THE KNOWLEDGE, OPINION AND ATTITUDE OF NIGERIAN CIVIL SERVANTS TOWARDS THE NATIONAL HEALTH INSURANCE SCHEME (NHIS) THE CASE OF SOKOTO STATE

BY

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DECLARATION

I hereby declare that this is an original work written by me and it is a record of my research work carried out under the supervision of Professor P. Singha of the Department of Community Medicine, Ahmadu Bello University, Zaria.

This work has not been presented in any previous application for the award of a higher degree.

The work of other colleagues on the field are acknowledged and referenced accordingly.



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CERTIFICATION

This project entitled: "The Knowledge, Opinion and Attitude of Nigerian Civil Servants Towards the National Health Insurance Scheme (NHIS): The Case of Sokoto State", meets the regulations governing the award of degree of Master of Public Health (MPH) of Ahmadu Bello University, Zaria.

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DEDICATION

This work is dedicated to the less fortunate members of our society who are desperately sick but cannot afford the cost of medical care.

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ABSTRACT

The central theme of this study is healthcare financing with focus on the Social Health Insurance system (National Health Insurance Scheme - NHIS) for Nigeria.

Like other developing countries of the world, the Nigerian government has been constrained in its effort to provide free healthcare services to its teeming population largely as a result of the global economic recession, Structural Adjustment Programme (SAP), IMF/World Bank imposed conditionalities of reduced public spending on social services (including health), and devaluation of the naira. These, coupled with a rapid population growth and political instability have resulted (over years) in a gradual decline in government expenditure on healthcare and an attendant deterioration of public healthcare services in terms of both quality and quantity.

This has reflected visibly on the health indices for Nigeria as evidenced by the high Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR) and the life expectancy at birth (55yrs).

In response to this, the Nigerian government was compelled to review its policy on

- healthcare financing and consequently introduced user charges in public health facilities in order to generate revenue for the health sector. Unfortunately, this effort failed, as the government could not (for equity reasons) fix user charges at levels high enough to generate substantial revenue for the sector.

Subsequently, a national health insurance system for Nigeria was seen and considered as a viable option to bring back to life our already bastardized healthcare system, thus the birth of the National Health Insurance Scheme (NHIS).

The NHIS was signed into law (May, 1999) and preparatory to take off, has embarked on public mobilization and enlightenment in order to create awareness on the scheme.

The NHIS is voluntary by design and has as major stakeholders, employers and employees of the organized formal sector whose level of awareness, opinion and attitude towards it are major determinants of success.

The Nigerian civil servants are probably the most important stakeholders, so also is their opinion and attitude towards the scheme.

It is in view of this that this study set out to assess the knowledge, opinion and attitude of civil servants in Sokoto State towards the scheme.

It took the form of a descriptive, cross - sectional intervention study employing focused group discussions and the Intensive Market Research Technique.

The first chapter gives an introduction to the subject and the National Health Insurance Scheme. It also tries to justify the relevance of the study.

Chapter two gives a theoretical discussion of the various forms of healthcare financing with emphasis on social health insurance. It reviewed the hlbtery of NHIS and described its structure and operation.

Chapter three is a description of the methodology while chapter four offers the results as obtained in the study

Chapter five is a discussion of the results, ending with a conclusion and recommendation.

By way of focused group discussions, the study revealed a very low level of knowledge (awareness) on the NHIS among the civil servants in Sokoto State.

Following an intervention with education materials aimed at creating awareness on the NHIS among these civil servants, the Intensive Market Research Technique was employed to assess their opinion and attitude towards the scheme.

The outcome revealed a very high receptivity and acceptability of the scheme among them. It also identified, grade level and family size as potent factors which may shape the opinion and attitude of civil servants towards the scheme.

LIST OF APPENDICES

i. Nigerian infant, child and maternal mortality rates (1981 – 1983) compared with some African and industrialized countries.

ii. International Comparisons of some dimensions of health, finance and status.

iii. Budgetary allocation to Health at Federal level (Nigeria) 1980 – 1994

iv. External Assistance to Health in Nigeria.

v. Aid contribution as a percentage of total healthcare expenditure for some African countries.

vi. Basic Data on Sub – Saharan Africa relevant to the Health Sector.

vii. Summary of Health Insurance Schemes in Sub – Saharan Africa.

viii. Characteristics of Countries' Social Health Insurance Schemes

ix. Morbidity and Mortality statistics for Sokoto State (1996 – 1999)

x. Healthcare facilities by category in Sokoto State (1999)

xi. Health Manpower by category in Sokoto State (1999)

xii. Organisational Structure (organogram) of the National Health Insurance Scheme (NHIS)

xiii. Education material on the NHIS

xiv. Questionnaire

LIST OF TABLES

A. DEMOGRAPHIC AND SOCIAL CHARACTERISTICS OF RESPONDENTS

Table I – Age – Sex Distribution of respondents

Table II – Frequency Distribution of Marital Status of Respondents

Table III – Frequency Distribution of Family Size of Respondents

Table IV – Frequency Distribution of Grade Level of Respondents

B. STATE OF HEALTH, PATRONAGE AND OPINION OF RESPONDENTS ON THE SERVICES IN HEALTH CARE FACILITIES

Table V - Frequency Distribution of State of Health of Respondents

Table VI - Frequency Distribution of Healthcare Facilities Patronized by Respondents

Table VII (a) - Frequency Distribution of the Opinion of Respondents on the Quality of care in Healthcare facilities

Table VII (b) - Frequency Distribution of the Opinion of respondents on the accessibility of Healthcare Facilities.

Table VII (c) – Frequency Distribution of the opinion of respondents on the availability of drugs and medical equipment in healthcare facilities.

Table VII (d) – Frequency Distribution of the opinion of respondents on staff attitude and waiting time in healthcare facilities.

C. HEALTH CARE EXPENDITURE, PAYMENT AND PERCEPTION OF RESPONDENTS ON COST OF MEDICAL CARE

Table VIII – Frequency Distribution of average monthly medical bill

Table IX – Frequency Distribution of payment of medical bills

Table X – Frequency Distribution of opinion of respondents on cost of medical care

as an obstacle to the use of medical services.

D. RESPONDENTS ATTITUDE, OPINION AND RECEPTIVITY TOWARDS THE NHIS

Table XI – Frequency Distribution of willingness to participate among respondents

Table XII – Frequency Distribution of the opinion of respondents on the 5% deduction from monthly gross earning.

Table XIII – Frequency Distribution of the opinion of Respondents on the Healthcare benefits to contributors.

Table XIV (a) – Frequency Distribution of the opinion of respondents on the potential of the scheme for success.

Table XIV (b) – Frequency Distribution of the opinion of respondents on the potential of the scheme for sustainability.

Table XV – Frequency Distribution of the opinion of respondents on the potential of the scheme to reduce / eliminate the inadequacies in our healthcare facilities.

Table XVI (a) – Frequency Distribution of the opinion of respondents on the potential of the scheme to protect families from huge medical bills.

Table XVI (b) – Frequency Distribution of the opinion of respondents on the potential of the scheme to improve the quality of care in healthcare facilities.

Table XVI (c) – Frequency Distribution of the opinion of respondents on the potential of the scheme to improve access to healthcare facilities.

Table XVI (d) – Frequency Distribution of the opinion of respondents to improve staff attitude and waiting time.

E. DEMOGRAPHIC, SOCIAL CHARACTERISTIC AND STATE OF HEALTH OF RESPONDENTS AGAINST OPINION AND ATTITUDE

Table XVII – Age structure of Respondents against willingness to participate

Table XVII – Family size of respondents against willingness to participate

Table XIX – Marital status of respondents against willingness to participate

Table XX – Grade – level of respondents against willingness to participate

Table XXI – State of health of respondents against willingness to participate

Table XXII – Age structure of respondents against opinion on 5% deduction from monthly gross earnings.

Table XXIII – Marital status of respondents against opinion on 5% deduction from monthly gross earnings.

Table XXIV – Family size of respondents against opinion on 5% deduction from monthly gross earning.

Table XXV – Grade level of respondents against opinion on 5% deduction from monthly gross earnings.

Table XXVI – Age structure of respondents against opinion on healthcare benefits to contributors.

Table XXVII – Marital status of respondents against opinion on Healthcare benefits to contributors.

Table XXVIII – Family size of respondents against opinion on healthcare benefits to contributors.

Table XXIX – Grade level of respondents against opinion on healthcare benefits to contributors.

Table XXX – State of health of respondents against opinion on healthcare benefits to contributors.

TABLE OF CONTENTS

Title page..... i
Declaration..... ii
Certification..... iii
Dedication..... iv
Acknowledgement..... v-vi
Abstract..... vii-ix
List of appendices..... x
List of tables..... xi-xiii
Table of contents..... xiv-xv

CHAPTER ONE

1.1 Introduction..... 1-2
1.2 History of medical services in Nigeria..... 2-4
1.3 Problems with medical services in Nigeria..... 4-5
1.4 Factors responsible for the current state of public health services in Nig.... 6-9
1.5 History of the National Health Insurance Scheme in Nigeria..... 9-11
1.6 Aim..... 12
1.7 Objectives..... 12

CHAPTER TWO

2.0 Literature Review..... 13
2.1 Introduction..... 13-14
2.2 Sources of finance for the health sector..... 14-18
2.3 Evaluation of framework for assessing ways of health care financing..... 18-19
2.4 Health insurance 19-22
2.5 Social health insurance..... 22-25
2.6 Advantages of social health insurance..... 25-26
2.7 Disadvantages of social health insurance..... 26
2.8 Prerequisites for a successful insurance scheme..... 26-28
2.9 Social health insurance in Nigeria (NHIS)..... 28-33

CHAPTER THREE

3.0 Methodology..... 34
3.1 Background to the study area..... 34-35
3.2 Materials..... 35-36
3.3 Methods..... 36-38
3.4 Data collection..... 38
3.5 Training of data collectors..... 38-39
3.6 Data analysis..... 39

CHAPTER FOUR

4.0 Results..... 40

CHAPTER FIVE

5.0 Discussions..... 66
5.1 Assessment of knowledge/awareness..... 66
5.2 Assessment of opinion and attitude..... 66-73
5.3 Conclusion..... 73-74
5.4 Recommendation..... 74

References..... 75-76

Appendices..... 77-96

CHAPTER ONE

1.1 INTRODUCTION

All over the world, the problem of health care financing has become a major policy issue confronting both the developed and the developing countries. While the former are struggling to contain the ever increasing cost of health care occasioned by advancing medical technology (2), the latter are pre occupied with ways / means to provide even the most basic health care services to their teeming population (3). For these (developing) countries which are mostly in Africa, Asia and Latin America, the basic problem is failure to finance health care with pervasive under funding and insufficiency of financial resources to provide minimally adequate health care for everyone who needs it (1). They have also failed to gain significantly from the advances in medicine which have made available all forms of technology for the delivery of promotive, preventive, curative and rehabilitative health care services. In most of these countries, health care services are in deplorable states; a condition that is mirrored pathetically on their health indices (2). One of the most important factors responsible for this, is the inadequacy of tax based revenue (inherited by these countries post – independence from colonial administration) as a source of funds for financing the already over burdened and bastardized public health care services. Fortunately, most of these countries have come to terms with this stark reality.

Appreciating the central role of health as a necessary ingredient for socio – economic development, and committed to the goal of health for all (HFA) by the year 2000 and beyond, the governments of these countries were forced to review their policies on health care financing in order to put in place more realistic, efficient and

sustainable sources of funds for the health sector. Various reform strategies were considered and adopted including among others: user fees, social health insurance etc.

The healthcare services in Nigeria share all the characteristic features of the pathetic state of services in other developing parts of the world. This however is not to say that these services have always been in this deplorable state. Certainly, during the first one or two decades post – independence when "Nigeria's problem was not money, but how to spend it" (Gowon) and when the population was 'manageable', services could be said to have been better organized and more effective in providing both preventive and curative health care services. The physical facilities albeit unevenly distributed and the quality of care in public health facilities for that time could be said to have been more acceptable than they are today.

The current state of medical services in Nigeria can be said to be a product of the interplay of a number of factors – social, political and economic which collectively resulted in a gradual deterioration of services in terms of access, quality of care and the state of physical facilities.

1.2 HISTORY OF MEDICAL SERVICES IN NIGERIA

The historical development of medical services in Nigeria was influenced chiefly by the evangelical activities of the missionaries and also by the colonial administration (9).

The first contact with European medical care can be said to have taken place towards the end of the first half of the fifteenth century through religious missions brought to Nigeria by the Portuguese in the process of their trading activities with the country.

The introduction of modern form of medical services into Nigeria was made possible by the adventurous voyages of Scottish doctors like Mango Park (1771 - 1806) and William Belfaur Baikie (1825 – 1864). The missionaries were however the first to establish organized medical care in Nigeria (7), building the first true hospital ever to be established in Nigeria in 1895. Services were given free to Nigerians as part of the evangelical activities of the missionaries.

The first government hospital was established in 1898 marking the beginning of government medical service which initially was organized to serve the British Army and the colonial administrators, but later gradually evolved by 1902 into a fully organized government medical service serving the whole civilian population irrespective of status or origin.

By independence (1960), government medical services were fully established with health care facilities in most parts of the country. Services (both preventive and curative) were offered free to the population and funded generally by way of tax – based revenue.

The period after independence (the seventies and early eighties) saw a rapid expansion in the government provided and funded services largely from the accruing

revenue from royalties and fees from the oil sector coupled with the favourable exchange rate of the naira.

1.3 PROBLEMS WITH MEDICAL SERVICES IN NIGERIA

Unfortunately, by early/late eighties, signs of inefficiency and ineffectiveness in the public health services were beginning to manifest and by the early nineties, public health facilities were already 'mere consulting clinics'. No doubt this problem has worsened over the years and today, it can easily be said that few (if any at all) health care facilities in the country are operating in ways and levels that they were initially intended.

The current state of public medical services in Nigeria was best described by Okoro sobo (8). According to him, healthcare services in Nigeria are characterized by:

- Hospitals, which are unable to function because of lack of staff or equipment.
- Shortage of drugs, dressing and other essential medical supplies.
- Poorly maintained (and poorly functioning) buildings, equipment, facilities etc.
- Transportation difficulties and immobile vehicles fleets caused by lack of spare parts and/or fuel.

Other problems with the public sector as recognized in the National Health Policy of 1996 (6) include:

- Inadequate coverage with only 54% of the population having access to modern health care services. The rural communities and the urban poor (who carry the biggest burden of disease) are greatly underserved.

- Poor and weak management of services resulting in waste and inefficiency as shown by the failure to meet targets and goals.

All these have resulted in reduced efficiency, reduced service quality, reduced service quantity, reduced confidence in the public sector facilities, with consequent low utilization, a shortened life span of capital investments due to poor maintenance and low morale amongst staff with consequent absenteeism and high turnover.

These problems have also reflected on the health status of Nigerians as evidenced by the following health indices which compare unfavourably with the indices in some African and industrialized countries (see appendix 1).

- Crude Death Rate (CDR) = 15 per 1000
- Infant Mortality (IMR) = 91 per 1000 live births
- Maternal Mortality Rate (MMR) = 8 per 1000 live birth
- Life expectancy at birth = 55 years
- Under five Mortality Rate (U5MR) = 191 per 100,000 live birth

Source: Nigeria Basic Health indicators 1994/95 (Health in Nigeria 1994/95) (9).

As earlier mentioned, a number of factors have been identified to account for this sorry state of services in Nigeria. These are discussed below.

1.4 FACTORS RESPONSIBLE FOR THE CURRENT STATE OF PUBLIC MEDICAL SERVICES IN NIGERIA

(a). Gross under – funding of Public Health Services.

Nigeria stands out among the nations of the world (including developing countries) as one particular country with an unacceptably low level of expenditure on health care (14). This position was clearly established in UNICEF's Health of the Nations for 1993 (see appendix II).

All the available data reveal glaringly gross underfunding of the public health sector as reflected in the very low proportion of total federal expenditure devoted to health. The share of the health sector in percentage terms ranged between 1.1% and 4.4% from 1980 – 1994 (8). Although nominal allocations have grown in absolute terms, expenditures in real terms have declined sharply by as much as 50% between 1980 – 1992 and the percentage of the Gross National Product (GNP) allocated to health has consistently remained below the minimum 5% recommended by WHO (see appendix III & IV).

This pattern of public expenditure on health has been attributed to the global economic crisis / recession of the eighties with its attendant increasing debt burden on the country, IMF/World Bank conditionalities of devaluation of the naira, decreased public expenditure on social services including health (3). In effect, a significant percentage of government earnings is used towards debt servicing. This coupled with the weak purchasing power of the naira and reduced allocation to the health sector, made it difficult or impossible for the government to carry out any meaningful expansion or even maintain available facilities. The government has also

not been able to afford the provision of the much needed medical equipment, drugs, vaccines, vehicles etc which unfortunately are import dependent and require foreign exchange.

(b). Population Growth

Nigeria with a population growth rate of 2.83% and population doubling time of 25yrs as a result of high fertility - 5.8 per woman (9), has witnessed a very rapid growth of its population over the past two to three decades.

Estimates put the population of Nigeria in 1985 at 98.1 million and if the current fertility rate should persist, the figure would rise to 162.6 million by this year, 280.7 million by 2015 and 501.4 million by 2030 (5).

Besides the increase in absolute number of the population, there is also an increase in the number of high health risk person's i.e. children under 5 yrs and women in child bearing years, (4) and (2).

This population growth has unfortunately not been accompanied by a corresponding expansion in the existing facilities and services as result of which they are over stretched at the expense of service quality and quantity.

(c). Changing Disease Pattern

As standards of living, urbanization and industrialization in Nigeria increase, so also does the incidence and prevalence of chronic illnesses (diseases of urbanization – diabetes, hypertension, cancers, coronary heart disease), road traffic and industrial

accidents, crime etc. There is also the problem of emerging and re – emerging infections particularly the HIV / AIDS scourge whose socio – economic impact cannot be over stated.

These add significantly to the financial burden on the already over stretched public health services.

(d). <u>Political Instability</u>

This has had a crippling effect on efforts at developing the healthcare services in Nigeria over the past years. Different governments come with them, different polices and plans for the health sector and in view of the frequency of change in government and the resulting inconsistencies, a number of social services including health suffer.

Successive governments of Nigeria have responded to these problems partly by an intensive action to control the rapid population growth (as contained in the National Population Policy – 1988) and also by considering alternative sources of funding for the healthcare services in order to make them more effective, efficient and responsive to the needs of Nigerians.

Among the options considered for financing health care services are cost – recovery and cost – sharing mechanisms with the introduction of user charges in public facilities and the introduction of a national health insurance system respectively.

User charges were introduced in public facilities considering the willingness to pay for health care services (of acceptable quality) by Nigerians as evidenced by the

patronage enjoyed by the private –for – profit health care providers, out-of-pocket payment made to purchase drugs and even payment for traditional medical practices. This alternative unfortunately failed to generate adequate funds required for improved service quality to justify user fees and therefore, maintain utilization. Many writers including (17 and 18) have attributed this failure to the government's unwillingness for equity reasons to fix user charges at a level high enough to ensure cost recovery and therefore maintain service quality.

Realizing the inadequacy of user charges as alternative funding strategy in addition to its equity implication, the issue of a national health insurance system for Nigeria came high on the agenda of health care financing reforms.

1.5 HISTORY OF THE NATIONAL HEALTH INSURANCE SCHEME IN NIGERIA

The first search for a health insurance system in Nigeria actually started in 1962 during the first republic. The then federal government invited Dr. Halevi through the International Labour Organization (ILO) to look into starting a health insurance system in Lagos. Dr. Halevi supported the system but the issue stopped there largely due to opposition from the NMA (Nigerian Medical Association).

The matter was resuscitated by the National Council on Health (NCH) in the early eighties. The ministry of health on the advice of the NCH commissioned a study led by Professor Diejomaoh of the Nigerian Institute for Social and Economic Research (NISER) in 1984. This was later followed in 1985 by a feasibility study chaired by Mr. Yinka LiJadu of the National Insurance Corporation of Nigeria (NICON), which found the scheme feasible, workable and desirable in Nigeria. Finally, in 1988, the

national committee on the establishment of the National Health Insurance Scheme (NHIS) chaired by Dr. Emma Umez – Eronini recommended the capitation model as it is easy to run and almost tailor made for our health system (12).

The reports of these committees were reviewed by a collaborative effort of a number of working parties with assistance from the ILO and UNDP. The result of this effort was a draft legislation and implementation guidelines for establishing the scheme in 1992.

Finally, the Federal Executive Council (FEC), which had given its approval in 1989, directed the Federal Ministry of Health in 1993 to start the scheme. This however has not been possible since the draft degree establishing the scheme was signed only in May 1999 by the then Military Head of State.

The scheme has presently embarked on intensive public enlightenment campaign targeting all stakeholders. Special effort is being made to enlighten the general public particularly employers and employees, of the organized formal sector who constitute a special group among the stakeholders. In addition, the scheme has embarked on advocacy at various levels in order to gain the support of all the stakeholders.

The scheme has currently, started an in – house pilot – testing of the programme in preparation for the official take – off which date is yet to be fixed.

The National Health Insurance Scheme for Nigeria has been structured to be a voluntary health insurance and private sector driven with Health Maintenance

Organizations (HMO's) playing a central role in the collection of contributions and health care provider payment.

On take – off, coverage will initially be limited to public sector employees, and employees of private establishments with more than ten (10) people. This will however expand later to cover the self-employed, the vulnerable etc.

The scheme shall operate with the NHIS assuming a central controlling, regulating and coordinating function overseeing the overall operation of the programme including quality control of healthcare providers.

Considering the 'voluntary' design of the NHIS, one can confidently say that the success or otherwise of the scheme depends a lot on the level of awareness and the attitude of stakeholders particularly employers and employees of the organized formal sector. This is what informed the effort of the NHIS to mobilize and enlighten the general public on the scheme and in effect, to shape their attitude for a successful take off and implementation.

The impact of this effort by the NHIS especially as it relates to the knowledge and attitude of stakeholders needs to be evaluated.

It is against this background that this study sets out to achieve the under listed.

1.6 AIM

- To assess the knowledge / awareness among civil servants in Sokoto State on the National Health Insurance Scheme (NHIS).
- To assess the general opinion and attitude of these civil servants toward the scheme.

1.7 OBJECTIVES

- To assess the level of knowledge among civil servants on the NHIS.
- To determine the opinion and attitude among civil servants towards the NHIS.
- To create awareness among civil servants on the NHIS.
- To identify factors that may influence the opinion and attitude of civil servants towards the scheme.
- Make appropriate recommendations.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 INTRODUCTION

During the 1980's, the cost and therefore the financing of healthcare moved high on the agenda of discussions of health policy. The subject was discussed at the Executive Board of the WHO in 1986, at the World Health Assembly (WHA) and the Commonwealth Health Ministers Conference in 1986 and was made the subject of the technical discussions at the WHA in 1987. The main concern particularly for the developing countries was how to maintain expenditure and if possible increase it to implement Health for all policies (3).

Clearly, these (developing countries) have been unable to allocate sufficient resources to the health sector to satisfy basic needs. This has necessitated the need to identify the various methods and options available to them in their search for generating more funds for health care services (1).

In response to this, so much has been said and written by experts on the subject. Individual governments with technical assistance from international agencies such as ILO, WHO, UNDP etc have constituted expert groups to consider options available to them.

Looking at the available literature, one can identify a number of broad policy options, which developing countries may consider in reducing the gap between plans and resources. Some of these include:

- Mobilizing additional resources from outside the health sector by increasing public expenditure (very unlikely) or by increasing external assistance.
- Mobilizing additional resources from inside the health sector.
- Increasing the efficiency with which existing resources are being utilized.
- Altering the organisational composition of the health sector and shifting responsibility for the provision of some services to the private sector.

These options either focus on relieving resource constraints by generating additional resources, or attempt to reduce problems by making better (more efficient, more effective) use of available resources.

Of concern to our discussion here are the policy options for government to generate additional resources for the health sector and attempt is therefore made to identify the various sources of finance available.

At this stage, it is important to note that no single country relies on only one source of finance, rather, the various sources are used in combinations to complement each other particularly since this ensures that both equity and efficiency goals are achieved. In addition, a diversity of sources has a stabilizing effect on the economy as a whole and allows better adaptation to the diverse economic and cultural conditions of the country.

2.2 SOURCES OF FINANCE FOR THE HEALTH SECTOR

There are basically, four principal sources of finance for the health sector.

These include:

a. Health Insurance

b. Government

c. Private sources and

d. External sources

2.2.1 Health Insurance

This is one of the most popular financing reforms adopted or being considered by various developing nations of Africa, Latin America and Asia. It forms the central theme of this study and shall be discussed extensively in the latter part of this chapter.

2.2.2 Government Financing

This includes health expenditure of all levels of government, together with the expenditure of public corporations. It is particularly important as a source of finance for health care since it ensures the provision of health services with public – good characteristics i.e. those services that cannot be left to the market (e.g. sanitation, health education etc) as benefits are not confined to individuals.

In Nigeria the principal source of funds for government financing of public health services is the federal allocation to the health sector from the revenue generated internally by domestic tax, income tax, import and export duties, value added tax (VAT), etc and predominantly from the revenues accruing to government coppers from royalties and fees from the oil sector.

As discussed in chapter I, this source of finance for health is grossly inadequate in most developing countries including Nigeria and the prospect of mobilizing additional funds from it is very bleak.

2.2.3 Private Financing

This can be direct or in – direct.

2.2.3.1 Direct Private Financing:

This includes personal payment made directly to a wide range of providers including public and private practitioners, traditional healers and private pharmacists.

These payments (User – fees) whether for government provided or privately provided health services are out – of – pocket payments and are therefore considered as private health financing.

Unfortunately in most developing countries, this form of financing, has failed to raise substantial revenue, as consumers of healthcare find themselves unable to pay the full cost of services when they are needed (13) and for this reason, user charges are fixed at levels low enough to ensure patronage of public facilities.

For Africa as a whole, income from user fees averages less than 5% of government expenditures for health. In Mozambique for example, the total fee income was estimated in 1992 at less than 1% of total government expenditure (13).

In Nigeria, user fees in government institutions.... cannot, by any stretch of imagination be relied on to make a significant contribution to the growth of health services in the country (MOH Nigeria, 1993).

The major problem with this source of finance is its equity implication. Without an alternative funding mechanism for the poor, they are deprived of access to health care services due to their inability to pay for them.

2.2.3.2 Indirect Payment:

This is mainly payment for health care services by employers (e.g. payment by large and privately owned industrial complexes) and health financing by other non – governmental bodies such as local charity fund raising for health services.

2.2.4 External Source

This has become an important source of healthcare financing, especially in certain developing countries where governments have been unable to meet their health needs and commitments from internal sources. Funds usually come in the form of grants or loans (deficit financing). They principally consist of multilateral and bilateral aid donors and to lesser extent, non – governmental agencies. This source of finance can be substantial in Africa where up to 90% of the total public funding for health in a few countries and 20% in several more comes from external sources.

For Nigeria, (appendix iv) gives a breakdown of the total external assistance to health from various sources for the period 1988 – 1992. See also (appendix v) for

the aid contribution as a percentage of total local heath expenditure for other sub – Saharan Africa countries.

2.3 EVALUATION FRAMEWORK FOR ASSESSING METHODS OF HEALTHCARE FINANCING

To assist developing nations to review and therefore make informed choice from these various sources of health sector financing a WHO study group (15) has developed an evaluation framework which identified criteria to be used in the review of alternative financing mechanisms. These criteria are:

2.3.1 Level of Funding

This refers to the reliability of the financing mechanism as well as its ability to generate substantial resources for the health sector as well as its effect on existing financing mechanisms.

2.3.2 Efficiency

This involves a number of elements including technical and allocative efficiency. The former is concerned with whether services are provided at the lowest possible cost while the latter is concerned more with the outcome of health care process and whether resources are allocated appropriately among the various health care services. The other elements are administrative efficiency and quality of service both of which are in effect determined by both technical and allocative efficiency.

2.3.3 Equity

This concerns the impact of the financing mechanism on access to services by those in need regardless of income and geographical distribution. It also concerns the distribution of burdens among various groups (tax payer Vs user, rich Vs poor, healthy Vs sick etc).

2.3.4 Viability

This refers to the acceptability and sustainability of the financing mechanism and is determined mainly by the attitude of consumers, healthcare providers and in response, that of the government.

2.3.5 Health Impact

This refers to the potential of the mechanism to have a significant impact on the overall health status of the people.

2.4 HEALTH INSURANCE

Health insurance is a system in which 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 is a mixed source of finance as it often draws contributions from both employees and sometimes from government. Contributions to such schemes are often mandatory but may be designed to be voluntary. Four principle types of health insurance are identifiable (13). These include:

2.4.1 Government or Social Health Insurance

This usually provides compulsory or, to a lesser extent voluntary coverage for people employed in the formal sector. Premiums or contributions are generally based on the individuals income regardless of actuarial risk.

2.4.2 Private Health Insurance

This provides coverage for groups or individuals through third party payer institutions operating in the private sector. Premiums are charged based on an actuarial calculation of the incidence of disease and the use of services and not related to income.

2.4.3 Employer – Based Health Insurance

This falls between the first two forms of insurance. Under this arrangement, employers, parastatals or private bodies serve as the third party payer or collection agent, with eligibility based on employment status.

2.4.4 Community – Based Health Insurance

This is organized locally by the community, with premiums paid by households, covering both those in formal and non – formal employment.

Generally, health insurance has been seen as a way of allowing governments to diversify the sources of revenue for the health sector, to improve efficiency by giving individuals some role in paying their own healthcare, and to spread the burden of health care costs over time and across a wider population, which will reduce risk. The existence of risk is the fundamental rational for insurance. Health care costs

may be infrequent, but they are potentially very high, this means that without insurance, individuals maybe unable to pay for healthcare even if they are willing to do so.

The origins of health insurance can be traced to medieval Europe when labour unions, associations of employers of labour and craftmen formed guilds, which in turn created funds to help members in times of needs on account of sickness. They started with cash benefits but later broadened the scope to request doctors to certify illness and paid them to provide healthcare for members. Overtime, the scheme became compulsory as employers in specific high-risk industries such as mining, began to make employment often tied together with willingness to pay contributions. With this, came the development of earnings – related contributions rather than risk related contributions.

The potential for such solidarity was exploited in Germany in 1883, Austria in 1887, Norway in 1902 and the United Kingdom in 1910. By the early 1930s, compulsory health insurance had been developed in most industrialized countries of Europe under the name of sickness and maternity insurance. (16).

Before the Second World War, private health insurance and social security in developing countries was mainly confined to some Latin American countries. By 1980s, out of 90 developing countries studied, 40 were using one or more forms of insurance to provide medical services (16). In a study in 1990 (16), six different forms of government insurance were identified in sub – Saharan Africa. This study found that formal insurance was available in only 7 out of 23 countries considered

and private sector voluntary insurance had a place in only five: Cote d'Ivore, Ethiopia, Kenya, Nigeria and Zimbabwe.

Increasingly, a number of African countries are contemplating increasing the role of risk sharing mechanism in the financing of healthcare. In most of these countries, the emphasis is on the introduction of various forms of "National Health Insurance" scheme designed to cover only some sectors of the population such as formal sector employees and members of agricultural co – operatives. In addition, various other forms of health insurance are currently being operated or considered (see appendix vii).

The National Health Insurance Scheme (NHIS) for Nigeria is a form of social health insurance thus justifying a more detailed discussion of the latter in the next part of this chapter.

2.5 SOCIAL HEALTH INSURANCE

This is a form of financing that pays for health services though contributions to a health fund. The most common basis for contributions is the payroll, with contributions from both employer and employees. Contributions are based on ability to pay and access to services depends on need. The health fund is usually independent of government, but works within a tight framework of regulations.

Social health insurance is based on mutual support and involves a transfer of resources from the relatively richer and healthier people to the relatively poor and

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sicker people. It works best when there is a consensus among the population that mutual support is a good thing (11).

According to (13) two types of scheme can be distinguished; the primary benefit model where health care benefits are financed by a specific health insurance contribution and the secondary benefit model where healthcare benefits are financed from general social security contributions which also cover other types of benefits. The International Labour Organization (ILO) classifies social (national) insurance schemes into three types:

2.5.1 Direct Insurance Scheme

Here, the national insurance scheme builds or rents its own premises exclusively for the use of insured persons and employs salaried professionals to work in them. This system is found in Sweden, Finland, Spain, Portugal, Israel, India and many countries in eastern Europe and Latin America. It has the advantage of ensuring continuity of medical records and where coverage of health insurance is high, the ability to service every aspect of the health of each local community by preventive, promotive and curative intervention. Its major weakness is the difficulty to ensure that patients obtain continuity of care by the same doctor on each visit.

2.5.2 Reimbursement

In this case, the patient buys his/her own medical care in private market and then sends the receipted bill to the insurer who reimburses the insured person, either for part of the full cost or on the basis of standard payments for particular services. This

system operates commonly in the USA and for services outside hospital in France and for hospital insurance in Philippines.

This system, provides completely unrestricted choice to the insured at the expense of continuity of care. Its greatest weakness is the escalation of costs due to duplicated and unnecessary services. In addition, there is no control on what the provider actually changes.

2.5.3 Indirect

Under this arrangement, the scheme makes contract with selected providers for the provision of defined services at negotiated prices. The insurer pays the provider according to the number of services he has provided or persons for whom he has provided them. This system is used in the minority of countries in Eastern Europe, in Japan, Korea, Indonesia, in parts of India and in Canada.

The National Health Insurance Scheme for Nigeria is designed to be indirect with healthcare providers (public and private) to be contracted out to give health care benefits to contributors.

Provider payment can take one of the following forms:

2.5.4 Fee - For - Service Payment

By this arrangement, doctors are paid by fee – for – service and the hospital by an itemized bill listing each drug, materials etc used.

The major weakness with this arrangement is that it encourages the provider to generate more and more service including those, which are unnecessary, of very limited value or even harmful.

2.5.5 Capitation Payment

This is generally suitable for general practitioners. In its pure and simplest form, each insured person chooses which doctor he wishes to register with. The doctor in return gets a monthly capitation payment (a payment per person negotiated whether they used the service or not) for giving such services as are necessary. Different forms of capitation payment operate in Denmark, the Netherlands, Italy, the United Kingdom and under Health Maintenance Organizations in the United States.

The National Health Insurance Scheme (NHIS) for Nigeria shall employ both types of provider payments; for specialist services (including laboratory services, drugs etc) and general practitioners respectively.

It is pertinent to note that there is no stereo – typed or standard design for a national health insurance scheme. Individual countries design their own insurance systems to suit their own socio – economic, cultural and political backgrounds.

Health insurance schemes in different countries usually differ in terms of the extent of coverage, benefit package, administration, health service delivery, provider payment and finance. See appendix viii for characteristic features of social health insurance in some African countries.

2.6 ADVANTAGES OF SOCIAL HEALTH INSURANCE

Charles Normand and Axel Weber (11) have identified the following as advantages of social health insurance as a form of healthcare financing:

- It can provide a stable source of revenue for services

- The flow of funds into the health sector is visible
- It can help to establish patient's rights as consumers of health care services.
- It combines risk pooling with mutual support, by allocating services according to need and distributing financial burdens according to ability to pay.
- It can operate in pursuance of government health policy goals, but it can maintain a degree of independence from government.
- It can be associated with efficient provision of services

2.7 DISADVANTAGES OF SOCIAL HEALTH INSURANCE

These include:

- High administrative cost
- Problem of cost containment
- Problem of ensuring coverage for workers in agricultural and the informal sector.

In view of the numerous advantages of social health insurance as a means of financing healthcare services, it has become a very attractive alternative for many developing countries thus informing the 'rush' by these countries to put in place a form of national health insurance system in order to put in shape their grossly inadequate, ineffective and inefficient health care systems.

2.8 PRE – REQUISITES FOR A SUCCESSFUL INSURANCE SCHEME

In designing and implementing national health insurance systems, Brian Abel Smith (3) has cautioned countries to ensure that certain pre – requisite conditions are being met in order to ensure success.

These conditions are listed below:

- There must be enough persons to cover with insurance. This is necessary to make the scheme viable and to take a noticeable load off the public sector health services.
- Services provided must be sufficiently attractive. Services must appear to insured persons worth paying for. A scheme is unlikely to work effectively if insured persons were offered exactly the same services as are available to those not insured.
- The scheme must be affordable. The scheme has to be affordable by employers and employees. It is very likely to have adverse effects if the scheme is designed without due consideration to the cost of its operation.
- The country must have the administrative capacity to operate the scheme efficiently. The success of the scheme will depend largely on the management capacity of those who are put in charge of it, the efficiency with which resources are utilized and how much corruption is put at check.
- There must be enough trained personnel. There must be sufficiently trained health workers in the country to provide services without robbing the services available to the rest of the population of staff, which they can ill afford to loose.

In addition, it is important to note that for countries wishing to establish voluntary insurance schemes; of utmost importance is the need to adequately educate the public targeting particularly the major stakeholders (i.e. the employees, employers and healthcare providers). The success or otherwise of such schemes will definitely

depend on the level of knowledge / awareness and the attitude of these stakeholders towards the scheme.

2.9 SOCIAL HEALTH INSURANCE IN NIGERIA

The National Health Insurance Scheme (NHIS) is a body corporate established under Law (Decree) number 35 of 1999 by the Federal Government of Nigeria in order to improve the healthcare of all Nigerians at a cost the government and the citizens can afford.

The establishment of the NHIS was informed among other things by the general poor state of the nations healthcare services, the excessive dependence and pressure on government provided health facilities and the inadequate participation of the private health services coupled with inappropriate distribution of both public and private facilities in the country.

By design, the scheme is voluntary, indirect (i.e. does not own health facilities but contract out to existing public and private facilities) and combines capitation and fee – for – service as provider payment mechanisms.

2.9.1 Objectives of the Scheme

- To ensure that every Nigerian has access to good health care services.
- To protect families from the financial hardship of huge medical bills
- To limit the rise in the cost of health care services
- To ensure equitable distribution of health care costs among different income groups

- To maintain high standard of health care delivery services within the scheme.
- To ensure efficiency in health care services.
- To improve and harness private sector participation in the provision of health care services.
- To ensure equitable distribution of health facilities within the federation.
- To ensure appropriate patronage of all levels of health care.
- To ensure the availability of funds to the health sector for improved services.

2.9.2 Coverage

The scheme will be implemented in phases to cover all Nigerians categorized as follows:

- **Persons Employed in the Private Sector:**

  Their contributions will be paid by/through their employers

- **Persons Employed in the Public Service:**

  Their contributions will be paid by/through their employers, i.e. the federal, State and Local Governments including parastatals and Agencies.

- **Self – Employed persons (Market Women, Traders, Farmers, and Business Men e.t.c.)**

  This category shall pay their contributions directly or through cooperatives formed by them.

- **Vulnerable Groups:**

  This includes the unemployed, the aged, disabled, street children, the retarded and the retirees.

  Their contributions shall be paid on their behalf by the government, NGOs, local communities and philanthropists.

- **Rural Dwellers not in above Categories:**

  For this group, suitably priced programmes shall be designed for them.

2.9.3 Stakeholders In The Scheme

These include:-

(a). Contributors

These are persons registered under the scheme who have their contributions paid by them or for them in order to receive health care benefits. For a token fee paid regularly, the contributors and their dependants are guaranteed good quality health care whenever they fall ill.

(b). Employers

These are public or private sector organizations employing persons for whom they are required to pay contributions.

(c). Health Maintenance Organizations (HMOs)

These are limited liability companies, which may be formed by private or public establishments registered to facilitate the provision of healthcare benefits to the contributors.

(d). Health Care Providers

These are licensed government or private health care practitioners or facilities registered by the scheme for the provision of prescribed health benefits to contributions and their dependants.

They are either primary care providers, or fee–for–service health care providers.

2.9.4 How the Scheme Works

Contributions made by/for an insured person entities him or herself, spouse and four children under the age of 18 years to full health benefits. Extra contributions will be required for additional dependants.

In order to participate in the scheme contributors will first register with an NHIS approved HMO and thereafter with a primary health care provider of his/her choice (private or public) from an NHIS approved list of providers supplied by his HMO.

Upon registration, a contributor will be issued an identity (I.D) card with a personal identification number.

In the event of sickness, the contributor presents his I.D card to his chosen primary healthcare provider for treatment.

A contributor has a right to change his primary care provider after a minimum period of six (6) months if he is not satisfied with the services.

Payment for services rendered to him will be made to the health care provider by the Health Maintenance Organization (HMO).

A contributor may be asked to make a small co – payment where applicable at the point of service.

2.9.5 Contributions

Employed persons shall be required to pay 5% of their gross earnings, while their employers shall pay 10% on their behalf. Employees already enjoying free medical services will have their employers pay the whole contributions for them.

Other contributors (voluntary, self employed, rural dwellers etc.) will pay flat rate contributions quarterly.

2.9.6 Health Care Benefits of the Scheme

Upon registration, contributors are entitled to the following benefits:

i. Defined elements of curative care such as:

- Out – patient attendance
- Maternity care for up to four (4) live births for every insured person
- Consultation with defined range of specialists.
- Hospital care in public or private hospital in a standard ward during a stated duration of stay for physical or mental disorders.
- Eye examination and care, excluding provision of spectacles.
- Dental care as defined:
  - Consultation
  - Oral examination
  - Preventive care
  - Pain relief

ii. Preventive care including immunization, family planning, antenatal and postnatal care, and health education.

iii. Availability of prescribed drugs and diagnostic tests.

iv. Prostheses and rehabilitation.

The organisational structure of the scheme (see appendix xii) comprises of a Board, and the management headed by an Executive Secretary.

In addition to the central headquarters of the scheme in Abuja, zonal offices have been established in Lagos, Kano, Enugu and Port Harcourt with the plan to open more to cover the whole country.

Even though the scheme has been signed into law since May 1999, it is yet to take off and the date is yet to be fixed. However in preparation, the scheme has instituted an in - house pilot testing of the programme pending its take off.

Appreciating the need to adequately educate and mobilize the public (particularly considering its voluntary design), the scheme has embarked on intensive public enlightenment targeting the major stakeholders.

Literature on the knowledge, opinion and attitude of stakeholders towards social health insurance (including the NHIS) is unfortunately grossly lacking.

This gross lack of literature on the subject matter makes this study even more imperative and it is hoped that it will serve as a stimulus for further work in the area.

CHAPTER THREE

3.0 METHODOLOGY

3.1 BACKGROUND TO THE STUDY AREA

Sokoto State is approximately located between latitude 10^0 to 14^0 and longitude 3^0 to 9^0. It covers an area of about 60,780 square kilometers and falls within the Guinea and Sudan Savannah Zones.

The topography of the state is dominated by urgently rolling peneplain which rise from an elevation of 300m in the North West to an average of 400m in the south – west. The State can be divided into two main parts by an almost straight line. In the north – west of the line are the Sokoto plains with crystalline basement rocks. The western part of the state is traversed by the wide and extensive flood plains of the Sokoto River system.

The state falls on the boundary between semi – arid region and the Sahel Savannah.

The rains occur during April to October and fall in a rather irregular pattern. Raining season decreases from the South to the Northern part of the state with 1,300 mm lasting 170 days and 600 mm lasting 120 days respectively.

Major rivers in the state include River Rima and River Sokoto both of which empty into the Niger via the Rima at a point upstream the Kainji Lake.

Sokoto state consists of 23 local governments and has an estimated population of 2, 470,176 with a sex ratio 97.68 and a population density of 74 per square km.

The predominant tribes in the state are Hausa – Fulani and the Gobirawas majority of whom follow the Islamic faith. There are however few other tribes such as Buzaye and other settlers.

Literacy level is generally low for both sexes with both primary and secondary school enrolment low. The people are mostly subsistent farmers with only a few gainfully employed in the organized formal sector making employment level low.

The most common causes of morbidity and mortality are malaria fever (67.00%), diarrheal diseases (9.75%), Pneumon a and other respiratory tract infections (7.8%), nutritional disorders (1.5%), measles (0.9%) etc (see appendix ix).

There are three (3) tertiary health institutions including a teaching hospital and a neuropsychiatric hospital. In addition, there are eight (8) general hospitals, five (5) and four (4) primary and rural health centres respectively. There are also twenty two (22) health clinics. (See appendix X).

The total health manpower in the state comprise of one hundred and seventy six (176) medical doctors, four (4) dentists, eight hundred and sixty seven (867) nurses and midwives. This gives a doctor population ratio of 1:25,399 and a nurse population ratio of 1:5,156 (See appendix XI).

3.2 MATERIALS

The materials for the study included:

- Writing materials for focused group discussions
- Education materials (see appendix XIII) on the NHIS

This contains simple, basic and relevant information about the scheme (NHIS) covering the following areas:

i. Objectives of the scheme

ii. Coverage

iii. Stakeholders

iv. How the scheme works

v. Contributions, and

vi. Healthcare benefits to contributors.

- **Questionnaire**

This was designed to be self administered, short and simple. A combination of open ended and close – ended questions were used (see appendix XIV).

3.3 METHODS

This work took the form of a descriptive, cross – sectional intervention study and was conducted in two phases:

- Phase I: Preliminary survey which assessed the level of knowledge (awareness) on the NHIS among the civil servants in the state.

This was necessary since the scheme is a relatively new programme and the impact of effort at public enlightenment not yet established.

This was done by focused group discussions.

- Phase II: This aimed at assessing the opinion and attitude of civil servants in the state towards the scheme (NHIS) using the Intensive Market Research Technique.

This technique is intervention in nature and involves the deliberate education of group(s) of people on a particular commodity, programme etc using relevant education materials following which an assessment of their opinion and attitude on that commodity or programme is made.

3.3.1 Preliminary Survey

This was done by way of focused group discussions.

Groups of 8 – 10 civil servants were formed in each of ten (10) state ministries and parastatals, which were purposively selected.

Discussions, which took place in – house (in each selected ministry/parastatal) lasted an average of twenty (20) minutes.

There was an interviewer and a moderator to guide the conduct of the discussions. Discussants were introduced to the scheme and asked what they knew about it i.e. whether or not they have heard about it and if they have, by what medium. Other points discussed were the structure of the scheme (i.e. how it has been designed to work), coverage, contributions, and healthcare benefits.

Discussions were analysed at the end of each session.

3.3.2 Assessment of the Opinion/Attitude of Civil Servants Towards the NHIS

This employed the Intensive Market Research Technique in the form of an intervention and was conducted in the following manner:

- Preparation of education materials on the NHIS to be given to participants.
- Design and preparation of questionnaires

- Pilot testing of questionnaires following which relevant corrections were made to the draft questionnaire.
- Ten (10) state ministries and parastatals were purposively selected from a list of all the ministries and parastatals in the state.
- Thirty (30) civil servants were selected from each of the ten selected ministries and parastatals, giving a sample size of 30x10 = 300.

Selection of participants was done from a comprehensive staff list of Sokoto state using proportionate random sampling (categorization by grade levels 1 – 5 (40%), 6 – 12 (30%) and 13 – 17 (30%). Each of these was given an education material (appendix XIII) on the scheme and asked to study it. An appointment was booked to meet after one week. During this meeting, issues (from the education material) not understood were cleared and a questionnaire administered.

NOTE: In civil service, grading of civil servants (1-17) is the basis for seniority and is determined by the number of years of service, educational qualification and experience.

Under the HAPSS (Harmonised Public Service Salary Structure) for public servants, employees on grade levels 1 – 7 are categorized as staffers and are the most junior workers. Those between levels 8 – 12 constitute the middle cadre officers while those on grade levels 13 – 17 constitute the management staff.

Remuneration and other benefits to civil servants are based on the grade level which is traditionally reviewed every three years.

3.4 DATA COLLECTION

Focused group discussion – lasted one week and the moderator was recruited from the team of trained data collectors.

Questionnaires were administered and retrieved using a team of five (5) well trained data collectors.

3.5 TRAINING OF DATA COLLECTORS

Data collectors were recruited from the final year class of the medical college, Usman Danfodio University Sokoto.

Training lasted 2 hours daily for 3 days and focused on:

- Introduction to the study – it's relevance, it's design etc.
- Detailed information on the National Health Insurance
- Method of questionnaire administration
- Anticipated difficulties

Note: One of the data collectors was recruited to serve as the moderator for the focused group discussions.

3.6 DATA ANALYSIS

This was done manually.

Statistical tests employed include:

- Chi – square (x^2) test of association
- Standard Normal Deviate (SND) test (Z test)
- Fishure's Exact Test

CHAPTER FOUR

4.0 RESULTS

4.1 ASSESSMENT OF KNOWLEDGE (AWARENESS)

Out of the 8 – 10 discussants from each of the ten groups, only 1 – 2 in each (≅15%) ever heard of the scheme (NHIS), all of whom claimed to have heard about it through the television. However, none of these could discuss any further as they knew virtually nothing about the scheme.

4.2 ASSESSMENT OF ATTITUDE AND OPINION

Of the three hundred (300) civil servants recruited in the study, only two hundred and seventy (270) responded to the questionnaires. Out of those that did not respond (30), 73% were women and 86% were on grade level 1 – 5.

The results as obtained from the questionnaires are given below:

4.2.1 Demographic and Social Characteristics of respondents.

TABLE I SHOWING THE AGE SEX DISTRIBUTION OF RESPONDENTS

AGE (YRS)	MALE	FEMALE	TOTAL
16 – 20	5	2	7
21 – 25	6	2	8
26 – 30	36	4	40
31 – 35	80	5	85
36 – 40	57	3	60
41 – 45	38	2	40
> 45	29	1	30
TOTAL	**251**	**19**	**270**

TABLE II SHOWING THE FREQUENCY DISTRIBUTION OF MARITAL STATUS

OF RESPONDENTS

MARITAL STATUS	NO	%
MARRIED	232	85.9%
SINGLE	38	14.1
TOTAL	**270**	**100.0**

Table II shows that of the two hundred and seventy civil servants that responded, 232 (85.9%) are married while only 38 (14.1%) are single.

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TABLE III SHOWING THE FREQUENCY DISTRIBUTION OF FAMILY SIZE OF RESPONDENTS

FAMILY SIZE	NO	%
≤ 6	142	52.6
> 6	128	47.4
TOTAL	**270**	**100.0**

Table III shows that of the 270 respondents, 142 (52.6%) have a family size equal to or less than six while 128 (47.4%) have a family size greater than six.

TABLE IV SHOWING THEFREQUENCY DISTRIBUTION OF GRADE LEVEL OF RESPONDENTS

GRADE LEVEL	NO	%
1 – 5	45	16.7
6 – 12	145	53.7
13 – 17	80	29.6
TOTAL	**270**	**100.0**

Table iv shows that 16.7% (45) of the respondents have a grade level between 1 – 5, while 53.7% (145), and 29.6% (80) are on grade levels 6 – 12, and 13 – 17 respectively.

4.2.2 STATE OF HEALTH, PATRONAGE AND OPINION OF RESPONDENTS ON SERVICES IN HEALTH CARE FACILITIES

TABLE V SHOWING THE FREQUENCY DISTRIBUTION OF STATE OF HEALTH OF RESPONDENTS

STATE OF HEALTH	NO	%
GOOD	263	97.4
POOR	7	2.6
TOTAL	270	100.0

Table v shows that of the 270 respondents, 97.4% (263) reported to be in good state of health, while 2.6% (7) reported to be in poor state of health.

TABLE VI SHOWING THE FREQUENCY DISTRIBUTION OF HEALTH CARE FACILITIES PATRONISED BY RESPONDENTS

FACILITY	NO	%
PRIVATE	50	13.3
SPECIALIST	165	44.0
TEACHING HOSPITAL	135	36.1
PHC	20	5.3
OTHERS	5	1.3
TOTAL	**375**	**100.0**

Table VI shows that only 5.3% (20) of the respondents patronize PHC[s] (primary health centres) while 44.0% (165), and 36.1% (135) patronize specialist and teaching hospitals respectively. Private facilities are patronized by 13.3% (50) and 1.3% (5) by others (comprising of traditional healers, roadside chemists etc).

TABLE VII (a) SHOWING THE FREQUENCY DISTRIBUTION OF THE OPINION OF RESPONDENTS ON THE QUALITY OF CARE IN HEALTH CARE FACILITIES

QUALITY OF CARE	NO	%
POOR	55	20.4
GOOD	215	79.6
TOTAL	**270**	**100**

Table viia shows that 20.4% (55) of the respondents reported as poor the quality of care healthcare in facilities while 79.6% (215) reported it as good.

TABLE VII (b) SHOWING THE FREQUENCY DISTRIBUTION OF THE OPINION OF RESPONDENTS ON THE ACCESSIBILITY OF HEALTH CARE FACILITIES

ACCESSIBILITY	NO	%
POOR	25	9.3
GOOD	245	90.7
TOTAL	**270**	**100**

Table VII (b) shows that out of the 270 respondents, 90.7% (245) reported access to healthcare facilities as good, while 9.3% (25) reported access as poor.

TABLE VII (c) SHOWING THE FREQUENCY DISTRIBUTION OF THE OPINION OF RESPONDENTS ON THE AVAILABILITY OF DRUGS AND MEDICAL EQUIPMENT IN HEALTH FACILITIES.

AVAILABILITY OF DRUGS & EQUIP.	NO	%
POOR	195	72.2
GOOD	75	27.8
TOTAL	**270**	**100**

Table VII (c) shows that 72.2% (195) of the respondents reported the availability of drugs and equipment as poor while 27.8% (75) reported as good.

TABLE VII (d) SHOWING THE FREQUENCY DISTRIBUTION OF THE OPINION OF RESPONDENTS ON STAFF ATTITUDE AND WAITING TIME IN HEALTH CARE FACILITIES

STAFF ATTITUDE & WAITING TIME	NO	%
POOR	130	48.1
GOOD	140	51.9
TOTAL	**270**	**100**

Table VII (d) shows that 48.1% (130) of the respondents reported staff attitude and waiting time as poor while 51.9% (140) reported it is good.

4.2.3 HEALTHCARE EXPENDITURE, PAYMENT AND PERCEPTION OF RESPONDENTS ABOUT COST OF MEDICAL CARE

TABLE VIII SHOWING THE FREQUENCY DISTRIBUTION OF AVERAGE MONTHLY MEDICAL BILL

AVERAGE MONTHLY MEDICAL BILL (N)	NO	%
< 300.00	55	20.4
300 – 1000	110	40.7
1000 – 5000	60	22.2
> 5000	45	16.7
TOTAL	**270**	**100**

Table viii shows that 16.7% (45) and 20.4% (55) reported their average monthly medical bill as less than N300 and greater than N5000 respectively. 40.7% (110) and 22.2% (60) reported their monthly bill between ₦300 – ₦1000 and ₦1000 to 5000 respectively.

TABLE IX SHOWING THE FREQUENCY DISTRIBUTION OF PAYMENT OF MEDICAL BILLS

PAYMENT OF MEDICAL BILL	NO	%
SELF	258	95.6
EMPLOYER	-	-
INSURANCE	-	-
OTHERS	12	4.4
TOTAL	**270**	**100**

Table IX shows that 95.6% (258) of respondents pay their medical bills while only 4.4% (12) reported others (mostly spouses for women).

TABLE X SHOWING THE FREQUENCY DISTRIBUTION OF OPINION ABOUT COST OF MEDICAL CARE AS AN OBSTACLE TO THE USE OF MEDICAL SERVICES

OPINION	NO	%
YES	203	75.2
NO	67	24.8
TOTAL	**270**	**100**

Table X shows that of the 270 respondents, 75.2% (203) reported cost of medical care as an obstacle to the use of medical services while 24.8% (67) reported otherwise.

4.2.4 RESPONDENTS ATTITUDE AND RECEPTIVITY TOWARDS THE NHIS

TABLE XI SHOWING THE FREQUENCY DISTRIBUTION OF WILLINGNESS TO PARTICIPATE IN THE SCHEME AMONG RESPONDENTS

WILLINGNESS	NO	%
YES	227	84.1
NO	43	15.9
TOTAL	**270**	**100**

Table xi shows that of the 270 respondents, 84.1% (227) are willing to participate in the scheme when is finally takes off, while only 15.9% (43) are not willing to participate.

TABLE XII SHOWING THE FREQUENCY DISTRIBUTION OF THE OPINION OF RESPONDENTS ON THE 5% DEDUCTION FROM MONTHLY GROSS EARNING

OPINION	NO	%
TOO HIGH	95	35.2
ACCEPTABLE	175	64.8
TOTAL	**270**	**100**

Table xii shows that 64.8% (175) of the 270 respondents reported the 5% deduction from monthly gross earnings as acceptable while 35.2% (95) reported it as too high.

TABLE XIII SHOWING THE FREQUENCY DISTRIBUTION OF THE OPINION OF RESPONDENTS ON THE HEALTH CARE BENEFITS TO CONTRIBUTORS

OPINION	NO	%
ADEQUATE	232	85.9
INADEQUATE	38	14.1
TOTAL	**270**	**100**

Table XIII shows that 85.9% (232) of the respondents reported the healthcare benefits to contributors as adequate while 14.1% (38) required it as inadequate.

TABLE XIV (a) SHOWING THE FREQUENCY DISTRIBUTION OF THE OPINION OF RESPONDENTS ON THE POTENTIAL OF THE SCHEME FOR SUCCESS

OPINION	NO	%
POOR	40	14.8
GOOD	230	85.2
TOTAL	**270**	**100**

Table XIV (a) shows that 85.2% (230) of the 270 respondents reported the scheme as having a good potential for success whereas only 14.8% (40) reported the potential of the scheme for success as poor.

TABLE XIV (b) SHOWING THE FREQUENCY DISTRIBUTION OF THE OPINION OF RESPONDENTS ON THE POTENTIAL OF THE SCHEME FOR SUSTAINABILITY

OPINION	NO	%
POOR	80	29.6
GOOD	190	70.4
TOTAL	**270**	**100**

Table XIV (b) shows that 29.6% (80), and 70.4% (190) of the 270 respondents reported the potential of the scheme for sustainability as poor and good respectively.

TABLE XV SHOWING THE FREQUENCY DISTRIBUTION OF THE OPINION AMONG RESPONDENTS OF THE POTENTIAL OF THE SCHEME TO REDUCED / ELIMINATE THE INADEQUACIES IN OUR HEALTH CARE FACILITIES

OPINION	NO	%
YES	238	88.1
NO	32	11.9
TOTAL	**270**	**100**

Table XV shows that of the 270 respondents 88.1% (238) reported the scheme as having the potential to reduce / eliminate the inadequacies in our health care facilities while only 11.9% (32) reported otherwise.

TABLE XVI (a) SHOWING THE FREQUENCY DISTRIBUTION OF THE OPINION OF RESPONDENTS ON THE POTENTIAL OF THE SCHEME TO PROTECT FAMILIES FROM HUGE MEDICAL BILLS

OPINION	NO	%
POOR	21	7.8
GOOD	249	92.2
TOTAL	**270**	**100**

Table XVI (a) shows that only 7.8% (21) of the respondents reported the potential of the scheme to protect families from huge medical bills or as poor whereas 92.2% (249) reported its potential as good.

TABLE XVI (b) SHOWING THE FREQUENCY DISTRIBUTION OF THE OPINION OF RESPONDENTS ON THE POTENTIAL OF THE SCEHEME TO IMPROVE THE QUALITY OF CARE IN OUR HEALTH CARE FACILITIES

OPINION	NO	%
POOR	28	10.4
GOOD	242	89.6
TOTAL	**270**	**100.0**

Table XVI (b) shows that only 10.4% (28) of the respondents reported the potential of the scheme to improve the quality of care in health care facilities as poor, while 89.6% (242) reported its potential as good.

TABLE XVI (c) SHOWING THE FREQUENCY DISTRIBUTION OF THE OPINION OF RESPONDENTS ON THE POTENTIAL OF THE SCHEME TO IMPROVE ACCESS TO HEALTH CARE SERVICES.

OPINION	NO	%
POOR	20	7.4
GOOD	250	92.6
TOTAL	**270**	**100.0**

Table XVI (c) shows that 92.6% (250) of the 270 respondents reported the potential of the scheme to improve access to healthcare services as good while only 7.4% (20) reported its potential as poor.

TABLE XVI (d) SHOWING THE FREQUENCY DISTRIBUTION OF THE OPINION OF RESPONDENTS ON THE POTENTIAL OF THE SCHEME TO IMPROVE WAITING TIME AND STAFF ATTITUDE TO PATIENTS IN HEALTH CARE FACILITIES

OPINION	NO	%
POOR	32	11.9
GOOD	238	88.1
TOTAL	**270**	**100**

Table XVI (d) shows that 88.1% (238) of the 270 respondents reported the potential of the scheme to improve waiting time and staff attitude to patients as good whereas only 11.9% (32) reported its potential as poor.

4.2.5 THE DEMOGRAPHIC, SOCIAL AND HEALTH STATUS OF RESPONDENTS AGAINST THEIR OPINION AND ATTITUDE TOWARDS THE SCHEME

TABLE XVII SHOWING THE AGE STRUCTURE OF RESPONDENTS AGAINST WILLINGNESS TO PARTICIPATE IN THE SCHEME

Age (Yrs)	WILLING		NOT WILLING		TOTAL	
	N	%	N	%	N	%
< 35	135	59.5	5	11.6	140	51.9
> 35	92	40.5	38	88.4	130	40.1
TOTAL	**227**	**100.0**	**43**	**100.0**	270	**100.0**

Table XVII shows that of the 227 respondents that responded wiling to participate in the scheme 59.5% (135) are equal to or less than 35 years where as 40.5% (92) are above 35 yrs. On the other hand 11.6% (5) and 88.4% (38) of those that reported not willing to participate are less than or equal to 35yrs and greater than 35 yrs respectively.

H_0 : No relationship between age and willingness to participate

$X^2 = 31.95$

Critical limits of x^2 at 1 df = 3.841 ($\propto = 0.05$)

H_0 is rejected, thus there exists relationship between age of respondents and willingness to participate.

TABLE XVIII SHOWING THE FAMILY SIZE OF RESPONDENTS AGAINST WILLINGNESS TO PARTICIPATE IN THE SCHEME

		WILLING		NOT WILLING		TOTAL	
		N	%	N	%	N	%
Family Size	< 6	139	61.2	3	7.0	142	52.6
	> 6	88	38.8	40	93.0	128	47.4
	TOTAL	**227**	**100.0**	**43**	**100.0**	**270**	**100.0**

Table XVIII shows that 61.2% (139) of the 227 respondents that reported willing to participate have a family size equal to or less than 6 while 38.8% (88) have a family size greater than six. The corresponding values for those that reported not willing to participate are 7.0% (3) and 93.0% (40) respectively.

Z = 6.7

Significance limits (-1.96 to + 1.96)

H_o is rejected, I.e. there is a statistically significant relationship between family size and willingness to participate.

TABLE XIX SHOWING THE MARITAL STATUS OF RESPONDENTS AGAINST WILLINGNESS TO PARTICIPATE IN THE SCHEME.

Marital Status	WILLING		NOT WILLING		TOTAL	
	N	%	N	%	N	%
MARRIED	192	84.6	40	93.0	232	86.0
SINGLE	35	15.4	3	7.0	38	14.0
TOTAL	**227**	**100.0**	**43**	**100.0**	**270**	**100.0**

Table XIX shows that 84.6% (192) and 15.4% (35) of the respondents that reported willing to participate are married and single respectively where as 93.0% (40) and 7.0% (3) of those that reported not willing are respectively married and single.

Z = i.8

Significance limits (-1.96 to + 1.96)

H_0 is accepted, i.e. there is no significant statistical association between marital status and willingness to participate.

TABLE XX SHOWING THE GRADE LEVEL OF RESPONDENTS AGAINST WILLINGNESS TO PARTICIPATE IN THE SCHEME

Grade Level	WILLING		NOT WILLING		TOTAL	
	N	%	N	%	N	%
1 – 5	42	18.5	3	7.0	45	16.7
6 – 12	135	59.5	10	23.3	145	53.7
13 – 17	50	22.0	30	69.7	80	29.6
TOTAL	**227**	**100.0**	**43**	**100.0**	**270**	**100.0**

Table XX shows that of the 227 respondents that reported willing to participate, 18.5% (42), 59.5% (135) and 22.0% (50) are on grade levels 1 – 5, 6 – 12 and 13 – 17 respectively. For those that reported not willing to participate, 7.0% (3), 23.3% (10), and 69.7% (30) are respectively on grade levels 1 – 5, 6 – 12 and 13 – 17.

$X^2 = 37.9$

Critical limits of x^2 at 2 df ($\alpha = 0.05$) = 5.991

H_0 is rejected, i.e. there exists a statistically significant relationship between grade level and willingness to participate.

TABLE XXI SHOWING THE STATE OF HEALTH OF RESPONDENTS AGAINST WILLINGNESS TO PARTICIPATE IN THE SCHEME

State of Health	WILLING		NOT WILLING		TOTAL	
	N	%	N	%	N	%
POOR	6	2.6	1	2.3	7	2.6
GOOD	221	97.4	42	97.7	263	97.4
TOTAL	**227**	**100.0**	**43**	**100.0**	**270**	**100.0**

Table XXI shows that of the 227 respondents that reported willing to participate in the scheme 2.6% (6) reported their state of health as poor, whereas 97.4% (221) reported there state of health as good. The corresponding values for those that reported not willing to participate are 2.3% (1) and 97.7% respectively.

P value using the Fishure's Exact Test = 0.0721

H_0 is accepted i.e. there is no statistically significant relationship between state of health and willingness to participate.

TABLE XXII SHOWING THE AGE STRUCTURE OF RESPONDENTS AGAINST OPINION ON 5% DEDUCTION FROM MONTHLY GROSS EARNINGS

		TOO HIGH		ACCEPTABLE		TOTAL	
		N	%	N	%	N	%
Age (Yrs)	≤ 35 yrs	35	36.8	105	60.0	140	51.9
	> 35 yrs	60	63.2	70	40.0	130	48.1
	TOTAL	**95**	**100.0**	**175**	**100.0**	**270**	**100.0**

Table XXII shows that of the 95 respondents that reported the 5% deduction as too high 36.8% (35) have an age less than or equal to 35 yrs whereas 63.2% (60) are over 35 yrs old. For those that reported the deduction as acceptable, 60.0% (105) are equal to or less than 35 yrs old and 40% (70) are over 35 yrs.

$X^2 = 12.8$

Critical limits of x^2 at 1 df ($\alpha = 0.05$) = 3.841

H_0 is thus rejected, establishing a statistically significant relationship between age of respondents and opinion on 5% deduction.

TABLE XXIII SHOWING THE MARITAL STATUS OF RESPONDENTS AGAINST OPINION ON 5% DEDUCTION FROM MONTHLY GROSS EARNINGS

Marital Status	TOO HIGH		ACCEPTABLE		TOTAL	
	N	%	N	%	N	%
MARRIED	87	91.6	145	82.9	232	86.0
SINGLE	8	8.4	30	17.1	38	14.0
TOTAL	**95**	**100.0**	**175**	**100.0**	**270**	**100.0**

Table XXIII shows that of the 95 respondents that reported the 5% deduction as too high 91.6% (87) are married while 8.4% (8) are single. For those that reported the deductions as acceptable, 82.9% (145) are married and 17.1% (30) are single.

$X^2 = 3.4$

Critical limits of x^2 at 1 df ($\alpha = 0.05$) = 3.841

H_0 is thus accepted, i.e. there is no statistically significant relationship between marital status and opinion on 5% deduction.

TABLE XXIV SHOWING THE FAMILY SIZE OF RESPONDENTS AGAINST OPINION ON THE 5% DEDUCTION FROM MONTHLY GROSS EARNINGS

Family Size	TOO HIGH		ACCEPTABLE		TOTAL	
	N	%	N	%	N	%
< 6	35	36.8	107	61.1	142	52.6
> 6	60	63.2	68	38.9	128	47.4
TOTAL	**95**	**100.0**	**175**	**100.0**	**270**	**100.0**

Table XXIV shows that of the 95 respondents that reported the 5% deduction as too high, 36.8% (35) have a family size equal to or less than 6 and 63.2% (60) have a family size greater than 6. For those that reported the deduction as acceptable, 61.1% (107) have a family size equal to or less than 6 while 38.9% (68) have a family size greater than 6.

$X^2 = 14.6$

Critical limits of x^2 at 1 df ($\alpha = 0.05$) = 3.841

H_0 is thus rejected, i.e. there is a statistically significant relationship between the family size and opinion on 5% deduction.

TABLE XXV SHOWING THE GRADE LEVEL OF RESPONDENTS AGAINST OPINION ON THE 5% DEDUCTION FROM MONTHLY GROSS EARNINGS

Grade Level	TOO HIGH		ACCEPTABLE		TOTAL	
	N	%	N	%	N	%
1 – 5	5	5.3	40	22.9	45	16.7
6 – 12	40	42.1	105	60.0	145	53.7
13 – 17	50	52.6	30	17.1	80	29.6
TOTAL	**95**	**100.0**	**175**	**100.0**	**270**	**100.0**

Table XXV shows that of the 95 respondents that reported the 5% deduction as too high, 5.3% (5), 42.1% (40) and 52.6% (50) are on grade levels 1-5, 6 -12, and 13-17 respectively. For those that reported the deduction as acceptable, 22.9% (40), 60.0% (105) and 17.1% (30) are respectively on grade levels, 1-5, 6-12 and 13-17.

$X^2 = 48.8$

Critical limits of x^2 at 2 df ($\alpha = 0.05$) = 5.991

H_0 is thus rejected i.e. there is a statistically significant relationship between the grade level of respondents and opinion on 5% deduction.

TABLE XXVI SHOWING THE AGE STRUCTURE OF RESPONDENTS AGAINST OPINION ON HEALTH CARE BENEFITS TO CONTRIBUTORS

		INADEQUATE		ADEQUATE		TOTAL	
		N	%	N	%	N	%
Age (Yrs)	< 35 yrs	8	21.0	132	56.9	140	51.9
	> 35 yrs	30	78.9	100	43.1	130	48.1
	TOTAL	**38**	**100.0**	**232**	**100.0**	**270**	**100.0**

Table XXVI shows that of the 38 respondents that reported the health care benefits to contributors as inadequate, 21.0% (8) are equal to or less 35yrs old, whereas 78.9% (30) are over 35yrs old. For those that reported the benefits as adequate 56.9% (132) are equal to or less than 35 yrs and 43.1% (100) are over 35 yrs old.

$X^2 = 17.7$

Critical limits of x^2 at 1 df ($\alpha = 0.05$) = 3.841

H_0 is thus rejected, i.e. there is a statistically significant relationship between age of respondents and opinion on healthcare benefits to contributors.

TABLE XXVII SHOWING THE MARITAL STATUS OF RESPONDENTS AGAINST OPINION ON HEALTH CARE BENEFITS TO CONTRIBUTORS

Marital Status	INADEQUATE		ADEQUATE		TOTAL	
	N	%	N	%	N	%
MARRIED	30	78.9	202	87.1	232	86.0
SINGLE	8	21.1	30	13.9	38	14.0
TOTAL	**38**	**100.0**	**232**	**100.0**	**270**	**100.0**

Table XXVII shows that of the 38 respondents that reported their opinion on the healthcare benefits to contributors as inadequate 78.9% 930) are married while 21.1% (8) are single. For those that reported their opinion as adequate, 87.1% (202) are married and 13.9% (30) are single.

$X^2 = 2.44$

Critical limits of x^2 at 1 df ($\alpha = 0.05$) = 3.841

H_0 is thus accepted, i.e. there is no statistically significant relationship between the marital status of respondents and opinion on healthcare benefits to contributors.

TABLE XXVIII SHOWING THE FAMILY SIZE OF RESPONDENTS AGAINST OPINION ON HEALTH CARE BENEFITS TO CONTRIBUTORS

Family Size	INADEQUATE		ADEQUATE		TOTAL	
	N	%	N	%	N	%
≤ 6	3	7.9	139	60.0	142	52.6
> 6	35	92.1	93	40.0	128	47.4
TOTAL	**38**	**100.0**	**232**	**100.0**	**270**	**100.0**

Table XXVIII shows that of the 38 respondents that reported their opinion on health are benefits as inadequate, 7.9% (3) have a family size equal to or less than 6 while 92.1% (35) have a family size greater than six, the corresponding values for those that reported their opinion as adequate are 60.0% (139) and 40% (93) respectively.

Z = 5.8

- *Significance limits (-1.96 to + 1.96)*

H_0 is thus rejected, i.e. there is a statistically significant relationship between the family size of respondents and opinion on the healthcare benefits to contributors.

TABLE XXIX SHOWING THE GRADE LEVEL OF RESPONDENTS AGAINST *OPINION ON HEALTHCARE BENEFITS TO CONTRIBUTORS*

		INADEQUATE		ADEQUATE		TOTAL	
		N	%	N	%	N	%
Grade Level	1 – 5	5	13.2	40	17.2	45	16.7
	6 – 12	15	39.5	130	56.0	145	53.7
	13 – 17	18	47.3	62	26.8	80	29.6
	TOTAL	**38**	**100.0**	**232**	**100.0**	**270**	**100.0**

Table XXIX shows that 13.2% (5), 39.5% (15) and 47.3% (18) of the 38 respondents that reported their opinion on health are benefits as inadequate are or grade levels 1-5, 6-12 and 13-17 respectively. For those that reported their opinion as adequate 17.2% (40) are on level 1-5, 56.0% (130) on 6-12and 26.8% (62) on level 13-17.

$X^2 = 6.88$

Critical limits of x^2 at 2 df ($\alpha = 0.05$) = 5.991

H_0 is thus rejected, i.e. there is a statistically significant relationship between the grade level of respondents and opinion on healthcare benefits to contributors.

TABLE XXX SHOWING THE STATE OF HEALTH OF RESPONDENTS AGAINST OPINION ON HEALTH CARE BENEFITS TO CONTRIBUTORS

State of Health	INADEQUATE		ADEQUATE		TOTAL	
	N	%	N	%	N	%
POOR	3	7.9	4	1.7	7	2.6
GOOD	35	92.1	228	98.3	263	97.4
TOTAL	**38**	**100.0**	**232**	**100.0**	**270**	**100.0**

Table XXX shows that of the 38 respondents that reported their opinion as inadequate 7.9% (3) reported their state of health as poor and 92.1% (35) as good while 1.7% (4) of those that reported their opinion as adequate reported their state of health as poor and 98.3% (228) as good.

Z = 2.2

Significance limits (-1.96 to + 1.96)

H_0 is thus rejected, i.e. there is a statistically significant relationship between the state of health of respondents and opinion on the healthcare benefits to contributors.

CHAPTER FIVE

5.0 DISCUSSION

5.1 ASSESSMENT OF KNOWLEDGE/AWARENESS

As seen in the results, the level of knowledge (awareness) on the National Health Insurance Scheme (NHIS), among the civil servants sampled is very low. Only about 15% of the 80 – 100 civil servants in the 10 groups sampled ever heard of the scheme (NHIS) and none of these knew anything about its structure, design and/or operation.

When this is projected on the larger population of civil servants in the state, the picture is not too attractive.

This low level of awareness among civil servants in the state may be attributable to a poor enlightenment effort by the scheme or to inappropriate methods of enlightenment. In either case, this may necessitate the need to redesign the present effort at public enlightenment.

5.2 ASSESSMENT OF OPINION AND ATTITUDE OF CIVIL SERVANTS TOWARDS THE NHIS

The response rate of 90% (270 out of 300) is quite high and is suggestive of a general interest in the scheme.

The poor response from women (as seen in the results) is probably attributable to the fact that majority of them are married and therefore see healthcare as the sole responsibility of their spouses and may therefore not be particularly interested in the scheme.

The poor response from those on grade levels 1 – 5 may be attributable to their literacy level, which for majority of them is low. For this reason, they may find it difficult to comprehend the education material (written in English language) or even respond appropriately to the questionnaire in spite of assistance from the trained data collectors.

Majority of the respondents (85.9%) are married, while the remaining 14.1% are single.

The highest response to the questionnaires was obtained from those on grade level 6 – 12 (53.7%) and the least response (16.7%) from those on grade level 1 – 5 (see discussion above).

Only 2.6% (7) of the respondents reported to be in poor state of health as against 97.4% (263) that reported to be in good state of health.

The patronage of healthcare facilities (as shown in table vi) is highest for specialist and teaching hospitals (44% and 36.1% respectively) and least for PHC (i.e. primary Health Centers) with 5.3% patronage.

This is in spite of the fact that the most common ailments reported by respondents are malaria, typhoid fever, respiratory tract infections; diarrheal diseases etc and these are problems that could have easily been taken care of at the lower facilities (PHC[s]).

This pattern may be attributable to the extremely poor state of services in the lower primary facilities as a result of which the secondary and tertiary facilities have assumed the role of primary health care providers instead of their designated secondary and tertiary care respectively.

A significantly high proportion of respondents (80%) are of the opinion that the quality of care and access to these services are good whereas an equal proportion of them (88%) are of the opinion that the availability of drugs and equipment in these facilities is poor. They are however equally divided in their opinion on the staff attitude and waiting time.

As is seen in Table viii, the highest proportion of respondents (40.7%) have an average monthly medical bill of N300 – N1000.00 and a significant proportion of them (16.7%) have an average monthly bill over N5000.

Strikingly, virtually all the respondents (Table ix) settle their medical bills out - of - pocket without any employer or insurance cover to protect them from unexpected huge bills.

Expectedly a high percentage of respondents (75.2% - Table X) are of the opinion that the cost of medical care is a significant obstacle to the utilization of medical services, that is to say those that are unable to pay for services are deprived of access to them and therefore do not utilize them.

The proportion of respondents willing to participate in the scheme when it finally takes off is very high (84.1% - Table XI) and an almost equal proportion of them (85.9%) are of the opinion that the healthcare benefits to contributors are adequate. Their opinion on the 5% deduction from monthly gross earnings is divided between too high (35.2%) and acceptable (64.8%).

A greater majority of those that reported not willing to participate made reference to the National Housing Fund which they feel is a failure and fear the NHIS may go the same way. Others feel the scheme is too elitist i.e. the urban poor, rural dwellers and the unemployed will be neglected. A small proportion of them are of the opinion that the scheme may contradict their religious injunctions.

Over 70% of all the respondents are of the opinion that the scheme has a good potential for success (85.2% - Table XIV a) and sustainability (70.4% Table XIV b) respectively.

An equally high proportion of these respondents (88.1% - Table xv) see the scheme as having the potential to reduce/eliminate the inadequacies associated with the healthcare facilities in the country.

A significantly high proportion of respondents are of the opinion that the scheme has a good potential for all the attributes, as follows: Protect families from huge medical bills (92.2% of respondents), improve quality of care in healthcare facilities (89.6% of respondents) improve access to healthcare services (92.6% of respondents) and improve staff attitude and waiting time in our healthcare facilities (88.1% of respondents).

As shown in table XVII, there seem to exist an inverse relationship between the age of respondents and their willingness to participate in the scheme.
The highest proportion of respondents not willing to participate (88.4%) are in the age group greater than 35 yrs.

This is probably so because of an almost direct relationship between the age of civil servants and grade level with the latter determining the size of the 5% deduction. It can thus be postulated that the higher the age/grade level, the bigger the size of the 5% deduction and therefore the less willing the employee is to participate.

The statistical significance of this relationship is established by the chi – square test with an x^2 value of 31.95, much higher than its 3.841 critical level at one degree of freedom.

A similar inverse relationship between family size of respondents and willingness to participate can be seen in table XVIII. Ninety-three (93%) percent of respondents not willing to participate have a family size greater than 6.

This relationship is statistically established using the standard normal deviate test, giving a z value of 6.7 much beyond the significance limits of (– 1.96 to + 1.96).

A probable explanation for this is the ceiling placed by the Scheme on the number of beneficiaries per contributor. The scheme has fixed the beneficiaries at 6 (contributor, spouse and 4 children). Extra contributions will have to be paid for any

beneficiary in excess of six. Employees with a family size greater than six are likely to see the scheme as discriminatory and may not be too willing to pay any contributions in addition to the 5% deducted from their gross earnings.

In contrast, there does not seem to be any relationship between the marital status of respondents and willingness to participate (table XIX).

This is confirmed by the z (SND) whose value (1.8) falls within its significant limits of (- 1.96 to + 1.96).

The earlier postulate of a relationship between grade level of employees and willingness to participate in the scheme is confirmed in table XX. As can be clearly seen, the proportion of respondents not willing to participate in the scheme increases with increasing grade level: 1 – 5 (7.0%), 6 – 12 (23.3%), and 13 – 17 (69.7%).

This relationship is established statistically using the chi – square test of significance (see table XX).

The earlier explanation applies here, i.e. with increasing grade level, the size of the 5% deduction increases to a level that the employee may feel that the monthly deduction is higher than his/her (monthly) medical expenditure and may therefore not see the need to participate.

Surprisingly, there does not seem to be any significant relationship between the state of health of respondents and willingness to participate as seen in table XXI.

473922

This is confirmed using the Fishure's Exact Test which gave a P value of 0.0721 (P = 7.21%)

A relationship between the age of respondents and their opinion on the 5% deduction from earnings can be seen on table XXII.

The proportion of respondents whose opinion on the deduction is that it is too high (63.2%) among those with age greater than 35yrs is much higher than for those whose age is equal to or greater than 35yrs (36.8%).

The statistical significance of this relationship is established by the chi – square (x^2) whose value of 12.8 is well above its critical limits at 1 df.

As seen in table XXIII, there does not seem to be any relationship between the marital status of respondents and the 5% deduction from employee earnings.

This is statistically established using the chi – square (x^2) test whose value of 3.4 is less than its critical limit of 3.841 at 1 df.

The highest association of the opinion of respondents on the 5% deduction is seen with the grade level of respondents (table XXV).

The proportion of respondents whose opinion is 'the deduction is too high' increases with increasing grade level.

This direct relationship is established statistically with the chi-square (x^2) test whose value (48.8) is well above its critical limit of 5.991 at 2 degree of freedom.

The probable explanation for this relationship is the increasing value of the 5% deduction with increasing grade level as described above.

The relationship of the opinion of respondents on the healthcare benefit to contributors can be seen to be highest with the family size of respondents (z = 5.8, significance limits – 1.96 to + 1.96, table xxviii) and least with their marital status (x^2 = 2.44, critical limits 3.841 at I df, table xxvii).

5.3 CONCLUSION

The conclusions derivable from this study are:

- The level of awareness/knowledge among civil servants in Sokoto State is low.
- The interest and willingness to participate in the NHIS among civil servants is high.
- With adequate public mobilization and enlightenment (aiming at creating awareness on the NHIS) the acceptability of the scheme among these civil servants in very high.
- The general opinion among civil servants in Sokoto State is that the scheme is likely to succeed and be sustained and that it has the potential to reduce/eliminate the existing inadequacies in our healthcare system.
- The 5% deduction from monthly gross earnings and the healthcare benefits to contributors are acceptable to most civil servants in the state.

- The grade level and family size of civil servants are potent factors which may determine their opinion and attitude towards the scheme.
- There is an existing fear among civil servants that the NHIS will eventually go the way of the National Housing Fund (NHF).

5.4 RECOMMENDATIONS

In the light of the findings of this study, the following are recommended:

- There is the need for the scheme to intensify effort at mobilization and enlightenment of civil servants in order to increase awareness.
- There is the need to identify more appropriate and effective means of creating public awareness on the scheme.
- Misgivings among stakeholders need to be addressed.
- There is the need for a periodic evaluation of the impact of effort at public mobilization and enlightenment.

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APPENDIX I

NIGERIAN INFANT CHILD AND MATERNAL MORTALITY RATES (1981 – 1993)

COMPARED TO SOME AFRICAN AND INDUSTRIALIZED COUNTRIES

	Infant Mortality rates (under 1)			Child Mortality Rates (under 5)			Maternal Mortality Rates	
Country	**1985**	**1986**	**1993**	**1985**	**1986**	**1993**	**1981-84**	**1992**
Nigeria	110	107	114	182	178	191	1500	800
Ghana	94	91	103	153	150	170	1074	1000
Kenya	76	74	61	121	118	90	168	170
U.S.A.	11	19	9	13	13	10	9	8
UK	10	9	7	12	11	8	7	8
Sweden	5	6	6	5	8	7	6	4

Source: **Adapted from the State of the World's Children (1981 – 1993)**

APPENDIX II

INTERNATIONAL COMPARISONS OF SOME DIMENSIONS OF HEALTH

FINANCE AND STATUS

	Share of Health in Government Expenditure (%)	Life Expectancy at Birth (Yrs)
GROUP A: DEVELOPED COUNTRIES		
United States	11.6	75
West Germany	17.9	75
UK	12.6	75
NIGERIA	3.6	51
GROUP B: OTHER DEVELOPING COUNTRIES		
Thailand	5.7	64
Brazil	6.4	65
Philippines	6.0	63

Source: World Development Reports 1988 and 1989.

APPENDIX III

BUDGETARY ALLOCATION TO HEALTH AT FEDERAL LEVEL (NIGERIA), 1980-1994 (MILLIONS OF NAIRA)

Year	Total Federal Budget	Total FMOH Budget (2)	(2) as a % of (1)
1980	11,722.52	266.93	2.00
1981	11,561.70	303.20	2.62
1982	9,877.03	341.72	3.46
1983	10,425.32	313.60	3.01
1984	7,450.17	190.38	2.56
1985	9,578.00	223.75	2.29
1986	12,219.46	360.22	2 95
1987	10,302.34	236.45	2.30
1988	24,367.27	443.11	1.82
1989	30,107.10	452.50	1.52
1990	36,943.3	904.8	2.5
1991	75,453.1	1087.9	1.4
1992	52,035.9	1050.0	2.0
1993	114,600.5	2682.9	2.3
1994	110,200.0	3062.3	2.8

Source: Report of a WHO Review: PHC the Nigerian Experience – WHO 1992 p. 15 and Statistical Bulletin, Vol. 5 No. 1 1994, CBN, Lagos.

APPENDIX IV

EXTERNAL ASSISTANCE IN US $ MILLION (NIGERIA)

Agencies	Period	Amount
Multilateral		
UNDP	1990	0.11
UNICEF	1990	21.14
UNFPA	1990	0.56
World Bank	1990	188.10
WHO	1990	1.83
UNDP/WHO	1990 – 92	3.00
Bilateral		
EEC	1985 – 90	8.16
USAID	1987 – 92	107.00
JICA	1990	N/A
CIDA	1990	1.73
Non – Government		
Ford Foundation	1990	1.06
AFRICARE	1990	N/A
GLOBAL 2000	1990	0.20

Source: Report of a WHO Review: Local Government Focused Acceleration of PHC – The Nigerian Experience, WHO 1992.

APPENDIX V

AID CONTRIBUTION AS A PERCENTAGE OF TOTAL HEALTH EXPENDITURE FOR SOME AFRICAN COUNTRIES

	HEALTH EXP AS % OF GDP 1990	PRIVATE EXP AS % LOCAL HEALTH EXP	AID CONTRIB AS % LOCAL HEALTH EXP
Benin	4.3	3.7	41.8
Burundi Faso	8.5	18	19.4
Burundi	3.3	48	42.7
CAR	4.2	38	35.8
Cameroon	2.6	62	13.4
Chad	6.3	25	43.0
Cote d'ivoire	3.3	48	3.4
Ethiopia	3.8	39	18.8
Ghana	3.5	51	14.2
Guinea	3.9	41	23.8
Kenya	4.3	37	22.3
Madagascar	2.6	50	21.5
Malawi	5.0	42	23.3
Mali	5.2	46	27.7
Mozambique	5.9	25	52.9
Niger	5.0	32	34.0
Nigeria	2.7	59	6.4
Rwanda	3.5	46	39.5
Senegal	3.7	38	16.9
Sierra Leone	2.4	33	33.0
South Africa	5.6	43	N/a
Tanzania	4.7	32	48.3
Togo	4.1	39	21.0
Uganda	3.4	53	48.4
Zimbabwe	6.2	48	10.0
Sub-Sahara Africa	4.5	44	10.4
India	6.0	78	1.6
China	3.5	40	0.6
Other Asia	4.5	60	1.4
Latin America	-0.3	40	1.3

Source: World Bank (1993)

APPENDIX VI

BASIC DATA ON SUB – SAHARAN AFRICA RELEVANT TO THE HEALTH SECTOR

	GNP PER CAPITA $ 1991	GNP GROWTH RATE (5) 1980-91	ANNUAL POP GROWTH RATE 1980-91	CHILD MORTALITY RATE 1990	DOCTOR PER 1000 POP 1988-92	% OF CHILDREN <1 YR WITH DPT3 1990-91	HEALTH EXP AS % OF GDP 1990	PRIVATE EXP AS % LOCAL HEALTH EXP	AID CONTRIB AS % LOCAL HEALTH EXP
Benin	380	0.9	3.2	170	0.07	67	4.3	3.7	41.8
Burundi Faso	290	1.2	2.6	159	0.03	37	8.5	18	19.4
Burundi	210	1.3	2.9	180	0.06	83	3.3	48	42.7
CAR	390	-1.4	2.7	132	0.04	82	4.2	38	35.8
Cameroon	850	-1.0	2.8	125	0.08	56	2.6	62	13.4
Chad	210	3.8	2.4	212	0.03	18	6.3	25	43.0
Cote d'ivoire	690	-4.6	3.8	90	0.06	48	3.3	48	3.4
Ethiopia	120	-1.6	3.1	197	0.03	44	3.8	39	18.8
Ghana	400	-0.3	3.2	170	0.04	39	3.5	51	14.2
Guinea	460	n/a	2.6	268	0.02	41	3.9	41	23.8
Kenya	340	0.3	3.8	83	0.14	36	4.3	37	22.3
Madagascar	210	-2.5	3.0	170	0.12	46	2.6	50	21.5
Malawi	230	0.1	33	201	0.02	81	5.0	42	23.3
Mali	280	-0.1	2.6	200	0.05	35	5.2	46	27.7
Mozambique	80	-1.1	2.6	280	0.02	19	5.9	25	52.9
Niger	300	-1.4	3.3	320	0.03	18	5.0	32	34.0
Nigeria	340	-2.3	3.0	191	0.15	65	2.7	59	6.4
Rwanda	270	-2.4	3.0	222	0.02	89	3.5	46	39.5
Senegal	720	0.1	3.0	156	0.05	60	3.7	38	16.9
Sierra Leone	210	-1.6	2.4	360	0.07	75	2.4	33	33.0
South Africa	2560	0.7	2.3	91	0.61	67	5.8	43	N/a
Tanzania	100	-0.8	3.0	165	0.03	79	4.7	32	48.3
Togo	410	-1.3	3.4	143	0.08	73	4.1	39	21.0
Uganda	170	n/a	2.5	185	0.04	77	3.4	53	48.4
Zimbabwe	650	-0.2	3.4	58	0.16	89	6.2	48	10.0
Sub-Sahara Africa	350	-1.2	3.1	175	0.12	52	4.5	44	10.4
India	330	3.2	2.1	127	0.41	83	6.0	78	1.6
China	370	7.8	1.5	43	1.37	95	3.5	40	0.6
Other Asia	n/a	n/a	n/a	97	0.31	81	4.5	60	1.4
Latin America	2390	-0.3	2.9	60	1.25	71	4.0	40	1.3

Source: World Bank (1993)

APPENDIX VII

SUMMARY OF HEALTH INSURANCE SCHEMES IN SUB – SAHARAN AFRICA

TYPE OF SCHEME	COUNTRIES CURRENTLY OPERATING SCHEME	COUNTRIES CONSIDERING SCHEME
Primary benefit SS	Cape Verde, Gabon, Kenya	Ethiopia, Ghana, Mozambique, Mali, Nigeria, Zambia.
Secondary benefit SS	Congo, Cameroon, Mali, Senegal, Togo, Gabon.	
Employer based schemes	Burundi, Madagascar, Mali, Nigeria, Togo, Swaziland, Zambia, South Africa, Namibia, Zimbabwe.	
Community based schemes	Guinea Bissau, Burundi and local schemes in Ghana and Zaire.	Zambia for rural areas

Source: ILO (1993) and background papers for WHO Nambia workshop

APPENDIX VIII

Characteristics of Countries Social Health Insurance Schemes

	CAMEROON (since 1956)	GHANA (proposed)	KENYA (since 1966)	MOZAMBIQUE (proposed)	NIGERIA (proposed)	ZAMBIA (proposed)
Coverage	380, (60% formal workforce) insured + dependants	Up to 2.5m for mal sector employees, civil servants and cocoa farmers + dependants.	Compulsory for all public sector employees. Voluntary for others.	Firms with 10 or more employees	Voluntary	Formal sector employees (3.9% pop)
Benefit package	Comprehensive	All excluding TB, AIDS and public health measures	Hospitalization	IP stays of more than 3 days	Comprehensive	Comprehensive
Administration	SS Fund	Independent body	Parastatal	Existing Social Security Institute	Proposed National Health Board. Problem of limited technical capacity	?
Health Service Delivery	Direct – high quality service but limited capacity & poor access	Indirect – Public & private. Problem of poor access in rural areas	Indirect – public and private including missions	Government – special clinics?	Problem re perception of quality	Indirect – public and private quality problem
Provider payment	Salaries & budgets	Retrospective fee-for-service outpatients, itemize billings for inpatients, based on agreed fee level.	Fee-for-service with partial reimbursement for private providers. Direct full payment for public providers.	? Capitation	Fee-for-service	?
Finance	12.45-19% of salaries for all SS benefits. Split between employer and employee.	Paid entirely by employer or cocoa marketing board for cocoa farmers.	Employee contribution only, approx. 3% on a graduated scale. Plans for employers to contribute 0.2% of salary.	Employer 4% salary. Employee 3% salary	15% of salary, of which employer pays 80%, employee 20%.	Formal – as a % salary. Informal – flat rate.

Source: WHO Namibia country background papers and ILO (1993)

APPENDIX IX

MORBIDITY AND MORTALITY STATISTICS FOR SOKOTO STATE (1996 – 1999)

S/no	Common disease	1996	1996	1997	1997	1998	1998	1999	1999
		C	D	C	D	C	D	C	D
1.	Diarrhoea simple without blood	173393	240	42036	455	190121	334	67434	112
2.	Diarrhoea with blood (Dysentery)	34356	362	16870	90	132334	212	58359	87
3.	Pneumonia	6041	152	11950	333	64517	196	42379	77
4.	Tuberculosis	2453	80	1479	66	4090	43	1866	33
5.	Tetanus others	52	25	338	83	75	29	584	14
6.	Leprosy	4769	5	1132	4	885		8+123	
7.	Ophthalmia Neonatorum	16		375		756		846	
8.	Measles	2691	166	7651	194	10255	231	5491	53
9.	Typhoid & Paratyphoid	2164	40	4452	168	3534	18	4109	4
10.	Whooping cough	1603	2			1694	2	4819	17
11.	Food poisoning	397	2	327	15	3452	13	2324	76
12.	Malaria	70744	680	94460	986	171845	751	404721	181
13.	Kwashiorkor, Marasmus & Others	222	9	701	9	10740	53	9305	22
14.	STD Others	493	3	403	3	629		1732	
	Total	**143340**	**1766**	**1821174**	**2406**	**594927**	**1882**	**603969**	**676**

KEY: C = Cases

D = Death

Source: Department of P.R.S Ministry of Health Sokoto

APPENDIX X

HEALTH CARE FACILITIES BY CATEGORY IN SOKOTO STATE AS AT 31ST DECEMBER, 1999

HEALTH FACILITIES	TOTAL
Teaching Hospital	1
Psychiatric Hospital	1
Army Hospital	1
Specialist Hospital	1
General Hospitals	8
Women and Children Hospital	2
NOMA Hospital	1
Leprosarium Hospital	1
College of Hospital Science	1
School of Nursing UDUTH	1
School of H. Tech. Gwad	1
School of Nursing and Midwives	1
School of Med. Rec. UDUTH	1
Health Clinic UDUS	1
School of Com. Med. UDUTH	1
WCWC	1
Primary Health Centres	5
Rural Health Centres	4
Health Clinics	22
Health Office	2
Epidemiological Unit	1
Zonal Health Offices	4
Upgraded Dispensaries	46
Dispensaries	399
Private Health Clinics	33
Patent Medicine Store	
Total	**540**

Source: Dept. Of planning Research and Statistics, Sokoto State February, 2000.

APPENDIX XI

HEALTH MANPOWER BY CATEGORY IN SOKOTO STATE AS AT 31ST JUNE 2000

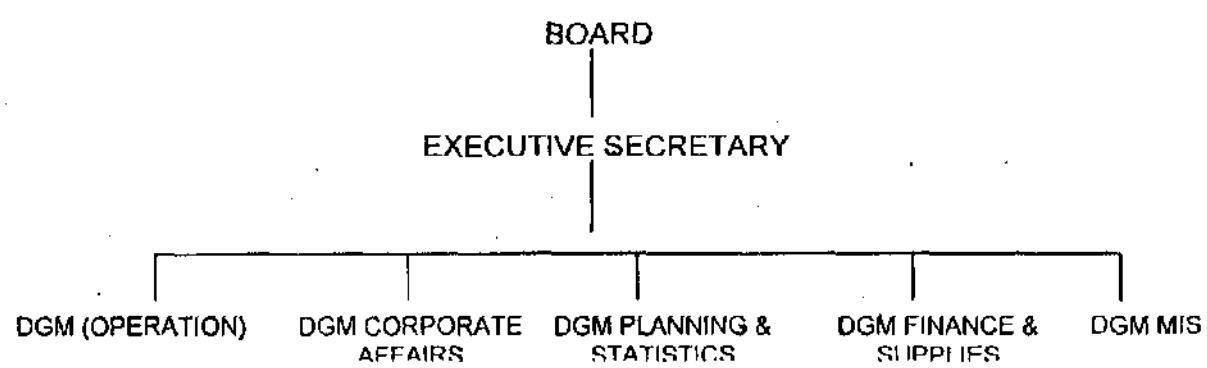
S/N	HEALTH PERSONNEL CATEGORIES	FEDERAL	STATE	LGA	PRIVATE	MALE	FEMALE	MALE	FEMALE	TOTAL
1.	a) Surgeons	4	3	5	19	31	1	8		40
	b) Physicians	2				2				2
	c) Pediatricians	3	1			4				4
	d) Obstetrics & Gynecologist	4	2			4	2			6
	e) Others (please specify) psyc.	9				6	2	1		9
2.	Medical practitioners	90	21			3			1	4
3.	Dental practitioners	3				3			1	4
4.	Health planners/Administrators		1	4		5				5
5.	Health Researchers		1			1				1
6.	Nurses (SRNs/SCNs	134	218	53	33	355	83			438
7.	Nurse Midwives (RMs/SCMs)	196	196	20	17		429			429
8.	Specialist Nurses	38				24	14			38
9.	Pharmacist	14	6			17	3			20
10	Pharmacy Technicians	9	31	54	3	87	10			97
11.	Environmental Health officers		24	48		69	3			72
12	Med. Lab. Technologist	20		1	1	16	6			22
13	Med. Lab. Technicians	6	31	7	2	41	5			46
14	Med. Lab. Assistants	26	13	5	3	41	6			47
15	Statisticians/Med. Record Off.	40	22	21	5	71	17			87
16	Radiographers	4	2			5	1			6
17	Community Health Officers	8	18	41		51	1			67
18	Comm.. Health Ext. Workers		31	584	3	462	156			618
19	Physiotherapists	4	2			6				6
20	Dental Technologists	1	3		2	4	2			6
21	Dental Therapists	3				3				3
22	Optometrists	1				1				1
23	TBAs			918			918			918
24	Health Educators	2	2	1		4	1			5
25	Epidemiologists									
26	Others	48	287	60	50	318	127			445
	Total	**669**	**915**	**1822**	**138**	**1730**	**1808**	**11**	**3**	**3557**

473922

Source: Dept. of planning Research and Statistics, Min. of Health Sokoto, Feb. 2000.

APPENDIX XII

ORGANISATIONAL STRUCTURE (ORGANOGRAM) FOR THE NHIS



APPENDIX XIII

NATIONAL HEALTH INSURANCE SCHEME (NHIS)

INTRODUCTION

The National Health Insurance Scheme (NHIS) is a body corporate established under Law (Degree) Number 35 of 1999 by the Federal Government of Nigeria to improve the healthcare for all Nigerians at a cost the government and the citizens can afford.

It is a form of social health insurance, which pays for healthcare 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 in risk sharing. By its very nature, health care expenditure is often unexpected and potentially large. Under an insurance scheme, a premium is paid by an individual and in return, the costs of care for that individual are covered should they fall ill.

The establishment of the NHIS was informed among other things by the general poor state of the nations health care services, the excessive dependence and pressure on government provided health facilities and the inadequate participation of private health services coupled with appropriate distribution of both public and private facilities in the country.

Objectives of the Scheme

- To ensure that every Nigerian has access to good health care services.
- To protect families from the financial hardship of huge medical bills
- To limit the rise in the cost of health care services
- To ensure equitable distribution of health care costs among different income groups
- To maintain high standard of health care delivery services within the scheme.
- To ensure efficiency in health care services.
- To improve and harness private sector participation in the provision of health care services.
- To ensure equitable distribution of health facilities within the federation.
- To ensure appropriate patronage of all levels of health care.
- To ensure the availability of funds to the health sector for improved services.

Coverage

The scheme will be implemented in phase to cover all Nigerians categorized as follows:

- **Persons Employed in the Private Sector:**

  Their contributions will be paid by/through their employers

- **Persons Employed in the Public Service:**

  Their contributions will be paid by/through their employers, i.e. the federal, State and Local Governments including parastatals and Agencies.

- **Self – Employed persons (Market Women, Traders, Farmers, and Business Men e.t.c.)**

This category shall pay their contributions directly or through cooperatives formed by them.

- **Vulnerable Groups:**

  This includes the unemployed, the aged, disabled, street children, the retarded and the retirees.

  Their contributions shall be paid on their behalf of the government, NGOs, local communities and philanthropists.

- **Rural Dwellers not in above Categories:**

  For this group, suitably priced programmes shall be designed for them.

Stakeholders In The Scheme

These include:-

a. Contributors

These are persons registered under the scheme who have their contributions paid by them or for them in order to receive health care benefit. For a token fee paid regularly, the contributors and their dependants are guaranteed good quality health care whenever they fall ill.

b. Employers

These are public or private sector organizations employing persons for whom they are required to pay contributions.

c. Health Maintenance Organizations (HMOs)

These are limited liability companies, which may be formed by private or public establishments registered to facilitate the provision of healthcare benefit to the contributors.

d. Health Care Providers

These are licensed government or private health care practitioners or facilities registered by the scheme for the provision of prescribed health benefits to contributions and their dependants.

They are either primary care providers, or fee–for–service health care providers.

How the Scheme Works

Contributions made by/for an insured person entitles him or herself, spouse and four children under the age of 18 years to full health benefits. Extra contributions will be required for additional dependants.

In order to participate in the scheme contributors will first register with an NHIS approved HMO and thereafter with a primary health care provider of his/her choice (private or public) from an NHIS approved list of providers supplied by his HMO.

Upon registration, a contributor will be issued an identity (I.D) card with a personal identification number.

In the event of sickness, the contributor presents his I.D card to his chosen primary healthcare provider for treatment.

A contributor has a right to change his primary care provider after a minimum period of six (6) months if he is not satisfied with the services.

Payment for services rendered to him will be made to the health care provider by the Health Maintenance Organization (HMO).

A contributor may be asked to make a small co – payment where applicable at the point of service.

Contributions

Employed persons shall be required to pay 5% of their gross earnings, while their employers shall pay 10% on their behalf. Employees already enjoying free medical services will have their employers pay the whole contributions for them.

Other contributors (voluntary, self employed, rural dwellers etc.) will pay flat rate contributions quarterly.

Health Care Benefits of the Scheme

Upon registration, contributors are entitled to the following benefits:

i. Defined elements of curative care such as:

- Out – patient attendance
- Maternity care for up to four (4) live births for every insured person
- Consultation with defined range of specialists.
- Hospital care in public or private hospital in a standard ward during a stated duration of stay for physical or mental disorders.
- Eye examination and care, excluding provision of spectacles.
- Dental care as defined:
  - Consultation
  - Oral examination
  - Preventive care
  - Pain relief

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ii. Preventive care including immunization, family planning, antenatal and postnatal care, and health education.

iii. Availability of prescribed drugs and diagnostic tests.

iv. Prostheses and rehabilitation.

ADAPTED FROM THE HANDBOOK FOR THE NATIONAL HEALTH INSURANCE SCHEME (1999).

APPENDIX XIV

A STUDY OF THE ATTITUDE OF CIVIL SERVANTS TOWARDS THE NIGERIAN NATIONAL HEALTH INSURANCE SCHEME

1.0 PERSONAL DATA

1.1 Age ☐

1.2 Sex — Male ☐ Female ☐

1.3 Marital Status — Married ☐ Single ☐ Others (Specify) ☐

1.4 Family Size — Spouse/s ☐ Children ☐ Dependents ☐

1.5 Duration of Service (yrs).....

1.6 Grade Level — 1 - 5 ☐ 6 - 12 ☐ 13 - 17 ☐

1.7 Rank / Position.....

1.8 Job Type.....

2.0 How do you perceive your present state of health? Good ☐ Fair ☐ Poor ☐

3.0 Are you or any family member or dependant suffering from any of the following?

4.0 *Hypertension* ☐ Diabetes ☐ Physical disability ☐ Any other chronic illness (Specify) ☐

4.0 a. During the last 3 months did you or any family member fall sick? Yes ☐ No ☐

b. What was the ailment?.....

c. How much was spent?.....

5.0 a. What is your average monthly medical bill?.....

b. Who pays these bills? Self ☐ Employer ☐ Insurance ☐ Others (specify) ☐

6.0 Where do you or family members seek for medical care when ill?

Private Facility ☐ General Hospital ☐ Teaching Hospital ☐ PHC ☐ Others specify ☐

7.0 What do you think of the services offered by these facilities in terms of:

		Poor	Good	V. Good
i.	Quality of care	☐	☐	☐
ii.	Accessibility	☐	☐	☐
iii.	Availability of drugs and equipment	☐	☐	☐
iv.	Staff attitude and waiting time.	☐	☐	☐

8.0 What do you think is/are responsible for the inadequacies (if any) with these facilities?.....

9.0 Do you consider the cost of medical care as an obstacle to the use of medical services? Yes ☐ No ☐

* **Having read the information on the National Health Insurance Scheme (NHIS), kindly respond to the following.**

			Yes	No
10.0	a.	Are you willing to participate in the scheme when it finally takes off?	☐	☐
	b.	If no, why?.....		

11.0 What do you think of the 5% deduction from your gross earning? .....

12.0 What do you think of the health care benefits from the scheme?

.....

13.0 What is your opinion about the scheme in terms of:

		Yes	No
a.	It's potential for success	☐	☐
b.	Sustainability	☐	☐

14.0 a. Do you see the scheme as being able to solve the problem of funding for the health care services? Yes ☐ No ☐

b. If no why? .....

15.0 Please assess the scheme in terms of its ability to:

		Poor	Good	V. Good
i.	Protect families / Individuals from huge medical bills.			
ii.	Improve quality of care in health facilities			
iii.	Improve accessibility to health care services.			
iv.	Improve waiting time and staff attitude to patients.			

16.0 Please express if any, your reservation about the scheme .....

Thank you for participation.

DR HAMZA ALIYU.