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Poverty and Social Exclusion from Health Care Services: Household Income, Accessibility and Utilization of Health Services in Nigeria. The Case of Oluyoro Catholic Hospital

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DEDICATION

To my lovely wife, Naomi and daughter, Unimashi, and to the All mighty God who has made all things possible.

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CHAPTER ONE: INTRODUCTION

In this opening chapter a brief introduction of the topic is provided, with explanations for the need to carry out such a study, and an indication of what the chapter outline would look like. There then follows, description of the country Nigeria, and then the study area, Oluyoro community and the Catholic hospital. The research problem and background, and the research questions and objectives will then be presented.

1.1 Introduction

The modern study of health care utilization was initiated in the 19th century, when Jarvis (Philip1990) detected an inverse relationship between distance from, and the use of mental hospitals. Since then, investigation of utilization behavior of people who are ill or trying to prevent ill health has become a major research area. Such studies are further complicated by the peculiarities characterizing the health delivery systems especially in the third world countries like Nigeria. The co-existence of modern, traditional and other alternative means of medical services (medical pluralism), lack of universal coverage, and economic and mobility problems, are all factors that make studies of utilization behavior difficult in third world settings. Fundamental issues influencing utilization of health care services include income, ethnicity, physical and social accessibility (Philips 1990).

This paper is identification or determination of the various variables influencing the utilization of health care services in Nigeria using the experiences of Oluyuro Catholic Hospital which serves the Oluyoro community in Ibadan, Oyo state, Western Nigeria, but is also patronized by clients from other parts of Ibadan in particular and Oyo state in general. This hospital, run by the Catholic mission provides health care services in two sections. The first section serves the general population while the other section caters for the richer members of the society or those prepared to pay more for some extra comfort. Oluyoro hospital appears to enjoy some popularity attracting its clientele from all parts of the state and beyond, while government health centers seem to remain underutilized. The aim of this paper is to study the factors influencing people's (households) decision to use Oluyoro hospital. The main area of interest is the influence of cost of treatment on the use of health services. It would focus more especially on how, if, household income determines utilization of Oluyoro, and the effect on household income that using the services poses. The information obtained

can hopefully be used to advice on or develop government policies that will make for better health care provisioning in Ibadan in particular and Nigeria as a whole if more studies of similar nature are carried out. In health care provisioning, it is important to recognize that access determines whether an interested individual is able to make contact with service, and once contact is made, certain factors may affect a potential client's decision whether or not to use a service.

Single- factor explanations for utilization of health care services are no longer satisfactory hence the need to study the various factors that may be involved.

The idea for this study was borne out of the personal experiences of the writer, when as a medical student and then later as a practicing physician, it became obvious that government health centers appeared to be poorly utilized, while mission hospitals in the same area enjoyed more patronage.

The study is divided into six chapters. In chapter one, introduction, followed by a description of study area ,research problem, objectives and questions, would be carried out . Chapter two is definitions of terms/concepts like health, household and poverty literature review and analytical/conceptual framework, while chapter three is a review of the Nigeria health system, its history, health indicators and national health policy. . In chapter four, the methodology of the study is discussed, while chapter five deals with the analysis of data obtained. Finally, chapter six summarizes the findings of the study and conclusion.

1.2 Description of Study area

Nigeria (Geographic and Demographic)

Nigeria is situated in the Western part of Africa and occupies a total area of 923,768 sq km, 910,768 of which is land and 13, 0000 is water (CIA World Fact Book 2001). The total land mass is 4, 4047 km and it has a coastline of 853km. Its population size is one of Nigeria's most significant and distinctive features. However, the precise figure is uncertain but national and international bodies have generated estimates and projections. The World Bank (Nigeria: Population Estimates and the Demographic Transition 2002) estimate of Nigeria's population in 1990 was 119 million with a growth rate of 3.3%. The July 2001 estimate by the CIA (World Fact Book 2001) is put at 126,635,626 with a population growth rate of 2.6%. Of this population, 45 percent is estimated to be living below the poverty line. The labor force is said

to be 66 million (1999 estimates) while the unemployment rate as at 1997 was 28%(World Fact Book 2001).Nigeria is a federation of thirty six (36) states with a national government located at the Federal Capital Territory, Abuja. There are 74 local government areas and 250 ethnic groups (Johnson 2000). There are however, three (3) main dominant groups, the Hausa in the North, Ibo in the east and Yoruba in the West. The area chosen for this study is predominantly Yoruba

Nigeria has no social security system and the implication of this was showcased by the tremendous amount of suffering that resulted from the severe economic depression in the 1980, following the austerity measures introduced with the structural adjustment program. Many families are yet to recover from these hardships as things continue to grow worse. For the mass of the people at the lower income level, malnutrition, poor health and overcrowded housing remains a perpetual problem (Nigeria: Welfare 2002). The traditional practice where family problems are handled by extended kinship groups and local authorities, though still present in rural settings, appears to be eroding due to the harsh conditions of scarcity and paucity of resources especially in the urban areas(Nigeria: Welfare).

Income distribution in Nigeria

Nigeria's national income Statistics of is limited in its reliability due to a number of reasons like inadequate industry-wide information especially of goods for domestic consumption; validity of data is questionable; quantification based on subjective judgments of state officials (Nigeria Income Distribution 2002). The Federal Office of Statistics (2000) reports that the National Integrated Survey of Households shows a continuous decline in real wages since 1980 leading to an intense income generated poverty in Nigeria. This wage decline affected both the rural and urban sector, and also the federal government wages. Until 1990 the National minimum wage was fixed at N125 per month, and added up to N150 when other benefits (transportation and housing), was included. In 1991 the nominal wage was increased to N250, and including benefits added up to N410 per month, while poverty line for rural areas rose to N505 from N120 in 1984, and N710 from N180 for urban areas.

The federal government wage is the highest of the three tiers of government, thus local and state government wages are expected to be much lower. In 1991, the wages of civil servants were doubled and in 1992 the monthly wages of civil servants was increased by 45%.

However, the protracted inflation eroded any improvements the wage increases may have brought to the living standards of the wage earners. The last wage increments were affected in January 2001.The federal minimum wage was raised to N5, 500. The state and local governments were to pay a monthly minimum wage of N3, 500 based on negotiation with the labor unions. Till date many local and state governments have not implemented these wage changes, and some of those that have agreed to pay, are owing many months of wages to their labor force, leading to prolonged strikes by civil servants. In Oyo state, the state government began paying the N3, 500 minimum wages in July 2001 after a series of negotiations, strikes and further threats of strikes.

The private sector real wages have also followed similar trends though at a slower pace. The living standard of the people has those been declining over time, and many people especially public sector employees and lower cadre private sector cadres are battling with survival strategies, as their incomes fall below the poverty line. In Nigeria, costs of commodities tend to increase whenever there is a proposed salary increment, thus reducing whatever benefits are expected from the salary increase.

The exchange rate for the Naira against major currencies of the world has remained unstable but on the downward trend, since devaluation of the naira in 1983.The current

Rate of exchange (For Nigerians November 2002) is 131.23 naira to a dollar; 205.362 naira to the pound. The naira exchanges at 129.909 to one euro.

The dwindling resources have severe implications for the people's access to and ability to afford the basic necessities of life. The dwindling incomes, low purchasing power coupled with high costs of drugs and treatment combine to keep health services out of the reach of many Nigerians (Federal Office Statistics 2000). This had lead to high infant and maternal mortality, increased death rate and inadequate access to basic health care.

Oluyoro community and hospital:

The Oluyoro community is a semi-urban) settlement area within the Ibadan North East Local Government Area in Oyo state Nigeria. The population, according to the 1991 population census, was 8, 966, (Source in National population Commission Ibadan) and current projections (2002) put its current population at about 12,264. The area was originally called Oke-offa, and the name Oluyoro was given to the area by Christian Missionaries who

set up a hospital in the area.

Oluyoro Catholic hospital

The Oluyoro Catholic hospital also known as 'Our Lady of Apostles, Catholic Hospital,' is situated in the Oluyoro community, Oke-Ofa, Ibadan. The proprietorship is under the Catholic Mission. The hospital was founded on the 12TH of May 1959 and has a total of 160 beds. The hospital provides health services in two sections, the private wing and the general side. The private wing is meant to provide 'better' services to those willing to pay a bit more money. Here, there is more privacy as it is usually less crowded. The waiting time to see the doctor is less. It also has a small pharmacy and cash point, so making payments for services and obtaining prescribed drugs takes less time, than in the general side. Clients that use this wing are mostly the well to do, other catholic organizations and schools, and some institutions (private and public) that have retainer ship arrangements with the hospital.

The general side provides services for the low and middle income individuals of the society or community. It is usually crowded, with longer waiting time to see the medical personnel, pay for laboratory investigations and then to pay for prescribed treatment. The cost of treatment here is usually less than at the private wing, and the tendency is to prescribe less expensive alternatives -drugs and/or treatment.

The cost of treatment and services provided in the hospital is as outlined in Fig.1 below.

Fig1: Cost of services at the different sections at Oluyoro Catholic hospital:

Services	**Costs (Nigerian Naira N)**
Private wing:	
Registration Card	600.00(first visit only)
Consultation fee	600.00 (each visit)
Bed charge per night	
Rooms 1-6	1,200.00
Rooms 7-12	1,700.00
Normal Delivery	3,500.00
General side:	
Registration card	
Adults	250.00
Children	100.00
Consultation fees	
Adults	200.00
Children	100.00
Bed charges per night	
Adults	200.00
Children	85.00
Normal Delivery	1,200.00

Source: Oluyoro Catholic Hospital

NB. All bills for first visits only unless stated otherwise.

The cost of drugs from the hospital pharmacy varies according to the prescriptions and according to the disease treated. The prescribed drugs for each ailment also vary, so there are no standard drugs for each disease pattern.

The costs of the drugs are essentially the same for both private and general sides. What varies is the type of treatment/drugs that may be recommended by the physician, and the services and extra comforts provided in the private who include self contained rooms with toilets and bathroom, Air conditioners and meals. It is also secluded for privacy.. Personal experience shows that in the general side, patients invariably get the treatment they can afford to pay. This means that drugs may be prescribed, but the client's financial capability determines whether he gets complete treatment or not.

Alubo (Alubo and Vivekananda 1995) presents a different and dismal picture about services provided by the government clinics in Benue state (same as in other government health centers across the country). Patients have to register and obtain a dossier before a specific time in the day necessitating some people to sleep over or come as early as 4 a.m. due to problems of distance and transportation. After registration, patients queue for consultation in a crowded waiting room. Consultations are done in most cases by nurses and only the privileged get to see the few available medical officers after which prescriptions are to be filled out in the pharmacy which provides sloppy services as drugs and medications are in short supply. The impatient facilities are equally poor with congested wards though free food ,albeit poor fare with no cutlery was served and free services provided until the re-introduction of hospital fees in 1984 by the military government. The elites and privileged on the other hand, receive medical care in the elaborate amenity facilities(also called senior staff/ service).Here out patients are accepted till 2pm, waiting time is reduced to 1-2 hours and consultations are only by medical officers. Impatient care is provided in the spacious amenity wards, with better feeding arrangements, though for some daily charge even before re-introduction of fees.

1.3 Research Problem and Background:

Few of the many models developed to describe, determine and predict the utilization of health services, have been employed in settings of developing countries like Nigeria. According to Philips (1990, 179) 'Patients in third World countries are more likely to be sensitive to financial, organizational, spatial and cultural impediments to health care services'. Fundamental issues like income, physical barriers and social accessibility influence utilization of health care services, much more than the more complex and elusive concepts of variations between health care specializations, individual differences in attitudes to, and recognition of illness and the need to maintain health. Economic barriers as well as physical barriers tend to exclude many people from utilization of health care services in Nigeria and other third world countries. Philips (1990) also listed economic and physical barriers that may include transport costs and time lost from work as factors which may prove too much for poor people to be able to use available health care services.

According to Narayan (2001), for the poor, health is affected by many factors and life is constantly being shaped by different factors such as hunger and exhaustion; risky and polluted

environment; waiting time and distance to services; costs of health care; and the behavior of services providers. The poor dread ill health because of the cost as well as income lost due to illness.

In many countries (Narayan D. 2001), particular in East Africa, Africa, Eastern Europe and Central Asia, families have to decide whether to use limited money for medical treatment of one family member or, for food for the others

Many variables and factors determine whether health services are used or not, and though many studies have identified a range of variables influencing utilization behavior especially in developed countries, there is still imperfect understanding of exactly how and why services are used. It is essential to recognize the relative importance of various barriers to utilization of health care services if effective health care services are to be provided to all who may need such services.

The Nigeria constitution guarantees the right to health care, but only 35% of the country's population is estimated to have access to the available health care services (Kila et al 1992, Alubo et al 1995). The observation that there is underutilization of health care services prompted Olikoye Ransome Kuti, former of health to state that (Vanguard Newspaper 2002):

'they have many empty beds in the hospitals because the cost of having health care is way beyond the reach of majority of our people...government should make services to be more accessible to our people so that the beds can be properly utilized'.

Since the early 1990s, medical services in Nigeria has become strictly 'fee- for-service' affair, one pays first before any service is provided. In the past, services were either free or heavily subsidized by government, and when some fees were introduced, one gets services and then is given a bill at the end of the treatment. Thus households must consider their financial situation before deciding whether or not to take an ill member of the family for medical care.

At the International Conference on Primary Health Care in Alma Ata, USSR 1978 the World Health Organization declared the objective of Health for All by year 2000, and adopted Primary Health Care (PHC) as the means to attain this stated objective.

The Nigeria government then led by President Ibrahim Babaginda promptly adopted a National Health policy focused on primary Health Care. There was thus a proliferation of rural and urban health care facilities with training of frontline health care workers and health assistants. Government spent heavily on the projects, and their services were heavily

subsidized and sometimes free.

However, the collapse of the world economy in the 1980s, and increasing debt burden lead the International lending institutions (World Bank and IMF) to impose structural adjustment programs on such debtor nations like Nigeria. Nigeria adopted the structural Adjustment Program in 1987 There was subsequent reduction of government expenditure on social services especially health and education with the introduction of cost recovery measures for these social services. Many PHC projects were uncompleted, abandoned and tasked to generate their own funding, thus the introduction of user fees into the Nigerian public health care system. By the 1990s, the Nigerian health system was faced with several problems including the sharp disparity in the availability of medical facilities among regions, rural versus urban areas, and among socioeconomic classes. There was severe shortage of medical supplies, drugs, equipment, and personnel which persists till the present times. Government and public health care facilities faced with rising costs, government budget cuts, and shortages of materials, continue to increase costs of the services offered. Public health care policies increasingly became an issue of policy debate and public contention. In the 1989 draft proposal Constituent Assembly, a clause specifying free and adequate health care to be available as a matter of right to all Nigerians within certain categories, but this was deleted by the president and governing council.

According to The Lancet (September 2000,) 'Poverty not only excludes people from the benefits of health-care systems but also restricts them from participating in decisions that affect their health'

There is therefore a need for more research on the accessibility and utilization of health care services and factors that influence them in Nigeria and other third world countries. The information obtained from such studies would then be used to help design better health policies that will make health services available and affordable to all strata of society.

1.4 Research objectives and questions

The research objective is to study the factors that influence household utilization of available health care services using the example of factors influencing use of Oluyoro hospital, with especial concentration on the influence of cost of treatment, and household income on the utilization of health care services. This information serves to provide government and other

institutions planning to set up health facilities on factors that** will make services accessible and affordable to all who need it, and thus improve utilization of health care services, and the general health and wellbeing of the poor in Nigerian .

The questions which this study hopes to find answers to include:

1. What are the basic factors that influence household's decision to use health care services provided by the Oluyoro hospital.
2. What influence does cost of treatment have on household decision to use health care services?
3. What are the main sources of funds used for the payment of household use of hospital services at OCH?
4. Who is responsible in deciding household use of hospital services, or other alternatives?
5. How does utilization of health care services affect household income/resources?

CHAPTER TWO: LITERATURE REVIEW AND ANALYTICAL FRAMEWORK

This chapter deals with definition of some of the terms or concepts which embodies this study. Presentation of findings from similar studies is done in the literature review, and a discussion of a few theories and concepts on which the study may rely is done in the analytical framework. Finally, a conceptual framework presented in figure 2 is attempted to show the interealations between the different factors affecting the demand and supply for health services, and how they influence household choices.

2.1. Definitions

The World Health Organization (WHO) defines health as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease in an individual'.

The provision of a full life as stated above can not be provided by just the health sector alone, but apparently requires a more comprehensive approach, and implies improvement and up-grading of the social and physical environment , of body and of mind. Health is therefore a social goal whose realization requires the action of many other social and economic sectors in addition to the health sector (Alma declaration in Mann et al 1999).

Thus health thinking has moved (Mann et al. 1999, 8) 'beyond a limited biomedical, and pathology based perspective to a more positive domain of well-being'.

The basic determinants of health can be said to include (Keysers 2001):

i.)Basic needs-food, shelter, and life style- health behavior

ii) environment-sanitation, safe drinking water, pollution level

iii) Eradication of diseases and preventive and curative services to all

iv) Medical care and health service- Should be available, affordable and within reach to all

v) Maternal care

The Household is a concept describing different social relations and context specified for the area, or situation of focus. (0'Laughlin 2001).The household is considered to be the individual unit for individual wellbeing. Defining the household is one of the intractable problems in anthropological and economics investigations. Social scientists see the household as the integration of economic functions ,that is, unit of production, reproduction and consumption, but the precise definition and boundaries remain unclear((Marito Garcia 1990:pg12),as the criteria for family relationships appear inadequate. Most economists see the

household as a collection of individuals who behave as if they are in agreement on how best to combine time, goods purchased in the market, and goods produced at home to produce commodities that maximize some common welfare index. Health is a central component of human capital, a building block that can provide people with the capacity to transform different assets to income, food and other necessities (Fisher et al 2001) (Poor) families may prioritize spending on health services over and above other expenditure in order to ensure that all household members either work or study (Moser quoted in Fischer et al 2001).

Poverty, according to Narayan (2001) is multidimensional and when viewed from the eyes of the poor themselves can be defined as holistic with material, social and psychological dimensions. A simple definition of poverty provided by Coudouel et al (2001) is 'whether household or individuals have enough resources or abilities today to meet their needs' and is based on the comparison of the individuals' income, consumption, education or other attributes with some defined threshold below which they are considered as being poor in that attribute. However there is no universally acceptable definition of poverty.

The United Nations Population Fund (2001) describes poverty to be not only about income, but to also include lack of education, health care, political influence, personal safety, adequate shelter and enough food to eat. It further adds that people living in poverty have a higher risk of poor health than richer people, and have less access to health care.

Income is just one of the indices of poverty. Any household that spends more than a specified maximum share of their income on basic needs such as food, housing, health care is considered poor (FOS 2000 quoting Engles and Ruggles).

In Tanzania, Mackintosh and Tibandebage (2001), observed impoverishment from the sale of possessions and borrowing to pay for hospital services.

2.2. Literature Review

The pattern of utilization in Nigeria varies from one locality to another depending on the socio-economic, demographic, cultural and environmental conditions (Onokerhoraye 1999). In a study on access and utilization of modern health care facilities, Onokerhoroye (1999) observed that in Balyesa state, factors affecting use of modern health care establishments included: level of education; level of income; cost of the services; and facilities in the health establishment. Other factors noted in the study include, alternative medical

services in the locality; Perception of the attention received in modern health establishment; distance to the health center which involves cost of travel and time spent to reach the health center ;and accessibility of health center to the people.

Balyesta state is one of Nigeria's oil producing state with a marginalized people who believe that they are not getting the benefits of been one of the country's source of revenue because of the lack of facilities in the communities of the state..

"Initiatives" an international Non Governmental Organization sponsored several studies on the demand and utilization of health services in Nigeria.. The first study (RMS Marketing Study 1994), on behalf of a health management organization (Refuge Medical Service) was carried out among four housing estates in Lagos that accommodated low and middle income workers. It involved a random house-hold survey to understand factors affecting health care decision-making among the residents of the estates and showed that though, quality of service and distance ranked highest, as determinants of demand and utilization of health services, to optimize utilization required that clinics offer a wide range of basic health care services with high quality, be conveniently located, have short waiting time with low costs for treatment.

The other studies sponsored by Initiatives, conducted in 1996 in Lagos and Obgomoso, was part of sustainability technical assistance program to examine the financial sustainability of sixteen (16) NGOs services. In Lawanson, Lagos, low income and middle income groups were studied on the acceptability of pre-paid Healthcare plan among informal sector workers. The targeted population was members of local trade associations like market women, and taxi drivers. Though there was discrimination in seeking health care, factors determining choice of private or public services included: quality of care; opportunity costs of waiting for service; actual cost of care; availability of equipment and trained specialists; respectful and caring personnel; and flexible payment options.

Decisions were taken by both husband and wife, based on referrals from friends and families, and payment for fee- for -services basis were borne by contributions from both partners. However, there was no guaranteed access to health care services because of fear of meeting health care costs, as most facilities do not provide treatment without advance payment. The aim of this study was to provide guidelines for designing appropriate health financing scheme for low income clients.

However, the study among low income residents in Osogbo, western Nigeria , to determine

the cause of the observed decline in clinic attendance (owned by nurses), produced a result contrary to the nurse's belief that the decline in clinic utilization rates was as result of economic hardship, but was from a lack of recognition and tarnished image. The survey also showed that the low income population patronized a variety of health care providers, formal medical personnel, traditional and spirituals healers seeking mostly high quality service and positive treatment outcomes. Areas that were judged to provide superior care were centers with kind personnel, prompt service, affordable rates and flexible payment options.

These studies (Initiatives in Nigeria-2002) all show that low income group though demand quality care, not too distant from them and, they also want low cost services with flexible methods of payments.

Ayodele et al (2001), conducted a household survey study of utilization pattern in the use of immunizations in Akinleye LGA, Oyo state, Ika and Bomadi LGAs in Delta state Nigeria. They observed that Nigerians were faced with high cost of medical care, and that, fees charged were likely to discourage people from using health care services.

The problems of accessibility and utilization of health care services appear not to be limited to only developing countries like Nigeria, as information from the US show. According to the Federal Agency for Health Care Policy and Research (AHCPR Press 1997), nearly 13 million(11.6%) out of about 110 million families in the United States of America experienced difficulty or delays in obtaining medical care or did not get the needed care in 1996. 7.6 million (60%) of the 13 million families had inability to afford the care they needed as the most common barrier. Other barriers included insurance-related problems, transportation and inability to obtain child care. The Medical Expenditure Panel Survey (1999) among the non-institutionalized population reported estimates for health care use in America in 1996.The survey showed that several factors influence the use of health care and these include health status; age; insurance; income; and other socio-economic factors.

In another report on Preventive Health Care utilization (Health United States 2001), it was observed that there was evidence of disparities in use of health services by race, ethnicity, and family income, and that access to health care varies by health insurance and poverty. It was further observed that hospital discharge rates were higher among poor persons than among those with higher family incomes.

Waishwell Lynn (1984) in his unpublished PhD thesis studied the utilization of four groups of

international students from different nationalities, Malaysian, Nigerian, Taiwanese, and Venezuelan. He observed that though the rankings for selection of health services varied across national groups, cost was identified as the most important reason for selecting health facility.

At the Asian and Pacific Forum on Poverty Manila in February 2001, Jacques Jeugmans (2001), described poverty and health as a vicious circle. Ill health creates or increases poverty, while poverty exposes health to risk, and affects availability and use of health services. He further states that even though the poor have greater health care needs, their use of health services is low, because of the economic, social and cultural constraints in seeking health that they face. . The Manitoba experience(Donner 2000) shows that though a detailed understanding of the mechanisms by which income and social status affects health is lacking, it is known that the connection is there. The study showed a connection between income and health services utilization for Manitoba, the Canadian province with the third highest rate of poverty. However, here, it was observed that the low income women had a higher health services utilization rate than women in the highest income group. This is because of the additional burden of ill health borne by women in the lower income group as shown by the existing link between women's household incomes and their health. But for preventive screening services (not covered by insurance), the highest income women were more like to use such services than the lower income women.

About 70% of the populations of the poorer third world nations do not have basic access to modern medicines or health care, and this may rise to more than 80% in some countries (Philips 1990).

2.3. Analytical and Conceptual Framework

Health problems and socioeconomic problems are intimately linked and there are considerable socioeconomic differentials in the availability and uses of health care especially in third world countries (Philips 1990). The current health and socioeconomic picture in Nigeria like in other third world countries is unsatisfactory and the future appears bleak. There appears to be socioeconomic marginalization with the lower socioeconomic group been unable to exert pressure for public goods and services including health care services. Marginalized households may be identified by their economic status, nutrition, access to

water, housing, family size and age. The majority of rural and urban residents in third world countries like Nigeria are relatively or absolutely poor, and factors that have been identified as operating against the poor include (Philips 1990): The direct correlate of poverty like low income, limited education and bad diets; among others. Health programs are often of high political priority, but in third world settings, are often accompanied by inadequate health care systems. Thus relatively few people have access to, or contact with modern medicines or health care.

The cost of using health care facilities is not only limited to immediate user charges/cost recovery measures which may be minimal. The actual cost includes the cash paid out for services, drugs, and transport as well as the value of time (traveling and waiting) expended on the visit- 'opportunity cost'. Transport costs and time lost from work are sometimes too great for poor people to be able to use these services.

For most residents in developing countries, direct health care costs are regarded as expensive and transport cost is a major cost component. There are also hidden costs like medicines to be bought sometimes from distant places from the health facility; payment (corrupt) for services that are supposed to be free; and payment for investigations and
ancillary services.

These direct and indirect costs may influence different groups of patients and potential patients to either use or avoid a given facility, to repeat attendance, or to select another private or public facility, or seek alternative care

For the conceptual framework, this study considered several health services utilization model. A simplified and modified concept of both the Aday and Anderson, and the Gross (Philips 1990) utilization models is considered. The Aday and Anderson model views the use of health services as the result of patient characteristics, and the provider and system characteristics. The Gross model incorporates a wide range of variables which may be; enabling factors like income, education and family size; predisposing factors like attitude to and knowledge of health care sources; accessibility factors- distance and availability of services; perceived health level; and individual and "area-wide exogenous variables".

In fig. 2 the various factors influencing the demand and supply of health care services are presented, as they determine household choices on the use of alternative health care services. The interrelationship between household income, household choices and sacrifices that may

be made to pay for the household decision are also attempted. It is note worthy to mention that these factors or variables as listed here are not exhausted.

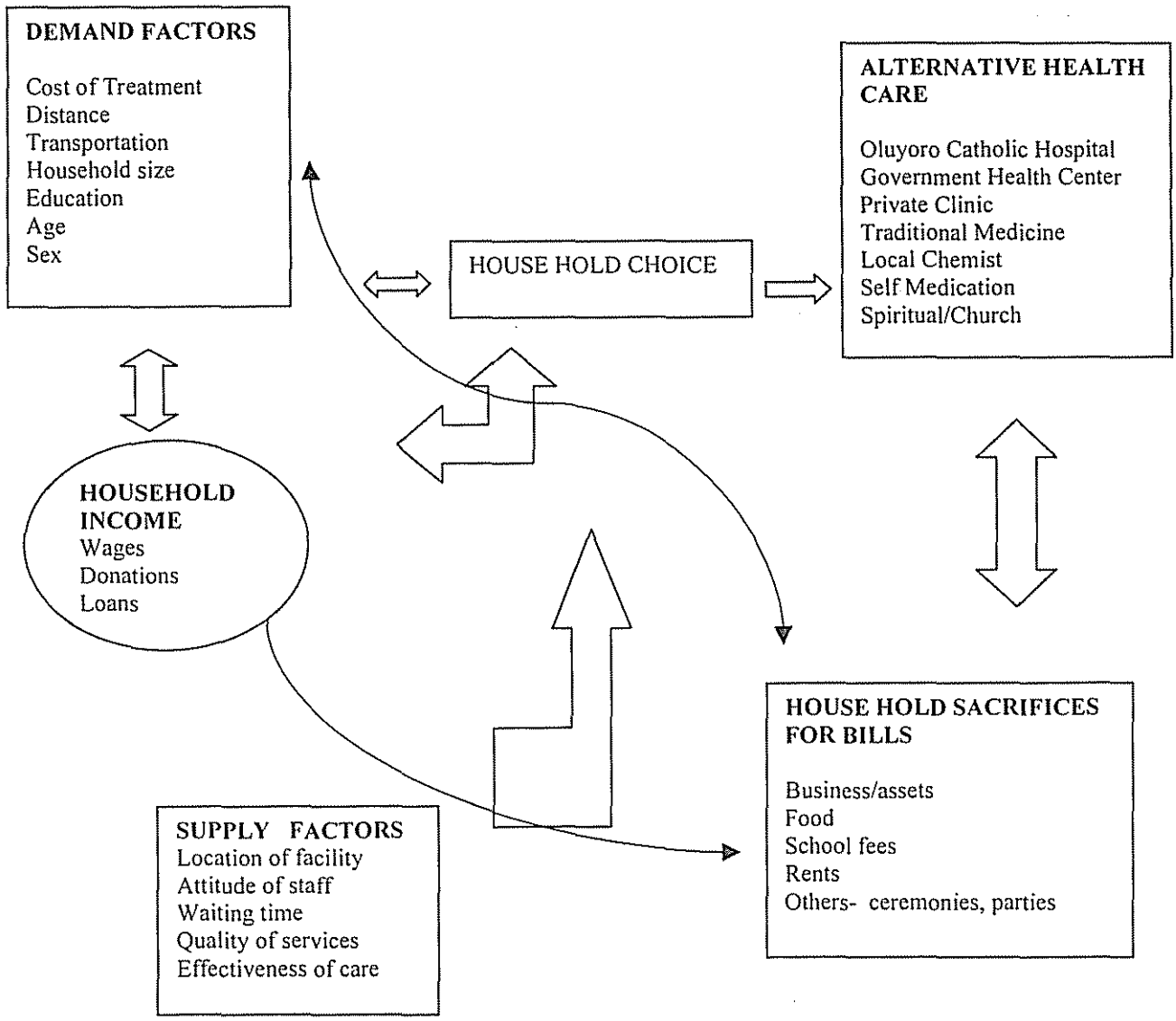

fig 2: Conceptual framework

CHAPTER THREE: NIGERIA: HEALTH CARE SERVICES, POVERTY ACCESSIBILITY, AND UTILIZATION

In this rather long chapter, the Nigerian health system is examined from its various aspects, from its history, to it structure and provision. Unfortunately not much information could be obtained on the role or importance of the missionary run health facilities in the Nigerian context .But personal experience and observation show that they were established in areas that used to considered as outskirts, provided(and some still do) cheaper medical services, and offered a wide range of medical and surgical services.

3.1 History of Modern Health in *Nigeria*

According to Osborne (2002), Western medicine was introduced into West Africa in 1500s by explorers, traders, and missionaries. Western biomedicine basically assumes that physical phenomena-bacteria, viruses, and other agents cause diseases. Diagnosis and treatment is focused on the individual patient separate from family, social, cultural and spiritual community, and applies chemicals, mechanical and electronic methods of treatment designed towards a specific offending agent.

The earliest goals of western medicine was to prevent and cure diseases which affected European colonial missionaries, traders and administrators, and after gaining independence western biomedicine became the official health care system of the new African national governments.

In Nigeria, Western medicine was formally introduced in 1860s with the establishment of the Sacred heart Hospital in Abeokuta, western Nigeria by the Roman Catholic missionaries. The British Colonial government began provision of formal medical services in the 1870s, but unlike the missionary hospitals, these were mostly initially for the use of the Europeans. The mission owned hospitals were more than government hospitals up to 1960, 118 mission hospitals as against 101 government hospitals (Nigeria: History of modern medical services 1991).

The ten year development plan announced in 1946 led establishment several health training institutions and the Ministry of Health to coordinate health services throughout the country as provided by the government, private companies and the missions. This led to a rapid growth in the number of health facilities so that by 1985, there were 84 federal health establishments,

3,023 state governments and 6331 local government owned health establishments, and 1436 private health establishments (including mission hospitals).

However, there was inequality in distribution of health facilities in the geographic regions, and inadequacies in rural health facilities and manpower which appear to persist till date. Hospitals were divided into general wards providing both out-patient and in-patient care for a small fee, and amenity (private) wards that charged higher fees for better conditions. The general wards were usually overcrowded, with long waits for registration and treatment, and patients hardly saw the doctors but were attended to by a nurse, or other practitioner. Many drugs were not available in the hospital pharmacy.

In the amenity wards, however, services available to wealthier or elite patients were better; drugs were more likely to be available. The highest level of Nigerian elite's, especially senior government officials frequently traveled abroad for medical care.

Statistics from the Federal office of Statistics(2000), show that by 1993 the federal government had ownership 0f 185 hospitals; the state governments, 2239; the local governments 8208; and private establishments were 3061.There were 535 mission hospitals, and a few owned by the community, joint ownership, corporations, and industry. There was sharp increase in the number of health establishments during the period 1985 to 1993 with a steady growth in the share of the local governments, individuals and private organizations. The highest increase occurred between 1991 and 1993 when there was emphasis on primary health care and the principle of privatization in all sectors of the Nigerian economy including health care services. However, at the same time, the cost of services in the government health facilities, and other establishments continued to increase with various cost recovery measures introduced.

Nigeria adopted the structural adjustment program(SAP) imposed by the world lending bodies in 1986, though prior to this had been austerity measures introduced in 1982 by the then civilian government. The stringent .measures adopted during the SAP era, among other consequences, resulted in currency devaluation which in turn lead to increase in prices of imported goods including medical equipments and drugs. Government and public health facilities suffered severely from the rising costs and government budget cuts. The demand for medical care outstripped its availability, and introduction of user fees (cost recovery charges) further increased the burden on the population that was already plagued by a general high

increase in cost of living, high unemployment rates as well as government job cuts (rationalization exercise), and increase in cost of fuel and petroleum products with its associated bandwagon effect on cost of food, transportation and requirements for daily living (Nigerian: Health 2002).

3.2. Basic Health Indicators

Despite the rapid increase in health facilities, the state of the health of the population continues to remain poor, as revealed by the health indicators (Tables 1.1 to 1.4). Okonkwo (2001), notes that it is impossible to give an accurate assessment of the health status of Nigerians. This is because there is no system of collecting basic health statistics on births, deaths, major diseases and other health indicators. Limited health statistics (Philips 1990) however show a low state of health of the population.

Nigerians current Human development index (HDI) ranking is 136(Human Development Report 2001), an indication of very low level of human development. According to Johnson (2000), 'The incidence of poverty in Nigeria is widespread and increasing with some of the worst poverty linked health indicators in Africa.' There has been a sharp increase in poverty form 1992 to 1996, with an estimated one third of the population living below 1 US dollar per day and nearly two third below 2 US dollar per day.

Table 1.1 below depicts the key health indicators (Data from WHO and World Bank), and reveals that the life expectancy for Nigeria males is 49 -52yrs and for women, 52yrs.These are poor figures, especially when compared to life expectancy values of 75-80yrs for males and females in many developed countries. The other health indicators show equally poor trends, infant mortality of 77- 81 per live births; and maternal mortality of 1000 per 100,000(Johnson 2000 in DFID Country Briefing Paper). These figures indicate substantial morbidity and mortality.

Table 1.1: Key health Indicators

Indicator	Value	
	Data from WHOreport:1999,WHO	Data from World development report 1999/2000 World Bank
Life expectancy	Male:49; female:52yrs	Male:52; female:55yrs
Infant mortality(per 1000 live births)	81	77
Under five mortality(per 1000 live births	Male: 154; Female 140	122
Maternal mortality(per 1000,000)	1000	1000
Total fertility rate	5.2	5.3
Contraceptive prevalence rate	Not available	69
Measles immunization	69%(1997 data)	Not available

Source: DFID Country Briefing paper- 2000

The basic health indicators for Nigeria as indicated by the number of medical facilities and personnel shown in table 1.2 are equally dismal. Though there may have been an increase in General hospitals, the number of hospital beds remain the same, a reason for the often description of the public health facilities as mere consulting clinics or glorified mortuaries due to the absence of drugs, and other essential diagnostic and treatment materials.

Table 1.2: Basic health indicators

Types of hospital	**1991**	**1992**	**1993**	**1994**
General				
No. of hospitals	451	451	1,170	1,170
No. of beds	46,544	46,544	46,544	46,544
Teaching hospitals				
No. of hospitals	26	26	14	14
No. of beds	7,652	7,652	7,652	7,652
Maternity				
No. of hospitals	1,748	1,748	3,263	3,263
No. of beds	34,858	34,858	18,111	18,111
Orthopaedic				
No. of hospitals	10	10	10	10
No. of beds	1,426	1,426	1,426	1,426
Infectious Diseases				
No. of hospitals	25	25	47	47
No. of beds	5,061	5,061	1,692	1,692
Other medical Establishments				
No. of hospitals	9,847	9,847	9.847	9,847
No. of beds	15,921	15,921	15,921	15,921

Registered Health Manpower				
Medical practitioners	20,210	21,325	21,739	21,739
Dentists	1,197	1,295	1,335	1,335
Pharmacists	6,060	6,474	6,474	6,474
Nurses & Midwives	129,748	136,207	154,159	154,159

Source: Basic Health Indicators- NigeriaBusinessInfo.com (figures from Federal :Ministry .Of Health)

NB. Figures for 1994 are provisional.

The number of teaching hospitals reduced as a result of rationalization exercise during the SAP era, but the number of beds remain the same if the figures are to be believed.

The number of registered medical personnel, when compared to the estimated population of Nigeria clearly do not meet world standard.

Further health indicators for Nigerian are shown in tables 1.3 and 1.4 below, this time comparing rich versus poor and urban versus rural values, and shows wide disparity to the disadvantage of the rural areas.

Table1.3: Health, Nutrition, and Poverty: Total Population (Nigeria 1990)

HNP Status Indicators	Quintiles					Population average	Poor/ rich ratio
	Poorest	2nd	Middle	4th	Richest		
IMR	102.2	102.3	93.1	85.8	68.6	91.6	1.490
U5MR	239.6	229.7	188.0	159.2	119.8	191.3	2.000
Stunted Children (%)	48.5	45.3	47.2	40.5	32.1	42.7	1.511

Underweight children(%moderate)	40.2	39.0	39.0	35.9	22.2	35.3	1.811
Underweight children(%severe)	16.4	16.2	10.6	10.1	4.9	11.8	3.347
Low mother's BMI (%)	N.A	N.A	N.A	N.A	N.A	N.A	N.A
Total fertility Rate	6.6	6.5	5.9	6.3	4.7	6.0	1.404
Age Specific Fertility Rate(15-19yrs)	194.0	213.0	116.0	151.0	66.0	146.0	2.939

Source-Adapted from Discussion draft on Socio-economic differences in Health, Nutrition, and Population in Nigeria

N.A Not available

Key(Indicator Definitions):

IMR: Infant mortality Rate. The numbers of deaths to children under 12 months of age per one thousand live births

U5MR:Under-Five Mortality Rate: The number of deaths to children under five years of age per 1000 live births.

Percent of Stunted Children: Percent of children with height measurements more than two standard deviations below the median reference standard for their age as established by the World Health Organization, The U.S. Centers for Disease Control, and the US National Center for Health Statistics.

Percent of Children Underweight: Percent of children whose weight measurement is more than two standard deviations (moderately underweight) or more than three standard deviations (severely underweight) below the median reference standard for their age as established by WHO and other US based organizations.

BMI: Percent of Mothers with Low body Mass Index. BMI is an indicator of adult nutritional status. No figures are presented for Nigeria.

TFR: Total Fertility Rate. The average number of births a woman could expect to have during her lifetime if she followed observed levels of fertility for her age group at every age.

Age Specific Fertility Rate for women 15-19years old (Adolescent fertility rate): The average number of births among women aged 15-19, per 1000 women in that age group.

The data used in these tables are from the Demographic and Health Surveys (DHS) program which collects information about a large number of health, nutrition, population and health services utilization measures, as well as data on demographic, social and economic characteristics of respondents. The values in the two tables (1.3 and 1.4) represent the health, nutrition, and population (hnp)-poverty relationship. For Nigeria, they indicate first a casual relationship between poverty and the health, nutrition and population status; secondly, a high rich/poor ratio for most indicators; and lastly, a wide gap between the urban and rural scenario.

Table 1.4: Health, Nutrition, Population, and Poverty: By Urban-Rural Residence

Indicator	Urban Quintile					Rural Quintile				
HNP Status Indicator	Poorest	2nd	Middle	4th	Richest	Poorest	2nd	Middle	4th	Richest
IMR	*	*	(102.2)	87.5	63.4	101.7	102.3	97.0	85.3	85.1
U5MR	*	*	(184.8)	152.0	109.5	241.6	232.4	188.5	161.4	(151.9)
Children Stunted (%)	(55.3)	36.9	46.8	40.3	30.7	48.3	45.7	47.3	40.6	36.6
Children underweight(%moderate)	(52.7)	36.1	33.3	32.5	21.3	39.8	39.2	39.5	36.9	25.0
Children underweight(%severe)	(19.4)	6.6	15.6	9.0	4.6	16.3	16.7	10.1	10.4	5.8
Low										

Mother's BMI (%)	*	*	*	*	*	*	*	*	*	*
Total Fertility Rate	*	*	*	(5.1)	4.8	6.6	6.5	5.9	6.8	(4.6)
Age Specific Fertility Rate	*	*	*	(132.0)	75.0	198.0	212.0	123.0	160.0	(37.0)

Source-Adapted from Discussion draft on Socio-economic differences in Health , Nutrition, and Population in Nigeria

3.3 National Health Policy of Nigeria

The current health policy in Nigeria is based on the basic tenets of the Primary Health Care (PHC) with the goal (yet to be achieved) of Health for all by year 2000. The PHC was launched as the corner stone of the National health policy in August 1987 by the then president of the Federal republic of Nigeria, President Ibrahim Babaginda. The goal of the national health policy is to bring about a comprehensive health care system based on PHC to ensure that for every citizen of the country, health care is promotive, protective, restorative and rehabilitative within available resources so that individuals and communities are assured of productivity, social wellbeing and enjoyment of living (Motherland Nigeria Health care, FOS 2000). This lofty ideas as launched included several components:

a. Education concerning prevailing health problems and the methods of preventing and controlling them

b. Promotion of food supply and proper nutrition

c. Maternal and child care, including family planning

d. Immunization against the major infectious diseases

e. Provision of essential drugs and supplies

. The main stated objectives of the Nigerian Health Policy included (Nigeria: Primary Health Care Policies 1991):

I. Accelerated health care personnel development

II. Improved collection and monitoring of health data

III. Ensured availability of essential drugs in all areas of the country

IV. Implementation of an expanded program on Immunization (EPI)- most concrete and probably most successful initially

V. Improved nutrition throughout the country

VI. Health awareness promotion

VII. Development of a national family health program

VIII.Promotion of oral re-hydration therapy (ORT) for treatment of diarrhea diseases in infants and children

IX. Population control program (partially) - Women encouraged to have no more than four children

These programs were supposed to be implemented mainly through collaboration between the Ministry of Health and participating local councils, with grants from the federal government. Within the health policy, special attention has been focused on the health of mothers and children hence a lot of the designed programs are targeted towards these two disadvantaged segments of the society. Private, mission, or jointly owned hospitals were encouraged to participate in providing these services.

3.4. The Nigeria Health System: Structure and Provision

The Nigeria health care system is composed of three tiers (FOS 2000):

The first tier is the Primary Health Care provided by the local government but supported by the state government and is run within the overall national health policy. Private practitioners may also be involved.

The second tier is the Secondary health care which involves specialized services to patients referred from the PHC facilities. It provides out-patient and in-patient services for general medical, surgical, pediatric (Children's medicine) and community health services at the district, divisional and zonal levels of the states. It expected to have adequate supportive services like laboratory, diagnostics, blood bank, rehabilitative and physiotherapy. The hospitals which provide these services are usually called General hospitals. Mission hospitals like Oluyoro Catholic hospital also provide secondary health care services.

The third tier, the tertiary health care, is for highly specialized services provided by the Teaching hospitals and other specialist hospitals. This tier is meant to provide care for specific

diseases like orthopedic, ophthalmic, maternity and pediatric cases. They are supposed to be evenly distributed, offering super services for effective referral services from the other two tiers. Providers of tertiary care are encouraged to develop special expertise and have the advantage of modern technology. To provide these services the federal government works closely with voluntary agencies, private practitioners, and other non-governmental organizations.

All three levels of government, the Federal, State and Local Government Areas (LGAs), have responsibilities for the provision of healthcare. They are responsible for all financial aspects of Secondary Health Care (SHC) and Primary Health Care (PHC) departments, including personnel costs, consumables, running costs and capital investment. The Federal government sets overall policy goals, co-ordinates activities, ensures quality, training and implements sector programs such as immunization. The co-ordination of activities is generally poor.

Recently, the Federal Minister of Health (allAfrica.com 2002) Prof Nwosu reported that there has been remarkable improvement in the health system of the country at the end of year 2001, since the inception of a civilian, democratically elected government. The improvements and innovations are said to have been recorded in the six areas of focus which include primary health care, tertiary care services, and campaigns against preventable diseases. Some of the projects been carried out include:

1. Construction of 200 health centers all over the country-now in completion stage 'visible landmarks... heralded as the most viable democratic dividends to the entire people of Nigeria'.

2. Establishment of the National Primary Health Care Agency (NPHCDA) in 2001. This agency is headed by Professor Olikoye Ransome Kuti, former Minister of Health. The National Primary Health Care Development Agency provides a source of technical knowledge and expertise on the provision of PHC and monitors PHC delivery on behalf of the federal government but has a limited capacity.

The mandate of the agency is to construct 200 health care centers annually around the country until every community can have access to the facilities.

3. Improvements of the 15 teaching hospitals and 32 medical centers, orthopedic and neuropsychiatry hospitals.

4.Uplift and infrastructural renewal of 8 hospitals including University Teaching hospitals

Enugu (UNTH), Port Harcourt (UPTH) and Jos(JUTH).

5. Campaign against preventable diseases via immunization programs against polio; advocacy, prevention and awareness campaign against HIV/AIDS; the Roll Back Malaria program

6. The hosting of international conferences like the global fund on AIDS; Roll Back Malaria summit; Africa Summit on HIV/AIDS, TB and other related infectious diseases

The minister further condemned the teaching hospital managements for not been able to generate enough revenue to be utilized for the smooth running of these institutions without clamoring for infusion of more capital funds by the federal government. This comment was immediately countered by the Secretary General of the Nigerian Medical Association .He claimed that the teaching hospitals are meant to teach, for research, and to provide services and not to make services unaffordable to the people, by charging too exorbitantly for services. This is important considering the fact that over the years there has been successive increases in the cost of the services of government hospitals including teaching hospitals and it is believed that this has contributed to the observed reduction in the number of people using these facilities (NigeriaMPS.pdf 2001).

The private sector and voluntary/missions sector also provide health care, and together with the traditional medical practice provide 60-80% of health care services(NigeriaMPS.pdf 2001).However, there is little regulation and standardization of services.

According Prof Kuti, the problem of the falling standard in the Nigerian health system is not that of funding, but the 'inability of the sector to evolve policies and programs that are far reaching in terms of spread' (allAfrica.com 2002).

CHAPTER 4: METHODOLOGY

The study is descriptive in nature, cross sectional and with synthesis of findings, and analysis of data.

4.1 Sources of data:-

The main sources of data for this study were:

a) Use of primary data, obtained by; (i)examination of Oluyoro hospital records and other information on the cost of services in both private and general wings of the hospital; disease pattern over a three year period(1999 to 2001); and inpatient numbers over the same three year period(See annex 2).

(ii) Collection of information using questionnaires (see annex 3) on households within the Oluyoro locality. A sample of 192 households was used drawn from the Oluyoro community of Ibadan North East local government area. Based on advice from staff of the National Population Commission in Ibadan, using the enumeration area (EA) demarcation of the national population commission (NPC), the first systematic sample of 1 in every 5 houses within the community was made. From the selected residential buildings, another systematic random sampling was done in order to select households relying again on the NPC household listing that was used for enumeration exercises. The estimated population size is 12,500(2002 NPC population projection). Initially 305 residential houses were targeted, but only 278 finally got the questionnaires. Out of this number, 238 were retrieved and only 192 questionnaires then accepted as the others were either had too many missing information or were improperly filled. It was hoped that it would be possible to conduct further in-depth interview on fewer respondents selected on the basis of the scale of problems encountered by the service at Oluyoro; for example, patients that had to sell assets to pay medical bills or made any other sacrifice in order to meet hospital bills. But this was not possible because of logistic problems.

b) Secondary data was used as supplementary evidence from sources like;

i) Documents and publications from Federal Office of Statistics (Socio-economic Development of Nigeria 2000); Human Developmental Report 2001; HNP/Poverty Thematic Group of the World Bank

ii) Internet Sources like CIA World Fact Book, Library of Congress/Federal Rese...Handbook Series/Nigeria/Tables, and others listed in the References

iii) Sources in the National Population Commission offices in Ibadan

4.2 Method of Analysis

Profile of the survey respondents was done by using simple Statistical measurements like percentages and means. This provides a description of the socio-economic background of respondents. Further analysis on the use of Oluyoro hospital was done by relating this background to usage of the hospital employing indices like reasons for choice of Oluyoro hospital, perception and satisfaction of services rendered, usage of alternative health care, sources of fund for treatment and mode of payment of bill (See example of questionnaire annex 3).

4.3 Scope and Limitations of the study

Review of just one case may not give a complete indication of the situation in the whole country .But supportive evidence was obtained from literature review and other data sources as listed. Not been on the field to conduct the field work lead to misunderstandings in the application of the questions. Such occurrences were minimized by repeated phone calls and emails to a colleague in charge of application of the questionnaire. There were a few omissions in the questionnaire, which affected the results obtained. Inability to obtain data on a government health facility for comparison was also a limitation in this study.

4.4 Background description of respondents

In order to achieve the objectives of the study, a total of 192 respondents were interviewed in Oluyoro community of Ibadan North Local government authority of Oyo State Western Nigeria where the Oluyoro Catholic hospital is situated. A brief, description of the socio-economic status of the respondents is given in table 3.1 below.

Table 2: Socio-economic indicators of survey respondents

VARIABLE	FREQUENCY	PERCENTAGE (%)
Sex		
Male	95	49.5
Female	97	50.5
Occupation		
Self employed	75	39.1
Civil servant	59	30.7
Employee(private)	31	16.1
Unemployed	27	14.1
Religion		
Muslim	61	31.8
Orthodox Christian	60	31.3
Pentecostal Christian	60	31.3
Traditionalist	1	0.5
White garment church	9	4.7
Other	1	0.5
Level of Education		
None	5	6.8
Primary	13	11.5
Secondary	22	20.8
Post Sec	40	59.9
Koran	2	1.0
Nearest health facility		
Government	46	24.0
Private	58	30.2
Oluyoro	88	45.8

Source: Fieldwork, Ibadan August 2002.

Looking at the distribution of respondents by sex, it is observed that there is an almost equal proportion of males and females with females having a slight edge at 50.5%.Alubo et al (1995) records from the Social Statistics in Nigeria, that for Oyo state the illness rates per thousand population by sex is equal for males and females (139 each).

With respect to occupation of respondents, self employed ranked first at 39.1%, civil servants are next(30.7%), private employee(16.1%). 14.1% of respondents were unemployed a value not too far from the figure of 10.03% recorded by the Federal Office of Statistics(FOS 2000) for urban unemployment rates.

The religious predisposition of respondents shows that 31.8% of respondents are Muslims while Christians constitute a larger proportion though spread among different denominations at 31.3% each for both orthodox and Pentecostal churches and white garment (syncretic) make up 4.7%. The level of education of respondents ranges from none to post secondary. Majority of respondents (59.9%) are post secondary which may include diploma (polytechnic, nursing) and university degrees. The next group is the secondary school (high school) graduates constituting 20.8%, primary school (11.5%). According to the FOS (2000) education indicators indices, Oyo state ranks 14th in Nigeria with a literacy rate of 60.22, so the values obtained seem to be in keeping with those previously recorded, and may account for the high percentage of respondents that are civil servants. With respect to the nearest health facilities to respondents, Oluyoro Catholic hospital is the nearest for 45.8% of respondents, private clinics to about 30 % and government hospital is nearest for just 24% of respondents.

The mean age distribution of respondents shows that respondents are on the average 37.65 years as at last birthday, though the age ranges from 18 to 85 years. About 67 of the male respondents had wives, with the minimum number of wives being one and maximum seven.

Average household size including respondent is about 5 with the 1 person being the smallest household size and 21 the largest. (See Table 3.2) .The 1990 Nigeria Demographic and Health Survey(FOS 2000: 119), showed an average of 3.2 people living in a room, about 45% having an average of 3-6 persons per room and 5.7% have an average of 7 people and above per room. The tendency is higher numbers in the rural than urban households.

Table 3: Mean distribution of respondents by age, number of wives and household size.

	Age	Number of wives if male	No. of persons in HH
Number	192	67	192
Mean	37.65	1.27	5.53
Minimum	18	1	1
Maximum	85	7	21

Source: Fieldwork, Ibadan August 2002.

CHAPTER FIVE: RESEARCH FINDINGS AND ANALYSIS OF DATA

5.1: Utilization of Oluyoro Catholic Hospital

The 192 respondents were interviewed as to whether they have ever utilized Oluyoro Catholic Hospital (OCH) for treatment of health problems of any member of the family or household. Out of the 192 respondents, 86% claimed to have utilized the hospital 14% of respondents have never used Oluyoro Catholic hospital (table 4).

Table 4: Percentage distribution of respondents by "ever-use" of Oluyoro hospital

Ever gone to Oluyoro	Number	Percent (%)
Yes	166	86.46
No	26	13.54
Total	192	100

Source: Fieldwork, Ibadan August 2002

Of the respondents that have ever used Oluyoro hospital, 51.2% are of the female sex, while for those who have never used Oluyoro hospital males constitute the highest number of 53.8%. When comparing the level of education of respondents to the use of Oluyoro hospital (table 5), it is observed that respondents with post secondary education (the highest level of education recorded) comprise 60% of ever users. Philips (1990, 204) stated that 'education is an important influence on the knowledge of both when to use health services and how to use them effectively'. He however warns that the effect of education is strongly linked to those of income and socioeconomic status. Furthermore, it has been observed that the educational levels of mothers and increased female literacy rates are generally strongly related to levels of infant mortality, effective feeding and good use of health services (Philips 1990), thus higher education means higher and more effective utilization of health services. The reverse may also be the case, that is, the poorer the education, the poorer the nutrition and sanitation levels and this often results in underutilization of health services.

Table 5: Percentage distribution of respondents by sex and level of education by ever-use of Oluyoro hospital

EVER USED OLUYORO	SEX					TOTAL	
	MALE (%)	FEMALE (%)				NUM	%
Yes No	48.8 53.8	51.2 46.2				166 26	86.5 13.5
Total	49.5	50.5				192	100
	LEVEL OF EDUCATION						
	None	1°	2°	3°	Koran		
Yes No	6.0 11.5	11.4 11.5	21.1 19.2	60.2 57.7	1.2 -	166 26	86.5 13.5
Total	6.8	11.5	20.8	59.9	1.0	192	100

Source: Fieldwork, Ibadan August 2002

Review of the income of the respondents show that out of the 166 respondents who have ever used Oluyoro Catholic hospital, a high proportion(36.6%) earn more than 10,000 Naira(Local currency) as average monthly income which is more than double the government approved minimum monthly wage for civil servants. The least proportion of users (6.6%) earns 5001-7500 average monthly income just above the minimum monthly wage of 3500 (table 6a). The Nigerian Labor Union calculates that an average Nigerian family requires 15 to 20 thousand naira to meet the basic needs of the household. But for this, study households whose incomes are less than N3500 are considered to poor; those with N3500 to N7500, moderately poor; and above N7500 are non-poor.

Table 6a: Percentage distribution of respondents who have ever-used Oluyoro hospital according to Average monthly Household (HH) income and Distance to hospital

Ever used Oluyoro	Average HH income per month(Naira)						Total	
	<1750	1751-3500	3501-5000	5001-7500	7501-10000	>10000	Num	%
Yes	13.9	7.2	18.7	6.6	15.1	36.6	166	86.5
No	11.5	3.8	19.2	15.4	19.2	30.8	26	13.5
Total	13.5	6.8	18.8	7.8	15.6	37.5	192	100
	Distance from residence to Oluyoro(minutes)							
	<10	<30	About 60(1hr)	About 120(2hrs)			Num	%
Yes	18.1	36.7	28.3	16.9			166	100
Total	15.6	31.8	24.5	14.6			166	100

Source: Fieldwork, Ibadan August 2002.

In tables 6b and 6c, attempts at determining the relationship between grouped income, and how often respondents visit OCH, and the nearest health facility are made. Though not conclusive, it was observed that all income levels, and no matter the hospital nearest to respondents' home, there was a high percentage of usage of OCH.

Table 6b: Percentage Distribution of respondents who have used OCH according to income group

Income group N	Frequency	Percent	Used OCH %
<3500(Poor)	39	20.3	89.7
3500-7500(Moderately poor)	51	26.6	82.4
7501+(Non-poor)	102	53.1	87.3
Total	192	100	86.5

Source: Field work, Ibadan August 2002

Table 6c: Percentage distribution of respondents who have used OCH according to nearest health facility to their residence

Nearest health facility to respondent	Ever used OCH	
	Yes	No
Government hospital	89.1	10.9
Private Hospital	87.9	12.1
Oluyoro Catholic Hospital	84.1	15.9
Total	86.5	13.5

Source: Field work Ibadan, August 2002

Table 6a also records respondent's response to the question of distance from respondent's home to Oluyoro Catholic hospital. It is noted that lowest percentage(about 16%) of respondents who have ever used the hospital, live about 2hrs away from the hospital, while the highest number (36.7%)live 30mins away. Most studies have shown a negative relationship between distance and utilization of health services, though the effects of distance depends on several factors like the type of illness, the road network, availability and cost of public transport, and availability of private transport. Distance may be measured as time and cost of travel and differs with the different facilities. The road linking Oluyoro hospital to the rest of the community, and the neighboring township is rather narrow, full of pot-holes, and heavily trafficked hence the likelihood of spending a longer time in traffic between destinations. Public transport (buses) which have a stop over at the hospital is however readily available, and affordable by most people.

5.2: Frequency and reasons for use of OCH

To determine how often respondents used OCH, respondents were asked to indicate how often they go to the hospital for medical care (table7). The highest percentage of respondents (56%) claim they use the hospital once a year or more, 16.9% use it monthly and about 13% of respondents each three monthly.

Table 7: Percentage distribution of respondents by regularity of use of Oluyoro Catholic hospital

Ever gone to Oluyoro	Regularity of Visit				TOTAL	
YES	Once a month	3monthly	6monthly	yearly or >	Num	%
	16.9	13.3	13.9	56.0	166	100

Source: Fieldwork Ibadan August 2002

Respondents were then asked for reasons why they chose Oluyoro hospital for their medical care (table 8). Of the total number of respondents that use Oluyoro hospital, almost 40% chose cost of treatment as their reason for using the hospital for their medical care. The next reason chosen is distance (38.6), and attitude of personnel (36.7). On the other hand, the least percent of respondents (60%), do not feel cost is a reason for choosing Oluyoro hospital, while the highest (83%) did not choose waiting time as reason. Studies have shown that the use of health services appear to have dropped in health facilities with the introduction of user fees .Philips (1990) uses examples of Kenya and Jamaica where introduction of user fees appear to have affected utilization of health negatively and says that the cost of treatment prescribed may be an important factor in deciding whether to use a service and the type of facility to use. Narayan (2001) also records that the costs of health care exclude many poor people from health care services. Cost of treatment refers to the direct medical charges which includes cost of registration and consultation fee; laboratory fees; cost of drugs; and other procedures like wound dressing, surgery. There are also indirect costs for transportation and unofficial fees.

Table 8a: Percentage distribution of respondents' by reason for using Oluyoro Catholic hospital

REASONS FOR USING OLUYORO	RESPONSE	
	YES	NO
Distance	38.6	61.4
Waiting time for treatment	16.3	83.7
Cost of treatment	39.8	60.2
Attitude of health personnel	36.7	63.3
Good services and treatment	25.9	74.1

Source: Field work Ibadan2002

Table 8b is a comparison of the respondents' regularity of visit to OCH with the distance of their residence from the hospital. It showed no clear pattern, but it can be observed that Those who live nearer OC H were more likely to visit more regularly, and those further away, less often. A further indication that distance plays a role in households' decision to use any hospital facilities.

Table8b: Percentage Distribution of users of OCH according to regularity of use and distance of home from OCH

Distance to OCH (minutes)	Regularity of visit to OCH %			
	Monthly	Every 3 months	Every 6 months	Once a year
<10	30.0	13.3	13.3	43.3
<30	9.8	8.2	6.6	75.4
60	21.3	17.0	17.0	44.7
120	10.7	17.9	25.0	46.4
Total	14.6	11.5	12.0	48.4

Source: Fieldwork, Ibadan August 2002

5.3 Alternative sources of health care

Though respondents would like to use institutional health care, it is observed that there are times when they would wish to resort to alternative health care delivery system.

A review of respondent's use of alternative medical care(table 9) showed that, about 59% of respondents engage in self medication, that is, use of home/local remedies, self prescribed medications (usually drug combinations) bought over the counter. The next common alternative care used by the respondents is the local chemists (53.9). These generally have no formal medical training. Some however may be owned by nurses, laboratory staff, trained pharmacists and other auxiliary medical personnel, who then employ people to sell drugs for them. Some may go beyond selling drugs to administering injections, doing wound dressing, and other unauthorized procedures about 10% of respondents go to church for spiritual care. Some churches however carry out some medical procedures with the active support of medical members of the congregation especially the white (syncretic) churches who run ante-natal and delivery services.

Table 9 Percentage distribution of respondents by use of alternative sources of health care

Alternative health care	frequency	Percentage (%)
Traditional medicine	46	27.9
Local chemist	89	53.9
Self medication	98	59.4
Church	17	10.3
Other	7	4.2

Source: Field work, Ibadan August 2002

5.4 Quality of service at OCH

The Oluyoro catholic hospital was established to provide basic health care services, and table.10 shows some common disease conditions that direct patients' preference for seeking health intervention at the OCH

Table 10 Percentage distribution of respondents according to Common ailments they experience

Ailment	Frequency	Percentage (%)
Malaria	120	72.7
Diarrhea	3	1.81
Typhoid	4	2.42
Allergies	9	5.45
Other ailments	9	5.45

Source: Field work Ibadan August 2002

The most common ailment that takes respondents to the hospital is malaria (72.7%).This is not so surprising because Nigeria known as a malaria endemic zone, being in the sub-tropics. Malaria is listed among the twelve preventable and communicable diseases that account for 95% of all ill health and death in Nigeria (Alubo, Vivekananda 1995). According to Belshaw D.and I. Livingstone (2002), over 90% of the population of sub-Saharan Africa live in areas with significant risk of malaria, and 75% live in high-risk areas. Nigeria is considered to be a high risk area. World wide, malaria accounts for about 1 million deaths out of an annual occurrence of 270- 480 million cases. Macroeconomic analysis puts the loss of GDP to sub-Saharan African countries from the burden of malaria, at between 3 to 12 billion US dollars per year (Desai V., R. Potter 2002: 338). Malaria also poses an excessive drain on limited health resources, disrupts child survival programs, and maintains poverty through low productivity (from frequent/recurrent attacks leading to inability to work) and impairs economic growth due to man-power loss.

Diarrhea accounts for only 1.81% of common ailments presented by respondents in this study, but constitutes significantly to overall infant mortality.

Respondents were questioned on whether or not they were satisfied with the services they received at the Oluyoro Catholic hospital. More than 72% of the respondents were satisfied with the services, 14.6% were dissatisfied and about 12% could not say whether on not they were satisfied. (See table 11)

Table 11 Percentage distribution of respondents' reason for satisfaction with the services provided at the Oluyoro Catholic hospital.

SATISFACTION	Frequency	Percentage (%)
Yes	120	72.7
No	24	14.6
Cannot say	21	12.7
Total	165	100.0

Reasons for lack of satisfaction

The respondents who claimed not to be satisfied with the hospital services were further queried to give reason for showing their displeasure with the Oluyoro hospital. The total number of respondents in this category may not necessarily add up to 24 respondents who were dissatisfied with the services at Oluyoro hospital because they were given the opportunity to mention more than one reason, and their responses are shown below in table 12

Table 12: Percentage distribution of respondents by reason for lack of satisfaction with the services at Oluyoro hospital

Reason for lack of satisfaction	Frequency (24)	Percentage (%)
Cost of Treatment	8	33.3
Poor services	4	16.7
Long waiting time	15	62.5
Negative Attitude of personnel	5	20.8
Other reasons	3	12.5

Source: Fieldwork, Ibadan August 2002

Long waiting was cited by majority of respondents who were dissatisfied with the services at Oluyoro hospital. Long waiting time can result from time waiting to be seen by the medical doctor, much longer waiting time at the laboratory first to submit laboratory request and sample, and then to collect the results before going back to see the doctor. Time is also

spent queuing at the pharmacy to collect drugs prescribed, after spending an equally long time waiting to make payments at the account office. Other reasons cited include cost of treatment (33.3%), negative attitude of personnel (20.8%) and poor services (16.7%).

5.5 Payment for services at Oluyoro Catholic hospital

Respondents were then questioned on the main source of funds used to settle their hospital bills and mode of payment. A large proportion of respondents (88.5%) claimed they paid with their personal income, about 6% with donations, 3% with loans and only 1% with insurance (Table 13).

Table 13: Percentage distribution of users of Oluyoro Hospital according to Main source of funds by mode of payment for services

Main source of fund	Mode of payment %			Total %
	Cash	Kind	Cheque	
Personal income	97.9	1.4	7.0	88.5
Loan	66.7	16.7	16.7	3.3
Donations	100.0	-	-	6.7
Insurance	50.0	50.0	-	1.2
Total	96.4	2.4	1.2	100.0 (165)

Source: Field work Ibadan August 2002

Out of those who paid with personal income, about 97% paid cash, 7% by cheque and 1% by kind, probably services rendered in place of money. 100% of those who relied on donations paid for services with cash, while of those who had to obtain loans, 66.7% was by cash 16.7 was by both kind and cheque. For those who used insurance 50% each was by cash and kind (Table 13). Nigeria is cash based economy and most transactions are done by cash.

It was observed that 93% of respondents who have ever used Oluyoro Catholic hospital paid fully for the services while 6.7% were allowed partial payments. Out of those that made full payments, 57.8% made sacrifices to pay for the services, and 72.3% of those that made partial payments made sacrifices (table 14).

Table 14: Percentage distribution of users of Oluyoro hospital according to modes of payment of bills by sacrifices made to meet the bills.

Mode of Payment of Bills	Sacrifices made to meet hospital bills		Total %
	Yes	No	
Full	57.8	42.2	93.3
Part-time	72.7	27.3	6.7
Total	58.8	41.2	100.0 (165)

Source: Fieldwork Ibadan August 2002

5.6 Sacrifices made to pay bills

The respondents were then asked if they made any personal sacrifices to pay hospital bills, and 97 of the 166 respondents who admitted to having ever used Oluyoro hospital claimed that they had made sacrifices to settle their hospital bills.30.9% of these belong to the highest income group earning more than N10, 000 monthly. However this may be as result of the fact that they constitute the highest number of respondents (36.6%). When the proportion of respondents in the lowest income group (<N1750) who have ever used Oluyoro hospital and made sacrifices is compared to those in the highest income group who make sacrifices we have a ratio of 65.4 to 41.7, showing that more people in the lowest income group actually make sacrifices to pay their hospital bills. (Table 15)

Table 15 Percentage distribution of respondents who make sacrifices to pay their hospital bills by average monthly household income of respondents

ANY SACRIFICES	AVERAGE MONTHLY HOUSEHOLD INCOME (Naira)						Total
	<1750	1751-3500	3501-5000	5001-7500	7500-10000	>10000	
Yes	17.5	9.3	18.6	7.2	16.5	30.9	97
No	8.8	4.4	19.1	5.9	13.2	48.5	68
Total	13.5	6.8	18.8	7.8	15.6	37.5	100

Source: Field work Ibadan August (2002)

The type of sacrifices made by respondents to settle their hospital bills (table 16) include school fees(1%), rent (7.2%), food(17.5%) and business(53.6%). This is quite significant because even those with stable employment earning well above the minimum wage, engage in petty trading and other small scale businesses like buying and selling to supplement their income. Business sacrifice here may entail selling off assets, using all or part of the business funds, and so on. These businesses thus constitute important sources of revenue for the respondents and to give these up to settle hospital bills is indeed big sacrifice.

Table 16 Percentage distribution of respondents by types of sacrifices made to settle hospital bills

Sacrifices	TYPE OF SACRIFICE MADE TO PAY BILL					Total	
	School fees	Food	Business	Rent	Other	Num	%
Yes	1	17.5	53.6	7.2	20	97	100

Source: Field work Ibadan 2002

A review of the grouped household size of respondents that have ever used Oluyoro hospital according to sacrifices made to pay hospital bills showed that households with 4 to 6 people made the most sacrifice(58.8%), those with 7-21 21.6% and those with 1 to 3 people 19.6%.(table 17). Household of all sizes were most likely to claim they sacrificed their businesses, with household size 4-6 highest at 57.9%, while household group sizes 7-21 and 1-3 each have about 47% of respondents sacrificing their businesses. Among the largest Household size (7-21) food was the second most sacrifice good to pay their hospital bills, and group size 4-6 had the least (12.3%). Only the largest household size had respondents that made any sacrifice of school fees, and all groups had small number of respondents that sacrificed their rent, 5.3% group size 1-3; 7.0 group 4-6 and 9.5% group size 7-21. It was observed that 31% of respondents that made sacrifices classified as others, belong to the household group size 1-3. These would include luxuries, ceremonies like weddings, burials child dedication and so on which would have to be postponed or celebrated in low key fashion. The Yoruba appear to set high premium on such events.

Table 17: Percentage distribution of users of Oluyoro hospital grouped according to house hold size and type of sacrifices made to meet hospital bills

Grouped household	Type of Sacrifice (%)					Total % ofHHs who made sacrifice
	School fees	Food	Business	Rent	Other	
1-3	-	15.8	47.4	5.3	31.6	19.6
4-6	-	12.3	57.9	7.0	22.8	58.8
7-21	4.8	33.3	47.61	9.5	4.8	21.6
Total HHs	1.0	17.5	53.6	7.21	20.61	97

Source: Fieldwork Ibadan August 2002

5.7. Decision making on whether to use Oluyoro

The respondents were then questioned as to who decides on the use of health services in the household and their response in shown in table 18 below.

Table 18 Percentage distribution of respondents by who decides use of OCH

Decision maker	Number	Percent (%)
Wife	18	10.8
Husband	71	42.8
Family	74	44.6
Friends	1	0.6
Others	1	0.6
Total	166	100.00

Source: Field work Ibadan August 2002

It was observed that 44.6% of the respondents claim that the family decides whether to use OCH. The family comprises of the extended family members like relatives of both partners. In Nigeria, the extended family tends to a significant role in decision making in the household. The husband decides for about 42% of the respondents, while the wife makes the decision for just 10.8% of respondents.

There are two main models for household decision making. The unitary and collective models. The traditional model or unitary model sometimes called 'common preferences' or 'altruism' or the 'benevolent dictator' model, based on the notion that either all household members share the same preference or a single decision maker acts for the whole household. This model is also called the unitary model because the household acts as one with a single preference function (Quisumbing A and Maluccio J, 2000; 4).

The unitary model explains differences in individual well-being and consumption patterns within a household, and assumes that all household resources are pooled and that if preferences are not common to all members of the household, at least one member must have the ability to monitor the others. The unitary approach considers household to be black boxes, identical to individuals, and behavior depends only on total income.

Collective models focus on the individuality of the household members and the possible differences in their preferences .Collective models allow different decision makers to have different preferences, and they do not require a unique household welfare index to be interpreted as a utility function, but the index is price, income and taste dependent.

The decision on whether or not to use a hospital facility or whether to go to hospital however depends on several variables, rather than on any single factor.

CHAPTER 6: SUMMARY AND CONCLUSIONS

This study started with the premise that in societies where individuals have to pay for health care services, household income had a major influence on the household's decision to utilize available health care services whether provided by government, private or other sectors. To study the validity of this hypothesis, various literature were consulted, data sourced, and a questionnaire survey conducted in the Oluyoro community of Ibadan North East LGA, Nigeria to provide practical/ on the ground information. Though the information so gathered has not been conclusive, several things have been gleamed and these are summarized in this last chapter which ends with a conclusion on some of the things to be considered in setting up an effective health system to ensure accessibility and utilization of health care especially to the poor and disadvantaged in our society.

Summary of findings

This study reveals the difficulty of investigating utilization of health care services, and determining factors influencing people's decision to use hospital services. The different models considered here provide what appears to be a shopping list of variables. This means that no single model may be completely effective in explaining and predicting utilization behavior.. The pluralistic nature of health care in third world settings is evident when one considers the different alternative sources of care available to respondents in this study. This is an important consideration because many studies in utilization tend to concentrate only on the modern sector without reckoning with the influence of other locally available alternatives. However, three main factors stand out clearly; cost of treatment, distance of health facility from clients' home and quality of service provided by the health facility, in this case Oluyoro Catholic hospital .This observation appears consistent in the literature, and also in the household survey, though admittedly, the questionnaire may have omitted several important queries, like further questioning of respondents who have never used OCH as to why not; respondents not classed into whether they used the private or public wing of the hospital.

Some of the things observed in this study include:

The socioeconomic profile of the individuals or households who do or do not use or have access to OCH reveals a broad range .People of all ages, educational background and income

level are included in both users and non-users alike. All sectors of the society whether poor, non-poor or moderately poor tend to consider cost, distance and quality of service as important factors before deciding to use health services. However, households are prepared to make sacrifices in other to get health care they need, as evidenced by the observation that no matter the income level, distance or health facility nearest to them ,a high percentage of respondents utilize OCH. But it is also and indication on how much cost of treatment may influence household decision on using health care services, to note that so many households, both poor and non-poor have to make some form of sacrifice, rely on donations/contributions, or obtain loans and even appeal to be allowed partial payments, to pay for hospital services. It therefore implies that households that do not have such avenues would be socially excluded from use of health care services, and one may conclude that those who have not used OCH probably belong to this category. The fact that all classes of respondents do make sacrifices to pay hospital bills may also be an indication that the so called non-poor are not really that well-off

The fact that households have to sacrifice like loosing their businesses to pay for hospital bills, means that the household income was not enough to meet the bills, and also confirms that ill health may promote poverty, as Bloom and Canning (2001) quote the World Bank as saying that the poor households become poorer mainly from illness, injury or death. Further evidence that poverty may cause social exclusion in terms of accessibility and utilization of health services may be drawn from the observation that poor households have had to sacrifice their meals to pay hospital bills.

Though this study did not present information and data from government health facility for comparison, one can summarize by quoting from The World Bank's consultation with the poor (Bloom et al 2001, 39) which:

Identifies corruption, and rudeness of health staff as key reasons for not using government health facilities. Travel to the nearest health centre is also seen as too expensive and time consuming, creating disincentive for people to seek treatment. Waiting times, as well as travel times, are often longer than a family can afford. There are often drug shortages, or drugs that are meant to be free are being charged for, or are too expensive. Costs are prohibitive. Families often sell livestock and property to get health care-and, even then, they may not have enough money. Poor people complain of discrimination at health care centers, and they

commonly receive poor quality treatment. In many cases, health services are both ineffective and expensive, draining scarce resources for little result, and corruption cited as a major factor by those who decided to avoid formal services altogether.

The long quote summaries the feelings of the poor concerning government health facilities, and is representative of the poor anywhere. It explains and provides support for the reasons giving for satisfaction in the use of OCH by respondents for this study.

The Nigerian health system is a fee- for –service system, and it was observed in this study that households paid cash for utilization of health services, and only a very minor percent have any insurance. It was also observed that households sometimes depend on contributions/donations, and loans to be able to afford hospital services. One could suppose that those who claimed not to have used the services provided at OCH, could not afford to pay for such services, especially since most of them were unemployed, and probably had no income.

The list of common ailments that take household members to hospital shows that malaria is still a very important disease in the Nigeria context, and underscores the need for more aggressive control measures. The cost of treatment for uncomplicated malaria infection may cost anything from N350 (general side) to N1500 in the private wing. The effect of this as often more than one household member at a time is affected, on the household income can not be overemphasized. This finding is confirmed by the hospital records (annex 2).

Finally, the issue of decision making in the household with regards to the use of health care services, showed the family as playing a significant role. This may be ascribed to the fact, not reflected in the study that the contributions and loans used for payment of bills are from family members.

Conclusion

One of the major barriers to access to effective health care for the poor households are 'an inability to pay for goods and services, particularly in times of serious illness' (Bloom et al 2002, 435).

Sen's entitlement failure can be defined as 'the inability of a household to preserve a minimal acceptable livelihood with the resources it commands and the production and market conditions it confronts' (Marc Wuyts 1992, 21-22). In later works (Gasper 1993), Sen and his

associates elaborated entitlement analysis to include medical attention, health services, basic education, sanitary arrangements, provision of clean water and eradication of infectious epidemics .The 'state's provision of health care helps to guard a family against crippling expenditures associated with illness or disease' (Wuyts 1992, 25).. Health services may be viewed as a public good and legal entitlement. Inability for any reason, to be able to make use of health services may then be regarded as an entitlement failure.

The importance of affordable health service for poor men and women cannot be overstressed. The Nigerian health care system has the important role of changing the way in which health care services are planned, delivered and evaluated, to better meet the needs of the poor (low income).there is also a need to work with other sectors outside of health to assist in understanding the health impacts of policies in this sectors so that collective action can be planned and executed.

Though a detailed understanding of how income affects health care utilization and accessibility may not be possible, it is or should be, accepted that there is a relationship, and this realization or knowledge should be used to make changes in health services provisioning in other not to exclude the socially disadvantaged from services they need.. Health sector interventions need to become more poverty focused with a better insight into the decision making and strategies of poor people.

The present civilian government of Obasanjo, by its utterances seem, genuinely interested in improving the health services provision in the country. With the setting up of the Kuti led - National PHC Development agency (NPHCDA), and its mandate to build so many hospital facilities yearly may be a good start. As this study as shown, to the improve health care service provision,studies on the influence of the various determinants of health care utilization, that is, the demand for health care, household choices, and the supply factors are all important.

Cost recovery and user fee charges do not seem to have had a good impact, rather further, taking health services out of the rich of the poor. The plan to establish a National Health Insurance scheme hopefully may bring some succor to the severely impoverished poverty stricken masses.

Appendix

Annex 1 :

Distribution of staff and facilities at Oluyoro Catholic hospital

Open Ward	Isolation			
Amenity				
1a Wards: Male Medical & Surgical	3		20	1
Female Medical, Surgical * Gynaecology	30	3		3
Maternity, Mothers' Beds	41	3		3
Babies cots	30	-		5
Psychiatry Beds	-	-		-
Paediatrics Beds	34	3		2
Special Care Baby Unit	10	-		-

1b.Staff capacity	250 + 14 part time
Doctors	12
Nurses	76
Laboratory Scientists	12
Laboratory Technicians	08
Pharmacist	01
Pharmacy technicians	01
Pharmacy Assistants	15
Account technicians	01
Account Clerks	03
Radiographer	10
Assistant Radiographer	01
Medical Recorder	02
Assistant Medical Recorder	04

Computer Operator/Librarian	01
Others(ancillary staff)	87
Tutors(Schools)	8 full time, 7 part time

1c.Training facilities

School of Midwifery

- Duration of Training = 12 months
- Students' population = 39
- Certificate attained on completion = Nigerian Registered Midwife

School of Medical Laboratory Sciences

- Duration of Training = 3 years
- Student's population = 50
- Tutors = 4 full time; 3 Part time
- Certificate attained on competition = technician

Annex 2 : HOSPITAL RECORDS FOR OCH FOR 1999, 2000, 2001

2(i)Disease Pattern for OCH (In-Patients)

Disease	**Year**		
	1999	**2000**	**2001**
Malaria	190	207	134
Typhoid	34	36	36
Anemia	62	58	69
Gastroenteritis	96	120	78
Pneumonia	33	23	28
Surgery	452	392	413

Source: Oluyoro Catholic Hospital Medical Records

2(ii) Maternity Registration in Private wing and General side

Year	**Number of Patients**	
	Private	**General**
1999	128	2518
2000	103	2368
2001	157	2284

Source: Oluyoro Catholic Hospital Medical Records

2(iii) Private and General In-patients Record (male and females)

Year	**Number of Patients**	
	Private	**General**
1999	435	1744
2000	451	1329
2001	544	1949

Source: Oluyoro Catholic Hospital Medical Records

Annex 3

QUESTIONAIRE ON THE USE OF OLUYORO HOSPITAL FACILITY

NB. DEAR RESPONDENT,

THIS IS A PRIVATE SURVEY, AND THE RESPONSES WILL BE KEPT AS SUCH. ANY INFORMATION YOU GIVE WILL BE KEPT IN STRICT CONFIDENCE. FURTHER COMMENTS ARE HOWEVER WELCOMED.

THANK YOU

S/No.	QUESTION	OPTION	SKIP TO
Q1	Age of respondent (at last birthday in completed years)		
Q2	Sex	Male Female	
Q3	Main Occupation of Respondent	Self-employed Civil Servant Employee (private sector) Unemployed	
Q4	Religion	Muslim Christian (orthodox) Christian (pentecostal) Traditionalist White garment church Other:.....	
Q5	Level of Education of respondent	None Primary Secondary Post-Secondary Koranic	
Q6	Number of wives (if respondent is male head of household)		
Q7	Number of persons in household (including head)		
Q8	Average household income per month	< N1750 N1751-	

		N3500 N3501-N5000 N5001-N7500 N7501-N10000 > N10000		
Q9	What is the nearest health facility to you?	Government hospital Private Clinic Oluyoro hospital		
Q10	Have you or any member of your household ever gone to Oluyoro hospital to seek medical attention before?	Yes No		If (b), then end.
Q11	What is the distance between your place of residence and Oluyoro hospital (from the time you set out from home)	< 10 minutes < 30 minutes about 1 hour about 2 hours		
Q12	What mode of transport do you use to Oluyoro?	Private Public Other:.....		
Q13	How often do you use the Oluyoro hospital?	Once in a month Once in 3 months Once in 6 months Once a year or over		
Q14	Why did you choose to use Oluyoro hospital? Distance Waiting time for treatment Cost of treatment Attitude of personnel Quality of facility Good services/ treatment	Yes	No	
Q15	What is your main source of fund for treatment sought or received?	Personal income Loan Donation Insurance		

Q16	What was the mode of payment for the last treatment received?	Cash Kind Cheque Insurance Selling of Assets		
Q17	Was the payment demanded for in full or were you allowed part-payment?	Full Part-payment		
Q18	Have you ever used any of the following alternatives to healthcare? Traditional medicine Local chemist Self medication Church Other.....	Yes	No	
Q19	Are you satisfied with the hospital services?	Yes No Cannot say		If a or c, go to Q21
Q20	If No in Q19, why? Cost of treatment too high Poor services Long waiting time Negative attitude of Staff Other.....	Yes	No	
Q21	What are the common ailments in your household?	Yes	No	
	Malaria			
	Diarrhea			

	Typhoid			
	Allergies			
	Other			
Q22	Have you ever made any sacrifice in meeting hospital bills?	Yes No		Q24
Q23	What type of sacrifice did you have to make in order to pay your hospital bill?	School fees Food Business Rent Other		
Q24	Who has the major say in deciding to use health facility	Wife decides Husband decides Family decides Friends Others		

THANKS FOR YOUR COOPERATION

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