LUND UNIVERSITY
School of Economics and Management

Master in Economic Development and Growth

Social Capital and Ghana's National Health Insurance Scheme: Understanding Informal Sector Participation

Kofi Akuoko
kofi_abankwa.akuoko.205@student.lu.se

Abstract: Pursuing Universal Health Care in a developing economy like Ghana is a bold, laudable idea. Given the immutable benefits of Social Health Insurance in this pursuit, the long-term performance of Community-Based Health Insurance (CBHI) Schemes in developing countries remains a conundrum when viewed from the predominant economic and health system frameworks. In the context of a weak state with a large informal sector however, this study demonstrates that the inclusion of a social context in the foundational framework yields valuable insights that must inform the conceptualization, design and implementation of CBHI-founded Social Health Insurance initiatives across the developing world.

Key words: Social Capital, Community-based Health Insurance, Social Health Insurance, Universal Health Coverage

EKHM52
Master thesis, second year (15 credits ECTS)
June 2014
Supervisor: Ellen Hillbom
Examiner: Christer Gunnarsson

Acknowledgment

My utmost thanks and praise to God Almighty! Thou (Oh LORD) have a famous reputation that has never been forgotten! To You alone be all the Glory through our Lord Jesus Christ!

To my best friend, partner and wife, Lois, this work is another product of our partnership. We look into the future with hope towards many more blessed undertakings. To my mum Ellen, I hope that you will be proud of this work – it is a result of your selfless work.

I also owe a lot of gratitude to my supervisor, Prof Ellen Hillbom, who provided valuable guidance and critique. It has been an honour to learn from you.

Soli Dei Gloriam!

Kofi Akuoko.

List of Tables and Figures

1. Introduction

Financing healthcare is a global challenge. In the resource-constrained environments of developing countries however, this challenge frequently assumes epic proportions, a problem that has long been recognised. In 1997, the World Bank estimated average per-capita public health spending in low-income countries at $6 in comparison with $1,890 in developed countries. Such low levels of spending invariably translate into low input levels, insufficient investment in capacity development and low levels of health technology; poor remuneration and brain drain of health professionals; and ultimately, poor (even harmful) quality of healthcare.

Many initiatives have been implemented in developing countries to try and remedy this challenge. In the immediate aftermath of independence from colonial rule, many developing countries provided free healthcare for their populations. The negative growth patterns that followed the initial boom, coupled with the failure to develop the institutional capacity to rope in a large tax base (primarily due to a large informal sector) however made it impossible to sustain universal state provision. While continuing to receive external assistance therefore, many developing countries have been seeking autonomy in healthcare finance by experimenting with user fees, private financing and various risk-pooling mechanisms including Community-Based Health Insurance (CBHI) and Social Health Insurance (SHI). It is these last two initiatives that are the objects of interest of this study.

CBHIs are frequently cited as a promising transition mechanism to achieving universal health coverage through SHI. Discussions concerning CBHI and SHI in developing countries are invariably founded in economic or 'health system' frameworks, both perspectives emphasizing rational individual utility maximisation as the central factor to

consider in a successful implementation of health insurance. It is increasingly apparent however that these two frameworks are inadequate to explain the murky evidence on the long-term sustainability of CBHIs and their potential to transform into successful SHIs in many of today's developing countries (Bennett, Kelley et al. 2004). In contrast to the historical precedent in 19th century European and Japanese societies where CBHIs arose spontaneously from grassroots organisations, CBHIs in current developing countries are mostly interventions initiated by governments or aid organisations (Meessen, Criel et al. 2002). Thus, it cannot be assumed as a matter of course that CBHIs in today's developing countries will grow into national health insurance systems just as they did in Europe and Japan. The difference in institutional setting may therefore be a pointer for an explicit consideration of social context in thinking about CBHIs today, especially if the goal is to attain sustainable health financing for Universal Health Coverage (UHC) through that medium.

Social Capital theories provide a complimentary framework in this direction. The nature and strength of societal relationships are facilitators of any voluntary association, a defining feature of CBHIs. In fact, this feature assumes heightened importance in today's developing countries because a large informal sector means that employing a formal commitment mechanism to enforce regular contributions is impractical if the aim is UHC. Invariably, other mechanisms must be relied upon to drive (continuous) membership and guarantee willingness to pay in the informal sector; frequently, these 'other' mechanisms are social in nature. It is therefore beneficial for any assessment of the potential of a CBHI to transition into a National SHI to consider the social norms, values and expressions of societal association that manifest in the specific context.

The aim of this dissertation is to apply a Social Capital framework to investigate the potential for universal informal sector participation in a SHI scheme grounded in CBHIs, using Ghana's National Health Insurance Scheme (NHIS) as a case study. The specific research questions are:

(1) What do the revealed social norms, values and patterns of association indicate with regards to the strength or otherwise of Social Capital in Ghana?

(2) What are the implications for voluntary informal sector participation in Ghana's NHIS? What do they mean for the Scheme's design with regards to financial sustainability?

We believe such an investigation is important as application of Social Capital theory to analysis of CBHIs can offer important insights that can positively affect the design and reform of SHI initiatives that are founded in CBHIs in developing countries.

1.1 The Challenge of Healthcare Financing in Ghana

1.1.1 History

(Agyepong and Adjei 2008) provide a historical overview of changes to healthcare finance in Ghana. Before independence, the citizenry paid for healthcare out of pocket. In the immediate post-independence period, the socialist government of the day introduced free healthcare at the point of delivery, financed out of general taxation. The failure of the formal economy to take off however meant that that arrangement was unsustainable leading to the introduction of user fees in the mid 1970s and substantial hikes in these fees in the 1980s. According to (MOH 2001), user fees reduced essential drugs and supplies shortages and achieved the financial objective of raising revenue to cover at least 15% of recurrent expenditure. (Gilson 1997) thinks otherwise, arguing that Ghana only managed

to initially recoup up to 12% of government recurrent expenditure before the figure fell to lower levels, rising again only with fee increases. The sustainability of financing healthcare out of user fees was therefore doubtful to say the least. More importantly, user fees reduced access to both basic and essential healthcare, particularly for the poor, leading in many cases to catastrophic consequences (Waddington and Enyimayew 1990, Asenso-Okyere, Anum et al. 1998, Agyepong 1999, Nyonator and Kutzin 1999). The situation prevailed however until the passage of Act 652 in 2003 with the explicit purpose of eliminating the '*cash and carry'* system (as payments for healthcare services are termed in Ghana).

The NHIS is an attempt to provide a social welfare state, at least with respect to healthcare. The Scheme's conceptualisation, design and implementation was highly politicised with very little input from technical personnel or academics (Agyepong and Adjei 2008). The need for and the ethical uprightness of ensuring access to healthcare across the population, irrespective of the ability to pay, dominated the discussions about the NHIS and with the benefit of hindsight, it is evident that policymakers may have underestimated the difficulty of implementing a viable social welfare system under Ghana's peculiar characteristics.

1.1.2 Ghana's National Health Insurance Scheme (NHIS)

In 2003, Ghana's parliament passed the National Health Insurance Act 650, the primary purpose of which was to "secure the provision of basic healthcare services to persons resident in the country through mutual and private health insurance schemes". The Act provided the legislative backing for the establishment of a National Health Insurance Fund (NHIF) to be managed by a National Health Insurance Authority (NHIA) in pursuit of the stated aim through the medium of a National Health Insurance Scheme (NHIS). To

fully operationalize the NHIS, Act 650 (2003) was followed by the passage of Legislative Instrument (LI) 1809 in 2004 which detailed the regulations under which the NHIS was to operate, paving the way for the actual implementation of the NHIS in 2005. In 2012, Act 852 was enacted to replace Act 650 as the main legal instrument. Tables 1 and 2 summarise the main elements of Ghana's NHIS and the benefits package respectively.

Table 1: Main elements of Ghana's NHIS (Culled from Acts 852 (2012) and 650 (2003) and LI 1809 (2004)

Legislative instruments	**Act 852 2012 (which replaced Act 650 (2003)) and LI 1809 2004 are the main legal frameworks guiding the implementation of health insurance in Ghana**
Governance	A Fifteen (15) member National Health Insurance Council manages a National Health Insurance Fund, regulate the private health insurance market and accredit and (in collaboration with relevant agencies) monitor service providers under the scheme.
Administration	A national Health Insurance Secretariat provides administrative support to the National Health Insurance Council in the implementation of the Scheme. Private sector schemes may be established but do not receive subsidies from government. These operate as insurance schemes based on a premium, contract and policy. A Health Complaints Committee of the NHIC with decentralised offices in every district office of the Council.
Membership	Enrolment and membership in the National Health Insurance Scheme is mandatory for all residents of Ghana. Persons eligible to membership are expected to pay a contribution of Gh¢ 7.2 per year (equivalent of US$ 7.74 at time of passage of Act 650).. The scheme provides for persons to be exempted from paying membership fees. These are: • Contributors to the SSNIT or those drawing pension benefits on SSNIT • Persons in need of ante-natal, delivery and post-natal health care services • Persons under the age of 18 • Persons above the age 70 years • Persons classified as indigents by the Minister for Social Welfare • Other categories prescribed by the Minister

Service Provision	The legislative instrument defines a benefit and an exclusion package for which a member of the scheme may have access Any service provider wishing to provide services to members of the scheme may apply to the NHIC for accreditation to provide a specified set of services from the benefit package according to their assessed competency.

Table 2: NHIS Benefits Package (Culled from LI 1809 (2004))

Outpatient Services	General and specialist consultation reviews General and specialist diagnostic testing, including laboratory investigation, X-rays, ultra sound scanning Medicines on the NHIS list Surgical operations such as hernia repairs, incision and drainage, haemorrhoidectomy Physiotherapy
Inpatient Services	General and specialist in-patient care Diagnostic tests Medication prescribed on the NHIS medicines list, blood and blood products Surgical operations In-patient physiotherapy Accommodation in general ward Feeding provided by health facility
Oral health	Pain relief (tooth extraction, temporary incision and drainage) Dental restoration (simple amalgam filling, temporary dressing)
Maternity care	Antenatal care Deliveries (Normal and assisted) Caesarean section Postnatal care

Eye Care services	Refraction Visual Fields A- Scan Keratometry Cataract Removal Eye Lid Surgery
Emergencies	Medical emergencies Surgical emergencies Paediatric emergencies Obstetric and gynecological emergencies Road traffic accidents Industrial and Workplace accidents Dialysis for acute renal failure

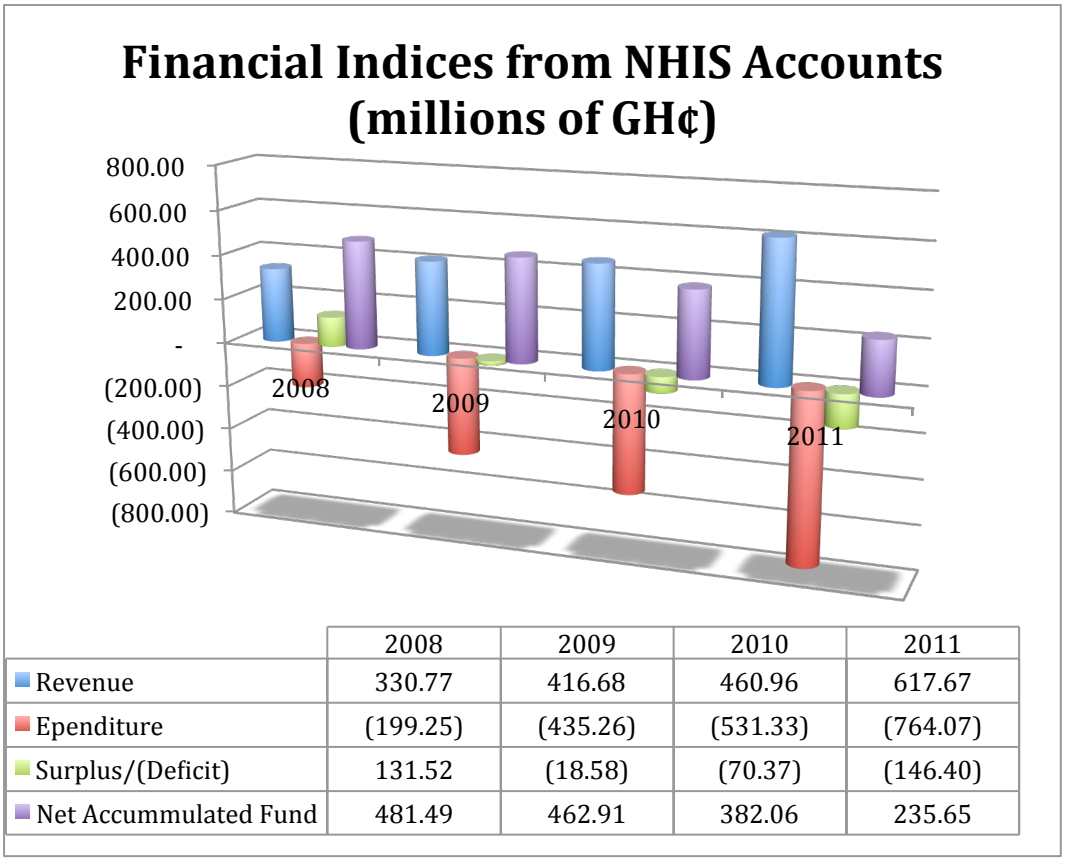
The replacement of Act 650 (2003) by Act 852 (2012) fundamentally changed the structure and operation of the NHIS – the district mutual funds, hitherto the basic unit of the NHIS, were collapsed into the centralised NHIA. The operation of Ghana's NHIS has been fraught challenges on many fronts, the most significant of which is the dangerous revenue-expenditure mismatch that has left the scheme on the brink of insolvency (Schieber, Cashin et al. 2012) .

Although it is an attempt to provide social health insurance, Ghana's NHIS has peculiar characteristics that distinguish it from traditional models of social health insurance practised in other countries. In particular, the combination of a large informal sector, weak state capacity and a small tax base means that an economy-wide compulsory commitment mechanism is impractical to implement. Although Act 852 (2012) (and 650 (2003) before it) stipulated mandatory membership, in de facto,

enrolment in the NHIS is voluntary, making it an ideal test case to investigate the potential for CBHI to attain UHC. Increasingly, Social Capital is seen as the critical success factor for voluntary CBHI schemes in the developing world. Social Capital has implications for willingness to pay, moral hazard, adverse selection and the management of schemes, among other things. Although promoted by the Ghanaian government, the NHIS has its genesis in CBHIs, the District-Mutual Health Insurance Schemes (DMHIS) that initially formed the basic units of Ghana's NHIS. The defining characteristic of CBHIs, their voluntary nature, has been retained by the NHIS' design. Even formal sector workers, who compulsorily contribute to the Scheme's financing through payroll taxes, are required to physically enrol in the scheme by paying a registration fee at a scheme office before they can access benefits under the scheme. Informal sector workers, who form the majority of Ghanaians, are required to pay a (graduated) premium (in addition to the registration fee) to enrol on the scheme.

1.1.3 Financial Sustainability of the NHIS

The NHIS' revenues are currently insufficient to meet its expenditures (Fig. 1). Although much discussed, options to increase revenues from the current financing arrangements are seriously constrained in practice by many considerations (Schieber, Cashin et al. 2012 p. 154-163). In terms of relative contribution however, the most serious revenue shortfall occurs in contributions from the informal sector, which currently accounts for less than 5% of the NHIS revenues (Fig 2), in spite of the sector employing over 75% of Ghanaians. Clearly the revenues of the NHIS are insufficient to meet current obligations, let alone future ones, and the Scheme is dangerously tottering on the verge of insolvency. A seemingly viable option therefore is to increase enrolment from the informal sector as this would increase revenues while broadening the risk pool. But is this truly feasible?



	2008	2009	2010	2011
Revenue	330.77	416.68	460.96	617.67
Ependiture	(199.25)	(435.26)	(531.33)	(764.07)
Surplus/(Deficit)	131.52	(18.58)	(70.37)	(146.40)
Net Accummulated Fund	481.49	462.91	382.06	235.65

Figure 1: NHIS Financial Indicators (Source: NHIA Annual Reports, 2008-2011)

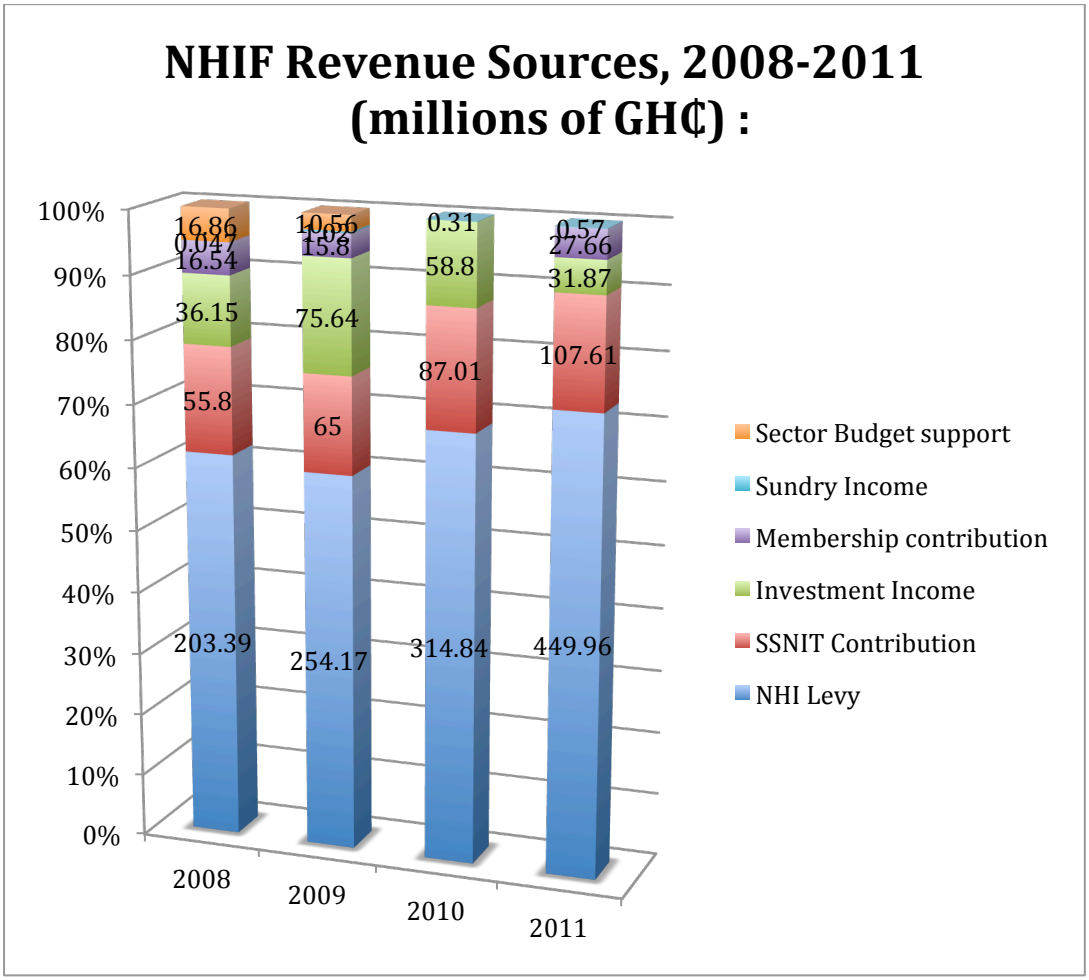


Figure 2: Actual NHIF Revenue by source (Source: NHIA Annual Reports, 2008-2011)

1.1.4 The Social Welfare State

If Ghana's attempts can be interpreted as an attempt to institute a social welfare state (at least in the health sector), then it is beneficial to examine the conditions under which such an undertaking is feasible. The Social Welfare state "has the ultimate aim of securing a minimum welfare to its citizens, protecting them against the risks of unemployment, sickness, maternity and old age, and providing an adequate accumulation of human capital through public investments in education and health" (Segura-Ubiergo 2007). Among the prerequisites that enable a viable social welfare state, the most prominent are high productivity levels from the employed population and "a large and relatively well-off population that can absorb high rates of taxation" (Karger 1996). Of course this implicitly assumes a strong state capacity to raise revenue through direct and indirect taxation. Also quite important for the current discussion, (Karger 1996) makes the observation that the majority of job creation in the globalised economy occurs in low-paying service or secondary (informal) sectors, a fact that makes it all the more difficult for under-developed African countries to achieve the preconditions stated earlier while at the same time increasing their need for social welfare institutions.

1.1.5 Informality and the pursuit of Social Welfare in Ghana

The very term informal sector was coined in Ghana in the seminal 1971 study by the British anthropologist Kevin Hart which focused on the economic activities of the migrant Frafra in urban Accra (Hart 1973). Since then, Ghana has not done much to lose the unenviable tag of having a 'large informal economy'. If anything, the informal sector has rather increased in size. (BOG 2007) and (Aryeetey and Baah-Boateng 2007) both estimated the sector to account for 80% of employment in Ghana. Tables 4 and 5, taken from the 2010 Population and Housing Census, present

the most comprehensive estimates of the extent of informal sector employment in Ghana. As shown in table 5, a staggering 86% of employment in Ghana is in the private informal sector.

While employment opportunities in the sector are not necessarily inferior – it is well established that many people in developing countries voluntarily choose to work there (Maloney 2004, Günther and Launov 2012) – it is the case in Ghana that the sector is characterised by low productivity, low remuneration and non-existent job security (MOFEP 2012). These characteristics of the Ghanaian economy pose effective constraints to the government's revenue raising efforts an example of which is the recent revelation by the government's Tax Policy Advisor that only two million out of six million eligible tax payers in Ghana pay taxes (Siaw 2014). The Bank of Ghana also estimated Ghana's tax revenues as a percentage of GDP to be 16.7% in 2011 (BOG 2012), a far cry from the upwards of 30% realised in most OECD countries (with the important exception of the United States).

Table 3: Persons aged 15+ by locality and activity status (Source: (GSS 2013)

All Localities				
Persons 15 years and older	**Employed**	**Unemployed**	**Not economically active**	**All status**
Both Sexes	10,243,476	575,807	4,389,142	15,208,425
Males	5,005,534	254,955	1,965,412	7,225,901
Females	5,237,942	320,852	2,423,730	7,982,524
	URBAN			
Persons 15 years and older	**Employed**	**Unemployed**	**Not Economically active**	**All status**

Both Sexes	5,125,635	410,267	2,687,047	8,222,949
Males	2,477,284	182,894	1,202,927	3,863,105
Females	2,648,351	227,373	1,484,120	4,359,844
	RURAL			
Persons 15 years and older	**Employed**	**Unemployed**	**Not economically active**	**All status**
Both Sexes	5,117,841	165,540	1,702,095	6,985,476
Males	2,528,250	72,061	762,485	3,362,796
Females	2,589,591	93,479	939,610	3,622,680
	Unemployment rate			
	All localities	Urban	Rural	
Both sexes	5.30%	7.40%	3.10%	
Men	4.80%	6.90%	2.80%	
Women	5.80%	7.90%	3.50%	

Table 4: Employed persons by locality and sector of employment (Source: (GSS 2013)

	All localities (Total sectorial employment)	**Urban**	**Rural**	**Sectorial Share of total employment**
All occupations	**All Sectors**			
Both Sexes	**10,243,476**	**5,125,63**	**5,117,841**	**100.0%**
Male	5,005,534	2,477,284	2,528,250	
Female	5,237,942	2,648,351	2,589,591	
All occupations	**Public**			
Both Sexes	**638,862**	**481,662**	**157,200**	**6.2%**
Male	405,320	299,274	106,046	
Female	233,542	182,388	51,154	
All occupations	**Private Formal**			
Both Sexes	**699,746**	**572,021**	**127,725**	**6.8%**
Male	486,216	395,336	90,880	
Female	213,530	176,685	36,845	

All occupations	**Private Informal**			
Both Sexes	**8,834,639**	**4,021,852**	**4,812,787**	**86.2%**
Male	4,066,499	1,747,240	2,319,259	
Female	4,768,140	2,274,612	2,493,528	
All occupations	**Semi-public/Parastatal**			
Both Sexes	**13,581**	**10,357**	**3,224**	**0.1%**
Male	9,649	7,452	2,197	
Female	3,932	2,905	1,027	
All occupations	**NGOs and International Organisations**			
Both Sexes	**56,648**	**39,743**	**16,905**	**0.6%**
Male	37,850	27,982	9,868	
Female	18,798	11,761	7,037	

With this background in context therefore, Ghana's policymakers were innovative in their introduction of social health insurance into a difficult environment. They did not restrict the NHIS to the formal sector because doing so would have effectively impeded progress towards Universal Health Coverage. The design of the funding mechanism to incorporate an indirect tax, a payroll tax for the small formal sector and premiums from the informal sector reflect an attempt to circumvent the constraints identified above while accounting for the fact that ultimately, someone had to pay for the cost of healthcare. The need for social health insurance was indisputable if access to healthcare was to be divorced from ability to pay. To emphasize the point, the design of the NHIS, with particular reference to the financing arrangement, may be interpreted as an acknowledgement by policymakers that the conventional approach to social health insurance employed in advanced nations would be impractical in Ghana for various reasons. These reasons include fiscal constraints, the structure of the economy and the inter-sectorial division of employment between the formal and informal sectors.

Ultimately however, the innovative design notwithstanding, the current challenges being faced by the NHIS have made it apparent that the explicit attempt to incorporate the informal sector and the de facto voluntary nature of enrolment brings up new considerations of what factors assume the role of critical enablers in order to facilitate the 'new' model's success at raising sufficient revenues to cover expenditures. As already noted in the Introduction, the economic and health systems frameworks that are the staples of health insurance discussions are unable to explain the confounding factors noted in in the performance of many CBHIs across the developing world and therefore their potential to transition into viable SHIs. Increasingly, the literature is converging on Social Capital as the critical enabling factor that has been ignored in the analysis, the inclusion of which is beneficial if a complete understanding of the workings of CBHIs in today's developing world is to be attained.

2. Conceptual Framework

2.1 CBHI and Universal Health Coverage

Universal coverage is achieved in a health system when all residents of a country are able to have access to adequate healthcare at affordable prices (Carrin, James et al. 2004). The current international policy model linking CBHI and universal coverage is implicitly informed by the history of health service financing in Europe and Japan, where CBHI schemes in the 19th century eventually merged into various forms of national health financing structures (Criel and Van Dormael 1999). However, many studies highlight that although lessons can be learned, assuming that CBHIs in today's developing world will follow the historical precedent and transform into sustainable forms of national health financing is fatally simplistic given the different socio-economic contexts and circumstances (Criel and Van Dormael 1999, Bärnighausen and Sauerborn 2002, Ogawa, Hasegawa et al. 2003, Carrin and James 2005).

For instance, although there were approximately 27,000 'friendly societies' that functioned like CBHIs in the United Kingdom alone in the 19th century, the total number of CBHIs in the whole of West Africa in 2003 was estimated at 585 (Bennett, Kelley et al. 2004). In fact, (Asenso-Okyere, Osei-Akoto et al. 1997) document only one community-wide health insurance scheme in Ghana – the Nkoranza Community Health Insurance Scheme – just six years before the CBHI-based NHIS was initiated. Another dissimilarity is that today's CBHI schemes are mostly top-down interventions led by development agencies or national governments, in contrast to those of 19th century Europe and Japan that were locally initiated by working class movements and employers (Criel and Van Dormael 1999, Meessen, Criel et al. 2002).

In sum, the conditions prevailing in today's developing world differ considerably

from those in Europe and Japan 150 years ago. Recognition of this difference crucially underscores the need to go beyond the current construct of policy-conception if constraints to increasing CBHI coverage and sustainability are to be successfully addressed. In this pursuit, the social capital framework can be viewed as a practical attempt to remedy this need for an alternative, or complement, to income-based and purely economic approaches to development (Bebbington 2004).

Several studies show that low-income households are willing to pay for CBHI (Dong, Kouyate et al. 2003, Asgary, Willis et al. 2004, Dror, Radermacher et al. 2007, Gustafsson-Wright, Asfaw et al. 2009). We highlight (Asenso-Okyere, Osei-Akoto et al. 1997 pp. 225) which had as its expressed goal the assessment of "the willingness of the informal sector to join and pay premiums for health insurance under a National Health Insurance scheme in Ghana." Employing contingent valuation, the authors found that up to 63.3% of a sample of households in the informal sector were willing to pay premiums of about $3.03 a month.

However, "in empirical analyses, ignoring the role of social capital in WTP may result in omitted variable bias, as the decision to pay…may be correlated with variables which are not included in the model. As a matter of fact, social capital in a community is vital for the sustainability and effective functioning of CBHI" (Donfouet and Mahieu 2012 pp. 2).

Social capital is a major determinant of the WTP for CBHI; the greater the social capital in the community, the more people are willing to prepay for CBHI (Hsiao 2001). Solidarity and trust between members form a key foundation for the successful functioning of a CBHI (BIT 2002). A high level of social capital is also associated with a high level of altruism among individuals making it possible to consider the welfare of other members of the group (Durlauf and Fafchamps 2004). As a matter of

fact, (De Allegri, Sanon et al. 2006) found that relevant social and political incentives may be diametrically opposed to incentives designed using technical and scientific expertise (such as economic theory) in a qualitative study of a CBHI in Burkina Faso.

(Donfouet, Essombè et al. 2011) utilize an interval regression model to confirm a positive and significant impact of social capital on the demand for CBHI across six villages in the Western Region of Cameroon. Using logistic regression, (Zhang, Wang et al. 2006) demonstrate that social capital measured by trust and reciprocity has a positive and significant effect on the demand for CBHI subsidized by the Chinese government – people are more willing to accept the implicit cross-subsidization. (Desmet, Chowdhury et al. 1999, Criel and Waelkens 2003, Schneider 2005) have also confirmed the importance of this solidarity in Bangladesh, Guinea and Rwanda respectively.

On the other hand, strong intra-group ties may have negative consequences for sustainable CBHI schemes by promoting adverse selection or crowding out the formal insurance scheme as was found by (Atim 1999) in Ghana and (Jowett 2003) in Vietnam respectively. Probably therefore, the presence of more than one *type* of social capital may be required for it to have a positive effect on CBHIs. One Guatemalan scheme, which failed on first launch, was later revived with the support of the Catholic Church, an important social institution in the country (Ron 1999). Community involvement in the scheme's decision-making and the relationship between scheme members on one hand and the governing authority on the other have also been demonstrated to affect the sustainability of CBHIs in Senegal (Franco, Mbengue et al. 2004).

Already therefore, these provide pointers that may contribute towards understanding the low level of NHIS membership 10 years into its implementation, which is

markedly at variance with the prognosis that (Asenso-Okyere, Osei-Akoto et al. 1997)'s study suggested. Incorporating the social factor, including the sense of kinship and shared concern for each other in the community, through an engagement with Social Capital theories therefore has the potential to contribute valuable conceptualization, design, implementation and reform lessons for CBHI-founded SHI initiatives in developing countries.

2.2 Social Capital

There is a consistency at the general level in the literature on what Social Capital entails although it defies a standard definition. Among the earliest definitions are those by (Bourdieu 1980) and (Coleman 1988), two authors who are among the first to have published systematic expositions of Social Capital. They respectively defined Social Capital as "the sum of resources, actual and virtual, that accrue to an individual or a group by virtue of possessing a durable network or less institutionalized relationships of mutual acquaintance and recognition' (Bourdieu 1980) and "…a variety of different entities having two characteristics in common: they all consist of some aspect of social structure and they facilitate certain actions of individuals who are within the structure' (Coleman 1988). More recent definitions include

"social networks and the norms of reciprocity and trustworthiness that arise from them…" (Putnam 2001 p. 19)

"trust, concern for one's associates, a willingness to live by the norms of one's community and to punish those who do not"(Bowles and Gintis 2002 p. F419) and

a person's or group's sympathy toward another person or group that may produce a

potential benefit, advantage, and preferential treatment for another person or group of persons beyond that expected in an exchange relationship". (Robison, Schmid et al. 2002 p. 19)

As noted by (Allinger 2013), the multiplicity of definitions is due to different authors referencing either its "nature" or its "effects" in their conceptualization.

Among the common concepts that come to mind with the mention of Social Capital are therefore trust, solidarity, reciprocity, togetherness, social networks and such-like terms. Social Capital does not merely inhere in the existence of social relationships but in the extent to which these relationships can be leveraged for some (invariably common) good. In this sense, it may be compared to other forms of Capital (viewed as an investment good or a factor of production), although there is much debate on the extent of comparability (Arrow 2000). In discussions of the concept therefore, it is essential to highlight that not all social relations are 'Social Capital' and that indeed some types of Social Capital may have undesirable consequences that preclude manifestations of supposed benefits. It is also important to point out that the different types of Social Capital inhering in society have different roles to play and as is being increasingly recognised in the literature, the extent to which Social Capital is productive depends on the particular combination of Social Capital types that exist in the community. This understanding is particularly crucial for examining the potential of collective endeavours that transcend the immediate group level. The dichotomy is usually drawn with reference to "strong ties" and "weak ties". (Woolcock and Narayan 2000) explain strong ties as the close relationships that exist between individuals and their families, friends, ethnic groups etc, that is the personal interactions that pertain in a particular closed group. This is intra-community Social Capital. "Weak ties" on the other hand consist in interactions over different open

groups or networks (interactions with other ethnic groups, civil society organisations, local/national government etc) and corresponds to extra-community Social Capital. In summary therefore, (Woolcock and Narayan 2000) consider bonding (strong) and bridging (weak) Social Capital at both the micro intra-community and macro extra-community levels, noting that the presence to different degrees of these types will determine the success potential for collective action at different social group levels.

In a pioneering attempt to explicitly incorporate the application of Social Capital to analysis of CBHI in developing countries, (Mladovsky and Mossialos 2008) have adapted Woolcock's framework (Woolcock 1998, Woolcock 2001, Woolcock and Narayan 2006), and it is their synthesis that is employed in this dissertation to examine Ghana's NHIS in a quest to understand informal sector participation. This is crucial in evaluating the feasibility of the oft-suggested policy recommendation to raise the level of informal sector enrolment in the pursuit of scheme sustainability. For the purposes of this dissertation therefore, we adopt the following definition of Social Capital provided by Woolcock: "the information, trust and norms of reciprocity inhering in one's social network'' (Woolcock 1998 p. 153).

2.3 Theoretical Framework

(Mladovsky and Mossialos 2008) summarise the rich Social Capital literature into an evaluative framework for the analysis of Community-Based Health Insurance Schemes, taking into account contextual considerations. Their key proposition is that incorporation of "the social determinants of CBHI could result in structures that differ from those proposed by current analytic frameworks". Are the current contraptions of CBHI being implemented in developing countries missing out on critical success factors by ignoring 'social determinants'? Is the assumption by Ghana's NHIA that

the informal sector will simply (rationally) voluntarily subscribe to the NHIS because of the risk-mitigation it offers flawed? What do the revealed social norms, values and patterns of association in Ghanaian society indicate with regards to the strength or otherwise of Social Capital? What are the implications for voluntary informal sector participation in the NHIS and the Scheme's financial viability? Would considering such 'social determinants' provide pointers on the appropriate design and implementation of such a CBHI-founded SHI? These are the questions that this dissertation seeks to find answers to by employing (Mladovsky and Mossialos 2008)'s framework. In their adaptation of Woolcock's work for the analysis of CBHI, they categorise Social Capital into four types that elucidate the key Social Capital concepts of trust, solidarity and togetherness as well as social linkages in both intra and extra community networks and state-society relations. This makes their framework an ideal tool to explore the implications of Social Capital for CBHI and SHI. These important contextual factors particularly influence voluntary enrolment, willingness to pay and the feasibility of different financing options, key determinants of long-term Scheme viability and sustainability. A fuller exposition of the four categories follows in the sub-sections below.

2.3.1 Bonding Social Capital inhering in micro-level intra-community ties

The basic category of Social Capital is present in "dense networks within communities" and is thought of as being particularly productive because it inheres in the basic behavioural norms and expectations, channels of information, trustworthiness of structures and sanctions that are the foundations of beneficial interactions (Coleman 1988). This type of Social Capital is therefore essentially conceived as the cornerstone of community development, a critical enabler of personal and communal socio-economic advancement. (Woolcock 2001)'s framework however recognises that in certain settings, the same intra-community

bonding ties may become unproductive, as for instance when abuse of trust results in free-riding or when sanctions impede the flow of information. This may hamper effective communal action.

Applied in the context of voluntary CBHIs, (Mladovsky and Mossialos 2008) note that bonding Social Capital inhering in micro-level intra-community ties have both positive and negative effects which have implications for adverse selection, moral hazard, and (most importantly from the perspective of this study), on the willingness to pay (enrolment). Thus trust may reduce adverse selection and moral hazard, while solidarity or feelings of togetherness may increase the willingness to pay. Therein lies the perceived power of Social Capital - to persuade agents into participating in insurance through mechanisms that are distinctly different from the usual 'what is in it for me' (rational agent utility maximisation theorem) that dominates standard models of insurance. In the absence of a formal compulsion mechanism therefore, it is easy to see the critical facilitating role that bonding Social Capital in micro-level intra-community network may play in any social health insurance endeavour. This positive role of bonding micro-level Social Capital is further strengthened by trust in the respective providers of health and insurance services at the local level. This Social Capital may be generated by behavioural norms such as increased politeness and improved quality of care by medical staff, transparency, accountability and community involvement in scheme management and recourse to justice in case of fraud (Atim 1999, Meessen, Criel et al. 2002, Criel and Waelkens 2003, Schneider 2004, Schneider 2005). Taken together therefore, bonding Social Capital inhering at the micro-level can "facilitate willingness to pay" because solidarity promotes acceptance of the "implicit cross-subsidisation" that is the hallmark of social insurance (Mladovsky and Mossialos 2008).

The effects of Social Capital inhering at the micro level are not unambiguously positive however, and the negative effects can powerfully contrast the positive so that the overall effect in a particular setting is empirical. In the case of a social health insurance, individuals with strong intra-community norms of trust and reciprocity may see no need to enrol in and contribute to a national pool as they perceive as adequate the informal health risk management mechanism that already exists – in this case, "Social Capital 'crowds out' voluntary health insurance" (Meessen, Criel et al. 2002, Jowett 2003). The unwillingness to enrol in a social health insurance scheme can also result in a setting where there is strong fragmentation along ethnic lines with little inter-ethnic trust and/or rapport. The strong intra-ethnic bonds are then negative for a social health insurance scheme that is sustainable only through participation by a large number of people, over and above individual ethnic group sizes.

Considered in the context of willingness to pay for a voluntary national health insurance scheme therefore, bonding Social Capital inhering at the micro-level has positive effects only if it inheres *both* within *and* across heterogeneous groups in the community. Since this type of Social Capital is not easily constructible, it is not simply the case that imposing a formal structure that bypasses ethnic and other sub-group organisations will ensure that it is positive. Therefore, it is this type of Social Capital that is the principal object of interest for this investigation as it is the kind that primarily affects willingness to voluntarily enrol/pay. The success of a social health insurance scheme is dependent on more than just the willingness to pay however. We briefly mention the other types of Social Capital in (Mladovsky and Mossialos 2008)'s framework and consider their implications for voluntary health insurance.

The main goal is to highlight the potential (if somewhat indirect) impact they may have on the willingness to pay.

2.3.2 Bridging Social Capital inhering in micro-level extra-community networks

(Mladovsky and Mossialos 2008) sub-categorise this type of Social Capital into horizontal civil society links and vertical bridging links. The horizontal civil society links have an effect on the overall success of the SHI by enlarging the number of insured persons, diversifying the risk profile of the scheme, improving solvency and enabling professional involvement in scheme management, audit and supervision as well as formal linkages with other health system actors (Maeda and Schieber 1997, Meessen, Criel et al. 2002). The positive effects of these horizontal links are perceived to be even more effective when the linkages are across heterogeneous groups. (Mladovsky and Mossialos 2008) also argue that vertical linkages allow CBHIs to build capacity in technical areas. They particularly mention non-governmental organisations (NGOs) and faith-based organisations (FBOs) as having crucial roles to play in this way.

In a national social health insurance scheme, vertical and horizontal links are inherent in the design as local schemes are linked into a national supervisory body for support, supervision, subsidies and promotion of interactions with other health system institutions. In particular, Ghana's government mandated insurance scheme instituted a formal structure in which the NHIA plays a central coordinating role. With this in mind, horizontal civil society and vertical bridging links such as support from NGOs and FBOs inures to the benefit of the scheme in many ways. Of particular interest to this dissertation is the fact that they may foster enrolment and willingness to pay by continually promoting solidarity among heterogeneous groups. This is especially true

of faith-based organisations as religion holds a very special place in Ghanaian society (Addai, Opoku-Agyeman et al. 2013).

2.3.3 Bridging Social Capital inhering in relations between communities and macro-level state institutions

According to (Mladovsky and Mossialos 2008), engagement by state officials (local and central) in promoting and sustaining citizen involvement generates positive Social Capital for the achievement of social policies, even as the same may inhere if effective links exist between various groups and public institutions.

With respect to CBHIs, the authors note that government can promote state-society 'synergy' through 'complementarity' and 'embeddedness' (Evans 1996). Complementarity is basically the provision of an enabling environment for the effective operation of the health insurance scheme. This may be pursued through effective monitoring and regulation of health providers and "improving quality, efficiency and sustainability through strategic purchasing". Embeddedness constructs Social Capital through continuous informal interactions between various groups/ private organisations and public institutions at the local level. This is argued to facilitate 'listening' and to allow locally tailored responses to emergent issues within defined limits. In a weak institutional setting however (particularly societies with large inequalities), embeddedness may result in clientelism and corruption.

(Mladovsky and Mossialos 2008) highlight state-society synergy as being particularly important in countries such as Ghana where government scales up CBHIs into a national social health insurance scheme. To promote equitable access in such as scheme, indigents will need to be subsidized while the large informal sector is targeted to make contributions. The potential to successfully target the informal sector for enrolment is the object of this study. The literature points to the conclusion

that the primary determinant of the willingness to voluntarily enrol (pay) for a national health insurance scheme is the Social Capital inhering in micro-level intra-community ties, and this should be considered first if any targeting of the informal sector is to have a chance of veritable success.

2.3.4 Bonding Social Capital inhering in macro-level social relations within public institutions.

This type of Social Capital effectively refers to commitment within public institutions to work to advance collective goals in a professional manner, such commitment embedded in relations between the individuals who constitute these institutions. Such Social Capital ("organisational integrity"), if sufficiently shared across a wide spectrum of the society, will serve as a natural constraint on corruption, nepotism and clientelism (Woolcock 1998).

Obviously this has an effect on the success of a national health insurance scheme such as Ghana's NHIS. The NHIA is the primary public institution responsible for the implementation of Ghana's NHIS and its integrity is inextricably linked to the overall success of the scheme. How well it performs its functions will, among other things, affect the willingness of people in the informal sector to (continuously) participate in the scheme, as will the integrities of the supervisory Ministry of Health (MoH) and the public Ghana Health Service (GHS).

3. Methodology and Data

A formal approach is essential in any attempt to investigate the relationship between informality, Social Capital and the potential to increase the NHIS' revenues through voluntary enrolment. An evaluative framework permits assessment of policy effectiveness and minimises resource waste (Downie, Tannahill et al. 1996) aiding policymakers in their decisions regarding the continuance or otherwise of a policy (Costongs and Springett 1997). There are additional demands on the policy process due to the complex nature of health public policy necessitates a greater use of qualitative methods supplemented by quantitative data as needed (Oneill and Pederson 1992). Quite as important, they also assert that this allows "for more attention to values, for wider participation in policy-making, for an explicit assessment of policy impact on health and for a greater understanding of the policy process."

Considering the above, (Mladovsky and Mossialos 2008)'s theoretical framework is well-suited for the analysis of the relationship between assessed Social Capital and the willingness to voluntary enrol in Ghana's NHIS. Their adaptation is also explicit in its attempt to incorporate matters of consideration for countries that scale up CBHIs into National Social Health Insurance Schemes, a distinctive fact that reflects Ghana's experience with the NHIS. (Mladovsky and Mossialos 2008) represents a pioneering attempt to incorporate behavioural thinking into analysis of CBHIs, reflecting the need to move beyond traditional economic and health system frameworks in order to understand the not-so-obvious factors that frequently confound expected outcomes. The four categories they present have clear linkages to areas of impact in the milieu of factors that make for a successful SHI as has been extensively discussed above and this makes it a superior framework for health policy evaluation.

3.1 Research Design

Following a survey of empirically tested measurement frameworks, we adopt Narayan and Cassidy (2001)'s construct to evaluate the existence and strength of Social Capital in Ghanaian society in the data analysis. Their assessment framework encapsulates **Social Capital measures** (*group characteristics; generalized norms; togetherness; everyday sociability; neighbourhood connections; volunteerism; and trust*), **determinant measures** (*identity; communication*) and **outcome measures** (*quality of government; honesty/corruption; peace, crime and safety; political engagement*). To the extent of data availability, this typology forms the sub-sections of the data analysis, which mainly employs a descriptive presentation of the data in quantifying the manifest Social Capital in Ghanaian society.

The second part of the work analytically presents the implications of the existent Social Capital for voluntary informal sector participation. The theoretical framework is employed to draw the relationship between the level of Social Capital that manifests within and across groups in Ghanaian society and the experienced level of voluntary informal sector participation in the NHIS. The four types of Social Capital in the framework therefore form the sub-sections in the discussion section.

A conclusion summarizes the evidence on Social Capital presented from the data analysis and the implications drawn from the application of (Mladovsky and Mossialos 2008)'s framework to that Social Capital.

3.2 Data

Our main data source for the evaluation of Social Capital is the Afrobarometer, a comparative survey of **subjective** public attitudes in participating African countries, which has been conducted in 5 rounds from 1999 to 2012. It is a joint enterprise of the Institute for Democracy in South Africa (IDASA), the Center for Democratic

Development (CDD-Ghana), the Institute for Empirical Research in Political Economy (IREEP), and the Institute for Development Studies (IDS) at the University of Nairobi in Kenya, with additional technical support provided by Michigan State University (MSU) and University of Cape Town (UCT). The Afrobarometer National Partner in Ghana is the Ghana Center for Democratic Development (CDD-Ghana). To the best of our knowledge, the Afrobarometer is the only survey that comprehensively and systematically includes measures of Social Capital in its research of public attitudes in African countries. The survey also makes it clear that it is a gauge of ***subjective*** public attitudes, a fact that is in direct agreement with a concept as subjective as Social Capital.

The sample is designed as a representative cross-section of all non-institutionalized citizens of voting age in a given country (on occasion, the researchers also exclude people living in areas deemed inaccessible due to conflict or insecurity). The goal is to give every adult citizen an equal and known chance of selection for interview. The researchers strive to reach this objective by (a) strictly applying random selection methods at every stage of sampling and by (b) applying sampling with probability proportionate to population size wherever possible. Samples usually include either 1200 or 2400 cases. A randomly selected sample of 1,200 cases allows inferences to national adult populations with a margin of sampling error of no more than plus or minus 2.5 percent with a confidence level of 95 percent. If the sample size is increased to 2,400, the confidence interval shrinks to plus or minus 2 percent. The sample design is therefore a clustered, stratified, multi-stage, area probability sample, and based on this methodology, Afrobarometer data sets can be treated as being approximately self-weighting (Afrobarometer 2013). Ghana has participated in all 5 rounds. In this study, we select Rounds 1, 3 and 5 (1999, 2005 and 2012), signifying before NHIS implementation, fledgling stage of NHIS implementation and mature

NHIS implementation respectively. The significant time stretch covered by the selected years allows us to capture any changes in attitudes and perceptions over time. It is also interesting to mention that these 3 rounds were undertaken under 3 different governments as political power alternated between the 2 largest political parties over this period. Our choice of years therefore allows us to also account for the possibility that attitudes are affected by political biases. For the selected years, the final total cases achieved were 2,004 (1999), 1,197 (2005) and 2,400 (2012). To make a plausible assessment of the level of Social Capital present across Ghanaian society, we present descriptive diagrams based on respondents' answers to questions that principally deal with Social Capital in the Afrobarometer survey.

Like all surveys however, the Afrobarometer is not perfect. For our purposes, the first issue is that the questionnaire does not address all of the seven measures of Social Capital outlined by (Narayan and Cassidy 2001)'s typology. The second issue is that the survey does not address all measures, determinants and outcomes of Social Capital in all 3 years under study – some are captured for 2 out of the 3 selected years. Lastly, the phrasing of some questions and/or possible answers also varies between some rounds. The second and third issues are relatively unimportant for the following reasons: the most important Social Capital measures are unaffected; 2 years still allows a comparative analysis to be made; and we account for the differential wording in questions and/or answers in our presentation of results.

The first problem is however more difficult to deal with and we have to (imperfectly) address this by relying on the 2003 Ghana Core Welfare Indicators Questionnaire (CWIQ) Survey of 2003 which captured measures of togetherness and neighbourhood connections. The CWIQ was a nationwide sample survey, designed to provide

indicators for monitoring poverty, vulnerability and living standards in the country, at national, regional and district levels. It was a district-based probability sample that covered a total of 49,003 households nationwide. The 2003 CWIQ Survey was based on a two stage national sample of households. At the first stage a sample of enumeration areas (EAs) was drawn from an updated national sampling frame derived from the 2000 Population and Housing Census. For the first stage selection, the frame was stratified within the 10 administrative regions into local government district domains comprising the 110 administrative districts, the sub-metropolitan areas of Accra, Kumasi and Shama-Ahanta East and Tema Municipal Area that was split into two zones. These divisions were accorded " Statistical district" status for the purpose of the CWIQ Survey, thus yielding a total of 121 district domains nationwide. At the first stage of sampling, a random systematic sample of 27 enumeration areas (EAs) was drawn from each district stratum/domain, independently, with probability proportional to size of the EA (i.e. the number of households in the EA as obtained from the 2000 Population and Housing Census). At the second stage, households within each EA were listed and households were selected systematically from each to yield 49,005 household. The survey was designed to yield a total sample of 49,003 households nationwide but a total of 43,880 households were successfully interviewed indicating a response rate of 88.5 percent (GSS 2003). Based on our extensive research, this survey is the only other existing public survey in Ghana that explicitly satisfied our requirement of a (limited) component targeted at measuring subjective attitudes and perceptions. Two Social Capital sub-measures (everyday sociability and volunteerism) are however not captured in any of the Afrobarometer rounds or in the CWIQ and we have no choice but to leave them out. We have no such problems for the Determinant and Outcome measures which are adequately captured by the Afrobarometer surveys.

3.3 Measurement of Social Capital

While (Mladovsky and Mossialos 2008) provide the conceptual framework for the application of Social Capital to analysis of CBHI, the measurement of the concept, like any other in social science, is tricky. "Theories such as Social Capital comprise constructs that are inherently abstract and require subjective interpretation in their translation into operational measures" (Narayan and Cassidy 2001). The earliest work to assess Social Capital on a cross-country basis is Ronald Inglehart's World Values Surveys between 1981 and 1997 (Inglehart 1997). Its most well known aspects are the variables that deal with trust and group membership, those most intrinsically associated with Social Capital. Other country-based studies that have constructed and applied generic measures of Social Capital are (Onyx and Bullen 2000) (New South Wales), (Sudarsky 1999) (Barometer of Social Capital), (National Commission on Civic Renewal 1996) (Index of Civic Health, USA) and (Narayan and Cassidy 2001) (Global Social Capital Survey (GSCS)). Culled from (Narayan and Cassidy 2001), Figure 3 presents a summary of the variables investigated in the studies and is remarkable in the level of consistency across studies in the key dimensions highlighted as Social Capital measures. (Narayan and Cassidy 2001)'s construct represents the most comprehensive of the above studies in the dimensions and measures it employs and we therefore adopt their measurement framework, the parameters of which have already been mentioned under Research Design. Their work draws extensively on prior research and consolidates the most standard approximations of Social Capital into a measurement framework; further validation is provided by the fact that the sets of Social Capital questions that encapsulate their measurement framework is consistent to a very large degree with the questions asked in the Afrobarometer series, our main data source. Their study is also of special application to this dissertation because the dimensions they include in their

framework were validated upon research application in Ghana and Uganda.

	Studies				
Underlying Dimensions of Social Capital	*World Values*	*New South Wales*	*Barometer Social of Capital*	*Index of National Civic Health*	*Present Study (GSCS)*
Trust	✓	✓	Institutional	✓ Includes institutional (government) trust	✓ Trust, including institutional trust
Memberships in associations/ participation in local community	✓	✓	Horizontal relationships	✓	✓ Included in the dimension 'group characteristics'
Proactivity in social context		✓	Social control		Empowerment
Crime and safety		✓		✓	(Outcome)
Neighborhood connections		✓	Horizontal relationships		Asking for help ✓
Family and friend connections		✓	Horizontal relationships	✓ Divorce/ non-marital birth rates	Everyday sociability ✓
Tolerance of diversity		✓			(Outcome)
Reciprocity		✓	✓		Included in the dimension 'generalized norms'
Political engagement			✓	✓	(Outcome)
Subjective well-being					✓ Variables related to trustworthiness of people; how well people get along, etc. are subsumed under the social capital dimensions 'generalized norms' and 'togetherness'. Variables specifically related to self-reported happiness, satisfaction with life, etc. are defined here as outcome variables

Figure 3: Comparison of Social Capital Dimensions across studies (a tick indicates inclusion of that dimension in the particular measurement framework)

4. Assessing Social Capital in Ghanaian Society

The literature reviewed above hypothesizes that Social Capital effectively underlies the ability of a social health insurance scheme to succeed in a voluntary setting. Our interest in this study lies in the Social Capital that primarily determines the willingness to pay (enrol). If trust, togetherness and solidarity within and across heterogeneous groups in the society are crucial in gauging the potential for voluntary NHIS enrolment, what are their manifest levels in Ghanaian society?

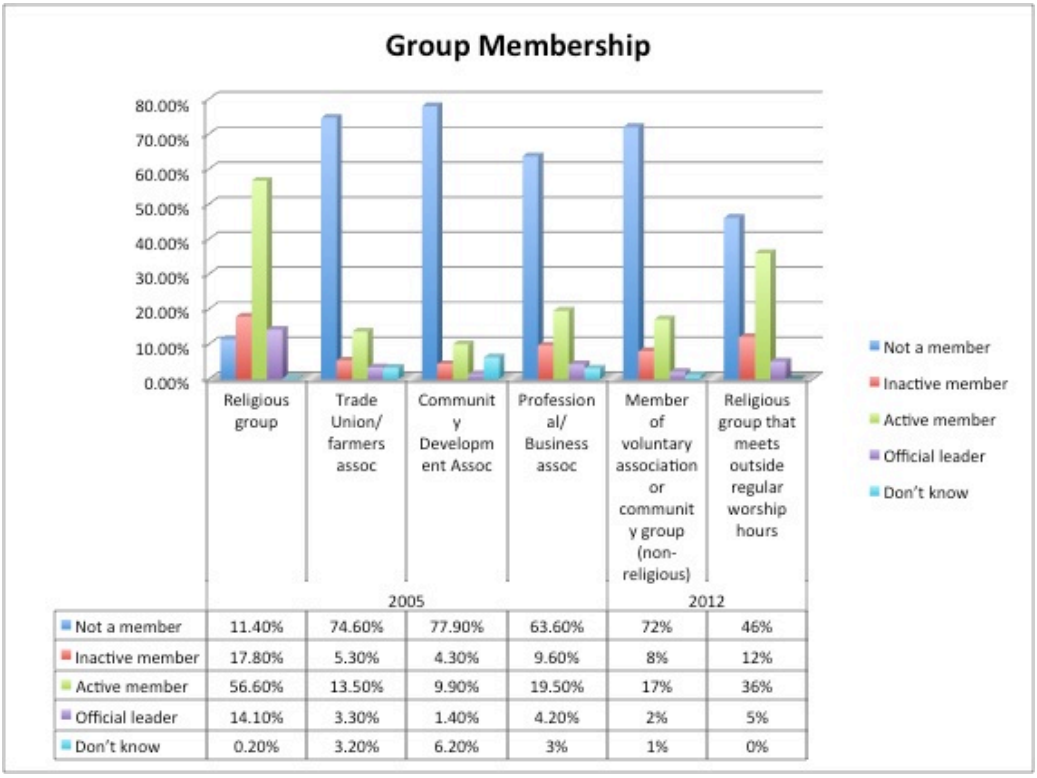
In this section, we assess the strength of Social Capital *both* within *and* across heterogeneous groups in Ghanaian society as revealed in the social norms, values and patterns of association (research question 1). We analyse the responses to questions in the Afrobarometer series, conducting the investigation with reference to the three broad categories of Social Capital measures, Determinant measures and Outcome measures (and their sub-categories) in (Narayan and Cassidy 2001)'s Social Capital Assessment Framework.

4.1 Social Capital Measures

4.1.1 Group Characteristics

The level of memberships in informal groups, associations and networks with particular characteristics is a primary measure of Social Capital in a society. Since these groups are voluntary by nature, they represent social connectedness with reference groups. They are also a primary means of expressing solidarity – they are particularly important in lower/middle income countries, substituting for formal insurance in many cases (Sorensen 2000). The Afrobarometer surveys for 2005 and 2012 reveal a consistent trend in the pattern of voluntary association membership in Ghana. In both years, an average of 70% of respondents affirmed non-membership of

trade unions/farmer associations, community development associations, professional/business associations and other voluntary groups (Fig 4). Religious group membership stands out as an important outlier – in 2005 70% of respondents affirmed active group membership. Although the results for 2012 appear to be confounded by the wording of the question (*religious group that meets outside regular worship hours*), slightly more than half of all respondents affirmed membership of a religious group. To further emphasize the importance of religious group membership, Figs. 5 and 6 report frequency of attendance of group meetings for (1999 and 2005 questions) and the importance attached by the respondent to religious activities (2012 questions). For 1999 and 2005, more than 70% of survey respondents attended religious services on a frequencies of either once a week or more than once a week, while 88% of 2012 respondents rated religion as very important in their life.



	Religious group	Trade Union/ farmers assoc	Community Development Assoc	Professional/ Business assoc	Member of voluntary association or community group (non-religious)	Religious group that meets outside regular worship hours
	2005				2012	
Not a member	11.40%	74.60%	77.90%	63.60%	72%	46%
Inactive member	17.80%	5.30%	4.30%	9.60%	8%	12%
Active member	56.60%	13.50%	9.90%	19.50%	17%	36%
Official leader	14.10%	3.30%	1.40%	4.20%	2%	5%
Don't know	0.20%	3.20%	6.20%	3%	1%	0%

Figure 4: Self-reported group membership levels (source: Afrobarometer)

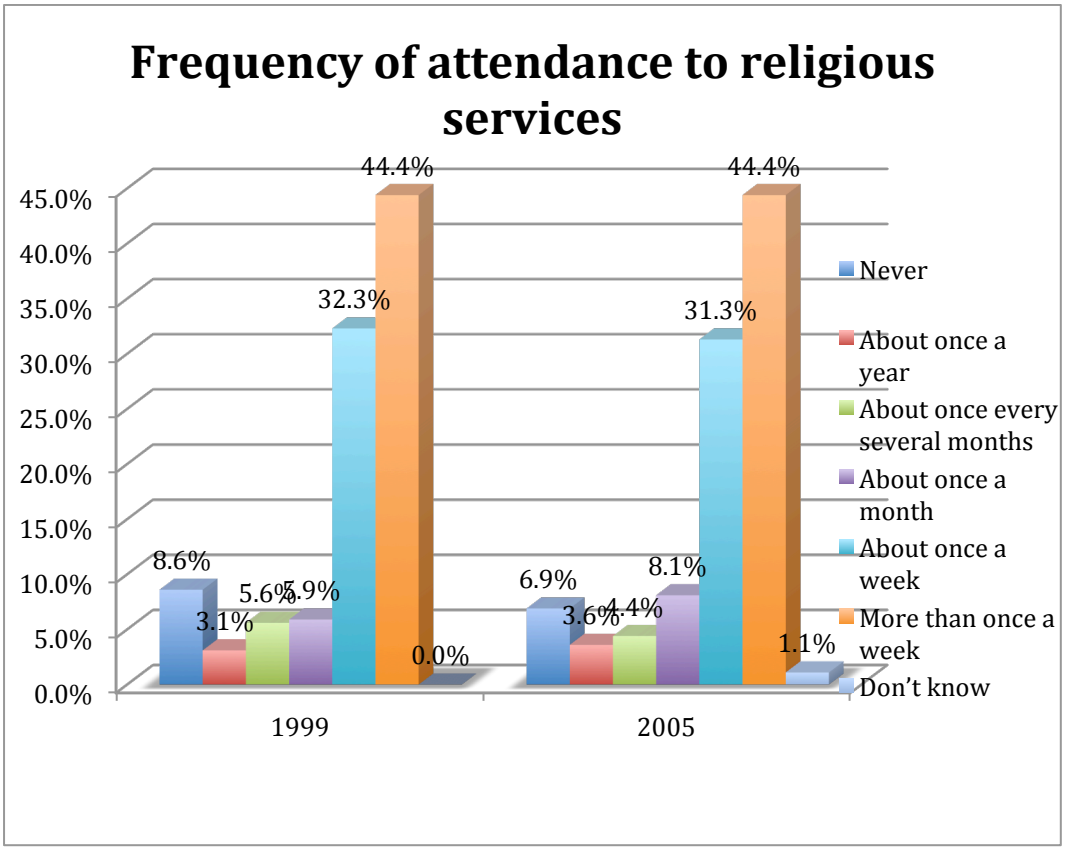


Figure 5: Frequency of attendance of religious services (source: Afrobarometer)

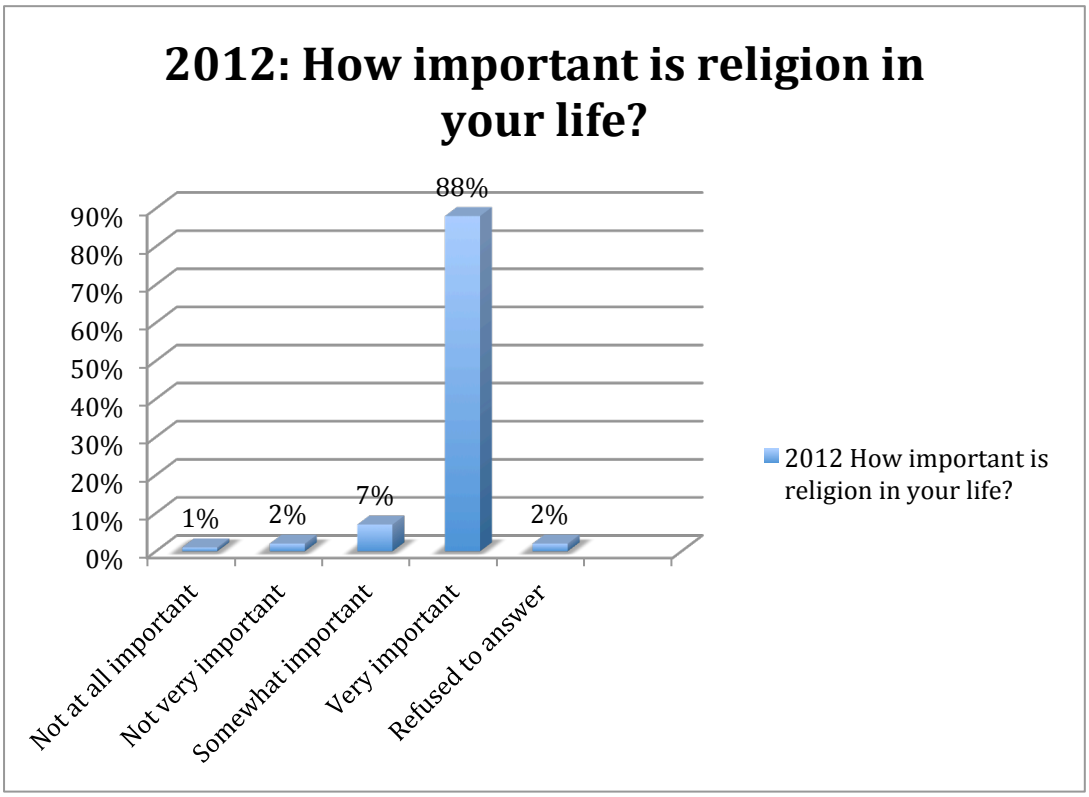


Figure 6: Importance of religion (source: Afrobarometer)

To summarize therefore, the survey reveals low levels of voluntary association membership in Ghanaian society, with the important exception of religious groups. Against this background therefore, the current low enrolment into the NHIS is not surprising – it is consistent with the revealed associational preferences exhibited for voluntary group membership across other groupings in the society.

4.1.2 Generalised norms

This Social Capital measure deals with generalized norms of reciprocity and exchange that determine the unit of trust and solidarity in society. These norms serve as positive or negative reinforcements of expected social behaviour – positive in returning benefits or favours, and negative in returning unfavourable treatment. Generalised norms are therefore a powerful Social Capital measure, reflecting the society's 'culture of relating to one another'.

The results of the Afrobarometer for the years 2005 and 2012 are striking in this respect (Fig. 7). Upwards of 83% of the respondents in both years felt that one must be very careful when dealing with most people. The Core Welfare Indicators surveys had 46% of respondents saying that most people looked out only for their own interest and 20% saying that one could not say for a certainty what people's behaviour would be in a given society (Fig. 8). Only 33% thought that most people try to be helpful. According to these results therefore, the norms of reciprocity in Ghanaian society reinforces negative behaviour – unfavourable treatment is expected from most people, and this has negative implications for solidarity, a key expression of Social Capital.

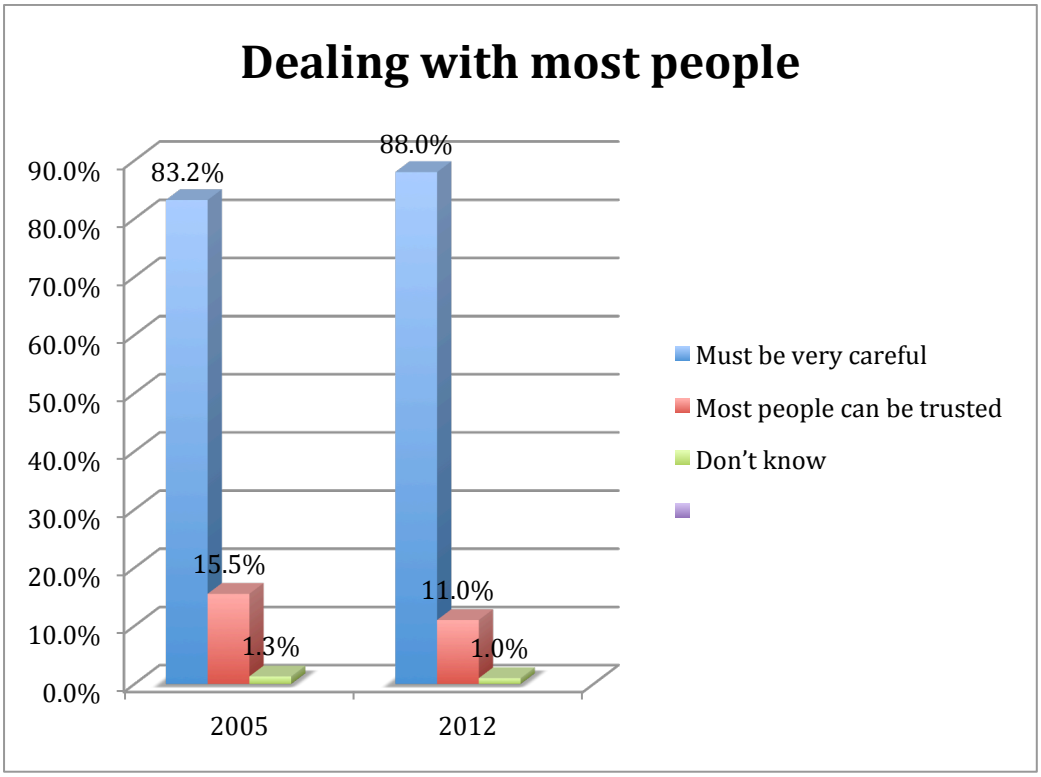


Figure 7: Attitude for dealing with people (source: Afrobarometer)

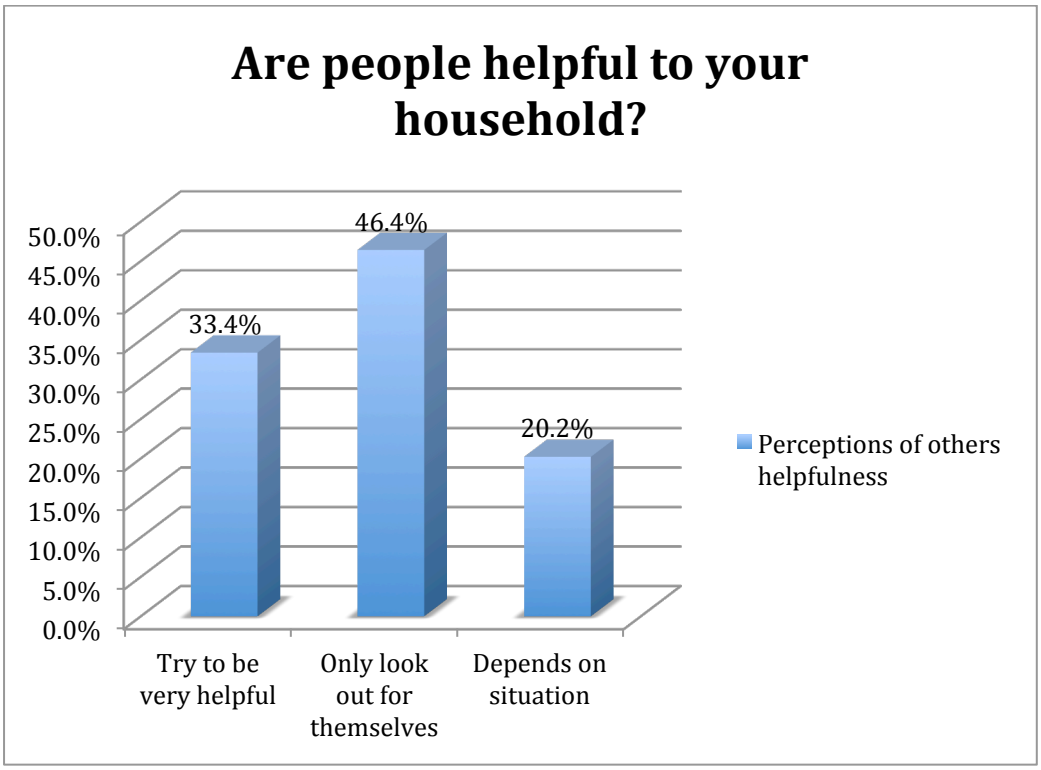


Figure 8: Perceptions of others helpfulness (source: Core Welfare Indicators survey, 2003)

4.1.3 Togetherness

The Togetherness measure may be construed as an assessment of the extent of 'community' in the society. It is a measure of whether and how members of the society get along. To a lesser extent, it is also a gauge of the feeling of belonging in the society. The Core Welfare Indicators survey indicates very little tension/disagreement or communal violence in Ghanaian society (Figs. 9 and 10). This is consistent with Ghana's historic tradition of peaceful co-existence among diverse groups and is a positive indicator of Social Capital.

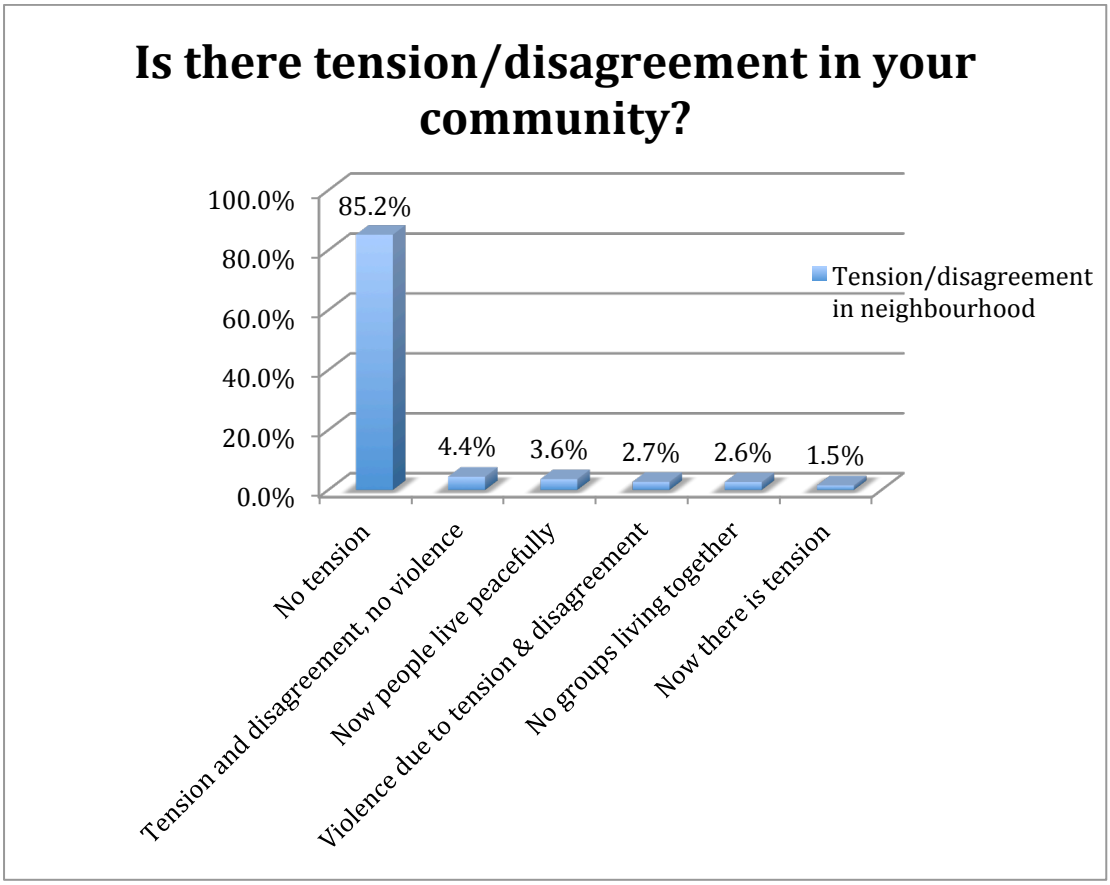


Figure 9: Incidence of community tension (source: Core Welfare Indicators Survey, 2003)

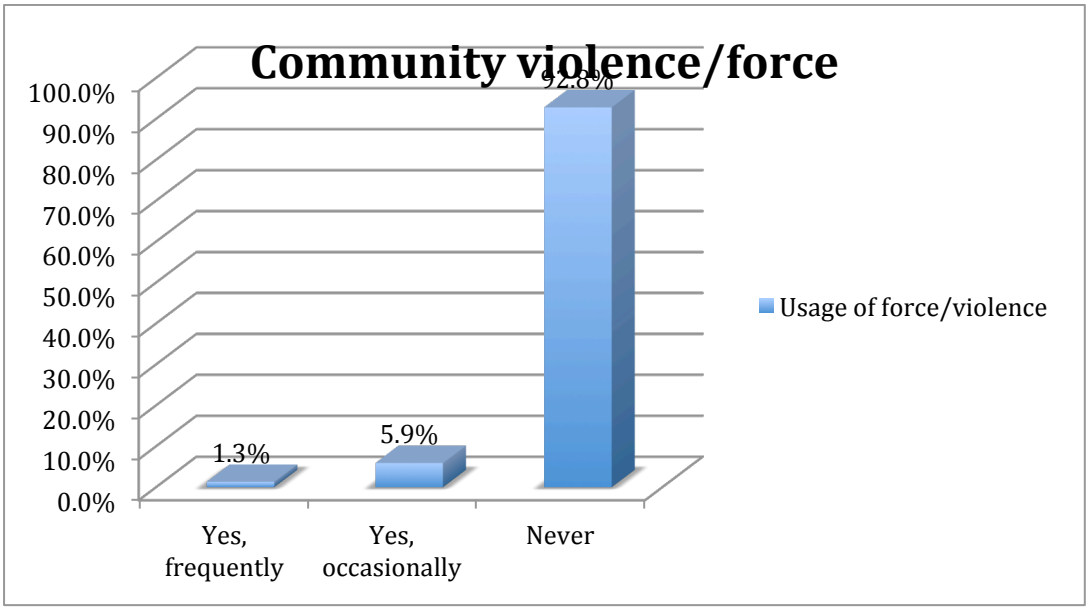


Figure 10: Prevalence of community violence (source: Core Welfare Indicators Survey, 2003)

4.1.3 Neighbourhood Connections

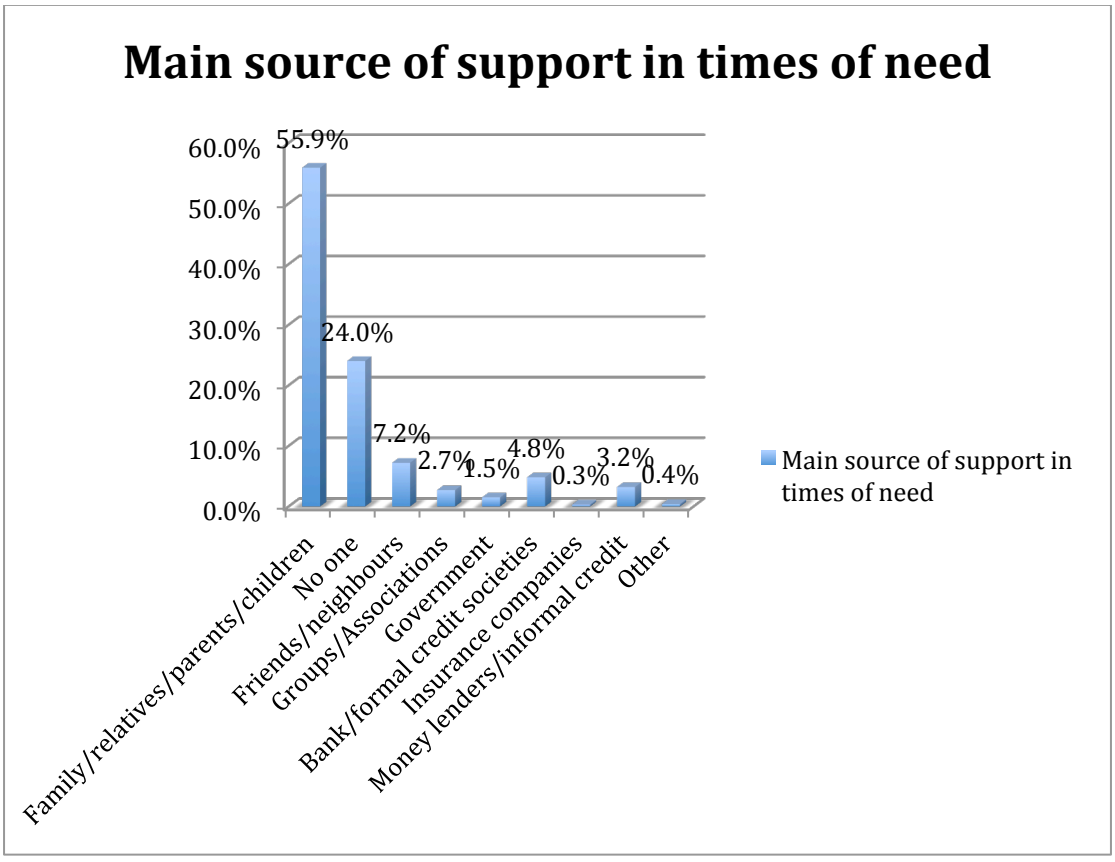


Figure 11: Emergency support network (source: Core Welfare Indicators Survey, 2003)

Neighbourhood connections measures the extent to which people can fall on their neighbours temporarily in times of need. It is a measure of the extent of solidarity within the immediate neighbourhood, rather than just a measure of the frequency of association with those closest to you. The Core Welfare Indictors indirectly captures the extent of connections with neighbours through a question on the main source of support in times of need (Fig. 11). About half of respondents will rely on close family, while about a quarter report no one to rely on. Strikingly, only 7% of respondents consider their neighbours a source of help in times of need. Outside the family unit therefore, the perception of solidarity is quite weak according to the survey results.

4.1.4 Trust

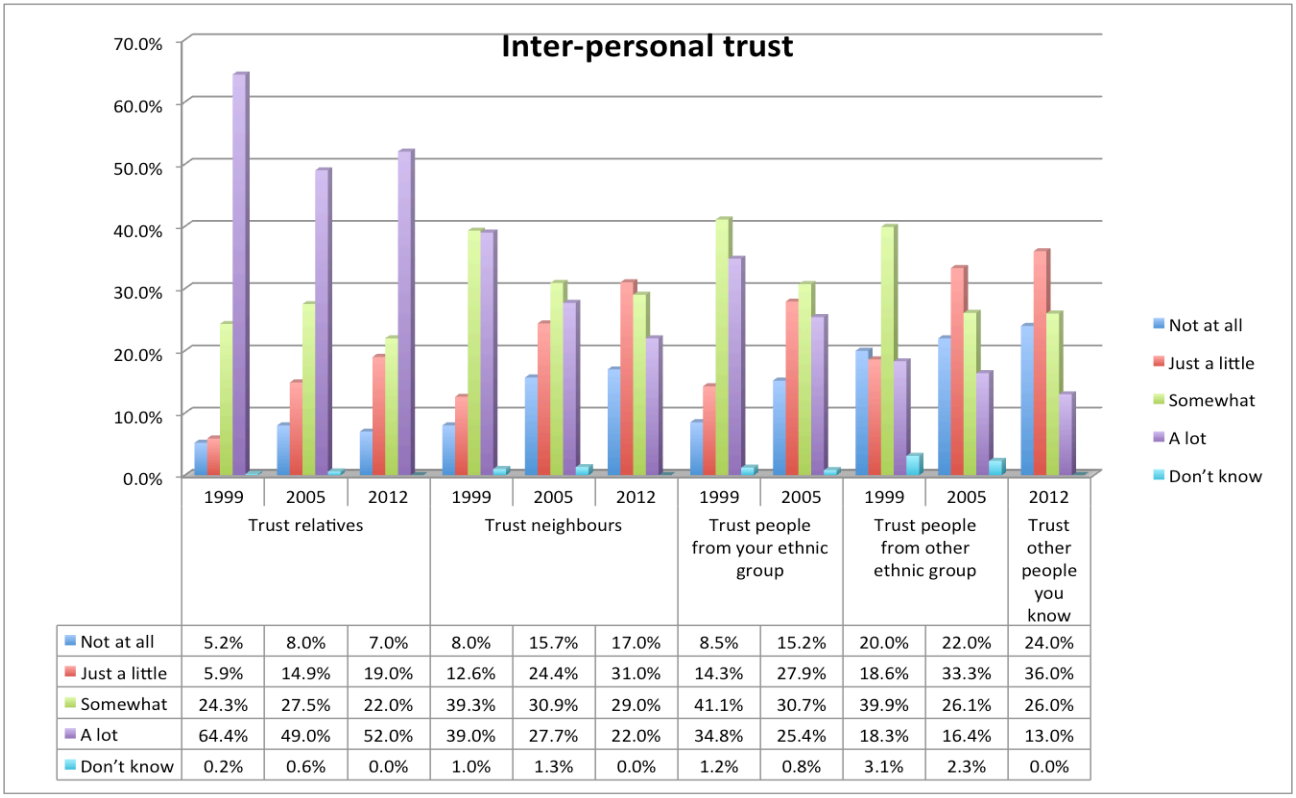
Trust is the quintessential indicator that comes to mind when mention is made of Social Capital. If people find solidarity only in the family, (what (Banfield 1958)) calls amoral familism), then horizontal relationships, which are a major source of Social Capital is lacking. Fig. 12 reveals that across all the 3 selected years of Afrobarometer surveys, trust was highest among relatives – 64%, 49% and 52% of respondents trusted their relatives 'a lot' in 1999, 2005 and 2012 respectively. The corresponding figures for neighbours were 39%, 28% and 22%, reflecting a substantial decline over the period. Also interesting is that fact that more people trust people from their own ethnic group 'a lot' (35% and 25% in 1999 and 2005 respectively) than trust people from other ethnic groups (18% and 16%). When we look at the same indicator from the other side, 11%, 23% and 26% of respondents did not trust their relatives at all or trusted them only a little in 1999, 2005 and 2012 respectively. For neighbours however, the corresponding figures were 21%, 40% and 48%. A similar comparison can be made for own ethnic group versus other ethnic

group trust levels, where the respective 1999 and 2005 figures were 23% and 43% for own group, versus 39% and 55% for other group. In 2012, only 13% of respondents trusted other people they know 'a lot' (outside family and neighbours) while a combined 60% did not trust them at all or trusted them just a little. Apart from the striking differences in levels of trust for people of different relational proximities, there also appears to be a general trend of decline in inter-personal trust levels over the years across all the categories of relationships studied.

Another measure of horizontal relationships is the trust levels in politicians, local government and the police/judges/courts. This is particularly important for institution building, and a critical determinant of successful society-wide collaboration. The results are not clear-cut when it comes to trust in police, judges and local government (Fig. 13). A quarter to a third of respondents in the 3 years report that they trust the authorities 'somewhat' – perhaps a reflection of politeness in response. However, 50%, 32% and 57% of respondents report 'not trusting the police at all' or 'trusting them just a little' in 1999, 2005 and 2012 respectively; the corresponding figures for judges are 39%, 30% and 41%; and for local government 38%, 41% and 55%. These are worrying levels of mistrust for any society. Conversely, 18%, 38% and 18% of respondents trusted the police 'a lot' in 1999, 2005 and 2012; 24%, 35% and 25% did same for judges; and 21%, 33% and 15% reported same for local government authorities. Again, there's a stagnant or declining trend in the trust levels for these authorities.

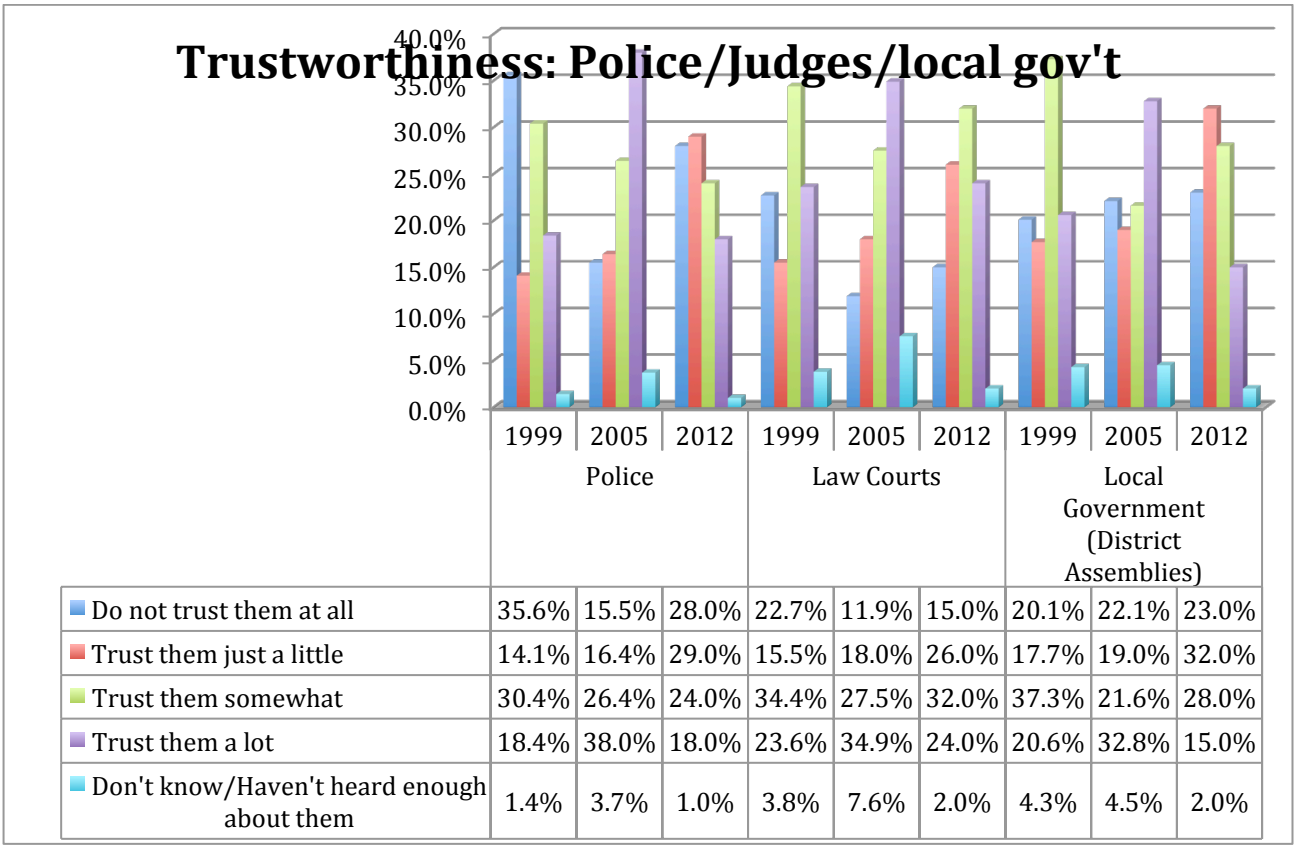
Trust in politicians also presents a plausible measure of the extent to which vertical bridging linkages exist between the society and state actors. This has a huge impact on perceptions of accountability and on ordinary people's willingness to participate in

state initiatives, as these are the people who exert control over the state. The importance of the measures should not be exaggerated too much though as politicians are generally suffer from low levels of public trust worldwide. Nevertheless, Ghanaian politicians appear to enjoy respectable levels of public trust as seen in Fig. 14. 70%, 68% and 49% of respondents trusted parliamentarians 'somewhat' or 'a lot' in 1999, 2005 and 2012; while 75% and 56% reported same for the president in 2005 and 2012. The ruling party was trusted 'somewhat' or a lot by 67% and 47% of respondents in 2005 and 2012, compared to 51% and 54% for the opposition. In 1999, 61.4% of respondents trusted all political parties 'somewhat' or 'a lot'. These figures are impressive given the generally low levels of public trust in politicians that are recorded in surveys across different countries in the world. There is no immediate a priori reason why this should be so, but it is plausible to say that it is an anomaly given the low levels of interaction with elected representatives, the low levels of perceived ability to influence representatives and the perceptions of corruption among public officials as reported under 4.3.



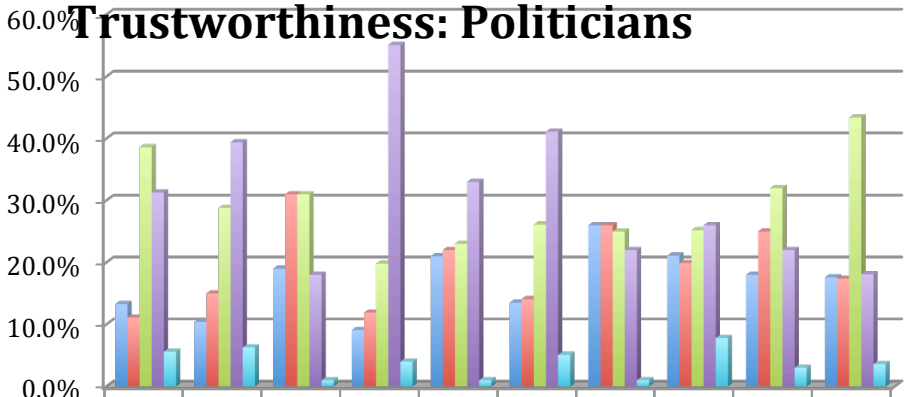
	1999	2005	2012	1999	2005	2012	1999	2005	1999	2005	2012
	Trust relatives			Trust neighbours			Trust people from your ethnic group		Trust people from other ethnic group		Trust other people you know
Not at all	5.2%	8.0%	7.0%	8.0%	15.7%	17.0%	8.5%	15.2%	20.0%	22.0%	24.0%
Just a little	5.9%	14.9%	19.0%	12.6%	24.4%	31.0%	14.3%	27.9%	18.6%	33.3%	36.0%
Somewhat	24.3%	27.5%	22.0%	39.3%	30.9%	29.0%	41.1%	30.7%	39.9%	26.1%	26.0%
A lot	64.4%	49.0%	52.0%	39.0%	27.7%	22.0%	34.8%	25.4%	18.3%	16.4%	13.0%
Don't know	0.2%	0.6%	0.0%	1.0%	1.3%	0.0%	1.2%	0.8%	3.1%	2.3%	0.0%

Figure 12: Intra-community trust (source: Afrobarometer)



	1999	2005	2012	1999	2005	2012	1999	2005	2012
	Police			Law Courts			Local Government (District Assemblies)		
Do not trust them at all	35.6%	15.5%	28.0%	22.7%	11.9%	15.0%	20.1%	22.1%	23.0%
Trust them just a little	14.1%	16.4%	29.0%	15.5%	18.0%	26.0%	17.7%	19.0%	32.0%
Trust them somewhat	30.4%	26.4%	24.0%	34.4%	27.5%	32.0%	37.3%	21.6%	28.0%
Trust them a lot	18.4%	38.0%	18.0%	23.6%	34.9%	24.0%	20.6%	32.8%	15.0%
Don't know/Haven't heard enough about them	1.4%	3.7%	1.0%	3.8%	7.6%	2.0%	4.3%	4.5%	2.0%

Figure 13: Trustworthiness public institutions (source: Afrobarometer)



	1999	2005	2012	2005	2012	2005	2012	2005	2012	1999
	Parliament			President		Ruling Party		Opposition party		All political parties (1999)
Do not trust them at all	13.3%	10.4%	19%	9.1%	21.0%	13.50%	26%	21.1%	18.0%	17.6%
Trust them just a little	11.1%	15.0%	31%	11.9%	22.0%	14.10%	26%	19.9%	25.0%	17.4%
Trust them somewhat	38.6%	28.8%	31%	19.8%	23.0%	26.10%	25%	25.2%	32.0%	43.4%
Trust them a lot	31.3%	39.4%	18%	55.1%	33.0%	41.10%	22%	26.0%	22.0%	18.1%
Don't know/Haven't heard enough about them	5.6%	6.3%	1%	4.0%	1.0%	5.10%	1%	7.8%	3.0%	3.6%

Figure 14: Trustworthiness - Politicians (source: Afrobarometer)

4.2 Determinant Measures

4.2.3 Pride and Identity

This measure captures respondent's perceptions with regards to their sense of identity – that is who they are, where they have come from and their sense of belonging. It is a measure of the group with which the respondent most identifies and their sense of pride in belonging to that group. The Afrobarometer measured the extent to which respondents identified with their ethnic groups versus their Ghanaian heritage. The results for both 2005 and 2012 reveal a definite trend (Fig 15) - 42% of respondents in 2005 identified equally with their ethnic identity and Ghanaian identities; while the corresponding figure for 2012 was 51%. Similarly, 25% and 34% of respondents identified themselves as Ghanaians only. Conversely, only 14% and 11% of respondents responded feeling more ethnic than Ghanaian in 2005 and 2012 respectively. On the whole therefore, the results present a commendable level of

'nationhood' because a priori, it would be unrealistic to expect very weak ethnic group identities within the Ghanaian context. That the majority of persons proudly perceive themselves either solely as Ghanaians or as Ghanaians in equal proportion to their tribal affiliations is a definite indicator of positive Social Capital.

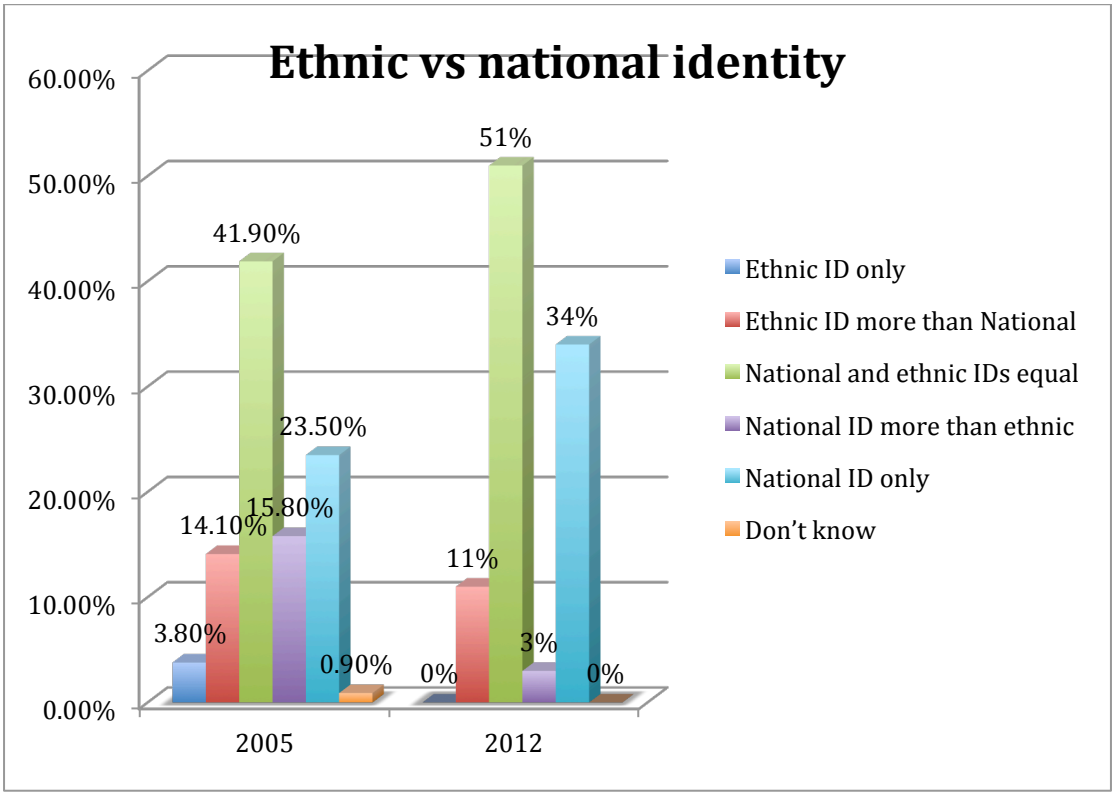


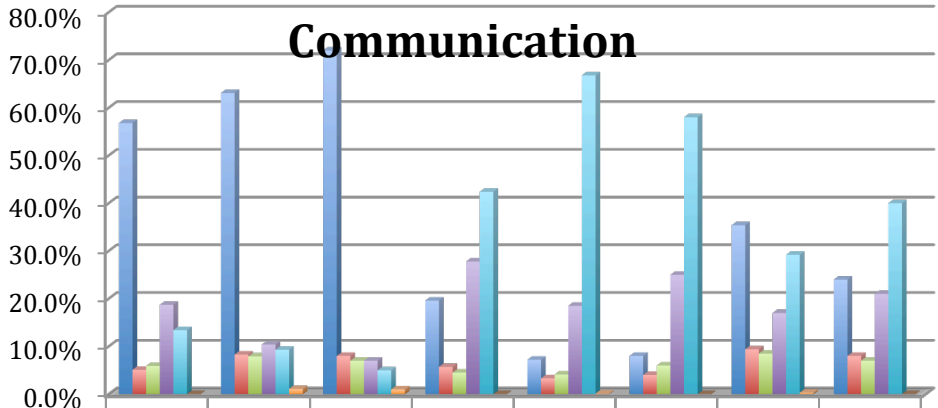
Figure 15: Identity (source: Afrobarometer)

4.2.4 Communication

The measure of communication as a determinant of Social Capital details the extent to which persons in the society keep themselves current on social happenings. The extent to which an individual is informed definitely affects the probability of involvement in any communal activities. An informed citizenry is also more able to keep elected representatives accountable since public opinion is critical to politician's success.

Radio represents the most important source of information for most respondents to the Afrobarometer, with 42%, 67% and 58% listening to the radio news bulletin

everyday (Fig 16). Television has also become relatively important in recent times reflecting increased TV ownership across the population since the turn of the millennium; the proportion of respondents listening to the TV news everyday increased from 29% in 2005 to 40% in 2012. The proportion that report never listening to the news on radio has fallen from 19.6% in 1999 to only 8% in 2012 while the corresponding proportion for TV has declined from 35% to 24% between 2005 and 2012. Newspaper readership however has declined over the years – Only 5% of respondents read a newspaper daily in 2012, compared to 13% in 1999, while those who never read newspapers have increased from 57% of respondents to 72%. To the extent that radio and television mediums broadcast relevant information therefore, the Afrobarometer results imply that there is an appreciable level of communication in Ghanaian society.



	1999	2005	2012	1999	2005	2012	2005	2012
	Read Newspaper			Listen to radio news bulletin			Television news	
Never	56.8%	63.1%	72.0%	19.6%	7.2%	8.0%	35.4%	24%
less than once a month	5.1%	8.3%	8.0%	5.7%	3.3%	4.0%	9.4%	8%
A few times a month (about once a month-1999)	5.9%	7.9%	7.0%	4.5%	4.1%	6.0%	8.5%	7%
A few times a week (about once a week-1999)	18.7%	10.4%	7.0%	27.8%	18.5%	25.0%	17.0%	21%
every day	13.4%	9.3%	5.0%	42.4%	66.8%	58.0%	29.2%	40%
Don't know	0.0%	1.1%	1.0%	0.0%	0.1%	0.0%	0.3%	0%

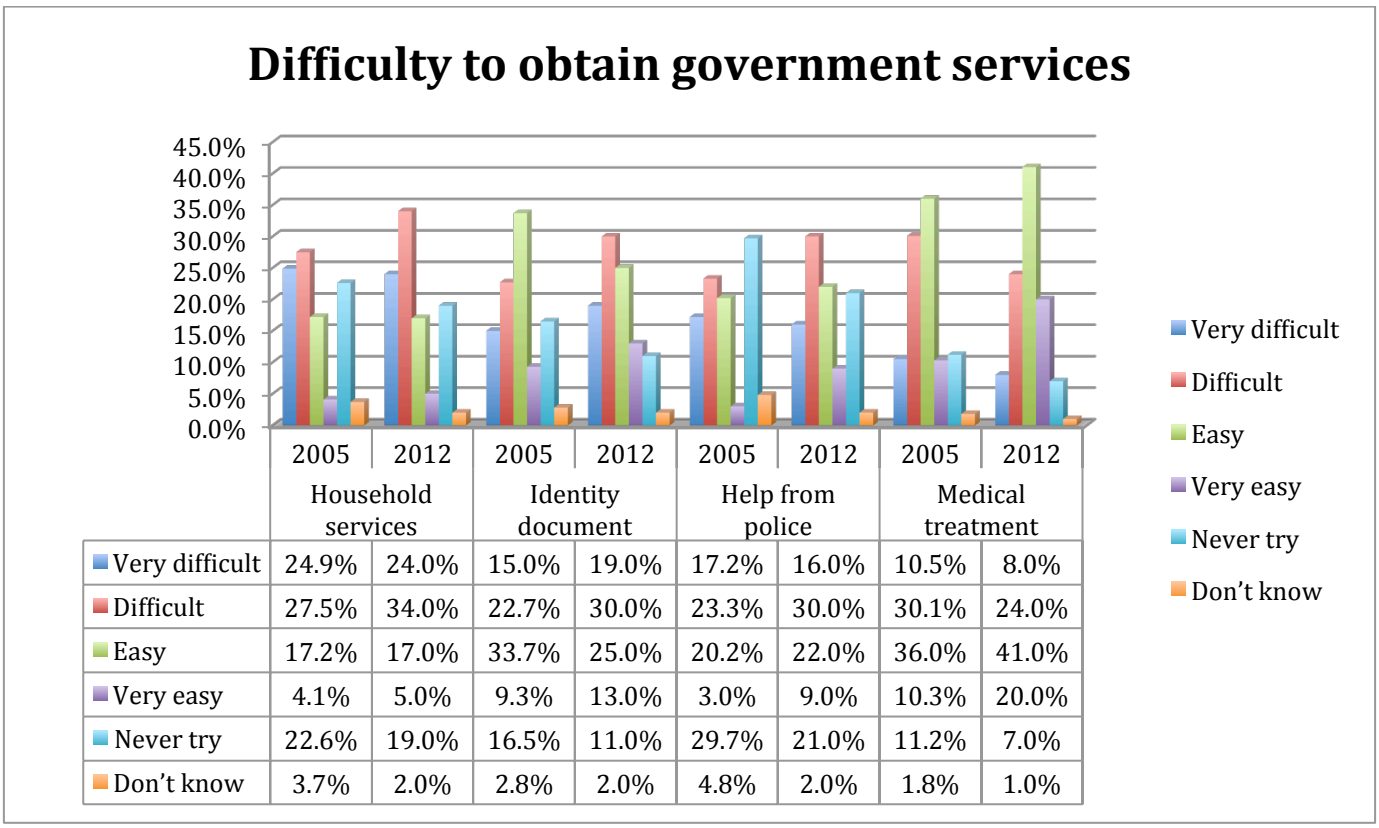
Figure 16: Keeping Informed (source: Afrobarometer)

4.3 Outcome Measures

4.3.1 Quality of Government

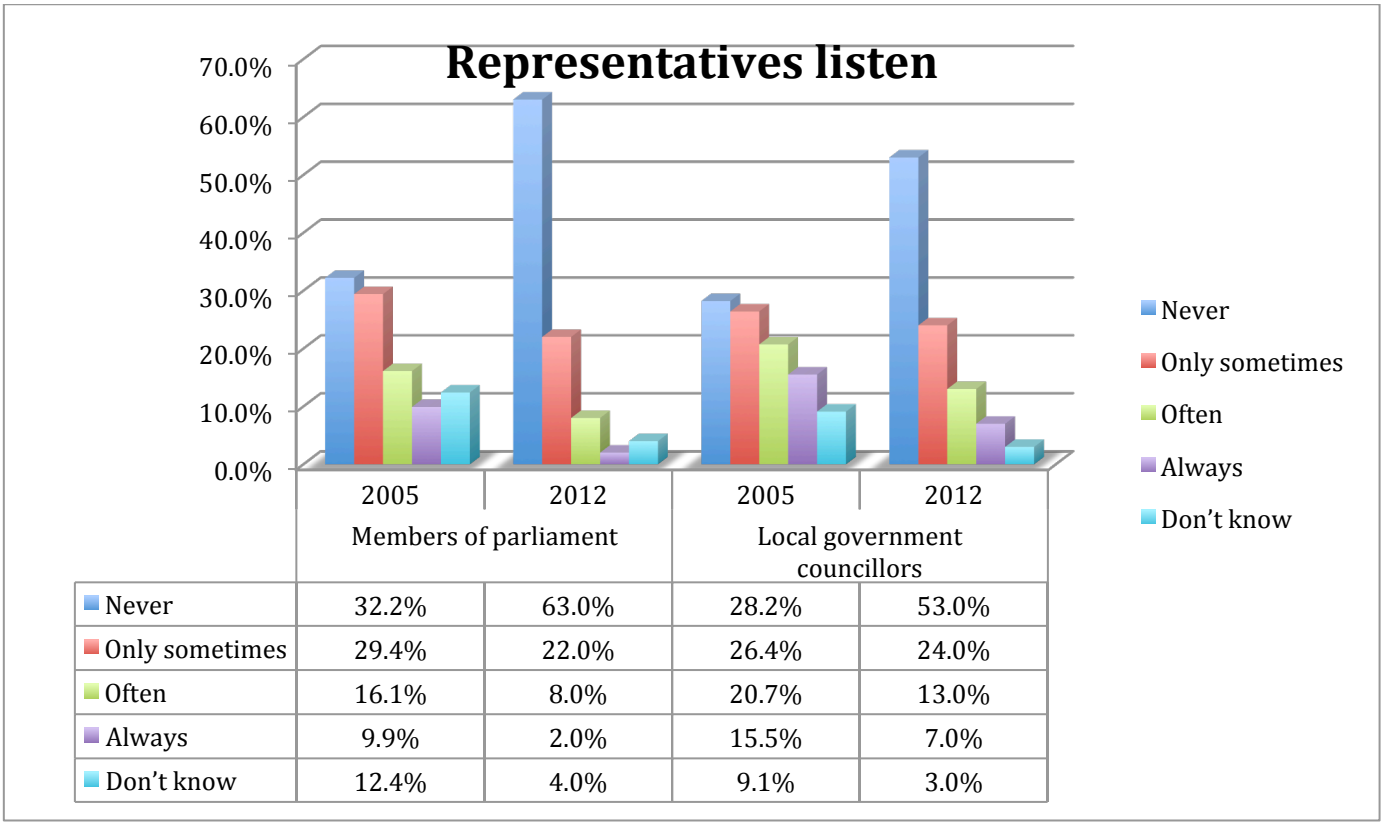
Quality of government as an outcome measure of Social Capital considers the ease with which households obtain government services in everyday transactions. It is a reflection of the level of Social Capital inherent in the society. From (Fig. 17) below, it is evident that many respondents experience difficulties in obtaining government services, with the exception of medical treatment at public hospitals, which is somewhat easier to obtain. A combined 74% and 77% of respondents never try to obtain 'household services' or thought it was (very) difficult to obtain them in 2005 and 2012 respectively; for obtaining 'help from the police', the corresponding figures were 70% and 67%; while the proportion which responded similarly for 'obtaining identity documents' were 49% and 60% in 2005 and 2012 respectively. Receiving medical treatment on the other hand is relatively straightforward with 60% of respondents finding it easy or very easy to obtain services. This outcome measure of Social Capital reveals difficulties.

A further indication of the quality of government is the extent to which respondents perceived that they could influence their representatives in making changes in rules, policies and laws that affect their lives – whether their concerns are taken into account (Fig 18). In 2012, 63% of respondents felt that their MPs never listened to them, as against 32% in 2005; the corresponding figures for local government councillors were 53% and 28.2% respectively. The proportion of respondents who felt that their representatives listened to them sometimes or often was 46% and 30% for MPs and 47% and 37% for local government councillors respectively for 2005 and 2012. These figures suggest that communication channels between the people and their elected representatives are far from satisfactory.



	2005	2012	2005	2012	2005	2012	2005	2012
	Household services		Identity document		Help from police		Medical treatment	
Very difficult	24.9%	24.0%	15.0%	19.0%	17.2%	16.0%	10.5%	8.0%
Difficult	27.5%	34.0%	22.7%	30.0%	23.3%	30.0%	30.1%	24.0%
Easy	17.2%	17.0%	33.7%	25.0%	20.2%	22.0%	36.0%	41.0%
Very easy	4.1%	5.0%	9.3%	13.0%	3.0%	9.0%	10.3%	20.0%
Never try	22.6%	19.0%	16.5%	11.0%	29.7%	21.0%	11.2%	7.0%
Don't know	3.7%	2.0%	2.8%	2.0%	4.8%	2.0%	1.8%	1.0%

Figure 17: Obtaining Government services (source: Afrobarometer)

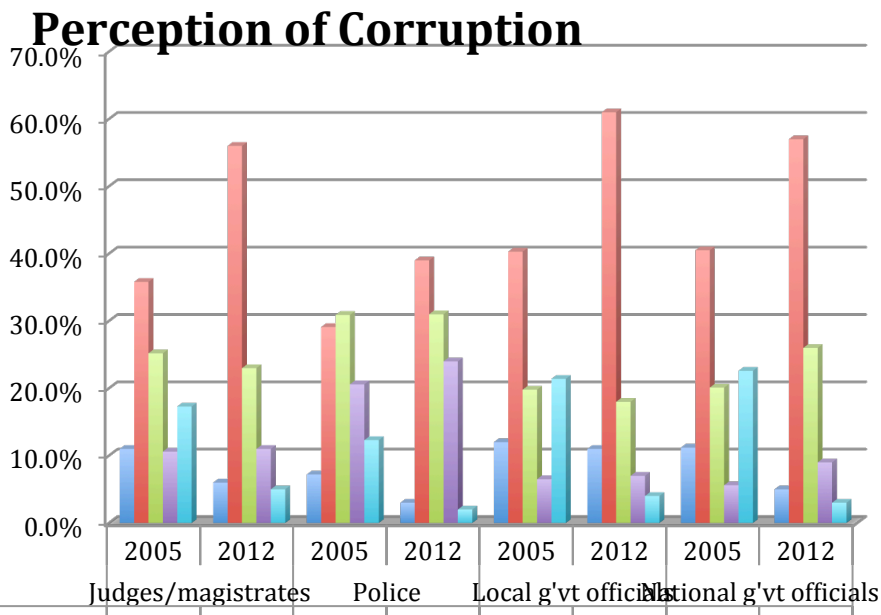


	2005	2012	2005	2012
	Members of parliament		Local government councillors	
Never	32.2%	63.0%	28.2%	53.0%
Only sometimes	29.4%	22.0%	26.4%	24.0%
Often	16.1%	8.0%	20.7%	13.0%
Always	9.9%	2.0%	15.5%	7.0%
Don't know	12.4%	4.0%	9.1%	3.0%

Figure 18: Influencing Representatives (source: Afrobarometer)

4.3.2 Honesty and Corruption

This quintessential manifestation of the level of Social Capital in a society is on par with trust in reflecting the extent of reciprocity and solidarity between societal actors with varying levels of power. Having to pay additional money to government agencies in order to get things done is a reflection of poor Social Capital. Perceptions of corruption are therefore a powerful indicator of the richness of a society's Social Capital, and the level of institutional policing (transaction costs) that is required to ensure the success of collective endeavours.



	Judges/magistrates		Police		Local g'vt officials		National g'vt officials	
None	11.0%	6.0%	7.2%	3.0%	12.0%	11.0%	11.2%	5.0%
Some of them	35.8%	56.0%	29.1%	39.0%	40.3%	61.0%	40.5%	57.0%
Most of them	25.2%	23.0%	30.9%	31.0%	19.8%	18.0%	20.1%	26.0%
All of them	10.6%	11.0%	20.6%	24.0%	6.5%	7.0%	5.6%	9.0%
Don't know/havent heard enough	17.3%	5.0%	12.3%	2.0%	21.4%	4.0%	22.6%	3.0%

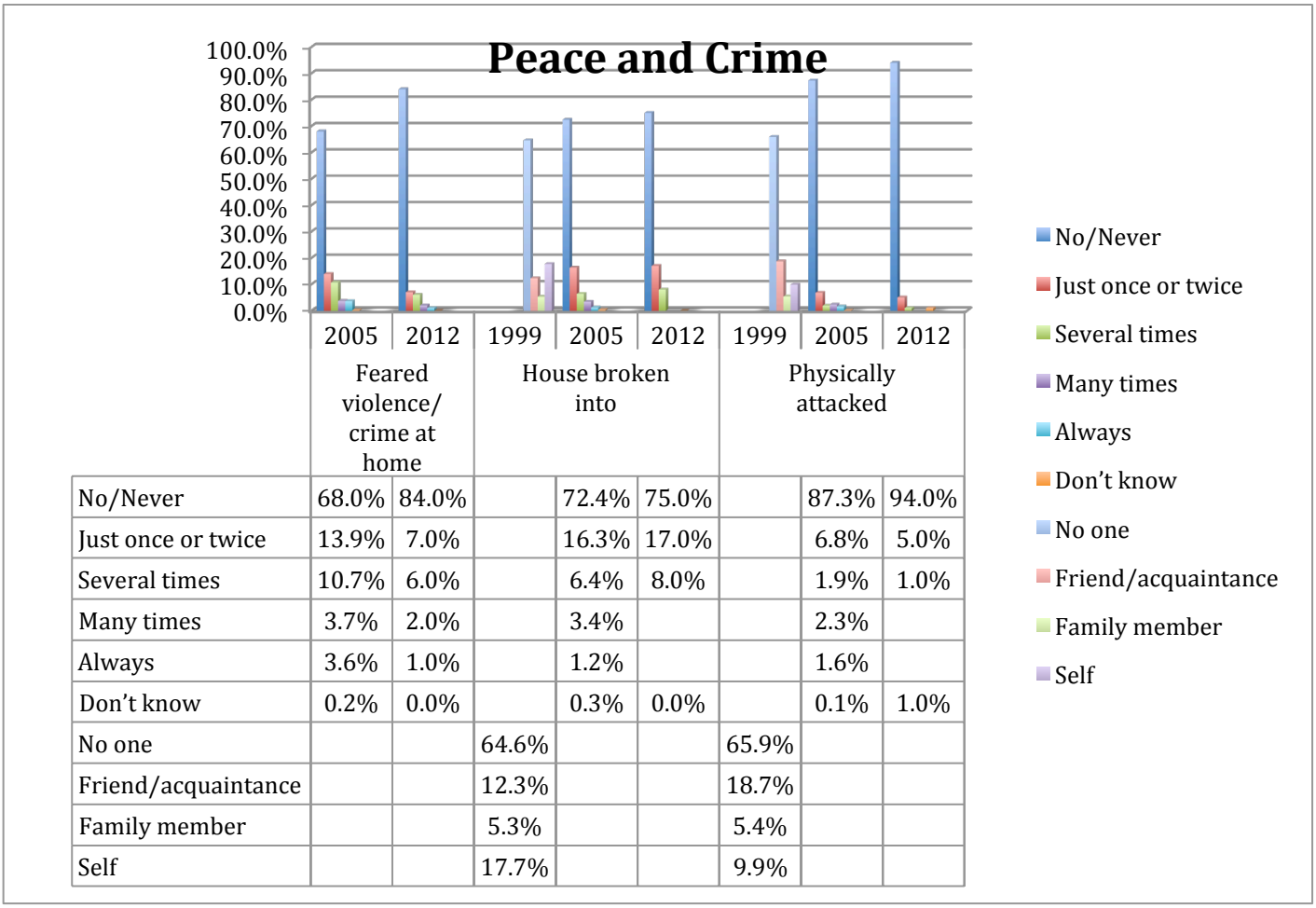
Figure 19: Corruption (source: Afrobarometer)

From figure 19 above, most respondents perceive pervasive corruption among public officials in Ghana with perceived corruption worsening between 2005 and 2012. As much as 90%, 94%, 86% and 92% of respondents in 2012 thought there was some level of corruption among judges, the police, local government officials and national government officials respectively (the comparative figures for 2005 were 72%, 81%,

67% and 66% respectively). The astonishing levels of perceived dishonesty is a huge constraint for effective Social Capital building in Ghana.

4.3.3 Peace, Crime and Safety

This outcome measure, to an extent, reflects social cohesion, an important form of Social Capital. A low-crime society may reflect embedded feelings of belonging, association, reciprocity and solidarity. This effect may however be confounded by other important factors such as the level of policing or a general aversion to crime in the society. To the extent that these factors are can be controlled for, a low-crime society can reflect strong Social Capital.



	2005	2012	1999	2005	2012	1999	2005	2012
	Feared violence/ crime at home		House broken into			Physically attacked		
No/Never	68.0%	84.0%		72.4%	75.0%		87.3%	94.0%
Just once or twice	13.9%	7.0%		16.3%	17.0%		6.8%	5.0%
Several times	10.7%	6.0%		6.4%	8.0%		1.9%	1.0%
Many times	3.7%	2.0%		3.4%			2.3%	
Always	3.6%	1.0%		1.2%			1.6%	
Don't know	0.2%	0.0%		0.3%	0.0%		0.1%	1.0%
No one			64.6%			65.9%		
Friend/acquaintance			12.3%			18.7%		
Family member			5.3%			5.4%		
Self			17.7%			9.9%		

Figure 20: Crime and Safety (source: Afrobarometer)

This appears to be the case in Ghana where crime levels are generally low, as shown in the figure above. The overwhelming majority of Afrobarometer respondents had

never feared crime/violence at home, had their house broken into or been physically attacked in all the 3 years. The proportion reporting never being victims to crime also increased over the period. This is consistent with the earlier Social Capital measure of togetherness, which revealed a consistent trend of peaceful co-existence among different groups in the society.

4.3.4 Political Engagement

This final outcome measure of Social Capital reflects the degree of civic involvement by members of the public, and is intrinsically linked to individual perceptions of ability to influence social outcomes through participation. Political engagement also gives a hint of the potential for the state to engage the citizenry's interest in state initiated programs.

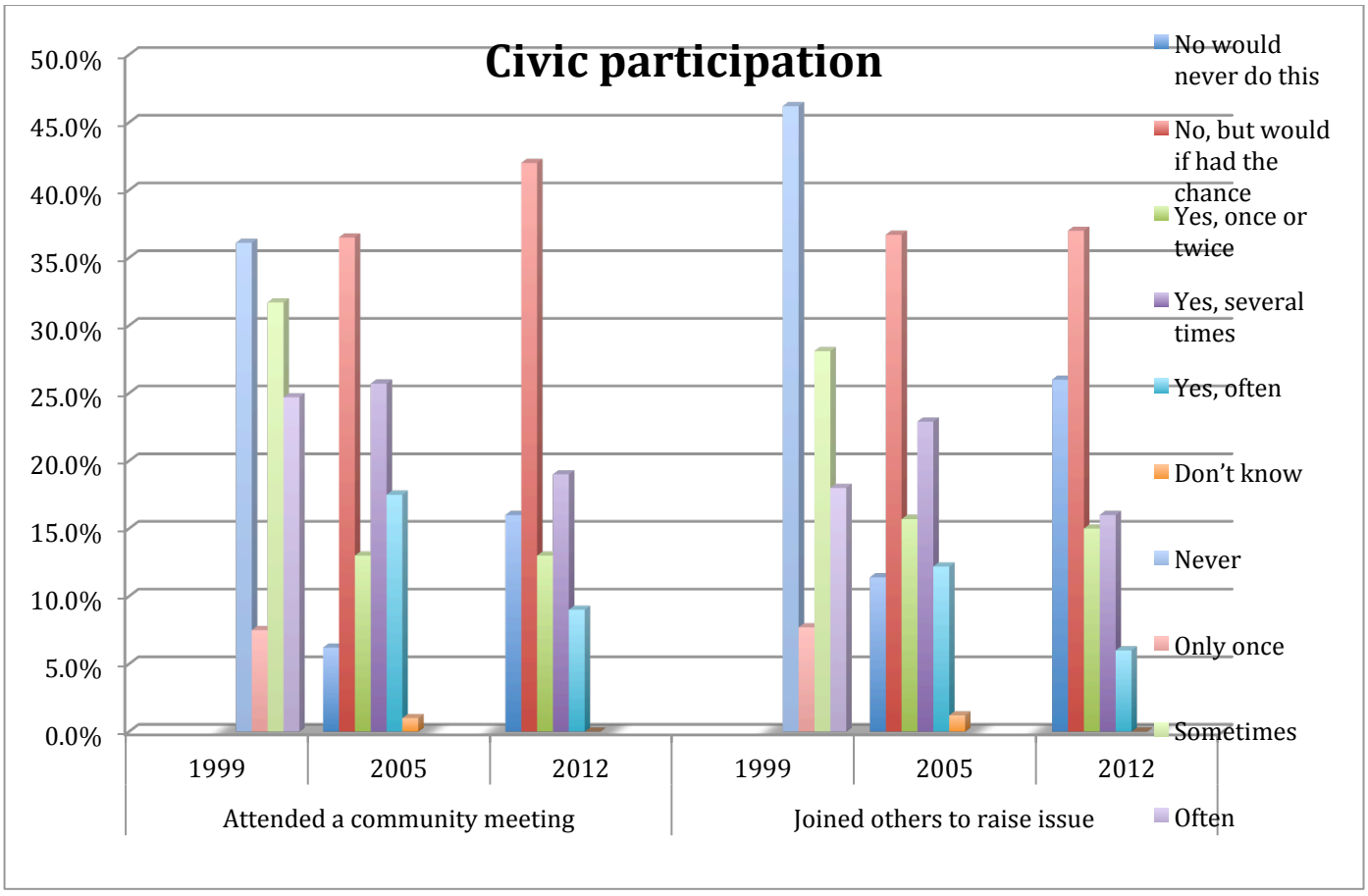


Figure 21: Citizen engagement (source: Afrobarometer)

There is a mix of signals when it comes to political engagement among the survey respondents. While the overwhelming majority of respondents voted in the previous election (Fig 22), the overwhelming majority in all years had also never contacted a local government councillor, an MP, an official of a government agency or a political party official over any issue (Fig 23). Again, majority of respondents responded that they had never attended a community meeting or joined others to raise an issue, or that they had not but would if they had the chance (Fig. 21). Indirectly therefore, the extent of political engagement appears to be effectively constrained by individual perceptions of very limited ability to influence decisions beyond casting the vote for a particular political party (which may actually be more influenced by considerations such as tribal affiliations).

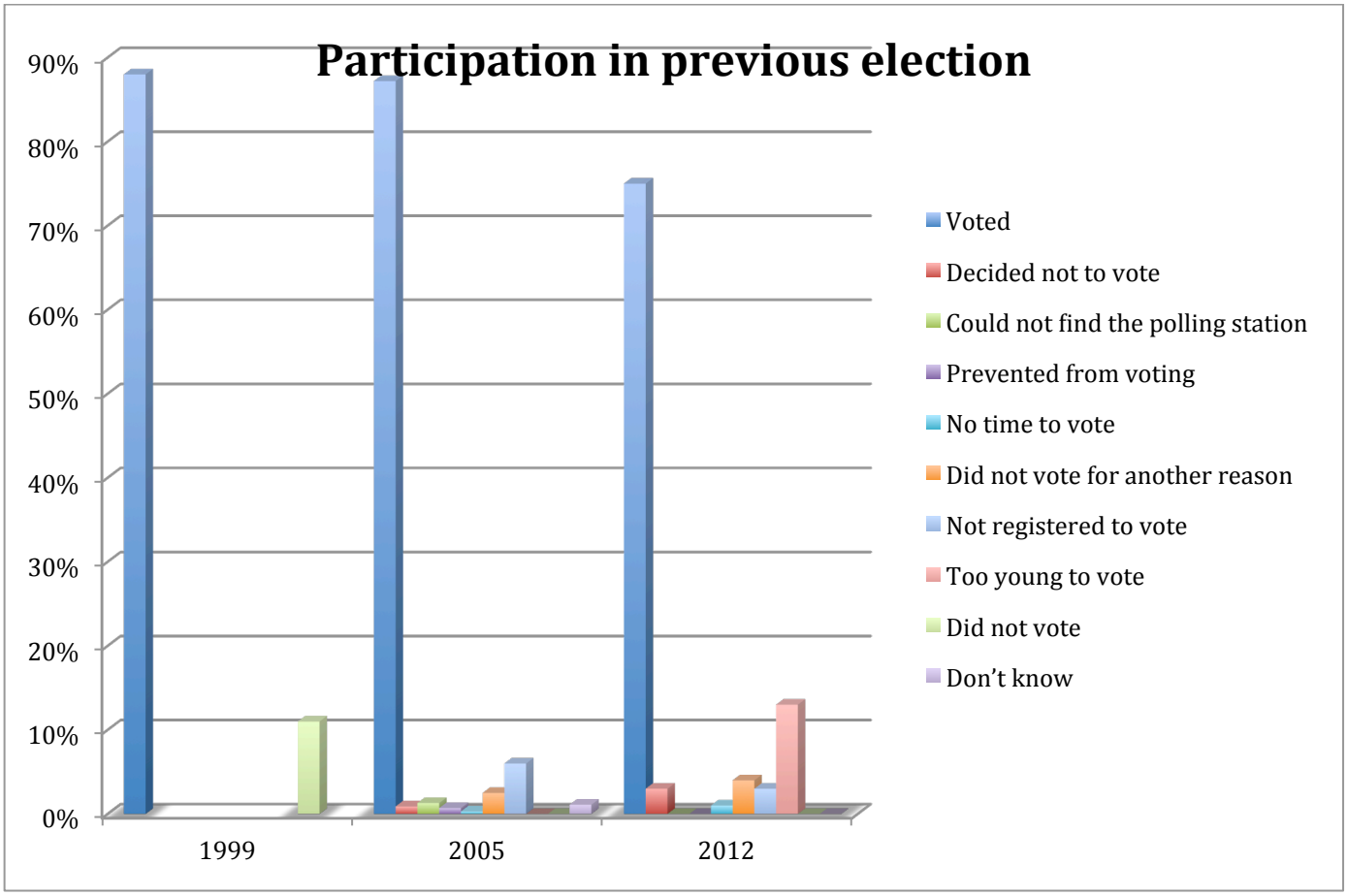
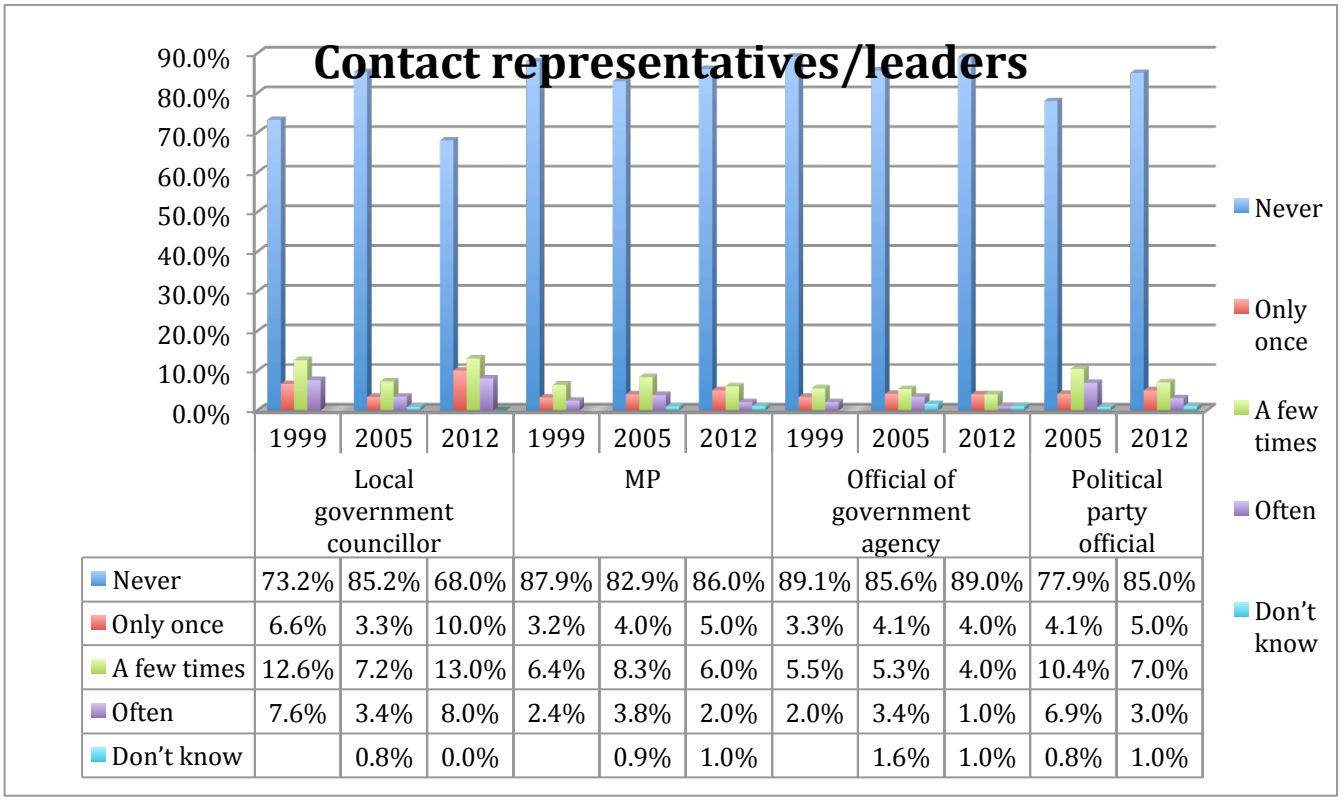


Figure 22: Participation in Elections (source: Afrobarometer)



	1999	2005	2012	1999	2005	2012	1999	2005	2012	2005	2012
	Local government councillor			MP			Official of government agency			Political party official	
Never	73.2%	85.2%	68.0%	87.9%	82.9%	86.0%	89.1%	85.6%	89.0%	77.9%	85.0%
Only once	6.6%	3.3%	10.0%	3.2%	4.0%	5.0%	3.3%	4.1%	4.0%	4.1%	5.0%
A few times	12.6%	7.2%	13.0%	6.4%	8.3%	6.0%	5.5%	5.3%	4.0%	10.4%	7.0%
Often	7.6%	3.4%	8.0%	2.4%	3.8%	2.0%	2.0%	3.4%	1.0%	6.9%	3.0%
Don't know		0.8%	0.0%		0.9%	1.0%		1.6%	1.0%	0.8%	1.0%

Figure 23: Contact with representatives (source: Afrobarometer)

5. Analyzing Ghana's NHIS through the lens of a Social Capital Framework

The data presented above allows us to incorporate considerations of Social Capital into the discussions about Ghana's NHIS. As noted under section 1.1.3, contributions from the informal sector currently make up a very small percentage of the Scheme's overall revenues. With the Scheme tottering on the verge of bankruptcy, it has been suggested that increasing participation among this majority section of the Ghanaian workforce is a feasible way to improve the solvency of the NHIS.

5.1 Theory meets the evidence

Following from the discussion of the evaluative framework presented under section 2.3, we analyse the potential for increasing voluntary informal sector participation in the NHIS in the light of the evidence on Social Capital presented in the previous section. Specifically, with reference to research question 2, this section summarizes the evidence on the social norms, values and patterns of association that are apparent from the data analysis and draws their implications for voluntary informal participation in the NHIS employing the four categories in our theoretical framework.

5.1.1 Micro-level bonding Social Capital within communities

For Ghana's voluntary NHIS, the framework postulates that the major determinant of willingness to enrol/pay is bonding Social Capital inhering within communities. Trust, solidarity and norms of reciprocity within and across heterogeneous groups in society are the crucial social determinants here, and their existence to different extents and at different social levels may either provide positive Social Capital to drive voluntary enrolment or present effective social arguments to discourage it. Figure 12 implies that inter-personal trust in Ghanaian society is substantially present

only in familial relationships – individuals mainly trust their relatives and to a lesser extent, members of their own ethnic group. They exhibit substantially lower trust levels for other groups such as neighbours, members of other tribes and other people they know – in fact, perhaps it is more accurate to state that they do not trust these groups. Unsurprisingly therefore, Fig. 11 reinforces the familial relationship as the overwhelming Social Capital bond in the society by revealing that over half of respondents have their relatives as the main source of support in times of need. Contrastingly, only 7% of people perceive their neighbours as reliable sources of help in times of need while as much as a quarter had no one to fall on in a temporary crisis. In consonance with (Mladovsky and Mossialos 2008)'s argument that strong intra-group (family/tribe) ties must be complemented by positive bonds across groups in order to generate positive Social Capital, Figs. 7 and 8 reveal a marked dearth of solidarity in Ghanaian society as perceived by respondents. Only a third of the people surveyed thought that others tried to be helpful to them, with the overwhelming majority responding that people only looked out for their own interests or that their behaviour could not be predicted a priori. In response to the question of the attitude to adopt when dealing with people on a day to day basis, an even bigger majority (over 80%) of respondents replied that one had to be 'very careful' when dealing with people in the ordinary business of life. The levels of self-reported voluntary group membership may therefore be interpreted as manifestations of this culture of a lack of trust and solidarity. With the important exception of religious groups, participation in social groups such as trade unions, farmer organisations, professional/business organisations and other voluntary associations is very low. When individuals do not trust each other in ordinary activities of life, selfish self-interest (or the perceptions of it) makes it very difficult for them to join together with others to advance common sublunary interests.

In summary, while familial relationships are perceived as a reliable bastion of help in emergencies, there is a palpable lack of solidarity outside this group and manifestations of weak Social Capital across heterogeneous groups in Ghanaian society. (Perceptions of) selfish self-interest also poses effective constraints to collective ambition as manifested in the low levels of voluntary group membership. If vested interest organisations such as trade unions, farmer organisations and business associations that can advance member interests with a high degree of certainty suffer low membership, then perhaps it is unsurprising that voluntary enrolment for the NHIS is low given that benefits may not accrue at all, as in the absence of illness. Similarly, if people see the family unit as the only trustworthy social relationship, it is plausible to infer that they are only willing to contribute towards the welfare of their immediate relatives and not towards a larger social pool with implicit cross-subsidisation. Individuals who expect their families to bail them out in times of health emergencies therefore have a reduced incentive to contribute to a social health insurance scheme with less than certain expected benefit occurrence. In the absence of a formal commitment mechanism therefore, this absence of solidarity is a critical missing factor in encouraging enrolment.

Interestingly, when one considers 'togetherness' as measured by tension, disagreement or violence in the community, the responses imply a feeling of community, hypothesizing the existence of some positive Social Capital. The measures considered above however make it explicit that the apparent sense of 'togetherness' belies the fact that social connections are weak across heterogeneous groups, and that the lack of violence, tension and disagreement may reflect factors other than the existence of positive Social Capital linkages. While we refuse to

speculate on what such factors may be, it is obvious that when the whole spectrum of measures are considered, the balance of the evidence indicates that the most vaunted forms of Social Capital (trust, solidarity and positive reciprocity) are lacking in Ghanaian society; and this is consistent with the low levels of voluntary enrolment into the NHIS.

5.1.2 Micro-level bridging Social Capital

The Social Capital measures mentioned above are somewhat difficult to explain in terms of the determinant measures experienced in the Ghanaian case (Figs. 15 and 16), which would predict positive Social Capital in Ghanaian society. It inures to the benefit of Ghanaian society that the majority of people identify themselves with the nation as such feelings can spur productive effort for the common good. An informed citizenry is also more likely to be active participants of civic initiatives than an uninformed one. However, just as the Social Capital measures considered above imply, it is apparent that an appreciable sense of nationhood and the proliferation of radio and TV mediums of communication are not sufficient to guarantee the existence of useful social relationships. In fact as mentioned by (Mladovsky and Mossialos 2008), it is doubtful whether policy can, or indeed should attempt to, construct affective and emotional relationships. Therefore, while good undertakings in their own right, the promotion of a free press or a campaign for increased identification with the Ghanaian nation will not of themselves birth communal norms of trust, solidarity and positive reciprocity. The low rates of civic participation, whether it is joining others to raise issues or attending community development meetings reflect this dearth in collective action potential

5.1.3 Bridging Social Capital at the macro-level

The Social Capital context that affects the potential for voluntary enrolment into the NHIS is also reflected in the outcome measures to which we now turn our attention. In their framework, (Mladovsky and Mossialos 2008) conceive that engagement by state officials (local and central) in promoting and sustaining citizen involvement generates positive Social Capital that vastly improves the potential for successful implementation of social policies.

Embeddedness, which constructs Social Capital through continuous informal interactions between public actors and their communities, suffers a dearth in the Ghanaian context according to the data presented above. That the overwhelming majority of respondents to the surveys had never contacted a government official (local or central) or other representative is symptomatic of a lack of a culture of interaction between state actors and members of the society. Given that the NHIS is implemented by a public agency, this is an indication that there are problems with creating embeddedness or what is more commonly referred to as 'fostering ownership' for social policies in Ghana. Perhaps this lack of interaction is explained by the fact that majority of respondents in both years surveyed for attitudes of representatives felt that representatives were barely interested in listening to their concerns when making decisions that affect their lives (Fig. 18). This general ethos indicates a lack of effective communication channels through which society members may interact with their representatives. If people feel that they cannot influence even the leaders who depend on their votes to secure office, then it follows that they may perceive that they lack a means of influencing unelected public servants (NHIA officials). Such a perceived lack of community influence presents a negative marker for the pursuit of embeddedness in social policy and possibly serves as a disincentive to voluntary enrolment in the NHIS. The reasons adduced for the revision of the

NHIA law to, among other things, abolish the District Mutual Health Insurance Scheme (DMHIS) as the basic unit of the NHIS (Government of Ghana 2012) also provide further evidence of problems posed by a weak institutional environment when seeking embeddedness in social policy. The major reason cited by the NHIA was a lack of accountability by the DMHISs. It remains to be seen how responsive the new structure will be to subscribers, but the experience so far indicates that the NHIS has not as yet been adequately 'embedded'.

Another area in which bridging Social Capital at the macro-level is important for the successful implementation of a CBHI is complementarity. This involves the "provision of public goods and an enabling rule of law, while private institutions produce goods and services" (Mladovsky and Mossialos 2008 pp. 599). At least on the surface, Ghana's NHIS appears to have 'complementarity' inherent in its design because the law mandates the NHIA to accredit providers (after quality assessment) before they can provide services under the scheme, and to continuously monitor providers to guarantee the quality of healthcare services. Good quality of care has a positive effect on (continued) willingness to enrol (Dong, De Allegri et al. 2009, Polonsky, Balabanova et al. 2009). The surveys we employ are lacking in direct information on perceptions of the competence, effectiveness or quality of the NHIA, but there is some indirect evidence on the Ghana Health Service (GHS). Obtaining hospital services is relatively easy when compared to accessing household services, identity documents or help from the police. It must be noted however that a majority of Ghanaians pay out-of-pocket for medical services as the NHIS currently covers only 36% of the population (National Development Planning Commission 2013). To the extent that receiving medical services is dependent on making payments, the positive ratings medical services enjoys may not be necessarily a result of effective monitoring and regulation by the NHIA. With specific regards to receiving services

under the NHIS, other studies have revealed poor (perceived) quality of care (SEND-Ghana 2010), (Alfers 2009). This, together with the difficulties reported in accessing other 'public goods', shapes negative perceptions about an effective government complementarity role. Social Capital theory postulates that this will hinder voluntary enrolment.

5.1.4 Bonding Social Capital at the macro level

Organisational integrity among the institutions that transcend the public-private divide is an expression of macro Social Capital that has a positive influence on social policy. If the social relations among the bureaucracy foster the positive norm of pursuing collective goals coherently and competently, there will be a positive effect on professionalism and capacity building that will inexorably lead to improved outcomes in social policy. In the absence of a strong Weberian bureaucracy however, (Evans 1996) argues that state-society synergy will not be a good force and will foster corruption instead. The balance of the evidence in Ghana forcefully supports this latter view. Reflecting the dearth in positive reciprocity at the micro-level, corruption at the macro level is a major problem in the country (Fig 19). It seems implausible to assume that these perceptions of corruption will have no bearing on the decision to voluntarily contribute money towards a social pool over which the individual has very little control. There is a deficiency in bonding Social Capital at the macro level, and this reinforces the incentives to stay away from a voluntary SHI.

5.2 Social Determinants of Informal sector participation in Ghana's NHIS

The analysis indicates that the low level of participation in the NHIS by Ghana's large informal sector is inadequately explained in the health insurance discourse grounded in economic and health systems frameworks. The commonly held view that premiums are preventing the "majority poor" from enrolling can only be partially true. Ghana is touted to have reduced poverty rates from 52% in 1992 to 28.5% in 2006 at the measurement of $1.25 per day (PPP) (World Bank 2014)). Annual premiums charged for NHIS membership range from Gh¢ 7.2 to Gh¢ 48 ($4.8 to $32 in 2011) based on ability to pay, but in practice the absence of accurate data on incomes means that the typical DMHIS applies a flat rate to subscribers in its catchment area. This was estimated at a national average of Gh¢ 8-10 ($5.3 – 6.7) by (Blanchet, Fink et al. 2012), with urban Accra having a significantly higher average of Gh¢ 21 ($14). (Amporfu 2013) also reports Gh¢ 21 as the average premium charged by DMHISs in Accra and Kumasi. A person living in Accra on just $1.25 would therefore be able to pay his premium in 12 days if he (unrealistically) forewent all other expenditure. Assuming that he instead saved $0.05 a day, he would be able to pay his annual premium in 280 days. These extreme calculations using the highest cost areas for health insurance premiums are just to make the point that the 71.5% of Ghanaians who live above the poverty line could afford to pay the NHIS premiums if they so wished. This implies that current 35.5% NHIS participation rate of the informal sector (National Development Planning Commission 2013) is more than just a question of affordability. Discussions concerning subscriber enrolment into the NHIS that are founded in the economic and health system frameworks therefore fail to totally explain the mechanisms at work here. The status quo is even more baffling given the documented catastrophic nature of out-of-pocket healthcare spending in Ghana (Lewis 2007, Osei-Akoto and Adamba 2010, Novignon, Nonvignon et al.

2012). These show that the pursuit of increased informal sector membership is unlikely to be a viable policy option to improve the NHIS' financial sustainability prospects.

It is apparent then that income and economic theory based frameworks are insufficient to capture the complex array of factors at play in Social Health Insurance initiatives that are founded in voluntary Community-Based Health Insurance Schemes. Such concern has led the search for new evaluative and explanatory frameworks that can systematically incorporate the critical social context into the discussion. (Mladovsky and Mossialos 2008) present the most comprehensive adaptation of a Social Capital framework for the conceptual analysis of CBHI. In particular, they were interested in explaining why most CBHIs "do not appear to be on course to follow the 19th century precedent, achieving significant levels of population coverage in a sustainable way". The analysis presented above on Ghana's NHIS lends support to their assertion. Regarding the four types of Social Capital presented in the framework, (Woolcock 1998 p. 186) argues that "all four dimensions must be present for optimal developmental outcomes. This successful interaction within and between bottom-up and top-down initiatives is the cumulative product of an on-going process that entails 'getting the social relations right'." We have therefore examined Ghana's NHIS under this lens in order to see the direction in which the decision to voluntarily enrol is influenced by the existing social context.

The analysis implies that voluntary enrolment into the NHIS may be negatively affected by a poor level of bonding Social Capital as reflected by paucity of trust and positive reciprocity in Ghanaian society. Beyond the familial unit, there is not much in terms of solidarity, a key catalyst for any social health insurance scheme, which

assumes an even higher level of importance in the absence of a formal compulsion mechanism. The perception that only familial bonds are reliable (and therefore valuable) appears to have crowded out voluntary enrolment in the NHIS – beyond the familial, most people are not interested in cross-subsidizing healthcare for others. Measures of group membership and civic participation also reveal poor levels of micro-level bridging Social Capital, with the important exception of religion. The important social role that religious organisations play in Ghanaian society has been well documented (Addai, Opoku-Agyeman et al. 2013). If the NHIA would more formally incorporate them into its enrolment drive, their Social Capital could lead to increased (and sustained) voluntary enrolment, through playing possible roles in serving as a commitment mechanism (sustained social pressure on congregants) and premium collectors (weekly instalments that may be easier for members to pay). Currently however, the lack of micro-level bridging Social Capital in other societal arrangements negatively affects voluntary enrolment into the NHIS.

The NHIS is also challenged with regards to embeddedness and complementarity, two critical roles played by bonding Social Capital at the macro-level. There is insufficient interaction between state actors and society members and this makes it difficult to foster ownership of the NHIS. The feeling among individuals that they have little influence on public officials is a disincentive to participation in a collective endeavour for which payment is required. In the case of untoward outcomes, how will their complaints be addressed? Who will they even complain to? If even they are not voiced out, subconsciously, these social considerations will affect the decision to voluntarily pay for social health insurance. These negative perceptions are further reinforced by a weak complementary role by the public authorities, both actual and perceived. The disenrollment of many hitherto NHIS subscribers has been explained

in many circles by the poor quality of service received, a perfectly understandable reaction. Institutional weaknesses complete the abysmal picture of Social Capital in Ghanaian society as reflected in weak state-society synergy. The high levels of corruption in Ghanaian society epitomises weak bonding Social Capital at the macro-level, serving as another potent disincentive to voluntary enrolment in a social health insurance scheme.

When all four types of Social Capital are considered therefore, the analysis finds that the low levels of voluntary enrolment into Ghana's NHIS are totally consistent with the implications of Social Capital framework.

6. Conclusion

The study was set out to investigate the potential for universal informal sector participation in a Social Health Insurance Scheme with foundations in Community-Based Health Insurance Schemes, using Ghana's National Health Insurance Scheme as a case study, and has identified Social Determinants that affect the decision to voluntarily enrol. The study has also sought to know whether the oft-prescribed policy intervention of seeking improved informal sector membership is a viable endeavour in the noble quest for Universal Health Coverage and what its feasibility or otherwise means for financial sustainability efforts.

The general theoretical literature on this subject and specifically in the context of low income countries with large informal sectors is steeped in economic and health system perspectives and is inconclusive on several vital questions on the frequently poor performance of CBHIs with respect to informal sector membership and therefore as a means of achieving UHC. Using an alternative of a Social Capital theory-based framework, the study has sought an explicit consideration of Social Factors that should be incorporated in the conceptualisation, design and implementation of CBHI-founded SHI schemes in low-income, informal-sector dominated countries by seeking answers to the following questions:

(1) What do the revealed social norms, values and patterns of association indicate with regards to the strength or otherwise of Social Capital in Ghana?
(2) What are the implications for voluntary informal sector participation in Ghana's NHIS? What do they mean for the Scheme's design with regards to financial sustainability?

The main empirical findings are chapter specific and were summarized within the respective empirical chapters: Assessing Social Capital in Ghanaian Society and Analyzing Ghana's NHIS through the lens of a Social Capital Framework.

a. Evidence on social determinants of voluntary SHI enrolment and willingness to pay: Overall, the Social Capital that inheres within and across various social groupings in Ghana is weak. With the exception of familial and religious groupings, there is not much intra and extra-community trust, solidarity and positive reciprocity. The revealed social norms, values and patterns of association show that there is weak Social Capital in Ghanaian society.

b. Implications for informal sector membership: 'Amoral familism' appears to have crowded out voluntary NHIS enrolment – the combination of poor levels of trust, solidarity and positive reciprocity of social norms and values give a poor outlook in terms of the potential to significantly improve the current poor level of informal sector membership in Ghana's NHIS.

c. Financial sustainability efforts: In its current contraption, the NHIS is unlikely to be able to significantly increase informal sector membership on its own in the quest to improve its solvency.

The theoretical cases for voluntary CBHI membership therefore need to be augmented with consideration of social determinants in order to achieve a more complete understanding of the dynamics of the decision-making among informal sector workers and how this knowledge can be incorporated into the design and implementation of CBHI-founded Schemes in low-income countries. The economic systems frameworks frequently couch willingness-to-pay (and therefore enrol) in

terms of rational individual utility-maximization considerations. Dissemination of market information about price, quality and benefits are therefore frequently prescribed in order to drive membership (Dror 2001, Pauly 2007). It is however noted from this study that ingrained resistance to collective effort may thwart the obvious risk-minimization benefits of insuring against high out-of-pocket health expenditures. Trust, solidarity and mutual concern for others beyond the familial unit affects people's willingness to pay – invariably, Social Capital is vital for the effective functioning and sustainability of CBHI. This pattern is consistent with that presented by (Atim 1999, Hsiao 2001, Jowett 2003, Zhang, Wang et al. 2006). Social factors also directly influence the perceptions of the health system in the general context of institutional functioning (Bennett 2004, Bennett, Kelley et al. 2004, Criel, Atim et al. 2004), and the low trust levels invariably affect the perceptions of pervasive institutional decay, with negative consequences for voluntary CBHI-membership.

Ghana's NHIS is one particular health financing intervention with extended economic and health system theoretical underpinnings which has been hailed as an icon of success by varied actors, including the World Health Organization (Durairaj, D'Almeida et al. 2010). However, evidence from several studies, including from the World Bank, reveal that the Scheme is seriously challenged on many fronts including the informal sector membership and financial sustainability that are the focus of this study (Apoya and Marriott 2011, Schieber, Cashin et al. 2012). This study has used empirical analyses to show that the current design of the NHIS ignores important social considerations that are critical to the Scheme's success. The theoretical arguments for this justification suggest the need for a review of the current implementation model to incorporate a social commitment mechanism to effectively drive and maintain membership (Mladovsky and Mossialos 2008) – in Ghana's

specific case, the formal involvement of religious groups may have a tremendous positive effect. Alternatively, while formalization of the economy represents the ideal that Ghana must aspire towards (De Soto 2003), innovative tax financing that leverages current formal-informal sector linkages to progressively raise revenues for the NHIS can significantly improve the Scheme's financial sustainability prospects in the short to medium term. As summarized succinctly by (Wagstaff 2010 pp. 510) "covering the poor by paying their contribution through general revenues has proved easier than persuading the informal sector to enroll."

The scale of the SHI debate across developing countries is therefore extensive and multifaceted. To generate sustainable policy interventions, there is the need for more case studies at the country level that allow further assessments of the Social Capital dimensions of the subject. This study, which has offered an evaluative perspective on an important national social welfare program utilizing data collected for a different purpose, is a humble attempt in that direction. The limitations of the methodology employed notwithstanding, the important role of Social Capital for the success of CBHI-based Social Health Insurance Schemes in today's developing world has been conclusively demonstrated. In spite of the economic and health system frameworks' emphasis on individual utility-maximization and the quality of care obtained under insurance as the main areas of focus for Ghana's NHIS, the Scheme's success has been thwarted by the lack of consideration for Social Determinants in its design and implementation. Within the context of a low-income and informal-sector dominated economy, these Social Determinants have been shown to be vital for SHI viability and sustainability.

REFERENCES

Addai, I., et al. (2013). "An exploratory study of religion and trust in Ghana." Social indicators research **110**(3): 993-1012.

Afrobarometer (2013). "Sampling Methods." Retrieved 20th February, 2014, from http://www.afrobarometer.org/survey-and-methods/sampling-principles.

Agyepong, I. A. (1999). "Reforming health service delivery at district level in Ghana: the perspective of a district medical officer." Health Policy and Planning **14**(1): 59-69.

Agyepong, I. A. and S. Adjei (2008). "Public social policy development and implementation: a case study of the Ghana National Health Insurance scheme." Health policy and planning **23**(2): 150-160.

Alfers, L. (2009). "The Ghana National Health Insurance Scheme Draft Document." Retrieved 20 March, 2014, from http://wiego.org/sites/wiego.org/files/publications/files/alfers-ghana-nhis-case-study.pdf.

Allinger, K. (2013). Social capital, Political Participation and Civil Society: A Critical Review. Economics Department, University of Warwick. **MSc**.

Amporfu, E. (2013). "Equity of the premium of the Ghanaian national health insurance scheme and the implications for achieving universal coverage." International journal for equity in health **12**(4).

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

Arrow, K. J. (2000). "Observations on social capital." Social capital: A multifaceted perspective: 3-5.

Aryeetey, E. and W. Baah-Boateng (2007). Growth, investment and employment in Ghana, International Labour Organization.

Asenso-Okyere, W., et al. (1998). "Cost recovery in Ghana: are there any changes in health care seeking behaviour?" Health Policy and Planning **13**(2): 181-188.

Asenso-Okyere, W. K., et al. (1997). "Willingness to pay for health insurance in a developing economy. A pilot study of the informal sector of Ghana using contingent valuation." Health policy **42**(3): 223-237.

Asgary, A., et al. (2004). "Estimating rural households' willingness to pay for health insurance." The European Journal of Health Economics, formerly: HEPAC **5**(3): 209-215.

Atim, C. (1999). "Social movements and health insurance: a critical evaluation of voluntary, non-profit insurance schemes with case studies from Ghana and Cameroon." Social science & medicine **48**(7): 881-896.

Banfield, E. (1958). "The moral basis of a backward society." Glencoe, Illinois: The.

Bebbington, A. (2004). "Social capital and development studies 1: critique, debate, progress?" Progress in Development Studies **4**(4).

Bennett, S. (2004). "The role of community-based health insurance within the health care financing system: a framework for analysis." Health Policy and Planning **19**(3): 147-158.

Bennett, S., et al. (2004). 21 questions on CBHF: an overview of community-based health financing. The Partners for Health Reformplus Project. Bethesda, MD**:** Abt Associates Inc.

BIT (2002). Micro-assurance santé. Guide d'introduction aux mutuelles de santé en Afrique. Programme Stratégies et Techniques contre l'Exclusion sociale et la Pauvreté (STEP). Genève, Bureau international du Travail (BIT).

Blanchet, N., et al. (2012). "The effect of Ghana's National Health Insurance Scheme on health care utilisation." Ghana Medical Journal **46**(2): 76-84.

BOG (2007). Issues on Wages and Labour Market Competitiveness in Ghana. Accra, Research Department, Bank of Ghana.

BOG (2012). Monetary Policy Report: Fiscal Developments, Bank of Ghana. **2**.

Bourdieu, P. (1980). "Le capital social: notes provisoires. 3, 2-3." Actes de la Recherche en Sciences Sociales(3): 2-3.

Bowles, S. and H. Gintis (2002). "Social Capital And Community Governance*." The Economic Journal **112**(483): F419-F436.

Bärnighausen, T. and R. Sauerborn (2002). "One hundred and eighteen years of the German health insurance system: are there any lessons for middle-and low-income countries?" Social Science & Medicine **54**(10): 1559-1587.

Carrin, G. and C. James (2005). "Social health insurance: key factors affecting the transition towards universal coverage." International Social Security Review **58**(1): 45-64.

Carrin, G., et al. (2004). Reaching universal coverage via social health insurance: key design features in the transition period. Geneva, World Health Organization.

Coleman, J. S. (1988). "Social capital in the creation of human capital." American Journal of Sociology: S95-S120.

Costongs, C. and J. Springett (1997). "Towards a Framework for the Evaluation of Health-related Policies in Cities." Evaluation **3**(3): 345-362.

Criel, B., et al. (2004). "Editorial: Community health insurance (CHI) in sub‐Saharan Africa: researching the context." Tropical Medicine & International Health **9**(10): 1041-1043.

Criel, B. and M. Van Dormael (1999). "Mutual health organizations in Africa and social health insurance systems: will European history repeat itself?" Tropical Medicine and International Health **4**(3): 155-159.

Criel, B. and M. P. Waelkens (2003). "Declining subscriptions to the Maliando Mutual Health Organisation in Guinea-Conakry (West Africa): what is going wrong?" Social Science & Medicine **57**(7): 1205-1219.

Criel, B. and M. P. Waelkens (2003). "Declining subscriptions to the< i> Maliando</i> Mutual Health Organisation in Guinea-Conakry (West Africa): what is going wrong?" Social Science & Medicine **57**(7): 1205-1219.

De Allegri, M., et al. (2006). "Understanding consumers' preferences and decision to enrol in community-based health insurance in rural West Africa." Health policy **76**(1): 58-71.

De Soto, H. (2003). Mystery of capital: why capitalism triumphs in the West and fails everywhere else, Basic books.

Desmet, M., et al. (1999). "The potential for social mobilisation in Bangladesh: the organisation and functioning of two health insurance schemes." Social Science & Medicine **48**(7): 925-938.

Donfouet, H. P. P., et al. (2011). "Social Capital and Willingness-to-Pay for Community-Based Health Insurance in Rural Cameroon." Global Journal of Health Science **3**(1).

Donfouet, H. P. P. and P.-A. Mahieu (2012). "Community-based health insurance and social capital: a review." Health economics review **2**(1): 1-5.

Dong, H., et al. (2009). "Drop-out analysis of community-based health insurance membership at Nouna, Burkina Faso." Health policy **92**(2): 174-179.

Dong, H., et al. (2003). "Willingness‐to‐pay for community‐based insurance in Burkina Faso." Health economics **12**(10): 849-862.

Downie, R. S., et al. (1996). Health promotion: models and values, Oxford University Press Oxford.

Dror, D. M. (2001). "Reinsurance of health insurance for the informal sector." Bulletin of the World Health Organization **79**(7): 672-678.

Dror, D. M., et al. (2007). "Willingness to pay for health insurance among rural and poor persons: Field evidence from seven micro health insurance units in India." Health Policy **82**(1): 12-27.

Durairaj, V., et al. (2010). "Ghana's approach to social health protection." World health report 2010. Background paper **2**.

Durlauf, S. N. and M. Fafchamps (2004) Social Capital. NBER Working Papers

Evans, P. (1996). "Government action, social capital and development: reviewing the evidence on synergy." World development **24**(6): 1119-1132.

Franco, L. M., et al. (2004). Social participation in the development of mutual health organizations in Senegal. The Partners for Health Reformplus Project. Bethesda, MD, Abt Associates Inc.

Gilson, L. (1997). "The lessons of user fee experience in Africa." Health policy and planning **12**(3): 273-285.

Government of Ghana (2012). The National Health Insurance Act (Act 852). Accra.

GSS (2003). 2003 Core Welfare Indicators Questionnaire Survey. Accra, Ghana Statistical Services.

GSS (2013). 2010 population and housing census Ghana - Demographic, Social Economic & Housing Characteristics. Accra, Ghana Statistical Service.

Gustafsson-Wright, E., et al. (2009). "Willingness to pay for health insurance: An analysis of the potential market for new low-cost health insurance products in Namibia." Social Science & Medicine **69**(9): 1351-1359.

Günther, I. and A. Launov (2012). "Informal employment in developing countries: opportunity or last resort?" Journal of Development Economics **97**(1): 88-98.

Hart, K. (1973). "Informal income opportunities and urban employment in Ghana." Journal of modern african studies **11**(1): 61-89.

Hsiao, W. C. (2001). Unmet health needs of two billion: is community financing a solution? Health. A. S. Prekar. Washington, World Bank.

Inglehart, R. (1997). Modernization and postmodernization: Cultural, economic, and political change in 43 societies, Cambridge Univ Press.

Jowett, M. (2003). "Do informal risk sharing networks crowd out public voluntary health insurance? Evidence from Vietnam." Applied economics **35**(10): 1153-1161.

Karger, H. J. (1996). "The Public Good and the Welfare State in Africa." Journal of Social Development in Africa **11**(1): 5-16.

Lewis, M. (2007). "Informal payments and the financing of health care in developing and transition countries." Health Affairs **26**(4): 984-997.

Maeda, A. and G. Schieber (1997). A curmudgeon's guide to financing health care in developing countries. Innovations in Health Care Financing: Proceedings of a World Bank Conference, March 10-11, 1997, World Bank Publications.

Maloney, W. F. (2004). "Informality revisited." World development **32**(7): 1159-1178.

Meessen, B., et al. (2002). "Formal pooling of health risks in sub‐Saharan Africa: Reflections on the obstacles encountered." International Social Security Review **55**(2): 71-93.

Mladovsky, P. and E. Mossialos (2008). "A conceptual framework for community-based health insurance in low-income countries: social capital and economic development." World Development **36**(4): 590-607.

MOFEP (2012). Private Sector Development: Access to Credit, Markets and Land Consultative Group Paper, Ministry of Finance and Economic Planning.

MOH (2001). The Health of the Nation. Reflections on the First Five Year Health Sector Programme of Work 1997–2001. R. o. G. Ministry of Health. Accra.

Narayan, D. and M. F. Cassidy (2001). "A dimensional approach to measuring social capital: development and validation of a social capital inventory." Current sociology **49**(2): 59-102.

National Commission on Civic Renewal (1996). The Index of National Civic Health. College Park, MD, University of Maryland.

National Development Planning Commission (2013). The Implementation of the Ghana Shared Growth and Development Agenda (GSGDA), 2010-2013 - 2012 Annual Progress Report. Accra, National Development Planning Commission.

Novignon, J., et al. (2012). "Health and vulnerability to poverty in Ghana: evidence from the Ghana Living Standards Survey Round 5." Health economics review **2**(1): 11.

Nyonator, F. and J. Kutzin (1999). "Health for some? The effects of user fees in the Volta Region of Ghana." Health Policy and Planning **14**(4): 329-341.

Ogawa, S., et al. (2003). "Scaling up community health insurance: Japan's experience with the 19th century Jyorei scheme." Health Policy and Planning **18**(3): 270-278.

Oneill, M. and A. P. Pederson (1992). "BUILDING A METHODS BRIDGE BETWEEN PUBLIC-POLICY ANALYSIS AND HEALTHY PUBLIC-POLICY." Canadian Journal of Public Health-Revue Canadienne De Sante Publique **83**: S25-S30.

Onyx, J. and P. Bullen (2000). "Measuring social capital in five communities." The Journal of Applied Behavioral Science **36**(1): 23-42.

Osei-Akoto, I. and C. Adamba (2010). "Health Insurance and Vulnerability to Health Shocks in Ghana."

Pauly, M. V. (2007). "Insights on demand for private voluntary health insurance in less developed countries." Private Voluntary Health Insurance in Development: Friend or Foe: 25-54.

Polonsky, J., et al. (2009). "Equity in community health insurance schemes: evidence and lessons from Armenia." Health Policy and Planning **24**(3): 209-216.

Putnam, R. D. (2001). Bowling alone, Simon and Schuster.

Robison, L. J., et al. (2002). "Is social capital really capital?" Review of social economy **60**(1): 1-21.

Ron, A. (1999). "NGOs in community health insurance schemes: examples from Guatemala and the Philippines." Social Science & Medicine **48**(7): 939-950.

Schieber, G., et al. (2012). Health Financing in Ghana, World Bank Publications.

Schneider, P. (2004). "Why should the poor insure? Theories of decision-making in the context of health insurance." Health policy and planning **19**(6): 349-355.

Schneider, P. (2005). "Trust in micro-health insurance: an exploratory study in Rwanda." Social science & medicine **61**(7): 1430-1438.

Segura-Ubiergo, A. (2007). The political economy of the welfare state in Latin America, Cambridge University Press.

SEND-Ghana (2010). "Balancing Access With Quality Health Care: An Assessment of the NHIS in Ghana (2004-2008)." Retrieved 20 March, 2014, from http://gh.sendwestafrica.org/downloads/RESEARCH REPORTS/HEALTH POLICIES MONITORING/Balancing Access With Quality Health Care, Accessment of NHIS in Ghana.pdf.

Siaw, L. E. (2014). "Only 2 million pay tax." Retrieved 25th Februrary, 2014, from http://www.myjoyonline.com/business/2014/February-12th/only-2million-pay-tax.php.

Sorensen, C. (2000). Social capital and rural development: a discussion of issues, World Bank, Social Development Family, Environmentally and Socially Sustainable Development Network.

Sudarsky, J. (1999). Colombia's social capital: the national measurement with the BARCAS, National Planning Office.

Waddington, C. and K. Enyimayew (1990). "A price to pay, part 2: The impact of user charges in the Volta region of Ghana." The International Journal of Health Planning and Management **5**(4): 287-312.

Wagstaff, A. (2010). "Social health insurance reexamined." Health Economics **19**(5): 503-517.

Woolcock, M. (1998). "Social capital and economic development: Toward a theoretical synthesis and policy framework." Theory and society **27**(2): 151-208.

Woolcock, M. (2001). "Microenterprise and social capital:: A framework for theory, research, and policy." Journal of Socio-economics **30**(2): 193-198.

Woolcock, M. and D. Narayan (2000). "Social capital: Implications for development theory, research, and policy." The world bank research observer **15**(2): 225-249.

Woolcock, M. and D. Narayan (2006). Social capital: Implications for development theory, research, and policy revisited. The search for empowerment. Social capital as idea and practice at the World Bank. A. Bebbington, M. Woolcock, S. Guggenheim and E. A. Olson, Kumarian Press. .

World Bank (2014). World Development Indicators.

Zhang, L., et al. (2006). "Social capital and farmer's willingness-to-join a newly established community-based health insurance in rural China." Health Policy **76**(2): 233-242.