

Investigating the Impact of Community-Based Health Insurance Scheme among the Rural Dwellers of Sokoto State, Nigeria

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Abstract

The purpose of this paper is to examine a few sample data on the investigation into the impact of community-based health insurance scheme among the rural dwellers of Sokoto state. Thus instrument such as content and face validity, reliability and data normality were also examined based on the revised version by expert, a few data were analyzed using the statistical software SPSS version 18. The result reveals that the instruments are reliable and the data for pilot study show evidence of rational normality.

Keywords: Policy Process, Economic Growth, Health Financing, Health Care Delivery, Scheme Design, Scheme Mobilization, Institutional design, Communication, Pilot Test, Sokoto, Nigeria.

1. Introduction

Health protection seen as a method of conveying the monetary risk connected with the variety of singular's human services used by pooling expenses over the long run through prepayment and other individuals with risk pooling (OECD, 2004). The health protection approach looks to evacuate financial boundaries to gaining a satisfactory layer of wellness mind and requires the affluent to experience the expense of support of the unhinged; the component of cross-subsidy is crucial (Enthoven 1988). Moreover, 'when a social order acknowledges accommodating health services by offering health protection, to some considerable level, at the general population's upkeep, such protection projects furnished through charges or regulations called social protection programs' (WHO 2010; Carrin and James 2004; Folland et al, 2004). In perspective of this, there necessity emerges for the organization to put resources into movement approaches and decides that will support the utilization of neighborhood health protection plan. Consistent with Rosenthal (2001), rural people may be less slanted to look for health care services owing to the climbing expenses of therapeutic administrations.

The need to develop a comprehensive health insurance scheme dated back to the middle ages. The responsibility of furnishing medical care for the sick and injured was vested in the family, neighbors, church, big businessman (for his people), master (for his servants) and employer (for his employees). Governments during those days often supplemented those provisions through public authority and funds. In developed countries, a health insurance scheme was first rested on volunteer activities. The inadequacies of the private systems made those countries increase the government intervention.

Social health protection has been spreading for a century accompanying its constitution in Germany by Bismarck in 1883 (Saltman and Dubois 2004). Worldwide, so far 27 nations have created the standard of general scope through Social Health Insurance (Carrin and James 2005). This procedure took 127 years to attain in Germany, 118 in Belgium, 79 in Austria, 72 in Luxembourg, 48 in Japan, and 26 in the Republic of Korea.

SHI has been implemented in so many developing countries such as Thailand, Philippines, Kenya, and Ghana. These states have been implementing social health insurance in their several lands and some of these nations were capable to attain universal health coverage while some are even struggling to introduce and enforce the social health insurance scheme.

Social Health Insurance in Nigeria, it is first discussed in 1962 by Haevi Committee, which sanctioned the recommendation through the Lagos Health Bill presented to parliament. The measure was not snuffed it, until 1984 when the campaign re-ordained. The craving to hotspot for trusts on social insurance administrations made the National Council on Health under Admiral Patrick Koghoni, (the Minister of Health) set up a commission led by Professor Diejomoh, which advised the regime on the attractive quality of Health protection conspire in Nigeria and prescribed its acceptance as a means to fund the health sector. In Nigeria, the Formal Sector, Social, Health Insurance Programmed was first presented in 2005.

Nigeria's over-riding objectives since independence in 1960 has been to achieve stability, material prosperity,

peace and societal advance. Nevertheless, this has been hampered as a consequence of national predicament. These include lacking human capital improvement, powerless framework, and uninspiring development Health division, fabricating segment, unemployment, the poor administrative environment and blunder and abuse of assets. The continuity of these troubles is not unconnected with institutional failure. Institutional is only the lack of or weak capacity for efficient service delivery by organizations. It is an established fact that the level of development of any society is influenced by so many factors, including functional institutions (Ubi, Effiom and MBA, 20011). Institutions are seen as "formal and casual principles, requirement qualities of standards, and criteria of conduct that structure rehashed social connection", between people, inside or between associations, through motivating forces, disincentives, requirements and improvement (North's, 1989) Thus, the central component of any local government, state or national level is service delivery to its citizenry through its creations. Hence, due to successive failure of the previous governments in Nigeria to provide its community with affordable health maintenance services across all the three grades of government there is a need to bring in health care reform in the strain of social security in which emphasis should be laid along both the formal and informal sector in Nigeria.

Nonetheless, preparing and putting through a sustainable health care funding, strategic framework is a key success element for health sector reforms in Nigeria and in bettering the health status of a majority of the masses, both in the immediate, medium and long-term view. Such strategy aims at striking a strategic, sustainable and fair balance through state budget; social health insurance; individual health insurance and to include non-governmental and developing partners' help; each mark well as regular and community-based health insurance scheme, with constrained out-of-pocket sources to health care services. Previous studies have distinguished four types of financing community-based health insurance scheme (Dong H, Kouyate B, Cairns J.2004). These are (i) Community prepayment scheme where the community gathers payment (in money or kind) ahead of time, control the provisions discharged, and pays the social insurance providers on activity of its endorsers; (ii) User fees managed by community depending on out-of-pocket human services, payment are at the point of social insurance usage (iii) Connected group health revolving fund hence the community serve as an agent of the state or social health protection in connecting with the rural individuals and whatever is left of community through some form of understanding or contracts. (Dong H, Kouyate B, Cairns, 2004).

In view of the information the paper intent to use policy process, financing of health care, health care delivery, economic growth, scheme design, institutional design, communication and community mobilization as independent variables while impact of community-based health insurance scheme as the dependant variable to do empirical pilot test in the contest of community based health insurance scheme in Sokoto state, Nigeria. Which previous study not captured.

To this end, this paper presents the result of pilot test with regard the policy process, financing of health care, health care delivery, economic growth, scheme design, institutional design, communication and community mobilization on the impact of community-based health insurance scheme in the context of the rural dwellers of Sokoto state, Nigeria.

2. Methodology

Knowing to the information that this study is a pilot test of ongoing research small samples of individuals among the rural dwellers was randomly selected. This is in accordance's with the commendation by Malhotra (2008) that the sample size for pre-test is usually few, starting from 15-30 respondents but it can be increase substantially if the test involves several stages. Hence, a total of 50 copies of questionnaires were individually circulated and 45 were completed and returned.

Sekaran and Bourgie (2010) specified that the most accepted test of inter-item uniformity reliability is Cronbach's alpha coefficient. Thus, Cronbach alpha test is engaged in this research to determine internal uniformity of the tool. The data was analyzed using SPSS version 18 for windows. Before the delivery of the questionnaires, the draft was first submitted to expects and also to the distinctive respondent for look and content validity. The entire procedure was finished between the periods of four weeks in the months of Feb. 2014.

2.1 Instrumentation and Measurement of Variables

A well prepared questionnaire compressing of closed ended multiple choice-questions were used for the study. Given that mainly of the items in the questionnaire are besieged to measuring the respondents' perceptions. Thus, Likert-type scale is regarded as the most appropriate and reliable (Alreck & Settle, 1995; Miller, 1991).

The mostly rating scales for measuring the latent construct in social science will be used in the study (Churchill & Peter 1984). The research will structure all construct in the measuring instrument to use 5- point Likert type of scale. Despite some other literatures have argued on the benefits inherent in 7-point Likert type of scale, but still a 7-point Likert scale is said to provide detail feedback and also not subjecting the respondents into any undue cognitive burden (Hair et al., 2010; Cavana et al., 2001; Churchill & Peter 1984).

The key factors contained in the study are: policy process, financing of health care, health care delivery, economic growth, scheme design, institutional design, communication and community mobilization as

independent variables. All the constructs/variables are uni-dimensional Section 1: consist of a set of seventeen questions that seek to measure the level of policy process on the impact of community based health insurance scheme. Section 2. Consist of five questions targeted at measuring the impact of health financing in community based health insurance scheme. Section 3: consist of five questions which attempt to measure the impact of health care delivery as perceived by the respondents. Section 4: contains five questions that are directed to measure the impact of economic growth on community based health insurance scheme as perceived by the respondents. Section 5: consist of six questions to measure the impact of scheme design as perceived by the respondents. Section 6: contains six questions that seek to measure the impact of institutional design as perceived by the respondents. Section 7: consist of six questions based on impact of communication as perceived by the respondents. Section 8: consist of eleven questions base on the impact of mobilization as perceived by the respondents. Finally, section 9: Consists of questions about the demographic facts of the respondents. Only the significant items that will be used in answering the research questions are included in the questionnaire. Furthermore, responsive questionnaire are not included in order to obtain high response rate (Sekaran & Bougie, 2010).

3. Results of Validity and Reliability Tests

3.1 Content and Face Validity

In order to make sure that the determine consists of an sufficient and representative position of items that spout a exacting idea, this involves a orderly appraisal of the scale's ability to determine what is theoretical to measure. Thus, content validity entails requiring a few samples of characteristic respondents and/or team of specialist to make judgment on the appropriateness of the items chosen to determine a variable (Hair, Money, Samouel & Page, 2007; Hair, Black, Babin, Anderson, Tathan, 2010; Sekaran and Bougie, 2010).

Therefore, a sample of the instrument of this paper was circulated to specialist in order to get outcome regarding the appropriateness, comfortable, and sufficiency of the items that are planned to determine the constructs under examination. Similarly, some Ph.D. candidates who are well-know with the context of the study were also contacted to make sure the clearness of the instrument. A number of observations were reworded/rephrase in order to determine the constructs properly and also to be clear to the possible respondents. This process of seeking for specialist opinion was completed within three-week period. Following pleasant into consideration of the observation by the specialist, then the researcher come up with an enhance version of the instrument which was eventually administered for the pilot study.

3.2 Reliability Test

Apart of the content and face validity different kind of reliability tests are frequently employed, therefore, the common method used by researchers is the internal consistency reliability test (Litwin, 1995). It is refer as the degree to which items "dangle jointly as a set" and are able of autonomously measuring the identical concept to the degree that items are related with one another. Thus, Sekaran and Bougie (2010) state that the most accepted test of inter-item consistency reliability is Cronbach's alpha coefficient. Therefore, Cronbach alpha test is employed in this study to determine internal consistency of the mechanism. After administration the data using SPSS version 18 for windows, the result reveals that all the measures have high reliability criterion ranging from 0.70 to 0.887. This is in line with the yardstick that an instrument with coefficient of 0.60 is considered to have an average reliability while the coefficient of 0.70 and above shows that the instrument has a high reliability standard (Hair, Black, Babin, Anderson, & Tatham, 2006, 2010; Nunally, 1967; Sekaran & Bougie, 2010) and coefficient of 0.50 as supportive (Nunally, 1967). Furthermore, Hair, Money, Samouel, and Page (2007) view that researcher usually regard that an alpha value of 0.70 as a least, however, lower coefficients may be acceptable. Table 1 shows the digest of the reliability results. It may perhaps be seen from the table that the result of pilot study shows that Cronbach's alpha values for the variable under examination are all above 0.70. Accordingly, given recognized yardstick of 0.70 to 0.539 variables are reliable.

However, it manifest from table 1 that policy process, scheme design, mobilization, health care delivery, economic growth and institutional design are more reliable than communication and financing of health care among the rural dwellers of Sokoto state Nigeria according to the respondents who participated in this pilot study. Also representatives of households having 31% and female having 48.9% responded well in this study.

3.3 Data Distribution

Generally, the inferential statistical methods necessitate the completion of normality hypothesis (Pallant, 2001; Tabacknich & Fidell, 2007). Normal data is the one that is balanced, bell-shape, with the maximum frequency of scores in the middle and smaller distribution towards the extreme ends. Normality can be measure by using the values of skewness and kurtosis. While skewness deal with the symmetry, kurtosis shows the extent to which the data is peak or flat (Tabacknich & Fidell, 2007). Therefore values of skewness and kurtosis the data can be regarded as rationally normal.

4. Conclusion

The objectives of this study is pilot study is the validity and reliability of the instrument of a continuous project in homework for the large scale study. Thus, the end of this study is tied to its aims which are mainly statistical in nature at this point. The implication of the constructs would be fully exposed after the main study is carried out. This study brings the few scale data that was collected during the pilot study. Content and face validity were carry out which consequently led consideration of specialist view to attain the revised version of the instruments. Moreover, the inter-item reliability test indicated that variable policy process, mobilization, scheme design, health care delivery and economic growth are statistically significant. While variable financing of health care, institutional design and communication are not significant in this study. (Hair, Black, Aderson & Tatham, 2006, 2010; Nunally;1967; Sekaran & Bougie, 2010). Furthermore, Hair, Money, Samouel, and Page (2007) view that researcher usually regard that an Alpha value of 0.70 as a least, however lower coefficient may be accepted. The findings of this study showed that the prospect of community-based health insurance scheme depend on respondents policy process, scheme design and mobilization. It could therefore be recommended that the policy makers in Nigeria should take those factors into consideration before the introduction of community-based health insurance scheme. The governments at both federal state and local governments should intensify efforts in having effective policy process, scheme design and in creating awareness about the benefits of providing the rural people with equitable and accessible health care. Finally, normality test using skewness and kurtosis shows that the data as entire is rationally normal.

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Table 1. Summary of Reliability Study SPSS version 18 for windows

Construct	No of items	Cronbach's Alpha
Policy process	17	0.749
Financing of health care	5	0.42
Health care delivery	5	0.539
Economic growth	5	0.539
Scheme design	6	0.643
Institutional design	6	0.52
Communication	6	0.393
mobilization	11	0.678
Total	61	

Table 2. Demography of respondent

S/N	Items	Frequency	Percentage (%)
1	Status in your household		
	Female heads of household	11	24.4
	Male head household	12	26.7
	Wives	5	11.1
	Grandmother	3	6.7
	Representative of household	14	31.1
2	Are you the main income earner in your household?	16	35.6
		29	64.4
3	How many people live in your household		
	1 - 5	6	13.3
	6 - 15	35	77.8
	16 - 25	2	4.4
	26 -35	1	2.2
	35 - above	1	2.2
4	How old are you		
	0 - 18	3	6.7
	19 – 25	32	71.1
	25 – 35	9	20.0
	35 – above	1	2.2
5	Sex		
	Male	12	26.7
	Female	22	48.9
7	What occupation is your major source of income		
	Famer	2	4.4
	Petty trading	1	2.2
	Government worker	5	11.1
	Employed in private sector	14	31.1
	Unemployed	6	13.1
	Big business	9	20.0
	Self-employed professional	8	17.8
	Others		