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Citation: Kusi, A., Fenny, A. P., Arhinful, D. K., Asante, F. A. & Parmar, D. (2018). Determinants of enrollment in the NHIS for women in Ghana. *International Journal of Social Economics*, 45(9), pp. 1318-1334. doi: 10.1108/ijse-10-2016-0291

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Link to published version: <https://doi.org/10.1108/ijse-10-2016-0291>

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Determinants of enrollment in the NHIS for women in Ghana

Journal:	<i>International Journal of Social Economics</i>
Manuscript ID	IJSE-10-2016-0291.R2
Manuscript Type:	Research Paper
Keywords:	health insurance, social health protection, Ghana, household survey

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Abstract

Background

The National Health Insurance Scheme (NHIS) was introduced in 2005 to provide equitable access to healthcare. Furthermore, concessions were made for pregnant women, yet inequities in access continue to exist. This study explores whether dimensions of social exclusion explain why some groups of women are not benefitting from the scheme.

Methods

Data was collected from 4050 representative households in five districts. Logistic regression is used to examine the factors that determine enrolment of women under the NHIS.

Results

The study sample consists of a sub-sample of 3,173 women out of whom 58% were insured. The majority (64.9%) of the women were in the reproductive age (15-45 years). The results show that wealth status, age, health status, locality, perception about the quality of care at health facilities and perception of the NHIS, are the key factors that determine enrolment into the scheme.

Conclusion

With women dominating the informal sector of Ghana's economy which is often characterised by relatively low incomes, these inequities in access need to be addressed.

Key words: health insurance, enrolment, women, household survey, social health protection

Background

Healthcare financing in Ghana has gone through many dynamics, from free healthcare at the eve of independence to the introduction of the nominal fee in the 1970s and the 1980s full cost recovery, popularly known as the 'Cash and Carry' system. Recognising that direct out-of-pocket payment limited access to healthcare, the Government of Ghana declared its intention to abolish the system, and began exploring the feasibility making health care more affordable by the introduction of a National Health Insurance Scheme (NHIS). Since its implementation in 2005, the NHIS has become one of Ghana's flagship social protection interventions with the aim of increasing access to healthcare and improving the quality of basic healthcare services for all citizens, especially the poor and vulnerable.

It is expected that with the NHIS in place, equitable access to healthcare will be assured for all groups of people. However, ten years on, access remains a challenge especially for women who are faced not only with different health needs and risks but also bear a greater burden of disease [1]. Women are faced with unequal rights and resources coupled with minimal participation in household decision making which further restricts their access to quality care [2,3,4]. Although gender equality incorporates discussions on issues affecting men and women this paper focuses on women in Ghana due to disadvantaged position in which many of them find themselves in terms of access to resources. Indeed, some of the factors underlying differential health outcomes among women and men have been noted to be socioeconomic with factors such education, income, occupation and cultural cited as some of the strongest [5-7].

A number of authors have attributed the low coverage of the scheme to unaffordable premium, perceived poor quality of health services, lack of trust, and confusion over basic details of the scheme, among others [8-10]. It has been found that certain groups of persons, especially the poor are systematically excluded from the NHIS [11-14]. Women have been noted to face greater difficulties in accessing adequate care. Widows and elderly women have been known to delay or forego treatment without external support [15-16]. However, fewer papers on the NHIS have taken account of the specific health needs and constraints of women. We aim to fill this gap by using a social exclusion lens to explore what factors determine the participation of Ghanaian women (i.e. 15 years and above) in the scheme.

Literature review

The justification for the introduction of health insurance in developing countries has been seen as a means of sharing risks as well as mobilising resources [17-19]. Health insurance replaces out-of-pocket expenditures at the point of need with smaller regular contribution (premiums), which allows individuals to gain access to care, especially some of those who previously could not afford it [20-21]. While health insurance improves access to health care for members, there will still be individuals who cannot afford the premiums [13, 22]. Access to health care can also be restricted by other indirect financial and non-financial barriers, such as travel costs, loss of income, and other social and cultural values [23-25]. There are also some systemic barriers which also deter individuals from accessing insurance in the first place. These include the bureaucratic nature of accessing insurance benefits, the limited portability of the insurance scheme and the perceived negative attitude of health staff towards patients insured [26].

Identifying which determinants influence individuals in their decision to seek health insurance is a daunting task. This is due to the extensive range of potential factors spanning across many dimensions such as economics, social, political and culture. A number of empirical studies have also shown that there are several factors that determine women's enrolment in insurance schemes [27 -30]. Kirigia et al., [27] identified some demographic and socio-economic attributes of South African women that influenced health insurance ownership. Studies in Ghana, have found income, religion, age and access to relevant information on health as significant predictors of demand for insurance [28 -30]. Spatial location and wealth status were found to be significant in determining participation in health insurance among women in Ghana [31]. In Indonesia, Christiani et al. [32], examined determinants of access to health insurance by women in some major cities using multilevel logistic regression analysis. The results showed that, women's age, education, wealth status and being in paid work were consistently associated with the probability of having health insurance.

The literature, both theoretical and empirical reveal the multidimensional nature of the factors that determine women's enrolment into health insurance scheme. This study uses the SPEC framework which encapsulates several exclusionary factors to explain some of the key determinants of enrolment into health insurance schemes by women.

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6 The SPEC (social, political, economic and cultural) framework

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8 Social exclusion can be described as the systematic denial of particular groups of people from
9 fully enjoying a set of social opportunities, such as the right to “participate on equal terms in
10 social relationships in economic, social, cultural or political arenas” [33]. Social exclusion theory
11 builds on the evidence that the causes of poverty and inequality are embedded in the structures of
12 social systems and relationships – in exclusionary processes – and not in individual inadequacies
13 [34]. This theory was established by the Social Exclusion Knowledge Network (SEKN) whose
14 aim was to present a framework for understanding and tackling social exclusion [35]. The SPEC
15 model is therefore built on the exclusionary theory proposed by SEKN, which defines social
16 exclusion in the following way: exclusion consists of dynamic, multidimensional processes
17 driven by unequal power relationships interacting across four main dimensions – economic,
18 political, social and cultural and at different levels including individual, household, group,
19 community, country and global levels [36]. In Ghana, health inequities are seen to be a major
20 form of social exclusion. There are rural-urban disparities in access to health care services,
21 inequitable distribution of health workers; disparities in access to health services between rich
22 and poor and gender gaps in access due to poverty and deprivation.
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35 Based on the multidimensional nature of social exclusion, a four dimensional framework was
36 developed by the research team (Health Inc) to allow the study to capture all aspects of social
37 exclusion. Through literature review, Health Inc explored each of these four dimensions,
38 resulting in the Health Inc SPEC framework. The domains and variables, and hypothesis on how
39 they are linked to social exclusion and access to social protection programs in Ghana, are
40 described in the Table 1. The social dimension is constituted by proximal relationships of
41 support and solidarity (such as friendship, kinship, family, neighbourhood, community, social
42 movements) that generate a sense of belonging within social systems. Social bonds are
43 strengthened or weakened along this dimension [33]. The political dimension is constituted by
44 power dynamics in relationships which generate unequal patterns of formal rights embedded in
45 legislation, constitutions, policies and practices and the conditions in which rights are exercised,
46 including access to safe water, sanitation, shelter, transport and power and to services such as
47 healthcare, education and social protection. In the context of this study we looked at two main
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3 areas, political resources and political and civic participation. The economic dimension is
4 constituted by access to, and distribution of, material resources necessary to sustain life (such as
5 income, employment, housing, land, working conditions and livelihoods). The final area is the
6 cultural dimension where we consider the patterns of relational exclusion that have been found to
7 have cultural and historical origins, where people uphold norms and values which lead them to
8 set themselves above others based on a variety of attributes. Boundaries between social and
9 cultural dimensions are difficult to draw because social participation is highly connected to
10 cultural aspects such as values and norms translated into current social practices.
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18 **Table 1 SPEC Framework: Dimensions, Domains, Variables and Indicators**

19 *Methodology*

20 *Study design*

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25 The study uses data from a cross-sectional household survey conducted in five districts of Ghana
26 in 2012. A multi-staged systematic sampling approach was used to select the households for the
27 study. The first level was the random selection of the 5 districts representative of three ecological
28 zones in Ghana. The five districts comprised Abura-Asebu-Kwamankese (AAK), Kwaebibrim,
29 Ejisu-Juaben Municipal, Asutifi and Savelugu-Nanton. Secondly, in each district, 27
30 Enumeration Areas (EAs) were randomly selected based on the 2000 Ghana Population and
31 Housing Census for the selected districts [37]. These EAs are made up of rural and urban
32 localities and are determined by the GSS for nationally representative surveys. Finally, 30
33 households were sampled from the household listing in each EA. Thus, in each district, 810
34 households (i.e. 30 households x 27 EAs) were interviewed resulting in a total of 4,050
35 households with an estimated household population of 16,200. In each household, the respondent
36 was the head or an adult member who is normally responsible for major household decisions.
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47 The household questionnaire was made up of two modules with the first part focused on general
48 information about the household and its members. Information collected included socio-
49 economic and demographic characteristics of the household members, their health status, NHIS
50 membership status, reasons for non-membership, access to social services and ownership of
51 assets, among others. The second module assessed the awareness and opinions of the household
52 head or the spouse on specific social, political, economic and cultural factors which are likely to
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act as drivers of social exclusion. It also assessed their opinions on the NHIS. While the first module was answered by the household head, the second was answered separately by the household head and the spouse if available. A total of 5,292 social exclusion (i.e. module 2) questionnaires were administered of which 60% (3,173) of the respondents were women.

Theoretical framework

The choice of the estimation model for this study is based on the expected utility theory which has been used to explain decision making under conditions of uncertainty in Welfare economics (27, 38-39). Cutler and Zeckhauser [39] have explained that the value of health insurance is rooted in the unpredictability of medical spending associated with ill-health. People's attitude to this risk is important in the decision to purchase health insurance or not. Though some individuals may be aware of their health state, many may have little or no idea about future cost of illness at the time they decide to purchase health insurance. Health insurance is expected to reduce this uncertainty associated with ill health and the resulting financial consequences [38-39]. The decision by an individual to purchase health insurance or not is treated as a discrete choice problem under the assumption that the individual chooses the alternative which provides the greatest utility [40-41]. Given that the choice available to a particular woman is whether to enroll in the NHIS or not, this was treated as a binary choice problem and estimated by a logistic regression.

Statistical analysis

We assessed the determinants of enrolment in the NHIS for women aged 15 years and above by estimating a binary logistic regression model. The dependent variable is the current health insurance status of a woman which is treated as a binary variable where the probability of enrolment in the NHIS is specified as:

$$Enrolled_i = \beta_0 + \beta_1 X_i + \beta_2 SPEC_i + \epsilon_i$$

Enrolled_i is a binary variable that denotes the enrolment status of a woman; where *Enrolled* =1 if a woman is currently enrolled in the NHIS and *Enrolled* =0 if the woman is not.

X_i is a set of general variables;

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3 SPEC_i is a set of key variables selected across social, political, economic and cultural (SPEC)
4 dimensions;
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6 ϵ_i is the random error.
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10 The choice of the independent variables is informed by recent studies in assessing the
11 determinants of enrolment in the NHIS in Ghana and other LMICs [8,11, 15, 27 -29, 42]. Table 2
12 presents a detail description of the variables used for the estimation of the determinants of
13 enrolment of women into the NHIS in Ghana. The independent variables included in the
14 estimation were grouped into personal/demographic characteristics of the women, socio-cultural
15 variables, gender-specific variables, perceptions about quality of health care at health facilities,
16 perceptions about the NHIS, political variables and economic variables. The demographic
17 characteristics included variables such as district of residence and whether the woman resided in
18 a rural and urban locations, their ages, religious affiliation, marital status and whether the woman
19 had a chronic illness as a proxy for their health status. Respondents were also asked to indicate
20 whether they had given birth in the last 12 months prior to the survey.
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31 The sociocultural variables on the other hand consisted of a series of questions to solicit the
32 respondents' views on proximal relationships of support and solidarity in their communities.
33 They were asked about their membership in social associations, their ability to participate in
34 community activities, their satisfaction about their currently social life and whether or not they
35 have ever face any form of discrimination in their community. The gender-specific questions
36 focused on autonomy, empowerment and how they perceived power dynamics in their
37 relationships.
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44 Respondents were asked to express their perception about the quality of healthcare at health
45 facilities. The questions covered issues such as respect to patients, communication, availability
46 of information, patient privacy and whether their health facilities really serve their needs. In
47 addition, respondents answered questions on how they felt about the NHIS with respect to
48 convenience of NHIS, trust, quality of service, their understanding of the solidarity concept
49 inherent in the NHIS and their overall satisfaction about the performance of the NHIS. The
50 political variables included educational attainment of respondents and their spatial access to
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important social services such as health and information which tend to result in the unequal distribution of opportunities which create unequal living conditions. The political participation in community and national activities were examined. Finally, the economic variables sought to measure respondents' economic empowerment in the area of work and the ownership of material resources necessary to sustain life.

A number of SPEC variables (as explained under the SPEC domains) were used to construct indices for each of the four SPEC dimensions using principal component analysis (PCA). These were sociocultural, political and economic indices. The economic index score was however divided into quintiles and household wealth status and paid or unpaid income. The household wealth status was generated using PCA based on asset indicators ranging from households' dwelling characteristics to access to utilities and sanitation facilities as well as households' ownership of consumer durables such as refrigerator, bicycle, television, radio and mobile phone [43]. Additional indices generated include gender, quality of care at health facility and perception of the NHIS.

From the variables listed in Table 2, an empirical model was built for the estimation and was specified as follows:

$$\log\left[\frac{p}{1-p}\right] = F(\beta_0 + \beta_1 \text{District} + \beta_2 \text{Location} + \beta_3 \text{Age} + \beta_4 \text{Religion} + \beta_5 \text{Marital} + \beta_6 \text{Relation} + \beta_7 \text{Chronic} + \beta_8 \text{Childbirth} + \beta_9 \text{Socio-cultural_index} + \beta_{10} \text{Gender_index} + \beta_{11} \text{Quality_index} + \beta_{12} \text{Perception_index} + \beta_{13} \text{Political_index} + \beta_{14} \text{Economic_index})$$

The logit model was deemed appropriate for the estimation because it is commonly used for the estimation of a binary outcome variable (i.e. insurance status) and also generates coefficients which can be transformed into odds ratios for easy interpretation [40, 44]. All statistical analyses were performed using STATA 14.0 software. The model goodness-of-fit was assessed using Hosmer-Lemeshow test and the result that the model fits the data well ($p=0.4179$) [41]. A test for multicollinearity among the exploratory variables was performed using Variance Inflation Factor (VIF) test. The results showed that the VIF test has a mean value of 2.72 (max=4.83), an indication of no multicollinearity problem.

Results

Descriptive statistics

About 58 percent of the 3,173 women were active members of the scheme having in their possession valid NHIS membership cards as at the time of the survey (Table 3). Only 3.3% of the women were below twenty years while about 7% were 70 years or more. The majority (67.2%) were between 20-49 years. More than half of them had urban residence with a significant proportion (59%) of the insured being urban dwellers ($p=0.000$). About 63 percent of the women were married with no significant difference between insured and uninsured ($p=0.134$). About 40 percent of the women were heads of their households with the majority (50%) being spouses of the household head. On health status, the insured women were more likely to report a chronic health problem (10.8 vs. 4.5, $p=0.000$). A higher proportion of the insured women compared to the uninsured reported to have given birth in the last 12 months prior to the survey (13.9% vs. 8.8%, $p=0.000$).

On the social-cultural dimension, the results did not show any significant difference in the scores between insured and uninsured women. A significant proportion of the insured women had a positive score on the gender index (78.8% vs. 70.4%, $p=0.000$). The gender score reflects a woman's assertiveness; therefore, a higher score means a woman is more assertive in the home. A similar observation was made with respect to the perception about quality of healthcare, the perception about the NHIS and the political variable. For instance, a significant proportion of the insured had a positive score on the perception of the NHIS than the uninsured (63.3% vs. 53.7%, $p=0.000$). On the economic index, the results show a significant difference between the insured and uninsured women with respect to their wealth status ($p=0.000$). There were a higher proportion of the uninsured women in the first (poorest) (28.6% vs 14%) and second poorest (22.35% vs 18.4%) wealth quintiles.

Table 3: Descriptive statistics of selected variables by health insurance status of women in Ghana, 2012

Determinants of enrolment in the NHIS by women

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3 Table 4 presents the estimates of the determinants of enrolment in the NHIS by women. Results
4 show that the district of residence and whether a woman resides in urban location have positive
5 effect on enrolment in the NHIS. Generally, compared with the Ejisu-Juabeng district in the
6 Ashanti region, being in the Abura-Asebu-Kwamankese district in the Central region and the
7 Savelugu-Nanton district in the Northern region reduces the odds of a woman's enrolment in the
8 NHIS. The two districts are relatively poor and dominantly rural.
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15 With regards to age, elderly women aged 70 years or more were 3.5 three times more likely to
16 enrol in the NHIS relative to women aged 15-19 years. The likelihood of enrolment into the
17 NHIS was also observed to decrease with other women in the households relative to the woman
18 who is the head. Women with chronic health problems were about 2.2 times more likely to be
19 members of the NHIS relative to those without chronic illness. The odds of enrolment in the
20 NHIS also increases with women who reported to have given birth in the past 12 months.
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27 Generally, women with gender assertiveness and score positive on the gender index were 1.4 times
28 more likely to enroll in the NHIS compared to those who score negative. The results also show that
29 having positive perceptions about the quality of health care at health facilities and about the performance
30 of the NHIS increases the likelihood of women enrolling into the scheme. Finally, from an economic
31 perspective, household's wealth status has a positive and significant effect on a woman's
32 insurance status. The probability of enrolling in the NHIS increases with an increase in
33 household's wealth status. Women in the third wealth quintile are 1.9 times more likely to enrol
34 in the NHIS compared to women in the first wealth quintile. This increases to 2.5 times and 4.2
35 times for women in the fourth and fifth wealth quintiles respectively.
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43 The sociocultural index is a significant determinant of enrolment in the NHIS (1 percent
44 significance level). For the exposure status to be related to the outcome, the relative risk must
45 differ from 1. However, the relative risk is 1.00 for a negative score and 0.85 for a positive score,
46 which implies that there is only a small difference in the way a unit increment in the
47 sociocultural index affects the two groups (insured and uninsured). The same is reflected in the
48 political index score.
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3 **Table 4: Logistic regression estimates of the determinants of enrolment in the NHIS by**
4 **women in Ghana, 2012**
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11 **Discussion**

12 This study sought to assess the determinants of women's enrolment in the NHIS in order to
13 identify the groups of women who are not participating in the NHIS and whether this could be
14 attributed to social exclusion. Our study shows that enrolment is relatively higher among the
15 elderly women which points to the fact that they may be taking advantage of the exemptions
16 offered to elderly aged 70 years and above under the NHIS. On the flip side, elderly women
17 residing in rural areas, widowed, uneducated and from poor households raises are vulnerable.
18 Parmar et al. [15] found a strong evidence of inequity in enrolment caused by a combination of
19 economic, political and socio-cultural factors with elders in the richest quartiles being more
20 likely to enrol than those in the poorest quartile.
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30 Rural-urban disparities have been well profiled and documented in several studies in Ghana.
31 Residents of urban slums, extremely poor people in the northern regions of Ghana and people
32 who are geographically isolated due to lack of road access face extreme challenges in accessing
33 social services [45]. In line with this profiling, our results show that rural women were less
34 likely to enroll in the NHIS with reasons being that NHIS registration centres were far from their
35 communities they had limited information about the scheme. Long distances to registration
36 centres, registration process rigidities and activities of unscrupulous NHIS registration agents
37 have been noted to exclude rural women from enrolling in the NHIS [14, 36,46]. Longer
38 distances to health facilities means that sometimes the cost of transportation to seek health care
39 could exceed the cost of enrolling in the NHIS. This could discourage people from enrolling in
40 the scheme.
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50 The importance of the health status as a determinant of enrolment into the health insurance is
51 clear from the results. Kirigia et al [27] show that having excellent or good health had a negative
52 effect on the log of odds of health insurance ownership among women in South Africa.
53 Individuals who are less healthy or suffering from chronic diseases may join the health insurance
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3 scheme in order to enjoy its benefits [47]. The results also show that women who have given
4 birth in the past 12 months are more likely to be insured. This could be due to the free maternal
5 policy under the NHIS.
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10 The role of economic factors emerges in our study as important determinants of enrolment in the
11 NHIS. From the descriptive statistics, the insured and uninsured differed significantly in their
12 wealth status. Generally, women in Ghana dominate the informal economy often running small
13 businesses which require low capital injections but yield very low incomes. As observed by
14 Alfes [12] there are a significant number of informal workers who do not earn enough to be able
15 to afford to pay the NHIS premium. As observed by other studies, our results show a positive
16 relationship between wealth status and enrolment in the NHIS, buttressing the point that a
17 woman from a poorly resourced household would more likely be excluded from enrolling in the
18 NHIS. In a study among women aged 15-49 years in the Upper East region of Ghana, it was
19 observed that enrolment into the NHIS is influenced by household's socio-economic status and
20 location of residence among others [48]. Perception of the quality of care at health facilities and
21 perception of the NHIS are significant factors to enrolment. Some insured patients, do complain
22 of poor quality of health services provided at the health facilities which include long waiting
23 times, bad attitude by health facility staff, and drug shortages [31, 49, 50].
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36 The study provides a quantitative assessment of the multiple factors that affect enrollment into
37 social protection programs and also highlights the importance of economic factors as the key
38 drivers of social exclusion in this process. However, social exclusion is a complex and dynamic
39 concept which will require further research to unpack the exclusionary mechanisms. In addition,
40 the survey in Ghana was part of a larger study exploring enrolment of all individuals in NHIS
41 and was not specifically targeted towards the female population.
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46 **Conclusion**

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48 By conceptualising social exclusion as the multi-dimensional processes driven by unequal power
49 relationships which lead to differential inclusion and exclusion in social systems, our study
50 provides evidence of factors that influence women enrolment into the NHIS. With women
51 dominating the informal sector of Ghana's economy, the NHIS is seen as an important social
52 protection intervention for informal workers and especially women. While not all the uninsured
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3 women could be described as socially excluded from the NHIS, the results suggest that factors
4 that drive women to be socially excluded from enrolling in the NHIS are economically related.
5 Others include age, health status, locality, perception about the quality of care at health facilities
6 and the perception of the NHIS. How the NHIS adapts its features to ensure access for these
7 vulnerable groups for whom these factors become a clear barrier to accessing health services
8 needs critical attention. Policy should aim at identifying and targeting these excluded women.
9 Rural–urban disparities with regards to general infrastructure need to be addressed to reduce the
10 physical barriers to health care and to encourage more people to enrol in the scheme.
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46 **List of abbreviations**

48	CHPS	Community Health Posts Services
49	EAs	Enumeration Areas
51	IRB	Institutional Review Board
53	NGOs	Non-Governmental Organisations
55	NHIS	National Health Insurance Scheme

NMIMR	Noguchi Memorial Institute for Medical Research
SEKN	Social Exclusion Knowledge Network
SPEC	Social, Political, Economic and Cultural

Ethics approval and consent to participate

Ethical clearance was sought and granted from the Institutional Review Board (IRB), of the Noguchi Memorial Institute for Medical Research (NMIMR), University of Ghana before the study was done. Study objectives, benefits, risks and the right to refuse participation and confidentiality of responses were explained to participants. Written informed consent was obtained from each participant.

Acknowledgements

The study is part of a larger project, Health Inc. The authors would like to thank members of the Health Inc. Consortium who have contributed to the development of the social exclusion framework and research methodology.

References

1. Scheil-adlung, X., Kuhl, C., & Office, I. L. (2012). *Evidence on gender inequities in social health protection : The case of women living in rural areas* (No. 29) (p. 28). Geneva.
2. United Nations Research Institute for Social Development (UNRISD). (2010). *Combating poverty and inequality: Structural change, social policy and politics*. Geneva, Switzerland
3. Ministry of Manpower, Youth and Employment (MMYE). (2007). *The National Social Protection Strategy (NSPS): Investing in people*. Government of Ghana, Accra, Ghana.

4. Kabeer, N. (2008). *Mainstreaming Gender in Social Protection for the Informal Economy*. Commonwealth Secretariat, London, 2008.
5. Moss NE (2002) Gender equity and socioeconomic inequality: a framework for the patterning of women's health; *Social & Economic Patterning of Womens Health in a Changing World; Social Science & Medicine*; 54, 649–661
6. Orfila F, M. Ferrer, R. Lamarca, C. Tebe, A. Domingo-Salvany, J. Alonso. Gender differences in health-related quality of life among the elderly: the role of objective functional capacity and chronic conditions. *Social Science & Medicine*, 63 (2006), pp. 2367–2380
7. World Health Organization. Commission on Social Determinants of Health. *Closing the Gap in a Generation- Health equity through action and the social determinants of health*. Geneva: World Health Organization. 2008. Accessed 28-03-15
8. Chankova, S., Atim, C., Hatt, L. (2010). Ghana's National Health Insurance Scheme. In M.L. Escobar, C. Griffin, & R.P. Shaw (Eds.), *Impact of Health Insurance in low- and middle Income Countries* (pp.58-87). Washington DC: Brookings Institution Press.
9. Kotoh, M.A. (2013). *Improving health insurance coverage in Ghana*. African Studies Centre studies collection, vol. 51. Leiden, The Netherlands.
10. Kusi A, Enemark U, Hansen KS, Asante FA. Refusal to enrol in Ghana's National Health Insurance Scheme: is affordability the problem? *International Journal for Equity in Health* 2015, 14:2 doi:10.1186/s12939-014-0130-2
11. Asante, F., & Aikins, M. (2008). *Does the NHIS cover the poor?* DANIDA, Accra, Ghana.
12. Alfers, L. (2009). *The Ghana Health Insurance Scheme*. WIEGO Social Protection Case Study.
13. Sarpong, N., Loag, W., Fobil, J., et al. (2010). National health insurance coverage and socio-economic status in a rural district of Ghana. *Tropical Medicine & International Health*, 15, 191–7.
14. Jehu-Appiah, C., Aryeetey, G.C., Spaan.E., E., De Hoop, T., Agyepong, I. and Baltussen, R. (2011a). Equity aspects of the National Health Insurance Scheme in Ghana: Who is enrolling, who is not and why? *Social Science and Medicine*, 72, 157-165.
15. Parmar, D., Gemma, W., Dkhimi, F., Ndiaye, A., Asante, F., Arhinful, D., Mladovsky, P. (2013). Enrolment of elders in social health protection programs - does social exclusion play a part? *Social Science and Medicine*. 119, 36–44. doi:10.1016/j.socscimed.2014.08.011

16. Angel, J. L., Montez, J. K., & Angel, R. J. (2011). A Window of Vulnerability: Health Insurance Coverage Among Women 55 to 64 Years of Age. *Women's Health Issues, 21*(1), 6-11.
17. Ekman B The impact of health insurance on outpatient utilization and expenditure: evidence from one middle-income country using national household survey data. *Health Research Policy and Systems, 2007*.5:6
18. Hsiao W, Shaw RP. *Social Health Insurance for Developing Nations*. The World Bank Washington, D.C. 2007
19. McIntyre D, Kutzin J: Revenue collection and pooling arrangements in financing. In *Health systems in low- and middle-income countries*. Edited by Smith RD, Hanson K New York: Oxford University Press; 2012: 77-101
20. Nyman JA. The value of health insurance: the access motive. *Journal of Health Economics 1999; 18:141–52*.
21. Zweifel, P., Manning, W.G. *Handbook of Health Economics*. Vol. 1, edited by Culyer A.J., Newhouse J.P., Elsevier Science. 2000.
22. Jowett M, Deolalikar A, Martinsson P: Health insurance and treatment seeking behaviour: evidence from a low-income country. *Health Economics 2004, 13:845-857*.
23. Spaan E, Mathijssen J, Tromp N, McBain F, Ten Have A, Baltussen R: The impact of health insurance in Africa and Asia: a systematic review. *Bull World Health Organ 2012, 90:685–692*.
24. Lagarde M, Haines A, Palmer N. Conditional cash transfers for improving uptake of health interventions in low- and middle-income countries: a systematic review. *Journal of American Medical Association 2007;298:1900–10*.
25. Ensor T, Cooper S. Overcoming barriers to health service access: influencing the demand side. *Health Policy Planning, 2004. 19: 69–79*.
26. Fenny, AP, Hansen, KS, Asante, FA & Enemark, U 2014, 'Patient Satisfaction with Primary Health Care – A Comparison between the insured and non-insured under the National Health Insurance Policy in Ghana' *Global Journal of Health Science, Vol 6*(4)
27. Kirigia, J. M., Sambo, L. G., Nganda, B., Mwapu, G. M., Chatora, R., & Mwase, T. (2005). Determinants of health insurance ownership among South African women. *BMC Health Services Journal, 5*(17).

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54
55
56
57
58
59
60
28. Nketiah-Amponsah, E. (2009). Demand for health insurance among women in Ghana: Cross-sectional evidence. *International Research Journal of Finance and Economics*, 33, 179-191.
 29. Dixon, J., Luginaah, I., & Mkandawire, P. (2014). The National Health Insurance Scheme in Ghana's UpperWest Region: A gendered perspective of insurance acquisition in a resource-poor setting. *Social Science & Medicine*, 122, 103-112.
 30. Kimani, J. K., Ettarh, R., Warren, C., & Bellows, B. (2014). Determinants of health insurance ownership among women in Kenya: evidence from the 2008–09 Kenya demographic and health survey. *International Journal for Equity in Health*, 13(27), 1-8.
 31. Kumi-Kyereme, A., & Amo-Adjei, J. (2013). Effects of spatial location and household wealth on health insurance subscription among women in Ghana. *BMC Health Services Research*, 12(221), 1-8.
 32. Christiani, J., Byles, J. E., Tavener, M., & Dugdale, P. (2017). Health insurance coverage among women in Indonesia's major cities: A multilevel analysis. *Health Care for Women International*, 38(3), 267-282.
 33. SEKN (2008). *Understanding and tackling social exclusion. Final report to the WHO Commission on Social Determinants of Health from the Social Exclusion Knowledge Network*. Geneva, World Health Organization (http://www.who.int/social_determinants/knowledge_networks/final_reports/sekn_final%20report_042008.pdf, accessed 23 December 2012).
 34. Mathieson, J., Popay, J., Enoch E., Escorel S., Hernandez M. (2008). Social Exclusion meaning, measurement and experience and links to health inequalities: A review of the literature.
 35. Williams G., Mladocsky P., Dkhimi F., Soors W, Parmar D. (2014). Social exclusion and social health protection in low- and middle-income countries: an introduction. In B Criel, V.D. Brouwere, W.V. Damme, B Marchal B (Eds), *Health Inc - Towards Equitable Coverage and More Inclusive Social Protection in Health* (pp. 8-32) Antwerp: ITG Press, Health Inc. Consortium
 36. Popay J, E.S., Hernández M, Johnston H, Mathieson J & Rispel L (2008). *Understanding and tackling social exclusion. Final report to the WHO Commission on Social Determinants of health*. Lancaster: Social Exclusion Knowledge Network.
 37. Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF Macro. (2009). *Ghana Demographic and Health Survey 2008*. Accra, Ghana: GSS, GHS, and ICF Macro .

- 1
2
3 38. Card, D., Dobkin C., and N. Maestas (2008). "The Impact of Nearly Universal Insurance
4 Coverage on Health Care Utilization: Evidence from Medicare." *American Economic*
5 *Review*, 98(5): 2242–58.
6
7
8
9 39. Cutler DM, Zeckhauser RJ. The anatomy of health insurance. CH 11:563-643 in Culyer AJ,
10 Newhouse JP. Handbook of health Economics-Vol I. 2000. Amsterdam. Elsevier Science
11
12 40. Train, K.E 2009 Discrete Choice Methods with Simulation, Cambridge Books, Cambridge
13 University Press, number 9780521766555. 2009.
14
15 41. Long, JS and Freese J. 2006. Regression Models for Categorical Dependent Variables Using
16 Stata, Second Edition. College Station, Texas: Stata Press
17
18 42. Mensah, J., Oppong, J.R., Bobi-Barimah, K., Frempong, G. & Sabi, W. *An evaluation of the*
19 *Ghana National Health Insurance scheme in the context of the health MDG's.* (The Human
20 Science Resource Council: Commissioned by the Global Development Network (GDN)).
21 2010 http://www.hsrb.ac.za/Research_Publication-21974.phtml. Accessed 20-05-2012
22
23
24 43. Jolliffe, IT. Principal Component Analysis. Second ed. Springer Series in Statistics. New
25 York: Springer-Verlag New York. 2002.
26
27 44. Cameron AC, Trivedi PK, Milne F, et al. A Microeconomic Model of the Demand for
28 Health Care and Health Insurance in Australia. *Rev Econ Stud* 1988; 55(1): 85–106.
29
30 45. UNDP-Ghana (2007). Ghana Human Development Report. Towards a more inclusive
31 society. The United Nations Development Programme, Ghana Office.
32
33 46. Gobah, F.F.K., & Liang, Z. (2011). The National Health Insurance Scheme in Ghana:
34 prospects and challenges: a Cross-Sectional evidence. *Global Journal of Health Science*, 3(2),
35 90-101
36
37 47. Andersen, R., & Newman, J. F. (2005). Societal and individual determinants of medical care
38 utilisation in the United States. *Milbank Memorial Fund Quarterly. Health and Society*,
39 83(4), 1-28.
40
41 48. Akazili et al.: Is Ghana's pro-poor health insurance scheme really for the poor? Evidence
42 from Northern Ghana. *BMC Health Services Research* 2014 14:637. doi:10.1186/s12913-
43 014-0637-7
44
45 49. Fenny, A.P., Kusi, A, Arhinful, D.K & Asante, F.A. 2016, 'Factors contributing to low
46 uptake and renewal of health insurance: a qualitative study in Ghana', *Global Health*
47 *Research and Policy*, 2016, DOI: 10.1186/s41256-016-0018-3 F
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60

50. Fenny AP, Hansen KS, Asante FA, Enemark U. Patient satisfaction with primary health care – a comparison between the insured and non-insured under the National Health Insurance Policy in Ghana. Global Journal of Health Science. 2014;6(4).

Table 1. SPEC FRAMEWORK: DIMENSIONS, DOMAINS, VARIABLES AND INDICATORS

Domains	Hypothesis	Indicator(s) selected
SOCIOCUTURAL DIMENSION		

Social discrimination	Social discrimination can generate power dynamics that underpins resource distribution patterns. They can affect access to economic resources and economic, political and civic participation of an individual.	Urban / Rural split
Social capital/ Social and community participation	<p>Social participation is highly connected to economic resources and social support. Feeling of solidarity directly impacts on the volumes of social protection transfers, and so to say on economic resources. Boundaries between social and cultural dimensions are difficult to draw because social participation is highly connected to cultural aspects such as values and norms, translated into current social practices.</p> <p>Limited social and community participation may reflect the low status of the individual in the community and the individual may feel 'excluded'.</p>	<p>Participation in common social activities</p> <p>Member of any social/cultural association or club</p>
POLITICAL DIMENSION		
Access to information and services	<p><u>Access to health</u></p> <p>The link between health and economic resources is widely demonstrated, in both directions: good health reduces economic vulnerability, while better economic situation is related to better health. Access to health care thus impacts on economic resources, as well as on opportunities of economic participation. More recent research has demonstrated correlation between distance to health facilities and enrolment in health insurance schemes</p>	Distance to public health centre
	<p><u>Access to transport infrastructures</u></p> <p>Access to good roads has implications on access to health facilities and economic participation. Where this is lacking, populations feel more excluded from basic infrastructure and services.</p>	Distance to the nearest all-seasoned road
	<p><u>Access to administrative services</u></p> <p>Access to district capital is correlated to economic participation and also access to institutions who are based in district capitals. For instance, the NHIS district offices are more accessible to those who live closer to the district capital.</p>	Distance to the district capital
	<p><u>Access to information</u></p> <p>Access to information and communication technologies is increasingly correlated to economic participation, social resources, as well as education opportunities.</p> <p>Lack of information about health care facilities as well information about schemes, policies and programs can be a key determinant for individuals to be left out from these interventions.</p>	Ownership of a radio or television

Political participation	<u>Civic participation</u> Economic participation, as well as social participation both triggers sense of belongingness and hope for the future, factors that increase civic and political participation. This implies having a sense of empowerment which is reflected in one's participation in decisions in the household	Free to express personal opinion in the family Free to express personal opinion in group meeting
	<u>Democratic participation</u> Civic participation results in the development of social networks. Civic participation is related to access to political resources. Affiliation/disaffiliation from the political system are related to economic resources.	Voted in any recent elections
ECONOMIC DIMENSION		
Material and economic resources	<u>Physical and financial assets</u> Poverty is a major risk factor in all other domains of social exclusion. Poverty is associated with hunger, low health and education status and lower productivity. It can limit people's savings, property ownership and access to credit and reduce hopes, aspirations, and self-esteem leaving them less able to improve their situation.	Ownership of property/assets (radio, TV, telephone, bike, or motorbike etc).

Table 2: Definition of variables

Variable	Variable description
Dependent variable	
<i>Insurance status</i>	0 = Uninsured, 1 = Insured
Independent variables	
Personal/Demographic characteristics	
<i>District</i>	District of residence. 0=Ejisu-Juabeng, 1=Asutifi, 2=AAK, 3=Kwaebibrem, 4=Savelugu
<i>Location</i>	Location of residence. 0=Rural, 1=Urban
<i>Age</i>	Respondent's age in years. Age categories (0=15-19years, 1=20-29years, 2=30-39years, 3=40-49years, 4=50-59years, 5=60-69years, 6= \geq 70 years)
<i>Religion</i>	Religious affiliation of respondent. 0 = Christian, 1 = Muslim, 2 = other

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3	<i>Marital</i>	Marital status of respondent. 0 = never married, 1 = married/in union, 2 =
4		divorced/separated, 3 = widowed
5	<i>Relations</i>	Respondent's relationship to household head. 0 = household head, 1 = spouse, 2 = child, 3
6		= other
7	<i>Chronic/Health</i>	Presence of a chronic illness. 0 = No, 1 = Yes
8	<i>Childbirth</i>	Given birth in the past 12 months. 0=No, 1=Yes
9	<i>Socio-cultural variables for the construction of the Socio-cultural index</i>	
10	<i>Membership</i>	Respondent is a member of a social organisation. 0 = No, 1 = Yes
11	<i>association</i>	
12	<i>Participation</i>	Respondent is able to participate in social activities in community. 0 = No, 1 = Yes
13	<i>Social_life</i>	Satisfied with social life lately. 0=Disagree, 1=Agree
14	<i>Personal_fate</i>	A person's fate is determined by God. 0=Disagree, 1=Agree
15	<i>Discrimination</i>	I have ever faced discrimination in my community. 0=Yes, 1=No
16	<i>Gender related variables for the construction of an index for Gender</i>	
17	<i>Gender1</i>	A good wife obeys her husband even if she disagrees with him. 0=Disagree, 1=Agree
18	<i>Gender2</i>	A man has a good reason to hit his wife if she doesn't complete housework to his
19		satisfaction. 0=Agree, 1=Disagree
20	<i>Gender3</i>	A man has a good reason to hit his wife if she refuses to have sexual relations with him.
21		0=Agree, 1=Disagree
22	<i>Gender4</i>	A man has a good reason to hit his wife if she disobeys him. 0=Agree, 1=Disagree
23	<i>Gender5</i>	I make my own decision to seek health care when I am sick. 0=No, 1=Yes
24	<i>Perceptions about quality of health care at health facility for the quality index</i>	
25	<i>Respect</i>	I feel I am treated with respect when I visit the health facility. 0=No, 1=Yes
26	<i>Concerns</i>	I feel my concerns are listened to seriously by medical staff. 0=No, 1=Yes
27	<i>Needs</i>	I feel I receive services that covers my needs at the health facility. 0=No, 1=Yes
28	<i>Information</i>	I get sufficient information from medical staff when I visit the health facility. 0=No,
29		1=Yes
30	<i>Privacy</i>	I feel health facilities provide adequate privacy during examination.
31	<i>Communication</i>	I do understand the vocabulary used by medical staff during consultation. 0=No, 1=Yes
32	<i>Perception about the NHIS for the construction of perception index</i>	
33	<i>Perception1</i>	Spending money on health insurance is not a priority. 0=Disagree, 1=Agree
34	<i>Perception2</i>	Health insurance is something for the poor. 0=Agree, 1=Disagree
35	<i>Perception3</i>	It is good to be a member of the NHIS even if you don't fall sick. 0=Disagree, 1=Agree
36	<i>Perception4</i>	The NHIS office for registration and renewal is convenient. 0=No, 1=Yes
37	<i>Perception5</i>	Insured members of the NHIS are given poor quality medicines. 0=Yes, 1=No
38	<i>Perception6</i>	NHIS members still pay for drugs and treatment. 0=Yes, 1=No
39	<i>Perception7</i>	I do trust the NHIS. 0=No, 1=Yes
40	<i>Perception8</i>	I am satisfied with the performance of the NHIS. 0=No, 1=Yes
41	<i>Political variables for the construction of the Political index</i>	
42	<i>Education</i>	Years of schooling. 0=No formal education, 1=<6 years, 2=6-10 years,
43		3=Secondary/Higher
44	<i>Health_15mins</i>	Reside within 15 minutes distance to the nearest public health centre. 0 = No, 1 = Yes
45	<i>Road_15mins</i>	Reside within 15 minutes distance to the nearest all-seasoned road. 0 = No, 1 = Yes
46	<i>Capital_60mins</i>	Reside within 60 minutes distance to the district capital. 0 = No, 1 = Yes
47	<i>Radio_TV</i>	Whether household has access to radio or television. 0 = No, 1 = Yes
48	<i>Vote</i>	Respondent voted in the recent national elections. 0 = No, 1 = Yes
49	<i>Opinions_family</i>	Free to express personal opinions in the family. 0 = No, 1 = Yes
50	<i>Opinions_group</i>	Free to express personal opinions in group meetings. 0 = No, 1 = Yes
51	<i>Economic variables for the construction of the Economic index</i>	
52	<i>Work_12months</i>	Respondent worked for income or family gain in the last 12 months. 0 = No, 1 = Yes
53	<i>Wealth</i>	Wealth quintiles. 0 = first, 1 = second, 2 = third, 3 = fourth, 4 = fifth
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Table 3: Descriptive statistics of selected variables by health insurance status of women in Ghana, 2012

Variables	Health Insurance Status		Total n (%)	<i>p-value</i> ^a
	Uninsured n (%)	Insured n (%)		
Personal/Demographic characteristics				
District				
Ejusu-Juabeng	233 (17.8)	449 (24.1)	682 (21.5)	
Asutifi	184 (14.1)	452 (24.2)	636 (20.0)	

Abura-Asebu-Kwamamkese	408 (31.2)	255 (13.7)	663 (20.9)	0.000
Kwaebibrem	195 (14.2)	414 (22.5)	614 (19.4)	
Savelugu-Nanton	287 (21.9)	291 (15.6)	578 (18.2)	
Location of residence				
Rural	709 (54.3)	771 (41.3)	1,480 (46.6)	
Urban	598 (45.8)	1,095 (58.7)	1,693 (53.4)	0.000
Age (years)				
15-19	50 (3.8)	54 (2.9)	104 (3.3)	
20-29	304 (23.3)	507 (27.2)	811 (25.6)	
30-39	307 (23.5)	413 (22.1)	720 (22.7)	0.000
40-49	288 (22.0)	313 (16.8)	601 (18.9)	
50-59	192 (14.7)	254 (13.6)	446 (14.1)	
60-69	113 (8.7)	152 (8.2)	265 (8.4)	
≥70	53 (4.1)	173 (9.3)	226 (7.1)	
Religion				
Christian	943 (72.2)	1,419 (76.1)	2,362 (74.5)	
Muslim	332 (25.4)	422 (22.6)	754 (23.8)	0.000
Other	31 (2.4)	25 (1.3)	56 (1.8)	
Marital status				
Never married	143 (11.0)	204 (11.0)	347 (11.0)	
Married/In-union	841 (64.2)	1,177 (63.0)	2,018 (63.5)	0.134
Divorced/separated	165 (12.7)	209 (11.2)	374 (11.8)	
Widowed	158 (12.1)	276 (14.8)	434 (13.7)	
Relationship to household head				
Head	503 (38.5)	773 (41.4)	1,276 (40.2)	
Spouse	667 (51.0)	913 (48.9)	1,580 (49.8)	0.407
Child	100 (7.7)	132 (7.1)	232 (7.3)	
Other	37 (2.8)	48 (2.6)	85 (2.7)	
Health status				
Presence of chronic illness (% Yes)	59 (4.5)	202 (10.8)	261 (8.2)	0.000
Childbirth in the last 12 months (% Yes)	115 (8.8)	259 (13.9)	374 (11.8)	0.000

Table 3: Descriptive statistics of selected variables by health insurance status of women in Ghana, 2012 (Continued)

Variables	Health Insurance Status		Total n (%)	<i>p-value</i>
	Uninsured n (%)	Insured n (%)		
Sociocultural index score				
Negative	811 (62.1)	1,148 (61.5)	1,959 (61.7)	

Positive	496 (37.9)	718 (38.5)	1,214 (38.3)	0.763
Gender index score				
Negative	387 (29.6)	395 (21.2)	782 (24.7)	
Positive	920 (70.4)	1,471 (78.8)	2,391 (75.3)	0.000
Perception about quality of healthcare index score				
Negative	525 (40.2)	467 (25.0)	992 (31.3)	
Positive	782 (59.8)	1,399 (75.0)	2,181 (68.7)	0.000
Perception about NHIS index score				
Negative	482 (36.9)	375 (20.1)	857 (27.0)	
Positive	825 (63.1)	1,491 (79.9)	2,316 (73.0)	0.000
Political index score				
Negative	605 (46.3)	684 (36.7)	1,289 (40.6)	
Positive	702 (53.7)	1,182 (63.3)	1,884 (59.4)	0.000
Economic index score (Wealth quintiles)				
First (poorest)	374 (28.6)	262 (14.0)	636 (20.0)	
Second	291 (22.3)	344 (18.4)	635 (20.0)	
Third	262 (20.2)	371 (19.9)	633 (20.0)	0.000
Fourth	225 (17.2)	410 (22.0)	635 (20.0)	
Fifth (richest)	155 (11.9)	479 (25.7)	634 (20.0)	
Total	1,307	1,866	3,173	

a. Pearson's chi-square (χ^2) test for categorical variables

Table 4: Logistic regression estimates of the determinants of enrolment in the NHIS by women in Ghana, 2012

Variables	Odds Ratio ^a	[95% Confidence Interval]		VIF ^b	Coef.	“t”
		Lower	Upper			
Personal/Demographic characteristics						
District						
Ejisu-Juabeng	1.00					
Asutifi	1.67***	1.29	2.16	1.96	0.51	0.00
AAK	0.38***	0.30	0.48	2.01	-0.97	0.00
Kwaebibirem	1.33*	1.03	1.72	1.91	0.29	0.03
Savelugu-Nanton	0.67*	0.44	1.00	4.62	-0.41	0.05
Location of residence						
Rural	1.00					
Urban	1.30***	1.10	1.55	2.55	0.27	0.00
Age (years)						
15-19	1.00					

20-29	1.35	0.84	2.15	4.83	0.30	0.21
30-39	1.07	0.65	1.77	4.66	0.07	0.78
40-49	0.99	0.59	1.67	4.23	-0.01	0.98
50-59	1.19	0.69	2.03	3.64	0.17	0.54
60-69	1.21	0.68	2.17	2.77	0.19	0.52
70+	3.49***	1.85	6.58	2.86	1.25	0.00
Religion						
Christian	1.00					
Muslim	1.29	0.93	1.78	3.8	0.25	0.13
Other	0.86	0.46	1.60	1.06	-0.15	0.63
Marital status						
Married	1.00					
Never married	1.02	0.72	1.45	1.96	0.02	0.89
Divorced/Separated	0.83	0.61	1.15	1.84	-0.18	0.27
Widowed	0.98	0.70	1.38	2.45	-0.02	0.91
Relations to household head						
Head	1.00					
Spouse	0.77*	0.60	0.99	4.6	-0.27	0.04
Child	0.78	0.53	1.13	1.63	-0.25	0.19
Other	0.59**	0.36	0.99	1.13	-0.52	0.05
Health status						
No chronic illness	1.00					
Chronic illness	2.17***	1.53	3.06	1.26	0.77	0.00
Childbirth in the past 12 months						
No	1.00					
Yes	1.73***	1.32	2.26	1.3	0.55	0.00

Table 4: Logistic regression estimates of the determinants of enrolment in the NHIS by women in Ghana, 2012 (continued)

Variables	Odds Ratio ^a	[95% Conf. Interval]		VIF ^b	Coef.	“t”
		Lower	Upper			
Sociocultural index score						
Negative	1.00					
Positive	0.85**	0.72	1.01	1.66	-0.16	0.06
Gender index score						
Negative	1.00					
Positive	1.35***	1.12	1.62	4.28	0.30	0.00
Perception about health care index score						
Negative	1.00					
Positive	1.78***	1.50	2.12	3.27	0.58	0.00
Perception about NHIS index score						
Negative	1.00					

Positive	2.25***	1.89	2.69	3.74	0.81	0.00
Political index score						
Negative	1.00					
Positive	1.10	0.92	1.30	2.88	0.09	0.30
Economic index score (wealth quintiles)						
First (poorest)	1.00					
Second	1.53***	1.19	1.97	2.05	0.43	0.00
Third	1.85***	1.44	2.39	2.1	0.62	0.00
Fourth	2.47***	1.91	3.21	2.19	0.91	0.00
Fifth (richest)	4.16***	3.12	5.56	2.5	1.43	0.00
Constant	0.18	0.10	0.34		-1.69	0.00
<i>Total observation (N)</i>		3,172				
<i>LR chi² (30)</i>		653.30***				
<i>Pseudo R² (Cox-Snell)</i>		0.186				
<i>Pseudo R² (Nagelkerke)</i>		0.251				
<i>Hosmer-Lemeshow statistic (P>chi²)</i>		11.67(0.17)				
<i>Mean VIF (max)</i>		2.72 (4.83)				
Note:						
a. *p<0.05, **p<0.01, ***p<0.001						
b. uncentered variance inflation factors						