Knowledge of National Health Insurance Scheme (NHIS) By Federal Civil Servants (FCSS) In Abuja Municipal Area Council (AMAC) Federal Capital Territory (FCT)

Michael Anene Agu[1*]& Ngwu, Dorathy Chinwe[2]
[1,2] Department of Human Kinetics and Health Education University of Nigeria Nsukka
* Corresponding Author

Abstract

The study investigated the knowledge of NHIS by federal civil servant in Abuja municipal area council of federal capital territory of Nigeria. A cross-sectional survey designed was employed. The population consisted of 2015 federal civil servant. Whereas 400 were drawn as sample using stratified random sampling techniques. Researchers designed instrument was used for data collection. Three research questions were formulated to guide the study and were answered using mean percentage. Two null hypotheses were postulated and tested at .05 level of significance using ANOVA statistic. The findings revealed that FCSs had very high level of this dimension of NHIS, FCSs did not differ in their level of knowledge of NHIS according to gender and FCSs differ in their level of knowledge of NHIS according to age. Recommendations were made among which include that NHIS and Ministry of Health should still embark on some more intensified public enlightenment efforts in other to improve the knowledge of NHIS by FCSs to a very high level. Institutions of higher learning should include, (and vigorously teach) NHIS in school curricula to get students acquainted with NHIS before graduation in order to carry it on throughout life.

Keywords: Knowledge, NHIS and Federal Civil servants.

Introduction

The sustainability and viability of a country's economic and social growth depend largely on vibrant healthcare sector of that nation. In Nigeria health care delivery system is characterized by weak response towards access to health care services for vulnerable members of the society, especially women and children. The knowledge of health insurance are now gaining wider popularity day by day among the nations of the word, especially third world countries whose heath care financing had hitherto, been adjured grossly inadequate (Afolayan-oloye, 2008). Health insurance as a health care financing mechanism has become a short-after approach to the problems of financing health care all over the world. The current concern with financing, and the specific interest in health insurance is often the result of parallel trend: the recognition of basic health care for all citizens as a right on the one hand, and the difficulties faced by government in developing and maintaining resource to provide health care through general taxation revenue on the other (Ron, 1993). The world Health Organization (who) has been giving tremendous support and cooperation to nation that pursues their citizen's welfare through health insurance. Nations equally are canceling large chunk of their budget to the attainment of good health for their people (kupferman, 1996).

In the United States of America (USA) and Canada, for example, one of the key political issues, according to Afolayan-Oloye (2008) has been how to achieve comprehensive health care for the populace through one form of health insurance or another. This, according to him, has always occupied the front burner in almost all electioneering campaigns. The citizens take the issue of health seriously and demand that politicians fulfil their promise in the respect. Health insurance, according to Agada Amada (2004) is assuming to status of a global phenomenon. It was first introduced in Germany in 1883 under General von Bismarck's old age and disability insurance scheme. Since then health insurance has continued to gain prominence in the other industrialized nations like France, United Kingdom and other nations. Developing countries has also have joined in beaming their health search light on health insurance. Prominent among them are Costa-Rica, Brazil, Bangladesh, china, india, Kuwait, Pakistan and Thailand. In Africa, it has been introduced in Egypt, Tanzania, Kenya, Ghana, South Africa and Zimbabwe (Hamza, 2001).

In Nigeria, as Afoloyan-Oloye (2008) maintained, the rising cost of medical care coupled with under-funding of the health care sector by government, consequent upon the severe down turn in the Nigeria economy in 1980s and 1990s resulted in the abysmally low patronage of the orthodox medical and other health care or health institutions. Most of these health institutions either down sized or closed down completely and the health practitioner's brain drained for greener pasture. Majority of the people, according to Afoloyan-oloye (2008) resorted to patronizing alternative health care practitioners, such as herbalist and the spiritualist. Mortality from common disease becomes the order of the day. In the face of a situation like this, the government has a critical role to provide and implement policies and programmes that can allow the development of a healthy citizenry. Since then, government has implemented various intervention designs. These include the Bamako initiative, user-fees and Drug Revolving fund for the achievement of easy access to quality care for the Nigerian people (Agada-Amade, 2004). After several committees and commissions, Federal Government approved the National Health Insurance Scheme (NHIS) in 1989. It was formally launched on October 15, 1997 and the decree was signed into law in May 1999. The Scheme was flagged off in Ija, Niger State in March 2002.

According to international labour organization (Il0, 1996) insurance, which is risk sharing or risk pooling may be defined as the reduction or elimination of the certain risk or loss for the individual or household by combining a larger number of similarly exposed individuals or households who are included in a common fund that makes good the loss caused to any one member. Health insurance is defined as protection against loss by disease, bodily injury or illness and other related health care needs (Karen, 2000). Health Insurance, according to Okezie (2002) refers to a system of a prepayment plan in which participants pay a regular amount of money which is then pooled to provide for those needing care. In the context of this study, health insurance refers to a mechanism in which people contribute some amount which is pooled and later utilized for members against unplanned and unaffordable expenditure for health care service in the event of illness. The nomenclature for this type of scheme in Nigeria is National Health Insurance Scheme (NHIS).

National health insurance scheme (NHIS) is an initiative or system of health care financing established under Act 35 or 1999 by the Federal Government of Nigeria to improve the health of all Nigerians at an affordable cost (NHIS Handbook, 2005). NHIS, according to Dogo (2007) is a social security system adopted by Nigerian Government to guarantee the provision of needed health services to persons on the payment of token contribution to the common pool, at regular interval. In the context of this study, NHIS is a system of health care financing introduced by Federal Government of Nigeria for addressing the problems of health care delivery which has affected by challenges. It can be seen as a typical public-private partnership in health care delivery in Nigeria. Its main goal is to enhance the health status of the citizens through provision of financial protection and customer satisfaction. The hope of the average Nigerian to have a reliable and affordable care delivery services has been brightened with the take-off of the long awaited NHIS (Dogo, 2005). It is non-profit in concept and contribution is based on the ability to pay (Mohammed, 2005). Federal government has introduced this scheme for its workers.

The main programmes of NHIS as enunciated in NHIS handbook (2005) include: formal Sector Social Health Insurance Programme which consists of Public Sector (Federal, State and Local Government). Armed forces, police and uniformed services, organized private sector, students of tertiary institutions and voluntary participants. Informal sector group is made up of rural community and urban self-employed, vulnerable group which consist of permanently disabled persons and the aged, children under five and prison inmates. Others consist of international travel health insurance, pregnant women and orphans, retirees and unemployed. In the components of the scheme, according to Dogo (2006), there is invariably something for everyone.

According to Hamza (2001), four principal types of health insurance are identified. These include: government or social health insurance which usually provides compulsory or to a lesser extent voluntary coverage for the people employed in the formal sector. Premium or contributions are generally based on the individual's income regardless of actual risk. NHIS falls under this type. Private Health insurance – this provides coverage for groups or individual through third party prayer institutions operating in the private sector. This type is practiced in the Germany and United States of America, alongside other health insurance. In this premium are charged based on an actual calculation of the incidence of diseases and the used services and not related to income. Employer-Based Health

insurance; this falls between the first two forms of insurance (Agada-Amada, 2004). Under this arrangement, employer, parastatals or private bodies serve as the third party or collection agent, with eligibility based on employment status. It is practiced in Taiwan (Monasch, 1998). Community – Based Health Insurance – this is organized locally by the community, with premium paid by households, covering both those in formal and non-formal employment. This type is practiced in Philipines (Ron and Kupferman, 1996).

Generally, health insurance has been seen as a way of allowing government to diversify the source of revenue for the health sector to improve efficiency by giving individuals some role in paying for their own health care and to spread the burden of health care cost over time and across a wider population, which will reduce risk. The existence of risk is the fundamental rational for insurance health care. Costs may be infrequent, but they are potentially very high, this means that without insurance, individuals may be unable to pay for health care even if they are willing to do so. The knowledge of this system of health care financing by the federal civil servant become necessary for their cooperation and sustainable support to the scheme. Federal civil servant are among the major stakeholders in NHIS programme and were selected for the study because they are from, and represent the thirty six states and the Federal Capital Territory, of the federation. Federal civil servants exhibit all characteristics found in Nigerian population and thus could be used to judge the whole population.

Knowledge, according to Winifred (1989) is accumulated facts, truth, principles and information to which human mind has access. Knowledge can be defined as the sum of conceptions, view and propositions which has been established and tested (Takenchi, 2004). In the context of this study, knowledge refers to the act of having adequate information and understanding of the concept, objective and operations of NHIS by federal civil servants as well as the benefits and responsibilities attached to it. The introduction of National Health Insurance Scheme (NHIS) as a health care financing mechanism should be welcome with enthusiasm and sense of relief by all stakeholders in the health care industry, especially federal civil servants in Abuja. Specific benefit of NHIS to enrolees include: easy access to efficient health care service at all time, protection from financial hardship of huge medical bills and affordable health services for all income groups.

Regrettably the emergence of NHIS seems not to garner the much expected acceptance support and cooperation from the civil servants. It appears that majority of them reject it out rightly, others are still reluctant to take a stand. They are all suspicious of governments' motive, intention and strategies especially when they realized that there will be monthly deductions from their salaries as their contribution into the 'solidarity pool' for running the scheme. Government on the other hand sees the need for implementing the scheme and had made frantic effort towards convincing the civil servants through series of activities, including dialoguing with the Nigerian Labour Congress (NLC). Despite such efforts, mutual suspicion, recrimination and subtle flexing of muscles are still palpable in both camps. This problem does not seem to be abated, but rather worsens day by day. This deadlock has created serious problem in Nigerian health delivery. Those who are supposed to bridge this gap has not been allowed to thrive. Some resort to patronizing alternative health care providers such as herbalists and spiritualists. Mortality from common diseases is still the order of the day. Thus, health care financing has become an intractable problem facing health sector in Nigeria despite the seeming foreseeable prospects of National Health Insurance Scheme.

The researchers see that this seemingly unwillingness to the scheme may be as a result of lack of knowledge of the scheme by federal civil servant in Abuja Municipal Area Council (AMAC). In search of solution to the above conflicting situation, the researchers, after identify the problem decided to engage in a study on knowledge of NHIS by federal civil servant in Abuja municipal area council. This is necessary since to the best knowledge of the researchers, the study will uncover the actual situation surrounding the knowledge of Federal Civil Servant (FCSs) regarding the scheme, beside the fact that such study has not been conducted in the area. It was therefore, against this backdrop that this study was directed at answering three research questions thus:

1. What is the civil servants level of knowledge of NHIS?
2. What is the difference between male and female federal civil servants level of knowledge of NHIS?
3. What is the difference in the level of knowledge of federal civil servant regarding NHIS according to age?

In addition, the study tested the following null hypotheses at .05 level of significance.

1. There is no significant difference in the level of knowledge of federal civil servants regarding NHIS according to gender.
2. There is no significant difference in the level of knowledge of federal civil servants regarding NHIS according to age.

Method

The cross-sectional survey research design was adopted for the study. The population of the study consisted of all the civil servants in Abuja Municipal Area Council (AMAC). The Yaro Yamen formula for sample size was employed to arrive at a sample size of 400 civil servants. The instrument for data collection was the researchers designed knowledge of National Health Insurance Scheme by Federal Civil Servants Questionnaire KNHIS. The instrument was validated by five experts in the department of Human Kinetics and Health education, University of Nigeria Nsukka. The reliability of KNHIS was established using split half method. A reliability coefficient of .84 was obtained and this was considered high enough. Ogbazi (1994) states that in a reliability test, if the correlation coefficient is up to .60 or above, the instrument is considered reliable. The copies of the questionnaire were distributed to the respondents in their individual offices. Data collected with KNHIS was analyzed using mean and percentages using Ashur's (1997).

Results

The results of this study are organized and presented in two parts thus: Data answering the research questions and data answering the hypothesis.

Table 1

Percentage of federal civil servants level of knowledge of NHIS (N = 360)

1.	CNHIS (Concept of National Health Insurance Scheme)	**369**	**73.1**
2.	ONHIS (Objectives of National Health Insurance Scheme)	369	82.3
3.	RONHIS (Role of National Health Insurance Scheme)	369	56.6
4.	RENHIS (Responsibilities of National Health Insurance Scheme)	369	58.4
5.	BENHIS (Benefits of National Health Insurance Scheme)	369	76.9

Criterion means score

40% = Low knowledge 41 – 59% = Average knowledge 60 – 80% = High Knowledge 81 and above = very High

The data in table 1 shoes the overall mean scores of FCSs level of knowledge of the various dimensions of NHIS as follows: CNHIS (73.1%) and BENHIS (76.9%) which fell between 60-80% indicating that FCSs had high level knowledge of these dimensions. Whereas in RONHIS (56.6%) and RENHIS (58.4%) it fell between 40-59 indicting that FCSs had average level knowledge of these two dimensions. The table further shows that FCSs had mean score on ONHIS (82'3%) which was above 80 per cent. This implies that FCSs had very high level of this dimension of NHIS.

Table 2

Percentage Analysis of Differences between Male and Female Federal Civil Servants in the Level of Knowledge of NHIS (n = 567)

S/N	Dimensions of knowledge of NHIS	Male (N = 205) X = 1%	Female (n = 164) X = 2%
1.	CNHIS	72.9	73.4
2.	ONHIS	82.3	82.3
3.	RONHIS	55.9	57.5
4.	RENHIS	58.9	57.7
5.	BNHIS77.1	76.6	
	Overall mean	**69.4**	**69.5**

The data in Table 2 shows that female FCSs had an overall mean (73.4 %) knowledge score on CNHIS which was slightly higher than that of males (72.9 %) which fall between 60 – 80%. This

implies that FCSs had high knowledge of CNHIS. On knowledge of ONHIS, female FCSs had overall mean score (82.3%) which was slightly higher than that of male FCSs (82.3%) which was above 80 per cent. This implies that both female and male FCSs had very high knowledge of ONHIS. The table further shows that female FCSs had overall mean score (57.5%) on RONHIS which was slightly higher than that of male FCSs (55.9%) which fell between 40-59 per cent. This implies that FCSs had average knowledge of RONHIS.

The table further shows that male FCSs (58.9%) had overall mean knowledge score on RENHIS which was slightly higher than that of female FCSs (57.7%) which fell between 40-59 per cent. This implies that FCSs had average knowledge of RENHIS. The data in the table also show that male FCSs had an overall mean knowledge score (77.1%) on BNHIS which was slightly higher than that of female FCSs (76.6%) which fell between 60-80 per cent. This implies that FCSs had high knowledge of BNHIS.

Table 3

Differences in the Level of Knowledge of Federal Civil Servants Regarding NHIS According to Age

S/N	Dimensions of knowledge	under 30 years (n1 = 69) X1	Decision	31-40 years (n2 = 145)X2	Decision	41-50 years (n3= 145)X3	Decision	51 and above (n4 = 145)X4	Decision
1.	CNHIS	65.24	High	71.97	High	76.98	High	80.2	Very high
2.	ONHIS	73.4	High	83.5	Very High	85.6	Very high	83.3	Very high
3.	RONHIS	53.6	Average	54.3	Average	63.2	High	48.98	Average
4.	RENHIS	43.5	Average	59.3	Average	63.96	High	64.6	High
5.	BNHIS	64.3	High	76.6	High	81.6	Very high	87.5	Very high

Table 3 shows that level of knowledge of FCSs under 30 years was average for RONHIS (50.6 %) and RENHIS (43.5 %); high for CNHIS (65.24%), ONHIS (73.40%) and BNHIS (64.30%) This implies that both female and male FCSs had very high knowledge of ONHIS. Those FCSs aged 31-40 years possessed average knowledge for RONHIS (54.3%) and BNHIS (59.30%), high for CNHIS (65.24%), ONHIS (73.40%) and BENHIS (64.6%) and very high level for ONHIS (85.6%), while those aged 41-50 years possessed high level of knowledge for CNHIS (76.98%), RONHIS (63.2%), RENHIS (63.96%) and very high level for ONHIS (85.6%) and BNHIS (81.6%). Those aged 50 years and above possessed high level of knowledge of RENHIS (64.6%) and very high level for CNHIS (80.2%), ONHIS (83.30%), BNHIS (87.5%) and average level of knowledge for RONHIS (48.98%).

Table 4

Result of t-Test Analysis Testing the Null Hypothesis of no Significant Difference in the Level of Knowledge of FCSs Regarding NHIS according to Gender

S/N	Dimensions of Knowledge	Male (n = 250) $SD1 \times 1$		Female (n = 164) SD2	X2	t – cal	df	P- value
1.	CNHIS	72.866	73.391	17.6097	21.2677	0.259	367	0.796**
2.	ONHIS	82.282	82.326	23.6918	25.6901	0.0719	367	0.986**
3.	RONHIS	55.940	57.526	31.9036	31.4118	0.478	367	0.633**
4.	RENHIS	58.864	57.726	30.8634	31.1447	0.351	367	0.726**
5.	BNHIS	77.078	76.634	28.7790	27.9223	0.149	367	0.88**
	Overall mean	69.406	69.520	26.5695	27.4873	0.261	367	0.80**

Table 4 shows the t – calculated values for CNHIS (t2 = 0.259, p = .790), ONHIS (t2 = 0.719, p = .986), RONHIS (t2 = 0.478, p = .633), RENHIS (t2 = 0.351, p = .726) and BNHIS (t2 = 0.261, p = .804) with their corresponding p- values which are greater than .05 level of significance at 367 degrees of freedom. The null hypothesis of no significance difference was therefore accepted. This implies that FCSs did not differ in their level of knowledge of NHIS according to gender.

Table 5
Result of ANOVA Analysis Testing the Null Hypothesis of no Significant Difference in the Level of Knowledge of FCSs Regarding NHIS Based on Age

S/N	dimensions of knowledge	sum of squares	mean score	df	mean score	F-cal	p
1.	CNHIS	Between groups	7929.854	3	2643.285	7.474	0.000*
		Within groups	129083.1	365	353.652		
2.	ONHIS	Between groups	7025.010	3	2341.670	3.974	0.008*
		Within groups	215058.1	365	365.589		
3.	RONHIS	Between groups	8545.437	3	2848.479	2.887	0..036*
		Within groups	360155.1	365	986.726		
4.	RENHIS	Between groups	20515.626	3	6838.542	7.518	0.000*
		Within groups	332032.2	365	909.677		
5.	BNHIS	Between groups	17338.572	3	5779.524	7.569	0.000*
		Within groups	278722.1	365	763.622		

*Significant
****** Not significant

Table five shows the F-calculated values for CNHIS (F- cal = 7.474, P = 0.000), ONHIS (F-cal = 3.974, P = 0.008), RONHIS (F- cal = 2.887, P = 0.036), RENHIS (F- cal = 7.518, P = 0.000) and BNHIS (F- cal = 7.569, P = 0.000) with their corresponding p- values which are less than .05 level of significance difference at 3 and 365 degrees of freedom. The null hypothesis of no significant difference was therefore, rejected. This implies that FCSs differ in their level of knowledge of NHIS according to age.

Discussion

The findings of the study showed that FCSs possess high level of knowledge of NHIS. This is not surprising because of level of public campaign mounted steadily by the scheme, especially for federal civil servants who are the major stakeholders in the formal sector programme of NHIS. FCSs are considered much educated and enlightened and as such could understand and embrace government programmes. The finding is remarkably higher than the findings of Hanaza (2001) which showed low level of knowledge of Sokoto state civil servants regarding NHIS. The finding is also not in agreement with that of Agada Amade (2004) revelation of low level of awareness of federal staff in Abuja regarding NHIS. The disparity in the findings of the three studies could be attributed to differences in the times and respondents of the studies. Many things and change could have taken place within 2001-2004 and now – the time of the present study which might have influenced the views of the respondents. The implication, however, is that FCSs still need more encouraging campaign and other efforts to move to higher level of knowledge of NHIS. On the other hand, the findings imply that with well-organized campaign, public education and sustained enlightenment are veritable tools for making people accept government programme and change in general.

Results of the study also showed that male and female FCSs both possessed high level of NHIS. The females, however, had slightly higher (69.5%) level of knowledge than males (69.4%) implying that FCSs do not differ in their level of knowledge according to gender. Similar findings were reported by Hamaza (2001) and Agada - Amade (2004) from their various studies of knowledge of civil servants. These findings are not surprising considering the fact that females are more sensitive, pay more attention to health matters (Kilpatrick, 2006). This finding may also be attributed to the effects of campaigns for women education, enlightenment and participation which are paying off handsomely. The implication is that females in Nigeria are catching up with their counterparts in almost all endeavours. Those campaign efforts should be sustained as our nation will be better.

The study also revealed that on the level of knowledge of NHIS among FCSs across age groups, 41-50 years had higher (74.26%), 51 years and above (72.92%), 31-40 years (69.11%) and under 30 years (60%) implying that FCSs differ significantly in their level on knowledge of NHIS according to age. The finding is in agreement with Hamza (2001) and Agada - Amade (2004) in their various studies, confirming that age was one of the demographic factors in the FCSs knowledge of

NHIS. The disparity, as Agada- Amade (2004) maintained could be attributed to the fact that older people gave more attention to health and health related matters than the under 40 years. The later were always busier about the pursuit for achievements and advancements and might not care much about health matters. Secondly, it may be imputed to level of intensity and appealing which NHIS enlightenment efforts impacted on this age group. The implication is that the under 40 years may not avail themselves much from the benefits of NHIS if more vigorous and aggressive campaign with this particular age-suited appeals, are not designed and mounted by the scheme and other NHIS stake holders (Okezie, 2001).

Conclusions

Based on the findings and discussions, it was concluded that:

1. Federal civil servants had higher level of NHIS.
2. Gender was not a significant factor in the level of knowledge of NHIS by FCSs.
3. Age played role in the level of knowledge of NHIS by FCSs.

Recommendations

Based on the conclusions, the following recommendations were made:

1. NHIS and Ministry of Health should still embark on more intensified public enlightenment efforts in other to improve the knowledge of NHIS by FCSs to a very high level.
2. Institutions of higher learning should include, (and vigorously teach) NHIS in school curricula to get students acquainted with NHIS before graduation in order to carry it on throughout life.

References

Afolayan-Oloye, B. A (2008). The implication of NHIS in the Universities of Nigeria. *Clinical Digest* 4 (4), 30-33 Abuja.

Agada-Amade, Y. A. (2004). Awareness of Health Insurance Model as a Health Financing Option among Health Workers and Civil Servants. (a case study of Abuja FCT). *Unpublished Master's thesis, University of Maiduguri, Maiduguri.*

Ashur, S. S (1997). *An evaluation plan for the development and up-dating of nutrition Curriculum at the upper elementary and preparatory levels in Jordan*. IVNS/UNESCO.

Dogo, M. (2005). *Contemporary issue in health insurance administration:* A paper presented At 2nd health care providers' workshop. Abuja.

Dogo, M. W. (2007). *Quality Assurance in the delivery of benefits to enrollees: the role of Health Maintenance Organization (HMOs)*. A paper presented at HMOs workshop. Abuja

Hamza, A. (2001). Knowledge/Awareness among civil servants in Sokoto State on National Health Insurance Scheme. *Unpublished master's thesis*, Amadu Bello University, Zaria.

Kupfeman, A. (1996). *A community health insurance scheme in Philippines: extension of Community based integrated project*. Geneva: WHO.

National Health Insurance Scheme (2005). Operational Guideline Abuja: Heritage Press Ltd. NHIS Handbook Abuja.

Ogbazi, J. N &Okpala (1994). *Writing research report, guide for researchers in education. The Social Science and Humanities.* Enugu, press time Ltd.

Okezie, A. U (2001). History and overview of the National Health Insurance Scheme. A paper presented at the 2nd Senior Staff Workshop: Abuja.

Ron, A & Kupferman (1998). Health Insurance in developing countries. The social security approach. Geneva. ILO.

Ron, V. (1993). Planning and Implementing Health Insurance in Developing Countries. Guideline and Case Studies. Geneva: WHO.