EXPERIENCES AND SATISFACTION WITH NATIONAL HEALTH INSURANCE SCHEME AMONG NON-TEACHING STAFF OF COLLEGE OF MEDICINE, UNIVERSITY OF IBADAN, NIGERIA

BY

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A DISSERTATION IN THE DEPARTMENT OF HEALTH PROMOTION AND EDUCATION SUBMITTED TO THE FACULTY OF PUBLIC HEALTH COLLEGE OF MEDICINE IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF PUBLIC HEALTH (HEALTH PROMOTION AND EDUCATION) OF THE UNIVERSITY OF IBADAN

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DEDICATION

I dedicate this work to the Almighty God for His Grace and Mercy upon my life

ABSTRACT

National Health Insurance Scheme (NHIS) aims to ensure that every Nigerian has access to good health care services at affordable costs. Inspite of the NHIS benefits, poor utilisation rate has been documented in previous studies and out-of-pocket means of payment still remain high. This study was therefore designed to investigate the experiences, level of satisfaction and attitude towards NHIS among Non-Teaching Staff (NTS) of College of Medicine, University of Ibadan (CoMUI), Ibadan, Nigeria.

This cross-sectional study involved 375 randomly selected consenting NTS of CoMUI from the 4 Faculties and 8 administrative Units. A semi-structured self-administered questionnaire was used to elicit information on the socio-demographic characteristics, experiences, satisfaction, attitude and factors influencing utilisation of NHIS. Experience, satisfaction and attitude were measured on 16-point, 18-point and 20-point scales respectively. Experience scores of <8 and ≥8 were rated bad and good respectively. Satisfaction scores of <9 and ≥9 were rated not satisfied and satisfied respectively. Attitude scores of <10 and ≥10 were rated negative and positive respectively. Nine Key Informant Interviews (KIIs) were conducted among heads of units and the most senior staff. Quantitative data were analysed using descriptive statistics, Chi-square and logistic regression tests at $p \leq 0.05$ while qualitative data were analysed thematically.

Age of respondents was 42.9±8.0 years, 54.7% were males and 92.5% were married. Most (93.6%) of the respondents registered with NHIS, out of which 36.3% were not utilising NHIS services as at the time of conducting this study. Reported reasons for not using NHIS were non-availability of personal identification number (68.3%) and having a family clinic which they were reluctant to change (41.1%). Among users, 49.6% had good experience, 44.6% have benefitted from NHIS services, and 43.3% reported they were given prompt attention at the hospital. More than one third (38.9%) were satisfied with the type of services available from NHIS while 31.2% mentioned that NHIS services met all their health needs. Attitude score was 14.7±3.7, 47.2% had positive attitude towards NHIS while 21.1% carried their registration cards regularly. Attention given to the patients by the health workers (93.6%), having adequate information about the scheme (91.7%) and quick registration process (84.8%) were some of the factors perceived that could influence NHIS service utililsation. Young adults between 24-40years were more likely to have good experience compared to the middle age (OR: 0.35; 95% CI: 0.127–0.983). Majority of the key

informants revealed that healthcare facilities were imposed on enrollees, registration process was very slow and no evidence of appraisal of service delivery. Most participants were not fully enlightened on the components and structure of NHIS.

Some of the respondents had good experiences with National Health Insurance Scheme services, few of the workers were satisfied with the services received and less than half had positive attitude towards NHIS. Modification of existing policies guiding registration process and quality of service of National Health Insurance Scheme is advocated for. Frequent monitoring and evaluation of all the healthcare facilities for proper appraisal is hereby recommended.

Keywords: National Health Insurance Scheme, Healthcare Provider, Non-teaching staff

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CERTIFICATION

I hereby certify that this study was carried out by OLALERE Akinfenwa Adebimpe in the department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Nigeria.

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CoMUI	-	College of Medicine, University of Ibadan
CT	-	Computerised Tomography
DMHIS	-	District Mutual Health Insurance Scheme
ENT	-	Ear, Nose and Throats
ERC	-	Ethical Review Committee
FGD	-	Focused Group Discussion
FMOH	-	Federal Ministry of Health
FSSHIP	-	Formal Sector Social Health Insurance Scheme
GDP	-	Gross Domestic Product
HMO	-	Health Management Organisation
IEC	-	Information Education and Communication
ILO	-	International Labour Organisation
KIIs	-	Key Informant Interviews
MHIS	-	Mutual Health Insurance Scheme
MIS	-	Management Information System
MRI	-	Magnetic Resonance Imaging
NCBI	-	National Centre for Biotechnology Information
NGO	-	Non Governmental Organisation
NHIS	-	National Health Insurance Scheme
NHP	-	National Health Policy
NTS	-	Non-Teaching Staff
OECD	-	Organisation for Economic Co-operation and Development
PIN	-	Personal Identification Number
ROK	-	Republic of Korea
SHI	-	Social Health Insurance
UCH	-	University College Hospital
UI	-	University of Ibadan
UK	-	United Kingdom
UNAIDS	-	United Nations Programme on HIV/AIDS
UNDP	-	United Nations Development Programme
UNICEF	-	United Nations International Children's Emergency Fund
WHO	-	World Health Organisation

CHAPTER ONE

INTRODUCTION

1.1 Background

National Health Insurance is a scheme that insures national population for the costs of health care and usually it is instituted as a programme of healthcare reform. It may be administered by the public sector, the private sector, or a combination of both. Funding mechanisms vary with the particular programme and country. National health insurance does not equate to government run or government financed health care, but it is usually established by national legislation (Shubha and Srivastava, 2010). The National Health Insurance Scheme (NHIS) is a social health insurance programme designed by the Federal Government of Nigeria to complement sources of financing the health sector, and to improve access to health care for the majority of Nigerians.

National Health Insurance Scheme was established under Act 35 of 1999 by the Federal Government of Nigeria. It is aimed at providing easy access to healthcare for all Nigerians at an affordable cost through various prepayment systems. It is totally committed to securing universal coverage and access to adequate and affordable healthcare in order to improve the health status of Nigerians, especially for those participating in the various programmes/products of the scheme (NHIS, 2009).

It had been assumed that employees, particularly those in the formal sector would voluntarily participate in the scheme, given the inconvenience many had experienced with the previous arrangement of the user fee policy (cash and carry) in the public sector which resulted in inequities in financial access and utilisation of basic and essential health services between different socio-economic groups and between poor rural and richer urban dwellers. (Waddington and Enyimayew 1990; Asenso-Okyere, Anum, Osei-Akoto and Adukonu. 1998; Nyonator and Kutzin 1999; Agyepong, 1999).External loans and grants in form of technical assistance, general taxation and free drugs especially for preventive services (Onyedibe, Goyit and Nnadi, 2012).

The Nigerian government instituted a social health insurance system to bring succor to the plight of its citizens through the National Health Insurance Scheme. Health insurance involves the application of insurance principles to cover cost of defined medical benefit packages. It involves risk sharing between those who will need the benefits and those who will not. It also involves

spreading the burden of cost of healthcare services to the insured over time so that the insured can access services anytime without paying (Onyedibe, et al., 2012). However, workers at the state and local government levels have not started benefitting from the scheme not to talk of private employees and the broad objective of the scheme is to ensure that every Nigerian has access to good health care services at affordable costs.

Healthy population and indeed work force are indispensable tools for rapid socio-economic and sustainable development the world over. Despite this indisputable fact, in Nigeria like most African countries, the provision of quality, accessible and affordable healthcare remains a serious problem (WHO, 2007a; Oba, 2008; Omoruan, Bamidele and Philips, 2009). This is because the health sector is perennially faced with gross shortage of personnel (WHO, 2007a), inadequate and outdated medical equipment (Yohesor, 2004; Johnson and Stoskopf, 2009), poor funding (WHO, 2007aandb), policies inconsistence (Omoruan et al., 2009) and corruption (Oba, 2008). Evidence shows that, only 4.6 percent of both public and private Gross Domestic Product (GDP) in 2004 was committed to the sector (WHO, 2007a, b andc).

Other factors that impede quality health care delivery in Nigeria include inability of the consumer to pay for healthcare services (Sanusi and Awe, 2009), gender bias due to religious or culture beliefs (National Centre for Biotechnology Information, 2009) and inequality in the distribution of healthcare facilities between urban and rural areas (Omoruan et al., 2009). Sequel to the aforementioned, the country is continually ranked low in healthcare delivery by international organisations. In 2000 for instance, WHO report on healthcare delivery ranked Nigeria 187 out of 191 countries, eight years later, Human Development Report 2007/2008, ranked the country 158 out of 177. In 2005 only 48 and 35 percents of infants were fully immunized against tuberculosis and measles respectively. Between 1998 and 2005, 28 percent of the children within the ages of 1 – 5 years who suffered from diarrhoea received adequate treatment. Between 1997 and 2005 only 35 percent of births in Nigeria were attended by skilled health personnel (UNICEF, 2006; World Bank, 2007; UNDP, 2008).

Furthermore, between 2000 and 2004, only 28 percents of Nigerians had access to physicians (UNICEF, 2006; World Bank, 2007; UNDP, 2008). While the situation in the health sector

persists, Nigeria continually loses her professional to other countries. It was reported in 1986 that more than 1,500 health professionals left Nigeria to other countries (Agba, Ushie and Osachukwu, 2010). In 1996, UNDP report revealed that 21,000 medical personnel were practicing in the United States of America (USA) and United Kingdom (UK), while there was gross shortage of these personnel in the Nigerian health sector (Akingbade, 2006). The health situation in the country shows that only 39 percent in 1990 and 44 percent of Nigerians in 2004 have access to improved sanitation (UNDP, 2008).

In 1990/92 and 2002/04, the percentage of Nigerians undernourished were 13 percent and 9 percent respectively (UNDP, 2008). HIV prevalence in Nigeria within the ages of 15 to 49 years was 3.9 percent in 2005 (UNAIDS, 2006). In an attempt to address the precarious and dismal situation in the health sector, and to provide universal access to quality health care service in the country, various health policies by successive administration were made including the establishment of primary health care centres, secondary and tertiary hospitals. The perennial health problem informed the decision of Gen. Abdulsalami Abubakar on May 10, 1999, to sign into law the National Health Insurance Scheme (NHIS, 2005) Decree Number 35 (NHIS Decree No. 35 of 1999); with the aim of providing universal access to quality healthcare to all Nigerians. NHIS became operational after it was officially launched by the Federal Government in 2005.

More than four years of NHIS existence in Nigeria, opinion is polarized among Nigerians on the efficacy of the scheme in addressing the health problems in the country, because of disheartening reports in the continual health situation. For instance, World Bank (2008) survey on the scheme shows that only one million people in Nigeria or 0.8 percent of the population are covered by NHIS. The report further reveals that many low-income persons would not benefit from NHIS for at least another 10 years. The purpose of this study therefore, is to determine the experiences and level of satisfaction with NHIS among non-teaching staff of College of Medicine, University of Ibadan, Ibadan, Oyo State.

1.2 Statement of the Problem

Access to healthcare is severely limited in Nigeria (Otuyemi, 2001). This may be due to inadequate facilities or inabilities of the consumer to pay for the services as well as the health

care provision that is far from equitable. As far back as 1988, estimates from the Federal Ministry of Health and the Social Services showed that not more than 35% of the population had access to modern health care services (Adeyemi and Petu, 1989; Falegan, 2008; Ngowu, Larson and Kim, 2008). Also, allocations to the health sector by the Federal Government have always been quite low. For instance, between 2000 and 2004, an average of 3.52% of the entire budget of the government was spent on health (Adeyemi and Petu, 1989; Falegan, 2008; Ngowu et al., 2008) leaving a noticeable gap of 1.48% from the recommendation of the World Health Organisation (WHO, 1999).

A growing number of countries have implemented, or are considering alternatives to government budget allocations for financing health services. Thus many developing countries design health policy towards achieving universal access to medical care. According to (Ngowu et al., 2008) and Falegan (2008) in Nigeria an increased proportion of the nation's resources are being spent on health and medical care than it was at independence. Nonetheless, it was observed that the nation's ratio of population per health resources has shown large decreases from 47,330 persons per doctor in 1960-6,200 in 1986 and 1,042, 240 persons per dentist in 1960-99,000 per dentist in 1986, also, 8,600 persons per registered nurse in 1960-1,950 in 1986 and a decrease in population per hospital bed from 2,520 persons in 1960-1,000 in 1986 (Ononokpono, 2008).

In spite of these achievements however, majority of Nigerians still do not have access to medical care when they need it. The government instituted the National Health Policy (NHP) in 1988 with the primary objective of improving the health status of the people to allow Nigerians to have wholesome, productive, social and economic lives, yet a large proportion of the privileged few who have access to medical facilities cannot afford to pay for health care due to its rapidly escalating cost (Sanusi and Awe, 2009). Many low-income households regularly postponed medical treatment, resorted to self treatment, or used alternatives provided by unregulated healers, spiritualist, and itinerant drug vendors, often with disastrous results (Mensah, Oppong and Schmidt, 2010).

The Nigerian government is of the notion that NHIS which is a healthcare risk spreading mechanism is probably what is required to solve the problem of inequality in the provision of

healthcare services (Ibiwoye and Adeleke, 2007). Thus the scheme was proposed to help spread the risks and minimize the costs of health care. Inspite of the NHIS benefits, poor utilisation rate has been documented in previous studies (Umar and Muhammed, 2011) and out-of-pockets means of payment still remains with catastrophic health consequences. This study seeks to investigate the experiences and level of satisfaction of NHIS among non-teaching staff of College of Medicine, University of Ibadan, Ibadan, Oyo State.

1.3 Justification

This study is important for three reasons. The first is that it would be useful in ascertaining the level of satisfaction of University staff with the NHIS services. This would serve as baseline information for designing and implementing relevant programmes such as training of health workers, orientation programmes for new enrollees and training of NHIS staff. Secondly, the study will suggest more effective strategies needed in planning and implementing NHIS services in other parastatals.

Thirdly, the findings could inform discussion on the formulation of evidenced-based policies towards promoting good health. It is expected that the policies which would be formulated using the useful finding gear towards developing personal skills, creating supportive environments, re-orientating, strengthening community action, advocating, mediating, enabling and also participatory health management that would include Health Management Organisations, healthcare providers and consumers of NHIS services. It could also be useful in evaluating the quality of care as an outcome variable and also as indicators of which aspect of the service needed to be changed in order to improve workers response by the policy makers.

The non-teaching members of staff of the College of Medicine working in University of Ibadan College Hospital premises are part of Federal Government workers who are in an environment saturated with health information. Hence, they are expected to have easy access to health information including NHIS services. This justifies their being used as the target population to use their experience and level of satisfaction as inference to other Federal Government workers that are not working in hospital environment.

Research Questions

1. What is the attitude of non-teaching staff in College of Medicine towards the use of NHIS?
2. What are the experiences of non-teaching staff in College of Medicine that have used NHIS facilities?
3. What are the factors associated with utilisation of NHIS among non-teaching staff of College of Medicine?
4. What is the level of satisfaction of non-teaching staff in College of Medicine on NHIS?

1.4. Broad Objective

To investigate the experiences and satisfaction with National Health Insurance Scheme among non-teaching staff of College of Medicine, University of Ibadan.

1.5 Specific Objectives

1. To determine the attitudes of non-teaching staff in the use NHIS facilities
2. To document the experiences of non-teaching staff that have used NHIS facilities
3. To identify factors associated with utilisation of NHIS among non-teaching staff
4. To assess the level of satisfaction of non-teaching staff on NHIS

1.6 Research Hypotheses

Based on the variables to be measured, the following null hypotheses were formulated:-

1. There is no significant relationship between the marital status of the respondents and their attitudes towards NHIS.
2. There is no significant relationship between respondents' number of children and their experiences relating to the utilisation of NHIS facilities.
3. There is no significant difference between respondents' category and their experiences relating to the utilisation of NHIS facilities.
4. There is no significant difference between respondents' years in service and their experiences relating to the utilisation of NHIS facilities.
5. There is no significant difference between respondents' level of education and their level of satisfaction on NHIS.

1.7 Operational Definition of Terms

Healthcare provider: People that render health services for examples, doctors, nurses, laboratory scientists etc.

National Health Insurance Scheme: It is a nationwide health care financing system that seeks to provide affordable and accessible health care. It may be provided through a government-sponsored social insurance programme, or from private insurance companies. Individuals or groups may be covered by the scheme through the payment of premiums or taxes to help protect them from high or unexpected healthcare expenses.

Non-teaching staff: People who are officially employed to do administrative work in different areas in the College of Medicine other than teaching.

Satisfaction level: The difference between pre-registration expectations and the performance or quality of the product or service rendered by the scheme. This is how the non-teaching staff feel about NHIS services after utilisation whether they are contented with the programme or not.

Attitude: Activities undertaken intentionally by an individual to take care of his/her health by utilising a facility.

Experience: Things that have happened when the NHIS hospitals/clinics are visited that influence the way an individual think and behave towards NHIS services.

CHAPTER TWO

LITERATURE REVIEW

2.1 Global View of National Health Insurance Scheme's Evolution

The Campaign for some form of universal government funded health care has stretched for nearly a century in the US on several occasions, Advocates believed they were on the verge of success; yet each time they faced defeat. The evolution of these efforts and the reasons for their failure make for an intriguing lesson in American history, ideology, and character (Karen, 1999).

Other developed countries have had some form of social insurance (that later evolved into national insurance) for nearly as long as the US has been trying to get it. Some European countries started with compulsory sickness insurance, one of the first systems, for workers beginning in Germany in 1883; Germany has the world's oldest national health insurance, through the world's oldest universal health care system, with origins dating back to Otta von Bismark's social legislation, which included the Health Insurance Bill of 1883, Accident Insurance Bill of 1884, and Old Age and Disability Insurance Bill of 1889 (Shubha and Srivastava, 2010).

In Britain, the National Insurance Act 1911 marked the first steps towards national health insurance, covering most employed persons who had been continuous contributors to the scheme for at least five years whether they were working or not. In 1948, they extended health care security to all legal residents. Most other countries national health insurance systems were implemented in the period following the Second World War in spirit of Article 25 of the Universal Declaration of Human Rights of 1948 by nation, which had adopted the declaration as signatories (Shubha and Srivastava, 2010).

Other countries including Australia, Hungary, Norway, Britain, Russia, and the Netherlands followed all the way through 1912. Other European countries, including Sweden in 1891, Denmark in 1892, France in 1910, and Switzerland in 1912, subsidized the mutual benefit society that workers formed among themselves (Karen, 1999).

2.2 Brief History of NHIS in Africa

Ghana was the first country in sub-Saharan Africa to win independence from British and her future was ever so bright. Under the leadership of Kwame Nkrumah, Ghana set up a National Health Service which was fully financed from State revenue. The advantage of this system was that, it was progressive. (Dalinjong and Laar , 2012)

Introduction of Mutual Health Insurance Scheme (MHIS) in Ghana was very much influenced by the introduction of user fees in 1984, difficulties in affording the cost of health care, loss of revenue for many hospitals, challenges within the health sector prompted some health care facilities, mainly mission hospitals, to introduce insurance schemes managed jointly with communities (Creese and Benneth, 1997). The Nkoranza scheme for instance, the first MHIS in Ghana, was initiated by the Catholic Diocese of Sunyaniin 1989, Other schemes, such as Damongo and Dangme West MHIS became models for other communities to replicate. NHIS bill passed into law in 2003 provided the basis for the establishment of MHIS at the district level in Ghana (Ghana Ministry of Health, 2004b).

The National Health Insurance Scheme in Ghana primary goal was to improve access to and quality of basic health care services in Ghana through the establishment of mandatory district-level MHIS. The policy objective is that every resident of Ghana shall belong to a health insurance scheme that adequately covers him or her against the need to pay out-of-pocket at the point of service use in order to obtain access to a defined package of acceptable, quality health services" (Government of Ghana 2004).

Health Insurance (HI) Act provides the legislative framework for the establishment of a regulatory body, the National Health Insurance Council. The HI Act provides for the establishment of three types of schemes:

–District Mutual Health Insurance Schemes (DMHIS)

–Private Commercial Health Insurance Schemes

–Private Mutual Health Insurance Schemes (Ghana Ministry of Health, 2004a).

Benefit Package of NHIS in Ghana

The benefits package cover basic health care services, including outpatient consultations, essential drugs, inpatient care and shared accommodation, maternity care, eye care, dental care, and emergency care, family planning and immunization, excluded from the benefit packages are cosmetic surgery, drugs not listed on the NHIS drugs list, assisted reproduction, organ transplantation, and private inpatient accommodation (Ghana Ministry of Health, 2002a)

Financing the NHIS in Ghana

The Act provides for the establishment of a National Health Insurance Fund to mobilize financial resources for the fund, the Government of Ghana established a NHI Levy of 2.5% on specific goods and services. In addition, 2.5% of the 17.5% social security contributions paid by formal sector employees will automatically be diverted to support the NHIS and formal sector employees and their dependants (below 18 years) will automatically be enrolled. District Mutual Health Insurance Scheme will raise funds from premiums for informal sector members to be set in consultation with the National Insurance Authority It is estimated that 70-75% of total revenue comes from the NHI levy while formal sector contributions made up about 20-25%. The informal sector premiums constituted only about 5% (Witter and Garshong, 2009).

2.3 National Health Insurance Scheme in Nigeria

In Nigeria, it is obvious that the quality of health services facilities is very poor. At all levels, health services facilities are dilapidated or non-functional. The health referral system is simply non-operational. Thereby translating to inefficient and unequal health services delivery, fake and substandard drugs are widely proliferated in the Nigerian markets (Owumi, Omorogbe and Raphael, 2013). It is believed that public financing of medical care is necessary and justified so that increased consumption of medical services can lead to improved health status and positive externalities (Collins, Davis, Doty, Kriss and Holmgren, 2006).

In line with this school of taught, NHIS was first introduced in Nigeria in 1962, during the First Republic (Johnson and Stoskopt, 2009). The scheme then was compulsory for public service workers. The operation of NHIS was obstructed following the Nigerian civil war. In 1984, the Nigerian Health Council resuscitated the scheme and a committee was set up to look at the

National Health Insurance. And in 1988, the then Minister of Health Professor Olikoye Ransome Kuti commissioned Emma-Eronmi led committee that submitted her report which was approved by the Federal Executive Council in 1989. Consultants from International Labour Organisation (ILO), and United Nations Development Programme (UNDP) carried out feasibility studies and come up with the cost implication, draft legislature and guide lines for the scheme.

In 1993, the Federal Government directed the Federal Ministry of Health to start the scheme in the country (Adesina, 2009). In 1999, the scheme was modified to cover more people via Decree No.35 of May 10, 1999 which was promulgated by the then Head of State, Gen. Abdulsalami Abubakar (Adesina, 2009; NHIS Decree No. 35 of 1999). The decree became operational in 2004 following several flagged off; first by the wife of the then president, Mrs Stella Obasanjo on the 18th of February 2003 in Ijah a rural community in Niger State, North Central Nigeria. Since the Rural Community Social Health Insurance and the under-5 children Health Programmes of the NHIS scheme were flagged up by the First Lady, other flagged offs were carried out in Aba, Abia State South East Zone among others (Office of Public Communications, 2006). As in September 2009, 25 states of the Federation agreed to partner with NHIS. These include- Akwa Ibom, Rivers, Edo, Taraba, Adamawa, Kaduna, Zamfara, Kebbi, Sokoto, Katsina, Nassarawa, Anambra, Jigawa, Imo, Niger, Lagos, Abuja, Borno, Kwara, Oyo, Enugu and Kogi States. Others include Bauchi, Ogun and Cross River States; these states are at various stages of implementation of the scheme (NHIS, 2009).

Evidences from countries that have institutionalised national health (insurance) programmes indicate positive impact on health care system and productivity of labour (Adamache and Sloan, 1983; Stephen, 1984; Akin, Griffin, Guilkey and Popkin, 1986; Collins, White and Kriss, 2007; KaFaFoHeRET, 2007). In terms of benefits, health insurance was discovered to have two sides to its coin. Empirical studies suggested that workers in jobs with health insurance coverage had higher productivity and lower job turnover than workers without health insurance benefits (Karoly and Rogowski, 1994; Buchmeller and Valletta, 1996; O'Brien, 2003; Collins et al., 2006). On the other hand, other studies suggest that offering health insurance has no effect on job turnover (Getler, Locay and Sanderson, 1987; Mwabu and Wang'ombe, 1997; Collins et al., 2007). However, it is generally believed that people without health insurance are more likely to

be in worse health condition and have higher death rates than those people with insurance coverage because they are less likely to seek medical care. Conventional theory holds that people purchase health insurance because they prefer the certainty of paying a small premium to the risk of getting sick and paying a large medical bill (O'Brien, 2003; Collins et al., 2006). The Nigerian government (formally) instituted the National Health Insurance Scheme (NHIS) in June 2005.

Objectives of the National Health Insurance Scheme

The general purpose of NHIS is to ensure the provision of health insurance "which shall entitle insured persons and their dependants the benefit of prescribed good quality and cost effective health services" (NHIS Decree No. 35 of 1999, part 1:1). While the specific objectives of NHIS include:

1) The universal provision of healthcare in Nigeria.
2) To control/reduce arbitrary increase in the cost of health care services in Nigeria.
3) To protect families from high cost of medical bills.
4) To ensure equality in the distribution of healthcare cost across income groups.
5) To ensure high standard of healthcare delivery to beneficiaries of the scheme
6) To boost private sector participation in healthcare delivery in Nigeria.
7) To ensure adequate and equitable distribution of healthcare facilities within the country.
8) To ensure that, primary, secondary and tertiary healthcare providers are equitably patronized in the federation.
9) To maintain and ensure adequate flow of funds for the smooth running of the scheme and the health sector in general (NHIS Decree No. 35 of 1999, part II: 5; NHIS, 2009). The provision of healthcare is a concurrent responsibility of the three ties of government in Nigeria. The mixed economy practiced in the country also gives room for private sector participation in medical care provision. NHIS is therefore a mixed bag of two broad categories of stakeholders-government and the private sector (Agba, Ushie, Ushie, Bassey and Agba 2009).

Stakeholders

The stakeholders include- government at all levels, employers (in the public or private sector organisation), self employed and Rural Community Health Insurance Programme, health maintenance organisations, board of trustees, health providers (including primary, secondary or

tertiary healthcare providers), international organisations (including donors and collaborating partners), commercial banks, NGOs, community leaders and the media (NHIS, 2009). Government under the scheme provides not only standards and guidelines but ensure the enforcement of the same for the smooth and effective running of the programme. Apart from funding by government and donors or partnering organisations, employees under the scheme contribute 5 percent of their basic salary while the employer 10 percent of employees' basic salary to NHIS (NHIS, 2009).

Programmes of NHIS

In order to ensure that every Nigerian has access to good health services the NHIS has developed various programmes to cover different segments of the society. These are stratified as follows:

Formal sector

- Public sector (Federal, State, Local government)
- Organized Private Sector
- Armed forces, police, other uniform services and students of tertiary institution social health insurance programmes

Informal sector

- Community based social health insurance programmes
- Voluntary contributors' social health insurance programmes

Vulnerable group

- Physically challenged persons
- Children under the age of 5years
- Prison inmates
- Refugees, victims of human trafficking, internally displaced persons and immigrants
- Pregnant women (NHIS, 2012)

The formal sector social health insurance programme (FSSHIP) is what is being implemented for now while the other groups would be brought on board as the scheme becomes more established (Federal Ministry of Health, 2003).

Benefit Package within the FSSHIP

Primary Health Care Services

(i) Access to curative services for common ailments including consumables as out patient care.

(ii) Essential drugs from NHIS accredited pharmacy providers and provision of pharmaceutical care by the Pharmacist. Beneficiary is expected to pay 10% of the total cost of drugs (Co-payment)

(iii) Routine Laboratory investigations

(iv) Health education to prevent and control health problems such as counseling and testing for HIV/AIDS etc.

(v) Maternal and Child care

(vi) Primary Eye care, Dental and Mental services

(vii) Accident and Emergency services.

Secondary Healthcare Services

- Specialist care for medical, surgical, Paediatric, Internal Medicine, Obstetric and Gynaecology, Psychiatry, ENT, Ophthalmology, Management of HIV/AIDS etc.
- Hospitalisation in a general ward for a maximum of 15 days per annum
- Physiotherapy for restorative and rehabilitative services
- Radiology/Medical imaging and diagnostic laboratory services
- All prescribed pharmaceuticals from Federal Ministry of Health (FMoH) essential drug lists and Co-payment Tertiary Healthcare Services
- All Referrals from primary and secondary health care levels

Contributions

Contributions are earnings-related. For the Public (Federal) sector programme, the employer pays 3.25% while the employee pays 1.75%, representing 5% of the employee's consolidated salary. For the private sector programme and other tiers of Government, the employer pays 10% while the employee pays 5% representing 15% of the employee's basic salary. However, the employer may decide to pay the entire contribution. The employer may also undertake extra contributions for additional cover to the benefit package (NHIS, 2012). The contribution made by or for an insured person entitles him/her, a spouse and four biological children under the age of 18 to health benefits as contained in NHIS health benefits package. Additional contributions will be required for extra dependants (NHIS, 2005).

2.4 Modus Operandi of NHIS

Participation in the programme involve a contributor registering with NHIS approved Health Maintenance Organisations (HMO) which are limited liability companies which may be formed by private or public establishments registered by the scheme to facilitate the provision of health care benefits to the contributors. Thereafter, the contributors are to register with the primary health care providers of their choice (private or public) from an NHIS approved list of providers supplied by the HMO. Upon registration, a contributor will be issued with an identified card (ID) with a personal identification number (PIN). The enrollee will be able to access healthcare after a waiting period of 90 days. This will enable the completion of all administrative processes. Treatment is to be provided upon presentation of ID card by the contributor. A contributor is at liberty to change his or her primary care provider if he or she is not satisfied with services rendered after 6 months while the Health Maintenance Organisations will make payment for service rendered to the health care provider (Agba, Ushie and Osachukwu, 2010). The HMO will make payment for services rendered to an enrollee to the healthcare provider an enrollee may however be asked to make a small co-payment (where applicable) at the point of service for example 10% cost of drug (NHIS, 2005, NHIS, 2012).

Payment System

Healthcare providers under the scheme will be paid by capitation, Fee-for-Service per diem or case payment.

a) Capitation: This is payment to a primary health care provider by the HMOs on behalf of a contributor, for services rendered by the provider. This payment is made regularly in advance for services to be rendered irrespective of whether enrollees utilise the service or not.

b) Fee-for-Service: The HMO makes this payment to non-capitation-receiving health care provider who renders services on referral from other approved providers.

c) Per diem: Per diem are payments for services and expenses per day (medical treatment, drugs, consumables, admission fees etc) during hospitalization.

d) Case Payment: This method is based on a single case rather on a treatment act. A provider gets paid for every case handled to the end.

Arbitration

The State Health Insurance Arbitration board in each state of the Federation and the Federal Capital Territory shall consider complaints by aggrieved parties (NHIS, 2005).

Health Maintenance Organisations in the Nigerian National Health Insurance Scheme

The National Health insurance Scheme in Nigeria is designed to be driven through the operation of Health Maintenance Organisations (HMOs). These may be Private or Public Companies for-profit and not-for-profit registered entities with the aim of ensuring the provision of qualitative and cost effective health care services to contributors under the Scheme (NHIS, 1999).

2.5 Health Maintenance Organisation

Health Maintenance Organisations (HMOs) have been described in many different ways. But they are generally perceived as insurance-based health systems that have the responsibility for the provision of a comprehensive package of care to an enrolled population for a prepaid fixed fee (Robinson and Steiner, 1998). In practice they offer 'prepaid health plans' in which patients are usually covered only if they use providers specified by the plan and access them according rules established by the plan. Although similar, the HMOs within the Nigerian context are defined by the law establishing the scheme as – an institution, company or provident association using its administration or insurance companies to provide health care for its clients through associated health centres. The incorporation of HMOs – mainly private sector organisations, into the national health insurance scheme was said to be underpinned by the desire of the government to promote an economic policy based on pursing a private-sector driven economy of which the health sector was regarded to be a significant part (Asoka, 2011).

Registration of Health Maintenance Organisation under NHIS

The registration of an organization under the scheme shall be in such form and manner as may be determined from time to time, by the council, using guidelines, which shall include provisions requiring the organisation to:-

(a) Be financially viable before and after registration

(b) Make complete disclosure of the ownership structure and composition of the organization

(c) Have an account with one or more banks approved by the council

(d) Be insured with an insurance company acceptable to the council and

(e) Give an undertaking that the organization shall manage and invest the funds accruing to it from contributions received in pursuant to this decree in accordance with guidelines to be issued, from time to time, by the council.

The registration of HMOs will go through the following sequence:

The scheme shall upon receipt of an application, carry out through its staff or through its authorised agent a survey of and inspection of the facilities of the HMOs and ascertain the following:

i. The Board of Directors of the HMOs to ascertain whether or not they are fit and proper persons to run or manage HMOs

ii. The policy documents and manuals of the HMOs.

iii. The organisational structure of the HMO with a view to ascertaining how the structure could enhance the efficiency and ability of the HMO.

iv. The management team of the HMO.

v. The provider network of the HMO including development and management networks.

vi. Health management procedures

vii. Marketing management procedures.

viii. Information management process that shall include computer based technology

ix. Evidence of registration with Corporate Affairs Commission and minimum paid-up capital

x. Certificate of mandatory deposit of 25% of paid-up capital with Central Bank of Nigeria.

xi. Evidence of tax payment and returns, and adherence to legal obligations under the NHIS

xii. Minutes books with a view to ascertaining attendance of Directors and adherence to these rules and regulations by the Board of Directors and Management team.

xiii. The Scheme shall register or reject the application.

xiv. The Scheme shall issue a certificate of registration to every successful HMO, which is subject to review every four years (NHIS, 1999).

Consequences of Registration on Health Maintenance Organisation

Any HMO registered under the scheme shall:

- Be a corporate body capable of suing or being sued and of doing or causing to be done all such things as may be necessary for or incidental to the exercise of its powers or the performance of its functions in terms of its rules.
- Carry on business as an HMO after due registration.
- Assume liability for and guarantee the benefits offered to its contributors and their dependents.
- Establish a bank account in a bank appointed by NHIS into which shall be paid every contribution by or on behalf of a contributor.
- No person shall have any claim on the assets or rights or be responsible for any liabilities or obligations of an HMO except in so far as the claim has arisen or the responsibility has been incurred in connection with transaction relating to the business of the HMO.
- The assets, rights, liabilities and obligations of an HMO existing immediately prior to its registration, shall vest in the HMO without any formal transfer or cession.
- All moneys and assets belonging to an HMO shall be kept by that HMO and every HMO shall maintain such books of accounts and other records as may be necessary for the purposes of such HMO
- Every HMO shall have its registered office(s) in Nigeria
- HMO shall carry on any business other than the business of health care management as provided by the Decree.
- The funds management of the HMO should be in accordance with specific guidelines that prevent fraud on solvency problems.
- HMOs shall be prohibited from directly engaging in any business that is not related to health.
- HMO's may not be directly affiliated to banks
- HMOs shall observe prescribed standards of reporting fund holdings for verification purposes (NHIS, 1999).

Contracts between Health Maintenance Organisation and Healthcare Providers

Every contract between an HMO and a provider shall include the following:

The operating hours at which the provider shall be ready to receive contributors and such hours shall not be less than six hours a day: Monday to Friday and three hours on weekends. The acceptance by the provider of responsibility for providing care in emergencies, 24 hours a day, and 365 days in the year. The agreement shall include the arrangement for securing this and the system of notifying contributors of these arrangements. Maximum number of contributors and their dependants based on the facilities of the provider, accept contributors applying to them up to the maximum number without discrimination. A provider cannot reject a patient except on appeal stating the exceptional circumstances. If the scheme is satisfied with these reasons it would have power to require another provider to accept that patient. Agreement to stock drugs on the list approved for the scheme and to obtain them only from approved suppliers (in the case of pharmacy providers). Agreement that all contributors shall be given adequate treatment, shall not see a contributor as a private patient and to send patients only to approved specialists or facility. There is an agreement to use only registered ancillary services, register all births on certificates supplied by the government and to be insured against malpractice for claims for the stipulated amount (NHIS, 1999).

The HMO shall provide every registered primary provider with a list of approved or registered blood banks, hospitals, pharmacies, x-ray and medical laboratories, specialists in areas of medicine and medical care. Providers shall be inspected periodically. HMO representatives shall be allowed reasonable and meaningful access to the provider's premises, all records relevant to the operations of the scheme (NHIS, 1999).

Exit of Health Maintenance Organisation

Allowing HMO's to haphazardly enter and leave the market contributes in no small way to market instability and erodes consumer confidence. For this reason the HMOs shall be required to observe the following:

- HMO's shall give a reasonable notice of at least 6 months to providers
- HMO's shall provide a plan demonstrating how claims and obligations will be settled.

- A processing fee shall be paid to the NHIS regulatory agency to cover the cost of overseeing an orderly exit.
- HMO's shall submit yearly actuarial opinion of adequacy of resources reserves, and premiums to provider claims (NHIS, 1999).

Major Roles of Health Maintenance Organisation in Nigeria

Consequently, the HMOs were given a major role in the implementation of the scheme. These include: collect contributions from all eligible employers and employees; collect contributions from voluntary contributors; pay capitations to health care providers participating in the scheme; render returns to the council of the NHIS; contract with only health care providers approved by the council for the purpose of rendering health care services under the scheme; and ensure that contributions are banked according to guidelines approved by council in banks participating in the programme. No doubt from the foregoing, it can be seen that much of the success or otherwise failure of the NHIS depended on how well these organisations are operated and managed (Asoka, 2011).

Exclusions of National Health Insurance Scheme

The NHIS package has certain healthcare services that are not covered in the scheme. These exclusions are either total or partial. Total exclusions healthcare services such as occupational or industrial injuries, radiologic investigations like computerized tomography (CT) scan, magnetic resonance imaging (MRI), epidemics, cosmetics surgeries, open heart surgeries, neurosurgeries, and family planning commodities are totally excluded from the NHIS. Injuries arising from natural disasters, earthquakes, landslides, conflicts, social unrests, riots and wars are not included in the benefit package. Similarly, injuries arising from extreme sports such as car racing, polo, boxing and wrestling are also not covered by the NHIS. Epidemics and therapies accruing from drug abuse and addiction, transplant and surgical repairs of congenital anomalies and purchase of spectacles are also excluded (Obadofin, 2006).

Partial exclusions also exist. Generally, conditions of sizable prevalence, social importance and high cost are partially covered by the scheme. Terms of the partial coverage are such that the HMO pays 25% while the employer or employee pays 75% of the cost of the healthcare service.

This applies to surgeries like prostatectomy, myomectomy and orthopedic repairs. In the case of high technological investigations in life saving emergencies, the HMO pays 10% while others pay 90% of the total cost of the service. Investigations like CT scan and MRI are included here. Other investigations like mammography, Pap smear, tumour markers, hormonal assays, laparoscopic or fluoroscopic tests, radio opaque studies and barium studies are also covered in this way. (Obadofin, 2006)

2.6 Attitudes of Workers towards NHIS

According to Sanusi and Awe, 2009, 87.4% of the respondents were aware of NHIS programme and 14.6% of those that are aware of the programme have not register under the scheme. The reluctance of workers to register with NIHS may be attributed to lack of confidence in the programme like previous government programmes (such as free health care services) or lack of social insurance model that will ensure universal coverage. In the eyes of the uninsured, insurance is meant to help equalise financial risk between the healthy and the sick, hence the healthy will not be willing to register. In this same study, it was revealed that 58.9% of the respondents have started enjoying services under the NHIS programme (since about 1 year of registration) and it equally shows that about 97% of the respondents have fallen sick, while about 72% had their dependants falling sick at one time or another after registration with the programme. About 75% of the respondents have received treatment from the registered health care providers under the NHIS programme. This indicates slowness in the progress of the programme, in spite of the level of respondent's registration with, awareness of and contribution to the programme. Findings of the study showed that NHIS coverage in Nigeria was restricted so far; because not all registered persons have started enjoying services from the programme (Sanusi and Awe, 2009).

Sanusi and Awe (2009) reported that respondents who have been treated under the program wanted it discontinued. This indicates that people have little hope in the program. They do not think that the program is worth keeping owing to the way that previous schemes and projects turned out in recent times. However, the study did not provide reason why the people wanted the scheme discontinued. Adeniyi and Onajole (2010) did a study on perception of dentist in Lagos state, findings showed that majority of them viewed NHIS as a good idea that will succeed if properly implemented and majority of them believed that the scheme will improve access to oral

health service, affordability and availability of service. Onwekusi (1998) carried out a study to assess NHIS among Nigeria health care Professional workers in Nigeria. Findings showed that Nigeria health care professionals who are main stakeholders in the program have grossly inadequate knowledge of rudimentary principle of the operation of the social health insurance scheme. This study was however carried out on healthcare professionals who are also important stakeholders in the scheme.

In a study conducted by Olugbenga-Bello and Adebimpe, 2010, most of the respondents in this study 183 (83.9%) admitted that more staff and their family members attended the staff clinic after implementation of NHIS. This was in keeping with a study carried out in the same center where records were reviewed pre and post commencement of NHIS. Before NHIS implementation an average of 357 patients were managed in the staff clinic monthly while post commencement, an average of 870 patients were managed at the clinic (Akande, Salaudeen, Babatunde, Durowade, Agbana, Olomofe and Aibinuomo, 2011). Studies in Ghana also revealed a doubling of utilization of health care facilities from 37% in 2004 (pre-NHIS era) to 70% in 2007 (post-NHIS era) (USAID, 2009). Similarly, in the United States of America, children with public insurance were significantly more likely than privately insured children to use 2 of the 4 medical services and 5 of the 7 health related services (Weller, Minkovitz and Anderson, 2003). The implication of these findings of increased utilization secondary to commencement of NHIS is that there were many cases of illnesses that do not present in the health centers as a result of lack of money to pay under other forms of health care financing. This could secondarily lead to increased morbidity and mortality of diseases. However, it should be noted that there could be abuse of the NHIS scheme by utilizing unnecessary medical care known as, moral hazard" (Onyedibe et al., 2012).

Moreover, many of the respondents see health insurance as an end in itself and do not seek to either promote preventive and promotive health care or extend adequate provider linkages (Rao, 2008). According to Olugbenga-Bello and Adebimpe, 2010, the study revealed that one hundred and seventy one (45.1%) of respondents believe that health care system needs to be properly funded, and 47(12.4%) believes that individuals should pay for expenses incurred. About 60% are aware of out of pocket as the most prevalent form of health care financing. About 34.15%

believes that NHIS should be made compulsory for all workers while another 34.15% believes that government should take total control of the scheme.

Health Seeking Behaviour

Good health is of critical importance to many people while they are generally aware that their behaviour plays an important role in achieving and maintaining physical well-being. In western societies, it is difficult not knowing that one is, to some extent, responsible for one's own health as people are continuously reminded of the importance of their behaviour for staying healthy by both public health campaigns and medical care professionals (Brownell, 1991). Yet, even though good health is generally considered important, and many people have good intentions for health behaviour, the vast majority report difficulties in consistently performing those behaviours. They may find it hard, for instance, time to register for National Health Insurance Scheme.

The proverbial road to hell does indeed seem to be paved with good intentions (Power, Koestner and Topciu, 2005). The question is: why is it so difficult to act upon intentions or maintain attempts for changing health behaviour, even for people who seem to be motivated? In a broad sense, health behaviour refers to the actions of individuals, groups, and organisations as well as their determinants, correlates, and consequences, including social change, policy development and implementation, improved coping skills, and enhanced quality of life (Parkerson, Timko, and Ajzen, 1993). This is similar to the working definition of health behaviour that Gochman proposed (though his definition emphasized individuals): it includes not only observable, overt actions but also the mental events and feeling states that can be reported and measured. He defined health behaviour as: "those personal attributes such as beliefs, expectations, motives, values, perceptions and other cognitive elements; personality characteristics, including affective and emotional states and traits; and overt behaviour patterns, actions and habits that relate to health maintenance, to health restoration, and to health improvement" (Gochman, 1982; Gochman, 1997). Gochman's definition is consistent with and embraces the definitions of specific categories of overt health behaviour proposed by Kasl and Cobb in their seminar articles (1966a, 1966b). Kasl and Cobb define three categories of health behaviour as follows:

Preventive Health Behaviour: This is defined as any activity undertaken by an individual who believes himself to be healthy, for the purpose of preventing or detecting illness in an asymptomatic state.

Illness Behaviour: This is known as any activity undertaken by an individual who perceives himself to be ill, to define the state of health, and to discover a suitable remedy (Kasl and Cobb, 1966a).

Sick-role Behaviour: Is any activity undertaken by an individual who considers himself to be ill, for the purpose of getting well. It includes receiving treatment from medical providers. It generally involves a whole range of dependent behaviours, and leads to some degree of exemption from one's usual responsibilities (Kasl and Cobb, 1966b).

2.7 Factors Associated with NHIS utilisation

Achieving universal coverage through health insurance is not easy. Evidence from 8 countries with SHI schemes for which sufficient information is readily available—Austria, Belgium, Costa Rica, Germany, Israel, Japan, Republic of Korea (ROK) and Luxembourg— shows that the transition period (defined as the number of years between the first law related to health insurance and the latest law enacted to implement universal coverage) is 79 years (Austria), 118 years (Belgium), 20 years (Costa Rica), 127 years (Germany), 84 years (Israel), 36 years (Japan), 26 years (ROK) and 72 years (Luxembourg). These countries embarked on SHI when their economies were still underdeveloped; moreover, coverage is not necessarily a simple linear increase, as some groups are harder to reach than others. For example, moving from 25% to 50% coverage might take less time than moving from 50% to 75% (Carrin and Chris 2004).

International experience suggests the following factors impacting the speed of transition to universal coverage using the SHI financing option:

1. The level of income and structure of the economy (specifically, the relative size of the formal and informal sectors) determine the feasibility of collecting contributions as well as the amounts that may be raised through SHI schemes.
2. Distribution of the population and infrastructure determine the capacity of SHI schemes to deliver the benefit package.

3. The administrative structure and solidarity in a country determine its ability to actually implement SHI and with legitimacy.

In India, its large rural and informal sector accounting for 90% of the population, lack of cohesion and solidarity, and poor institutional capacity to organize them etc. will be constricting factors for the upscaling of the SHI in the near or medium term. The experience with collecting income tax predicts problems in assessing incomes and collecting premiums from small, unregistered firms, unorganized industries and the rural sector. The consumer redressal mechanism may also not function effectively because of the large illiterate population. The SHI is therefore likely to be restricted to the employed population and largely in urban areas, where collection of premium is easier and administrative costs minimal (Rao, 2008).

Some reasons that explain for the slow expansion of health insurance are as follows:

1. Lack of regulations and control on provider behaviour

The unregulated environment and a near total absence of any form of control over providers regarding quality, cost or data-sharing, makes it difficult for proper underwriting and actuarial premium setting. This puts the entire risk on the insurer as there could be the problems of moral hazard and induced demand. Most insurance companies are therefore wary about selling health insurance as they do not have the data, the expertise and the power to regulate the providers.

Weak monitoring systems for checking fraud or manipulation by clients and providers, add to the problem (Rao, 2008).

2. Unaffordable premiums and high claim ratios

Increased use of services and high claim ratios only result in higher premiums. The insurance agencies in the face of poor information also tend to overestimate the risk and fix high premiums. Besides, the administrative costs are also high— over 30%, i.e. 15% commission to agent; 5.5% administrative fee to TPA; own administrative cost 20%, etc. Patients also experience problems in getting their reimbursements including long delays to partial reimbursements (Rao, 2008).

3. Reluctance of the health insurance companies to promote their products and lack of innovation

Apart from high claim ratios, the non-exclusivity of health insurance as a product is another reason. In India, an insurance company cannot sell non-life as well as life insurance products. Since insurance against fire or natural disaster or theft is far more profitable, insurance companies tend to compete by adding low incentive such as premium health insurance products to important clients, cross-subsidizing the resultant losses. With a view to get the non-life accounts, insurance companies tend to provide health insurance cover at unviable premiums. Thus, there is total lack of any effort to promote health insurance through campaigns regarding the benefits of health insurance and lack of innovation to make the policies suitable to the needs of the people (Rao, 2008).

4. Too many exclusions and administrative procedures

Apart from delays in settlement of claims, non-transparent procedures make it difficult for the insured to know about their entitlements, because of which the insurer is able to, on one stratagem or the other; reduce the claim amount, thus demotivating the insured and deepening mistrust. The benefit package also needs to be modified to suit the needs of the insured.

Exclusions go against the logic of covering health risks, though there can be a system where the existing conditions can be excluded for a time period—one or two years but not forever. Besides, the system entails equity implications (Rao, 2008).

5. Inadequate supply of services

There is an acute shortage of supply of services in rural areas. Not only is there non-availability of hospitals for simple surgeries, but several parts of the country have barely one or two hospitals with specialist services. Many centres have no cardiologists or orthopaedicians for several non-communicable diseases that are expensive to treat and can be catastrophic. If we take the number of beds as a proxy for availability of institutional care, the variance is high with Kerala having 26 beds per 1000 population compared with 2.5 in Madhya Pradesh (Rao, 2008).

6. Co-variate risks

High prevalence levels of risks that could affect a majority of the people at the same time could make the enterprise unviable as there would be no gains in forming large pools. The result could be higher premiums. In India this is an important factor due to the large load of communicable diseases. A study of claims (Bhat and Reuben, 2001) found that 22% of total claims were for communicable diseases.

There are a number of challenges facing the actualisation of NHIS in Nigeria. Funding remains a major problem to the scheme, the percentage of government allocation to health sector has always been about 2% to 6.7% of the national budget. In 1996, 2.55% of the total national budget was spent on health, 1.92% in 1997, 2.99% in 1998, 1.95% in 1999, 2.5% in 2000, and 4.58 in 2001, there was a decrease to 2.66 in 2003 and there was increase to3.5% in 2004. In 2005, it was 3.06%, 3.65% in 2006, there was a marginal increase to 5.4% in 2007, and it decreases to 5.1 in 2008, 5.0% in 2009, 4.0% in 2010 and 2011. There was consistent increase to 5.6% in 2012, 6.04% in 2013 and 6.7% in 2014 (WHO, 2007a, b and c, Central Bank of Nigeria, 2013 and Nigeria Health Watch, 2014). Consequently, per capita public spending for health in the country is less than US$5; which is far below the US$34 recommended by WHO for low-income nations (WHO, 2007aandc). While the Nigeria per capita health expenditure dwindles, South Africa per capita health expenditure is US$22 in 2001 (The Vanguard, 2005). NHIS is also impeded by obsolete and inadequate medical equipment. The country suffers from perennial shortage of modern medical equipment such as X-rays, computerised testing equipment and sophisticated scanners (Johnson and Stoskopt, 2009). Where these equipment are available repair/services are always a problem.

According to Oba (2008), this situation is not unconnected with corruption. Money meant to boost the health sector ends up in private pockets; example is the 300 million naira scam involving the Minister of health and his assistants in 2008. Lack of adequate personnel in the health sector is another impediment to the scheme. The country for instance had 19 physicians per 100,000 people between 1990 and 1999 (The Vanguard, 2005). In 2003 there were 34,923 physicians in Nigeria, that is 0.28 physician per 1000 persons and 127,580 nurses (1.03 nurses per 1000 persons) as compared to 730,801 physician (2.5 per 1000 population) in 2000 in the

United States of America; and 2,669,603 nurses (9.37 per 1000 persons). Migration of health personnel to USA, UK etc is jointly responsible for the personnel situation in the health sector (For instance in 2005, there were 2,393 Nigerian doctors practicing in the US and 1,529 in the UK).

Attributing factor includes poor remuneration, limited postgraduate medical programmes and poor condition of service in Nigeria (WHO, 2007a). According to World Bank Development Indicators (2005), the personnel situation in the health sector influenced birth attendance in Nigeria. For instance between1997 and 2005 only 35% of births were attended by skilled health personnel in the country. Cultural and religious practices also impact on the effectiveness of NHIS in Nigeria. Sexual inequality still exists and encouraged by some religious/cultural sects in the country because of lack of awareness; women are discriminated against and have limited access to social services such as education and healthcare (National Centre for Biotechnology Information, 2009). Other challenges include inequality in the distribution of healthcare facilities between urban and rural areas and policies inconsistency (Omoruan, et al., 2009). Furthermore, poverty and the inability to pre-pay are significant challenge to NHIS. According to Schelleken (2009) "people are not willing to pre-pay; and because people do not pre-pay there is no risk pool. And because there is no risk pool, there is no supply side."

The core roles of NHIS in health financing include raising of revenue and pooling of resources for health care so that health risk can be effectively shared among members on the NHIS (Akande et al., 2011; Shafiu, Mohammmed and Hengjin, 2011). This is one of the major indicators of a growing society as no society can be said to be genuinely growing unless the vital indicators of better living are evident (Akhakpe, Fatile, Igbokwe-Ibeto, 2012). This will reduce the probability that households have to forgo other subsistence need for health care hence serving as safety net (Akande et al., 2011) and not only that the financial barrier of accessing health services can be minimized (Shafiu et al., 2011). Since the introduction of NHIS during this last decade in many African countries, there has been increase in utilization of health facilities and a reduction in Out-of-Pocket (OOP) expenditure (Shafiu et al., 2011; Olugbenga et al., 2010; Liao, Chang, Yang, 2012; Adinma, Nwakoby and Adinma, 2010; Agar and Noemi, 2010 ; USAID, 2009). A research on evaluation of the effects of NHIS in Ghana revealed a doubling of

utilization of health care facilities from 37% in 2004 (pre-NHIS era) to 70% in 2007 (post-NHIS era) and this was equally accompanied by a substantial reduction in Out-of-Pocket (OOP) expenditure for health care from 43,604cedis ($4.69) to 19,898cedis ($2.14) (USAID 2009). Similarly, (Nguyen, Yogesh, Hong, 2011) from their study on financial protection of NHIS underscores disparity between OOP expenditure by uninsured persons [29,843cedis ($3.21)] and insured persons [21,503 ($2.31)] (Nguyen et al., 2011).

In Nigeria, before NHIS implementation an average of 357 patients were seen in the staff clinic of a tertiary institution monthly but after introduction of the scheme there was 150% increase in utilization (Akande et al., 2011). Similar study in Nigeria showed that there was significant utilization of maternal health services after implementation of health insurance scheme (Adinma et al., 2010). In United States of America, children with public insurance were significantly more likely than privately insured children to use 2 of the 4 medical services and 5 of the 7 health related services (Weller, Minkovitz, Anderson, 2003). Likewise in Taiwan, introduction of National Health Insurance reduced the disparity of patient utilization between the previously uninsured and insured older urban residents by 12.9 (22.0) percentage points (Agar et al. 2010).

The knowledge of the employees' view of the factors that influence the usage of the scheme gives insight into the important challenges influencing their ease of access to the scheme. The majority, approximately 68 percent of the respondents said there were delays in the release of names in accessing the service, while 18 percent said the age limit (below18years) was not in their interest. 14 percent said improper attention by the health care providers. Only 1.0 percent of the respondents said Non-consultation with all stakeholders. This is probably due to the long waiting period experienced by the respondents (Owumi, Omorogbe and Raphael, 2013).

2.8 Experiences with Health Insurance

In a study carryout by Agba, 2010, it shows that there is enough awareness of the scheme among registered members. This is reflected in the 100 percent of the respondents who indicated that they are aware of the existence of the scheme. This awareness may have motivated 97 percent of the respondents to register with the scheme as against percent who did not register. By personal observation and interview it was discovered that some of the workers of the Federal Polytechnic

Idah had technical problems with their registration in the scheme while other have developed general apathy towards government programme because of frequent failure associated with them in the past years. The study revealed that majority (86 percent) of the registered members among the respondents have been accessing services from their health providers. Only 14 percent of the respondents said they have not been accessing services from their health providers probably because they have cultivated the attitude of cold feet toward government programmes. The average number of times respondents and their family members visit their health providers for medical attention on monthly bases were analysed thus; More than half of the population studied (66 percent) indicated a range visit of 1 to 2 times; 11 percent stated 3 to 4 times; 8 percent said their visit is between 5 and above times while 14 percent ticked not applicable perhaps because they were not too sure of their facts. The number of times the respondents visit their health providers reveals that the workforce at various times suffers from one ailment or the other demanding medical attention. Most of the ailments are minor requiring fewer funds to handle. The quality of service rendered by their health service providers was revealed. Although services are rendered, 48 percent of the respondents rated them poor due to absence of drugs, poor prescriptions and attention (Agba, 2010).

On the other hand, 26 percent of the respondents rated the services in terms of quality as high basing their stand on good attention they received, availability of drugs, timeliness and professionalism displaced their health service providers. Twenty-six percent of the respondents evaluated the attitude of health workers to them as substandard. In view of the majority of the respondents who indicated poor followed the opinion of substandard attitude, we cannot but conclude that services rendered by health service providers in the scheme are poor. This reflects the deteriorating state of health institutions in the country culminating in foreign medical attention by the rich. The National Health Insurance Scheme has not improved the health status of the registered members of the scheme through better medical attention. This is reflected in the 48 percent of the respondents whose views were in line with the above statement as against 37 percent who indicated that the scheme has improved their health status. 14 percent remained undecided. The impact of the scheme on workers was not encouraging as 46 percent of the respondents indicated that the programme has not improved their status thus has not affected the

quality of services they rendered, the programme has no serious impact on the commitment and dedication to official duties (Agba, 2010).

Furthermore, the scheme has not led to a reduction in absenteeism or increase the time spent at work. For them they have been dedicated and committed to task assigned to them even before the scheme was introduced. Majority (46 percent) of the respondents argued that the scheme has not boosted their morale and job satisfaction. However, 31 percent of the population maintained that the programme has boosted their morale and job satisfaction while 23 percent of the respondents were undecided. Sixty percent maintained that there is no reduction in what they spend on medical services as against 40 percent who said the scheme has helped them financially by cutting down what they spend on medical bills. However, the contention of the paper is that the programme has brought some respite financially on registered workers who care to access services rendered. Despite the negative impact the scheme seems to have had on workers, 51.4 percent of the respondents said the scheme should not be scrapped. This is against 37.1 percent who were of the view that government should discontinue the scheme. Only 11.4 percent were undecided. It could be inferred that although the scheme is judged to be ineffective, there is still room for improvement hence it should not be scrapped. As expressed by some of the respondents, the scheme should be sustained because it has brought some form of financial relief to some of the beneficiaries; it could serve as a source of motivation on workers if properly managed; it increases availability and affordability of functional health care to beneficiaries; and the scheme has the ability of affecting all the sectors of the economy because it takes good health to be productive (Agba, 2010).

An insight into the perceived self assessment by the respondents of their health care status provides information for evaluating their current health care status following their usage of the scheme. It was pertinent to examine respondents' perceptions of their health care status. While nineteen percent claimed that their health status was excellent, about 43 percent claim that their health status was good. It shows that many of those who registered are really using the scheme and experience better health. Twenty-seven percent claims that their health status was fair, only 2 percent claim that their health status was poor while 1.8 percent claims that they do not know (Owumi et al, 2013). An insight into the benefits perceived by respondents on specific health care services of NHIS provides information for evaluating the performance of the scheme and

possible areas on which improvements need to be made. The NHIS covers health care areas such as free maternity care, consultation, medical treatment, nursing care services and prescribed drug supply from which enrollees can benefit. The prominent areas reported by the respondents include, Free Maternity Care (48 percent), Prescribed Drugs (17 percent), Consultation (11 percent), Nursing Care Services (13 percent), only 6 percent claim\ that Medical Treatment is the aspect from which they derived their benefits (Owumi et al, 2013).

An IDI informant noted that there were many benefits to gain from using the scheme when individuals go to seek healthcare in the University health services. Such included access to different consultants/specialist during consultations that could meet the health needs of clients when patients are being referred. Another informant corroborated this by saying, she enjoys the benefit of collecting drugs from the University health centre because of the free consultation she needs and during the period she is pregnant because the cost is practically free because she is using the scheme. These views were not surprising because a large proportion of the respondents were within the ages of the married and fertile. The expectations of the family concerning having children are enhanced in a society where the culture puts a premium value on the existence of children (Owumi, 2002). The working class is obviously aware that health seeking under the scheme in the University of Ibadan will give them access not only to consultation within but also to consultation outside the setting for specialist attention made possible through referrals (Owumi et al, 2013).

2.9 Satisfaction with Health Insurance

The Concept of Satisfaction

Every organisation is concerned with satisfying the users of its products or services, whether they called clients, customers, consumers, enrollees or patients. Since the first satisfaction studies by Cardozo in 1965, there has been a proliferation of research on the subject with much academic and trade articles published on consumer satisfaction. Peterson (1992) opined that, this interest is due primarily to the fact that for a business to be successful in the long run it must satisfy its customers, while at the same time satisfying its own set objectives.

Satisfaction is the state felt by a person who has experienced a performance (or outcome) that are fulfilled his or her expectations. It is thus a function of relative levels of expectation and perceived performance. These expectations are formed on the basis of past experiences or exposures with the same or similar situations, statements made by friends and significant others, as well as statements made by the supplying organisation (Kotler and Clarke, 1987).

Satisfaction may therefore mean the consumer's fulfillment response. It is a judgment that a product or service feature, or the product or service itself, provided (or is providing) a pleasurable level of consumption-related fulfillment, including levels of under-or over-fulfillment (Oliver, 1997).

Satisfaction or dissatisfaction in marketing is more than a reaction to the actual performance or quality of a product or its service. It may be influenced by prior expectations regarding the level of quality. The expectancy-disconfirmation model assumes that, consumers often form beliefs about product performance based upon prior experience with the product and/or upon communications about the product that imply a certain level of quality. When something performs the way we expect it to. We usually may not think much about it. But if, on the other hand, something fails to live up to its expectations, a negative effect results immediately. However, if the performance happens to exceed our expectations, we are satisfied and pleased (Solomon, 1996). The historical and current definitions of consumer satisfaction centre on the concepts of expectations, experience, perceived service, and a resulting evaluation.

Satisfaction in Healthcare

In recent years consumers' satisfaction with healthcare however has gained widespread recognition as a measure of quality. This has arisen partly because of the desire for greater involvement of the consumer in the healthcare process and partly because of the links demonstrated to exist between satisfaction and patient compliance in areas such as appointment keeping, intentions to comply with recommendation treatment and medication use (Wilson and McNamara, 1982). Since high quality clinical outcome is dependent on compliance which, in turn, is dependent on enrollee satisfaction the latter has come to be seen as a legitimate health care goal and therefore a prerequisite of quality care. Unless enrollees are satisfied, care cannot

be of high quality (Vuori, 1987) as the satisfied enrollee is usually an indispensable means in creating a sustainable advantage in a competitive environment of the producer (Peters, 1991).

The complexities of the relationships between needs, healthcare provisions and outcomes have led both researchers and practitioners to seek to evaluate healthcare through the intermediate outcome of patients' satisfaction. (Wilkin, Hallam, and Dogget, 1992; Tse, Franco, and Wilton, 1990; Arahony and Strasser, 1993) in their findings argued that satisfaction with care will be directly related to the final outcome of that care and also that consumer satisfaction should be the ultimate objective of healthcare providers, just as it is that of other service providers. Therefore satisfaction should be seen as an attitudinal response to value judgments that patients make about clinical encounter.

It is reported that patient's satisfaction with the healthcare they receive is an important health outcome which should be given particular emphasis in current review of health service delivery (Maxwell, 1984). Nevertheless, the relationship between satisfaction and the quality of care received is a complex factor and is affected by patient, doctor and service factors (Kinnersley, Andrew and Parry, 2000). Recent commentators have speculated that patient expectation of the care they will receive has an important impact on satisfaction (Bryan-Brown and Dracup, 1996). Patients with inappropriately high expectations may be dissatisfied with optimal care, and those with inappropriately low expectations may be satisfied with deficient care. Furthermore, observed differences in satisfaction between people from different social classes, age, sex and cultural group or between different services and types of care may be confounded by match or mismatch between expectation and the service received (Kinnersley et al, 2000; Kinmonth, Woodcock, Griffin, Spiegal and Compbell, 1998).

Patient expectation of care is being conceptualized as having two aspects; what patients expect as a result of their own or others' experiences (normative/comparative expectation) and the care they would like and/or hope for (idealized expectation) (Prakash, 1984). Characteristics of patient's satisfaction can be influenced by the manner in which health care is delivered. The type of health care setting (Rubin, Gandek, Rogers, Kosinski, McHorney and Ware, 1993; Kerr, Hays, Mitchinson, Lee and Siu, 1999) and characteristics of the medical provider, such as experience

(Hall and Dornan, 1988) age and gender (Hall, Irish, Roter, Ehrlich and Miller, 1994) influence patients' satisfaction.

Assessment of Patient's Satisfaction

Many authors have earlier attempt to meaningfully identify the determinants of patient's satisfaction. However, these major four determinants of satisfaction have been constantly identified, they include: (Hall, et al 1994)

1. Socio-demographic characteristics of the patients' expectation of the medical encounters and health status.
2. Characteristics of providers including personality traits and the 'art' and 'technical' quality of the care dispensed.
3. Aspects of the physician-patients' relationship, including the clarity and completeness of communication between patients and provider and the outcome of the encounter.
4. Structural and setting factors, including accessibility, mode of payment and treatment length, which may predispose patients towards a feeling of satisfaction or dissatisfaction.

However, additional measures were identified by Urden, (2002) who summed up common satisfaction measures to include but not limited to the following:

1. Accessibility – both physical and financial access to care.
2. Communication skills – of the doctors, nurses and others involved in direct patient care.
3. Personality and demeanour – of doctors, nurses and others involved in direct patient care (outward behaviour and appearance relating to person's character)
4. Quality of medical care processes – as provided directly to the patient.
5. Care continuity – regarding the handing over of care made by one health provider to another health provider.
6. Quality of healthcare facilities – in terms of having the appropriate equipment, supplies and peripheral resources available.
7. Efficiency of office staff – in handling, scheduling and billing.

The aspects of medical care usually evaluated include; responsiveness to urgent emergency situation, referral to appropriate level of care, humanness, communication of information,

coordination and continuation of care, primary prevention, case finding, evaluation of presenting compliant, diagnosis and management which include the following: patient education, referral/consultation, therapy, monitoring and follow up. The focus of patient satisfaction relies on providers going beyond the mechanical delivery of medical care to the delivery of a true health service. Satisfaction with the quality of health care is important as it is associated with improved therapeutic outcomes and health-related behaviour (Ware and Davies, 1983); Grogan, Conner, Norman, Willits and Porter, 2000; O'Malley, 1997). It was earlier assumed that healthcare organisations would ensure adequate quality (OECD, 2004). However, the escalating costs of treatment and nursing care, with health care being subjected to competition, policy makers now perceive a need to address the issue focusing on patient satisfaction (OECD, 2004; Johansson, Oleni and Frilund, 2002).

Level Satisfaction with National Health Insurance Scheme

Various studies done in Nigeria reiterate patients‟ satisfaction with NHIS and its positive impact on financial burden, in Osun State of Nigeria, 39.1% and 2.9% of civil servant respectively "Agree" and "Strongly agree" that NHIS reduces the burden of medical bills (Olugbenga-Bello et al., 2010). Also in Zaria, a study revealed that 42.1% of client are "more satisfied" while 57.9% are "less satisfied" with NHIS (Shafiu et al., 2011). In another study among dentists in Lagos, 76.6% admit the scheme will improve access to oral health and 71.4% believed affordability of health services will equally increase with NHIS (Adeniyi et al., 2010). More so, Oyibo in his study on OOP payments for health services posited that majority of people have difficulties in accessing quality health care services as a result of financial hardship (Oyibo, 2011). This also reiterates the finding from a study carried out in Sagamu, Nigeria where poor quality of emergency care for ruptured uterus was mainly due to financial constraint and for this reason the importance of NHIS on financial protection cannot be over-emphasized (Oladapo and Durojaye, 2010).

In the study conducted by Shafiu et al, 2011, it was revealed that clients satisfaction rate with the health insurance scheme was somewhat low. Enrollee's satisfaction of service provision served as an important aid to monitor the progress of implementation activities of the scheme. However, certain factors such as general knowledge of the health insurance scheme and awareness of

monetary contributions greatly influenced enrollee's satisfaction of health care delivery. Ways of creating better knowledge of health insurance activities among the population were given top priority by both the policy and decision makers, which previously were insufficient until this stage (middle) of implementation. These formed a major part of considerations in the amended medium term strategic plan of operations of the NHIS.

Older clients were more satisfied with service provision than the younger clients. There is direct relationship between enrollee's satisfaction and age which has been similar with related studies (Pascoe, 1983 and Ware, Davies-Avery and Stewart, 1978). Studies in the developed nations have demonstrated that, the most consistent relationship with service satisfaction are the age and sex of clients (Pascoe, 1983 and Ware, et al, 1978). Still, in developing nations, variations in marital status had influence on enrollee's satisfaction. The polygamous were more satisfied than the monogamous. It was a contrary to our initial hypothesis which suggested that, enrollees with polygamous status would be less satisfied due to the entitlement of principal beneficiary. Already, the NHIS specified that "contributions made by an insured person entitled him, his spouse and four biological children under the age of 18 years to a defined health benefits package" (NHIS, 2005 and Haviland, Morales, Dial and Pincus, 2005). But, polygamy is a religious and cultural norm in many societies in Nigeria as well as other African countries which required careful consideration. Information on how to extend coverage to other family members might enhance enrollee's satisfaction which has not been readily available. Studies within the country context have shown that, marital status has a significant influence on peoples attitude towards insurance (Gbadamosi, Hamadu and Yusuf, 2009). These findings assisted NHIS policy makers to incorporate the socio-cultural context of marital status into the medium term strategic plan of operations, aimed at improving the dissemination of information to all users of the health insurance scheme on how other extra dependent family members of the insured persons are to be enrolled (NHIS, 2008).

Insured persons' knowledge of the health insurance scheme was a vital determinant of perceived satisfaction of health care services. Enrollees' knowledge of the health insurance was aggregated to their understanding of insurance to be a good way of helping clients' to relieve their health

expenditure problems and also their knowledge of the basic benefits package of the health insurance scheme. Poor knowledge of the benefit package has affected utilization rates of health facilities in developing countries (De Allegri M, Sanon M, Bridges J, Sauerborn, 2006 and Tien 2005). Effective monitoring mechanisms should be implemented to ensure that the benefit package has been used in full by all those who are entitled which can improve their satisfaction. Unless information on benefit package is readily available to enrollees, they may not fully access all services because of lack of understanding of their entitlements (Carrin and James, 2005 and Normand, 1999). Enrollee's poor knowledge of health insurance leads to less satisfaction of health service provision. Enrollee satisfaction improves only if they have good understood of how the health insurance scheme works and knew what has been offered by the scheme. The amended medium term strategic plans has emphasized that health maintenance organizations must collaborate with the regulatory agency in the provision of IEC materials regarding the benefit package offered to enrollees (Shafiu et al, 2011).

Insured persons are more satisfied if they have been aware of the contributions made by both the employees and employer. The less awareness of enrollees with health insurance activities, the less satisfied they become of its offerings in terms of service provision. Better awareness of the enrollees might enhance interactions between patients and health care providers due to better satisfaction of services. There are tendencies that, those who do not have full knowledge of insurance services offered would likely evaluate schemes poorly (European Commission, 2005).

With the low level of enrollee's satisfaction with service provision, monitoring of health service provision could assist to provide important information when health insurance satisfaction declines. Regulatory agencies should check the situation regularly so as to avert problems before they become crises. Policymakers and monitors needed to realise that, individual patients recognize an effective health system or health insurance scheme as one that provides timely access to the full array of necessary services, efficacious and safe care leading to improvement in health, continuity of care, and respect (WHO, 2000, European Commission, 2005, Institute of Medicine, 2001 and Basys, Instead, Irdes and Igss, 2005).

General knowledge of the health insurance package, awareness of monetary contributions, frequent hospital visits due to illnesses, length of employment and length of enrolment in the

health insurance programme confirmed the researcher hypotheses because they positively influenced satisfaction. Conversely, more satisfaction in the polygamous enrollees was contrary to the supposition as previous mentioned. Positive linkages with satisfaction were associated with enrollees who had more knowledge of the health insurance, frequently visited the hospital, had longer length of enrolment, and also had some awareness of monetary contributions. These findings suggest that enrollee's satisfaction with health services provision in the scheme could be influenced by several factors. The factors which lead to less satisfaction could be addressed properly to improve on the health insurance activities. Health care provider's politeness toward clients, decreased hospital waiting times, and increased availability of hospital personnel at all times served as composite measure of satisfaction and will help in improving client satisfaction (Shafiu, et al, 2011).

2.10 Health Promotion and Education: A tool to influence policy change on NHIS

The Ottawa Charter (WHO, 1986) identified Healthy Public Policy as one of five key health promotion actions. A Healthy Public Policy is a policy that increases the health and well-being of those individuals and communities that it affects. Milio 1986 argued that public policy should set a framework within which individuals and communities were enabled to take control of their own health and well-being. Healthy Public Policy might be conceived of as favourably influencing the determinants of health at the higher levels described by Whitehead (1995). These levels are general socio-economic, cultural and environmental conditions, living and working conditions, and social and community influences. Individual lifestyle factors together with age, sex and heredity also determine health but are less important than the higher level determinants (Evans, Barer and Marmor, 1994; Marmot, 1998). Health services, while important in determining the outcome of episodes of illness, are relatively unimportant in determining population health. It follows that virtually all aspects of public policy impact on health, and it is self-evidently desirable that all public policy should be Healthy Public Policy.

The notion of health, promoted by advocates of Healthy Public Policy, is a broad one. Both equity and sustainability would be regarded as necessary conditions for health. Inequity is both bad *per se* and is a mechanism through which the health of individuals and communities is damaged. It is therefore appropriate that reduction of health inequalities is advocated as an

essential feature of Healthy Public Policy in WHO Health 21 targets number 1 and 2 (WHO Regional Office for Europe, 1999). Sustainability may be defined as 'meeting the needs of the present without compromising the ability of future generations to meet their own needs' (World Commission on Environment and Development, 1988). Since Healthy Public Policy is concerned with the health of future, as well as present generations, it must be concerned with sustaining ecosystems, which support the well-being of human populations (Cole, Eyles, Gibson and Ross 1999).

Healthy public policy is clearly desirable, but two conditions have to be satisfied if it is to be produced:

- The health consequences of different policy options have to be correctly predicted.
- The policy process has to be influenced so that health consequences are considered.

Influencing the Policy Process

If health promoters are to influence policy making one has to understand the nature of the policy-making process. Definitions of policy are elusive. De Leeuw quotes Blum's definition of policy as: A long term, continuously used, standing decision by which more specific proposals are judged for acceptability in terms of means to be employed, ends to be pursued and time frame in which these proposals will have to fit (De Leeuw, 1989). According to Ham (1993), A policy consists of a web of decisions and actions that allocate values. He notes that policies arise from a web of decisions and actions rather than a single decision. That decision without action does not make a policy, and that non-decision making and inaction are often important in policy genesis. It is therefore unsurprising that policy formulation is rarely a simple rational deductive process in which a series of sequential steps are taken to attain a given objective. Much more often policy formulation is incremental, consisting of no more than marginal adjustments to existing policies and structures. These adjustments are limited to what is deemed possible on the basis of value judgments and careful negotiations with interested parties. Sometimes both rational-deductive and incremental elements can be identified in policy making.

2.11 Health Advocacy

Public health advocacy has been defined as the process of overcoming major structural barriers to public health goals (Chapman and Lupton, 1994). It usually works by influencing and then expressing public opinion, and so shaping policy maker's judgments as to what is politically possible or popular. Therefore, there is need for health promoters in Nigeria to take a bold step in influencing the policies related to National Health Insurance Scheme, whereby public opinions are heard.

2.12 Conceptual framework for the study

The model used for this study was PRECEDE-PROCEED Model.

The PRECEDE-PROCEED Model

The PRECEDE-PROCEED model provides a comprehensive structure for assessing health and quality-of-life needs and for designing, implementing, and evaluating health promotion and other public health programs to meet those needs. PRECEDE (Predisposing, Reinforcing, and Enabling Constructs in Educational Diagnosis and Evaluation) outlines a diagnostic planning process to assist in the development of targeted and focused public health programs. PROCEED (Policy, Regulatory, and Organizational Constructs in Educational and Environmental Development) guides the implementation and evaluation of the programs designed using PRECEDE.

Behaviour is shaped by predisposing, reinforcing and enabling factors.

- Predisposing factors, which motivate or provide a reason for behaviour; they include knowledge, attitudes, cultural beliefs and readiness to change.
- Enabling factors, which enable persons to act on their predispositions; these factors include available resources, supportive policies, assistance and services.
- Reinforcing factors, which come into play after behaviour has been initiated; they encourage repetition or persistence of behaviors by providing continuing rewards or incentives. Social support praise, reassurance, and symptom relief might all be considered reinforcing factors.

Among the contributions of the PRECEDE model is that it has encouraged and facilitated more systematic and comprehensive planning of public health programs. Sometimes practitioners and researchers attempt to address a specific health or quality-of-life issue in a particular group of people without knowing whether those people consider the issue to be important. Other times, they choose interventions they are comfortable using rather than searching for the most appropriate intervention for a particular population. Yet, what has worked for one group of people may not necessarily work for another, given how greatly people differ in their priorities, values, and behaviours.

2.13 Analysis of experiences and satisfaction with NHIS among non-teaching staff Using Precede Model

PRECEED

Predisposing factors: The sex of non-teaching staff, their age, level of education, marital status, number of children, and years in service could have effect on non-teaching staff attitudes, experiences and satisfaction with NHIS.

Reinforcing factors: Influence of registered spouse, dependant's health condition, health condition of the staff, friends, boss or colleague's experience with the scheme are some of the factors that would encourage staff to register and utilise NHIS services frequently.

Enabling factor: The availability of policies guiding NHIS, NHIS awareness programmes on mass media, establishment of Health Management Organisations, provision of NHIS office in the University of Ibadan environment, availability of University Teaching Hospital in the staff working environment, affiliation with well equipped hospitals/clinics, availability of skillful health personnel in NHIS approved hospitals/clinics, being Federal Government workers are some of the enabling factors that could influence the staff to utilise NHIS services.

PRECEEDE MODEL

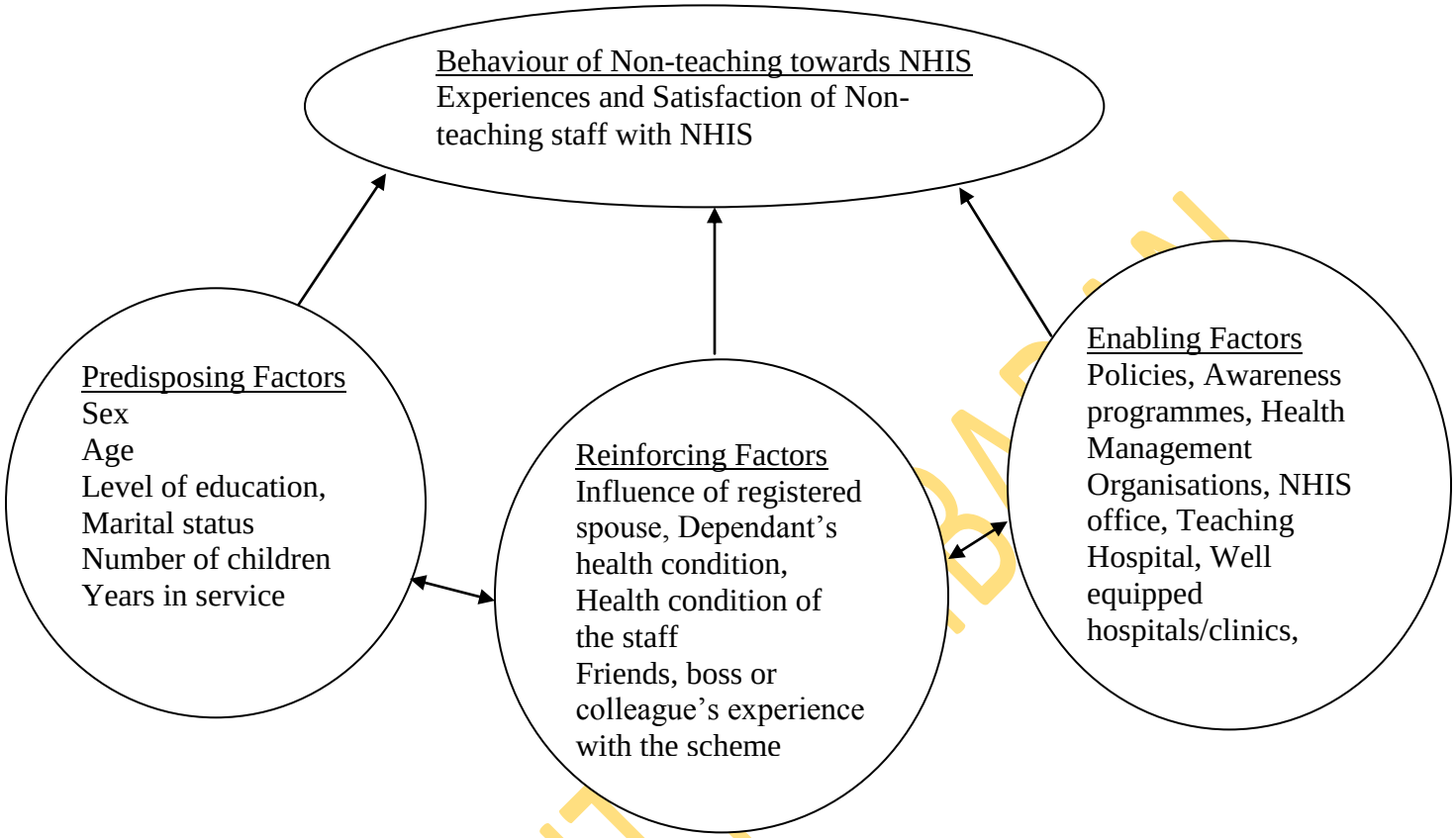

Figure 2.1: Application of the Precede model to the experiences and satisfaction with NHIS among non-teaching staff in University of Ibadan

CHAPTER THREE

METHODOLOGY

3.1 Study Design

Cross-sectional design was adopted in this study because the design will interpret and integrate data, as well as point to their implication in interrelationships (Cohen and Manion, 1980). It allows the use of questionnaires (Babbie, 1986). It was used to study University of Ibadan College of Medicine non-teaching staff's experiences and level of satisfaction with NHIS.

3.2 Scope of the Study

The scope of the study was delimited to experiences and satisfaction with National Health Insurance Scheme among Non-teaching staff of College of Medicine, University of Ibadan, Ibadan, Nigeria.

3.3 Study Area

The study was carried out at the College of Medicine, University of Ibadan; the institution is located in Ibadan North Local Government Area of Ibadan. Ibadan is the capital of Oyo state located in the south western part of Nigeria. The College of Medicine was established on 17 November, 1948 under the University of Ibadan. It occupied the old site previously used by the 56th Military General Hospital about eight kilometers away from the 'new' or permanent site. The new site covered over 1,032 hectares of land generously leased by the Chief and people of Ibadan for 999 years. College of Medicine is a reputable medical school in the country. The Dean of the Faculty of Medicine then was appointed as the first Provost of the College of Medicine in person of Professor E .O Akande. College of Medicine has 44 Departments with total number of 476 Non-teaching staff. Thirty six out of the forty-four Departments are located at the University of Ibadan, College of Medicine and one at Ibarapa community. The University College Hospital (UCH) is located within the College of Medicine premises and it is one of the NHIS approved health facility. The non-teaching staff are in three blocks, according to their locations within UCH, the Administrative block, Hospital block and Academic block.This study focused only on Non-Teaching Staff of College of Medicine who were in the Departments located in the University College Hospital Ibadan (36 Departments). This is because these

members of staff work in the environment that is saturated with health information and could easily access the National Health Insurance Scheme facility.

3.4 Study Sample

The samples were non-teaching staff of the various Departments in the College of Medicine who are in the University College Hospital Ibadan only. This cross-sectional study involved 375 consenting NTS of CoMUI from the 4 Faculties and 8 administrative units.

3.4.1 Inclusion Criteria

The study respondents included all consenting non-teaching staff of College of Medicine whose Departments are located within the University College Hospital.

3.4.2 Exclusion Criteria

Non-teaching staff that are on leave as at the time of the study as well as those who are newly employed (less than one year) and those that are not willing to participate in the study.

3.5 Sample Size

The minimum sample size was calculated using Leslie-Kish formula (Araoye, 2004)

$$N = \frac{Z^2 pq}{D^2}$$

N = minimum sample size required, Z = standard normal deviation set at 1.96 which corresponds to the 95% confidence level; p = prevalence of satisfaction with NHIS = 61.5% (Onyedibe et al, 2012); q = 1 – p. (1 – 0.615 = 0.385); D = level of significance desired set at 0.05.

$$N = \frac{1.96^2 \times 0.615 \times 0.385}{0.05^2}$$

$$= \frac{3.842 \times 0.615 \times 0.385}{0.0025}$$

$$= 363.875$$

$$= 364$$

Therefore, the sample size is equals to three hundred and sixty-four (364)

3.6 Sampling Techniques

Table 3.1 reflects the total population of non-teaching staff in all the Units/Faculty located in College of Medicine, University of Ibadan. Purposive sampling techniques was adopted, the total sample of the consenting target group was used.

Table 3.1 Distribution of the Non-teaching staff in College of Medicine

S/N	Departments	Number of Non-Teaching Staff
1	Alexander Brown Hall	7
2	Biomedical Communication	13
3	College Office	72
4	Finance	27
5	Medical Library	15
6	Provost Office	25
7	Dean's Office, Faculty of Basic Medical Sciences	8
8	Chemical Pathology	9
9	Haematology	8
10	Medical Microbiology	11
11	Pathology	7
12	Virology	7
13	Institute for Medical Research and Training	14
14	Dean's Faculty of Clinical Sciences	10
15	Anaesthesia	5
16	Community Medicine	10
17	Medicine	8
18	Obstetrics and gynaecology	16
19	Ophthalmology	5
20	Oto-Rhino-Laryngology	2
21	Paediatrics	14
22	Physiotherapy	5
23	Psychiatry	4
24	Radiology	3

25	Radiotherapy	1
26	Surgery	7
27	Institute of Child Health	10
28	Dean's Office, Faculty of Public Health	8
29	Health Promotion and Education	4
30	Epidemiology and Medical Statistics and Environmental Health	15
31	Dean's Office, Faculty of Dentistry	9
32	Preventive Dentistry	2
33	Child Oral Health	3
34	Oral Pathology	6
35	Oral Surgery	3
36	Restorative Dentistry	6
	Total	379

Ref: Personnel office, College of Medicine, University of Ibadan Non-Teaching Staff statistics as at July 2012.

3.7 Instruments for data collection

Both qualitative and quantitative methods of data collection were used for this study.

3.7.1 Key Informant Interview Guide

Key Informant Interview guide was used to collect qualitative data. The Key Informant Interview guide contained twenty-five (25) unstructured questions to allow probing. Nine Heads of unit and Directors of unit/centre among the NTS were recruited for the interview, three from each of the blocks where NTS are located. This helped to elicit information on respondents' attitude, experiences, level of satisfaction on NHIS programme and factors associated with NHIS utilisation. It also helped in improving the quality of data collected. A total number of nine Key Informant Interviews were conducted. Informed consent was obtained and confidentiality of information was put into consideration.

3.7.2 Questionnaire

Questionnaire was used to collect quantitative data. The questionnaire was designed based on the themes in the research objectives. Each research objective had a section in the instrument. The questionnaire was divided into five sections: Section A contained socio-demographic variables of the respondents, section B contained questions on respondents' attitude on NHIS, section C contained questions on respondents' experiences on NHIS, section D contained questions on factors that can make respondents' adopt NHIS services and section E contained questions on respondents' level of satisfaction with NHIS.

3.7.3 Validity of Instrument

The instruments were properly reviewed and validated by researcher's supervisor and other lecturers whose necessary corrections were effected. Thereafter, the instruments were pre-tested among 38 non-teaching staff members of college of Health Sciences, Obafemi Awolowo University, Ile-Ife (being 10% of the total sample size for this study) due to its similarities in characteristics to the study area. Effectiveness of the instrument in collecting appropriate data relevant to the objectives were determined as well as the level of comprehension of the questions.

3.7.4 Reliability of the instrument

The reliability coefficient of questionnaire was determined from the pre-test using the Alpha-Cronbach correlation coefficients. The Alpha-Cronbach reported a coefficient of 0.8 which was interpreted to be high. It therefore agrees with a correlation coefficient greater than 0.5 which was interpreted as high reliability. All lessons learnt during the pre-test were used to modify the instrument such as, restructuring of questions to properly suit the research objectives and time management for data collection.

3.8 Ethical Consideration

The following ethical considerations were considered for this study

- Ethical clearance was obtained from UI/UCH Ethical Review Committee (ERC).

- Informed consent was sought from each of the respondents, to ensure that all respondents are willing to answer the questions in the questionnaire without coercion or influence of vulnerability.
- All information given by the participants were kept secret and would not be shared with any other person.
- Respondents/participants can withdraw at any time without giving reasons and they will not be penalised for withdrawing.

3.9 Training of Research Assistants

Three research assistants were trained by the researcher; they assisted in collation and collection the data. The training laid emphasis on content, mode of administration of questionnaire, appropriate decoding of staff gesture and disposition, objectives of the study and communication skills. The training lasted for two days.

3.10 Method of Data Collection

Self- administered method of data collection was adopted for the quantitative method. The research assistants helped in distributing and collecting the questionnaires from the respondents. After proper greeting and introduction in each office and obtaining of informed consent, the researcher/research assistant gives questionnaire to consenting non-teaching staff. He/she will wait in case there is need for clarification on any of the questions, and then wait to collect the questionnaire or come back for it if the staff is busy at the moment. Key Informant Interviews were conducted in the three blocks where non-teaching staff of College of Medicine were located. Appointments were booked with nine consenting Head of units for the KII. Return visits were made to respondents who default the appointment given. The key informant interviews were conducted by the researcher and a colleague who served as a note taker and an observer. Key Informant Interview guide was used and discussions were properly recorded. Each interview lasted for between 40 minutes to 1hour while the whole exercise lasted for three weeks.

3.11 Data Management and Analysis

A semi-structured self-administered questionnaire was used to elicit information on the socio-demographic characteristics, experiences, satisfaction, attitude and factors associated with

utilisation of NHIS. Experience, satisfaction and attitude were measured on 16-point, 18-point and 20-point scales respectively. Experience scores of <8 and ≥8 were rated bad and good respectively. Satisfaction scores of <9 and ≥9 were rated not satisfied and satisfied respectively. Attitude scores of <10 and ≥10 were rated negative and positive respectively. The questionnaire was serially numbered for control and recall purposes, and the data collected were checked for completeness and accuracy on a daily basis. The data were sorted, edited and coded manually by the researcher with the use of coding guide. The data were imputed into the computer using the SPSS software version 15 to analyse the data. Quantitative data were analysed using descriptive statistics such as frequencies, mean and standard deviation to explore the data. Chi-square was used to find out the relationship between categorical data. Logistic regression test was used to find out the predictors of variable that were significant when cross tabulated (significant relationship was set at $p \leq 0.05$). Qualitative data were analysed thematically.

3.12 Limitations of the Study

The following were the limitations to the study:

1. The results of this study may only be generalised to similar populations of non-teaching staff. They may not be applicable to non-teaching staff in other government Parastatals.
2. Some of the respondents were not willing to supply all the information required by the researcher for one reason or the other. Efforts were made to assure them of the confidentiality of information since their names or employment numbers were not required.
3. Some of the principal officials selected for Key Informant Interview could not meet up with the time booked for the interview. Return visits were made to their offices as many times as possible for them to meet up.
4. Some of the respondents for the questionnaire were not available due to one reason or the other. They were revisited at other times and this made the data collected period to be longer than expected.
5. Some respondents could not fill their questionnaire immediately the researcher gave them due to their schedule in the office. The questionnaires were dropped for them to fill but few lost their questionnaire. Extra copy of questionnaire was given to them and filled immediately during the researcher's subsequent visit to the respondents.

CHAPTER FOUR

RESULTS

The result of this study was presented in this chapter and organised into six sub-Headings: Socio-demographic characteristics, Attitude of workers towards NHIS, Experience of workers with NHIS, Factors associated with utilisation of NHIS, Level of satisfaction of workers with NHIS and Ways to improve NHIS services.

4.1 Socio-demographic Characteristics

The socio-demographic characteristics of the respondents are as shown in Tables 4.1 and 4.2. There were more male (54.7%) respondents. The age range of the respondents was 24 – 60-years with the mean age of 42.9 ± 8.0-years. Most (86.7%) of the respondents were Christians. Respondents who are married constituted the majority 92.5% of which monogamists were 88.3%; 77.6% of the married respondents had between 1 – 4 children and 89.6% of the respondents were Yoruba. Most had tertiary education (85.3%). Furthermore, 21.3% had been working as a university staff ≤5 years. The administrative staff accounted for 78.4%. Those working at the service Department (42.9%) had the highest number of respondents.

Table 4.1 Socio-demographic characteristics of respondents (N = 375)

Variable	Number	%
Sex		
Male	205	54.7
Female	170	45.3
Age		
Young Adult (24 – 40 years)	165	44.0
Middle Age (41 – 60 years)	210	56.0
Religion		
Christianity	325	86.7
Islam	50	13.3
Marital Status		
Married	347	92.5
Single	26	6.9
Separated	1	0.3
Widow/Widower	1	0.3
Type of Family		
Monogamous	331	88.3
Polygamous	12	3.2
No Response	6	1.6
Not Applicable	26	6.9
Years in Service		
≤ 5	80	21.3
6 – 10	53	14.1
11 – 15	91	24.3
16 – 20	44	11. 7
21+	59	15.7
No Response	48	12.9
Educational Qualification		
Primary	16	4.3
Secondary	39	10.4
Tertiary	320	85.3

Table 4.2 Category of Workers (N = 375)

Variable	Number	%
Category of Respondents		
Technical staff	81	21.6
Administrative staff	294	78.4
Technical Staff		
Technologist	48	59.2
Driver	25	30.9
Electrician	2	2.5
Accountant	3	3.7
Artist	3	3.7
Administrative Staff		
Administrative officers	50	17.0
Executive officers	85	28.9
Securities	8	2.7
Typist	29	9.8
Clerical officers	48	16.3
Messengers	12	4.1
Porter	11	3.7
Secretary	42	14.3
Library officer	9	3.1
Faculty/Unit		
Clinical Sciences	69	18.4
Public Health	25	6.7
Basic Medical Sciences	57	15.2
Dentistry	38	10.0
Institute of Child Health	10	2.7
Institute for Medical Research and Training	15	4.0
Service Department	161	42.9

Registration of respondents with National Health Insurance Scheme

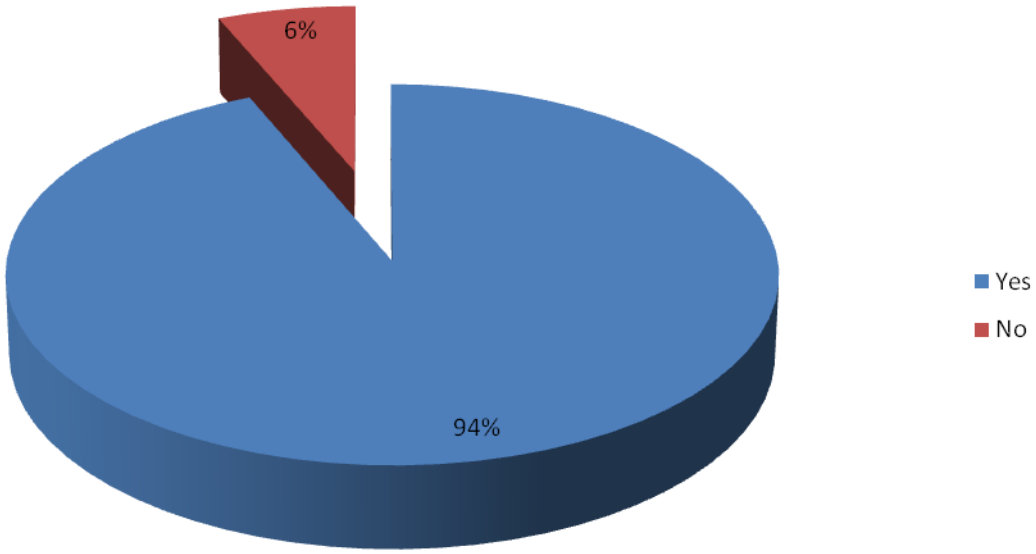

Figure 4.1: Respondents' registration status

4.2 Attitudes of workers towards National Health Insurance Scheme

The KII revealed that some of the respondents had negative attitudes towards NHIS. The following were the responses of some of the Head of units and the most senior staff interviewed during this study in respect to their attitudes towards NHIS.

An interviewee who happened to be the Head of his Department responded to the question asked about his attitudes towards NHIS by saying;

> *"I am a registered member, but since I registered, a lot of obstacles have cropped up that I am unable to use it. I registered my children along with me but when the name came out the children's name were not there. I was asked to bring ₦500 bank draft for each of the children before I can register them.' (You want to use my money for my safety and I have to be punished for that?). I have to ignore that because of the problem of going to the bank paying for bank draft."*

Another senior staff who had been working for 31years responded and said;

> *"I was disappointed because my sickness could not be covered by NHIS, I was asked to go and queue up with general patients and since then I have not been going there"*

She also complained about the age limit of the children that could benefit which also affected her family attitudes towards the scheme by saying;

> *"My children have passed the age limit of the children that could benefit and my husband does not live with me, so the scheme is not useful to me or any member of my family"*

One of the Head of unit interviewed responded, thus;

> *"The time I went to their (NHIS) office at UI, I was asked to wait, they said they were short of staff and nobody is to attend to us. I have to leave the place and I refused to go back there again."*

During the interview, it was also discovered that many workers have registered but they did not follow up the registration process. A senior staff responded this way;

"Yes, I have registered two years ago but I have not collected my number, I don't know whether is ready or not"

One of the interviewee was bitter about the fact that healthcare facilities were imposed on the enrollees, he said;

"They did not allow us to register in the hospital we wanted, I work inside UCH Ibadan, College of Medicine and they gave me a hospital in old Ife road after Gbagi market, even far from where I live that is why I refused to go there."

Another Head of unit who was concerned in case of emergency saw a need for enrollees to rather spend their money on their health because before the protocols involved in utilising NHIS facilities can be followed by any worker involved, such worker might have lost his/her life. His response is stated below;

"Another problem we are facing here is that whenever anybody is sick instead of me going to the staff clinic, they will ask me to go and collect NHIS form from Jaja UI, whereas even before I reach that place something would have happened. So I decided not to use NHIS I would rather spend my money on my own health."

Figure 4.1 revealed that majority of the respondents (93.6%) had registered with NHIS out of which 36.3% were not utilising NHIS services as at the time of conducting this study. Reported reasons for not using NHIS services were non-availability of Personal Identification Number (68.3%) and having a family clinic which they were not willing to change (41.1%). Among those that were not registered, multiple response questions revealed that 54.1% claimed they had no time, 29.1% could not withstand the long queue during registration, while 33.3% mentioned that their spouses were already registered and 70.8% claimed not to be interested in the scheme (Tables 4.3 and 4.4).

Furthermore, majority (63.7%) reported that they do not hold their registration cards regularly. Meanwhile only 31.2% visited their NHIS approved healthcare facilities for regular medical checkup and 52.5% accessed their NHIS approved healthcare facilities when they do not have money. Majority of the respondents registered their spouse and children under NHIS services (50.9%), 38.1% mentioned that their spouse and children use NHIS facility and 30.1% visited NHIS hospital only when their children were sick. Most of the respondent reported that going to other hospitals is better than using NHIS facility (51.8%), 48.8% responded that accessing NHIS facility is a waste of time and resources. Likewise 46.7% responded that NHIS services are not relevant in the College of Medicine environment (Table 4.5). Above all, only 47.2% had positive attitude towards NHIS (Figure 4.3).

Table 4.3: Perceived reasons by those who did not register (N=24)

Perceived reasons by those who did not register	Number	%
I have no time	13	54.1
There was a long queue	7	29.1
My spouse is already registered	8	33.3
I am not interested in the scheme	17	70.8

Multiple Responses

Table 4.4: Reasons for not using NHIS services yet (N=136)

Reasons for not using NHIS facility	Number	%
PIN is not ready	93	68.3
My spouse is a health officer	6	4.4
I have just collected my PIN Number	4	2.9
I was given wrong primary healthcare centre	4	2.9
I have not been sick since I registered	7	5.1
I have a good family clinic and am not willing to change	56	41.1
No follow up on registration	28	20.5
The healthcare facility is far from my house	5	3.6
Yet to complete registration	11	8.0

Multiple Responses

Table 4.5: Attitudes of respondents towards NHIS (N = 375)

Statement	Agree Number (%)	Disagree Number (%)	Not Sure Number (%)
Use of NHIS services regularly	153 (40.8)	220 (58.7)	2 (0.5)
Visit NHIS facility (hospital) for regular medical checkup	117 (31.2)	252 (67.2)	6 (1.6)
Don't hold registration card regularly	239 (63.7)	124 (33.1)	12 (3.2)
Registered spouse and children under NHIS services	191 (50.9)	178 (47.5)	6 (1.6)
Spouse and children are allowed to use NHIS facility	143 (38.1)	215 (57.3)	17 (4.5)
Access NHIS services when I do not have enough money	197 (52.6)	174 (46.4)	4 (1.06)
Only visit NHIS hospital when my children are sick	113 (30.1)	246 (65.6)	16 (4.3)
Going to other hospitals is better than using NHIS clinic/hospital	194 (51.8)	166 (44.3)	15 (4.0)
NHIS services are not relevant in the university environment	175 (46.7)	195 (52.0)	5 (1.4)
Accessing NHIS facility is a waste of time and resources	183 (48.8)	190 (50.7)	2 (0.6)

Based on the table above, the attitudinal score was calculated for each respondent using a 20-point attitudinal scale. The attitudes of the respondents towards NHIS were contained in the statements which had a score of 2-points for positive attitude and 0-point for negative attitude and for those that were not sure of their attitudes. The scores were then summed up to give a total attitudinal score for each respondent. The score above average (>10-20) shows positive attitude towards NHIS while scores from 0-10 show a negative attitude.

One hundred and seventy seven respondents (47.2%) had above average attitudinal score between 11 and 20 points which was categorized positive attitude, while 52.8% had below average between 0 and 10 points (negative attitude).

4.3 Factors associated with utilisation of NHIS

Some of the factors mentioned that can be associated with utilisation of NHIS during the KII were quoted below.

The interviewees identified the issue of quality drugs as one of the factors associated with utilisation of NHIS. Stated thus;

"If the hospitals are equipped with more quality drugs"

"If we can be given quality drugs that will help us recover quickly and avoid given us low quality drugs that we can easily buy from patient medicine store"

During the KII, the Head of finance unit and most of the interviewees were interviewed. It was discovered that they do not understand the mode of operation of NHIS and believed that if the workers are carried along with the components and structure of the scheme and most especially their monetary involvement it could improve the adoption of the programme among the workers.

"There should be sensitisation on the benefits and the right of enrollees, many workers don't even know their right, so they need to be educated on the scheme (The monetary aspect of contribution, we staff don't know anything about it)"

Other factors like accessibility, proximity, registration process and cost affordability were highlighted by the interviewees.

"If it is accessible anywhere in the country just like Automatic Teller Machine"

"Proximity to our places of work, affordability and in terms of the personnel, we don't have to go to quacks, we know that we are going to professionals for adequate medical care."

"If the NHIS staff can improve on the registration process, whereby workers will not have to queue or wait for long before they collect their personal identification number

"In case of fund, often times Nigerians don't have enough money to take care of themselves when they are sick. The NHIS can at least give the staff the boldness to go to hospital and avoid self medication."

The quantitative data shows that affiliation with good healthcare facilities (96.2%), availability of skilful health personnel (95.7%) and cost affordability (94.1%) were the leading factors indicated that can make respondents adopt NHIS. Some stated that attention given to the patients by the health workers (93.6%), proximity to affiliated hospitals/clinics (93.3%), having adequate information about the scheme (91.7%) and how fast the registration process is (84.8%) were others factors mentioned (Table 4.6). On the other hand, factors that can prevent workers from adopting NHIS were also highlighted (Table 4.7); when NHIS does not meet up with their health needs (74.4%), when necessary drugs are not given (56.8%), when the workers are not registered on time (45.1%), if the worker falls into a bad hospital (47.5%), if the worker does not fall sick (35.2%), if he or she is a medical personnel (24.8%), religion of the worker (17.6%) and when family members are not benefitting (4.3%). Meanwhile, 70.6% agreed there is nothing that can prevent the workers from adopting NHIS because they had no choice.

Table 4.6: Factors associated with utilisation of NHIS services (N=375)

Statement	Number	%
Adequate information about the scheme	344	91.7
Affiliation with good hospitals/clinics	361	96.2
Proximity to affiliated hospitals/clinics	350	93.3
Availability of skilful health personnel	359	95.7
Attention given to the patients by the health workers	351	93.6
Cost affordability	353	94.1
Prompt response by the health workers	349	93.1
Quick registration process	318	84.8

Multiple Responses

Table 4.7: Factors that can prevent workers from utilising NHIS services (N=375)

Statement	Number	%
Religion	66	17.6
When it does not meet up with their health needs	279	74.4
When necessary drugs are not given	213	56.8
When family members are not benefitting	16	4.3
When they are registered on time	169	45.1
Nothing can prevent workers from adopting NHIS because they have no choice	265	70.6
If the worker falls into a bad hospital	178	47.5
If the worker does not fall sick	132	35.2
If he or she is a medical personnel	93	24.8

Multiple Responses

4.4 Experiences of workers with NHIS

Respondents who have registered and had been utilising NHIS services described their experiences and some of the experiences were stated below which mainly talked about the registration process, quality of drugs given and general service delivery after which the quantitative data were presented. The Heads of units interviewed talked about their experiences on registration process.

> *"When I registered I had two children but right now I have another child, I have been processing that she gets registered but I have not got a reply from them."*

> *"When I registered, I discovered that my children could not be registered with me because of the age limit, my last child was above 18years as at that time."*

> *"At the early stage when they just started registration process, there use to be long queue, I had to go there for more than three times before I can be registered."*

This respondent was faced with poor infrastructure at the NHIS facility but she was referred to a better equipped facility. The only problem she had with accessing NHIS facility was the provision of effective drugs which are considered to be expensive.

> *"Where I registered, they had the drugs, but for the equipment there was a time I was sick, they don't have equipment and I was referred to a better equipped facility."*

> *"They are still ok, whenever you go there whatever your complaints, they do scan, X-ray but there are some effective drugs which are considered to be expensive drugs they don't normally give, they write it for you to buy."*

Another Head of unit that was interviewed, complaints bitterly on the quality of service received, doctor's competency and the infrastructural facilities in his primary health care facility. He said;

> *"The experience I got there was that the quality of service I received was very poor."*

"Often time the doctor prescribes drugs without test. Most of the time, I have to use my discretion to go and do test in another private laboratory with my money before I come for treatment."

"Many times when I go there they will be lightening candle."

The respondents (215) using NHIS facilities were interviewed on their experiences with NHIS services. Table 4.8 revealed that more than half of the respondents (55.4%) had not benefitted from NHIS services, 83.7% did not get all the prescribed drugs, 90.7% said that they were not given effective drugs which were said to be expensive (drugs above ₦100) and 52.6% claimed to have been denied of healthcare services when accessing NHIS facility. However, majority (89.3%) of the respondents reported that the doctor commenced his diagnosis after listening to their complaint and that the pharmacists do explain how the drugs would be taken to the respondents (93.5%). Also, (45.1%) were very well received by the health workers and 43.3% were given prompt attention at their health care facilities.

Table 4.8: Experiences of respondents with NHIS (N = 215)

	Yes Number (%)	No Number (%)
Respondents have benefitted from NHIS services	96 (44.6)	119 (55.4)
Doctor allow respondents to finish complaints before diagnosis	192 (89.3)	23 (10.7)
Respondents get all the prescribed drugs	35 (16.3)	180 (83.7)
Respondents were given expensive drugs (drugs above ₦100)	20 (9.3)	195 (90.7)
Pharmacist explains how respondents will take the drugs	201 (93.5)	14 (6.5)
Respondents were received very well by the health workers	97 (45.1)	118 (54.9)
Respondents were given prompt attention at the hospital	93 (43.3)	112 (56.7)
Respondents were denied of healthcare services when accessing NHIS facility	113 (52.6)	102 (47.4)

Based on Table 4.8, the experience score was calculated for each respondent using a 16-point experience scale. The experiences of the respondent with NHIS services were contained in the statements which had a score of 2-point for good experience and 0-point for bad experience. The scores were then summed up to give a total experience score for each respondent. The score above average (>8-16) shows good experience with NHIS while score between 0-8 shows a bad experience.

One hundred and seven respondents (49.8%) had below average experience score which was categorised good experience, while 50.2% had above average between 0 and 8 points (bad experience) (Table 4.9).

Table 4.9: Experience of respondents with NHIS (N = 215)

Experience	Number	%
Bad experience	108	50.2
Good experience	107	49.8
Total	215	100.0

4.5 Level of Satisfaction of respondents with NHIS

The qualitative data revealed that the workers were not satisfied with the services received from NHIS services. The following were the responses of the respondents interviewed concerning their levels of satisfaction with NHIS.

Some of the interviewees visited during this study expressed their level of satisfaction by saying;

> *"I was expecting that we have the best of satisfaction as far as medical delivery is concern but as is turn out to be, the reverse is the case. We are not getting what we expected. The quality of medical delivery is not satisfactory."*

> *"The reception I received from the hospital staff was not satisfactory."*

In another unit, the Head of the unit rated NHIS services based on the attitudes of his primary healthcare facility workers. In his remark, he said;

> *"I am not satisfied with NHIS, if I will rate NHIS in this environment, I will rate them 20%. 20% because of the staffing, the facility in place not the work they are doing."*
>
> *"The reception I received from the hospital staff was not satisfactory."*

Another interviewee who almost lost his wife in the hand of the workers in his primary healthcare facility revealed that there is lapses in the area of monitoring and evaluation of the NHIS approved facilities because what he experienced could not have happened if they are evaluated and monitored regularly.

> *"There is no evidence of appraisal of service delivery by designated authorities. That is why the hospitals can afford to do what they like."*

> *"My wife was sick sometimes ago, we kept going to the hospital severally they were busy given her drips and I have to advise the doctor that my wife should go for a test before treatment he said 'no'. I later went to a private laboratory and a test was conducted, belief me, the blood level of my wife was as low as 22% and the person in charge of the laboratory was blaming me 'why were you joking with the life of your wife?' so it look as if I did not take my wife to the hospital."*

However, only the respondents (215) that were utilising NHIS facilities were interviewed on their satisfaction level. The quantitative data revealed that ninety-six respondents (44.7%) stated that the quality of treatment received during their last visit to the NHIS clinic/hospital was satisfactory, 38.1% of the respondents mentioned that the courtesy of the health workers during their last visit was impressive. Less than half of the respondents get all the prescribed drugs during their last visit (31.2%), 46.5% of the respondents reported that they received adequate answers to the questions asked during their last visit while 36.7% agreed that doctor diagnosis was perfect. Only 35.8% mentioned that the thoroughness and accuracy of diagnosis was acceptable, 23.7% of the respondents accepted that they were referred to a specialist when needed. Some of the respondents responded that the quality of test conducted in the laboratory during their last visit was accurate (23.3%) and 31.2% of the respondents agreed that the hospital meets all their health needs during the last visit (Table 4.10). Above all, 38.9% of the respondents were satisfied with the services received from NHIS facilities.

Table 4.10: Respondents' Level of Satisfaction with NHIS (N = 215)

Statement	Satisfied Number (%)	Not satisfied Number (%)	Neutral Number (%)
The quality of treatment respondents received during the last visit to the NHIS hospital was satisfactory	96 (44.7)	105 (48.8)	14 (6.5)
Courtesy of health workers during the last visit was impressive	82 (38.1)	113 (52.6)	20 (9.3)
Getting all your prescribed drugs during your last visit was good	67 (31.2)	144 (66.9)	4 (1.9)
Respondents received adequate answers to the questions asked during the last visit	100 (46.5)	108 (50.2)	7 (3.3)
Doctor diagnosis was perfect	79 (36.7)	103 (48.0)	33 (15.3)
Thoroughness and accuracy of diagnosis was acceptable	77 (35.8)	104 (48.4)	34 (15.8)
Referral to a specialist when needed	51 (23.7)	112 (52.1)	52 (24.2)
The hospital meets all respondents' health needs during last visit	67 (31.1)	127 (59.1)	21 (9.8)
The quality of test conducted in the laboratory during respondents' last visit was accurate	50 (23.3)	107 (49.8)	58 (26.9)

Based on the table above, the satisfaction score was calculated for each respondent using a 18-point satisfaction scale. The level of satisfaction of the respondents with NHIS services were contained in the statements which had a score of 2-points for satisfied and 0-point for not satisfied. The scores were then summed up to give a total satisfaction score for each respondent. The score above average (>9-18) shows they were satisfied with NHIS services while score between 0-9 shows they were not satisfied with NHIS services.

Eighty-three respondents (38.9%) had above average satisfaction score which was categorized satisfied, while 50.4% had below average between 0 and 9 points (not satisfied) (Figure 4.2).

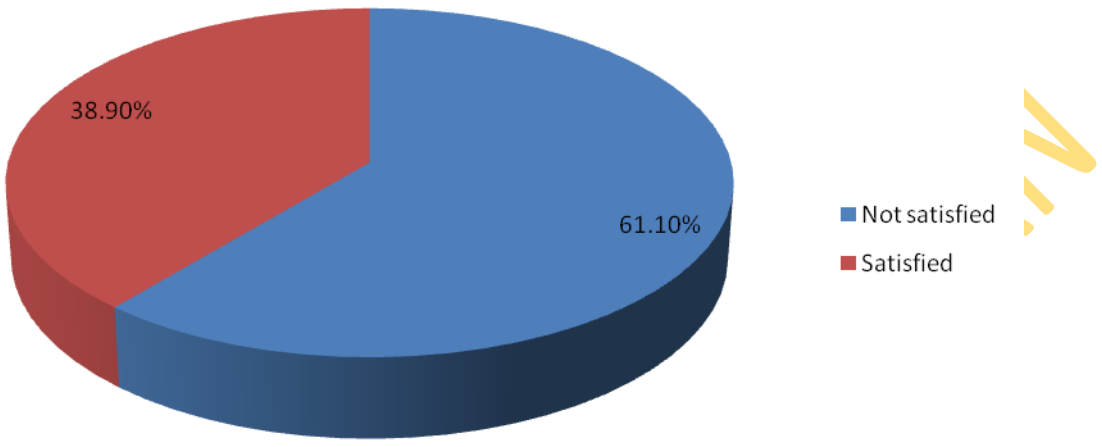

Figure 4.2: Respondents' satisfaction measurement

4.6: Ways to Improve NHIS Services

The following were some of the ways the respondents thought NHIS services can be improved when they were interviewed.

One of the Head of units interviewed highlighted easy accessibility to any health care facility in case of emergency.

> *"If they can digitalise it that you can go to any place and immediately they type your number into the system your name will come out just like Automatic Teller Machine."*

He further stretched that people whose house is far from their primary health care facility can be rescued on time if they can access health care at any NHIS approved facility.

> *"The place I live if I have a dog or snake bit before they rush me to Jaja clinic or UCH the person would have died. We should be allowed to use the card in any nearby hospital."*

Availability of drugs to all the health care facilities was also highlighted.

> *"Government can provide more drugs so that enrollees can get all the prescribed drugs not that 75% of the drugs will have to be bought."*

Another Head of unit visited mentioned the need for educating the enrollees on the scheme as one of the ways to improve NHIS services. He said;

> *"There should be sensitisation on the benefits and the rights of the enrollees. Many workers don't even know their rights, so they need to be educated on the scheme."*

He also advised that NHIS staff should check for all necessary things that are expected to be in a hospital including the workers before giving them the approval.

"Most of the hospital included for NHIS need to be scrutinised very well, because some of the hospitals are substandard."

"The quality of personnel involved, because this is life of people. The people should be sufficiently trained."

It was raised by one of the interviewees the need to lay emphasis on preventive care rather than curative care. He advised policy makers by saying;

"Health education and promotion should be laid emphasis on when people come to hospital not curative medicine alone but mainly preventive medicine should be used to compliment the curative aspect."

He further said that;

"There should be frequent monitoring and evaluation of all the healthcare facilities that are under NHIS programme."

In the quantitative result, almost all the respondents responded that more quality drugs should be provided (99.2%). Majority of them stated that communication among stakeholders should improve (97.6%), awareness of what NHIS does should be publicised (98.4%), registration process should be faster (96.0%), more funds should be released for the scheme (96.5%) and it should cover all ailments (98.4%). Moreover, some also mentioned that children's age limit should be increased (97.0%), more personnel should be employed (98.4%) which is similar to those that agreed that the scheme should be extended to aged parents and that retirees should be included in the scheme (Table 4.11).

Table 4.11: Ways to Improve NHIS Services

Statement	Number	%
Communication among stakeholders	366	97.6
Awareness of what NHIS does	369	98.4
Registration process	360	96.0
It should cover all ailments	369	98.4
More fund should released for scheme	362	96.5
Children's age limit should be increased	364	97.0
More quality drugs should be provided	372	99.2
It should be extended to aged parents	369	98.4
Retirees should be included	369	98.4
More personnel should be employed	369	98.4

Multiple Responses

4.7: Test of Hypotheses

The following null hypotheses were tested in this study:

1. There was no significant relationship between the marital status of the respondents and their attitudes towards NHIS
2. There is no significant difference between respondents' age and their experiences relating to the utilisation of NHIS facilities
3. There is no significant relationship between respondents' number of children and their experiences relating to the utilisation of NHIS facilities
4. There is no significant difference between respondents' years in service and their experiences relating to the utilisation of NHIS facilities
5. There is no significant difference between sex and level of satisfaction with NHIS services

4.7.1: Hypothesis one:

The first hypothesis states that there was no significant relationship between the marital status of the respondents and their attitudes towards NHIS. Respondent's attitude towards NHIS was cross tabulated with their marital status using Chi-square statistics. The Pearson chi-square analysis revealed that there is a relationship between marital status and attitude with 46.4% of the married and 0.8% of the singles having positive attitude towards NHIS. The regression analysis further shows that the married are three times more likely to have a positive attitude towards NHIS compared to the singles (OR: 13.44; 95% CI: 2.48 – 72.29). The observed result is statistically significant with married having positive attitudes towards NHIS compared to the singles, (p-value = 0.000). Therefore the null hypothesis was rejected (Table 4.12).

Table 4.12: Relationship between marital status and attitude

Marital Status	Attitude category		Total	x^2, df (p value)	OR (95% CI)
	Negative (%)	Positive (%)			
Married	173 (46.1%)	174 (46.4%)	347 (16.16%)	16.16, 1 (0.000)	13.44 (2.48 – 72.29)
Single	25 (6.7%)	3 (0.8%)	28 (7.5%)		
Total	198 (52.8%)	177 (47.2%)	375 (100.0%)		

4.7.2: Hypothesis two:

The second hypothesis states that there was no significant difference between respondents' age and their experiences relating to the utilisation of NHIS facilities. The Pearson chi-square analysis revealed that there is a relationship between age and experience with 20.6% of young adults and 72.4% of the middle age having bad experience with NHIS services (Table 4.4.3). The regression analysis further shows that the young adults between 24-40years were more likely to have good experience with NHIS services compared to the middle age (OR: 0.35; 95% CI: 0.127 – 0.983). The observed result is statistically significant with the middle age having bad experience with NHIS services compared to the young adults. (p-value = 0.00). Therefore the null hypothesis was rejected (Table 4.13).

Table 4.13: Relationship between age and experience

Age	Experience category		Total %	x^2, df (p- value)	OR (95% CI)
	Bad (%)	Good (%)			
Young Adult	19 (20.6)	73 (79.4)	92 (100)	36.29, 1 (0.00)	0.353 (0.127 – 0.983)
Middle age	89 (72.4)	34 (27.6)	123 (100)		
Total	108 (50.4)	107 (49.6)	215 (100)		

4.7.3 Hypothesis three:

The third hypothesis states that there was no significant relationship between respondents' number of children and their experiences relating to the utilisation of NHIS facilities. This relationship was found not to be statistically significant (p-value =0.50). Therefore the null hypothesis was accepted, indicating that their number of children have no effect on their experiences relating to the utilisation of NHIS facilities. (Table 4.14).

Table 4.14: Relationship between number of children and experience

Number of children	Experience Category		Total	X^2 Value	Df	p-value
	Bad Experience (%)	Good Experience (%)				
1 – 4	143 (87.7)	23 (85.1)	166 (87.4)	0.455	1	0.50
5+	20 (12.3)	4 (14.9)	24 (12.6)			
Total	**163 (100.0)**	**27 (100.0)**	**190 (100.0)**			

4.7.4 Hypothesis four:

The forth hypothesis states that there was no significant relationship between respondents' years in service and their experiences relating to the utilisation of NHIS facilities. This relationship was found not to be statistically significant (P-Value =0.054). Therefore the null hypothesis was accepted, indicating that the workers' years in service have no effect on their experiences relating to the utilisation of NHIS facilities (Table 4.15).

Table 4.15: Relationship between years in service and experience

Years in Service	Experiences of workers with NHIS		Total	X^2 Value	Df	p-value
	Bad Experience (%)	Good Experience (%)				
≤5	30 (17.5)	1 (4.3)	31 (15.9)	0.482	1	0.054
6 – 10	26 (15.2)	2 (8.7)	28 (14.4)			
11 – 15	55 (32.1)	6 (26.1)	61 (31.4)			
16 – 20	25 (14.6)	5 (21.7)	30 (15.5)			
21+	35 (20.5)	9 (39.1)	44 (22.7)			
Total	**171 (100.0)**	**23 (100.0)**	**194 (100.0)**			

4.7.5: Hypothesis five:

The fifth hypothesis states that there was no significant difference between sex and level of satisfaction with NHIS services. This relationship was found not to be statistically significant (P-Value =0.457). Therefore the null hypothesis was accepted, indicating that gender has no effect on respondents' satisfaction level with NHIS services (Table 4.16).

Table 4.16: Relationship between sex and satisfaction

Sex	Satisfaction Category		Total	X^2 Value	Df	p-value
	Not Satisfied (%)	Satisfied (%)				
Male	80 (54.8)	37 (53.6)	117 (54.4)	6.82	1	0.457
Female	66 (45.2)	32 (46.4)	98 (45.6)			
Total	**146 (100.0)**	**69 (100.0)**	**215 (100.0)**			

CHAPTER FIVE

Discussion, Conclusion, Recommendations

5.1: Introduction

This study surveyed experiences and satisfaction with NHIS among non-teaching staff as well as their attitudes and factors that can make the staff adopt NHIS. In this section, the results presented in the preceding chapter are well explained. Explanation of the socio-demographic characteristics; attitudes of workers towards NHIS, experiences of workers with NHIS, Factors associated with utilisation of NHIS , level of satisfaction of workers with NHIS, conclusion and recommendations.

5.2 The socio-demographic characteristics of the respondents

Three hundred and seventy five young and middle aged persons participated in the study. This is consistence with the findings of an earlier study among employees of the federal, state and local government that were health care consumers in Oyo state, Nigeria, the respondents fell within the age bracket of 25-55 years which implies that majority of the respondents were within the (active) working class of the population (Sanusi and Awe, 2009). However, another study conducted in Nigeria among young and middle aged people, though it's a community based study. (Omuemu, Okojie and Omuemu, 2006). The results presented in chapter four indicated that the study sample consisted of more males than females which correlates with the earlier study conducted in Oyo state which revealed there were more males than the females (Sanusi and Awe, 2009). Another study conducted in Cross Rivers revealed that majority of the participants were males (Agba et al, 2009). However, it is different to the findings in Kwara state, where there were more females than the males (Akande et al., 2011).

Almost all of the respondents were married this is most likely to happen because culturally, people of their age range are expected to be married and this can be compared to a study carried out in Federal Polytechnic, Idah where the percent distribution of the marital status of the respondents revealed that 88 percent were married (Agba, 2010). The study area was South-Western Nigeria; this explains why most of the respondents were of the Yoruba ethnic group. Most of the respondents had tertiary education. It can be corroborated with the study conducted

in Oyo state where majority of the respondents attended tertiary institutions (Sanusi and Awe, 2009), (Shafiu, et al., 2011).

5.3 Attitudes of the respondents towards NHIS

Though many of them were registered, but generally the university of Ibadan non-teaching staff's attitudes were not encouraging. As at the time of conducting this study, almost all respondents had registered with NHIS out of which less than half were not utilising NHIS services. This can be compared with the experience in India where most of the sample covered under the scheme supported it, but a little above half actually joined it (Rao, 2008). In this study, some of the respondents would have had a very good attitude but they were disappointed when they found out that the scheme could not cover their ailments, the process of registration was very poor and healthcare facilities were forced on many of the enrollees. This is line with a study carried out in Osun state where personal spending still accounts for high percentage of health care spending among respondents, respondents believed that NHIS services does not cover all their health needs and this same study also found out that about two thirds of respondents believed that the present funding does not adequately cover all required health expenses, and not even all dependants (Olugbenga-Bello and Adebimpe, 2010). This is in support of a South African study, where the majority wants health care system to provide everyone with all the needed health care and medical services (Akpala and Onuekwusi, 2008).

Majority of the staff were registered with NHIS and out of those that were registered, many of them were not utilising NHIS facility. This is comparable to a study in Oyo state which showed that NHIS coverage in Nigeria was restricted so far because not all registered persons have started enjoying services from the programme (Sanusi and Awe, 2009). This can be blamed on the following reasons; non-availability of PIN card, having a family clinic they were not willing to change, some claimed they have never been sick since they registered, while some were given facilities that are far from their houses and places of work. All these contributed to the poor attitudes of the workers towards NHIS.

However, for those that have not started using NHIS facility the reasons given were; non-availability of Personal Identification Number, wrong primary healthcare facility (different from

the facility they preferred during registration), not being sick since they registered, failure to follow up the registration process, while some were yet to complete their registration, having a good family clinic which they were not willing to change, insufficient time, one of the spouses had registered and some seems not to be interested in the scheme.

Less than half of the respondents had positive attitudes towards the scheme because some do not hold their registration cards regularly, many of them do not visit NHIS facility for regular medical check up while some only access NHIS facility when they do not have money. Although almost all the married respondents registered their spouse and children under NHIS services but not all of them make use of the services. Meanwhile, some of interviewees believed that going to other hospitals is better than using NHIS facility and that accessing NHIS facility is a waste of time and resources. It is supported by a study conducted in Jos metropolis where few of the respondents preferred private insurance or the fee for service to NHIS (Onyedibe et al., 2012). Another study also revealed that some of the respondents preferred existing arrangements. Among those who were not participating in the NHIS, about half of the total respondents, used public hospitals or dispensaries. Another high percentage, reported that they made use of private hospitals. Among the remaining respondents, some use patients medicine stores while some alluded to other factors for not enrolling in NHIS. In this last group there were preponderance of answers like "God is my healer", "God is my doctor" (Ibiwoye and Adeleke, 2008). This study revealed that there is a relationship between marital status and attitude towards NHIS. This is in line with the study conducted by Gbadamosi, Hamadu and Yusuf (2009) which also supported that marital status has a significant influence on peoples' attitude towards insurance.

5.4 Experiences of the respondents with NHIS

In this study, less than half of the respondents had benefitted from NHIS services this is not as low as the study in which only few of the respondents had benefited so far from NHIS (Olugbenga-Bello and Adebimpe, 2010). The respondents reported they had very good experience with the doctor's diagnosis after listening to their complaint, some of the respondents stated that they were very well received by the health workers and close to half were given prompt attention at their health care facilities and almost all the interviewees reported that the pharmacists do explain how the drugs would be taken to the respondents. In this study, it was

reported that most of the respondents did not get all the prescribed drugs and they were not given effective drugs which were said to be expensive (drugs above ₦100). These could be corroborated with the study conducted in Kwara where there were similar target population; some of the following problems were highlighted with the scheme which includes non-availability of some prescribed drugs, lack of expensive drugs; inadequate coverage and poor attitude of health workers. In that study, most of the staff and/or their relatives experienced non-availability of some prescribed drugs and a very high percentage of the respondents lack expensive drugs (Akande et al., 2012). This was also reported in Ghana where patients were asked to pay for drugs which were said not to be in stock or better drugs not provided under NHIS (Adinma et al., 2010). Similarly, Agba's study also revealed the quality of service rendered by their health service providers. Although services were rendered, some of the respondents rated them poor due to absence of drugs, poor prescriptions and attention (Agba, 2010).

However, previous studies also showed that the implementation of NHIS has some drawbacks. One of such drawbacks is that there have been pockets of reports on providers commonly soliciting informal payments by charging for services out of hours, asking patients to pay for drugs which are said not to be in stock or for drugs or services not covered by the scheme (Akande et al., 2011; Shafiu et al., 2011; Olugbenga-Bello et al., 2010). It was revealed in this study that both the insured and uninsured pass through a lot of stress when trying to register with the scheme or utilise the NHIS services. This is in keeping with a study in Ghana (Adinma et al., 2010) which involved both qualitative and quantitative data. The in-depth interview conducted with the health insurance managers collaborated the finding of the survey by confirming that the insured experience a lot of delays when seeking health care:

"*We've received numerous complaints of delays by our clients at the facilities. Some insured clients spend a whole day seeking health care in the facilities".* (In-depth Interview)

This situation does not encourage the insured to attend the facilities when ill as they used to when the NHIS was initially introduced. This finding was supported by the qualitative study. The results showed that the insured complained of long waiting times (Dalinjong and Laar, 2012). In

all, there were both good and bad experiences but the people that had bad experiences superseded the people who had good experiences.

5.5 Factors associated with utilisation of NHIS

Almost all the respondents agreed that affiliation with good healthcare facilities, availability of skilful health personnel, prompt attention given to the patients by the health workers, proximity to affiliated hospitals/clinics, fast registration process, cost affordability and having adequate information about the scheme could be factors that can make respondents adopt NHIS. This is in support of a Nigeria study where poor detailed knowledge of the objective and components of the scheme among the civil servants was observed as one of the factors that was affecting the workers' willingness to participate in NHIS programme and it was also observed in the same study that a significant association exists between willingness to participate in the NHIS scheme and awareness of methods of options of health care financing (Olugbenga-Bello and Adebimpe, 2010). Another study conducted in Lagos also supported poor awareness as a major factor affecting participation in the scheme (Ibiwoye and Adeleke, 2008). Similarly, a study in India revealed that information puts the patient and the insurer at a disadvantage due to their inability to resist or challenge medical opinion regarding an existing condition or future treatment. Besides, in the absence of knowledge of prices, the provider can short-change the two by overcharging (Rao, 2008).

The interviewees in this study highlighted some other factors that can prevent workers from adopting NHIS; when NHIS does not meet up with their health needs, when necessary drugs are not given, when the workers are not registered on time, if the worker does not fall sick, if he or she is a medical personnel, the religion of the worker, and when family members are not benefitting and some believe that nothing can prevent the workers from adopting NHIS because the workers had no choice. Meanwhile, a study in Idah by personal observation and interview, it was discovered that some of the workers of the Federal Polytechnic Idah had technical problems with their registration in the Scheme (Shafiu et al., 2011) and it was also reported in Ghana that the insured clients were not happy with high premium payment for registration, the delay in processing the insurance identity cards (ID cards) after registration, and the yearly renewal of the ID cards. Besides the perceived limited benefit package of the NHIS and the unreliable nature of

the insurance agents were other issues the insured were not pleased with. The insurance agents were accused of charging unofficial fees and also causing delays in the processing of the insurance ID cards. The above issues therefore do not motivate them (uninsured) to subscribe to the NHIS (Dalinjong and Laar, 2012).

5.6 Level of satisfaction of respondents with NHIS

Both the qualitative and the quantitative data in this study revealed that the respondents were not satisfied with NHIS service provision. This finding can be corroborated with a study in Ghana (Dalinjong and Laar, 2012) which the point was buttressed by the qualitative study as well. Some insured discussants were not physically examined by providers before prescribing drugs for them. This was seen in both districts. It was also discovered in this same study that most insured clients in both districts perceived that providers discriminated against them by causing delays for them when they come for their hospital folders at the records unit. Providers also prescribe low quality drugs for them, issue prescription forms for them to buy drugs out of the facilities, and sometimes verbally attacking them for no apparent reason. It was also reported by the insured that providers tend to give preferential treatment to the rich, who were well dressed and attended the facilities in cars. The insured therefore concluded that it was because they were not making instant payment for health care services, they were being discriminated against by the providers (Dalinjong and Laar, 2012).

This study and other previous studies have showed that the satisfaction level with NHIS services is relatively low this can be confirmed with the studies conducted by these researchers (Shafiu et al., 2011; Olugbenga-Bello et al., 2010; Agba, 2010; Mohammed et al, 2011; Dalinjong and Laar, 2012). This level of dissatisfaction can be blamed on evaluation of the HMOs, the service providers and the NHIS staff because if proper appraisal is done, it would have corrected some of the problems causing dissatisfaction for examples, delays in registration process, liberty in making choice of health facility by the enrollees, poor referral system, quality of drug supplied, facilities with poor infrastructures, denial of health services, delays in receiving required services and unavailability of required service and supply of full information on terms and conditions of NHIS before enrolments are made.

Some of these issues causing dissatisfaction are expected to be addressed at the policy making level, the service providers and enrollees have little to do to correct the problems. According to Olugbenga-Bello et al, 2010, the non coverage by the insurance scheme of some of the services required by enrollees is a policy issue which can only be dealt with at the level of policy formulation. Suffice to note that some enrollees will not mind increasing their contributions into the scheme in as much as these services would be covered in the benefit package. Another critical area the policy makers need to look closely into is the aspect of monitoring and evaluation. It is common especially in this part of the world that people do not handle government properties or programme seriously that is why some HMOs and service providers can afford to give the enrollees substandard care. Rao (2008) mentioned that there could be perverse interests to provide low quality of care over-diagnose or under-treat for making profits, but if there is a strong monitoring and evaluation it would solve some of these issues causing dissatisfaction.

This point can be supported by a study conducted in India where Rao, 2008 found out that there is no exhaustive evaluation of the Community Based Health Insurance Schemes in India due to the lack of uniformity in Management Information System (MIS). Many questions remain unanswered and need to be researched to see if some models can be implemented and replicated in India. For example, it is not clear how much it costs to administer such schemes, or its impact on strategic purchasing of services, developing provider networks or on the local quack, or the problems for up scaling. He also said that, many of the schemes see health insurance as an end in itself and do not seek to either promote preventive and promotive health care or extend adequate provider linkages (Rao, 2008). This can also be corroborated with a study conducted in Zaria at Ahmadu Bello University, located at high plains of Northern Nigeria, it was stated that enrollee's satisfaction of service provision served as an important aid to monitor the progress of implementation activities of the scheme. However, certain factors such as general knowledge of the health insurance scheme and awareness of monetary contributions greatly influenced enrollee's satisfaction of health care deliver. Similar to the finding in Zaria, North-Western Nigeria where it was stated that lack of satisfaction with NHIS has the potential to negate the positive aspects of the scheme if not looked into (Shafiu et al., 2011).

It was also discovered in this study that present NHIS services laid emphasis only on the curative health care aspect, thereby leaving the preventive health care which is the most important; this is also affecting the quality of services rendered by NHIS. In support of this, a study conducted in Osun state, it was mentioned that in the present NHIS in Nigeria, basic curative care were covered, thus neglecting preventive health matters. In addition, it caters less for rehabilitative health care, for family members outside the first wife, for the first four children and for hospital admissions outside the first twenty one days. This indirectly still constitutes financial burden to affected families most especially in the poverty ridden sub Saharan African region of the world, where polygamy and preference for children persists (Olugbenga-Bello and Adebimpe, 2010). Aside all these, Nigeria of today few people have the opportunity to be enrolled because averagely few people are employed into the Federal government Parastatals with many dependants, even children of twenty-one years and above still depend on their parents and any worker whose children ages fall above eighteen years cannot enjoy the NHIS services.

5.7 Implication of the findings to Health Education

Finding of this study reveals that with NHIS, respondents are not able to access quality healthcare services due to the bad experiences they had when accessing NHIS service and their level of satisfaction with the scheme. It was observed that some of the hospitals/clinics accredited under NHIS had poor infrastructures, social amenities and lack major equipment to give quality healthcare to the enrollees. There is need for intensive advocacy to reach the policy makers in order to address issues mentioned above, so that the main purpose of establishing NHIS can be achieved on time.

There exists lack of monitoring and evaluation on the side of NHIS workers and the HMOs which affect the standard of healthcare services the workers are receiving from their various primary health facilities. This is an aspect of health promotion and education where some of the stakeholders can be trained on monitoring and evaluation which would help the scheme to bring out a desirable outcome.

It was also reported that the respondents are not enlightened on the components and structure of the scheme. If the enrollees are not well informed about the component and structure of NHIS it

could affect their satisfaction level. Public enlightenment programmes is one of the major aspects of health promotion and education. Campaigns through the use of the mass media should be further encouraged but not limited to this because the mass media is good in raising the level of general awareness about health issues but may not necessarily give in depth details of the issue in question. Short orientation programmes could be packaged for the staff in batches to further educate them on the components and structure of the scheme. If this is done properly it would help the staff to appreciate the programmes under the scheme better.

It was noted that only the curative aspect of healthcare services were offered neglecting the preventive aspect of the healthcare delivery. If the aspect of preventive healthcare services were to be addressed, not all the time an enrollee visit the hospital/clinics necessarily need to see a medical doctor before some of their health problems could be solved. Some problems are emotional, psychological, behavioural and so on. What some people need some times is enlightenment and encouragement. Health promotion and education unit could be implemented in all the accredited hospitals/clinics to handle these aspects and further reduce the workload of the medical doctors.

5.8 Conclusion

This study has shown that Nigerians still have needs to access quality health care at affordable rate and in all indications Nigerian Government has not been able to achieve her general purpose on NHIS which is to ensure the provision of health insurance in which insured persons and their dependents shall be entitled to the benefit of prescribed good quality and cost effective health services. The non-teaching staff of College of Medicine University of Ibadan still experience a lot of troubles to cater for their health needs through this scheme not to talk of other workers and the community at large. National Health Insurance Scheme policy makers need to wake up to their responsibilities ensuring that everybody in this country is under health insurance otherwise the Millennium Development Goals; one (to eradicate extreme poverty and hunger), four (to reduce child mortality), five (to improve maternal health) and six (to combat HIV/AIDS, malaria and other diseases) would not be achieved.

Ignorance of the components and structure of NHIS is another vital issue affecting the experience and satisfaction level of the enrollees. For example, some of the respondents mentioned that they do not understand the mode of payments which actually made some workers not to participate or utilise NHIS services because of fear of withdrawing their money from the source. In terms of what the workers experienced trying to register with NHIS, accessing NHIS services and the workers' satisfaction level, there is need for modification of existing policies guiding registration process and quality of service of NHIS. Enrollees should have access to information through a short orientation programme, provision of Information Education and Communication (IEC) materials and public enlightenment campaigns through the use of the mass media like television and radio jingles with emphasis on the structure and components of NHIS.

5.9 Recommendations

The following recommendations were made:

i. Frequent monitoring and evaluation of all the HMOs and healthcare facilities for proper appraisal should be put in place by relevant stakeholders.
ii. NHIS enlightenment programme should be included in the orientation programme for the newly employed staff on how the health insurance scheme works and knowing what has been offered by the scheme.
iii. Health Maintenance Organisations and healthcare providers must realise that enrollees have the right to choose who their service providers should be and could change to another when not satisfied with services rendered. Therefore, NHIS staff or HMOs should not force health facilities on enrollees
iv. All problems encountered in the registration process should be removed in order to fast track registration of new and existing employees into the scheme
v. Strategies to fast track the enrolment of other Parastatals and every Nigerians should be one of the scheme priority, so that Nigerians can have access to good quality health care
vi. More funds should be released to the scheme so that they can provide quality health services in terms of laboratory examinations, provision of effective drugs, qualified health personnel and modern equipments to the approved health facilities.

vii. If the registration number can be digitalised so that anyone can go to any nearby hospital and immediately the number is typed into the system the user name will come out, just like Automatic Teller Machine. This will help in case of emergency.

viii. Before any health facilities can be approved, it must be well scrutinized to be sure that the hospitals approved by the scheme are not substandard

ix. Health education and promotion should be laid emphasis on, when people come to hospital not curative medicine alone but mainly preventive medicine should be used to compliment the curative aspect

x. Children's age limit should be reviewed because at age twenty-one and above children still depend on their parents in this part of the world.

5.10 Suggestion for Further Study

There two categories of staff in the CoMUI, the Teaching and Non-teaching staff. This study covers only the Non-teaching staff, therefore a study on experiences and satisfaction with NHIS among teaching staff of College of Medicine, University of Ibadan is hereby suggested.

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APPENDIX I

QUESTIONNAIRE

Dear Sir/ma

Introduction:

I am a student in the Department of Health Promotion and Education, College of Medicine, University of Ibadan. I am carrying out a study on the **Experiences and Satisfaction with National Health Insurance Scheme among Non-Teaching Staff in College of Medicine, University of Ibadan**. The study is being conducted as part of MPH dissertation and it is strictly for academic purpose.

Participation is voluntary and will not take much of your time. Your identity, responses and opinions will not be shared with anyone. All information will be kept confidential and no name is required in filling the questionnaire. You are requested to please give the honest responses to the questions as much as possible because your responses with others will be used to make appropriate recommendations for the improvement of the programme.

Date_____

Department/Unit _____ Faculty _____

Thank you.

Akinfenwa Olalere

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For official use only

Instruction: Please where required, kindly tick your response to the question asked as you deem appropriate and supply the needed information in the blank spaces provided for the other questions.

SECTION A: SOCIO DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

1. Age of respondent as at last birthday (In years)_____
2. Sex of respondents 1.Male 2.Female
3. Marital status: 1. Single 2. Married 3. Separated 4. Divorced 5. Widow/widower
4. Number of children _____
5. Type of family 1.Monogamous 2.Polygamous
6. Religion: 1. Christianity 2. Islam 3. Traditional 4. Others (specify) _____
7. Ethnicity: 1. Igbo 2. Yoruba 3. Hausa 4. Others (please specify)_____
8. Educational Qualification: 1. Primary School leaving certificate 2. SSCE 3.OND/NCE 4. HND/First Degree 5. Masters 6. PhD 7. Others (specify)_____
9. How long have you been working as a staff of this University? (specify the year) _____
10. What is your category? 1. Technical Staff 2. Administrative Staff
11. For Technical staff
    1. Technologist 2. Driver 3. Gardener 4. Others specify _____
12. For Administrative staff
    1. Administrative officers 2. Executive officers 3. Securities 4. Typist
    5. Clerical officers 6. Messengers 7. Others specify _____
13. Are you registered with NHIS in Nigeria? 1. Yes ( ) 2. No ( )
14. If no, why are you not registered? _____

_____

15. If yes, have you started using NHIS services? 1. Yes ( ) 2. No ( )
16. If no, why have you not started using NHIS services? _____

_____

SECTION B: ATTITUDES OF UNIVERSITY WORKERS ON NHIS

(Tick (√) Agree, Disagree or Not Sure about the following statements

S/N	Indicators	Agree	Disagree	Not Sure

17.	I make use of NHIS services regularly?			
18.	I visit NHIS facility (hospital) for regular medical checkup?			
19.	I don't hold my registration card regularly?			
20.	I registered my spouse and children under NHIS services			
21.	I allow my spouse and children to use NHIS facility			
22.	I access NHIS services when I do not have enough money			
23.	I only visit NHIS hospital when my children are sick			
24.	Going to other hospitals is better than using NHIS clinic/hospital			
25.	NHIS services are not relevant in the university environment			
26.	Accessing NHIS facility is a waste of time and resources			

Total Score	
Score Obtained	
Code	

SECTION C: EXPERIENCES OF UNIVERSITY WORKERS ON NHIS

27. Have you benefitted from this scheme? 1. Yes ( ) 2. No ( )

28. During your last visit to your NHIS hospital did the doctor allow you to finish your complaints before making his/her diagnosis? 1. Yes ( ) 2. No ( )

29. During your last visit did you get all the prescribed drugs? 1. Yes ( ) 2. No ( )

30. If no which drugs/injection/service were you not given? _____

31. At the pharmacy, did the staff explain how you are to take the drugs prescribed?
1. Yes ( ) 2. No ( )

32. How were you received by the health workers the last time you visited your NHIS clinic/hospital?

_____

33. What do you think could be responsible for such reception? _____

34. The last time you visited NHIS clinic/hospital did the staff give you prompt attention?

1. Yes ( ) 2. No ( )

35. Have you ever been denied of any health service(s) since you registered under the scheme?

1. Yes ( ) 2. No ( )

36. If yes why? _____

37. Will you continue to be using NHIS services? 1. Yes ( ) 2. No ( )

38. If yes why? _____

39. If no why? _____

SECTION D: FACTORS ASSOCIATED WITH UTILISATION OF NHIS

S/N	Statement	Yes	No
40.	Adequate information about the scheme		
41.	Affiliation with good hospitals/clinics		
42.	Proximity to affiliated hospitals/clinics		
43.	Availability of skillful health personnel		
44.	Attention given to the patients by the health workers		
45.	Cost affordability		
46.	Prompt response of the health workers		
47.	Quick registration process		

48. What do you think can prevent workers from adopting NHIS services?

_____

SECTION E: LEVEL OF SATISFACTION OF UNIVERSITY WORKERS ON NHIS

Rate the following services based on Agree, Disagree or Not Sure

S/N	Statement	Satisfied	Not Satisfied	Neutral
49.	The quality of treatment you received during the last visit to the NHIS hospital was satisfactory			
50.	Courtesy of health workers during the last visit was impressive			

51.	Getting all your prescribed drugs during your last visit was good			
52.	I received adequate answers to the questions I asked during the last visit			
53.	Doctor diagnosis was perfect			
54.	Thoroughness and accuracy of diagnosis was acceptable			
55.	Referral to a specialist when needed			
56.	The hospital meets all your health needs during your last visit?			
57.	The quality of test conducted in the laboratory during your last visit was accurate			

Total Score	
Score Obtained	
Code	

58. If you have an alternative healthcare facility, would you switch to it? 1. Yes ( ) 2. No ( )

HOW NHIS SERVICES CAN BE IMPROVED

59. **Tick Yes or No against the areas you think NHIS services need improvement**

i. Communication among stakeholders 1. Yes ( ) 2. No ( )

ii. Awareness of what NHIS does 1. Yes ( ) 2. No ( )

iii. Registration process 1. Yes ( ) 2. No ( )

iv. More funds should be released for scheme 1. Yes ( ) 2. No ( )

v. It should cover all ailments 1. Yes ( ) 2. No ( )

vi. Children's age limit should be increased 1. Yes ( ) 2. No ( )

vii. More quality drugs should be provided 1. Yes ( ) 2. No ( )

viii. It should be extended to aged parents 1. Yes ( ) 2. No ( )

ix. Retirees should be included 1. Yes ( ) 2. No ( )

x. More personnel should be employed 1. Yes ( ) 2. No ( )

APPENDIX II

KEY INFORMANT INTERVIEW GUIDE

I am a student of the Department of Health Promotion and Education, Faculty of Public Health, University of Ibadan.

I am carrying out a research on the "Experiences and Satisfaction with National Health Insurance Scheme among Non-Teaching Staff of University of Ibadan". Information gathered would be used to design appropriate intervention programme. Participation is voluntary. I would like to take your permission to use tape recorder for proper documentation of our discussions.

Please are you willing to participate in this study? Yes No

If yes continue, if no, thank the respondent and leave

1. Please tell me about yourself. Probe for Age as at last birthday (In years), qualification, number of years in service, position?
2. How do feel when NHIS was introduced? Probe for expectations
3. Have you registered for NHIS? 1.Yes 2. No
4. If yes, how long have you registered for the scheme?
5. If No why, probe for reasons (and then go to q23)
6. How many of your family members are included in the scheme?
7. How often do you visit the hospital you registered with?
8. How often do you hold your registration card when going out?
9. When last did you make use of NHIS facility?
10. What happened to you the last time you visited the hospital? Probe: If he was adequately attended to.
11. Are your spouse and children visiting your NHIS hospital? Probe for last time they visited the hospital/clinic
12. How many time(s) have you or the person close to you ever been denied of any health service(s) when accessing NHIS facility?
13. What is your view on drugs and equipment stocked in approved NHIS clinics/hospitals?

14. What can you say about the healthcare services rendered by the scheme?
15. How often do you encourage workers under your supervision to register with the scheme?
16. What are the factors that can make workers to register for NHIS?
17. What are the benefits you or the person close to you personally derived in utilizing NHIS facilities? Probe for the - 5% monthly contribution and 10% cost of drug
18. Can you say the monthly contribution should be increased?
19. What are the disadvantages of utilising NHIS facilities?
20. What is the level of health satisfaction that your dependants derived from the scheme?
21. How often does your request been granted by NHIS staff?
22. How satisfied are you about the scheme?
23. What do you think government can do to improve services rendered by NHIS?
24. How can NHIS staff improve their quality of service?
25. What can NHIS staff do to ensure all Federal Government workers are registered with the scheme?

Thanks you for the time spent with me

APPENDIX III

INFORMED CONSENT FORM

Title of Research: Experiences and Satisfaction with National Health Insurance Scheme among Non-teaching Staff in College of Medicine, University of Ibadan.
Name of Researcher: Olalere Akinfenwa Adebimpe
Purpose of Research: To investigate the experiences and level of satisfaction of with National Health Insurance Scheme among Non-teaching Staff of College of Medicine, University of Ibadan**.**
Procedure of the Research: A 5-section questionnaire will be administrated and filled by each participant.
Expected duration of research participant's involvement: An average of 15minutes will be required to fill the questionnaire.
Risks: There are no risks involved in participating in this study.
Costs to the participants, if any, of joining the research: There is no cost implications involved in this study by the participant.
Benefits: This study will help in identifying the experiences and level of satisfaction with National Health Insurance Scheme among the staff which will serve as baseline information for designing and implementing relevant programmes that will help to improve the quality of service.
Confidentiality: All information collected in this study will be given study numbers, no name will be recorded. This cannot be linked to you in any way and your name or any identifier will not be used in any publication or reports from this study.
Voluntariness: Your participation in this research is entirely voluntary.
Due Inducement: You will not be paid any dues/fees for participating in this study.
Consequences of participant's withdrawal from research: You can choose to withdraw at any time from the research. Please note that some of the information obtained from you before withdrawal may have been modified or used in reports and publications.
Outcome of research: The researchers will publish outcomes of this study in relevant bulletins and journals.

Statement of person obtaining informed consent:
I have fully explained this research to _____and have given sufficient information, including about risks and benefits, to make an informed decision.
DATE: _____SIGNATURE: _____
NAME: _____
Statement of person giving consent:
I have read the description of the research. I understand that my participation is voluntary. I know enough about the purpose, methods, risks and benefits of the research study to judge that I want to take part in it. I understand that I may freely stop being part of this study at any time. I have received a copy of this consent form and additional information sheet to keep for myself.

DATE: _____ SIGNATURE: _____

NAME: _____

WITNESS' SIGNATURE (if applicable): _____

WITNESS' SIGNATURE (if applicable): _____

This research has been approved by the Ethics committee of the University of Ibadan and the chairman of this committee can be contacted at Biode Building, Room T10, 2nd floor, Institute for Advanced Medical Research and Training, College of Medicine, University of Ibadan, Telephone: 08032397993, E-mail: uiuchirc@yahoo.com. In addition, if you have any question about your participation in this research, you can contact the researcher, Olalere Akinfenwa, Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, Telephone; 08038532020, E-mail: adebimpeakin@yahoo.com.

PLEASE KEEP A COPY OF THE SIGNED INFORMED CONSENT.

APPENDIX IV

ETHICAL APPROVAL

INSTITUTE FOR ADVANCED MEDICAL RESEARCH AND TRAINING (IAMRAT)
COLLEGE OF MEDICINE, UNIVERSITY OF IBADAN. IBADAN, NIGERIA.
Director: Prof. A. Ogunniyi, B.Sc(Hons), MBChB, FMCP, FWACP, FRCP (Edin), FRCP (Lond)
Tel: 08023038583, 08038094173
E-mail: aogunniyi@comui.edu.ng

UI/UCH EC Registration Number: **NHREC/05/01/2008a**

NOTICE OF EXPEDITED REVIEW AND APPROVAL

Re: Experiences and Satisfaction with National Health Insurance Scheme among Non-Teaching Staff of College of Medicine, University of Ibadan, Ibadan, Nigeria

UI/UCH Ethics Committee assigned number: UI/EC/12/0276

Name of Principal Investigator: **Akinfenwa A. Olalere**

Address of Principal Investigator: Department of Health Promotion & Education, College of Medicine, University of Ibadan, Ibadan

Date of receipt of valid application: 23/08/2012

Date of meeting when final determination on ethical approval was made: **N/A**

This is to inform you that the research described in the submitted protocol and other participant information materials have been reviewed and *given expedited approval by the UI/UCH Ethics Committee.*

This approval dates from 20/12/2012 to 19/12/2013. If there is delay in starting the research, please inform the UI/UCH Ethics Committee so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. *All informed consent forms used in this study must carry the* UI/UCH EC *assigned number and duration of* UI/UCH EC *approval of the study.* It is expected that you submit your annual report as well as an annual request for the project renewal to the UI/UCH EC early in order to obtain renewal of your approval to avoid disruption of your research.

The National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the UI/UCH EC. *No changes are permitted in the research without prior approval by the* UI/UCH EC *except in circumstances outlined in the Code. The* UI/UCH EC *reserves the right to conduct compliance visit to your research site without previous notification.*

20 DEC 2012
APPROVED
COLLEGE OF MEDICINE, U.I.

Professor A. Ogunniyi
Director, IAMRAT
Chairman, UI/UCH Ethics Committee
E-mail: uiuchirc@yahoo.com