Willingness to Pay for Health Insurance in Benue State – A Report

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This report is produced by Nigeria Health Watch. This report is supported by funding from Christian Aid UK, Nigeria Office through the #Health4AllNaija Advocacy.

Executive Summary

In September 2015, the United Nations adopted Universal Health Coverage (UHC) as part of the Sustainable Development Goals (SDGs) to be achieved by 2030 (United Nations, 2015).

UHC is the global aspiration that all people obtain health services they need without suffering financial hardship paying for them. This requires coverage with a range of services such as promoting, preventive, curative, rehabilitative and palliative services (Kieny and Evans 2013).

Effective coverage means that there is an adequate supply of health services to meet the demand. Furthermore, this supply also must be equitably distributed across communities and socioeconomic classes.

A recent review of health-system financing for UHC in Nigeria shows high out-of-pocket expenses for health care, a very low budget for health at all levels of government, and poor health insurance penetration.

The purpose of this report is to highlight the willingness of the people in Benue State to pay for health insurance.

This study adopted a cross-sectional study design with mixed-methodology and adopted both qualitative and quantitative research methodologies.

Two Local government Areas were randomly selected from each of the 3 Senatorial districts, making a total of 6 Local Government Areas. Sample size for the quantitative component was 384 while the quantitative component had 25 respondents for in-depth interviews and 16 respondents for focus group discussions.

The major themes that were curated from the qualitative component of the study include

- Health Seeking Behavior
- Out of pocket Expenditure
- Willingness to pay for health Insurance
- Recommendations for Health Insurance

For the quantitative component, the majority of the respondents (73.78%) were male. This is the first indication that the majority of the main decision makers in the households are disproportionately males. The majority of the respondents who were both the main income earners and main decision-makers were males (67.3%). The majority (61.29%) of the households had 4 to 8 people living in them.

The survey also showed that the majority of the respondents reported malaria (45.12%), typhoid (20.73%) and malaria and typhoid (8.94%) as the most recent type

of sickness or poor health condition [they] had in [their] household within the past month.
Majority of the households (46.97%) used motor bikes (Okada) as their means of transportation to their preferred places of treatment and most of them also spent less than 15 minutes (48.26%) getting to the place of treatment.

For this study, the majority of respondents (67.3%) were both main income earners and main decision makers. This suggests 67.3% of respondents are able to make financial, informed decisions for health insurance for the family based on their economic statuses.

The majority of the households (26.42%) sought treatment first at the chemist (patent medicine dealer).

The study also showed that the respondents took an average of 15 minutes to get to the location of treatment; an average of 200 naira was spent on transportation to get treatment by respondents; an average of 3700 Naira was spent on treatment by the respondents; and an average of 3850 Naira was spent by the respondents on both transportation and treatment respectively.

The survey has shown that comparatively, the average amount of money spent on out-of-pocket payment for healthcare is significantly higher than that which would have been used to pay for health insurance. But the factors that have influenced the low uptake of insurance which include factors related to health-seeking behaviors, effects of out-of-pocket payment, perceptions about health insurance, fears and uncertainties related to health insurance have been observed.

Some of the recommendations that would make people agree to pay for health insurance include support from the government, community mobilisation, involvement of religious societies, increased advocacy for health insurance, and support for the health institutions in terms of equipment, infrastructure and personnel.

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BACKGROUND:

In September 2015, the United Nations adopted Universal Health Coverage (UHC) into the Sustainable Development Goals to be achieved by 2030 (United Nations, 2015). The 17 goals and 169 targets, including one specific goal for health integrate the three dimensions of sustainable development around people, planet, prosperity, peace and partnership. Health has a principal place as a major contributor to and beneficiary of sustainable development policies. There are many linkages between the health goals, other goals and targets reflecting the integrated approach that is underpinning the SDGs. UHC, one of the 13 health goal targets, provides an overall framework for the implementation of a broad and ambitious health agenda in all countries.

Increasing the access of African populations to healthcare is one of the great challenges facing the continent. UHC is the global aspiration that all people obtain health services they need without suffering financial hardship paying for them. This requires coverage with a range of services such as promoting, preventive, curative, rehabilitative and palliative services (Kieny and Evans 2013). UHC calls for universal effective coverage, which emphasises giving people equal access to health services.

Effective coverage means that there is an adequate supply of health services to meet demands. Furthermore, this supply also must be equitably distributed across communities and socioeconomic classes.

The statement by the former director general of the World Health Organisation (WHO) Margaret Chan, that universal health coverage is "the single most powerful concept that public health has to offer", attests to the increasing worldwide attention given to UHC (World Health Organisation 2010). Countries around the world, from low, middle and high-income countries, all seek to improve health care and ensure universal coverage.

However, UHC is also broader than health because improving the population's health enables adults to work and earn an income, and provide education for children, thereby allowing many to escape poverty. Low-income countries particularly must see it as a way to reduce financial impoverishment caused by reduction of health spending and increased access to key health services (Hsiao and Zhang 2014; Mcintyre *et al* 2006). Studies have shown significant impact on household levels economy due to out-of-pocket

expenditure on health care on low-middle-income countries (LMICs) (Lagomarsino *et al* 2012; Mcintyre *et al* 2006)

There is an over-reliance on Out-Of-Pocket (OOP) payments in Nigeria. Above 80 million Nigerians are living in poverty, which is defined as living on less than $1 a day (Nigerian Living Standards Survey (NLSS), 2019. OOP payments can make households and individuals incur catastrophic health expenditure and this can exacerbate the level of poverty. In Nigeria, the percentage out-of-pocket health expenditure is 75% (National Health Accounts 2010 -2016). OOP health expenditure, also known as user-charges where the health facility owners impose some charges on individuals for healthcare services up-take. OOP health expenditure could be incurred directly by a patient to a health service provider without reimbursement. It covers payment for healthcare services at the point of need. Health user-fees could include drug costs, medical material costs, entrance fees, and consultation fees. OOP expenses also comprise user-fees in public health facilities and any other private payments to healthcare providers for medicals and other treatment received. Similarly, healthcare financing across the less developed and developing countries is still characterized by OOP health expenditure.

Less than 5% of Nigeria's estimated 200 million population have health insurance with most enrolled in formal sector, which requires regular contributions compatible with formal sector earnings whereas there is very poor coverage in the informal sector, i.e. individuals who live predominantly in the rural areas. Note that about 62% of Nigerians live in rural areas (Onoka *et al* 2016). Two states (Bauchi and Cross River) attempted enrolling their employees, but nine states (Abia, Enugu, Gombe, Imo, Jigawa, Kaduna, Lagos, Ondo, and Oyo) have indicated interest. Other states including Lagos, Kwara, Ogun, and Akwa Ibom are implementing state-led community-based health insurance programmes to reach the informal sector with varying levels of coverage and inherent sustainability challenges (Arhin *et al* 2001).

Nigeria has shown commitment to achieving UHC. However, progress has been rather slow (Onoka *et al* 2016). Nigeria's National Health Bill was signed into law by President Jonathan on December 9, 2014. The Nigerian Senate passed the National Health Bill into law following its 3rd reading at the National Assembly, the aim of the Act is to establish a framework for the Regulation, Development and Management of a National Health

System, to set standards for rendering health services in the Federation and other matters concerned therewith. The Act is set to help Nigeria achieve UHC and meet the Millennium Development Goals (MDGs) target. The Act also provides for the elimination of quacks from professionalism and provides basic health funds needed by Nigerians (Nigeria National Assembly, 2015). Benue State House of Assembly passed the Benue Health Management Agency Bill on September 19, 2018. The bill was signed into law by the Governor and facilitated the establishment of the Benue State Health Management Agency. This agency is working to institute a health insurance scheme for all residents of the state with focus on the informal sector. (Vanguard, 2018).

Health insurance could be described as a mechanism for spreading the risks of incurring healthcare costs over a group of individuals or households (Ijeoma *et al* 2019). Some studies have shown that rural community households are initially reluctant to join insurance schemes because they do not readily buy into the idea of "paying" for services they might not use in the long run. Interpreting such findings as evidence that these households have risk attitudes non-supportive of insurance (risk neutral or risk-loving attitudes) would predict limited potential for insurance schemes targeting these households (Babatunde *et al* 2012; Arhin *et al* 2001). However, studies conducted in Ghana, Burundi, and Guinea-Bissau suggests that households in rural areas are risk-averse with regard to healthcare (Arhin *et al* 2001). In general, willingness to pay data are rarely collected or used as part of designing health insurance schemes in developing countries. In Nigeria enrolment in some Community Health Insurance schemes have been low with small average premiums because of a lack of study on willingness to pay before such schemes took off. Perhaps WTP information for a target population would be key in the facilitation of scheme design and eventual implementation (Babatunde *et al* 2012). This precisely is the purpose of this report, to highlight the willingness of the people in Benue State to pay for health insurance.

RESEARCH OBJECTIVES:

The objectives of the study were as follows:

- To gauge the general perceptions of the people about health insurance
- To ascertain the willingness of the people in keying into health insurance

- To determine how much monetary value the people are willing to commit into health insurance
- To explore the conditions that should be met before people agree to participate in health insurance
- To analyze the views of healthcare workers and policy makers on the feasibility of health insurance in Benue State
- To make appropriate recommendations to the Government and partners on the methodologies to be followed in setting up and effectively running the health insurance.

RESEARCH TABLE				
Objectives	Questions	Methods	Tools	Respondents
To gauge the perception of the people about Health insurance in general	• What do you know about Health Insurance? • How do you think Health insurance is run? • Do you think health insurance is beneficial? • Do you have any friend or relative that is involved in health insurance? How is their experience?	• Focus Group Discussions • Key Informants interview • Household interviews	• Interview Guide • Consent Forms • Writing materials • Recorders	• Household members • Community/Religious Leaders • Women Groups • Youth Groups • Traders • Farmers • Taxi Drivers/Keke Napep Riders
To ascertain the willingness of the people in keying into (HEALTH INSURANCE)	• Have you lost any friend or relative because you couldn't afford his health care bill? • Have you spent a huge amount of money on healthcare for yourself or friend/family member? • Do you know that you can set up and participate in health insurance in your community? • If health insurance is set up in your community are you willing to join? • Would you register/pay for your family? • How many members of your family will you be able to enroll for health insurance?	• Focus Group Discussion • Key Informants Interview • Household interviews	• Interview Guide • Consent forms • Writing materials • Recording Materials • Recorders	• Household Members • Community/Religious Leaders • Women Groups • Youth Groups • Traders • Farmers • Taxi Drivers/Keke riders

To determine how much the people are willing to commit into HEALTH INSURANCE	• What is your average monthly earning right now? • How much do you normally spend on healthcare for you and your family in a month? • How much are you willing to pay per month for health insurance	• Focus Group Discussion • Key Informants Interview • Household interviews	• Interview Guide • Consent Forms • Writing Materials • Recording Materials • Recorders	• Household Members • Community/Religious Leaders • Women groups • Youth Groups • Traders • Taxi Drivers/Keke Riders • Farmers
To explore the standard quality of care that would spur people to sign up for health insurance.	• How is the state of infrastructure in your healthcare facilities? • Are drugs and commodities readily available in your health facilities? • Are there adequate numbers of health workers? • Are health workers knowledgeable about patient centered care?	• Focus Group Discussion • Key Informants Interview	• Interview Guide • Consent Forms • Writing Materials • Recorders	• Household Members • Community/Religious Leaders • Women Groups • Youth Groups • Traders • Taxi Drivers/Keke Riders
To explore perceptions of healthcare workers and policy makers on the feasibility of Health Insurance in Benue state	• How will you describe the healthcare delivery in this community/LGA? • How is healthcare financed in this community/LGA • What do you think are the hindrances in achieving quality healthcare in the Community/LGA?	• Focus Group Discussions • Key Informants Interview	• Interview guide • Consent Forms • Writing Materials • Recorders	• Community Health workers • Local Government Health Officials • State Health Officials

	• Do you think money is a factor mitigating against acquiring quality healthcare in this Community/LGA? • Do you think Health Insurance is possible in this Community? • How do you think Health insurance should be implemented? • What do you think should be done before Health Insurance is implemented	• Household interviews		
To make appropriate recommendations on willingness to pay for Health insurance in Benue state.	• What recommendation will you make to improve the number of people signing up for health insurance?	• Focus Group Discussions • Key Informants Interview • Household Interviews	• Interview Guide • Consent forms • Writing materials • Recorders	• Community/Religious Leaders • Community Health workers • Local Government Health officials • State health officials • Women groups • Youth Groups • Traders • Taxi Drivers/Keke Riders • Farmers

METHODOLOGY

Study Location:

The study took take place in Benue State. Two Local government areas were randomly selected from each of the 3 Senatorial districts, making a total of 6 Local Government Areas. One Urban and one Rural LGA were selected per senatorial Zone.

Description of Sample Size Selection

The sample size for this study was calculated using the formula: $n= (Z^2pq)/B^2$

Where;

n = desired sample size (when the population>10,000)

Z = number of normal deviation from the mean; set at 1.96 for a level of 95%

p = proportion (prevalence) in the target population estimated to have particular characteristics. This is set at 0.5 (50%) because of non-availability of survey data

q = 1-p (proportion in the target population not having the particular characteristics)

B = Margin for random error set at 0.05 (5%)

n = minimum sample size

Substituting, n= 1.96 x 1.96 x 0.5 x (1- 0.5)/0.05 x 0.05

= 3.84 x 0.5 x 0.5/0.0025

= 384 participants in the state.

Study Design:

This was a cross-sectional study design with mixed methodology that adopted both qualitative and quantitative research methodologies.

Desk research

An in-depth review to analyze existing studies, data, publications, and reports on health insurance in general and Community Based Health Insurance in Nigeria in particular.
The appropriate data sources such as published studies, research and survey reports and relevant grey literatures were reviewed. These documents were synthesized to summarize ongoing and resolved challenges, gaps and benefits of health insurance to the Nigerian populace.

In-Depth Interviews

In-depth interviews (IDIs) with key stakeholders at the State, LGA and community levels were conducted. To not miss any essential information, an interview guide with open-ended questions was developed to further explore information from all respondents. Respondents for this survey were Community/Religious Leaders, Household members,

Women group members, Traders, Community Health Workers and Local Government Health officials. The community-based organisations within the selected LGAs constituted significant portions of the study respondents. Prospective respondents were recruited either via telephone, letter, or face-to-face to confirm a suitable time before interviews were conducted to capture the required information from the stakeholders.

Levels	Representative	No of IDI
National Level	GM HEALTH INSURANCE NHIS	**1**
State Level	Commissioner of health	**1**
	Executive Secretary Benue State PHCDA	**1**
	Benue State NHIS coordinator	**1**
	Chairman House committee on Health (BSHA)	**1**
LGA Level	Local Government Chairman	**1**
	Councillor in charge of health	**1**
	Director of Health (1 per LGA)	**6**
	Health Facility in charge (2 per LGA)	**12**
Community Level	Community Leader (1 per LGA)	**6**
	Faith Leader (2 per LGA)	**12**
	Women Leader (1 per LGA)	**6**
	Total	**48**

Focus Group Discussions

Focus Group Discussions (FGDs) allowed participants to discuss topical issues in detail, explore and clarify their points of view, thus enhancing in-depth discussions. The focus group discussions mainly involved community members. The FGD sessions enabled exploratory and confirmatory questions to be asked from participants to achieve deeper understanding of their interests and needs. In achieving this, we ensured homogeneity of participant groups that captured the key attributes of the target population. We constituted groups in ways that did not hamper the discussion of sensitive topics due to differences in age, occupation, lifestyle, roles and status in the community. We maintained manageable group sizes and strived to achieve saturation of the responses.

Sample frame for the Focus Group Discussions (qualitative)

• Female farmers (1 per LGA) • Youth Groups (1 per LGA) • Okada/Keke Naped riders (1 per LGA) • Male Farmers (1 per LGA)	• 4 FGDs per LGA • 8 FGDs per Senatorial Zone • Total number of FGDs - 28

Household Interviews

The research team conducted structured community-based household surveys in the selected LGAs. The objective was to select representative sample households in each of the LGAs selected to represent fully both rural and urban perceptions of the subject matter. To achieve this, in each of the 3 Senatorial zones in the state, 2 Local Government Areas were randomly selected making 6 Local Government Areas in total. One urban and one rural Local Government Area was selected per senatorial zone.

After the selection of LGAs, we selected households from enumeration areas (EAs) based on rural and urban stratification. We ensured, as much as possible, that every household had an equal probability of being selected. Due to this approach, our working sample frame (table below) changed slightly in proportion, but the target number of households remained the same.

State	Senatorial zone	LGA Composition		Total
		Urban	Rural	
Benue	Benue South	85	43	128
	Benue North-East	85	43	128
	Benue North-West	85	43	128
Grand Total		**255**	**129**	**384**

In each selected LGA, Enumeration Areas (EAs) were selected by simple random sampling. In each selected EAs, households were selected by simple random sampling. In each selected household, Head of the Family (either a man or a woman) was randomly selected to respond to the survey questions. In cases where the selected respondent is not available for the survey, one more attempt was made at various times of the day to

re-contact the respondent. After that, the household was replaced, and a different respondent selected. The same principle of replacement applied in situations where consent is not given.

RESULTS:

Quantitative Results

1. **Introduction**

The analysis is affected by a high level of attrition of cases because of missing and illogical responses. This affected variables, like gender, that should not have been affected in any situation. In addition, the survey instrument has some validity and reliability weaknesses. For example, it is easy to ignore that the respondents were providing answers for the households and not for themselves.

The above posed some real challenges and made the analysis very difficult. Respondents had to be reselected at different steps. With every selection, the analysis was repeated from the beginning.

The level of attrition and the exclusion criterion of Question 4 (***Do you consider yourself to be the main decision-maker in your household about what your household spends money on?***) reduced the number of cases for analysis from the sample size of 420 to 279. All the analyses reported below are based on the latter.

Table 1 Table showing if respondents consider themselves to be the main decision-maker in the household about what their household spends money on

Q4 - Do you consider yourself to be the main decision-maker in your household about what your household spends money on?			
SN	**Decision**	**Frequency**	**Percent**
1	No (Stop the interview)	40	12.54
2	Yes (Continue the interview)	279	87.46
Total		**319**	**100**

This also shows the responses to Question 4 referred to above

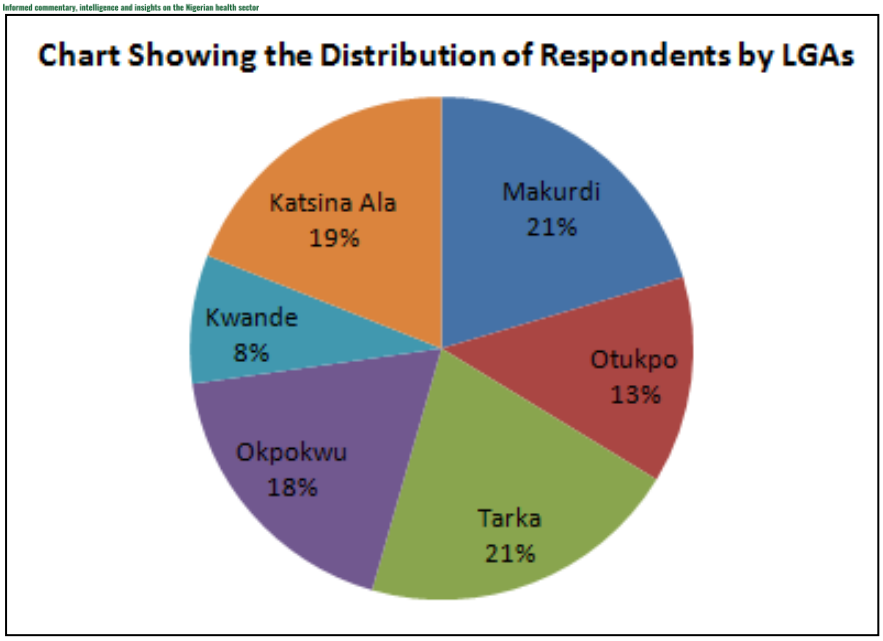


Figure 1: Distribution of Respondents by LGAs

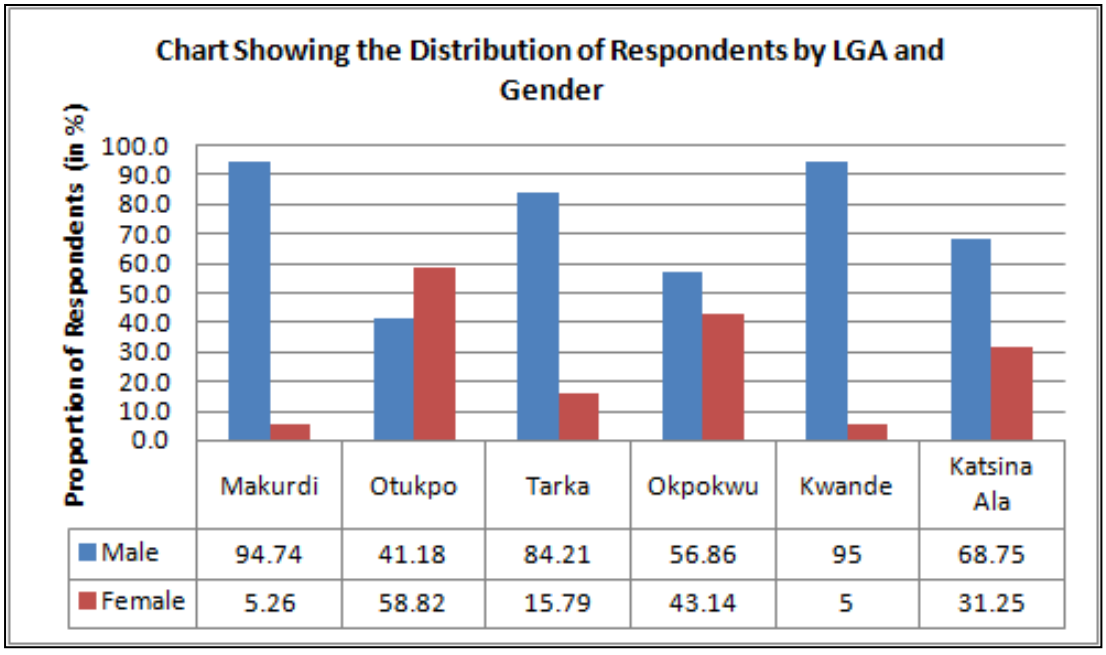


Figure 2: Chart Showing the Distribution of Respondent by LGA and Gender

In the figure above, the majority of the respondents (73.78%) are male. This is the case for all the LGAs except Otukpo (male – 41.18% and female – 58.82%). This is the first indication that the majority of the main decision makers in the households are males.

Table 2: Table showing respondent position the household

Q2 - What is your position in this household?

SN	Responses	Frequency	Percent
1	Wife	56	20.66
2	Husband	178	65.68
3	Grandmother	1	0.37
4	Grandfather	4	1.48
5	Other adult income earner	32	11.81
Total		**271**	**100**

The table above shows that distribution of the respondent's position in the households they represented individually in the survey

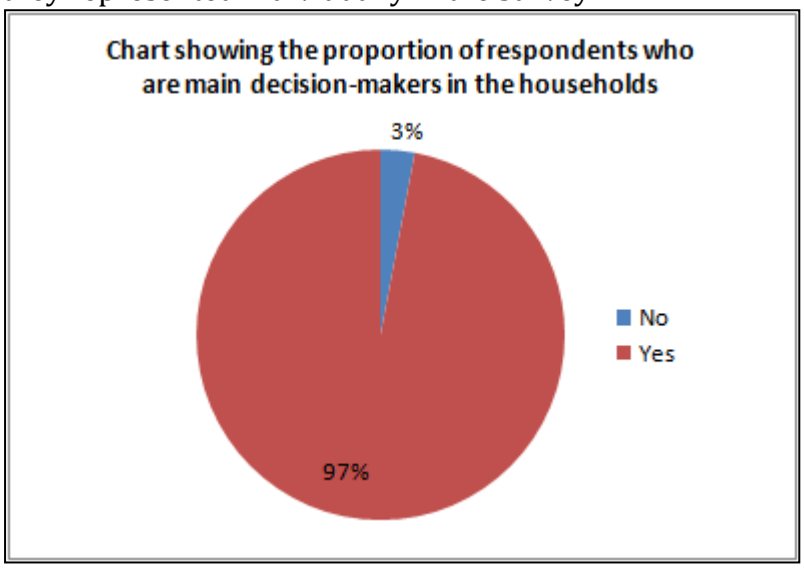


Figure 3: Chart showing the proportion of respondents who are main decision-makers in the households

The figure above show that 97.13 percent of the respondents are the main income earners in their respective households

Table 3: Table showing the main income earners in the households by their positions

SN	What is your position in this household?	Are you the main income earner in your household?				
		No		Yes		Total
		Freq	Percent	Freq	Percent	
1	Wife	3	5.36	53	94.64	56
2	Husband	1	0.56	177	99.44	178
3	Grandmother	0	0	1	100	1
4	Grandfather	0	0	4	100	4
5	Other adult income earner	4	12.5	28	87.5	32
Total		**8**	2.95	**263**	97.05	**271**

The table above is a crosstab disaggregating the main income earners in the households by their positions (wife, husband, grandmother, grandfather and others) in the households.

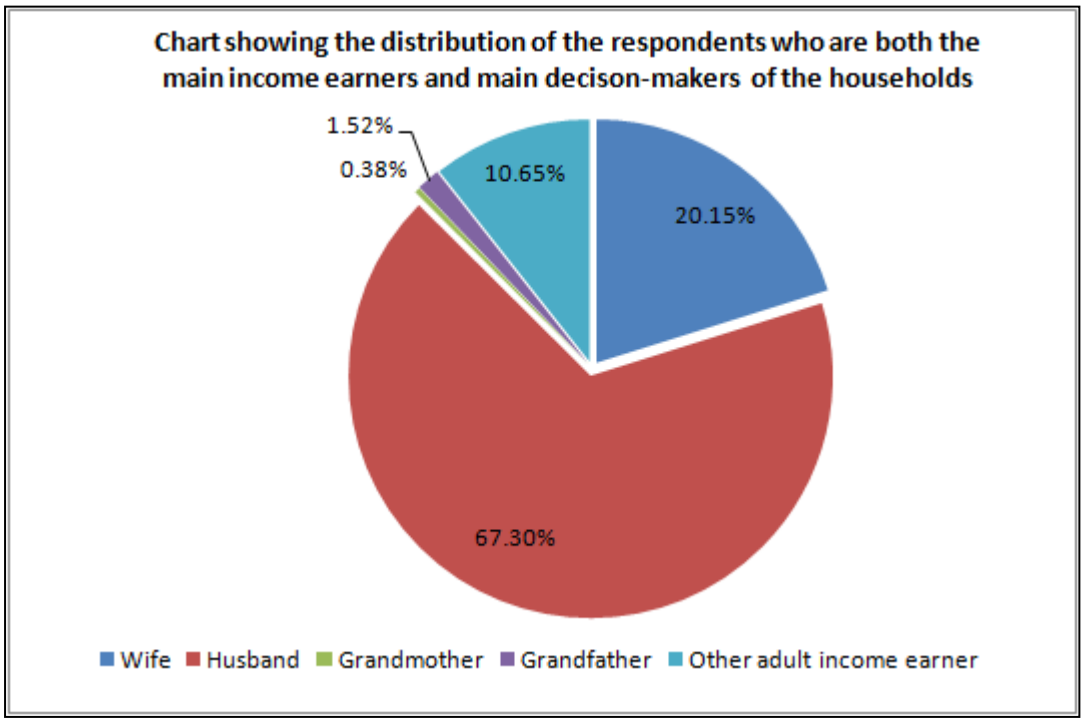


Figure 4: Chart showing the distribution of the respondent who are both the main income earners ad main decision-makers of the households

The figure above combines the responses to whether respondents are main income earners and main decision-makers in their households. The majority of the respondents who are both are males (67.3%).

Table 4: Table showing the number of people living in the households

Q5 - How many people live in this household, including yourself?			
SN	Number per household	Frequency	Percent
1	1	7	2.51
2	2	6	2.15
3	3	16	5.73
4	4	25	8.96
5	5	47	16.85
6	6	37	13.26
7	7	32	11.47
8	8	30	10.75
9	9	21	7.53
10	10	22	7.89
11	11	8	2.87
12	12	10	3.58
13	13	3	1.08
14	14	5	1.79
15	15	1	0.36
16	16	3	1.08
17	17	2	0.72
18	18	2	0.72
19	20	1	0.36
20	22	1	0.36
Total		279	100

The table above shows the number of people living in the households surveyed (represented by the respondents). The majority (61.29%) of the households have 4 to 8 people living in them.

Table 5: Table showing the top five household types

Top Five Household Types			
SN	Number of people who live in the household	Frequency of household type	Percent of total household types
1	5	47	16.85
2	6	37	13.26
3	7	32	11.47
4	8	30	10.75
5	4	25	8.96
Total		171	61.29

The table above shows the top five household types (by the number of people living in them). The household type that has 5 people is first and represents 16.85% of all households. The household type that has 4 people represents 8.96% of all households. The top four types represent 52.33% all households

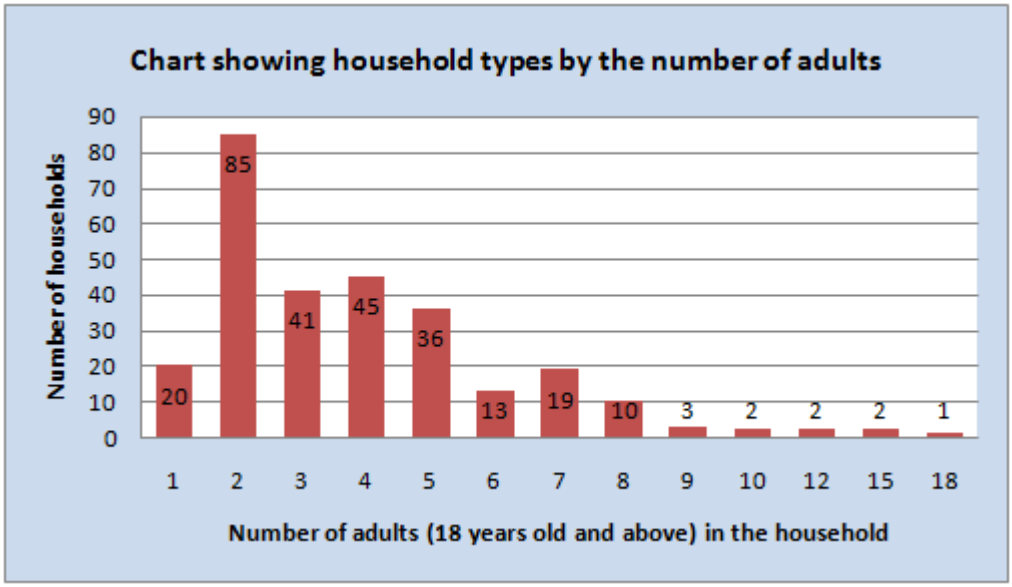


Figure 5: Charts showing household types by the number of adults

The figure above shows household types by the number of adults (18 years old or above) who live in them. The majority (61.29%) of the households have 2-4 adults.

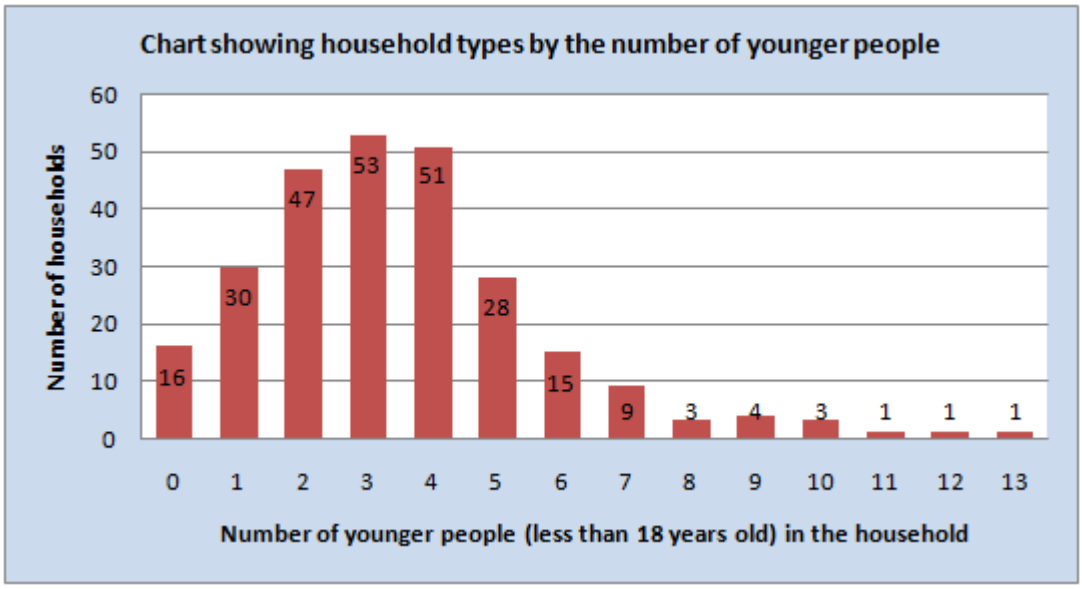


Figure 6: Charts showing household types by the number of younger people

The figure above show household types by the number of younger people (less than 18 years old) who live in them. The majority (57.63%) of the households have 2-4 younger people.

Table 6: Table showing the most recent type of sickness or poor health condition respondents had the household within the past month

Q8 - What was the most recent type of sickness or poor health condition you had in your household within the past month?			
SN	**Responses**	**Frequency**	**Percent**
1	Malaria	111	45.12
2	Malaria and Others	1	0.41
3	Malaria and Typhoid	22	8.94
4	Malaria and Diarrhoea	3	1.22
5	Typhoid	51	20.73
6	Typhoid and Others	2	0.81
7	Pneumonia	7	2.85
8	Pneumonia and Others	1	0.41
9	Diarrhoea	18	7.32
10	Others	30	12.2
Total		**246**	**100**

The table above shows that the majority of the respondents reported malaria (45.12%), typhoid (20.73%) and malaria and typhoid (8.94%) as the most recent type of sickness or poor health condition [they] had in [their] household within the past month.

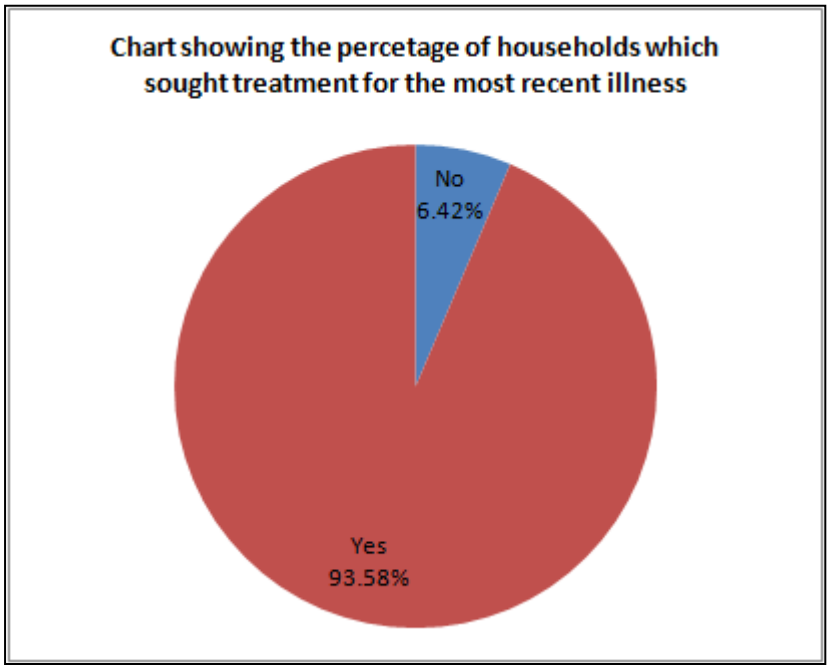


Figure 7: Chart showing the percentage of households which sought treatment for the most recent illness

The figure above shows that 93.58% of the respondents/households sought treatment for the illness reported in the previous month.

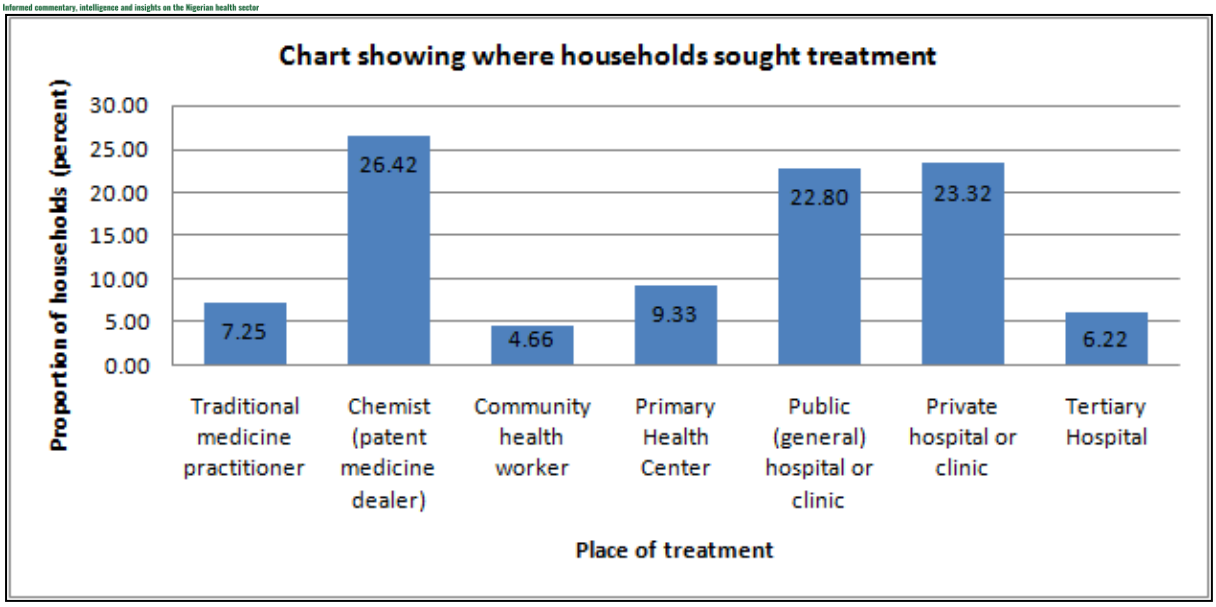


Figure 8: Chart showing where households sought treatment

The figure above shows that the majority of the households (26.42%) sought treatment first at the chemist (patent medicine dealer). This by private hospital or clinic and public (general) hospital or clinic at 23.32% and 22.8% respectively.

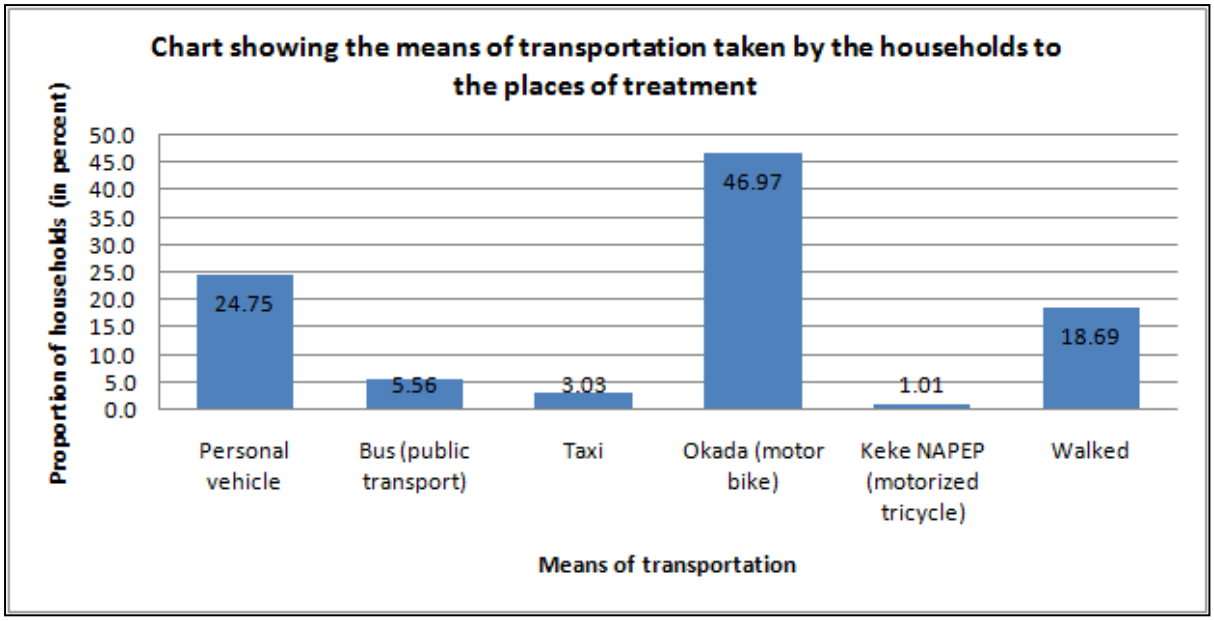


Figure 9: Chart showing the means of transportation taken by the households to he places of treatment

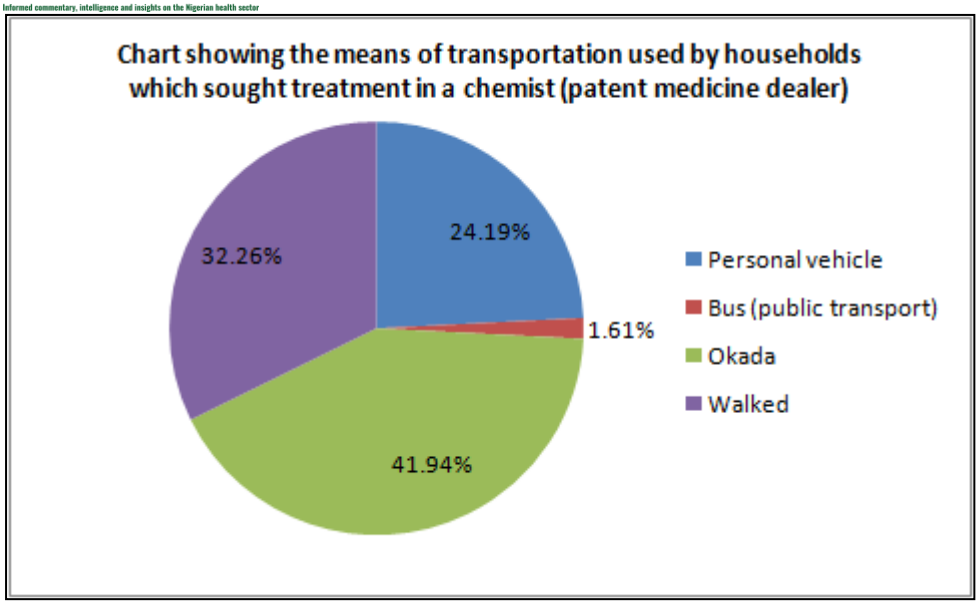


Figure 10: Chart showing the means of the transportation used by the households which sought treatment in the chemist (patient medicine dealer)

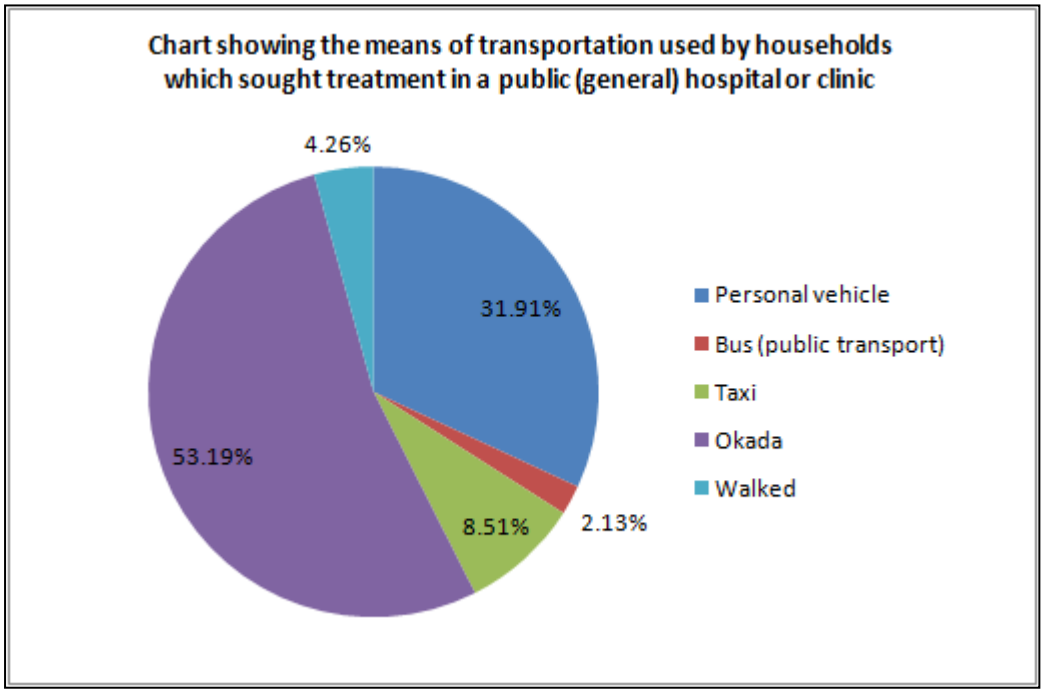


Figure 11: Chart showing the means of transportation used by households which sought treatment in a public (general) hospital or clinic

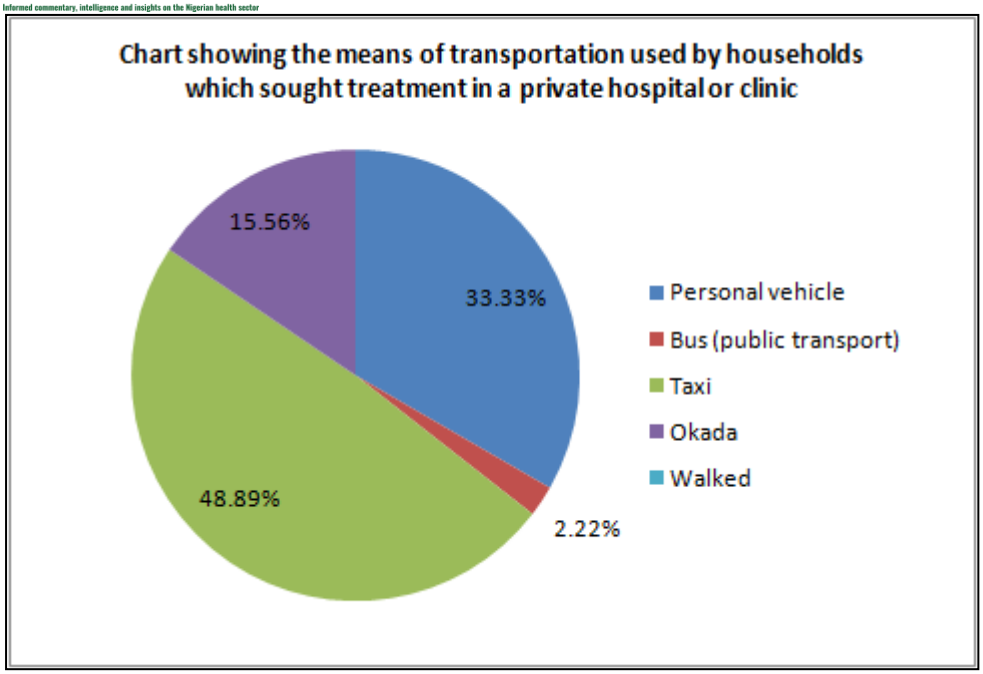


Figure 12: Chart showing the means of transportation used by households which sought treatment in a private hospital or clinic

The figure above shows the means of transportation used by the households in getting to the chosen place of treatment. Majority of them (46.97%) took motor bikes (Okada). Those that walked constitute 18.69% of the households.

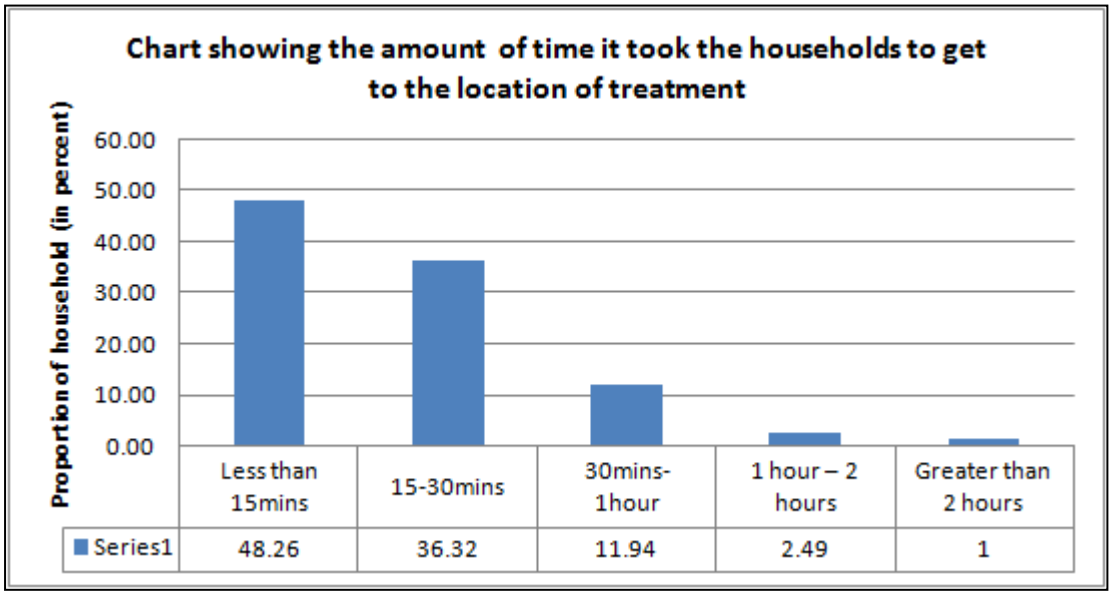


Figure 13: Chart showing the amount of time it took the households to get to the location of treatment

The figure above show the amount of time spent by the households to get to the location of treatment. Most of them spent less than 15 minutes (48.26%) and 15-30 minutes (36.32%).

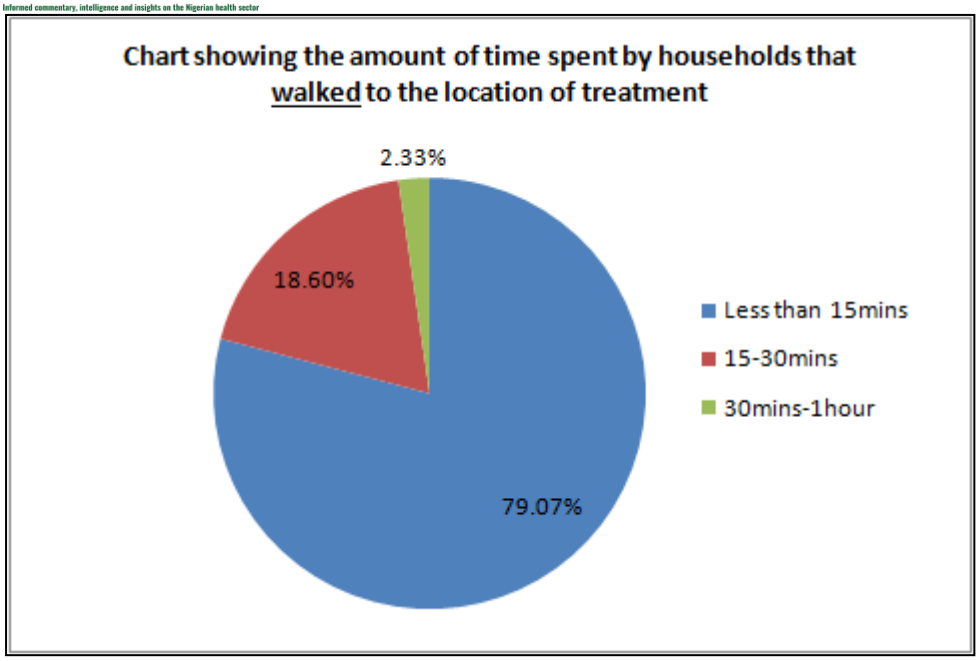


Figure 14: Chart showing the amount of time spent by households that walked to the location of treatment

The figures above show a further breakdown of the amount of time spent by households to get to the location of treatment. In these scenarios and the one above, the majority of the households spent less than 15 minutes. Time could be a strong factor in the choice of where households seek treatment.

The first figure above shows the amount of time spent by the households that walked to get to the location of treatment

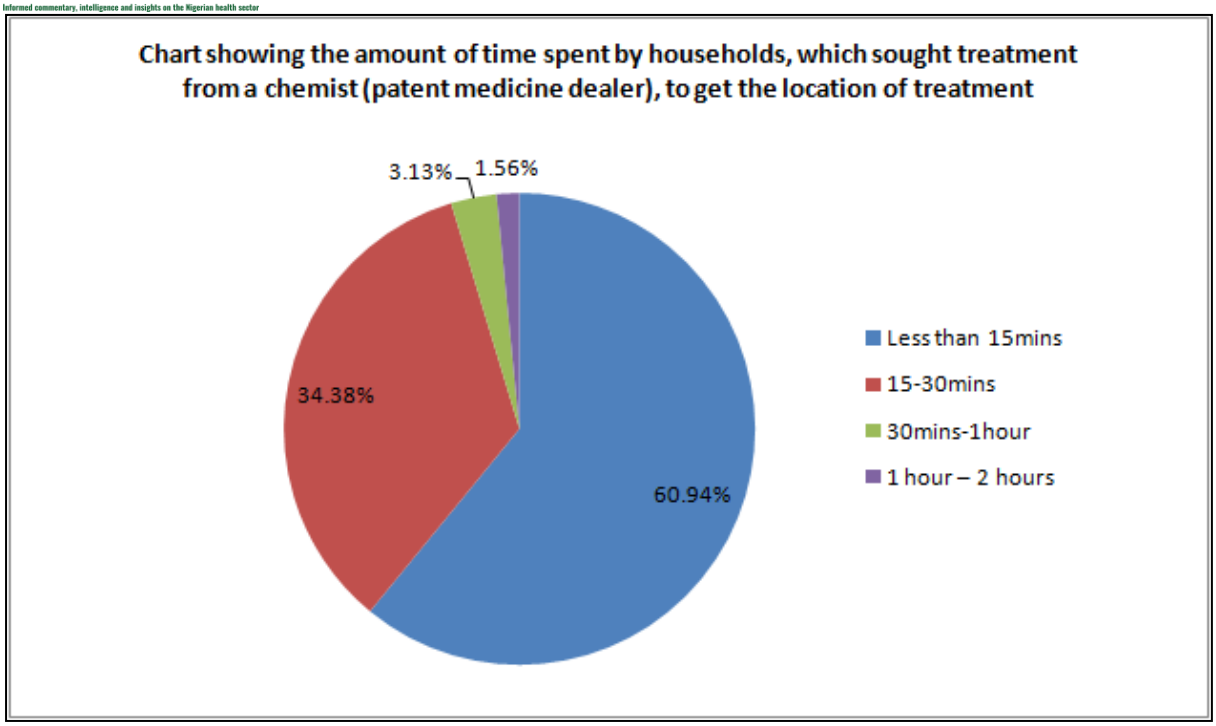


Figure 15: Chart showing the amount of time spent by households, which sought treatment from a chemist (patient medicine dealer), to get the location of treatment

The figure above shows the amount of time spent by the households, which sought treatment with a chemist (patent medicine dealer), to get to the location of treatment

Table 7: Table showing the amount of minutes It takes respondent to get to the location of treatment

Q13 - Approximately how many minutes did it take you to get to the location of treatment?		
N	Valid	198
	Missing	6
Mean		27.02
Minimum		2
Maximum		1,200
Median		15

The table above shows that it took the households an average of 15 minutes (median time) to get to the location of treatment.

Table 8: Table showing the amount spent by respondents on transportation to receive this treatment (to and fro) in Naira

Q14 - How much did you spend on transportation to receive this treatment (to and fro) in Naira?		
N	Valid	154

	Missing	50
Mean		522.27
Minimum		14
Maximum		10,000
Median		200

The table above shows that on the average, the households spent 200 Naira (median amount) on transportation to the location of treatment

Table 9: Table showing the amount spent by respondents on treatment in total in Naira

Q16 - Approximately how much did you spend on treatment in total in Naira?		
N	Valid	199
	Missing	5
Mean		7,499.35
Minimum		100
Maximum		150,000
Median		3,700

The table above shows the households from 100 Naira to 150,000 Naira on treatment. The average spending (median amount) is 3,700 Naira.

Table 10: Table showing the total expenses of respondents- Q14 (transportation) and Q16 (treatment)

Total Expenses - Q14 (transportation) and Q16 (treatment)		
N	Valid	200
	Missing	4
Mean		7,863.99
Minimum		100
Maximum		150,700
Median		3,850

The table above shows the households from 100 Naira to 150,700 Naira on both transportation and treatment (total expenses). The average spending (median amount) is 3,850 Naira.

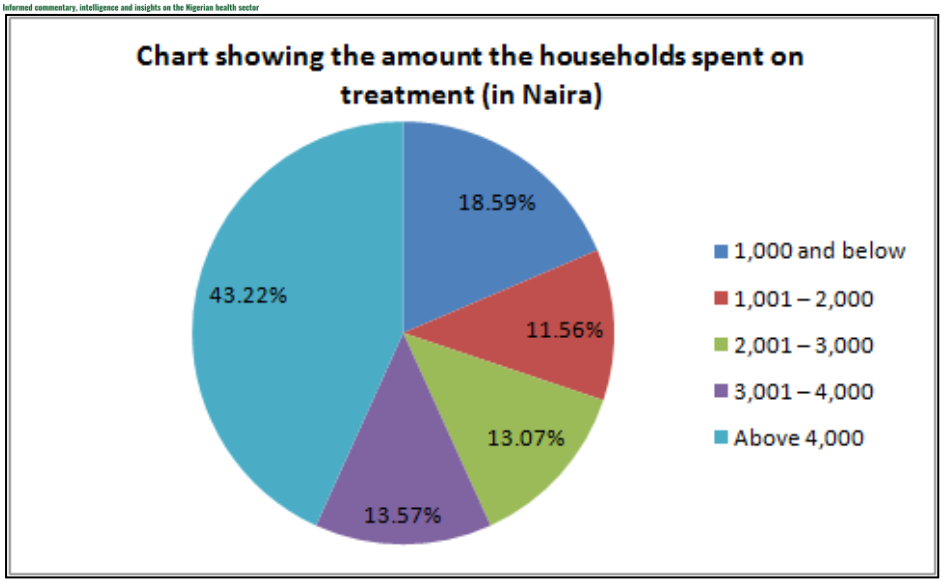


Figure 16: Chart showing the amount the household spent on treatment (in Naira)

The figure above categorize the amount which the households spent on treatment (as estimated by the respondents). From the table, 56.78% of the households paid 4,000 Naira or less. This matches closely the median amount given earlier.

Table 11: Table showing if respondents had to remain in the health facility visited for more than one day

Q17 - Did you have to remain in the health facility visited for more than one day?			
SN	**Responses**	**Frequency**	**Percent**
1	No (go to Q19)	152	77.55
2	Yes (go to Q18)	44	22.45
Total		**196**	**100**

The table above shows that 22.45% of the respondents (or household members), who sought treatment, had to remain in a health facility for more than one day

Table 12: Table showing number of days respondents remained at the facility

Q18 - If *YES* to question 17, how many days did you remain at the facility?			
SN	**Responses**	**Frequency**	**Percent**
1	1	2	5.13
2	2	11	28.21
3	3	7	17.95
4	4	5	12.82
5	5	2	5.13
6	6	1	2.56
7	7	3	7.69
8	11	1	2.56
9	12	1	2.56

10	14	2	5.13
11	21	1	2.56
12	30	1	2.56
13	50	1	2.56
14	60	1	2.56
Total		**39**	**100**

The table above shows that majority of the people (see Table 20), who had to stay more than one day in a health facility, spent two days (28.21%) to three days (17.95%)

Table 13: Table showing if respondents recovered after receiving this treatment

Q19 - Did you recover after receiving this treatment?			
SN	**Responses**	**Frequency**	**Percent**
1	No (go to Q20)	17	9.24
2	Yes (go to Q23, Section 2B)	167	90.76
Total		**184**	**100**

The table above shows that majority of the people (see Table 20), who did not have stay more than one day in a health facility, recovered after receiving treatment (90.76%)

Table 14: Table showing if respondents were referred to another health facility to complete treatment

Q20 - Were you referred to another health facility to complete treatment?			
SN	**Responses**	**Frequency**	**Percent**
1	No (go to Q23, Section 2B)	8	66.67
2	Yes (go to Q21)	4	33.33
Total		**12**	**100**

The table above shows that 33.3% of the household candidates, who did not recover after receiving treatment (see Table 22), were referred to another facility to complete treatment

Table 15: Table showing where respondents went to receive further treatment

Q21 - Where did you go to receive further treatment?			
SN	**Responses**	**Frequency**	**Percent**
1	Traditional medicines	1	25.00
2	Public (general) hospital or clinic	3	75.00
Total		**4**	**100**

The table above shows that 75% of the referred patients (see Table 23) received further treatment in *public (general) hospital or clinic*.

Table 16: Table showing the approximate total cost spent (transportation/drugs/others) until they recovered after the referral in Naira

Q22 - What was the approximate total cost you spent (transportation/drugs/others) until you recovered after the referral in Naira?			
SN	**Responses**	**Frequency**	**Percent**
1	1,100	1	25.00
2	24,000	1	25.00
3	43,000	1	25.00
4	200,000	1	25.00
Total		**4**	**100**

Table 17: Table showing the average of the approximate total cost spent (transportation/drugs/others) until they recovered after the referral in Naira

Q22 - What was the approximate total cost you spent (transportation/drugs/others) until you recovered after the referral in Naira?		
N	Valid	4
	Missing	0
Mean		67,025
Minimum		1,100
Maximum		200,000
Median		33,500

The tables above show that the referred patients, who received further treatment, spent much more on further treatment and transportation than the average (median amount) for treatment and transportation spent by all respondents. The patient who spent 1,100 on further treatment indicated that he/she was seen in traditional medicine

Table 18: Table showing respondents willingness to enroll in the health insurance scheme

Q23 - Will you be willing to enroll in the health insurance scheme?			
SN	**Responses**	**Frequency**	**Percent**
1	No	20	7.27
2	Yes	255	92.73
Total		**275**	**100**

The table above shows that 92.73% of the respondents will be willing to enrol in the health insurance scheme?

Table 19: Table showing reasons given by respondents for not being willing to enrol

0	Already enrolled
0	

0	
0	I don't know if it will work
0	
0	I don't trust government
0	Because my earning is small
0	
0	No reason
0	I don't know if it will work
0	We are not paid salary
0	I don't want to
0	I don't do english treatment
0	Already enrolled in National Health Insurance Scheme
0	No money/ income for the house hold [widow]
0	I DON'T NEED IT
0	
0	I DON'T WANT ANYBODY TO EAT MY MONEY AND GO
0	I DON'T HAVE THE MONEY
0	I DON'T HAVE THE MONEY TO BE PAYING
0	I DON'T TRUST THIS INSURANCE PEOPLE
0	NOT BOW, MAYBE LATER
0	WITH THE NONE PAYMENT OF SALAR[ES, I CANT PAY
0	BECAUSE I MAY NOT HAVE THE MONEY TO CONTINUE
0	I WOULD LOVE TO BUT I DON'T HAVE A SOURCE OF INCOME
0	I DON'T FALL SICK OH
0	FOR NOW I DON'T HAVE MONEY TILL I START WORKING

The table above explores the reason why respondents will not be willing to enrol in the health insurance

Table 20: Table showing respondents willingness to enroll other household members in the health insurance scheme

Q24 - Will you be willing to enroll other household members in the health insurance scheme?			
SN	**Responses**	**Frequency**	**Percent**
1	No	28	10.61
2	Yes	236	89.39
Total		**264**	**100**

The table above shows that 89.39% of the respondents will be willing to enrol other household members in the health insurance scheme?

Reasons given by respondents for not being willing to enroll other household members

Family structure.

- *Because I am single*
- *For now, I am single*
- *I stay alone*
- *I live alone*
- *They are adults and will bear the cost themselves*

Lack of understanding of the insurance concept

- *What if no one falls sick in my family? My money will be wasted*

Lack of trust in the government

- *I don't trust government*
- *I don't know if it will work*
- *I don't know if it will work*
- *I want to try it first and know if it is real*

Belief systems

- *We don't patronize English medicine*
- *Because traditional medicine doesn't fail*

Finance

- *We are not paid salary*
- *I don't have money*

The table above explores the reason why respondents will not be willing to enroll other household members in the health insurance scheme

Table 21: Table showing respondents willingness to enroll self and/or other household members in the health insurance scheme

Q23 and Q24 Combined - Willing to enroll self and/or other household members in the health insurance scheme			
SN	**Responses**	**Frequency**	**Percent**
1	"NO" to self and others	11	3.94
2	"YES" to self	18	6.45
3	"YES" to self and others	235	84.23
4	"YES" to others	1	0.36
5	"YES" for self, no response about others	2	0.72

6	"NO" for self, no response about others	8	2.87
7	No response to either self or others	4	1.43
Total		**279**	**100**

The table above combines the responses to Questions 23 and 24. It shows that 84.34% of the respondents will be willing to enroll themselves and other household members in the health insurance scheme

Table 22: Table showing the price of monthly insurance premium (contribution) respondents are willing to pay

Q25a - The price of a monthly insurance premium (contribution) is 1,000 Naira; are you willing to pay?			
SN	**Responses**	**Freq**	**Percent**
1	No (continue to 25b)	46	17.69
2	Yes (continue to 25g)	214	82.31
Total		**260**	**100**

The table above shows that 82.31% of the respondents will be willing to pay 1,000 Naira monthly for insurance premium

Table 23: Table showing the maximum amount respondents are willing to pay

Q25b - What is the maximum amount you are willing to pay (for less than N900)?			
SN	**Responses**	**Freq**	**Percent**
1	0	1	2.56
2	300	1	2.56
3	500	35	89.74
4	700	1	2.56
5	1,000	1	2.56
Total		**39**	**100**

The table above shows that 89.74% of the respondents, who will not be willing to pay a monthly premium of 1,000 Naira, will be willing to pay 500 Naira monthly.

Table 24: Table showing the premium (990) respondents will be willing to pay

Q25c - What if the premium is 990 Naira, will you be willing to pay?			
SN	**Responses**	**Freq**	**Percent**
1	Missing	1	100.00
Total		**1**	**100**

The table above shows that there is no valid response from one respondent the meets the criterion for Question 25c

Table 25: Table showing the premium (890) respondents will be willing to pay

Q25d - What if the premium is 890 Naira, will you be willing to pay?			
SN	**Responses**	**Freq**	**Percent**
1	No (go to Q25e)	22	95.65
2	Yes (go to Q25g)	1	4.35
Total		**23**	**100**

The table above shows that 23 of 38 (see Table 33 above) provided valid answers. Of the 23 respondents, 95.65% indicated that they would not pay a monthly insurance premium of 890 Naira.

Table 26: Table showing the real maximum amount respondents are willing to pay for the health insurance premium

Q25e - What really is the maximum amount you are willing to pay for the health insurance premium?			
SN	**Responses**	**Freq**	**Percent**
1	500	19	95.0
2	700	1	5.0
Total		**20**	**100**

The table above shows that 95% of the respondents who would not pay 1,000 Naira will not pay more than 500 Naira

Table 27: Table showing the final maximum amount respondents are willing to pay per month to join the health insurance scheme if there is an increase to the amount

Q25f - You may have to increase the amount if you really want to join the health insurance scheme. So, what is the final maximum amount you are willing to pay per month to join the health insurance scheme?			
SN	**Responses**	**Freq**	**Percent**
1	500	27	72.97
2	600	4	10.81
3	700	4	10.81
4	890	1	2.7
5	900	1	2.7
Total		**37**	**100**

The table above shows that even with further prompting, 72.97% of respondents (who would not pay 1,000 Naira or 890 Naira) insisted on paying a monthly insurance premium of 500 Naira

Table 28: Table showing the maximum amount respondents is very certain to pay bearing in mind the average monthly household income and money spent on various items

Q25g - If due to inflation or other uncertainties, the premium for the health insurance scheme increases, what is the maximum amount you are very certain to pay bearing in mind your average monthly household income and money you spend on various items?			
SN	**Responses**	**Freq**	**Percent**
1	0	3	1.27
2	100	4	1.69
3	200	5	2.11
4	300	2	0.84
5	500	37	15.61
6	550	1	0.42
7	600	7	2.95
8	700	8	3.38
9	750	1	0.42
10	800	1	0.42
11	1,000	57	24.05
12	1,050	1	0.42
13	1,100	9	3.80
14	1,200	20	8.44
15	1,300	5	2.11
16	1,400	5	2.11
17	1,500	57	24.05
18	1,600	2	0.84
19	2,000	8	3.38
20	3,000	2	0.84
21	4,000	1	0.42
22	5,000	1	0.42
Total		**237**	**100**

From the Table above the majority (70.89%) among all the respondents, irrespective of preferences expressed earlier, are willing to pay 1,000 Naira or more for monthly insurance premium – 1,000 Naira (24.05%), 1,100 Naira (3.8%), 1,200 Naira (8.44%) and 1,500 (24.05%). When compared to 82.31% of the respondents, who are willing to pay 1,000 Naira for monthly insurance premium (see Table 32, page 22), we can conclude that the majority of the respondents are willing to pay at least 1,000 Naira monthly insurance premium.

Table 29: Table showing the average of the maximum amount respondents is very certain to pay bearing in mind the average monthly household income and money spent on various items

Q25g - If due to inflation or other uncertainties, the premium for the health insurance scheme increases, what is the maximum amount you are very certain to pay bearing in mind your average monthly household income and money you spend on various items?		
N	Valid	237
	Missing	42
Mean		1,086.71
Minimum		0
Maximum		5,000
Median		1,000

The table above shows the average monthly insurance premium, calculated from Table 38 above. The median premium is 1,000 Naira

Table 30: Table showing the price of monthly insurance premium (1000) respondents is willing to pay per household member

Q26a - The price of a monthly insurance premium is 1000; are you willing to pay this amount of money per household member?			
SN	**Responses**	**Freq**	**Percent**
1	No (go to Q26b)	64	28.57
2	Yes (go to Q26g)	160	71.43
Total		**224**	**100**

The table above shows that the 71.43% of respondents are willing to a monthly insurance premium of 1,000 Naira for every household member

Table 31: Table showing the maximum amount respondents are willing to pay

Q26b - What is the maximum amount you are willing to pay?			
SN	**Responses**	**Freq**	**Percent**
1	0	4	8.7
2	100	1	2.17
3	200	1	2.17
4	500	35	76.09
5	600	1	2.17
6	700	2	4.35
7	1,000	2	4.35
Total		**46**	**100**

The table above shows that 76.09% of the respondents, who would not pay 1,000 for every household member, are willing to pay 500 Naira monthly insurance premium for every household member

Table 32: Table showing the premium (890 Naira) respondents will be willing to pay

Q26d - What if the premium is 890 Naira, will you be willing to pay?			
SN	**Responses**	**Freq**	**Percent**
1	No (go to Q26e)	19	95.0
2	Yes (go to Q26g)	1	5.0
Total		**20**	**100**

The two respondents, who are willing to pay 900 Naira or more for a monthly insurance premium, did not provide any response to Question 26c.

The table above shows that 95% of the respondents, who are not willing to pay 1,000 Naira (see Table 40, page 26), won't be willing to pay 890 Naira monthly insurance premium for their household members.

Table 33: Table showing the real maximum amount respondents is willing to pay for the health insurance premium

26e - What really is the maximum amount you are willing to pay for the health insurance premium?			
SN	**Responses**	**Freq**	**Percent**
1	500	17	94.44
2	700	1	5.56
Total		**18**	**100**

The table above shows that 94.44% of the respondents, who are not willing to pay either 1,000 Naira (see Table 40, page 26) or 890 Naira (see table 42 above), will be willing to pay 500 Naira monthly insurance premium for their household members.

Table 34: Table showing the final maximum amount respondents is willing to pay per month per person for other household members to join the health insurance scheme

Q26f - You may have to increase the amount if you really want your other household members to enrol in the health insurance scheme. So, what is the final maximum amount you are willing to pay per month per person for other household members to join the health insurance scheme?			
SN	**Responses**	**Freq**	**Percent**
1	200	1	3.13
2	500	28	87.5
3	550	1	3.13

4	700	2	6.25
Total		**32**	**100**

The table above shows that even with further prompting, 87.5% of respondents (who would not pay 1,000 Naira or 890 Naira) insisted on paying a monthly insurance premium of 500 Naira for their household members.

Table 35: Table showing the maximum amount respondents are very certain to pay per household member bearing in mind the average monthly household income and money spent on various items

Q26g - If due to inflation or other uncertainties, the premium for the health insurance scheme increases, what is the maximum amount you are very certain to pay per household member bearing in mind your average monthly household income and money you spend on various items?			
SN	**Responses**	**Freq**	**Percent**
1	0	4	1.91
2	100	4	1.91
3	200	4	1.91
4	300	1	0.48
5	500	36	17.22
6	600	3	1.44
7	700	6	2.87
8	800	1	0.48
9	900	1	0.48
10	1,000	50	23.92
11	1,050	1	0.48
12	1,100	9	4.31
13	1,200	14	6.70
14	1,300	5	2.39
15	1,400	5	2.39
16	1,500	52	24.88
17	1,600	2	0.96
18	2,000	8	3.83
19	2,500	1	0.48
20	3,000	2	0.96
Total		**209**	**100**

The table above shows that majority (71.29%) among all the respondents, irrespective of preferences expressed earlier, are willing to pay 1,000 Naira or more monthly insurance premium for their household members – 1,000 Naira (23.92%), 1,100 Naira (4.31%), 1,200 Naira (6.7%), 1,300 Naira (2.39%), 1,400 Naira (2.39%) and 1,500 (24.88%). When compared to 71.43% of the respondents, who are willing to pay 1,000 Naira monthly insurance premium for everyone of their household members (see Table 40, page 26), we can conclude that the majority of the respondents are willing to pay at least 1,000 Naira monthly insurance premium everyone of their household members.

Table 36: Table showing the average of the maximum amount respondents are very certain to pay per household member bearing in mind the average monthly household income and money spent on various items

Q26g - If due to inflation or other uncertainties, the premium for the health insurance scheme increases, what is the maximum amount you are very certain to pay per household member bearing in mind your average monthly household income and money you spend on various items?		
N	Valid	209
	Missing	70
Mean		1,072.49
Mode		1,500.00
Minimum		0
Maximum		3,000
Median		1,000

The table above shows the average monthly insurance premium, calculated from Table 45 above. The average (median) premium is 1,000 Naira

Table 37: Table showing respondents willingness to contribute 1,000 Naira per year so that some of the poorest people could be enrolled in the private health insurance scheme

Q27a - Are you willing to contribute 1,000 Naira per year so that some of the poorest people could be enrolled in the private health insurance scheme?			
SN	**Responses**	**Freq**	**Percent**
1	No (go to Q27b)	98	42.79
2	Yes (go to Q27b)	131	57.21
Total		**229**	**100**

The table above shows that 57.21% of all respondents are willing to contribute 1,000 Naira per year so that some of the poorest people could be enrolled in the private health insurance scheme, while 42.79% are not willing to contribute 1,000 Naira per year so that some of the poorest people could be enrolled in the private health insurance scheme

Table 38: Table showing average of the maximum amount of money that respondents are willing to contribute yearly so that some of the poorest people could be enrolled in the private health insurance scheme

Q27b - What is the maximum amount of money that you are willing to contribute yearly so that some of the poorest people could	ALL	YES to Q27a	NO to Q27a

be enrolled in the private health insurance scheme?				
N	Valid	129	97	31
	Missing	150	34	67
Mean		1,211.63	1,517.53	261.29
Minimum		0	50	0
Maximum		24,000	24,000	1,000
Median		1,000	1,000	200

The table above shows the maximum amount of money the respondents are willing to contribute yearly so that some of the poorest people could be enrolled in the private health insurance scheme. The average (median) is 1,000 Naira for both categories of respondents in Table 47 (page 29) above

Table 39: Table showing if respondents believe that access to health insurance will improve your access to healthcare services in your community

Q28 - Do you believe that access to health insurance will improve your access to healthcare services in your community?			
SN	**Responses**	**Frequency**	**Percent**
1	No	11	4.72
2	Yes	222	95.28
Total		**233**	**100**

The table above shows that 95.28% of the respondents believe that access to health insurance will improve your access to healthcare services in your community

Table 40: Table showing if respondents believe that being enrolled in the health insurance plan will make health care more affordable for you and the members of your household

Q29 - Do you believe that being enrolled in the health insurance plan will make health care more affordable for you and the members of your household?			
SN	**Responses**	**Frequency**	**Percent**
1	No	11	4.18
2	Yes	252	95.82
Total		**263**	**100**

The table above shows that 95.82% of the respondents believe that being enrolled in the health insurance plan will make health care more affordable for you and the members of your household

Table 41: Table showing if respondents believe that health is their right

Q30 - Do you believe that health is your right?			
SN	**Responses**	**Frequency**	**Percent**
1	No	14	5.32
2	Yes	249	94.68
Total		**263**	**100**

The table above shows that 94.68% of the respondents believe that health is their right

Table 42: Table showing if respondents hold elected representatives (politicians) accountable for provision of healthcare

Q31 - Do you hold you elected representatives (politicians) accountable for provision of healthcare?			
SN	**Responses**	**Frequency**	**Percent**
1	No (continue to Q32)	172	68.8
2	Yes	78	31.2
Total		**250**	**100**

The table above shows that 68.8% of the respondents do not hold elected representatives (politicians) accountable for provision of healthcare

Table 43: Table showing the reasons why some respondents do not hold elected representatives (politicians) accountable for provision of healthcare

Q32 - Why don't you hold politicians accountable for the provision of healthcare?			
SN	**Responses**	**Frequency**	**Percent**
1	I don't trust politicians	70	41.67
2	I am afraid of the consequences	14	8.33
3	Politicians are not accessible	78	46.43
4	It is not my portion to fall ill	1	0.6
5	I can pay for my own healthcare	5	2.98
Total		**168**	**100**

The table above shows the reasons why some respondents (see Table 4x above) do not hold elected representatives (politicians) accountable for provision of healthcare

Qualitative
Analysis Software – MAXQDA

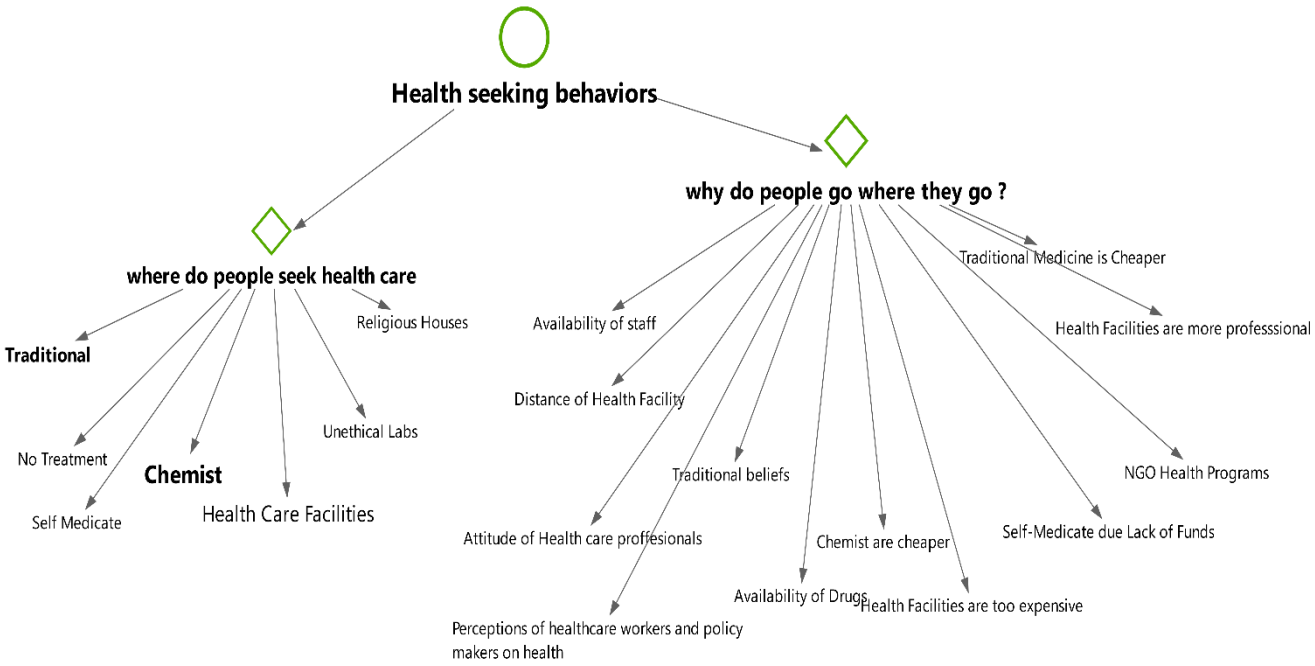
Level	In-depth Interviews	Focus Group Discussions
State	3	-
Local Government Area	6	-
Facility	11	16
Community	5	

Total Number of Interviews analyzed: 41

A multiple layer analysis method was adopted for this study. The analysis generated 4 major themes

- Health Seeking Behavior
- Out of pocket Expenditure
- Willingness to pay health Insurance

- Recommendations for Health Insurance



Health Seeking Behavior

This theme highlighted the various health seeking points for the residents of Benue state and the underlying reasons for their choices. The theme generated two sub-themes namely:

- Where do people seek health care
- Why do people go where they go to seek Healthcare?

Where do People Seek Health Care

Chemist: this came out as one of the strongest sub-themes for where people seek care, the respondents attributed this strongly to lack of funds to visit the healthcare centres. For most respondents at community level, the chemist or patent medicine vendor is considered the "first point" for health care.

> *"Because of the economic situation, when we fall sick, we go to the chemist to buy drugs first but when the sickness persists, then we go to the hospital."* Tarka- FGD- Female farmers

> *"We do first aid, we get some drugs from drug vendors there are patent medicine stores and when they are not able to help us, we go to the hospitals. So, we go to chemist first when they are not able to help us, we go to the hospital"* Tarka- FGD- Male farmers

Traditional and Religious Houses: Cultural and spiritual beliefs also take precedence in choosing where to seek medical care. While lack of funds plays a role in this choice, some of the respondents strongly believed that the traditional and religious houses were

more efficient than health facilities. Again, the health facility is seen to be the last option for some of the respondents.

> *"In other cases, we give traditional medicine first but when that doesn't work, we go to the chemist to buy drugs and if the sickness persists, we take them to the hospital. That is what we normally do"* Tarka- FGD- Kada/Keke Napep riders

> *"I have spent up to N7,000 for dental care in the General hospital and I didn't even get better, it was the traditional medicine I used that cured me"* Tarka- FGD-Male farmers

> *"Immediately they fall sick they consult the oracle. The oracle tells them what is causing that illness and proffers a solution to remedy it and they go about looking for the remedy in a traditional way."* Makurdi LGA- Director of Health

Unethical Labs: Some respondents described some unethical practices where lab tests are run in the homes of the health practitioners to cut costs.

> *"Also, they are men that work in the hospitals that can carry out the tests at home, and the results will be given to an experienced nurse who will write out the prescription, the nurse will be seen at home also."* Okpokwu-FGD-Female farmers

Health Care Facilities: As seen above, health facilities seem to be the last resort of most of the respondents due to poor understanding of the risks of self-treatment and lack of funds.

> "*If they don't get wel,l they now realize that there are healthcare giving centers."* Commissioner

> *"Those who are a little bit more enlightened, who know the risk in self-treatment and have the money, seek medical attention in the public or private secondary health care facilities, while the poor ones go to public primary health care centers in the villages"* Chairman, Okpokwu Community

No Treatment: Also due to lack of funds some respondents highlighted no treatment at all

> *"Because of the level of poverty when they are sick, they stay at home because they don't have money"* Makurdi LGA- Christian faith Leader

Why Do People Go Where They Go?

A deeper probe highlighted possible reasons why people sought healthcare where they did. Lack of funds came up strongly for the unconventional health-seeking practices such as self-medication, traditional medicine, chemists, no treatment etc. The respondents considered the health facilities to be more professional. However, the attitudes of the health staff, availability of doctors and drugs were also seen as reasons for unconventional heath seeking practices.

Health Facilities are more professional

"To avoid death and to get well" Tarka- FGD-Female farmers

"One of the things is that when they come to the facility, they go for lab test and they will diagnose the cause of the ailment before treatment" Tarka LGA- Health Facility in Charge

"Because you know that when you stay at you can't treat yourself but when you go to the hospital you will be treated, and you will get better." Otukpo – FGD-Okada/Keke Napep riders

Self-Medicate due Lack of Funds

"Sometimes we don't go to the hospital because of lack of money. If we go we can't afford to pay for the cost of the treatment" Tarka- FGD-Female farmers

Health Facilities are too Expensive

"Its lack of funds, so we will rather seek for a solution that we can afford. So we go to the clinics because we can afford the charges there." Tarka-FGD-Male farmers

"People don't usually go to the hospitals because the bills are usually too high. You will be asked to pay for the entire test and pay for the doctors consultation fees." Okpokwu-FGD- Female farmers

Chemists are Cheaper

"If there is money, one will go straight to the hospital but if there is no money, we go straight to the chemist" Tarka- FGD-Male farmers
"Sometimes it is poverty and the cost of the treatment. Because in the facility they have to pay to get a card and for consultation and thereafter buy the drugs. But in the chemist you tell them your symptoms and the give you drugs even with as low as N100"
Tarka LGA- Health Facility in Charge

Attitude of the Health Care Professional

"Firstly, lack of money. Secondly, the medical personnel's hostile attitude to patients." Kwande-FGD- Male farmers
"Availability of drugs, the approach of the health personnel at the various centers and their awareness of the importance of the health services around them" Kwande LGA- Health Facility in Charge

"Even the bad attitude of doctors and nurses keeps the patients from the hospitals. These are patients that even have the money to take care of their hospital bills, but the bad attitudes of the doctors and nurses keep them away." Commissioner

Availability of Drugs

"Availability of drugs, the approach of the health personnel at the various centres and their awareness of the importance of the health services around them" Kwande LGA- Health Facility in Charge

Availability of staff

"For many years they have been on strike, doctors aren't coming. Its only some reasonable nurses that are helping in treating people so in the area of health, there is much suffering. We also have a private missionary hospital but it is not serving everyone because to even obtain a card you will have to spend N3,000. So, we don't have good health facilities in this community." Okpokwu-FGD-Male farmers

Traditional Medicine is Cheaper

"To a very large extent, cost of treatment affects health care. Like I told you earlier one of the reasons why people go for traditional medicine is because they don't have the money or they don't even want to spend the money. They value cash here because cash is not available, they will give out their farm produce for ridiculously low amounts because they value the cash." NHIS

"Most of them number 1 is lack of funds, that is why most of them in the villages go for the traditional medicine which they think is a little bit cheaper" Makurdi LGA-Director of Health

Traditional and Religious Beliefs

"One is their belief, they are either Christians or Muslims or traditionalists. Number two it is the cost, many people are poor and cannot afford the hospital bills, I know a woman who died because they were busy looking for money meanwhile, she had some money in her waist that she would have produced. Another important thing is transportation. Most facilities are not within reach and it's a challenge to transport to them some that are within reach especially in the rural areas are not even equipped." NHIS

"There are taboos that prevent some sick persons, from attending health facilities" Kwande-FGD-Male farmers

"Some people especially the villagers believe in their traditional ways and when a person is sick he believes there is a spiritual cause for it" Kwande- LGA Chairman

Distance of the Facility

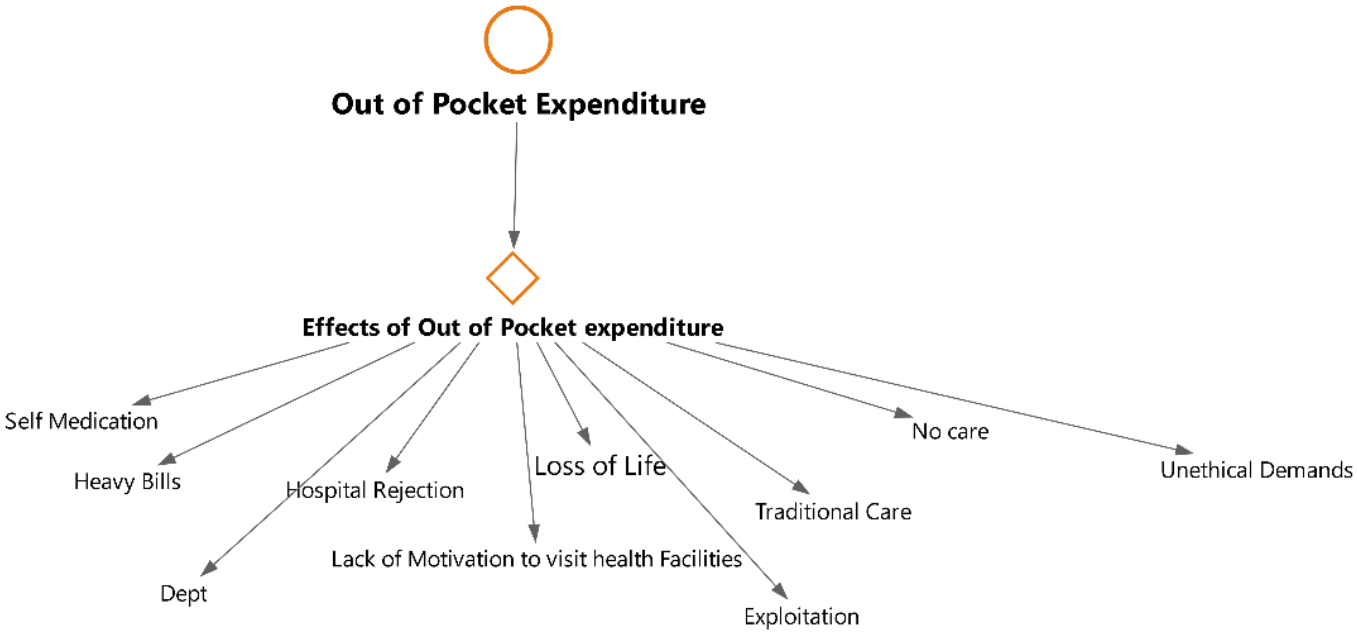
> *"It is because of the distance and also the private clinics they give us better attention and care than at the government health institutions"* Tarka-FGD-Male farmers

NGO Health Programs

> *"We have the primary health care centers as I mentioned earlier and NGOs who are partnering with primary health care, are sponsoring some programmes that are targeting certain diseases, so the people go there and benefit from the services free of charge. This encourages the people a lot in seeking health care."* Kwande LGA-Director of Health

Out of Pocket Expenditure

This theme generated one sub theme tilted "effects of out of pocket expenditure". The theme highlighted various effects that could be experienced from out of pocket expenditure by residence of Benue State. The effects of OTP expenses are captured under this theme.



Effects of Out of Pocket Expenditure

Exploitation

> *"In the hospitals we are overcharged and exploited this happens especially in the private hospitals."* Otukpo -FGD-Artisans Female

"The problems we face there is that, they overcharge us and they exploit us. At times we are neglected – the doctors don't come in the government hospitals" Otukpo LGA-Christian faith Leader

Hospital Rejection

"Without a deposit you won't be attended to, so a lot of us are discouraged from going to the hospitals" Otukpo -FGD-Artisans Female

"Knowing that treatment is not free when I fall sick I know there is no point going to the hospital because as you are arriving, they are chasing you away" Makurdi-FGD-Female farmers

No Care Gotten

"But me even if it is serious I don't go to the hospital because of money. Even as I am seated here, I can't go to the hospital because I do not have money" Makurdi-FGD-Female farmers

Dangerous Self Medication

"I'm always sick and I'm always buying drugs but the frequency at which I buy the drugs has made me lose count even yesterday I bought drugs for N500 that's all I can remember" Makurdi-FGD—Female farmers

Traditional Care

"*The cost of health care affects because some people are mostly famers and they get their money seasonally when they harvest their crops they sell and get money at a that time they have money to pay for their hospital bills but after that time, there is no money so when they fall sick some of them resort to traditional medicine or prayer houses to get healed"* Makurdi LGA- Director of Health

No Care Gotten

"Sometimes it is the issue of money, when there is no money it is hard to go to the pharmacy or to the clinic." Markudi-FGD- Okada/Keke Napep riders

Loss of Life

"Last week a woman was pregnant and the husband went about looking for money, before he got back the woman had given birth at home. There were no health personnel to take care of the baby and the baby died. This was because of lack of

money. Because when you get to the hospital, you will be asked to make a deposit, pay for drugs etc." Markudi-FGD- Okada/Keke Napep riders

"Yes there was a boy who because of lack of money to go to the hospital he died. While we were gathering our contributions in the community to take him to the hospital it was already too late." Kwande LGA- Community Leader

Unethical Demands

"When a person falls sick and he goes to the hospital he has to buy a card, carry out laboratory tests and he has to pay money for all these services. The person says he doesn't want to do any of that he just wants to be given drugs" Kwande LGA- Health Facility in Charge

Lack of Motivation to visit health Facilities

"There is no motivation, no aid from any organisations or private individuals. When a person has the money, they go to the hospital and when they don't have they stay at home and maybe die there." Kastina-Ala-FGD-Male farmers

Heavy Bills / Dept

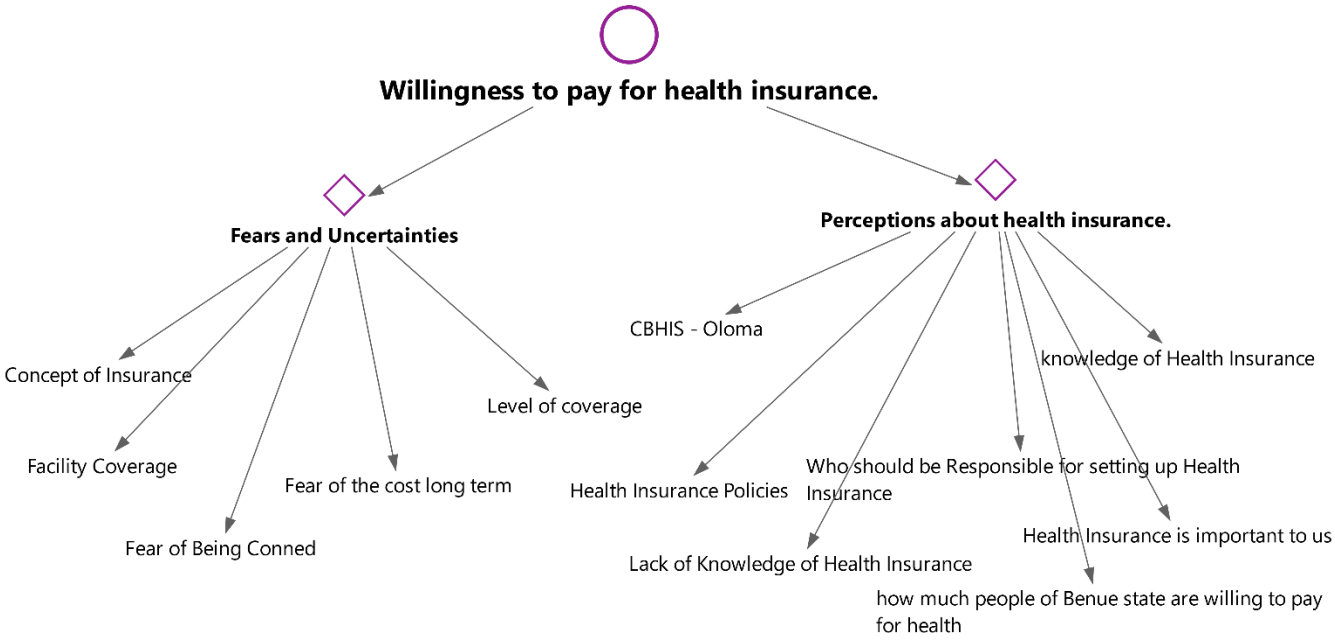
"Not just one person, this happens in almost all the health facilities we have around. If for instance someone needs to have a surgery and he is billed N50,000 for a drug and not more than 10% of the people in this society can afford that money immediately." Katsina-Ala LGA- Director of Health

"People go out to borrow money when they fall sick and they don't have any money to treat themselves. So, whether there is money or not, people borrow money to go to the hospital" Otukpo LGA- Christian faith Leader

Willingness to Pay for Health Insurance

This theme highlighted the perceptions of the residents of Benue state towards health insurance and highlighted their fears and uncertainties. The theme generated two sub-themes namely:

- Fears and Uncertainties
- Perceptions of Health insurance



Perceptions about Health Insurance

1. **Lack of Knowledge of Health Insurance**

"I have not heard it" Tarka LGA – Christian faith leader

"We have heard of health insurance for a long time but we don't have it in this local government. We only deal with local treatment here. And we have a general hospital here and a missionary hospital and we have been paying them a lot of money to receive treatment without assistance." Okpokwu-FGD- Okada/Keke Napep riders

2. **Health Insurance is Important to Us**

"I think it is good because it is the cheapest way of treating ourselves". Tarka-FGD – Male farmers

"Yes it is important because of the level of poverty here. If the person is registered and is paying little when they go to the health facility for treatment they won't be burdened with making out of pocket payments". Tarka LGA - Health Facility in Charge

"Because if I have been dropping something monthly when I fall ill I can be treated at any time" Makurdi LGA- Christian Faith Leader

3. **Knowledge of Health Insurance**

"My little knowledge of health insurance is that you contribute some money and you become an enrolee, you are registered with a health management organisation so that when you fall sick, you go to the health facility with your card and you pay a little money for the cost of treatment." Makurdi LGA- Director of Health

"I have been hearing of insurance not health insurance. I have heard of life and property insurance but this health insurance I'm hearing it for the first time. But from my own understanding I think the insurance is meant to protect you from sickness or when you cannot afford the cost of treatment you can be assisted" Makurdi-FGD- Male farmers

"To my understanding health insurance is to guarantee health care delivery even in the absence of money" Okpokwu- FGD-Okada/Keke Napep riders

4. **Who should be Responsible for setting up Health Insurance**

"It is a collective effort even though the majority is the government they will drive it, but the success of health insurance scheme is a collective effort. The HMOs, The patients, the state government that will organise the structuring and run it. But I believe the government is the most important." Chairman, health.aac

"All the 3 tiers of government should be included with the federal government monitoring." Okpokwu- FGD-Male farmers

"It is the individual; the individual should take responsibility and take ownership of their health, the able, the strong in the community should take responsibility" NHIS

5. **Health Insurance Polices**

"The NHIS does not cover a single person in this community. In the Generals hospital you must pay cash before you are attended to. So, nothing was done free in terms of health insurance in this community. That's why we hardly take our family members to the hospital"
Okpokwu- FGD-Male farmers

"This policy is very laudable because the local people are highly neglected in terms of provision of medical facilities. The mortality rate in the local area is usually high so it will be a very good thing if the local government people are also provided for."
Okpokwu LGA Chairman

"We are in the process of getting approval for the Benue State Supported Health Insurance scheme. If it's in place everyone will be able to access health care their status or income notwithstanding." Commissioner

6. **CBHIS – Oloma**

"I will just tell them depending on the community I visit; some farmers form themselves into groups and work in turn in the farms of each member of the group that is the term I use in describing health insurance to them. It is called 'Oloma'. The person who falls sick, benefits from the contributions of members of the group. But for 'Oloma', the people know whose turn is next but for health insurance nobody knows whose turn is next. 'Oloma' is an Idoma term but every other dialect has their own name for it." NHIS

Fears and Uncertainties

People are afraid and uncertain, and some questions came up for example; "Will the medical institutions be aware of this?" Kwande-FGD-Male farmers

Fear of Being Conned

"Let me first say this, people use our desperation/situation to dupe us. A group of people came to say they will supply us with fertilizers, they will give us herbicides, and people agreed and paid the money and it dies a natural death. So that is why some of us are afraid of a program of this magnitude because of uncertainties. Sometimes we contribute money willingly and voluntarily and the program will just die and the money which we will have used for other things will be gone. So I don't know how you are going to convince us that this is different. I agree that this program is good and after you have fully convinced us, I will be contributing N500 monthly" Tarka-FGD-Male famers

Concept of Insurance

"If a person is not sick for a whole year, will they get anything from the health insurance?" Otukpo LGA- Health Facility in Charge

"That is why we want to understand and know before we can say how much we can pay. What if I have been making monthly payments for about 3 months and I don't fall sick and in the fourth month I go to the hospital and I die it's an illustration, what will happen to the money? Will my family members continue from where I stopped, or will it just be a loss?" Tarka FGD - Female farmers

"*After registering with the health insurance, will you still pay at the hospital if you fall sick?"* Okpokwu-FGD- Female farmers

Costs

"If it is introduced to the church people will be encouraged to register. But if the cost for registering is too high, then many people will draw back." Okpokwu LGA-Community Leader

"The scheme is good but my fear is that I may not be able to afford the premium monthly if it is monthly example if I have to pay N1,000 monthly, I may not be able to afford it" Makurdi-FGD- Male farmers

Facility Coverage

"In this insurance scheme, will we be required to go to a specific hospital or with the card can we go to any public facility?" Makurdi-FGD- Male farmers

Level of Coverage

"Is it only the person who registered that the insurance covers or it is the entire family of that person" Makurdi-FGD- Male farmers

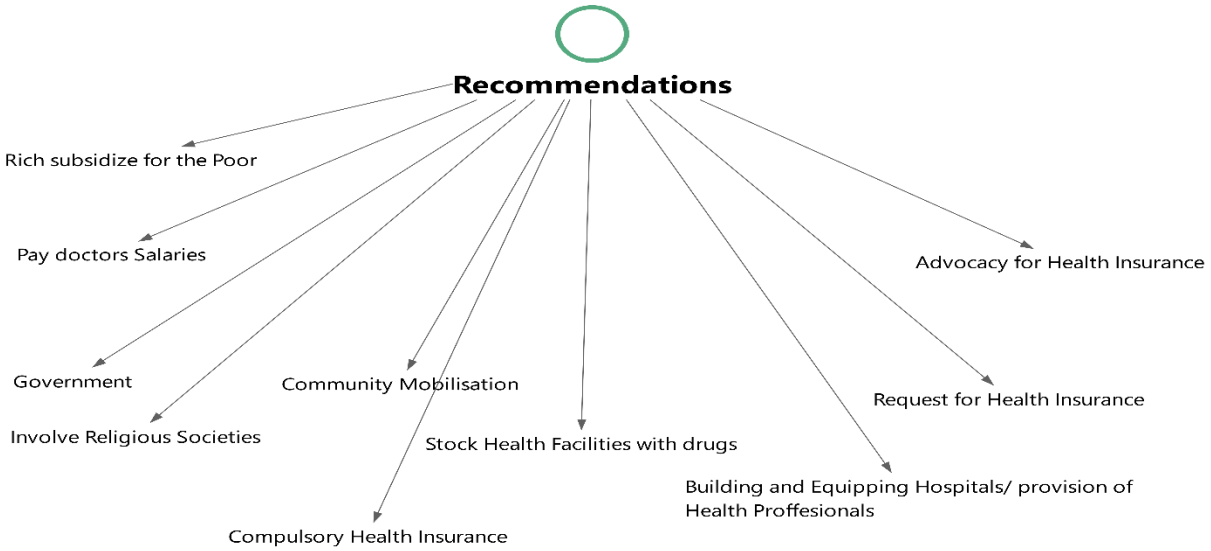
"My question is will my health insurance be valuable to my family" Makurdi-FGD- Male farmers

Tarka LGA					
FGD at Community level				**IDI**	
S/N	FGD group members	Range per month/quarterly	Range per year	IDI Respondent	Range
1	Female farmers	N20 – N350	N100	Health Facility in Charge	N200 – N300
2	Okada/Keke Napep riders	N100 – N1,000	Nil	Community Leader	N200 (monthly) N2,000 (per year) N2,500(per year including family members)
3	Male farmers	N500 – N3,000	N500	Women Leader	N500 (monthly)
Otukpo LGA					
1	Okada/Keke Napep riders	Nil	N50 – N1,000	Christian Faith Leader	N5,000 – N100,000
2	Artisans Female	Nil	N1500-N100,000	Health Facility in Charge	N3,000 – N15,000
Okpokwu LGA					
1	Female farmers	N1,000 – N5,000	Nil	Community Leader	N2,000 – N3,000
2	Okada/Keke Napep riders	N200 – N2,000	Nil	Women Leader	N4,000 – N5,000
3	Male farmers	N500	N3000		
Makurdi LGA					
1	Female farmers	N50 – N300	Nil	Community Leader	N5,000
2	Male farmers	N100 – N500	Nil		
3	Okada/Keke Napep riders	N200 – N700	Nil		

Kwande LGA					
1	Male farmers	N500 – N15,000	Nil	Community Leader	N3,000 – N5,000
2				Christian Faith Leader	N5,000
Kastina-Ala LGA					
1	Female farmers	N200 (for each for the family members) – N2,000	Nil	Health Facility in Charge	N10,000 (per month)
2	Male farmers	N500 (for children) – N10,000	Nil	Christian Faith Leader	N200 (for family) – N1,000 per month
3	Okada/Keke Napep riders	N1,000 – N5,000	Nil		

Recommendations

This theme sought to unfold the conditions that should be met before people agree to participate in health insurance.



Request for Health Insurance

> *"The government should bring health insurance to this community"* Tarka-FGD-Female farmers

Government

"Government should provide companies that will be operating within this community and government should look into their economic situation and help them financially. Government should provide a specific hospital in this community for that purpose so that they can be attending that hospital as they are contributing" Tarka-FGD-Female farmers

"If the government can provide us with skills acquisition then everyone of us will have a skill that engaged can bring us incomes so we can make our financial commitments to the health insurance scheme and still have money left for my spending and savings" Tarka-FGD- Okada/Keke Napep riders

Community Mobilization

"Community members need to join. Those of us just joining will create awareness an advocacy for people to join" Tarka LGA- Community Leader

Involve Religious Societies

"There are so many ways the Christian organizations and even the Muslims can come in. it's a local thing so anybody can assist." Otukpo -FGD-Artisans Female

"I don't know about the government but regarding the church, the NGO officials can contact the church leaders and they will look at ways to bring it because it concerns health and no one can ignore it." Makurdi LGA- Community Leader

"This is the stakeholders I was talking about, carrying the people along. Majority of the people believe so much in their pastors, whatever their pastors say from the pulpit, they believe it 100%. So, if you disregard the religious or faith based organizations, you are missing your way." Chairman, Otukpo community

Advocacy for Health Insurance

"My role is to inform and educate them from the pulpit on Sundays, organize seminars, to tell them about the health insurance" Otukpo LGA –Christian faith leader

"In my own opinion, insurance is a personal thing so there are things that the government may not be able to intervene totally. But if the government can, they could come in and support. Kastina-Ala-FGD-Male farmers

"As religious organizations, the members will be educated and told the importance of having the health insurance some are not insured because they do not know, so it is the education first because when they understand it well, then they can join it" Kwande LGA- Christian faith leader

Compulsory Health Insurance

"The government can make it mandatory for every civil servant to join the scheme and the government will deduct something from his salary. Religious organizations can also educate their members/followers on the importance of health insurance and they can organize some monetary contributions and encourage them to form groups. Same as the community organizations, some of them already run community banks." Kwande LGA- Director of Health

Rich subsidize for the Poor

"I don't know if it is the NGOs or government, they should bring these health facilities close to the people. Also, they should subsidize the cost of these treatments because that is what scares people so when they fall sick, they find alternative ways to get treatment instead of going to the hospitals because of the high charges." Markudi-FGD- Okada/Keke Napep riders

"It is just for the rich to subsidize for the poor, those who have to subsidize for those who do not have. Government can do that they can earmark some funds out of their revenue for health care for people. Also organize the people to fulfil a minimal condition, to be able to access that health care" NHIS

Pay Doctors Salaries

"Doctor's salaries should be paid so they will be encouraged to treat the patients better" Okpokwu-FGD-Female farmers

Provide Health Facilities with Drugs

"The government should provide more drugs" Okpokwu-FGD-Female farmers

Request for Health Insurance

"Maybe by coming to the community to register people. They can send people to the health facility and the less privileged ones can be registered, or anybody that they feel like helping" Otukpo LGA- Health Facility in Charge

Building and Equipping Hospitals

"The government should build hospitals specifically for this. The government can also use the existing hospitals around as centers for this program" Tarka-FGD- Male farmers

"By providing more health institutions in the villages and communities so that these facilities will be close to the people and it will enable them access health care easier." Otukpo -FGD-Artisans Female

"To build well equipped hospitals /health centres and have enough doctors and nurses. Also the government should monitor these health facilities because drugs meant for the patients are being taken away by doctors and nurses. They own the chemists that we are referred to, to buy drugs." Okpokwu-FGD-Male farmers

DISCUSSION

The objective of this survey was to study the willingness to pay (WTP) for health insurance (HI) of individuals in the informal sector in Benue State, Nigeria, using a purposely designed survey of a representative sample of this sector.

For this study, the majority of respondents (67.3%) were both main income earners and main decision makers. This suggests 67.3% of respondents are able to make financial, informed decisions for health insurance for the family based on their economic statuses.

Findings revealed that over majority of respondents had 4-8 people living in their households. This is a major factor influencing willingness considering the extent to which out of pocket payment can influence the economic status of the family.

Findings revealed that most respondents reported malaria as the most recent type of sickness that they have had in their household over the past month and the survey also shows most of them sought treatment for the illness.

Findings further revealed that most of the respondents sought for treatment at the Chemist. This may be directly connected to inability to access healthcare due to OOP which encourages them to seek the cheapest alternative.

Although majority of the respondents recovered after receiving treatment, findings further revealed that majority of the respondents who had to remain in the health facility after treatment spent two to three days. This will definitely increase exponentially the amount of money spent for treatment.

Findings further showed that 33.3% of the respondents who didn't recover after treatment were referred to another facility to complete the treatment and 23.75% of the respondents were referred to public (general) hospitals or clinics.

Findings also showed the approximate total cost the respondents spent on transportation/drugs/others until they recovered after the referral which was more than the average stated earlier. It also showed an average mean of 33,550 Naira for cost the respondents spent on transportation/drugs/others until they recovered after the referral.

Even though findings revealed a high percentage of willingness of the respondents to enroll in the health insurance scheme, it also highlighted reasons given by respondents for not being willing to enroll which were similar to the reasons observed in the qualitative results. One of the similar reasons was not trusting the government to go through with it. They also highlighted that they couldn't afford it while some said they don't need it.

Findings from the survey showed that 89.74% of respondents will not be willing to pay a monthly premium of 1000 Naira but instead are willing to pay 500 Naira monthly and less than 10% of respondents will be willing to pay 1000, 700 Naira or nothing at all.

Further inquiries revealed that majority of respondents would be willing to pay 500 Naira as their final maximum amount per month to join the health insurance scheme bearing in mind their average monthly household income.

Table 37 showed that the average monthly insurance premium was 1,000 Naira, calculated from Table 45 above.

Findings from the survey also revealed a willingness from about 57.21% of the respondents to contribute 1,000 Naira per year so that some of the poorest people could be enrolled in the private health insurance scheme.6nm

Findings also revealed that majority (95.8%) of the respondents believe that access to health insurance will improve their access to healthcare services in their community, that being enrolled in the health insurance plan will make health care more affordable for you and the members of your household, and that they believe that health is their right.

Findings also revealed that majority of the respondents do not hold their elected representatives (politicians) accountable for provision of healthcare due to various reasons varying from lack of trust, being afraid of the consequences, inaccessibility to politicians, their ability to pay for healthcare by themselves and their own beliefs that that it's not their portion to fall ill.

CONCLUSION:

This study has effectively examined the factors influencing the willingness to pay for health insurance both positively and negatively. This study was able to identify and discover that most respondents recognized that access to health insurance will improve access to healthcare services in their community and increased affordability for health care.

The study identified the factors inhibiting the adoption or willingness to pay for health insurance where respondents spoke about lack of trust of the system, inability to afford the monthly premiums and some respondents believe that they simply do not need it.

This study has shown that 84% of respondents were willing to pay for health insurance for themselves and for others, 71% of respondents all said they were willing to pay 1000 naira or even more monthly for health insurance for their household members. 57% assessed said they are willing to pay an average of 1000 naira for the poorest of people not even related them. This goes to show that with the right literacy drives, Benue State Health insurance can be operational with strong altruistic components.

Most community members in the areas studied could afford the monthly or yearly premiums for community-based health insurance. The factors that have influenced the low uptake of insurance which include factors related to health-seeking behaviors, effects of out-of-pocket payment, perceptions about health insurance, fears and uncertainties related to health insurance have been observed. Understanding that there is not a problem of ability but rather trust will help frame messages that target the relevant decision makers in families to enable them to make more informed decisions. This will help change their perceptions about accessing holistic healthcare services from the right sources.

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