

**SATISFACTION WITH THE NATIONAL HEALTH INSURANCE SCHEME  
PROVIDER SERVICES AMONG CIVIL SERVANTS AT THE FEDERAL  
SECRETARIAT, IBADAN**

BY

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## ABSTRACT

The National Health Insurance Scheme (NHIS) was introduced in Nigeria to support health care financing in order to improve access to health care. The first phase is targeted at workers in the civil service. End users' satisfaction is an important determinant of success of health programmes which should be routinely assessed for identification of areas of improvement. This study was therefore designed to assess civil servants' satisfaction with NHIS.

A cross sectional study was conducted. All consented staff at the Federal Secretariat, Ibadan who have enrolled in NHIS for at least one year were recruited for the survey. A total of 417 respondents were recruited for this study. A semi-structured questionnaire was used to obtain data on socio-demographic characteristics, experiences with NHIS and satisfaction with health care services. The NHIS service areas such as drug availability and waiting time were rated using a 5-point likert scale. Overall satisfaction was a composite score of NHIS service areas. Satisfaction with Health Care Provider (HCP) services was determined by scoring each domain and finding a cut off point. Scores below this cut off mark were classified as not satisfied and scores  $\geq$  cut off were classified as satisfied. The satisfaction ratings for different aspects of NHIS which includes enrollee's choice of HCP and registration/enrolment ranged from 1 to 5 and was dichotomized such that those that scored between  $\leq 2$  were classified as not satisfied and those that scored between 3 and 5 were classified as satisfied. Chi-square test and binary logistic regression were used to analyze data at 5% level of significance.

Mean age of respondents was  $42.5 \pm 8.0$  years, 53.0% were males, 88.3% were married and 88.0% had tertiary education. Majority (80.0%) had to wait for 7 - 24 months after registration to receive NHIS number and card. Sixty-three percent reported having difficulty registering their dependants, 88.0% had utilized the NHIS services within the last one year preceding the study. Of these, 38.0% had changed their HCP due to poor services. Mean satisfaction score for NHIS service areas was  $89.8 \pm 8.9$ . Fifty-two percent of the respondents were satisfied with staff attitude, 55.6% with drug availability, 56.2% with services provided, and 78.0% with waiting time. Overall, 55.3% of the respondents were satisfied with the NHIS service areas provided by their HCPs. About 62.0% rated the copayment plan, change of HCP processes (55.4%), the registration/enrolment processes (54.7%) and range of services covered (50.5%) to

be poor while 66.0% rated the choice of HCP and referral system (58.7%) to be good. The satisfaction with NHIS service areas was significantly higher among those that used public facilities (OR=1.9, p=0.026), those who registered at the inception of the programme (OR=3.1, p=0.019), and those in grade level 11 and above (OR=2.8, p=0.008).

About half of the respondents were satisfied with the services they had received. Areas of dissatisfaction included co-payment system and range of services covered. Efforts should be made to address areas of dissatisfaction to encourage continued participation and utilization of services.

**Keywords:** National health insurance scheme, Health care provider, User Satisfaction

**Word Count:** 497

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## CERTIFICATION

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## LIST OF ABBREVIATIONS

CHF	-	Community Health Fund
DRG	-	Diagnosis Related Group
FMOH	-	Federal Ministry of Health
FOS	-	Federal Office of Statistics
GDP	-	Gross Domestic Product
HCP	-	Health Care Provider
HSU	-	Health Service Users
HMO	-	Health Maintenance Organization
IFI	-	International Financial Institution
ILO	-	International Labour Organization
IMF	-	International Monetary Fund
MOH	-	Ministry of Health
NHIA	-	National Health Insurance Authority
NHIF	-	National Hospital Insurance Fund
NHIS	-	National Health Insurance Scheme
OECD	-	Organization for Economic Co-operation and Development
OOPS	-	Out-Of-Pocket Spending
PHC	-	Primary Health Care
PVHI	-	Private Voluntary Health Insurance
SAP	-	Structural Adjustment Programme

- SHI - Social Health Insurance
- UI/UCH- University of Ibadan/University College Hospital
- UNDP - United Nations Development Programme
- WHO - World Health Organization

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## CHAPTER ONE

### INTRODUCTION

#### 1.1 Background to the study

Globally, the early nineties were labeled as the decade of market reforms in health care. Several market reforms were initiated in most European countries in order to reduce increase in health care cost. It was believed in the United Kingdom (UK) that it is possible to have an alternative system that retained the British National Health Service and also expanding the choices of consumers and reducing inefficiencies in supply (Organization for Economic Co-operation and Development (OECD), 1994). This was to be achieved by distinguishing between the purchaser and the provider of health services in the hospital and communities, the creation of general practitioners as 'holders of fund' and the formation of a competing hospital trusts (OECD, 1995).

Also, in the Netherlands, the reforms that took place (Dekker reforms) and the Blum reforms in Germany was majorly on delivering health care by introducing a market-oriented system. The Dekker reforms supplied provider incentives to produce cost-effective care and the private insurance sector was streamlined by creating a common risk-related premium in order to address problems with inefficiency and uncoordinated financial structure (OECD, 1994, 1995; Quaye, 2001). Competition was also encouraged under the Blum reform among health care providers through the Diagnosis Related Group (DRG) - based reimbursement payment system and to monitor sickness funds, new regulations were introduced (Quaye, 2001). Market reforms were also introduced in health care delivery run publicly in Sweden. In the early 1990s, a Stockholm model was introduced to strengthen patient's position in their choice of care, and to provide effective health care (Hakansson, 1994; Quaye, 1997).

In the past decade, a number of forces have changed how health care is financed in Africa. There is increasing focus on, and concern about, the quality of medical care, financial constraints and the problem of access and equity in health care. As a means of dealing with these, user fees or cost sharing mechanism have been extensively used in Africa. These financing strategies came about due to debt crisis and political instability which has led to

several adjustment programmes being implemented. The African governments have been disappointed with the performance of health care delivery. The major cause of death has failed to be effectively dealt with by the prevailing healthcare system which was fashioned after the western medical system. Most mortality and morbidity cases have been caused by malnutrition which is a chronic state of under nutrition (Quaye, 1991). About 70% of the health care budget went to curative medicine while preventive care takes only 10%. There has been a maldistribution of health resources where resources were allocated for the urban few at the expense of the poor majority and this has implication for the health status of Africans (Quaye, 1991).

In the 1980s, the African government's dependency on cash crop for export in order to fund major projects was seriously affected due to the fact that export of agricultural products alone accounted for 65% of the total export earnings and a decline in terms of trade would have serious repercussions on the economies of these countries. Due to the recession that took place in the early 1980s in the western world, the economy of Africa witnessed a decline. Both internal (fragility of democratic institutions and wars) and external economic constraints imposed by adverse terms of trade led to a substantial decrease in earnings (Quaye, 1991).

The failure of the state to resolve and respond effectively to the central problem of both foreign capital and local class interests eroded the state's hold over the economy. This led many African countries to balk at the International Monetary Fund's (IMF) initial stabilization program. The debt crisis loomed by the end of 1980 in the African continent. African countries were compelled from foreign creditors to initiate stabilization policies (Quaye, 1991). These were designed to reduce basic imbalances in the economy e.g. devaluation, removal of subsidies, wage freezes and reduction in state expenditure on social services (Cornia et al., 1990). A retrenchment policy was pursued by several African governments in which government workers were laid off and a major consequence of these stabilization policies was user fees that were introduced in the utilization of health services.

In Kenya, a cost sharing mechanism in government hospitals and health centres was established by the Ministry of Health in 1989 (Huber, 1993). According to Gilson and Russell (1995), about 14 to 15 countries have introduced user fees (Gilson, 1997). A model whose goal is to protect the interest of the most vulnerable in the society has among its objectives the need to make health services more efficient and equitable. In this regard, the goal was to introduce sector changes and to use other incentive methods to ensure efficient delivery of health services by health care providers. For instance, the Kenyan government introduced a policy directive to exempt the poor in order to achieve equity (Wang'ombe et al., 2002).

Bamako initiative is the second approach which is widely used now in Tanzania through the community financing programme and it is a strategy designed towards the long term sustainability of Primary Health Care (PHC). The aim is majorly to strengthen the district management in order to revitalize the public sector health care delivery system by capturing some of the resources people are spending on health (Panos Report, 1994). It has been documented that user fees are highly regressive and it is more of a problem because it has a negative effect on the poor (Mwabu et al., 1998) and it has led to a decrease in service utilization. Also, the introduction of user fees was introduced to reduce the use of health services unnecessarily. As regards user fees as a source of revenue, the evidence suggests that this has not materialized.

## **1.2 Overview of user fees**

There were two main contributory factors to the rapid growth in explicit policies of charging user fees for government health services in African countries. Firstly, various international organizations vociferously advocated for the introduction of user fees (Akin et al., 1987; De Ferranti, 1985; Jimenez, 1987). The World Bank and International Monetary Fund were in a particularly strong position to influence policy in African countries as user fees and other cost recovery mechanisms were often an integral part of these institutions' loan conditionality and associated Structural Adjustment Programmes (SAPs).

Secondly, macro-economic difficulties in many countries (related to low or negative economic growth and increasing indebtedness) limited the resources available to government for financing and providing health services and led to financing strategies that increasingly placed the burden on service users (Bennett, 1992; Gilson and Mills, 1995). From the perspective of

national governments, two objectives were most frequently cited when introducing or increasing user fees. These were revenue generation and improvement in quality of public sector health services, particularly through availability of medicines at facilities (Nolan and Turbat, 1995). It was anticipated that user fees would generate significant revenue to cover the health care financing gap facing government health services in African countries.

Another objective that was set in some countries was to enhance community involvement in the management and 'taking ownership' of local facilities. International organizations which favoured user fees as a cost-recovery mechanism suggested there were a host of other 'benefits' of fees. These included the idea that user fees prevent unnecessary or frivolous health service utilization and send 'price signals' to patients about the cost of services at different levels of care and thereby promote appropriate use and adherence to referral mechanisms (Akin et al., 1987; De Ferranti, 1985).

They also argued that providers are more likely to be responsive to patients' needs and concerns and to provide good quality care when patients are paying for services. Lastly, it was suggested that fees would promote equity in that those who could afford to pay would ease the burden on government who could then concentrate its resources on the poor. However, the experience of user fees in African countries has been dismal relative to these objectives. For example, fees have on average tended to generate revenue of less than 5 percent of total operating costs (Creese, 1991); although they may cover a sizeable proportion of non-salary operating costs (Creese and Kutzin, 1995). When the collection and other fee related administration costs are taken into account, net revenue is even lower.

The evidence also highlights that the introduction or increase in fees usually leads to dramatic declines in health service utilization (e.g. of two-thirds in Ghana, over 50% in Kenya, and by a third in Zambia), particularly for the most vulnerable groups (Frankish, 1986; Waddington and Enyimayew, 1989; Waddington and Enyimayew, 1990; Mwabu et al., 1995; Hussein and Mujinja, 1997; Blas and Limbambala, 2001; Kipp et al., 2001). While some argue that user fees will mainly prevent unnecessary or frivolous health service utilization, this argument does not recognize that the use of health services is seldom costless. Time, transport costs and other



costs of obtaining health care can be significant, which will already deter unnecessary utilization (Abel-Smith and Rawal, 1992).

There appears to be little or no explicit targeting of revenue receipts to extend and improve services for the poor. As noted by Gilson et al (1995: 380), who conducted an extensive literature review, “no study was found which directly assessed whether fee revenue use has disproportionately benefited the poor or the nature and extent of cross-subsidies within user fee systems”. The African experience also demonstrates that exemption mechanisms, particularly those aimed at protecting the poor, are frequently ineffective (McPake et al., 1992; Gilson et al., 1995; Willis and Leighton, 1995).

### **1.3 Household level consequences of fees**

The limited revenue generating potential and adverse utilization consequences of fees, as well as the ineffectiveness of exemption mechanisms in protecting the most vulnerable groups, have been extensively documented in African countries, particularly since the early 1990s. A more recent focus has been the consequences of charging users for public sector health services at the household level, both in terms of treatment seeking decision-making (whether or not one seeks care when ill and which providers are used) and their effect on household livelihoods. In South Africa, a national household survey of health needs and health care affordability, conducted just after the introduction of free care services for young children and pregnant women, showed that 22 percent of African interviewees reported having been refused treatment on the grounds of being unable to pay. Approximately 54 percent of unemployed Africans and 18 percent of white-collar workers reported not seeking treatment as they felt unable to pay for it (Hirschowitz and Orkin, 1995).

A survey in Tanzania among individuals who had used health services in the preceding four weeks indicated that 84 percent of rural dwellers found it either difficult or very difficult to find money for health service utilization, while 81 percent of urban dwellers experienced similar problems (Abel-Smith and Rawal, 1992). A more recent study in one rural district in Tanzania found that 73% of the poorest households cited lack of funds as the reason for not seeking care for a reported chronic illness, while none of the richest households reported being unable to afford health care for chronic illness (Save the Children, 2005). The 1994

Demographic and Health Survey in Zimbabwe indicated that 42% of the urban poor and 14% of the rural poor cited inability to afford health care fees when indicating why they had not sought care for an illness they reported experiencing in the previous month (Bitrán and Giedion, 2002). In Burundi, 34% reported not seeking care due to lack of funds (Bate and Witter, 2003) and in a rural district in Ethiopia, over two-thirds gave this as the reason for not seeking care (McIntyre et al., 2005).

Similar results have been found in many other African countries and demonstrate that user fees create a major barrier to accessing health care when needed, particularly for the poor. For those who do seek health care when they are ill, the direct costs of obtaining such care can account for a substantial proportion of households' income. Payments for health services and medicines accounted for an average of 4-5% of household incomes in the African countries included in one study (Makinen et al., 2000). When other direct costs associated with obtaining care (such as transport costs) are included, some studies have found that total direct costs can be as high as 10% of household income (Lucas and Nuwagaba, 1999).

The direct costs of long-term fatal illness, particularly AIDS, have the most devastating effects on households. A study in Tanzania has estimated that the direct costs of treatment for a person living with AIDS during a six month period is about 64% of per capita household income for the same period (Tibaijuka, 1997). There is consistent evidence that the heaviest burden of health care costs, particularly those that are considered catastrophic, falls on the poorest households (Xu et al., 2003). For example, a study in Malawi found that the cost of malaria to households was over 7% of their income on average, but for the poorest households, these costs were as much as a third of their income (Ettling et al., 1994).

One of the first strategies of coping with the costs of illness is to try to avoid these costs altogether "by modifying illness perception (the phenomenon of ignoring disease)" (Sauerborn et al., 1996). The poor often delay seeking care until an illness is severe, which may ultimately lead to higher costs of treatment (e.g. if the person has to be admitted to hospital). Self-treatment using allopathic or traditional medicines available at home, or purchased from a drug seller or traditional healer at a relatively lower cost than at public facilities (and sometimes on credit), is another frequent strategy for avoiding or at least minimizing costs (McIntyre et al.,

2005; Save the Children, 2005). Where costs are incurred, households use coping strategies such as reducing consumption (including of basic necessities), selling assets and borrowing (McIntyre et al., 2005).

A recent study in Ethiopia found that households which had used available cash to pay for health care had intended to use the money for basic consumption needs including food, fuel, clothes and education (Russell and Abdella, 2002). Assets sold may include those that are essential to the household's future livelihood such as livestock and land. Borrowing to cover health care expenses is extremely widespread in Africa, and while some are able to access loans from family and friends at low or no interest, others have to accept loans at ruinous interest rates.

A survey in Tanzania found that 40% of respondents had borrowed money to pay for health services used in the preceding four weeks (Abel-Smith and Rawal, 1992). Another study found that between 25% and 49% of respondents in surveys in Kenya, Uganda, Nigeria, Guinea and Burundi borrowed money from family and friends to pay for health services (McPake et al., 1993). In Burundi, levels of borrowing to cover health care costs were found to be 35% in the poorest quintile (Bate and Witter, 2003); in Khartoum, Sudan they were 57% on average for all groups (Witter, 2005); and in a Tanzanian rural district were 63% in the poorest group and 43% in the richest group (Save the Children, 2005). As McPake et al (1993: 1391-1392) have noted, "the evidence suggests that when ill, most people seem to find amounts of money which appear large in relation to their regular incomes. This is probably a tribute to the informal risk sharing mechanism of the extended family and other community support mechanisms. Nevertheless, it highlights the plight of those who fall through this safety net for whom even charges for very basic care may be prohibitive."

There is growing international evidence that health care costs may plunge households into poverty and that the likelihood of a poor household ever being able to move out of poverty diminishes when confronted with illness-related costs (Whitehead et al., 2001). Recently, the WHO has estimated that 100 million people become impoverished by paying for health care each year and that a further 150 million face severe financial hardship from health care costs (World Health Organization, 2005). While household impoverishment through health care

costs is particularly related to catastrophic illness, even routine ambulatory care with so called nominal fees can worsen the situation of extremely poor households.

The available evidence on the impact of illness and health care costs at household level clearly demonstrates that the most vulnerable households face enormous constraints in accessing care when they are required to pay user fees, particularly where geographic access is poor and other costs of treatment seeking are high (e.g. for transport). With the high levels of poverty throughout Africa, household livelihoods are so fragile that if a member does have to use health services and pay fees at the time of service use, the household may have to take actions to access cash that could lead to further impoverishment.

#### **1.4 Reversing user fee policies**

The evidence about the adverse consequences of user fees for household livelihoods is so overwhelming that even the arch protagonist of user fees in the 1980s and 1990s, the World Bank, has acknowledged that “Out-of-pocket payments for health services – especially hospital care – can make the difference between a household being poor or not” (Claeson et al., 2001) and indicates that alternative financing mechanisms such as insurance may be preferable. Another institution that has historically supported user fees, the US government, in its 2001 foreign appropriations bill report requires the US Congress to oppose any World Bank, IMF or other multilateral development bank loan which includes user fees for basic health or education services, and to report to Congress within 10 days if any loan or other agreement is approved which includes such fees (US Network for Global Economic Justice, 2003). Even though it is encouraging that the key International Financial Institutions (IFIs) that have historically insisted that African countries levy user fees for public sector health (and other social) services are changing their position, and that there is increasing explicit international advocacy for the removal of fees (e.g. by Save the Children and the British government), the challenge of reversing fee policies is enormous. Some African countries, most notably South Africa and Uganda, have already abolished all or some user fees and their experience provides some useful insights.

### **1.5 Issues arising from the experience of user fee removal**

All of the information from the two African country experiences of user fee removal indicates that abolishing user fees for at least some health services has reduced financial barriers to access and resulted in immediate and dramatic service utilization increases. In some cases, this has been shown to particularly benefit the poor, but in other cases there are remaining barriers to access (such as geographic distance and associated time and transport costs) that limit the extent to which the poor are able to benefit. Thus, fee removal should be seen as only one component of a comprehensive package to improve the availability, affordability and quality of public sector health services (Gilson and McIntyre, 2005).

The African experience of fee removal to date also clearly demonstrates that fee removal cannot occur overnight. There is a need for careful planning and for improved resource availability if fees are removed, not only to offset any fee revenue lost (which is frequently very low), but more importantly to continue to provide adequate quality services in the face of increased utilization. Plans for increased drug supplies are particularly important, and it is critical to monitor staff workloads and to address staff shortages where they arise. It is also essential to adequately communicate with frontline health workers, to explain the reasons for fee removal and to promote their support for the policy, as well as to fully inform the general public of changes in fee policies (Gilson and McIntyre, 2005).

In Nigeria, financing of public health services has experienced government subvention funded majorly from petroleum export and user fees for patients. Health care experienced decline in funding which commenced after the mid 1980s following a drastic reduction in revenue from oil exports, increased external debt burden and rapid population growth rate (Shaw et al., 1995).

Many health financing mechanisms are operational in Nigeria but the predominant one is the Out-Of-Pocket Spending (OOPS), this was also as a major response to the introduction of user fees for health services in the country. User fees was introduced in Nigeria for health services to serve as another means of financing government health services within the framework of the Bamako initiative drug revolving funds( Ogunbekun et al., 2002). There is a high reliance on user fees and other Out-Of-Pocket Spending (OOPS) by the poor and other vulnerable groups

due to the fact that they are both impoverishing and it also provides a financial barrier to care (James et al., 2006). A lot of inappropriate payments for health care mostly occur through Out of Pocket spending by individuals and households (Onwujekwe and Uzochukwu, 2004). Public expenditure now in Nigeria accounts for 20-30% of total health expenditures leaving 70-80% of the expenditure uncontrolled for in terms of value for money and their potential to generate health gains (Soyibo, 2004).

Hence, private expenditures accounts for 70-80% of the expenditures and the dominant private expenditure is OOPS, which is about US \$ 22.5 per capita and accounts for 9% of total household expenditures (Federal Office of Statistics (FOS), 2004). Half of those who could not access care did not do so because of its costs (FOS, 2004). The dominant reliance on this non-pooled financing instrument and the related absence of risk sharing transfers the largest financing burden on the poor and the clear absence of exemption mechanisms and pre-paid instruments are largely responsible for impoverishing health expenditures (Preker, 2005).

The demand for medical care has been said to be irregular because it is determined by illness or risk of death (Arrow, 1963) therefore, for the purpose of increasing societal care, there is a need that everyone have access to basic medical care and the economic status of an individual should not be a criteria for the distribution of basic care. The price of medical care reduces utilization and cause a decrease in the use of health care thereby reducing health status (Collins et al., 2006). What determines the use of health care services includes: incidence of illness, cultural, economic and demographic factors. The cultural demographic factors include age, marital status, education etc (Collins et al., 2006). Economic factors include individual's level of income, price and time cost of receiving treatment.

Since the cost of quality healthcare is very high in Nigeria (Akin et al., 1995) and with an increasing deteriorating living and livelihood conditions of a large proportion of the population (Madu, 2007), more than 50% of the entire population in Nigeria could be said to have access to quality health care because they cannot afford such services even if they should demand for it. Having said that the rate at which health care services is utilized is dependent on income and price of health services, it goes to say that some sources of financing healthcare may be inadequate.

In order to ensure effective demand of health care in Nigeria, the method of health care financing must have the ability to generate revenue for the health sector, ensure equity in the distribution of quality health packages, pool health risks together for the entire nation to remove the problem of income inequality, ensure efficiency in funding and managing the health sector, and also ensuring sustainability in health care financing.

The real challenge of health care financing in Nigeria as in many Sub-Saharan African countries lies not primarily in the acute scarcity of resources, but in the absence of intermediation and insurance mechanisms to manage risk, and in inefficient resource allocation and purchasing practices (Soyibo, 2004). Hence, the National Health Policy as well as the National Health Financing Policy articulates that in addition to improving the efficiency of public expenditures, additional sources of pooled revenue to annual tax revenue are needed and these additional sources urgently include various forms of health insurance (FMOH, 2004 & 2006).

### **1.6 Hypothesis**

There is no association between NHIS and satisfaction

### **1.7 Problem Statement**

It has been said that the government's expenditure on health in sub-Saharan Africa is insufficient and inadequate (World Health Organization (WHO), 1993). Recently, user fees apply to healthcare services owned by the Nigerian government with the aim to generate more funds for the health sector, in order to improve the quality of health services (Federal Ministry of Health (FMOH), 2004). Out-of-pocket expenditures are regressive while social assistance and fee exemptions are either not present or they are not well directed at those that are mostly in need (Nguyen et al., 1995; Wagstaff, 2002; Nabyonga et al., 2005).

The inavailability of prepaid instruments is largely responsible for impoverishing health expenditures (Preker, 2005). Seventy percent of Nigerians live below one dollar per day (World Bank, 2003), and they rely excessively on Out-Of-Pocket expenses to curb their health needs. This exposes households to financial risk of expensive illness at the time when



there are both affordable and effective health financing instruments to address their problems with low income.

Health insurance has been implemented as part of the strategies to provide effective and efficient health care for enrollees. There has been insufficient knowledge of the health insurance activities by those enrolled in the scheme. There has been complains about providers charging additional fees on the pre-text of non-inclusion of the service in the benefit package (NHIS, 2006). Insured persons have also complained of poor attitude and behaviour of service providers operating in the health insurance scheme. This is evident in the study conducted among NHIS enrollees at the Federal Polytechnic Idah, Kogi State which equally showed that 48% of the respondents rated the quality of services rendered by their health service providers to be poor due to the inadequate supply of drugs, poor prescriptions and attention. They also evaluated the attitudinal disposition of health workers as lacking and substandard.

### **1.8 Justification**

It has been agreed upon by scholars in health care that clients' assessment, when used in concert with other effective and efficient measures, could provide a more comprehensive consideration for organizational strategy options and policies aimed at improving service quality. This is necessary because studies have shown that in spite of the introduction of the scheme, over 90% of health services in Nigeria remained paid for through Direct User Fee (Ichocku, 2005). This is evident in a study done to determine the impact of NHIS on the finance of federal workers in Kogi State where 60% maintained that there is no reduction in what they spend on medical services despite their enrolment. Problems related to providing health care services need to be understood and rapidly resolved all the time. This would help in future implementation strategies of the scheme by identifying what has happened and how to progress to make it better for all. This would aid improvement in the monitoring of health providers' activities within the scheme.

Although NHIS is just a few years in operation in Nigeria, few studies have been done to assess the satisfaction of those enlisted in the programme especially their satisfaction with the enrolment processes in the scheme. However, the assessment of clients' satisfaction with



regards to health service delivery and the factors responsible for the low utilization of these services need to be assessed.

Hence, this study will provide useful information for addressing clients' concerns about the satisfaction of health services in health facilities. In a bid to ensure continuous participation, the need to consider client satisfaction in the implementation of policies, should be given due precedence, a requirement this study aims to establish by assessing civil servants at Federal Secretariat, Ibadan.

### **1.9 General Objective**

To assess satisfaction with the NHIS provider services and associated factors among civil servants at the Federal Secretariat, Ibadan

### **1.10 Specific Objectives**

- To determine civil servants' utilization and experiences with the NHIS at the Federal Secretariat, Ibadan.
- To determine satisfaction with the services provided by the scheme among civil servants at the Federal Secretariat, Ibadan.
- To identify factors associated with satisfaction with NHIS services among civil servants at the Federal Secretariat, Ibadan.

### **1.11 Operational definition of terms**

The following operational definitions were used during the conduct of this study.

- Satisfaction: attaining one's need or desire
- Experience: Practical contact with and observation of facts or events.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

There is a rapid transformation in the health care industry to meet the needs of the population. Health care providers are no longer seeing patients as uneducated and with little service demands (Howard, 2000). There is a need to have better information on the existing service provision in order to move towards improved quality care. There is also the need to have better information on the interventions offered and on the major constraints on service implementation. Consumers need to be better informed about what is good and bad for their health, why not all their expectations can be met, and that they have rights which all providers should respect (WHO, 2003).

Recent research has found out that people's lives are affected on how health systems are designed, financed and managed. This is essential for global prosperity and the well being of the society. There is growing interest in improving the performance of health systems in many countries. It is a major preoccupation, reflecting common pressures for cost containment on one hand and raising consumer's expectations on the other hand leading to recent initiatives both to measure and to improve performance against quality, efficiency and equity goals. Initiatives are being developed by countries to measure performance to guide the improvement process.

Measurement and improvement are increasingly linked, as it is indicated by phrases like 'evidence-based medicine' and 'evidence-based policy' (Zeynep, 2002). If action is to be taken to improve performance, there is a need to understand the roles and motivation of different actors and available instruments in each health system. "Performance" is defined as the extent to which the health system is meeting a set of key objectives. The key objectives for the health system are suggested as being: improving health outcomes and responsiveness to consumers, economic efficiency and equity of health (or access to care). The success or failure of any initiative to improve health performance will depend on the political and institutional context in which it is placed.

Many countries face similar problems in assuring and improving the performance of their health care system. Some of the main topics that are increasingly being raised on the health policy agenda in most countries include the following: Improving health status and outcomes for the entire population, raising clinical effectiveness -ensuring that clinical decisions are based on the best current practice (avoiding over-use and under-use), improving safety or reducing medical errors - developing health care organizations that are capable of detecting medical errors or adverse events to patients, and which are then able to effectively act on them to avoid future occurrences, raising responsiveness of the system - providing timely services (reducing wasteful delays) which are patient-centered and respectful of individuals' preferences, needs, and values, improving efficiency/containing costs - providing the right incentives to providers, funders and consumers to get better value for money, and ensuring the equity - ensuring that the same quality of care is provided to all, regardless of race, gender, geographic location, or ability to pay, and reducing the gaps in health outcomes across different regions and socio-economic or ethnic groups (Shaw, 2002).

Important roles are played by regulations to determine the availability, cost, accessibility and also the quality of services provided. Regulation often secures the major values and objectives of each health system and this has been used to serve different functions in each country. It can have an extensive control function by defining and checking on unacceptable medical practices, or it can encourage good practice by providing positive principles according to which the medical profession should operate. Regulation also plays an important role in facilitating the accountability of the system and protecting patient's rights.

Health care has been referred to as a global issue in which despite the differences in the level of funding in health care, the challenges and solutions in quality are similar between countries. These national concerns include: unequal access to health care services, unsafe health systems, dissatisfaction on the part of the users, waiting lists, practice and outcomes, unacceptable levels of variations in performance, misuse, overuse or under use of health care technologies, inefficient delivery and unaffordable costs to society (Shaw, 2002). Innovations in the fields of genetics, biotechnology and communication technologies are bringing benefits in the prevention, diagnosis and treatment of disease as well as access to care (Cortis, 2003). These innovations are carried out in the private sector and this makes it costly. It is also a risky

process with many promising leads failing at successive hurdles before a safe, efficacious and high quality product is brought to the market. Countries are now seeking to establish these health priorities which should take account and help guide the direction of innovation.

## **2.2 The impact of health insurance**

There are a number of studies measuring the impact of health insurance on health care utilization and spending in developing countries. Positive impacts of health insurance on health care demand and utilization has been found in several studies which include: Newhouse (1993), Benman (2001), Wagstaff and Pradhan (2005), Wagstaff et al., (2009). On the contrary, the effect of health insurance can be negligible if the coverage and benefit package of health insurance are limited. For instance, Sapelli and Vial (2003) found a negligible impact on Chilean health insurance on hospitalization. Ekman, 2007 found that health insurance did not help financial protection from the catastrophic spending on health care in Zambia. Carrin et al., 1999 found a very limited impact of health insurance on reduction of healthcare expenditure burden in China.

In Vietnam, the impact of health insurance has been evaluated quantitatively in several studies. Wagstaff and Pradhan, 2005 found that health insurance increased the probability of using health care services and the number of hospital visits. Also, health insurance helped in the reduction of annual Out-Of-Pocket health expenditures. According to Sepehri et al., 2004, it was found that health insurance reduced the Out-Of-Pocket expenditures by around 36 to 45%. Findings from Jowett et al., 2003 showed that health insurance decreased the average Out-Of-Pocket expenditures by approximately 200%. The impact of free health for the poor was also assessed by Bales et al., 2007 and Wagstaff, 2007. Although, Wagstaff, 2007 found a positive impact of the health insurance on health care utilization, he did not find a significant impact on Out-Of-Pocket health expenditures. On the contrary, Bales et al., 2007, did not find a significant impact on health insurance on health care utilization.

Evidences from countries that have institutionalized National Health Insurance Programmes indicate positive impact on health care system and productivity of labour (Adamache and Sloan, 1983; Stephen, 1984; Akin et al., 1986; Collins et al., 2007; Kafafheret, 2007). It was discovered that health insurance has benefits in which studies suggested that workers in jobs

with health insurance coverage had higher productivity and lower job turnover than workers without health insurance benefits (Karoly and Rogowski, 1994; Buchmeller and Valletta, 1996; O'Brien, 2003; Collins et al., 2007). On the other hand, other studies suggest that offering health insurance has very little or no effect on job turnover (Getler et al., 1987; Mwabu and Wang'ombe, 1997; Collins et al., 2007).

However, it is generally believed that people without health insurance are more likely to be in worse health condition and have higher death rates than are people with insurance coverage because they are less likely to seek medical care. Conventional theory holds that people purchase health insurance because they prefer the certainty of paying a small premium to the risk of getting sick and paying a large medical bill (O'Brien, 2003; Collins et al., 2006). In other words, people will be more likely to purchase a health insurance when the premium is low compared to the value of the coverage to the consumer.

The adverse impacts of health shocks can be reduced if people have health insurance. There is no doubt that health insurance has a very important role in health care and financial protection, especially for the poor. Health insurance helps insured people access expensive health care services. It also protects people from financial burdens and poverty caused by health shocks (Wagstaff, 2005a; Wagstaff, 2005b).

One strategy to improve revenue mobilization and purchasing of cost-effective services in Nigeria is the National Health Insurance Scheme (NHIS), launched in 2005. The NHIS has the objective to provide universal coverage to the population in 15-20 years. This scheme is unique and innovative in that it is government driven but operated by private sector health-maintenance organizations (HMO). Presently, in phase I of the scheme, the NHIS limits its coverage to Federal government civil servants. The NHIS is contributory and the annual premium is 15% of the basic salary of the employees, with the employer contributing 10% and the employee contributing 5%. In addition to the NHIS, the government has increased support for the introduction and expansion of Private Voluntary Health Insurance (PVHI) offered by private sector insurers/HMOs, targeting the formal private sector labour market (NHIS, 2005).

### **2.3 Past and present challenges of NHIS in Nigeria**

There are a number of challenges facing the actualization of NHIS in Nigeria. Funding remain a major problem to the scheme, the percentage of government allocation to health sector has always been about 2% to 3.5% of the national budget. In 1996, 2.55 of the total national budget was spent on health, 2.99% in 1998, 1.95% in 1999, 2.5% in 2000 and a marginal increase to 3.5% in 2004 (WHO, 2007ab&c). Consequently, per capita public spending for health in the country is less than US\$5; which is far below the US\$34 recommended by WHO for low-income nations (WHO, 2007a&c). While the Nigeria per capita health expenditure dwindles, South Africa per capita health expenditure is US\$22 in 2001 (The Vanguard Editorial, 2005).

NHIS is also impeded by obsolete and inadequate medical equipment. The country suffers from perennial shortage of modern medical equipment such as X-rays, computerized testing equipment and sophisticated scanners (Johnson & Stoskopt, 2009). And where these equipments are available repair/services are always a problem. According to Oba (2009), this situation is not unconnected with corruption. Money meant to boost the health sector ends up in private pockets; example is the 300 million naira scam involving the Minister of health and his assistants in 2008. Lack of adequate personnel in the health sector is another impediment to the scheme. The country for instance had 19 physicians per 100,000 people between 1990 and 1999 (The Vanguard Editorial, 2005). In 2003 there were 34,923 physicians in Nigeria, that is 0.28 physician per 1000 persons and 127,580 nurses (1.03 nurses per 1000 persons) as compared to 730,801 physician (2.5 per 1000 population) in 2000 in the United States of America; and 2,669,603 nurses (9.37 per 1000 persons).

Migration of health personnel to USA, UK etc is jointly responsible for the personnel situation in the health sector. For instance in 2005, there were 2,393 Nigerian doctors practicing in the US and 1,529 in the UK. Attributing factor includes poor remuneration, limited postgraduate medical programmes and poor condition of service in Nigeria (WHO, 2007a). According to World Bank Development Indicators (2005), the personnel situation in the health sector influenced birth attendance in Nigeria. For instance between 1997 and 2005 only 35% of births were attended by skilled health personnel in the country. Cultural and religious practices also impact on the effectiveness of NHIS in Nigeria.

Sexual inequality still exists and encouraged by some religious/cultural sects in the country because of lack of awareness; women are discriminated against and have limited access to social services such as education and healthcare (NCBI, 2009). Other challenge includes inequality in the distribution of healthcare facilities between urban and rural areas and policies inconsistency (Omoruan, Bamidele & Philips, 2009). Furthermore, poverty and the inability to pre-pay are significant challenge to NHIS. According to Schelleken (2009) “people are not willing to pre-pay; and because people do not pre-pay there is no risk pool. And because there is no risk pool, there is no supply sides.”

#### **2.4 Historical Background**

Among the industrialized countries, insurance can be traced back to the time of the developing era. Pooling of resources by groups of individuals in order to protect themselves against certain types of adversity such as disability and sickness can be traced back to the 11th and 12th centuries. In European cities, funds were built by guilds from periodic contributions of their members and the money used for members facing problems such as illness. Later in the 18th and early 19th centuries, factory wage earners replaced independent artisans, they formed groups in particular industries and certain localities and called the organization - 'Sickness Funds'. This insurance idea grew in thousands in Europe in the late 19th century.

In 1883, German Chancellor Bismarck enacted a law requiring all workers with wages less than a certain amount to benefit from social insurance. This marked the birth of Social Security Movement. Similar development followed in Austria, Hungary, Great Britain and the Scandinavian countries. By 1927, all industrialized countries of Europe had followed suit including France although the range of population coverage and health service benefits differ from country to country. In Africa, Algeria in 1949 adopted a statutory health insurance programme, followed by Libya in 1957, Tunisia in 1960 and Egypt in 1967. Guinea was the first to establish social security for health care in Sub-Saharan Africa.

The first attempt at adopting a health insurance system in Nigeria started in 1962 during the First Republic. The Federal Government invited Dr Halevi through the International Labour Organization (ILO) to look into starting a health insurance system in Lagos. The then Minister for Health, Dr Majekodunmi, also presented the first bill to the parliament. The Nigerian civil war years caused the subject to be shelved but were resuscitated by the health council in 1984



when a committee was commissioned to study the National Health Insurance. In 1988, Professor Olikoye Ransome-Kuti commissioned the National Committee on Establishment of the NHIS, chaired by Emma-Eronmi. In 1989, Eronmi committee report was submitted and approved by the Federal Executive Council. The United Nations Development Programme (UNDP) and International Labour Organization (ILO) consultants conducted their own studies in Nigeria to provide costing, draft legislation and implementation guidelines for establishing the NHIS in 1992.

The Federal Executive Council which had given its approval in 1989 directed the Federal Ministry of Health in 1993 to start the scheme. In 1999, the enabling decree - Decree 35 was promulgated in May 10, 1999. On the 6th of June 2005, the formal sector of the social health insurance scheme was flagged off by Chief Olusegun Obasanjo the then president of the Federal Republic of Nigeria. As at today, the scheme have covered all the Federal Ministries, Parastatals, Agencies, the Nigerian Police and Armed Forces. It is also firmly established in the organised private sector.

Health insurance is now regarded as probably the most common form of financing health care which is the ability to get health services when required without having to pay fully at the time of need because payment has been made through a fixed regular contribution by the insured or his/her employer or both (prepayment plan). National Health Insurance is therefore the health insurance that insures a national population for the costs of health care and is usually instituted as a programme of healthcare reform.

## **2.5 How the Scheme operates in Nigeria**

There are five major stakeholders in the scheme:

- a) Employer
- b) Employee
- c) Health Care Providers - Primary and Secondary
- d) Health Maintenance Organizations (HMO) - Operators of the scheme
- e) Government Agency (NHIS) - Regulator of the scheme.



## **2.6 Guidelines for the operations of the Formal Sector Social Health Insurance Programme**

The Formal Sector Social Health Insurance Programme is a social health security system in which the health care of employees in the Formal Sector is paid for from funds created by pooling the contributions of employees and employers (NHIS, 2006).

The Formal Sector consists of:

- Public Sector
- Organized Private Sector
- Armed Forces, Police and Allied Services
- Students of Tertiary Institutions and
- Voluntary Contributors

### **2.6.1 Membership**

Employees of the public and organized private sector employing ten (10) or more persons shall participate in the Programme.

### **2.6.2 Contributions**

Contributions are earnings-related. The employer pays 10% while the employee pays 5%, representing 15% of the employee's basic salary. However, the employer may decide to pay the entire contribution. In accordance with the existing contractual agreement between employers and employees, especially in the organized private sector, an employer may undertake extra contributions for additional cover to the benefit package (NHIS, 2006).

### **2.6.3 Waiting Period**

There shall be a processing (waiting) period of thirty (30) days before a participant can access services.

### **2.6.4 Scope of coverage**

The contributions paid cover healthcare benefits for the employee, a spouse and four (4) biological children below the age of 18 years. More dependants would be covered on the payment of additional contributions from the principal beneficiary. However children above 18 years that are in tertiary institution will be covered under Tertiary Insurance Scheme (NHIS, 2006).

### **2.6.5 Benefit Package**

Healthcare providers under the Scheme shall provide the following benefit package to the Contributors (NHIS, 2006):

- i- Out-patient care, including necessary consumables;
- ii- Prescribed drugs, and diagnostic tests as contained in the National Essential Drugs List and Diagnostic Test Lists;
- iii- Maternity care for up to four (4) live births for every insured contributor/couple in the Formal Sector Programme;
- iv- Preventive care, including immunization, as it applies in the National Programme on Immunization, health education, family planning, antenatal and post-natal care;
- v- Consultation with specialists, such as physicians, pediatricians, obstetricians, gynaecologists, general surgeons, orthopaedic surgeons, ENT surgeons, dental surgeons, radiologists, psychiatrists, ophthalmologists, physiotherapists, etc.;
- vi- Hospital care in a standard ward for a stay limited to cumulative 15 days per year. Thereafter, the beneficiary and/or the employer pay. However the primary provider shall pay per diem for bed space for a total 15 days cumulative per year.
- vii- Eye examination and care, excluding the provision of spectacles and contact lenses;
- viii- A range of prostheses (limited to artificial limbs produced in Nigeria); and
- ix- Preventive dental care and pain relief (including consultation, dental health education, amalgam filling, and simple extraction).

### **2.6.6 Registration of Employers and employees**

- (a) Every employer shall register with the NHIS, upon which a registration number shall be allotted to it by the Scheme.
- (b) Every employer shall appoint an NHIS-registered Health Maintenance Organization (HMO) of their choice.
- (c) Every registered employer shall supply the following information to the Scheme and to the appointed HMO:
  - i- Name of employer.
  - ii- Category of employer (public or private).
  - iii- Management structure of the organization.

- iv- Staff lists, including basic salaries.
- iv- The employee shall register self, a spouse and four (4) biological children below the age of eighteen (18) years with the Scheme. A contributor has the right to change his/her HCP after a minimum of six months if He/she is not satisfied with the services there.

## **2.7 Objectives of the Scheme**

The objectives of the scheme include:

1. To ensure that every Nigerian has access to good healthcare services.
2. To solve the problem of inappropriate use of levels of healthcare, leading to unnecessary cost and under-utilization of specialized facilities ensuring equitable patronage of all levels of health care.
3. To improve and private sector participation in health care service delivery and to ensure institutional quality assurance.
4. Protect families from the financial hardship of huge medical bills
5. To ensure equitable distribution of healthcare cost among different income groups
6. Limiting the rise in the cost of healthcare service
7. To maintain high standard of healthcare delivery services within the scheme.
8. To ensure availability of funds to the health sector for improved services and foster research in the health sector.
9. To ensure efficiency in healthcare services
10. To ensure adequate distribution of health facilities within the federation. (NHIS, 2006)

## **2.8 Experiences with Health Insurance Service utilization**

Health service users (HSUs) have a legitimate interest in the provision of health care with a high level of quality as they are financial contributors, taxpaying citizens and recipients of care (WHO, 2000). However, public health services, particularly in developing countries, struggle to provide not only a high technical quality of care but also responsiveness to non-medical expectations (Baltussen and Ye, 2006; Rao et al., 2006). As a result many health service users, particularly in developing countries, prefer using fee-for-service care with high out-of-pocket expenditures.

Health Service Users perception of health services quality is a result of two principal factors which include their experiences with access to care and use and the respective ratings or value they assign to these experiences, it has been argued that it is important to analyze both experiences and ratings simultaneously (Epstein et al., 1996; Sofaer and Firminger 2005; Crow et al., 2002; Coulter, 2006). Reported experiences with access to health services include, among other aspects, transport time to the health service facility and the waiting time. Experiences with use include for example the physical examination by the physician, information provided by the health care provider to the user and the length of consultation. The ratings include, for example, how long the user perceived the travel time to be, waiting time at the facility (e.g. long or very long) and how they rate the information they received (very adequate or adequate).

Many previous studies have focused only on patient's satisfaction (e.g. the percentage of patients satisfied with the waiting time) without taking into consideration the actual experience (e.g. length of waiting time) of access to and use of services (Gattinara et al., 1995; Leon, 2003; Cabrera et al., 2008; Baustista, 2008). The evaluation of patient's satisfaction does not necessarily mean measuring of patient's experiences as "satisfaction involves a cognitive evaluation of and emotional reaction to health care" (Fitzpatrick, 1993). Hence, Coulter (Coulter, 2006) has argued that it is central to measure patients' experience in combination with their respective ratings. Information on both of these aspects is essential to improving quality in health services, as they can provide important reference points against which health service user experiences can be measured.

In some countries, insufficient quality of services and user dissatisfaction with the public and social security services have been cited as two of the main reasons why people opt to use fee-for-services despite its financial implications. The use of fee-for-services among insured and uninsured population has increased over the last years. In year 2000, 31.1% used fee-for-service in Mexico (Valdespino et al., 2003), meanwhile in 2005, 37.6% reported using them (Olai-Fernandez et al., 2006). Fee-for-service care has been receiving the highest overall user satisfaction in recent years (De J Ramirez- Sanchez et al., 1998).

To make providers more accountable, health service user satisfaction with quality of services is reported periodically. For instance, in 2006 an average of 98% of ambulatory care patients were satisfied with the information received from the physician and 89% with the prescription filling (Secretaria de Salud, 2006). However, the data reported do not identify what experiences resulted in 11% of the HSUs reporting that they are not satisfied with their prescription filling (e.g. partial prescription filling, receiving no medicines or receiving inadequate information).

Previous studies on user satisfaction with the quality of care comparing different service providers in Mexico reported that the primary reasons for perceived low quality were long waiting times and poor clinical examination (De J Ramirez- Sanchez et al., 1998). Other studies have focused on comparing interpersonal quality of care between different health care providers in Mexico, which found that ambulatory health service HSUs were most frequently unsatisfied with the waiting times whereas hospitalized health service HSUs most frequently mentioned limited choice of provider as the reason for dissatisfaction (Puentes-Rosas et al., 2005).

A recent study by Puig et al., 2009 focused on which health service user characteristics are associated with the perception of overall good quality of health care and found that age, health status and education were associated with the overall perception of health care quality. Although these studies provide insight into the reasons why HSUs perceived the overall quality as low (De J Ramirez- Sanchez et al., 1998; Puentes-Rosas et al., 2005) or what HSU characteristics influence the perception of good quality of care (Puig et al., 2009) they do not provide information on which HSU experiences specifically resulted in a low quality rating and therefore, need to be improved. In other words, to give some examples, we need to know the average waiting time a HSU would rate as acceptable and what choice of providers is most frequently rated acceptable.

To improve health quality programs in Mexico and other countries this information is of high relevance. In addition, there is a paucity of information about which aspects of the experience of care most influenced the general perception of low quality when adjusting for patient characteristics. Such information would allow prioritizing in programs most relevant to HSUs.

Empowering patients can help cut health care costs and also improve quality (Leatherman, 2001). Better informed patients have better outcomes, avoid equivocal treatments and also choose less risky procedures. This should increase confidence that patients can not only make constructive use of performance data designed for them, but can also be reliable informants for performance assessment. Health care professional's role is of great importance so as to assure high quality services and should be provided with dignity and respects to patients. The general notion of responsiveness can be decomposed in many ways. One basic distinction is between elements related to respect for human beings as persons – which are largely subjective and judged primarily by the patient – and more objective elements related to how a system meets certain commonly expressed concerns of patients and their families as clients of health systems, some of which can be directly observed at health facilities (WHO, 2000). Respect for persons includes: 1) respect for the dignity of the person; 2) confidentiality or the right to determine who has access to one's personal health information; 3) autonomy to participate in choices about one's own health. This includes helping choose what treatment to receive or not to receive.

Health service users want appropriate interventions with safe treatment and care. They also want accurate information that is relevant and timely. If this is to happen then consumers believe that patients must be involved and consulted not only in relation to their health but also about service planning and delivery, health evaluation and research (Graham, 2001).

Errors occur when consumers are not heard which can be avoided by measuring consumers' experiences through satisfaction surveys. There is a need for an effective evaluation of the acceptability of complaint procedures and the introduction of incentives, such as feedback and proof of real action, to encourage and support complaints. To participate as equal partners, health services consumers need to be able to consult, to develop policy and strategies and to train for their advocacy role.

Health insurance constitutes the major share of health care financing which has been extensively used in the western world. One major disadvantage of health insurance is its limited coverage and this creates several problems for government. The National Hospital Insurance Fund (NHIF) is the only well established government insurance in Kenya and this

only covers those in the public sector while other form of insurance covers only about 20% of the population. According to a study conducted by Wang'ombe, it was concluded that those who used insurance to pay for their medical care was about 3% of the Kenyan household.

Also, it was found out that several patients were less likely to use insurance to pay for their medical care in public hospitals due to limited coverage and the long delays in reimbursement from the National Hospital Insurance Fund. Reports from this study also showed that patients were generally not satisfied with the services they received from government hospitals (Wang'ombe et al., 2002).

Experiences from the Kenyan health insurance shows that insurance doesn't address the barrier to access. Another Kenyan study suggested that in some cases, insurance might discourage timely use of health care services which causes severe implication for their health (Wang'ombe et al., 2002). Also, insurance is said to be aggressive in nature which is a major drawback in terms of use. Governments in other African countries prefer a flat rate contribution than the one based on income earnings. This shows that those that utilize the service do so with their money which doesn't encourage the use of insurance services. Most of the insurance plans are for employees in the formal sector. These employees mostly live in urban centres. However, large segments of the population working from the informal economic sector live in rural communities, making health insurance availability a tall order.

In a study done to analyse the feasibility of social health insurance in Uganda, it was found out that most prevailing conditions in Uganda may make the development of social health insurance (SHI) risky and difficult (Government of Uganda, 2001). It was observed that the problem was actually the revenue that would be used to support the programme. By estimation, in 1990/2000, total public expenditure was equal to 20.7% of the GDP while that of the total revenue was 11.9%. External budget supports 30% of the total government expenditure, therefore depending on external sources would create problem for the affordability and sustainability of the programme (The Republic of Uganda, 2000).

A review of funding sources indicates that about 43% of the total sources of revenue come from donors (internal and external), households contribute 34%, 3% from employers and 30% came from the government (Ugandan Ministry of Health, 2000). This shows that increasingly,



the Ugandan government is playing a smaller role in this area and yet at the same time has a wider mandate for promoting health services. This may explain why user fee was removed by the Ugandan government in 2001. The government's major source of revenue is from income tax where 27% is obtained from individuals in the private sector, and 16.5% is from civil servants (Government of Uganda, 2001).

About 91% of total donor contributions go mainly to finance primary health care, while over 58% of total government funding is allocated to the national referral hospitals serving 15% of the population (Government of Uganda, 2001). Uganda, like other African countries, faces similar problems with access. The utilization of services is reported to be low, especially among rural populations. They attribute these delays to transportation costs and the inability to pay for services. The quandary for most patients is that even though user fees have been abolished, the limited availability of drugs and the long delays and poor quality of service make virtually all users in practice pay for their own health more or less. This is seen in the roughly 30% of patients who self-treat themselves. Analysing the total revenue generated from user fees was about 3.6% of the total public health expenditure. Also, it has been argued that 'the lack of clear understanding of how social insurance fits into the overall health care financing strategy [has] led to the neglect of preventative and primary care services' (Government of Uganda, 2001).

Furthermore, evaluation shows that it would be difficult for civil servants to contribute their income/earnings to a new social health insurance scheme because they pay tax and at the same time not satisfied with the services they received. One major fear expressed by people was about the fact that they were not convinced that the money would be used appropriately because of their prior experiences with programmes like the retirement scheme, (National social security fund and national insurance company). What continuously appear to be useful in all of this is a policy of decentralization and the use of local resources in planning and financing health care.

Tanzania has a long history of state intervention in the financing of health services. From its socialist objectives of the 1960s, culminating in the Arusha declaration, the directive by the government has been that 'health services should be made available to all Tanzanians at no



cost to the people' (Tanzanian Ministry of Health, 1994). This was followed by the nationalization of hospitals and a ban on private medical practice in 1977. This was perceived by the government as a way to guarantee equity and access to health with no regard to income or geography.

The government reassessed its view of health care financing due to a decline in the economy of Tanzania. Therefore, user fee was introduced in 1993. This was considered as supplementing options by the government in order to finance health care services and also to ensure that health care is efficiently delivered. The user fee that was introduced at the district hospital had mixed results because it negatively influenced health care utilization. This mode of health care financing was introduced with limited understanding on willingness to pay and the household perception on health seeking behaviour (Hiza and Masanya, 1997).

A study was conducted in Tanzania to assess health insurance among civil servants, which was as a result of the bill which was passed to establish the National health insurance scheme for civil servants. It was anticipated that it would be phased in gradually starting with a small percentage of the public sector workers. The specific provisions under this act were that the scheme will be mandatory and will cover employees, spouses and children or legal dependants not exceeding four family members and contributions will come from both the employer (3%) and employee (3%) (Bituro, 1999). The idea of the health insurance scheme was considered by teachers to be sound though its implementation has been thwarted. For instance, it has been documented that some of the healthcare providers are unaware of this particular program and are not keenly aware of the existing payment models, leading to some providers not to treat patients without payment up front. Some of the users of the plan have also complained about the services provided and some are frustrated with the abuses that they have received from healthcare providers, including long delays and inferior services. As a result, an informant indicated that the system has not been popularized enough and it is most likely that the whole public insurance system will be done away with.

The primary health care approach seems to work in Tanzania and this was when community health fund (CHF) was introduced. The objectives was to improve the well being of all

Tanzanian focusing mainly on the population at risk in order to ensure that health services are responsive to the needs of the population (Tanzanian Ministry of Health, (1994).

The community health fund is a rural health financing in which a pre-determined amount of money cover health care services of house members. Experiences from other countries where CHF has been introduced suggest that community involvement in health care has been positive. Individual and community members report greater satisfaction with the services they received from these centers and generally believed that access to drugs has markedly improved. As reported by Hiza and Masanja (1997), the experience from Guinea Bissau suggest that the programme has been quite successful in addressing the key elements of equity, cost and accessibility. The specific forms included the provision of CHF cards for family members. This guaranteed their access to health services. In the CHF scheme, households members typically pay 5000 shillings per year. In Igunga district, the user fees for non-members is 1000 shillings per visit (Hemed, 1999). In the CHF scheme, exemptions of poor households are given by village committees.

In their evaluation of the programme in Igunga district where the scheme has been introduced, Hiza and Masanja (1997) reported that the scheme has made cheap prescription drugs widely available. The prepayment aspect of it made it worthwhile for families where employment was seasonal. Participants interviewed reported that the scheme was of great benefit to them. In terms of the limitations of the programme, they stressed that communities were not adequately informed about the benefits of the programme, leading to a reduced household participation of only 5%. Another concern raised was the fact that the scheme did not sufficiently address the problems of polygamous families. Since this family arrangement is a well-established practice, the scheme should have offered alternative payment arrangements for households as well. Another concern raised was the limited range of health services available to the participants and the restrictive use of services to only health centers and dispensaries. Another point mentioned was the timing of the programme. Since the premium cycle starts in July and ends in June, it did not allow for greater participation by other members of the community because of the short duration of coverage.

From the perspective of the Ministry of Health, the initial evaluation of community health financing programme suggests that the programme has been well received and that it has the

potential of meeting the clear objectives of the Tanzanian government in protecting the most vulnerable groups in society. The cost-sharing aspect has been deemed appropriate and the fees assessed are not too prohibitive to affect access.

Above all, patients have reported general satisfaction with the services provided, especially the availability of drugs. The involvement of the community in the design and implementation of the programme has given the community a sense of ownership.

Given the fact that about 75% of Tanzanians live in the rural areas, CHF has worked very well in addressing the problem of access. The lesson from Tanzania is that the government can create an enabling environment through its decentralization programmes and offer health resources to help communities meet the target of extending health services to the population.

The information gathering in the national health insurance scheme in Nigeria is one major problem that reflects on how care givers respond to emergencies, treatment and services in the health system. The information gathering of the NHIS is still not fully achieved and utilized to improve the quality of service. The present mode of registration of prospective members into the scheme in Nigeria is manually done. To register, one has to present his/her letter of employment and thereafter given a data caption form capturing the vital details about the person. The liaison officer resident in the health care centre collects the form and generates a temporary ID card which is used to assess health care temporarily until either minimum of 3 months or maximum of 6 months before a permanent ID card is issued. Most times it takes a year or two to get an ID card (Akwukwuma and Igodan, 2012).

In the NHIS system, there is little or no computerized system for the registration of patients in the hospital that would facilitate the processing of registration of patients for timely collection of NHIS permanent cards and also, patients cannot enjoy the benefits of the scheme in another hospital where they are not registered as NHIS patients. This is so because of the lack of a centralized information system (Akwukwuma and Igodan, 2012).

In Nigeria, it is a thing of concern that the Nigerian system allows private health care providers as major stakeholders despite the establishment of the national health insurance scheme. Public and private hospitals still operate on a fee for service basis for most of their clients. Also, long

queues are still usual sights while the issue of unavailability of required services still occur in NHIS approved hospitals. Furthermore, there are still weak and ineffective referral systems among health care providers (Onyedibe et al., 2012).

In a study done to evaluate the impact of the NHIS in northern Nigeria, respondents expressed their dissatisfaction over the terms of coverage of NHIS services as regards the number of people that can be enrolled in a family. This complaint was majorly from respondents with polygamous status (Umar et al., 2009). The NHIS's proxy definition of a family (husband, wife, and four biological children) may also lead to a perception of non-inclusiveness that the programme inherently disregards or disapproves of an accepted cultural or traditional feature of certain population subgroups. As a result, potential enrolees could view joining the NHIS as a threat to their way of life. This perception could precipitate resistance to enrolment, creating or increasing inequities in coverage. In the past, misconceptions about the insurance benefit package have caused potential enrolees to lose interest or become opposed to insurance scheme (Huber et al., 2002)

## **2.9 Satisfaction with NHIS**

Users' of health services play an important role in assessing and monitoring health care quality. This therefore enables them to express their preference and to choose among alternative strategies of care (Donabedian, 1987). Consumers also provide useful information in judging health care quality. Most importantly, consumers can pass a judgement about many aspects and process of care by expressing satisfaction or dissatisfaction about a service. Expectations of patients as values i.e. their expectation can be expressed as perceived needs, wants or standards (Kravitz, 1996). These expectations may pertain to health care in general or to a specific health care encounter such as a clinic visit or hospitalization. Patients' satisfaction measure is seen to be important in outcomes research and quality improvement efforts (Maxwell, 2001). This has a link to greater service utilization as well as risk management.

Patient satisfaction with care has been given considerable attention and this is important for many reasons because patient satisfaction can be viewed as a positive outcome of the care provided and they deserve to be satisfied with the services. It also gives health care providers

information about the process and outcome of care. It also helps to maximize an organization's quality of care it provides (Bell et al., 1997). To patients, the "appearance of environment and employees, reliability, dependability of service delivery, responsiveness, and competence, understanding the patient, access, courtesy, communication, credibility, and security" indicate quality care. Patient satisfaction also hinges on whether the "service experience meets consumer expectations" Bell., 1997.

Consequently, assessing patient satisfaction and quality care depends on the way in which quality care is defined. Data from patient satisfaction surveys are used to identify particular patient needs and develop interventions addressing those needs and priorities, thus enabling hospital administrators and clinicians to evaluate the services they provide.

Different dimensions of client satisfaction have been identified which ranges from admitting patients to when they are discharged. It also includes medical care and also interpersonal relationship. Major criteria include responsiveness, attitude, level of communication, physical skill, hospital amenities, food services etc. (Rubin, 1990; Rubin et al., 1990; Cleary et al., 1991; Carey and Seibert, 1993). Patients also assess hospitals based on interpersonal and technical skills of health care providers (Donabedian, 1988; Tokunaga et al., 2000). Studies showed that patient characteristics which include age and education may influence how patients assess the performance of a hospital (Larsen and Rootman, 1976; Hall and Dorman, 1990; Hargraves et al., 2001). Other predictor of patient's overall satisfaction level includes health status and the severity of illness (Cleary et al., 1991; Kane et al., 1997; Corinsky et al., 1998; Hargraves et al., 2001). The relationship between health care providers and patients (i.e. interpersonal skill) has been reported to be most influential factor for patient satisfaction (Hall and Dornam, 1990).

In most countries there is a lack of information for consumers of health services to choose a preferred health care provider. Also, personal channels of communication with relatives and friends are major source of information for people wishing to obtain details concerning hospital performance (Hibbard et al., 1997; Hsieh et al., 2000). Most times, recommendations from friends or family become a source of information for selecting health care providers.

Recommendation as well as satisfaction is based on personal experience concerning the services that one has received from health care providers (Rubin, 1990).

Studies have suggested that patient recommendation of a hospital should be analyzed. According to Burroughs et al, the most important factors that influences a patient's intention to recommend a provider or for that patient to return to the same provider includes respect, comfort, personal attention, etc. These findings are in agreement with previous studies which indicated that patient satisfaction is determined majorly by a health care provider's attitude and care rather than technical skills (Cleary and McNeil, 1988; Hall and Dorman, 1990). Also associated with this is the physician's care delivery which includes frequency of checking, skill and also explanation. This was associated with patient's recommendation or return.

According to Boudreaux et al., 2000, it was reported from their study that overall patient satisfaction and the likelihood of recommendation were influenced by respect, safety and understandable instructions. Also, the technical skills of the nurses and the waiting time were also associated with recommendation.

A study done in Taiwan revealed that there was an increase in the use of health care services among those who were formerly uninsured and this increase was at the same level with those who were previously insured (Cheng et, al. 1997). Also, with regards to quality of care, it was shown that it neither increased nor decreased since the implementation of the health insurance scheme. The scheme has not been able to influence the provision of high technology medicine. With regards to waiting time for care, no change has been reported to take place because it has not revealed any increase in waiting time for service (Health conduct reports, 2000).

Assessing the financial risk protection of those insured, it was reported that users of health insurance are well protected against uncertain medical expenses and it shows that out of pocket payments fell from 48% of the total amount spent on health care in 1993 to 30% in 2000.

Assessing the satisfaction with health insurance scheme few months after implementing the scheme, their satisfaction was low which was about 40% but it later rose to about 60% after a year. It has been fluctuating since then between 64% and 71% (Preker, 1998).

Assessing the impacts of health insurance on the health status of the study participants, it was found out that evaluating the impact of health insurance on health status was extremely

difficult. It was challenging finding the appropriate variable for measuring health status and to capture the changes in quality of life which can be related to improved access to services covered under the benefit packages. Also it was difficult to determine whether the observed differences in health status variables were as a result of health insurance. Therefore there was no concluding evidence on whether health insurance has an impact on health status.

Also, health insurance was found to greatly reduce the probability of incurring catastrophic expenditure. This result was significant for different thresholds, but the significance and the size of impact decreases as the percentage of income spent increases. Health insurance significantly reduces access barriers for employed individuals and their unmet needs reduced by 2%. It also reduced financial barriers to access by 14% among the employed.

Insurance increases the use of both formal curative health care and preventive services. It increased the likelihood of enrollees using formal care when ill by 57% among the employed and it reduced self medication by 28% among them (Pinto, 2008) With regards satisfaction with NHIS registration, a study done in Ghana showed that 100% reported they were either satisfied or very satisfied with their decision to register.

Although all respondents were satisfied, a number of issues were raised predominantly around the length of time taken to receive their NHIS card and that it did not cover all their health expenses. Health care utilization was also assessed and out of the 22 respondents who did not have NHIS registration there was a total of 13 visitations to health services. This is compared to the 55 participants who had NHIS registration who reported a total of 49 visitations to a health service. From this information it can be said that for every 100 people who have NHIS registration there will be 89 visits to a health service compared to every 100 people not registered with NHIS, there will only be 59 visits to a health service. It can therefore be said that people with NHIS are more likely to access health services than those without health insurance. This shows significant role in NHIS enhancing health service utilization (Abay and Johannes 2007).

In another Ghanaian study to evaluate the performance of NHIS in a household survey, individuals who were covered by NHIS were about three times as likely to report an illness in the past two weeks and were also more than twice more likely to report a chronic health



condition than the uninsured. Also, the patient exit survey data showed that NHIS enrolled patients were more than twice as likely to report a chronic illness, 28% of patients enrolled in NHIS reported such illness compared to 14% of the patients who were not enrolled. This result provides some indication of adverse selection into NHIS, whereby those with poorer health status were more likely to enroll than healthier individuals. Multivariate regression analyses indicated the likelihood of NHIS enrollment increased with education (Ghana health service, Annual report 2007).

In another study done in Ghana to assess citizen's assessment with the national health insurance scheme, it was found out that respondents ranked low cost of treatment as the most important benefit they have derived from the scheme. About 70% of them indicated that the scheme has made them to receive care at a low cost. Also, they (40%-45%) indicated the quality of care has improved as regards the availability of nurses and drugs, cleanliness of facility, and the staff attitude towards them while less than 40% of the respondents indicated the quality of the remaining components of health care provision has improved. As regards socioeconomic status, about 87% of the poorest 20% of household expressed great satisfaction with the scheme for providing affordable health care. In all, less than 50% of the respondents from the various income groups were satisfied with the emergency services they received under NHIS (Di McIntyre, 2007).

As regards availability of drugs at health facilities, majority of the respondents are of the opinion that drugs are now more available than before. Other respondents indicated that the health care they received under the scheme with regards to drugs given, quality and availability of drugs at the facilities have been worse. Of the respondents, about 50% perceive NHIS card holders receive better health care services than the non card holders while about 20% think otherwise. This implies in the opinion of the respondents that NHIS card holders are receiving better health care services than the non card holders irrespective of the location where they access NHIS services. However, some of the respondents believe the NHIS card holders receive the same quality of care as the non card holders (National Health Insurance Authority (NHIA) operations report, 2009).



As regards the overall performance of NHIS, it was rated high among the respondents as a good social protection intervention. The study suggested that about 92% of those insured with the scheme were either satisfied or very satisfied with the performance while 85.8% of those who were partially insured indicated they were either satisfied or very satisfied with the scheme. The level of satisfaction does not significantly vary with socio-economic status, as about 82% of the lowest 20% income group and 74.6% of the upper 20% income group were either satisfied or very satisfied with NHIS performance. When the respondents who indicated they were either satisfied or very satisfied with the scheme were requested to rank the aspect of the scheme which they were satisfied or very satisfied with, publicity emerged as the most important issue and nearly 84% of them indicated they were satisfied or very satisfied with the educational campaign. Other areas included registration of members (74.5%), accreditation of providers (70.4%), provision of exemptions (69.6%), collection of premium (69.4%), procedure of access to benefits (68.9%) and renewal of membership (61.5%) (NHIA operations report, 2009).

In Nigeria, a study done in Ilorin, Kwara State to assess the effect of NHIS on health care utilization, a total of 8,550 patients were seen at the University of Ilorin Teaching Hospital before the implementation of NHIS and 20,872 patients were seen after implementation. The age group with the highest frequency of attendance at the clinic before implementation was 0-10 years but it changed to 41-50 years after implementation. This observed difference was statistically significant. Malaria accounted for the highest number of cases with 7,241 (34.7%) patients after implementation (Akande et al., 2011).

A study conducted among registered staff of the Federal polytechnic, Idah, Kogi state shows that majority (86%) of the respondents have been accessing health care services from their health care providers and only 14% said they have not been accessing services from their providers. Sixty six percent of the respondents indicated a range visit of 1 to 2 times, 11% stated 3 to 4 times, 8% 5 times and above. Most of the ailments presented were those requiring fewer funds to handle. Respondents also indicated that the quality of service rendered by their health care providers, 48% rated the services to be poor due to absence of drugs, poor prescription and attention while 26% rated the services in terms of quality as high based on

good attention received, availability of drugs, timeliness and professionalism displayed by their providers. The attitude of the staff was rated to be substandard by 26% of the respondents and 48% indicated that health insurance has not improved their health status. Also, 46% reported that the scheme has not boosted their job satisfaction and 60% said there is no reduction in what they spend on medical services. Overall, 51% reported that the scheme should not be scrapped despite the negative impact on the users (Agba, 2010).

In a study done to assess civil servants' knowledge and attitude to the scheme, it was found out that about three quarter of respondents in the study fund their health care through personal or out of pocket expenses despite their enrolment and about one third were not satisfied with the present mode of payment. About two third of the respondents in the study believe that the present funding does not adequately cover all required expenses and not even all dependants. About 0.3% of the respondents have benefitted from the health insurance scheme, while a little over half are willing to participate in the scheme (Olugbenga-Bello and Adebimpe, 2010).

## **2.10 Factors associated with satisfaction with NHIS**

Patient satisfaction has been known to be important in determining and evaluating how the needs of patients are met by the health sector. Evaluating the factors affecting satisfaction would be useful for health care providers and planners to improve the quality of services rendered to patients (Ware et al., 1978; Kravitz, 2001; Crow et al., 2002). Studies showed that satisfaction reported by users of health services is influenced by patient related factor, health provider characteristics and health system structure (Sixma et al., 1998; Lancry et al., 2001; Murray et al., 2001). For instance, determining patient satisfaction with drug services and medication use does not only depend on symptom's resolution, the control of disease progression and prevention but it also depend on the route of administration, drug tolerability, trademark name and so on (Levy, 1992; Morris and Schulz 1993; Lundberg et al., 1998; Motheral and Henderson, 1999; Shikiar and Rentz, 2004). It has also been suggested that it is important to take into consideration how a health care system is structured and also the cultural factors when estimating patients' satisfaction (OECD, 1995; Del Banco, 1996; Kerssens et al., 2004).

According to the study done at ABU Zaria, the study showed that satisfaction with NHIS could be influenced by many factors which include marital status, awareness on contribution on the scheme, general knowledge about NHIS, duration of enrolment, hospital visits, staff duration in service, salary income, native language, religion, residence, educational level, occupation status, family size etc. According to the study done among formal sector workers at the Ahmadu Bello University, Zaria to determine their satisfaction with the Nigerian National Health Insurance Scheme showed that factors that positively influenced clients' satisfaction include staff duration in service and their level of income. Those that negatively influenced satisfaction include marital status, general knowledge, and awareness on contribution, hospital visits, and duration of enrolment. Some factors had no significant effect on satisfaction and this include family size, occupational status, residence, native language and religion (Mohammed, 2010).

What determines the use of health care services includes: incidence of illness, cultural, economic and demographic factors. The cultural demographic factors include age, marital status, education, etc (Collins et al., 2007). Economics factors include individual's level of income, price and time cost of receiving treatment.

In a study done to assess client's satisfaction with health insurance scheme in Nigeria, the client's experience as well as the factors influencing satisfaction was assessed. The study showed that of the respondents, those with longer length of employment were more satisfied than those with shorter length of employment. Also, there was no significant association between respondents' religion and satisfaction. Respondents with tertiary education (61.0%) were less satisfied while those below (52.0%) were more satisfied. Of the respondents, most of the senior staff (62.0%) were less satisfied while the junior staff were more satisfied. Polygamous status also influenced satisfaction where respondents with polygamous status were more satisfied compared to those with non polygamous status. There is also a significant difference in respondents' satisfaction with NHIS and length of enrolment. Fifty four percent of those with longer length of enrolment were more satisfied while those with shorter length of enrolment were less satisfied. Respondents' general knowledge of health insurance influenced satisfaction.

Those with less knowledge (75.0%) were less satisfied while those with more knowledge (70.0%) were more satisfied. Furthermore, respondents with less awareness to the monetary contribution in the health insurance (64.0%) were less satisfied while those with more awareness were more satisfied (70.0%). There was a significant difference in satisfaction ( $p=0.02$ ) with respondents' health condition. Also there was a significant association with respondents' hospital visits and satisfaction ( $p=0.007$ ). The factors that significantly influenced satisfaction with health service provision in the health insurance scheme includes marital status ( $p=0.05$ ), general knowledge of health insurance ( $p=0.001$ ), and awareness of monetary contribution ( $p=0.05$ ) (Mohammed et al., 2011).

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## CHAPTER THREE

### MATERIALS AND METHODS

#### 3.1 Study Area

The study area of this research is Ibadan, the largest city in West Africa and the capital city of Oyo state of Nigeria. It is some 145 km north eastwards from Lagos and is directly connected to many towns in Nigeria via its rural hinterland by a system of roads, railways and air route. Ibadan has one of the highest population densities in Nigeria. The total population of Ibadan was 2,258,625 inhabitants according to the 2006, census made up of 1,125,843 urban and 1,132,782 rural population sizes. The choice of Ibadan is as a result of the presence of government institutions and these (institutions) are the starting point of the implementation of the NHIS programme. The Federal Secretariat in Ibadan was the study area for this research. The Federal Secretariat consists of different ministries, Agencies, commissions and Para-military. Workers who have enrolled for the NHIS programme among the Federal workers at the secretariat were therefore recruited for this study.

#### 3.2 Study Population

The study participants' were civil servants at the Federal Secretariat, Ibadan. The total number of female workers constitutes about 46.4% of the entire population of the civil servants at the federal servants while the male population constitutes about 53.6%.

#### 3.3 Study design

A descriptive cross sectional design was carried out over a period of 4 weeks in the month of July, 2011. This study design was used in order to assess civil servants' satisfaction with the NHIS from different HMO and Health Care provider perspective. This was based on the fact that they would have different experiences from their providers, a factor which would help in assessing satisfaction.

#### 3.4 Sample size estimation

Sample size was estimated by using the formula for estimating sample size for single proportion.

$$N = \frac{Z^2 \alpha / 2 pq}{d^2}$$

N= sample size

$$Z^2 \alpha / 2 = 1.96$$

P= 42.5 (the satisfaction prevalence found in a study done in ABU Zaria among workers utilizing the NHIS Services)

$$Q = 100 - 42 = 57.5$$

D= Level of error put at 5% (95% confidence interval)

$$N = 376$$

### **3.5 Sampling strategy**

A total survey of civil servants at the Federal Secretariat, Ibadan who have been enrolled in the NHIS for at least one year were recruited for the survey. Respondents were first asked if they had enrolled on the scheme and if their enrolment is up to a year before they could take part in the survey.

### **3.6 Inclusion criteria**

Participants who were civil servants at the Federal Secretariat, Ibadan and had been enrolled in the health insurance scheme for at least a year before the survey was conducted were eligible for the study.

### **3.7 Exclusion criteria**

Participants who had not been enrolled in the scheme and are not civil servants at the Federal Secretariat was excluded. Also any staff that has not spent at least a year in his/her organization was excluded.

### **3.8 Data collection instrument**

The satisfaction questionnaire that was used for this study was adapted from a validated SERVQUAL questionnaire (Francis, 1996) which was then modified. Strongly agree was used to represent strongly satisfied, agree to represent satisfied, strongly disagree to represent strongly unsatisfied, disagree to represent unsatisfied while undecided remained undecided. The questionnaire was administered in English since the staff has the ability to read.

The questionnaire was pre- tested among staff of Federal Ministry of Agriculture and Rural Development (Nigerian Stored Products Research Institute in Ibadan) having similar categories of staff like the Federal Secretariat, Ibadan.

The questionnaires were self administered though supervised to minimize misinterpretation. The questionnaire was divided into two sections which include: Section A- civil servants' experiences with the NHIS, Section B- Satisfaction with drugs, services rendered, waiting time, staff attitude and NHIS as a whole.

### **3.9 Data collection method**

A semi structured self-administered questionnaire was administered to the study participants in their respective offices. In situations where a participant was not able to read or understand the questions properly, an interviewer administered technique was used. Clarifications were provided to those who required them.

### **3.10 Data management and statistical analysis**

The questionnaires were serially numbered for control, ease of identification and recall purposes. Data collected were cleaned, coded, compiled and properly recorded for ease of retrieval and this was done on daily basis to forestall the occurrence of missing data as the questionnaires were collected. At the end of the whole process of data collection, data were checked for completeness and accuracy. The health care provider service areas such as drug availability and waiting time were rated using a 5- point Likert scale.

For satisfaction with drugs, each question was scored. Respondents who scored 5 and above were said to have had overall satisfaction with drugs. For satisfaction with HCF services, each questions were scored and respondents who 4 and above were said to have had good overall satisfaction with HCF services. Also, for satisfaction with waiting time, each question was scored and respondents who scored 3 and above were said to have had overall satisfaction with waiting time. For satisfaction with staff attitude, each question was also scored and respondents who scored 6 and above were said to have overall satisfaction. Overall satisfaction was determined by scoring the entire satisfaction domain. Respondents who scored 19 and above were said to have had overall satisfaction with the service areas.

The satisfaction rating for different aspects of NHIS which includes respondent's choice of health care provider and registration/enrolment ranged from 1 to 5 and was dichotomized such that those who scored below 2 were classified as not satisfied and those who scored 3 and above were classified as satisfied. The Chi-square and binary logistic regression test analyses were used 5% level of significance.

### **3.11 Ethical consideration**

Approval was sought and obtained from the University of Ibadan/ University College Hospital (UI/UCH) ethical review board before the study was conducted. Strict confidentiality was maintained with the information gathered and there was no means of identification on the questionnaire by the respondents. The study also did not involve any invasive study as blood samples were not collected. The aim of the study is to help improve NHIS service provision.



## CHAPTER FOUR

### RESULTS

#### 4.1 Socio-Demographic Characteristics

Four hundred and seventeen (417) questionnaires were administered to participants who had enrolled in the NHIS for at least one year preceding the study and 380 questionnaires were returned completed giving a response rate of 91.0%. Age of the respondents was  $42.5 \pm 8.0$  years. Table 4.1 shows that 114 respondents (32.7%) were aged between 35 and 44 years, while 153 (43.8%) were aged between 45 and 54 years. Two hundred (52.8%) respondents were males, while 179 (47.2%) were females. Two hundred and ninety one (77.0%) respondents were Christians, while 87 (23.0%) were Muslims. Three hundred and thirty two (88.1%) respondents were Yoruba, while the remaining were either Igbo 20 (5.3%), Hausa or Edo 25 (6.6%).

Three hundred and fifteen (83.3%) respondents were married, 46 (12.2%) were single, while 17 (4.5%) were either widowed or divorced. Three hundred and twenty six (85.3%) respondents had tertiary education, 44 (11.5%) had completed primary and secondary education, while 12 (3.2%) had a higher degree. Respondents' number of children ranged between 1 and 2 (77, 24.7%), 3 and 4 (193, 61.9%), while others had between 5 and 6 (42, 13.4%). Respondents' duration in service included those that had spent between 1 and 5 years (71, 18.9%), 6 and 10 years (78, 20.8%), while (66, 17.6%) had spent between 16 and 20 years. Of the respondents, 115 (31.4%) were between grades level 5 and 7, 179 (48.9%) were between level 8 and 10, 50 (13.7%) were between level 11 and 13, while 22 (6.0%) were between level 14 and 16.

#### 4.2 Respondents' experiences with NHIS

The respondents' experience with NHIS is presented in table 4.2. Fifty two (15.7%) respondents had enrolled in the scheme between 1 and 2 years, 60 (18.2%) between 3 and 4 years and 218 (66.1%) for more than 5 years before the study was conducted. Forty five (11.9%) respondents enrolled more than once, while 332 (88.1%) enrolled once. Of the respondents that enrolled more than once, 41 (95.3%) had enrolled twice, while 2 (4.7%)

enrolled more than twice. Seventy-two (21.1%) respondents received their NHIS number in less than six months after their enrolment, while 270 (78.9%) received theirs after six months following enrolment. Also, 62 (18.1%) respondents received their NHIS cards in less than six months, 254 (74.3%) received their cards after six months of enrolment, while others 26 (7.6%) were yet to receive theirs. Of the respondents, (116, 42.8%) had between 1 and 2 of their dependants enrolled on the scheme, while others had between 3 and 4 (124, 45.8%), 5 and 6 (31, 11.4%) of their dependants enrolled on the scheme.

One hundred and twenty six (34.2%) respondents reported to have had the cause to enroll new dependants, while 242 (65.8%) have not had the cause. Of those that have had the cause to enroll other dependants, 47 (37.3%) were able to enroll them, while 79 (62.7%) reported difficulty in enrolling their new dependants.

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**Table 4.1. Socio-Demographic characteristics of the Respondents**

<b>Variable</b>	<b>Frequency</b>	<b>%</b>
<b>Age group(years)</b>		
25-34	71	20.3
35-44	114	32.7
45-54	153	43.8
≥ 55	11	3.2
<b>Sex</b>		
Male	200	52.8
Female	179	47.2
<b>Religion</b>		
Christianity	291	77.0
Islam	87	23.0
<b>Tribe</b>		
Yoruba	332	88.1
Igbo	20	5.3
Hausa/Edo	25	6.6
<b>Marital status</b>		
Single	46	12.2
Married	315	83.3
Widowed/Divorced	17	4.5
<b>Level of Education</b>		
Primary and Secondary	44	11.5
Tertiary	326	85.3
Higher Degree	12	3.2
<b>Number of children</b>		
1-2	77	24.7
3-4	193	61.9
5-6	42	13.4
<b>Duration in service (years)</b>		
1-5	71	18.9
6-10	78	20.8
11-15	48	12.8
16-20	66	17.6
21-25	61	16.3
26+	51	13.6
<b>Grade Level</b>		
5-7	115	31.4
8-10	179	48.9
11-13	50	13.7
14-16	22	6.0

**Table 4.2. Respondents' experiences with NHIS**

<b>Variable</b>	<b>Frequency</b>	<b>%</b>
<b>Number of years of Enrolment</b>		
1-2	52	15.7
3-4	60	18.2
5+	218	66.1
<b>Filled registration form more than once</b>		
Yes	45	11.9
No	332	88.1
<b>Number of times form was filled</b>		
Twice	41	95.2
More than twice	2	4.7
<b>Length of time to collect registration number</b>		
< 6 months	72	21.1
≥ 6 months	270	78.9
<b>Length of time to collect registration card</b>		
< 6 months	62	18.1
≥ 6 months	254	74.3
Not yet received	26	7.6
<b>Number of dependants on the scheme</b>		
1-2	116	42.8
3-4	124	45.8
5-6	31	11.4
<b>Opportunity to register additional dependant</b>		
Yes	126	34.2
No	242	65.8
<b>Have you been able to register them</b>		
Yes	47	37.3
No	79	62.7

### 4.3 Utilization of Health Care Provider (HCP) Services

Two hundred and eighty three (76.3%) respondents chose private health facilities to receive NHIS services, while 88 (23.7%) chose public health facilities (Table 4.3 and 4.4). Of the respondents, 333 (87.6%) reported to have used the services provided by their health care providers, while 47 (12.4%) reported not to have used it. About half of the respondents, 93 (46.3%) reported to have used it monthly, 3 (1.5%) used it every 2 months, 19 (9.5%) used it once in 3 months, 29 (14.4%) used it twice in a year, 26 (12.9%) used it thrice in a year and 31 (15.4%) used it once in a year. Among those who have ever used their provider services, 240 (72.1%) had used the NHIS service between 6 and 11 months before the study was conducted. The reasons for which NHIS service was sought among the respondents indicated that 201 (52.9%) of them were treated for malaria, while other services sought included, medical check up (22, 5.8%), blood pressure check (22, 5.8%), dental care (11, 2.9%), child delivery (10, 2.6%), ear care (3, 0.8%), and eye care (2, 0.5%).

Few of the respondents, 29 (7.6%) sought other services. As regards referral, 4 (5.8%) were referred to state hospitals, 5 (7.3%) to general hospitals, 19 (27.5%) to private hospitals, 39 (56.5%) to federal hospitals, while 2 (2.9%) were referred to other facilities. Ninety three (28.0%) of the respondents reported to have changed their health care providers, while others 239 (72.0%) did not change. Of the respondents, 33 (37.5%) changed their health care provider due to poor services they had received from their providers, 32 (36.4%) due to distance to the health facility, while 23 (26.1%) changed due to transfer from their previous work location. The change of health care provider process took 51 (87.9%) of the respondents between 7 and 24 months before change was effected while it took 7 (12.1%) about 6 months to get it effected. Fifty two (22.0%) respondents reported that they would like to change their health care provider in future, where 30 (62.5%) would change due to the poor services they were receiving in their health facilities, 13 (27.1%) would change due to distance to their health facility and 5 (10.4%) would change due to transfer. Of the respondents, 47 (12.4%) had not accessed NHIS service since enrolment.

**Table 4.3. Utilization of Health Care Providers (HCP) Services**

<b>Variables</b>	<b>Frequency</b>	<b>%</b>
<b>Type of HCP used</b>		
Private	283	74.5
Public	88	23.2
<b>Ever used HCP services</b>		
Yes	333	87.6
No	47	12.4
<b>Frequency of use</b>		
Monthly	93	24.5
Every two months	3	0.8
Quarterly/once in 3 months	19	5.0
Twice in a year	29	7.6
Thrice in a year	26	6.8
Once a year	31	8.2
<b>Last time service was used</b>		
< 6 months	20	5.2
6-11 months	240	63.2
≥ 11 months	31	8.2
<b>Service sought</b>		
Treatment of Malaria	201	52.9
Blood pressure check	22	5.8
Medical Check-up	22	5.8
Dental services	11	2.9
Child delivery	10	2.6
Ear treatment	3	0.8
Eye treatment	2	0.5
Others	29	7.6

**Table 4.4. Utilization of Health Care Provider Services (Cont'd)**

<b>Variables</b>	<b>Frequency</b>	<b>%</b>
<b>Referred Facility</b>		
General Hospital	9	13.1
Private Hospital	19	27.5
Federal Hospital	39	56.5
Others	2	2.9
<b>Ever changed HCP</b>		
Yes	93	28.0
No	239	72.0
<b>Reasons for change</b>		
Transfer	23	24.7
Distance	32	34.4
Poor services	33	35.5
<b>Length of time to change HCP</b>		
≤ 6 months	7	7.5
≥ 7 months	51	54.8
No response	35	37.6
<b>Would like to change HCP in future</b>		
Yes	52	22.0
No	184	78.0
<b>Reasons</b>		
Transfer	5	10.4
Distance	13	27.1
Poor services	30	62.5

## **4.4 Satisfaction with NHIS**

### **4.4.1 Satisfaction with NHIS drug services**

Two hundred and forty six (77.1%) respondents were satisfied with NHIS drug availability at their various hospitals, while 73 (21.9%) were not satisfied (Table 4.5). Of the respondents, 243 (78.1%) were satisfied with the pharmacist's compliance with the doctor's prescription of drugs, while 68 (21.9%) were not satisfied. Most of the respondents, 243 (80.5%) were satisfied with the drugs prescribed to them by the doctor, while 59 (19.5%) were not satisfied. Of the respondents, 127 (42.1%) were satisfied with the 10% co-payment of drugs, while 175 (57.9%) were not satisfied.

Few respondents, 141 (50.4%) were satisfied with the generic drug authorized by NHIS to be given to patients, while 139 (49.6%) were not satisfied. Of the respondents, 262 (83.4%) were satisfied with the pharmacist's explanation on drug use, while 52 (16.6%) were not satisfied. Few of the respondents, 133 (46.8%) were satisfied with the pharmacist's explanation on unavailability of drugs, while 151 (53.2%) were not satisfied. Two hundred and twenty five (81.5%) respondents were satisfied with the pharmacist's attitude towards them, while 51 (18.5%) were not satisfied.

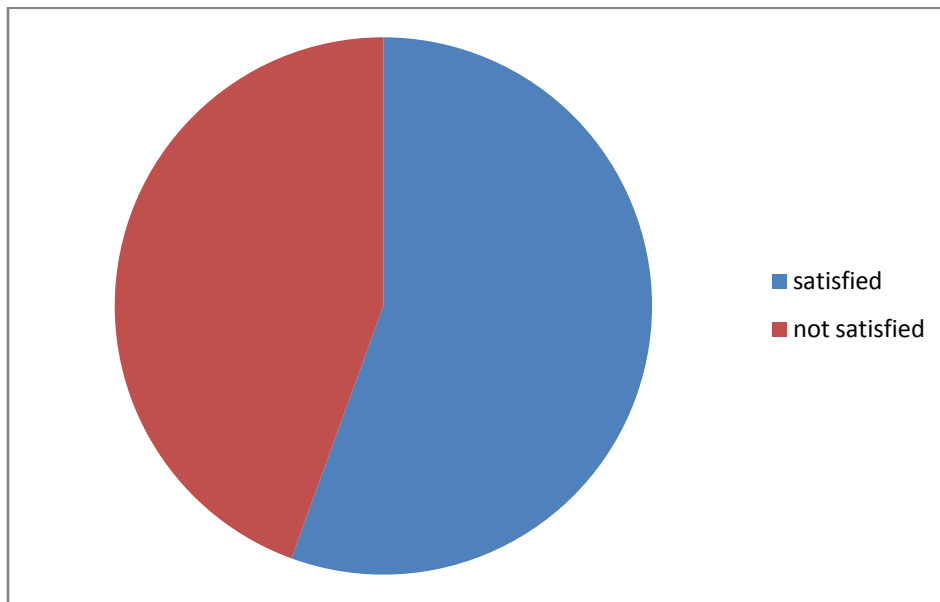
Overall, 185 (55.6%) of the respondents were satisfied with NHIS drug services while 148 (44.4%) were not satisfied. See table 4.6 below.



**Table 4.5. Respondents' responses with regards to NHIS drug services**

<b>Items</b>	<b>Satisfied</b>	<b>Not satisfied</b>	<b>Total</b>
Satisfaction with Drug availability at the hospital	246 (77.1%)	73 (22.9%)	319
Satisfaction with Pharmacist's compliance with the doctor's prescription of drugs.	243 (78.1%)	68 (21.9%)	311
Satisfaction with Doctor's prescription of drugs for your ailment	243 (80.5%)	59 (19.5%)	302
Satisfaction with the 10% co-payment of drug	127 (42.1%)	175 (57.9%)	302
Satisfaction with the generic drug authorized by NHIS to be given to patients	141 (50.4%)	139 (49.6%)	280
Satisfaction with Pharmacist's explanation on drug usage	262 (83.4%)	52 (16.6%)	314
Satisfaction with Pharmacist's explanation on unavailability of drugs	133 (46.8%)	151 (53.2%)	284
Satisfaction with the Pharmacist's attitude	225 (81.5%)	51 (18.5%)	276

**Figure 1. Respondents' satisfaction with drug services**



#### **4.4.2 Satisfaction with health care provider services**

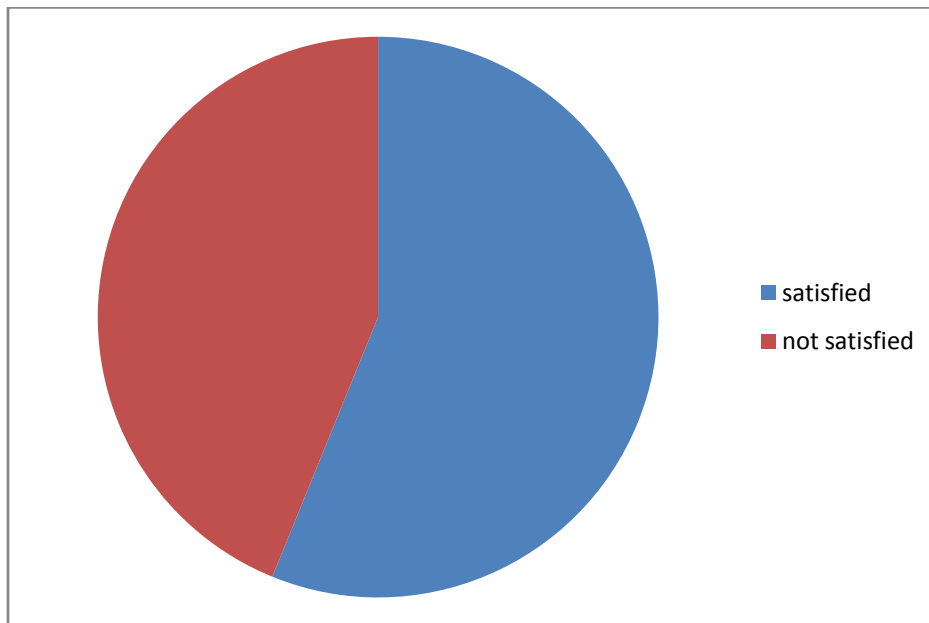
Most of the respondents, 225 (72.8%) were satisfied with the facilities available for treating patients at their various hospitals, while 84 (27.2%) were not satisfied (Table 4.7). Of those who were satisfied, 220 (87.0%) were satisfied with staff being readily available in their hospitals, while 33 (13.0%) were not satisfied. Two hundred and forty (86.6%) respondents were satisfied with staff's knowledge of treating patients, while 37 (13.4%) were not satisfied. A little over half of the respondents, 174 (56.9%) were satisfied with NHIS patients being treated well, while 132 (43.1%) were not satisfied. Some of the respondents, 160 (54.6%) were satisfied with the quality of service that was rendered to them at their hospitals, while 133 (45.4%) were not satisfied. Few of the respondents, 31 (10.2%) were satisfied with the hospital's improvement in rendering quality health services, while 272 (89.8%) were not satisfied.

Overall, 187 (56.2%) of the respondents were satisfied with the services they received from their health care providers, while 146 (43.8%) were not satisfied. See table 4.8 below.

**Table 4.6. Satisfaction with health care provider services**

<b>Items</b>	<b>Satisfied</b>	<b>Not satisfied</b>	<b>Total</b>
Satisfaction with the Facilities available for treating patients	225 (72.8%)	84 (27.2%)	309
Satisfaction with Staff's availability at the hospital	220 (87.0%)	33 (13.0)	253
Satisfaction with Staff's knowledge of treating patients	240 (86.6%)	37 (13.4%)	277
Satisfaction with treatments given to NHIS patients	174 (56.9%)	132 (43.1%)	306
Satisfaction with the quality of services rendered to NHIS patients	160 (54.6%)	133 (45.4%)	293
Satisfaction with the hospital's improvement in rendering health services	31 (10.2%)	272 (89.8%)	303

**Figure 2. Respondents' satisfaction with health care provider services**



#### **4.4.3 Satisfaction with waiting time**

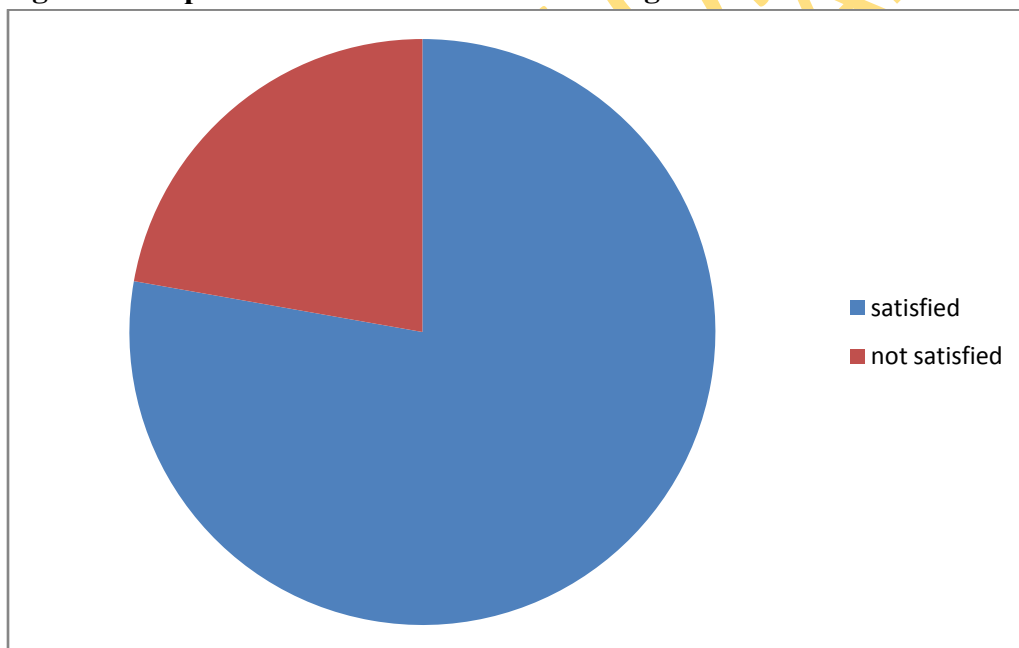
Majority, 305 (94.4%) were satisfied with the hospital's opening hour, while 18 (5.6%) were not satisfied (Table 4.9). Of the respondents, 210 (68.2%) were satisfied with the waiting time before receiving care, while 98 (31.8%) were not satisfied. Most of the respondents, 219 (80.2%) were satisfied with the waiting time before receiving emergency care, while 54 (19.8%) were not satisfied. Vast majority of the respondents, 281 (90.6%) were satisfied with the hospital's waiting room, while 29 (9.4%) were not satisfied.

Overall, 259 (77.8%) of the respondents were satisfied with their waiting time to receive NHIS service, while 74 (22.2%) were not satisfied. See table 4.10 below.

**Table 4.7. Satisfaction with waiting time**

Items	Satisfied	Not satisfied	Total
Satisfaction with the Hospital's opening hour	30(94.4%)	18(5.6%)	323
Satisfaction with waiting time before receiving care	210(68.2%)	98(31.8%)	308
Satisfaction with waiting time before receiving emergency care	219(80.2%)	54(19.8%)	273
Satisfaction with the comfort level of the Hospital's waiting room	281(90.6%)	29(9.4%)	310

**Figure 3. Respondents' satisfaction with waiting time**



#### 4.4.4 Satisfaction with staff attitude

Two hundred and sixty four (85.4%) respondents were satisfied with the receptionist politeness, while 45 (14.6%) were not satisfied (Table 4.11). Most of the respondents, 282 (89.2%) were satisfied with the doctor's questions of their symptoms, while 34 (10.8%) were not satisfied. Of the respondents, 279 (90.3%) were satisfied with the attention paid to them by the doctor, while 30 (9.7%) were not satisfied. Most of the respondents, 261 (87.0%) were satisfied with the way they were put at ease when they were receiving treatment, while 39 (13.0%) were not satisfied. Some of the respondents, 176 (61.8%) were satisfied with the time the doctor spent with them, while 109 (38.2%) were not satisfied.

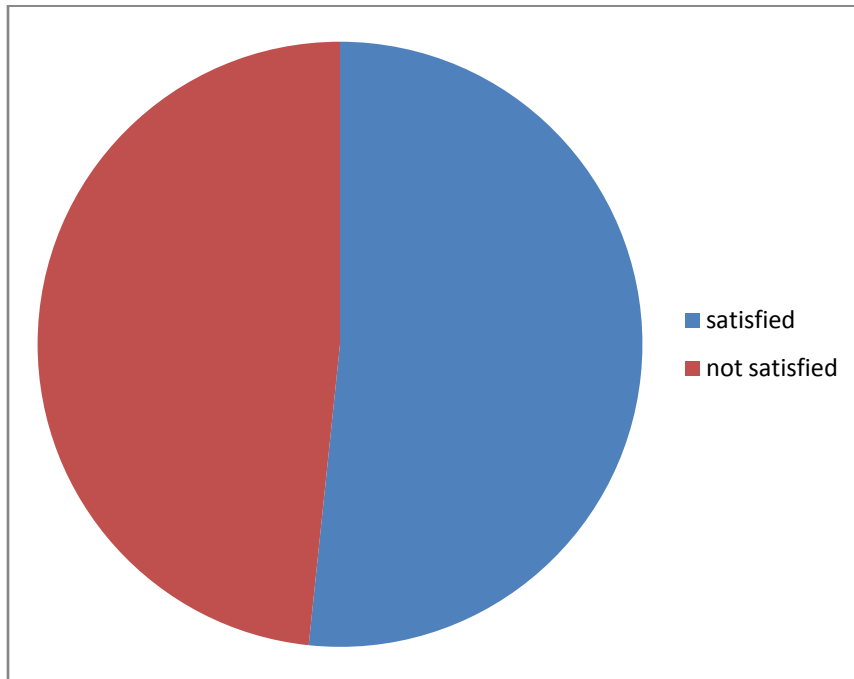
Of the respondents, 273 (89.8%) were satisfied with the patience the doctor had with their questions and worries, while 31 (10.2%) were not satisfied. Vast majority, 252 (91.0%) were satisfied with the doctor's caring attitude, while 25 (9.0%) were not satisfied. Few of the respondents, 27 (9.1%) were satisfied with the attention paid to their privacy, while 270 (90.9%) were not satisfied. Of the respondents, 150 (51.7%) were satisfied with the advice given to them on how to stay healthy and avoid illness, while 140 (48.3%) were not satisfied because they were rarely given advice on how to stay healthy.

Overall, 172 (51.7%) of the respondents were satisfied with staff attitude, while 161(48.3%) were not satisfied. See table 4.12 below.

**Table 4.8. Satisfaction with staff attitude**

<b>Items</b>	<b>Satisfied</b>	<b>Not satisfied</b>	<b>Total</b>
Satisfaction with the receptionist's politeness	264(85.4%)	45(14.6)	309
Satisfaction with the Doctor's questions on your symptoms	282(89.2%)	34(10.8%)	316
Satisfaction with the attention paid to you by the doctor	279(90.3%)	30(9.7%)	309
Satisfaction with the ease at which the doctor put you during treatment	261(87.0%)	39(13.0%)	300
Satisfaction with the time the doctor spent with you	176(61.8%)	109(38.2%)	285
Satisfaction with the Doctor's patience with your questions and worries	273(89.8%)	31(10.2%)	304
Satisfaction with the Doctor's care and concern for you	252(91.0%)	25 (9.0%)	277
Satisfaction with the attention paid to your privacy when receiving care	27(9.1%)	270(90.9%)	297
Satisfaction with the Doctor's advice on ways to avoid illness and stay healthy	150(51.7%)	140(48.3%)	290

**Figure 4. Respondents' satisfaction with staff attitude**



#### **4.5 Satisfaction with NHIS**

Less than half of the respondents, 148 (45.3%) were satisfied with the NHIS registration and enrolment processes, while 179 (54.7%) were not satisfied (Table 4.13). Of the respondents, 161 (49.5%) were satisfied with the range of services covered under NHIS, while 164 (50.5%) were not satisfied. Some of the respondents, 214 (66.0%) were satisfied with their choice of health care provider, while 110 (34.0%) were not satisfied. Of the respondents, 120 (37.9%) were satisfied with the 10% co-payment plan for NHIS drugs, while 197 (62.1%) were not satisfied. Over half of the respondents, 166 (58.7%) were satisfied with the NHIS referral system, while 117 (42.3%) were not satisfied. Less than half of the respondents, 129 (44.6%) were satisfied with the change of health care provider processes, while 160 (55.4%) were not satisfied. Majority of the respondents, 271 (83.6%) of the respondents were satisfied with NHIS, while 53 (16.4%) were not satisfied with the scheme.

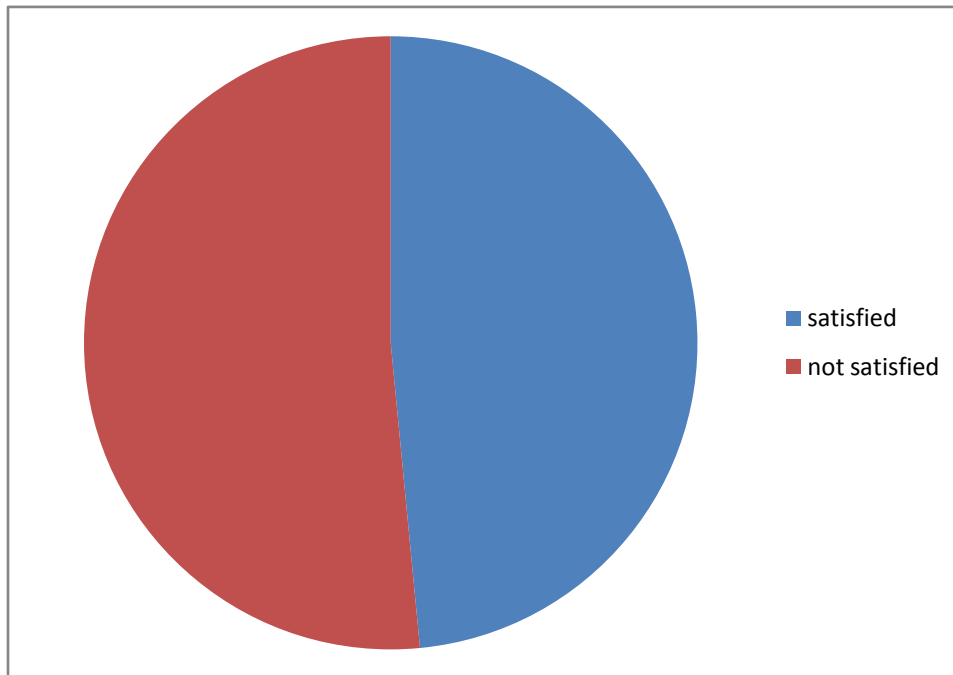
Of the respondents, 169 (51.5%) were satisfied with NHIS as a Scheme while 159 (48.5%) were not satisfied. See table 4.14 below.



**Table 4.9. Satisfaction with NHIS**

<b>Items</b>	<b>Satisfied</b>	<b>Not satisfied</b>	<b>Total</b>
Registration/ Enrolment	148(45.3%)	179(54.7%)	327
Range of services	161(49.5%)	164(50.5%)	325
Choice of HCP	214(66.0%)	110(34.0%)	324
Co-payment plan	120(37.9%)	197(62.1%)	283
The referral system	166(58.7%)	117(42.3%)	283
Change of HCP process	129 (44.6%)	160(55.4%)	289
The overall Scheme	271(83.6%)	53(16.4%)	324

**Figure 5. Satisfaction with NHIS**



#### **4.6 Association between NHIS drug services and Socio-demographic characteristics**

The association between NHIS drug services and respondents' age showed that 65 (63.1%) of the respondents between age 35 and 44 years were satisfied than those in other age groups ( $p > 0.05$ ) (Table 4.15). Also, males 100 (57.5%) were satisfied with drug services than the females 85 (53.5%) ( $p > 0.05$ ). Respondents from other tribes i.e. Hausa or Edo, 14 (58.3%) were satisfied than respondents who were Yoruba 165 (56.3%) and Igbo 5 (33.3%) ( $p > 0.05$ ). The respondents who belonged to other marital groups i.e. Widowed/Divorced 8 (61.5%) showed higher level of satisfaction than the singles 14 (43.8%) and the married 162 (61.5%) ( $p > 0.05$ ).

The association between NHIS drug services and respondents' religion showed that respondents who were Christians 149 (58.0%) were satisfied than those who were Muslims 35 (46.7%) ( $p > 0.05$ ). Respondents with tertiary education 162 (56.4%) were also satisfied with drug services than those who had just primary and secondary education 18 (47.4%) ( $p > 0.05$ ).

Respondents with a family size of between 1 and 2 persons, 44 (64.7%) were satisfied than those with a family size of between 3 and 4 persons (98, 54.4%), and between 5 and 6 persons (160, 56.1%) ( $p > 0.05$ ). Respondents with grade level between 14 and 16 (17, 81.0%) were satisfied than those between grade level 5 and 7 (57.7%), 8 and 10 (53.2%), 11 and 13 (59.1%) ( $p > 0.05$ ). Respondents who used the private facilities, 149 (56.4%) were satisfied than those who used the public facilities 36 (52.2%) ( $p > 0.05$ ).

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**Table 4.10. Association between NHIS drug service satisfaction and Socio-demographic characteristics**

Variables	satisfied (%)	Not satisfied (%)	Total	$\chi^2$	p-value
<b>Age group (years)</b>					
25-34	23(43.4)	30(56.6)	53(100)	5.49	0.06
35-44	65(63.1)	38(36.9)	103(100)		
45+	85(55.6)	68(44.4)	153(100)		
<b>Sex</b>					
Male	100(57.5)	74(42.5)	174(100)	0.54	0.46
Female	85(53.5)	74(46.5)	159(100)		
<b>Tribe</b>					
Yoruba	165(56.3)	128(43.7)	293(100)	3.14	0.21
Igbo	5(33.3)	10(66.7)	15(100)		
Others	14(58.3)	10(41.7)	24(100)		
<b>Marital status</b>					
Single	14(43.8)	18(56.3)	32(100)	2.08	0.35
Married	162(56.4)	125(43.6)	287(100)		
Others	8(61.5)	5(38.5)	13(100)		
<b>Religion</b>					
Christianity	149(58.0)	108(42.0)	257(100)	3.0	0.83
Islam	35(46.7)	40(53.3)	75(100)		
<b>Level of Education</b>					
Primary& secondary	18(47.4)	20(52.6)	38(100)	1.11	0.29
Tertiary	287(100)	162(56.4)	125(43.6)		
<b>Family size</b>					
1-2	44(64.7)	24(35.3)	68(100)	3.08	0.21
3-4	98(54.4)	82(45.6)	180(100)		
5-6	160(56.1)	125(43.9)	37(100)		
<b>Grade level</b>					
5-7	56(57.7)	41(42.3)	97(100)	5.96	0.11
8-10	84(53.2)	74(46.8)	158(100)		
11-13	26(59.1)	18(40.9)	44(100)		
14-16	17(81.0)	4(19.0)	21(100)		
<b>Type of HCP</b>					
Private	149(56.4)	115(43.6)	264(100)	0.4	0.53
Public	36(52.2)	33(47.8)	69(100)		

#### **4.7 Association between HCP service satisfaction and socio-demographic characteristics**

The association between health care provider services and respondents' age showed that those who were 45 years and above (91, 69.5%) were satisfied than those aged between 25 and 34 years (28, 52.8%), 35 and 44 years (57, 55.3%) ( $p > 0.05$ ) (Table 4.16). The male respondents, 101 (58.0%) were satisfied with their health care provider services than the females, 86 (54.1%) ( $p > 0.05$ ). Of the respondents, those who were Christians, 145 (56.4%) were satisfied than the Muslim respondents 41 (44.7%) ( $p > 0.05$ ).

The respondents who belonged to other tribes, 15 (62.5%) were satisfied with the services they received than the Yoruba 162 (55.3%) and Igbo respondents 9 (60.0%) ( $p > 0.05$ ). Also, the respondents who belonged to other marital groups, 10 (76.9%) were satisfied than the single 16 (50.0%) and the married 160 (55.7%) ( $p > 0.05$ ). Respondents whose family size was between 1 and 2 persons (41, 60.3%) were satisfied compared to those who had between 3 and 4 persons (95, 52.8%), and between 5 and 6 persons (22, 59.5%) ( $p > 0.05$ ).

Of the respondents, those who had tertiary education, 168 (58.5%) were satisfied compared to those who had completed primary and secondary education 16 (42.1%) ( $p = 0.05$ ). The respondents who registered at the beginning of the programme in 2005 (86, 61.4%) were satisfied than those who registered afterwards i.e. 2006 (34, 56.7%), 2007 (15, 46.9%), 2008 (13, 54.2%), and 2009 (15, 44.1%) ( $p > 0.05$ ).

Respondents who used their health care provider services within year 2005 and 2009, (14, 70.0%) were satisfied compared to those who used it afterwards i.e. between January-June 2010 (12, 52.2%), July-December 2010 (36, 42.4%) and January-March 2011 (84, 64.1%) ( $p < 0.05$ ). The respondents who chose and received care in a public facility, 47 (68.1%) were satisfied than those who chose and received care in a private facility 140 (53.0%) ( $p < 0.05$ ).

**Table 4.11. Association between HCP services and socio-demographic**

<b>Variables</b>	<b>satisfied (%)</b>	<b>not satisfied (%)</b>	<b>Total</b>	<b>x<sup>2</sup></b>	<b>p-value</b>
<b>Age group (years)</b>					
25-34	28(52.8)	25(47.2)	53(100)	0.89	0.64
35-44	57(55.3)	46(44.7)	103(100)		
45+	91(69.5)	3(40.5)	153(100)		
<b>Sex</b>					
Male	101(58.0)	73(42.0)	174(100)	0.53	0.46
Female	86(54.1)	73(45.9)	159(100)		
<b>Religion</b>					
Christianity	145(56.4)	112(43.6)	257(100)	0.72	0.78
Islam	41(44.7)	34(45.3)	75(100)		
<b>Tribe</b>					
Yoruba	162(55.3)	131(44.7)	293(100)	0.56	0.75
Igbo	9(60.0)	6(40.0)	15(100)		
Hausa/Edo	15(62.5)	9(37.5)	24(100)		
<b>Marital status</b>					
Single	16(50.0)	16(50.0)	32(100)	2.78	0.25
Married	160(55.7)	127(44.3)	287(100)		
Widowed/divorced	10(76.9)	3(23.1)	13(100)		
<b>Family size</b>					
1-2	41(60.3)	27(39.7)	68(100)	1.41	0.49
3-4	95(52.8)	85(47.2)	180(100)		
5-6	22(59.5)	15(40.5)	37(100)		
<b>Level of education</b>					
Primary & secondary	16(42.1)	22(57.9)	38(100)	3.68	0.05
Tertiary	168(58.5)	119(41.5)	287(100)		
<b>Year of registration</b>					
2005	86(61.4)	54(38.6)	140(100)	5.21	0.39
2006	34(56.7)	26(43.3)	60(100)		
2007	15(46.9)	17(53.1)	32(100)		
2008	13(54.2)	11(45.8)	24(100)		
2009	15(44.1)	19(55.9)	34(100)		
<b>Last time services was used</b>					
Before 2010	14(70.0)	6(30.0)	20(100)	3.76	0.01
Jan-Jun 2010	12(52.2)	11(47.8)	23(100)		
Jul-Dec 2010	36(42.4)	49(57.6)	85(100)		
Jan –Mar 2011	84(64.1)	47(35.9)	131(100)		
<b>Type of HCP</b>					
Private	140(53.0)	124(47.0)	264(100)	5.17	0.02
Public	47(68.1)	22(31.9)	69(100)		

#### **4.8 Association between waiting time satisfaction and socio-demographic characteristics**

The association between waiting time and respondents' age showed that those who were aged between 35 and 44 years, (83, 80.6%) were satisfied compared to those in other age groups i.e. 25 and 34 years (42, 79.2%), and 45 years and above (115, 75.2%) ( $p > 0.05$ ) (Table 4.17). The female respondents, 127 (79.9%) were satisfied than males 132 (75.9%) ( $p > 0.05$ ). The Muslim respondents, 61 (81.3%) were satisfied with waiting time than the Christians 197 (76.7%) ( $p > 0.05$ ).

Of the respondents, the singles 25 (78.1%) were satisfied than the married, 224 (78.0%) and those in other groups 10 (76.9%) ( $p > 0.05$ ). The respondents who had just primary and secondary education, 33 (86.8%) were satisfied compared to those with tertiary education 220 (76.6%) ( $p > 0.05$ ).

The respondents who were Yoruba, 233 (79.5%) were satisfied than the Igbos, 10 (66.7%) and those who belonged to other tribes 15 (62.5%) ( $p > 0.05$ ). Respondents between grade level 5 and 7 (77, 79.4%) were satisfied than those in other levels i.e. 8 and 10 (125, 79.1%), 11 and 13 (31, 70.5%), 14 and 16 (16, 76.2%) ( $p > 0.05$ ).

Those who registered at the inception of the programme in 2005 (63, 90.0%) were satisfied with waiting time than those who registered afterwards i.e. 2006 (47, 78.3%), 2007 (20, 62.5%), 2008 (17, 70.88%), and 2009 (27, 79.4%) ( $p < 0.05$ ). Those who used private hospitals, 209 (79.2%) were satisfied than those who used public hospitals 50 (72.5%) ( $p > 0.05$ ).

**Table 4.12. Association between waiting time satisfaction and socio-demographic characteristics**

<b>Variables</b>	<b>satisfied (%)</b>	<b>not satisfied (%)</b>	<b>Total</b>	<b>x<sup>2</sup></b>	<b>p- value</b>
<b>Age (years)</b>					
25-34	42(79.2)	11(20.8)	53(100)	1.13	0.56
35-44	83(80.6)	20(19.4)	103(100)		
45+	115(75.2)	38(24.8)	153(100)		
<b>Sex</b>					
Male	132(75.9)	42(24.1)	174(100)	0.7	0.37
Female	127(79.9)	32(20.1)	159(100)		
<b>Religion</b>					
Christianity	197(76.7)	60(23.3)	257(100)	0.73	0.39
Islam	61(81.3)	14(18.7)	75(100)		
<b>Marital status</b>					
Single	25(78.1)	7(21.9)	32(100)	0.009	0.9
Married	224(78.0)	63(22.0)	287(100)		
Widowed/Divorced	10(76.9)	3(23.1)	13(100)		
<b>Level of education</b>					
Primary & secondary	33(86.8)	5(13.2)	38(100)	2.01	0.15
Tertiary	220(76.6)	67(23.3)	287(100)		
<b>Tribe</b>					
Yoruba	233(79.5)	60(20.5)	293(100)	4.90	0.09
Igbo	10(66.7)	5(33.3)	15(100)		
Hausa/Edo	15(62.5)	9(37.5)	24(100)		
<b>Grades level</b>					
5-7	77(79.4)	20(20.6)	97(100)	1.71	0.63
8-10	125(79.1)	33(20.9)	158(100)		
11-13	31(70.5)	13(29.5)	44(100)		
14-16	16(76.2)	5(23.8)	21(100)		
<b>Year of registration</b>					
2005	63(90.0)	7(10.0)	70(100)	12.2	0.04
2006	47(78.3)	13(21.7)	60(100)		
2007	20(62.5)	12(37.5)	32(100)		
2008	17(70.8)	7(29.2)	24(100)		
2009	27(79.4)	7(20.6)	34(100)		
2010	16(64.0)	9(36.0)	25(100)		
<b>Type of HCP</b>					
Private	209(79.2)	55(20.8)	264(100)	1.42	0.23
Public	50(72.5)	19(27.5)	69(100)		



#### **4.9 Association between staff attitude satisfaction and socio-demographic characteristics**

The associations between respondents' age and staff attitude showed that respondents aged between 35 and 44 years (56, 54.4%) were satisfied than those aged between 25 and 34 years (23, 43.4%), 45 and above (78, 51.0%) ( $p > 0.05$ ) (Table 4.18). Female respondents, 84 (52.8%) were satisfied with staff attitude than the male respondents 88 (50.6%) ( $p > 0.05$ ). Those who were married, 153 (53.3%) were satisfied than the singles 13 (50.6%), and those in other groups 6 (46.2%) ( $p > 0.05$ ).

The Christian respondents, 137 (53.3%) were satisfied than the Muslim respondents 35 (46.7%) ( $p > 0.05$ ). Those with tertiary education, 152 (53.0%) were satisfied than those with primary and secondary education 17 (44.7%) ( $p > 0.05$ ). Respondents that had spent between 16 and 20 years in service 46 (74.2%) were satisfied with staff attitude than those in other categories i.e. those who had spent between 1 and 5 years (18, 35.3%), 6 and 10 years (37, 55.2%), 11 and 15 years (22, 50.0%), 21 and 25 years (29, 50.9%), and 26 years and above (19, 40.4%) ( $p = < 0.05$ ).

Respondents between grade level 14 and 16 (16, 76.2%) were satisfied than those in other level which includes those between level 5 and 7 (40, 41.2%), 8 and 10 (79, 50.0%), 11 and 13 (29, 65.9%) ( $p < 0.05$ ). Of the respondents, those who used public facilities 38 (55.1%) were satisfied with staff attitude than those who used private facilities 134 (50.8%) ( $p > 0.05$ ).

**Table 4.13. Association between staff attitude satisfaction and socio-demographic characteristics**

<b>Variables</b>	<b>satisfied (%)</b>	<b>not satisfied (%)</b>	<b>Total</b>	<b>x<sup>2</sup></b>	<b>p-value</b>
<b>Age</b>					
25-34	23(43.4)	30(56.6)	53(100)	1.68	0.43
35-44	56(54.4)	47(45.6)	103(100)		
45+	78(51.0)	75(49.0)	153(100)		
<b>Sex</b>					
Male	88(50.6)	86(49.4)	174(100)	0.16	0.68
Female	84(52.8)	75(47.2)	159(100)		
<b>Marital status</b>					
Single	13(50.6)	19(59.4)	32(100)	2.03	0.36
Married	153(53.3)	134(46.7)	287(100)		
Widowed/Divorced	6(46.2)	7(53.8)	13(100)		
<b>Religion</b>					
Christianity	137(53.3)	120(46.7)	257(100)	1.3	0.31
Islam	35(46.7)	40(53.3)	75(100)		
<b>Level of education</b>					
Primary& secondary	17(44.7)	21(55.3)	38(100)	0.91	0.34
Tertiary	152(53.0)	135(47.0)	287(100)		
<b>Duration in service</b>					
1-5	18(35.3)	33(64.7)	51(100)	21.2	0.001
6-10	37(55.2)	30(44.8)	67(100)		
11-15	22(50.0)	22(50.0)	44(100)		
16-20	46(74.2)	16(25.8)	62(100)		
21-25	29(50.9)	28(49.1)	57(100)		
26+	19(40.4)	28(59.6)	47(100)		
<b>Grade level</b>					
5-7	40(41.2)	57(58.8)	97(100)	12.9	0.005
8-10	79(50.0)	79(50.0)	158(100)		
11-13	29(65.9)	15(34.1)	44(100)		
14-16	21(100)	16(76.2)	5(23.8)		
<b>Type of HCP</b>					
Private	134(50.8)	130(49.2)	264(100)	0.41	0.52
Public	38(55.1)	31(44.9)	69(100)		

#### **4.10 Suggestions made by respondents to improve NHIS**

More than half of the respondents' gave useful suggestions on what can be done to improve both the scheme and the services provided by the health care providers. These are presented in table 4.19. Most frequent suggestions made by respondents 34 (13.4%) was a need for the scheme to improve on the registration and enrolment processes. Respondents 24 (9.4%) also suggested that the range of services covered by the scheme should be improved on such that other health issues like cancer management can be attended to. Of the respondents, 23 (9.1%) suggested that the services run by health care providers should be monitored by health maintenance organizations because most providers doesn't meet up to the criteria of NHIS accredited hospital.

Improvement in the services rendered by HCPs was also suggested by 18 (7.1%) of the respondents because most of them rely on NHIS to meet with their health care needs. Eighteen (7.1%) respondents also reported that there is a need for the provision of quality drugs to patients. Removal of the 10% co-payment plan was also suggested by 17 (6.7%) of the respondents. Seventeen (6.7%) respondents also said there should be an improvement in the change of HCP processes because it takes too long before the change is effected and this prevents them from receiving care from the new health care provider. Making drugs available always was suggested by 17 (6.7%) of the respondents.

Also, some reported 16 (6.3%) that it takes time for them to add a dependant therefore, a need to reduce the time for adding additional dependants. Fifteen (5.9%) respondents also indicated that there is a need for the scheme to improve. Of the respondents, 9 (3.5%) indicated that HCPs should have more facilities for treating patients so that it would reduce the stress of being referred to another facility. Government need to provide more fund for the scheme. This was suggested by 9 (3.5%) of the respondents. They also indicated 8 (3.1%), that NHIS patients should be treated well like those that pay for their services.

Of the respondents, 8 (3.1%) suggested that patients should be allowed to receive treatment anywhere they are and this is due to distance and also because some of them had been transferred so it may be difficult going to where they registered. They also suggested 6 (2.4%),

that the scheme should cover everyone irrespective of age and that awareness should be created the more. This was indicated by 5 (2.0%) of the respondents. Five (2.0%) respondents, also said provision should be made for those that doesn't use the service but are paying and 5 (2.0%) also said prompt attention should be given to patients at their various centres.

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**Table 4.14. Suggestions made by respondents**

<b>Suggestions</b>	<b>Frequency*</b>	<b>%</b>
Registration and enrolment should be improved on	34	13.4
The range of services covered should be increased	24	9.4
HMOs should monitor how HCPs run their services	23	9.1
Health care providers should improve on their services	18	7.1
Quality drugs should be given to patients	18	7.1
The 10% co-payment should be removed	17	6.7
The change of HCP processes should be improved on	17	6.7
Drugs should always be available	17	6.7
The time for adding dependants should be shortened	16	6.3
The scheme should be improved	15	5.9
HCPs should have more facilities for treating patients	9	3.5
Government should provide more fund for the scheme	9	3.5
NHIS patients should be treated like patients that pay for their services	8	3.1
Patients should be allowed to receive treatment anywhere	8	3.1
The scheme should cover everyone	6	2.4
Awareness should be created the more	5	2.0
Provision should be made for those that don't visit hospital	5	2.0
Prompt attention should always be given to patients	5	2.0

\* Multiple responses

## CHAPTER FIVE

### DISCUSSION

This study shows that older patients reported higher levels of satisfaction than the younger ones although not significantly so. This finding is consistent with a past study (Mohammed et al., 2011). Studies have shown that there is direct relationship between enrolees' satisfaction and age. It has been demonstrated by studies done in the developed countries that age and sex of clients has the most consistent relationship with service satisfaction (Ware et al., 1978; Pascoe, 1983).

These findings may be due to the level of awareness of improvements in health care over a period of time or it may be due to exposure to various type of care. Also, another reason may be that there is usually a higher expectation from the younger age group or that those in the higher age group have closer relationships with the doctor (Fitzpatrick, 1984). It was speculated by Matteo and Hays (1980) that older people view doctors more favourably, or that they may feel a greater sense of urgency, patience and being more polite in treating older patients and usually provide them with better care.

There is no significant gender difference in satisfaction. This is also consistent with past study done in ABU Zaria among NHIS enrolees where males and females also showed no significant difference in satisfaction (Mohammed et al., 2011).

Respondents' religion did not have any significant effect on satisfaction. Related study (Shafiu et al., 2010) showed that religion did not significantly affect clients' satisfaction. Mohammed et al., 2011 had related findings that there was no significant difference in satisfaction among respondents' religion, ethnic group and satisfaction.

In this study, no significant relationship was demonstrated between level of education and satisfaction with NHIS. This may imply that people know what is good for them health wise regardless of their educational status. This is in contrast with the study done by Mohammed et

al., 2011 where it was found out that respondent with tertiary level of education were less satisfied while those below the tertiary level were more satisfied with NHIS.

This study also showed that there was no significant association between respondents' family size and satisfaction with NHIS. This is consistent with the study done to determine the knowledge and attitude of civil servants with NHIS in Osun state. The study showed that the present funding does not adequately cover the required need of the enrolees and their dependants. NHIS in Nigeria caters less for family members outside the first wife and hospital admissions outside the first 21 days. This constitutes financial burden to affected families especially in the northern part of the country where polygamy is practised (Al Olugbenga-Bello and Adebimpe, 2010).

There was no significant relationship between respondents' duration in service and satisfaction. This is in contrast with the study done among civil servants in Zaria (Shafiu et al., 2011) where respondents with longer duration in service were more satisfied with NHIS than those with shorter duration.

This study shows that there is a significant association between grade level and satisfaction. This finding is in consistence with the study by Mohammed et al (2011) where most of the senior staff were more satisfied with NHIS than their junior colleague.

This study showed that it took majority of the respondents a long time to get their NHIS number and card. This is in contrast with the information on the NHIS operational guidelines where it was stated that there would be a waiting period of 30 days before enrolees can access NHIS services but this study shows that it took most of the respondents more than 7 months before they were able to get their NHIS numbers and card. This is similar to a study done among Federal workers at Federal Polytechnic, Idah Kogi State where respondents reported that they had problems with their registration (Agba, 2010).

Also, from the evaluation done in Ghana as regards NHIS, a number of issues were raised predominantly around the length of time taken to receive NHIS card. Also, the findings from this study as regards registration under the scheme is in contrast with another study done in Ghana where majority of the respondents were either satisfied or very satisfied with registration under the scheme. As regards enrolment of dependants, this study showed that

most respondents had difficulty enrolling additional dependants and this is in agreement with a study on the assessment of NHIS in Ghana where respondents indicated the need for more dependants to be added on the scheme (Ghana NHIS, 2008).

There is no statistically significant association between clients' type of health care provider and satisfaction. This study shows majority of the respondents had utilized NHIS services from their health care provider and this is similar to the study done among Federal Polytechnic staff, Idah, Kogi State by Agba, 2010 where 86% of the respondents had assessed service from their providers. There is also a similarity from findings in this study and that obtained from enrollees who chose University of Ilorin Teaching hospital as their health care provider (Akande et al., 2011) where malaria treatment was the service that was mostly sought. Furthermore, in Ghana, the utilization of health facilities under insurance cover revealed that malaria was the commonest illness (Sulzbach, 2005). Also, a study done to assess the feasibility of Ghana NHIS showed that respondents indicated they suffered from a number of diseases and the disease frequencies were determined in the study group. Malaria was the commonest disease constituting 86% of all the cases (Edoh and Brenya, 2002). The finding in this study is also consistent with the study done to assess the perceptions and experiences of health care providers and clients under the National Health Insurance Scheme in Ghana. The study showed that malaria tops the list and accounts for 55% of the clients' attendance (Dalinjong and Laar, 2012).

This study shows that most of the respondents were satisfied with the NHIS drug services though this is not statistically significant. This is in contrast to findings from Agba, 2010 where most of the respondents reported the NHIS drug services to be poor due to absence of drugs, poor prescriptions and attention. However, a study done in Ghana to assess respondents' perception of the effect of NHIS on quality of care is consistent with this study because respondents were satisfied with drug availability under the scheme and they indicated that the quality has improved (Ghana NHIS, 2008).

There is a significant association between year of enrolment into the scheme and respondents' satisfaction with waiting time where respondents who registered at the inception of the programme were more satisfied than those who registered later. This is an indication that the



scheme has relaxed in rendering their responsibilities to the enrollees. This is in consistence with the study done in Ghana where respondents from the various income groups were satisfied with the emergency services they received under the national health insurance scheme (Ghana NHIS, 2008).

This study showed that there is a significant association between respondents' choice of health care provider and the quality of services received from them. This is in contrast with a study done among NHIS enrollees in Ghana where clients revealed that they were not pleased with the service provision. Reasons for the dissatisfaction were that providers discriminated against them by causing delays for them when they come for medical care. Providers also issue prescription forms for them to buy drugs out of the facilities (Dalinjong and Laar, 2012).

This study showed that respondents who assessed health care service from their providers before year 2010 were more satisfied with the services they received. This also is an indication that there is a need for improvement as health care providers are relenting in rendering quality health services to their clients which was not so when the scheme started. This study showed that respondents were satisfied with the availability of staff in their hospital and this is similar to the findings in a study done in Ghana where respondents indicated that the service quality under NHIS has improved due to the availability of nurses and the cleanliness of the health facility (NHIA report, 2008).

Also this study showed that respondents were satisfied that NHIS patients are well treated like patients that pay for their services i.e. the regular patient. This is similar to the findings in the study done in Ghana to assess NHIS where respondents indicated that NHIS card holders receive the same quality health care as non card holders (NHIA report, 2008).

In determining the association between respondents' grade level and satisfaction with staff attitude, it was found out that respondents' with grade level 14 and above were more satisfied with staff attitude. This is in contrast with the study done by Mohammed et al., 2011 where most of the senior staff were less satisfied while the junior staff were more satisfied. There was no significant relationship between respondents' duration in service and overall satisfaction.

However, in assessing respondents' satisfaction with staff attitude, those who had spent between 16 to 20 years in service were more satisfied with staff attitude. This is similar to the findings from the study done among staff of ABU Zaria where respondents with longer length of employment were more satisfied than those with shorter length of employment. This is in contrast to the report by NHIS (NHIS 2006), where insured-persons have complained of poor attitude and behaviour of service providers operating in the health insurance scheme. Findings from Agba, 2010 also revealed that respondents were not satisfied with the attitude of staff operating in health insurance scheme. However, findings from the study done to assess NHIS in Ghana indicated that the scheme has improved because of the way patients were treated.

In general most of the respondents that participated in this study said the scheme should not be scrapped because there is always a room for improvement and this is also similar to the suggestions made by respondents in a study done by Agba, 2010 that the scheme should not be discontinued.

This study showed that respondent's level of education, the last time a service was sought, type of health care provider chosen by respondents, year of registration into the scheme, staff duration in service and grades level were some of the factors that influenced enrollee's satisfaction with the various service areas provided under the scheme. This is consistency with the findings in a study done in Zaria to assess enrollee's satisfaction with NHIS where length of enrolment and respondent's duration in service influenced satisfaction.

### **Conclusions**

Respondents' experiences with the scheme revealed that the duration for the registration processes, the change of health care provider processes and the time taken to enroll dependants needs to be looked into as some of the enrollees and their dependants are yet to enjoy the scheme due to these lapses. Just a little over half of the respondents were satisfied with the services they had received. The NHIS scheme was rated less than average for the co-payment system and change of health care provider processes. Generally, this study showed that the scheme has relented in carrying out their duties effectively as respondents that registered and used the NHIS service at the inception of the programme were more satisfied than those that registered and used it afterwards.

These service areas need to be addressed to encourage continued participation and utilization of services by enrollees if the objectives of the scheme are to be achieved. Although the study showed that the scheme is a welcome development in the country but the areas of dissatisfaction needs to be addressed. These areas give signals that enrollees are yet to be satisfied with NHIS and this may have unresponsive effect on the future implementation of the scheme.

### **Recommendations**

The following are the recommendations:

- (1) There is a need to ensure that the waiting period for registration into the scheme is reduced in order to ensure that the targeted groups are captured.
- (2) The range of service covered under the scheme should also be reviewed in order to meet the need of the populace and to also to encourage utilization

### **Suggested further research**

- (1) The impact of NHIS services on the health status of enrollees
- (2) The willingness of the health care providers to administer NHIS services to enrollees
- (3) Enrolee's perception on the performance of NHIS

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**APPENDIX**  
**QUESTIONNAIRE**

Serial No.....

Users' satisfaction with the NHIS services among Federal Secretariat Staff, Ibadan

Dear Sir/ma,

I am a student of the Department of Health policy and Management, University of Ibadan. I am carrying out a study to assess users' satisfaction with NHIS services among the Federal Secretariat staff. It is being conducted as part of the requirement for the award of Masters Degree in Health Services Administration and it aims to help improve NHIS Service provision.

Participation is voluntary and will not take more than 20 minutes of your time. Your identity, responses and opinions will be kept confidential and no name is required in filling the questionnaire. You are requested to please give honest responses to the questions as utmost confidentiality is assured.

Thanks for your anticipated cooperation.

**SECTION A: SOCIO- DEMOGRAPHIC DATA**

Please mark your answer for each question by writing the number picked in the box provided

1. Age as at last birthday.....
2. Sex  
(1) Male (2) Female
3. Religion  
(1) Christianity (2) Islam (3) Traditional (4) others (specify) .....
4. Tribe  
(1) Yoruba (2) Igbo (3) Hausa (4) others (specify) .....
5. Marital Status  
(1) Single (2) Co-habiting (3) Married (4) Separated (5) Divorced (6) Widowed
6. Level of Education  
(1) No formal Education (2) Completed Primary (3) Completed Secondary (4) Tertiary  
(5) others (please Specify) .....
7. Number of Children/ Family size.....

**OCCUPATIONAL INFORMATION**

- 8. How many years have you been working in this organization .....
- 9. Grade level/cadre (e.g. level 1/step 2) .....
- 10. Designation (e.g. Admin. Officer) .....

**SECTION B: EXPERIENCES WITH NHIS**

- 11. Are you a registered member of the National Health Insurance Scheme?  
(1) Yes (2) No
- 12. When did you register? .....
- 13. Did you have to register more than once?  
(1) Yes (2) No
- 14. If yes, how many times did you have to register? .....
- 15. How soon after you registered did you get your NHIS number? (Please indicate the number of months or years) .....
- 16. How long did it take you to get your card after you registered? (Please indicate the number of months or years) .....
- 17. How many dependants do you have registered on the scheme?  
(1) None (2) one (3) two (4) others specify .....
- 18. Have you had the cause to register another dependant?  
(1) Yes (2) No
- 19. If yes, have you been able to register him/her/them?  
(1) Yes (2) No

**EXPERIENCE WITH HEALTH CARE PROVIDER (HCP)**

- 20. Name of Health Care Provider (i.e. name of the hospital you receive NHIS services)  
.....
  
- 21. What type of HCP did you choose?   
(1) Private (2) Public
  
- 22. Have you ever used the services of your HCP? If NO move to questions 33 & 34  
(1) Yes (2) No
  
- 23. If yes, how often do you use the services? ...../month or ...../year
  
- 24. When was the last time you used the service? (Please indicate the number of months or years) .....
  
- 25. What type of service was sought and what was wrong with you at your last visit?  
.....  
.....
  
- 26. Have you ever had the cause to be referred to another health care provider?  
(1) Yes (2) No
  
- 27. If yes, to which type of facility?  
(1) State hospital (2) General Hospital (3) Private Hospital (4) Mission Hospital  
(5) Federal Hospital (6) others (please specify).....
  
- 28. Have you ever changed your health care provider?  
(1) Yes (2) No
  
- 29. If yes, what necessitated the change?.....  
.....  
.....
  
- 30. How long did it take for the change to be effected? (Please indicate number of months or year) .....
  
- 31. If you have never changed your hospital would you like to change?   
(1) Yes (2) no

32. Why would you want to change.....  
 .....  
 .....

33. If you don't use the NHIS services at all please state your reasons  
 .....  
 .....

34. If you don't use the NHIS services, what do you do when you or your dependant are ill?  
 .....  
 .....

**SECTION C: SATISFACTION WITH HCP SERVICES**

**DRUGS**

Please state your opinion about the following statement. Please mark your answer for each question by circling the number

S/N	Items	Strongly Agree	Agree	Undecided	Strongly Disagree	Disagree
35	Drugs are always available at the centre	1	2	3	4	5
36	The right quantity of drugs prescribed to you by the doctor is always given to you at the pharmacy.	1	2	3	4	5
37	The right drug for your ailment is not always prescribed to you by the doctor	1	2	3	4	5
38	The 10% co-payment of drug is alright by you.	1	2	3	4	5
39	The generic drug authorized by NHIS to be given to patients is okay by you.	1	2	3	4	5
40	The Pharmacist don't always explain how you are to use your drugs	1	2	3	4	5
41	The Pharmacist doesn't always explain why some drugs are not available.	1	2	3	4	5
42	The attitude of the Pharmacist to me is unpleasant	1	2	3	4	5

## SERVICES

Please state your opinion about the following statements. Please mark your answer for each question by circling the number.

S/N	Items	Strongly Agree	Agree	Undecided	Strongly Disagree	Disagree
43	The hospital has enough facility for treating patients.	1	2	3	4	5
44	Staff are not readily available in the hospital					
45	The staff are not current with the latest methods of treating patients.	1	2	3	4	5
46	NHIS patients are well treated like patients who pay for their services.	1	2	3	4	5
47	Quality services are not rendered to NHIS patients in my hospital.	1	2	3	4	5
48	There is a need for my hospital to improve on their services.	1	2	3	4	5

## WAITING TIME

Please state your opinion with the following statements. Please mark your answer for each question by circling the number

S/N	Items	Strongly Agree	Agree	Undecided	Strongly Disagree	Disagree
49	The Hospital's opening hour is okay by me	1	2	3	4	5
50	I usually don't wait for a long time before I receive care	1	2	3	4	5
51	It is easy to get medical care in an emergency	1	2	3	4	5
52	The comfort level of the Hospital's waiting room is okay	1	2	3	4	5

## STAFF ATTITUDE

Please state your opinion about the following statements. Please mark your answer for each question by circling the number.

S/N	Items	Strongly Agree	Agree	Undecided	Strongly Disagree	Disagree
53	The reception Staff is polite	1	2	3	4	5
54	I am always thoroughly asked about my symptoms and how I feel	1	2	3	4	5
55	The Doctor don't listen to what I have to say	1	2	3	4	5
56	The Doctor put me at ease during any treatment that I need	1	2	3	4	5
57	The Doctor doesn't spend much time with me.	1	2	3	4	5
58	The Doctor is patient with my questions and worries	1	2	3	4	5
59	The Doctor is not caring and concerned about me.	1	2	3	4	5
60	My privacy should be paid attention to when I am receiving care.	1	2	3	4	5
61	Doctors rarely give me advice about ways to avoid illness and stay healthy	1	2	3	4	5

Please rate on a scale of 1-5 how satisfied you are with the various aspect of NHIS

S/N	Items	Poor	Fair	Good	Very Good	Excellent
62	Registration/ Enrolment	1	2	3	4	5
63	Range of services covered by NHIS	1	2	3	4	5
64	Your choice of Health care Provider	1	2	3	4	5
65	The services provided by your HCP	1	2	3	4	5
66	The co-payment plan	1	2	3	4	5
67	The referral system	1	2	3	4	5
68	The change of health care provider process	1	2	3	4	5
69	The overall NHIS Scheme	1	2	3	4	5



**Recommendations for improvement**

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Department of Health Policy and Management,  
Faculty of Public Health,  
University of Ibadan,  
Ibadan.

Chairperson,  
UI/UCH Ethics Committee,  
College of Medicine,  
University of Ibadan.

Dear Sir,

Application for Ethical Approval of Proposed Research titled: User's Satisfaction with NHIS Services among Civil Servants at the Federal Secretariat, Ibadan.

I wish to request for the Ethical approval of the above named research study. I am a student in the department of Health Policy and Management, University of Ibadan.

The proposed research is for my Masters Degree of the postgraduate School, University of Ibadan.

Please, find attached 4 copies of the research protocol, an electronic version, evidence of Ethics training, CV in NIH format and receipt of payment of two thousand, five hundred naira only. (2500.00)

Thank you for your anticipated approval

Yours Faithfully,

**Oludoyi Abidemi**



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

**NOTICE OF FULL APPROVAL AFTER FULL COMMITTEE REVIEW**

*Re: Users' Satisfaction with the NHIS Services among the Federal Secretariat Staff, Ibadan*

UI/UCH Ethics Committee assigned number: UI/EC/11/0108

Name of Principal Investigator: **Abidemi Oludoyi**

Address of Principal Investigator: Department of Health Policy & Management,  
College of Medicine,  
University of Ibadan, Ibadan

Date of receipt of valid application: 10/05/2011

Date of meeting when final determination on ethical approval was made: **21/07/2011**

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

This approval dates from 21/07/2011 to 20/07/2012. If there is delay in starting the research, please inform the UI/UCH Ethics Committee so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. *All informed consent forms used in this study must carry the UI/UCH EC assigned number and duration of UI/UCH EC approval of the study.* It is expected that you submit your annual report as well as an annual request for the project renewal to the UI/UCH EC early in order to obtain renewal of your approval to avoid disruption of your research.

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



**Dr. J. A. Oriagha**  
Chairman, Medical Advisory Committee,  
University College Hospital, Ibadan, Nigeria  
Vice-Chairman, UI/UCH Ethics Committee  
E-mail: [uiuchire@yahoo.com](mailto:uiuchire@yahoo.com)

Research Units: ■ Genetics & Bioethics ■ Malaria ■ Environmental Sciences ■ Epidemiology Research & Service  
■ Behavioural & Social Sciences ■ Pharmaceutical Sciences ■ Cancer Research & Services ■ HIV/AIDS