European Journal of
Health Sciences
(EJHS)

Factors Determining Enrollee's Choice of Private and Public Healthcare Providers of Community Based Health Insurance Scheme in Edu Lga Kwara State

Sheshi Idris Mohammed, Agbana Emmanuel Busayo, Sani Mohammed Dambam, Jiya Samuel Ndagi, and Liman Abbas Shu'aibu

European Journal of Health Sciences
ISSN 2520-4645 (online)
Vol.7, Issue 6, pp 34 - 44, 2022

www.ajpojournals.org

Factors Determining Enrollee's Choice of Private and Public Healthcare Providers of Community Based Health Insurance Scheme in Edu Lga Kwara State

Sheshi Idris Mohammed[1], Agbana Emmanuel Busayo[2], Sani Mohammed Dambam[3], Jiya Samuel Ndagi[4], Liman Abbas Shu'aibu[5]

[1]Department of Health Research, Niger State Ministry of Health, Minna
[2]Department of Community Medicine, College of Health Science, Kogi State University Anyigba
[3]Department of Community Medicine, Abubakar Tafawa Balewa University Bauchi.
[4]Department of Disease Control and Immunization, Niger State Primary Healthcare Agency, Minna
[5]Department of Public Health, Niger State Ministry of Health, Minna

Abstracts

Purpose: Private sector is the major providers of Primary health care for the poor in many low- and middle-income countries. In the public healthcare providers, the health facilities are built by the government and the healthcare workers, draw their salaries from government treasuries. In the private providers, the health facilities are owned by individual or a group of people and the salaries of the workers are paid from the resources generated in the facilities. They are either for profit or non-profit making. Enrollees are given freehand to choose either of the providers, but the information available to them is not enough to make decision on which of the providers to choose. This study aimed at determining the enrollee's choice of private and public healthcare providers of community-based health insurance scheme in Edu LGA Kwara state.

Methodology: The design was descriptive cross-sectional study. Sample size of 400 was used in each of the provider. The respondents were recruited by systematic sampling method among private healthcare provider while multistage sampling method was adopted in public healthcare providers. Data was collected using semi structured questionnaire. Focus Group Discussion was also carried out. Data collected were analyzed using SPSS version 23.0. Results were tabulated and logistic regression was adopted to determine level of significance. Level of Significance was set at $P<0.05$

Findings: Nine- point-five (9.5%) of the respondents of the private healthcare provider and 5.7% of the respondents of the public healthcare providers had good knowledge score of community based health insurance scheme. The difference in knowledge score was statistically significant as the $p=0.035$. Mode of premium collection had Odd ratio 2.99 (CI =1.934- 4.622), $P<0.001$; Trust of the system Odd ratio 2.987 (CI = 1.884-4.733); Quality of health care Odd ratio 2.673 (CI = 1.757-4.065) $P<0.001$; Proximity to health facility Odd ratio 2.225 (CI = 1.412-3.506) $P=0.001$. Mode of joining the scheme Odd ratio 0.400 (CI = 0.290-0.552) $P<0.001$ and cost of accessing care Odd ratio 0.577 (CI = 0.42-0.779) $P<0.001$.

Recommendation: It was recommended that private health facilities should be maintained which will improve access to health care for the enrollees. The government should also improve the quality of health care in the public healthcare providers.

Keywords: *Choice, private and public healthcare providers, community based health insurance scheme.*

INTRODUCTION

Private sector is the major providers of primary health care for the poor in many low and middle income countries[1]. Private healthcare providers may be formal, that is, recognized by law or by legally recognized regulatory authorities and informal, that is not recognized by the law[2]. Formal private healthcare providers comprises of for-profit and non-for- profits hospital. For-profit/not-for-profit dichotomy is not so distinct in practice. Informal allopathic providers includes quacks lay health workers, drug sellers and ordinary shop keepers[3]. Public healthcare providers on the other hand, are health facilities built by government and the healthcare workers draw their salaries from government treasuries. This facility type is not intended for profit making.

With the introduction of community-based health insurance scheme under the Act 35 of 1999, one of the policy statements was the incorporation of private healthcare providers in order to achieve universal coverage. Enrollees are given freehand to choose either of the healthcare providers, but the information available to them is not enough to make decision on which of the providers to choose. There is dearth of studies to determine factors influencing choice of healthcare providers among the enrollees but in a related study conducted in Ghana to determine choice of health care providers under the national health insurance Scheme, factors such as cash amount paid, waiting time and proximity to facility were found to discourage the use of orthodox health care among insured persons[4]. This study aimed at determining the enrollee's choice of private and public healthcare providers of community based health insurance scheme in Edu LGA Kwara state.

METHODOLOGY

The study design was cross sectional descriptive. The minimum sample size for the study for each group was calculated using the formula for the comparison of two proportion[5]. For this study 379 size was calculated including nonresponse but 400 enrollees of each of public and private healthcare providers of community based health insurance scheme were used. Systematic sampling technique was used to choose the respondents in private healthcare provider. For the public healthcare providers, multistage sampling technique comprising of stratified and systematic sampling technique to choose the respondents. For the FGD, subjects were selected by purposive sampling technique among the active enrollees that were not part of the quantitative study. The participants were informed a week before each session. There was a note taker, a tape recorder and photographer while the researcher was the moderator. Ten participants were used for each session. Each session of the FGD lasted for an hour.

Interviewer administered semi-structured questionnaire was used to collect data. A total of 40 questionnaires for each provider was pre-tested in Asa LGA for a similar Community Health Insurance Scheme in the area. Data was analyze using SPSS version 23.0. Ethical approval for this study was obtained from the ethical review committee, University of Ilorin Teaching Hospital. Informed written consent was also obtained from the study subjects before conducting the interview.

RESULTS

Table 1: Socio-demographic characteristics of the respondents

Variable	Service Providers			
	Public (%)	Private (%)	X^2	P
Age Groups(years)				
18 – 28	140 (35.0)	122 (35.5)		
29 – 38	93 (23.3)	80 (20.0)		
39 – 48	53(13.2)	48 (12.0)		
49 – 58	61 (15.2)	67 (16.7)		
59 and above	53 (13.3)	83 (20.8)	9.360	0.053
Sex				
Male	141 (35.2)	117 (29.2)		
Female	259 (64.8)	283 (70.8)	6.051	0.049
Marital status				
Single	54 (13.5)	48 (12.0)		
Married	340 (85.0)	349 (87.3)		
Divorced	0 (0)	2 (0.5)		
Widowed	6 (1.5)	1(0.2)	3.124^x	0.372
Ethnic group				
Nupe	284 (71.0)	330 (82.5)		
Yoruba	74 (18.5)	50 (12.5)		
Hausa	6 (1.5)	3 (0.8)		
Igbo	8 (2.0)	4 (1.0)		
Other	28 (7.0)	13 (3.2)	15.913	0.003
Religion				
Islam	301 (75.2)	340 (85.0)		
Christianity	99 (24.8)	60 (15.0)	13.093	0.001

^{x}*Yate correction*

Table 2: Socio-demographic characteristics of the respondents

Variable	Service Providers			
	Public (%)	Private (%)	χ^2	P
Income Group				
<₦5,000	121 (30.2)	155 (38.7)		
₦5,000 – ₦10,000	84 (21.0)	73 (18.3)		
₦10,001 – ₦20,000	76 (19.0)	61(15.3)		
₦20,001 – ₦30,000	34 (8.5)	20 (5.0)		
₦30,001 and above	85 (21.3)	91(22.7)	10.436	0.034
Type of Marriage				
Polygamy	141 (40.8)	167 (47.3)		
Monogamy	205 (59.2)	186 (52.7)	3.048	0.081
Length of Enrolment(years)				
6 month to < 1 years	30 (7.5)	19 (4.8)		
1 years to < 2 years	42 (10.5)	38 (9.5)		
3 years – 4 years	91 (22.8)	81 (20.2)		
5 years – 6 years	94 (23.5)	92 (23.0)		
>6 years	143 (35.7)	170 (42.5)	6.118	0.191
Household Size				
<5	160 (40.0)	166 (41.5)		
≥ 5	240 (60.0)	234 (58.5)	0.186	0.666

Table 1 shows that the age of respondents ranged from 18 years to 80 years with mean age of 38.48 ± 14.90 for the respondents of public healthcare providers and 41.53 ± 16.45 for the private healthcare provider. There is no statistical difference in mean age as the P=0.053. Modal age in the two healthcare providers was 18-28 years. The predominant sex among the respondents of both providers were female, 70.8% for private healthcare provider and 64.8% for public healthcare providers. The differences in value between the healthcare providers was significant, P=0.049. Islam was the major religion of the respondents of both private healthcare provider 85.0% and public healthcare providers 75.2%, the differences in value was significant, with P = 0.001.

Table 2 shows that majority of respondents earn their monthly income below ₦5000 with private healthcare providers being 38.7% and public providers being 30.2%. Five percent 5% of the respondents of the private healthcare provider and 8.5% of the respondents of the public healthcare providers receive monthly income of between ₦20001-₦30000, which is the least. The differences in these value was statistically significant as p<0.05.

Table 3: Respondents overall knowledge grading of community insurance scheme

Knowledge score	Service Providers			
	Public (%)	Private (%)	X^2	p
Poor	124(31.0)	99(24.8)		
Fair	253(63.3)	263(65.7)		
Good	23(5.7)	38(9.5)	6.685	0.035

Small fraction of the respondents of both healthcare providers 5.7% of public providers and 9.5% of private provider have good knowledge of community-based health insurance scheme. Majority of the respondents of both healthcare providers of community based health insurance scheme, 63.3.0% of public providers and 65.7% of the private provider had fair knowledge while 31.0% of respondents of public healthcare providers and 24.8% of the respondents of private healthcare provider had poor knowledge. There was statistical significance difference of knowledge score between public and private healthcare providers, $p<0.05$

Table 4: Factors influencing respondent's choice of healthcare providers of community based health insurance scheme

Variable	Service Providers			
	Public (%)	Private (%)	X^2	P
Distance of place of residence to the facility	369 (92.2)	337 (84.2)	12.344	<0.001
Mode of Collection of Premium	315 (79.2)	366 (91.9)	25.925	<0.001
Trust on the System	325 (81.6)	370 (93.0)	23.232	<0.001
Quality of healthcare delivery	315 (79.2)	364 (91.0)	22.239	<0.001
Mode of joining the scheme	251 (62.9)	323 (80.9)	31.933	<0.001
Waiting time in the health facility	154 (38.3)	179 (44.7)	3.291	0.193
Cost of accessing healthcare	257 (64.4)	302 (75.6)	13.275	0.001

Multiple Response

Majority of the respondents of the public healthcare provider 92.2% as against 84.2% of the respondent of private healthcare provider considered distance as influencing factor for choosing the provider with $P<0.001$. Trust on the system was an influencing factor for 93% of respondents of the private provider as against 81.6% of the respondents of public provider for choosing the provider with $P<0.001$. Majority of respondent of both provider, 91% for private provider and 79.2% for public provider said quality of health was an influencing factor for choice of provider with $P<0.0001$. Majority of respondent of both providers, 75.6% for private provider and 64.4% for public provider said cost of health care was an influencing factor for choice of their respective providers with $P=0.001$. Less than half of the respondents of both providers, 38.3% for public provider and 44.7% for private provider claimed waiting time influence them to choose their respective providers. The difference was not statistically significant as the $P=0.193$.

Table 5: Logistic regression of factors influencing choice of healthcare providers of community based health insurance scheme

Factors influencing registration with health facility	ODD	P value	95% CI RATIO
Distance of place of residence to the health facility	2.225	0.001	1.412 – 3.506
Mode of collection of premium	2.990	<0.001	1.934 – 4.622
Trust on the system	2.987	<0.001	1.884 – 4.733
Quality of healthcare delivery	2.673	<0.001	1.757 – 4.065
Mode of joining the scheme	0.400	<0.001	0.290 – 0.552
Cost of accessing healthcare	0.577	<0.001	0.427 – 0.779

Note: Public provider was used as a reference

Mode of premium collection has almost 3 times likelihood of influencing of choice of private provider, P<0.001. Followed by trust on the system has 2.99 times likelihood of influencing the enrollees for choice of private provider, P<0.001. Quality of health care has 2.67 times likelihood of influencing choice of private provide, P<0.001. Proximity of residence to health facility has 2.23 times likelihood of influencing the choice of private provider, P=0.001. Mode of joining the scheme has odd of choice of private provider 60% less than public provider with true population effect between 55% to 29%, P<0.001. Cost of accessing care has odd of choice of private provider 43%less than the public provider with true population effect between 77% to 42%, P<0.001.

DISCUSSION

The mean age of the respondents of the public provider was 38.48 ±14.89 years and the respondents of the private provider was 41.52 ± 16.45 years. The modal age group in both providers was 18 – 28 years. There was no significant difference with P=0.053. This is in contrast to the study carried out in rural community of Ilorin[6] and Abuja[7]with modal age group of 30 – 39 years. It is consistent with finding from Osun[8] state which was 20 – 29 years.

Nine point five percent (9.5%) of respondents of private provider and (5.7%) of respondents of public provider had good knowledge. The difference was statistically significant as the P<0.035. This is similar to study carried out in rural Community of Ilorin where respondents with good knowledge was (2.5%)[6]. This is in contrast to a study carried out in Kwergoro community of Mangu LGA, Plateau state which demonstrated high level of good knowledge of community based health insurance scheme (71%)[9]. However, level of good knowledge is higher in private healthcare provider compare to the public provider, the reason may be due to the fact that Bacita, where the private health facility is located is an heterogeneous community consisting of different ethnic group from different states of the federation, following the establishment of sugar company in the area, there could be level of interaction between the enrollees and some people who may have some experience of community health insurance scheme from their place of origin. In addition, the private provider may have an edge over the public provider in terms of community sensitization. Low level of knowledge of community health insurance scheme may have an implication for the scheme. Any slight policy changes may not be well received by the enrollees. Their premium of five thousand naira (#500) per capitation which is paid annually may be

adjudged by the enrollees to be enough to cater for all the benefits package obtainable in the scheme. This is contrary, because the scheme obtains financial support from Pharm Access with counterpart funding from the state Government. So, if scheme decides to adjust the offer of benefits to the enrollees base on the limited resources that is available to them. Some of the enrollees may protest against it simply because of lack of knowledge on contributions to the scheme. In addition, low level of knowledge among the respondents may explain why some enrollees have negative perceptions about the scheme. Some enrollees felt there is no need to enroll into the scheme where they would be made to pay certain amount of money at the time when there was no need of health care.

Research had shown that patients do not take choice of providers into consideration when seeking for health care. Because information about quality of health services delivery in the health facilities is either not enough or not available to make decision[10]. However, evidence has shown that health insurance scheme promotes choice of provider because the enrollees would want to justify the premium, they paid[11]. In this study, large percentage of respondents of public healthcare provider (92.2%) said proximity to the health facility was an influential factor for choosing the provider. More of public than private. The difference was significant as the $P<0.001$. This is similar to study conducted in Ghana[12] which showed that (65.5%) of the respondents chose the public health facility because of proximity to their home and (28%) chose the private health facility because of the same proximity. However, logistic regression shows that proximity to the health facility has 2.22 times likelihood of choice of private. An increase in distance from home to the health facility indicate paying some extra cost on transport to access health care in the facility as in contrast to seeking self-treatment.

Distance add an extra burden to the monetary cost of treatment. Given the fact those who go to access health care in the private health facilities have already made a decision to spend extra money on treatment. Distance should not be a barrier for accessing good health care because most enrollees will deny themselves quality healthcare base on distance. Majority of respondents of private healthcare provider (93%) and (81.6%) for public healthcare provider said trust was responsible for choice of private provider. Trust in this context implies a relationship between the providers and health care and the household, in which it is believed by the household members that quality care will be offered by the provider when needed. In a Focus Group Discussion carried out in Cambodia[13] there was mixed responses. In Treas village, where one of the Focus Group Discussion was conducted, the respondent trusted private healthcare provider more than public provider. This is because private healthcare providers visit their house immediately after phone call, treat them carefully and they thought the treatment let's patients recover quickly. This is in contrast to Focus Group Discussion carried out in slorkram village in the same country, the respondents trusted the public provider than the private provider because doctor from the provider was said to be friendly, tell them about the status of their disease and on call at any time. They also felt at ease knowing fully well that public healthcare provider would not hold on to patients they cannot treat.

However, from the quantitative study carried out in the same country (28%) of the respondents against (10%) chose private healthcare provider on ground of trust. This finding was similar to a study carried out in rural Tanzania where (89.1%) of respondent had trust in private healthcare provider and (74.7%) in public healthcare provider[14]. This finding was similar to a study carried out in Australia[15], the respondents had greater trust in the private healthcare provider compared to

public hospital but among the insured, greater trust in the public healthcare provider compared to the private healthcare provider was observed. In this study quality of health care was responsible for choosing the private healthcare provider (91%) which was higher than public healthcare providers (79.2%). The differences was significant with P<0.001. The logistic regression showed that quality of health care has 2.67 times likelihood of choice of private healthcare provider. This is similar to a study conducted among the staff of local government's secretariat which showed that the respondents were 3.9 times more likely to choose private health care provider due to quality of healthcare[16] This is also similar to a study conducted in rural area of Ibadan to determine factors influencing choice of healthcare providers among farming and non-farming households, majority of households prefer to use private healthcare provider on ground of quality of care[17]. From the Focus Group Discussion carried out among the female respondents of the public provider, majority of the respondents affirmed that

''If you go to the hospital for an ailment, it is only God that will determine your survival. Most cases are referred to Bacita (private healthcare provider)''.

''If you go to the hospital, you will not be allowed to see doctor even during the antenatal clinic instead you will see nurses and instead of them to use fetoscope to check for the child wellbeing, they will not. It is only those with diabetes and hypertension that see doctor''

This is in contrast to a study conducted in Calabar where (66.1%) of the respondents patronize public hospital and large percentage of the respondents said good attitude and high quality of health care services were the major reasons of choosing the facility[18]. The implication of choice of private healthcare provider over the public on ground of quality is that most enrollees may decide to change their provider from the public to private, given the fact that enrollees are given freehand to change the providers if they are not comfortable. This will reduce the number of enrollees that are registered with the public healthcare provider thus rely on small budget, further compromising quality of healthcare more in the public provider.

The cost of treatment only influence choice when patients have to make payment themselves. For example, in a study carried out in France[19] women do not have to pay from their pocket. However, with community-based health insurance scheme, the cost of accessing health care is reduced because there is no copayment and the premium is the same in both provider except that not all services are covered by the scheme. For such services, the cost is expected to be high in private healthcare provider, since it is for profit. But for the services covered by the scheme, the cost might be the same. From the qualitative study carried out for the public healthcare provider the female respondents said there were extra charges requested by the public healthcare providers,

"In the past, they use to collect money for delivery if it is male birth they would collect #6,000, the female is #5000 naira. This is preferable compare to now that you have to pay for gloves, everything, even if the fuel for hospital generator finishes, you would go and buy them"

From the quantitative study carried out, cost of accessing care, (75.6%) of the respondents of private healthcare provider said cost of accessing care was one of the influencing factors for choosing the facility as against (64.4%) of the respondents of the public healthcare provider who said cost of accessing health care was an influential factor for choosing the provider. The difference was significant as the p <0.011. This is similar to study conducted in Burkina Faso, where majority of the respondents patronizes public healthcare provider and cost of services was a major factor[20].

The logistic regression showed that the respondents have (43%) Odd of choice of private healthcare provider less than the public healthcare providers. The implication of high cost resulting from extra monetary charges is that it may influence enrollees' dissatisfaction with the scheme, later affecting their continuous subscription with the scheme.

Less than half of the respondents of the private healthcare provider (44.7%) and (38.3%) of the respondent of the public healthcare provider claimed waiting time was an influencing factor for choosing the respective provider. The differences were not significant, the P=0.094. This is similar to the study conducted among the staff of local government secretariat in west of Nigeria. The study revealed that respondents who described shorter waiting time as being good were 3.9 times more likely to have private healthcare facility as their chosen health care[16]. In the regression analysis, waiting time was statistically significant in influencing the choice of private preferred provider. Shorter waiting time was a positive determinant of choice of private healthcare provider service while it was negative for public healthcare provider and it was, statistically significant for private healthcare provider after multinomial logistic regression.

Large percentage of respondents of private healthcare provider (91.9%) said mode of collection of premiums is one of the influencing factors in choosing their provider while (79.2%) of the respondents of public healthcare provider said is one of the influencing factor in choosing public provider. The difference was statistically significant as the p=0.001. In this scheme there was no specific time premium is paid. Premium is paid at any time the subscription expires. This takes place in the two-provider studied. The result obtained may be due to friendly nature exhibited during collection of premiums in the private healthcare provider that may be responsible. This conduct will attract more enrollees to the private health care provider compared to the public. There are no studies carried out to determine influence of mode of collection of premiums on choice of providers.

Large percentage of respondent of the public healthcare provider (62.9%) and (80.9%) of the respondents of the private healthcare provider said mode of joining the scheme was an influencing factor in choosing their provider. The difference was statistically significant at p=0.001. Both healthcare providers enroll their clients as individual not as household. Although at initial stage, the scheme may have been enrolling as household. The regression showed that mode of joining the scheme had (60%) odd of choice of private provider less than public P<0.001. There are no studies done to determine effect of mode of joining the scheme and mode of collection of premiums on choice of provider.

CONCLUSION

Proportion of respondents in both providers with good knowledge are low. The following are likely to predict the choice of private healthcare provider: proximity of residence to health facility, mode of collection of premium, trust and quality of health care where as the following are less likely to predict choice of private healthcare provider; mode of joining the scheme, cost of accessing healthcare.

RECOMMENDATION

It was recommended that private health facilities should be maintained within the scope of healthcare providers of community based health insurance scheme, the policy of incorporating private healthcare providers, which will improve access to health care for the enrollees, hence

universal coverage. Also, the Government should improve the quality of health care in the public healthcare providers. In addition, monitoring of both healthcare providers should be strengthened to guard against their excesses. Finally, periodic community sensitization and awareness creation about the provisions of community based health insurance scheme should be instituted

REFERENCES

1. Shantayanan Devarajan, Ritva Reinikka. Wor;ld development report. Making services work for poor people. Washington (District of Columbia) World Bank and Oxford University press. 2004. Available at www.inf.org/external/pubs/ft/fandd/2003/09/pdf/dearasja.pdf Last accessed June 2020

2. Murray CJ. Lopez AD, Alternative projection of mortality and disability by cause 1990-2020. Global Burden of Disease study. Lancet 1997;349:1498-1504

3. Bloom G. Standing H, Liod R. Markets information asymmetry and health care towards new social contracts. Soc. Sci. Med 2008; 66:2076-2087

4. Ama P Fenny, Felix A, Asante, Ulrika Enemark, Kristian S Hansen. Treatment seeking behavior and social health insurance in Africa, the case of Ghana under NHIS, Global Journal of Health Science. 2014;7(1):296-314

5. Araoye MO. Research Methodology with statistic for health and social science. Mathadex publishers, 2003;(1):118-120

6. Babatunde OA, Babatunde OO, Salaudeen AG, Aderibigbe SA, Adewoye KR, Alao TA, Idowu OA, Atoyebi OA. Knowledge of community health insurance among household heads in rural communities of Ilorin. International Journal of Science Management, 2014;3(3):800-810

7. Christian Ogbe. Knowledge and perception of rural communities in Abuja, Nigeria on community-based health insurance scheme. South American Journal of Public Health. 2014;2(4):534-560

8. Bamidele JO, Adebimpe WO. Awareness, Attitude and willingness of Artisan in Osun state, south western Nigeria to participate in community based health insurance. Journal of community Medicine and Primary Health Care. 2013;24(1&2): 1-11

9. Banwat ME, Agbo HA, Hassan Z, Lassa S, Osagie LA, Ozoilo JU, Ogbonna C, Community bassed health insurance knowledge and willingness to pay: A survey of a rural community in North Central zone of Nigeria. Jos Journal of Medicine 2012; 6(1):54-59

10. Fotaki M, Roland M, Boyd A, McDonald R, Scheaff R, Smith. What benefit will choice bring to patient? Literature review and assessment of implication. J Health Serv Res Policy 2008;13:178-184

11. Halasa Y. Nande A, K Kumar. Factor determining choice of health care provider in Jordan. Eastern Med Health Journal. 2009;15(1):53-6Sx

12. Stephen Russel. (2008) Demand side factor affecting health seeking behavior in Ghana. GU Journal of Health Science, 5, No, 1. Available at https:/blogs.commons.georgetown.edu/journal-of-health-sciences/issues-2/previous-volumes/vol-5-no-1april-2008/demand-side-factors-affecting-health-seeking-behavior-in-ghana/ Last accessed in 2020

13. Sachiko Ozawa, Damian G Walker. Comparism of trusty in public vs private health care provider in rural Cambodia. 2011;2(suppl 1):20-39

14. Elizabeth H, Shayo Kesheri, P Senloro, Romanus Momburi, Jeans Byskov, Samuel A Makundi. Access and utilization of health care services in rural Tanzania. A comparism of public and non public facilities using quality equity and trust dimension. International Journal for Research, policy and practice. 2016;11(4):407-422

15. Elizabeth A, Harlie, Christian R, Critchley. Public perception of Australia doctor, hospital and health system. Med J Australia 2008;189(4):210-214

16. OC Uchendu, OS Ilesanmi, AE Olumide. Factors influencing the choice of health care providing facility among workers in a local government secretariat in south western Nigeria. Ann Ib postgrad Med. 2013;11(2):87-95.

17. Oni OA, Agboje IA, Determinants of choice of healthcare provider among farming and non-farming household. Evidence from selected rural area of Ibadan Oyo state. Nig J of Agriculture, Food & Environment. 2014;6(1&2):33-46

18. Osuchukwu Nelson, C Osonwa, Kalu O, Eko Jimmy E, Uwanene CC, Abeshi SE, Offiong Dominic A. Evaluating the impact of national health insurance scheme on health care consumer in calabar metropolis southern Nigeria. International J of Learning and Devt. 2013;3(4):30-45

19. Combier E, Zeitlin J, de Courcel N, Vasseur S, Lalouf A, Amat Roze Jet al. Choosing where to deliver. Decision criteria among women with low risk pregnancies in France. Soc Scie Med. 2004;58(11):2279-89

20. Idrissa Beogo, Chieh Yu Liu, Ying Jang, CVhouChuam, Yu Chan, Nicvole Huang. (2014)Health seeking pattern in the emerging private sector in Burkina Faso. A popular based study of Urban Adult resident in Ouagadogou. PLos ONE 9(5):e97521