'AYADECARE' and state workers access to health care delivery in Southern Senatorial District, Cross River State

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Abstract
Man's quest for optimal level of health is a cultural universal across societies. This could be explained by the fact that good health is crucial both for man's survival and his ability to meet set goals and aspirations in life. For man to live and function to his fullest capacities, use of health facilities is crucial. That is why the Cross River State government developed patterns of health services called "Ayadecare" to care for their people. This study adopted a survey research design which involves the collection of data to accurately and objectively describe existing phenomena. A sample size of 380 respondents was drawn through simple random sampling technique across the workers in the State Ministries. A self-administered questionnaire was used for the study. Data collected were inputted into Scientific Package for Social Sciences (SPSS) version 20. The results and discussion of the finding is presented using descriptive statistics. The study found out that the level of access to the scheme is not encouraging, and could be attributed to workers' poor knowledge of the scheme and low awareness, which may be due to workers laxity in registering in the scheme. The study recommend that, there is need for public awareness to be created on the relevance of Ayadecare to people, communities and workers through social workers, community leaders, stakeholders and employers at work place.

Keywords: Ayadecare; Workers; Worker's awareness; Worker's access; Healthcare services.

Introduction
Health is a fundamental right of every citizen and health is essential to every living thing. To guaranty that every citizen realizes this right, government of different nations see it as part of their responsibility to provide their citizens with quality healthcare delivery that will guaranty equality, equity and efficiency (Yunusa, Irinoye, Suberu, Garba, Timothy, Dalhatu & Ahmed, 2014). It is in view of this the governor of Cross River State in 2018 lunched a health insurance scheme that is captured 'Ayadecare Health Insurance Scheme' which is named after the governor. The Ayadecare Health Insurance Scheme just like the National Health Insurance Scheme (NHIS) aimed at providing quality and efficient health care delivery to those who need it most at affordable cost and making healthcare delivery closer to where people live and work.

Several approaches abound in financing healthcare. These range from fees for service to private insurance, general taxation, social insurance, community financing, loans and grants. In Nigeria, combinations of all these in different proportions have been practiced for decades (Onyedibe, Goyit, & Nnadi, 2012). Health insurance is a way of paying for some or all of the costs of health care which reflects what is known as healthcare financing. It protects insured persons from paying high treatment costs in the event of sickness. The basic health insurance process entails that a consumer makes a regular payment to a managing institution which is responsible for holding the payments in a fund and paying a health care provider for the cost of the consumer's care (Metiboba, 2012). This process seems straightforward and involves three main groups: consumers, managing institutions (usually described as third party institutions), and health care providers. The outcome of the process is that the costs of an individual consumer's health care needs are met.

The same principle and concepts apply to health insurance as to car insurance but the case of health insurance is more likely to experience problems because: moral hazard and cost escalation are particular problems, as patients are not able to identify what treatment they really need; and the risk of adverse selection means that insurers want to exclude high risk cases or charge them higher premiums, yet for social policy reasons. However, governments want all their population to have access to health care. These factors have led to governments taking an

active role in the health insurance sector, through regulating the private sector and/or developing social insurance schemes (Akande, Salaudeen & Babatunde, 2011).

How a nation finances its health care delivery system could be a clear parameter in assessing the premium placed on its people's health. As a critical developmental component like food, shelter and clothing, the health sector requires adequate funding (Aminu, 2015). However, the funding of health care system varies across different countries. In the case of Nigeria, the financing of the health care delivery system is majorly through tax revenue, out-of-pocket payment or user fees, donor funding and social health insurance. The federal government introduced the National Health Insurance Scheme (NHIS) because it considered funding health so demanding due to dwindling economy, perennial shortage of qualified and competent health personnel, shortage of drugs and other health infrastructures (Eboh, Akpata & Akintoye, 2016). More importantly, the introduction of the scheme was to guarantee good and qualitative access to efficient health care services such that it could reduce catastrophic household out-of-pocket health expenditure. Since its inception and resuscitation, several States across the Country have keyed into it and one of these States is Cross River State (Ayadecare). However, actual implementation of the scheme by some of these States appeared not to have commenced fully. In addition, the introduction of the scheme has tremendously scaled up the patronage and utilization of health facilities and reduction in out-of-pocket expenditure for health services rendered.

Statement of the problem

The underutilization of healthcare services especially in the public sector is a big problem in most Nigerian states of which Cross River State is inclusive. Although the Ayadecare health insurance scheme has been in existence for some time now, there tend to be a gap between the scheme and the state workers. This is as a result of the inability of the scheme's impact felt in the lives of the state workers, as well as the extent to which the health insurance scheme has embraced its scope and coverage which is mainly the state civil servants and the less privileged in Cross River State. Therefore, this research work hopes to achieve the stated objectives and aims outlined below.

General objective of the study

The general objective of this study was to assess Ayadecare Health Insurance Scheme and workers access to healthcare delivery in Southern Senatorial District of Cross River State, Nigeria.

Specific objectives of the study

The specific objectives of the study were to: Find out the extent of state workers access to Ayadecare health insurance scheme in terms of healthcare delivery in Southern Senatorial District of Cross River State, Nigeria.

Research questions

The following five-point questions where formulated and distributed to the state workers:

i. What proportion of state workers benefit from the scheme?
ii. Is the scheme impactful in terms of healthcare delivery?
iii. Does the scheme include in itself pharmaceutical services?
iv. What proportion of the beneficiaries is satisfied with the scheme?

Statement of hypotheses

The following null (H_0) hypothesis was formulated: State workers have not significantly gained access to the Ayadecare health insurance scheme for healthcare delivery.

Scope of the study

The primary areas of focus for this study are the communities within the Southern Senatorial District of Cross River State. It is one of the three Senatorial Districts of the State. It is made up of 7 Local Government Areas (CRSG, 2007). These Local Governments are: Akamkpa, Akpabuyo, Bakassi, Biase, Calabar Municipality, Calabar South, and Odukpani. This will include the working populace who are adults above the age of eighteen (18) years in Cross River State, who have enrolled into the scheme.

Significance of the study

It is hoped that this study will serve as an available reference source and will help other researchers in this field; thus contributing to the existing literature. Moreover, the study will help government and managers of the scheme in policy formulation and administration for better service delivery and improvements in the scheme, as well as a step towards the achievement of universal health coverage.

Literature review

Scope of Ayadecare health insurance schemes

The Ayadecare Health Insurance Scheme drew its inspiration from what is known today as the National Health Insurance Scheme (NHIS) that was first introduced in Nigeria in 1962 under the leadership of the then minister of health, Dr. Moses Majekodunmi (Agba, Ushie & Osuchukwu, 2010). The scheme then was compulsory for public service workers. Unfortunately, its full operation was later truncated following the escalation of the Nigerian civil war. After several years of dormancy, the Buhari-led military regime in 1984 resuscitated the scheme and a committee was set up with a mandate to review it. Consequent upon this in 1988, the then Minister of Health, Professor Olikoye Ransome Kuti commissioned the Emma-Eronmi committee whose report was approved by the Federal Executive Council in 1989 (Agba, Ushie & Osuchukwu, 2010).

Similarly, the International Labour Organization (ILO) and the United Nations Development Programme (UNDP) carried out feasibility studies and came up with the cost implication, draft legislature and guidelines for the scheme. In 1993, the Federal Government directed the Federal Ministry of Health to start the scheme in the country (Eboh, Akpata & Akintoye, 2016). The scheme was modified to cover more people via Decree No.35 of 10th May 1999, which was promulgated by the then Head of State, Gen. Abdulsalami Abubakar. The decree later became operational in 2004 following several flag offs; first by the wife of the then president, Mrs. Stella Obasanjo on the 18th of February 2003 in Ijah, a community in Niger State, North-Central Nigeria. Since the Rural Community Social Health Insurance and the Under-5 children Health Programmes of the NHIS scheme were kick-started by the First Lady, similar flag offs were carried out in Aba, Abia State in the South-East Zone among others. As at September 2009, 25 states of the Federation had bought into the scheme. These included Akwa Ibom, Rivers, Edo, Taraba, Adamawa, Kaduna, Zamfara, Kebbi, Sokoto, Katsina, Nassarawa, Anambra, Jigawa, Imo and Kogi States including Bauchi, Ogun and Cross River States which were at various stages of implementation of the scheme (Adefolaju, 2014). This led to the Governor of Cross River State to flag off the Ayadecare Health Insurance Scheme.

Health Insurance Schemes are built on the foundation of healthcare financing. Healthcare financing can be defined as the mobilization of funds for healthcare services (Oyefabi, Aliyu & Idris, 2014). It is still based on this healthcare financing the Ayadecare Health Insurance Scheme is built on. In other words, it is the provision of money, funds or resources to the activities designed by government to maintain people's health. These activities in the Ayadecare like every other Health Insurance Schemes encompass the provision of medical and related services geared toward maintaining good health, especially in the aspect of disease prevention and curative treatment. The concept of health care financing succinctly deals with the quantity and quality of resources a country expends on health care. The amount of resources earmarked for health care in a country is said to be a reflection of health value placement vis-à-vis other categories of goods and services. It has been opined that the nature of health care financing defines the structure and the behaviour of different stakeholders and quality of health outcomes (Metiboba, 2012).

The vision of the Ayadecare Health Insurance Scheme is to build a virile, dynamic and responsive Health Insurance Scheme that is totally committed to securing universal coverage and access to adequate and affordable health care in order to improve the health status of Nigerians, especially for those participating in the various programmes/products of the scheme (Akande, Salaudeen & Babatunde, 2011). The scheme provides regulatory oversight to the Health Maintenance Organizations (HMOs) and participating health providers. It is also driven by the mission of facilitating fair-financing of health care costs through pooling and judicious utilization of financial resources aimed at providing financial risk protection and cost burden-sharing for people against high cost of healthcare, through various prepayment programmes/products prior to their falling ill (Michael, 2010).

Just like the scope of NHIS, the Ayadecare is principally concerned with the contributions paid to cover health care benefits for the employees, a spouse and four (4) biological children below the age of eighteen (18) years; more dependents or a child above the age of 18 years is covered on the payment of additional contributions by the principal beneficiary as determined by the scheme. Even though principals are entitled to register four (4) biological children each, a spouse or a child cannot be registered twice.

Health insurance schemes and access to healthcare delivery

According to Adefolaju, (2014), Health insurance is a social security mechanism that guarantees the provision of needed health services to persons on the payment of some amount at regular intervals. It is designed to pay the costs associated with health care by paying the bills and therefore to protect people against high cost of health care by making payment in advance of falling ill. The scheme therefore protects people from financial hardships occasioned by large or unexpected medical bills. It saves money on the short run and protects the poor from medical conditions that can lead to greater loss of money on the long run (Nigerian Tribune, 24, May, 2010). Imoughele and Ismaila (2013) posits that, access to health care delivery is essential to guarantee good health because good health boosts worker effectiveness and the productivity of an individual via increase in physical and mental capacities, which are necessary for economic growth and development. In the words of Owumi and Sakiru (2013), as important as this social good (health) is, access to it as an integral part of the overall health system has been fraught with some difficulties in terms of financing and cost of billing for the services received. Consequently, like many public services, it is not equally accessible to all people, and so, limited physical access to basic health care continues to be a major impediment to achieving the goal of health care for all. In the light of the foregoing, governments all over the world consciously attempt through policy formulation and implementation to bring health care services closer to people across economic divides and

different social strata. This is basically to reduce the constraint of finance in accessing health services (Owumi & Sakiru, 2013).

According to the NHIS Decree No. 35 of 1999, part 1:1, the general purpose of the scheme is to ensure the provision of health insurance that shall entitle insured persons and their dependents the benefit of prescribed good quality and cost-effective health services. It is still upon this purpose the Ayadecare is anchored. While the specific objectives as noted by some authors (Adefolaju, 2014; Owumi, Omorogbe & Raphael, 2013; Eteng & Utibe, 2015) entail: the universal provision of healthcare; to control/reduce arbitrary increase in the cost of health care services; to protect families from high cost of medical bills; to ensure equality in the distribution of health care service costs across income level distribution; to ensure high standard and quality of health care delivery to beneficiaries of the scheme; to boost private sector participation in health care delivery; to ensure adequate and equitable distribution of health care facilities; to ensure equitable patronage of primary, secondary and tertiary health care facilities; and, to maintain and ensure adequate flow of funds for the smooth running of the scheme and the health sector in general.

In terms of access to good and qualitative health care services, the scheme has developed various programmes to include different socio-demographic segments especially State workers (Aminu, 2015). Workers get access to: outpatient care, pharmaceutical care through the provision of drugs in the scheme's essential drug list, listed diagnostic tests, preventive healthcare services like immunization, antenatal and postnatal care, hospital care (15 days hospitalization by the scheme) and so forth. The scheme is so important that workers do not need cash to access treatment when required except the 10% co-payment for the cost of drugs. This can invariably reduce the catastrophic effects of household health expenditure. Socio-economically, there is no doubt that the scheme has latently generated employment and investment opportunities through the activities of health facility managers (Adefolaju, 2014). According to Agba, Ushie and Osuchukwu (2010), despite the fact that some State governments have keyed into the scheme, access to quality health care delivery still remains a high profile challenge. Furthermore, it has been noted that there is a discrepancy among employees in their access to the Ayadecare just like the NHIS, it was noted with federal civil servants having more access to the scheme than their counterparts do in the State civil service (Agba, Ushie & Osuchukwu, 2010).

Theoretical framework

The sociological theory employed in this study is the conflict theory to explain the phenomenon investigated. Karl Marx is associated with conflict theory, thus the concept and theory of class. To him, society is stratified into two dichotomized classes based on economic termination. That is, on the basis of the ownership of the means of production (Etobe, Takim, Utibe, Undelikwo, Okorie, Ikpi, & Bassey, 2017). According to Ottong, (2011), social class is the division of people into social categories based on the principle of wealth and access to wealth and power. Theorists using the conflict perspective suggest that issues with the healthcare system, as with most other social problems, are rooted in capitalist society. According to conflict theorists, capitalism and the pursuit of profit lead to the commoditization of health: the changing of something not generally thought of as a commodity into something that can be bought and sold in a marketplace. In this view, people with money and power, the dominant group are the ones who make decisions about how the healthcare system will be run. They therefore ensure that they will have healthcare coverage, while simultaneously ensuring that subordinate groups stay subordinate through lack of access. This creates significant healthcare and health disparities between the dominant and subordinate groups.

Methodology

The research design adopted for this study was survey research design. A survey research involves the collection of data to accurately and objectively describe existing phenomena. Studies that make use of this approach are employed to obtain a picture of the present condition of particular phenomena. According to Isangedighi (2012), a survey research design involves the collection of data to accurately and objectively describe existing phenomena. This design enables the researcher to study a sample of the population which the finding would be generalized to the population. This design is suited for this study because State workers were objectively described in the study. Finally, studies that make use of this approach are employed to obtain a picture of the present condition and situation of a particular phenomenon and the researcher sort to achieve this as a reason for employing the design.

The study area was Southern Senatorial District. It is one of the three senatorial districts in Cross River State. According to the Federal Republic of Nigeria 2006 Population Census, it has a total population of 1,189,801 (610,696 Males, and 579,105 Females). It is made up of 7 Local Government Areas (CRSG, 2007). These Local Governments are: Akamkpa, Akpabuyo, Bakassi, Biase, Calabar Municipality, Calabar South, and Odukpani. It lies within latitude 5.25^0 and 8.0^0 N and Longitude 70 50' and 9.30^0 E. It has a land mass of 7,300 square kilometres, and is bounded by Akwa Ibom State to the South, Yakurr Local Government Areas to the North, Abi Local Government Areas to the East and the Republic of Cameroon to the West where the Atlantic Ocean lies. It has the largest forest area in the State and a very fertile land, watered by many rivers, streams and springs, the people are mostly agrarian. The people are blessed with an international airport, seaport, roads, the Tinapa business resort, the Marina Resort, the Museum, etc. The major occupation of the people is fishing, farming and mining of stone and gravels. The major religions of the people are Christianity, Islam and traditional believers. The people are blessed with traditional and cultural heritage that ranges from Ekpe, Nnabor, to Nchebe. The major languages spoken by the dwellers apart from English and Nigerian Pidgin are Efik, and Edjagam whose tribe are Efiks, Edjagam and the Quas. The urban dwellers of the study area are averagely literate.

It has institutions like; University of Calabar, Cross River University of Technology (CRUTECH), School of Nursing and Health Technology, University of Calabar Teaching Hospital. It as well has some companies like, United Cement Industry (UNICEM), Flour Mill, markets and shops with a high concentration of small scale businesses and fashion shops especially the Professor Benedict Ayade's Fashion and Textile Factory.

The sample size for the study was three hundred and eighty (380) respondents drawn through simple random sampling technique across the workers in the State Ministries. This sampling technique was adopted for this study because it gave all the respondents equal opportunity of being sampled and participating in the study. A self-administered questionnaire was used for the study. Data collected were inputted into Scientific Package for Social Sciences (SPSS) version 20. The results and discussion of the finding is presented using descriptive statistics displayed in frequencies, percentages, means, and Standard Deviation.

Results/Findings

The study was to assess Ayadecare Health Insurance Scheme and workers access to healthcare delivery in Southern Senatorial District of Cross River State, Nigeria. The specific objectives were to assess the scope of Ayadecare Health Insurance Scheme in Cross River State, Nigeria; and to find out the access of workers to the scheme in terms of healthcare delivery in Southern Senatorial District of Cross River State, Nigeria. Data was collected from 380 workers in the study area. Of this sample size, 184(48.42%) respondents were females while 196 (51.58%) respondents were males. About 67(17.63%) respondents were 18-25 years,

94(24.74%) were 26-33years, 120(31.58%) were 34-41years, 56(14.74%) were 42-49years, while respondents who were 50 years and above were 43(11.32%). Educational certificates acquired by respondents were primary, secondary and tertiary certificate. That is 95(25.00), 102 (26.84%) and 188(49.47%) respectively. There were 158 (41.58%) junior workers and 222(58.42%) senior workers upon which data were elicited. Out of this, 98(25.79%) had less than 3 years work experience, 100(26.32%) had 3-5years work experience while 182(47.89%) had work experience above 5 years. This data is summarized in Table 1.

Furthermore, the interview method was also used by way of interaction with some state workers to back up the qualitative data derived from the field. Some interviewees expressed their thoughts with negative responses as per being aware of the scheme but have never made use of the services as a result of non-accessibility. According to Idigie, a civil servant who serves in Ikom local government council who was interviewed, (a 46 year old man) expressed in dismay, recalled: "I only hear about the scheme but it does not exist in this part of the State and I am not sure if such programme covers up to this area". This response by Mr. Idigie tends to support the hypothesis stated in the null form that there is no significant access of the State Health Insurance Scheme by the State workers. Another interviewee by named Mrs. Akwajie, a staff in the Ministry of Lands and Housing responded thus: "I don't think the Ayadecare is in existence, if it was before, it could be it was only functional for a while but as it is, I don't think it is working" (Mrs. Akwajiobe, a 55 year old interviewee).

TABLE 1: Socio-demographic characteristics of respondents

Variables	Frequency (N)	Percentage (%)	Mean	SD
Gender			3.33	1.012
Male	196	51.58		
Female	184	48.42		
Total	**380**	**100**		
Age				
18-25 years	67	17.63	2.32	1.021
26-33 years	94	24.74		
34-41 years	120	31.58		
42-49 years	56	14.74		
50 years and above	43	11.32		
Total	**380**	**100**		
Educational certificate				
Primary	95	25.00	3.16	0.239
Secondary	102	26.84		
Tertiary	188	49.47		
Total	**380**	**100**		
Staff level				
Junior staff	158	41.58	3.22	1.479
Senior staff	222	58.42		
Total	**380**	**100**		
Work experience				
Less than 3Year	98	25.79	1.74	0.773
3-10Years	100	26.32		
Above 10years	182	47.89		
Total	**380**	**100**		

Considering access of workers to Ayadecare Health Insurance Scheme for healthcare services, since this was a mini research, five (5) questions were used to prop respondent to assess whether workers have access to the scheme. The following were the statistics gathered from participants. Out of the 380 respondents, only 45% admitted that they have access to the scheme. That is, only 171 workers out of the total number used for they study had access to the

scheme. This finding corroborates with the study of Agba, Ushie and Osuchukwu (2010) who posited that despite the fact that some State governments have keyed into the scheme, access to quality health care delivery still remains a high profile challenge and has been noted that there is a discrepancy among employees in their access to the Ayadecare. When questioned on the types of services that are accessed by workers, respondents listed that as part of the services provided by the scheme: inpatient care 163(42.89%), outpatient care 210(55.26%), pharmaceutical care 210(55.26%), laboratory tests 130(34.21%), and mother and child care 80(21.05%). This is supported by the study of Aminu (2015) who reported that in terms of access to good and qualitative health care services, the scheme has developed various programmes to include different socio-demographic segments especially State workers as they get access to: outpatient care, pharmaceutical care through the provision of drugs in the scheme's essential drug list, listed diagnostic tests, preventive healthcare services like immunization, antenatal and postnatal care, hospital care (15 days hospitalization by the scheme) and so forth. This translates that workers do not need cash to access treatment when required except the 10% co-payment for the cost of drugs which can invariably reduce the catastrophic effects of household health expenditure. This is summarized in Table 2.

TABLE 2: Access of workers to Ayadecare Health Insurance Scheme

S/N	Services in the scheme	Frequently	Percentage (%)	Mean	SD
1.	Inpatient care	163	42.89	3.24	0.034
2.	Outpatient care	210	55.26	3.08	0.512
3.	Pharmaceutical care	210	55.26	3.08	0.515
4.	Laboratory tests	130	34.21	2.91	1.093
5.	Mother and child care	80	21.05	2.51	0.490

Summary, conclusion and recommendations

Ayadecare Health Insurance Scheme was one of the best things the government of Cross River State implemented for the good of the people and workers in particular. The scheme was launched in 2018 with laudable scope, vision, mission, goals and objectives where the people are at the center of it all. This scheme is to reduce out of pocket expenditure on healthcare especially to State workers. Ayadecare drew its motivation from the National Health Insurance Scheme upon which more that 80% of the scope of the Scheme was borrowed from the National Programme in a bit to key into it.

This study found out that the level of access to the scheme is not encouraging at all. This could be attributed to workers' poor knowledge of the scheme and low awareness. More so, it could be due to workers laxity in registering in the scheme or in a case where a worker is registered, he or she does not show up to benefit from the services. On this premise, it is recommended that, there is need for public awareness to be created on the relevance of Ayadecare to people, communities and workers through social workers, community leaders, stakeholders and employers at work place. More so, from the quantitative data gathered, it would suffice to conclude that the Ayadecare Health Insurance Scheme was formerly active but due to poor management of the scheme, poor financing, political monopoly, poor awareness and lack of encouragement in terms of publicity, the scheme may be on the verge of becoming ineffective if corrective measures are not implemented. The lack of widespread engagement and participation in the scheme suggests that significant reforms are needed, particularly in terms of enhancing awareness campaigns, ensuring consistent and adequate funding, and improving overall management practices. It is crucial for both the government and relevant stakeholders to prioritize the scheme's sustainability by addressing these challenges to ensure it meets its original goals of providing accessible and affordable healthcare to state workers.

Without these improvements, the full potential of the Ayadecare Health Insurance Scheme may not be realized, ultimately undermining its effectiveness and its ability to alleviate the financial burden of healthcare for workers in Cross River State.

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