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National Health Insurance Scheme (NHIS) Services and Consumer Perception: A Study of Usmanu Danfodiyo University, Sokoto (UDUS), Nigeria

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Abstract:
The study investigated the perception of consumers on National Health Insurance scheme (NHIS) services at Usmanu Danfodiyo University, Sokoto (UDUS) Nigeria. The Population of this study is 976 (Nine hundred and seventy-six) academic staff, out of which 278 (two hundred and seventy-eight) were sampled, using stratified random sampling techniques. Structured questionnaire was administered to the respondents. It was found that, 99.3% of the respondents were cognizant of the scheme, but unfortunately majority of the staff had bad perception of NHIS services, which led to low enrollment of the scheme within the university. However, it has been recommended that, the NHIS authorities in charge of service provision within the university, should (as a matter of urgency) improve the quality through the introduction of National Mobile Health Insurance Program (NMHIP) it's a novel concept, that provides mobile networks operators the platform to register, select HMO and provider and choose payment option and plans, all on their mobile phone, and at their convenience. NHIS service providers should also intensify positive awareness campaign of their services, which will allow the consumers to get a good perceptual image about the services of NHIS, hence more enrollees in to the scheme.

Keywords: *Consumer, perception, National Health Insurance Scheme (NHIS), services, staff*

1. Introduction

The perception of consumers about the product is to a larger extent a factor that affect the usage and buying of any product. However, the extent to which product has been marketed is related to how effectively perception is developed. Of recent, firms are intensifying their efforts in marketing so as to capture customer attention and positive feelings of their minds (Dickenson,1994).

However, to get a background understanding on consumer perception on the National Health Insurance Scheme (NHIS). One mostlyunderstands that, Nigeria's ten-year plan for development and welfare (1946-56) incorporated the first attempt at planning for health services (Aderounmu 1992). Since 1st October 1960, succeeding Nigerian governments including both Civilian and Military have come up with the establishment of 2nd, 3rd and 4th National Development Plans all of which dedicated a section to addressing issues related to national health care system.

Today in Nigerian, the health system is into three categories: primary, secondary and tertiary health care. Health at the primary level is designed to take careof delivery mainly to the doorstep of the populace and act as the gatekeeper to the health care system. Existing studies suggested that heath care services to government officials, their dependents and students were supposed to be free before the advent of NHIS, while people in the community were expected to pay out of pocket (OOP). Hence, health insurance became highly important as a complementary or alternative source of health care financing, most especially in the in the developing world (McIntyre, 2007). More so, healthcare service has been implemented as part of health reform programs and strategies with the basic aim of providing effective and efficient health care deliveries for citizens, especially for the poor and vulnerable.

Also, Health insurance systems in many underdeveloped countries, especially in the African land, are still at their initial phases of execution with the main aim of capturing the whole population. Hence, Act 35 of 1999 established NHIS so as to provide Social Health Insurance (SHI) in Nigeria in which health care services of the contributors are paid for, from the joint contributed made by participants in the scheme (Aderounmu, 1992).

Consequently, encouraging and defending health is central not only to people's wellbeing but also to a continued financial and community development. In more than last 30 years ago, our Alma-Ata Pronouncement signatories, made it known that health for all would improve quality of life and global peace and security (WHO, 2010). The World Health Assembly resolution of 58.33 in 2005 equally stated that everyone should be opportune have to access health services, likewise, no one should find it difficult in doing so. Despite these efforts made, the goals are still far to the realization.

In many countries, nearly up to 11% of the population suffers this type of basic financial hardship each year, and up to 5% is forced into poverty. According to WHO (2010) statistics, about 150 million people live below financial standard annually, while 100 million live below poverty level. However, the sole aim of NHIS in Nigeria is provide health insurance so that insured persons and their dependents would be able to have access to good quality and cost-effective healthcare services (NHIS, 2005).

It is the specification of NHIS in the formal sector that contributions made by an insured person entitled him or herself, a spouse and 4 biological children whose age lies within 18 years to a defined health benefits package (NHIS, 2005). Despite these appreciable aims, evidences on ground still suggests that the scheme is still facing quiet a number of challenges. In this, enrollees' perception and satisfaction with the objectives of the scheme and operations are highly conflicting. Neither adequate nor proper effort were made to educate enrollees. Enrollees were equally not aware of their rights under the scheme.

Hence, this article valuates consumerperceptions on the services provided by NHIS in UsmanuDanfodiyo University, Sokoto.Understandingthe enrollee's perception on the provision of health service in the health insurance scheme so as to effectively monitor the process, and improve it is implementation becomes important.

2. Conceptual Framework

2.1. Concepts of Consumer Perception

In consumer behavior, perception is described not only to mean the organic usage of senses, but also the way in which stimuli relates and integrates in consumer. Although, there exists numerous definitions explaining perception from consumer behavior's point of view, event, or relation which may be designated as the percept (Walters et al, 1989). According to Walters et al.(1989), consumer perception is made up of a person who construes through the senses of something, event, or relation which may be designated as the percept. Van der Walt (1991) suggested that perception occurs when sensory receptors receive stimuli via the brain, code and categorize them and assign certain meanings to them, depending on the person's frame of reference. A person's frame of reference consists of all his previous held experiences, beliefs, likes, dislikes, prejudices, feelings and other psychological reactions of unknown origin. Consumer perception is identified by the color, shape, and taste of the product. It would be realized from the foregoing that the perception process has long been recognized as the most significant barrier to effective communication. It is at this juncture that the sender does or does not get through to the receiver (Aaker et al, 1987). By implication correct decoding of marketing information lies on the consumer's perception of the communication content.

A problem still with perception and related studies (Schiffman et al., 1999) is that two individuals may be subjected to the same stimuli under a clear same condition, but how they recognize, select, organize and interpret them is a highly individual process based on each person's own needs, values, expectations and others. More so, individuals act and react on the basis of their perceptions, not on the basis of objective reality. Holding this assumption, it is important for marketers understand the whole view of perception and its related concepts so that they can be more ready to determine what influences consumers to buy.

The perception process is however not simple due to the chances that an individual may be encouraged below their level of conscious awareness (known as subliminal perception). This suggests that one can unconsciously perceive the stimuli. A certain amount of indecision is equally experienced by an individual as at when a purchase decision is being made and this limits their capacity to consider all the various forms of information obtainable at that point in time. Hence, a selective perception (i.e., a situation where potential customers are faced to make decision with what their knowledge capacity can handle among the available information about the product, by paying selective attention and then interpret them to be in line with their previously held beliefs and attitudes) becomes the only alternative. Only messages aligning with the held beliefs are retained.

2.2. National Health Insurance Scheme

Among the reforms of government in the health sector were to improve efficiency in health care markets and cover the poor who have previously been marginalized (Sanusi& Awe, 2009). These efforts were justified with a record which shows that government in several African and Asian countries in 1990, have spent not up to $10 of their per capital income while U.S.A government have spent not less than $2,700 of their per capital on health (Adesina, 2009). As a result of this, the ability of government especially in the developing nations, to implement their health policies, strategies, programmes and projects has been greatly affected.

This chronic underfunding of the health sector makes it increasingly difficult for the public sector to provide health services for its populace in most part of the developing nations (Carrin et al., 2011). The success of the MDGs is also becoming bleak due to inadequate funding. Health sector in Nigeria is principally financed by the government leading to limited access to healthcare (Sanusi& Awe, 2009; Okoro, Ohagwu&Njoku 2010).

The government is faced with various challenges such as a stagnant mono-cultural economy that depends on crude oil as a single export commodity (if not for recent development in the agricultural sector), a rapid population growth, political instability and high rate of unemployment (Adesina, 2009). Hence, the government cannot afford to commit enough money to the health sector which is now faced with the consequence of underfunding decreased efficiency, decreased quality/quantity of service, diminished confidence in public sector health facilities and poor maintenance of equipment. NHIS was established by Decree 35 of 1999, thereby creating a new frontier of healthcare financing in Nigeria. This became a major breakthrough in healthcare administration in the country.

Until then, funding of the sector in Nigeria had been grossly inadequate (Ijeomah. 2005). The scheme, which is a social security system is designed to deliver to healthcare services to all Nigerians at a reasonable price via numerous prepayment systems (NHIS, 2010). Under the scheme, 15% of the contributors' basic salaries are deducted at source and paid to NHIS. The establishment of NHIS in Nigeria since 2005 has significantly contributed to the healthcare development in the country.

The scheme was designed to deliver the following benefits (among others) to healthcare consumers in Nigeria: (1) Easy access to healthcare (2) reduction in healthcare financing burden, (3) high standards of healthcare delivery (3) efficient care delivery, (4) spread of healthcare facilities in Nigeria.

2.3. How the Scheme Operates in Nigeria

There are five major stakeholders in the scheme which include: 1) The Employer 2) Employee, 3) Primary Health Care Providers (Primary and Secondary), 4) Health Maintenance Organizations (HMOs) and 5) Government Agency (NHIS) (Regulator of the scheme). For the contributors to partake in the scheme, they would need to get registered with any of the NHIS approved HMO and then register with a primary healthcare provider (PHP) they like among the registered and approved ones by HMO. The contributor and his/her dependents are issued ID cards on registration. In the event of sickness, he presents to his chosen Primary Care Provider (PCP) with his ID card.

It is the right of a contributor if wished to change his PCP after a minimum of six months if he is not satisfied with the services there (Adesina, 2009). A contribution made by the insured person accommodates husband and wife, together with their four children under the age of 18years to full health benefits (Osungbade, Obembi&Oludoyi 2014). However, students in school up to the age of 25 years qualify as dependents. Extra contribution will be required for additional dependents. Contribution to be made by formal sector employees for health benefits under the scheme will be 15% of wages, the payment of which will be by both the employer and employee.

The employee pays 5% while the employer pays the remaining 10%. The employee's part of the contribution is deducted from his pay with the employer adding the remaining and forwarding the total payment to the appropriate quarters - (HMO and NHIS). The execution of the scheme was meant to be in phases to cover all Nigerians as follows: (i) Employers in the formal sector (Public and Private). In the private sector their contributions will be paid by their employers and those in public sector by the Federal, State, and Local Government Parastatals, Ministries and Agencies as appropriate, (ii) Self-employed persons (market women, traders, artisans, farmers, business men etc.). They will be encouraged to pay their contributions either by themselves or through co-operative bodies formed by them, (iii) Employers of labour with ten or more workers in their establishment are to subscribe to the scheme and make contributions for their employees as aforementioned, (iv) Rural dwellers- This group will enjoy suitably tailored programmes designed for them which will be implemented in consultations with various organizations like banks, co-operatives, donor agencies, NGOs, local, state and federal governments,(v) Vulnerable groups which include the unemployed, the aged, the disabled, the street children, retarded children and retirees. Their contribution is expected to be made by the Federal, State, and Local governments, NGO, local communities and philanthropists. The implementation of this coverage plan is however expected to be in phases. As it is today, only the employees of Federal Government ministries, agencies, and staff of the Nigerian Police Force, Nigerian Army and employees of the organized private sector enjoy the scheme in Nigeria. Usmanu Danfodiyo University Sokoto being a Federal Government ministry started registering the employees in 2010 following the NHIS, Decree No. 35 of 1999. This covers both senior and junior workers.

4. Empirical Evidence on the Perception of Nhisin Nigeria

Researchers conducted by Iyabode et al.(2017), Olawumi et al.(2005),Osuorji(2015),Philip and Alexander(2014) revealed that in some part of Nigeria respondents perceived NHIS as a means to improve their health, some of them perceived NHIS as being capable of providing prescribed drugs. However, some respondents preferred to be given monthly medical allowance to take care of their health and that of their dependents than receiving treatment under NHIS services. Philip and Alexander (2014) also claim that 10% of the respondents were of the opinion that the scheme is unable to improve the healthcare delivery in the country. There is an abuse by the insured the high attendance and perceived service abuse by the insured had led to an increased workload for providers.

Some researches criticize NHIS. Accordingto Onuekwusi et al.(1998),FMOH (2011) and Soyibo(2005), Nigerian healthcare professionals who are major stake holders in the programme have grossly inadequate knowledge of the rudimentary principle of the operation of a social health insurance scheme, some researched reported 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. This indicates that people have little hope in the programme.

A survey of Primary Health Care (PHC) facilities, for instance, shows that only a quarter of health facilities had >50% of the minimum equipment package, and up to 40% of the facilities had less than a quarter (Adeniyi, 2001). These facts were corroborated by findings of a study in rural Osun in South Western Nigeria conducted by Oyekale and Eluwa (2009), where the general ratings of the conditions of health facilities were found to be very poor. This is represented by the country's very low health indicators when compared with other less endowed African countries, resulting from the systems' perennial inability to sufficiently meet the increasing demand for health care (FMOH, 2009).

5. Methodology

5.1. Study Area

The location of Sokoto State is found on the Northwestern Nigeria. The State was created from Old North- western in 1976; it assumed its present form after the creation of Kebbi State (in 1991) and Zamfara State (in 1996) It is bounded by Zamfara State to the South, Kebbi state to the west, Katsina State to the east and Niger Republic to the north. The State has 23 Local Governments with Sokoto Metropolis being the capital, and the capital comprises of the Sokoto North, Sokoto South and some part of Dange Shuni, Kware and Wammako Local Government Areas.

It is mainly composed of people who are Hausa/Fulani; others are Zabarmawa, and other various tribes from different parts of the country while Islam is the predominant religion. The vegetation is that of Savannah zone with grassland suitable for the cultivation of grains and animal husbandry. The people are mainly farmers. However, some engage in art work like shoe making, tanning, dying and other various kinds of trading. The university, 'Usmanu Danfodiyo University, Sokoto' was formerly known as University of Sokoto. It is one out of the 4 Universities that were created in September 1975 by the FGN.

Its development started at temporary site called City Campus with the commencement of the classes on the 20th October, 1977. The class started with 93 undergraduate students pursuing Bachelor of degrees in various fields such as Arts, Science Education and Science with 33 academic staff. Progressively, by January, 1978, 102 students have applied for a two-year pre-Degree Programme in the faculty of Humanities and Basics Sciences. With this modest beginning, the University officially graduated 72 students in its first convocation which took place in November 22nd, 1980. Currently, the university is blessed with thirteen faculties and one postgraduate school. The above faculties have various departments and units under them. The following table gives the distribution of the various departments and units in the university.

Faculty	Departments and Units	Lecturer
Agriculture	Animal Sciences, Soil Sciences, Crop Science, Fishery, Forestry	51
Art and Islamic Studies	Arabic, English, French, Islamic Studies, Nigerian Languages, Modern European Languages and Linguistic.	130
Basic Medical Sciences	Anatomy, Biochemistry, Chemical Pathology, Microbiology, Hematology, Physiology and Pharmacology.	78
Clinical Sciences	Community Health, Medicine, Nursing Sciences, Obstetrics and Gynecology, Pediatric, Psychiatric, Radiology, Radiography, Surgery	125
Education and Extension Service	Adult Education and Extension Services, Curriculum Studies and Educational Technology, Educational Foundations, Science and Vocational Education.	71
Engineering	Civil Engineering, Mechanical Engineering and Electrical	24
Law	Public Law and Jurisprudence, Islamic Law, Private and Business.	26
Management Sciences	Accounting, Business Administration and Public Administration	47
Medical Laboratory Sciences	Chemical Pathology, Hematology, Histopathology, Immunology and Microbiology	56
Pharmacy	Pharmacognosy and Ethical Medicine, Pharmacy and Toxicology, Pharmaceutics and Pharmacy Microbiology, Pharmaceutics and Medicine Chemistry, Clinical Pharmacy and Pharmacy Practice	69
Science	Applied Chemistry, Biochemistry, Biology, Pure Chemistry, Microbiology, Geology, Physics, Mathematics, Computer Science, Statistics.	175
Social Sciences	Economics, Geography, Political Sciences and Sociology	74
Veterinary Medicine	Anatomy, Biochemistry, Medicine, Microbiology, Pathology, Parasitology, Pharmacology, Physiology, Public Health, Theriogenology, Surgery and Radiology	50
Total		976

Table 3.1: Distribution by Faculties, Departments and Number of Lecturers
Establishment Unit, UDUS, 2020

5.2. Population, Sample Size and Sample Frame of the Study

The population comprised of Academic Staff Union members of UsmanuDanfodiyo University Sokoto, Nigeria, that are on ground during the study period. Lecturer that are on Study Leave and Non-Academic Staff member were also excluded from this study. Therefore, the population of the study is 976 members of academic staff as at February 2020. Structured questionnaire was administered to;

Sample Size:The minimum sample size was determined using the formula

$n = \frac{z^2pq}{d^2}$(Ibrahim, 2009) where:

n= Minimum sample size
z= Standard normal deviate at 95% confidence interval= 1.96
p= Prevalence
d= Precision expected at 95% confidence limit (0.05) precision of tolerable alpha Error.

An outpatient baseline user's utilization and satisfaction survey conducted in some selected NHIS accredited healthcare providers in the Northwest geopolitical region of the country in 2008 (NHIS, 2008) showed that 65% of the findings are said to be accurate. Therefore, with this information the size of the sample of the clients was determined using the same formula as follows:

Proportion of clients that are very satisfied = 65% (0.65)
Proportion of clients that are not very satisfied = 35% (0.35)
The population at large was > 10,000.

$q = 1 - p(1 - 0.65) = 0.35$

From $n = \frac{z^2pq}{d^2}$

$n = \frac{(1.96)2\times (0.65) \times (0.35)}{(0.05)^2}$ Therefore n= 349.5 ≈ 350

Allowing for 10% non-respondent rate the optimum sample size will be n/RR (Ibrahim, 2009)where n=350, RR=90% (0.9) this gives 350/0.9= 388.8 ≈ 389.

Therefore, since the total population is less than 10,000 the study applies following formula

$$Np = \frac{n}{1 + \left({}^{n}/_{N}\right)}$$

Where N = 976 (Number of Academic staff present during the study)
n= 389

$\frac{389}{1+\left({}^{389}/_{976}\right)} = 278$is the total number of the study sample size.

5.3. Sampling Frame

UsmanuDanfodiyo University Sokoto had a total of 13 faculties, with 976 Academic staff as at the time of this study. As a result, proportional allocation was adopted in the selection of the respondents (sample unit) from the sample frame. That is

$$\frac{Number of Lecturers in each faculties}{Total Number of Lecturers} \times SampleSize$$

For example: Using Faculty of Management Sciences with 47 Lecturers, we have$\frac{47}{976} \times 278 = 13$lecturers that were chosen at random. The same formular will apply to other faculties.

6. Discussion of Results

Variables	**n (%)**
Age (Years)	
20-29	12(4.3)
30-39	84(12.9)
40-49	104(37.4)
50-59	36(30.2)
≥60	42(15.2)
Mean Age= 28.6, ±7.03	
Sex	
Male	268(96)
Female	10(4)
Marital status	
Single	20(7.1)
Married	256(92.1)
Separated	2(0.8)
Family size	
Less than 5	80(28.8)
5-10	88(31.7)
11-20	28(10.1)
21 above	82(29.4)
Highest qualification	
Degree	40(14)
Masters	108(39)
PhD	132(47)

Table 1: Socio-Demographic Profile of Respondents
Source: Field Survey, 2020

A total of 278 questionnaires were distributed to the sampled respondents, 271questionnaires were returned. Table 4.1 shows that (37.4%) of respondents were between age range 40-49 years, 96% were male and 92.1% have married 31.7% reported having 5 to 10 children. Out of 271 eligible participants, 132 (47%) had PhD as their highest qualification,

Variable	n(%)
Respondent awareness of NHIS	
Yes	276 (99.3)
No	2 (0.7)
Source of Information	
Friends/Relatives	148 (53)
Newspaper	20 (7.2)
Workshop/seminars	12 (4.3)
Doctors/Hospital	52 (18.7)
Working place	46 (16.8)
Enrollment	
Yes	136 (48.9)
No	142 (51.1)
Place of enrollment	
Specialist Hospital Sokoto	19 (13.9)
UsmanuDanfodiyo University Sokoto Clinic	81 (59.6)
UDUTH, Sokoto	36 (26.5)

Table 2: Respondent's Awareness and Enrollment into NHIS
Source: Field Survey, 2020

Table 4.2 contains data on enrollees' awareness of NHIS, majority 270 (99.3%) were aware of the scheme and the commonest source of this information is through friends and relatives probably those that are benefited from the services and almost half of the respondent do not enrolled into the scheme, those that enrolled accesses services 59.6% from the university clinic.

The level of awareness regarding the NHIS in this study was very high 99.3%. This is similar to study done by Sanusi and Awe (2009) to assess the awareness level of NHIS among healthcare consumers in Oyo state, the report shows that 65% of the respondents are aware of NHIS.

Variables	Agree	Disagree	Undecided	Total
Do you Consider NHIS service provides up to date medical services	120 (43.2)	136 (48.9)	22 (7.9)	278
NHIS has provided easy access to healthcare	92(33.1)	168(60.4)	18 (6.5)	278
I prefer NHIS services than the cash-and-carry system of healthcare	60(21.6)	200(71.9)	18(6.5)	278
Protect families from financial hardship of large medical bills.	52 (18.7)	220(79.1)	6 (2.2)	278
Total	356(32.01%)	724(65.11%)	32(2.88%)	1112

Table 3: Respondents Perception on NHIS Services
Source: Field Survey, 2020

From the table 3 above it can be seen that,48.9% of the respondents disagreed with the provision of up-to-date medical services for enrollees. This could be due to the fact that most of the services rendered to the respondents could not cover some of their prevailing ailments. 60.4% of the respondents equally disagreed that NHIS provide easy access to healthcare. This implies that the majority of the respondents find it highly difficult to access services through NHIS when compare to those who are ready to pay out of pocket.

However, a reasonable number of the respondents constituting 71.9% find it difficult to belief that NHIS is better than the cash and carry, 79.1% also disagrees that NHIS safeguard families from financial hardship of large medical bills. The reason arising from this could be that some essential and qualitative drugs were not made available for respondents on NHIS as at when situation demands which made them not to see it as what protect them from financial burden. The above investigation is nearly on the same page with the findings of Sanusi and Awe (2009) where about 72% of the respondents indicated that, healthcare personnel consume larger part of their time in attending to them when assessing health care services while 87% of respondents did not perceived any significant difference between the services provided under the cash and carry system and the NHIS

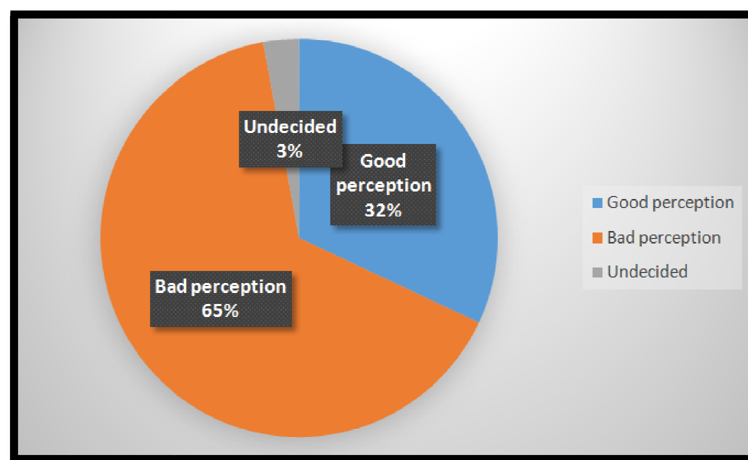

Figure 1: Pie Chart Showing Perception of Respondents on NHIS Services
Source: Field Survey, 2020

The perception of NHIS services was generally poor with 65% of the respondents having bad experience of the scheme. In this study,3% of the respondents did not know how the NHIS works. While, 32% have good perception of the scheme. This is somehow difference from finding of Iyabode et al. (2017) that found 51.4% had good knowledge while 48.6% had poor knowledge about NHIS program. Salawudden (2008), in Kaduna, found out that majority of the respondents 71.5% had good knowledge of what NHIS services.

7. Conclusion

The study of the perception of NHIS services in UDUS with academic staff strength of 976, sampled-out278 staff using stratified random sampling technique with a returned rate of 271 structured and self-administered questionnaire found out that 51.1% of the respondents did not enroll in the Nithi'sis likely as a result of the disagreement on issues of; up to date medical services, disagreement on easy access to health care, also that NHIS services is worse than cash and carry etc. Thus, this has led to 53% of the sample with poor perception of the scheme.

8. Recommendations

It has been recommended that, the NHIS authorities in charge of service provision within the university, should (as a matter of urgency) improve the quality through provision of up-to-date medical services, and easy access to health care. These would in a long way help the scheme (NHIS)to be more preferable when compare to cash and carry. The scheme should also be structured in a way to protect the families from financial hardship of large medical bills. Hence, NHIS services providers should intensify positive awareness campaign of their services, which will allow the consumers to have good perceptual image about their services, which will result to more enrollees into the scheme.

More so, all bottlenecks encountered in the registration process should be removed in order to fast track the registration of new and existing employees into the scheme, by introducing National Mobile Health Insurance Program (NMHIP). It'sa novel concept, that provides mobile networks operators with the platform to register, select HMO and provider as well as choose payment option and plans, all on their mobile phone, and at their convenience.

Also, the authorities concern should compulsion and enforce the enrolment into the scheme at the onset of recruitment process for all working Nigerians starting with those working in government establishments. This will improve our dismal health indices as most Nigerians will then have access to better healthcare services without the encumbrance of large out of pocket expenses.

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