AVAILABILITY AND UTILIZATION OF NATIONAL HEALTH INSURANCE SCHEME (NHIS) AMONG URBAN AND RURAL CIVIL SERVANTS IN BAUCHI STATE

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M.ED/EDUC/18947/2007-2008

A THESIS SUBMITTED TO THE POSTGRADUATE SCHOOL,

AHMADU BELLO UNIVERSITY, IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTER OF EDUCATION DEGREE IN HEALTH EDUCATION

DEPARTMENT OF PHYSICAL AND HEALTH EDUCATION

AHMADU BELLO UNIVERSITY, ZARIA.

JULY, 2011

DECLARATION

I declare that the work in this thesis report entitled "Availability and Utilization of National Health Insurance Scheme (NHIS) among urban and rural Civil Servants in Bauchi State" has been written and compiled by me in the Department of Physical and Health Education under the supervision of Dr. (Mrs.) M.A. Suleiman and Prof. J.A. Gwani. All sources of information have been appropriately acknowledged in the text and written in the list of references. No part of this thesis was previously presented for another degree at any university.

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OMACHI SUNDAY DATE

CERTIFICATION

This thesis entitled "AVAILABILITY AND UTILIZATION OF NATIONAL HEALTH INSURANCE SCHEME (NHIS) AMONG URBAN AND RURAL CIVIL SERVANTS IN BAUCHI STATE" written by Omachi Sunday meets the regulations governing the award of the Masters Degree in Health Education of Ahmadu Bello University, and is approved for its contribution to knowledge and literary presentation.

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I gladly dedicate this work to the Almighty God whose mercies and guidance brought me this far and made this research work possible.

ACKNOWLEDGEMENT

The researcher's heart-felt appreciation and gratitude go to his able supervisors Dr. (Mrs.) M.A. Suleiman and Prof. J.A. Gwani whose patience and guidance made this research work possible. May the Lord God bless their endeavours.

The researcher's special thanks goes to Dr. (Mrs.) T.N. Ogwu, Prof. (Mrs.) C.O. Adegbite, Prof. C.E. Dikki, Dr. E.A. Gunen, and all members of staff in the Department for their contributions to the success of this research work. Special appreciation is however expressed by the researcher to all who contributed in one way or the other in making this research work a success.

It is the researcher's pleasure to recognize the financial support of his beloved brothers, Omachi Paul and Omachi Daniel throughout this Masters Degree Programme. May the Lord God bless the works of their hands.

ABSTRACT

The purpose of this study was to assess the availability and utilization of National Health Insurance Scheme (NHIS) among urban and rural civil servants in Bauchi State. The survey research method was used to study 488 subjects drawn from six Local Government Areas in Bauchi State. The subjects were drawn through simple random sampling. A close-ended questionnaire was used to obtain responses from the subjects. Data collected for this study were analyzed using descriptive statistics of frequency, percentage, mean and standard deviation, and inferential statistics of t-test and Pearson product moment correlation analysis. O.05 level of significance was used for all tests of significance. The findings showed that Significant difference existed between rural and urban civil servants in the availability and utilization of National Health Insurance Scheme services in Bauchi State ,t (486)= 1.960 $P \leq 0.05$. Utilization of National Health Insurance Scheme services is significantly influenced by cultural/ religious belief among urban and rural civil servants in Bauchi State, t (486)=1.960 $P \leq 0.05$. Utilization of National Health Insurance Scheme services among urban and rural civil servants in Bauchi State is significantly influenced by access to the health care service, r (486)= 0.087 $P \leq 0.05$. Based on the findings above, the following recommendations were made: explicit consideration should be given to the need for equal distribution of health care facilities in Bauchi State. If secondary and to some extent primary health services are to be attracted and made functional in the rural communities, essential infrastructural services such as roads, water and transport, should be provided. Measures such as giving adequate remuneration for rural services and provision of decent housing should be taken to expand the availability of professional health care personnel in rural areas. The NHIS should undertake periodic redefining of policy and plans of operation vis-à-vis people's needs to enhance better utilization of the services among the civil servants. The National Health Insurance Scheme needs to intensify its effort in public mobilization and enlightenment on the activities and significance of the scheme to help overcome/eliminate existing cultural/religious barriers in the use of the scheme among the civil servants. Accessibility may be further improved by adding more health care centres in the rural areas to bring the services within walking distance of the population.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF APPENDICES

ABBREVIATIONS

CDC:	Centers for Disease Control and Prevention
ENT:	Ear, Nose and Throat
HMOs:	Health Maintenance Organizations
HOS:	Head of Service
IAR:	Institute for Agricultural Research
ID:	Identity
ILO:	International Labour Organization
MHOs:	Mutual Health Organizations
NHIS:	National Health Insurance Scheme
US:	United States
USSR:	Union of Soviet Socialist Republics
WHO:	World Health Organization

OPERATIONAL DEFINITION OF TERMS

ACCESS: The ability to reach or use the NHIS health care services by civil servants insured under the scheme in Bauchi State.

AVAILABILITY: Getting NHIS health care services by the civil servants insured under the scheme in Bauchi State at all times of their needs.

CIVIL SERVANTS: Employees of Bauchi State government.

HEALTH INSURANCE: A system of health care in which civil servants in Bauchi State who are prospective consumers of care make payment to a third party in the form of an insurance scheme, which in the event of future illness will pay the provider of care for some or all of the expenses incurred.

HEALTH INSURANCE SCHEME: Health care programme that guarantees the provision of a benefit package of health care services to civil servants in Bauchi State from funds created by pooling the contributions of participants.

PRIMARY HEALTH CARE: The first level of personal health services where initial professional attention is payed to current or potential health problems of civil servants insured under the NHIS in Bauchi State.

SOCIAL HEALTH INSURANCE: Resource pooling, risk sharing health care programme that provide quality health care financing to employees, the sick, aged, and indigents in Bauchi State.

SOCIAL SECURITY: Social insurance programme providing protection to civil servants against socially recognized conditions, such as poverty, old age, and disability in Bauchi State.

SOLIDARITY: A cross-subsidization from civil servants with a lower incidence of illness to those who require care more frequently in Bauchi State.

UTILIZATION: The use of NHIS health care services by civil servants insured under the scheme in Bauchi State.

CHAPTER ONE

1.0 INTRODUCTION

Health insurance, like all other types of insurance, is a risk -and cost- spreading process. That is, the cost of one person's injury or illness is shared by all in the group. Each person in the group has a different chance (or risk) of having a problem and thus needing health care. The concept of insurance has everyone in the group, no matter what their individual risk, helping to pay for the collective risk of the group. The risk of costly ill health is spread in a reasonably equitable fashion among all persons purchasing insurance, and everyone is protected from having to pay an insurmountable bill for a catastrophic injury or illness, (James, Robert and Jerome, 2008).

Conditions requiring medical care of a preventive or curative nature occurring during every individual's life lead to financial commitments that many persons cannot meet from their own resources or those of their family. When, however, risks and resources are pooled among a larger group of persons with different probabilities of requiring care, the security of each individual is enhanced. The larger the group, the higher are the chances that the funds pooled together will be sufficient to pay for the care that each member is likely to require, (James et al., 2008).

Groups practising solidarity can be formed spontaneously. Otherwise society can choose to make mandatory the constitution of "population" groups which will mutually support one another. When legislation makes affiliation compulsory for a prescribed and large section of the population (that is, all employees or certain categories of employees), good and bad risks are shared and resources are pooled. The financial viability of the joint

undertaking becomes much higher than when affiliation is voluntary,(Aviva, Brian and Giovanni, 2000).

When this process of solidarity is compulsorily applied to health related risks, each individual can expect to receive as of right, appropriate medical care whenever it is needed. The individual's right stems from membership of the group of persons protected, irrespective of the amount of the contribution made to the joint fund. Such contribution will normally be related to ability to pay, rather than to the individual's health risk which will vary according to age, sex and physical condition. Compulsory health insurance thus holds a strong social purpose unlike private or commercial health insurance where individual risk is the basis used by the insurance carrier for establishing the insurance premium. For this reason "social insurance" is the term currently used to describe compulsory health insurance or similar benefit programmes based on social solidarity. The emphasis is on the term "social" more than on the term "insurance",(Aviva et al., 2000).

The mechanism to cover health risks described above creates a demand for health services and health care, a demand sustained by ability and capacity to pay. The response to this demand must be an acceptable supply of services and care. A choice of "providers" of medical care is generally offered. These will include public non-profit institutions, private non-profit providers and, in all cases, also self-employed professionals and often profit-making hospitals. The ultimate feasibility of introducing a social health insurance scheme will depend on the availability and stability of the relevant infrastructures. These are the medical resources, both manpower and facilities, the ability to contribute on the part of all three sources (employer, employee and government), and the administrative capacity to implement and operate the scheme with increasing efficiency. Along with these factors,

political determination in creating the necessary legislation is needed. Very often such major issues face long delays in debate as the country goes through periods of socio-economic instability without real gains in the health status of the nation in the interim. During this period, the argument is often put forward that health insurance raises labour costs and may be inflationary. However, regular contributions may in fact replace ad hoc costs already made by employers in providing health care for their workers,(Aviva et al., 2000).

The recent evolution of compulsory health insurance has been influenced by the call for a new approach to health and health care in order to achieve a more equitable distribution of health resources and to attain the goal of "Health for All". It has become evident that serious shortages in the allocation of resources from state or from local health budgets would impair progress in the implementation of national strategies to achieve the goal of Health for All. The need to mobilize additional resources has obliged governments to look for new options in health care financing. It has thus been recognized that one of the most promising options is compulsory health insurance in the form of a social security programme. This view has been supported internationally by the competent United Nations specialized agencies such as the International Labour Organization, the World Health Organization, the World Bank and Regional Development Banks, (U.S. Department of Health and Human Services, 2000).

The beneficial effect of compulsory health insurance development in various parts of the developing countries has been felt beyond the welcome expansion in national resources devoted to health. Other induced effects include a significant development of human resources (Medical and Para- Medical staff), the creation of jobs in the health sector and the

alleviation of a burden traditionally carried by the Health Ministries enabling them to shift resources to rural areas and to preventive-oriented services and programmes, a positive demonstration effect which has triggered better standards all around, (Aviva et al., 2000).

The importance of National Health Insurance Scheme to the welfare of the working population prompted the researcher to undertake a research study on the 'Availability and utilization of National Health Insurance Scheme (NHIS) among urban and rural civil servants in Bauchi State. NHIS is seen by many countries as the right response to the expectations of workers and their families. The availability of a National Health Insurance Scheme would improve health care in many ways: the working population would by regular payments ensure that services of a standard they and their dependants want to use are available when they need to use them. Regular payments are affordable; no one should be at risk of having to find sudden large sums when serious illness strikes the family. Health insurance spreads risks between those with high needs for health services and those with low needs. No one can be sure in advance into which category he or she may ultimately fall. A national scheme can buy health services more economically than any individual. Just as a supermarket can get favourable prices by buying in bulk, so can National Health Insurance.

1.1 STATEMENT OF THE PROBLEM

The increasing cost of health care services and development is a major concern to all governments in both developed and developing countries. Coupled with this is the fact that current policies have failed to mobilize enough financial, human and other resources to meet existing or anticipated needs. While this phenomenon may hold true for all nations of the world, the developing countries are worst in that for these countries in Latin America, Africa

and parts of Asia, the prospect of achieving even minimal adequacy of health and health services is a distant goal. The basic health needs of vast numbers of people remain unmet and the pursuit of improved standards of health has become a primary concern over recent years, (World Health Organization, 2000).

The sources of these problems are traceable to issues concerning efficiency, equity and resource constraints. Particularly following the oil crisis in 1981, most developing countries have been faced by mounting external debts, and resources used to service these debts have been diverted from other areas of government expenditure including the health sector. This has led to pervasive underfunding of existing health services resulting in diminished quality, (James, 2003).

One of the peculiarities of the health "market" is, however, that society may well agree and arrange for some or all kinds of health services to be available free of charge. The state assumes the role of provider, drawing the necessary resources from its general revenue based on direct and indirect taxation. in an extreme situation where all services are virtually free at the point of delivery and every citizen is covered and is satisfied with the free care available, there would be no point in encouraging or promoting the creation of groups practising solidarity to meet their health care needs, simply because the need has already been met, (Milton, Roemer and Maeda, 2001).

Unfortunately such an ideal situation is rarely found, particularly in developing countries. A free public health sector often exists but coverage is limited. Supply falls short of the current and the emerging demand. General revenue financing for health has severe budgetary constraints that it would be foolish to ignore or underestimate. History shows that

there is ample scope for organizing the process of solidarity – normally understood and defined as compulsory health insurance, a social security undertaking, (National Committee for Quality Assurance, 2006).

There are a number of important factors at play in extending social security programmes to health care. Dissatisfaction with the quality and quantity of curative services provided by public systems, along with growing inability of a substantial proportion of the population to pay for private medical services, often stimulate debate on whether basic health care should be provided as a right of every citizen. The wage-earning population becomes discontent with the generally long distances and waiting times involved in receiving a low level of public services, and with their own inability to afford private services, (World Health Organization, 2000).

Though health insurance is an acquired or imported concept, rather than an expression of the traditional national culture, and this has remained an element for criticism, there has nevertheless always been a rationale behind the desire to introduce the health insurance approach, which stemmed from the urgent need to satisfy people's aspirations to better and more accessible medical care combined with the unlikelihood that the state could – in the foreseeable future – meet such aspirations through the traditional public health services supported by general revenue financing.

Every attempt to provide adequate health care is beset by many problems including inadequate funding, inadequate manpower, and poor infrastructure. These inadequacies are not always in quantity but in distribution and quality of the available resources. For instance the available manpower may choose to concentrate in the cities to the detriment of the rural

villages where the bulk of the population still resides, (Hamza, 2006).To establish a successful health policy, solutions must be found to these problems. It was in an attempt to arrest this deplorable situation and redress the imbalances in the distribution of resources for health care services that the Federal Government established the National Health Insurance Scheme in 1999. Unfortunately, several States are reluctant in implementing the scheme.

This study was therefore designed to assess the availability of National Health Insurance Scheme to civil servants in urban and rural settlements in Bauchi state, as well as to determine the utilization of the services. Specially, this study would attempt to find answers to the following research questions.

1.2 RESEARCH QUESTIONS

i. Does availability and utilization of National Health Insurance Scheme services differ between urban and rural civil servants in Bauchi state?
ii. Does cultural/religious belief influence the utilization of National Health Insurance scheme services among urban and rural civil servants in Bauchi state?
iii. Does access to National Health Insurance Scheme health care services influence utilization of the services among urban and rural civil servants in Bauchi State?

1.3 PURPOSE OF THE STUDY

The purpose of this study was to:

i. Determine the availability and utilization of National Health Insurance Scheme among urban and rural civil servants in Bauchi State.

ii. Assess the influence of cultural/religious belief on utilization of the National Health Insurance Scheme services among urban and rural civil servants in Bauchi State.

iii. In light of the findings from the above, offer recommendations on the availability and utilization of the National Health Insurance Scheme services among urban and rural civil servants in Bauchi State.

1.4 SIGNIFICANCE OF THE STUDY

The outcome of this study would be significant to civil servants in Bauchi State in particular and Nigeria in general in the following respects:

i. The results of this study would provide information and baseline data for National Health Insurance Scheme evaluation in Bauchi State with a view to improving the operation of the scheme, as well as enhance better utilization of the services.

ii. The study would promote fair implementation and operation of the National Health Insurance Scheme in Bauchi State as it aims at ensuring that the civil servants get their due once they have fulfilled their part of the contract.

iii. The study would enlighten many civil servants to be very receptive to the National Health Insurance scheme as it highlights the importance of the scheme to their welfare.

iv. The study would encourage employers to support the National Health Insurance Scheme in Bauchi State as they would gain a healthier work force by paying part of the cost of health insurance for their employees and regular contribution

is in fact easier than ad hoc costs made by employers in providing health care for their workers.

1.5 HYPOTHESES

In order to achieve the objectives of this study and to critically address the questions raised in the study, the following hypotheses were formulated.

1.5.1 MAJOR HYPOTHESIS

There is no significant difference between urban and rural civil servants in their opinion on the availability and utilization of National Health Insurance Scheme services among civil servants in Bauchi State.

1.5.2 SUB-HYPOTHESES

i. There is no significant difference between urban and rural civil servants in the availability and utilization of National Health Insurance Scheme services in Bauchi State.

ii. Utilization of National Health Insurance Scheme services is not significantly influenced by cultural/religious belief among urban and rural civil servants in Bauchi State.

iii. Utilization of National Health Insurance Scheme health care services among urban and rural civil servants in Bauchi State is not significantly influenced by access to the health care services.

1.6 BASIC ASSUMPTIONS

This study was based on the following assumptions:

i. That National Health Insurance Scheme services are available to urban and rural civil servants in Bauchi State.

ii. That cultural/religious belief influences the degree of utilization of National Health Insurance Scheme services among urban and rural civil servants in Bauchi State.

iii. That accessibility of National Health Insurance Scheme health care services influence utilization of the services among urban and rural civil servants in Bauchi State.

iv. That availability of National Health Insurance Scheme can influence the utilization of National Health Insurance Scheme services among urban and rural civil servants in Bauchi State.

1.7 DELIMITATIONS OF THE STUDY

This study was delimited to National Health Insurance Scheme services and resources in six (6) Local Government Areas selected from the three senatorial zones in Bauchi State, these include: Bauchi,Toro(Southern Senatorial zone),Ganjuwa, Ningi (Central senatorial zone), and Giade, Jama'are (Northern senatorial zone). It was basically concerned with the availability and utilization of National Health Insurance Scheme services in the selected Local Government Areas. Specifically, only civil servants in the selected Local Governments were involved in the study.

1.8 LIMITATIONS OF THE STUDY

National Health Insurance Scheme is a nascent concept in Nigeria therefore very little work has been done on the research subject matter in the country for now, this made literature review for appropriate comparison limited.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.0 INTRODUCTION

This study was carried out to assess the availability and utilization of National Health Insurance Scheme (NHIS) among urban and rural civil servants in Bauchi State. The purpose of the study was to ascertain the provision of health insurance to civil servants in urban and rural settlements in Bauchi State, as well as to determine the utilization of the services. The review of related literature is presented under the following sub-topics:

1. The concept of National Health Insurance Scheme.
2. Historical evolution of Health Insurance.
3. History of National Health Insurance Scheme in Nigeria.
4. The health services.
5. Availability of National Health Insurance Scheme/services.
6. Utilization of National Health Insurance Scheme services.
7. Summary.

2.1 THE CONCEPT OF NATIONAL HEALTH INSURANCE SCHEME

The National Health Insurance Scheme (NHIS) is a body corporate established under Act 35 of 1999 by the Federal Government of Nigeria to ensure access to health care by all Nigerians at an affordable cost. James (2003) defined the National Health Insurance Scheme as a social health insurance programme designed by the Federal Government of Nigeria to complement sources of financing the health sector and to improve access to

health care by the majority of Nigerians. It is a form of social health insurance which pays for health care services through contributions to a health fund. Contributions, which are usually from both employers and employees, are based on payroll and ability to pay while access to services is based on need. The fundamental rationale for health insurance is risk sharing. According to James (2003), the programme aims at:

- Ensuring that every Nigerian has access to good health care services.
- Protecting families from the financial hardship of huge medical bills.
- Limiting the rise in the cost of health care services.
- Ensuring equitable distribution of health care costs among different income groups.
- Maintaining high standard of health care delivery services within the system.
- Ensuring efficiency in health care services.
- Improving and harnessing private sector participation in the provision of health care services.
- Ensuring equitable distribution of health care facilities within the federation.
- Ensuring the availability of funds to the health sector for improved services; and
- Ensuring equitable patronage of all levels of health care.

The National Health Insurance Scheme was launched formally as a Public Health Policy in 1997. The government recognizing the importance of the scheme as a good opportunity for mobilizing additional resources towards financing the health sector showed some political commitment by embarking on public enlightenment/ official launching of the scheme in the various geo-political zones, preparatory to its take off. According to Okonkwo (2001), National Health Insurance Scheme (NHIS) has been introduced in Nigeria in response to

inadequate provision of health facilities, the general poor state of the nation's health care services, the excessive dependence and presure on government provided health facilities, the inadequate participation of private health services coupled with inappropriate distribution of both public and private facilities in the country, low income per person, the country's poor health indices, and its large population. The scheme is at the initial phase of transition to universal coverage in Nigeria. The first phase is the implementation of the Formal-Sector programme that began five years ago. As a complementary or alternative source of health care financing, Mohammed (2008) reported that National Health Insurance Scheme has become important in developing countries. According to him, it is implemented as part of health reform programmes and strategies towards providing effective and efficient health care for all citizens, most especially the poor and the vulnerable populace. Mohammed further reported that the scheme (NHIS) which aims at providing risk sharing in health expenditures through the contribution of enrolled members is at the tail-end of its first-phase in Nigeria. As part of the health sector reform, the scheme's vision is "a strong, dynamic and responsive government parastatal (Agency) that is totally committed to securing universal coverage and access to adequate and affordable health care in order to improve the health status of Nigerians, especially for those participating in the various programmes/products of the scheme; while the mission is to facilitate fair-financing of health care costs through pooling and judicious utilization of financial resources to provide financial risk protections and cost-burden-sharing for people against high cost of health care, through various prepayment(s) programmes/products prior to their falling ill (NHIS Annual Report, 2006).

It is essential to note that the National Health Insurance Scheme (NHIS) often called Social Health Insurance is a mandatory health insurance that covers the entire population, including the vulnerable individuals. It is based on the principle of social solidarity. Contributions can be customized to income level and in some instances to the number of dependants covered by the scheme. In essence, the concept is all about risk pooling and fund pooling to prevent or avoid unforeseen catastrophic event which could be sudden or futuristic; paying for health care, and ensuring access to services by providing a mechanism for sharing the risk of incurring medical expenditures among different individuals (Kutzin, in: Mohammed,2008). The Nigerian National Health Insurance (NHI) popularly referred to as "NHIS" is a scheme which has assorted categories: Formal, Informal and the vulnerable groups (Mohammed, 2008). As part of the strategy for achieving universal coverage and to ensure that every Nigerian has access to qualitative and affordable health care services, the NHIS programmes have been reshaped into four broad groupings, these include: Formal-Sector group, which consists of public sector (Federal, State, Local Government), Armed Forces, police and other Uniformed Services, Organized private sector, Students of Tertiary Institutions and Voluntary participants; Informal-Sector group, which consists of Rural community and Urban Self-employed; Vulnerable group, which consists of permanently disabled persons and Aged, Children Under-5, and Prison Inmates; and Others, which consists of International Travel Health Insurance, pregnant women & orphans, Retirees and Unemployed, (NHIS Annual Report, 2006).

As a complementary or alternative source of health care financing, National Health Insurance is seen as a key to attaining one main social target of governments, international organizations, and the whole world community which is the attainment by all people of the

world of a level of health that will permit them to lead a socially and economically productive life (Hamza, 2006). The attainment of the highest possible level of health is the most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to health sector. Hamza (2006) noted that the need for good health care delivery system as part of an enlarged poverty alleviation programme makes National Health Insurance Scheme essential to all. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life. According to the National Health Insurance Scheme Annual Report (2006), the benefits of implementing the Compulsory Health Insurance Scheme include:

- The scheme provides the pooling of resources for cross subsidization of health costs where those in high income bracket subsidize those in low income bracket, the healthy subsidize the sick while the young subsidize the old.
- The burden of funding health care services is shared between government, private employers and enrollees.
- Quackery is minimized due to standards for personnel and equipment set for providers by the scheme.
- Competition among health care providers to attract and retain clients leads to improvement in the quality of services.
- Assured and steady market encourage private investors to set up health care facilities in the less developed areas of the country.
- The scheme provides employment opportunities for health professionals in the health care delivery system and thereby reduces brain drain.

- Donor Agencies/Government will have the confidence to donate to rural communities or less privileged through the proposed vulnerable group fund.
- Provider compensation mechanism under the scheme is a deterrent to strike actions as capitation may be withheld if providers are on strike.
- Improved services resulting from improved income reduces the need for overseas treatment, thereby conserving the country's foreign reserve.
- Improved access to health care services creates a healthier work force for increased economic activities and national prosperity.
- Communities and associations contribute for their health care services without viewing it as tax or levy as they are the financial managers and administrators of their programme and reap the benefits there from.
- False and/or exaggerated claims for refund of medical expenses by employees is eliminated, thereby freeing more money for employers and the government.

Like all other types of health insurance, there are several issues in the National Health Insurance Scheme. These include inefficiency, high cost, adverse selection, moral hazard and fraud. In developing countries, other issues which can add up to the foregoing include underestimation of costs, revenue mobilization from the informal sector, free rider dilemma, social factor, poverty and political problems (nepotism and instability),(Mohammed, 2008).

NHIS in Nigeria, from the policy point of view, could also stand as the regulatory body of the health insurance with a corporate headquarters at the country capital, Abuja, which provides oversight functions to organs (Health maintenance organizations and participating providers) that are involved in direct delivery of services to members. The

health insurance is a single fund like that of France and Tanzania. The essence of the single fund is to enhance easy implementation and coordination of the scheme through the Health maintenance organizations (HMOs). It also provides easy planning for distribution of health services and at the same time reduces the chance of moral hazard, (Mohammed, 2008).

2.2 HISTORICAL EVOLUTION OF HEALTH INSURANCE

The practice of pooling resources to ensure protection against the risks of ill-health grew mainly out of labour developments. In Mediaeval Europe, craftsmen formed societies ("guilds") which in turn created funds to help members in times of distress due to sickness. Each member contributed to the fund on a regular basis. The threat to the individual worker's earnings because of illness was seen as a risk to be shared, and from the late eighteenth and early nineteenth centuries groups of workers and small farmers in the same industry or location formed sickness funds as mutual benefit societies to serve this purpose. First cash benefits were provided, then the guilds asked doctors to certify sickness. To ensure services for their members, some guilds then began to contract with providers on a regular basis, and later to develop their own medical services, particularly in countries with a low supply of doctors and hospital beds. New initiatives came from employers: the schemes often becoming compulsory as employers in specific high-risk industries, such as mining made employment conditional upon regular contributions to a fund to cover health care. With these developments, the concept of contributions related to earnings rather than to individual risk became firmly established in some countries,(ILO in collaboration with the Pan-American Health Organization, 2000). Most funds initially chose the capitation method, whereby doctors were paid a monthly sum for each insured person registered on their lists. The capitation method of paying physicians, rather than the ad hoc system of

billing for each item of service provided, provided the insured person with a regular source of medical care, and was therefore the first mechanism to promote continuity of care at the general practitioner or family doctor level. A different form of payment was later introduced. The patient paid the doctor directly after the consultation and treatment, according to the stipulated fees for the actual services provided, and then the major part of this expenditure (initially 80 per cent) was refunded by the social insurance administration.

From the late 1930s a major development took place in social policy: the emergence of the concept of "social security" and its gradual implementation through reforms and the expansion of earlier social insurance legislation. This development had a major impact on health insurance. Public measures included a broad variety of programmes: compulsory/or voluntary social insurance, social assistance, and employers' liability to provide benefits and services mandated by law. Such programmes pre-existed in many countries and were retained and enhanced under the new social security policy. In practice each country proceeded to develop a social security system suited to traditional values, national conditions and preferences as well as social ideology. Initially, compulsory health insurance legislation and institutions took shape in developing countries which reflected the social policies which had gained - or were gaining – acceptance in Europe. Such policies either had an intrinsic appeal to the political leaders or were part of the broad cultural inheritance from colonial powers and of the education of the elite nurtured abroad. Health insurance was therefore an acquired or imported concept, rather than an expression of the traditional national culture, and this has remained an element for criticism. Since the social and economic context was different from the European one, developing countries had to adapt the approach to health insurance to their own situation, in particular with regard to

coverage and the methods of delivering health care as benefits mandated by law,(Aviva et al, 2000).

The evolution of compulsory health insurance has undoubtedly been influenced by the historic international conference on Primary Health Care in Alma-Ata, USSR (1978), which called for a new approach to health and health care in order to achieve a more equitable distribution of health resources and to attain the goal of "Health for All". The unanimous acceptance by governments of the strategies outlined at Alma-Ata have been responsible, at least to some extent, for the increased awareness of the place that compulsory health insurance occupies or should take within a national health policy. Developing countries (mainly in Africa, Asia or the Caribbean) that had so far ignored compulsory health insurance, either deliberately or by neglect or because of special circumstances, show signs of a change in attitude. The need to mobilize additional resources has obliged governments to look for new options in health care financing. It has thus been recognized that one of the most promising options is compulsory health insurance in the form of a social security programme,(US Department of Health and Human Services, 2000).

2.3 HISTORY OF NATIONAL HEALTH INSURANCE SCHEME IN NIGERIA

The National Health Insurance Scheme (NHIS) is a body established under Act 35 of 1999 by the Federal Government of Nigeria. The act was signed into law by the past Head of State, General Abdusalam Abubakar,(NHIS Annual Report, 2006). Processes for the establishment of the National Health Insurance Scheme have been on going since the 1950s. The pioneer Federal Minister of Health Chief (Dr.) Moses A. Majekodunmi along with other officers of the Nigerian branch of the British Medical Association had worked out and

submitted to the government in 1954 “Blue Print of a Health Service for Nigeria”. This formed the kernel of a health bill introduced by the then Minister of Health. The most important aspect of the bill was the detachment of the health services from civil service control. In the bill it was advocated that a contributory health service which will be funded by all, the government, employers of labour and individuals should be introduced. Unfortunately this was met with vigorous opposition from stakeholders, the trade unions and all categories of health professionals, (James, 2003).

Although Social Health Insurance was introduced as a strategy and option for health care financing in Nigeria in 1962 through a Health Bill, nothing happened until 1970s when a Basic Health Service Scheme was introduced, (NHIS Annual Report, 2006). The National Council on Health in 1984, set up a committee on Health care financing to address the poor funding of the health sector. It was this committee that recommended the establishment of a National Health Insurance Scheme as the only viable option for funding health services. In August 1985 another committee was set up to take a look at the feasibility of a National Health Insurance Scheme as recommended by the previous committees. Their report was submitted in 1986 and was forwarded to yet another committee in January 1989 headed by Dr. Umez-Eronini. The Umez-Eronini committee in its report stated the requirements and procedures for setting up a Health Insurance Scheme in the country. In 1992, the report of the Umez-Eronini committee was forwarded to the Federal Executive Council and was approved in principle, (NHIS Annual Report, 2006). A committee was then set up by the Federal Ministry of Health comprising of experts from International Labour Organization (ILO) and external consultant (Prof. Brian Abel-Smith) to give their expertise advice on the establishment of the scheme. The committee developed a framework that touched on aspects

of legislation, policy issues, infrastructure, and organizational structure among other areas. The framework was however reviewed in 1997 with the inclusion of the Health Maintenance Organizations (HMOs) and the introduction of Public-Private Partnership.

Even though the scheme was launched formally as a Public Health Policy in 1997 by General Abdusalam Abubakar, the Formal Sector Programme, one of the programmes under the scheme designed to cover employees in both the public and the private sector was only flagged off by President Olusegun Obasanjo on June 6th, 2005. The first batch of 100,000 ID cards was presented to the Head of Service (HOS) on 13th September, 2005. This therefore marked the commencement of access to Health Care to this category of the Nigerian citizenry,(National Health Insurance Scheme Annual Report, 2006).

The launching of the Formal Sector Social Health insurance Scheme sprung up series of activities under the scheme ranging registration of enrollees, issuances of Identity Cards, registration of Hospitals, Banks and registration of HMOs to serve as the managers of the NHIS Funds.

2.4 THE HEALTH SERVICES

To ensure the attainment of the objectives of the National Health Insurance Scheme, the scheme has been designed to include a broad collection of health care services which, according to NHIS Operational Guideline (2005) include:

i. Out-patient care, including necessary consumables.
ii. Prescribed drugs, pharmaceutical care and diagnostic tests as contained in the National Essential Drugs List and Diagnostic Test Lists.

iii. Maternity care for up to four (4) live births for every insured contributor/couple in the Formal Sector programme.

iv. Preventive care, including immunization, health education, family planning, antenatal and post-natal care.

v. Consultation with specialists such as physicians, pediatricians, obstetricians, gynaecologists, general surgeons, orthopaedic surgeons, ear, nose and throat (ENT) surgeons, dental surgeons, radiologists, psychiatrists, ophthalmologists and physiotherapists.

vi. Hospital care in a standard ward for a stay limited to cumulative 15 days per year. Thereafter, the beneficiary and/or the employer pays.

vii. Eye examination and care, excluding the provision of spectacles and contact lenses.

viii. A range of prostheses (limited to artificial limbs produced in Nigeria); and

ix. Preventive dental care and pain relief (including consultation, dental health education, amalgam filling, and simple extraction).

2.5 AVAILABILITY OF NATIONAL HEALTH INSURANCE SCHEME/ SERVICES

According to Aviva et al., (2000), initially Compulsory Health Insurance Scheme took shape in developing countries which reflected the social policies which had gained acceptance in Europe. They noted that since the social and economic context was different from the European one, developing countries had to adapt the approach to Health Insurance to their own situation, in particular with regard to coverage and the methods of delivering health care as benefits mandated

by law. In Nigeria the National Health Insurance Scheme was launched formally as a public health policy in 1999. But the Formal Sector programme, one of the programmes under the scheme designed to cover employees in both the public and the private sector was only flagged off in 2005, (NHIS Annual Report, 2006). This marked the commencement of access to the health care by enrollees in Nigeria. The launching of the Formal Sector Social Health Insurance Scheme sprung up series of activities under the scheme ranging from registration of enrollees, issuance of identity cards, registration of hospitals, banks and registration of HMOs to serve as the managers of the NHIS funds. They are expected to collect contributions from employers, employees, and voluntary contributors, pay health care providers for the services they render and ensure the maintenance of quality assurance in health care delivery under the Formal Sector Social Health Insurance programme (NHIS Annual Report, 2006). As part of health reform programmes and strategies towards providing effective and efficient health care for all, most especially the poor and the vulnerable group, availability of the Health Insurance Scheme/services are highlighted under some key indices as follows:

2.5.1 **Implementation:** According to Andrew (2007), the gradual implementation of compulsory health insurance according to geographical areas is perhaps the most frequent feature in developing countries. It is, according to him, the obvious response to the uneven distribution of medical infrastructure and personnel throughout the national territory and to the obstacles facing administrators in the identification, registration and control of paid employment or self-employment in rural areas or in regions where records and communication systems are not

sufficiently reliable. Andrew (2007) further explained that there might also be shortages of trained personnel which cannot be surmounted in the initial stages. He further noted that one often finds that the capacity of employers and employees to contribute is much lower outside the urban sectors of the economy, and that naturally the size of a country plays a decisive role. Small states/countries have rapidly reached full geographical coverage while large countries have followed the pattern of extending compulsory health insurance by geographical areas over a number of years.

With regards to implementation of the health care programmes and the benefits that the law entrusts to the sub-system, Andrew (2007) stated that ideally coverage in terms of persons protected should be as wide as possible, but most developing countries do not have the resources (infrastructure, human resources, ability to pay) to honour from the start all the mandated benefits in respect of large and often geographically scattered population groups. According to Andrew (2007), experience shows that a step-by-step approach has definite advantages, provided that it does not become, at a later stage, an 'excuse' for avoiding larger responsibilities and wider coverage. Andrew (2007) further stated that gradualism can be applied with regard to various criteria, such as:

- The size of the enterprise;
- Geographical area;
- Category of insured persons or of dependants automatically covered; and
- Type of benefit.

In the explanations of Aviva et al., (2000), the principle of gradualism in implementation may affect the "package" of the benefits provided. For instance, the types of medical care benefits provided in the first stages of implementation are often limited excluding the less essential ones or those whose cost may be deemed high. Such limitations often apply to dental services, psychiatric care, cosmetic surgery, domiciliary visits, and so on. They further stated that alternatively, the initial limitation may be applied to selected types of diseases or to certain expensive treatments. According to Sule, Ijadumola, Onayade, Fatusi, Soetan and Connell (2008), there is a general agreement that the initial limitation of the scope of compulsory health insurance and the principle of extending it gradually, which have been adopted by a number of developing countries, are wise and realistic process. Any attempt to embrace the whole of the country or the entire active population within the health insurance sub-system from the very beginning is likely to lead to inefficiencies and shortages which can only undermine the credibility and the authority of the insurance institution. Sule et al., (2008) further stated that implementation by stages creates in effect privileged groups and possible discrimination between enterprises. Consequently, any initial restriction of coverage can be ultimately justified only as a transitory measure which must be constantly kept under review and superseded as soon as circumstances permit.

The World Health Organization (2003) noted that the danger in gradual extension is that progress in implementing desirable extensions of coverage may be too slow. This may be due not only to economic and financial constraints, but also to the lack of dynamic initiatives from the social security management and their

political leaders. The world Health Organization further stated that instability in the management has been identified in developing countries as a cause of their unwillingness to explore ways and means to extend coverage, particularly towards rural areas. The "sub-system" has therefore its boundaries in terms of coverage: they are flexible and they should extend gradually; the final profile of coverage depends on the country, its ideology and its peculiar social and economic conditions.

To meet the needs of appropriate health care within the health insurance sub-system, James et al., (2008) noted that the benefits must have certain essential characteristics. Equity is a basic principle and the factors that serve to provide this condition are primarily equitable accessibility and availability of services to all parts of the population covered. They further noted that there are obvious problems in fulfilling these conditions, as apart from a general inadequacy of health care resources, we usually find very significant geographical inequalities, including urban – rural and central and peripheral regional differences. According to them, within the health care resource supply one often find imbalances in the categories of professionals, with a disproportionate number of specialist, and high technology diagnostic services concentrated in cities that are at the same time sorely lacking in primary care providers needed to deal with the social welfare problems of rapid urbanization and industrialization.

2.5.2 **Payment of contribution:** In the words of Haraldson (2005), it is also common for compulsory health insurance to be applied first to selected categories of persons in the labour force. A clear preference is to start with categories of

employees, leaving compulsory insurance for the self-employed for a later stage. Ability to pay is one of the main reasons underlying this option, as well as the problems connected with the identification of self-employed persons and with the determination of their earnings or income to which compulsory contributions are normally related. Haraldson noted that financial considerations are often advanced when coverage is restricted initially to the employee with the exclusion of his family dependants.

According to Naseem, Muzamil, Aladin, Talal and Jacob (2002), unlike public health services, medical care under social security is a right granted against payment of a specific individual contribution. It is argued therefore that the patient has already paid – by a deduction from his salary – for the right to the medical care benefit. Consequently cost – sharing at the point of delivery is not so much imposed to raise additional revenue but to prevent abuse or misuse of available benefits (such as pharmaceutical products) when the benefit is provided free of charge directly by the insurance institution to the insured person. This disincentive, they noted, has however to be handled with great care among population groups which are at subsistence level or who chronically lack cash, because cost-sharing may have the opposite result: to prevent people who should be treated for illness or injury from claiming the service and aggravating their health condition, the treatment of which will later be more costly.

According to Mario (2004), under the compulsory health insurance scheme all health care, except in emergency, is obtained by first visiting the chosen practice/centre. In other words, access to other doctors or to hospital can only be

covered on referral from the practice with which the patient is registered. This ensures that the three levels of health care system from primary to tertiary care is preserved. Mario (2004) further stated that there are important advantages for both the insured person and the doctors participating. Those using the services have advantage of building up relationships with the staff and are known by them. Moreover, their medical history is recorded by the practice and thus does not have to be repeated at subsequent visits. The doctor knows all prescribed medicines the patient is taking and thus there is less risk of a patient taking prescribed drugs by different doctors which could be dangerous when taken at the same time. Mario (2004) further explained that continuity of care has also advantages from the doctor's point of view. Time is saved in taking medical histories; it provides the doctor with the professional satisfaction of seeing the long term results of past treatments. Moreover, having normally taken care of the whole family, physical symptoms due to emotional stress arising from family interaction can often be recognized and treated accordingly.

But when the insured person is out of his station, Hamza (2006) revealed that he may visit National Health Insurance Scheme registered hospital or clinic for services provided he presents his identification of membership. Evidence for such treatment is confirmed and signed by both the doctor and the patient at the time of service. Payments by NHIS is done at approved agency rates. This is to ensure that emergency treatment out of one's usual station is commenced but without financial detriment to the primary clinic.

2.5.3 **Public expectations:** Al-Shammari, Khoja and Jaralla (2002) reported that in providing health care services under the compulsory health insurance scheme there are public expectations and preferences to deal with. According to them there tends to be greater reliance on hospital care, and unnecessary drug dependency, with the insured believing that any encounter with the health system at a time of illness must include drug prescription. For many, they reported, the transfer from a "free" public system to a regular contributory system creates a tendency to seek maximal use of the benefit covered. This "milking" of the system further complicates the attempt to reach rational and balanced utilization of health care. The solutions to these problems are often passed on to the patient (that is, the insured seeking care at the time of illness) rather than the providers, for instance in the form of cost – sharing.

2.5.4 **Cost of Insurance:** According to the U.S National Centre for Health Statistics Reports (2007), increases in the cost of health insurance in developed and developing countries leads to continuous dropping in the percentage of employers who offer health benefits to their employees. Of those employers who continue to offer health benefits to their employees, most are shifting more of the cost onto their employees by: (1) increasing the workers' share of the premium, (2) raising the deductibles that workers must pay, (3) increasing the co-payments for prescription drugs, and (4) increasing the number of items on the exclusion list.

2.5.5 **Provider attitude:** The Health Insurance Scheme has over the years faced the problem of provider attitude and behaviour to the beneficiary in operating the programmes. The age-long rivalry between various professional groups in the health care industry has found its way into NHIS provider network. While some providers

withhold care to enrollees on flimsiest excuses, others charge additional fees on the pretext of non-inclusion of the services in the benefit package (NHIS Annual Report, 2006).

2.5.6 **Economy:** According to Mohammed (2008), poor economy hinders wide spread implementation and sustainability of Social Health Insurance in developing countries. Poor economy affects the spread of its coverage to the informal sector, it reduces spread to rural areas and weakens the ability of self-employed people to pay contribution.

2.6 UTILIZATION OF NATIONAL HEALTH INSURANCE SCHEME SERVICES

Andersen's behavioral model of health services utilization proposes that people's use of health care services is a function of their predisposition to use services, the factors enabling or impeding use, their need for care, and their satisfaction with services, (Andersen, 1995). The utilization of National Health Insurance Scheme services varies across different cultures for a variety of reasons. But it appears, according to Nora (2005), that the determining factors are universal. Nora noted that utilization of National Health Insurance Scheme services is determined not only by its availability but by a number of other factors, some of which are highlighted as follows:

2.6.1 **Location/distance:** Nora (2005) reported that place of residence has been an important factor in the utilization of the services. The urban population make greater use of services than those in rural areas. Nora (2005) further noted that distance from

the health care service centre, education of the participants, as well as their age are the strongest determinants of service utilization among participants in developing countries.

2.6.2 **Accessibility:** In the explanations of Fiedler (2003), access to health care services is considered as the link between the health care system and the population it serves; the volume and type of services, whether or not the service can be reached, the client's perceptions of the relative worth of the service and acceptability of services provided, all influence access and the utilization of services. In line with the postulates of the central place theory, health care facilities in Nigeria constitute a hierarchical system which is reflected in space by the geographical arrangements of service outlets in which a particular area tend to have numerous primary health facilities, much fewer secondary facilities and very few tertiary facilities if at all. Consequently, the findings of studies conducted by Okafor (2007) on the petroleum - producing region of Nigeria (the Niger Delta) revealed that inaccessibility of the available health care facilities in the region has obviously affected the utilization of health care services by a vast proportion of the beneficiaries who still depend on traditional medical care and self medication.

The need for health care varies in space and so the organization of provision necessarily has a spatial component. Neither population totals nor population characteristics such as age, sex, occupation et cetera are uniform in space. In a like manner, the physical environment varies in characteristics from place to place and this invariably has implication for the pattern of demand for health care. The spatial dimension is also important in utilization behaviour since accessibility is a major determinant of the use of health care service (Okafor, 2007).The spatial pattern of utilization of service of the various categories of health establishments by the

beneficiaries show marked differences between local governments where tertiary and secondary health establishments are accessible and those where such facilities are not accessible. There is no doubt, reported by Okafor (2007), that many other factors influence the utilization pattern of health care services among beneficiaries in the Niger Delta region including the level of formal education, facilities available in the health establishments, availability of alternative medical attention in the locality, perception of the attention received in the health care centre and the distance to the centres in terms of travel cost and time of reaching the health centre.

2.6.3 **Client's perception of services:** According to Fiedler (2003), the clients perceptions of the relative worth of the services and acceptability of services provided, influence the utilization of NHIS services among participants. One of the most common reasons for not seeking care among participants and/ or beneficiaries is a lack of satisfaction with services.

2.6.4 **Self-rated health status:** Geitona, Zavras and Kuriopoulos (2007) revealed that the utilization of National Health Insurance services among participants depends on self-rated health status, age, gender, and region. Individuals with moderate and poor self-rated health, older people, and women showed increased utilization of health care services in Epirus, while individuals with better self-rated health status showed decreased utilization of health care services. The frequency of utilization of services depends on region and lower evaluations of health status among participants. In addition, factors influencing how symptoms and illness may be perceived, such as commonality of the disease, familiarity of the symptoms or clinical/physical changes are partly responsible for health care seeking behaviour among participants. According

to Dibley et al., (2003) the most common reason for not seeking care is the expectation that the individual would recover. Other reasons include distance to provider or facility and lack of satisfaction with services.

2.6.5 **Level of education:** Riedel (2002) reported that though differences in access to rural and urban health care units also account for differences in utilization, tendencies towards higher utilization of the health care services emerge, first of all from education which is described as a major force in breaking down reliance upon traditionalistic worldviews and folk practices, or as instrument in helping individuals cope with their needs by making intelligent use of available social and health care services. Maternal education was identified as an important factor affecting utilization of the health care services, as higher educational levels have been associated with an increased self perception of health status and influence the use of both curative and preventive health care services.

2.6.6 **Gender:** According to Charles (2001), sex is one of the most influential variables affecting the use of the National Health Insurance Scheme services. Sex has influence on utilization of the health care services through its association with other predictors of utilization such as tendency to use services, anxiety and skepticism. Charles noted that levels of personal distress are an important trigger in the use of health care services; since women have higher levels of distress, they make more use of the health care services. Charles (2001) further stated that another possible explanation for the higher rate of utilization among women is that they are more dependent and affiliated and thus seek interpersonal solutions to feelings of distress more than the men.

2.6.7 **Culture:** Swendson and Windsor (2004) defined culture as the values, beliefs, norms and practices of a particular group. It consists of all the things which socially characterize the group, that is, their language, food, music, religion, sculpture, painting and occupation. According to Henry (2002), the health status of members of a society is positively correlated to their cultural practices. Culture determines what symptoms/signs are recognized as illness, the cause to be associated with them, who has authority to assess and diagnose them and most importantly who should be consulted for treatment. Mohammed (2008) reported that cultural perception of ill health has been identified as a hindrance to health insurance. Cultural problems evolve with the belief of illness and risk which may be affiliated to religion or traditional norms. When illnesses are perceived ethnically or religiously by the society as punishment for certain misdeeds, it affects the rate of enrollment in health insurance; in the end, acceptance and participation in the health insurance is jeopardized. According to Swendson and Windsor (2004), culture plays a very big role in the life of man, specifically with regards to his medical life. This has also brought about good impacts and sometimes bad impacts to the people who behold these cultures, this is with regards to different circumstances and the way the particular people think in relation to their culture which has a social, psychological and ethical impact in health care services. Swendson and Windsor (2004) further noted that culture is usually assumed to affect choice of health care services/enrollment in health insurance through such factors as health-related behaviours and beliefs. According to Helman (2001), cultural problems have been underestimated by so many scholars. Culture is passively mentioned and treated when discussing ways and avenues to improve utilization of health care services of man. Most often emphasis is placed on socio-economic conditions as the main determinants

of people's willingness to enroll in a health insurance scheme, neglecting culture which also has much impact. Helman (2001) further reported that it is of paramount importance to note that illness and choice of health care services is shaped by cultural factors governing perception in the sense that how we perceive and cope with disease is based on our explanations of sickness, explanation specific to the systems of meaning we employ. It is not surprising then that there can be marked cross-cultural variation in how diseases are defined and coped with in our societies. Helman (2001) concluded by saying that it is obvious that culture and ethnicity are influential social determinants of willingness to enroll or use a health insurance scheme. The findings of studies conducted by Naseem et al., (2002) on the use of National Health Insurance services by participants in rural communities in Saudi revealed that despite the availability of services, these groups tend to under use the services due to traditional conservatism and resistance to ideas from outside; deep rooted traditions and customs, including health beliefs and practices, which create a tendency to over utilize the services of traditional healers. Knutsen (2002) reported that it is well established that life – style and culture influence health seeking behaviours of women with ill children under the health insurance system in rural communities in Vietnam. Knutsen (2002) further reported that cultural perceptions about illness account for differences in seeking health care for children among female spouses of participants in rural communities. Dealing with cultural issues needs effective and efficient advocacy, and series of awareness and sensitization. Government may, at the long run, impose a compulsory participation.

2.6.8 **Poverty:** According to Mohammed (2008), wide spread poverty hinders the spread of Social Health Insurance to rural areas in developing countries. Poverty weakens the ability

of self employed people to pay contribution. Willingness to pay is positively correlated with income; wealthier people have higher willingness to pay than the poor. According to Sabriya (2006), an analysis of poverty rates and health published in the September 2005 issue of the American Journal of preventive medicine found that people living in extreme poverty tend to have more frequent and severe disease complications and make greater demands on the health care system. Sabriya (2006) further reported that fewer people in the U.S can claim that poverty does not affect them as more individuals face layoffs and cutbacks, and are unable to afford health insurance. As financially strapped families struggle to cover basic needs such as food, shelter and the increasing cost of energy, health insurance often takes a back seat on the list of priorities (Sabriya, 2006). A National Health Survey Conducted by the U.S. Centers for Disease Control and prevention (CDC, 2005) found that more than 40 million people of all ages went without insurance at some points in 2005. More than half remained uninsured specifically because they simply couldn't afford it. The U.S. CDC (2005) noted that poverty's impact is felt most by the nation's children. Uninsured children are at greater risk of experiencing health problems such as obesity, heart diseases and asthma that continue to affect them later in adulthood. The prevalence of these illnesses does not bode well for future generations.

2.6.9 **Social factor:** The ethnic, cultural and religious diversity of societies or people within a society reduce solidarity and people's willingness to enroll or pay premium. This is due to lack of homogeneity and close link to assemble mutual trust (Doherty, Mclyntyre & Gilson, 2000).

2.6.10 **Moral hazard:** Is a tendency of entitlement to the benefits of health insurance to act as a strong incentive for people to consume more and "better" health care and a weak incentive for them to maintain a healthy lifestyle (Atim, 2001). It also occurs on the side of the provider and vice versa. Moral hazard entails overuse of the insurance services provided which is caused by both demand and supply sides (patients and health care providers). It occurs in all types of insurance, be it public or private (compulsory or voluntary). It always deter the purchase of very generous coverage against relatively high probability, low-cost form of treatment. Reports from several case studies in different African countries such as Cameroon and Ghana by Atim (2001) on Mutual Health Organizations (MHOs) showed that moral hazard can be controlled by imposing co-payments or deductibles.

2.6.11 **Fraud:** The use of members identity documents by people not entitled to the benefits poses a real danger when the controls are not effective enough to prevent or minimize this. One way of handling this is to leave the task of checking identification to the hospital staff at the time of admission, (Atim, 2001).

2.6.12 **Adverse selection:** This is also known as biased selection. It is the likelihood that a person with a high risk of illness and a greater need for frequent health care would enroll in health insurance scheme than a person with a low risk of illness and less need for frequent health care use. This is common when enrollment of individuals into health insurance scheme is voluntary (Dorfman, 2000). Adverse selection occurs as a result of information asymmetry that arises when insurance subscribers have better information about their individual risks than the insurer. Higher risk individuals pay an average premium that is well below what an actuarially appropriate rate for their risk group should be. This destabilizes voluntary insurance markets since healthier individuals eventually drop out as

premiums rise. One prominent way of eliminating adverse selection is through compulsory membership of the target population, (Dorfman, 2000; Atim, 2001).

Dissatisfaction with the quality and quantity of curative services provided by public systems, along with growing inability of a substantial proportion of the populace to pay for private medical services led to the extension of social security programmes to health care. But despite the availability of services participants/beneficiaries in several rural communities of developing countries tend to underutilize the services for various reasons some of which include: high rates of illiteracy among spouses of participants, and lack of understanding of National Health Insurance Scheme among health professionals and decision – makers resulting in poor quality services. Sule et al., (2008) reported that implementation of a National Health Insurance Scheme alone cannot guarantee improvement in the health status of people, it is their effective utilization of the health care services that can contribute to the health of the people. Utilization of the health care services is affected by a variety of constraints like availability, acceptability, accessibility and affordability. Factors of awareness and availability act as the main barriers to innitial utilization. Once these have been achieved people may then begin to find the intensity and frequency of the utilization limited by accessibility and acceptability. They noted that first and foremost, for people to utilize the health care services they should be available. Even if they are available they should be acceptable to the people because utilization of any health care service depends, to a great extent, on cultural preferences. Riedel (2002) further reported that increased utilization is resulting from modernizing tendencies in the health care services themselves, described in terms of greater expertise in the health care institutions. Riedel

revealed that health care facilities with greater range of competent personnel attract greater use of the health care services.

2.6.13 **Provider-related factors:** Just as certain users-related factors influence the utilization of National Health Insurance Scheme services, certain provider-related factors also play an important part. According to Jerome (2004), once the need for a certain type of health care service has been identified, the degree to which it is met may depend on the health care provider's desire to meet that particular need. More frequently, Jerome noted, the limiting factor is not whether the health care providers want to offer certain health care service, but whether the providers are able to offer it. It is obvious that health care providers cannot offer a health service unless the necessary personnel, equipment and facilities are available. Jerome (2004) further noted that the fact that the resources and ability to offer certain health care services are available at an accredited health care centre does not necessarily mean that the services will be offered in the optimal fashion by any means. The manner and attitude with which those services are offered may seriously affect the utilization of those services. Similarly, the success of services offered depends on the degree to which it fits the lifestyle and needs of the users. Jerome recommended that the health care services should as much as possible be offered at a time and in a place that is compatible with the way users actually live. In the opinion of Johnson (2002) the entire atmosphere of the health care services should not be greatly at variance with the prevailing culture, lifestyle, language, or beliefs of the users. According to Johnson, this provider-related factor that influences the utilization of National Health Insurance Scheme services is the provider's set of values, the reasons why the provider is offering the services in the first place. This is centrally important because the reasons why a health care provider wants to

offer a particular health care service may well decide how it is offered. In turn, how a service is offered may determine its full utilization or otherwise.

The attitude with which users are treated also has an effect on how the health care services are utilized. The findings of studies conducted by Hamza (2006) on the attitudes of Nigerian civil servants towards the National Health Insurance Scheme in Sokoto State revealed under use of services by beneficiaries. Hamza noted that one important factor identified for the under use of services by beneficiaries concerns the way in which staff at health care centres treat patients; nurses were described as being impatient and unsympathetic. According to Hamza (2006), beneficiaries feel entitled to the best services available but are easily upset if treated rudely or roughly. Hamza further stated that the availability of a complete range of services in a given health care system does not necessarily mean those services will be used, let alone used well. There are certain factors in the users, the providers of the health care services, and in society in general that directly affect the utilization of services once they exist. Unless these important factors are considered, a good system of health care such as the National Health Insurance Scheme could be designed and implemented but may never have the impact it should on the health of the population it is meant to serve.

2.7 SUMMARY

Generally, health insurance is seen as a way of allowing governments to diversify the sources of revenue for the health sector, to improve efficiency by giving individuals some roles in paying their own health care and to spread the burden of health care cost over

time and across a wider population, which will reduce risk. The existence of risk is the fundamental rational for insurance.

The establishment of the NHIS was informed among other things by the general poor state of the nation's health care services, the excessive dependence and pressure on government provided health facilities coupled with inappropriate distribution of both public and private facilities in the country. It is a mixed source of finance as it often draws contribution from both employees and sometimes from government. Contributions to such schemes are often mandatory but may be designed to be voluntary. The total contribution paid by or on behalf of the insured person entitles to benefit both the insured and the dependants (normally the spouse and four children under a prescribed age).

In statutory health insurance programme, medical care benefits are given as of right. Each member, regardless of his contribution, has a legally enforceable individual right to defined and mandated benefits appropriate to his medical needs at the time of use. The main difference between health services provided by public health authorities (Ministries of Health) and medical care benefits through social security is that as a counterpart of imposing compulsory health insurance contributions, those covered are given a right to specified individual items of care (curative and preventive). In public health services a local health dispensary will often supply only such care as its resources permits, irrespective of the potential demand. No such discretion operates in a health insurance scheme. The gradual implementation of compulsory health insurance according to geographical areas is perhaps the most frequent feature in developing countries. It is the obvious response to the uneven distribution of medical infrastructure and personnel throughout the national territory and to the obstacles facing administrators in the

identification, registration and control of paid employment or self-employment in rural areas.

Utilization of the National Health Insurance Scheme services varies across different cultures for a variety of reasons, but available literature shows that the determining factors are universal. Such factors as the level of formal education, facilities available in the health establishments, availability of alternative medical attention in the locality, perception of the attention received in the health establishment and the distance to the centres in terms of travel cost and time of reaching the health centre influence utilization of National Health Insurance Scheme services among participants/beneficiaries.

Available literature shows that despite the availability of National Health Insurance Scheme services participants/beneficiaries tend to underuse services for several reasons, including difficulties associated with transportation, high rates of illiteracy among spouses of participants, deep rooted traditions and customs, including health beliefs and practices, and a lack of understanding of the scheme.

CHAPTER THREE

METHODOLOGY

3.0 INTRODUCTION

This study was conducted to assess the availability and utilization of National Health Insurance Scheme (NHIS) among urban and rural civil servants in Bauchi State. The steps followed are outlined in this chapter under the following sub-headings:

1. Research design.
2. Population for the study.
3. Sample and sampling technique.
4. Instrument for data collection.
5. Validity of instrument.
6. Procedure for data collection.
7. Procedure for data analysis.

3.1 RESEARCH DESIGN

The survey research method was used in this study. Bowling (1999) revealed that survey research enables the collection of detailed and factual information. Survey research also describes existing phenomenal and justifies current conditions and practices.

3.2 POPULATION FOR THE STUDY

The population for this study consisted of all civil servants (Local Government Employees, Teachers, Doctors, Nurses) in Bauchi State. The estimated population size is twenty nine thousand (29000), (Department for Local Government Federal Secretariat Bauchi, 2010).

3.3 SAMPLE AND SAMPLING TECHNIQUE

The total sample used comprised of five hundred and four (504) civil servants from the sampled Local Government Areas. This selection is in accordance with Roscoe (1969) who recommended five hundred (500) samples or more for researches in Social Sciences. The 504 was, however, to allow for equal number of samples in each of the Local Government Areas sampled. Sampling procedure used involved simple random sampling technique using the hat-drawn sampling method to select 2 Local Governments from each of the three senatorial zones in Bauchi State, these include: Bauchi, Toro (Southern Senatorial Zone),Ganjuwa, Ningi(Central Senatorial Zone), Giade, Jama'are (Northern Senatorial Zone).The names of the Local Governments in each senatorial zone were written on slips of paper, the slips were folded and put in a container. After thorough reshuffling, the researcher, not looking into the container, dips his hand and picks one slip. He unfolds the slip and records the local government it contains. This process was repeated until he draws the required number of Local Governments in each of the senatorial zones. The selection from senatorial zones was done in order to ensure that the data collected provides unbiased, suitable close estimates of the characteristics of the sampled population pertaining the problem being studied. In view of the fact that all the selected Local

Government Areas have the same category of staff organizations, equal number of samples were allocated to them. Eighty four (84) samples were drawn from each of the six Local Government Areas sampled. Description of the three senatorial zones in Bauchi State, the Local Government Areas sampled and sample size of civil servants used are presented in table 3.3.1 below.

Table 3..3.1: Description of the three senatorial zones in Bauchi State, Local Government Areas sampled and sample size of civil servants used.

S/N	Senatorial Zone	Local Government Areas	Local Government Sampled	Sample Size Of Civil Servants Used
1.	Southern Senatorial Zone	Alkaleri Bauchi Bogoro Dass Kirfi Tafawa Balewa Toro	Bauchi Toro	84 84
2.	Central Senatorial Zone	Dambam Darazo Ganjuwa Missau Ningi Wargi	Ganjuwa Ningi	84 84
3.	Northern Senatorial Zone	Gamawa Giade Itas Gadau Jama'are	Giade Jama'are	84 84

		Katagun Shira Zaki		
	Total	20	6	504

The questionnaires were distributed to the civil servants available in their various departments at the time of visit. The samples were drawn from the executive officers, teachers, engineers, clerks, drivers, security men, doctors, nurses, messengers and labourers, in the departments of Agric and Natural Resources, Budget and Planning, Education and Social Development, finance, Personnel Management, Primary Health Care and Works and Housing, in proportion to the number of people in the departments.

3.4 INSTRUMENT FOR DATA COLLECTION

The instrument used in this study was a questionnaire developed by the researcher. The questionnaire consisted of four sections: section A contained four statements on personal data of the respondents; section B contained seven statements on availability of National Health Insurance Scheme health care services; section C contained thirteen statements on utilization of the National Health Insurance Scheme services; while section D contained five statements on access to National Health Insurance Scheme health care services. The instrument was a modified questionnaire developed from Umar (1999) and Mohammed (2008) to suit the purpose of this study.

3.5 VALIDITY OF INSTRUMENT

In order to ensure the content validity of the instrument, the researcher-structured set of questionnaire was submitted to five professional experts in the fields of Health Education, Exercise and Sport Science and Community Medicine for vetting so as to ensure their appropriateness, relevance and clarity.

3.6 PROCEDURE FOR DATA COLLECTION

To collect data for this study, a total of five hundred and four (504) questionnaires were distributed to civil servants in the six (6) Local Government Areas selected for study. The researcher employed the services of six research assistants (one research assistant from each of the Local Government Areas) in the distribution and collection of the questionnaire. The research assistants were drawn from among the Primary Health Care Workers in the Local Governments' Primary Health Care Offices. They were oriented on the purpose and nature of this study, and were trained in the techniques of administering the questionnaires. Completed copies of the questionnaire were retrieved the next day. The data analysis was based on the responses of the four hundred and eighty-eight (488) subjects whose questionnaires were correctly completed and returned.

3.7 PROCEDURE FOR DATA ANALYSIS

The statistical techniques that were used in analyzing the data collected for this study are:

a. Descriptive statistics of frequencies, percentages, means and standard deviations.

b. Inferential statistics of t-test and Pearson Product Moment Correlation coefficient analysis were used to test the hypotheses. All tests were carried out at the 95% confidence interval.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.0 INTRODUCTION

The purpose of this study was to assess the availability and utilization of National Health Insurance Scheme (NHIS) among urban and rural civil servants in Bauchi State. To achieve this purpose, the data collected were statistically analyzed at the data processing unit of the Institute for Agricultural Research (IAR) of Ahmadu Bello University, Zaria. The items scores ware based on the five (5) points Likert Scale The relative means for each of the items were calculated with 5 as the highest and 1 the lowest score with 3 as the mid point between the two extremes of agree and disagree. Thus the criterion or acceptance mean of 3.50 was used in making decisions. If the relative mean of an item is equal to or greater than 3.50, it is considered that the respondents are in agreement with the suggested item while any mean less than 3.50 implies disagreement. The demographic variables are presented in frequencies and percentages while all other items are represented by their mean scores as expressed by the respondents. The corresponding standard deviations for each of the items are also shown in the respective tables. t-test statistics and Pearson product moment correlation coefficient statistical analysis were used to test the hypotheses at 0.05 level of significance and appropriate degrees of freedom. The results are presented and discussed in this chapter according to the hypotheses stated in chapter one.

4.1 PRESENTATION OF DEMOGRAPHIC VARIABLES.

Demographic variables are considered in this section, these include: age, higher educational qualification, staff department and location of the respondents. Table 4.1below shows the demographic characteristics of the subjects involved in the study.

TABLE 4.1 Demographic Characteristics of Respondents

Variable	Category	Frequency	Percentage
Age	20-24 years	41	8.4
	25-29 years	64	13.1
	30-34 years	45	9.2
	35-39 years	117	24.0
	40-44 years	144	29.5
	45 years and above	77	15.8
	Total	488	100
Higher Educational Qualification	Primary school leaving certificate	17	3.5
	WASC/GCE/SSCE/TC II.	100	20.5
	NCE/OND	153	31.4
	B.SC/B. ED/B.A/HND	190	38.9
	Others	28	5.7
	Total	488	100
Staff Department	Agric and Natural resources.	60	12.3
	Budget and planning.	40	8.2
	Education and social development.	150	30.7
	Finance.	42	8.6
	Personnel management.	59	12.1
	Primary Health Care.	84	17.2
	Works and Housing.	53	10.9

	Total	488	100
Location	Urban Area. Rural Area.	239 249	49.0 51.0
	Total	488	100

Table 4.1 above shows that 41 (8.4%) of the respondents were between the ages of 20 and 24 years, and 64 (13.1%) of them were between the ages of 25 and 29 years. 45 (9.2%) of the respondents were between the ages of 30 and 34 years, and 117 (24.0%) of them were between the ages of 35 and 39 years. 144 (29.5%) of the respondents were between the ages of 40 and 44 years, while 77 (15.8%) of them were within the age of 45 years and above.

The educational qualification of the respondents ranged from primary school leaving certificate to B.Sc/B.Ed/B.A/HND, and others. 17 (3.5%) of the respondents had Primary School Leaving Certificate. 100 (20.5%) had O'level Certificate which were either WASC, GCE, SSCE or TC II. 153 (31.4%) had NCE/OND. 190 (38.9%) of the respondents had Bachelors degree which were either B.Sc, B.Ed. B.A or HND, while 28 (5.7%) had other kinds of degree which were either MBBS, M.Sc, M.Ed or M.A.

Among the civil servants under study, 60 (12.3%) were from the Department of Agric and Natural Resources. 40 (8.2%) of the respondents were from Budget and Planning Department; 150 (30.7%) were from Education and Social Development Department. 42 (8.6%) of the respondents were from Finance Department, and 59 (12.1%) were from Personnel Management Department; 84 (17.2%) of the respondents were from Primary Health Care Department, while 53 (10.9%) of the respondents were from Works

and Housing Department. Out of the 488 subjects, 239 (49.0%) were from urban areas, while 249 (51.0%) were from rural areas.

4.2 AVAILABILITY OF NATIONAL HEALTH INSURANCE SCHEME SERVICES

Availability of a complete health care system is an important determinant of health services utilization. Availability within the context of this study refers to the fact that the people have an identified health care centre or facility where NHIS services are provided to them and that when these services or care is sort, it is regularly seen to be there. Table 4.2 provides information on the respondent's responses to statements on availability of National Health Insurance Scheme services.

Table 4.2: Respondents responses on availability of National Health Insurance Scheme Services

s/n	Availability of National Health Insurance Scheme services	Mean	Standard deviation
1.	National health insurance scheme health care services are available in my district.	3.86	0.979
2.	The identified health care service centers are functional.	3.99	0.761
3.	Hours of service delivery at the health care centres are adequate.	3.40	1.010
4.	Health personnel at the health care service centres are adequate.	2.75	0.938
5.	Health personnel at the health care service centres are always present	2.99	0.930
6.	Vaccines and drugs are adequately available at the health care service centres	2.77	0.870
7.	Social amenities such as electricity and water supply are available at the health care service centres	3.59	1.119

	Aggregate mean score	3.34	0.944

The mean scores shown in table 4.2 above are based on the five points Likert Scale. The table shows that item number 2 had the highest mean score (3.99) which indicates that the respondents are in agreement with the idea that the respective NHIS health care service centres are functional (working/useful). Next to item 2 is item number 1, which had a mean score of 3.86, which indicates that NHIS services are available in the respondents senatorial districts. This is followed by item number 7, with a mean score of 3.59, which indicates that the respondents agreed that social amenities such as electricity and water supply are available at the respective NHIS service centres in Bauchi State.

For all other items, the mean scores were relatively less than 3.50, which imply that the respondents disagreed with the suggested items. Among these were item 3, with a mean score of 3.40, indicating that hours of service delivery at the NHIS health care centres are inadequate; item 5, with a mean score of 2.99, which indicates that health personnel at the health care service centres are not always present at their respective service centres; item 6, which had a mean score of 2.77, indicating that vaccines and drugs are inadequately available at the respective health care service centres; and item number 4, with a mean score of 2.75, which indicates that health personnel at the identified health care service centres are inadequate.The aggregate mean score of 3.34 indicates that National Health Insurance Scheme Services are not readily available to most of the respondents at all times of their needs at the respective health care centres.

4.3 UTILIZATION OF NATIONAL HEALTH INSURANCE SCHEME

Certain basic elements are present in any complete health care system. That a complete range of services exists does not necessarily mean that those services will be used, let alone used well. There are certain factors in users, in the providers of health care services, and in society in general that directly affect utilization of services once they exist. Unless these important factors are considered, an ideal system of health care services such as the National Health Insurance Scheme could be designed and implemented but might never have the impact it should on the health of the community or population it is meant to serve. Table 4.3 shows the respondents views on utilization of National Health Insurance scheme.

Table 4.3: Respondents view on Utilization of National Health Insurance Scheme.

S/n	Utilization of National Health Insurance Scheme	Mean	Standard deviation
1	I am registered in the National Health Insurance Scheme	4.11	1.058
2	My children/dependants are registered in the National Health Insurance Scheme	3.78	1.127
3.	After my registration for health insurance I and my family/dependants always go to the hospital when sick	3.64	1.040
4.	I receive attention by the health care workers at any time when I go to the hospital	3.31	1.058
5.	I and/or my family have used the following health care benefits package in the past one year:		
i.	Out-patient care and prescribed drugs (that are in the Essential Drug List) only.	3.17	1.071

ii. iii	In-patient, out-patient, and preventive care including specified consumables only. In-patient, out- patient, preventive, dental and eye care with other specified consumables.	3.11 2.59	0.999 0.806
6.	I collect all or most of my drugs in the hospital.	3.15	1.000
7.	Prescribed drugs are always available at the time of collection in the pharmacy store within the hospital premises.	2.92	1.045
8.	I undergo all my diagnostic tests as requested by the doctor when sick.	3.93	0.906
9.	The health care services are affordable	3.80	0.575
10.	The health care services are acceptable to me	3.72	0.761
11.	Cultural/religious belief influences my use of the health care services	2.52	1.173
12.	Long travelling distance to the identified health care centre prevents my use of the services when sick	2.40	0.991
13	Long waiting time at the identified health care centre prevents my use of the services when sick	2.92	1.116
	Aggregate mean score	3.775	1.133

Table 4.3 above shows that item number 1 had the highest mean score (4.11), which indicates that most of the respondents are registered in the National Health Insurance Scheme. Next to item 1 is item number 8, with a mean score of 3.93, indicating that the respondents undergo all of their diagnostic tests as requested by the doctor when sick. An examination of the table shows that the mean score of item number 9,2,10 and 3 (3.80, 3.78, 3.72 and 3.64 respectively) are all on the agreement side of the scale used in the instrument for the study, which indicates that the NHIS health care services are affordable

to the respondents; the respondents' children/dependants are registered in the National Health Insurance Scheme; the health Care Services are acceptable to the respondents; and the respondents and their family/dependents always visit the identified health Care Centre (hospital) when sick or ill after their registration for the health insurance scheme.

It is evident from the table that the mean scores of all other items were relatively less than the criterion or acceptance mean of 3.50, which imply that the respondents disagreed with the suggested items. These include item number 4, which had a mean score of 3.31, indicating that not all the time the respondents visited the identified NHIS health care service centre they received attention by the health care workers; item 5i, with a mean score of 3.17, which indicates that the respondents made little or no use of the out-patient care in the past one year. Item number 6, which had a mean score of 3.15, indicating that the respondents do not collect all or most of their drugs in the hospital; item 5ii, with a mean score of 3.11, which indicates that the respondents made little or no use of the in-patient and preventive care services in the past one year. Item number 7 & 13, which had a mean score of 2.92 each, indicating that prescribed drugs are not always available at the time of collection in the pharmacy store within the hospital premises, and long waiting time at the identified health care centres does not prevent the respondents' use of the health care services when sick; item 5iii, with a mean score of 2.59, which indicates that the respondents made little or no use of a combination of in-patient, out-patient, preventive , dental and eye care with other specified consumables in the past one year. Item number 11, which had a mean score of 2.52, indicating that cultural/religious belief does not influence the respondents' use of the health care services; and item 12, with a mean score of 2.40, which indicates that long travelling distance to the identified health care service centres

does not prevent the respondents' use of the services when sick. The aggregate mean score of 3.775 indicates that most of the respondents use the National Health Insurance Scheme.

4.4 ACCESS TO NATIONAL HEALTH INSURANCE SCHEME SERVICES

Physical access variables are strong determinants in utilization of health care services. Although access can be viewed from various perspectives, this study, however, focused on physical dimensions. Distance/location, that is, the time it takes to get to the identified health care centre, the transport facilities, service time, as well as the manner and attitude with which services are offered formed the criteria for assessing the physical accessibility. Table 4.4 provides information on the respondents' responses to statements on access to National Health Insurance Scheme Services.

Table 4.4: Respondents responses on access to National Health Insurance Scheme health care Services.

S/n	Access to National Health Insurance Scheme health care services	Mean	Standard deviation
1.	National Health Insurance Scheme health care service centre is not too far from your home.	3.62	0.932
2.	There are access road networks to the health care service centre.	3.73	0.810
3.	There is adequate transportation to the health care service centre.	3.74	0.819
4.	Health care personnel at service centres are friendly, helpful and considerate.	2.96	0.891
5.	Time when services are offered is convenient and satisfactory.	3.06	0.929
	Aggregate mean score	3.422	0.876

With regard to access to National Health Insurance Scheme health care Services, table 4.4 above shows that item number 3 had the highest mean score (3.74), which indicates that the respondents agreed that there is adequate transportation to the respective NHIS health care service centres. Item 3 is closely followed by item number 2, with a mean score of 3.73, which indicates that there are access road networks to the identified health care service centres. Next to item 2 is item number1, which had a mean score of 3.62, indicating that the respondents agreed that the NHIS health care service centres are not too far from their home. For all other items, the mean scores were relatively less than the criterion or acceptance mean of 3.50, which imply that the respondents disagreed with the suggested items. These include item number 5, which had a mean score of 3.06, indicating that the respondents are of the opinion that service time at the identified health care centres are neither convenient nor satisfactory; and item number 4, with a mean score of 2.96, which indicates that health care personnel at the respective service centres are not friendly, helpful or considerate in their attitude towards the respondents. The aggregate mean score of 3.422 indicates that most of the respondents do not receive NHIS health care services easily at all times of need.

4.5 TEST OF HYPOTHESES

This study has one major hypothesis and three sub-hypotheses on the Availability and Utilization of National Health Insurance Scheme. The t-test statistical technique and Pearson product moment correlation coefficient analysis were used to test them at 0.05 alpha level and relevant degrees of freedom. The results are presented according to each of the hypothesis stated.

4.5.1 Major Hypothesis

There is no significant difference between urban and rural civil servants in their opinion on the availability and utilization of National Health Insurance Scheme services among civil servants in Bauchi State.

4.5.2 Sub-Hypothesis 1

There is no significant difference between rural and urban civil servants in the availability and utilization of National Health Insurance Scheme Services in Bauchi State.

To test this hypothesis, t-test was used for the difference between rural and urban civil servants in the availability and utilization of National Health Insurance Scheme Services. The use of this procedure was informed by the need to test for differences between the means of two independent variables. t –test, according to Roscoe (1969), is the most suitable statistical method for this purpose.

Table 4.5.2: t- test results of differences between rural and urban civil servants in the availability and utilization of National Health Insurance Scheme Services.

Variable	Location	N	Mean	Std. Deviation	Std. Error	t-value	Df	P	t-Crit.
Availability and utilization of National Health Insurance Scheme services	Rural area Urban area	249 239	3.0826 3.6013	0.64085 0.52657	0.04061 0.03406	9.747	486	0.000	1.960

t (486)= 1.960 ≤ 0.05 Significant

Examination of table 4.5.2 indicates that the availability and utilization of National Health Insurance Scheme Services differ significantly between rural and urban civil servants in Bauchi State. This is because the observed t-calculated (9.747) is greater than the critical value (1.960). The null hypothesis is therefore rejected.

4.5.3 Sub-Hypothesis 2

Utilization of National Health Insurance Scheme Services is not significantly influenced by cultural/religious belief among urban and rural civil servants in Bauchi State.

This hypothesis was also tested with the t-test statistical technique because of the same reason advanced for its use in sub-hypothesis 1. Table 4.5.3 shows results of the t-test analysis.

Table 4.5.3: t-test results of the influence of cultural/religious belief on utilization of NHIS services among urban and rural civil servants in Bauchi State

Variable	Location	N	Mean	Std. Deviation	Std. Error	t-Value	Df.	P	t-Crit.
Influence of cultural/religious belief on utilization of NHIS services among civil servants	Rural area Urban area	249 239	3.1379 3.4112	0.38813 0.42091	0.02460 0.02723	7.460	486	0.000	1.960

t (486) =1.960 $P \leq 0.05$. Significant

Information on table 4.5.3 above shows that from the results of t-test conducted, a calculated value of 7.460 was obtained. This value is found to be significant at 0.05 alpha level. This result is an indication that utilization of National Health Insurance Scheme services is significantly influenced by cultural / religious belief among civil servants in Bauchi State ($t \leq 0.05$). The observed t-calculated (7.460) is greater than the critical value (1.960). The null hypothesis is therefore rejected.

4.5.4 Sub-Hypothesis 3

Utilization of National Health Insurance Scheme health care Services among urban and rural civil servants in Bauchi State is not significantly influenced by access to the health care services.

To test this hypothesis Pearson product moment correlation coefficient was used for correlation between utilization of National Health Insurance Scheme Services and access to the health care services, the results of which are presented in table 4.5.4.

TABLE 4.5.4: Correlation coefficient between utilization of NHIS services and access to the health care services.

Variables	Mean	Std-Deviation	r - Cal.	Df	P	r - Crit.
Utilization of NHIS services	3.272	0.4266	0.413	486	0.000	0.087
Access to NHIS Health Care Services	3.423	0.5659				

r (486) = 0.087 P ≤ 0.05 Significant

The result as indicated in table 4.5.4 above shows that utilization of National Health Insurance Scheme Services among urban and rural civil servants in Bauchi State is significantly influenced by access to the Health Care Services (r ≤ 0.05). The observed r-calculated (0.413) is greater than the critical value (0.087). The null hypothesis is therefore rejected.

4.6 DISCUSSIONS

The findings of this study showed that there is significant difference between urban and rural civil servants in the availability and utilization of National Health Insurance Scheme Services in Bauchi State. This finding is in agreement with Umar (1999) and Andrew (2007). According to Umar (1999), reasons for the differences are related to differences in type of Health Care facility, the availability of professional personnel, functional equipment, and hours of service delivery. In line with the postulates of the central place theory, health care delivery facilities in Nigeria which are of three grades (primary, secondary and tertiary) can be conceived as constituting a hierarchical system with the tertiary facilities at the top, the secondary facilities in the middle and the primary facilities below. This hierarchical system is reflected in space by the geographical arrangements of service outlet in which a particular area tend to have numerous primary health facilities, much fewer secondary facilities and very few tertiary facilities if at all. There is generally a marked difference between urban and rural areas in Nigeria in terms of satisfying the threshold population requirements. Urban centres are known areas of high population concentration. Consequently it is easier for the threshold population requirements for the three tiers of health care facilities to be attained in most urban centres. The problem, however, is in the rural areas where settlements are quite small in terms of population size and transport facilities are poorly developed or non-existent. In most rural areas in Nigeria it is difficult and in most cases impossible to attain the minimum threshold population to provide secondary health care facilities. In such areas it is basically unrealistic to plan the provision of tertiary health care facility which will achieve the required efficiency in terms of the utilization of scarce resources (Andrew, 2007). Available

evidence from previous study (Umar, 1999) on differences between rural and urban areas in the availability of professional health personnel showed that the number of available manpower in the urban areas is higher than that of the rural areas. In a study of human resources development for primary health care, WHO (2000) found that the distribution of professional health personnel within developing countries is almost universally proportional to the distribution of the people and consequently outside the urban areas there are a few professional health personnel. Several key factors are attributable to the disparity in availability of health care professionals between rural and urban areas some of which include: availability of better infrastructure in urban areas; poor working conditions; and lack of an effective incentive system for rural services. As a way of attracting health workers to the rural areas, the World Health Organization (2000) suggested that adequate remuneration should be paid to workers in rural areas and they must have career structure with prospects for advancement. In addition, other forms of inducement, for example the provision of decent housing could be adopted. It is also important that health workers in the rural areas have the opportunity for advancing their knowledge, ambition and status within their respective functional roles.

According to Umar (1999) disparity in functional equipment is a function of an overall development policy which is largely oriented towards urban areas and economically advanced areas, as a result of which rural areas in general appeared to be underserved with functional equipment and health facilities. This is a pointer to some serious problems in health planning, particularly in developing nations, with their emphasis on increasing health facilities and equipment to reach certain global targets for a country as a whole, without paying attention to the more critical problems in the distribution over the various regions

and sections of the population. This trend must be revised if the goal of "Health for All" is to be attained in the nearest possible future.

Andrew (2007) reported that differences in hours of service delivery between rural and urban areas are attributable to differences in the availability of manpower, basic infrastructures and materials relevant for proper execution of health care services. Shortage in manpower, basic infrastructures and materials makes most Primary Health Care centres in Nigeria organize different activities on scheduled days while few others offer these services daily.

The result of this study also revealed that utilization of National Health Insurance Scheme Services is significantly influenced by cultural/religious belief among urban and rural civil servants in Bauchi State. This finding is in agreement with Mohammed (2008) who reported that cultural perception which may be due to religion or cultural norms is identified as a possible influential hindrance to Health Insurance in Nigeria. Utilization of health service is said to be a complex behaviour, determined by a wide range of interacting socio-cultural, organizational, consumer related and provider related factors all of which are hardly dissociable. Most studies on utilization of health services generally agree on determinants of utilization but often differ on the relationships between these determinants and utilization behaviour. Culture is usually assumed to affect health through such factors as health-related behaviours and beliefs. The concept of culture has been constantly used to draw boundaries and justify the inclusion or exclusion of people from prevailing social, economic and political activities and health care is not an exception. Culture has been a barrier in maintaining, giving and obtaining health care in many minority ethnic communities in many countries (Swendson and Windsor, 2004). Cultural background in the

form of beliefs, behaviour, perceptions, religion, attitudes to illness, pain and other forms of misfortune have either positive or negative consequences for health and health care delivery (Helman, 2001). Utilization of health care services varies across cultures for a variety of reasons. Unequal utilization of health care facilities may be based on cultural perception of illness.

The outcome of this study revealed that utilization of National Health Insurance Scheme Services among urban and rural civil servants in Bauchi State is significantly influenced by access to the health care services. Health service utilization is determined not only by its availability but by a number of other factors; place of residence has been an important factor in their utilization. Previous studies (Joseph and Philip, 2005; Welch and Larson, 2003) have implicated certain physical access variables as strong determinants in the use of services in some countries of the Eastern Mediterranean Region. Access to health care services is considered as the link between the health care system and the population it serves. Utilization is prove of access or is evidence that access has been achieved (Fiedler, 2003). The volume and type of services, whether or not the service can be reached, the cost of the services, the client's perceptions of the relative worth of the service and the acceptability of services provided, all influence access and the utilization of services (Penchansky and Thomas, 2001). A combination of sociodemographic and access variables that best predicted the choice of health care services, determined in a stepwise discriminant analysis procedure, showed distance as the best discriminant variable. This was followed by the participants education and age respectively (Penchansky and Thomas, 2001).

Numerous studies (Haynes, 2001; love and Lindquist, 2002; Welch and Larson, 2003) have shown that distance to health care services is inversely associated with utilization. Distance is clearly an important factor in utilization of health care services in most urban and rural areas of developing countries. Studies in Zaire (Haddad, and Fournier, 2005) have shown a close correlation between the proximity of health services and their use. The extent to which a health facility is used diminishes with the distance to be covered by the recipient of care. In other words, the farther one has to travel to reach a health facility, the less frequently one makes use of such services (Haddad andFournier, 2005). In Uganda the average number of visits to health facility declines by 60% for every two miles that people live from a health facility (Umar, 1999). De Allegri, Sanon, Bridges and Sauerborn (2005) noted that the use of traditional healers in several districts in Zambia is facilitated by physical inaccessibility factors. Dong (2003) also established a distinct correlation between the use of health service and its proximity to the people. Geographic access variable of distance is a special concern to many people who reside in rural areas. A distance decay effect in consumer travel behaviour is often found; that is, increasingly smaller proportions of populations use services at greater distances from them. The degree of distance decay varies by type of illness or illness severity, level in a service hierarchy, and various population characteristics.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 SUMMARY

The purpose of this study was to assess the availability and utilization of National Health Insurance Scheme (NHIS) among urban and rural civil servants in Bauchi State. The variables assessed were availability, accessibility and utilization of National Health Insurance Scheme Services. To achieve the purpose of the study, three research questions were raised; one major hypothesis and three sub-hypotheses were formulated. They were aimed at identifying differences in the availability and utilization of NHIS services between rural and urban civil servants in Bauchi State; the influence of cultural/religious belief on utilization of NHIS services among urban and rural Civil Servants in Bauchi State; and the influence of access to NHIS health Care Services on utilizations of the services among urban and rural Civil Servants in Bauchi State. Six Local Government Areas were randomly selected for this study from the three senatorial zones in Bauchi State. Four hundred and eighty-eight Civil Servants randomly selected from seven departments in each of the six Local Government Areas Sampled were involved in the study. A researcher-structured questionnaire was the instrument used for this study. The instrument was a modified questionnaire developed from Umar (1999) and Mohammed (2008) to suit the purpose of this study. The statistical techniques used in analyzing the data collected for this study were descriptive statistics of frequencies, percentages, means and standard deviations, and inferential statistics of t-test and Pearson product moment correlation

coefficient analysis were used to test the hypotheses. Major findings of the study revealed that:

1. There was significant difference between urban and rural civil servants in the availability and utilization of National Health Insurance Scheme Services in Bauchi State.
2. Utilization of National Health Insurance Scheme Services is significantly influenced by cultural / religious belief among urban and rural civil servants in Bauchi State.
3. Utilization of National Health Insurance Scheme Services among urban and rural civil servants in Bauchi State is significantly influenced by access to the Health Care Services.

5.2 CONCLUSION

On the basis of the findings of this study, the following conclusions have been drawn about the availability and utilization of National Health Insurance Scheme among urban and rural civil servants in Bauchi State:

1. The availability and utilization of National Health Insurance Scheme Services differ between urban and rural civil servants in Bauchi State. The disparity was considered to be a function of differences in type of health care facility, the availability of professional personnel, functional equipment, and hours of service delivery.
2. Cultural / religious belief affects utilization of National Health Insurance Scheme Services among urban and rural civil servants in Bauchi State.
3. Access to National Health Insurance Scheme health care services affect utilization of the services among urban and rural civil servants in Bauchi State.

5.3 RECOMMENDATIONS

In light of the findings of this study, the following recommendations are made:

1. Explicit consideration should be given to the need for equal distribution of health care facilities in the area. If secondary and to some extent primary health services are to be attracted and made functional in the rural communities, essential infrastructural services such as roads, water and transport, should be provided. This requires the participation of the Local Government authorities, the private sector, non-governmental organizations and the State Government agencies particularly those responsible for the development of the areas.
2. Measures such as giving adequate remuneration for rural services and provision of decent housing should be taken to expand the availability of professional health care personnel in rural areas.
3. The NHIS should undertake periodic redefining of policy and plans of operation vis-à-vis people's needs to enhance better utilization of the services among the civil servants.
4. The National Health Insurance Scheme needs to intensify its effort in public mobilization and enlightenment on the activities and significance of the scheme to help overcome/eliminate existing cultural/religious barriers in the use of the scheme among civil servants.
5. Access to health care services is the link between the health care system and the population it serves. Accessibility may be further improved by adding more health care centres in the rural areas to bring the services within walking distance of the population.

5.4 SUGGESTION FOR FURTHER STUDIES

It is suggested that a study be carried out on perceptions of the civil servants on National Health Insurance Scheme in Bauchi State. This will serve as a spring board to enable the redefining of policy and plans of operation where necessary in accordance with people's needs. The acceptance and active participation in the scheme will equally be enhanced. This is essential in order to meet the final goal (universal coverage) in line with the stated objectives of the scheme.

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APPENDIX I

Department of Physical and Health Education,

Ahmadu Bello University,

Zaria.

2nd June, 2010.

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Dear Sir/ Madam,

REQUEST TO VET QUESTIONNAIRE ON "AVAILABILITY AND UTILIZATION OF NATIONAL HEALTH INSURANCE SCHEME SERVICES AMONG CIVIL SERVANTS IN BAUCHI STATE"

Omachi Sunday is a post graduate student of this Department. He is developing an instrument on Availability and Utilization of National Health Insurance Scheme Services Among Civil Servants in Bauchi State to be used in his research.

In this regard he has prepared a number of statements reflecting dimensions and factors of utilization of National Health Insurance Scheme services, details of which are attached to the statements.

He has been asked to submit the list of statements to you for your critical evaluation and necessary suggestions. The Department would be grateful if you could extend your fullest cooperation to him in this regard.

Thank you in anticipation.

Yours' sincerely

Signed

Prof. J.A. Gwani

Supervisor

APPENDIX II

QUESTIONNAIRE FOR CIVIL SERVANTS

DEPARTMENT OF PHYSICAL AND HEALTH EDUCATION, AHMADU BELLO UNIVERSITY, ZARIA

The researcher is a Postgraduate student of THE above Department. In partial fulfillment of the requirements for the award of Master of Education Degree in Health Education, he is conducting a research on "Availability and Utilization of National Health Insurance Scheme (NHIS) Among Civil Servants in Bauchi State".

In this regard, he seeks your cooperation to honestly respond to the statements. Your responses should best describe your feeling to each statement relating to the research topic. All information provided will be used mainly for the purpose of this study and strictly treated confidential.

SECTTION A: PERSONAL DATA

Please tick (√) the column that is most appropriate to you.

1. Age

15 - 19 Years	[ ]
20 – 24 Years	[ ]
25 – 29 Years	[ ]
30 – 34 Years	[ ]
35 – 39 Years	[ ]
40 - 44 Years	[ ]
45 Years and above	[ ]

2. Higher Educational Qualification:

Primary School Leaving Certificate	[ ]
WASC/G.C.E/SSCE/TC II	[ ]
NCE/OND	[ ]
B.Sc./B.Ed/B.A/HND	[ ]

Others (Please specify)……

3. Staff Department:

Agric and Natural Resources	[ ]
Budget and Planning	[ ]
Education and Social Development	[ ]
Finance	[ ]
Personnel Management	[ ]
Primary Health Care	[ ]
Works and Housing	[ ]

Others (Please Specify)…….

4. Location:

Urban Area	[ ]
Rural Area	[ ]

SECTION B: AVAILABILITY OF NATIONAL HEALTH INSURANCE SCHEME SERVICES.

Please tick (√) the column that is most appropriate to you.

S/N	Availability of National Health Insurance Scheme services	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
1.	National Health Insurance Scheme health care services are available in my district.					
2.	The identified health care service centres are functional.					
3.	Hours of service delivery at the health care centres are adequate.					
4.	Health personnel at the health care service centres are adequate.					
5.	Health personnel at the health care service centres are always present.					
6.	Vaccines and drugs are adequately available at the health care service centres.					
7.	Social amenities such as electricity and water supply are available at the health care service centres.					

SECTION C: VIEWS ON UTILIZATION OF NATIONAL HEALTH INSURANCE SCHEME

Please tick (√) the column that is most appropriate to you.

S/N	Utilization of National Health Insurance Scheme	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
1.	I am registered in the National Health Insurance Scheme.					
2.	My children/dependants are registered in the National Health Insurance Scheme.					
3.	After my registration for the Health Insurance I and my family/dependants always go to the hospital when sick.					
4.	I receive attention by the health care workers at any time when I go to the hospital.					
5.	I and/or my family have used the following health care benefits package in the past one year: i. Out-patient care and prescribed drugs (that are in the Essential Drug List) only. ii. In-patient, out-patient, and preventive care including specified consumables only. iii. In-patient, out-patient, preventive, dental and eye care with other specified consumables (drugs).					
6.	I collect all or most of my drugs in the hospital.					
7.	Prescribed drugs are always available at the time of collection in the pharmacy store within the hospital premises.					
8	I undergo all my diagnostic tests as requested by the doctor when sick.					

9	The health care services are affordable.					
10	The health care services are acceptable to me.					
11	Cultural/religious belief influences my use of the healthcare services.					
12	Long travelling distance to the identified health care centre prevents my use of the services when sick.					
13	Long waiting time at the identified health care centre prevents my use of the services when sick.					

SECTION D: ACCESS TO NATIONAL HEALTH INSURANCE SCHEME HEALTH CARE SERVICES

Please tick (√) the appropriate column against each statement which best describes your feeling

S/N	Access to National Health Insurance Scheme health care services	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
1	National Health Insurance Scheme health care service centre is not too far from your home.					
2.	There are access road networks to the health care service centre					
3	There is adequate transportation to the health care service centre					
4.	Health care personnel at service centres are friendly, helpful and considerate					
5.	Time when services are offered is convenient and satisfactory					