TRAINING NEEDS ASSESSMENT OF STAKEHOLDERS IN THE HEALTH INSURANCE INDUSTRY IN SOUTHWEST REGION OF NIGERIA: IMPLICATIONS FOR UNIVERSAL HEALTH COVERAGE

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ABSTRACT
Background: The coverage of the social health insurance scheme in Nigeria has been low. The scheme may benefit from personnel training which has been shown to improve organisational performance.
Objective: This study, therefore, aimed to assess the training needs of personnel in the health insurance industry in Southwest Nigeria.
Method: This was a cross-sectional survey conducted among personnel of the health insurance industry in Southwest of Nigeria. The survey tool adapted was the Hennessy-Hicks Training Needs Analysis Questionnaire. The tool has been psychometrically tested for validity and reliability. Originally, the tool has 30 items with an allowance for modification without compromising its psychometric properties. The 30 items were grouped into six superordinate categories; management/supervisory, administration, clinical/service delivery assessment, communication/ teamwork, facility financial audit/assessment, and facility infrastructure assessments. Respondents rated each item along two seven-point scales. In the first scale, respondents rated how important (importance rating) the item is to their job while in the second scale, respondents self-rated their current performance level of the item (performance rating). A training need index was generated by subtracting performance rating from the importance rating for each of the six superordinate categories.
Results: Training needs for each of the six subcategories ranked by the magnitude of the derived training need index (from highest to lowest) were; clinical/service delivery, facility infrastructure, facility financial audit, management/supervisory skills, communication, and teamwork, and administration.
Conclusions: Training need was demonstrated in all six subcategories. Emphasis on the relevant training need of personnel in the health insurance industry in Nigeria is important to improve efficiency and performance.

INTRODUCTION

The low level of population coverage by health insurance schemes in developing countries is a concern for stakeholders globally.[1] Many factors have been attributed to this scenario, among which are the characteristics of the potential beneficiaries of such schemes, for example, poverty, low trust in the integrity of public policies, and poor understanding of schemes among others.[1,2] Factors of the contextual environments such as the political institutions and structure,[3-6] weak health systems, and population characteristics, which is, formal and informal[1,7,8] have also been cited. Likewise, important skills required for a successful implementation of a health insurance scheme such as technical, administrative (or managerial) capacities of the personnel in the health insurance industry who are the 'drivers' of the schemes have been referred to as contributory factors.

The transition period to universal health coverage (UHC) differs from country to country, especially in Europe, Asia, and Latin America, while some lasted about a century, some others were able to achieve UHC in a few decades.[9] Encouraging reports have been documented in some African countries. [1] Estimates

have stipulated gradual transition to UHC at 60-80% over nine years after implementation.[8] In Nigeria, the social health insurance scheme was implemented in 2005, the same period as in Ghana. However, while current population coverage in Nigeria is abysmally low at less than 10%, present population coverage in Ghana, is more encouraging at about 40%.[11]

Technical and managerial capacities of personnel in organisations have been shown to improve with training.[12-16] In addition to capacity building, training, also improves employees' creativity for better decision making and productivity, which eventually enhances organisational productivity.[17,18] Training programmes could take the form of structured formal types linked with background educational qualifications, on-the-job non-structured types organized by and carried out during routine workplace activities among other types.[19, 20]

Studies on the low population coverage of the scheme in Nigeria have been focused most of the time on factors other than training.[2,3,5] Very few if any, have researched other contributory factors to low population coverage of the scheme such as the capacities and skills need of the 'drivers' of the scheme. This study was carried out to assess the capacity and training needs of personnel of selected major stakeholders in the health insurance industry in the Southwest of Nigeria. Findings will contribute to the efforts to improve population coverage under the scheme in Nigeria and similar other countries.

MATERIALS AND METHODS
Study design
This was a cross-sectional survey to assess the training needs of personnel of three major stakeholders in the health insurance industry in southwest Nigeria. The Southwest of Nigeria consists of six states, namely; Ekiti, Lagos, Ogun, Ondo, Osun, and Oyo. In Nigeria, the social health insurance industry is a tri-partite arrangement of the National Health Insurance Scheme (NHIS), the Health Maintenance Organisation (HMOs), and the health care providers. The NHIS is a parastatal of the Federal Ministry of Health and, it is responsible for the design of the scheme, provides the policy direction, and as well as performs supervisory roles over other stakeholders in the industry. The HMOs are private organisations. HMOs purchase health care services on behalf of the NHIS for the scheme enrollees and, also provides supervisory roles over the health care providers licensed to provide care in the scheme.[10] Recently, the National Council on Health in Nigeria decentralized the social health insurance industry. With this development, the states are encouraged to establish State Supported Social Health Insurance Programme (SSHIP).[21] The structural and functional outlook of the SSHIP is similar to the national scheme. The two schemes could co-exist in a particular state and interested individuals could choose the preferred scheme as a platform to access healthcare services. While there was the presence of the NHIS (offices and personnel) in each of the six states of the Southwest of Nigeria, only four states namely, Lagos, Ogun, Osun, and Oyo had functional SSHIPs as at the time of this study. Ethical approval for this study was obtained from the University of Ibadan/ University College Hospital Ibadan joint Ethical Board Committee of Nigeria, with approval number UI/ EC/18/0653. Permission to conduct the study was obtained from the following organization; the NHIS, all the states' SSHIP, and the HMOs that participated in the study. Informed consent was also obtained from individual study participants in the organizations listed above.

Data collection tool and technique for the assessment of subcategory scores
The data collection tool used in this study is the Hennessy-Hicks Training Needs Analysis Questionnaire. The tool has been adopted by the World Health Organisation as a training assessment tool. It has been used in previous similar studies.[22-24] The description of the tool in the study conducted among health care workers in St. Lucia by Gaspard and Yang in 2016[23] was adapted for this study. The tool has been psychometrically tested for validity and reliability and, originally, it has 30 items with an allowance for modification.[25] This rule was strictly adhered to in modifying the questionnaire to suit the study objective and the audience. The 30 tasks in the Basic Questionnaire belong to one of six super-ordinate categories – management/supervisory, administration, clinical/service delivery assessment, communication/ teamwork, facility financial audit/assessment, and facility infrastructure assessment tasks (Table 1).

Scoring the instrument
Respondents rate each item on two seven-point scales according to two criteria: how critical the task is to the successful performance of the respondent's job (importance rating) and how well the respondent is currently performing the task (performance rating). The ratings for the first criterion provide an overall occupational profile of the respondent's job, and those for the second criterion provide an index of the skill level or performance.[26] Differences between performance rating and importance rating for each item were calculated simply by subtracting the performance score from the importance score for each questionnaire item, thus yielding a difference score that reflected the extent of training need. In this study,

questionnaire items (30) were grouped into six task subcategories. Relative training needs for each of the six task subcategories were calculated. This was derived by calculating the average difference score for the items in each of the given subcategories. The extent of need was calculated as the difference between the importance attributed to a task or item (Rating A on the questionnaire) and how well the respondents considered to have performed the task (Rating B on the questionnaire). The largest gap indicates the maximum training need. High scores on the importance and low scores on performance indicate a training need. The higher the difference score, the greater is the training need.[23] This yielded six average scores – one for each sub-category. The average scores for each of the six sub-categories were plotted on a graph (Fig. 1). This instrument allows for measuring training needs within broad categories as well as enables comparisons between categories. Therefore, each category can be used independently or in combination with other categories to obtain the required information. The instrument is semi-opaque meaning that the respondents are less likely to be able to distort their responses; therefore, the obtained data would more accurately reflect the training requirements. [26] Thus, the instrument has an advantage over other similar instruments. The results suggest that tasks considered to be highly crucial but not well performed require training, whereas items with similar scores for criticality and performance require little training.

Data collection procedure

Data collection spanned four months between November 2018 and February 2019. The questionnaires were self-administered, however, where an individual needed the assistance of the research assistants, such was provided. While the majority of the questionnaires were collected the same day after they were administered, a few others were collected some days after at the request of respondents. Study respondents were personnel of the NHIS, HMOs and in the states where there they existed, the SSHIP. From the register made available by individual stakeholders, there were a total of 275 personnel in the industry in the zone. All were scheduled to be recruited into the study, thus, a total sampling of all available personnel was adopted. Those who were on leave from work and those who declined to participate were excluded. Invalid questionnaires were also excluded.

RESULTS

A total of 275 questionnaires were administered to eligible individuals, however, 234 individuals eventually participated (response rate of 85.1%). The mean age

Table 1: Questionnaire items and classification sub-category classification

Sub-category	Questionnaire item
Management/supervisory skills	Facilitate improved provider and patient relationship
	Appraising your own performance
	Address patient complaints/concerns
	Introducing new ideas at work
	Use health services from HCF in report writing
	Showing colleagues how to do things
	Organizing your time effectively
	Making do with limited resources
	Personally coping with change in the health service
Administration	Doing Paperwork and/ or routine data inputting
	Use technical equipment, including computers
	Undertaking administrative activities
Clinical/ Service delivery Assessment	Setting guidelines for the scheme
	Assessing HCF for service delivery
	Assessing HCF for waste management
	Assessing patients' clinical needs
	Observe and assess the appropriateness of the process of service delivery
Communication and team work	Getting on with colleagues
	Communicating with patients face-to-face
	Providing feedback to colleagues
	Giving information to patients/carers
	Address patient/ provider misunderstanding
	Working as a member of a team
Facility financial audit/assessment	Verify, collate and process payment of claims to health service providers
	Verification of quality n quantity of service by providers
Facility infrastructure assessment	Assess the adequacy of facility infrastructure
	Assess the adequacy of facility drugs supply and other consumables
	Assess availability of health facility human resources
	Assess the adequacy of facility machines & equipment
	Collecting and collating relevant health facility data

Table 2: Socio-demographic characteristics of respondents (N = 234)

Socio-demographic characteristics	Frequency	Percent (100)
Age (years)		
19-34	80	34.2
35-49	107	45.7
50-60	21	8.9
No response	26	11.1
Mean age = 37.11 ± 8.3 years		
Sex		
Male	125	53.4
Female	109	46.6
Academic qualifications		
Health-related degree	32	13.7
Non-health related degree	157	67.1
Others	38	16.2
No response	7	2.9
Formal training in actuarial science		
Yes	119	50.9
No	115	49.2
On the job actuarial training		
Yes	148	63.3
No	86	36.8
Duration of training		
≤ 1 week	124	83.8
≤ 2 weeks	15	10.1
No response	9	6.1

of respondents was 37.11 ± 8.3 years. Participants between the age of 19 and 49, 187(79.9%) were more than the other age groups, of this, individuals between the age of 35-49 years were of the higher proportion, 107(45.7%). Male participants 125(53.4%) were more than were females. Only 32(13.7%) reported having a training background in health-related degrees, work-related (actuarial science) training 119(50.9%), while 148(63.3%) reported having had a form of on-the-job actuarial science and related training (Table 2). Training needs for each of the six subcategories in this study are as shown in Fig.1. Ranked by the magnitude of the derived training need, Clinical/ Service delivery Assessment ranked first, this was followed by Facility Infrastructure Assessment and other subcategories. Administration subcategory ranked the least. The subcategories and the items that made up each of them are as shown in Table 1.
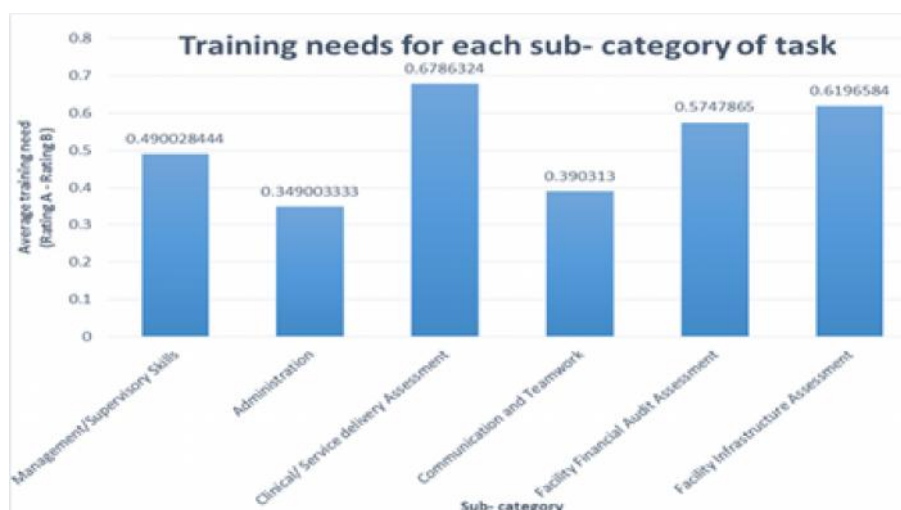

Fig. 1: Training need by sub-category of tasks

DISCUSSION

The majority of the study participants were in the active productive age group. Evidence abounds that in many aspects of measures of learning, the younger the individuals, the more malleable and the more likely they are to be open to learning new skills and innovations and, thus the desired improvement in the work environment.[27-30] This could be an advantage to the health insurance industry if this inherent potential is appropriately channeled to the industry's most pressing needs. This study reiterates the demographic pattern with regards to gender and employment opportunities; the most current survey[31] shows that women have lower opportunities, especially in formal employment. This not only reflects a gender inequity with regards to formal education and other forms of learning, but also it mirrors the lower socioeconomic empowerment among women compared to their male counterparts. Not only do access to economic opportunities important for women's empowerment, but it also benefits their children and their households. Decision-making with regards to personal and household health-seeking, control over earnings, and protection from domestic violence are much better among women who are economically empowered.[31-34] This is a call to promote female empowerment in all its dimensions in Nigeria and similar other environments for all the beneficial reasons.

Compared to the countries in the Western world, and some Asian countries, the concept of social health insurance in the SSA is relatively new.[1,8,9] Also, as evidenced by some indicators such as population coverage, the performance of these schemes vary from country to country; while schemes in countries like Ghana, Rwanda, South Africa, and Kenya[1,11] demonstrates improving performance, population coverage of social health insurance scheme in Nigeria has been nearly static hovering between 4%-6% of the total population[10] since it was established almost two decades ago.[10,35]

Among other factors, poor technical and managerial skills of 'drivers' of health insurance schemes as well as non-commensurate organisational structure have been attributed to low performance of health insurance schemes especially in developing countries.[1,7,36] While they may not suffice in themselves as evidence of technical skills required to perform effectively in a health insurance scheme, acquisition of training in health-related discipline and especially in actuarial science could serve as a proxy of such skills. Just above ten percent and only about half of the participants in this study claimed to have acquired health-related and actuarial training respectively before taking up jobs in their respective organisations. In addition to this, many of those who claimed to have been exposed to a form of on-the-job training reported such training to last a maximum of one week. This is not the desired scenario, stakeholders are entreated to make a positive change to the current training need and, as well pay more attention to the training background of prospective employees in the industry.

As depicted in the subcategories, the most pressing of the training needs was Clinical/Service delivery followed closely by the Facility Infrastructure Assessment, while the least was the Administration subcategory. Most training needs are conventionally initiated by employers to equip employees for organisational goals. However, this study was conducted to engage employees in directly identifying capacity-building needs with the assumption that specific needs are identified and addressed. This approach will serve two purposes, firstly, in resource-constrained environments preference is given to the most pressing needs and thus an efficient deployment of resources is achieved. In addition to this, involving the potential beneficiaries in identifying the needs is more likely to engender a sense of ownership and thus active participation and better capacity-building outcome with a positive impact on health service delivery. To achieve these two benefits, stakeholders in the health insurance industry in Nigeria are encouraged to address the needs as expressed in this study and enhance its performance.

Compared to previous similar others[23,24], conducted using the same instrument, the degree of training need in this study was not as high as expressed in those, this notwithstanding, we strongly believe it has expressed training needs in the respective subcategories, and therefore, a room and a need for improvement in the health insurance industry. To believe otherwise may be counterproductive to the desired performance improvement in the health insurance industry in Nigeria especially.

This study has grouped needed training needs into subcategories. It would be more appropriate if these items are individually listed for item-specific identification and targeted intervention. This will be more helpful, especially in resources constrained environments. We accept this as a limitation. It is recommended that studies that will address this are conducted to provide more useful information.

Declarations
Authors declare no conflict of interest.

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