ASSESSMENT OF CLIENTS' SATISFACTION AND QUALITY OF OUTPATIENT CARE UNDER THE NATIONAL HEALTH INSURANCE SCHEME AT BARAU DIKKO SPECIALIST HOSPITAL KADUNA, KADUNA STATE

BY

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DECLARATION

I hereby declared that this research work titled Assessment of client satisfaction and quality of care under the National Health Insurance Scheme, a case study of Barau Dikko Specialist Hospital Kaduna; was carried out by me under the supervision of Dr A.A. Aliyu of department of community medicine, Ahmadu Bello University Zaria in year 2010. Efforts of other researchers in related areas of my study were duly acknowledge and listed in the references.

_____ _____

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CERTIFICATION

This thesis entitled **"ASSESSMENT OF CLIENTS' SATISFACTION AND QUALITY OF OUTPATIENT CARE UNDER THE NATIONAL HEALTH INSURANCE SCHEME, A CASE OF BARAU DIKKO SPECIALIST HOSPITAL KADUNA"** by **SALAWUDEEN, Sikiru Abdulrasheed** meets the regulations governing the award of the degree of Master in Public Health of Ahmadu Bello University, Zaria and is approved for its contribution to knowledge and literary presentation.

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DEDICATION

This work is dedicated to Almighty Allah (SWAT) for His infinite mercy and guidance throughout the programme to my wife Mrs Hussaina Salawudeen and my children, Abdulkabir and Khadijah for their patience, understanding and support during this programme.

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ABBREVATIONS

A&E	-	Accident & Emergency unit
BDSH	-	Barau Dikko Specialist Hospital
CDR	-	Centre for Development Research
CBHI	-	Community Based Health Insurance
COPE	-	Consumer Oriented Performance Evaluation
CAHPS	-	Consumer Assessment Health Plan Strategy
DRF	-	Drug Revolving Fund
DDM	-	Data for Making Decision
GHS	-	Ghana Health Survey
GDP	-	Gross Domestic Product
GOPD	-	General Outpatients Department
HCP	-	Health Care Provider
HDI	-	Human Development Index
HMO	-	Health Maintenance Organisation
HHRAA	-	Health & Human Resources Analysis for Africa
HND	-	Higher National Diploma
ILO	-	International Labour Organization
MDGS	-	Millennium Development Goals
MHO	-	Mutual Health Organization
NHIS	-	National Health Insurance Scheme
NEEDS	-	National Economy & Empowerment Strategy
NLSS	-	National Living Standard Survey
NHFP	-	National Health Financing Policy
OOPS	-	Out of Pocket Spending

OND	-	Ordinary National Diploma
QUATE	-	Quality of Healthcare Services through Eye
RN/RM	-	Registered Nurse/Registered Midwife
SHIP	-	Social Health Insurance Programme
SAHR	-	South Africa Health Review
SQUAT	-	State Quality Assurance Team
SPSS	-	Statistical Package for Social Science
THE	-	Total Health Expenditure
WHO	-	World Health Organization

SUMMARY

Its widely acknowledge that the performance of a national health system is largely determined by its financing mechanism. Hence, the Federal government through the NHIS is implementing a social health insurance programme and hopes to achieve a more flexible, more innovative and more competitive response to the health sector in order to ensure that every Nigeria has access to quality healthcare, that families are protected from the financial hardship of huge medical bills, ensure equitable distribution of healthcare costs among different income groups, improve and harness private sector participation in the provision off health services, equitable distribution of healthcare facilities within the federation, ensure availability of funds to the health sector for improved services.

The study was conducted to assess the Knowledge and quality of outpatient care from the perspective of the NHIS clients, health providers and health managers under the scheme at Barau Dikko Specialist Hospital Kaduna. Five years after the commencement of the scheme, although the level of awareness is very high, 41.7% of the NHIS enrollees, 48.6% of the healthcare providers and 55.6% of the healthcare managers of the facility were knowledgeable on various aspects of the operation of NHIS. The NHIS enrollees and healthcare providers of the facility rated positive staff attitude, adequate information/communication about services and technical competence of the healthcare provider as the most important quality indicator in the outpatient care whereas the healthcare managers are looking at quality of care in the direction of improved funding, provision of physical infrastructure and having adequate trained personnel. Majority of the enrollees said that past experience and high expectations are the main reasons for choosing the hospital during registration. The of rate utilization of outpatient care of 38% per annum by NHIS clients shows some improvement while the pattern of utilization is more of re-visit with the referrals very low. The level of NHIS enrollees' satisfaction with outpatient care services in facility is 43%. The awareness of the existence of the scheme was very encouraging; however, this was not translated into knowledge of the

principles of the operation of the scheme, these therefore call for an aggressive publicity drive and intensive educational campaigns. This study showed that client satisfaction with outpatient care under NHIS is largely determined by the knowledge of the rudimentary principles of the operation of the scheme.

CHAPTER ONE

INTRODUCTION

Health care financing and health sector reform have engaged the attention of policy makers in the World with the focus centred on reviewing the ways their health systems are financed. Healthcare financing is one of the four functions of health sector reform agenda[1]. In developing countries, which are mostly in Africa, Asia and Latin America, the basic problems are failure to finance healthcare with pervasive under funding and insufficient financial resources to provide minimally adequate healthcare for everyone's needs. One of the most important factors responsible for this, is the inadequacy of tax based revenue as a source of fund for financing already over burdened and bastardised public healthcare services. Appreciating the central role of health as a necessary ingredient for socio-economic development, the government of these countries were forced to review their policies on healthcare 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 which include among others: user fees, cost recovery mechanisms (DRF), health insurance etc.

Public health system in Nigeria, have failed to delivered adequate level of services, especially to the disadvantage groups[3]. Firstly, access to public healthcare is limited, due to financial barriers such as availability and accessibility of health facilities. Secondly, public health workers morale is poor, as salaries in public health sector are low in Nigeria, especially at state levels. As result of poor healthcare delivery system, the utilization of public health services is actually decreasing in some areas. Discontent with present situation is continually increasing among the general population; significant improvement is highly expected with the establishment of NHIS.

Arguably, the Nigeria Economic Empowerment Development Strategies (NEEDS) framework is the reference point of government's commitment to implementation of substantial cross sectional coordinated economic growth, development, stability and a rapid and significant transformation and improvement in standards of life and welfare of all Nigerians.

The Nigerian Health sector is no doubt one of the cardinal sectors whose successful reform will shape the direction and pace of national economic growth and development. However the sector has witnessed several years of neglect, decay of infrastructure, poor funding, inappropriate human resources, lack of comprehensive healthcare financing mechanism and limited financial risk protection. At the inception of the present civilian administration 1999, Nigeria was reported as having one of the lowest annual budgets dedicated to health sector in Africa, which is less than 5% of the total budgetary allocation[2]. The Nigeria per capita expenditure of US$5 is far below the US$14 recommended by World Bank in 1997/98 and US$34 suggested by WHO micro-economic commission on health in 2000; for effective healthcare delivery system. The Nigeria Total Health Expenditure (THE) per capita of US$17 is inadequate when compared with WHO's recommended per capita THE of US$33 to US$40 for low income countries. A large portion of the total health expenditure is out of pocket payment for healthcare services[3].

It is widely acknowledged that the performance of a national health system is largely determined by its financing and payment mechanism[4]. It is therefore of little surprise that one, if not, the most important policy goal and objective of a national health system is to secure a stable and sustainable ways and means by which funds are mobilised to pay for essential health services in equitable, fair and just manner, such that everyone is protected

against the catastrophic and poverty induced effects of ill-health. Developing and implementing a sustainable healthcare financing strategy are key success factor for health sector reforms in Nigeria and in improving the health status of a majority of Nigerians.

In our attempt to reform the Nigerian health system, a Federal Ministry of Health led health sector reform process has been put in place and has since 2005 commenced implementation. A major thrust of the reform process is putting in place a sustainable mechanism to finance health care. It is widely acknowledged that the most important control knob for reforming the health sector is financing mechanism. The National Health Insurance Scheme (NHIS), though very recent in commencement, represent till date, the singular most important element in a rapidly emerging health care financing strategy for our national health system.

Through the NHIS the government is implementing a Social Health Insurance Programme (SHIP) and hopes to achieve more flexible, more innovative and more competitive response to the health sector in order to ensure that every Nigerian has access to quality healthcare. Families are protected from the financial hardships of huge medical bills, ensure equitable distribution of health care costs among different income groups, improve and harness private sector participation in the provision of healthcare services, equitable distribution of healthcare facilities within the federation and ensure the availability of funds to the health sector for improved service. The NHIS is responding with programmes and products such as the Formal Sector Health Insurance Programme, Organised Private Sector Health Insurance Programme, Vulnerable Group Social Health Insurance scheme, Student of Tertiary Institution Health Insurance Scheme and Armed Forces, Police and other Uniformed Services Social Health Insurance Programme.

In Nigeria, like other developing countries, the quality of public health services and facilities was either very low or there was prevalence of substandard and unregistered health institutions. The resultant effects of these were that at some point, our health institutions become shadow of themselves and consequently, reduced to poorly managed 'consulting clinic' which could hardly handled serious health problems. This ugly development took its toll on ordinary Nigerians who could not afford to travel abroad for quality health care attention and this caused an increase in mortality rates and the incidence of ill-health.

In recent years developing countries, influenced heavily by funding of healthcare system, are increasingly putting more emphasis on assessment of the quality of their healthcare. Underutilization of public healthcare services in developing countries is widely believed to be a result of consumer disappointment with quality of care[5].

Healthcare providers all over the world are facing difficult challenges and the public's expectation of them continues to rise. Yet as a result of fiscal constraints, often created by worsening economic conditions, they are asked to provide more, higher quality health services with fewer resources.

The term 'satisfaction' and 'quality assessment' are often used interchangeably and while they have one thing in common, satisfaction is generally seen to be the broader concept and one that can be viewed at individual service encounter level or at more global level[5]. Client evaluation is relative to knowledge of services, to expectations; to the help received from other services, to perceptions of the 'pleasantness' of the health worker[6]. Unless such factors are taken into account, we can never be sure whether the high rate of client satisfaction is related to factors of knowledge or limited expectations, than the actual helpfulness of the social contact. Client satisfaction is a fundamental indicator of

success in any form of service delivery and is therefore a key component of quality of healthcare.

Quality of care is a complex multidimensional concept which presents researchers with challenges when attempt are made to evaluate it[7]. From the available literature, there are evidence that patient satisfaction as an indicator of quality is compromised on a number of fronts and also conflicting information on how Healthcare Providers (HCPs) and users of healthcare services think about quality. Quality of healthcare is best looked at in the perspective of the three key players of the health services, the client, the healthcare provider and the health manager[8]. Most of the quality improvement initiatives are provider centred making it difficult to predict the patients' needs while few are patient centred neglecting the provider who is giving the care directly to the patients[10]. Again in most instances studies about quality of care were basically mere assessment of quality of care in various health institutions, while overlooking what actually constitute quality in the perspective of all the key players during service delivery.

Consumer satisfaction with healthcare has in recent years, gained widespread recognition as a measure of quality of care. Since high quality healthcare outcome is dependent on compliance which, in turn, is dependent on patient satisfaction, the latter has come to be seen as a legitimate healthcare goal and therefore of quality care. Hence care cannot be high quality unless the patient is satisfied. Increasing consumerism poses challenges for healthcare providers (HCPs), particularly for those in primary care. Quality improvement to meet patients' heightened demands for service excellence will require effective continuous measurement of patient perspectives. By systematically measuring patient satisfaction and perception of quality, medical practices can increase the effectiveness of primary care, improving patients' outcome and control cost[8].

Client satisfaction is regarded as one of the ultimate goals that all health system should strive for; it reflects the health system in client prospect. Yet public health care in developing countries have failed to achieve adequate level of services. In Nigeria for example, satisfaction for public health care is considerably low. To improve public participation and effectiveness of the undergoing health reform initiative in Nigeria, the underlying factors that contribute to consumer's satisfaction for public health services must be fully understood.

CURRENT STATE OF THE HEALTH SERVICES IN NIGERIA

Indication that all was not well with the health services started manifesting in the early 1980s. Then the health institutions in the country were variously described as ''mere consulting clinics'', ''Glorified mortuaries'' and so on. Public healthcare facilities were severely affected by rising costs, government budget cuts, and material shortage. Couple with this identified defects of the health system which among others include the following

i. High poverty rate in the face of raising out of pocket payment.
ii. Inadequate coverage, as no more than 35% of the population has access to modern health care services, rural dwellers and urban poor not well served, due largely to the inequitable distribution of health resources.
iii. Poor quality of healthcare delivery.
iv. Dilapidated infrastructure with obsolete equipments and inadequate qualified personnel, compounded by flight of skill health professional for greener pasture abroad.
v. Little or no support for training and research.
vi. Poor private sector participation in the nation at health sector.

All these problems have reflected on the health status of Nigerians as evidenced by the national health indices which compare unfavourably with that of some sub-Saharan African countries and some war torn countries in the world.

Recent assessments of the health of the Nigeria population indicate that the health situation in Nigeria and of Nigerians is dismal and efforts to change the situation over the years have been insignificant. Indeed, Nigeria lags behind many other African countries on various health indicators. A WHO evaluation of the health situation in different parts of the world placed Nigeria 187 out of 191 countries that were surveyed in 2000. Indeed, UNDP's 2005 Human Development Report ranks Nigeria 158 out of 177 countries in the World in terms of overall Human Development Index (HDI). Compared with South Africa and Ghana, the indices for life expectancy, infant mortality, and maternal mortality rates are higher in Nigeria than in other countries. For 2000- 2005, life expectancy at birth was estimated at 43.3 years for Nigeria, compared to 56.7 years for Ghana and 49 years for South Africa. In 2003, infant mortality rate was estimated at 97% per 1000 live births for Nigeria, while the figures for Ghana and South Africa were 59 and 53, respectively.

STATEMENT OF PROBLEM

Recently available data from National Health Account (NHA) [3] shows that a disproportionately large portion of expenditure for health in Nigeria comes from households; in the form of out of pocket spending (OOPS), only about 22% comes from the combined total federal, state and local governments. Direct out of pocket payments for health are widely agreed to be inequitable, inefficient, impose major financial burden and serve as a barrier to quality healthcare and utilization of health services. OOPS has also been widely adjudged as not a preferred method of financing access to quality

healthcare, as it tends to push low income households into poverty as they are often forced to borrow and/or decapitalised their saving or asset in order to raise money for the household. The alternative sources of financing of health such as user fees and Drug Revolving Funds (DRF) that were instituted some years ago have collapsed in most instances. Until recently, the slow pace of the take off of the NHIS did not help matters. Available data from NHA also suggest that less than 4% of Total Health Expenditure (THE) comes from some form of health insurance, which is wholly private and with the commencement of social health insurance coverage has risen to about 15% of THE in 2005 alone[1].

Presently, public expenditure funded through general tax revenue in Nigeria account for 20 – 30% of THE and private expenditures account for 70 – 80% of expenditure and the dominant private expenditure is OOPS, which is about US$22.5 per capita and account for 9% of total household expenditures as reported by the Federal Office Statistic,2004. Nigeria was reported as having one of the lowest annual budgets dedicated to health sector in Africa, which is less than 5% of the budgetary allocation. Nigeria per capita expenditure of US$5 per person per capita is far below the US$14 recommended by World Bank in 1997/98 and US$34 suggested by WHO micro-economic commission to provide an essential package of public health interventions in order to achieve health related MDGs[3].

In addition to the relatively low level of healthcare financing, Nigeria needs to face the challenges associated with the combination of health financing mechanisms in the country. The existing national financial risk pooling mechanism, the NHIS, leaves the vast majority of the population employed in the rural area and informal sector without any protection against financial risks associated with illness. Consequently, the majority

of Nigerian families' rely heavily on OOPS in their interactions with formal Health Care Providers (HCPS) which constitute major barriers to access to quality health care and a major risk of impoverishment in the case of catastrophic illness. Nigerian families' out of pocket expenditures account for 60-70% of total health expenditure, compared to 20-30% of total health expenditure from federal, state and local government sources combined.

In a country where health insurance is known and enjoyed by few, with over 80% of the populace still picking up their medical bills regardless of their employment status, Nigeria, no doubt has a health care crisis at hand. The facts are clear and hardly incontestable, with the larger population remaining unemployed or underemployed. Access to quality healthcare, in a country like Nigeria, is still seen as a privilege rather than a right. Even with in the league of the employed or those who have bought one health insurance product, the fact that there is the absence of a broad based functional national health insurance scheme, which is limited only to the formal sector of the society, still has a peculiar way of exerting added pressure on one's purse.

As with any new people oriented programme, especially in Nigeria, one may expect criticisms and objections mostly premised on insufficient or distorted information or even outright ignorance of the operation of the programme. Therefore the success of NHIS would be determined to a great extent by its wide acceptability which in itself is subject to the level of awareness and understanding of the scheme by all stakeholders. The knowledge of these clients, healthcare providers and healthcare managers is therefore crucial for the realisation of the objectives of the scheme. Also, the fact that very little work has been done in this area, the ones conducted in Enugu[10], Minna[11] and Jos[12] on the knowledge of healthcare providers and in Sokoto[13] on the knowledge of civil servants on NHIS revealed grossly inadequate knowledge and awareness and due to the fact that

these studies were carried out before the commencement of the NHIS formal sector programme in 2005, makes this particular study imperative.

Client's satisfaction with public health care delivery, especially since the inception of NHIS in Nigeria, has not been widely studied. Several unpublished surveys revealed that the overall service utilization and satisfaction with public healthcare in Nigeria despite the commencement couple with the slow pace of implementation of NHIS since 2005 is considerably low and the possible contributing factors include poor knowledge and awareness of the NHIS operational modalities by the public, Skeptism and lack mutual trust of the public on government policies/programmes with NHIS not an exception, ,cumbersome NHIS referral system, poor healthcare providers attitudes, conflicts among healthcare professionals as regards their roles in the scheme, fraud/corruption in the Health Maintenance Organisation(HMO) operation in the scheme etc[14].

In an effort to cope with the spiralling cost of health care, the Nigerian National Healthcare Financing Policy (NHFP) 2006[15] articulates funding of health sector from budgetary sources, and recognizing additional avenues of revenue such as health insurance schemes and direct financing by employers of labour. Thus, NHIS represents very promising sustainable healthcare financing strategy, through which the government hopes to achieve more flexible, more innovative and more competitive response to the health sector in order to ensure every Nigerian has access to quality healthcare services.
The study intends to assess the knowledge of the client, the healthcare providers and the healthcare managers, and also to look at quality in the perspectives of all the three key players of a health system, the level and pattern of utilization of outpatient care and clients' satisfaction with outpatient care under the NHIS in BDSH Kaduna. The survey questions were intended to gauge the respondent's knowledge/awareness, healthcare user

preference, satisfaction levels, perceived quality and efficiency of public healthcare delivery in terms of financial affordability, physical accessibility, environment, workforce strength, health workers attitude, confidentiality/ privacy, pricing etc. This study also intends to look at the impact of NHIS intervention on the quality of healthcare in public healthcare delivery system since its inception, which is one of the major problems of the nation health system and to recommend a comprehensive quality package to the management of the NHIS and BDSH Kaduna

The research topic was chosen because studies examining patient's satisfaction with healthcare provision in Nigeria and, more specifically, the perceived quality given by the healthcare providers and the healthcare managers are limited. Moreover the influence of health insurance on the levels of patient's satisfaction and quality of care is relatively unexplored, since the commencement of the NHIS in 2005. The choice of the facility was born out of the fact that it has one of the highest numbers of NHIS registered beneficiaries and general outpatient attendance to allow for recruitment of diverse number of clients with diverse experiences of the outpatient facilities.

OBJECTIVES

GENERAL OBJECTIVES:

To assess the clients satisfaction and the quality of outpatient care under the National Health Insurance Scheme at Barau Dikko Specialist Hospital, Kaduna.

SPECIFIC OBJECTIVES:

1. To assess level of knowledge of clients, healthcare providers and healthcare managers on the operations of NHIS.
2. To identify what constitutes quality of outpatient care in the perspectives of the client, healthcare providers and healthcare managers.

3. To assess the rate and pattern of utilization of outpatient care by NHIS clients at Barau Dikko Specialist Hospital Kaduna from January to December, 2009.
4. To determine the level of NHIS client satisfaction with outpatient care at Barau Dikko Specialist Hospital Kaduna.

CHAPTER TWO

LITERATURE REVIEW

HEALTHCARE FINANCING

Over the years, policy makers have been confronted with the question of how much revenue can be raised for the health sector, and how much resources can be allocated in a manner that is most equitable and efficient. This has feature severally on the agenda of discussions of health policy makers. The main concern particularly for the developing countries was how to maintain expenditure[15]. Clearly, 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 healthcare services.

The Nigeria National Financing Policy 2006 (NHFP 2006)[16] call for federal, state and local government to allocate not less than 15% of their total budgets to health in accordance with the Abuja declaration of 2000 in order to move towards filling the funding gaps of the health sector and funding needs towards reaching the health MDGs. Health expenditures are relatively low in Nigeria; total per capita health expenditure is estimated to be between US$ 10 – 15 which is substantially lower than the US$34 per person year recommended by the Commission for Macroeconomics and Health to meet the MDGs.

The NHFP has identified policy options which, if effectively elaborated and combined, could contribute to facing these challenges associated with combination of health financing mechanism in the country. These policy options include financial provisions to be made for poor and vulnerable groups in the form of direct payments, subsidies, paying for insurance contributions or any other methods. The NHPF encourages the expansion of

social health insurance through NHIS to cover the informal sector as a means of increasing resources for health, ensuring universal access to care and providing financial protection to the poor and vulnerable. In addition, the NHFP framework identify the exploration and strengthening of community based healthcare financing schemes as an option of extending coverage in the informal sector and rural areas.

SOURCES OF FINANCING THE HEALTH SECTOR

There are generally five primary methods of funding healthcare system.[15]

1. Direct or out of pocket payments
2. General taxation
3. Social health insurance
4. Voluntary or private health insurance
5. Donation or community health insurance

Funding health in Nigeria is from variety of sources that include budgetary allocations from government at all levels, loans and grants, health insurance, private sector contributions and out of pocket expenses. Although Federal Government health recurrent budget showed an upward trend from 1996 to 1998, a decline in 1999 and began to rise again in 2000, available evidence indicates that the bulk of health recurrent expenditure as a share of total Federal Government recurrent health expenditure stood at 2.55% in 1996, 2.96% in 1997%, 2.99% in 1998, declined to 1.95% in 1999 and 2.5% rose in 2000[17].

According to Asenso-Okyere, [18] the sources of finances for health sector in Ghana are the government budgetary allocations, private sectors (firms & household), health insurance (NHIS/community-based), donors and Mutual Health Organizations (MHO). Although, per capita public health spending has been increasing steadily over the period, 2000-

2006, according to Asenso- Okyere it is still below the levels achieved by some sub-Saharan African countries such as Mauritius, Botswana and South African, the WHO reported that Ghana's per capita public health expenditure was US$31 while Mauritius had US$105, nevertheless this is by far greater than that of Nigeria. It is worth mentioning that the boost in public health spending in Ghana has been fuelled by donor support. For instance, the donor support as a proportion of public health spending amounted to 11.1%, 16.2% and 14% in 2003, 2005 and 2006 respectively.

South Africa has a health delivery system which is a mix of robust private sector, struggling public sector and some non-governmental not- for profit organisations. Private health insurance cover, delivered through medical schemes, is voluntary and serves only the 14.8% of the population with higher incomes. Healthcare is delivered to these members predominantly in the private sector which is well developed, resources intensive and highly specialised. It is estimated that 21.1% of the population are not covered by health insurance but prefer to use private primary care providers on an out-pocket-basis. This group is almost entirely dependent on the public sector for specialist and hospital care. The remaining 64.2% of the population are dependent on the public sector for all their conventional services[19].

Approximately 60% of the total expenditure on healthcare in the country flows via private intermediaries and only 40% through the public sector. The major difficulty with the over- resourcing of private health insurance and under-resourcing of the public sector is that healthcare providers have been attracted to more lucrative private system.

In another study by James A[20], the incidence of healthcare financing in Ghana, South Africa and Tanzania, as in high-income countries, general tax revenue and health

insurance were found to be progressive in all the three countries and there was not a consistent trend in relation to OOPS.

HEALTH INSURANCE

Health insurance as a means of promoting universal health coverage has attracted considerable interest in the past[21]. Yet, the multi-dimensional nature of health insurance makes more studies on health insurance knowledge/awareness, perception, coverage, access and impact necessary.

Many of the earlier studies have concentrated on developed economies where, the insurance system is well developed. Recently, however, we begin to see papers that address the use of health insurance as an option for financing and facilitating access to healthcare in developing economies. Notable among the recent researches is that of the Centre for Development Research (CDR) [22] that examined the feasibility of health insurance scheme in rural areas in a number of developing countries including Senegal and Ghana in West Africa, Ethiopia in East Africa and Tanzania in Southern Africa.

An overview of these researches reveals that two factors appear to be driving developing countries towards a health insurance option. One is the need to attract more resources to the health sector and another is their dissatisfaction with the existing services[23]. Jutting[22] provided some evidence of government limitation and failure in a number of developing countries. In Nigeria, for instance, 67% of Gross Domestic Product (GDP) for medical expenses is met by OOPS. Jutting argued that such high proportion of out of pocket expenditure is sufficient justification to switch to private insurance that can spread the risk of above- average OOPS.

In Senegal, jutting[24], using combined logit and log-linear models, found that members of the rural populace who participate in the insurance scheme have higher probability of

using hospitalization services than non-members and pay substantially less when they need care, this reinforces the findings of Agba[25] in a study conducted among the staff of Federal Polytechnic, Idah, Nigeria on the perceived impact of NHIS. In Uganda, Manje L[26] reported that provision of low-cost income workers enabled insurance premiums increased the sustainability of health financing. Instances where, health insurance seems to have worked in Nigeria is Anambra state community health systems and healthcare financing scheme[58] and the Community based social health insurance scheme in Songa, Kwara state, being co-funded by the state government and a donor agency from Netherlands[25].

Health Insurance is social security arrangement that guarantees the provision of the needed health care services to a person on the contribution of a token to provide financial protection to the participants. Health insurance is a mechanism for protecting families against the unexpected high costs of illness by sharing the risks of future costs among healthy and sick populations in the form of regular predictable payments.

Three principal types have been identified, but in Africa, studies have revealed four common models[28,29]. These include:

i. Social Health Insurance Scheme
ii. Private Health Insurance Scheme
iii. Employer Based Health Insurance
iv. Rural Community Based Health Insurance

In a study in 1990[22], six different forms of government health insurance were identified in sub-Saharan Africa. This study found that social health insurance was available in only seven out of twenty three countries considered and private sector voluntary health insurance had a place in only five – Cote d'ivore, Ethiopia, Kenya, and Nigeria. Health

insurance schemes in different countries usually differ in terms of the extent of coverage, benefit package, administration, health services delivery, provider payment and finance.

In studying resource mobilization in five countries (South Africa, Ghana, Zambia, Zimbabwe & Botswana), Health and Human Resources Analysis for Africa (HHRAA)/ Data for Decision Making (DDM) project[30] found that health insurance was of increasing policy of interest as a method of raising resources and, potentially, improving the supply and provisions of health services. HHRAA/DDM research, however, indicated that only small percentages of the populations studied had any kind of health insurance and that insurance scheme currently do not contribute significant resources to total health care financing. Current health insurance scheme also tend to cover mainly the more wealthy income groups or the formally employed, limiting the reach of such scheme into lower income or rural populations, similar to what is found in Nigeria.

The proponents of health insurance argue that people may be more willing to pay for health insurance rather than being heavily taxed or charged user fees, this was not collaborated by the findings of the study conducted by Onwuyekwe O et al[31] on willingness' to pay for Community Based Health Insurance (CBHI) in Anambra and Enugu states of Nigeria, where less than 40% of the respondents were willing to pay for CBHI membership.

SOCIAL HEALTH INSURANCE

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 "Social Health Insurance Scheme''[27].

Social health insurance is based on the principles of social solidarity and mutual support which involve the transfer of resources from the relatively richer and healthier people to

the relatively poor and sicker people. According to Crocco P[27], two types of social health insurance scheme can be distinguished; the primary benefit model where the healthcare benefit 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 organisation (ILO) classified social health insurance into three types:

i. Direct Social Health Insurance Scheme
ii. Reimbursement
iii. Indirect Social Health Insurance Scheme

The NHIS for Nigeria is designed to be indirect social health insurance scheme with healthcare providers (public and private) to be contracted to give health care benefits to contributors[32].

Many of the earlier studies on NHIS in Nigeria have concentrated on health care providers or professionals, assessing their level of awareness on the operation of the scheme. Recently, however, we begin to see studies that address the client knowledge/awareness, utilization and satisfaction of NHIS, and moreover the impacts of health insurance intervention on assess and quality of health care in the country.

An overview of these researches reveals that the civil servants and healthcare professionals that are the major stakeholders in the programme are adequately aware of NHIS but have grossly inadequate knowledge of the basic principles of the operation of social health insurance scheme. Examining some of these works further can be illuminating. In Sokoto, Hamza A[13], in 2002 reported a low level of awareness and knowledge of NHIS among civil servants with generally high interest on NHIS. In a

related work done by Sanusi et al in 2009[33] to assess the awareness level of NHIS among healthcare consumers in Oyo state, the report shows that 65% of the respondents are aware of NHIS. However, respondents who have been treated under the programme wanted the scheme to be discontinued.

Onwujekwe O et al, in a study examine differences in enrolment and utilization in two community- based health insurance (CBIH) schemes in the South eastern Nigeria, found that enrolment was associated with enrollees perception of financial risk protection and quality of care, and the primary reasons for non-enrollment were inability to pay premiums, concurrent enrollment in government NHIS, and distance from an enrolled facility. The study further shows that the differential enrolment in the two programs can be attributed to insufficient community involvement, lack of trust in the programs, and the voluntary nature of the enrolment.

In the studies conducted on the knowledge and attitude of NHIS among healthcare professionals before the commencement of the scheme in 2005, Onuekwusi et al (1998)[10] in Enugu and Sabitu et al. (2002)[12] in Minna reported a very low proportion of the respondents who are knowledgeable on the various aspect of the operation of the scheme. In a related study done to assess the knowledge, attitude and opinion healthcare providers in Jos towards NHIS, report is in line with findings of the studies of Enugu and Minna with high proportion of the respondents expressing willingness to participate in the scheme, Danladi C. (2003)[12].

In 2009, four years after the commencement of the scheme, Okaro et al[34] report on the assessment of awareness and perception of NHIS among radiographers in Southeast Nigeria, shows good attitudinal predisposition towards the scheme, despite their lack of

adequate knowledge of the rudimentary principles of the operation of a social health insurance scheme.

TOOLS FOR MEASURING QUALITY OF HEALTH CARE

Different methods and tools are used to assess quality of healthcare worldwide, which include the following:

The Client Oriented Provider Efficiency (COPE)[24]

This is a self assessment guide designed to manage and improve quality of care in health delivery sites. Using the COPE approach, members of staff work on site to:

1. Discuss the quality of services they provide
2. Identify areas of their work that needs improvement
3. Identify what they need to provide better services
4. Find ways to solve identified problems

The tool has 5 components:

i. Self assessment guide: these are ten and are organised according to the rights of the clients and the needs of the staff that are necessary to ensure quality of care.
ii. Client's interview: these are performed by the staff with the aid of client interview forms.
iii. Clients flow analysis: this is a low technology method of tracking clients from the time they enter the facility until they leave.
iv. IMCI (Integrated Management of Child Illness) record review check lists: this instrument is used in health facilities utilizing the algorithm of management of childhood illnesses.

v. Action plan: this contains series of activities, time schedule, possible outcome of the activities, resources required and the persons to undertake the intervention activities.

Client Centred Questionnaire of the Jigawa State Quality Assurance Team (SQUAT)[36]

This tool was developed by the Jigawa State quality assurance team to track the progress of QA activities in the state. The tool is simple and user friendly; it is applied in an exit interview with the clients to capture their feelings pertaining to the quality of care they received during the visit. The questionnaires are unstructured and close ended with about 18 quality indicators at outpatient unit. This study intends to adopt some of the quality indicators developed by SQUAT.

The QUOTE Document[37]

QUOTE document is an instrument used in measurement patient satisfaction developed by Netherlands Institute of Public Health, which simply mean ‘**’Quality of health care services through patient eye’s’**’. It is a methodology that standardises the measurement of patient satisfaction as the discrepancy between patient’s needs and the extent to which this needs are being met. The QUOTE document has two sections:

1. Part 1 – This has a generic outline and is same for all QUOTE questionnaires. It contains background information about the respondent.
2. Part 2 – This is modelled to fit into any aspect of healthcare service to be assessed e.g. QUOTE Cataract, measures the quality of care of cataract patient, QUOTE Liver Disease questionnaire, measures the quality of care of patients with Liver diseases etc.

The QUOTE survey questionnaires distinguish themselves in two different aspects:

1. First of all, they do not only measure experiences of health consumers, but also focus on the importance consumers attach to the different quality aspects of care.
2. Secondly, apart from the generic items each questionnaire comprises of group specific, care-specific and disease- specific items.

The tool uses a four point scale of grading and it is client centred. This tool is adopted with some modifications in this study.

SERVQUAL SCALE[38]

The SERVQUAL scale is a quality measuring instrument currently used by several organisations to assess the quality perception of their clients and to improve their performance accordingly. This scale is composed of two sets of statements, each set consist of 26 indicators. The first set represents perceptions of service delivery (P) whereas the second set designates matching expectations of performance (E). Each item or indicator in both sets is measured using a 7-point Likert scale (1=strongly disagree & 7 =strongly agree). Service quality is calculated by subtracting expectations of performance from perception of service delivery (Q=P-E) for all indicators. The possible range of quality scores is -6 to +6. The mid-point ‘’zero’’ represents the state where perception of service delivery exactly matches expectation of performance. Quality scores above zero imply that perception of service delivery exceeds expectations, this reflecting a judgement of high quality. Finally, negative quality scores (below zero) signify a judgement of low quality. The scale items are divided into five quality dimensions as follows:

1. Tangible (4 items): physical facilities, equipment, and appearance of personnel.
2. Reliability (5 items): ability to perform the promised service dependably and accurately.

3. Responsiveness (4 items): willingness to help customers and provide prompt service.
4. Assurance (7 items): knowledge and courtesy of employees' and their ability to convey trust and confidence.
5. Empathy (6 items): caring and individualized attention given to customers.

The Consumer Assessment of Health Plan Strategy (CAHPS)[39]

The CAHPS instruments measures the healthcare experiences from the perspective of patients and consumers, providing comparative information on performances of providers to aid consumer choices and provider contracting. Is a valid and reliable instrument use to measure patient experience of hospital care. The factors structured in this tool are doctor's communication to patient, nurses' communication to patient, nursing care, communication about medication and physical environment of the hospital. In contrast to the QUOTE methodology, CAHPS questionnaires do not take the importance of the quality aspects into account and do not include group-, care-, and disease- specific items. However, these questionnaires are widely used and translated into different languages. Furthermore, the four point Likert scale answering structure of the CAHPS questionnaires (never, sometimes, often, and always), and the three –point scale (not a problem, a small problem, a big problem) affiliates well to international research.

QUALITY IN OUTPATIENT CARE

a. In The Perspective of The Client

Studies carried out to assess the quality of outpatient care in the perspective of the client included the work of Adeoye (2007)[14] and the users utilization and satisfaction survey conducted by the NHIS Northwest zonal office, Kaduna (2008)[40]. Their findings were similar in that both found low level of service utilisation and average level of user's

satisfaction with quality of services being offered by the healthcare providers under NHIS. In a study conducted Blazevka et al[41], on patients satisfaction with the care services provided by Ambulatory Care Units, about half of the respondents pointed out better communication with the healthcare professionals and better provision with information about patient health and treatment as most important quality indicator in outpatient care. In another done in rural Bangladesh to measure the client's satisfaction and the quality of outpatient care by Jorge M. et al[42], revealed that the most powerful predictor of for client satisfaction with public healthcare services was provider behaviour, especially respect and politeness. For patient this aspect was much more important than the technical competence of the provider. Furthermore, a reduction in waiting time was more important to clients than a prolongation of the quite short consultation time, with 75% of client being satisfied. This tend to underscores the facts that clients satisfaction is determined by the cultural background of the people and only looked at quality in client views without considering other key players in the delivery of quality care. Saleh M et al[43], in a similar study conducted in Jordan to assess the patient expectation and satisfaction in different hospitals found out that patient satisfaction was mainly influenced by patient expectation of received care even after adjustment for socio-demographic variables. This study therefore, argues that while assessment of patient satisfaction is a monitoring indicator for overall health care delivery performance, still there is a need to examine client expectations and tailor services accordingly since satisfaction measures can only diagnose a problem while expectation assessment can identify needs and thus health program managers can better design health services delivery. In a telephone survey with parents of enrollees using the CAHPS questionnaire conducted by Texas and Human Services Commission,2004[44] to assess parents satisfaction with their children's healthcare in the health insurance program, revealed that

families are very satisfied with the care their children receive in the program and the quality of care in the program is generally rated as very good for the children.

b. In The Perspective The Healthcare Provider

As part of the findings of the study carried out by Blazevka et al[41], also showed that on the average the healthcare providers rates technical competence in terms of professional knowledge and qualification as the most importance to the level of patient satisfaction. The study also conducted by Christine L et al[45] on the important element of care: a comparison of patient and physicians perspective in the Netherlands showed that survey response rates differed in the two groups by 58% in terms of what the patients considered as quality care as opposed to the physicians view. While the study carried by Kabir I[46] at Dutse General Hospital on the quality of outpatient care from the perspective of client, healthcare providers and healthcare managers revealed manpower strengthening and training as most important quality issues, as well as incentives to healthcare personnel from the healthcare providers perspectives. A similar study done by Jatau T[47] on quality of care at Specialist Hospital Lafiya showed that structure in terms of environmental cleanliness and equipments as well as staff strengthening, training and rewarding system are the most important predictors of quality of healthcare from the healthcare providers perspectives.

c. In The Perspective Of Healthcare Managers

From both Dutse[46] and Lafiya[47] studies, the Healthcare managers in contrast, describe quality as having adequate funding, good physical infrastructures with adequate functional equipment and improving the general welfare of their staff.

CLIENT SATISFACTION WITH HEALTHCARE

Consumer satisfaction with healthcare has, in recent years gained widespread recognition as a measure of quality of care. This has arisen partly because of the desire for greater involvement of the consumer in healthcare process and partly because of the link demonstrated to exist between satisfaction and compliance in areas such as appointment keeping, intension to comply with recommended treatment and medication use[6]. Since quality clinical outcome is dependent on patient satisfaction the latter has come to be seen as a legitimate health care goal and therefore of quality care. Care cannot be of high quality unless the patient is satisfied.

Client satisfaction assessment is widely used to evaluate the quality and the effectiveness of various healthcare service deliveries. Different methods and instruments are used to measure consumer's satisfaction. Consumer satisfaction with healthcare services is associated with many contributing factors, among which are related to health providers and healthcare delivery process.

The relationship between consumers' socio-demographic characteristics and their satisfaction with medical care is widely examined, such as age, ethnicity, gender, socio-economic status, marital status and family size. For example, Linghui J et al.[48] identify older consumers report greater satisfaction with mental healthcare services. Hall and Dorman[49] conduct a meta-analysis of 221 studies, which examines the relation of consumers' socio- demographic characteristics to their satisfaction with medical care and conclude that greater satisfaction is significantly associated with greater age and less education and marginally significantly associated with being married and having higher social status. The average magnitudes of these relations are very small, with age being the strongest correlate of satisfaction. No overall relationship is found for ethnicity, gender, income or family size.

Doyle and Ware[50,] examined major dimensions of consumer satisfaction perceptions of accessibility, availability of medical personnel's, completeness of facilities, continuity of care, and doctor's conduct and found that physician conduct was the most important factor in the general satisfaction with healthcare. Instructions regarding medication and health education by healthcare providers were found to be associated with greater levels of satisfaction in healthcare in a study carried out by Onwudiegwu U[51].

Consumer factors also have an influence on patient's satisfaction with the healthcare delivery. In a longitudinal study with 344 patients, Kumar et al[52], found that consumer's experience with healthcare was strongly associated with satisfaction and with intent to continue using the new medication.

In a related work done by Nketiah-Amponsah et al[53] on the assessment of determinants of consumers satisfaction of health care in Ghana, shows that the satisfaction level with the health system is generally high (65%), while 11% were dissatisfied. In term of specific providers, subscribers of private healthcare are more satisfied than those who demanded care from other provider's of services. Furthermore, distance, waiting time, level of education, communication, and cleanliness as well as the general attitude of the healthcare providers was found to be significant predictors of healthcare satisfaction.

In Uganda, Manje L,[26] in a study to analyse client satisfaction with health insurance in Uganda, found that awareness/knowledge on the concept of risk pooling is very poor, perceptions have been influenced by previous negative experiences with insurance and health insurance providers have not been explicit enough on the benefits, terms and condition of their policies.

Shafiu M et al[54], in a study conducted among staff of Ahmadu Bello University (ABU) Zaria to assess Client's satisfaction with the health insurance scheme in Nigeria, reported

low satisfaction which is attributed with marital status especially in polygamy, adequate knowledge of health insurance, longer duration of enrolment and also being aware of money contribution for the scheme. Better attitude of the providers towards clients, decreased waiting time in hospitals, and availability of hospital personnel at all times was also found to be significant predicator of satisfaction and would help in improving clients' satisfaction in terms of access and utilization of services.

Ibiwoye et al[23], in their work a linear analysis of factors affecting the usage of Nigeria's NHIS, reported a considerable high usage of NHIS among civil servants. The study also revealed that occupation, income and other socio-economic factors affect the use of NHIS in Nigeria and these factors are mutually exclusive. Also Ibiwoye and Adeleke[55], in their study to assess the impact of the NHIS in promoting access to healthcare, identifies the ineffectiveness of the scheme and the need for all stake holders to engage in the active promotion of awareness on health insurance as option of healthcare provisioning. In a similar study by Michael S.A.[25], to assess the perceived impact of NHIS among registered staff of Federal polytechnic Idah, Kogi state, also shows that although the scheme is ineffective it should not be discontinued because in a long run if properly managed its benefits will be tremendous on the workforce.

Smith K.B et al[56]. in a study to measure the level of consumers' satisfaction on Health Maintenance Organization (HMO) found that methods of healthcare provider's payments also have an impact on consumer satisfaction, that is, consumer satisfaction with HMOs is negatively correlated with the proportion of healthcare providers' who are compensated on a capitation- fee basis and positively correlated with a fee-for- service incentive.

CHAPTER THREE

METHODOLOGY

BACKGROUND INFORMATION ABOUT THE STUDY AREA

Kaduna State is located within the Northwest geopolitical region of the country, lying between latitude 09^{o} 21' and 11^{o} 33' north of the Equator and 06^{o} 10' and 08^{o} 50' east of the Greenwich meridian, occupying a land mass of about 48,473.2 km^2 and a total population of 6,066,562 with 3,112,028 males and 2,954,534 females as reflected in the 2006 population census result[60]. Kaduna State has 23 local government areas and shares common boundaries with Katsina, Kano, Plateau, Nassarawa and Niger states. Kaduna is the state capital and used to be the administrative headquarters of the defunct Northern Nigeria.

The study area is Barau Dikko Specialist Hospital Kaduna, which was established in 1930, then as Nursing Home, to serve the colonial masters and the top civil servants in the defunct Northern region. In 1999 the hospital was upgraded to the status of specialist hospital and renamed Barau Dikko Specialist Hospital Kaduna in honour of the first medical doctor from the northern Nigeria. It is located in the north- eastern part of the Kaduna metropolis within the Kaduna North Local Government Area. The hospital is headed by a Chief Medical Director and a management committee. The hospital has a total bed capacity of 210 beds and a total of 7021 registered NHIS enrollees with an average attendance of 214 NHIS enrollees per month.

The hospital has the following departments and units-

- Administrative Department
- Surgical department
- Medical department

- Obstetrics/Gynaecology department
- Paediatrics department
- Laboratory department
- Pharmacy department
- Radiology department
- physiotherapy department
- General Outpatient Department (GOPD)/ A&E
- Dental unit
- TBL unit
- Haemodialysis unit
- HIV/AIDS control unit

The hospital has a total staff strength of 538 comprising of

- 28 medical doctors- 10 specialist consultants and 18 general practitioners.
- 240 nurses/midwifes.
- 9 pharmacists and 26 pharmacy technicians.
- 18 medical laboratory scientists, 8 laboratory technicians, and 6 laboratory assistance.
- 1 radiologist, 6 radiography technicians and 1radiography assistance.
- 5 physiotherapists.
- 1 dental surgeon and 5 dental technicians.
- 33 medical record staff
- 78 administrative staff and the rest are the supporting unskilled staff.

The General Outpatient Department has seven consulting rooms, a treatment room, side laboratory, minor theatre and a medical record unit. The pharmacy is situated outside the GOPD.

STUDY DESIGN

A cross sectional descriptive study was used to assess the knowledge of the clients, healthcare providers and the healthcare managers, client satisfaction, utilization and quality of outpatient care under the National Health Insurance Scheme.

SAMPLING TECHNIQUE

STUDY POPULATION

The study population comprises the following categories:

1. Clients enrolled through NHIS using the services
2. Healthcare professionals/providers of the facility involved in the outpatient care delivery, which comprise the following:
    - Medical Doctors -14
    - Nurses – 18
    - Laboratory staff – 32
    - Medical records staff – 33
    - Pharmacy staff – 35
3. Healthcare managers of the facility, which comprise the following-
    - Medical Director
    - Head of Clinical Services
    - Hospital Matron
    - Hospital Secretary
    - Hospital Accountant
    - Chairman Hospital NHIS committee
    - Hospital NHIS Desk Officer
    - Head of Medical Records

- Head of Pharmacy
- Head of Laboratory

SAMPLING SIZE DETERMINATION

Sample size for client: an outpatient baseline user's utilisation and satisfaction survey conducted in some selected NHIS accredited healthcare providers in the Northwest geo-political region of the country in 2008[40], showed that 65% of the users of these facilities were very satisfied with the services. So with this information the size of the sample of the clients was determined as follows:

- Proportion of clients that are very satisfied = 65% (0.65)
- Proportion of clients that are not very satisfied = 35% (0.35)
- The population at large was > 10,000.

Sample size (n) = $\left\{ \frac{z^2 pq}{d^2} \right\}$[59]

Where: p = proportion of client satisfied = 0.65

q = proportion of client not satisfied = 1- p

q = 1 – 0.65 = 0.35

n = sample size

d = degree of accuracy =5 % (0.05)

z = standard deviation at 95% confidence interval = 1.96

$$n = \frac{(1.96)^2 \times 0.65 \times 0.35}{(0.05)^2}$$

$$= 349.58 \approx 350$$

Sample size for healthcare providers: all the healthcare professionals involved in the provision of outpatient care in the facility were recruited for the study as listed above.

Sample size for the healthcare managers: all healthcare managers involved in NHIS activities in the hospital were recruited for the study as listed above.

SAMPLING TECHNIQUE

A systematic sampling method was used for the study. The sampling interval was determined by using the average number of clients per day and dividing it by the serial number of the first client to report to the pharmacy that day on the NHIS enrollee register. Hence, every 3rd enrollee was selected until the sample size was attained.

For healthcare providers all the health professional staff involved in the administration of outpatient care were interviewed and for the health managers categories the study included the medical director, chief matron, hospital secretary, hospital accountant and the heads of pharmacy, laboratory and medical records departments, as well as the chairman of the hospital NHIS committee and facility NHIS desk officer.

Inclusion criteria:

1. All NHIS enrollees that passed through the process of card collection, consultation, laboratory investigation and pharmacy for drug collection.
2. Child beneficiary of NHIS accompanied by an adult, who consented to participate in the study.

Exclusion criteria –

1. All NHIS enrollees referred for secondary care services.
2. All NHIS enrollees for antenatal visits.
3. All NHIS enrollees that ended up being admitted.

DATA COLLECTION TOOLS

i. Interviewer administered, structured and close ended questionnaire for the client.

ii. Self administered, structured and close ended questionnaire for the facility healthcare providers.

iii. Self administered, structured and close ended questionnaire for the facility health managers.

iv. A checklist to assess the level and pattern of utilization of the services by NHIS enrollees from January to December, 2009.

DATA COLLECTION TECHNIQUE

The different questionnaires used for the study, were designed as an adoption of the Jigawa State Quality Assurance Team (SQUAT)[36] tool and the ''Quality of Healthcare Services Through Patients Eye'' (QUOTE)[37] tool of the Institute of Public Health of Netherlands, one for the clients, one for the healthcare providers, and the other for the healthcare managers. The healthcare providers and the manager's questionnaires were self administered while the client's questionnaire was administered through the use of research assistants, recruited from School of Health Technology Tudun Wada, Kaduna.

The fieldwork was preceded by five days training course, which covered the understanding and translating the items in the questionnaires into Pidgin English and Hausa language, and pretesting of the instruments at Yusuf Dantsoho Memorial Hospital Kaduna. The lead researcher, assisted by two others, trained the research assistants/ interviewers, the translations into the Pidgin English and Hausa languages, involved courses about appropriate terminology and the extent to which translations captured the intended meaning. The translation and interpretation was further refined by interactions during the pre-test. Completed questionnaires were reviewed by the lead researcher at the end of each day to ensure completeness and accuracy of data collected. The study was conducted over a period of four weeks, from 1st to 30th July, 2010.

The check list to assess the level and pattern of utilization of outpatient care by NHIS enrollees was given to the hospital NHIS desk officer to provide information on the outpatient attendance of NHIS enrollees from January to December, 2009.

DATA ANALYSIS

Two types of data were generated from the study, quantitative and qualitative, which were analysed both manually and by the use of statistical package for social sciences (SPSS) software. The quantitative data were presented in the form of tables, graphs and charts, while measures of central tendency (mean, media & mode) and measure of variability (standard deviation) were used where appropriate. For the qualitative data the use of narrative was employed.

For the assessment of knowledge of the respondents on the operation of the various aspects of NHIS, 40% ‘’pass mark’’ was used to assess the adequacy in the study, which was measured on a two point scale as ‘’Good’’ for those that score ≥ 40% and ‘’Poor’’ for a score of ≤ 39%.

ETHICAL ISSUES

Ethical clearance was sought from the faculty of medicine Ahmadu Bello University, Zaria and also consent for the study was obtained in written form from the hospital management committee and NHIS zonal office in Kaduna. Verbal consent from each of the respondent for the interviewer administered questionnaires or through the introductory statement at the top of the questionnaires in the case of those that were self administered.

LIMITATIONS OF STUDY

1. The study was conducted in only one NHIS accredited facility and therefore might be difficult to generalised findings.

2. Lack of any study on the assessment of quality of care in the hospital, which will form a basis for comparison to assess the quality of care with intervention of NHIS since its inception.

CHAPTER FOUR

RESULTS

A total of 350 NHIS clients enrolled with the facility were successfully interviewed. For the NHIS healthcare providers directly involved in the provision of outpatient care in the hospital, one hundred and thirty two (132) questionnaires were distributed by direct issuance and one hundred and five (105) of the questionnaires were properly completed and returned giving a return rate of 79.6%. While for the health managers directly involved in the administration of NHIS activities in hospital ten (10) questionnaires were distributed but only nine (9) were properly completed and returned giving a return rate of 90%. The results would be presented accordingly in the perspective of the NHIS clients, the healthcare providers and the health managers.

ASSESSMENT OF KNOWLEDGE OF NHIS OPERATION AND THE QUALITY OF OUTPATIENT CARE UNDER THE SCHEME FROM THE PERSPECTIVE OF THE NHIS CLIENTS.

Table 1: Demographic and social characteristics of the respondents

Age group(years)	Frequency	Percent (%)
≤ 18	14	4.0
19 – 28	28	8.0
29 – 38	112	32.0
39 – 48	100	28.6
49 – 58	96	27.4
Total	**350**	**100.0**
Sex		
Male	150	44
Female	200	56
Total	**350**	**100.0**
Marital Status		
Married	308	88.0
Singled	40	11.4
Widowed	2	0.6
Total	**350**	**100.0**
Educational Qualification		
Degrees	71	20.3
Diplomas	105	30.0
Prof. Certificate	64	18.3
Secondary school cert.	79	22.6
Primary school cert.	10	2.9
Koranic education	15	4.3
None	6	1.7
Total	**350**	**100.0**
Family Size		
<6	188	53.7
≥6	162	46.3
Total	**350**	**100.0**
Dependents Registered		
Spouse only	30	8.6
Spouse & one child	27	7.7
Spouse & two children	68	19.4
Spouse & three children	80	22.9
Spouse & four children	112	32.0
None	33	9.4
Total	**350**	**100.0**

Majority of respondents were between the age ranges of 29 – 38 years (32.0%) with mean age of 40 ± 2.1 years, 56% were female while 44% were male and 88% are married. Among the respondents 68.6% had tertiary education, 53.7% had a family size of more than six persons and 32% registered spouse and 4 children.

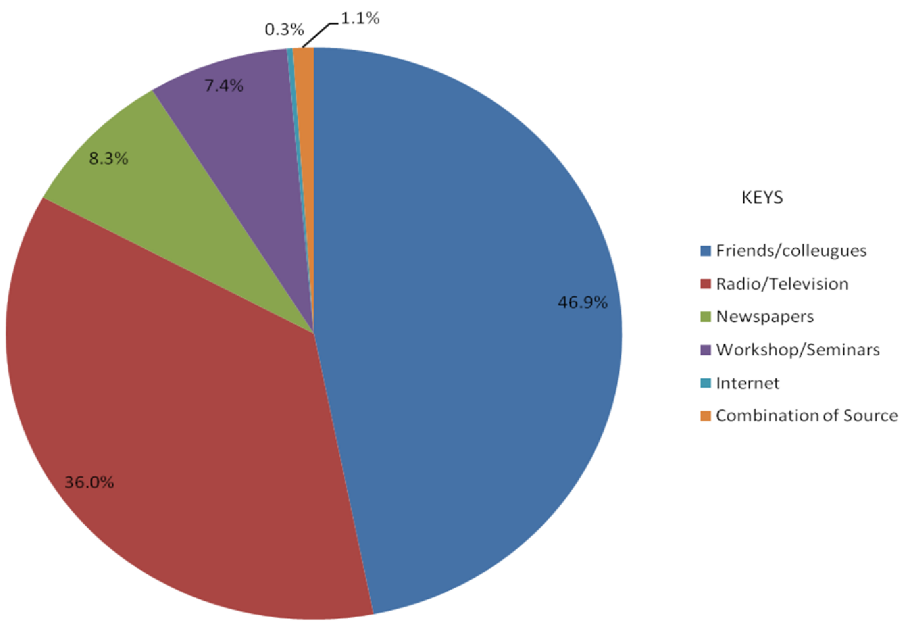

Figure 1: Distribution of NHIS Clients by Sources of information

Majority of the respondents (46.9%) had friends/colleagues as source of information on NHIS while internet with 0.3% is the least as a source of information.

Table 2: Distribution of NHIS client's based on the knowledge of NHIS operations

General Knowledge on Operation of NHIS	Frequency	Percent (%)
Good	146	41.7
Poor	204	58.3
Total	**350**	**100.0**

Among the respondents majority (41.7%) had good knowledge of the activities of the scheme as against 58.3% with poor knowledge.

Table 3: Distribution of NHIS Clients on reason(s) that informed the choice of the Hospital

Reason(s) for choice of the hospital	Frequency	Percent (%)
Proximity to place of residence	64	18.3
Hospital been use before NHIS	120	34.3
Staff Attitude	14	4.0
Adequate Personnel& Equipments	84	24.0
Skill& Expertise of Personnel	46	13.1
Cost of Treatment	5	1.4
Friends & colleagues influence	16	4.6
No Response	1	0.3
Total	**350**	**100.0**

Majority of the respondents (34.3%) chose the hospital based on previous experience while 1.4% chooses the hospital due to affordable cost of treatment.

Table 4: Proportion of NHIS clients rating the importance of various indicators of quality of care at OPD

Warm reception at OPD	Frequency	Percent (%)
Very important	305	87.1
Important	41	11.7
Fairly important	1	0.3
Not important	2	0.6
Indifferent	1	0.3
TOTAL **Mean score = 4.84 ±0.158**	**350**	**100.0**
Waiting time to see doctor		
Very important	291	81.1
Important	44	12.6
Fairly important	6	1.7
Not important	5	1.4
Indifferent	4	1.1
TOTAL **Mean scores = 4.74±0.155**	**350**	**100.0**
Doctor's Attitude		
Very important	311	88.9
Important	30	8.6
Fairly important	3	0.9
Not important	1	0.2
Indifferent	5	1.4
TOTAL **Mean score = 4.53±0.148**	**350**	**100.0**
Need to listen to patient well before prescription		
Very important	325	92.8
Important	20	5.7
Fairly important	1	0.3
Not important	1	0.3
Indifferent	3	0.9
TOTAL **Mean score = 4.91 ±0.164**	**350**	**100.0**
Conduct thorough physical examination		
Very important	325	92.8
Important	20	5.7
Fairly important	1	0.3
Not important	1	0.3
Indifferent	3	0.9
TOTAL **Mean score = 4.91 ± 0.164**	**350**	**100.0**
Request for relevant investigation		
Very important	185	52.9
Important	138	39.4
Fairly important	18	5.1
Not important	4	1.1
Indifferent	5	1.4
TOTAL **Mean score = 4.77 ±0.159**	**350**	**100.0**

Follow up visits		
Very important	190	54.3
Important	135	38.6
Fairly important	13	3.7
Not important	4	1.1
Indifferent	8	2.3
TOTAL **Mean score = 4.41±0.152**	**350**	**100.0**
Privacy		
Very important	214	61.1
Important	123	35.1
Fairly important	6	1.7
Not important	1	0.3
Indifferent	6	1.7
TOTAL **Mean score = 4.67±0.148**	**350**	**100.0**
Confidentiality		
Very important	190	54.8
Important	140	40.0
Fairly important	10	2.9
Not important	3	0.9
Indifferent	7	2.0
TOTAL **Mean score = 4.44 ± 0.148**	**350**	**100.0**
Cleanliness of OPD environment		
Very important	219	62.6
Important	123	35.0
Fairly important	2	0.6
Not important	3	0.9
Indifferent	3	0.9
TOTAL **Mean score = 4.58 ± 0.152**	**350**	**100.0**

Ratings
5 = very important,
4 = important,
3 = indifferent,
2 = fairly important,
1 = not important

With regards to NHIS clients' perception of quality of care in the OPD, majority of the respondents rated as very important the following - warm reception (87.1%), waiting time (83.1%), doctor's attitude (88.9%), privacy (50%), confidentiality (61.1%) and cleanliness of OPD (62.6%).

Table 5: Proportion of NHIS clients rating the maximum waiting time quality of care at the various service points of GOPD

Card room	Frequency	Percent (%)
Less than 15 minutes	300	85.7
Between 15 to 30 minutes	39	11.2
More than 30minutes	2	0.5
Indifferent	9	2.6
Total	**350**	**100.0**
Consulting Room		
Less than 15 minutes	91	26.0
Between 15 to 30 minutes	220	63.0
More than 30minutes	37	10.5
Indifferent	2	0.5
Total	**350**	**100.0**
Pharmacy		
Less than 15 minutes	176	50.3
Between 15 to 30 minutes	150	42.9
More than 30 minutes	20	5.7
Indifferent	4	1.1
Total	**350**	**100.0**
Laboratory		
Less than 15 minutes	120	34.3
Between 15 to 30 minutes	200	57.1
More than 30 minutes	25	7.1
Indifferent	5	1.4
Total	**350**	**100.0**
Treatment room		
Less than 15 minutes	92	26.3
Between 15 to 30 minutes	235	67.1
More than 30 minutes	21	6.0
Indifferent	2	0.6
Total	**350**	**100.0**

Majority of the of respondents (85.7%) rated less than 15 minutes as the best waiting time in the card room and pharmacy (50.3%) while a waiting time of between 15 to 30 minutes was considered to be the best waiting time in the consulting room (63.0%), treatment room (67.1%) and laboratory (57.7%).

Table 6: Proportion of NHIS clients rating the most important quality issue in the various service points of the GOPD

Card room	Frequency	Percent (%)
Prompt attention	254	73.4
Staff attitude	55	15.7
Orderliness	34	9.7
No response	4	1.2
Total	**350**	**100.0**
Consulting room		
Prompt attention	45	12.9
Doctors Attitude	140	40.0
Detailed history taking	105	30.0
Thorough physical examination	40	11.4
Privacy	6	1.7
Confidentiality	6	1.7
Orderliness	2	0.6
No response	6	1.7
Total	**350**	**100.0**
Pharmacy		
Prompt attention	37	10.6
Staff attitude	44	12.6
Explanation on the drug usage	214	61.1
Cost of drug	10	2.9
Well stocked pharmacy	36	10.3
No response	9	2.3
Total	**350**	**100.0**
Laboratory		
Prompt attention	65	18.6
Staff attitude	103	29.4
Explanation on the test to be done	105	30.0
Cost of laboratory test	41	11.7
Waiting time for result to be out	11	3.1
Adequate laboratory equipment	1	0.3
Cleanliness	16	4.6
No response	8	2.3
Total	**350**	**100.0**
Treatment		
Prompt attention	38	10.8
Staff attitude	86	24.6
Staff skill & expertise	184	52.6
Confidentiality	9	2.6
Privacy	10	2.8
Cleanliness	9	2.6
No response	14	4.0
Total	**350**	**100.0**

Majority of the respondents rated the most important quality issue to be prompt attention in the card room (73.4%), doctor's attitude in the consulting room (40%), pharmacist advice/counselling (61.1%), explanation on the test to be conducted in the laboratory (30%) and staff skill/expertise in the treatment room (52.6%).

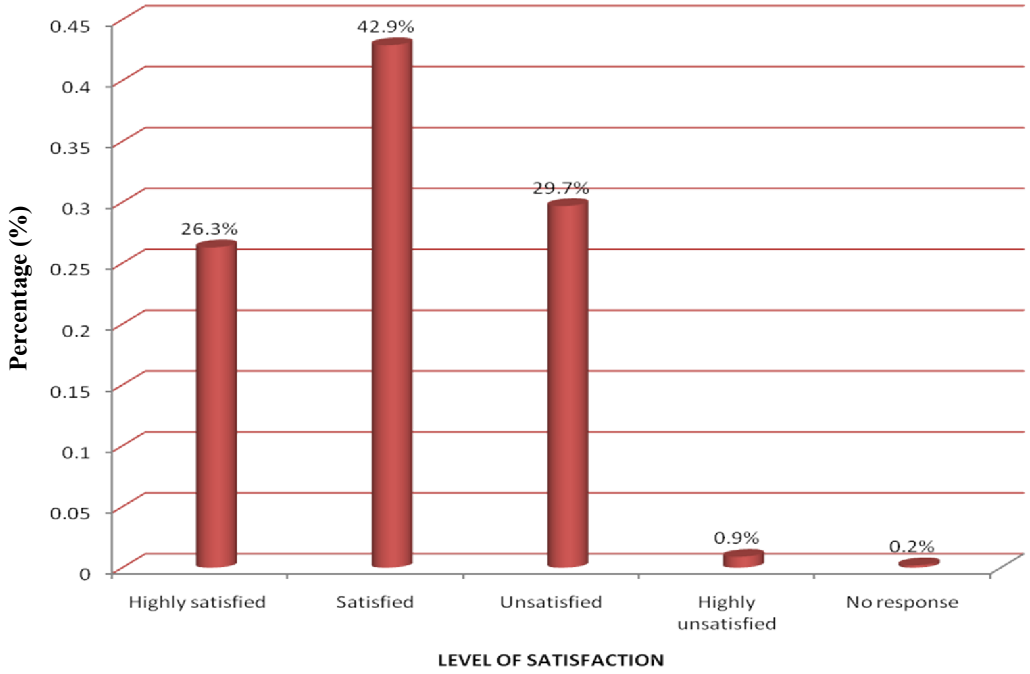

Figure 2: Distribution of NHIS clients by level of satisfaction with quality of care at GOPD

Majority of the respondents (42.9%) were satisfied with quality of care at the OPD under the scheme as against about 31% of the clients who were dissatisfied.

Table 7: Recommendations for improved quality of outpatient care under NHIS

Variables	Frequency	Percent (%)
Review of NHIS drugs & service lists	11	3.1
Training of existing staff	41	11.7
Review of NHIS referral system	42	12.0
More funding of the scheme	48	13.7
Employment of more staff	59	16.9
Creation of separate NHIS unit	125	35.7
No response	24	6.9
Total	**350**	**100.0**

Majority of the respondents (35.7%) recommended creation of a separate NHIS clinic complex as way to improve the quality of outpatient care in facility under the scheme.

ASSESSMENT OF KNOWLEDGE OF THE OPERATION OF NHIS AND QUALITY OF OUTPATIENT CARE FROM THE PERSPECTIVE OF THE HEALTHCARE PROVIDERS UNDER THE SCHEME

Table 8: Distribution of Socio-demographic characteristics of NHIS Healthcare Providers

Age group (years)	Frequency	Percent (%)
21 – 30	47	44.8
31 – 40	36	34.3
41 – 50	15	14.2
51 – 60	7	6.7
Total	**105**	**100.0**
Sex		
Male	50	47.6
Female	55	52.4
Total	105	100.0
Professional category		
Doctors	14	13.3
Nurses	19	18.1
Pharmacists	16	15.2
Pharmacist Technicians	3	2.9
Medical Laboratory Scientist	11	10.5
Medical Laboratory Technician	11	10.5
Medical Record Officers	32	30.5
Total	**105**	**100.0**
Educational qualification		
MBBS	14	13.3
B.PHARM	16	15.2
B.LAB. SCIENCES	11	10.5
RN/RM	16	15.2
PROF.DIPLOMAS	29	27.6
SSCE	19	18.1
Total	**105**	**100.0**
Years of experience		
<10	93	88.6
10 – 19 years	9	8.6
20 – 29 years	3	2.6
>30 years	0	0
Total	**105**	**100.0**

More than 70% of the professional staffs in the GOPD were within the age range of 21 to 40 years with a mean age of 33.8±2.6 years and 52.4% were females. Among the respondents 30.5% were record officers and 88.6% had worked for about 10 years.

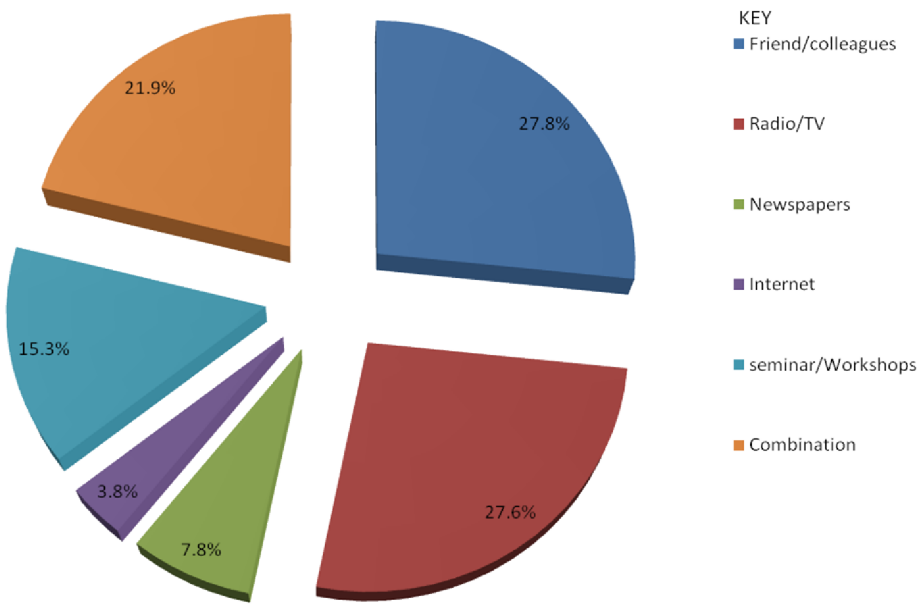

Figure 3: Distribution of healthcare providers by source of information

Friends/colleagues (27.8%) constitute the highest source of information on the scheme while internet recorded the least with 3.8%.

Table 9: Knowledge of Healthcare providers on the operation of NHIS

Variables	Frequency	Percent (%)
Good	51	48.6
Poor	54	51.4
Total	**105**	**100.0**

About half of the respondents (48.6%) had good knowledge on the operation of the scheme against 51.4% with poor knowledge.

Table 10: Distribution of Healthcare providers with Good knowledge on the various aspects of NHIS operation

Variables	Frequency	Percent (%)
Registration process	20	19.0
Contribution mechanism	25	23.8
Scope of coverage	30	28.6
HMOs	34	32.4
NHIS programmes	39	37.1
NHIS referral system	40	38.1
Hospitalization process	44	41.9
Payment mechanism	54	51.4
NHIS stakeholders	67	63.8
Benefit package	69	65.7

n = 105

Majority of the respondents (65.7%) had good knowledge of NHIS benefit package while knowledge on NHIS registration process accounted for the least with 19%.

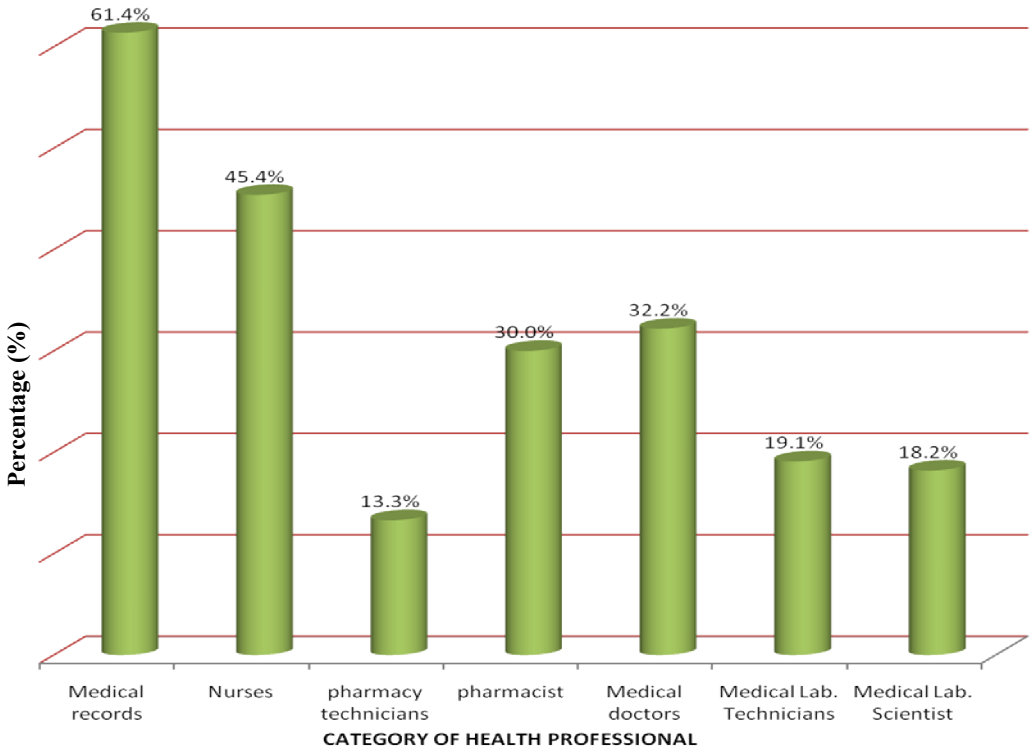

Figure 4: Distribution of knowledge of healthcare providers on the operation of the scheme by category of health professional

Medical record staff had highest percent score (61.4%) while Pharmacy technicians had the lowest percent score in term of adequacy of knowledge of all aspects of the scheme activities.

The healthcare providers rated the following indicators of quality of care at the OPD as very important: warm reception (81.0%), doctor's attitude (91.4%), request for relevant laboratory (76.2), cost of drugs (44.8%), privacy (78.1%), confidentiality (81.9%), cleanliness of the OPD (84.8%) and general staff attitude (74.2%).

Eighty eight (83.8%) of the healthcare providers considered the maximum waiting time at card room to be less than 15 minutes as against about 2% that considered more than 30minutes, 54.3% of the respondents considered maximum waiting time at consulting room to be within 30 minutes while 1% of the respondents considered a delay of more than 30 minutes, 63.8% of the healthcare providers considered the maximum waiting time at the pharmacy to be about 15 minutes as against 1% that considered more than 30 minutes, 51.4% of the respondents considered the maximum waiting time at the laboratory to be less than 15 minutes, and 56.2% of the respondents considered the maximum waiting time at the treatment room to be less than 15 minutes, while 3.4% are satisfied with delayed of more than 30 minutes.

The most important quality indicator in the card room was rated by 52.4% of the healthcare providers to be prompt attention, 54.3% of the respondents ranked doctors' attitude as the most important quality issue in consulting room, 67.6% of the healthcare providers ranked pharmacist advice/ explanation on the drugs as the most important quality indicator in the pharmacy, 31,4% of the OPD professional staffs ranked waiting time for the laboratory result to be out as the most important indicator in the laboratory and 37.1% of the healthcare providers ranked staff skill/expertise as the most important indicator in the treatment room.

Table 11: Recommendation for improved outpatient care under NHIS by healthcare providers

Response to variables	Frequency	Percent (%)
Building more infrastructure	7	6.7
Computerization of medical records	10	9.5
Employment of more staff	10	9.5
Review NHIS referral system	16	15.2
Training of existing staff	18	17.1
Creation of separate NHIS unit	20	19.0
Adequate funding by NHIS	24	22.9
Total	**105**	**100.0**

Majority of the respondents (22.9%) recommended adequate funding of the scheme by upward review of capitation payment as the best way of improving the quality of outpatient care in the hospital.

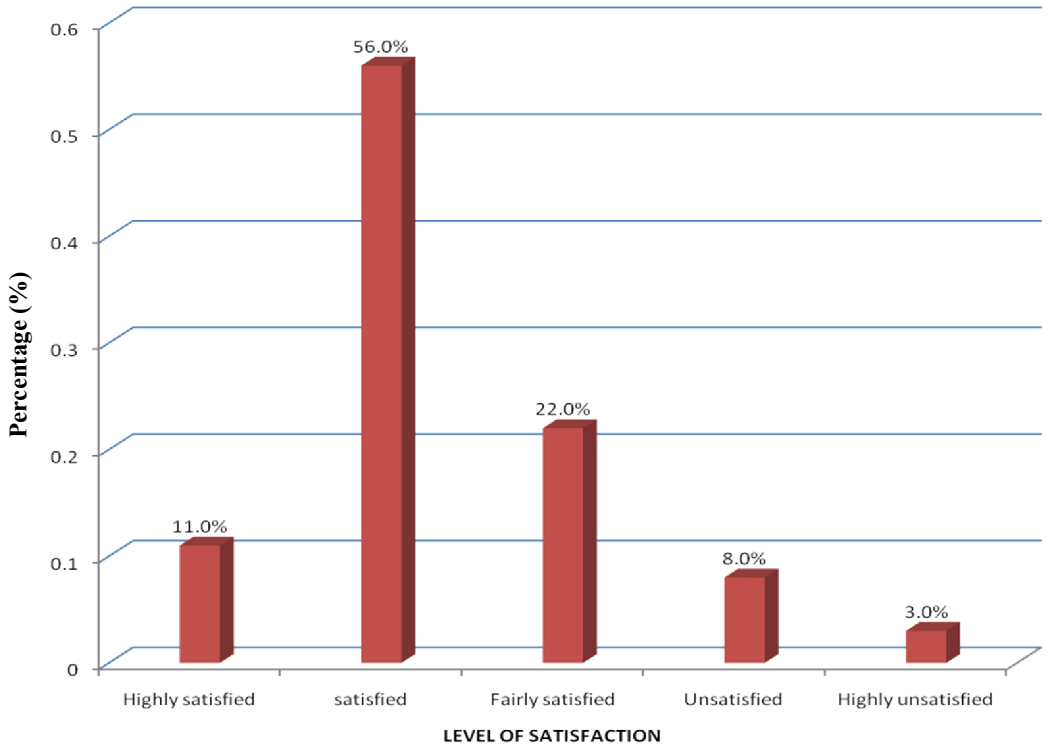

Figure 5: Levels of satisfaction among Healthcare providers with regards to the quality of care they provide under the scheme

Majority of the respondents (56%) of the healthcare providers were satisfied with quality of outpatient care been provided under the scheme against 11% that were unsatisfied.

ASSESSMENT OF KNOWLEDGE OF THE OPERATION OF NHIS AND QUALITY OF OUTPATIENT CARE FROM THE PERSPECTIVE OF THE HEALTHCARE MANAGERS UNDER THE SCHEME

A total of nine (9) health managers directly involved in running the activity of NHIS in the facility were interviewed.

The mean age of the facility health managers was 44.4±2.4 years, of which 55.6% were female and 44.4% male, all were married.

The medical doctors, nurses and the administrative officers accounted for 22.2% each of the facility health managers respectively.

Five of the respondents (55.6%) had various forms of degrees followed by diplomas with 33.3% and professional certificates with 11.1%.

Seven of the health managers (77.8%) had been working with the hospital over the last 10 years and 55.6% had training on job more than thrice within this period. Although none had any formal training in hospital health management, some of them had some form of capacity building training on hospital management by PATHS.

Five (55.6%) of the health manager's source of information was from seminars/workshops while print media with 11.1% recorded the least as a source of information.

All the health managers of the facility had good knowledge on the operation of NHIS with an average score of 71.5%. Of the various aspects of the operation of the scheme, majority of the respondents (n=9) had good knowledge on all aspects of the scheme with the exception of NHIS registration process and contribution mechanism with 22.2% and

11.1% respectively. The medical record officer had the highest percent score on overall knowledge with 80% followed by the medical doctors with 70%. Administrative officers had the least score with 55%.

All the health managers of the hospital involved in running the activities of the scheme considered warm reception, attitude of the staff, skill/expertise of staff, communication on service to be rendered, cleanliness of environment, privacy and confidentiality as very important indicators of quality of outpatient care, while 44.4% rated consideration of the cost of the drugs before prescription as not important. Staff attitude is rated highest as the most important quality indicator of outpatient care by majority of the respondents (80%). All the respondents suggested that the maximum waiting to receive outpatient care at the hospital should be about 15 minutes with the exception of the consulting room in which majority of the respondents (77.7%) suggested about 30minutes, due to shortage of medical doctors in the hospital.

All the respondents considered increased funding of the scheme, creation of a separate NHIS unit, reviewing NHIS drugs/services price list & referral system, training of staff on the operation of NHIS and employment of more staff as key to the provision of quality outpatient care in the facility.

Six of the management staff (66.6%) expressed dissatisfaction with their jobs with regards to NHIS activities in the hospital, as incentives were lacking and work load was too much despite the enormous resources accruing from the scheme.

LEVEL OF UTILIZATION OF OUTPATIENT CARE

The hospital had a total of 7021 registered NHIS enrollees between January and December, 2009 and the overall enrollees attendance recorded was 2666 per annum with

a mean monthly attendance of 222 enrollees per month. The daily average enrollees attendance was 7 enrollees per day.

The overall utilization rate of outpatient care by NHIS enrollees within the period under study was 38% per annum with a mean monthly utilization rate of 3% per month.

PATTERN OF UTILIZATION OF OUTPATIENT CARE

Table 12: NHIS clients' utilization of the GOPD from January to December 2009

S/No.	Month	Visits	Re-visits	Referred	Total
1	January	55	86	30	171
2	February	33	90	25	148
3	March	50	120	33	203
4	April	55	150	28	233
5	May	49	120	30	199
6	June	49	380	35	464
7	July	59	70	16	145
8	August	60	140	22	222
9	September	58	200	23	281
10	October	60	170	27	257
11	November	34	97	24	155
12	December	71	86	31	188
	Total	**633 (23.7%)**	**1709 (64.1%)**	**324 (12.2%)**	**2666**

The data above are secondary data obtained from the hospital records. Majority of the patients (64.1%) were re-visiting cases followed by first visits with 23.7% and only 12.2% were referred cases within the period under study.

CHAPTER FIVE

DISCUSSION

National Health Insurance Scheme (NHIS) was introduced recently in Nigeria in response to the dwindling funding of the nation health sector, with the aim of improving the quality of health services, improving access with equity, and promoting utilization of health services by all participants. The first phase of implementation started five years ago with the enrollment of formal sector employees. Greater acceptability and active participation in the scheme is essential if the desired goal of the scheme is to be achieved. To ensure continuous participation in the scheme, future planning efforts need to consider the clients satisfaction which, of course, is based on the knowledge and awareness of the enrollees. The study was conducted five years after commencement of the formal sector programme of the scheme in Barau Dikko Specialist Hospital Kaduna.

Three hundred and fifty registered enrollees with the hospital were recruited for the study. The majority of the respondents (33.3%) were in the age group 29 – 38 years. This implies that majority of respondents were in active working class of the population, which is expected in formal sector programme of the scheme currently in operation. While for the 105 healthcare providers interviewed 44.4% were in the age range 21 – 30 years, a probable pointer to the emerging younger labour force now at various levels of employment in the study. The majority of the health managers (44.4%) were in the age range 41 – 50 years.

Most of the respondents in this study were female (56.0%), with male: female ratio of 2:3, this is in contrast with the study of Sanusi et al[33]. This implies that more female than male enrollees were covered by the study which is not surprising as women and children tend to seek for healthcare more than men. For the healthcare providers, the male to

female ratio in the study of 105 respondents was 1:1; this is in line with the report of Onuekwusi et al[10] in Enugu while in contrast with that of Dnladi[11] in Jos. Eighty eight percent of NHIS clients recruited for the study were married. Fifty four percent of the respondents had large family size of more than six persons as against 46.4% with about six persons, of which majority (32.0%) registered a maximum of five persons as against 9.4% that registered none. These findings are in line with earlier study of Sanusi et al in Ibadan and Shafiu et al[54] in Zaria. About 70% of the NHIS enrollees were educated up to tertiary level; hence significant proportions of the respondents appreciate the programme. Majority of the healthcare providers (30.5%) are drawn from the medical record officer followed by the nursing profession with 18.1% where the predominance of females over the years is again exhibited. For the healthcare managers there was an equal number for nursing, medical doctors and administrative officers with 22.2% each.

In this study, the proportion of NHIS enrollees who are knowledgeable on the overall operation of the scheme was 41.7% which show some improvement in contrast to the finding of Sanusi et al. On the various aspects of operation of the scheme, the NHIS clients are only knowledgeable on the benefit package (73.4%), drug collection process (93.7%) and co-payment mechanism (59.1%). About forty nine percent of the healthcare providers were knowledgeable on the overall operation of the scheme, which is higher than the figure reported Onuekwusi et al in Enugu[10], Sabitu et al[12] in Minna and Okaro et al[34] in South East of Nigeria. The medical record staff are more knowledgeable on the operational guideline of the scheme (61.4%) followed by the medical doctors with 32.2%.

The reason for this finding is not farfetched, because most of the activities of the scheme in the hospital are based in the medical records unit. With regards to the knowledge of the

health professionals on the various aspects of the operation of the scheme, the study showed that the respondents are only knowledgeable in aspects of benefits package (65.5%), payment mechanism (51.4%), NHIS stakeholders (63.8%), and hospitalization process (41.9%). All the management staff interviewed had good knowledge on the operation of the scheme and majority of the respondents (55.6%) had good knowledge on all aspects of the activity of the scheme. The level of awareness among respondents was high but there was no correlation between awareness exhibited by majority of respondents and their understanding of the working of the scheme, a trend exhibited by majority of respondents in the different cadres.

Majority of the enrollees (46.9%) had friends/colleagues as their main source of information while seminars/workshops a veritable source of information with regards to the scheme had the least with 7.4%, these findings were similar to that of the study in Ibadan. While for the health professionals their main sources of information were friends/colleagues (27.8%) and electronic media (27.6%). In a similar studies conducted in Minna by Sabitu et al reported electronic media (82.1%) and print media (29.1%), Enugu study revealed print media (39.8%) and electronic media (37.3%) and Zaria study showed print media (33.0%) and friends/colleagues (22.0%) as the main sources of information. It is interesting however to note that in all the studies seminars/workshops accounted for a lower source of information. This is quite surprising when considered that these are supposed to be important sources of information for health professionals. With regards to the healthcare managers, their main source of information was seminars/workshops (55.5%). This finding is contrary to that of Dandali [61] in a similar study conducted in Jos. Despite efforts made by the scheme to sensitize and increase awareness of the Nigerians on operation of NHIS five years after commencement, only 41.7% of the respondents in this study were adequately informed.

There could be many reasons why patients may choose to attend a health facility[42]. In this study, majority of the enrollees chose the hospital because of their previous experience. This supports the value of the patients experience and its contribution to satisfaction. This is in agreement with the findings of Manje[26] in Uganda who found that clients awareness/knowledge on the concepts of health insurance is very poor, a perception influenced by previous negative experience. Among other reasons that influenced the enrollees to choose the hospital include adequate infrastructures, technical competence of the staff and proximity to place of residence. This supported the fact that assessment of patient's expectation is one of the ways of learning about patients' needs.

Findings from the study revealed that the most important quality indicator from client perspective in the card room with a score of 73.4% was the issue of the prompt attention of which majority of the enrollees (88.7%) suggested a maximum waiting time of about 15 minutes. A similar study conducted by Kabir[46] in Dutse, Jigawa State was in agreement with findings of this study. Another study in Michigan by Christine et al[62], in contrast reported that the most important quality issue from the perspective of the clients with regards to record department was provision of adequate and correct information and communication. About 52% of the facility health professionals rated prompt attention as the most important quality issue in the card room.

The issue of doctor's attitude was recognised by 40% of the NHIS clients as the most important quality indicator in the consulting room contrary to the Dutse study which found prompt attention as the most important quality indicator. Jorge et al[42] in Bangladesh found that the most powerful predictor of client satisfaction with public health facility was the doctors behaviour towards the patient, particularly respect and politeness, which was found to be more important than the providers technical

competence. This finding was in agreement with that of this study. Majority of the respondents (63.0%) rated the maximum waiting time at the consulting room to be 30 minutes at most. Doctor's attitude in the consulting room was also rated by 54.3% of healthcare providers of the facility as the most important quality issue as opposed to what was reported in the Dutse study with confidentiality in the consulting room as the most important quality issue.

The enrollees rated pharmacist explanation/advice on medication with a score of 61.1% as the most important quality indicator in the pharmacy which is in line with the findings of Singh et al[63] in Trinida & Tobago but again not agreeing with Dutse study where prompt attention was the most important issue. Many studies showed that patients equate availability of drugs with quality of health services. According to Opere et al[64], a study conducted in Kenya reported that drug availability the health facility had a positive impact on demand for services and another study in Uganda also concluded that the availability of drugs in rural health facilities brought satisfaction not only to the users, but also to the provider. While for the healthcare providers, majority of the respondents (67.6%) also rated pharmacist explanation on medication as the most important quality issue in the pharmacy contrary to the findings of Dutse study which reported prompt attention. Majority of the respondents rated a maximum waiting time in the pharmacy to be about 15 minutes with 63.8%.

The most important quality indicator according to 30% of enrollees in the laboratory was explanation on the test to be conducted while in contrast, prompt attention and cost of investigation was the most important quality indicator in the laboratory in Dutse study. Thirty two percent of the health professionals ranked waiting time to get the laboratory result as the most important quality indicator in the laboratory as opposed to the Dutse

study which ranked prompt attention as the most important quality issue. Majority of the respondents rated the maximum waiting time in the laboratory to about 15 minutes with 51.1%.

Both the NHIs clients and healthcare providers ranked technical competence of the staff as the most important quality issue in the treatment room with 52.6% and 37.1% respectively. This supported the findings of the Dutse study and also in agreement with Brawley[66] that reported that health clients were more particularly concerned about qualifications and training of the service provider. The majority of the respondents (56.7%) rated the maximum waiting time in the treatment room to be about 15 minutes.

The management staff directly involved in running the activities of the scheme in the hospital rated staff attitude and technical competence as the most important indicator in outpatient care, which is in line with the findings of Bangladesh and Trinida & Tobago studies and contrary to Jigawa State SQUAT survey[36], which reported provision of structure in terms of physical infrastructure & equipment and improvement of staff remuneration as the most important quality issue in the outpatient care.

With regards to overall satisfaction, 43.0% of the clients said they were satisfied which supported the findings of Shafiu et al and contrary to baseline NHIS client utilization and satisfaction survey[40] conducted three years ago which reported a satisfaction rate of 65.0%. This unacceptable level of client dissatisfaction may imply deterioration of quality of care being provided under the scheme coupled with poor knowledge of the operation of the scheme. About 60.0% of the facility health providers and all the management staff of the hospital interviewed expressed satisfaction with regards to the out patience care they provide under the NHIS. The enrollees, healthcare providers as

well as the health managers would not want the scheme to be discontinued as reported by Okaro et al which is in contrast to the finding of Sanusi et al.

Thirty six percent of the NHIS clients suggested that the quality of outpatient care under the scheme in the hospital would be best improved by providing a separate NHIS clinic complex fully complemented with information/record unit, consulting room, laboratory, dispensing room and treatment room. While adequate funding of the scheme, creation of a separate NHIS unit in the hospital and training/re-training of existing staff on the operation of the scheme were considered by health professionals as key to the provision of quality care to their outpatient clients. The health managers in contrast, recommended provision of good equipment, adequate funding and improved general welfare of their staff as ways of improving the quality of outpatient services.

The level of utilization of outpatient care by NHIS enrollees from January to December, 2009 is 38% per annum contrary to Adeoye et al[14] study which reported a utilization rate of 12.5% in some selected NHIS accredited facilities in the Northwest geopolitical region of the country three years ago. Although the result is still very low when compared to the level of enrollment but the findings show some improvement. This might be attributed to the slow registration process characterised by delayed ID cards production and distribution to prospective enrollees. A similar study conducted by Ibewoye et al[23] reported a considerable high level of usage of healthcare services under the NHIS among the federal civil servants in Lagos. This might be a direct result of the fact that they were probably constrained by the employers to comply. The pattern of utilization of the outpatient services is highly dependent on re-visits followed by first visits. The re-visits signify that most patients are well enlightened and aware of the importance of continuation with medical care. The NHIS referral in the facility is low, which is not

surprising, because of the cumbersome nature of the referral system which required mandatory authorization by the HMOs.

In summary, this study found that the level of knowledge of NHIS clients and health providers on the various aspects of NHIS activities is still poor five years after commencement, but there is very much improvement when compared to earlier findings of Onuekwusi in Enugu, Sabitu et al in Minna, Danladi in Jos, Sanusi et al in Ibadan and Shafiu et al in Zaria. This might probably be due to the aggressive public enlightenment campaign in both print and electronic media and regular stakeholder's interactive forum embarked upon by the scheme.

Majority of the respondents interviewed expressed satisfaction with quality of outpatient care provided in the hospital, as related to such factors as staff behaviours, communication/information, waiting time, and hospital environment. This was supported by the findings of this study which revealed that majority of enrollees chose the hospital based on their previous experience and expectation.

The service utilization under the scheme is still very low as reported by Adeoye et al, three years ago; hence there is a need for more aggressive sensitization and enlightenment of all the stakeholders about the operations of the NHIS. The referral for secondary care is very low, which call for urgent review of the NHIS referral protocol.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

The study revealed that NHIS clients, healthcare providers and health managers have good attitudinal predisposition towards the scheme, despite their lack of adequate knowledge of the rudimentary principles of the operation of a social health insurance scheme. This implies that if adequate information is made available to them, the likelihood of their participation and consequent improved implementation will be high. This calls for a conscious publicity drive and intense educational campaigns. Also the findings of the research would be important to the scheme as it gave a clear picture of the feelings of the beneficiaries of the formal sector programme as well as insight into some remarkable achievements made by the healthcare providers as a result of regular funding from the scheme, five years after commencement.

RECOMMENDATIONS

1. In order to consolidate the gains so far made there is need for the management of NHIS to embark on an intensive enlightenment and awareness campaign of all stakeholders' regular interactive forum and seminars/workshops.
2. The management of the scheme should as a matter of urgency put in place an effective monitoring and evaluation programme in order to gauge the utilization of the scheme and fine tune its operations.
3. There is urgent need for the management of NHIS to review their policy documents (operational guideline, benefit package etc) and update their website regularly to keep in touch with prevailing situation.
4. There is the need for the management of Barau Dikko Specialist Hospital to establish a quality assurance committee in the hospital and to incorporate the findings of this study to the minimum health package of the facility.

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APPENDICES

APPENDIX I

CLIENTS QUESTIONNAIRES

Hello, this questionnaire is purely for research purpose, the survey is being conducted with NHIS enrollees of this hospital to find out what you really think about this healthcare facility which you have chosen. We want your honest answers to help NHIS and BDSH Kaduna to improve their services to you and future NHIS enrollees. Your answers are strictly confidential and we thank you for your participation and honesty.

Please tick as appropriate.

S/N	SECTION A – DEMOGRAPHIC DATA	
1.	Age	1. ≤18 years [ ] 2. 19 – 28 years [ ] 3. 29 – 38 years [ ] 4. 39 – 48 years [ ] 5. 49 – 58 years [ ] 6. ≥ 59 years [ ]
2.	Sex	1. Male [ ] 2. Female [ ]
3.	Marital status	1. Single [ ] 2. Married [ ] 3. Others (specify).....
4.	Family size	1. Less than six [ ] 2. Six or more than six [ ]
5	Number of dependents registered with hospital under the scheme	1. Spouse only [ ] 2. Spouse & one child[ ] 3. Spouse & two children[ ] 4. Spouse & three children[ ] 5. Spouse & four children[ ] 6. Other (specify).....
5.	Place of Residence	
6.	Highest Educational Qualification Obtained	1. Degree [ ] 2. Diploma [ ] 3. Professional certificate [ ] 4. Secondary school certificate [ ] 5. Primary school certificate [ ] 6. Koranic Education [ ] 7. Others (specify).....

SECTION B- KNOWLEDGE ON HOW NHIS WORKS		
7.	What is the source of your information on NHIS?	1. Friends/colleagues [ ] 2. Radio/ Television [ ] 3. News papers/Books [ ] 4. Workshops/seminars [ ] 5. Internet [ ] ***6.*** Others (specify).....
8.	Which of the following is covered by NHIS?	1. You, your spouse and four children under the age of 18 years. [ ] 2. You, your spouse and four children irrespective of age. [ ] 3. Your extra dependants [ ] 4. Self employed persons [ ] 5. Nigerian residing abroad [ ] 6. Foreigners residing in Nigeria [ ] 7. Students of tertiary institution [ ] 8. Rural dwellers [ ] 9. Retirees/pensioners 10. Others (specify).....
9.	Way(s) of registering with NHIS is/are as follows-	1. Your employer chooses and registered you with his preferred hospital. [ ] 2. You chooses and registered with your preferred hospital [ ] 3. Your employer chooses a hospital for you 4. NHIS chooses a hospital for you [ ] 5. NHIS issues you with ID card [ ] 6. Waiting period of three months before assessing care [ ] 7. You can change your hospital after 3months of registration[ ] 8. There is provision for up-date registration which is paid for [ ] 9. Up-date registration is free [ ]
10.	Which of the following service(s) is/ are offered by the scheme?	1. General outpatient care[ ] 2. Emergency care [ ] 3. Maternity care for up to four live birth[ ] 4. Maternity care irrespective of number of live birth [ ] 5. Pharmacy services [ ] 6. Laboratory services [ ] 7. Admission in hospital [ ] 8. Immunization [ ] 9. Specialist care [ ]
11.	The following is/are true about contributions in NHIS?	1. The contribution is supposed to be 15% of total salary.[ ] 2. The contribution is supposed to be 15% of basic salary.[ ] 3. You are supposed to contribute 5% while your employer contribute 10% of your basic salary[] 4. You are supposed to contribute 10% while your employer contributes 5% [ ]

		5. For now it is government that is only contributing 10% on your behalf while you are not contributing [ ] 6. You pay 10% of the total cost of treatment 7. You pay 10% of the total cost of drugs only [ ]
12.	Which of the following is/are true about co-payment in NHIS?	1. Co-payment is 10% of the total cost of all treatment.[ ] 2. Co-payment is 10% of total cost of drugs only[] 3. Co-payment is paid at the card room[ ] 4. Co-payment is paid at pharmacy [ ] 5. Co-payment is not paid on laboratory and x-ray services [ ]
13.	Under the NHIS where are you supposed to collect your drugs out of the following?	1. Doctors office [ ] 2. Hospital pharmacy [ ] 3. NHIS registered hospital pharmacy [ ] 4. NHIS registered pharmacy outside the hospital[ ] 5. Unregistered pharmacy outside the hospital[ ] 6. Patent medicine stores[ ]
14.	In case of hospital admission under NHIS, which of the following is/are true?	1. You are to be admitted in general ward[ ] 2. You are to be admitted in private ward[ ] 3. It include feeding[ ] 4. NHIS covers 15 days cumulatively in a year[ ] 5. Hospital stay for 15days cumulatively in year is paid by you or your employer[ ] 6. You pay 10% of the admission fee 7. You only 10% of the total
	SECTION C - QUALITY OF CARE	
	PLEASE RATE QUESTION 16 – 27 IN ORDER OF IMPORTANCE WITH REGARDS TO QUALITY OF CARE YOU RECEIVE.	
15.	What informed your choice of this hospital?	1. It is the closest hospital to my place of residence. [ ] 2. It is the hospital i have been using before NHIS [ ] 3. The staff of the hospital are friendly/courteous [ ] 4. The hospital has adequate personnel & equipments. [ ] 5. Skill and expertise of it personnel [ ] 6. Cheap cost of treatment [ ] 7. It is the hospital chosen by the majority of the staff of my working place. [ ] 8. Others (specify).....
16.	Warm reception to a patient at the card room.	1. Very important [ ] 2. Important [ ] 3. Fairly important [ ] 4. Not important [ ] 5. Indifferent [ ]

17.	Patient waiting time before seeing a doctor for consultation.	1. Very important [ ] 2. Important [ ] 3. Fairly important [ ] 4. Not important [ ] 5. Indifferent [ ]
18.	The attitude of the doctor to the patient during consultation.	1. Very important [ ] 2. Important [ ] 3. Fairly important [ ] 4. Not important [ ] 5. Indifferent [ ]
19.	The need for the doctor to listen to the patient well as he described his problem before examination and prescription of drugs.	1. Very important [ ] 2. Important [ ] 3. Fairly important [ ] 4. Not important [ ] 5. Indifferent [ ]
20.	The need for thorough physical examination of the patient by the doctor at OPD consultation.	1. Very important [ ] 2. Important [ ] 3. Fairly important [ ] 4. Not important [ ] 5. Indifferent [ ]
21.	The issue of requesting for relevant investigation at OPD consultation.	1. Very important [ ] 2. Important [ ] 3. Fairly important [ ] 4. Not important [ ] 5. Indifferent [ ]
22.	The doctor telling patient what is wrong with him/her?	1. Very important [ ] 2. Important [ ] 3. Fairly important [ ] 4. Not important [ ] 5. Indifferent [ ]
23.	The doctor telling the patient whether or not to return for Follow-up?	1. Very important [ ] 2. Important [ ] 3. Fairly important [ ] 4. Not important [ ] 5. Indifferent [ ]
24.	Privacy during OPD consultation.	1. Very important [ ] 2. Important [ ] 3. Fairly important [ ] 4. Not important [ ] 5. Indifferent [ ]
25.	Confidentiality at the OPD consultation.	1. Very important [ ] 2. Important [ ] 3. Fairly important [ ] 4. Not important [ ] 5. Indifferent [ ]
26.	The general attitude of other staff for an outpatient care.	1. Very important [ ] 2. Important [ ] 3. Fairly important [ ] 4. Not important [ ] 5. Indifferent [ ]

27.	The general cleanliness of the hospital for an outpatient care.	1. Very important [ ] 2. Important [ ] 3. Fairly important [ ] 4. Not important [ ] 5. Indifferent [ ]
28.	How long should the patient wait at the card room before he gets a card?	1. Less than 15 minutes [ ] 2. Between 15 to 30 minutes [ ] 3. More than 30 minutes [ ]
29.	In your opinion waiting time at the consulting room to see the doctor should be.	1. Less than 15 minutes [ ] 2. Between 15 to 30 minutes [ ] 3. More than 30 minutes [ ]
30.	For how long should the patient wait at the pharmacy before he gets an attention?	1. Less than 15 minutes [ ] 2. Between 15 to 30 minutes [ ] 3. More than 30 minutes [ ]
31.	What should be the patient waiting time at the laboratory before he gets an attention?	1. Less than 15 minutes [ ] 2. Between 15 to 30 minutes [ ] 3. More than 30 minutes [ ]
32.	In your opinion for how long should the patient wait at the treatment /injection /dressing room before he gets an attention?	1. Less than 15 minutes [ ] 2. Between 15 to 30 minutes [ ] 3. More than 30 minutes [ ]
SECTION D - GENERAL COMMENT		
33.	What in your opinion should be regards as the most important in the quality of care in the card room?	1. Prompt attention [ ] 2. Attitude of the staff [ ] 3. Orderliness/Queue [ ] 4. Others (specify).....
34.	What do you consider most important in the quality of care in the consulting room?	1. Prompt attention [ ] 2. Attitude of the doctor [ ] 3. Detailed history [ ] 4. Proper physical examination [ ] 5. Privacy [ ] 6. Confidentiality [ ] 7. Others (specify).....
35.	In your opinion which of these is the most important in the quality of care in the pharmacy?	1. Prompt attention 2. Attitude of the staff 3. Explanation on how to use the drug [ ] 4. Cost of the drugs [ ] 5. Others (specify).....
36.	Quality of laboratory services will be most enhanced by which of the following?	1. Prompt attention [ ] 2. Attitude of the staff [ ] 3. Explanation on the test to be conducted [ ] 4. Cost of the laboratory test [ ] 5. Cleanliness [ ] 6. Others (specify).....
37.	Which of the following is the most important in the quality of care in the treatment/ injection /dressing room?	1. Prompt attention [ ] 2. Attitude of the staff [ ] 3. Skill/expertise of the staff [ ] 4. Confidentiality [ ] 5. Privacy [ ] 6. Cleanliness [ ] 7. Others (specify).....

38.	Overall how would you rate the services you received today in this hospital?	1. Highly satisfied [ ] 2. Satisfied [ ] 3. Unsatisfied [ ] 4. Highly unsatisfied [ ] 5. Indifferent [ ]
39.	What do you think can be done to improve the quality of outpatient care in this hospital under the NHIS?	1. Have a separate unit for NHIS enrollees. [ ] 2. Employ more staff. [ ] 3. Training of existing staff. [ ] 4. More funding of the programme by NHIS [ ] 5. Make the referral system less cumbersome. [ ] 6. Others (specify).....

Thank you very much for giving us your time, to respond to this questionnaire. Your honest and unbiased response will certainly go a long way in shedding light to where improvement needs to be made on the quality of outpatient care in this hospital and on the implementation of the NHIS programmes to ensure efficiency and sustainability.

APPENDIX II

HEALTHCARE PROVIDERS QUESTIONNAIRES

Hello, this questionnaire is purely for research purpose, we are conducting a survey with NHIS healthcare providers of this facility to find out their perceptions on what constitute quality of outpatient care. We want your honest answers to help NHIS and BDSH Kaduna to improve their services. Your answers are strictly confidential and we thank you for your participation and honesty. Please tick as appropriate.

S/N	SECTION A - DEMOGRAPHIC DATA	
1.	Age	1. 21 – 30 years [ ] 2. 31 – 40 years [ ] 3. 41 – 50 years [ ] 4. 51 – 60 years [ ] 5. Above 60 years [ ]
2.	Sex	1. Male [ ] 2. Female [ ]
3.	Category/Cadre	1. Doctors [ ] 2. Nurses [ ] 3. Pharmacist [ ] 4. Pharmacy technicians [ ] 5. Medical laboratory scientist [ ] 6. Medical laboratory technician [ ] 7. Medical Record officer [ ] 8. Others (specify).....
4.	Highest Educational Qualification obtained	1. MBBS [ ] 2. B. Pharm. [ ] 3. B.Lab.Sciences [ ] 4. RN/RM [ ] 5. Professional Diplomas/certificates [ ] 6. Others (specify).....
5.	For how long have you been working in this hospital?	1. 1 – 10 years [ ] 2. 11 – 20 years [ ] 3. 21 – 30 years [ ] 4. Above 30 years
6.	When were you promoted last?	1. Last 3 years [ ] 2. Last 6 years [ ] 3. Last 9 years [ ] 4. More than 9 years [ ] 5. None [ ]
7.	How many training did you received since you were employed?	1. None [ ] 2. Once [ ] 3. Twice 4. Thrice [ ] 5. More than thrice [ ]
8.	Do you require any further training to make your work better?	1. Yes [ ] 2. No [ ]
9.	What motivate you most as you work in this hospital?	1. The remuneration/salary [ ] 2. Good working condition [ ] 3. Conducive working environment [ ] 4. Just to render help [ ] 5. Others (specify).....

10.	Are you remunerated commensurate to your job?	1. Yes [ ] 2. No [ ]
SECTION B – KNOWLEDGE ON THE OPERATION OF NHIS		
11.	What is the source of your information on NHIS?	1. Friends/Colleagues[ ] 2. Radio/Television[ ] 3. Newspapers/Books[ ] 4. Internet[ ] 5. Seminars/Workshops[ ] 6. Others (specify).....
12.	Who is covered by the Programmes of NHIS?	1. Workers in public and private sectors[ ] 2. Rural community dwellers[ ] 3. Self employed person(artisan, traders, market women etc)[ ] 4. Vulnerable group (prison inmate, disable persons, retirees etc)[ ] 5. Student of tertiary institution[ ] 6. Foreigners residing in Nigeria[ ] 7. Others (specify).....
13.	What is the scope of coverage of NHIS?	1. Employee his spouse and four biological children below the age of 18 years[ ] 2. Employee his spouse and four biological children above the age of 18 years 3. Employee extra-dependent with surcharges[ ] 4. Maternity services for only four live births[ ] 5. Maternity services for more than four live births[ ]
14.	How does NHIS operate?	1. Employer chooses an HMO and register his worker with it[ ] 2. The worker chooses a preferred healthcare provider and register with it[ ] 3. The employer chooses healthcare provider for his workers[ ] 4. NHIS assigned healthcare providers to the beneficiaries[ ] 5. Waiting period of three months before accessing care [ ] 6. The registered beneficiary can change healthcare provider after 3months with genuine reason [ ] 7. There is provision for update registration [ ]
15.	Which of the following services are offered by NHIS?	1. General outpatient care [ ] 2. Accident & Emergency care[ ] 3. Pharmacy services[ ] 4. Laboratory & Radiology services[ ] 5. Maternity care for only four lives births[ ] 6. Maternity care for more than four live births [ ] 7. Eye care with provision spectacles[ ] 8. Hospitalization in an amenity ward[ ] 9. Immunization, family planning & health education[ ]
16.	The following is/are true about contributions in NHIS	1. Contribution is 15% of the total salary of the worker[ ] 2. Contribution is 15% of the basic salary of the worker[ ] 3. The employer contribute 10% while the worker contribute 5% of the basic salary[ ] 4. The employer contribute 5% while the worker contribute 10% of the basic salary[ ] 5. The employer can contribute all the 15% of the basic

		salary of his workers 6. For now federal government is the sole contributor to the scheme while the workers are yet to start contributing[ ]
17.	Mode of payments of healthcare providers under the NHIS include some or all of the following-	1. Capitation fee for primary providers[ ] 2. Fee-for-service for secondary providers[ ] 3. Per-diem fee for bed space[ ] 4. 10% co-payment on drugs[ ] 5. Users charges for primary providers[ ] 6. Re-imbursement payment for secondary providers[ ] 7. Case payment for secondary provider[ ] 8. Co-insurance for all categories of providers [ ]
18.	Stakeholders under the NHIS include some or all of the following-	1. Government[ ] 2. Private employer with minimum of ten worker[] 3. Healthcare providers[ ] 4. HMOs[ ] 5. Labour unions & organisations[ ] 6. NGOs & Donor agencies[ ] 7. Students of tertiary institution [ ] 8. Retirees/pensioners [ ] 9. Banks 10. Insurance companies [ ]
19.	The following is/are true about HMOs	1. HMOs stands for Mutual Health Organizations[ ] 2. Are life insurance company registered with NHIS[ ] 3. HMOs means Health Maintenance Organisation[ ] 4. Collect contribution from eligible contributors[ ] 5. Pay healthcare providers for services render[ ] 6. Give authorization for referrals[ ] 7. Ensure quality of care among the NHIS healthcare providers networks[ ] 8. Act as arbiter between the beneficiaries and health providers [ ] 9. Registration of beneficiaries [ ] 10. Accreditation of health providers [ ] 11.
20.	Which of the following is /are true about hospitalization under NHIS?	1. NHIS cover for a total of 15 days cumulatively in a year for admission only[ ] 2. Primary provider pay the secondary provider for bed space[ ] 3. HMO pay the secondary provider for bed space[ ] 4. Admission is in a standard general ward[ ] 5. Admission is in an amenity ward[ ] 6. It include feeding[ ] 7. Hospitalization beyond 15days in year will be paid for by the worker or his employer [ ]

21.	Which of the following is/are true about Referral system under the NHIS?	1. Authorization by the HMOs is most[ ] 2. Authorization by the NHIS is most[ ] 3. The HMO sent approval code for authorization to the provider[ ] 4. NHIS sent approval code for authorization to the provider[ ] 5. In case of emergency the patient is attended to while the HMO is notified within 48hours. [ ] 6. In case of emergency the patient is attended to while the NHIS is notified within 48hours. [ ]
SECTION C – QUALITY OF CARE **PLEASE RATE QUESTIONS 11 – 20 IN ORDER OF IMPORTANCE WITH REGARDS TO QUALITY OF CARE YOU RECEIVED**		
22.	Warm reception to patient at the card room with regards to his care.	1. Very important [ ] 2. Important [ ] 3. Fairly important [ ] 4. Not important [ ] 5. Indifferent [ ]
23.	The attitude of the doctor to the patient in the consulting room.	1. Very important [ ] 2. Important [ ] 3. Fairly important [ ] 4. Not important [ ] 5. Indifferent [ ]
24.	The need for the doctor to listen to the patient complaint well before further interrogation and prescription of drugs.	1. Very important [ ] 2. Important [ ] 3. Fairly important [ ] 4. Not important [ ] 5. Indifferent [ ]
25.	Thorough physical examination of patient by the doctor at OPD consultation.	1. Very important [ ] 2. Important [ ] 3. Fairly important [ ] 4. Not important [ ] 5. indifferent [ ]
26.	The issue of privacy during OPD consultation.	1. Very important [ ] 2. Important [ ] 3. Fairly important [ ] 4. Not important [ ] 5. Indifferent [ ]
28.	Confidentiality at the OPD consultation.	1. Very important [ ] 2. Important [ ] 3. Fairly important [ ] 4. Not important [ ] 5. Indifferent [ ]
29.	Requesting for relevant investigation at the OPD consultation.	1. Very important [ ] 2. Important [ ] 3. Fairly important [ ] 4. Not important [ ] 5. Indifferent [ ]
30.	The issue of cost while prescribing drugs to a patient during OPD consultation.	1. Very important [ ] 2. Important [ ] 3. Fairly important [ ] 4. Not important [ ]

		5. Indifferent [ ]
31.	The general attitude of other staff for an outpatient care.	1. Very important [ ] 2. Important [ ] 3. Fairly important [ ] 4. Not important [ ] 5. Indifferent [ ]
32.	The general cleanliness of the hospital important for an outpatient care.	1. Very important [ ] 2. Important [ ] 3. Fairly important [ ] 4. Not important [ ] 5. Indifferent [ ]
33.	In your opinion for how long should the patient wait at the card room before he gets a card?	1. Less than 15 minutes [ ] 2. Between 15 to 30 minutes [ ] 3. More than 30 minutes [ ]
34.	How long should the patient wait at the consulting room before he sees a doctor?	1. Less than 15 minutes [ ] 2. Between 15 to 30 minutes [ ] 3. More than 30 minutes [ ]
35.	What should be the waiting time at the pharmacy before the patient gets an attention?	1. Less than 15 minutes [ ] 2. Between 15 to 30 minutes [ ] 3. More than 30 minutes [ ]
36.	For how long should the patient wait at the laboratory before he gets an attention?	1. Less than 15 minutes [ ] 2. Between 15 to 30 minutes [ ] 3. More than 30 minutes [ ]
37.	The waiting time at the treatment room before a patient gets an attention should be in your opinion.	1. Less than 15 minutes [ ] 2. Between 15 to 30 minutes [ ] 3. More than 30 minutes [ ]
	SECTION D – GENERAL COMMENTS	
38.	The most important indicator of quality of care in the card room in your opinion is.	1. Prompt attention [ ] 2. Staff attitude [ ] 3. Cost of card [ ] 4. Cleanliness of the area [ ] 5. Orderliness (Quire) [ ] 6. Others (specify).....
39.	What do you consider most important in the quality of care in the consulting room?	1. Prompt attention [ ] 2. Attitude of the Doctor [ ] 3. Detailed History taking [ ] 4. Thorough physical examination [ ] 5. Privacy [ ] 6. Confidentiality [ ] 7. Cleanliness [ ]
40.	Quality of pharmacy services would be better enhanced by the following-	1. Prompt attention [ ] 2. Attitude of the staff [ ] 3. Cost of drugs [ ] 4. Explanation on how to use the drugs [ ] 5. Others (specify).....
41.	In your opinion which of these is most important in the quality of care in the laboratory?	1. Prompt attention [ ] 2. Attitude of the staff [ ] 3. Cost of laboratory test [ ] 4. Explanation on the test to be conducted [ ]

		5. Cleanliness [ ] 6. Waiting time for test result to be out [ ] 7. Others (specify).....
42.	Which of the following do you consider as most important indicator of quality of care in the treatment room?	1. Prompt attention [ ] 2. Attitude of the staff [ ] 3. Skill & expertise of the staff [ ] 4. Explanation with regards to the treatment [ ] 5. Cleanliness [ ] 6. Privacy [ ] 7. Confidentiality [ ] 8. Others (specify).....
43.	Overall how would you rate the services you received today in this hospital?	6. Highly satisfied [ ] 7. Satisfied [ ] 8. Unsatisfied [ ] 9. Highly unsatisfied [ ] 10. Indifferent [ ]
44.	What do you think can be done to improve the quality of outpatient care in this hospital with regards to NHIS?	1. More funding from NHIS 2. Creating a unit for NHIS client [ ] 3. Make NHIS referral system less cumbersome [ ] 4. Review of NHIS drug/service price list[ ] 5. Employment of more staff [ ] 6. Training of existing staff [ ] 7. Building more physical infrastructure [ ] 8. Computerization of med. record unit [ ] 9. Others (specify).....

Thank you very much for giving us your time to response to this questionnaire. Your honest and unbiased response will certainly go a long way in shedding light to where improvement needs to be made on the issue of quality of outpatient care in this facility and on the implementation of the NHIS programmes to ensure efficiency and sustainability.

APPENDIX III

HEALTHCARE MANAGERS QUESTIONNAIRE

Hello, this questionnaire is purely for research purpose, we are conducting a survey with NHIS healthcare providers of this facility to find out their perceptions on what constitute quality of care. We want your honest answers to help NHIS and BDSH Kaduna to improve their services. Your answers are strictly confidential and we thank you for your participation and honesty.

Please tick as appropriate.

S/N	SECTION A – DEMOGRAPHIC DATA	
1.	Age	1. 21 – 30 years [ ] 2. 31 – 40 years [ ] 3. 41 – 50 years [ ] 4. 51 – 60 years [ ] 5. Above 60 years [ ]
2.	Sex	1. Male [ ] 2. Female [ ]
3.	Category/Cadre	1. Doctors [ ] 2. Nurses [ ] 3. Pharmacist [ ] 4. Medical laboratory scientist [ ] 5. Medical Records Officer [ ] 6. Administrative Officer [ ] 7. Others (specify).....
4.	Highest Educational Qualification obtained	1. Degree [ ] 2. Diploma [ ] 3. Professional certificate [ ] 4. School leaving certificate [ ] 5. Others (specify).....
5.	For how long have you been working in this hospital?	1. 1 – 10 years [ ] 2. 11 – 20 years [ ] 3. 21 – 30 years [ ] 4. Above 30 years
6.	When were you promoted last?	1. Last 3 years [ ] 2. Last 6 years [ ] 3. Last 9 years [ ] 4. More than 9 years [ ] 5. None [ ]
7.	How many training did you received since you were employed?	1. None [ ] 2. Once [ ] 3. Twice [ ] 4. Thrice [ ] 5. More than thrice [ ]
8.	What motivate you most to make you remain in this present work in this hospital?	1. The remuneration/salary [ ] 2. Good working condition [ ] 3. Conducive working environment [ ] 4. Just to render help [ ] 5. Others (specify).....

SECTION B - KNOWLEDGE ON THE OPERATION OF NHIS		
9.	What is the source of your information on NHIS?	1. Friends/Colleagues[ ] 2. Radio/Television[ ] 3. Newspapers/Books[ ] 4. Internet[ ] 5. Seminars/Workshops[ ] 6. Others (specify).....
10.	Who is/are covered by the Programmes of NHIS?	1. Workers in public and private sectors 2. Rural community dwellers[ ] 3. Self employed person(artisan, traders, market women etc)[ ] 4. Vulnerable group (prison inmate, disable persons, retirees etc)[ ] 5. Student of tertiary institution[ ] 6. Foreigners residing in Nigeria[ ] 7. Pensioners 8. Others (specify).....
11.	What is the scope of coverage of NHIS?	1. Employee his spouse and four biological children below the age of 18 years[ ] 2. Employee his spouse and four biological children above the age of 18 years[ ] 3. Employee extra-dependent with surcharges[ ] 4. Maternity services for only four live births 5. Maternity services for more than four live births[ ] 6. Students of tertiary institution[ ]
13.	How does NHIS operate?	1. Employer chooses an HMO and register his worker with it[ ] 2. The worker chooses a preferred healthcare provider and register with it[ ] 3. The employer chooses healthcare provider for his workers[ ] 4. NHIS assigned healthcare providers to the beneficiaries[ ] 5. Waiting period of 3months for accessing care [ ] 6. The registered beneficiary can change healthcare provider after 3months with genuine reason [ ] 7. Provision for update registration of dependents [ ]
14.	Which of the following services are offered by NHIS?	1. General outpatient care [ ] 2. Accident & Emergency care[ ] 3. Pharmacy services[ ] 4. Laboratory & Radiology services[ ] 5. Maternity care for only four lives births[ ] 6. Maternity care for more than four lives birth [ ] 7. Eye care with provision spectacles[ ] 8. Hospitalization in standard general ward[] 9. Hospitalization in an amenity ward [ ] 10. Immunization, family planning & health education[ ]
15.	The following is/are true about contributions in NHIS	1. Contribution is 15% of the total salary of the worker [ ] 2. Contribution is 15% of the basic salary of the worker[ ] 3. The employer contribute 10% while the worker contribute 5% of the basic salary[]

		4. The employer contribute 5% while the worker contribute 10% of the basic salary [ ] 5. The employer can contribute all the 15% of the basic salary of his workers[ ] 6. For now federal government is the sole contributor to the scheme while the workers have not started contributing[ ]
16.	Mode of payments of healthcare providers under the NHIS include some or all of the following-	1. Capitation fee for primary providers[ ] 2. Fee-for-service for secondary providers[ ] 3. Per-diem fee for bed space[ ] 4. 10% co-payment on drugs[ ] 5. Users charges for primary providers[ ] 6. Re-imbursement payment for secondary providers[ ] 7. Case payment for secondary provider[ ] 8. Co- insurance for all categories of providers [ ]
17.	Stakeholders under the NHIS include some or all of the following-	1. Government [ ] 2. Private employer with minimum of ten worker[ ] 3. Healthcare providers[ ] 4. HMOs[ ] 5. Labour unions & organisations[ ] 6. Students of tertiary institutions [ ] 7. NGOs & Donor agencies[ ] 8. Banks 9. Insurance companies
18.	The following is/are true about HMOs	1. HMOs stands for Mutual Health Organizations[ ] 2. Are life insurance company registered with NHIS[ ] 3. HMOs means Health Maintenance Organisation[ ] 4. Collect contribution from eligible contributors[ ] 5. Pay healthcare providers for services render[ ] 6. Give authorization for referrals[ ] 7. Ensure quality of care among the NHIS healthcare providers networks [ ] 8. Act as arbiter between the beneficiaries and providers [ ] 9. Registration of the beneficiaries [ ] 10. Accreditation health providers [ ]
19.	Which of the following is /are true about hospitalization under NHIS?	1. NHIS cover a total of 15 days cumulatively in a year for admission only[ ] 2. Primary provider pay the secondary provider for bed space[ ] 3. HMO pay the secondary provider for bed space[ ] 4. Admission is in a standard general ward 5. Admission is in an amenity ward[ ] 6. It include feeding [ ] 7. Hospitalization beyond 15days in a year will be paid by the worker or his employer
20.	Which of the following is/are true about Referral system under the NHIS?	1. Authorization by the HMOs is most[ ] 2. Authorization by the NHIS is most[ ] 3. The HMO sent approval code for authorization to the provider[ ] 4. NHIS sent approval code for authorization to the provider[ ] 5. In case of emergency the patient is attended to

		while the HMO is notified within 48hours.[ ] 6. In case of emergency the patient is attended to while the NHIS is notified within 48hours.[ ]
SECTION C – QUALITY OF CARE **PLEASE RATE QUESTIONS 21 – 35 IN ORDER OF IMPORTANCE WITH REGARDS TO QUALITY OF CARE YOU RECEIVED**		
21.	Warm reception to patient at the card room with regards to his care.	6. Very important [ ] 7. Important [ ] 8. Fairly important [ ] 9. Not important [ ] 10. Indifferent [ ]
22.	The attitude of the doctor to the patient in the consulting room.	6. Very important [ ] 7. Important [ ] 8. Fairly important [ ] 9. Not important [ ] 10. Indifferent [ ]
23.	The need for the doctor to listen to the patient complaint well before further interrogation and prescription of drugs.	6. Very important [ ] 7. Important [ ] 8. Fairly important [ ] 9. Not important [ ] 10. Indifferent [ ]
24.	Thorough physical examination of patient by the doctor at OPD consultation.	6. Very important [ ] 7. Important [ ] 8. Fairly important [ ] 9. Not important [ ] 10. indifferent [ ]
25.	The issue of privacy during OPD consultation.	6. Very important [ ] 7. Important [ ] 8. Fairly important [ ] 9. Not important [ ] 10. Indifferent [ ]
26.	Confidentiality at the OPD consultation.	6. Very important [ ] 7. Important [ ] 8. Fairly important [ ] 9. Not important [ ] 10. Indifferent [ ]
27.	Requesting for relevant investigation at the OPD consultation.	6. Very important [ ] 7. Important [ ] 8. Fairly important [ ] 9. Not important [ ] 10. Indifferent [ ]
28.	The issue of cost while prescribing drugs to a patient during OPD consultation.	6. Very important [ ] 7. Important [ ] 8. Fairly important [ ] 9. Not important [ ] 10. Indifferent [ ]
29.	The general attitude of other staff for an outpatient care.	6. Very important [ ] 7. Important [ ] 8. Fairly important [ ] 9. Not important [ ] 10. Indifferent [ ]
30.	The general cleanliness of the hospital important for an outpatient care.	6. Very important [ ] 7. Important [ ] 8. Fairly important [ ]

		9. Not important [ ] 10. Indifferent [ ]
31.	In your opinion for how long should the patient wait at the card room before he gets a card?	4. Less than 15 minutes [ ] 5. Between 15 to 30 minutes [ ] 6. More than 30 minutes [ ]
32.	How long should the patient wait at the consulting room before he sees a doctor?	4. Less than 15 minutes [ ] 5. Between 15 to 30 minutes [ ] 6. More than 30 minutes [ ]
33.	What should be the waiting time at the pharmacy before the patient gets an attention?	4. Less than 15 minutes [ ] 5. Between 15 to 30 minutes [ ] 6. More than 30 minutes [ ]
34.	For how long should the patient wait at the laboratory before he gets an attention?	4. Less than 15 minutes [ ] 5. Between 15 to 30 minutes [ ] 6. More than 30 minutes [ ]
35.	The waiting time at the treatment room before a patient gets an attention should be in your opinion.	4. Less than 15 minutes [ ] 5. Between 15 to 30 minutes [ ] 6. More than 30 minutes [ ]
	SECTION C – GENERAL COMMENTS	
36.	The most important indicator of quality of care in the card room in your opinion is.	1. Prompt attention [ ] 2. Staff attitude [ ] 3. Cost of card [ ] 4. Cleanliness of the area [ ] 5. Orderliness (Queue) [ ] 6. Others (specify).....
37.	What do you consider most important in the quality of care in the consulting room?	1. Prompt attention [ ] 2. Skill & expertise of doctor [ ] 3. Attitude of the Doctor [ ] 4. Detailed History taking [ ] 5. Thorough physical examination [ ] 6. Privacy [ ] 7. Confidentiality [ ] 8. Cleanliness [ ]
38.	Quality of pharmacy services would be better enhanced by the following-	1. Prompt attention [ ] 2. Attitude of the staff [ ] 3. Cost of drugs [ ] 4. Explanation on how to use the drugs [ ] 5. Others (specify).....
39.	In your opinion which of these is most important in the quality of care in the laboratory?	1. Prompt attention [ ] 2. Attitude of the staff [ ] 3. Cost of laboratory test [ ] 4. Explanation on test to be conducted [ ] 5. Cleanliness [ ] 6. Waiting time for test result to be out [ ] 7. Others (specify).....
40.	Which of the following do you consider as most important indicator of quality of care in the treatment room?	1. Prompt attention [ ] 2. Attitude of the staff [ ] 3. Skill & expertise of the staff [ ] 4. Explanation on the treatment [ ] 5. Cleanliness [ ] 6. Privacy [ ] 7. Confidentiality [ ] 8. Others (specify).....

41.	What do you think can be done to improve the quality of outpatient care in this hospital with regards to NHIS?	1. More funding from NHIS 2. Creating a unit for NHIS client [ ] 3. Make NHIS referral system less cumbersome [ ] 4. Employment of more staff [ ] 5. Training of existing staff [ ] 6. Building more physical infrastructure [ ] 7. Computerization of medical record unit [ ] 8. Others (specify).....

Thank you very much for giving us your time to response to this questionnaire. Your honest and unbiased response will certainly go a long way in shedding light to where improvement needs to be made on the issue of quality of outpatient care in this facility and on the implementation of the NHIS programmes to ensure efficiency and sustainability.

APPENDIX IV

CHECKLIST FOR GOPD UTILIZATION BY NHIS CLIENTS,BDSH, KADUNA

GOPD MONTHLY NHIS ENROLLEES ATTENDANCE, JANUARY-DECEMBER, 2009

S/N	MONTH	VISIT	REVISIT	REFERRED	TOTAL
TOTAL					

COMMENTS.....
.....
.....

NHIS DESK OFFICERS
SIGNATURE/DATE.....

APPENDIX V

ETHICAL CLEARANCE CERTIFICATE

DEPARTMENT OF COMMUNITY MEDICINE

FACULTY OF MEDICINE, AHMADU BELLO UNIVERSITY, ZARIA

VICE CHANCELLOR: **Professor Abdullahi Mustapha,**
B.Sc (Hons) Pharm, A.B.U. Ph.D, (London) FPSN

A.g. HEAD OF DEPARTMENT: **Dr. S.H. Idris,**
MBBS, DMLD, FWACP (COMM. HEALTH)

Telephone: 069-551718
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Fax: 069-550022

Our Ref: MPH/MED/11929/2008-09 Date: April, 2010

MEDICAL DIRECTOR
BARAU DIKKO SPECIALIST
HOSPITAL, KADUNA.

Dear Sir/Madam,

INTRODUCTION OF MASTER IN PUBLIC HEALTH (MPH) STUDENT AND RESEARCH PROJECT: DR. SALAWUDEEN S. ABDULRASHEED - MPH/MED/11929/2008-09

This is to certify that the above named MPH student is conducting his Research Project on the topic: Assessment of Client Satisfaction and Quality of Out Patient Care under the National Health Insurance Scheme at Barau Dikko Specialist Hospital, Kaduna, Kaduna State.

I shall be grateful for your assistance in giving him all the necessary information/data relevant to the project title to enable him handle the assignment with confidence and success.

Thank you.

Yours faithfully

Dr. S.H. Idris
HEAD OF DEPARTMENT

A.B.U. ZARIA