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ABREVIATIONS

CAADP - Comprehensive African Agricultural Development Programme

DMHIS – District-Level Mutual Health Insurance Scheme

GOG – Government of Ghana

ILO – International Labour Organization

IMF – International Monetary Fund

NHIA – National Health Insurance Authority

NHIR – National Health Insurance Regulations

NHIS – National Health Insurance Scheme

SAP – Structural Adjustment Program

SSNIT – Social Security and National Insurance Trust

WHO – World Health Organization

ABSTRACT

Health insurance is regarded as an essential means of ensuring healthcare services for people of all walk of lives and plays the role of an important tool for creating an inclusive society. Given this, Ghana instituted the National Health Insurance Scheme (NHIS) more than a decade ago to promote social inclusion and ensure the participation of vulnerable groups in society. However, to ensure that the scheme is sustainable, it is very relevant to find out the successes as well as the challenges confronting the scheme. This study, therefore, seeks to assess the social inclusiveness brought by the NHIS of Ghana. The purely qualitative research obtains data from 10 subscribers and 5 NHIS officials who are purposively sampled. The findings of the study reveal that while both groups of respondents agree that the NHIS has improved access to healthcare and promotes social inclusion, there are mixed reactions when it comes to the quality of healthcare under the NHIS. Concerning the challenges confronting the scheme, the subscribers state poor treatment by health professionals, non-inclusion of some essential drugs and medical conditions, and delay in activation of NHIS cards as some of the main challenges confronting the NHIS. It ultimately partly affects the social inclusion promoted by the scheme. On the part of the scheme officials/workers, poor internet network, insufficient internet bundle, delay in the release of funds, the inability of local offices to correct subscribers' details, and not printing the validity date on new NHIS cards are mentioned as some of the challenges.

As regards the solutions, subscribers recommend educating health professionals on the need to relate well with patients, the inclusion of essential medicines in the NHIS scheme, and instant activation of cards, among others. In contrast, officials or scheme workers suggest the rapid restoration of internet connection, backup for internet data bundles, empowering other officers to correct subscribers' details, and timely release of funds to local offices, among others.

CHAPTER ONE

1. INTRODUCTION

1.1 Background of the study and Problem Statement

Social inclusion/exclusion has gained prominence is sociological and development discourse over a period. In its basic form, social inclusion seeks to ensure that citizens and other inhabitants in specific locations can access certain essential services that ensure human dignity and existence. Gidley, Hampson, Wheeler, and Bereded-Samuel (2010) argue that social inclusion can pertain to several groupings, including socio-economic status, culture and primary language, gender, and sexual orientation, and health (including physical and mental disabilities). It is essential to note that health outcomes are one of the critical issues in the 21st century. Especially when neoliberal policies of various states exclude citizens and other persons from accessing quality healthcare.

Consequently, globally, the health care system designed by countries to deal with the health issues of citizens is one of the most critical sectors of every nation. Correspondingly, universal access to decent and quality healthcare has continued to be an issue of primary importance. For that matter, many countries have established various means of healthcare financing schemes that include National Health Insurance (NHI) that offers the opportunity of universal primary healthcare access. On the continent of Africa, some community-based health insurance interventions are established and yielding different results. These established health care systems in lower and middle-income African countries are operating despite being fraught with operational and financial sustainability challenges (Alhassan et al., 2016).

In Ghana, the National Health Insurance Scheme (NHIS) was established by the Government of Ghana through Act 650 in 2003 to ensure equitable access to universal

healthcare for Ghaianains, particularly the vulnerable and those in lower socio-economic groups. Its purpose was to facilitate and provide for Ghanaians, a wide range of healthcare services undertaken through the district, and private health insurance programs (GOG, 2003). However, a new law, that is, the National Health Insurance Act 852 has been implemented in October 2012 to consolidate the NHIS by eliminating obstructive administrative procedures, tackle corruption, promote transparency, and ensure good regulatory governance of the scheme (GOG, 2012). Before the NHIS came into effect in Ghana, there was the 'cash-and-carry' system of healthcare where all health services provided in health facilities across the country carried point-of-care user charges (Grebe, 2015). The NHIS aims to improve accessibility, affordability, and utilization of medicines and healthcare services by the poor and vulnerable groups, and ultimately replace the obnoxious effects of user fees on access to healthcare (Witter & Garshong, 2009). This system of 'cash-and-carry' led to significant social exclusion whereby the poor and vulnerable groups in the society could not access healthcare services.

In contrast to social inclusion is social exclusion which deals with a situation where an individual is disadvantaged based on several factors, and this affects several aspects of their life. For example, Schneider and Bramley (2008) suggest that it affects people's status as members of a community and their political influence as members of a state; consequently, the wider society is also affected. World Bank (2020) expounds on the effects of social exclusion and argues that it may cause certain groups to drop out of markets, services, and spaces, with costs to both individuals and the economy of a nation. Therefore, any opportunity to promote social inclusion must be amplified at all levels to ensure that the deleterious consequences of social exclusion are decisively eliminated.

The NHIS has been in existence for over a decade ago, and it still serves its purpose of ensuring that citizens and inhabitants have access to healthcare services. NHIS is a significant enabler of universal health coverage for Ghanaian citizens. For the NHIS to continue with ensuring comprehensive health coverage, it needs to be sustainable in terms of sources of financing for the scheme. One main reason for the introduction of NHIS was to promote social inclusion and ensure that vulnerable groups in society have the opportunity to access healthcare without barriers. Notwithstanding, there is little empirical evidence on the successes and challenges of the NHIS in Ghana, particularly in its quest to ensure social inclusion through the provision of access to healthcare. Thus, studies focusing on the impact of NHIS in fostering social inclusion is missing in the literature. The overarching question then is, to what extent has the NHIS promoted social inclusion among the Ghanaian population?

1.4 Research Objectives

The thesis generally examines the NHIS as a tool for promoting social inclusion in Ghana. The following specific research objectives are pursued to achieve the set goals.

1. To examine general access to healthcare through NHIS as a way of promoting social inclusion.
2. To determine the social inclusion benefits (health-wise) accrued to NHIS subscribers.
3. To ascertain the key challenges confronting the NHIS in its quest to promote social inclusion.
4. To identify possible solutions to the challenges confronting the NHIS in its quest to promote social inclusion through universal healthcare.

1.5 Research Questions

Consistent with the specified research objectives, the following research questions are formulated to guide the study. These are:

1. How does access to healthcare promote social inclusion in Ghana?
2. What are the benefits of NHIS as a social inclusion policy for subscribers?
3. As a policy geared towards social inclusion, what are the challenges or problems associated with the NHIS?
4. How can the challenges or problems be addressed to promote social inclusion through universal health coverage?

1.6 Significance of the Study

This study contributes to existing research on social inclusion through the provision of universal healthcare using the National Health Insurance Scheme (NHIS) in Ghana. This document will become relevant for researchers who intend to undertake similar studies in the future. The findings of this research from the perspective of theory can lead to further theorizing related to the research problem. Moreover, the current study can be the foundation upon which subsequent but related studies may are conducted. Practically, this study is significant in the sense that its findings and recommendations can serve as a guide to the drawing of measures and policies that seek to strengthen the National Health Insurance Scheme (NHIS).

This study primarily aims at informing action. Therefore, in-depth knowledge about the NHIS's methods, activities, and challenges can aid government and other bodies in the adoption of new policies or revisions of old ones to achieve social inclusion through the provision of healthcare for the vulnerable in society who are usually

disadvantaged. This research offers insight into subscriber behavior and expectations that can be considered in NHIS policies and implementations.

1.7 Scope of the Study and limitation

The geographical area of focus for the study is Suame Municipality. The municipality is under the Kumasi Metropolitan area in the Ashanti Region, the second capital of Ghana – West Africa. The study covers NHIS officials who work in the NHIS offices and outposts in the Suame Municipality. It also covers NHIS card bearing subscribers/ participants in the Suame Municipality. It is one of the largest in the country in terms of municipality and subscriber base. As a result, findings from using it as a case could offer analytical generalizations for other studies that are similar in scope and objectives.

The thesis examines the National Health Insurance Scheme. As objectives: the study examines how NHIS subscription has influenced access to healthcare; assesses specific benefits of NHIS to subscribers, investigates the progress made by NHIS since inception, ascertains key challenges confronting NHIS and unearths possible solutions to NHIS's problems. These were embarked upon through feedback obtained from interviews with officials and participants. The interviews aimed to derive answers to research questions on; social inclusion through the accessibility of healthcare under NHIS. Similarly, the benefits of access to healthcare under NHIS as a social inclusion policy and challenges associated with NHIS in a quest to achieve social inclusion and possible solutions to problems related to the NHIS.

The study is limited because of the timeframe. The research had to be completed at an unusual time that the world is facing the menacing Covid-19. This global pandemic has disrupted almost every activity, while lockdowns make it very difficult for

research activities, including data collection, because of the need to respect social distancing protocols.

1.8 Organization of the Study

The study is organized into five chapters. The first chapter presents a general introduction to the study. The chapter further covers a broad background to the study, statement of the research problem, research objectives, and related research questions, significance of the study, the scope of the study, and limitations of the study. The second chapter presents the literature review (and theoretical/ conceptual framework) of the research. The chapter reviews prior empirical studies that are related but relevant to the study (and presents offers the theoretical or conceptual foundation for the study). Chapter three explains the research methods employed for this study. The chapter further details the research approach, population, sampling size and sampling techniques, sources of data, the research instrument, ethical considerations, and data analysis approach. Chapter four presents the analysis and discussion of the results and the findings of the study. Chapter five finally deals with the summary of findings, conclusions, and recommendations resulting from the study.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL CONTEXT

2.1 Introduction

This chapter examines the literature in the field and adopts a specific theoretical approach to situate the research in context. It reviews empirical studies that are relevant to this study. The chapter brings to the fore the importance of the research while at the same time identifying research and methodological gaps to fill. It further substantiates and grounds the research questions and objectives set in chapter one of this thesis by way of contribution to knowledge. The chapter discusses topics including theoretical propositions of social inclusion and its dynamics, social inclusion and health, healthcare access and social inclusion, health, historical antecedents of healthcare in Ghana, social intervention policies as a way of achieving healthcare access in Ghana, the national health insurance scheme and its contribution in ensuring healthcare access as a way of promoting social inclusion.

2.2 Social Inclusion Theory

Social inclusion can be traced as far back to the 19th century German sociologist Max Weber and regard for the importance of social cohesion. In contemporary time, the term is commonly identified through social exclusion. This dates back to the French notion of ‘les exclus’ – people excluded from the social insurance system in the 1970’s (Hayes et. al, 2008). In the 1980’s and 1990’s, the concept became widespread throughout Europe and the United Kingdom. It surfaced in Tony Blair’s government, resulting in a Social Exclusion Unit, promoted its usage in Australia, the first time in South Australia in 2002, and recently in 2008 through Rudd’s government’s inauguration of Social Inclusion Board (Gidley et al., 2010).

Social inclusion covers a broad area base of social groupings. They involve

demographic differentiation with regards to socio-economic status, culture and primary language, religion, geography (regional, rural, remote), gender and sexual orientation, different age groups, health (physical and mental), unemployment, homelessness, and incarceration. In terms of the degree of inclusion, social inclusion can be understood in these ways. The neoliberal notion primarily talks about access. The social justice notion deals with understanding social inclusion as participation, and the human potential perspective deals with social inclusion as empowerment (Gidley et. al, 2010).

Neoliberal access: this is related to the onset of neoliberal ideas in the 1980's. from this viewpoint, increasing social inclusion is primarily concerned with investing in human capital and improvement in skills shortages for the main objective of economic growth that is linked to nationalist agenda for nation's economy building for better performance in a competitive global market(Gidley et. al, 2010).

Social justice participation: this perspective presents a more inclusive interpretation of social justice. Promoting social inclusion is primarily about ensuring human rights, equality of opportunity, human dignity, and fairness for all. The ultimate aim is to enable all humans to contribute to society while their dignity is wholly respected actively. This perspective consolidates community engagement and participation and can be linked to notions of community sustainability and contextualized within paradigmatic conceptions of participation (Langworthy, 2008; Saunders et. al., 2007).

Human potential empowerment: This perspective transcends beyond justice human rights and advances to maximize the potential of each human being. It dwells on models of possibility instead of models of deficiency. Empowerment is the main focus of an interpretation of social inclusion (Gidley et. al, 2010).

Presently, threats of exclusion from active participation in societal interaction of people concerning vital services and access to opportunities persist. Social inclusion fosters the sustainability of humanity through the integration of the excluded and marginalized from such opportunities and resources, including access to healthcare. Therefore, a health insurance programme that is designed to promote the health needs of the poor and marginalized groups in society is one vital means of facilitating social inclusion among people in a community. To understand social inclusion, the main factor which it purports to address, that is, social exclusion must first be clarified.

Social exclusion is "a state of individuals' and populations' precluded from participation in various aspects of life in their surrounding society" and involves "populations excluded from society for reasons such as racism, discrimination, and poverty" (Haron, 2013, 55). According to Wilson, (1987), inequality, segregation, as well as poverty, which affects a geographically isolated minority group, are all elements of social exclusion. In this context, social exclusion refers to the barriers that prevent or impede people from access to quality and affordable healthcare.

Social Inclusion as defined by the World Bank (2020) is: "*the process of improving the terms for individuals and groups to take part in society, and the process of improving the ability, opportunity, and dignity of those disadvantaged based on their identity to take part in society."* Silver (2015) also indicates that social inclusion may refer to a process of promoting social interaction between people with various socially advantageous attributes or an impersonal institutional setup of widening access to participation in all spaces of social life.

Social inclusion needs opportunities and resources that are relevant to foster participation of the excluded from economic, social, political, and cultural life.

Availability of such would be the catalyst to offer people the standard of living and well-being that is acknowledged as normal in their society. Also, these provisions uphold the respect and consideration of their voices in decision-making processes about their lives (Krisha and Kummmitha, 2017).

2.3 Social Inclusion and Health

Universal health coverage (UHC) is one crucial policy for realizing and sustaining improved access to health services, financial risk protection and safeguarding the health of a population while assisting to not leave anyone behind in terms of access and use of health services. Certain barriers obstruct some individuals from access to and the utilization of health and social services as well as in the participation of economic activities. Exclusion may be based on gender, race, caste, indigenous origin, ethnicity, and religion, diseases like HIV/AIDS and tuberculosis, and disability, migration and displacement (Tangcharoensathien et al., 2018). Groups that are at risk of being socially excluded include, the unemployed, people with mental health challenges, women and children, older people, rural dwellers, migrants and refugees, single parent families and people residing in institutions (World Bank, 2007).

Poverty and social exclusion, according to the World Health Organization (WHO) are major factors that were contributing to health inequality for millions of people living across 53 Member States of the European Region (WHO, 2010). Health systems can lead to equity, social justice and eventually end exclusion when primary healthcare is made readily available for all. The significant role of health systems and primary health care in tackling social exclusion and bettering the health status of populations cannot be underestimated and are strongly emphasized by the WHO. Further, the course to improve the health of vulnerable populations must be established on a human rights approach to health, and primary healthcare must be its values and principles. This must emphasize the inclusion of poor communities and social exclusion in the design planning, implementation, monitoring and evaluation of policy and practice (WHO, 2008; WHO, 2010).

2.4 Meaning of Health

According to the World Health Organization (WHO), health constitutes a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (WHO, 1948). Thus, WHO specifies that having good health does not necessarily indicate the absence of illness but importantly, also having a sound physical, mental, and psychological state. Suffice it to say that a claim of good health is not a matter of outward look but rather contingent upon other factors or situations. Improving upon people's health, therefore, calls for a holistic approach: necessarily, an encompassing perspective based on human existence. When a population is healthy, it comes with great benefits that cannot be substituted for anything. It, therefore, comes as no surprise as health improvement has been a focus of most forms of developmental agendas and is linked inextricably to economic prows of a country. Larson (1999) in Conceptualization of Health, outlines four main models of health. The medical model, the WHO model, the Wellness model and the Environmental model of health.

The medical model connotes the absence of disease or disability. Wood (1986), in his observations of the medical model, differentiates between disease, illness, and health. He asserts that disease is a condition in which the structure or function of the body is disordered or agitated. Illness, in contrast, is the subjective opinion or perception that an individual is suffering from a disease. Health, on the other hand, according to Wood (1986), is difficult to define and that it is relative rather than absolute. Measurements of it in the medical model have to be made concerning illness, its consequences (including disability), and potentially other factors like economic factors (Ibid).

The WHO Model draws attention to the state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. The WHO definition of health according to Greenfield and Nelson (1992), seemed utopian in 1948 until recently regarded as conventional wisdom by many. Critical health studies in the United States utilized this model and contributed significantly to its wide acceptance. One such experiment is the RAND Health Insurance Experiment, which used measurements that are based on the WHO definition. Physical, mental, and social well-being were all given operational definitions. In the study, physical health was defined as functional status and the ability to perform a range of activities, including caring for self, household work, and leisure activities. The focus of mental health measure was on affective (mood) disorders, anxiety disorders, positive well-being, and self-control. Ware et al. (1981), on the other hand, defined social health in relation to social participation in activities and interpersonal interactions.

The wellness model harmer on health promotion and conscientious efforts towards higher functioning, energy, comfort, and integration of mind, body, and spirit (Larson, 1999). The wellness model has the objective of higher levels of health and wellness (Dubos, 1979). The catalyst, influencing medical research has been the wellness model. It has been achieving growing interest in health promotion and health education for patients on advisable habits on eating, exercising, and avoidance of stress. The hope for the future is quality physician-patient communication bourn of respect for patients' rights. The wellness model is also committing more research into the impact of lifestyle on disease and disability and the therapeutic effect of spiritual beliefs (Larson, 1999).

The environmental model refers to the adaptation to physical and social surroundings – that is, a balance devoid of the distressing feeling of pain, discomfort, or disability. The environmental model is actively spearheading research on some diseases, for example, asthma and allergies, and what way the physical environment that contributes to those diseases can be controlled. The effect of surgery on health-related quality of life and the influence of social support to recovery will be a subject for future exploration. The environmental model exerts an influence regarding future medical research on the psychological adjustment to work and family life as well as factors affecting a healthy balance (Larson, 1999).

2.5 Historical Perspective of Ghana's Healthcare System

In understanding the changes that have occurred in the healthcare system of Ghana since the introduction of the NHIS, it is crucial to commence with an examination of the structure of and influences initially occurring in Ghana's healthcare system. Hitherto to the inception of the NHIS, the system at work was the 'cash and carry' system. This system in 1985 started as a response to the Structural Adjustment Promgram (SAP) laid out by the International Monetary Fund (IMF). SAPs are specified mandatory plans and conditions, which ought to have been satisfied by developing nations before loans were granted. Ghana's economic situation had a downward turn in the early 1980s that critically affected profits from cocoa - Ghana's major export commodity (Quaye, 1991). The government of Ghana at the time in a bid to salvage the struggling economy committed to conditions mandated for loans from the IMF. Ghana, through adherence to the terms and conditions of the SAP became one of IMF model nations for implementing recommended policies.

'Cash and Carry' connotes a healthcare delivery system where a client pays for medical care before healthcare is received. The payment must be in full before

medical care could be accessed. This system had the rationale of increasing the resources needed for financing health facilities, improve access to healthcare, and an overall improvement in the efficiency of operations. This system did not favour the vulnerable; the poor, disabled, and victims of accidents were all required to make on the spot payment for medical care or get turned away.

The 'cash and carry' system came in a period when workers were being laid off, leaving only those who could afford access to medical care - as the poor were left out of medical care due to 'cash and carry' introduction (Quaye, 1991). The evident high-cost factor became a significant barrier to health care access and use, leading to social exclusion. As a result, some measures were implemented to alleviate the situation partially. This was the Exclusion Policy implemented in 1997 through which essential services were waived for children below five years, women needing antenatal care, elderly persons over 75 years, and those suffering from snakebites (Owusu-Mensah, 2010).

2.6 National Health Insurance of Ghana

Through the National Health Insurance Act of 2003, the National Health Insurance Scheme (NHIS) was established, and it has been a significant achievement by one of few Sub Saharan nations to implement at the national level. It is a universal health insurance program (Karigia et al, 2006) to promote social inclusion. A mandated body – the National Health Insurance Authority (NHIA) was instructed to safeguard the implementation of policies concerning national health insurance by ensuring primary healthcare access to all residents (GOG, 2003). The NHIA offers licenses to as well as regulates activities of district-level mutual health insurance schemes (DMHISs) and other permissible schemes under the Act. The NHIA also gives accreditation to

providers, evaluates, and determine premium levels in consultation with DMHISs, and supervises reports on NHIS operations (NHIA, 2020).

The NHIS has four primary sources of finance which include; a value-added tax charged on services and goods (National Health Insurance Levy), a portion of Social Security and National Insurance Trust (SSNIT) taken from formal sector workers, individual premiums, and miscellaneous funding sources ranging from investment returns, Parliament, or donors (Yankah, 2009).

A single benefit package through Legislative Instrument 1809 has been designed for the NHIS and all DMHISs, which the NHIA describes as covering 95 percent of disease conditions affecting Ghanaians (Witter et al., 2009). Coverage for the NHIS extents to outpatient services, oral health treatments, all maternity care services, emergency care, and all drugs on the centrally-established NHIA Medicines List (NHIA, 2020). However, there are exemptions on the NHIS package (Blanchet et al., 2012).

The package does not cover some of the very costly procedures like certain surgeries, cancer treatment (except breast and cervical cancer), organ transplants, and dialysis. Also, the NHIS does not cover services like cosmetic surgery and HIV antiretroviral drugs (subsidized on a separate National AIDS Program). The NHIS has certain limits placed on subscribers' consumption of benefits. There are no sharing of cost above premiums, no annual or lifetime limits, and little gate-keeping (Blanchet et al., 2012).

Even though they are required to pay for NHIS registration, the following groups are exempted from paying for premiums: elderly persons above 70 years, children below 18 years who have both parents subscribing to NHIS, the 'core poor' (NHIR, 2004), and pregnant women since July 2008 (Sarpong et al., 2010). Apart from the exempted groups, all Ghanaians are supposed to pay an annual insurance premium as well as the

registration fee. However, the amount paid as premium is not the same for the different income or wealth groups. The very poor people pay the least while the affluent pay the highest premium (NHIA, 2010).

2.7 Threats to Ghana's National Health Insurance Scheme

The NHIS, even though it plays a crucial role in the realization of universal health coverage, it still faces challenges. Alhassan et al. (2016) in, a review of the National Health Insurance Scheme in Ghana, indicates that NHIS's ability to continue operations in Ghana faces financial and operational threats. These threats include; cost escalation, likely political interference, inadequate technical know-how, the spatial distribution of health facilities and health workers, inadequate monitoring mechanisms, large exemption groups, inadequate client education, and limited community engagement. Clients' trust in the scheme has been affected by poor quality care in some NHIS-accredited health facilities that has negatively affected enrollment.

According to Fusheini et all (2012), the major threats posed to the sustainability of Ghana's NHIS is categorized into financial, political, and operational risks. Threats that are related to the financial sustainability of the NHIS are mainly: fraud and corruption at health insurance schemes; improper use of the gate keeper system/ initial point clients report for primary healthcare before possible referral to an advanced facility, low premium payments, and broad benefits package without co-payment.

Fusheini et al. (2012) also indicate that political threat to NHIS includes political influences in the scheme management as the appointment of the Chief Executive Officer (CEO) is by the president of the day, and that could serve as grounds for

political interference. Operational threats become possible when clients keep visiting different health facilities in search of a facility which offers the best healthcare, delays in service provider reimbursements, the spatial distribution of NHIS recognized health facilities and staff, weak human resource capacity in the district offices and delay in card issuance even though this has recently improved.

Poor quality of health care services in NHIS partner facilities happens to be one significant threat to the sustainability of the NHIS scheme. Some NHIS subscribers believe that the quality of health care they receive is terrible compared to the ones experienced by people who make on the spot payment for health care services. They experience longer waiting times, poor human relations of health workers, and the lack of channels for complaints (Alhassan et al., 2015).

According to Agyepong and Nagai (2011), another threat is that some health service providers make an unlawful alteration of exemption policy under the NHIS to delayed reimbursement of a claim by NHIA to health service providers. Witter et al. (2009) also shed light on the sizeable number of subscribers as against limited revenue of the NHIS characterized by low premiums, broad benefits package and enormous size of exemption groups as major challenges to the financial sustainability of Ghana's NHIS. Doing away with NHIS related threats will require coordinated efforts from all major stakeholders, including health insurance managers, service providers, insurance subscribers, as well as policymakers and political representatives (Alhassan et al., 2016).

2.8 Pro-Poor Social Protection Policy

Social Protection mainly functions to address poverty and to offer protection for people from unexpected risks and shocks, therefore provides a cushion for a

meaningful life. Social protection is often public-funded and contributions based. In poorer countries, when hit by natural disasters, economic downturn, and food crisis Social Protection becomes problematic even though they are then needed the most to offer protection for citizens against negative consequences.

The International Labour Organization maintains that social protection is primarily when people and families have security against vulnerabilities and contingencies; it is having access to health care. It is about working in safety (Garcia & Gruat, 2003). Social Protection has a broader meaning other than social security, and it encompasses two main dimensions. These are income security and the availability of medical care (ILO, 2010).

Historically at the time of independence, the government of Ghana in 1957 had made provisions for free universal health care for the citizens of the country. This free health care system became unsustainable because it was mainly financed by generated tax revenue as the government had to also commit to supporting other sectors of the economy. To keep the healthcare system running, the government started the introduction of nominal fees and later on the cash and carry system of direct payment before medical care access (Sulzbach et al., 2005).

According to Dei (2001:3; cited in Abebresse, 2011p 5), in typical African settings like Ghana, traditional systems of Social Protection have always been present and are based on the support of the extended family. There are weaklings in most families, for example, the elderly and the sick, but these vulnerable individuals were supported by the traditional systems of social protection through the extended family provisions. However, this form of social protection originating from strong extended family ties

has been sharply eroded due to increasing globalization and urbanization. There is a lack in support for older and or vulnerable members of the extended family as a result of the exodus of younger families into the cities. The most vulnerable people in society depended on the traditional and informal Social Protection system that is now weakened (Abebresse, 2011).

The weakened traditional social protection calls for the emergence of more robust and more reliable forms to cushion to vulnerable groups in society. In Ghana, the major Social Intervention programs that have been implemented in the country include: Social Security and National Insurance Trust (SSNIT); Highly Indebted Poor Country (HIPC) Fund, National Social Protection Strategy and Ghana Poverty Reduction Strategy, National Health Insurance Scheme (NHIS), Ghana School Feeding Programme, and Livelihood Empowerment Against Poverty (LEAP) Social Grant Scheme.

The Social Security and National Insurance Trust: Ghana in 1965 through the Social Security Act had established a nationwide Social Security Scheme. This resulted in the creation of a Provident Fund Scheme, which offered a monetary resource for lump sums provided for old age, invalidity, and survivor's benefits. The Social Security Law in 1991 ushered the Provident Fund Scheme into a Pension Scheme, named the Social Security and National Insurance Trust (SSNIT). The provisions of the SSNIT indicate that contributions summing up to a total of 17.5% of workers' monthly salaries must be made – employers paying 12.5% whiles employees paid the remaining 5%. Self-employed persons had to contribute the entire 17.5% by themselves. The implementation of the new Pensions Act (National Pension

Regulatory Authority (NPRA)) raised the monthly contributions from 17.5% to 18.5% of workers' monthly salary (Abebresse, 2011).

The Highly Indebted Poor Country (HIPC) Fund: the HIPC fund originated as a result of government decision to make an impact by reducing poverty and the debt burden of Ghana in 2003. A substantial amount of the country's financial expenditure was going into debt servicing, leaving the country with minimal financial capacity for investment in the social sector resulting in increasing poverty. Ghana's participation in the HIPC initiative allowed Ghana's major creditors to erase debts over time, making way for such monies to be expended in investments in the social sector. By fulfilling conditions for debt erasure, the government of Ghana had to develop a Poverty Reduction Strategy and spend money generated from the HIPC fund towards outlined programmes in the strategy (MOF, 2011 cited by abebresse 2011 p7).

Ghana School Feeding Programme: Ghana's School Feeding Programme was implemented in the year 2005 within the context Comprehensive African Agricultural Development Programme (CAADP) III and in response to the first and second Millennium Development Goals (MDGs) towards the eradication of extreme poverty and hunger and achieving universal primary education. The underlying motive for the implementation of this programme is the provision for children in public primary schools and kindergartens with one hot and nutritious meal that has been prepared with locally grown foodstuffs on every school-going day. The overarching objectives were that the Schools Feeding Programme would contribute to an improvement in enrolment in schools, improve attendance and retention of pupils in deprived communities in Ghana and strategically; stimulate an increase in domestic food production and consumption; increased incomes of poor rural people; and bring about

an improvement in the health and nutrition of pupils (GoG, 2015).

The Livelihood Empowerment Against Poverty (LEAP): The LEAP offers cash payments to very poor people, especially households that have orphans or vulnerable children, elderly people and extremely disabled persons. LEAP beneficiaries also get enrolled on the NHIS for free. As objectives, the LEAP programme is purposed to alleviate short-term poverty and also to promote the development of human education, experience and abilities (Davis et al, 2014). Under the LEAP programme, support is provided for selected households through monthly cash transfers between GHS 8 and GHS 15 depending on the number of people within a particular household. Cash distribution to persons with disability and elderly persons over 65 years are unconditional (Sultan & Schrofer, 2008).

CHAPTER THREE

METHODOLOGY

3.0 Introduction

In research, there are three primary methodologies. The quantitative: the qualitative and the mixed research methods. The quantitative research method is rooted in the positivist notion of finding a single truth by employing hypothesis, variables, statistics, and some numerical approaches, but it is criticized for the lack of depth in answering real-world questions (O'Leary, 2014). Qualitative research method, on the other hand, depends on subjectivism, social constructivism and interpretivism to gain knowledge through multiple realities by in-depth studies on small number of cases (O'Leary, 2014). Qualitative research methods seek to establish the meaning of a phenomenon based on the views expressed by participants. The qualitative methods used by researchers entail case studies, thematic analysis, narration, and ethnography (Creswell, 2014). The mixed research method situates within the pragmatic research paradigm as it emphasizes on the use of assumptions from both quantitative and qualitative methods. That is to say, different research paradigms offer different assumptions that position the appropriate methodology. Therefore, it is essential for researchers to choose the right methodology together with the right research worldview. In view of the nature of this study, the qualitative research method was deemed most appropriate and therefore selected for the thesis.

3.1 Research Design

This thesis adopts a wholly qualitative research design. This method is selected to obtain detailed information from the respondents regarding the promotion of social inclusion through universal healthcare access.

The qualitative research approach is primarily needful in unearthing the meanings that people ascribe to events and phenomena they experience (Merriam, 1998). The qualitative research methods deployed for this research are: the ***purposive sampling method*** used in the selection of scheme workers/ providers; ***the snowballing method*** used in the selection of the subscribers and ***open-ended interviews*** for data collection. The data originating from the interviews were thematically presented and analyzed while social inclusion was the main theoretical lens used.

3.2 Background Characteristics of Respondents

The respondents of the study involve 10 subscribers and 5 scheme workers/providers. The subscribers involved 7 females and 3 males. The ages of the subscribers range from 25 years to 40 years. Regarding educational background of subscribers, 8 have tertiary level of education while 2 have senior high school level of education. Concerning the employment status of subscribers, while 1 is a student and another 1 is unemployed, all the remaining subscribers are employed. Among those who are employed, one is a sales executive, three are teachers, two are traders and the remaining two are nurses.

Among respondents from the scheme providers/officers, while three of them are males, the remaining two are females. The ages of the scheme providers are between 27 years to 35 years and all of them have tertiary level of education.

3.3 Population and Sampling Techniques

The target group of people considered in a research generally forms the population of a study. In the light of this, the population of any study comprises of many people. This thesis for instance, the population comprises of Ghana National Health Insurance Scheme subscribers and officers/ workers. Specifically, the population of the study is made up of active card bearing NHIS subscribers and NHIS officers/ workers in the

Suame Municipality of the Ashanti region of Ghana. Because it was not possible to study the entire population given the time and resource factors, a sample was selected out of the population to represent the entire population. Correspondingly, the process of choosing a few from a larger group, using their views and opinions to generalize for the entire population is known as sampling.

O'Leary suggests, there are two main approaches to choosing a sample from a population: random sampling and non-random sampling. Random sampling connotes an unsystematic means of selecting participants from a population (O'Leary, 2014). Therefore, each member within the population has equal chance of getting selected. Varied types of random sampling entail; simple random sampling, stratified sampling, systematic sampling and cluster sampling. However, on the other hand, in non-random sampling, the selection is primarily not contingent on probability (O'Leary, 2014).

Non-probability sampling techniques were used in choosing the respondents for the study. The purposive sampling technique was used to select NHIS officers in the Suame Municipality. This is because the purposive sampling technique offered the opportunity to identify and select NHIS professionals who are knowledgeable and also familiar with the activities and operational procedures of NHIS work in the Suame Municipality and are therefore deemed appropriate to answer questions pertaining to the study. This goes to ascertain that, participants of the research are of a high-level experience and knowledge. Therefore, views that they expressed emanates from experience, good judgment and sound knowledge and therefore ensuring high level of reliability of the research, culminating into valid findings and conclusions.

The snowball method was used in selecting other research participants (subscribers) in the Suame Municipality. The researcher had to rely on this method when it was observed during the research process that visiting out-patient facility to interview clients was a bit of inconvenience to subscribers. NHIS staff therefore offered cues that led to conveniently meeting up with subscribers who have been around to renew their cards.

The purposive sampling method was used to select the officers/ workers of the NHIS in the Suame municipality. This method was chosen because it allowed the researcher the opportunity to interview specific experienced workers of the NHIS who have worked for several years and are fully informed about the scheme's activities and progress.

In all, 5 NHIS officers/providers and 10 respondents/subscribers were sampled for the study. The NHIS workers range from those in top management, data input officers among others.

3.4 Sources of Data

An important point of focus in research is the sources of data. Extensive sources of data collection are utilized in the case study method and they include; documentation, interviews, direct observation, archival records, participant observation, physical artefacts, photography, films, video tapes, life history and ethnography (Marshall & Rossman, 1989; Voss et al., 2002). Yin (2003) also unearths six often-used data sources of evidence for collecting information on case studies that includes documentation, archival records, interviews, direct observation, participant observation and physical artifacts.

3.5 Data Collection Instrument

3.5.1 Interviews

Interviewing is a qualitative data collection method through open-ended questions to obtain information from interviewees about various topics, themes, and questions (O'Leary, 2014). Facilitating a congenial interviewing atmosphere as well as maintaining a fluid interviewing process is necessary to ensure that interviewees feel comfortable and confident in giving out information. Yin (2003), in this regard, posits that it is essential for researchers to stick to the main line of inquiry in the course of a research interviewing process while simultaneously asking real conversational questions in a manner that is not biased to generate the required information. Predetermined questions guide the conversation and serve a strict proof material for the interview based on the type of interview selected for a research enquiry (Easton, 1995).

In general, questions designed for interviews are carved from themes or topics of interest related to case studies that a researcher is studying. The questions are purposed to address the research questions and objectives of a study. Interviewing questions are categorized into two: Open ended and closed ended. Open ended questions offers respondents the opportunity to provide a wide range of answers on issues whiles the closed ended questions provides very limited room for participants to give alternate answers to questions (Runeson & Höst, 2009).

However, most researchers involved in case studies employ the use of open ended questions for generating information. Moreover, interviewees may also be asked to offer insights into case studies to set the pace for further enquiry. Interviews were employed to augment other data sources for this thesis. It offered the opportunity for the research participants to contribute to the thesis and guaranteed that the findings of

the thesis were practical. Three main types of interviews are identified; fully structured, semi-structured, and unstructured (Robson, 2002). This thesis employed the face-to-face semi-structured interviews to obtain information from study participants. In the semi-structured face-to-face type of interview, there is an already prepared set of questions, but the researcher is not obliged to orderly follow these questions. It offers the flexibility where researchers can ask probing question that comes from participants' answers.

An interview guide is used as the data collection instrument. The study used two interview guides; one for subscribers and another one for NHIS workers. The interviews were conducted in the NHIS offices and premises in the Suame municipality where NHIS officers, as well as NHIS card bearing members were available. The main sections of the interview guides are access to health services, benefits/progresses (successes) of the NHIS, challenges of the NHIS, and solutions to challenges of the NHIS.

3.6 Ethical Consideration

Before the conduct of the interviews, the researcher visited the NHIS office in the Suame municipality in the Ashanti region of Ghana, introduced himself as a student of Nord University – Norway, and obtained authorization for the research. The study maintained high ethical standards by allowing respondents to decide to participate in the study voluntarily. This was facilitated through the issuance of an informed consent form to participants, which they signed in agreement to voluntarily participate in the research or otherwise. The informed consent form indicated that the purpose of the thesis is purely academic activity. Therefore, a high level of anonymity was ensured to participants.

3.7 Data Analysis Approach

This thesis uses thematic analysis to analyze the responses shared by participants. Thematic analysis is prevalent in qualitative research analysis for examining and recording patterns in qualitative data. Thematic analysis, according to Braun and Clarke (2006) is a method for identifying, analyzing, and reporting patterns (themes) in data and is recognized as the foundational method for qualitative data analysis. Thus, commonalities in participants' responses are grouped whiles meanings are generated based on the patterns that emanate from the data. Notes were taken on the vital information given by participants. These notes were assigned codes and grouped into themes and, subsequently, were analyzed in-depth. The presentation of data and results of the theses are supported by quotes from the interviews. Also, inferences are made from the results, and the quotes buttress the interpretations and arguments of the researcher.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.0 Introduction

This chapter presents the results of the thesis on the social inclusion and universal healthcare access using the Ghana National Health Insurance Scheme (NHIS) in the Suame Municipality. It commences with access to health services as a way of promoting social inclusion. This is followed by, quality matters in healthcare access in the promotion of social inclusion. Thirdly, is the presentation on evidence of social inclusion through NHIS-progress of subscription. This chapter further presents the benefits of the NHIS in promoting social inclusion. Challenges of the NHIS in promoting social inclusion is presented next, this is followed by the solutions to challenges of the NHIS to promote social inclusion. Lastly, a summary of the chapter is presented. Perspectives of both subscribers and scheme workers/providers are captured.

4.1. Access to health services as a way of promoting social inclusion

One theme emerging from the empirical data is access to healthcare via the use of the NHIS cards and how that has influenced their participation in community activities leading to social inclusion. Social exclusion has a mechanism that affects individuals' quality of life as well as the equity and social cohesion within societies. It encompasses the absence or obstruction to resources, rights, goods and services, and also the inability to play a role in normal social relationships and activities that are at the disposal of majority of people in a society, being it economic, social, cultural or political sphere (Levitas et. al, 2007). All the respondents (except only one who states that her ability to access care has not changed) say their ability to access healthcare is unimpeded by monetary considerations unlike previously. As a result, they can

participate in health care services in their various communities. As evidence, a female sales executive who is 25 years stated that *''my ability to access healthcare after enrolling on to the National Health Insurance Scheme has been good so far and very helpful as it saves time and money for other community activities"*. Also, another respondent stated that *''There is easy accessibility within my area and other neighborhoods where hospital facilities exist, due to no charges associated with accessing healthcare, we save money for other eventualities".* Similarly, another respondent among the subscribers stated that **''***I can access healthcare at different hospitals because many hospitals are providing services for NHIS subscribers at the sub-metro, and as a result, access to a major hospital for healthcare is not a problem. Previously, I would have had to pay exorbitant fees to have health care".* A 30 year old housewife said that "*access to healthcare is good. I can go to the hospital regularly with the National Health Insurance card, thereby promoting good health".*

Further, a 26 year old male student stated that *access to health services had not been a challenge. Even though I don't visit the hospital often because I hardly fall sick, each time I do fall ill, I can quickly locate an NHIS compliable hospital to attend. It saves a lot of money to support myself because I paid so much money the last time I visited the hospital without the NHIS card, and I was not a subscriber".*

According to the staff of the NHIS who were interviewed for their views on healthcare access through NHIS as a way of promoting social inclusion, they suggested a substantial increase in the number of people accessing the scheme. All the respondents from NIHIS say people's ability to access healthcare from various health facilities has increased. For example, a 27 year old male worker had this to say, *''There has been a general improvement in access to healthcare*. *Subscription to NHIS has increased, enabling subscribers to access healthcare freely.''* Also, a 30

year old male worker stated that *''This NHIS is eliminating the cash and carry system whereas access to healthcare has greatly changed from money before service is offered, which caused deaths of so many people.' '*Besides, a 35 year old male respondent stated that **''***Confidence in the scheme has led to a corresponding increase in healthcare facilities subscribing to the scheme. This has also contributed to increased access to healthcare. People have the opportunity to go for healthcare at various partner hospitals and clinics".* Also, a 28 year old female respondent states that ''*Now that the NHIS has come to replace the hitherto cash and carry healthcare system, there has been universal access to healthcare. For a small amount of 28 GHS subscribers can access healthcare as many times as possible''*. Moreover, a 31 year old female respondent states that ''*Healthcare access is high with the implementation of the NHIS. People are freely able to attend hospitals from different locations for healthcare".*

In a cross-case analysis, respondents from both categories; subscribers and staff, concurred on the fact that there is access to healthcare. To this end, it can be argued that universal healthcare access has been facilitated to an enormous extent through the NHIS in Ghana because the system it is devoid of barriers or mechanisms that excludes or obstructs sections of the population from accessing healthcare in Ghana. Such access to healthcare is an essential milestone in achieving social inclusion because such marginal groups that are sometimes excluded due to poverty and other related factors could access healthcare without barriers. According to Silver (2015), Social inclusion encompasses the processes of promoting social interaction between people with varied socially ascribed statuses or an impersonal institutional setup of expanding access to participation in all spheres of social life.

This corroborates the findings in the thesis, and similarly affirmed by World Bank that puts social inclusion as "*the process of improving the terms for individuals and groups to take part in society, and the process of improving the ability, opportunity, and dignity of those disadvantaged based on their identity to take part in society."* (World Bank, 2002).

The introduction of NHIS has generally aided accessibility in promoting social inclusion. Such a view is shared by both staff and subscribers of the scheme. The above finding suggesting good access to care after subscribing to the NHIS is not farfetched because insurance makes healthcare easily accessible by reducing the cost associated with healthcare. As already suggested, healthcare access improves social inclusion and discourages exclusion related to the inability of citizens to participate in essential services in a country. As indicated by the empirical data, the majority of respondents are of the view that access has improved. As a result, they can participate in healthcare, which hitherto was available to a privileged few who could afford it. To this end, it can be concluded that through such a vital social intervention programme in the health sector of Ghana, social inclusion has been improved to a large extent. Therefore, healthcare programmes such as universal health access by citizens offer minority and marginalized groups the opportunity to be socially included in the activities of a nation.

4.1.1 Participation in Other Community Activities due to Access to Healthcare

An emerging theme from the empirical data was determined as the ability of subscribers to participate in other community activities due to access to healthcare via the NHIS. Over the world, about 150 million people are estimated to incur financial catastrophe while 100 million people are forced below the poverty line every year as a result of out-of-pocket (OOP) expenditure (WHO, 2010). For this reason, it becomes

a necessity for global health systems to protect their populations from adverse economic implications of out-of-pocket expenditure in healthcare through universal health coverage.

In this regard, the universal healthcare access through the NHIS in Ghana has succeeded to a great extent in shielding most Ghanaians from unplanned but expensive out-of-pocket healthcare expenditures. This has led to the empowerment of most subscribers financially (extra money subscribers get to keep from little expenditure on health through the NHIS) and socially as they are able to participate fully in social activities (funerals, weddings, church activities, among other) making them feel important in society. The WHO (1998) defines empowerment in health promotion as a process through people achieve great control concerning decisions and actions that affect their health. To a wider extent, empowerment may be a social, cultural, psychological or political mean which individuals and groups express their needs, showcase their concerns, fashion out strategies for partaking in decision-making, and forge political, social and cultural action to meet those needs (WHO, 1998).

Based on the responses provided by respondents, a follow-up question was asked to understand the community activities engaged in by respondents as a result of their subscription to NHIS. Respondents suggested that they can participate in community activities such as attending community gatherings to provide feedback on government policies at the local level and donations at funerals and weddings. They can do these because it is free to access healthcare. As a result, they have extra income to spend on such activities, which hitherto was not possible. For instance, a 30 year old female respondent indicated that, *"because I don't have to pay money at the hospital when I or my children get sick I am able to save money some of which I do donate at funerals*

and weddings and that makes me socially recognized". Also, a 35 year old man mentioned that, *"I am very religious and I take my Christian life very serious. I am able to give offertory and other donations to church. I believe I am able to help my church and community because I save a lot on my family's medical costs because of the NHIS subscription".* Moreover, a 26-year-old male student indicated that, *"for a student, any little money is good money. Savings on health costs through the NHIS allows me to spend a little on partying and socializing with my friends"*. Furthermore, a 31-year-old female indicates that, *"I was indeed surprised the last I was at the hospital when I didn't have to pay anything. I was able to buy gifts for my friend while attending her wedding ceremony".* Also, a 28-year-old female mentioned that, *"in our community, one good trait desired of people is their ability to support others in their times on need. Because I am able to save money through the NHIS subscription, I am able to attend funerals, weddings, church among others and also make donations".*

In essence, the NHIS has served as a means of accessing healthcare at no cost. Citizens, who were previously excluded from universal healthcare are now part of the healthcare system and are able to access health care when they are sick at no charge. The NHIS has promoted health inclusion in Ghana through active participation of subscribers in in the Scheme. The NHIS has succeeded in promoting the *human potential empowerment*, of subscribers as this perspective of social inclusion advances to maximize the potential of each human being, dwelling on models of possibility rather than deficiency and it stresses on empowerment as the main focus of social inclusion (Gidley et. al, 2010). The low-cost benefit of the NHIS that has eliminated out-of-pocket expenditure to subscribers, has also led to subscribers' financial inclusion in society by enabling them to save enough money which otherwise would

have been spent on full cost of health care. The extra monies are utilized towards their participation in social and cultural demands of the Ghanaian society (donations at funerals, weddings, church among others). In effect, the cost of healthcare is channeled to community activities that promote their inclusion making them socially relevant and curb social exclusion.

4.2 Does Quality Matter in Healthcare Access as a Promoter of Social Inclusion?

Wellbeing of people is significantly affected by the lack of participation in socio-cultural, economic, political activities and low empowerment (health-wise). On the social level Berkman and Glass (2000), mentions that people who live lives disconnected or isolated from others are more susceptible to living a shorter life compared to those who have better established social connections. Health in general (physical, emotional, and psychological) affects how a person relates with others socially. Therefore the importance of quality healthcare cannot be overemphasized. In many instances, access to such services alone may not be enough because the quality or poor quality may engender usage or deter access to healthcare, respectively. Thus, if services rendered under the universal healthcare system that ensures inclusion is sub-standard, users of the service may not patronize it. There is a tendency to possibly result in non-usage, which manifests as an exclusion in a different form. However, if the quality or perceived quality expected by users is available, high usage is expected, leading to inclusion.

The question of quality as a promoter of access and inclusion produced mixed responses. Thus, while others say the quality of care under the NHIS is good, others say it is inadequate. For instance, a 32 year old male trader stated that ‘‘*The quality of healthcare is satisfactory because you get the needed medication. Surgery (C-sections) is free under the NHIS, which used to be very expensive’’.* Another 30 year

old housewife stated that ‘‘*The quality of healthcare is still good under the NHIS. Health workers provide good services and also education on medication, exercise, etc.’’*. However, a 27 year old female nurse stated that ‘‘*The quality of healthcare on the NHIS is poor. This is because it does not cover some major surgeries and some medicines. You will still need to pay extra money for services (top-up).’’*

Also, a 29 year old female teacher stated that *‘‘Quality is very poor if you visit the hospital with your NHIS card. Those without the NHIS card are offered much better medical treatment because they have to pay money to the hospitals’’*. A 38 year old female teacher stated that ‘‘ *Quality of healthcare is somehow questionable, medications under the scheme are usually not original or very potent’’*. NHIS workers also expressed their opinions about the quality of the healthcare under the NHIS. For instance, a 30 year old male worker mentioned that, *“at the current state of the NHIS, the quality of service is good from my own observation. Care provided in health facilities to subscribers is similar to the ones non-subscribers receive with respect to services covered in the scheme”.* Besides that, a 31 year old female worker indicated that, *“Though I am a worker of the NHIS, my family and I are all covered and subscribed to the NHIS. If the quality was bad, we wouldn’t be on the scheme”.* Also, a 28 year old female worker was of the opinion that, *“Quality of service under the NHIS is generally good. That is why the number of subscribers has increased and it is still rising.”* However, on the contrary, a 35 year old male worker expressed that, *“I have been informed by some subscribers that they received poor quality of services under the NHIS”.*

These responses are not uniform. However, a critical analysis of this negative response is an indication of a possible lack of proper education on coverage of the

NHIS. Because the scheme does not cover some major surgeries, the respondent suggested it to be a lack of quality. Indeed, the scheme does not include some significant operations but might not be equated to the quality of healthcare for certain primary health issues. Similarly, an extra payment for medications is usually a common feature of most healthcare systems, even in advanced countries. Despite the few negative responses, there is still the suggestion that users are happy with the scheme and using it.

4.3 Evidence of Social Inclusion through NHIS-Progress of Subscription

The emerging theme from the interviews was the progress of the scheme in terms of the number of users. Ultimately, an increased number of subscribers is evidence of confidence in the scheme, inclusion, and promotion of social inclusion. NHIS workers mentioned that nationwide access to healthcare, has increased subscription of members to the scheme, and recognition of the scheme as a model for other African countries, among others, is testament to the importance of the scheme in social inclusion. For example, a 27-year-old male worker of the scheme stated that *''There is increased subscription. People now know the importance of the National Health Insurance Scheme (NHIS)''.* Also, a 30-year-old male respondent has this to say *''In the past, the scheme was mutual where clients could only access healthcare from three facilities in one region of the country but now; healthcare can be accessed nationwide across all facilities. Other countries have come to learn Ghana's model of NHIS because it has become very attractive and worth emulating*'' and ''*in the past, subscribers had to visit NHIS offices for subscribing to the scheme, but now there are outreach teams that go round to register clients and renew expired cards to promote inclusion*''. The view of a 35-year-old male worker was captured as **''***There has been a constant growth in membership or subscribers each year''.* The growth in numbers

alone is significant evidence of the importance of NHIS in achieving social inclusion for citizens. Also, a 28-year-old female worker stated that ‘‘*Enrollment under the scheme has been increasing yearly. This is actually great for the future of the scheme’’. The scheme has become a good model that some other African countries are emulating’’.*

Moreover, a 31-year-old female worker stated that ‘‘*The rate of subscription has increased since the NHIS started. Every year, the number of subscribers increases’’.* Such a significant increase in numbers is a testament to the growth of the scheme for the citizens in promoting social inclusion. In effect, Ghana’s NHIS programme has been instrumental in promoting ***social justice participation*** in healthcare (health inclusion). That is, the rise in subscriber base is an indication that Ghana’s NHIS continues to facilitate human rights to health, equality of health opportunity, enhancing the dignity of subscribers, and fairness, enabling people to participate in society while their dignity is respected as indicated by Langworthy (2008), and Saunders et. al, (2007). Previously, the health system was based on cash before healthcare, and this resulted in exclusion of those who couldn’t pay for healthcare services, but now the NHIS has addressed this concern by also providing the opportunity for participation in health care for the impoverished and vulnerable in the modern Ghanaian society.

4.4 Benefits of the NHIS in Promoting Social Inclusion

Social inclusion policies seek to ensure that users receive some benefits from its implementation. As a result, the study sought to understand the benefits derived from the implementation of the scheme to the users. All respondents agreed that the NHIS had been beneficial to users, ranging from removal of lesser financial burden, free antenatal and postnatal care, among others. Explicitly, a 25-year-old female sales

executive stated that *''It saves money''*. In comparison, a 38-year-old male trader stated, ''*Reduced cost of hospital bills due to the insurance'', quality drugs''* and *''lessoned financial burdens on users since the scheme absorbs some of the cost''*. Also, a 32-year-old male trader states that "*we the poor can go to the hospital whenever we are sick, and NHIS is very good for pregnant women because antenatal, labour and postnatal care are free under the scheme''*. A 27-year-old female nurse stated that ''*it is pro-poor as it reduces the cost of healthcare (pay less for healthcare). It has helped pregnant women from conception to delivery, and in case of emergency, the subscriber can access healthcare at affiliate hospitals nationwide''*. Moreover, a 32-year-old female teacher states that ''*You can visit the hospital whenever the need arises without thinking about you not having money if you have already enrolled unto the NHIS.'' ''Some surgeries are on the scheme. The burden of looking for loans before surgeries are done is now a thing of the past, and delivery of babies is free of charge''*. A 30-year-old female housewife states that ''*financially, I don't pay much of hospital bills as I used to when I was not enrolled in the scheme. Medications are also included for free in the services offered in the hospitals, and ''Because healthcare is almost free under the insurance scheme, I can attend hospital regularly for reasons of slight abnormality in the body for medical care or advice''*.

A 29-year-old female teacher states that *''The health insurance has been beneficial, especially to pregnant women. They are fully taken care of from conception to delivery free of charge''*. Also, according to a 38 year old female teacher "*when you are admitted at the hospital, the scheme covers almost all your medical bills, some medications are covered by the NHIS, now a subscriber can renew his or her card online and the contributions are cheaper for SSNIT registered staff and for children under 5 years and free antenatal and postnatal care''*. A 26-year-old male student

stated that *''it is very useful in times of emergencies when people are without money. The poor can attend hospitals anytime without worrying about what to pay at the hospitals''* and ''*It has helped many women to free healthcare from the time they conceive till the time they give birth and beyond''.*

The above indicates that all subscribers agree that the NHIS has been beneficial in several forms. More importantly, the poor in the Ghanaian society who couldn't afford healthcare and were excluded are now roped into the system. According to ILO, Social protection is when people and families have security against vulnerabilities and contingencies; it is having healthcare and also working in safety (Garcia & Graut, 2003). In the broader sense, social protection encompasses the dimensions of income security and availability of medical care (ILO, 2010). In view of the evidences indicated by participants, it can be argued that, Ghana's NHIS has been hugely beneficial and has greatly promoted social inclusion by ensuring that people from all walks of life have access to healthcare.

4.5 Challenges of the NHIS in promoting Social Inclusion

Subscribers report several challenges, including poor treatment by health professionals, non-inclusion of some essential drugs, and delay in activation of NHIS cards, among others, during the interviews. For instance, a 25-year-old sales executive states that ''*Some health facilities do not treat customers well, especially the government hospitals. They sometimes ignore people with NHIS cards and attend to those who are going to pay on the spot for healthcare''.* A 38-year-old male trader stated that ''*it does not cover some essential drugs that are costly''* while a 32-year-old male trader said that ''*it takes a long time to renew NHIS cards, and this becomes a problem if you need to visit the hospital as soon as possible''.* A 27-year-old female nurse had this to say ''*Problems after expiry of NHIS cards. It takes about a month*

for an expired card to be active again after renewal. And it is mostly a problem for the needy/poor people when they are required to pay extra money for accessing healthcare concerning a particular health condition that is not fully covered under the scheme''. A 32-year-old female teacher states that ''*Certain drugs are not covered under the National Health Insurance Scheme'.' ''You cannot visit facilities of your choice because they might not be on the scheme'.' ''The hospitals, especially the government ones are congested because everyone can visit those hospitals because of the NHIS scheme.'' ''Cheap drugs are sometimes offered if you are on the scheme'' and ''certain hospitals do not offer the best treatments because they complain the government does not pay them their entitlements on time.''*

A 30-year-old housewife states that *''Because healthcare and medication is free under the NHIS, there is always a long queue at the hospitals that causes a lot of time loss.'' ''The NHIS does not cover all medications and surgeries that are critical to healthcare. Clients are compelled to pay extra in most of the time.'' And ''Cards do not automatically become valid after renewal. It becomes active after a month, and this becomes a problem when subscribers need to go to the hospital as soon as possible.''* Also, a 29-year-old female teacher has this to say *''There is preferential treatment for those without the NHIS card. Cheaper medications are reserved for those who visit hospitals on the NHIS card because that is what the insurance can cater for. Whereas more potent and quality medicines are given to those who visit hospital with money to pay for services.''*

A 26-year-old male student states that: ''*Lack of more potent medicines under the NHIS. For very useful medicines, subscribers will have to pay more otherwise, they will be given basic medicines that mostly are not good enough'' and ''long queues at*

the hospitals (mostly government hospitals) because they are mainly taking the NHIS. You would have to wait for a very long time before a doctor can attend to you.''

Last but not least, a 40-year-old female trader states that ''*Difficulties in Access to healthcare after the renewal of NHIS card. It takes a long time for cards to be active again after renewal.'' And ''Not every medicine is provided under the NHIS. You will have to buy some medicines that are not listed or covered on the scheme.''*

The above therefore indicates several challenges that confront subscribers of the NHIS, which need resolution. If the ultimate objective is to achieve inclusion, these challenges could pose a threat and resort in a situation where subscribers may revert to the old system for convenience and ease of access.

Evidence from the staff on the challenges of the scheme is detailed as follows. Respondents stated that unstable internet, partly centralized operations, delay in the release of funds, inability to operate the NHIS software by some hospital staff, ID cards not bearing the date of validity, and the NHIS not covering all medical conditions among others. For instance, *''Internet (Network problems): This usually happens on Mondays and it is able to disrupt services for the whole day, which makes it difficult to register new subscribers and renew existing cards. Outreach teams for registration use specialized internet modems, and when they run out of data for browsing, it takes a few days for the NHIS Headquarters to restore it. When there is a data entry mistake that appears on subscribers' cards during registration, subscribers must provide their birth certificates and or passports to enable corrections that are done only at NHIS Headquarters, and that could take a whole month''.* Such is a statement of a 27-year-old male worker of the scheme. Also, a 30-year-old male worker has this to say, *''Now, there are delays in the release of funds for financing programs and activities concerning the scheme. In the past, when it was a*

complementary scheme, funds were locally and readily available, but now, that it has become a national scheme, memos must be sent to the Headquarters in Accra for funds to be approved and released to fund activities and programs''. A certain 35-year-old male worker states that **''***There is the problem of network that lengthens the waiting time during processing and issuance of I.D. cards for subscribers.'' ''Some staff at partner healthcare facilities are not well-trained in the operation of computer software for the NHIS, creating the problem of needless billing to subscribers which leads to a lot of complains at scheme offices.'' ''Newly issued I.D. cards do not bear the start and end date of the validity period. This creates the problem for clients to monitor when they need to renew their cards.''* Also, a 28 year old female worker of the scheme has this to say: ''*For field staff and data entry workers, bad internet network has been a major problem they encounter on weekly basis. This usually affects their work for whole day.''* "*Difficulty in effecting corrections for subscribers when there has been a mistake on their ID cards. Subscribers usually need to provide their birth certificates or passports and sometimes even affidavits to support need for corrections which are done at NHIS head office.*" Further, a 31-year-old female worker states that ''*Even though the scheme covers wide enough, the NHIS does not cover all health issues. This sometimes creates problem where subscriber's health conditions are not captured under the scheme while they expect to be treated for free under the insurance.'' "There has also been the technical problem of unstable network and internet access. This causes a lot of delays".*

Some of the challenges mentioned, such as internet access affecting the work of the staff, are operational. As a result, it is not directly emanating from or inherent in the structure of the scheme. Internet access could be a national problem because there are occasions of internet outages in various parts due to maintenance works. Though the

staff mentioned it as a problem, I can't entirely agree that it inhibits the proper operations of the scheme. Of course, it could be improved, but it is not an inherent feature of the scheme. One of the challenges that have the potential to cause exclusion is the long lead times for the renewal of the subscription to the scheme. As pointed out by staff, it takes quite some time for cards to re-issued, and this can cause people to lose faith and trust in the system. This was corroborated by the users of the scheme as well. In times of emergencies, if a card has not been renewed, users cannot access health service on the ticket of NHIS cards but will have to pay full cost of healthcare. Out-of-pocket expenditure on health keeps driving millions of people worldwide into financial catastrophe that leads a lot of people below the poverty line (WHO, 2010). It can be advanced that, lengthy lead-time for NHIS card renewals has the potential to cause financial burden to subscribers when they need to pay out-of-pocket or entirely lead to total health-exclusion.

4.6 Solutions to Challenges of the NHIS to Promote Social Inclusion

Subscribers recommend several solutions including educating health professionals on the need to relate well with patients, the inclusion of essential medicines in the NHIS scheme, instant activation of cards, making all health facilities NHIS providers, increasing the premiums to enhance the range and quality of services provided and making room for patients to book appointments/ make reservations before reaching the hospitals. Evidence indicates, *''health workers must be friendly and act professionally. Essential drugs must be covered under the NHIS, and doctor-patient ratio issue must be resolved with a sense of urgency''.* Also, a 25-year-old female sales executive states that *''they need to go around all health facilities and educate workers that we are all important people whether we have money to pay for services or we have to use our NHIS cards''.* A 32-year-old male trader states that ''*Cards*

should be instantly activated for use immediately after paying for renewal''. Further, a 27-year-old female nurse states that ''*the premium at subscription and renewals should be increased a little so that subscribers would not have to pay extra money for accessing healthcare in future for all health conditions and renewals must take effect immediately, instead of the one-month wait period to access healthcare''.* A 32-year-old female teacher has this to said *''all hospitals must be put on the scheme to avoid cheap congestion drugs should not be reserved for patients on the National Health Insurance Scheme''.* A 30-year-old female housewife states that ''*to avoid long queues and waste of time, reservations must be made in advance before a trip to the hospital. Also, emergency units in NHIS partner hospitals must be expanded to take up more clients at a time. Premiums must be increased a bit so the NHIS can adequately cover all forms of ailment, medications, and surgeries. Registration under the NHIS and card renewals must take effect immediately for people to access healthcare. Waiting for a month for a card to be active before access to healthcare becomes a problem when there is an emergency.* A 29-year-old female teacher had this to say ''*the government must increase his contributions allocated for the scheme, as well as a slight increase in contributions from subscribers so that better medicines can be prescribed to treat all medication conditions''.* A 38-year-old female teacher states that ''*There should be prompt communication of information concerning stock and availability of medicines and at which pharmacy. There must be strict supervision in the work of NHIS partners, especially those in the pharmacies''.* A 26-year-old male student has this to say, *''Government must make sure that the scheme becomes more attractive by raising the standards of medicines provided under the NHIS coverage.''* "*Government must entice more private hospitals to join the NHIS by paying their claims on time so that they would have enough money to run their*

facilities to absorb more sick people to reduce congestion at government-run facilities''. Similarly, a 40-year-old female trader states that *''NHIS cards must be immediately activated for healthcare once it has been subscribed to. Government must try to make sure that all essential medicines are covered under the scheme so that subscribers would not have to go and pay extra money for medicines when they are sick.''*

NHIS staff respondents suggest a number of solutions ranging from rapid restoration of internet connection, backup for internet data bundles, empowering other officers to correct subscribers' details, rapid release of funds to local offices, training staff at partner health facilities for them to be able to use the NHIS software, printing ID cards with date of validity and increasing premiums. For example, a 27-year-old male worker of the scheme recommends *''Rapid restoration of Internet or network challenges.'' "Backup plan for Internet data replacement or restoration." "Schemers must be granted permission to effect corrections after subscribers provide supporting documents right at the point of registration."* Also, a 30 year old male worker has this to say: *''NHIS Headquarters must work faster to make funds available to lower levels so that programs can be implemented on time.'' ''Some funds must also be set aside and at the lower levels that would rapidly be used to alleviate difficult situations which come about along the way.*''

One 35-year-old male worker states that: **''***Staff at partner health facilities must be well-trained to be able to adequately handle the computer software used to serve subscribers at the hospitals." "The problem related to internet/ network must be addressed as soon as possible to facilitate smooth operations of the NHIS staff." ''I.D. Cards must be printed bearing the date of validity of the cards so that subscribers and health facility staffs can easily check their validity.''*

Additionally, a 28-year-old female worker states that ‘‘*For speed and ease of work, permission must be granted for corrections on ID cards to be effected at various registration points provided relevant documents have been provided.’’ “Rapid restoration of internet/ network (backup plan) for work to resume soon enough to save work time*” Last but not the least, a 31 year old female worker states that ‘‘*premium paid for insurance must be increased slightly so that the NHIS can treat all forms of ailment and medications. Authorities must put in place measures to solve the internet and network problems that usually obstruct the work of the NHIS professionals’’.*

A cross-case analysis of the views shared by both subscribers and staff of the scheme indicated a concurrence in evidence. All respondents agreed that those issues mentioned if left unaddressed could hamper a smooth operation of the scheme and possibly lead to exclusion from participation in the NHIS or desertion. However, a solution to these issues would potentially strengthen the NHIS, facilitate its continuous growth and culminate into social inclusion in a wider sense through health care access.

4.7 Summary of the Chapter

This chapter presented results and findings on access to healthcare through the NHIS to promote social inclusion. Findings indicate that access to health services promotes social inclusion. Other benefits such as lower fees and ease of access to healthcare services through the NHIS promotes social inclusion. The poor in society, who hitherto could not access healthcare can now attend clinics at no charge. The result is enhanced inclusion of all citizens in the healthcare system. Despite these numerous benefits, the NHIS is fraught with challenges hat needs the resolution to ensure the continuous promotion of social inclusion.

CHAPTER FIVE

CONCLUSIONS, RECOMMENDATIONS AND FURTHER SCOPE FOR RESEARCH

5.0 Introduction

This chapter presents a summary of the findings of the thesis, suggestions for future studies, final comments, and recommendations for policy and practice. To place the results in context, it is vital to reiterate the objectives set in the initial phases of the research. The objectives set for the thesis included;

1. To examine general access to healthcare through NHIS as a way of promoting social inclusion.
2. To determine the social inclusion benefits (health-wise) accrued to NHIS subscribers.
3. To ascertain the key challenges confronting the NHIS in its quest to promote social inclusion.
4. To identify possible solutions to the challenges confronting the NHIS in its quest to promote social inclusion through universal healthcare.

5.1 Summary of Findings for Each Objective

This section presents a summary of the findings of the thesis based on the perspectives of the subscribers and scheme workers/providers. Concerning how the NHIS subscription has influenced access to healthcare and ultimately promoting social inclusion, the study found that almost all subscribers agreed that their ability to access healthcare had been enhanced due to the NHIS, which corroborates the views of all the workers. It was also found out that the ability to access healthcare at no cost ensures that they can save money for other social and community activities such as contributions to funerals. It promotes social inclusion because they can attend these funerals and perform their communal duties as the culture demands.

On the quality of care and promotion of social inclusion, there are mixed reactions on the part of both subscribers and scheme providers. Thus while others believe the quality of care is high because healthcare can be accessed nationwide for free covering a range of medications and health conditions, others believe that health personnel give preferential treatment to non-NHIS subscribers relative to subscribers. Also, others state that the medicines covered by the NHIS are not potent, while certain surgeries and drugs are excluded. Further, some providers pointed out that delay in releasing funds by the government has affected the quality of healthcare delivery under the scheme.

About the specific benefits of the NHIS, subscribers stated that NHIS has significantly reduced their health expenditure. Hence, they can access healthcare, including free medicines and surgeries anytime nationwide, to promote social inclusion because they can also enjoy some of these services, which were for a privileged few. Some subscribers specifically mentioned that the free postnatal and maternal healthcare are significant benefits of the scheme. On the part of the scheme providers regarding specific progress that have been achieved since the inception of the scheme, some stated universal access to healthcare, increased subscriptions, and the scheme becoming a model for other African countries as some of the main successes achieved. It was argued that these benefits fundamentally promote social inclusion in the Ghanaian society.

Concerning the challenges faced by the scheme, the subscribers stated poor treatment by health professionals, non-inclusion of some essential drugs and medical conditions, delay in activation of NHIS cards, and congestion in public health facilities as the main challenges confronting the NHIS. The service providers

suggested poor internet network, insufficient internet bundle, delay in the release of funds, the inability of local offices to correct subscribers' details, not printing the validity date on new NHIS cards, the non-inclusion of some medical conditions and the failure of some health personnel to use the NHIS software at the facility level as some of the significant challenges confronting the scheme. These challenges hamper service delivery and can affect the confidence of users in the scheme.

The participants proposed several solutions. With regard to solutions to the challenges confronting the scheme, subscribers recommended educating health professionals on the need to relate well with patients, the inclusion of essential medicines in the NHIS scheme, instant activation of cards, making all health facilities NHIS providers, increasing the premiums to enhance the range and quality of services provided, making room for patients to book appointments/make reservations before reaching the hospitals to avoid long queues and also expanding the emergency units of NHIS health facilities. On the part of the scheme providers, they suggested rapid restoration of internet connection, backup for internet data bundles, empowering other officers to correct subscribers' details, rapid release of funds to local offices, training staff at partner health facilities for them to be able to use the NHIS software, printing ID cards with date of validity and increasing premiums as some of the solutions to the challenges confronting the NHIS. It's argued that when these interventions are executed, the problems will be eliminated to ensure that services are delivered promptly.

5.2 Suggestions for Further Research

Given that this study solely used a qualitative approach, future research can be executed using quantitative methods or a combination of both to study how healthcare can promote social inclusion, which would help immensely in complementing the qualitative results. Similarly, other researchers that seek to promote social inclusion through healthcare can adopt this thesis and use it to guide further studies into an examination of the nexus between social inclusion and healthcare policies of various countries.

5.3 Final Comments, Recommendations for Policy and Practice

In all, from both the perspective of subscribers and scheme providers, the universal healthcare system adopted by Ghana has significantly enhanced access to healthcare by the poor and marginalized, thereby promoting social inclusion. However, efforts must be made toward improving the quality of care. Given the findings of the study, the following recommendations are made for policy and practice.

Firstly, efforts must be made toward ensuring instant activation of the NHIS card immediately after renewal to make subscribers access healthcare when needed. Thus, instant activation will forestall a situation of *"lack of subscription, no healthcare,"* which can lead to exclusion. Secondly, health professionals must be trained in good customer relations, which would improve their interactions with subscribers or patients. This has the potential to prevent non-patronage of the scheme due to disrespectful behaviors from some providers, which may lead to exclusion. Furthermore, increasing the premiums paid while taking into consideration the vulnerable should be done to widen the range of medical conditions and medicines covered under the NHIS. Doing so will go a long way in enhancing the quality of healthcare.

Timely release of funds to local scheme providers, as well as health providers by the NHIS headquarters, should be prioritized to enhance the quality of care. Thus, because the NHIS is indebted to some health facilities, some subscribers are ignored while attention and care are given to patients who are willing to pay cash. This ultimately will lead to a cash-based system if allowed to fester, with potential ramifications for social exclusion. The NHIS should collaborate with the telecommunication firms to increase the quality of their internet networks and get internet bundles at subsidized rates. Also, some autonomy should be given to local NHIS offices for them to effect corrections on subscriber's details provided the subscribers submit the required documents.

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APPENDICES

APPENDIX A: Informed Consent Form

(Form for research participant's permission)

Purpose: *This research is strictly for academic purposes and it is meant to aid in the conduct of a thesis required for the completion of Master of Social Science (social work) program at Nord University - Norway*

Title of research project: *Social Inclusion and Universal Healthcare Access: the Case of National Health Insurance Scheme in Ghana.*

1. I …… hereby voluntarily grant my permission for participation in the project as explained to me by ……..……..
2. The nature, objective, and possible implications have been explained to me and I understand them.
3. I understand my right to choose whether to participate in the project and that the information furnished will be handled confidentially. I am aware that the results of the investigation may be used for the purposes of publication.
4. Upon signing of this form, I will be provided with a copy.

Signed: _____ Date: _____

Researcher: _____ Date: _____

APPENDIX B: Interview Guide for Subscribers

This interview guide is to aid me conduct a research *about social inclusion and universal healthcare access: the case of National Health Insurance Scheme in Ghana.* I will therefore be thankful if you could give your views on the following questions. Kindly note that the project is for only academic purposes and any information provided will be treated with confidentiality.

Sex _____

Age _____

Educational level _____

Employment Status _____

Occupation _____

A. Access to Health Services

1. How would you describe your ability to access healthcare after enrolling on to the National Health Insurance Scheme?

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2. How would you describe the quality of healthcare after enrolling on to the National Health Insurance Scheme?

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B. Benefits of the National Health Insurance Scheme

3. What are some of the specific benefits that are associated with enrolling on to the National Health Insurance
Scheme?.....

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C. Challenges of the National Health Insurance Scheme

4. What are some of the specific challenges or problems that are associated with enrolling on to the National Health Insurance Scheme?

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D. Solutions to Challenges of the National Health Insurance Scheme

5. How can the above mentioned challenges or problems that are associated with the National Health Insurance Scheme be addressed?.....
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…… ……

APPENDIX C: Interview Guide for Providers and Scheme Managers

This interview guide is to aid me conduct a research about *social inclusion and universal healthcare access: the case of National Health Insurance Scheme in Ghana.* I will therefore be thankful if you could give your views on the following questions. Kindly note that the project is for only academic purposes and any information provided will be treated with confidentiality.

Respondent Category _____

Sex _____

Age _____

Educational level _____

Occupation _____

A. Access to Health Services

1. How would you describe peoples' ability to access healthcare after the implementation of the National Health Insurance Scheme?

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2. How would you describe the quality of healthcare provided under the National Health Insurance Scheme?

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B. Progresses Achieved after the Implementation of the National Health Insurance Scheme

3. What are some of the specific progresses attained after the implementation of the National Health Insurance
Scheme?.....……
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C. Challenges of the National Health Insurance Scheme

4. What are some of the major challenges or problems confronting the National Health Insurance Scheme?

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D. Solutions to Challenges of the National Health Insurance Scheme

5. How can the above mentioned challenges or problems that are associated with the National Health Insurance Scheme be addressed?**.....**……
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