ASSESSMENT OF THE KNOWLEDGE AND ATTITUDE OF HEALTH EMPLOYEES TOWARDS ENTREPRENEURING HEALTH SYSTEM IN ABAKALIKI

Okorie, Ebere Florence
Department of Business Management, Faculty of Management Sciences, Ebonyi State University, Abakaliki, Nigeria. okorieef@gmail.com

Dr. Okafor, Lawrence Chima
Department of Business Management, Faculty of Management Sciences, Ebonyi State University, Abakaliki, Nigeria.

Akpu, Blessing Oko
Society for Family Health, 8 Port Harcourt Crescent, Off Gimbiya Garki, Abuj**a**

Prof. Uneke, Chigozie Jesse
David Umahi Federal University of Health Sciences, Uburu, Nigeria

Abstract
This study assessed level of knowledge and attitude of health workers towards health entrepreneurship. Historical/descriptive primary and secondary data sources methods were adopted. Likert order structured questionnaire were utilized and data analyzed using percentages, mean, median and range. Results showed as "unencouraging" knowledge of support to policy provision for entrepreneurial involvement (2.64); "inadequate" knowledge of successful health facilities owned by non health workers (2.34). Efforts at health care provision showed "inadequate" (2.22 and 2.62) respectively. Disposition towards policies on entrepreneurial involvement "fairly acceptable" (3.27); "possibility of success" of investors' involvement (3.27); "willingness to work in" and "possibility of sabotage" (3.09 and 3.57) respectively. Study established the need to enhance deplorable conditions in the health system. As public funds/allocation cannot meet health needs, it becomes needful to explore alternative support avenues. Given appropriate sensitization backed by proper legislation, entrepreneurial foray into health facility provision could be a feasible venture.

Key Words: Knowledge, Attitude, Health Workers, Entrepreneur, Health care system, Abakaliki.

Key Messages:

Implications for policy makers

iv. To come to terms with the necessity of involving entrepreneurs in the provision of adequate health care facilities and incorporating same in their policy on health care provision, management and qualifications of different categories of providers.

v. To provide ready evidence for policy dialogue as it concerns the subject matter.

Implications for Health workers

- To understand that entrepreneurial involvement in the provision of health facilities may not necessarily reduce the quality of health care provided and that such involvement might boost adequacy.

Implications for public

- To alleviate the high costs associated with sourcing medical attention outside the shores of the state/country.

- To reduce the high mortality associated with the delays encountered in transit when seeking medical attention outside.
- To understand that private initiatives may engender competition which result in overall quality service delivery.

Introduction

Adequate and accessible health care and health facilities needed to attend to the health needs of the populace are the desire of every government and society. "Adequate and accessible" health care in this regard include highly and vastly equipped facilities featuring state of the art machines, enough hospital beds, well equipped private rooms to cater to such needs as they may arise, refectory, recreational areas, personalized services and qualified personnel to go round effectively. Eme, Uche and Uche[1] defined health care facilities as 'those basic equipment, stock of drugs, vaccines, portable water, constant supply of energy (power), medical record tools, ambulances for mobility of patients, solar freezers, availability of qualified health officers and medical personnel, etc., which make it possible for the improvement of the patients' healthy living'. They also include 'hospitals, clinics, dental offices, out-patient surgery centers, birthing centers and nursing homes.' Their report stated that the wards in some of the hospitals are so run down and bare they look like they would be sources for new outbreaks of diseases contributing to increase in mortality rate in the country.

Provision of such has been majorly left under the orbit of the government. As such, strides to actualizing this dream competes with other teeming interests in the society thereby limiting the extent to which the government can intervene in ensuring delivering of these health needs. Furthermore, divergent interests of policy actors in the health sector can boost or deter this quest in the bid to maintain exclusivity of the sector. To this end, the reality of health care provisions on ground is a far cry from what is desired or expected. Hence, health care and facilities tend not to go round where needed, are not adequately equipped and staffed if available and solutions to all health issues not actually accessible when needed. In support of this, Lambo[2] in the Revised National Health Policy had recognized that a very high proportion of primary health care facilities serve only about 5-10% of their potential patient load, secondary health care facilities are in prostate conditions; diagnostic and investigative equipment in tertiary health institutions are outdated. Public expenditure on health is less than $8 per capita, compared to the $34 recommended internationally.

Resultant from this is the quest for employment, adequate medical attention and facilities outside the shores of the state and country (abroad) giving rise to increase in brain drain, mortality rate and even economic flight. These are caused by the inability to offer adequate employment to our teeming medical practitioners, delays attendant with seeking medical attention "abroad" and the loss of cash that would have entered into the state cum national coffers that is now being invested "abroad". Eme, Uche and Uche[1] posit that inadequate and obsolete equipment in Nigerian hospitals had over the years contributed to the exodus of Nigerian doctors and other health personnel "abroad" in search of better opportunities. It also necessitated a scenario where those who can afford it go to industrialized eastern countries to get treatment for health problems, while those with smaller pockets go to places like India, with cheaper healthcare. As a way forward, they opined that for the management of any health care system to be successful it should be typically directed through a set of policies and plans adopted by the government, private sector business and other groups in areas such as personal health care delivery and financing, pharmaceuticals, health human resources and public health. This opinion is buttressed in the report of Osotimehin[3] that the health sector is characterized by lack of effective stewardship role of government, fragmented health service delivery, inadequate and inefficient financing, weak health infrastructure, mal-distribution of health work force and poor coordination amongst key players. To address these, the federal government implemented the Health Sector Reform Program (HSRP) from 2004-2007, which addressed seven strategic thrusts revolving around government's stewardship role; management of the national health system; the burden of disease; mobilization and utilization of health resources; health service delivery; consumer awareness and community involvement; partnership, collaboration and coordination. This is in addition to the recognition

of the private health sector as a major contributor to healthcare delivery in most parts of Nigeria and is often the first point of contact with the health system for the majority of people.

All these point to the need for increased funding and partnering in the health sector; and one of the ways to ensure this is to accommodate private hands or entrepreneurs in the provision of health care facilities. This observation have support in the Revised National Health Policy where it pointed out that there is no broad-based health financing strategy and that partnerships between the public and private sector are non-existent or ineffective and as a way forward encourages the establishment of private health facilities.

Private health care facility as opposed to public health care facility is in the ownership structure. It is a facility that is owned and governed by a person or group of persons managing and controlling the activities concerned with that facility like funds, staffing and administration for a profit. It is characterized by the fact that it can pander to the clientele or patients according to their whims and caprices with regards to quality and other things that normally facilitate seeking such medical attention and can also accord personalized attention and care (Koshal[4]). Furthermore, it can:

a. identify and deploy their human resource needs in line with government policies.

b. strengthen and update their institutions/hospitals and train manpower needed to provide the desired health care services.

c. at all times comply with the approved guidelines in human resources for health care delivery in recruitment of personnel and setting up of facilities.

Further in section 5.16 the policy document states that the Ministries of Health, in collaboration with relevant bodies shall review the distribution and types of existing health care facilities and their status and shall work out a master plan of minimum requirements for health centres, dispensaries and first level referral hospitals. Section 5.17 on National Health Care Financing stated that as it is within the rights of individuals to participate in the economy of the nation, private individuals shall be encouraged with generous tax breaks to establish and finance private health care services in under-served areas'. This presupposes the recognition of the fact that with proper regulation, private individuals or entrepreneurs can be factored into health care provision in order to improve the country's health status.

Meanwhile, Udu, Udu and Eze[5] noted that entrepreneurship is a process by which economic and commercial activities necessary for the improvement of the standard of living of the society are created and commercialized by entrepreneurs – individuals, institutions, corporations and government'. To them, entrepreneurs are private investors or risk bearers in any field of endeavour that control the necessary funds needed to make things happen with the expectation of returns. They can be seen as people who demonstrate initiative, think and imagine creatively, organize and utilize appropriately economic and social resources at their disposal in seemingly unexisting opportunities and bear the attendant risks or failure associated with such ventures. Their involvement and regulation in the provision of health care facilities with adequate legal (policy) backing, monitoring and control should be considered in the bid to bridge the existing wide gap between need and solution to health care.

Demand for an adequate and somewhat affordable health care and facility buffets anyone that has ever been in need of such, but the exchange gotten for these demands seem to be less than the average. End users live in the hope that the near future might bring solutions to these plights by bridging the gaps between the obtainable and the expected. Whether these can be obtainable and feasible through private or entrepreneurial involvement is yet to be determined. As such, assessing the knowledge of different categories of health workers on policy provisions and involvement of entrepreneurs in adequate health care facilities provision is of paramount importance. So also is the need to gauge their attitude towards the quest to incorporate the resources of entrepreneurs in provisions and management policies. An outcrop of these assessments will be the needed pointers as to the feasibility and benefits accruable from the involvement of entrepreneurs in the provision of health care facilities, hence, this study.

These phenomena are not exclusive to the Nigerian scenario as the need and demand for increased private health seem to be a global concern. Other countries like United States of America and China among others had at one time or the other experienced such challenges and had seen the necessity for developing policies or legal backups to accommodate the fray in the bid to boost health care delivery. Masucci and

Asheld[6] disclosed how the Governor of New York's budget proposal contains language that authorizes allowing the Public Health and Health Planning Council to approve business corporations to own or operate hospitals though they are to affiliate academic medical centres. They opined that it is being designed to promote development of new sources of capital and to evaluate the impact private equity investment would have on quality of and access to care and its benefits to the hospital, its patients, and the community. Inculcated in the budget proposal is a call for authorization of broader waiver of NYS Public Health Law Article 28 provisions addressing ownership structures.

Yang[7] found as of 2013 in China that private hospitals were 9800 in number and represents almost half of the total number of hospitals in the country still lagged severely due to low utilization, talent shortages and incomplete social insurance coverage. Further findings in the study show that there are ongoing healthcare reform initiatives with the of goal increasing the share of patients treated by private hospitals to 20% by the end of 2015, improving equity and accessibility of quality health care as a top priority. To facilitate these investments according to Yang[7], the Chinese government appears to be relaxing its restrictions on private and foreign investment in this sector.

PricewaterhouseCoopers LLP[8] while collaborating with these findings in China further opines that private facilities will add competition into the marketplace and offer care alternatives to the middle and upper classes, making them an attractive potential investment. They highlighted staff shortages, weak primary care system, overuse of services and overcrowding and few high-quality step-down care facilities as the shortcomings in the public sector that necessitated the privatization bid.

The Global Health Group[9] carried out a study on public-private investment partnership for health (PPIP) in several countries. In their opinion, some governments are wary of working with the private sector in healthcare partly because of general distrust between the private and public sectors and partly because of an inherited aspiration to create a public monopoly healthcare system.

Methods

Study Design

Historical and descriptive study designs were adopted on the basis that past trends in health care provisions, present situations and the future necessities for the involvement of entrepreneurs need to be reiterated and presented. Study was divided into two stages: (a) knowledge assessment; and (b) attitude assessment and appropriate questionnaire were developed and administered to the eligible participants. To further enhance credibility verbal (oral) interactions were established with randomly selected health workers and other stakeholders as might be involved in the health policy processes.

Study Area and Participants

The study was carried out at the subnational level and the participants were drawn from Abakaliki area of Ebonyi State in the South-Eastern Nigeria. Area restriction was based on the nature of the research work and as a result of the fact that Abakaliki houses the largest concentration of diverse categories of health workers in the state making them more accessible for the researcher to source information. Participants were drawn from different sections in health care management like consultants, pharmacists, registrars, directors, nurses to mention but a few. Also included for oral participation is one each of these – politicians, entrepreneurs, lawyers, academics and NGOs on the basis that they form part of the policy making process.

Inclusion Criteria

One of the qualifications for participation as a respondent to this study was being certified health workers duly attached to a known, official and government health facilities as they are the group likely to influence and hold sway on any policy dialogue and decisions. Another qualifying factor was the residential or contact location of the respondents (must be within Abakaliki for ease of accessibility).

Data Analysis

The data was collected by means of questionnaire was analyzed using the methods developed at McMaster University Canada by Johnson and Lavis.[11] The analysis is based on mean (MNR) and median (MDR) ratings and range. The Likert rating scale of 1-5 points were used in the figures and 1 point = grossly inadequate; 2 points = inadequate; 3 points = fairly adequate; 4 points = adequate and 5 points = very adequate or the like depending on the type of question and the response to be elicited. Measured in the

analysis are parameters assessing the knowledge and attitude of the respondents. In terms of interpretation, values ranging from 1.00 to 2.79 points are considered negative, while values ranging from 2.80 to 5.00 points are considered positive.

Results

A total of 100 health workers were assessed by means of questionnaire administration, though most of them deemed it unimportant to provide answers to all the questions based on their judgements which are unknown to the researchers. Information as elicited from the respondents is in 2 categories based on knowledge and attitude assessment. The profile of the respondents is as contained in Table 1 and included the following: Staff/Admin/Accounts (21%), Analyst/Intern (13%), Scientist/Physiotherapist (15%), Pharmacist/Optometrists (11%), Nursing officers (14%), Consultants/Registrars (10%), Directors/Assistant Directors/Heads of departments (5%) and Residents/Academic (9%). A total of 37% and 8% of the respondents have fair and maximal influence on policy making processes respectively with 67% and 15% of them having bachelors and postgraduate degrees as highest qualifications respectively. The outcome of the assessment of the knowledge and attitude of these health workers in mean, median and range are presented in tables 2 and 3 respectively.

Table 1: Profiles of Research Respondents

Respondents' Attributes	No (%) of Participants, N = 100	Respondents' Attributes	No (%) of Participants, N = 100
Gender		**Institutional affiliation**	
Female	56 (56)	Federal Teaching Hospital	91 (91)
Male	39 (39)	National Obstetric fistula Centre	1 (1)
Missing	5 (5)	State Ministry of Health	3 (3)
Age (y)		Local Government Service Commission	1 (1)
<25	3 (3)	Primary Health Care	1 (1)
26 – 34	42 (42)	Mother and Child Support Programme	1 (1)
35 – 44	40 (40)	Educational Institution	1 (1)
≥45	13 (13)	Missing	1 (1)
Missing	2 (2)	**Official designation**	
Experience (yrs)		Staff/Admin/Accounts	21 (21)
<5	60 (60)	Analyst/Intern	13 (13)
6 – 14	27 (27)	Scientist/Physiotherapist	15 (15)
15 – 24	8 (8)	Pharmacist/Optometrists	11 (11)
≥25	1 (1)	Nursing officers	14 (14)
Missing	4 (4)	Consultants/Registrars	10 (10)
Influence on policy		Directors/Ass. Directors/Heads of depts.	5 (5)
Minimal	49 (49)	Residents/Academic	9 (9)
Fair	37 (37)	Missing	2 (2)
Maximal	8 (8)	**Highest Academic Qualification**	
Missing	6 (6)	SSCE/Certificate	6 (6)
Professional Aff.		Bachelor	67 (67)
Yes	67 (67)	Post Graduate	15 (15)
No	19 (19)	Fellowship	6 (6)
Missing	14 (14)	Missing	6 (6)

With respect to knowledge assessment, the rating of the adequacy of facilities provided by the government has a mean of 2.38, median of 2 and range of 1-5 proving the provision to be inadequate. The score on the performance and adequacy of additional health care facilities provided by professional health care workers are inadequate with a mean of 2.78, median of 3 and range of 1-5. The respondents rated their level of

knowledge about health care facilities established by non health workers as inadequate with a mean of 2.76, median of 3 and range of 1-5. On knowledge of health care policies towards entrepreneuring health care facilities in Nigeria, the result rated fairly adequate at 2.89, 3 and 1-5 for mean, median and range respectively.

2.48, 2 and 1-5 are the mean, median and range scores for knowledge of policies on establishment of health facilities with regards to non health workers, making it inadequate for sound judgment. The knowledge of the respondents on successful health care facilities established by non health workers is inadequate with mean, median and range of 2.68, 3, 1-5 respectively. The respondents also rated inadequate the performance of health care facilities established by non health workers 2.41, 2 and 1-4 with respect to mean, median and range respectively. On their knowledge about general health workers' attitude towards entrepreneuring health facilities the mean is 2.99, the median is 3 and the range is 1-5 making it a fairly adequate knowledge.

Table 2: Responses on Knowledge Assessment

Parameter assessed	Total	Mean	Median	Range
1. How would you rate the adequacy of available health care facilities provided by the Government?	99	2.38	2	1-5
2. How would you rate the performance and adequacy of additional health care facilities provided by professional health care workers?	99	2.78	3	1-5
3. How would you rate your level of knowledge about health care facilities established by non health workers?	98	2.76	3	1-5
4. How is your knowledge of health care policies towards entrepreneuring health care facilities in Nigeria?	99	2.89	3	1-5
5. How would you rate policies on establishment of health facilities with regards to non health workers?	99	2.48	2	1-5
6. How is your knowledge of successful health care facilities established by non health workers?	98	2.68	3	1-5
7. How would you rate the performance of health care facilities established by non health workers?	99	2.41	2	1-4
8. How would you rate your knowledge about general health workers' attitude towards entrepreneuring health facilities?	99	2.99	3	1-5

Also gathered and assessed were the responses of the health workers on their attitude towards entrepreneuring health care facilities. The results show disagree with a mean, median and range of 2.48, 2, 1-5 respectively on their level of agreement for health care facilities to be provided by non health workers. In terms of their level of acceptance towards policies for entrepreneuring health facilities, the response was fairly acceptable with a mean of 3.20, median of 3, and range of 1-5. The mean score for their support for policies on establishment of health facilities in favour of non health professionals is 2.69, the range is 3, and the median is 1-5 showing a negative response. There is a fairly possible rate of success of health facilities established by non health workers response with a mean of 3.10, median of 3 and range of 1-5. A fairly acceptable result going by the mean of 3.26, median of 3 and 1-5 was recorded on the respondents' disposition towards entrepeneuring health facilities. On their rate of willingness to work in health facilities established by non health workers, the results is fairly willing with a mean of 2.98, median of 3 and range of 1-5. They also responded as fairly positive the general health workers' attitude on entrepreneuring health with a mean, median and of 2.95, 3 and 1-5 respectively. The responses tilted towards possible going by the median of 4 but fairly possible going by the mean of 3.56 on the possibility of sabotage by health workers towards working in facilities established by non health workers, the range is 1-5.

Table 3: Responses on Attitude Assessment

Parameter assessed	Total	Mean	Median	Range
1. How would you rate your level of agreement for health care facilities to be provided by non health workers?	99	2.48	2	1-5
2. How would you describe your level of acceptance towards policies for entrepreneuring health facilities?	98	3.20	3	1-5
3. As a (potential) health policy maker, how would you rate your support for policies on establishment of health facilities in favour of non health professionals?	100	2.69	3	1-5
4. How would you rate the possibility of success of health facilities established by non health workers?	99	3.10	3	1-5
5. How is your disposition towards entrepeneuring health facilities?	97	3.26	3	1-5
6. How would you rate your willingness towards working in health facilities established by non health workers?	97	2.98	3	1-5
7. How would you rate general health workers' attitude on entrepreneuring health?	98	2.95	3	1-5
8. How would you rate the possibility of sabotage by health workers towards working in facilities established by non health workers?	95	3.56	4	1-5

Table 4: Questions for Oral Interview

	Questions
1.	What is your view concerning entrepreneuring health care facilities?
2.	As a (potential) health policy maker, how would you describe your support for policies that will promote entrepreneuring of health care facilities?
3.	What do you think can be done to promote the entrepreneurship of health care facilities?

Furthermore, questions and views of respondents from personal oral interviews conducted by the researchers on key individuals from sections considered as possible integral part(s) of a policy making process in the health sector respectively are as presented in Tables 4 and 5 respectively. Three questions were presented to each of them for input. The composition of the respondents comprises of a doctor (D), a pharmacist (Ph), a nurse (N), a laboratory scientist (LS), an administrator (Ad), a legal practitioner (L), a politician (P), an academic (A), an entrepreneur (E) and an NGO (N) representative.

Table 5: Responses from Oral Interview

	Responses
D	It will be a welcome development to enhance availability and retain earnings within the state/country
	I have a strong support
	Awareness of stakeholders should be improved. Private companies should also be gotten to design good offers
Ph	It is a good initiative
	Professionally, expertise should be the watchword and the motive to enhance so as not to overwhelm the health workers
	A pilot study should be conducted to know feasibility and eventual viability of the project
N	It will be a welcome development though expensive in the Nigerian perspective. The advantages in terms of availability and revenue generated outweighs the disadvantages in terms of emergency, mortality rate, revenue flight and inadequate health facilities
	I am strongly in support of any such policy

	A supporting policy should be put in place in order to curb sabotage and bureaucratic bottle necks that may try to choke such ventures
Ad	It is a good concept that can boost and stabilize our economy by generating capital inflow
	My support is very high
	A subsidized support by government will encourage this kind of venture; Regulatory rules should be enacted to ensure quality of serviced; Importation of needed equipments should not be overtaxed; Other concerned sectors should be involved in the health policy making process.
L	a) It is a viable option worth exploring. Health care is driven by entrepreneurship in developed countries which is not so here. I hope and pray it gets here. It should be taken as business so that it can be improved and for it to work.
	b) Positive support should be gotten through law makers and making.
	c) Awareness should be created and sensitization done inviting all stakeholders to participate in the process.

Responses from Oral Interview (contd.)

	Responses
P	It will be a good programme as it has to do with entrepreneurs, Public Private Partnership making it a programme for all. Ensures complete participation in bringing good health to the people.
	My support is high for such an interesting idea because it will help revive the almost dead health system and revive our referral system
	The first is to ensure the presence and interest of the entrepreneurs in the programme. Secondly to put in place a sustainable policy that can stand the test of time and finally to bring on board all the concerned stakeholders – government, health workers, entrepreneurs, NGOs, legal bodies and even representatives of the citizens in the policy process
	Health policy makers should not be so far removed from end users because the current situation is such that health policy makers are alienated from the beneficiaries of health care facilities and as well from health care operators; there is urgent need to bring the three parties together at the point of policy formulation in the sense that most of the beneficiaries who are well to do may see the need to collaborate and help to improve some facilities that are needed for efficient operations of the health system.
A	It will be one of the best things to happen in the country because without collaboration between those who have the skill, knowledge and experience of issues relating to health and those who are in a position to provide policy support and financial willpower the desired improvement of our health system will be difficult.
	I will in all honesty give a tacit support to policies that will promote entrepreneuring of health care facilities
	Health policy makers should not be so far removed from end users because the current situation is such that health policy makers are alienated from the beneficiaries of health care facilities and as well from health care operators; there is urgent need to bring the three parties together at the point of policy formulation in the sense that most of the beneficiaries who are well to do may see the need to collaborate and help to improve some facilities that are needed for efficient operations of the health system.
E	It will be a very welcome development
	My support will be 100% invested given that it will be a good business opportunity and also a means to improve our health system.
	An all inclusive position should be taken to get all stakeholders involved in the policy making and implantation process to ensure general acceptability and success.

NGO	It is acceptable if it can strengthen the health system without compromising standards
	My support is very strong because so far the health practitioners have not succeeded in meeting all the health care needs in demand from my experiences in the field
	Support policies should be enacted to disband the monopolistic powers of health workers; External donors like USAID, DFID, UNICEF and the like should be involved in the process; A pilot venture should be used to demonstrate and ascertain the possibility and feasibility.

Discussion

Health service delivery conditions, the dilapidated state of most public health facilities, lack of state of the art medical equipments and technologies and the not so adequate complementary efforts of qualified medical practitioners in private practice might well be indicators and call for additional measures to be taken in order to buffer our health system. These are collaborated by the findings in this study where respondents rated the adequacy of health care facilities provided by the government as inadequate with a mean of 2.38, median of 2.0 and range of 1-5 and performance and adequacy of additional health care facilities provided by professional health workers at inadequate with a mean of 2.78, median of 3.0 and range of 1-5. Also reviewed literature show an affinity with these findings (Eme, Uche and Uche[2], Lambo[3], Osotimehin[4], PricewaterhouseCoopers LLP[8], and Global Health Group[9]). One of these additional measures could be the involvement of entrepreneurs into the health system foray as have become the practice in some other places like Australia, Spain, Portugal, Lesotho, Turks and Caicos Islands and China and highlighted in the literature review (Masucci and Asheld[6], Yang[7], PricewaterhouseCoopers LLP[8] and Global Health Group[9]). This viable alternative notwithstanding, it has not yet become an enforceable option in the Nigerian health sector scenario because from the findings of this study the knowledge of its possibility and attendant advantages in boosting the health sector are mostly inadequate and underrated. This was as noted from the findings of this work where responses on knowledge about health care facilities established by non health workers (2.76, 3.0 and 1-5), knowledge of health policies towards private engagement in provision of health care facilities in Nigeria (2.89, 3.0 and 1-5), knowledge of successful health care facilities established by non health workers (2.68, 3.0 and 1-5) and knowledge about general health workers' attitude towards entrepreneuring health facilities (2.80, 3.0 and 1-5). These are also as observed from reviewed literature (Lambo[3], Yang[7] and Global Health Group[9]). Also from the study, it is observed that given adequate knowledge and sensitization on the benefits and regulation of facilities established by entrepreneurs there could be adequate support given to such policy. This can be gotten from the responses on level of acceptance towards policies for entrepreneuring health facilities at mean 3.20, median 3 and range 1-5; disposition towards entrepeneuring health facilities at mean 3.26, median 3 and range 1-5; and rating of general health workers' attitude on entrepreneuring health facilities at mean 2.95, median 3 and range 1-5. All these responses are fairly acceptable and fairly positive.

Furthermore, from the findings of this study, there is the likelihood of sabotage against facilities established by non health workers or entrepreneurs in terms of support to and being engaged to work there. Support for this assertion on level of agreement for non health workers to provide health care facilities is at 2.48, 2 and 1-5 for mean, median and range respectively. On the possibility of sabotage by health workers towards working in facilities established by non health workers the result is at 3.56, 4 and 1-5 for mean, median and range respectively. This was in response to knowledge of health workers' behaviour but response on health workers' attitude as gotten from the response on willingness towards working in health facilities established by non health workers is fairly willing with a mean of 2.98, median of 3.0 and range of 1-5. It was also found that given enough encouragement and legal backing, health facilities established by non health workers are likely to be successful and beneficial to the nation as supported by responses thus – fairly possible with a mean of 3.10, median of 3.0 and range of 1-5 on possibility of success of health facilities established by non health workers. In collaboration with these results from the analyses are the responses on the oral interviews conducted which were all positive. The questions and responses for the oral interviews are as presented in Tables 4 and 5 respectively.

Conclusion

From the foregoing, it is established that available health care, health personnel and health facilities are inadequate. That there is need to work on and eradicate, reduce or possibly eliminate unfavourable conditions in the nation's health system and that public funds and allocation cannot meet the health needs of the nation as it should. This is as buttressed by Lambo[3] in his saying that 'Public expenditure on health is less than $8 per capita, compared to the $34 recommended internationally'. There is also need to explore alternative ways through which these conditions can be improved. This makes a consideration of involving entrepreneurs into the sector to boost the health system and improve our ratings. As the countries studied (Global Health Group[9]) and already engaged in these endeavours are better rated than us with regards to performance of health systems. This can be seen from the World Health Organization rating of countries' health systems in 2000 where the countries studied in this work like Australia ranked 32, China ranked 144, Lesotho ranked 183, Portugal ranked 12, Spain ranked 7 and Turks and Caicos Islands ranked 37, while Nigeria ranked 187 out of 191 countries (WHO[11]).

Recommendations

1. This study recommends a review of the health systems policy(ies) with the view of possible upgrade where necessary and inclusion of private involvement requirements and clauses.
2. If the first recommendation is acceptable then guiding laws, means of monitoring and evaluation, sanctions to be meted out to defaulters and the monitoring and implementing agencies should be clearly specified.
3. Operational modalities as to the extent of control and if there is a possibility of takeover by the government and when it is expected should be agreed on.
4. Knowledge translation should be enhanced to educate health workers on the why, need for and benefits of such private engagements and possibly combat biases and monopolistic tendencies where observed. This possibility is as noted from the Global Health Group[9] study reporting that some governments are wary of working with the private sector in healthcare partly because of general distrust between the private and public sectors and partly because of an inherited aspiration to create a public monopoly healthcare system.
5. Furthermore, collaborative measures should be established between the health and non health workers' partnership to ensure successful implementation and improvement of the Nation's health system. This will also boost referrals between public and private hospitals as the need may arise. It might also possibly arrest the brain drain and capital flight experienced when citizens seek better conditions of employment and medical care outside the country. As observed by Lambo[2] 'the referral system between various types of facilities is non-functional or ineffective'.

Ethical Issues

Approval for this study was obtained from the Directorate of Research, Innovation and Commercialization (DRIC), Ebonyi State University, Abakaliki, Nigeria. The approval was based on the agreement that participation in the research was voluntary following informed consent; that participants' anonymity would be maintained; and that every finding would be treated with utmost confidentiality and for the purpose of this research. All these conditions were strictly adhered to in this study.

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Competing Interests

Authors declare that they have no competing interests.

Authors' Contributions

Idea for the study was conceived, developed and executed by OEF while logistics, guidance and counsel were provided by OLC, ABO and UCJ. OEF drafted the manuscript while OLC, ABO and UCJ edited and revised it.

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