Exploring the experiences of National Health Insurance Scheme subscribers and non-subscribers in accessing healthcare within the Accra Metropolitan Area

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Table of Contents

Table of Contents i
Chapter 1: Introduction *1*
1.1 Background **1**
1.2 Overview of Ghana's National Health Insurance Scheme **2**
1.3 Problem statement **3**
1.4 Research objectives **4**
1.5 Health promotion, health equity and social justice **4**
1.6 Outline of the thesis **6**
Chapter 2: Theoretical framework *7*
2.1 Introduction **7**
2.2 Integral Theory **7**
Chapter 3: Literature Review *11*
3.1 Introduction **11**
3.2 Literature search strategy **11**
3.3 General provision of health care (ITS) **11**
3.3.1 Global concept of National Health Insurance System 12
3.3.2 International Concept of Health Insurance (Africa) 13
3.3.3 Ghanaian National Health Insurance (NHIS) 14
3.4 The uptake of National Health Insurance Scheme (IT) **15**
3.4.1 Facilitators 15
3.4.2 Barriers 17
3.5 Collective attitudes to health and health care (WE) **20**
3.5.1 Collective perception of the NHIS 21
3.5.2 Alternatives to health care 21
3.6 Individual health seeking behaviour (I) **22**
Chapter 4: Methodology *24*
4.1 Introduction **24**
4.2 Research Design **24**
4.3 Data Generation **25**

4.3.1 Study site....25
4.3.2 Participants....25
4.3.3 Recruitment Strategy....27
4.3.4 Data Generation Methods....28
4.3.5 Data Management....29
4.4 Data Analysis....29
4.5 Ethics....32
4.6 Quality Assurance....33
4.6.1 Trustworthiness, credibility, dependability, transferability, and confirmability....33
4.7 Role of the researcher....34
4.8 Limitations....35
Chapter 5: Findings....36
5.1 Introduction....36
5.2 Findings from interviews with the main participants and key informants....36
5.2.1 Self-consciousness of health and motivation to subscribe to the National Health Insurance Scheme (NHIS)....38
5.2.2 Shared perceptions towards health and the NHIS....41
5.2.3 Behaviour towards health care and the NHIS....45
5.2.4 Governance and systems surrounding the NHIS and access to health care....49
Chapter 6: Discussion....55
6.1 Introduction....55
6.2 Discussion of findings and its implications using the Integral Theory....55
6.3 Discussion of findings using the Integral Theory as the framework....61
6.3.1 Self-consciousness of health and motivation to join the NHIS (I-quadrant)....61
6.3.2 Shared perceptions towards health and the NHIS (WE-quadrant)....62
6.3.3 Behaviour towards health and the NHIS (IT-quadrant)....63
6.3.4 Governance and systems surrounding the NHIS and access to health care (ITS)....65
6.4 Discussion of findings in relation to the literature....67
6.5 Discussion of findings in relation to Health promotion.....69
6.5.1 The dilemma of NHIS as a form of universal health care and health promotion....69
6.6 Limitation of the study....70
6.6.1 Participants....70
6.6.2 Challenges with conducting interview online....70
6.6.3 Theoretical limitation....71
Chapter 7: Conclusion....72

LIST OF TABLES

Table 1: Stratified Sampling of Participants. 27
Table 2: Summary of the themes developed during data analysis 37

LIST OF FIGURES

Figure 1: Integral model displaying four dimension of life (Lundy, 2010, p. 47) 8
Figure 2: NHIA Claims-Processing Flowchart (Wang et al., 2017). 20
Figure 3: An adaptation of the Integral Model. 31
Figure 4: Thematic Network Analysis of Data 32

LIST OF APPENDICES

APPENDIX 1: Interview guides 81
APPENDIX 2: NSD Ethical Approval Letter 84
APPENDIX 3: Informed Consent form 86

ABSTRACT

Maintaining the health and wellbeing of a nation largely depends on the state of health care policies and programs that guarantees citizens access to health care. Policies and social intervention programs such as the National Health Insurance Scheme (NHIS) should create an enabling operational environment for health institutions.

The study examines the experiences of subscribers and non-subscribers of the National Health Insurance Scheme in accessing health care in the Accra Metropolitan Area (AMA) in Ghana.

It identifies the challenges in accessing health care, the resources available to individuals and the other strategies individuals employ in accessing health care. A combination of primary and secondary sources was used to collect data for the study.

Using a qualitative research design, twelve participants were sampled using a stratified sampling technique. Interviews conducted revealed that many participants had negative experiences in accessing health care with the National Health Insurance Scheme (NHIS). Delays in registration processes, long queuing systems at health centres and delays in reimbursement of health centres by the government were some of the core challenges that led to these negative experiences in accessing health care.

As a result, many people resort to alternative means to cater for their health needs. The study further revealed that some people utilized the formal health care facilities only in critical conditions due to past negative experiences and perceptions around accessing health care with the National Health Insurance Scheme (NHIS).

However, the NHIS was seen or perceived as an important mechanism for removing financial barrier to achieving equitable access to health care for all citizens in Ghana. The results further showed that the NHIS has improved access and benefits to maternal and child health services.

The study concluded by advocating for an improvement and a rebalance of efforts by decision makers to inculcate more health promotion approaches or concepts in making policies concerning public health.

Keywords: *Health care, health insurance, universal health care, experiences, access to health care, health seeking behaviour, Ghana*

List of Acronyms and Abbreviations

NHIS	National Health Insurance Scheme
SSNIT	Social Security and National Insurance Trust
CHAG	Christian Health Association of Ghana
DHIS	District Health Insurance Scheme
NHIA	National Health Insurance Authority
LMIC	Lower- and Middle-Income Country
CBHI	Community Based Health Insurance
NSD	Norwegian Centre for Research Data
SDGs	Sustainable Development Goals

Chapter 1: Introduction

1.1 Background

Health is an essential element for human survival and ensuring access to quality health care is deemed a necessity and a fundamental driver for society and economic growth. Issues pertaining to health are major concerns to every society and its members. In the absence of health, one is bedevilled by sickness either physical or mental. It is mentioned by scholars such as Marmot, Friel, Bell, Houweling, and Taylor (2008) that the wealth of nations depends on the health of its citizens and therefore, health care provision and accessibility are a major concern for development. The United Nations (1948) defined Health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The universal access to good health care remains a major concern of health systems globally. In view of this, target 3.8 of the Sustainable Development Goal (SDG) goal 3, aims to achieve universal health coverage including financial risk protection, access to quality essential healthcare services and affordable essential medicines and vaccines for all (World Health Organization, 2016). It is worth mentioning that this represents a more western-style or formal health care system, which fails to include other forms of traditional or local context of health systems. In a resource constrained setting such as low- and middle-income countries (LMIC), traditional health care systems or medicines are the main form of primary health care. For many people within LMIC, traditional medicine is culturally embedded in their daily health seeking behaviour and it is an important component of health care and in some instances it is the only available and affordable health care option especially in remote areas (Park & Canaway, 2019).

Universal health coverage can be defined as providing financial protection from the cost of using health services for all people of a country as well as enabling them to obtain the health services that they need, where these services should be of sufficient quality to be effective (McIntyre & Kutzin, 2016). It is eminent that this definition embodies equity, quality and financial protection in the use of health care services. Universally, raising funds for health insurance is either mandatory or voluntary. According to McIntyre and Kutzin (2016) Mandatory or compulsory comprises of general revenue from central or local government sourced from taxes levied on individuals and firms (direct taxes), or taxes levied on consumption such as value added tax (VAT). Voluntary health insurance structure is typically health insurance schemes that may be run by communities or for-profit or non-profit entities.

According to Fenny (2017), Mtei et al. (2012) over the last 20 years, many countries have been looking at possibilities of introducing and expanding health insurance coverage, implementing effective exemption mechanisms for those who are unable to pay, and improving tax collection and allocation to health care. This model has been in line with the World Health Organisation's (WHO) policy to include health insurance as a tool for financing health care in all countries (World Health Organization, 2000). The primary explanation was that prepayments and financial risk pooling within health insurance can ensure the utilization of a fairly distributed and quality access to health care services to the insured at affordable rates on the basis of their ability to pay the premiums (Macha, Kuwawenaruwa, Makawia, Mtei, & Borghi, 2014).

Though health spending in low-and-middle income countries (LMIC) is mainly financed by government budget and personal financing where patients pay directly to health care providers also known as out-of-pocket payments. In certain LMICs like Ghana, alternative programs such as the Livelihood Empowerment Against Poverty (LEAP) programs are used. According to Alatinga, Daniel, and Bayor (2019), it was implemented on a pilot basis in Ghana to provide conditional and unconditional cash transfers to extremely poor households in order to enable people to meet their basic needs and empower them. Participants in the LEAP program reported that, the program made them better off in many dimensions including removing financial barriers to access health care. It is worth mentioning that this was in a rural setting. On the other hand, in a more urban or on a global scale, other health financing mechanism such as a National Health Insurance Scheme (NHIS) is adopted to ensure universal access to quality health care. Health Insurance is the coverage against the risk of incurring medical and related financial costs (Ho, 2015). It is one of the ways that people in various countries pay for their medical needs. There is a growing argument as well as evidence that the introduction of health insurance, leads to improvement in peoples' access to healthcare especially among the poor (Berk & Monheit, 2001).

1.2 Overview of Ghana's National Health Insurance Scheme

In 2003, Ghana passed the National Health Insurance Act (Act 650), and it became fully operational in 2005. The scheme was operated as a decentralised social health insurance system involving district wide mutual health schemes. It was implemented to make healthcare more affordable and accessible for Ghanaians and in turn to also move Ghana towards achieving a universal coverage as stated in SDG 3. The scheme enables persons resident in the country to access basic health care services without paying money at the point of delivery of service.

The National Health Insurance Scheme (NHIS) sought to make health care cost effective to all. It replaced the cash-and-carry system that was established in 1985 under the hospital fee Act. The NHIS is a kind of social health insurance that adopts a method of prepayment of financial contributions for healthcare, this pre-paid mechanism collects funds through taxes and insurance contributions which allows people to access services when needed (WHO, 2005). The minimum benefits package of the NHIS include outpatient and inpatient care, maternal care diagnostic tests, generic medicines and emergency care, many dental and eye services as well as the cost of general ward and meals. The scheme generally covers 95 per cent of the health problems confronting Ghana.

1.3 Problem statement

The introduction of NHIS resulted in high general healthcare spending by government and reduced share of private and out-of-pocket spending. Although it reduced out-of-pocket expenditures over the years, the financial protection in Ghana's health system has been inadequate (Schieber, Cashin, Saleh, & Lavado, 2012). Government's investment has not been enough to meet the rising healthcare costs. Funding inadequacy has therefore led to hospital commercialization. Hospitals are then compelled to increase service prices to generate funds for maintaining medical equipment's and general administration. High cost of out-of-pocket expenditures on health care eventually devastates socio economic status of households (Novignon, Olakojo, & Nonvignon, 2012). The Ghana National Health Insurance Scheme (NHIS) was established to ensure an improvement in the access and quality of basic healthcare services for citizens, especially the poor and vulnerable. This form of social protection system was intended to provide a relief for healthcare expenditure problems. However, after more than ten years, less than forty percent of the population are enrolled in the scheme (Agyepong et al., 2016). More often than not, attention is usually drawn to the challenges confronting the operation of the NHIS. Challenges such as delays in reimbursement claims, misappropriation of funds, increase in utilization of healthcare facilities by insured patients without corresponding increase in staff and health facilities. On the other hand, little is mentioned on experiences and the coping mechanisms of both subscribed or non-subscribed alike, in accessing and utilizing healthcare services. An attempt to understand a close range of experiences and opinions of health care seekers will aid in exploring both real and out of sight problems that confront the implementation, continuity, and sustainability of a social health intervention program such as the NHIS.

1.4 Research objectives

- This research aims to explore the experiences of subscribers and non-subscribers of the NHIS in accessing healthcare in Accra Metropolitan Area, Ghana

Sub-Objectives

- What are the challenges of enrolling and accessing healthcare with the NHIS?
- What are the resources available to individuals or households in accessing healthcare?
- How do experiences of subscribers and non-subscribers of NHIS differ in accessing healthcare?
- What other strategies are used in accessing healthcare within the Accra Metropolitan Area?

1.5 Health promotion, health equity and social justice.

An understanding of the experiences of people in accessing health care with the NHIS has some practical implication for the development of health promotion in these current times. Health promotion as defined by the World Health Organization (1986) in the Ottawa Charter is the process of enabling people to increase control over and to improve their health. It is worth noting that good health is not only determined by a single factor, a variety of factors such as social, environmental, and economic conditions have an impact on health. These factors not only impact health but can also make it easier or more difficult for people to make changes to their health. Health promotion attempts to improve health not only by targeting people at an individual level to change their behaviour but by taking a comprehensive approach in addressing a broad spectrum of health factors and determinants. Over time the importance of Health promotion has received global attention and the creation of the Ottawa Charter has been influential in providing guidance to the goals and concepts of Health Promotion. The Ottawa Charter describes three strategies required for a secured foundation in improving health and five action areas to achieve health. The strategies are to advocate, enable, and mediate. For the purpose of this study, I only focused on one of the action areas; Building healthy public policy. This is a process of developing policies that support health. This is done by a coordinated approach of legislative, regulatory, organizational, and taxation changes. These are made by all levels and sectors of government and other organizations.

Health promotion emphasizes on health care being a common good and not a market commodity (Marmot et al., 2008). However, the healthcare system as we know it now is not reflective of this concept. Currently, there is still a huge gap of health inequity which is better understood through the social determinants of health framework. This huge gap has been identified as a social injustice with an ethical imperative inviting more countries to have conversations on how to close this gap (Marmot et al., 2008). The social determinant of health gives insight into how specific factors play key roles in affecting one's health. For example, one's job status is a very key determinant of health as this can affect their financial security, social status, social relations, and psychosocial hazards (Marmot et al., 2008). Although, only having a job does not guarantee an individual good health. Things like the nature of the work and employment conditions also factor into the individual's overall health (Marmot et al., 2008). The social determinants of health framework also explain how geographical regions can affect one's health. Individuals in African countries are expected to live less than 50 years in comparison to people in Japan who could expect to live more than 80 years. This unequal distribution of health experiences is attributed to a combination of poor social policies and programmes, unfair economic arrangements, and bad politics. This creates the structural determinants of health that continues to increase the health inequity gap between and within countries. A very practical and more vivid example of this structure is with the COVID-19 pandemic the world is presently facing. Countries with better public health policies have been able to manage the pandemic better than other countries without them. Some countries like Norway and some European countries were able to allocate emergency funds to support certain individuals which sheltered them from the health outcomes of the COVID-19. The research shows that four in every five people worldwide lack basic social security coverage that comes from people having to go through vulnerable periods such as the pandemic, disability or loss of job and income (Marmot et al., 2008).

Although, these outcomes are explained by the social determinants of health it holds no solutions as to how this could be changed. The health promotion paradigm states that if systematic difference in health for different groups of individuals are avoidable by reasonable action then their existence is unfair and creates health inequity (Marmot et al., 2008). Meaning health outcomes created by the lack of health equity policies and actions creates an unfair disadvantage for individuals who suffer from this inequity. The paradigm proposes a comprehensive approach that first acknowledges that there is a huge health inequity issue that needs to be addressed. The paradigm also proposes an approach which will also have to include the whole government, civil society, local communities, businesses, and international agencies (Marmot et al., 2008). It will also have to be comprehensive enough that it does not solely seek to focus on the health of the individual but other factors that affect the health of the individual.

The health promotion paradigm in practice supports universal coverage and access to health as a social justice issue making it relevant to this research as well. The NHIS in Ghana was created as a way to somehow close the health inequity gap amongst the people in the country. However, over the years the different social policies that have been in support of this initiative has not seen a lot of improvements from the review of literature. Although, the research focused on the experiences of subscribers and non-subscribers in the NHIS, it also gives context to how health promotion as a paradigm is important to informing all public health initiatives.

1.6 Outline of the thesis

This thesis is organised into seven chapters. This introductory chapter outlined the background for the study by defining the necessary concepts. This is followed by an overview of Ghana's National Health Insurance Scheme, the main research problem, and the research objectives. Chapter one concluded with a brief overview of Health Promotion, Social Justice, and Health Equity.

Chapter two presents the theoretical framework for this study. Ken Wilber's Integral Theory is used in demonstrating the integrated nature of this study involving the experiences of individuals, communities, and health systems within the health care sector.

Chapter three covers relevant academic literature relating to aspects of health care, health insurance, and experiences of individuals in accessing health care.

Chapter four presents the appropriate philosophical foundation for this study followed by the research methodology including the research design, methods, data generation and data analysis.

Chapter five provides the empirical findings from the interviews conducted. These findings are then further discussed with their implications in detail in Chapter six.

Lastly, chapter seven concludes with a summary of key findings and recommendations.

Chapter 2: Theoretical framework

2.1 Introduction

In this chapter, a brief introduction to the theory that framed this study is discussed, demonstrating a summary of its basic ideas or concepts and how these concepts are relevant and suitable in providing a framework for analysis of this study.

2.2 Integral Theory

Taking into account the integrated nature of this study, involving the experiences of individuals, communities and systems; Ken Wilber's Integral Theory is relevant to present a holistic framework in understanding the experiences of subscribers and non-subscribers of the National Health Insurance Scheme in accessing health care. According to Esbjörn-Hargens (2010, p. 34). Integral theory is the comprehensive study of reality which weaves together the significant insights from all the major human disciplines of knowledge acquisition. These include the natural and social sciences as well as the arts and humanities. Integral theory also identifies a variety of key areas of human experiences (Lundy, 2010, p. 46)

A framework such as this is vital in understanding the experiences people have with health systems in accessing healthcare. Integral theory consists of five core elements, these include quadrants, levels, lines, states, and types. However, for the purposes of this study, I used only quadrants as a framework and analytical tool for understanding the multidimensional and interlinked issues around experiences in accessing healthcare. This aided to frame a holistic picture of these experiences, cutting across the interior, exterior, individual and collective perspectives (Lundy, 2010). These are the four irreducible perspectives that must be consulted when attempting to fully understand any issue or aspect of reality (Esbjörn-Hargens, 2010). Two axes frame the four quadrants. The vertical axis shows the individual at the top and the collective at the bottom. The horizontal axis shows the interior at the left and the exterior at the right (see Figure 1). Putting these two axes together creates a simple model of four quadrants: the individual interior (Subjective or I); the collective interior (Intersubjective or We); the individual exterior (Objective or It) and the collective exterior (Interobjective or Its). These are explained systematically in the next paragraph.

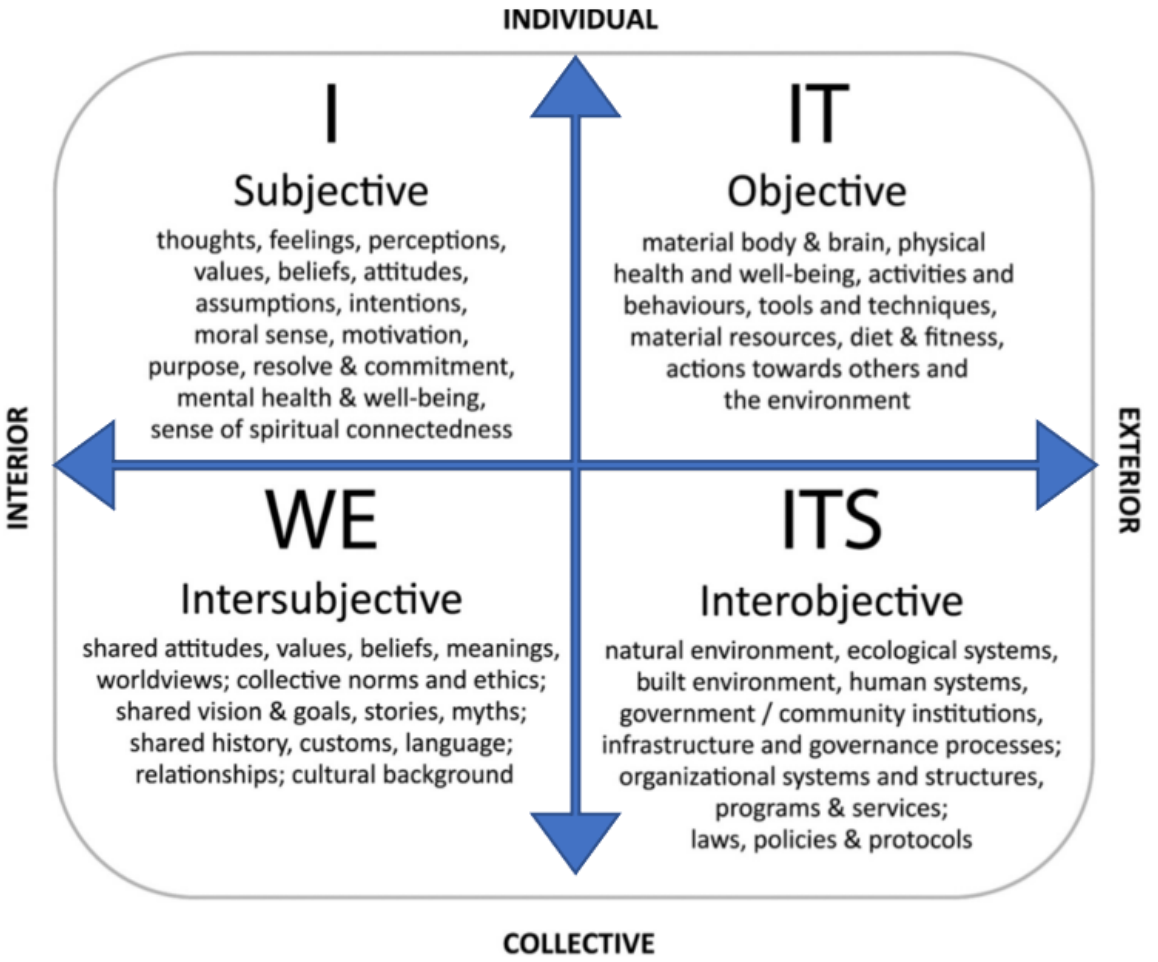

Figure 1: Integral model displaying four dimension of life (Lundy, 2010, p. 47)

Quadrants, an element of the Integral theory, represents the dimensions of human experiences. It also takes into consideration the subjective experiences as well as the objective experiences and pays equal attention to the individual and collective perspectives. Thus, demonstrating the complexity of interrelationships between and among individuals, organizations and communities, which in this case represents individual or collective experiences, beliefs or perceptions and health systems in accessing healthcare either in the formal or traditional system (Lundy, 2010).

The I-Quadrant in the upper left describes the interior individual or the subjective experiences. It aids in understanding an individual's own thoughts, perceptions, and motivations. The world of our inner individual, experiences, emotions, memories, and state of mind is described in this quadrant. In relation to this study, it helped in understanding what health means on a personal basis and also what drives a person to enrol on the national health insurance scheme or not. It

aided in understanding what drives an individual to even access healthcare in a hospital or traditional health system regardless of their health insurance status.

The We-Quadrant in the lower left focuses on the collective interior or intersubjective experiences. It explores the shared aspects of the inner collective including shared values, meanings, family, and relationships. It is also the culture, social norms, assumptions, and worldviews shared by a group. There is a community identity in the beliefs and meanings associated with a phenomenon. In this case, it aided in understanding community consciousness, beliefs, and shared attributes towards healthcare and the NHIS.

The It-Quadrant, found in the upper right describes the individual exterior or objective activities and behaviour. The exterior parts illustrate behaviours and skills one has learned and exhibits. They are the things we can see and touch or observe scientifically in space and time. These are visible in practice. Thus, they are actual actions an individual takes towards their health care. This quadrant guided the study to understand which individuals sought which type of health care, for example pregnant women seeking antenatal care.

The Its-Quadrant which is the lower right examines collective exterior or the interobjective. These are the outer collective things like governance processes, organizational systems, structures, networks, and policies put in place to ensure the proper functioning of a system. This aided in exploring health systems, laws, policies, programs and health care services that are available in accessing health (Lundy, 2010).

The Integral Theory is comprehensive, inclusive, balanced not leaving anything out. The map makes room for all forms of action and inquiry, and the evidence they generate.(Lundy, 2010, p. 46). The four quadrants explore relational patterns generated by multiple interactions. For example, I to IT: a person's beliefs about health care (I) might motivate him or her to actually go to the hospital to seek health care (IT). A good experience at as result of going to the hospital (IT) might reinforce the personal belief (I). ITS to IT: Policies and organizational systems and structures (ITS) when well enforced and implemented might encourage people to visit and utilise health care facilities (IT) rather than resorting to other means for their needs. (WE to IT): Shared attitudes and beliefs within a group or community (WE) might motivate people to seek health in a particular way. (ITS to WE) and (ITS to I): The nature of policies on health care turn to shape the experiences and perception of individuals and groups.

Thus, all four quadrants are linked and interact in a number of ways to bring an outcome or experience. The capacity to use these quadrants and understand the closely linked and

interrelated web of connections aided this study in exploring the experiences of people in accessing healthcare regardless of their health insurance status.

Locating aspects of health care within these four quadrants and addressing them through all possible interactions is likely to lead to a fully integrated understanding of my main objective to explore the experiences of subscribers and non-subscribers of the National Health Insurance Scheme in accessing healthcare. The use of the four quadrants in this model covers all aspects of this study.

Chapter 3: Literature Review

3.1 Introduction

This chapter focuses on empirical research relating to aspects of health care, health insurance, experiences of people in accessing health care and health seeking behaviour. An inquiry or examination of current and relevant literature aided in informing and contextualising my research. This facilitated a meaningful discussion of my findings in relation to other studies.
The literature review followed a structure that draws a connection between theory and available literature. The review is in four phases in accordance with the theory discussed in chapter two. The first part addressed the outer collective processes (ITS). i.e., governance, organisational systems, and structures that are put in place to ensure the proper functioning of the health systems. The second part addressed the outer individual (IT). i.e., the facilitators or resources available to individuals in addressing their health needs and the barriers that hinder their access to health care. Thirdly, the inner collective (WE) focused on the inter subjective experiences of people in accessing health care i.e., the perceptions of health insurance policy holder and the alternative beliefs, norms and values people share in accessing health care. Finally, the inner individual (I) or the subjective experiences and personal health beliefs of individuals towards their health are reviewed accordingly.

3.2 Literature search strategy

An electronic search for academic articles were searched from Oria (University of Bergen Library database) as well as Google Scholar. With regards to inclusion and exclusion criteria, I considered only published peer-reviewed papers because the author's scholarly work, research or ideas have been subjected to scrutiny of other expects in the same field and are of accepted high standards as compared to unpublished papers. I limited my searches to literature published in English. To ensure reliability, relevance, and concurrency I gathered literature published within the last ten years, between 2011 to 2021.
The keywords I utilized in the scope of research included: Health Insurance, universal healthcare, access to healthcare, health insurance premiums, private insurance, challenges to health, education, health seeking behaviours, and enrolling in universal healthcare. These search words informed some of the underlying themes in different sections of the review.

3.3 General provision of health care (ITS)

The following sections give an overview of different health systems on a global level in order to provide a general understanding of the various health systems that some countries adopt. The subsequent sections funnelled down health care systems in Africa and then Ghana. The

use of this structure is to identify how the "ITS" quadrant of the integral theory shapes human experience in areas such as health.

Governments are usually responsible for providing health care to the population. They play a central role in setting policy agenda and service requirements for health systems within a country. Some governments totally or partly finance social health insurance for basic or primary health care through subsidies from general taxation and reallocation of payroll levies (Mossialos, Wenzl, Osborn, & Sarnak, 2016). Social health insurance policies are believed to be primarily linked to the concept of health being a form of human right (Yamin, 2017). However, across the review of the literature, the most commonly identified reason is based on equal access to healthcare as well as reduced healthcare costs. The implementation of social or universal health care is required to adhere to all basic health care needs as well as coverage with good health services. These health services should not be limited in function and should include other services like rehabilitation and palliation (Evans, Hsu, & Boerma, 2013). Conversely, there has been more arguments on if the goal of these health insurance schemes should be universal health coverage or universal health access. These two concepts seem to be working independent of each other seeing how universal healthcare is being implemented in countries such as Ghana, where national health coverage does not necessarily mean national health access (Evans et al., 2013). Authors such as (Evans et al., 2013; Fusheini, 2016; Ridde, Queuille, & Ndour, 2014), believe universal health coverage is attained when people can access necessary health services while benefiting from financial risk protection. Although, different countries are still taking the steps to achieve this form of healthcare other negative factors have been identified in the process affecting the full functionality of social or national health care insurance schemes.

3.3.1 Global concept of National Health Insurance System

In an article by Katuu (2018) a statement is made about how a country's system is not a product of one logical policy-making experience but rather a manifestation of many years of historical development. This statement holds a lot of weight in the evolution of some healthcare systems introduced in this section of the literature.

National Health Insurance Schemes are used elsewhere globally and in Africa. Countries like Germany, UK and the Netherlands are known to be some of the few developed countries that adopted a form of universal health care post World War two. Other countries like Canada joined in the later years. These countries adopted two different models of health care insurance (Maioni, 2015, p. 80). The *Beveridge* model, which was developed in Britain, where general

revenues of the state were used to fund more centralized healthcare systems (Maioni, 2015). This model is used by the British, Swedish and Italian health care system (Maioni, 2015).
The second model is known as the *Bismarckian* model, which is characterized by social insurance, meaning insurance coverage is compulsory for all workers in the country (Maioni, 2015). Everyone is required to contribute into a designated fund usually based on income with provided governments exemptions for individuals who may not be in the labour market (Maioni, 2015). Most health care systems follow either of these models, though countries like Canada have similarities to Germany, it does not necessarily conform to either of these models. Canada is considered a big spender in health care since 11% of its GDP is devoted to health care (Maioni, 2015). Both Canada and Germany's universal health care is financed publicly. Some similarities include the way physician care is delivered and paid for which is by a fee-for-service for outpatient care. The differences include the ability for provincial government to alter their health insurance policies to meet specific provincial needs without federal government interference in Canada unlike in Germany where everything is fixed through the federal government. Secondly, Canada funds its universal health care through a tax-based system while Germany uses a system where workers contribute to a sickness fund which is somehow limiting for individuals who may not be employed. Canada's healthcare system also allows for additional private insurance for amenities not provided through the universal health care such as assistive medical devices. Most German health workers are paid through the government with minimal to no connection with the private sector (Maioni, 2015). Both countries offer a different scope on the functionality of national health insurance schemes. They illustrate the different advantages and disadvantages that could potentially arise with the use of these models, which can also be further explored as an issue to the effective provision of healthcare.

3.3.2 International Concept of Health Insurance (Africa)

African countries have tried to implement certain models of free healthcare into their health system in different capacities. Countries like Mali made malaria and caesarean section free for all its citizens, while Burkina Faso also implemented subsidized deliveries (Ridde et al., 2014). However, on the intracontinental level of the functionality of universal health care systems, South Africa was the main focus. The South African health system is described as a two-tiered system which is divided along socioeconomic lines (Republic of South Africa Department of Health, 2017). It is classified into Public Healthcare and Private Healthcare. The public healthcare is primarily funded by the government giving its citizens free access to healthcare (Republic of South Africa Department of Health, 2017). The literature available does not

discuss specific information on how the South African health system is funded but it provides insights on an ongoing discussion for the need to implement a National Health Insurance fund (NHI) (Katuu, 2018). The introduction of the fund was set to begin testing within the years of 2012 to 2025 yet there has been no information on the inauguration of this fund (Katuu, 2018). The South African free healthcare system includes all forms of care including the supply of wheelchairs, crutches and home care visits, services which are usually at an extra cost for other countries with similar health systems (Republic of South Africa Department of Health, 2017). Knowing that South Africa has a large number of low-income citizens this form of healthcare complements the need of the people.

The private sector serves as an optional form of access to healthcare, where individuals opt to pay for private insurance premiums. Individuals who purchase these premiums must only access health care through private health facilities. These premiums are expensive, so South Africa is known to have more public than private hospitals (Republic of South Africa Department of Health, 2017). In the private sector all other surplus expenditure such as the wheelchairs, crutches, pharmaceuticals, and home visits all come at additional costs to the individual. Although, there are pros and cons to both tiers, they cater to the different population demographic of South Africans as needed. Although, the funding of the healthcare system is still an ongoing conversation, the literature revealed other observations within the healthcare system in South Africa that posed as a challenge to the effectiveness of the public system. These observations ranged from issues with wait time to the medical equipment's used as well as the use of laboratory samples (Republic of South Africa Department of Health, 2017). These issues show the gap within the system and how this could affect patient experience with accessing healthcare.

3.3.3 Ghanaian National Health Insurance (NHIS)

This section of the literature review, narrowed down into Ghana to provide an overview of the National Health Insurance Scheme. It also helped to form a basis to explore other parts of the study. The implementation of the NHIS in Ghana started between 2003 and 2004 to replace out of pocket fees at point of service as a more equitable and pro-poor health financing policy (Kusi, Enemark, Hansen, & Asante, 2015). It is publicly financed by a national health insurance fund, which has three main sources (Kusi et al., 2015). The first making up about 70% of the fund is a 2.5% value added tax (VAT) known as the National Health Insurance Levy. The second is a Social Security and National Insurance Trust (SSNIT) which makes up about 20-25% of the fund. The SSNIT fund is financed by contributions from employees in the public and private formal sector. SSNIT contributors do not pay an out-of-pocket premium because

of direct income deductions. The last form of funding comes from out-of-pocket premiums ranging between GH7 ($1.20) to GH48 ($8.29) for members who do not pay through the SSNIT due to being informal sector workers (Kusi et al., 2015). There is also an annual registration fee of approximately GH4 ($0.70) currently GH 25 ($5.50) for all members enrolled under the NHIS however, the government has specific categories for exemption from these fees (Kusi et al., 2015). Persons who are exempted from these premium fees must identify under one of these four criteria's: (i) the person is unemployed and has no visible source of income, (ii) does not have a fixed place of residence according to standards determined by the scheme, (iii) does not live with a person who is employed and who has a fixed place of residence, (iv) does not have any identifiable consistent support from another person (Kusi et al., 2015). These criteria's have been described as very strict since very few people in Ghana fit into either of these criteria's, however, many people still have difficulties in paying the SSNIT out-of-pocket premiums (Kusi et al., 2015). The issue of paying premiums is seen as a major gap to the steady enrolment in the NHIS since these criteria eliminate a good percentage of the population's informal workers who lack the means to pay.

3.4 The uptake of National Health Insurance Scheme (IT)

As mentioned earlier, there are certain facilitators and barriers that influence the uptake of the national health insurance scheme by individuals and households. This section reviewed literature on some key facilitators or resources available within the healthcare system in Ghana and how they also contribute to the strength and improvement of the healthcare system and subsequently reviewed the uptake of NHIS through the lens of quality assessment. The lack of quality assessment has served as a form of barrier to accessing healthcare with the NHIS. This part of the literature depicts the objective or "IT" quadrant i.e., available resources to access health, actions, or behaviours toward health care.

3.4.1 Facilitators

In regard to the healthcare infrastructure or resources in Ghana there are an estimated 3,500 public, private, and faith-based health care facilities (Wang, Otoo, & Dsane-Selby, 2017). Fifty-seven (57) percent of these facilities are public, thirty-three (33) percent are private, and seven (7) percent are operated by the Christian Health Association of Ghana (CHAG) (Wang et al., 2017). These healthcare facilities are said to include compounds, health centres, clinics, maternity homes and seven (7) types of hospitals i.e., district, municipal, metropolitan, regional, teaching, psychiatry and uncategorized (Wang et al., 2017). The research shows that

as of February 2016, an estimated 104,652 healthcare workers were employed by public and CHAG facilities with nurses making up a significant percentage of these numbers (Wang et al., 2017). This shows the importance of the roles of the nurse since they are most likely to be an initial source of care in the chain of healthcare provision services. There is no data available to show how much of these numbers is also reflective in private facilities. Most healthcare professionals are nurses (59%), followed by trainees (13%), allied health professionals (13%), physician assistants (4%) and doctors (4%) (Wang et al., 2017). These statistics give you a perspective of what the healthcare structure looks like in terms of healthcare workers to patient ratios as well as availability of healthcare personnel to cater to the country's health care needs. The literature gave an interesting perspective on the distribution of this workforce. These healthcare workers are distributed fairly across the different regions in the country. Conversely, heavily urbanized regions like the Greater Accra region and sparsely populated Upper East and Upper West regions are outliers to this trend (Wang et al., 2017). The Greater Accra region has a high number of healthcare workers per capita due to the concentration of doctors in that area while the Upper East and Upper West regions have high numbers of health workers per capita due to their low population density (Wang et al., 2017). The other regions are said to have between 2.5 and 2.9 healthcare workers per 1000 people (Wang et al., 2017). These statistics not only invite the conversation of healthcare workers to patient ratios as an important part to the effectiveness of a healthcare system, but it also shows how the distribution of healthcare services in a country could shape different patient experiences in different areas.

This distribution trend cannot be said to be true for the private sector, as there is no available data, making estimates a bit skewed as the private sector also play a huge role in the Ghanaian healthcare system.

According to Adebayo et al. (2015), several factors influence people to subscribe to health insurance to seek treatment a formal health facility. They identified the quality of health care and the use of modern medicine as key factors that influenced the uptake if the scheme by individuals.

A major attributing success to the implementation of the NHIS is its relationship with maternal and child death experience. The issue of maternal and child health was very prevalent in Ghana and the introduction of the NHIS helped reduce the growing effect of this issue. The maternal mortality rate dropped from 580 per 100,000 live births to 350 per 100,000 live births after the implementation of the NHIS (Singh et al., 2015). The children under five mortality rates decreased from 122 per 1000 live births to 78 per 1000 live births (Singh et al., 2015). In full retrospect the issue of maternal and child heath in Ghana is far from being eradicated but the literature has provided an example of its improved success through the NHIS.

This section provided a brief overview of the different healthcare systems and that of Ghana. It also showed how implemented structures can affect an individual's experience in health care. The implementation of the right policies, laws and building of the right governmental and human systems shape the interobjective aspect which is categorized by the "ITS" section of the integral theory.

3.4.2 Barriers

The NHIS initiative proved to be very advantageous for most Ghanaians, however, its functionality as a universal health insurance scheme is still being examined and experimented. The lack of quality assessment has served as a form of barrier to accessing healthcare with the NHIS. The topic of 'quality of healthcare' is becoming more common in the language of healthcare providers and patients. The measure of 'quality' however is still a debatable topic as the word in itself may mean different things on the individual and societal level. Nonetheless, the lack of a specific definition does not negate its importance or role in the healthcare system. The NHIS is said to place a great emphasis on the provision of quality healthcare that satisfies its clients. Section 68 of the NHIS Act provides quality assurance measures that mandate the National Health Insurance Council to take appropriate measures to ensure that a good measure of quality health services is provided (Kodom, Owusu, & Kodom, 2019). This act is said to still fall short to the conceptualization of 'quality' as it is difficult to measure and define the word. To this fault, policy practitioners and scholars have adopted a multidimensional definition to give the word a more holistic understanding as well as including different measures of quality in care (Kodom et al., 2019). In this multidimensional definition of quality of care, scholars are believed to have a general consensus on how this definition in whatever capacity it is captured in should be beneficial to their clients as well as meet their individual health care needs (Kodom et al., 2019). A commonly used and cited definition of quality healthcare defines it as 'the degree to which health services for populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge' (Kodom et al., 2019). This definition identified by the Nepal Institute of Medicine differs slightly in parameters from other definitions generally used by other scholars (Kodom et al., 2019). The oldest measure of service quality however dates back to the 1970s and it was called the SERVQUAL (service quality) model or Rater model (Kodom et al., 2019). It was used to assess quality using five indicators: *Reliability*, *Responsiveness*, *Assurance*, *Empathy* and *Tangibles* (Kodom et al., 2019). Although this measure of quality has been used mostly in other organizations outside of the healthcare sector, it became a useful tool in measuring quality

of healthcare. It created the right template to assess patient expectations ad satisfaction with the quality of care received. The continuous use of the SERVQUAL in the healthcare sector led to a more condensed conceptualization of quality, where it was redefined by Mostafa into three indicators: providers' performance, providers' reliability and the quality of facility (Kodom et al., 2019). This definition stemmed from a research study he did in a Pakistani hospital (Kodom et al., 2019). Alternatively, the World Health Organization (WHO) defined quality of care using six dimensions. They believed quality care ensured care that was *effective*, *efficient, accessible, acceptable*/*patient-centred, equitable* and safe (Kodom et al., 2019).. These six dimensions capture a lot by the definition of quality but this is where a lot of the dilemma comes in as quality in health care could mean other things like timeliness, empathy, comprehensiveness, responsiveness and more (Kotoh & Van der Geest, 2016).

The literature showed that the measure of quality used for assessing quality of healthcare under the NHIS includes variable that were based on the perspective of respondents (Kodom et al., 2019). Some of these variables included patient wait times, nature of the healthcare facility, services provided under the NHIS and poor attitude of healthcare service providers most especially nurses (Kodom et al., 2019). These variables are said to be consistent with other research studies that took into account variables such as the long wait times and realized in regions such as the Builsa district in the Northern region of Ghana and the Dangme West district of Ghana, insured clients under the NHIS waited longer than uninsured clients (Kodom et al., 2019). These long wait times are believed to be as a result of the increased access to healthcare services provided by the NHIS, however, a measure of quality as the literature defines it, will ensure that these wait times do not affect patient experience. Other variables such as the services provided under the NHIS captures the complains of subscribed individuals who disclosed that they received cheap medicines under the NHIS (Kodom et al., 2019). The NHIS and the individuals that support the service are believed to have a fair understanding of the health insurances' inability to provide quality medications and require patients to pay more money out of pocket for better medications (Kodom et al., 2019). Most people are left to depend on these cheap medications or do not get them at all. These variables identified by some of the literature provides a necessary perspective to the topic of quality of care and how it could be very important to the success and improvement of the NHIS.

It is good to note that the literature mostly provided information on the public sector. Therefore, statistics such as the population per health care facilities only takes into account government healthcare facilities since the NHIS' services are provided publicly (Brugiavini & Pace, 2016).

The literature supported the importance of quality assessment regarding how it directly correlates to individual's decision to subscribe. There were studies that showed a significant positive correlation between NHIS enrolment and formal antenatal check-up intake (Brugiavini & Pace, 2016). This raises the question of quality as well since these women were said to seek antenatal health care based on the quality of the health care facilities and the availability to offer good antenatal services. Although, women who are educated and well informed are more likely to give birth in a health care facility over assisted birth by a trained person (doctor, nurse, midwife or community health officer) their options are limited based on availability of the service within the NHIS (Brugiavini & Pace, 2016). These issues were identified by the research as a disincentive to seek formal care hence affecting the importance of enrolling in the NHIS (Brugiavini & Pace, 2016).

The reimbursement process that is ingrained within the scheme does not prove efficient and it is believed to affect people's willingness to subscribe to the insurance. The chart below gives you a glimpse of how this process takes place and how delays in one aspect could affect the entire flow of the reimbursement process.

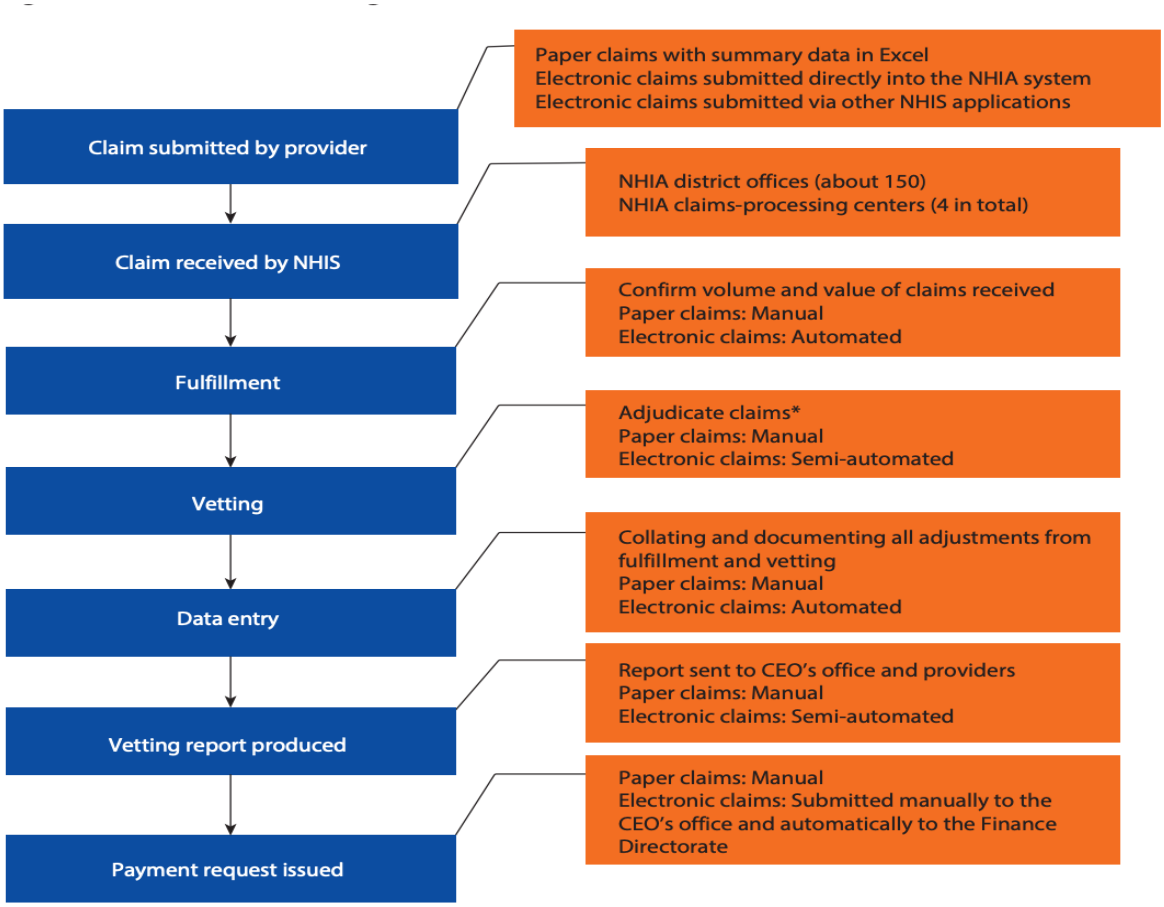

Figure 2: NHIA Claims-Processing Flowchart (Wang et al., 2017).

Some key facilitators that were identified in the literature include nurses and healthcare workers in charge of reimbursement programs within the NHIS. The literature connotes to the fact that these roles have played a vital role in shaping patient experience through their behaviour towards and the nature of resources available. The roles of the facilitators are also said to be a barrier to individuals accessing healthcare through the NHIS. A quote captured by a qualitative research study on factors contributing to low uptake and renewal of healthcare insurance stated how the reimbursement program could have health facilities in five months arrears (Fenny, Kusi, Arhinful, & Asante, 2016). This process puts a strain on the system and further ripples down to the individual's experience with accessing healthcare services.

3.5 Collective attitudes to health and health care (WE)

In this section the literature supported the intersubjective (WE quadrant) of the integral theory. It showed how shared beliefs, customs and common worldview shape the human experience. The nature of the culture in Ghana creates an environment where this intersubjective nature informs a lot of major decisions. The level of education of the population does not breed an environment for fact checking or seeking more information to support decisions especially in areas such as healthcare.

Most people support the initiative of the NHIS only because it is tied to or was initiated by their political party of preference and not necessarily for the benefit of the insurance scheme. This level of thinking has also been grounded in how the NHIS is managed. With the change of any political party in power the NHIS does not get the same level of priority. This lack of continuity that is found within the scheme is also believed to create gaps in the system. This is what Imurana, Kilu, and Kofi (2014) termed as *Ego dimension of politicians:* Most politicians twist and turn policies usually for the political survival and perpetuation of party interest. New governments come into office and fail to continue with policies started by previous opposition government. The political atmosphere of the country plays a huge role in the NHIS. Ghana although having multiple political parties usually tend to support two specific major parties namely, the New Patriotic Party (NPP) and the National Democratic Congress (NDC). The NHIS as an initiative is seen as a part of a basket of pro-poor policies implemented by the New Patriotic Party (NPP) to reduce the financial burdens of Ghanaians in accessing healthcare (Atinga, 2012; Imurana et al., 2014). Groups of people in support of the NPP endorse this initiative.

3.5.1 Collective perception of the NHIS

In low-and-middle income countries, health Insurance is increasingly recognised as a primary tool for the financing of equitable health care. Several articles have discussed the determinants of enrolment in health insurance schemes. Some determinants include cost of premiums, distance to health facilities, place of residence, poor quality of care, timing of premium payments (Agyei-Baffour, Kudolo, Quansah, & Boateng, 2017; Akazili et al., 2014; Fenny et al., 2016).

Community health beliefs, attitudes, values, and knowledge that people have about health insurance may influence household perceptions in participating in health insurance. According to Jehu-Appiah, Aryeetey, Agyepong, Spaan, and Baltussen (2012) a household's decision to enrol and remain in the NHIS is influenced unequally by perceptions relating to providers, insurance schemes and community attributes. They further stated that, perceptions relating to schemes are found to be the most important and that policy makers need to recognize household or community perceptions as potential barriers or enablers to enrolment. To them the likelihood of providing solutions to health care financing lies within community preferences, shaped by social, cultural, and economic contexts as well as experiences that are well understood and inculcated in the design of a community or national health insurance scheme.

3.5.2 Alternatives to health care

The use of alternative medicines by a significant number of Ghanaians also shows the collective nature of the healthcare experiences of individuals. This form of medicine is not fully integrated into the healthcare system in Ghana but has been introduced in some capacity serving as an additional support to their healthcare needs (Kretchy et al., 2016). These medicines are used mostly as primary as opposed to seeking necessary healthcare services to address the issue. This process of using alternative medicine is seen as a major delay in the process from illness to wellness (Kretchy et al., 2016). The tendency for the average Ghanaian to rely on these forms of treatments could sometimes change the outcomes of their illness positively or negatively. These alternative forms of seeking healthcare when question in a qualitative study mostly linked it to herbal medications (Kretchy et al., 2016). There is a debate to professionally train these "herbalists" to ensure they are being held to a standard due to the significant patronage they receive. Another study showed that the substantial use of herbal medicines in Ghana is as a result of the efficacy, usage, accessibility and affordability over conventional medicines (Agyei-Baffour et al., 2017).

3.6 Individual health seeking behaviour (I)

This section reviewed literature on subjective experiences and one's own individual perceptions values and motivations to guide their decision to seek health care with health insurance.

The social determinants of health do play an active role in an individual's decision to get insured. From the literature, the primary reason identified is affordability, however, other factors such as the size of the household, place of residence and level of education also affect this decision (Akazili et al., 2014). A study showed that there was a 16% dropout rate from the NHIS with reason being the inability of individuals to afford renewal payments and since at least 8% of them had not used the services they decided to opt out from the scheme (Jehu-Appiah et al., 2012). In Akazili et al. (2014) we recognize how one's level of education can influence their decision to obtain the insurance with 65.4% of educated people compared to 37% of non-educated people being insured. In the Upper East region of Ghana known as one of the most remote and poorest of the country reported an insurance coverage of 40% of the entire people in the region. This finding is believed to corroborate with patterns evident where an individual's place of residence and demographics affect healthcare decisions. Lastly, the size of the household is evident in affecting decisions to be insured. Households with a mixture of formal and informal sector workers were most likely to have a higher number of insured persons (Kusi et al., 2015). These household were also tested for the variability of marriage and identified that households with a male head (22%) were more likely to be insured than household with divorced or widowed members (14.7%) (Kusi et al., 2015).

Other health seeking behaviours include nature of family dynamics. A descriptive statistic from a research study showed that at the household level a total of 446 households (15.8%) with children under the age 18 were partially enrolled in the NHIS, 1174 were non-enrolled (41.6%) and 1199 (42.4%) were fully enrolled (Williams et al., 2017). A good percentage of households that were fully enrolled or partially enrolled were located in urban areas and belonged to the richest two quartiles and had a female household head with good access to medical and healthcare facilities (Williams et al., 2017). The health seeking behaviour of some individuals especially children are also determined by the geographic location. Children residing in urban areas are 1.6 times more likely to enrol in the NHIS than other children in rural areas (Williams et al., 2017). The statistics also shows how children who were more likely to be admitted in the early stages of their lives encourages the parents to enrol in the NHIS (Williams et al., 2017). The tendency for children to enrol In the NHIS is 12 times more likely to happen if the household head is insured

(Williams et al., 2017). The size of the household is also said to influence enrolment as well as the ages of the oldest members of the household. Although Ghana has a very active political atmosphere, there has not been a significant number of statistics to show that politics influenced an individual's willingness to enrol in the NHIS, however there is literature supporting how the political atmosphere affects the continuity and quality of the services provided by the NHIS. The only form of political concern affecting one's decision to enrol is the individuals trusts and distrust for the government.

In conclusion though the NHIS is continuously gaining popularity throughout the country with increasing education. There seems to be some level of dissatisfaction with subscribed members. These members are still very concerned about the effectiveness and practicality of the scheme even though they agree with the objectives of universal healthcare. The definition of health may differ from person to person. In order to attest to the full functionality of health care systems, it is crucial to understand that it will be dependent on individual interactions with the system. This perspective is explored through the context of this study.

Chapter 4: Methodology

4.1 Introduction

In this chapter, I present the research design necessary to complete this research and to address the research problem identified in the initial chapter. Accordingly, this chapter captures the philosophical dimensions, research design, data generation process and data analysis approach adopted for this study. An emphasis on efforts taken to ensure quality and ethics across the entire research process is elucidated in this chapter.

As a researcher, it is essential to begin with an overview of research paradigms, as this primarily affects ways to conduct social research including the choices of a particular research methodology (Wahyuni, 2012). A paradigm is a structure or set of suppositions and ideas that provides a pathway to see what the world looks like when its scientific aspect is related to its assumptions; it also provides questions and puzzles to be revealed and interpreted and indicates the research methods to be used (Neuman, 2011). According to Saunders, Lewis, and Thornhill (2009) the two main philosophical dimensions to differentiate existing research paradigms are ontology (the view of how one perceives reality) and epistemology (the nature of knowledge). I consider my ontological position to be a constructivist/ interpretivist, that is, I believe there are multiple realities. Furthermore, my epistemological position sides with interpretivism, which suggest that social science should uncover inside perspectives or real meanings of social phenomena from its participants as a source of knowledge. A study such as this, delving into multiple realities and experiences of different people and how they access healthcare. Interpretation and specific context from different participants are crucial in addressing the research objectives. A qualitative research approach which is identified with constructivism/ interpretivism was chosen for this study and as such, it guided the strategy framework, how and from whom data was collected and analysed (Punch, 2014, p. 114).

4.2 Research Design

To achieve the objectives of the study, a qualitative research design was adopted. “A research design means all the issues involved in planning and executing a research project from identifying the problem through to reporting and publishing the results” (Punch, 2014, p. 114). A qualitative research design and methodology are more effective in understanding and exploring the experiences of subscribers and non-subscribers of the Ghana National Health Insurance Scheme (NHIS) in accessing healthcare. This approach seeks to inform and understand people, systems, and events in their natural setting as opposed to quantitative approach which is more experimental (Punch, 2014, p. 118).

In qualitative research, a qualitative design is credible in producing knowledge of interpretations and perspectives from different people on the same topic. To truly achieve an in-depth understanding of the objectives of this study; Phenomenological methodology strategy was utilized to understand the essence of experiences different people have in accessing healthcare with or without health insurance in Ghana.

Phenomenology is the study of experience, particularly as it lived and as it is structured through consciousness. "Experience" in this context refers not so much to accumulated evidence or knowledge as something that we "undergo". It is something that happens to us, and not something accumulated and mastered by us (Friesen, Henriksson, & Saevi, 2012).

Ultimately, the present study is based on an interpretative approach because, I am trying to see the social world from the participants' perspective and personal experiences and also to consider perception (Skinner, Edwards, & Corbett, 2014). In this regard, I conducted mostly interviews (semi-structured).

4.3 Data Generation

4.3.1 Study site

Ghana is situated along the Atlantic Ocean (Gulf of Guinea) in the south and it's bordered by Togo, Cote d'Ivoire and Burkina Faso on the east, west and north respectively. Ghana is located in the western coast of Africa. It has a population of about 29.6 million. Administratively, Ghana is divided into 16 regions and a total of 260 districts and 6 major metropolitan areas, of which Accra Metropolitan Area (AMA) is one. By a decentralization process, power is dissolved to regional districts, local and unit levels respectively (GSS, 2012).

The Accra Metropolitan Area (AMA) is situated in. the south along the Gulf of Guinea. It is further divided into 11 administrative entities called Sub-metros. The major criteria for choosing AMA was that, it is located in the administrative capital and it is currently the largest city in Ghana with characteristics of a true urban city, exhibiting various classes of residential patterns; high and middle class settlements coexisting with slums for the poor (GSS, 2012).

It is also where I come from, and I am familiar with the local language and the culture.

4.3.2 Participants

As mentioned early on, the inclusion criteria for interviews included participants who are either subscribed or non-subscribed to the NHIS, participants who are above 18 years. Participants under age 18 were excluded. Both male and female were included in the study and finally all

participants in the study were selected across all three residential patterns, categorized under income brackets within the study area.

I interviewed individuals both male and female. 12 of these participants were selected across high, middle- and low-income residential areas. Two males and two females from each category. These participants included both subscribers and non-subscribers on the NHIS. This was achieved with the aid of stratified sampling technique. According to Neuman (2011, p. 262) this technique first divides the population into sub populations (strata) on the basis of supplementary information; afterwards a random sample is drawn from the strata. Thus, in stratified sampling, there is control of relative size of each stratum.

In this case, the residential category (High, middle and low income) set by the Accra Metropolitan Assembly (AMA) became my stratum (World Bank, 2010). The participants were then selected from these sub-groups (strata/ residential category). This according to Neuman (2011, p. 262) if accurately done, produces stratified samples that are more representative of the population than those of simple random sampling.

It is worth mentioning that, due to the challenges in recruiting participants for the online interviews, I had to resort to interviewing three Ghanaians who live in Norway in order to fill gaps in my sample population. Although, these participants, did not fall into the geographical requirements needed for the purpose of the research, through an open dialogue and discussion about the purpose and scope of the research, I was able to identify that these participants fall into the residential category. This made their experience relevant to the research. The three participants in question are indicated by asterisk (*) in (Table 1) below. Pseudonyms names have been used to protect the identities of interview participants. Their geographical location stated in (Table 1) below is not enough to reveal their identities.

Table 1: Stratified Sampling of Participants.

Residential category	Geographical location	Selected for Study	Subscribed		Non-subscribed	
			Male	Female	Male	Female
High Income	Airport residential area North Labone Ridge Cantoments Dzorwulu East Legon	Cantoments Dzorwulu	Boateng *	Johanna	Abdullah	Monica
Middle Income	Teshie Nungua Dansoman Adabraka Asylum Down Kaneshie	Adabraka Asylum Down	Kwame *	Nicole	Joe	Angela
Low Income	Osu Labadi Korle Gonno South Labadi	Osu South Labadi	Carl-Jonas	Yvette *	Abeeku	Nyhira

4.3.3 Recruitment Strategy

A purposive sampling strategy was chosen to identify participants who met the criteria for the study. According to Neuman (2011, p. 274) Purposive sampling is appropriate in selecting unique cases or participants that are especially informative. In this instance, the study requires participants who are either subscribed or not subscribed to the National Health Insurance Scheme (NHIS) and have some experience with accessing healthcare. That is, they share some common characteristics (inclusion criteria) and have the capability to provide data or information, relevant to the study.

Travel restrictions due to the COVID-19 pandemic also affected and slightly altered the plans I had for data collection (fieldwork). I then had to resort to online interviews, making use of resources such as Zoom and WhatsApp applications to facilitate my data collection.

To do this, I had to gain access to my participants via a gatekeeper. A gatekeeper controls or grants access to benefits (information or data) valued by others who are researchers; the access granted is not owned by the gatekeeper and the information or data (benefits) are external to the gatekeeper (Corra & Willer, 2002, p. 180). In my case, my gatekeeper was the Assembly man of my study area. An Assembly man is a respectable person, elected within a community to represent members in deliberating on issues with higher authority in a Metropolitan area. Assemblymen are usually charismatic people who have good rapport with community

members. He was of great assistance in recruiting participants within the study area. I presented him the category of participants required for the study and the inclusion and exclusion criteria were made known to him.

4.3.4 Data Generation Methods

I conducted interviews (online using Zoom and WhatsApp applications). In order to ensure credibility of data collection. Interviews are conversations of daily lives of people where knowledge is constructed in an interaction between an interviewer and interviewee (Kvale & Brinkmann, 2009, p. 2). According to Punch (2014, p. 114) interviews are the most prominent data collection tool in a qualitative research. It is a good way of becoming better acquainted to peoples' experiences, perceptions, meaning, definitions of situations and construction of reality. Depending on the setting during data collection (fieldwork) interviews within the study employed either structured or semi-structured interviews. Semi-structured interviews enabled me to probe and ask follow-up questions.

The interviews included an array of participants. The key informants interviewed, included two officials from the NHIS, and one health care official at the out-patients department. In addition, one pharmacist was interviewed. I also retrieved a copy of the NHIS policy document to aid as secondary source of data for this study.

With the aid of the Assembly man as stated earlier and the description stated in (Table 1), served as a guide to facilitate the selection of parti on my behalf. I then arranged with the participants and conducted individual semi-structured interviews using an interview guide with open ended questions (see APPENDIX 1). Interviews were conducted online due to travel restrictions as a result of the Covid-19 pandemic. The interviews were conducted by me in English with most of the participants. However, three of them were conducted in Ga (local Ghanaian language). At the beginning of each interview, I painstakingly explained the purpose of the study to all participants.

The interviews were scheduled to last between 30 to 45 minutes. They were conducted at the convenience of the participants. With their permission, all interviews were recorded using the record option on Zoom and interviews that took place via Whatsapp were recorded and securely saved. The interview guide was developed to constitute key elements of the objectives of the study, including challenges of enrolling and accessing health care with the NHIS; resources available to individuals in accessing health care; experiences in accessing healthcare and finally to understand the other strategies participants use in accessing health care.

The interview guide for the main participants also included questions on challenges and experiences in enrolling with the NHIS, resources available in accessing healthcare and

alternative strategies used in accessing healthcare. The interview guide also commenced with the personal understanding or perception on what health is. More details can be found in the full interview guide in APPENDIX 1.
Another interview guide was designed to facilitate interviews with officials of NHIS and health care workers who were relevant to the study.

4.3.5 Data Management

With permission both from the consent form and verbal request before each interview, I recorded all interviews electronically and took some notes during the interviews. All audio recordings were transcribed with the aid of Happyscribe, an automatic transcription and subtitle generator. All transcripts were stored on my personal password protected computer. Names and personal forms of identification were not included in the transcripts. Audio files were deleted at the end of the study.

4.4 Data Analysis

I used the Thematic Network Analysis to analyse the qualitative data. According to Attride-Stirling (2001, p. 385) Thematic Network is a robust and highly sensitive tool for the systematization and presentation of qualitative data to unearth the themes salient points in a text at different levels. With the aid of NVivo, a data management tool, I started my initial basic coding with the transcribed data; thus, making my analytical approach an inductive one "bottom up". With multiple familiarizations of the data collected, I then generated codes that categorized data into significant fragments of text that stood out in relation to the study. The coded text fragments were then sorted into themes with the same aid of NVivo. These themes were categorized into codes, basic, and organizing themes. I further grouped these into networks based on theoretical connections. Based on the Integral theory, the organizing themes for analysis became pre-determined on the basis of the four quadrants of Integral Theory. The basic themes which were inductively drawn directly from the data were then allocated into the pre-determined organizing themes (subjective, intersubjective, objective and interobjective) which are concurrently referred to as "I", "WE", "IT" and "ITS" respectively. Making this also a deductive approach. Thus, the analytical approach for this study took a hybrid approach; in which the coding and basic themes were inductive "bottom up" and the organizing theme took a deductive "top-down" approach based on the Integral Theory.
The upper left quadrant which is the "I" describes the individual interior or the subjective experiences. This represents self-consciousness, motivation, attitudes, and thoughts. The lower

left quadrant which is the “WE” describes the inner collective or the intersubjective experiences. This represents the shared culture, worldview, and attitudes i.e., towards health care or the NHIS. The upper right quadrant, “IT” or objective describes the behaviour, practices, and material resources, available to people in accessing health care either with or without the NHIS. Finally, the lower right quadrant, which is the “ITS” or interobjective, represents governance process, laws, policies, infrastructure, and the human system. All these are shown in an adaptation of the Integral Theory in Figure 3. The organizing themes and their linkages with the basic themes indicating underlaying patterns within the network are further described in the thematic network in Figure 4 below to address the objectives of this study.

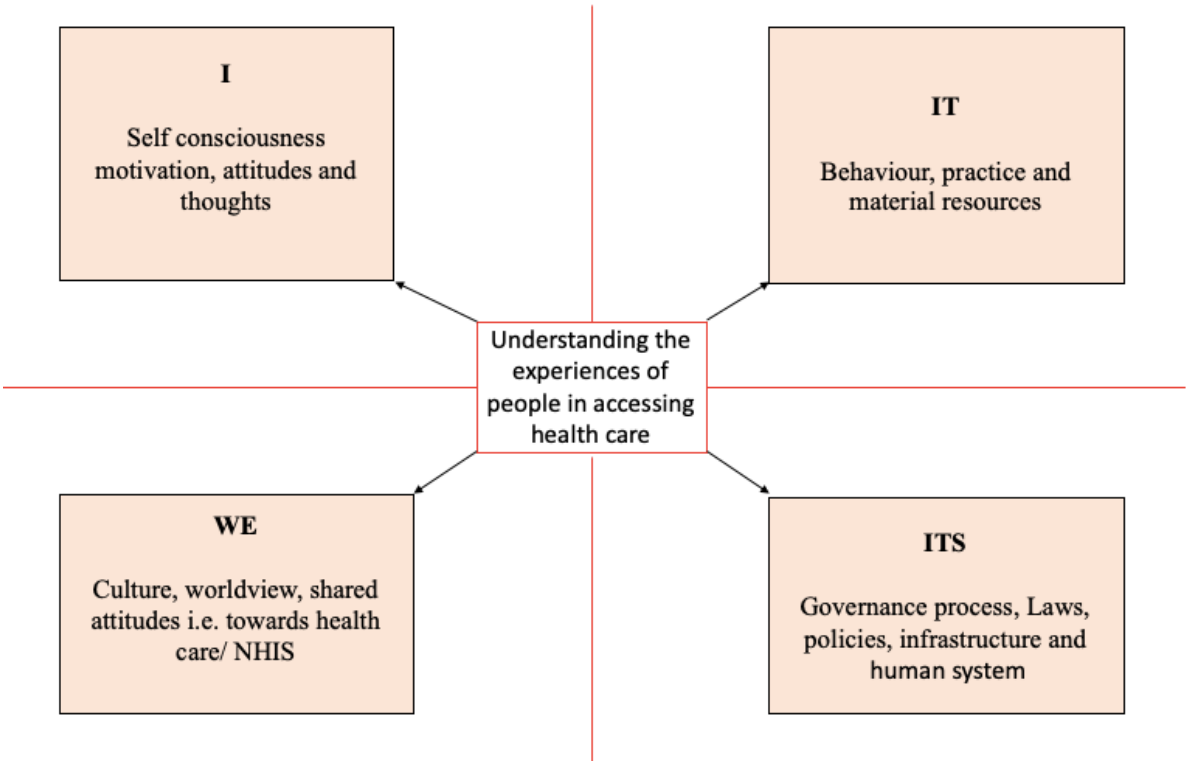

Figure 3: An adaptation of the Integral Model.

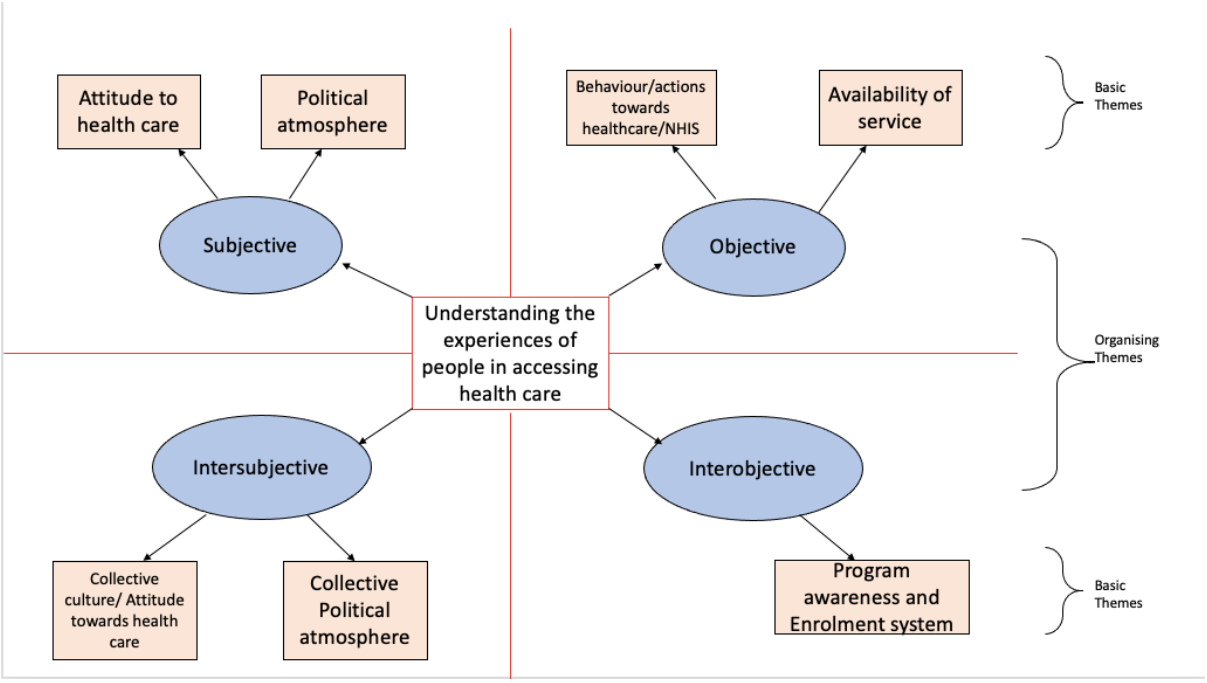

***Figure 4*: Thematic Network Analysis of Data**

4.5 Ethics

Ethics is the study of what are good, right or virtuous courses of action. Punch (2014, p. 36) defines Research ethics as a branch of applied ethics focused on the specific contexts of planning, conducting, communicating, and following up research.

Issues of ethics arise in all designs, approaches and at all stages. As a researcher, I followed the principles that have been formalized into codes of ethical practice in promoting issues of access and consent, confidentiality, and anonymity especially in this study which sought to explore and understand the financial status and personal health information of participants in order to answer the research questions. I presented a voluntary informed consent form to all participants. This form provided adequate information to all participants and prospective ones about the study and its purpose. I also indicated an estimated duration of the research and interview sessions, Lastly, it addressed the rights of the participants, that is the issue of confidentiality, anonymity, and data protection. Most important of all, it stated the fact that participants agreed freely to participate and they are at liberty to withdraw their agreement at any time throughout the research process (Punch, 2014, p. 44). Another ethical dilemma posed during my study was publishing of field reports. According to Neuman (2011, p. 470) intimate knowledge obtained and reported can create an ethical dilemma between what is right of privacy and the right to know. As a researcher I cannot always reveal every detail I learn or obtain without violating the privacy or reputation of someone, yet failure to make this

information public keeps details hidden. I overcame this foreseeable ethical dilemma by making information about participants or informants anonymous. Finally, I declared in the consent form that although the study may be for academic purposes now, it may be published in the future. Permission to conduct this study was sought from the Norwegian Centre for Research Data (NSD) (APPENDIX 2) before I commenced with data collection. The purpose of this was to receive ethical clearance to conduct a research study through the University of Bergen.

4.6 Quality Assurance

4.6.1 Trustworthiness, credibility, dependability, transferability, and confirmability

According to Polit and Beck (2009) Trustworthiness refers to the degree of confidence in data, interpretation and methods used to ensure the quality of a study. Lincoln and Guba (1985) outlined some criterion, accepted by many qualitative researchers, these include credibility, dependability, transferability, and confirmability to ensure trustworthiness or quality of a study. *Credibility,* according to Lincoln and Guba (1985) is the confidence in the truth or findings. It is achieved when research methods engender confidence in the truth of data and in the researchers' interpretations of (and inferences from) the data.

To achieve this in my study, Triangulation, which is the use of multiple sources or referents to draw conclusion about what constitutes truth were inculcated into the research design. Interviews from an array of participants (subscribed, non-subscribed, officials and health workers) and the use of secondary data sources (NHIS policy documents) were employed. During data generation and analysis, interpretation of data was cross-checked with participants to be more reflexive and curb my own bias as a researcher. Finally generating codes with my colleagues and comparing them; an activity organized by my supervisor also went a long way to increase credibility of the study.

Dependability refers to the stability of the data over time and over conditions of the study (Polit & Beck, 2009; Yilmaz, 2013). This is similar to reliability in quantitative research. However, in a phenomenological study such as this, where experiences of people are being studied; varying situations from time to time were recorded.

In light of this, to establish dependability, I addressed all activities that happened during the study and decisions about aspects of this study. For instance, I provided detailed information about the purpose of the study, research design and my option for data generation methods.

Interviews were conducted online instead of face-to-face. All these factors play a role in data generation.

Transferability, this can be achieved when findings of qualitative study can be compared with other or similar setting (Yilmaz, 2013). This is analogous to generalization in quantitative research. However, qualitative researchers focus on the informants or participants and their story without saying this is everyone's story. This qualitative study supports transferability with a rich, detailed description of the context, study area and the people studied.

Confirmability is the neutrality or the degree to which findings are consistent and could be repeated (Polit & Beck, 2009). To Yilmaz (2013) this can be achieved when the findings of the study are based on the analysis of the data collected and through thorough examination. This is analogous to objectivity in quantitative research. I achieved this by keeping detailed notes of my decisions and analysis as I undertook the research. I reviewed these notes with some colleagues to prevent biases from my own perspective on the research. These practices aided me in Phenomenology. Husserl (1999); (McNarry, Allen-Collinson, & Evans, 2019) refers to this as *Bracketing* i.e. The researchers' aim to set aside their tacit assumption, knowledge, and experience about a phenomenon to approach it freshly without prejudgment.

4.7 Role of the researcher

According to Lincoln and Denzin (2003) in qualitative studies, the researcher is considered an instrument of data collection, thus the human factor plays a role in the data generation process rather than just the questionnaires and other tools for gathering data. With this in mind, I aimed to be reflexive in the research approach. I described relevant aspects of self; including any biases, assumptions, expectations and experiences while conducting this study (Greenbank, 2003).

Although I was aware of my role as a researcher, I believe certain parts of some of my interviews challenged this role. There were some interviews done over online video calls where I was able to connect to the participants and familiarize myself with their experiences making me less objective in those situations. Other interviews done over audio calls, I felt an impersonal connection to the participants making me more subjective in my inquiry and trying different approaches to understand their lived experience with the NHIS. In these online interviews it was easier for me to create a neutral ground during the interview since the participants had no visual attribute such as gender, ethnicity or class that creates these positional spaces as well as power dynamics.

My motivation for undertaking this study was to really understand how people, regardless of their economic capacity, manage to access health care in Ghana.

4.8 Limitations

There were more unprojected limitations involved with this research due to the current climate of the times in which this research was being conducted. Recruitment strategies had to be revaluated and changed, interview process was modified as well as select groups for participation. The initial process of recruitment was supposed to be based on stratified sampling within given areas, however, parts of the research had to alter sampling to make use of a convenience sample. This narrowed the eligibility criteria for the participants included in the research because some interviews were limited to people familiar to me. Secondly, the interviews had to be done online (video or audio) calls since I was not able to physically travel to conduct these interviews. This process was challenging because of the technological intellect needed. This eliminated some eligible participants since they did not have access to the required technology needed for the interviews. Some participants that were willing to participate also had preferential means of communication which required some adjustments. The process of the interview done over the video posed as a limitation, where participants felt more impersonal and lacking good communication skills that could have potentially allowed the participants to explore their responses limiting the inquiry process. Select groups of people needed for the interview had to be revaluated due to lack of access. Government officials needed to inform important parts of the research had to be altered during the data collection process creating a potential gap in the research. However, since most of these limitations were restricted to technology and access, I devised creative ways to ensure that all the concerns of the participants were addressed to ensure the data collection process.

Chapter 5: Findings

5.1 Introduction

In this chapter, the findings from the study are presented. The first section unveils findings from interviews conducted with the main participants. Under this section, findings relating to self-consciousness of health and motivation to subscribe to the National Health Insurance Scheme (NHIS); the shared perceptions towards health and NHIS; behaviour towards health care and the NHIS and finally the governance and health worker practices surrounding the NHIS and access to health care was revealed. The chapter also include findings from interviews with key informants.

5.2 Findings from interviews with the main participants and key informants

With the aid of Thematic Network Analysis and NVivo, I organised coded text from interview transcripts into Codes, Basic and Organising themes.

Table 2: Summary of the themes developed during data analysis

Codes	Basic Themes	Organizing Themes
Perceptions of health Importance of Health Relationship with health Perception of unversal health Frequency of health care visits Attitude towards healthcare Attitude towards personal funding of healthcare	Perspectives on health care	(I) Self consciousness of health and motivation to join the NHIS
Perception of the effectiveness of the NHIS Relevance of the NHIS Awareness of NHIS Perception on premiums Reasons for non-subscription Positive experiences from subscribers of NHIS	Perspectives on the NHIS	
Affordability of premuims	Income levels	
Challenges in accessing healthcare Challenges with NHIS Confidence in the effectiveness of NHIS Cultural biases affecting enrolment into the NHIS Benefits to the family Negative experiences from non subscribers Recommendations to improve NHIS	Community consciousness of health care and NHIS	(WE) Shared perceptions towards health and the NHIS
Shared family attitude towards healthcare Shared community attitude towords health (Traditional or formal)	Family or community attitudes	
Available resources Accesibility of services Behaviour towards personal health care Convienience of the NHIS as a health plan Alternate forms of medicine	Health seeking behaviour	(IT) Behaviour towards health care and the NHIS
Other health seeking behaviour Frequency in actual visits to the hospital Accesibility of health services via NHIS	Physical visits to hospitals	
Available resources in procuring medication Quality of medication	Acquisition of medication	
Limited number of health facilities to offer NHIS services Scope of services covered by NHIS Limited points of registration affecting enrolment Political atmosphere surrounding the implementation Politics of health Limitations within the program Media coverage of NHIS Quality of service Patient to doctor ratio Quality control Reimbursement strategies Prescription drugs under NHIS	Governmental measures	(ITS) Governance and Systems surrounding the NHIS and access to health care
Access to NHIS Health workers attitude to NHIS Hospital wait times Significant difference between private health insurance and NHIS Sources of information Registration process of NHIS	Health worker practices	

Remarkable findings demonstrating or explaining various experiences with the NHIS and accessing health care emerged through the analyses. As mentioned early on, the hybrid approach aided in presenting a structural analysis by inductively generating codes from the data and deductively using the Integral Theory as a framework to guide the organising themes.

5.2.1 Self-consciousness of health and motivation to subscribe to the National Health Insurance Scheme (NHIS)

In order to explore the "how and why" people access health care the way they do in their everyday lives, participants were asked to share their personal understanding or perception on health and further asked to describe their own health. In addition, participants were also asked about universal health care and their awareness of the Ghana National Health Insurance Scheme. Further probing led to exploring the motivation behind the participants decision to subscribe to the Ghana National Health Insurance Scheme or not. The basic themes that emerged were the perspectives on health care, the NHIS and income levels as a motivational factor to either subscribe to the national health insurance or not.

The findings presented an interesting spectrum of different perceptions of health. Some people described health more from a physical point of view.

> *"… for me, health is the wellness of the body"* (Boateng)

Another participant stated:

> *"…to me, health means, being free from any illness or let's say not being hindered by anything to enable me complete a task"* (Abdullah)

> *"… So, I'll say health is when you take good care of yourself to prevent some common and preventable diseases*" (Nicole)

Others incorporated the mental and lifestyle aspects of health in their description.

> *"I will say health is being unhindered to be able to do a task both mentally and physically to accomplish a task"* (Abdullah)

> *"Health means, I am devoid of any form of sickness either mentally, physically or emotionally"* (Monica)

Carl-Jonas said:

> *"Health means everything to me, because health is wealth. There are very few things you would want to joke with in your life and one of them is your health. For me it's a priority"*

These perceptions give a more concrete and diverse understanding of what health means to these participants on an individual level.

In order to ascertain the views of participants about the NHIS and their experiences as either subscribers or non-subscribers of the scheme in accessing health care; participants were asked if they had ever heard of the NHIS. In response, all the participants from both categories responded in the affirmative. A follow up question was asked, this required participants to mention their source of knowledge about the NHIS. Various sources where mentioned, majority of them were from television, radio, and health care centres. Some participants got their knowledge about the insurance scheme from family and friends.
Furthermore, participants were asked to describe their understanding of universal health care, most of them described it as an insurance plan, while the language used by other participants described it as a health care subsidy plan.

> *"…the little I know about universal health care is, providing health care for all. No matter the class or income. So far as, the person is a citizen of a particular country. And no matter the sickness of that person. The country should be able to provide necessary service for people"* (Boateng)

> *"To me, universal health care means every individual in a country has access to primary health care and they have access to the health services they need; when and where they may need them without being restricted due to financial challenges"* (Monica)

In the same vein, Participants were asked to describe their views on the Ghana National Health Insurance Scheme and what they know about its operations. Most of the participants perceived the NHIS as a government initiative to provide health care services for all people, especially the poor. Others described it as a social insurance scheme for accessing free health care. One female participant described it as a system for pregnant women to attend ante-natal and deliver at the hospital for free. It was striking to find out that one participant described it as a pension scheme.

"…it was introduced by one of the political parties to pay for health care for all Ghanaians to make health care more accessible…first it used to be cash and carry and then one of their (NPP political party) promises was to make health care more accessible and more subsidized" (Abdullah)

"…NHIS is like a pension scheme indirectly because you don't know when there will be an emergency I don't know when something serious will happen and I will need the government to pay for me to access a surgery or something" (Yvette)

For another participant, it was introduced to provide health care for the poor:

"… the idea was to provide health services for all people, initially it was for the poor, those they thought could not afford health care. So, they started that way, providing health care for the poor, then progressed to cover almost all people" (Boateng)

"…I used to remember some people saying, when you are going to give birth, they do not pay for anything. So, it covers prescriptions. It has some few benefits for patients to enjoy" (Yvette)

Others perceived it as a scheme where resources are pooled together by contributions of subscribers and used to fund health care in times of sickness. An official from the scheme was of this view:

"The intention of the health insurance scheme is to provide a safety net for the less privileged and vulnerable people in society. However, people below or just above the poverty line and older people are exempted from premium payments… The system has found a level of efficiency where people do not need to carry cash to be able to access health care… pregnant women upon paying a token premium can access free ante-natal, delivery and post-natal health care." (Key Informant 2)

In the interviews, participants were asked about their motivations or reasons that guided their decisions to either be subscribers or non-subscribers in the NHIS as a means to cater for their health needs. Participants with higher income levels showed and inconsistency in renewing and utilizing the NHIS to cater for their health care needs. Most of them explained that they had alternatives such as private health insurance. Others also made it clear that they opt for better or healthier lifestyle.

"I used to be a subscriber, but I never really used the NHIS card since I'm already insured by a private health insurance. I don't see the point in resubscribing to it (NHIS) anyway" (Abdullah)

"I hardly go to the hospital so I feel like I do not need to subscribe to the National Health Insurance Scheme because I will not use it much… I guess it's my lifestyle choices to live a healthy life" (Angela)

On the other hand, participants with a relatively lower income also subscribed to the NHIS. Their responses as to what motivated them to enrol and utilize the NHIS brought some salient points to light. To most of the participants in this category, the definition and perception they have about the NHIS as a social insurance health scheme which provides poor and vulnerable people an access to free health care and medication upon paying a token premium was their main motivation to subscribe in order to benefit.

"I personally believe the NHIS was to benefit people like me who cannot afford health care any other way. I don't think rich people use the NHIS like that because they have the money to pay" (Nicole)

It was also found that the middle- and low-income level participants who were employed in the formal sector were more likely to subscribe and renew their NHIS simply because, individuals who are employed in the formal sector are contributors to the Social Security and National Insurance Trust (SSNIT) and their NHIS premiums are automatically deducted from their salary.

"…but like I said, I don't usually pay the money up front since I am a civil servant. I pay something very little which is of course taken out of my salary, so I don't feel it that much" (Carl-Jonas)

5.2.2 Shared perceptions towards health and the NHIS

Participants in the study expressed their perception towards health care and the National health Insurance Scheme. These responses aided in addressing the shared challenges of enrolling in the NHIS and accessing health care. It further aided in identifying the resources available to people in accessing health care and enrolling in the National Health Insurance Scheme. The basic themes that emerged during analysis were the community approach and consciousness in

seeking health care; family attitudes in accessing health care and the common experiences in accessing and utilizing the national health insurance scheme. These collective worldviews or experiences that emerged from the statements of the participants cut across the accepted way of tackling health care among the people within a community and how they navigate their way amidst the challenges to gain access to health care with the NHIS.

It appeared that most of the participants especially those within the middle- and low-income bracket acknowledge both traditional healing or health system and the formal or western health system. These two income bracket groups utilize these health care systems according to the severity of their illness or condition. One participant stated that, depending on how he feels, he either stays home and self-medicates using herbs because over a period of time he and his family have been able to study symptoms of some common illness that infect them. For example, Malaria and some chronic skin infections.

> *"…in Ghana, one disease that is common here is Malaria and the medication is readily available, so there is no need to go to the hospital… I also like herbal medicine in my area there are lots of it growing around my house. There is a particular herb called the bitter leaf (Vernonia amygdalin). Inasmuch as its bitter for me, it works so well."* (Carl-Jonas)

Another participant also shared how he and his household utilize traditional healing or medication because of its affordability. He pointed out that, poverty is a deterrent to the use of formal or modern healthcare in Ghana.

> *"I feel that, most of us in this area use herbal medicine because we can afford it. Most of us moved from the villages to Accra and in the village that's what we used. In Accra, we sometimes have to give money to nurses and doctors before we can receive treatment and the medicine is very expensive. There are many people who cannot afford it around here, so we rely on traditional medicine and herbs even for our children"* (Abeeku).

The above statements exhibited how a collective way of thinking or perception among the people impact how they access health care. The following paragraphs presented findings on how shared attitudes, history and experiences of some participants impacts how they access health care with the National Health Insurance Scheme.

Most of the participants shared negative experiences in gaining access to the NHIS to cater for their health care needs.

"The fact is that, quite a number of people are enrolled on this project (NHIS), so going to the hospital to access health care we always have to join very long queues. That is sometimes very annoying" (Carl-Jonas).

Another participant shared that:

"I see that one of the biggest challenges is the long waiting times when we get to the hospital ... Basically, there are no appointment schedules so when you feel sick it means you report to the hospital and join a long queue before a doctor attend to you" (Yvette).

Many participants shared similar views on the challenges with the NHIS. These ranged from enrolment process with the NHIS.

"So, the major challenge in enrolling in the health insurance in Ghana is, oh my God! the queue. It takes a long time before you can even get access to them to register you. The systems being used are slow and the network is really poor" (Yvette).

Another participant said:

"*it takes a long time for you to be able to register. So, some people decide that they can't enrol because, for example, if you have a nine to five job, you can't go and join the queue to register because it will take you like five hours. You can't leave your job. So, with that, it'll be difficult for a worker to register. And some of the people decide, okay, then if I'm going to go through this stress, then I will not even register at all. So, I think the major problem is the registration process."* (Boateng).

Interestingly, one of the participants shared how she was able to enrol with ease using her family as a resource.

"My parents helped me with the process. They tutored me through. What I did was when I went to the office there was a queue. Basically, I had a bit of a procedure tips on how I should talk what I should do to be able to get it as fast and leave the place." (Yvette)

Others shared their challenges with regards to the services offered and the limited medication or drugs approved on the NHIS list.

"I know all medical or health procedures are not covered by the NHIS…let's say cardiac issues are not fully covered even medications…I have a colleague whose father is subscribed to the NHIS and still had to pay out of pocket for a cardiac surgery" (Abdullah).

"I think that, taking a lab test at the hospital should be included in their service. The health insurance should also cover cost of X-rays or scans and all sort of lab tests; reason being that majority of Ghanaians have low income. So, if a subscriber has tried so much to be part of this scheme, he or she should at least have good measure of medical care. If out of the blue, someone gets injured and goes to the hospital and it becomes necessary to take a scan and he or she has no money at that particular time, it means that the entire service (NHIS) becomes useless" (Carl-Jonas).

Quite a number of participants also shared the view about the NHIS and government not paying back health centres in good time for services rendered to subscribers.

"It takes time for health centres to recoup or get their money… They (health workers) sometimes complain that the government does not reimburse their money as and when its needed. So, most at times, the hospital may exhaust all their medications for months and will not have the needed money to restock medication or drugs and pay hospital stuff" (Carl-Jonas).

In spite of these challenges shared by some participants, it was also found that others see the operations of the NHIS as beneficial in catering to financing their health needs.

"The NHIS covers sometimes up to 40% or 50 % of the number of drugs prescribed by the doctor and the rest is paid out of pocket… I do take a lot of lab tests to check myself every month. So, I feel I benefit because when I take my lab tests, about half of the cost is covered by the health insurance so I feel good about it" (Yvette).

"I believe this is very beneficial because it gives subscribers access to free quality health care in the country." (Monica)

5.2.3 Behaviour towards health care and the NHIS

To explore the experiences of people in accessing healthcare based on their NHIS status and to identify other strategies that are employed by people when seeking healthcare, findings revealed an interesting mix of personal encounters among the participants. Some spoke of positive experiences while others had negative experiences from accessing health care as a National Health Insurance Scheme subscriber.

These led me to understand the behaviour of people or participants towards their own health and the perceptions they have about the health insurance scheme.

For most of the participants, being a subscriber or a "card holder" as referred by many does not guarantee one a good and quality health care at the hospital or formal health care facility. Most of them expressed their dissatisfaction with delays or prolonged waiting times before they got attended to by health workers. Inadequate information at health centres, unfair queuing systems, appalling staff attitudes and low grade of drugs at accredited hospitals.

> *"Sometimes I don't even like going to the hospital because when you get there, they will make you wait for the doctor. You see other people come and cross you (or cut the line) because they are paying cash and it just makes you frustrated. It's like when you go, they just tell you to wait they are coming, they don't give you information on what you are supposed to do while you wait. You end up sitting there long hours you end up getting angry. Sometimes the sickness can even leave your body while you are waiting so because of that it takes a lot for me before I decide to go to the hospital. I would rather try a pharmacy or other avenues before going to the hospital. I think for when I'm going to the hospital I would only go if I had the cash to pay for the additional services that doesn't come with my NHIS"* (Nicole)

For this other participant, being subscribed also means you have to definitely endure longer duration before receiving any medical attention.

> *"The fact is that many people are enrolled on this project, so going to the hospital to access health care you always have to join a very long queue that is sometimes very annoying"* (Carl-Jonas)

The same participant further shared his experience:

"When I go to the hospital. I first join the process to retrieve my folder, but before that, I usually have to join a queue for about 15 to 30 minutes … I'm then handed my folder then I have to wait for consultation with the doctor. I usually wait for a while, sometimes about 1 hour because there are many people who are in line to receive consultation with the same doctor as me" (Carl-Jonas)

Participants within this study experienced unfair queuing systems. Subscribers actually received a degrading level or quality in health care and generally encountered negative experiences at health centres. It came to light that there are differences in the health care delivery process for subscribed and non-subscribed patients at the health facilities. The service delivery procedure at authorised health providers with the NHIS are such that they have to process reimbursement claims for consultation, diagnosis and medication for all subscribed patients. On the other hand, for the non-subscribed patients, health centres only have to provide the necessary care and receive cash payments instantly. Thus, the non-subscribers are held in a different queue, where they are attended to quickly by health workers, given the necessary prescription for their medication and sent home. Whereas the subscribed patients spend prolonged hours in queues to go through the NHIS process for receiving health care. Non-subscribers do not mostly experience the long waiting times that the subscribed patients experience. As shared by Nicole earlier.

"…You see other people come and cross you (or cut the line) because they are paying cash and it just makes you frustrated"

Experiences such as this shape or influence the health seeking behaviour of people as portrayed by Nicole again.

"…I would rather try a pharmacy or other avenues before going to the hospital. I think for when I'm going to the hospital I would only go if I had the cash to pay for the additional services that doesn't come with my NHIS"

An official of the NHIS when asked about the functionality of the system and how it can be improved, he stated

"We usually hear reports about how some of health officials treat NHIS card bearers at their facilities. Some ask for extra identity cards, extra money and other unnecessary items which in turn delay the NHIS card holder at these facilities. We also heard about how they sometimes separate NHIS card holders from individuals paying cash with the

intention of catering to cash holders first at the expense of the NHIS card holders." (Key Informant 2)

Alarming health worker practices such as this brought to light some of the stories of how health workers who are directly involved with providing NHIS services to patients and the roles they play on subliminal level in affecting people's behaviour towards seeking formal health care.

Interestingly, a couple of participants shared an opposing notion to the conventional negative experiences portrayed by the other participants. To them they have had a satisfactory experience using the NHIS to access health care.

"I feel like so far they (NHIS) have done well. Even though the quality has reduced they are still in operation, which is good. I will encourage people to still join the NHIS. I am comfortable in paying some parts of my medical bills out of pocket" (Johanna).

An unusual finding about one participant who was a non-subscriber but has a wife who was subscribed to the NHIS, shared some positive experiences his household encountered with NHIS in accessing health care. To him and his family the only challenging part with the health insurance scheme was getting his wife registered. Besides that, his family especially his wife and young children have benefitted greatly from the scheme.

"Well, I think that because the National Health Insurance Scheme has catered for all the cost involved in the birth of all my children. Even before the child was born, when we go to the hospital with the card, we just show it and get the care. We did not have struggles" (Joe).

An interview with an official from the NHIS revealed that the scheme is utilized across all income levels. He further disclosed that, a lot of women especially pregnant women and children utilize the NHIS more often. This same assertion was also perceivable in interviews with the participants, most of them expressed how well NHIS is beneficial especially during maternity care. (Ante-natal, delivery, caesarean section, and post-natal care)

"... so, in July 2008, a free maternal health policy was implemented under the NHIS. This policy basically allowed all pregnant women to have free registration within the scheme and additionally be entitled to free services throughout their pregnancy, child

delivery and I think about 3 months post-partum. Because of this we have a lot of women subscribing and utilizing the NHIS" (Key Informant 2)

The aforementioned challenges to seeking health care were not the only experiences accounted for through the interviews. These interviews were able to shed light on other adaptive strategies to how these individuals sought out health care services. These adaptive health seeking behaviours cut across a wide range of services including how medications were acquired and how some individuals resulted to other means of health services as their primary source of health care. One working class participant with a low income shared how he actually visits the hospital to seek treatment and patiently goes through all the laborious process as a subscribed member of the NHIS but does not use the hospitals' dispensary. He also disclosed that he usually asks the doctor to prescribe alternate brands of the medication since the ones listed on the NHIS approved drugs list are mostly generic and of lower quality.

"I usually ask the doctors to write a prescription for me on what they think would be a better option of the medicine they have under the NHIS scheme so that I buy those. ... I have to spend extra on better quality medication than what is listed on the NHIS drug list" (Carl-Jonas).

Quite a number of the participants emphasised that they will rather go to a pharmacy or chemist first to seek health treatment. Formal hospitals will be another option if their illness is severe or if they have the financial capability.

"I would rather try a pharmacy or other avenues before going to the hospital. I think for when I'm going to the hospital I would only go if I had the cash to pay for the additional services that doesn't come with my NHIS" (Nicole)

Another participant said.

"Sometimes if I feel my sickness is familiar or minor, I just go to the pharmacist instead of the hospital." (Yvette)

Most of the participants within the low-income bracket, highlighted that they resort to herbal medication and home remedies because its more convenient and readily available to them.

"…in Ghana, one disease that is common here is Malaria and the medication is readily available, so there is no need to go to the hospital… I also like herbal medicine in my area there are lots of it growing around my house. There is a particular herb called the bitter leaf (Vernonia amygdalin). Inasmuch as its bitter for me, it works so well. So, unless I feel it is so necessary, I will not go straight to the hospital" (Carl-Jonas)

Another participant said:

"I feel that most of us in this area use herbal medicine because we can afford it... There are many people who cannot afford it (hospital care) around here, so we rely on traditional medicine and herbs even for our children" (Abeeku)

5.2.4 Governance and systems surrounding the NHIS and access to health care

Health care systems are shaped heavily by policies and governance. The role the government plays affect the outcome of health care and health seeking behaviours. Unfortunately, in Ghana the health care system is highly politicized affecting the nature of policies implemented or not. The presence or lack thereof of these policies also shapes healthcare worker practices. This section presents the findings on how governmental measures and health care worker practices affects health seeking behaviours of Ghanaians and their decisions to subscribe or not subscribe to the NHIS.

The political atmosphere surrounding the implementation of the National Health Insurance Scheme and its operation over the years has also influenced the utilization of the scheme and subsequently the health seeking behaviour of people.
Most of the participants were all aware or well informed about the political party that introduced the NHIS. Most of them even defined the NHIS as an initiative by the New Patriotic Party (NPP) to improve access to health care. Participants in the study shared their concerns on how they feel the NHIS has been politicized to an extent that its success has been compromised by change in government between the two major political parties in Ghana.

"The NHIS started NPP time and NDC (National Democratic Congress) should have also seen the importance of this health care plan so they continue building this thing. Like by now the NHIS will be better but NDC people came to power and forgot about

it. Only to wait for NPP to come back to power to continue with their thing. This is why I don't like politics they add it to everything even when it doesn't benefit us" (Nicole)

Another participant interestingly shared her experiences which turns to buttress that the NHIS is highly politicized leading to the change in quality of service.

"I also feel that the quality of health insurance services changed a little bit with the change in government.
...former President Kufuor (NPP) introduced the NHIS but usually when there is change in government the quality does not remain the same" (Yvette)

On the same topic of politics of health, one participant said:

"...it (NHIS) becomes popular during election time because political parties use it to get votes. Also, most people think it is an NPP thing so sometimes they don't want to participate (subscribe) in it to make it grow. The government too will not put money inside for it to work." (Nicole)

Other concerns that were raised during interviews were about the reimbursement. It came to light that the government is responsible for reimbursing accredited hospitals and health care centres for providing NHIS services to patients. However, this is not usually done in a timely manner and therefore has repercussions on the health system as a whole.

"... some hospitals that gave health services to patients on the NHIS find it difficult to reclaim their money from the NHIS. Therefore, some of the health care centres have withdrawn their services to NHIS subscribers" (Key Informant 1)

In a similar vein, another participant said:

"It takes time for the health centres to recoup their money.
... they sometimes complain that the government does not reimburse the money as and when they need it. So, most at times the hospital may exhaust all their medications for months and will not have the needed money to restock medication and pay the hospital staff" (Carl-Jonas).

The delay in reimbursement has had consequences in other aspects of the whole scheme. The reimbursement made to health care providers is usually referred to as claims. Claim payments are crucial to the sustainability of health care provision in Ghana due to its strategic role. It seemed the policies and bureaucracy surrounding these claims leads to delays. An interview with key informant who is a service provider (Pharmacist)

> *"I understand that they (NHIS) have to do their job but sometimes they frustrate us so much. They delay in vetting the submission of our claims months after we have disbursed a drug to patients"* (Key Informant 3)

Other concerns that were raised during the interviews were about the quality and scope of medication approved on the list of medicines which the scheme covers. Most of the participants shared their dissatisfaction with the service.

> *"The medicine they give us are sometimes useless because the government only provides the low-grade ones through the NHIS. So sometimes if you want quality medicine you have to go to another pharmacy outside the hospital. On some occasions they will tell you the medicine is finished, and they are waiting for more"* (Nicole).

Again, on the topic of quality of prescription drugs, one of the participants said:

> *"I depend on the consultation from the doctor when I go to the hospital but like I said earlier, the medication they give under NHIS are of low grade or quality so I usually ask the doctors to write a prescription for me on what they think would be a better option of the medicine listed under the scheme so that I buy those"* (Carl-Jonas).

Another participant whose major concern about the quality of medication offered under the scheme had this to say:

> *"…because we are taking these drugs into our bodies, the quality of the drugs should be improved. Since the main goal is to make patients get better"* (Yvette).

In relation to the governmental measures or policies, common themes that emerged include the limited number of health facilities that offer NHIS services, others also talked about the limited points of registration for the NHIS.

> *"I don't think the government cares about the NHIS. We have been complaining that they should add more hospitals and health care centres. Sometimes you go somewhere (health care centre) they will tell you they don't take NHIS then you have to find another place to go. It can be very frustrating"* (Nicole).

When it comes to registration, a lot of participants shared how difficult it was to get enrolled on the NHIS. Interviews suggested that the convenience of registration and the systems put in place has an effect on enrolment which in turn affects the health seeking behaviour of people.

> *"I also think that more hospitals and health care centres should be included in the scheme to facilitate the registration process.*
> *... Government can extend the scope by giving licences to as many clinics and health care centres nearby to register people and offer services"* (Johanna).

Another participant said:

> *"When you think of the electoral voting registration, there are so many points for registration because these politicians want their votes, and they care about their votes but when it comes to the NHIS you have to look for places to register. Some hospitals will tell you that they take NHIS, but they can't register you over there. They have to find a way to add more registration points"* (Nicole).

Policies shape how aspects of society function and the lack of it creates a form of dysfunction in the regulation of social entities. The NHIS as an entity involves a lot of moving parts to ensure the functionality of the program to provide the right service is being provided. However, this is not the reality. This research identifies individual experiences most people tend to have in their pursuit of health care services. This helps to paint a picture of how the lack of functioning
policies affect points of service in the NHIS. Additionally, as presented in the previous sections the participants were able to provide an understanding of the role of politics in NHIS giving precedent to individual experiences within the NHIS.

Health care worker practices tend to influence people's experiences in accessing health care and in turn affect health seeking behaviour. Health care worker in this case is not only limited to individuals directly offering a health care service but includes other individuals such as NHIS enrolment officers and public health administration officers that serve as the main gate keepers to policies that are implemented to govern the health care system. Their roles are

essential to how the policies will come into play to shape health seeking behaviour of individuals in the society. As identified in the previous sections, there seems to be a gap in the functionality of health care policies surrounding the NHIS, making the role of the gate keepers take on an individualistic approach instead of a collective one. Some patients are usually denied some form of access to health care services using the NHIS. This was identified as a result of the struggling reimbursement strategies within the NHIS. Participants communicated this by explaining how they would be discriminated against, delayed, or denied a service to prevent the said facility from having to go through that strenuous process of being reimbursed. Health care workers such as Nurses and Pharmacists participate in acts that hinder the success of the NHIS. Nurses are said to sometimes prioritize individuals who are paying cash or with a private insurance over members with the NHIS due to the extra amount of paperwork processing that the scheme requires. An intriguing piece of information that came up during the interview process showed how this may be true, where the participant said that:

> *"To avoid all this stress, we sometimes tell card holders (NHIS subscribers) that we do not have the medicine. Though we have it, we prefer selling it to patients who can pay cash, so we don't have to deal with the NHIS for claims"* (Key Informant 3)

The process of obtaining the NHIS membership card does not come as easy as other national services like the voter's registration card as stated earlier. Although contradictory experiences were shared by participants, it emerged that it was generally a difficult process to get enrolled. The participant who shared a contrary view actually had help from her parents who knew people within the NHIS registration office. These experiences shared by participants indicate that there are deficiencies in the policies or its implementation denying people an easy access to register for health insurance.

Other participants also communicated how the level of service offered at the point of registration can sometimes be a deterrent to go through the process of subscribing for membership.

> *"So, the major challenge in enrolling in the health insurance in Ghana is, oh, my God, the queue takes a long time before you can even like get access to them to register you. Because the systems being used are slow and the network is really, really poor"* (Boateng).

The different ways individuals are treated upon arrival at healthcare facilities gives an understanding of the inbuilt hierarchy they operate in. There is usually a significant difference between private health insurance and the National Health Insurance. The difference is seen in

the scope of services available to patients. The time spent at the hospital and the priority with which patients are chosen to see the doctor. Participants described how they recognized that in some healthcare facilities, individuals who were paying out of pocket or had private insurance usually had more services offered to them. In addition to that these individuals were processed in a much shorter time than individuals with the NHIS. Private insurance card holders are known by these healthcare services to have a better reimbursement plan, so this knowledge is said to affect how health care workers relate to individuals seeking healthcare services.

> *"I use private insurance because I think it works better for me and I get it through my job. I have heard too many complains about the NHIS I haven't even bothered to inquire about it because my insurance always reimburses the facilities quickly so I'm okay."* (Abdullah)

Chapter 6: Discussion

6.1 Introduction

The goal of the study was to identify the experiences of individuals who are subscribed or non-subscribed to the NHIS in Ghana. This was to highlight key experiences between the two categories to identify how it affected their access to health.

From the findings in the previous chapter, participant accounts showed how they perceive health, health care and universal health care. They also demonstrated their understanding of health insurance in the Ghanaian context and how their experiences, perceptions and beliefs influence the manner in which they address issues pertaining to their health or their health seeking behaviour as regularly used in this study.

The findings of this study and the quadrants of the Integral Theory guided the discussion in this section. It discussed the theory within the context of the findings and demonstrated how it supported the findings of this study. It also focused on how the literature supports the findings and identified some of the gaps within it.

Lastly, the limitations and challenges encountered during the research process are also presented to give insight into how that could have potentially affected the nature of the findings presented.

6.2 Discussion of findings and its implications using the Integral Theory

My first research objective was to find out the challenges of enrolling and accessing health care with the National Health Insurance Scheme. Findings showed that my participants understood health care from both informal or traditional and formal or western health care point of view. The divergent perceptions on health aided in exploring some of the challenges faced when accessing health care. The NHIS is only functional in the formal or westernized health care system. Majority of the participants shared negative experiences in gaining access to health care using the NHIS. The negative experiences stated in the findings were both institutional and operational. Issues such as difficulty and delays in the registration process, limited access to registration centres, difficulty in obtaining the membership cards and delays, long queuing systems at health centres because of ones NHIS subscriber status and health care coverage limitations were some of the concerns raised. Other empirical studies have shown similar results, including a study of Ghana's National Health Insurance Scheme, looking at the challenges and dilemmas, they found delays in processing and issuing NHIS cards, delays in claims reimbursement and absence of basic health services as major challenges (Agyepong et al., 2016; Aryeetey, Nonvignon, Amissah, Buckle, & Aikins, 2016; Atinga, 2012). I agree that

such awareness of these challenges was also experienced by my participants. A plausible implication for this could be that, seeking health care under the NHIS as a subscribed members in most cases will be laborious and may lead to a bad experience or low quality in health care due to the differences in the health care delivery process for subscribers and non-subscribers of NHIS as shared by participants in the findings chapter. These experiences will then have negative influence on their perception of health care quality especially with the formal or westernized type of health system.

This assertion is in line with the Integral theory (refer to Figure 3) where an interaction between the I (upper left) quadrant and the IT (upper right) quadrant shapes an individual's behaviour towards health. Thus, a good or positive experience at a formal health care centre may shape and strengthen an individual or group of individuals beliefs, perceptions, and motivations to seek health care. A reverse of that may also lead to them finding other unconventional resources to cater for their health needs.

This is consistent with findings by Fenenga, Boahene, Arhinful, de Wit, and Hutter (2014) that subscribers of the NHIS in Ghana expressed dissatisfaction with long waiting times, unfair queuing systems, poor health worker attitudes, inadequate information and poor quality of medicines at accredited health facilities. On the same issue of negative experiences or challenges in accessing health care, Narain and Katz (2016) also found barriers to health care similar to the ones found in this study. One that remained consistent was the limited scope in health insurance coverage. In their study several respondents reported a dissatisfaction with gaps in their health insurance coverage. Gaps including dental coverage, prescription medication, vision and mental health coverage were also mentioned. The similar findings from these studies demonstrates how health insurance gaps can result in possibly worse and more expensive health outcomes or even influence health seeking behaviour of people.

On the other hand, the situation of difficulty and delays with registration and access to health care seemed to be nuanced. One participant in this study shared how she gained easy access to register as a member of the NHIS. She made mention of using her parents' connections or influence to get easy access. An implication could be that there are loopholes in the system where services are rendered on "who you know" basis rather than meeting requirements and first come first serve basis.

My second research objective was intended to explore the resources available to people or households in accessing health care. For the purposes of this study, resources were defined as any action or strategy which may be adopted in adverse circumstances in order to function effectively. Findings revealed that participants utilised both formal and traditional forms in accessing health care. For those who used the formal health system like the regional hospitals, district hospitals and small clinics they had to face a dilemma of either using the NHIS as a resource or make the decision to access and finance formal health care out of pocket. The utilization of health care services under the NHIS are confirmed by other studies. A study by Aryeetey et al. (2016) aimed to assess the effects of the introduction of NHIS on health service delivery in health facilities in Ghana using service delivery indicators such as outpatient and inpatient turn out. In their results the total outpatient and inpatient visits for all facilities before the introduction of the NHIS in 2003 were 1,677,731 and 141,234 respectively, and 2,749,405 outpatient visits and 213,175 inpatient visits were recorded some years after the implementation of the NHIS (i.e., 2010). The results of the study show that outpatients visits increased by 64% and inpatients visits increased by 51%. These results indicate high service utilization as result of the introduction of the NHIS. Other studies also showed that the implementation of the health insurance scheme either the national or community-based results in people seeking for formal care once they have been insured. Blanchet, Fink, and Osei-Akoto (2012) in their study demonstrated that on average, women enrolled in the insurance scheme are more likely to seek formal health care when sick. My findings also confirmed that a lot of women especially pregnant women and their children utilize the National Health Insurance Scheme more often in seeking health care. Even though several participants shared negative experiences in accessing health care with the NHIS it seemed to be beneficial to pregnant women and children. According to (Key informant 2),

"*…the policy basically allowed all pregnant women to have free registration within the scheme and additionally be entitled to free services throughout their pregnancy…"*

In relation to the Integral Theory, (see Figure 3) the lower right or interobjective quadrant (ITS), which represents governance, policies surrounding the NHIS, and maternal health care, interacting with the (I) upper left and (We) lower left quadrants to influence the perceptions of most pregnant women to seek formal health care during their pregnancy. These interactions then influence their health seeking behaviour found in the upper right or objective quadrant (IT) describing the behaviour of pregnant women towards maternal health care in this case.
In summary the policies of the National Health insurance Scheme and the Ghana Health Service to provide financial support and access to health care to people are likely to influence

the individual or subjective perceptions of people and motivate them to choose formal health care and subscribe to the NHIS for their health needs rather than resorting to self-medication at home or use some other means.

It became clear that some people use the family as a resource to access health care in various ways. Some depend on the family for financial assistance to pay medical bills others also use the family connections to access parts of the health care system like the registration of the NHIS. A study conducted by Palmer et al. (2011) on the affordability of health care by disability status to assist in an equitable health care utilisation, cost burden and coping strategies for people with disabilities. The results showed that disabled population were more prone to hospitalization and spend more on inpatient stays at hospitals and on pharmaceuticals. It also emerged that such households are at greater risk of catastrophic health expenditures and debt financing. In order to fund for relatively minor medical costs such household resorted to private savings or borrowed from friends and relatives. One limitation in using this particular study to buttress the findings only rests in the fact that the study by Palmer et al. (2011) was limited to households with patients with disability. However, the concept of using family as a resource to finance health care is clearly communicated here.

Despite the difficulties in accessing health care especially with the NHIS as reported by participants in this study, one participant (Yvette) shared how easy it was for her to get registered as a NHIS member. It turned out that her family (parents) had connections at the NHIS office and that is how she got easy access. An implication could be that people are being rendered this service on "who you know" basis. In this sense Yvette was able to access the NHIS using her family as a resource.

Participants in the middle- and low-income bracket acknowledged both the use of formal and informal (traditional) health care. Depending on the severity of their illness and other factors including financial capability and personal beliefs. Some of these people resorted to traditional healing as a resource for their health needs. Blanchet et al. (2012) in their study defined formal care as any visit where an individual was treated by a physician, dentist, nurse, or medical assistant. Alternatively, informal care was defined as any visit to a drug or chemical seller, traditional healer, or herbalist. The findings in this study showed that some families hold on to traditional means of healing and these have been passed down through generations. These subjective (I) and intersubjective (We) beliefs or perceptions also influence the behaviour of people towards accessing health care. This is evident in this study and other studies have also reported this. In a study conducted by Gyasi et al. (2016) to examine how relative effects of personal health beliefs influence the use of traditional medicine in the Ashanti region of Ghana. In evaluating health care behaviour, they discovered that values and sociocultural factors such

as customs, religious, personal beliefs, and philosophies are critical agents that pull people into the use of traditional medicine.

My third research objective was to explore the experiences of subscribers and non-subscribers of the NHIS in accessing health care. Findings revealed that most participants who were subscribed to the scheme had negative experiences or were dissatisfied with the service and quality of care they received under the NHIS as compared to participants who were not subscribed. According to the participants, factors that accounted for these experiences ranged mainly from extended or long waiting times at health centres for subscribers. They also mostly paid extra cost to access basic services such as scans, laboratory, and medicines. Others also spoke of poor attitude of health care workers towards subscribers of the scheme. Another interesting finding was that participants in this study mentioned that under the scheme, subscribers of the NHIS usually receive cheap medicines and at times they even have to buy some out of pocket even though these medicines should have been provided as part of the package of enrolling in the scheme. These findings are consistent with findings by (Atinga, 2012; Kodom et al., 2019).

On the other hand, non-subscribers rendered a different account of their experiences at health centres. Their willingness to pay out of pocket for health services granted them easier and smoother access to care. Thus, non-subscribers who had the financial capacity did not have to endure long wait times at health centres, they were able to afford good quality medicines. As accounted for by (Key Informant 2)

"...we also heard about how they sometimes separate NHIS card holders from individuals paying cash with the intention of catering to cash holders first at the expense of the NHIS card holders."

This issue may be attributed to the delays in reimbursement by the government as indicated in the findings of the study and other empirical studies (Fenny et al., 2016). Health centres attempt to focus or prioritize out of pocket payment patients in order to have funds available to keep the health centre in operation, rather than having to wait for months to get reimbursed by the government.

Prioritizing patients or non-subscribers who are willing to make out of pocket payments could have an implication on the perception of people on how they access health. In the findings chapter, Nicole lamented on her experiences at the health centre, and this has perhaps altered her health seeking behaviour.

"...it takes a lot for me before I decide to go to the hospital. I would rather try a pharmacy or other avenues before going to the hospital. I think for when I'm going to the hospital I would

only go if I have the cash to pay for the additional services that doesn't come with my NHIS". (Nicole).

This finding corroborates with the integral theory and how events are interconnected and interact with each other to reveal a homogenous understanding. Nicole's perception (I) has been influenced by the NHIS and Health system (ITS) which has then affected her behaviour toward health (IT). Here we see the (I), (ITS), and (IT) interacting to paint a holistic picture of the situation.

My fourth and final research objective was to find out the other strategies people are using in accessing health care. The results from this study revealed that some participants depending on the state or severity of their illness decide to self-medicate at home. Many participants within the middle- and low-income bracket shared how they rather preferred to go to a local pharmacy, chemist, or drug store to seek health consultation and buy their medicines or drugs there rather than going to seek care from a formal health centre. One of the participants, Carl-Jonas disclosed that even though he goes to a formal health centre he does not buy his medicine from the hospitals' dispensary. He said he strongly believes that the medicine issued out to patients under the National Health Insurance Scheme are not of good quality and since his health means a lot to him, he rather asks the doctor to write him a prescription of a better quality in order for him to spend extra money to purchase a high-quality medication. Others, especially in the low- and -middle income bracket resort to the use of traditional or herbal medicine to cater for their health needs. Simply because it is affordable and readily available to them. One participant in this study (Abeeku) shared how he likes herbal medicine because it is affordable, and he relies on traditional medicine and herbs in catering for his children's health needs.

According to Agyei-Baffour et al. (2017) herbal medicine is culturally acceptable and widely utilized in most parts of Africa for a wide spectrum of clinical illness. They further stated that knowledge of herbal medicine is almost universal in most homes with evidence of increasing usage. In many parts of the country, people are using herbal medicine to either treat malaria or compliment allopathic anti-malaria drugs (Agyei-Baffour et al., 2017).

In relation to the Integral Theory, it is evident that people's health seeking behaviour found in the upper right (IT) quadrant is being influenced by the lower right (ITS) consisting of structures, laws, and policies governing the health system, making it difficult for people to access health care or support them to have equal access to formal health care. From the findings, several participants especially in the low- and middle-income category sharing alternative health seeking behaviour (IT) or means in addressing their health needs due to difficulty or challenges within the health system (ITS).

6.3 Discussion of findings using the Integral Theory as the framework

As stated in the findings the use of the Thematic Network Analysis and NVivo helped to organize coded text from the interviews. This was to help paint a clearer picture of the findings and how they connected to the theory. Table 2 , generated in the findings chapter showed how these codes translated to the various quadrants of the Integral Theory. The findings showed interrelations between the quadrants. These are further elaborated in the discussion below. This part of the discussion focused on the organizing themes although inferring from some of the specific codes in relation to the Integral Theory. The organizing themes are the: Self-consciousness of health and motivation to join the NHIS (I), Shared perception towards health and the NHIS (WE), Behaviour towards healthcare and the NHIS (IT), Governance and systems surrounding the NHIS and access to healthcare (ITS).

6.3.1 Self-consciousness of health and motivation to join the NHIS (I-quadrant)

This section of the organizing theme captured the participants perspective on health care as well as the NHIS and the role their income played on their health. In the course of the interviews when participants were asked to describe what health meant to them, they each had deliberately different answers. Their responses showed how perceptions of health differ from person to person. Although, each of them understood the importance of health one way or the other, their definition of health did not always reference the absence of disease or illness. Each of the participants were also questioned on their understanding of the NHIS as a universal health insurance scheme and what it meant to them in their everyday lives. A significant number of the participants recognized the NHIS as a subsidy for easy access to health care services, although, one participant described it as a pension scheme. This means that the goal of the scheme is well known but as to the functionality of it many of the participants held their reservations. I think it was interesting to find that the media was the common source of information or resource about the NHIS. This proves that the government is doing a considerably good job in making sure individuals are well informed as a way to encourage them to enrol. I can assume that most of the participants understand the relevance and importance of the NHIS although, it has not been an encouraging factor to get some of them to subscribe as per personal experiences and perceptions on how to manage their health. They believe their decisions to enrol in the NHIS or not does not negate their opinion on in its relevance, but their personal preferences just motivated them to choose other options to managing their health. The I quadrant of the Integral theory is seen in play here where the individual's perception is shaping their health in some capacity. In terms of other personal motivations that can also affect one's conscious decision to join the NHIS is income. The type

of income coming into a household determines where health is placed in the family's finances. Families with low incomes are more likely to put health on the back burner as proven by the research. So, the level of income becomes a defining conscious factor to not being able to afford the premiums. This factor ties into the general self-consciousness of health because most people who are in low-income families understand health as a choice for people with higher income. Their level of income has been translated to a certain perspective of what it means to be able to afford health. The NHIS as a health care service provided by the government can be seen as a way to bridge this health inequity gap even though its success can be affected by such perceptions of health. The role of individuals perceptions to health can be classified as the combination of many other defining factors which now shape the mental models on how they view health. It is believed that perception comes from experiences, and we see that this is coherent in the findings since most of the participants indirectly spoke to how their individual experiences have shaped how they define and access health.

6.3.2 Shared perceptions towards health and the NHIS (WE-quadrant)

Individual perceptions end up becoming shared or collective perceptions. From the study, one of the participants had expressed learning about the NHIS from family. This process creates a shared perception because each family member's confidence in the effectiveness of the insurance scheme is then shared amongst other family members and individuals within the community. The findings showed how families in which members were subscribed to the NHIS were likely to get other family members to subscribe. One participant shared how she was coached through the registration process by her parents making the entire process easy for her as compared to someone who had to navigate this same process from the beginning. One of the participants in this study shared the importance of the NHIS to him and his family and how that has been a motivating factor to their continuous subscription. The insurance scheme had catered to the cost of bearing all his children, making this insurance of primary importance to him. Although, many expressed the challenges with the registration and access to certain healthcare facilities as a problem, it did not entirely affect their collective decision to subscribe or not subscribe. A common expression of the NHIS enrolment process described it as a very tedious process even to the point of potentially threatening one's job should they decide to take the initiative to enrol. One of the participants described how a person who has a nine to five job does not have the luxury of standing in long queues waiting to enrol as the process could take as long as five hours. Shared perceptions like these being motivated by experiences tend to potentially deter others from enrolling which could affect the success of the NHIS.

Furthermore, the research sought to identify any cultural biases affecting enrolment in the NHIS, however, there was no evidence of that in the findings. The only collective perception that was evident in the findings was the political history of the NHIS. This position, however, did not seem to have affected decisions to subscribe or not but the collective recognition of the NHIS as a political initiative seems to be a very common conversation amongst the discussion of the NHIS. The WE-quadrant of the integral theory explains how shared intersubjective beliefs and attitudes could help understand shared collective behaviour of individuals. From the choice of utilizing alternate medicine to other means of treating health care issues shows how individuals perceive certain aspects of the NHIS. For example, accessing pharmaceutical drugs or primary care. Some of the participants expressed having to resort to other means before accessing care at a formal facility. The known collective logic seems to be to access care through the NHIS only if it was of the absolute essence or had something to do with maternal and childcare. These shared believes in the case of this research study did significantly identify why others chose to subscribe or not since a lot of them held a collective believe on wait times in the health care facilities using the NHIS. Lastly from the findings, I noticed that a lot of the participants had a shared collective perspective on what the NHIS could offer as a service to make it more efficient, and it included issues like wait times, the inclusion of prescription drugs, a broader scope of service and the inclusion of more healthcare facilities within the NHIS.

6.3.3 Behaviour towards health and the NHIS (IT-quadrant)

The interrelationship between the WE and IT quadrants ushers us into this section of the discussion. The IT quadrant focuses on the objectivity of individuals when it comes to their health and the importance of the NHIS. In this section of the theory, it explains how availability of resources and services could help individuals be more objective about their health. It explains how convenience also creates need and, in this case, we see it in the form of alternative medicine or in the use of pharmacies. The inconveniences that participants described with accessing health care services through primary health care facilities created the need for other alternatives. One of the participants talked about using alternative medicine as a result of convenience. He mentioned having some herbal plants in his backyard making treatment accessible and easy. From the findings it seemed people realized how quick and convenient pharmacies were; making them a means of quick access to certain basic health care needs. The following quote captures the shared convenience of accessing care through pharmacies to most of the participants

"...I would rather try a pharmacy or other avenues before going to the hospital. I think for when I'm going to the hospital I would only go if I have the cash to pay for the additional services that doesn't come with my NHIS" (Nicole)

Most of the participants also shared their concerns on some services that were lacking within the NHIS. Services like prescription, lab testing, x-rays and surgeries were seen as an important service that required coverage. These services for example prescription drugs, accounts for the bulk of the everyday medical expenses for certain individuals. This does not make the NHIS seem like a suitable health plan since it leaves the bulk of the medical expenses for the individuals to bare.

"I know all medical or health procedures are not covered by the NHIS…let's say cardiac issues are not fully covered even medications…I have a colleague whose father is subscribed to the NHIS and still had to pay out of pocket for a cardiac surgery" (Abdullah)

The quote above showed how redundant it seemed for members who supposedly had access to a health insurance plan but still had to pay out of pocket for a substantial amount of health care services. The NHIS, however, is known to have good maternal and child health care plans which some of the participants could attest to its effectiveness. This shapes the objective mindset of pregnant women although this was seen as the only thriving part of the NHIS considering how some of the responders were aware of its success and benefit to the health care system. Overall, from the findings it does not seem like the NHIS is good with granting one access to quality care as most people have to end up supplementing the bulk of their healthcare bills especially with medications. The quality of medication provided through the NHIS is also considered to be low grade and of poorer quality. One of the participants mentioned how he usually asked for the prescription to take it to a pharmacy of his choice to choose a better option over what was offered. Due to most of the responder's reservations about wait times it seems like they are only most likely to access health care when circumstances are dire however, this is not considered good practice for a country with a universal health insurance. This quadrant of the integral theory also shows a causal relationship between the (ITS) and (I) quadrants since individual's perceptions can convince them to interact with the world different. For example, someone who believes in a holistic kind of health is more likely to be focused on their diet and fitness as a way to interact positively with their environment thereby shaping their health.

6.3.4 Governance and systems surrounding the NHIS and access to health care (ITS)

This section can be considered of outmost importance since most of the health promotion initiatives start with governments coming out with a comprehensive strategy to building the NHIS while improving access. In this section in relation to the findings I identified that most of the participants were not impressed with the scopes of services within the NHIS. Some of them hoped that it will include more services such as pharmaceuticals and laboratory services. This section is where policies and funding that will support the NHIS is decided. The findings also showed that the political atmosphere surrounding the NHIS affected the effectiveness of the scheme depending on which party was in power. From the findings it was evident that some of the participants believed the NHIS was only as effective as the political party in power. One of the participants mentioned how whenever there was the opposing party in power certain aspects of the NHIS was not very functionable. This instability makes the topic of health promotion and quality of care all the more relevant since having such foundations in place eliminates the effects of the politics on the NHIS. The government must ensure that quality of care and the effectiveness of the NHIS is at the centre of their political initiatives irrespective of their differences in political positions.

The findings also revealed limited points of NHIS healthcare facilities, registration locations as well as poor reimbursement strategies. Each of these challenges are dependent of government policies supporting the NHIS. Participants have expressed being turned away from accessing services since some specific facilities did not make use of the NHIS card. This creates an access issue as for this participant in question would have to find another location that may not be in close proximity to be able to access the necessary care needed. Another challenge that goes hand in hand with lack of NHIS healthcare facilities is the reluctance to accept individuals accessing care with the NHIS. The scheme is known to have poor reimbursement strategies that makes it difficult for certain health care facilities to function on the NHIS. They would rather prefer to accept individuals paying cash so as to avoid the government's reimbursement procedure. This renders the NHIS ineffective in most cases as individuals will be indirectly coerced to pay out of pocket to get the services they need. These personal experiences shape how individuals view health and the NHIS. Another sector where participants expressed how the government could be failing in supporting the effectiveness of the NHIS is with points of enrolment. The desire to enrol is trumped by the challenges involved with the enrolment. The process is not as direct and feasible to most people. This affected their willingness to enrol or stay enrolled. It made most of the participant more drawn to private health insurance policies since they seem to present them with better access to services.

Lastly, the health care system seems to be overburdened in the country as seen in the hospital wait times and the patient to doctor and nurses to patient ratios. One participant described the average person having to wait at least one hour to see a doctor. This time does not factor in individuals who are paying cash which is always preferred by most facilities and giving preference to cut the lines. This practice was notoriously seen to be high amongst nurses who are also usually left to deal with the administrative work involving reimbursements. These nurses rather opt to make their lives easier by choosing a means that ensures that the necessary funding is secured to keep these health facilities afloat. However, it comes at the cost of their reputation. Although it is understandable why they would prefer individuals who are paying cash this does not help boost the reputation of the NHIS. The role nurses play in this initiative is of key importance as well since they serve as a gate keeper to services provided under the NHIS.

Overall, the findings were coherent with the literature and the theory although a lot of other themes emerged, and connections were drawn based on the findings to fill in the gap in the literature. Based on the findings, in order for the NHIS to be more effective, the government will have to find comprehensive ways to addressing the challenges raised in the research. A good way to ensure that the newer policies address the stated issues could be using the health promotion framework in conjunction with the social determinants of health to make sure not only are being giving access to quality health but promote a healthy quality of life.

6.4 Discussion of findings in relation to the literature

The literature showed how the push to universal healthcare was mainly to ease financial costs on individuals accessing health care however different countries have struggled in different capacities to achieve this without it affecting access and quality. Some countries have had success in implementing specific aspects of universal healthcare that has seemed to work based on the prominent issues faced by the country. For example, when countries like Mali made malaria and caesarean sections free for all its citizen while Burkina Faso also implemented subsidized deliveries. (Ridde et al., 2014). This initiative although very specific gave the impression to have been an effective change in their health care system in those areas. Bringing the focus back to Ghana, although the NHIS was meant to be a universal coverage initiative, it seemed like some aspects of it served more of an importance to people than others. This gave every indication that the NHIS was successful for those who be utilized those services however, it might not be general to the population still creating concerns about the effectiveness of the NHIS to Ghanaians. From the findings a significant amount of the participants indicated positive reactions to the effectiveness of the NHIS in maternal and childcare. They spoke about how the insurance policy covered both prenatal and antenatal care. Ghana was known to have high child and maternal mortality rate, so it is no surprise this initiative reflects positively on the NHIS.

The NHIS as a pro-poor health financing policy however is still under question as many of the participants mentioned how they always had to supplement some of their basic health care needs even with the NHIS. The literature stated that in low-middle income countries, some of the factors that determine the enrolment in health insurance schemes include the cost and timing of premium payments, however this was not coherent with the findings (Agyei-Baffour et al., 2017; Akazili et al., 2014; Fenny et al., 2016). Most of the participants had no issues with the premiums they had to pay since they saw it as a small fee in comparison to what they would have been paying for full out-of-pocket services rather the enrolment process was seen as quite challenging. One of the participants stated

"So, the major challenge in enrolling in the health insurance in Ghana is, oh my God! the queue. It takes a long time before you can even get access to them to register you. The systems being used are slow and the network is really poor" (Yvette)

This quote captures most of the other participants frustration with the enrolment process. This shows that there is a desire to utilize the service however, challenges like this deter people from wanting to patronize the services. As more people struggle to enrol in the scheme this ends up

becoming a shared community health belief which was stated in the literature as an important aspect that policy makers need to recognize as a barrier to enrolment in health insurance schemes (Jehu-Appiah et al., 2012).

One aspect of the findings that was very consistent to the literature is the use of alternative medicine. The literature showed a significant number of Ghanaians use other means to supplement their healthcare needs and this was true from the findings. Although, the literature stated that the use of this medicine is seen as a major delay in the process from illness to wellness, it seems to be a commonly used method (Kretchy et al., 2016). Most of the participants stated how they resulted to such means as a result of the pressure already present in the healthcare system. They had no intentions of staying in long queues to access healthcare services if they believed their symptoms were not as severe. A significant amount of the participants utilized pharmacies as their primary source of care for some mild symptoms. They were more likely to follow the consult of the pharmacist or herbalist based on the commonness of the healthcare issue and the treatment plans already available. This is captured in this quote by one of the participants who stated,

"…in Ghana, one disease that is common here is Malaria and the medication is readily available, so there is no need to go to the hospital… I also like herbal medicine in my area there are lots of it growing around my house. There is a particular herb called the bitter leaf (Vernonia amygdalin). Inasmuch as its bitter for me, it works so well." (Carl-Jonas).

The participant saw no need going through the trouble of accessing healthcare through a facility especially since remedies that have been known to work for the most part is conveniently accessible.

The literature available was mostly coherent with the findings and supported a significant amount of what was found. However, there were still some identifiable gaps in the literature. The literature failed to acknowledge the interrelationship between the hospital wait times and the individual need to utilize alternative medicines. The literature posed the use of alternative medicine as a cost issue as well as an efficacy issue but upon further review of the findings from the study, the use of alternative medicine to also eliminate hospital wait times was seen as a defining factor to using alternative medicine. Furthermore, the literature stated how the use of alternative medicine was being debated to be formally implemented into the healthcare system because of the patronage it receives. However, the literature made no mention of how this was going to continue access as medication is already a challenge in the formal healthcare system based on the findings and research.

Findings indicated differences in experiences with accessing health care either as a subscriber or non-subscriber of the NHIS. Most participants in this study shared negative experiences in their quest to seek health care especially with the National Health Insurance Scheme. However, a significant number of participants and evidence from empirical research discussed earlier indicated positive reactions to the effectiveness of the National Health Insurance Scheme (NHIS) in the area of child and maternal health care.

Another remarkable observation was the fact that participants who were subscribed to the NHIS reported of unfair treatment and prolonged waiting times when they went to the hospital or health care facility for treatment. Various explanations were given for this prolonged waiting times as a subscribed member. Participants and key informants shared how there are red tapes in the processing of paperwork for subscribers. As a result of these complex and strenuous process just to access healthcare, people have adopted other strategies in catering for their health needs. It was found that some self-medicate at home, other use traditional herbal medicine etc.

6.5 Discussion of findings in relation to Health promotion.

6.5.1 The dilemma of NHIS as a form of universal health care and health promotion

Universal health coverage (UHC) is believed to centre on delivering effective and affordable health care which focuses heavily on curative care (Coe & de Beyer, 2014). The NHIS in Ghana as a public health policy is an example of this form of coverage and how it focuses heavily on curative care which is contrary to the core values of health promotion. The review of the available literature stated how significant different life expectancies are easily identified between geographical regions often considered as first and third world. This issue is mostly attributed to the state of health care services in those countries. A deeper review and understanding into this phenomenon reveal that these countries also have different health promotion practices if brought to comparison. The framework of health promotion ensures that people stay healthy so they do not have to access continuous formal health care services an approach that can promote universal health and not just in health care services. Putting policies in place where individuals can take control of their health is a better option than having to deal with the remnants of an overburdened health care system. The state of the NHIS now as gathered from the findings could benefit from a Health promotion approach. The insurance policy in itself is struggling to provide the quality of care defined by the WHO and other health organizations defining quality of care as an essential part of the healthcare system. The definitions of health presented by the participants showed that they attribute a personal element to the success of their health which could be used as a form of leverage to support health

promotion initiatives. Different minor initiatives that have been taken on by different countries have shown significant changes. For example, in Thailand when a 2% tax from tobacco and alcohol companies was used to fund "ThaiHealth" an independent state agency, there was a 178 million litres reduction in sales of beer and whiskey between 2008 and 2009 (Coe & de Beyer, 2014). This initiative was said to reduce domestic expenditures by almost 8% (Coe & de Beyer, 2014). I believe initiatives like this will help support the countries healthcare system better since most of the participants within the cause of the study already expressed how they had to find other ways to support their health outside of the formal health care system. Thus, a health promotion approach such as the example from Thailand where health agenda was put in a policy that combined diverse but complementary approach to include legislation and taxation to support public health should be instilled in policy making in Ghana.

6.6 Limitation of the study

This study was conducted in unprecedented times making the strategy of the research take some unconventional means to adapt. First and foremost, one of the major challenges to the research was the selection of participants. Secondly the manner in which the interviews took place and lastly is some aspects of the theory employed. This section details the limitations and events that occurred during the study which had an impact on the overall outcome.

6.6.1 Participants

It needs to be acknowledged that there were some challenges during this research process which have potentially affected the outcome. Due to the pandemic in 2020, the period in which this research was being conducted; The COVID-19 travel restrictions prevented me from travelling to Accra, Ghana to conduct my fieldwork. I then had to resort to an alternative plan to obtain participants for the study. As explained in Chapter 4 (Methodology) I sought help from the Assemblyman in my study area to aid in selecting participants for the study. I believe my absence in the field had an impact on this process. However, the use of the Stratified Sampling of participants in Table 1 aided in overcoming this challenge.

Another challenge with the participant recruitment process also led me to interview three Ghanaians who live in Norway in order to fill the gaps in my sample population. Although they did not match the geographical requirements as showed in Table 1 they matched the residential category, interviewing them here about their experiences with the NHIS was relevant to this study and ensured that the target category was reached.

6.6.2 Challenges with conducting interview online

There are specific considerations with online interviews which may have impacted the quality of the data gathered during the study or interviews. First of all, the process was challenging due to technological intellect. This ruled out eligible participants since they did not have easy access to the required technology. For instance, Zoom which was more secure and encrypted. Others had a weak or poor internet connection which made the whole interview process frustrating and time consuming. The weak data signals in Ghana affected the flow of the interviews as sometimes the connection disrupted the responses leaving room for interpretation of what was last said.

Some participants also requested strictly for audio calls. This had an impact on the interview process. Nonverbal cues such as facial expressions and gestures which are important in facilitating engagement and promoting a natural and relaxed conversation as posited by Archibald, Ambagtsheer, Casey, and Lawless (2019) were all lost due to the participants preference for audio calls rather than video calls.

6.6.3 Theoretical limitation

Ken Wilber's Integral Theory was employed in this study to present a holistic framework in understanding the experiences of subscribers and non-subscribers of the NHIS in accessing health care in Ghana. According to Esbjörn-Hargens (2010) Integral theory is the comprehensive study of reality which weaves together the significant insights from all the major human disciplines of knowledge acquisition and it consist of five core elements (i.e. quadrants, levels, lines, states, and types). However, this thesis only focused on the quadrants, and it did not employ the other core elements that together constitute the five elements of the integral model to give an overall comprehensive overview. Thus, the utilization of the Integral theory was not all encompassing or inclusive. On the other hand, applying the full model would greatly surpass the scope of this master's thesis.

Chapter 7: Conclusion

The overall objective of this study was to explore the experiences of subscribers and non-subscribers of Ghana's National Health Insurance Scheme (NHIS) in accessing health care.
In the course of the study, Universal Health care or National Health Insurance schemes as a public health policy was seen as gaining acceptance of almost if not all international communities. This is partly due to the safety net and financial risk protection it offers to everyone especially the poor and vulnerable in society. Such schemes or programs in some contexts make room for the poor have increased access to health care across the country.
It could be argued that the Ghana National Health Insurance Scheme which continues to play a critical role towards attaining SDG 3, universal health coverage is burdened with challenges that could potentially affect the scheme and trickle down to how people access and experience health care in Ghana.
The findings in this study are summarized in three parts in this chapter. The first addressed the challenges within the NHIS. The second focused on the stronghold of the NHIS in accessing health care in Ghana and lastly, the distinct differences in the experiences of health seekers with respect to their NHIS status is discussed.

The National Health Insurance Scheme (NHIS) is still relevant it is still utilized Ghanaians. However, the scheme is imbued with challenges both institutional and operational. In the sense that some of these challenges are caused by the design of the policy itself. Red tapes and bureaucracy. For operational challenges, it was evident that the day to day running of the scheme has been altered due to many factors already discussed within the study. The NHIS policy document does not match or tally with its daily operations. For example, the policy document states that the scheme covers about 95 percent of health problems confronting Ghana, but in reality, it does not. This is according to findings in this study and other empirical study according to literature reviewed. As a result of this, health seekers in many cases have had to resort to other means to address their health needs.

The second main finding in this study is a positive one. It was found that the National Health Insurance Scheme is excelling in the area of child and maternal health. Findings in this study showed that many participants were pleased and satisfied with maternal care using the NHIS. This finding is in line with other empirical studies as stated in the literature review chapter.

The third and final main finding in this study is the distinct differences in how subscribers and non-subscribers of the NHIS gain access to health care at health centres. Finding showed how patients or health seekers are treated upon arrival at health care facilities. This portrayed an

understanding of an inbuilt hierarchy or preference system in which service is delivered according to ones' NHIS status. In summary, non-subscribers or patients who were willing to pay out of pocket usually had more services offered to them, some participants reported that even nurses were more friendly. It was found that non-subscribers who were willing to pay out of pocket generally spent less time in queues to seek consultation from a doctor. On the other hand, subscribers to the NHIS unfortunately had to endure long wait times in queues at accredited hospitals or health centres. They had to settle for low grade medicines since those were what the scheme provided. According to some participants in this study, an explanation for the long duration in queues were due to the fact that, health workers prioritized out of pocket payment patients over those subscribed to the NHIS (cardholders). However, upon further interviews with key informants in the health sector, it was revealed that the cardholders or NHIS subscribers had to go through a documentation process at all NHIS accredited health centres in order to gain access to the health care they need. This process is claimed to be tedious, and every detail must be filled carefully if not the health centre does not get reimbursed by the scheme management or government. (See Figure 2) on how claims processing is done.

In conclusion, this study contributes to research on health care, health insurance, health equity and aspects of health promotion, it highlights the experiences of individuals in accessing health care and emphasises on the aspect of health equity within the Ghanaian context by illustrating the various experiences people go through just to gain access to health care. It also shed light on some alternatives people resort to as a result of inequity in health care in Ghana. This study reveals how policies should be revised in order to make health care more accessible to all while providing a financial risk protection to health seekers.

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APPENDICES

APPENDIX 1: Interview guides

Interview guide for subscribers

1. What does health mean to you?
2. How would you describe your own health?
3. What do you understand universal health care?
4. What do you know about the NHIS?
5. How did you get the information about NHIS? *(Was it enough?)*
6. What do you know about the benefits of the program?
7. What are some of the challenges in enrolling with the NHIS?
8. What are some of your challenges in accessing healthcare?
9. How much of your healthcare costs are covered by the insurance?
10. What extra health cost do you have? *(With regards to accessing healthcare as an insured member of the NHIS)*
11. How could NHIS be improved?
12. Can you describe your experience accessing healthcare as a subscribed member of the NHIS?
13. Could you tell me about how you fund the health care needs in your household *(Do you allocate funds for health care needs or addressed as they come?)*
14. What percentage of your family's expenses or personal expenses go towards health in the past 12 months?
15. How often do you go to a health facility for health care treatment?
16. Tell me about when you go to a health care facility *(Clinic or hospital)*
17. Tell me about your perception on paying premiums even if you rarely access health care services
18. How happy are you with the amount you have to pay?
19. Can you tell me about other sources of health care you may access? (*e.g. pharmacists, herbalists, etc.*)
20. What services would you like to see covered by NHIS? Would you be willing to pay more to improve the program? How much do you think the government should

subsidize the NHIS premiums? *(How would you benefit from it. How do you think that will cover very poor people)?*

Interview guide for non-subscribers

1. What does health mean to you?
2. How would you describe your own health?
3. What do you understand universal health care?
4. What do you know about the NHIS?
5. What do you know about the benefits of the program?
6. Why have not joined the NHIS? *(What in particular stopped you from joining?)*
7. Can you describe your experience accessing healthcare as a non-subscribed member of the NHIS?
8. Could you tell me about how you fund the health care needs in your household *(Do you allocate funds for health care needs or addressed as they come?)*
9. What percentage of your family's expenses or personal expenses go towards health in the past 12 months?
10. How often do you go to a health facility for health care treatment?
11. Tell me about when you go to a health care facility *(Clinic or hospital)*
12. Tell me about your perception on subscribers who pay for premiums even when they rarely access health care services
13. Can you tell me about other sources of health care you may access? (*e.g. pharmacists, herbalists, etc.*)
14. What services would you like to see covered by NHIS?
15. What might encourage you to join the NHIS? *(If the government subsidised it more, would you join?)*

Interview guide for health workers and NHIS officials

1. Can you tell me about your perception on the NHIS?
2. What do you feel about the uptake of people in the NHIS? (*With regards to enrolment)*
3. In your experience, is it mostly the richer or poorer people who participate in the NHIS?
4. What do you feel about the quality of the service?
5. How could the system be improved?

APPENDIX 2: NSD Ethical Approval Letter

NSD NORSK SENTER FOR FORSKNINGSDATA

NSD's assessment

Project title

Exploring the experiences of National Health Insurance Scheme subscribers and non-subscribers in accessing healthcare within the Accra Metropolitan Area.

Reference number

291039

Registered

19.07.2020 av Isaac-Glover Bannerman-Agbeshie - Isaac-Glover.Bannerman-agbeshie@student.uib.no

Data controller (institution responsible for the project)

Universitetet i Bergen / Det psykologiske fakultet / Hemil-senteret

Project leader (academic employee/supervisor or PhD candidate)

Marguerite Daniel, Marguerite.Daniel@uib.no, tlf: 4755583220

Type of project

Student project, Master's thesis

Contact information, student

Isaac Glover Bannerman-Agbeshie, glvr007@gmail.com, tlf: 4791298821

Project period

01.08.2020 - 30.06.2021

Status

21.07.2020 - Assessed

Assessment (1)

21.07.2020 - Assessed

Our assessment is that the processing of personal data in this project will comply with data protection legislation, so long as it is carried out in accordance with what is documented in the Notification Form and attachments, dated 21.07.2020, as well as in correspondence with NSD. Everything is in place for the processing to begin.

NOTIFY CHANGES
If you intend to make changes to the processing of personal data in this project it may be necessary to notify NSD. This is done by updating the Notification Form. On our website we explain which changes must be notified. Wait until you receive an answer from us before you carry out the changes.

TYPE OF DATA AND DURATION
The project will be processing special categories of personal data about health, and general categories of personal data, until 30.06.2021.

LEGAL BASIS
The project will gain consent from data subjects to process their personal data. We find that consent will meet the necessary requirements under art. 4 (11) and 7, in that it will be a freely given, specific, informed and unambiguous statement or action, which will be documented and can be withdrawn.

The legal basis for processing special categories of personal data is therefore explicit consent given by the data subject, cf. the General Data Protection Regulation art. 6.1 a), cf. art. 9.2 a), cf. the Personal Data Act § 10, cf. § 9 (2).

PRINCIPLES RELATING TO PROCESSING PERSONAL DATA
NSD finds that the planned processing of personal data will be in accordance with the principles under the General Data Protection Regulation regarding:

- lawfulness, fairness and transparency (art. 5.1 a), in that data subjects will receive sufficient information about the processing and will give their consent
- purpose limitation (art. 5.1 b), in that personal data will be collected for specified, explicit and legitimate purposes, and will not be processed for new, incompatible purposes
- data minimisation (art. 5.1 c), in that only personal data which are adequate, relevant and necessary for the purpose of the project will be processed
- storage limitation (art. 5.1 e), in that personal data will not be stored for longer than is necessary to fulfil the project's purpose

THE RIGHTS OF DATA SUBJECTS
Data subjects will have the following rights in this project: transparency (art. 12), information (art. 13), access (art. 15), rectification (art. 16), erasure (art. 17), restriction of processing (art. 18), notification (art. 19), data portability (art. 20). These rights apply so long as the data subject can be identified in the collected data.

NSD finds that the information that will be given to data subjects about the processing of their personal data will meet the legal requirements for form and content, cf. art. 12.1 and art. 13.

We remind you that if a data subject contacts you about their rights, the data controller has a duty to reply within a month.

FOLLOW YOUR INSTITUTION'S GUIDELINES
NSD presupposes that the project will meet the requirements of accuracy (art. 5.1 d), integrity and confidentiality (art. 5.1 f) and security (art. 32) when processing personal data.

To ensure that these requirements are met you must follow your institution's internal guidelines and/or consult with your institution (i.e. the institution responsible for the project).

FOLLOW-UP OF THE PROJECT
NSD will follow up the progress of the project at the planned end date in order to determine whether the processing of personal data has been concluded.

Good luck with the project!

Contact person at NSD: Tore Andre Kjetland Fjeldsbø
Data Protection Services for Research: +47 55 58 21 17 (press 1)

APPENDIX 3: Informed Consent form

Topic: **Exploring the experiences of National Health Insurance Scheme subscribers and non-subscribers in accessing healthcare within the Accra Metropolitan Area.**

Background and purpose

My name is Isaac-Glover Bannerman-Agbeshie. I am a student at the University of Bergen, Norway. I am pursuing a Master of Philosophy in Global Development- Theory and Practice. I am currently undertaking a research project to explore the experiences of subscribers and non-subscribers of the National Health Insurance Scheme in accessing formal healthcare in the Accra Metropolitan Area. I would kindly like to request your participation in this study.

Confidentiality

Any information collected from this interview will be confidential. Your identity will not be made known in this study. The interview tapes will have numbers and no names will be linked to them. This interview is not mandatory; therefore, you have the option to withdraw as a participant from the study at any time without any further explanation or penalty. If you withdraw from the study, all information provided by you will be made anonymous and excluded from the data collection.

Benefits and Risks or Exposure

The information that you provide will be of great value to this study. Your participation will not expose you to any form of risk or disclose any sensitive issue that will be discussed. It will rather add to knowledge on about the topic at hand.

Participation

The interviews are scheduled to last between 30 to 45 minutes. The time and venue will be at your convenience. With your permission I will record and take notes during the interview session.

If you would like to participate in this study, kindly sign the informed consent agreement below.

For any inquiries, please contact the researcher or supervisor at Faculty of Psychology, University if Bergen, Norway

Researcher: Isaac-Glover (iba021@uib.no)

Supervisor: Marguerite Daniel (Marguerite.Daniel@uib.no)

By signing below, I acknowledge that I have understood the above information and thereby give my consent to be part of the study

Signature…… Date……. /……/……