

Knowledge and Attitude Towards National Health Insurance Scheme in Nigerian Research Institutes

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Abstract: This study investigated the knowledge and attitude towards National Health Insurance Scheme in Nigerian research institutes. Assessment of National Health Insurance Scheme after four years of its operation in Nigeria revealed less than 3% coverage of the national population, hence, opinion are polarized on its efficacy in curbing Nigerian health challenges. Descriptive survey research design was used for the study. The instrument for data collection was self-developed and structured questionnaire of Knowledge towards National Health Insurance Scheme Questionnaire (KNHISQ) designed in four-point Likert-scale format. Descriptive statistics of frequency count and percentages were used to describe the demographic data, while regression analysis was used to test the hypotheses at 0.05 alpha level. A total number of two hundred and ninety one respondents were used for this study. The study revealed that though the members of staff in these institutes are aware of National Health Insurance Scheme, their level of awareness appeared to be low. It was therefore recommended that aggressive mobilization should be made for more public participation in the scheme.

Key words: Insurance, health, healthcare, health insurance, enrollee.

INTRODUCTION

Nigerian National Health Insurance Scheme (NHIS) was launched with the aim of improving accessibility and equity in health care delivery. Health insurance is a legal contract that protects people from the financial loss that results from loss of life, law suits, loss of health, or loss of property. It provides a means of coping with some of the risks faced in everyday life for individuals and societies. People who wish to be insured against particular types of losses agree to make regular payment called premium to an insurance company. It makes business operation safer; it encourages business to make transaction that are of economic benefit to the nation. Insurance has become a significant economic force in most industrialized countries. Employers buy insurance to cover their employees against work related injuries and health problems.

Health is one of the basic capabilities that give value to human life; it contributes to both social and economic development. Better health translates into greater and more equitable distribution of wealth by building human and social capital that increases national productivity (Bloom, 2004; World Health Organization, 2001). A health

insurance scheme has been defined as an arrangement in which contributions are made by or on behalf of individuals or groups (members) to a purchasing institution (a fund) which is responsible for purchasing covered services from providers on behalf of the members of the scheme (Kutzin, 1997).

The federal government of Nigeria in its 26th National Council of Health meeting in July 1984 approved the introduction of a national health insurance scheme as an alternative for funding health care service. Health insurance is the pooling of resources of individuals or groups to pay for or part of health services specified in an insurance policy or law. This entails risk sharing by contributions when the illness or injury to be insured is unpredictable and the cost or its occurrence is high, those fortunate enough to be healthy pay for those who are sick, their cost will in turn be covered by the latter.

Health insurance is a form of managed care services that pools regular financial contributions of members and pay a network of providers of health care for defined specific set of health care services that in turn are accountable for the cost containment and improving health outcomes. The importance of health in the development of an economy cannot be over emphasized. A healthy population is the vehicle of development of any nation; hence, provision of adequate healthcare to the citizenry of a nation is a must if such a nation will advance.

Johnson and Stoskopt (2009) stated that National Health Insurance Scheme was first introduced in Nigeria in 1962 during the First Republic. In 1993, the Federal Government directed the Federal Ministry of Health to start the scheme in the country. In 1999, the scheme was modified to cover more people via Decree No. 35 of May 10, 1999 which was promulgated by the then Head of State, General Abdulsalami Abubakar (NHIS Decree No. 35 of 1999; Adesina, 2009). The general purpose of NHIS is to ensure the provision of health insurance which shall entitle insured persons and their dependants the benefits of prescribed good quality and cost effective services (NHIS Decree No. 35 of 1999; NHIS, 2009). The following were further listed as the specific objectives of NHIS:

1. The universal provision of healthcare in Nigeria.
2. To control/reduce arbitrary increase in the cost of health services in Nigeria.
3. To protect families from high cost of medical bills.
4. To ensure equality in the distribution of health care service cost across income groups.
5. To ensure high standard of healthcare to beneficiaries of the scheme.
6. To boost private sector participation in healthcare delivery in Nigeria.
7. To ensure adequate and equitable distribution of healthcare facilities within the country.
8. To ensure that primary, secondary and tertiary healthcare providers are equitably patronized in the federation.
9. To maintain and ensure adequate flow of funds for the running of the scheme and the health sector in general.

According to WHO (2007a), the provision of quality, accessible and affordable healthcare remains a serious problem because of inadequate funding and lack of government commitment to the provision of healthcare policies and covers all citizens. The percentage of government allocation to the health sector has always been about 2% and 3.5% of the annual budget. A social health insurance scheme involves contribution based on means and utilization based on need (WHO, 2007b).

Nigeria is in the category of developing countries which share the characteristics of relatively low level of per capital gross national product (GNP), low ratio of taxable surplus to GNP and a limited taxation base due to wide spread poverty, the structure of unemployment and administrative difficulties. Government has responded with various measures over the years to tackle the seemingly un-surmountable problems of health sector with generous budgetary allocations. The allocation to the health sector in the first National Development Plan Period (1961-1968) was 17.076million pounds which later grew to as much as N43million during the fourth National Development Plan Period (1981-1985).

Enrollee's knowledge of health insurance leads to less satisfaction of health service provision, whereas their satisfaction improves only if they have good understanding of how the health insurance scheme works and knew what has been offered by the scheme. The less awareness of enrollees with health insurance activities, the less satisfied they tend to become of its offerings in terms of service provision. Better awareness of enrollees might enhance interactions between patients and health care providers due to better satisfaction of services. There are tendencies that those who do not have knowledge of insurance service offered would likely evaluate schemes poorly (European Commission, 2005).

Ibiwoye and Adeleke (2007) noted that it is the opinion of Nigerian government that NHIS will probably solve the problem of inequality in the provision of healthcare services and help to improve the accessibility of healthcare. However, complaints have arisen where providers denied enrollees their full entitlements and some providers have charged additional fees on the pretext of non-inclusion of the service in the benefit package; again, insured persons have complained of poor attitude and behavior of service providers operating in the health insurance scheme (NHIS, 2006).

WHO (2007a); Oba (2008); Omoruan, Bamidele and Philips (2009) hinted that in Nigeria like most African countries, the provision of quality, accessible and affordable healthcare remains a serious problem. This is because the health sector is perennially faced with gross shortage of personnel, inadequate and outdated medical equipment, poor funding and corruption. Evidence shows that only 4.6% of both public and private GDP in 2004 was committed to the sector (WHO, 2007a).

According to World Bank (2007); United Nations Development Programme (2008), in 2005 only 48 and 35 percent of the children within the ages of zero-to-one old were fully immunized against tuberculosis and measles respectively; between 1998 and 2005, 28% of the children within the ages of 5 years who suffered from diarrhea receive

adequate treatment; between 1997 and 2005 only 35% of births in Nigeria were attended to by skilled health personnel, while between 2000 and 2004, only 28% of Nigerians in every 100,000 persons had access to physicians. Nigeria continually loses her professionals to other countries. It was reported in 1986 that more than 1,500 health professionals left Nigeria for other countries; UNDP report revealed that 21,000 medical personnel were practicing in the United States of America and United Kingdom, whereas, there was shortage of personnel in the Nigerian health sector (Akinkugbe, 2006).

Okaro, Ohagwu and Njoku (2010) found that the high level of awareness of the existence of the scheme is not translated into participation as more than half of the respondents did not register with the scheme. It is based on this premise that the researchers investigated the knowledge and attitude towards national health insurance scheme in research institutes in Nigeria.

Opinion is polarized among Nigerians on the efficacy of NHIS in addressing the health problems in the country after more than four years of the scheme because of the disheartening reports in the country's health situation. For instance, World Bank (2008) survey on the scheme showed that only one million people in Nigeria or 0.8% of the population are covered by NHIS, while many persons have to pay for medical care out of their pockets or do without healthcare. The report further revealed that many low-income persons would not benefit from NHIS for at least another 10 years. Assessment of the programme after four years of operation revealed less than 3% coverage of the Nigerian population (Okaro, Ohagwu and Njoku, 2010). Based on the foregoing, the researchers investigated the knowledge and attitude towards National Health Insurance Scheme in Nigerian research institutes.

The following research questions were answered: What is the level of knowledge of people regarding services provided by NHIS? What is people's knowledge of the content of NHIS services? Two hypotheses were tested, viz: There will be no significant joint effect of knowledge, sex, age, educational status and marital status on attitude towards National Health Insurance Scheme. There will be no significant relative effect of knowledge, sex, age, educational status and marital status on attitude towards National Health Insurance Scheme.

METHODOLOGY

The descriptive survey research design was used for this study and the instrument for data collection is self-developed and structured questionnaire of Knowledge of National Insurance Scheme Questionnaire (KNISQ) with twelve items designed according to the variables tested in the study in four point likert scale format. The population for this study comprised all members of staff at the two research institutes used for this study, viz: Nigeria Institute of Medical Research and Nigeria Institute of Social and Economic Research. Two hundred and ninety one (291) questionnaires were administered but only two hundred and nine (209) returned their questionnaire yielding 71.8% response rate. 111(53.1%) of the respondents were males while 98(46.9%) were females, 30(14.4%)

were SSCE/GCE holders, 25(12.0%) were OND/NCE certificate holders, 80(38.3%) were HND, B.SC/B.A certificate holders, 66(31.6%) were M.Ed/M.Sc/M.A certificate holders, while 8(3.8%) were Ph.D holders. 170(81.3%) were married, 32(15.3%) were singles, 4(1.9%) were widowers, 3(1.4%) were widows.

Results and Discussion

Table 1: Frequency distribution on knowledge of content and services provided by NHIS

S/N	Content of NHIS	YES	NO
1.	Enrollees can visit any hospital for free healthcare.	70(33.5%)	139(66.5%)
2.	NHIS security system is meant for workers in the formal sector.	112(53.6%)	97(46.4%)
3.	15% of basic salary of employee is contributed towards NHIS.	132(63.2%)	77(36.8%)
4.	NHIS has processing (waiting) period of 30 days.	64(30.7%)	145(69.3%)
5.	Employees' NHIS benefits covers spouse and four children.	177(84.7%)	32(15.3%)
6.	Additional contributions by enrollee would cover more dependants.	103(49.3%)	106(20.7%)
7.	Basic healthcare standards are observed for healthcare providers' participation in NHIS.	117(56.0%)	92(44.0%)
8.	Health professionals are categorized under NHIS.	113(54.0%)	96(45.9%)
9.	Retirees may continue as voluntary contributors.	96(46.0%)	113(54.1%)
1.0	NHIS is a means of generating more funds for healthcare services.	126(60.3%)	83(39.8%)
Services Provided by NHIS			
11.	NHIS provides free healthcare for enrollees.	125(59.8%)	84(40.2%)
12.	NHIS provides free prescribed drug enrollees.	114(54.5%)	95(45.5%)
13.	NHIS provides maternity care up to four (live) births for enrollees.	128(63.9%)	81(38.8%)
14.	NHIS provides free consultation with health specialists for enrollees.	118(56.4%)	91(43.6%)
15.	NHIS provides hospital care (for stay) up to 15days for enrollees.	67(32.1%)	142(68.0%)
16.	NHIS provides eye care excluding provision of lenses/spectacles for enrollees.	89(42.6%)	120(57.4%)

Tables 1 shows that tangible number of the participants in this study have low knowledge of the content and services provided by NHIS. This finding is in line with that of Onuekwusi and Okpala (1998) in earlier work done to access the awareness and perception of NHIS among Nigerian healthcare professionals, they was found out that

one year after the launching of the scheme Nigerian healthcare professionals who are major stakeholders in the programme still have inadequate knowledge of the rudimentary principle of the operation of a social health insurance scheme. In a related work done to assess the perception of NHIS among healthcare consumers by Sanusi and Awe (2009) the result showed that 65% of the respondents have received treatment from registered healthcare providers under the NHIS programme, however, respondents who have been treated under the programme wanted the programme discontinued which implies that people have little hope in the programme.

Hypothesis 1: There will be no significant joint effect of knowledge, sex, age, educational status and marital status on attitude towards National Health Insurance Scheme.

Table 2: Regression table on joint effect

Model	Sum of Squares	df	Mean Square	F	Sig
Regression	4938.096	5	987.619	15.229	.000
Residual	13164.899	203	64.852		
Total	18102.995	208			

R = 0.522, R² = 0.273, Adj R² = 0.255. Null hypothesis rejected.

Table 2 above shows that the linear combination of the effect of knowledge, sex, age, educational level and marital status on the attitude towards National Health Insurance Scheme is significant ($F(5, 203) = 15.229$; $R = 0.522$; $R^2 = 0.273$; $Adj. R^2 = 0.255$; $P < 0.05$). The finding of this study that there is significant joint effect of knowledge, sex, age, educational level and marital status on attitude towards National Health Insurance Scheme is in line with the finding of National Centre for Biotechnology Information (2009) which showed that factors such as gender bias due to religious or cultural belief affect people's attitude towards health schemes. Studies within the country context have shown that marital status has a significant influence on people's attitude towards insurance (Gbadamosi, Hamadu and Yusuf, 2009).

Inequality in the distribution of healthcare facilities between urban and rural areas also affects healthcare delivery in Nigeria (Omoruan, Bamidele and Philips, 2009). Periodic identification of related influencing factors on client satisfaction could assist in guiding policy and decision making to detect promising pathways to improve any nascent programme like health insurance schemes. Similarly, Sanusi and Awe (2009) in their study of perception of National Health Insurance Scheme by healthcare consumers in Oyo State, Nigeria found that some of the factors that impede quality healthcare delivery in Nigeria include inability of the consumers to pay for healthcare services.

Hypothesis 2: There will be no significant relative effect of knowledge, sex, age, educational status and marital status on the attitude towards National Health Insurance Scheme.

Table 3: Regression table on relative effect

Model	Unstandardized Coefficient		Standard Coefficient	T	Sig.
	B	Std. Error			
Constant	22.737	5.236		4.342	.000
Knowledge	.392	.051	.635	7.669	.000
Sex	-2.868	1.164	-.154	-2.464	.015
Age	-.341	.086	-.33	-3.949	.000
Educational status	-.657	.538	-.076	-1.221	.224
Marital status	.043	1.087	.003	.040	.968

Table 3 shows that the relative contribution of knowledge, sex and age were significant while that of educational status and marital status were not. This finding is in line with that of Mohammed, Sambo and Dong (2011) which showed that improved knowledge and better awareness of the scheme's activities by the enrollee's could be augmented through the provision of requisite information to the insured persons at all times. Community health beliefs and attitude, value and knowledge that people have about health and risk sharing concepts of health insurance may influence household perception on the need and participation in health insurance; literature has shown that it is significant determinants of accurate knowledge and practice (Lee, Milgrom, Hueber and Conrad, 2010). Insured person's knowledge of health insurance scheme is a determinant of perceived satisfaction of healthcare services. Poor knowledge of the benefits has affected the utilization of health facilities in developing countries (De Allegri, Sanon, Bridges and Sauerborn, 2006; Tien, 2005).

CONCLUSION

The result of this study showed that knowledge, sex, age, educational level and marital status have significant effect on attitude towards National Health Insurance Scheme. NHIS can be a very powerful tool for social protection if appropriately designed and implemented. In the developing countries where poverty and lack of access to healthcare are extremely serious problems, introducing and implementing equitable financing mechanisms and insuring against catastrophic health expenditures should be given high priority in national policy making. The aim of ensuring the provision of health insurance which shall entitle insured persons and their dependants the benefits of prescribed good quality and cost effective health services as conceived in NHIS is so much needed to maintain a productive population because a healthy population is an indispensable tool for sustainable national development.

RECOMMENDATIONS

Based on the findings of this study, it is therefore recommended that:

Efforts should be made to increase upon the present coverage and performance of NHIS through aggressive mobilization of the people in a manner that will attract better public participation.

Similarly, public enlightenment and awareness public awareness about this scheme is germane as it will help to clear misunderstanding about the programme and this will ensure attitudinal change in the people.

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