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Research Article

Knowledge, Acceptability, Enrollment, and willingness to support health insurance Program among traders in an Urban Community in Abia State

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Abstract

Background: The desire to provide equitable access to healthcare delivery in Nigeria led the Federal Government of Nigeria to introduce National Health Insurance Scheme (NHIS). For this program to succeed, there must be adequate knowledge, acceptability, enrollment, and willingness to support national health insurance program among the masses.

Objectives: To assess the knowledge and acceptability of health insurance among traders in Umuahia, Abia State, Nigeria. To assess their level of enrollment and suggested voluntary monetary contribution to a community-based health insurance program.

Methods: This study took place in Umuahia, the capital city of Abia State, Nigeria. A pre-tested interviewer-administered questionnaire was used to collect information on socio-demographic data and knowledge of health insurance from a group of traders selected by simple random sampling at an urban market. Following collection of data on baseline knowledge of health insurance, the Universal health coverage and Community-based health insurance schemes were explained to respondents and responses were obtained. Results were analyzed using SPSS Version 24.

Results: A total of 564 traders were interviewed out of which 39% were aware of national health insurance scheme. Amongst these group that are aware of the program, 68% knew about National Health Insurance scheme, while 27% were aware of only community-based health insurance. Only 5.3% of the traders were enrolled in a health insurance scheme. Following education and public enlightenment on universal health coverage and community-based health insurance, over 80% of respondents believed health insurance was beneficial to achieving universal health coverage. Overall, 83.5% of respondents would be willing to support a community-based health insurance scheme if introduced in their communities. The mean amount suggested by respondents as monthly contribution to a community health insurance was nine hundred and twenty naira (N920.00)

Conclusion: Awareness of health insurance, especially community health insurance is low. However, acceptability is high. It is imperative that greater awareness be created in communities to enhance enrollment. Government subsidies will also be necessary to ensure sustainability.

Keywords: Knowledge; Acceptability; Health Insurance; Traders; Umuahia

Introduction

The desire to provide equitable access to healthcare delivery in Nigeria led the Federal Government of Nigeria to introduce National Health Insurance Scheme (NHIS).

In most developing countries, particularly in Nigeria, there is a clear lack of universal coverage of health care, and little equity. Access to healthcare is severely limited in Nigeria [1]. Inabilities of the consumers to pay for the services, as well as the healthcare provision that is far from being equitable, have been identified among other factors to impose the limitation [2].

Financing of public health services in Nigeria has been through government subventions, funded mainly from earnings from petroleum exports and out of pocket payment for patients. Decline in funding for healthcare commenced after the mid 1980's following a drastic reduction in revenue from oil exports, mounting external debts burden, structural adjustment program and rapid population growth rate [3]. The result as in most other developing countries was a rapid decline in the quality and effectiveness of publicly provided healthcare services [3]. As a way out, the government of Nigeria launched the NHIS in June 2005 [4].

A social health insurance scheme involves contribution based on means and utilization based on need. A health insurance scheme has been defined as an arrangement in which contributions are made by or on behalf of individuals or groups to a purchasing institution (a fund) which is responsible for purchasing covered services from providers on behalf of the members of the scheme [5]. It is the believe of Nigerian government that the NHIS will probably solve the problem of inequality in the provision of healthcare services and help to improve the accessibility to healthcare [6]. Assessment of the program after four years of operation reveals less than 3% coverage of the Nigeria population [7]. The question now is, does NHIS lack public awareness or people's acceptance?

In earlier work [8] done to access the awareness and perception of NHIS among Nigerian healthcare professionals, it was reported that one year after the launching of the NHIS, Nigerian healthcare professionals who are major stake holders in the program have gross inadequate knowledge of the rudimentary principle of the operation of a social health insurance scheme [8]. There is no evidence that the story has changed today. In a related work done to assess the perception of NHIS among healthcare consumers, 65% of the respondents received treatment from registered healthcare providers under the NHIS program. However, respondents who have been treated under the program wanted the program discontinued. This indicates that people have little hope in the program [2].

It can be seen from the above stated that the problems with the implementation of NHIS does not only border on awareness but also on the perception of the sustainability of the program in line with the objectives of its initiation.

This study was conducted to assess the knowledge, acceptability, enrollment, and willingness to support health insurance program among traders in an urban community in Abia State, Southeast, Nigeria.

Materials and Methods

The study was conducted in Umuahia, Abia State. Abia State was created from the old Imo State, in the South-Eastern geopolitical zone of Nigeria on August 27th, 1991 [9]. It occupies a land mass of 3,935 km [2], with a population of 3.2 million people based on the 2006 national population census, with a growth rate of 3.2%. The people of Abia State are predominantly peasant farmers, civil servants, bankers, and traders.

This is a prospective cross-sectional study that targeted all the traders in Umuahia, Abia State, Southeast Nigeria. A 24 items questionnaire designed by the authors in line with the objectives of the study was used to collect data. A pre-tested interviewer-administered questionnaire was used to collect information on sociodemographic data and knowledge of health insurance from a total of 564 traders selected by simple random sampling at an Urban market in Umuahia. Following collection of data on baseline knowledge of health insurance, universal health coverage and community-based health insurance were explained to respondents and their responses obtained. The questionnaires were administered by the authors together with trained house offices who volunteered to help with the study. Five hundred and sixty-four questionnaires were distributed to the traders by direct issuance, and all the questionnaires were properly completed and returned giving a return rate of 100%. The traders were adults and youths in low and middle-income social classes. They compulsorily belonged to the state traders' union, which has 2244 registered members [10]. Only those aged between 25 years and 64 years who have been registered for 2 or more years in the market were selected for this study.

Data collected were analyzed with Statistical Package for Social Sciences (SPSS) version 22.0. Frequencies tables and percentages

were generated for all variables of interest. Chi Square test was used to compare variables, and for all analyses, a p-value < 0.05 was taken as statistically significant, and within a confidence interval of 95%.

Results

Table 1 shows the socio-demographic variable of the participants. Age-group 25 – 34 years (54.1%) constitute the greatest number of the participants while those aged 55-60 years (6.7%) were the least in number. Among the 564 participants, there were 65.4% males and 34.6% females giving a male: female ratio of 1.9:1. Three hundred and twenty (86.7%) men who participated in the study were bread winners, while 192 (98.5%) women who participated in the study were also bread winners in their homes. There were extra 3(1.5%) women that participated in the study who were not bread winners.

Concerning places for medical care, private hospitals played a major role caring for 248 (44%) participants while traditional/herbal healers were the least patronized with 8 (1.4%) participants (Table 1). Expert care 188 (33.3%) was the major reason for patronizing their choice of health facility while time 30 (5.3%) was the least reason.

The main mode of payment of medical bills was 'out of pocket expenditure' which was adopted by 524 (91.9%) participants, while only 10 participants used community-based health insurance scheme. Three hundred and ninety-three (69.6) participants patronized hospital facility while 174 (30.4%) patronize non-hospital facility (Table 1).

Variables		Frequency	Percentage (%)
Age group	25 -34 yrs	305	54.1
	35 - 44 yrs	150	26.6
	45 - 54 yrs	71	12.6
	55 - 64yrs	38	6.7
Total		564	100
Sex	Male	369	65.4
	Female	195	34.6
Total		564	100
Bread Winner	Men Alone	320	56.7
	Women Alone	52	9.2
	Both spouses	192	34.1
Total		564	100
Place to go for medical care	Health center	51	9
	Teaching hospital	60	10.6
	Private hospital	248	44.0
	Chemist	151	26.8
	Medical lab	37	6.6
	Traditional/Herbal healers	8	1.4
	Prayer house	9	1.6
Total		564	100
Patronize hospital facility	No	168	29.8
	Yes	396	70.2
Total		564	100

Table 1: Socio-demographic parameters of the traders.

Table 2 indicates that 237 participants have heard of health insurance scheme, while 327 have not heard about it. Two hundred and eighty participants don't know of any type of insurance scheme existing. Four hundred and fifty-five (80.7%) participants know that health insurance is beneficial to universal health coverage. Thirty-two (5.7%) participants had registered with an insurance scheme, while 506 (89.9%) had not and 25 (4.4%) do not know if they had registered. Among those who have registered, the types included community insurance, NHIS and NGO.

Variable	Response	Number	Percentage (%)
Heard about health insurance	Yes	237	42.0
	No	327	58.0
Total		564	100
	National health insurance	149	26.4
	Social insurance	36	6.4
	Private insurance	37	6.7
	Community health insurance	63	11.1
	None	280	49.4
Total		564	100
Know that health insurance is beneficial to universal health coverage	Do not know	24	4.3
	yes	455	80.7
	no	85	15.1
Total		564	100
Registered with any insurance scheme	Do not know	25	4.4
	yes	32	5.7
	no	507	89.9
Total		564	100
The type of insurance scheme registered	None	542	96.1
	Community health insurance	12	2.1
	Social Insurance	1	0.2
	NGO	2	0.4
	NHIS	7	1.2
	Total	564	100

Table 2: Knowledge about Health Insurance and its importance to Universal Health Coverage.

Distribution of children among the participants range from 'no child' to 'twelve children'. Those participants with no child constituted 265 (47%) while only one participant had 12 children.

In table 3, expert care constituted the major factor that determined choice of health care facilities as indicated by 188 (33.3%) participants, while 169 (29.9%) chose 'nearness' as a reason. Cost of health care was the reason given by 136 (24.1%) participants. Only 30 participants access health care because of 'time factor' while 41 (7.3%) had no reasons for accessing care.

Reasons for patronizing their choice of health facility	Near ness	169	29.9
	Cost	136	24.1
	Expert care	188	33.3
	Time	30	5.3
	Other reasons	41	7.3
Total		564	100

Table 3: Reasons for patronizing their choice of health facility.

Majority of the participants, 524 (92.9%), access health care by out-of-pocket expenditure while the rest accessed care by other forms of health insurance scheme (Table 4).

Methods of payments	Frequency	Percentage (%)
Out of pocket payment	524	92.9
Social HEALTH Insurance	30	5.3
Community based health insurance	5	0.9
Non- Profit organization (NGO)	1	0.2
Others	4	0,7
Total	564	100

Table 4: Method of payment of medical bills.

Table 5 shows the amount the participants were willing to pay monthly for health insurance, with 471 (83.5%) accepting to pay anything less than #1000 monthly, 67 (11.9%) were willing to pay between #1000 to #1,900 monthly, 19 (3.4%) were willing to pay #2,000 to 2,900 monthly, 3 (0.5%) were willing to pay #3,000 to 3,900 monthly and only 4 (0.7%) were willing to pay #4,000 and above.

Amount payable (Naira)	Frequency	Percentage (%)
<1,000	471	83.5
1000 - 1900	67	11.9
2,000 - 2,900	19	3.4
3,000 - 3,900	3	0.5
4,000 and above	4	0.7
Total	564	100

Table 5: Willingness to pay monthly for health insurance scheme.

Two hundred participants accepted to pay #1000 as insurance premium, 37 participants agreed to pay #2,000 and only 2 participants accepted to pay #20,000 while majority of them could not pay beyond #800.00 only.

Discussion

Majority of the participants in this study were in the age range of 25-34 and this may be because they were the active workforce, unlike in a study in Ghana where majority of the participants were among the < 18-year-olds and the elderly (aged 70+ years) relative to the working-age adults (18–59 years) because of exemption policy among this age groups [11].

More males enrolled in the scheme than females in this study unlike in Ghana where females and children aged 18 years and below constituted the majority in the enrollment [12]. Majority of the participants in this study patronized private hospitals as against public health facilities, whereas in Ghana, public health facilities received more patronage than the private hospitals [13]. Greater number of the participants settle their medical bills by out-of-pocket expenditure and few participants settles by community-based health insurance scheme. This is similar in study in Abuja where participants in the study had to pay by selling of household assets as one of the ways of cushioning effects to offset medical bills [14]. Also in a Ugandan study, about 55% of respondents sold household assets to pay medical bills [14].

Our findings showed that 42% of the participants have not heard of health insurance scheme and this is comparable to a study in Abuja where level of awareness was found to be 13% concerning Community Health Insurance (CHI) among the respondents. This is expected because the program was just at its initial stages in Abuja

at the time of this study. The general principles of CHI were also poorly understood by the respondents as none of the principles was known by more than 33.4% of respondents. This finding is comparable to a study in Uganda where majority (64.5%) of insured persons had poor knowledge of community health insurance [14].

Majority of our study participants (80.7%) believed that health insurance is beneficial to universal health coverage. This is similar in a study in Ghana, where insurance scheme generated benefits to local health systems. reported at most sentinel sites in Africa where improved standards are pre-requisites for the conduct of clinical trials [15-17] may have facilitated the higher NHIS enrollment in the study area.

Most of the breadwinners were male while few of them were female. This was not a common finding in studies from Abuja and Ghana as this was not reported in their study. Majority of the participants had no child and majority of those who had children took them to private hospitals for routine medical check-ups, while varying number of them took to laboratory, teaching hospital, chemist, and prayer houses for routine medical care.

Our findings showed that 5.7% of the participants who registered with insurance scheme are members of the poorest households, those without formal education and living in rural areas. This finding is similar to observations by Akazili et al in Ghana, where women of lower social economic stat us, living in rural settings and have no formal education were less likely to register with the scheme [18]. The inadequacy of health care facilities within reasonable reach of rural residents requires that they travel longer distances at greater cost to access health care services unlike their urban counterparts [11]. The associated high non-medical cost is a disincentive for rural residents and poorer households to purchase insurance [19,20].

The mean amount that household heads were willing to pay per month for insurance premiums was #1000 in Umuahia. Our findings differed considerably from studies conducted in Kaduna, Anambra, Enugu States and in the north-central region (Kwara State) of Nigeria where the amount respondents were willing to pay was 513 ± 47 naira ($1.68), 260 naira per month, 260 naira per month and 522 naira per year respectively [21,22]. This disparity is likely because of differences in socio-economic conditions, limited sample size, inflation (due to economic differences at the time of the studies), and differences in geo-political zones.

Expert care constituted major factors that determine choice of health care while time factor constituted least factor for accessing care. Our findings showed that 92.9% of the respondents made out of pocket expenditure on health care. This is higher than the Nigerian rate which is put at 70% of total health expenditure which also greatly exceeds the recommended 30% threshold [23,24].

Nigerian's out of pocket expenditure is among the highest in the world and highest in Africa which translate to catastrophic spending in a majority of household [25]. There is substantial evidence that shows that reliance on out-of-pocket source for health care have adverse effects on demand of service and increase the financial burden of households. This leads to impoverishment of the participants that accessed care by out-of-pocket expenditure. Only a few accessed care by insurance scheme. That majority of the participants agreed to support community-based insurance scheme if it is introduced to their community while few disagreed to support the scheme is in keeping with previous studies [26-28].

Conclusion

Awareness of health insurance, especially community health insurance is low. however, acceptability is high. Enrollment is low. It is imperative that awareness needs to be created in communities to enhance enrollment. Awareness can be created in churches, marketplaces, town union meetings, radio announcement by radio jingles etc. Government subsidies will also be necessary to ensure sustainability.

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Conflict of Interest

Authors have nothing to declare.

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Authors' Contribution Details

- Onyemachi PEN conceived and designed the manuscript, helped in acquisition of data, analysis, and interpretation of data, and wrote the manuscript.
- Okoronkwo N C contributed to the design, writing and revision of the manuscript and gave final approval of the version to be published.

- Onyearugha C N helped with acquisition of data and interpretation of the analyzed data, edited the manuscript, and gave final approval of the version to be published.

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