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Artisan Reactions to National Health Insurance Scheme in Lagos State, Nigeria

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Abstract

Artisans generally constitute a significant proportion of the Nigerian population with remarkable contributions to development but they face neglect and marginalization in the ongoing implementation of the National Health Insurance Scheme (NHIS). The scheme was established with Decree 35 of 1999 to ensure that every Nigerian has easy access to good healthcare services at subsidized rates, among other objectives. Failure to reckon artisans in the NHIS will affect the success of the scheme and the declared interest on national development. Therefore, within the ambits of the Health Belief Model and Theory of Planned Behaviour, the present article addresses artisans' reactions to NHIS in Nigeria. The data used for the study were derived from relevant documents in the library, two focus group discussions and 45 in-depth interviews, involving staff of NHIS, health-care providers (HCP) and artisans in Yaba areas of Lagos State. The findings revealed only a few artisans with expression of knowledge about the NHIS, thereby confirming the culture of limited accessibility to subsidized health services in Nigeria. The majority of the artisans were indifferent to the scheme due to their zero awareness about it. They largely expressed their concerns about health-care system in Nigeria. Community focus is therefore suggested for the success of the NHIS in Nigeria.

Keywords: *Artisans, health insurance, public health, social services, Nigeria.*

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The health of the artisans' class has been neglected in Nigeria despite the magnitude of their contributions towards the development of the Nigerian society. Artisans have been described in various ways, namely, craftsmen, tradesmen, and mechanics; for instance, they were known as Mechanics in most American cities in the nineteenth century (Dawley, 1976; Stott, 1996). Alongside other groups such as guardians (rulers) and warriors, artisans were not only described but also recognised in Plato's Republic given their contributions to societal development through production of basic human needs, especially food, clothing and shelter (Coby, 1983).

In fact, Socrates thinks that a true craftsman, who is unable to practice his art because of chronic disease, would find life so miserable that death would come as a welcome deliverance(Coby, 1983, p. 520). The present article deals with the following questions: What are the health conditions of artisans in Nigeria? How do artisans react to health insurance? Do artisans embrace health insurance? Can the artisans survive without health insurance? Which health-care services do artisans prefer, and why?

In Nigeria, evidence of artisans' contributions to development was observed in different regions in the pre-colonial era when old craftsmen formed guilds from where industrial techniques were conserved and transmitted from older generations to younger generations (Hambly, 1935, p. 403). In recognition of artisans' creativity and innovation, historical evidence made it clear that for perhaps a thousand years great emporia of manufacture and trade have existed in West Africa, notably at Ghana, Timbuktu, Kano, Sokoto, Katsina, and in Bornu (Hambly, 1935, p. 418).

Also, apart from Nigerian handicraft in general, the industries of Benin have been of such importance as to require description. The arts of the city, chiefly casting in bronze, wood-carving, and ivory-carving, had reached their zenith when Europeans arrived, at the end of the fifteenth century (Hambly, 1935, p. 399). Presently, artisans are still relevant to the Nigerian economy despite the changes that occurred in the colonial era and the changes that have been occurring since the Nigeria's attainment of political independence from Britain in October 1960.

Similarly, the traditional German guild system comprises tailors, shoemakers, joiners, smiths, or coopers (Eisenberg, 1991, p. 508). With involvement of many artisans, the guild system provided impetus for the development of the modern labour movement in England and Germany. Artisans' workshops then became the base of trade unionism. The guild system has also facilitated the continued existence of one-man businesses and small scale enterprises. These are ubiquitous in Nigeria and in many countries.

However, as argued in several studies, artisans have been adversely influenced by the vagaries of exploitation in the capitalist market system (Dawley, 1976; Gervai, 1968; Oliveira-Correa,Rial, &Queluz,2012; Mohsini, 2011; Stott, 1996). In contrast, it is equally noted that artisans have capacity for dynamic response to changing conditions (O'Connor, 1996). Artisans' experience in a market economy cannot be ignored, as many of them flourished in the wake of the industrial revolution. This is evidenced by the continuity of the master-journeyman-

apprentice craft-based system in many countries where the increase in capitalist production resulted in rising demands for craft workers.

However, some artisans experienced a downward spiral due to the industrial revolution (Stott, 1996, p. 267). Besides, it appears that the artisans' class in Nigeria presently contends with a number of awkward issues including occupational hazards and lack of social protection, thereby living in the vicious circle of deprivation, which is detrimental to their health conditions. Unfortunately, there is paucity of data on the issue of occupational health and safety (OHS) among the artisans' class.

Based on her study on pollution by artisans in Osun state of Nigeria, Olayiwola (2011) revealed that the soil in mechanic workshops is grossly polluted with iron and lead, showing that mechanic workshops create many different types of hazardous waste during their operations; the most dangerous waste commonly created in mechanic workshops is from the solvents used to clean parts. Many part cleaners and solvents are dangerous to workers' health. The above statement lends credence to the following description of the relationship between wealth creation and development throughhealth:

> Health is wealth and to create wealth at the individual, family, community or national level, people must be healthy; to enjoy wealth that is created, an individual, family, community or nation must be healthy. Health is the good entry point for breaking the vicious circle of ill-health, poverty and underdevelopment and for converting it to the vicious circle of improved health status, prosperity and sustainable development (Saka, Saka, Isiaka, Agbana, & Bako 2012, p. 28)

Consistent with the above statement, countries across the world presently consider health insurance as a means of ensuring access to health care and protecting patients from financial risks **(**Yang, 2013, p. 1). Expectedly, many African countries have established health insurance schemes due to the need for improvements in health service provision, on the one hand, and the promotion of health care utilization, on the other hand (Mohammed, Sambo, & Dong, 2011).

In the mid 1980s in Nigeria, a ministerial committee on alternative methods of health funding submitted its report to the Minister of Health, who then announced that national health insurance would soon start in Nigeria (Ityavyar, 1987, p. 309). The Nigerian government established its National Health Insurance Scheme (NHIS) through Decree 35 of 1999 (Okoro & Shekari, 2013), although the bill on national health insurance was first proposed in 1962 by the then Minister of Health. The foremost national health insurance was launched in October 1997, albeit without an enabling law for its implementation.

The actual implementation of the new national health insurance commenced in 2002 and the implementation of the scheme was consolidated in 2005 with a focus on employees in the formal sector (Ewelukwa, Onoka, & Onwujekwe, 2013; Lawan, Iliyasu, & Daso, 2012; Welcome, 2011). It has been shown that currently, only employees in the public sector, a subset of the formal sector group has been actively participating in the scheme (Mohammed, Sambo, & Dong, 2011). In the words of Gibson and Mills (1995), it is essential to consider how policy interventions such as the NHIS have influenced the barriers to health care utilization, which not only include geographical access, but also perceived quality of care and access to information.

Kruk and Freedman (2008) also observe that measures of health system effectiveness should be aligned with improvements in access to quality of care and client satisfaction. Unfortunately, the Nigerian health-care system has suffered several downfalls due to inadequate

health facilities (Welcome, 2011, p. 470). The 2009 communiqué of the Nigerian national health conference raises concerns over the continued weakness of the health care system.

Available data shows that only 43.3 per cent of the Nigerian people have access to health care and about 70 per cent of the health care is provided by private vendors, despite the various reforms in the Nigerian health sector (Onwujekwe et al., 2010). This situation has not been addressed in the ongoing implementation of the NHIS. As shown by Welcome (2011, p. 474), the ineffectiveness of the NHIS has been attributed to the fact that the scheme represents only 40% of the entire population, while it neglects 52-60% of the population, especially those who are employed in the informal sector, i.e. the domain of the artisans' class. Also, it has been shown that the national policy framework on health sector reform had been narrowly based in a small number of institutions (Saka, Saka, Isiaka, Agbana, & Bako 2012, p. 28).

Recent evidence shows that NHIS covers less than 5% of the population most of whom are federal civil servants, while other health insurance schemes like private health insurance and community-based health insurance (CBHI) cover less than 1% of the population (Onwujekwe et al., 2010 [cited in Ewelukwa, Onoka, & Onwujekwe, 2013, p. 2]). Thus, the Nigerian workers, especially the artisans' class generally lack access to adequate healthcare due to intensification of social inequalities in health-care delivery system.

Consequently, the Nigerian working class faces many difficulties in a bid to finance their personal health services. This situation exacerbates the level of poverty in Nigeria but the concerns of the poor are yet to attract serious attention from the state and the dominant class, who constitute the key decision makers in the Nigerian health system. As a result of the neglect of the majority of the Nigerian population in the health-care delivery system, Nigeria has hitherto failed to meet the health target in the Millennium Development Goals (MDGs).

Against the above background, the present article examines artisans' reactions to NHIS in Lagos state, Nigeria. Research on artisans largely deals with their experience in the western world and for this reason there is need for studies on artisans' experience in developing countries like Nigeria. In addition, important issues about artisans' reactions to government policies remain unresolved. Specifically, there is need for studies on artisans' standard of living in relation to the health of the artisan system, and the ensuing development. Investigating the artisans' reactions to NHIS will offer the Nigerian government a realistic assessment of the significance of national health insurance to development in Nigeria. The present article therefore articulates a linkage between the artisan system and the health system in Nigeria. A close examination of the health of the artisans will promote development efforts in Nigeria through an evaluation of the strengths or weaknesses of the NHIS from the perspectives of artisans in the margins of the Nigerian economy.

THE ROLE OF THE STATE IN HEALTH CARE DELIVERY SYSTEM

The Nigerian state has embarked on various activities, aimed at promoting the health of Nigerians. The state is responsible for formulation of health policies. The state is responsible for funding of health-care institutions. The state is also expected to provide financial support to all health establishments. As stipulated in the Nigerian constitution, the responsibility for health care delivery is shared between the federal, state and local levels of government. The division of responsibilities among various agencies of the state was described in a recent study:

> In Nigeria, the Federal Ministry of Health has the responsibility to develop policies, strategies, guidelines, plans and programmes that provide direction for the national health care delivery system. In addition, the Federal Ministry of Health is currently a major provider of tertiary health care services and various other health intervention programmes aimed at promoting, protecting and preventing ill-health of Nigerians (Saka, Saka, Isiaka, Agbana, &Bako, 2012, p. 28).

Besides the role of the Federal Ministry of Health, the state government manages the various general hospitals, i.e. secondary healthcare, while local government focuses on dispensaries, i.e. primary healthcare. Both the primary and secondary healthcare are regulated by the federal government through the National Primary Health Care Development Agency (NPHCDA) (Okoro & Shekari, 2013).

However, private providers of healthcare delivery have also played visible role in the health-care delivery in Nigeria; this is due to the fact that Nigeria operates a mixed economy. In 2010, private expenditure on health constituted 62% of the overall health care spending in Nigeria (Ewelukwa, Onoka, & Onwujekwe, 2013, p. 1). Thus, it is noted that health-care delivery in Nigeria is provided by the government with a major input from the private sector which includes private individuals, corporate bodies and churches that are owned and run by organisations offering healthcare to the public. (Ewelukwa, Onoka, & Onwujekwe, 2013, p. 2) The above constitutes an extension of the argument advanced in earlier study by Ityavyar (1987, p. 290):

> There are two main categories of medical services offered in Nigeria, i.e. those provided free by government and charity organizations, and those that require payment. […] Recently, due to Nigeria's present economic fortunes, token fees were introduced in almost all government health facilities. […] Hospital fees in Christian mission hospitals are similar to those in government hospitals.

The performance of the Nigerian state in the development of health services can be seen in the outcomes of the ten year (1946 – 1956) Development Plan established in the colonial era and the four post-independence (1960 – 1985) National Development Plans. During the colonial era in Nigeria, a ten year development plan (1946 – 1956) was introduced to enhance health care delivery and this led to establishment of health facilities including medical schools, health institutions, clinics and health centres (Welcome, 2011, p. 472).

Like the situation in the colonial era, the Nigerian state did not show adequate interest on health matters during the First National Development Plan (1960 – 1969) in which only one page was devoted to health out of 362 pages of the plan. The need for more attention on health was recognised in the Second and Third National Development Plans (1970 – 1980) but there was no remarkable improvement in the health of Nigerians, because the plans neglected social inequalities in access to health services. In the process, the urban and rural poor had less than the minimum health services they needed because they lacked enough income to buy the services (Ityavyar, 1987, p. 291). Expectedly, discontent is a natural expression of the disadvantaged if their poverty and suffering is profound enough. Several cases of uprising in the Arab world can be employed to illustrate the linkage between chronic deprivation and civilian revolts. The issue of Arab revolts is however not the focus of the present article.

The neglect of the artisans' class in the health care delivery led to many protests by the working class in Nigeria in the 1970s, prior to the establishment of the Third National Development Plan (1975 – 1980), which addressed manyneeds of the rich and the poor. Then, the Basic Health Services Scheme (BHSS) was launched for the working class. However, less than half of the health policy reforms outlined in the plan were implemented. Lack of effective implementation of existing programmes in the health sector was a focal point in the Fourth Development Plan (1981 – 1985) with emphasis on strategies of implementing the existing programmes. The outcomes of the national development plans in relation to the development of health in Nigeria were summarised by Ityavyar (1987, p. 294) as follows:

> The health policy of Nigeria and the role of the state in health have not substantially changed in spite of the various mimic reforms purported in the four post-independence development plans. Social inequalities in health are in fact growing. The personal health of Nigerian factory workers, women, children, and the poor is largely disregarded by the state.

To improve the awkward situation in the heath-care delivery system, the Nigerian government launched its primary health care plan in August 1987. According to Welcome (2011, p. 473), the primary health care plan made little impact on the health sector, as it continued to suffer major infrastructural, and personnel deficit, in addition to poor management of public health, which is an important element of national security. Nevertheless, a stock of available health care institutions in Nigeria includes the followings: 33,303 general hospitals, 20,278 primary health centres and 59 teaching hospitals and federal medical centres. In the face of the available health institutions, the general health conditions have become worrisome for the majority of the Nigerian population. Table 1 shows some instances of public health indicators in Nigeria.

TABLE 1: SOME HEALTH INDICATORS FOR NIGERIA (2007 & 2010)

HEALTH INDICATORS	ESTIMATED FIGURE	REFERENCE YEAR
Birth Rate	36.1 per 1000 population	2010
Death Rate	16.3 per 1000 population	2010
Infant Mortality Rate	93.0 per 1000 live births	2010
Life Expectancy	47 years	2010
Cholera	29115	2010
Meningococcal Disease	17462	2010
HIV Prevalence	2.6 million	2007
HIV Deaths	170,000	2007

Adapted from the Library of Congress Country Studies cited in Welcome (2011, p. 473)

In the light of the above, the Nigerian experience of high rate of morbidity and low life expectancy can be partly based on inadequate attention to health infrastructure. Other factors can be derived from the politics of health service in Nigeria, notably with a commitment to the capitalist mode of production. As observed by Ityavyar (1987, p. 289), a meaningful discussion on social factors influencing the development of health services in Nigeria can start from the

analysis of an entangled and intertwined relationship between the state and factions of the dominant class. The state and the dominant class determine how health services are socially and geographically distributed in Nigeria. This suggests that the health problems in Nigeria will continue to escalate unless there is a fundamental change in the structure of social relations between the working class and the state.

CURRENT DEBATES ON THE NHIS OF NIGERIA

Studies on the NHIS of Nigeria reveal some of its objectives, namely, to ensure that every Nigerian has easy access to good health-care services and to protect families from the financial hardship of huge medical bills (Mohammed, Sambo, & Dong, 2011; Monye, 2006). This implies that the scheme shows the Nigerian government's intention to defray the cost of health-care services for every Nigerian. Other objectives of the scheme include the following: to ensure adequate distribution of heath facilities within the federation; to ensure the availability of funds to the health sector for improved services; and to ensure equitable patronage of all levels of healthcare.

The NHIS objectives have been well observed in several studies (Akwukwuma & Igodan, 2012; Lawan, Iliyasu, & Daso, 2012; Mohammed, Sambo, & Dong, 2011; Monye, 2006; Okoro & Shekari, 2013; Saka, Saka, Isiaka, Agbana, & Bako 2012; Welcome, 2011). It is believed that the National Health Insurance Scheme will considerably improve access to health services and facilities through decrease in physical distance to health amenities, enhancement of quality and increase in the rate of affordability of healthcare (Ajayi, 2005).

Based on the premise that that patients' satisfaction with health service provision has often been neglected since numerous activities take place concurrently during the implementation of health insurance schemes, Mohammed, Sambo, and Dong (2011) conducted a study on patients'satisfaction with health service provision under a health insurance scheme and the factors which influence the satisfaction; the study was conducted among employees of Ahmadu Bello University, in Zaria, a city in northern Nigeria.

The study by Mohammed, Sambo, and Dong (2011) recorded 42.1 per cent patients' satisfaction rate and this was positively influenced by the following factors: (1) marital status, (2) general knowledge and awareness of contributions by beneficiaries, (3) length of employment, (4) level of income, (5) hospital visits and, (6) duration of enrolment. Essentially, the above study revealed that clients satisfaction rate with the health insurance scheme was somewhat low. This suggests that the stated objectives of the NHIS are yet to be fully actualized.

Already there has been insufficient knowledge and awareness of the health insurance activities by those enrolled in the scheme. The implementation of the NHIS is fraught with complaints. It is revealed that some providers have denied enrollees their full entitlements and some providers have been charging additional fees on the pretext of non-inclusion of the service in the benefit package (NHIS, 2006).The insured-persons have also complained of poor attitude and behaviour of some service providers operating in the health insurance scheme.

Because of the above situation, scholarly opinions are divided on the importance of national health insurance in the development of health-care delivery system in Nigeria. Presently, there is a mismatch between the input and output of the national health insurance scheme. Few instances of perception of the input and output of the NHIS is presented in Table 2 for comparison.

TABLE 2:SCHOLARLY ANALYSIS OF INPUT AND OUTPUT IN THE NHIS

Perceived Input in the NHIS	Perceived Output in the NHIS
NHIS was structured to cover all groups in society. Thus, there is the formal sector health insurance; urban self-employed health insurance program; rural community program; the under-five children insurance program; the permanently disabled social health insurance program; the prison inmates program, and the international travel health insurance program. (NHIS Handbook, 2009 [cited in Lawan, Iliyasu, &Daso, 2012, p. 34])	The NHIS has hardly attained any height as health care delivery continues to be limited; not equitable and does not meet the needs of the majority of the Nigerian people. […] The appendage program of the NHIS launched in October 2008 – Millennium Development Goals – also reported little positive effect a year later. […] At its present state, it is true that the scheme does not adequately account for the needs of the Nigerian people. (Welcome, 2011, p. 473)

Besides, several studies have shown that the implementation of the NHIS has been marred by some pitfalls. Presently, the NHIS of Nigeria does not have a centralized patient information system for the health-care centres in Nigeria to access patients' information for health-care delivery; and patients' data kept by the NHIS are scattered among various Health Maintenance Organisations (HMOs) (Akwukwuma & Igodan, 2012, p. 15). The HMOs serves as the intermediary between the NHIS and health-care providers (HCPc), on the one hand, and the intermediary between the HCPs and the enrollees, on the other hand.

The HMO makes payments to the HCP for services rendered using one of the following alternatives: (1) capitation, which involves regular payment in advance of treatment based on membership size; (2) fee-for-service, which is mostly applicable to private providers based on 'authorised referrals,' (3) per diem, namely daily fees for medical treatment during hospitalization, or (4) per case payment (Odeyemi, & Nixon, 2013, p. 10). The role of the HMO is reinforced by the bureaucratic structure in the NHIS; owing to the known history of corruption in Nigeria, this arrangement will pose a threat to the development of the Nigerian health care delivery system.

In the words of Okoro and Shekari (2013, p. 4), the Nigerian health-care delivery system is fragmented; pharmacist has not been fully integrated into the healthcare team, and more so, there is shortage of pharmacies in Nigerian hospitals and the few available ones are over laboured. Consequently, there is patient congestion when the rate of patient arrival at the pharmacy is greater than the service rate. Further, as shown in a study in urban Kano of northern Nigeria:

> More than half (52.0%) of the respondents had poor knowledge of the NHIS. Respondents' knowledge of NHIS did not differ significantly by age, sex, ethnicity, marital status, educational level or occupation. Although the majority (74.7%) of the respondents opined that the NHIS is a good initiative […] 31.3% said that it is a good scheme but not practicable and 28.0% felt that it only for the rich. (Lawan, Iliyasu, & Daso, 2012, p. 34)

The need for intensification of public enlightenment about the NHIS was suggested by the above-mentioned authors given the belief that the success of the implementation of the NHIS largely depends on public knowledge about the scheme.Consistent with the above, a study by other scholars also indicated that the informal sector requires an NHIS awareness campaign as membership is not mandatory in the sector (Odeyemi, & Nixon, 2013, p. 12).

However, evidence from developing countries suggest that public voluntary insurance programmes, especially the ones that require substantial premiums and patient cost-sharing, may have little effect on improving the use of public financed health services of the poor (Yang,2013, p. 2). In contrast, Ahuja (2004, p. 3171) showed that:

> Health insurance is emerging as an important financing tool in meeting the health care needs of the poor.[…] Insurance or pooling of risks through pre-paid schemes has a number of advantages. Besides being more equitable, it is one of the significant drivers of improvement in health care provision.

In the furtherance of support for health insurance, Ahuja (2004, p. 3172) concurred that private insurance has certain pitfalls such as leaving out low-income individuals who may not be able to afford the premium. It is then noted that the pitfalls associated with private health insurance can be reduced through appropriate regulation. A close observation of the various arguments on the issue of health insurance suggests that both the antagonists and the protagonists recognise the need to protect the interest of the poor in the implementation of health insurance. Artisans' poverty is the focus here.

THEORETICAL ANALYSIS OF ARTISANS' REACTIONS TO NHIS

Considering the importance of application of theories towards the spread of knowledge on a given phenomenon, the focus of the present article is therefore situated within the ambits of the Health Belief Model and the Theory of Planned Behaviour. Rosenstock (1966) put forth the Health Belief Model in '*Why people use health services'*.

At the center of the model is perception of consequences and benefits of human actions or inactions. The components of the model are identified as barriers to an action; benefits of an action, severity of the condition requiring a reaction; susceptibility of an individual to an undesirable condition; and cues which prompt specific actions. The model deals with the confidence that an individual has in his or her ability to prevent an undesirable health condition and the assurance that whatever action taken in this regard is able to forestall such undesirable condition.

Based on the central argument in the Health Belief Model, an artisan would consider subscribing to the NHIS if he or she perceives some disadvantages in not doing so. Alternatively, a rational artisan will choose to ignore the NHIS if subscribing to the scheme would not eliminate the perceived disadvantages in the failure of subscription to the NHIS.

The alternative perspective may hold sway for the artisans' class in Nigeria due to the fact that many Nigerians have become sceptical about the credibility of "anything that is based on insurance." Thus, with an emerging culture of doubt in the credibility of insurance packages in Nigeria, inaction will be an expected reaction to NHIS among many artisans in Nigeria.

This suggests that an intended inaction may inform the actions of artisans towards the NHIS. Theory of Planned Behavior is required to buttress the above point. The Theory of Planned Behaviour originated from the thought of Ajzen (1985), who explained the relationship

between intention and actions in a given situation. The theory indicates that attitude, beliefs, norm and perceived control are all drivers of a person's intention which in turn informs behaviour.

In essence, an individual's behaviour can be predicted when there is an understanding of intention while the measurement of attitude, beliefs, and norm in relation to an action as well as perceived ability to act in a specific way aids the analysis of intention.The Theory of Planned Behaviour has been found to be especially useful in predicting health-related behaviour. With the benefit of hindsight from the Theory of Planned Behaviour, artisans' reactions to the NHIS would depend on their beliefs, attitude, and perception irrespective of the actions they have taken on their health conditions.

METHODS OF DATA COLLECTION AND ANALYSIS

The study was conducted in Lagos state of Nigeria. All levels of healthcare services are available in Lagos State. The state accommodates different categories of people from all walks of life. The study population comprises three categories of persons. The first category of the study population comprises members of staff of the NHIS in Lagos State. The second category of the study population entails the NHIS-accredited healthcare providers (HCP), while the third category of the study population comprises different artisans.

The artisans were selected among the following crafts: (1) aluminium makers, (2) barbers, (3) basketry, (4) beads making, (5) blacksmith, (6) block making, (7) bricklayers, (8) carpenters, (9) conductors, (10) decorators, (11) designers, (12) drivers, (13) drummers, (14) electricians, (15) furniture makers, (16) goldsmith, (17) hairdressers, (18) mechanics, (19) motorcyclists, (20) painters, (21) panel beaters, (22) photographers, (23) plumbers, (24) pottery, (25) printers, (26) repairers, (27) rewires, (28) scavengers, (29) shoemaking, (30) stylists, (31) tailors, (32) traders, (33) upholstery, (34) vulcanizers, (35) weavers, (36) welders, etc.

Considering its suitability for a qualitative study, purposive sampling method was used to select a total of 45 participants for the study. Participants' selection was based on employment status, relevance and availability. The staff of the NHIS and employees of the HCP constitutes one group, while artisans constitute another group.

Three researchers visited some of the NHIS-accredited healthcare providers (HCP) and the NHIS Office in Yaba areas of Lagos State, Nigeria. The general purpose of the visits was to conduct in-depth interviews and seek necessary clarifications about the implementation of the NHIS. The specific purpose of the visit is for a cross examination of the stated objectives of the NHIS and the reality on ground.

Primary and secondary data were used for the study. While the secondary data used for the study comprises relevant documents obtained from the library, the primary data used for the study was derived from two focus group discussions (FGDs) and a total of 45 in-depth interviews (IDIs) involving two groups, namely, the staff of the NHIS and employees of the NHIS-accredited health care providers (HCP) as well as artisans in various crafts.

The participants in the two groups were purposively selected from different locations in Yaba areas of Lagos State. A total of 20 in-depth interviews (9 males and 11 females) were conducted in the NHIS/HCP Group, and a total of 25 in-depth interviews (14 males and 11 females) were conducted in the Artisans Group; 45 in-depth interviews (23 males and 22 females) were conducted among the two groups.

The enthusiasm displayed by some of the participants led to the conduct of two focus group discussions (FGDs), one among the NHIS/HCP Group and the other among the Artisans

Group. Each FGD comprised five members including men and women. The FGD was based on the same research protocol used for the IDIs.

Each interview lasted for an average of one hour and it was based on a set of 11 questions dealing with the following issues: background information of the participants, awareness of eligibility for NHIS, financial contributions to the NHIS, knowledge of the NHIS-accredited healthcare providers (HCP), benefits from the NHIS, health conditions (a descriptive aspect of medical history and types of sickness and their frequency), choice of health-care delivery (visits to heath centre and purpose of the visits), and challenges of access to health insurance in Nigeria.

The 45 in-depth interviews were conducted in two days in August 2013, with collaboration among three researchers (one man and two women) in the Department of Industrial Relations and Personnel Management of the University of Lagos. The researchers moved in group to gain an easy entry into the field. One of the researchers brought a female research assistant, who participated in the conduct of in-depth interviews in the Artisans Group. However, the researcher did not inform other members of the research team before bringing a research assistant to join the team.

The use of language during the interview was based on observed preference of the participants. Thus, the interviews were conducted through the use of modern English, pidgin and vernacular. The researchers switched from modern English to vernacular in some cases in order to flow with the participants. However, all the responses were transcribed in modern English. The principal researcher has been properly trained to manage the challenges of translation and analysis of data based on the use of different languages. All the three researchers shared their experience and applied the same principle in the process of transcription and analysis of data obtained from the IDIs.

FINDINGS AND DISCUSSIONS

This section deals with the findings on Artisans' Reactions to NHIS in Nigeria. This is based on information obtained from 45 participants including 20 participants in the NHIS/HCP Group and 25 participants in the Artisans Group. The data for the two groups were analysed separately and then combined for a clearer understanding of the similarities and differences in their reactions to the issues of NHIS. The analysis of findings proceeds from backgrounds of the participants to substantive issues under investigation.

BACKGROUNDS OF THE PARTICIPANTS

The details of the participants' backgrounds are presented in Table 3. The backgrounds of members of the Artisans Group are comparable to those of members of the NHIS/HCP Group in terms of gender, religion, number of children, and marital status. Regarding their gender, 23 men (including 14 male artisans) and 22 women (including 11 female artisans) participated in the study.

The majority of the participants (including more than half of the artisans) identified with Christianity, although a higher number of artisans (10) identified with Islam compared to only two Muslim members found in the NHIS/HCP Group. Like their counterparts in the NHIS/HCP Group, the number of children was relatively low among members of the Artisans Group, as four out of every five artisans had less than four children.

The above finding shows that having many children is no longer desirable even among the artisans' class. Members of the two groups similarly attached strong values to marriage.

Close to four out of every five artisans were already married with one or two children like the situation among members of the NHIS/HCP Group.

However, a significant difference can be observed between the two groups, considering their distributions under the following factors: occupation, ethnic group, age, income, educational qualifications, and access to family doctors. About their occupation, members of the NHIS/HCP were relatively homogeneous as majority of them labeled themselves as civil servants or public servants but the Artisans Group represented different occupations within the artisan class.

Specifically, the occupational identities of the artisans who participated in the study include the following: seven traders, six tailors, three mechanics, two photographers, two hairdressers, two drivers/conductors, and others such as one block maker, one vulcanizer and one motorcyclist.

TABLE 3: CHARACTERISTICS OF THE PARTICIPANTS

ID	CHARACTERISTICS	NHIS/HCP	ARTISANS	TOTAL (N=45)
1	**Gender:**			
	Male	9	14	23
	Female	11	11	22
2	**Religion:**			
	Christianity	18	14	32
	Islam	2	10	12
	Traditional Religion	0	1	1
3	**Ethnic Group:**			
	Igbo	8	3	11
	Yoruba	7	**20**	27
	Other (Edo, Delta, Kogi, etc.)	5	2	7
4	**Number of Children (0-8):**			
	0-3	16	19	35
	4 and Above	4	6	10
5	**Age (Years):** (Range = 21 – 68)			
	Less than 40	16	13	29
	40 and Above	4	**12**	16
6	**Occupation:**			
	Civil/Public Servants/Formal	18	1	19
	Artisans (Varied)	2	24	26
7	**Income/Month (₦): No Response =7**			
	Less than 50,000	3	**9**	12
	50,000 – 100,000	10	10	20
	Above 100,000	5	**1**	6
8	**Educational Status:**			
	Primary/Secondary	1	**22**	23
	Bachelor/HND	13	2	15
	Other (e.g. PGS and OND)	6	1	7
9	**Marital Status:** (1 Widow)			
	Single	6	5	11
	Married	14	19	33
10	**Access to Family Doctor:**			
	Yes	11	5	26
	No	9	**20**	29

The Yoruba ethnics largely concentrated among the Artisans Group, whereas the NHIS/HCP Group was more inclusive. Most of the artisans were Yoruba, while the NHIC/HCP Group comprised almost equal proportions of different ethnic groups including eight Igbo, seven Yoruba and five ethnic minorities.

The participants' age ranged from 21 years to 68 years but members of the Artisans Group were older than their counterparts in the NHIS/HPC Group. Almost half of the artisans were aged above 40 years, although four out of every five members of the NHIS/HCP Group were below 40 years.

In spite of being relatively older, a lower level of income was recorded among members of the Artisans Group whose income ranged from ₦5,000.00 to ₦ 120,000 per month, unlike the ₦25,000.00 to ₦425,000.00 range of monthly income among members of the NHIS/HCP Group.

The observed low level of income could be attributed to the low level of educational qualifications among the artisans, as the majority of them had low educational backgrounds such as primary and secondary education. Almost all the participants with higher educational qualification were found in the NHIS/HCP Group.

Besides their experience of low income, low education and higher age, majority of the participants in the Artisans Group reported their lack of access to family doctors, whereas more than 50 per cent of their counterparts in the NHIS/HCP Group boasted of their experience of an easy access to their family doctors. The above discoveries show a basis for the analysis of artisans' reactions to an experience of recognition or marginalisation in the Nigerian health care delivery system.

AWARENESS OF ELIGIBILITY AND CONTRIBUTIONS IN THE NHIS

Table 4 shows the details of participants' awareness, eligibility and contributions to the NHIS. Most of the artisans expressed ignorance about the NHIS. Only few of them (one out of every five) reported their knowledge of the scheme. This shows a low level of awareness of the NHIS among artisans in Nigeria.

Contrary to the fact that many artisans were ignorant of the categories of persons covered by the NHIS, almost all members of the NHIS/HCP Group noted that NHIS is designed for everybody. Some participants in the NHIS/HCP Group noted as follows:

> NHIS is for everybody. Look at our motto (… easy access to health care for all). NHIS covers all employees in the public and private sector. Any organisation with ten staff can be part of it. Also, organisations with less than ten staff can participate in it. It is also applicable to individuals who are not already covered by any of the existing NHIS programme (IDI, Female,Yaba, August 29, 2013)

> NHIS can accommodate everybody. It is primarily for government workers but it can accommodate everybody now. For instance, it can accommodate market women. They fall under voluntary contributions. Some groups of voluntary contributors have come here and we have attended to them. (IDI, Male, Akoka, August 29, 2013)

TABLE 4: KNOWLEDGE OF THE NATIONAL HEALTH INSURANCE

ID	KNOWLEDGE OF NHIS	NHIS/HCP	ARTISANS	TOTAL (N=45)
1	**Perception of NHIS:**			
	Expression of Knowledge	18	8	26
	Expression of Ignorance	2	**17**	19
2	**Sources of Information:**			
	Media: TV, Radio, Website, etc.	19	12	31
	Uninformed	1	**13**	14
3	**Registration for NHIS**			
	Yes	20	5	25
	No/NA	0	**20**	20
4	**Ability to Have Access to NHIS:**			
	Yes	20	11	31
	No/NA	0	**14**	14
5	**Financial Contribution to NHIS:**			
	Expression of Knowledge	17	4	21
	Expression of Ignorance	3	**21**	24

Note: NA= Not Applicable

Twenty-one out of twenty five artisans expressed ignorance of financial contributions to the NHIS. In contrast, four out of every five participants in the NHIS/HCP Group correctly expressed their understanding of financial contributions to the NHIS. Two of the few artisans with correct information about the NHIS noted as follows:

> Like what they told us in the NATA meeting, NHIS is not free. There are different types of payment. There is one for N9,000.00. There is one for N15,000.00 and there is one for N40,000.00.The one for N9,000.00 does not include surgery. The one of N15,000.00 includes surgery. The one of N40,000.00 is for people that have special disease. God will not allow us to be in that category. The payment is for a year. That means the payment will be renewed every year. (IDI, Automobile Engineer, Bariga, August 30, 2013).

> My employer then used to make contributions to the NHIS on behalf of the employees in the bank. Maybe they later refunded the money back to us. I can't remember.(IDI, Tailor, Gbagada, August 30, 2013)

The above findings show artisans' experience of marginalisation or ignorance in the implementation of the NHIS of Nigeria.

HEALTH CONDITIONS AND BENEFITS FROM THE NHIS

The findings showed similar trends in the health conditions of members of the Artisans Group and their counterparts in the NHIS/HCP Group but the preference for health centres and reactions to the issue of the NHIS differed significantly among the two groups (See Table 5). Some participants including about one-third of the artisans disclosed their experience of uncommon sicknesses such as tonsillitis, meningitis, tuberculosis of the spine, hypertensive retinopathy, diabetes, and eyes problem.

Many participants mentioned their experience about different types of common sicknesses such as malaria, typhoid fever, cough, headache, stomach upset, and common cold. The sickness occurred regularly for more than half of the participants including more than two third of the artisans.

Concerning their preferences for health-care delivery, more than two-third of the artisans rejected government health centres; close to 50 per cent indicated their choice of private health centres while a significant minority among the artisans noted that they had nothing to do with any health centre. Over-the-counter medication was the usual practice among members of the minority group, who rejected both government and private health centres due to reasons best known to them.

However, the majority of the participants including more than two-third of the artisans expressed satisfaction with the quality of service delivery in their chosen health centres. This finding shows the artisans' general belief in efficacy of either over-the-counter medication or private health centres. An observation that Nigerians are made to finance their health services is hereby confirmed in the present article.

A study in southeast Nigeria showed that most of the respondents used out-of-pocket spending (OOPS) and own money to pay for healthcare, showing that the poor disproportionately bear the burden of health care costs (Ewelukwa, Onoka, & Onwujekwe, 2013, p. 1). Private out-of-pocket expenditure on healthcare remains at over 90% in Nigeria since the introduction and implementation of its NHIS (Odeyemi & Nixon, 2013, p. 1). This may be partly responsible for the continued low life expectancy in Nigeria.

TABLE 5: MEDICAL HISTORY AND EXPERIENCE ABOUT NHIS IN LAGOS

ID	KNOWLEDGE OF NHIS	NHIS/HCP	ARTISANS	TOTAL (N=45)
1	**Type of Sickness:**			
	Common Illness:	15	17	32
	Uncommon Illness / NA:	5	8	13
2	**Frequency of Sickness:**			
	Regular/Frequent/Few in a Year	13	14	27
	Irregular/Occasionally/Sometime	7	11	18
3	**Choice of Health Centre:**			
	Private Health Centre	6	11	17
	Government Health Centre	12	8	20
	Don't/Never/Not Applicable	2	6	8
4	**Satisfaction with Health Centre:**			
	Yes	17	18	35
	No/Never/Not Applicable	3	7	10
5	**Availability of Benefits in NHIS:**			
	Yes	15	4	19
	No/NA	5	21	26
6	**Obtained Treatment via NHIS:**			
	Yes	14	3	17
	No/NA	6	22	28
7	**Experience of Health Insurance:**			
	Satisfactory/Good	13	3	16
	Unsatisfactory/Bad/None/NA	7	22	29

8	**Ability to Survive W/O NHIS:** Yes No/Not Applicable	 12 8	 14 11	 26 19

Note: W/O = Without; NA= Not Applicable

There is no doubt in the fact that most of the artisans were indifferent as they expressed their ignorance with a negative attitude to the issue of NHIS. In fact, the majority of them did not respond to the question on availability of benefits in the NHIS. This suggests a state of unwillingness or predominant lack of awareness about the NHIS among the artisans. In fact, only 12 per cent of the artisans claimed to have obtained medical attention from NHIS-accredited health centres, while the overwhelming majority of them are yet to partake in the NHIS. The evidence of artisans' inaction on the issue of NHIS can be observed in this regard.

A similar trend was observed in their responses to the question bordering on their experience about health insurance. This may be due to their unconscious ignorance of the NHIS or deliberate attempt to criticize and avoid anything that comes from the Nigerian government. When asked about their ability to survive with or without the NHIS, the artisans' responses largely affirmed their perception that they have been surviving without participating in the NHIS and the belief that they would continue to do so was clearly expressed. The following statements show few instances of artisans' reactions to the question on whether they can survive without enrolling for the NHIS.

> Of course! Why Not. We are surviving already. With NHIS or without NHIS life must go on. Government just introduced NHIS in less than 10 years. Have we not been surviving before and does the government really mean well for the people? The truth is that divine health can make me survive without NHIS. (IDI, Tailor, New Garage, August 30, 2013)

> Yes, can't you see me? Do I look like a sickler? What kind of question are you asking me? What have I benefitted from the government since the day I was born? I am close to 50 years now and I cannot see the impact of government in my life. I have never enjoyed as a citizen of this country. I pay for everything I need. We are supposed to be killing the people in government one by one. Are you not one of them? If I have a gun now I will shoot you and stay and nothing will happen. […] Some Americans can do that. (IDI, Gbagada, Block Maker,August 30, 2013).

> Only God has a final say about survival. A lot of people will not fall sick if God says so. I hear that NHIS is good but I can still survive without it. (IDI, Automobile Engineer, Bariga, August 30, 2013).

SUGGESTIONS FOR IMPROVEMENT ON HEALTHCARE IN NIGERIA

The participants openly expressed their views on how to improve the health-care services in Nigeria. There was no significant difference in the opinions of members of the Artisans Group and their counterparts in the NHIS/HCP Group. About half of the participants (including 50 per cent of the artisans) expressed the belief that, for optimal performance, the health care system in Nigeria would require a lot of attention in terms of the following: Government Intervention,

Adequate Funding, Provision of State of the Art Facilities in Government Health Centres and Renovation of General Hospitals.

TABLE 6: HOW TO IMPROVE THE HEALTHCARE SERVICES IN NIGERIA

ID	HOW TO IMPROVE NIGERIA HEALTHCARE	NHIS/ HCP	ARTI SANS	TOTAL (N=45)
	How to Improve Health Care System in Nigeria:			
1	Govt. Intervention/Materials/Funding/Facility/etc.	8	12	20
	HCD / Quality Service/Rapid Response/GB/etc.	6	8	14
	Public Awareness/Clean Environment/NHIS/etc.	6	5	11
2	**Responsibility for Improvement on Healthcare:**			
	Govt./Ministers/Legislature/Health Workers/etc.	10	20	30
	Everybody/Govt./Private Sector/NGOs/People/etc.	10	5	15

Note: HCD = Human Capital Development; GB = Good Behaviour of Health Workers

One third of the participants (including one of every three artisans) opted for Human Capital Development, Quality Service, Rapid Response, and Good Behaviour of Health Workers as necessary preconditions of the desired improvement in the Nigerian health care delivery system. Also, a significant minority among the participants strongly advocated for the need to ensure improvement on the health-care system in Nigeria through public sensitization, clean environment and enforcement of the NHIS as a compulsory health policy for all Nigerians.

The participants also expressed their views on the responsibility for improvement in the health care system in Nigeria. This case showed a significant difference in the opinions of members of the Artisans Group compared to their counterparts in the NHIS/HCP Group.

Most of the artisans expressed their belief that it is the responsibility of the Nigerian governments and other agencies of the state to ensure improvement in the health care system in Nigeria. However, 50 percent of the members of the NHIS/HCP Group noted that everybody – governments, the organised private sector, civil society, NGOs, people, individuals, etc. – has a responsibility to contribute towards improvement of the health care system in Nigeria.

CONCLUSION

The issue of artisans' reactions to NHIS was addressed in the present article with a focus on their health conditions and experience about health-care services in Nigeria. It was discovered that artisans, who constitute the major consumers of healthcare in Nigeria, were ignorant of how to embrace the NHIS. Their ignorance is consolidated through preference for private hospitals and alternative medicine. Public health-care providers and employees of the NHIS recognised the Nigerian state's attempt to extend the NHIS to every Nigerian. However, the implementation of the scheme has been marred by lack of adequate representation of the working class in decision making about the health-care policy. This situation has discouraged many artisans from patronizing the public health-care delivery systemin Nigeria.

The above observation is consistent with the views of Ityavyar (1987, p. 312), showing that the linkages between different factions of the Nigerian bourgeoisie within the national mode of production have implications for health services policy. The development of the Nigerian health-care system has been hindered by some drawbacks in this process. As reported by

Ityavyar (1987, p. 312), the dominant class has the greatest influence on the development of health sector because it controls it.

In consonance with the above observation, the annual contribution expected from an artisan is relatively higher than the capitations being paid on behalf of a civil servant for the same period. This practice negates the principle of social health insurance which allows for cross subsidization, where the higher income group subsidizes for the lower income group.

The situation in the Nigerian health sector has attracted negative reactions from the public with adverse implications for the health of ordinary Nigerians, notably the artisan class. The situation in Nigeria is ripe for class struggle, although members of the working class are yet to adequately prepare themselves to take it beyond their sphere of influence. The present situation in the Nigerian health sector resonates with an observation made in the 1980s that the greatest losers in the atmosphere of health crisis will remain Nigerian peasants and workers (Ityavyar, 1987, p. 314).

It is noteworthy that the calculus of the health care delivery in Nigeria is influenced by three major social forces, namely, the state, the dominant class and the working class. The state has created a tradition of protecting the interest of the dominant class while the working class continues to struggle for recognition in the schemes of health services policy.

The current beneficiaries of the NHIS were largely recruited from the public and organised private sectors, whereas other categories of people are expected to go through the voluntary contributors' social health insurance programme (VCSHIP). Each participant in the VCSHIP is expected to register online in which at least ten steps must be followed before completing the registration process including visits to the office of a health maintenance organisation (HMO).

The current practice is at variance with the stated objectives of the NHIS, particularly to ensure provision of easy access to good health services to every Nigerian. If the Nigerian government is truly interested in its NHIS then there is urgent need for Health Service Commission that will encourage every Nigerian to lodge their complaints about the health care services in Nigeria. Such complaints can be used to carry out a comprehensive monitoring and evaluation of the progress of the NHIS.

Above all, members of the artisan class deserve good health and then priority attention should be given to them in the ongoing implementation of the NHIS in Nigeria. If the regime of payment and contributions to the NHIS is not reconsidered and reviewed downward to accommodate the needs of the poor masses, the artisans class will avoid the NHIS like plague and when this happens the Nigerian government will have to contend with catastrophe that will develop from the neglect of public health.

The present article has focused on artisans' health seeking behaviour and planned actions for several reasons. First, they have experienced marginalisation in the implementation of health reform. Second, their contributions towards development cannot be ignored. Also, as a group, the majority of Nigerian population is in the artisan class. Furthermore, artisans deserve social security and adequate protection from the Nigerian government due to their vulnerability to the vagaries of exploitation in the capitalist system. The strength of the study lies in its in-depth analysis of artisans' experiences about the NHIS. However, there is need for caution in the use of data in the present study, as it is not suitable for generalizations beyond the context of artisans in the study area.There is need for more studies to expand the frontiers of knowledge on the spread and degree of acceptability of the NHIS in Nigeria.

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