LIST OF ABBREVIATION AND ACRONYM

BOTs	Board of Trustees
CAQDAC	Computer-Aided Qualitative Data Analysis
CBHI	Based Health Insurance
CBHIP	Community Based Health Insurance Programme
CBN	Central Bank of Nigeria
CSMBS	Civil Service Medical Benefit Scheme
DRC	Democratic Republic of Congo
EBPHI	Employment-Based private health insurance
ESHI	Employer Sponsored Health Insurance
FERMA	Federal Road Maintenance Agency
FMF	Federal Ministry of Finance
FRSC	Federal Road Safety Corps
FSSHIP	Sector Social Health Insurance Programme
GoR	Government of Rwanda
HCHC	Hygeia Community Health Care
HCP	Health Care Providers
HIF	Health Insurance Fund
HMOs	Health Maintenance Organisations
HSR	Health Sector Reform
IDI	In-Depth Interview
IMF	International Monetary Fund
IMR	Infant Mortality Ratio
ISSHIP	Informal Sector Social Health Insurance Programme
KII	Key Informant Interview

LAUTECH	Ladoke Akintola University of Technology
LFN	Law of the Federation of Nigeria
LGAs	Local Government Areas
LMICs	Low-and–Middle-Income-Countries
LOS	Log Ordinary Least
MHA	Mutual Health Association
MMR	Maternal Mortality Ratio
NCH	National Council on Health
NCMS	New Cooperative Medical Scheme
NHIP	National Health Insurance Policy
NHS	National Health Service
NHIS	National Health Insurance Scheme
NPC	National Population Commission
NSDC	Nigerian Security and Civil Defence Corps
NTA	Nigerian Television Authority
OECD	Organisation for Economic Cooperation and Development
OOP	Out-of-Pocket
PHC	Primary Health Care
PHI	Private Health Insurance
PPACA	Patient Protection and Affordable Care Act
PSHI	Public Sponsored Health Insurance
SAPs	Structural Adjustment Policies
SES	Social-economic status
SHI	Social Health Insurance
SPSS	Statistical Package for Social Sciences

SSS	Social Security Scheme
TETFUND	Tertiary Education Trust Fund
TISHIP	Tertiary Institution Social Health Insurance Programme
UCH	University College Hospital
UCS	Universal Coverage Scheme
UHC	Universal Health Coverage
UK	United Kingdom
UNICEF	United Nation Children Education Funds
UNISA	University of South Africa
US	United State
VCSHIP	Voluntary Contributors Social Health Insurance Programmes
VGSHIP	Vulnerable Group Social Health Insurance Programme
WHO	World Health Organisation
WTP	Willingness to Pay

ABSTRACT

Given the general poor state of health care and the devastating effect of user fee, the National Health Insurance Scheme (NHIS) was instituted as a health financing policy with the main purpose to ensure universal access for all Nigerians. However, since NHIS became operational in 2005, only members of scheme are able to access health care both in the public and in private sectors, representing about 3% of Nigerian population. The thesis therefore examines the design and implementation policy of NHIS in Oyo state, Nigeria. Key design issues conceptual framework guides the analysis of data. The framework identifies three health interrelated financing functions namely revenue collection, risk pooling and purchasing. Data was collected from the NHIS officials, employees of the Health Maintenance Organisations (HMOs) and the Health Care Providers (HCPs) using key informant interview. In addition, in-depth interview and semi structure questionnaire were used to gather data from the enrolees and the non-enrolees. Empirical findings show that NHIS is fragmented given the existence of several programmes. In addition, there is no risk pooling neither redistribution of funds in the scheme. Revenue generated through contributions from the enrolees was not sufficient to fund health care services received by the beneficiaries because of the small percentage of the Nigerian population that the scheme covers. Further findings indicate that enrolled federal civil servants have not commenced monthly contribution to the NHIS. They pay 10% as co-pay in every consultation while federal government as an employer subsidised by 90%. Majority (76.8%) of the respondents agreed that they were financially protected from catastrophic spending. However, the overall benefit package was rated moderate because of exclusion of some priority and essential health care needs. Although above half (57%) of the respondents concurred that HMOs are accessible, in the overall, (47.6%) of the respondents were not satisfied with their services. In the case of the HCPs, majority (61.9%) of the respondents claimed that there is no excessive waiting time for consultation. Furthermore, (64.3%) rated their interpersonal relationship with the HCPs to be good. However, more than half of the respondents (54%) disagreed on availability of prescribed drugs in NHIS accredited health facilities. For the non-enrolees, findings show that most of the respondents (72.9%) were willing to enrol, but significant proportion (47.5%) indicated financial constraint as impediment to enrolment.

Key word: Social Policy, Structural Adjustment Policies, Health Sector Reform, Health Financing policy, Out-of-Pocket Payment, Social Health Insurance, National Health Insurance Scheme, Fragmentation, Nigeria.

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CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Health financing policy reform has been a major concern that is gaining prominence in the international health policy debate. It is a mechanism of providing financial solution to the challenges of health care costs caused by slow economic growth rate, which in turn resulted in inadequate financing of health care and uneven distribution of health services. Financing policy reform in the health sector involves a range of financing model, such as, tax finance system, Social Health Insurance (SHI) and Out-of-Pocket (OOP) payments etc., with the aim of increasing revenue to the sector. However, in recent time, SHI is at the centre stage of global health policy discourse as a means of generating adequate revenue (both from taxation and contribution) to finance health care (Hsiao and James, 2007). Many countries in the Organisation for Economic Cooperation and Development (OECD) have attained universal coverage via SHI (Barnighausen and Sauerborn, 2002). Besides, SHI has also been introduced in the Low Medium Income Countries (LMICs), to replace OOP payments, which for a long time remained as the main source of financing health care (Hsiao and Shaw, 2007).

The recent shift in the health financing debates towards SHI as a model that could offer households financial protection from the burden of healthcare costs became essential in the developing countries due to the collapse of tax-funded universal health care system and the devastating effects of OOP payments (Akin, et al., 1987; Mohindra, 2008). SHI has continued to gain recognition as one of the effective ways to protect households from financial burden of health care costs (World Health Organisation (WHO), 2005, 2013; Ataguba, 2016). For example, the WHO, a leading advocate for Universal Health Coverage (UHC), encourages the adoption of SHI as a cost-effective model to achieve universalisation of health care (WHO, 2005; McIntyre, et al., 2005). The WHO defines UHC as "ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship" (https://www.who.int/healthsystems/universal_health_coverage/en/).

In 2005, the World Health Assembly at its 58th congress adopted a resolution inspiring its member states to move towards UHC (WHO, 2005). Besides, in 2010, the WHO focused on prepayment initiative and risk pooling as the strategy to achieve the goal of UHC (WHO, 2010). Most countries in the OECD including Germany, Japan, Belgium and Costa Rica among others. have expanded and universalised health coverage through SHI (Carrin and James, 2004; Hsiao and James, 2007). Furthermore, a considerable number of countries in Africa, Asia and Latin America have also committed to achieving the goal of universalism of health care by engaging in political, legislative and technical debate on the inclusion of SHI as a financing policy in the attainment the universal access. For example, Ghana, Thailand and Colombia have steadily improved their health coverage to about 50%, 95% and 75% respectively, through the establishment of SHI (National Health Insurance Authority, 2010; La Forgia and Nagpal, 2012; Vargas-Zea, et al., 2012; Dutta and Hongoro, 2013). However, improving population coverage in other countries such as Nigeria and Dominican Republic among others remains a challenge, with about 3% and 10% coverage respectively (Barnighausen and Sauerborn, 2002; Odeyemi and Nixon, 2013).

Historically, the principle of development underpinned the Nigerian state in the immediate post-independence as social services provision was seen not just as a response to social ill but also as a driver of productivity and social cohesion (Adesina, 2007a). The fundamental normative components inherent in welfare state underpins the nationalist ideology. These include first, that individual well-being is a collective responsibility, meaning that the individual is not solely responsible for taking care of himself or herself, but rather being taken care of is a social right. Second, a normative commitment to promote public well-being should consider the entire population, not just a particular group or sub-section. Third, social provision must represent a sense of collective responsibility. Fourth, social service practices or activities must be congruent with the normative orientation of promoting the benefit of the whole population. Finally, the "social" must be autonomous from political or economic consideration–in other words given that social provisions are based on "social right," they must not be subordinated to economic or political considerations (Korpi and Palme, 1998; Kildal and Kuhnle, 2005. Adesina, 2007a).

The Nigerian government provided health care services including preventive and curative care for her citizens through general taxation. Universalization of social services was primarily the responsibility of the government, health and other basic social services like education were

seen as issues of social welfare rather than consumable goods and therefore health expenditure as a percentage of federal government expenditure was on an average of 3.5% in the 1970s (World Development Report, 1980). Besides, social services were seen as a complement to economic growth (Adesina, 2007a; Obono, 2007). Furthermore, social justice and equity was part of the national policy framework as people had access to these services not based on ability to pay, but rather on needs (Adesina, 2007b). However, in the post 1980s public health expenditure and other social services plummeted due to dwindling economic growth rate, cut in social spending, political instability and the introduction of Structural Adjustment Programmes (SAPs) which de-emphasised spending on health and other basic social services (Adesina, 2007a). Because of the inadequate public spending on health care, the WHO (2005) noted that many sub-Saharan African countries including Nigeria spend less than the recommended annual limit of $34 per capita on health services. These brought about poor socio-economic indices such as high infant and maternal mortality rate and low life expectancy. For instance, in Nigeria, health expenditure from federal government allocation reduced drastically from an average of 3.5% in the 1970s to less than 2% between 1980-90s, resulting in shortage of essential drugs and other medical supplies (Federal Ministry of Health, 1988).

The decline in the economic activity of the 1980s compelled Nigerian government to adopt the devastating neoliberal policy championed by International Monetary Fund (IMF) and World Bank economic recovery policy known as SAPs. The main elements of SAPs were neoliberal features including anti statist ideology, promotion of private sector and free market culture, reducing public spending on social services and opposition to publicly funded health system. Ideologically, neoliberalism embodies individualism and the primacy of the market with the notion of commodification of social services. Thus, public sector user charges policy was introduced to improve social funding and substitute poor budgetary provision to the health sector due to the following premises: first, it would generate and improve the quality of health services. Second, the policy would prevent unnecessary health services utilisation and adherence to referral systems. Third, health care provider would be more responsive to patients and provide quality care when patients make OOP payments for services. Lastly, user fees policy would stimulate fairness among the people (Akin, et al., 1987; McIntyre, et al., 2005; Adesina, 2007b). Furthermore, privatisation and liberalisation took the central stage of the economy, and thus affected the social services provision. For example, health care was subject to market forces and treated as a normal commodity rather than one based on equity, fairness and social justice. The country witnessed astronomical growth rate of private hospitals charging

exorbitant fees for health services. The results of SAPs were however devastating as many studies revealed that social indicators such as education, health care and life expectancy drastically declined rather than improve. The effect of SAPs was also notable by de-industrialisation and neglect of the nationalist development objectives (Adesina, 2007b; Obono, 2007; Shivji, 2009).

Consequently, overwhelming evidence highlights that user charges or OOP payment did not provide enough revenue to offset the decline in public funding for health care but rather worsened the decline in the funding of health care (Adesina, 2007a; Obono, 2007). This is because direct purchase of health care was difficult for many individuals and households and thus did not improve the health sector funding. Subsequently, the risk pooling through prepayment and mutual support mechanism was considered an alternative strategy to finance health care (Ogunbekun, et al., 1999; National Demographic and Health Survey (NDHS), 2003; Bodenheimer and Grumback, 2005; Save the Children, 2008; WHO, 2010).

Health insurance could be private, government or a mix of government and private financed. In the private health insurance, transaction requires the payment of a premium or contribution by an individual or private employer to an insurance organisation and a refund from the organisation to the provider. The government-financed health insurance is a single tax-financed health insurance system where the government takes sole responsibility of financing health care through taxation. The mixture of public and private financed model is a combination of tax funded and mandatory contributions from individuals, employers and employees of varying population groups to finance health care. SHI is a model of financing health care by both state and private as mentioned above. In the SHI model, members of the society are categorised and accommodated into different insurance plans irrespective of their socio-economic status, funding is provided through membership contribution and taxation to support certain income groups and exempt the low income and poor population group who cannot afford to make contributions (Carrin and James, 2004). This model has attained high level of universalisation of coverage both in the developed and in some developing countries.

Over the past decades, the developed countries such as Germany, Canada, UK and Japan among others have instituted social insurance programs namely accident, retirement, disability, unemployment and medical care (Bodenheimer and Grumbach, 2005; Macgregor, 2014). These countries have demonstrated largely state involvement in the management of health care

in the form of statutory health insurance, financed by tax revenue or a mixture of tax and contributory system with little support from private insurance thereby providing universal coverage for their populations. For example, Germany finances health care through a merger of social insurance and public financing model such that no distinction existed between employed individuals who contributed to their health insurance scheme and unemployed people whose contributions are made by the government. The German government ensures that there is no disparity in accessing health care by making sure funds is available in the sick funds to take care of the poor and the sick. Ninety per cent of the German population belongs to the mandatory sickness fund, 8% opts for private insurance, 2% receives medical services as members of the military and the allied services, and less than 0.2% has no coverage (File and Murray, 1995; Busse, 2004; Busse and Riesberg 2004).

Furthermore, Canadian government operates a tax-financed single-payer health system and all Canadians receive the same health insurance irrespective of individual social economic status. For instance, changing, quitting or retiring from a job has nothing to do with health insurance system in Canada. The Canadian health care system is so unique that UHC programme has designed a fairer system for distributing health care services. The government does not allow private insurance companies to market health insurance for services covered by provincial health plans in order to avoid preferential treatment (Bodenheimer and Grumback, 2005; Busse, 2004). Furthermore, health care in the United Kingdom (UK) is largely 'free of charge' at the point of use within the context of the National Health Service (NHS). A tax-based health care system provides UHC to a large percentage of the population. Funding includes direct and indirect taxes and contributions from the insured with supplement from free market of private health insurance (PHI). Largely, UK has low level of health care expenditures due to the institution of the governmental single payer system to limit budgets and mode of reimbursement of health care providers (Boyle, 2011; Adeyemi and Nixon, 2013).

Japan has several insurance plans with different categories like Germany's mandatory employment-based social insurance for workers. First, every employer of 700 employees and above are required to operate self-insured health plan for their employees and their dependants in a plan called the society-managed insurance plans–and this covers 23.7% of Japanese population. Second, employers of less than 700 employees enrolled in a single national health insurance program for small businesses operated by the national government and it covers 37.9% of the population. The third category of health insurance called citizens health insurance

plan covers self-employed and retirees, which made up of about 39.8% of the population. Another type, which is the fourth category, exists for government employees or civil servant and it covers 7.4% of the population. The fifth and final category of health insurance plan in Japan covers the physically challenged and institutional services. This category protects 1.2% of the population and it is financed by tax system and newly earmarked income tax. The entire health insurance plans in Japan are mandated to provide comprehensive benefits such as payment for hospital services, medications, maternity and dental care (Ikegami and Campbell, 2004; Ikegami, 2009; Jones, 2009).

Many developing countries are also driving towards the policy of universal coverage with substantial progress made. For instance, the Ghanaian NHIS is funded by a 2.5% National Health Insurance tax on selected goods and services, a 2.5% Social Security and National Insurance Trust fund from the government workers, premium from the informal sector workers and government budget allocations. However, some categories of people are relieved of paying premium in Ghana health insurance policy, these include children who are less than 18 years with at least one parent paying contribution; or covered by exception, as well as pregnant women, pensioners, aged and the indigents who could not afford the premiums.

The Ghanaian NHIS essentially combined SHI for formal sector employees and Community Based Health Insurance (CBHI) scheme for the informal sector to meet the policy goal of UHC with almost half of the population covered (Ghana NHIS, 2010; Dalaba, et al., 2012; Debpuur, et al., 2015). Similarly, the GoR began a dramatic reform of its health care system in1999, and by the year 2000, the country was committed to universal coverage using CBHIP called *Mutuelles de sante* as the main component of the national strategic plan to attain UHC (Rwanda Ministry of Health, 2010). While other SHI programmes such as the Military Medical Scheme and La Rwandaise d'Assurance Maladie were available, they only cover insignificant proportion of Rwanda population. However, to ensure universal coverage, several laws were promulgated including the Rwanda CBHI Policy in 2010 that made provisions for Rwandan residents to enrol in health insurance plan that provides quality care (Rwanda Ministry of Health, 2010). The CBHI scheme took the central stage of Rwanda strategic health plan in achieving universal coverage because it covers majority (90%) of the population while other health plans cover 5.4% of the population. The laudable achievement of high universal coverage in Rwanda through community insurance scheme was contingent on a number of funding such as 45% revenue from other sources such as tax revenue, external funding, other

insurance plans etc. and 55% revenue from contributions (Rwanda MoH, 2010; Nyandekwe, et al., 2014).

Furthermore, in mapping a path towards universal coverage in Thailand, the Thai government merged a wide range of health insurance plans to three that covers the entire population. The three health insurance plans include (1) Civil Service Medical Benefit Scheme (CSMBS) that covers government employees as well as retirees and their dependants. (2) Social Security Scheme (SSS) for private sector employees excluding dependants. (3) Universal Coverage Scheme (UCS for population not covered by CSMBS and SSS. The CSMBS is financed by general taxation and it covers 9% of the Thai population, SSS is financed by payroll deduction – tripartite contribution of 1.5% of salary from government, employer and employee and it covers 16% of the population. Moreover, the UCS is financed by general tax and it covers 75% of the population (Dutta and Hongoro, 2013). However, not much has been achieved in terms of universal coverage in Nigeria despite the fact that several health insurance programmes are in place such as formal sector, informal sector, voluntary individual, vulnerable group social insurance programmes etc. According to NHIS, only 3% of the population has been covered and benefited from the programmes (NHIS, 2011).

It is widely acknowledged that many developing countries have implemented different forms of SHI programmes, attaining different levels of coverage depending on the pace and stage of implementations. For example, Ghana, Rwanda, Thailand, Colombia and China have made significant progress towards achieving universal coverage. On the other hand, Nigeria, Dominican Republic and India among others have not achieved much in terms of population coverage. Achieving universal coverage has been very challenging in most developing countries especially with the way their health financing policy is organised and implemented. Therefore, this study investigates the institutional design and implementation policy of NHIS in Oyo State, Nigeria.

1.2 Statement of Problem

SHI has been at the forefront of health financing policy discourse in global south in recent times as many countries are at different stages of implementation. The stage and pace of implementation varies because of many factors such as legislative, political, economic etc. However, in Nigeria for example, the idea to introduce National Health Insurance (NHI) dates

back to 1962 when the central government was providing health care for all at no direct cost to individuals and households because health care and other social services were financed by general taxation. Therefore, the idea was halted because there was no reason for health insurance at the time, health services was readily available at government clinics and hospitals across the country. In this respect, the nationalist ideology was premised on a symbiotic relationship between social services and economic development. Therefore, government was investing heavily in social services including education and health to enhance human capacity, and thus increase economic growth and development. However, the idea re-emerged in 1984 due to the decreasing public expenditure on social services and declining state of health care delivery in the country. This prompted the National Council on Health (NCH) to commission a study on the feasibility of NHI in Nigeria. In 1988, however, NCH constituted a committee on the viability of the proposed NHI. The report of the committee was submitted to the Federal Ministry of Health and encouraged the government to start the NHIS in 1992 with a recommended template (www.oauife.edu.ng/.../NATIONAL-HEALTH-INSURAQNCE-SCHEME-IN-NIGERIA). The NCH endorsed rebranding of the scheme to accommodate private sector participation (NHIS, 2006). This idea brought about the introduction of Health Maintenance Organisation (HMOs) as financial manager of the scheme. Thereafter, the NHIS was finally unveiled in May 1999 by the military decree 35 (Awosika, 2005; NHIS, 2006).

In 2005, a segment of the programme for the formal sector was unveiled with the presidential directive given to NHIS to ensure no less than 30% of Nigerians are covered by the year 2015 and 70% by 2020. Furthermore, in 2016, President Mohammadu Buhari reiterated government commitment to ensure all Nigerians have access to health care, and thus mandated the scheme to ensure efficiency and protection from political patronage (This Day News, 2014; Health Reporters, 2016). After its institution in 1999, NHIS was set to achieve the following objectives: (1) "to ensure every Nigerian has access to good healthcare services" (NHIS Act, 2004: 5). (2) "Protect families from the financial hardship of huge medical bills" (NHIS Act, 2004: 5). (3) "Limit the rise in the cost of healthcare services" (NHIS Act, 2004: 5). (4) "Ensure equitable distribution of healthcare costs among different income groups" (NHIS Act, 2004: 5). (5) "Maintain high standard of healthcare delivery services within the scheme" (NHIS Act, 2004: 5). (6) "Ensure efficiency in healthcare services" (NHIS Act, 2004: 5). (7) "Improve and harness private sector participation in the provision of healthcare services" (NHIS Act, 2004: 5). (8) "Ensure adequate distribution of health facilities within the Federation" (NHIS Act, 2004: 5). (9) "Ensure equitable patronage of all levels of healthcare" (NHIS Act, 2004: 5). (10)

"Ensure the availability of funds to the health sector for improved services" (NHIS Act, 2004: 5).

To achieve the aforementioned objectives, NHIS operates in the form of SHI scheme to cover the Nigerian population. The scheme operates three main programmes to ensure the realisation of its objectives. These include the Formal Sector Social Health Insurance Programme (FSSHIP), Informal Sector Social Health Insurance Programme (ISSHIP) and Vulnerable Group Social Health Insurance Programme (VGSHIP). The establishment of the scheme is to expedite fair financing of healthcare costs through pooling of funds and prudent use of resources to provide financial risk protection for people through prepayment mechanisms before falling ill (NHIS, 2012).

Despite political and technical commitments to the scheme, NHIS has been lagging since its inception concerning the realisation of its set objectives and overall goal of universal access to health care. Only members of the scheme are able to access health care services in both the public and private sectors. Although studies have shown that federal government employees, employees of the private organisations, voluntary individuals etc. have joined the scheme, there is no accurate record of the total number of people covered in the scheme. It is estimated that about 5million Nigerians including 75% public employees and 25% private sector employees were insured (NHIS, 2011; Osuchukwu, et al., 2013; Health Reporters, 2016). Thus, achieving NHIS goal has been very challenging owing to the low patronage.

There are several studies on the impact of NHIS on health care in Nigeria. For example, a substantial amount of research has identified challenges facing NHIS in Nigeria (e.g. Nnabuchi, 2009; Oyendibe, et al., 2012; Onoka, et al., 2013; Odeyemi and Nixon 2013; Odeyemi, 2013; Ilesanmi and Ige, 2013). In addition, research has shown that NHIS provides reliefs from cost burden incurred through OOP payment (e.g., NHIS, 2012; Onyedibe, et al., 2012; Odeyemi, 2013). All these studies have broadened our understanding on the impact of NHIS on the Nigerian health care. However, there have been contradictions between NHIS stated objectives and actual implementation. The gap between the objectives and outcomes have shown policy fragmentation and loss of cohesion among programmes and players in the scheme, which in turn resulted in weak implementation of NHIS. It is therefore important to assess the institutional design and implementation policy of NHIS and its effects in achieving equitable and efficient financial and health benefits and the overall goal of universal coverage in Nigeria.

1.3 Research Objectives

The broad objective of this thesis is to assess the design and implementation policy of NHIS in Oyo State Nigeria, while the specific objectives are to:

1. Examine the structure and functions of NHIS in Oyo state.
2. Examine the mechanisms adopted by NHIS to meet universal coverage objectives in Oyo state.
3. Identify challenges inhibiting the achievement of the set objectives in Oyo state.
4. Assess the extent of equity in terms of financial contribution and health benefits among enrolees in Oyo state.
5. Determine the extent of availability and accessibility of services of the HMOs and health providers in the NHIS in Oyo state.
6. Examine the knowledge, attitudes and perceptions of non-enrolees about the scheme Oyo state.

1.4 Research Questions

The research study provides answers to some questions on NHIS' design and implementation. These include:

1. What is the structure and functions of NHIS in Oyo state?
2. What are the mechanisms adopted by NHIS to meet universal coverage objectives in Oyo state?
3. What are the challenges inhibiting the achievement of the set objectives in Oyo state?
4. What is the extent of equity in terms of financial contribution and health benefits among enrolees in Oyo state?
5. What is the extent of availability and accessibility of services of the HMOs and health providers in Oyo state?
6. What is the knowledge, attitudes and perceptions of non-enrolees about the NHIS in Oyo state?

1.5 Significance of the study

Design and implementation is very crucial in the redistributive process of any social policy in order to achieve a democratic and egalitarian objective. This is because realising promised outcomes in a poorly designed and implemented policy will be elusive. The debate about social health insurance is pertinent not only for the development towards the achievement of universal coverage in Nigeria but also for the development of universal coverage as an essential global health idea. Thus, this thesis provides an empirical analysis of the design and implementation policy employed by NHIS to meet the target objective of universal access. The thesis also provides information on financing and benefits of NHIS programmes, knowledge, attitudes and perceptions of the public about the scheme. Knowledge about the design and implementation of the scheme will be useful not only in policy making of the Nigerian government for the improvement of NHIS but also for other countries who are experiencing similar challenges of scaling up population coverage. Given the presidential mandate to provide coverage for no less than 30% of Nigerians by 2015, and the current administration efforts to ensure efficiency and the achievement of universal coverage, this thesis highlights the strategies required for scaling-up the NHIS and the achievement of universal coverage in Nigeria. The thesis emphasises the principle of redistributive health care as a mechanism for the achievement of universal access, and seek to advance knowledge in health financing policy literature.

Furthermore, the outcome of this research will be useful in establishing appropriate institutions to support and pave way for the achievement of universal health coverage in Nigeria. Policy formulation on the proper way of achieving health insurance coverage, implementing policy and accompanying programmes for a viable NHIS will positively contribute not only to solvingthe burden of households health expenditures, but also improve human capital, labour productivity, social cohesion and economic growth.

The scope of the study includes the three main urban areas of the state namely Ibadan, Oyo and Ogbomoso. In addition, three local government areas (LGAs) namely Iseyin, Surulere and Ibadan southeast were selected. Specifically in Ibadan, the following unit of study were selected: NHIS enrolees from public and private enterprises, NHIS officials, HMOs' employees and NHIS accredited health providers. In Oyo, NHIS enrolees were selected from public and private institutions. Similarly, in Ogbomoso, NHIS enrolees were selected from public and private institutions.

1.6 Thesis Structure

The thesis is presented in nine chapters. The current chapter presents background information to the thesis, outlines statement of problem, research questions and objectives. The chapter also points out that the thesis has the potential to add to knowledge on health financing policy literature. It also discusses the scope and delimitation of study.

Chapter 2 examines the historical development of NHIS in Nigeria. It also assesses the law and policies of the Federal Republic of Nigeria as it relates to the establishment of NHIS. In addition, the chapter discusses the operational guidelines of the scheme in relation to programmes, standards and accreditations, records and information, offences penalties and legal proceedings.

Chapter 3 reviews existing literature on health care reform. Specifically, we review the literature on the following themes, namely health sector reform, structural adjustment policies, risk sharing model, national health insurance policy, health financing policies in Nigeria and NHI in Nigeria. The chapter underscores health sector reform as a global health policy agenda with emphasis on overhauling of health system to bring about efficiency and equity putting into consideration values and culture that underpins various reforms in every country. For the developing countries; however, health sector reform implies dismantling the public health care system by reducing public spending on health, liberalising the health sector and expanding private participation. This idea resulted in structural adjustment policies with neo-liberal orthodoxy such as introduction of user fees in public health care system and risk sharing model as a viable alternative because of the failure of user fee to generate funding as proposed by the international financial institutions. The chapter appraises the trajectory of health financing in Nigeria putting into consideration tax funded health care system in the immediate post-independence, user fee or out-of-pocket payment initiated by the structural adjustment policy of the 1980s and the introduction of social health insurance as an alternative health care financing model in Nigeria. The chapter also presents a conceptual framework for the study.

Chapter 4 discusses research methodology used in this study, such as the description of the research design, study area, study population, sampling techniques, research instruments, pilot study, reliability and validity of the instruments, methods of data collection and data analysis, and research ethics. Specifically for the research instrument, key informant interview was used

to gather information from NHIS officials, employees of the HMOs, Health Care Providers (HCPs). In-depth interview and semi-structured questionnaires were used to elicit information from enrolees and non-enrolees.

Chapter 5 discusses the institutional framework of NHIS in relation to the set objective of universal access. Using the three interrelated health financing functions of the conceptual framework namely revenue collection, risk pooling and purchasing/provision, the chapter presents results of the key informant interview with the stakeholders namely NHIS officials, HMOs' employees and HCPs.

Chapter 6 presents the socio-demographic characteristics of the respondents. These include gender, age, marital status, education, religion, income, occupation and ethnicity. It analyses respondents' method of financial contribution, financial protection against catastrophic spending and heath care package.

Chapter 7 explores the quality of services of the HMOs and HCPs. Specifically, the analysis covers respondents' views on accessibility to HMOs, services of the HMOs and overall satisfaction with the HMOs. In addition, on HCPs, the analysis covers respondents' views on waiting time, availability of drugs, interpersonal relationship and overall rating of the services.

Chapter 8 explores knowledge, attitudes and perceptions of the enrolees about the NHIS. The analysis covers knowledge about NHIS, sources of knowledge, description of NHIS, willingness to enrol and the influence of social economic status such as education and income on willingness to enrol.

Chapter 9 concludes the chapters. It combines findings from the research and makes valuable suggestions for policy formulation.

CHAPTER TWO

HISTORICAL DEVELOPMENT OF NATIONAL HEALTH INSURANCE SCHEME IN NIGERIA

2.1 Introduction

Chapter 2 presents the historical account of the emergence of NHIS in Nigeria. It traces the historical trajectory of the evolution of NHIS. It also assesses the law and policies of the Federal Republic of Nigeria as it relates to the establishment of NHIS. In addition, the chapter discusses the operational guidelines of the scheme in relation to programmes, standards and accreditations, records and information, penalties for offences under the NHIS Act and legal proceedings.

2.2 Evolution of National Health Insurance Scheme in Nigeria

The first bill for the establishment of a national health insurance in Nigeria dates back to 1962 when the former federal minister of health Dr. Majekodunmi presented a bill to the National Parliament in Lagos for its establishment. The national health insurance was presented to the parliament at the time health care was tax financed and Nigerians health care needs were readily met without charges by government health facilities. Therefore, people did not see any reason to reform the health care system, and thus the bill was abandoned because it did not receive much support in the parliament. The idea re-emerged in the 1980s due to limited government resources to continue the provision of 'free' health care delivery for all. This prompted the National Council on Health led by the former minister of health Admiral Patrick Koshoni to commission a study headed by Prof. Diejomaohon on the idea to establish national health insurance in 1984.The reports of the study found national health insurance feasible and practicable in Nigeria (Awosika, 2005).

In 1989, the former Minister of Health, Prof. Olikoye Ransome-Kuti commissioned a committee chaired by Dr. Emma Umez-Eronini on the feasibility of a national health insurance in Nigeria. The committee came up with the possibility of establishing of a national health insurance, and thus, recommended the template for the establishment of the NHIS. However, the formal launching of the scheme was delayed due to lack of political will by the successive government and inter-professional rivalry among the stakeholders. In 1995, the National Health

Insurance Submit reiterated the need to begin the national health insurance (NHIS, 2006; 2015). The enabling law instituting NHIS as a social security system was promulgated in 1999 under Decree 35 (now Act). However, intermittent activities were carried out from 1999 to 2004. Nevertheless, the launching of the formal sector programme took place in 2005 with the official opening by the former president, Chief Olusegun Obasanjo (Awosika, 2005; NHIS, 2015; (www.oauife.edu.ng/.../NATIONAL-HEALTH-INSURAQNCE-SCHEME-IN-NIGERIA*)*.

2.3 National Health Insurance Scheme Act Cap 42 Laws of the Federation of Nigeria, 2004

The former Head of State General Abdulsalami Alhaji Abubakar signed the National Health Insurance Scheme into law on May 10, 1999 under Decree 35 Laws of the Federation of Nigeria (LFN); presently it is called Act Cap 42 LFN, 2004. The Act is divided into 9 parts and 49 sections. Part I Section I states that:

"There is hereby established a scheme to be known as the National Health Insurance Scheme (in this Act referred to as "the Scheme") for the purpose of providing health insurance which shall entitle insured persons and their dependants the benefit of prescribed good quality and cost effective health services as set out in this Act" (NHIS Act, 2004: 3).

Section 2 focuses on the establishment of the NHIS as a body corporate to provide quality and affordable health care for Nigerians. It also discusses the establishment of the scheme's governing council to include the chair, a representative from the Ministry of Finance, Health and office of the Establishment and Management Services etc. This part also highlights terms of appointment of members of the governing council including tenure of office and conditions for appointment and removal of any members.

Part II highlights the objectives, functions and the powers of the scheme. The objectives of the scheme include:

a) "Ensure that every Nigerian has access to good health care services" (NHIS Act, 2004: 5).
b) "Protect families from the financial hardship of huge medical bills" (NHIS Act, 2004: 5).
c) "Limit the rise in the cost of health care services" (NHIS Act, 2004: 5).

d) “Ensure equitable distribution of health care costs among different income groups” (NHIS Act, 2004: 5).
e) “Maintain high standard of health care delivery services within the Scheme” (NHIS Act, 2004: 5).
f) “Ensure efficiency in health care services” (NHIS Act, 2004: 5).
g) “Improve and harness private sector participation in the provision of health care services” (NHIS Act, 2004: 5).
h) “Ensure adequate distribution of health facilities within the Federation” (NHIS Act, 2004: 5).
i) “Ensure equitable patronage of all levels of health care” (NHIS Act, 2004: 5).
j) ”Ensure the availability of funds to the health sector for improved services” (NHIS Act, 2004: 5).

The functions and responsibilities of the scheme include:

a) “Registering health maintenance organisations and health care providers under the Scheme” (NHIS Act, 2004: 5).
b) “Issuing appropriate guidelines to maintain the viability of the Scheme” (NHIS Act, 2004: 5).
c) “Approving format of contracts proposed by the health maintenance organisations for all health care providers” (NHIS Act, 2004: 5).
d) “Determining, after negotiation, capitation and other payments due to health care providers, by the health maintenance organisations” (NHIS Act, 2004: 5).
e) “Advising the relevant bodies on inter-relationship of the Scheme with other social security services” (NHIS Act, 2004: 5).
f) “The research and statistics of matters relating to the Scheme” (NHIS Act, 2004: 6).
g) “Advising on the continuous improvement of quality of services provided under the Scheme through guidelines issued by the Standard Committee established under section 45 of this Decree” (NHIS Act, 2004: 6).
h) “Determining the remuneration and allowances of all staff of the Scheme” (NHIS Act, 2004: 6).
i) “Exchanging information and data with the National Health Management Information System, Nigerian Social Insurance Trust Fund, the Federal Office of Statistics, the Central Bank of Nigeria, banks and other financial institutions, the Federal Inland

Revenue Service, the State Internal Revenue Services and other relevant bodies" (NHIS Act, 2004: 6).

j) "Doing such other things as are necessary or expedient for achieving the objectives of the Scheme under this Decree" (NHIS Act, 2004: 5).

Section 7 of the provision *inter alia* empowers the council to manage day-to-day activities of the scheme such as to determine its overall policies including the financial and operational procedures and effective implementation of policies.

Part III of the Act discuses appointment of staff members of the scheme including the appointment of the Executive Secretary by the President of the country on the recommendation of the Minister of Health. In addition, the functions and conditions of service of the Executive Secretary were highlighted. This part also explains the responsibility of the council for the appointment of directors and other employees at the scheme. The conditions of service for all employees at the scheme include among others entitlement to pension and gratuity as stated in the pension Act were discussed in Section 10.

Part IV highlights provisions for the management and maintenance of the scheme under the council. These include money received from the HMOs, federal, states and local governments, private organisations and donors among others (Section 11(2)). This Section also highlights the use of the accrue fund for cost of the administration, payment of allowances to members of the council, payment of salaries to the employees and maintenance of property among others (Section 11(3)). Section 14 explains, "The council shall keep proper account of the scheme and appoint an auditor to audit the account in line with the guidelines supplied by the Auditor General of the Federation" (NHIS Act, 2004: 9). Section 15 explains the scheme's exemption from tax.

Part V discusses contributions into the scheme, health care providers' registration and payment mechanisms, and registration of public and private HMOs. Section 16 explains that "an employer who has a minimum number of employees not specified may pay contributions to the scheme as may be determine from time to time" (NHIS Act, 2004: 11). Section 18 details payment mechanism namely capitation and fee-for-service for accredited providers with the approved benefits package. Section 19 highlights the conditions for the accreditation of HMOs; these include that the HMOs must be financially viable before and after registration, have

account in at least a bank approved by the council and insured with insurance company approved by the same council among others. Section 20 emphasises the functions of the HMOs including collection of contributions from the enrolees, payment of providers and ensure that the providers give qualitative care by establishing quality assurance system.

Part VI of the Act emphasises the establishment of zonal health insurance offices in the country and their functions. Section 21 states that "the council shall divide the country into such number of zones as it may, from time to time, determine, and establish in each one, a Zonal Health Insurance Office" (NHIS Act, 2004: 11). Section 21 also explains the responsibilities of the zonal offices including general administration of the scheme, maintaining a register of health care providers and planning for a success of the scheme's implementation among others. Section 23 provides financial provisions relating to the zonal offices. These include grant from the scheme, government and donors. The section also explains that the zonal offices shall use the money at their disposal to run the zones such as payment of salaries and training of members. Section 24 mandates the zones to prepare annual report at the end of each financial year and submit such reports to the council with the audited account.

Part VII is on arbitration and it has two sections. Section 26 states that there shall be States Health Insurance and Federal Capital Territory Arbitration Board with the responsibility to arbitrate between aggrieved parties. Section 27 identifies members of the arbitration board to include:

1) A legal practitioner as the chairperson.
2) A representative of the Nigerian Medical Association in the states and the federal capital territory.
3) A representative of the Nigerian Employer Consultative Association in the states and the federal capital territory.
4) A representative of the Nigerian Labour Congress in the states and the federal capital territory.
5) Two persons to represent the public.

Part VIII states various offences, penalties and legal proceedings. Section 28 identifies offences and penalties such as (1) anyone who fails to pay into the account of the organisation within a given period commits an offence and is liable to a fine of 100,000 naira or 500 *per centum* of the amount of the contribution involved together with the accrue interest or imprisonment. (2)

Employer who deducts contribution from the employees 'wages and refuses to remit the contribution within the specified period is liable to 200,000 naira or *per centum* of the amount contributed including the accrue interest or imprisonment. Section 29-38 identifies various offences and their penalties within the scheme.

Part IX of the Act outlines miscellaneous in Section 39 and 40. Section 39 states that contribution to the scheme shall be inalienable. In other words, contributions to the scheme remains with the scheme and cannot be taken away by any means. Section 40 of the provision states that contribution to the scheme by an employer or employee forms part of the tax-deductible expenses. Section 41-49 discusses aspects of the provision including insurance indemnity for health care providers, transfer of liability in the case of merger or acquisition, contributions from members of the armed forces and the police and guidelines for contributions among others.

The Act empowers NHIS to develop operational guidelines that explain various programmes and the process for implementation. Some provisions of the Act that guide the development of the operational guidelines include Part III section 6(b), 6(g) and 7(f). The provisions state that:

- "The scheme shall be responsible for issuing appropriate guidelines to maintain the viability of the scheme" (NHIS Act, 2004: 5).

- "The scheme shall be responsible for advising on the continuous improvement of quality of services provided under the scheme through guidelines issued by the Standard Committee established under section 45 of this Act" (NHIS Act, 2004: 6).

- "The scheme shall be responsible for set guidelines for effective co-operation with other organisations to promote the objectives of the scheme" (NHIS Act, 2004: 6).

The scheme developed the first operational guidelines in 2006 and reviewed it in 2012. The operational guidelines are a policy document that sets out the operations of the scheme. It is divided into four sections: section one (programmes); section two (standards and accreditation); section three (records and information); and section four (offences, penalties and legal proceedings).

Section one of the operational guidelines discusses a range of programmes of the scheme that covers different segments of the Nigerian population and it is broadly categorised into three. The first one is the FSSHIP that is designed to cover: (1) employees in the public sector such as Federal, States and the Local Governments; (2) workers in the organised private sectors (3) Armed forces, Police and other allied forces; and (4) individual voluntary contributors. Second, ISSHIP is classified into two: CBHIP that takes care of the informal sector workers such as artisans and the rural populace; and TISHIP is designed for students in the higher institutions, such as Colleges of Education, Polytechnics and Universities. (3) The VGSHIP covers vulnerable groups such as the physically challenged, inmates, children under five, pregnant women, refugees and internally displaced persons. Section 2 discusses standards and requirements for accreditation of HMOs, health care facilities, mutual health association, civil society organisation, banks etc. Section 3 provides necessary flow of information among the stakeholders for proper implementation of the scheme. Section 4 emphasises offences, penalties and legal proceedings to ensure compliance with the provisions of the scheme (NHIS, 2006, 2012).

2.3.1 Formal Sector Social Health Insurance Programme

FSSHIP is a social security system designed to cover: (a) employees in the public sector such as Federal, States and the Local Governments; workers in the organised private sectors; (b) Armed Forces, Police and other allied services and (c) voluntary contributors' programme. However, different rules apply to different categories of the programmes concerning contributions and benefits.

(A) Public Sector and Organised Private Sector Employees

The Public Sector includes Federal States and Local Governments employees while organised private sector comprises of private organisations employing ten or more persons. Contribution into the formal sector programmes varies. For the civil servants, the employer contributes 3.25% and the employee contributes 1.75% signifying 5% of the employee's consolidated salary. For other tiers of government and the private sector, the employer contributes 10% and the employee contributes 5% amounting to 15% of the employee's basic salary (NHIS, 2012). Health care of the insured in this programme is paid for from the pooled funds to cover the employee, a spouse and four biological children below 18 years of age. However, coverage extends to more dependants based on additional payments by principal beneficiary. The

Operational Guidelines stipulates a 90-day waiting/processing period before an enrolee can access health services under the scheme. Benefits package is the same for all formal sector programmes. This include out-patient care and in-patient care; prescribed drugs; pharmaceutical care; diagnostic tests; maternity care including ante-natal, delivery and post-natal care of four pregnancies ending in live births; consultation with specialist; eye examination and care excluding contact lenses; dental care with the exception of those contained in the exclusion list. Other benefits include annual medical check-up (NHIS, 2006; 2012).

(B) Members of the Armed forces, Police and allied services

For members of the Armed forces, Police and other allied services including customs, prisons, federal road safety corps (FRSC), immigration services etc., contribution equals to 5% of the participant's consolidated salary paid by the federal government to cover the principal beneficiary, spouse and four biological children below 18 years of age. In addition, no waiting period is required for this group. Health care benefit is the same for the formal sector programme as mentioned above (NHIS, 2012).

(C) Voluntary Contributors Social Health Insurance Programme

The VCSHIP covers interested individuals, families and organisations with less than 10 employees, foreigners and Nigerians in diaspora etc. who are not covered by any other form of SHI programmes. Participants in the programme are required to pay contribution of 15,000 naira (US$ 81.9) per person once per annual or on instalment, though subject to periodic review. The benefits package includes some of the benefits in the formal sector programmes (NHIS, 2012).

2.3.2 Informal Sector Social Health Insurance Programme

The ISSHIP is a voluntary social insurance system for people in the informal economy such as employees of companies with less than 10 workers, artisans, rural dwellers, voluntary individual interested in the programme and others not included in the formal sector programme (NHIS, 2012). The informal Sector SHI is classified into two types: the Community Based Insurance Social Insurance Programme and the Students of Tertiary Institution Programme.

(A) Community Based Health Insurance Programme

The CBHIP is sub-divided into two: urban self-employed individuals and rural community dwellers programmes. The former pools resources and health risk of members usually occupational-based groups and provides protection for members against mutually determined health risks. It is designed for economically cohesive groups not less than 1000 members band together to form a Mutual Health Association (MHA). Financial contribution per member to a MHA is flat rate and paid in cash monthly or seasonally in advance in order to receive health benefit, albeit subject to review and vary from one MHA to another based on their health needs. The benefits package includes primary and secondary care that reflects prophylactic and therapeutic components of health care delivery. Participants in the programme are subject to a 60-day processing/waiting period before accessing benefit. A number of CBHIP management models exist to facilitate operations in the communities; these include Board of Trustees (BOT) as programme managers, BOT as programme managers with technical facilitators. A BOT comprises a representative from each of the groups that form the MHA. In the first model, BOT functions as a board and programme managers performing daily activities such as collection of contributions from members, making payment to providers and engaging stakeholders for the smooth running of the MHA. Second model: the BOT engages NHIS accredited facilitators to provide technical support while the board maintains ownership and management of the MHA. Third model: The technical facilitators are responsible for the management of the MHA including collection of contributions and payment of providers with support from the BOT in recruiting and monitoring members of the MHA.

The rural community dwellers programme shares some features with the urban self-employed individual programme such as forming a MHA of at least 1000 members managed by a BOT. Contribution is flat rate per individual or household members and can be paid monthly or seasonally, and it is subject to review; benefits package includes primary and secondary care. Moreover, the three CBHIP management models described earlier could be applied in the rural dwellers programme. However, distinctions exist such as that membership is not restricted to occupational-based groups as in the case of urban self-employed individual programme. Membership comes from different occupations, though in the same community. This creates room for more participants in the programme.

(C) Tertiary Institutions Social Health Insurance

The TISHIP is a social health system whereby health care needs of students in the tertiary institutions is paid for from a pool of fund from students' contributions in the tertiary institutions such as Universities, Colleges of Education, Polytechnics, Colleges of Agriculture, Mono-technics, Schools of Nursing and Midwifery and Health Technology among others. Students pay contributions annually on registration for every academic session. The present contribution rate is a community rated amount of 2000 naira ($US 10.9) per student and is subject to periodic review by the scheme. Benefits package includes primary and secondary care.

2.3.3 Vulnerable Group Social Insurance Programme.

The VGSHIP provides health care services to persons who because of disability cannot engage in any productive activity. Such people include the physically challenged, inmates, pregnant women, children under five, victims of human trafficking and people who are internally displaced etc. These groups have the same benefit package with the public-sector programme; save for children blow five years of age programme that covers major causes of morbidity and mortality such as malaria, diarrhoea, pneumonia, measles, and inadequate immunisation among others. Government, development partners and civil organisations are responsible for the funding of vulnerable group programme, and assigned the management of this group to accredited HMOs.

2.4 Standard and Accreditation

Section two of the operational guidelines discusses standards and requirements for accreditation of various stakeholders in the NHIS: HMOs, MHAs, health care facilities, BOT, insurance companies, etc. (A) HMOs are private or public incorporated companies registered by the NHIS to supervise the provision of health care services to enrolees by accredited health care facilities. They play a crucial role in the implementation of NHIS programme. Any group of individuals or organisation seeking registration as HMO is required among others to:

1. "Register with the Corporate Affairs Commission" (NHIS, 2012: 72).
2. "Have a minimum paid-up share capital requirement of HMOs" (NHIS, 2012: 72).
3. "Provide evidence of indemnity insurance cover with NHIS-accredited insurance company" (NHIS, 2012: 72).

4. “Maintain an operational account with an NHIS-accredited bank and undertake not to engage in any business other than the business of health care management” (NHIS, 2012: 74).

HMOs responsibilities include among others collection of contributions from enrolees; contracting with providers for delivery of health services; payment of providers and continuous sensitisation of enrolees. For accountability and transparency, HMOs are required to provide access to their bank account information, and rendering their annual reports and audited account to NHIS. Any HMO wishing to terminate its contract with NHIS shall give three months’ notice and fulfil other requirements. Presently, there are 76 national and states accredited HMOs in Nigeria working with accredited health care providers (HCPs) across the country. HMOs serve as intermediary between NHIS and HCPs; as well as interface between the HCPs and enrolees. They also make payments to HCPs for the services rendered to enrolees using: (1) capitation – regular payment in advance for treatment of insured members; 2) fee-for-service – direct payment for services based on referral of insured members to secondary or tertiary facilities (NHIS, 2012).

(B). MHAs are voluntary organisations providing health insurance services to their members. Members of this association help in managing the health plan of the association, determining the health package and negotiate with the providers. NHIS requires any associations seeking registration/accreditation, as MHA to *inter alia* register with the Corporate Affairs Commission; pay stipulated registration and accreditation fees; maintain current account with the NHIS, have a constitution/bye-laws. After the registration of a MHA, the following among others guides the association. (1) “Accreditation shall be renewable every two years” (NHIS, 2012:96). (2) “No person shall have claim on assets or rights of the association” (NHIS, 2012:96). (3) “NHIS may cancel accreditation of any MHA if the accreditation is based on fraudulent activities or unable to maintain the financial conditions stipulated by the scheme” (NHIS, 2012:96). (4) MHA is required under law not to have in its board any person of unsound mind because of ill health or is guilty of serious misconduct or convicted of any offence involving dishonesty. Exit of MHA from the contract requires three-month notice, payment of outstanding claims to providers and continue with its obligation within the three-month notice (NHIS, 2012).

(C). MHA elects BOT to manage the association. BOT members comprise of the chair, secretary, financial secretary, treasurer, public relations officer clerk and two others. Rules and regulations guiding BOTs include among others: members shall be resident of the community, elected in a democratic manner and operate in line with the constitution/byelaw developed by the association. Their functions include collecting contributions from members, conduct mobilisation and sensitization of community members on MHA, pay contribution collected to technical facilitators – in the case technical facilitators managed model, or pay providers – in the case of BOT managed model. BOTs members are entitled to remuneration as determined by the MHA. They are also required to audit the association account annually and submit the audited account to NHIS no later than six months after the association accounting year (NHIS, 2012).

(D). NHIS classifies health care facilities into primary, secondary and tertiary care. There are 11, 574 NHIS accredited primary, secondary and tertiary care in Nigeria. In Oyo state, there are 318 accredited health care facilities, these include primary health care facilities such as health care centres, nursing and maternity homes; secondary facilities including general hospitals, specialist hospitals, pharmacies, laboratories, dental clinics etc.; and tertiary facilities namely teaching hospitals and specialist hospitals. Health care facilities and providers seeking NHIS accreditation are required *inter alia* to register with Corporate Affairs Commission, possess relevant academic qualifications, possess indemnity cover, and pay required accreditation fees. After registration, the following among others guides health care facilities and providers: accreditation is renewable every three years and based on availability of skilled personnel, availability of information technology infrastructure, well-organised and proper management structures and compliance with the arbitration board etc. Any provider or health facility wishing to terminate its contract(s) with NHIS shall give a three-month notice, attend to NHIS enrolees within the three months and publish in the dailies its intention to exit.

(E). An Insurance Company seeking NHIS accreditation is required among others to "have a minimum paid-up share capital as determined by the National Insurance Commission" (NHIS, 2012:105), register with Corporate Affairs Commission, provides audited account of the company in the last three years, pay accreditation fee as determined by the NHIS. Moreover, accreditation is renewable every two years, subject to NHIS approval. In addition to settling of

outstanding claims with NHIS, health providers and HMOs, a period of three months is required for the termination of contract with the NHIS (NHIS, 2012).

2.5 Records and information

Section 3 highlights the necessary information and records required to ensure proper implementation of the NHIS programmes. For instance, the scheme requires every HMO to provide the following information:

- Information of itself for accreditation including name, address, phone numbers/email, insurance company, bankers etc.
- Bio data of new enrolees such as enrolee's NHIS registration number, name, address, date of birth, next of kin, phone number etc.
- Contributions from enrolees and employers on monthly basis, payments to health facilities or providers, annual audited financial reports and quality assurance report of health facilities etc.

Moreover, health providers are also required to: (1) supply necessary information to NHIS for accreditation such as name, address, registration number, certificate of practice, indemnity cover etc. (2) Report on a monthly basis to NHIS on information about the enrolees including NHIS registration number of patient, name of patient, complaints, treatments, etc. NHIS is required to supply stakeholders the list of accredited health facilities; list of accredited HMOs; list of medicine price; list of accredited bank and insurance companies etc.

2.6 Offences, Penalties and Legal Proceedings

Section 4 emphasises offences, penalties and legal proceedings guiding stakeholders to ensure conformity with the provisions of the NHIS operational guidelines. The Act provides a list of offences and penalties that would apply to defaulting stakeholders after the necessary legal proceedings (NHIS, 2012). The following examples are some of the offences and penalties:

(A). In the case of HMOs, any HMO that refuses to remit capitation, fee-for-service or other claims to providers after receiving the money from the NHIS within the given period as indicated in the policy document shall face the following penalties:

- Suspension for not less than three months.
- A fine of not less than 500,000 thousand naira (US$ 3, 225).
- Prosecution under the relevant laws that guide financial transactions.
- Delist repeated offenders from NHIS accredited HMOs list.

(B). HCP who discriminates and refuses to treat any enrolees and their covered dependants after receiving payment from the HMO on behalf of such enrolees shall face the following penalties: (1) warning; (2) a fine of not less than 100, 000 thousand naira (US$ 645); (3) suspension not less than three months; and (4) delisting of repeated offenders.

(C). NHIS beneficiary/enrolee who intentionally engages in multiple registrations shall face the following penalties: (1) warning, (2) prosecution, (3) deleting the excess registration and (4) notify the employer.

(D). NHIS accredited bank that fails to submit annual statements of the scheme within the stipulated time shall face the following penalties: (1) warning, (2) suspension and (3) delisting.

(E). Insurance company that fails to enter and comply with the NHIS agreement shall be delisted from NHIS accredited list of insurance.

2.7 Conclusion

This chapter explored the historical development of NHIS in Nigeria. It examined NHIS Act as it related to the development of the scheme. It also assessed the operational guidelines of the scheme in relation to the programmes – standards and accreditations; records and information; offences, penalties and legal proceedings. Thus, the NHIS Act and the operational guidelines set out the implementation of NHIS in Nigeria.

CHAPTER THREE

LITERATURE REVIEW

3.1 Introduction

Chapter 3 evaluates bodies of literature on Health Sector Reform (HSR). Specifically, the chapter analyses health-financing aspect of the reforms. The areas covered under the literature include:

1. Health Sector Reform
2. Structural Adjustment Policies
3. Risk Sharing Model
4. National Health Insurance Policy
5. Health Financing Policies in Nigeria
6. National Health Insurance Scheme in Nigeria

3.2 Health Sector Reform

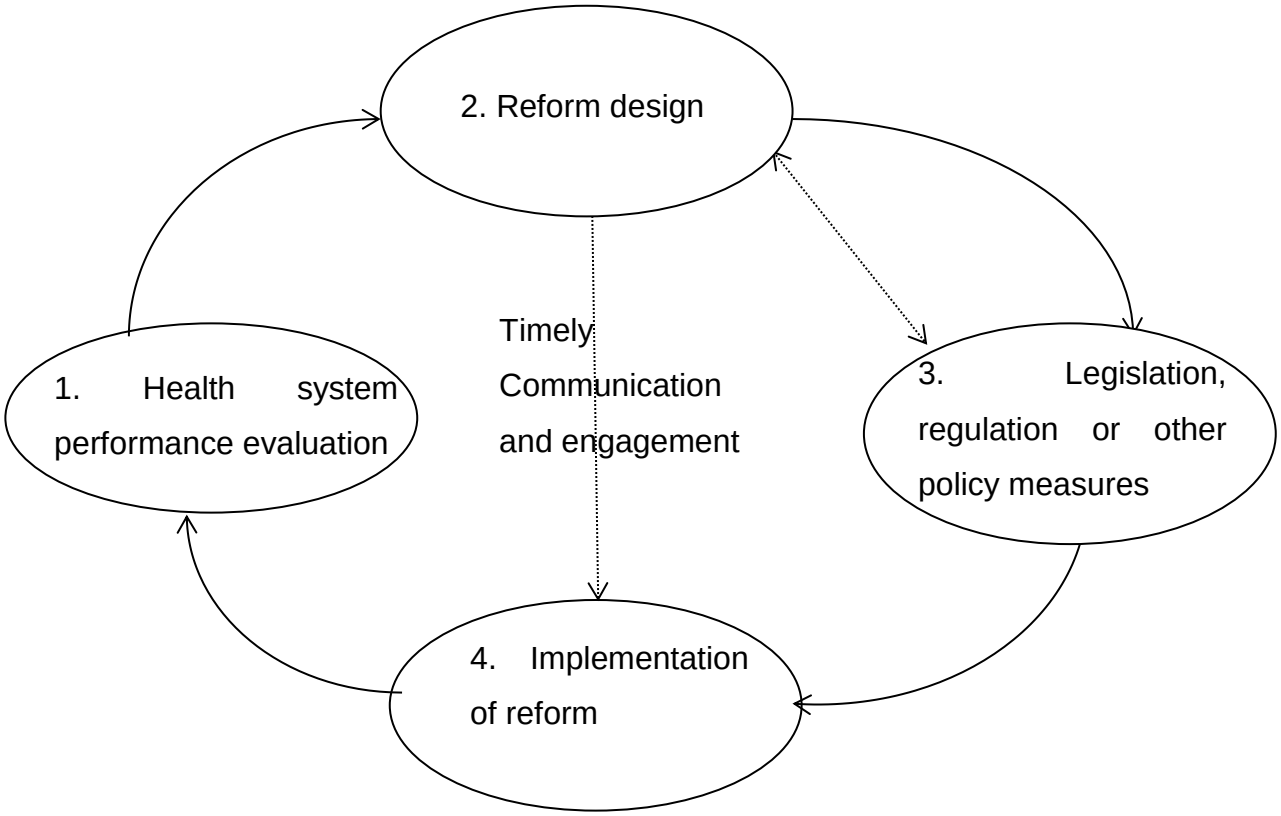
In the existing literature, discrete conceptual terminologies, such as health system reform (Hurst, 2010), health sector reform (Berman and Bossert, 2000), and health reform (WHO, 2000; World Bank, 1987) have been used to refer to the same thing, hence the concepts are used interchangeably in this thesis. While fundamental changes aimed at improving the health care system is central to HSR, there is no common definition of the term. Scholars deploy different definitions based on their understanding and purpose for the reform. Berman and Bossert define HSR as “sustained, purposeful and fundamental change” – “sustained” in the sense that it is not a "one shot" temporary effort that will not have enduring impacts. “Purposeful” in the sense of emerging from a rational, planned and evidence-based process; and “fundamental” in the sense of addressing significant, strategic dimensions of health systems” (Berman and Bossert 2000: 2). For koivusalo and Ollila, HSR has been described “as the process of improving the performance of existing system and of assuring efficient and equitable response to future changes” (koivusalo and Ollila, 1997: 137). It has also been perceived as an essential change in institutional procedures and policy to improve the function of the health services, which in turn would improve health condition of the people (WHO, 2004, 2005). Furthermore, the World Bank describes HSR in four dimensions to address the

problem of national health systems in the Low Medium Income Countries (LMICs). These include (a) charging users of publicly provided health services, especially for the types of curative care that benefit solely individual and their families; (b) encourage risk-coverage programmes; (c) strengthening non-governmental provision of health services and (d) decentralising the public health system. World Bank further notes that health care reform embodies a shift in health care financing from the government to the beneficiary, and in making decision from central planning authority to local authority for even accessibility (World Bank, 1987, 1989).

For better performance of HSR, Robert and colleagues note that it is fundamental for health sector reformer to diagnose the causes of health sector problems by exploring five control knobs of the sector. The "control knobs" "must be significant causal determinants of health system performance" (Robert et al, 2002: 32), and could be adjusted to bring changes in the functioning of health system. The five "control knobs" include (1) financing, the available resources for health care and it could be tax, insurance premium and direct payment by patients. (2) Payment, the method of reimbursing health care providers including capitation, budgets and fees for service. (3) Organisation, this includes organisation of health care providers in terms of their functions, roles etc. in health care markets. (4) Regulation, the use of force by regulatory body to enforce stakeholders in the health sector such as health providers and insurance companies to comply with rules of the sector. (5) Behaviour, this refers to the attitudes and responses of people and providers of health care, which in turn influence the functioning and outcome of reform of the health care system (Robert et al, 2002). The "control knobs" distinguishes reform in a two-way dimension with 'big R' reform signifying strategic and fundamental reform that established change in two or more "control knobs", including financing, regulation, payment etc. which in turn affect the overall health system performance in a positive way. On the other hand, 'small r' reform connotes limited, partial and incremental change that focuses on single "control knobs" which subsequently brings poor performance of the health system. For example, 'small r' reform include the introduction of user charges in public hospitals or granting of autonomy to the public clinics and hospitals (Berman and Bossert, 2000: 13). In contrast, Hurst describes HSR as complete overhaul of health system to bring about efficiency and equity putting into consideration values and culture that underpins various reforms in every country. In the Organisation for Economic Cooperation and Development (OECD), health reform has brought about extensions of health insurance to

different groups of the population over many years and result in the achievement of universal health insurance in most OECD countries (Hurst, 2010). Hurst (2010) further posits that reform in the health sector focuses on how to meet the main objectives of health policy including efficiency and equity. They provide a framework for the necessary reform and implementation in the health sector. Thus, the design and implementation of HSR could be in circular process of improvement as shown in Figure 1 below:

Figure 3.1: The process of health sector reform, design and implementation



Source: Nutley and Smith, (1998). Excerpted from Hurst, (2010).

The first step is the assessment of the health system by authorized agencies to reveal inadequacies in its performance. The second step involves designing and proposing structural reforms aimed at confronting the identified inadequacies in the sector. The third step involves the introduction of rules and regulation and other policy measures that would pave the way for reforms. The fourth step involves the implementation of reforms through financing and delivery of health services. There is interdependence between successive steps of reforms – all

steps must work together in a sequential pattern to ensure a viable reform. Therefore, reform in the health sector is continuous, that is, changing expectations of consumers, changes in technology and other components of the health system precipitate further reforms. This framework could be optimised if stakeholders demonstrate adequate commitment (Hurst, 2010).

While the notion of HSR is prominent in the global arena, it varies in both scale and scope from one country or organisation to the other. For instance, in the OECD countries, reforming health system has mainly focused on equity of access with microeconomic efficiency to curtail the continued rise in health care costs due to technological advancements in medicine, which subsequently increase the ageing population (OECD, 2012; Hurst, 2010). On the other hand, this concept became increasingly prominent in the LMIC in the 1980s and mainly concentrated on dismantling the public health care system by reducing public spending on health, liberalising the health sector and expanding private participation (Shiviji, 2009; Adesina, 2007b; Obono, 2007). Additionally, Gilson and Mills explain that reform in the health sector of LMICs include among others: one, strategy to increase the financing of health system. Two, provision of funds for the promotion of primary health care services. Three, devolution of public health sector to ensure even distribution and accessibility among the people. Four, liberalising the health sector to encourage private participation (Gilson and Mills, 1995a). Thus, these changes in health system were in line with World Bank development report "Investing in Health" as strategies in the LMICs to address fundament gaps in health care system including insufficient spending on cost – effective health programme; poor quality and inequitable distribution of health benefits (World Bank, 1987, 1993).

3.3 Structural Adjustment Policies and Health Sector Reform

Structural Adjustment Policies was an initiative of the international financial institutions led by the Word Bank and International Monetary Fund (IMF) on macroeconomic policies for the LMICs. The policies imposed on developing countries by these international institutions initiated a series of economic crises and limited resources, which in turn led to a drastic cut in social spending and preference for private sector economy activity than the public control of productive forces. The World Bank had been a major player in the international health policy since 1980s, not only as a policy adviser, but also as a lender and donor with strong support for neoliberalism (Mohindra, 2008; Heidhues and Obare, 2011). The neoclassical/neoliberal ideology in which structural adjustment policies was heavily rooted criticized democratic

welfare state model of developing countries where public funds are used for social services including education and health in order to maintain social justice, but encourages liberalisation, minimal government interference and free market forces (Cassels, 1995; Ortiz, 2007; Obono, 2007; Adesina, 2008). The World Bank SAPs initiative was in the form of designing macro-economic stabilisation policies, such as, fiscal control (e.g., government expenditures); institution (e.g., decentralisation), liberalization (e.g., privatisation) and deregulation (e.g., price control) (Berman, 1995; Slim and Katia, 2011).

The SAPs was introduced by the International Monetary Fund (IMF) to rectify the macroeconomic instability over the short term by restricting public expenditures and constraining demand for social services (IMF, 2004). Moreover, World Bank emphasised that "once the economy is stabilised, policy could then be implemented in the medium to long time measures for stimulating economic growth through liberalization, privatisation and deregulation" (World Bank, 1987:121). This initiative was made a precondition for structural adjustment loans and mechanism to bail developing countries out of the economic crises. Furthermore, most countries that experienced SAPs in the 1980s and 1990s initiated health sector reform that led to divestment of public investment and spending on public provisioning of health services but provide incentive for private participation because of the adjustment programme of stabilization and liberalisation. Consequently, divestment of public investment led to the financial crisis in the public sector, which in turn resulted in inadequate public health infrastructures, poor quality of health services and dwindling capacities on the part of government to provide 'free' health care (Obono, 2007; Mohindra, 2008; Slim and Katia, 2011).

Widespread debates abound on the impact of SAPs on social services in the LMICs. The exponents of SAPs argue that the cuts in social spending would not necessarily be detrimental, but rather improves social services through a more efficient use of resources (World Bank, 1983; De Ferranti, 1985). On the contrary, critics reveal that SAPs were not meant to revamp the social services in the developing countries; instead, it was harmful to social services notably education and health. Social indicator such as education, medical care, health, rate of literacy and life expectancy declined drastically (Gu and Tang, 1995; Obono, 2007; Atieno and Shem, 2007; Adesina, 2007b; Adesina 2008; Wang, et al., 2012). For instance, Adesina notes that social policy in a neoliberal regime "had deleterious effects on livelihood, economy and the

social fabric of the society" (Adesina, 2007b: 11) with the reversal of 'social right' and social citizenship. Adesina further maintains that SAPs was a fundamental reorganisation of the state with the development of an economic ideology that brought about severe cuts in social services, private participation in social services provisioning and market-centric policy framework. Furthermore, Gu and Tang (1995) assert that structural and economic changes imposed by marketization and privatisation had negative and detrimental impact on China health sector by dismantling the solidaristic mechanism of financing healthcare prior to the macro-economic reforms package. They emphasised that China had a robust rural cooperative medical scheme, a form of CBHI that covered 90% of the rural population before the economic reforms of the early 1980s. Subsequently, the abolishment of the rural CBHI during the reform had detrimental effect on China health care, for example, the percentage of rural population covered by health insurance dropped from 92.6% in 1976 to 6.1% in 1990.

The three proposed policies by World Bank to address the problems of health system in the developing countries include charging users of publicly provided health services; decentralizing the public health system and strengthening private provision of health services. These three policies are considered as a package that is closely related and mutually reinforcing (World Bank, 1987). The World Bank asserts that charging fee in the government facilities would not be enough in raising revenue unless competitive incentives such as private sector participation and decentralisation government sector are in place to support government in health care financing (World Bank, 1987, 1993). In summary, SAPs was heavily rooted in neoclassical/neoliberal ideology championed by the World Bank and IMF restraining state-led provisioning of social services in the developing countries and encouraging private participation in the provision and financing health care services with minimal government interference.

3.3.1 Charging Users of Public Health Facilities

Financing reform is central to HSR debates because of scarcity of resources available for public provisioning of health care services in most countries mainly due to destabilised economy, increase in the costs of health care and increasing aging population (Ikegami and Campbell, 2004; Ikegami, 2009; OECD, 2015), resulting in the reform of health care financing. Although reform in financing health care system is a global agenda, its priority varies from one country to another owing to social, political and economic differences. User fee a form of co-payment for health care is not prominent in the developed countries (OECD, 2012); instead, insurance

is given considerable attention as a financing model. For example, in Germany, UK and the United State (US) among others health care provision is largely financed through either tax or social insurance. In the US, employment-based private insurance and the Public Sponsored Health Insurance (SPHI) programmes such as Medicare designed for the elderly and Medicaid created for the poor were the main source of financing health care (Bodenheimer and Grumbach, 2005). However, Germany and the UK largely finance their health care either through social insurance, tax or the combination of both (Hurst, 2010; Bodenheimer and Grumbach, 2005).

Conversely, user fee became the main source of funding health care in the developing countries in the 1980s because of severe reduction in public spending (Adesina, 2007a, b). The economic crisis forced many countries to face the quandary on how to provide adequate health care services for their citizens in the face of dwindling revenue. Subsequently, the proposed user fee by the Word Bank was imposed. World Bank pushed governments to introduced user fee (cost recovery) at the point of service delivery on the basis that it would increase revenue, create greater rationalisation of services and improve equity. It thus noted that "as the contributions of households (especially the better-off) increase, there would be more money in the system and states would be able to recover significant proportion of their health costs through user fees" (World Bank, 1987: 26). The World Bank further maintained that "this approach would reduce government responsibility for paying for the kinds of health services that provides few benefits to society as a whole… more government resources would then be available to pay for services that provide many benefits to the whole society" (World Bank, 1987: 26). Thus, public funds could be used for "public goods" such as immunisation, waste disposal and in some cases for maternal and childcare (World Bank, 1987).

The developing countries launched cost recovery programmes in the 1980s based on the following World Bank assumptions firstly, that introducing user fees would not stop people from using health care when it is needed because health care is inevitable. Secondly, user fees would be offsets by improvements in quality. Thirdly, exception policies for the poor would be effective and finally, people were willing to pay (World Bank, 1987, 1989, 1993; De farranti, 1985). However, studies (e.g., Ogunbekun, et al., 1999; Asenso-Okyer, et al., 1998; Berman and Bossert, 2000; Sahn, et al., 2003; McIntyre, et al., 2006; Mohindra, 2008) have explored the impact of user fees in relation to Word Bank assumptions. A study on the demand for health

care found that users of health care were sensitive to price, and as a result, utilisation of health care declined drastically in rural Uganda as many people could not afford the costs (Sahn et al, 2003). Moreover, Berman and Bosset (2000) note that former communist states including former Soviet Union and Eastern Europe suffered negative consequences of user fees as they opened their economies to market forces.

In relation to the assumption that user fee would compensate by improvement in quality, studies have shown that quality was compromised for financial gain (e.g. McIntyre et al., 2006; Mohindra, 2008). A longitudinal study conducted by Haddad and Fournier revealed that utilization rate declined to 40% and 18 - 32% of this decrease is caused by costs in Zaire. They expressed that" regular supply of drugs and the improvement in the technical quality of the services – technical qualification of the staff, allocation of microscopes, and renovation of the infrastructures – was not enough to compensate for the additional financial barriers created by the increased cost of services" (Haddad and Fournier,1995: 744). On the exemption policy for the poor, studies reveal many difficulties related to exemption such as lack of financial capacity, poor political will, non-poor users being exempted and weak administrative capacity (McIntyre et al., 2005; Haddad and Fournier, 1995; Gilson and Mills, 1995). Similarly, researches have shown that many people made concessions such as selling off assets, removing children from schools, borrowing from relatives, reducing food consumption to be able to pay for medical bills, and a significant proportion of households' expenditures spent to offset medical expenses (Ogunbekun, et al., 1999; Asenso-Okyer, et al., 1998; Sahn, et al., 2003; McIntyre, et al., 2005). In summary, despite the claim that user fee (cost recovery) would bring about efficiency and equity in health care, studies have shown that user fee did not increase revenue and equity as stipulated by the Word Bank. Instead, it deprived many households access to health care services as people were sensitive to costs and these drastically reduced their access to health care.

3.3.2 Decentralisation of Public Facilities

Decentralisation of government health services implies granting financial and managerial autonomy to local units of the system, giving local units greater responsibilities for planning and budgeting, collection of user charges, and determining how collected funds and transfers from the central government will be spent (World Bank, 1987, 1989). The main objectives of decentralisation were to improve planning and management of health services, increase

accountability, create effective and efficient organisation of services, encourage community participation and minimise administrative costs (Gilson and Mill, 1995b). Decentralisation is viewed as a part of the policy reform agenda of international agencies not only to increase revenue available in the health sector, but also to increase access to health care in the community. Although decentralisation is purported to help increase access to health care and revenue, this programme had generated quite a debate in most developing countries (Mohindra, 2008). Some studies reveal this concept as complex and problematic (e.g., McPake, 1996; Larbi, 1998; Therkildsen, 2000). For example, in Ghana, the multiplicity of institutions involved in decentralisation such as the Ministry of Finance, the Comptroller and Accountant General, the Office of the Head of Civil Service, and the Public Services Commission were reluctant to liberalise control over human and financial resources, which in turn affected decentralisation negatively (McPake, 1996; Larbi, 1998).

McPake (1996), in an attempt to locate decentralisation policy of health reform in sub-Saharan Africa in a wider context, notes that the Gambia Medical Service Act of 1998 provides the medical framework, which established the Hospital Management Board. However, there are stringent restrictions of the board that affected its statutory role, which include financial and administrative management of public hospital in its jurisdiction. Similarly, in Ghana, there was no clear devolution of power between the Ministry of Finance and Hospital Management Board and this had implication on the logic of the use of competitive mechanism and decentralised management to improve efficiency. Decentralisation was considered to improve efficiency of resources and ensure inclusiveness in the communities. However, administrative and political constraints were found to impede decentralisation in Tanzania (Therkildsen, 2000). 'Leakage' of public resources meant for social provisioning was also noted in Uganda (khemani 2001). Additionally, decentralisation in China was biased in favour of economic viable region like the urban areas at the detriment of the rural settings (Gu and Tan, 1995). Decentralisation suffered many setbacks in the developing countries such as non-participatory policy process, misappropriation of funds meant for sub-national levels, political constraints, lack of planning for implementation and poor autonomy to the hospitals (Larbi, 1998; Therkildsen, 2000; Mohindra, 2008).

Nevertheless, decentralisation had resulted in the creation of many health district councils and devolution of public services to the districts or sub-national regions in the developing countries, and thus bringing services closer to the people (Mohindra, 2008). For instance, the Ghanaian

health districts increased from 65 to 110 in 1996 (Larbi, 1998). In Uganda, the district governments are empowered by the central government through devolution of power and thus responsible for social services provision such as health care. The districts are autonomous hence; they have their own budgets, recruit staff, health plans etc. though with strong support from the central government. However, despite devolution of power to the local council to enhance rural dwellers access to health care, geographical barriers, poor quality, failure to adequately stock drugs and long waiting time among others remain hindrances in the rural settings (Kassam, Collins, Liowa, and Rasoola, 2015; Uganda Ministry of Health, 2000).

Furthermore, Nigeria was recognised as one of the few countries in the developing countries to have significantly decentralised both financial resources and service delivery within its three tiers of government (Federal, State and Local) (Khemani, 2001, 2005). For instance, the National Health Policy was overhauled in the 1980s, assigning responsibility of Primary Health Care (PHC) delivery to the local government. In addition to the statutory allocations from the federal government, local governments have internally generated revenue to carry out their statutory responsibilities. Moreover, the federal and state governments provide logistical assistance to the local governments, primarily for the implementation of national programmes such as immunization, control of HIV/AIDS and malaria, and procurement of drugs and other essential equipment (Khemani, 2005). However, local governments have been financially constrained, and this has implication for their statutory responsibility in terms service delivery and payment of workers' salaries. Khemani argues, "as several developing countries are beginning to decentralise responsibility for local public services to local institutions, actual empirical evidence on local government accountability for services delivery is lagging" (Khemani, 2005: 286). In sum, despite the fact that several developing countries had decentralised their health care system, the issue of partial decentralisation where fiscal responsibility and authority were not fully transferred to the sub-national levels remains a challenge. In addition, sustainability of the sub-regions in terms of their generating capacity is also a concern.

3.3.3 Strengthening Private Provision of Health Services

Expanding private participation and reducing the state role in the provision of health care is another component of HSR instituted by the Bretton Woods Institutions, with the conviction that competition will bring about improvement and efficiency in the health care provision. The

World Bank argued that using private resources effectively helps mobilise resources from family, communities and voluntary groups and allow government resources to be directed to costs effective programmes including immunisation, malaria vector control and HIV/AIDS control that produce many benefits but for which individuals are reluctant to pay (World Bank, 1987, De Ferranti, 1985). The advocate of this approach further argues, "Almost nowhere are government clinics and hospitals the only source of care. At least, they often compete with private care providers including private for-profit, non-profit providers (religious missions) and traditional providers in the provision of health care, during which governments regulate the activities of the private providers and at times contracts with the private providers for certain 'public goods' or projects such as immunisations and vector control" (World Bank, 1993).

Literature has revealed the importance and the growing role of private sector in the provision of health care services (e.g., Ejughemre, 2014; Adeyemi and Nixon, 2013; Bodenheimer and Grumbach, 2005; Makinen, et al. 2000; Ogunbekun, Ogunbekun and Orobaton, 1999; Gilson and Mill, 1995; World Bank, 1993). For instance, a comparative analysis conducted by Makinen et al., (2000) on health services utilisation patterns in African, Asian and Latin American countries finds that although the better-off disproportionately use private health care providers, 56%, 60% and 58% of people in Paraguay, Guatemala and South Africa respectively sought health care through private providers. The activities of private drugs outlets have also been studied. Kassama et al (2015) observe that the proliferation of private outlets – drug vendors without formal training is on the increase in the developing countries with high patronage. Reasons given for using their services include proximity, access to cheaper drugs, adequate supply of drugs, opportunity to purchase drugs on credit and friendly service

A number of strategies have been adopted to encourage private participation, these include contracting their services, training of health professionals, integration into planning process and subsidising non-governmental organisations (NGOs) (Mohindra, 2008; Kassam, et al., 2015). For instance, the involvement of private sector in the distribution of Artemisinin Combination Therapies (anti-malaria drugs) has increased accessibility rate in most communities in Uganda (Kassam et al., 2015). As in other developing countries, private health care providers including medicine vendors remain the closest providers of health care to most communities in Uganda as they outnumbered the public providers (Kassam et al., 2015; Ejughemre, 2014). The mission hospitals have also been playing significant role in the

provision of health services in most African countries and at times designated as district hospitals with financial support from the states (Mclntyre and Mutyambizi, 2005).

The states have been responsible for addressing problems involving private for-profit providers through regulations. Nevertheless, studies have shown poor quality of services, unethical practices and high cost of care in the private-for-profit services (Kassam, et al., 2015; Mohindra, 2008; Mclntyre and Mutyambizi, 2005). For instance, proliferation of untrained private health care providers providing incorrect treatment was noted in rural communities in Uganda (Kassam, et al., 2015). In addition, they tend to charge higher fee than public health facilities in order to meet their financial obligations (Mclntyre and Mutyambizi, 2005). Despite the private sector contributions to health care provision, quality and cost control remains a heated debate given inadequate state regulation and monitoring of this sector in developing countries. After the initial licensing, the safety and quality of care provided by the private providers remain unmonitored and unregulated. Drug vendors and traditional medicine providers have free reign largely in the rural areas (kassam, et al., 2015).

3.4 Risk Sharing Model

As the user fee or cost recovery did not live up to the promise such as generating additional resources and increasing access to health care as claimed by the international financial institutions, but in most respect created a host of other problems, risk sharing approach was considered as alternative financing model. Cost sharing through prepayment is therefore considered to cover a large proportion of the population at modest cost and equitably with emphasis on social health insurance (World bank, 1987, 1993). Health insurance has a long history with the developed countries notably Germany, Japan, UK etc. On the other hand, this financing model is gaining recognition in the developing countries in recent decades (Hsiao and Shaw, 2007). Thus, prepayment models including individual private health insurance, employment-based health insurance, community health insurance scheme and social health insurance scheme are discussed below.

3.4.1 Individual Private Health Insurance

Individual private health insurance is a prepayment model, which has been in existence for centuries to replace direct purchase of health services. It is a pre-payment plan to protect individual from uncertain financial health care costs. Individual health insurance plan often

requires two transactions, that is, a premium or contribution payment from the individual to an insurance organisation and a reimbursement from the insurance plan to the health care provider. However, it is a purely market driven health insurance model based on fundamental principle of neoliberalism that individual should pursue their health care based on the notion that individuals must be free to define and pursue their own goals with minimal interference from the government. With individual private health insurance, people purchase health insurance and receive health care in the private institutions without state intervention (Mclntyre and Mutyambizi, 2005; Bodenheimer and Grumbach, 2005). Historically, individual private health insurance dates back to 1850 as a provisional support income for people with disability including death benefits to assist individual with burial costs. This model was very lucrative especially for insurance companies up to the Second World War (WW2) (Wagner, 2012).

In the capitalist economy like the US, where social policies are less generous and less egalitarian, values such as individualism and free market culture remained dominant. Individual private health insurance was developed by commercial private insurance companies to provide health care for people who could afford contributions or premiums (Bodenheimer and Grumbach, 2005). The advocates of this model argue that first individual private health insurance frees employers of the obligation to provide health insurance for their employees. Secondly, it gives people a stable source of health insurance irrespective of their employment status. Thirdly, small business owners are exempted from the expenses of insuring their employees. Lastly, it saves people from massive tax increases in order to insure the uninsured as in the case of government-financed health insurance (David and Schoen, 2003; Wagner, 2012). In addition, individual private insurance plays either or both supplementary or complementary roles to fill the gap in the public health care services. In the US for example, 41 million beneficiaries of the Public Sponsored Health Insurance programmes in 2003 had supplementary private insurance (Wagner, 2012; Marion, 2014). In Germany between 1975 and 2002, the number of people having individual private health insurance rose “from 4.2 million to 7.7 million, representing 6.9% and 9.3% of the population respectively” (Busse and Riesberg 2004: 77).

However, this model has been criticized on high cost of health insurance premium. The skyrocketing cost of individual private health insurance has prevented many people from being insured in this model. Secondly, this model is characterised by limited coverage because it

covers small proportion of the population (the affluent) and has contributed to considerable inequalities within the overall health system. For example, in the US, the model provides health insurance for only about 3% of the population in 2002 and 16.2% in 2016 (Bodenheimer and Grumbach, 2005, New York Time, 2016). Similarly, Sapakankunti notes that individual private insurance is specifically for the high-income class who can afford the premiums. The population coverage of this model was only 1.6% in 1992 and 2.0% in 1995 of the total population of Thailand and the increasing trend is not high (Sapakankunti, 2012). Thirdly, contribution is risk-related and there is no redistribution among members within or between groups. Prepayment level often determines one access to health benefits (Mclntyre, et al., 2005; Bodenheimer and Grumbach, 2005; Ataguba and McIntyre, 2012). In sum, individual private health insurance is certainly based on the principle of individualism and libertarianism whereby health care is seen as individual responsibility rather than the responsibility of society requiring social solidarity. Thus, this model is elitist because it provides health services for an insignificant proportion of the population (the better off) while the larger proportion of the population is left out of the model.

3.4.2 Employment-Based Private Health Insurance

Employment-Based private health insurance (EBPHI) is based on shared contribution in that employers and employees share the costs of health care while employers usually pay larger part of the premiums that purchase health insurance for their employees. Historically, this model dates back to the nineteenth – century in Germany where artisans' guilds mutual benefit funds and miner's unity funds were established to provide sickness, disability and funeral benefits to their members. Additionally, industrial workers also organised voluntary mutual aid societies like the artisans to provide similar benefits for their members; however, they only reached a small population and did not protect the members' needs sufficiently (Sigerist, 1999). Moreover, the German government that imposed duties on the employers to protect their workers in the wake of 19th century Industrial Revolution later passed three legislations. These include (1) employer's liability for compensation in case of accidents, (2) railroad companies were liable for accident of their workers and were compelled by law to compensate injured employees and (3) ship-owners were required to provide sustenance and medical care to ailing sailors (Sigerist, 1999). Prior to1883 Bismarkian statutory health insurance, diverse relief funds were available at different regions for different groups of workers in Germany, which were accessed by members. A number of voluntary relief funds were available on solidarity-based

support system whereby members have access according to needs rather than according to contributions to the funds. However, the rapid growth in employment – based health insurance was spurred during the WW2 when price control policy prevented wage increase but allowed the growth of fringe benefits. However, due to shortage of workers, employers began to offer health insurance to their employees as incentive. Besides, after the war, unions built on this trend and negotiated with their employers for health benefits for their members. The resultant effect of this negotiation was a dramatic growth in employment-based private insurance in Europe, the U.S and many other countries (Barnighausen and Sauerborn, 2002; Bodenheimer and Grumbach, 2005).

Primarily, EBPHI was premised on community rating approach with social solidarity – within each group people who become ill receive health benefits irrespective of their contributions. Funds are redistributed among different groups from the healthy to the sick, as a subsidy to pay the costs of health care of those unable to pay (Barnighausen and Sauerborn, 2002). However, this health insurance model attracted commercial insurance companies to health care and thus changed its dynamics entirely to market driven financing health system. The solidaristic and redistributive principle of this model therefore was weakened by experience rating approach where income is less redistributive from the healthy to the sick or from the better off to the poor.

In an evaluation of EBPHI, the US and South Africa share related institutions that supported this model not only because of the neoliberal policies and capitalist institutions that have largely reshaped their health care systems from community rating to experience rating, but also as a result of explicitly polarised health care system along socioeconomic line. In the U.S. for example, Bodenheimer and Grumbach (2005: 7) explain that experience rating is entrenched in the US insurance market. “Within each group, those who become ill are subsidised by those who remain well, but among different groups, healthier groups (e.g. bank managers) do not subsidise high-risk groups (e.g. mine workers)”. They note that in a laissez-faire competitive private health insurance that features predominantly in the US, community rating cannot survive, given that healthy people have no economic incentive to subsidise another group of sick people. However, this model received political support in the US in that employers are given incentives such as tax credit to cover employees voluntarily and medical savings account to support employees’ expenses (Bodenheimer and Grumbach, 2005). While employment-based private insurance was envisioned to expand health insurance coverage to the uninsured

Americans, the number of uninsured Americans remains high largely due to the rising cost of health insurance premium. The tax credit failed to reduce the numbers of uninsured workers. On the other hand, medical savings account divided the population into low and high-risk pool thereby the low risk people fails to subsidize high-risk people. Therefore, the incentives created by government within employment-based private insurance had little impact on the nation's health care cost (Schroeder, 2001; Bodenheimer and Grumbach, 2005; Walden, 2012).

In South Africa, Mclntyre, et al. (2005), Ataguba and McIntyre (2012) note that EBPHI is referred to as 'medical scheme' and membership depends on income and employment status: the non-formally employed and the poor are less likely to be scheme members. Moreover, 'medical scheme' has been severely criticised on the following reasons firstly it covers only a very small proportion of the population – about 16% of South Africans, and accounts for over 43% of the total health care financing. It also contributed to considerable inequities within the health system whereby the better off (usually small group) accesses private health care services while majority of the population depends on under-sourced public health services. Second, the proliferation of medical schemes has resulted in the fragmentation of the insured population into different risk pools, which has raised questions about redistributive mechanism and sustainability. Third, it has resulted in high costs of medical scheme in terms of private hospital admissions, administration and medicines. Finally, the use of limited tax resources estimated at US$1 billion to subsidize medical scheme which only benefited a small proportion of the population has shown the weakness of employment based insurance to engender social justice and equitable distribution of health care in South Africa (Mclntyre, et al. 2000; Mclntyre and Doherty, 2004; Ataguba and McIntyre, 2012; Ataguba, 2016).

Although South African Government has introduced legislative and regulatory framework to address the challenges with employment-based insurance in terms of contributions, benefits package and tax benefits, the population served entirely by the medical scheme coverage remained small and skewed in favour of the richest groups (Ataguba 2016; Ataguba and McIntyre 2012). In summary, the fundamental principle of social justice and solidarity in which employment-based insurance was traditionally established (whereby people benefit from the scheme according to need rather than exclusively on contributions) has been taken over by the neoliberal policies of individualism and market-based competition. This model is only available to insignificant proportion (employees of the formal sector) of the population, and thus, contributions and benefits are inequitably distributed.

3.4.3 Community-Based Health Insurance

CBHI is a prepayment model that is commonly practiced by the population groups characterised by community self-help, social justice and solidarity. There are calls from the international agencies for the establishment of CBHI in developing countries, as it provides insurance coverage to people with limited coverage like those who are not engage in formal sector employment. CBHI is considered as a promising model not only to increase access and generate revenue for health services, but also to reduce out-of-pocket spending through pooling of risk and resources (De Allegri, et al. 2006; Basaza, et al., 2008). Bennett (2004: 147) described CBHI "as any scheme managed and operated by an organisation, other than government or private for-profit company that provides risk pooling to cover all or part of the costs of health care services". For Jakab and Krishnan it is viewed as "populations with low income obtaining their subsistence from the informal sector (urban/rural) and/or socially excluded groups (due to cultural factors, physical or mental disability, other chronic illness) and often not able to take advantage of government and/or market-based health care financing arrangement" (Jakab and Krishnan, 2016: 4). Besides, Musau described it as "any not-for-profit insurance scheme that is aimed primarily at the informal sector and formed on the basis of an ethic of mutual aid and the collective pooling of health risk, and in which the members participate in its management" (Masau, 1999: 5).

CBHI is currently in the spotlight and widely promoted by the international agencies such as the World Bank and World Health Organisation as a financing option mainly for the people in the informal sector and the rural populace, and as a viable mechanism to achieve universal coverage (World Bank, 1989, 1993; WHO, 2005; 2012). CBHI is currently gaining attention in the developing countries as governments in these countries are increasingly recognising its role as part of a national financing strategy for health care. Many of CBHI schemes are developed in the sub-Saharan Africa and Asian countries. For example, Nkoranza in Ghana, SEWA in India, Health Card Scheme in Thailand and Ikosi-Isheri Mutual Health Insurance in Nigeria among others (Jakab and Krishnan, 2016; Centre for Public Policy Alternative, 2014; Bennett, 2004). Primarily, this model was to ensure the community (such as low-income earners who are socially excluded from other forms of insurance) is actively involved in mobilising, pooling and allocating resources for health care that reflects the principles of social solidarity (Jakab and Krishnan, 2016). However, CBHI schemes vary remarkably in terms of structures, funding, benefits package, composition, membership and objectives. For instance,

CBHI schemes are grouped into four categories: (1) some schemes were initiated by private-for-profit providers like Nkoranzi in Ghana and Bwamanda hospital pre-payment scheme in the DRC. (2) SEWA scheme in India was developed from micro-credit schemes and later added health insurance for its members' protection. (3) The traditional mutual health scheme such as the Gonosasthya Kendra in Bangladesh and Mutuelle de Sante, Rwanda. (4) Community financing supported by governments/social insurance/ NGOs such as Hygeia Community Health Care programme in Kwara State Nigeria and Community Health Fund in Tanzania (Jakab and Krishnan, 2016; Gustafsson-Wright, and Schellekens, 2013; Bennett, 2004).

Literature has shown the importance of CBHI scheme to health care financing (e.g., Bennett, 2004; Wang, et al., 2012; Gustafsson-Wright, and Schellekens, 2013; Ogben, 2014; Odeyemi, 2014; Jakab and Krishnan, 2016). For example, Jakab and Krishnan, in a literature review argue that CBHI schemes provide coverage to several people who cannot afford the costs of health care. They note, "Gonosasthya Kendra in Bangladesh is effective in reaching the poor. 80% of the people classified as destitute in the area are covered by the scheme, 46% of the poor, 20% of the middle class and 10% of the rich amounting to 27.5% total subscription rate" (Jakab and Krishnan: 2016: 26). Similarly, the Thailand Health Card Scheme shows significant supports for members with lower income group than non-members. This demonstrates a pro – poor targeting of the health card scheme in Thailand (Jakab and Krishnan, 2016).

Health Insurance Fund (HIF) initiated by a Dutch foundation in collaboration with the Kwara State government in Nigeria, has increased access of rural population to health care in Kwara State. In a quasi-experimental study conducted by the Amsterdam Institute of International Development on the impact of Hygeia Community Health Care (HCHC) among households in Nigeria in 2013 reveals that about 23,000 individuals or about 30% of the population had enrolled in the scheme. It was also revealed that the use of health care had increased on average by 20.5% for the treatment group (the insured) and HCHC has decreased out-of-pocket health care expenditures. "On average, these expenditures have declined by about 1,030 Naira per person per year, representing a 52% reduction in health expenditures when including the cost of the insurance premium" (Gustafsson-Wright, and Schellekens, 2013:11). Moreover, Polonsky, et al.'s (2009) survey of 506 households reveals that CBHI scheme for rural population in Armenia had a successful implementation by providing equitable health care to the vulnerable people including the poor, women and elderly.

However, a number of challenges of CBHI have been identified because of different ideological concepts upon which the foundations, objectives, structures and benefit packages of various CBHI schemes are based. Bennett (2004) argues that conflicting objectives and interests exist between government-financed (such as Community Health Fund in Tanzania) and individual CBHI schemes (such as SEWA in India). While government subsidised scheme is largely concerned with the equity, sustainability remains the dominant objective of individual schemes because without being in operation no other objectives would be achieved. Thus, the mechanisms of sustainability of individual scheme may conflict with equity with respect to wider health care system. Bennett (2004: 149) notes, "Exclusion of high-risk individuals from scheme membership will affect most vulnerable members of the population, increasing premium levels will most likely reduce the level of effective protection provided against financial risk". Bennett further argues that in principle the role of CBHI is to complement other forms of health care financing; however, in practice, there is minimal complementary role of CBHI schemes with other forms of the health care system. In addition, multiple risk pools exit in the developing countries operating in parallel with the social security schemes (Bennett, 2004).

Furthermore, Jakab and Krishnan in a comprehensive review of literature analyse CBHI on three themes: resource mobilisation capacity, social inclusion and financial protection. On resource mobilisation, they note that community-financing method had the strength to mobilise resources for health care. However, presence of disparity in relation to resource mobilisation capacity remains a challenge. On one hand, some schemes generate substantial revenue; on the other hand, others generate insignificant amount of revenue. For example, the SEWA scheme in India generates adequate revenues through membership fees to cover all expenses including salaries, drugs and overhead costs. Whereas, in RAHA scheme membership contributions covered between 10 to 20% of the operating costs (Jakab and Krishnan, 2016). Similarly, in an evaluation of nine mutual health organisations contribution to financing health care in West and Central Africa, Atim (1998) asserts that community health financing members account for less than 2.5% of hospital revenues in Senegal, though they made up of 30% of the admission. The contributions of members only cover a small fraction of what they spent on care. The major factor undermining revenue generating capacity of this model is the predominantly poor contributing population – the poor simply cross-subsidising the health care costs of other poor members(Jakab and Krishnan, 2016; Bennett, 2004).Thus, Atim (1998) concludes that community health organisations had inadequate contributions to finance health care.

On social inclusion, Jakab and Krishnan assert that although community or mutual health schemes are designed to provide financial protection for majority of the population who would otherwise not have financial protection, the poorest of the poor are often excluded from the schemes. They note further that social exclusion is applicable to all the categories of CBHI schemes. In the government support schemes in Thailand, Burundi and Nigeria, the lowest income group often dropouts of the scheme or face affordability problems. For instance, the government Health Card Scheme in Thailand specifically designed for the near poor and middle-income groups whereas the poorest of the poor were excluded from the scheme. Similarly, in the Health Card scheme in Burundi, social economic status and membership were positively correlated. Only 25% of households were to be part of the scheme while many households could not afford the contributions required for joining the scheme. In the provider-based community insurance (such as Nkoranzi) in Ghana, financial reason was the major hindrance for not being part of the scheme. Similar findings also reported in the mutual health fund in the Bangladesh – reasons for not being part of the scheme include inability to pay contributions, co-payments associated with the scheme etc. (Jutting, 2003; Jakab and Krishnan, 2016).

The registered CBHI schemes are either receiving subsidies from the government or donor agencies to subsidise their membership contributions. However, these subsidies are used as incentives for the scheme to register more members and generate more revenues. In Tanzania, for example, schemes with more members are likely to secure larger share of subsidies from the government or donors, whereas scheme with less members receives less subsidy. Funds from government or donors are used as 'matching grants' to support the amount of revenue generated by individual scheme. Although this serves as an incentive, it raises the question of equity among schemes because small schemes indicate poor revenue generation capacity, insolvency and poor managerial ability (Mclntyre, et al. 2005).

Regarding financial protection, literature reveals that CBHI schemes are effective in providing protection for members against 'catastrophic' health care costs (e.g., Arhin, 1994; Atim, 1998; Gumber and Kulkarni, 2000; Gustafsson-Wright, and Schellekens, 2013; Jakab and Krishnan, 2016). However, financial protection is restricted to members. For example, Gumber and Kulkarni, express that although SEWA scheme provides financial protection to members, the costs of seeking health care on household budget remained higher among members (Gumber

and Kulkarni, 2000). Moreover, Carrin, Waelkens, and Criel (2005) also note that the size of CBHI determines its risk pool. Given the voluntary nature of CBHI scheme, many people may not be willing to be part of the scheme, though other factors such geographical location, economic status, social cohesion and education are crucial. To sum up the debates about CBHI, its performance as a financing model is relatively fair, by ensuring its members are protected from huge and uncertain medical bills and have increased access to health care services. However, the problem of social exclusion whereby the poorest of the poor who could not afford the minimum contribution are excluded is a serious concern. Revenue generating capacity of the CBHI is also a challenge, although subsidized by the government and donors, risk-pooling remains limited. Similarly, the effectiveness of government targeting strategies (e.g. through subsidy) to promote equity by ensuring the poor have access to basic services remains controversial.

3.4.4 Social Health Insurance

SHI as an insurance model has distinctive characteristics. The first one is that SHI is based on compulsion – under this model every salaried employee must enrol and pay the specified premium, which often is a percentage of income. However, government may pay premiums (as subsidies either as a part or as 100%) on behalf of vulnerable groups of the population such as the poor, children and elderly. Two, it operates on eligibility – people are only entitled to the benefits only when the required contributions are made. Three, contributions to the scheme and benefits to the enrolees are presented in the rules and regulation establishing the contract between enrolees and the social insurance companies. In this model, the benefits for the enrolees are specified in the benefits package (Hsiao and Shaw, 2007). Historically, social health insurance was first introduced in Germany in the 19th century (Barnighausen and Sauerborn, 2002). Prior to this period, a number of small, informal, voluntary and CBHI schemes existed. Various relief funds such as craftsmen's guilds mutual funds, miners' funds, factory relief funds for employees; journeymen funds and community relief funds for the people unable to support themselves or did not belong to any relief funds were available and operated on the principle of community self-help, social justice and social solidarity (Barnighausen and Sauerborn, 2002; Carin and James, 2004).

German health care system operates the principle of gradualism in the establishment of SHI. In the pre-Bismarkian statutory health insurance, laws were made based on the tenets of social solidarity and mutual support. However, in an attempt to move from mutual support schemes

to SHI a number of steps were taken by the German government. These include (1) Laws guiding the establishment of voluntary health insurance scheme moved from general rules to specific rules, that is, having well-established rules guiding the development and operation of the scheme. (2) It was compulsory for people to joint any insurance fund within the ambit of the regulatory body. For instance, Barnighausen and Sauerborn, (2002: 1562) assert, "In 1854, local governments were allowed to pressure all uninsured into creating insurance funds for mutual support". (3) Compulsory membership spreads to the entire German territory for one skilled group: miners. Subsequently, the miners were mandated to join one of the several miners' regional funds (Barnighausen and Sauerborn, 2002; Sigerist, 1999).

The three incremental phases in the development of German health insurance system paved the way for the introduction of SHI in 1883 for a larger number of skilled workers. The incremental approach adopted in Germany led to the achievement of universal coverage. It was estimated, that the health insurance law of 1883 brought coverage among worker from 5% to 10% of the population. Subsequently, the coverage grew from 11% in 1885 to 37% in 1910 and by 1930 and 1950, population coverage reached 50% and 70% respectively (Carrin and James: 2004: 6). In 1981 other professional groups such as the artists, publicists were covered and by 2000, 88% of the German population was covered in the SHI. Universality of coverage with SHI was not 100% in Germany, remaining 12% are largely covered under the private health insurance, above certain income ceiling one can opt out of the SHI for other health insurance (European Observatory of Health Systems, 2000; Barnighausen and Sauerborn, 2002; Busse and Riesberg 2004).

Similarly, many high and middle-income countries following an incremental approach similar to Germany have achieved high insurance coverage with social health insurance model. In the United Kingdom, for example, the National Insurance Act was established 1911. Subsequently, several health insurance funds including trade union and employers' funds, mutual health funds and commercial health insurers became prominent and about half of the population was covered. Nevertheless, the insurance arrangement was highly complex with contribution flowing between related voluntary funds and the insured in the commercial insurance. The insured could only receive benefit in relation to the amount they had contributed (Bodenheimer and Grumbach 2005). However, in 1942, Sir William Beveridge published the agreement on social insurance. The Beveridge report recommended that British's social insurance and public assistance programmes such as retirement, disability and unemployment benefits, be financed

in a uniform manner (Scott and Marshall, 2005). However, in 1948, the National Health Service was established chiefly financed through general taxation to ensure the British population is covered (Sigerist, 1999; Scott and Marshall, 2005; Bodenheimer and Grumbach 2005).

Japan, like Germany – builds on pre-existing small, voluntary mutual funds until mandatory employment-based social insurance was established for selected groups of workers in 1922. However, in the 1930s Japanese government promoted the expansion of community health insurance nationwide. Five years after, 12 models of community health insurance were established at the national level and this paved the way for 1938 National Citizens Health Insurance Law founded on the principles of community financing (Carrin and James, 2004). The law was designed to meet the needs of farmers, self-employed in the rural communities, small companies and the poor. Subsequently, both the compulsory employment-based insurance for selected workers and the National Citizens Health Insurance Coverage covered 60% of the Japanese population in 1945. After the WW2, coverage was expanded to 90% of the population, and subsequently in 1958 law establishing compulsory insurance for all Japanese was adopted with full implementation in 1961 (Carrin and James, 2004; Ikegami and Campbell, 2004; Kobayashi, 2009).

By adopting Bismarkian model in Korea, the same systematic approach was used for the extension of SHI across distinct population groups. Korea had the first voluntary health insurance fund in 1965 and by 1977; there were 11 voluntary health insurance funds in the country. Similarly, in 1977, it became mandatory for employers of 500 employees to provide health insurance for their workers and their dependants. Sequentially, coverage was extended to companies with 300, 100 and 16 employees by 1983. Between 1979 and 1980, government officials, military service men, private school teachers, and their dependants were compulsorily insured. Finally, between 1988 and 1989 universal compulsory coverage was achieved through schemes covering rural and urban self-employed respectively, 26 years since the enactment of the 1963 Health Insurance Act (Carrin and James, 2004; Hust, 2010).

Based on the antecedents and success narratives of SHI in the developed countries such as Germany and Japan, the WHO encourages developing countries to establish social health insurance as a financing option with the promise of technical support as part of the resolution of the World Health Assembly in 2005 (World Health Assembly Resolution, 2005). WHO described SHI as a strategy for mobilising "more resources for health, pooling risk, providing

more equitable access" (WHO, 2005: 5), and delivering better services. According to Hsaio and Shaw (2007), the World Bank and other agencies, endorsed SHI for developing countries has a policy instrument to facilitate four desirable of health sector reform due to inadequate revenue to finance health care for all. The first one is that through SHI, government funds would be used to subsidise costs of health care for the poor instead of providing universal health care for all. Second, government funds would be used to provide public services including immunisation, child and maternal care etc. Third, there would be a separation between the demand and supply side of health care provision thereby outsourcing the supply side to separate entities in order to improve efficiency and quality of care. Finally, SHI would ensure people access to health care by using non-governmental organisations and private providers through means of contracting (Hasio and Shaw, 2007).

Many LMICs have adopted SHI as well, either with incremental approach – building on the existing community health funds or transformational approach – changing or replacement of the existing structure to SHI (Barnighausen and Sauerborn, 2002). While some have made substantial progress in terms of population coverage, others face the problem of extending coverage to the preponderance of the population. Costa Rica, China and Thailand have made a giant stride in reference to population coverage. For instance, Costa Rica developed SHI through the Costa Rican Social Security Fund established in 1941. The process of the set goal of universality was incremental. Initially, membership to the social security fund was targeted at the urban population as well as the workers in the coffee producing zones of Valle Central, but benefit from the social security fund was restricted to the insured workers with the exclusion of their family members. However, due to the pressure from workers and other social movements, mandatory family coverage was established in 1956 for spouses and their children below the age of 12. In addition, in 1961 legislation was made to extend coverage to all the population including self-employed and indigent. By 1990, 29 years after the legislation for universal coverage 85% of the population was covered in the SHI (Carrin and James, 2004).

Similarly, Thailand and China have had previous insurance schemes of different forms, scope, and impacts that are being incorporated into SHI. They build on various existing funds, at some stages, some funds were merged and changes were made. For instance, at the time of schemes integration in China in 2009, more than 200 million people were not covered in any insurance. However, in 2011, about 95% of Chinese were covered in different insurance some kind of coverage, and by 2013, the coverage had reached 99% of the population under the NCMS.

Overall, 93% of Chinese population had some form of insurance. In Thailand, a number of schemes including Medical Welfare Scheme, Health Card Scheme, Civil Servant Medical Benefits Scheme and Social Security Scheme were instrumental in the SHI development and the achievement of 99% of the population coverage in 2002 (Dutta and Hongoro, 2013; Talampas, 2014). Moreover, in the sub-Sahara Africa, Ghana and Rwanda used the combination of pre-existing voluntary funds and SHI model to expand population coverage. In Ghana, the combination of SHI for the formal sector employees and CBHI for the informal sector were used to expand coverage to about half of the population (NHIS Ghana, 2010; Dalaba et al., 2012). Similarly, The Rwanda government expanded population coverage to 90% of the population with SHI, through compulsory insurance in the exiting insurance funds (Rwanda MoH, 2010; Nyandekwe et al., 2014). However, population coverage remains a challenge in most developing countries that have established SHI including Nigeria, Cameroon, Kenya, Vietnam and the Dominican Republic among others (Barnighausen and Sauerborn, 2002; Adeyemi and Nixon, 2013; Muiya and Kamau, 2013).

As discussed above, many developing countries are facing serious challenges in scaling up population coverage, which is the main target of SHI. Studies have identified impediments to expanding population coverage through SHI (Barnighausen and Sauerborn, 2002; Carrin and James, 2004; Mclntyre, et al. 2005; Hurst, 2010). Barnighausen and Sauerborn based their argument on three dimensions first they argued that though many developing countries have established SHI, the replication of German's 19th century SHI is impracticable because of different principles and rationales underlying insurance schemes. They emphasise that different fundamental principles underpin traditional risk sharing in Africa. For example, some are founded on mutual benefits whereby people expect to receive from an insurance scheme as they contributed to the scheme. On the other hand, others are based on conditional mutual benefits –where members only receive benefits if they fall victim of the event they insured against. However, the pre-Bismarkian social insurance was originated on comprehensive instead of provision mutual benefits as its core principle whereby mutual self-help, social solidarity were developed, and these formed the fundamental principles for the evolution of mandatory health insurance funds in Germany.

Second, Barnighausen and Sauerborn argue that in Africa, community-based health schemes are largely introduced by external agencies that are alien to African society and thus lack the

dynamics and operation of an internal social movement which are essential for scheme performance. They maintain that labour union plays essential role in fast tracking insurance scheme, "non- movement-based schemes do not pose a threat to government and thus fail to prompt government to take over the schemes" (Barnighausen and Sauerborn, 2002: 1562). However, over time non-movement-based schemes need to incorporate elements of group action as these would not only enhance their performance, but also encourage government involvement in the expansion of social protection to the majority of the population. Third, SHI schemes were established in many countries particularly in the developing context on voluntary basis. Voluntary social health insurance sired adverse selection in that many low risk individuals are likely not to join the SHI. They observe however, that countries with successful SHI based their SHI on compulsion, such as in Germany, Japan and Korea among others.

On the other hand, in many developing contexts the establishment of compulsory insurance might not be considered politically feasible and enforceable for administrative and economic reasons. As a result, many have established SHI to some segments of the population (Barnighausen and Sauerborn, 2002). In the same way, Nicholas et al. (2015) maintained that most developing countries that targeted a limited group and provided health services for them first (usually the formal sector employees) with the plan to reach out to the informal sector workers usually the largest proportion of the population often end up with (1) a large proportion of the population uncovered. (2) Fragmented system and higher administrative costs. (3) The richest households often benefit disproportionately. Nicholas and colleagues further note that countries adopting this incremental approach, a reversal of Bismarkian model, are making very slow progress towards universal insurance coverage (Nicholas et al. 2015). However, they argue for full population coverage from the outset, noting that countries such as Thailand, China and Brazil have adopted full population coverage and they are making progress and moving rapidly to higher levels of insurance coverage.

For Hasio and Shaw, a country's level of economic structure and development influences how many people could be covered and scaling up of SHI towards universality of health. While developing countries such as Nigeria, Kenya and Ghana have large informal sector employment, which hinders mandatory pay roll tax deduction and collection of premiums, the structural features of the developed economy tend to contribute to the enabling environment for SHI such as the case of Germany and Japan. However, they note that large informal sector

economy, high prevalence of poverty, low per capita income, high dependency ratio etc. represent immense challenges to the scaling up of SHI in sub-Sahara Africa context (Hasio and Shaw, 2007). Moreover, Mclntyre, et al. (2005) explain that in contrast to the Germany incremental approach (from small, informal, voluntary and solidarity schemes which pave the way for larger, formal and compulsory schemes); many developing countries planned to achieve national health insurance coverage with limited targeted group (e.g., formal sector) being the first step. The authors based their argument on two points: one, introduction of SHI has divided the people into parts. The insured who have access to a number of good health services and the uninsured who regularly encountered poor public health services and high cost of private health care. Two, in many instances, the civil servants are usually the first group of employees to be covered under the SHI. Although they represent the largest group of formal sector employees in the African context, the limited public funds often used to subsidise mandatory health insurance for them. In that case, very limited government funds may likely be available to provide health care for majority of the population who depends on publicity-funded services (Mclntyre, et al., 2005).

Furthermore, Mclntyre and colleagues posit that fragmentation of a number of voluntary insurance schemes in the sub-Saharan African with a wide range of contributions and benefit packages pose a challenge to the mandatory health insurance with a common health package and contributions. They note, for example, the resistance from the exiting community-based health insurance schemes in Ghana over restructuring of their contributions and benefits package in order to incorporate them into the national social health insurance schemes. However, they argue for a health insurance with common contribution and benefits package from the onset rather than fragmented health insurance with different contributions and packages, which could be a hindrance to the attainment of universal coverage in developing nations (Mclntyre, et al. 2005). In summary, SHI has been used to expand coverage to the greater part of the population mainly in the high and middle-income countries. In the countries with high universality of coverage, SHI was based on the principle of incremental approach of the exiting small, informal and voluntary insurance schemes to large, more formal and compulsory schemes. In Germany as in other countries with universal SHI, legislation incrementally formalised, expanded and made health insurance compulsory. However, SHI largely remains voluntary in many LMICs

3.5 National Health Insurance Policy

National Health Insurance Policy (NHIP) is a government programme that guarantees health insurance coverage for all residents of a nation. The NHIP objectives is to ensure everyone is covered for basic health care services, promote costs containment, ensure cost effective provider reimbursement and financial accessibility of health care for all. NHIP is generally financed by a replacement of out-of-pocket payment with one or a mixture of other forms of prepayment model including tax-financed (i.e., single-payer system or Beveridge model) and SHI (multiple-payer system or Bismarck model). Under the tax-financed system, everyone is entitled to health care without having to make direct contribution into the insurance fund. Contributions into insurance fund are from taxes. For instance, countries like Canada, UK, Finland and Sweden have tax-financed, single-payer health care system (Ortiz, 2007; Carrin, 2002).

Historically, for example, the Canadian tax-financed health insurance started in 1947 when the publicly financed universal hospital insurance was first introduced in Saskatchewan province. In 1957, exactly 10 years after, the Canadian government adopted the Hospital Insurance Act, which was implemented completely in 1961. Moreover, in 1966, the same government ratified universal medical insurance for the entire population which was in used in 1971 (Bodenheimer and Grumbach, 2005). Thus universal national health care system in Canada started out in a single province (Saskatchewan) and later spread from there to the entire nation. Similarly in the UK, the Beveridgeian proposed model of unified single-financed health care system brought about the development of a National Health Service in 1948 (Scott and Marshall, 2005). Like other Nordic countries, Finnish health care system offers comprehensive universal coverage of health care funded through general taxation and relied largely on public health care (Hurst, 2010).

Advocates of single-payer tax-funded NHIP based their arguments on (1) universality, that is, every individual in the country is covered in the same plan because of being a resident. (2) Solidarity and trust: everyone is insured on the same conditions irrespective of socioeconomic status. (3) Efficiency: all citizens are insured in the same national pool of fund thereby making risk pooling more efficient and lower health expenditures. (4) Health insurance is separated from employment status: whether an individual is employed or not, he/she is covered under the nation health programme (Ortiz, 2007; MacGregor, 2014). However, critics of this model argue that first, tax-financed, single-payer health care system has too much power on people's health

choice by restricting them to type treatments and health care providers they can access, which in turn results in rationing of care and excessive waiting time in most of the publicly funded health care facilities. Second, it functions on taxes, and thus depends on the amount of taxes that can be collected. In the case of insufficient funds, there is possibility of increasing tax levy on the taxpayers to support the dependent population (Bodenheimer and Grumbach, 2005).

On the other hand, social health insurance functions on multiple-payer system such that mandatory contributions are made from employers, employees, self-employed, enterprises and government into decentralised social health insurance funds. The starting point for contribution into the insurance funds is certain percentage of a formal worker's salary, whereas self-employed pay contribution either by estimated income or flat rate. However, government pays contribution or subsidizes insurance membership of vulnerable population groups such as the elderly, disabled, low-income informal sector workers and the poor who may not be able to afford contributions. Achieving universal health insurance by SHI varies among countries. It may be faster in some countries but slow in others, putting into consideration economic, political and social and cultural factors (Carrin and James, 2004). This model is largely found in Western Europe including Germany, Austria, Belgium, Netherland and Switzerland among others. Similarly, many countries in Asia, Africa and Latin America have also adopted this model. Although many countries (especially in the OECD) have attained universalization of health insurance with SHI, at different pace, attaining this target remains difficult in many developing countries.

Exponents of this model hold the view that firstly, given the high cost of medical care; governments alone would not be able to provide health care for all. Therefore, mandatory contributions from employers and employees are seen as the only way to raise fund to finance health care. In the developing countries, for example, the World Bank and WHO champion and recommend SHI for the achievement of universal health care. In 2005, the World Health Assembly passed a resolution thereby mandating its member states to adopt and sustain SHI because firstly it is a strategy for more resource mobilisation for health care, risk pooling, delivery of better quality care and provision of equitable access to health care for the poor (WHO, 2005). Secondly, SHI reduces moral hazard – co-payment and pre-payment ratio often reduces moral hazard (i.e., excess demand for health care) because when people share costs of health care, they tend to use it wisely and thus helps to ensure better financial accessibility for all. Thirdly, SHI makes public resources available for the provision of health services for the

targeted population (i.e., the poor) who cannot afford to pay premiums rather than public financing and provisioning of universal health care for all. Finally, SHI encourages private participation by outsourcing private facilities and providers to improve the insured access to health care services (WHO, 2005; Hsiao and Shaw, 2007; Word Bank, 2009; McGregor, 2014).

However, literature has shown that many developing countries adopting SHI strategy to finance NHIP face series of challenges. One, poorly targeted public resources thereby the public services are inefficiently and ineffectively managed to provide public services to the target population. Often times, public facilities operate under bureaucratic rules, as a result, they suffer delay of funds because funds do not reach health facilities on a timely basis, which in turn result in low productivity and shortage of drugs and supplies. Two, public funds often spent disproportionately for the rich as against the poor that are targeted. For example, public resources are chiefly located to public hospitals in the urban areas such as secondary and tertiary hospitals that are mostly used by the affluent urban residents. Three, SHI do not operates the logic of risk pooling mechanism, which is the basis for health financing policy towards universal health insurance in most developing countries. For example, coverage of target group (i.e., the formal employees) is a demonstration that certain population groups are administratively easier to manage than the other population groups. This often results in exclusion of the majority: the informal sector workers, rural dwellers and the poor (Mclntyre et al., 2005; Hasio and Shaw, 2007; La Forgia, and Nagpal, 2012).

Achieving universal health insurance is the aim of any national insurance programme with technical support from international agencies notably the WHO and United Nations. UHC has been acknowledged as the most crucial goal of every health system (WHO, 2014; Nicholson et al, 2015; Abiiro and De Allegri, 2015). Historically, the General Assembly of the UN in 1948 approved and declared the Universal Declaration of Human Rights. In the declaration, Article 25 states inter alia, "everyone has the right to a standard of living adequate for the health and wellbeing of himself and his family including medical care…" (United Nations, 1948: 5). In addition, the Alma-Ata Declaration of 1978 states among others that it is the responsibility of governments to provide health care delivery for their people which could be fulfilled primarily by provision of PHC services to achieve the set goal of universal health care…" (Alma-Ata Declaration, 1978). In 2012, the United Nation General Assembly reiterated that all its member states should pursue the transition of their health systems toward universal coverage

(United Nations, 2012). Furthermore, in 2014, the global conference on UHC called for the universal coverage of every health system for inclusive and sustainable growth (Bristol, 2014).

It was being debated in the UN assembly that universal coverage would be the potential goal for post 2015 global development agenda to ensure people have access to health services without facing financial hardship paying for the services (Global Health Strategies, 2015). In the light of the several international calls and declarations, several countries committed to achieving the goal largely dependent on one or a mixture of tax-funded and SHI (Gustafsson-Wright and Schellekens, 2013; Hasio and Shaw, 2007). To achieve the set target of universal coverage, WHO (2010) suggests that governments should take into account three policy questions (1) who in the population is covered? (2) Which services are covered? (3) What level of financial protection do people have when accessing services? Similarly, Nicholas and colleagues note that although no country has reached a utopian state of universal coverage, universal coverage could be measured along population coverage, service coverage and financial protection (Nicholas et al., 2015). On population coverage, for instance, literature has shown that most countries in Western Europe uses SHI to expand their population coverage, though transition period vary from one country to the other, high insurance coverage was attained within the transition period. In Germany, 88% of the German population was covered by SHI, notwithstanding that above certain income cap the insured can opt out of SHI for private health insurance. In Austria, 96% of the population was achieved using SHI. Similarly, 99% of the Japanese population had been covered under the SHI model (Barnighausen and Sauerborn, 2002; Carrin and James, 2004). However, single tax-funded health care has been used to attain universal insurance coverage in Demark, Sweden, Finland, UK, and Portugal among others (McGregor, 2014; Bodenheimer and Grumbach, 2005).

Furthermore, to achieve universal health insurance coverage in the US, Employer Sponsored Health Insurance (ESHI) and Public Sponsored Health Insurance (PSHI) were designated to expand insurance coverage (Walden, 2012). Despite this harmonised programme, literature shows that the number of uninsured persons in the US remains high. The number of uninsured in the US, for example, was 25 million people in 1980 and the number increased to 43.6 million in 2002. Furthermore, analysis shows that uninsured persons in the U.S. were on the increase by 2011 with 48.6 million (15.7%). However, in 2012, the number declined to 48 million (15.4%). Thus, the decline in the percentage of the US uninsured in the recent time was attributed to Patient Protection and Affordable Care Act (PPACA) of the Obama administration

(U.S. Census Bureau as cited in Bodenheimer and Grumbach, 2005; Walden, 2012; New York Times, 2012).

The US, under Obama administration had intention to increase health coverage to uninsured Americans by 2019 by making PSHI mandatory to the uninsured through federal policy and legislation (PPACA). PSHI has been in the form of Medicare for the elderly and Medicaid for the physically challenged, and workers with low-income who are 65 year and above and not covered in any form of health insurance (Wagner, 2012). Medicare exemplifies SHI model, for example, Medicare part A is accessible only to those who have paid social security taxes and Medicare part B is for people who paid monthly contributions albeit supported by the government. However, Medicaid replicates tax-funded health care system (Wagner, 2012; Bodenheimer and Grumbach, 2005). The PSHI is focused on increasing the number of Americans covered with health insurance. However, literature has argued that Obama health care programme is rationally attractive, but remains contentious. While the advocates assert that 'Obamacare' would increase the number of insured American to health care, critics argued that the programme is politically and financially unacceptable (Bodenheimer and Grumbach, 2005; Hadley, et al., 2008; Wagner, 2012).

In the LMICs, most countries are also taking the route of SHI in achieving universal health insurance coverage, though at different stages and pace of implementation. Some have reached high level of coverage, for example, Thailand, China, Colombia and Rwanda. Thailand achieves high coverage of approximately of 90% of Thai population with the configuration of different schemes such as Medical Welfare Scheme, Health Card Scheme, Civil Servant Medical Benefits Scheme and Social Security Scheme (Dutta and Hongoro, 2013; Talampas, 2014;). Similarly, the integration of existing schemes in China such as Urban Employee-Basic Medical Scheme, Urban Residents-Basic Medical Scheme, NCMS and the supplementary schemes to cover critical diseases of rural unemployed resulted in high insurance coverage of the population to 93% (Liu et al., 2012; Talampas, 2014). Colombia had similar trend with China and Thailand in terms of integration of different schemes to achieve 70% coverage of the population (Hsiao and Shaw, 2007). Coverage in Rwanda was about 90% of the population (Rwanda MoH, 2010; Nyandekwe et al., 2014). In contrast, many countries are struggling with expanding insurance coverage, for example, 10% of the population in Dominican Republic is covered (Barnighausen and Sauerborn, 2002). About 5% of Nigerian population is covered (NHIS, 2012; NMA, 2015).

On service coverage, studies show that countries with tax-funded health insurance demonstrate comprehensive health care package (Hurst, 2010; Macgregor, 2014). For example, the health benefits of Canadian provinces are broad including in-patient, outpatient services and diagnostic technologies, and as a result, it created a decent health care delivery system. Low income Canadians receive more health services than higher income groups, this is often in proportion to the higher burden of disease in lower income groups (Klatt, 2000). It is worth noting that Canadian health system prohibits private health insurance from services included in the provincial health plans to avoid preferential treatment of privately insured patients. Similarly, in Sweden as in other Scandinavian countries, all citizens are entitled to comprehensive health services mainly provided by public health facilities in such that no distinction exists among the people in terms class, status and income (Bodenheimer and Grumbach, 2005; OECD, 2012). On the other hand, service coverage with SHI countries differs among countries, most developed SHI countries offer a wide array of in-patient and outpatient care including the use of diagnostic technology and x-ray, whereas, services coverage in the developing countries seemed not to be comprehensive, many services are often not included in the benefits package. In Vietnam, for example, services excluded from the benefits package include HIV/AIDS prevention and treatment programmes, dental care and some pharmaceuticals among others (Talampas, 2014). Similarly, health reform in China had increased the equity scale on health care utilisation in both in-patient and outpatient services among the people than pre-reform era. However, disparity existed between people of higher and lower socioeconomic status in terms of the use of diagnostic technologies because the reform is primarily aimed at targeting basic health care services (Liu et al., 2012). The study conducted by Liu and colleagues reveals that socioeconomic status including education, income and position at work influenced outpatient care and use diagnostic technology among the study population in China.

On Financial protection viewpoint, national health insurance model operates different methods of protecting insured financially and keeping health care expenditures low. While Countries with a tax-financed system of national health insurance such as Canada and the Scandinavia, ensure their population are protected, with little or no cost sharing in the form of co-payments (a percentage of the cost of services paid out-of-pocket at the time of receiving medical care services) as part of reimbursement transaction to contain costs. Other methods such as global budgets for hospitals expenses and expenditure caps for the health providers feature prominently and serve as a mechanism to control costs and keep expenditures low. Hospitals

and providers are compelled to stay within the allocated funds, and thus expenses outside the global budgets or expenditure limits are not entertained by the insurance funds (Bodenheimer and Grumbach, 2005). In contrast, patient cost sharing features prominently in most SHI countries as part of reimbursement transaction. For example, patient cost sharing became prominent in Japan in 1997 following the increase in health care costs as a result of aging population and economic recession in the 1990s. Co-payments increased from 10% to 20% of all services; however, due to excessive burden of co-payments on patients, monthly limit of co-payment was capped at about $500 while the aged were exempted (Ikegami and Campbell, 2004; Bodenheimer and Grumbach, 2005; Kobayashi, 2009). Similarly, in Korea, cost sharing is one of the policies widely used to control health care cost, it induces inequitable medical services utilisation such as ambulatory care. It does not decreased moral hazard as purported; instead it increases inequitable health care distribution among different income groups (Kwon, 2003; Kim, et al., 2005).

Furthermore, Ewelukwa, et al. (2013) in their study of health expenditures and payment mechanism in Nigeria, reveal that patients with lower socioeconomic status were less likely to adhere to recommended medications compared to patients with higher socioeconomic status. They further note that increase in patient out-of-pocket spending for prescribed drugs is likely to exacerbate health disparities between low and high-income earners. Nevertheless, literature has shown that cost-sharing model reduces unnecessarily use of emergency services without affecting appropriate use of health services if it is used in modest amounts (Selby, et al., 1996; Sabik and Ghandhi, 2015). However, it is designed to encourage patient to use lower-cost effective care such as clinic rather than to discourage use of health services. In sum, NHI is a state programme to ensure universal health insurance for all without financial burden. While countries with tax-financed single-payer system have attained universal insurance coverage, disparity exists among SHI countries in terms of achieving this goal. However, the developed SHI countries have attained high population coverage while majority of LMICs are still struggling in scaling up coverage. Low population coverage, minimal benefits package and patient cost sharing remain prominent in the LMICs.

3.6 Health Financing Policy in Nigeria

Health care financing in Nigeria is grouped into two: pre-1980 and post-1980 (Adesina, 2007a, b). In the pre-1980, health care was financed from general taxation that guaranteed ‘free’ universal access for all. Adesina (2007a: 23) assert, “Health care was readily available at public

hospitals and clinics at no charge". In this regard, financial barrier to health care access was avoided as social spending on health was seen as social investment to enhance economic growth and development (Adesina, 2007a, 2009). Adesina further notes that similar to education, "social spending on health was part of the wider objective of defeating the triad of ignorant, poverty and disease" (Adesina, 2007a, 25). Moreover, the nationalist ideology was driven by inclusive approach to development whereby government was responsible for all aspects to development without external interference. The result of this was positive correlation between health-related indices and economic growth in the first decade of post-independence Nigeria (Adesina, 2009). For instance, Nigeria's GDP grew from 3.1% in 1960 to 7.5% in 1970 with agriculture and manufacturing largely responsible for the astronomical growth of the economy. Agriculture share of the GDP in 1965 and 1970 was 50.2% and 38.2% while manufacturing share in the same period was 5.0% and 3.4% respectively (World Bank, 1980). Interestingly, the total population per medical doctor declined drastically from 73,710 to 15,740 between 1960 and 1975, infant and under-five mortality per 1,000 live births also declined from 50 in 1970 to 22 in 1979 (World Bank, 1980).

However, the post-1980 was characterised by slow economic growth rate as a result of poor agricultural output, decline in international petroleum prices, balance-of-payment deficit and fiscal crisis coupled with the increase in government budgetary obligations (World Bank, 1980; 1987; Helleiner, 1983), which in turn resulted in the cuts of social spending (Adesina, 2009). The health sector and other basic social services then began to receive less allocation from the federation account starting from this period. For example, public health spending as a percentage of the GDP between 1981 and 1989 were as follows: 2.0% in 1981; 1.6% in 1982; 2.0% in 1983; 1.1% in 1984; 1.99% in 1985; 1.82% in 1988 and 1.50% in 1989 (Central Bank of Nigeria (CBN), 1983, 1990). In addition, health expending as a percentage of government expenditures dwindled from an average of 3.5% in the 1970s (World Bank, 1980), to less than 2% in the 1980s. Moreover, public spending on health as a percentage of GDP hovers around 2% in the successive years (Ogunbekun, et al., 1999; Obono, 2007).

3.6.1 Financing Reforms

Given the low growth rate in the economy and limited fiscal space experienced in the 1980s, the international financial institutions led by the World Bank and IMF introduced Structural Adjustment Policies as the prerequisite for structural adjustment loans for the developing

countries (Adesina, 2007a; Obono, 2007; Obasan 2013;). Part of the conditions for the loan includes minimal government intervention in their economies, private participation and introduction of user fees in government facilities with the assertion that there would be more money in the system through private participation and subsequently be used to improve quality, and increase access to health services (World Bank, 1987, 1993).

In examining the equity impacts of user fees, literature is complicated and contentious on the impact of user fee in health status of individual(s) following its implementation. An advocate of user fees assert that "the demand for health care was "price inelastic" such that implementation of user fee or increasing costs would not deter people from using health care services" (de Ferranti 1985: 35). In contrast, critics have demonstrated in studies that demand for health care is "price elastic" and malleable, that is, demand for health care is easily influence by costs of health care utilisation especially among the poor (e.g., Asenso-Okyer, 1998; Jütting, 2003; Akashi, et al., 2004; Jacobs and Price, 2004). In addition, studies have also indicates that user fees brought out a number of coping strategies that could be devastating to health care users over a long time period. These include self-treatment, not seeking treatment at all and delaying in seeking treatment (e.g., Ogunbekun et al. 1999; Sahn, et al., 2003; Mohindra, 2008). Similarly, Oyibo (2011) observed among government employees in Abakaliki, Nigeria that 85% of respondents reported paying for services through OOP payment; health services were obtained at the expense of selling off assert, seeking financial support from relatives offset medical bills, spending substantial part of household budget on medical bills etc.

As indicated earlier, government expenditure on health as a proportion of GDP declined slowly from 1.99% in 1980 to 1.39% in 1998 (Obono, 2007). Within the same period, health budget from government annual allocation was estimated at 533.6 million US dollars in 1980 and 683.8 million US dollars in 1998 (CBN, 1985, 2002). However, the burden of paying health care fell disproportionately on households, for instance, of the total health expenditure in Nigeria between 2000 and 2006, private health expenditure accounted for 66.5% and 70.3% while government expenditure in the same period accounted for 33.5% and 29.7% respectively. Further analysis shows that in the private health expenditure, OOP payments accounted for 92.7% and 90.4% respectively (WHO, 2009), the figures barely changed by 2012 (WHO, 2015). Moreover, evidence reveals that the burden of OOP payments reflected in the unpleasant health-related indices such as Maternal Mortality Ratio (MMR) and Infant Mortality Ratio (IMR). For example, MMR was 1200 death per 100,000 live births in 1999 and in 2013 560

deaths per 100,000 live births, while IMR in the same period was 114.70 deaths per 1000 live births and 75.40 deaths per 1000 live births respectively (WHO, 2000; 2015). Although the above evidence shows a decrease in the mortality rate in Nigeria, it is very different compared to other sub-Saharan countries such as Ethiopia and South Africa.

The abrupt changes in the Nigerian health care financing in the 1980s denied most Nigerians access to basic health care services. Per capita income fell from US$1600 in 1980 to US$270 in2000, putting Nigeria among the 20 poorest countries in the world (OECD, 2012). The successive years brought no respite; rather the situation became more severe. Life expectancy at birth was fixed at 47 (WHO, 2007, 2012), HIV/AIDS, malaria and childhood diseases remain widespread, and the country's health system ranked 187th out of 191 countries (WHO, 2002). However, the impact of SAP health initiative has generated a heated debate. The advocates argued that health sector reform to some extent had positive impacts in the countries where they were successfully implemented, but acknowledged the failure of user fee to increase revenue in most LMIC particularly in the sub-Saharan Africa (World Bank, 1993, 1994). On the other hand, critics described user fee as devastating, excruciating and a disaster, causing a dire plunge in virtually all health indices in the sub-Saharan countries (Mkandawire, 2007; Adesina, 2009). Arising from the failure of user fee to increase revenue, the World Bank, IMF and other international agencies resulted in rethinking a flexible alternative funding that would ensure financial protection of households from health care costs with more recognition of government role in the provision of social services notably education and health (World Bank, 1993, 1994; WHO, 2000).

The international agencies led by the World Bank and WHO recognise the potency of risk sharing model of social health insurance in the developing countries to stimulate four desirable components of health sector reform due to inadequate tax revenue to fund health care for all. These include one, government funds would be used to subsidise costs of health care for the poor instead of providing universal health care for all. Second, government funds would be used to provide public services including immunisation, child and maternal care etc. Third, there would be a separation between the demand and supply side of health care provision thereby outsourcing the supply side to separate entities in order to improve efficiency and quality of care. Finally, SHI would ensure people access to health care by using non-governmental organisations and private providers through means of contracting (Hsiao and Shaw, 2007). Several developing countries including Nigeria therefore had begun to shift their

financing policy to SHI (WHO, 2010; Gilson and Mclntyre, 2005). In summary, the international agency admitted the failure of user fee or OOP to increase revenue and access to health care in the developing countries including Nigeria and therefore advocated for a shift to SHI.

3.7 National Health Insurance in Nigeria

Given the unpleasant conditions of health care delivery in Nigeria such as inability of government-owned health facilities to provide 'free' health care for all, poor condition of health facilities, declining of government financial allocation to health care in the face of rising costs, and devastating effects of user fee, NHIS was established in 1999. The law establishing NHIS states that:

> "There is hereby established a scheme to be known as the National Health Insurance Scheme (in this Act referred to as "the Scheme") for the purpose of providing health insurance which shall entitle insured persons and their dependants the benefit of prescribed good quality and cost-effective health services as set out in this Act" (NHIS Act, 2004: 3).

With the aim to:

> "facilitate fair-financing of health care costs through pooling and judicious utilisation of financial resources to provide financial risk protections and cost-burden sharing for people against high cost of health care through various prepayment programmes prior to their failing ill" (NHIS, 2012: 18).

It is a health financing reform aimed at providing financial protection for people against huge financial costs through prepayment system. NHIS was officially launched in 2005 as a SHI programme. It functions with three broad programmes including formal sector, informal sector and vulnerable group. NHIS relies on contributions from employers, employees, individuals and government revenue as source of funding. A mixture of private and public providers who are reimbursed by HMOs supplies health services to the beneficiaries (NHIS, 2009, 2012).

A number of contribution rates exist for different programmes in the NHIS. For instance, contribution to the scheme for the Formal Sector Social Insurance Programme varies, for the federal government employees, the employees pays 1.75% while the employer pays 3.25%

representing 5% of the employees' gross salary. However, for other tiers of government and the private sector, the employee pays 5% while the employer pays 10% representing 15% of the employee's basic salary (NHIS, 2012). Furthermore, for the Voluntary Individual Social Insurance Programme, interested individual pays 15,000 naira (US$ 96.7) per person annually, though subjected to review. Tertiary Institutions Social Insurance Programme for the students of higher institutions is funded by students' contributions. The premium replaces the medical fees charged by various institutions. Contributions are determined actuarially and a minimum premium of 2,000 naira (US$10.9) is to be charged while other sources of funds may include government subsidies, charitable and philanthropic organisations among others (NHIS, 2012, 2015).

Under the CBHIP, contribution is flat rate per individual or members of an occupation-based group such as farmers. Their contributions could be paid in cash monthly or seasonally. For example, in Ayedun community in Ekiti State each member pays 1,200 naira (USD 6.5) per annum or 100 naira (US$ 0.54) monthly, in Abuja community members pay 1,500 naira (US$ 8.1) per annum while the federal capital territory administration pays 13,500 naira (US$ 73.7) as subsidy for each member (Centre for Public Policy (CPP), 2014). The concern of different contribution rates allocated to different groups in reference to benefits, quality and access remains a debate. For instance, studies conducted in the southeast Nigeria reveal that community participation in CBHIP was low due to initial minimal payment attached to the programme. Low willingness to pay contributions among low-income earners was revealed as the main impediment to CBHIP in the area (Uzochukwu et al, 2009; Onwujekweet al, 2010). Moreover, because of low willingness to pay premiums, Christian Aid (2005) asserts that significant involvement of subsidies through government and donors, inclusion of payment exemptions to population in the lowest poverty quartile is essential for setting a sustainable and equitable programme.

3.7.1 Financing and Benefits in National Health Insurance Scheme

Equity is the ability without prejudice to recognise the right of everyone, and with a sense of justice and objectivity being its guiding principles (Bodenheimer and Grumbach, 2005). There are two types of equity horizontal and vertical. Horizontal equity occurs when people with equal needs receive similar treatments irrespective of socioeconomic status of the people. On the other hands, vertical equity happens when people with different ability to pay have access

to different health care needs based on ability to pay (Bodenheimer and Grumbach, 2005). Equity in financing could be progressive when payment as a percentage of income increases with income. In contrast, it could be regressive when payment as a share of income decreases as income increases, which in turn disproportionately affect lower-income earners (Bodenheimer and Grumbach, 2005). Odeyemi and Nixon (2013: 15) explain that the objective of any national health programme "is to mobilise resources for the health system, set the right financial incentives for providers and ensure all individuals have access to equitable health care services".

Studies have analysed equity in financing and benefits among the enrolees (e.g., Uzochukwu, et al., 2009; Polonsky, et al., 2009; Onwujekwe, et al., 2010; Wang, et al., 2012; Macha, et al., 2012; Liu, et al., 2002; Odeyemi and Nixon, 2013; Ilesanmi and Ige, 2013; Ewelukwa, et al., 2013). For example, in a study conducted by Liu, et al., (2002) assessing equity in the urban health insurance reform in China, observe that after the reform there was horizontal equity in accessing basic care among different income groups. The low-income earners had significant increase in outpatient care. However, vertical equity existed in accessing health care among the people; low-income earners did not have access to advanced diagnostic technology. In a similar study, Wang, et al., (2012) reveal that regardless of the fact that the poor had access to the village-level outpatient and inpatient care; the rich accessed the overall inpatient care utilisation disproportionately. Furthermore, in a survey of 506 rural households operating insurance schemes in Armenia, Polonsky, et al., (2009) observe an equitable distribution of health benefits among community health insurance scheme in Armenia. However, participation was low because of inability to pay contributions and lack of a comprehensive health package that includes coverage for chronic diseases like hypertension, diabetes and AIDS.

Odeyemi and Nixon (2013) in a review-based comparative analysis of equity in Nigeria and Ghana, assert that great disparity existed in funding and accessing health care in Nigeria compared to Ghana. OOP payment in Ghana had fallen from 80% to 66%. In contrast, OOP payment remains high in Nigeria with over 90% of the population. In spite of the introduction of NHIS in both countries, majority of the population makes OOP payment for health care services (Odeyemi and Nixon, 2013). They further note that NHIS in Ghana offers uniform benefits across all beneficiaries while benefit package in Nigeria depends on membership category. Moreover, in a study of health benefits among NHIS enrolees in Enugu state Nigeria. Obikeze, et al., (2013) find socio-economic status such as income, gender and occupation as a

determinant of health care utilisation. They note in the study that the poorest group (quartile 1) received the highest benefits for both in-patient and outpatient care whereas the poor group (quartile 3) received highest delivery care. Therefore, the poorest group (quartile 1) made more payment for inpatient and outpatient treatment than other socioeconomic groups, while the poor group (quartile 3) made more payment for delivery care. However, the poorest group disproportionately paid for health care than other socioeconomic groups.

On the other hand, in a survey conducted among rural, semi-urban and urban communities in Anambra and Enugu states, Onwujekwe, et al., (2010) observe that socioeconomic status such income, gender, education and place of residence were among other factors that determine people willingness to pay for CBHI. They note that less than 40% of the rural population were willing to pay membership contributions for themselves and their households. The amount they were willing to pay vary between 250 Naira (US$1.7) to 343 Naira (US$2.9). They further reveal that the higher the socioeconomic status, the higher the WTP amount. Further to the study, male with more education indicated higher WTP than female with less education. The log ordinary least square (LOS) shows negative relationship between paying OOP for health care and willingness to pay. In contrast, there was positive relationship between paying for health care using insurance and to WTP. In the same way, in a comparative study of NHIS enrolees and fee-paying patient in Ibadan, Ilesanmi and Ige (2013) observe unequal access to care and costs between the two groups. They reveal that 15% of NHIS patients had a diagnostic test while 28.5% of fee-paying patients had access to the same test. On the costs of care, the mean cost for the fee-paying patients was $14.2 while NHIS patient was $18.4.

3.7.2 Quality of Health Care Services

High quality care "is the care that assists healthy people to stay healthy, treats people's acute illness, and allows chronically ill people to live long and fulfilling a life as possible" (Bodenheimer and Grumbach, 2005: 114). The type of health care an individual receives when he/she is ill determines his/her response to treatment. To receive quality care it necessary for people to have good health facilities including qualified health care providers. There is a likelihood for people with disadvantaged health care to suffer worse health outcomes compared to those with access to high quality care (Bodenheimer and Grumbach, 2005). Many people visit hospitals, health care providers, and other caregivers to receive magnificent quality care,

however, they are denied quality care due to many factors including inadequate scientific knowledge and incompetent health care providers (Bodenheimer and Grumbach, 2005: 114). According to National Committee for Quality Assurance (NCQA) (2010) "between 8% and 24% of ambulatory patients, receive prescription drugs that are inappropriate or contraindicated and one-third of abnormal laboratory tests" (NCQA, 2010; 15).

Researches have explored the quality of health care in health insurance. While some scholars (e.g., Obermann, et al., 2006; Ibiwoye and Adeleke, 2008; Agba, et al., 2010; Onyedibe, 2012) observe that health insurance offers poor services. For example, Obermann, et al., (2006) note that although SHI in Philippines has been successful in enrolment, quality and price control remains a major challenge. In the same way, Onyedibe, et al., (2012) in a survey of 200 respondents in Jos Nigeria, reveals that unavailability of required services has become a frequent occurrence in the NHIS. Twenty-six per cent of respondents were not satisfied with the scheme because of the following reasons inadequate registration system, delay in receiving required services, defective referral system, and lack of coverage of some required services in the scheme. In addition, a significant relationship was found in the study between the percentage of enrolees and poor health indices. Similarly, Agba, et al., (2010) in a study of employee' access in Cross River State, find disparity among employees' access to NHIS. The federal employees had more access to the scheme than the state, local government employees did and self-employed. The study also reveals insufficient personnel and medical facilities as the potent hindrance of NHIS in the state.

In contrast, scholars (e.g., Ibrahimipour, et al., 2011; Mohammed, et al., 2011, 2014; Owumi, et al. 2013) observe high quality with health insurance services. For example, Owumi, et al., (2013) in a survey of NHIS services in Oyo State found approximately 80% of the respondents preferred NHIS services because it reduced OOP payments. Sixty per cent of the respondents were thus satisfied with NHIS services. However, 40% of the respondents were dissatisfied with some of the services including the practices of HMOs in terms of process of authorisation code when referred from secondary to tertiary facility. Furthermore, Mohammed et al. (2011) in a study of client satisfaction with NHIS in Jos, revealed satisfaction rate (42%) among the respondents. Marital status, general knowledge and awareness of contribution were found to positively influence clients' satisfaction. In another study by Mohammed et al. (2014) on providers' perspective, they revealed that in providers' payment mechanism domain, 95% of the providers prefer capitation as payment method. On benefits package domain, 97% of the

providers were satisfied with the package. On the administrative efficiency domain, 80% was recorded for both promptness and referral system while 93% for prompt arrival of funds. However, monitoring mechanism performed inadequately (37%). In a study of users' satisfaction of NHIS services in Ibadan, Osugbade, et al., (2014) observe different areas of satisfaction among the respondents, 55.6% were satisfied with drugs prescriptions; 51.7% were satisfied with the attitude of staff and 77.8% satisfied with waiting time.

O'Neil and Seifer, (1995) assert that policy develops gradually in a cyclical manner to find solution to problems but in the process create new problems that required new solution. Policy changes over time in order to proffer solution to a pressing problem such as inadequate access to health care and burden of health care costs, but also frequently produce a number of unexpected results such as gap in medical coverage, stimulating inflation in health care cost (Bodenheimer and Grumbach, 2005: 187). In Nigeria, the policy goal of universal insurance coverage within the ambit of NHIS is to the following objectives: (1) "ensure every Nigerian has access to good healthcare services" (NHIS Act, 2004: 5). (2) "Protect families from the financial hardship of huge medical bills" (NHIS Act, 2004: 5). (3) "Limit the rise in the cost of healthcare services" (NHIS Act, 2004: 5). (4) "Ensure equitable distribution of healthcare costs among different income groups" (NHIS Act, 2004: 5). (5) "Maintain high standard of healthcare delivery services within the scheme" (NHIS Act, 2004: 5). (6) "Ensure efficiency in healthcare services" (NHIS Act, 2004: 6). (7) "Improve and harness private sector participation in the provision of healthcare services" (NHIS Act, 2004: 6). (8) "Ensure adequate distribution of health facilities within the federation" (NHIS Act, 2004: 6). (9) "Ensure equitable patronage of all levels of healthcare" (NHIS Act, 2004: 6). (10) "Ensure the availability of funds to the health sector for improved services" (NHIS Act, 2004: 6). However, several constraints have been identified militating against the achievement of the policy goal and objectives, these are categorised into three parts, namely (1) financial challenge (2) institutional inadequacy (3) fragmentation in funding pools (Achime, 2005; Omoruan, et al., 2009; Obasan, 2013; Onoka, et al., 2013; Uzochukwu, et al., 2016).

3.7.3 Financial Challenge

Financing is a fundamental constraint to achieving UHC in the developing countries. Limited coverage of health policy has been attributed to scarce financial resources (Achime, 2005; Garrin and James, 2005; Hsiao, 2007; WHO, 2014). In Nigeria, government spending on health

sector has been very inadequate over the years (Ogunbekun et al, 1999; Obasan, 2013; Ejughemre, 2014; WHO, 2014). Evidence reveals that health sector share as a percentage of total budget was 4.3% in 2009 and 5.7% in 2013 (Federal Ministry of Finance (FMF), 2013; Obasan, 2013; Uzochukwu, 2016), this is very different from 15% of Abuja declaration in 2001 (WHO, 2001). Moreover, within the same period, government expenditure to health as a percentage of GDP declined from 0.6% to 0.4% respectively (FMF, 2013, Uzochukwu, et al., 2016). High rates of informal economy pose a challenge to NHIS in terms of coverage and sustainability because informal economy constitutes largest percentage of labour force in the developing countries, and thus results in inability for most of them to afford health care services (Ogben, 2014). Although there is a programme designed for the low-income group, ability and willingness to pay premiums by this group has been a challenge (Centre for Public Policy (CPP), 2014). Ogben (2014) observed in a cross-sectional survey among 287 respondents in rural community in Nigeria that price of health insurance was perceived to be high by some of the respondents basically because most of them (63.4%) earn bellow the country's minimum wage of 18,000 naira (US$ 98.3) monthly. Most people in the informal economy especially low-income workers like the artisans face the challenge of inability to finance their health care, thus affects the policy goal of expanding coverage (Jutting 2003; Achime, 2005; Uzochukwu, 2009; Owujekwe, et al., 2010).

3.7.4 Institutional Capacity

Institutional factor is another serious challenge facing the attainment of universal insurance coverage in Nigeria. In a comparative study of NHIS in the southeast Nigeria, Onoka, et al., (2013) observe that the federal system of government practiced in Nigeria gives other tiers of government such as state and local government autonomy to discuss some federal government policies such as NHIS whether to join or not, which in turn shapes its outcome. NHIS is a programme established by the central government without bidding on other federating units because of the system of government in Nigeria. In addition, they assert that NHIS is a federal government programme, established by federal law and the Act establishing the scheme does not compel the states and local governments to be part of the programme. Therefore, the states and local governments can join by volition. Secondly, indifference on the part of states policy makers such as the governors affects the direction the states governments take on some policies issues relating to federal government. The states have their own legislatures that deliberate on whether to join the federal government policies or not (Onoka, et al., 2013). Furthermore,

Odeyemi (2014) observed that political power or persuasion is critical to successful implementation of any reform. NHIS adoption at other tiers of government is influenced by the standpoint and influence of main actors like the executives and the legislators in those levels. However, where these actors are not in the mainstream of NHIS management, save only to mobilise funds into the scheme remains a challenge (Odeyemi, 2014).

3.7.5 Fragmentation of Funding Pools

Primarily, SHI was developed to deal with the problem of unpleasant health care utilisation under the OOP payment with use of a strategy "to distribute health care more in accordance with human need rather than exclusively based of ability to pay" (Bodenheimer and Grumbach, 2005: 8). Redistribution of funds among different sub-population groups such as young healthy group to old and unhealthy group helps in the payment of health costs of those unable to pay. However, this principle of redistribution is defeated when there are many pools of funds with weak capacity of redistribution (Bodenheimer and Grumbach, 2005). Onwujekwe and Uzochukwu, (2012) assert that NHIS is fragmented along different lines such as occupation, geographical, ability to contribute etc., which subsequently affect the operation of the scheme (Ezeoke, et al., 2012; Obermann, et al., 2006).

Studies have shown fragmentation in funding pools has a challenge to NHIS policy goal and objectives (Onoka et al, 2013; Odeyemi and Nixon, 2013, Odeyemi, 2014). For example, Onoka et al. (2013) noted in their study that fragmentation of risk pools has subjected the low-income and the vulnerable group to poor access to health care. Furthermore, fragmentation has deprived most Nigerians particularly the poor unemployed and low-income earners financial risk protection from huge costs of health expenditure (Eweluka et al, 2013). Odeyemi and Nixon (2013) observed in CBHI that inequity in financing through a lack of integration among risk pools, offers limited opportunities to raise sufficient funds among the populations.

3.7.6 Knowledge Attitudes and Perceptions of Community Members on NHIS

Community knowledge, attitudes and perceptions play a significant role in the implementation and success of any social policy. Several studies have been conducted on perception and awareness of enrolees in reference to health insurance (e.g. De Allegri, et al., 2006; Sanusi and Awe, 2009; Agba, 2010; Okaro, et al., 2010; Macha, et al., 2012; Owu, et al., 2014; Obse, et

al., 2015). However, little research is available on the public (non-enrolees) knowledge, attitudes and perceptions on social health insurance (e.g. Ogben, 2014; Jehu-Appiah, et al., 2011). For example, Ogben (2014) in a cross-sectional survey of 287 respondents in rural community in Abuja Nigeria revealed that 242 (84.3%) respondents were aware of the scheme, out of which 152 (62.8%) enrolled into the scheme. Twenty-eight per cent of those who were aware did not enrol themselves or their dependants because they had no proper understanding on how the scheme operates. In addition, 11.2% did not see how they would benefit from the scheme. In another survey of 3301 household in Ghana, Jehu-Appiah et al. (2011) observe that many factors influenced family decision to enrol in NHI in Ghana. These include past experience with insurance scheme, peer pressure, health belief and integrity of the management of the scheme among others.

Furthermore, Jehu-Appiah and colleagues note that peer pressure could negatively influenced enrolment because information spreads faster as people listen to one another. Therefore, opinions of leaders, family members and peers among others influence people's decision to enrol. Perceptions is another feature that influence household decisions to voluntarily enrol and remain in the scheme after enrolment (Jehu-Appiah et al, 2011). Moreover, De Allegri et al. (2006) in a study of 393 uninsured households in a rural community in Burkina Faso observe that: (1) Higher education. (2) Higher socioeconomic status. (3) Familiarization with extensive risk sharing. (4) Wrong opinion about the competence of traditional care. (5) Close proximity to health facility. (6) Finally, lower level of socio-economic inequality within the community influence decision to enrol. In summary, the review shows that many factors including socioeconomic, education knowledge, attitudes influence decision to enrol and remain after enrolment in health insurance scheme.

3.8 The Limits of existing Literature

The available studies on NHIS are not mainly review-based analysis but also focus on the outcomes and implementation of programmes without examining the institutional design of the scheme, which influences the outcomes. For example, Nnabuchi (2009) study was a review-based analysis of NHIS programmes and challenges. Omoruan, et al.'s (2009) is a general overview of NHIS actors' contributions to the scheme. Mohammed, et al.'s (2014) examine providers' perspective in Kaduna state on optimal resource use domain. The study however

based exclusively on providers' perspective without taking into consideration other actors. Regarding NHIS mechanisms to meet universal coverage, CPP's (2014) is a piloted study on selected community-based insurance programme in Lagos State, identifying benefits and challenges of the programme, but the study was restricted to Lagos state. Christian Aid's (2014) is a comparative review of community-based insurance in Nigeria and Ghana. The study identifies similarities, differences and peculiarities in the two countries; however, it is more generalised and lack specificity in its approach. Gustafsson-Wright and Schellekens' (2013) study examines public-private-partnership in community-based insurance model in Kwara state, identifying the joint role of donor and government in community-based insurance. This study however, highlights private participation (donor funding) in the funding of community-based insurance model.

On financing mechanism, Uzochukwu, et al.'s (2016) is a review-based analysis of various financing models in Nigeria. Similarly, Obasan's (2013) is a review-based analysis of the challenges of health care financing in Nigeria. Onoka, et al.'s (2013) examine the constraints of the states in financing NHIS; however, the study was restricted to Ebonyi and Enugu states. Adeyemi and Nixon (2013) study indicates inequitable financing and access to NHIS services in Nigeria than Ghana. The study is however a view-based analysis. Ilesanmi and Ige (2013) study was based on NHIS enrolees and fee-paying patients in Ibadan, but the study was restricted to private health facilities. Although Owujekwe, et al.'s (2013) reveal gender, income, occupation and place of residence as the determinant factors of people's willingness to pay for NHIS services, it was exclusively a quantitative study. Similarly, Obikeze, et al., (2013) is a quantitative study of benefits incidence among different socioeconomic group in Enugu state.

Owumi et al. (2013a) study on the impact of NHIS on employees' health status was restricted to University of Ibadan. In another study, Owumi et al.'s (2013b) investigate NHIS dispensing outreach programme on the users' health status. The study was however, restricted to the insured in the private organisations. Ibiwoye and Adeleke's (2008) study investigates access and quality of NHIS services among the insured in Lagos state. The study was purely quantitative and restricted to the formal sector. Other studies on NHIS services among users include Mohammed, et al., (2011) who assessed client satisfaction with insurance scheme in Zaria. Osungbade, et al., (2014) study on users' satisfaction with NHIS services in Ibadan. Both studies are purely quantitative. On knowledge, attitudes and perceptions of NHIS in Nigeria,

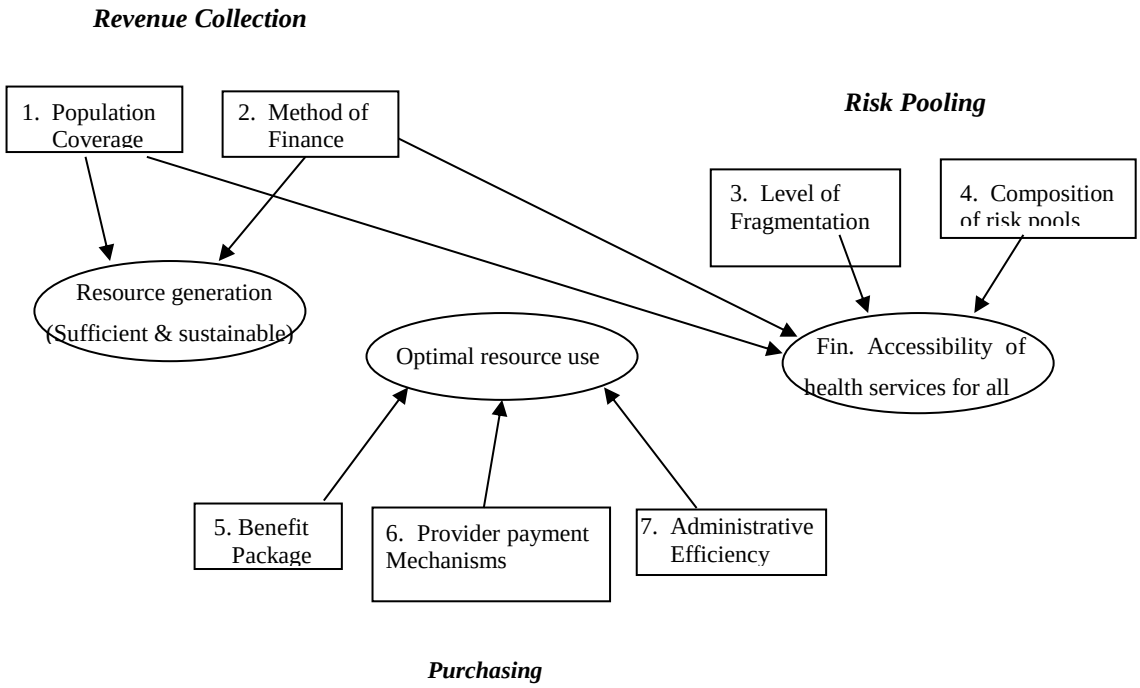
most studies (e.g., Bamidele and Adebimpe, 2013; Akinwale et al. 2014; Owu et al. 2014) focused on enrolees. Few studies however, (e.g., Ogben, 2014; Omotowo, 2016) examine the non-enrolees. For example, Ogben (2014) study focused on knowledge and perceptions of rural community in Abuja and Omotowo et al. (2016) study was on households' perceptions, willingness to pay, benefit package preferences in Enugu.

From the above review, it is evident that most studies did not examine the institutional design of NHIS policy in Nigeria, and the available studies in this area were largely review-based analysis. Taking into consideration that there are contradictions between NHIS stated objectives and the actual implementation of programmes, there are research gaps. For example, the gap between NHIS objectives and outcomes have shown policy fragmentation and loss of cohesion among players in the scheme, and thus resulted in weak implementation of NHIS' policies. Because any policy that is successfully implemented is premised on the design of such policy, therefore, an empirical study on the institutional design of NHIS is crucial for its successful implementation. In addition, limited studies are available on the knowledge, attitudes and perceptions of the non-enrolees in Nigeria. These gaps in the literature are therefore addressed in this thesis.

3.9 Conceptual Framework: Key Design Issues in the Health Financing Functions

Key design issues in the health financing functions conceptual framework was developed by Carrin and James (2004) (see Figure 2.2). The framework is built on the ideology that health-financing performance hinges on the institutional architecture and practice of a social health-financing model. The distinctive feature of this model is that it focuses on the fundamental part of health financing system, which stems from institutional design and organisational practice. The framework organised the broad features of health financing model such as social health insurance into three interrelated financing functions namely revenue collection, risk pooling and purchasing. Authors of the framework highlight the relationship between the three-health-financing functions with seven health financing performance indicators and three health-financing objectives. Substantial improvement towards the achievement of universal coverage could be attained within the prevailing health financing system by taking into cognizance a strengthening the key design issues in the health financing.

Figure 3.2: Key design issues in the health financing sub-functions



Carrin and James: 2004

The authors maintain that a well-designed health financing model is a function of the three interrelated health financing functions:

- "Revenue collection – the process by which the health system receives money from households, enterprises, government and other organisations like donors" (Carrin and James, 2004: 20).

- "Pooling – the accumulation and management of revenues collected in order to spread risk of payment for health care among all members of the pool, so that individuals no longer bear their risk on an individual basis" (Carrin and James, 2004: 20).

- "Purchasing – the process by which the pooled contributions are used to pay providers to deliver a set of specified or unspecified set of health interventions" (Carrin and James, 2004: 20).

The three interrelated health financing functions are measured by the seven health financing performance indicators namely "population coverage, method of financing, level of

fragmentation, composition of risk, benefit package, provider payment mechanisms and administrative efficiency" (Carrin and James, 2004: 20). The functioning of the seven health financing performance mentioned above leads to health financing objectives such as financial accessibility, sufficient and sustainable resource generation and optimal use of resources (Carrin and James, 2004). Thus, the conceptual framework above guides this thesis.

3.10 Conclusion

This chapter provided an overview of HSR. It explained that HSR in the developing countries reduces state roles in social services provisioning and encourages private participation in the provision of social services. The chapter is divided into five sections. Section 1 demonstrates that HSR in the global south was premised on the neoliberal ideology of SAPs, which heavily criticised democratic welfare state model as the impediment to socioeconomic development of the region. Section 2 analyses four health reform policies in the developing countries namely user fee, decentralisation, competition in health care provision through private participation and prepayment mechanism. Section 3 appraises various health insurance models including individual private insurance, community-based insurance, employment-based insurance and social health insurance model. Section 4 evaluates national health insurance and the two financing models commonly used within the ambit of national health insurance to achieve universal coverage. Finally, section five reviews health care financing in Nigeria in the pre-1980 and post-1980. The section also reviews the design and implementation of NHIS policy in Nigeria. A conceptual framework posited by Carrin and James (2004) guides the thesis. Chapter 4 discusses processes in data collection and analysis.

CHAPTER FOUR

RESEACRH METHODOLOGY

4.1 Introduction

Chapter four presents details of the research methodology including the description of the research design, study population, study area, sampling techniques, research instruments, pilot study, reliability and validity of the instruments, methods of data collection and data analysis, and research ethics.

4.2 Research Design

A research design is the 'blue print' that directs the researchers as they collect, analyse and interpret observation (Frankfort-Nachmias and Nachmias, 2009: 98). According to Nachmias and Nachimas, (1982: 75) research design "is a logical model of proof that allows the researcher to draw inferences concerning causal relations among the variables under investigation". It is pondering about the project or research in which a researcher want to embark on before the project begins in terms of how the research would be conducted and the tools required in conducting the research. A research is distinguished from other forms of observation because of its designed and planned nature (Durrheim, 2012). In research, a number of research design exists these include experimental, cross-sectional, quasi-experimental designs interview etc. Experimental design comprises of comparative groups, that is, an experimental group and a control group. The two groups are alike but one is subject to the independent variable while the other is not. On the other hand, quasi-experimental design allows researcher to select randomly sample from a population but it does not require comparison groups such as the treatment and control group as in the case of experimental design. Moreover, cross sectional design is the most prominent and widely use method in the social sciences for data collection and analysis. It is identified with survey research where a random sample of a population answers a set of questions posed them. Its advantages include less expensive, best to determine prevalence and identifies associations in a study that could otherwise be more rigorously studied, possibility of studying multiple outcomes and risk factors from the data collected (Frankfort-Nachmias and Nachmias, 2009; Babbie, et al., 2012).

The purpose of research could be descriptive, exploratory and explanatory. In addition, exploratory and descriptive research are often cross sectional (Babbie, et al., 2012). There are different approaches to research, these include quantitative, qualitative and a combination of both (Durrheim, 2006: 227). This study thus employed cross sectional research design to gain more insight into the design and implementation policy of NHIS in the study area. In achieving this, a combination of qualitative and quantitative technique was used in order to ensure that the weakness of one technique is compensated by the strength of the other.

4.2.1 Qualitative Method

Qualitative method in research is commonly used in the social sciences to get first-hand information in a study. "Qualitative research as a method of data collection and analysis derives from the *Verstehen* tradition" (Frankfort-Nachmias and Nachmias, 2009: 280), that scientists must gain an understanding of human behaviour and the subject aspect of the human experience. It is the appropriate method often used to study attitudes and behaviours within their natural settings (Frankfort-Nachmias and Nachmias, 2009). "Qualitative research method describes and interprets people's feelings and experiences in human terms rather than through quantification and measurement" (Blanche, et al., 2006: 272). This method uses a broad methodological approach to the study of social action including (1) gaining access to research subjects using snowball, purposive sampling etc.; (2) qualitative method of data collection includes participant observation, focus group discussions among others; and (3) qualitative method of data analysis uses grounded theory, narrative analysis, discuss analysis etc.

In qualitative method, non-probability sampling technique is often used to select a sample for research (Babbie, et al., 2012). This study employed snowball and purposive sampling to select required sample. "Snowball refers to the process of accumulation as each located subject suggests other subject" (Babbie et al. 2012: 235). It is a form of accidental sampling used in the qualitative field research to locate members of a population when it is difficult. In this case, the interviewee suggest another participant for the interview, and thus, the sample 'snowball' as each interviewee suggested another. In contrast, purposive sampling connotes sampling in a premeditated way or relies on the knowledge of the researcher about the population under study. The researcher therefore selects a sample from a population in a subjective manner that is based on personal mind-sets or experience. The likelihood that a particular subject will be selected for the sample is subject to the personal decision or opinion of the researcher. Thus, these two sampling techniques were used to select the sampling units for the interviews.

The qualitative methods of data collection adopted in this study involved a triangulation of in-depth interview and key informant interview. IDI is a semi-structured individual or personal interview method frequently used for data gathering in the qualitative research. It is "an unstructured, direct, personal interview in which a single respondent probe by a highly skilled interviewer to uncover underlying motivations beliefs, attitude and feeling on a topic" (Ogunbameru, 2003: 138). The interviewer asks an interviewee questions designed to elicit answers pertinent to the research questions in a face-to-face situation. The way and manner the questions are arranged, worded and presented is the hallmark of in-depth interview questions, (Frankfort-Nachmias and Nachmias, 2009). According to Kelly (2006: 297), interview is "simply a conversation similar to hundreds of short and long conversations we have all the time, but at the same time, they are based on highly skilled performances". On the other hand, KII is a semi-structured personal interview with interviewees such as professionals, community leaders and residents who have first-hand information or knowledge regarding a topic under consideration (Kelly, 2006)

Quite a number of data analyses exit in qualitative research; however, this study employed interpretive analysis and Computer-Aided Qualitative Data Analysis (CAQDAC) – ATLAS.ti for the analysis. Interpretive analysis is widely used in qualitative research to provide "a thorough description of the characteristics, processes, transactions, and contexts that constitute the phenomenon being studied, expressed in language not alien to the phenomenon, as well as an account of the researcher's role in constructing this description" (Blanche, et al. 2012: 321). In further description of interpretative analysis, Blanche and colleagues note that, "Interpretative analysis can be seen as a back-and-forth movement between the strange and the familiar, as well as between a number of other dimensions – description and interpretation, foreground and background, part and whole". These processes involved in interpretive analysis is to make findings convincing to the people who are familiar with the phenomenon being studied and also make them see the phenomenon in a new perspective. Although interpretive analysis does not proceed in an orderly manner, it could take the following steps: familiarisation and immersion, inducing themes, coding, elaboration and interpretation. ATLAS.ti package is one of the CAQDAC packages designed to analyse qualitative data. It is a code-based theory-builder aiding researcher in data analysis process (Babbie et al., 2012).

4.2.2 Quantitative Method

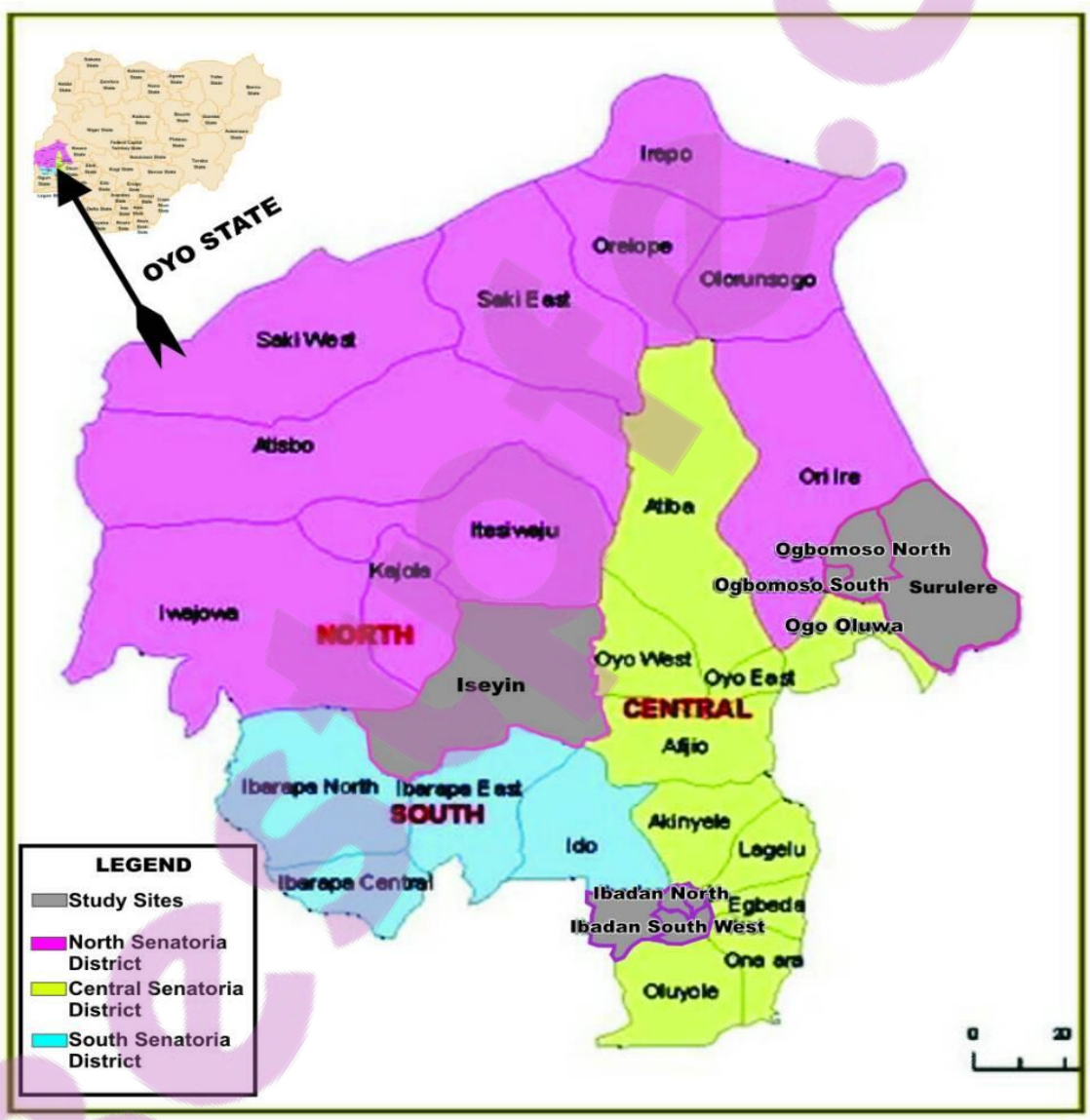
Quantitative research method involves measuring social realities by conceptualisation and assigning numbers to the derived constructs for statistical analysis. It is premised on positivist paradigm that social realities should be collected and analysed by method of objective quantitative measures. Durrheim and Painter (2012) opine that social scientists preferred to measure social issues such as crime, inequality, religion, depression malnutrition, etc., instead of asking people of their views and opinions on such matters. They further note that the reason scientists preferred quantitative data to qualitative is the general acceptance of positivism paradigm. The primary features of quantitative method include objectivity of data and generalizability of findings. Given the large number of the sample frame for the enrolees, this study employed survey research to complement the qualitative approach by using questionnaire to elicit information from the participants. Social scientists use survey research to collect data from a population considered too large to observe directly using carefully constructed standardised questionnaires (Babbie et al. 2012). Moreover, simple random sampling is used to select the sample that reflects those of the larger population for the study. Simple random sample is the probability that each element of the sample frame have the same chance of being selected (Durrheim and Painter, 2012).

For analysis of data, this study used Statistical Package for Social Sciences 21. SPSS is a set of comprehensive statistical programmes designed for use by social scientists (Sweet and Grace-Martin, 2006). Using SPSS, the data were analysed into univariate, bivariate and multivariate analyses. Univariate analysis explores the characteristics of individual variables in isolation from all other variable in a data set. For example, this involves the use of descriptive statistics and distributions of data with tables and graphs including bar charts, pie charts, histogram, etc. Bivariate analysis explores the relationships between two variables in a data set. It shows pattern of co-variation between two variables and this could be presented in a tabular form, graphic and correlation coefficient. Multivariate analysis tests the simultaneous relationship of many variables in order to document collective effects and account for potential spurious factors, and this could be achieved either through linear or logistic regression (Sweet and Grace-Martin, 2006).

4.3 Study Area

The study area is Oyo state, Nigeria (see figure 4.1). Oyo state is located in the South-West geopolitical zone of the country. The state was formed in 1976. However, in 1991 Osun state was established from of the state because of nationwide state creation exercise (http://logbaby.com/encyclopedia/history-of-oyo-state_9881.html). Oyo state " now covers 27, 249 square kilometres of land mass and it is bounded in the south by Ogun state, in the North by Kwara state, in the west, Oyo state is bounded partly by Ogun state and partly by Republic of Benin, while in the East, it is bounded by Osun State" (Adeyeye, 2006: 7).

Figure 4.1 Study Area



The state has an estimated population of 5.5 million people (National Population Commission (NPC), 2009). The state is homogenous, consists of Yoruba ethnic group who speaks Yoruba language. However, a considerable number of people from different parts of the country lives and works especially in the urban areas of the state such as Ibadan, Ogbomosho and Oyo etc. Most people in the state practice Christianity and Islam with few people practising traditional religion (Adeyeye, 2006). Oyo state is a cosmopolitan state and comprises of 33 Local Government Areas (LGAs). The state was chosen for the study mainly because of substantial numbers of enrolees (158, 152 enrolees) in the state and also because of prior experience of the researcher on NHIS programme in the state (NHIS, as cited in Oyedibe et al, 2012; Omoruan et al. 2009; Omoruan, 2011).

4.4 Study population

A study population "is that aggregation of elements from which the sample is actually drawn" (Babbie et al. 2012:174). It could also be referred to as entities in which the units of study are selected (Frankfort-Nachmias and Nachmias, 2009). The study population or unit of analysis for this study was NHIS stakeholders namely NHIS officials, HMOs officials, HCPs, enrolees and non-enrolees. As described by Babbie, (2012: 84) a unit of analysis refers to objects, individuals, groups, organisations and the like that researchers are interested in investigating. From a study population a sample is drawn for the study. Studying the entire population would generate a lot of data that would take a lot of time to process or would be difficult to process. Therefore, sampling provides focus for the study and leads to a better and quality study.

4.5 Sampling Techniques

In a study of this magnitude, the use of sampling is inevitable in order to lessen the "burden" of data collection faced by the researcher. Sampling technique is a process of collecting a sample of the population being studied while a sample is a sub-set of a study population that is systematically drawn with the characteristics of the population in order to serve as a point of access to data (Frankfort-Nachmias and Nachmias, 2009). In addition, Durrheim and Painter (2006: 272) explain, "effective sampling ensures that the elements selected for a sample accurately resemble the parameters of the population they were selected from". Thus, this follows that one major principle of sampling is its "representativeness." In other words, a

sample is expected to be a true reflection of a population's characteristic like the socio-economic composition, among others (Frankfort-Nachmias and Nachmias, 2009).

A sample can be selected using probability or non-probability sampling technique. Probability sampling simply means each sampling unit of the population has the same probability of being included in the sample. "It provides an efficient method for selecting a sample that should adequately reflect variations that exist in the population" (Babbie, et al. 2012: 202). However, in practice, probability samples are difficult to obtain and expensive (Durrheim and Painter, 2012). On the other hand, "non-probability sampling refers to any kind of sampling where the selection of elements is not determined by principle of randomness" (Durrheim and Painter, 2012: 138). Although researchers could make accurate estimate of the population's parameters with probability samples, a considerable number of social sciences researchers rely on non-probability samples (Durrheim and Painter, 2012). Non-probability sampling method is employed for certain reasons: when it is difficult to accurately identify a sampling population and when a sampling frame of the population under study is not available. Thus, both probability and non-probability sampling techniques were employed in this survey research.

Selection of the Enrolees

For the selection of the enrolees, the following stages were adopted to select the sample members for the study:

Stage one: sampling ratio was used to calculate the sample size from the sampling frame. According to Durrheim and Painter, (2012:139) sampling ratio is a common practice used to calculate sample size from a sampling frame depending on the size of the sampling frame. However, for a large population of approximately 150,000, 1% is required. The sampling frame for this study was 158,152. Sample size was calculated: 158,152 multiplied by 1 divided by 100 (158,152×1/100) = 1581. Therefore, 1581 was the sample size for the study.

Stage two: Due to unavailability of a comprehensive list of enrolees in the study area, purposive sampling technique was used to select three urban areas in the three senatorial districts of the state where NHIS enrolees are predominant namely Ibadan, Oyo and Ogbomoso.

Stage three: The following organisations were purposively selected in Ibadan, University of Ibadan, Federal Secretariat and Federal Road Maintenance Agency (FERMA) for the public enterprise while New Age Beverages and Rom Oil and Mills for the private enterprise. In Oyo town, Federal School of Survey and Federal College of Education (special). In Ogbomoso, Federal Government College. In addition, six NHIS accredited health facilities were purposively selected in order to reach individual' enrolees who are self-employed and others who could not be reached in their offices. The health facilities include Ladoke Akintola University of Technology Teaching Hospital Ogbomoso, Bowen Teaching Hospital Ogbomoso, University College Hospital Ibadan (UCH), Alafia Hospital Ibadan, Baptist Hospital Oyo, Peakmak Hospital and Maternity Centre, Oyo.

Stage four: Due to a large number of enrolees in the academic institutions selected, the institutions were stratified into faculties and units. A combination of purposive and snowball techniques was used to identify NHIS enrolees at various faculties and units of the institutions because not all employees are NHIS enrolees. Similarly, purposive and snowball techniques were used at the Federal Government College Ogbomoso, Federal Secretariat, FERMA, New Age Beverages and Rom Oil and Mills. Table 3.1 below indicates the number of questionnaires administered in the selected organisations. However, 1402 representing 88% of the total questionnaires were retrieved and found usable for the analysis.

Table 4.1 Selected study sites, number of questionnaires administered and retrieved

S/N	SELECTED STUDY SITES	QUESTIONNAIRE ADMINISTERED	QUESTIONNAIRE RETRIEVED	PERCENTAGE
1	University of Ibadan	495	453	91.5
2	Federal School of Survey	110	84	76.3
3	Federal College of Education (Special) Oyo	164	131	79.8
4	Federal Secretariat	250	216	86.4
5	FERMA	48	41	85.4

6	Federal Government College, Ogbomoso	36	31	86.1
7	Rom Oil and Mill	85	83	97.6
8	New Age Beverage	75	68	90.6
9	Bowen Teaching Hospital	45	41	91.1
10	LAUTECH Teaching Hospital	30	28	93.3
11	UCH	155	151	94.4
12	ALAFIA Hospital	28	28	100.0
13	Baptist Hospital	35	33	94.2
14	Peakmak Hospital	25	24	96.0
Total		1581	1402	88.6

Selection of the Non-Enrolees

To select the non-enrolees, multi-stage sampling techniques were employed. **Stage one:** the state was stratified into three senatorial districts or strata. A senatorial district is one of the territorial district from which a senator to a federal legislature is elected. Each senatorial district in Oyo state has certain number of LGAs. Oyo north senatorial district has thirteen LGAs these include: Saki west, Saki east, Iwajowa, Kajola, Olorunsogo, Irepo, Ogbomoso North, Ogbomoso south, Iseyin, Orelope, Orire, Itesiwaju and Atisbo. Oyo central senatorial district has eleven LGAs namely Atiba, Akinyele, Surulere, Egbeda, Afijio, Lagelu, Ogooluwa, Oluyole, Ona-ara, Oyo west and Oyo east. Oyo south senatorial district has nine LGAs namely Iddo, Ibarapa north, Ibarapa east, Ibarapa central, Ibadan south-west, Ibadan southeast, Ibadan north-west, Ibadan north and Ibadan North-east.

Stage two: Stat-Trek's Random Number Generator was used to randomly select one LGA from each senatorial district. Stat-Trek's Random Number Generator is a computer software package

that generates random numbers using statistical algorithm (http://stattrek.com/statistics/random-number-generator.aspx). It generates a list of random numbers, depending on the requirement of the following:

- The quantity of random numbers desired
- The minimum and maximum values of random numbers in the table
- Whether or not duplicate random numbers are permitted.

For Oyo north senatorial district, the LGAs were assigned numbers from 1 to 13 since there are 13 LGAs. Stat-Trek's Random Number Generator was used to generate one LGA – Iseyin. For Oyo central, the LGAs were assigned numbers from 1 until the last name, and there are 11 LGAs. Stat-Trek's Random Number Generator was used to generate one LGA – Surulere. Similarly, in Oyo south, the LGAs were assigned numbers from the first to the last and Stat-Trek's Random Number Generator was used to generate one LGA – Ibadan south-east.

Stage three: all the political wards in each LGA selected were listed, out of which half of the wards were randomly selected using Stat-Trek's Random Number Generator. Political wards are geographic units of LGAs and consist of between 300 to 500 housing units. In Surulere LGA with 10 wards, 5 wards were randomly selected these include: Baya-oje, Iredaadu (i), Iresaadu (iii), Iresaadu (iv) and Oko (iii). In Iseyin with 11 wards, 6 wards were selected: Ado-awaye, Akinwumi/Osogun, Faramora, Isalu (ii), Koso (i) and Koso (ii). In Ibadan southeast with 12 wards, 6 wards were selected namely C1, S3, S4a, S4b, S6a and S6b.

Stage four: Since there is no comprehensive list of the housing unit in the selected wards, the researcher purposively selected 130 households across the selected wards in each LGA by a door to door enquiry to identify non-enrolees. The questionnaires were self-administered by male or female adult in the selected households while researchers assisted respondents who could not complete it by themselves. The total number of questionnaires administered in each LGA was 130 and this gave 390 questionnaires in the three selected LGAs as indicated in the table 3.2 below. However, 376 questionnaires representing 96% of the total sample were found usable for the data analysis.

Table 4.2 Selected LGAs and the number of questionnaires administered and retrieved

S/N	STUDY SITES	QUESTIONNAIRE ADMINISTERED	QUESTIONNAIRE RETRIEVED	PERCENTAGE
1	Surulere	130	126	96.9
2	Iseyin	130	123	94.6
3	Ibadan south-east	130	127	97.6
TOTAL		390	376	96.4

For the IDIs, 30 participants were selected among the enrolees; 10 participants each from the three selected urban areas namely Ibadan, Ogbomoso and Oyo, using purposive and snowball techniques. In addition, 5 participants were purposively selected among non-enrolees in each of the three selected LGAs making a total of 15 participants. For the KIIs, 15 participants were selected purposively, five each among NHIS officials, accredited HCPs and HMOs.

4.6 Research Instruments and Pilot Testing

Research instruments consist of a wide range of instruments often used for data gathering in a research study, these include among others questionnaire, focus group discussion, observation, IDI and KII. In this study, the following instruments were used: questionnaire, IDI and KII.

4.6.1 Questionnaire

Babbies el al. (2012: 646) defines a questionnaire as "a document containing questions and other types of items designed to solicit information appropriate to analysis". It is a carefully constructed set of questions used to gather information from a sample population after substantial pretesting has been done (Frankfort-Nachmias & Nachmias, 2009). There are two main responses formant used in the questionnaire to elicit information from the respondents. These include open-ended and closed-ended formant. The open-ended formant allows respondent to present their opinions or view in their own way without restriction from the researcher. On the other hand, in the closed-ended formant, respondents are restricted to a list of answers provided in the questionnaire (Kanjee, 2006). Questionnaire as a data collection instrument is appropriate in this study because of the large samples of enrolees and non-

enrolees, and as such, “the instrument has the capacity to generate quantifiable data on large numbers of people representative of the wider population” (Babbie, 2012: 245). A questionnaire is made up of a number of separate subparts and each subpart contains a number of items (Kanjee, 2006). In this study, the questionnaire consists of open-ended and closed ended questions to allow the respondents elaborate more on some of the responses. The use of both open-ended and closed-ended questions increased the comprehensiveness of the study. Similarly, measurement scales in the questionnaire consist of dichotomous questions, multiple choice and scale items. There were two sets of questionnaire for this study: enrolees and non-enrolees. The questionnaire for the enrolees was structured as follows:

Section A: Socio-economic and Demographic Characteristics has nine questions – the purpose of the questions was to obtain demographic and socio-economic information of the participants.

Section B: Equity in financial contributions and health benefits has seven questions – the aim was to investigate equity in terms of financial contribution and health benefit among the enrolees.

Section C: Availability and Accessibility of services of the HMOs and HCPs has twenty-seven questions – the purpose was to investigate the extent to which the services of the HMOs and HCPs are available and accessible to the enrolees. For the non-enrolees, the questionnaire was structured as follows:

Section A: Socio-economic and Demographic Characteristics has eight questions – the aim of the questions was to obtain demographic and socio-economic information of the respondents.

Section B: Knowledge, Attitudes and Perceptions about NHIS has seven questions – the aim was to examine the level of knowledge, attitudes and perceptions of non-enrolees about the NHIS.

Section C: Impediments to enrolment has seven questions – the aim was to study the extent to which different factors deter people from enrolments.

4.6.2 In-depth Interview

An Interview is simply a long or short conversation for gathering information. It could be structured, semi-structured and unstructured (Kelly, 2012). IDI is a semi-structured individual interview method frequently used for data gathering in the qualitative research. It entails a situation whereby the interviewer allows the interviewee to speak for him/herself rather than providing predetermined hypothesis-based questions (Babbie et al. 2012). It has also been described as "a face-to-face situation in which the interviewer asks an interviewee questions designed to elicit answers pertinent to the research questions. The questions, wording and their sequence defined the structure of the interview" (Frankfort-Nachmias and Nachmias, 2009: 239). Two sets of IDIs were conducted in the study. The first set for the enrolees and the second set for the non-enrolees. Various IDI questions were stemmed from the research objectives. For instance, in the case of the enrolees, questions related to NHIS health package and financial contributions, services provided by the HMOs and HCPs were discussed in the interviews. Similarly, for the non-enrolees, IDIs were conducted on issues related to their knowledge, attitudes and perceptions on NHIS (see appendix III).

4.6.3 Key Informant Interview

As mentioned elsewhere, KII is a semi-structured personal interview with an individual who has first-hand information or knowledge regarding a topic under consideration (Kelly, 2006). In addition, key informants are people such as government officials, professionals, community leaders and residents who are more knowledgeable about subject under research. They provide detailed and insightful information that informed decisions due to their skills and position in the society (Babbie, et al. 2012). KIIs were conducted among NHIS officials, HMOs and HCPs who are the main stakeholders in the design and implementation policy of NHIS. Different sets of questions were used in the interview for the stakeholders. For instance, in the case of NHIS officials, salient questions related to the design of NHIS policy and its implementations to meet the policy goal of universal health coverage were asked and discussed. On the other hand, questions related to the roles of other stakeholders namely HMOs and HCPs in the implementation of NHIS were also discussed (see appendix III).

4.6.4 Reliability and Validity of the Research Instruments

The test for reliability and validity of measures of research instruments is central to research study. According to George and Mallery (2014: 242) "many constructs are measured in which a subset of relevant items is selected, administered to subjects, and scored – and then inferences are made about the true population values". In order to ensure that construct indicators or measures best captured abstract concepts or variables, they must be reliable and valid. Although the two measuring device reliability and validity measures for different purposes, they are related. Reliability is "the degree to which an indicator or a measure is a consistent measuring device" (Sweet and Grace-Martin, 2006: 3). It "is the dependability of a measurement instrument; the extent to which an instrument yields the same results on repeated trial" (Durrheim and Painter, 2006: 152). In order to measure the reliability of an instrument, Durrheim and Painter, (2006) posit that if the scores on a test correlate after different testing, it could be considered that the test is reliable.

There are different ways to test whether a measure is reliable or not, these include test-retest, split half, internal consistency etc. (1)Test-retest method of reliability – refers to a situation whereby a "researcher administers the measuring instrument to the same group of persons at two different times and compute the correlation between the two sets of observations. Thus, the coefficient obtains through this means is the reliability estimate" (Frankfort-Nachmias and Nachmias, 2009: 171). (2) Split half method – as the name implies, is the process of obtaining reliability estimate by either parallel form of splitting an instrument or treating different parts of a measuring instrument as a separate scale. (3) Internal consistency method of measuring reliability though similar to split half, it does "not rely on either parallel forms or the splitting of tests" (Durrheim and Painter, 2006: 154). It is based on reliability estimate by the amount to which every element in a measure correlates with each other. Like other methods of reliability, internal consistency is determined mathematically to obtain the reliability estimates (Durrheim and Painter, 2006; Frankfort-Nachmias and Nachmias, 2009).

Validity refers to when an indicator measures what is expected to measure. Durrheim and Painter (2006: 147) note that the reason for verifying measurement validity was to (1) "ensure that the conceptual definition of a construct corresponds with the attributes being measured; and (2) the operational definition corresponds to the conceptual definition". Testing the validity of a measure is mostly determine by non-statistical means, though factor analysis may be

applied to create an instrument that measure well what researcher is attempting to measure (George and Mallery, 2014). Different methods of measuring validity exist, these include criterion, content and construct validity. According to Durrheim and Painter (2006: 147), "criterion-related validity – is the extent to which a measure is related to some other standard or criterion that is known to indicate construct accurately". On the other hand, content validity relates to the extent in which a measure reflects a specific domain of content and it is determined by ensuring the specified area is covered when developing the construct definition. "Construct validity is the extent to which a measure of a construct is empirically related to other measures with which it is theoretically associated" (Durrheim and Painter, 2006: 151). To confirm the reliability and validity of the measurement scales in the study, internal consistency measure of reliability and content validity was employed in a pilot study conducted as indicated below.

4.6.5 Pilot study

Pilot study is an essential aspect of a research; it improves the genuineness of the research. Kelly (2012: 490) maintains that "pilot studies are conducted to identify possible problems with proposed research, using a small sample of respondents before the main study is conducted". The purpose of the pilot study therefore was to improve the credibility and quality of the study. In order to improve the research instruments used in the study, a pilot study was conducted between 20 and 30 January 2015 in the area and among respondents not included in this study. Eighty (approximately 5% of the sample size) questionnaires were purposively distributed among NHIS enrolees who were employees of Nigerian Television Authority (NTA) and Nigerian Security and Civil Defence Corps (NSCDC) in Ibadan. Twenty (approximately 5% of the sample size) questionnaires were purposively distributed among non-enrolees in Ogbomoso. In addition to completing the questionnaires, participants were asked to comment on the following:

1. If the questions were easy to understand, clear and to the point.
2. Were the questions relevant to the topic under research?
3. If completing the questionnaire did not take much of their time.

For the IDI, two enrolees were purposively selected in NSCDC and two non-enrolees in Ogbomoso. Moreover, for the KII, two NHIS officials, two HMOs officials and two HCPs who

were easily accessible in Ibadan volunteered to be part in the interviews. However, before the end of the interviews, the participants were asked to comments on the questions that is, if they were relevant to the topic and time spent on the interviews.

4.6.5.1 Pilot study findings

Out of the 80 questionnaires distributed among the enrolees, 62 were completed and returned with observations and comments. Moreover, for the non-enrolees, out of 20 questionnaires distributed, 16 were completed with observations. The comments and observations include:

1. Re-phrasing of some question items
2. Questions were clear and easy to understand
3. Long questionnaire items
4. Time consuming

All the necessary comments and observations were therefore incorporated to the questionnaires in order to ensure content validity. In addition, to ensure internal consistency of the instruments, Cronbach's Alpha correlation coefficient was used to calculate the reliability. Both questionnaires for the enrolees and non-enrolees had .834 and 6.50 respectively, indicating that the instrument had a high proportion of internal consistency based on inter-item correlation. For the IDI and KII, comments and observations such as rephrasing of questions and time adjustment were raised because most of the participants were conscious of their time.The researcher therefore incorporated the observations and comments into the interviews guides.

4.7 Procedure for Data Collection

A number of procedures were taken to ensure adequate data collection for the study; these include engagement of research assistants, time of data collection, administration of questionnaires, and interview of participants.

4.7.1 Engagement of Research Assistants

Three research assistants were employed and trained for data collection. One of the main reasons for those employed is their ability to read and write effectively in Yoruba language, because some of the respondents (especially non-enrolees) could not communicate effectively in English. The questionnaires were administered to the respondents in the various study sites

by the researcher with the assistance of the research assistants. The research assistants were also available to assist the researcher in the interviews sessions by recording and taking notes where applicable.

4.7.2 Dates of Questionnaires Administration

The period of fieldwork was between February 2015 and September 2015. The researcher ensured that questionnaires for the enrolees were first administered, then followed by questionnaires for the non-enrolees. Table 3.2 indicates dates questionnaires were administered at the selected sites.

Table 4.3 Selected Sites and Dates for Questionnaire Administration

S/N	SELECTED STUDY SITES	DATES FOR QUESTIONNAIRE ADMINISTRATION
1	University of Ibadan	2 to 14 February, 2015
2	Federal Secretariat, Ibadan	16 to 21 February, 2015
3	FERMA, Ibadan	23 to 28 February, 2015
4	Rom Oil and Mill, Ibadan	2 to 5 March, 2015
5	New Age Beverage, Ibadan	6 to 11 March, 2015
6	UCH, Ibadan	12 to 21 March, 2015
7	ALAFIA Hospital, Ibadan	24 to 28 March, 2015
8	Federal Government College, Ogbomoso	30 March to 4 April, 2015
9	Bowen Teaching Hospital, Ogbomoso	6 to 11 April, 2015
10	LAUTECH Teaching Hospital, Ogbomoso	13 to 17 April, 2015
11	Federal School of Survey, Oyo	20 to 25 April, 2015
12	Federal College of Education (Special) Oyo	27 to 30 April, 2015
13	Baptist Hospital, Oyo	4 to 9 May, 2015
14	Peakmak Hospital, Oyo	11 to 16 May, 2015
15	Surulere	18 to 23 May, 2015
16	Iseyin	25 to 30 May, 205
17	Ibadan south-east	1 to 6 June, 2015

4.7.3 Administration of Questionnaire

The researcher with the assistance of the three research assistants started the questionnaire administration in February 2, 2015 for the enrolees at the University of Ibadan. Subsequently, other sites where covered one after the other. Although there was some apathy at the initial stage at various study sites, this was resolved after the researcher explained the purpose of the research. Therefore, the respondents cooperated with the research team and everything went on successfully. In the process of administering the questionnaires to the enrolees, the researcher observed that: (1) Most of the respondents demanded to complete the questionnaires on their own. (2) Greater number of the respondents were met in their offices and workplace environment during the working hours. (3) Some asked us to wait for collection while others asked us to come back the following day for collection. (4) Some of the questionnaires administered at the hospitals were done by researchers because the respondents could not understand English language clearly; the research team read out the questions and responses in Yoruba and provided clarification where applicable. However, some of the questionnaires administered (those that were given out to the respondents to complete on their own) had incomplete information; some questions were left unanswered and some copies of the questionnaires could not be retrieved.

For the non-enrolees, the researcher team observed some reluctance at the initial stage. However, after series of explanations of the purpose of the research, they agreed and cooperated with the research team. The research team administered most of the questionnaires, though some respondents insisted to complete the questionnaires on their own. The literacy level for this group was a bit low, and thus, the questions and responses were read out in Yoruba to the respondents were applicable. The research team waited and collected the questionnaires that were completed by the respondents, though some asked us to come back for collection. Some questionnaires were not completed in full, questions were left unanswered and few questionnaires could not be retrieved. See table 3.2 for the total number of questionnaires retrieved.

4.7.4 In-Depth Interview

IDIs for the study were conducted with the enrolees and non-enrolees. For the enrolees, 30 IDIs were conducted. The interviews shed lights on issues related to the implementation of NHIS programmes in the study area and were tape-recorded. In addition, the research assistants in

the course of the various interviews took notes. English and Yoruba were the languages used in the interview, depending on interviewee's preference. Personal profile from the interviewees was collected and recorded on data form. The form has the following: interviewee's consent, organization/LGA, designation, date of interview, time of the interview, the time the interview ended, language of interview, venue's name and interviewer's names (see Appendix III). After questionnaire administration was concluded on the 6 June2015, IDIs with the selected participants (enrolees) began the following week, that is, on the 8 June 2015. Ten IDIs were conducted in each urban area selected namely Ibadan, Ogbomoso and Oyo.

In Ibadan, six IDIs were conducted at University of Ibadan between 8 and 9 June, 2015, in FERMA 4 interviews were conducted on the 10 June, 2015. The time of the interview sessions ranged between an hour and an hour 30 minutes. All the interviews conducted at the University of Ibadan and FERMA with the enrolees took place in their offices or any conducive environment within their work places. Moreover, in Ogbomoso, 5 IDIs were conducted in Federal government college Ogbomoso on the 16 June, 2015 and 5 among Federal Road Safety Corps officials on the 17 June, 2015. The research team uses Yoruba and English languages in the interviews. In Oyo, 8 IDIs were conducted in Federal College of Education between 22 and 23 June, 2015 and 2 in School of Survey on the 24 June, 2015. Similarly, English and Yoruba were used as the medium of communication and the interviews were conducted in the offices or convenient locations chosen by the interviewees. It is worth noting that all the interviews conducted were successful, though some delays were observed in some cases before the commencement of the interview sessions.

For the non-enrolees, 15 IDIs were conducted. Five IDIs were conducted in the selected wards in Surulere LGA, on the 29 June 2015. In Ibadan Southeast, five IDIs were also conducted in the selected ward on the 30 June 2015. In Iseyin, five IDIs were conducted on the 4 July 2015 in the selected wards of the LGA. The interviews shed lights on the interviewees' knowledge, attitudes and perceptions on NHIS. Yoruba and English were used in the interview. Interview sessions for this group (non-enrolees) took place either in their houses or in workplace environment. Although some challenges like delays in some cases before the commencement of the interviews and interference were observed; however, they were rectified and all the interview sessions were successful.

4.7.5 Key Informant Interview

KIIs were conducted among NHIS officials, HMOs employees and HCPs to elicit more information about the design and implementation of NHIS programmes in the study area vis-à-vis Nigeria. The main reason of these interviews was to bridge the gaps on issues that needed clarity on the design and implementation of various NHIS programmes. The interviewswere tape-recorded;the research assistants also took notes during the various interview sessions. English language was usedin all the interviews for this category of respondents. Personal profiles of all the interviewees were collected and recorded on the data form. The form has the following: interviewee's consent, organization, designation, date of interview, the time the interview starts, time the interview ended, language of interview, venue's name and interviewer's names (see Appendix III). Fifteen KIIs were conducted. Five among NHIS officials, five among HMOs personnel and five among HCPs.

For the NHIS officials, three KIIs were conducted in the NHIS Zonal office in Bodija Ibadan on the 6 July 2015, and 2 KIIs were conducted in the NHIS state office in Agodi Ibadan on the 7 July 2015. In the case of HMOs, two KIIs were conducted with the employees of United Health Care International Limited, Ibadan in their offices on the 8 July 2015. Similarly, two KIIs were also conducted with the employees of Total Health Trust Limited in their offices on the 9 July 2015. One KII was conducted with the employee of Ronsberger Nigeria Limited, Ibadan on the 10 July 2015.

Moreover, For the HCPs, two KIIs were conducted with medical doctors in their offices at UCH, Ibadan and one KII with a medical doctor at his office in Alafia Hospital Ibadan on the 11, July 2015. Two KIIs were conducted in Ogbomoso, one was done with the medical director Ireti-olu hospital, in his office, and another KII with a medical doctor in his office at Bowen Teaching Hospital Ogbomoso, on the 13 July 2015. It is worth noting that the time used in the interview sessions ranged between an hour and an hour 30 minutes. Most of the interviewees in this category had knowledge about research and participated in previous research so they welcomed the research team and complied with the interview procedures. Therefore, the KIIs were successfully conducted without much disturbances or interference.

4.8 Data Analysis

Data analysis "is the process of ordering and organising raw data in order to extract useful information for making decisions" (Frankfort-Nachmias and Nachmias, 2009: 334). The data collected in this study were analysed using quantitative and qualitative methods. Blanche, Durrheim and Kelly (2006) note that there are two approaches to analysing data: quantitative and qualitative.

4.8.1 Quantitative Analysis

Quantitative data analysis involves using statistical methods to analyse data. However, before data analysis, Durrheim (2006: 189) explains that the preliminary stages of data analysis include (1) coding data – transforming raw data into meaningful numerical format; (2) entering data – entering numerical codes into computer in a format that can be analysed using statistical method; (3) cleaning data – checking the dataset for errors and then correcting these errors. The research team adhered to these three stages in order to ensure the data are error-free before analysis.

The research team ensured that all the retrieved questionnaires were coded between 20 and 21 July 2015. After that, they entered the numerical data into the computer on the 22 July 2015 for analysis. However, in order to ensure the data was error-free, the researcher generated a full set of univariate analysis with frequency tables for each of the variables in the data set. Each variable was scrutinised to identify any error. Although some errors were discovered, for example, variable sex was coded 1 for male and 2 for female; however, some subjects had code 3 for variable sex, this and other related errors were rectified. Once the researcher ensured the dataset is error-free, the data were then analysed using descriptive and inferential statistics.

4.8.1.1 Descriptive and Inferential Analysis

According to Babbie at al. (2012: 641), "descriptive statistics describe the characteristics of a sample or the relationship among variables in a sample, and summarizes a set of sample observations". Frankfort-Nachmias and Nachamias, (2009: 588) defined descriptive statistics as "procedures used for describing and analyzing data that enable the researcher to summarise and organize data in an effective and meaningful way". Descriptive analysis enables researchers to gain an initial impression of the data collected by knowing the characteristics of

individual variables, inform researchers of the "types of advanced statistical procedures that are appropriate to apply when examining associations between variables" (Sweet and Grace-Martin, 2012: 47). IBM SPSS 21 was used to generate univariate analysis including frequency distributions and graphs of the characteristics of individual variables related to the research objectives. In addition to using univariate analysis, the researcher performed bivariate analysis to text the relationship, association or differences between two variables meant to achieve the research objectives.

4.8.2 Qualitative Analysis

The data collected through In-depth Interviews and Key Informant Interviews were analysed using interpretive analysis and ATLAS.ti package. As mentioned earlier, interpretive analysis is widely used in qualitative research "to provide a thorough description of the characteristics, processes, transactions, and contexts that constitute the phenomenon being studied" (Blanche, et al. 2006: 321). Blanche and colleagues note that in order to have a convincing account of the phenomenon being studied, the following sequence is central to analysing data using interpretive analysis: familiarization, inducing themes, coding data, elaboration and interpretation. In addition, ATLAS.ti was used to complement interpretive analysis in data coding.

- Familiarization and Immersion: this is the first step using interpretive analysis. It "involves development of ideas and theories of phenomenon being studied" (Blanche, et al. 2006: 322). To realize this first step, after data collection, the researchers read through the texts (field notes) and listened to recorded interviews many times, make notes, draw diagrams and brainstorm with the research team on the texts in order to be familiar with the texts.

- Inducing themes: Is the process of organizing data into themes using familiar expression with the phenomenon under study. In this stage, the researchers ensured that the texts were summarized into thematic schemes covering a broad array of issues related to the research objectives. However, these were later rearranged into main themes with several subthemes under each main theme.

- Coding data: This is the process of marking different sections of your data relevant to one or more themes. Blanche, et al. (2006) posit that different sections of the data could be coded into phrases, sentences and paragraphs known as textual 'bit' or extract that contains material pertaining to the themes under investigation. In addition, Blanche and colleagues note, "textual 'bit' could be labelled with more than one code if it relates to more than one theme" (Blanche, et al. 2006: 325). In this stage, the coding was done using ATLAS.ti package by clustering textual 'bit' or extract into meaningful pieces under each code heading or theme and in relation to other clusters.

- Elaboration: Is the process of appraising the coded themes by carefully examining extract clustered together for differences. The researchers at this stage explored the coded themes and subthemes closely to captured nuances of texts not captured in the original coding and rectified were applicable for easy interpretation.

- Interpretation and Checking: Is the process of putting together textual 'bits' or extracts into meaningful ideas. At this stage, the researchers put all the distinct coded themes together in line with the research objectives.

4.9 Fieldwork Challenges

There were some challenges encountered in the fieldwork. In case of the questionnaire, the questionnaires' administration for the enrolees was initially faced some resistance as many of the respondents saw it as a time-wasting venture. As a result, they were busy with their businesses without recognising the presence of the research team. However, after several explanations by the researchers with evidence (such as student identity card and consent form) that the research is for academic purpose and advancement of knowledge, the respondents then agreed to take part in the survey. Moreover, for the non-enrolees, the challenges faced by the research team were similar to the challenges mentioned above. In addition, most of the respondents in this category expected us to pay them for participating in the survey. However, the research team explained further that the survey is purely for academic purpose and there was no money earmarked for the research. Thus, the respondents cooperated and the survey went on successfully. Generally, retrieving the questionnaires from those who decided to complete the questionnaires on their own and asked us to come back for collection was also a

challenge because some of them did not complete the questionnaires in time. For instance, it took some respondents two to three days before they could complete and return the questionnaires. In addition, some respondents misplaced theirs and could not return them.

For the interviews, the research team also experienced a number of challenges with the interviewees. Permissions were obtained at various organisations before interviews were granted. For instance, permissions were obtained from the Medical Directors at various hospital before interviews were conducted. Similarly, the researchers obtained a permission from the Director, NHIS zonal office in Ibadan before the interviews were granted with the employees of the organisation. The researchers had to reschedule some of the interviews because some of the interviewees were not available at the time earlier scheduled. For instance, before some medical doctors were interviewed, the interviews were rescheduled for about two times due to the nature of their work. Similarly, interviewing some enrolees and non-enrolees was quite challenging. Initially some interviewees did not want their voice recorded, but after much explanation, they consented and allowed the interview sessions to proceed.

4.10 Ethical Consideration

This study went through ethical review and obtained ethical approval from the Department of Sociology and the Senate Research Ethics Committee of the University of South Africa. The research team observed the following ethical issues: informed consent, confidentiality, beneficence and non-maleficence, and dissemination of research in line with the ethical considerations.

- Informed consent: Participants in the study were dully informed of the purpose of the study and their involvement. They were also informed that they could withdraw from participating in the study at any point in time, if they feel intimidated or uncomfortable, and the data already collected from them would be destroyed. The par ticipants were required to complete and sign informed consent forms.

- Confidentiality: The researcher promised to protect the anonymity and confidentiality of the participants. As a result, the names of the participants were not used in reporting the findings from the interviews. Participants were adequately informed of the need torecord the interview through note-taking and audio recording. In addition, the

researchers also promised not to disclose in any way, the address of the interviewees or respondents. If there is a need to use the name/address of any of the participants, the researcher promised to seek the permission of the participant concerned before doing so.

- Beneficence and non-maleficence: The researchers acknowledged all contributors to the research study and maximised the expected benefits to the participants. The researchers also ensured that no harm befalls participants as direct or indirect consequences of the research.

- Dissemination of the research: The researchers promised to make the findings of the research available to the participants. In addition, copies of the thesis would be available in the University Library.

4.11 Conclusion

This chapter explained in details the research design adopted in the study. The chapter also discussed the reasons for adopting both qualitative and quantitative methods in the study. It gives details information of the study area. The chapter simultaneously explained the study population, sampling techniques and sample size. In addition, the process involved in pilot study of the research instruments were clarified. The chapter also described the quantitative and qualitative methods of data collection adopted. Semi structured questionnaire designed from the research questions was used for the quantitative data collection while in-depth interview and key informant interview were adopted for the qualitative data collection. The chapter also discussed various procedures adopted for analysing the data collected. The challenges encountered by the research team in the cause of this study and the ways they were resolved were explained. The chapter also explained in detail the research ethics regarding the welfare of the study participants. Chapter 5 examines the policy framework of National Health Insurance Scheme in Nigeria.

CHAPTER FIVE

IMPLEMENTATION OF NATIONAL HEALTH INSURANCE SCHEME IN NIGERIA

5.1 Introduction

Chapter 5 presents a brief background that led to the emergence of NHIS. The chapter presents results of the key informant interview with the stakeholders namely NHIS officials, HMOs' employees and HCPs using the three interrelated health financing functions. The three interrelated health financing functions provide a framework for the design and implementation of a social health financing model in order to improve and strengthen the health system for optimal resource use, adequate and sustainable fund generation and financial accessibility of health financing for all.

5.2 Health Care Financing and the Emergence of NHIS in Nigeria

Health care in Nigeria in the immediate post-independence was financed from general taxation. Health care and education took centre stage of government social services provisioning. The Nigerian government provided free universal access to health care for all, as health care services were available at government clinics and hospitals at no costs (Adesina, 2007b). Financial barrier to health care access was avoided; social spending on health was seen as social investment to enhance economic growth and development. Furthermore, Adesina (2009: 2) notes, "social spending on health was part of the wider objective of defeating the triad of ignorant, poverty and disease". As a result, social democratic approach drives the nationalist ideological commitment to development whereby development in all areas were driven by primarily government without external interference. The result of this was positive relationship between health-related indices and economic growth in the first decade of post-independence Nigeria (Adesina, 2009). For example, the total population per medical doctor declined drastically from 73,710 to 15,740 between 1960 and 1975, Infant and under-five mortality per 1,000 live births also declined from 50 in 1970 to 22 in 1979 (World Bank, 1980).

However, the global economic crisis of the 1980s had its worst hit on the developing countries. In Nigeria for example, the post-1980 was characterised by slow economic growth rate notably poor agricultural performance and decline in international petroleum prices, balance-of-payment imbalances and fiscal crisis (World Bank, 1980; 1987; Helleiner, 1983), which in turn resulted in the deep cuts in social expenditure (Adesina, 2009). The health sector then began to receive less allocation from the federation account starting from the 1980s, though with subtle difference in the years before SAPs. For example, public health expenditure as percentage of the total government budget between 1981and 1989 were as follows: 2.0% in 1981; 1.6% in 1982; 2.0% in 1983; 1.1% in 1984; 1.99% in 1985; 1.82% in 1988 and 1.50% in 1989 (Central Bank of Nigeria (CBN), 1983, 1985). In addition, health expenditure as a percentage of federal government spending dwindled from an average of 3.5% in the 1970s (World Bank, 1980), to below 2% in the 1980s and 1990s (Ogunbekun, et al., 1999; Obono, 2007). Moreover, public spending on health as a percentage of GDP was hovering in the successive years around 2%.

Given the low growth rate in the economy and limited fiscal space experienced in the early 1980s, the international financial institutions led by the World Bank and IMF introduced SAPs and its neo-liberal policies as conditions to accessing bailout loans for developing countries including Nigeria (Obasan 2013;Adesina, 2007a; Obono, 2007). Part of the conditions includes among others private participation in social services provisioning, introduction of user fees in government facilities, minimal government intervention in the economy and provision of social services. With the claim that there would be more money in the system through private participation and thus improve quality, and increase access to health services (World Bank, 1987, 1993). In a contrary view, Adesina (2007b: 23) notes that this erroneous assumption and concept of SAPs manifested in ways: “One was to assume that there was a market in health care services to take care of the impact that the fiscal retrenchment of the state would create. The second was to assume as unproblematic, resources endowment for all the citizens for procuring their health care needs in the new marketplace; and the third was to assume that public resources spent subsidizing the citizens were a waste”. Neoliberal policies therefore were more ideological than reality in solving poor allocation to health care and increase revenue to in the sector (Adesina, 2007b).

The institution of user fee or cost recovery mechanisms became prominent in the 1986 as neo-liberal policies took centre stage in the social services provisioning, for instance, free health

services was abolished at state owned health facilities and user fee was introduced in the state clinics and hospitals, private health facilities were on the increase. The consequence of lack of subvention to public health facilities that solely depended on government includes poor hospital services, arbitrary increase in the costs of medical services, drug shortages and poor physical structures among others (Ogunbekun, et al. 1999). Payment for health care services was thus shifted from the state to the individual and households. In addition, there was a shift from curative care to primary health care in order to reduce costs in health care spending and inequalities in provision of health care. The primary health care initiative held in Bamako in 1987 was to expand primary health care in the sub-Saharan Africa countries (Ogunbekun, et al., 1999). However, United Nation Children Education Funds (UNICEF) (1989) posits that the initiative was not only to expand health care delivery but a plan for self-sustaining primary health care in the sub-Saharan Africa countries through charges of basic essential drugs (drug revolving funds) and community financing mechanisms. This act contradicts the principle of solidarity that exist in the community prior to SAPs whereby a network of mutual support and obligation exist (Adesina, 2007b). Moreover, the burden of paying health care fell disproportionately on households, and resulted in severe decline in the Nigerian health indices (UNICEF, 1989; World Bank, 1987, 1993). Sixty percent of total health expenditure was from private sources by 1990 of which about 90% was from OOP payments (World Bank, 1993). Furthermore, studies show that user fee was counterproductive to individual and households especially over a long period time. These include self-treatment, taking significant proportion of household budget, delaying or not seeking treatment at all and seeking treatment from informal providers etc. (Ogunbekun, et al., 2009; Sahn, et al., 2003; Mohindra, 2008).

Arising from the failure of user fee to increase revenue, the World Bank, IMF and other international agencies that introduced user fee then resulted in rethinking an alternative funding for health care which would reduce households health expenditure, increase financial protection and recognition of government position in social services provisioning. Unlike user fee model where government role in health care provision was restricted, an alternative model that recognises government role and support in health care provisioning was advocated (World Bank, 1993, 1994; WHO, 2000). The international agencies therefore recognised the potency of risk sharing model especially social health insurance in the developing countries to stimulate four desirable components of health sector reform due to inadequate tax revenue to fund health care for all. These include one, SHI creates room for contributions from those who can afford

payment while government subsidises for the poor who cannot afford premiums rather than providing health care for all. Two, SHI frees up public funds available to be used for public goods and services such as immunisation, HIV/AIDS and vector control. Three, SHI would ensure government subsidy is shifted from the supply side to the demand side by separating the responsibilities of collecting and managing SHI financing from providing health services. SHI would therefore encourage outsourcing of services provision to providers that are separate entities in order to improve efficiency and quality of care. Finally, SHI ensures people access to health care by using non-governmental organisations and private providers through means of contracting (Hsaio and Shaw, 2007). Several developing countries including Nigeria therefore had begun to shift their financing policy towards SHI (WHO, 2010; Gilson and Mclntyre, 2005).

In order to investigate the performance of the scheme's programmes, the "three-health financing functions: revenue collection, risk pooling and purchasing/provision of the conceptual framework" posited by Carrin and James (2004: 20) (see chapter 3 for details) were used as a guide. The three-health financing functions determine the performance of health financing model using seven key health financing performance indicators such as "population coverage, method of financing, level of fragmentation, composition of risk, benefit package, providers payment mechanisms and administrative efficiency" (Carrin and James, 2004: 21).

Table 5.1. Social Health Insurance Programmes in Nigeria

Name of Programme	Contribution Type	Enrolees Contribution	Employer Contribution	Government/Donor subsidies	Pooling	Identification Criterion
Formal Sector Social Health Insurance Programmes						
a. Public sector						
• Federal	Fixed premium	1.75%	3.25%	Not specified	Public sector funds	Civil servant
• States	Fixed premium	5%	10%	Not specified	Public sector funds	Civil servant
• LGAs.	Fixed premium	5%	10%	Not specified	Public sector funds	Civil servant
b. Organised Private Sector	Fixed premium	5%	10%	Not applicable (N/A)	Public sector funds	Employer of 10 or more employees
c. Armed Forces, Police and other allied Forces	Fixed premium	1.75%	3.25%	Not specified	Public sector funds	Armed Forces and other allied forces
d. Voluntary Individual Contributors	Fixed premium	N15,000		N/A	Special funds	Self-employed

Informal Sector Social Health Insurance Programmes						
a. CBHIP	No fixed Premium	Not fixed	N/A	Not specified	CBHI funds	Low income/Rural dwellers
b. Tertiary Institutions	Fixed premium	N2,000		Not specified	Student funds	Student
Vulnerable Groups Social Health Insurance Programmes						
a. Pregnant women	N/A	N/A		100%	Vulnerable funds	Vulnerable
b. Children under five	N/A	N/A		100%	Vulnerable funds	Vulnerable
c. Physically challenged persons	N/A	N/A		100%	Vulnerable funds	Vulnerable
d. Prison inmates	N/A	N/A		100%	Vulnerable funds	Vulnerable
e. Refuges, internally displaced persons etc.	N/A	N/A		100%	Vulnerable funds	Vulnerable

5.3 Revenue Collection

Revenue collection is one of the three related health financing functions. Under revenue collection, two health financing performance indicators namely level of population coverage and level of funding served as themes. Questions related to population coverage and method of financing were posed to the interviewees in order to elicit information on this subject.

5.3.1 Level of Population Coverage

Nigerian former president Chief Olusegun Obasanjo formally launched the formal sector programme of the NHIS in 2005, and thus, the population covered by the formal sector programme represents insignificant proportion of the Nigerian population (Odeyemi and Nixon, 2013). However, in order to increase population coverage and ensure universal access, the community based financing scheme was introduced in 2008 to increase coverage to the informal sector workers and the rural population that makes up 70% of the Nigerian population (Uzochukwu et al. 2016; Bamidele and Adebimpe, 2013). Despite the introduction of community based programme to increase population coverage, literature has shown that coverage is stuck to less than 3% of Nigerian population (Uzochukwu et al. 2016; Odeyemi and Nixon, 2013, Odeyemi, 2013; Obikeze et al. 2013). The Table 5.2 below shows that 2.3 Million people including their dependants were covered in the NHIS by 2015.

Table 5.2 Enrolees registered with Health Maintenance Organisations

No	Health Maintenance Organisation	Total Principal Counts	Total Dependant Count	Total Extra Dependant Count	Total Beneficiary Count
1	Hygeia	48,988	79,197	-	130,185
2	Total Health Trust	58,751	106,388	-	165,139
3	Clear Line Integrated Limited	50,884	97,221	-	148,105
4	Health Care International Ltd	61,780	105,762	-	167,542
5	Medi Plan Health Care Ltd	34,400	64,111	-	98,511
6	Multishade Nig. Ltd	40,211	74,990	-	115,201
7	United Health Care International	86,727	151,408	-	238,135

8	Premium Health Ltd	68,523	129,666	-	198,189
9	Ronsberger Nig. Ltd	18,521	41,297	-	59,818
10	International Health Management	24,891	58,555	-	83,446
11	Expat Care Health International	28,727	57,578	-	86,305
12	Songhai Health Trust	20,014	42,033	-	62,047
13	Integrated Health Care	19,179	20,229	-	39,408
14	Premium Medic Aid	36,201	70,709	-	106,910
15	Manage Health Care Services	17,220	35,811	-	53,031
16	Pristine Health	18,836	46,349	-	65,185
17	Maayoit Health Care Ltd	18,381	39,480	-	57,861
18	Wise Health	25,707	51,431	-	77,138
19	Wetlands Health services	15,945	34,123	-	50,068
20	Zenith Health Care Ltd	30,673	63,082	-	93,755
21	Defence Health Maintenance Ltd	60,121	120,152	-	180,273
22	United Comprehensive Health	17	6	-	23
23	Health Care Security	1,379	3,839	-	5,218
24	Royal Health Maintenance Services	2,762	5,452	-	8,214
25	Arewa Health Maintenance Services	2,503	6,225	-	8,728
26	Zuma Health Trust	1,763	2,592	-	4,355
27	PrePaid Medicare Services	450	1,079	-	1,529
28	Precious Health Care	4,405	7,899	-	12,307
29	Oceanic Health Maintenance	211	312	-	523
30	Complete Medicare Ltd	2,801	6,232	-	9,033
31	Life Care HMO Ltd	88	219	-	307
32	NonSuch Medicare Ltd	167	402	-	569
33	Sahel Health Trust Ltd	283	687	-	970
34	Prudent Health Care Management	1	3	-	4
35	Ultimate Health Maintenance Services	1,226	2,108	-	3,334
	Total	802,738	1,546,697		2,329,435

Source: NHIS, 2015

5.3.2 Level of funding

According to NHIS operational guidelines as depicted in figure 5.1 above, enrolees, employers and government/donors are committed to different financial obligations. Each of the three categories is expected to make its financial contribution for effective operation of the scheme. The researchers engage the key informants on the level of financial commitment of government, employers and enrols to the scheme. In the case of government, many opinions exist among the interviewees on its financial commitment as both employer and governing authority. It was revealed that government as an employer subsidises up to 90% of employee's health care costs. An interviewee explained that:

> "I think the federal government is more committed to enrolees who are its employees than others. Government as an employer of labour is required to pay 3.25% for each of its employee; however, as I speak, that plan has not happened. I learnt that, the Nigerian Labour Congress is not in agreement with the government on pay roll deduction. The labour congress disagreed on the ground that there are several deductions being made on the salaries of its members already and what is left cannot take care of their basic needs therefore the union resisted the plan to make deduction for NHIS. Consequently, the federal government decided to subsidise the medical bill for each of her employee who has enrolled in the NHIS up to 90% while the enrol pays 10% as co-payment. On the other hand, there is no such extent of robust subsidies to other programmes" **(KII, an NHIS official, 6 June 2015).**

Another interviewee corroborated the above view:

> "Government as an employer of labour ensures its employees who joined the scheme are protected from a huge financial cost of health care services. They are highly subsidised from the incurred health care cost" **(KII, an NHIS official, 6 July 2015).**

For Government role as a governing authority of the scheme, a number of views were expressed in the interview such as inadequate and inequitable financial commitment, and delay in government financial commitment to the programme. An interviewee noted that:

> "Government financial commitment to the scheme is inadequate. It is only meant for those who have enrolled. Once you register, you are qualified for certain subsidy; however, someone who is not an enrolee does not benefit from the subsidy. For example, majority of Nigerians who are not members of the scheme because they cannot afford premiums are denied the benefits" **(KII, an NHIS official, 6 June 2015).**

Another interviewee substantiated the above view:

> "Only the enrolees benefit from the programme and their numbers represent an insignificant proportion of Nigerian population. Although Government has made financial commitment to ensure all Nigerians are covered with basic health care as stated in the NHIS Act, there is delay in the implementation. For example, Article 11 of the National Health Act (2014) made provision for Basic Healthcare Provision Fund whereby 1% of Consolidated Revenue Fund will be disbursed among others for Basic Minimum Health Package for all Nigerians through the NHIS, but we are still waiting for the implementation of this Provision"**(KII, an NHIS official, 7 June 2015).**

In the case of financial commitment from others such as enrolees and employers (private Organisations), the interviewees noted that financial contribution could be through either payroll deduction or individual contribution. The private organisations that have insured their employees in the NHIS pay their contributions on regular basis. The employer contributes 10% whereas the employee contributes 5% making 15% of the employee basic salary. For the voluntary individual enrolee; however, the interviewees noted that the 15,000 thousand naira per individual still stands and it could be paid in instalment on monthly basis or once per annum. It was further noted in the interview that the contribution from CBHIP is not fixed; it varies from one to the other and as

determined by the BOT. However, it was noted that contributions to the scheme is progressive on one hand for the formal sector programme because contribution is proportional to their income, and on the other hand, it is regressive for the voluntary individual sector because it is based on fixed premium method. An interviewee explained that:

> "Contribution is very important to the sustenance of NHIS because it is the primary source of funding of SHI. In the case of employees, they are usually in the form of a wage-related contribution, often paid in part by the employers. On the other hand, In the case of the self-employed, they can be flat-rated or income-rated. Income-rated contributions are preferable to flat-rate contributions on equity grounds, as those with a higher income will accordingly pay higher contributions and contributions are based more on ability to pay than in a flat-rate design"**(KII, an NHIS official, 7 June 2015).**

Further investigation shows that financing NHIS through contributions from the enrolees alone is not generating sufficient resources for the scheme. Indeed, the poor, student, unemployed and retired persons among others also need coverage. These contributions from the enrolees are complemented in a number of ways. "As noted earlier, the main supplementary source of funds usually comes from government funding like the Consolidated Revenue Fund. These can secure affordability of health care to a greater number of people who otherwise cannot afford contributions. It also contribute to improved equity in the setting of contributions" **(KII, an NHIS official, 7 June 2015).**

From the above statements, it can be deduced that contributions are the primary source of NHIS. However, it is not generating sufficient resources for the sustenance of the scheme. Like in most countries operating SHI model, supplementary funding usually from government comes from general taxation earmarked tax etc. in order to ensure fair distribution of health care services among the people and to ensure sustenance of the scheme.

5.4 Risk pooling

Risk pooling is the second health financing functions. It refers to "spreading of risk among members of a pool and offer greater protection against high cost health expenditures which then

leads to financial accessibility of health services" (Carrin and James, 2004: 29). Under risk pooling, discussions were focused on level of fragmentation and composition of risk pools in the scheme. Risk pooling is crucial to a health financing system because it allows redistribution of funds among pools: from low risk pools to high-risk pools which in turn pave the way for financial protection of members of different pools. Risk pooling remains the hallmark of social health insurance. It increases people access to health care with less consideration of their financial capacity.

5.4.1 Level of Fragmentation

On the level of fragmentation within the NHIS, the interviewees revealed that the scheme is fragmented into different programmes such as formal sector programme, voluntary individual programme, students programme, community-based programme and vulnerable group programme etc. However, they stressed that there is no risk pool within the existing programmes. An interviewee noted that:

> "The scheme has many programmes especially in the CBHIP with each covering specific group of people who are related by both or either socioeconomic or geographical factors. In fact, each of these programmes are made up of small population as members are characterised by low-income earners and thus lack capacity to pool funds" **(KII, an NHIS official, 7 June 2015)**

5.4.2 Composition of Risk Pool

The basic principle of SHI is that contributions are not risk-related but rather based on ability to pay and result in equitable access to health care services among people of the same pool irrespective of individual financial contributions. The interviewees were engaged on the reason(s) why there is no risk pool in the scheme. It was revealed that membership to the scheme is voluntary; therefore, nobody is compelled by law to join and thus this affects the scheme in terms of capacity to make up a pool. Government encourages people through subsidy to join the programme. An interviewee explained that:

> "…even membership for the civil servants is voluntary, subsidy is only used as incentive and to encourage people to join the scheme. In fact, the scheme was established on a voluntary basis. There is no provision of the Act where people are compelled to join. This is the main reason for lack of composition of risk pool in the scheme, though the common principle in social health insurance is that the size of a risk pool determines the financial flow and protection of its members" **(KII, an NHIS official, 7 June 2015).**

The non-compulsory nature of membership affects the composition of risk pools of the scheme. It was explained in the interview that because NHIS Act did not make it compulsory for anyone to join the scheme, the number of people in the scheme remains stuck to less than 3% of the Nigerian population, and thus affects the composition of risk pool. In addition, the problem of attrition is a recurrent issue of the scheme. People withdraw from the scheme at any time due to one problem or the other including inability to continue payment of contribution. An interviewee explained that:

> "The sustainability of the scheme remains unclear because there is no substantial risk pool available, even within the formal sector programme government has been heavily involved in the financing of the scheme both as employer and governing authority. The labour unions did not support deduction from their members' salary towards the scheme. In fact, it remains unclear the sustainability of the programme without the support of the labour force" **(KII, an NHIS official, 7 June 2015).**

From the above statements, it can be deduced that NHIS is fragmented with several programmes such as Civil servants, private sector employees, urban self-employed etc. with no risk pool existing within the scheme. Voluntary membership was identified as the main reason for lack of capacity to have a risk pool in the scheme. Countries with successful SHI programmes, build on redistribution of risk among pools. However, lack of risk pool in NHIS contradicts the principle SHI that entails redistribution of funds among pools: from low risk pools to high-risk pools which in turn pave the way for financial protection of members of different pools.

5.5 Purchasing/Provision

Purchasing/ Provision is the third health financing functions that is instrumental not only to the principle of health financing but also to the achievement of the objective of universal coverage. Purchasing entails benefit package, providers' payment mechanisms and administrative efficiency, which results in optimal use of resources.

5.5.1 Benefit Package

The pooled contributions in a SHI scheme is usually used to purchase health care package for all insured members as stipulated in the agreement between an insurance system and the providers at all levels of the health care system. The researcher therefore engaged the interviewees on the benefit packages available to various programmes in the scheme and the extent to which funding helps members to access health care services. It was revealed in the interview that different benefit packages exist for different programmes, though there is similarity in terms of basic or essential health care services across programmes that reflects prophylactic and therapeutic components of health care services but to a limited range in some programmes. An interviewee explained that:

> "The benefit packages have similarities for the basic essential services in the case of the formal sector and individual contributors' programmes but with difference when compared to other types of programmes such as community-based insurance and the tertiary insurance programmes. The enrolees for the formal sector programme have access to primary, secondary and tertiary health care while community programme is restricted to primary and secondary health care services. The programme in which one belongs determines access to health services" **(KII, an NHIS official, 7 June 2015).**

An HCP explained that:

> "I think the basic services cut across board but when it comes to specialist care, some programmes are excluded because of their financial strength.

> The financial strength of some programmes cannot afford them beyond basic and priority package" **(KII, an HCP, 11 July 2015).**

When asked the reasons for the variation in the benefit packages, it was revealed that it is likely based on the composition of various programmes in terms of the socioeconomic status of members and their ability to pay. It was also explained in the discussion that the whole health package for the scheme is not comprehensive because some essential health care services are not included such as treatment for people with chronic disease, occupational related injury, infertility related problem etc. Members can only access health care services available in the health care package available for their plans. For example, access to benefit package by primary health care providers cut across all programmes. These include access to curative services and common ailments such as minor wounds, treatment of malaria, diarrhoeal disease, and education for control and prevention of health problem etc. However, the secondary and tertiary health care providers offer specialised services to patient based on referral from the primary health care through the HMOs. The services include complex cases that cannot be treated at the primary level such as surgical procedures; specialist consultation, pharmacy services, diagnostic laboratory services etc.

The extent to which funding from government helps members to access health care were raised in the discussions. Interviewees explained that the sustainability of the scheme greatly rests on the shoulder of the government. An interviewee noted that:

> "The cost of health care expenditures to many households is huge and without subsidy from the governments many would not be able to access health care. Even with subsidy, we still have some cases where people dropped out because they could not continue with the contribution. Therefore, subsidy plays an important role not only by reducing the financial health expenditures of enrolees but also by sustaining the scheme" **(KII, an HCP, 11 July 2015).**

Furthermore, in the discussion, the interviewees explained that many enrolees remained in the scheme because of the financial assistance from the government. It is important to note that the financial assistance from the government is only available to the enrolees.

5.5.2 Payment Mechanism for Providers

The NHIS accredited providers are required to deliver specified health care services to NHIS enrolees. Providers' payments mechanism for services provided for the enrolees is crucial to ensure financial protection of the issued members. The researcher engaged the interviewees on the nature of contract between the providers and the HMOs, the methods of payment for their services and the extent to which this influence equity and efficiency of services. The interviewees explained that HMOs sign contract with the accredited providers in order to render stipulated health services to the enrolees. The contract is subject to renewal based on the terms and conditions of the contract. Moreover, the mode of reimbursement for providers' services is a blended payment of capitation and co-payment for services rendered to the enrolees. An HMO pays capitation a form of salary on a monthly basis to individual providers or health care facilities for the services they rendered to the enrolees within that HMO. In addition, co-payment is also used as part of reimbursement of providers' services. An interviewee explained that:

> "Capitation is the principal mode of paying providers under the NHIS for basic health care services. In addition, co-payment of 5% to 10% is often required from the enrolees as consultation fee" **(KII, an HCP, 11 July 2015).**

It was noted that the intent of co-payments at the point of service delivery was to discourage patient from excessive request for services because people with insurance coverage are more likely to use services excessively than when they are not covered under insurance. However, co-payment in the form of cost sharing is not the main source of reimbursement to providers but rather a part of the reimbursement plans. On whether capitation as a mode of payment positively influence providers' behaviour and reflects efficiency and equity of services to the beneficiaries. The interviewees

explained that capitation is one of the methods widely used for paying providers for their services. Like other methods of payment, it has its own strengths and weaknesses. One of the strengths of capitation is to contain costs by encouraging health providers to provide efficiently a set of services for the assigned enrolees. On the other hand, the weaknesses include among others underproduction of services because health care providers are short-changed for the quantity of health services rendered to the enrolees; they are likely to reduce the services to the enrolees, and thus attracted by financial incentive to care more for fee-for-service patients. Health care providers however explained in the interview that often times there is unnecessary delay in the payment of capitation and reimbursement for their services. They complained that at times they go through a rigorous claim process before they are reimbursed by the HMOs. A health care provider explained that:

> "Capitation is internationally recognised as a method of provider payments under health insurance system and it is a good method. Nevertheless, low capitation and delay in payment by the HMOs remains a serious challenge to the scheme. Many at times we have to wait for so long before we are paid for services rendered to the enrolees. In addition, the capitation is very small given the inflation rate and the cost of medical equipment in the country. Of course, this affects providers' behaviour towards NHIS patients because there is that notion that even after rendering services to the enrolees and being reimbursed might be delayed" **(KII, an HCP, 11 July 2015).**

However, on the discussion with the HMOs about the complaints of providers on the delay in payments or claims after rendering services to the enrolees, they argued that there is no unnecessary delay in ensuring that the providers are duly paid as at when due, but there is bureaucratic process that must be followed before payment. The administrative processes include among others verification of the claimant documents, routine check on the accredited providers and monitoring of patients, that is, the enrolees to confirm that they received the said treatment before payments are made. However, it is worth noting that process for provider payment remains

contentious between providers and HMOs. Both providers and HMOs stand on different point of views regarding the payment processes.

On the discussion on whether provider payment affect efficiency and equity, an interviewee explained that the mode of provider payment in NHIS determines provider efficiency and equity. "It is possible for a provider to maintain less efficiency in exchange for a greater degree of equity, depending on the incentive available to the provider. However, in the case of NHIS enrolees, personally, I make sure that I strike a balance between efficiency and equity, and thus, the enrolees are given the necessary services as specified in the contract agreement" **(KII, an HCP, 13 July 2015).**Similar trend applies to other providers in the interview. They explained that they are committed to providing health care services to the enrolees as stipulated in the contract agreement.

5.6 Administration and Management Efficiency

Administrative efficiency of the NHIS is important because it determines the overall performance of the scheme based on its day-to-day activities. The interviewees were engaged in the discussion on administrative costs of planning and management of the scheme in terms of revenue collection, handling of claims and referral system. It was revealed in the interview that administrative costs of the scheme is huge but the aggregate percentage of expenditure on administrative costs could not be ascertained. However, conflicting opinions exit among the interviewees on administrative efficiency. On one hand, an HMO employee explained that:

> "The administrative costs is not something that can be easily determined because of different stakeholders involved in the day-to-day activities of the scheme. For example, the administrative cost of an HMO differs from another HMO which include overhead cost such as payment of staff salary, maintenance of utility vehicles, payment of rent, buying of stationery etc., However, in terms of efficiency, I think the HMOs are trying their best. We need to follow the normal protocol to ensure providers are paid their claims as at when due and ensure our clients get the best health services and if referral is needed they are referred immediately. There are procedures we

must follow in all these things to ensure things are done properly" **(KII, Ronsberger, 8 July 2015).**

On the other hand, health care providers in the interview argued that there is administrative inefficiency in reference to delay in reimbursement of providers and referral of patients. A provider explained that:

> "In term of administration, I think there is still more to be done given the unnecessary delay in the processing of claims by the HMOs. Many issues have come up on these bureaucratic bottleneck involved in the processing of claims. I think the HMOs need to improve on their administrative procedure in terms of payment on referral cases and capitation. Once their clients are given the necessary health services and the required documents are forwarded payment should not be a problem" **(KII, an HCP, 13 July 2015).**

The overall administrative costs of the scheme could not be determined in the interview. However, the administrative procedure involved in the reimbursement of providers remain contentious. On the management efficiency, a number of factors were considered as management inadequacy, which in turn affect the achievement of the scheme objectives.

5.6.1 Policy Content

A well-designed policy framework is critical to the implementation and achievement of the set target of a social health insurance, which is universal coverage. However, deficiency in the policy framework could affect the achievement of the set target. The researcher therefore engaged the interviewees in the discussion on issues related to the policy content and process in reference to the set objectives and overall goal of universal coverage. The policy content of the NHIS Act was criticised in the interview. The interviewees noted that NHIS law remain as the main hindrance to the scaling up of population coverage in Nigeria. It was further explained that some provisions of the Act contributed to the current slow rate of population coverage in the country. An NHIS official explained that:

> "The wording of the Act is the main problem affecting the scheme from achieving its set target. For example, section 16(1) of Act says, "An employer who has a minimum often employees **may**, together with every person in his employment, pay contributions under the scheme, at such rate and in such manner as may be determined, from time to time, by the Council". The word 'may' means 'wish'. Those who desire to join the scheme should join. In other words, joining is not by force, it is voluntary. I think there is need for amendment of the Act… before positive change in the population coverage will begin to take place" **(KII, an NHIS official, 6 June 2015).**

In an interview with a HMOs employee, she explained that:

> "In my own opinion, although, the scheme has the potential to provide health care services to all Nigerians and remain a major driving tool for achieving universal health coverage; however, the factor mitigating against the wider coverage of the scheme has to do with the Act that instituted the scheme. When the government introduced pension scheme in this country…it made it mandatory for every employee to participate. However, NHIS was made optional. Many public and private enterprises have no health insurance for their employees because the law did not mandate them to do so. In that regards, government cannot achieve anything tangible the way the scheme is going except there is amendment of the law" **(KII, an employee of HMO, 8 June 2015).**

Furthermore, a health care provider also had similar stance on the point raised by other interviewee he explained that, "how can the government say it is committed to securing universal coverage for all Nigerians when other tiers of government are not involved? That is the problem with NHIS. The states and local governments are not part of the scheme; even those that showed interest among them sometimes ago are yet to take part in the programme. In addition, government said membership is mandatory for the federal civil servants, but this is not backed by law, as I speak not all have enrolled in the scheme. So how can we achieve universal coverage in such manner?"

(KII, HCP, 11 July 2015). Referring to the NHIS Act, the interviewees explained that the contents of the Act is not properly phrased and this has affected the implementation of the scheme. However, they call for amendment of the Act in order to rectify the points raised in the discussion and to accommodate every Nigerians. In the discussion, another important point raised was government commitment. The interviewees explained that government financial commitment to the scheme is inadequate. It was noted that government subsidy was only meant for the enrolees while those who are not enrolled because they could not afford the minimum contribution were excluded from the scheme. A health care provider noted, "The scheme at the moment is restrictive to those who can afford contribution while ignoring most deserving least-privileged people who cannot pay the required subscription. This act shows misconception of the nature and principle of social health insurance whereby everyone is involved irrespective of ability to pay. In addition, it also contravened the NHIS Act because it was stated in the Act that the scheme is committed to ensure every Nigerian have access to good health care services" **(KII, HCP, 11 July 2015).**

In addition to lack of government commitment to the programme, inadequate mobilisation campaign was also raised in the interview. The extent of any government sponsored programme that dependent on direct financial contribution from the population hinges on rigorous campaign in order to gather support from the population. However, the scheme is lacking in this regard. A health care provider explained, "Many Nigerians may have heard of the scheme but lack knowledge of its operation and also many still do not understand how the scheme works in reference to risk pooling and cost sharing even among the insured. Therefore, I think government is not doing enough to enlighten people about the scheme" **(KII, HCP, 13 July 2015).** Furthermore, the interviewee explained that although the incremental approach adopted by the government is not a bad idea, the modus operandi adopted is defective given the fact that the scheme started with the formal sector programme with few-targeted population instead of the informal sector programme that has the larger population of the country. It was further noted that progressive universalism that initially targeted the poor by exempting them from contribution tends to fast track the achievement of universal coverage than the one that at the outset targets the non-poor as this tends to slow down the achievement of universal coverage and of course, this is the case of Nigeria.

5.7 Conclusion

This chapter explored the three-health-financing functions namely revenue collection, risk pooling and purchasing among NHIS stakeholders including NHIS officials, HMOs employees and health care providers. The three health financing functions were examined under eight themes namely population coverage, method of financing, level of fragmentation, composition of risk, benefit package, provider payment mechanism, administrative and management efficiency. The findings indicate NHIS is heavily subsidised by the government because of the insufficient revenue generated through enrolees' contributions and co-payments to the total costs of health care benefits. The contributions represent a fraction of what enrolees spent on health care. Therefore, every enrolee receives a subsidy from the government to limit the direct financing burden of health care costs, though the percentage of the subsidy varies from one programme to the other. Furthermore, NHIS is fragmented with a number of programmes exist in the scheme such as formal sector programme, voluntary individual programme, students programme, community-based programme, vulnerable group programme etc. with no risk pool in existence. Enrolees are entitled to a benefit package as specified in their programmes, though the basic health package – under the primary health care providers cut across all packages, referral system from the secondary and tertiary levels of care hinges on HMOs approval or pre-authorisation.

Furthermore, the scheme is confronted with administrative and management challenges. These include poor referral of patients and providers reimbursement system. In addition, the phrasing of the Act coupled with non-compulsory nature of the scheme, inadequate and delay government financial commitment, and inadequate mobilisation campaign among others were identified as challenges hindering scaling up of population coverage and the achievement of universal coverage in Nigeria. It is worth noting that for NHIS to achieve it set objectives there must be adequate financial resources for the sustainability of the programme, adequate risk pooling and purchasing and strong institutional capacity.

CHAPTER SIX

FINANCIAL CONTRIBUTION AND HEALTH BENEFITS AMONG ENROLEES OF THE NATIONAL HEALTH INSURANCE SCHEME

6.1 Introduction

Chapter 6 discusses the socio-demographic characteristics of the respondents in Oyo state Nigeria. It assesses the extent to which financial contribution of the respondents determines their health benefits. Questions regarding financial contribution and health care services were assessed in this chapter in order to establish the extent of equity in terms of contribution and benefits among the respondents. However, the chapter begins with the assessment of the socio-demographic characteristics of the respondents and then move to issues related to financial contribution and health benefits, which in turn determines the equity level among the enrolees.

6.2. Socio-Demographic Characteristics of the Respondents

The socio-demographic characteristic of the respondents namely enrolees and non-enrolees were discussed in this section. The section discusses percentage distributions of the enrolees first, and then followed by the non-enrolees.

Table 6.1: Percentage Distribution of Respondents by Socio-demographic Characteristics

Variables	Enrolees (no =1342)	Non-enrolees (no =376)
Gender		
Male	719 (53.6%)	207 (55.1%)
Female	623 (46.4%)	169 (45.1%)
Age		
18 – 20	0 (0%)	37 (9.8%)
21 – 25	52 (3.9%)	42 (11.2%)

26 – 30	149 (11.1%)	101 (26.9%)
31 – 35	231 (17.2%)	88 (23.3%)
36 – 40	376(28.0%)	50 (13.3%)
41 – 45	163 (12.1%)	30 (8.0%)
46 – 50	210 (15.6%)	22 (5.9%)
>51	161 (12.0%)	6 (1.6%)
Marital Status		
Married	898 (66.9%)	224(64.9%)
Single	256 (19.1)	64 (17.0%)
Divorced	74 (5.5%)	49 (13.0%)
Separated	86 (6.4%)	18 (4.8%)
Widowed	28 (2.1%)	1 (0.3%)
Education		
No formal education	0 (0%)	10 (2.7%)
Primary Cert	15 (1.1%)	19 (5.1%)
Secondary Cert	90 (6.7%)	121 (32.2%)
OND/NCE	167 (12.4%)	104 (27.7%)
HND/First degree	732 (54.5%)	75 (19.9%)
Post Graduate	338 (25.2%)	47 (12.5%)
Religion		
Tradition	34 (2.5%)	52 (13.8%)
Islam	512 (38.2%)	161 (42.8%)
Christianity	743 (55.4%)	151 (40.2%)
Others	53 (3.9%)	12 (3.2%)
Income Per Month		
<10,000 Naira	64 (10.8%)	41 (10.9%)
10,100 - 30,000	179 (13.3%)	203 (54.0%)
30,100 - 50,000	250 (18.6%)	101 (26.9%)
50,100 - 70,000	266 (19.8%)	15 (4.0%)
70,100 - 90,000	221 (16.5%)	7 (1.9%)

90,100 - 110,000	192 (14.3%)	5 (1.3%)
>110,000	170 (12.7%)	4 (1.1%)
Occupation		
Civil Servant	962 (71.7%)	68 (18.1%)
Self-employed	139 (10.4%)	283 (75.3%)
Private Sec Employee	241 (18.0%)	25 (6.6%)
Ethnicity		
Yoruba	961 (71.6%)	263 (69.9%)
Hausa	89 (6.6%)	15 (4.0%)
Igbo	231(17.2%)	89 (23.7%)
Others	61 (4.5%)	9 (2.4%)

Source: Fieldwork, 2015

From table 6.1 above, male respondents among the enrolees were 719 (53.6%) while female were 623 (46.4%). This indicates that there were more males in the study than females. Age distribution of the respondents indicates that none was below the age of 20 years. However, 52 (3.9%) were between the age of 21 – 25. In addition, 149 (11.1%) were within the age range of 26 – 30. 231 (17.2%) were within the age range of 31 – 35. 376 (28.0%) were within the age range of 36 – 40. 163 (12.1%) were within the age range of 41 – 45. 210 (15.6%) were within the age range of 46 – 50. 161 (12.0%) were 51years and above.

The marital status of the respondents indicates that those who were married were 898 (66.9%). Single were 256 (19.1%). Seventy-four (5.5%) were divorced, 86 (6.4%) were separated while 28 (2.1%) were widowed. The implication of this is that majority of the respondents were married in the study. Furthermore, from the assessment of the educational status of the respondents, none had no formal education. Fifteen (1.1%) had primary education, 90 (6.7%) had secondary education while 167 (12.4%) had either OND or NCE. In addition, 732 (54.5%) had either HND or First degree, 338 (25.2%) had post-graduate degree. This shows that all the respondents had formal education, though with different levels of education.

The respondents distribution also indicates that 743 (55.4%) of the respondents practiced Christianity, 512 (38.2%) practiced Islam. In addition, 53 (3.9%) practiced other religions while 34 (2.5%) practiced Traditional religion. Moreover, the income of the respondents varies markedly. Sixty-four respondents (10.8%) earned less than 10,000 naira ($50.2) monthly, 179 (13.3%) earned between 10,100 - 30,000 naira ($50.7 and $150.7). In addition, 250 (18.6%) respondents earned within the range of 30,100 - 50,000 naira ($151.2 and $251.2), 266 (19.8%) respondents earned between 50,100 - 70,000 naira ($251.7 and $351.7), 221 (16.5%) respondents income ranged between 70,100 - 90,000 naira ($352.2 and $452.2). Moreover, 192 (14.3%) respondents earned 90,100 - 110,000 naira ($452.7 and $552.7). Only 170 (12.7%) respondents earned above 110,000 naira (above $552.7). It is important to note that exchange rate was 199 naira to one US dollar as at April 2015 during data collection.

From the assessment of the occupational status of the respondents, 962 (71.7%) were civil servants, 241 (18.0%) were private sector employee while 139 (10.4%) were self-employed. Furthermore, the ethnicity of the respondents indicates that 961 (71.6%) were Yoruba, 231(17.2%) were Igbo, 89 (6.6%) were Hausa while 61 (4.5%) were others.

However, the percentage distribution of the respondents (non-enrolees) indicate that 207 (55.1%) were male while 169 (45.1%) were female. This indicates male are more in the study than the female. The age distribution shows that 37 (9.8%) were within the age range of 18 – 20, 42 (11.2%) were within the age range of 21 – 25, 101 (26.9%) were within the age range of 26 – 30, 88 (23.3%) were within the age range of 31 – 35, 50 (13.3%) were within the age range of 36 – 40. In addition, 30 (8.0%) were within the age range of 41 – 45, 22 (5.9%) were within the age range of 46 – 50 and 6 (1.6%) were 51 years and above.

The marital status of the respondents shows that 224 (64.9%) were married, 64 (17.0%) were single, 49 (13.0%) were divorced, 18 (4.8%) were separated; one (0.3%) was widowed. This shows that majority of the respondents were married. Moreover, the educational distribution of the respondents indicates that 10 (2.7%) had no formal education, 19 (5.1%) had primary education, 121 (32.2%) had secondary education, 104 (27.7%) had either OND or NCE, 75 (19.9%) had either Higher National Diploma or First degree, 47 (12.5%) had post-graduate qualification. The religion

distribution of the respondents shows that 52 (13.8%) practiced Traditional religion, 161 (42.8%) practiced Islam, 151 (40.2%) practiced Christianity, 12 (3.2%) practiced other religions.

The income distribution of the respondents shows that 41 (10.9%) earned less than 10,000 naira; 203 (54.0%) earned between 10,100 - 30,000 naira; 101 (26.9%) earned between 30,100 - 50,000 naira; 15 (4.0%) earned between 50,100 - 70,000 naira; seven (1.9%) earned 70,100 - 90,000 naira; five (1.3%) earned between 90,100 - 110,000 naira and four (1.1%) earned 110,000 naira and above. The occupational distribution of the respondents shows that 68 (18.1%) were civil servants, 283 (75.3%) were self-employed and 25 (6.6%) were private sector employees. Moreover, the ethnic distribution shows that 263 (69.9%) were Yoruba, 15 (4.0%) were Hausa, 89 (23.7%) were Igbo, and nine (2.4%) were others.

The result on the socio-demographic characteristics of the respondents shows that majority of the enrolees 719 (53.6%) and non-enrolees 207 (55.1%) were male. In terms of age, greater number of the enrolees 376(28.0%) were between the age of 36 – 40 while majority of the non-enrolees 101 (26.9%) were between the age of 26 – 30. The implication of this is that young people are more dispose to this study and issues related to NHIS. On marital status, majority of the respondents both enrolees 898 (66.9%) and non-enrolees 224(64.9%) were married. On education, greater number of the enrolees 732 (54.5%) were either HND or First-degree holder while for the non-enrolees, majority 121 (32.2%) had secondary school certificate, only 10 (2.7%) had no formal education. This shows that most of the respondents were educated. On religion, greater number of the enrolees 743 (55.4%) were Christians. On the other hand, greater number of the non-enrolees 161 (42.8%) were Muslims. This indicates that Christianity and Islam were the two main religions in the area. Only few respondents practiced traditional religion and other types of religions.

On income, most of the enrolees 161 (42.8%) earned between 50,100 - 70,000 naira monthly compare to the non-enrolees with majority 203 (54.0%) earned between 10,100 - 30,000 naira monthly. This indicates that enrolees were in favourable conditions in terms of socio-economic status than the non-enrolees were. This agrees with the findings of Gu and Tang (1995) that higher quintile are disposed to accessing health care than the lower quintile in China. In terms of respondents' occupation, while majority of the enrolees 962 (71.7%) were civil servants (federal

employees), for the non-enrolees, majority 283 (75.3%) were self-employed. This shows that civil servants are the most beneficiary of the scheme. This could also be attributed to the fact that the scheme started with the federal employees (NHIS, 2009) and therefore, the federal civil servants are the major enrolees in the Oyo state while the state government is yet to be part of the programme. On ethnicity, most respondents for both enrolees 961 (71.6%) and non-enrolees 263 (69.9%) were Yoruba. This is because the study was carried out in Oyo state where Yoruba is the dominant ethnic group.

6.3 Enrolees Method of Financial Contribution

Health care financing in Nigeria is a mixed method of user charges, government funding, insurance and donor assistance with user charges accounting for more than two-thirds of the total spending . However, NHIS was established to replace user charges and give people more financial protection from health care expenditures. NHIS is financed by revenue generation from members, employers, government and donor assistance. Revenue generation could be by prepayment or co-payment. Prepayment is always preferred because it is a precondition of risk pooling among members and offers better protection against health care costs while co-payments serve as additional revenue generation. In addition, the level of prepayment shows how accessible the health package of a SHI scheme will be. In other words, the extent of a benefits package of a SHI scheme is contingent on the financial contribution. Table 6.2 shows respondents distribution by method of financial contribution to the scheme.

Table 6.2 Percentage Distributions of Respondents by Method of Financial Contribution

Method of Contribution	Frequency	Percentage
Prepayment	479	35.7%
Co-payment	863	64.3%
Total	1342	100%

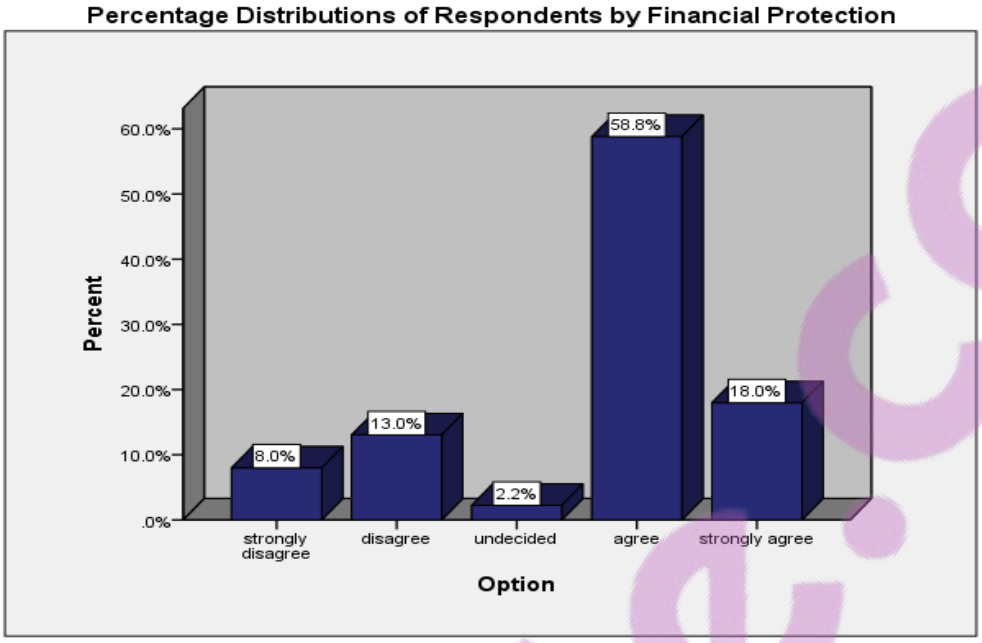
Source: Fieldwork, 2015

Table 6.2 above indicates that majority of the respondents 863 (64.3%) made their contribution to the scheme through co-payment while 479 (35.7%) contributed by prepayment. This shows that co-payment instead of prepayment is largely used among respondents as a means of financial contribution to the scheme. The federal civil servants constituted the highest percentage of the respondents in the study in that they expressed in the interview that they are yet to commence prepayment because of lack of agreement between the labour union congress and NHIS on payroll deduction. Consequently, this action has stalled prepayment by this group to the scheme. An enrolled civil servant in the NHIS pays 10% as co-payments of the costs of the services per visit to health care providers. On the other hand, prepayment is predominantly used by other employees including private organisations employees and self-employed.

Revenue generation through prepayment is recognised as a strategy to ensure financial protection of members of a SHI scheme because it gives room for redistribution of risks among members (Carrin and James, 2004). However, this study found that the federal civil servants that make up of the highest percentage of the enrolees are yet to commence prepayment to the scheme. "Co-payments are not regarded as a 'generator' of resources for the scheme. Instead, the health care providers receive revenues generated from co-payments primarily to check moral hazard" (Carrin and James, 2004: 34). It is not a good method of financing health care in SHI. However, the primary source of financing a SHI system is contribution in the form of a wage-based contribution and tax funding; these are a relatively sustainable source of revenue for the scheme (Carrin, 2002; Carrin and James, 2004).

Furthermore, NHIS is required to protect members against huge financial expenditure that may arise from health care costs. Figure 6.2 shows the extent to which respondents agreed or disagreed with NHIS as a financial protection against catastrophic spending.

Figure 6.1 Percentage Distributions of Respondents by Financial Protection against Catastrophic Spending



Source: Fieldwork, 2015

Assessing respondents' financial protection against catastrophic spending, figure 6.1 shows 789 (58.8%) agreed that they were protected, 241 (18.0%) strongly agreed while 175 (13.0%) disagreed and 107 (8.0%) strongly disagreed. Only 30 (2.2%) were undecided. On the aggregate, majority of the respondents 1030 (76.8%) agreed, 282 (21.0%) disagreed while 30 (2.2%) remained undecided. Responses from the qualitative data supported these findings. Out of 30 respondents interviewed, five disagreed that they had financial protection against catastrophic spending while a good number (23) of them agreed in the discussion that they were protected from huge medical bills. Below are excerpts from the interview:

> "NHIS has really helped me and my family members. Though no one pray to be sick but once sickness comes, the first thing to think about is money. However, with NHIS I do not bother much on the financial aspect because NHIS will take care of most of the expenses. Sometime ago, I was sick and went to the hospital. Being an NHIS enrolee, I was not scared of my medical

bill because I was rest assured that NHIS will foot the bill" **(IDI, male enrolees, 52 years Old, 8 June 2015).**

Other respondents explained that:

> "Last week my daughter was down with malaria and I took her to the hospital for treatment. When we got there, I only paid 10% of the medical bill and that is about 500 naira. Therefore, NHIS saved me 90% of the medical bill. I think NHIS is good because it saves people from uncertainty of health care expenditure. There is no way you can compare NHIS with out-of-pocket spending. With NHIS, you are certain of the amount to pay for health care but not so with out-of-pocket spending" **(IDI, female enrolees, 48 years Old, 8 June 2015).**

> NHIS has many benefits. In fact, I have really benefited a lot from the scheme. In terms of cost of medical bills, my family expenditure has reduced drastically since I joined the scheme two years ago. We do not always consider the cost of health care as a major issue in the family anymore. The money my family would have spent on medical expenses is now redistributed among other household needs such as children' education, asset etc." **(IDI, female enrolee, 40 years Old, 9 June 2015).**

However, those with opposite view noted that the scheme did not do enough to protect them against catastrophic health expenditure. Reason being that they still pay out of pocket for essential care outside NHIS health package. In addition, their contributions outweigh the benefits because of the status of their health. Below are some of the responses from the respondents with conflicting notions about the scheme.

> "I have not derived any benefit from the scheme. Since I registered last year, my husband and I have not used the services because we hardly fall sick. We only pay our contributions to the scheme but do not get sick to use our

> money. I wish the scheme we pay or give us rebate at the end of the year since we are not using the health services, but I do not think the scheme will agree on this"**(IDI, female enrolee, 45 years Old, 9 June 2015).**

Another respondent explained that:

> "As an enrolee, one has to pay for most of the major things in the hospital such as laboratory tests, x-ray and drugs among others. I do not see any difference between NHIS and out-of-pocket payments. Many times, fee-for-service patients have better care than NHIS enrolees do. For example, I went to the hospital for treatment, after the medical tests, the drugs prescribed for me were not available in the hospital. I bought the drugs in a pharmacy. However, if I am a fee-paying patient, the hospital will sell the drugs for me because I believe the drugs are available in the hospital pharmacy" **(IDI, a male, 54 years Old, June 9 2015).**

In the interview, majority of the participants (23) agreed that they were financially protected against huge costs of medical bills only small number (7) disagreed. This finding confirm Barnighausen and Sauerborn (2002) assertion that cost containment is best achieved by a social health insurance scheme while other method such as co-payments is used for mobilization of additional funds, containment of costs and prevention of moral hazard among the insured. Similarly, Nguyen, et al., (2011) study on the effect of NHIS financial protection in Ghana reveal that NHIS significantly reduced catastrophic OOP payments on health services. In addition, it serves as a safety net for households thereby reducing their health care costs and increases their budgets for other essential needs.

6.4 National Health Insurance Scheme Health Package

Another important feature of a SHI scheme is its benefits package. Health benefits package varies from one health plan to the other with some have a wide range of coverage while others have limited coverage depending on the financial contribution of the enrolee (Bodenheimer and Grumbach, 2005). Hsiao and Shaw (2007) posit that SHI is not only to ensure members' protection

against catastrophic health medical expenses but also to provide health care services including prophylactic and therapeutic care as specified in the benefit package. They however note that mobilizing more funds by SHI may not necessarily produce adequate health care for members. This perhaps happens where multiple funds exist and risks fragmented which in turn results in different benefit packages. Nevertheless, contributions from insured members are used to purchase a specified benefits package. However, it was gathered in the interview that the NHIS benefit packages include preventive and curative care provided by the three levels of care including primary, secondary and tertiary care, but there is no well-defined demarcation among the existing benefit packages within the scheme. An interview noted:

> "Everyone subscribed to primary health care package. That is the first port of call to health care services in the NHIS. The primary health care services include out-patient care, in-patient care, maternity care, routine check-up and all uncomplicated cases of care. However, the secondary health care services offer specialized care services on referral from the primary health care levels through the HMOs. Such services include Specialist care for Medical, Surgical, Paediatric and Obstetrics and Gynaecology cases Pharmacy, radiological and laboratory services etc. The tertiary health care services is the third and final stage of care. It consists of all services provided at the secondary level of care, and other highly specialized services referred from the secondary level" **(IDI, female enrolee, 46 years Old, 10 June 2015).**

Another respondent substantiated the above view:

> "I enrolled for the primary health care package because it is the 'gateway' to other types of care. Secondary and tertiary care are available only by referral. Anyone who want to join NHIS must enrolee for primary health care. No one can jump queue the way the system is arranged. One moves from the primary type of care for common diseases to secondary facilities for serious illnesses and to tertiary (teaching hospital) care for complex

illnesses. That is how the scheme operates" **(IDI, male enrolee, 38 years Old, 16 June 2015).**

From the above findings, respondents subscribed to primary health care package (the first port of call) while secondary and tertiary health care services are dependent on referral from the primary care. Furthermore, it was noted in the interview that the federal civil servants, self-employed and employees of private organisations who are interested in joining the scheme, register with the contracted HMOs and pay their contributions where applicable. HMOs with long history of insurance, wider scope and record of accomplishment tend to have more contracts and more enrolees than those who are limited in scope. For example, most of the HMOs with national status such as Hygeia Limited, Total Health Trust Limited, Ronsberger Nigeria Limited among others have about 200 hospitals and clinics across the country and this also influenced the number of enrolees in these organisations. Most of the participants in the interview enrolled with the aforementioned three HMOs and have access to prophylactic and therapeutic health care services within the network of the HMOs. No enrolee is allowed to use health care services outside the network of the HMOs. Below are excerpts from the interview.

"All of us here in this institution are under Ronsberger Nigeria Limited as our HMO. I think one cannot just go outside the contracted HMOs for his/her organisation. Every organisation has its own assigned HMO and interested employees approach the HMO for registration in the NHIS" **(IDI, male enrolee, 31 years Old, 16 June 2015).**

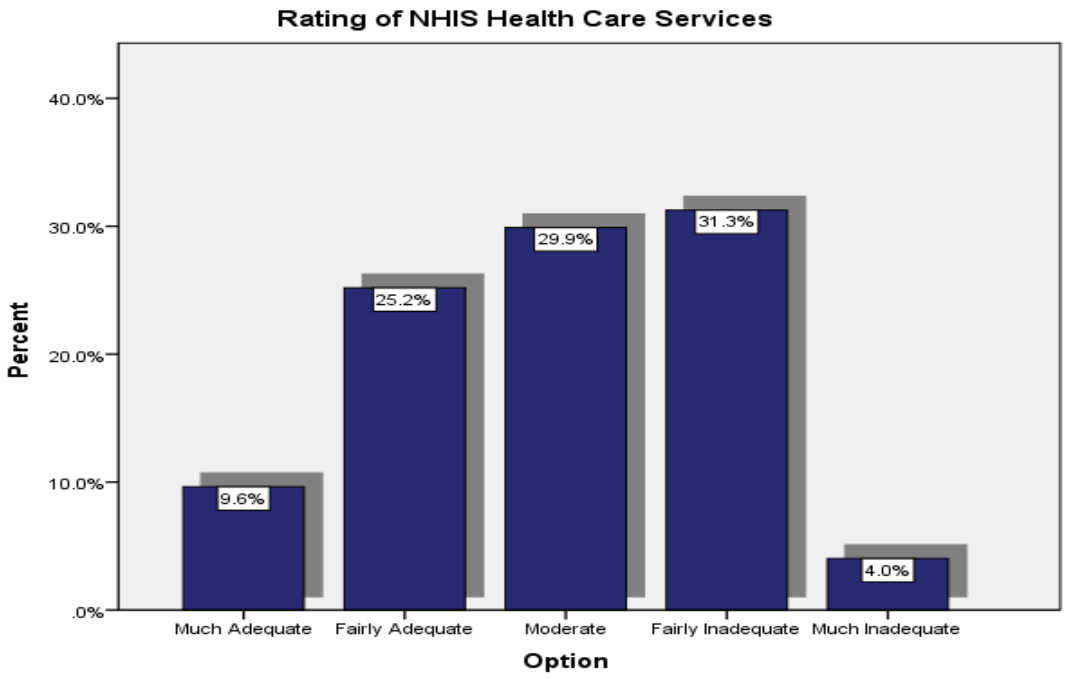
Another interviewee explained that:

"Employers of organisations sign agreement with the HMOs to cover their employees, except for Voluntary Individual Programme whereby interested members in NHIS approach HMOs of their choice for registration. For us in this organisation, we are under the Hygeia Limited. Hygeia Limited is the assigned HMO for us. It has office here to attend to clients. We approach

the HMO for registration and supply all the require documents" **(IDI, female enrolee, 37 years Old, 16 June 2015).**

The interview indicates that HMOs sign contracts with organisations except for the individual contribution programme where interested members of the public approach HMOs of their choice for registration. The enrolees are entitled to preventive and curative care including consultation with specialists, pharmacy services etc. Figure 6.2 below shows respondents rating of health care services under the NHIS.

Figure 6.2 Percentage Distributions of Respondents Rating of NHIS Health Care Services.



Source: Fieldwork, 2015

From figure 6.2 above, 127 (9.6%) of the respondents indicate that the health services is much adequate. 332 (25.2%) shows that it is fairly adequate. 394 (29.9%) shows that it is moderate. 412 (31.3%) indicates that it is fairly inadequate while 53 (4.0%) indicates that it is much inadequate. In sum, greater number of the respondents 465 (35.3%) indicate that the health services is adequate, 459 (34.8%) indicate that it is inadequate while 394 (29.9%) reveal that it is moderate. These

findings is further explained in the interview, though with conflicting views from respondents about the health services. Out of the 30 participants interviewed 24 explained that the services is not comprehensive because there are essential services excluded from the package while 6 noted that there should be exclusion of some services that may not be needed by everyone. Below are excerpts from the interview:

> "I am not too comfortable with the NHIS health care services. The scheme says it offers both primary, secondary and tertiary care but in practice, there is limitation to the services it offers. You pay out-of-pocket for many things as an enrolee these include drugs, medical tests, x-ray among others, these are essential things that need to be covered by the scheme" **(IDI, female enrolee, 35 years Old, 10 June 2015).**

Another interviewee explained that:

> "The scheme is not offering a comprehensive health package because several services are excluded. In theory, the scheme covers almost all health conditions but in practice, essential services are left out. Health services for people with chronic diseases and eye care and many more are being paid for out-of-pocket. These are services one should have access to because for example, as one grows older, the possibility to see an optometrist may arise but since such services is excluded from the package paying out-of-pocket may be overwhelming" **(IDI, male enrolee, 30 years Old, 16 June 2015).**

On the other hand, those with contrasting views explained that:

> "I do not think the scheme has adequate resources to offer a comprehensive health care package. A comprehensive health service is capital intensive and I do not think the scheme can afford such. In fact, a comprehensive service comprises of many services that may not be a priority to the population. For example, luxurious services such as cosmetic surgery is not a priority for

everyone. Those interested in such services should pay directly. However, services including family planning, treatment for people with chronic disease, eye care etc., should be included" **(IDI, male enrolee, 48years Old, 16 June 2015).**

"I think the issue is not the comprehensive package but rather priority and relevant services that are needed by the people is the most important thing. Presently, the schemes offers a wide range of health services that are relevant to the population. However, there is need to expand the services gradually to include other essential services including pharmaceutical because when the doctor prescribes drugs for you that are not available in the hospital. You pay extra money to buy these drugs in private pharmacies" **(IDI, male enrolee, 51 years Old, 16 June 2015).**

The above findings indicate that participants differ on their views regarding what makes a comprehensive health care package but they advocated for a comprehensive package that includes priority and relevant needs of the population without paying out-of-pocket for most of the services. Furthermore, it was noted in the interview that the services offer by the scheme affect perceptions and attitudes of people to enrolee in the scheme and remain after enrolment. Barnighausen and Sauerborn (2002) has argued that countries with established SHI and modelled Bismarckian incremental approach should aim for priority package and then gradually extend the benefits package to comprehensiveness though with the exclusion of luxurious services. Further analysis shows a chi-square test between occupation of respondents and the rating of health care package in order to get a clearer picture of how respondents differ based on their occupation and rating of health care package as indicated in table 6.3 and figure 6.3

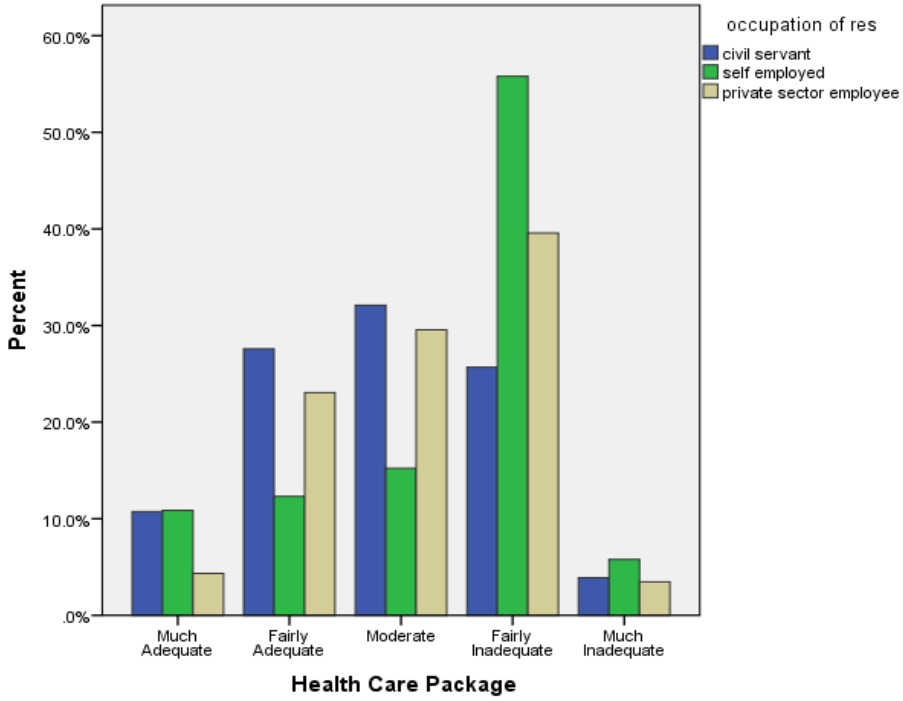
Table 6.3 Chi square test of association between health services and occupation of respondents

Rating of NHIS Health Care Package	**Occupation of Respondents**			Total
	Civil Servant	Self-employed	Private Sector Employee	
Much Adequate	102 (10.7%)	15 (10.9%)	10 (4.3 %)	127 (9.6%)
Fairly Adequate	262 (27.6%)	17 (12.3%)	53 (23.0%)	332 (25.2%)
Moderate	305 (32.1%)	21 (15.2%)	68 (29.6%)	394 (29.9%)
Fairly Inadequate	244 (25.7%)	77 (55.8%)	91 (39.6%)	412 (31.3%)
Much Inadequate	37 (3.9%)	8 (5.8%)	8 (3.5%)	53 (4.0%)
Total	590 (100%)	138 (100%)	230 (100%)	1318 (100%)
Calculated chi square: 73.634; df: 8; Probability value: 0.000				

Source: Fieldwork, 2015

Table 6.3 above indicates an association between the rating of NHIS health care services and occupation of respondents. Occupation and health care services are mutually dependent, that is, the rating of health care services is dependent on the occupation of the enrolees. The relationship was significant at χ^2 (8, N=1318) = 73.6, P<0.05). Further analysis is depicted in Figure 6.3 below. Highest percentage 32.1% of the civil servant rated the health package to be moderate. For the self-employed, the highest percentage 55.8% rated it to be inadequate while highest percentage of the private sector employees 39.6% rated it to be inadequate. Reasons for variation in the rating were noted in the interview. These include poor referral system, limited pharmaceuticals, and out-of-pocket payments for most of the services. An interviewee explained that: "when I went to the hospital for treatment because I was down with malaria, I was only given generic paracetamol and malaria drugs; these are drugs that do not have branded names. They were put in the plastic sachets for me instead of giving me branded drugs. In addition, many times proper investigation are not done before treatment such as taking blood sample for analysis before treatment. The doctor just asked, "What is wrong with you" and after my explanations, he prescribed drugs for me immediately without medical tests. The disheartening part of the issue is that most of these drugs are not available at the hospital pharmacy. One need to get it elsewhere at your own cost" **(IDI, male enrolee, 35 years Old, 16 June 2015).**

Figure 6.3 Percentage Distributions of Respondents Rating of Health Package by Occupation.



Source: Fieldwork 2015

The findings show that respondents differ in their rating of NHIS health package based on their occupations. Those with formal employment, higher social economic status tend to have a benefit package with more services than those with informal employment and lower social economic status. Literature has also shown an association between health care package, occupation and social economic status of the beneficiaries. Liu et al. (2002) assessing equity in the urban health insurance reform in China, observe that after the reform there was horizontal equity in accessing basic care among different income groups. The low-income earners had significant increase in outpatient care. However, vertical equity existed in accessing health care among the people; low-income earners did not have access to advanced diagnostic technology. In the same way, Polonsky et al (2008) observe an equitable distribution of health benefits among community health insurance scheme in Armenia. However, participation was low because of inability to pay contributions and lack of a comprehensive health package that includes coverage for chronic diseases like hypertension, diabetes and AIDS etc. Thus, financial contribution of a health insurance scheme determines the benefit package available to the scheme. Carrin and James (2004: 25) note, “Better

performance of insurance schemes is associated with evidence that the benefit package is comprehensive and in accordance with society's preferences so that resources are best utilised".

6.5 Conclusion

This chapter explored socio-demographic characteristics of the respondents. It also examined financial contribution and health care benefits among enrolees. The findings indicates that federal civil servants are yet to commence monthly contribution to the scheme through pay-roll deduction but pay 10% co-payments per visit to health facilities while other groups including self-employed and employees of private organisations pay monthly contributions to the scheme. All the respondents were enrolled in the same benefit package comprises of primary health care, the 'gateway' to secondary and tertiary health care through accredited HMOs contracted either by their employers in the case of formal sector programme or by interested individual for the voluntary contributors programme. Primary health care service is the entry point to the scheme, secondary and tertiary health services are based on referral from the primary care with approval by the HMOs. The contracted HMOs ensured that the enrolees have access to health care services within the network of providers. The respondents rated NHIS health care services to be adequate. However, conflicting views existed in the interview in reference to the composition of health package. Some noted that the benefit package excluded most essential and priority services needed mostly by the people; others advocated for a comprehensive package that includes priority and relevant needs of the population without paying out-of-pocket for most of the services.

Furthermore, the study reveals a significant relationship between health care package and occupation of respondents, that is, health care package is mutually dependent on the occupation of the respondents. Occupation and socio-economic status tend to determine the benefits package available to the enrolees. This is observed in the chi-square analysis and rating of the benefits package by occupation of respondents.

CHAPTER SEVEN

QUALITY OF SERVICES OF HEALTH MAINTENANCE ORGANISATIONS AND HEALTH CARE PROVIDERS

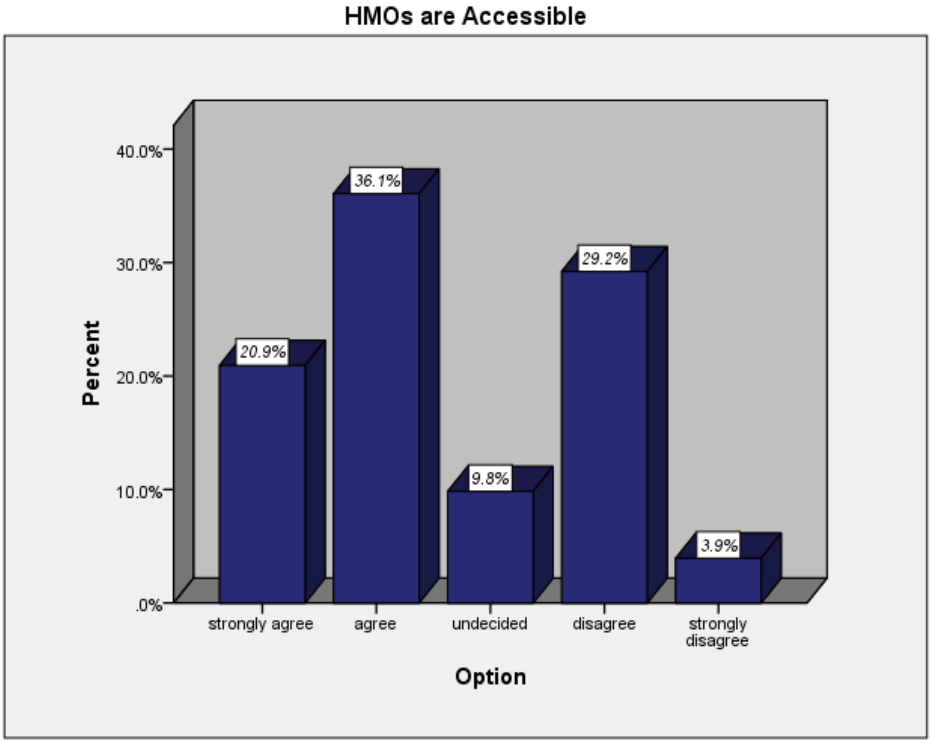
7.1 Introduction

Chapter 7 examines the quality of services of HMOs and HCPs in the study area. Exploring the services of the two actors is important because it gives a better understanding of their roles and contributions to the implementation of NHIS. HMOs and HCPs are central to the implementation of NHIS in Nigeria in that the assessment of the two actors would help to improve their services and scale up NHIS coverage. The chapter covers discussions on the quality of services of HMOs and HCPs but analyses and discusses data for the HMOs first then HCPs.

7.2. Health Maintenance Organisations

As mentioned earlier, HMOs occupy an important position in the implementation of NHIS in Nigeria. They are private or public organisations registered with the NHIS whose responsibility includes among others enrolment of prospective enrolees, collection of contributions from enrolees, contracting with providers to render a set of health services to the enrolees under the HMO and ensure payment of providers. The NHIS operational guidelines specifies the functions, obligations, etc., of the HMOs. HMOs play a significant role in the management and operation of the NHIS. Nevertheless, there is a concern about the quality of services expected by the HMOs. For that reason, a composite of questions on availability and accessibility were posed to the respondents. On whether HMOs are accessible to the enrolees, figure 7.1 shows that281 (20.9%) strongly agreed, 484 (36.1%) agreed, 392 (29.2%) disagreed, 53 (3.3%) strongly disagreed while 132 (9.8%) undecided. On the aggregate, majority 764 (57%) agreed that HMOs services were accessible while 445 (33.1%) disagreed. 132 (9.8%) did not give any response.

Figure 7.1 Percentage Distributions of Respondents Rating of Access to Health Maintenance Organisations



Source: Fieldwork, 2015

Furthermore, the qualitative data substantiated this finding. Most of the participants (20 out of 30 participants) in the interview noted that HMOs are easily accessible especially where their clients are located. A participant in the interview explained that: "to locate a HMO for registration is not a problem. They are easily located especially across the cities where they have offices. For example, I registered with Ronsberger Nigeria Limited here in University of Ibadan because there is one of their offices here" **(IDI, male enrolee, 35 years Old, 23 June 2015).**Thus, participants noted that HMOs are quite easy to locate for registration and other related matters.

Table 7.1 Chi square test of association between accessibility to HMOs and occupation of respondents

Accessibility to HMOs	**Occupation of Respondents**			Total
	Civil Servant	Self-employed	Private Sector Employee	
Strongly agree	210 (21.8%)	25 (18.0%)	46 (19.1 %)	281 (20.9%)
Agree	367 (38.1%)	20 (14.4%)	97 (40.2%)	484 (36.1%)
Undecided	119 (12.4%)	13 (9.4%)	0(0.0%)	132(9.8%)
Disagree	231 (24.0%)	72 (51.8%)	89 (36.9%)	392 (29.2%)
Strongly disagree	35 (3.6%)	9 (6.5%)	9 (3.7%)	53 (3.9%)
Total	962 (100%)	139 (100%)	241 (100%)	1342 (100%)
Calculated chi square: 92.397; df: 8; Probability value: 0.000				

Source: Fieldwork, 2015

The above table indicates an association between the rating of accessibility to HMOs and occupation of respondents. The table shows that access to HMOs and occupation of respondents are mutually dependent, that is, the occupation of respondents tend to influence their perceptions about accessibility to HMOs. There is relationship between the two variables and the relationship was significant at χ^2 (8, N=1342) = 92.397, P<0.05).

Table 7.2 Chi square test of association between accessibility to HMOs and gender of respondents

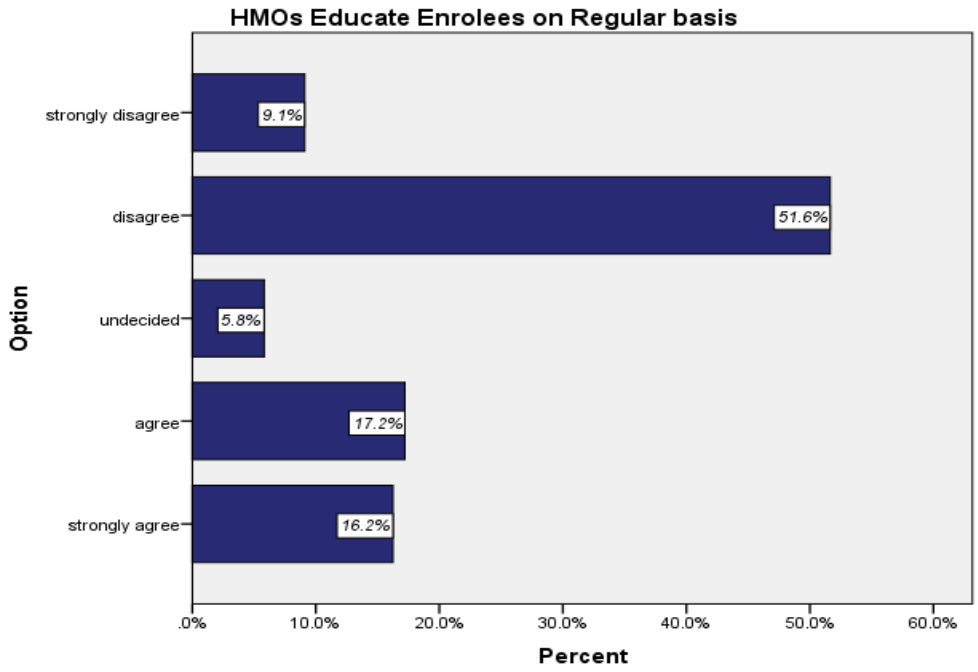
Accessibility to HMOs	**Gender of Respondents**		**Total**
	Male	**Female**	
Strongly agree	123 (17.1%)	158 (25.4%)	281 (20.9%)
Agree	293 (40.8%)	191 (30.7%)	484 (36.1%)
Undecided	87 (12.1%)	45 (7.2%)	132(9.8%)
Disagree	182 (25.3%)	210 (33.7%)	392 (29.2%)
Strongly disagree	34 (4.7%)	19 (3.0%)	53 (3.9%)

Total	962 (100%)	139 (100%)	1342 (100%)
Calculated chi square: 38.795; df: 4; Probability value: 0.000			

Source: Fieldwork, 2015

The above Table 7.2 indicates an association between accessibility to HMOs and gender of respondents. The table shows that access to HMOs and gender of respondents are mutually dependent, that is, the gender of respondents tend to influence their perceptions about access to HMOs. The relationship was significant at χ^2 (4, N=1342) = 38.795, P<0.05).

Figure 7.2 Percentage Distributions of Respondents Rating of Health Maintenance Organisations Enlightenment Programmes.



Source: Fieldwork, 2015

Figure 7.2 above indicates 122 (9.1%) of the respondents strongly disagreed on regular enlightenment programme from the HMOs, 693 (51.6%) disagreed, 218 (16.2%) strongly agreed, 231 (17.2%) agreed while 78 (5.8%) undecided. On the aggregate, majority of the respondents 815 (60.7%) disagreed that they received regular enlightenment programmes from the HMOs, while

449 (33.4%) agreed. The finding clearly shows that 78 (5.8%) did not decide make any decision. The findings clearly shows that enrolees are not receiving regular educational or enlightenment programmes from the HMOs about the NHIS. The qualitative data corroborate the above findings. Out of the 30 participants in the interview, 28 noted that they were not adequately enlightened about the operation and the activities of the NHIS. A participant explained in the interview that:

> "I got the information about the NHIS including how to enrol for the scheme from colleagues. The HMOs are not doing enough in educating people about the programme and I think that is a problem because many people do not really understand how the scheme operates. As I said earlier, a friend gave me the information and linked me up with a HMO for the registration. However, it is the responsibility of the HMOs to educate people on regular basis about the programme as well as their right as enrolees. Because having better knowledge about the scheme would help us to know what we are entitled to as enrolees" **(IDI, male enrolee, 46 years Old, 22 June 2015).**

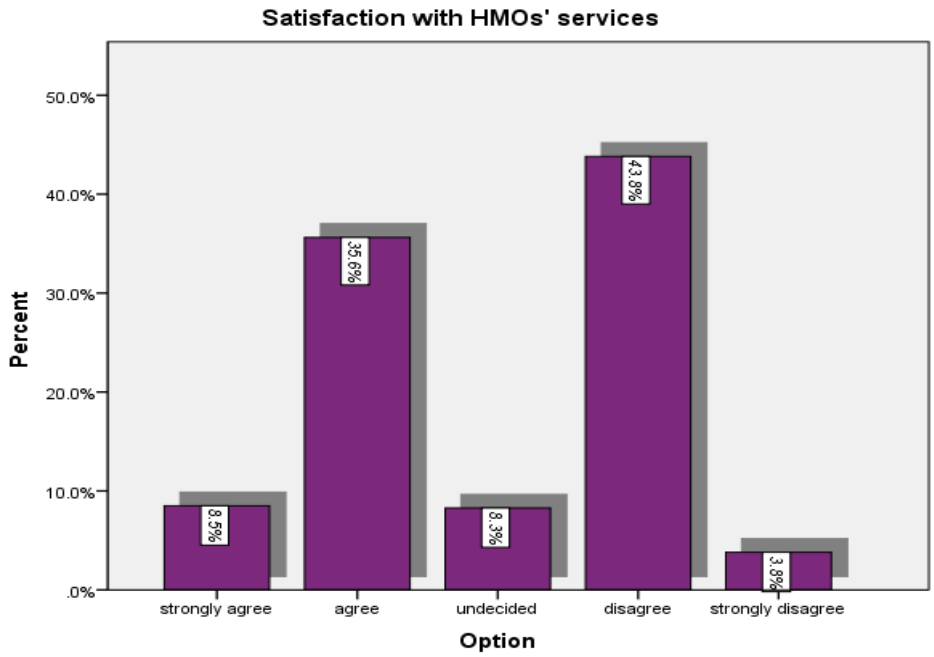
Another respondent substantiated the above view:

> "I have never heard that any HMO has organised an educational programme to educate and enlighten people about the NHIS especially for the non-enrolees. I think it is part of their responsibility to get people informed about the scheme including the registration process, privileges and benefits of the scheme" **(IDI, female enrolee, 50 years Old, 23 June 2015).**

The above statements indicate that HMOs are lacking in the area of educational and enlightenment programmes not only for the enrolees but also for the non-enrolees. The interviewees reiterated that HMOs are one of the major players in the implementation and achievement of NHIS objectives because they are involved in the day-to-day activities of the scheme. These include enrolment of interested individuals, collection of contributions on regular basis from the enrolees where applicable, ensure enrolees receive proper treatment in the case of illness and pay providers for their services. In addition, because of their significant functions in the implementation of the

scheme, they are located across the major cities in order to ensure interested individuals, employers and employees are enrolled. However, they are not doing enough to educate the public about the scheme as well as their functions since it is their responsibility to sensitize the public. Figure 7.3 shows respondents rating of satisfaction with the services of HMOs.

Figure 7.3 Percentage Distributions of Respondents Rating of Satisfaction with HMOs' Services



Source: Fieldwork, 2015

Figure 7.3 above indicates 114 (8.5%) of the respondents strongly agreed that they were satisfied with HMOs services, 478 (35.6%) agreed, 588 (43.8%) disagreed, 51 (3.8%) strongly disagreed while 111 (8.3%) undecided. The findings shows that highest proportion of the respondents 639 (47.6) were not satisfied with HMOs' services while 592 (44.1%) were satisfied, 111 (8.3%) did not make any decision. The qualitative data substantiate these findings. Out of the 30 participants in the interview, 19 noted that they were not satisfied with the HMOs' services while 11 were satisfied. Conflicting views exist among the participants on the services of the HMOs. Those who were satisfied gave reasons for their satisfaction; these include accessibility, attitude of the employees, prompt response to clients' queries etc. Some of the participants explained that:

> "HMOs are accessible. They are very easy to locate because they have contacts with their enrolees on regular basis. In fact, I have my HMO' phone number. I contact them on regular basis on issues relating to enrolment and benefit package. For example, sometime ago I wanted to register my son, I called my HMO and their response was fantastic. They make sure their enrolees are well treated, even in the case of health care" **(IDI, female enrolee, 43 years Old, 23 June 2015).**

Another participant explained that:

> "I think the HMOs are trying to give the best to their client, that is, the enrolees. Whenever I went to their office or called them, they respond quickly to my query. There was a time I was in Lagos and I needed to know the health care providers in their network because I wanted to do my regular check-ups. I called them and they told me the nearest health care facilities to my location. They also check their enrolees on regular basis in the hospital in the case of hospitalisation" **(IDI, female enrolee, 52 years Old, 24 June 2015).**

On the contrary, those who were not satisfied noted poor attitude of HMOs to enrolees most especially in the case of referral. Some of the respondents explained that:

> "Most of these HMOs do not know their responsibility. In fact, they are very slow in responding to cases especially when it comes to referral of patients. They always want patients to remain in a particular hospital even when doctors make referral. There was a time my friend was sick and he went to the hospital for treatment. The doctor wanted to refer him to a specialist but he could not get approval from the HMOs on time. My friend had to wait for some days before the referral was approved. This is just one of the

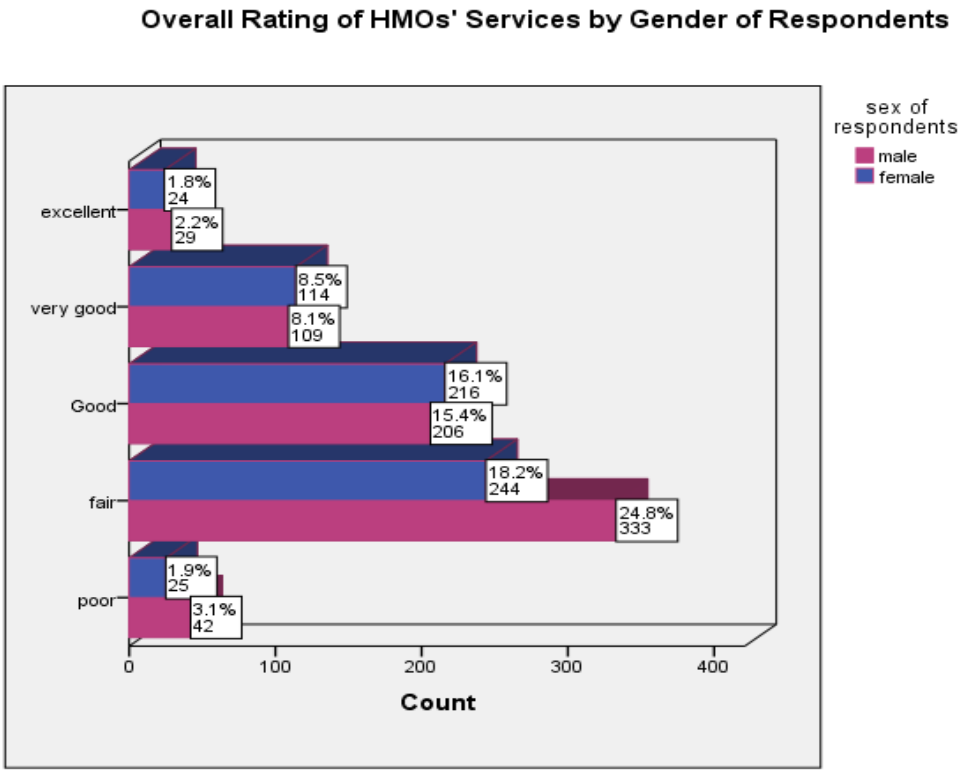
> instances where the HMOs were very reluctant to carry out their duty appropriately" **(IDI, male enrolee, 46 years Old, 23 June 2015).**

Another participant noted that:

> "I am not satisfied with their services for many reasons. I will give you two. One is the unnecessary waiting period the HMOs subject enrolees to go through. I waited for many months before my registration as an enrolee was finalised. I do not understand the unnecessary delay. Two, poor communication between the enrolees and the HMOs. For example, it is the role of the HMOs to give their clients proper and regular information about their rights but HMOs do not feel concern about this because of the fear that when the enrolees know their rights they may challenge them on irregular activities they perpetrate on regular basis **(IDI, female enrolee, 40 years Old, 23 June 2015).**

Although divergent opinions existed among the participants on the services of the HMOs, majority note that HMOs need to improve in their services to their clients especially in the area of referral. In addition, HMOs need to organise forums and educational and enlightenment programmes on regular basis so that enrolees can express their feelings and grievances and suggest ways to improve HMOs' services which in turn will increase population coverage in NHIS. Figure 6.4 below shows the overall rating of HMOs' services by gender of respondents. Most of the respondents male 333 (24.8%) and female 244 (18.2%) rated HMOs' services to be fair while male 206 (15.4%) and female 216 (16.1%) rated it to be good. The findings indicate that the HMOs need to intensify efforts to improve in their services. Since they occupy a significant position in the implementation process of the NHIS, as the intermediary between the health providers and enrolees, they need to improve in their services regular basis to their clients.

Figure 7.4 Overall rating of HMOs services by gender of respondents.

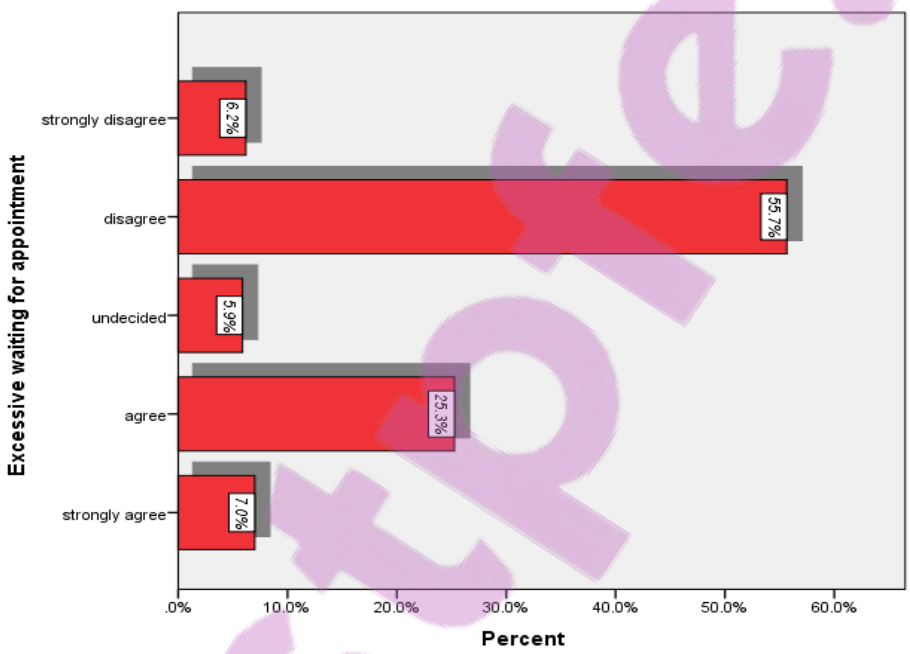


7.3 Health Care Providers

Health care providers or facilities is another important actor in the implementation of NHIS in Nigeria. Health care providers include Doctors, Nurses, Pharmacists, Laboratory Scientists, Physiotherapists, and Radiographers etc. The NHIS operational guidelines specifies the functions and obligations of the HCPs to include provision of primary health care, secondary and tertiary services to the enrolees within the range of specific health package for the target groups. HCPs sign contract with the HMOs in order to offer a set of health care services to enrolees under the HMO (see chapter 2). However, a considerable debate dwelled on the perceived quality of services provided by the HCPs to the enrolees. To assess services of the HCPs, a range of questions were posed to the respondents. Percentage distributions of respondents based on their responses to various questions were presented in different charts. On excessive waiting for appointment, figure

7.4 shows that 79 (7.0%) respondents strongly agreed, 339 (25.3%) agreed, 747 (55.7%) disagreed, 83 (6.2%) strongly disagreed while 79 (5.9%) undecided. On the total, majority of the respondents 830 (61.9%) disagreed on excessive waiting for appointment with HCPs while418 (32.2%) respondents agreed, 79 (7.0%) respondents were undecided. Most of the participants in the interview noted that the scheme has improved in the area of consultation in the hospital. "One don't need to queue up or sit down in the hospital unnecessarily because he/she wants to see a doctor for treatment or check-up. Doctors are very timely in attending to patients and I think this is an area in which the scheme is getting it right" **(IDI, female enrolee, 46 years Old, 23 June 2015).**The findings corroborates existing literature that NHIS has reduced excessive waiting time for medical consultations (Hurst, 2010; Mohammed et al. 2011; Owumi, 2013).

Figure 7.5 Percentage Distributions of Respondents Rating of Excessive Waiting for Appointment.

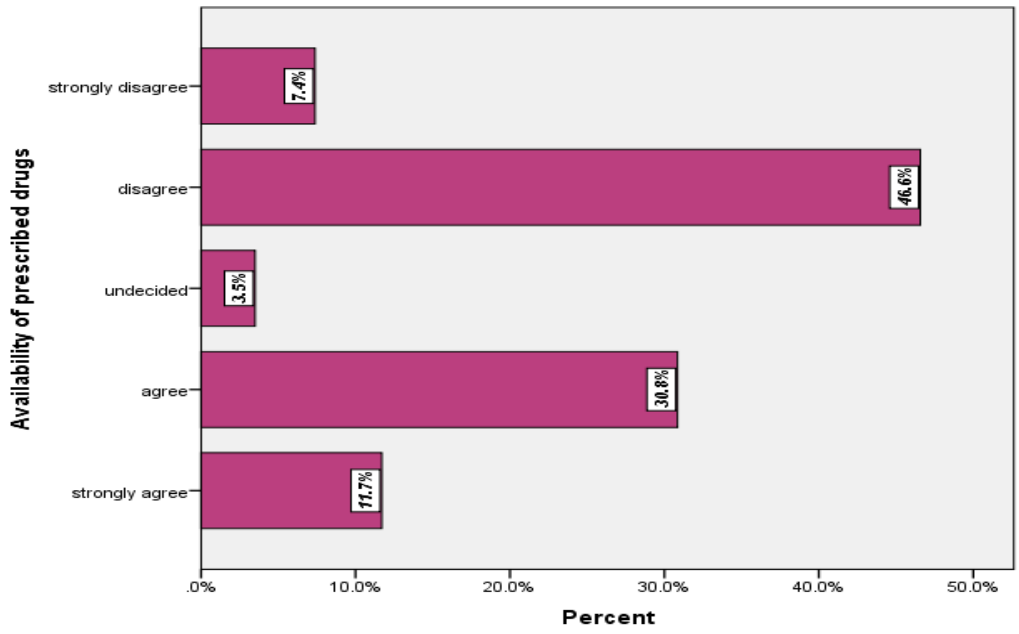


Source: Fieldwork, 2015

On availability of prescribed drugs, Figure 7.5 below indicates that 157 (11.7%) respondents strongly agreed, 414 (30.8%) agreed, 625 (46.6%) disagreed, 99 (7.4%) strongly disagreed, 47 (3.5%) undecided. In total, majority 724 (54%) disagreed on the availability of prescribed drugs

in health care facilities, on the other hand, 571 (42.5%) agreed and 47 (3.5%) did not make any decision.

Figure 7.6 Percentage Distributions of Respondents Rating of Availability of Prescribed Drugs



Source: Fieldwork, 2015

Corroborating the above findings are results of the various in-depth interview sessions, though conflicting ideas were presented in the interview, majority of the participants (25) severely complained that most of the prescribed drugs are usually not available in the health facilities. Some of the participants responded as thus:

> "I think availability of prescribed drugs in the NHIS health facilities is a serious problem facing the programme. Though I have witnesses on this issue, I have also witnessed this problem of non-availability of drugs at the hospitals. There was a time I went to the hospital went I had malaria. After the examination, the doctor prescribed drugs for me to buy in the pharmacy

instead of collecting the drugs at the pharmacy since my insurance covers it" **(IDI, female enrolee, 46 years Old, 23 June 2015).**

"Most of the prescribed drugs are not available at the health facilities. The available ones are just the common drugs like paracetamols, vitamins etc. I can tell you that about 80% or more of the prescribed drugs are not available at the health services for the enrolees. Most enrolees are given prescription to buy at the pharmacy" **(IDI, male enrolee, 56 years Old, 23 June 2015).**

On the other hand, those with contrary views noted that though not all prescriptions are available at the health facilities for the enrolees, some of the prescribed drugs are usually available and dispense to the patients whether you are NHIS enrolees or not. A participant explained that:

"There are drugs at the health facilities for the enrolees but at times when the prescribed drugs are out of stock, one may be asked to buy at the nearest or available pharmacy. Though most of the prescribed drugs are generic, I think it is just a way to reduce costs of health expenditures for the enrolees" **(IDI, female enrolee, 52 years Old, 24 June 2015).**

Another participant explained that:

"I will not say there are no drugs at the health facilities. The problem is not that there are no drugs but generic drugs is what people are worried about. People do not believe in the efficacy of generic drugs, they often considered generic drugs as substandard to branded drugs. I have seen my colleagues complained of the generic types of drugs usually dispensed at the health facilities for the enrolees. Because they are cheaper and affordable, patients usually complain of its efficacy. I think there is different between availability of drugs and prescription of generic drugs. Generic drugs is the

main issue that affects people' satisfaction with NHIS services" **(IDI, male enrolee, 56 years Old, 24 June 2015).**

Based on the above findings, although conflicting ideas existed in the interview, majority 25 out of 30 participants were of the view that non-availability of prescribed drugs at the health facilities for the enrolees is a usual occurrence while others disagreed. This finding however contradicts Osungbade, et al., (2014) who observed high satisfaction in drug prescription among respondents in Ibadan.

A cross tabulation and χ^2analysis was carried out to investigate the relationship between occupation of respondents and their perceptions about availability of prescribed drugs (Table 7.3)

Table 7.3 Chi square test of association between occupation and availability of prescribed drugs.

Availability of Prescribed drugs	**Occupation of Respondents**			Total
	Civil Servant	Self-employed	Private Sector Employee	
Strongly agree	123 (12.8%)	0 (0.0%)	34 (14.1 %)	157 (11.7%)
Agree	273 (28.4%)	42 (30.2%)	99 (41.1%)	414 (30.8%)
Undecided	47 (4.9%)	0 (0.0%)	0(0.0%)	0(0.0%)
Disagree	450 (46.8%)	89 (64.0%)	86 (35.7%)	625 (46.6%)
Strongly disagree	69 (7.2%)	8 (5.8%)	22 (9.1%)	99 (7.4%)
Total	962 (100%)	139 (100%)	241 (100%)	1342 (100%)
Calculated chi square: 63.881; df: 8; Probability value: 0.000				

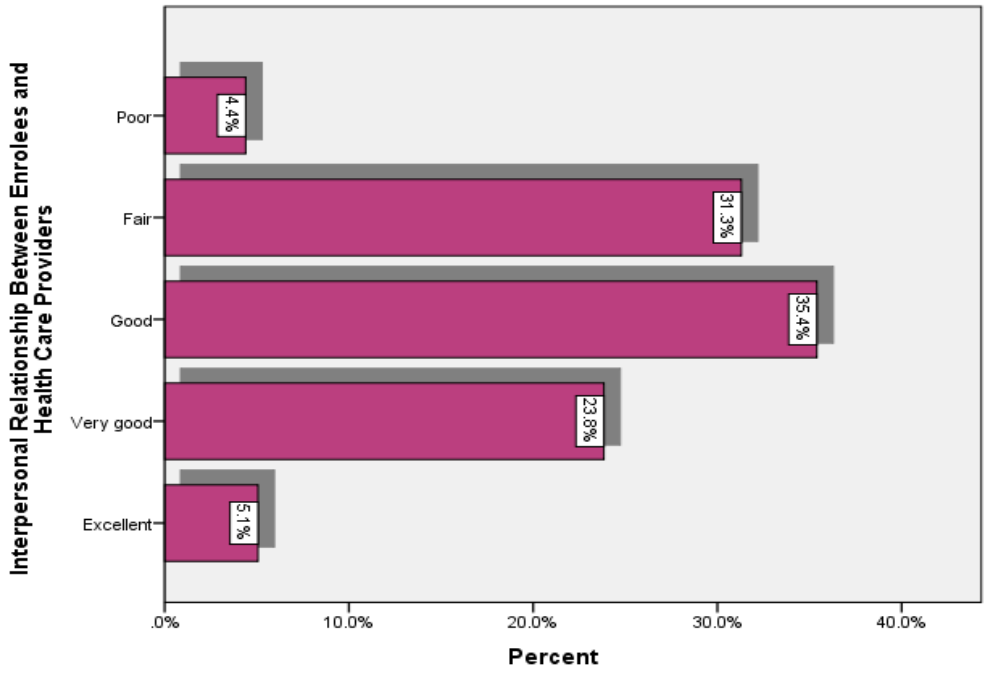
Source: Fieldwork, 2015

The above findings show that the respondents differ in their perceptions about availability of prescribed drugs. The highest percentage by occupations indicates that 89 (64.0%) of the self-employed disagreed with the availability of prescribed drugs, 450 (46.8%) of the civil servant disagreed while 99 (41.1%) of the private sector employee agreed. However, the χ^2analysis shows that occupation of respondents tends to influence their views about the availability of drugs

(occupation and availability of drugs are dependent). The relationship between two variables was significant at χ^2 (8, N=1342) = 63.881, P<0.05).

On interpersonal relationship between enrolees and HCPs, Figure 7.7 below shows that 59 (7.4%) respondents rated it to be poor; 420 (31.3%) rated it to fair, 475 (35.4%) rated it to be good, 320 (23.8%) rated it to be very good and 68 (5.1%) rated it to be excellent. On the aggregate, greater number of the respondents 863 (64.3%) rated their interpersonal relationship with health care providers to be good, 420 (31.3%) rated it to be moderate while 59 (7.4%) rated it to be poor. This indicates that majority of the enrolees have good interactions with the providers whenever they visit providers for health care services. This finding confirms Mohammed, et al., (2011) who posit that client's satisfaction with health facilities is a composite of many factors including receipt of courteous attention at the hospital. In addition, Bodenheimer and Grumbach, (2005) note that some patient interactions with health providers influence their decisions to use health care services.

Figure 7.7 Percentage Distributions of Respondents Rating of Interpersonal Relationship with Health Care Providers.

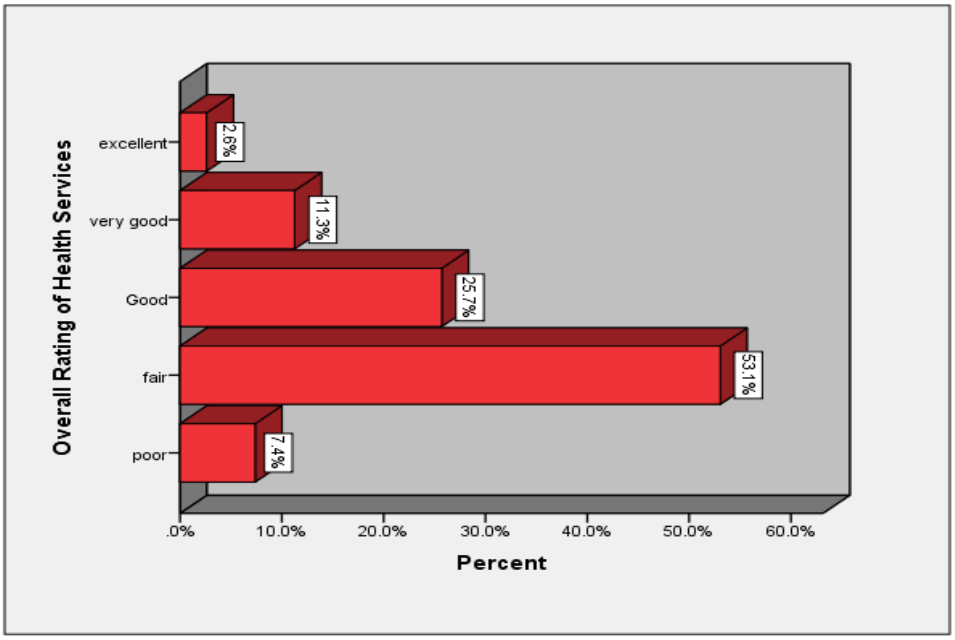


Source: Fieldwork, 2015

On the overall rating of health services as indicated in the Figure 7.8 below, the highest number of the respondents 712 (53.1%) rated it to be fair, 345 (25.7%) rated it to be good, 151 (11.3%) rated it to be very good, 99 (7.4%) rated it to be poor and 35 (2.6%) rated it to be excellent. The qualitative data substantiate these findings. Out of the 30 participants in the interview, 19 noted that the health services is moderate reason being that NHIS enrolees tend to receive less services compared to those who pay out of pocket. A participant noted, "health care providers including doctors and nurses treat patients who pay out-of-pocket better than NHIS enrolees. This action is notable in many areas including drugs prescription, and diagnostic test" **(IDI, male enrolee, 59 years Old, 24 June 2015).**Another participant substantiate this view as thus:

> "I think the health care services received by the enrolees is unsatisfactory because we are not only restricted to services, we are also not treated equally with those who pay directly for their services. In my own view, I think they are treated better than we are and this undermines peoples' interest in the scheme" **(IDI, female enrolee, 42 years Old, 24 June 2015).**

Figure 7.8 Percentage Distributions of Respondents Rating of Health Services.



Source: Fieldwork, 2015

Table 7.4 Cross tabulation of Respondents Occupation by Health Care Services

HEALTH CARE SERVICES	OCCUPATION			TOTAL
	Civil Servant	Self employed	Private Sector Employee	
Poor	85 (8.8%)	5 (3.6%)	9 (3.7%)	99 (7.4%)
Fair	519 (54.0%)	68 (48.9%)	125 (51.9%)	712 (53.1%)
Good	217 (22.6%)	35 (25.2%)	93 (38.6%)	345 (25.7%)
Very good	109 (11.3%)	29 (20.9%)	13 (5.4%)	151 (11.3%)
Excellent	32 (3.3%)	2 (1.4%)	1 (0.4%)	35 (2.6%)
Total	962 (100%)	139 (100%)	241 (100%)	1342 (100%)

Source: Fieldwork, 2015

The above table shows more than half 519 (54.0%) of civil servant, 68 (48.9%) of self-employed and more than half 125 (51.9%) of private sector employee rated the NHIS health care services to be fair. The implication of this is that NHIS needs to improve its health care services to the enrolees. When people have confidence on health care services, it increases their interest and enrolment rate (Mohammed, et al., 2011).

7.4 Conclusion

This chapter explored the quality of services of HMOs and HCPs. The findings indicates that HMOs are quite accessible for registration of potential enrolees and other related matters especially in the urban areas because they have offices across the main cities. However, the findings reveals that HMOs are lacking in the area of educational and enlightenment programmes not only for the enrolees but also for the non-enrolees. Because the HMOs occupy a very important position in the implementation of NHIS, for example, enrolment of prospective enrolees, collection of contributions from insured members, signing contract with providers to provide a set of services to the specified enrolees and payment of providers, they need to organise on regular basis informative, educative and sensitization programmes. It was revealed in the study that the HMOs are not doing enough in this respect and thus, undermines peoples' knowledge and interest in the

scheme. The findings shows that majority of the respondents were not satisfied with the services of the HMOs. Areas in which they expressed dissatisfaction include (1) lack of prompt responses to referral because providers need to take approval from the HMOs before a referral can be made and (2) inadequate informative programmes about the scheme to the public. People are not well informed about the scheme though it is part of the responsibilities of the HMOs.

For the HCPs, the findings reveals that HCPs have improved in the area of excessive waiting for consultation in the hospital, as timely intervention by providers was revealed in the study. However, the findings reveals that most of the respondents were disagreed with the availability of prescribed drugs though there were conflicting views on this subject. Some noted that there is usual occurrence of unavailability of prescribed drugs; others expressed prescription of generic drugs as the main challenge. Furthermore, majority of the respondents rated their interpersonal relationship with the enrolees to be good. On the overall rating of the health services, the findings indicates that majority of the respondents rated the services to be fair and needs improvement.

CHAPTER EIGHT

KNOWLEDGE, ATTITUDES AND PERCEPTIONS OF NON-ENROLEES ABOUT NATIONAL HEALTH INSURANCE SCHEME

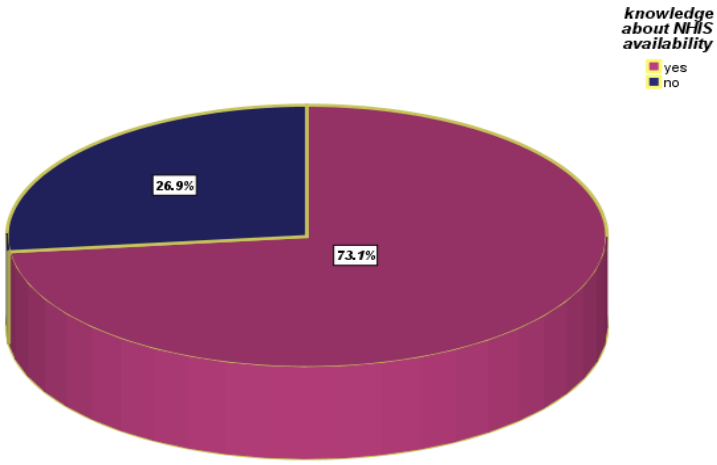
8.1 Introduction

Chapter 8 examines knowledge, attitudes and perceptions of non-enrolees. Research on non-enrolees is imperative because it provides better understanding of their knowledge, attitudes and perceptions about the NHIS, which in turn will enhance their confidence and interest on the scheme. It will also help the scheme to strategize in reaching out to the public. A range of questions regarding knowledge, attitudes and perceptions of non-enrolees were examined in this chapter.

8.2 Knowledge about National Health Insurance Scheme

Knowledge is an important factor in the decision to enrol in NHIS. It is when people are knowledgeable about the scheme that their interest will be inspired. In other word, knowledge is a condition in which public interest in the scheme is based. Therefore, a well-informed people tends to make informed decision. The respondents in the study were asked a number of questions regarding their knowledge. On whether the respondents have knowledge about the availability of NHIS as indicated in the Figure 8.1 below, 275 (73.1%) stated 'yes' they have knowledge about its availability while 101 (26.1%) stated 'no' they have no knowledge about the scheme. This find shows that majority of the respondents have knowledge about the availability of the scheme. The qualitative data confirmed this finding as majority (13) out of (15) participants noted that they have heard about the scheme. A participant explained, "I have heard about the NHIS about four years ago" (**IDI, Female, non-enrolee, 29 June 2015).** In the same manner, most of the participants expressed their views regarding their knowledge of the scheme. Only few did not have knowledge of the scheme' existence. Adequate awareness of NHIS has also been reported in the literature (Ogben, 2014; and Jehu-Appiah et al., 2011). Both studies conclude that adequate awareness of NHIS tends to influence people's decision to enrol.

Figure 8.1 Respondents' Percentage Distributions of Knowledge about NHIS



Source: Fieldwork, 2015

Table 8.1 Chi square test of association between occupation and knowledge of NHIS.

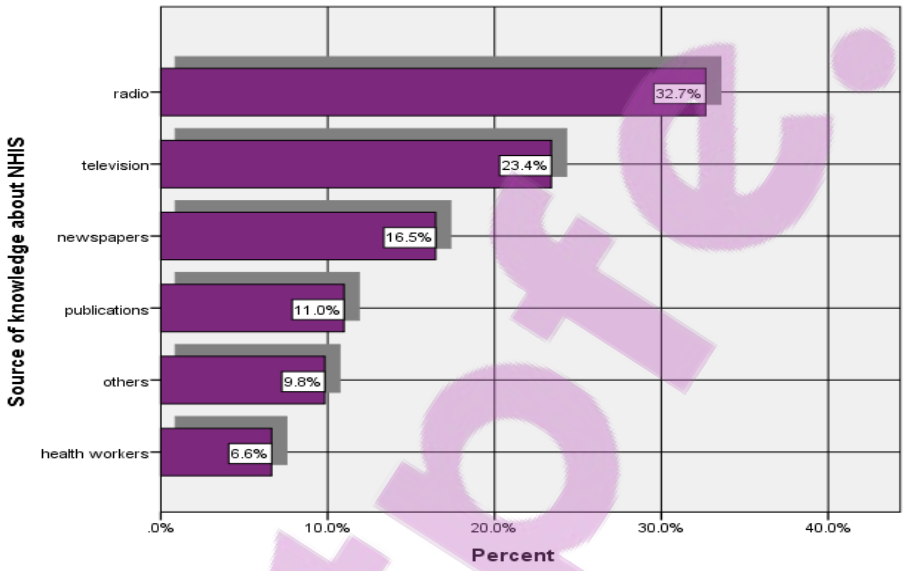
Occupation	Knowledge		Total
	Yes	No	
Civil servant	63 (22.9%)	5 (5.0%)	68 (18.1%)
Self employed	192 (69.8%)	91 (90.1%)	283 (75.3%)
Private sector employee	20 (7.3%)	5 (5.0%)	25 (6.6%)
Total	275 (100.0%)	101 (100.0%)	376 (100.0%)
Calculated chi square: 17.809; df: 2; Probability value: 0.000			

Source: Fieldwork, 2015

The above χ^2analysis indicates that occupation and knowledge of respondents are dependent. The occupation of respondents tends to influence their knowledge of the scheme. The relationship was significant at χ^2 (2, N=376) = 17,809, P<0.05).

On the sources of knowledge about NHIS, Figure 8.2 below indicates that 113 (30.1%) respondents indicated radio as their source of knowledge of the NHIS. Eighty-one (21.5%) indicated television, 57 (15.2%) indicate newspapers. Thirty-eight (10.1%) indicated publications such as magazines and flyers of the scheme, 34 (9.0%) indicated others such as family members, colleagues and friends as their source of knowledge while 23 (6.1%) indicated health workers such as nurses etc., as source of their knowledge. Thus, different sources of information were available to the respondents though most of them got information about the scheme from the mass media such as radio, television and newspapers. Mass media occupies an important position in dissemination of information about NHIS to the public.

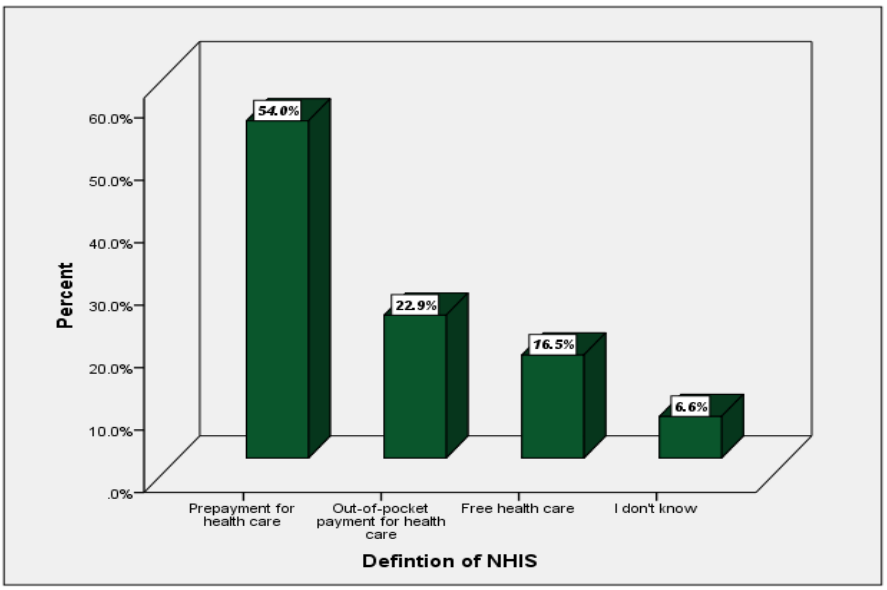
Figure 8.2 Sources of Knowledge about National Health Insurance Scheme



Source: Fieldwork 2015

On the description of the NHIS, Figure 8.3 shows that 203 (54.0%) respondents described NHIS as a prepayment scheme for health care, 86 (22.9%) described it as out-of-pocket payment, 62 (16.5%) described it as free health care while 25 (6.6%) could not give any description of the NHIS. Thus, this indicates that majority 203 (54.0%) of the respondents had knowledge about the basic assumption of NHIS as a prepayment mechanism for health care.

Figure 8.3 Percentage Distributions of Respondents on the Description of NHIS



Source: Fieldwork, 2015

Table 8.2 Cross tabulation of Education and the Definition of NHIS

Education	**Definition of NHIS**				**TOTAL**
	Prepayment	OOP Payment	Free health care	I don't know	
No edu.	4 (2.0%)	2 (2.3%)	1 (1.6%)	3 (12.0%)	10 (2.7%)
Primary sch	9 (4.4%)	5 (5.8%)	2 (3.2%)	3 (12.0%)	19 (5.1%)
Sec. school	50 (24.6%)	27 (31.4%)	19 (30.6%)	4 (16.0%)	100 (26.6%)
NCE/HND	64 (31.5%)	28 (32.6%)	23 (37.1%)	10 (40.0%)	125 (33.2%)
HND/B.Sc	50 (24.6%)	15 (17.4%)	6 (9.7%)	4 (16.0%)	75 (19.9%)
P/graduate	26 (12.8%)	9 (10.5%)	17 (17.7%)	1 (4.0%)	47 (12.5%)
Total	203(100.0%)	86 (100.0%)	62 (100.0%)	25 (100.0%)	376(100.0%)

Source: Fieldwork, 2015

The Table 8.2 above indicates a relationship between education of respondents and definition of NHIS. More than half of the respondents 199 (52.9%) who had a form of education defined NHIS as a prepayment scheme. Qualitative data substantiate the above findings, though some of the participants in the interview have had about the scheme but they did not understand the basic assumption of the scheme. Out of 15 interviewees, 11 had understanding of the principle of NHIS. Below are extracts that clearly describe most definitions of the participants:

> "I think NHIS is about paying small amount on a regular basis for health care, in case one falls sick, he/she then will be able to use health care without having to pay directly at the hospital for medical costs" (**IDI, Female, non-enrolee, 42 years Old, 29 June 2015).**

Another participant explained that:

> "In my own understanding, NHIS is about planning ahead for uncertainty about one' health by paying small amount on monthly, quarterly or annually to an insurance company. The money will then be used to pay for health care should the person or family members fall sick. Anyone can be sick at any time and the money one has contributed will be used to pay for the person's medical bills" (**IDI, male, non-enrolee, 56 years Old, 29 June 2015).**

On the other hand, those with less knowledge of the NHIS explained the scheme in a different way. Below are extracts:

> "I think NHIS is a government programme to provide health care for people at no cost. It is about providing free health care for people and I think it is a good gesture if government can make it a reality because we all want free health care for our households"(**IDI, Female, non-enrolee, 61 years Old, 30 June 2015).**

Another participant depicted:

> "NHIS is paying for health care at the point of service. There is no free health care provision anywhere because one has to pay whenever he/she needs health care services" **(IDI, Female, non-enrolee, 59 years Old, 4 July 2015).**

Although there were some participants in the interview who were not adequately informed about the basic assumption of NHIS in reference to prepayment mechanism, most (11 out of 15) participants were better informed about NHIS as a prepayment model for health care provision whereby one pays small amount on a regular basis prior to falling ill. Knowledge of the scheme basic assumption constitutes an appropriate tool, relevant in the implementation the insurance programme (De Allegri, et al., 2006).

8.3 Attitudes and Perceptions about National Health Insurance Scheme

Attitude and perception are individual traits that influence people decision to enrol and remain in the NHIS. NHIS is a voluntary scheme and therefore people views, opinions and emotional responses are important factors that determine their willingness to enrol in the scheme. A number of questions on attitudes and perceptions were posed to the respondents. On whether respondents are willing to enrol for NHIS, Figure 8.4 below shows that 274 (72.9%) respondents indicated 'yes' while 74 (19.7%) indicated 'no'. Moreover, most (11) out of 15 participants in the interview indicated their willingness to enrol in the scheme if they have the opportunity such as financial capability. Below are extracts from the participants on their willingness to enrol in the NHIS.

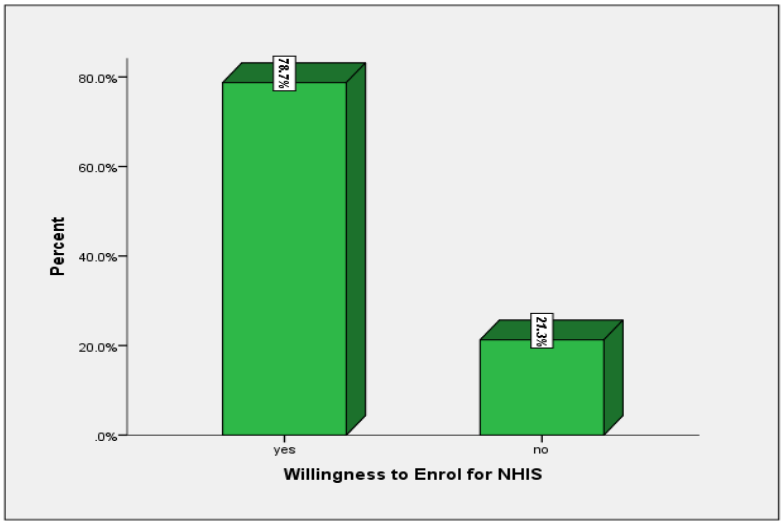
> "I am interested in the NHIS because it is a very good programme that helps to pay for health care. It saves people from huge financial costs of medical bills. Paying directly out-of-pocket for health care can be very overwhelming most especially when one does not have cash to pay. In fact, I have sold some of my property some time ago to pay for medical bills, so this programme will save one from taking different and perhaps

inconvenient steps such as the one I have mentioned earlier which could negatively affect the whole family" (**IDI, Female, non-enrolee, 58 years Old, 30 June 2015).**

Another participant noted:

"It is good to save money for health care and that is what exactly NHIS stands for because illness does not give notice. It can just happen at any time. Gone are those days when our elders used to say that it is not good to plan for something unpleasant such as illness. Therefore, to avoid such unpredictable health issues, it is better for a person to enrol in the NHIS. Once I am financially buoyant, I will enrol my wife, children and myself for the programme" **(IDI, male, non-enrolee, 64 years Old, 30 June 2015).**

Figure 8.4 Percentage Distributions of Respondents Willingness to Enrol for NHIS

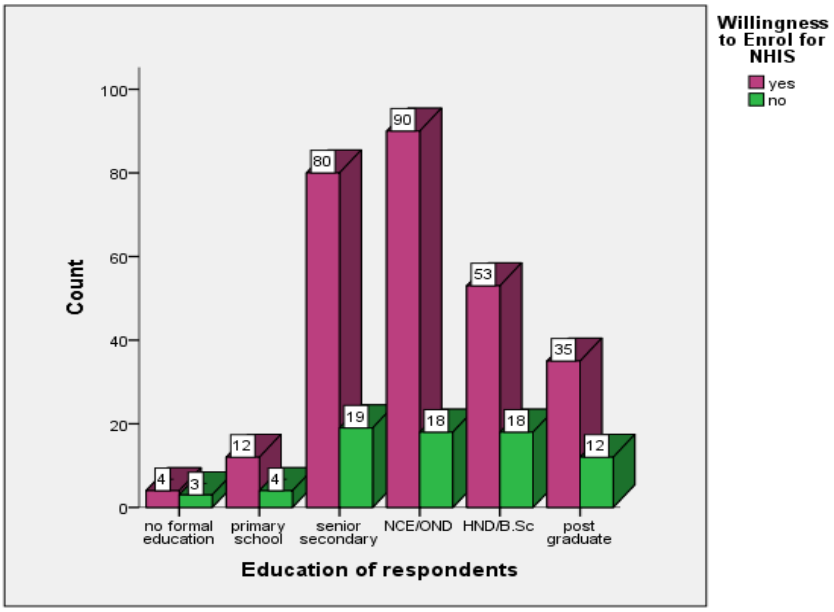


Source: Fieldwork, 2015

The above findings shows that most of the respondents are willing to enrol in the NHIS. This was evidenced as majority 274 (72.9%) indicated 'yes' and most of the participants in the interview indicated willingness to enrol. However, respondents differ in their socioeconomic characteristics

and willingness to enrol. Figure 8.5 shows that education of respondents tends to influence their willingness to enrol. Ninety (83.3%) of respondents with NCE/OND indicated 'yes' while 18 (16.7%) indicated 'no'. For respondents with secondary school education, 80 (80.8%) indicated 'yes' while 19 (19.2%) indicated 'no'. Fifty-three (74.6%) of those with HND/BSc indicated 'yes' while 18 (25.4%) indicated 'no'. For those with postgraduate education, 35 (74.5%) indicated 'yes' while 12 (25.5%) indicated 'no'. For respondents with primary education, 12 (75.0%) indicated 'yes' while four (25.0%) indicated 'no' On the other hand, those with no formal education varied slightly. Four (57.1%) indicated 'yes' while three (42.9%) indicated 'no'.

Figure 8.5 Percentage Distributions of Respondents Level of Education and Willingness to Enrol



Source: Fieldwork, 2015

Table 8.3 Chi square test of association between education and willingness to enrol

Education	Willingness		Total
	Yes	No	
No formal education	4 (1.5%)	3 (1.4%)	7 (2.0%)
Primary school	12 (4.4%)	4 (5.4%)	16 (4.6%)

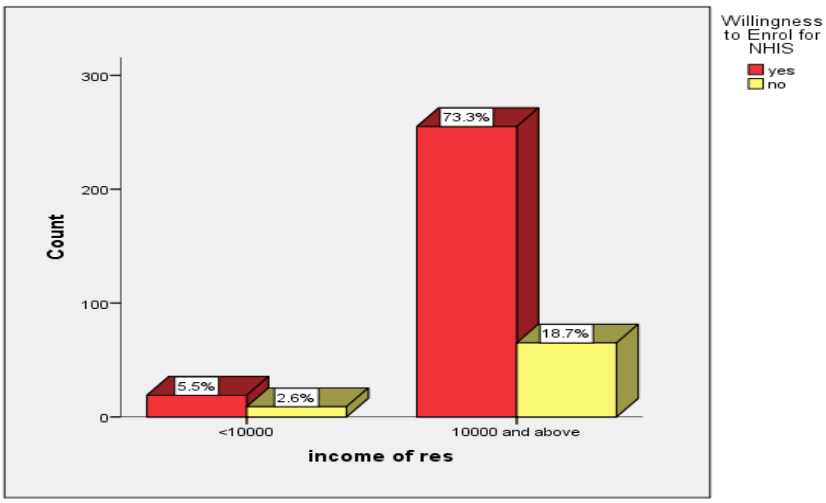
Secondary. School	80 (29.2%)	19 (25.7%)	99 (28.4%)
NCE/HND	90 (32.8%)	18 (24.3%)	108 (31.0%)
HND/B.Sc	53 (19.3%)	18 (24.3%)	71 (20.4%)
Post graduate	35 (12.8%)	12 (16.2%)	47 (13.5%)
Total	274 (100.0%)	74 (100.0%)	348 (100.0%)
Calculated chi square: 4.920; df: 5; Probability value: >.05			

Source: Fieldwork, 2015

The above χ^2analysis indicates that education and willingness to enrol in NHIS are independent of each other, that is, formal education does not necessarily influence willingness to enrol in the scheme. The relationship was not significant at χ^2 (5, N=348) = 4.920 P>0.05).

Figure 8.6 below indicates respondents' level of income and willingness to enrol. For those that earned above 10000 naira ($50.2) monthly, 255 (73.3%) indicated 'yes' while 19 (18.7%) indicated 'no'. In contrast, those that earned less than 10000 naira monthly, 65 (5.5%) indicated 'yes' while nine (2.6%) indicated 'no'.

Figure 8.6 Percentage Distributions of Respondents Level of Income and Willingness to Enrol



Source: Fieldwork, 2015

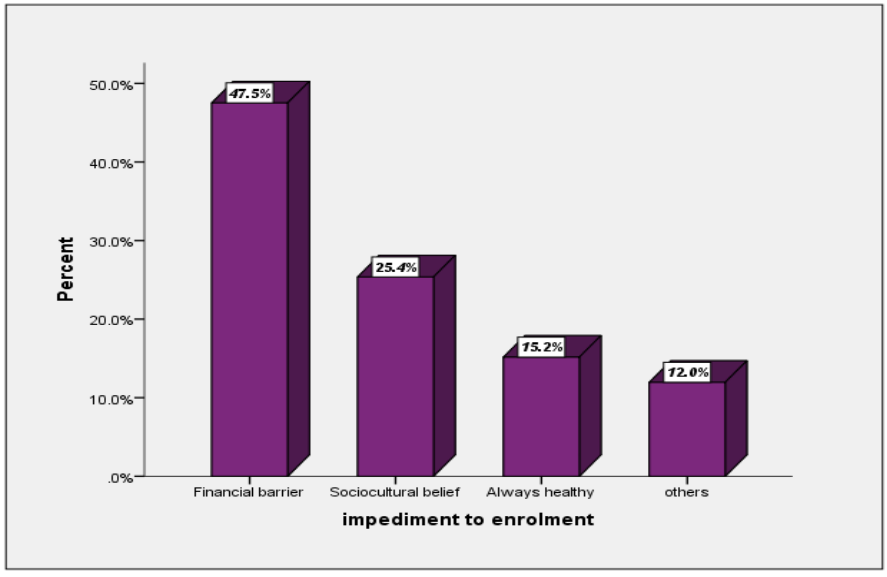
Table 8.4 Chi square test of association between income and willingness to enrol

Income	Willingness		Total
	Yes	No	
<10000 naira	19 (6.9%)	9 (12.2%)	28 (8.0%)
10000 naira and above	255 (93.1%)	65 (87.8%)	320 (92.0%)
Total	274 (100.0%)	74 (100.0%)	348 (100.0%)
Calculated chi square: 2,152; df: 1; Probability value: >.05			

Source: Fieldwork, 2015

The above χ^2analysis indicates that income and willingness to enrol in NHIS are independent of each other, that is, income does not necessarily influence willingness to enrol in the scheme. The relationship was not significant at χ^2 (1, N=348) = 2.152 P>0.05). The above findings confirm existing literature (e.g., Allegri, et al., 2006) that a number of factors influence peoples' willingness and decision to enrol; however, these may not necessarily result in actual enrolment.

Figure 8.7 Percentage Distributions of Respondents Impediment to Enrolment



Source: Fieldwork, 2015

Figure 8.7 above shows that 163 (47.5%) respondents indicated financial barrier as the impediment to enrolment, 87 (25.45) indicated sociocultural belief as the impediment, 52 (15.2%) indicated that they are always healthy, and thus, need not to enrol while 41 (12.0%) indicated other reasons as hindrance to enrolment. The findings show that most 163 (47.5%) of the respondents attributed their financial constraints to enrolment. These findings are further corroborated in the interview, though with a range of views from the participants about the impediment to enrolment. Although most of the participants, 8 out of 15 explained that financial constraints remained as the main challenge to enrolment, 2 noted that their religious belief simply does not encourage them to enrol because it is a perceived plan ahead for illness. Others indicated other reasons such as unavailability of NHIS programme in their community. Below are extracts from the participants:

> "My problem is money. If I have money, nothing will stop me from joining the NHIS because I have seen some of the beneficiaries, even my neighbours are among them. They testified about the programme and encouraged me to join. One of them even told me that he does no longer feel threatened or intimidated because of money whenever any of his family members is sick since he joined the NHIS. This word really motivated me to join but money is my problem" (**IDI, male, non-enrolee, 60 years Old, 30 June 2015).**

Another participant noted:

> "Since I was informed about NHIS, I have been longing to enrol but my fear is the monthly contribution. You know that I have to pay my contribution but I do not have a good job. I am just managing somewhere as a journeyman. The little pay I get from my job barely sustain my family and me, so getting money to enrol and pay subsequent contributions is a challenge" **(IDI, male, non-enrolee, 57 years Old, 4 July 2015).**

On the other hand, participants with sociocultural viewpoints noted:

> "I do not belief in paying upfront for illness. In fact, it is against my conviction. As a Christian, I pray for good health and my healing is in Jesus Christ because He has promised good health for his followers. Therefore, having announced Christ as my healer, it will be odd for me to start paying money should in case I fall sick" (**IDI, female, non-enrolee, 48 years Old, 4 July 2015).**

> "Look! I do not believe in this western medicine because they only lessen illnesses but not totally cure them. Whenever, I feel unhealthy, I used 'agbo' traditional herb and within 2 two days I feel better and get back to work. Therefore, I am not interested in the NHIS stuff because I do not need it" (**IDI, male, non-enrolee, 65 Years Old 30 June 2015).**

However, some of the interviewees explained that though money is a factor in enrolment and continued with the scheme after enrolment, unavailability of NHIS programmes in many towns and villages is also a challenge. Below are excerpts from the interviewees:

> "There is no NHIS programme in this village even if I want to enrol where will I enrol? NHIS is only for people in the city. People in the rural areas do not feel the impact of the NHIS and that is the problem. We only heard of the programme but we are not opportune to be part of the beneficiaries. I wish the programme is available here many people including me would have tried to enrol though money to pay is an issue too" (**IDI, male, non-enrolee, 60 years Old, 30 June 2015).**

Financial constraint toped the discussion on impediment to enrolment. This has also been reported in the literature (Amo, 2014), as impediment to enrolment in Ghana. However, another significant factor noted is the non-availability of NHIS programmes in the rural areas. The non-enrolled individuals in the rural areas explained that they are aware of the scheme but had no opportunity to take part in the programme. They explained that NHIS programme is biased towards the urban areas. In addition to financial constraint and unavailability to NHIS programme in the rural areas,

belief system, and perceived good health status, also stand out as impediment to enrolment. This is in line with Jehu-Appiah et al. (2011) who observed that household's decision to enrol in Ghana was influenced by health beliefs and attitudes among others. However, on what could be done to increase the number of enrolment, the participants unanimously called for 'free' enrolment of the poor. Below are excerpts.

> "I think if government can make NHIS free for the poor people who cannot afford to pay the contribution; the problem of low enrolment will be fixed. Many people especially the low-income earners or rural population find it difficult to pay. Let me tell you, to eat is very difficult for many people. Therefore, where will such people get money to pay for NHIS" (**IDI, male, non-enrolee, 54 years Old, 30 June 2015).**

Another participant corroborate this view.

> "I think NHIS should be free for all if government is determined to cover everybody. I told you earlier that the problem to enrolment is money. People want to be protected from the burden of official cost because if you go for treatment in the hospital, you cannot say exactly what the cost of the treatment will be but with NHIS, one would not bother about the expenses. The scheme will pay for the medical bill. If NHIS makes announcement today that enrolment is free, half of Nigerian population will enrol within a month" (**IDI, Female, non-enrolee, 50 years Old, 30 June 2015).**

8.4 Conclusion

This Chapter examined knowledge, attitudes and perceptions of non-enrolees about the NHIS. The findings indicate adequate awareness of NHIS among the respondents from different sources including radio, television, newspaper, publication etc. Moreover, the respondents' awareness of the scheme was reflected in their description of NHIS as majority described NHIS as a prepayment scheme. The study also indicates respondents' willingness to enrol. The χ^2analysis shows

significant relationship between occupation and knowledge about the scheme. Although education and income of respondents are among other factors that influenced their willingness to enrol, the relationship is not significant. Furthermore, the findings reveals that financial constraint topped the impediment to enrolment. However, others issues were also revealed in the interview as hindrance to enrolment. These include perceived good health status, religious belief and belief in traditional medicines and unavailability of NHIS programme. The study also shows that for NHIS to increase population coverage, enrolment should either be free for the poor and low-income earners, or free for all.

CHAPTER NINE

CONCLUSION

9.1 Introduction

Chapter 9 concludes with synthesis of the research findings. This thesis was predicated on the lacuna between NHIS objectives and actual implementation of programmes, which in turn negatively affects scaling up population coverage in Nigeria. It is from this proposition, specific research questions were formulated, these include (1) what is the structure and functions of NHIS? (2) What are the mechanisms adopted by NHIS to meet universal coverage objectives? (3) What are the challenges that inhibit the achievement of the set objectives? (4) What is the extent of equity in terms of financial contributions and health benefits among enrolees? (5) What is the extent of availability and accessibility of services of HMOs and providers? (6) Finally, what is the knowledge, attitudes and perceptions of non-enrolees about the scheme? The rest of this chapter presents evidence on the outline of the thesis, the contribution of the thesis to knowledge, policy recommendations and areas for further research.

9.2 Overview of the thesis

To have a better understanding of this study, it is necessary to have a summary of the whole thesis. The thesis commenced with background information on health care financing policy in general and this was narrowed down to health care financing in Nigeria, and thus, research problem for the study was identified. Chapter 2 provided historical development of the evolution of the NHIS. It traced the historical context for the establishment of NHIS to 1962 when the bill was first introduced to the national parliament. However, because health care provision and other social services was being provided by government, financed through taxation and meting heath care needs of every Nigerian at no direct costs on individual and households, the bill was jettisoned. The bill was reintroduced to the parliament in the 1980s because of government inability to continue to finance health care due to slow economic growth rate and structural adjustment policies of the international financial institutions as a condition to access bailout loan. The chapter also

discussed institutionalisation of NHIS and analysed the provisions of the Act and the operational guidelines that guides implementation of NHIS policy.

Chapter 3 presented bodies of literature on health sector reform. Subjects reviewed in the literature include health sector reform, structural adjustment programmes and health sector reform; risk sharing scheme, national health insurance, financing health care in Nigeria, and NHIS in Nigeria. The chapter also presented the conceptual framework used in this thesis, that is, key conceptual issues in health care financing functions developed by Carrin and James (2004). The framework hinged on the theory that for SHI financing model to achieve its set objectives including "sufficient and sustainable resource generation, optimal resource use and financial accessibility of health services for all" (Carrin and James, 2004: 20), the three interrelated financing functions namely revenue collection, risk pooling and purchasing must work together because they are interdependent.

Chapter 4 discussed the research methodology used in this thesis. Firstly, the chapter presented theoretical underpinning for the cross sectional research design used. Secondly, it argued for the adoption of a mixed method of qualitative and quantitative techniques. Thirdly, it presented the study area, study population, sampling techniques, research instrument etc. Fourthly, it presented data collection and data analysis. Fifthly and finally, it discussed challenges experienced in the fieldwork and ethical issues namely informed consent, confidentiality, beneficence and non-maleficence, and dissemination of research in line with the ethical considerations. Feedback from research questions gathered in the course of this research work using this methodological procedure were presented in chapter 5, 6, 7 and 8 as presented below.

Chapter 5 presented key informant interview with the NHIS officials, HMOs' employees and HCPs using the three interrelated health financing functions namely revenue collection, risk pooling and purchasing. On revenue collection, questions on population coverage and method of financing were posed to the interviewees. Empirical findings indicated that there is no accurate number of the total enrolled population in NHIS and this was due to lack of comprehensive database of the enrolees, which in turn resulted in conflicting numbers of total population coverage by the scheme. Moreover, on the method of financing, the study revealed that the federal

government as an employer of labour subsidises the health care cost of each of its employees who has enrolled in the NHIS by 90% because payroll deduction has not commenced for this group due to the impasse between the government and the labour union. Other beneficiaries including private organisations and voluntary individuals pay their financial contributions on regular basis. However, government subsidises the cost of health care of all enrolees.

The study revealed that the revenue generated through contributions from members of the scheme was not sufficient to fund health care services of members given the small proportion of the Nigerian population covered. On risk pooling, the study indicated that the scheme is fragmented with so many programmes in place without risk pooling among the existing programmes. Membership to various programmes is voluntary and thus affects the size in terms of population coverage. Overall, the study revealed that NHIS is fragmented and there are no transfer or redistribution of funds among the existing programmes.

On purchasing/provision, research evidence showed that there were similarities among benefit packages in the scheme in terms of provision of preventive and curative services. Primary Health Care is the first point of health care provision in the scheme. All members enrolled in the Primary Health care, access to Secondary and Tertiary care is by referral from the primary care. Moreover, the study showed that there is disagreement between the HMOs and the HCPs in terms of payment of capitation and other reimbursements, which often influenced providers' behaviour towards NHIS patients. In addition, a number of issues were revealed that hindered the achievement of NHIS objectives. These include policy content, government commitment, inadequate mobilisation etc.

Chapter 6 presented socio-demographic characteristics of the respondents, financial contribution and health benefits of the enrolled individuals in NHIS. Research evidence showed that financial contribution to the scheme is progressive in the formal sector programme and regressive in the informal sector programme because of the fixed contribution rate. Findings also revealed that employees of the federal civil service pay 10% as co-pay for consultations while other enrolees pay their statutory monthly contributions. Furthermore, the study showed that majority of the respondents agreed that they were financially protected from catastrophic spending. However, the

overall benefit package was rated moderate because of the exclusion of some priority and essential needs. Further analysis showed a significant relationship between occupation of respondents and health package, that is, the level of health care package is dependent on the occupation of the enrolees.

Chapter 7 examined quality of services of the HMOs and HCPs. For the HMOs, evidence showed that most of the respondents agreed that HMOs are accessible. However, the study revealed that most of the respondents were disagreed that HMOs organise educative and informative programmes on regular basis. On the overall satisfaction with the HMOs' services, most of the respondents were not satisfied. For the HCPs, majority of the respondents indicated improved waiting time good interpersonal relationship between enrolees and providers. However, they disagreed with the availability of prescribed drugs. On the overall rating of the services, most of the respondents rated the services to be fair. Further analysis showed access to HMOs and occupation of respondents are mutually dependent, that is, the occupation of respondents tends to influence their perceptions about accessibility to HMOs. There is relationship between the two variables and the relationship was significant at χ^2 (8, N=1342) = 92.397, P<0.05). In addition, study also shows that access to HMOs and gender of respondents are mutually dependent, that is, the gender of respondents tends to influence their perceptions about access to HMOs. The relationship was significant at χ^2 (4, N=1342) = 38.795, P<0.05).

Chapter 8 examined knowledge, attitudes and perceptions of the enrolees about NHIS. Evidence indicated adequate knowledge among the respondents through different sources including radio, television, newspaper etc. In the same way, most of the respondents described NHIS as a prepayment mechanism. The study also revealed that most of the respondents were willing to enrol in the NHIS. The χ^2analysis indicates that occupation and knowledge of respondents are dependent. The occupation of respondents tends to influence their knowledge of the scheme. The relationship was significant at χ^2 (2, N=376) = 17,809, P<0.05). Willingness to enrol is influenced by socioeconomic factors. However, the χ^2analysis indicates that education and willingness to enrol in NHIS are independent of each other, that is, formal education does not necessarily influence willingness to enrol in the scheme. The relationship was not significant at χ^2 (5, N=348) = 4.920 P>0.05). Similarly, χ2analysis indicates that income and willingness to enrol in NHIS are

independent of each other, that is, income does not necessarily influence willingness to enrol in the scheme. The relationship was not significant at χ^2 (1, N=348) = 2.152 P>0.05). Further analysis showed hindrances to enrolment with financial barrier as the most hindrance. Others include sociocultural belief, perceived good health status and non-availability of NHIS programmes especially in the rural areas.

9.3 Thesis' Contribution to Knowledge

The NHIS was instituted to protect individuals and households from financial hardship and ensure financial accessibility of health services for all. However, the percentage of Nigerians who are benefiting from the scheme remained stuck to less than 3% of the population. The thesis therefore investigated questions associated with the design and implementation of NHIS programmes. The design and implementation of NHIS programmes is crucial in the redistributive process in order to achieve democratic and egalitarian objective of universal coverage. In this respect, the thesis' contribution to knowledge is group into methodological and empirical as explained below:

9.3.1 Methodological Contributions

The thesis used empirical methods to explore the design and implementation policy of NHIS. Cognizance of different stakeholders involved in the implementation of NHIS policy, both quantitative and qualitative approaches were used to allow in-depth exploration. Key informant interview was used to elicit open and in-depth information from the NHIS' officials, employees of the HMOs and health care providers on broader issues regarding the design and implementation policy of NHIS. In addition, a combination of in-depth interview and semi structure questionnaire was used in order to elicit robust information from the enrolees and non-enrolees taking into consideration sample size. In accordance with recommended high standard of enquiry, the use of sampling techniques served the purpose of capturing differences in view, opinions, experiences, common preferences. As a result, the use of a mixed method provided better understanding of broader issues on the design and implementation policy of NHIS.

9.3.2 Empirical Contributions

The design and implementation policy of NHIS in Nigeria is understudied. The fact remains that health-financing policy is a pertinent concern in the face of increasing deprivation of majority of Nigerians from accessing health care because of the huge medical cost of health services. Available studies on NHIS have focused on benefits, quality of services and challenges. There are research gaps. For example, where NHIS objectives contradicted implementation policy or fails to meet its statutory objectives of universal access. Thus, this thesis contributed to existing literature in health financing policy in the following ways:

9.3.2.1 Fragmentation of Programmes

Research evidence indicated that although there are three main programmes designed by the scheme to cover the Nigerian population. These include the formal sector programme, informal sector programme and the vulnerable group programme. However, only two namely the formal and the informal programmes are operational. Furthermore, evidence indicated that within the two operational programmes, there are a number of sub-programmes. Thus, the scheme is fragmented in a number of ways including one, presence of several programmes covering different population groups related by socio-economic status, occupation etc. Two, lack of risk pools in the scheme, which negates the fundamental principle of social insurance scheme. Thus, the fragmentation of the programmes and lack of risk pools has affected the financial strength of not only individual programme but also the entire programmes to achieve a fair financial protection of members. In addition, evidence from the study indicated that the voluntary nature of NHIS hinders several people (those who can afford premiums) especially the middle or high-income earners from joining.

9.3.2.2 Limitation to Health Care Services

Primary Health Care package is the first port of call to health care provision in the scheme. All members enrolled in the Primary Health care, access to Secondary and Tertiary care is by referral from the primary care. The study showed limitation to some essential services including pharmaceutical services, laboratory test etc. which results in paying for these services through out of pocket payment.

9.3.2.3 Level of funding

The thesis showed that the government subsidises the cost of enrolees in the NHIS. Because the revenue generated by contribution from the enrolees remained insignificant compared to the services offered, government is heavily involved in subsidization of the costs. Furthermore, lack of fairness based on the fixed contribution showed regressive nature of financial contribution among the enrolees of individual contributors programme, in that the low-income earners pay proportionately higher contributions than the high-income earners. Evidence also showed that federal government as an employer of labour subsidised the health care cost of its employees who has enrolled in the NHIS by 90% while the employee paid 10% co-pay for every consultation.

Another area the thesis contributed to knowledge is that research evidence showed that respondents were not satisfied with the services of the HMOs. Areas of dissatisfaction include referral services and irregular organisation of informative and educative programmes for the public including the enrolees. Furthermore, the thesis showed improved waiting time good interpersonal relationship between enrolees and providers, albeit it showed disagreement with the availability of prescribed drugs. The thesis also contributed to scholarship in the area of public knowledge, attitudes and perceptions on social policy in that it showed public knowledge of NHIS as a health financing policy with the principle of prepayment mechanism. However, financial constraints, sociocultural and unavailability of NHIS programmes among others were revealed as hindrances to enrolment.

9.4 Policy Recommendations

In the light of the research evidence, the followings are recommendations: First, merging of the existing pools into manageable size. Although NHIS has three main programmes, several sub-programmes that cover different population groups with smaller number of population coverage existed. Therefore, government should ensure integration of the existing smaller programmes into the major ones. This would enhance the organisation and better management of the existing programmes. Second, merging all funds together and establishing a single national fund. Since the goal of NHIS is to ensure universal coverage and financial accessibility of health services for all, government should ensure merging of existing funds into a single one and then ensure existence of risk pools. Merging of funds improve risk pooling; reduce adverse selection as well as increase

efficiency and equity in the SHI. Third, the best way to fund NHIS in order to achieve universal coverage is through tax revenue. Therefore, in order to break the fetter of slow population coverage, government should resort to funding of NHIS through taxation. However, based on the fiscal constraint, making membership compulsory for some programmes such as the formal sector programmes would increase funding to ensure low-income earners and the poor have access to health care through subsidization. It is acknowledged in the literature that several countries that have achieved high population coverage adopted compulsory membership for middle or high-income group of their populations while government pays the contribution of low-income earners through general tax.

Finally, NHIS should intensify effort to ensure there is a comprehensive database of the total number of enrolees, because having knowledge of the total number of the enrolled individuals would help the scheme to plan for extension to the population uncovered. Furthermore, the scheme should ensure the quality of services of the health care providers and HMOs are improved. It is when enrolees have quality services that they will be willing to encourage others to join the scheme.

9.5 Area for further Research

The study was conducted in Oyo state, Nigeria, further research in other states would shed light on the similarities and differences because of the socioeconomic diversities that exist in the country. Furthermore, since this study was conducted among the civil servants, self-employed and private sector employees, it would also be insightful to conduct similar research in the community-based programme.

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APPENDIX 1

ETHICAL CLEARANCE

UNISA

DEPARTMENT OF SOCIOLOGY RESEARCH ETHICS REVIEW COMMITTEE

06/03/2015

Ref #: 2014_SOCDERC_003
Name of applicant
Mr AJ Omoruan
Student #:55761305

Dear Mr Omoruan,

Decision: Ethics Approval

Name: AT Omoruan (Department of General Studies, Ladoke Akintola, University of Technology, Ogbomoso, Nigeria; 55761305@mylife.unisa.ac.za; +234-8035023630) under the supervision of Prof JOT Adesina (adesij@unisa.ac.za; 012 337 6002)

Proposal: The design and Implementation Policy of National Health Insurance Scheme in Oyo State, Nigeria

Qualification: Doctoral degree in Sociology

Thank you for the application for research ethics clearance by the Department of Sociology Research Ethics Review Committee for the above mentioned research. Final approval is granted for the next four years or until the conclusion of the study (whichever comes first).

For full approval: *The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Department of Sociology on 5 December 2014.*

The proposed research may now commence with the proviso that:

1) *The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*
2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the (Name of unit/sub-unit) Ethics Review Committee. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*
3) *The researcher will ensure that the research project adheres to any applicable*

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APPENDIX 2

CONSENT FORM

UNISA university of south africa

Dear Sir/Madam

CONSENT FORM FOR RESEARCH

My name is A. I. Omoruan. I am a registered student at the SARChI (South African Research Chairs Initiative) Chair in Social Policy at the University of South Africa, and am enrolled for a Doctoral Degree in Sociology. To complete this degree I have to conduct research on a topic of my own choice. The title of my research project is "**The Design and Implementation Policy of National Health Insurance Scheme in Oyo State, Nigeria**"

In undertaking my fieldwork, I formally request for your participation in this research project, which seeks to (Assess the design and implementation policy of NHIS in terms of coverage, equity and quality in Oyo State Nigeria). The study will involve me talking to you on your opinions and experiences in this regard. I would like to digitally record our discussions, which will be typed out with your permission. Your decision to participate in this study is voluntary, and you may decide to withdraw your participation at any stage without prejudice. Your participation will be anonymous as your name will not be mentioned in the research report (except you expressly request your name to be mentioned).The information obtained in the course of our discussion may be used subsequently for a research paper.

Thank you for considering my request. If you agree to participate in the study, please sign the attached form. If you require more information, please discuss with me, or you may contact me at *autinoma2002@gmail.com*.

Augustine Idowu OMORUAN
Student number: 55761305

INFORMED CONSENT FORM
"The Design and Implementation Policy of National Health Insurance Scheme in Oyo State, Nigeria".

I hereby agree to participate in the above research project. I understand that I can withdraw from the study at any stage. I agree that the interview may be digitally recorded and typed out, and the information may be used at a later date. I also understand that my name will not be used in the research report in order to ensure anonymity (except I expressly request for my name to be mentioned).

PARTICIPANT NAME: _____

SIGNATURE: _____ DATE: _____

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APPENDIX 3

QUESTIONNAIRE FOR THE ENROLEES

Department of Sociology
College of Human Sciences
University of South Africa

.

Serial No…

Date …

Dear Respondent,

I am a postgraduate student of the department of Sociology University of South Africa, carrying out a study on the topic **The Design and Implementation Policy of National Health Insurance Scheme in Oyo State Nigeria**. I request your support to answer questions contained in this questionnaire. You have been selected randomly for this study and all the information you will supply will be strictly kept confidential.

Thanks in anticipation of your cooperation.

Yours Sincerely,

Augustine Omoruan

SECTION A: Socio-economic and Demographic Characteristics

S/N	QUESTION	RESPONSES AND CODING CATEGORIES	
001	What is your sex?	Male [ ] Female [ ]	1 2
002	What is your age range (in years)?	18-20 [ ] 21-25 [ ] 26-30 [ ]	1 2 3

		31-35 [ ] 36-40 [ ] 41-45 [ ] 46-50 [ ] 51 and above [ ]	4 5 6 7 8
003	What is your marital status?	Married [ ] Single [ ] Divorced [ ] Separated [ ]	1 2 3 4
004	What is your highest educational qualification?	Primary school [ ] WASCE/GCE/NECO[ ] OND/NCE [ ] HND/First Degree [ ] Post graduate[ ]	1 2 3 4 5
005	What is your religious affiliation?	African traditional religion [ ] Islam [ ] Christianity[ ]	1 2 3
006	What is your monthly income?	Less than 10000[ ] 10000-30000 [ ] 30001-50000 [ ] 50001-70000 [ ] 70001-90000 [ ] 90001-110000[ ] 110001 and above [ ]	1 2 3 4 5 6 7
007	What is your occupational status?	Civil servant [ ] Public servant [ ] Self-employed [ ] Private sector employee [ ] Teachers[ ] Lecturers [ ] Others (pls specify)	1 2 3 4 5 6 7
008	What is your ethnic origin?	Yoruba [ ] Hausa [ ] Igbo [ ] Others (pls specify)	1 2 3 4
009	Where do you live?		

Equity in financial contributions and health benefits

S/N	QUESTION	RESPONSES AND CODING CATEGORIES	
010	Is there any deduction from your salary as your contribution to NHIS?	Yes[ ] No [ ]	1 2
011	What health plan did you subscribe?		
012	Is your financial contribution determines the volume of your health benefits?	Yes[ ] No [ ]	1 2
013	Do you pay for extra charges after being attended to by healthcare providers?	Yes[ ] No [ ]	1 2
014	Is your health plan covers other members of your household?	Yes[ ] No [ ] (If No)	1 2
015	Why?		1
016	How would you rate the health benefits in terms of your financial contribution?	Adequate [ ] Fair [ ] Inadequate [ ]	1 2 3
017	Has NHIS reduced your health care cost?	Yes[ ] No[ ]	

Availability and Accessibility of NHIS Services

Please indicate the extent of your agreement with the following statement (kindly tick your answer)

S/N	STATEMENT	Strongly agree	Agree	undecided	Disagree	Strongly disagree
018	Joining the scheme has benefited me					
019	NHIS is better than OOP payment					
020	No difficulty in accessing services					
021	The service I received worth my financial contribution.					

022	NHIS has considerably increase my savings from paying hospital bills					
023	I do not need money to pay for hospital care any more					
024	I get immediate care if I need it					
025	Treatment through NHIS is effective for recovery and cure					
026	The quality of medication is good					
027	The provider do a good clinical examination					
028	There are adequate health personnel in NHIS accredited hospitals					
029	The medical equipments are adequate					
030	Attitude of health staff is good					
031	No delay in responding to NHIS enrolees					
032	NHIS health service providers are closer to my house					
033	I am satisfied with the services received from the providers					
034	HMOs are adequate in terms of service delivery					
035	Most often, it is difficult to get HMOs officials for registration and other processes.					
036	Most often HMOs officials failed to attend to their clients complaints.					
037	The relationship between HMOs and healthcare providers is cordial					
038	I am satisfied with the services of HMOs					
039	I will visit NHIS hospital again if it becomes needful for me					

040	Hospital meeting with my expectation about equipment					
041	I am not delayed unnecessarily in the hospital when I go for treatment					
042	Availability of medication in pharmacy					
Kindly Rate the following statements		Excellent	Very good	Moderate	Fair	Poor
043	Interpersonal relationship with the health personnel					
044	Overall rating of health services					

APPENDIX 4

QUESTIONNAIRE FOR THE NON-ENROLEES

DEPARTMENT OF SOCIOLOGY
UNIVERSITY OF SOUTH AFRICA

Section A: Demographic Characteristics

No	Questions	Response	Value	Skip
1	Sex of respondent	Male Female	1 2	
2	What is your age range (in years)?	18-20 [ ] 21-25 [ ] 26-30 [ ] 31-35 [ ] 36-40 [ ] 41-45 [ ] 46-50 [ ] 51 and above [ ]	1 2 3 4 5 6 7 8	
3	Which ethnic group do you belong?	Yoruba [ ] Hausa [ ] Igbo [ ] Others (pls specify)…	1 2 3 4	
4	What is the highest level of school you have completed?	No formal education Primary school Junior secondary Senior secondary NCE/OND HND/B.Sc Postgraduate	0 1 2 3 4 5 6	
5	What religion do you profess?	Christianity Islam ATR Others (specify)	1 2 3 4	
6	What is your current marital status?	Single Married Divorced Separated	1 2 3 4	

		Widowed	5	
7	What is your present occupation?	Civil servant [ ] Self-employed [ ] Private employee [ ] Others (pls specify)…	1 2 3 4	
8	What is your average monthly income?	Less than 10000[ ] 10000-30000 [ ] 30000-50000 [ ] 50000-70000 [ ] 70000-90000 [ ] 90000-110000[ ] 110000 and above [ ]	1 2 3 4 5 6 7	

Section B: Knowledge, Attitudes and Perceptions about National Health Insurance Scheme

9	Have you heard about National Health Insurance Scheme?	Yes No	1 2	
10	From which source did you get the information about NHIS?	From the health workers Television Radio Newspapers, Publication and Journals Others.....	1 2 3 4 5 6	
11	How would you describe NHIS?	Prepayment for health care Out-of-pocket payment for health care Free health care I don't know	1 2 3 4	
12	Are you willing to enrol for NHIS?	Yes No	1 2	
13	Why did you not enrol in NHIS?	Financial barriers Culturally unacceptable Always healthy	1 2 3	

		Others …….	4	

APPENDIX 5

DEPARTMENT OF SOCIOLOGY
COLLEGE OF HUMAN SCIENCES
UNIVERSITY OF SOUTH AFRICA

KEY INFORMANT INTERVIEW GUIDE FOR NHIS OFFICIAL

1. What is the total number of the population coverage in the NHIS?

2. Since financing of NHIS is important in order to ensure financial protection of enrolees against health care costs, what is the level of financial commitment of government, employers and enrolees to the scheme? Probe.

3. What is the ratio of contribution from enrolees to the total costs of benefit package? Probe.

4. How does NHIS ensure that households are protected against catastrophic expenditures?

5. What is the composition of risk pools and is there cross subsidisation among the existing pools?
6. What measures are in place to ensure effective risk pooling among pools? Probe.

7. Is there variation among existing benefit packages? Probe

8. How are providers being paid? Probe

9. What mechanism is in place to ensure universal health insurance coverage? Probe.

10. What are the challenges militating against NHIS? Probe

11. How do you think NHIS can improve its coverage? Probe.

APPENDIX 6

DEPARTMENT OF SOCIOLOGY
COLLEGE OF HUMAN SCIENCES
UNIVERSITY OF SOUTH AFRICA

KEY INFORMANT INTERVIEW GUIDE FOR EMPLOYEES OF THE HMOs

1. How would you describe NHIS contributions in reference to its financial protection of Nigerians? Probe.

2. What is the total number of enrolees in your organisation?

3. How would you describe your relationship among other stakeholders, especially the healthcare providers? Probe.

4. How do you ensure that the enrolees are well informed on the processes for registration and related issues? Probe.

5. What Challenges do you encounter in the course of discharging your services? Probe.

6. What mechanism do you employ in the payment of providers for their services?

7. How do you think NHIS can improve its coverage? Probe.

APPENDIX 7

DEPARTMENT OF SOCIOLOGY
COLLEGE OF HUMAN SCIENCES
UNIVERSITY OF SOUTH AFRICA

KEY INFORMANT INTERVIEW GUIDE FOR HEALTH CARE PROVIDERS

1. What is your perception about NHIS as a viable financial option to OOP payment?

2. What health care packages available to the enrolees? Probe.

3. How would you describe the relationship exists between provider (you) and HMOs? Probe.

4. How are you reimburse for your services to the enrolees and how will you describe the process for the reimbursement? Probe.

5. What challenges do you encounter as NHIS healthcare provider? Probe.

6. What general comment do you have on how NHIS can improve its coverage? Probe.

APPENDIX 8

DEPARTMENT OF SOCIOLOGY
COLLEGE OF HUMAN SCIENCES
UNIVERSITY OF SOUTH AFRICA

IN-DEPTH INTERVIEW GUIDE FOR ENROLEES

1. How would you describe OOP payment with NHIS? Probe.

2. How would you describe your experience with HMOs and healthcare providers?

3. What are the bureaucratic procedures involve in the registration as enrolees in NHIS? Probe.

4. What type of NHIS plan did you subscribe for and are you satisfied with it? Probe.

5. How would you describe equity in terms of your financial contribution and benefits? Probe.

6. Are you satisfied with the services of health care providers and health maintenance organisations? Probe.

7. Does socio-economic status of employees determine their access to healthcare services? Probe.

8. What challenges do you think are hindering coverage of NHIS in the country? Probe.

9. Would you encourage people to join the scheme? Probe.

APPENDIX 9

DEPARTMENT OF SOCIOLOGY
COLLEGE OF HUMAN SCIENCES
UNIVERSITY OF SOUTH AFRICA

IN-DEPTH INTERVIEW GUIDE FOR NON-ENROLEES

1. Have you heard about NHIS? If yes,

2. From what source?

3. How would you describe NHIS? Probe

4. Are you willing to enrol? If yes

5. What stop you from enrolment? Probe

6. What do you think government can do to increase the number of enrolment in the NHIS? Probe.