

Original Research Article

A PRELIMINARY STUDY ON ENROLLEES PERCEPTION AND EXPERIENCES OF NATIONAL HEALTH INSURANCE SCHEME IN LAGOS STATE, NIGERIA

ABSTRACT

Aim: To assess enrollees' perception and experiences on the National Health Insurance Scheme, launched in Nigeria, in 2005 and made mandatory for all Federal civil servants.

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

Methodology: Three tertiary health institutions were purposively selected. Systematic sampling was employed in selecting 150 enrollees. Quantitative data were collected from each consenting selected enrollee using semi-structured questionnaire which probed into demographic characteristics, knowledge, expectations, services accessed, experiences, perceptions and, suggestions for improvement.

Results: A total of 143 enrollees (males 43.7%; females 56.3%) completed the questionnaire. Majority (97.2%) had knowledge of the scheme: easy access to affordable healthcare (40.7%), subsidized health care services (22.2%) and pooling of resources (11.1%). Subsidized treatment, quality healthcare provision and free treatment were the most mentioned expectations. Treatment and general care were the most accessed services (55.7%). One in every five enrollees (22.9%) never accessed the services and, 18% had no knowledge of complaints channels. More than half (59.8%) were dissatisfied with services accessed for 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%) however claimed reduction in out-of-pocket expenses. Major suggestions proffered by enrollees (53.1%) for improving the scheme covered regular monitoring, continuous availability of genuine drugs, sensitisation, prompt response to enrollees' complaints and continuous review of the policy.

Conclusions: Regular monitoring of the scheme's operations is expected to contribute greatly to improvement of the scheme which should minimise out-of-pocket health expenses. Continuous enlightenment is desirable with emphasis on ensuring enrollees' satisfaction for sustainability to secure the universal health coverage target in the country.

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

INTRODUCTION

The National Health Insurance Scheme (NHIS) was launched in Nigeria in 2005 as part of the health systems reform to improve health services [1]. The scheme offers different types of health insurance schemes ranging from social health insurance to community-based health insurance (CHI) and private for-profit insurance, defined mainly by the source of financing for the premium [2]. Effective implementation of a combination of these schemes 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 scheme has an overall goal of achieving universal health coverage which ensures access to and use of quality health care services by all citizens, and protection from catastrophic financial effect of ill-health [2,5]. However, out-of-pocket health expenses, as high as 60%, as of 2013, as shown by the World Bank [6,7] still plays a major role in health financing in Nigeria. This would not promote equitable access to quality health care as also observed by Akande et al [8].

Contributions to the scheme are earnings-related for federal civil servants. The employer pays 10% while the employee pays 5% (deductible at source), representing 15% of the employee's basic salary towards the scheme [2]. This contribution confers health care benefits to the employee, one spouse and 4 biological children below the age of 18 years [2]. The benefit package covers out-patient care, maternity care, preventive care that includes immunization, health education and family planning among others [2].

Given that the scheme which has been in operation for at least a decade presently covers less than 7% of the Nigerian population [9], most of whom are Federal government workers (for whom enrolment is mandatory) and the formal private sector [2], there is urgent need to appraise operations of the scheme, especially from the viewpoint of the enrolee, to enable effective scale-up.

Several studies have addressed key factors that would enable effective scale-up of insurance schemes. One of these is enrolee's satisfaction with services provided by the health insurance scheme. Enrolee's satisfaction is a valuable tool for assessing quality of care. It is a measure of how the services provided meet expectations, reflected as adequate information, good

communication and enrollee-health provider/worker relationship, minimum waiting time, easy access to affordable care and proper diagnosis and reduced cost of care as shown in Ghana [10]. Similarly, another study [11] approached this through assessment of staff attitude, waiting time and consultation process, highlighting the importance of enrollee's perceptions in assessing the insurance schemes.

Enrolees' satisfaction with the services provided by health insurance schemes has been shown in Ghana [10,12] and in Ibadan south west Nigeria [13], to constitute one of the key factors for sustaining the scheme and, for expansion. Women accessing health services from Primary Health Care facilities in Nnewi, Nigeria expressed high level of satisfaction with the quality of maternal services [14].

A well implemented health insurance scheme should transform lives especially of the poor, by enabling access to previously unaffordable medical treatment and good quality health care.

Given the dearth of literature from low and middle income countries (LMICs) on clients' satisfaction with national health insurance schemes [15], recording enrolees experience and their identified concerns should enable improvement for effective implementation. Against this background, this study sought to generate evidence to improve the functioning of the NHIS in Nigeria. It assessed Federal civil servant enrolees' experiences, perceptions, and their proffered suggestions for improvement. It addressed the following research questions; Are enrolees satisfied with the scheme? What are enrolees' perceptions on the scheme? What are enrolees' suggestions for improving the scheme? Findings from the study would generate some evidence on NHIS achievements on some of its set goals of reducing out-of-pocket expenses (OPE) and meeting enrolees' expectations.

METHODS

Study Area

The 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) all located in Lagos, South west Nigeria. These are three of five such institutions (of the Federal Ministry of Health), located within 1km radius, including 4 hospitals and 1 research institute, all existing in Lagos State.

Lagos State lies between latitude 6° 23' N and 6° 41' N and longitude 2° 42' E and 3° 42' E. It covers an area of 3,577 sq. km, less than 0.5% of the country's landmass, the smallest landmass area of the 36 states in Nigeria. It has a population of 9,113,605 people based on the 2006 National Population Census with a projected population of 12,420,908 people for 2015 [16] comprising 51.8% and 48.2% males and females respectively [17], and a population growth rate of 3.16% per annum making it one of the fastest growing cities in the world. Lagos State is divided into three Senatorial Districts made up of five Administrative Divisions, which are further divided into 20 Local Government Areas (LGAs) and 37 Local Council Development Area (LCDAs), comprising 374 political wards. Two of the nation's largest sea ports are located therein and it is the commercial nerve centre of the country and the hub of national and regional integration and trade. It houses more than 65% of all commercial activities and about 60% of Nigeria's non-oil economy [18]. It also served as the country's capital until 1991.

Study Design

This was a descriptive, cross-sectional study that focused on three tertiary health institutions in Lagos State. Quantitative data were collected using semi-structured questionnaire designed to probe into knowledge of NHIS, satisfaction with the services accessed, channels of communication, perceptions of the scheme and suggestions for improvement.

Study Population

This study focused on Federal civil servant enrolees who are mandatorily enrolled with the National Health Insurance Scheme (NHIS) and all of whom are adults, above 18 years of age.

Sampling Procedure

The three surveyed institutions were purposively selected from five of such institutions of the Federal Ministry of Health (FMoH) within Lagos State. Two were hospitals and one a research Institute. Field testing of the survey instrument had been conducted in one of the remaining two institutions that were not selected. The sample size was determined on the basis of the study being a preliminary. Fifty (50) enrolees were selected from each Institution. Systematic sampling was applied in the selection of the respondents using each institutional nominal roll as the sampling frame. The sampling interval was determined by dividing the total number on the

nominal roll by the proposed 50 respondents by institution. All the institutions belong to the same health sector and given that the National Health Insurance Scheme is driven by the same Ministry of Health it is expected that staff of these institutions will be more informed about the scheme and therefore their responses should serve as a good reflection of the NHIS.

Data Collection Procedures

Descriptive analyses which include counts, percentages, mean and median were used to present the data. Quantitative data were collected using self-administered semi-structured questionnaire which were deposited with the NHIS focal person of each institution. A two-week period was allowed for completion of the questionnaire following which they were collected through the Institutions' NHIS focal persons between August and September 2014. The questionnaire probed into the following: demographic characteristics of respondents (age, sex, marital status, education and religion), knowledge of NHIS, expectations on health services offered by the scheme, services accessed, satisfaction with the scheme, overall perception of the scheme and suggestions for improvement.

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. Multivariate analyses were carried out to determine the predictors of the uptake of the services. The analyses were carried out using variables such as the socio-demographic background (independent variables) and dependent variables that included enrolees' 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) and, suggestions for improving the scheme.

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

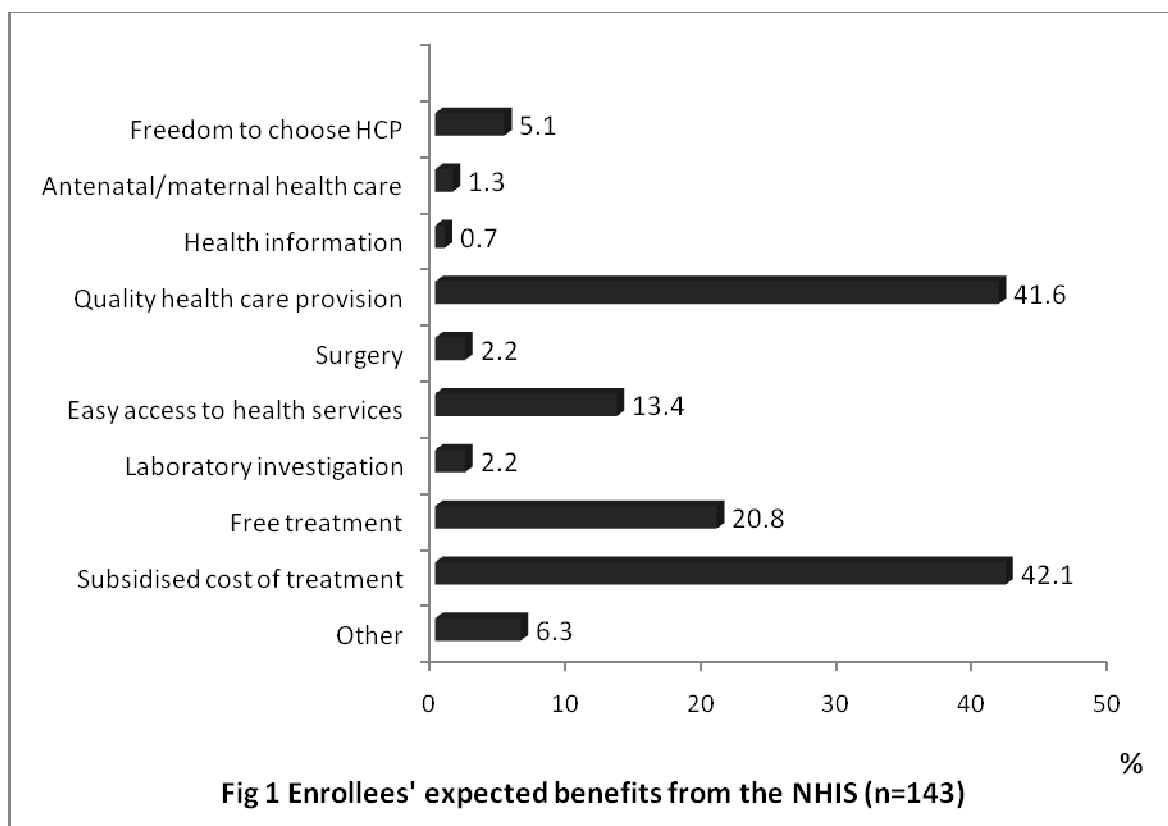
27 to 59 years, with mean age of 41.7 years and median of 41 years. Majority (86.6%) of them were married with 1-4 children (80.9%) and only few (6.9%) had above 4 children. Majority (78.4%) of the respondents had been enrolled with the scheme for at least 3 years and the rest (21.6%) for less than 3 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 cost of health care services and 11.1% as a pooling of resources to fund health needs of enrolees.

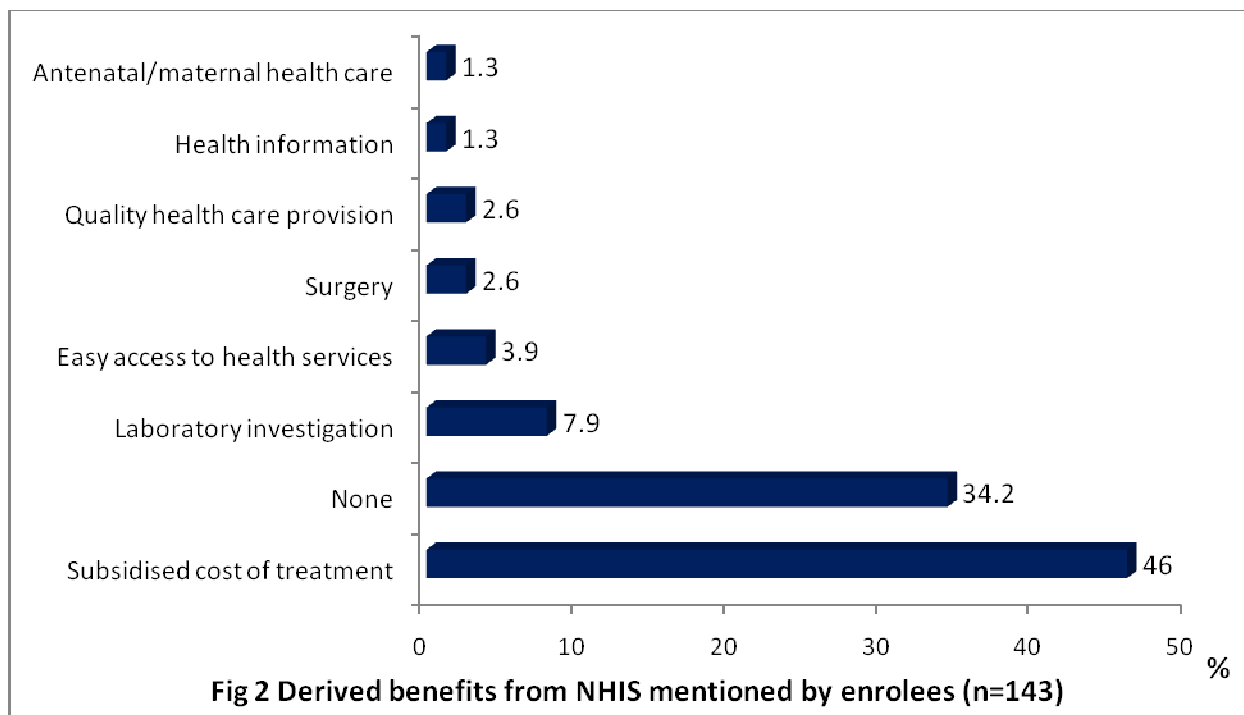
Table 1: Respondents' perception of National Health Insurance Scheme (NHIS)

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 enrollees to fund the health needs of individuals under the scheme	12	11.1
NHIS does not cover surgery and expensive Drugs	3	2.8
No idea	3	2.8



Enrolees' expected benefits from the scheme

All enrolees had expectations of the scheme, varying from subsidized cost of treatment (42.1%) (most recurring) to antenatal/maternal care (2.2%) (least mentioned). Subsidized cost of treatment (42.1%), quality health care provision (41.6%), free treatment (20.8%) and easy access to health services were the major expectations. It is interesting that health education and promotion/information was mentioned by a marginal few (0.7%) as illustrated in Figure 1. Other expectations which included referral and opportunity to lodge complaints and seek redress for poor services were grouped together as "others" which accounted for 8.4%.



Enrolees derived benefits from the scheme

Access to subsidized cost of treatment was the most mentioned benefit derived from the scheme (46%), while 34.2% of the enrolees claimed they did not derive any benefit since enrolment. Quality health care provision represented 2.6% of the claimed derived benefits (Figure 2).

Awareness on the health services available within the scheme

Enrolees displayed varied levels of awareness on the health services available within the benefit package offered by the scheme (Table 2). The question generated multiple responses. Access to all services available within the scheme accounted for 48.3%, while others were more specific. For instance, 16.8% each mentioned antenatal and post natal care and delivery and, treatment of minor illnesses; while 14.7% mentioned medication and drugs. The least 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 (n=143)

Category of services	Yes	%	No	%
All services	69	48.3	74	51.7
Antenatal/post natal/ Maternity care and delivery	24	16.8	119	83.2
Medication/Drugs	21	14.7	122	85.3
Treatment of minor illnesses	24	16.8	119	83.2
Lab investigations/tests	15	10.5	128	89.5
Surgery	12	8.4	131	91.6
Consultation	10	7.0	133	93.0
Inpatient Care	6	4.2	137	95.8
Paediatric Care	3	2.1	140	97.9
Immunization	2	1.4	141	98.6
X-ray	2	1.4	141	98.6
Health education	1	0.7	142	99.3
Others	11	7.7	137	92.3

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%) (Fig3). One in every five (22.9%) of the enrolees claimed not to have accessed health service through the NHIS since enrolment in the scheme (Table 3).

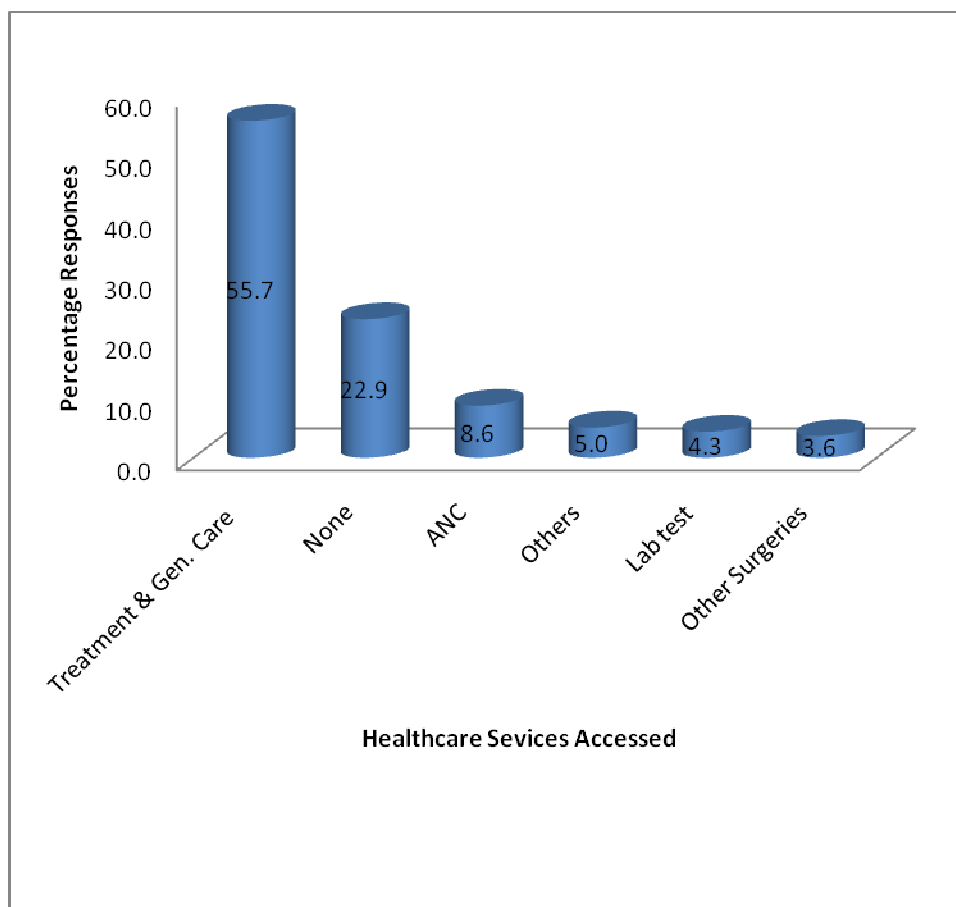


Figure 3: Healthcare services accessed by enrolees

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).

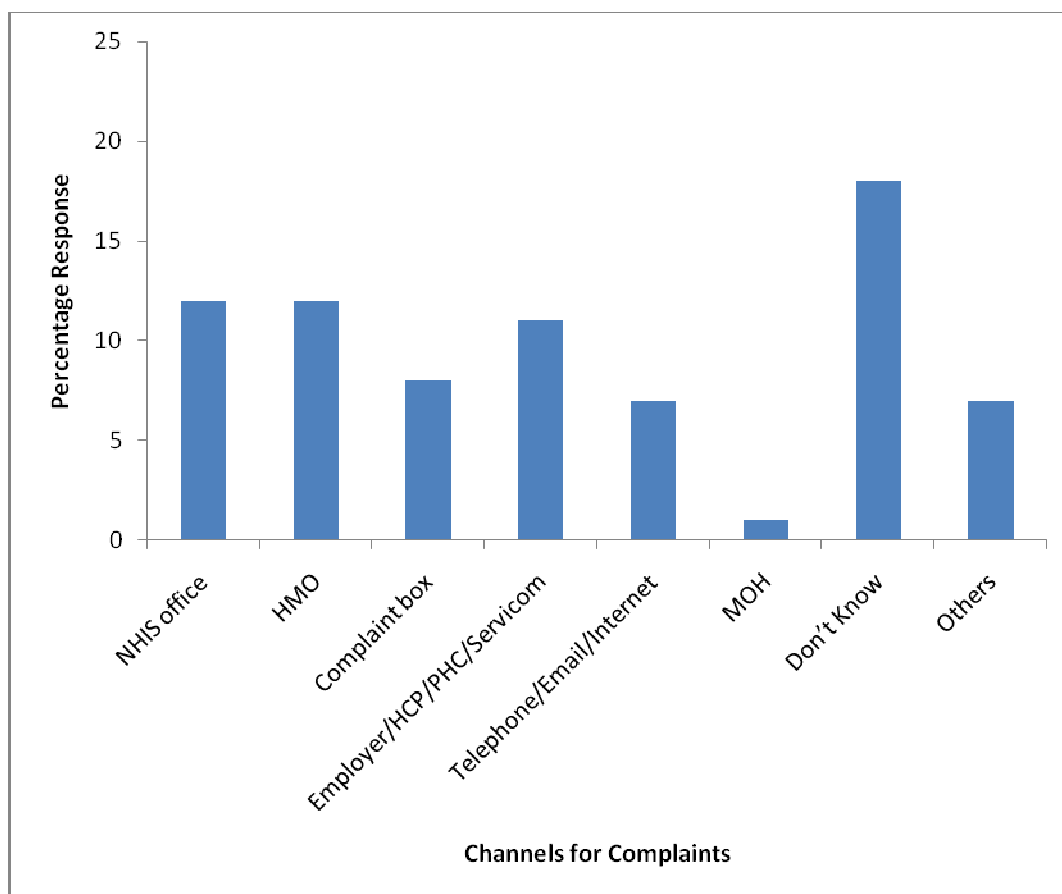


Figure 4: Enrolees' knowledge of communication channels for complaints

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 enrolees' 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

Reasons	Frequency	Percentage
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
Doctors not in all fields	2	3.5
Poor documentation	2	3.5
Dissatisfied with treatment	2	3.5
No doctor	1	1.8

Effect of enrolment on out-of-pocket health expenses

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

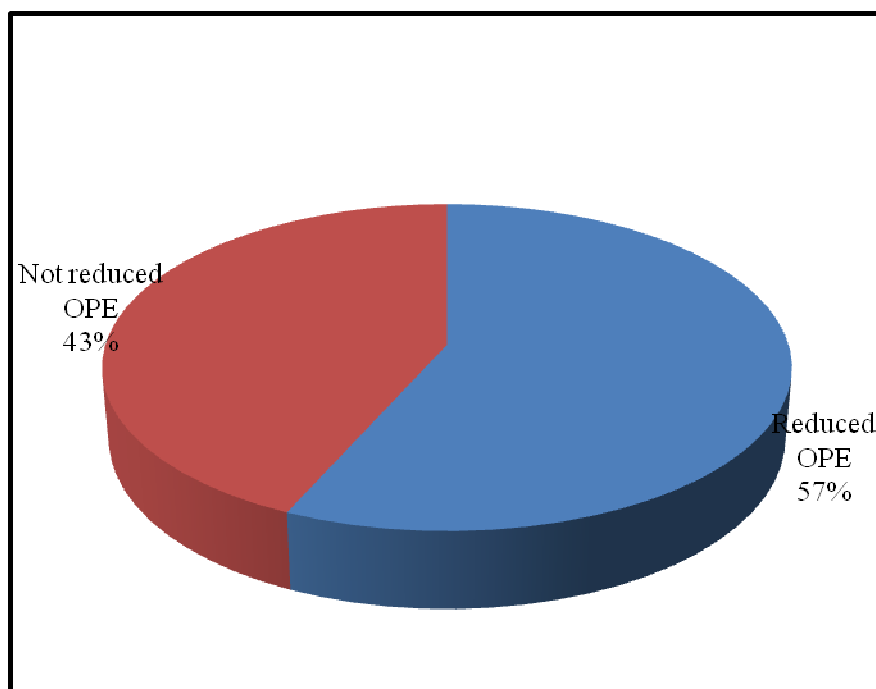


Fig 5: Effect of enrolment on out-of-pocket health expenses

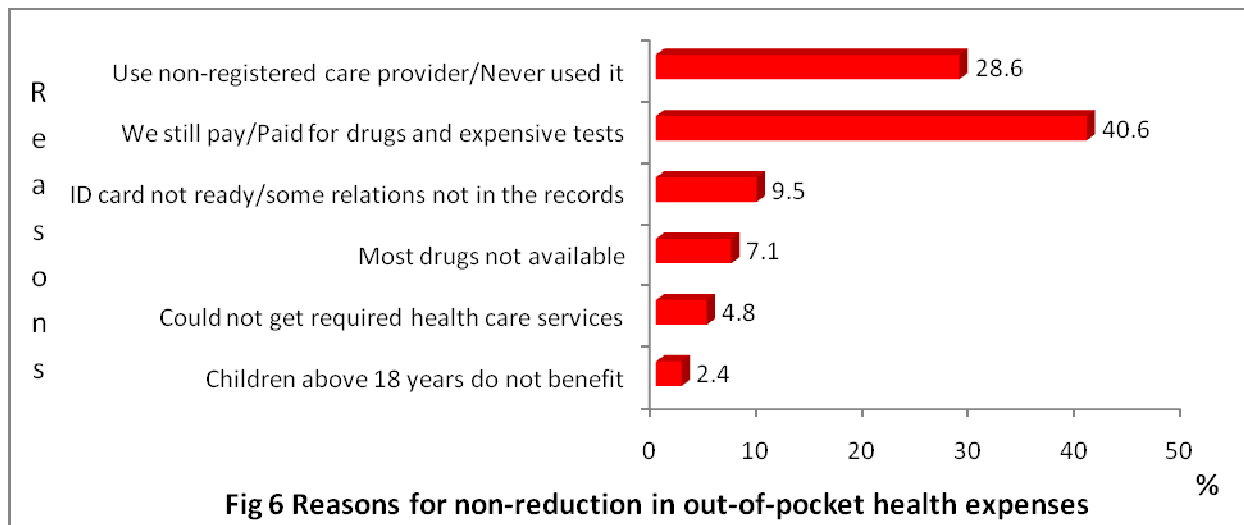


Fig 6 Reasons for non-reduction in out-of-pocket health expenses

Suggested ways of improving NHIS by respondents

Continuous availability of genuine drugs, all inclusiveness, continuous sensitization, prompt response to enrolees' complaints and regular monitoring of the scheme by the regulator were the major issues suggested for improvement of the scheme (Table 5). Others were quality care,

affordable treatment and diagnostic cost, and prompt payment of capitation to the HCPs to enable efficient healthcare delivery.

Table 5 Suggested ways of improving NHIS by respondents

Suggested ways of improving NHIS	Number (n=143)	Percentage
Availability of genuine drugs	15	10.5
All inclusive treatment/Continuous review of the scheme's guidelines such as exclusion list/review of age restriction	15	10.5
Regular monitoring of the scheme's operations by regulator	16	11.1
Continuous sensitization	15	10.5
Affordable treatment and diagnosis	6	4.2
Prompt response to enrolees' complaints	15	10.5
Provision of quality healthcare services	8	5.6
Increase number of registered HCPs/ Address issue of proximity of HCPs to enrolees' residences	10	7.0
Ensure prompt payment of capitation to HCPs for efficient healthcare delivery	3	2.1
Other e.g. employment of qualified health personnel/minimize administrative bureaucracy	2	1.4

DISCUSSION

The data obtained from this study are preliminary although this does not undermine its validity. The fair representation of both sexes, 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 representation of married respondents with 1-4 children, a reflection of the Nigeria's Policy on Population for Development [19] and, the finding that majority of respondents registered their family members, enables insight into family's needs and access to the health services. While this study did not analyse for influence of gender on perception of the scheme, a study in Ghana [12] showed that gender was one of the 3 factors that influenced perception of the Ghana national health insurance scheme. Furthermore, although our study did not assess the effect of financial status on enrolees' level of satisfaction, that study reported that financial status influenced level of satisfaction with services accessed, with the poor showing greater level of satisfaction and vice versa with the rich. By contrast, national health insurance in Taiwan was reported to have resulted in reduction of household health expenditure by 23% especially among affluent households [20].

The finding, in this study, that a high proportion had been enrolled for at least 3 years gave reliability to the responses elicited, based on fairly long term experience with the scheme. Overall, knowledge of available services provided by the scheme, which covered major aspects by the NHIS, was very high indicating good dissemination of information on activities of NHIS. The fact that the study was conducted in tertiary health institutions may have further contributed to the high level of knowledge. 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. This is in agreement with the findings of Chubike [21] that nurses were more knowledgeable on NHIS compared to civil servants from other sectors.

Enrolees' expected health benefits also align with their level of knowledge on the health package offered by the scheme. Health education and promotion, which were not mentioned among expected health benefits, need to be emphasised in the scheme given that preventive care plays a major role in disease occurrence and control, as also observed by Ibiwoye and Adeleke [22]. Patient's empowerment through provision of health information enables decision to be made at both individual and household levels. It is noteworthy that enrolees' acclaimed derived benefits from the scheme, on subsidised cost of treatment, surpassed the expected and was the most recurring benefit mentioned. By contrast however, there was a remarkable difference in enrolees' expectation on quality health care provision compared to that derived. Similar observation was made on free treatment and enrolee's expectation on easy access to health care. These indicate

unmet expectations and reflect barriers such as long waiting time that need to be addressed. Similar observations were reported from Ghana where most of the insured were reported to have experienced long waiting time and verbal abuse [23] compared to the affluent and uninsured, attributed to delayed payment of capitation to the HCPs. Ilesanmi and Ige [24] also observed disparities in the processes and cost of care for NHIS enrolees and fee paying patients at a health facility in Ibadan, Nigeria. The finding that enrolees' expectations on antenatal/maternal care matched derived benefits reflects government's efforts at addressing maternal and child health which largely contribute to poor national health performance. Various government programs exist on maternal and child health, which have strong sensitization and mobilization components. These include the Conditional Cash Transfer (CCT) and the Midwives Service Scheme (MSS) [25,26]. For the CCT, government provides some money to pregnant women on the premise that they will both attend antenatal and postnatal clinics and also deliver at the health facilities. The Midwives Service Scheme (MSS) augments skilled birth attendance by re-engaging retired midwives [25,26]. Enrolees' access to laboratory investigations which surpassed their expectations reflects improved patient's management, since laboratory investigations aid proper management of diseases, as also observed in Malawi [27]. The findings that 1 in 5 enrolees claimed not to have accessed services of the NHIS coupled with 1 in 3 enrolees who claimed not to have benefited from the scheme are issues for further investigation to ensure inclusiveness, confidence in the scheme and sustainability.

It is surprising that an appreciable proportion of enrolees claimed lack of knowledge on where to lodge complaints despite the fact that contact telephone numbers of Health Maintenance Organizations (HMOs) are provided on their identification cards. The varied complaint channels mentioned indicate the need for pooling and processing of such complaints to feed into implementation, and feedback to the enrolees. Some enrolees also expected to be provided all services contrary to the package, as captured in the NHIS Operational Guidelines [2]. While community-based health insurance (CHI) allows for voluntary participation, in contrast to the mandatory nature of NHIS to Federal civil servants in Nigeria, benefit package and quality of care were some of the concerns with CHI performance reported from a review of empirical evidence, from 11 countries, on factors such as enrolment, ratio of prepaid contributions to healthcare costs, risk pooling and strategic purchasing [28]. It is suggested that efforts at dissemination of information to enrolees be enhanced using the most effective channels.

The finding in this study on high level of dissatisfaction especially with unavailability of prescribed drugs agrees with the observation of Agba [29] in his study among civil servants of Kogi State, Nigeria. Sustainable and quality drugs supplies should be assured to stem the out-of-stock complaints that are impacting on out-of-pocket health expenses. It is possible that, as observed in Ghana [23], delayed payment of capitation may be one of the underlying factors for the out-of-stock experiences. Out-of-pocket payments do not allow for financial protection and needs to be monitored and minimised.

Regulatory oversight on HCPs by NHIS should be strengthened for efficiency. The quality of service including health workers attitude should be continuously monitored by the HMOs for improvement. Ibrahim [30] suggested that the increased outpatient health facility utilization at all levels of the health system consequent to introduction of NHIS in Ghana, resulted in additional workload of public health facility workers which tended to trigger negative health worker attitude.

Given that the scheme is yet to achieve an appreciable coverage, the quality of its services, especially as adjudged by enrolees' level of satisfaction and, suggestions proffered for improvement, 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 of choice of HCP among those registered with NHIS and, it is encouraging that this right is being respected. Transportation cost, and the time taken to access care are significant components of out-of pocket health expenses, as also reported by WHO [31] that, on average, transportation cost in 39 low income countries studied constituted 12% of per visit treatment charges for out-patient services. Adequate and prompt documentation on enrolees, such as prompt issuance of identification cards, will protect against undesirable expenditures in accessing subsidized care at health care facilities (HCF).

Onwujekwe [32] 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 order for the country to achieve universal health coverage (UHC), States will need to start mandatory health insurance scheme for their workers to significantly contribute towards this, in contrast to voluntary pre-payment

[15]. In this wise, enrolees' reasons for dissatisfaction with the scheme, as reported in this study, need to be addressed for inclusion in expansion of the scheme, to ensure that benefits are closely linked to enrolees' needs.

The dissatisfaction expressed by majority of enrolees on services, attitude of health workers, and availability of drugs, is in agreement with observation of Mohammed et al in Zaria, Nigeria, among staff of Ahmadu Bello University [15]. Most of the suggestions given by enrolees for improving the scheme are issues that can be covered through constant monitoring of the HCPs and the enrolees' views on services provided and accessed. It is expected that as the scheme expands, it would inevitably increase its number of HCPs in providing for the increased number of enrolees which hopefully will address the issues raised on proximity to enrolees' residence, in line with WHO recommendation on access to health care within 5 km radius of patient's residence as observed by Smith et al [33].

Monitoring healthcare providers' activities on the quality of care and efficiency within the scheme as emphasised by Omoruan et al [34] is critical as 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 [35] will enable enrolees' utilisation of healthcare facilities and uptake of services as well as protect them from impoverishment resulting from health costs. Ghana has achieved about 40% coverage of its population [36], and the scheme's beneficial effects on health are evident with infant mortality dropped by 19% since 2000, and the number of infant deaths from malaria by almost a third since the scheme's inception. 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. Continuous review of the benefit package 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 that enrolees' expectations of the scheme are met, is crucial to its sustainability to secure the universal health coverage target in the country by the NHIS.

The findings from this study suggest further studies, as anticipated by the authors, that would better inform the objectives of the scheme. Nonetheless NHIS, if well implemented, will appreciably expand access to quality healthcare to all and sundry as observed by Owusu-Sekyere and Bagah [37] and Uzoichukwu et al [38].

CONCLUSIONS

The National Health Insurance Scheme in Nigeria has taken steps in the needed direction of not only addressing issue of impoverishment but also in ensuring equity in access to quality health care. Enrolees' satisfaction, given the mandatory nature of the scheme for Federal civil servants, is however paramount in the scheme's quest towards expansion to achieve universal health coverage in Nigeria. Effective regulatory oversight is required through monitoring of the quality of service including health workers attitude and out-of-pocket payments, for effectiveness and efficiency of the scheme. 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 enrolees demands. Prompt pooling and processing of enrolees' complaints to feed into implementation, and feedback would further contribute to guaranteeing enrolees' 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 enrolees on the services of the scheme is desirable. The needed focus and emphasis on ensuring that enrolees' expectations of the scheme are met, is crucial to sustainability in securing the universal health coverage target of the country. Nonetheless, findings from this preliminary study suggest further studies as anticipated by the authors.

ETHICAL ISSUES

Approval for this study was obtained from the Institutional Review Board of the Nigerian Institute of Medical Research (IRB/13/237). Permission was obtained from the management of each Institution and 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.

REFERENCES

1. Federal Ministry of Health. Health sector reform programme 2004-2006. Federal Ministry of Health: strategic thrusts, key performance objectives and plan of action. Abuja: Federal Ministry of Health, 2004.
2. National Health Insurance Scheme. Operational guidelines. Revised October, 2012. Abuja Nigeria. Available from: http://www.ghmlnigeria.com/downloads/NHIS_OPERATIONAL_GUIDELINES (Revised). Accessed 5th October, 2013
3. Dutta A, Hongoro C. Scaling Up National Health Insurance in Nigeria: Learning from Case Studies of India, Colombia, and Thailand. Washington, DC: Futures Group, Health Policy Project; 2013.
4. Vargas-Zea N, Castro H, Rodríguez-Páez F, et al. Colombian Health System on Its Way to Improve Allocation Efficiency - Transition from a Health Sector Reform to the Settlement of an HTA Agency. Value in Health Regional Issues. 2012; 1(2): 218–222.
5. Ekman B. Community Based Health Insurance in low-income countries: a systematic review of the evidence. Health Policy and Planning. 2004; 19: 249-270.
6. The World Bank (2013). 2.15 World Development Indicators : Health systems. <http://wdi.worldbank.org/table/2.15>.
7. The World Bank. Out-of-pocket health expenditure (% of private expenditure on health); 2013. Available:<http://data.worldbank.org/indicator/SH.XPD.OOPC.ZS>
8. Akande T, Salaudeen A, Babatunde O. The effects of national health insurance scheme on Utilization of health services at Unilorin Teaching Hospital Staff Clinic, Ilorin, Nigeria. Health Science Journal. 2011; (5)2: 98-106.
9. Federal Ministry of Health. Concept note on presidential summit on universal health coverage in Nigeria. Abuja: Federal Ministry of Health. 2014.
10. Fenny AP, Enemark U, Asante FA, Hansen KS. Patient Satisfaction with primary health care - a comparison between the insured and non-insured under the national health insurance policy in Ghana. Global Journal of Health Science. 2014; 6 (4): 9-21.

11. Osungbade KO, Obembe TA, Oludoyi A. User satisfaction with services provided under National Health Insurance Scheme in South-western Nigeria. *Int. J. Trop Disease & Health* 2014; 4(5): 595-607.
12. Dixon J, Tenkorang FY, Luginaah I. Ghana's National Health Insurance Scheme: a national level investigation of members' perceptions of service provision. *BMC International Health and Human Rights*. 2013; 13(35): 1-10.
<http://www.biomedcentral.com/1472-698X/13/35>
13. Adebayo AM, Asuzu MC. Utilisation of a community-based health facility in a low-income urban community in Ibadan, Nigeria. *Afr J Prim Health_Care Fam Med*. 2015 May 5; 7(1). doi: 10.4102/phcm.v7i1.735
14. Nnebue CC, Ebenebe UE, Adinma ED, Iyoke CA, Obionu CN, Ilika AI. Clients' knowledge, perception and satisfaction with quality of maternal health care services at the primary health care level in Nnewi, Nigeria. *Niger J Pract*. 2014 Sep-Oct; 17(5):594-601. doi: 10.4103/1119-3077.141425
15. Mohammed S, Mohammed NS, Dong H et al. Understanding client satisfaction with a health insurance scheme in Nigeria: factors and enrollees experiences. *Health Research Policy and Systems*. 2011; 9(20): 1-8.
16. National Population Commission. 2010. 2006 population and housing census of the Federal Republic of Nigeria: housing characteristics and amenities tables – priority tables (LGA). Abuja: National Population Commission, volume 2. NPC/CENSUS 2006/PT/VOLUME II
17. National Bureau of Statistics. 2009. Annual abstract of statistics 2009: Federal Republic of Nigeria. Abuja: National Bureau of Statistics.
18. Adelekan, I.O. 2010. Vulnerability of poor urban coastal communities to flooding in Lagos, Nigeria. *Environment and Urbanization*. 22(2): 433-450.
19. Federal Ministry of Health [Nigeria]. National policy on population for development, unity, progress and self-reliance. Lagos: Federal Ministry of Health [Nigeria], 1988.
20. Chu T, Liu T, Chen C, Tsai Y, Chiu W. Household Out-of-Pocket Medical Expenditures and National Health Insurance in Taiwan: Income and Regional Inequality. *BMC Health Serv Res*. 2005; 5(60): 1-9.

21. Chubike ND. Evaluation of National Health Insurance Scheme (NHIS) awareness by civil servants in Enugu and Abakaliki. *International Journal of Medicine and Medical Sciences*. 2013; 5(7): 356-358. DOI: 10.5897/IJMMS2013.0920
22. Ibiwoye A, Adeleke AA. The impact of health insurance on health insurance on health care provision in developing countries. *Ghana Journal of Developing Countries*. 2007; 4(21): 49-58.
23. Dalinjong PA, Laar AS. The National Health Insurance Scheme: perceptions and experiences of health care providers and clients in two districts of Ghana. *Health Econ Rev*. 2012; 2(13).
24. Ilesanmi OS, Ige OK. Equity of care: a comparison of National Health Insurance Scheme enrollees and fee-paying patients at a private health facility in Ibadan, Nigeria. *Journal of Public Health and Epidemiology*. 2013; 5(2): 51-55.
25. National Primary Health Care Development Board. Primary Health Care in focus 2012: activity and progress report of the National Primary Health Care Development Board. Abuja, Nigeria: National Primary Health Care Development Board, 2012.
26. National Primary Health Care Development Agency. Increasing Skilled Birth Attendance in Nigeria. -Midwives Service Scheme and PRRINN-MNCH collaboration - an update. Abuja: National Primary Health Care Development Agency, 2012.
27. Dacombe R.J, Squire SB, Ramsey ARC, Banda HT, Bates I. Essential Medical Laboratory Services: Their Role in Delivering Equitable Health Care in Malawi. *Malawi Medical Journal*. 2006; 18(2): 77-79
28. Carrin G, Waelkens M, Criel B. Community-based health insurance in developing countries: a study of its contribution to the performance of health financing systems. *Tropical Medicine and International Health*. 2005; 10(8): 799-811.
29. Agba MS. Perceived impact of the National Health Insurance Schemes (NHIS) among registered staff in Federal Polytechnic, Idah, Kogi State, Nigeria. *Studies in Sociology of Science*. 2014; 1 (1): 44-49
30. Ibrahim A. Poor Health Worker Attitude: Are the Health Workers Solely to Blame or do Health Policy Decisions Contribute As Well to this Poor Attitude? Knowledge Translation Network (KTNet) Africa, 2016. Available at:

- http://ktnetafrica.net/blog/poor-health-worker-attitude-are-health-workers-solely-blame-or-do-health-policy-decisions Accessed June 24 2016
31. Saksena P, Xu K, Elovainio R, Perrot J. Health Services utilisation and Out-of-pocket Expenditure at Public and Private Facilities in Low Income Countries. Geneva: World Health Organisation. Background Paper 20, 2010.
 32. Onwujekwe O. Achieving universal health coverage in Nigeria: options for Federal, State and LGAs. The Presidential Summit on Universal Health Coverage. Abuja, Nigeria, March 2014.
 33. Smith M, Solanki G, Kimmie Z. The second Kaiser Family Foundation survey of health care in South Africa. Washington: The Hendry J Kaiser Family Foundation, 1999.
 34. Omoruan AI, Bamidele AP, Phillips OF. Social Health Insurance and Sustainable Healthcare Reform in Nigeria. *Ethno-Med*, 2009; 3(2): 105-110.
 35. Lagomarsino G, Garabrant A, Adyas A, Muga R, Otoo N. Moving Towards Universal Health Coverage: Health Insurance Reforms In Nine Developing Countries in Africa and Asia. *Lancet*. 2012; (380): 933-943.
 36. Kisakye A. Growing Africa's Health Insurance. Knowledge Translation Network (KTNNet) Africa, 2016. Available at: <http://ktnetafrica.net/blog/growing-africa%E2%80%99s-health-insurance> Accessed June 24, 2016
 37. Owusu-Sekyere E, Bagah DA. Towards a sustainable health care financing in Ghana: is the National Health Insurance the solution? *Public Health Research*. 2014; 4(5): 185-194.
 38. Uzochukwu BSC, Ughasoro MD, Etiaba E, Okwuosa C, Envuladu E, Onwujekwe OE. Health care financing in Nigeria: Implications for Achieving Universal Health Coverage. *Nigerian Journal of Clinical Practice*. 2015; 18(4): 437-444.