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Evaluating the Impact of National Health Insurance Scheme on Health Care Consumers in Calabar Metropolis, Southern Nigeria

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Abstract: This study was aimed at evaluating the impact of National Health Insurance Scheme (NHIS) on health care consumers in Calabar metropolis, southern Nigeria. A pre-tested, 43 itemed questionnaires were designed and administered to 200 respondents using the household survey and patient exit survey methods. The result of this study showed that respondents were predominantly males (58.0%), Christians (94.5%), married (56.0%), civil servants (39.5%), had tertiary level of education (60.5%) and aged 30-34 years (27.5%). A reasonable proportion of the respondents 89.0% were aware of the scheme but enrolment into the scheme was only 37%. Inadequate information on the scheme, deficient delivery of health care services and lack of trust on scheme management were significant barriers to enrolment into the scheme. The scheme has a positive impact on health seeking behavior, utilization of maternal health services and reducing out-of-pocket expenditure for health services. About 72% of the respondents expressed their satisfaction with the performance of the scheme, whereas those who were dissatisfied with the scheme's performance suggested it should be reformed. Wider coverage and increase awareness about the scheme will enhance equitable access to health care.

Keywords: National Health Insurance Scheme, Health Care Consumers, Nigeria.

1. Introduction

Health care in Nigeria is financed by a combination of tax revenue, out-of-pocket payments, donor funding, and health insurance (social and community) (WHO, 2009). Nigeria's health expenditure is relatively low, even when compared with other African countries. The total health expenditure (THE) as percentage of the gross domestic product (GDP) from 1998 to 2000 was less than 5%, falling behind THE/GDP ratio in other developing countries such as Kenya (5.3%), Zambia (6.2%), Tanzania (6.8%), Malawi (7.2%), and South Africa (7.5%) (Soyinbo, 2005). Limited institutional capacity, corruption, unstable economic, and lack of political will have been identified as factors why some mechanisms of financing health care have not worked effectively (Adinma & Adinma, 2010).

In Nigeria, households bear the highest burden of health expenditure. A review carried out by Olakunde (2012), revealed that health financing system is largely characterized by low

investment by the government, extensive out-of-pocket payments, limited insurance coverage, and low donor funding. Obviously, out-of-pockets account for the highest proportion of health expenditure in Nigeria. Out-of-pocket expenditure constituted the larger proportion of total health expenditure averaged 64.59% from 1998 to 2002 (Soyinbo, 2005). In 2003, it accounted for 74% of total health expenditure (THE). It decreased to 66% in 2004 and later increased to 68% in 2005 (Soyibo, Olaniyan & Lawanson, 2009). Since most Nigerians depend on their pockets to utilize health services, the low income groups such as the unemployed, poor, disabled, youths, housewives and illiterates are usually victims of circumstances leading to low patronage of health facilities when they need treatment from ill-conditions. This has contributed largely to the poor health indices in Nigeria especially in areas of maternal and child mortality, HIV/AIDS, tuberculosis and life expectancy which obviously threaten the achievement of MDGs targets. Hence, to ensure equitable access to health care to all citizens, reduce excessive dependence on government owned health facilities and reinvigorating the dwindling health care financial system, the government introduced the National Health Insurance Scheme (NHIS) to salvage the health situation in Nigeria.

1.1 Nigeria's National Health Insurance Scheme

The Nigerian government established the National Health Insurance Scheme (NHIS) under Act 35 of 1999 with the aim of improving access to health care and reducing the financial burden of out-of-pocket payment for health care services. It is based on a prepayment system where both the employer and employee make contributions to the scheme and the employee accesses the scheme whenever he or she is ill.

The scheme was officially launched on June 6, 2005 and services to enrollees started in September 2005. According to an article published by Osae-Brown (2013), over four million identity cards have been issued, 62 HMOs have been accredited and registered and more applications are being processed. Presently, 5,949 healthcare providers, 24 banks, five insurance companies and three insurance brokers have also been accredited and registered, according to information on the NHIS website.

The contributions paid to the scheme cover healthcare benefits for the employee, a spouse and four (4) biological children below the age of 18. More dependants or a child above the age of 18 would be covered on the payment of additional contributions from the principal beneficiary. However, children above 18 years who are in tertiary institution will be covered under Tertiary Insurance Scheme, the information on the NHIS website shows.

The seven-year-old NHIS in Nigeria is yet to fully service its first category which is the public sector. According to information gathered by the Nigerian Tribune, majority of the over five million people accessing healthcare through the scheme are Federal Government employees and members of their families and a percentage of the organized private sector. It is certain that only Cross River and Bauchi State governments have subscribed to the scheme but it is uncertain whether any local government has enrolled for the NHIS services.

1.1.1 Benefits of National Health Insurance Scheme

Healthcare providers under the Scheme shall provide the following benefit package to the contributors: Out-patient care, including necessary consumables; Prescribed drugs, pharmaceutical care and diagnostic tests as contained in the National Essential Drugs List and Diagnostic Test Lists; Maternity care for up to four (4) live births for every insured contributor/couple in the Formal Sector Programme; Preventive care, including immunization, as it applies in the National Programme on Immunization, health education, family planning, antenatal and post-natal care Consultation with specialists, such as physicians, pediatricians, obstetricians, gynaecologists, general surgeons, orthopaedic surgeons, ENT surgeons, dental surgeons, radiologists, psychiatrists, ophthalmologists,
physiotherapists, etc.; Hospital care in a standard ward for a stay limited to cumulative 15 days

per year. Thereafter, the beneficiary and/or the employer pay. However the primary provider shall pay per diem for bed space for a total 15 days cumulative per year. Eye examination and care, excluding the provision of spectacles and contact lenses; A range of prostheses (limited to artificial limbs produced in Nigeria); and Preventive dental care and pain relief (including consultation, dental health education, amalgam filling, and simple extraction).

1.2 Achievement of the Scheme

A survey carried out by Olanrewaju (2011), revealed that, within six years of NHIS existence, the scheme claimed to have recorded a number of pluses, some of which are: Over 5 million enrollees accessing care through the scheme, 2 states (Cross River & Bauchi) already folded into the scheme, about 20 more at various stages are folding in, Developed operational tools e.g. operational guidelines, protocols etc., Accredited 7850 health facilities across the country, Accredited 61 HMOs to run the scheme, Developed blueprints for implementing the informal sector programme, community — based and Tertiary Institution Social Health Insurance programmes, Secured approval to implement MDG subsidy funding for pregnant women and children Under-5, Employment generation from activities of new HMOs and expanded capacity of providers, Near completion of a robust IT platform (e-NHIS) to drive operation and regulation of the scheme, Establishment of a vibrant National Call Centre, Establishment of central data centre, Draft of new NHIS Act, Re-organization and restructuring of the NHIS to meet future challenges, Monitoring and evaluation system in place for HMOs and providers, Enhanced funding to providers (public and private) and improvement of quality of care.

1.2.1 Challenges of the scheme

An extensive survey carried out by the "Nigerian Tribune" revealed a number of challenges encountered by the scheme. Some of which are: Inadequate coverage (i.e. informal sector and unemployed not covered), low quality of health care services, high cost of premium charges by enrollees, low level of awareness about the scheme and lack of health facilities or medical centers for smooth take off of the scheme in rural areas. Despite these challenges, managers of the scheme are committed to ensuring optimal and quality health service delivery to the populace. According to an interview section with Mr M.B.W Dogo-Muhammed, the Executive Secretary of NHIS, "the scheme intends to cover 40 per cent of the Nigerian population by 2013".

1.2.2 Objective of the study

The objective of this study was to evaluate the impact of National Health Insurance Scheme on Health care consumers in Calabar metropolis, Southern Nigeria.

The specific objectives of this study were to:

i. determine the socio-demographic characteristics of health care consumers in Calabar metropolis.
ii. determine the level of awareness and membership of health care consumer on National Health Insurance Scheme in Calabar metropolis.
iii. assess the level of health seeking behavior and utilization of health services among health care consumers in Calabar metropolis.
iv. determine the perception of health care consumers towards the scheme and health service delivery.

2.0 MATERIALS AND METHODS

2.1 Study Setting

The study area is Calabar metropolis. It is situated in the southern part of Nigeria. Calabar metropolis is made up of two local government areas, Calabar Municipality and Calabar South local government area with an estimated population of 196,630 for Calabar South and 176,218 for Calabar Municipality (NPC, 2006). Calabar Municipal council has 10 political wards while Calabar South has 12 political wards making a total of 22 political wards. The Calabar Municipality has a land mass of 141,33 square kilometer while the South which lies in the coastal area empty into the Atlantic ocean and located between latitude 4055 and 8030 East of the Green Meridian, it has a land mass of 181,42. The metropolis is bounded by Calabar river to the west, Akpabuyo local government area to the east, Odukpani local government area to the north and Atlantic ocean to the south. It is a cosmopolitan city which embraces all ethnic groups in Nigeria. The three dominant ethnic groups are the Efiks, Quas and the Efuts which share common culture and religion. English and Efik are the languages widely spoken. The metropolis is predominantly a Christian city with few Muslims and traditional religious groups and mainly occupied by civil servants, businessmen and traders. It also has industries and establishments such as airport, export processing zone, Naval and Army base, Tinapa, NNPC depot, cement factory etc. The metropolis has three levels of health care facilities, 41 primary health facilities, 2 secondary health facilities with 56 private health facilities. Calabar are famous for their rich cultural heritage, warm hospitality and peace-loving disposition.

2.1.1 Study Population

The study population comprised of health care consumers (both the insured and uninsured above 18years of age) in Calabar Metropolis, southern Nigeria.

2.2 Study Design

A cross-sectional triangulation study was employed to evaluate the impact of National Health Insurance Scheme on health care consumers in Calabar, metropolis, southern Nigeria between April-June, 2013.

2.2.1 Sampling Procedure

1. ***Household survey***

A stratified systematic sampling technique was employed to select research participants for this study. About 50 respondents each were gotten from two strata; Calabar south and Calabar municipal giving a total of 100 respondents. In each stratum, every 2nd household was sampled until 50 households have been sampled giving a total of 100 household that was sampled. The questionnaire was administered to the head of every household who consented to participate in the study.

2. ***Patient exit survey***

Simple random sampling technique was employed in the selection of 100 respondents. In-patient and out-patient clients were the target population for the patient exit survey.

3. Hence, the sample size for this study is 200.

2.2.2 Data Collection

Data were generated using a structured questionnaire and was self-administered to consented participants. It consisted of 43 items and compartmentalize into four sections. The questionnaire comprised of questions on socio-demographic characteristics of health care consumers, knowledge and membership on national health insurance scheme, health seeking behavior and utilization of health services and perception of health care consumers towards the scheme and services delivery.

2.3 Data Analysis

The questionnaires were manually sorted out and analyze using Statistical Package for Social Science (SPSS, version 15.0). Data was summarized using frequency tables, graphs, means and standard deviations.

2.3.1 Ethical Consideration

Informed consent was duly sought and obtained from research participant who volunteered to take part in the study. The research participants were assured of anonymity and confidentiality of information elicited.

3.0 RESULTS

{{{{ A total of 200 completed questionnaires were distributed and analyze giving a response rate of 100%. Majority of the respondents were within the age group of **30**-34 years 55 (27.5%) followed by 25-29 years 45 (22.5%) and then those aged 50 years and above 30 (15.0%) with a mean age of 36.07 and standard deviation of 9.78. Out of 200 respondents who participated in the study, about 116 (58.0%) were males and 84 (42.0%) were females. Most respondents were predominantly Christians 189 (94.5%), married 112 (56.0%) and those who had attained tertiary level of education 121 (60.5%). However, a lesser percentage (39.5%) had attained one form of education or the other. Civil servants 79 (39.5%) constituted the highest respondents in this study while the others were largely students 42 (21.0%) and the unemployed 30 (15.0%). Most respondents reported to earned 90,000 to 100,000 naira 33 (32.0%) followed by those who earned greater than 100,000 31(30.1%) on monthly basis 89 (86.4%) (Table 1).

Table 1: Socio-demographic Characteristics of Respondents

VARIABLES	**FREQUENCY (PERCENTAGES)**		
Ages in years	**Insured (N=74)**	**Uninsured (N=126)**	**Total**
18-24	4 (2.0)	11 (5.5)	15 (7.5)
25-29	1.2 (6.0)	33 (16.5)	45 (22.5)
30-34	1.7 (8.5)	38 (19.0)	55 (27.5)
35-39	4 (2.0)	7 (3.5)	11 (5.5)
40-44	9 (4.5)	13 (6.5)	22 (11.0)
45-49	11 (5.5)	11 (5.5)	22 (11.0)
≥ 50	17 (8.5)	13 (6.5)	30 (15.0)
Total	**74 (37.0)**	**126 (63.0)**	**200 (100)**
Sex			
Male	45 (22.5)	71 (35.5)	116 (58.0)
Female	29 (14.5)	55 (27.5)	84 (42.0)
Total	**74 (37.0)**	**126 (63.0)**	**200 (100)**
Religion			
Christianity	72 (36.0)	117 (58.5)	189 (94.5)
Islam	-	3 (1.5)	3 (1.5)
Traditional Religion	1 (0.5)	3 (1.5)	4 (2.0)
No Religion	1 (0.5)	3 (1.5)	4 (2.0)
Total	**74 (37.0)**	**126 (63.0)**	**200 (100)**
Marital Status			
Married	49 (24.5)	63 (31.5)	112 (56.0)

Single	22 (11.0)	59 (29.5)	81 (40.5)
Widowed	2 (1.0)	3 (1.5)	5 (2.5)
Separated	-	-	-
Divorced	1 (0.5)	1 (0.5)	2 (1.0)
Total	**74 (37.0)**	**126 (63.0)**	**200 (100)**
Level of Education			
No formal education	-	-	-
Primary education	4 (2.0)	8 (4.0)	12 (6.0)
Secondary education	11 (5.5)	56 (28.0)	67 (33.5)
Tertiary education	59 (29.5)	62 (31.0)	121 (60.5)
Total	**74 (37.0)**	**126 (63.0)**	**200 (100)**
Occupation			
Trader	6 (3.0)	9 (4.5)	15 (7.5)
Civil servant	42 (21.0)	37 (18.5)	79 (39.5)
Student	12 (6.0)	30 (15.0)	42 (21.0)
Driver	5 (2.5)	12 (6.0)	17 (8.5)
Unemployed	3 (1.5)	27 (13.5)	30 (15.0)
Others	6 (3.0)	11 (5.5)	17 (8.5)
Total	**74 (37.0)**	**126 (63.0)**	**200 (100)**
Level of Income			
Daily	3 (2.9)	7 (6.8)	10 (9.7)
Weekly	1 (1.0)	3 (2.9)	4 (3.9)
Monthly	26 (25.2)	63 (61.2)	89 (86.4)
Total	**30 (29.1)**	**73 (70.9)**	**103 (100)**
Range of income			
2000-5000 naira	-	3(2.9)	3 (2.9)
10,000-20,000 naira	1 (1.0)	7 (6.8)	8 (7.8)
30,000-40,000 naira	3 (2.9)	6 (5.8)	9 (8.7)
50,000-60,000 naira	6 (5.8)	8 (7.8)	14 (13.6)
70,000-80,000 naira	3 (2.9)	2 (1.9)	5 (4.9)
90,000-100,000 naira	7 (6.8)	26 (25.2)	33 (32.0)
>100,000 naira	10 (9.7)	21 (20.4)	31 (30.1)
Total	**30 (29.1)**	**73 (70.9)**	**103 (100)**

About two-third of the respondents 178 (89.0%) reported to have heard of National Health Insurance Scheme (NHIS) before. While all the insured claimed to have heard of NHIS, 22 (11.0%) out of 126 (63.0%) of the uninsured reported not to have heard of NHIS before (Table 2). The media (Radio/TV) 75 (37.5%), health workers 65 (32.5) and managers of the scheme 44 (22.0%) were their top three source of information about NHIS. More than half of the respondents 126 (63.0%) were not registered member of NHIS. Only 74 (37.0%) were duly registered with the scheme. The formal sector constituted 21.0% of membership. Reasons for not joining the scheme among the uninsured were majorly that education on the scheme was not enough 72 (57.1%), not aware of the scheme 22 (17.5%) and don't trust the organizers 14 (11.1%). About 9 (7.1%) respondents said NHIS does not cover their health needs while 7 (5.5%) said they cannot afford the required premium charges. However, 2 (1.6%) out of 126 said they do not need insurance. Reasons given by the insured for joining the scheme were largely that receiving health services as a registered member of the scheme is cost-effective 44 (59.5%) and provision of free access to medical care 18 (24.3%). Out of 74 insured respondents, 9 (12.2%) reported joining the scheme when they had a particular health problem

and 3 (4.0%) joined because others joined. While a larger proportion of the respondents 164 (82.0%) reported not to have encountered any barrier when trying to enroll in the scheme, 36 (18.0%) said issuance of identity card 24 (66.6%) was their main challenge when trying to enroll in the scheme. About 5 (13.9%) complained of distance of registration center from their houses (Table 2).

Table 2: Knowledge and Membership of the scheme among Respondents

VARIABLES	FREQUENCY (PERCENTAGES)		
Ever heard of National Health Insurance Scheme before	**Insured**	**Uninsured**	**Total**
Yes	74 (37.0)	104 (52.0)	178 (89.0)
No	-	22 (11.0)	22 (11.0)
Total	**74(37.0)**	**126 (63.0)**	**200 (100)**
Source of information about NHIS			
Radio/TV	9 (4.5)	66 (33.0)	75 (37.5)
Health worker	41 (20.5)	24 (12.0)	65 (32.5)
Managers of the scheme	20 (10.0)	24 (12.0)	44 (22.0)
A member of the scheme	4 (2.0)	4 (2.0)	8 (4.0)
Friend	-	2 (1.0)	2 (1.0)
Handbills/posters	-	4(2.0)	4 (2.0)
Others	-	2 (1.0)	2 (1.0)
Total	**74 (37.0)**	**126 (63.0)**	**200 (100)**
Registered member of National Health Insurance Scheme			
Yes	74 (37.0)	-	74 (37.0)
No	-	126 (63.0)	126 (63.0)
Total	**74 (37.0)**	**126 (63.0)**	**200 (100)**
Reasons for not joining the scheme	-		
Not aware of the scheme	-	22 (17.5)	22 (17.5)
Education on the scheme not enough	-	72 (57.1)	72 (57.1)
The scheme does not cover all my health needs	-	9 (7.1)	9 (7.1)
Do not need insurance or not interested	-	2 (1.6)	2 (1.6)
Don't trust the organizers	-	14 (11.1)	14 (11.1)
Can't afford premium charges	-	7 (5.5)	7 (5.5)
Exempted from registering	-	-	-
Other reasons	-	-	-
Total	-	**126 (100)**	**126 (100)**
Reasons for joining the scheme			
The scheme provides free access to medical care	18 (24.3)	-	18 (24.3)
I Joined the scheme when I had a particular health problem	9 (12.2)	-	9 (12.2)
Health services under NHIS is cheap and affordable	44 (59.5)	-	44 (59.5)
No reason	-	-	-
I joined the scheme because others joined	3 (4.0)	-	3 (4.0)
Total	**74 (100**	-	**74 (100)**
Experience any barrier to enrolment			
Yes	16 (8.0)	20 (10.0)	36 (18.0)
No	58 (29.0)	106 (53.0)	164 (82.0)
Total	**74 (37.0)**	**126 (63.0)**	**200(100)**

Barriers to enrolment			
Issuance of identity card	8 (22.2)	16 (44.4)	24 (66.6)
Registration process is cumbersome	-	-	-
Registration center far away from home	3 (8.3)	2 (5.6)	5 (13.9)
Education on the scheme not enough	-	2(5.6)	2 (5.6)
Others	5 (13.9)		5 (13.9)
Total	**16 (44.4)**	**20 (55.6)**	**36 (100)**

In table 3, more than half of the respondents 112 (56.0%) reported to have received treatment from ill-health or injury in one health facility or the other in the last 12 months. The recipient of treatment from these health facilities were largely among the insured 66 (33.0%) than the uninsured 46 (23.0%). Government hospitals 74 (66.1%) were the most patronized health facility. About 14 (12.5%) and 12 (10.7%) said they received treatment from comprehensive health centers and private hospitals respectively. Self medication was reported among 12 (10.7%) of the respondents. Good attitude of health worker and high quality of health services 36 (32.1%), cost-effectiveness of health services rendered 26 (23.2%), close proximity of health facility to their homes 18 (16.1%) were their major reasons for their choice of health facility. However, about 8 (7.1%) said they have no reason for choosing a particular type of health facility. Illness that warranted most respondents to patronize their choice of health facility were malaria 70 (62.5%), typhoid fever 18 (16.1%), operation or surgery 9 (8.0%) and pregnancy 8 (7.1%). The numbers of visit to their choice of health facility were largely once 44 (39.3%), followed by twice 27 (24.1%) then thrice 22 (19.6%). However, the percentage of utilization of health facilities was higher among the insured (58.9%) than the uninsured (41.1%). Sixty-eight out of one hundred and twelve respondents said they were asked to pay for services rendered at the health facility largely within the income range of 1,500 to 3,000 naira 20 (29.4%) followed by 4,000 to 9,000 (19.4%). About 10 (14.7%) respondents reported to have spent from 21,000 naira and above. Payment for health services was higher among the uninsured 46 (67.6%) than the insured 22 (32.4%). Most respondents 40 (58.8%) considered the cost of treatment average.

Table 3: Health seeking behavior and Utilization of Health services among Respondents

VARIABLES	**FREQUENCY (PERCENTAGES)**		
Ever received treatment from ill-health or injury from any health facility in the last 12 months	**Insured**	**Uninsured**	**Total**
Yes	66 (33.0)	46 (23.0)	112 (56.0)
No	8 (4.0)	80 (40.0)	88 (44.0)
Total	**74 (37.0)**	**126 (63.0)**	**200 (100)**
Choice of health facility for treatment			
Government hospital	48 (42.8)	26 (23.2)	74 (66.1)
Private hospital	4 (3.6)	8 (7.1)	12 (10.7)
Comprehensive health center	11 (9.8)	3 (2.7)	14 (12.5)
Herbalist/Traditional healers	-	-	-
Self medication	3 (2.7)	9 (8.0)	12 (10.7)
Total	**66 (58.9)**	**46 (41.1)**	**112 (100)**
Reason for choice of health facility			
Health workers friendly and deliver quality health services	29 (25.9)	7 (6.2)	36 (32.1)

Availability of drugs	6 (5.3)	1 (0.9)	7 (6.2)
Prompt attention	4 (3.6)	8 (7.1)	12 (10.7)
The health center is close to my house	5 (4.5)	13 (11.6)	18 (16.1)
Health services is cheap and affordable	22 (19.6)	4 (3.6)	26 (23.2)
No reason	-	8 (7.1)	8 (7.1)
Other reasons	-	5 (4.5)	5(4.5)
Total	**66 (58.9)**	**46 (41.1)**	**112 (100)**
Type of illness that warranted treatment			
Malaria	41 (36.6)	29 (25.9)	70 (62.5)
Typhoid fever	9 (8.0)	9 (8.0)	18 (16.0)
Surgery or operation	8 (7.1)	1 (0.9)	9 (8.0)
HIV/AIDS	-	3 (2.7)	3 (2.7)
Pregnancy (antenatal or post-natal visit)	4 (3.6)	4 (3.6)	8 (7.1))
Others	4 (3.6)	-	4 (3.6)
Total	**66 (58.9)**	**46 (41.1)**	**112 (100)**
Number of visits to choice of health facility for treatment in the last 12 months			
Once	18 (16.1)	26 (23.2)	44 (39.3)
Twice	20 (17.8)	7 (6.3)	27 (24.1)
Thrice	12 (10.7)	10 (8.9)	22 (19.6)
Four times	12 (10.7)	2 (1.8)	14 (12.5)
Five times	3 (2.7)	1 (0.9)	4 (3.6)
Six times and above	1 (0.9)	-	1 (0.9)
Total	**66 (58.9)**	**46 (41.1)**	**112 (100)**
Asked to pay for services rendered			
Yes	22 (19.6)	46 (41.1)	68 (60.7)
No	44 (39.3)	-	44 (39.3)
Total	**66 (58.9)**	**46 (41.1)**	**112 (100)**
Amount payed for services rendered			
Less than 1000 naira	7 (10.3)	-	7 (10.3)
1,500-3,000 naira	11 (16.2)	9 (13.2)	20 (29.4)
4,000-9,000 naira	-	19 (27.9)	19 (27.9)
10,000-20,000 naira	1 (1.5)	11 (16.2)	12 (17.6)
≥ 21,000	3 (4.4)	7 (10.3)	10 (14.7)
Total	**22 (32.4)**	**46 (67.6)**	**68 (100)**
Rating of cost of treatment			
High	4 (5.9)	13 (19.1)	17 (25.0)
Low	4 (5.9)	7 (10.30	11 (16.2)
Average	14 (20.6)	26 (38.2)	40 (58.8)
Total	**22 (32.4)**	**46 (67.6)**	**68 (100)**

Results from table 4 showed a considerable level of utilization of maternal health services among female respondents where 24 (28.6%) reported to have given birth in the hospital/clinic 20 (83.3%) in the last 12 months. Most respondents reported that a train health worker 21 (87.5%) assisted them during the delivery process. This was reported higher among the insured than the uninsured (Table 4). Eight out of twenty-four respondents said they were asked to pay for services rendered. This was only among the uninsured. Amount ranging from 2,000 to 10,000 naira was reported to have been payed for health services received among the uninsured. Five out (62.5%) of the eight respondents stated that the cost of treatment was

average from their own perspective. About 66 respondents reported to have attended antenatal and post-natal care (Table 4).

Table 4: Utilization of maternal health services among female respondents

VARIABLES	FREQUENCY (PERCENTAGES)		
Given birth in the last 12 months	**Insured**	**Uninsured**	**Total**
Yes	12 (14.3)	12 (14.3)	24 (28.6)
No	17 (20.2)	43 (51.2)	60 (71.4)
Total	**29 (34.5)**	**55 (65.5)**	**84 (100)**
Place of delivery			
Hospital/health center/clinic	12 (50.0)	8 (33.3)	20 (83.3)
Herbalist/Traditional healer	-	-	-
At my home/resident	-	4 (16.7)	4 (16.7)
Total	**12 (50.0)**	**12 (50.0)**	**24 (100)**
Assisted by who during delivery process			
Trained health worker	12 (50.0)	9 (37.5)	21 (87.5)
Traditional birth attendants (TBAs)	-	2 (8.3)	2 (8.3)
Family member/friend	-	1 (4.2)	1 (4.2)
Total	**12 (50.0)**	**12 (50.0)**	**24 (100)**
Asked to pay any money for hospital bills			
Yes	-	8 (33.3)	8 (33.3)
No	12 (50.0)	4 (16.7)	16 (66.7)
Total	**12 (50.0)**	**12 (50.0)**	**24 (100)**
Amount payed for services			
Less than 1000 naira	-	-	-
2,000-5,000 naira	-	4 (50.0)	4 (50.0)
6,000-10,000 naira	-	4 (50.0)	4 (50.0)
Total	**-**	**8 (100)**	**8 (100)**
Rating of cost of treatment			
High	**-**	**1 (12.5)**	**1 (12.5)**
Low	**-**	**2 (25.0)**	**2 (25.0)**
Average	**-**	**5 (62.5)**	**5 (62.5)**
Total	**-**	**8 (100)**	**8 (100)**
Ever attend antenatal care			
Yes	33 (50.0)	33 (50.0)	66 (100)
No	-	-	-
Total	**33 (50.0)**	**33 (50.0)**	**66 (100)**
Ever attend post-natal care			
Yes	33 (50.0)	33 (50.0)	66 (100)
No	-	-	-
Total	**33 (50.0)**	**33 (50.0)**	**66 (100)**

Findings from table 5 revealed that, about 108 (54.0%) respondents agreed that the quality of health care services rendered was better than before while, 77 (38.5%) respondents felt the quality of health services is the same as before. Only 15 (7.5%) respondents said that health services rendered is worse than before. However, while most of the enrollees or insured 52 (28.0%) rated health services better than before, most of the uninsured 66 (33.0%) rated

health services same as before. Areas that have undergone notable improvement according to the insured includes availability of essential drugs 53 (28.6%), waiting time 36 (19.4%) and attitude of health worker 29 (15.7%). The uninsured on the other hand, said that areas such as waiting time 69 (41.8%), availability of essential drugs 27 (16.4%), attitude of health workers 23 (13.9%) are still the same as before. Cost of treatment 49 (46.2%) and availability of essential drugs 31 (29.2%) were rated worse than before among the uninsured and insured respectively. A larger proportion of the respondents 72.0% indicated that they were either very satisfied or satisfied with the performance of the scheme; while, 28.0% indicated that they were very dissatisfied or dissatisfied with the performance of the scheme. However, most respondents recommended that the scheme should be reformed 49 (87.5%). Others said the scheme should be dumped. Out of 74 enrollees, 68 expressed their wish to continue to be a member of the scheme in order to enjoy free and easy access to quality health services.

Table 5: Perception of health care consumers towards the scheme and services delivery

VARIABLES	**FREQUENCY (PERCENTAGES)**		
Assessment of the quality of health services	**Insured**	**Uninsured**	**Total**
Same as before	11 (5.5)	66 (33.0)	77 (38.5)
Better than before	56 (28.0)	52 (26.0)	108 (54.0)
Worse than before	7 (3.5)	8 (4.0)	15 (7.5)
Total	**74 (37.0)**	**126 (63.0)**	**200(100)**
Health services that has improved			
Waiting time	12 (6.4)	24 (13.0)	36 (19.4)
Availability of essential drugs	20 (10.8)	33 (17.8)	53 (28.6)
Cost of treatment	16 (8.6)	10 (5.4)	26 (14.0)
Attitude of health workers	9 (4.9)	20(10.8)	29 (15.7)
Availability of laboratory services	6 (3.2)	14 (7.6)	20 (10.8)
Privacy during medical examination	4 (2.2)	12 (6.4)	16 (8.6)
Others	-	5 (2.7)	5 (2.7)
Total	**67 (36.2)**	**118 (63.8)**	**185 (100)**
Health services that is same as before			
Waiting time	38 (23.0)	31 (18.8)	69 (41.8)
Availability of essential drugs	13 (7.9)	14 (8.5)	27 (16.4)
Cost of treatment	5 (3.0)	18 (10.9)	23 (13.0)
Attitude of health workers	9 (5.4)	14 (8.5)	23 (13.0)
Availability of laboratory services	-	13 (7.9)	13 (7.9)
Privacy during medical examination	-	8 (4.8)	8 (4.8)
Others	-	2 (1.2)	2 (1.2)
Total	**65 (39.4)**	**100 (60.6)**	**165 (100)**
Health services that is worse than before			
Waiting time	3 (2.8)	9 (8.5)	12 (11.3)
Availability of essential drugs	22 (20.7)	9 (8.5)	31 (29.2)
Cost of treatment	10 (9.4)	39 (36.8)	49 (46.2)
Attitude of health workers	2 (1.8)	7 (6.6)	9 (8.5)
Availability of laboratory services	-	5 (4.7)	5 (4.7)
Privacy during medical examination	-	-	-
Others	-	-	-
Total	**37 (34.9)**	**69 (65.1)**	**106 (100)**
Assessment of NHIS performance			
Satisfactory	48 (24.0)	49 (24.5)	97 (48.5)
Very satisfactory	6 (3.0)	41 (20.5)	47 (23.5)

Dissatisfactory	16 (8.0)	23 (11.5)	39 (19.5)
Very dissatisfactory	4 (2.0)	13 (6.5)	17 (8.5)
Total	**74 (37.0)**	**126 (63.0)**	**200 (100)**
Opinion based on dissatisfaction with the scheme's performamce			
Dumped	3 (5.4)	4 (7.1)	7 (12.5)
Reformed	44 (78.5)	5 (8.9)	49 (87.5)
Left as it is	-	-	-
Total	**47 (83.9)**	**9 (16.0)**	**56 (100)**
Wish to continue to be a member of the scheme			
Yes	68 (91.9)	-	68 (91.9)
No	6 (8.1)	-	6 (8.1)
Total	**74 (100)**	**-**	**74 (100)**

4.0 Discussion

Majority of the respondents in this study were within the age group of 25-34 years. However, a greater proportion of the insured (8.5%) and uninsured (19.0%) are within the age group of 30-34 years. This finding is comparable to a study carried out in Ghana where majority of the respondents were within the age group of 18-35 years but the greater proportion of the insured (18.8%) and the uninsured (8.4%) are within the age groups of 18-24 years and 25-29 years respectively which is not consistent with the present study (Gobah & Liang, 2011). More than half of the respondents were males (58.0%) while female respondents constituted 42.0%. This may be attributed to the fact that respondents during the household survey were predominantly males since the head of every household was the targeted respondents during the survey. In the African context, the man is the head of every household and this may also probably account for higher males than females in this study. However, more males enrollees than female enrollees were reported in this study (Table 1). Respondents who had attained tertiary level of education were reported highest 60.5% as compared to others who had primary (6.0%) and secondary (335%) education. However, a greater proportion of the respondents with tertiary level of education (29.5%) were insured as compared to those with primary (2.0%) and secondary (5.5%) education who were equally insured. This finding conforms to that of Goban et al (2011). Individuals with tertiary level of education tend to be more aware of the benefits of the scheme than those with primary and secondary level of education who are relegated due to lack of awareness and importance of the scheme. A reasonable proportion of the respondents were civil servants (39.5%) which constituted the formal sector of Nigerian's economy and they tend to record a higher number of enrollees (21.0%) in the scheme than the others in the informal sector (Table 1). This may be attributed to the fact that the Nigerian government kicked-off the scheme with federal government workers by deducting 10% from their monthly salary to pay for premium contributions. This study is similarly reported in Oyo state, Nigeria where majority of the respondents insured were workers in civil services (Sanusi & Awe, 2009).

A high level of awareness was recorded in this study as 89% of the respondents reported to have heard of NHIS largely through the electronic media (Radio/TV) (37.5%). Other sources of information on NHIS were health workers (32.5%) and managers of the scheme (22.0%). This finding substantiate that of Gobah et al (2011), where 99.1% were aware of the scheme and 47.9% reported to have heard of it through the electronic media. Most times, the media is reported to be the fastest, cheapest and easiest means of passing a piece of information to a conglomerate of audience. However, it should be used to reach others who seem to be less aware of the scheme. Notably, only 4.5% of the insured heard of the scheme from the media; whereas, a larger proportion of the insured heard of the scheme from health

workers (20.5%) and managers of the scheme (10.0%). About 33.0% of the uninsured heard about NHIS through the electronic media. This certifies the relevancy of the media to increase awareness about NHIS especially among non-government workers. Health care providers and the scheme management could also assist to increase awareness about the scheme by reaching out to clients in their respectively health facilities when they come for health services. Out of 89.0% who claimed to be aware of NHIS, only 37.0% respondents reported to have registered with the scheme. Reasons for enrolment by the insured were largely that health services under NHIS are cost-effective (59.5%) and provision of free access to medical services (24.3%). The greater percentage of the respondents 63.0% which constitute the uninsured clearly indicated that inadequate information on the scheme (57.1%), lack of proper awareness (17.5%), lack of trust on the organizers (11.1%) and unable to afford premium charges (5.5%) were major reasons they did not enroll in the scheme. The government in collaboration with other relevant stakeholders should intensify awareness of the scheme to increase membership and access to quality health care among Nigerians. This also calls for strengthening of the exemption policy especially for the poor and vulnerable to ensure equity in access to health services which is one of the mandates of the NHIS. Issuance of identity cards (66.0%) was reported to be a major barrier to enrolment especially among the uninsured (44.4%). Systematic and administrative review in the issuance of identity cards to enrollees should be enforced by the scheme management. According to Carrin et al (2005), integrity and competence of managers of the scheme may have an effect on enrolment.

The scheme had positive impact on health seeking behaviour and utilization of maternal health services. Among respondents who had received treatment from ill-health or injury within the last 12 months, those enrolled in NHIS were twice as likely to have sought care from a government hospital (42.8%) where quality health care is rendered and health care providers show friendly attitude towards their clients (25.9%). This finding corroborates a survey carried out by the Research and Development Division of the Ghana Health Service in 2009. Malaria (62.5%), Typhoid fever (16.1%) and pregnancy (antenatal or post-natal care) (10.7%) were the disease or health conditions that recorded highest among respondents who visited the hospital at least once for treatment. Individuals who are insured are more likely to visit the health facility frequently for treatment than the uninsured whom most times relegate to self-medication probably because of lack of funds to seek health care or transport to health facility. This could result in complication and poor health outcomes. Hence, enrolment is recognized as a significant determinant to access quality health care.

The study also showed that the scheme has the potential of reducing out-of-pocket payment at the point of service utilization. While most of the uninsured (41.1%) were asked to pay for service rendered at their choice of health facility, the insured on the other hand were less likely to pay for health services rendered. This finding suggests that NHIS has a significant influence on out-of-pocket expenditure and frequency of utilization of health services at health facilities covered under NHIS. It is argued that health insurance can make health care more accessible to a wider segment of the population and help reduce the huge expenditure on health without reducing quality (Ibiwoye & Adeleka, 2007). Hence, there is need to strengthen the existing workforce to meet the need of clients at all times. Indubitably, NHIS also has the potential to improve maternal and child health as the insured women in this study are more likely to deliver at a health facility and supervised by a trained health worker. In Cross River State, southern Nigeria, health care services is officially free for pregnant women and children-under five. This free access to health care has significantly reduced the out-of-pocket payment for hospital bills and has contributed to high attendance to antenatal and post-natal care. This finding is consistent with other literatures on health insurance scheme (Mensah et al, 2010; Shimles, 2010; Saksena et al, 2010; Nguyen et al, 2011; Chankova et al, 2009 and Chankova et al, 2008; Ghana Health Service, 2009).

More than half of the respondents (54.0%) rated the quality of health services "better than before". The proportion was reported more among the insured (38.0%) than the uninsured (26.0%). Thirty-eight percent rated the quality of health care services "same as before" largely among the uninsured (33.0%) than the insured (5.5%). A negligible percentage of the uninsured rated the quality of health services "worse than before". This finding revealed that enrollees have started enjoying the full benefit package of the scheme. This study substantiates that of Gobah et al (2011). Areas of health services that have experience notable improvement according to the insured includes; availability of essential drugs (28.6%), waiting time (19.4%) and attitude of health workers (15.7%). The uninsured on the other hand, highlighted areas of health services that are still the same as before which includes; waiting time (41.8%), availability of essential drugs (16.4%) and attitude of health workers (13.9%). Cost of treatment was largely rated "worse than before" among the uninsured. Out-of-pocket payment of health services is a major issue in the Nigerian health care system. Criel and Waelkens (2003), in their study noted that the perception of low quality health care in areas rated "same as before" and "worse than before" could serve as a barrier to enrolment and renewal of membership with the scheme.

About 72.0% respondents expressed their satisfaction with the performance of the scheme so far, but indicated that there is still room for improvement. The proportion of the respondents who said that they were either very dissatisfied (8.5%) or dissatisfied (19.5%) suggested that the scheme should be reformed (87.5%) while 12.5% said it should be dumped. However, a reasonable proportion of the insured declared their wish to continue their membership with the scheme in order to continue enjoying the free, affordable and easy access to quality health services. Only 8.1% said they wish to discontinue their membership probably because of low quality of health care. This finding is similarly reported in other studies within and outside Nigeria (Akande, Salaudeen, Babatunde, Durowade, Agbana, Olomofe and Albinuomo, 2012; Agba, 2010; Gobah et al, 2011). Wider coverage, improvement in health services, transparency and accountability and increase awareness were the suggestions given by respondents to improve the performance of the scheme.

5.0 Conclusion

National Health Insurance Scheme in Nigeria is unarguably an indispensible strategy for ameliorating the poor health indices of the country and reducing out-of-pocket expenditure for quality health care services. This study reported a high level of awareness among the insured and uninsured but enrolment into the scheme was slow. Hence, to enhance the achievement of Millennium Development Goal 4 and 5, the Nigerian government should ensure that some bottlenecks in the scheme are appropriately ratified to improve the rapid up-take of the scheme.

Recommendations

Based on the findings in this study, the following recommendations are made as follows;

1. The government in collaboration with relevant stakeholders should ensure optimal awareness and education on NHIS to all Nigerians. This will definitely trigger the increase in the number of enrollees.

2. The scheme should focus on quality improvement of health services to increase the satisfaction level of enrollees

3. The current NHIS policy should be reformed to gain a wider coverage and ensure equity in accessing health services especially among the poor and vulnerable populace.

4. Functional structures of arbitration should be established to constantly engage the scheme management, health care providers and enrollees in order to minimize mistrust and improve uptake and service delivery.

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