**KNOWLEDGE AWARENESS AND BENEFITS OF NATIONAL HEALTH INSURANCE SCHEME AMONG CIVIL SERVANT IN UYO LGA**

**CHAPTER ONE**

**INTRODUCTION**

**1.1 BACKGROUND TO THE STUDY**

Ever since Emperor Otto Von Bismarck of Germany enacted the mandatory legislation on the “sickness funds” for working Germans in 1883, different models of health insurance have continued to evolve worldwide albeit with the same general insurance principles. In the developed world, insurance in one form or the other is a veritable and sustainable tool for financing healthcare. The National Health Insurance (NHIS) was launched in Nigerian on October 15, 1997 and was passed into law in May 1999. The original scheme has been modified to include healthcare for less privileged persons in the country (FMH, 1998).

According to the World Health Organization (WHO) in 2005, Nigeria was ranked 197th out of 2000 nations; life expectancy was put at 48 years for male and 50 years for female while healthy life expectancy (HALE) for both sexes was put at 42 years. Nigeria accounts for 10% of global maternal mortality with 59,000 women dying annually from pregnancy and child birth; only 39% are delivered by skilled health professionals. In order to provide equitable distribution of health, the NHIS was introduced in Nigeria. The need for the establishment of the scheme was informed by the general poor state of the nation’s healthcare services, excessive dependence and pressure on the government’s provision of health facilities, dwindling funding of health care in the face of rising cost, poor integration of private health facilities in the nation’s healthcare delivery system and overwhelming dependence on out – of - pocket expenses to purchase health.

Like any other insurance scheme, the premium for the NHIS is the amount charged by the insurance compared with the promise to pay for any eventual “covered medical treatment” for the designated “coverage”. Consequently health insurance makes it possible to substitute a small but certain cost for a larger but uncertain loss (chain) under an arrangement in which the healthy majority compensate for the risks and costs of the unfortunate ill minority. The NHIS currently represents 15% of one’s basic salary. The employer is to pay 10% while the employee contributes 5% of his/her basic salary to enjoy healthcare benefits. The contribution made by the insured person entitles his/her spouse and four children under the age of 18 to full health benefits (FMH 2005).

NHIS was designed to provide minimum economic security for workers with regard to unfavorable losses resulting from accidental injury, sickness, old age, unemployment and premature death of family wage earner. NHIS is made compulsory because the government based on past experiences predicted that some citizens cannot engage in the scheme and the government also has the duty to protect the general welfare of all citizens (Ibiwoye and Adedeke, 2007). It is also the government’s belief that NHIS will help to break the vicious cycle of poverty in the country. It is also a form of social support for workers (Jutting, 2003). There is lack of health care coverage and little equity. Access to healthcare is limited and most Nigerians are unable to pay for health services and health facilities are far from being equitably distributed. All these contributed to the limitation in health services (Samin and Awe, 2009). The available health services are very expensive and the common man cannot afford it; only the privileged few can get access to good health. This study aims at assessing the level of knowledge, awareness and benefits of NHIS to the civil servants in Uyo LGA.

**1.2 STATEMENT OF THE PROBLEM**

Insurance is a veritable tool for healthcare financing, it has been used by most advanced countries in its various forms to fund healthcare. It is only recently being applied by poorer developing nations to address the glaring problem of inadequate healthcare provision, which was hitherto financed exclusively from public taxation. The health sector can be subdivided into two main categories, healthcare infrastructure and healthcare financing. Health funding relates directly to all production and financial activities and resources expended on goods and services consumed by or provided to the human population for the purpose of improving health.

Awareness and interest towards government policies and programs can be aroused by individual attitude and behaviour. Whenever there are negative perception and attitude and knowledge towards these policies and programs, such policies and programs are bound to fail. Awareness of these government programs and activities makes the governed to have positive attitude and perception towards these programs, thus, improving their participation and responsiveness to these programs. The National Health Insurance Scheme (NHIS) was introduced in Nigeria with the promulgation of degree No. 35 of 1999.5 with the broad objective of ensuring that every Nigerian has access to good health care services at affordable costs. Participants are expected to pay capitation fees to licensed Health Maintenance Organizations (HMOs), which would allow the subscriber to have access to registered health care providers. In this degree, Federal Executive Council approved National Health

Insurance Council (NHIC) as an omnibus regulator of the entire NHIS, which perhaps will correspond to the institution/corporate body. Also National Health Insurance Fund (NHIF) was established to manage deductions from public sector employees and employers while HMO would receive contributions from their organized private sector counterparts. These study seek to determine the level of knowledge, awareness and benefits of NHIS among civil servants in Uyo LGA.

**1.3 OBJECTIVES OF THE STUDY**

The following are the objectives of this study:

1. To examine the level of knowledge and awareness of NHIS among civil servants in Uyo LGA.
2. To identify the benefits of NHIS among the civil servants in Uyo LGA.
3. To determine the factors limiting the successful implementation of NHIS in Uyo LGA.

**1.4 RESEARCH QUESTIONS**

1. What is the level of knowledge and awareness of NHIS among civil servants in Uyo LGA?
2. What are the benefits of NHIS among the civil servants in Uyo LGA?
3. What are the factors limiting the successful implementation of NHIS in Uyo LGA?

**1.6 SIGNIFICANCE OF THE STUDY**

The following are the significance of this study:

1. Given the inefficiencies experienced in public hospitals, it was expected that the populace would readily embrace the scheme. For some reason this does not appear to be the reality. Outcome of this study will increase the knowledge, awareness of NHIS in Uyo LGA by making the civil servants understand the benefits of the scheme.
2. This research will also serve as a resource base to other scholars and researchers interested in carrying out further research in this field subsequently, if applied will go to an extent to provide new explanation to the topic

**1.7 SCOPE/LIMITATIONS OF THE STUDY**

This study will cover all the objectives of NHIS and the benefits with a view of increasing the knowledge and awareness of the scheme.

**LIMITATION OF STUDY**

**Financial constraint**- Insufficient fund tends to impede the efficiency of the researcher in sourcing for the relevant materials, literature or information and in the process of data collection (internet, questionnaire and interview).

**Time constraint**- The researcher will simultaneously engage in this study with other academic work. This consequently will cut down on the time devoted for the research work.

**CHAPTER TWO**

**LITERATURE REVIEW**

1. **INTRODUCTION**

National Health Insurance Scheme (NHIS) is one of the major strategies government uses to affect the needed change among civil servants in Uyo Akwa Ibom state, Nigeria.

National health insurance which is sometimes called statutory health insurance (SHI) is a legally enforced scheme of health insurance that insures a national population against the costs of health care which may be administered by the public sector, the private sector, or a combination of both (Wikipedia)

NHIS involves gradually putting funds aside while you are healthy to take care of you when you are sick or ill. It entails contributions from the government, employers of labour, workers and other prospective beneficiaries.

The NHIS is expected to provide easy access to qualitative health care services at an affordable price to all civil servants in Uyo. This Scheme guarantee’s a feasible alternative funding mechanism for the health sector and ensures sustainable and long lasting funding for the health sector and make makes sure health services are affordable and assessable.

* 1. **CONCEPTUAL FRAMEWORK**

The vision of NHIS in Uyo is to secure universal coverage and access to adequate and affordable health care in order to improve the health status of Nigerians**.**

Insurance is a veritable tool for healthcare financing, it has been used by most advanced countries in its various forms to fund healthcare. It is only recently being applied by poorer developing nations to address the glaring problem of inadequate healthcare provision, which was hitherto financed exclusively from public taxation (Benson 2009). The health sector can be subdivided into two main categories, healthcare infrastructure and healthcare financing. Health funding relates directly to all production and financial activities and resources expended on goods and services consumed by or provided to the human population for the purpose of improving health (Adebayor).

Awareness and interest towards government policies and programs can be aroused by individual attitude and behaviour. Whenever there are negative perception and attitude towards these policies and programs, such policies and programs are bound to fail. An attitude is a learned disposition to behave in a consistently favourable or unfavourable way with respect to a given object.

Stated differently, it positions people into a frame of mind of liking or disliking things, of moving toward or away from them3. It is acknowledged that people have attitudes toward almost everything - religion, politics, clothes, music, and food.

Awareness of these government programs and activities makes the governed to have positive attitude and perception towards these programs, thus, improving their participation and responsiveness to these programs. The National Health Insurance Scheme (NHIS) was introduced in Nigeria with the promulgation of degree No. 35 of 1999.5 The broad objective of the scheme is to ensure that every Nigerian has access to good health care services at affordable costs. Participants are expected to pay capitation fees to licensed Health Maintenance Organizations (HMOs), which would allow the subscriber to have access to registered health care providers.

In this degree, Federal Executive Council approved National Health Insurance Council (NHIC) as an omnibus regulator of the entire NHIS, which perhaps will correspond to the institution/corporate body. Also National Health Insurance Fund (NHIF) was established to manage deductions from public sector employees and employers while HMO would receive contributions from their organised private sector counterparts. These would constitute the formal sector programme, while the informal sector programme will comprise community and self-employed micro-insurance and also a government funded programme for the vulnerable groups such as children under five years, permanently disabled, elderly and prison inmates. The current mode is to break the circle of planning and take actions that will translate policies into action. The Nigerian National Health policy objective is the attainment of a level of health that will enable all Nigerians to achieve socially and economically productive lives. Primary Health Care (PHC) has been the key to achieving this national goal. Hence, PHC has been the number one national health priority since its launching in 1986; the focus of PHC initially was to redress the imbalance in the distribution of health resources between urban and rural areas. However, a growing demand for modern medical care, brought on by a rapidly, expanding population, rising literacy levels, and technological advancement lead to high expectation from the health services. This has shifted demand in favour of hospital care. The world economic recession in the 1980s and the consequent macro-economic adjustments, which have continued until now; have led to a continuous decline in public spending for health. It is unlikely that, additional funding will be available from public sources to finance health care activities given the demand on total public incomes from other sectors. An autonomous health fund would be needed to provide additional finance that would sustain the health care demands of a growing population, initiate new developments in health care and improve standards of care, herein, the establishment of the NHIS. The original intention of the scheme in Nigeria is to provide resources that will allow cross subsidisation in the health sector so that the healthy pay for the sick, the rich pay for the poor and the young pay for the old. However, this sort of social solidarity is possible where there is a huge formal sector, and/or where the government is willing and able to pay the contributions of the old, children and poor people. With large informal sector and the diversity in economic status in Nigeria, it is difficult for social health insurance to determine premium equitably. It became obvious that several other programmes would be required under the scheme to achieve universal coverage. It is quite encouraging to note that consensus has been achieved in this respect. As anxiety grows over the phased implementation of the NHIS starting with formal workers in the employment of the federal government, major stakeholders have given support to piloting the programme in a limited number of sites. This is on the premise of some obvious factors in the country.

**2.3 History ofNational health insurance scheme (NHIS)**

The idea of creating a governmental body to address health care concerns in Nigeria had its origins in 1962, but the idea was shot down at the time by government officials. AlhajiAbdusalamiAbubaker enacted NHIS into military law on 10th of May, 1999, but the Nigerian public had to wait 40 more years for the NHIS to become official. President OlusegunObasanjo became the first registered NHIS member when he formally launched the agency in 2006.

Though there was some resistance and speculation in the outset, in 2013 98 percent of all Nigerian federal employees and two million additional private sector workers were signed up with NHIS. Also, two million additional Nigerians signed up with NHIS through the Programme for Pregnant Women and Children Under Five.

Though the NHIS’s stated goal is to provide universal health care access, sadly the percentage of the Nigerian population with health care coverage remains stuck at around 10 percent. Part of the problem has to do with wording of the NHIS Act itself, which requires only federal government employees and private sector businesses with 10 or more employees to register with NHIS. Unfortunately, the majority of government workers work for state agencies, not federal agencies. Since the law does not apply to them, most don’t opt to join [NHIS](http://www.einsurance.com.ng/nhis-operational-guidelines-explained-know-your-rights/). Another problem is that in the private sector, many Nigerian companies don’t register their employees with the government to avoid paying taxes. Employees who work under-the-table don’t receive health insurance, so it’s a losing situation for everyone except for the employer.

The main problem, though, boils down to a lack of funding. Less than 2% of Nigeria’s GDP is reinvested into its health care programs. Labor unions have blocked efforts to enact laws that would require employees to contribute to their own health care plan with salary deductions, so there just isn’t much money to go around.

Before any significant improvements can be made, the law needs to change. The more people that join the NHIS, the cheaper it will be for everyone– so more people should be forced to join. Also, policyholders should be required to pay at least a small portion towards the total cost of the NHIS. Additionally, the public should be provided with more information about NHIS because as the situation stands today, many people have heard the name NHIS but few really know what it means. Currently, most Nigerians view health insurance as just another monthly expense, but in reality health insurance is an investment that can save lots of money in the event that a health problem suddenly occurs. Once public perception begins to change, the dream of universal [health insurance in Nigeria](http://www.einsurance.com.ng/health-insurance-in-nigeria-acronyms-to-know/)will begin to look more like a reality.

**2.2. Knowledge awareness and benefits of national health insurance among civil servants in Uyo**

The knowledge and awareness of NHIS among civil servants in Uyohelps them to achieve equitable access to health care as an alternative source of funding for a rapidly extending and increasingly costly health care system.

The knowledge awareness of National health insurance in Nigeria, Uyo precisely gives civil servant in Uyoaccess to good health care services.

Protectsthem and their families from the financial hardship of huge medical bills, limits the rise in the cost of health care services ensures equitable distribution of health care costs among different income groups.

Maintain high standard of health care delivery services within the Scheme.Ensuresefficiency in health care services.  
Improves and harness private sector participation in the provision of health care services;  
ensure adequate distribution of health facilities within the Federation  
Ensures equitable patronage of all levels of health care;  
ensure the availability of funds to the health sector for improved services.

**2.3. Benefits of Nationalhealth insurance scheme**

The role of insurance in health financing is to fold, to raise revenue for health care services to put these resources so that health risks can be effectively shared among the members of the insurance scheme.

The dictionary central explains that health care demand is the maximum rate of use of health service facilities as a function of various independent variables like health status, price, distance from facility; time spent obtaining the service, income, wealth and educational attainment (Dictionary Central, 2000). It is further defined as the amount of health services that the people are willing to obtain as a function of the service prices, given people’s socio-economic and demographic characteristics, their perception of the quality of services, the people’s geographical location relative to health providers and the environment (Kings: 2001). Holding other factors constant, health care demand basically has to do with the relationship between the consumption of health care service and its price. The concept of health insurance on the other hand, has to do with the type of insurance coverage that covers the cost of an insured individual’s medical expenses. Health insurance therefore helps to protect an individual from high medical care costs. Thus, National health insurance insures a national population for the health care costs. It may be administered by the public or the private sector or a combination of both. National health insurance is usually instituted as health reform and is therefore enforced by law. One of the goals of Nigeria’s health sector reform is to improve access to health care and also to make it affordable. So the goal is tackled through the provision of primary health care which is being implemented by all the tiers of government as well as the national health insurance scheme (NHIS). Though the idea of a national insurance was conceived in 1962 under the Halevy’s Committee’s Lagos Health Bill and it was only promulgated in 1999 and launched in 2005. NHIS has about 10 objectives out of which are: to ensure that every Nigerian has access to good health care services, to protect families from the financial hardship of huge medical bills, to limit the rise in the cost of health care services, etc. Nigeria has both formal and the informal sectors, in order to avoid the exclusion of others; the scheme comes in a package of six components: The Formal Sector Social Health Insurance Program, the Urban Self-employed Social Health Insurance Program,the Rural Community Social Health Insurance Program,the U-5 Children’s Program, Prison Inmates Social Health, and Insurance Program

Its structure reveals the following bodies

• The council

• State licensure boards Dickson Vonke and Baba Sunday

• State health insurance offices

• Standards committee and inspectorate systems

• Health maintenance organizations

• Health insurance companies (public and private)

• Arbitration boards

• Malpractice insurance schemes

• Banks and Banking systems

Funding is pooled from enrollee’s 5% basic monthly salary, while 10% of the enrollee’s basic salary is contributed monthly by the employer (NHIS, 2005). The insured chooses his primary health care provider who is associated with the HMOs.Nwachukwu(2012) explained that the primary health care provider is to be registered by the NHIS according to the guidelines of the standard committee made up of statutory professional registration boards. State licensure boards approve premises for practice by the health care provider. Liability insurance companies (public and private) will provide professional indemnity cover (malpractice insurance) for the health care providers. The role of the arbitration boards will be to handle conflicts between the above relationships. Furthermore, the Health Maintenance Organizations (HMOs) are limited liability companies which are licensed by the NHIS to facilitate the provision of health care benefits to contributors under the formal sector social health insurance program to interface between eligible contributors including voluntary contributors and the health care providers. NHIS in Nigeria is bedeviled with a lot of problems. Anyaka (2012) pointed that NHIS appears to be a free scheme operating only with government’s contributions. GbengaAdenuga (2013) identified the following problems of the NHIS in Nigeria:

**2.4. Problems /challenges the NHIS may face**

Some problems/challenges the NHIS may face include lack of validity and meaning with socioeconomic reality, lack of financial planning and commitment by the government, lack of accountability and mismanagement of funding, unnecessary/excessive bureaucracy, political intrigues and power tussle among principal officers, and inability of the government to carry the people along. For these and other reasons, several laudable government programmes in the past have failed, e.g. Operation Feed the Nation (OFN), Green Revolution, etc.

Howbeit, a well-conceived and implemented NHIS will considerably improve access to health services and facilities enhance quality and increase affordability.

**2.5 Review of knowledge awareness and benefits of NHIS among civil servants in Uyo**

The health sector in Uyo, Akwa Ibom has experienced an unprecedented revolution since the advent of the previous administration of Chief (Dr.) GodswillAkpabio. The present government has invested enormous financial resources through the Ministry of Health to revamp and restructure the sector in order to make health care delivery not only accessible and affordable for every Akwa Ibom person but also to ensure that nobody dies from a preventable disease.

Other achievements in the health sector include:

Construction of a world class Specialist Hospital at EkimItam – 20th Anniversary Hospital.

Donation of N50million to University of Uyo Teaching Hospital (UUTH) and building of a pediatrics block.

Building of an oxygen plant at General Hospital, IkotEkpene, the first in the history of the State.

Activation and expansion of 8 Anti-Retroviral therapy centres, 15 prevention of mother to child transmission (PMTCT) centres and 37 HIV counseling and testing centres. All rendering free services.

Procurement and commissioning of State-of-the-art ambulances

Construction of new PHCs in the three (3) Senatorial Districts of the State

Procurement of utility vehicles to 159 doctors in the State government employ to facilitate theirs transportation.

Construction of Cottage Hospitals in EssienUdim, Ibeno, Ukanafun, Eastern Obolo and Ika

High immunization coverage to eradicate polio and all other childhood killer diseases.

Provision of counterpart funding for all health programmes by donor organization like UNICEF, UNFPA, Operation Roll Back Malaria, HIV/AIDs World Bank Assisted Programme.

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**CHAPTER TWO**

**LITERATURE REVIEW**

**2.1 INTRODUCTION**

This chapter gives an insight into various studies conducted by outstanding researchers, as well as explained terminologies with regards to knowledge awareness and benefits of national health insurance scheme among civil servants.

The chapter also gives a resume of the history and present status of the problem delineated by a concise review of previous studies into closely related problems.

**2.1 AN OVERVIEW OF HEALTHCARE SERVICES DELIVERY**

**IN NIGERIA**

An important question most health experts have tired to address in discussing healthcare services delivery in Nigeria has been: "what really determines the overall health condition of the Nigerian populace" one obvious possible answer is health services, and the number of physicians or hospital beds as well as availability of drugs and other related factors. According to Soyinka (2000:19) good health is one of the most important basic needs of mankind and is indispensable in social and economic development of a nation.

The Nigerian governments had recognized the need good healthcare services for the nation and have been purchasing the objective of adequate healthcare services delivery since the nation attained political independence in 1960.

Although the nation's health facilities were not developed as they are today, it is acknowledge that healthcare services delivery was efficient and effective in most parts of the country in the 1960s and 1970s.

According to Dimeji (2000:10), it was a period all levels of government were very much committed to ensuring adequate health care services even with the limited health personnel and physical facilities. Health considerations were taken into account in all development planning then rather than having health regarded as a matter of giving money to the Ministry of Health for a new hospital or adding a clinic to a development project.

A comparative study on healthcare service in Nigeria for the periods 1960 - 1980 and 1981 - 2000 showed that there were fever number of medical and health personnel, hospital and other health facilities in the country in 1960 - 1980 period i.e. fever number of doctors, nurses, hospital, clinics and community health centers.

Dimeji (2000: 10) remarks that despite the high doctor - patient and nurse - patient ratios health service were more effective and effective than what obtained in the period 1980 - 2000. although there was rapid expansion of health facilities in the second half of the 1970s due to oil boom that saw budgetary allocation expanded in the health sector, the rapidly growing population more than offset the progress in the second half of the 1980s to the 1990s.

This finding was collaborated by that of the world Health Organization (2001:42) that showed a marked deterioration in Nigeria's health care services delivery in 1985 - 1995 relative to 1975 - 84 period. It was found that over these periods, there had often been much emphasis on sophisticated and expensive clinical practice in large urban hospitals.

At the same time, environmental health, water supply and sanitation had generally received little emphasis until the 1990s, except to a little extent in a few major cities.

While this may have corresponded to the realities of powerful social and political forces - the vested interests of an urban elite and of the medical profession - such activities have scarily touched the health problems of he bulk of the population, who often live in rural areas out of reach of official personnel services and whose health situation is hardly affected by episodic curative health care.

Ramesome Kuti (1992:17) posits that it is this discouraging healthcare condition that informed the launching of the Primary Healthcare Services Scheme in 1990. Under this scheme, there was proliferation of public and private health intuitions and facilities throughout the country. Since then there is at least one private health institution in every town and one public health institution in each local government throughout the country (Mba, 2002:8).

The rapid expansion of private health care institutions since the mid - 1980s represents a milestone in the quest for improved healthcare services delivery in the country. This then called for effective integration of the private health institutions into the National Health Policy so as to ensure effective provision of healthcare service throughout the country.

**2.2 THE GOALS OF NATIONAL HEALTH POLICY**

The Nigeria government has been pursuing a national policy on health aimed at ensuring adequate efficient and effective healthcare services delivery since the 1960s although this quest faced serious 1980s.

In his 1989 budget speech, ex-president Ibrahim Babangida (1989:12) remarks that; "Government is, in particular, deeply concerned about the state of the nation's health system, especially, the rising cost of healthcare services. The problem, accordingly called for speedy action in order to improve the deteriorating health services in the country"

In this regard, the goal of national policy is to ameliorate the sufferings of Nigerians arising form high cost of health care services. Commenting on the goal of improved healthcare services, Fadeji (2004:6).

"To achieve improved healthcare services the federal government has launched a number of result - oriented health improvement programme. Among these are the Primary healthcares Scheme, the Guinea worm Eradication Programme, the kick out polio Programme, Malaria Eradication Programme and material healthcare programme" Most of these programmes are being implemented with the aid of donor agencies such as the World Health Organization (WHO) the World Bank and UNUDO. Explaining the national policy goals on ensuring improved health conditions and healthcare services in the country, Ugbaja (2003:25) states that these intervention programmes are aimed at eliminating sanitation, air and water-bone and human waste - related diseases which include typhoid, dysentery cholera polio and hepatitis. Diarrheal disease, also in this group, is probably the biggest single cause of death among children under five, and of illness in adults.

Many worm diseases also belong to this group, including tapeworms, hook worms and bilharzias such air- borne diseases also included are tuberculosis, pneumonia, diphtheria, bronchitis, whooping cough, meningitis, influenza and measles.

Thus, Nwatu (2002:2) outlines the goals of the national health policy to include, among other things;

- Improving healthcare delivery system.

- Improving the range of healthcare services

- Increasing the number of health institution including teaching hospitals, specialist hospitals, general hospital, clinics maternities and health centers.

- Increasing the number of qualified medical doctors, nurses and other health personnel.

- Ensuring adequacy of drugs health facilities and equipment and beds.

- Providing adequate, effective and efficient healthcare services at affordable costs to the entire citizenry.

- Providing changes in knowledge, attitudes and practice relating to sanitation, sewage disposal and environment pollution and

- Encouraging good nutritional practices among the people.

**2.3 IMPERATIVES OF IMPROVED HEALTHCARE**

**SERVICES DEVELOPMENT**

The essence of good healthcare system has been Acknowledged by many well-meaning Nigerians. First, a good and effective healthcare services promote a healthy citizenry, healthy in the sense of minimized incidence of diseases and ill - health. According to Abdukadri (1998:12) a healthy citizenry is one that has a very low mortality (infant, material and adult) rate as well as a high life expectancy. Thus, adequate and effective healthcare system promotes long life of the, people.

Second, it ensures higher productivity in the national economy. Abdukadri (1998:12) also states that another potentially significant case for improved healthcare services is the reduction in productivity looses caused by debility of substantial portion of the labour forces, besides, it prolongs productive years of the labour force. Accordingly, increases in the life expectancy of adults would add years to the working lives (rather than retirement years) of most adults. Other things being equal, a lengthening of working life reduces the country's dependency ratio.

Lower dependency ratios, of course, increase per capital income and potentially, per capital savings, as family incomes are required to support fever numbers.

Third, good health care services promote the peoples standard of living. Ugbaja (2003:27) posits that a nation with healthy population is always productive with the individuals meaningfully earning their living. With increasing income at their disposal, they can improve their standard of living by satisfying most of their basic needs. According to Grange (2007:2) efforts to improve the nation's health care service are predicated on the imperatives of effective and adequate healthcare system.

This depends on the ability of the government to embark on effective health planning and formulation of effective health policy that will benefit the populace, especially rural dwellers who have continually been neglected by past health policies.

**2.4 FINANCING OF HEALTHCARE SERVICE IN NIGERIA**

According to Lambo (2006:18) healthcare financing in Nigeria is form a variety of sources that include budgetary allocation from all level of government, foreign loans and grants sector contributions and user-fee (or out - of - pocket expenses). Public spending per capital for health is less than $5 and can be as low as $2 in some parts of Nigeria, which is below $34 countries within the Macroeconomic Commission Report. According to Usman (2005:1) although the federal government recurrent budget with respect to health showed an improvement from 1996 to 1998, a decline in 1999 and increasing trend since 2000, evidence shows that the bulk of health recurrent expenditures went to personnel. According to Usman (2005:2) recurrent health expenditure stood at 2.55 percent in 1996 2.96 percent in 997, 2.99 percent in 1999 and increased 2001 to 2004, there was a steady increase in the budgetary allocations, a concern in funding health sector in Nigeria is the gap between budgeted figures and the actual funds released from treasury for health services.

However, Uduma (2005:3) notes that personal healthcare expenditures account for about 90 percent of the total having increased significantly in the first five years of the new millennium. These have been increasing at rate percent to 12 percent per annum when the economy was growing at 4 percent per cent per annul the cost structure, Uduma (2005:3) states that external sources financed less than 20 percent of the total expenditure. It is also shown that the domestic sources financed much of government, individual and insurance companies' expenditure.

External donors financed more than 20 per cent of capital investment in the health sector.

Direct - financing methods were increasingly advocated for as a sources of additional resources for healthcare services delivery. Such methods include user- fees for health services or drugs for health services or drugs and prepayment schemes for healthcare. User-fee method requires payment at the time healthcare services is received while the prepayment entails a payment in advance for the right to receive care if and when healthcare services is needed. Ogechukwu (2004:21) states that user- fees and drug sales are the methods most frequently used in the public sector because of their greater administrative simplicity and because the close link between revenues and services makes monitoring cash flow and book - keeping straight for - ward. In contrast prepayment scheme requires greater financial management expertise and involves complex administrative duties.

Typically, the revenues generated by the user-fees Scheme in the public sector are modest. Nwosu (2004:8) i estimates user-fee revenues as a percentage of the current expenditures of government health services between 1990 and 2003. The Average was only 7 percent modest revenues from user-fee were partly due to the fact that the government subsidized the fees for healthcares services. And yet, even these modest revenues were not earmarked for the financing of health services but instead went into the general fund of the health sector.

**2.5 THE NATIONAL HEALTH INSURANCE SCHEME (NHIS)**

Generally, social insurance is a compulsory insurance scheme designed to provide a minimal socio-economic security for affected individual especially low - income earners. According to Teriba (2005:29) it is a mandatory insurance scheme whose objective is to provide a minimum standard of living. It provides an answer to the question of dependency in our society and on the government for certain services social insurance embraces large group of individual and the cost is sometime distributed among participants in the scheme and, sometimes, among all and sundry.

Ugbaja (2003:18) remarks that central to social insurance in the health sector is the concept of social security which, in turn, is predicated on two concepts. The first is the responsibility of the government to see that every one has a clam as or right to some financial provision to meet the expenses of a large family with respect to healthcare services. The second concept is that government should not allow the health condition of any individual to fall below a certain level.

This obtains essentially in advanced countries of the west where there is effective system of social security.; In accordance with the principles, whenever the income of a family is inadequate to meet their health need payments are made to them form public funds bring their health condition to a minimum level considered acceptable vis- a vis current standard.

According to Teriba (2004:30) contributions;for social insurance benefits are compulsory for those concerned. Public assistance in contrast to social insurance includes contributions or payments directly form individual and or employers. Usually this is financed form general tax revenues. Under the social insurance scheme, revenues individual is required not only to provide security for himself and his family but also to contribute to the needy in the community (Chikeleze, 2004:18).

According to Musa (2005:2) health insurance scheme is a Social Security programme that guarantees the; provision of health services to individuals on the payment of taken contributions at regular intervals. (Chikeleze 2004:32) defines heallth insurance as the financing of medical expenses by means of contributions or taxes paid into a common fund, to pay for all or par} of health services specified in any insurance policy or law.

The legal instrument for the establishment of the Health Insurance Scheme in Nigeria is the National Health Insurance Scheme Act 35 of 1999. In his speech during the inception of the scheme ex- president Obasanjo (2005:2) gives the following as the need for or basis for the establishment of the National Health Insurance Scheme;

i. The General Poor State of the Nation's healthcare System.

ii. The excessive dependence and pressure on government to fund health services

iii. Dwindling funding of healthcare in the face of rising costs,

iv. Poor integration of private health facilties in the nation's healthcare delivery system.

Obasanjo (2005:2) further explains that government Hopes to achieve an efficient competitive and innovative health care system with the following objective;

i. To ensure that every Nigeria has access to good health care services.

ii. To protect families form the financial hardship of huge medical bills.

iii. To limit the size of the cost of healthcare services.

iv. To ensure equitable distribution of health care costs among different income groups.

v. To ensure efficiency in the healthcare services

vi. To improve and harness private sector participation in the provision of healthcare services, viii. To ensure equitable distribution of healthcare within the of healthcare, sector for federation.

vii. To ensure appropriate patronage of all levels.

viii. To ensure the availability of funds to the health improved services.

**2.6 NATIONAL HEALTHCARE INSURANCE SCHEME**

**PROGRAMMES**

The national health insurance scheme Act classifies

The NHIS Programmes into the following;

i. Formula Sector Social Programme, which is design for public servants and employees in the organized private sector.

ii. Urban self- employed social Health insurance Programme

iii. Rural Community Social health insurance programme.

iv. Children under- five social insurance programme

v. Permanently Disabled persons social insurance programme.

vi. Prison-inmates social insurance programme

vii. Tertiary institutions and voluntary participants social health insurance programme.

viii. Armed forces polices and other unformed services social insurance programme.

ix. Diaspora family and friends social insurance programme.

x. International travel health insurance programme.

Currently, only the formal sector programme has been Implemented and this covers the following;

i. Public sector employees which includes civil servant at all level

ii. Organizations with more than 10 employees, and

iii. Armed forces, policy and other uniformed services (Arum, 2006:18):

**2.7 HEALTHCARE SERVICES OF NATIONAL HEALTH**

**INSURANCE SCHEME**

According to the NHIS Act, the healthcare of the scheme to the beneficiaries includes the following;

i. Out - patient care (including consumable)

ii. Prescribed drugs as contained in the NHIS

iii. Diagnostic test as contained in the NHIS diagnostic test list

iv. Antenatal care

v. Material care for up to four live births for every insured person

vi. Post natal care.

vii. Routine immunization as contained in national programme on immunization.

viii. Family planning.

ix. Consultation with a defined range of specialist e.g. physielaris surgeons, etc.

**2.8 EXCLUDED SERVICES FROM THE NHJS SCHEME**

According to the NHIS Act, the flowing are excluded from the NHIS services list;

i. Occupational/industrial injuries

ii. Epidermis

iii. Injuries from extreme sports

iv. Drug abuse/addition

v. Cosmetics surgeries

vi. High cost surgical procedures e.g. organ transplants open-heart surgeries, etc.

vii. Provision of hearing aids

viii. Infertility management, and ix. Congenital abnormally.

**2.9 MANAGEMENT OF THE NATIONAL HEALTH INSURANCE SCHEME (NHIS)**

2.9.1 The National Health Insurance Scheme Act provides for the Mowing in the management of the scheme;

1. National Health Insurance Scheme Council !(NHISC)

According to the act, the council (NHISC) performs The following functions under the scheme;

i. Regulation and supervision of the scheme^ established under the NHIS Act.

ii. Issuing guideline, for remittance to Health, Maintenance organization (HMOS) and Health Services providers (HSPs)

iii. Establishing standard, rules and guideline for the management of the scheme.

iv. Approving, financing, regulating and supervising the health maintenance organization (HMOs) and health services providers (HSPs).

v. Receiving and investigation complaints of improperly against any HMOs or HSPs.

**2.9.2 HEALTH MAINTENANCE ORGANIZATION (HMOS)**

These are individual organization empowered by the NHIS Act to Play the rule of a contractor under the scheme by lessoning between the National health insurance scheme council and the health services providers. They directly coordinate and oversee the activities of the HSPs with respect to provision of the service under the scheme.

The NHIS Ac empowers the HMOs to carry out the following functions under the scheme;

i. Open account for the Health Service Providers registered with (each of) them,

ii. Receive the contributions by the government and workers via the National Health Insurance Scheme Council.

iii. Make payment to health services providers tor medical services provided for public servants registered with them.

iv. Oversee the activities of Health Service Providers.

**2.9.3 HEALTH SERVICES PROVIDERS (HSPs)**

These are the healthcare institutions registered by the National Health Insurance Scheme Council to provide health services to the people under the scheme. These institutions are classified into the following;

1. Primary Healthcare Providers:- These include community health centers, private clinics, hospital and maternity.

2. Secondary Healthcare Providers: - These include state government general hospital and big private hospitals.

3. Tertiary Health Providers:- These include specialist and teaching Hospital which serves essentially the scheme. According to the Act, the functions of Health Services providers include;

**2.9.4 FUNDING OF THE SCHEME**

According to Usman (2005:6) National Health Insurance Scheme (NHIS) is a contributory scheme in which both the employer and employees contribute to a common fund? Contributions are earning - related. In other words each workers contributes a specific proportion of his/her monthly or annual basic salary to the fund. Initially, contribution represented 15 per cent of basic salary.

The government paid 10 percent while the workers paid 5 percent. But since January 2007 workers have started paying the 15 percent. A monthly capitation is paid to the primary health services provider fee-for- service is paid to all secondary health service providers while per diem is paid for hospital bed space. There is also co-payment for drugs received from primary health services providers in which the recipient pays only 10 percent of the total cost of drugs received at instance.

**2.9.5 OPERATIONAL PROCEDURES AND COVERAGE**

The National health insurance scheme (NHIS) allows each Individual worker to decide and choose a health services providers with which to register for medical or health services. For each .worker, the scheme covers;

- Him/her (her insured known as the principal)

- A spouse (the wife or husband) and

- A Biological child. The scheme doers not provide coverage for dependently, an NHIS ID card is then given to the principal and each of the registered member of the family with which the health services provider visited for medical attention and treatment.

According to Arum (2006:17) for treatment and drug Administered on any of he beneficiaries only 10 paid to the HSp There is no limit to the number of visit at any given.

**2.10 EVALUATION OF THE NHIS**

Conceptually, NHIS is a welcomed innovative and development in the Nigeria health sector given its objective. However, Its effectiveness, or otherwise, can only be determined by the extent to which it has achieved its objectives. The following questions should be addressed in evaluating the effectiveness of NHIS.

1. To what extent has the scheme improved the general state of the nation's healthcare system?

2. To what extent has the scheme reduced dependence on government funding of health service in the country?

3. To what extent has the scheme contributed in increasing the funding of health care?

4. To what extent has the scheme integrated the private sector health facilities in the nation's health care delivery system? With respect to improvement in the general state of the nation's Health care system, Nwosu (2002:9) scores the scheme fairly high especially for public servants who now benefit from the benefits the scheme. They now receive much attention and are given adequate treatment in public hospitals. But Arum (2006:11) argues that the scheme has limited success since the larger segment of the Nigerian society are not yet benefiting from the scheme.

Only federal public servants benefit now as only the public sector programmes has been implemented Bothers that would beneficial to the society at large.

On reduction of dependence on government for funding health services, Arum (2006:11) acknowledges that the scheme has reduced the burden on the government and improved the funding of health service through its contributory strategy. The 15 percent deduction form basic salaries of workers, which are remitted to the NHIS and the co-payment system, have all increased healthcare funding.

The scheme however, has been rated iow in the integration of private sector healthcare delivery system. According to Lambo (2006:12) most of the health service providers are; government owned hospital. Few private health institutions operate the scheme. While some have stopped the scheme so many others refuse to register additional clients. It is also observed that most of them lack the personnel and requisite facilities for operation of the scheme.

Nevertheless, Teriba (2005:31) states that most of the objectives of NHIS are far from being achieving two years after its take- off. For instance not every Nigerian has access to good healthcare service under the scheme because of poverty, high cost of drugs and lack of healthcare facilities.

Many are still facing financial hardship caused by huge medical bills. Only few hospitals provide high standard healthcare services. Furthermore, ensuring equitable distribution of healthcare services through out the federation under the scheme is still far - fetched.

**2.11 PROBLEMS AND PROSPECTS OF THE NHIS**

Currently, the implementation of NHIS has nor been easy in inadequate physical health facilities and personnel, administrative and logistics bottlenecks. The nation does not have enough healthcare providing institutions with adequate medical facilities and personnel for effective implementation of the scheme besides, the administration of the scheme has not been easy given the delays in processing document of registered beneficiaries and remitted contributions to the NHIS and HMOS and HSPs.

Furthermore, the informal sector is very difficult to organized for the scheme. Even private hospital and clinic are becoming unwilling to embrace the scheme.

Nevertheless, the seems to be prospects for the success of the scheme. As Usman (2005:6) points cut, the increasing political commitment or government support as well as 'international Donor Agent as support for the scheme indicate prospects for the scheme in Nigeria. Besides, many organized private sector enterprises now bracing up for the scheme.

**CHAPTER THREE**

**RESEARCH METHODOLOGY**

**3.0 INTRODUCTION**

The methodology involves the systematic collection and analysis of data in research. It also involves the research design, population of study, sample size, sampling methods or techniques, sources of data, instruments of data collection and the techniques of data analysis. The components of the methodology of this research are outlined hereunder.

**3.1 RESEARCH DESIGN**

The descriptive survey design was adopted for this study. Brown (1985) explained that the descriptive survey research tries to identify variables that exist in a given situation and tries to describe the relationship among the variables, as well as identify the factors that exist among them.

**3.2 POPULATION OF STUDY**

The National Population Census of Nigeria in 2006 puts the population of Nigeria at one hundred and forty million, four hundred and thirty one thousand, seven hundred and ninety, in which Akwa Ibom state figures stood at three million, two hundred and thirty-three thousand, three hundred and sixty-six (3,233,366). The population of Akwa Ibom State was used in the investigation of this study. However, it comprises of the three senatorial districts of Akwa Ibom State. The results obtained can therefore be used to generalize voter participatory behaviour towards elections in Nigeria.

**3.3 SAMPLE SIZE/SAMPLING TECHNIQUE**

The sample size of this study was 1,200 respondents which comprises of male and female adults of voting age (18 years and above). This is a representative sample of the population of electorate in the three senatorial districts of Akwa Ibom State. The sample size of 110 respondents was drawn from the population for interview and administration of questionnaire through the use of stratified random sampling.

**3.4 RESEARCH INSTRUMENT: QUESTIONNAIRE/ IN-DEPT INTERVIEW**

The standardized questionnaire was used to elicit information from the respondents. It guarantees subjects anonymity and encourages high response rate. The questionnaire comprised of standardized questions structured to appropriately elicit useful information from the respondents. The questionnaire was divided into two sections, sections A and B. Question in section A dwells on the bio-data of respondents – sex, age, educational qualifications, gender and occupation. Section B comprised of questions that relate to the subject-matter of the research – questions that relate to the nature, causes and consequences of voter political participation or voter turnout, and other related issues which enabled us to get the required information or data for the analysis.

Also, officials of the State Independent Electoral Commission and officials of the State political parties’ secretariats were interviewed.

**3.5 VALIDITY AND RELIABILITY OF INSTRUMENT**

Reliability and validity of data was fortified by allowing experts in statistical analysis to make useful inputs on the research instruments. The questionnaire construct was also given to experts in Social Science to scrutinize so as to ensure that the research instruments were consistent with variables raised in the hypotheses and that they actually measure the issues under study by the researcher. This therefore improved without doubt the validity of the research instruments.

**3.6 SOURCE OF DATA COLLECTION**

For the purpose of the study, primary and secondary data formed the nuclei of data collection for analysis. The primary source of data was based on the administration of questionnaire and the conduct of interviews, while the secondary source included perusal of textbooks, journals, newspapers, magazines, internet amongst others.

**3.7 TECHNIQUES OF DATA ANALYSIS**

The data collected was analyzed using standardized methods. To this end, the Chi-Square (x2) and simple percentage were used to analyze the questionnaire. Analysis of data by simple percentage enabled the researcher to know the different opinions in assessing and testing the hypothesis for interpretations. The chi-square was used to substantiate the data or facts of the study. The data was presented in tables according to bio-data information like sex, age, marital status, educational qualification, and occupation.

The formula for the computation of the chi-square (x2 ) is given below:

X2=∑(fo=fe)2

fe

Where:

(x2) = Chi-square

Fo = Observed frequency

Fe = Expected frequency

While the formula for computing the simple percentage is:

% = PC × 10

N 100

Where

PC = Percentage compliance

N = Total number of respondents

100 = Common base of simple percentage

**CHAPTER FOUR**

**DATA ANALYSIS AND INTERPRETATION**

5.0 **INTRODUCTION**

In this chapter, the researcher presents and analysis the data collected from field survey. Deduction/findings are also made.

5.2 **DATA PRESENTATION AND ANALYSIS**

A total of 50 questionnaires were administered in Uyo metropolis where NTA is situated, but only 32 questionnaires were retrieved. Data presentation and analysis is made in tabular form and analysis is made in tabular form and frequency of responses calculated in percentages. The questionnaire data are also backed up by interview data. All these are shown below.

**CHAPTER FOUR**

**DATA PRESENTATION, ANALYSIS AND INTERPRETATION**

This chapter is devoted to the presentation, analysis and interpretation of the data gathered in the course of this study. The data are based on the number of copies of the questionnaire completed and returned by the respondents. The data are presented in tables and the analysis is done using the chi-square test.

**4.1 Data Presentation and Analysis**

The data presented below were gathered during field work:

**BIO DATA OF RESPONDENTS**

| **Table 1 sex of respondents** | | | | | |
| --- | --- | --- | --- | --- | --- |
|  |  | Frequency | Percent | Valid Percent | Cumulative Percent |
| Valid | male | 16 | 50.0 | 50.0 | 50.0 |
| female | 16 | 50.0 | 50.0 | 100.0 |
| Total | 32 | 100.0 | 100.0 |  |

Source: field survey, November, 2015.

Table 1 above shows the gender distribution of the respondents used for this study.

16 respondents which represent 50.0percent of the population are male.

16 respondents which represent 50.0percent of the population are female.

| **Table 2 age grade of respondents** | | | | | |
| --- | --- | --- | --- | --- | --- |
|  |  | Frequency | Percent | Valid Percent | Cumulative Percent |
| Valid | below 20 years | 3 | 9.4 | 9.4 | 9.4 |
| 21-30 years | 6 | 18.8 | 18.8 | 28.1 |
| 31-40 years | 8 | 25.0 | 25.0 | 53.1 |
| 41-50 years | 10 | 31.2 | 31.2 | 84.4 |
| 51-60years | 5 | 15.6 | 15.6 | 100.0 |
| Total | 32 | 100.0 | 100.0 |  |

Source: field survey, November, 2015.

Table 2 above shows the age grade of the respondents used for this study.

3 respondents which represent 9.4 percent of the population are below 20yrs.

6 respondents which represent 18.8percent of the population are between 21-30yrs.

8 respondents which represent 25.0 percent of the population are between 31-40yrs

10 respondents which represent 31.2 percent of the population are between 41-50yrs.

5 respondents which represent 15.6 percent of the population are between 50-60yrs.

| **Table 3 educational qualification of respondents** | | | | | |
| --- | --- | --- | --- | --- | --- |
|  |  | Frequency | Percent | Valid Percent | Cumulative Percent |
| Valid | WASSCE/SSCE | 4 | 12.5 | 12.5 | 12.5 |
| OND/HND/BSC | 10 | 31.2 | 31.2 | 43.8 |
| PGD/MSC/PHD | 10 | 31.2 | 31.2 | 75.0 |
| OTHERS | 8 | 25.0 | 25.0 | 100.0 |
| Total | 32 | 100.0 | 100.0 |  |

Source: field survey, November, 2015.

Table 3 above shows the educational background of the respondents used for this study.

Out of the total number of 32 respondents, 4 respondents which represent 12.5 percent of the population are WASSCE/SSCE holders.

10 respondents which represent 31.2percent of the population are OND/HND/BSC holders.

10 respondents which represent 31.2percent of the population are Table 3 above shows the educational background of the respondents used for this study.

Out of the total number of 32 respondents, 4 respondents which represent 12.5 percent of the population are FSLC holders.

10 respondents which represent 31.2percent of the population are SSCE/WASSCE holders.

10 respondents which represent 31.2percent of the population are OND/HND/BSC holders.

8 respondents which represent 21.0 percent of the population are MSC/PGD/PHD holders

8 respondents which represent 21.0 percent of the population have other types of certificates.

| **Table 4 Marital status of respondents** | | | | | |
| --- | --- | --- | --- | --- | --- |
|  |  | Frequency | Percent | Valid Percent | Cumulative Percent |
| Valid | single | 10 | 31.2 | 31.2 | 31.2 |
| married | 20 | 62.5 | 62.5 | 93.8 |
| divorced | 1 | 3.1 | 3.1 | 96.9 |
| widowed | 1 | 3.1 | 3.1 | 100.0 |
| Total | 32 | 100.0 | 100.0 |  |

Source: field survey, November, 2015.

Table 4 above shows the marital status of the respondents used for this study.

‘Out of the total number of 32 respondents, 10 respondents which represent 31.2 percent of the population are single.

20 respondents which represent 62.5 percent of the population are married.

1 respondent which represent 3.1 percent of the population is divorced.

1 respondent which represent 3.1 percent of the population iswidowed.

| **Table 5 position of respondents** | | | | | |
| --- | --- | --- | --- | --- | --- |
|  |  | Frequency | Percent | Valid Percent | Cumulative Percent |
| Valid | junior staff | 20 | 62.5 | 62.5 | 62.5 |
| senior staff | 12 | 37.5 | 37.5 | 100.0 |
| Total | 32 | 100.0 | 100.0 |  |

Source: field survey, November, 2015.

Table 5 above shows the level or position of respondents used for this study.

Out of the 32 respondents, 20 which represent 62.5 percent of the population are junior staff.

12 which represent 37.5 percent of the population are senior staff.

| **Table 6 years of service of respondents** | | | | | |
| --- | --- | --- | --- | --- | --- |
|  |  | Frequency | Percent | Valid Percent | Cumulative Percent |
| Valid | 0-2 years | 8 | 25.0 | 25.0 | 25.0 |
| 3-5 years | 10 | 31.2 | 31.2 | 56.2 |
| 6-11 years | 10 | 31.2 | 31.2 | 87.5 |
| above 12 years | 4 | 12.5 | 12.5 | 100.0 |
| Total | 32 | 100.0 | 100.0 |  |

Source: field survey, November, 2015.

Table 6 above shows the years of experience of the respondents used for this study.

Out of the 32 respondents, 8 which represent 25.0percent of the population have had 0-2yrs experience at work.

10 which represent 31.2 percent of the population have had 3-5yrs experience.

10 which represent 31.2percent of the population have had 6-11yrs experience.

4 which represent 12.5percent of the population have had more than 12yrs experience.

**TABLES BASED ON RESEARCH QUESTIONS**

| **Table 7 WORKERS ARE AWARE OF THE NATIONAL HEALTH INSURANCE SCHEME** | | | | | |
| --- | --- | --- | --- | --- | --- |
|  |  | Frequency | Percent | Valid Percent | Cumulative Percent |
| Valid | strongly agree | 18 | 56.2 | 56.2 | 56.2 |
| agree | 10 | 31.2 | 31.2 | 87.5 |
| undecided | 2 | 6.2 | 6.2 | 93.8 |
| disagree | 2 | 6.2 | 6.2 | 100.0 |
| Total | 32 | 100.0 | 100.0 |  |

Source: field survey, November, 2015.

**Table 7 above shows that workers are aware of the national health insurance scheme.**

18 respondents which represent 56.2 percent of the population strongly agreed.

10 respondents which represent 31.2 percent of the population agreed.

2 respondents representing 6.2 percent of the population are undecided.

2 respondents which represent 6.2 percent of the population disagreed.

| **Table 8 THE NATIONAL HEALTH INSURANCE SCHEME IS BENEFICIAL TO CIVIL SERVANTS** | | | | | |
| --- | --- | --- | --- | --- | --- |
|  |  | Frequency | Percent | Valid Percent | Cumulative Percent |
| Valid | strongly agree | 16 | 50.0 | 50.0 | 50.0 |
| agree | 10 | 31.2 | 31.2 | 81.2 |
| undecided | 4 | 12.5 | 12.5 | 93.8 |
| disagree | 2 | 6.2 | 6.2 | 100.0 |
| Total | 32 | 100.0 | 100.0 |  |

Source: field survey, November, 2015.

**Table 8 above shows that the national health insurance scheme is beneficial to civil servants.**

16 respondents which represent 50.0percent of the population

10 respondents which represent 31.2percent of the population agreed.

4 respondents representing 12.5 percent of the population are undecided.

2 respondents which represent 6.2percent of the population disagreed.

| **Table 9 THE NATIONAL HEALTH INSURANCE SCHEME HELPS TO PROTECT THE NIGERIA WORK FORCE** | | | | | |
| --- | --- | --- | --- | --- | --- |
|  |  | Frequency | Percent | Valid Percent | Cumulative Percent |
| Valid | strongly agree | 10 | 31.2 | 31.2 | 31.2 |
| agree | 19 | 59.4 | 59.4 | 90.6 |
| undecided | 2 | 6.2 | 6.2 | 96.9 |
| strongly disagree | 1 | 3.1 | 3.1 | 100.0 |
| Total | 32 | 100.0 | 100.0 |  |

Source: field survey, November, 2015.

**Table 8 above shows that the national health insurance scheme helps to protect the Nigeria work force.**

10 respondents which represent 31.2 percent of the population strongly agreed.

19 respondents which represent 59.4 percent of the population agreed.

2 respondents representing 6.2 percent of the population are undecided.

1 respondent which represent 3.1 percent of the population disagreed.

| **Table 10 NATIONAL HEALTH INSURANCE SCHEME HAS BEEN ESSENTIAL IN SAVING LIVES** | | | | | |
| --- | --- | --- | --- | --- | --- |
|  |  | Frequency | Percent | Valid Percent | Cumulative Percent |
| Valid | strongly agree | 16 | 50.0 | 50.0 | 50.0 |
| agree | 10 | 31.2 | 31.2 | 81.2 |
| undecided | 4 | 12.5 | 12.5 | 93.8 |
| disagree | 2 | 6.2 | 6.2 | 100.0 |
| Total | 32 | 100.0 | 100.0 |  |

Source: field survey, November, 2015.

**Table 8 above shows that the national health insurance scheme has been essential in saving lives.**

16 respondents which represent 50.0percent of the population

10 respondents which represent 31.2percent of the population agreed.

4 respondents representing 12.5 percent of the population are undecided.

2 respondents which represent 6.2percent of the population disagreed.

**RESEARCH HYPOTHESIS**

Ho: The national health insurance scheme has not been beneficial to Nigerian civil servants.

Hi: The national health insurance scheme has been beneficial to Nigerian civil servants.

**Level of significance**: 0.05

**Decision rule**: reject the null hypothesis if the p-value is less than the level of significance.

| **Table 11 Test Statistics** | |
| --- | --- |
|  | The national health insurance scheme has not been beneficial to Nigeria civil servants |
| Chi-Square | 49.000a |
| df | 4 |
| **Asymp. Sig.** | **.000** |
| a. 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 12.0. | |

**Conclusion based on the decision rule:**

Since the p-value (0.000) is less than the level of significance (0.05), we reject the null hypothesis and conclude that the national health insurance scheme has been beneficial to Nigerian civil servants.

**CHAPTER FIVE**

**FINDINGS, CONCLUSION AND RECOMMENDATION**

The objectives of the study were to

* Findings from the study revealed the following:
* Civil servants are aware of the national health insurance scheme.
* The national health insurance scheme is beneficial to civil servants.
* The national health insurance scheme helps to protect the Nigerian work force.
* National health insurance scheme is essential in saving lives.

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**QUESTIONNAIRE ADMINISTRATION**

**INSTRUCTION:** Please endeavor to complete the questionnaire by ticking the correct answer (s) from the options or supply the information required where necessary.

**SECTION A:** Personal Information/Data

1. Gender
2. Male
3. Female
4. Age grade
5. Below 20yrs
6. 21-30yrs
7. 31-40yrs
8. 41-50yrs
9. 51-60yrs
10. Above 60yrs
11. Educational qualification
12. WASCE/SSCE
13. OND/HND/BSC
14. MSC/PGD/PHD
15. Others
16. Marital status
17. Single
18. Married
19. Divorced
20. Widowed
21. Experience/years of service
22. 0-2yrs
23. 3-5yrs
24. 6-11yrs
25. Above 12yrs
26. Level/position
27. Junior staff
28. Senior staff

**SECTION B:**

Questions on knowledge awareness and benefits of national health insurance scheme among civil servants.

1. Workers are aware of the national health insurance scheme.
2. Strongly agreed
3. Agreed
4. Undecided
5. Disagreed
6. Strongly disagreed
7. The national health insurance scheme is beneficial to civil servants.
8. Strongly agreed
9. Agreed
10. Undecided
11. Disagreed
12. Strongly disagreed
13. Briefly outline other benefits of the national health insurance scheme to civil servants.

\_ \_ \_\_\_ \_\_ \_ \_ \_ \_\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_\_ \_ \_ \_ \_\_ \_ \_ \_ \_ \_ \_\_ \_ \_ \_ \_ \_ \_ \_ \_\_

1. What are the ways of further improving the national health insurance scheme?

\_ \_ \_\_\_ \_\_ \_ \_ \_ \_\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_\_ \_ \_ \_ \_\_ \_ \_ \_ \_ \_ \_\_ \_ \_ \_ \_ \_ \_ \_ \_\_

1. The national health insurance scheme helps to protect the Nigeria work force.
2. Strongly agreed
3. Agreed
4. Undecided
5. Disagreed
6. Strongly disagreed