently insured in the NHIS though this was an improvement over 22.4 % previously insured in 2014. The poorest had the lowest enrolment rate: poorest (17.6 %), compared to the richest 44.4 % (p = 0.000). Kotoh and Van der Geest found that the poor's low enrolment is widely attributed to their poverty. On the side of the staff of NHIS, they also found their lack of commitment to pursue NHIS's equity goals.

Gruber (2009) investigated the "impact of health insurance on health-related outcomes in rich countries." This researcher did a meta-analyses of 130 research articles that investigated the impact of health insurance on health-related outcomes for people aged 18 years to 64 years. Findings suggested that "uninsured adults are less than half as likely as those insured to receive needed care for a serious medical condition." On the side of women who are not insured, "their new-borns receive less prenatal care and are more likely to have poor outcomes during pregnancy and delivery, including maternal complications, infant death, and low birth weight." Gruber also found that, the uninsured lack regular access to medications to manage conditions, such as hypertension and HIV. Again, they do not receive care recommended for chronic diseases, such as timely eye and food exams to prevent blindness and amputations in people with diabetes. Such ones even go without cancer screening tests, which delays diagnosis and leads to premature death. More so, such individuals who are uninsured receive fewer diagnostic and treatment services after a traumatic injury or a heart attack, causing an increased risk of death even when in the hospital.

Critical analysis of the work of Gruber (2009) on the issues of health insurance and health-related outcomes in rich countries indicate that, the uninsured do not get better services when it comes to matters of health than the insured. Instead, the insured gets better coverage and treatment than the uninsured. However, Gruber only examined articles in relation to individuals aged 18 years and

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above to the neglect of children. Health insurance is designed to cover children less than 18 years as well, however, there appeared to be a gap in Gruber's study.

Arodiogbu (2005) investigated the role of social health insurance to solve problems of poor health financing in Nigeria. According to Arodiogbu, Nigeria enacted the social health insurance policy in 1999. It has been based on the user fee system as at the time of the research. The user fee system suggest that, each person pays some amount to get registered so that he or she can enjoy some free healthcare in cases where the need arises. Using the household cluster survey, Arodiogbu reported that the social health insurance has to a greater extent improved resource mobilization for the health sector in Nigeria while ensuring to some extent, access to healthcare in an equitable manner. However, the researcher also found that, most people in poorer communities were not getting enrolled onto the national health policy. Further probe into the matter revealed that there were a number of impediments to their enrolment such as transportation to the health policy registration centres, inadequate money to pay for their user fee and lack of access to hospitals in those rural communities.

Analysis of Arodiogbu's (2005) study on social health insurance in Nigeria reveals that a lot more would have to be done to enhance the quality of the health insurance, provider arrangements, and access to the poor in society and monitoring mechanisms to help it reach its goals. It is also beneficial to have known the factors that impedes the poor from getting enrolled. This is because, knowing such factors helps in social policy intervention to augment the enrolment of the poor. In Ghana where the very poor in society have access to enrol for free on the LEAP and NHIS, research indicates that, the enrolment patterns is not the best and needs some restructuring (Joha, 2012).

Brugiavini and Pace (2010) investigated the effects of the National Health Insurance Scheme in Ghana. To these researchers, exploring the potential of the current health insurance to increase

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access to and affordability of health care in Africa is highly essential. They focused on recent experiences of people who have registered with the National Health Insurance Authority as well as people who have not been able to enrol. Using nationally-representative household data from the Ghana Demographic and Health survey, Brugiavini and Pace found that there is large coverage of the NHIS even in rural areas of the country (Ghana), yet, the effect of the NHIS on health care demand and out-of-pocket expenditures was below expectation. Moreover, they found that, family caregivers have had to spend a lot on caring for their own, especially the popular stricken malaria. Again, a significant number of family heads who had enrolled onto the NHIS acknowledged that, they have had to resort to local or traditional medications to help curb the expenses involved in seeking allopathic treatment. Specifics were given that, the NHIS only had some medications it covered such as common pain-killers, for that matter, some household residents preferred to use the NHIS to seek those medications while finding alternative means to get holistic treatment.

A critical look at Brugiavini and Pace's (2010) findings indicate that a lot more needs to be achieved in the healthcare system of Ghana in order to create a health system that reduces the out-of-pocket expenses as long as healthcare is concerned. However, Brugiavini and Pace's data collection took place in late 2005, although, their findings were published in 2010. This is a fact worth highlighting because, a lot more has happened as long as the NHIS is concerned since 2005, 2010 and in 2018. For example, Gbedemah, Jones and Pereznieto (2010) and Abbey, Odonko and Boateng (2014) reported about the LEAP while Kotoh and van der Geest (2016) reported about a high patronage. What is left hanging now is why the poor are less enrolled.

Fenny, Hansen, Asante and Enemark (2014) investigated the impact of health insurance in the livelihoods of Ghanaians and Tanzanians. It was more of a comparative study using household surveys, patient exit surveys and in-depth interviews in Ghana and Tanzania. Findings indicated

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that, health insurance provides financial protection and increases utilization of formal health care, especially hospital services for those who have enrolled on the insurance programme for both Ghanaian's and Tanzanians. Membership does not have larger effect on treatment seeking among the least wealthy compared to the wealthiest. Again, it was reported that, membership contributions is not unaffordable in absolute terms, but forms part of a value for money assessment against the expected capacity of the system to deliver timely quality healthcare. Quality of care did not also differ much by insurance status, however, adherence to standard guidelines when it comes to providing healthcare for those enrolled on the health insurance policy was generally low. Furthermore, number of workdays lost to illness was lower among those insured, and they were more likely to adopt healthy behaviour among residents in both countries. In Tanzania where both community health funds and national health insurance funds exist however, more community health funds than national health insurance funds households reported risk factors for healthcare utilization and less wealth, suggesting a need for risk equalization to increase equity. The majority supported redistribution across the funds and favoured a partial subsidy.

The findings of Fenny et al. (2014) are quite similar to that of a series of evaluation of the LEAP that was done in 2013. Handa and Park (2013) who did an impact evaluation of the LEAP in Ghana found that, there has been numerous inconsistencies in implementation of the LEAP. Since 2011 to 2013, they realized that households received only 20 months' worth of payments. Again, there was a long gap in cash payments to households in 2011, followed by an attempt to settle arrears. Thus, the LEAP beneficiaries did not receive a steady flow of predictable cash with which to smooth their consumption. However, Handa and Park found the implementation of NHIS coverage among LEAP households to be impressive since they discovered that, 90% of LEAP households have at least one member enrolled in NHIS at follow-up. Moreover, Handa and Park realised that,

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the LEAP increased school enrolment among secondary school aged children by 7% and reduced grade repetition among both primary and secondary school aged children. Also, among primary aged children, the LEAP has reduced absenteeism by 10%.

Darko and Osei-Akoto (2013) also examined the LEAP in Ghana. They also reported that despite the large increase in NHIS coverage among the LEAP which was also found by Handa and Park (2013), LEAP has not had an impact on curative care seeking but has increased preventive care among girls aged 0-5 years. Again, the results on morbidity is such that, while it is increasing for children aged 0 – 5 years, it is decreasing for children aged 6 – 17 years. Darko and Osei-Akoto also found some impact of LEAP on males and females. For example, they reported that, secondary school enrolment was limited to more of boys than girls, but attendance in school was bigger for girls than boys. At the household levels too, they found that, the impact of LEAP on food security and happiness was higher among households with females as heads than households with males as heads. Interestingly, these researchers also found that, the LEAP led to a significant increase in the likelihood of household savings and gifts received as well as an increase in debt repayment and reduced loan intake especially among households with females as heads.

Davis and Diadone (2013) also examined the LEAP in terms of its impact on productivity and social networking. These researchers found that, among households with four members or less, there was much productivity in the way LEAP benefit was managed such as spending some of the benefit on the farm, purchasing of more seeds and the like. On the side of social networking too, Davis and Diadone (2013) reported that, the LEAP has had a positive impact on a person's social networking or relations which generally contributed to their overall happiness in life. LEAP beneficiaries were also able to extend gifts and credits to others such as contributing to expenses incurred on a funeral of a close relative or friend as well as caring for the sick. Furthermore, they

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reported that there was significantly 16% increase in general happiness among LEAP households that are managed by females than by males.

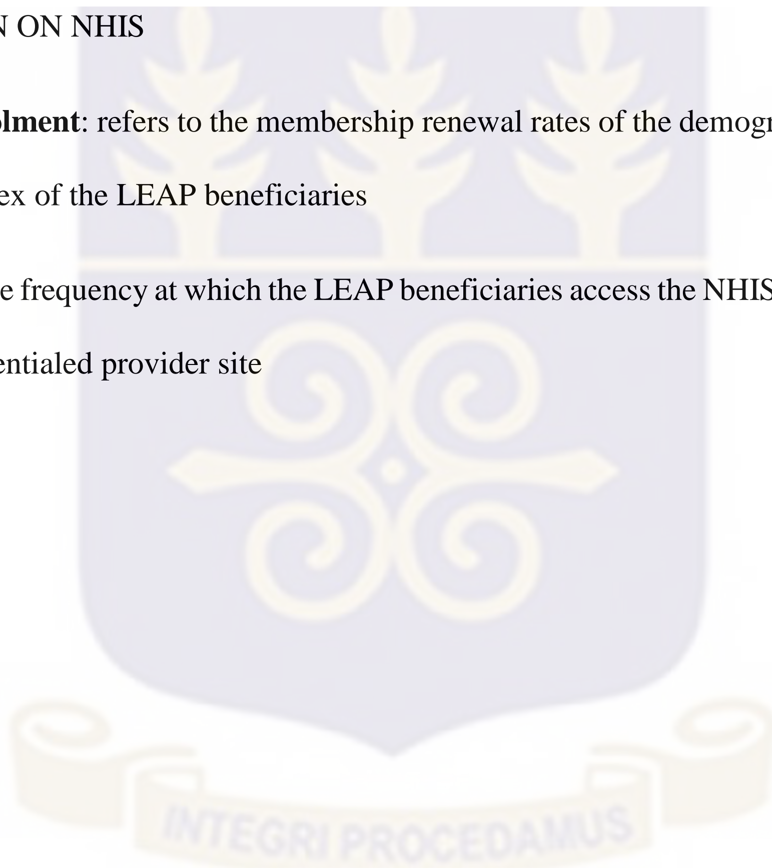
2.4 Operational Definition of Terms

LEAP: refers to Livelihood Empowerment Against Poverty. It is a government social cash transfer programme which provides cash transfer to the extremely poor and vulnerable households in Ghana.

REGISTRATION ON NHIS

Patterns of Enrolment: refers to the membership renewal rates of the demographic characteristic such as age and sex of the LEAP beneficiaries

Use of NHIS: The frequency at which the LEAP beneficiaries access the NHIS healthcare services at the NHIS credentialed provider site



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CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter explains the methods used in this study. It provides information on the research design, population, sample, sampling technique, sample size, data collection techniques used, study area as well as procedures and ethical considerations.

3.2 Research Design

The research adopted a simultaneous mixed methods design which combines quantitative and qualitative research techniques (Johnson & Onwuegbuzie, 2004, p.4). The quantitative section used an exploratory cross-sectional research design. The reasons for using this design is the fact that, it allowed the researcher to compare responses of LEAP beneficiaries of the New-Juaben Municipality on various demographic backgrounds. Again, this design helped to describe and investigate the relationship between phenomena understanding enrolment of the poor in NHIS – at a fixed point in time (Creswell, 2008). More so, the qualitative section employed phenomenology. According to Fischer (2006, p.9), "making conscious experience accessible to investigation is the hallmark of the phenomenological method." It thus allowed the researcher to focus on the essence or structure of experience of LEAP beneficiaries of the New-Juaben Municipality, thereby, understanding implementation challenges and prospects concerning their enrolment and use in NHIS.

3.3 Study Area

The study was conducted in the New-Juaben Municipality of the Eastern Region. Staff of the National Health Insurance Scheme office in New-Juaben Municipality and LEAP beneficiaries in the Municipality participated in the study. The population of New Juaben Municipality, according

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to the 2010 Population and Housing Census, is 183,727 representing 6.9 percent of the Eastern Region's total population of 2,633,154. Males constitute 48.3 % and females represent 51.7 percent. More than 90 percent (93.3%) of the population in the Municipality live in urban localities. The Municipality has a sex ratio of 93, implying that to every 100 females there are 93 males. The Municipality has a youthful population with about one third (30.8%) of the population below 15 years. This age structure results in a broad base population pyramid which tapers off with a small number of elderly persons (7.3%). The total age dependency ratio for the Municipality is 56.1. According to the Ghana Statistical Service (2014) the population of New-Juaben Municipality is 183,727. Furthermore, the population of LEAP beneficiaries in the Municipality which is the population of the study is 4,291 from 33 towns, according to the LEAP secretariat of New-Juaben Municipal Assembly.

3.4 Population

The researcher used the LEAP beneficiaries in the New-Juaben Municipality with respect to their perspectives about the Health Insurance Scheme and why some of the LEAP beneficiaries were unable to enrol. Staff of the NHIS of New-Juaben Municipality also formed part of the study. They served as a fulcrum to understand administrative factors that impede the enrolment of LEAP beneficiaries in the NHIS.

3.5 Sample and Sample Size

According to Saks and Allsop (2007, p.41), the "sample size is dependent on the accuracy required and the possible variation of the population characteristics." They further highlighted that, "the larger the sample size, the smaller the error would be in estimating the characteristics of the whole population." This is because; a small number of participants would make the research tantamount to a Type II error where an effect/difference would not be obtained when there is actually an

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effect/difference (Opoku, 2006). However, a large sample size will make the external validity of the research open to doubt, since an extremely large sample size will make the study a probable subject of Type I error whereby an effect/difference would be determined when actually there is none (Opoku, 2006).

To proceed further, the Ghana Statistical Services (2012) report that, there are a total of 24,658,823 – approximately 25 million – Ghanaians. The Eastern Region which covers a total area of 19,323 km^2 has a resident population of about 2,633,154.

According to the Ghana Statistical Service (2014) the population of New-Juaben Municipal is 183,727. Furthermore, the population of LEAP beneficiaries in the Municipality which is the population of the study is 4,291 from 33 towns, according to the LEAP secretariat of New-Juaben Municipal Assembly.

In view of the foregoing, a "formula for sample size determination" by Araoye (2003, p.39) was used to calculate the sample size so as to minimize errors but promote the interest of the research. The following formula for sample size determination (n) was used:

$$n = \frac{z^2pq}{d^2}$$

where:

z = the "standard normal deviate set at 1.96, which corresponds with the 95% confidence interval."

p = the proportion in the target population estimated to be LEAP beneficiaries. This was found to be 4,291 ÷ 183,727 x 100 = 2.33%. i.e., "p = 0.023"

q = 1 – p; thus q = 1 - 0.023 = 0.98

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d = "degree of accuracy desired" usually set at .05

Therefore, $n = \frac{(1.96)^2 (0.023) (0.98)}{(0.05)2} = \frac{3.8416 \times 0.02254}{0.0025} = \frac{0.086589664}{0.0025} = 34.64$

The minimum respondents needed was 35.

3.6 Sampling Technique

Multistage sampling technique was used. It is a probability sampling technique. The purpose for using it was because according to Gravetter and Forzano (2006), it allows everyone a fair chance of participating in the study. The technique is useful for descriptive, exploratory and correlational studies (Burns & Grove, 2005).

In order to accommodate non-response in the interviews, ninety-six (96) respondents were used for the quantitative study. Again, 96 were used because according to Burns and Grove (2005), quantitative studies require larger sample size due to its reliance on numbers.

Forty-eight (48) participants from the ninety-six (96) households were selected for the qualitative study. Eight (8) participants each in the six (6) sampled communities for the study. The qualitative participants included 48 household heads of LEAP beneficiaries who have a total of 168 eligible dependants. For a fact, these household heads who were themselves LEAP beneficiaries were interviewed because they served as the "gate-keepers" of the information concerning LEAP, enrolment onto NHIS and the challenges faced (Johnson & Onwuegbuzie, 2004).

The LEAP beneficiary interview-guide was administered in six LEAP beneficiary communities. Six National Service Persons were recruited and trained as field interviewers for the data collection. Again, five staff of the New-Juaben Municipal Office of NHIS were also interviewed.

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In each community, a total of eight households were selected and the household head was interviewed.

The 96 households were sampled in six communities for the study. From the LEAP Secretariat records, the New Juaben Municipality has 33 LEAP Communities. Using the multistage sampling technique, the communities were clustered into urban and rural – including 23 communities for urban and 10 communities for rural.

Names of all the 23 urban communities were written on pieces of paper. The pieces of paper were then folded and put into a closed box after which three were randomly selected. The same exercise was undertaken to select the three rural communities. Afterwards, a systematic random sampling technique was employed to interview 16 respondents from each of the six communities for both the urban and rural LEAP communities in the New Juaben Municipality.

Furthermore, eight out of the 16 respondents from each community were randomly sampled using systematic random sampling such that, every other person/household sampled for the quantitative study was used for the qualitative section as well. To explain further, the 16 samples from a community were assigned numbers beginning from 1 to 16. Those with even numbers including from 2, 4, 6, 8, 10, 12, 14 and 16 were used for the qualitative aspect. Those with odd numbers only responded to the quantitative questionnaires. Table 3.1 below contains a summary of the communities and number of households that were randomly selected.

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Table 3.1 Table for Sample Selection

COMMUNITY	NO. OF HOUSEHOLD SELECTED
URBAN	
Suhyen	16
Akwadum	16
Koforidua Zongo	16
RURAL	
Nyamekrom	16
Trom/Agavenya	16
Kentenkren	16
TOTAL	**96**

3.7 Research Procedure

Introductory letters were collected from the University of Ghana Centre for Social Policy Studies to the NHIS Municipal office and the Department of Social Welfare at the New-Juaben Municipality who provided immense assistance in obtaining staff of the office as well as permitting the researcher to engage the LEAP beneficiaries for the study. The researcher then contacted these staff (N = 5) and LEAP beneficiaries (N = 96) and explained the purpose of the research to them.

After seeking and obtaining their consent, the questionnaires were then administered for the required data which was then collected and analysed. Six National Service Personnel were recruited and trained to help gather the data in time.

3.8 Ethical Concerns

As far as research in policy studies involving the national health insurance and LEAP is concerned, ethical concerns such as informed consent, anonymity/privacy and confidentiality were strongly upheld.

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Informed Consent is “the prospective subject’s agreement to participate in a study as a subject/participant, which is reached after assimilation of essential information” (Burns and Grove, 2005, p.9). According to Burns and Grove “it consists of four elements, specifically, disclosure of essential information, comprehension, competency, and voluntarism.” The staff of the NHIS Municipal Office were allowed to carefully read the informed consent letter and disagree or agree formally by appending their signature at a column provided for such purpose. For the LEAP beneficiary household heads who could not read, the consent letter was read to them and they thumb printed as haven consented before data was collected. To ensure that the informed consent is truly valid or ethical, it include the purpose of the study, any reasonable “foreseeable risks to the individual, potential benefits to the individual or others, extent of confidentiality protections for the individual, contact information for questions regarding the study, participants’ rights and in case of injury, as well as conditions of participation, including the right to refuse or withdraw without penalty” (Burns and Grove, 2005, p.9)

Privacy was ensured by protecting the opinions, records and other private information of the respondents (Edwards & Mauthner, 2002). More specifically, all data received were well kept for which only the primary researcher had access to. For that reason, the researcher was heavily indebted and responsible for any leakage of identifying private information.

3.9 Data Analyses

Quantitative data analyses involved the use of parametric techniques such as Pearson Product Moment Correlation, Independent t test and One-Way ANOVA tests as well as graphic presentations of results for easy interpretation and understanding. These techniques were used for the quantitative data analysis.

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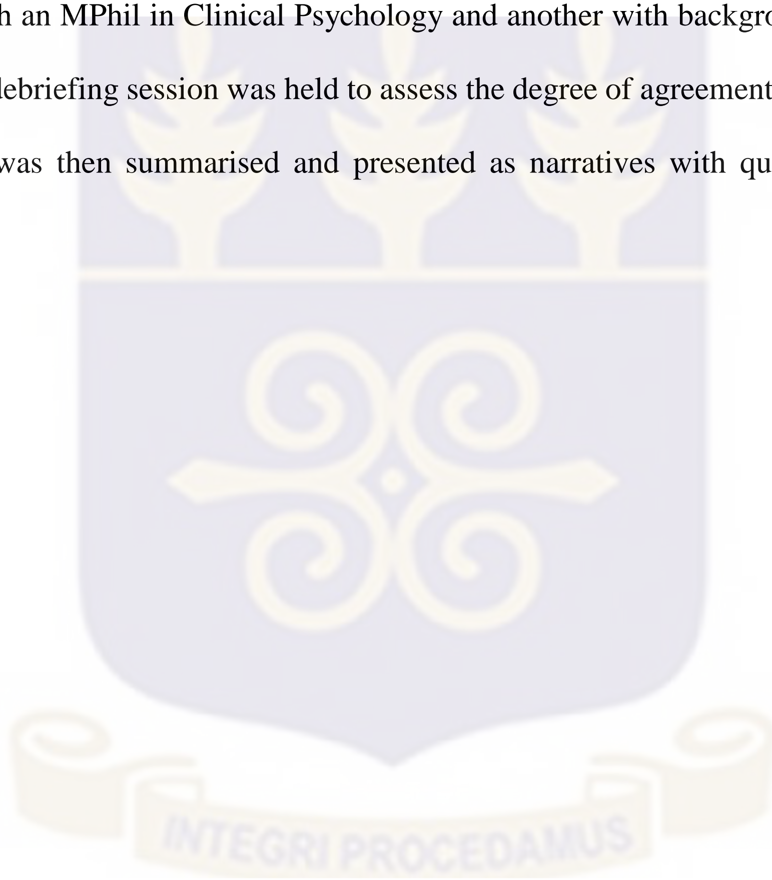
The qualitative data analyses involved using thematic analysis. This analyses was based on Hycner's five steps for thematic analysis which includes *Step 1*: transcription; *Step 2*: bracketing and the phenomenological reduction; *Step 3*: Listening to the interview for a sense of the whole; *Step 4*: delineating units of general meaning; and *Step 5*: delineating units of meaning relevant to the research question (Hycner, 1985).

For the sake of reliability of the qualitative findings, the data was reviewed by two independent persons (One with an MPhil in Clinical Psychology and another with background in Community Research) and a debriefing session was held to assess the degree of agreement to the objectives of the study. Data was then summarised and presented as narratives with quotes to support the findings.



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CHAPTER FOUR

RESULTS AND DISCUSSIONS

4.1 Introduction

This chapter is centered on the analysis of data gathered from the research. It presents results from the data analysis and their interpretations which includes the descriptive data (standard deviation, mean, etc.). The respondents were the residents of New-Juaben Municipality who are enrolled onto the LEAP (N = 96 for quantitative and 48 out of this number for the qualitative studies). It also includes five (5) staff of the National Health Insurance Authority in the New-Juaben Municipality. The Pearson Product Moment Correlation was used to determine whether knowledge of NHIS by LEAP beneficiaries relates to their reported challenge of enrolment. Moreover, the Independent t test was used to test whether a significant difference exists between females and males when it comes to challenges faced by LEAP beneficiaries. One-Way ANOVA was used to assess whether educational background impacts a LEAP beneficiaries knowledge about NHIS all at the .05 level of significance with the help of Statistical Product and Service Solutions (SPSS).

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4.2 DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS

First the summary of the demographic characteristics of the participants are presented in table 4.1.

Table 4.1 Summary of Demographic Characteristics of Participants (N = 96)

Variables		Frequency	Percentage
Sex:	Male	22	22.9
	Female	74	77.1
Total		96	100
Age	30 years	4	4.2
	40 years	16	16.6
	45 years	28	29.2
	52 years	8	9.0
	55yrs	10	9.7
	65 years	30	31.3
Total		96	100
Education Level	No Formal Education	34	35.4
	Basic Education/O Level	56	58.3
	SSCE/A Level	6	6.3
Total		96	100
Years of Enrolment in LEAP	1 year	6	6.3
	2 – 4 years	38	39.6
	5 – 7 years	52	54.2
Total		96	100
Work/Occupation	Farmer	8	8.3
	Trader	50	52.1
	Unemployed	38	39.6
Total		96	100
Marital Status	Married	54	56.3
	Widow/Widower	38	39.6
	Divorced/Separated	4	4.2

Source: Field Data 2017 (N = 96 LEAP beneficiaries of the New-Juaben Municipality)

From Table 4.1 above, it could be observed that, more females (constituting 77.1%) were interviewed than male LEAP beneficiaries (constituting 22.9%). The mean age of LEAP

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beneficiaries sampled was 51.42 years. Furthermore, most of the LEAP beneficiaries had their basic/O level education (constituting 58.3%).

Table 4.2: Demographic Characteristics of NHIA Staff of New-Juaben Municipality

SN.	SEX	AGE	OCCUPATION	POSITION AT WORK	NUMBER OF YEARS AT WORK	HIGHEST LEVEL OF COMPLETED EDUCATION
01	F	35	Office Administration	Admin Asst.	10yrs	Tertiary
02	M	33	MIS	MIS Asst.	10yrs	Tertiary
03	F	39	Mgt. Accounting	Dist. Accountant	11yrs	Tertiary
04	M	40	Public Relations	PRO	13yrs	Tertiary
05	M	44	Cost Accounting	Claims Officer	12yrs	Post graduate

Source: Field Data 2017 (N = 5 Staff of NHIA – New-Juaben Municipality)

From Table 4.2 above, it could be observed that more male than female staff were obtained. In terms of age, the mean age of the NHIA staff of New Juaben Municipality is 38.2 years. More so, most staff sampled for the study were within 30 and 39 years of age and 40% within the 40 – 49 age range. They all had 10 to 13 years working experience in the National Health Insurance Authority. Besides, all staff interviewed have had their tertiary education with one having a post graduate education.

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4.3 Knowledge of LEAP beneficiaries of the New-Juaben Municipality about the NHIS and its use

This question was primarily addressed to the NHIA staff at the New-Juaben Municipality. It was asked to help identify the patterns and procedures of enrolment for the LEAP beneficiaries. To fully ascertain this, various questions such as, "Indicate the procedures and processes used for the enrolment or renewal of LEAP beneficiaries", "What information is given to LEAP beneficiaries before enrolment?" "How many weeks after registration does it take for a person to receive a card?" "Apart from your office, how many other registration or renewal centres are there in your district?" "What payments do LEAP beneficiaries in your district have to make in order to receive NHIS support?

Enrolment Procedures

The five staff of NHIA in the New-Juaben Municipality were asked to *indicate the procedures and processes used for the enrolment or renewal of LEAP beneficiaries*. Below is the thematic analyses of procedures and processes indicated by the staff.

Registration: involves members with LEAP eligibility criteria whose names are submitted by LEAP are registered" (R1)

District Office Verification: Registered LEAP beneficiaries submit their proof of registration or ID cards to the district office at New-Juaben Municipality (R1 & R5)

Verification and Approval from Department of Social Welfare: "For transparency, law requires that the Department of Social Welfare verifies all people enrolled onto the LEAP before they are fully recognized as LEAP beneficiaries (R3).

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Issuance of Zero Receipts: "… since [LEAP] beneficiaries do not pay anything for the enrolment, they are issued a zero receipt" (R1).

ID Card of Membership Issued: "… registration is done. ID card is issued to the beneficiaries" (R3).

4.3.1 Information given before Enrolment

The five staff of NHIA in the New-Juaben Municipality were asked to *indicate the information given to LEAP beneficiaries before Enrolment*. Below is the thematic analyses of the information provided to eligible LEAP beneficiaries before enrolment as indicated by the staff.

Benefit Package: "The beneficiaries are told the benefit package they are to enjoy" (R5)

ID Card Renewal: "… that they are required to do renewal of ID cards annually" (R2)

Non-Payment: "The LEAP beneficiaries are told that they do not have to pay money or anything during registration" (R1)

"No payment is done for any service done or item provided for the registration" (R3)

Payment for Out-Of-Umbrella Services: "services outside the benefit package would have to be paid for" (R4).

"All services and items that are not covered in the LEAP service package would be paid for by the individual" (R3).

Purpose of Benefit: "We explain to the beneficiaries the purpose of the benefit package. It is not for partying …." (R1)

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Time Period for Receiving ID card

It was realized that, information given by staff of NHIA before enrolment of LEAP beneficiaries include the benefit package, renewal of ID cards, no payment for registration, payment for out-of-umbrella services, and the purpose of the benefit. These shows that enough information is provided to the LEAP beneficiaries before enrolment. However, it is evident that, the manner of communication is just a one-time oral encounter.

The five staff of NHIA in the New-Juaben Municipality were asked about the time frame from registration at which LEAP beneficiaries get their Cards issued to them. Table 15 contains a summary of their response.

Table 4.3: Time period for LEAP beneficiaries to receive their ID card

Time Frame for Receiving ID card	Frequency	Percentage
Within One Week	5	100%

Source: Field Data 2017 (N = 5 Staff of NHIA – New-Juaben Municipality)

Table 15 above indicates that, 100% of the NHIA staff of the New-Juaben Municipality admit that it takes a period of one week for LEAP beneficiaries to receive their ID card. However, these staff also admitted that ideally, the issuance of ID cards should have been instantly, but this delay arises due to problems with internet connectivity and logistics.

4.3.2 Registration/Renewal Centres in the District

The five staff of NHIA in the New-Juaben Municipality were asked about the registration or renewal centres in the New-Juaben District. Table 16 contains a summary of their response.

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Table 4.4: Registration/Renewal Centres

Registration/Renewal Centres	Frequency	Percentage
Four (4)	5	100%

Source: Field Data 2017 (N = 5 Staff of NHIA – New-Juaben Municipality)

The table 4.16 above indicates a unanimous response that there are four (4) registration or renewal centres throughout the New-Juaben Municipality.

4.3.3 Payments made for NHIS Registration

The five staff of NHIA in the New-Juaben Municipality were asked about the payment made by LEAP beneficiaries in the New-Juaben District in order to get registered for the NHIS. Table 4.17 contains a summary of their response.

Table 4.5: Payments made for NHIS Enrolment/Renewal

Payments made for NHIS Enrolment/Renewal	Frequency	Percentage
No Payment	5	100%

Source: Field Data 2017 (N = 5 Staff of NHIA – New-Juaben Municipality)

The table 4.17 above indicates a unanimous response that there are no payments made in the New-Juaben Municipality for LEAP beneficiaries to get enrolled onto the NHIS.

4.3.4 Reliability Analysis of Quantitative Data

This aspect of the quantitative analysis examines an important assumption for use of parametric tests – reliability analyses. It is essential because parametric tests such as the Pearson Product Moment Correlation, Independent t test, and One-Way ANOVA was used. In this regard, the 2

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quantitative scales used – namely Knowledge and Use of NHIS questionnaire as well as the Challenges of enrolment questionnaire – were examined for reliability. These techniques were used although a non-probability sampling techniques was not used, Burns and Grove (2005) admits that it should be accounted for as a limitation when used.

Table 4.6: Reliability Statistics (Cronbach's Alpha) for Scales Used

Scale	**α**	**No. of Items**
1. Knowledge & Use of NHIS	.87	9
2. Challenges of Enrolment	.74	7

Source: Field Data 2017 (N = 96 LEAP beneficiaries of the New-Juaben Municipality)

From table 4.6 above, it can be observed that the reliability coefficients for the Knowledge and Use of NHIS questionnaire as well as the Challenges of enrolment questionnaire as used for the analysis are beyond .70. According to Wells and Wollack (2003), a Cronbach's alpha of .70 and beyond can be considered reliable. This means that they are very high or good in reliability and for that matter can be used for testing the various hypotheses (Wells & Wollack, 2003).

4.3.5 Test for Normality of Quantitative Data

The normality assumption which is the extent to which the distribution of the sample data is consistent with a normal distribution (Fields, 2010) was checked by inspecting the skewness and kurtosis values of all the variables. The results of this analysis is presented in table 4 below.

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Table 4.7: Summary of the Means, Standard Deviation, Skewness and Kurtosis (N = 96)

Scale	Min	Max	Mean	SD	Skewness	Kurtosis
1. Knowledge & Use of NHIS	22.00	42.00	34.31	4.51	-.18	-.12
2. Challenges of Enrolment	13.00	27.00	20.15	4.21	-.10	-1.24

Source: Field Data 2017 (N = 96 LEAP beneficiaries of the New-Juaben Municipality)

Table 4.7 above shows results of the descriptive statistics for scales used (that is, Knowledge and Use of NHIS questionnaire as well as the Challenges of enrolment questionnaire). The skewness and kurtosis scores above shows that all scores fall within the acceptable range of +2 to -2 and +3 to -3 respectively which shows that they are normally distributed and thus satisfy the condition for the use of parametric tests (Tabachnick and Fidell, 2007; Doane & Seward, 2011). Since these scores were observed to be within the acceptable range they did not deviate from the normality required for hypotheses testing.

4.3.6 Correlation Matrix between Knowledge & Use of NHIS and Challenges to Enrolment

The relationship between the two main scales – namely, the Knowledge and Use of NHIS indicators as well as the Challenges of enrolment indicators with its sub-scales – were examined and the results is presented in the summary table (table 5) below. Note that the sub-scales for the Challenges of enrolment questionnaire include convenience factors, cost factors, and staff attitude.

Table 4.8: Pearson Product Moment Correlation results on Knowledge and Use of NHIS as well as the Challenges of enrolment scale)

Scales Used	1	2	2a	2b	2c
1. Knowledge & Use of NHIS	-				
2. Challenges of Enrolment	.08	-			
2a. Convenience Factors .	.09	.74*	-		

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2b. Cost Factors	-.11	.59*	.29*	-	
2c. Staff Attitude	.14	.71*	.22	.09	-

* Significant at the .05 level of significance

From Table 4.8 above (Summary of Pearson Product Moment Correlation Matrix of Scales - that is, the Knowledge and Use of NHIS questionnaire as well as the Challenges of enrolment questionnaire with its sub-scales) it could be observed that there is no correlation between knowledge and use of NHIS and Challenges of enrolment ($r = .08 > .05$ level of significance). This means that, the extent of a person's knowledge and use of NHIS does not impact on the challenges they experience with enrolment. However, it could be essentially observed that a significant positive correlation exists between cost factors associated with enrolment and convenience factors associated with enrolment ($r = .29 < .05$ level of significance). This means that, as cost factors associated with enrolment increases, convenience factors associated with enrolment also increases. On the other hand, as cost factors associated with enrolment decreases, convenience factors associated with enrolment also decreases. The relationship between cost factors associated with enrolment and staff attitude was not significant.

Table 4.8 above contains a summary of the Pearson Product Moment Correlation for the relationship between knowledge and use of NHIS by LEAP beneficiaries and challenges of enrolment. From Table 4.5 above, it could be observed that there is no significant negative relationship between knowledge and use of NHIS by LEAP beneficiaries and challenges of enrolment since the Pearson r value was .08 with a $P < .05$ level of significance. This means that, the extent of a person's knowledge and use of NHIS does not impact on the challenges they experience with enrolment.

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Table 4.9 below indicates a summary of the Independent t test table for gender differences in challenges of enrolment onto the NHIS.

Table 4.9: Summary of Independent t test for Gender differences in challenges of enrolment onto the NHIS

Gender	**N**	**Mean**	**SD**	***t***	***df***	***P***
Male	22	19.36	4.42	-.698	46	.488
Female	74	20.38	4.18			

* Significant at the .05 level of significance

From Table 4.9 above, it could be observed that the differences between males (M = 19.36; SD = 4.42) and Female (M = 20.38; SD = 4.18) was not significant *P (*.488; *df* = 46*)* > .05. This suggests that, there are gender differences when it comes to challenges of enrolment onto the NHIS among LEAP beneficiaries of the New-Juaben Municipality. A critical look at the means of table 6 indicates that, females reported more challenges of enrolment onto the NHIS than males, however, the significant value indicates that the difference is due to chance.

Table 4.10:: Summary of One-Way ANOVA indicating differences in knowledge and Use of NHIS based on Educational Background (N = 96)

Educational Background	**N**	**Mean**	**SD**	**df**	**F**	***p***
No Formal Education	34	22.71	1.23			
Basic/O Level Educ.	56	28.71	1.43	2.45	15.179	.00*
Secondary/A Level Educ.	6	40.11	2.57			

* Significant at the .05 level of significance

From table 4.10 ANOVA above, it can be observed that the differences between LEAP beneficiaries who have No Formal Education (M = 22.71; SD = 1.23), Basic/O Level Education

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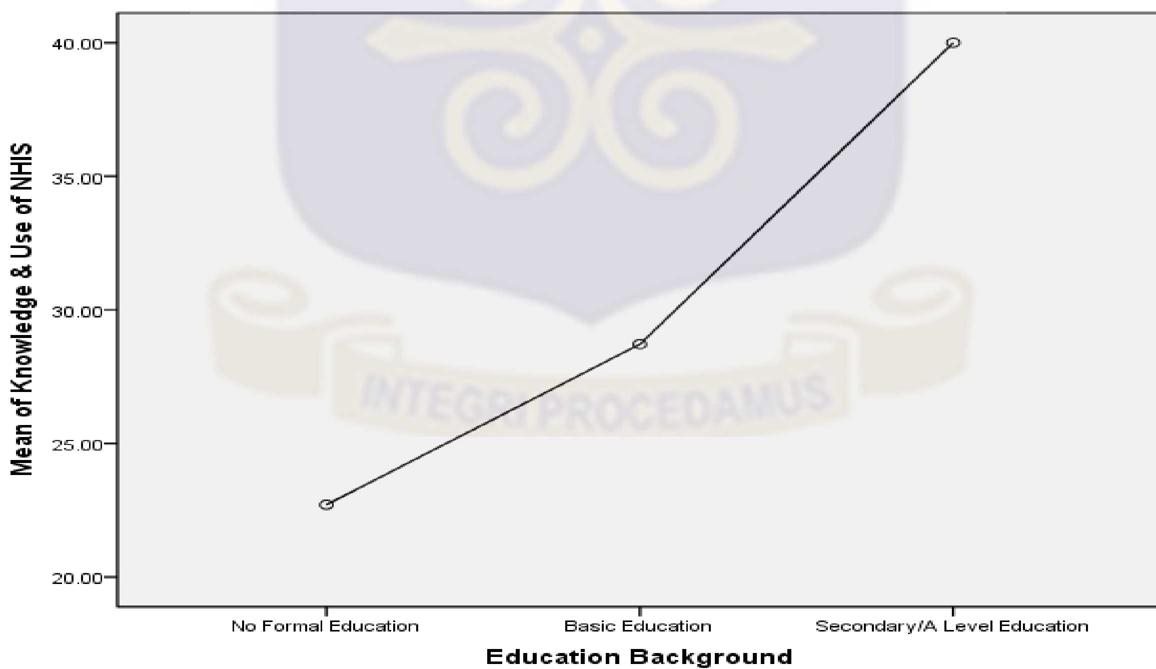
(M = 28.71; SD = 1.43), and Secondary/A Level Education (M = 40.11; SD = 2.57) on knowledge and use of NHIS was significant $P(.00; F = 15.179; df = 2,45) < .05$. This means that, the difference between at least two of the means is significant. For that matter, Bonferroni was used for the Post hoc (multiple comparisons) as indicated in Table 4.11 below.

Table 4.11:: Post Hoc Analysis indicating differences in in knowledge and Use of NHIS based on Educational Background (N = 96)

Educational Background	1	2	3
1. No Formal Education	-		
2. Basic/O Level Education	6.01*	-	
3. Secondary/A Level Education	17.29*	11.29*	-

* Significant at the .05 level of significance

Figure 4.1: Differences in knowledge and Use of NHIS based on Educational Background



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From Table 4.11 above, it can be observed that, the mean differences between LEAP beneficiaries who only have Basic/O Level Education and No Formal Education is significant (Mean Difference = 6.01; $p < .05$). This means that LEAP beneficiaries who only have Basic/O Level Education have significantly better knowledge and use of NHIS than those with No Formal Education. Comparing those with Secondary/A Level Education too and Basic/O Level Education, it can be observed that, the mean differences between them is significant (Mean Difference = 11.29; $p < .05$). This means that LEAP beneficiaries who only have Secondary/A Level Education have significantly better knowledge and use of NHIS than those with Basic/O Level Education. From the figure 4.1 above, it can clearly be observed that knowledge and use of NHIS by LEAP beneficiaries rises with higher levels of education.

4.4 BASIC DESCRIPTIVE STATISTICS AND QUALITATIVE ANALYSES

In this section, four (4) research questions are answered. They are (1) what is the pattern of enrolment onto NHIS among LEAP beneficiaries and their dependants? (2) What knowledge do the LEAP beneficiaries have about NHIS and its importance to their eligibility? (3) What are the patterns (categories such as children, adults and the aged) in the enrolment of LEAP beneficiaries and use of the NHIS? (4) What are the administrative and practical challenges associated with the enrolment of the LEAP beneficiaries and the management enforcement of the Health Insurance registration conditionality?

4.4.1 Pattern of enrolment onto NHIS among LEAP beneficiaries and their dependants

To fully ascertain this, questions were asked about year of enrolment, source of prompting for enrolment, renewal of NHIS card, and payment for renewal length of renewal waiting period.

Year of Enrolment: LEAP beneficiaries were asked, “In which year did you enrol onto LEAP?” the following were their responses.

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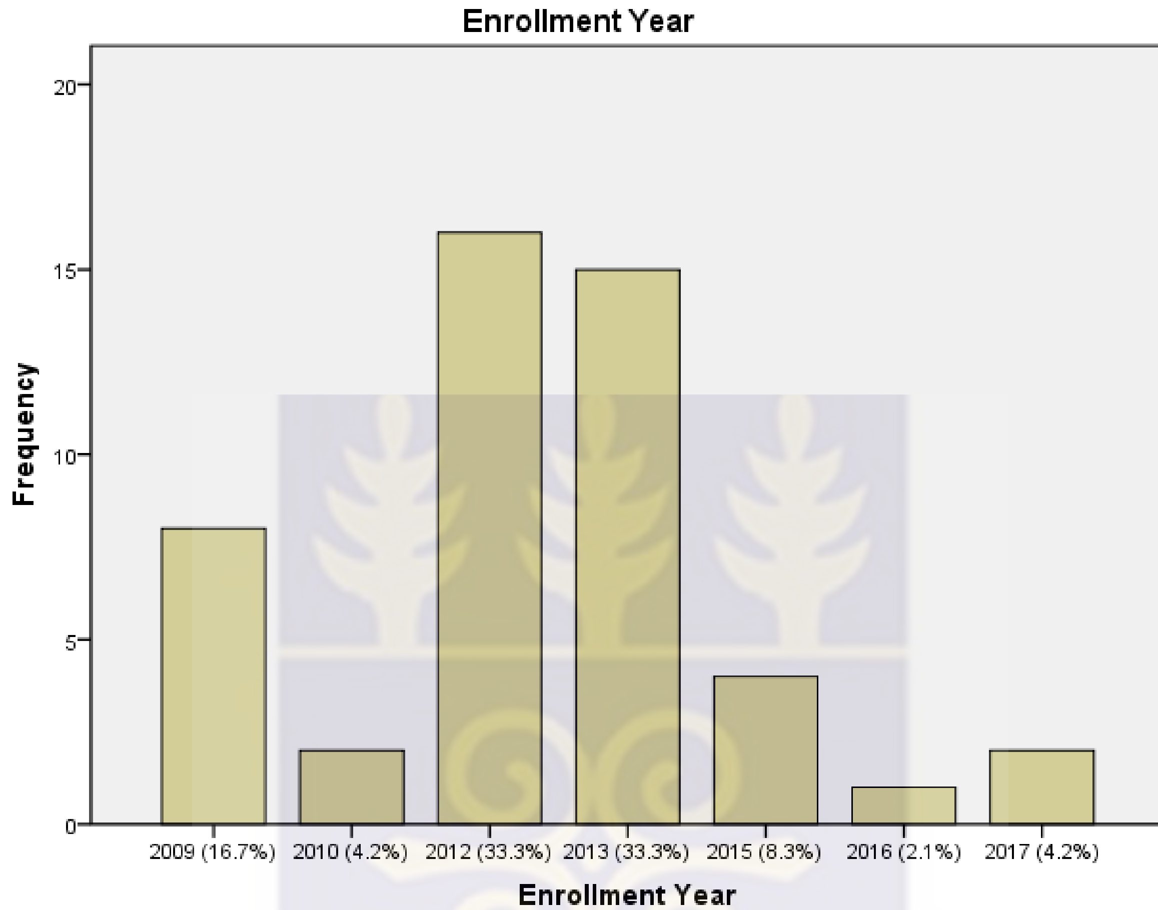
Figure 4.2



It could be observed from Table 4.9 and Figure 4.2 that the majority of LEAP beneficiaries enrolled in 2012 (33.3%) and 2013 (31.3%).

Source of prompting to Enrol onto NHIS: LEAP beneficiaries were asked, "Were you asked by the LEAP officials to enrol onto NHIS?" Figure three (3) below indicates their responses.

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Figure 4.3

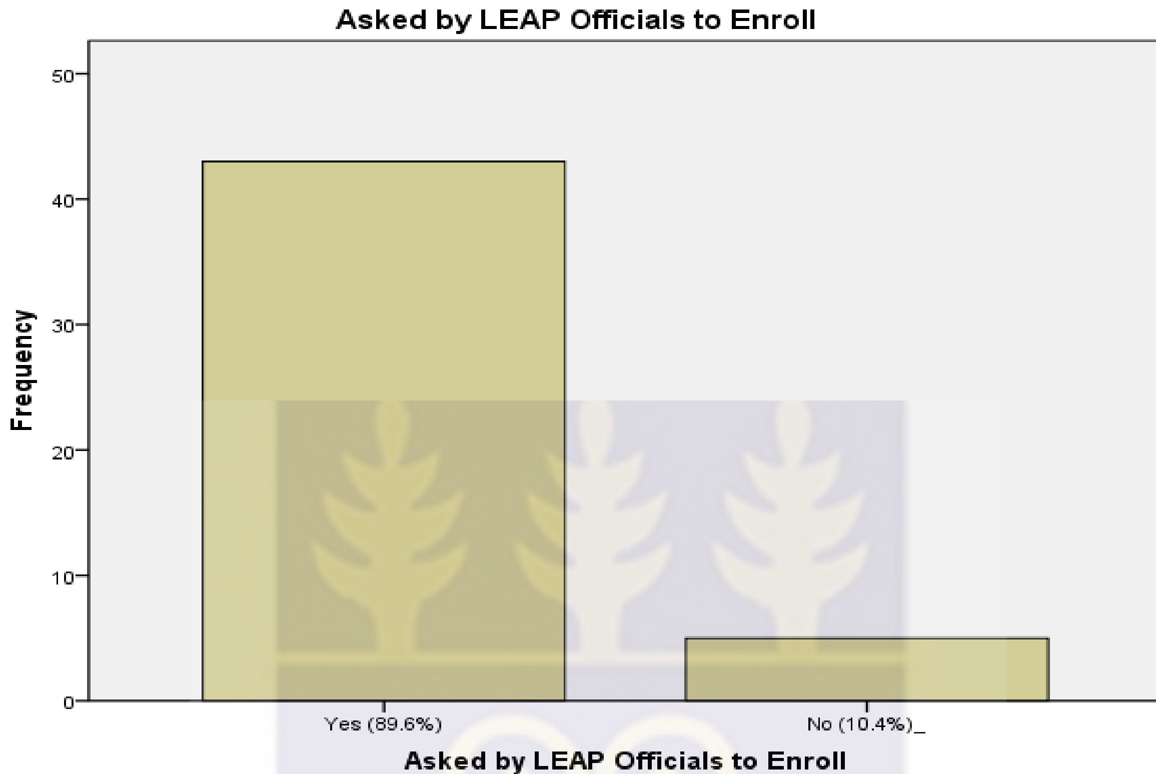

Figure 4.3 above indicates that a far greater number of LEAP beneficiaries attest to the fact that, the NHIA officials in the New-Juaben District asked them to enrol onto the NHIS, in line with the programme expectations. Only 10.4% claim they were not told. In view of this, the next question asked was if the LEAP beneficiary is enrolled onto the NHIS. Table 10 contains a summary of the response.

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Table 4.12: Enrolment onto NHIS

Enrolled onto NHIS	Frequency	Percentage
Yes	44	91.7%
No	4	8.3%

Source: Field Data 2017 (N = 48 LEAP beneficiaries of the New-Juaben Municipality)

It is evident from Table 4.12 that most of the household heads of LEAP beneficiaries (91.7%) are enrolled onto the NHIS with only 8.3% not enrolled.

For the 91.7% of LEAP beneficiaries (that is, Heads) who are already enrolled, these were asked if they have renewed their NHIS. Table 4.13 below presents a summary of the findings.

Table 4.13: Renewal of NHIS

Renewal of NHIS	Frequency	Percentage
Membership Renewed	35	72.9%
Membership Not Renewed	9	18.8%
Not Applicable	4	8.3%

Source: Field Data 2017 (N = 48 LEAP beneficiaries of the New-Juaben Municipality)

Table 4.13 indicates that more LEAP beneficiaries enrolled onto the NHIS have renewed their membership indicating 72.9% with only 18.8% not yet renewed.

LEAP beneficiaries registered for the NHIS were asked to indicate the payment they made as part of the enrolment or renewal. The figure 4.4 below presents a summary of the findings.

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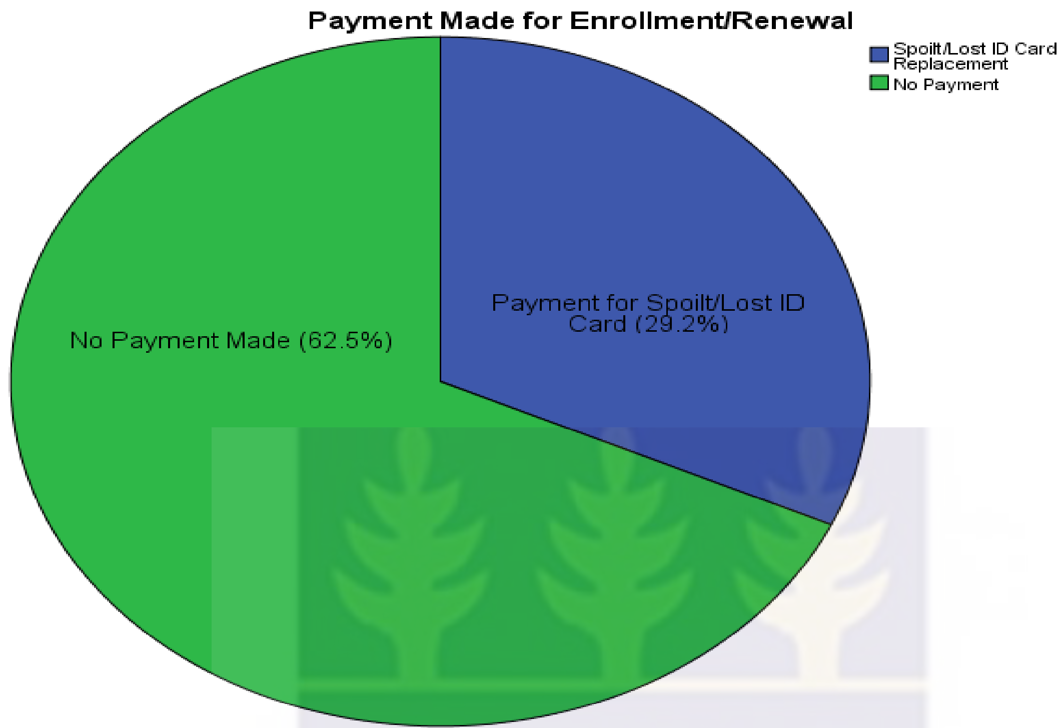
Figure 4.4



It is evident from figure 4.4 that the majority of LEAP beneficiaries did not pay for their enrolment onto NHIS or the renewal as indicated by 62.5%. However, 29.2% claim they paid money for the replacement of spoilt or lost ID card.

To know more about how long it takes to receive their card, LEAP beneficiaries were asked about how long it took them to receive their NHIS card after registering. Below is a summary of their responses.

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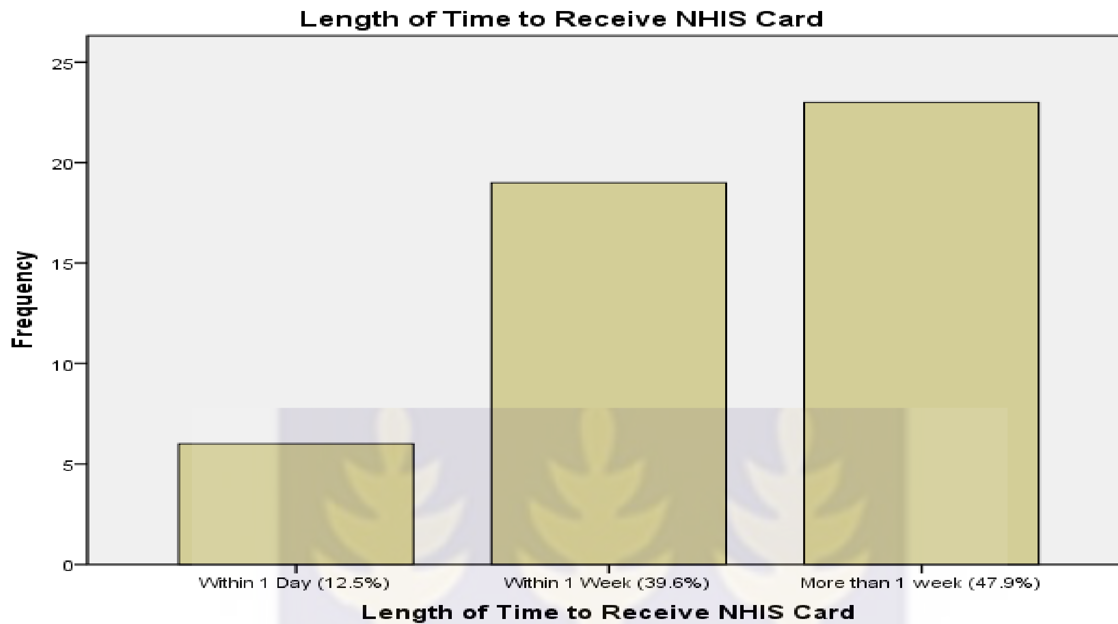
Figure 4.5



From Figure 4.5 above, it could be observed that a lot more of the LEAP beneficiaries receive their NHIS card in more than 1 week (constituting 47.9%), and this is followed in descending order by those who receive it within a week (constituting 39.6%) and within a day (constituting 12.5%). The earliest batch of all receive their card within 1 day (very few) and the latest batch constituting who are the majority received their NHIS card in more than 1 week.

Enrolment of Household Members: A household Listing was undertaken from these household heads and Table 4.14 below presents a summary of the findings.

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Table 4.14: Household listing of members for LEAP beneficiaries

Household Listing		Frequency	Percentage
Sex:	Male	80	47.6%
	Female	88	52.4%
Age:	Children under 18 years	118	70.24
	18 years & above Dependants	50	29.76
Relationship:	Child	138	82.1%
	Grand Child	30	17.9%
Level of Education:	No Formal Education	16	9.5%
	Basic Education	126	75.0%
	Secondary/A Level Education	26	15.5%
Members Currently in School:	Yes	114	67.9%
	No	54	32.1%
Religion:	Christian	132	78.6%
	Islam	36	21.4%
Occupation:	Butcher	1	0.6%
	Labourer	10	6.0%
	Seamstress	6	3.6%
	Student	104	61.9%
	Trader	8	4.8%
	Unemployed	39	23.2%
Enrolled onto NHIS:	Yes	150	89.3%
	No	18	10.7%
NHIS Renewed:	Yes	46	27.4%
	No	122	72.6%
Children under 18 NHIS Renewed		21	12.5%
Children under 18 NHIS Not Renewed		97	57.73%

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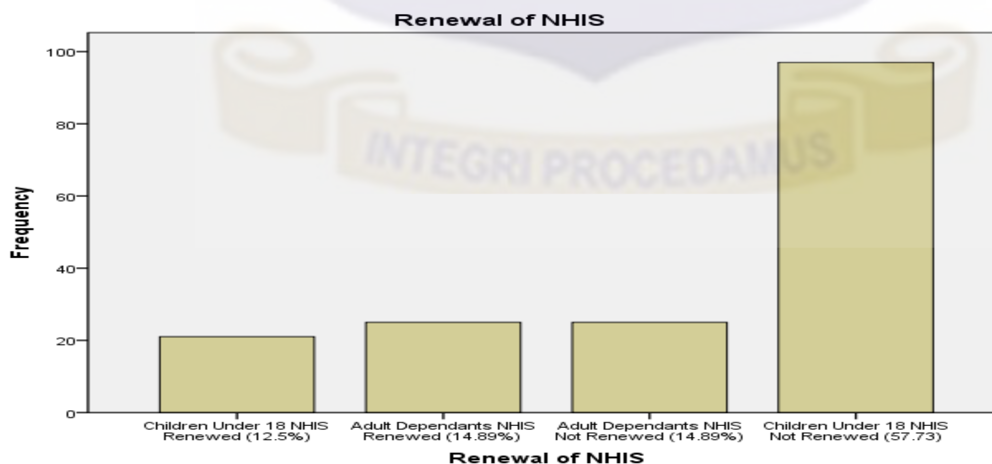
Adults Dependants NHIS Renewed	25	14.89%
Adults Dependants NHIS Not Renewed	25	14.89%
Total	**168**	**100%**

Source: Field Data 2017 (N = 4168 household members of LEAP beneficiaries of the New-Juaben Municipality)

From Table 4.14 above, it could be observed that, more dependants of LEAP beneficiaries are females as this is depicted by 52.4% with 47.6% as males. This means that, more proportion of females than males stand to benefit from the LEAP. Again, most of these dependants are children under 18 years of age with few as dependants who are 18 years and above. This suggests that, dynamics of the LEAP and NHIS would affect children under 18 years more than adults. Furthermore, majority of these dependants of LEAP beneficiaries have or are still pursuing their Basic education. This suggests that most interventions for LEAP beneficiaries should take note of more dependents at school going age. It's of great importance to note that 89.3% of these dependants have been enrolled onto the NHIS with 10.7% not yet enrolled, however, as much as 72.6% of these dependants have not renewed their NHIS. This is quite alarming.

Figure 4.6 below depicts the percentages of dependants of LEAP beneficiaries and their NHIS renewal patterns.



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From figure 4.6, it could be noted that just 12.5% of children under NHIS and 14.89% of adult dependants have renewed their NHIS. However, 14.89% of adult dependants and 57.73% of children under 18 years have not had their NHIS renewed.

Furthermore, LEAP beneficiaries were asked: "Have you or any member of your household members used the NHIS card in the last four weeks? Table 4.15 below contains a summary of the responses.

Table 4.15: Use of NHIS within the last four weeks

Use of NHIS within the last 4 weeks	**Frequency**	**Percentage**
Yes	14	29.2%
No	34	70.8%

Source: Field Data 2017 (N = 48 LEAP beneficiaries of the New-Juaben Municipality)

Perhaps those who did not use their cards did not have to do so due to the fact that no one had been ill in those households.

LEAP beneficiaries who have used their NHIS card in the last four weeks were asked to indicate which household members used it. Figure 7 below indicates their responses.

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Figure 4.7

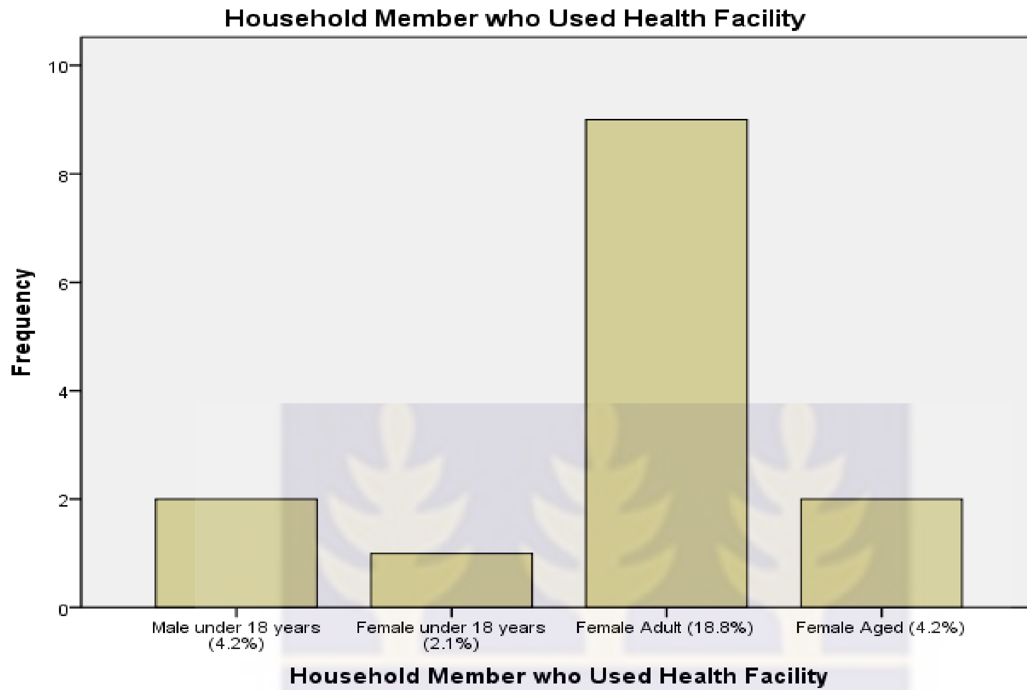

Figure 4.7 above shows that the Female adults were the highest user of the NHIS within the last four weeks

The next question asked LEAP beneficiaries about which health facility they visited with their NHIS card. Table 4.16 contains a summary of the responses.

Table 4.16: Health Facility visited with NHIS card

Health Facility visited with NHIS card	Frequency	Percentage
Government Hospital	11	78.57%
Private Hospital	3	21.43%

Source: Field Data 2017 (N = 14 LEAP beneficiaries of the New-Juaben Municipality)

From Table 4.16, it could be observed that Government hospitals were more widely used by the beneficiaries, compared with private hospitals.

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Furthermore, all LEAP beneficiaries interviewed were asked if membership of NHIS had reduced their out-of-pocket expenses on health for their household. Table 4.14 indicates their responses

Table 4.17: Use of NHIS and reduction in out-of-pocket expenses for health in your household

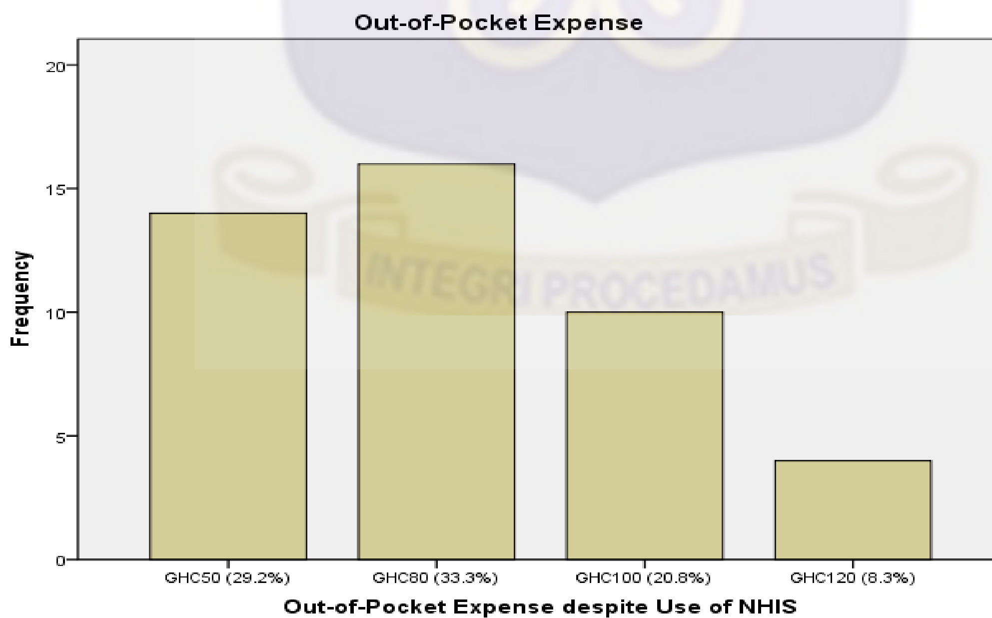
NHIS reduction in Health Expense	Frequency	Percentage
Yes	44	100.0%
No	0	0.0%

Source: Field Data 2017 (N = 44 LEAP beneficiaries of the New-Juaben Municipality)

From Table 4.17, it could be observed that, all LEAP beneficiaries who have registered for the NHIS card admitted that the use of NHIS have reduced their out-of-pocket expenses on health.

Figure 4.8 indicates how much out-of-pocket expenses were incurred by LEAP beneficiaries (N = 44).

Figure 4.8



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From Figure 4.8 it could clearly be observed that, most users of NHIS said they spent GHC80 aside their use of NHIS as out-of-pocket expense. This was followed by 29.2% who spent GHC50, 20.8% who spent GHC100 and 8.3% who spent GHC120.

Participants were then asked to indicate the types of ill health for which they used their NHIS card? Table 4.18 presents a summary of the findings in multiple responses.

Table 4.18: Health Problem for which NHIS card was used

Health Problem & Use of NHIS	Frequency	Percentage
Medical Examination	38	86.36%
Fever	41	93.18%
Serious Pain	19	43.18%
Hospitalization (in patient)	20	45.45%
Surgery	11	25%

Source: Field Data 2017 (N = 44 LEAP beneficiaries of the New-Juaben Municipality)

4.5 Administrative and Practical Challenges Associated with the Enrolment of the LEAP Beneficiaries and Enforcement of the Health Insurance Registration Conditionality

The question was mainly addressed to the staff of the New-Juaben Municipality NHIA office. However, the LEAP beneficiaries were also made to list challenges they faced with respect to enrolment. Specific questions asked in this regard in order to answer this research question includes "Indicate the logistics that you do not have an adequately supply of", "What are the

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administrative and operational bottlenecks associated with enrolment of LEAP beneficiaries onto the NHIS", "What steps should be taken to improve the enrolment of LEAP beneficiaries?"

Logistics Needed to Enable Registration of LEAP Beneficiaries

The five staff of NHIA in the New-Juaben Municipality were asked about the logistics needed to enable them register the LEAP beneficiaries in the New-Juaben District. Table 4.18 to 4.20 contains summaries of their responses

Table 4.19: Logistics Needed to Enable Registration of LEAP Beneficiaries

Logistics Needed for Registration	Frequency	Percentage
BMS Machines	1	20%
Mobile Kits	5	100%
Printers	2	40%
Ribbons	5	100%

Source: Field Data 2017 (N = 5 Staff of NHIA – New-Juaben Municipality)

From Table 4.19, it can clearly be observed that, the New-Juaben Municipal NHIA office would greatly need Mobile Kits and Ribbons as 100% of the staff strongly highlighted that. This then is followed by Printers (40%) and BMS Machines (20%).

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Table 4.20: Matrix for Qualitative Findings – Administrative Challenges with Enrolment

THEME	ILLUSTRATIVE RESPONSES	COMMENT
Network Challenges	"Bad network in some registration centres in communities" (R5) "The network is usually bad in some areas of the district, for that matter, the beneficiaries would have to be referred to the [municipal] office to complete the process" (R3)	It was emphasized that network inconsistencies serves as a barrier to effective enrolment since the internet is needed at all times to complete the registration process
Logistics	"Shortage of ribbons for printing ID cards" (R1) "To actually get our services to the people, we need adequate supply of mobile kits and ribbons. These as at now are our main logistical concerns that makes registration tedious for us and inconveniencing to our beneficiaries" (R4)	Logistics such as ribbons for printing ID cards and mobile kits are needed to reach people at remote areas. Lack of these serves as a barrier to successful enrolment
Distance	"… and we have observed that those beneficiaries who are closer to the registration Centre turn to use the services adequately unlike those who stay far away from the office." (R1) "I once asked a woman who has been reluctant in getting her card renewed for a while as to why she is delaying. She said that our office is far away from where she comes from and the office would not accept a third party mobilizing all the cards and renewing them at a go …." (R2)	The registration center appears to be far away from the beneficiaries. This therefore makes it difficult for many to register as they should.

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Table 4.21: Matrix for Qualitative Findings – Operational Challenges with Enrolment

THEME	ILLUSTRATIVE RESPONSES	COMMENT
Transportation	"I had to wake up very early and walk a long distance … before I can get a car. The fare too is not easy" (Married female LEAP beneficiary, 46 year old with Basic Education) "I spend a lot going up and down for this [registration and renewal]" (59 year old Married female with No formal education)	It is evident from the perspective of the LEAP beneficiaries and the staff that long distance and expenses on transportation is a challenge to enrolment
Delay	"… the National Health Insurance people … they delay us too much. Every day, they will say go and come … the network is not good" (44 year old Married male with basic education) "The card takes too long to come. When you even fall sick, that one it takes long … [before you get it]" (36 year old Married female with basic education)	Beneficiaries see delays on the part of staff of NHIS office as a barrier to their enrolment
Staff Attitude	"the way some of the people talk to us is no fine especially the females. They say we always come there but we are suffering …." (44 year old Married male with basic education)	The unwelcome attitude of some staff of the NHIS office deters some beneficiaries from enrolling.

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Table 4.22:Matrix for Qualitative Findings – Practical Intervention to Mitigate Enrolment Challenges

THEME	ILLUSTRATIVE RESPONSES	COMMENT
Logistics	"… and the NHIA must provide adequate supply of mobile kits and ribbons" (R4)	
Reliable Network	"the [NHIA] must provide a strong network to make the work easier and faster" (R3)	
Education	"I think we have to educate the masses about conditions for qualification onto LEAP. Most people tend to hear from their friends and some have not even heard about it at all." (R2) "We have to let the beneficiaries properly understand the cost implication of falling on self-medication when their NHIS cards do expire." (R5)	Participants suggest that education is needed to make the enrolment of LEAP beneficiaries onto NHIS a success
Operations	"Ghana Health Service must get qualified personnel to man the chip compounds" (R5) "Mechanisms should be put in place so that … NHIS renewal becomes compulsory for all LEAP beneficiaries. It should become a pre-requisite for cash transfers" (R3)	It is evident that the operations of the LEAP enrolment needs streamlining.
Effectiveness of NHIS Card	"There should be a policy for health care to all LEAP beneficiaries with the NHIS card to be completely free." (R2) "Services and drugs outside the NHIS benefit package could be paid for to enable LEAP beneficiaries get 100% healthcare service delivery" (R1)	Participants suggest that, the NHIS Card should be a multipurpose for LEAP beneficiaries to enhance the rate of enrolment

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4.6 Discussion of Key Findings

By means of quantitative analysis and thematic analysis, it has been found that, there is no correlation between knowledge and use of NHIS by LEAP beneficiaries and challenges of enrolment among LEAP beneficiaries of New-Juaben Municipality. In relation to the study done by Joha (2012) about the "effects of Livelihood Empowerment programme in reducing poverty of beneficiary households in Yama" it could be said that, the findings of the present study support that research since the sample in Joha's study also acknowledged a variety of challenges to enrolment, yet they persevered because of a rational choice. As suggested by Rational Choice Theory (Scott, 2000) the LEAP beneficiaries seem to value the benefits of LEAP and so despite challenges, yet, most of them go ahead to register for NHIS. This therefore suggests that, if attempts are made to minimize the challenges associated with enrolment onto the NHIS, LEAP beneficiaries would make very good use of the services.

This study also agrees (only to some extent) with the standard economic theory which suggests that as prices of goods or facilities decreases, the quantity demanded increases (Hatt et al., 2013). Certainly, if the LEAP registration coupled with the NHIS registration had a cost as to that of rich citizens, the poor and vulnerable in society wouldn't have been able to afford to such extent. If the cost of NHIS registration should be zero or free to LEAP beneficiaries, then their demand for enrolment onto the NHIS would be very high as suggested by Harvey and Yoshino (2006). Harvey and Yoshino even reported again that, most individuals turn to self-medication because of the rise in cost of health. This means that, using the standard economic theory from a policy perspective, making health insurance free would see a rise in registration for health insurance which would put a virtual end to self-medication/treatment. However, that wasn't the case in this study, some LEAP beneficiaries still stick to self-medication first before later relying on the use of NHIS to seek healthcare because, a number of challenges such as quality of treatment and nearness of health facility among others is an impediment to seeking healthcare by the poor and vulnerable despite free health access.

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Furthermore, the no gender differences in reported challenges of enrolment onto the NHIS among LEAP beneficiaries addresses the gap in knowledge identified in Joha's (2012) and Hatt et al. (2013) study. Joha for instance reported numerous challenges LEAP beneficiaries undergo, but failed to identify which gender experiences the most challenges. For now, it is clear that both male and female LEAP beneficiaries undergo the same depth of challenges. It is essential to know this now because in policy making and intervention, if we do not determine areas of greater challenges and perceive all areas as equal, we may end up focusing much attention in places that require less or less attention in places that require much. For that matter, social policy and intervention must aim at treating all equally unless there is reason to provide differential support. Anecdotal evidence makes most of us believe that, women are much vulnerable than men, however, as far as enrolment patterns for LEAP beneficiaries is concerned, males are as vulnerable as females and would require equal assistance for that matter.

LEAP beneficiaries with higher forms of education such as Secondary School or A level have significantly better knowledge and use of NHIS compared to those with Basic/O level education who also have significantly better knowledge and use of NHIS than those with no formal education. Again the finding that, most LEAP beneficiaries appear to have enrolled onto the programme between 2012 and 2013 while, only few beneficiaries reportedly were enrolled during 2016 and 2017 presents a dim picture about enrolment.

In relation to the research done by Abbey et al. (2014) concerning a beneficiary assessment of the LEAP, it could be said that the findings from this present study does not partially support that of Abbey et al. These researchers found that, 80% of the LEAP beneficiaries do not know about the amount due them and the time intervals to receive payment. More so, they found that, the key feature of regularity and reliability required of cash transfer delivery was weak. In this present study, LEAP beneficiaries have knowledge of LEAP and NHIS, however, their main concerns were the impediments that befall each beneficiary irrespective of their knowledge.

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For this present study, in terms of knowledge that the LEAP beneficiaries have about NHIS and its importance to their eligibility, it became evident that nearly one-third (29.2%) had used their NHIS card for health concerns within the last four weeks and this use within the last four weeks benefitted females especially female adults more than any other group. Among these, more than two-thirds (78.57%) used their NHIS cards in government hospitals while the remaining few used private hospitals

Witter and Garshong (2009) who investigated social health insurance in Ghana reported that, the NHIS was reported to have a pro-rich bias and pro-urban bias in relation to renewals. In this present study, it was found that, most LEAP beneficiaries who have registered for the NHIS have not renewed their cards, especially, that of their dependants. In relation to the study by Atulley (2015), it could be said that similar findings were observed in this present study. Atulley found that, “57% of the LEAP beneficiaries interviewed are above sixty years and 66.3% of these are females.” A greater number of the household heads who are LEAP beneficiaries as found in this present study are also aged. This therefore suggests that, enrolment/renewal procedures that are quite involving would end up making them fail to complete the due process for the benefits.

In relation to the study done by Jaha and Sika-Bright (2015) who researched the “challenges of the LEAP programme in the Upper West region of Ghana” using the institutional perspective, it could be said that, similar findings have been found in the New-Juaben Municipality. Findings from Jaha and Sika-Bright’s (2015) study indicated that, the LEAP programme has made some efforts to alleviate poverty in the District and improve the living conditions of the local people in the Upper West Region of Ghana. However, the programme was marked with several adminitrative difficulties, irregular inflow of funds as well as “perceived political interferences.” On the side of beneficiaries, Jaha and Sika-Bright (2015) found from the pespective of the LEAP officials that, delay in payment of monies served as a

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major challenge for beneficiaries. Yet, in this present study, most LEAP beneficiaries complained about cost of transportation for renewal despite their cash flows.

Furthermore, this study supports that of Kotoh and Van der Geest (2016) who investigated, 'why the poor are less covered in Ghana's national health insurance.' Kotoh and Van der Geest reported that there has been "a distinct rise in the NHIS' enrolment among the general population but the poor were less covered." Of the 6790 individuals covered in their survey, "less than half (40.3 %) of the population were currently insured in the NHIS and 22.4 % were previously insured. The poorest had the lowest enrolment rate: poorest 17.6 %, poor 31.3 %, rich 46.4 % and richest 44.4 %. The LEAP beneficiaries in the New-Juaben Municipality in this present study were found to have been unable to renew their NHIS, especially for their household dependents. Since Kotoh and Van der Geest focused on quantitative techniques only, they failed to comprehend why the poor enrolment is so; this present study has revealed why the enrolment/renewal pattern is so. Among other things, the LEAP beneficiaries highlight that their transportation cost to the Municipality, delay in the issuance of ID cards and poor NHIA staff attitude toward them serves as a challenge to their enrolment.

The need to overcome the challenges to accessing NHIS among leap beneficiaries is urgent as like Gruber (2010) also found that, the uninsured lack regular access to medications to manage health conditions. Indeed, this shows that, good health on the side of LEAP beneficiaries and their dependants dwells on their enrolment and renewal of the NHIS.

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CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter focuses on a summary of the entire study. These are based on the objectives of the study which were to (1) Examine the knowledge the LEAP beneficiaries have about NHIS and its importance to their eligibility; (2) Identify the patterns in the enrolment of LEAP beneficiaries and use of the NHIS; and (3) Identify the administrative and practical challenges associated with the enrolment of the LEAP beneficiaries and the management enforcement of the Health Insurance registration conditionality. Furthermore this chapter includes the recommendations for social policy and practice.

5.2 Summary

Findings from this study indicate that, there is no correlation between knowledge and use of NHIS by LEAP beneficiaries and challenges of enrolment among respondents of New-Juaben Municipality. The extent of a LEAP beneficiaries' knowledge and use of NHIS did not impact on the challenges they experience with enrolment however, LEAP beneficiaries with formal Education significantly have better knowledge and use of NHIS than those with no Formal Education irrespective of their gender difference.

Most LEAP beneficiary household heads are enrolled onto the NHIS (91.7%) but only two-thirds of the household heads (72.9%) have renewed their NHIS after it expired. It's of great importance to note that 89.3% of dependants have been enrolled onto the NHIS, however, as much as 72.6% of these dependants have not renewed their NHIS. 57% of these dependants who are under 18 years and form a major part of the vulnerable group had not renewed their membership in 2016 and 2017. This is very alarming.

Interestingly, there was a one hundred percent (100%) acceptance that NHIS has reduced out-of-pocket expenses for LEAP beneficiaries. About a third of subscribers, especially females,

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had used their cards in the month in which the interview took place. Most of the users went to government hospitals with complaints of fever or for a medical examination. Challenges in enrolment as perceived by LEAP beneficiaries was attributed largely to cost of transportation to and from the point of registration, delay in the registration process, and bad staff attitude toward LEAP beneficiaries for some. The NHIA staff of New-Juaben Municipality also remarked that their challenges to enrolment stems from inadequate logistics such as mobile kits and printers for issuing ID cards.

5.3 Conclusion

Having examined the patterns of enrolment and use of NHIS by LEAP beneficiaries, it has been realized that all LEAP beneficiaries undergo similar levels of challenges irrespective of their knowledge and use of NHIS. More so, males undergo the same challenges as females.

Challenges in enrolment as perceived by LEAP beneficiaries was attributed largely to cost of transportation to and from the point of registration, delay in the registration process, and bad staff attitude toward LEAP beneficiaries. Again, inadequate logistics such as mobile kits and printers for issuing ID cards were the major challenges that impeded enrolment of the LEAP beneficiaries at the New-Juaben Municipality office of the of NHIA.

5.4 Recommendations

Based on the study, the following are recommended

- The National Health Insurance Authority should ensure that, since LEAP beneficiaries qualify for free enrolment onto the NHIS, then their yearly renewal should be automatic for the five year period of the card for which they hold. In that case, they would avoid the administrative challenges associated with renewal of membership.
- The NHIA should ensure that the Municipal office has enough logistics, as well improved network situation which would make registration or enrolment/renewal for the poor-especially, the LEAP beneficiaries.

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APPENDIX 1
UNIVERSITY OF GHANA, LEGON

CENTRE FOR SOCIAL POLICY STUDIES

PATTERNS OF ENROLMENT AND USE OF NHIS BY LEAP BENEFICIARIES IN THE NEW JUABEN MUNICIPALITY

QUESTIONNAIRE FOR LEAP BENEFICIARIES (QUANTITATIVE ONLY)

John Awuku-Ahevi
Supervisor: Prof. Ellen Bortei-Doku Aryeetey

INFORMED CONSENT STATEMENT

This interview guide is designed to investigate the patterns of enrolment and use of National Health Insurance Scheme (NHIS) by LEAP beneficiaries. To examine this in-depth, the New Juaben Municipality of which you are part is being used for the study. This interview guide is to elicit your views on the enrolment patterns and the impact of the NHIS on you as a LEAP beneficiary. Questions are also asked about the challenges of enrolling in the NHIS. Please note that these are about your personal experience which will not be graded to affect you in any way. The interview is in three sections: the first section asks for demographic information about yourself. The second section is about your knowledge and use of NHIS. Section three asks about your perception about the challenges of enrolling in the NHIS. The entire study might take about ten (10) minutes of your time. **Be assured that, any and all information obtained from you during the study will be treated confidential, and would be used for the research purposes only.**

***Do you have any questions?* ....**

After your participation in the research you are still welcome to make any enquiries about this research (in that case, please contact the University of Ghana – Centre for Social Policy Study or awukutse@gmail.com – the researcher).

Please Sign here if you agree to be part of this interview: ………………………………..

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SECTION ONE

DEMOGRAPHIC INFORMATION

(1) Sex: O Male
O Female

(2)Age: …………Years

(3) Highest Level of completed Education:
- O No Formal Education
- O Basic/O Level Education
- O Secondary/A Level Educ.
- O Tertiary

(4) Years of Enrolment in LEAP

…………………Years

(5) What Work do you currently do?

……………………………………

(6) Marital Status:

- O Single
- O Married
- O Widow/Widower
- O Separated/Divorced

(7) Telephone:

…………………………………

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SECTION TWO

KNOWLEDGE & USE OF NHIS BY LEAP BENEFICIARIES

NHIS means National Health Insurance Scheme

LEAP means Livelihood Empowerment Against Poverty

Please rate the following according how much it applies to you where

1 = Strongly Disagree; 2 = Disagree; 3 = Not Sure

4= Agree; 5 = Strongly Agree;

No.	**Issues associated with the use of NHIS**					
1	As a LEAP beneficiary, you qualify for free NHIS	1	2	3	4	5
2	NHIS is to assist the orphans and vulnerable in society to get access to free basic health care.	1	2	3	4	5
3	Services provided by NHIS Health Service Providers are of good quality	1	2	3	4	5
4	Medicines dispensed by NHIS Health Service Providers are of high quality	1	2	3	4	5
5	Under the NHIS, children are given special attention	1	2	3	4	5
6	Under the NHIS, women (especially those who are pregnant) are given special attention	1	2	3	4	5
7	Under the NHIS, the aged are given special attention	1	2	3	4	5
8	Those who use NHIS are given prescription to buy medicines	1	2	3	4	5
9	Healthcare Services provision are unduly delayed to NHIS clients	1	2	3	4	5

SECTION THREE

Challenges of enrolment onto NHIS

Please rate the following according how much it applies to you where

1 = Strongly Disagree; 2 = Disagree; 3 = Not Sure

4= Agree; 5 = Strongly Agree;

No.	**Challenges associated with enrolment onto NHIS**					
	CONVENIENCE FACTORS					
1	The location of the District Health Insurance Office is far or not convenient	1	2	3	4	5
2	The District Health Insurance Office working hours are not convenient	1	2	3	4	5
3	The length of time for production and collection of Insurance card is not convenient	1	2	3	4	5
	COST FACTORS					
4	Some amount of money is demanded in order to get you enroled or your membership renewed	1	2	3	4	5
5	It cost me so much money to run up and down until I finally get my NHIS card	1	2	3	4	5
	STAFF ATTITUDE					
6	The NHIA staff do not have patience in talking to us during the enrolment process	1	2	3	4	5
7	The NHIA Staff unduly delay us in the office during enrolment process	1	2	3	4	5

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APPENDIX 2
UNIVERSITY OF GHANA, LEGON

CENTRE FOR SOCIAL POLICY STUDIES

PATTERNS OF ENROLMENT AND USE OF NHIS BY LEAP BENEFICIARIES IN THE NEW JUABEN MUNICIPALITY

INTERVIEW GUIDE FOR LEAP BENEFICIARIES (QUALITATIVE INCLUSIVE)

John Awuku-Ahevi
Supervisor: Prof. Ellen Bortei-Doku Aryeetey

INFORMED CONSENT STATEMENT

This interview guide is designed to investigate the patterns of enrolment and use of National Health Insurance Scheme (NHIS) by LEAP beneficiaries. To examine this in-depth, the New Juaben Municipality of which you are part is being used for the study. This interview guide is to elicit your views on the enrolment patterns and the impact of the NHIS on you as a LEAP beneficiary. Questions are also asked about the challenges of enroling in the NHIS. Please note that these are about your personal experience which will not be graded to affect you in any way. The interview is in four sections: the first section asks for demographic information about yourself. The second section is about your enrolment in LEAP and NHIS. The third section seeks your knowledge and use of NHIS. Section four asks about your perception about the challenges of enroling in the NHIS. The entire study might take about fifteen (15) minutes of your time. **Be assured that, any and all information obtained from you during the study will be treated confidential, and would be used for the research purposes only.**

***Do you have any questions?* ....**

After your participation in the research you are still welcome to make any enquiries about this research (in that case, please contact the University of Ghana – Centre for Social Policy Study or awukutse@gmail.com – the researcher).

Please Sign here if you agree to be part of this interview: ………………………………..

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SECTION ONE

DEMOGRAPHIC INFORMATION

(1) Sex: ○ Male
○Female

(2)Age: …………Years

(3) Highest Level of completed Education:
- ○ No Formal Education
- ○ Basic/O Level Education
- ○ Secondary/A Level Educ.
- ○ Tertiary

(4) Years of Enrolment in LEAP

…………………Years

(5) What Work do you currently do?

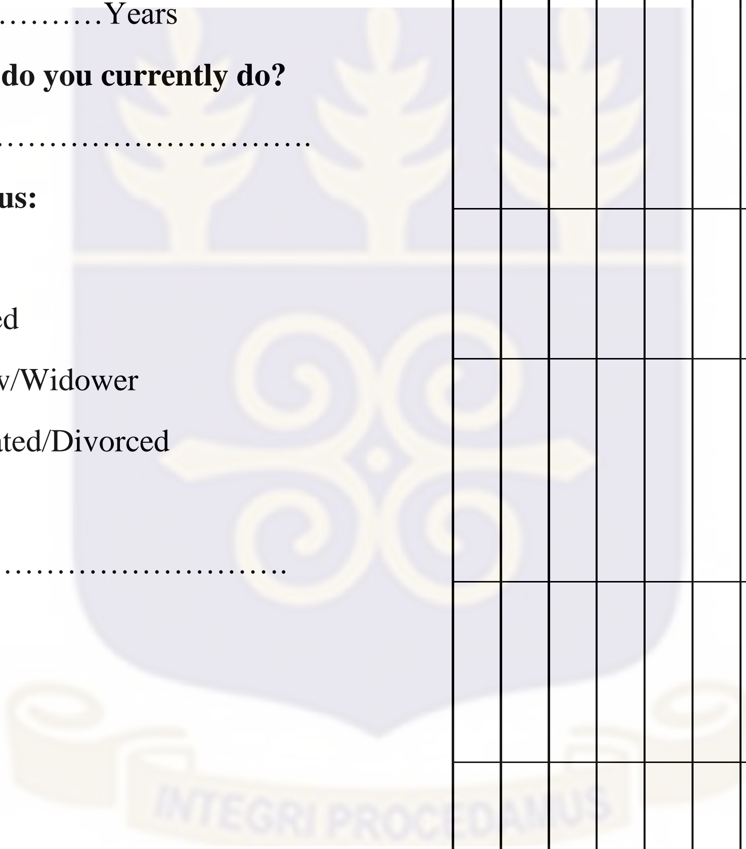
……………………………………

(6) Marital Status:

- ○ Single
- ○ Married
- ○ Widow/Widower
- ○ Separated/Divorced

(7) Telephone:

…………………………………



(8) HOUSEHOLD ROASTER

Please provide the following information on your household members who are on LEAP

SN	Sex	Age	Relation to Person	Level of Education	Currently in School?	Religion	Occupation	Enrolled in NHIS?	Renewed Membership in NHIS?
1									
2									
3									
4									
5									
6									

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SECTION TWO

ENROLMENT ONTO LEAP AND NHIS

1. In which year did you enrol onto LEAP? ………………………………

2. Were you asked by the LEAP Officials to enrol onto NHIS?

- O Yes
- O No

3. Are you enroled onto NHIS?

- O Yes
- O No

4. If yes to question 3, have you renewed your NHIS card?

- O Yes
- O No

5. If yes to question 3, please indicate the payment you made as part of the enrolment/Renewal?

- O Registration
- O ID card
- O Spoilt ID card replacement
- O Other (specify) ……………………..
- O No payment

6. How long did it take you to receive your card after registration? …………………….

7. Do you or any member of your household enroled onto the LEAP have any form of Disability?

- O Yes (If yes, then how many altogether? ………………)
- O No

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SECTION THREE

KNOWLEDGE & USE OF NHIS BY LEAP BENEFICIARIES

NHIS means National Health Insurance Scheme

LEAP means Livelihood Empowerment Against Poverty

Please rate the following according how much it applies to you where

1 = Strongly Disagree; 2 = Disagree; 3 = Not Sure

4= Agree; 5 = Strongly Agree;

No.	**Issues associated with the use of NHIS**					
1	As a LEAP beneficiary, you qualify for free NHIS	1	2	3	4	5
2	NHIS is to assist the orphans and vulnerable in society to get access to free basic health care.	1	2	3	4	5
3	Services provided by NHIS Health Service Providers are of good quality	1	2	3	4	5
4	Medicines dispensed by NHIS Health Service Providers are of high quality	1	2	3	4	5
5	Under the NHIS, children are given special attention	1	2	3	4	5
6	Under the NHIS, women (especially those who are pregnant) are given special attention	1	2	3	4	5
7	Under the NHIS, the aged are given special attention	1	2	3	4	5
8	Those who use NHIS are given prescription to buy medicines	1	2	3	4	5
9	Healthcare Services provision are unduly delayed to NHIS clients	1	2	3	4	5

10. Have you or any member of your household members used the NHIS card the last four weeks?

- ○ Yes
- ○ No

11. If yes to question10, who among the household members used it?

- ○ Male under 18 yrs.
- ○ Female under 18 yrs.
- ○Male adults
- ○Female adults
- ○Male Aged
- ○Female Aged

12. Please indicate the type of health facilities where you used your NHIS card

TYPE OF FACILITY	**RESPONSE**	
	YES	**NO**
GOVERNMENT		
PRIVATE		
TRADITIONAL		
NONE		
OTHER (SPECIFY) ………………………		

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13. Has membership of NHIS reduced out-of-pocket expenses for health in your household?

- ○ Yes
- ○ No

14. How much out-of-pocket did you incur on you last hospital visit where you used your NHIS card? ……………………….

15. Date last visited health facility with NHIS card

Month: ………..

Year: ………….

16. List all out-of -pocket expenses associated with your last hospital visit

ITEM/SERVICE	APPROXIMATE AMT (GH¢)
Outpatient Consultation	
Lab	
X-ray	
Drugs	
Inpatient	
Tips to Hospital Staff	
Roundtrip Transport	
Food	
Others (specify)	

17. Indicate the types of health problems for which you used your NHIS card?

HEALTH PROBLEM	RESPONSE	
	YES	NO
Medical examination		
Fever		
Serious pain		
Hospitalization (inpatient)		
Surgery		
None		
Other (Specify)…………		

18. When you are sick where do you first seek treatment?

- ○ Self-Medication
- ○ Traditional

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○ Public Health Facility

○ Private Health Facility

○ Prayer Camp

○ Other (Specify)

19. After the first place where do you seek treatment?

○ Self-Medication

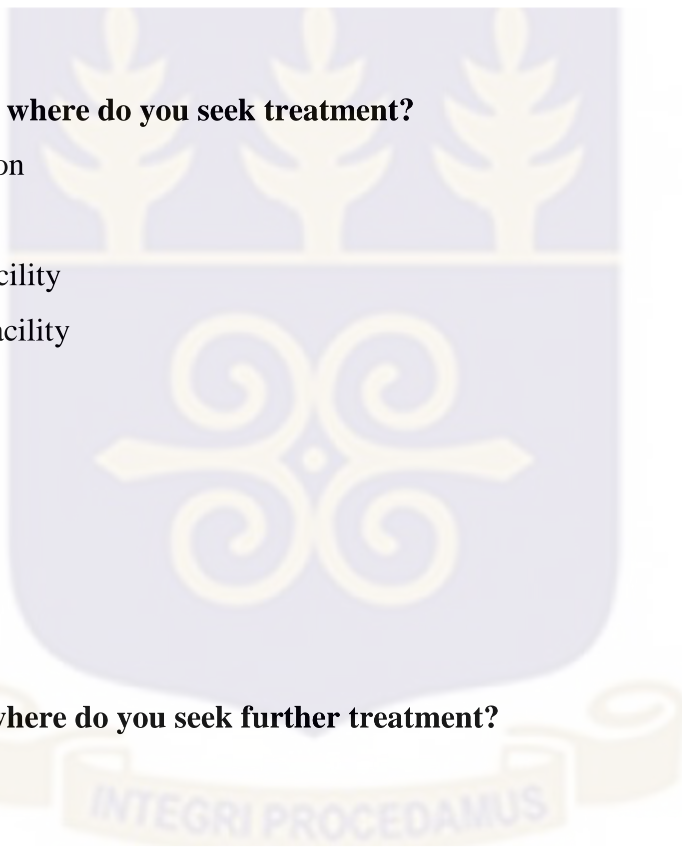
○ Traditional

○ Public Health Facility

○ Private Health Facility

○ Prayer Camp

○ Other (Specify)



20. After the second place where do you seek treatment?

○ ○ Self-Medication

○ Traditional

○ Public Health Facility

○ Private Health Facility

○ Prayer Camp

○ Other (Specify)

21. After the third place where do you seek further treatment?

○ Self-Medication

○ Traditional

○ Public Health Facility

○ Private Health Facility

○ Prayer Camp

○ Other (Specify)

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SECTION FOUR

Challenges of enrolment onto NHIS

Please rate the following according how much it applies to you where

1 = Strongly Disagree; 2 = Disagree; 3 = Not Sure

4= Agree; 5 = Strongly Agree;

No.	**Challenges associated with enrolment onto NHIS**					
	CONVENIENCE FACTORS					
1	The location of the District Health Insurance Office is far or not convenient	1	2	3	4	5
2	The District Health Insurance Office working hours are not convenient	1	2	3	4	5
3	The length of time for production and collection of Insurance card is not convenient	1	2	3	4	5
	COST FACTORS					
4	Some amount of money is demanded in order to get you enroled or your membership renewed	1	2	3	4	5
5	It cost me so much money to run up and down until I finally get my NHIS card	1	2	3	4	5
	STAFF ATTITUDE					
6	The NHIA staff do not have patience in talking to us during the enrolment process	1	2	3	4	5
7	The NHIA Staff unduly delay us in the office during enrolment process	1	2	3	4	5

8. Have you ever delayed in renewing your card or the card of any member of your household?

- O Yes
- O No

9. If yes to question 8, explain what happened.

………………………………………………………………………………………..

………………………………………………………………………………………..

10. If yes to question 8, did the LEAP officials suspend your grant?

- O Yes
- O No

11. Have you ever been told to renew your card by the LEAP Official?

- O Yes
- O No

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12. Do you know anybody whose grant was suspended because of failure to renew the NHIS card?

- ○ Yes
- ○ No

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APPENDIX 3
UNIVERSITY OF GHANA, LEGON

CENTRE FOR SOCIAL POLICY STUDIES

PATTERNS OF ENROLMENT AND USE OF NHIS BY LEAP BENEFICIARIES IN THE NEW JUABEN MUNICIPALITY

INTERVIEW GUIDE FOR NHIA STAFF AT THE DISTRICT OFFICE

John Awuku-Ahevi
Supervisor: Prof. Ellen Bortei-Doku Aryeetey

INFORMED CONSENT STATEMENT

This interview is designed to investigate the patterns of enrolment and use of National Health Insurance Scheme (NHIS) by LEAP beneficiaries. To examine this in-depth, the New Juaben Municipality of which you are part is being used for the study. The interview guide asks questions concerning the enrolment patterns and the impact of the NHIS on the LEAP beneficiaries. Moreover, it asks questions about the challenges of enroling the LEAP beneficiaries onto the NHIS. Please note that these are about your personal experience which will not be graded to affect you in any way. The interview is in three sections: the first section asks about some demographic information about yourself. The second section seeks your view on enrolment onto NHIS and its operational challenges. The third section also seeks your knowledge on the use of NHIS by the LEAP beneficiaries. The entire study might take about fifteen (15) minutes of your time. **Be assured that, any and all information obtained from you during the study will be treated confidential, and would be used for the research purposes only.**

Do you have any questions? ....

After your participation in the research you are still welcome to make any enquiries about this research (in that case, please contact the University of Ghana – Centre for Social Policy Study or awukutse@gmail.com – the researcher).

Please Sign here if you agree to be part of this Research: ………………………………..

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SECTION ONE

DEMOGRAPHIC INFORMATION

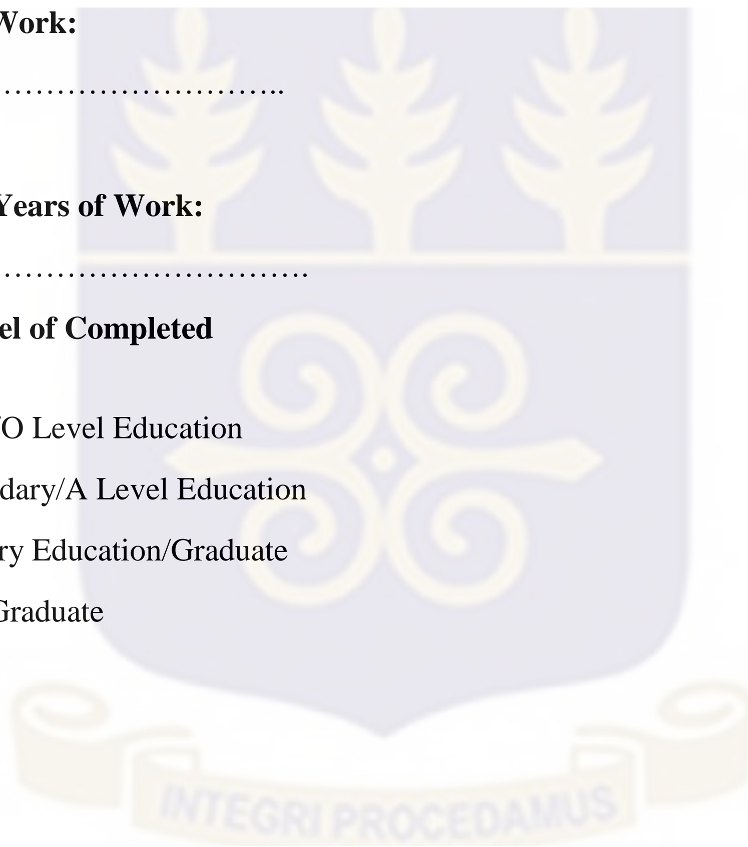
(1) Sex: ○ Male
○Female

(2)Age: ……………..Years

(3) Occupation:

………………………………………

(4) Position at Work:



…………………………………………..

(5) Number of Years of Work:

…………………………………………….

(6) Highest Level of Completed Education:

○ Basic/O Level Education

○ Secondary/A Level Education

○ Tertiary Education/Graduate

○ Post-Graduate

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SECTION TWO

ENROLMENT ONTO NHIS & OPERATIONAL CHALLENGES

1. In a LEAP household do you enrol all the members of the household and grant them the exemption or do you only enrol and grant exemption to members with LEAP eligibility criteria? (OVC, PWD, AGED 65 year and over)

……………………………………………………………………………………………

……………………………………………………………………………………………

2. Indicate the procedures and processes used for the enrolment or renewal of LEAP beneficiaries?

……………………………………………………………………………………………

……………………………………………………………………………………………

……………………………………………………………………………………………

………………………………………

3. What information is given to LEAP beneficiaries before enrolment?

……………………………………………………………………………………………

……………………………………………………………………………………………

……………………………………………………………………………………………

………………………………………

4. How many weeks after registration does it take for a person to receive a card?

……………………………………………………………………………………………

5. Apart from your office, how many other registration or renewal centres are there in your district?

Number of other centres …………………

6. If your office is the only Centre, how do you reach out to those who cannot make it to the office?

……………………………………………………………………………………………

……………………………………………………………………………………………

8. What payments do LEAP beneficiaries in your district have to make in order to receive NHIS support?

- O Premium
- O Processing fee

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- (Other specify …………………………….)
- No payment

9. List the logistics you need to enable you register LEAP beneficiaries

…………………………………………………………………………………………………..
…………………………………………………………………………………………………
…………………………………………………………………………………………………

10. Indicate the logistics that you have an adequate supply of, for registering LEAP beneficiaries.

…………………………………………………………………………………………………
…………………………………………………………………………………………………
…………………………………………………………………………………………………

11. Indicate the logistics that you do not have an adequate supply of, for registering LEAP beneficiaries.

…………………………………………………………………………………………………
…………………………………………………………………………………………………
…………………………………………………………………………………………………

12. What are the administrative and operational bottlenecks associated with enrolment of LEAP beneficiaries onto the NHIS?

…………………………………………………………………………………………………
…………………………………………………………………………………………………
…………………………

13. What steps should the NHIA take to improve the enrolment of LEAP beneficiaries?

…………………………………………………………………………………………………
…………………………………………………………………………………………………
…………………………
…………………………………………………………………………………………………
……………

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SECTION THREE

USE OF NHIS BY LEAP BENEFICIARIES

1. **How would you describe the pattern of use of the average LEAP beneficiary?**

………………………………………………………………………………….

2. **What do you think makes it possible for some leap beneficiaries use NHIS when they are ill?**

……………………………………………………………………………………………
……………………………………………………………………………………………
…………………………

3. What do you think makes it difficult for some leap beneficiaries use NHIS when they are ill?

……………………………………………………………………………………………
……………………………………………………………………………………………
…………………………

4. What do you know about the health seeking behaviour of leap beneficiaries on NHIS?

……………………………………………………………………………………………
…………………………………………………………………………………………….

5. What is your source of information about the health seeking behaviour of LEAP beneficiaries?

……………………………………………………………………………………………
……………………………………………………………………………………………
…………………………

6. What channel of communication do you have for getting feedback from the beneficiaries about their use of NHIS at the health facility?

……………………………………………………………………………………………
……………………………………………………………………………………………
………………………..

7. What channel of communication do you have with the health facilities to give them feedback on beneficiaries view about treatment of NHIS card holders at the health facility?

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……………………………………………………………………………………………
……………………………………………………………………………………………
…………………………

8. What steps should the Ministry of Health take to improve the quality of service NHIS card holders receive from healthcare facilities?

……………………………………………………………………………………………
……………………………………………………………………………………………
…………………………

9. What steps should the Ghana Health Service take to improve the quality of service NHIS card holders receive from healthcare facilities?

……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………

10. What steps should the Ministry of Gender, Children and Social Protection take to improve the quality of service NHIS card holders receive from healthcare facilities?

……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………