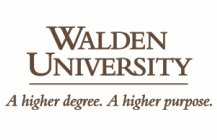

2019

Perceptions of Financial Bribery and Kickbacks on Nigerian Healthcare Public Policy

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
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Abstract

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Policy and Administration

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Abstract

Financial bribery and kickbacks are characteristics of corruption that are considered a serious threat to healthcare development in Nigeria. The influence of corruption leads to financial waste and negative health consequences for citizens. High demand for quality healthcare and other socioeconomic development infrastructures in the rural areas of the state provide opportunities for misappropriation of allocated healthcare development funds. Using Kingdon's multiple streams theory as the foundation, the purpose of this case study of a single city in Nigeria was to understand how state and city legislators and health administrators perceive the influence of corruption on senior healthcare development, its service delivery, and the lives of residents. Data were collected through interviews with 15 individuals representing older adult participants, state and city legislators, and healthcare administrators and publicly available government data. Following a root cause analysis framework, these data were inductively coded and subject to a thematic analysis procedure. Identified key themes from the study findings were (a) healthcare services, (b) poor infrastructure, (c) poverty, (d) healthcare cost, (e) government and corruption, (f) unpaid wages, (g) health centers, and (h) public and private hospitals. The positive social change implications stemming from this study include recommendations to National Health Insurance Scheme to formulate policies that may improve quality healthcare service and delivery, improve communication between local government and residents, and reduce the high out-of-pocket cost of healthcare. These recommendations may enhance healthcare provider insight on equal healthcare access to seniors and the entire rural community.

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Dedication

I dedicated this work to my lovely family, my lovely four children, Jeffrey, Kennedy, Emmanuel and adorable daughter Lauren Chiamaka whose inspiration, motivation and consistent warm ups kept me going through the entire process of this journey. Also to my dearly lovely mother Maria Mbagwu whose untouchable caring love and my siblings, especially in their blessed memories, my late lovely black queen sister Gertrude Elekwachi and my memorable father who passed before I got to this stage but laid a concrete foundation for this journey with his everlasting words of thought to make education a priority in my life.

Acknowledgement

This journey would not have been a success without the shielding mercies and protection from God the almighty, who comforted me with good health, and provided protection and strength as I pursued this doctoral study. I sincerely express my gratitude to Dr. Bethe Hagens, for stepping up to agreeing to become my Committee chair when I was in desperate need of one during my second residency, for accepting my request with faith and professionally staying close in mind and guidance, her timeless feedbacks that kept me going on until she was medically diagnosed. I wish you Dr. Bethe God's protection and his shielding grace of good health restoration, in faith and love of the Lord Amen.

Similarly, I wish to thank my prior Committee Member Dr. Eliesh O'Neil Lane, who is currently my Committee Chair, through the entire process has devoted towards this study to this stage of the final status. I thank you from the deepest of heart for your tirelessness for encouraging me, motivating and directing me to the completion of the stage. And thanks to my committee member Dr. Olivia Yu. Although, in the brief time your time with me was encouraging to the completion of the stage. Many thanks to Dr. Melanie Smith, University Research Reviewer, and the entire Walden University staff who in one way or the other made this doctoral study a success. Furthermore, I thank my colleagues, Dr. Ugwu Malachy, Dr. Charles Ndikum, and Dr. Kennedy Ongwae whose encouragements, and academic discussions energized this study success. Thanks to the ethical clearance committee staff in Abuja, Nigeria.

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Chapter 1: Introduction to the Study

The National Health Insurance Scheme (NHIS) was established in 2005 with the vision of providing healthcare coverage to citizens in Nigeria (NHIS, 2010). The system was created to alleviate expensive out-of-pocket fees to providers of healthcare and to ensure that healthcare services become accessible to all (NHIS, 2010). In the process of its policy window and implementations, NHIS did not include all demographics to its coverage, though in due process of its policies, it proclaimed inclusion of familial coverage for those employed by its stakeholders (Abdulraheem et al., 2012). Therefore, NHIS coverage excluded artisans, the unemployed, farmers, street vendors or market vendors, and many other rural entrepreneurs (Onyedibe, Goyit & Nnadi, 2012). Healthcare schemes in the sub-Sahara regions of Africa are consistently changing from nation to economies (Transparency International, 2010). These dynamic and structural changes in healthcare are consequential regarding government's ability to contain healthcare cost to impact the citizens' healthcare delivery. Healthcare costs increased because of the increase of the aging population, and technological advancement was challenged with high rise in unemployment rate, corrupt government, and poor accountability to healthcare in developing countries such as can be witnessed in Owerri, Nigeria (Ayinka, 2014).). To that effect, there was a great need for concern that healthcare requires affordability and to operate the system more efficiently in developing countries (Anyika, 2014).

Financial bribery and other corrupt practices, as well as an unreliable economy, pose a negative impact on the national healthcare system. Among most corrupt countries,

Nigeria is classified 10th position between 1998 and 2003, which impacted healthcare delivery (Ijewereme, 2013). Further assessment on corruption conducted by Transparency International (2010) espoused Nigeria healthcare management as impacted by a high scale of corruption (Mackey & Liang, 2012). Also, inefficient governance and nonaccountability of fund allocation towards the support of healthcare facilities and projects accounts for the finding of corruption of leadership and management in the sector are factors of corruption (Transparency International, 2012citation). It can be noted that corruption in many dimensions in Nigeria accounts for the near collapse of the healthcare system and access difficulty (Ogbeidi, 2012). The impoverished rural dwellers find it difficult to access healthcare owing to shortages in healthcare delivery as well as expensive out-of-pocket healthcare expenses due to the inefficient system for universal healthcare. NHIS currently has not included any policy programs that cover the healthcare for seniors (Etobe & Etobe, 2013). This study was aimed at advocacy for such policy recommendations which goal would to provide better healthcare services and care for the senior population in Nigeria.

Background

The healthcare system appears to be burdensome when addressing the healthcare needs of low-income earners and seniors. In this qualitative case study, the problem focus was how financial bribery and kickbacks affect the healthcare of seniors in Owerri, Nigeria. The NHIS goal that was supposed to alleviate the financial burden of healthcare for all citizens has proven to be unreachable and ineffective (Ijewereme, 2013). The prime role of NHIS was to monitor, regulate, administer, and ensure quality

implementations of the healthcare system (NHIS, 2010). NHIS was set up to provide proper care for the marginalized or disadvantaged in communities (Odeyemi & Nixon, 2013). About 46 million Nigerians are not supported or covered by NHIS (Joint Learning Network, 2016). Estimates from a 2012 poverty reduction study suggested that about 126 million out of the national population of 168.8 million people still live below poverty level with a daily income of 1.25 USD or N220.00 in Nigeria (World Bank, 2014). Several scholarly authors have explored and provided evidence on the pervasive nature of corruption and effects on the welfare and wellbeing of Nigerian population (Anazodo, Okoye, & Chukwuemeka, 2012; Nkom, 1982). The Nigerian position in the world were conceived as corrupt because of factors to include inefficient leadership and endemic systemic corruption. Consequently, the effect has been to hinder several of Nigeria's socio-economic developments (Imhonopi & Ugochukwu, 2013). Further, corruption's influence on the national employment rate has brought an increase in youth unemployment as recorded in an investigation by the Bureau of Statistics released in 2010 (Njoku & Okezie, 2011).

As is in several other sectors and agencies within federal and state levels, financial bribery and kickbacks are no longer considered hidden but practiced among public administrators and citizens as well (Waziri, 2010). Poor wages, irregularities in regulation and monitoring of corruption, uncertainty in healthcare, and rise in the employment rate are responsible for most of the underdevelopment and healthcare inefficiencies (NHIS, 2010). Statistics from the World Health Organization (2009) have signaled an alarming warning about the health condition of the nation. Global Life

expectancy rate in Nigeria has remained below average rating of 54 years (Transparency International, 2010). The recorded maternal mortality stands at 608 for every 1,000 live births, doubling the ratio of 300 for every 1,000 births in South Africa (Odeyemi & Nixon, 2013). The child mortality rate and sudden deaths of seniors in the emergency waiting and delivery rooms in the rural areas are a result of nonadequate preparedness, lack of medical equipment, shortage of health professionals, and even absenteeism (Ijewereme, 2013).

As can be regarded as a consensus of opinion among other federal and state agencies in Nigeria, corruption effects have become outrageous (Waziri, 2010). Corruption effects range from underdevelopment, infrastructural decay as in insufficient clean water and energy, misappropriation of the scarce national resources that led to high youth unemployment and increase in crime, low-quality education standard, and the large gap between the poor and the rich absent a middle class (Waziri, 2010). Owing to these deficiencies in the governance and inefficient leadership, formulation and implementation of public policies pose a risk based on the effect of deficiencies in policy implementation on national integrity, and how it enabled the rise in institutions' corruption rate and other government agencies (Idemudia, Cragg, & Best, 2010).

This background encompasses the many influences of corruption which according to Transparency International (2010) have resulted in the denial of significant access to healthcare services. Basic education on these issues ignites political upheavals and violence, threatens social destabilization through anger and poverty which in turn exacerbates internal conflicts and violent behaviors (Transparency International, 2012).

The Nigerian constitution amendment of 1999 condemned corruption and provided support for laws prohibiting political corruption and bribery (Ijewereme, 2015). However, political corruption persisted notwithstanding the constitutional amendments of 1999 (Ijewereme & Dunmade, 2014).

Problem Statement

Financial bribery and kickbacks in Nigeria have caused development crises in the healthcare improvement and management for seniors (Mohammed, 2013). The impact of corruption on healthcare services and delivery has reached immense scale as indicated by Transparency International (Mackey & Liang, 2012). Ineffective management and leadership by the legislators and administrators in the Ministry of Health reflect corrupt behaviors that have affected the healthcare development and the Millennium Development Goal (Akinbajo, 2012) in Owerri. Seniors in Owerri have been witnessing negligence and sudden deaths due to the inability to afford kickbacks and bribery to providers owing to high out-of-pocket pay for easy care access necessitated by NHIS (Etobe & Etobe, 2013). The consistent mortality rates among seniors, as well as the dilapidated state of hospitals and clinics, are as a result of corruption (for personal gain) among elected officials and healthcare administrators (Adémólá-Olátéjú, 2016). Management and leadership failure in the health sector is owing to corruption within the Ministry of Health and misappropriation of funds in the sector's development (Imhonopi & Ugochukwu, 2013). The consistent death rate among seniors in the state has raised an outcry due to denial of adequate care policies by the government (Shofoyeke & Amosun,

2014). There is a need for improvement in senior healthcare delivery by addressing poor management of the sector.

Corruption in the industry has manifested ineffectiveness, reduced quality services, poor hospital maintenance, and made health policies and provision of care ineffective (Husmann, 2011). The need to curb these systemic problems has become critical and requires control of informal payments in the form of financial bribery and kickbacks among providers, legislators, and consumers. The exercise of financial bribery and kickbacks in the sector can be understood in terms of Cohen's (2012) theory of informal payment which contended that in low-income countries, patients made payment for healthcare delivery under the table for easy access to care.

Purpose of the Study

The purpose of this qualitative case study was to investigate and explore in-depth how healthcare providers and policymakers within the three-tier healthcare system operation (federal, state, and local government) perceive the delivery of healthcare to seniors and the management of healthcare resources. The goal objective of the study was aimed towards improving the quality of life of the seniors and common citizens in Owerri, Nigeria. This region has been challenged with poor healthcare services due to unsatisfactory management and leadership in the industry (Chukwudozie, 2015). The influence of corruption on healthcare services and delivery has reached an immense scale as indicated by Transparency International (Mackey & Liang, 2012). By consolidating the perceptions and viewpoints of policy and health professionals, as well as gathering the perspectives of the seniors in Owerri, this exploratory case study enhanced the

possibilities for incorporation of ideas and outcomes from this study of opinions of healthcare policymakers and stakeholders in future policy frameworks in Owerri that could promote positive social change in the sector.

Further, the study focused on leadership's perceptions of the impacts of corruption and the elderly and seniors in Owerri locality ages between 55 and 65. The United Nations (2010) defined *seniors* as those aged 60 years and beyond while the Federal Government of Nigeria (2004) defined *elderly* as those that have reached age 65 years and above. The geographical location of Owerri was selected for this study due to its multiethnic mixed population that embraces all Nigerian ethnicities and other racial-ethnic diversity. The location comprises of low and high-income earners. This study's focus on leadership and management's perceptions of the mixed quality of healthcare among seniors should lead to assessments of causes, impacts, and unintended consequences of corruption and needed policy frameworks. Results should also reveal methods of improving equality in healthcare standards and opportunities, gender care equality, and wage equality in the sector.

Research Question

How do the state legislators and health administrators, and seniors in Owerri perceive the influence of financial bribery and kickbacks on senior healthcare development in Owerri?

Theoretical and Conceptual Frameworks

A healthcare policy framework requires defining policy issues or problems as a process through experience and some intuition rather than objective methodology. Root

cause analysis (RCA) will serve this study to form a structured theoretical framework to understand, analyze, and define the causes and effects of bribery and corruption upon the delivery of healthcare services to seniors (Fatima, 2011). These three components approach the problem of corruption from understanding why corruption is endemic in the Nigerian mainstream, and how to analyze the practices of bribery and kickbacks in both citizens and stewards in healthcare and policymakers in Owerri. This study was guided with a theoretical framework of understanding whether corruption stemmed from greed as a root cause, as well as whether the impact of low wages of health and human services providers might trigger public and organizational interest in accepting bribery and kickback for exchange of quality healthcare services to vulnerable seniors and the impoverished. RCA can guide multidisciplinary anti-corruption agencies such as the Independent Corrupt Practices Commission (ICPC) and Economic and Financial Crimes Commission (EFCC), during investigations on corrupt activities. Further, medical malpractices can be advanced in error check keeping with the RCA without evading accuracy and ethical policies in healthcare system. The use of RCAs within investigation agencies on corruption issues could serve as case study for specific errors and served as a guide to identify patterns of malpractices, behaviors, system changes and focus on a solution to such abnormal events in the investigated systems. As it relates to healthcare, the agenda configuration in policymaking requires that three objectives—problem identification, possible solutions and attached political environments—streamline together as an alignment which opens a policy window (Kingdon, 2011). This study employed these two theoretical frameworks to structure an argument and in-depth

investigation of the effects of bribery and corruption on the delivery of health services to seniors in Owerri and on how to improve healthcare delivery and policies.

RCA methodology was applied in a study of the U.S. healthcare system in 1999 (Fatima, 2011), and it can be applied to this study to understand ways and means of changing policy ideologies as relates to the senior healthcare protection plan in Nigeria's NHIS. The state regulation of drugs, monitoring, and service infrastructures was targeted areas for interviews and should lead to the identification of root cause(s) of corruption as well as considerations for improvement and development of programs (Okes, 2009). Chapter 2 provided clarity of understanding of the relationship between my study and previous studies on senior healthcare leadership and management within the NHIS protection plan development.

Shleifer and Vishny (1993) provided a conceptual framework that is applicable and complementary to the study phenomenon: that corruption would emerge as a by-product of practices, and interventions from government functionaries in a public system. They did not, however, consider the ways in which governmental corruption could adversely affect the provision of publicly funded services to its people through either bribery or kickbacks. Shleifer and Vishny contended that corruption could influence an increase in the price and lower drastically the level of services and output in an affected government. It could also impact the quality of public services. These conditions may trigger citizens to opt for private providers.

In the case of Nigeria, however, the cost of privately provided services in healthcare and education is higher, limited, and unattainable by the poor rural indigents.

Tendencies in rural healthcare include increased delays in receiving publicly funded services, congestion of the service system, an increased opportunity for rent-seeking bribery and kickback, and consistent or frequent utilization of discretionary power by administrators and officials (Odeyemi and Nixon, 2013). Shleifer and Vishny (1993) were suitable to analyze the influence of corruption on healthcare for seniors in the rural areas and to frame the ways in which legislators and health administrators in Owerri perceive the impact of kickbacks and bribery on the quality of lives and NHIS healthcare provisions among Owerri's poor seniors and impoverished rural residents.

Employing constructivism as an interpretive framework to illuminate meaning from data obtained from Shleifer and Vishny's (1993) theory into RCA framework to elaborate and provide a clearer understanding on the impacts of corruption in senior healthcare during interviews. Interviews provided more insight on the impact of how bribes were conducted, paid by clients to obtain healthcare services through government officials and administrators exercising the monopoly of public office or power to determine the quantity of output of services provided and arising to collusion. When government provided public services such as in healthcare are influenced by corrupt practices and projects for personal gain, this became critical for most of the population and thereby impacted the full realization of the government spending.

Corruption was identified as a barrier to economic development, healthcare and welfare growth associated with a country's level of involvement with the practice (Egweni & Monday, 2010; Transparency International, 2011; World Bank, 2013). Financial kickback and bribery as tools of corruption were characterized as the tempo of

leadership and governance traits in Nigeria (Mackey & Liang, 2012). As a hallmark of my research, the conceptual and theoretical frameworks I have chosen are postpositivist in application and emphasized the social constructivist context. Postpositivist theory is often used in research studies about how "corruption socially and culturally impacts the society's public system in the form of abuse of public office and resources" (Johnston, 1996, p. 331). The abuse of public office for private gains, whether legally or otherwise, impacts a society's public system, public role, and resources (Johnston, 1996). Corruption theory, as defined by Shleifer and Vishny (1993), fostered investigation in research to further understand how corruption, as a concept of abuse of public-provided services as in healthcare; private gain or interest; administration and politics; institutions and power; society and state; and shared interest among the bribed, and the client, are influenced within time and place. It was in the moment of these given encounters and interaction that permitted the conception of corruption that abuse of public integrity was manifested or discovered (Johnston, 1996).

Furthermore, the idealist theory was included in the conceptualization of corruption through explaining corruption from the perspective of selfish ideas in contrast to the moral values of the society and its systems (Anazodo et al., 2012; Nkom, 1982). Corruption influences culture, behaviors, and prevailing factors in the organization of the society (Anazodo et al., 2012; Nkom, 1982). Idealist theory provided clarity to the many concepts and variables that could be associated with this study. It is therefore important to examine and further elaborate on the following concepts.

Corruption (financial kickbacks and bribery) are factual components holding against every socioeconomic development in many African and developing countries. The corruption behavior of many elected Nigerian and other African leaders could be believed traceable from their colonial masters (Ogbeidi, 2012). Owing to this factor, financial kickbacks and bribery have grown deep into the Nigerian polity spreading out to several of its institutions, from healthcare to education, and down to financial mainstream of affairs (Ijewereme, 2015). Corruption is a complete ban to socioeconomic development and moral decadence that sets a nation in the dusk. Instances of such impact could be in areas of national security, infrastructural development investments, and social service development such as in education, healthcare, water supply, and electricity (Obuah, 2010). The effect of lack of transparency was as a result of corrupt administrators. Corruption behavior of Nigerian leaders and those in developing nations could be blamed as a result of low wages and poor worker incentives (Ademola, 2011).

Leadership and management form that helm of governance that could direct every internal and external control of resources and influence on national welfare (Waziri, 2010). A corrupt leadership led its people to poverty and misguided them with dishonesty, creating a lack of trust (Transparency international, 2012). Effective management, bound with efficient governance tend to promote a healthier nation, ensures citizens welfare and builds on long-term positive development (Ijewereme, 2015). Corrupt management of any institution becomes an impediment for development, and in the case of Nigeria, it has become critical the corrupt leadership behaviors have become a road block to the millennium development goals (MDGs) (Mensah, 2014). Corrupt

behavior of leadership and management was responsible ineffectiveness and collapses of first (1960-66), and second (1979-83) republics and holding reasons to the nation's oil which was attracted financial kickbacks and bribery of the most part (Obuah, 2010).

NHIS is the Nigerian federal government initiative designed to oversee and enforce universal health coverage (UHC) (Odeyemi & Nixon, 2013). The role of which comprises regulation, ensures equality and enforcement, monitors and administers equitable healthcare system up to the disadvantaged across the nation (NHIS, year). According to Odeyemi and Nixon (2013), the sector is operated within three subsectors:

- The formal sector social healthcare insurance program (FSHIP).
    - This is mainly for public employees surrounding national and state ministries and agencies.
- The urban self-employed social health insurance program (USSHIP)
    - This encompasses nonprofit organizations' health insurance which must reach about 500 members to maintain capability of reaching its financial enrollment;
- Rural communities are in involved with social health insurance program known as rural community social health insuranceprogram (RCSHIP)
    - RCSHIP can also be nonprofit but from a cohesive group of individuals and households, including community-based, faith-based and the nongovernment organizations (NGOs).

According to the Senate of Federal Republic of Nigeria (2008) the essence of the NHIS was to operate within the mission objective of the following:

1. To ensure that healthcare is accessible to all Nigerians. (
2. Alleviate and safeguard Nigerians from the burdensome medical financial in healthcare cost.
3. Streamline and stabilize healthcare service cost.
4. Ensure the sector's efficiency in service delivery.
5. Maintain equitable and affordable healthcare cost among all income levels and equal service delivery.
6. Ensure and maintain quality healthcare service delivery of the NHIS.
7. Harness and improve that NGOs inclusion in the sector providing service to its employees.
8. Maintain affordable and equal service delivery of healthcare equipment and supply across Nigeria.
9. Ensure adequate funding available to stakeholders and improved service delivery within the sector.

Equality in healthcare is to ensure that citizens access equal healthcare opportunity (Dike, 2010). Nigeria has created an unhealthy environment where a high degree of neglect from antenatal to labor care causing obstruction, medical malpractices, and severe infections (Mohammed, 2013). The inequality to care is blamed for the high cost of hospital user fees deterring seniors and women and the impoverished rural duelers from hospital emergencies, leading to high morbidity and mortality problems (World Databank, 2010). Besides, adequate and well-equipped health facilities, supplies and equipment, and health personnel pose a barrier to the most need of rural Nigeria, allowing

the wealthy opportunity to access adequate healthcare overseas and in urban areas (Federal Republic of Nigeria, 2011).

Policy issues includes policy concerns for fair and good governance (Odeyemi & Nixon, 2013). Nigeria, in its efforts to improve healthcare services and family planning and other healthcare-related issues, has not achieved its millennium development goal objectives (World Bank, 2013). As a result of poor implementation and inadequate power provided to states and local governments, healthcare policy frameworks have significantly suffered stagnant developments among funding, inadequate resources, and scarce access to implementing projected programs and services in their jurisdiction (Transparency Internationl, 2012). Based upon these policy challenges, the United States Aid (USAID) (2010), which is one of the funding organs in healthcare in developing countries, encouraged strengthening the ability of the Nigerian government and society stakeholders to ensure and foster efficient commitment among communities, institutions, and organizations through partnerships to ensure a successful and productive action on healthcare policies and funding. The Nigerian 2005 national policy for the sustainable development adopted policy was not effectively implemented and the targeted objectives of quality and improved standard of life for Nigerians, healthcare interventions, and other development strategies were not met (Transparency International, 2012). When policy frameworks are not implemented or become ineffective it affects the projected policy areas. Such has been the issue with the Nigerian polity and policy window. Therefore encouraging policies that may encourage fair and good governance would strengthen public officials, reduce corruption and improve quality healthcare service delivery.

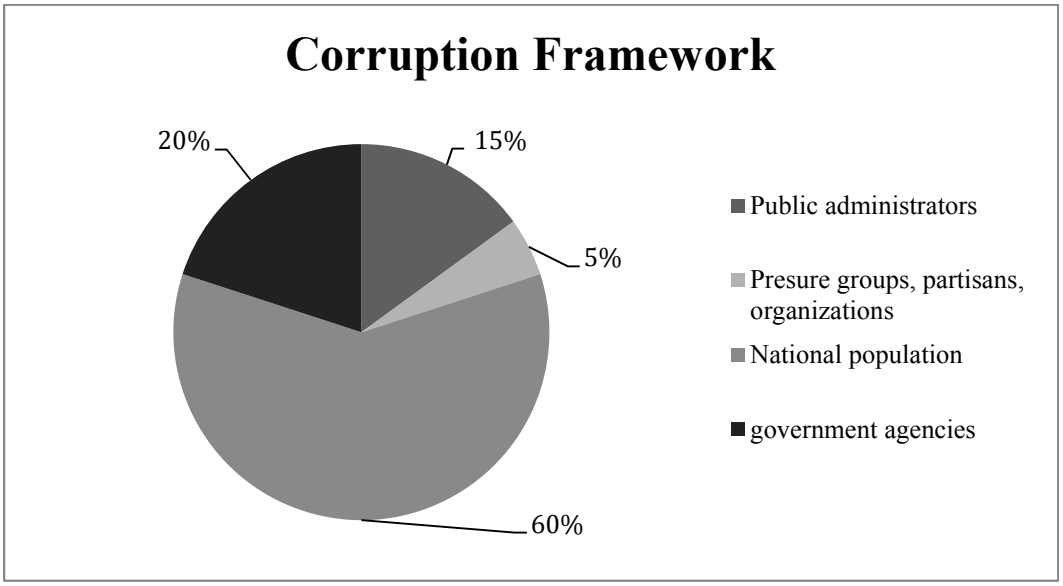

Figure 1. Corruption framework in Nigeria

Corruption affects healthcare development in Nigeria and can be viewed from the perspective of poor leadership and inefficient management in governance. Corruption is considered a pervasive problem in healthcare development and citizens' welfare due to the systemic corruption rate which has consequential impact on economic development (Arukwe, 2010). From the figures in the chart, the impact of corruption on national development and services reflects that about 60% of the national population is corrupt; government agencies represent 20%; public administrators account for 15% while pressure groups, partisans, and organizations maintain about 5% on corruption level (Arukwe, 2010). Development in all sectors in Nigeria has remained difficult and unrealizable because corruption has become the national norm (Oluwabamide, 2013). The conceptual framework for this study includes abuse of public office and resources (Anazodo et al., 2012; Nkom, 1982). This theory was used to explain that financial kickback and bribery tools are the root cause of the many of leadership and governance

failures which are orchestrated from greed by Nigeria's leaders towards development. Leadership in many public institutions in Nigeria is based on selfish ideas that bedevil the development of healthcare, education, and other public provided service delivery for private gain through financial bribery and kickbacks (Mostert et al., 2015). Petroleum Revenue and special Task Force have been recorded lost in a robbery of about 100 billion dollars by leaders and administrators (Ijewereme, 2015). The unethical behavior of Nigerian leaders can be considered from the viewpoint of looting of public resources, public office, and susceptibility to corruption of public providers and players of the delivery of services (Vian, Savedoff, & Mathisen, 2010). Egwemi and Monday (2010) further characterized the tendencies from this viewpoint by stating the following:

> Corruption practices in Nigeria has been incompatible to the country's millennium development plan. It distorts the set-aside resources for sectorial developments, concedes injustices, accommodates poverty, and a high crime rate. The epidemic is unfavorable for local and foreign investors, endangers societal welfare, development, promotes or encourages infrastructural decay and tensions on socio–economic and political crises, which leads to nationwide underdevelopment. (p. 164)

Corruption affects Nigeria's healthcare system in the same way it affects other institutions in the country. The impact reduces public welfare and promotes misappropriation, nepotism, bribery, embezzlement, and sets a negative impact on economic development, investment and its political process (World Bank, 2013). The abuse of power has been characterized as a result of a monopoly of services, and lack in

discretion, accountability, citizen's voice, transparency, and enforcement within the framework of leadership and management in the health sector (Waziri, 2010). Figure 2 is a presentation of the consequences of government control of healthcare system, where the entire system is monopolized by either the government or wealth-driven agents that make it difficult for citizens to make their own choice of healthcare provider.

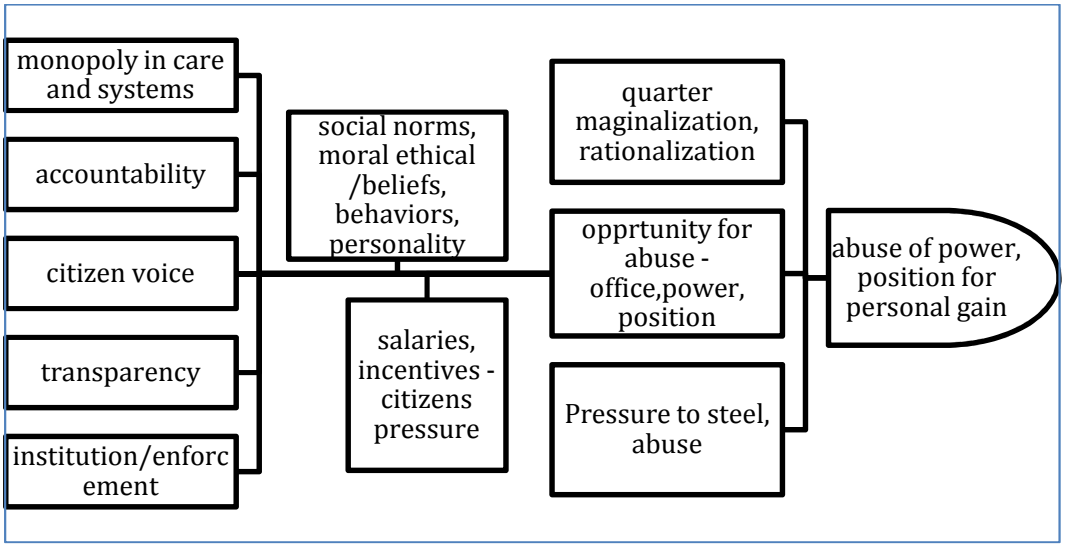

Figure 2. Corruption framework (adapted from Vian, Savedoff, & Mathisen, 2010)

The monopoly of the provision of public delivery of services can be detrimental to efficiency and can lead to corruption due solely to discretionary power in making decisions. Such is the case with healthcare delivery and in this way, monopoly creates the opportunity for corruption within the discretion of decision makers without accountability (Vian et al., 2010). The same way discretion refers to government's autonomy in becoming the sole decision maker in housing and health infrastructures, medicines, and service, contracting-healthcare administrators undertake decision making without general public meeting or involving the community (Mackey & Liang, 2012). These behaviors

allow corruption through taking of bribes and kickbacks, favoritism, and embezzlement of public funds (Tormusa & Idom, 2016). Lack of proper accountability has contributed immensely towards the rise in corruption level in Nigeria and, as such, has hampered healthcare development in rural areas (Waziri, 2013). When community initiatives and participation in the decision making of the affairs of the community are thwarted by government officials, there is the possibility of corruption (Ogundiya, 2012). Hence, denying citizens their voice and not following established rules of law is not only corruption but abuse of political power. There is a required need for checks and balances in the decision-making process to ensure balanced policy implementation and to maintain accountability in the management of resources in healthcare operation control (Vian et al., 2010). In so doing, transparency and enforcement of resources inventory and services could minimize collusion and health product diversion which can result in corruption.

Financial bribery and kickbacks can affect healthcare in several other areas. The contributing areas in healthcare system that can be affected are facilities, purchase of equipment or health products, the regulatory process and quality assurance, scientific research, and professional acquisition components (Vian et al., 2010). Table 1 shows healthcare areas and types of corruption.

Table 1

Types of Corruption and Results Effect on Nigeria Healthcare System (Vian et al., 2010)

Areas	Types of corruption	Results
Health facilities	Financial bribery and kickbacks within the political spectrum of management and leadership influencing the contractual process and lack of accountability	Low-quality and inflated cost of construction of facilities that is not suitable and durable
Purchases such as equipment and healthcare products	Bribery and kickbacks through political influence and lack of referral for proposal procedures which accommodate collusion and creation of opportunities for counterfeit drugs and unethical diversion of supplies for private gain	High and inflated cost of supplies and/or medical equipment with funds diverted to contractors and health administrators
Regulatory process and quality assurance	Bribery to evade quality and sanitary standards of the equipment or product through speedy processes without proper inspection of regulatory procedures or measurements	Enabling low-quality and fake medications which may poison consumers as well as other risks which endanger the health of citizens
Scientific and medical research	Influence by lobbyists through bribery and kickback to evade national specification of drug control measures and to favor political and legislative specifications or guidelines on healthcare products	Hampers effective and efficient research education and evidence-based results, and encourages bias in research and trustworthiness
Health professionals	Bribery and kickbacks to acquire professional positions, to obtain certificates for practice, with a diversion of earmarked funds	Low-quality of services due to inefficiency result in unmet needs in the sector, an increase in patient deaths, and excessive government loss in investment

Nature of the Study

The qualitative exploratory methodology is a complex research approach and used purposefully to unveil complex phenomena and gain an in-depth understanding of a multifaceted and understudied problem (Denzin & Lincoln, 2001). Qualitative inquiries gain data through interviews, observation, and investigation to gain more knowledge (Leedy & Ormrod, 2005; Yin, 2012). The study involved qualitative interviews with eight to ten seniors, five healthcare administrators, and five public policy administrators in Owerri. To understand the effect of financial bribery and kickbacks on senior healthcare, I used open-ended questions to conduct interviews with the participants and used an exploratory paradigm to buttress correlations and themes bounded by the principle that the phenomena have intricate relativity to several coincident actions which makes understanding them require broad knowledge of contexts—temporal, or spatial—political, historical, cultural, personal, social, and economic (Stake, 2010). I employed constructivism as an interpretive framework to illuminate meaning on Shleifer and Vishny's (1993) theory and enabled place data into the RCA framework to provide clearer insight on the impacts of corruption in senior healthcare during interviews. The justification for using a qualitative, exploratory case study approach yielded a nuanced understanding of policymakers' and health administrators' and seniors' perceptions of the effect of corruption on senior healthcare improvement and development. Conversely, employing a quantitative method would require a deductive method of testing theories, challenging, and replication (Creswell, 2013). Therefore, quantitative design was not

appropriate for this research work because this study did not require close-ended questions of a quantitative approach (Christensen, Horn, & Johnson, 2011).

The case study was essential to this research to gain an understanding of very complex and interwoven social phenomena; case study approach enables researchers to conserve a holistic and true meaning of the participant's life experiences (Yin, 2012). The researcher, therefore, is required to inquire into that which is common and particular to the research study or case. This includes in-depth and careful consideration about the nature of the phenomena (senior healthcare policy, administration, future development, and availability of healthcare to seniors), physical setting, historical background, political contextual inclinations, and other institutions (Stake, 1998). The case study was an appropriate design considering the studied population, a setting in Owerri, and political involvement of policymakers and practitioners in healthcare decision making.

Definitions

Several terms used in this study require concise and clear definitions to provide such clarity to the meaning attached to this study which ensured proper understanding of this study context.

Corruption (financial bribery and kickbacks). Corruption was perceived in several meanings and term of usage. Though there is no distinct definition for corruption, systemic corruption as relates to the health sector is the impediment in accomplishing the long-term millennium goals which debilitate set structures and health services (Holmberg & Rothstein, 2010). Cohen (2012) defined kickbacks and bribery as a theory of informal payments. Transparency International (2009) noted that financial kickbacks and bribery

are conceived to be corrupt behaviors where bureaucrats misappropriate or divert national resources, or the misuse of their vested power for personal.

Governance. This concept refers to all processes and procedures of governing, which can be utilized by government, formal or informal organization, network or market, organizations, whether over a tribe, people, family, groups, region and through the legislation, rules, tradition, language, and power (Bevir, 2013). In a more complex form, governance is composed of all processes of decision making and interactions among involved actors regarding a collective phenomenon that results in the creation, propagation of social rules, or reinforcement and institutions (Hufty, 2011).

Leadership. Leadership is the process of influencing groups or followers towards the accomplishment of its goals (Roach & Behling, 1984). According to Bass and Bass (2008) "Leadership is about the behavior that fosters the combinations of cognitions, opportunities, perceptions of threats, risk preferences and analyses" (p. 43). Leadership is whole effort to inspire trust in and provide believing support to followers or people needed in the achievement of organizational goals (DuBrin, 2012).

Management. Management focuses on improving the present, looking inward, mindfulness, controls, coordinating, directing and planning the work of others, and the ability to bear responsibility for outcome or results (Hellriegel & Slocum, 2010).

National Health Insurance Scheme (NHIS). NHIS is an embodiment of legislative Act852 established to ensure an implementation of health policies that can encourage citizens' access to primary healthcare needs and services in located areas of operation (NHIS, 2012).

Public policy. A dynamic, complex and interactive approach through which public problems can be identified as well as countered by reinforcing and creating new or existing public policies bound by constitutions, legislative acts, regulations, and institutions that facilitate and coordinate the effective decision making and persuade to achieve its goals (John, 2013).

Root Cause Analysis (RCA). This is a structured theoretical framework which guides for an understanding, to analyze serious negative events, and define the cause and effects of the studied phenomenon (Fatima, 2011).

Senior. The chronological age between 55 and 65 years is attributed to the elderly or older persons (WHO, 2015). In Nigerian context, the chronological change in social role and change in capabilities ranges from 65 years of age and becomes decreasingly weak, multifaceted, pensionable, and increasingly relating to their health status, depending on the region, setting and country (Etobe & Etobe, 2013). Seniors needed to be between 55-65 years old to participate in this study.

Symptom. This is an outward indication of an internal change or condition or sign of undesirable situation of something different from its normality or morality. Such abnormality can be attributed to a change that indicates that something bad exists (Merriam-Webster's Collegiate Dictionary, 1999).

Assumptions

This study may appear to have a philosophical conflict between the underlying conceptual framework and the research method of choice. This study is supported with conceptual framework of Kingdon (2011) policy streams theory, and Fatima (2011)

theory of RCA which was complimented with Shleifer and Vishny (1993) that described corruption as by-product of government functionaries. I assumed that these frameworks were sufficient to guide and underpin this study design, approach, data gathering and analysis, results, and the study's contribution to positive social change. Nonetheless from an ontological point of view, the framework, and perhaps the researcher's bias seems to be following a realist approach. The realist approach rejects logical positivist epistemology and has the tendency to guide the researcher towards a single truth that cannot be changed (Schwandt, 2014). If the truth is stating that corruption is bad, then the method of the study would naturally follow an etic epistemological approach and try to find out by conductive reasoning that all the harm that is cause by corruption.

To neutralize this inherent bias, I choseto implement an emic epistemological approach of inductive reasoning through taking an interview-based data collection approach that would use me an instrument of data collection in the field setting. I assumed that this axiological tangent would allow me to distance my bias from the data collected from the perspective of the participants. I am assumedthat this approach would allow the results to define the local values of the participants and help me view the emerging values relative to the realist approach of the underlying framework. To achieve this goal, I assumed that I would be able to create a distinction between the values derived from the stories of the participants, and the data resulting from the scholar's observations. According to Olivier de Sardan (2015), making a distinction between the local discourse and the scholarly discourse is more valuable than mixing the two dissertations.

From the practical aspect of data collection, I assumed that the chosen key informant interviewees as major source of primary data. The informants lived in Owerri for at least 5 years and have perceived lived experiences that may contribute to the study investigation. I assumed that study participants would provide honest responses, willingly respond, and use their best ability to participate throughout the study interviews. Also, I assumed that the participants' responses were dependent on their perception, lived experiences, and depended on how much they could be able to share from the reflection of their past experiences. Moreover, when I analyzed participant responses for thematic purposes, generalized data yielded overall patterns that could be usedin the formulation of modest healthcare services and delivery that may best serve the peoples need in Owerri.

Some of the participants were key providers and involved in the implementation of healthcare policy involved in this study. Furthermore, it was assumed that the study participants may not look at the study as evaluation of their job accomplishment as that could lead to bias or influence their opinion. Therefore, it was anticipated that they would provide sincere responses as well as remain objective to ensure the study credibility.

I assumed that the result of the study would properly reflects healthcare situations for Owerri inhabitants and ease access to affordable healthcare services. Also, the results may reduce financial bribery and kickbacks and provide data that may be useful for the development of healthcare model that may serve the Owerri residents' need as described by the study participants. Furthermore, I anticipated that the data gathered from this study result would be helpful to the healthcare system and providers in Owerri. Assumptions in

this study may be considered limitation since I employed small sample size of the study population for data collection in this study.

The above assumptions are limitations to the study that is relatively controlled and at same time assumed to be basic and credible (see Leedy & Ormrod, 2010). Hence the small sample size would have not represented the generality of the whole population and their lived experiences. As a result of the study small sample size, participant opinions or responses cannot be overweighed than basic or generalize overall findings to the general Owerri population. This study therefore, serves as an initiative to gain understanding of the conditions attached to residents' perceptions, experiences about healthcare financial bribery and kickbacks, access to affordable senior healthcare delivery and services, and be able to meets the need of the people of rural Owerri in the development of affordable healthcare and for further studies about the study phenomena.

Scope and Delimitations

The scope of this study was confined to its geopolitical context, demographic confinement, and social economic poverty owing to health challenges among its aging population. Furthermore, the scope of the study was the extrinsic need for extension of healthcare delivery service, financial and social support, accountability, policy objectives, and effective governance of leadership and management that has been eroded with corruption and ethical decadence. The study is confined to interviews to investigate the perceptions of nine seniors, three legislators, and three healthcare administrators on how corruption influences public policy and quality of services in rural Owerri.

Study participants were selected from the healthcare sector in Owerri and state legislature who have accrued 2 or more years of experience and understand the influence of financial bribery and kickbacks on public policy and service delivery, and seniors from Owerri City or community district who demonstrate the ability to understand the study phenomenon. Seniors willing to participate were selected from the Owerri community district center where I remained in direct communication to ensure that the recruitment form was appropriately coordinated. All study participants were selected through their voluntary willingness to take part in the study and agreed to maintain a constant presence during the scheduled interview study. The study results served in sustaining the policy window objectives and empowered effective leadership and management in the sector. Results also served for encouraging the rebuilding of ethical and moral relationships between consumers and the healthcare officials and fostered fairness and equality in the healthcare service delivery to the seniors in Owerri.

Limitations

While the results from this study may apply to enhance the leadership and management in the sector, they might not be applicable to other agencies due to the geographical context of the studied location of the study participants and the evolution of their ethnic and cultural values, coupled with the varied tenets of the population, age, ecological texture, philosophy, and practices within the region. A limitation of the study could be biased in information given. Study participants remained unbiased in the provision of information. I made every attempt to maintain an unbiased position in the interpretation of data and information provided by study participants. Interviews

employed simple words and English language that was easily understood by participants to support the fulfillment of this qualitative case study analysis. To ensure validity in this study, I encouraged participants who provided honest information and data in the interviews without fear of reprisal.

Significance of the Study

The significance of this qualitative case study was to document the views of healthcare providers and policymakers and seniors in Owerri on how and why corruption influences NHIS policy failed to provide healthcare coverage for all citizens or exemption for senior healthcare. Approximately 46 million Nigerians are not supported or covered (NHIS, 2016). This includes seniors, poor families, and average Nigerians not covered by the protection plan or who do not have access to quality healthcare in Owerri but are bound to "exorbitant out-of-pocket healthcare payments" (Gustafsson-Wright & Schellekens, 2013, p. 9). An additional factor was the absence of the senior programs and services in Nigeria due to the corrupt practices of governing officials and health administrators (Etobe & Etobe, 2013). The findings should lead to policy initiatives that encourage establishment and reform in the NHIS protection plan to accommodate seniors and to significantly reduce payments currently being made by poor families. Further, the findings provided insight into policy agendas and pathways that encourages rehabilitation of care facilities, programs, ease of access, and rethinking of well-equipped recreation for seniors.

The conceptual and theoretical frameworks in this study usedthe RCA, publicly provided services, and problem identification as a critical investigation to the

phenomenon. The result may ensure an effective and efficient service delivery in healthcare sector. NHIS was established through the federal government with a fundamental purpose of adopting UHC for all citizens. This was to make high-quality healthcare affordable and accessible to all citizens and to provide protection from all catastrophic financial difficulties associated with care (Dutta & Hongoro, 2013). Between 1998 and 2003, Transparency International corruption perception index (CPI) rated Nigeria among 10 most corrupt nations (Anyika, 2014).

Cumulatively, these factors have posed a tremendous challenge to average citizens and seniors as well as low-income health workers. Through this study, I aimed to gather expert opinions on how identified problems could be alleviated with well-designed healthcare policies. Also, it may alleviate blocks on healthcare development and delivery systems brought about by corruption and bribery. The intent was to provide reflections and gather data from Owerri legislators and healthcare administrators and seniors which was helpful for improving public healthcare systems; the establishment of senior healthcare facilities and senior recreation and programs; health worker wage increase; development of scientific training centers; and to provide insight and suggestions that may encourage corrupt behavior changes in the public institutions and healthcare sector. In this study, I collected expert opinions that enabled better evaluation of the effects of corruption on healthcare development in the sector and in Owerri.

Summary and Transition

The healthcare sector in Nigeria has operational and implementation process for citizens in the 32 states of the Federal Republic of Nigeria. However, the many citizens in

the rural areas are not covered nor do they have access to healthcare services owing to the corruption of leadership and management. Approximately 46 million Nigerians are not supported or covered by the NHIS services (NHIS, 2016). The effect of corruption in the healthcare sector in the delivery of its health products has recorded immense scale as indicated by Transparency International (Mackey & Liang, 2012). Ineffective management and leadership failure in the health sector has contributed to corruption practices within the Ministry of Health, and misappropriation of funds in the sector's development (Imhonopi & Ugochukwu, 2013). The constant premature death rate among poor seniors in the state has raised an outcry due to denial of adequate care policies by the government (Shofoyeke & Amosun, 2014). In this study, I explored the basic understandings of legislators and management in Owerri city and state health sector perceived the impact of bribery and kickbacks on the people to whom they are entrusted to provide services.

This research study focused and explored the problem using the theory of RCA and Kingdon's multiple streams framework to understand the influence of corruption on the price of a public provided service and to proffer suggestions through purposive interviews of the study participants in the Owerri city and state health department. The results of these interviews were useful for the formulation of efficient policies, and strategies for policy implementation in the sector. Outcomes of the study encouraged changes to the behavior of financial bribery and kickbacks that have decomposed an endemic healthcare situation in Owerri. The positive social change objectives of this study are to ensure that the outcome result of the study may provide social change

foundation for future healthcare development, provided insight to public policy agents, and encouraged the realization of long-term change in the sector.

The result of this study may go as far as encouraging positive social change by reaching the administrators and health providers. Further, the study may provide clearer insight into the leadership failures in the sector which have been responsible for the many predicaments and healthcare pitfalls in Owerri and many other national institutions (Ijewereme & Dunmade, 2014). Management and potential healthcare policy options were identified and encouraged change in implementation and procedures. The outcome of this study provided in-depth understanding and insight into the root cause of corruption through financial bribery and kickbacks and suggested the best leadership and management strategic skill developments that could encourage training, innovations, practices and professional ethics for a more successful healthcare system for seniors and those living in poverty.

Chapter 2 is an analysis the research literature analysis relevant to this study. That included a thorough overview of both the theory of RCA and corruption's influence on price and effects on quality of health delivery. Furthermore, I detail the agenda configuration in policymaking, which requires three significant objectives: problem identification, possible solutions, and attached political environments—streamlined together as an alignment while addressing corruption, leadership, and management. Chapter 3 presented the research methodology, sampling, data collection, and analysis process.

Chapter 2: Literature Review

This qualitative constructivist case study served to understand how financial bribery and kickbacks influence the healthcare public policy and the sector's management of health delivery services in Owerri, Nigeria. This chapter connected the problem statement, theoretical and conceptual frameworks, and the research problem as was presented previously in Chapter 1 with a clear identification of the gap identified in the literature. The study presented as its first two components in the literature review analysis the theoretical framework of RCA (Fatima, 2011) and the multiple streams policy making and configuration (Kingdon, 2011). Problem identification in healthcare encouraged efficient policy formation within the Owerri legislative environment that could monitor financial bribery and kickbacks tendencies and may ensure possible changes in leadership and management behavior in the health sector. Sources of literature on corruption in the healthcare development were analyzed which consisted of the following: NHIS database, the government database, healthcare administrators and managers in healthcare sector, peer-reviewed articles, and internal and external funders' databases.

Literature Search Strategy

The literature review for this research was conducted utilizing many sources of information to enhance knowledge of the study population and health systems. Corruption information was accessed using *financial bribery and kickback* as the root cause of the problem inquiries. Other search terms in the study such as *NHIS, seniors, governance, leadership,* and *management* were included to narrow down the study search

tools and strategies. From the articles found using the search strategies, a review of a previous author's references was employed into the study research to find more keywords when a general search did not provide adequate information. Overall, the primary source of information was researched to obtain in-depth information on the study. The Nigerian Government database on NHIS was utilized for the research. The Walden University library was useful and provided several of the needed peer-reviewed articles for this review. Furthermore, the World Health Organization, Transparency International, and several other international journals databases such as *Google Scholar, ProQuest,* and *World Cat* were used to search for information and articles related to the impact of corruption on the healthcare system and economic development in Owerri and Nigeria in relation to senior healthcare.

Theoretical Foundation

Healthcare policy is confounded with several issues that require defining policy issues or problems as a process through research participant experience and concerned intuition rather than objective methodology. I used RCA to form a theoretical framework that enabled an understanding, analysis, and defined the cause and effects of the studied phenomenon (see Fatima, 2011). The focus of RCA is situated within the ability to identify causes and emerging effects for any problems or negative outcomes in an institution or sector (Reason, 2000).

This structured method can be essential to systemic failures and adverse events such as in corruption in healthcare. This theoretical method was essential in identifying several underlying issues likelihood in errors which was important to avoid trapping of

individual mistakes but focused on latent errors in complex systems. RCA was useful for investigation protocol which began with data collection and to ease reconstruction in the event of questioning and recorded reviews for clarity of errors in participant interviews and for quality assurance purposes. RCA can guide multidisciplinary corruption monitoring programs, independent corrupt practices commission (ICPC); and economic and financial crimes commission (EFCC), during corruption investigations (Waziri, 2010). Further, medical malpractices can be advanced in error check keeping with the RCA without evading accuracy and ethical policies in healthcare system (Reason, 2000). The use of RCAs within investigation agencies on corruption issues could serve as case study for specific errors and serve as a guide to identify patterns of malpractices, behaviors, system changes and focus on the solution to such abnormal events in the investigated systems. RCA originated in the Japanese auto industry to synergize and identify production problems in the sector in 1950 (Fatima, 2011). As was practiced in Japan auto industry, a reactionary analysis was used to discover what problem the roadblock was analyzing (safety, auto productivity, to systems based analysis in the auto industr and found ways of solving the primary problem and prevented it from reoccurring (Fatima, 2011). RCA was resourceful to effectively differentiate between root causes of auto industry problem and range of effects which provided insight to define the primary cause and to determine a solvable action to the problem.

Corruption can be considered a fundamental factor in healthcare sector which causes most parts of the many healthcare institutions or departments to be ineffective (Ogundiya, 2012). In this perspective, allocated scarce resources proposed for investment

are wasted through financial bribery and kickbacks and affect the welfare and health of citizens (Tormusa & Idom, 2016). As it relates to healthcare, the agenda configuration in policymaking requires that three objectives—problem identification, possible solutions, and attached political environments—streamlines together as an alignment which opens a policy window (Kingdon, 2011). This study employed these policy theory frameworks to build an argument and in-depth investigation of the study problem on how to improve healthcare delivery and policies for seniors.

RCA methodology was applied in the United States healthcare system in 1999 (Fatima, 2011), and was used in healthcare in the U.S. medical institute to address complex adverse outcome in patient safety, preventable care errors, resulting in deaths and preventable diseases from human errors, and in industries (Institute of Medicine, 2009) and was included as preferred mechanism in healthcare and risk management. I used this as a guide to understand ways and means of changing policy ideologies as relates to the healthcare protection plan in Nigeria's NHIS for seniors.

Three basic criteria were regarded as functional mechanism while investigating negative events with questions: (a) Would certain problems have happened if the cause of corruption was not the case? (b) Will problem reoccur if its causes of corruption are not corrected or avoided? (c) Would similar or related problems happen again if the cause(s) was corrected or even eliminated? These analysisquestions served to probe, to identify, state, model and define the problem, helped to find a solvable solution on corruption such as greed and selfishness, insurance fraud, inequality, poor treatment, fake drugs and dispensary, education, and poverty. Also, a symptom of the root causes of the social issue

could be helpful strategies to problem identification of corruption in the system. Such symptoms were poor patient care, high cost of insurance, starvation and poverty, sudden deaths in emergency rooms, random emergency visits, healthcare worker's low wages, cost of healthcare, transportation issues and rural electrification and unqualified practitioner. Understanding the root causes of corruption and recognizing its effect to the community and healthcare consumers, finding suggestions on solvable measures to eliminate the problem would enhance positive result in efficient service delivery and policy formulation. Also, this could reinforce institutions or NHIS towards thinking critically on tackling any identified problems rather than effects.

This methodology might lead to the formulation of efficient policies that can effectively solve problems as relates to the principal root cause of corruption or, as Gano (2011) suggested, "caused by" (i.e. greed or selfishness) after identifying the primary root cause of the problem. Productivity in healthcare service, though intangible, will be increased by reducing the primary cause of corruption and improve efficiency in service and profitability through preventive measures in the form of a policy framework. The state regulation of drugs, monitoring, and service infrastructures were targeted areas during interviews and led to the identification of root cause(s) of corruption as well as considerations for improvement and development of programs (Okes, 2009). Public administrators and legislators could focus on policy mechanisms that are bounded with transparency, accountability and fair equality in services that could ensure positive healthcare outcome for seniors and rural development.

Understanding the primary root cause of abuse interrelated to why people prefer to abuse public office and national resources for their private gain, and how their actions affect the lives of people they represent would provide insight to modelling the problem for easy identification and definition. It would enable positive and critical thinking on what policies that can be made to monitor corrupt behavior resulting from bribery and kickback of the agents. By employing such a theoretical approach as RCA, production of effective and efficient intangible service delivery of healthcare products became universally accessible to the impoverished community (Ijewereme & Dunmade, 2014). Enhancing an accountable and transparent public funded healthcare delivery without agents of financial bribery and kickbacks could boost productivity in service delivery. Providing healthcare workers good pay standing, have access to suitable housing, good transportation system, constant electricity within the rural areas, quality education and benefits and entitlements (programs) that can eradicate poverty gap between the poor and the elite or rich, reducing the inducement or pressure of citizens on administrators and legislators to accept bribe for treatment or services (Abdulraheem, Olapipo, & Amodu, 2012), all these are necessary criteria for achieving a solvable action in rural healthcare. Corruption could be monitored, measured, and even curtailed through effective policy frameworks with stringent implementation in the healthcare system that could yield well desired patient senior and rural care outcome.

Conceptual Framework: Corruption Influence in Healthcare

Corruption has become the consequential blame for socioeconomic development failures in Nigeria and an endemic threat to the global health result outcome that has led

to waste of financial resources and is responsible for the tremendous negative health consequences (Arukwe, 2010; Egweni & Monday, 2010; Mackey &Liang, 2012). Healthcare system corruption within the domestic and rural levels in Nigeria poses a serious impact to community health development efforts of Owerri scarce-resource environments and provisional growing economy. Financial bribery and kickbacks in the health sector drain resources causing scarcity in healthcare allocation for the already poor rural dwellers and other fragile health sectors, as well as hindering access to pertinent life-saving care for seniors and the most vulnerable (Holmberg & Rothstein, 2010; Mackey & Liang, 2012). Holmberg and Rothstein (2010) reported survey results suggesting that 80% of individuals from the developing nations have in one way or the other experienced healthcare sector corruption which thereby impacted the poor who have little or no resources. Ensuring that allocated funds for rural healthcare development is maintained in the rural areas may enhance rural quality healthcare and ease access to health care for the rural dwellers. In an effort to reduce the magnitude of corruption in the sector, the government must focus in the reduction of poverty, infrastructural development and the inability of political and public offices encourage ethical without consistent perception on financial bribery and kickbacks. In so doing will enhance the ability to utilize public funding towards its earmarked projects, adopt policies that could encourage constructive ideology on how to improve quality life for all. The constructivist perspective of the events of corruption in Nigeria is a remaining of an unyielding attitude, willed towards self-aggrandizement through traditional loyalties in luxurious gifts, and

parochial protectionism of ones kinship from the justice system (Anazodo, Okoye & Ezenwile, 2012).. Add summary and synthesis to fully conclude the paragraph.

Corruption has been vigorously defined from several perspectives. The phenomenon has accounted extensively for development decline in various communities and has been explored with special attention and reviewed by scholars (Dike, 2010; Ijewereme, 2013; Obuah, 2010; Ogbeidi, 2012) who have accorded it varied definitions. The World Bank's chapter, International Corruption Hunters Alliance (ICHA), maintained that its integrity was focused to understand corruption as any offenses towards giving, offering, receiving or the solicitation of any values intended to influence improperly those actions of another party (World Bank, 2013). The above definition supports the World Bank corruption definition which condemns the behavior as "abuse of public office for private gain" (World Bank, 1997, p. 8). Several studies defined corruption as either systemic or political corruption which consisted of abuse of public office for personal interest as a form of bribery and kickback or giving and receiving which interrupts or violates regulations (Egweni & Monday, 2010; Ijewereme, 2013; Obuah, 2010; Waziri, 2010). It is widely understood among researchers that corruption encompasses graft, undue influence through acceptance of extravagant gifts, embezzlement, private gains through awarding of business or contracts by public officials to family members, cronies, bribery and kickbacks, misappropriation and diversion of public resources or funds for personal gain (Ijewereme, 2013). The influence of bribe seeking and giving exists among citizens who are loyalties to public officers which encourages corruption. Therefore, setting out parameters that can control and minimize

corruption may require vetting on educating the people against corruption of bribe seeking and giving. Hence, the axiomatic perception here is that the attitude of depending on natural resources which includes oil, and gas tend to be slow in growth. Such slow pace in growth leads to poverty and thereby having impact on the rural development and its healthcare development as has been witnessed in southeast of Nigeria and some parts of the north (Otaha, 2012).

In Nigeria, corruption has hampered the healthcare development and resulted in dilapidated hospitals and infrastructures, youth poverty, encouraged cluelessness and mediocrity in professional conduct and leadership, and is responsible for the falling quality of education (Ademola, 2011). It has created the effect of a continuing gap between the rich and poor (Waziri, 2010). These effects of systemic corruption have contributed to the hopelessness among seniors and community members who find it difficult to access healthcare and who circumvent fake medications by bribing the health administrators to obtain contracts to supply low-quality medications and even fake medications in exchange for private gain (Garuba, Kohler, & Huisman, 2009). The control of medication inflow in the Nigerian markets and the healthcare sector require a firm regulatory board capable of investigating loopholes, corrupt persons that go contrary to the regulatory rules that guide importation and sell of medications. Provide more protection and coverage for medications, prescriptions and ensure that the rural community have available resources that can sustain their healthcare needs. That will also improve infrastructures, develop research centers and improve in the uality of life of the rural areas. The NHIS in its levy on out-of-pocket fees for healthcare remains regressive

among informal and rural areas while remained progressive among the informal sector (Odeyemi & Nixon, 2013). The belief is that the government has it as responsibility to provide health coverage for all of its citizens. A negative impact of expensive out-of-pocket cost of healthcare includes purchase of medication and other related services in the sector which makes it difficult for rural dwellers live in denial of fair healthcare and delays in accessing quality healthcare (Folland, Goodman & Stano, 2010).

Despite the war against corruption by the several past administrations, an Okigbo panel was set in the third Republic of the Nigerian by a military coup leader who investigated the defunct military leader and the central bank governor in their frivolous spending and siphoning of national treasury (Anazodo et al., 2012; Ijewereme & Dunmade, 2014). However, there is a distinction between these studies and the scope of this study which focuses on how financial bribery and kickbacks generally impact seniors and poor rural dwellers in the Nigerian society without effective health policies, using root cause analysis to identify possible solutions. Ogundiya (2012) asserted that corruption in the fourth Republic has become a norm among government personnel with the desire for embezzlement and diverting contracts to enrich their personal gain. According to the World Health Organization (2010), the healthcare sector was identified as an attractive target for corruption practices. In the United States, there is a yearly record of $5.2 trillion as healthcare services expenditure, including pharmaceutical cost of about 750 billion in U.S. dollar value. (Mackey & Liang, 2012) TI estimated about 27% of the publicly procured expenditure were the international aid, NHIS recorded a mismanaged cost of healthcare to corruption (WHO, 2010). Consequently, to above-

estimated result, the World Health Organization further noted that corruption is blamed for having negatively impacted access to and the quality of healthcare in a threefold manner:

- Healthcare has been affected with deficiencies in government ability toward the provision of fair care access to good and universal health services and medical infrastructures. Due to bribery to government officials, counterfeit medications and fake healthcare products have flourished in the markets and health centers.
- Economic factors hold it that low-income nations have been recorded as the hardest hit with corruption. Pharmaceutical corruption may be represented with about 5% of their national health costs amounting to detrimental impact to the economy.
- "Trust in the face of corruption in healthcare becomes abuse and lacking transparency which adversely reduces credibility of public institutions, and otherwise erodes donor and public confidence in the government" (Mostert, Sitaresmi, Njuguna, Van Beers, & Kaspers, 2012, p. 325).

In comparison to other developing economies, Indonesia's economy has manifested a triple positive increment over the past 20 years utilizing its oil revenue in development projects in improving its healthcare, education, and agriculture (Otaha, 2012). During the same time, Nigeria's position in the world oil producing countries has been engulfed with corrupt practices within its bureaucratic embodiment and systems. Such atrocities have set its rural projects at a standstill and increased infrastructural decay (Anazodo et al., 2012). The health sector has been influenced by the endemic corruption.

This “cancer” rips the sector’s performance, implementation of Policies and diversion of set funds to provide primary healthcare to the rural communities. A survey conducted by the National Demographic Health Survey (NDHS) in 2009 indicated that above 83% of women from urban areas in comparison to about 45% from local communities were provided standard prenatal services delivery from their care providers (Oluwabamide, 2013). From the above survey result, it can be deduced that there was a failure in the healthcare delivery scale since 70% of the rural inhabitants are existed in the rural areas due to a diversion of earmarked funds to develop rural health facilities for private gain or pockets.

There has been very noticeable corruption in the way health facilities, personnel, funds, and care services have been distributed across the country. From the survey, the number of healthcare personnel:

- Owerri with population figure 401,873 in 2006 has been allocated N4, 289,244,075 (Federal Ministry of Health, 2016).
- Yaba Lagos received N726, 311, 410 (Federal Ministry of Health, 2016).
- Kastina received N534, 239,710 (Federal Ministry of Health, 2016).
- Sokoto awarded N6, 021,089,164 (Federal Ministry of Health, 2016).
- Abakiliki N8, 552,833,657 (Federal Ministry of Health, 2016).

On the contrary, State funding of healthcare has undermined several of the communities including Owerri in providing funds for the well-equipping of projects for healthcare infrastructures to ensure quality care and services. The effect of this appears as inequality. Imo State University of technology hospital had experienced poor funding by

the state government (Uzoechi, 2014). Ijewereme (2013) argued that the looting of earmarked health development funds in 2007 by the Minister for Health contributed to the pitfalls in sustainable health development in rural Nigeria. Unfortunately, certain programs designed to combat corruption such as ICPC and EFCC became ineffective and Transparency International ranked Nigeria 32nd among its 147 surveyed nations in the world in 2007 due to high levels in political corruption (Eme & Okoh, 2011; Ijewereme, 2013). The RCA theory becomes essential to finding causes of the underdevelopment in women. It can be understood from the account that a low number of treatment centers health services and utilizes Kingdon's (2011) theory of problem identification, solution formulation and policy window initiative to identify changes needed in Owerri. This can be achieved by encouraging governments and healthcare providers to establish structural education and promotion of transparency monitoring procedures that will include community leaders and independent auditors on corruption activities. Enforcing continuous training of anti-corruption awareness and healthcare behaviors would be imperative for all actors.

Leadership and Management

Elected officials and administrators can utilize their office discretion to abuse power through corrupt practices in awarding practicing licenses, accreditation of health facilities, health products, use of services which results in the abuse of power, and national resources for their private gain (Tormusa & Idom, 2016). Also, leadership can be best defined as the process through which groups of people are being influenced by an individual in an effort of accomplishing the set goal or organizational mission

(Northouse, 2010). Though leadership and management appear similar but differ from each other, both co-exist in the influencing of people. Both are required and concerned for the accomplishment of common vision, goal, and social change. The fact that leadership can be a two-way processor interactive event, which deals with either side being positively or negatively influenced by the other, makes the process nonlinear in structure. Hence, the leadership and management concept in this study holds that in the healthcare sector, leadership negatively influences followers and coercively impacts citizens. Ethically, leaders in this sector lack ethical influence that can yield positive results (Agbor, 2012). An ascending level of corruption has been witnessed among Nigeria's leaders, affecting the health sector as was noted in the EFCC scrutiny of health minister, senator, and deputy for misappropriation of earmarked allocations to the health ministry during the present fourth Republic (Agbor, 2012). The view of management and governance within the Nigerian leadership perspective has been strongly researched in scholarly literature (Agbor, 2012; Ezirim, 2010) and suggested that the country has been plagued by poor leadership.

Such view can be asserted that there is leadership crisis coupled with inexorable corruption phenomena; however, incompetent management and difficulties in operation (such as in low rates of enrollment in public health insurance) also reveal a lack of clear legislation within policy formulation and implementation. That resulted in exaggerated expenses, insufficient control, and measures for effective and efficient risk management which continued to impact NHIS (De Allegri, Sauerborn, Kouyaté, & Flessa, 2009). These outcomes within the Nigeria style of management and governance rest on extreme

ethical decadence deprived of moral standards and attitudinal debauchery (Ogundiya, 2009).

Akinnaso (2014) suggested that there were prevalent difficulties in efficient and effective healthcare delivery policy implementations at the state level given the height of corruption among healthcare officials and legislators. Furthermore, Matsheza, Timilsina, and Arutyunova (2011) indirectly addressed corruption in terms of bribery and kickbacks but maintained that besides the corruption of embezzlement of funds, Nigerian health workers partake in a high standard of absenteeism. Such behavior can lead to low-quality of healthcare delivery and low volume of service delivery, though healthcare workers may not assume their action is corruption but rather the result of low wages brought about by higher-level corruption. Corruption at the leadership and management level of healthcare delivery, however, has witnessed levels of embezzlement, private gain, bribery, and kickbacks. The ethical and moral decadence caused by negligence and the gap between the poor and the rich has been stretched by poor governance.

Hadi (2015) condemned the state of healthcare centers in the rural areas and commented that primary healthcare centers were flooded with expired drugs and cobwebs and in a state of structural breakdown. World Health Organization (WHO) indices analyzed that Nigeria's budgetary expenditures at all levels for healthcare have created a substantial record of poor health services and with less than 5% of its national budget set-aside for healthcare, despite its signatory to commit 15 % in the year 2000 Abuja Declaration to increase healthcare (WHO, 2010). The United Nations Development Program (UNDP) (2011) noted that informal payments among healthcare providers as a

form of bribery for providing of medical and other service delivery occur most frequently in low-income nations, resulting in barriers to providing healthcare services for patients with less or no resources for care cost as has happened in rural Nigeria (De Jaegere & Finley, 2009; UNDP, 2011). Corruption has directly impacted the poor rural population through the denial of affordable access to health insurance and hence jeopardizes opportunities and hope in health delivery (UNDP, 2011).

National Health Insurance Scheme

NHIS has been the leading national insurance provider for healthcare in Nigeria since its inception in 2005. Leadership and governance in the NHIS has been committed to providing service coverage to civil servants without spreading coverage to the overall millions of citizens without health coverage. The agency has not recorded many improvements to amplify its considered vision of operation and set up objectives: to alleviate out-of-pocket expenses, universal health coverage (UHC), was considered one of the poorest and worst health indicators (Gustafsson-Wright & Schellekens, 2013). Nigeria has had an estimated 2.5% rise in population (since 2005- 2010), and in 2012 recorded about 168.8 million, making it the most populous African country.

Estimates from World Bank indicated that the health indicators for Nigeria within the past decade have either worsened or stagnated, notwithstanding Nigeria's federal government efforts to improve the sector (World Bank, 2012). The corruption impact in Nigeria are outrageous and accounted to underdevelopment, poverty, poor housing, polluted water, polluted environmental sanitation, and malnutrition due to unbalanced food, inefficient leadership outputs, rural unemployment, and hopelessness. Rural

residents in Nigeria suffer critical health conditions and tend to underuse primary healthcare (PHC) services as a result of poor quality and service inadequacy (Waziri, 2010). Most of the needs and problems encountered by rural dwellers in Nigeria are multifactorial and require effective multidisciplinary interventions (Abdulraheem et al., 2012; Abiodun, 2010). The overall health condition in Nigeria has been such that in 1990 only 39 % and in 2004 only 44 percent, had access to healthcare and improved sanitation, while from 1990-1992, and 2002 -2004, 13% and 9% of Nigerians respectively were recorded as malnourished (UNDP, 2008). National Health Insurance Scheme (1999) was established for the provision of healthcare coverage for Nigerians in the formal sector with focus on federal civil servants, ministries, agencies, parastatals, and those involved in the extra-ministerial levels, providing outpatient and inpatient services for themselves and including their families and siblings under 18 years of age (Akande, Salaudeen, & Babatunde, 2011). In lieu of the inabilities of NHIS to provide healthcare and primary health coverage to all Nigerians, the extent to which NHIS coverage is limited is that the sector does not provide health coverage to artisans, sole proprietors, farmers, the unemployed, or local street vendors in rural areas (Onyedibe et al., 2012). There is a wide gap in the quality of healthcare provision designed for rich from the poor. In 2010 when NHIS recommended the rural community social health insurance program (RCSHIP), enrolment was allowed for only employees from formal ministerial sectors (Gustafsson-Wright & Schellekens, 2013).

The creation of health funds earmarked for the year 2013 through a 2% health tax on luxurious goods was proposed to include coverage for a vast majority of the seniors

from age 65, inmates, children under 5, pregnant women, and indigent persons. It remains at a low pace and unaccounted (Agba, Ushie, & Osuchukwu, 2010; Akande et al., 2011; Gustaffsson-Wright & Schellekens, 2013; Onyedibe et al., 2012). Despite the challenges of the poor rural inhabitants in Nigeria, the state government has not responded to their outcry or contributed significantly towards expanding health insurance in the rural areas (Asoka, 2012). Dutta and Hongoro (2013) and Gustaffsson-Wright and Schellekens (2013) asserted that the health programs and NHIS are required to be evaluated periodically and monitored in their activities. NHIS policies are to be re-assessed to ensure that the Universal healthcare (which is a prime goal of NHIS) to comprehensively improve longevity especially for the poor rural dwellers through quality healthcare insurance and infrastructures (Dutta & Hongoro, 2013). This has not happened. Primary healthcare (PHC) currently serves only 20% of the population as opposed to its plan to be the bedrock of Nigeria's healthcare policy (Abdulraheem et al., 2012).

Other factors affecting NHIS efficacy in Nigerian rural areas are strongly identified as poor healthcare facilities, lack of awareness, lack of retention of medical professionals, and inadequate funding (Agba et al., 2010; Sanusi & Awe, 2009). The NHIS is obstructed by inadequate and obsolete healthcare equipment for healthcare service providers. As a result of corruption networking of government and health agents, Nigeria suffers from reoccurring shortages of modern and technological medical equipment suited to millennial care such as radiographic testing tools, diagnostic scanners, well-equipped facilities, and sustainable energy to ensure durable storage and laboratories for medical research results and record keeping (Johnson & Stoskopt, 2009;

Oba, 2009). Several challenges confronting the NHIS are inequality in the process line of supply of healthcare services and infrastructures among urban and local environments, as well as associated inconsistencies in the policy framework. Poverty and lack of education on pre-pay related healthcare services have remained core challenges to the accomplishment of the millennial goal of NHIS (Omoruan, Bamidele, & Philips, 2009; NCBI, 2009; Schellekens, 2009).

Equality

Nigeria has witnessed high inequality level which hinders healthcare development and economic growth. NHIS was formed in 2005 with the impression of providing universal health coverage to the millions of citizens of Nigeria. There is a huge distinctive inequality between the urban and rural settlements regarding the provision of primary healthcare to the settlements (Ademiluyi & Aluko-Arowolo, 2009). There has been marginalization in the management of healthcare centers in the rural areas. The approach has become desolate, and the accessibility of healthcare has become difficult in local areas as compared to cities. Morbidity and prevention in mortality cases in Owerri is an example of such factor owing to inequality in the sector. Equality in the delivery of health services in Nigeria has been influenced by leadership failures, non-effective policy, and implementation of processes to safeguard health services delivery.

The result is that Nigerians in the rural areas have been denied quality healthcare. Literature has noted that between the years 2005 and 2012, there was an increase in the Nigerian human development indicators (HDI) value from 0.434 to 0.471, approximately a 1.2% annual incremental rise (Human Development Report, 2013). Politicians and

administrators, however, travel abroad for medical services (Eneji, Juliana, & Onabe, 2013), whereas the poor citizens and the elderly search for healthcare services in their localities and fail to access care. This poses a more significant widening of the inequality in the sector which makes it impossible for equal distribution of healthcare service. Such actions widen the opportunity for financial kickback and bribery in the sector. Funds allocated for economic development, social welfare development, and healthcare have been utilized by the few high-profile persons in power for their interest. WHO (2010) recommended a mandated list of regulatory, financial, educational, and supportive services to enhance the promotion of healthcare workers in the rural areas. The intention was to provide and ensure that healthcare services reach the rural areas in Nigeria and to support, train, and regulate services and policies.

There is a dialectical issue when discussing equality in the Nigerian context. Although the 1999 Constitution of the Federal Republic of Nigeria Sections 15(2) condemned discrimination within the specifics of sex or gender, the Laws provided by customary and religious institutions restricted women's rights (Constitution of Nigeria, 1999). These laws vary from one state to the other and from one religion to another. The geopolitical dimension of Owerri is a majority of Christians with one fundamental customary law but discretionary in community interpretations and implementations. The economic status of this geopolitical location is mostly farming, trade, and fishing. Daily living in its rural areas has proven that the greatest blockage or factor hindering citizens from accessibility to healthcare is the prevalent poverty rate in Nigeria. Poverty alone could prevent an individual who lives close to a health facility from accessing healthcare

due to his or her inability to afford costs of the healthcare. Hence, it is perceived that access to healthcare depends not only on the distance one can travel to access a health facility. At the same time, physical distance can be understood as some kind of hindrance, the access to healthcare encompasses socio-economic, geographic and socio-cultural factors which determines important roles players regarding healthcare accessibility in certain nations (Mensah, 2014). Equal access to healthcare for all citizens and inhabitants who need care requires economic and political attribution and input (Qidwai, Ashfaq, & Khoja, 2011). Within this perspective, the inhabitants in the rural areas of Nigeria, including Owerri, do not have enough resources to maintain sustainable economic power to attain affordable healthcare. Financial support that the local government might render to the locality is very low compared to the urban inhabitants and their economic and political input to healthcare.

It is important to underscore that the economic power of a nation has some pivotal role and impact upon the financing of healthcare for its people (Olakunde, 2012). The NHIS coverage package did not comprehensively include the unemployed or seniors unrelated to someone employed by one of the NHIS stakeholders. Olakunde (2012) was adamant when he stated that the prime wealth of any country is its health. The situation in Nigeria's rural areas tends to account for the World Bank assessment survey in 2010 that about 62% of Nigerians continue to live below the daily income of $1.25 (World Bank, 2014). However, Nigeria took an active part in the 1985 convention on the elimination of all forms of discrimination against women (CEDAW). In the Sub Sahara Africa, equal right for women were ratified in 2005 as a protocol within the African Charter on Human

and Peoples' Rights (Africa Union, 2010). As is practiced in most advanced countries and societies, progressive healthcare budgeting and financing operate in an environment that the richer pay more from the proportion of their income through health taxation than the poor proportion of the population (Carapinha, Ross-Degnan, Desta, & Wagner, 2014). Corruption, however, has invaded the healthcare system and other institutions in Nigeria. In contrast, as practiced in Russia, the established healthcare system is compulsory, and funding is solely generated from taxation (Rao, Petrosyan, Araujo, & McIntyre, 2014). Employing this proven model in Nigeria could be effective but may only be functional if the persistent challenges confronting the national Nigerian taxation system in the form of endemic corruption, inefficiency, policy deficiencies, inaccessibility of tax records, and unaccountability of revenue from national resources could be overcome (Micah, Ebere, & Umobong, 2012).

Having delved into the specifics of equality problems in Nigeria and particularly Owerri, the demographic and health survey (DHS) of 2008 revealed high numbers in the mortality rate of males' under-five as compared to females though does not indicate elements of bias in the early childhood of boys. The Global Health Initiative accounted the Nigerian government with coordination of USAID to enhance human resources to improve health, high impact service delivery, leadership and management strengthening objectives, governance, ensuring accountability for program ownership, and enhancement of sustainability (United States Aid, 2016). The intent is to apply measures and control of the funds and their implementation to ensure equality in service delivery and effective leadership and management in the healthcare sector due to poverty and consistent corrupt

practices in the sector. The problems do not exclude previous operational deficiencies such as incompetent management, lack of clearer legislation within the policy window in healthcare, unaccounted expenses, and lack of measures for to control fraudulent intents which continue to derail the scheme (De Allegri et al., 2009).

These commitments to equality and equity were known to both legislators and healthcare administrators interviewed in this study, and was perhaps a stance from which they reflected upon the need to ensure equity in healthcare for all. Notwithstanding the rich resources with which Nigeria is endowed, the government has failed in many facets of healthcare, development plans, and policies regarding the many social issues facing citizens and the country's development goals. Social problems such as inequality, insecurity, unemployment, corruption, illiteracy, and quality education are part of the ill effects of poor governance (Oluwabamide, 2013). Factors such as socio-economic status, poor living conditions among seniors, increased isolation and lack of networking affect both rural and senior access to quality healthcare (Schmitt, Sands, Weiss, Dowling, & Covinsky, 2010; Shiovitz-Ezra, 2010).

Policy Issues

Due to the threats and challenges, the population faces owing to healthcare corruption, positive and effective health policy solutions should be required and explored by the government (Mackey & Liang, 2012). Nigeria operates the most expensive out-of-pocket healthcare spending while at the same time is noted for the poorest health indicators among all nations (Gustafsson-Wright & Schellekens, 2013). Nigerian health policy was formulated and drafted in 1997, signed into law in 1999, and in June 2005 was

launched as an implementation. The intention was for providing universal, comprehensive health coverage that would ensure affordable cost to formal sector employees, the self-employed, rural citizens, and Nigeria's indigent population (Onyedibe et al., 2012). A Transparency International (TI) (2010) reported on global corruption report of 2006 recommended that measurable policies are essential in the fight against healthcare sector domestic corruption via institutional reforms and individual state-based legal measurable models which include allocation, auditing, monitoring, tools for tracking health expenditure, and a reformed code of conduct and rules that can effectively increase transparency and ethics (TI, 2010). However, Babayemi (2012) argued that part of the challenges the healthcare system in Nigeria faces is the lack of scientific and evidence-based research in planning and policy making. Effective policy objectives were aimed to focus on how to realize Universal Healthcare (UHC) and pertinently related to how and where to raise funds for healthcare; how to overcome its related financial barriers that may exclude several sectors of the poor from access to healthcare delivery services; and identifying measures for providing equitable and efficient healthcare services. Such policies included health financing policies, management policies, and Plan for Health Improvement Strategies (2010-2015) (Lawanson, Olaniyan, & Soyibo, 2013). The vision to these policies and plan are to ensure that there are sufficient and substantial resources in the sector and earmarked towards the up-keeping of efficient, affordable, equitable healthcare and consumption.

The framework of policies on health expenditure and financing was formulated by National Health Ministry to accommodate these policy frameworks in 2006 (Obansa, &

Orimisan, 2013). Other policy frameworks include the Community-Based Health Insurance (CBHI) policy designed to enhance healthcare accessibility to people living in rural areas who cannot access adequate public and private, or employer coverage (Uzochukwu Onwujekwe, Soludo, Nkoli, & Uguru, 2011). Deficiencies encountered from this particular policy which affects residents in rural Owerri appear to threaten their financial ability to reach health services. The policy procedure and insurance were affected by lack of community trust on the scheme management; and lack of attractiveness in health coverage, quality, and affordability of proposed healthcare (Onoka, Onwujekwe, Hanson, & Uzochukwu, 2011). The community dwellers in rural Owerri and other Southeast Nigerians view CBHI as retrogressive and insufficient, thereby entrenching enrollment and implementation.

Furthermore, the out-of-pocket package of the NHIS, which serves as user fees within the point of service, covers about 70% of the healthcare service payment for Nigeria's federal and state employees and their families including an incremental increase from year to year (Onwujekwe, Hanson, Uzochukwu, Ichoku, Ike, & Onwughalu, 2010). In 2007, private expenditure increased from 92.7% to 95.9%. An average household in Owerri or the Southeast spends almost half of their earning to attain health services and 15% of the residents from the Southeast, Owerri inclusive have experienced catastrophic consequences, reducing them to aggravated poverty and health malady (Onwujekwe, Hanson, Uzochukwu, Ichoku, Ike, & Onwughalu, 2010).

WHO (2015) noted that the majority of poor people living in the rural areas of Nigeria that are not covered by NHIS insurance and are unable to afford out- of –pocket

health bills are at a higher risk of mortality when challenged with easily treatable and preventable illnesses or diseases such as malaria. Odeyemi and Nixon (2013) reported that from their study conducted in 2013, it was observed that after Nigeria's NHIS structure was compared with Ghana's- both countries having the same middle-income, respectively, and having launched NHIS during the same period—Ghana, recorded a high margin decline in out- of –pocket expenditures since inception in 2004 from 80% to 66%. In the same period, Nigeria recorded a high margin in out-of-pocket expenditures from 93% to 95% during the period from 2000 to 2010. Access to healthcare in Nigeria's rural areas for seniors and the poor, uninsured, unemployed, and even artisans is difficult, and healthcare services delivery remains very low as a result of expensive mandated out-of-pocket expenses (Amaghionyeodiwe, 2009). Ichoku, Fonta, and Ataguba (2013) maintained that despite the several donors and agencies that provide health funding assistance and other numerous services within the different levels of the Nigerian government, federal and state health ministries, local primary healthcare, including private and nonprofit organizations, the cost of healthcare remains unrealizable for the majority of the poor rural people. Odeyemi and Nixon (2013) and Micah et al. (2012) affirmed that the NHIS structure in Nigeria is regressive as opposed to progressive owing to its adverse effect and due to its inherent health inequality emanating from expensive finance related –insurance rather than the richer paying more in healthcare taxes than the poor. The poor people who are also considered to be a majority of the population in Nigeria find healthcare cost unaffordable as a result of high cost of quality health services (World Bank, 2014). The gap in the literature and the scope of the study is the impact of

corruption on healthcare for the Owerri rural seniors and the poor. Onwujekwe et al. (2010) contended that between the narrow scope in coverage provided by the NHIS and the unfair payment policy associated with private insurance programs, the poor rural indigenes are challenged with impossible affordability or are excluded from coverage.

The United Nations Council on rural healthcare development has taken the stance that health is an important human right and should be attainable by everyone. Notwithstanding, setting the conditions for healthcare attainability in Nigeria rests on the federal government. The rising costs in healthcare require an increase in the public funds allocated for healthcare through compelled prepayment that can ensure efficient and effective methods for achieving universal healthcare coverage through taxation of the general public based on income in terms of risk-polling. This study investigated whether or not such a policy window could work or become effectively operative in Nigeria if the challenges in the form of endemic corruption and unaccountability faced by healthcare and many other sectors are strategized through massive efforts to enforce health insurance as compulsory policy as in the US and the UK (Amanda, 2015; Micah et al., 2012; WHO, 2010).

Summary

Financial bribery and kickbacks are characteristics and types of corruption that have engulfed and remained endemic to Nigeria's socio-economic development. As a result of high corruption occurrences in every sector in Nigeria, both the main mechanisms and resources that would have enhanced development for the entire country

are bypassed for personal gains (Diara & Onah, 2014). These effects can be traceable to single individuals, households, and community levels concerning the negative effects of corruption on the citizen's welfare and health. These negative effects have attracted both domestic and international attention, even from healthcare donors, about the impacts and how corruption can be monitored, combatted and avoided (Hadi, 2015). Furthermore, to ensure proper efficient and effective healthcare delivery services in rural Owerri and other localities, there is the need for mobilization and the distribution of resources, process information, and motivation of health providers to efficiently serve the ideals of national development and good governance (Tormusa & Idom, 2016).

There are considerable fundamental knowledge gaps identified in the literature review that this research study addressed. First, the impact of corruption on the behavior or ethical standard of delivery of healthcare services has not been studied in as much as it affects the welfare of rural indigenes from the perspective of root cause analysis theory, particularly as regards healthcare administrators' and state legislators' corrupt practices which demonstrated a negligence of office and citizens' wellbeing.

Second, while the existing literature acknowledged the effects of corruption in socio-economic development, including healthcare, there has not been sufficient focus on policy windows or on the identification of the causes of financial bribery, kickbacks, and other corruption practices; solutions to the corruption issues; or strategic ways to reform policies that can cover gaps in the existing healthcare policies to avoid and combat tactfully the influence of corruption and monitor its actors within government and the public.

Third, although the research literature has delved into corruption monitoring programs, the ICPC of 1979, EFCC, including other corruption-based and fraud monitoring bodies, the rise in corruption has continued without any successful outcome since corruption has deeply penetrated the entire society's governing organs. It is taken for granted among Nigerians that accepting official responsibilities for their private gain is the norm. Existing studies have delved into corruption effects, yet these typologies of corruption left a wide gap by not emphasizing the root causes of corruption and measures or solutions for controlling it. Hence, the previous EFCC leader noted that more than $400 billion was robbed by Nigerian leaders from Nigeria in 2008, and argued that this amounted to six times a total value in funds commissioned after cold war to rebuild European communities" (Ademola, 2011, p. 312).

This study addressed the importance and intersection of these three knowledge gaps and provided valuable insight for the formulation of policies that can:

- encouraged behavior changes, improve healthcare delivery,
- encouraged wage increase to reduce absenteeism of healthcare providers, and
- instilled professional ethical standards among administrators and legislators in the discernment of duties or services to the citizens in the state of Owerri.

This study further probed the interviewees for relevant and more effective policies that could be framed towards the enhancement of the aforementioned variables, as increasing awareness on the importance public policy interest or need may alleviate income inequalities, poverty, and corrupt practices. Long-term policies that could

enhance technological advancement in healthcare and infrastructural development could be a progressive way to enhance stepping up of funding on healthcare and educational sectors to enhance the growth of the domestic economic goals. Long-term policies may boost both the domestic economy and reduce the high poverty level to align with the Millennium Development Goals (MDGs).

In Chapter 3, the research design was elaborated and presented. The role of the researcher was expressed and discussed. Research methodology was presented in detail to allow study replication. The chapter included issues of trustworthiness, credibility, conformability, and ethical concerns in the conduct of the study were reviewed and examined.

Chapter 3: Research Method

The purpose of this qualitative case study was to gather in-depth knowledge on how healthcare providers and policymakers and seniors within the three-tier healthcare system operation (federal, state, and local government) perceive the delivery of healthcare to seniors and the management of healthcare resources. This chapter was describes the research process for this study. The research design is presented and the role of the researcher is discussed in detail. Furthermore, the methodology employed in this study was described in such a way that it could be replicated. Tools for analysis and methodology follows, as well as an examination of the study quality and trustworthiness with focus on validity, dependability, confirmability, and reliability. A thorough examination of the ethical dimensions of the study was concluded in the chapter.

Research Design and Rationale

As previously emphasized in Chapter 1, the research question for this study was: How do the state legislators, health administrators, and seniors in Owerri perceive the influence of financial bribery and kickbacks on senior healthcare development in Owerri. The study used a central research phenomenon of this study as financial bribery and kickbacks and the phenomena's influence on healthcare public policy in Owerri, Nigeria. Among the corruption, influences are the impact of corruption on the behavior or ethical standard of delivery of healthcare services, the identification of the causes of financial bribery, kickbacks, and other corruption practices. The intent of this study was to gather knowledge that suggests solutions to the corruption issues or to suggest strategic ways to reform policies that can cover gaps in the existing healthcare policies. The intent of this

study was also to avoid and combat the influence of corruption to encourage healthier community and foster positive social change for long-term economic development. This study used Fatima's (2011) RCA and Kingdon's (2011) three objectives of agenda configuration in policymaking (problem identification, possible solutions, and attached political environments) that, when aligned, could open or develop a policy window. The use of root cause analysis in the investigation of the core beliefs of why administrators and healthcare providers concede and partake in bribery and kickback from patients and clients would be helpful for policymakers. An additional benefit may be the ability to apply policy strategies that could cover loopholes in the healthcare policy, improve quality healthcare products and boost productivity, which will potentially help control corruption practices in the system.

This study employed qualitative exploratory case study methodology. This methodology was chosen because of its flexibility and suitability for an in-depth exploration of a complex social phenomenon (Creswell, 2009; Maxwell, 2013; Yin, 2012). The study explored real-life experiences of the study participants in real time to enable collection of in-depth descriptive data to enable the identification of emerging themes (Creswell, 2013). I further made use of the exploratory approach to buttress correlations and themes bounded by the principle that the phenomena have intricate relativity to several coincident actions which require a broad knowledge of contexts: temporal, spatial, political, historical, cultural, personal, social, and economic (see Stake, 2010).

Another important and critical concern for employing the qualitative case study methodology in this study was for a careful analysis of the validity and potential bias within the exploratory phase to ensure that the corruption variables are explained adequately and critically reviewed (Grant & Booth, 2009; Yin, 2009, 2012). Critical review served as an appropriate assessment for this study's quality in the literature analysis which involved conceptual innovations and description of analysis. To enable an interactive process in the study, a qualitative case study best fits this research due to its exploratory nature. The methodology provided flexibility to adjust while the study took place and made possible the incorporation of emergent data (Maxwell, 2013).

The qualitative case study strategy provided several meaningful benefits for this study. The procedure was inductively viewed alongside with emerging questions during data gathering from potential participants. This involved analyzing data evolving from single to emerging themes within concepts. The process was enabled thorough interpretations and enhanced validation and confirmed the reliability of data outcome in the study (see Creswell, 2013). Interacting with study participants regarding their experiences on the corrupt practices that hinder healthcare development and delivery of services to the seniors in rural Owerri enabled me to understand and explore in-depth the causes of the study phenomenon. I considered data within the study environment in a real world where the topic was crucial, observed participant's behavior, and made it possible to examine the data outcome from reports and documents that enhanced the credibility of the study (see Morse, 2011; Yin, 2014). While legislators and health administrators in Owerri city, state, and local areas could be responsible for the financial bribery and

kickbacks that obstruct inequality of healthcare delivery and corruption influence, a case study on this phenomenon intends to provide clearer insight for legislators as healthcare policymakers and administrators.

Before delving into the study with case study strength, three other strategies were evaluated for this study. Grounded theory was a strong contender but was not considered because of its focus on belief, feelings, values, and exploring study participants' ideologies rather than the study phenomenon (see Creswell, 2013). Phenomenology and ethnography were not appropriate for the study. Qualitative case study strength explores and explains in-depth the gain in knowledge of this study from participants.

Role of the Researcher

The researcher in qualitative exploratory methodologies is identified as the "research instrument" (Maxwell, 2012, p. 79). Therefore, I participated in designing the research data collection tools, obtained detailed data from study participants, and analyzed the data collected. This study incorporated both personal and the extension of practical knowledge development within the studied environment.

As a Nigerian, I grew up in Imo State and attended high school in Owerri. I have good knowledge of the geographical, demographical, customs, and tradition of how affairs in healthcare was operated. I have a clear understanding of senior health circumstances, behaviors that can be considered corrupt, activities that can be regarded exploitative from public administrators, and when seniors exaggerate their opinions on issues of service delivery. This enabled me the opportunity to consult a community leader to help in the introduction process at participant recruitment locations for this study. The

community leader walked me to the community organization center and churches and introduced me to the people. After brief introduction of the study topic and procedures, participants were informed that anyone that is interested to participate in the study could volunteer to participate. The potential participants were identified, provided study location, and time of the meeting. This process continued until 18 to 20 maximum participants were identified and selected for the interview.

I have extensive experience living and interacting with seniors during intermittent visits to local neighborhoods. I have engaged with seniors during medical missions in neighboring rural towns of Owerri and Mbaise. These experiences offered me an advantage and ability to respectfully ask seniors questions and engaged in follow up that enabled me to explore concepts and themes. That interaction also helped me to gain more knowledge about the beliefs and perceptions of seniors, the administrators, and legislators about what they may felt influenced corruption in healthcare.

The rapport that I developed with seniors, public administrators and legislators in the community enabled my research toyield positive awareness in healthcare. I developed the data collection tools, open-ended questions, and created probing questions as a method of follow up. Data collection took place through conducting 45-minute interviews and 20-minute follow up meetings and transcribing data from the interview recordings.

Following are situations or factors that contribute to researcher bias because the function researcher occupies in displaying the instrumentation (Pannucci & Wilkins, 2010):

- Researcher's inadequately preparedness to conduct field study;

- The background and experience of the researcher may influence data collection and its analysis might be a threat towards true data representation;
- Researcher's proficiency with the studied phenomenon and the population may impact the profundity in analysis and participant's curiosity about research studied phenomenon.

My self-strong belief of having trained in public policy and administration, mindfulness, and my familiarity with the constituency, people, healthcare system, behavior and the interview environment help minimize any of my biases in this research study. My passion with seniors and the Owerri indigenes contributed to my interest in this research topic and contributed to my zeal to reduction in corruption on healthcare, a reduction in out-of-pocket expenses for seniors; improve quality of healthcare for residents and the poor. I have no affiliation with NHIS, or healthcare administrators in Owerri, but hope that my opinion and suggestions about the reduction on the influence of financial bribery and kickbacks in Owerri, Nigeria could also affect the trustworthiness of data collection and analysis including the selection of participants. To ensure objectivity in data collection and analysis, I felt that I kept my personal belief out of the conversation without sharing personal opinions. I kept personal opinions, feelings, and beliefs from the interviewees throughout the study process.

Participants were free to provide information and utilize the designed approach for the study, and those who choose not to participate had no repercussions for their decision and free to withdraw. The study environment of Owerri as my birthplace provided me the benefit of depth background knowledge, added to my knowledge of the

study phenomenon, and allowed me to control any bias that I already had. Thus, this led me to apply triangulation which enabled me to reduce any effects of possible bias during participant selection. I asked the interviewees to cross-check data interpretation, used peer-review to ensure accuracy, and bias reduction techniques in the interview process. I maintained and remained neutral as an observer, and collector of data by keeping a journal with daily entries along with field notes.

Methodology

This section serves to describe the methodology that I applied in this research study and provides detailed information for rigorous analysis. Detailed information on the selection process of participants was discussed. This section provides information about data sources, sample size, procedures for the collection of data, and steps of analysis.

Participant Selection Logic

In this study, I focused on exploring how healthcare providers and policymakers within a three-tier healthcare system operation (federal, state, and local government) in Owerri perceive the delivery of healthcare to seniors. Significant attention was directed to the management of the sectors' resources as influenced by financial bribery and kickbacks. Therefore, the population for this study was the seniors from Owerri city and rural communities who have been affected by the corrupt practices of their legislators and healthcare administrators or providers. The study participants include administrators in the rural healthcare sector of Owerri or are state legislators who have represented residents of Owerri community in the phase of a depilated healthcare corruption and seniors who have experienced healthcare out-of-pocket mandate, delivery delays, and the

enormous practices of bribery that hinders healthcare efficiency for the community. The selected study participants provided clear and meaningful information about the phenomenon in the inquiry. Participants were known to meet criteria after completion of recruitment form and a researcher review of their provided information.

A purposeful sampling method was used to conduct the qualitative exploratory study, which included identifying five healthcare administrators from Owerri, five state and city legislators, and eight to ten seniors from Owerri rural community through the community leader. I selected the participants once the community board leader introduced me to the research sites: the Owerri Community Development Center and the legislator's office, also known as the community town hall, where I met with individuals for study explanation in Owerri, Imo State, Nigeria. The potential selected participants were asked to participate in the interviews. There was a minimum of 15 participants and maximum of 20 participants involved in this case study. Variance occurs in recommended sample sizes in a qualitative case study, hence Creswell (2006) asserted the need of five to 20 participants. Participant selection was based on their lived experience and knowledge about the impact of financial bribery and kickback influence on the senior healthcare and out-of-pocket mandate for seniors in the community. The purpose of this qualitative research sampling strategy provides vital importance to the selection of participants depending on the "abundance and relevant data as relates to research question" (Yin, 2011, p. 311). Yin (2011) further suggested that sample size of 18-20 participants is appropriate for the qualitative case study. Others have suggested the point of saturation as an appropriate sample size when no new themes could emerge

(Mason, 2010). The interviewer skill is essential in this process and requires a skilled interviewer in getting to the point of saturation and be able to reach saturation with fewer participants than unskilled interviewer (Mason, 2010).

Sample population. This study targeted three groups of interviewees for data collection. Targeted groups included 8 to 10 seniors from Owerri community, five healthcare administrators from Owerri, and five legislators from Owerri. These groups were chosen for the study for the primary reason that it was expected that the lived experiences from each group of interviewees give significantly nuanced understandings of the experiences of seniors seeking healthcare in the context of bribery and kickbacks. Since this study employed a qualitative case study methodology, it became vital to have study participants with diverse backgrounds and who have experience with the same phenomenon.

The seniors lived experiences gave me rich knowledge of their beliefs on the influence of corruption on senior healthcare delivery and services in Owerri rural community. As discussed in Chapter 1, the exorbitant out-of-pocket healthcare payments that are claimed to have impacted seniors' access to healthcare services are due to exclusion from NHIS (Gustafsson-Wright & Schellekens, 2013). The seniors have first-hand knowledge and could have been impacted in efforts to access healthcare delivery and services. The discussion of their beliefs on the phenomenon enhanced this study's results and provided expert insight that increased my understanding of the financial kickbacks and bribery in healthcare.

Healthcare administrators were necessary to the study as a result of their professional experience with senior healthcare in rural Owerri. Their perception on the senior enrollment in healthcare, NHIS health coverage policy, and the senior's inability to afford needed out-of-pocket payment for healthcare helped me build my knowledge regarding how seniors are covered in the NHIS policy, its implementation, and how healthcare services management operates in Owerri. The administrators' perceptions of health funding, management of resources, and the delivery of health products, structure and facility environment provided insight to the study on how healthcare is operated. The inclusion of healthcare administrators as the study interviewees enabled me to obtain knowledge on the claim (discussed in Chapter 1) from the 2010 Transparency International study, which espoused Nigeria healthcare management as impacted by a high scale of corruption (Mackey & Liang, 2012).

Furthermore, to understand and acquire balanced knowledge on the study phenomenon, I also interviewed legislators from Owerri to enable me to build awareness on how healthcare policies are legislated and designed which excluded seniors from its coverage. Participants from this particular group shared the insight of their perception and belief as to how out-of-pocket healthcare payments for rural senior residents are suited for affordable healthcare access, services, delivery and fair purchase of healthcare products. Their professional experiences on policy issues regarding healthcare enabled me to understand the policy windows or initiatives surrounding the claim that NHIS currently has not included any policy programs that cover the healthcare for seniors (Etobe & Etobe, 2013). Having legislators as study participants were helpful owing to

their ability to interpret policy issues and their perceptions about corruption in the healthcare sector. That also enabled me to employ the conceptual and theoretical frameworks in the study to gain knowledge of the control of crime in healthcare and provided easy access to documents that yielded more insight and experience on the studied phenomenon.

Therefore, studying this phenomenon with participants from the three groups provided a balanced knowledge on how financial bribery and kickbacks of corruption influences the delivery of healthcare to seniors in Owerri, added clarity to the claims of corruption within the leadership and management levels, and also served as validation of sources of data in this study. That increased levels of credibility, transferability, and accuracy of the data collection process in this study. Overall, this enhanced my ability to gain a balanced knowledge about this study phenomenon and may enable readers to gain a clearer understanding of the data collected within the areas of the study.

Recruitment procedure overview. Before the commencement of the study, I met with the community board leader and introduce myself, the study topic, and purpose of the study. I expressed my interest in recruiting potential participants for my study. I explained to the community leader that study participants would include 8 to 10 seniors who must be between ages 55 to 65 years old, five healthcare administrators from Owerri, and five legislators from Owerri. Community board leader served to introduce me to the various participating groups: seniors, administrators, and legislators, where I identified and recruited potential interviewees. The community board leader was not

available during my selection of participants. The informed consent form applied to all the three groups involved in the study.

The community board leader walked me to the community development center in Owerri where he introduced me to the people and where the sample of seniors was located, identified, and recruited. I spoke to the people and explained my study purpose, nature and explained to them the importance of participation in the study. I explained to them about criteria for participation in the study. I identified all interested participants, and I discussed the informed consent form with the participants. The potential selected participants were handed the informed consent during recruitment meeting to sign at the community center.

The Owerri community board leader also walked me to the healthcare administrators headquarter in Owerri where he made a recommendation about me and introduced me and my study to the administrators. I spoke to the healthcare administrators and explained my study purpose, nature, and explained to them the importance of participation in the study. I also shared with them the criteria for participation in the study, informed them that healthcare participants should have had experience working with NHIS, community healthcare sector in Owerri. I explained to them about providing me access to review documents that may provide more insight and knowledge about healthcare delivery policies and procedure in rural Owerri. Interested administrators who agreed to participate were given the informed consent and recruitment letter in person, by me, and I answered any questions they have. When they agreed to participate in the study, I asked them to sign the consent form and explained

that I would be in contact to schedule an interview time and location. The community leader was involved with this group of interviewees only during the introduction period.

Finally, I greeted and spoke to the legislators at the community Board Center and informed them about the purpose and nature of my study. I also explained the importance of legislators' participation in the study and the criteria for participation: background experience on healthcare policy making or other in areas of community development, and working experience in health policy in the legislature. I requested access to review documents that may provide more insight and knowledge about healthcare policies in rural Owerri and documents that might explain control on corruption influencing health delivery and services. I provided copies of informed consent form to legislators potentially interested in participating. I presented options for returning the signed form to me and scheduling an interview time and location.

Assuring adequate purposeful sample. The study participants were identified and selected through purposeful sampling. This sampling method encourages the selection and identification of participants with rich and lived experience which can yield efficiency and accuracy in data collection. This sampling procedure was appropriate for this type of case study as its objective was to explore senior participants' beliefs, and legislators' and healthcare administrator's perceptions of an experienced phenomenon: the influence of corruption on senior healthcare delivery and services in Owerri. The community board leader did not know about the participating seniors, healthcare administrators and legislators and his absence served to ensure proper sample representatives for the study confidentiality. Purposeful sampling was utilized to make a

final selection of 15-20 participants. 8-10 participating seniors were selected from the Owerri rural community development board by me.

The point of saturation in a qualitative study is that appropriate sample size is reached when no new themes, variables, or categories emerge (Mason, 2010). In the case if recruitment results in too few participants, the plan will be to continue recruitment until data collection reached saturation. I anticipated that the 18 to 20 interviewee sample size of this study would yield data that will reach saturation. At that point, I concluded with the data collection. The study reached saturation as well as to efficiently organize and manage information as themes emerge and variables and categories are identified iteratively so as to arrive at validation with trustworthy data (Creswell, 2007), utilized member checking of the transcript of the provided data, notes, and audio-recorded information from the interview. The interviewer skill is essential in this process and requires a skilled interviewer in getting to the point of saturation and be able to reach saturation with fewer participants than an unskilled interviewer (Mason, 2010).

Other methods including a review of written documents enabled me to gather more knowledge to balance and assess when information provided during the face-to-face individual interviews and audio-recording and note taking has reached a point of saturation. Interviews, review of documents, observation and note taking of information are fundamental sources of confirmability in data collection for qualitative research analysis (Creswell, 2009; Locke, Silverman, & Spirduso, 2010).

Instrumentation

Data collection for this study was through semi-structured interviews of participants. Interviews are believed to be an important data collection tool for qualitative research design study (Yin, 2011). The importance was for the collection of information through participants lived experiences which enabled the researcher to gain knowledge and understanding of participant's behaviors, thoughts, and perceptions about the reality attached to the research topic and questions (Fontana & Frey, 2005). Interviews were audiotaped after participants have consented and I transcribed all audible contents. I employed face-to-face interviews and observation process after participants have been explained procedures, their privacy, protection in the study and they signed informed consent, and I signed to avoid taking up time in the interview process. After meeting the participants, I gave participants the copy of their signed consent to take home after meeting with them.

English is the official general language in Nigeria, according to National Literacy Survey (2010), statistics from the survey study indicated that 96.4 percent of the Owerri adults are fluent in English language. I conducted interviews in fluent and straightforward English language without a translator to minimize researcher bias and ensure trustworthiness.

I remained in direct contact with the community board leader to ensure that interview meeting is scheduled during the period community members have access to the community development town hall and local health center. The exact meeting scheduling took place after consulting seniors and the health administrators and legislators in the

Owerri house of community development board and after obtaining their permission to sit in their center, office, and town hall as an observer. Legal documents were not mandatory from legislators and administrator, but if legislators or administrators provided any documents that can yield importance to the study such as policy documents, Dossiers, and manuscripts, I will review them and incorporate data that could yield extra knowledge to the study result.

Interview process. I contacted seniors by the method they preferred to schedule a 45-minute face-to-face interview at the community development center. The selected legislators and healthcare administrators were contacted by their preferred method to schedule a 45-minute interview in the location of their office in Owerri. The intent for choosing this location is to minimize security risk, anonymity, minimize fear of providing information from the contrasting groups, and to enable nearness to review of documents that might be valuable to enhance my knowledge of the studied phenomenon.

All interviewees had returned to me a signed Informed Consent form, and I returned a copy to them with my signature affixed. I explained my data collection methods (audio recording, note-taking, and transcription) before the interview. I informed all participants about a follow-up interview for any additional comments they would like to make and went over the accuracy of their transcribed interviews. Participants were also informed that copy of the major findings would be provided to them at the end of the study as part of the social change this study intends. Participants received their copies through their provided contact address or email.

Before the formal beginning of each interview, I reviewed the details of the Informed Consent form concerning privacy and protection of participants, confidentiality of study participants, audio-recording of the interview, and topics that were brought up in the interview (See Appendix A). Once participants indicated they feel comfortable and are aware and knowledgeable about their protection, rights, and privacy during their participation, I invited them to answer the questions. I further emphasized to them that they can ask any questions and that at any time they may withdraw from the study.

Interview protocols. The interview protocol consists of 15 prepared questions that addressed the topics of financial bribery, kickbacks, healthcare policies and senior enrolment in rural healthcare. The interview questions in the protocol were suitable for seniors, legislators, and administrators. Appendix A (interview protocol) contains these data collection instruments.

For the seniors, the open-ended interview questions were prepared to probe their lived experience of how they believe corruption has influenced the delivery of healthcare, and their opinion on how delivery of healthcare services could be handled differently from how it has been handled in the past and at this present time. Other questions address their understanding and lived experience on ethical issues of the healthcare providers towards consumers.

The prepared open-ended questions served to probe legislators and administrators about their perception and to explore in-depth on areas of professionalism and specialty. The questions enhanced my knowledge about healthcare policy, management of healthcare funding, and implementation of healthcare policies in the rural Owerri. Also,

although interview questions for legislators and administrators will be based on how management perceives corruption in the system and how they perceive implementation of healthcare policies. Questions explored how corruption impacts delivery of healthcare services to local communities.

The interview questions are structured to provide different opinions, views and participants' feelings towards the studied phenomenon. Appendix A defines the four components that were covered in the interview which include: the participant's background, organization background, and basic engagement about the study topic. Appendix A contains benefits and risk inherent in participation, and a conclusion.

Participants were informed about further probe questions that were intended to open doors for the interviewees to provide the full story of their lived experience. The probe questions also enabled me to gain deep knowledge of the areas that require more insight, reasoning, and clarity about how, what and why in the information provided. Probe questions provided clarity on what participants said, get more details, about variations in events and circumstances of occurrence, and to accommodate emotions during the interview process (See Appendix C). Other probing questions provided the interviewee an opportunity to focus more specifically on their understandings, intentions, and insight on NHIS, and policy development, and their participation in rural healthcare development in Owerri (See Appendix C).

The conclusion section of the interview included an overview of data, review, and verify of the interviewee's opinion and asked any remaining questions regarding the study. During this period, I thanked participants for their voluntary support and

willingness to provide information that enabled me to gain knowledge and understanding of the issues. Participants were reminded that the interview transcripts would be provided to them for their review accuracy of the transcripts and to provide any necessary edits. At the end of the conversation, I informed participants about future opportunities for them to provide feedback after the analysis phase. Participants received the summary once it was completed.

Data Analysis Plan

I used audiotapes from the interviews to transcribe word for word from interview results. The use of transcription in the data analysis enabled me to become even more familiar with responses, and I gained an in-depth understanding of the interviewees through the review of data. This process ensured interpretative clarification of data recorded in audio format and served as an opportunity for clarifying themes, phrases, and words that were unclear during audio data collection in the interviews. Participants were contacted during the transcription phase for clarification as needed. The sample size of a minimum of 15 and maximum of 20 participants facilitated the collection of a manageable quantity of rich, thick data, and I gradually combined and related the collected pieces of data to ensure progression while utilizing comparison of data from the interviewees to access description and result conclusions. Data analysis in qualitative study progresses from inductive and develops into deductive process as more meaningful pieces of information that are pertinent to answering study topic, and question become mutually exclusive, and conceptually congruent to themes that reduce into fewer categories that can yield easier interpretation and communication (Lodico, Spaulding, &

Voegtle, 2010; Merriam, 2009). When differentiating between individual experience and the agency or organizational experiences, I revisited my field notes and journaling data to ensure accuracy. Although challenging, I asked the interviewees individually to review any ambiguous aspects of their interview before my coding. This cross-checking of data provided an aspect of triangulation for data trustworthiness. Following field notes edits, audiotaped data transcription, and interview results confirmed by participants, all confirmed data were loaded into NVivo 10.0 with an effort to demonstrate rigor, trustworthiness, and validity (Gibbs, Friese, & Mangabeira, 2002).

Table 2

List of Preliminary Codes

Seniors	Codes	Legislatures and Healthcare Administrators	Codes
Health crises/guilt of bribe giving	Challenges Victimhood	Financial bribery and kickback	Transparency/PC
Corrupt leadership/ Insurance mandate	Hope Change	Perception of senior healthcare crises Leadership/ management/policies	Assurance Change/hope
Fair T /OPTN	Trust	Providers consistency/fair delivery	Accountability

Data were reviewed line-by-line and coded using the preliminary coding framework (see Appendix C). Computer-assisted qualitative data analysis software is important to improve quality, rigor, credibility, and trustworthiness (Smith & Hesse-Biber, 1996). The data were coded compared to community healthcare representatives'

responses versus legislators as well as coded against responses of the rural community (seniors) representatives. Concepts from the literature review and research question were coded into NVivo 10.0. The data were highlighted in codes and captured in nodes. Disaggregate data were sorted into manageable components, names assigned to particular segments, and aligned. Data that does not align in the order of the structure were captured through a node recognized as “Other" for further review process. NVivo 10.0 software enhanced emerging concepts and categories, and themes became easily coded, edited, and recorded (Smith & Hesse-Biber, 1996). However, I continued to lead the study’s analysis process and remained the primary tool for analysis of data to ensure accuracy (Weitzman, 2000). NVivo 10.0 enabled clarity of interpretation of data and established potential structural themes that enhanced participatory continuity in the study. In the case of discrepant information, all data that does not correspond will be acknowledged. I recoded such data for future analysis or until new nodes, patterns or themes emerged.

Issues of Trustworthiness and Credibility

Credibility. The most important criteria for issue of trustworthiness and credibility was that of internal validity, through which I employed to assure that this study measures what it is intended and ensuring that information gathered from the interviewees are equivalent to the study concept (Yin, 1994), and deals with the research question. Ensuring the credibility of the studied phenomenon is a critically important factor to establish by the researcher when conducting a qualitative research study to attain trustworthiness (Lincoln & Guba, 1985). Through this approach, I incorporated appropriate designing of open-ended questioning procedures as the operational method of

attaining data gathering and data analysis from study participants. Credibility also enhances relationship and awareness between researcher and study participants and the thorough awareness of the studied phenomenon through member checking of data, and as such my meeting with legislatures in their official operational location enabled review of official journals, documents and enhanced close awareness to the study topic also known as "prolonged engagement" (Erlandson, Harris, Skipper, & Allen, 1993, p. 53) and ensured credibility in triangulation of data process. To ensure credibility, I ensured that participants have the opportunity to opt out if they are not willing to participate to ensure the honesty of information from participants who are willing to participate and encouraged the free will to share ideas or thoughts. Making sure that findings from the interviewees are credible and reliable, I ensured that there was prolonged engagement with participants during the interview seasons, frequent debriefing, and cross-checking of data findings. To ensure reliability and credibility for internal validity of the project, I checked transcripts for obvious errors; avoided deviations in the code definition, and carefully monitored the NVivo 10.0 application in the coding process. I cross-checked codes and information collected on the interviewees (Creswell, 2009).

Transferability. Another method I employed to ensuring trustworthiness is that of external validity which will enable me to balance findings of different other situations related to the study topic. Merriam (1998) suggested that to ensure external validity; findings were based on the degree to which results of any single study could be compared and applicable to another context. My concern in this perspective was to ensure that sufficient information and description of the studied phenomenon are gathered and

provided in the document to allow readers to gain proper understanding and can make a substantial comparison of events of corruption in the research report for future research studies. The breath of which discoveries of this study applies to a wider range of the situations in not only the researched context such as corruption influence on healthcare, but extended to other delivery of services.

The diversity of participant selection was to ensure that the interpretation and description of participant perceptions were not impacted by different factors or influenced by others. I asked participants to review their interview transcripts to ensure accuracy, and represent the true meaning of their beliefs; this process is member checking (Thomas & Magilvy, 2011). The rich, extensive description of participants about geographical and demographics of the study serves as open doors for an external consideration for future studies if the findings in the study could be transferred to another study (Lincoln & Guba, 1985). In this process applying the findings from this study will provide more insight when applying it to other study contexts or in application to another population may establish study transferability. Transferability in the form of external validity served to provide sufficient contextual data about fieldwork sites (location of interviews was Owerri due to its cultural and natural background, and this study environment provided suitable atmosphere for the study, nearness to health centers, markets, and universities) are provided to enable readers to be confident with the study result. Therefore, conveying the boundaries of the study to ensure that participants are aware before the start of the study includes the following factors:

- The number of agencies, the organization participating in the study and their locations
- The number of study participants involved in the study
- Employed method of data collection
- Length of data collection employed and depth of data
- Timeframe employed in the data collection process.

Dependability. I ensured and gave appropriate importance to reliability techniques which provided information about repeatability in the study context involved same participants, and ensured that similar results were obtained in the study. I ensured that the study employed individual interviewing and made sure that description of the research process to enable future studies on the phenomenon to gain an understanding of how the study results were gained. Providing in-depth details of the influencing factors of how this study was conducted enables another study researcher to gradually understand the decisions made in this study and then address dependability from this study. The study detailed the research design, and implementation process and repeatability of the process involving same study participants and ensured similarity of results (Marshall & Rossman, 1999). Thus, about 75% of study participants provided feedback, this study was able to address trustworthiness.

I explained the study process and study topic to the interviewees before the commencement of interview and after the interviews; participants were asked if they are willing to participating for further interviews and review of transcripts of their interview. To envisage proper research, follow up and practices, probe questions were designed to

enable clearer understanding of the employed methods, effectiveness and data collected. These were evaluated, assessed and maintained reflective focus on the appraisal of the data collected and documentation of observed situations and what happened during the entire study seasons. Also, information provided by legislators and health administrators aided the dependability of this study when compared with the data provided by seniors and serves as checks and balances for trustworthiness and dependability of data. Data that appear political perceptions from legislators and health administrators were weeded out during transcription and explained to participants to ensure and maintain political neutrality in case of future study dependability of this study. The study provided detailed information of reflectivity of the study project and its evaluating process of the undertaken inquiry; provides descriptive detail of data gathering which addressed time of fieldwork operations, and the employed research design and implementation, detailing the planning and execution of the employed strategic levels.

Confirmability. As associated with objectivity, appropriate strategies to attest to confirmability of the research findings, steps were taken to ensure confirmability through the in-depth gaining of knowledge from participants' ideas, and experiences of financial bribery and kickbacks. I applied triangulation as an important way to reduce bias. Miles and Huberman (1994) asserted that critical importance for confirmability in qualitative approach as the scope that researcher predisposes or admits his predispositions. This process allowed me the admission of my beliefs and assumptions of the study. Triangulation aids this study through utilizing three points of data, employing two or more theoretical approaches, field notes, and observation which may enhance and enable

counterbalance or possible deficiency reduction inherent in a single strategy, thus, increases the possibility of interpreting the interview findings (Descombe, 2014).

Utilizing English language in the study, theories and methods enhanced validity of data, and confirmability. Also, employing procedures of taking field notes, monitoring and evaluating multiple sources of data, and debriefing, member checking, and providing a dense and rich descriptions of the interviewees or participants perception and their background ensured confirmability and validity of data. Reflective commentary on results derived from the employed research approach which made it impossible to use other research techniques was an essential part of the methodological description. As an observer, a step-by-step approach was utilized as a method of tracing the study process and in decision making and described procedures. This process allows in-depth integrity related to research results through methodological description. Through these cumulative processes, all data relevant to healthcare corruption, bribery, and kickbacks were reviewed and confirmed for consistency, and emerging themes and patterns were validated by participants on how the information resonates with them as individuals.

Ethical Procedures

The study required an informed consent form which the interviewees completed before participate in the study. The informed consent form and request to contact study participants were approved by Walden University's Institutional Review Board (IRB_ (no. 10-25-17-0523401). This process of consent information began at the initial stage before contacting and selection of potential study participants. The information contained

in the informed consent form was discussed with participants to ensure that participants are clear about all aspects and parameters of the study.

The participants were notified about the nature of the study when I initially contacted them. Participants were given time to indicate and identify what might prevent them from participation. I asked all possible participants about any potential political or organizational consequences in their participation that might become a hindrance to the study's data collection phase. Participants were made aware that their information will remain anonymous and their name will never be revealed. Pseudonyms were used as identifiers for each participant's interview. This helped maintain the confidentiality of each participant. The pseudonyms were entered on NVivo 10.0, retrievable by flash drives and other backup storage. All study information was safely stored on a password-protected computer in my home office for seven years, after which it will be destroyed. Data will not be accessible on the Internet. To ensure quality and proper ethical conservation of data, all data must be destroyed through method of shredded or indefinite delete within the stated timeframe. Participants were informed about the dissemination of the study results in writing. In the process of this study if any findings related to criminal activities or child/elder abuse that might necessitate, I provided the interviewee the NHIS contact and encouraged the interviewee to notify their medical provider (see Appendix A).

Summary

This study was conducted with a qualitative exploratory case study strategy with the goal of understanding the influence of financial bribery and kickbacks on the delivery

of healthcare to seniors and the impoverished rural Owerri residents. The qualitative approach was appropriate to explore in-depth how selected seniors, healthcare administrators within Owerri community NHIS, and state legislators perceived the prevailing challenges faced by the study population. I employed a purposeful sampling strategy in the selection of study participants.

The study utilized a semi-structured in-person interview designed to gain a clearer and more meaningful understanding of the nine senior participants, and three legislators, and three healthcare administrators' experiences with corruption and its impact on healthcare delivery. I have expressed my role and that of potential participants in this process. I have established my position in the event of possible biases and explained the method and means of mitigating them should they arise. Trustworthiness and reliability for this study were ensured through the aforementioned techniques of maintaining consistency in data collection validity, transparency, and triangulation and the described data analysis procedures. The interviewees did not receive interview protocol but were provided with interview topics.

Methods of handling ethical concerns have been identified for this research process. The protocol and procedures for handling ethical issues including consent for release of information, confidentiality, and anonymity were proposed. A detailed explanation of the study purpose, possible risk, participant rights, and other aspects of this voluntary participatory approach were described. Methods for storage of data, dissemination of findings, and the process of destroying data were identified.

Chapter 4: Results

Introduction

The purpose of this qualitative exploratory case study was to gain more knowledge from seniors, healthcare providers, and legislators' perceptions and lived experiences on how financial bribery and kickbacks influences healthcare service delivery in Owerri Imo state, Nigeria. Qualitative paradigm is employed by researchers to explore in-depth about phenomena and concepts that may require clearer understanding or pose difficulty to gain understanding (Hoang-Kim et al., 2014). I used an exploratory case study to explore a greater understanding of the studied phenomenon and to gain a better explanation of the causal sources of the everyday context of the phenomena (see Yin, 2009.)

The central research question in this study is "How do seniors, the state legislators, health administrators in Owerri perceive the influence of financial bribery and kickbacks on senior healthcare development in Owerri?" This study employed an exploratory case study approach to gain knowledge of seniors lived experiences, healthcare providers and legislators' perceptions of what influences individuals experience in receiving and accessing healthcare in Owerri. For this study, I gathered in-depth and rich information or data through interviews of 15 selected study participants. The interviews were recorded and carefully transcribed. The study interpretation and analysis of data from the interviews were guided by the study central research question and the interview questions.

In this chapter, I present thorough reviewing of data and well detail-rich sorted data during the analysis process. In qualitative case studies, analyzing data based on a single report is helpful before cross comparison of cases (Yin, 2009). Thus, ensuring close attention to variations among each case and paying attention to relationship between the various causes, outcomes, and effects (Huberman, 1994) and use an exploratory instrument in data collection, obtain detailed data from selected participants, and employed analytical approach in case study data analysis (Maxwell, 2012) as explained in Chapter 3. The chapter consists of seven sections. In the first section, I described the research settings. In the second section, I described the demographic features of the selected participants. The third section consisted of a description of the data collection process. In the fourth and fifth sections, I described the use of Lodico, Spaulding, and Voegtle's (2010) inductive to deductive qualitative analysis process where more meaningful pieces of information that are pertinent to answering study topic and question become mutually exclusive, and conceptually congruent to themes that reduce into fewer categories that can yield easier interpretation and communication. The process described how cross checking of gathered data enabled triangulation aspect to ensure trustworthiness of interviewees provided data, field edits, transcriptions, and interview results with the use of software analysis NVivo. In the sixth section, I explained the factors that were considered to confirm the trustworthiness of the research findings. There remained numerous factors that were unconfirmed following data analysis. In Chapter 5, an overview of the research methodological procedures and a summary of the research results were discussed.

Research Setting

The research was conducted at the Owerri Community and Development Board) center Owerri Imo state, Nigeria. The perception and experiences of the community members, seniors, providers, and legislators concerning the provision of healthcare services and delivery on how financial bribery and kickbacks influences healthcare service delivery in Owerri Imo state, Nigeria constituted the subject of this qualitative exploratory case study. Eamples of this include the following:

- The three-tier healthcare system.
- The federal medical center.
- The general hospital and the rural health centers in Owerri healthcare delivery and services.
- Healthcare insurance.
- Community response towards healthcare service and delivery cost.
- Health infrastructures.
- Management.
- Policies and legislation.
- Behavior towards community members (seniors, adults and children) within the 2013 healthcare plan until 2017.

Case study is a suited qualitative research method for understanding social phenomenon within their natural setting and real-life events (Yin, 2003). The interviews were in-depth and conducted face-to-face with research study participants. The interviews were conducted individually based on the participants' preference of location

and availability. The 15 interviews were conducted in different locations of Owerri Community Board Center in Owerri. The interviews took approximately 45 minutes each (see Appendix A). All interviews followed the same structure to help maintain consistency. The participants disclosed basic demographics during the interviews such as age, gender, educational background, and employment status. The introductory approach in the interview helped to establish trust and rapport between interviewer and participants. Confidentiality agreements were executed by all participants. Participants were informed that they could withdraw from the study at any point in the proceess. The interviews were conducted in a familiar setting for the participants with minimal distractions that could hinder the credibility of the research findings. The facility where the interviews were conducted had limited electricity, but these conditions did not affect the voice recordings.

Demographics

The studied population consisted of seniors between the ages of 55 to 65 who were legislators and healthcare providers in Owerri Imo State, Nigeria. After obtaining the Walden University's IRB approval to collect data for the study and the National Health Ethics Committee of Nigeria, I began making contacts for community partnership. I contacted the Owerri Community Board leader who accepted my request to recruit participants through their community board. After IRB approved my request to have them as my community participant, I remained in contact with the Owerri community board leader that later introduced me to the community members. I addressed the community at the center where I later commenced recruitment by identifying potential

participants. The process for recruitment lasted for 1 week. The study employed a purposeful sampling method. The three common sampling strategies are group sampling, criterion sampling, and time–location sampling (Patton, 2015). To make a possible discretionary selection of participants using their demographic profiles, group selection sampling was employed (see Miles, Huberman, & Saldana, 2014).

The selected participants' demography is tabulated on table 1, including their gender, ages which ranged seniors: 55 to 65 (codes MP 1- MP 9); providers: 42 to 61 (codes FP 10 –MP 12), and legislators: 41 to 60 (codes FP 13 – MP 15). The female participants have represented with codes FP, and male participants have represented with codes MP. Among them were nine seniors who are six pensioners and two self-employed traders, and one unemployed; three legislators, and three providers employed in hospitals and pharmacist with a standard college education. 33%of the interviewed participants are female, while 67% of the interviewed participants are male (see Figure 3). Table 3 represents the demographic information of the study participants.

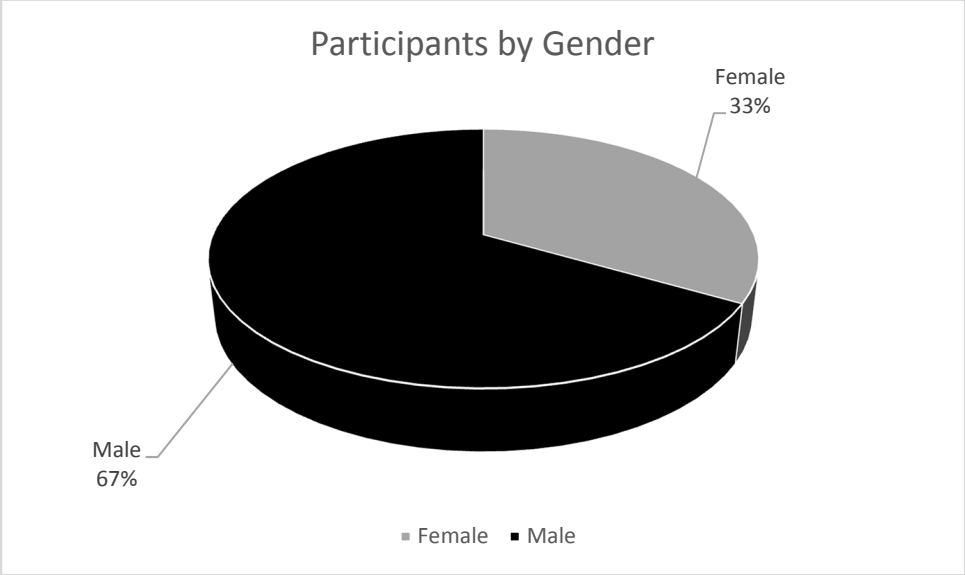

Figure 3. Participants by gender

Table 3

Participants' Demographic Information

Assigned Code	Age	Participants Status	Level of Education	Gender
MP1	64	Senior	College	Male
FP2	65	Senior	College	Female
MP3	57	Senior	Diploma	Male
MP4	60	Senior	Diploma	Male
FP5	65	Senior	College	Female
MP6	63	Senior	Diploma	Male
FP7	60	Senior	Diploma	Female
MP8	61	Senior	Diploma	Male
MP9	56	Senior	Diploma	Male
FP10	50	Provider	College (NP)	Female
MP11	58	Provider	College (MD)	Male
MP12	49	Provider.	College	Male
FP13	57	House-Legis.	College	Female
MP14	49	House-Legis.	College	Male
MP15	58	House-legis.	College	Male

MP= Male Participant

FP= Female Participant

Data Collection

I employed interviewing as the data collection tool for this study research. I relied on the data collected from participants' real-life experiences and perceptions of how financial bribery and kickbacks influences healthcare service delivery in Owerri Imo state, Nigeria. I commenced the data collection procedure by selecting the potential participants for the research study. Recruitment of participants lasted for 1 week after I had obtained the National Health Research Ethics committee of Nigeria approval (nu. NHREC/01/01/2007) and the Walden University IRB approval (IRB, no. 10-25-17-0523401) to collect data for this study. I employed purposeful sampling strategies (group sampling and time-location selection) in the selection of participants and their continuous residency in Owerri in the past 5 years. To ensure inclusion criteria for the study, participants were needed to have (a) lived in the Owerri rural area for at least 5 years, (b) seniors may have participated or received healthcare and (c) have experienced healthcare conditions in Owerri. Also participating healthcare administrators and legislators may know healthcare conditions in Owerri, (i.e., community healthcare sector; and healthcare policy making or in other areas of community development).

Interested individuals met with me after the community meeting in the privacy of the general public and I further explained the purpose of the study to the potential participants, study protocol, and completed consent for release of information to participate in the study. I contacted the potential participants who agreed to be interviewed at the community board and had informal discussions regarding their voluntary willingness to participate in which I engaged them individually that the study

required their honest description of their experiences and perceptions regarding financial bribery and kickbacks, their influence on senior healthcare in rural Owerri, healthcare public policies and healthcare services and delivery. The participants confirmed their willingness to honestly participate in the study. They confirmed their satisfaction with the inclusion criteria in the study by having lived in Owerri in the past 5 years, participated in healthcare services and delivery in Owerri, policy issues affecting development of healthcare in rural Owerri, and what they think can improve healthcare and its policies as provided through the NHIS. Furthermore, they provided their demographic profiles which included: gender, age, employment status and educational background of the healthcare providers and legislatures.

Twenty-five potential participants were initially identified after my initial address to the community board members. However, 10 individuals were not selected because they did not meet the needed inclusion criteria for the study; either their age was below the age bracket for seniors, or they may not have lived in Owerri in the past 5 years and as well as did not have enough lived experience in the study topic. I employed maximum variation (heterogeneity) sampling strategy to purposefully select based on age, gender, lived experience, length of time lived in Owerri, level of education, employment status, and carrier bracket in healthcare and legislation. Qualitative research study requires random sampling process (Creswell, 2015). The 15 participants were randomly selected to ensure that participants' perceptions are goal-directed to the study topic. Also, group sampling strategy was employed to select individual seniors with the different demographic profiles such as (age, gender, period of residency) in Owerri. Fifteen

selected participants were eventually selected and addressed for the interview. The rest of the individuals who expressed their willingness to take part in the study but were not selected during a randomized procedure of the initial 25 potential participants were told that they would remain alternate participants in the list and would replace those who may decide to withdraw from the study or dropped out of the study.

The study had no rigid guidelines or rules leading to the appropriateness in a sample size of a qualitative research approach. According to Patton (2015), sample size in a qualitative research study is determined by its research question, study purpose, resources to aid the research, time availability, and credibility of the research findings. Conducting qualitative research, sample size does not need to be too large but to be able to contain and provide in-depth and central to adequacy, information richness of data (Onwuegbuzie & Leech, 2007). This study was proposed to employ a sample size selection of 18-20 participants, I rather selected a sample size of 15, which was sufficient enough to answer the research question as key qualitative criteria which typically limits, respond to the central study phenomenon, and capable to explain, interpret, and describe the study research question (see Maxwell, 2013; Morse & Field, 1993). At that point, I decided that the data saturation had been accomplished through the amount of data I had gathered, which I believe was enough to answer the research phenomenon during which I could no longer obtain any further new information after I had interviewed the selected 15 participants.

After my introduction and address to the Owerri community board center, Iannounced that interested potential individuals could come to meet with me at the

designated visiting room on the East wing of the center. About 15 individuals from the community came up and I met with them individually. I provided them a thorough explanation of the study topic and purpose of the study and the informed consent form. I further explained to them that the study could only take place if they only verbally agree and willingly accept to participate and proceed to sign the informed consent form. I verified that participants met the criteria for participation (e.g., have lived in Owerri in the past 5 years, participated and experienced healthcare in Owerri) to ensure that they satisfied the criteria for participation. I asked each selected individual if they feel comfortable to be interviewed at the community center and informed them they could also choose where they might feel more comfortable for the interview. Most parts of the selected participants agreed to be interviewed at the community center and provided the dates and time that they would be free to present to the interviews. After location, date, and time of interviews were agreed, participants were invited to come for the interview. I explained to them that their information would be kept confidential and that their real names would not be made available in the study but masked with assigned codes. I also explained to participants that they were free to withdraw from participation in the study interview at any time without reprisal and also may be accepted to return if they changed their mind, but would have to complete and sign a new informed consent form before they could participate in the study interview.

When each potential participant verbally accepted to participate, and confirmed an interview date, location and time were established, I gave them the informed consent form to sign and return to me a signed copy. I collected the signed consent form; then I

initiated the interview. The interview was conducted on different days and times in their mutually convenient, comfortable quiet arranged location of the community center. Nine of the seniors preferred their community board center. The participants were handed the interview questions in advance of the interview date.

Before the interviews commenced, all the individual participants agreed and confirmed verbally that they were willing to participate and be interviewed for the study and accepted that the interview could be electronically recorded. I then reaffirmed to them that their names will be kept confidential with assigned codes. Codes MP1 to MP 9 was assigned to the interviewed participant seniors. I confirmed with the participants that the interview would last for a maximum of 45 minutes. Further, participants were reminded that they could withdraw from the interview and leave without reprisal at any time. The study contained semistructured and open-ended interview questions which were contained in the study interview protocol (see Appendix A). The semistructured and open-ended interview questions enabled study participants to remain focus on the issues arising from interview questions and speak freely about their lived experiences and perceptions. As the interview evolved, I asked participants probing questions to gain clarity related to their responses on certain issues.

To ensure that the study data collection was unambiguous and maintained consistency, I used the same interview protocol for all interview study participants. I remained neutral all the time of the interviews leaving aside any preconceived ideas and requested further explanations of identified rival story descriptions to reduce bias (Yin, 2009). While conducting the interviews, notes were taken. I informed all individual

participants that they would be contacted again for further clarification for their review of information they provided or for review of their responses during the interview. As a method of accuracy, interview notes were reviewed, and digital recordings were transferred to a removable flash drive. After I transcribed the recorded interviews, I compared the transcriptions with the digitally recorded interviews. I presented the transcripts to individual participants during their second interview (see Appendix A) for confirmation and verification to ensure that the information in the transcripts matches with their honest descriptions of their lived experiences and true perceptions regarding financial bribery and kickbacks: their influence on senior healthcare in rural Owerri, Imo State.

Data Analysis

For data analysis, I conducted framework as envisaged by the four stages of analysis detailed by Morse (1994): Understanding, synthesizing, decontextualizing and theorizing. I used word-for-word transcripts from the audiotaped interviews and field notes in the study data analysis. The study explored real-life experiences of the study participants in real time that enabled collection of in-depth descriptive data which enhanced the identification of emerging themes (Creswell, 2013). The use of transcripts from the recorded audiotaped interviews enabled me to get a clearer understanding of the participants' responses. I gained an in-depth understanding of data from the interviewees' lived experiences on the study topic through open-ended questions. Through observation of participants' gestures, facial expression, and simple language usage, I learned more about their perceptions on how they viewed healthcare corruption, infrastructure,

healthcare services and healthcare management in rural Owerri. Transcribed audio record of the interviews enabled me to gain clarity and better asses the themes, phrases, and words that was not clear following the interviews. Yin (1993) points out that opposite response of the majority of the responses can be significant. To make conceptual similarities and to compare information provided among the different participant perceptions, Yin (2009) noted that in case studies, "data analysis comprises of categorizing, examining, tabulating and recombining of evidences to a draw conclusion" (p. 129). I followed the study theoretical framework of root cause analysis as a strategy to remain focused on intrinsic data, and define co-occurring themes and their explanations (Yin, 2009). I used computer-based tools analysis NVivo 11 in the analytical purpose of data which enhanced coding and categorized participants transcribed data that I collected through the interviews. The use of computer-based tool NVivo was helpful in the data analysis but much of its functionality was not computer controlled, but can be considered analyst-driven (Yin, 2009), and as a result, I manually entered data in NVivo, analyzed and interpreted descriptive theories. As noted previously, coding in qualitative analysis is a key process which enhances qualitative research study. During this period, I uploaded all my gathered data in NVivo and at which point became broken down into more manageable parts (Beekhuyzen, Hellens, & Nielsen, 2010). Furthermore, I then reconstructed the analyzed data, and I reflected and gained a clearer view of the reality about participants' description of corruption in healthcare system in Owerri. Data analysis in qualitative study progresses from inductive and develops into a deductive process as more meaningful pieces of information that are pertinent to answering study

topic and question became mutually exclusive, and conceptually congruent to themes that reduce into fewer categories that can yield easier interpretation and communication (Lodico, Spaulding, & Voegtle, 2010; Merriam, 2009).

Table 4

Themes That Emerged From Open-Ended, Semistructured Interviews

No.	Themes	Participants
1.	Poor Infrastructure	15 of 15
2.	Poverty	15 of 15
3.	Healthcare cost	15 of 15
4.	Healthcare Services	15 of 15
5.	Government and Corruption	15 of 15
6.	Health Insurance	15 of 15
7.	Unpaid Wages	14 of 15
8.	Health Centers	14 of 15
9.	Public and Private Hospitals	15 of 15

I used NVivo computer software for coding and after analysis, nine themes emerged from the significant interview statements which I tabulated on (Table 4) and referenced on (Figure 4). The figure expressed what percentage that participants contributed to the emerged themes (see Figure 4). The discussion that follows covered the description of the themes.

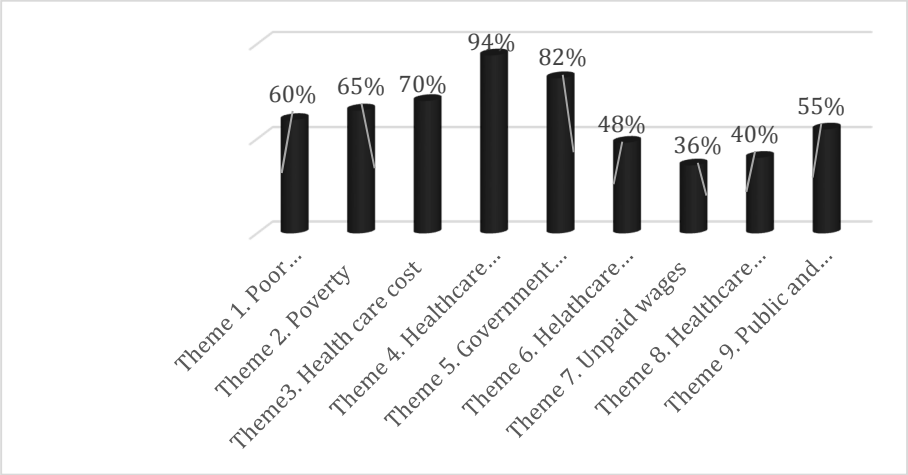

Figure 4. Nine key themes emerging from thematic

Table 5

Interview Questions

1. How do you access healthcare in Owerri?
2. What difficulties do you experience with healthcare service delivery and products?
3. What do you believe are the primary reasons for rural healthcare corruptions?
4. How has healthcare agency benefitted from healthcare funding? You can describe in what ways?
5. Have you been deprived healthcare services because of high out-of-pocket cost of care? If yes, can you explain?
6. How has out-of-pocket fees impacted you from receiving quality healthcare?
7. What are the contributing factors to senior healthcare delays?
8. What public policies or laws do you think need improvement in healthcare delivery in Owerri?
9. What difficulties do you experience from enrolling into primary healthcare insurance?
10. Do you know of any direct or indirect funding resources that healthcare agency receives for senior and rural healthcare development?
11. What is your perception about turn-out for senior healthcare enrolment in Owerri?

12. What motivates providers in bribery behavior and how do you perceive the impact on senior healthcare?
13. What is your perception about NHIS policy on fair and equal healthcare benefits?
14. What legislative policies (if any) deprive NHIS community health development from becoming transparent, report efficiency and deficiencies in their operation?
15. How do you measure success and detriments in the agency and community participation in NHIS enrollment?
    Probe (a): So, you stated that when people can't afford to pay for their hospital bill, they will be detained. How does that work?
    Probe (b): "Please can you explain more on what happens when people are charged expensively at the hospitals or health centers and they don't have the money?
    Probe (c): Please can you explain why the system is not working proper?

Perceptions of the Key Informants on the Themes

To answer the interview questions in relation to the influence of financial bribery and kickbacks and to gain a clear understanding of the participants' perceptions and lived experiences, participants were asked same questions as in table 5. From the coded interview transcript of participants' statements emerged nine themes. However, 1 theme [Diversion of patients] was inconsistent and was not considered important for the study due to nonconfirming data to the study.

Theme 1: Poor Infrastructure

According to the transcribed result from the participants' information and analysis collected under this theme, financial bribery and kickbacks in the healthcare sector. Participants were uncomfortable with the condition of roads to the hospital, depilating conditions and unhygienic conditions of the hospitals and the health centers. Also, mention was made about inconsistent electricity at the hospitals and environment. The

following significant statements from transcribed interview notes support the opinion that poor infrastructures in the healthcare sectors in Owerri were in poor conditions and hindered adequate healthcare provision for residents in the Owerri community. Participants who explained their perceived and lived experiences over the poor infrastructural condition of health facilities, bad roads that lead to the healthcare centers, inadequate equipment in hospitals and unsanitary conditions of the dilapidating structures in Owerri. MP1 noted that: "People go to the Federal Medical center but you need money also to travel to the location and with the bad roads, you may even get there late". This 65 years old senior citizen expressed her concern about how the bad condition of roads to the federal medical center is a barrier for her to access healthcare services. "Also, there is no infrastructure, no equipment in our hospitals like you people have in America" (MP1).

FP 2: While describing the poor conditions of the road that lead to the hospital, attributed that due to bad roads most healthcare workers are unable to get to work on time "In fact the bad roads alone make them not to come to work……. no good roads, no electricity in our community. Our local health centers are depilating and its bad" and further added that:

> Politicians, government officials travel overseas to get quality treatment because our hospitals are bad, corrupt, no good resources, people are poor and unemployed. I don't believe that people are treated equal and fairly in this part of Nigeria. Look at our roads, they are all full of port holes, when you are sick it takes you hours to get to the hospital, if care is not taken, one may end up dying

> before you get there, no electricity, how do you function hospitals without constant electricity, bad water and just name it (FP2).

Their description of the poor infrastructure in the rural Owerri tells how the community is left unattended and unmaintained by the government. The difficulties stand clear when people are challenged with poverty, underpaid, infrastructural decay in our systems and hospitals, insufficient aid to support our hospitals and healthcare research centers. MP3 noted that "The poor people don't get quality medical services, our hospitals and clinics are not maintained, no infrastructures and equipment in most facilities".

All the participants contributed to their own belief and lived experience that the condition of infrastructure in the community is owing to the corruption of both the government and the health administrators. FP 4 stated:

> I will not say it is a standard one, the sector is hazardous because of the political system, the hospitals have poor infrastructure, nonchalant attitude of the workers, non-payment of salaries and etc.…. no infrastructures, equipment, ethical decadence of workers and greed are all difficulties in our healthcare system. The federal medical center that is supposed to be cheaper among all is overcrowded, the state general hospitals are not that standard with infrastructures and equipment, and so people are even charged differently based on their primary cases. I know of a doctor who complained of contracting diseases from the hospital due to hospitals not having adequate infrastructures or research-based systems in place (FP4).

The above participant FP4 referred to the government and the political system that control the entire agency, condemned the nonchalant behavior of healthcare worker towards citizens that seek healthcare treatment and the overall situations of the federal and state hospitals in Owerri. FP5 also affirmed that "The hospitals are very poorly furnished, cracks on the walls and everywhere smells bad. No maintenance at all. If I did not give the nurse worker extra money when she told me I couldn't see the doctor claiming that they were closing I may have had complications for my surgery".

All participants made their notation on the same theme. MP 6 contended that "sometimes most of the government hospitals are underfunded or are ill-equipped, very poor infrastructures. So even some of the doctors may want to treat you there but the facilities or infrastructures are not there". FP 7 commented that "Well, I think the government should do more for our people, improve our health center, it's falling off, no infrastructures, the beds are old and very few workers". The participants maintained a critical description of the infrastructural condition of the hospitals, federal and state and their local health centers due to lack of maintenance or not putting funds earmarked for renovation of hospitals and its up keep. Our hospitals are not well equipped for treatment, some are dilapidated and lack maintenance".

MP 11 responding affirmed that "Contributing factors to senior healthcare delays include adequate education, healthcare funding which involves health insurance and special cases for seniors, ability to determine when someone is sick and want to seek treatment, aftercare services, transportation, and economic status of patients, environmental which affects seniors or elderly patients".MP 12 attested that "The health

centers have little or no infrastructures, no constant electricity, people are tired of their lies and poor services…… Could you believe that the hospitals don't have electricity to do surgery and at times no money to buy fuel on their generators, people die all the time as a result of that."

FP 13 said that, "The difficulties stand clear, when people are challenged with poverty, underpaid, infrastructural decay in our systems and hospitals, insufficient aid to support our hospitals and healthcare research centers".

The participants described their lived experience of the unsatisfactory condition of health infrastructure and those of the environment as odious and not meeting sufficient health standard for the community.

MP 14 noted that "The federal medical center that is supposed to be cheaper among all is overcrowded, the State general hospitals are not that standard with infrastructures and equipment, and so people are even charged differently based on their primary cases".

While MP 15 commented that:

> Here in Owerri, the hospitals are not really that in great condition, people stay on long wait lines to be seen by the doctor, if you are lucky to be attended you will be ready to pay off your pockets because you will be required to pay for scissors used in treating you, pay for gauge, pads, and you begin to wonder what they are doing with both money realized from patients and allocations for healthcare services. Sometimes people don't have access to transportation to go to the hospital in distant places or areas. The government should make available

> medication, surgical, and equipped health centers in our communities to make sure that the vital tools are available in those local health centers to enable health accessible to all. The difficulties are many here, you can talk about our deplorable condition of the roads here, and worst in our rural communities. No ambulance, not even accessible ride for our elders when they are sick, think about electricity-is zero electricity here, our hospitals are in very bad conditions, and people in power or top positions make it difficult for our poor people because they divert funds allocated for healthcare projects and rural development to their own selfish interest (MP15).

Theme 2: Poverty

The interview question: "What difficulties do you experience with healthcare service delivery and products?" was aimed at eliciting participants lived experience and perception on the difficulties encountered in accessing healthcare delivery and services. MP 8 also noted that: "although the cost of living is very expensive here today, poor infrastructures, transportation is deplorable-bad roads, and all boils down to greedy and selfishness of both officials and providers" (MP 8). Also, MP9 stated "You know because of the distance of the federal medical center and the general hospital; people don't have a lot money to travel and are scared about the bad road, so they go to the health center and get medication scripts. Our hospitals are not well equipped for treatment, some are dilapidated and lack maintenance". Both participants commented on the transportation situation up to the hospital deplorable condition which does not actually serve the neediest purpose due to poor infrastructure and expensiveness.

FP 10 noted "The rest of healthcare agency benefit is for the providers that steal money allocated for hospital infrastructure, machines and drugs to their private clinics. In Owerri. The theme poverty was derived from the statements provided by several participants and could be evidential from other interview questions which made this theme one of the most concerns of the participants. They all made references to poverty as their main barrier toward the inability to afford healthcare delivery and services and expect that there is a need for reduction in healthcare cost or a universal healthcare system (UHC) that may enhance the opportunity for all to have well-defined healthcare insurance that will be affordable to all. MP 1 said that:

> Accessibility of healthcare in Owerri is hard and very difficult because people are poor. We don't have money to pay for good health treatment. Poverty and hardship among families is a difficult case among our people. Sometimes when I go to the healthcare center for treatment, they charge too much money and I only take checkup and receive some medications or prescription to go to local pharmacy to buy tablets (medication for malaria or fever, but I can't get proper treatment (MP1).

Participants also stressed that poverty among the rural indigenes was as a result of government not paying salaries to workers, not paying pensions and that makes it difficult for people to access quality healthcare and their loved ones. Some perceived that healthcare enrollment was delayed principally due to inadequate education on healthcare and poverty. In confirmation, FP 2 added that: "People can't afford the high cost and they are poor, some are not paid where they work, government owes passions and gratuities

from seniors. The poverty spreads through the economy. The funding is not there for providers, to improve the quality and reduce the cost of healthcare for us. Also, while on factors contributing to senior healthcare delays" MP 3 also referenced poverty, indicated it as a result of peoples' inability to access quality healthcare such as

> The poor people don't get quality medical services, a lot of people are carelessly dying because of what is happening within the healthcare system, no medications in hospitals, high cost of accessing health treatment, most of us are retired without getting paid our pension or even gratuities, so how do we pay for medical treatment when there is no insurance (MP3).

Some participant expressed that high out-of-pocket impacts quality healthcare delivery and services due to inability to afford high cost. Treatment in Owerri they said depends on how much money one has, and that will tell what quality of treatment one can be able to access. They described Owerri rural area community population covering a majority of farmers, traders and civil servants and are poor. The seniors most times depend on family members, and if those members are not being paid or sell their products in the market, they can't afford quality healthcare for their loved ones. MP4 affirmed that:

> The impact I get from high out of pocket is as result of not having health insurance and if I don't have enough money to go to treatment, I might not be seen by the doctor or get the proper treatment I would need. This is because if you don't have money, you will not get treatment or even quality healthcare and that is why wealthy people go overseas to get quality healthcare (MP4).

FP 5 commented that:

> I go to the local health center here in Owerri when I don't have enough money to pay to private hospitals for admission deposit and treatment. Healthcare here is very expensive, most of us in this community are farmers, traders and few civil servants and we don't get that much money to be charged that expensively for treatment, and so when you don't have enough money to pay to either private hospital or state and federal hospitals, you can't get quality or even ordinary treatment…… What motivates bribery behavior is not just moral but certain triggers like poverty, greed, and selfishness is part of their motivators (MP5).

MP 6 stated that "My brother-in-law continues to have his leg bones deformed like that for a long time, he was deprived of quality healthcare, and elderly people out there in the community at times are deprived, because of poverty." FP 7 referenced poverty in her response that "Our people are poor, some are farmers, traders and some teach in our local schools and the government don't even pay pension, so how do they want us to survive. Our children don't have good jobs, and many are unemployed, it really impacts us when we don't have money to get treatment" On responding to fair and equal healthcare services, participant also in commented that:

> There is no equal treatment in our healthcare system when vulnerable population will be denied care for the simple fact of their poor economic inequality, poverty, unemployment and less fortunate status while the wealthy gets best treatment, attention, and does not wait on the line to be attended by healthcare workers and practitioners (FP7).

Participants were concerned about the poor living conditions of the community and worried about the government negligence about payment of workers' salaries, pensions and are with an opinion that poverty made it difficult for the citizens and seniors to access treatment at the hospitals. People were not getting the assistance they needed when in either health crises or financial crises due to poverty and government not concerned about the people they represent. Some of the participants also perceive that there is not equal healthcare treatment in the state and the entire country. They linked poor economic inequality, poverty, unemployment to the poor governance where the less fortunate status deteriorates while the wealthy get best treatment, attention from hospitals and travel abroad for health treatment. MP 8: When asked question about how to measure success in healthcare aimed at understanding how people value the outcome of healthcare delivery and services in Owerri referenced "Hunger is part of why people go a lot to hospitals, poverty, and bad water". MP8 also noted that "The thing is that one can die if the person doesn't have the money to pay, everybody pays from their pocket, nothing else. Yes, people get deprived of treatment because they don't have money to pay, people sell properties at times to be able to afford hospital bill". MP 9 commented that "The government is not doing nothing for us, they take our local health centers and expand them to the hospital and they deny us affordable healthcare. They don't deliver to us, people here are poor and needy. For me, I don't go there all the time because this our work you don't get a lot of money from labor job and the little I get I use it for my family and buy medication from the chemist in the market". FP 10 noted that "The reasons I think responsible for healthcare corruption in our rural community Owerri is just poverty.

Owerri is poor- people also don't know where to get help, people don't have access to healthcare insurance". Further participant emphasized references on the cost of health products and living situation of Owerri residents in a similar manner that several others had noted the cost of healthcare has become unbearable, and unpaid wages and pensions endangered the lives of citizens.

Participants tied their perception on the causes of constant strike in the sector, leading to the closure of hospitals for weeks. Many participants talked about unpaid salaries by the government and employees and expressed their frustration with the high cost of healthcare and their inability to afford healthcare. From their responses, it is evident that there is high unemployment of their youths and the consistent denial from the government towards their wellbeing aggravated poverty and sadness. Aimed to gain more information about participants lived experience on what deprive citizens of healthcare access. MP 11 said "So poverty and no availability of money may prevent people from accessing healthcare". And on the rate of turn-out of enrollment, participant MP 12 stated that "We pay a lot to the hospitals and if you don't have the money to pay for hospital charges, they will not treat you. They will tell you that you have to go home and return when you have money. Although it has not happened to me, yes it has happened to my family members and friends, they have been deprived of treatment when they can't afford the high cost of hospital treatment".

FP 13 referenced on the following challenges impacted by out-of-pocket and what influences senior healthcare enrollment as:

> The difficulties stand out clear when people are challenged with poverty, underpaid….and what really happens is that when citizens don't have enough money to support their hospital bill, the hospital has the right to retain them until family members could make the necessary arraignments to pay off their bill. Our people are poor, many of which are just traders, and farmers with little income. So the challenge here is the cost of getting treatment from the providers, private and government health providers (FP13).

The stories told by participants about their frustration over healthcare condition, high out-of-pocket cost of healthcare, high cost of living in Owerri where citizens are mostly poor find it difficult to access quality healthcare. The theme of poverty according to their lived experience was as a result of not enough resourceful policies that could hold the government responsible to pay workers' salaries on time and pension to seniors to enable them to live healthy and amiable. And FP13 further stated that the following factors motivated bribery and corruption: "There is the notion that hospital workers go on strike due to unpaid salaries and underpaid case to case issues, truant employees and ghost workers which are often investigated. So, bribery or kickbacks could be motivated today for several reasons from greediness to poverty". MP 14 noted that: "Although, we already know what it intends in our community where people often don't have enough to afford the high out-of-pocket cost of hospital bills. However, people outside of Nigeria look at Nigeria and see this country as oil producing country, poverty has high place among our citizens. Thereby making it hard for communities to afford standard living and healthcare services". MP 15 stated that "Our people are just poor, no job, senior citizens don't get

their pensions from the government and also added that making healthcare very expensive for us has impacted many lives, left many families in tears and sorrow" (MP15).

Theme 3: Healthcare Cost

This theme is another theme that emerged as a significant statement among the fifteen interviewed participants. The theme emerged from different questions aimed to elicit information about how seniors and residents perceive the cost of healthcare in Owerri. The cost of healthcare is challenging when it has to be coughed out from pocket or life savings of the rural citizens without proper health insurance to cover certain cost. MP 1 described his perceived experience on healthcare cost and stated that:

> Accessibility of healthcare in Owerri is hard, and very difficult because people are poor. We don't have money to pay for good health treatment. Poverty and hardship among families is a difficult case among our people. Sometimes when I go to the healthcare center for treatment, they charge too much money and I only take checkup and receive some medications or prescription to go to local pharmacy to buy tablets (medication for malaria or fever, but I can't get proper treatment (MP1).

MP1 further elaborated that, "We get healthcare by paying from our own pocket, if you or your family members don't have money to pay, you will know that there is nothing to do to save yourself from sickness" Participants also provided their lived experiences while trying to gain knowledge about quality healthcare and its impact from out-of-pocket cost from residents and seniors, FP2 stated that:

> At times due to high out of pocket healthcare cost, people can't afford to buy good medications, they go to quacks to get medication, most of which are either fake or expired medication floating our markets. With my family and me, we have afforded the cost. But 80% of the populace don't have access to healthcare or treatment from hospitals because of high cost of healthcare in Owerri today. That is why they prefer to consult quack or poorly trained doctors when they are sick or their health needs (FP2).

The response was a reflection of how illegal pharmacies flood the rural areas without monitoring of what kinds of medication are sold to the people, and as a result of high out of pocket cost, people prefer to consult untrained or unprofessional providers for treatment. Asking about participants understanding of what are the responsible factor for senior healthcare in Owerri and its cost, MP 3 emphasized that:

> The whole thing depends on how much money you have to be able to access healthcare. Since we don't have priority for senior healthcare, the case is that if we don't have family members that can afford our healthcare cost, it then becomes difficult for one to get treatment services. The government is supposed to provide programs that can enhance seniors to access health through low or reduced cost, be it insurance or free medical treatment (MP3).

The participants believe that accessing healthcare in Owerri depends on how much you can afford out of pocket since insurance does not exist in the area for citizens who are basically traders, farmers, and civil servants. MP 4 noted that "This community has the majority of farmers, traders and civil servants and are poor. The seniors most times

depend on family members, and if those members are not being paid or sell their products on the market, they can't afford quality healthcare for their loved ones". FP 5 perceived that for her to access healthcare and spend according to her limited expense said:

> I go to the local health center here in Owerri when I don't have enough money to pay to private hospitals for admission deposit and treatment. They are too expensive to access, and when you don't have the kind of money they are asking for, it's better you go to our local chemists in the marketplace to buy any medication for your illness. Sometimes too, when my children send me money I go to the general hospital, although they ask you to buy hospital registration card, pay a deposit and wait on line until you may be called in to meet with the doctor (FP5).

Also during further expression on healthcare cost, FP5 further expressed that: "Here you have to pay for everything, the hospital will write you prescriptions and you will have to go to the local chemist (pharmacy) to buy your medication. Medications are expensive, you have to pay from your pocket, and if you don't have enough money the hospital will hold you in the hospital until your bill is cleared by your family or relatives". Participants' reaction to certain question showed frustration and distress.

MP 6: This participant referenced her frustration with the condition of healthcare services and delivery in Owerri as unbearable as he stated that, "This is a very big problem for seniors like us. I've seen cases where hospitals detain patients because they can't afford to pay for their hospital bill or they don't have the money to clear their hospital bill". When probed with this question "So you stated that when people can't

afford to pay for their hospital bill, they will be detained. How does that work?" aimed to elicit clarity from her previous statement regarding patient detainment in hospital. Participant further stated:

> Yes, sounds illegal, but patients can be detained until when their relatives can afford their loved ones' hospital bill or make payment. That is, the doctors will not discharge patients or certify the patient for discharge until his/her hospital bill is made or an arrangement is put in place for payment. The case is to say that people here see healthcare as very expensive, and sometimes can't afford the high cost of care or treatment. People are poor, no jobs, the government does not pay workers, and they can't afford hospital cost……even when they want to operate under the stipulated projects, they charge patients expensively, outrageously and that makes healthcare very expensive……. people pay a lot to attain healthcare treatment and even their counterpart, the private hospitals operate without any guidelines, nobody monitors how they treat our people and even what they do to provide better healthcare service delivery, charges are very expensive, people are dying anyhow, nobody gives account of all these (MP6).

The frustration here is that getting someone detained in the hospital for not having enough money to pay for his hospital bill. There are varying feelings here, people are poor, can't afford expensive cost of treatment, may go to private hospitals but may still be charged same expensive cost and a show of hopelessness from the people. When discussing the cost of healthcare in Owerri, participants expressed their lived experiences

of the cost of healthcare, their perception of their understanding of how out-of-pocket cost could deprive treatment to patients FP7 stated:

> If you don't have the money they charge you, forget it you may be dying there they will not touch or care about you. Listen, here in Owerri and in short, the whole of Nigeria if you don't have money to pay at the hospital, you better remain and die at your house or you go to the chemist to buy medications……. also, if you don't have money here you can't get treatment from our hospitals. Of course, it impacts you because you may eventually die, remain in pain and humiliated at the hospital. They don't have manners; they talk to you any how and ask you to walk out if you don't have the money. Everybody here I believe pay from his pocket to get treatment. There is no insurance to get treatment here, maybe people in a big position in government have (FP7).

Asking question aimed to elicit information about challenges inherent from accessing healthcare in Owerri. MP8 responded that:

> The fact about the healthcare system in this our community is that many of our people especially the elderly doesn't have enough that money they charge for treatment…. It is hard here, the distance too because we have bad roads, fuel is too expensive, buses are expensive to go the location of both general hospital and FMC. So, people find it difficult to go to the hospital because they will spend too much on transportation, hospital bill, feeding, and even they ask you to give some money on the side before they allow you to see the doctor," and concludes that "Although the cost of living is very expensive here today, poor infrastructures,

> transportation is deplorable-bad roads and all boils down to greedy and selfishness of both officials and providers (MP8).

Participants are with the belief that the cost of healthcare is expensive and also the cost of living standard is expensive and that makes it difficult for citizens to go to the hospital. Recounted were transportation cost, bad roads, hospital bill and people are worried because they are afraid of being asked to give bribe to hospital workers before they could be allowed access to meet with physicians. MP 9 disclosed that:

> Hospital treatment here in our community is very expensive…. They charge you a whole lot of money before you will see the doctor and if they said that you will be admitted, they will ask you to pay half of the hospital bill in advance as a deposit. If you don't have the money, they will not admit you. They ask us to pay too much money to get treatment when the cost of treatment is too expensive and unaffordable by our poor community, that's why we don't get quality health treatment. They have many private and government hospitals in this our community but they are very expensive, so people are discouraged because of the high cost, too much going on at the hospitals, people die without proper attention, denied treatment or even detained from discharge until they fully pay their bill or they do some work at the hospital to make up their hospital charges before they will be discharged. People are scared, and not trust the government and hospitals anymore (MP9).

Furthermore, some participants that work with the health department are in support of the notion that the high healthcare cost has impacted lives and families. FP10 referenced in

her statement that “If I was not working in the hospital, I might have been denied also because if I don’t have enough money to pay for healthcare or treatment, hey, I may be in a difficult situation today”. He also noted that, “We currently have many reported and unreported deaths as a result for one not having money to go to specialized hospitals either in Owerri or the other cities”. FP 10 perceived that the Imo State is corrupt and have very corrupt system that has made it uneasy for both seniors and the general public from accessing quality healthcare. MP 11 linked healthcare cost to affordability and therefore claimed that people shop for treatment based on their affordability of out-of-pocket and noted, “You know basically people access healthcare based on what they can afford from their pockets”.

There is however the opinion that Owerri community have people who are not employed or are pensioners and farmers or traders, most of which are elders or senior citizens that do not have medical insurance to access healthcare. The idea that many people do not have out of pocket payment in accessing healthcare was also linked to poverty. There is also the claim that when people present with common illnesses to the hospitals, even middle-aged adults, young and children but they and their family members have to pay from their pockets. To gain clarity from participants over claims of not providing healthcare to patients who have little or no money to access healthcare services, I used Probe (b): and MP11 said “Sure, they cannot be treated because if you don’t have money, no services can be provided. The basic thing about elderly treatment here in Owerri is that about 98% of the senior citizens receive healthcare services from out-of-pocket cost, which is expensive. But things will get better in the future”. MP 12

noted that “To the best of my knowledge, people here don’t even know between what is quality healthcare and just treatment from our local hospitals because the cost of healthcare here is too expensive for our poor residents in this community. Our hospitals have failed us, and we have no alternative than to accept whatever services they can offer most times.”

Participants perceive that if one can’t afford to pay the hospital bill, it is better one doesn’t go there because they will embarrass you and will not attend to the person. People are over charged to get treatment especially when you don’t have anybody to advocate for you. Sometimes citizens are worried what happens to their most vulnerable persons, the elders that are approaching 80 years who no longer can go to their farms or trade in the local markets, no pensions, and that they go through a lot to get treatment at the local hospitals. Participants believe that the situation is horrible, they get denied treatment because they can’t afford to give bribes or expensive cost of treatment. In confirmation to that, FP 13 stated “What really happens is that when citizens don’t have enough money to support their hospital bill, the hospital has the right to retain them until family members could make the necessary arraignments to pay off their bill” (FP13). The whole process has become profit maximizing than its usual holistic nature where treatment was based on saving life. Today the industry has evolved into a new purpose which makes it expensive for people to access easily. Healthcare is supposed to be the backbone of every nation. FP 13 also stated that “Accessing healthcare here in our city is expensive, but I believe people feel the pain due to people are poor, high unemployment,

our transportation is poor". MP 14 also expressed his frustration over the high cost of healthcare saying that:

> People often don't have enough to afford the high out-of-pocket cost of hospital bills. The effect of this high cost does not mean that there is a possibility for one to gain quality healthcare. So, the high cost also impacts the ability of one to come forward to access healthcare because the cost outweighs the need, ability to afford, which may require many poor families sacrificing lifelong savings just to get treatment. And that was why I said earlier that it is catastrophic, exorbitant and dangerous for our community (MP14).

In response to Q 1, MP 15 affirmed that "people go to the hospital and health centers without getting the proper services, only to be charged expensively and without any form of insurance to aid their financial situations. Sometimes people don't have access to transportation to go to the hospital in distant places or areas".

Theme 4: Healthcare Services

Healthcare services were among the 8 themes that attracted significant statements from the 15 interview analysis codes. The interviewees provided significant statements regarding their perceived knowledge about the quality of healthcare they received and also referenced about their wait time at the public and private hospitals, and health centers. The theme served to elicit and gain knowledge of the participants' perception about how they are treated by healthcare providers and the quality of healthcare services delivered. Participants identified and referenced healthcare services in ways that they felt they perceived. MP 1 described his perception of healthcare services which involves that

if citizens don't have what providers ask you to pay before you see the doctor or admitted to the clinic or hospital, you will not be seen. Sometimes, when citizens don't know somebody at the healthcare center or hospital, there is evidence of negligence from providers, negative attitude from healthcare workers, which will or may lead to one leave or be told that the doctor is busy or that workers will ask you to come back the next day. People leave due to frustration, and before you know it or the next day that person will die. MPI then said "we the poor seniors are here suffering to get healthcare and when we go to the hospital, sometimes the doctors and nurses don't even provide us with services. There are no equal and fair healthcare services in this our community".

FP 2 stated "Many times, I hear people within this community complain of not getting the attention or help they need when they go to the hospital, either turned back because they can't afford to pay for their treatment or they can give somebody extra money to permit them access to see a doctor". Poverty could lead to the inability to afford the high cost of healthcare in Owerri. So, participants described their lived experience on health services based on the impact of poverty and the high cost of care and as a result they don't want to go waiting at hospitals for treatment when they don't have money to pay. MP 3 stated "Honestly, it has been an appalling thing the way healthcare is managed in Owerri. The healthcare system is not managed properly, it is ineffective, and I would say the healthcare needs proper attention".

To elicit clearer information towards why the healthcare system is not managed proper, I used Probe (c), and MP 3 in response said "Yes, why it's not working proper is because when you visit the hospital, the doctors are not there, the general public is

discouraged and are not getting proper healthcare services. What works depends on how much money you can afford to buy medical services, give bribes to healthcare workers" (MP3). Describing payment for healthcare services, MP 4 stated:

> I receive treatment when I go to the hospital but I hear people complain. Take for instance my previous personal experience I narrated earlier, what I would pay for N. 5000.00 I paid about N. 200,000.00 the quality of services is very low or poor. Personally, I have seasonal sickness, I went to meet a doctor who discovered after tests that I have enlarged heart. They gave me medication that had bad side effects on me, that made me almost paralyzed, in such a way that I could no longer walk (MP4).

Healthcare services in Owerri is designed from the perspective of the NHIS regulatory rules which leaves people to pay from out-of-pocket as a method of accessing healthcare for the general population. In her narrative FP 5 expressed:

> I have experienced several difficulties in the past while trying to get treatment. One time I was at the general hospital for about 5 hours without seeing the doctor and all I see was people that arrived to the hospital after I had registered were being called before me to go to meet with the doctors. Medications are expensive, and if you don't have enough money they hold you in the hospital until your bill is cleared by your family or relatives (FP5).

FP5 further narrated her lived experience regarding how she went to the general hospital last year for a checkup and with high fever, managed to find transportation to the hospital and the hospital said her money was not enough. She was not seen and she waited for so

long begging for the doctor to attend to her, but later left and went to buy tablets for fever from the chemist and went home. MP5 stated, “People in this community complain about how unfair they are treated by healthcare worker in our hospitals, poor treatment services, sometimes they are closed because of a strike and people are suffering”.

MP 6 said that “Healthcare in Owerri is basically suffering from everything that any other thing is suffering from in Nigeria. Just like individuals, young and old take money out of their pockets to pay for healthcare. This is a very big problem for seniors like us”.

He further narrated of seeing cases where hospitals detain patients because they can’t afford to pay for their hospital bill or they don’t have the money to clear their hospital bill which makes life miserable. In that case, FP 7 affirmed that, “My husband died waiting to be seen at the general hospital after he was involved in a car accident. They could not treat him immediately because he had no money to deposit before he could be admitted or seen by the doctor. Many people here in our community have been treated same way and that is how they work.” (MP7).

In his description of healthcare services in the past 61-year-old MP 8 narrated vividly that he was always going to the local health center before they built and opened the general hospital 40 years ago by the state government. He later began going for treatment at the general hospital in Owerri. His opinion was that hospital workers were good then, although recently, they have made a lot of abnormal changes such as he mentioned, “too long waiting line, strikes and many stories go on there.” Yin (1993) points out that opposite response of the majority of the responses can be significant. MP8

in his words stated that “The doctors are good but if you don’t have the kind of money they charge for deposit before they can attend to you or admit you, they will ask you to go somewhere else or refer you to another hospital.” Also, MP14 perceived that “We have good doctors, nurses in our local hospitals, and the only issue noticeable when I go to visit people or go to get treatment is the long waiting time, people complain about high cost, while some providers also complain about underpaid, not being paid for some months, I can understand those challenges.” Further significant was suggested from MP 14 that:

> We (lawmakers) are asking for Universal healthcare in our state that can be able to accommodate every resident here. That way our residents will have access to health insurance to primary healthcare and that may bridge the current issues we are faced with both primary healthcare and our entire healthcare system. Here in Owerri I don’t think there are systems in place for everyone to enroll into healthcare insurance, although Our National health insurance scheme describes that citizens could have healthcare access through health insurance (MP14).

Seven participants expressed their perception about healthcare services in Owerri with their lived experience which according to them impacted family members of friends. The effect of poor hospital and healthcare centers services, participants attest that their loved ones are unfairly treated at local and federal or state hospitals, either denied access to healthcare because they don’t have enough money, doctors and healthcare workers’ consistent strikes, residents are either neglected or workers seeking bribe and kickbacks before they can have access to treatment and the deplorable conditions of the hospital and

health centers. Participants believe that the government is not promoting or encouraging equal health for all and does nothing to improve the quality of healthcare and access to all citizens. “So, at times when you don’t have enough money to be able to pay completely what they charge you at the hospital they will not treat you and ask you to come back next time when you have the money. People die as a result. That’s how I lost one of my relatives” (MP 9).

FP 10 in her opinion stated:

> One of the difficulties is that most of the times when you go to the hospital, doctors are on strike, if not, you should know somebody who will assist you get treatment, if not, you will have to be charged a lot and meaning you have to pay for everything up to wipes you use in the hospital. If you don’t have the money to pay you might end up not seen or treated, and may end up dying before you get treatment (FP 10).

Expressing similar service condition from the private healthcare provider, MP 11 confirmed that though residents may not have the needed cash for service or amount hospital may require for certain health issues; the hospital may refer those patients to the federal or state hospitals where they may receive services cheaper.

> They do out of pocket payment in accessing healthcare. And when they present with common illnesses that we attend, even middle-aged adults, young and children but they and their family members have to pay from their pockets. There are cases in which patients will present here and in such cases patients don’t have money to pay their deposit before admission, that’s cold case, you don’t admit

> them and they will be referred to general hospital or the federal medical center. They don't have medical insurance because there is no medical insurance, in essence, to the general public and at times their family members may not have money to afford the hospital cost or bill. So, poverty and no availability of money may prevent people from accessing healthcare (MP 11).

MP 12 contributed his lived experience and expressed that "the healthcare system here is tertiary system and the difficulties involved is that they are not well coordinated when it comes to providing treatment services, attending to patient needs, long waiting list, requesting for kickbacks from patients to jump the line, charging very expensively for services and also poor referral procedures."

FP 13 also perceived that the healthcare service conditions are not getting better, although suggested for Universal healthcare, but stated "the case in Owerri is that people usually go to their nearest hospital, many prefer to go to the local health centers because they are cheaper and less reliable compared to those of Federal, state, and private hospitals. Our people go to shop for cheaper healthcare treatment because they pay from their pockets, no established insurance yet" (FP13).

Further on healthcare facility issues and challenges facing residents, the senatorial representative expressed that the case with the public hospitals is that Owerri or Imo State revenue on healthcare is not robust to serve all of its citizens. The perception on healthcare service problem in Owerri as in other states or local areas is that families bear the most health expenditure as a result of varying healthcare cost even within territorial basis. It was expressed to understand that, "at times people could not afford the cost and

there is no offence committed when hospitals present you with a bill before treatment which includes deposit before admission to the hospital, consultation fees, and medical cost of materials, drugs and referral for special illnesses" (MP14).

The theme mostly expressed frustration and anguish from healthcare service and delivery conditions in Owerri local areas. MP 15 stated "Doctors and healthcare providers, hospitals, clinics and health centers does not accept people in their facility without down payment or deposit before treatment or even first aid. It's called cold case here. People are challenged with both government hospitals and the privately-operated hospitals that have become outrageously expensive for the poor."

Theme 5: Government and Corruption

The interview question: "What do you believe are the primary reasons for rural healthcare corruptions?" was aimed to gain understanding of the interviewee's perception on the claim that rural healthcare in Owerri is corrupt. Government and corruption was the emerged theme from analytical codes and participants perceived responsible for the delay in the senior healthcare enrollment, poor and expensive healthcare delivery and services to residents, looting of earmarked healthcare allocations, and inability to ensure consistent resources in the healthcare system, non-payment of salaries or wages to both workers and pensioners. MP 1 perceived that:

> The government is corrupt, doctors don't get a salary, nurses are not being paid well and sometimes the workers wait a long time before they get their salary so for them to survive and take care of their families the ask for money from patients before they can get treatment. So rural healthcare is poorly managed, we only get

> good treatment when we hear of medical assistance or medical mission from foreign countries that come to our local community. The healthcare system like other government departments are corrupt- they are selfish, "sighs and shake of head," we are suffering, people are poor, nobody care about us. Many people say they don't get medical services and the system is corrupt (MP1).

FP 2 in her perceived opinion about the government and corruption noted that:

> Is all about the corrupt system where we the poor are always turned around when people don't have the resources to afford the expensive out-of-pocket cost in healthcare in Owerri and entire Nigeria. Those in power are looting and diverting money that could have been used to improve our health clinics, local hospitals, they prefer to travel for treatment abroad and leave us to die. Many hospital workers go on strike due to non-payment of their salaries by the government. So, poverty and non-payment of salaries are core factors why they are motivated to become corrupt, taking a bribe from patient to have access to treatment (FP2).

The participants in their perception of how government operates healthcare system are with the impression that the government has not accomplished enough for the citizens. People have lost confidence in the government and the health administrators in the community. MP 3 noted, "They said when the head is bad, every other part of the body is bad (proverb). The government really have to sit up, be honest within themselves, they should purge the bad people out. They use healthcare system to enrich themselves, to them it's like a money-making machine, selfish merchandise, the sell medication and services that would serve the people." MP 4 condemned the government corrupt

behaviors and expressed his perception on why people don't get proper healthcare and why the healthcare is unattainable. He then said:

> I don't think we have primary healthcare. My father is already a pensioner who contributed what we call pension scheme so that when you retire from work you can be able to take care of yourself. But the government don't even pay the pensions, they pay them very poorly. That there is corruption because the government sits on top of allocation for pensions payment or they use that money to take care of their own selfish interest, leaving people poor, people begin to find ways of taking bribe and kickbacks to take care of their family problems (MP4).

FP 5 also noted, "Well, corruption in our hospitals and clinics I believe is because providers are not being paid well and most times when they don't get paid they will go on strike. They are always on strike, time after times because the government do not pay. They divert monies meant for hospital services, salaries, and monies for buying medication, equipment and even for renovation projects." MP 6 perceived that "Nobody trust the government, no one takes the government seriously, and there is a lot of mistrust over the government because of corruption. The government does not satisfy us with their governance on healthcare, people pay a lot to attain healthcare treatment". FP 7 said "Our government don't care about us. They steal all the money and drive big cars with their families and loyalties, corruption everywhere, nobody does nothing". MP 8 was against the government position with how healthcare is managed and expressed that:

> The ministers are looting allocations for healthcare development and projects, give contracts through taking money under the table, and assign their family

> members to sensitive positions, friends to become contractors even without any experience, that's bribery and corruption. They lie to us, the government officials are liars and looters, no transparency in whatever they do, and people are being owed salaries, projects uncompleted, and monies gone unaccounted for from the hospital workers to their big boss, up to ministers of health, are not people to be trusted anymore (MP8).

The fifteen residents interviewed were of the opinion that the government is corrupt and that healthcare administrator's corruption was as a result of non-payment of salaries and greediness to self-aggrandizement. MP 9 stated:

> I don't know, but I think corruption at the hospital is because the workers and their boss want to take more money from you. Sometimes they may tell you that you have to pay for everything they used on you at the hospital, from bandages to even water. That there I think is stealing from the poor people or you can call it corruption. Their stealing makes people don't want to go to the hospital especially our senior citizens (MP9).

FP 10 commented that "Accessing healthcare means, I see it as very poor, not because there are no good doctors, but things are not well distributed, Imo state has a high level of corruption. Appointments are based on your senatorial zone; workers are not paid or not paid on time. There is no healthcare insurance anywhere, most population in Owerri is poor". MP 11 was with the opinion that "Rural healthcare corruption is rooted from how the government provides health services to the people. Generally, corruption is one of our problem in this community. We have federal, state and local governments. In our

situation, local government has not been in full operation over healthcare because the state governments appoint local government administrators that operate and protect their interest".

Further on government and corruption, MP 12 responded:

> Rural healthcare corruption is very common among our federal, state and local government funded providers here in Owerri and I think elsewhere in this Nigeria. They are the same people, the government on seat appoints their own people, and due to that, they have godfathers that cover their corrupt behaviors. Corruption in this part of the world is becoming some normal or daily occurrences because it involves almost every government department due to worker don't get paid, and people are greedy (MP12).

FP 13 in her perception believed that "Rural healthcare corruption is something lacking sufficient attention among our government officials and systems out there. The claim that our rural healthcare system is corrupt is pertinent to what is available or what people call corruption in that sector because corruption today is distracting a lot of programs and projects". Also, MP 14 noted, that "So sad that today listening to every Nigerian, their conversations are all about corruption. I don't blame them. The country is facing a tough challenge with corruption, not only in Owerri but across levels of governments. To tell you that there is becoming troubling". MP 15 perceived that:

> The difficulties are many here, you can talk about our deplorable condition of the roads here, and worst in our rural communities. No ambulance, not even accessible ride for our elders when they are sick, think about electricity-is zero

electricity here, our hospitals are in very bad conditions, and people in power or top positions make it difficult for our poor people because they divert funds allocated for healthcare projects and rural development to their own selfish interest. Again, low wage, poor transportation and high cost of transportation and poor employment benefits may be contributing factors to the corrupt act.

Theme 6: Health Insurance

This interview question "What difficulties do you experience with healthcare service delivery and products, and from enrolling into Primary healthcare insurance as in figure 3." was presented to elicit participants' perception and understanding about healthcare delivery and services challenges in Owerri with or without healthcare insurance. The theme emerged as all the participants had their perception towards the non-available health insurance for everybody except for some set of people that work for either state of federal government. MP 1 noted, "There is no primary healthcare insurance in Owerri, may be people in Abuja has primary healthcare because they work for the federal government. Now I have retired about three years ago, I did not have health insurance, they don't tell us about healthcare insurance. I pay from my pocket to see a doctor, to buy my medications, and they are expensive". FP 2 stated, that "The point is that insurance services are not in use, even in other services like car insurance, we only have the 3rd party. That is the only insurance I know about. Assuming there is any such thing as health insurance, the only people that may be getting health insurance will be federal government workers or to be used in federally sponsored health facilities". MP 3 suggested that "It is high time the government should introduce healthcare polices like

health insurance especially for us adults and also for the general masses. People are poor to be paying this expensive money from their pockets even as we don't get paid our pensions, arrears and gratuities."

Another participant expressed his perception and lived experience by describing how he and his family was impacted by not having health insurance, medical negligence, and no compensation afterward. MP4 noted that:

> The impact I get from high out of pocket is as result of not having health insurance and if I don't have enough money to go to treatment I might not be seen by the doctor or get the proper treatment I would need. From personal scenario, when my own immediate senior sister (older than me she is 68 years old), was pregnant, she did not have health insurance, and if not us family members that supported her with money she may have died. Personally, I have seasonal sickness (MP4).

FP 5 explained that "I know that federal government workers have federal benefits that include healthcare insurance and a friend of mine works in one of the oil companies, she said that she has health insurance that the company gave them from third party health management organization, (HMO). There is in essence no health insurance for the general public in Nigeria, not even to talk about the forgotten regional Owerri". MP 6 also noted that "When the system does not have good health insurance policies, they can't recuperate money from patients. The healthcare system in Owerri is suffering like every other individual agency is going through in Nigeria. People don't have the trust because the healthcare system is not well organized and as such people prefer to pay out

of pocket". FP 7 responded "We don't have health insurance here. As I said to you before, only government workers get that, if it exists. If they offer us health insurance, I think people will enroll".

Although participants perceived that the government is not doing much to improve and extend health insurance to the general public, some participants were also with the perception that there is not adequate education on how health insurance can be reached and that the NHIS should extend health education services to the rural areas on how citizens can get aid. MP 8 expressed that:

> No one asks us to enroll into primary healthcare insurance. We know that here in order to get treated for any illness at our hospitals you must pay from your pocket. Health insurance would be a good option to reduce this outrageous cost in treatment, make it affordable to everyone. The National Health Insurance Scheme is a federal program, the federal ministry of health, they don't care about us here in Owerri and our surrounding communities (MP8).

Again, MP 9 affirmed "To be honest I don't have insurance, but I don't know if anyone has insurance here. We pay them with cash. The hospital doesn't ask for insurance they always ask us for cash money. We need education about the National health insurance scheme. Most people living in Owerri are either farmers or traders and only some fraction of our community are government workers who can afford the high cost of healthcare here". In response to Q 2, NP 11 stated, "You know basically people access healthcare based on what they can afford from their pockets. We have government healthcare scheme, the government health insurance scheme, though it does not function well or

appropriately implemented. We have a couple of insurance companies that sell health insurance to workers from the federal government agencies and large companies that can afford the cost for its employees." MP 12 said "I am a senior citizen, I am 62 years old and does not have health insurance. The government does not care about us, they focus on their pockets and that of their families". The participant further suggested what can improve healthcare accessibility and reduce high out-of-pocket cost in his own words.

> If the government apply policies that can monitor offenses at hospitals, safeguard citizen's right to treatment, provide health insurance for all and also increase healthcare worker wages, fixe our roads, provide constant electricity, I believe Nigeria will become a healthy place to talk about healthcare services and become measurable (MP12).

FP 13 explained from her perception that:

> The Federal government has a nation centered health insurance scheme that has been dormant waiting for states to implement policies and mechanisms that may enable them initiate Universal health coverage (UHC). People here in Owerri are surly challenged with the exorbitant high cost of healthcare, our economy is growing and the unemployment is higher than expected to reduce in the States proposed 20-year projected reduction in youth unemployment that could boost our economy (MP12).

MP 14 suggested that:

> There should be either community-based health insurance that should factor local income base providers to even base on per-capita income per person. We are

> asking for Universal healthcare in our state that can be able to accommodate every resident here. That way our residents will have access to health insurance to primary healthcare and that may bridge the current issues we are faced with both primary healthcare and our entire healthcare system, but noted -that here in Owerri I don't think there are systems in place for everyone to enroll into healthcare insurance, although Our National health insurance scheme describes that citizens could have healthcare access through health insurance (MP 14).

The participants had similar perception on the impact non-available health insurance had on the residents and some made positive suggestions on how the government can assist in providing policies and measures that may improve the quality of healthcare and making healthcare more accessible to the public by introducing health insurance education in rural areas and having open access to health insurance enrollment for all especially the seniors. MP 15 noted that:

> The delay in senior healthcare enrollment is as a result that there is no health insurance available to encourage or promote healthcare and that's why I mentioned before that we have not got there yet……., I believe if the state governments have access to handle healthcare without getting oversight from federal ministry of health as sole comptroller of National health insurance scheme, states can then go in for Universal health coverage which will make it easy for everybody to access health insurance.

Theme 7: Unpaid Wages

This theme emerged from the many significant statements from participants transcribed and coded data from interviews. The participants perceived that unpaid wages are a main issue for not accessing healthcare treatment from many of the hospitals in Owerri. Several participants were had mentioned, (none payment of salaries, pensions, wages, gratuities and underpaid) during the interviews. This was evident in some interview questions. Many of the participants related their perception, and in response to Q 8, MP 1 responded "The government should pay salaries to workers, doctors, and those that are in pension. Nurses and other workers in our hospital are not getting paid or not paid well, so many of them sell medications, ask for money on the side to help you get access to go to receive treatment before other patients. A lot motivates the provider in corruption because the system is corrupt, the government is corrupt". FP 2 explained differences within the federal and state health institutions cost of care and noted that:

> With federal government owned institutions, you have facilities, specialized practices, and paramedical staff in their setups. With them, their cost is cheap, and they operate with more specialized doctors and nurses. Then followed the state hospitals (general hospitals) that also operate with good doctors but in their system, exist much truant staff who because they are not paid well or many times the state government owes them salaries, they don't always report to work or due to laxity. The government is actually not doing anything to keep up with the conditions of things in our hospitals, doctors and healthcare workers go on strike all the time because they are not being paid (FP2).

MP 3 added from his perception that "Our children don't get their salaries on time and at times they are owed for many months. Life is hard here; people die every day from not getting good treatment. The way things are working, people are not paid, it brings corruption, it sets a goal for kickbacks among agency workers and things are not really working well". Participant MP 4 stated, "I will not say it is a standard one, the sector is hazardous because the political system, the government does not pay the pensions, they pay them very poorly." Participants continue to comment that the believed corruption in healthcare sector is as a result of unpaid wages, pension and gratuities and workers are not paid well. In support of that believe, FP 5 stated:

> Well, corruption in our hospitals and clinics I believe is because providers are not being paid well and most times when they don't get paid they will go on strike. They are always on strike, time after times because the government does not pay. The workers have family and need to feed, provide for their loved ones, travel from their homes to work and when they are not paid, they ask patients for kickbacks, people give bribes to access healthcare quicker and to get more healthcare attention (FP 5).

Other participants also affirmed that unpaid wages lead to poverty and corruption among healthcare workers and workers in other government agencies. Their responses can be retraced towards the influence of corruption in the community and its impact to accessing healthcare in rural areas where people are perceived as poor and unskilled workers. MP 6 perceived that "People are poor, no jobs, government does not pay workers, and they can't afford hospital cost. And secondly many of the pensioners don't get their money

because the pensions don't get to us on time, and the retirement benefits don't come when due and just like they (government) owe workers."

These participants expressed her perception that her understanding is that people lost hope in the federal and state governments and FP7 noted: "They say that the federal government and the state have not paid salaries, they don't give us medication and when they do, they prefer to charges us a lot of money. People prefer to go to the local chemist for medications. To be honest, Nigeria is too corrupt today than in the past years" MP 8 stated, "They lie to us, the government officials are liars and looters, no transparency in whatever they do, and people are being owed salaries, projects uncompleted, and monies went unaccounted for". MP 9 also followed and stated, "Many of the workers complain that the government owes them their salary and that they are not paid enough money for their services. Their stealing makes people don't want to go to the hospital especially our senior citizens, they don't have the money to give in bribery or kickbacks".

Also, in response to Q 3, FP 10 said "Workers sell drugs the hospital or clinic could use for primary healthcare treatment because they don't get paid and ask for money from patients before they could allow them access to meet with doctors. We currently have many reported and unreported deaths as a result for one not having money to go to specialized hospitals either in Owerri or the other cities. Pensioners are not paid; the government is corrupt and will not use allocations for healthcare and other agencies proper. The cost of health products has gone high, people go to work and don't get paid, and pensions are not paid to senior citizen retirees. Doctors and other healthcare providers don't get paid and are mostly on strike thereby closing hospitals for weeks.

Imagine how many that die during the hospital worker's strike in Owerri alone, (sad face). When I don't get paid, I can't afford transportation to work; doctors can't as well". MP 12 stated that "The government doesn't pay workers on time and most times they are owed for months without paying, so they need to make laws and policies that will set guidelines for hospital workers to get their salaries on time. If the government do all these, I think things might improve". FP 13 responded that "The issue of bribery has a devastating effect on service delivery and the health of our communities. There is the notion that hospital workers go on strike due to unpaid salaries and underpaid, case to case issues, truant employees and ghost workers who are often investigated".

The many data gathered from this theme relates mostly on how the federal and state governments have failed in their efforts to fulfill the promise of paying workers' salaries, pensions and gratuities to enable citizens' gainful living standard. MP 14 and M15 had a similar notion to that of the rest 13 participants who had the same opinion. MP14 noted "You see that there is a whole complex issue between the people and healthcare workers. I think bribery in our local hospitals today are as a result of low wage earning among health administrators and their staff" while MP 15 concluded that:

> Many workers also involved in the corrupt act because when you work, and you don't get salaries, you will be tempted to look for ways of getting money to take care of your problems. The government does not pay salaries on time, owes both healthcare workers and other agencies like teachers for many months before they begin to pay gradually. Again, low wage, poor transportation and a high cost of

transportation and poor employee benefits maybe contributing factors to the corrupt act (MP 15).

Theme 8: Health Centers

The interview question "How do you access healthcare in Owerri?" was meant to extract information from the participants' perception on which healthcare facility in Owerri they find more accessible for healthcare treatment and the theme emerged from the participants' many responses to the most interview questions was the health centers. The theme emerged from the coded transcribed data where many of the participants perceive that health centers are nearer to them although they are not thoroughly equipped and well managed by doctors and nurses they are cheaper and affordable than federal, state and private hospitals in Owerri. Factors mentioned as great barriers are bad roads, distance, transportation cost and time, poverty or financial problems, healthcare cost, wait time, bribery and kickback of the workers and administrators. They also mentioned that although the hospitals are expensive, their treatment is better, professional, proper healthcare or better services and medication. MP 1 perceived that "People go to the hospital or our local health center to get treatment services. Accessibility of healthcare in Owerri is hard and very difficult because people are poor. We don't have money to pay for good health treatment. Poverty and hardship among families is a difficult case among our people". FP 2, noted that "Most people prefer to go to the few mission clinics, private hospital and our local health center for services. There they may get access to someone that can listen to their suffering and allow them to see a practitioner-a doctor or nurse who can advise on what to do or as well as provide them with medications or prescription

to buy medication from our local pharmacy". MP 3 said "When you go to the rural areas, we have chemists and health centers. The doctors will gather people through announcing free medical checkups, and people will come out in full just to be able to talk to the doctors who will then write medication for them to get from the chemist".

To identify other means of healthcare provision that reaches the community, FP 5 stated:

> I go to the local health center here in Owerri when I don't have enough money to pay to private hospitals for admission deposit and treatment. The only senior healthcare delay I can talk about is from our local health centers where yearly we have been getting medical assistance from doctors that come from overseas, America and Europe who operate as non-government organizations, world health organizations, and some churches. Our local health centers are depilating, and it's bad (MP5).

Some participants referenced that seniors don't get required healthcare services they need and believe that health centers are more accessible but need improvement in infrastructure, medication and professional staffing to better serve citizens. MP 6 stated that "Certainly, seniors are not getting the healthcare they deserve. The general hospital keeps people in a long waiting time list, and people may even die before they are permitted to meet with the doctor". FP 7 affirmed that "I go to our local health center and sometimes to the general hospital when I am sick or take my children there when they don't feel well. You have to wait to get hospital admission card, wait for them to call you which most times takes the whole of my day. It is very bad here and we don't see what

they are doing with the money the government is paying to improve our health center and hospitals. The doctors sometimes will refer us to their private clinics and tell us that their hospital is the best. That is how corruption in our local hospitals and health centers go on every day without any arrest". MP 8 expressed in detail that:

> I was always going to our local health center before they built and opened our general hospital 40 years ago by our state government. But, listen I still go to our health center sometimes when the line at the general hospital is very long". If you want to spend less, you may go to the health center where they may write you medication slip, and you go to buy medication from the chemist. Normally our local health center communicates mostly with our pregnant women, and children (MP8).

Also, MP 9 detailed that "I go to the hospital and our health center to get treatment when I don't feel well… so some people prefer to go to the health center but you will only gat medication script, or if you are lucky, you may be able to be seen by a visiting doctor who may also refer you to his own clinic. When the cost of treatment is too expensive and unaffordable for our poor community, that's why we don't get quality health treatment." For participant FP 10, she noted how health centers are beneficial to the community "When we have community health center outreach, people turn out in large numbers to receive free medication from organizations that may want to assist in healthcare delivery…… Mostly senior citizens do the most turn out because many youths are in the cities or abroad".

Although participants express their lived experiences and perception on the phenomenon, some other participants have the passion to detail more information about the structure of the healthcare system, their relationships and how they are being operated in the country. They also narrate their perception in such a manner that readers can understand in-depth what they want you to know. Some participants during the process try to bring in their fair suggestion for improving the quality of the health centers and other healthcare facilities. MP 11 expressed that:

> "Healthcare generally, at its generality we have tertiary institutions that provide healthcare services. We have general hospitals that are run by state government. Federal medical centers that are funded by the federal government and local health centers in our rural communities serviced by local governments. The state government does not allow local governments to operate independently as was structured but bureaucratically, they are being oppressed by their state government and legislatures, and that prevents the health centers in their locality from providing adequate services to the seniors and the entire community" (MP11).

Also, MP 12 stated, "Here in Owerri like other parts of Nigeria we have the health centers that are run by local governments, the general hospitals that are operated by the State government and then the Federal Medical Center, which is funded by the Federal government." FP 13 stressed the fact that nearness and fair prices are factors people to go to health centers for treatment and noted:

> Every Nigerian either from Owerri or other parts of Nigeria tend to go to either state, federal or private hospital when they are sick. The case in Owerri is that people usually go to their nearest hospital, many prefer to go to the local health centers because they are a bit cheaper and less reliable in areas of quality healthcare outcome compared to those of Federal, state, and private hospitals. Senior healthcare although is not represented in the current National health insurance scheme rolled out by the federal government, but the Federal medical center and our local health centers place priorities on our seniors when it comes to providing healthcare needs at the centers (MP13).

Although that majority of participants are with the perception that the government is not doing enough to improve health centers and hospitals, and the believe that there have been weekly reports of good turnouts for medical check-ups on the elderly, vaccinations for several illnesses and to access free medical checkups from doctors without boarder. MP 14 perceived that "In Owerri, as we speak, the federal ministry of health supervises, oversees all healthcare activities, mandates supervisory obligations to the state ministry of health which controls our general hospitals and our local healthcare centers, also known as primary health centers." MP 15 also perceived that:

> People go to the hospital and health centers without getting the proper services, only to be charged expensively and without any form of insurance to aid their financial situations. Sometimes people don't have access to transportation to go to the hospital in distant places or areas. The government should make available medication, surgical, and equipped health centers in our communities to make

sure that the vital tools are available in those local health centers to enable health accessible to all (MP15).

Theme 9: Public and Private Hospitals

Public and private hospitals are one of the themes that emerged from the interviewee's statements which emanated from the interview questions concerning the participants' access to healthcare treatment in Owerri. Some examples include statements such as "What is your perception about turn-out for senior healthcare enrolment in Owerri?" which was meant to prompt information from participants' perception on difficulties behind healthcare delay, corruption impact, and public hospitals. The participants were also prompted to compare public hospitals to the private hospitals' services delivery, condition, and accessibility to treatment services. Participants perception on this theme ranged from people shopping for healthcare treatment, the impact of high out-of-pocket cost, poverty, deposit fare before admission, and some made positive suggestions that may encourage improving the sector in a way that it will become easily accessible and affordable to the community. MP 1 noted that "People shop for treatment in different hospitals (public and private) before they will find who will ask you to pay less money before you are treated. "Sighs and shake of head", we are suffering, people are poor, and nobody cares about us. We need good equipped hospitals and free healthcare system because Nigeria is producing oil and many of us are farmers too."

FP 2 stated "In Owerri, or within Owerri there are three healthcare models, and healthcare is handled instead by 3-4 categories such as Federal category known as

Federal Medical Center, State government-run hospital known as general hospital, local government handles local health centers and also Missions that handle church-owned hospitals". MP 3, however expressed frustration over the economic situation of the people before they can be able to access healthcare and said "Some people sell their properties in other to get money to attain or have access to healthcare treatment from hospitals" without distinguishing from the state, federal and private hospitals".

In contrast, MP 4 described the conditions of the different health facilities in his own words "I will not say it is a standard one, the sector is hazardous because the political system, the state hospitals and even the federal medical centers we go to have poor infrastructure, nonchalant attitude of the workers, and non-payment of salaries. So, I prefer to go to our rural health center, it's not crowded, fast to get treatment. The private hospitals are too expensive as well". FP 5 also made similar identification and stated "I go to the local health center here in Owerri when I don't have enough money to pay to private hospitals for admission deposit and treatment. The hospitals are very poorly furnished, cracks on the walls and everywhere smells bad. No maintenance at all". MP 6 stated "I've seen cases where hospitals detain patients because they can't afford to pay for their hospital bill or they don't have the money to clear their hospital bill. When the system does not have good health insurance policies, they can't recuperate money from patients. Many of the government-run hospitals are affordable to the general public than the private ones, although they may be more efficient". FP 7 stated "I go to our local health center and sometimes to the general hospital when I am sick or take my children there when they don't feel well. You have to wait to get hospital admission card, wait for

them to call you which most times takes the whole of my day. The doctors sometimes will refer us to their private clinics and tell us that their hospitals are the best. That is how corruption in our local hospitals and health centers go on every day without any arrest".

Some participants describe that bribery in the local hospital and private hospitals often become irritating to motivate citizens to go to get treatment, and expressed his frustration on so many things the hospitals charge people for when they go to the hospital. Other suggestions focused on ways in which the government could improve by an introduction of regulation and policies. MP 8 stated:

> Every one of the providers charges you differently from government hospitals to the private ones. Too much bribery out there, they ask you for this and that to allow you jump the line, the take money from patients to buy pads, gauze, water and even plasters in the hospital. So, there should be laws that regulate the money they hospitals are making, funds coming in and going out of the ministry of health and other agencies. Health insurance would be a good option to reduce this outrageous cost in treatment, make it affordable to everyone. (MP8)

MP 9 also added that "People are scared, and not trust the government and hospitals anymore. So, I think they should make laws that can improve how they treat us, reduce the expensive hospital charges, and to build more hospitals. The private hospitals also charge very high; the government should step in to control and regulate services and delivery, the quality of care" FP 10 noted "Our public or government-funded hospitals are not well equipped for treatment, and some are dilapidated and lack maintenance. They should open clinics that can be linked to general hospitals and federal hospitals in

our local areas. Create HUBs or centers that can educate people about healthcare, provide laws that can monitor fake medications, pay workers or raise healthcare workers' income to stop them from stealing medications and referring patients to their private hospitals". MP 11 stated, "We have private hospitals and clinics that private individuals run to provide extra services and scattered all over the communities like here in Owerri, that's how people access healthcare." MP 12 stated "People are over charged to get treatment especially when you don't have anybody to advocate for you. The agency does not have stringent laws and policies that may incriminate offenders, hold workers accountable for their actions, a lot of people die in our hospitals for negligence, maltreatment, unethical behaviors but no one is held accountable because the law does not exist and no policies in place that safeguard citizens right to treatment". FP 13 stated "The difficulties stand clear when people are challenged with poverty, underpaid, infrastructural decay in our systems and hospitals, insufficient aid to support our hospitals and healthcare research centers. When our hospitals –state and federal ones are on strike, it affects our citizens from accessing healthcare and becomes lost in resources to the state and our local communities".

The theme provided great attention from the participants, many of which identified difficulties posed by both public hospital and private hospitals, while other participants although they had some similar opinion but had suggestions that may guide to improve the way services and delivery is provided in the healthcare sector in Owerri. Participants made clear their perception to enable researcher and readers to gain good knowledge of the process of healthcare in Nigeria, it's operational system, financing and

how residents are challenged with high cost of care, bribery and kickbacks, suggested causes of corruption, and suggested measure that may make positive social change in the sector. MP 14 also stressed that "The challenge we have noted among our residents in Owerri with healthcare delivery is the high cost of the service and lack of medical insurance to assist our residents in accessing treatment in our local hospitals. The reason being the economic situation of most of our people who are considerably poor, farmers, traders and artisans living on very low wages". MP 15 expressed both his perception of the services and frustration that people go through to attain healthcare delivery. The participant also made positive suggestions that can help in the improvement of the sector. "People go to the hospital and health centers without getting the proper services, only to be charged expensively and without any form of insurance to aid their financial situations. Doctors and healthcare providers, hospitals, clinics and health centers do not accept people in their facility without down payment or deposit before treatment or even first aid. It's called cold case here. The government should make policies that can require hospitals be monitored and audited from year to year, monitor medication and improve patient act or law that can protect our citizens when they go to either government or private run hospitals" (MP15)

Contextualized Organization of the Analysis

There are at least two ways to further analyze the data reported here in chapter 4. One approach is to look at the responses in the context of the status of the participant, and the other is to categorize the themes into contextual groupings. The participants can be grouped under four status categories, the pensioners, the unemployed, the employed, and

the legislators. Table 4 below shows how the viewpoints of participants about their experience with a local healthcare facility and corruption deviated across the status categories. Table 6 provides rich contextual data that could be used to triangulate the key issues from multiple perspectives embedded in the Owerri community.

Table 6

Deviation in Viewpoints Based on Social Status

	Pensioners	Unemployed	Employed	Legislators
Experience of Local healthcare facility	Direct	Alternate	Direct	Indirect
Opinion about cause of corruption	Poverty	Greed	Mismanagement	Economy, Greed

Figure 7 shows how the emerging themes can be categorized into contextual groupings to understand better the issues stated by the participants. Collectively, the data views presented in table 6 and figure 7 present a rich contextual view that can provide a basis for data synthesis and a deeper understanding of the phenomenon under study. Data synthesis of this analytical view will be discussed in chapter 5.

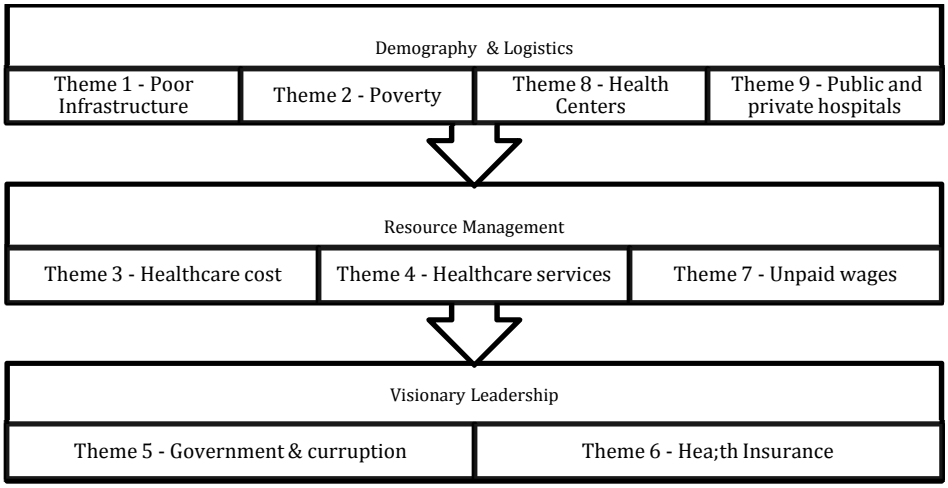

Figure 5. Emerging themes categorized into a contextual grouping

Results

Yin, (2014) "asserted that a case study is an empirical inquiry which investigates in-depth a contemporary case or phenomenon within its world context" (p. 16). This study employed case study research qualitative analysis to investigate the study participants lived experiences and perceptions regarding the studied phenomenon through data collection technique of semi-structured and open-ended interview. I applied specific data analysis of the interviewees provided information after I had transcribed and contacted participants for verification of data they provided before thematic analysis was employed through computer web-based software NVivo to capture emergent themes, and cases from the clustered statements of the interviewed participants. The emerged themes were used to make textual descriptions of the participants lived experiences, perceptions, and make structural descriptions of what factors precipitated interviewees lived experiences, perceptions and synthesized circumstances that influenced what they experienced and impact of the phenomenon to the participants. The data analysis from the study revealed a vivid connection between poor infrastructure and corruption of financial bribery and kickbacks and a high out of pocket healthcare cost.

Organizing the Horizons and Themes into a Coherent Contextual Description

The challenge in the description is intended to determine contextual components of lived experiences and perceptions of the "what" resulting from the phenomenon

(Mouskatas, 1994) is therefore constructed from the collection of the significant themes and statements that subsequently emerged from the study participants. I made contextual descriptions of the participants lived experiences and perceptions of how financial bribery and kickbacks influenced senior healthcare in Owerri, Imo State.

Composite contextual descriptions.

The study participants expressed their true lived experiences of the healthcare were accessed in Owerri, and the state of poor infrastructure and a high healthcare out-of-pocket cost impacted the residents from accessing quality healthcare without available healthcare insurance. The participants consistently mentioned their perception of inadequate infrastructures in the local and public government funded hospitals, clinics, and health centers in Owerri. Participants also discussed the unsatisfactory delivery of healthcare services and products and a high financial bribery and kickbacks within the sector which was perceived influenced accessibility, modality of patient admission to the hospitals, poor services, and distrust among government and healthcare providers.

Participants described the healthcare service and delivery as unsatisfactory with poor infrastructures, dilapidated, bad transportation and claimed that the bad roads remained a hindrance to accessing healthcare at the local hospitals. Other challenges discussed was availability of electricity, high out-of-pocket cost of receiving treatment, unpaid wages, healthcare workers attitude and seeking bribes, health administrators and the government officials engaged in financial kickbacks. And looting of allocated funds for hospital and healthcare services. This participant FP 2 stated “that due to bad roads most healthcare workers are unable to get to work on time “In fact the bad roads alone

make them not to come to work……. no good roads, no electricity in our community. Our local health centers are depilating, and it's bad" during question about "What is your perception about turn-out for senior healthcare enrolment in Owerri?" she stated "Politicians, government officials travel overseas to get quality treatment because our hospitals are bad, corrupt, no good resources, people are poor and unemployed. I personally, I don't believe that people are treated equally and fairly in this part of Nigeria. Look at our roads, they are all full of portholes, when you are sick it takes you hours to get to the hospital, if care is not taken, one may end up dying before you get there, no electricity, how do you function hospitals without constant electricity, bad water and just name it". MP 4 stated that "I don't think we have primary healthcare. My father is already a pensioner who contributed what we call pension scheme so that when he retires from work, he can be able to take care of himself. But the government don't even pay the pensions; sometimes, they pay them very poorly. That there is corruption because the government sits on top of allocation for pensions payment or they use that money to take care of their selfish interest, leaving people poor, workers and officials begin to find ways of taking bribe and kickbacks to take care of their family problems".

Many of the participants shared their lived experience on the deplorable situation of healthcare, unaffordable to residents, delays in accessing healthcare and expressed their perceptions of unethical the attitude of providers towards patients. MP 6 commented that "Healthcare in Owerri is basically suffering from everything that any other thing is suffering from in Nigeria. Just like individuals, young and old take money out of their pockets to pay for healthcare. This is a very big problem for seniors like us. I've seen

cases where hospitals detain patients because they can't afford to pay for their hospital bill or they don't have the money to clear their hospital bill". MP 8 self-employed mechanic felt worried about the high cost of living in Owerri and also about financial bribery and kickbacks among government officials, healthcare providers and social injustices and then stated that: They are greedy, they want more money all the time, and that's why they keep looting, because they are never satisfied with their salaries. Although the cost of living is very expensive here today, poor infrastructures, transportation is deplorable-bad roads and all boils down to greedy and selfishness of both officials and providers. Listen, if people would stop giving bribe and learn to say no when they ask extra money or gifts, I believe our system may become attainable. The ministers are looting allocations for healthcare development and projects, give contracts through taking money under the table, assign their family members to sensitive positions, friends to become contractors even without any experience, that's bribery and corruption, doctor and nurses refer patients to their clinics, take side money from patients, sell medication supposed for free and that affects our healthcare, makes us to spend more for treatment and to purchase medications from the chemist.

Some of the participants provided recommendations for policy reformation to take place in Owerri which they hope will improve:

- the quality of healthcare services and delivery,
- ease accessibility to hospitals and healthcare center,
- suggested universal healthcare (UHC) which may enable affordable healthcare insurance for all,

- encourage accountability,
- efficiency,
- reduce financial bribery and kickbacks, and
- ensure improved infrastructures in both hospital and the environments

Participants policy framework reform were suggested at the end of each interview to gain information about what they think may improve or make changes in the way healthcare services and delivery of products are being operated in Owerri. The participants made references such as MP 12; medical provider suggested that: the government needs policies that can hold public officials accountable for their corrupt behaviors. Those administrators in public agencies are incoherent and lack best practices, want to take all our funds without doing nothing for the people. The government has put in place the investigators for fraud and looting but those investigators turned around to become corrupt, talking kickbacks from those investigated, no one has been jailed and where are all the funds realized. The system is entirely corrupt, and the healthcare system of NHIS has also become an avenue for them to loot and punish the general masses, even senior citizens. The agency does not have stringent laws and policies that may incriminate offenders, hold workers accountable for their actions, a lot of people die in our hospitals for negligence, maltreatment, unethical behaviors but no one is held accountable because the law does not exist and no policies in place that safeguard citizens right to treatment.

Also, FP 13 legal practitioner suggested when she described NHIS as a complex agency without broad management locations across states and said that: I think NHIS is broad in operation and lacking guidelines that can manage stakeholders, and across state wide operation

of healthcare. Although its policy is for a two-payment method- HMO and out-of-pocket payment method which in essence, does not operate here in Owerri where our citizens don't have Health Management organization (HMO) insurance but full range in out-of-pocket method only. The NHIS could do better if they spread its management across board with policies, laws that could safeguard equal and fair healthcare for all Nigerians. So, for there to be transparency, efficiency, and at the reach of all Nigerians, State governments can be able to enforce and implement in cooperation with NHIS some sort of Universal health coverage (UHC). If I am not sure, I believe only Cross River State among other states that has begun in 2016 to operate UHC which is estimated to cover residents in that state. Policy framework within NHIS needs some kind of reformation, restricting, and decentralized in that way community health development and our rural healthcare may become transparent and be able to record efficiency in their operation. While FP 5 senior resident suggested that: There is no transparency in our healthcare departments, hospitals and health centers. The government need to implement rules and laws with honest people that can report fraud, stealing of money allocated for hospital development, projects, medication stealing and all the extra monies that they charge us before we can get treatment from the hospitals. People in this community complain about how unfair they are treated by healthcare worker in our hospitals, poor treatment services, sometimes they are closed because of a strike, and people are suffering. There should be laws that can prevent workers from charging us too much money to get treatment, laws, and policies that can improve the quality of our healthcare such as after care treatment, geriatric care for our elderly people, and health insurance for all. Listen if you don't have money here to go to the hospital, you may die before you get treatment.

Textual-Structural synthesis is employed to ensure the composite description of how themes emerged during analysis of transcribed data from interviews. Given the description participants provided during the one-on-one interview, the themes that emerged focus on poor infrastructure and poverty, healthcare cost and government and corruption and emerged from participants' description of their lived experiences regarding the study phenomenon. On the other hand, factors that influenced participants' experiences and perception on the study phenomenon emerged themes: health insurance, unpaid wages, public and private hospitals and health centers as well as the government and corruption of financial bribery and kickbacks. The above themes emerged based on responses from participants on how they believed they were impacted by the way healthcare system was mismanaged (i.e., without provision of health insurance, non-available education or information regarding enrollment to health insurance and its process and procedures, inadequate infrastructures, long wait time to access healthcare services and high cost of the services and delivery and loss of trust in the government). They perceived that elected officials were corrupt, untrustworthy and expressed their distrust and disappointment in the entire healthcare system. They reported that the level of poverty and unpaid wages and pensions were not paid on time or most times not paid while looting and diversion of allocated funds became rampant among officials and providers.

Direct Observation

I employed in direct observation of interview participants in their natural environment and used field notes to clearly and thoroughly portray a picture of what was observed to enable others who may want to develop a clearer image of what occurred (Yin, 2014). I carried out two forms of observation which included actions and behaviors of interviewees that participated in

the process from their attending to full participation. I paid more attention and made notes on what participants and attendees said, their body language, my reflective notes, and natural environments. From my observation, participants were focused, moved body parts, maintained eye contacts and facial cures. Participants' behaviors and emotions were observed during the interview while they expressed their precipitations about the impact of healthcare system corruption, government and providers' unethical behavior from the looting of funds to bribery from patients, description of the infrastructural decay of the hospitals and environment. The description of their lived experiences on how poverty deprived them of the unaffordable cost of healthcare in Owerri. Attendees who as a result of not meeting the age bracket designed for the study procedure were not able to participate in the study were observed leave freely and shared their interest for future studies. I recorded in my field notes all observations, such as [smiles] as with MP 15 who laughed while he made a comment "Not yet, [laugh], we've not gotten to that stage yet, because before we start asking for fair and equal healthcare services, we have to have an active healthcare system or one that is accessible to every Nigerian". FP 10 stated: "Imagine how many that die during the hospital worker's strike in Owerri alone, [sad face]" … expressed as sad emotional face in her statement, and varied behaviors.

Evidence of Trustworthiness

The instrument I used for data collection in this qualitative case study was interviewing. The interviews were one-on-one conversational and employed open-ended questions. Yin (2014) noted that among the essential sources of qualitative case studies, interviews are often the best approach to gathering data. I used various strategies to evidence that the result of the study is Credibility, transferable, dependable, and confirmable.

Credibility

I employed Yin, (1994) internal validity data analysis that is a valid exploratory case study method of inquiry that ensured that information gathered from the study were equivalent to the study concept and are credible. I established a good rapport with study participants and allowed them the flexibility to withdraw from the study at any time to maintain the credibility of the study. I carefully listened to the participants while I maintained focus and made field notes and asked probe questions to ensure clarity to information provided by individual participants – such as: Please, can you explain more on the issue. Please, do you mean that? What do you mean? – To gain more clarity to participants' responses to the interview questions and to ensure credibility of the interview findings. When conducting qualitative case research study, it is important that researcher establish credibility about gathered data and the studied phenomenon that can ensure trustworthiness (Lincoln & Guba, 1985).

I employed frequent debriefing, cross-checking of interview findings with participants, checked interview transcripts and field notes for obvious errors and avoided deviations in the code definition to ensure credibility and reliable findings. I employed participant member checking research strategy by confirming with participants that the interview transcripts are in conformity with their statements or information provided and recorded. During data analysis, I contacted some of the participants to confirm that analyzed data represents the accuracy of their experiences and perceptions of the influence of financial bribery and kickbacks on senior healthcare in Owerri.

Transferability

Thick study description in a qualitative research study enables readers to understand to what extent the research findings could be transferred to other study settings (Lincoln & Guba, 2005). I presented a clear and simple description of the study sampling strategies, and data collection and analysis procedures, research purpose and its entire design and findings to the study participants. I thoroughly explained the study participants' selection process, the interview procedures, the need for member cross-checking procedures and how I employed Yin, (2014) internal validity and observation data collection and computer-based software analysis and carefully and clearly read interview transcriptions and ensured that information provided was accurate and verified by individual participants for credibility purpose.

Dependability

I used to probe questions during the interviews to ensure clarity and corroboration in participants' statements and the description of their personal lived experiences and perceptions. I cross-checked transcription of the interviews for the conformity with their provided information. I utilized digital recorder and field notes for data collection strategy and data collected were transcribed for data analysis to entail enhanced dependability of the research findings. I will store all physical records, field notes, transcribed documents, and a removable disk for five years after completion of my study to ensure privacy and dependability.

Confirmability

In a qualitative research study, the issue of bias raises a lot of concern because it can influence participants' perception and during data collection. I used the internal validity of the participants' description of their personal lived experiences and perceptions without influencing

their judgment, and preoccupations. I remained neutral from their descriptions and maintained reflexive through clarifying and re-examining my thoughts, biases with an esteemed reflection of the internal validity of described cases. I did not influence participants any time during the study and ensured a cross-check of data with participants during data collection, transcription, and analysis.

Summary

The purpose of this qualitative case study is to investigate and explore in-depth how healthcare providers and policy makers within the three-tier healthcare system operation (federal, state, and local government) perceive the delivery of healthcare to seniors and the management of healthcare resources in Owerri, Imo State, Nigeria. The goal objective of the study was to provide a better understanding of how seniors and residents in Owerri perceive the influence of financial bribery and kickbacks on senior healthcare, and gain in-depth knowledge of evolving management and policy framework of NHIS. In this chapter, I provided a clear and detailed research analysis of the study findings and addressed specifically the research purpose, problem, and research question. I presented an in-depth description of the study data collection, data analysis employed in the study. I also provided the thematic analysis of the research findings. The themes were derived from significant statements of the study participants' description of their lived experiences and perception. Nine themes emerged from the interview data which showed common similarities between the participants lived experiences and honest perceptions.

I provided diagrams that showed a percentage of participants by age and gender as study cases. The following nine themes emerged (a) Poor Infrastructure, (b) Poverty, (c) Healthcare cost, (d) Healthcare Services, (e) Government and Corruption, (f) Health Insurance, (g) Unpaid

Wages, (h) Health Centers, (i) Public and Private Hospitals. The first theme showed the poor infrastructure in hospitals and the community environment. The second revealed the level of poverty which participants perceived was contributed by government negligence and corruption in the society. The third theme showed the challenges of expensive out-of-pocket cost faced by seniors and residents from accessing healthcare in Owerri. The fourth theme revealed an unsatisfactory state of healthcare as influenced by financial bribery and kickbacks in Owerri. The fifth theme revealed that the elected officials (government officials) and healthcare providers are corrupt, uses their office and position for self-enrichment. The sixth theme described how seniors and residents were challenged with minimal assistance to afford healthcare without health insurance. The seventh theme revealed another barrier that contributed to inaccessibility of healthcare, corruption of the government and hardship among citizens whose salaries were either paid late or forcefully withheld by government and pension system. The eighth and ninth themes showed the healthcare facilities and how seniors and residents were challenged by the tertiary healthcare system, their condition of operation and strategies the National Health Insurance Scheme (NHIS) used in its operation, policies and mismanagement and its inability to control service delivery and monitor healthcare corruption across the board. I explained the research findings and discussed how themes support literature. With the findings, I also addressed the study implications for future research study and included final conclusion in chapter 5.

Chapter 5: Discussion, Recommendations, and Conclusion

Introduction

The purpose of this qualitative case study was to investigate and explore in-depth how healthcare providers and policymakers within the three-tier healthcare system operation (federal, state, and local government) perceive the delivery of healthcare to seniors and the management of healthcare resources in Owerri, Imo State, Nigeria. The study was necessitated by the need to gain an understanding of the influence of financial bribery and kickback on senior health services and delivery in Owerri. The study was guided by the central research question "How do the state legislators and health administrators, and seniors in Owerri perceive the influence of financial bribery and kickbacks on senior healthcare development in Owerri?" I employed Fatima's (2011) theory of RCA as a theoretical lens to investigate the phenomenon of financial bribery and kickbacks on senior healthcare. The theory helped me to form a structured theoretical framework to understand, analyze, and define the causes and effects of bribery and corruption upon the delivery of healthcare services to seniors.

The objective of the study was to collect in-depth and information-rich data through qualitative exploratory case study to explore and gain an understanding about participants lived experiences. Their perceptions focused on the influence of financial bribery and kickbacks, provision of healthcare services and the delivery of healthcare products, accessibility of healthcare services, and the impact on seniors and residents in Owerri. Qualitative case study approach was best suited for the study because it enabled seniors, legislators, and healthcare providers who resided in Owerri in the past 5 years, had received healthcare services in Owerri,

and have been exposed to the phenomenon of financial bribery and kickbacks to best describe their lived experiences.

The research study employed Kingdon's (2011) threefold policy agenda or multiple streams, which function in the premise of policies, politics and problem streams that be put together where there is open window for making new policies (Sabatier & Weible, 2014). Such claims included problem identification as indicated by study participants' information through identification of some of the significant problems that hinders their access to healthcare. Also, on policy streams, participants claimed that the government and NHIS could do more to improve healthcare through the formulation of new policies or reformation of existing policies that may enhance healthcare affordability. Kingdon's political stream was evidenced from participants who suggested that government should lay off problematic employees in the system to sanitize the agency, weeding off of "bad eggs" in the system, an inclusion of what Kingdon (1995), cited "open windows, primeval soup" (p. 116)- metaphors in policy streams intended to capture attention.

I used semistructured, open-ended interviews to capture the participants' description of their thought and lived experiences. The open-ended questions used in the semistructured interviews enabled me to identify problems while participants suggested problem solutions and possible policy reformations that may encourage positive social change in the health sector. Morse (1994) noted that for data analysis, the following four stages are important: understanding, synthesizing, decontextualizing and theorizing. I used word-for-word transcripts from the audiotaped interviews and field notes in the study data analysis. A sample of 15 individual participants was used for the study. The exploratory case study showed themes that

emerged from the participants' significant statements regarding their perceptions and real-life lived experiences. Finding from the study were detailed in the previous chapter. In this chapter, I provided a full discussion of the study's findings and recommendation for the study.

Briefing on Themes

My focus in this section is to make conclusions on the result of the research study. Nine themes emerged from the study data analyses. I used the themes to synthesize the structural and contextual descriptions. The emerged themes gave meaning to the following findings:

- Poor infrastructure was a high concern and was lacking in the health facilities and the community environment. The themes emerged from several responses from study participants detailed from bad roads or inaccessibility to health facilities, inadequate electricity, and a need for healthcare services and delivery.
- Poverty was derived from the state of financial ability to access healthcare services and the ability to afford the out-of-pocket healthcare cost. The findings were that the people are poor, often farmers or unemployed. It was also noted that the government is inefficient in paying salaries, and the area has a high cost of living.
- Healthcare cost was high in Owerri, and the theme was derived from the participants' statements on high out-of-pocket cost, access to healthcare, and the insensibility of both healthcare providers and the NHIS for not lowering cost of care. The residents felt compelled to pay any available healthcare cost just to get treatment, charges on treatment, admission, deposit before admission, and fear of being detained when hospital bill is paid on discharge.

- The healthcare providers are corrupt and that became an issue of healthcare services in Owerri due to the consistent request of bribes and kickbacks from residents before they can access the doctors or treating practitioners. The theme healthcare services derived from healthcare enrolment delays, fair and quality healthcare where residents were felt disappointment with services, delivery of health products and the delay, long wait lists, and unsanitary state of the health facilities.
- Government and corruption were derived from the various interview discussions on senior healthcare services, motives for financial bribery and kickbacks, which was described as the corrupt elected officials, greed, selfishness, unpaid wages of the healthcare workers, looting of top government officials and unethical behaviors of the providers.
- Health insurance was not available to all. This theme developed from the resident's expectation from the government which was not accomplished after elected officials and NHIS could not deliver their promises to the people. People believe that only the federal government employees, multinational company employees, and other higher income earning people were able to obtain health insurance, expensive through the third-party, people are poor, unemployed, the government owed salaries to people.
- Unpaid wages of the workers, pensioners, and gratuities to the seniors. The theme emerged from the many significant statements of the participants who believe that the government was insensitive, unconcerned to their needs, deliberately witheld salaries due to selfishness, looted earmarked funding for healthcare services and disregarded citizens' welfare steaming from corruption.

- Health centers in the rural areas were not functional with trained doctors. The rural health centers or dispensaries were not staffed with professional practitioners, doctors, nurses but with nursing assistants, and unprofessional health workers. Treatment at these centers was limited to check-ups, vaccines, medical mission assistance location for visiting medical aid and visiting practitioners on announcements. Unsanitary, and lack of adequate treatment services and delivery of products.
- Public and private Hospitals in Owerri make up the hub of the healthcare system in Imo State, Nigeria. This theme derived from access to healthcare in Owerri. Given the inability of the NHIS to manage and coordinate affordable healthcare, the healthcare system became competitive leaving the cost very high and unaffordable for seniors and other residents in Owerri.

Poor Infrastructure

This research study findings on financial bribery and kickback in the senior healthcare in Owerri has conformed to the basics of the literature review. Hadi (2015) condemned the state of healthcare centers in the rural areas and commented that primary healthcare centers were flooded with expired drugs and cobwebs and in a state of structural breakdown. The state of healthcare and infrastructure are described as inadequate and deplorable. Many participants during study research interviews described that the infrastructure in the health centers, hospitals and the environment as unsatisfactory. The inability of the seniors and residents to access quality healthcare as a result of poorly maintained health facilities, high cost in healthcare products, inaccessibility of roads and transportation to hospitals was presented as barriers to accessing healthcare.

In relation to the literature review it is conceivable that perceptions and lived experiences of the study participants affirm what NCBI, 2009; Omoruan, Bamidele, & Philips, 2009; Schellekens, (2009) asserted that several challenges confronting the NHIS are inequality in the process line of supply of healthcare services and infrastructures among urban and local environments, as well as associated inconsistencies in policy framework. Poverty and lack of education on pre-pay related healthcare services have remained core challenges to the accomplishment of the millennial goal of NHIS. Funding from state governments and Federal governments for healthcare owing to several corrupt practices has undermined several of the communities which include Owerri in the provision of funds for the well equipment of projects for healthcare infrastructures (Uzoechi, 2004) could be evidenced from participants lived experiences and perception of the poor infrastructure conditions in Owerri. Further, among other factors affecting NHIS infrastructure efficacy in Nigerian rural areas are strongly identified as poor healthcare facilities, lack of awareness, lack of retention of medical professionals, and inadequate funding (Agba et al., 2010; Sanusi & Awe, 2009) as was noted by study participants.

Poverty

The findings were that the people are poor, farmers, unemployment and government inefficiency in paying salaries, and a high cost of living. Poverty was recorded from the study as an obstacle for healthcare access which was as a result of unemployment, unpaid salaries from the state and the federal government. The Owerri community is essentially farmers, civil servants and traders who depended mostly on their produce, sales, pension and monthly payments. The government inability to pay worker contributed immensely to the corrupt behavior of many healthcare workers and

administrators. The diversion of earmarked funds for the development of healthcare by government officials and healthcare administrators triggered strike actions of healthcare workers, delay in the healthcare treatment services and products, waste in resources, and an inability for those seniors who depended on their pensions to access high out-of-pocket healthcare cost. Holmberg and Rothstein (2010) report survey results suggesting that 80% of individuals from the developing nations have in one way or the other experienced healthcare sector corruption which thereby impacted the poor who have little or no resources.

Also, the effect of healthcare corruption in the rural Owerri and Nigeria is responsible for a delay in equal healthcare delivery to all. Financial bribery and kickbacks in the health sector drain resources causing scarcity in healthcare allocation for the already poor rural dwellers and other fragile health sectors, as well as hindering access to pertinent life-saving care for seniors and the most vulnerable (Holmberg & Rothstein, 2010; Mackey & Liang, 2012). Since most residents and seniors depended on their life savings to access healthcare services in Owerri, their inability to offer a bribe to providers and other healthcare sources caused many sudden deaths, underdevelopment, homelessness, hunger, infrastructural decay, emotional breakdown and loss of hope in the healthcare system and government. The corruption impact in Nigeria are outrageous and accounted to underdevelopment, poverty, poor housing, polluted water, polluted environmental sanitation, and malnutrition due to unbalanced food, inefficient leadership outputs, rural unemployment, and hopelessness. Rural residents in Nigeria suffer critical

health conditions and tend to underuse primary healthcare (PHC) services as a result of poor quality and service inadequacy (Waziri, 2010).

Healthcare Cost

The healthcare cost in Owerri is considered very high compared with the cost of living for the survival of the residents. The participants' statements on high out-of-pocket cost, to access healthcare reflected that there is insensibility of both healthcare providers and the NHIS for not lowering cost of care. The residents felt compelled to pay any available healthcare cost just to get treatment services, hospital admission, and deposit of money before admission into the hospitals and clinics, and fear of being detained when hospital bill is not made available on discharge. The high out-of-care cost in Owerri affects both seniors and other residents especially the pensioned and those living at the expense of their family members whose salaries have not been paid in the past one year to 9months. As is in several other sectors and agencies within federal and state levels, financial bribery and kickbacks are no longer considered hidden but practiced among public administrators and citizens as well. Poor wages, irregularities in regulation and monitoring of corruption, uncertainty in healthcare, and rise in the employment rate are responsible for most of the underdevelopment and healthcare inefficiencies (NHIS, 2010).

As was discussed in the theoretical framework, this study established that impact of low wages of the healthcare workers, non-payment of worker salaries and greed of the government officials triggered most of the discussed corruption practices in healthcare sector. As is in several other sectors and agencies within federal and state levels, financial

bribery and kickbacks are no longer considered hidden but practiced among public administrators and citizens as well. Poor wages, irregularities in regulation and monitoring of corruption, uncertainty in healthcare, and rise in the employment rate are responsible for most of the underdevelopment and healthcare inefficiencies (NHIS, 2010). The need for reduction in healthcare cost was echoed by study participants as a measure to balance quality healthcare for all and to reduce the high demand of bribery and kickback in the sector and to enable easy access of care to seniors, the poor and children. Healthcare cost increased because of the increasing number of aging population, and technological advancement is challenged with high rise in unemployment rate, corrupt government, and poor accountability to healthcare in developing countries such as can be witnessed in Owerri, Nigeria. To that effect, there is a great need for concern that healthcare requires affordability and to operate the system more efficiently in developing countries (Anyika, 2014). Although healthcare services have been supported by different international organizations that would aid in the reduction of healthcare cost, Ichoku, Fonta and Ataguba (2013) maintained that despite these several health funding assistance and other numerous services within the different levels of the Nigerian government, the cost of healthcare remains unrealizable for the majority of the poor rural people.

Healthcare Provider Corruption

The healthcare providers are corrupt, and that became an issue of healthcare services in Owerri due to the consistent request of bribe and kickback from residents before they can access or be able to visit the doctors or treating practitioners. The citizens

felt that healthcare enrolment experienced very high delays from providers in public and private healthcare sectors. There was a need for fair and quality healthcare in the community that would serve the peoples need. Although, residents felt disappointment with services, delivery of health products and the delay, long wait list and unsanitary state of the health facilities which resulted from ineffective healthcare management of the National health insurance scheme, federal ministry of health and the state ministry of health. Odeyemi and Nixon (2013) and Micah, Ebere, and Umobong (2012) affirmed that the NHIS structure in Nigeria is regressive as opposed to progressive owing to its adverse effect and due to its inherent health inequality emanating from expensive finance related –insurance rather than the wealthy paying more in healthcare taxes than the less fortunate. That results to inequality in healthcare provision, looting of healthcare earmarked funds and seeking bribery and kickbacks from seniors, resident and denial of healthcare to residents who were unable to afford healthcare cost and inability to afford health insurance.

Study participants noted that healthcare providers and the government health insurance failed in the provision of health coverage to all citizens and the rising healthcare cost became unaffordable for the rural poor farmers and seniors. Onwujekwe et al. (2010) contended that between the narrow scope in coverage provided by the NHIS and the unfair payment policy associated with private insurance programs, the poor rural indigenes are challenged with impossible affordability or are excluded from coverage. Corruption in Owerri rural area has become rampant and practiced in the open because the government appoints their loyalties in the health sector and as such does no longer

monitor, control malpractices, and rent seekers. Seniors in Owerri have been witnessing negligence and sudden deaths due to the inability to afford kickbacks and bribery to providers owing to high out of pocket pay for easy care access necessitated by NHIS (Etobe & Etobe, 2013). The need for curbing healthcare corruption was pointed out by a participant as an importance to make changes that the sector operates and may increase effectiveness. Management and leadership failure in the health sector is owing to corruption within the Ministry of Health and misappropriation of funds in the sector's development (Imhonopi & Ugochukwu, 2013).

Government and Corruption

In the literature review, it was disclosed that corruption is identified with the government personnel given their desire to embezzle and diverting of public funds and frivolous contracts (Ogundiya, 2012). All of the 15 interviewed participants reported that healthcare providers, workers, and public officials engaged in seeking of bribery and kickbacks from patients and illegal contracts. They expressed that top officials connive with workers to ask for bribe from patients before they could be admitted or allowed access to meet with treatment providers. They made claims that the government is corrupt, negligence to their needs, and were selfish, and greedy. Findings from the study evidenced that government officials are corrupt, diverted funds for their private gain, give contracts to their friends and families. High and inflated cost of supplies and medical equipment with funds diverted to contractors and health administrators by government officials (Vian, Savedoff, & Mathisen, 2010). The frequent financial kickbacks and bribery, seeking of bribe from residents and seniors before they could have access to healthcare, seeking of kickbacks from contractors, lobbyist and other citizens before they can obtain

contracts are evidenced from the study as noted previously in the literature review. The World Bank's chapter, International Corruption Hunters Alliance (ICHA), noted that its integrity was focused on understanding corruption as any offense consisting of acts such as giving, offering, receiving or the solicitation of any values intended to influence improperly those actions of another party (World Bank, 2013). The systemic corruption of government officials and healthcare providers (Garuba, Kohler, & Huisman, 2009) in the community contributed to the hopelessness of the seniors and other residents towards the government and healthcare providers. This study evidenced that bribing of healthcare workers; government officials affected contracting of healthcare projects, infrastructure, the supply of low-quality medications and products and the circumvention of fake medications among local or rural chemists and health centers and the markets. The study result showed that ineffective management and leadership failure in the health sector had contributed to corruption practices within the Health ministry, and misappropriation of earmarked funds in the sector's development (Imhonopi & Ugochukwu, 2013).

Health Insurance (National Health Insurance Scheme System)

The mismanagement of healthcare funding and the inability of the NHIS in the regulation and control of management within the sector was one of the main significant concern of the interviewed participants. This was evidenced in the literature review as Uzoechi (2014) asserted that Imo State University of technology hospital had experienced poor funding by the state government. Also, Ijewereme, (2013) noted that the earmarked funding for health development funding evidenced looting in 2007 by the Minister for Health who contributed to the difficulties in sustainable health development in rural Nigeria. Participants in the interview study were

concerned about the insensitivity of the National health insurance for not educating residents about the functionalities of NHIS and inability to make health insurance available to all citizens. The participants expressed disappointment in the health management in Owerri and the health department owing to their frustration with poor healthcare services and delivery, high –out-of-pocket cost of healthcare, bad infrastructural conditions, seeking of bribe by healthcare workers, and the deplorable wage regulations structure in the system and consistent strikes by healthcare workers.

Participants expressed frustration over insufficient information, education of citizens about NHIS inefficiency in management became another factor which impacted residents and seniors from accessing healthcare. There was not sufficient healthcare education available to residents and senior to understand how healthcare is managed, and where to access information to attain health insurance. Health insurance was limited or never existed in the community but was only accessible to federal workers and their families. Approximately 46 million Nigerians are not supported or covered by the NHIS services (NHIS, 2016).

Regarding the unethical behavior of the healthcare providers on poor patients, seniors and residents in Owerri, participants expressed grief, pain and what the belief is an unlawful way of health treatment by the NHIS and healthcare system. Inhuman treatments on residents and seniors that did not have enough out-of-pocket to access healthcare by healthcare providers are unethical and violate patients' rights such as withholding patients from leaving health centers and hospitals, assigning patients labor in exchange for services before they could be discharged.

Unpaid Wages

Unpaid Wages of the workers, pensioners, and gratuities to the seniors. The theme emerged from the many significant statements of the participants believe that the government was insensitive, unconcerned to their needs, right and deliberately owed salaries due to selfishness, looting of earmarked funding for healthcare services and disregarded citizens' welfare steaming from corruption. The unpaid wages of the worker have also contributed to the financial bribery and kickbacks in the healthcare sector. Many workers both in the healthcare and other sectors in the country suffer the same pain and emotional distress of not getting paid either on time or never gets paid in a long time. Many participants stated that their family members and friends have not been paid for their labor for several months. As a result, they could not access healthcare and other lifesaving resources, such as shop for food, take care of their children and loved ones, pay bills, and commute to work. Thus, people are as a result subjected to starvation, poverty, in debt, stealing, bribery and kickbacks, and possible sudden deaths of the vulnerable seniors and children. Participants suggested that all workers should be paid on time, receive increment in wages, receive good benefits, and receive health insurance. That will ensure accountability of workers in the different sectors and healthcare from seeking bribe and kickbacks. Worker accountability and timely paid wages may reduce bribery and kickbacks in the sector provided healthcare workers are in good pay standing, have access to suitable housing, good transportation system, and constant electricity within the rural areas, assured quality education for both workers and citizens. Also, policy windows that may promote benefits, and entitlements (programs) that can reduce poverty

gap between the poor and the rich, reduce the inducement or pressure of citizens on administrators and legislators to accept bribe that can enable them jump treatment or services described procedures (Abdulraheem et al., 2012). Every worker and worked time deserves on-time payment and when not paid violates labor laws. To effectively maintain accountability, efficiency, and control corruption of workers and their administrators in the health sector, workers' wages must be paid like in every nation that democratically governs and has the best interest of their nation at heart.

Health Centers

Health Centers in the rural areas were not functional with trained doctors. The rural health centers or dispensaries were not staffed with professional practitioners, doctors, and nurses but with nursing assistants, and unprofessional health workers. Treatment at these centers was limited to check-ups, vaccines, medical mission assistance location for visiting medical aid and visiting practitioners on announcements. Unsanitary, and lack of adequate treatment services and delivery of products. Health centers were located in most rural areas close to residents to enable them access to healthcare aid, emergency assistance to pregnant women, seniors and children to receive vaccines and control diseases. Although, this plan of the National health insurance scheme failed due to conversion of health centers or dispensaries to federal medical centers. Most health centers according to study participants do not receive aid in funds and lack maintenance and therefore dilapidated. The World Health Organization (2010) noted that corruption is blamed for having negatively impacted access to and the quality of healthcare in a threefold manner. Healthcare has been affected by deficiencies in government ability

towards the provision of fair care access to good and universal health services, and medical infrastructures. Due to bribery to government officials, counterfeit medications and fake healthcare products have flourished in the markets and health centers.

Public and Private Hospitals

The study captured participants' perceptions about reasons why healthcare providers and public officials engage in the seeking and collection of financial bribery and kickbacks from residents. All participants have shared opinions regarding their inability to afford healthcare cost and as a result of bribery seeking from healthcare workers and how the public officials looting of allocated funds to improve healthcare services and delivery has impacted their ability to attain affordable healthcare. Such reasons can be tied to information gathered from literature review of the study. Ineffective management and leadership by the legislators and administrators in the Ministry of Health reflect corrupt behaviors that have affected the healthcare development and the Millennium Development Goal (Akinbajo, 2012) in Owerri. Poverty, unemployment, and non-payment of worker salaries, pensions and other senior gratuities by the state and the federal government were mentioned several times as part of contributing factors to corruption among private and public healthcare providers. The high out-of-pocket cost of healthcare in Nigeria is also responsible for delays in healthcare accessibility in the rural areas. Nigeria operates the most expensive out-of-pocket healthcare spending while at the same time is noted for the poorest health indicators among all nations (Gustafsson-Wright & Schellekens, 2013).

The impression from participants is that their frustration with the financial bribery and kickbacks going on in the sector has become a challenge and lead to distrust, discouragement of the residents for not getting quality healthcare in Owerri. Corruption in the industry has

manifested ineffectiveness, reduced quality services, poor hospital maintenance, and made health policies and provision of care ineffective (Husmann, 2011). Regarding the effect of corruption of bribery and kickbacks in the healthcare sector and its influence on the senior healthcare, the quality of healthcare as described by participants were also impacted. Corruption affects Nigeria's healthcare system in the same way it does other institutions in the country. The impact reduces public welfare and promotes misappropriation, nepotism, bribery, embezzlement, and sets a negative impact on economic development, investment and its political process (World Bank, 2013). Besides the expensive cost of healthcare in rural areas in Nigeria such as in Owerri, the corrupt practices of healthcare providers have also impacted citizens from healthcare access. The most reports from the study recorded that high poverty rate and inability to afford health cost and bribes are considered a high risk to residents' life and survival. WHO (2013) noted that the majority of poor people living in the rural areas of Nigeria that are not covered by NHIS insurance and are unable to afford out- of– pocket health bills are at a higher risk of mortality when challenged with easily treatable and preventable illnesses or diseases such as malaria.

Synthesis of the Study

The emic epistemological approach of data collection did work out to help create a distinction between local and the scholarly discourse of the narratives. Where the realist framework focused on finding the root cause of the disaligning factors behind the single truth (corruption is bad), the local discourse provided more indepth perspectives that may have helped explain the reasons behind sustained corruption.

When we look at these collected data from the contextual lenses introduced in chapter 4, people belonging to different social status seem to have distinct perceptions about their

experience with healthcare facilities, and their opinion about the root cause of corruption. People who have a consistent source of employment either through a current job or in the form of their pensions, seem to have a direct experience of how their local health facilities work. People belonging to this social status seem to present the meaning of the society that is making sufficient money to strive their way through the system and available facilities. Although the pensioners and currently employed people both seem to have a direct experience of the corruption that runs and their local healthcare facilities, their understanding of the root cause seems to be a little different. The pensioners, having been retired from the system, seem to be a bit more understanding about the needs of a common man when they blame the root cause of corruption on poverty. On the other hand, the currently employed citizens, who are engaged in the system on a daily basis, seem to reflect their frustration and blame corruption on mismanagement. The understanding of the retired and currently employed members of the society seem to be a little different than the unemployed.

The unemployed members of the society have limited direct experience with the local healthcare facilities because they cannot afford to pay either the bills or the bribes that are required to go through the process. They also dread the reported practice of the healthcare facilities of detaining the patient until the bills are paid. For this reason, the unemployed have a greater direct experience of the alternate herbal medicine that is available cheaper at the rates they can afford. The perception of the unemployed about the root cause of corruption is interestingly in contrast with the pensioners and the employed members of the community. While the pensioners tried to justify corruption by blaming outspread poverty, and the employed viewed corruption as extreme mismanagement, the unemployed reviewed the corruption among

the employed members of the healthcare facilities as pure greed. It is very interesting to see how the unemployed members of the community perceive the healthcare personnel to be making sufficient money that does not solicit illegal practices. Quite interestingly, the perception of the unemployed about the funding of the healthcare professionals aligns with the legislators who also think that they are supplying sufficient funds to pay the salaries of the healthcare professionals. The legislators seem to hold an elite status of utilizing either private or foreign medical services for their personal needs. Their lack of first-hand experience of getting treatment from a local healthcare facility is visible in their indirect mentions of what they know about people's experiences. Quite in contrast, all other members of this community talked about their interaction with healthcare facilities while answering the questions.

These diviations in perspectives highlight the multiple realities existing in the Nigerian social fabric. Perhaps in social circles where poverty has been accepted as a reality of life and is perceived as an unchangeable abosulute, corruption is viewed just as a byproduct of the absolute condition. In social circles where poverty is not a reality, corruption may seem to appear as a problem of a certain social class, or perhaps as a natural way to hold status quo.

This division of perceptions in the society makes it almost impossible to look at the holistic picture and identify the problem. While responding to interview questions, regardless of their social status, none of the participants admitted to the ownership of the problem but blame the bad practices on the hypothetical "them." The problems the members of the society mentioned around the phenomena of corruption in healthcare services can be divided into three categories as suggested in chapter 4. Demography and logistics, resource management, and lack of visionary leadership, define the three major categories under which all the emerging themes

can be grouped. Among these categories, poor resource management seems to have the highest number of issues mentioned. Issues such as deficient healthcare services, its steep healthcare cost, and improper distribution of wages mark this as the key problem area identified by all participants regardless of their social status. Demography and logistics appear to be the second most problematic area where people indicated their dissatisfaction with overall infrastructure, economy, and the difference between public and private hospitals. The themes of government and corruption, which is the second most cited theme, along with lack of insurance services were grouped under the category labeled as the lack of visionary leadership.

The lack of visionary leadership from this perspective seem to be the least defined and unknown variable of this phenomena. Based on these analyses, the researcher would like to argue that a lack of awareness about the strength of the visionary leadership and the apparent absence thereof, along with the lack of a sense of ownership may be the very root cause of the phenomena under study.

Identifying the gaps between the narrations of various members of the society about the phenomena of corruption in the Owerri healthcare system, and filling the gaps by using concepts discussed in the literature review, I have attempted to visualize a possible alignment of shared perspectives that may provide a blueprint to tackle the issue of corruption under study. Figure 8

depicts my synthesis of a possible alignment of perspectives.

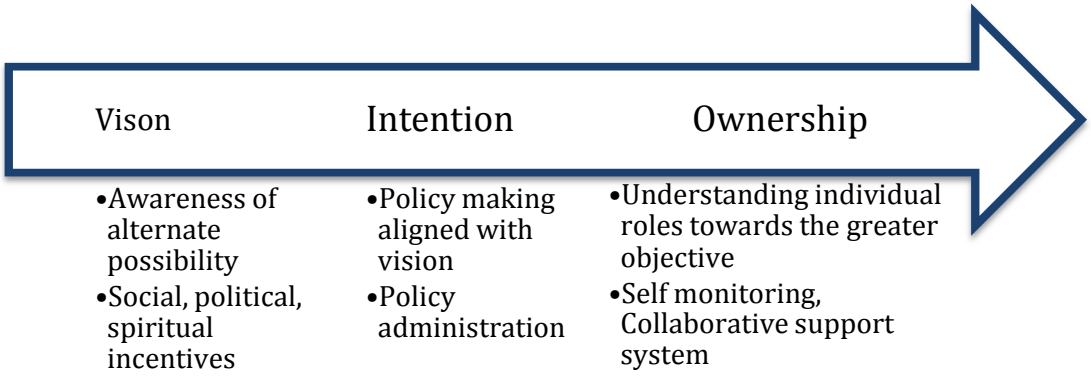

Figure 6. Alignment of perspectives

Figure 7 depicts that a common community-wide, or national vision that people can relate to may provide a common sense of direction. People could only attempt to alter their existing conditions if they are aware of an alternate possibility. A common understanding of the alternate possibility is likely to generate various incentives for people belonging to any social status within the community. If the vision has a common appeal among the people of Owerri, it can be converted into an intention by creating and administrating appropriate policies. As long as the people of the community are driven towards the same vision, despite various incentives, policy implementation can become a reality. Finally working towards a common goal, under a common vision, and the momentum generated by appropriate intentions is likely to generate a sense of ownership that moves the onus of success from the hypothetical them to every member of the community.

This concept aligns with the Northouse (2010) who explained that leadership could be best defined as the process through which groups of people are being influenced by an individual in an effort of accomplishing the set goal or organizational mission. In the case of Owerri, the

problem seems to be finding the source of such leadership. Can the vision be initiated at a grass root level by common citizens, or does it require a charismatic leader in a top-down leadership model? Perhaps this concept can be tested or studied by future researchers, and by combining results from this study with other studies done through share public opinion as source of social construction. From a philosophical perspective, perhaps the corrupt practices are difficult to be changed until the relativist perceptions about ill practices converge into a unified realist perception strong enough to bring about a change across all social circles.

Limitations of the Study

This qualitative exploratory case study explored the perceptions and lived experiences of seniors, legislators and healthcare providers who participated in the study interviews in Owerri, Imo State, Nigeria. The study used a semi-structured open-ended question to gather and analyze data obtained from participated individuals who provided first hand lived experience information about how financial bribery and kickbacks influenced senior healthcare services and delivery in Owerri. A sample of 15 participants was employed to obtain data-rich and in-depth information about their experiences of the study phenomenon.

The study was limited to Owerri Imo State local area. There is no doubt that the 15 participants did not represent the entire Owerri community and did not provide information that represented all the Owerri healthcare challenges, socio-economic challenges that seniors and residents faced, and might not cover all essential variables. The limitedness of the study at the Owerri local rural area and its relatively small sample size might pose a difficulty for the study to generalize or transfer obtained data from this study and the findings from this research to a larger population or other study locations.

The study was aimed to gather lived experiences of the study participants. Onwuegbuzie & Leech (2007) asserted that sample size is not required to be too large for a study to be deemed capability to gather data rich-information. The study therefore used a diverse participant population, sample size, personal background to satisfy the study's inclusion criteria which were carefully selected. The use of the small sample sized enabled the researcher to accomplish credibility of the study and made it possible to reach the study purpose.

Besides the aforementioned limitations, the study may yield or apply to other researchers who may need to apply it to other study context. Also, the research findings of the study are generalizable due to the detailed descriptions attainable from the research study and the knowledge or insight gained from this qualitative case study financial bribery and kickbacks influence phenomenon (Onwuegbuzie & Leech, 2007).

Recommendations

Review of literature set a firm lens between financial bribery and kickbacks and the delivery of healthcare Public services to seniors and residents in Owerri. This study found meaning and insight to build a connection between financial bribery and kickbacks influence and healthcare delivery services among seniors and residents in Owerri. It also found relevant insight over a reciprocal relationship that existed between residents and healthcare providers and the public officials. The study found that the influence of financial bribery and kickbacks of the public healthcare officials and poor management of the NHIS ignited societal infrastructural decay, inaccessibility for seniors and residents to access affordable healthcare, high out-of-pocket cost of healthcare, disappointment, distrust on the providers and government, looting and embezzlement of allocated healthcare development and infrastructure funds, willingness to offer

bribe and bargain-seeking of bribery in other to access easy treatment and contracts, poverty and unpaid wages of both workers and pension gratuities. It was discovered that hence residents celebrated corruption in their effort to share from the national cake, the effect of the bribery and kickbacks ravaged deeply into the fabrics of the healthcare system governance, and influenced hardship on the community as a result in government negligence, selfishness and greed to self-enrichment. There is an important need for further research to discern the extent to which improvement in the control or regulation of financial bribery and kickbacks may enhance affordable healthcare services and delivery, improve quality socioeconomic of the community and quality or affordable healthcare for all residents in Owerri.

The study explored and examined financial bribery and kickbacks influence on healthcare from the aspect of the seniors and residents' healthcare consumers. The NHIS need to develop policy frameworks and make available educational initiatives that can inform residents about healthcare services education about patient rights and encourage consumer's opinion, monitor and implement firm and stringent laws that can safeguard public funds and the improvement of healthcare infrastructural development, increase insight towards workers' wages and payment of salaries and pensions to enable both seniors and residents to have resourceful means to access an affordable healthcare. The Federal Government Ministry of Health needs to evaluate residents' healthcare needs across states to ensure that healthcare could become a universal funded goal to meet its millennium goal through implementation of policies that can support states establish universal health coverage (UHC) and remodify health insurance policies. There is the absolute need to encourage non-governmental healthcare management organizations that could promote healthcare products, aftercare services for seniors, and dissemination of educational projects to

improve citizens' awareness on patient rights and discourage bribe-seeking and giving in the system which may be goal-directed towards the well-being of citizens and good governance.

Implications for Positive Social Change

The findings of this study have substantial implications for positive social change in Nigeria and other evolving democracies. This research study filled a gap in the literature by its ability to identify possible connectivity and interactions between the financial bribery and kickbacks and its influence on senior healthcare services and public services. The study found that the financial bribery and kickbacks impacted the ability of seniors, residents and citizens from affordable healthcare access, and contributed to the inadequate infrastructural developments, and equal quality healthcare with socioeconomic inequalities. Therefore, this study may become an inspiration for other researchers for further exploration of the extent to which well-designed affordable healthcare and equality of quality healthcare access may reduce socioeconomic inequalities orchestrated by corruption in Owerri and Nigeria.

This research findings will lead to positive social change through enabling NHIS invigorate its focus in ensuring that the provision of equal healthcare opportunities to all, ensure a firm implementation of policies that can combat financial bribery and kickbacks in the sector, and promoting the enactment of laws, regulations and policies against financial bribery and kickbacks. Furthermore, it will also, help in sanitizing and sensitizing public service agents from unethical behaviors of seeking bribes and gifts from patients, reduce the looting of public funds earmarked for infrastructural development, eradicate fraudulent behaviors of elected and public appointees' corrupt behaviors in the public health facilities to ensure efficiency in the delivery of healthcare services to seniors and residents.

Another positive social change implication that may be inherent from this study findings is that it may lead to awareness to the NHIS as a lens to understand the residents feeling, perception and serve as lens to develop an educational program that may increase healthcare information to teach seniors and residents' patient rights and healthcare products available to the residents. The study has detailed lived experiences of the residents which may lead to a better understanding of the needs of the people, ensure there are regulations in place to ensure that workers' salaries are paid on time and regulate truancy of workers. Maintaining an accountable public service in the sector that will be void of patient negligence, ensure well-equip of hospitals and facilities that will serve the purpose of millennium goal to provide equal opportunity for all to access affordable universal health coverage.

Conclusion

The purpose of this study was to gain knowledge by investigating seniors, healthcare providers and legislators' perceptions and lived experiences on how financial bribery and kickbacks impacts healthcare service delivery in Owerri Imo state, Nigeria. This study focused investigation and examined the study phenomenon financial bribery and kickbacks through the theoretical lens of Fatima (2011) root cause analysis- to understand, analyze and define the causes and effects of the influence of corruption on the delivery of healthcare services to the seniors and residents in Owerri. The study used the Kingdon (2011) agenda configuration or streams as a lens to identify problems, sorted out possible solutions and attached political environment based on the effects of the corruption of financial bribery and kickbacks to open policy window to improve healthcare through policy ideation. The theories are placed in the

study to understand ways of combating the phenomenon and make possible policy suggestions that can improve healthcare services delivery and the socioeconomic well-being of seniors and residents in Owerri and Nigeria at large.

The findings of this study revealed that the inadequate environmental infrastructures and triggered poor healthcare delivery to residents, impacted residents from easy access to healthcare, hindered progress in the health sector, and also the lack of trust and disappointment of residents were all shortfalls from corruption of embezzlement of public funds earmarked for healthcare and infrastructural development. On the behavioral aspects, the healthcare providers seeking of financial bribery and kickbacks catalyzed unethical behaviors, bad management, strikes as a result of non-payment of salaries, unprofessionalism of public service and negligence towards patients' right and well-being. Overall, the findings of this study were that corruption in the health sector crystalized negligence, poverty, bad governance, inequality and seeking of financial bribes with a demonstration of willingness to accept financial gifts to enable access to treatment and healthcare. Emotionally, residents were discouraged, detained as a result of an inability to source finances to attain healthcare services, loss of loved ones, and suffering.

The study findings may help the healthcare agency and other relevant sectors to improve and sensitize the sectors. The findings may also help with formulation of policies that may safeguard patient rights, monitor corruption, and reduce the high out-of-pocket cost of healthcare. The findings may serve as raise awareness on how to make healthcare accessible to all through the introduction of universal health coverage for all citizens through gainful health products or package for all. The findings also may help the sector to minimize the phenomenon through implementation of on timely wage payment to workers, wage evaluation and increase to

healthcare workers, increase the number of health facilities in the rural areas to enable closeness to residents which may reduce cost of transportation and ensure steady electricity in all healthcare facilities that may help reduce health risk or treatment risks.

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Appendix A: Interview Protocol

Perceptions of Financial Bribery and Kickbacks on Nigerian Healthcare Public Policy

Date_____

Time of interview_____

Place_____

Interviewer_____

Interviewee_____

Project Purpose

The purpose of this study is to understand the extent to which financial bribery and kickbacks in the rural healthcare delivery service (NHIS) is affecting seniors? The purpose of this study is to gain meaningful knowledge and clear insight about healthcare corruption in Owerri, and on how to improve the healthcare system and policies in Owerri in such a way that can ensure seniors healthcare improvement and development, community health system change, and corruption behavior changes.

Project Description

This research study explores participation in NHIS and the widespread believe about how financial bribery and kickback affects senior healthcare in Owerri rural community, and this study is looking to get opinion from those who have the experience. The past 5 years is believed to have recorded endemic corruption level that has impacted senior healthcare efficiency, and several challenges facing the healthcare access in rural Owerri such as healthcare benefits and insurance. This study is to explore your

experience about how you perceive the challenges seniors are facing with healthcare system and how those challenges might be improved to enable quality care access to the seniors and Owerri community.

Four components will be covered as contents in the interview, which will include the participant's background, organization background, and basic engagement about the study topic benefits and risk inherent from participation, and a conclusion. Participating legislators and healthcare administrators will be interviewed with same interview questions but based on their level of perception on corruption in the system and how they perceive implementation of healthcare policies or how corruption impacts delivery of services to local communities. It is important that participants provide their honest perceptions without fear of reprisal or any negative consequence. The lists of study topics will be covered by participants before the interview and I will review all with participants during the meetings.

Interview Questions

The following questions are for participants to try to provide their honest perceptions without fear of reprisal or any negative consequence. The interview questions in the protocol will consist of uniform format designed to suit the different participating groups in this study. Further probing questions will provide the interviewee opportunity to focus more specifically on their personal understandings and intentions and insight on NHIS and policy development, and their participation in rural healthcare development in Owerri. These questions are also intended to explore in-depth the interviewee's understanding of NHIS and service delivery to the rural community seniors and residents.

You are not required to mention names of persons involved in corruption acts to ensure confidentiality and protection of study participants and stake holders.

In the process of this study if any findings related to criminal activities or child/elder abuse that might necessitate, I will provide the interviewee the NHIS contact and encourage the interviewee to notify his/her medical provider.

1. How do you access healthcare in Owerri?
2. What difficulties do you experience with healthcare service delivery and products?
3. What do you believe are the primary reasons for rural healthcare corruptions?
4. How has healthcare agency benefitted from healthcare funding? You can describe in what ways?
5. Have you been deprived healthcare services because of high out-of-pocket cost of care? If yes, can you explain?
6. How has out-of-pocket fees impacted you from receiving quality healthcare?
7. What are the contributing factors to senior healthcare delays?
8. What public policies or laws do you think need improvement in healthcare delivery in Owerri?
9. What difficulties do you experience from enrolling into primary healthcare insurance?
10. How has healthcare agency benefitted from healthcare funding? You can describe in what ways?

11. Do you know of any direct or indirect funding resources that healthcare agency receives for senior and rural healthcare development?
12. What is your perception about turn-out for senior healthcare enrolment in Owerri?
13. What motivates providers in bribery behavior and how do you perceive the impact on senior healthcare?
14. What is your perception about NHIS policy on fair and equal healthcare benefits?
15. What legislative policies (if any) deprive NHIS community health development from becoming transparent, report efficiency and deficiencies in their operation?
16. How do you measure success and detriments in the agency and community participation in NHIS enrollment?

Closing Remarks and Thanks

- Thank the interviewees for their willingness to share their experiences and thoughts.
- Assure the interviewees that their responses will remain confidential.
- Inform the interviewees about the follow up interview
- Inform the interviewees that they will receive a copy of the interview transcript for their review to correct any information that they feel was misinterpreted.
- Reiterate that participants have the choice to drop out of the study participation without consequences.

Appendix B: Initial Coding Structure

Perceptions of Financial Bribery and Kickbacks on Nigerian Healthcare Public Policy

The study will use preliminary codes like those listed in previous part of data plan analysis derived from the literature review and research question as samples of how data collected from participant's will be coded into computer assisted software. This will involve individual opinion, senior healthcare policy issues, public policy frameworks, and other variables during the process.

Pre-Code	Code
IO Individual Opinion	CI - Collective Influence
PF– Policy Framework	BC – Behavior Changes
LR – Leadership Role	PF-Policy Framework
TR – Trust	
CDG-Community Development Goal	
SHCM- Senior Healthcare Mandate	
PP- Public Policy	
PM – Personal Motivation	
OM - Organizational Motivation	
CP - Community Pressure	
NHISM- National Health Insurance Scheme Mission	
CI – Corruption Influence	

SI – Societal Influence

BC – Behavior Changes

TI – Treatment Impact

OT - Other

CI – Corruption Influence

SI – Societal Influence

Appendix C: Interview Probes

Perceptions of Financial Bribery and Kickbacks on Nigerian Healthcare Public Policy

The interview probes will serve the purpose of opening doors to explore clearer information from previously provided information by the interviewees. Probe questions for this study will be utilized to get a fuller story where I think that the information or data provided need extra explanation. Below are such categorical areas that I might use the drafted probe models to gain extra knowledge on the issues in question. The probe question model will apply to all participating communities in the study.

Clarity on What Participants Said

For responses provided by the interviewees that contain abbreviations, phrases, terms, or utilize short sentences that do not provide clarity of information, I will use probes such as:

1. When you say (term or phrase), what are you actually saying?
2. It sounds like you are saying "……" is that a fair summary of what you are saying?

Get More Details

For responses that require more information than has been provided—e.g. abbreviated summaries from the interviewees that may require more details to build fuller knowledge of the facts--I will employ probe questions such as:

1. Can you tell me more about that?
2. Can you give me an example of what you are saying?

3. What was your reaction to that?
4. Do you know of other people that have similar experiences?

Questions about Variation in Events

For responses that I feel might be different under different circumstances or in the case of different events, I would use these probe questions:

1. How has your approach changed over time?
2. What motivated this change?

Accommodate Emotions

There is the possibility that seniors could become emotional while in the interview—while venting frustration or crying as they recall past experiences. If such a situation occurs, I will attempt to convey a comforting mood and will turn off the tape recorder. I will encourage the interview to take a brief break until they feel calm enough to continue. Before continuing, I will ask if s/he is ready to continue, and at which point I will resume recording the interview. In this case, I will use probes that could acknowledge the emotions without saying much:

1. Can you relate something about why this issue made you very emotional?
2. What aspects of this issue would you think caused you this strong emotion?