

Original Research Article

ENROLLEES PERCEPTION OF NATIONAL HEALTH INSURANCE SCHEME

ABSTRACT

Aim: To assessed enrolees' perception of the National Health Insurance Scheme (NHIS), launched in 2005 and made mandatory for all Federal civil servants.

Study Design: This descriptive cross-sectional study conducted in August and September 2013 focused on civil servant enrollees of three tertiary health institutions in Lagos South-West Nigeria.

Methodology: Random sampling was employed in the selection of 150 enrolees from the nominal rolls of the three Federal tertiary health institutions in Lagos State, Nigeria. Each consenting selected enrolee was requested to complete a semi-structured, self-administered questionnaire which probed into their demographic characteristics, knowledge and expectations, services accessed, and overall perception on the scheme.

Results: A total of 143 enrolees (males 43.7%; females 56.3%) completed the questionnaire. Majority (97.2%) had knowledge of the scheme: easy access to healthcare at affordable cost accounted for 40.7%, subsidized health care services (22.2%) and pooling of resources to fund health needs of enrolees (11.1%). Subsidized treatment, quality healthcare provision and free treatment were the most mentioned expectations while treatment and general care were the most accessed services (55.7%). A substantial proportion (22.9%) never accessed the services and, 18% had no knowledge of complaints channel. More than half (59.8%) were dissatisfied with services accessed, reasons ranging from drug unavailability (27.8%) to poor quality of service (12.6%) and out-of- pocket payment on drugs and tests (11.4%). Majority (57%) claimed reduction in out-of-pocket expenses.

Conclusions: Regular monitoring of the scheme's operations should contribute greatly to enrolees' satisfaction, confidence and sustainability of the scheme. Sustainable and quality drugs supplies, inclusion of frequently required laboratory tests should minimise out-of-pocket health expenses. Continuous enlightenment on the scheme services is desirable with emphasis on ensuring enrolees' satisfaction for sustainability to secure the universal health coverage target in the country.

Key words: Health Insurance; Perception; Civil servants; Enrolees; Nigeria.

INTRODUCTION

The launching of the National Health Insurance Scheme (NHIS) in Nigeria in 2005 serves as one of the key building blocks of the health system restructuring and strengthening and the health sector reform to improve the health services and thus the poor national health indices of Nigeria [1]. Out-of-pocket health expenses play a major role in health financing in Nigeria which does not promote equitable access to quality health care thus the need for financial risk protection from ill health. The scheme has an overall strategy of achieving universal health coverage which ensures access to and use of quality health care services by all citizens, and protection from any catastrophic financial effect of ill health [2]. The scheme offers different types of health insurance schemes ranging from social health insurance to community-based health insurance and private for-profit insurance, defined mainly by the source of financing for the premium. Effective implementation of a combination of these will enable the country achieve a high coverage of the population as obtains in some countries such as Colombia with 95% coverage [3] and Thailand with very few citizens without insurance coverage [4].

The NHIS which presently covers less than 7% of the Nigerian population [5], mostly Federal government workers and the formal private sector, aims at increasing access to quality health care and protect from sudden high financial burden of purchasing health care by pooling of funds and sharing the risk of unexpected health events [6] among a population still striving to tackle the problem of widespread poverty, as exists in most parts of Africa [7]. Enrolment in the scheme is mandatory for all government employees at the federal level and contributions to the scheme are earnings-related. The employer pays 10% while the employee pays 5%, representing 15% of the employee's basic salary towards the scheme [1]. The contribution confers health care benefits to the employee, one spouse and 4 biological children below the age of 18 years while the benefit package covers: out-patient care, including necessary consumables, prescribed drugs, pharmaceutical care and diagnostic tests, maternity (ante-natal, delivery and post-natal) care for four pregnancies ending in live births, preventive care, including immunization, health and family planning education, consultation with specialists, hospital care and a stay limited to cumulative 21 days per year; eye examination and care, provision of low priced spectacles but

excluding contact lenses, range of prostheses, dental care and annual medical check-up unrelated to illness [1].

Enrolees' satisfaction with the services provided by the scheme is a key factor for sustaining the scheme and, for expansion. This is a measure of how the services provided meet the enrolee's expectations reflected as; adequate information, good communication, good enrolee-health provider/worker relationship and easy access to affordable care, including adequate diagnostic tools for proper diagnosis, as defined in the package with reduction in out-of-pocket health expenses. Given that health insurance schemes transform lives especially of the poor in particular, by enabling access to previously unaffordable medical treatment, good quality health care which is not compromised in an attempt to make it affordable needs to be assured. Enrolees' satisfaction with services provided by the scheme is a valuable tool for assessing quality of care, especially defined/ captured as enrolee-health worker relationship/attitude, communication, waiting time and cost of care. Adebayo and Asuzu [8] attributed high level of utilization of community-based health facility to patients' satisfaction with the care received previously. Likewise, high level of satisfaction was reported among women utilising maternal services from randomly selected Primary Health Care facilities in Nnewi, Nigeria [9].

Given that there has been insufficient literature in low and middle income countries (LMICs), most especially in Africa, that dealt with clients' satisfaction based on knowledge and awareness of enrolees within the health insurance scheme setting [10], recording enrolees experience and identifying concerns would enable improvement for effective and efficient health care for the citizens to access quality care which however is a vital aspect of the scheme that will continually engage enrolees' interest. This study sought to generate evidence to improve the functioning of the NHIS in Nigeria. It assessed Federal civil servant enrolees' experiences, opinions and challenges experienced with the scheme as well as proffered suggestions for improving the scheme.

METHODS

Study Areas

This study covered three tertiary health institutions namely; Nigerian Institute of Medical Research, Yaba (NIMR), National Orthopaedic Hospital, Igbobi (NOHIL) and Federal Neuropsychiatric Hospital, Yaba (FNH) in Lagos South-West Nigeria.

Study Design

This was a descriptive cross-sectional study that focused on three tertiary health institutions in Lagos. The study probed into knowledge of NHIS, satisfaction with the services assessed, channels of communication and overall perception of the scheme.

Study Population

This study focused on civil servant enrollees who are mandatory contributors to the National Health Insurance Scheme (NHIS).

Data Collection Procedures

Multi-stage sampling was used in the study. Purposive sampling was employed in the selection of the surveyed institutions and, systematic sampling in the selection of 50 respondents per institution using the Institution's nominal roll. Data were collected using self-administered semi-structured questionnaire. The questionnaire probed into the following; demographic characteristics of respondents (age, sex, marital status, education, religion), knowledge of NHIS, expectations on accessible health services offered by the scheme, services accessed, satisfaction with the scheme, and overall perception on the scheme.

Data Analysis

Data collected were entered into the computer and analysed using SPSS software version 20. Categorical data were presented as cross tabulations and test of significance was by Chi square at 95% confidence interval and $p < 0.05$. Multivariate analyses were carried out to determine the predictors of the uptake of the services. The analyses were carried out using important variables such as the socio-demographic background (independent variables) and dependent variables that included enrollees' knowledge and perception of the health insurance scheme, out-of-pocket expenditure on health, type of healthcare services accessible under the health insurance, perceived satisfaction with access and quality of care provided by the health care providers (HCPs). Others covered challenges enrollees and their household members experienced in accessing and utilizing health care services. Other critical issue considered for analysis included enrollees perceived satisfaction with the scheme.

Limitations of the Study

The main limitation of the study is the small sample size from only tertiary health institutions in one part of the country. Nonetheless, the limitation does not undermine the validity of the study findings.

RESULTS

Socio-demographic characteristics of respondents

A total of 143 civil servant enrolees completed the self-administered questionnaire in the three institutions with males representing 43.7% of the respondents. Ages of respondents ranged from 27 to 59 years, with mean age of 41.7 years and median of 41 years. Majority (86.6%) of them were married with 1-4 children (80.9%) and only few (6.9%) had above 4 children. Majority (78.4%) of the respondents had been enrolled with the scheme for at least 3 years and the rest (21.6%) for less than 3 years. Of those enrolled (23.5%) registered “self only” with 9.9% of these classified as never married. The rest (76.5%) of those enrolled registered their family members as well.

Knowledge of the scheme

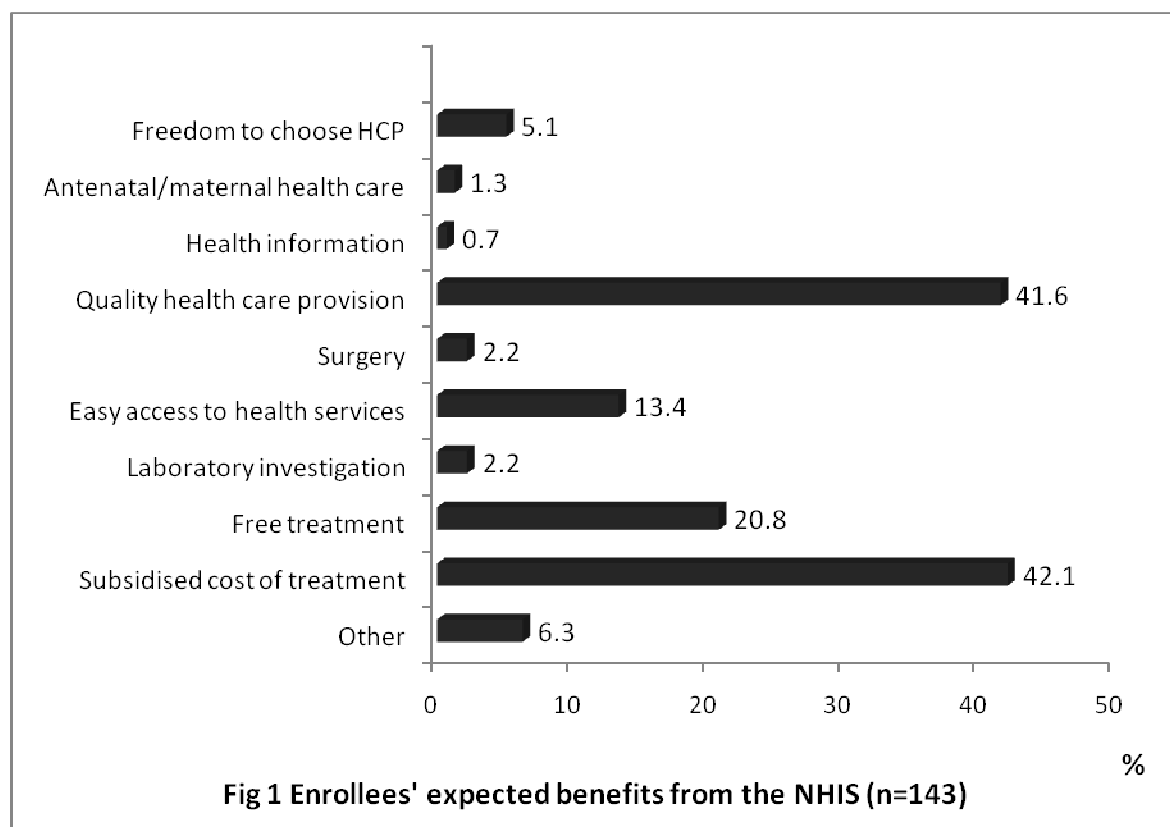
Majority (97.2%) had knowledge of the scheme (Table 1). Among the responses of 108 enrolees on knowledge of the scheme, 40.7% stated that the scheme enables people get access to health care easily and at an affordable cost; 22.2% as a scheme designed to subsidize health care services and 11.1% as a pooling of resources to fund health needs of enrolees.

Table 1: Respondents’ perception of National Health Insurance Scheme (NHIS)

	Respondents’ perceptions on NHIS	Frequency	Percentage
State all you know about NHIS	NHIS is a health insurance scheme that enable people get access to health care easily and at an affordable cost.	44	40.7
	NHIS is a health insurance scheme designed to subsidize health care services	24	22.2
	NHIS is a health insurance that insures The health of civil servants and their families.	22	20.4
	A pooling of resources from enrolees to fund the health needs of individuals under	12	11.1

154	the scheme		
155			
156	NHIS does not cover surgery and expensive	3	2.8
157	Drugs		
158			
159	No idea	3	2.8

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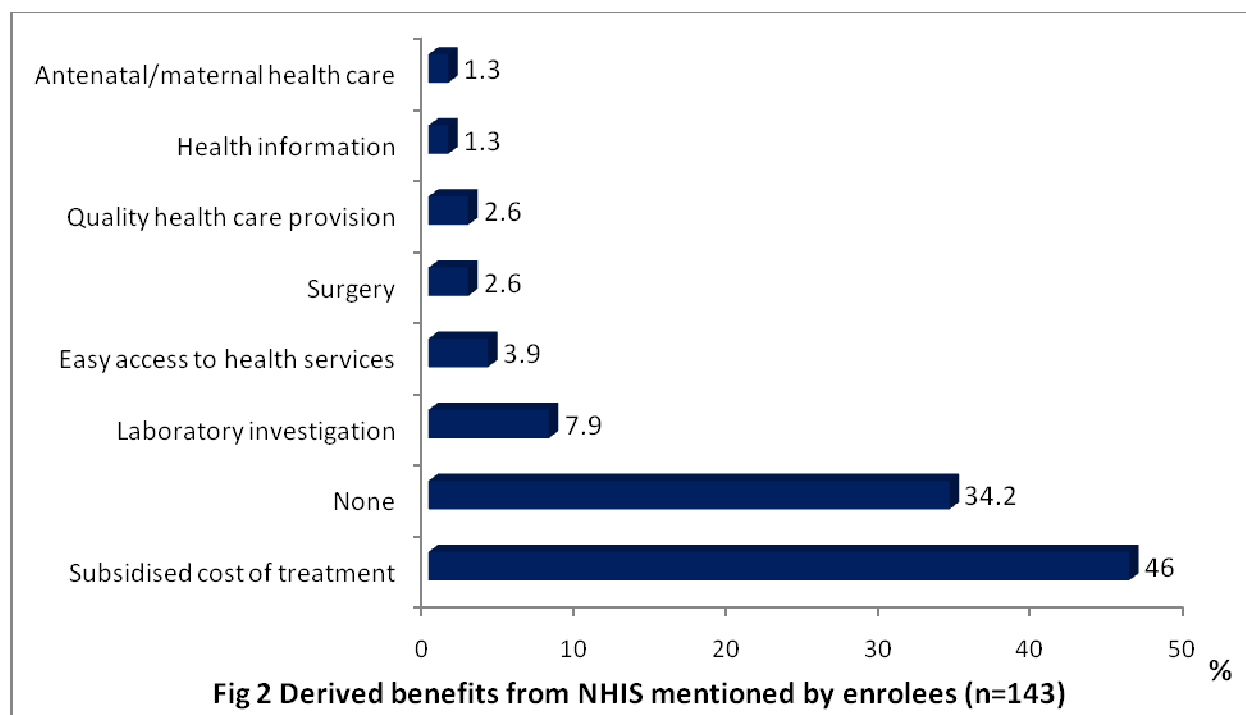
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163 Enrolees expected benefits from the scheme

164 All enrolees had expectations of the scheme, varying from subsidized cost of treatment (42.1%)
 165 (the most recurring) to antenatal/maternal care (2.2%) (the least mentioned). Subsidised cost of
 166 treatment (42.1%), quality health care provision (41.6%), free treatment (20.8%) and easy access
 167 to health services were the major expectations. It is interesting that health education and
 168 promotion/information was mentioned by a marginal few (0.7%) as illustrated in Figure 1. Other

169 expectations which included referral and opportunity to lodge complaints and seek redress for
 170 poor services were grouped together as “others” which accounted for 8.4%.
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 174 **Enrolees derived benefits from the scheme**
 175 Access to subsidized cost of treatment was the most mentioned benefit derived from the scheme
 176 (46%), while a substantial proportion (34.2%) of the enrolees claimed they did not derive any
 177 benefit since enrolment. Quality health care provision represented 2.6% of the claimed derived
 178 benefits (Figure 2).

179 Awareness on the health services available within the scheme

180 Enrolees displayed varied levels of awareness on the health services available within the benefit
 181 package offered by the scheme (Table 2). The question generated multiple responses. While
 182 majority (48.3%) claimed that all services could be accessed within the scheme, others were
 183 more specific. For instance, 16.8% each mentioned antenatal and post natal care and delivery
 184 and, treatment of minor illnesses; while 14.7% mentioned medication and drugs. The least
 185 mentioned was health education, accounting for 0.7%. Other health services the enrolees

mentioned they were aware of as part of the NHIS package which included medical check-up and out-patient care were grouped together as “others” which accounted for 7.7% in Table 2.

Table 2: Enrolees awareness of health services in the NHIS package

Category of services	Frequency	Percentage
All services	69	48.3
Antenatal/post natal/ Maternity care and delivery	24	16.8
Medication/Drugs	21	14.7
Treatment of minor illnesses	24	16.8
Lab investigations/tests	15	10.5
Surgery	12	8.4
Consultation	10	7.0
Inpatient Care	6	4.2
Paediatric Care	3	2.1
Immunization	2	1.4
X-ray	2	1.4
Health education	1	0.7
Others	11	7.7

Healthcare services accessed by enrolees

Healthcare service most frequently accessed by enrolees was treatment and general care (55.7%) followed by antenatal care (8.6%). A substantial proportion (22.9%) of the enrolees claimed not to have accessed health service through the NHIS since enrolment in the scheme (Fig 3).

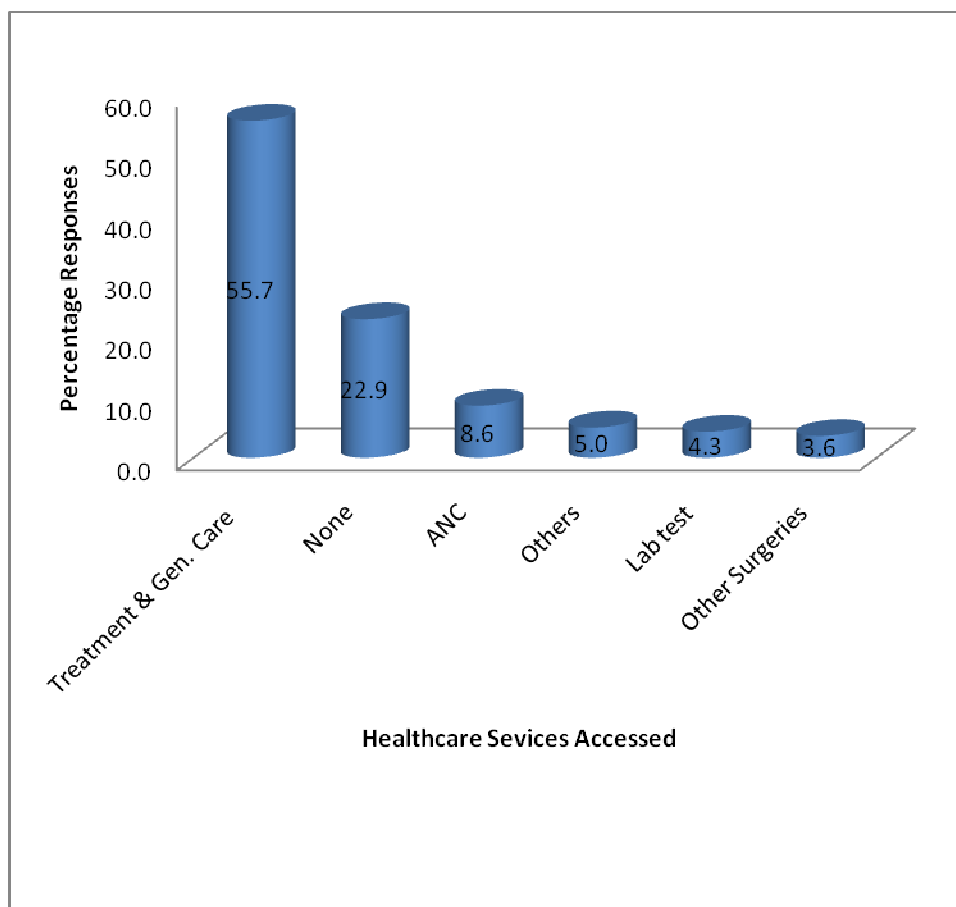


Figure 3: Healthcare services accessed by enrolees

Communication channels

The enrolees mentioned different communication channels for lodging complaints on services of the scheme. Topmost among the different channels mentioned were NHIS office (12%), HMO (12%) and complaint box/centre (8%). Many (18%) of the enrolees had no knowledge of where to channel complaints on services of the scheme (Fig 4).

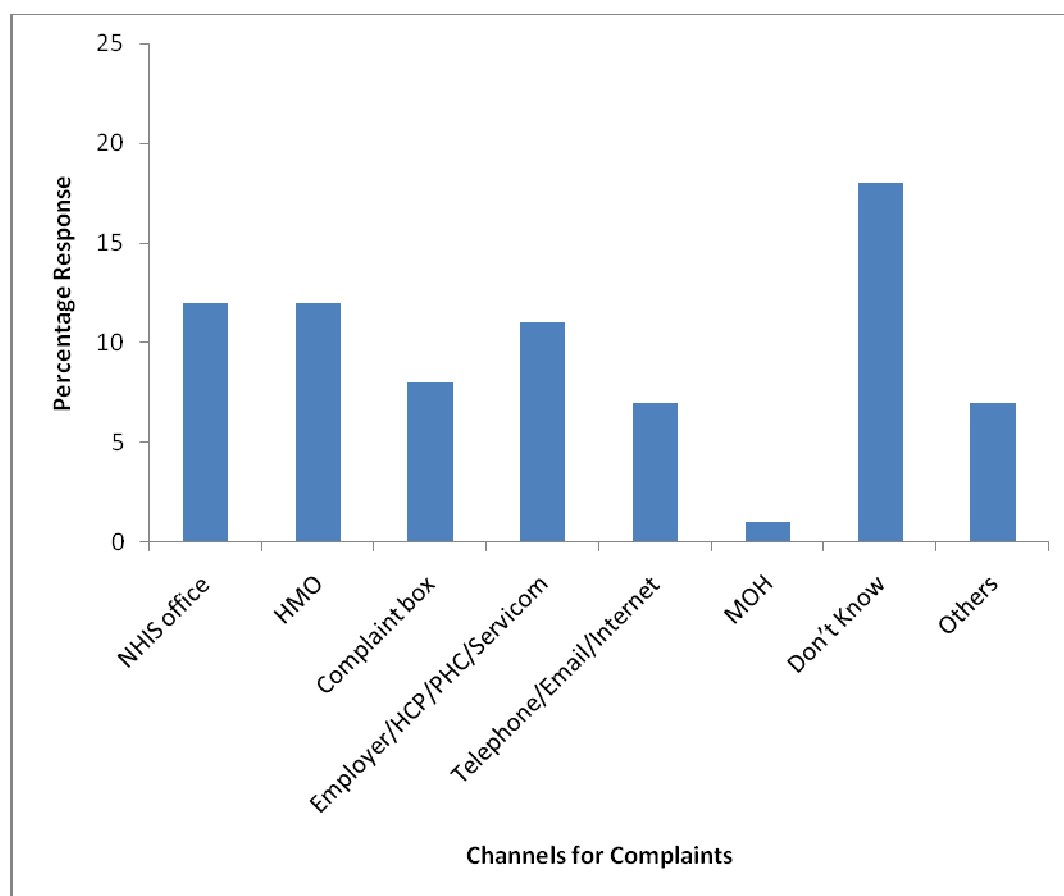


Figure 4: Enrolees knowledge of communication channels for complaints

Reasons for dissatisfaction with services

More than half (59.8%) of the respondents were dissatisfied with services accessed through the scheme while 1.1% were indifferent. Reasons for dissatisfaction ranged from non-availability/low quality of prescribed drugs/ exclusion of prescribed drug in the benefit package (27.8%); exclusion of some prescribed treatment/medication (17.7%) in the scheme; to poor quality of service (12.6%). Out-of-pocket payment for drugs and diagnostic tests was mentioned by 11.4%. Other reasons for dissatisfaction with services accessed mentioned by enrolees which included bureaucratic challenge and long distance of chosen HCP from enrolees' residence were grouped together as "others" which accounted for 7.6%. (Table 3).

Length of enrolment in the scheme had no significant influence on enrolee's level of satisfaction ($p=0.52$). Similarly, there was no significant difference in satisfaction with the health services accessed and the sex of enrolees.

Table 3: Respondents reasons for dissatisfaction with services accessed

<u>Reasons for Dissatisfaction</u>	<u>Frequency</u>	<u>Percentage</u>
Drugs	22	27.8
Low quality; Exclusion of Prescribed drugs from the package or Out-of-stock		
Out-of-pocket payment		
For services (drugs, tests)	11	13.9
Long waiting time	4	5.1
Attitude of Health workers	6	7.6
Exclusion of some treatments/ Medication	16	20.3
Poor quality of service	11	13.9
Poor record management of enrolees information	3	3.8
Others	6	7.6
Total	79	100

Almost half of the enrolees (49.6%) had had reasons to change healthcare providers (HCP), the major reason proffered for this (52.6%) being distance between location of health facility and enrolee's abode. Other reasons mentioned include the need for comprehensive care (26.3%), imposition of health care provider in contrast to choice (5.3%) and respondents' dissatisfaction with the previous treatment accessed (Table 4).

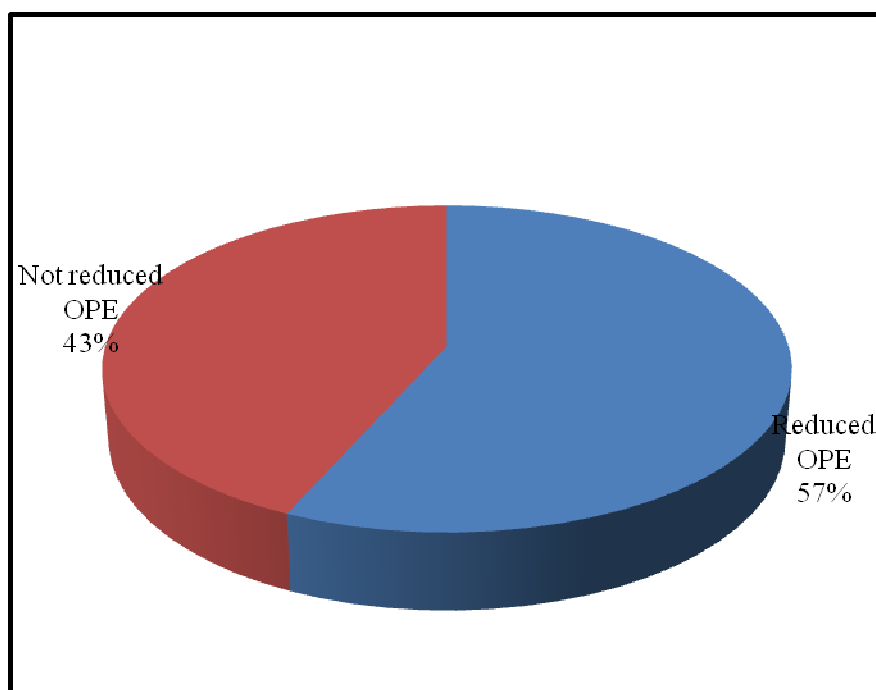
Table 4: Change of Health Care Provider (HCP) and Reasons

<u>Reasons</u>	<u>Frequency</u>	<u>Percentage</u>
Distance	30	52.6
Need for comprehensive Healthcare services	15	26.3
Imposition of HCP & not choice	3	5.3
Employee of the HC facility	2	3.5

292	Doctors not in all fields	2	3.5
293			
294	Poor documentation	2	3.5
295			
296	Dissatisfied with treatment	2	3.5
297			
298	<u>No doctor</u>	<u>1</u>	<u>1.8</u>
299			

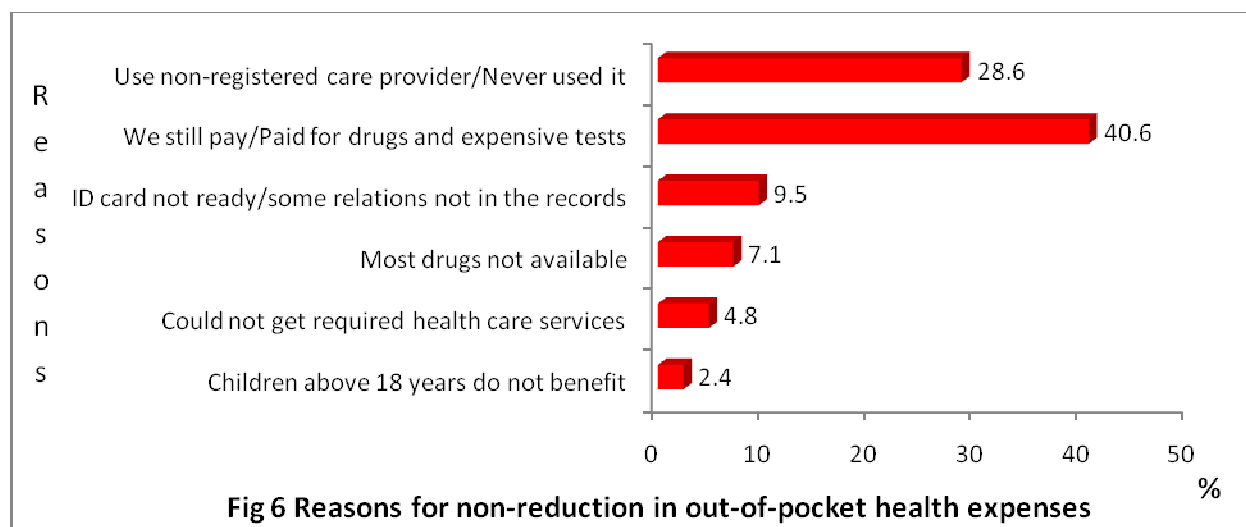
300 **Effect of enrolment on out-of-pocket health expenses**

301 Among the 97 enrolees who responded to the question on the effect of the scheme on their out-
 302 of-pocket expenses, 57% claimed that the scheme had reduced their out-of-pocket expenses on
 303 health care (Fig. 5). Various reasons given by those who felt contrary ranged from out-of pocket
 304 payment (40.6%), use of other non-registered care providers (28.6%), poor documentation
 305 (9.5%) to no-access to required health services [4.8%] (Fig. 6). There was no significant
 306 relationship between the length of registration as enrolees and reduction in out-of-pocket
 307 expenses of enrolees ($p=0.58$). Also, there was no significant difference between the reduction in
 308 out-of-pocket expenses of male and female enrolees ($p=0.1$).



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 310 **Fig 5: Effect of enrolment on out-of-pocket health expenses**

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DISCUSSION

The fair representation of both sexes, 43.7% males and 56.3% females among the respondent civil servant enrolees provides a fairly balanced platform for assessing the services of the National Health Insurance Scheme (NHIS). Furthermore, the high (86.6%) representation of married respondents with 1-4 children (80.9%) and, the finding that 76.5% of respondents registered their family members as well, enables insight into family's needs and access to the health services, which cuts across the defined age groups catered for by the scheme. The finding also, that a high proportion (78.4%) had been enrolled in the scheme for at least 3 years further ensured that responses elicited were based on fairly long term experience with the scheme. Overall, knowledge of available services provided by the scheme which covered major aspects covered by the NHIS was very high (97.2%) indicating good dissemination of information on activities of the scheme by the NHIS.

The added fact that the study was conducted in tertiary health institutions may have further contributed to this high level of knowledge on the scheme. There was good understanding of the concepts of NHIS principles on risk pooling of financial resources to fund health service provision for enrolees and access to affordable quality health services.

The expected health benefits, as expressed by the enrolees on the scheme also aligns with their level of knowledge on the health package offered by the scheme, which covers consultation, management of common ailments and non-communicable diseases, maternal and child health, diagnostic tests, minor surgeries, subsidized treatment and right to choice of health care provider

(HCP). It is however noteworthy that health education and promotion was not mentioned, given that preventive care plays a major role in disease occurrence and control, an aspect that should be addressed in the implementation of the scheme. It is noteworthy that enrolees' acclaimed derived benefits from the scheme, on subsidised cost of treatment, surpassed the expected (46.0% vs. 42.1%) and was the most recurring benefit mentioned. By contrast however, there was a remarkable difference in the enrolees' expectation on quality health care provision as compared to that derived (41.6% to 2.6%); as well as on free treatment (which dropped from 20.8% among expected benefits to 0.0%), indicating unmet expectations. Likewise, easy access to health services dropped from 13.4% to 3.9%. While expectations on antenatal/maternal care matched derived benefits, there was a higher level in access to laboratory investigations compared to expectations (2.2% vis-a-vis 7.9%). Health information was also captioned by a marginal few as one of the derived benefits. The finding that 34.2% of enrolees claimed not to have benefited from the scheme is an issue that needs to be further investigated to ensure inclusiveness, confidence in the scheme and sustainability. Likewise, none of the enrolees mentioned choice of health care provider (HCP) as one of the derived benefits but rather as a denial as captured among reasons for dissatisfaction with the scheme. Varied communication channels for complaints as expressed by enrolees suggest pooling and processing of these complaints to feed into implementation, action and feedback to clients. Furthermore, the lack of knowledge on where to lodge complaints by an appreciable proportion of enrolees suggests a need for improvement on communication on operations of the scheme such as through advocacy, sensitization and mobilization using the most effective approach. While enrolees mentioned internet facility (e-mails) etc in lodging complaints, it is not clear if the NHIS has designated e-mail addresses for this. Although it is noted that contact telephone numbers of Health Maintenance Organizations (HMOs) are provided on registered enrolees' identification cards (IDs). Reasons for dissatisfaction with the scheme, as mentioned by over half of the enrolees, reflect unmet expectations and these need to be addressed by the scheme in its efforts at improvement. Sustainable and quality drugs supplies should be ensured at the health facilities registered for the scheme to stem the out-of-stock complaints that are impacting on out-of-pocket health expenses. Likewise the inclusion of frequently required laboratory services by enrolees in the health care services should also be addressed to ensure that services provided to further reduce enrolees out-of-pocket expenses. The quality of service including health workers attitude

should be continuously monitored by the HMOs for improvement. The needed regulatory oversight by NHIS should be implemented to improve effectiveness and efficiency of the scheme. Given that the scheme is yet to achieve an appreciable coverage, the quality of its services especially as adjudged by enrolees expectations and satisfaction, is paramount in its quest towards universal health coverage of Nigerians, with the anticipated buy-in of the States. It is also noteworthy that almost half of the enrolees had had cause to request for change of their HCPs for varied reasons but mainly on the need for proximity to residence. Enrolees have the right to their chosen HCP provided it is among those registered for the scheme and it is encouraging that this right is being respected. Transportation cost, and even the time, to access care is a significant component of out-of pocket health expenses which the scheme is designed to minimise. The high percentage (43%) of enrolees who claimed that the scheme, contrary to expectations, has not reduced their out-of-pocket health expenses largely due to purchase of unavailable prescribed drugs and payment for diagnostics tests are issues of concern. Out-of-pocket payments do not allow for financial protection and needs to be monitored and minimised. Improvement is desirable in the documentation on enrolees to safeguard enrolees from unjustifiable expenses in accessing subsidized care at health care facilities (HCF) such as prompt issuance of ID cards, adequate documentation on enrolees at designated HCF, and prompt updating of enrolees records especially on additional family members.

States will need to start mandatory health insurance scheme for their workers to significantly contribute to achieving universal health coverage (UCH) for Nigerians since voluntary pre-payment will not enable achievement of universal health coverage [11]. Onwujekwe [12] highlighted the 3 ways needed for expansion of coverage in moving towards UHC as; proportion of the population that enjoy social health protection, range of essential services necessary to effectively address people's health needs and, portion of health-care costs covered through pooling and pre-payment mechanisms. In this wise, enrolees' reasons for dissatisfaction with the schemes need to be addressed along these lines to meet enrolees' expectations and thus ensure high level of satisfaction with the scheme. Benefits need to be closely linked to enrolees' needs. The perception and level of awareness of the respondents influenced their expectations of benefits derivable from the scheme. Unfortunately their high expectation of benefits did not correspond to their derived benefits. Despite the fact that majority of the respondents expected

treatment subsidy and they got it, they still felt that the quality of healthcare was below their expectations being one of their perception of the essence of the scheme.

The awareness of enrolees on health care services available within the scheme varied, depending on their needs and some expected their enrolment to cover all services which may be practically impossible, as also captured in the NHIS documents. The NHIS needs to continuously interact and enlighten enrolees on limitations in services provided by the scheme. The dissatisfaction expressed by majority of enrolees was as a result of their experience with their healthcare providers which has to do with quality of drugs and services they adjudged as poor, or human relations issues with HCPs as also observed by Mohammed et al [10]. This necessitates the need to have a mechanism for monitoring healthcare providers' activities on the quality of care and efficiency within the scheme as emphasised by Omoruan et al [13]. One of the expected advantages of NHIS enrolment is the reduction of out-of-pocket expenses as attested to by majority of the enrolees. This, according to Lagomarsino et al [14] will enable enrolees' utilisation of healthcare facilities and uptake of services as well as protect them from impoverishment resulting from health costs. Protection of enrolees from the burden of ill-health and sub-optimal levels of access and utilization of health services are issues that ought to be continuously monitored for the attainment of set goals of the scheme. A proper determination of minimum benefit packages dependent on the leading causes of morbidity and mortality in the country coupled with increased emphasis on preventive strategies will help in achieving success. The needed focus and emphasis on ensuring enrolees' expectations of the scheme is crucial to its sustainability to secure the universal health coverage target in the country by the NHIS.

CONCLUSIONS

Enrolees' satisfaction is paramount in the scheme's quest towards expansion to achieve universal health coverage of Nigerians, with the anticipated buy-in of the States. Effective regulatory oversight is required to monitor quality of service including health workers attitude and out-of-pocket payments, for effectiveness and efficiency of the scheme. Reduction in enrolees' out-of-pocket expenses will enhance uptake of services as well as protect from impoverishment resulting from health costs. Regular monitoring of the scheme's operations should contribute greatly to enrolees' satisfaction and ensure inclusiveness, confidence in the scheme and sustainability. Benefits need to be closely linked to enrolees' needs while review of the benefit package should be dependent on the leading causes of morbidity and mortality in the country

with increased emphasis on preventive strategies and enrollees demands, to achieve success. Prompt pooling and processing of enrollees' complaints to feed into implementation, and feedback to clients would contribute to guaranteeing enrollees' satisfaction. Sustainable and quality drugs supplies as well as inclusion of frequently required laboratory services should be ensured at the health facilities to minimise out-of-pocket health expenses.

Continuous interaction and enlightenment of enrollees on the scheme services is desirable. The needed focus and emphasis on ensuring enrollees' expectations of the scheme is crucial to sustainability to secure the universal health coverage target in the country.

ETHICAL ISSUES

Approval for this study was obtained from the Institutional Review Board of the Nigerian Institute of Medical Research (IRB/13/237). Each respondent's consent was obtained in writing before completing the questionnaire. The study was conducted in accordance to the tenets of the Helsinki Declaration of 1964 as amended in 2000.

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