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Global Social Welfare and Social Policy Debates: Ghana's Health Insurance Scheme Promotion of the Well-Being of Vulnerable Groups

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ABSTRACT

This article analyses social welfare, social policy with individualist and collectivist theoretical perspectives. It discusses the well-being of vulnerable groups and their access to social services including healthcare in the implementation of the National Health Insurance Scheme (NHIS) in Ghana. The aim is to find out the extent of vulnerable groups enrollment and if their welfare and well-being have improved in the implementation of Ghana's health insurance scheme. Also, it examines whether NHIS is a pro-poor social intervention program or not. Data sources include census data, documents from health insurance authority, in-depth interviews, focus group discussions, direct observations at social service delivery points. Purposive, cluster and snowball sampling techniques are used to select participants. The sample size is 107 participants with 12 months of intensive data collection in three phases from 2012, 2013 and ended on October 2014. Results show more vulnerable groups are enrolled in NHIS compared with contributors. This suggests people who do not pay annual premiums constituted most health insurance subscribers. Also, the results show health insurance covered 38% of Ghana's population for the 10 years of implementation of NHIS (2004–2013). Despite the progressive increase in coverage of NHIS, there are still some implementation challenges. The research found certain behaviors, practices, and attitudes of some social service providers as inhibiting subscribers' enrollment. Future research may focus on social intervention programs for vulnerable groups across states.

KEYWORDS

Health insurance scheme; social policy; social services; social welfare; vulnerable groups; well-being

Introduction

The article focuses on healthcare welfare provision and starts with individualist and collectivist theoretical perspectives of welfare from developed world context. It also contributes to social policy debates with social policy theorists' arguments for universalism, particularism or a combination of the two (reconciling universalism with particularism) from a global context to an African context of social policy.

The article presents evidence on the National Health Insurance Scheme (NHIS) efforts toward the promotion of the well-being of vulnerable groups in Ghana. In this research, vulnerable groups refer to "categories of persons exempted from payment of contributions"- that is those exempted from payment of health insurance annual premium (Government of Ghana, 2012, p. 19). These vulnerable groups include "indigent persons" (core poor in society) as "classified" by social welfare minister/department, persons with mental disorders, children less than 18 years, elderly (older) persons above 70 years, pensioners of Social Security and National Insurance Trust (SSNIT), pregnant women- seeking ante-natal, delivery and post-natal healthcare services (Government of Ghana, 2003, 2004, 2012). This research investigates the problem of whether NHIS is enrolling and meeting the social/healthcare needs of the vulnerable groups in Ghana or not. Thus, the justification for the conduct of this study.

Welfare Provision: Individualist and Collectivist Theory of Welfare

Social welfare is defined as "a condition or state of human well-being that exists when people's

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needs are met, problems are managed, and opportunities are maximized." The opposite of social welfare is social ill fare (Midgley, 2008, p. 6). This conception of social welfare is quite narrow as it limits social welfare to a particularistic perspective (meeting social and healthcare needs of the poor, needy or vulnerable people). In a broader meaning, social welfare involves "well-being for all people and indeed for society as a whole" (Midgley, 2008). The term "welfare" refers to "happiness, prosperity, and well-being in general" of people in terms of health and contentment (Heywood, 2004, p. 303). Also, if welfare provision is based on needs, rights or desserts that are "socially constructed as deserving poor or needy; citizens" rights; or entitlements respectively. There are two theoretical perspectives on social welfare provision: individualist and collectivist.

The collectivist theory of welfare is also known as the "welfare states" which seeks to secure the basic level of equal well-being of all citizens through the provision of basic needs such as food, shelter, and healthcare. The collectivist principle of welfare is that the government through the state has a responsibility to promote or improve the social well-being of its people (citizens). In this regard, states set up social welfare institutions to carry out social responsibility in improving the general well-being of all citizens through the provision of social welfare services including healthcare services.

The individualist theory of welfare postulates the general well-being of citizens, which is a result of individuals "pursuit of self-interest, regulated by the market" (Heywood, 2004). Other social theorists seek a balance between collectivism and individualism. They base their argument on the recognition that citizens have both "welfare rights and moral responsibilities" toward welfare provision. These scholars constitute the "third-way" welfare thinkers (Heywood, 2004, p. 304). It is important to note that all welfare services or programs aimed at addressing poverty reduction. In developing countries including Africa, there are welfare programs in education, health, pensions, social services in place in tackling the chronic issue or the problem of poverty.

Debates on Social Policy

The social policy involves programs of governments or charity organizations that affect the welfare of people in society. The social policy seeks to enhance the living conditions of people or to improve the social well-being of people (Midgley, 2008). It involves the provision of a wide range of community facilities and safeguards, provision of social amenities, social services including healthcare to individuals or groups. Thus, social policy is seen to be beneficent, redistributive or otherwise (Titmuss, 1974). While some social policy theorists argue in favor of universalism, others are for particularism or combination or reconciling. Proponents of universalism argue for "greater social justice and equality," "fair" allocation or distribution of social services to mitigate the inegalitarian effects of market forces (Ellison, 1999, p. 59). Universalism seeks to apply the same rule or standard to all individuals in the determination of eligible persons and allocation of resources or benefits. Particularism on another hand seeks to apply different standards in different ways or circumstances for different individuals eligible for social services including healthcare or welfare benefits. Particularism emphasizes or demands recognition for difference, fragmentation, diversity, and pluralism in need, interest, identity, and experience et cetera. While the mainstream tradition of social policy gives priority to universalism, postmodernists stress "fragmentation and difference" toward particularism (Ellison, 1999, p. 59; Thompson & Hoggett, 1996). Other social theorists seek a combination of the two perspectives. These scholars argue that contemporary social policy can merge universalism with particularism and merge equality/egalitarian with diversity. Hence, the divide between universalism and particularism is "misconceived" (Thompson & Hoggett, 1996). Thus, make healthcare services available to all and meeting the healthcare needs of a particular group of persons ("special services" for "disadvantaged" ones (Fuller, 1997, p. 153; Kipo-Sunyehzi, Ayanore, Dzidzonu, & Yakubu, 2019). The blend of the two is the bedrock of multi-cultural healthcare services provision (Taylor, 1994).

Social Policy in an African Context

Social policies in developing countries, including Africa in the 1960s and 1970s assume some "universalistic" forms like free health care, free education, and subsidized food policies. However, these countries experienced a shift in social policies toward "targeting" in the 1980s and 1990s. The shift in the 1980s and 1990s is believed to be "conditioned by the context of macroeconomic and aid policies" with the central aim of addressing poverty. Ideological factors also account for the shift due to domestic and external pressures (Mkandawire, 2005). Social policy is for economic welfare, equity and social justice of all "members of society".

The African Union (AU) Social Policy Framework for Africa sees social policy with "guiding principles" like human rights, advancing society well-being and the participation of beneficiaries and recipients in social policy decision making. The AU social policy framework puts emphasis on poverty alleviation, disadvantaged groups' well-being, improvement of living standards of all and the reduction of inequalities in member states (African Union, 2008). Non-Governmental Organizations like HelpAge International hailed the Social Policy Framework for Africa and described it as "historic" as it seeks to meet the basic needs of the aged, vulnerable and marginalized groups in Africa (HelpAge International, 2008). Wright and Noble (2010) on social policy in the context of Africa emphasized the importance of "social security as a form of social protection." Adesina (2007) looked at social policy in the sub-Saharan African context and conceptualized it as the public efforts made at promoting and "protecting the well-being of people" in a country. The next section is on social policy (NHIS efforts toward the promotion of the well-being of subscribers).

Literature Review

Ghana's Health Insurance Scheme in the Context of Vulnerable Groups

The Act of Parliament of Ghana (Act 560) established the National Health Insurance Scheme (NHIS) in 2003 with the aim to secure the provision of basic social or healthcare services to persons resident in Ghana. In pursuit of that, the Act made provision for a certain group of persons to be exempted from payment of annual premium. Section 38 prescribes "indigent members"- poor persons through a means test to be exempted to have access to basic healthcare services (Government of Ghana, 2003, p. 12). The new Act (914), passed in 2012 under section 29 expanded the "categories of persons exempted from the payment of contributions" (annual premium) to include children and those below 18 years, persons in need of ante-natal, delivery and post-natal services, the aged (more than 70 years), pensioners of the Social· Security and National Insurance Trust (SSNIT), persons with mental disorder, disabled persons or categories of differently-abled persons determined by the Minister for Social Welfare (Government of Ghana, 2012, p. 19). Persons with a mental disorder are included in NHIS exempted groups (as vulnerable ones) and is part of the implementation of the mental health law in Ghana. Both provisions aim to improve the healthcare conditions and offer social protection for persons with a mental disorder (Walker & Osei, 2017). NHIS exemption list applied to some prisoners and persons like children in social welfare homes or orphanages – "residential care homes" (Manful, Umoh, & Abdullah, 2019, p. 1) or "children in residential care" in Ghana where there is professional relationship with children rather than parental (Manful, Takyi, & Gambrah, 2015). Thus, NHIS per its laws and regulations provided an insurance cover for most vulnerable groups in Ghana (Government of Ghana, 2003, 2004, 2012). Vulnerable groups or vulnerable people and "vulnerability" is connected to the "notions of need, risk, susceptibility to harm or neglect, or lacking durability or capability." Furthermore, there can be the vulnerability of people based on their age, sex, race or ethnicity and or vulnerability based on social status or access to resources (Mechanic & Tanner, 2007, p. 1221). Per the NHIS laws in Ghana, vulnerable groups are those persons exempted from payments of the annual premium. The rationale is to increase their access to social services- healthcare services in all accredited public and private health facilities

(hospitals, clinics, diagnostic centers, and pharmacies) across Ghana.

Vulnerable groups are seen to be more susceptible to harm or neglect in society due to their social status or age. It may also be due to the nexus between their financial mobilization and their capacity to deal with some societal challenges they are faced with, such as access to healthcare or social services in Ghana. The framers of Ghana's health insurance scheme identify "indigent persons" as persons who are poor, homeless, incapable to take care of themselves in terms of feeding, clothing and or shelter. Their vulnerability may be associated with their disadvantage positions or their personal incapacities and societal perceptions for them based on societal norms, values or mores (Government of Ghana, 2003, 2004).

Since the NHIS laws and regulations made special provisions for vulnerable groups in Ghana, it is expected that more vulnerable groups will be enrolled in NHIS to secure access to basic health care services. To make the NHIS a pro-poor and friendly social policy, it should seek the well-being of the poor and vulnerable ones in Ghanaian society. Several studies have been done on the level of coverage of NHIS on vulnerable groups in Ghana. Some studies identified NHIS in Ghana as "not pro-poor" in terms of enrollment of more vulnerable groups (Apoya & Marriott, 2011; Averill, 2013; Sarpong et al., 2010). Some findings show that NHIS exemptions are applied in "favor of under-fives, antenatal care, the aged and public servants to the disadvantage of the poor" (Derbile & van der Geest, 2012, p. 586). Also, studies in Ghana on the implementation of NHIS found unequal enrollment and the lowest rate of enrollment was among vulnerable groups of the "poorest socio-economic quintiles than the richest" (Jehu-Appiah et al., 2011). Moreover, some empirical findings or studies suggest that NHIS is not friendly to the poor in Ghanaian society in terms of their access to healthcare services due to some socio-economic conditions and political factors such as "over politicization and political interference" in the implementation process of NHIS (Fusheini, 2016).

Also, other scholarly works or studies attributed the inadequate access to healthcare services for vulnerable groups to some "bad attitude" of some health service providers, "certain bad practices" at accredited pharmacies, hospitals, clinics- service delivery points. Such negative attitudes are more in the public sector (Kipo, 2011, p. 108; Kipo-Sunyehzi, 2018, p. 68). The bad attitudes from the studies are linked to some behaviors, attitudes, actions, and acts that are exhibited by the social service providers such as clinicians-physicians, physician assistants, nurses, midwives, pharmacists during social service provision. Some health insurance subscribers also complained of insults, shouts, and the use of unpleasant words. Similar studies found "bad attitudes" of health workers toward some clients (Andersen, 2004, p. 2003) and unequal status among clients, where some clients or "patients are more equal than others" with "differential treatment" (Atinga, Bawole, & Nang-Beifubah, 2016). Other negative practices like the use of "foul language" toward clients especially the poor ones during healthcare or social services delivery in a public hospital in Ghana. It found differential treatments for clients, based on social status, sociocultural and bureaucratic norms, practices. The findings show the clients who are called "villagers" received lower services or less attention while non-villagers received good, high standard care (Andersen, 2004). These research findings suggest some forms of discrimination still exist among clients seeking social services at health facilities due to the socio-economic status of clients. Such practices at social service delivery points in Ghana defeat the global call for equal treatment for all people (World Health Organization (WHO), 2007).

On the other hand, the NHIS is seen as one of the biggest social intervention policies in Ghana in terms of addressing poverty. In this regard, the government touted it as an essential part of the overall poverty reduction strategy (Fusheini, Marnoch, & Gray, 2017; McIntyre et al., 2008; Ministry of Health, 2014). The Ministry of Health (MoH) report indicates most clients (two-thirds) that visit healthcare facilities (hospitals, clinics among others) to access social healthcare services belong to exempt groups (vulnerable

Table 1. Research participants, social service delivery points and location.

Categories of participants	Social Service Delivery Points	Location	Number
Health service providers	Hospitals, Clinics	Tamale	26
Health Insurance Subscribers	Hospitals, Clinics	Tamale	47
Health insurance officials	National, Regional, District	Accra, Tamale	4
Health Insurance Subscribers	district health insurance office	Tamale	5
Department of Social Welfare (DSW) & other stakeholders	Department of Social Welfare Nyohini Children Home	Accra, Tamale Nyohini	7
Community-level-Focus Groups Discussions with health insurance subscribers	Community/homes of health insurance subscribers	Moshie-Zongo, Lamashegu, KalpohinEstate	18
Total Sample Size 107			

groups). The increasing numbers of exempt groups imply that more money is allocated to subsidize and reimburse health service providers for the healthcare services provided to vulnerable groups. Moreover, vulnerable groups have free access to a wide range of healthcare services across Ghana under NHIS (Ministry of Health, 2014). This MoH report implies that NHIS has increased vulnerable groups' access to healthcare services in Ghana. But the report admitted to the challenges of financing NHIS due to the increasing numbers of vulnerable groups (exempt groups) being enrolled in NHIS. Agyepong and Nagai (2011) work show vulnerable groups (children under five years) have been protected from the negative effects of "user-fees." But they found a big challenge of "provider reluctance to provide exemptions" to clients-under five years (Agyepong & Nagai, 2011, p. 232). The current exemptions protect the vulnerable groups in the implementation of NHIS. Witter, Adjei, Armar-Klemesu, and Graham (2009) confirmed that pregnant women irrespective of their positions benefit from NHIS free maternal healthcare. Similar findings on Ghana's health insurance show it has good social protection as well as coverage for pregnant women ("maternal healthcare utilization") since 2008. Moreover, NHIS enhanced facility visits, checkups for maternal healthcare (Wang, Temsah, & Mallick, 2017). Hence, NHIS is beneficial for all especially the poor since its "exemptions policy" started in 2004 in Ghana (Witter et al., 2009, p. 1).

Research Aim and Questions

The main aim of this research is to examine the extent to which national health insurance scheme (NHIS) has contributed toward enrollment of vulnerable groups into NHIS in Ghana in terms of the promotion of their well-being and access to social services including healthcare services. In this regard three specific questions were asked:

1. Is NHIS a pro-poor social intervention policy in Ghana?
2. Is NHIS enrolling all the vulnerable groups in Ghana?
3. How and why do exempt group members join the NHIS?

Methods

Sample

The study took place in Tamale, which is the biggest city in Northern Ghana. Tamale Metropolis was chosen because it is the most densely populated city. Moreover, it has the highest number of health facilities in the implementation of NHIS. The population of Tamale Metropolis in 2010 was 371,351 (Ghana Statistical Service, 2012, p.10). One hundred and seven (107) participants were involved in the study and participants were selected from public and private sectors at three levels: national, regional and local. The officials are health insurance, health service providers, social workers, and other key stakeholders (see Table 1).

The selection of research participants was based on the categories of exempt groups (vulnerable groups) for similarities and differences using a semi-structured interview guide. The participants were selected through the "purposive sampling" method (Bryman, 2012, p. 416). This method aims to reach out to a wide range of people with relevant knowledge of the research questions. Also, the purposive sampling method allows for "analytical generalizations" of findings

by comparing a case study results in a previously developed theory (Yin, 2014). In doing so, the article used "sampling of context" in which three "contrasting residential" locations were selected based 2010 Ghana population and housing census data. The criteria used are based on the socio-economic status of people in the location which were categorized into the low, middle, and upper representing Moshie-Zongo, Lamashegu, and Kalpohin Estate respectively (Ghana Statistical Service, 2014). Three focus group discussions (FGDs) took place in the three communities in Tamale Metropolis. There were also four FGDs at each of the four selected health service providers (hospitals and clinics) on the public-private basis for comparability of the four cases. The FGDs involved subscribers. The criteria used in the selection of the four health service providers is based on their duration and the number of health services they provide to health insurance subscribers. This research duration is operationalized as more than 10 years in the provision of social healthcare services in Tamale Metropolis of Ghana.

The article also utilized what Bryman (2012, p. 417) called the "sampling of participants" within the three locations: home setting, hospitals, and clinics setting, scheme setting. Moreover, the study utilized other sampling techniques like cluster sampling and snowball. The cluster sampling technique helped to get all the categories of NHIS subscribers especially the vulnerable groups (exempt groups) like the poor, needy, beggars, those with mental disorders, children in orphanages and institutionalized homes. Other participants were later identified and interviewed who were not initially part (snowball). The age and the gender of participants are important and considered in-depth interviews and FGDs. In all 107 persons were interviewed for a period of 12 months. The data collection was structured in three stages, the first stage was two (2) months in 2012, the second stage was for six (6) months in 2013 and the final stage was for four (4) months which ended on October 2014 in the Tamale Metropolis of Ghana.

Research Design

The study utilized a qualitative comparative case study design (Yin, 2014). Qualitative research design allows participants to share their views, opinions, and perspectives on the implementation of NHIS. The qualitative research design helped examine issues concerning subscribers particularly vulnerable groups' well-being, welfare and their access to social services like healthcare services. Qualitative research questions are framed in terms of "words" and utilize the "open-ended" questions. But some statistics (figures) are used to complement the largely qualitative data sources (Bryman, 2012; p. 380; Creswell, 2009, p. 2; King, Keohane, & Verba, 1994, p. 3–4). In this article, open-ended questions were used to address the three main research questions. This research design enabled the participants to freely share their views, opinions, and experiences on social service delivery at the three social service delivery points (hospitals, clinics, and health insurance office). Thus, a comparative case study design was adopted to enable the participants to share their views, perspectives, and experiences on service providers on the implementation of NHIS in the Tamale Metropolis of Ghana. Also, the choice of comparative case study approach allows for comparison between public and private sector social service providers. In this regard, the article examines the kind of social services like healthcare services that the health insurance subscribers (clients) received at the three social service delivery points.

Instrument Used

The main instrument used in this research is a semi-structured interview guide. It has two sets of questions, one for implementers (like health service providers-hospitals, clinics, health insurance office) the other for beneficiaries (health insurance subscribers). The purpose is for each group to share their views, opinions, and experiences on whether NHIS has improved their well-being or not, whether they have access to social services like healthcare services or not. Also, to find out their view on the question of whether NHIS is a pro-poor social intervention policy or not? Whether NHIS is friendly to vulnerable groups or not. Moreover, to find out if NHIS has reduced out of pocket payments or not. To examine issues of payments for diagnostic tests, payments for drugs and services and payments

for social services provision at health insurance offices. In addition, to find out why subscribers join the NHIS, whether they renew their annual membership of NHIS or not. These questions/issues aim to answer the three main research questions toward the study objective. The researcher used probing questions during interviews, the interviews lasted 30–60 minutes, in some circumstance's it exceeded an hour. Most interviews were audio-recorded but those participants who objected to this, the researcher and the research assistants used field notes.

Procedures

Two research assistants were trained to assist the researcher on how to use the interview guide for in-depth interviews and FGDs at facilities levels (hospitals and clinics) and homes of participants at the community level. The trained research assistants used in data collection were tertiary students. The included criteria are persons who registered for the National Health Insurance Scheme (NHIS) in Ghana while non-registered persons are excluded from the research.

The researcher first sought for the informed consent of each participant. For participants below 18 years, parental permission was sought, the parents or guardians voluntarily signed on their behalf to participate. Participation was voluntary, issues of privacy, confidentiality, anonymity, were adhered to in the conduct of social science research (Creswell, 2009). Other ethical issues like institutional permission were sought from Ghana Health Service (GHS) and the National Health Insurance Authority (NHIA). These were granted which enabled the researcher and the assistants to use their facilities and offices. Some relevant documents: annual reports, attendance, claims forms, and other secondary data were obtained. In addition, some direct observations were made during social service delivery between health service providers/health insurance offices and health insurance subscribers.

Addressing Issues of Validity and Reliability

To address these issues, this article adopted two criteria for assessing and establishing the quality of qualitative research in terms of "trustworthiness and authenticity" (Bryman, 2012; Guba & Lincoln, 1994). This was achieved through triangulation of data to build themes and sub-themes and diverse participants' perspectives; this was one validity measure used to deal with bias. The three periods of data collection helped the researcher to utilized "member-checking" as an effective way of participants verifying the accuracy of the earlier findings or data gathered at the second stage. Another validity strategy is "rich, thick description" of study findings (Creswell, 2009). This was possible due to the extensive and longer period spent in data collection in the field. For the reliability of the findings, there was interview transcription, as well as translation with expert's assistance.

Data Analysis

The research dependent and independent variables were analyzed through "content analysis" and "thematic analysis"- major/sub-themes (Bryman, 2012, 2016; Creswell, 2009). Fieldnotes were typed out, interview recordings, discussions transcribed and manually analyzed along with themes. The article examines how four factors affect the effective implementation of NHIS. The dependent variable is operationalized as the promotion of vulnerable groups' well-being and their access to social services (healthcare services). The research analytical framework shows the relationship between the independent variables (inputs) and the dependent variables (outputs) (see Figure 1).

Results

Coverage of NHIS for All Vulnerable Groups in Ghana

The article tried to solicit the views of health service providers and subscribers on enrollments. The strategies used in getting many vulnerable groups enrolled in NHIS. The questions aimed to find out if the NHIS is enrolling all the exempt groups or not and why. Five health insurance subscribers shared their views on the services

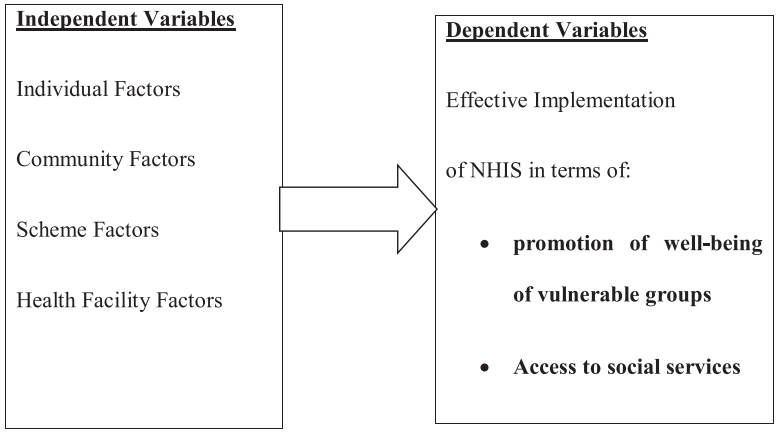

Figure 1. Analytical framework.

they received at the district health insurance office.

A pregnant woman shared her views on the registration process at the health scheme office in Tamale:

> I am surprised that my colleague woman is the officer doing the registration, but she does not mind or give priority to pregnant women, we have been sitting here for hours. (Health Insurance Subscribers (HIS), vulnerable group member)

A sixteen-year student of Business Secondary School in Tamale shared her views on the registration process at the health insurance office in Tamale. This was what she said:

> There is so much delay in registration, there is a long queue and if you don't know someone here you will spend the whole day. I spent more than two hours and I am still here. The process is slow, and I am really discouraged with the services. My worry is if I don't register today, I will not get exeat to come here again. (HIS, vulnerable group member)

An indigent person at the health insurance office also shared his views on enrollment into NHIS:

> I have always desire to get a health insurance card but who will send me there and who will pay for me. It was one meeting in Tishigu that they asked us to give our names to be registered. I did not pay any money. The social welfare people called for the meeting. Since then when I go to the central hospital, I don't pay money because of health insurance. It is a very good program for us. (HIS, vulnerable group member)

Four out of five subscribers expressed their frustrations in the registration process at the district health insurance office. The responses showed the registration process is inhibiting more subscribers including vulnerable groups from registration and renewals of their membership cards for NHIS.

On the question of whether NHIS is enrolling all vulnerable groups in Ghana, interview results show that the NHIS is doing well in getting many vulnerable groups into NHIS through these strategies. The health insurance offices across Ghana collaborate with the Department of Social Welfare (DSW) to identify and enroll "indigent persons"-the core poor into NHIS. In this regard, beneficiaries of Livelihood Empowerment Against Poverty (LEAP) programs in Ghana are enrolled in NHIS. Enrollment extends to beggars in the street, some prisoners, homeless people and those in orphanages and children's homes. Interview responses at the Nyohini Children Home confirmed partnership between DSW and NHIS offices toward enrollment of poor into NHIS. This was what a social welfare official at the Department of Social Welfare in Tamale said:

> The Department of Social Welfare everywhere in Ghana work hand in hand with health insurance officials to get more of the needy and the poor ones into health insurance. It is our duty to assist and make health insurance a success story in Ghana. (Official, Department of Social Welfare (DSW)

There are interviews with Health Service Providers (HSP) at the two hospitals and two clinics on some factors that facilitate or inhibit the implementation of NHIS in terms of subscribers' access to healthcare services. In this regard twenty-six (26) HSPs were interviewed

Table 2. Coverage of NHIS for all Vulnerable Groups in Ghana.

	Levels of NHIS coverage for vulnerable groups		
Years	National (%)	Regional (%)	Local (%)
2010	63.5	74.1	64.4
2011	59.1	74.6	63.5
2012	60.4	86.4	68.7
2013	62.6	78.5	69.0
2014	62.6	–	–

Source: NHIS Annual Reports, 2009–2013.

(see Table 1). From the implementers' view, these factors are identified as the facilitating factors: lump-sum payments of claims for services rendered to subscribers, public-private sector collaboration in terms of referrals and prescriptions, regular reviews of NHIS tariffs and cooperation with health insurance offices for submissions and payments of claims through banks checks. The HSPs identified the slow pace of payments of claims as to the biggest setback/impediment on implementation of NHIS. The financial officer of the private hospital said this on the implementation of NHIS:

> Our main source of revenue is NHIS followed by cash and carry and other sources including those from Church Organisations, NGOs, foreign donors, and individuals. (Private health service provider (HSP)

The public hospital counterpart has this to say on the implementation of NHIS:

> We get our finances largely from health insurance, second source cash and carry as IGFs, then from the government of Ghana and other sources. (Public HSP).

The private clinic administrative officer-in-charge of finance said on implementation of NHIS:

> We generate revenue from health insurance and cash and carry. You see we have some foreign donors and local NGOs. Without money can we build this clinic, buy drugs, tools, and equipment? We also need more money to pay our workers I think you know that. (Private, HSP)

Besides the financial gains from the implementation of NHIS, most of the HSPs (public and private) indicated that NHIS had indeed increased the most vulnerable groups' access to healthcare services in Tamale and Ghana. Under the implementation of NHIS, the practice of poor patients running away from hospitals at midnight for lack of money to pay medical bills stopped. In was found in the interviews with HSPs that the poor in Ghanaian society constituted the highest number of health facility visits for out-patient services including malaria. Thus, the success story of Ghana NHIS.

In terms of data triangulation, this article examined relevant documents for information on NHIS coverage for vulnerable groups in Ghana. Thus, to compare interview responses with documents.

Annual reports were obtained from the National Health Insurance Authority (NHIA) at national, regional and district offices for the years (2010–2015). There is coverage of vulnerable groups in Ghana at three levels: national, regional (Northern Region NHIA) and the local level (Tamale Metropolitan Mutual Health Insurance Scheme (TMMHIS)). Data obtained from the fieldwork revealed that vulnerable groups are the largest NHIS subscribers in Ghana. As the results show that vulnerable groups constituted between 60–64% at the national level, 74–79% at the regional level while 64–69% at the local level (see Table 2). The article found that NHIS is enrolling more vulnerable groups (with over 60% coverage) but not all vulnerable groups in Ghana.

Factors That Affect the Enrollment of Vulnerable Groups into NHIS in Ghana

Individual Factors - Perspectives of Health Insurance Subscribers

The article tried to examine some individual factors that affect the implementation of NHIS in Ghana. By individual factors, the researcher refers to the actions and inactions of individuals that affect the implementation of NHIS. Health Insurance Subscribers (HIS) are of two categories: vulnerable groups (those exempted from payment of NHIS annual premium) and those who pay or contribute to NHIS (contributors). These individuals' views, opinions, and experiences are crucial toward effective implementation of NHIS in terms of their well-being and their access to healthcare services. The two individuals' views

were sought in an attempt to answer the question:

Have You Benefited from Exempt Policy? Yes/No. If Yes, How Did You Benefit from It? If No, Why?

Seventy (70) health insurance subscribers (HIS) were interviewed at three social service delivery points namely hospitals, clinics, and health insurance offices. This includes the three FGDs held at community/homes (see Table 1). The results show 50 HIS answered the question, 34 of them answered in the affirmative (68%) while 16 with "no" response (32%). The lead researcher and the trained research assistants probed on how subscribers benefited from NHIS in Ghana. The responses from the subscribers on how they benefitted from NHIS varied. Some subscribers linked their benefits to exemption from payment of annual premium of 14 Ghana Cedis (GH₵ 14.0 = US$3.7)[1]. Some linked the benefits of NHIS to healthcare services they received at the social service delivery points such as hospitals and clinics. Others linked the benefits of NHIS to the services they obtained at health insurance offices (HIOs). This was how health insurance subscribers said on the benefits of NHIS:

> You know health insurance is good for the poor. Without money in the pocket, you get free health care, free drugs what is more than this. (HIS, premium payee)

Another Health Insurance Subscriber (HIS) at a different social service delivery point (district health insurance office) expressed his interest in joining NHIS and renewal of his membership with NHIS despite some implementation challenges. This was what he said:

> As a public servant, I don't pay a premium I only paid for the registration fees which is a very small amount. The policy is very good and helpful except a waste of time you really cannot tell what the health insurance officials are doing there. I see favoritism in the way they handle clients. Yet I am encouraged to stay and will encourage others to join health insurance. (HIS, contributor)

A seventeen-year student also expressed his interest in NHIS and indicated that his real motive for joining NHIS was for the health insurance card but not healthcare services. Thus, his comments:

> I don't get sick easily, so I did not register for sake of free health care, but I just need the card to do my own things like open account and to show the card to my teachers. I don't need renewals because I can use my friends' insurance cards to visit hospitals and clinics. The doctors and nurses don't check the card well. (HIS, vulnerable Group Member)

The fieldwork interview findings revealed two main motives for joining NHIS and for the renewal of membership for NHIS in Ghana. Most subscribers joined NHIS for economic reasons, which is free access to healthcare services and to save the cost of healthcare services and drugs. Few subscribers just need the NHIS Card for other purposes other than for healthcare services.

The researcher also tried to find out if there is any connection between behavioral and attitudinal factors and the implementation of NHIS. Hence, the researcher asked questions on subscribers' attitude toward NHIS. Most health insurance subscribers including vulnerable groups show a positive attitude toward the implementation of NHIS. Some individuals were positive about the implementation of NHIS while others look negative. Out of 70 interviewed, 46 of the subscribers representing (66%) were positive of NHIS and indicated that NHIS helped them have free access to healthcare services including outpatient, in-patient and emergency services.

However, 24 of HIS representing 34% were not enthused of NHIS. They mentioned problems such as discrimination between Health Insurance Subscribers (HIS) and non-subscribers (those paying cash). Findings show the poor attitude of Health Service Providers (HSPs) toward health insurance subscribers (HIS) during social service delivery compared with persons who offer cash for healthcare services at hospitals and clinics. The HIS complained of shouts, insults, and other verbal abuses during social service delivery from HSPs particularly those in the public sector.

Community Factors

This article looks for the role of community members in the selection of vulnerable groups at

Table 3. Reasons for joining NHIS and Non-renewal of Membership of NHIS.

Reasons why members joined NHIS	Reasons for non-renewal of membership
Have free health care services	Lack of knowledge on expiry dates/illiteracy
Have access to more health care facilities	Poor services for NHIS members
To save cost of treatment, drugs, diagnosis	Poor attitudes of health professionals
To save lives and access to quality services	Poor attitudes of health insurance officials
For protection in terms of emergencies	Not prone to sicknesses/ illnesses mentality
NHIS is the best social policy in Ghana	The use of other members cards for services

the community level. Chiefs and community leaders played very important roles. Interviews sources revealed chiefs; elders of communities were consulted to help health insurance officials identify indigent persons (core poor). Other key actors include social welfare workers who also assisted health insurance officials with information on orphans, beggars, and other vulnerable persons. It found cooperation among the health insurance offices and the social welfare department as well as community leaders to reach out with vulnerable groups in the Tamale Metropolis of Ghana.

Scheme Factors

The article looks at factors at health insurance offices that affect the implementation of NHIS. The essence is to find out some factors or conditions that facilitate or inhibit the implementation of NHIS at health insurance offices namely headquarters, regional and district offices of NHIA. The most important activities or services that occur at the various offices include registrations, renewals of subscribers' membership and administration of claims. The researcher looks at how these services affect subscribers particularly vulnerable groups in terms of access to health or social services at scheme offices, why they register and renew their membership and reason why they sometimes do not register and or do the renewal. The in-depth interviews and FGDs responses from health insurance subscribers (HIS) are categorized into two: reasons for joining NHIS, and reasons for non-renewal of the annual NHIS membership (see Table 3).

Facility Factors

The researcher solicited views and opinions of Health Service Providers (HSPs)-health workers in the four selected health facilities (two hospitals and two clinics on the public-private basis) on factors or conditions that may promote or inhibit the well-being of health insurance subscribers particularly vulnerable groups in the implementation of NHIS. Some of the conditions or factors perceived to promote or hinder health insurance subscribers especially vulnerable groups' well-being and their access to healthcare services at facilities have been summarized (see Table 4).

Most health workers praised NHIS implementation due to the public-private partnership in the provision of healthcare services and the inter-organizational cooperation, collaboration and commitments toward meeting the health care needs of health insurance subscribers. The last key factor was free access to health care services. The biggest challenge was delayed in payments for services rendered to health insurance subscribers. Most subscribers especially vulnerable groups were very happy for free access to a wide range of social healthcare services but unhappy with the attitude of workers (see Table 4).

Coverage of NHIS for All Citizens and Other Persons Resident in Ghana

The article presents data on the level of coverage of the National Health Insurance Scheme (NHIS) in Ghana for the ten-year period of NHIS (2004–2013). The researcher presents the percentage coverage of NHIS at three levels: national, regional and local. It explored the possible factors responsible for the enrollment rates at the three levels through an in-depth interview, some focus group discussions and document analysis. Information was obtained official documents from the National Health Insurance Authority (NHIA) national, regional and district offices in Ghana. The percentage terms, patterns of NHIS coverage at national (Ghana), at the regional level (Northern Region (N.R)) and local level coverage (Tamale Metropolis) are illustrated (see Figure 2).

The population distribution is based on Ghana's 2010 Population and Housing Census and NHIA Annual Reports, 2009-2013

There were some errors with 2004 to 2009 enrollment data from NHIA, hence their exclusion from this study. The results show substantial increases in enrollment during the last four years (2010–2013) of the ten-year period. Enrollment at the local level experienced the highest increase from 22% in 2010 to 41% (close to 100%). The enrollment coverage at the regional level also increased from 24% in 2010 to 37%. The national-level coverage moved from 33% in 2010 to 38% (approximately 15%). Though there has been good progress in NHIS enrollment coverage from 2010 to 2013 (10th Anniversary year) at the three levels (local, regional and national), it may still take Ghana many more years to achieve the goal of NHIS for all citizens and all vulnerable groups (universal health coverage). If 10 years the highest percentage coverage for the entire country (Ghana) is 38%, the results suggest that over 60% of Ghana's population is not covered by NHIS. This situation may create some difficulties in accessing healthcare services particularly the poor and vulnerable ones in Ghana. More efforts for Ghana's move toward the promotion of the well-being of vulnerable groups and their access to healthcare services throughout Ghana.

Table 4. Facility factors from the perspectives of health workers and vulnerable groups.

Categories	Facility Factors
Health Workers	Referral system in terms of higher facilities, prescriptions forms
	Public-Private Partnership in health service delivery
	Inter-organisation cooperation, collaboration, commitments
	Free access to health care services under health insurance scheme
	Delays in payment of monthly health insurance claims
Vulnerable Groups	Free access to drugs, medicines, scans and laboratory tests
	The fear of medical bills belongs to the thing of the past in Ghana
	Poor attitude and bad language against the poor and villagers
	Too many waiting hours at facilities and small payments at facility

Discussion

On the issue of whether the NHIS is a pro-poor social intervention policy in Ghana, findings from interviews with the social service providers at hospitals, clinics, health insurance offices, and the Department of Social Welfare (DSW) workers support that NHIS is a pro-poor social policy. These reasons identified include reduced cash payments at the various social service delivery points, no more fear for payment of medical bills, improved and increased access to healthcare services and then poverty reduction among vulnerable groups in Ghana. Most health insurance subscribers hailed the NHIS as the biggest government social intervention policy in Ghana. Thus, health insurance subscribers are ready to register and renew their membership of NHIS despite

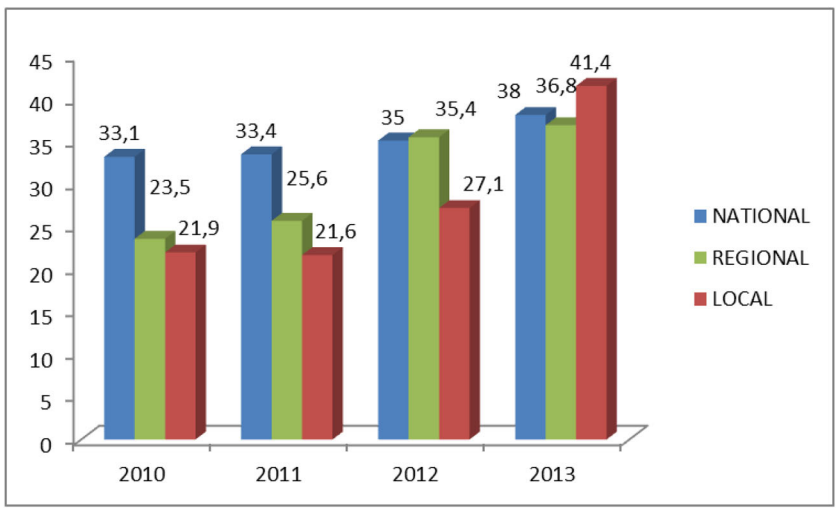

Figure 2. National, regional and local levels coverage of NHIS (percentage terms).
Source: NHIS Annual Reports, 2009–2013.

challenges at the various social service delivery points (see Table 3). Beside interview responses, document sources support that most beneficiaries of NHIS that is health insurance subscribers are vulnerable group members (see Table 2). On whether NHIS is enrolling all the vulnerable groups in Ghana, the research results show that NHIS is indeed enrolling more vulnerable groups into NHIS compared with contributors. The results suggest that NHIS aims at poverty reduction among the vulnerable groups and can be called "pro-poor" social policy. This article finding is supported by Witter et al. (2009), Ministry of Health (2014), and Fusheini et al. (2017). Based on the findings, it is important to note NHIS is indeed enrolling more vulnerable groups but not all vulnerable groups in Ghana.

However, findings in this research are inconsistent with other findings in Ghana that see NHIS as "not pro-poor" social policy due to its low coverage among all vulnerable groups (Apoya & Marriott, 2011; Averill, 2013; Jehu-Appiah et al., 2011; Sarpong et al., 2010).

On the question of "how and why" exempt group members join the NHIS, Yin (2014) opines that qualitative case study researchers often addressed such questions. The empirical evidence from the field revealed that although some progress made by NHIS on enrollment of vulnerable groups, some implementation challenges still persist at the three social service delivery points (hospitals, clinics, health insurance district office). On yearly renewals of their membership of NHIS, some subscribers failed to renew their annual membership as they complained about discrimination, negative attitudes of health insurance officials toward them as reasons for non-renewals (see Table 3). Some vulnerable groups are not interested in NHIS due to the perceived poor attitude or negative actions of service providers toward them. Other vulnerable groups are described as "villagers," "poor" and "non-serious people" among other stereotypes by some health service providers. Moreover, some subscribers complained about favoritism, discrimination-differential treatment between them and those patients who pay with cash. Findings show that such negative statements or abusive languages against some subscribers are more among public sector social health workers than their private counterparts. The research findings agree with Andersen (2004), Kipo (2011), Atinga et al. (2016), and Kipo-Sunyehzi (2018).

Implications of Findings

One implication from the finding is that Ghana's health insurance scheme combines the elements of universalism with particularism (collectivism with individualism). This implies that the health insurance scheme aims at enrolling all the citizens (universalism) but its first target or strategy is to enroll more of the vulnerable groups (particularism). Thus, Ghana as a developing country, its social policy in the form of NHIS adopts "universal and targeted" programs. This collaborates with the work of Mkandawire (2005) on social policy in a developing world context of Africa. Another implication of the findings is that more efforts are needed from all the citizens, health insurance authority and the government to support the scheme in achieving full population coverage.

Implications for Social Policy and Practice

Findings revealed that health insurance is the best policy toward poverty reduction in Ghana, as it provides financial protection or cover for the poor, the needy and the most vulnerable against cash payments at social service delivery points like hospitals and clinics across the country.

Implications for Social Welfare and Practice

The findings revealed the tremendous role of the Department of Social Welfare (DSW) workers play in the enrollment of vulnerable groups into NHIS. The DSW has credible information on the most vulnerable groups and therefore collaborates with NHIA to identify and enroll the poor into NHIS.

Conclusions

This research contributes to knowledge on social welfare and social policy in a developing world

context of Ghana on how a social intervention helped improve well-being of vulnerable groups by increasing their access to healthcare against cash payments at social service delivery points.

This study has a geographic limitation as it is limited to only one political district and region in Ghana. But the study findings are transferable to other places with a similar setting and have rigor in terms of "analytical generalization," though the findings may suffer in terms of "statistical generalizations of findings" (Yin, 2014).

Future Research

Future research should focus on cross-country studies on social intervention programs of states. It should be quantitative/statistics on how the programs improve the well-being of citizens/people and their access to basic social services like healthcare, social security, and basic social needs.

Note

1. http://www.xe.com/currencyconverter/convert/?Amount=14&From=GHS&To=USD (Accessed on 17 April 2015)

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Declaration of Interest Statement

The author declares no conflict of interest.

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References

Adesina, J. O. (2007). *Social policy in sub-Saharan African context: In search of inclusive development*. Houndmills: Palgrave.

African Union. (2008). First Session of the AU Conference of Ministers in Charge of Social Development (Publication No. CAMSD/EXP/4(I)). Windhoek, Namibia, 27–31 October 2008.

Agyepong, I. A., & Nagai, R. A. (2011). We charge them; otherwise we cannot run the hospital" front line workers, clients and health financing policy implementation gaps in Ghana. *Health Policy*, *99*(3), 226–233. doi:10.1016/j.healthpol.2010.09.018

Andersen, H. M. (2004). "Villagers": Differential treatment in a Ghanaian hospital. *Social Science & Medicine*, *59*(10), 2003–2012. doi:10.1016/j.socscimed.2004.03.005

Apoya, P., & Marriott, A. (2011). *Achieving a shared goal: Free universal health care in Ghana*. Oxford: Oxfam International.

Atinga, R. A., Bawole, J. N., & Nang-Beifubah, A. (2016). 'Some patients are more equal than others': Patient-centred care differential in two-tier inpatient ward hospitals in Ghana. *Patient Education and Counseling*, *99*(3), 370–377.

Averill, C. (2013). *Universal health coverage: Why Health Insurance Schemes are leaving the poor behind*. Oxford: Oxfam International.

Bryman, A. (2012). *Social research methods* (4th ed.). Oxford: Oxford University Press.

Bryman, A. (2016). *Social research methods*. Oxford: Oxford University Press.

Creswell, J. W. (2009). *Research design: Qualitative, quantitative and mixed methods approaches* (3rd ed.). Thousand Oaks, CA: Sage Publications, Incorporated.

Derbile, E. K., & van der Geest, S. (2012). Repackaging exemptions under National Health Insurance in Ghana: How can access to care for the poor be improved? *Health Policy and Planning*, *28*, 586–595. doi:10.1093/heapol/czs098

Ellison, N. (1999). Beyond universalism and particularism: Rethinking contemporary welfare theory. *Critical Social Policy*, *19*(1), 57–85. doi:10.1177/026101839901900104

Fuller, J. (1997). Multicultural health care: Reconciling universalism and particularism. *Nursing Inquiry*, *4*(3), 153–159. doi:10.1111/j.1440-1800.1997.tb00093.x

Fusheini, A. (2016). The politico-economic challenges of Ghana's national health insurance scheme implementation. *International Journal of Health Policy and Management*, *5*(9), 543–552. doi:10.15171/ijhpm.2016.47

Fusheini, A., Marnoch, G., & Gray, A. M. (2017). Implementation challenges of the National Health Insurance Scheme in selected districts in Ghana: Evidence from the field. *International Journal of Public Administration*, *40*(5), 416–426.

Ghana Statistical Service. (2012). *2010 population and housing census*. Accra: Sakoa Press Limited.

Ghana Statistical Service. (2014). *2010 population and housing census: District analytical report-Tamale Metropolis*. Accra: Sakoa Press Limited.

Government of Ghana. (2003). *National Health Insurance Act. (Act 650)*. Accra: Ghana Government.

Government of Ghana. (2004). *National Health Insurance Regulations. (L. I.1809)*. Accra: Ghana Government.

Government of Ghana. (2012). *National Health Insurance Act. (Act, 852)*. Accra: GoG.

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105–117). Thousand Oaks, CA: Sage.

HelpAge International. (2008). *Investing in social protection in Africa: Summary report of National Consultations Held in Burkina Faso, Cameroon, Mozambique, Rwanda, Sierra Leone and Tunisia*. London: HelpAge International.

Heywood, A. (2004). *Political theory: An introduction* (3rd ed). Basingstoke: Palgrave Macmillan.

Jehu-Appiah, C., Aryeetey, G., Spaan, E., De Hoop, T., Agyepong, I., & Baltussen, R. (2011). Equity aspects of the National Health Insurance Scheme in Ghana: Who is enrolling, who is not and why? *Social Science & Medicine*, *72*(2), 157–165.

King, G., Keohane, R. O., & Verba, S. (1994). *Designing social inquiry: Scientific inference in qualitative research*. Princeton, NJ: Princeton University Press.

Kipo, D. D. (2011). *Implementation of public policy at the local level in Ghana: The case of national health insurance scheme in Sawla-Tuna-Kalba District* (Master's thesis). The University of Bergen.

Kipo-Sunyehzi, D. D. (2018). Principal-agent problems in implementation of Ghana's health insurance scheme. *Journal of Operations and Supply Chain Management*, *11*(2), 59–74.

Kipo-Sunyehzi, D. D., Ayanore, A. M., Dzidzonu, D. K., & Yakubu, A. Y. (2019). Ghana's journey towards universal health coverage: The role of the national health insurance scheme. *European Journal of Investigation in Health, Psychology and Education*, *10*(1), 94–109. doi:10.3390/ejihpe10010009

Manful, E., Takyi, H., & Gambrah, E. (2015). Admission to exit: Acquiring life skills whilst in residential care in Ghana. *Social Work & Society*, *13*(2), 1–13.

Manful, E., Umoh, O., & Abdullah, A. (2019). Examining welfare provision for children in an old relic: Focusing on those left behind in residential care homes in Ghana. *Journal of Social Service Research*, 1–12. doi:10.1080/01488376.2019.1670322

McIntyre, D., Garshong, B., Mtei, G., Meheus, F., Thiede, M., Akazili, J., … Goudge, J. (2008). Beyond fragmentation and towards universal coverage: Insights from Ghana, South Africa and the United Republic of Tanzania. *Bulletin of the World Health Organization*, *86*(11), 871–876. doi:10.2471/BLT.08.053413

Mechanic, D., & Tanner, J. (2007). Vulnerable people, groups, and populations: Societal view. *Health Affairs*, *26*(5), 1220–1230. doi:10.1377/hlthaff.26.5.1220

Midgley, J. (2008). The nature of social policy. In J. Midgley & M. Livermore (Eds.), *The handbook of social policy* (pp. 1–83). Thousands Oaks, CA: Sage Publications Inc.

Ministry of Health. (2014). *Holistic assessment of the health sector programme of work 2014*. Accra: Ministry of Health, Ghana.

Mkandawire, T. (2005). *Targeting and universalism in poverty reduction*. Geneva: United Nations Research Institute for Social Development.

National Health Insurance Authority. (2009). *NHIS annual report*. Accra: NHIA.

National Health Insurance Authority. (2010). *NHIA annual report*. Accra: NHIA.

National Health Insurance Authority. (2011). *NHIA annual report*. Accra: NHIA.

National Health Insurance Authority. (2012). *NHIA annual report*. Accra: NHIA.

National Health Insurance Authority. (2013). *NHIA annual report*. Accra: NHIA.

Northern Region (N.R). *National Health Insurance Authority annual reports 2010-2013*. Tamale: NHIA.

Sarpong, N., Loag, W., Fobil, J., Meyer, C. G., Adu-Sarkodie, Y., May, J., & Schwarz, N. G. (2010). National health insurance coverage and socio-economic status in a rural district of Ghana. *Tropical Medicine & International Health*, *15*(2), 191–197.

Tamale Metropolitan Mutual Health Insurance Scheme (TMMHIS). *Annual reports, 2010-2013*. Tamale: NHIA.

Taylor, C. (1994). The politics of recognition. In A. Gumann (Ed.). *Multiculturalism: Examining the politics of recognition* (pp. 25–73). Princeton, NJ: Princeton University Press.

Thompson, S., & Hoggett, P. (1996). Universalism, selectivism and particularism: Towards a postmodern social policy. *Critical Social Policy*, *16*(46), 21–42.

Titmuss, R. (1974). *Social policy*. London: George Allen and Unwin.

Walker, G. H., & Osei, A. (2017). Mental health law in Ghana. *BJPsych International*, *14*(2), 38–39. doi:10.1192/S2056474000001768

Wang, W., Temsah, G., & Mallick, L. (2017). The impact of health insurance on maternal health care utilization: Evidence from Ghana, Indonesia and Rwanda. *Health Policy and Planning*, *32*(3), 366–375. doi:10.1093/heapol/czw135

Witter, S., Adjei, S., Armar-Klemesu, M., & Graham, W. (2009). Providing free maternal health care: Ten lessons from an evaluation of the national delivery exemption policy in Ghana. *Global Health Action*, *2*(1), 1881–1885. doi:10.3402/gha.v2i0.1881

World Health Organization (WHO). (2007). *Strengthening health systems to improve health outcomes: WHO's framework for action*. Geneva: WHO.

Wright, G., & Noble, M. (2010). Recent social policy developments in Africa. *Global Social Policy: An Interdisciplinary Journal of Public Policy and Social Development*, *10*(1), 111–119. doi:10.1177/1468018109354491

Yin, R. K. (2014). *Case study research: Design and methods* (5th ed.). Thousand Oaks, CA: Sage Publications, Inc.