

UNIVERSITY OF GHANA

**SOCIAL CAPITAL AND ENROLMENT IN SOCIAL HEALTH
INSURANCE: THE EXPERIENCE OF GHANA'S NATIONAL HEALTH
INSURANCE SCHEME (NHIS)**

EMMANUEL KOFI AYISI

(10061193)

**THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA,
LEGON IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR
THE AWARD OF PHD PUBLIC ADMINISTRATION DEGREE**

JULY 2018

DECLARATION

I do hereby declare that this thesis is the result of my own original research and has not been presented by anyone for any academic award in this or any other University. I bear sole responsibility for any shortcomings in this work.

.....

EMMANUEL KOFI AYISI

(10061193)

.....

DATE

CERTIFICATION

I hereby certify that this thesis was supervised in accordance with procedures laid down by the University of Ghana.

.....

Date.....

PROF. JUSTICE N. BAWOLE

(Lead Supervisor)

.....

Date.....

DR LILY YARNEY

(Supervisor)

.....

Date.....

DR THOMAS BUABENG

(Supervisor)

DEDICATION

1. The Almighty God; the source of my knowledge and strength
2. My Heartbeat; Regina Konadu Poku who had to shelve her own academic dreams so I could achieve mine
3. My Army; Papa Mante, Nana Poku, Kwaku Gyamfi and Aseda for giving me a reason to press on.

ACKNOWLEDGEMENT

I give thanks to the Almighty GOD for the blessings and mercies He showered upon me throughout this PhD project, and indeed for my life. As a David, I was tending my flock in the wilderness, but He brought me home for this glory that I am so underserving of. I am eternally grateful, my Lord. My sincere appreciation goes to my lead supervisor and head of department, Professor Justice Bawole, who turned out to be my reliable fortress in several respects. His sense of responsibility, guidance, patience, and support amazed me, and my bonding with him was the envy of my PhD fellows in the department. Prof, I appreciate you very much and thank you for pushing me to deliver. To the other members of my supervisory team; my leading light, Dr Thomas Buabeng and the affable Dr Lily Yarney, I am grateful for your support, guidance and feedback which helped in molding this final report.

I want to offer special thanks to my wife, Regina Konadu Poku, for her patience, sacrifice and prayer support. I also thank my kids for the sacrifices and concessions they had to make whilst I was away from them on this voyage. I also wish to express my appreciation to my parents, Richard Ayisi and Comfort Darkoa for their invaluable moral and financial support without which this dream would not be realized. Being a parent now, I appreciate the sacrifices you had to make so I could attain the highest laurel in education. Also, to my uncle and mentor, Dr Seth Kumi of the United Nations, thanks for encouraging me to pursue a doctoral degree.

To you wonderful department administrators, Auntie Mary and Ernest, your support and encouragement made this difficult process less painful. Lastly, to my PhD family; Ben, Mary, Esi, Thess, Akonnor, Andoh, Peter and my two special buddies; Dallas and Titti, I am grateful for your psychological, intellectual, and social support throughout the period. On a final note, I wish to express my gratitude to all research participants. Without your responses, experiences and time, this research project would have remained a mere proposal.

TABLES OF CONTENTS

DECLARATION	i
CERTIFICATION	ii
DEDICATION	iii
ACKNOWLEDGEMENT	iv
TABLES OF CONTENTS.....	v
LIST OF FIGURES	xiii
LIST OF TABLES	xiv
LIST OF ABBREVIATIONS	xv
ABSTRACT.....	xvii
CHAPTER ONE	1
GENERAL INTRODUCTION.....	1
1.0 Introduction	1
1.1 Statement of the Problem.....	2
1.2 Research objectives	7
1.3 Research Questions	7
1.4 Justifications for the Research Questions	7
1.5 Significance of the Study	9
1.6 Outline of the Thesis	10
1.7 Conclusion	12

CHAPTER TWO	13
SOCIAL CAPITAL, PUBLIC POLICY IMPLEMENTATION AND THE DECISION TO ENROLL: A CRITICAL OVERVIEW	13
2.0 Introduction	13
2.1 Public Policy Implementation Research: A State-of-the-art	13
2.1.1 Difficulty of Policy Implementation	15
2.1.2 Implementation Research in a Governance Framework	17
2.2 Social Health Insurance (SHI)	18
2.3 Social Health Insurance and Universal Health Coverage	20
2.4 Enrolment in SHI: What are the Determinants?	20
2.4.1 Economic Factors	21
2.4.2 Organisational and Scheme Related Factors	22
2.4.3 Social Determinants	23
2.5 Understanding the Decision to Enroll in SHI: Two Dominant frameworks	25
2.5.1 The Health Systems Framework	25
2.5.2 The Economic Systems Framework	26
2.5.3 Limitations of the Health Systems and Economic Systems Frameworks	26
2.6 Social Capital: A Viable Framework for Understanding Enrolment in SHI	28
2.6.1 Defining Social Capital	29
2.6.2 Dimensions of SC Theory	32
2.6.3 <i>Forms of SC</i>	36
2.7 SC and Public Policy	39
2.8 SC and Social Health Insurance	40

2.9 SC: A Critique.....	41
2.10 Towards a Conceptual Framework for the Study	44
2.10.1 SC Framework by Grootaert et <i>al.</i> , (2004)	44
2.11 The Literature and Research Questions Connect.....	51
2.12 Conclusion	53
CHAPTER THREE.....	54
CONTEXTUAL OVERVIEW OF THE RESEARCH SETTING	54
3.0 Introduction	54
3.1 The Country Context: Ghana	54
3.1.1 <i>The Study Context: Ashanti Region</i>	55
3.2 Ghana’s Healthcare System	56
3.3 Healthcare Financing in Ghana.....	58
3.3.1 The Era of User-Fees	59
3.3.2 Community Based Health Insurance (CBHI) Initiatives as a Prelude to the NHIS.....	60
3.4 The National Health Insurance Scheme (NHIS).....	62
3.4.1 Funding Architecture of the NHIS	64
3.4.2 Enrolment in the NHIS.....	65
3.4.3 NHIS Benefits Package.....	66
3.4.4 Status of Enrolment in the NHIS	67
3.5 Social Context of the NHIS.....	69
3.6 Political Context of the NHIS	70
3.7 Ghana’s Informal Sector and the NHIS	71

3.8 Conclusion	72
CHAPTER FOUR.....	74
RESEARCH METHODOLOGY.....	74
4.0 Introduction.....	74
4.1 Philosophical Assumptions and Paradigms in Social Science.....	74
4.2 Philosophical foundation of the study and its appropriateness	76
4.3 The Qualitative Research Approach	77
4.4 Case Study Design	79
4.5 Sampling	80
4.6 Data collection methods and sources	82
4.7 Data Collection Process	85
4.8 Validity and Rigour through Triangulation	87
4.9 Data Analysis Procedure.....	88
4.10 Quality Assurance.....	92
4.11 Ethical Considerations and Research Clearance.....	94
4.12 Conclusion	95
CHAPTER FIVE.....	97
SOCIAL CAPITAL IN THE COMMUNITIES	97
5.0 Introduction.....	97
5.1 Bonding SC in the Communities: Any Evidence?.....	97
5.1.1 Traditional family structure and support.....	97

5.1.2 Norms of behaviour.....	100
5.1.3 Weakening bonds	103
5.1.4 Community networks and connections: friends and neighbours	106
5.2 Bridging SC (Voluntary Associations and Groups).....	107
5.2.1 Membership of voluntary associations and groups.....	107
5.2.2 Benefits of Voluntary Associations and Groups.....	107
5.2.3 Dominance of religious groups in the communities	111
5.3 Linking SC in the Communities.....	113
5.3.1 Trust in public institutions and officials.....	113
5.3.2 Relations between Community and Public Institutions	114
5.4 Conclusion	116
CHAPTER SIX	117
SOCIAL CAPITAL AND THE DECISION TO ENROLL	117
6.0 Introduction.....	117
6.1 Bonding SC and the decision to enroll.....	117
6.1.1 Impressing on family members to register.....	117
6.1.2 Reciprocity and the decision to enroll.....	119
6.1.3 Community solidarity and the decision to enroll - obligations and expressions.....	120
6.1.4 Family, friends and neighbours as immediate sources of information on NHIS	122
6.2 Bridging SC and the decision to enrol	125
6.2.1 ‘Group think’ and the decision to enrol	125
6.2.2 Group solidarity and the decision to enrol	126

6.2.3 Groups and associations as sources of information on the NHIS	127
6.2.4 Group leaders and the decision to enroll.....	128
6.3 The Informal Sector and voluntary enrolment.....	128
6.4 Linking Social Capital and the decision to enrol	130
6.4.1 Relationships and experiences with NHIS agencies: effectiveness and credibility are important	131
6.4.2 Trust in scheme management/staff and the decision to enroll	133
6.5 Relationships and experiences with healthcare providers.....	134
6.6 Lack of Control over Scheme Management and Service Providers	139
6.7 Information, Communication and the Decision to Enroll.....	142
6.8 Conclusion	149
CHAPTER SEVEN.....	151
EXPLORING THE ROLE OF SOCIAL CAPITAL STRUCTURES FOR ENROLMENT AND EFFECTIVE IMPLEMENTATION OF THE NHIS.....	151
7.0 Introduction	151
7.1 Traditional Authorities	151
7.2 Stimulating Enrolment: The Role of Religious Groups.....	158
7.3 Assembly Members and Opinion Leaders	161
7.4 The Role of NGO's in Stimulating Enrolment	162
7.5 Trade Unions and other Professional or Business Groups.....	163
7.6 Community-Based Organisations and the Decision to Enrol	164
7.7 Conclusion	165

CHAPTER EIGHT	167
INTERPRETATION AND DISCUSSION OF FINDINGS	167
8.0 Introduction	167
8.1 Forms of SC in the Communities.....	167
8.2 Social Capital and the Decision to Enroll	170
8.3 Trust as a Major Component of SC and the Decision to Enroll.....	176
8.4 Information and communication: Key Vehicles for Increasing Enrolment and Effective Policy Implementation	178
8.5 Leveraging Social Capital in the Communities for Enrolment.....	180
8.6 Embeddedness and Complementarities: Insights for Policy Management.....	183
8.7 Implications for Governance (Participation, Transparency and Accountability)	186
8.8 Conclusion	188
CHAPTER NINE.....	189
SUMMARY, CONCLUSION AND RECOMMENDATIONS	189
9. 0 Introduction.....	189
9.1 Summary of the chapters.....	190
9.2 Summary of Key Findings	192
9.3 Conclusions	193
9.4 Contribution to Knowledge.....	194
9.5 Implications for Practice and Policy Management	198
9.6 Limitations of the study	199
9.7 Recommendations	201

9.8 Directions for future research.....	203
REFERENCES.....	207
APPENDICES	241

LIST OF FIGURES

Figure 1.1 Thesis Structure.....	11
Figure 2.1 Forms of social capital	38
Figure 2: SC and the decision to enroll in Ghana’s NHIS.....	51
Figure 3.1: Map of Ashanti region showing the three case study areas.....	56
Figure 3.2: Ghana’s Healthcare System.....	58
Figure 3.3: Annual NHIS Membership Trend from 2012-2017.....	68
Figure 6.1: Thematic network on bonding SC and the decision to enrol.....	122
Figure 6.2: Thematic map of bridging SC and the decision to enrol.....	130
Figure 6.3: Linking SC and the decision to enroll in the NHIS.....	149
Figure 7.1: Final Thematic map of SC forms and influences on enrolment in NHIS.....	166
Figure 8.1: Three key norms of bonding, bridging and the decision to enrol.....	178

LIST OF TABLES

Table 2.1 Selected definitions of social capital.....	32
Table 2.2 Structural and cognitive dimensions of social capital.....	50
Table 3.1: Key Components of Ghana’s NHIS.....	63
Table 3 2: NHIS Benefits Package.....	67
Table 4.1 Key components of Ghana’s NHIS.....	82
Table 4.2 NHIS benefits package.....	87
Table 4.3: Data Analysis process.....	91
Table 8.1: Trust as a major linking device in all forms of social capital.....	178
Table 9.1: Findings of the study by Research Question.....	193

LIST OF ABBREVIATIONS

CBHI	Community Based Health Insurance
CBO	Community Based Organisation
CHAG	Christian Health Association of Ghana
DMHIS	District Mutual Health Insurance Scheme
GHS	Ghana Health Service
GNAT	Ghana National Association of Teachers
LMIC	Lower and Middle Income Country
MOH	Ministry Of Health
NDC	National Democratic Congress
NDPC	National Development Planning Commission
NGO	Non-Governmental Organisation
NHIA	National Health Insurance Authority
NHIF	National Health Insurance Fund
NHIS	National Health Insurance Scheme
NPP	New Patriotic Party
OOP	Out Of Pocket Payment
SC	Social Capital
SES	Socio-economic status
SHI	Social Health Insurance
SSNIT	Social Security and National Insurance Trust
TUC	Trade Union Congress
UHC	Universal Health Coverage

WHO	World Health Organisation
LI	Legislative Instrument
VAT	Value Added Tax
PCHIC	Private Commercial Health Insurance Schemes
PMHIC	Private Mutual Health Insurance Schemes

ABSTRACT

In response to calls for studies that highlight the social determinants of Social Health Insurance enrolment, this study investigated the forms of social capital (SC) in selected communities in Ghana and how they influence the enrolment decision. It also explored how SC structures in the selected communities could be leveraged to drive enrolment in Ghana's National Health Insurance Scheme (NHIS). Situated in an interpretive paradigm, the study adopted a qualitative research methodology with semi-structured interviews, focus group discussions and documentary reviews as the key data collection tools. The data was analyzed thematically in a six staged process.

The study established that SC capital facilitates enrolment decisions in three main ways; bonding, bridging and linking. Although weakening in recent years, bonding SC expressed through solidarity, trust and reciprocity within the familial unit is prevalent, providing social support to people in the communities. Bonding influences the enrolment decision in several ways. Solidarity creates a sense of responsibility in family members to impress on others to register. Family, friends and neighbours are trusted sources of information on the NHIS and whether positive or negative, such information influenced the enrolment decision. On the other hand, bridging SC in the form of groups and associations was also found to be predominant with religious groups, as the most important. The groups and associations compensated for the weakening bonds in traditional family structure. Linking SC in the form of relationships with state institutions seemed weak, with less engagement between community and state institutions, and mistrust in public officials and institutions reinforced some negative sentiments among respondents which affected decisions to enroll. The study revealed that key structures and local community organisations including, traditional rulers, religious groups, trade unions, business groups NGO's, CBO's and their leaders, are trusted and have a social advantage and their involvement in the NHIS will serve as a badge of assurance and accountability, and thereby drive people to enrol.

The study makes a number of contributions to enhance understanding of enrolment in social health insurance (SHI). Situating the enrolment analysis in a SC framework moves the argument beyond the prevailing dominant explanation that economic factors are the most important determinants of enrolment. The study demonstrates that in addition to economic factors, other considerations based on solidarity, reciprocity and trust relations within and among communities shape people's decision to enroll in voluntary SHI. By this, SC has proven to be sharper and comprehensive in explaining enrolment outcomes. Also, the study's careful examination of the SC structures and actors that impinge on enrolment (policy outcomes) in a manner which hitherto, had not been so clearly articulated in this study offers a more nuanced understanding of the subtle relations between individuals, communities and government institutions, as well as the strategies through which policies can be embedded and complemented by these structures.

CHAPTER ONE

GENERAL INTRODUCTION

1.0 Introduction

In recent years, there is a growing interest in social capital (SC) as an important resource for achieving public policy outcomes. The upsurge is largely due to the recognition that SC stimulates spontaneous citizen participation, cooperation and collective action among various actors and institutions for effective policy implementation (Bryson, Crosby & Bloomberg 2014; Krishna & Uphoff, 2002). This is against the backdrop that the traditional modes of implementing policy have proven ineffectual in eliciting the needed support and participation by the citizenry, and hence, the need to look for supplements or alternatives (Fung 2015; Nabatchi 2012). SC is a preferred option in current public management discourse because, it facilitates the development of important networks between public officials and the citizenry, leading to trust (Bowles & Gintis, 2002; Fukuyama, 2001), ownership (Hamilton, Helliwell & Woolcock, 2016), participation (Suebvises, 2018) and increased levels of policy performance (Moore & Kiwachi, 2017).

In terms of research, SC theory has also come up as an important conceptual tool for explaining individual and collective actions within a ‘social structure’ (Coleman 1988; Burt 2017; Lin 2017). SC elements, usually expressed in networks, trust norms, solidarity, and information sharing, foster cooperation and coordination for the achievement of policy goals (Pestoff, 2014; Rothstein, 2011). But while the usefulness of SC is amply demonstrated by studies in different policy fields, its utility for explaining Social Health Insurance (SHI) policy outcomes and enrolment in particular has been limited. In the case of Ghana’s National Health Insurance Scheme (NHIS), current enrolment analysis is steeped in the health systems and economic systems frameworks. Besides the inadequacy of these frameworks in explaining the social factors that impinge on the enrolment

decision, their dominance have also steered the discussions away from SC, despite its proclivity to explain social phenomena in its appropriate contexts (Fenenga et al., 2014; Mladovsky et al., 2014).

It is against this background that this study explores SC as a viable alternative to understand the enrolment decision in Ghana's NHIS. The study contends that an engagement with SC may better unveil the social forces behind the enrolment decision and generate further insights for a fuller understanding of the determinants of enrolment. This chapter presents a general introduction to the study, setting the background and outlining the areas which constitute the research problem. These are developed into specific research objectives and subsequently formulated into three specific research questions. The chapter also discusses the justifications of the research questions and the relevance of the study. It ends with a chapter outline of the entire thesis and a conclusion.

1.1 Statement of the Problem

Ghana's NHIS has made significant strides. The policy is credited with improvements in the health-seeking behaviour of a number of Ghanaians, and an increase in the utilization of healthcare services (Abihiro & McIntyre, 2012; NHIA, 2017; Osei Assibey & Agyeman, 2017; Sakyi et al., 2012). The scheme has contributed to reducing the financial barriers to healthcare, currently covering about forty percent of Ghana's population, and enrolling over 3,500 healthcare providers, both public and private (Atinga et al., 2015; Fusheini et al., 2017; NHIA, 2016).

These successes apart, evidence in the extant literature suggests that the scheme has several constraints. While some of these border on financial sustainability of the scheme, others are on the efficient management of the policy. There are also issues concerning enrolment and how to extend the scheme to cover all Ghanaians, particularly the poor (Alhassan, Nketia-Amponsah & Arhinful

2016; Fusheini et al., 2017; Nguyen, Rajkotia & Wang, 2011). The issue of enrolment in particular has pre-occupied scholars, governments and other international agencies, essentially because of its implications for universal health coverage (UHC) (Abihiro & McIntyre, 2012).

So far, research on enrolment in Ghana's NHIS have explored a number of factors that influence enrolment such as; premium cost (Atinga et al., 2015; Kotoh, Aryeetey & Van der Geest, 2018), cumbersome registration and renewal procedures (Witter & Garshong, 2009) reliability in health services (Fusheini et al., 2017) among others. While these have contributed knowledge to enhance understanding of the enrolment decision, other important issues have been overlooked by scholars, leaving a number of research gaps to be explored. These are detailed as below.

Concentration on Financial and Organisational Determinants of Enrolment

Although research on enrolment in the NHIS have surged, much of the attention has been on the financial and organisational determinants (Adomah-Afari 2017, Dalinjong & Laar 2012; Fusheini, Marnoch, & Gray 2017, Sakyi et al., 2012; Williams 2016). This concentration has steered the discussions off other social factors that come to bear on the decision to enroll (Alhassan, Nketiah-Amponsah & Arhinful, 2016). Within these social factors however, are societal relationships based on mutual trust and other norms of association, which have been important facilitators of voluntary associations like 'susu' (saving money and collecting in turns) and 'nnoboa' (pooling labour for farm work) in the communities (Arhinful 2003; Maclean, 2003). Hyden (2012, p.16) refers to the social logic driving such relationships as the "economy of affection". These are the very philosophies behind SHI, but current analyses have not adequately explored how such relationships influence the decision to enroll. This study attempts to fill this void by exploring how SC, in the form of community associations and networks and its accompanying norms and values influence the enrolment decision. Such an enterprise will not only enhance understanding of the

determinants of enrolment, but also direct attention of scholars to previously overlooked drivers of policy implementation.

Dominance of Health and Economic Systems Frameworks

Current studies on enrolment in SHI have largely been conducted within two main explanatory models: the economic systems and the health system frameworks. From the economic systems framework, the decision to enroll is analyzed in terms of individual expected utility with individuals conceived as rational actors who calculate insurance benefits before signing up (Fenenga, 2014; Schneider, 2005). The health systems framework on the other hand, situates the enrolment decision in the broader institutional context of exchanges between clients, insurance schemes, health service providers and the state (Criel et al., 2004; Donfouet & Mahieu, 2012). These frameworks have served scholars well in the past but they have also been found to ignore the social context within which the enrolment decision is made. Their dominance have also obscured the application of SC which better explains social phenomena in its right contexts (Mladovsky et al., 2014). Specifically on the NHIS, studies that employ SC in the enrolment analysis are few, even though evidence in the general SHI literature is that, at least, in relation to Community based Health Insurance (CBHI) schemes, different forms of SC influence the decision to enroll in different ways (Donfouet & Mahieu, 2012). This study attempts to close this gap by exploring how the different forms of SC influence the enrolment decision in Ghana's NHIS. This will enhance further understanding of the determinants of enrolment and also provide pointers to more sustainable strategies for scaling up enrolment.

Social Capital and the NHIS: Different Dynamics, Different Challenges

Although, current analysis of the determinants of enrolment have been dominated by the health system and economic systems frameworks, some research have explored SC for Ghana's NHIS

(Akuoko 2014; Fenenga, 2014). However, the focus has largely been on CBHI's with the research indicating that features such as the smallness of schemes, availability of information, trust and solidarity among community members, are important facilitators of enrolment

However, with the transformation of Ghana's NHIS into a fully national status per Act 852, different dynamics and challenges emerge. For example, while the smallness and solidarity that fuels enrolment in CBHI's is absent by default, the structure and operation of the NHIS has changed. The district mutual schemes which were hitherto the basic unit of the NHIS, have been collapsed into a centralized NHIS. These have led to concerns that a fully centralized NHIS may not enjoy the confidence and trust of the citizenry as was the case with CBHI's (Alhassan, 2015; NHIA 2016). The transformation therefore makes it critical to find out whether the SC influences which facilitate enrolment at the community level will still apply in a fully state controlled scheme (Adomah-Afari, 2017; Fenny, Kusi, Arhinful & Asante, 2016).

Mandatory membership, Voluntary Enrolment

An important dimension that has received less detailing in the literature is the membership architecture of the NHIS and its influence on enrolment (Duku et al., 2016; Amporfu, 2013). Whereas, membership in the NHIS is legally mandatory, it is voluntary in practice. No sanctions exist for not enrolling, but people are expected to voluntarily enroll by paying premiums, before they enjoy the benefits (Jehu-Appiah, et al., 2011; NHIA 2013).

The question that arises however, is how a policy that is mandatory but does not have a compulsion mechanism can ensure voluntary enrolment when it requires the payment of a prescribed premium. This is pertinent given Ghana's large informal sector and its associated irregular incomes, as well as complaints of corruption, mismanagement and poor quality services that characterizes the scheme (Abiuro & McIntyre, 2012; Amporfu, 2013). In the absence of a formal mechanism to

compel people to enroll, as may be in the case of vehicle insurance for instance, how the NHIS can enhance voluntary enrolment in the communities warrants some scholarly attention (Akazili et al., 2012). This study argues that, the theoretical assumption that individuals will voluntarily enroll because of expected benefits is essentially defective and that, a better understanding of the enrolment decision can be gleaned from SC theory which sheds useful insights on voluntary and collective action in the communities. The study situates the enrolment decision in the context of SC theory in the bid to generate insights for a better understanding of the enrolment decision.

Limited Application of SC in Developing Country contexts

The application of SC to explain policy outcomes is grounded in several theoretical and empirical studies (Dubos 2017; Grootaert & Van Bastelaer, 2002). However, a review of the literature shows that, most of these studies focus on developed country contexts. Thus, of the number of studies that apply SC to public policy, studies that focus on developing countries are either few or non-existent. So far, not much has been done to integrate SC into the policy implementation analysis in developing countries like Ghana, although the literature is consistent that policies thrive when there is a good amount of SC. Given that SC varies according to geographical location (Lin 2017), it is possible that applying SC to a developing country context with different institutions, and informal structures could yield different results. A SC lens in investigating enrolment in the Ghanaian context will therefore broaden understanding on the role of SC in enhancing or hampering policy objectives, and also generate insights on how to leverage the resource for effective policy management.

1.2 Research objectives

The study generally aims at investigating the role that SC plays in the enrolment decision in the NHIS. It is to determine how existing forms of social relationships and their associated norms and values in selected Ghanaian communities influence enrolment decisions in the NHIS. To achieve this broad objective, the following specific objectives were pursued;

1. To ascertain the forms of SC in selected communities in the Ashanti region of Ghana.
2. To determine how the forms of SC influence the decision to enroll and remain in the NHIS.
3. To explore how SC in the Ghanaian communities can be leveraged to enhance enrolment and effective implementation of the NHIS.

1.3 Research Questions

In pursuit of these objectives, the following specific research questions steered the research.

1. What are the forms of SC in the selected communities in the Ashanti region of Ghana?
2. How do these forms of SC influence the decision to enroll and remain in the NHIS?
3. How can SC in the communities be leveraged to enhance enrolment and effective implementation of the NHIS?

1.4 Justifications for the Research Questions

An important part of any academic study is the extent to which the underlying research questions are relevant and justified. This goes to the heart of whether or not the study will in the end bring anything new to the table by way of contributions to what is already known. The research questions outlined above are warranted, mainly in terms of the grey areas that were identified in the literature well discussed and presented in chapter two. The study provides insights into the context specific

factors influencing the enrolment decision and contributes to the literature by exploring SC as an important perspective for understanding enrolment decisions. The necessity of the research questions are summarized as follows.

The first research question is a response to the paucity of studies on SC in developing country contexts generally and Ghana in particular. This purely descriptive question sets the basis for a deeper analysis, by establishing the forms of SC that exist in the selected communities and their main expressions. The question also addresses in part, the social factors and contexts within which the enrolment decision is made.

The second research question responds to the limitation in the literature with regards to the application of SC theory to the enrolment analysis. This forms the study's main point of departure from existing scholarly work which was found to explain enrolment along the health and economic systems frameworks. The question is therefore in response to the increasing calls for studies to highlight the communal nature of the enrolment decision to balance the income based approaches which is driven by the notion that there are no incentives to enroll unless one sees a benefit (Fenenga, et al., 2015). Also embedded in this question is the gap on how the NHIS mandatory architecture can achieve voluntary enrolment. The question seeks to draw insights from how community obligations relating to existing SC can drive people to voluntarily enroll. Finally, it addresses the peculiar challenge of Ghana's NHIS, which has transformed into a full national scheme thereby presenting different dynamics.

The third research question follows from the need to distil lessons from SC, not just to enhance enrolment in the NHIS, but also the overall effectiveness in implementation of the NHIS. The question therefore further details the SC structures in the Ghanaian context, to find out how they

can be leveraged to drive enrolment in the NHIS and through that, draw lessons for implementation of public policies in general.

1.5 Significance of the Study

The study is significant in three main respects: research, practice and policy. The study recognizes that although several studies exist on why people enroll in health insurance, they have been limited to the economic and organisational issues. The social aspect has not been given enough attention, although these social forces and other context specific considerations are important for the enrolment decision. Against this background, this study is intended to fill the gap by contributing empirically verifiable data on the social forces underpinning the enrolment decision by applying SC theory. It is to generate further insights for better understanding by highlighting the significant virtue that SC theory holds. This will offer richer and better explanations of public policy outcomes.

With reference to the study's significance to practice, it directs the attention of managers as well as other stakeholders of the NHIS to indigenous approaches, institutions and actors that can help stimulate enrolment. The study provides pointers to previously overlooked ways of whipping up enrolment in developing country contexts where informal structures have more social acceptability. It also signals to managers to integrate its governance approaches to those of the local people.

In terms of policy, the study helps bridge the conventional divide between scholars, practitioners, and policymakers and offer richer explanations of policy implementation influences and outcomes. The study helps to integrate the macro world of policymakers with the micro world of individual implementers and beneficiaries.

1.6 Outline of the Thesis

This study is organized into nine distinct chapters. Chapter one sets the tone of the study by giving a general background and delineating the issues that constitute the research problem. The chapter also outlines the research objectives and research questions. Specifying the research objectives and questions were useful in ensuring that the study was steered along a particular course and within boundaries, in the midst of the many issues that were stumbled upon as the study progressed. The chapter also justifies the research questions of the study as well as the contributions that findings to the questions make to extend existing knowledge. The chapter ends with the study's significance and outline.

Chapter two reviewed existing theoretical and empirical work on the topic to serve as a background to the study and also map out grey areas (gaps) that require attention. Three main strands of literature were reviewed; policy implementation literature, health insurance literature and SC literature. A conceptual framework that integrates elements from the SC literature reviewed was developed to underpin the study.

As a qualitative piece, the context of research is an important consideration. Therefore, chapter three situates the study in its appropriate context in order to give life and meaning to the data that is collected and analyzed. Chapter four presents the methodology employed to execute the study. The chapter discusses the underpinning research philosophy and its related approaches, design and methods. It also discusses the sampling, sample size, data collection and analysis methods. Ethical decisions made in the study and the challenges encountered in the data collection process are all presented.

Chapters five, six and seven present analysis of the findings in response to the three research questions. Chapter eight interprets and discusses the overall findings of the study situating it in the

context of existing literature. Chapter nine sums up the key research findings, distills the relevant conclusions, contributions of the study to knowledge, policy recommendations, and gives directions for future research. The organisation of the study is summarized in figure 1.1 below.

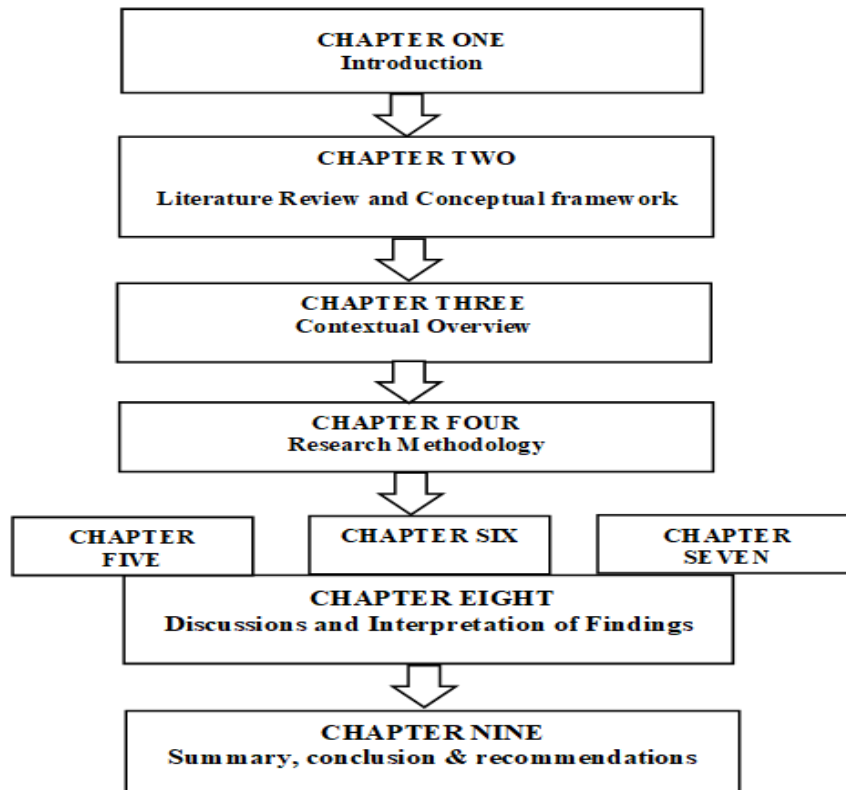


Fig 1.1: Thesis Structure

Source: (Author 2018)

1.7 Conclusion

This chapter introduced the study, setting the background and delineating the areas that constitute the research problem. Five research gaps were outlined, underscoring a dearth of studies on the social determinants that impinge on the decision to enroll in health insurance. Pursuant to this, a case was made for the deployment of the SC perspective which interprets social phenomena in its appropriate contexts. The research gaps identified were expressed as the study's objectives, which were consequently formulated into three key research questions. The scope of the study, its significance as well as a chapter disposition of the entire thesis were also presented. The next chapter provides a review of relevant literature within which the study is grounded.

CHAPTER TWO

SOCIAL CAPITAL, PUBLIC POLICY IMPLEMENTATION AND THE DECISION TO ENROLL: A CRITICAL OVERVIEW

2.0 Introduction

This chapter aims at achieving a number of objectives. Among other things, it seeks to provide a background literature within which the current study is situated. It is also to identify existing gaps in current knowledge that require scholarly attention. Since the thesis seeks to understand enrolment as a part of how the NHIS policy is implemented, the chapter first does a brief state-of-the-art of implementation studies with a focus on the current governance approach and its implications for implementation research. This is followed by a review of the extant literature on SHI, particularly on the determinants of enrolment, to establish whether the current discourse is missing out on other important factors by overlooking the social determinants. As a point of departure, the chapter reviews the literature on SC as a viable alternative to better organize, interpret and enhance understanding of the decision to enroll in SHI. In the final part of the chapter, two models of SC are reviewed and synthesized into a conceptual framework to guide analysis and interpretation of the study findings. The chapter concludes with a discussion on the connections between the gaps identified and the study's research questions.

2.1 Public Policy Implementation Research: A State-of-the-art

The reference point for contemporary implementation research has been Pressman and Wildavsky's ground-breaking work in 1973 titled *"Implementation: How Great Expectations in Washington Are dashed in Oakland; or Why It's amazing that Federal Programs Work At All"*. Following this work, research in the field was delineated along the top down and bottom up

perspectives. The top down perspective perceives policy implementation as a process that follows a deterministic path towards the realization of intended goals (Mazmanian & Sabatier 1981; Van Meter & Van Horn 1975). So positioned, scholars focused on tracking the extent to which policies made by senior officials are carried out as it goes through the administrative machinery (Hupe & Hill 2016; Matland 1995; Saetren 2014). This approach reflected the rational and scientific inclination of the time with implementation research embedded in the Weberian thought of bureaucracy, and perceived as hierarchical, linear and unproblematic (Hupe & Hill 2016). Thus, implementation was conceived as a linear and rational process moving toward a desired objective and the extent to which the policy objectives are achieved determined success or failure (Grindle & Thomas 1991; Van Meter & Van Horn 1975).

Framing implementation research in such prescriptive terms enhances the pursuit of effectiveness. By focusing on the extent to which legal mandates are carried out, research is aligned with the original intentions of policy makers and that makes it easy to track effectiveness or otherwise. However, the approach has been criticized for excessively focusing on top politicians and senior officials to the neglect of lower-level officials, local implementing officials and other private sector actors, even though they play significant roles in the implementation process (Berman 1979; Lipsky 1980; Sabatier 1986). Also, in the quest to develop universal theories and prescriptions that can be applied in all jurisdictions, the approach ignored the contexts within which policies are implemented (Ayee 1994; Riggs 1964)

Out of the theoretical weaknesses of the top down perspective, a contrary perspective, the bottom up approach emerged. The approach marks a theoretical shift in emphasis from the top hierarchy of government to lower level staff involved in implementation. Lipsky (1980), captures the essence of this shift when he argues that: “Public policy is not best understood as made in legislatures or

top-floor suites of high-ranking administrators, because in important ways it is actually made in the crowded offices and daily encounters of street-level workers” (pg xii). Lipsky’s view highlights the shift of implementation research focus onto ‘street level’ implementers because of the discretion they exercise in applying policy, which eventually influences policy direction. In this regard, bottom up-scholars conceive of implementation as a non-linear, dynamic and open-ended interaction among multiple actors and institutions who engage in a complex interaction and exchange of different viewpoints. To some extent, the approach accounted for the contextual factors that impinge on implementation of programmes.

While each of these approaches provide insights into policy implementation, Winter (2003), argues that each approach ignores a significant portion of ‘implementation reality’ that could be explained by the other approach. Therefore, in the bid to leverage on the strengths of both perspectives, attempts have been made by scholars to reconcile them (Hill & Hupe 2002; Matland 1995). But even still, there is no unanimity. While some scholars propose different ways of combining the two perspectives in research, others advocate for consideration to be given to the conditions under which one approach is more appropriate than the other (Hupe & Hill 2016; Matland 1995; Sabatier 1986; Saetren 2014).

2.1.1 Difficulty of Policy Implementation

The policy implementation stage is critical because it is the standard by which the effectiveness of government and public administration in general is measured (Ayee 1994; Makinde 2005; Saetren 2014). However, implementation is acknowledged to be a difficult stage, with gaps usually recorded between stated goals and their execution (Bardach, 1977; Grindle & Thomas 1991; Pressman & Wildavsky 1973). Hargrove (1975) labels these gaps between policy-making and

implementation as the ‘missing link’. The difficulty and disappointment from expected results of implementation had earlier been signalled by Pressman & Wildavsky, (1973) (see page 13). This difficulty had been captured by Bardach, (1977, p. 3);

“...It is hard enough to design public policies and programmes that look good on paper...it is harder still to formulate them in words and slogans that resonate pleasingly in the ears of political leaders and the constituencies to which they are responsive. And it is excruciatingly hard to implement them in a way that pleases anyone at all, including the supposed beneficiaries or clients”

As a result of the inherent difficulties in policy implementation, scholars have been engrossed with the enduring question of why it is relatively easy to formulate policies but more difficult to implement them. The implementation literature identifies several factors that constrain effective implementation. These include inadequate personnel and financial resources, (Ayee 2012; Van Meter & Van Horn 1975); lack of cooperation among implementing agencies (Robichau, & Lynn Jr. 2009); the role of politics and lack of support from the political class (Grindle 2017) and poor management (Ayee 2012; Hupe & Hill 2016).

The literature further identifies conditions that must exist for implementation to be successful. These include framing implementation statutes in unambiguous terms to give clear directives to the implementers (Van Meter & Van Horn 1975); grounding implementation in a sound theory and relating changes in target group behaviour to the achievements of the desired end (Mazmanian & Sabatier 1979); and ensuring that policy goals are not undermined over time by the emergence of conflicting public policies or by change in relevant socio-economic conditions that undermine the statute’s technical theory or political support (Grindle & Thomas 1991; Sabatier 1986).

While the identification of various factors enhances a comprehensive understanding of the implementation process, it also complicates implementation research as it is difficult, if not impossible to explore all the factors in any one single study. In third world countries like Ghana where a combination of other contextual factors like corruption and inefficiency impinge on the realization of policy goals, the difficulty in policy implementation is even more pronounced (Ayee, 2012; Makinde 2005; Grindle 2007).

2.1.2 Implementation Research in a Governance Framework

The research field of policy implementation is a dynamic one. Accordingly, the field has evolved from the initial clear cut top-down, bottom up posturing to a more complex approach that focuses on the dynamics of the implementation process and the important issue of participation by various actors (Bryson, Crosby & Stone 2015). This shifts implementation research to the governance framework, with an interest in not just the outcomes of public policies but more importantly, the processes of achieving policy goals. Central to this interest is the extent to which relevant actors are actively involved in the implementation process. Milward & Provan (2000), had argued earlier that situating implementation in a governance framework implies a; "...concern with creating the conditions for ordered rules and collective action, often including agents in the private and nonprofit sectors, as well as within the public sector. The essence of governance is its focus on governing mechanisms – grants, contracts, agreements – that do not rest solely on the authority and sanctions of government" (p. 3). The observation by Milward & Provan does not only emphasize the shift from governments to governance but it also captures the essence of the new governance approach to implementation. It indicates that public policies and programmes are now

administered through complicated webs of actors and institutions, nonprofit organisations, collaborations, networks, and partnerships.

Situating implementation research in a governance milieu has two important consequences which are relevant for this study. First, it directs the attention of scholars to the interaction of multiple actors, institutions, and levels in the implementation process (Hill & Hupe 2016). It makes it possible to focus on the collaborations between institutions and activities, drawing attention to the diversity of state-societal relations within which policies are implemented (Bryson, Crosby, & Stone 2015). Second, the multiplicity of actors, necessitates contextualization in implementation research (Newig & Koontz 2014). The multiplicity results in complexities, not only in policy interventions, but also in the interactions between the many actors, structures as well as the implementation context. For this study, this makes it pertinent to understand the Ghanaian context within which the NHIS is implemented.

Finally, multiplicity makes it difficult if not impossible for a single theory to anticipate and capture all of the complex interactions that impinge on a particular policy. This makes it relevant to situate studies in the country-specific contexts within which public policies are implemented (Boschken 2017; Hupe & Hill 2016). As a study that investigates enrolment as part of the broad issue of how the NHIS is implemented, the governance framework aligns the study to explore the governance arrangements in the Ghanaian context that can help drive the enrolment decision.

2.2 Social Health Insurance (SHI)

Social Health Insurance (SHI), is a health financing arrangement through which resources are pooled to finance the cost of healthcare (Kutzin Yip & Cashin 2016; Yu 2015). This approach provides members with financial protection from the cost of health care through prior payments

such that they do not pay upfront in times of ill health. SHI is a preferred option in low and middle income countries (LMIC) where raising revenues for financing the delivery of healthcare has been difficult; and where user charges and its consequent out-of-pocket payments (OOP) have had catastrophic consequences on individuals and families (McIntyre et al. 2006; Wagstaff 2009).

Generally, SHI is financed through a combination of tax revenues, private insurance, and social insurance. It is usually administered by the public sector or the private sector, or a combination of both. The development of SHI's tend to follow the approach of beginning from the foundations of CBHI's and transitioning into a full Health insurance scheme. This trend is influenced by the development of health service financing in the Beveridge and Bismarck models in Europe and Japan, where autonomous CBHI schemes eventually merged to form various types of national health insurance (Bennett, Kelley, & Silvers 2004; Criel & Van Dormael 1999;).

While several lessons are learnt from these models for developing country scheme's, particularly in terms of organisation, some scholars indicate that the contexts are different and hence the need for a contextualization of schemes to fit local conditions (Wagstaff et al., 2016). To a large extent, SHI in developing country contexts has been unsuccessful in securing the required numbers to sustain schemes, as is typified by Ghana's example which is bedeviled with low and stagnating enrolment numbers (NHIA 2016). For Ghana and other developing countries with low levels of public health expenditure, financing health insurance mainly from tax revenue has not been sustainable and this has affected the effectiveness of implementation (Agyepong & Agyei 2008; Jehu-Appiah, et al., 2011).

2.3 Social Health Insurance and Universal Health Coverage

An important context within which SHI is discussed in the literature is Universal Health Coverage (UHC). UHC as a standard in the health financing discourse is grounded in the philosophy that, citizens of all countries, developed and developing, should have access to affordable and quality healthcare (Obermann, Jowett & Kwon, 2018; Reich et al., 2016; WHO 2010). UHC is rooted in the principles of universality, equity and social solidarity. The World Health Organisation (WHO 2005, p.1) defines UHC as “access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost”. In this regard, a particular country achieves UHC, when all of its citizenry receive the quality health services they need without suffering financial hardships (WHO 2010; Yu 2015).

While the goal of UHC has over the years been more readily realized by the rich nations of the world, many middle-income and lower-income countries have not been able to keep up. Developing countries that have attempted instituting SHI programmes for its citizens include Brazil, Mexico, Thailand, the Philippines, Vietnam, Rwanda and Ghana. However, for many of these countries, although SHI is seen as an important vehicle towards the realization of UHC, the lack of adequate financial means to support the achievement of tax based health for all has remained elusive (Cotlear & Rosemberg 2018).

2.4 Enrolment in SHI: What are the Determinants?

Enrolment in SHI has been widely researched over the years. The issue has attracted the attention of scholars, governments and other international organisations not only because of its implications for UHC, but also because of its impact on the sustainability of schemes particularly (MHO)’s, and CBHI’s, which depend on premiums of subscribers for their sustenance (Abihiro & McIntyre

2012; Amporfu 2013; Schneider 2005). Given that enrolment in SHI is largely voluntary, previous studies have explored a range of factors that influence individuals to enroll in a SHI. These factors can be subsumed under three main categories. The first category comprises issues emanating from an individual's economic circumstances, largely referred to as the economic determinants of enrolment (Brugiavini and Pace 2016; Fusheini, Marnoch & Gray, 2012). The second category consider factors clustered around the characteristics of implementing agencies (Sakyi *et al.*, 2012). Studies that have explored these factors treat the enrolment decision as a function of how well schemes are organized and how efficient they are. The third category relates to the social characteristics of individuals and communities within which social health insurance policies are implemented (Atinga *et al.*, 2015; Fenenga *et al.* 2014; Schneider 2005). The issues here are of a social nature and include the social demographics of individuals, the general values and norms of communities, the general social context within which SHI policies are implemented and how these influence the enrolment decision. While some of the factors independently influence the enrolment decision, others do so in combination with other factors, and at varying levels of influence (Adebayo and Uthman 2015; Gottret & Schieber 2006; Jehu-Appiah *et al.*, 2011; Jütting, 2004; Lui & Chen, 2002)

2.4.1 Economic Factors

Echoes of the economic determinants of enrolment are dense in the literature with the discourse revolving around three interrelated factors; price, affordability of premiums and incomes of individuals (Chankova *et al.*, 2008; Folland, Goodman & Stano 2012; Jehu-Appiah *et al.* 2011). This stream of studies establish that the single most important determinant of enrolment, particularly in developing countries, is affordability of premiums, which is also a function of level

of income (Boateng & Awunyor-Victor, 2013; Odeyemi & Nixon, 2013; Witter & Garshong, 2009).

For example, in their study on Ghana's NHIS, Sarpong *et al.*, (2010) found that the wealthy were five times more likely to enroll than the poor. Similarly, an evaluative study of CBHI schemes in Nepal by Mishra (2015) revealed that enrolment was rather low among the poor, while retention of members was pro-rich bias. In that same regard, findings by Wang *et al.*, (2005) show that individuals with low income were less likely to enroll in CBHI programmes in rural China. In Moldova, Richardson, *et al.*, (2012) found that being unemployed or self-employed and having low income were significantly associated with non-insurance. Overall, these studies drum home the point that, the poor are less likely to enroll or more likely to drop out as opposed to the rich who can afford premiums. Thus, price and inability to afford insurance premiums serve as a hindrance to enrolment by the poor.

Contrary to this general view however, on the economic determinants, other studies suggest that the cost of premiums or income level is not a limitation to enrolment and that the poor could afford to pay premiums if they wanted to (Dixon, Tenkorang & Luginaah, 2011; Dixon 2014; Kotoh 2016). Implicit in this argument is the suggestion that other factors may be accounting for the decision to enroll instead of the much trumpeted income or cost of premium factor. But this notwithstanding, the price and affordability arguments have implications on enrolment because SHI, are pro-poor policies which aim at providing some kind of buffer for the poor.

2.4.2 Organisational and Scheme Related Factors

Research on enrolment have also explored organisational characteristics of implementing agencies as either enhancing or inhibiting efficient delivery of health insurance services and the decision to enroll. Scholars have explored scheme organisation related factors such as, managerial competence

and resources, provider attitudes, efficiency of agencies, convenience, communication, quality adequacy, constancy and reliability of services and certainty of benefits package as influencing membership and retention (Adomah-Afari 2017; De Allegri, Sauerborn, Kouyate & Flessa 2009).

For example in their study on the managerial problems of Ghana's NHIS, Sakyi *et al.*, (2012) found issues relating to reimbursement, claims management, waiting time, and other organisational factors as constraining service delivery. Other administrative factors relating to how schemes and their related service providers are organized, their internal processes and their responsiveness to client needs in the delivery of quality healthcare are also investigated. Within this context, the attitudes of implementers, experiences and influences of community members are also discussed (Arhinful, 2003; Fenenga, 2014). A central finding of these studies is that administrative bottlenecks facing implementing agencies serve as deterrents to enrolment in voluntary health insurance (De Allegri, Sanon, Bridges & Sauerborn, 2006; Jehu-Appiah, *et al.*, 2012). There is also some consistency in these studies that effective monitoring and supervision of implementing agencies and service providers, as well as understanding consumer preferences and integrating them into the design of health insurance are ways by which enrolment in SHI can be enhanced

2.4.3 Social Determinants

Apart from the economic and administrative factors, the literature has also examined the social factors influencing enrolment. Within the social factors, there are issues that play out at the individual level, while others emanate from the social and community context (Abihiro & McIntyre 2012; Boateng & Awunyor-Victor, 2013). The variety of issues explored under this category include, socio-demographic factors such as age, gender, education, family size, religion, marital

and health status, geographical location and other household characteristics (Dixon 2014; Gobah & Zhang, 2011; Pokharel & Silwal 2018).

In an impact evaluation study on the effects of Ghana's NHIS, Sulzbach *et al.* (2005) found that several household head characteristics, predicted insurance enrolment at the household level. Also, studies by Ahlin, Nichter and Pillai (2016) on membership in India's scheme found education level of household head, marital status, and household size to be significantly associated with the decision to enroll. Similarly, Chankova, Sulzbach & Diop (2008) used multiple regression analysis of household survey data from Ghana, Mali and Senegal to investigate the determinants of enrolment in MHOs, and the impact of MHO membership on use of health care services and on out-of-pocket health care expenditure for outpatient care and hospitalization. They observe that households headed by women were more likely to enroll in MHOs than households headed by men. According to Gnawali *et al.*, (2009), factors associated with dropping out of a community-based health insurance programme in Burkina Faso included; household head's education, larger household size, lower number of illness episodes in the past months and poor perceived quality of care. In a similar study in the Volta region of Ghana, Boateng and Awunyor-Victor, (2013) reported that females, Christians and married persons were more likely to enroll in the NHIS.

In recent times, there are also a few studies that have broadened the investigation of these social factors to cover the relationships between insurance and health service providers on one hand and community members on the other (Kipaseyia 2016; Mladovsky 2014). Such studies have analyzed enrolment to include other issues of trust and guarantee in services by the insurer and other healthcare providers, as well as the extent to which services provided meet clients' expectations. A gleaning of the literature however shows that studies that take this perspective are rather minimal with most of them focusing on CBHI's. There have been calls for more work to explain how these

social factors explain SHI outcomes especially in developing country contexts where their influence is much more profound.

2.5 Understanding the Decision to Enroll in SHI: Two Dominant frameworks

The foregoing discussions indicates that research into the determinants of enrolment in SHI have been very vibrant, with a plethora of studies, carried out in different jurisdictions, addressing different aspects of the enrolment decision. Generally, the research has been framed within two main perspectives; the economic systems and health systems (Akuoko 2014; Dror 2001, Mladovsky 2014; Preker 2004, Schneider 2005). The following subsections discuss these frameworks and their major limitation of blurring the social determinants as well as the context specific factors that influence the decision to enroll. The discussions serve as basis for the study's major contention that the social context is key in understanding the decision to enroll and that, SC theory is a better option to understand the dynamics of the social context.

2.5.1 The Health Systems Framework

A major framework within which scholarship on SHI has been conducted over the years is the health systems framework. This framework is consistent with the general model of health system analysis as set out by international agencies, particularly the World Health Organisation (WHO). Studies that are foregrounded in this framework explain the functioning of insurance schemes generally, and enrolment in particular in terms of the broader institutional context of countries (Bennett, 2004; Criel, et al., 2004; Mladovsky 2014). Research conducted from this perspective are framed in terms of the exchanges between clients, insurance schemes, health service providers and other related institutions of state (Bennett 2004; Bennett, Kelley & Silvers 2004; Criel et al. 2004; ILO 2002).

In terms of enrolment, the decision to register is seen as a function of the extent to which health institutions and allied agencies effectively coordinate to deliver quality services to the citizenry (Bennett 2004, Bennett, Kelley et al. 2004, Criel, Atim *et al.* 2004). Factors such as institutional decay, malfunctioning and poor performance of institutions and officials are cited as discouraging people from enrolling. These studies recommend improvement in organisational and technical competence of implementing institutions as an important means to bolster enrolment (Busse, Aboneh & Tefera 2014; Sakyi *et al.*, 2012).

2.5.2 The Economic Systems Framework

Another stream of literature explains the sustainability of SHI schemes and enrolment from the economic systems perspective. This framework, sets the enrolment analysis within the logic of market transactions and its determining factors such as price and quality, premium cost, information about products and services, and satisfaction of clients (Pauly 2004; Preker 2004; Zhang et al 2006). Anchored firmly in the neo classical economic view of rational utility assumptions, this framework is aligned with mainstream view of insurance that individuals will enroll in SHI to the extent that they can afford premiums, or are satisfied with the quality of services (Bennett, 2004; Bennett *et al.*, 2004; Criel, Atim, Basaza, Blaise, & Waelkens, 2004). To encourage enrolment, these studies prescribe the frequent dissemination of market information about price, improvements in quality and enhanced benefits in order to drive membership (Dror 2001; Mladovsky 2014; Pauly 2004).

2.5.3 Limitations of the Health Systems and Economic Systems Frameworks

A central assumption that underpins both the economic and health system frameworks is its view of individuals as rational actors. From this outlook, these two frameworks treat individuals as self-interested parties, who consider their interests and ‘what is in it’ for them before making the

decision to enroll or renew their membership (Dror 2001; Pauly 2004). While this approach has helped in highlighting the economic drivers of enrolment, they have been found to ignore the social context within which the enrolment decision is made (Fenenga 2014; Flyvbjerg 2001; Mladovsky 2008; Schneider 2005). Critics of these frameworks contend that it is too simplistic to analyze the enrolment decision solely at the individual level, because individuals exist within a broader social context made up various associations, groups, and web of relationships (Alder *et al.*, 2016; Arhinful 2003; Fenenga 2013; Mladovsky *et al.*, 2014). Central to the sustenance of these groups and communities are certain social and context-specific norms, values and expectations which exert influences, and to which individuals are tied in making decisions. For example in her study on CBHI in Rwanda, Schneider (2005) found community norms and values to have accounted for the decision to enroll. These influences, which are mostly informal have been found to be important in closely knit African societies where communal values and norms of association sometimes supersede individual choices and aspirations (Arhinful 2003; Hyden 2012) Therefore in the context of such communities, the social context and its associated norms and values are vital for understanding SHI viability and sustainability (Jowett 2003; Schneider 2005; Zhang, *et al.* 2006).

Furthermore, the concentration of these frameworks on the individual level has led to the neglect of other group dynamics that come to bear on decision making. Therefore, their prescription that high premiums prevent the “majority poor” from enrolling and therefore must be reduced has been found to be partially true. More recent research have found that even the so called poor could afford to pay premiums if they so wished. In the case of Ghana’s NHIS for example, evidence that those who are exempt from premium payment are rather not enrolling gives support to the position

that the current 40% participation rate is more than just a question of affordability of premiums (Kotoh & Van der Geest 2016; NHIA 2016).

These go to show that although the decision to enroll occurs with due consideration to the benefits that individuals are expected to gain, the fact that they exist within broader social-structural milieus puts some limitations on them. This makes it imperative to open up the discussion beyond the individual rational considerations, to cover the broader arena of community obligations and its influences. It calls for fresh and complementary directions in thinking, particularly on those that focus on the values, goals and norms of association in the communities and how it relates to enrolment and SHI policies in general (Arhinful 2003; Flyvbjerg 2001). Contributions from Andersen and colleagues for instance give support to the need for scholars to focus on socio-behavioural drivers of accessing health care (Andersen, 1968; Andersen, 1995; Gelberg, Andersen & Leake, 2000). SC theory as part of broad social theory becomes pertinent in this regard because of its proficiency in explaining social phenomena in its right contexts. It is against this call that this study draws on SC theory to integrate the various considerations that come to bear on the enrolment decision and for a systematic incorporation of the social context into the analysis, to enhance understanding.

2.6 Social Capital: A Viable Framework for Understanding Enrolment in SHI

The foregoing sections discussed the dominant frameworks that have been employed to analyze enrolment in SHI. The discussions revealed that the rational individualist assumptions that drive these frameworks have been limited because they do not incorporate the social determinants into their analysis. Also, these frameworks have been limited by their lack of consideration for the context specific factors that impinge on the enrolment decision. These make it imperative to look

for other complementary frameworks which capture the complexities of the social forces on the enrolment decision. Therefore, as a point of departure, this study adopts the SC framework as a viable alternative, with the contention that incorporating a ‘social thinking’ into the analysis enhances a better understanding of the decision to enroll.

2.6.1 Defining Social Capital

Like most concepts in the social sciences, SC does not lend itself to a single definition. There is no conceptual agreement among scholars on what SC entails. Several definitions of SC are found in the literature with any particular definition adopted depending on the focus of the study, discipline and level of investigation (Dolfsma & Dannreuther 2003; Manning 2017). According to Allinger (2013), the array of definitions reflect differences in author focus; with some concentrating on its nature and effects, while others focus on its possible benefits and where it resides.

Among the initial conceptualizations of SC are those given by (Bourdieu 1986) and (Coleman 1988). These scholars are known to be the first to have outlined systematic elucidations on SC. Kwon and Adler (2010) indicate that whereas the value of SC was recognized by Bourdieu, its theoretical framework was sketched by Coleman. Bourdieu (1986) defines SC as “the aggregate of the actual and potential resources which are linked to the possession of a durable network” (pg. 248). Bourdieu’s definition highlights the benefits that an individual or group can accrue (whether material or symbolic) from the various networks available to them. Also, embedded in his definition is the notion that networks are the primary means through which these benefits can be accessed. In Bourdieu’s reckoning, the benefits are either guaranteed by social institutions such as family, friends and acquaintances or from the establishment and maintenance of relationships

involving obligations that are subjectively felt (through feelings of gratitude, respect or friendship) (Bourdieu 1986; Field 2003).

These initial views of Bourdieu were criticized as too simplistic, concentrating just on the micro level and ignoring the power relations that exists within other networks beyond one's family and friends. To broaden the scope, Coleman (1988) introduced another dimension that focused on the relations among groups and not just individuals. He defined SC as “a variety of different entities (which) all consist of some aspect of social structure, and (which) facilitate certain actions of actors—whether personal or corporate actors—within the structure” (p. 598). So defined, Coleman viewed SC in a broader fashion, based on a combination of two significant components: “the social structure” and the “facilitation of action by individuals within the structure”. In his view, the groups serve as an important structure of society that connects people for the performance of certain actions.

The group dimension of SC and the benefits accrued from them which is very prevalent in the literature is as a result of Coleman's elucidation. Besides, although not explicitly stated, within Coleman's definition is the element of trust that has been recognized by succeeding scholars as vital for the facilitation of social action (see Burt 2017; Fukuyama 1995; Lin 2017). Trust is important for people to join groups for collective advantages and scholars have explored it as an essential element that allows members in a society to function independently of one another, but with a high degree of confidence that other members will act in the interest of all (Fukuyama 1995; Misztal 2013).

Beyond Bourdieu and Coleman, much of the current literature on SC is influenced by Putnam's (1993) work on civic participation and institutional performance in which he conceives of SC as ‘features of social organisation, such as networks, norms and social trust that facilitate coordination

and cooperation for mutual benefit' (1993, p. 6). Besides explicitly highlighting trust, Putnam also identifies the networks implied by Bourdieu as facilitating cooperative activities. In his later work, Putnam (2007), focused on the relationships between people and their social networks, and the associated norms of reciprocity and trustworthiness as serving as invisible glue that binds people and society together. This insightful conceptualization by Putnam's has been the theoretical basis for most policy scholars and other development actors.

In particular regards to public policy and development, Woolcock and Narayan (2000) have explored SC as a productive tool that can be accessed for development, being roughly equivalent to the social processes that facilitate collective action. They define SC as "the norms and networks that enable people to act collectively" (pg. 3). Woolcock and Narayan indicate that these norms include the information, trust and other norms of reciprocity inhering in one's social network. This view draws largely on Putnam's later work which broadened the scope further by analyzing SC as a 'stock', thus, the property of a group or community, district or even nation and enshrined in the features of social organisation - "networks, norms, and social ties that facilitate coordination and cooperation for mutual benefit" (Putnam 1995, p. 67). These expositions also introduced informal networks as important features of civic engagement which helps to build SC for improved community governance.

Author (Year)	Definition
Bourdieu (1986)	Social capital is the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition—or in other words, to membership in a group—which provides each of its members with the backing of the collectively-owned capital, a ‘credential’ which entitles them to credit, in various senses of the word
Coleman (1988)	Social capital is defined by its function. It is not a single entity, but a variety of different entities with two elements in common: they all consist of some aspect of social structures, and they facilitate certain actions of actors—whether persons or corporate actors—within the structure. ... Unlike other forms of capital, social capital inheres in the structure of relations between actors and among actors. It is not lodged either in the actors themselves or in physical implements of production.
Putnam (1995)	Social capital refers to the features of social organization, such as networks, norms and social trust that facilitate coordination and cooperation for mutual benefit
Woolcock & Narayan (2000)	Social capital refers to the norms and networks that enable people to act collectively

Table 2.1 Selected Definitions of Social Capital

Source: Author’s construct

2.6.2 Dimensions of SC Theory

SC has been characterized as a multi-dimensional concept with different typologies found in the literature (Narayan & Cassidy 2001). Liu & Besser (2003) for example, identify four dimensions of the concept: informal social ties, formal social ties, trust, and norms of collective action. For Onyx & Bullen (2001, p. 49), there are eight distinct dimensions of SC, many of which are related to each other. They identify these as; trust, social agency, tolerance of diversity, value of life, community connections, neighbourhood connections family and friends’ connections and work connections. While the category of any particular scholar has depended on the focus of study and

level of analysis, some of the issues identified tend to overlap all the classification. This study reviews three broad categorizations which seem to cut across all the different dimensions identified in the literature.

SC as ‘Capital’

The dimension of SC as capital goes back to the work of Bourdieu (1986) in which he identified SC as one of the three forms of capital (economic, cultural and social), each with its own relationship to the class structure of any given society. Following that, SC has been treated as some kind of wealth or capital that resides in social relations or the networks that an individual possesses (Krishna & Uphoff 2002; Portes 1998). Compared with the other commonly known types of capital such as human and financial which reside in one’s knowledge, skills, landed property or labour in production, SC is reckoned to reside in social relations that facilitate the achievement of otherwise difficult objectives of the acquisition of other resources (Krishna & Uphoff 2002). These social relationships are therefore seen as assets or ‘capital’ that “can be called upon in a crisis, enjoyed for its own sake, and/or leveraged for material gain” (Woolcock, 2001, p.12)

In contemporary discourse on SC, scholars emphasize this ‘capital’ dimension to refer to the worth of social relations, and resources such as information, ideas, and support that individuals are able to secure by virtue of their relationship with other people (Burt 2017; Donati 2013). Viewed this way SC, comprises the set of resources accessible through social relations; relations that are social in nature (Grootarert & Van Bastelaer 2002; Krishna & Uphoff 2002). In this sense, SC in the form of family, friends and associates is a form of capital which can be utilized or transformed into other forms to meet one’s needs.

SC as 'Function'

SC has also been conceptualized in instrumental terms and according to its function. In outlining SC as a theoretical tool for understanding social action, Coleman (1988) presented a functional elucidation of SC and argues that its value resides in the role that it performs. According to Coleman, this is so because like other forms of capital, SC is productive, and makes possible, the attainment of certain ends. This view is consistent with Lin (2017) who describes SC as the resources 'accessed and/or mobilized in purposive actions'.

Coleman elaborates further that although SC comprises a variety of different entities, it has two core elements. The first is that, it consists of some aspect of the social structure and second, that it facilitates certain actions of actors within the structure. In addition, he identifies two specific types of social structures that are especially important in facilitating the various forms of SC. The first is one that creates closure in the social network so that all actors are connected in a way that obligations and sanctions can be imposed upon its members. The second is an organisation created for one purpose but utilized for another. Viewed this way, Coleman broadened the boundaries of the concept to include vertical and horizontal associations and behaviour within and among other units. Thus 'bridging' SC, for example is much more heterogeneous, cutting across diverse social cleavages and is therefore useful in connecting to external assets and for information diffusion

However, defining SC according to its function is one perspective that has been heavily criticized in the literature. Scholars such as Portes (1998) point to the ambiguity of focusing on function and the "laundry list" of forms — compounding the sources, determinants and outcomes of SC. Such scholars argue that this opens the way to confusion and contradiction in the wider SC literature pointing to the failure of Coleman and Putnam to distinguish the definition of the concept both theoretically and empirically from its attributed effects.

SC as 'Networks'

Another important conceptualization of SC is the network view which emanates from the work of Bourdieu (1986). Building on the work of Granovetter (1973), he defines SC as; “the aggregate of the actual or potential resources which are linked to the possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition” (pg.248). Embedded in the network view are a number of useful ideas, with implications for how SC has been applied in the literature. Bourdieu’s treatment of SC in instrumental terms highlights the benefits that come to people who possess important networks in a social structure. As noted by Lin, (2001, pg. 29) resources are “embedded in a social structure that can be accessed and/or mobilized in purposive actions”; where the social structure refers to relationships (that are the frame of a network) among social actors. The relationships constitute the network of an actor and ultimately his SC (Lin 2017).

Overall, the literature shows some divergence among scholars on what SC constitutes, largely because of the different uses and perspectives of the concept. However, the different perspectives offer the opportunity for scholars to emphasize different aspects of the concept for a complete understanding. Therefore, while each dimension on its own is not able to explain the concept in its entirety, they collectively contribute to its comprehensive meaning (Putnam, Leonardi, & Nanetti 1993). In all of it however, one sees a central thread running through all the dimensions, and that is that, SC comprises social relationships between people or groups, and inherent in these relationships are resources that can be harnessed to better the lot of an individual or group. This position seems to be well captured by Woolcock & Narayan (2000) who observed that the basic idea of SC is that “one’s family, friends, and associates constitute an important asset, one that can be called upon in crisis, enjoyed for its own sake, and/or leveraged for material gain”(pg. 3). Overall, the various views of SC are discussed across key concepts including; trust (Coleman 1988;

Fukuyama 1997; Putnam 1993); rules and norms governing social action (Coleman 1988; Portes & Sensenbrenner 1993; Fukuyama 2001); network resources (Kilpatrick 2000; Snijders 1999); social interaction (Snijders 1999); networks (Burt 1997; Putnam 1995).

2.6.3 Forms of SC

The forms that SC can take are also very much contested in the literature. While some scholars view the forms across its constitution, others, discuss it along the various levels of interaction. In terms of what it constitutes, two main forms are discussed and these are; structural and cognitive (Krishna & Shrader, 2000, Ferrari 2016). These two are dynamically linked and are seen as mutually reinforcing, although not essentially. There is however a third dimension, referred to as relational SC, but which is largely seen as a product of the two main ones. In regards to the levels of interaction, micro (bonding), meso (bridging) and macro linking) forms of SC are discussed (Coleman 1988; Lin, 2017).

Structural and Cognitive SC

Structural SC encompasses the basic structures of society, mainly rules, procedures, and norms that underpin social obligations (Lin 2017; Mouw 2006). They are the building blocks of communities and are embedded within one's contacts (Lin, 2017; Coleman 1988). These building blocks facilitate mutually beneficial collective actions through the establishment of social networks and roles (Uphoff, 1999) and are valuable because although latent, they can be mobilized in times of need (Grootaert 2004). Therefore the volume of SC possessed by a given agent depends on the size of the network of connections that he can effectively mobilize (Bourdieu 1986). In this regard, individuals who occupy key strategic positions and those whose ties span important networks are said to have more SC than those who do not. This is precisely because their position gives them heightened access to more and better resources.

However, SC does not only reside in the existence of social relationships and structures but also in the extent to which these relationships can be leveraged by individuals and groups for some good (Arrow 2000; Grootaert & Van Bastelaer 2002). Therefore, cognitive SC on the other hand covers the norms and values that orient or predispose people towards taking advantage of the structures and resources for both individual and collective action. It is this predisposition that gives rise to the values in solidarity, trust and cooperation (Grootaert & Bastelaer, 2002; Uphoff, 1999). Cognitive SC then, is the result of socialization processes through internalization of a particular set of values and norms that one can take advantage of and/or be taken advantage of by others. Cognitive SC is linked to the individual's view of available networks which is quite significant because the same set of networks and relationships can be perceived differently by different individuals and consequently condition their tendency to effectively utilize them.

Bonding Bridging and Linking forms of SC

The forms of SC are also discussed along the various levels of association; which are the micro, meso and macro levels (see fig 2.1). Szreter and Woolcock (2001) present a “three-dimensional approach” that recognizes the different types of social connections - bonding, bridging, and linking. Woolcock and Narayan (2000) identify bonding SC as the relationships and connections that exists within a group or community characterized by high levels of similarity in demographic characteristics, attitudes, and available information and resources. Bonding SC exists at the micro level between ‘people like us’ who are ‘in it together’ and who typically have strong close relationships. Solidarity and trust are the basis of these bonds and they reside in networks of family members, close friends, and neighbours (Adler & Kwon 2002; Poortinga 2006)

Bridging SC, exists at the meso level and it integrates individuals, groups, and communities into societies. They exist between social groups, social class, race, religion or other important socio demographic or socioeconomic characteristics. Linking SC exists at the macro level between individuals, communities and their formal institutions (Grootaert & Van Bastelaer 2002; Lin 2017; Woolcock & Narayan 2000).

In this study, the forms of SC are applied along the lines of bonding, bridging and linking. In assessing these forms in the communities however, the structural and cognitive forms are also considered. The bonding, bridging and linking forms are further detailed out in the conceptual framework of the study in section 2.10.2 of this chapter.

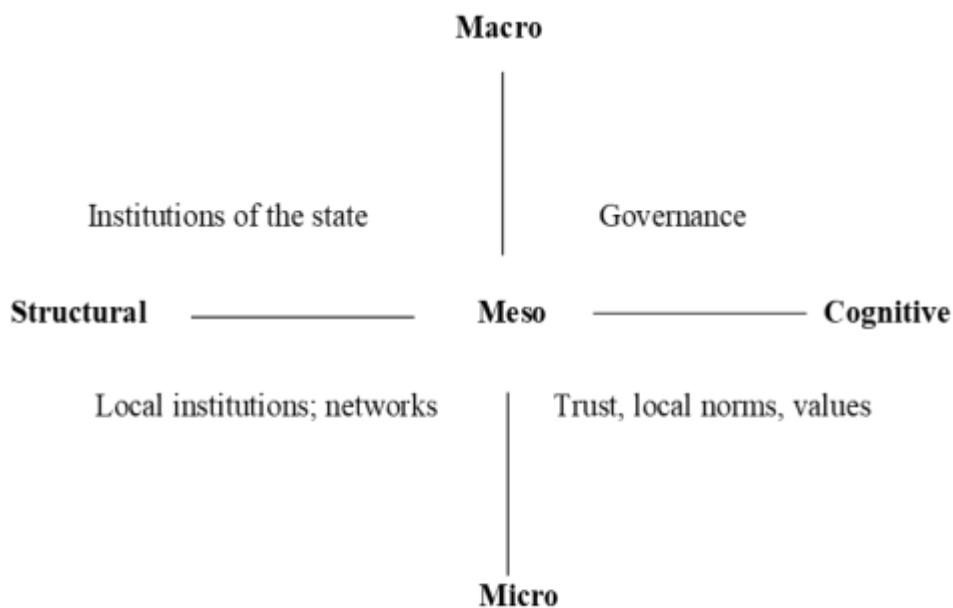


Fig 2.1: The forms of SC

Source: Grootaert and Van Bastelaer (2002:18)

2.7 SC and Public Policy

The nexus between SC and public policy has been theoretically and empirically established in the literature (Dubos 2017; Lang & Hornburg 2010; Kumlin & Rothstein 2005). The theory's potential and usefulness for policy development and implementation has grown among scholars because they identify social relations key sources of mobilization and support; two vital ingredients for effective policy implementation. This is against the backdrop that orthodox implementation research has largely been based on frameworks and theories that do not adequately consider the environments in which policy decisions are implemented (Lang & Hornburg 2010; Peters et al., 2008).

In exploring the utility of SC for effective functioning of public policies, scholars have been keenly interested in its potential to identify and understand how these resources and support are invested in and developed, how they are accessed, and what kind of benefits flow from them. So understood, scholars are well placed to better harness its potential in realizing the objectives of public policies (Woolcock & Narayan 2000). The literature recognizes SC as important to the efficient functioning of public policies as aspects of the concept such as inter-personal trust are clearly desirable in themselves while other aspects are more instrumental (Bankston & Zhou 2002). Narayan and Cassidy (2001) for example opine that optimism, satisfaction with life, perceptions of government institutions and political involvement, all stemming from the fundamental dimensions of SC have important implications for public policy effectiveness. The resource is also credited with the effectiveness of institutions of government (Aldridge & Meyer 2015; Moore & Kawachi 2017; Putnam et al. 1993); community governance, and economic problems (Lang & Hornburg 2010; Bowles & Gintis 2002).

2.8 SC and Social Health Insurance

SC and its relevance for understanding enrolment in SHI has also attracted some scholarly attention. Attempts have been made by scholars over the years, to link SC theory to health insurance outcomes, and several empirical studies exist in this regard (Akuoku 2014; Apoya & Marriott 2011; Donfouet & Mahieu 2012; Fenenga 2014; Mladovsky & Mossialos 2008; Mladovsky et al., 2014). As far back, Asenso-Okyere et al. (1997) used contingent valuation method to study CBHI in Ghana and established that community members are willing to pay for health insurance because of high levels of SC among them. In a similar study on Cameroon and Burkina Faso, Donfouet and Mahieu (2012) found that solidarity and trust between members formed a key foundation for the successful functioning of CBHI in those countries. Schneider (2005) also investigated micro-health insurance in Rwanda, and found trust as a component of SC to influence membership. Factors that came up as important considerations in Schneider's study include: the management of the insurance scheme; the capacity of the scheme to respond to consumer needs and patient concerns; and the mechanisms instituted by the managers to ensure quality care for clients. Schneider's study is particularly significant because it unveiled key factors that promote trust in insurance: clients' ability to influence appointment of management, accounting systems, sound financial management, timely provider reimbursement and negotiations with providers for better quality care. Other recent studies that have and SHI include Apoya & Marriott (2011); Donfouet & Mahieu (2012); Fenenga (2014); Mladovsky et al., (2014). Generally, these studies have found the smallness, trust and solidarity among community members as well as full information as important facilitators of CBHI's. Consequently, the prevailing notion is that, the greater SC in the community, the more people are willing to enroll and pay for health

insurance. SC has been found to improve SHI outcomes through increased knowledge and information flows, collective action and accountability between schemes and communities.

While the review so far suggests that a significant number of studies linking SC and SHI outcomes exists, it is also clear that most of these studies have been done on CBHI's. However, in most cases, CBHI's have been used as vehicles to achieve fully national health schemes as happened in Europe, Japan and Ghana (Mladovsky 2014). This makes it pertinent to find out whether the SC features which have been found to facilitate enrolment in CBHI's also apply to nation-wide SHI programmes, where management seems more distant and accountability leaves the domain of the local people (Akuoko 2014; Atinga et al., 2015). In addition, some disagreements still remain among scholars on the exact channels through which SC facilitates enrolment. Beyond identifying the linkages, existing studies have not explored the role of the SC structures in the communities for the enrolment decision. Finally, the review shows that none of the existing research is conducted from a policy implementation perspective in a way that links the SC influences to policy outcomes. These gaps warrant some scholarly attention and that is what this study attempts to do.

2.9 SC: A Critique

The foregoing sections have outlined several positive implications of SC generally and specifically for SHI policies. While the concept is very much celebrated as an important framework for explaining collective actions that facilitate policy and development outcomes, it has also been criticized for several weaknesses both as a resource and as an analytical tool for explaining policy outcomes.

The loudest critique of SC, comes from scholars in the field of economics (Durlauf & Fafchamps 2004; Matsukawa & Tatsuki 2018; Portes 2017). These scholars maintain that SC cannot be

classified as ‘capital’, because the notion of capital implies things that can be owned and transferred, but compared to say, economic capital, it is difficult to change the ownership of SC. As argued by Arrow (1999), capital is something “alienable”, whose ownership can change from one person to another. This view has however been watered down by other scholars who invoked Coleman (1988, 1990), argument that SC is an incidental by-product of different relational activities, and therefore can be analytically treated as an externality (Seferiadis, Cummings Zweekhorst & Bunders, 2015).

As a resource, SC has been criticized for being a double edged sword. Some scholars argue that whereas it can be used for good purposes, it can also hinder an individual, group or community’s welfare (Grootaert et al., 2003; Moore & Kiwachi 2017). Thus, the SC which produces benefits for certain groups of people by virtue of their membership of that group, also excludes others who do not belong to the group. Classic examples are tribalism in Africa and closed groups like mafia in Italy, which tend to produce benefits for only its members. In such situations, SC benefits members of a few, and not non-members or the community at large (Itaya & Tsoukis 2018; Woolcock & Narayan 2000).

Also, because SC is not evenly distributed across individuals and communities, it is criticized for exacerbating already existing inequalities (Lin 2000; Strathdee 2000). Also, individuals who have some forms of SC capital can have access to more resources thereby increase their SC as opposed to the poor and less networked. Related to these deductions are the ideas of Bourdieu (1986) that SC forms are fungible and that individuals who already hold some forms of capital (economic, social, cultural and/or symbolic) are strategically more adept at accumulating and transforming them. This also suggests that not all relations are beneficial to everyone and not all social relations are ‘SC’.

In particular regards to public policy, the potency of SC in enhancing policy and development outcomes has been questioned with several country level studies showing that merely having high levels of SC and informal groups do not necessarily guarantee development. For instance, a World Bank study on Rwanda indicates that in addition to over 30,000 informal groups, about 3000 cooperatives and farmer groups existed in that country, but that could not stop the world's most harrowing civil war from happening in that country (Woolcock & Narayan 2000; World Bank 1989). Likewise, in many Latin America countries indigenous groups are often characterized by high levels of social solidarity, but experience high levels of poverty nonetheless because they lack the resources and access to power that is necessary to shift the rules of the game in their favour (Narayan 1999; Woolcock & Narayan 2000).

Finally, as a theoretical tool, SC has been flawed for its lack of conceptual clarity and standard means of measurement (Grootaert & Van Bastelar, 2002; Fukuyama 2001; Onyx & Bullen 2000). Grootaert & Van Bastelar (2002) contend that in addition to a lack of congruence among scholars on what the concept actually entails, it has also been difficult to develop concrete, tangible evidence of SC especially in terms of how to measure it. For some scholars the popularity of the SC is what seems to have encouraged the application of overly aggregated, heterogeneous indexes (Knack 2002). Others maintain that due to the abstract nature of SC and varying definitions, it is often measured inconsistently between studies (Liu & Besser 2003; Putnam 2001).

2.10 Towards a Conceptual Framework for the Study

This thesis argues that the decision to enroll in health insurance goes beyond mere economic and rational considerations. It contends that the decision to enroll is influenced by certain underlying social forces which are better understood by framing research within SC theory. This final section reviews two SC frameworks, as a means of developing an appropriate conceptual framework to guide the study.

2.10.1 SC Framework by Grootaert et al., (2004)

This study draws from a SC measurement framework developed by Grootaert et al., (2004). The framework gives due consideration to the multi-dimensionality of SC, focusing on both the structural and cognitive dimensions. Consequently, it categorizes the SC dimensions into six broad groups for analysis. The framework reflects the study's objective of ascertaining SC in the communities and how the group membership (structural) and subjective perceptions of trust and norms (cognitive) manifest, and influence the enrolment decision. The key elements of the framework are presented as follows.

Groups and Networks

This category relates to an individual's membership, nature and extent of participation in various types of social organisations and informal networks. It covers the various groups and networks that people can call upon, as well as the range of contributions that they make to these groups. This category also considers the diversity of a groups' membership, how its leadership is selected and how ones involvement changes over time. Groups and networks are desirable to foster development and that, the more groups and networks are available in a community, the better it is for development.

Solidarity and Trust

Solidarity and trust are two important pillars of SC, and on which social relationships are established. Solidarity is the extent to which members of a particular group have a sense of protecting each other. Trust on the other hand is the expectancy that other social actors or members of a group will act in the interest of all. According to the authors, this category is an important gauge of cognitive SC, as it helps to understand an individual's disposition to depend on family members, neighbours, and other agents of state and how these change over time. Trust and solidarity are important to understand how individuals stick to their families or groups as well as why they join forces to undertake other collective activities. This is because underlying collective decisions and actions are issues of solidarity and trust.

Collective Action and Cooperation

Collective action and cooperation is the extent to which individuals come together to solve common problems. According to the authors, this can also be expressed in how individual's or community members work with others in the community on joint projects and or in response to a crisis. The category also considers the consequences of violating community expectations regarding participation and relates to the density of associational life or the frequency of community collective action. The usefulness of this for SC analysis is that in a majority of settings, development or communal activities are possible only if a significant amount of SC exists in the community. Therefore, this category is concerned with three main issues: the extent of collective action, the type of activities undertaken collectively, and an overall assessment of the extent of willingness to cooperate and participate in collective action.

Information and Communication

In Grootaert et al., (2004) classification, information and communication are considered very crucial. This dimension focuses on the extent of one's access to information; the ways and means by which people receive information regarding market conditions and public services as well as the extent of their access to communication infrastructure. The authors recognize information as important in helping citizens make informed choices while communication offers them the opportunity to participate in the decision making process, thus giving them a voice in matters affecting their well-being. It also enables policy makers get feedback on the impact of their decisions.

Social Cohesion and Inclusion

According to the authors, one of the positive indicators of SC in a community is the incidence of frequent social interactions. Therefore, this dimension brings together, three main concerns in SC analysis: sociability, conflict and violence. These are important to explore social unity and togetherness in the community as well as specific experiences of exclusion. The category examines whether communities are characterized by various forms of conflict, the nature and extent of such differences, the mechanisms by which they are managed and which groups are excluded from key public services. Issues pertaining to everyday forms of social interaction also fall in this category.

Empowerment and Political Action

Empowerment is defined by Grootaert et al., (2004) to mean the ability to make decisions that affect everyday activities. They combine empowerment with political action which is the extent to which one engages in concrete political activities such as attending public meetings, meeting with politicians or public servants, participating in demonstrations and voting in elections. Altogether,

this category captures the extent to which individuals are empowered to have a measure of control over institutions and processes directly affecting their well-being. It emphasizes issues such as an individual's capacity to influence both local events and broader political outcomes.

2.10.2 Policy Framework of SC (Woolcock & Narayan 2000)

This study also draws extensively from the SC framework developed by Woolcock and Narayan (2000). The framework synthesizes different perspectives of SC and discussions on whether individuals are rational agents or governed by values, norms and social obligations into one policy context. Consistent with classical conceptualizations by Bourdieu (1986) and Coleman (1988), the framework distinguishes between bonding, bridging, and linking SC at the three main levels of interaction: micro, meso and macro. To aggregate the concept into a unified conceptual framework for policy analysis, the authors introduce a fourth dimension made up of two key concepts: embeddedness and complementarity.

Bonding SC (micro level)

SC resides in the relationships/interactions that exist between people. Building on previous literature, Woolcock & Narayan (2000, p.3) apply bonding SC to mean the “exclusive ties of solidarity between individuals who share common characteristics”. Bonding refers to the social support provided by indigenous social institutions such as family, friends and neighbours, at the basic levels of social organisation. Bonding is characterized by a strong feeling of solidarity, identity, reciprocity and shared values, and is usually confined to people of the same family, homogeneous ties, and backgrounds. Bonding ties generate trust and other norms of reciprocity within and among members of the family and it is the basic resource for members to manage risk and vulnerability helping them to “get by” in life. According to the authors, this level is assessed

simply by the number and density of groups in a given community. Because of their importance for community development and other cooperative activities, they maintain that bonds are inherently good and that “more is better”. Thus, the presence of bonding SC has a positive effect on development.

Bridging SC: relations across individuals (meso level)

According to the authors, bridging SC refers to the connections across people of different ethnic, religious or occupational groups and who are more or less equal in terms of their status and power. Bridging manifests in the prevalence of various forms of associations and groups. Examples are social and welfare groups that provide solidarity and mutual support in the communities. Woolcock and Narayan indicate that the underlying motive for this kind of SC is reciprocity. Thus, by associating with a solidarity group, an individual protects his or her own interest. This also forms the basis of the network view of SC which argues that residing in a given network is SC which can be leveraged or utilized for some benefits.

Linking SC: relations between communities and state institutions

Woolcock and Narayan (2000) focus on a third level of interaction which is linking SC. This level draws on the social and political environment that shapes the “social structure” and enables the development of norms (North, 1990; Olson, 1982; Woolcock & Narayan 2000). Existing at the macro level, linking SC refers to the relations between communities and their formal administrative institutions. Other institutional scholars focus on this level and indicate that the strength of community linkages and civil society is largely a result of the political, legal and institutional environment (North 1990; Skocpol, 1995). Therefore, the capacity of individuals and communal associations to act in their collective interest is contingent on the quality of the formal institutions under which they reside. Linking SC of an individual or community therefore includes

the institutions, the relationships, the attitudes and values that govern interactions among people and contribute to their economic and social development. According to Woolcock & Narayan, this level comprises the most formalized institutional relationships and structures, such as the political regime, civil and political liberties, the judicial system and the rule of law. Overall, the performance of public institutions rest on their own internal consistency, competency and their external accountability to the public.

Finally, Woolcock and Narayan postulate that relations between communities and state institutions (state-society synergy) can be enhanced through ‘embeddedness’ and ‘complementarity’ (see table 2.3). Embeddedness refers to the nature and extent of ties connecting citizens and public officials as well as how policy structures and processes are aligned with local community structures. Complementarity on the other hand, refers to mutually supportive relations between public institutions and community groups, civil society organisations. These allow for co-production, complementarity, participation, and linkages for effective policy management. The key perspectives and their policy prescriptions are organized in table 2.3 below.

Situating the study in Woolcock and Narayan’s framework is useful for understanding the enrolment decision in several respects. First, it helps to better analyze the motivations underlying enrolment by focusing on how responsibilities that flow from solidarity and trust are nurtured; how the proliferation of social networks induces the desire to engage in communal activities, and how information is diffused. Secondly, it helps to explain how community relations with formal implementing agencies facilitate trust, solidarity, social exchange and community engagement at the different levels of interaction. The framework is also consistent with current policy implementation research which emphasizes the inclusion of multiplicity of actors, structures and institutions in the governance process.

Perspective	Key Actors	Policy Prescriptions
<i>Communitarian View</i> Local associations	Community groups Voluntary sector	‘Small is beautiful’ Recognize social assets of the poor
<i>Networks View</i> Intra (‘bonding’) and inter (‘bridging’) community ties	Entrepreneurs Information brokers’	Decentralization ‘Bridging’ social divides
<i>Institutional view</i> Political and legal institutions	Private / public sector	Civil and political liberties, transparency, accountability
<i>Synergy View</i> Community networks state-society relations	Community groups, civil society, firms and states	Co-production, complementarity, participation, linkages ‘Scaling up’ local organizations

Table 2.2 Perspectives of SC: key actors and policy prescriptions

Source: Woolcock & Narayan (2000:14)

2.10.3 Conceptual framework for the study

Whereas the two frameworks outlined above were found to be the most relevant in helping to ‘think about’ how SC influences the decision to enroll in the NHIS, it was found that not all elements in the frameworks were relevant for the study. Therefore the researcher considered the most relevant elements and synthesized them into a ‘tailor-made’ framework to guide the study. The synthesized framework is presented below in fig 2 below. The framework argues that SC in the communities in the forms of bonding, bridging and linking may influence the decision to enroll. Whereas bonding, expressed through family solidarity, norms of reciprocity and trust, and information are important for enrolment, bridging in the form of groups, networks and sources of

information are important. For linking SC, community and state relations, trust, engagement and information and communication are significant.

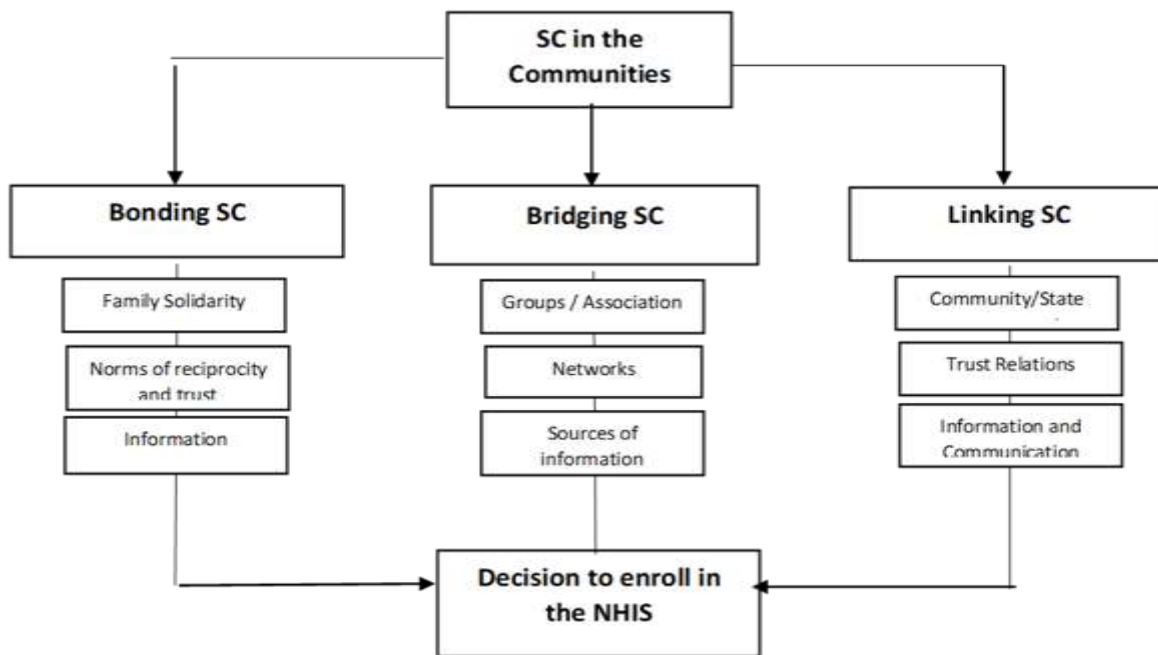


Fig 2.2: SC and the decision to enroll in Ghana’s NHIS

Source: Author conceptualization from reviewed literature (2018)

2.11 The Literature and Research Questions Connect

The review so far shows that there have been considerable research conducted on SHI and enrolment in particular. However, the research has been limited because it focuses on the economic and organisational induced constraints, with the enrolment decision explained by two main prevailing frameworks; the health systems and the economic system frameworks. The fundamental assumption behind these frameworks is expected utility as espoused by the rational individualist

model of decision making. Although useful, these frameworks explain enrolment at the individual level, and do not take into consideration, the social context within which decisions are made. They have also steered the discussions off the social dynamics of the enrolment decision. The frameworks explain. Others scholars contend that these more are more tailored to developed country contexts characterized by formal structures and institutions. In developing country contexts where informal institutions and structures are predominant, these frameworks have not sufficed. It is against this backdrop, that the thesis explores SC theory as a complementary option to fully capture the complexities of the decision to enroll in Ghana's NHIS.

The first research question which examines existing forms of SC in selected communities arises from the paucity of studies on SC in Ghana. Because research on SC in the Ghanaian context is limited, this question is to establish the status quo, by exploring the structural building blocks of SC and its forms (bonding, bridging and linking). This is a purely descriptive, theory laden question that sets the basis for further and deeper investigation. The second research question builds on the previous one, to explore the influences of the forms of SC on the decision to enroll. The question details the cognitive dimension, examining the extent to which individuals are influenced by the existing structural forms and how that manifests in the decision to enroll. The third and final research question arises from the need to draw insights from the SC structures and actors identified in the study, as a way of complementing current strategies to drive enrolment and effective implementation of the NHIS.

2.12 Conclusion

This chapter presented the literature in which the study is positioned. Three main strands of literature were reviewed: policy implementation literature, SHI literature and SC literature. The policy implementation literature was reviewed to provide a background and to bring the study up to speed on research so far. It was also to highlight the governance focus of implementation research in contemporary times. The health insurance literature was reviewed to identify weaknesses in the current discourse and the inadequacy of the dominant frameworks in accounting for the social determinants of enrolment. The review established that the economic systems and health systems frameworks have dominated research, but their inherent assumption of individual rationality has limited understanding. They do not adequately address the context-specific considerations even though they are important in the enrolment decision. The chapter established that rational decisions are also socially constructed and context determined and individuals made rational decisions to the extent that they are consistent with established social norms and values. These social norms and values include norms of solidarity, reciprocity, trust relationships and other informal constructions in society.

As a point of departure, the chapter reviewed the SC literature as an alternative to better understand enrolment decisions in the NHIS. The potential of the SC framework lies in its versatility, depth and comprehensiveness. Thus, while accounting for the social forces underpinning individual and group action, SC theory also captures the rational and economic motives of the health systems and economic systems framework, which is very much accounted for at its macro level (linking SC).

CHAPTER THREE

CONTEXTUAL OVERVIEW OF THE RESEARCH SETTING

3.0 Introduction

This chapter presents a background overview of the context within which Ghana's NHIS is implemented. As a qualitative study, the context chapter is relevant to provide life and meaning to whatever data is collected and analysed. The chapter therefore sets the tone for the empirical chapters by addressing two key issues. The first is on the peculiar features of the healthcare delivery system in Ghana whereas the second covers the prevailing context and conditions, within which the NHIS was introduced, and how that impacts scheme generally and enrolment in particular.

The chapter first presents a brief country context of Ghana and a description of the Ashanti region where the study is carried out. This is followed by a sketch of Ghana's healthcare system and the health financing strategies employed from independence till date. In so doing, the weaknesses of the user fee policy are highlighted leading to a discussion of the NHIS and why it was particularly woven on social solidarity arrangements. The chapter then outlines the social and political contexts within which the scheme was introduced. It ends with the implications of the informal nature of the country's economy for the decision to enrol.

3.1 The Country Context: Ghana

Ghana is the first country south of the Sahara to gain its independence from Britain in 1957. Located on the west coast of the African continent, the country is bounded to the north by Burkina Faso and in the south by the Gulf of Guinea about (5 °N of the equator). It is also bounded to the west by Cote d'Ivoire and to the east by Togo. Although the country is bordered by three French

speaking countries, its official language is English. It has a total land area is 238,537 square kilometres, with an estimated population of about 27 million (GSS, 2015). The country is divided into three main ecological zones: a sandy coastline backed by a coastal plain vegetated by savannah grasslands, scattered by several rivers and streams; a middle belt and western parts of the country heavily forested with many streams and rivers; and a northern savannah, drained by the Black and the White Volta rivers. About 70% Ghana's population live in peri-urban areas but the rural areas are generally considered deprived, without basic infrastructure such as roads, electricity and water supply (Seddoh et al., 2011).

3.1.1 The Study Context: Ashanti Region

The study is conducted in the Ashanti region, located in the middle belt of Ghana. Kumasi is its capital, and it shares boundaries with four of the ten political regions of Ghana: Brong-Ahafo, Eastern Central and Western. The region has thirty districts made up of one metropolitan, four municipal and twenty five districts. The 2010 population and housing census (PHC) puts the region's population at 4,780,380 making it the most populous in Ghana. The predominant ethnic group of the region is the Asante, although it has a diverse mix of other ethnic groups.

In terms of economic activities, the region has about 85.7% of its employed persons in the informal sector with the public sector, accounting for only 6.6 percent (GSS, 2010 PHC). A vast majority of jobs in the public sector are concentrated in its capital Kumasi and other big towns. Like other regions of Ghana, residents in the rural areas are mostly engaged in agriculture. Majority of the economically active population are self-employed, mainly in the private informal sector jobs like masonry, carpentry and trading which provides job opportunities, particularly for those with little or no formal education. In terms of health, the regions has about five hundred and thirty (530) health facilities. This is made up of one hundred and seventy (170) government owned, seventy-

one (71) by missions; two hundred and eighty-one (281) by private individuals and organisations and the eight (8) by quasi government institutions. About 32% of all health facilities in the region are managed by the Ghana Health Service (GHS) (GHS 2015). Figure 3.1 below presents the map of Ghana showing the case study regions.

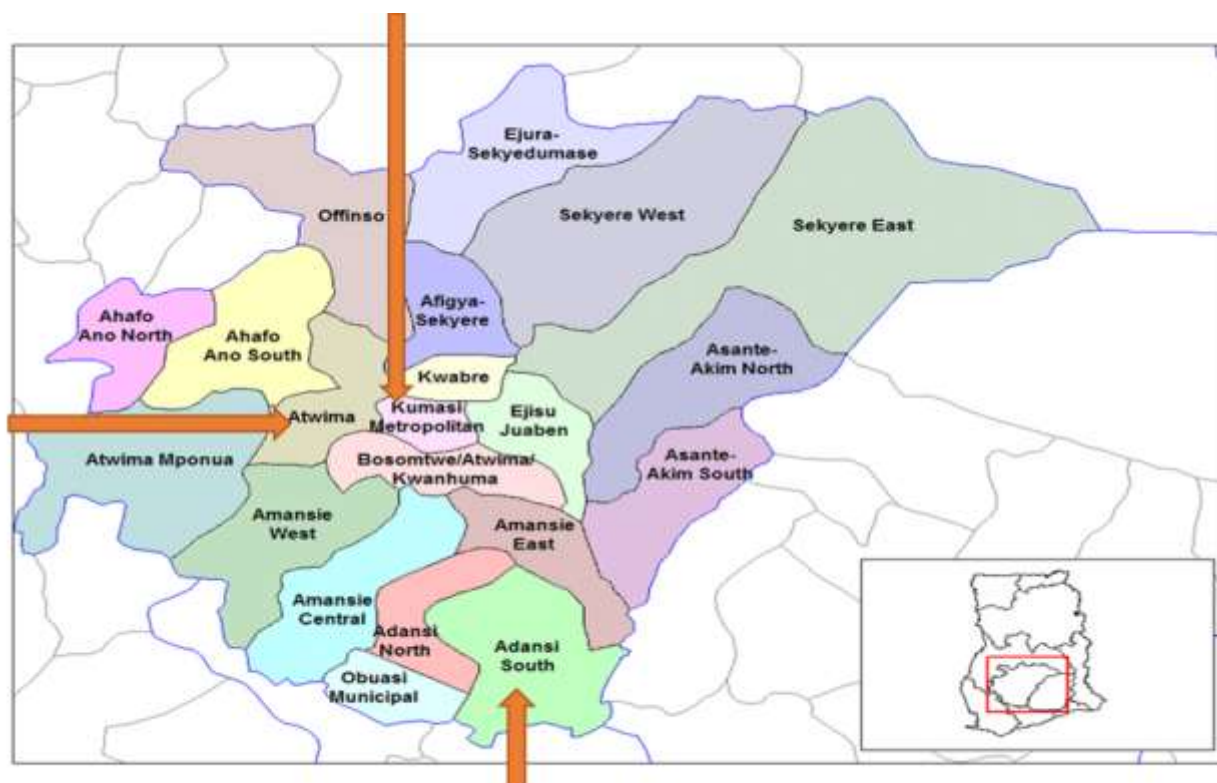


Figure 3.1 Map of Ashanti region showing the three case study areas

3.2 Ghana's Healthcare System

Ghana has an integrated and multilevel health system that comprises a range of teaching, regional and district hospitals as well as health centres, community-based health planning and service zones, private health providers, and non-governmental health-related organisations to deliver healthcare across the country (see Figure 3.2). At the top of affairs is the Ministry of Health (MOH) which superintends the entire health sector with other regulatory bodies and the National Health

Insurance Authority (NHIA). Like other ministries in Ghana, the MOH has its headquarters in the capital Accra with regional and district offices spread across the country. The MOH performs key functions relating to healthcare provision and this revolves around formulating policy, mobilizing, and allocating resources (Appiah-Denkyira et al., 2013; Seddoh et al., 2011). The ministry also monitors, regulates and evaluates the delivery of health services by the Ghana Health Service (GHS), the teaching hospitals and other related agencies.

Central to the healthcare system, is the Ghana Health Service (GHS), with the mandate to manage the public health system. Their mandate is to “ensure access to health services at the community, sub-district, district and regional levels” (Appiah Denkyira et al., 2013; GHS 2014; Rajkotia 2007). Also vital is the Christian Health Association of Ghana (CHAG), a private, not-for profit, semi-autonomous agency partly funded by the MOH, with surrogate authority for managing mission based health facilities. There is also the private-for-profit sector, comprising private hospitals, clinics, maternity homes and pharmacy shops, mostly found in the towns and cities, as well as chemical shops, traditional herbal practitioners in both rural and urban areas. The system also covers the quasi-government hospitals and clinics of the various security services - police service, the armed forces; and the universities. Although these quasi-government facilities are primarily set up for the respective institutions, their services are open to the general Ghanaian public (Appiah-Denkyira et al., 2013).

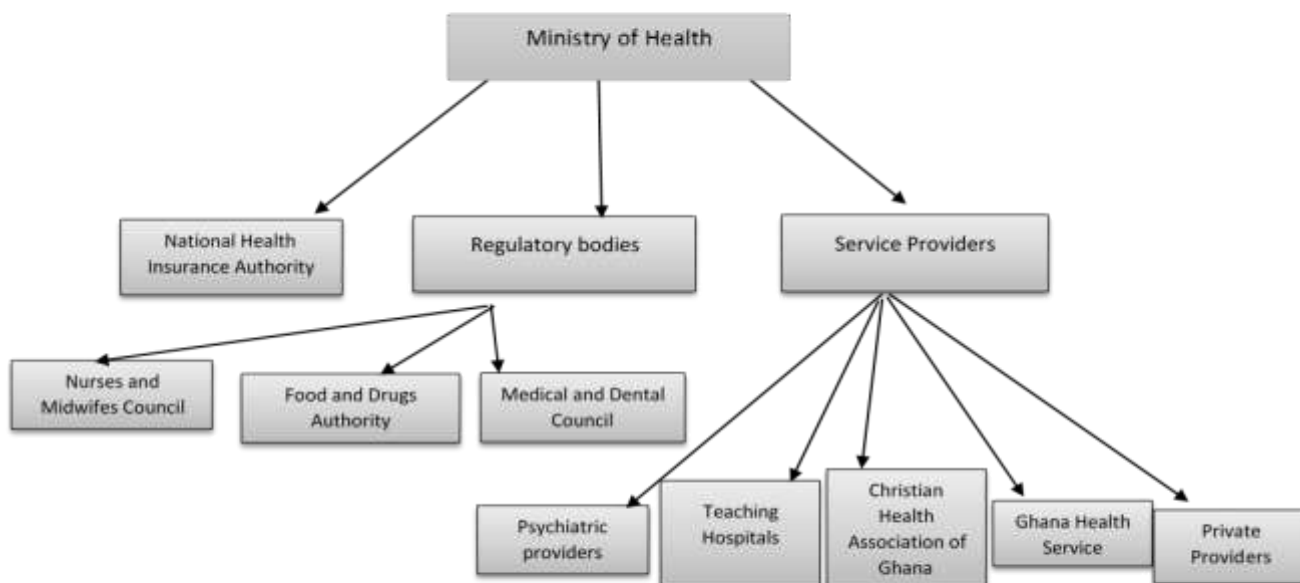


Fig 3.2: Ghana's Healthcare System

Source: MOH, modified by World Bank (Schieber et al., 2012)

3.3 Healthcare Financing in Ghana

Financing healthcare in Ghana has gone through a chequered development. While some periods were characterized by free healthcare, funding at other times was through user fees. The mode of financing at any point in time has had consequences on the delivery of healthcare services and infrastructure, as well as the health seeking behaviour of the citizenry (Addae-Korankye, 2013; Akazili, & Mooney 2011).

Prior to independence, healthcare was funded mainly by out of pocket payments (OOP) (Agyepong, 2013). Although some public financing existed, it was a preserve of expatriate civil

servants, and ordinary citizens were not covered (Agyepong, 2013; Agyepong & Agyei, 2008; Yevutsey & Aikins, 2010). In the immediate post-independence period, free healthcare financed from general taxation, was introduced by the new government. This was consistent with the pro-socialist orientation of the government of the day, which wanted to correct the inequities that had been inherited from the colonial era (Yevutsey & Aikins, 2010). The government expanded public sector infrastructure with health care facilities increasing from ten (10) to forty-one (41) between 1957 and 1963. New health care facilities were established at the local level as part of government's efforts to bridge the gap between rural and urban areas (Agyepong, 2013; Osei-Akoto 2004).

The fee free policy existed alongside private sector health care that was paid for by users. This was in spite of later attempts by the government to ban private medical professionals and private health care facilities from charging patients after rendering health care services to them. Later on, the 'free health for all' agenda and the ambitious health expansion projects of the government could not be sustained as the country's economy faced challenges and began to record budget deficits (Agyepong, 2013; Mensah et al. 2010; Yevutsey & Aikins, 2010).

3.3.1 The Era of User-Fees

As has already been hinted, the fee free programme of the immediate post-independence era became difficult to sustain in the context of economic decline in the mid-1960s. According to Rajkotia, (2007, p. 18), shortages of basic drugs, supplies and equipment at the hospitals that characterizing the adoption of IMF and World Bank structural adjustments programmes (SAP) by the Government in 1983 necessitated a policy change: the introduction of user charges and subsequently the "cash and carry" system in 1985. The user fee system was therefore to recover

part of the cost of health care in the country (Escobar et al., 2011; Gilson, 1997; Mensah et al., 2010).

However, the cash and carry system had negative consequences for healthcare delivery in Ghana with several harrowing experiences by citizens. Generally, it led to a situation where access to healthcare became a preserve of the rich because they could pay. The poor were denied access because health care facilities were unwilling to offer services to people who could not pay (Agyepong & Adjei, 2007; Sunyazi, 2003; Waddinton & Enyimayew, 1990). Atim and Sock (2000) report that because of the inability to pay, most people were hesitant to go to the hospital until their illness intensified or became complicated. While some patients absconded from hospitals after their treatment, others had no alternative but to rely on traditional practitioners or resort to self-treatment/medication (Atim et al., 2001). Notwithstanding these negative consequences, the policy could not achieve much; not its target of recovering 20% of operational costs from patients. The era of user fees only made healthcare unaffordable, inequitable and inaccessible to the ordinary Ghanaian.

3.3.2 Community Based Health Insurance (CBHI) Initiatives as a Prelude to the NHIS

In the context of the debilitating effects of the ‘cash and carry’ policy, policy makers and other stakeholder’s searched for more viable and humane alternatives to finance healthcare in Ghana. A preferred option in this regard, was for CBHI’s which was mushrooming in many developing countries at the time (Preker et al., 2007; Shaw & Griffin, 1995). But while CBHI in other countries were largely at the instance of their governments, those that took place in Ghana were hatched by private interests and limited to certain geographical areas (Atim et al., 2002; Singleton, 2006).

The first CBHI, the Nkoranza District Health Insurance Scheme, started in 1992 by the Catholic Diocese of Sunyani, which managed the Nkoranza District Hospital. The initiative was primarily a facility cost-recovery scheme that to deal with the persistent problem of patients inability to pay for care (Atim & Sock, 2000; Escobar et al., 2011). This was followed by a community health insurance arrangement by the West Gonja Catholic Hospital at Damongo in Northern Region in 1995 (Atim & Madjiguene 2000; Sunyazi, 2003). These initiatives by the Catholic Church excited other stakeholders, mainly the MOH and government, who began to explore prospects of setting up similar schemes in other parts of the country. Around 1999, a new model, the mutual health organisation, was introduced. The model typified by the Nkoranza scheme, was based on social solidarity, community ownership, and democratic control, as opposed to the provider driven model. This model spread rapidly in the country, expanding from three (3) schemes in 1999, to forty seven (47) in 2001, 159 in 2002, and 258 in 2003 (Atim et al., 2002). Several factors have been found to account for the viability of CBHI's. Of these, the hardships of user-fees has been found to be the most important, providing fertile grounds for people to enthusiastically embrace the concept of an alternative healthcare financing that does not exert financial stress on individuals and families during times of sickness (Agyepong, 2013; Atim & Sock, 2000).

The problems associated with the user fee system and the excitement about mutual health organisations was a key issue in political discussions, but it got to a crescendo in the heat of the 2000 general elections. The then leading opposition political party New Patriotic Party (NPP), harped on the issue, and promised to supplant the cash and carry with a health insurance scheme if they won power (Rajkotia, 2007; Singleton, 2006). Upon winning power, the NPP government established the NHIS as an alternative means of financing and providing affordable and accessible health care to all persons in Ghana. Although several disagreements characterized the discussions,

the NHIS was still considered the most viable alternative to replace the user fee policy, and to improve access to health care in Ghana.

3.4 The National Health Insurance Scheme (NHIS)

Ghana's NHIS began in 2003 with the passage of the National Health Insurance Act 650, by parliament. The policy provides a social health policy framework that delivers a financially viable and socially inclusive healthcare system with the specific objective to "secure the provision of basic healthcare services to persons resident in the country" (NHIA 2003). To fully operationalize the scheme, Legislative Instrument (LI) 1809 was passed in 2004 to provide regulations under which the NHIS was to operate, paving the way for actual implementation in 2005. The Act provided for the establishment of a National Health Insurance Authority (NHIA) to manage the scheme and a National Health Insurance Fund (NHIF) to provide a sustainable means of funding the scheme.

Three types of health insurance schemes are approved to operate under the National Health Insurance Act. These are; District Mutual Health Insurance Schemes (DMHIS), Private Commercial Health Insurance Schemes (PCHIC) and Private Mutual Health Insurance Schemes (PMHIC). Whereas the private commercial schemes operate as limited liability companies, the private mutual schemes are organised by individual groups of persons for their own benefit. Under the NHIS Act, these two do not receive any financial support from the government. The Act further mandates districts to establish their own district mutual health insurance schemes (DMHIS). These were independent but operated under the NHIA, which also provides subsidy from the National Health Insurance Fund (NHIF), for their operations. The state sponsored DMHIS were the dominant health insurance schemes across the country, operational in all the districts of Ghana. In 2012, a new legislation, Act 852 was enacted to replace Act 650 and that has affected the structure

and operation of the NHIS. An important implication of the new law is that the DMHIS's have been merged to form a nationwide National Health Insurance Scheme (NHIS). Thus, the district mutual schemes, which hitherto were the basic units of the NHIS, have been collapsed into a fully centralized NHIA (Schieber et al., 2012). Table 1 summarizes the main elements of Ghana's NHIS.

Table 3.1: Key Components of Ghana's NHIS. Source (s): NHIA Act 650 (2003), LI 1809 (2004) and Act 852 (2012)

Key Elements	Selected Highlights
Legislative instruments	The main legal frameworks guiding the implementation of Ghana's health Insurance; Act 852 2012 (which replaced Act 650 (2003) and LI 1809 2004
Governance	A National health Insurance Authority; A fifteen (15) member National Health Insurance Council to manage the National Health Insurance Fund, regulate the private health insurance market and accredit and (in collaboration with relevant agencies) monitor service providers under the scheme
Administration	A national Health Insurance Secretariat to provide administrative support to the National Health Insurance Council in the implementation of the Scheme.
Membership	<p>Enrolment and membership in the National Health Insurance Scheme is mandatory for all residents of Ghana.</p> <p>Some persons are to be exempted from paying membership fees and they include;</p> <ul style="list-style-type: none"> • Contributors to the SSNIT or those drawing pension benefits on SSNIT • Persons under the age of 18 • Persons above the age 70 years • Persons in need of ante-natal, delivery and post-natal health care services • Persons classified as indigents by the Minister for Social Welfare and other categories prescribed by the Minister

3.4.1 Funding Architecture of the NHIS

A major point of disagreement that characterized the design and implementation of the NHIS has been how to fund the policy. As a low income country, the contest has been over the capacity of the state to fund the policy mainly from taxes, and also the lack of clarity on how to sustain it in the long term. These disagreements have characterised the scheme since its inception with implications for effective implementation of the policy (Addae-Korankye 2013; Abihiro & McIntyre 2012).

The establishing Act of the NHIS earmarked three main sources of funding the scheme. The first is tax revenue in the form of a 2.5 % VAT or NHI levy on selected goods and services which amounts to about 70 % of the fund. There is also a 2.5 % of contribution of Social Security and National Insurance Trust (SSNIT) members, which contributes about 20 % to the fund. The third source is from out-of-pocket income adjusted premiums ranging from GHS7.2-GHS48 (US\$ 2-US\$12) for non SSNIT contributors. Premiums account for less than 5% of the total inflows to the NHIF. These main sources aside, there are other inflows of revenue to the fund. These include sector budgetary support allocated by the Parliament of Ghana, income accruing to the NHIF from investments made by the NHI Council, and grants, fees, donations, gifts and voluntary contributions made to the fund. There are also a 2.5% of Social Security and National Investment Trust (SSNIT) and pension scheme contributions, money allocated by parliament, money accruing from the fund investment, gifts, donations, grants and other voluntary contributions.

At the local (district) level, the DMHIS are mandated by NHI Act to collect annual premiums from subscribers, except the exempt groups. The premiums are determined by schemes in accordance with directives of the NHIA. Another source of funding for DMHIS is registration fees; the Act has mandated DMHIS to collect registration fees in addition to premiums (NHI Act 2003). The

DMHIS are to make payments of claims to health care providers. According to Regulation 38, the time for payment of healthcare claims to health care facilities and providers should be “within four weeks after the receipt of the claim from the health care facility” (NHI Regulation 2004: 18). Well-timed reimbursement of health care facilities is necessary for them to render quality healthcare services to NHIS clients at all times.

3.4.2 Enrolment in the NHIS

Enrolment in the health insurance schemes has been a topical issue mainly because of its implications for UHC. For the NHIS, the establishing Act makes membership mandatory for all residents in Ghana, with enrolment done on individual basis. The new Act 852 of 2012, also makes it obligatory for employers to ensure that all their employees are registered under the NHIS. Individual adults aged 18–69 years in the informal sector pay annual premiums (i.e. direct premium-paying adults) as determined by the DMHIS and approved by the NHIA. The premium ranges between 7.2 Ghana cedis (GhC) (US\$4.8) to GhC48.0 (US\$32) depending on the socio-economic status (SES) of the individual. However due to the difficulty in determining SES of people in the informal sector, the premium is in practice set at a flat rate and varies from district to district. Formal sector workers are exempted from direct premium payment to become members because they contribute to SSNIT. They are however not automatic members of the NHIS until they physically enroll with a DMHIS of their choice by paying a registration fee.

As a social protection policy, the NHIS provides several exemptions to the poor and vulnerable. Initially, the establishing Act exempted children under 18 years from paying premium if at least one parent or the guardian is a valid card holder. This provision has however been scrapped by the new Act 852 of 2012. The registration of children under five years has also been decoupled from that of their parents and therefore they can be registered even if their parents are not registered.

Other groups covered by the premium payment waiver are the elderly (≥ 70 years), SSNIT pensioners, and core poor indigents identified by communities. Also, pregnant women are exempt from (for antenatal, delivery and post-natal healthcare services) are also exempted from paying premiums to become members of the scheme. Apart from the indigents and pregnant women, all exempt populations are required to pay a registration fee of Gh¢4.0 (US\$2.7) but this varies according to the districts.

3.4.3 NHIS Benefits Package

The NHIS has a comprehensive benefit package which covers over 95% of disease conditions in Ghana (NHIA, 2016). The package includes out-patient and inpatient care, deliveries (including complications), diagnostic tests, generic medicines, and emergency care (Escobar *et al.*, 2011). The benefit package however excludes treatment for cancers apart from breast and cervical cancers, HIV retroviral drugs, dialysis for chronic renal failure, hormone and organ replacement therapy and few others. The benefits package is standard and must be adhered to by all districts and facilities.

Table 3 2: NHIS Benefits Package. Source: Culled from NHIS Service and Drug list 2016:14

Type of Service	Benefits
Out-patient Services	General and specialist consultation reviews General and specialist diagnostic testing, including laboratory investigation, X-rays, ultra sound scanning Medicines on the NHIS list Surgical operations such as hernia repairs, incision and drainage,
In-patient Services	General and specialist in-patient care; Diagnostic tests; Medication prescribed on the NHIS medicines list, blood and blood products Surgical operations; In-patient physiotherapy
Oral health	Pain relief (tooth extraction, temporary incision and drainage) Dental restoration (simple amalgam filling, temporary dressing)
Maternity Care	Antenatal care; Deliveries (Normal and assisted); Caesarean section Postnatal care
Eye Care services	Refraction; Visual Fields; A- Scan; Keratometry; Cataract Removal; Eye Lid Surgery.
Emergencies	Medical, surgical, paediatric, obstetric and gynaecological emergencies Road traffic accidents Industrial and Workplace accidents Dialysis for acute renal failure

3.4.4 Status of Enrolment in the NHIS

The NHIS has made significant progress in providing healthcare to a number of Ghanaians who would have been excluded from the health system. Since becoming operational in 2005, the schemes' enrolment rate has increased steadily, albeit with some declines, from 6 % in 2005 to a current 40 % of the population, translating to about 11 million people active members (Adusei-Asante, 2017; NHIA, 2017). While this represents an improvement over the years, it is considered

low by some scholars, given that NHIS premiums and registration fees are relatively affordable and there is a comprehensive premium exemption package for a large section of the population (Kusi 2015). There are also doubts that the enrolment figures are inaccurate, and that enrolment rates may actually be lower when non-renewals are taken into account (Apoya & Marriott, 2011; Brugiavini, & Pace 2016). For instance, Dixon, Tenkorang & Luginaah (2011) point out that the NHIA’s calculations for active membership (i.e., the portion of registered members with up to date premium payments and card renewals) overestimate active membership by improperly tracking membership identification cards. While these suspicions may also be contested, it signals to scholars to focus more attention on enrolment to understand the undercurrents and explain why people are reluctant to enroll in the NHIS even when they are exempted from paying premiums.

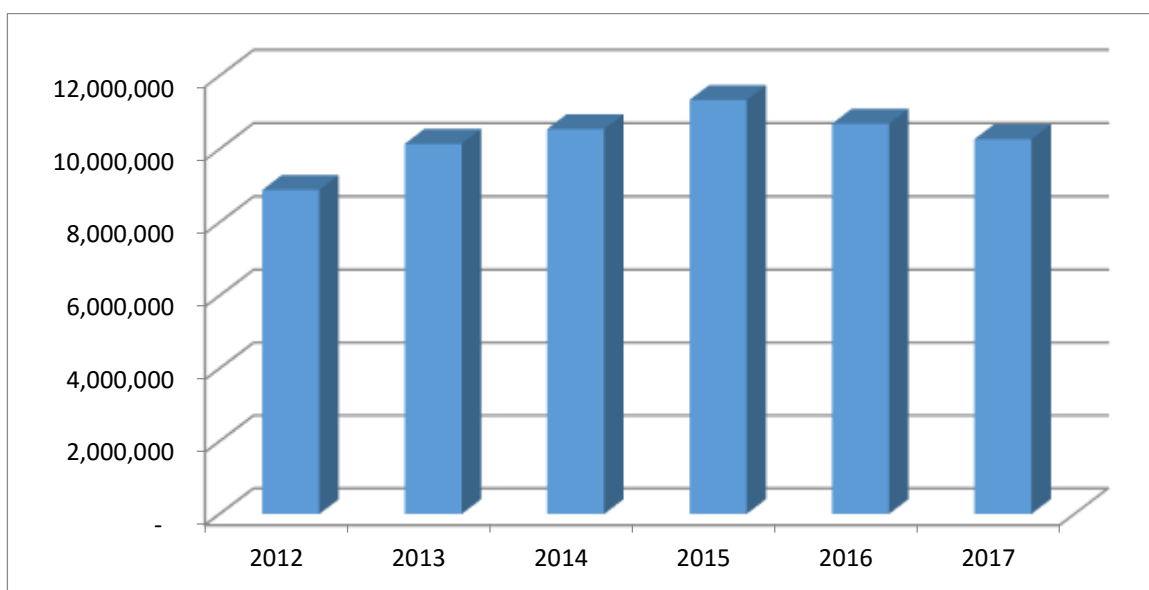


Fig 3.3 Annual NHIS Membership Trend from 2012-2017

Source: NHIS 2018 (*2017 Figures are provisional)

3.5 Social Context of the NHIS

The social context within which public policies are implemented influence outcomes to a very large extent (Brinkerhoff, 1996; Grindle 2007; May, Johnson & Finch 2016). For the NHIS, the social context is particularly relevant for a better appreciation of the solidarity arrangements built into the policy. The NHIS was introduced as an alternative framework for mobilising social support through contributions from premiums and taxes in a pre-payment system. This was in the context of harrowing experiences of the then cash and carry system which had created barriers to healthcare access and excluded the majority of Ghanaians particularly those in rural areas (Agyapong & Adjei 2008; Arhinful, 2003).

The cash and carry system was inconsistent with the Ghanaian social system which is built on solidarity and caring for others (Arhinful, 2003; Durairaj, D’Almeida & Kirigia, 2010). The NHIS was therefore a response to the need for a humane health financing system in Ghana properly aligned to the values of the Ghanaian society. It also explains why a number of social protection elements are built into the NHIS. The objective was to institute a mechanism of financing health with a direct impact on lives of the poor by providing assistance to those most in need and insuring them against adverse shocks (Durairaj, D’Almeida & Kirigia, 2010).

The development of Ghana’s scheme followed the typical approach of beginning as CBHI’s, and transitioning into a full national scheme. This trend of development is influenced by the Beveridge and Bismarck models in Europe and Japan, where independent CBHI schemes in the nineteenth century eventually merged to form various types of national health insurance (Bennett, Kelley & Silvers, 2004; Criel & Van-Dormael, 1999). While several lessons have been drawn from such development models to inform Ghana NHIS, the variations in social contexts have led to different results particularly in terms of enrolment. The Ghanaian context has peculiar characteristics that

distinguish it from other settings within which SHI are implemented (Arhinful, 2003; Agyepong, and Adjei, 2008; Fenenga, 2014). In particular, the combination of a large informal sector, weak state capacity and a small tax base, and the absence of a compulsion mechanism have made UHC through voluntary enrolment difficult to realize. Although Act 852 (2012) and 650 (2003) stipulate mandatory membership, in de facto, enrolment in the NHIS is voluntary, and that has made it difficult for the scheme to oblige people to enroll.

3.6 Political Context of the NHIS

Several political disagreements characterized the introduction of the NHIS with implications for its implementation particularly in terms of financial sustainability and enrolment (Ayee, 2001; Carbone, 2011; Sulzbach et al., 2005; Tetteh, 2012). The disagreements were mainly on which health financing option was appropriate for Ghana at the time. While discussions on the need for a national health insurance policy had always been in the background, it took centre stage in the run up to the 2000 general elections. The main opposition party then, the New Patriotic Party (NPP) vilified the existing cash-and-carry system and promised to introduce a more equitable system through health insurance. In contrast, the ruling National Democratic Congress (NDC) proposed a fusion of insurance schemes to work together with an enhanced cash-and-carry system (Agyepong 2008; Ayee, 2003; Carbone, 2011).

It is against this politically divided milieu that the NHIS was introduced in 2003. Generally, most Ghanaians welcomed the policy, because of its prospects of achieving universal coverage, but with some reservations, particularly on how it will be funded (Mensah et al., 2010; Sulzbach et al. 2005; Wahab, 2008). These reservations were expressed in several ways. For example, the Ghana National Association of Teachers (GNAT) resisted the use of 2.5% of their SSNIT contributions

to fund the scheme. The TUC also issued threats of suing government for not having thorough discussions in parliament, and sufficient consultation with stakeholders, before the bill was passed (Carbone, 2011; Rajkotia, 2007; 2004).

Similar disagreements went on in parliament before approval of the NHIS bill, with the opposition walking out of parliament before voting was done (Agyepong & Adjei, 2008; Carbone, 2011; Wahab, 2008). The bill got passed in the end, but the unresolved disagreements were still in the background. The lack of adequate inputs from technical experts and consensus on sustainable means of funding left in its wake, financial challenges that have bedevilled the scheme till date (NHIA, 2015). In relation to enrolment, it led to a ‘wait and see’ attitude on the part of some Ghanaians during the early stages of implementation and up until today, the scheme is still politicised, with consequences on enrolment (Fusheini 2016; NHIA 2017; Rajkotia, 2007; Wahab, 2008). With time, it has become apparent that although the need to extend healthcare access to the entire population, regardless of the ability to pay, was critical at the time, policymakers may have underestimated the need to balance this, with careful consideration for Ghana’s political context.

3.7 Ghana’s Informal Sector and the NHIS

An important feature of the Ghanaian context with implications on the enrolment decision is its large informal sector. The country wears a tag for having a large informal economy, with several studies conducted to evaluate its impact on individuals, households and the national economy (Aryeetey, 1996; Debrah, 2007; Palmer, 2007). The large informal sector label was given Ghana by Keith Hart, a British anthropologist in his seminal study of the economic activities of the migrant Frafra in urban Accra (Hart, 1973). Hart observed that the informal economy served as an important source of employment and income to a vast majority of migrants from the Northern part

of Ghana and other rural areas. Several years down the line, the informal sector has increased with national data indicating that close to 80 percent of Ghana's employed population are in the informal sector (GSS, 2016; MOFEP, 2016).

The informal economy characteristic has also got a rural-urban twist (Osei-Boateng & Ampratun, 2011). The rural areas are characterized by agricultural activities such as fishing, farming, wood carving, carpentry, wood processing, among others, whereas the urban areas have more official, formal occupations and businesses (GLSS, 6). Although having a large informal sector is not necessarily undesirable, the major challenge with it is that the sector is characterized by low remuneration, poor working conditions, job insecurity and irregular incomes (Günther & Launov, 2012; Maloney, 2004; MOFEP, 2016). These were envisaged to have implications for enrolment and explains why policy makers instituted different enrolment arrangements for the informal sector. But unfortunately, that has not done much to engender the needed enrolment from those in the sector (NHIA, 2016). For a study on the decision to enroll, such a context specific feature of the Ghanaian society, thus, its large informal sector has implications that cannot be discounted.

3.8 Conclusion

This chapter provides a contextual overview of the setting in which this study is conducted. The chapter presented the general context of Ghana as well as the specific case of the Ashanti region where the study is conducted. The healthcare system of Ghana was also presented, with brief overview of the financing strategies employed in the pre-independence era till the current NHIS. The enrolment issue is also situated in its context with an update of current enrolment figures. The chapter observed that the social and political contexts within which the NHIS was introduced left in its wake, important consequences for the scheme's design, sustainability and enrolment. With

regard to the social context, it was noted that the cash and carry system which the NHIS supplanted was inconsistent with the Ghanaian social system which is built on solidarity and caring for others. The NHIS was therefore to realign healthcare to the values of the Ghanaian society; to reduce poverty and vulnerability to shocks, as well as decrease inequality in access to healthcare. It is this philosophy that explains why the scheme is woven on social solidarity arrangements with a number of social protection elements built into it.

With regard to the political context, the chapter established that political disagreements that characterised the conceptualization and design of the scheme had a number of effects. It led to a situation where the unresolved tensions were postponed for the implementation stage and which has persisted till today. In relation to enrolment, it led to a 'wait and see' attitude on the part of some Ghanaians during the early stages of implementation. Finally, Ghana has a large informal economy, and that has implications for the enrolment decision.

CHAPTER FOUR

RESEARCH METHODOLOGY

4.0 Introduction

This chapter presents the research procedure followed for conducting the study, in terms of the philosophical assumptions; its related approaches, methodology, data collection and analysis processes. The chapter briefly reviews the major philosophical assumptions of social science research as a basis for identifying the most appropriate framework within which to position the current study. This dovetails into discussions on the positioning of the study in a subjective, interpretive framework. The chapter further discusses the consequent adoption and suitability of the qualitative framework, the case study technique, the purposive sampling procedure, as well as interviews, focus group discussions (FGD), and document reviews as strategies for data collection. There is also a detailed report of how the data was collected, managed and analysed. The chapter ends with ethical issues considered in the study and a conclusion.

4.1 Philosophical Assumptions and Paradigms in Social Science

All approaches to academic research in the social sciences have their foundations deeply rooted in competing assumptions as to what constitutes valid research. These assumptions are usually a product of scholarly perceptions of how the world works and how people behave. The assumptions spring from frames of thinking or philosophies generally referred to as research paradigms (Burrell & Morgan, 1979; Kuhn, 1962; Lincoln & Guba, 2011). Paradigms are intellectual frameworks that are used to construct a view of reality and they serve as benchmarks that specify a discipline's proper domain, appropriate research questions, and rules of inference (Burrell & Morgan, 1979; Guba & Lincoln 1994; Kuhn 1962; Morgan, 1980).

However, owing to the fundamental differences in conceptions about the nature of reality different paradigms are found in the literature. Generally, the philosophical assumptions that inform the various research paradigms are expressed in four main dimensions namely; ontology (objectivism versus subjectivism), epistemology (positivism versus interpretivism), methodology (quantitative versus qualitative) and axiology (value free and value laden) (Burrell & Morgan, 1979; Guba & Lincoln, 1994)

Ontology reflects on the nature of reality (what is out there to know), whereas epistemology borders on what and how we can know about it. Methodology on the other hand, is concerned with the logic of scientific inquiry and relates to the science and study of methods and assumptions about the ways in which knowledge is produced (Creswell 2009; Lincoln et al., 2011; Lincoln, Lynham & Guba, 2000). According to Grix, (2002) methodology is about investigating the potentialities and limitations of particular techniques or procedures in research. Axiology borders on the role of values in an inquiry. Generally, a distinction is made between the quest to ensure objectivity in research, and therefore separating facts from the values of the knower (inquirer) and knowing object; and the view that conducting research without the imposition of values is impossible. The latter admit the value- laden nature of information gathered in research as well as that of the researcher and therefore actively report their values and biases (Burrell & Morgan, 1979; Lincoln Lynham & Guba, 2000).

These paradigms exert profound influences on what scholars think and the steps they take in conducting inquiry in their fields or disciplines (Blaikie 2007; Burrell & Morgan 1979; Lan & Anders 2000). They are important to all studies including this one, because assumptions made by a researcher have consequences for the strategies and tools adopted (methodology) as well as judgements made about values (axiology) in the entire research process (Blaikie, 2007; Creswell

2009; Hughes & Sharrock 1993). While of these classifications come with their own strengths and weaknesses, the researcher is of the view that it is not just trumpeting the strengths of one paradigm over the other that is important but rather, the awareness that having fundamentally different assumptions lead to different strategies and the possibility of producing different outcomes.

4.2 Philosophical foundation of the study and its appropriateness

Subjective ontology; interpretive epistemology

The study explores SC as a viable option to understand the social forces behind the enrolment decision. It sought to determine how SC, expressed in networks and relationships in the communities influences the decision to enroll in Ghana's NHIS. Considering the nature of the objectives, and the research questions, the study was positioned in a subjective ontology and conducted from an interpretive epistemology. The reasons underlying this positioning are discussed as follows.

First, the researcher recognizes that the two key issues being explored; SC and the decision to enroll, are non-concrete constructs made up of fundamentally subjective attitudes. Their complete understanding required a subjective articulation and interpretation (Grootaert, Narayan, Jones & Woolcock 2003; Onyx & Bullen 2000). Therefore, the study was steeped in a subjective framework to effectively capture the particular values, norms, and interpretations of community members and the various officials associated with the implementation of the NHIS. This allowed for a fuller appreciation of the idiosyncratic meanings that people attach to these values that impinge on the decision to enrol.

Secondly, the researcher is of the view that knowledge is co-created by an active engagement between the researcher and research subjects. This outlook implied that the researcher influences the research process and cannot be discounted as a mere external passive observer of independently existing phenomena (Blaikie, 2007). His values and choices have consequences on the knowledge that is created. Therefore, the study was situated in an interpretive framework to provide an adequate ambience for such values and choices to be accounted for.

Finally, because the study aimed at understanding the context-specific determinants which influence the enrolment, it was imperative that it be positioned in an interpretive framework. These context specific determinants which include community and group obligations, that shape thinking and action in the communities was deemed to be best captured from the perspectives of clients, service providers, officials and other stakeholders and that made the interpretive paradigm most appropriate (Angen, 2000). The paradigm was chosen because it orients the study to elicit detailed accounts based on contextual knowledge, and interactions between and among the various actors and institutions in the NHIS enrolment architecture. Positioning the study in the interpretive framework therefore enhanced a deeper understanding while offering flexibility to better highlight the complexities surrounding the decision to enroll (Raadschelders, 2011).

4.3 The Qualitative Research Approach

In line with the study objectives and philosophical anchorage, the study was conducted from the qualitative approach. The approach is a systematic process of understanding social reality, based on the building of a complex and holistic picture of detailed views of participants gathered in a natural context (Creswell, 2009; Silverman, 2006). Boateng (2016) argues that fundamental to the choice of qualitative studies are considerations over context, timing and experience. Hence,

adopting qualitative strategies made it possible to better appreciate the processes, situations and related complexities, values, circumstances and backgrounds of participants within which the study was conducted (Creswell, 2009).

As has been alluded to, a major objective of this study, is to understand the social context, the social relationships, and how the values underpinning these relationships influence the decision to enrol. The qualitative perspective and the use of its accompanying methods therefore allowed for the generation of rich data and insights into these experiences and relationships with managers of the NHIS and its related providers. Besides, given that the decision to enroll is rooted in a complex mix of considerations, which are largely subjective, the qualitative approach was suitable to provide a more authentic and comprehensive understanding of the deep seated motivations underlying these decisions (Creswell, 2009; Denzin & Lincoln, 2011; Yin, 2009)

Furthermore, qualitative studies are appropriate when one wants to explore a phenomenon in its natural setting (Creswell, 2009). That this study was conducted in the communities, offices and service centres; the natural environment within which the respondents live and operate, made the approach appropriate. The approach enabled the detailing of the experiences of beneficiaries and officials from their own settings and offered them the platform to share their views on issues, from their own perspectives.

Finally, due to the subjective nature of the study, the researcher needed an approach that is emergent rather than tight figured. Therefore for its flexibility and the ability to readjust the study to reflect new developments and data, the qualitative approach was chosen. Situated in a qualitative ambience, the study was driven by the researchers own interests, beliefs, skills and resources and is therefore value laden (Creswell, 2009).

4.4 Case Study Design

The major contention in this study is that the decision to enroll in Ghana's NHIS has a social dimension which could be better understood by applying SC theory. As a qualitative study, the basic research question guiding the study is framed in terms of *'how'* SC influences the decision to enrol. This required a strategy that is incisive, and could reach beyond what is just seen on the surface as far as the decision to enroll is concerned. Therefore, among the several other possible designs, such as ethnography, archival analysis, phenomenology, and grounded theory, that are available for qualitative research, the case study strategy was chosen. The strategy oriented the study to delve deep into the social context surrounding the enrolment decision and to achieve the core objective of understanding the deep seated motives behind enrolment in the NHIS (Creswell 2009; Denzin & Lincoln 1995). The case study design best suited the researcher's purpose of seeking to understand in- depth, the values and norms of relationships underpinning the enrolment decision (Saunders & Lewis, 1997; Yin, 2009).

Case study designs also allow for the availability and use of multiple sources of information that are interactive and humanistic (Creswell, 2009; Yin, 2009). Designing the study as a case study therefore afforded the researcher the opportunity to use multiple sources of building evidence. These included document review, in depth interviews and focus group discussions. Besides allowing for a fuller exploration of the research questions, it also helped in triangulating and validating the data (Creswell, 2009; Yin, 2009).

Finally, given the limited time of two years within which the researcher had to complete the PhD thesis, the case study was deemed practically expedient. This is because it was not possible to study all communities and all NHIS agencies in Ghana within the period. The costs and resources

needed for such a wide scale study is beyond the researcher. The study therefore adopted the case study design where three unique cases were selected and studied.

4.5 Sampling

The study used purposive sampling techniques to select cases/communities as well as individual respondents for the study. The main assumption behind purposive sampling is that, certain cases are more appropriate for the purposes of a study than others. The method was chosen because it allowed for the selection of communities of unique location and characteristics relevant for the study. It also enabled the targeting of officials best positioned to offer useful information that answered the study's research questions as well as maximise the possibility of making valid inferences (Creswell, 2009)

In selecting cases for the study, the research problem and objectives were decisive. The study sought to investigate SC influences on enrolment from the perspectives of community members, management and professionals and in their own contexts. In order to cover a wide range of contextual factors, two key factors were taken into account in selecting the communities from where data were collected. These were, the geography or location and the occupational / economic sector of communities. The geography was important because a review of the literature revealed that the forms of SC are context-specific, varying across communities and geographical regions. Therefore attention had to be given to these differences, which was done along the urban, peri-urban and rural cleavages in the Ghanaian setting.

The occupation mix, borders on the formal/informal divide and it was important for the study because earlier studies have found that the decision to enroll is also dependent on the type of occupation (economic activity) that an individual is engaged in (Ritchie & Lewis, 2003; Schieber

et al., 2012). Given the different enrolment arrangements for formal and informal sector workers, this consideration was important to explore how difficult or easy it was, for people to enroll and remain in the NHIS as a result of the occupation sector and the accompanying enrolment arrangements.

After considering these factors, the Ashanti region was selected as the region for the study. Apart from its unique character of having a heterogeneous mix of people, the region has a good blend of its residents in formal and in informal sector (GLSS 6, 2014). Two other regions which had similar characteristics to the Ashanti region, the Greater Accra and Western were excluded because an earlier study by Fenenga et al., (2014) on SC had been conducted in these regions. Within the Ashanti region, the Atwima Nwabiagya, Adanse South and Bantama sub-metro were purposively selected as the areas of study along the rural, peri-urban and urban divides. In so doing, the cases varied especially in terms of SC, such that although all they are all in the Ashanti region, they also differed because of their geographical location (King, Keohane & Verba, 1994; Yin, 2014).

In similar vein, individual community members were purposively selected. In each district, respondents made up of four categories, namely, NHIS officials, service providers, key stakeholders, and community members (both insured and uninsured) were interviewed. The researcher adopted the technique of continuing with the interviews to the point of saturation where no new issues came up from further interviews. Data saturation was reached at 43 community members and 12 NHIS officials and service providers.

Location	FGD	Other Key informants	NHIA Officials
Bantama Sub-metro (Abrepo, North Suntreso)	3 (20)	3	2
Adanse South New Edubiase, Atobiase, Apagya.	3 (19)	2	2
Atwima Nwabiagya Esaase, Atwima Koforidua, Toase Nkawie	4 (20)	3	1
NHIA Office, Kumasi			1
NHIA Head Office, Accra			2
Kumasi: Service Providers			4
Total	10 (59)	8	12

Table 4.1: Fieldwork interview participants

Source: Author's construct (2018)

4.6 Data collection methods and sources

An underlying reason for the choice of the qualitative approach for this study is the opportunity it affords in terms of the use of multiple sources of data. Relying on multiple sources of data offers a chain of evidence and facilitates triangulation, which in turn enhances validity and reliability of the data and findings. In this regard, the study employed a number of data collection methods. These are; face to face in-depth interviews, focus group discussions and documentary reviews. Overall, the study collected data from both primary and secondary sources.

Interviews

Data for the study were mainly built through interviews, which is considered fundamental to qualitative research (Creswell, 2013; Myers & Newman, 2007). Bearing in mind the nature of the research objectives and its related questions, the semi-structured interview method was chosen. The flexibility of the semi structured interviews allowed the researcher to give respondents enough room to provide personal accounts on issues while keeping them within the boundaries of the study (Yin, 2009). The method served as a valuable means of detailing the subjective interpretations behind people's decision to enrol.

Interview guides were developed from the literature on SC and the study's conceptual framework (see appendices 1, 2 and 3). The issues covered bonding relations within family, friends and neighbours in the community; bridging relations in groups and associations; linking relations and experiences with the NHIS and other service providers, information, communication and accountability in governance etc. As a qualitative piece, the study was conceived as an inductive process. Therefore, although the interview guides were derived from the literature, they only served as initial guides. They were made flexible to accommodate issues that emerged in the course of field work (Myers & Newman, 2007).

Focus Group Discussions (FGD's)

In addition to interviews, the researcher gathered data through FGD's from community members. The strategy is considered useful for qualitative research due to its ability to rake in data that is difficult to generate in one-on-one interviews (Creswell, 2013; Kitzinger, 1995). Besides its ability to cover several participants within the shortest possible time, the FGD's served as an exciting forum for stimulating group-based thinking and discussions on SC as well as the intricacies of enrolment. It served as a platform for bringing people of different backgrounds together to openly

discuss their reasons for signing up or disengaging from the scheme as well as sharing different insights, meanings and experiences on their interactions with NHIS officials and service providers. The FDG's aided in the generation of spontaneous and insightful research data as a result of the interaction among participants (Wong, 2008; Kitzinger, 1995).

Before fieldwork, three FGD's made of different combinations - insured only, uninsured only and mixed insurance status were planned to be organized in each community. But this was found to be duplicating after the first two, and therefore, a decision was taken to limit it to the mixed composition only. Overall, one FGD was organized in each community, coming to a total of ten (10) in all. Before the commencement of discussions, the researcher explained the purpose of the study to members. All FGD were conducted outdoors under trees and that provided social comfort to participants. Each FGD was made up of 6-8 persons and lasted for an average of thirty five minutes.

Documentary Reviews

The two main themes being explored in this study; SC and enrolment in the NHIS, have generated a lot of scholarly articles, reports and documents. The documentary review aspect of the study therefore involved an extensive review of existing literature on the subject, which lasted almost throughout the duration of the study. The review helped the researcher get a full appreciation of the issues, their related concepts, theories and underlying dynamics. Documents reviewed included the NHIS policy document as well as the new Act 852 (2012), NHIA annual reports, NHIS enrolment trends, books, journal articles, internet reports - both published and unpublished, and media reports. Official documentations from other health facilities and agencies connected to and working with the NHIS were also reviewed. These sources provided a background understanding

of the study, helping to identify gaps in the literature and framing the research questions, as well as providing insight into the analysis and reporting of the findings.

4.7 Data Collection Process

The entire data collection process consisted of a mix of field methods and desk research of secondary data sources over a period of over six months. However, the actual field data collection process was carried out over a three month period, in three main phases, with the first phase beginning with a pilot study in March 2017. Given that studies on SC in Ghana generally, and its implications on enrolment in particular are limited, the pilot study was conducted prior to the main study to test and refine the content and procedures for data collection (Yin, 2014). For ease of access, the pilot was conducted on some NHIS management and individuals in Aburi in the Eastern region. Preliminary responses from the pilot were discussed with the researcher's supervisory team as well as other colleagues during seminars. Emerging issues, such as a clearer operationalization of SC, informed a re-calibration of the questions to ensure that they were clear and coherent enough to elicit appropriate responses to the research objectives. The second stage consisted of the actual data collection between April and June 2017, during which data was collected in the selected districts. The third phase was in July 2017 and that was dedicated to data collection at the regional and national levels. A colleague PhD student served as a research assistant in collecting the district level data. He handled the recording device and also helped in writing out some of the responses to serve as a back-up to the recording device.

The first three days of fieldwork were used to go round the districts to book appointments with the NHIA agencies and relevant authorities from where interviews were to be conducted. This went on smoothly because introductory letters from the University of Ghana had already been delivered

to these institutions. Formal interviews began in the second week with community members in Nkawie, the capital of the Atwima Nwabiagya district. The individual interviews were capped with FGD among community members. The interview strategy began with questions first posed in an open-ended fashion to elicit general views of informants on enrolment and their SC. Participants were asked to recall and reflect on their experiences with NHIS officials as well as the various forms of association and relationships in the communities. After this initial interaction, interviews took a more focused approach based on the research protocol prepared in line with the research questions of the study (see Appendix 1). All interviews and FGD's were audio-recorded with the permission of participants. The one on one interviews lasted for an average of twenty five minutes while the FDG's lasted for thirty five minutes on average (see table 4.2). This process was followed in all the communities visited.

A similar approach was employed for the interviews with officers at the NHIS agency in the district, but theirs was to have a sense of what the policies, regulations and the state of enrolment are, as well as their interactions and experiences with community members and how these facilitated or inhibited enrolment. The same strategy was adopted for other service providers, with an interest in their relationships with clients and the NHIA and what the relationships entailed, as illustrated in the interview protocol/questions (see appendix 3). This process was replicated in all the districts visited in the entire data collection process.

Technique	Source	Collection method	Total Duration/Period
Semi-structured interviews	NHIA/NHIS Management, service providers, opinion leaders, religious and traditional leaders and community members	Audio recording and writing	25 minute average One month
Focus Group Discussions	Community members; mixed composition, clients and non-clients	Audio recording and writing	35 minutes 1 week
Documents reviews	Secondary data/information on enrolment; NHIS policy document; website content/pages on the NHIS generally and enrolment in particular; press releases and news items	Writing	Prior to fieldwork till final report

Table 4.2: Data collection techniques employed in the study

Source: Author's construct (2018)

4.8 Validity and Rigour through Triangulation

A major challenge for qualitative research is its ability to achieve rigour and validation. For case studies, Yin (2009) suggests a number of strategies that can be employed to ensure rigour and validity. These include; using multiple sources of evidence, establishing a chain of evidence, doing pattern matching, using theory in single case studies, using case study protocol and developing a case study data base. These strategies are generally built around triangulation which is recognized as a vital means of ensuring rigour and validity in qualitative case studies (Yin, 2009).

In this study, rigour and validity were ensured mainly by the use of multiple sources of evidence. The main stream of data from interviews was complemented by those from FGD's as well as

scholarly publications, official documentation and website publications on the NHIS. Besides generating different types of data, these sources served as a check on themes that emerged in each stream of data. The interviews considered multiple viewpoints; and that meant that different people with different perspectives were interviewed. The study therefore followed a ‘triangulation’ approach, by interviewing various respondents on the same topic and integrating multiple sources of evidence in the development of the final report. This made it possible to reduce the likelihood of misinterpretation and aided in addressing rival explanations as the information is examined from different angles (Creswell 2009; Yin 2009). To be sure that the data reported really reflected what was collected, two key informants were made to review the draft report before the final report was done. Field notes were also taken as complementary information before exiting the field.

4.9 Data Analysis Procedure

Data analysis is a process of examining, classifying, illustrating and evaluating data through logical and analytical reasoning. It is a thorough search for meaning from raw data to allow for their processing in a scientific manner, such that whatever data is collected could be effectively communicated (Hatch, 2002, p. 148). For qualitative studies, a broad range of data analysis methods are available. These include, interpretative phenomenological analysis (Smith & Osborn, 2003); conversation analysis (Hutchby & Wooffitt, 1998); grounded theory (Glaser, 1992; Strauss & Corbin, 1998); discourse analysis and thematic analysis (Braun & Clarke, 2006).

The study employed the thematic analysis method; which is an iterative and reflexive procedure of identifying, classifying analyzing, interpreting and expressing patterns in a data set (Attride-Stirling, 2001; Braun & Clarke, 2006). The method was chosen for two important reasons. First, it offered the researcher theoretical freedom and flexibility in providing a rich, detailed, and yet,

complex account (Braun & Clarke, 2006) of the social forces behind the decision to enroll. Second, it provided a useful and nuanced approach to reducing the large volume of data into more meaningful themes that facilitated easy analysis and interpretation. In analysing the data gathered, the researcher followed a six stage systematic process as proposed by Braun & Clarke (2006). This covered; data familiarization, initial code generation, theme search, theme review, theme definition and naming, and the final stage of writing up the report. Because data for the study were personally collected by the researcher, analysis of the data started from the field. The researcher listened to recorded interviews at the end of each day to identify gaps and weaknesses for correction in subsequent interviews. The researcher also kept a research diary in which striking issues, informal chats and other reflections were noted before exiting the field (Gibbs, 2007). The formal data analysis began with transcription of all recorded interviews and FGD's verbatim using VideoLan media player, built with enhanced features for pausing and slowing down the audio speed. Playing the audio back and forth to pick up and transcribe the hunches correctly, gave the researcher an opportunity to begin familiarizing with the data. All transcriptions were done by the researcher and although time-consuming, it served as an important means to familiarize with the data (Gibbs, 2007; Riessman, 2005). Other informal chats, as well as issues that were written were harmonized with the audio transcripts into one data journal. The researcher then read and re-read the text to identify meanings and initial patterns. This initial 'sense making' step helped the researcher have a fair idea of the text data and also recognize important themes and patterns. At the end of this stage, an initial list of ideas about what the data held and what was fascinating about them was generated (Braun & Clarke, 2006; Patton, 2002).

The familiarization stage dovetailed into the second stage of generating initial codes from the data. At this stage, the researcher used coloured pen to make notes on the texts, to indicate patterns and

to see whether these patterns could be linked to the SC theory. The researcher combined both the inductive and deductive approaches to thematic analysis. Therefore, whereas the themes emerged from the data, the researcher also kept an eye on the theoretical linkages with these themes. Attention was paid to details in terms of frequently occurring issues, repeated expressions, dominant words, quotes, and observations that were important and common to most respondents.

The third stage of searching for themes followed after all data had been coded and collated. The goal here was to reduce the data through focusing, abstracting and transforming it (Ryan & Bernard, 2003). This phase, which focused the analysis at the broader level of themes, rather than codes, involved sorting the different codes into potential themes, and collating all the relevant coded data extracts within the identified themes. Initial thematic maps were constructed at this stage to help in identifying relationships between codes, between themes, and between different levels of themes (Miles, Huberman, & Saldana, 2013).

As a fourth stage, the themes were further re-read and fine-tuned. Over here, some initial themes were collapsed into others as it was found that they were not themes after all. For instance, information and communication were initially separated as two different sub-themes, but they were collapsed into one after this review. The exercise gave the researcher, a fairly good idea of what the different themes are, how they fit together, and the overall story they tell about the data.

At the fifth stage, the themes were defined and named for analysis. Here, the researcher identified and described the essence of each theme and which aspect of the overall data it captures. They were also organized into a coherent and internally consistent account with accompanying narratives. The accounts and descriptions provided the context of action, the intentions of the various actors, and the process in which the actions are embedded. This made it possible to

adequately sort out the different forms of SC and what it entails in the communities and explain how they influenced the enrolment decision. This was important because the ultimate goal of the study is not just to describe the data but to understand, interpret and explain. Therefore, the comprehensive reporting and vivid descriptions did not only allow for understanding, but also laid the basis for interpretation and analysis (King, Keohane & Verba, 1994; Patton, 2002)

The final stage involved the concluding analysis and write-up of the report where a painstaking effort was made to write out the report in a concise, coherent, logical, non-repetitive and interesting manner. Table 4.3 below captures the process of analyzing the data in this study.

Stage	Activities undertaken during the stages
Familiarization with data	Transcription of data; synchronizing transcripts into one data journal; reading and re-reading the data and noting down initial ideas.
Generating initial codes	Coding interesting features of data systematically across the entire data set. Collating data relevant to each code.
Theme search stage	Collating codes into potential themes, gathering all data relevant to each potential theme.
Reviewing themes	Checking if the themes work in relation to the coded extracts and the entire data set. Generating a thematic ‘map’ of the analysis.
Defining and naming themes	Analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
Producing the report	Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature; producing a report of the analysis.

Table 4.3: Data Analysis process

Source: Adapted from Braun and Clarke (2006: 87)

4.10 Quality Assurance

The researcher followed Lincoln and Guba's (1985) evaluative criteria to ensure integrity of the research procedure, particularly in terms of the steps taken in data collection, analysis, and interpretation. These evaluative standards, comprising; credibility, dependability, transferability and conformability are discussed below.

To achieve credibility which evaluates the degree of trustworthiness of research findings, and the extent to which the researcher communicated the responses correctly this, a number of steps were taken. First, having done more than three months of fieldwork, the researcher had sufficient engagement with participants and to be able to gather enough data. Secondly, the researcher employed multiple data collection and analysis methods strategies to ensure the accuracy of reported findings and interpretations. These helped to fully utilize the reasoning behind inferences made about specific occurrences of the issue and contexts under study. Thus, overall, the use of a wide range of data collection techniques, multi-faceted approaches of data collection, and a six-phase data analysis procedure enhanced the credibility of the research.

Dependability assesses the extent to which another study may yield similar results if same processes described in this research were used in future. It also borders on the level of reliability and consistency of a study's results and conclusions. In this regard, a thorough discussion and recording of the research process including details of how each step was executed is provided, in this chapter and also the attached appendices. As part of this quality control, detailed accounts of all the data collection and analysis strategies, processes, timelines, durations, organisations, cases, and interviewees are documented. Such a vivid protocol provides a scrutiny track (Janesick, 2000) that allows examiners and other researchers to make assessments about the appropriateness of the research practices, as well as their quality (Shenton, 2004).

The transferability standard borders on the extent to which a study's findings can be applied to other jurisdictions, thus generalised. As has already been noted, this study is qualitative and therefore did not seek statistical generalisation, but instead context and theoretical generalisation (Ritchie & Lewis, 2003, p. 275). To ensure this, a detailed justification for the selection of cases and respondents, as well as a comprehensive description of the context of the research setting are provided in chapter 3. In the bid to satisfy the 'thick description' criterion, the study considered multiple views, processes, and experiences relating to SC and the enrolment decision (Ritchie & Lewis, 2003). The sources of data and fieldwork processes including the interview procedures are all reported in adequate ample detail above. All these were done to ensure that the findings and conclusions distilled can be applied to other contexts, or transferred to situations elsewhere (Shenton, 2004). All together, the study has provided a comprehensive description of the research background, procedures and boundaries for the evaluation of transferability.

The final benchmark is conformability which is the extent of impartiality in the methodological choices made in a study. It touches on issues, such as whose views are being reported, investigator bias, preferences, values preferences and research limitations (Miles & Huberman & Saldana, 2013; Lincoln & Guba, 1985). It shows the degree to which the conclusions drawn, elucidations and recommendations made are grounded in the evidence. In pursuit of this, the researcher relied on multiple perspectives on the forms of SC and its influences on the enrolment decision. Second, the study's theoretical, methodological, and analytical choices have been clearly articulated and justified. Thirdly, as noted earlier the study was conceived as an interpretive process; the researcher's assumptions, beliefs and position have a bearing on the knowledge produced, and these have been duly acknowledged. The researcher ensured a fine balance between reporting the way by which participants made sense and interpreted their SC and its influences on their health

insurance decisions; and how the findings could be analytically integrated into existing literature and theory so it could be extended beyond the study context. Finally, the study's limitations are also acknowledged in the concluding chapter.

4.11 Ethical Considerations and Research Clearance

In keeping to the ethics of social science research, some ethical principles were observed to ensure that the confidentiality, anonymity, interest and safety of all respondents and organisations involved in the study were protected. This study complies with the ethical guidelines/policies on research of the University of Ghana which include: informed consent, no pressure on individuals to participate, respect for individual autonomy, avoidance of harm, maintenance of anonymity and confidentiality.

Ethical clearance was first sought from the University of Ghana by an application to the Ethics Committee. Supporting documents added to the application included an introduction letter from the Department of Public Administration and from the researchers lead supervisor; a research proposal with the purpose of the research and the methodology explained in detail; the research protocol; and an outline of the data collection process. The final clearance upon receipt, was forwarded well in advance to the NHIA, as well as its related agencies and selected service providers before data was collected. The objectives, potential risks and benefits relating to the study were all explained to them in advance as part of seeking their consent. This gave the institutions ample time and information in taking a decision on whether to participate or not (Bailey, 2007; Johnson & Christensen, 2008)

During interviews, the research values of confidentiality and voluntary participation were very much observed. Accordingly, respondents were not required to indicate their names and they were

informed of their freedom not to answer questions they deemed too sensitive. They were also informed of their right to postpone interviews or even truncate it at their convenience. In interviewing NHIS officials, due consideration was given to confidentiality and integrity, such that a mutually benefiting agreement was reached with regard to the use of data, its analysis and dissemination. They were assured, and shown copies of draft reports for their consent before the final report was put together (Carling, 2013; Tracy, 2010).

The importance of avoiding plagiarism and adhering to copyright regulations in research was very much considered in this study. Therefore, University of Ghana's policy on research ethics, which forbids any form of plagiarism, piracy, falsification or the fabrication of results at any stage of research, was a major guiding line in this study. To ensure compliance with these ethical standards therefore, materials used are duly acknowledged and referenced.

4.12 Conclusion

This chapter presented the philosophical and methodological alignments of the study. The study adopts a subjectivist ontology and an interpretive epistemology. The subjective positioning, enabled a full capture of the social forces behind the decision to enrol, which are defined by the subjective opinions and interpretations of community members and implementing officials of the NHIS. The interpretive orientation also allowed the researcher to carry out the study relying upon the subjective interpretations of the researched as well as the researcher and in the overall context of the study. The chapter also discussed the consequent adoption of the qualitative approach and its strategies, making a case why they are most appropriate for studies of this nature. Furthermore, the semi-structured interviews, documentary reviews, and FGD's, as the methods of data collection are discussed. The chapter also overviewed how the data was analysed as presented in chapter five.

The chapter was relevant not only in providing a philosophical bases for the study, but also in providing justifications for the methodological choices made. The next chapter presents an overview of the research setting as a prelude to the empirical chapters.

CHAPTER FIVE

SOCIAL CAPITAL IN THE COMMUNITIES

5.0 Introduction

This chapter presents findings pertaining to the first research question on the forms of SC in the selected communities. Data on this question was collected along bonding, bridging and linking forms as discussed in the literature. In analyzing the data, attention was paid to the two main components of SC; structural and cognitive. While the structural aspect covered the externally observable social structures, such as; institutions, associations, networks and the rules they embody, the cognitive aspect focused on the more intangible and subjective elements such as attitudes, norms of behaviour, shared values, reciprocity and trust. Consequently, for each form analyzed, the structural components are first presented, followed by the cognitive aspect which assesses the extent to which these social relationships are utilized by community members.

5.1 Bonding SC in the Communities: Any Evidence?

5.1.1 Traditional family structure and support

An important means by which SC is expressed in the communities is through bonds within the traditional family structure. This is constituted from family relations, made up of the nuclear family, as well as extended family members. The study found that within the family structure, a web of relationships and networks are built between members. These form the basic building blocks of social life within the community, with the different families and networks making up the community. This unique system of living, a feature of traditional society is still prevalent in the communities, and serves as an important source of social support for most people. Majority of respondents indicated that the family structure serves as their back bone and it is important for

them because they derive various forms of assistance from other family members in times of need. These include helping to raise children, providing financial and emotional assistance, and serving as sources of information and knowledge on various issues. The value of traditional family ties as a form of bonding SC is captured by a respondent;

“Yes, the traditional family support system is still predominant around here. Most of us still hang around our kinfolk; both nuclear and extended family members and count on them for all kinds of support. People show love and support for each other within the familial unit” [Field work Data: Individual interview Toase].

Another respondent captures the incidence and value of the family structure more graphically;

“I have my own family i.e. husband and four kids. But my extended family still serves as an important source of support for me, both financially and emotionally. During childbirth and the nursing of my three kids, I depended on my mother and other aunties for assistance. Even now, anytime I want to travel, I leave my kids with them in the family house. Apart from that, although my husband and I are both working, I sometimes depend on my mother and two brothers who live abroad for financial assistance. Anytime I am in need, I call my mother and she informs my brothers who will send money. Honestly, there is no way I could take care of my kids without the support of my family. For me, the traditional family support is still valuable” [Field work Data: FGD Esaase]

The sentiments expressed above gives support to how the family, both nuclear and extended serves as reliable bastions of support for people in the communities. In this regard, the family structure and the support it provides represents SC for most people.

Relatedly, the study found that bonding within the familial unit is expressed through commitment and attachment to other member's needs and concerns. Most people felt a sense of obligation to their families, indicating that their way of life and actions are influenced by their family values, which they felt obliged to comply with. These obligations are expressed in several ways including attending family programmes like weddings, naming, and funeral ceremonies. It also included supporting other family members in ways such as paying their school fees and hospital bills. For most people, such obligations are non-negotiable requirements for one to be accepted as a good family member. Family members are also committed to such values because cases of non-adherence could lead to isolation. A respondent remarked;

“My family is very closely knit and we have a cliché that, it is when you do it for others that others will do it for you. Therefore, we all see it as a responsibility to help those who are in need. If you come across as someone who does not care about others, nobody will mind you when you are in need. Apart from that, you will be sanctioned when we go for family meetings. Therefore, we show a lot of commitment to the interest of others” [Field work Data: FGD Bantama].

The findings show the presence of closely knit families and its associated responsibilities in the communities. The family bonds and connections socialize members to show concern for each other, and that is also made possible by the ability of the family to ensure adherence through informal sanctions.

5.1.2 Norms of behaviour

Within the family structure are certain norms through which SC is generated. The field work data revealed three key norms - trust, solidarity and reciprocity as important in holding (bonding) families together. These norms were found to ensure a sense of belonging, fellow feeling, goodwill, affection, togetherness, and mutual support for one another, within the familial unit. They nurture a sense of commitment to the common good and encourage give-and-take among family members. They also serve as inducements - positive and negative of expected social behaviour; positive in giving rewards or benefits, and negative in prescribing sanctions. These norms are presented as follows.

Trust in family members

This study found that an important element that keeps the familial unit together is mutual trust between family members. Trust within and among the familial unit was found to be important for majority of respondents who indicated that they trusted their family members more to come to their aid in times of trouble. Most people indicated that they are comfortable around their own family members and trust them over others people from outside to offer support in times of trouble. A respondent asserts;

“Oh yes, I trust my family members more than others from outside. My family members show up anytime I am in need and that I why I trust them the more. But of course I have friends and even colleagues whom I trust so well. It’s just that experience has taught me that family is family. No matter what they will stick with me even when others desert me” [Field work Data: Individual interview, Atobiase]

This view reflects the general trend of trust in familial relationships in the communities. Notwithstanding the general expression of trust within and among family members, the study found a drift where trust in family members had waned over the years. Thus, whereas majority of respondents indicated their trust in family members to have their back in times of trouble, they were quick to point out that this trust in family members had declined with time, and one could not fully count on family. This is highlighted by a respondent;

“These days, you cannot fully trust or rely on your own family members like the past. It is sad but that is how it is. Sometimes you are so sure the person can help you but he/she will decline. Apart from not being willing to help you, they are the same people who will ‘sell’ you problems to other people. So I am careful with some family members these days” [Field work interview Abrepo]

Sticking together: Solidarity in the communities

Solidarity within the familial set up is the sense of unity and shared concern for each other. It is a disposition to rally around ones family members, especially the vulnerable and weak, and offer them support. This study found the ethos of solidarity very much rooted within the familial unit in the communities. Respondents generally expressed a sense of concern for each other, indicating that the need to care for others particularly the older ones is an obligation to belong to the family and the community as a whole. The interviews revealed a pattern of this shared value and/or solidarity with other members of the family and the larger community. This came up in one FGD;

“In this community, we take care of our own. It shows in how we take care of own family members. We show love to our family members and rally round each other

especially in times of trouble such as sickness and death or even supporting family members financially”[FDG Nkawie]

It was also revealed that as a means of expressing solidarity, a common practice among families was the pooling of resources. Several forms of pooling came up in the interviews. These included, contributing to support others when the need arises, saving money and collecting in turns and other cooperative activities, not only as an expression of solidarity but also as a form of social security.

A respondent explains;

“When we rally around each other in the family context and support each other, it binds the family. That is the meaning of family anyway. In my family, we have created a fund into which we make monthly contributions. It is also mandatory for every one of us to support each other when the need arises. If something happens to a family member and you do not show up, you will be subjected to serious questioning during family meetings. If it continues, you will be isolated and nobody will care about you” [Field work Data: Individual interview, Apagya]

Reciprocity within families and the community: A smile gets a smile back

Reciprocity is the social norm of responding to a positive action with another positive action. As part of the SC construct, it is the extent to which people felt obliged to give back kind actions to their families and the community at large. This sense of giving back was found to be very much valued in the communities. Majority of respondents indicated that they got help from people when they needed it and they felt obliged to pay back. Community members were inclined to give back kind actions because they received same from others, but also as a liability in doing one’s part to produce a common good, and also. Apart from fostering unity and solidarity among family

members, reciprocity was found to place a sense of responsibility on family members and the community as a whole. One respondent pointed out;

“I know very well that I have to support other people especially those from my family because others supported me to get to where I am. This is important because like they say, it is through the tree that the climbing plant gets to the top” [Field work Data: FDG Atobiase]

Another respondent drives home the point more forcefully;

It is only people who do not have a proper social upbringing who live around here and say that they are on their own, and don't care about others. Anybody who was brought up well within a proper family and communal setup knows that they have a responsibility to give back. If you ask anybody around here, I have so many people I cater for, not because I have the money to waste, but because I always remember that people helped me to come this far” [Field work Data: Individual interview, Atwima Koforidua].

5.1.3 Weakening bonds

While bonds within the familial unit are valued and form a critical part of social life in the communities, it was also found that these bonds were disintegrating in modern times. Thus, most respondents pointed to the family (nuclear and extended) as their source of social support, but they also indicated that these family structures particularly the extended family structure, has weakened over the years. For most respondents, the traditional support system that generated a sense of unity and mutual support in families could no longer be fully counted on as a trusted source of support.

Although, the family structure exists, they were becoming less important in people's lives; a phenomenon that had affected the extent of bonding in families.

“Our families were more closely knit in the past and members looked out for their own and reached out to other family members. I am where I am because although I came from the village, I had the opportunity to live with my uncle in Kumasi where I learnt a trade. I was supported by other uncles and aunties and we all lived in the same family house. They all supported me till I completed and became a ‘master’. Back then, I could walk into any of my aunties and grandmothers’ kitchen and get something to eat. But now, that supportive system of living has changed and people care only for their nuclear families. One cannot rely on the extended family anymore” [Field work Data: FDG North Suntreso].

This view echoes the general sentiment expressed by community members that family solidarity had reduced in the communities. Changes in social developments, increased heterogeneity, modernization, education, and aspiration for better economic conditions, urbanization, influences of the western culture, religious beliefs, economic hardships and other processes of social transformation came up as factors that have contributed to weaken the traditional family structures and the sense of bonding in families.

Coping with weakening bonds

Against the background that the traditional family support systems are disintegrating in the communities, people devised other strategies to cope. Community members found refuge in other support systems with a popular strategy being, joining of groups and other pooling and micro credit schemes. Religious groups was found to be common in this regard with leaders and other members

serving as new families and providing the bond and solidarity that is lost with the disintegration of the extended family support system. The necessity of these coping strategies is captured by a respondent;

“Now you cannot fully count on your family members when you are in need. The truth is that times are hard and they all have their problems so one cannot blame them. One may therefore have to look for other ways of security. So I have joined a money lending scheme organized among my fellow traders in the market. We pool money and collect them in turns and that is what I have been using to support my kids through school” [Field work Data: Individual interview, Toase]

Another respondent observed;

My own family members are not supportive. It is not that times are hard, because I am well aware that some are very well to. They just don't seem to care about others so I do not look up to them when I am in need. Now my pastor is my new father and my church members are my new relatives. They know I don't work and they support so they support me sometimes. In fact there is one man who gives me money every Sunday we meet in church. [Field work Data: Individual interview, Abrepo]

These views go to show that while social transformation and its related factors weaken bonding and traditional family institutions, new forms of social support are found, mainly in groups and associations as replacement. For most people, emotional and financial support is derived from members and leaders of these social groups, and they compensate for the weakening family structure.

5.1.4 Community networks and connections: friends and neighbours

Beyond the familial units are other bonding structures made up of neighbours and friends usually within the same community or village. These community connections serve as a source of social support on which people fall in times of need. Most respondents indicated that they have connections with friends and neighbours, and they served as a source of solidarity beyond the family unit. According to community members, these community connections provided them with sociability, information, comfort, security, material help, social identity and sense of belonging. Beyond the family, these localized interpersonal networks served as a form of bonding available to community members in times of need.

“As a human being, you live in the community with other people. Therefore, you have to relate with neighbours and others in the wider community because it is not everything that a family member can provide for you. In fact if something happens in this house right now you will see how my friends and neighbours will troop in here to ask what happened and to offer their support. Relating with others beyond the family is important here and anyone who is not that open is despised” [Field work Data: Individual interview, New Edubiase].

Put together, the findings indicate bonding SC is prevalent in the communities. Traditional family ties still serve as a source of support for most people in the communities although they have weakened over the years. Bonding is expressed in various ways including solidarity and trust within the familial unit, as well as reciprocity. Connections with friends and neighbours also formed part of bonding ties in the communities.

5.2 Bridging SC (Voluntary Associations and Groups)

Group and association membership is a basic determinant of bonding SC. Membership of these groups and associations is mostly voluntary and signifies communal connectedness. In assessing bridging SC in the communities, this study explored people's membership of various groups in both structural and cognitive forms. The structural forms were assessed by membership in informal voluntary groups and it involved identifying the groups that community members belonged to. The cognitive dimension covered the extent to which people are committed to these groups as well as the trust, solidarity and norms of reciprocity within and across them. The extent of adherence to group norms and how well people generally got 'along' in these groups were also considered.

5.2.1 Membership of voluntary associations and groups

The study found groups and associations to be a common feature of the communities. These groups cut across homogeneous ties and blood relations, and serve as an important means of expressing solidarity beyond the familial unit. The study found that community members belong to various voluntary groups and associations with almost every respondent acknowledging membership of one group or the other. Notable groups that came up are, trade and farmer associations, community development groups, cooperatives, professional/ business associations, Muslim and Christian groups, rotating credit and savings associations, microcredit groups, fun and sports clubs, micro credit clubs and funeral groups. People regard membership and contribution to these social groups as an important obligation to be accepted as part of the general community and they valued the relationships and connectivity built through these groups and associations.

5.2.2 Benefits of Voluntary Associations and Groups

Groups and associations in the communities were found to be important in diverse ways. Respondents indicated several benefits from joining these groups and these include; information

sharing and networking, risk pooling and mutual support, motivation, and joint communal action. Respondents indicated that joining groups and being in association with peers is beneficial because it gave them access to more and better resources. The groups also substituted for weakening traditional familial ties and the absence or ineffective formal government structures. The benefits are detailed as follows.

Groups as social networks and sources of information

Groups and associations serve as a source of network and information for people. They provide members with a range of contacts and networking, giving them access to resources they could not access on their own. Most respondents indicated that groups serve as sources of information on issues that are important for them and the networks help them develop ideas from which new ventures can emerge. The groups and associations were also found to permit individuals to develop their skills, knowledge and understanding. They expose people making them understand issues better in order to make sound and informed decisions.

“I sell used fridges at Suame Magazine and I belong to an association of similar traders. Our group is very important because in this age and time we rely on one another. The group serves as a platform for me to network with other people. I get information on what business is trending and other means of expanding my business from other members [Fieldwork Data: FGD North Suntreso]

Groups as sources of social support

Groups and associations serve as a dependable bastion of social support to people in times of need. Two important benefits stood out in the interviews; financial and emotional support. It was found that apart from group members rallying around others, and providing them with the required support in times of difficulties, they also served as a safety net providing financial support when

the need arises. Respondents recounted experiences during which these groups came to their aid to deal with difficult situations. An interviewee narrates the social support he derives from his group.

In addition to my church, I belong to an association of sprinter bus drivers. The association is very important to me because apart from supporting me financially, the members provide me with emotional support in times of crisis. I remember that when my father died, all the group members went with me to the village for the funeral and made a hefty donation” [Individual interview, Male insured, Nkawie]

Another respondent opined;

I have noticed that you cannot go through life if you stick by your family members alone. If you live in this area and you don't get involved in any communal association, you will be deserted when trouble befalls you. So apart from the Methodist church to which I belong, I am also a member of our trade association. Anytime something happens to me, they show up, comfort me and donate something
[Field work Data: Individual interview, Abrepo]

These views indicate that individuals derive emotional and financial security from joining groups. In times of difficulties, the groups provide the needed emotional and financial support to help people contain the situation.

Groups as platforms for communal action

Voluntary associations and groups bring people of diverse backgrounds together to solve common challenges. As a collection of different people with different backgrounds, groups enable individuals to bring their skills and resources to bear on the activities of groups, helping to achieve

goals that inure to the interest of all. This was found to be important for people in the communities because it made it possible for them to provide basic needs in the communities that governments fail to provide. By joining these groups, community members indicated that they do not only secure their own interest but that of the group and community. The importance of groups for achieving community needs is captured by a respondent.

The groups are very important because they are a means of achieving self-help ventures. As you are well aware, there are so many social services that are needed in our communities that government is either incapable of providing or just not willing to provide. The groups are therefore a vehicle for bringing people together to help ourselves in some of these areas. I am a member of the neighbourhood watchdog association which is very important around here. We have a responsibility to patrol the community and ward off thieves especially in the night

[Fieldwork Data: FGD, Atwima Koforidua]

Groups as agents of positive behaviour

Groups and associations are usually organized along certain defined ends. To achieve these ends, the groups have rules and regulations to guide activities of the members towards achieving the set goals. Apart from ensuring order and cohesion among members, the rules and regulations also helped to ensure positive behaviour among members. They therefore served as a source of social control among members and in the community at large. A female respondent opines;

My mosque has a number of rules and regulations, although most of them are unwritten. For example, we are supposed to be active in all activities, be friendly to every member and reach out to those in need. Apart from that, there are also so

many things I cannot do. For instance, I cannot dress to expose myself because it will bring dishonor to my mosque and religion in general [Fieldwork Data: Interview, New Edubiase]

5.2.3 Dominance of religious groups in the communities

As has been seen, community members value connectivity with others beyond the familial unit, and this is expressed by joining groups and associations in their communities. Of all the groups however, the study found religious groups as the most dominant. The data revealed some consistency where every person interviewed belonged to a church or mosque. For most respondents, religious groups served as a source of social support and compensated for the weakening of bonding ties. Thus, religious groups and associations were found to be increasingly important to fill the void created by weakening traditional social ties. A young man shares her story;

“I came to the Kumasi to find something worthwhile to do. I have done many things but now, I sell mobile phones in Kejetia. I am aware of my situation that I don’t have anybody to turn to in time of trouble, so I have joined a micro credit association and a church. My church in particular is very important for me because they are like second family here. My pastor and the other members always come to my aid when something happens to me and they make me feel accepted around here. I needed to get such a back-up to fall on when the need arises” [Fieldwork Data: Individual interview, Bantama]

Community members saw membership of religious groups as a kind of responsibility and indication of living a responsible life. Beside the primary purpose of connecting members with

God, they served as avenues for networking and providing emotional and material support particularly in difficult times. Respondents showed great attachment to religious activities in general with most people frequently attending meetings. Most people pointed to religion as very important in their lives. One respondent intimated;

“...I belong to the Gospel Light Church and I am very active in church activities. It is not possible to live here without being a member of a church. They are very important to us here and almost everybody in this community belongs to one church or the other. You should come here on Sundays to see how the churches are full. If you are here and you don't join such groups, it will be difficult for you when you are in need” [Fieldwork Data: FGD Esaase, Atwima Nwabiagya]

Finally, religious leaders were also found to be influential in the communities and they were found to enjoy a lot of trust from community members. People trusted their religious leaders to help them in times of need, with some respondents indicating that they actually trusted their leaders sometimes more than their own family members.

Altogether, the study found groups as an expression of bridging SC to be predominant in the communities. Community members were very much inclined to joining one group or the other and they derived several benefits from doing so. The interactions and relationships built among members in these groups served as sources of social support to members either directly or indirectly. Community members attach a lot of importance to these connections within and among these groups and associations. Groups and associations were also found to have become important to cater for the gaps created as a result of weakening traditional family ties. Rotating micro credit schemes, and other trading associations were found to be very predominant in the urban

communities, where people felt that they were on their own and therefore needed to seek some refuge in these groups.

5.3 Linking SC in the Communities

The study further assessed the prevalence of linking SC, which refers to relations between communities and formal institutions of state. Two main determinants of linking SC; trust in public officials and community interactions with public institutions and agents were explored to determine the incidence or otherwise of linking SC in the communities. The findings are presented as follows:

5.3.1 Trust in public institutions and officials

Trust in public institutions and officials is an important pointer to SC between the society and state actors and a critical determinant of effective society-state collaborations. As part of assessing linking SC in the communities, the study attempted to ascertain the extent to which community member's trusted public officials (not politicians) and institutions generally to work in their interest. From the interviews, an overwhelming majority of community members expressed a sense of cynicism about public officials and institutions. Respondents gave examples of several public institutions in Ghana which they thought were inefficient, expressing uncertainty that the institutions will perform as expected. Also majority of respondents did not trust public officials to work in their interest. They believed that these officials were not interested in pursuing the cause of the public but rather their own selfish interests. This was found to be largely as a result of previous negative experiences with these institutions and officials or reports by relatives and friends, or in the media of abuse and corruption by these public officials. A respondent observed;

“...it is so bad where we are in Ghana today but I don’t trust public officials and their institutions to work in my interest and I don’t think anybody out there trusts them anymore. Over the years, these officials have only used their offices to advance their own interests and not that of the public that they purport to serve. With time, I think most people have also come to the realization that public officials don’t care about us but just themselves. Public institutions in Ghana are inefficient and cannot be trusted”. [Fieldwork Data: Individual interview, Bantama]

This view gives support to the general sentiment expressed by respondents about their trust in public institutions and officials. It was obvious from the interviews that most people in the communities did not trust public institutions and its officials.

5.3.2 Relations between Community and Public Institutions

Another expression of linking SC that was assessed in this study is relations between community members and their formal government institutions. In the SC construct, this borders on interactions between individuals, communities and their public actors/institutions. It is also the extent to which private individuals and institutions support and partner with state institutions to provide public goods. These can either be formal or informal and they are intrinsically linked to community member’s ability to influence social outcomes through participation and engagement with public actors.

This study found the extent of engagement between the communities and the various institutions of state to be low. Most people indicated that beyond patronizing these institutions for public services, they never related or engaged with them on any public issue in the community. Although a few people recalled attending one public forum or some community sensitization programme by

a state agency, they maintained that it was not often, and not engaging. Respondents indicated that such programmes were limited to the institutions merely coming to pass on information about their programmes, with opportunities for engagement or participation by the citizenry, either ineffective or non-existent. Community members acknowledged some attempts by local authorities, particularly the assembly members to organize community meetings and forums of engagement, but these were not well organized to truly get to the people. In addition, community members felt that public officials did not even take their views seriously and that constrains community engagement. This position was captured by one respondent;

“...I don’t see that kind of engagement between public institutions and those of us in the community. Of course I go to their offices when I need public services but the way things are done around here, it is not easy to have any form of engagement beyond that. There are no avenues for one to engage with these public officials. In this community it’s only the assembly man here who sometimes organizes some meetings but I don’t usually get involved because I don’t see anything coming out of it” [Fieldwork Data: Individual interview, Apagya]

Views expressed by other opinion leaders corroborate the position of community members. They indicate that they are not involved by the public institutions in the administration of their programmes. A religious leader noted;

“No, I am have never been involved any public institution on any public issue. I don’t think anybody has a plan to include us. The way things are, it is only the few people who can align themselves to politicians who are involved but many of us are

left out in public issues” [Fieldwork Data: Pastor, XXX ministry, Atwima Koforidua].

Overall, these views reflect the extent of linking SC in the communities. It shows that although some form of connection exist between communities and the formal institutions of state, it is rather minimal.

5.4 Conclusion

This chapter presented findings on forms of SC existing in the communities. The chapter established that different forms of relationships and networks available to community members. The findings reveal the prevalence of all three forms of SC albeit at different levels. In relation to bonding SC, it was established that, bonds expressed in familial solidarity, trust and reciprocal norms although weakening over the years, still served as a bastion of support for most people. To make up for the disintegration of bonding SC, community members joined groups and associations – bridging SC. These groups and associations as expressions of bridging SC were found to be predominant in the communities with religious institutions standing out. Linking SC was however found to be low with low levels of trust for formal government institutions and officials as well as less engagement between community and these institutions. The evidence gathered in this chapter serves as a basis to explore how SC influences the enrolment decision which is presented in the next section.

CHAPTER SIX

SOCIAL CAPITAL AND THE DECISION TO ENROLL

6.0 Introduction

This chapter presents the evidence gathered on how SC influences the decision to enroll as set out in the second research question. The chapter is a follow up on the previous one which explored the forms of SC in the communities. While that chapter focused on identifying the structural components that make up SC, this chapter details the cognitive dimension; examining the extent to which individuals are predisposed towards utilizing available structural forms in their decision to enrol. The chapter therefore delves deeper into people's social relations and networks, in the bid to determine how they influence the decision to enroll. The evidence is presented along the three main forms of SC that were explored in the previous chapter.

6.1 Bonding SC and the decision to enroll

6.1.1 Impressing on family members to register

As was established in the previous chapter, bonding relations within the familial unit is a common feature of the various communities. The traditional family structure, although weakening over the years, is still appreciated and valued as a source of social support for most people. As a result of the shared concern for each other within the family unit, a sense of responsibility is created on people to care for other family members, and this serves as an important influence on the decision to enrol. An important way of expressing this responsibility for family members is to impress on others to register and renew their membership. A respondent intimates;

"I live in this house with my sisters. Although we are all here together, they take care of themselves because they have their own husbands and children. But if you

ask them, they will tell you that I am always on their neck to renew their NHIS membership. Honestly, I know that, if they don't renew and any emergency happens, I cannot help but find money to support them” Fieldwork Data: Interview, North Suntreso]

This shows that impressing on other family members to register is also a means of averting the situation where one will be called upon to cough up money when a relative is sick. People reasoned that a family member's failure to enroll created some liability for them in times of ill health. Consequently, familial bonds and its associated sense of shared feeling created a sense of interdependence among family members and consequently obliged them to exert mutual influence over one another. This sense of interdependence nurtures a sense of obligation to ensure that other relatives enroll so they are protected against health hazards, because what affects one member of the family affects all others. How this finds expression on the enrolment decision is captured by a respondent;

“For a long time, I did not register in the NHIS, and I got a lot of pressure from my friends and family, especially from my grandmother who always tried to convince me that it was in my own interest to sign up. But I also know that it was because she did not want me to be a burden on them if I fell ill without any insurance cover as I did not have a job then. The fact is that, if a relative is taken ill, it creates a liability for other family members who must either alter their lifestyle and take on some of the responsibilities of the sick person, or provide some money for his/her treatment if he or she is not insured. And so even now that I am working, and registered, my grandmother in particular keeps checking to see if I have renewed”

[Fieldwork Data: Interview, Nkawie]

6.1.2 Reciprocity and the decision to enroll

Related to the concern for each other within the family structure are prevailing norms of reciprocity with implications for individual and collective decisions to enroll in the NHIS. The study found that, out of the tacit sense of obligation to give back the support people have enjoyed from other family members, a sense of duty is felt, particularly by those who are better off, to seek the well-being of others. For most people, this obligation includes taking care of the health needs of incapable family members, which also includes ensuring that they are duly registered under the NHIS. This experience of reciprocity on the enrolment decision is shared by a respondent;

“If you come to my family, everybody looks up to me. It is because I am the only one who is a bit well to do. I take care of everything from food to health bills and school fees. In terms of health, I ensure that all my nieces, nephews, sisters, cousins, brothers etc. are registered under the NHIS so that they do not inundate me with health bills” [Fieldwork Data: Interview, Bantama]

Another respondent corroborates this view;

“I live here with my aged mother. I take care of her but the money for her upkeep is usually sent by my elder brother in Tema. Although I have my own cosmetic business, it is my brother who takes care of all of us. He pays our premiums and renewal charges and so anytime he comes to Kumasi for a funeral or some other meeting, he will check and give out money to anyone who has not renewed to do so. He always warns us that if we don’t renew and we are taken ill, we should not call him” [Fieldwork Data: Interview, North Suntreso]

These findings indicate that the virtue of reciprocity within the familial set up is expressed by caring for the incapable members in the family. Older family members for example deemed it their responsibility to provide for the young and non-working family members. On their part, the young and able in the family felt a responsibility to provide for older members. This disposition obliged people to ensure that their relatives are registered in the NHIS as a part of bearing that responsibility. This sentiment is captured by a respondent;

“You know, we have all been brought up to support each other, especially the elderly in our family. My two other siblings and I have the responsibility of taking care of our aunt. She is not too healthy and visits the hospital often. Because we don’t want to incur any unexpected charges when she visits the hospital, we ensure that she renews her membership all the time” [Fieldwork Data: FGD, Atobiase].

These findings go to show that apart from showing concern for one’s family, people ensured that their family members register and renew their membership in the NHIS because of existing norms of reciprocity.

6.1.3 Community solidarity and the decision to enroll - obligations and expressions

The study found that solidarity expressed within the familial unit is also extended to members of the larger community. Opinions expressed reveal a sense of concern for other members of the community, including an interest in their health. There is a sense of shared values and/or solidarity with other members of the larger community, with most respondents indicating their willingness to go the extra mile to secure the health of other members of the community. People are willing to act in ways that will not only inure to their benefit alone but that of the entire family or community. For instance, most respondents were willing to join the scheme and contribute to the pool to cater

for all, indicating their preparedness to pay something extra to cater for others. Most people are prepared to support community members who are incapable of paying, by increasing their own contributions. Others would not mind if other members of the community who could not afford premiums were made to join the scheme for free.

“I think the NHIS is far better than the cash and carry where everybody was left to care for himself. This one seeks the welfare of all Ghanaians, so anybody who cares for himself, his family members and other people will join and support it to thrive. For me, I joined way back in 2006 because apart from the fact that it covers me in times of ill health, I thought it is in the interest of the entire Ghanaian population. So I would still go ahead to pay even if I would not utilize the NHIS myself, because, I would have had done something good for the community by contributing to the insurance fund” [Fieldwork Data: FGD, Toase].

This view is reinforced by another respondent;

Solidarity and caring for each other is very much rooted in our way of life. That is the whole sense of living together, and that is precisely how our forebears lived. You have to consider the interests of other people and rally around each other. So I don't mind contributing towards the NHIS by paying premiums even if I will not benefit directly. If I am healthy and I pay premiums, I may not go the hospital for say two years but at least, my contribution could be used to cater for my grandmother or some other person who may need it. So in the end when you enroll and pay premiums to the NHIS, it is not just for your benefit, but you also help others” [Fieldwork Data: Interview, Esaase].

Thus, bonding SC which is expressed in a sense of solidarity and togetherness was found to influence people's willingness to join the NHIS. But while most people were prepared to pay something extra to cater for the poor, they were concerned that the resources may not be well managed by officials. Most people who were not willing to pay beyond their own premiums indicated that, their sacrifice will not serve its purpose, but rather end up in the pockets of public servants and politicians. This sentiment was echoed in one of the FGD's.

“The problem is not with me contributing to the scheme even if I will not benefit. For me, my problem is whether the schemes resources will be managed well. Looking at our officials and politicians, I don't think it will be worth my while. They will mismanage the resources just like we hear them do every time” [Fieldwork Data: Interview, Apagya]

This suggests that even though people are willing to join the scheme or even pay something more to cater for others who cannot afford, they do not trust that officials will manage the scheme's resources well and that influenced their decision to join.

6.1.4 Family, friends and neighbours as immediate sources of information on NHIS

Inherent in bonding SC is the tendency to rely on information from close relations. This study found that for most people, their family, friends and neighbours served as their immediate sources of information on the NHIS because of their trust for them. Whether good or bad, such information about the scheme influenced people's decision to join or abstain from the scheme.

“I remember very well that I joined the scheme in 2009, based on information I got from my brother who lives in Sunyani. At the time, information about the scheme was not that accessible and people peddled a lot of falsehood. Since then, I have

been an active member, always renewing my membership. However, for some time now I have been hearing reports from other acquaintances that the scheme is not working well. That puts me off these days although I am lucky not to have visited the hospital” [Fieldwork Data: FGD, Esaase]

This indicates that the decision to enroll or otherwise is also based on information and recommendations of family members. It further shows that the opinions and experiences of close relatives and friends about the scheme influence other people’s decisions and actions. Put together, the interviews indicate that solidarity, reciprocity and a shared concern for each other are important influences on the decision to enroll. This influence was however found to be more prevalent in the rural communities with homogeneous, close-knit communities than in urban areas with diverse populations comprising people of different ethnic origin, religion and culture.

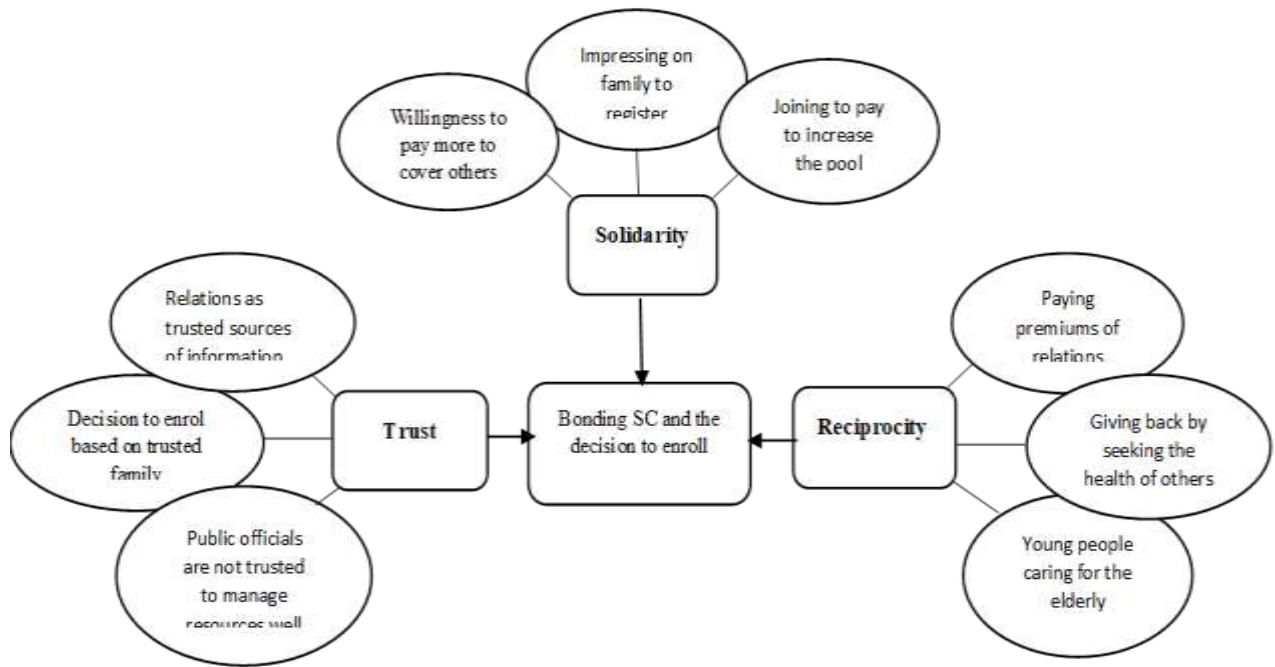


Fig 6.1: Thematic network on bonding SC and the decision to enrol

Source: Author's construct (Fieldwork data 2018)

6.2 Bridging SC and the decision to enrol

As was established in the previous chapter, membership of voluntary groups and associations form a key part of social life in the communities. The relationships and networks developed in these groups generate a sense of trust, mutual concern and solidarity for and between members. This is bridging SC and it cuts across familial bonds or homogenous groups to link different people of diverse backgrounds. The data gathered suggests that bridging SC generated among individuals as a result of the groups they join impinge on their decision to enroll in the NHIS. The main ways through which bridging SC influence people's decision to enroll as found in the interviews are presented in the following sub-sections.

6.2.1 'Group think' and the decision to enrol

Groups align individual interests with those of other group members in order to solve common problems. The groups serve as bridges and networks and influence people's decision making and actions. As far as the decision to enroll in the NHIS is concerned, the interviews revealed a trend where most respondents indicated that they enrolled because they heard that other members of their group had enrolled. Apart from doing so to ensure conformity and harmonious living with group members, some people indicated that they felt secured to enrol, once they got to know that other members of their groups had joined. This was highlighted in one FGD;

“You see, when you are in a group, you get together and start to think collectively with one mind. The thing is, you want to think and act like other members of the group. So when you hear that your group members have signed up, you are also encouraged or perhaps compelled to do same. In my case, I did not ask further questions, nor assess whether the NHIS is good or not; once I heard that other

group members were joining, I also joined” [Fieldwork Data: FGD, Atwima Koforidua]

This suggests that some people ground their decision to enroll in the assurance and encouragement from trusted group members. Whether good or bad the desire to think and act like ones group members influenced people to enroll or abstain from the NHIS.

6.2.2 Group solidarity and the decision to enrol

Group solidarity orients members to share beliefs and norms, and as individuals who are interdependent, exert mutual influence over one another. As a result of the shared concern and solidarity generated within groups and associations, some influences are brought to bear on individuals in their decision to enroll. The interviews reveal that out of this concern for members, some groups made it obligatory for their members to register and renew their membership in the NHIS. Besides ensuring that members can access healthcare in time of sickness, this was also to reduce the cost of welfare expenditure to be borne by the groups in cases where a member did not have health cover. This was found to be very common with the local churches and professional associations. A leader of a traders association intimated;

“As a group that seeks the welfare of our members, we ensure that every member registers and renews their membership of the NHIS. It is to protect ourselves from out of pocket payments, which we all know can be very devastating. It is also to ensure that we reduce the welfare expenditure on our members, because in the end if someone is not registered and is in crises, we may have to step in and support”
[Fieldwork Data: Interview, Nkawie].

Apart from influencing members to enrol, the study found that some groups also paid for the registration of members who could not afford NHIS premiums. This practice was quite predominant among the churches and was seen as a way of supporting those who are financially weak.

“In my church, we identify people who are incapable of paying for the NHIS and we pay for them. That is our way of showing love to the poor and vulnerable as is demanded by the Bible” [Fieldwork Data: Interview, Atwima Koforidua]

These go to show that the decision to enroll is also influenced by the group to which one belongs. The solidarity generated among group members can be an important influence in people’s decision to enrol.

6.2.3 Groups and associations as sources of information on the NHIS

An important means through which groups influence the decision to enroll is by serving as networks or channels for accessing information. The study found that for most respondents, their fellow group members served as channels of information on the NHIS and that influenced their enrolment decision making and actions. Some respondents indicated that their decision to enroll was based on information they got about the scheme from their group members. One respondent noted;

“I get information about what is trending, including information on the NHIS, from my group members. Most of the members are particular about us registering in the NHIS. As women, we understand that the scheme is very beneficial for us and our children, so you will usually get members talking about it and reminding ourselves to update our registration with the NHIS” [Fieldwork Data: Interview, Bantama].

6.2.4 Group leaders and the decision to enroll

The leaders of various groups and associations in the communities were found to be important influences on the enrolment decision. It was found that as a result of the concern for their members, group leaders encouraged and sometimes insisted that their members enroll in the NHIS. Consequently, members responded positively by enrolling as a result of the trust and reverence for these group leaders. The leaders also serve as authoritative channels through which people sourced information on the NHIS and their opinions on the NHIS were also found to be important in influencing enrolment decisions.

“My pastor has been hammering on how useful the NHIS is; particularly for the poor. Every now and then he reminds the church members of the need to register so that we would not be found wanting when sickness strikes. I actually registered because of his counsel” [Fieldwork Data: FGD, Atobiase]

Therefore, while group leaders directly influence their members by encouraging them to enrol, general leadership support for the NHIS was also found to encourage participation and adherence among members.

6.3 The Informal Sector and voluntary enrolment

Against the background of Ghana’s large informal sector, the study explored the extent to which community members who work in the sector found it easy or difficult to enrol. The interviews revealed a trend where respondents in the informal sector indicated that they found it very difficult to pay premiums at fixed times. While some respondents attributed their difficulty to the cost of premiums, majority of them indicated that it was due to the fact that the premiums and renewals had to be done at fixed times which made it difficult for them because of the irregularity and

unpredictability of their jobs and incomes. This served as a challenge to the decision to enroll. A leader of one trade association explains;

“We are in the informal sector and our incomes are not reliable so the tendency for you to either postpone or even forget about your NHIS renewal is high. We have had several cases where people are struck by illness only for them to go for their cards and realize that they have not renewed. So unlike those in the formal sector, we are disadvantaged and that is why we always hammer that when we go for meetings. Apart from ensuring that everyone registers, it is also a way of reminding them” [Fieldwork Data: FGD, Abrepo]

The NHIS agencies acknowledge the problem of the informal sector. They note that in terms of coverage, it has always been difficult to get those in the informal sector to enroll and particularly renew on time. They reckon that it is because of the nature of their jobs and incomes, for which reason some attempts were made to help the situation. An official explains;

“Compared with those in the formal sector, enrolment by those in the informal sector; the traders, mechanics, farmers, etc, has always been a problem for us. I think it is because they don’t have stable and regular incomes like those in the formal sector. Because of this, we tried to meet them halfway by having some of our agents go into the villages and collect premiums payments in small amounts. That helped but, it also came with problems of accounting for the money so it is not encouraged anymore” [Fieldwork Data: Interview, PRO Bantama NHIS agency]

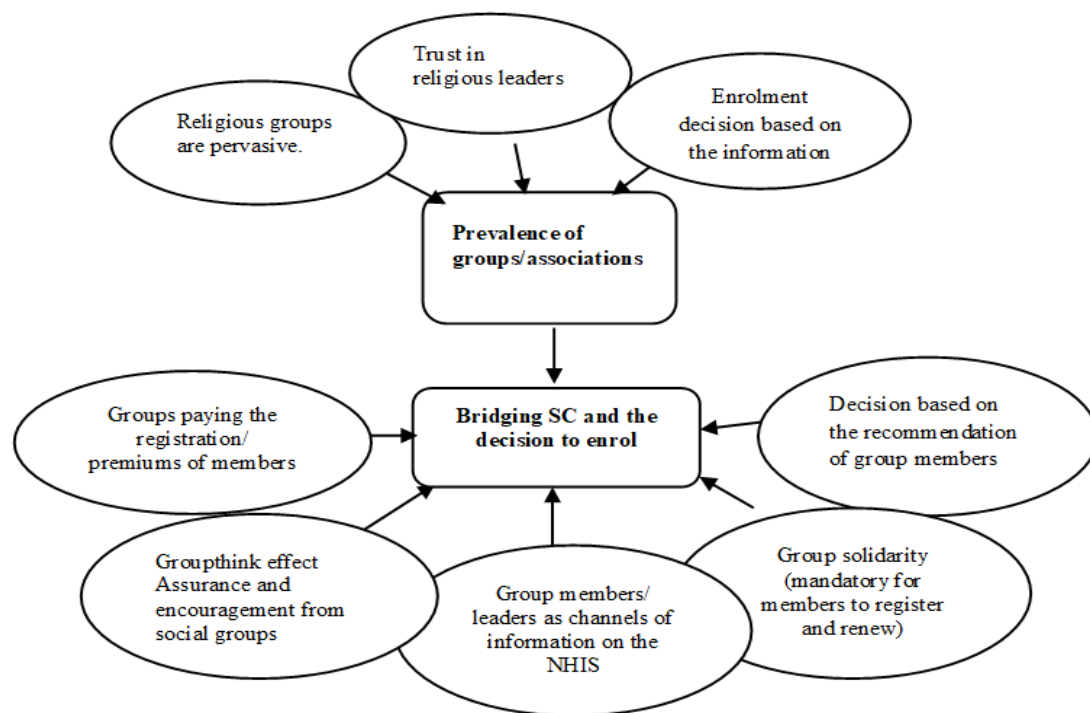


Fig 6.2: Thematic map of bridging SC and the decision to enrol

Source: Author's construct (Fieldwork 2018)

6.4 Linking Social Capital and the decision to enrol

Linking SC refers to the relationships between communities and the formal institutions of state. It is the extent to which members of the communities trust public officials to work in their interest. Therefore this study sought to detail how people's relationships with the NHIS and its related service providers influenced their decision to enrol. The findings are organized under sub-themes which include: relationships and experiences with NHIS agencies; trust in scheme management;

relationships and experiences with healthcare providers; information and communication. Overall, the data revealed a number of issues arising from these experiences, and which had contributed to a weakened linking SC. These are presented as follows.

6.4.1 Relationships and experiences with NHIS agencies: effectiveness and credibility are important

Generally, people enroll in the NHIS to the extent that they found management and officials effective and credible. Thus, the decision to enroll is very much influenced by clients' assessment of the effectiveness and credibility of the NHIS agencies and officials. The study found that the daily experiences and relationships with scheme officials, the effectiveness of their procedures and processes as well as their management of NHIS resources played a key role in securing people's interest and their subsequent decision to enrol. In this regard, it was found that majority of community members had enrolled in the NHIS; an indication of a certain level of assurance in the system. Community members acknowledged that generally, the services rendered by the NHIS agencies and their general effectiveness have improved over time. One respondent shares her experience;

“First, the NHIS had a lot of difficulties. You could go to the office several times just to get a membership card or to have it renewed. But now, it is better in terms of services. Renewals for instance can be done in a few hours. When my daughter went to deliver, there were a lot of complications but because all of that was covered under the NHIS, I did not pay anything” [Fieldwork Data: FGD, New Edubiase].

Respondents were particularly delighted about the introduction of biometric cards, instant card issuance and renewals. They indicated that their health-seeking behaviour had improved as they

visited the healthcare facilities more often. This had generated some measure of confidence in the system, scaling up the SC between the community and the NHIS, with positive implications for the decision to enrol.

However, several negative experiences with NHIS agencies and the conduct of some scheme officials were found to be a disincentive to most respondents. Inconveniences in the enrolment procedure, the careless attitude of some staff, poor client service and other administrative challenges associated with the NHIS were cited as negatively influencing enrolment and renewal of membership. A respondent opines;

“I tried to renew my membership sometime last year but there was a long queue anytime I visited the NHIS agency in the district so at some point I stopped going there and so as at now, I have not renewed. It is also not fair when you renew and they say you have to wait for about three weeks before you can access healthcare. That is why I have not bothered to renew, I just go and pay” [Fieldwork Data: FGD, Atwima Koforidua]

Concerns about favouritism and corruption at the agencies also came up as discouraging people from enrolling. While respondents agree that this is not only peculiar to the NHIS but symptomatic of the general patron client situation in Ghana, they indicate that such negative practices affected the credibility of the agencies. Respondents expressed lack of confidence in the NHIA, its local agencies and the government as a whole to efficiently manage NHIS resources. They pointed to the lack of control and supervision of services as an important factor. For most respondents, unfavourable experiences with the scheme relating to its effectiveness and transparency in administration negatively affected their decision to enrol.

6.4.2 Trust in scheme management/staff and the decision to enroll

An important influence on the decision to enroll which results from the relationships and experiences with management is trust. Trust in management is built over time as community members relate with managers and officials, and depends on how openly services are provided; how staff demonstrate competence; and general client's satisfaction when they visit the NHIS agencies. Trust in the NHIS staff was found to be very important for most people because it gave them some measure of assurance that norms established as part of the insurance contract will be respected.

However, the interviews revealed that most respondents expressed a sense of skepticism about the NHIA, its related agencies and officials. Most people indicated that they did not think the institutions and officials work in their interest. The reasons underlying such mistrust include previous personal or reported experiences of poor services, lack of transparency as well as theft, and bribery and corruption reported in the media, all of which served as disincentives for enrolment.

“I don't really trust the managers of the NHIS especially when it comes to transparency in their services. Sometimes you go to the office for a service and you have people bypassing you because they know people at the agency. I am also aware that a lot of 'connections' go on at that place so people can circumvent the system if they can pay something to somebody. It makes me see them with some suspicion and sometimes decide not to have anything to do with them”. [Fieldwork Data: Interview, Nkawie]

6.5 Relationships and experiences with healthcare providers

Quality of healthcare services and the decision to enroll

The decision to enroll in the NHIS depends on the guarantee that people will be well taken care of in times of ill health. The study found that people sign up and renew to the extent that they have confidence in the general healthcare system, the various healthcare providers, and whether they respected the agreed social norms. In this regard, negative experiences, particularly in terms of unmet expectations of quality of care by service providers was found to be a concern for most people. While acknowledging that the scheme provided some buffer, in times of ill health, interviewees expressed a general feeling of dissatisfaction in the general healthcare system of the country and service providers. Most respondents were generally unhappy with the quality of care under the NHIS. As a result of past experiences, most people who really wanted quality care did not depend on the NHIS. One uninsured respondent shared his experience;

“Most of us know that if you need proper care, you don’t have to rely on the NHIS. My brother’s wife went to the hospital to deliver and she laboured for a whole night. The only nurse on duty had gone to sleep in the nurses’ room. In the end, she lost the baby and we regretted because we were very sure that if we had taken her to a private facility where we paid cash, the treatment will have been different. So what is the use of buying insurance which does not serve you well when you visit the hospital?” [Fieldwork Data: Interview, Apagya]

This shows that community members preferred the private institutions, many of which are not accredited to the NHIS to deliver quality care. They indicated that compared to the public facilities, documentation is not cumbersome, and patients are treated with more respect. In their own

assessment, the private facilities are more responsive to patients needs and do detailed checks. The influence of these comparisons on the decision to enroll is argued out by a respondent;

“Why would I buy insurance and yet go to the hospital and be given basic treatment. I took my daughter to the NHIS accredited hospital here and all they did was some basic checks on her and they gave us drugs. Her situation did not improve so I changed to Dr XXX’s hospital which is unaccredited and I paid 250 GHC in all. In three days she was ok and could go back to school. You ask anybody around here; Dr XXX does not take health insurance but most people in this area prefer to go there... all because of the kind of proper care they receive [Fieldwork Data: FGD, Toase).

Bias against NHIS clients

Experiences of unfair treatment handed NHIS card bearers by accredited service providers influence the decision to enroll. While acknowledging that poor treatment is a general problem with public service delivery in Ghana, most respondents indicated that compared to the uninsured, NHIS clients were discriminated against in the various service centres. They reckoned that non-clients who pay cash at the service centres were preferred by service providers because of delays by government in reimbursing them. The poor treatment handed NHIS clients and the reason behind it is argued by a respondent;

“NHIS clients are not treated well by service providers and I think it’s because they prefer those who pay cash. But of course they will prefer those who pay cash because we hear every time that government is not paying these service providers. They also need to run their institutions and take care of their recurrent expenditures” [Fieldwork Data: Interview Abrepo Nkawie].

Another respondent articulates how it affects enrolment;

“The NHIA is part of the problem. How can they expect providers to deliver all these services, and they won’t pay them? No wonder that sometimes when you visit the clinic with insurance, you are made to feel as if you are coming for something free or someone is doing you a favour. You will join a long queue and you go through a lot of processes. In the end they don’t even treat you well. But it is not the same for those who pay cash directly to them. They are treated better and on time and that is what deters people from renewing” [Fieldwork Data: FGD, Bantama]

While service providers do not fully agree to this view, they acknowledge that insured clients waited longer than the uninsured in service centres. According to them this was due to the increasing number of NHIS users and the accompanying documentation processes; a development that could negatively affect enrolment and renewals. They acknowledge that some facilities created different queues for the insured and uninsured, but explained that it was a strategy to bring efficiency in the processing of clients. However, the NHIS queues were typically long because they required more documentation to check frivolous utilization of services. One hospital official explained the reason;

“We have created different queues for the insured and uninsured. This is because we spend more time checking and documenting information on NHIS card bearers because that is what we forward to the authorities for reimbursement. The uninsured or OOP category have less documentation and that is why we spend less time on them. The different queues help us to sort out the cases more easily”
[Fieldwork Data: Interview, Suntreso hospital administrator].

Health service providers however expressed doubts about the commitment of the NHIA to reimburse them on time to ensure solvency of the scheme. They maintain that government and the NHIA paid lip service when it came to honoring their end of the bargain; a position which seemed to resonate with clients suspicions.

“But we are all in this country and we witness how they manage these things. See, we go for loans to be able to provide services and drugs to clients and the NHIA is expected to pay us so that we can also pay our suppliers. But if you wait for over six months or sometimes, one year before you pay us, what do you expect us to do. I don’t do that but when I hear that others prefer OOP’s, I always say it’s just logical for them to do that” [Fieldwork Data: FGD, Pharmacy owner Bantama].

Inconsistencies and Inadequacy of the NHIS drug and service list

Respondents were concerned that a number of health conditions that require expensive treatment are not covered under the NHIS drug and services list. There are also worried about the uncertainty of the services and how the drug list kept changing. Respondents indicated that sometimes, clients were made to pay for services and drugs covered by the NHIS list. These inconsistencies affected people’s level of assurance in services and the relationships between clients and managers. The effect of these on the decision to enroll in expressed by a respondent;

“The insurance covers only minor diseases for which one can easily get treatment by going to the drug store. When it comes to the expensive ones like kidney diseases, they say it is not covered. Sometimes too, you are very sure that some drugs or services are covered, but providers tell you to pay. What is worse is that these days when you are on admission, they may charge you between GH¢ 200 and 300 for

just 2 or 3 days. So in the end, it comes up to the same thing and one is better off just paying cash when the need arises” [Fieldwork Data: Interview, Bantama]

Conflict of interest

Related to the respondent views on unfair treatment of NHIS clients are suspected cases of conflict of interest which negatively influences the decision to enroll. In this regard, a concern that came up was that some doctors own pharmacies and laboratories around the health centres and the experiences of interviewees were that such doctors could prescribe basic drugs for patients to get at the hospital pharmacy and then direct them to their private shops to pay cash and get better drugs. Sometimes, they recommended or referred them to their private hospitals for better treatment. A respondent shares some experiences;

“Some facilities tell NHIS patients they don’t have the drugs in stock but if you send somebody else to purchase with cash, you will be surprised but the drugs will be given instantly. It is even more worrying when doctors prescribe medicines which are not available in the NHIS accredited pharmacies and you have to buy them with cash from other private shops which are for them. Now we all know that if you want quality treatment or drugs, you don’t have to show your card, you have to show money” [Fieldwork Data: Interview, Esaase].

Altogether, these experiences of poor quality, bias against card bearers and conflicts of interests do not encourage current and potential enrolees to go ahead and enroll or renew. It rather signals to them that they are better off as uninsured and that their insurance does not entitle them to any privileges in the service centres.

6.6 Lack of Control over Scheme Management and Service Providers

The extent to which citizens can influence the management of policies and programmes that directly affect them contributes to the SC between them and public institutions. Apart from enabling them to exercise control over public officials, it also makes them feel a part of the process and engenders ownership of policies and programmes. Generally, community members felt that they did not have any control over NHIS officials, service providers and other health professionals and that was a major concern for them. Although most people are conscious of their duty to play their part to help the system, they felt constrained, not only because of the lack of opportunities to do so, but also because of the likely negative consequences from these professionals. Others could not be bothered and felt that their interventions will not even count because of the way the system is designed. This feeling of helplessness was highlighted in a FGD;

“There are so many things that these officials do that do not auger well for the scheme. At the heart of it all, is the poor treatment of clients in the service centres. The truth is that, you don’t get what you expect when you visit the facilities. And it is as if you cannot do anything about it so you just keep quiet and suffer. In fact, if something is going bad and you dare raise a voice, you will be met with disdain, sometimes from other officials. I think it is also because there is no supervision over these service providers” [Fieldwork Data: FGD, Suntreso].

Respondents felt that the NHIA did not have adequate mechanisms to control abuse and fraud by managers and other service providers. People were concerned that, in cases of untoward treatment, they did not even know who to complain to, and how their complaints will be addressed. This feeling of uncertainty and lack of capacity to influence officials was found to be a disincentive to participation in a collective endeavour like the NHIS for which payment is required. Thus, the

study established that, because enrolment in the scheme is not legally binding, the best reaction to the seeming lack of control for most people is the decision not to enroll or renew. A respondent intimated;

“I think the conduct of service providers in particular is a major reason why most people are not encouraged to enroll and renew their insurance when it expires. I have not renewed my membership for the past three years because I don’t see the reason why I will pay money, only to go the service centre and be treated like someone is doing me a favour. This problem has gone on for years and it is as though nothing can be done about it. So under the circumstances, the best thing for one to do is to disengage and hope that nothing happens” [Fieldwork Data: Interview, Edubiase]

These go to indicate that although discontent of enrolees as a result of poor conduct of staff and services may not be voiced out, subconsciously, they affect the decision to voluntarily enroll. The perceived lack of control over officials and service providers served as a disincentive and the ability to exercise control is important for eliciting support and ensuring accountability of officials. Community members indicated that they will feel a part of the system and be encouraged to enroll if adequate opportunities are created for them or their own representatives to exercise some control over the implementing professionals. One respondent remarked;

“The thing about the NHIS is that it is not like the normal government programmes that we sit and watch public officials alone to implement. This one thrives on our own contributions and so we are interested and cannot be left out. If the scheme is to get the full support of the citizenry, they must find ways of getting us involved in

the process. That will also put the officials in check because they know we are watching them” [Fieldwork Data: Interview, Suntreso].

The sentiments expressed by community members were somehow acknowledged by the NHIA, the main authority for managing the NHIS and regulating service providers. They observe that the health insurance policy is also a fund into which citizens contribute, and therefore consumer voice is important. Management however admit that the level of engagement with citizens has not been effective as expected. They observe that provisions made for the establishment of structures such as the community insurance committees as a way of involving community members for instance was never established or used by schemes. They are also aware of the negative implications of the conduct of health professionals for enrolment. According to them, they receive a lot of these complaints and it is the reason why they have intensified their checks in recent times. An official situates the role of the authority in controlling schemes and service providers in context;

“We are aware of the complaints of poor quality of service handed to clients in the service centres. It is a big problem and it is as a result of the many complaints from clients, the NHIA is extremely thorough in inspecting, assessing and accrediting service providers these days. Now, we strictly apply the accreditation tool which has a lot of standards to be met by these facilities before they are accredited. Initially, provisional accreditation was given to all public health facilities after which, inspection, accreditation and grading of the facilities were done. Now it is the reverse, we inspect your facility before we bring you on. I can tell you on authority that we have had cause to revoke the accreditation of a number of facilities which do not meet the standard. We insist that agencies do not go beyond

the average waiting period of thirty minutes for registration” [Fieldwork Data: Interview, NHIA official, Accra]

While the NHIA showed commitment to regulate the various service providers and bring some sanity into the system, they also concede that some areas still required attention. Notable ones include the concerns on clarity of the NHIS benefits package and poor attitudes of some staff towards clients. They were also particularly concerned about the quality of healthcare which in their view, had implications for interpersonal relationships and medical-technical value. Their objective is to achieve short waiting times, fair queuing system, and pleasant attitude of staff, accurate and timeous claims processing, suitability of diagnostic procedures and dispensing of quality drugs. However, on the conduct of staff, they maintained that apart from their own NHIS staff, the control of various health professionals, fell outside their jurisdiction.

“The conduct of some health professionals particularly in the public facilities is a problem that we are aware of. But the Authority is somehow limited because unfortunately, disciplining of health professionals falls outside the mandate of the NHIA. So what we do when we get such complaints, is that we report culprits to the relevant professional bodies to which they belong. Sometimes too, we ask the facility managers to take action” [Fieldwork Data: Interview NHIA official Kumasi]

6.7 Information, Communication and the Decision to Enroll

An important part of the linking SC construct is information and communication. The availability of information and effectiveness in communication are seen as bedrocks upon which community members make informed decisions and choices. They also help to alleviate suspicion enabling

people to trust each other to engage in cooperative activities. Consequently, this study set out to explore the extent to which information on the NHIS is available; whether or not there is effective communication between officials and community members; and how these influence the enrolment decision. Two key aspects of information and its influences came up in the interviews. The first is the level of information on the NHIS and its services, and the second is the kind of information, whether positive or negative on the enrolment decision. On communication, community members indicated that it has not too effective. How these affect the decision to enroll are presented below.

Level of information

Regarding the level of information, the study found that general awareness and accessibility of information on the NHIS had increased over time. Respondents noted that compared to the past, information about the scheme is currently more accessible. The main sources of information about the NHIS are national and local media platforms, NHIS posters and flyers, handbills, friends and family. The NHIA engages in several campaigns to educate community members on its services and benefits package and the local agencies have information and public relations sections which go into the communities to disseminate information on the scheme. All these had made information on the NHIS relatively accessible and understood among clients. In the view of respondents, this had reduced uncertainty and anxiety among clients, and ultimately enhanced enrolment. A respondent affirms;

“I did not join the scheme when it came first. I did not understand the issues because information was not available and I only depended on hearsays. I remember that those days, we were unsure about how to access healthcare when one found himself in another district. Also, when you went to a facility and they told

you a particular condition or medicine was not covered, you could not say anything because the information was not available. Now, there is a lot of information about the NHIS and that puts everyone at ease. I am better informed and can insist on what I deserve” [Fieldwork Data: Interview, Abrepo]

This notwithstanding, respondents noted there are other areas on which information was still lacking. These included clarity of information on benefits and services package, and the financial status of the scheme.

Reports of policy unreliability and publicized corruption

An important aspect of information that was found to influence the decision to enroll is reports of the NHIS’ unreliability and ineffectiveness that goes round the communities. Respondents indicated that they consistently heard negative commentary about the NHIS, sometimes from people in authority. This was a major concern because, it sent wrong signals among the citizenry and discouraged people from signing up and renewing their membership.

“Most of the time you hear people saying that the NHIS is collapsing because of one reason or the other. Sometimes it’s because government is indebted to the providers. At other times, you hear that clients visited hospitals and they were asked to pay or they were not attended to. I don’t understand the whole arrangement and I don’t know whether these reports are true either, but it makes me feel I cannot trust the system with my life” [Fieldwork Data: Interview, Nkawie]

The effect of such negative information was acknowledged by management of the NHIS. Officials were particularly worried that influential people and other politicians speak ill of the policy on

various media platforms. In their view, this affected the morale of clients and hampered enrolment and renewal rates. One official shares his frustration;

“When influential people who are supposed to know better, sit on radio and say all sorts of negative things about the NHIS, it breeds disaffection and affects people’s desire to enroll and renew. We admit that the scheme has challenges and it has not been perfect, but if you hear big men saying for instance that the scheme has collapsed and people are being charged in the hospital when, that has never happened, it does not help matters. Spreading such falsehood affects people’s zeal to renew” [Fieldwork Data: Interview, Atobiase].

The study also found a trend where negative reports and publicized corruption scandals by some scheme management and officials created a ‘confidence deficit’ for the NHIS. This was found to have a negative influence on people’s decision to enroll, as community members felt that it was their hard earned premiums that were being embezzled by these officials. Views expressed by respondent’s show that cases of corruption by NHIS officials provided incentives and reinforcement for the decision not to enroll in the NHIS. The negative reports fed into the prevailing thinking among the citizenry, that public officials appropriate public funds for their personal use; a challenge which constitutes a wicked policy problem in its own right. One respondent reasoned thus;

“I would rather keep the money for buying insurance to myself than indirectly add it what these corrupt public servants and politicians are already taking from us. It is very hurting to see that people are dying in the hospitals because of the lack of basic drugs and equipment.... and in the midst of all that, you hear that one person has embezzled so much” [Fieldwork Data: FGD, Esaase].

Although most people are not fully aware of the implications of a state centred scheme, the few respondents who understood the dynamics were sceptical because of the negative tendencies of public institutions in Ghana. They indicated that it concentrated control of the scheme to the centre, something they felt will further fuel corruption. An official in one of the districts noted;

“Collapsing the district schemes and giving all the powers to the NHIA under the pretext that they want to control corruption is just a façade. In effect, they are only concentrating the corruption at the centre. Nothing will change” [Fieldwork Data: Interview, Toase]

Communication and the decision to enroll

Besides information, communication with officials was also found to be critical for most people. Views expressed by community members suggest that some communication went on between them and the managers of the scheme. They acknowledged that the NHIS agencies sometimes organized some campaigns and forums where they related with the community, and that had empowered them to understand issues and processes surrounding the scheme to some extent. However community members were unanimous that communication has not been too effective and regular, and they have not been well organized to truly get the views of the people. These appear to be effectively constrained by individual perceptions that the NHIA does not even take their views seriously. This has contributed to doubts and suspicions in the minds of many people about the scheme. This sentiment was captured by one respondent who quizzed;

“I will say communication with the managers of the NHIS has not been too effective. To a large extent, they only disseminate information without any forms of engagement. But the few times that we had the opportunity to engage them has been

very useful in clearing up some misconceptions and misinformation as well as helping us understand the motives behind their decisions. For example, when they piloted capitation, there was suspicion all around that it was a political arrangement against the Ashanti region. But after the NHIA went round to communicate with clients, people understood it and went along” [Fieldwork Data: Interview, Assembly member, Abrepo].

The NHIA acknowledges the important role of communication in the decision to enroll. They indicate that communicating with clients, stakeholders and the community helped them to understand clients’ needs and respond to them appropriately. It served as a means of generating feedback, helping them to evaluate the impact of their interventions and for improvement in their services to satisfy clients. The feedback generated better positions them to be more responsive to clients’ needs. An official argues;

“Communication with community members has been very instrumental in how far we have come as an authority. When we go on outreach programmes, you will be surprised by the kind of feedback we get. It has proven to be very important in helping us improve on our services over the years. I can tell you that most of the changes and innovations that have been introduced in recent times have been as a result of the feedback we collate from the field” [Fieldwork Data: Interview, NHIA official, Kumasi]

Being aware of the benefits of communication, the authority had instituted a number of measures. An official explains;

“The NHIA identifies effective communication with clients as a challenge. It affects the delivery of services and overall enrolment. Consequently, the improvement of communication has been on top of our agenda with efforts made to enhance communication and engage with clients. We have strengthened our public relations unit to serve as an interactive interface between the NHIS and the general public. In addition, we introduced the call centre in 2011 to give a listening ear to subscribers, stakeholders and the general public. We also insist that all agencies have regular seminars and sensitization programmes for people to be educated and for them to express their views. Through such means, client challenges are identified and addressed” [Fieldwork Data: Interview, NHIA official, Accra].

These findings go to show that information and communication are important for the NHIS just as it is for clients. While it enables clients to make informed choices and therefore influence their decision to enroll, it serves as a vehicle through which management explain misconceptions and misunderstanding of the principles of health insurance as well as its benefits.

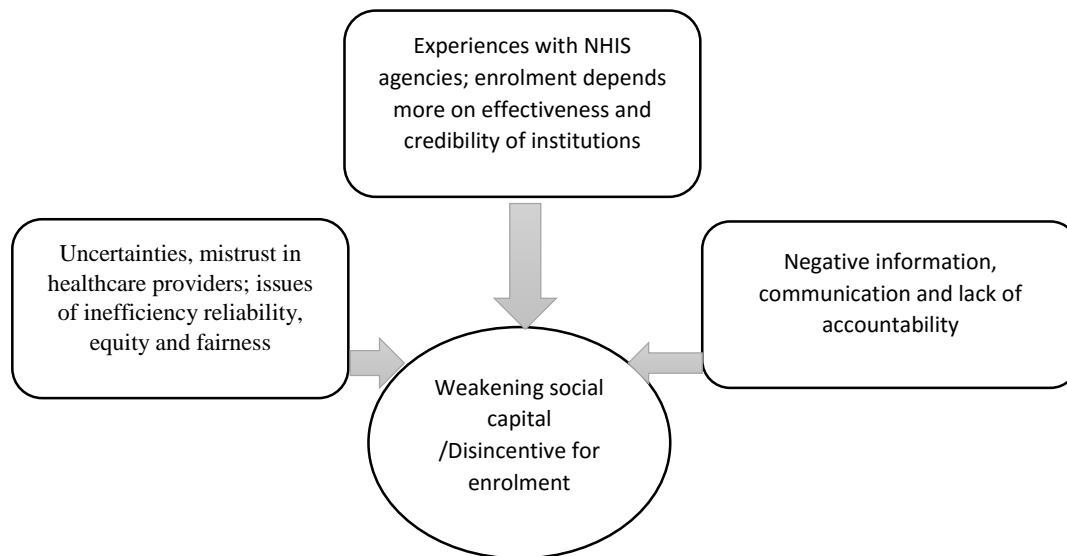


Fig 6.3: Linking SC and the decision to enroll in the NHIS

Source: Author's construct (2018)

6.8 Conclusion

This chapter addressed the second research question which was to examine how SC in the communities influenced the decision to enroll. Various means through which the forms of SC in the communities influence the enrolment decision were identified. With regard to bonding SC, the chapter established that the shared concern for each other in the familial unit, expressed through solidarity, reciprocity creates a sense of responsibility in family members. This responsibility is expressed in ways including, impressing on other members to register and sometimes paying for their premiums. Also, family members, friends and neighbours, served as trusted sources of information and by that, influenced people's decision to enroll.

On bridging SC, the various groups and associations to which community members belonged served as sources of information on the NHIS for members. Group norms of solidarity and trust

also made it possible for members to show concern for other members. Some groups paid premiums of incapable members and also made it mandatory for members to enroll in the NHIS.

In relation to linking SC, the chapter established that clients' rational decision to enroll depends on their perception of membership as beneficial. It also depended on the extent to which the NHIS and its agencies respected agreed norms. Overall, the daily experiences with the NHIS and related service providers in terms of quality of services, reliability, equity and fairness accountability, information and communication were found to be pertinent for community members, and influenced their decision to enroll. The study finds that to a very large extent, community members did not think the institutions and officials have performed well on these and that had contributed to a weakened linking SC between them and these institutions, thereby influencing the decision to enroll negatively.

CHAPTER SEVEN

EXPLORING THE ROLE OF SOCIAL CAPITAL STRUCTURES FOR ENROLMENT AND EFFECTIVE IMPLEMENTATION OF THE NHIS

7.0 Introduction

This chapter puts together the evidence gathered on the third research question, which investigated how existing SC structures in the communities can be leveraged to enhance enrolment in the NHIS. The chapter builds on the previous chapters which explored the forms of SC and how they influence the enrolment decision. In those chapters, certain structures, groups were found to be dominant in the communities. The chapter therefore explored how these structures, including, traditional rulers, religious groups, assembly members, trade unions, other business groups and their leaders and NGO's could be leveraged to propel the decision to enroll in the NHIS. This is against the background that these SC structures, groups and leaders, have a way of influencing their members or subordinates to embark on collective actions. Thus, this objective aimed at finding out how SC could serve as a driving force and a means through which the NHIS could reach out to the broader segment of society.

7.1 Traditional Authorities

Traditional authority involves all forms of social and political authority with a historical origin in the pre-colonial states and societies. Comprising chiefs, queen mothers and their elders, the institution remains a critical part of Ghanaian societies. They wield political and spiritual authority and they have legitimacy and control in their respective areas. The data gathered in this study found that as a result of the authority and control that these traditional institutions wield in the

communities, they have the potential to drive enrolment in the NHIS in several ways. These are presented in detail as follows.

Traditional Authorities: A Binding Force for Enrolment

Traditional authorities occupy a privileged position in the communities. Their position is deemed sacrosanct and they are seen as an embodiment of the people's heritage, safeguarding and sustaining traditional values, norms and principles. They serve as symbols of unity in the communities and most people rally around them. As a result of this, respondents believed that traditional authorities can serve as a binding force around which the enrolment agenda could be built. In the view of respondents, traditional authorities could help complement efforts of the NHIA by mobilizing community members to enroll unto the scheme. They were unanimous that traditional rulers could serve as a mobilizing force to whip up people's interest. A key respondent narrates;

“... in our communities, people honour chiefs and do not want to let them down and so they will get committed to any instruction that comes from them. Because of the power of summons that chiefs have, people know they have to respond to their call. I think we need to intensify the way we involve these opinion leaders even if we have to institutionalize such practices [Fieldwork Data: FGD, Atwima Koforidua]

This position was given support by another respondent who had refused to register for the scheme;

“I decided not to register again because I had a very bitter experience with the scheme that I don't even want to remember. Even now, I hear people saying every day that the thing is not working. But maybe, if I hear the chief leading the charge and encouraging

people to we register, I may change my mind and register” [Fieldwork Data: Interview, Edubiase]

To buttress the view above, an old woman who appeared much agitated bemoaned the politicization and opined that the active intervention by traditional authority could be beneficial. She submits;

“The whole thing has become politics, you will hear one party saying the thing has collapsed whilst the other says the thing is working; so which is which? These doubts could be cleared if our chiefs are brought on board to speak to us. We believe them more than these public officials who are seen as saying things just to fool us” [Fieldwork Data: Interview, Bantama].

While these sentiments also highlights how politicization of the scheme serves as a disincentive for enrolment, it underscores the role that involvement of chiefs could play. It also shows that people respond better to the traditional ways of social mobilization.

Traditional Authorities: Brokers for Mobilizing Support and Enrolment

Traditional authorities are symbols of community solidarity and therefore serve as catalysts for grass root mobilization and community development. Most respondents believe that because they are legitimate rulers and representatives of the people, they can have a significant influence in mobilizing their community members to support and subsequently enroll in the NHIS. Respondents suggested numerous ways through which traditional authorities could influence the decision of their subjects to enroll. These include the beating of gong-gongs in the communities,

town hall meetings, durbars, festivals and other such traditional media to which the local people better respond and associate with. On this, an interviewee opined;

“I think community members will better respond to the call of their local chief for them to register, than an advertisement on radio or television. Can you imagine the influence that the beating of gong-gongs at dawn to remind people to register and renew will have on the local people? I think the chiefs can persuade the people better; far better than public officials who are sometimes viewed with suspicion”

[Fieldwork Data: Interview, Nkawie].

The NHIA acknowledged the importance of local traditional institutions in enhancing its enrolment drive. They deem it crucial to make overtures to traditional authority with some officials noting that from their experience it is not possible to effectively implement the programme without the involvement of traditional authorities. An official observes;

“In fact, we have it as part of our programme to involve chiefs in the process, but it has not been too effective over the years. Now we are even more resolved that, that that is the way to go. That is why in the identification of the indigents for example, the scheme depends so much on the chiefs and other opinion leaders to assist. Despite collaborating with other ministries like gender and social protection and health for devising a common targeting mode to identify the poor, the involvement of opinion leaders and chiefs in particular have helped in identifying the poorest people in the various communities to be registered under the programme” [Fieldwork Data: Interview, NHIA official, Kumasi]

Traditional Authorities and Acceptability of Schemes

Traditional authorities command clout in the communities and can therefore provide the needed impetus to engender acceptability of the NHIS and subsequent enrolment by community members. Views expressed by respondents suggest that the status, power and authority of chiefs puts them in a position where they are often more listened to by their subjects. Therefore the belief is that when community members see that chiefs have accepted the NHIS, they will also be encouraged to enroll. This belief in the role of chiefs in whipping up interest and influencing people to enroll is emphasized by an opinion leader;

Most people in the communities see traditional authorities as symbolic “fathers”.

They go to them for counsel, and they believe in their judgment and discretion. With that kind of stature, these authorities appeal to their conscience and influence them a great deal. Because of the trust people have in these traditional authorities, they

can generate and sustain the enthusiasm of the local people to register in the NHIS.

There is no doubt that when people see that their chiefs have endorsed the NHIS and are involved, they will also be interested. Given the confidence that people have in chiefs, I think that they can convince people positively, if they are involved”

[Fieldwork Data: Interview, Apagya].

This view is corroborated by an official of one the NHIS agencies who observed that chiefs in particular can be pivotal in achieving community acceptability of the NHIS. He shares his experience on the role that chiefs play in the enrolment drive of his agency.

“The chieftaincy institution has endured in the Ghanaian society and is still a vibrant force in many ways. People in our communities, particularly those in the

rural areas still turn to chiefs as the last resort in areas where the central government and its sub-district structures have failed. Anytime we go on outreach campaigns and we are able to marshal the support of the local authority, we are able to get a lot more people coming to listen to us. In the end you see that it translates into more instant registrations and renewals” [Fieldwork Data: Interview, NHIA official Nkawie]

Traditional Rulers and Accountability of Schemes

This study found that an important means through which traditional rulers could influence the decision to enroll is by making them a part of the accountability architecture. Largely stemming from the disquiet among respondents about the NHIA to manage the scheme’s resources well, interviewees indicated that they will be more comfortable to see their local chiefs playing a part of the managing NHIS resources. A respondent opines;

“Chiefs have been the trustees of the peoples’ land, mineral resources and heritage for several years and they are trusted. Therefore, if they are made a part of the NHIS implementation, it will send the right signals to people that the schemes resources will not be mismanaged and that will get people to come along. I know people are skeptical of them these days, but they are more trusted than politicians. Also, because they are closer to the people, they can go to them and demand answers” [Fieldwork Data: FGD, Edubiase]

Another respondent argues out how the involvement of traditional authority could serve as an assurance of accountability and encourage people to enroll.

“The problem of enrolment is not a matter of whether people can pay or not. I don’t think that is the issue. With all the reports about the corruption and operational challenges of the policy, you can expect people to be apathetic and decide not to enroll. But if our own chiefs that we trust are involved in the schemes, they will feel secured to put in their premiums knowing that it will be well accounted for”. Involving them has the potential to facilitate accountability of the scheme to the people” [Fieldwork Data: Interview, Atwima Koforidua]

Hence, with the cynicism of community members about politicians and public officials in general, it is imperative for the NHIS to find in traditional authorities, something that is reassuring in the sight of the community members. This will give them some assurance that their resources will be safeguarded and not mismanaged.

But traditional rulers do not feel that they are being utilized enough to drive the enrolment process. Although they admit that they play some role, they think it is marginal and they could offer more. They indicate that, beyond the symbolic gestures made by the NHIS to them, their specific role in the process is very much limited and ill-defined. A representative of one local chief laments;

“...that has been the problem of our leaders in this country. I don’t think they really see the potential of traditional authorities in implementation of programmes. The traditional authorities command more influence in their areas of jurisdiction than the modern governance structure. But as far as I know, there has been little, if any, effective involvement of chiefs in facilitating enrolment in the NHIS. Their role is not well spelt out and it has largely been limited to merely inviting us to community sensitizations. It is just like you coming here and asking for our views; once in a

while, they invite them to some durbars and that is where it ends” [Fieldwork Data:
Interview, Esaase]

Altogether, it is clear from the evidence so far that active engagement of traditional authorities could help augment enrolment into the NHIS scheme by serving as a mobilizing force, enhancing the acceptability of the scheme, and also facilitating accountability of schemes to the local people. On their own, the NHIA recognizes the role that traditional rulers can play in driving enrolment. Although they do not have a formal arrangement on how to involve them, they maintain that they involve them when the need arises, for example when they go for sensitization in the communities. They however acknowledge that, more could be done to take advantage of traditional authorities.

7.2 Stimulating Enrolment: The Role of Religious Groups

As was noted in the previous chapters, religious groups stand out as an outlier amongst the associations and groups in the communities. Membership of these groups are usually voluntary and they serve as a source of solidarity and social support for members. Respondents believed that the solidarity generated among group members could be exploited to stimulate enrolment in the NHIS. Within the religious groups, there is an obligation to care and support each other and that meant that fellow members are interested in the welfare of others; and that could be used to foreground the enrolment drive by these religious groups. Thus, respondents felt that religious groups generate positive SC that has potential for whipping up membership involvement and enrolment in the NHIS. Of particular interest was the finding that some religious institutions made it mandatory for their members to register and renew their membership. This was found to be very

common with some churches and respondents felt that the NHIS could build on such initiatives for increased enrolment.

“The religious institutions do not only preach about salvation nor seek the spiritual development of members but also takes care of their social needs. The bonds among members are very strong and they can be utilized to increase enrolment. They are like second families to some of people, and therefore they will listen to a call by their fellow members to enroll” [Fieldwork Data: Interview, Atobiase]

Another respondent supports this position and suggests some ways through which religious institutions can play a role in supporting the enrolment drive

“Religious institutions are influential and I think there are so many ways through which they can help in the enrolment drive. Already some make it obligatory for their members to enroll so that is a good start. They can be made to register people on behalf of the NHIS and collect premiums whether weekly or monthly for onward transmission to the NHIS. I think people will find it easier to pay their premiums in church, just as they are able to pay tithes at the end of the month” [Fieldwork Data: Interview, Abrepo].

Beyond this, most respondents gave a sense that they trusted their religious leaders’ more than public officials, and sometimes even more than their own family members. Views expressed by respondents indicate that given this high level of trust, religious leaders’ views and attitudes towards the NHIS influence their decisions. Respondents therefore suggested that these leaders could be co-opted to be at the forefront of the enrolment drive. The leaders can be used to impress

on church members to register because they listen to them. Also because they are trusted, their involvement will give some assurance to people that NHIS funds will not be embezzled

“In Ghana today, religious leaders are influential. They are trusted, and their opinions shape the views and actions of their followers. Everyone knows that if the Chief Imam speaks for example, all Moslems will listen, so the NHIS can make him a member of the enrolment task force to go into the communities to convince people to enrol. The same can be done with other church leaders” [Fieldwork Data: FGD, North Suntreso].

Another respondent affirms;

“We trust these religious leaders, so when they are in the forefront of something (like the NHIS) many people will enroll and say ... they will not steal our money....they will seek our interest” [Fieldwork Data: Interview, Toase]

These findings suggest that the involvement of religious groups and their leaders, can have a tremendous effect on mobilizing members for massive enrolment and active participation in the process; a position that is shared by the NHIS. Officials indicate that they did engage religious groups and leaders in their sensitization programmes. A step in this direction is the practice where agencies sometimes mounted stands on church premises on Sundays and courted the support of church leaders to ask their members to enroll or renew after church. They indicated that the feedback has been good so far and plans were in place to roll it out across the districts. Overall, the findings signal to the NHIA to appropriately incorporate the religious institutions into its enrolment drive as this could enhance voluntary enrolment, through playing various roles,

including serving as a commitment mechanism (exacting social pressure on congregants), and premium collectors (weekly instalments that may be easier for members to pay).

7.3 Assembly Members and Opinion Leaders

The local government structure places assembly members and unit committee members as non-partisan individuals who represent respective electoral areas at the various MMDAs. They are popularly elected by local community people and therefore enjoy legitimacy and respect in the communities. They are also deemed to have mobilization skills to rally people within the communities. In this regard, their participation and involvement in the NHIS could help mobilize and court popular support for the programme. Respondents shared various views to indicate the impact assembly members in their own small ways facilitate the process. For example, an officer at the NHIA office remarked;

“In most cases, the assembly members are in tune with the views of the people. They are respected by the people, and our registration officials at times fall on them for briefing and familiarisation. If there is a way of their planned involvement, it should help in broad or mass mobilization” [Fieldwork Data: NHIA Office, Kumasi]

This position was given support by an assembly member who explained in adequate terms:

“We have the assembly structures here, besides me the assemblyman, there are other unit committee members who have specified zones and are in constant touch with the people and the people also know them... there are other well-known opinion leaders in the community who when are involved can entice many people to register for the NHIS” [Fieldwork Data: Interview, Esaase]

From these, the study observes that assembly members are people who have been popularly elected and as such well known by sections of the people and command respect. Therefore, their mobilization and persuasion skills cannot be over-emphasized. Their involvement in the scheme could help greater sections of the people to come on board which could also have a downward spiral effect on membership.

7.4 The Role of NGO's in Stimulating Enrolment

Non-Governmental Organisations (NGO's) usually operate in local communities and have some levels of legitimacy and well regarded by community members. They have their own networks and are very much in touch with the people. Because of the niche that they have carved for themselves as bodies that seek the welfare of the poor and vulnerable, respondents agreed that they have the potential to support the enrolment drive if they are involved. A local community member remarked:

“For the NGO people, we are with them and they provide some benefits to us already. In fact I know of some NGO's that register poor families en bloc and pay their premiums for them. I am very sure that people will demonstrate massive support if they see the NGOs getting involved in the NHIS registration or advocacy” [Fieldwork Data: Interview, Edubiase]

This was corroborated by another informant who argued on the credibility of NGOs as a leverage to court support for the ailing NHIS. She explained:

“The thing has been politicized and that’s why some people just don’t want to get along with it. I think if a third party such as NGOs gets involved in the mobilization process, it will help draw community members from diverse sections and orientations” [Fieldwork Data: FGD, Apagya]

The NHIA indicates that they collaborate with some NGO’s particularly in the identification of the poor in the communities. The nature of their work usually brings them into contact with the poorer segment of communities so they partner with them in that regard. It was found that some NGO’s paid for the registration and premiums of some of the poor people in the communities. The NHIA however acknowledge that they have no clear policy yet on how to involve NGO’s.

“Sometimes, some of the NGO’s write to LEAP or to us with a list of people to be considered. Sometimes too they reach out to the poor by paying for their registration. They are on the ground in the communities so going forward, I think that if we if engage more with them and get them to make enrolment in the NHIS as part of their advocacy, it will help a great deal” [Fieldwork Data: Interview, NHIA, Accra]

7.5 Trade Unions and other Professional or Business Groups

Trade, business and professional associations and groups were found to be very much a part of social life in the communities. The study found that, in the various communities, artisans and local professionals do come together to form associations to organize their members for many purposes. There are organized unions with leaders, rules and authority structure. These were identified to

have the potential to influence people in the mobilization process. A community member explained:

“When you come to the magazine (fitting shop), we have over 500 members who also have their own household, but I know most of these have not registered. If our chairman or secretary is to be the one fronting the mobilization and advocacy, trust me, no soul will be left unregistered....” [Fieldwork Data: Interview, Atwima Koforidua]

The sentiment above was shared by an opinion leader who narrated:

“It seems the NHIS people are doing their own thing, otherwise if you come here we have hairdressers association, association of carpenters, garages association and many others. I don’t think NHIS have a record of these or their leaders. But if they reach out and use such groups and their leaders as conduits, they can get so many people to come on board”
[Fieldwork Data: FGD, Bantama]

7.6 Community-Based Organisations and the Decision to Enrol

Community-Based Organisations (CBO’s) as a feature of the broader civil society organisations was found to be a source of SC in the communities. Within the communities, they mobilize members for the achievement of common goals, and their importance for community development lie in this capacity to marshal people. This study found that there are fun clubs, supporters’ clubs, singing groups, religious organisations and other social organisations which people join voluntarily in the communities. These associations influence members profoundly and they serve as important sources of spreading information as well. The various groups formulate codes of

action for observance by members, so they are able to maintain what they consider as important.

A respondent observes;

“...these groups are based here; they are controlled by our own people and we can influence them. So if we align them into the enrolment strategy of the NHIS, they can co-ordinate activities and drive people to enrol”

7.7 Conclusion

This chapter puts together the evidence gathered on the third research question, which examines how existing SC structures and networks in the communities can be leveraged to enhance enrolment. The chapter revealed that key structures and local community organisations including, traditional rulers, assembly members, religious groups, trade unions, NGO's, other business groups and their leaders are trusted in the communities and enjoy social acceptability. Community members better associate and respond to these groups and therefore have the potential to drive community members to enroll. It was found that while the NHIS itself recognizes the potential of these structures, they have not been able to integrate them into its enrolment strategies.

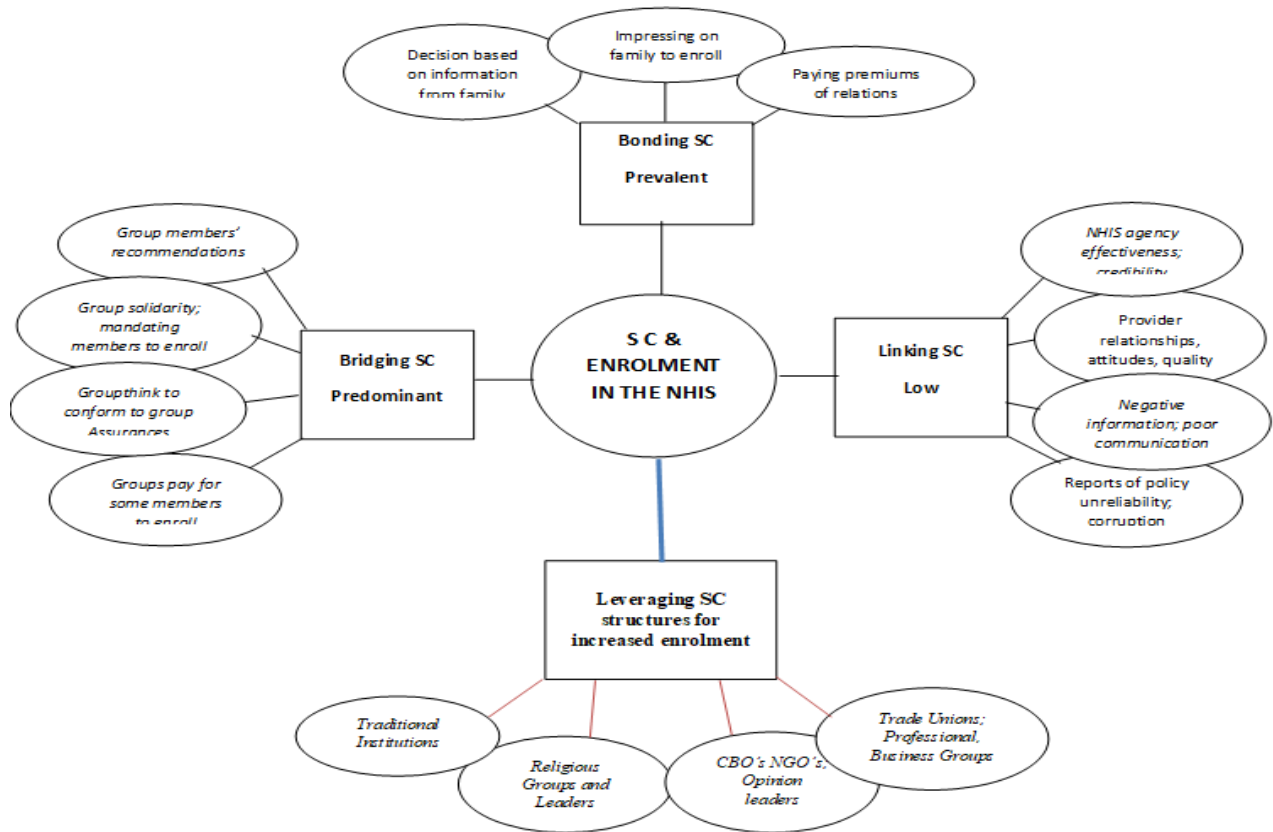


Fig 7.1: Final Thematic map of forms of SC, its influences, and how it can be leveraged to drive enrolment in Ghana’s NHIS

Source: Author’s construct (2018)

CHAPTER EIGHT

INTERPRETATION AND DISCUSSION OF FINDINGS

8.0 Introduction

The preceding chapters presented the results in response to the three research questions driving the study, as set out in Chapter 1. Within each of the questions and its associated findings, a number of pertinent issues with implications for research were identified. This chapter discusses and synthesizes these findings and the analytical issues identified alongside the study objectives and the literature reviewed. The discussion also places the evidence in the context of the conceptual framework as set out in chapter 2. These serve as a foundation for distilling the study's contribution to knowledge which are presented in the final chapter. In interpreting and discussing these findings, the chapter is organised into sub-themes, but due to the relatedness of the research questions, some of the issues overlap.

8.1 Forms of SC in the Communities

This objective was to ascertain the forms of SC in the selected communities in the Ashanti region of Ghana as a basis to investigate how they influence enrolment decisions in the NHIS. This was to address a key gap in the literature, arising from the paucity of studies on SC in developing country contexts generally, as well as its application to the NHIS enrolment analysis in particular. The findings show that different forms of SC exist in the communities and these are expressed in different ways.

The study's finding that bonding SC mainly expressed in familial relationships and its associated norms of trust, solidarity and reciprocity is prevalent in the communities sits well with the theoretical and empirical literature on SC. The findings echo with the popular research by Banfield

(1958) which found bonding ties to reside in traditional family structures; what he refers to as ‘amoral familism’. Like Banfield, the study established that the traditional family structure still serves as the immediate bastion of support for people in times of need and they derive emotional, social and financial support from family bonds.

The findings can also be interpreted through Durkheim’s (1984) theory of solidarity. As found in this study, kinship affiliations (labelled “mechanical solidarity” by Durkheim) typical of small cohesive and undifferentiated traditional societies are the most fundamental solidarity mechanisms. They are characterized by a strong feeling of solidarity, identity, reciprocity and shared values, and is usually confined to people of the same family and backgrounds. The study’s findings that families have their own ways of sanctioning members who did not show concern for other’s within the familial unit, affirms Durkheim’s theory that mechanical solidarity is based primarily on shared identity, social sanctions and authority of the collective. The findings validate the study’s conceptual framework as set out in chapter two by Grootaert’s (1997), and also tie in with recent research findings by Fenenga et al., (2015) which found similar results in the Western and Greater Accra regions of Ghana.

The study’s finding that traditional family structures are weakening also resonate with existing literature with earlier research by Fenenga et al., (2015), Kumado & Gockel (2003) and Nukunya (1992), all reporting of a decline in the economic and social support that flowed from the extended family system. However, the phenomenon of new social groups particularly churches as a means of replacing the disintegrating forms seems to be a recent trend, although earlier studies (see; Langer & Ukiwo 2008; Pokimica, Addai & Takyi 2012) had established that religion is a key part of social life of Africans and Ghanaians for that matter.

Bridging SC expressed in the form of voluntary groups and associations were also found to be predominant in the communities. The study revealed various benefits derived by community members by joining these groups. These include enhanced information sharing, capacity building, joint communal action and risk sharing. As was found in this study, the single most important fulcrum for these groups is the solidarity they provide, and they were found to be predominant because among other benefits, they compensate for waning bonding ties within the familial unit. As interesting as these findings are, they again fit in with Durkheim's postulation that solidarity changes as society becomes more complex and evolves into one that is based on integration of specialised economic and political organisations that emphasize equality among individuals, and social interdependence termed "organic solidarity". The findings are also consistent with other theoretical positions and empirical studies on group solidarity in the literature (see for example Coleman 1988; Granovetter 1983; Mladovsky 2014). They give support to the much trumpeted network view of SC as conceptualized by Bourdieu (1986) that "SC is the aggregate of the actual or potential resources which are linked to the possession of a durable network of more or less institutionalized relationships..." (pg. 248). Finally, the findings validate Grootaert's (1997) postulation in this study's conceptual framework that bonding SC connect people who are more heterogeneous and are of diverse ethnic, social, religious or occupational cleavages; thus, people who are more or less equal in terms of their status and power.

Linking SC in the form of interactions and trust relations between communities and the state were found to be low in the communities. Community members rarely interacted or engaged with state agencies and they did not trust these agencies and public officials to work in their interests. This signal of weak linking SC as found in this study is in the communities reflect the basic conceptions of SC by earlier scholars, Bourdieu (1986) and Coleman (1988). Their view of SC as residing in

relations between individuals and groups, as a result of shared experiences, finds place in this study. Indeed, as was found by the study, trust in these institutions and public officials was on the low because of previous negative experiences with these institutions by respondents or their friends and family. These findings confirm a recent empirical study by Sulemana and Issifu (2015) which also found low levels by most Ghanaians in their public institutions.

8.2 Social Capital and the Decision to Enroll

Bonding SC in the communities and the decision to enroll

Bonds within the family unit as well as with other individuals in the communities were found to be instrumental in the various decision making processes of community members. As found in the study, these bonds expressed in terms of solidarity, reciprocity and trust influenced the decisions and actions of other family member's in several ways. These include, impressing on them to register, paying their premiums, and serving as their trusted sources of information on the NHIS. These findings demonstrate that relations and associations between people of the same family and community generate forms of compatibility and fosters trust among them. It shows that bonding SC reinforces homogeneity and solidarity among people and that propels them to embark on actions that will serve the interest of the collective, and in this case enroll in the NHIS. Indeed, as confirmed by the study, solidarity, reciprocity and trust created in family members a certain orientation and obligation to act in ways that do not only benefit them as individuals as the rational economics perspective would have it, but also serve the interest of the collective sometimes even to the detriment of the individual. As was found in the study, people were willing to join the scheme and contribute something extra even if they were not going to benefit directly.

These findings sit well with the literature on SC. For instance it corroborates a similar recent finding by Wang et al., (2018) who used structural equation modelling in a multi-level investigation in China, and observed that SC as part of culture positively influence collective decision making. They provide support to an earlier argument by Poortinga (2012) that SC in the form of bonding among people helped in community health activities. It also confirms the conclusions of earlier work by Zhang et al., (2011) that people living in communities rich on horizontal SC (bonding and bridging) are more likely to participate in an insurance scheme than people living in low-SC communities. The idea of networks and solidarity among people in the form of common identities, geographical context and common interest help pool these en bloc for common purposes.

Using a similar frame to assess farmers' decisions and adoption of a technique, He et al., (2016) observed institutional trust as the largest driver, followed by civic engagement, interpersonal trust and norms of reciprocity networks. These observations confirm the findings by He et al., (2016) that among other things by NHIA, bond and linkage in the form of trust, solidarity and interconnection among people influence their decision to either enroll or to disengage with the NHIS. This is because a high level of bonding ties among people engenders higher levels of altruism, making it possible to consider the welfare of other members of the group and thereby encouraging all members to take collective actions (see also Durlauf & Fafchamps 2004). As argued by Lin (2017), SC "entails the resources (information, ideas, support) that individuals are able to secure by virtue of their relationship with other people". These resources are social in that they are only accessible through relationships, and with a potential for common actions. In this current study, community members were found to get information about the NHIS from other family members or friends because they were the most trusted source of information. This implies

that given appropriate measures, the NHIA could use the bonding ties among people to positively influence membership drive.

Bridging Social Capital in the Communities and the Decision to Enroll

Groups and associations are important expression of bridging SC in the communities studied. They influence the enrolment decision of members in several ways including; making it mandatory for them to register, serving as sources of information, members serving as motivation for others to register and groups paying premiums of other members. Trust in particular is also a major lubricant of such group associations and it makes it easy for individuals to join forces with others to advance common interests. Due to the trust for leaders and other members, these groups were found to have the potential for driving enrolment among membership. Group members are willing to contribute towards the welfare of others and also towards a larger social pool with implicit cross-subsidization. This provides support to the view by Sørensen (2016) that social networks serve as building blocks to facilitate mutually beneficial collective actions through the establishment of social networks and roles. Groups and associations remain useful for people's mobilization because of the legitimacy these groups have in the view of their members (see also Aldrich & Meyer 2015; Bourdieu, 1986). The observations in this study buttress findings by Mladovsky et al., (2014) who also found bridging SC to be relevant in people's decision to enroll in CBHI in Senegal. Bridging SC has proven to be a driver of mass group of people for collective action and in the current study, it proved to be relevant in mobilizing members for enrolment in the NHIS. Similar findings were recorded by Yang (2018) and Mebratie et al., (2015) in China and Ethiopia respectively.

Linking Social Capital and the Decision to Enroll

Linking SC refers to relationships between the citizenry and their formal government institutions. It was conceptualized in this study to mean the interactions and engagement between the NHIS, its related service providers, and the citizenry. It also covered the extent of trust for these institutions and its influence on the enrolment decision. The study found that negative experiences of community members with managers and healthcare providers, mistrust and uncertainty in their services, processes and procedures these institutions had contributed to a weakened linking SC. These negative experiences which are built over time discouraged people from enrolling and renewing their insurance. These findings reflect the basic conceptions of SC by earlier scholars, Bourdieu (1986) and Coleman (1988), as residing in relations between individuals and groups, resulting from shared experiences, accumulated over time and affecting cooperative activities.

As found in this study, the decision to enroll in the NHIS depends very much on the reliability, trustworthiness, and quality of services delivered by the NHIS and its related service providers. The concerns are particularly important in the decision to enroll because, unlike other public policies which may not necessarily depend on the membership of community members, the insurance dynamic and premium payment by members vested them with some power to demand them. Thus, although citizens may not demand quality of care from other public policies, they are empowered to do so with the NHIS because they contribute premiums. As shown in this study, in the case where individuals did not trust the NHIS and its agencies to reliably deliver quality they decided not to enroll or renew their membership. This is consistent with a study by Oh and Hong (2012) which draws a positive association between citizens' trust in government and their willingness-to-pay. The current findings drum home the point that people's confidence and trust in the state agencies influence their decision to enroll and in cases where there is mistrust, people

lose confidence and trust in the system. An analysis of the findings reveal that the guarantee in scheme management and service providers to observe norms as stipulated in the NHIS contract is pertinent for most people and influences the decision to enroll. Waning trust and suspicion in scheme managers, service providers, political elites, and institutions affect people's willingness to enroll and generally support the NHIS. These findings support Putnam's conception of "trust as lubricating cooperation" (1993, p. 171), and are also consistent with other studies (Jehu-Appiah et al., 2011; Kipaseyia 2016; Schneider 2005) which found trust and guarantee in services as important determinants of enrolment in SHI.

Concerns over accountability of NHIS resources and the failure to sanction officials who mismanage funds also came up strongly as influencing the enrolment decision. Community members expected accountability and responsibility in their interactions with managers and service providers in return for premium payments and renewal of membership. Both insured and uninsured respondents are discouraged from enrolling and renewing because they found rules and sanctions against mismanagement of NHIS resources as weak. Bureaucratic delays, corruption and favouritism, and inequalities in services were also identified as major impediments to generating SC between citizens, managers and providers. This confirms findings by Fenenga (2014) that effective mechanisms for constraining self-interested behaviours by officials are important to inspire a spirit of cooperation and voluntary enrolment in health insurance.

The findings on information asymmetries between managers and community is also pertinent. It suggests that people may be hesitant to enroll due to uncertainties and inconsistencies in information. These tie in with other studies in Ghana and elsewhere which find that people have no motivation to invest in a scheme with uncertain benefits and services. For example, in their study on mutual health care (RMHC) in rural China, Zhang et al. (2006) found that imbalance and

asymmetry in information led to adverse selection. Similarly, studies by Criel and Waelkens (2003) and Mladovsky *et al.*, (2014) found availability of information about schemes and their processes to be key drivers of the enrolment decision.

Overall, the analysis shows that, for public policies woven on a de-facto compliance arrangement like the NHIS, certainty and guarantee of quality services are important determinants, but even more crucial is the effectiveness and credibility of managers and providers. This study highlights the importance of trust as a key component of the decision to enroll, based on the expectation that the other stakeholders will also honour their part of the bargain. Indeed, as rational actors, community members calculate the costs and benefits before enrolling in health insurance, but that calculation is linked to their satisfaction with managers and providers, as well as quality of services provided. These findings resonate with Schneider's (2005) qualitative study on Rwanda which found the decision to enroll to be positively influenced by transparency, solidarity, honesty and trust between managers and community members. The study finds that, consistent with the framework by Grootaert *et al.*, (2004) and Woolcock and Narayan (2000), underpinning bonding, bridging and linking ties, and the decision to enroll, are norms of solidarity, trust and reciprocity, as shown in figure 8.1 below.

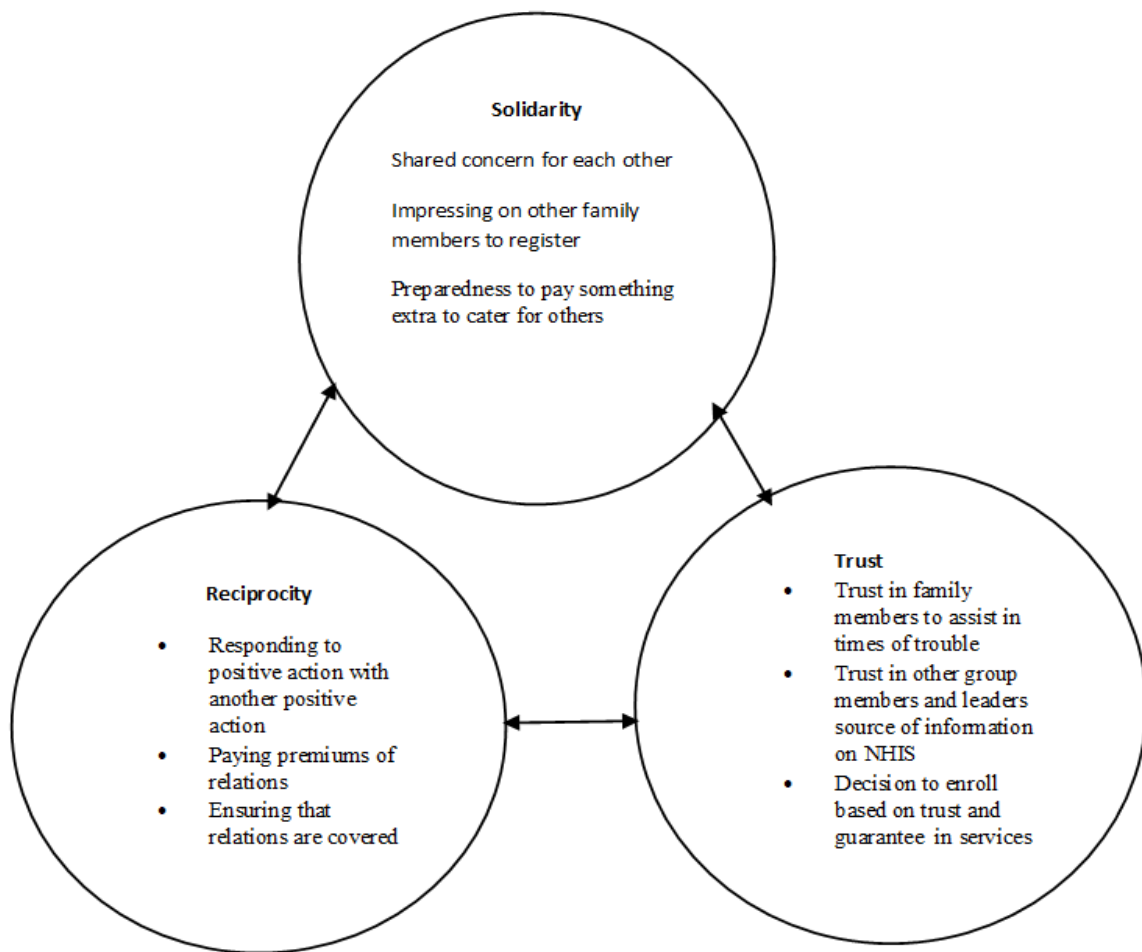


Fig 8.1: Three key norms of bonding, bridging and linking and the decision to enrol

Source: Author (2018)

8.3 Trust as a Major Component of SC and the Decision to Enroll

Trust was found to be an important linking device in all the forms of SC and more importantly, the decision to enroll (see table 8.1). For bonding SC, mutual trust between family members was important in keeping the familial unit together. It formed the basis on which members could depend on each other, and it oiled the various norms of solidarity and reciprocity and the responsibility to

reciprocate same. Other family members also served as sources of information on the NHIS because they are trusted.

For bridging SC expressed in the form of groups and associations, the study found that although membership is voluntary, community members were inclined towards joining them because, besides the benefits that they hope to gain, they trusted other group members and leaders in particular to act in their interest. Be it within professional associations or religious groups, trust in other members and leaders came up as an important 'binding glue'. These are consistent with earlier views expressed by Hardin (2002) that trust which is a rational expectation based on iterated relationships and reputation building between two agents is a key component of SC.

In the linking SC scheme, trust in managers of insurance, service providers and an assurance in quality of services is a key determining factor for people to join or disengage from the scheme. For service providers, trust was an issue as they did not trust government and the NHIA to maintain solvency of the scheme and reimburse them on time. Lack of trust undermined the relationships between managers and government, with reports of these providers threatening to pull out of the scheme every now and then. These findings do not only confirm trust as an important component of SC but also as a key ingredient for cooperative activities, as was found Ko *et al.*, (2018) in their study of CBHI in Nepal. They give support to earlier views of Putnam (1993) that the lack of reciprocal trust is detrimental to development. This is because, trust generally incentivises a willingness to do things in a social context based on the confidence that others will respond likewise and act in mutually supportive ways (Burt 2017; Onyx & Bullen 1997).

Trust as an essential component of the decision to enroll in SHI is also consistent with earlier studies by Donfouet and Mahieu (2012) which found trust to be vital for the sustainability and

effective functioning of schemes in Cameroon. They also resonate with Fukuyama’s (1995) long held view of trust as an expectation that arises within a community of regular, honest and cooperative behaviour, based on commonly shared norms, on the part of other members of that community (p. 26). The findings also sit well with a recent glossary on SC and health research by Moore and Kiwachi (2017) which also found trust as vital in connecting individuals and groups across formal or institutionalized structures of authority and power.

SC in the communities	Structural Dimension	Cognitive Dimension
Bonding	Strong family ties / bonds solidarity; based on trust	Trust in family members to assist in times of trouble Family as immediate and trusted source of information on NHIS
Bridging	Prevalence of groups and associations Relationships based on trust norms	Trust in group members and leaders Group members and leaders as trusted sources of information on the NHIS
Linking	Relationships with scheme management, service providers, government Relationships based on trust Low levels of trust	Trust and guarantee in services Service providers do not trust government to ensure solvency of scheme and reimburse them on time

Table 8.1: Trust as a major linking device in all forms of social capital

Source: Author (2018)

8.4 Information and communication: Key Vehicles for Increasing Enrolment and Effective Policy Implementation

Availability of information is necessary for public policies to be effectively implemented. Earlier empirical work on policy implementation by Frieden (2014); Grindle (2007); Newig, & Koontz,

(2014); emphasize information and communication as important in giving beneficiaries opportunities to play a role in implementation while providing implementers with feedback on their interventions. For enrolment in the NHIS, a policy to which citizens make a direct contribution by way of premiums, and where compliance is voluntary, this study found information and communication to be even more crucial. Findings of this study revealed that information on services including premium cost; method and timing of paying premium; benefits offered by the scheme; mechanisms for preventing and addressing fraud; and information about quality of health services provided was important for community members to make informed decisions to enroll. Also, communication with implementing agencies and providers was important for them to get feedback on the impact of their policy.

These findings are validate the study's conceptual framework, and is also consistent with the health insurance literature. For instance, it resonates with the research by Ridde *et al.* (2010), which found lack of information as a reason why people did not join the scheme in Vietnam. Similarly, Schneider (2005) and Mladovsky (2014) found information on health insurance services disseminated to communities to be crucial in raising interest and increasing enrolment in schemes in Rwanda and Senegal respectively. It also echoes with an earlier work done in Ghana by Jehu-Appiah *et al* (2011) that negative information and communication from friends and family to potential health insurance users have the ability to reduce enrolment in health insurance schemes.

While these validate and synthesize with earlier findings it is important to note that the relevance for the NHIS goes beyond mere validation. This because these earlier studies to which the findings resonate are largely on CBHI's which are closer to the members making information readily available and within reach. In the case of a state centred NHIS, information and communication is even more crucial for the community members to deal with suspicions against implementers. The

study found that, in the absence of this, enrolment suffers a dearth and is further compounded by negative information of corruption and the scheme's ineffectiveness. As demonstrated by this study, information and communication does not only lead to participation but also enhances transparency and trust and building a trustworthy reputation.

8.5 Leveraging Social Capital in the Communities for Enrolment

Empirical literature well establishes that low enrolment and retention in insurance schemes is linked with income and socio-economic status of people (Mishra et al., 2015; Richardson, et al., 2012). It should also be mentioned that people from these income streams or socio-economic brackets in one way or the other tend to live in rural communities, or in the informal sector with low education background, inadequate understanding and lack of trust in the formal system. Data from the study highlights various avenues through which people could be courted for enrolment. This is against a backdrop that existing studies signal that people's experiences and peer influences on community members influence enrolment decision (Arhinful, 2003; Fenenga, 2014).

Analysis of the study findings highlight respondents' belief in the necessity to pass on the NHIS agenda through traditional rulers who can effectively influence and mobilize their subjects to enroll. This observation echoes a long held argument by Aidoo (1978) that "you cannot go to any village and start propagating an ideology or programme or anything in the air ... the chiefs are very important if we are going to think about participation of all the people....we have to use them from the grassroots level to the national level" (p. 48). They are generally consistent with previous empirical studies which have well established that the social characteristics of individuals and the communities within which insurance policies are implemented remain crucial in policy enforcement and success (see Atinga et al., 2015; Fenenga et al., 2014; Schneider 2004).

This current study brought to the fore how closely knit local communities revere traditional authority as of symbols of accountability which could be useful in the enrolment process. Even though reservations were made about the conduct of some chiefs in current times, the cynicism about public officials as found in the study makes it crucial for the NHIS to find in traditional authorities something that is reassuring in the eyes of community members. It underscores the need for the NHIS to establish new norms of cooperation and collaboration with traditional authorities to enable them influence people to enroll because these traditional authorities are more trusted and wield authority over their subjects, especially in the rural communities. On the balance of the evidence gathered in this study, the active involvement of chiefs, would generate assurance and make it easier for people to register than the NHIS/government structures.

Regarding the role of religious institutions, the study demonstrates that the attachment of most people to these institutions and the much accorded respect and trust for religious leaders could help serve as a useful platform to step up the enrolment drive. Incorporating religious institutions which bind community members together provides a useful avenue to make the policy gain legitimacy and acceptance and lead to increased (and sustained) voluntary enrolment. This finding on religious leaders does not only validate the theoretical literature on trust as rules and norms governing social action (Coleman 1988; Collier 1998; Portes & Sensenbrenner 1993; Fukuyama 2001), but it also underscores the important social role that religious organisations play in the Ghanaian society (Addai, Opoku-Agyeman & Ghartey 2013; Sulemana 2015).

Trade unions and professional organisations in communities bind people operating in a similar trade together. For example, hairdressers and beauticians have their own association and leaders whilst other artisans and professionals have their own legitimate leaders who organize their members. These associations serve as SC and the building blocks of communities embedded

within people's contacts (Lin, 1999; Coleman 1988). They facilitate mutually benefitting collective actions through the establishment of social networks and roles (Uphoff, 1999) and remain useful for mobilizing members for actions including sensitizing members for NHIS enrolment (Grootaert 2004). As argued by Bourdieu (1986), the volume of SC possessed by a given agent depends on the size of the network of connections that he can effectively mobilize which in this regard makes such trade associations and professional groups a useful avenue incorporating into the NHIS to step up enrolment.

The foregoing argument holds true for NGOs and CBOs which operate in local communities and hence have constituencies which they can easily mobilize and sensitize for enrolment. The cumulative effect of these SC structures (traditional authority, religious groups, NGOs/CBOs, trade unions) should help to adequately mobilize a greater section of community members unto the NHIS. As argued by earlier scholars, (see Arrow, 2000; Grootaert & Van Bastelaer, 2002), SC does not merely reside in the existence of social relationships and structures but also in the extent to which these relationships can be leveraged for some good, whether individually or as a group.

Data from the study demonstrates how these social relationships could be leveraged to enhance enrolment drive of the NHIS and corroborates a similar observation by Fenenga et al., (2015) which also established that high levels of SC among community members influenced the willingness to pay for health insurance. It also confirms similar observations in Cameroun and Burkina Faso where Donfouet and Mahieu (2012) found solidarity and trust between members to have provided a key foundation for the successful functioning of CBHI's. The possibility and plausibility of leveraging on social nodes and other SC structures (as discussed above) for effective NHIS membership mobilization is to the extent that those structures and social institutions provide

basis for trust and legitimacy (Bourdieu 2018; Dubos 2017; Lin 2017) which are also springboards for mobilization purposes (Shatkin 2016; Schneider 2005).

8.6 Embeddedness and Complementarities: Insights for Policy Management

Within the SC construct, the results point to two main ways in which existing SC structures can influence the enrolment decision. These are embeddedness and complementarity as discussed in Woolcock and Narayan's policy framework. Whereas, embeddedness refers to the nature and extent of ties connecting citizens and public officials, thus enmeshing formal government structures with indigenous social structures, complementarity refers to the mutually supportive relations between public and private actors, thus, the extent to which public implementing agencies draw synergies from beneficiary communities. Together, embeddedness and complementarity indicate the extent to which formal governance structures and processes are dynamically wired to depend on local social organisations, in a manner that makes them perform and are responsive to communities.

As was found in the study, the NHIS has some 'complementarity' arrangements in its design because the scheme is woven to collaborate with accredited private providers to render certain services under the scheme. Also, albeit limited, the study found that some arrangements exist to draw on traditional institutions and assembly men for example in the identification of the poor in the communities to be considered for exemption and that shows some measure of embeddedness. However the study shows that embeddedness suffers a dearth as most identifiable social groups and their leaders within the communities have not been well and formally integrated, to draw on their potential to help drive enrolment.

The ability of the NHIA to forge synergistic relationship or complementarities with other social institutions in the communities could entice many people into the scheme due to the trust and solidarity people have for these institutions and their leaders. The study shows that the potential of these institutions is not merely in their existence but rather the nature and extent of the social acceptability in the communities. It therefore becomes crucial for the NHIS and state agencies alike to enhance their legitimacy by collaborating with other non-state institutions which could help draw their members on board. These findings echo with the views of Mladovsky (2014), that state-society synergy is particularly vital in countries where CBHIs are scaled up into fully national SHI schemes.

These insights are extremely crucial, given that most respondents particularly the uninsured pointed to inefficiencies and allegations of corruption against implementing authorities as reasons for their disengagement. It demonstrates that linking SC is central to participation in policy implementation particularly in countries like Ghana where official implementing agencies are tainted with inefficiencies and corruption and where social consideration tend to overshadow formal decisions and structures (see Ayee 2004; Makinde 2005; Riggs 1964). In such cases, local leaders and institutions who have social acceptability are useful to facilitate connections between communities and government programmes and therefore constitute an important source of SC (Tregear, & Cooper, 2016; Krishna 2002). Thus, the SC that flows from embedded networks will be important to ameliorate deficiencies and suspicions in public agencies and help sustain participation. This ties in well with Woolcock's (1998) postulation that spreading implementation responsibilities across a wide spectrum of the society and embedding relations between the individuals who constitute institutions, does not only serve as a natural constraint on corruption, but also ensures accountability. These interpretations gleaned from the study findings are

consistent with the theoretical basis of decentralization as well as current policy management discourse which emphasize community involvement as a central policy element (Dafflon 2015; Runya, Qigui & Wei 2015).

Put together, the study observes that attitude of community members towards the NHIS remains lackadaisical because the policy suffers the negative tag of inefficiencies, corruption, lack of trust and organisational integrity typically associated with public institutions in Ghana. Additionally, the policy has not been well embedded within the communities, neither has it been well positioned to draw synergies and complementarities from various community groups and their leaders. These are two implementation challenges which could easily be resolved by forging a closer association with various SC nodes of society which are deemed effective in drawing upon members and sensitizing them for collective and group actions. Leveraging greater ties and giving associational leaders some form of responsibility in the NHIA implementation structure could as well help the membership drive. The analyses reiterates the argument advanced by Bryson et al., (2014) on a need to move beyond the traditional public administration and NPM towards a New Public Service that centres on dialogue, and active collaboration or network with private or non-state associations in society to advance creation of public value (see also Denhardt & Denhardt, 2011). Arras and Braun (2017) discuss the rationale and relevance of involving diverse stakeholders in the implementation of formal policies or projects and observe similar findings as the current study.

The study ties in with calls in the current public management theory and practice for synergies, networks, complementarities and partnerships within and across different sectors because governments and their agencies, on their own do not possess the resources needed to promote broad-based, sustainable development (Lieberherr 2016; Sørensen & Torfing 2017). Findings of the study underscore the need for the NHIA to forge such synergies with community members to

stimulate and sustain membership. NGOs, traditional institutions, religious institutions CBO's and the other institutions identified in this study have established constituencies and status in the communities and can be leveraged to influence people to enrol. The wisdom in this had earlier been captured by Simatele and Binns (2008), who argued that "for local communities, whatever is done for them without them is not theirs" (pg. 12). The imperative then, is to identify the conditions under which these synergies develop so they can be harnessed effectively to elicit community support for public policies (Agranoff & McGuire 2003; Kettl 2006).

8.7 Implications for Governance (Participation, Transparency and Accountability)

This study drew on SC theory to explain how the decision to enroll is influenced by social determinants. The study has amply demonstrated that the decision to enroll does not merely depend on what people calculate to gain directly but also on other conditions that exist in the social context. As was seen in the findings, it also depends on the extent to which opportunities are created for people to be a part of the process. Involvement by members of the public is intrinsically linked to their own perceptions of ability to influence social outcomes through participation. These have implications for transparency and accountability; key ingredients of governance.

This study found transparency by the NHIS to be critical for most people. Transparency as a key feature of governance means openness on intentions, actions and goals which can also cultivate trust among interested stakeholders. As a scheme to which members contributed directly, transparency in operations was even more critical. They fit into Cohen & Prusak's (2001 pg. 46) contention that 'knowing who people are, and what they are doing, builds social connections and trust, just as secrecy builds suspicion'. Transparency has been found to be critical for effective governance (see Fenenga 2015).

Participation and transparency as above have implications on accountability. The extent to which community members and groups are made a part of the policy implementation process can stimulate their support, participation and ownership of policies and programmes. Community participation and support also depend on the extent to which individuals and groups are able to exercise control over implementing agencies and their processes. As was found in the study, transparency in scheme management; capacity to exercise control over the scheme; the existence of mechanisms for checking abuse/fraud, and accountability are key influences on the decision to enroll and renewal of membership. These are key variables which conceptually link SC to governance and in current public management discourse scholars like Fox (2015); Thonmann, Hupe & Sager (2018), have identified important mechanisms for developing beneficiary participation to include proper governance and accountability structures. A good accountability regime helps to ensure trust in systems. Therefore in a voluntary arrangement like the NHIS, it is pertinent that the scheme's internal and external governance measures are aligned properly to ensure transparency and accountability and trust, to drive enrolment. It highlights the imperative for the NHIS to fuse its governance structures with local indigenous structures as discussed under embeddedness and complementarities.

8.8 Conclusion

This chapter discussed and interpreted the study's findings to bring out the analytical issues in them. The findings were primarily discussed in relation to the literature reviewed in chapter two but they were also related to general policy and public administration literature. As part of this exercise, the validations and new insights that can be gleaned from the study are highlighted through an interrogation of how they agree and contrast with those of earlier studies. Consistent with the literature reviewed, the data gathered supports the assumption that SC effectively influences peoples decision to enrol, and for a SHI to succeed in a voluntary setting. Apart from the consistencies with other studies particularly on the linking SC issues such as quality of services and accountability, the study brought up new insights on embeddedness and complementarities as important for enhancing enrolment. The chapter established that for enrolment in the NHIS to be enhanced, there is a need for an alignment of the scheme's governance structures and enrolment arrangements with the social structures of the Ghanaian context. This alignment will not only help in stimulating interest in individuals and other recognized institutions in the communities, but will ensure transparency and accountability which will in turn influence the enrolment decision positively.

CHAPTER NINE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

9.0 Introduction

This chapter presents a summary of the entire thesis, makes appropriate conclusions, and on the basis of that, makes some recommendations. It also presents the study's contribution to literature as part of the conclusions drawn from the main lines of argument. The practical and policy implications are also presented, following an acknowledgement of some limitations of the study. The chapter gives some directions for future research in the section that follows, and closes with final concluding remarks.

The study set out to investigate SC in selected communities in the Ashanti region of Ghana and how it influences the decision to enroll in the NHIS. This broad objective was formulated into three research questions to guide the study. The research questions were intended to respond to a number of limitations that were identified in the literature. The first research question responds to the paucity of studies on SC in developing country contexts generally and Ghana in particular. The question also addresses in part, the limitation that studies on enrolment do not take into consideration, the social factors that influence the enrolment decision.

The second question addresses the gap that exists as a result of current analysis dominated by two major frameworks; the health systems and economic systems frameworks. These frameworks are underpinned by rational utility assumptions and do not give adequate attention to the social context within which the enrolment decision is made. And yet in developing country contexts like Ghana, social considerations tend to influence decisions sometimes more than the rational economic considerations. The third gap responds to the need to explore how SC structures and networks

identified in the communities could be leveraged to enhance enrolment in the NHIS as well as draw insights for effective policy implementation. To plug these gaps, the study employed SC theory to better elucidate the social forces that underpin the enrolment decision. SC theory was employed because of its capacity to explain social phenomena in its appropriate contexts. The study sought to provide new empirical data and subsequent analysis to inform theory, policy and practice.

9.1 Summary of the chapters

This sub-section summarizes the various chapters of the study. It presents the key issues that were discussed in each chapter. Chapter one set the tone of the study by giving a general background, and outlining the issues that constitute the research problem (gaps), the consequent research objectives and questions.

Chapter two reviewed the literature in which the study is anchored. Three main strands of literature were reviewed: public policy implementation, SHI literature and SC literatures. The chapter first did a state-of-the-art of implementation studies with a focus on the current governance approach and its implications for implementation research. This was followed by a review of the extant literature on SHI, with attention on the determinants of enrolment, to establish whether the current discourse is missing out on important factors by overlooking the social determinants. The review found that the key assumption underlying major analytical frameworks that individuals will rationally enroll in insurance, because of the health and economic benefits, is inadequate, and that, the decision to enroll particularly in contexts like Ghana are also influenced by other social considerations. This left a gap in the literature, and therefore as a point of departure, the chapter reviewed the literature on SC as a viable alternative to better organize, interpret and enhance

understanding of the decision to enroll. Two frameworks of SC were also reviewed and synthesized into a conceptual framework for analysis of data. The chapter concluded with a discussion on the connections between the gaps identified and the study's research questions.

Chapter three was on the research methodology, and it discussed the research procedure followed for the conduct of the study. The chapter briefly reviewed major philosophical assumptions of social science research as a basis for identifying the most appropriate framework within which to position the study. The chapter further discussed the adoption and suitability of the qualitative framework, the case study technique, the purposive sampling procedure, as well as interviews and focus group discussions (FGD), as strategies for data collection. There is also a detailed report of how the data was collected, managed, analysed and interpreted. The adoption of Lincoln and Guba's (1985) evaluative criteria for assessing the integrity of the study is presented. The chapter ends with ethical issues considered in the study.

Chapter four situated the study in the context within which the NHIS policy is implemented. As a qualitative study, the chapter was relevant in providing life and meaning to the data collected as well as analysis and interpretations gleaned. Two key themes were addressed in the chapter: the peculiar features of the healthcare delivery system in Ghana, and how the prevailing social and political context within which the NHIS was introduced, impinges on the scheme generally and enrolment in particular.

Chapters five, six and seven presented the study findings relating to the research questions; a summary of which is presented in this chapter (see table 9.1).

.

Chapter eight discussed and interpreted the research findings. The chapter synthesized the main findings from the research questions and analytical issues presented in light of the study objectives and the literature reviewed.

This last chapter, summarizes the study, provides a summary of the key findings and outlines the study's contribution to knowledge. It also highlights some limitations of the study, makes recommendations and concludes the study.

9.2 Summary of Key Findings

As outlined and discussed in chapter eight, a number of important findings emerged from this study. These are summarized in the table below.

Research Question	Key findings
What are the forms of SC in the communities?	<ul style="list-style-type: none"> • Bonding SC expressed in family solidarity and providing social support is prevalent • Bonding SC in traditional family structures exist but is weakening and losing its importance. • Bridging SC in the form of groups and associations; religious groups, an important outlier • Groups compensate for weakening bonds in traditional family structure • Linking SC in the form of relationships with state institutions • Less engagement between community and institutions of state • Low level of trust in public officials and institutions • Weak linking SC
How does existing SC capital influence peoples decision to enroll in the NHIS?	<ul style="list-style-type: none"> • Solidarity and reciprocity, key norms in the family and community create a sense of responsibility in people to look out for their own and impress on them to enrol. • Family members pay for the registration of others • Family, friends and neighbours are trusted sources of information on the NHIS; positive or negative influence on enrolment decision • Bridging groups and associations: group solidarity; making it mandatory for members to register and paying for other group

	<p>members; group think; members and group leaders are trustworthy sources of information on the NHIS;</p> <ul style="list-style-type: none"> • Linking SC: Relationships and experiences with NHIS agencies, service providers • Experiences of poor quality of care and interpersonal relationships, uncertainties, mistrust inefficiency, reliability, equity and fairness • Lack of accountability structures and the failure to sanction officials • Lack of opportunities for community members to exercise control over NHIS officers and processes • Reports of policy unreliability and publicized corruption • Ineffective communication leading to doubts and suspicion about the scheme • Weak linking SC disincentive for enrolment
<p>How can existing SC structures and networks in the communities be leveraged to enhance enrolment in the NHIS?</p>	<ul style="list-style-type: none"> • Key SC structures and networks in the communities are: traditional authorities, religious groups, assembly members, trade unions, business groups, NGO's and their leaders • These institutions and individuals are trusted and have a social advantage. Their involvement in the NHIS will serve as a badge of assurance and accountability. • Traditional institutions wield over their subjects, they can help in diverse ways to drive enrolment in the NHIS • Religious institutions and leaders can serve as a commitment mechanism, exacting social pressure on congregants and collecting premiums on behalf of NHIS collectors (weekly instalments that may be easier for members to pay • CBO's, and NGO's have effective mobilization skills that can be tapped into to drive enrolment.

Table 9.1: Findings of the study by Research Question

Source: Author (2018)

9.3 Conclusions

This study drew on SC theory to understand the decision to enroll in Ghana's NHIS. In view of its findings as has been captured above, the study draws the following conclusions. First community members still rely on the traditional support system of solidarity and risk sharing, organized within families, and community groups. In addition, SC in the form of groups and

community-wide social networks and solidarity provided them with information, solidarity, risk pooling and financial protection. The groups in particular are important and therefore attempts to increase enrolment must be built on them.

Also, the study shows that the decision to enroll in the NHIS depends very much on the reliability, trustworthiness, and quality of services delivered by the NHIS and its related service providers. Thus, linking SC has been shown to be central to enrolment and participation in policy implementation. This is found to be particularly important because official implementing agencies are tainted with inefficiencies and corruption. Under these circumstances, local leaders and institutions who are deemed trustworthy constitute an important source of SC that can be leveraged to drive enrolment and support for policies in general.

In view of the finding that SC structures in the communities are important for people, the study concludes that if voluntary enrolment in the NHIS is to be enhanced, the enrolment arrangements and governance structures must be aligned with the social structures in the Ghanaian context.

9.4 Contribution to Knowledge

The study makes several original contributions to knowledge. While some of the contributions may be seen as simply providing empirical evidence, others add to the literature and theories on policy implementation, SHI, SC and Governance. Some of the findings validate existing literature but there are new and interesting findings that provide further insights. These contributions are summarized as follows.

Empirical evidence of the prevalence of different forms of SC in the selected Ghanaian communities

A key gap that was identified in the literature was the limited application of SC to developing country contexts. Pursuant to this, the study aimed at ascertaining the forms of SC in the selected communities in the Ashanti region of Ghana. The study has shown that, different forms of SC exists in the communities. Bonding SC which are expressed in family solidarity and support, reciprocity and trust norms, and bridging SC, expressed in group norms was found to be prevalent. Linking SC, in the form of engagement was also found to exist between community members and institutions of state but this was found to be minimal. Trust in public officials was also found to be low signifying low levels of linking SC in the communities. By these findings the study has contributed empirical evidence to add to the knowledge on SC from a developing country context.

Empirical Demonstration of linkages between SC and the enrolment decision

A significant contribution of the study is its contribution of empirically verifiable data to the discourse on SC and its linkages with the decision to voluntarily enroll in a SHI. Hitherto, investigations into determinants of enrolment concentrated attention on the financial and organisational determinants. This obscured the social determinants even though they are quite profound in influencing thought and action particularly in closely knit contexts like Ghana. Response to the call for studies into these determinants were quite slow, save for Akuoko (2014) and Fenenga (2014) which also had different focus. The study has revealed that beyond the economic considerations, existing norms of solidarity, reciprocity and trust within the familial unit, community groups and with public institutions and officials are important influences on the enrolment decision. The study has provided further empirical evidence on these previously unexplored social determinants on the decision to enroll by explicitly detailing how SC in the communities influence enrolment decisions. In this vein, the study has conducted empirical work that has not been done before and has therefore contributed to knowledge (Phillips and Pugh 2010).

Contributions to SHI literature

The study was framed within SC theory as a better alternative to understand the decision to enroll in a SHI. This is against the background that the general literature on SHI and enrolment in particular is foregrounded in economic and health system perspectives. The study's contribution lies in its departure from these earlier frameworks, to analyse enrolment in the NHIS using SC theory. As has been demonstrated, the engagement with SC concepts equipped the study with fine-grained analytical tools to elucidate the social forces that underpin enrolment. These unique social forces include family and societal obligations and norms based on solidarity, reciprocity and trust in the communities. This has moved the analysis beyond the prevailing notion that economic factors particularly premiums are the most important determinants of enrolment. By demonstrating that in addition to economic factors, other considerations of a social nature also shaped the decision to enroll in voluntary SHI, SC has proven to be sharper and comprehensive in explaining the enrolment decision. This is particularly significant for theory development because it enables scholars to scratch beyond what is seen on the surface to understand the forces that drive enrolment decisions and actions.

Contribution to Policy Implementation Literature (New Insights for Implementation

Research)

This study has provided new insights that advance the policy implementation research field. The current study is unique, in that it is one of the few empirical studies to analyze policy implementation outcomes (NHIS enrolment decision) by deploying SC concepts. Departing from typical implementation and SHI research, which are largely steeped in rational assumptions and examination of the extent to which formal administrative structures carry out mandates, this study rather focuses on the informal community relationships, structures and actors in the policy context.

The study has demonstrated that the decision to enroll is also influenced by the obligations that result from social organisations and networks in communities. Also, the study's unveiling of the important role that traditional authorities, religious institutions, professional and business organisations, NGO's, CBO's and their leaders can play in stimulating enrolment is novel. It demonstrates that in developing country contexts, administrative structures for achieving policy goals need not necessarily be the formal agencies of state, but also that, there are several context-specific, mostly informal structures and actors can drive policy outcomes. The study's elucidation on how the NHIS can draw synergies and complementarities from local indigenous structures if a policy is well embedded has never been done. By this, the study has brought up new insights on previously unexplored actors and structures of policy outcomes. The contribution of the thesis then, is its careful examination of the SC structures and actors that impinge on enrolment (policy outcomes) in a manner which hitherto, had not been so clearly articulated. In this regard, the current study extends the frontiers of knowledge on policy implementation strategies and outcomes, by offering a more nuanced understanding of the subtle relations between individuals, communities and government institutions, as well the strategies through which policies can be embedded and complemented by these structures.

New insights on Governance

The study contributes insights on governance, particularly on the need to ensure transparency, accountability and participation as prerequisites for enhancing enrolment and support for public policies in general. As was amply demonstrated by the study findings, enrolment in the NHIS is related to the assurance that managers will be open and accountable for the schemes resources, and also act in the interest of all. Also of interest to community members was the extent to which they or their leaders were involved in the NHIS processes so they could exercise some measure of

control over managers. These findings give further support to the governance approach in public administration which emphasizes vertical collaborations and networks for achieving policy outcomes.

More importantly, the study provides insights on the need for formal structures of the NHIS to be enmeshed with social institutions. As shown by the study, governance structures based on formal government structures alone are largely sub-optimal as a result of lack of trust, understanding of local issues, and ineffectiveness. This study reveals that the organisational features of communities are rather more conducive to cooperative activities than formal government structures. Therefore, like the NHIS, voluntary compliance to policies will be better enhanced by integrating the formal implementation processes with the local structures that community member's trust and are used to.

9.5 Implications for Practice and Policy Management

Findings of the study have relevance for management of the NHIS. The study reveals that, inhering in local communities is SC, an important resource that can be leveraged to complement the enrolment drive of the NHIS. The study has further shown that the decision to enroll in the NHIS is also shaped by the nature and extent of social interactions between communities, existing local institutions and their formal government structures. Therefore, for effective management of the NHIS, managers must align implementation plans to the social environment in a manner that involves the citizenry and other important actors. Religious groups, business and professional associations and traditional leaders must be brought in to drive the enrolment charge. Involving these social structures and leaders of communities will leverage their wider network of connections, as well as their legitimacy and social acceptability not only to serve as a

counterbalance to officials, service providers and other forces within the system, but also mobilize the citizenry to support the policy.

Also, the study shows that policy management in a governance framework is a collaborative effort, involving government, the implementing agency, as well as the citizenry. This calls for a formal system of collaboration in the enrolment drive to leverage on the energies and resources of all stakeholders. It is also important for policy management to move from the government approach where compliance to policy is by rules and enforcement systems to a governance mode, where voluntary enrolment or compliance is achieved by soft means such as instilling trust and credibility in implementing institutions. Overall, knowing how SC influences the NHIS should help policy makers better understand the subtle but powerful forces that shape the relationship between individuals and the community and between community and their formal authorities of state.

Finally, this study directs policy makers to keep an eye on SC in the communities to enhance effectiveness in implementation of policies. The study shows that when opportunities are created for community members to make input into the implementation and management of policies, accountability, participation and support are achieved. They should therefore nurture a good measure of SC between them and the communities they serve.

9.6 Limitations of the study

While this study makes important knowledge claims out of its findings, it has a number of limitations which must be acknowledged. The first limitation relates to the possibility of generalizing the findings beyond the case contexts. As indicated in Chapter 4, the study is qualitative and therefore the sampling regime did not seek to meet representativeness but rather to provide analytical insights. Thus, although the case; Ashanti region and the districts were carefully

selected to bear an adequate reflection of the rural-urban cleavages, findings and conclusions drawn cannot be generalized to other regions and jurisdictions. In other words, the study acknowledges that its findings emanate from a qualitative study conducted in a particular region and district(s), and therefore cannot be stretched to apply to other parts of the country. While this limitation may apply to most qualitative studies, it is particularly crucial to this one, given that the main subject explored, SC, varies across geographical locations, hence, the possibility that SC in other parts of Ghana will be different from the areas explored.

It is also pertinent to note that the study is conducted in the context of individual SC. Thus, the study explored SC available to individuals in selected communities. However, SC has also got a collective dimension and therefore can be investigated as a collective property as well. The differences that exist in SC by virtue of geographical locations would have come out better if it had also been studied as a collective property.

Finally, the study reveals a number of social influences that come to bear on the decision to enroll in Ghana's NHIS. While this proved to be useful, the exact impact of each of these influences on the decision to enroll could not be established. The study acknowledges that the impact of these influences could have been better estimated using other quantitative methodologies. In view of this, the study could only make claims of association between SC and the enrolment decision. Be this as it may, the important role of SC for the decision to enroll in a voluntary SHI in a developing country context has clearly been demonstrated in this study.

9.7 Recommendations

Against the backdrop of the findings made and the conclusions drawn, the study makes the following recommendations to enhance enrolment in the NHIS and general policy implementation in Ghana.

Contextualizing Policy Interventions

This study demonstrates that like the NHIS, policy interventions operate in context and not in a vacuum. Community members still rely on informal systems of solidarity, organized within families and community groups. They depend on relationships and networks developed through family and community associations because they provide them with support, information, solidarity, and financial protection etc. They also trust their own institutions more than the formal government structures. It is therefore important that the NHIS and public policies are interacted with such community structures and norms to elicit desired attitudes.

The study recommends that to whip up enrolment in the NHIS, managers must consciously involve community structures such as traditional authorities, religious groups, business and professional associations and leaders in their operations. The NHIA must integrate its formal implementation processes with these local structures that community member's trust and are used to. Besides serving as some form of assurance to engendering enrolment, this will also enhance accountability to users, and facilitate community support for the scheme.

Given that those in the informal sector find it difficult to pay premiums at fixed times, the NHIS must adapt its strategies on enrolment and renewal to suit the needs of informal sector workers as well as other existing local conditions. They must be flexible in their strategies to take care of the needs and challenges of those in the informal sector. The approach of collecting premiums from

community members in groups as pertains in the ‘susu’ practice could be formalised to make it convenient for those in the informal sector. In this regard, religious groups like churches and mosques could be brought on board to help the NHIS collect premiums on their behalf. These could mitigate the shortfalls in enrolment particularly by those in the informal sector.

Enhanced Information and Communication: Important vehicles for increased enrolment

This study shows the importance of information and effective communication between NHIS agencies and the citizenry for enrolment in the NHIS. While information is important to enable the citizenry make informed choices, effective communication eliminates suspicions in the minds of the beneficiaries and provides implementers the necessary feedback on the impact of their decisions for subsequent redress. Therefore, in designing strategies for increasing enrolment, the NHIA should place premium on improving access to information and effective communication. The NHIA must adopt modern ways of disseminating information like radio and television, and internet driven modes like WhatsApp and face book, but they must also utilize traditional media like community announcements and gong-gong for example to which the local communities respond better. The NHIA must also facilitate the exchange of information across social groups like churches trade associations and disclose information on all aspects of the policy to demonstrate accountability of its institutions. The NHIA and its healthcare providers should engage clients and/or organized community groups/associations in routine monitoring and feedback on staff performance to make them more accountable to clients and promote client-centered healthcare delivery.

Strengthening linking SC for increased enrolment

While this study found bonding and bridging SC to be prevalent in the communities, linking SC which results from trust relations and engagement between community and the NHIS was found

to be weak, and that hampered the decision to enrol. Among others, the discontent of subscribers, relating to poor quality of services, administrative inefficiencies, and unfair treatment given to NHIS card bearers among others, had nurtured mistrust, and a disincentive to enrolment. The weak linking SC is further fuelled by reports of lack of accountability and corruption, as well as the inability of community members to exercise control over managers of the scheme. To enhance enrolment, there is the need for the NHIA to work to enhance its image among community members and build trust by being more efficient, transparent, and accountable. The NHIA and its related providers must continually engage with communities to understand their needs.

9.8 Directions for future research

This thesis has provided insights into the influences of SC for the decision to enroll in Ghana's NHIS. Nonetheless, some issues were identified that offer opportunities for studies to further elucidate the specific topic, as well as related ones.

First, as observed by the study, there is a dearth of studies applying SC to policy in Ghana. In response to this, the present study attempted to investigate SC, with new findings on the structures and actors in the communities. While this has yielded some useful insights on the resource, the study was limited to just three communities in the Ashanti region. There is the need for more case studies particularly at the country level to allow for further and deeper assessments, given the demographic distributions of SC. Thus, because variations exist in SC forms, structures and actors across geographical regions, there is the need for a further exploration of these structures and actors in other contexts to test their theoretical significance. It is possible that other contexts be it regional or national may reveal different perspectives. Further studies in this direction will help build scientific knowledge on SC in general and Ghana in particular.

Secondly, there is the need for further studies on SC and its impact on the NHIS. As has been alluded to, the study makes some claims of association particularly on the influences of SC on enrolment as set out in the conceptual framework. As a qualitative piece, establishing relationships as well as the exact impact of the influences could not be measured. This leaves a window of opportunity for further research to build on the influences identified in this study. It calls for a disaggregation of these influences through quantitative methodologies to establish the impact of each of them. Future research in this regard will help explain the impact of SC on enrolment and also broaden the frontiers of the field.

Finally, this study approached SC as an individual property. While it has yielded insights on the deep-seated motivations of the enrolment decision, a further treatment of SC on collective lines would further enhance knowledge regarding the association between SC and NHIS enrolment. This is an important area that future research can focus on.

9.9 Concluding remarks

This study investigated SC as an alternative framework to understand the decision to enroll in Ghana's NHIS. This was against the backdrop that the general theoretical literature on SHI and enrolment in particular has been foregrounded in the health and economic systems frameworks. The dominance of these frameworks blurred the social factors that influence the enrolment decision, even though these factors are profound in developing country contexts. The study was therefore underpinned by the SC framework developed by Grootaert et al., (2004) and the policy framework by Woolcock & Narayan (2000) which synthesizes different perspectives of SC and debates over whether individuals are just rational agents or governed by values, norms and social obligations. These were utilized as a guiding frame to 'think' about the themes that emerged from

analysis of the empirical data. Thanks to the qualitative approach, the thesis was able to detail the underlying social forces; the solidarity and trust-based norms, reciprocity induced responsibilities and other such informal social influences that come to bear on the decision to enroll.

With regard to bonding SC, it was established that the traditional family structures although weakening over the years was still dominant. The shared concern for each other in the familial unit, and the community as a whole, expressed through solidarity and reciprocity creates a sense of responsibility in people to ensure that their relations register, with some paying for the registration of family members. These served as a major influence on the decision to enrol.

Groups and associations as expressions of bridging SC were found to be predominant and complemented for the weakening bonds. They influenced member's decision to enroll in many ways. These include making it mandatory for members to register, paying for the premiums of incapable members, serving as sources of information on the NHIS for members inter alia.

On linking SC and the decision to enrol, the study found that the daily experiences with the NHIS and its related service providers in terms of quality of services, reliability, equity and fairness accountability, information and communication were found to be pertinent for community members, and influenced their decision to enrol. The study finds that to a very large extent, community members did not think the institutions and officials have performed well on these and that had contributed to a weakened linking SC between them and these institutions, thereby influencing the decision to enroll negatively.

Trust was found to be a central element in all the SC forms explored. For the decision to enroll in the NHIS, it proved to be the key reason why people renew or disengage. Doubts and mistrust in

public officials, quality of services, and the guarantee that NHIS resources will not be well accounted for by officials are major deterrents of enrolment.

Furthermore, the study unveiled the social institutions that have previously been overlooked by scholars even though they have their own SC and legitimacy to help drive enrolment. In a corollary manner, the research has given impetus to the traditional authorities, religious institutions, local business and trade associations, CBO's and NGOs as social forces that can help stimulate enrolment. It highlights the role of informal associations and relationships and community obligations on enrolment decisions. The thesis also demonstrates how embedding and integrating the indigenous informal structures into policy context, can help explain the more nuanced influences on voluntary enrolment.

Overall, the study has shown that the theoretical basis for understanding enrolment in health insurance is better enhanced by applying SC which gives due consideration to the social determinants. Thus, SC is a useful analytical tool for understanding the social forces underneath the enrolment decision. As shown by this study, framing studies in SC terms does not only enhance understanding, but also helps to identify strategies for increasing enrolment and improved policy outcomes.

REFERENCES

- Abihiro, G. A., & McIntyre, D. (2012). Universal financial protection through National Health Insurance: a stakeholder analysis of the proposed one-time premium payment policy in Ghana. *Health policy and planning*, 28(3), 263-278.
- Addae-Korankye, A. (2013). Challenges of financing health care in Ghana: the case of national health insurance scheme (NHIS). *International Journal of Asian Social Science*, 3(2), 511-522.
- Addai, I., Opoku-Agyeman, C., & Ghartey, H. T. (2013). An exploratory study of religion and trust in Ghana. *Social Indicators Research*, 110(3), 993-1012.
- Adebayo, E. F., Uthman, O. A., Wiysonge, C. S., Stern, E. A., Lamont, K. T., & Ataguba, J. E. (2015). A systematic review of factors that affect uptake of community-based health insurance in low-income and middle-income countries. *BMC health services research*, 15(1), 543.
- Adler, P. S., & Kwon, S. W. (2002). Social capital: Prospects for a new concept. *Academy of management review*, 27(1), 17-40.
- Adoma-Afari A. (2017). Mutual Health Organisations As Facilitators And/Or Barriers Towards The Successful Implementation Of Nhis In Ghana. *Annals of Public and Cooperative Economics*, 88(3), 369-402.
- Adusei-Asante, K. (2017). Beyond minimization of personal healthcare financing risks: An ethnographic study of motivations for joining Ghana's health insurance scheme in Daakye district. *Australasian Review of African Studies*, 38(1), 46.

- Agranoff, R., & McGuire, M. (2003). Inside the matrix: Integrating the paradigms of intergovernmental and network management. *International Journal of Public Administration*, 26(12), 1401-1422.
- Agyepong I.A. (2013). Ghana NHIS @ 10: Where have we come from, what have we learned and where are we going? *Presentation on 10th anniversary of the Ghana National Health Insurance Scheme, Accra International Conference Centre, 26th September, 2013, Accra.*
- Agyepong, I. A., & Adjei, S. (2008). Public social policy development and implementation: a case study of the Ghana National Health Insurance scheme. *Health policy and planning*, 23(2), 150-160.
- Ahlin, T., Nichter, M., & Pillai, G. (2016). Health insurance in India: what do we know and why is ethnographic research needed. *Anthropology & medicine*, 23(1), 102-124.
- Aidoo, A.K. (1978) "Chieftaincy", in Republic of Ghana, *Proceedings of the Constitutional Drafting Commission held at the Kwame Nkrumah Conference Centre, 7 June 1978.*
- Akazili, J., & Mooney, G. (2011). Social Health Insurance: To Each According to His Needs; From Each According to His Means—but What Might That Mean? *International Journal of Health Services*, 41(4), 679-690.
- Akazili, J., Garshong, B., Aikins, M., Gyapong, J., & McIntyre, D. (2012). Progressivity of health care financing and incidence of service benefits in Ghana. *Health policy and planning*, 27(suppl_1), i13-i22.
- Akuoko, K. A. (2014). Social Capital and Ghana's National Health Insurance Scheme: Understanding Informal Sector Participation.

- Alderslade, J. Talmage, J and Yusef Freeman (2006): Measuring the Informal Economy: One Neighborhood at a Time, Discussion Paper, The Brooking Institution Metropolitan Policy Programme, Washington D.C., September 2006. *Further information*.
- Aldrich, D. P., & Meyer, M. A. (2015). Social capital and community resilience. *American Behavioural Scientist*, 59(2), 254-269.
- Alhassan, R. K., Nketiah-Amponsah, E., & Arhinful, D. K. (2016). A review of the national health insurance scheme in Ghana: What are the sustainability threats and prospects?. *PloS one*, 11(11), e0165151.
- Allinger K. (2013). Social capital, Political Participation and Civil Society: A Critical Review. Economics Department, University of Warwick .MSc.
- Amporfu, E. (2013). Equity of the premium of the Ghanaian national health insurance scheme and the implications for achieving universal coverage. *International Journal for Equity in Health*, 12(1), 4.
- Angen, M. J. (2000). Evaluating Interpretive Inquiry: Reviewing the Validity Debate and Opening the Dialogue. *Qualitative Health Research*, 10(3), 378-395.
- Ansell, C., & Gash, A. (2008). Collaborative governance in theory and practice. *Journal of public administration research and theory*, 18(4), 543-571.
- Apoya, P., & Marriott, A. (2011). *Achieving a shared goal: free universal health care in Ghana*. Oxfam International.

- Appiah-Denkyira, E., Herbst, C. H., Soucat, A., Lemiere, C., & Saleh, K. (Eds.). (2013). *Toward Interventions in Human Resources for Health in Ghana: Evidence for Health Workforce Planning and Results*. World Bank Publications.
- Arhinful, D. K. (2003). *The solidarity of self-interest: Social and cultural feasibility of rural health insurance in Ghana*. Leiden: African Studies Centre.
- Arras, S., & Braun, C. (2017). Stakeholders wanted! Why and how European Union agencies involve non-state stakeholders. *Journal of European Public Policy*, 1-19.
- Arrow, K. (1999). Observations on Social Capital. In Dasgupta, P., Serageldin, I. (Eds), *Social Capital. A Multifaceted Perspective*. Washington: The World Bank.
- Arrow, K. J. (2000). Observations on social capital. *Social capital: A multifaceted perspective*, 3-5.
- Arrow, K., (2000), "Observations on Social Capital," in *Social Capital: A Multifaceted Perspective*, P. Dasgupta and I. Seragilden, eds., Washington DC: World Bank.
- Asenso-Okyere et al. (1997). Willingness to pay for health insurance in a developing economy. A pilot study of the informal sector of Ghana using contingent valuation. *Health Policy*, 42, 223-237.
- Asenso-Okyere, W. K. (1995). Financing Health Care in Ghana. *World Health Forum*, 16, 86-91.
- Atim, C., & Sock, M. (2000). *An external evaluation of the Nkoranza community financing health insurance scheme, Ghana*. Partnerships for Health Reform, Abt Associates.

- Atim, C., Grey, S., & Apoya, P. (2002). A survey of mutual health organisations in Ghana. *Bethesda, MD: Partnerships for Health Reform, Abt Associates.*
- Atim, C., Grey, S., Apoya, P. A., S.J. Anie & Aikins, M. (2001). *A Survey of Health Financing Schemes in Ghana. Bethesda, MD: Partnerships for Health Reform, Abt Associates.*
- Atinga, R. A. (2012). Healthcare quality under the National Health Insurance Scheme in Ghana: Perspectives from premium holders. *International Journal of Quality & Reliability Management, 29*, 144 – 161.
- Atinga, R. A., Abiiro, G. A., & Kuganab- Lem, R. B. (2015). Factors influencing the decision to drop out of health insurance enrolment among urban slum dwellers in Ghana. *Tropical Medicine & International Health, 20*(3), 312-321.
- Attride-Stirling, J. (2001). Thematic networks: An analytic tool for qualitative research. *Qualitative Research, 1*(3), 385–405.
- Ayee, J. R. (1994). *An anatomy of public policy implementation: The case of decentralization policies in Ghana.* Avebury.
- Ayee, J. R. (2004). Decentralized Governance and Poverty Reduction at the Local Level in Ghana. *Regional development dialogue, 25*, 71-87.
- Banfield, E C., (1958). *The Moral Basis of a Backward Society.* Free Press, Glencoe, IL.
- Bankston III, C. L., & Zhou, M. (2002). Social capital as process: The meanings and problems of a theoretical metaphor. *Sociological Inquiry, 72*(2), 285-317.
- Bardach, E. (1977). *The implementation game: What happens after a bill becomes a law.*

- Bennett, S. (2004). "The role of community-based health insurance within the health care financing system: a framework for analysis." *Health Policy Plan* no. 19(3):147-58.
- Bennett, S., Kelley, A. G., & Silvers, B. (2004). 21 questions on CBHF: an overview of community-based health financing.
- Bitran, R. (2014). Universal Health Coverage and the Challenge of Informal Employment: Lessons from Developing Countries. Health, Nutrition, and Population (HNP) discussion paper. <https://openknowledge.worldbank.org/handle/10986/18637> World Bank, Washington, DC
- Blaikie, N. (2007). *Approaches to social enquiry: Advancing knowledge*. Polity.
- Boateng, D., & Awunyor-Vitor, D. (2013). Health insurance in Ghana: evaluation of policy holders' perceptions and factors influencing policy renewal in the Volta region. *International Journal on Equity Health*, 12, 1-10.
- Boateng, R. (2016). *Research made easy*. CreateSpace Independent Publishing Platform.
- Boschken, H. L. (2017). Aligning a multi-government network with situational context: Metropolitan governance as an organisational systems problem. *The American Review of Public Administration*, 47(2), 189-208.
- Bourdieu, P. (1986). The forms of capital. In J. G. Richardson (Ed.). Handbook of theory and research for the sociology of education (Vol. xxiv, pp. 241–258). New York: Greenwood Press.
- Bourdieu, P. (2018). Structures, habitus, practices. In *Rethinking the Subject* (pp. 31-45). Routledge.

- Bowles, S., & Gintis, H. (2002). Social capital and community governance. *The economic journal*, 112(483), F419-F436.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, 3(2), 77–101.
- Brinkerhoff, D. W. (1996). Process Perspectives on Policy Change: Highlighting Implementation. *World Development*, 24, 1395-1401.
- Brugiavini, A., & Pace, N. (2016). Extending health insurance in Ghana: effects of the National Health Insurance Scheme on maternity care. *Health economics review*, 6(1), 7.
- Bryson, J. M., Crosby, B. C., & Bloomberg, L. (2014). Public value governance: Moving beyond traditional public administration and the new public management. *Public Administration Review*, 74(4), 445-456.
- Bryson, J. M., Crosby, B. C., & Stone, M. M. (2015). Designing and implementing cross- sector collaborations: Needed and challenging. *Public Administration Review*, 75(5), 647-663.
- Burrell, G., & Morgan, G. (1979). *Sociological paradigms and organisational analysis* (Vol. 248). London: Heinemann.
- Burt, R. S. (2017). Structural holes versus network closure as social capital. In *Social capital* (pp. 31-56). Routledge.
- Busse, H., Aboneh, E. A., & Tefera, G. (2014). Learning from developing countries in strengthening health systems: an evaluation of personal and professional impact among global health volunteers at Addis Ababa University's Tikur Anbessa Specialised Hospital (Ethiopia). *Globalization and health*, 10(1), 64.

- Carbone, G. (2011). Democratic demands and social policies: the politics of health reform in Ghana. *The Journal of Modern African Studies*, 49(3), 381-408.
- Carrin, G., & James, C. (2005). Social health insurance: key factors affecting the transition towards universal coverage. *International Social Security Review*, 58(1), 45-64.
- Chankova, S., Sulzbach, S., & Diop, F. (2008). Impact of mutual health organisations: evidence from West Africa. *Health policy and planning*, 23(4), 264-276.
- Christine J. Fenenga, Edward Nketiah-Amponsah, Alice Ogink, Daniel K. Arhinful, Wouter Poortinga and Inge Hutter (2015) Social capital and active membership in the Ghana National Health Insurance Scheme -a mixed method study. *International Journal for Equity in Health* 14:118.
- Cohen, D. J., & Prusak, L. (2001). In good company: How social capital makes organisations work. *Ubiquity*, 2001(January), 3.
- Coleman, J. S. (1988). Social capital in the creation of human capital. *American journal of sociology*, 94, S95-S120.
- Coleman, James. (1987). "Norms as Social Capital." In Gerard Radnitzky and Peter Bernholz, eds., *Economic Imperialism: The Economic Method Applied outside the Field of Economics*. New York: Paragon House Publishers.
- Cotlear, D., & Rosemberg, N. (2018). Going Universal in Africa: How 46 African countries reformed user fees and implemented health care priorities.
- Creswell, J. W. & Miller, D. L. (2000). Determining Validity in Qualitative Inquiry. *Theory Into Practice*, 39(3), 124-130.

- Creswell, J. W. (2013). *Qualitative Enquiry and Research Design: Choosing Among Five Traditions*, London, Sage Publications.
- Criel, B., & Van Dormael, M. (1999). [Mutual health organisations in Africa and social health insurance systems: will European history repeat itself?]. *Tropical Medicine and International Health*, 4(3), 155-9.
- Criel, B., & Waelkens, M. P. (2003). Declining subscriptions to the Maliando mutual health organisation in Guinea-Conakry (West Africa): what is going wrong? *Social science & medicine*, 57(7), 1205-1219.
- Criel, B., C. Atim, R. Basaza, P. Blaise, and M. P. Waelkens. (2004). "Editorial: Community health insurance (CHI) in sub-Saharan Africa: researching the context." *Trop Med Int Health* no. 9 (10):1041-3.
- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. Sage.
- Dafflon, B. (2015). The assignment of functions to decentralized government: from theory to practice. *Handbook of multilevel finance*, Edward Elgar, Cheltenham, 163-199.
- Dalinjong P.A. and Laar A.S. (2012). The national health insurance scheme: perceptions and experiences of health care providers and clients in two districts of Ghana. *Health economics review* 2(1), 13.
- Davies, P., & Carrin, G. (2001). Risk-pooling: necessary but not sufficient?. *Bulletin of the World Health Organisation*, 79, 587-587.

- De Allegri, M., Sanon, M., Bridges, J., & Sauerborn, R. (2006). Understanding consumers' preferences and decision to enroll in community-based health insurance in rural West Africa. *Health policy*, 76(1), 58-71.
- De Allegri, M., Sauerborn, R., Kouyaté, B., & Flessa, S. (2009). Community health insurance in sub-Saharan Africa: what operational difficulties hamper its successful development?. *Tropical Medicine & International Health*, 14(5), 586-596.
- Denhardt, J. V., & Denhardt, R. B. (2015). The new public service revisited. *Public Administration Review*, 75(5), 664-672.
- Denzin, N. K. & Lincoln, Y. S. (1995). Transforming Qualitative Research Methods *Journal of Contemporary Ethnography*, 24(3), 349-358.
- Denzin, N. K., & Lincoln, Y. S. (1994). *Handbook of qualitative research*. Sage publications, Inc.
- Denzin, N. K., Lincoln, Y. S. & Giardina, M. D. (2006). Disciplining qualitative research 1. *International Journal of Qualitative Studies in Education*, 19(6), 769-782.
- Dixon, J., Tenkorang, E. Y., & Luginaah, I. (2011). Ghana's National Health Insurance Scheme: helping the poor or leaving them behind?. *Environment and Planning C: Government and Policy*, 29(6), 1102-1115.
- Dolfsma, W., & Dannreuther, C. (2003). Subjects and boundaries: Contesting social capital-based policies. *Journal of Economic Issues*, 37(2), 405-413.
- Donati, P. (2014). Social capital and the added value of social relations. *International Review of Sociology*, 24(2), 291-308.

- Donfouet, H. P. P., & Mahieu, P. A. (2012). Community-based health insurance and social capital: a review. *Health economics review*, 2(1), 5.
- Dror, D. M. 2001. "Reinsurance of health insurance for the informal sector." *Bull World Health Organ* no. 79 (7):672-8.
- Dror, D., and A. Preker. 2002. *Social reinsurance: a new approach to sustainable community health financing*: World Bank and the International Labour Organisation.
- Dubos, R. (2017). *Social capital: Theory and research*. Routledge.
- Duku, S. K. O., Asenso-Boadi, F., Nketiah-Amponsah, E., & Arhinful, D. K. (2016). Utilization of healthcare services and renewal of health insurance membership: evidence of adverse selection in Ghana. *Health economics review*, 6(1), 43.
- Duku, S., Alhassan, R. K., & Nketiah-Amponsa, E. (2016). Barriers to Uptake and Renewal of Health Insurance Membership: Experiences from Ghana's National Health Insurance Scheme (NHIS).
- Durkheim, É (1984). *The division of labour in society*. 2nd ed, *Theoretical traditions in the social sciences*. Basingstoke: Macmillan.
- Durlauf, S. N. (2002). On the empirics of social capital. *The economic journal*, 112(483), F459-F479.
- Durlauf, S. N., & Fafchamps, M. (2004). Social Capital. The Centre for the Study of African Economies. *Berkeley Electronic Press*. (214), 89.

- Ekman, B. (2004). Community-based health insurance in low-income countries: a systematic review of the evidence. *Health Policy and Planning*, 19 (5), 249–70.
- Escobar, M. L., Griffin, C. C., & Shaw, R. P. (Eds.). (2011). *The impact of health insurance in low-and middle-income countries*. Brookings Institution Press. Washington, DC.
- Fenenga C. J., Boahene K, Arhinful DK, Rinke de Wit TF, Hutter I. Do prevailing theories sufficiently explain perceptions and health-seeking behaviour of Ghanaians? *Int J Health Plann Manag*. 2013. doi:10.1002/hpm.2159.
- Fenenga, C. (2015). A matter of trust: clients' perspective on health and health insurance services in Ghana.
- Fenenga, C. J., Boahene, K., Arhinful, D., de Wit, T. R., & Hutter, I. (2014). Do prevailing theories sufficiently explain perceptions and health-seeking behaviour of Ghanaians?. *The International journal of health planning and management*, 29(1), 26-42.
- Fenenga, C. J., Nketiah-Amponsah, E., Bailey, A., & Hutter, I. (2015). Participatory action approach for client-centered health insurance. *Action Research*, 13(4), 392-410.
- Fenenga, C. J., Nketiah-Amponsah, E., Ogink, A., Arhinful, D. K., Poortinga, W., & Hutter, I. (2015). Social capital and active membership in the Ghana National Health Insurance Scheme-a mixed method study. *International journal for equity in health*, 14(1), 118.
- Fenny, A. P., Kusi, A., Arhinful, D. K., & Asante, F. A. (2016). Factors contributing to low uptake and renewal of health insurance: a qualitative study in Ghana. *Global health research and policy*, 1(1), 18.

- Ferrari, M. Z. (2016). Beyond uncertainties in the sharing economy: Opportunities for social capital. *European Journal of Risk Regulation*, 7(4), 664-674.
- Fine B. (2001) *Social Capital versus Social Theory: Political Economy and Social Science at the Turn of the Millennium*. Volume32, Issue3. Pages 403-408.
- Flyvbjerg, B. (2001). Making social science matter: Why social inquiry fails and how it can count again. New York: Cambridge University Press.
- Folland, S., Goodman, A., & Stano, M. (2012) The Economics of Health and Health Care.
- Fox, J. A. (2015). Social accountability: what does the evidence really say? *World Development*, 72, 346-361.
- Frieden, T. R. (2014). Six components necessary for effective public health programme implementation. *American journal of public health*, 104(1), 17-22.
- Fukuyama, F. (1995). *Trust: The social virtues and the creation of prosperity* (No. D10 301 c. 1/c. 2). Free Press Paperbacks
- Fukuyama, F. (2001). Social capital, civil society and development. *Third world quarterly*, 22(1), 7-20.
- Fung, A. (2015). Putting the public back into governance: The challenges of citizen participation and its future. *Public Administration Review*, 75(4), 513-522.
- 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

- Fusheini, D., Marnoch, G., & Gray, A. M. (2012, April). The implementation of the National Health Insurance Programme in Ghana—an institutional approach. In *62nd Political Studies Association Annual International Conference in Defence of Politics* (pp. 3-5).
- Gibbs, G. (2007). *Analyzing qualitative data: Part of the qualitative research kit*. London: Sage.
- Glaser, B. (1992) Basics of grounded theory analysis. Sociology Press.
- Gnawali, D. P., Pokhrel, S., Sié, A., Sanon, M., De Allegri, M., Souares, A., & Sauerborn, R. (2009). The effect of community-based health insurance on the utilization of modern health care services: evidence from Burkina Faso. *Health policy*, *90*(2-3), 214-222.
- Gobah, F. K., & Zhang, L. (2011). The National Health Insurance Scheme in Ghana: prospects and challenges: a cross-sectional evidence. *Global Journal of Health Science*, *3*(2), 90.
- Gottret, P., & Schieber, G. (2006). *Health financing revisited: a practitioner's guide*. The World Bank.
- Granovetter, M. (1983). The strength of weak ties: A network theory revisited. *Sociological theory*, 201-233.
- Granovetter, M. (1985). Economic action and social structure: The problem of embeddedness. *American journal of sociology*, *91*(3), 481-510.
- Granovetter, M. 1973. "The Strength of Weak Ties." *American Journal of Sociology* 78:1360-80
- Grindle, M. S. (2007). Good enough governance revisited. *Development policy review*, *25*(5), 533-574.

- Grindle, M. S. (2017). *Politics and policy implementation in the Third World* (Vol. 4880). Princeton University Press.
- Grindle, M. S., & Thomas, J. W. (1991). *Public choices and policy change: the political economy of reform in developing countries*. JHU Press.
- Grix, J. (2002). Introducing students to the generic terminology of social research. *Politics*, 22(3), 175-186.
- Grootaert C. (1997) Social capital: 'The missing link' P. Dekker (Ed.), Expanding the measure of wealth: Indicators of environmentally sustainable development, World Bank, Washington, DC
- Grootaert, C., & Van Bastelaer, T. (2002). Conclusion: measuring impact and drawing policy implications. *The role of social capital in development*, 341-350.
- Grootaert, C., (2000), "Social Capital, Household Welfare, and Poverty in Indonesia," mimeo, World Bank.
- Grootaert, C., Narayan, D., Jones, V. N., & Woolcock, M. (2003). Integrated questionnaire for the measurement of social capital. *The World Bank Social Capital Thematic Group*.
- Grootaert, C., Narayan, D., Jones, V. N., & Woolcock, M. (2004). *Measuring social capital: An integrated questionnaire*. The World Bank.
- Grootaert, C., van Bastelaer (2002). Understanding and Measuring Social Capital: A Multi-Disciplinary Tool for Practitioners. Washington: World Bank.

- Guba. & Lincoln Y. S. (1994). Competing Paradigms in Qualitative Research *In: Denzin N. K & Lincoln, Y. S. (eds.) Handbook of Qualitative Research*. Thousand Oaks: Sage Publications
- Hamilton, K., Helliwell, J., & Woolcock, M. (2016). *Social capital, trust, and well-being in the evaluation of wealth*. The World Bank.
- Hardin, R. (2002). *Trust and trustworthiness*. Russell Sage Foundation.
- Harris, A., and Chapman, C. (2002) Democratic leadership for school improvement in challenging contexts. *International Electronic Journal for Leadership in Learning*, 6 (9). ISSN 1206-9620.
- Harriss, J., & De Renzio, P. (1997). POLICY ARENA: 'Missing link' or analytically missing?: The concept of social capital. Edited by John Harriss. An introductory bibliographic essay. *Journal of International Development: The Journal of the Development Studies Association*, 9(7), 919-937.
- Hatch, J. A. (2002). *Doing Qualitative Research in Education Settings*. Albany: SUNY Press.
- Hill, M. J., & Hupe, P. L. (2002). Implementing public policy: Governance in theory and practice (No. 04; H97, H5.).
- Hill, M., & Hupe, P. (2014). *Implementing public policy: An introduction to the study of operational governance*. Sage.
- Houston, D. J., & Harding, L. H. (2013). Public trust in government administrators: Explaining citizen perceptions of trustworthiness and competence. *Public Integrity*, 16(1), 53-76.
- Hughes, J. & Sharrock, W. (1993). *The Philosophy of Social Research*, 3rd edition, Pearson: Essex.

- Hunecke, C., Engler, A., Jara-Rojas, R., & Poortvliet, P. M. (2017). Understanding the role of social capital in adoption decisions: An application to irrigation technology. *Agricultural Systems*, *153*, 221-231.
- Hupe, P. L., & Hill, M. J. (2016). 'And the rest is implementation.' Comparing approaches to what happens in policy processes beyond Great Expectations. *Public Policy and Administration*, *31*(2), 103-121.
- Hutchby, I., Wooffitt, R. (1998) *Conversation analysis: principles, practices and applications*. Polity Press.
- Hyden, G. (2012). *African politics in comparative perspective*. Cambridge University Press.
- Janesick, V. J. (2000). The choreography of qualitative research design. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 379-399). Thousand Oaks, CA: Sage.
- 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.
- Jowett, M. (2003). Do informal risk sharing networks crowd out public voluntary health insurance? Evidence from Vietnam. *Applied economics*, *35*(10), 1153-1161.
- Kettl, D. F. (2006). Managing boundaries in American administration: The collaboration imperative. *Public Administration Review*, *66*, 10-19.
- King, G., Keohane, R. O., & Verba, S. (1994). *Designing social inquiry: Scientific inference in qualitative research*. Princeton university press.

- Kipaseyia, J. S. (2016). *Factors influencing membership uptake of National Hospital Insurance Fund among the poor: a pastoralist's perspective* (Doctoral dissertation, Strathmore University).
- Kitzinger, J. (1995). Qualitative Research: Introducing focus groups. *BMJ*, 311(7000), 299-302.
- Knack, S. (2002). Social capital, growth and poverty: A survey of cross-country evidence. *The role of social capital in development: An empirical assessment*, 42-82.
- Ko, H., Kim, H., Yoon, C. G., & Kim, C. Y. (2018). Social capital as a key determinant of willingness to join community-based health insurance: a household survey in Nepal. *Public health*, 160, 52-61.
- Kohli, Peter Evans, Peter J. Katzenstein, Adam Przeworski, Susanne Hoerber Rudolph, James C. Scott and Theda Skocpol *The Role of Theory in Comparative Politics: A Symposium: World Politics*, Vol. 48, No. 1 (Oct., 1995), pp. 1-49 Published by: Cambridge University Press.
- Koontz, T. M., & Newig, J. (2014). From Planning to Implementation: Top- Down and Bottom-Up Approaches for Collaborative Watershed Management. *Policy Studies Journal*, 42(3), 416-442.
- Kotoh, A. M., & Van der Geest, S. (2016). Why are the poor less covered in Ghana's national health insurance? A critical analysis of policy and practice. *International journal for equity in health*, 15(1), 34.
- Kotoh, A. M., Aryeetey, G. C., & Van der Geest, S. (2018). Factors that influence enrolment and retention in Ghana's National Health Insurance Scheme. *International journal of health policy and management*, 7(5), 443.

- Krishna, A. (2002). *Active social capital: Tracing the roots of development and democracy*. Columbia University Press.
- Krishna, A., & Shrader, E. (2000). Measuring Social Capital. *World Bank Social Capital Initiative Working Paper Series*.
- Krishna, A., & Uphoff, N. (2002). Mapping and measuring social capital through assessment of collective action to conserve and develop watersheds in Rajasthan, India. *The role of social capital in development: An empirical assessment*, 85-124.
- Kuhn, T.S. (1962). *The Structure of Scientific Revolutions*. Chicago: University of Chicago Press.
- Kumado, K. & Gockel, F. (2003). A study of social security in Ghana. Available at: <http://library.fes.de/pdf-files/bueros/ghana/50022.pdf>.
- Kumlin, S., & Rothstein, B. (2005). Making and breaking social capital: The impact of welfare-state institutions. *Comparative political studies*, 38(4), 339-365.
- Kutzin, J., Yip, W., & Cashin, C. (2016). Alternative financing strategies for universal health coverage. In *World Scientific Handbook of Global Health Economics and Public Policy: Volume 1: The Economics of Health and Health Systems* (pp. 267-309).
- Kvale, S. (1996). *Interviews: An introduction to Qualitative Research Interviewing*. Thousand Oaks, London, New Delhi: Sage Publications.
- Lan, Z., & Anders, K. K. (2000). A paradigmatic view of contemporary public administration research: An empirical test. *Administration & society*, 32(2), 138-165.

- Langer, A., & Ukiwo, U. (2008). Ethnicity, religion and the state in Ghana and Nigeria: perceptions from the street. In *Horizontal Inequalities and Conflict* (pp. 205-226). Palgrave Macmillan, London.
- Lieberherr, E. (2016). Trade-offs and synergies: Horizontalization and legitimacy in the Swiss wastewater sector. *Public Management Review*, 18(3), 456-478.
- Lin, N. (2000). Inequality in social capital. *Contemporary sociology*, 29(6), 785-795.
- Lin, N. (2017). Building a network theory of social capital. In *Social capital* (pp. 3-28). Routledge.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.
- Lincoln, Y. S., Lynham, S. A., & Guba, E. G. (2011). Paradigmatic controversies, contradictions, and emerging confluences, revisited. *The Sage handbook of qualitative research*, 4, 97-128.
- Lipsky, M. (2010). *Street-level bureaucracy, 30th ann. Ed.: dilemmas of the individual in public service*. Russell Sage Foundation.
- Liu, A.Q. & Besser, T. (2003). Social capital and participation in community improvement activities by elderly residents in small towns and rural communities. *Rural Sociology* 68: 343. (PDF) *Enhancing Recreation Sustainability....* Available from: https://www.researchgate.net/publication/291810018_Enhancing_Recreation_Sustainability_through_Social_Capital_Development [accessed Jul 29 2018].
- Liu, T. C., & Chen, C. S. (2002). An analysis of private health insurance purchasing decisions with national health insurance in Taiwan. *Social science & medicine*, 55(5), 755-774.

- Makinde, T. (2005). Problems of policy implementation in developing nations: The Nigerian experience. *Journal of Social sciences*, 11(1), 63-69.
- Mancur Olson, Jr. (1995). The Devolution of the Nordic and Teutonic Economies The American Economic Review, Vol. 85, No. 2, Papers and Proceedings of the Hundredth and Seventh Annual Meeting of the American Economic Association Washington, DC, January 6-8, 1995 (May, 1995), pp. 22-27 Stable URL: <https://www.jstor.org/stable/2117885>.
- Mark, E. S., Richard, T., & Andy, L. (1991). Management research: An introduction.
- Matsukawa, A., & Tatsuki, S. (2018). Crime prevention through community empowerment: An empirical study of social capital in Kyoto, Japan. *International Journal of Law, Crime and Justice*, 54, 89-101.
- Matland, R. E. (1995). Synthesizing the Implementation Literature: The Ambiguity-Conflict Model of Policy Implementation, *Journal of Public Administration Research and Theory: J-Part* Vol. 5, No. 2, pp. 145-174.
- McAdam, D., & Diani, M. (2003). Social movements and Networks. *Relational approaches to collective action*.
- Mebratie, A. D., Sparrow, R., Yilma, Z., Alemu, G., & Bedi, A. S. (2015). Enrolment in Ethiopia's community-based health insurance scheme. *World Development*, 74, 58-76.
- Mensah, J., Oppong, J. R., & Schmidt, C. M. (2010). Ghana's National Health Insurance Scheme in the context of the health MDGs: An empirical evaluation using propensity score matching. *Health economics*, 19(S1), 95-106.

- Miles, M. B., Huberman, A. M., & Saldana, J. (2013). *Qualitative data analysis: A methods sourcebook*. Thousand Oaks, CA: Sage Publications.
- Milward, H. B., & Provan, K. (2003). Managing the hollow state Collaboration and contracting. *Public Management Review*, 5(1), 1-18.
- Mishra, S. R., Khanal, P., Karki, D. K., Kallestrup, P., & Enemark, U. (2015). National health insurance policy in Nepal: challenges for implementation. *Global health action*, 8(1), 28763.
- Misztal, B. (2013). *Trust in modern societies: The search for the bases of social order*. John Wiley & Sons.
- Mladovsky, P. (2014). Why do people drop out of community-based health insurance? Findings from an exploratory household survey in Senegal. *Social Science & Medicine*, 107, 78-88.
- Mladovsky, P., Mossialos, E. (2008). A Conceptual Framework for Community-Based Health Insurance in Low-Income Countries: Social Capital and Economic Development. *World Development* 36 (4), 590-607.
- Mladovsky, P., Soors, W., Ndiaye, P., Ndiaye, A., & Criel, B. (2014). Can social capital help explain enrolment (or lack thereof) in community-based health insurance? Results of an exploratory mixed methods study from Senegal. *Social Science & Medicine*, 101, 18-27.
- Moore S, Kawachi I. (2017). Twenty years of social capital and health research: a glossary J Epidemiol Community Health Published Online First:. doi: 10.1136/jech-2016-208313.
- Morgan, G. (1980). Paradigms, metaphors and puzzle solving in organisation theory. *Administrative Science*.

- Morgan, G., & Smircich, L. (1980). The case for qualitative research. *Academy of management review*, 5(4), 491-500.
- Morris MacLean, L. (2003). State Social Policies and Social Support Networks: The Unintended Consequences of State Policymaking on Informal Networks in Ghana and Côte d'Ivoire. *International Journal of Public Administration*, 26(6), 665-691.
- Mouw, T. (2006). Estimating the causal effect of social capital: A review of recent research. *Annu. Rev. Sociol.*, 32, 79-102.
- Muller, C., & Ellison, C. G. (2001). Religious involvement, social capital, and adolescents' academic progress: Evidence from the National Education Longitudinal Study of 1988. *Sociological Focus*, 34(2), 155-183.
- Myeong, S., & Seo, H. (2016). Which type of social capital matters for building trust in government? Looking for a new type of social capital in the governance era. *Sustainability*, 8(4), 322.
- Myers, M. D. & Newman, M. (2007). The qualitative interview in IS research: Examining the craft. *Information and Organisation*, 17(1), 2-26.
- Nabatchi, T. (2012). Putting the “public” back in public values research: Designing participation to identify and respond to values. *Public Administration Review*, 72(5), 699-708.
- Narayan, Deepa (1999). Social Capital and the State: Complementarity and Substitution. World Bank Policy Research Working Paper No. 2167. Available at SSRN: <https://ssrn.com/abstract=623906>.

National Development Planning Commission (2009). *Citizens' Assessment of the National Health Insurance Scheme, 2008*. Accra, Ghana.

National Health Insurance Act, 2003 (Act 650).

National Health Insurance Authority (2010). *2010 Annual Report*. Accra.

National Health Insurance Authority (2011). *2011 Annual Report*. Accra.

National Health Insurance Authority (2016). *2015 Annual Report*. Accra.

National Health Insurance Authority (2016). *2016 Annual Report*. Accra.

National Health Insurance Authority (2016). *2017 Annual Report*. Accra.

Newig, J., & Koontz, T. M. (2014). Multi-level governance, policy implementation and participation: the EU's mandated participatory planning approach to implementing environmental policy. *Journal of European Public Policy*, 21(2), 248-267.

North, D., (1990), *Institutions, Institutional Change, and Economic Performance*, Cambridge: Cambridge University Press.

Nukunya G.K. (1992) *Tradition and Change in Ghana: An Introduction to Sociology*. Accra, Ghana: Ghana

Obermann, K., Jowett, M., & Kwon, S. (2018). The role of national health insurance for achieving UHC in the Philippines: a mixed methods analysis. *Global health action*, 11(1), 1483638.

- Odeyemi, I., & Nixon, J. (2013). Assessing equity in health care through the national health insurance schemes of Nigeria and Ghana: a review-based comparative analysis. *International journal for equity in health, 12*(1), 9.
- Odeyemi, I., & Nixon, J. (2013). Assessing equity in health care through the national health insurance schemes of Nigeria and Ghana: a review-based comparative analysis. *International journal for equity in health, 12*(1), 9.
- Oh, H., & Hong, J. H. (2012). Citizens' trust in government and their willingness-to-pay. *Economics Letters, 115*(3), 345-347.
- Olson, M. (1982). *The rise and decline of nations*. New Haven, CT: Yale University Press, 1982.
- O'Neill, M., & Pederson, A. P. (1992). Building a methods bridge between public policy analysis and healthy public policy. *Canadian journal of public health= Revue canadienne de sante publique, 83*, S25-30.
- Onyx, J., & Bullen, P. (1997). *Measuring social capital in five communities in NSW: An analysis*. University of Technology, Sydney, Centre for Australian Community Organisations and Management (CACOM).
- Onyx, J., & Bullen, P. (2000). Measuring social capital in five communities. *The journal of applied behavioural science, 36*(1), 23-42.
- Osei-Boateng, C., & Ampratwum, E. (2011). *The informal sector in Ghana*. Accra: Friedrich Ebert Stiftung.
- Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

- Pauly, M. V. 2004. *The demand for health insurance: insights from theory and voluntary markets in less-developed countries*: Background paper presented at Wharton Impact Conference on Voluntary Health Insurance in Developing Countries, March 15-16. University of Pennsylvania, USA.
- Pestoff, V. (2014). Collective action and the sustainability of co-production. *Public Management Review*, 16(3), 383-401.
- Pokharel, R., & Silwal, P. R. (2018). Social health insurance in Nepal: A health system departure toward the universal health coverage. *The International journal of health planning and management*, 33(3), 573-580.
- Pokimica, J., Addai, I., & Takyi, B. K. (2012). Religion and subjective well-being in Ghana. *Social Indicators Research*, 106(1), 61-79.
- Poortinga W. (2006) Social Capital: an individual or collective resource for health? *Soc Sci Med.*; 62(2):292–302.
- Poortinga W. (2006) Social relations or social capital? Individual and community health effects of bonding social capital. *Soc Sci Med.* 63(1):255–70.
- Poortinga, W. (2012). Community resilience and health: The role of bonding, bridging, and linking aspects of social capital. *Health & place*, 18(2), 286-295.
- Portes, A., & Sensenbrenner, J. (1993). Embeddedness and immigration: Notes on the social determinants of economic action. *American journal of sociology*, 98(6), 1320-1350.
- Portes, A., (1998), “Social Capital: Its Origins and Application in Modern Sociology.” *Annual Review of Sociology*, 1-14.

- Portes, A., (2000), "The Two Meanings of Social Capital." *Sociological Forum*, 15, 1, 1-12.
- Pressman, J. L., Wildavsky, A. B. (1984): Implementation, 3rd Edition. University of California Press, Berkeley.
- Putnam R. D, Leonardi R, Nanenetti R. (1993) Making Democracy Work: civic traditions in modern Italy. Princeton: Princeton University Press
- Putnam, R. D. (2001). Social capital: Measurement and consequences. *Canadian journal of policy research*, 2(1), 41-51.
- Putnam, R. D., Leonardi, R., & Nanetti, R. Y. (1994). *Making democracy work: Civic traditions in modern Italy*. Princeton university press.
- Raadschelders, J. (2011) Public Administration: The Interdisciplinary Study of Government. Oxford: Oxford University Press.
- Rajkotia, Y. (2007). The political development of the Ghanaian National Health Insurance System: lessons in health governance. *Bethesda, MD: Health Systems*, 20, 20.
- Reich, M. R., Harris, J., Ikegami, N., Maeda, A., Cashin, C., Araujo, E. C., ... & Evans, T. G. (2016). Moving towards universal health coverage: lessons from 11 country studies. *The Lancet*, 387(10020), 811-816.
- Riggs, F. W. (1964). *Administration in developing countries: The theory of prismatic society*. Houghton Mifflin.
- Ritchie, J., & Lewis, J. (2003). *Qualitative research practice: A guide for social science students and researchers*. London: Sage Publications.

- Robichau, R. W., & Lynn Jr, L. E. (2009). The implementation of public policy: Still the missing link. *Policy Studies Journal*, 37(1), 21-36.
- Rothstein, B. (2011). *The quality of government: Corruption, social trust, and inequality in international perspective*. University of Chicago Press.
- Runya, X. U., Qigui, S. U. N., & Wei, S. I. (2015). The third wave of public administration: The new public governance. *Canadian Social Science*, 11(7), 11-21.
- Ryan, G. W., & Bernard, H. R. (2003). Techniques to identify themes. *Field Methods*, 15(1), 85-109.
- Sabatier, P. A. (1986). Top-down and bottom-up approaches to implementation research: a critical analysis and suggested synthesis. *Journal of public policy*, 6(1), 21-48.
- Saetren, H. (2014). Implementing the third generation research paradigm in policy implementation research: An empirical assessment. *Public Policy and Administration*, 29(2), 84-105.
- Sakyi, E. K., Atinga, R. A., & Adzei, F. A. (2012). Managerial problems of hospitals under Ghana's National Health Insurance Scheme. *Clinical Governance: An International Journal*, 17(3), 178-190.
- Saunders, M., Lewis P. (1997). *Research Methods for Business Students*. London: Pitman Publishing.
- Schemes of Lawra and Sisala East Districts, Upper West Region, Ghana. *Ghana Medical Journal*, 44 (4), 130-137.

- Schieber, G., Cashin, C., Saleh, K., & Lavado, R. (2012). *Health financing in Ghana*. World Bank Publications.
- Schneider, P. (2005). Trust in micro-health insurance: an exploratory study in Rwanda. *Social science & medicine*, 61(7), 1430-1438.
- Schneider, P. 2004. "Why should the poor insure? Theories of decision-making in the context of health insurance." *Health Policy Plan* no. 19 (6):349-55.
- Seddoh, A., Adjei, S., & Nazzar, A. (2011). Ghana's National Health Insurance Scheme. *Centre for Health and Social Services*.
- Seferiadis, A. A., Cummings, S., Zweekhorst, M. B., & Bunders, J. F. (2015). Producing social capital as a development strategy: Implications at the micro-level. *Progress in Development Studies*, 15(2), 170-185.
- Shatkin, G. (2016). *Collective action and urban poverty alleviation: Community organisations and the struggle for shelter in Manila*. Routledge.
- Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, 22(2), 63-75.
- Silverman, D. (2006). *Interpreting Qualitative Data*. London: Sage Publications
- Simatele, D. M., & Binns, T. (2008, March). Motivation and marginalization in African urban agriculture: The case of Lusaka, Zambia. In *Urban forum* (Vol. 19, No. 1, pp. 1-21). Springer Netherlands.

- Singleton, J. L. (2006). *Negotiating Change: An Analysis of the Origins of Ghana's National Health Insurance Act. Honors Project. Macalester College, Department of Sociology, St. Paul, MN.*
- Skocpol, T. (1995). The aftermath of defeat. *Journal of health politics, policy and law*, 20(2), 485-489.
- Smith, J.A. Osborn, M. (2003) Interpretative phenomenological analysis. In Smith, J.A., editor, *Qualitative psychology: a practical guide to methods.* Sage.
- Smylie, M. A., & Evans, A. E. (2006). Social capital and the problem of implementation. *New directions in education policy implementation: Confronting complexity*, 187-208.
- Sørensen, E., & Torfing, J. (2017). Metagoverning collaborative innovation in governance networks. *The American Review of Public Administration*, 47(7), 826-839.
- Sørensen, J. F. (2016). Rural–urban differences in bonding and bridging social capital. *Regional Studies*, 50(3), 391-410. *The sociology of education*, edited by John G. Richardson, xxiv, 377 p. New
- Strathdee, R. (2000). *Social networks and the New Zealand National Qualifications Framework: the state's role in school-to-work transitions*, Unpublished doctoral dissertation, Canterbury universitz, Christchurch. NZ.
- Strauss, A., Corbin, J. (1998): *Basics of qualitative research: techniques and procedures for developing grounded theory.* Sage.
- Subramanian S.V., Kim D.J., Kawachi I. (2002) Social trust and self-rated health in US communities. A multi-level analysis. *J Urban Health*. 79(4):S21–34.

- Suebvises, P. (2018). Social capital, citizen participation in public administration, and public sector performance in Thailand. *World Development*, *109*, 236-248.
- Sulemana, I. (2015). An empirical investigation of the relationship between social capital and subjective well-being in Ghana. *Journal of Happiness Studies*, *16*(5), 1299-1321.
- Sulemana, I., & Issifu, I. (2015). An empirical examination of the determinants of trust in Ghana. *International Journal of Social Economics*, *42*(11), 1005-1023.
- Sullivan, H., & Skelcher, C. (2017). *Working across boundaries: collaboration in public services*. Macmillan International Higher Education.
- Sulzbach, S., Garshong, B., & Owusu-Banahene, G. (2005). *Evaluating the effects of the national health insurance act in Ghana: Baseline report*. Partners for Health Reformplus.
- Szreter, S., & Woolcock, M. (2004). Health by association? Social capital, social theory, and the political economy of public health. *International journal of epidemiology*, *33*(4), 650-667.
- Tetteh, E. K. (2012). Responding to the challenges of social health insurance in African countries. *Development Southern Africa*, *29*(5), 657-680.
- Thomann, E., Hupe, P., & Sager, F. (2018). Serving many masters: Public accountability in private policy implementation. *Governance*, *31*(2), 299-319.
- Tracy, S. J. (2010). Qualitative Quality: Eight “Big-Tent” Criteria for Excellent Qualitative Research. *Qualitative Inquiry*, *16*(10), 837-851.
- Tregear, A., & Cooper, S. (2016). *Embeddedness, social capital and learning in rural areas: The Universities Press*.

- Uphoff, N. 1999. "Understanding social capital: Learning from the analysis and experience of participation." In *Social Capital: A multifaceted perspective*, edited by I. Serageldin, 215-253. Washington DC: World Bank.
- Van Meter, D. S., & Van Horn, C. E. (1975). The policy implementation process: A conceptual framework. *Administration & Society*, 6(4), 445-488.
- Waddington, C. and Enyimayew, K.A. (1990). A Price to Pay, Part 2. "The Impact of User Charges in the Volta Region of Ghana. *International Journal of Health Planning and*
- Wagstaff, A. (2009). "Measuring financial protection in health". In *Performance Measurement for Health System Improvement: Experiences, Challenges and Prospects*, edited by Peter C. Smith, Elias Mossialos, Irene Papanicolas and Sheila Leatherman. Cambridge: Cambridge University Press.
- Wahab, H. (2008). Universal healthcare coverage: assessing the implementation of Ghana's NHIS law'. In *Workshop in Political Theory and Policy Analysis MiniConference, Bloomington, IN: Indiana University*.
- Wang, Z., McNally, R., & Lenihan, H. (2018). The role of social capital and culture on social decision making constraints: A multilevel investigation. *European Management Journal*.
- WHO. (2010). *The World Health Report: Health Systems Financing: the Path to Universal Coverage*. Geneva: WHO Press.
- Williams, R. (2016). *Resources of hope: Culture, democracy, socialism*. Verso Books.
- Witter, S., & Garshong, B. (2009). Something old or something new? Social health insurance in Ghana. *BMC International health and human rights*, 9(1), 20.

- Wong, L. (2008). Focus group discussion: a tool for health and medical research. *Singapore Med J*, 49(3), 256-60.
- Woolcock, M. (1998). "Social Capital and Economic Development: Toward a Theoretical Synthesis and Policy Framework." *Theory and Society* 27(2): 151-208.
- Woolcock, M., & Narayan, D. (2000). Social capital: Implications for development theory, research, and policy. *The World Bank research observer*, 15(2), 225-249.
- World Bank. (2007, May 22). *Publications-Documents and Reports*. Retrieved February 20, 2015, from The World Bank :http://www.wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2007/06/14/000020439_20070614085937/Rendered/PDF/39198.pdf.
- World Bank. 1989. "Staff Appraisal Report, Rwanda, Agricultural Services Project." Report 7599-RW. Agricultural Operations Division, South-Central and Indian Ocean Department, Africa Region. Processed
- Yang, K., Holzer, M., & Zhang, Y. (2007). Dealing with multiple paradigms in public administration research. In *Handbook of Research Methods in Public Administration*, Second Edition. CRC Press.
- Yang, M. (2018). Social health insurance: What determines enrolment in the Chinese new rural cooperative medical scheme? *China Economic Review*. York: Greenwood Press.
- Yevutsey, S. K., & Aikins, M. (2010). Financial viability of district mutual health insurance schemes of lawra and sissala East districts, Upper West Region, Ghana. *Ghana medical journal*, 44(4).

- Yin, R. K. (2009). *Case study research: Design and methods* (4th ed.). Los Angeles, CA: Sage.
- Yin, R. K. (2014). *Case study research: Design and methods* (5th ed.). Thousand Oaks, CA: Sage.
- Yu, H. (2015). Universal health insurance coverage for 1.3 billion people: What accounts for China's success? *Health policy*, *119*(9), 1145-1152.
- Zhang, L., Wang, H., Wang, L., & Hsiao, W. (2006). Social capital and farmer's willingness-to-join a newly established community-based health insurance in rural China. *Health Policy*, *76*(2), 233-242.
- Zhang, S., Anderson, S. G., & Zhan, M. (2011). The differentiated impact of bridging and bonding social capital on economic well-being: An individual level perspective. *J. Soc. & Soc. Welfare*, *38*, 119.

APPENDICES

Appendix 1: Interview Protocol for Community Members

UNIVERSITY OF GHANA BUSINESS SCHOOL

DEPARTMENT OF PUBLIC ADMINISTRATION AND HEALTH SERVICES

MANAGEMENT

Interview protocol for Community Members

This is a research instrument for data collection on the topic “Social Capital and Public Policy Implementation: The Experience of Ghana’s National Health Insurance Scheme”. The information collected is for only academic purposes. Please be assured of the strictest confidentiality.

SECTION A: Demographic Characteristics

- A. Community:
- B. District.....
- C. Region.....

SECTION B: Introductory questions

1. Are you registered in the NHIS? How long have you been a registered member of the NHIS? How does your membership of the scheme benefit you?
2. Do you face any challenges in your bid to enroll under the NHIS? What are these challenges? How about renewing your membership, do you face any challenges?

Section C: Social Capital in the Communities

I. Bonding Social Capital: Family, Friends and Neighbours/Enrolment decision

3. What is your main source of support in times of difficulty? Do you get any support from your family members in times of need? What are some of the benefits you get from your family? Do you trust your family members to come to your aid in times of trouble? Is your family a closely knit one?

4. How is your family kept together? Do you bear responsibility for the needs of any of your family members?? Does your family relationships place any responsibilities on you? How?
5. Does your association with relatives impact your decision to enroll in any way? If you were sick and needed medical treatment do you think your family or friends would render any kind of help? How does your relationships with family members influence your enrolment your decision to enroll? Does it affect your decision to influence other family member to enroll? How?
6. Do you get any benefits from your friends and neighbours in the community as far as your health/ health insurance is concerned? How well do you trust your friends, neighbours and other members in the community?
7. Does your association with your friends and neighbours influence your decision to enroll in the NHIS?

II. Bridging Social Capital: Voluntary associations and Groups and Enrolment decisions

8. Are you a member of any organisation/ church group within or outside this community? Which voluntary associations or groups do you belong to? Do you derive any benefits from these groups? What are they?
9. Considering the social groups and networks that you belong to, which ones do you trust to fall on in times of emergency? How do these associations and groups influence your decision to enroll in the health insurance?
10. How would you describe your community in general? Would you say there is a sense of association in this community? Are there any non-governmental organisations working in this town/village? Do they play any role in the NHIS?
11. Does your association with these groups and associations influence your decision to enroll in the NHIS? Please tell me how?

III. Linking Social Capital, Community relations with state institutions and Experiences with NHIS Agencies

1. How well do you participate in the affairs of your community? Is there any kind of engagement between your community and state institutions and officials?

2. Do you have any relations with public institutions and public officials; how often is this? How well do you trust public officials (not politicians) to work in your interest? Why do you trust/mistrust them?
3. How do you assess your experiences with the NHIS staff and the services they offer you? How satisfied with the services you are given when you go to the NHIS office to register or renew your membership? How adequate are the services provided in the NHIS package?
4. How do you trust the NHIS to respond to your health insurance needs promptly and serve your overall interest?
5. Do you trust the NHIS to be accountable for the resources they are entrusted with? Please explain in detail? Does accountability of the NHIS influence your decision to enroll?
6. Do you think you have some control over the NHIS staff? How does it influence your decision to enroll?
7. Do your trust / mistrust/ the NHIS and its staff influence your decision to enroll or renew your membership? How?
8. How does your experience with the NHIS, whether good or bad, influence your decision to enroll or renew your membership?
9. Does the kind of sector you are in, whether formal or informal affect your decision to enroll/ Please tell me how.

B. Experiences with Healthcare Providers

10. How are your experiences with your healthcare providers; doctor's /nurses/ pharmacists. How satisfied are you with the services when you visit the hospital/ health centre? What kind of concerns do you have in terms of services of NHIS and service providers? Do you trust your healthcare provider(s) to respond to your health needs promptly and serve your overall interest?
11. Do you trust healthcare service providers to be accountable for the resources they are entrusted with? How do trust/ mistrust/control over the various service providers affect your decision to enroll or renew your NHIS membership?

12. To what extent do you think you have any control over the various service providers? Does it influence your decision to enroll?

C. Information and Communication on the NHIS

13. How do you get information about the NHIS? How reliable is/are your source(s)?
What is your most important source of information about the NHIS matters?
Which ones do you trust and why? How adequate is the information from/about the NHIS?
14. Is the information you get about the NHIS positive or negative? Please explain?
Does the information you get influence your decision to enroll and renew your health insurance? Tell me how?

D Role of Social Capital Structures in the communities for enrolment

Finally, think about the groups and organisations like religious groups and voluntary associations etc which you belong in the communities? Do you think they involving them can influence you or other people in the community to enroll in the NHIS? Why and in which ways?

How about traditional leaders and religious leaders? Do you think they can useful for stepping up enrolment in the communities?

What do you think should be done to utilize these structures and actors to help get people to join the NHIS?

Appendix 2: Interview Protocol for NHIA Officials

**UNIVERSITY OF GHANA BUSINESS SCHOOL
DEPARTMENT OF PUBLIC ADMINISTRATION AND HEALTH SERVICES
MANAGEMENT**

Interview Protocol for District and National NHIA Officials

This is a research instrument for data collection on the topic “Social Capital and Public Policy Implementation: The Experience of Ghana’s National Health Insurance Scheme”. Please be assured that any information collected is solely for academic purpose. You are guaranteed the strictest confidentiality.

SECTION A: Demographic Characteristics

- D. Designation of respondent:
- E. Institution.....
- F. Community:
- G. District.....

1. What is the current state of enrolment in the NHIS in this district/Ghana?
2. What do you think are the factors influencing enrolment in your district/Ghana?
3. What are the main challenges facing your district/the NHIA as far as enrolment is concerned?
4. How do you address these challenges as a district?
5. In your own estimation, what do you think hinders people from enrolling and/ renewing in the NHIS?
6. How about the kind of occupation (formal/ informal) that an individual is in, does it affect the enrolment trends? How does your agency/NHIA deal with and difficulties in this regard?
7. How about your own services to clients, do you think it has something to do with community members’ interest to enroll?
8. Besides the ability to pay and other personal challenges, do you think that the associations and relationships among communities have something to do with enrolment? Please tell me how?
9. Do you think people in the community trust the NHIS to adequately cover them when they fall sick?

10. Do you think the trust/mistrust affects their enrolment? Please explain how?
11. Do you get clients sometimes complain about your services when they visit your office?
12. How do such complaints influence enrolment?
13. How does the NHIA deal with these complaints?
14. How about service providers like hospitals and pharmacies; Do you think their services and relationships with clients have something to do with people's willingness /unwillingness to enrol?
15. How does the NHIA deal with problems of poor services from service providers?
16. How often does the NHIA engage with community members?
17. How about information? How does the NHIA get information to the communities? Do you think is effective?
18. How does the NHIA communicate with community members?

D Leveraging the Social Capital Structures in the communities for enrolment

19. How about the social groups like religious groups and voluntary associations etc which people belong in the communities? Does it affect their willingness to enroll?
20. Thinking about the social groups do you think involving them in your programmes can help drive people to enroll in the NHIS? In which ways?
21. How about traditional authorities? Do you involve them? Do you think they can help
22. Do you think the various local structures and actors can influence people to enroll in the NHIS?
23. Do you think the NHIS can take advantage of the various social groups and networks?
24. Does the NHIA have any plans of involving these social structures and groups in the communities to increase enrolment in the NHIS? Please tell me how?
25. What do you think should be done to utilize these structures and actors to help get people to join the NHIS?

Appendix 3 Ethical Clearance



UNIVERSITY OF GHANA
ETHICS COMMITTEE FOR THE HUMANITIES (ECH)

P. O. Box LG 74, Legon, Accra, Ghana

My Ref. No.....

4th September, 2017

Mr. Emmanuel Kofi Ayisi
Department of Public Administration and Health Services Management
University of Ghana
Legon

Dear Mr. Ayisi,

ECH 016/17-18: INCREASING ENROLMENT IN GHANA'S NATIONAL HEALTH INSURANCE SCHEME (NHIS) EXPLORING THE ROLE OF SOCIAL CAPITAL

This is to advise you that the above reference study has been presented to the Ethics Committee for the Humanities for a full board review and the following actions taken subject to the conditions and explanation provided below:

Expiry Date: 29/08/18
On Agenda for: Initial Submission
Date of Submission: 12/06/17
ECH Action: Approved
Reporting: Bi-Annually



Please accept my congratulations.

Yours Sincerely,

Rev. Prof. J. O. Y. Mante
ECH Chair

CC: Prof. Justice N. Bawole, Department of Public Administration and Health Services Management, University of Ghana.