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A Qualitative Survey of Pre-payment Scheme for Healthcare Services in a Rural Nigerian Community

***Adewole, D.A[1] Adebayo, A.M[2], Osungbade, K.O[3]**

[1]Department of Health Policy and Management, College of Medicine, University of Ibadan, Nigeria,
[2]Department of Community Medicine, College of Medicine, University of Ibadan, Nigeria,
[3]Department of Health Policy & Management, College of Medicine, University of Ibadan, Nigeria

ABSTRACT

Prepayment method for financing health care is one of the means to achieving the desired universal health coverage. However, expanding health insurance to cover the larger informal sector of the population in Nigeria is a persistent challenge especially in the rural areas. This study was carried out to assess the perception of health insurance scheme among rural dwellers in southwest Nigeria. Qualitative data was obtained with the aid of a focus group discussion guide. The FGD questions were framed along familiar themes common to prepayment methods as found in health insurance schemes. A total of six FGD sessions were conducted. Each of the FGD sessions consisted of between 8 – 12 participants. Two FGD sessions, consisting of separate male and female homogeneous groups were conducted in each of the three wards selected for the study. One FGD session lasted between one and a half to two hours and was audio-recorded. Qualitative data were analyzed manually engaging predetermined as well as emerging themes. Awareness about the health insurance scheme was quite low among study participants. Knowledge of the few who had ever heard about it was inadequate. Respondents generally had a positive attitude towards prepayment schemes and willingness to participate in it was high but were skeptical about its sustainability. Strategies to improve awareness about health insurance and its benefit packages among potential beneficiaries are desirable.

Key words: Prepayment scheme, Health insurance, Informal sector, Rural dwellers

*Author for correspondence: *E-mail:* ayodadewole@yahoo.com; Tel: +234-8034052838

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INTRODUCTION

Illness, disability and poverty are a common and almost permanent life – long challenges for majority of people living in developing countries (Gopalan and Durairaj, 2012, Menon, 2006). Following the introduction of user/out-of-pocket payment systems in financing health care in many African countries in the 1980s, direct payment for costs of treatment and drugs, the indirect costs in lost productivity of the ill and the caregivers are also borne by the household (Mathauer *et al*., 2008, McIntyre *et al*., 2006). The spirit of the 1978 Primary Health Care Declaration as well as the relatively recent Millennium Declaration Goals tagged Millennium Development Goals (MDGs) is to make health care delivery services available and accessible to all people, irrespective of their socio-economic status. It is the belief that this objective would reduce existing inequality of access to health care services. One of the strategies designed to achieve this and to enable a universal coverage for health is the healthcare insurance scheme (WHO, 2005, WHO, 2010, WHO, 2012). In order to alleviate the burden of illness among the people, governments in many sub-Saharan African countries had initially provided either free or a highly subsidized service for their citizens (Chuma *et al*., 2013). However, over the years, efforts of the government have become unsustainable due to inefficiently managed available resources and also because of the dwindling resources in the face of the global economic crisis (Gilson and Mills, 1995). Major reforms in various aspects of the health systems in Nigeria have therefore been undertaken in order to ensure citizens right to health care.

One of these reforms is the implementation of the National Health Insurance Scheme (NHIS) as a form of health care

financing strategy to implement a social health insurance scheme in Nigeria. (FMoH, 2006, Omoruan *et al*., 2009). In the current context, the Formal Sector Social Health Insurance Programme of the NHIS was flagged off in 2005. This programme was designed to enrol employees in the public and the organized private sectors as well as the armed forces, police and allied services, students of tertiary institutions and voluntary contributors in the country. For the formal sector programme, contributions are earnings-related, representing 15% of the employee's basic salary out of which the employer pays 10% while the employee pays the rest, (FMoH, 2014). In the formal sector programme, only the federal government and, three out of the thirty six States in the country had adopted the scheme (Onoka *et al*., 2013). The Community Based Social Health Insurance Programme under the informal sector programme was launched in 2011. Other programmes under the NHIS are the Urban Self-employed Social Health Insurance Programme, Children Under-Five Social Health Insurance Programme, Permanently Disabled Persons Social Health Insurance Programme as well as the Prison Inmates Social Health Insurance Programme,(FMoH, 2014). Outside of the current formal sector programme, there is yet no known modality of enrolment in the others, efforts to establish a community-based programme in some selected states of the Country is not encouraging (Arin and Hongoro, 2013). However, a private scheme, the Dutch Health Insurance Foundation, in partnership with the Kwara State government implemented a form of an informal sector scheme in some rural areas in the State, sustainability of this scheme is a cause of concern for stakeholders (Humphreys, 2010).

There are challenges implementing social health insurance schemes especially in the developing countries; low level of awareness and understanding of the concept of the scheme among potential beneficiaries, concern about transparency with fund management, religious and superstitious beliefs associated with paying into a health fund are common (Agba *et al*., 2010, Brisibe *et al*., 2014, Chuma *et al*., 2013, Jütting, 2000, Onoka *et al*., 2013, Xu *et al*., 2006). Others are poverty and perceived poor quality health care services in the available health facilities especially in the rural areas may discourage participation (Arin and Hongoro, 2013, Jutting, 2001, Omoruan *et al*., 2009). Also, the inability to distinguish between health insurance as a concept, different from traditional microfinance institutions of reciprocal contributory mechanisms could be an obstacle, (Brown and Churchill, 2000, Platteau, 1997). Different forms of bonus had been advocated to assuage those who may not have a need to use the services and might therefore feel not benefiting from the scheme (Zweifel, 1987).

In Nigeria, the majority of the people still pay out of pocket (OOP) for their health care needs (Odeyemi and Nixon, 2013, Onoka *et al*., 2013). Oftentimes, individuals and families on many occasions sell assets, borrow money, deplete their savings and use properties as collaterals for financial loans. This tends to worsen already existing poverty (Damme *et al*., 2004, Ezeoke *et al*., 2012). More often than not, OOP payment increases non-utilization of health services, late presentation in health facilities, patronizing sub-standard health care facilities and or receiving poor quality health care services among others. The vicious cycle continues with an increase in morbidity and mortality in the general population, poor productivity of labour force which could adversely affect growth and development in all sectors of the society (Durairaj *et al*., 2010, Russell, 1996).

The NHIS commenced operations in Nigeria about a decade ago, it currently serves about 3.73% of the population, and these are mainly formal sector workers in the national civil service (Humphreys, 2010, Onoka *et al*., 2013). This scenario is similar to the experience of many developing countries especially in Africa, (Carapinha *et al*., 2011, Kimani *et al*., 2012). More than half of the Nigerian population live in the rural areas. Poverty is more prevalent in the rural areas of Nigeria for various reasons of which poor capacity to link and engage in existing profitable markets is key. Inadequate basic social infrastructural facilities play a major role in this. Therefore rural population are more vulnerable to difficulties in payment for health care needs and thus poor access and utilization of available healthcare services (Omoruan *et al*., 2009, WHO, 2010). Rural areas are also known to generally lack adequate number of trained healthcare personnel among others (Arin and Hongoro, 2013, Kale, 2012). Meeting the MDGs 4, 5 and 6 will require a health system that guarantees a sustainable universal health coverage that will enable an equitable access to healthcare services. In the current efforts to implement and expand a prepayment scheme for health care among the informal sector of the population especially the less privilege of the rural areas, an understanding of the perception of a prepayment system of financing health care among them is important to enable the design of a sustainable scheme.

METHODS

This is a cross-sectional survey carried out between February and March 2012 in Oriire Local Government Area (LGA) of Oyo State, Nigeria. The study population were the residents of three of the ten wards of the LGA namely; Ikoyi – Ile, Tewure and Olorunda. A multi-stage sampling technique was applied in the choice of respondents for the study; In stage 1, Oriire LGA was purposively selected. This was done to achieve the intention of conducting the study among informal sector population of a rural area. In stage 2, a list of the ten wards of the LGA was obtained. Three wards were selected by simple random sampling. Each of the wards were 10 – 15 kilometres apart. Stage 3 involved the selection of eligible adult members in the selected 3 wards by asking for volunteers for the focus group discussion sessions (FGDs). Two FGD sessions, one male and another female in separate groups were conducted per ward in each of the three wards selected, making six FGD sessions in all. Conducting the FGD sessions for men and women in separate sessions enabled free expression of opinions and ideas - especially for women because of the patriarchal nature of the society. A FGD group consisted of 10 – 12 people. A FGD session lasted between one and half to two hours and were audio recorded. Qualitative data was collected through FGDs using FGD guides. The FGD guide contained open-ended interview questions. The sessions were conducted in the Yoruba local language. Records of the discussion were also handwritten as a backup to the audio-recordings. The audio-recordings were transcribed and translated at the end of the interviews. The FGD questions were framed along themes such as the general awareness and knowledge of respondents about the NHIS, attitude to NHIS, their health-seeking

behaviour and consequences of any other payment system such as OOPs and suggested inputs into the methods of operation of the NHIS taking into consideration the socio-cultural value and economic status of the people. It was realised that awareness of the FGD participants about health insurance and the NHIS was almost nil. To enable them express their opinions and ideas, the basic principles of a prepayment scheme for health and the NHIS were explained to them (3). The potential benefits of a prepayment scheme were also highlighted. Verbal informed consent was obtained from participants prior to commencement of the FGD sessions. Participants were adults, working age and permanent residents of the three selected wards. Visitors were excluded from the study. Data collection was completed within a period of three weeks.

Data analysis

Qualitative data were analyzed manually- engaging predetermined as well as emerging themes from the transcribed notes. Words, phrases and ideas that occurred consistently and which enabled a deeper understanding of the thoughts and opinions of FGD participants about the issues as well as emerging themes were identified.

Ethical approval

Ethical approval to conduct the study was obtained from the Bowen University Teaching Hospital Research Ethics Committee, approval number NHREC/12/04/2012

RESULTS

Method of payment for healthcare services

All reported paying by out-of-pocket for health care services when there is a need to receive healthcare. Some however, mentioned paying by installment to the hospital after reaching an agreement to do so because of the often inability to pay for healthcare.

Men FGD

….Ah, we go to the hospital with, money in pocket, if you don't have money on you, nobody will listen to you. Sometimes if you don't have enough, you borrow from friends and relatives and pay back later when you have the money. Those people can come to borrow from you too if they have a need too, that's how we do it.

May God turn around the times for better…..there is no money!.....

Women FGD

Emmm ... there is no money in this environment, sometimes they allow you to pay little at a time until one finishes paying the total sum of the healthcare cost. Sometimes I run around to borrow, and you may not even get to borrow I some cases

Awareness about the NHIS

The majority of the respondents involved in the FGDs were unaware of the scheme at the time of the study. For the few who were aware, there was a clear lack of understanding of its meaning. This was shown in the following excerpts from three members of the male group:

Men FGD session

I have never heard about it'. Then another said '….em.., I have been hearing about it, around that Ilorin (capital of Kwara State, Nigeria) side. Then the third person said' …..yes, I have been hearing it, but it does not have any meaning to me, I hear about it on the radio.

Women FGD session

I have never heard about it, today will be my first time to hear about it.

Knowledge about the NHIS; modus operandi and contributions

Since the majority of the people involved in this study were unaware of the scheme and how it operates, efforts were made to explain to them the basics of the scheme such as collection of premiums, pooling collected funds, purchasing and provision of healthcare services among others. This was followed by discussing questions in the FGD guideline one after the other. Some of the responses by the FGD participants in both the male and the female groups are documented below. It shows that the majority of participants did not know how the scheme operates. Salient features on risks and benefits pooling and sharing and the rationale behind it, as well as the mechanisms for resources mobilization and allocation were some of the points of discussion. It was obvious that some of the participants took contributions in a prepayment scheme for health like any other savings and loans arrangement which is a popular practice in this environment. Excerpts from some of the participants are as shown below

Men FGD session

One of the participants have this to say; *I want to ask a question, may God not make us fall sick, the money that we keep contributing, what if we don't fall ill, our children do not fall ill, and our wives do not fall ill, what are we going to do about the money?*

... in life insurance scheme, you can use it as a collateral for obtaining a loan facility, can we make use of this for that purpose too?

…..this money we are talking about, would we be going to the bank to save it or you people would be coming to collect it from us, and does it have a time limit or are we going to continuing contributing without a time limit……?

...what I, as a person want to know is this, is this programme owned by the government or private organization, I want you to shed more light in that area that we may understand better.

Women FGD session

I have a little question, my question about it is this…. what time is this scheme starting and that when it starts, how do we make the contributions, where do we go to pay the money?

….this opportunity that you mentioned is it only available at the government hospital alone or that the private is also included?

Attitudes about the NHIS

Even with their present level of knowledge about the scheme, attitudes of the study participants were quite positive as they showed their willingness to participate, more so, they were keen to gain a better understanding of the scheme and its modus operandi. Some of their responses are shown below;

Men FGD session

when it start, and individuals are accepting it, we also would not want it to elude us, may God prevent us from falling ill, once it is a scheme meant for all, and the benefits is for all of us…. but there are certain

areas that are not yet clear though, but, …we may gradually come to its full knowledge with time…..

Women FGD session
…..Now that you have explained what the NHIS means, we would be happy to be part of it.

……It is for our well being, we all know that our bodies are not stones, there is nobody who cannot fall sick, and when we fall ill, we know that the issue of I don't have money on me will not arise again, we will quickly go and take care of ourselves in the hospitals.

… we will partake in it quite alright, because in this environment where we are, there is no money as such….. but with this type of opportunity to contribute little at a time, when illness comes, instead of running up and down looking for money it will not be a burden to receive health care services when illness comes. So I see reason in it.

Previous experience of financial difficulty at times of illness
Though the majority of the people in the FGD sessions did not answer in the affirmative about having experienced any difficulty in paying their medical bills in times of illness, some of them who reported having experienced such have the following to say;

Men FGD session
… borrowing money from friends and things like that has happened to us many times to take care of ourselves.

Women FGD session
if there is no money, I'll go to the hospital that we attend…get the treatment and go back to pay once we have enough money to settle the bill.

…hmmm in times of hardship we went to borrow money outside, but we later paid it back.

Suggestions/contributions and scepticism
FGD participants in both the male and the female sessions expressed a lot of doubt about the genuineness of this scheme. Abandoned and failed government programmes were cited as examples, and that they were waiting to see if this present programme would be different. Another dimension to these lines of doubt is that people seemed to have difficulties striking a balance between their religious faith/belief which encourages them to pray and wish for sound health and absence of ill-health on one hand, and a scheme that contradicts their beliefs, and which encourages them to keep saving money in anticipation of a time of illness that might come in the future.

Men FGD session
… we will be happy if it is introduced, but at the end of the day, it may collapse
…I have experience of three different community programmes in the past, after some time they just disappeared,
…..bringing any programme including this is not a problem, but at the end of the day,…..at a certain point in time you will not see them again.
when they come, if they will make good their promise……that we will not regret participating in it, we will join when it starts.

….when you asked us to be contributing money… it's like when someone want to cheat us, that's how it looks to me, except you explain it properly. Moreso… as we are ….as Muslims, it does not conform to our religious beliefs…..to keep contributing money….. in preparation for illness to come,….it does not conform to our tenets……..

…it's like we are praying for ill-health by making financial provisions for it in advance….

Women FGD session
This programme is good, but like the General Hospital in this place, when you go there, drugs will not be available, nothing would be available….when you go to the health centres, the staff are usually not there, they will stay for some few days in a week and disappear, for them to re-appear again the following week. As for me really, I cannot blame them, here in our village, there is no light, no water, health care workers fetch water from the nearby stream for their use like we do, the doors and windows of the health centres are almost falling apart, mosquitoes are everywhere, so the health staff are suffering when they are here, and that's why they run back to town after some days every week
…my own question is, how you are sure that this programme is genuine, so many similar programmes were introduced in time past, we participated, at last we discovered that they were frauds……

it is good, when they bring it, we will participate, God protect us from illness…. it is a form of assistance, but God will not allow us to have a sickness that will be too much for us, but there is no way it will not come, … if they bring it (health insurance scheme)it is good

DISCUSSION

In this study, almost all reported paying OOP at the point of service for healthcare. The obligation to pay directly for healthcare services (OOP) at the moment of need is a barrier to universal coverage. This method can result in impoverishment. Many people suffer financial hardship around the world each year and this is most common for people in low income countries, (Xu *et al*., 2007). In Nigeria, between 3.7 – 4 % of the population benefits from one form of health insurance, the rest pay by OOP, (Muanya and Oyebade, 2012, Olugbenga-Bello and Adebimpe, 2010), and similar to what is common in many other developing countries where there is a form of a health insurance scheme (Carapinha *et al*., 2011), the health insurance scheme in Nigeria has been limited to formal sector workers predominantly those who are in the Federal Civil Service, (Agba *et al*., 2010, Humphreys, 2010, Onoka *et al*., 2013). When people have to pay at the point of use of healthcare, the sick and family members bear the risk associated with the care which includes making a choice between paying for the care or paying for other basic needs at home. This can be worse among the poor who live mainly in the rural areas. Prepayment scheme for health provides financial protection for members in terms of reducing their OOP expenditures, improving utilization of inpatient and outpatient services and is considered pro-poor, (Chuma *et al*., 2013, WHO, 2012). To achieve the desired universal health coverage, it is important that countries rely much less on OOP, (McIntyre *et al*., 2008).
One of the challenges that could act against the implementation of a health insurance scheme in this population is the difficulty of identifying and usage of suitable mechanisms in collecting contributions efficiently (Kimani *et al*., 2012). Furthermore, there is no legislation that has made health insurance schemes compulsory in Nigeria, (Muanya and Oyebade, 2012, Onoka *et al*., 2013). Ensuring that the scheme is sustainable will require

legislation that makes it compulsory for all to ensure a viable pool for risk sharing and fund pooling.

Participants in the present study expressed interest in participating in a prepayment scheme for health. This is similar to the findings in a pilot work by a Dutch Government supported organization carried out in partnership with a local health maintenance organization, on private health insurance among rural farmers in Kwara State Nigeria, (Humphreys, 2010). There are other similar examples in previous studies in Cameroun and Kenya (Donfouet *et al*., 2011, Mathauer *et al*., 2008). An actual or a potential benefit in a functional prepayment scheme might elicit a sense of relief in people many of whom reported at least an experience of financial hardship as a result of having to make OOP payments in the past, as well as having been exposed to attendant consequences, (Russell, 1996). However, other factors which conflict with this expression of interest are religious and cultural beliefs. Generally, among Africans almost all of daily activities and attitude towards life revolve around religion and failure to understand this could create a big gap in understanding peoples' lives and behaviour. In a study by ARHAP (African Religious Health Assets Programme of the WHO) in 2006 to determine the contribution of religion to health and wellbeing in Zambia and Lesotho, it was observed that religion plays a vital role in African search for wellbeing, and that religion dictates their values, attitudes, perspectives and decision-making frameworks (WHO. and De Gruchy, 2006). Mume (1996), Sofoluwe (1996) in separate works on religion asserts that people patronizes religious houses for divine guidance, protection from illnesses and perceived negative forces as well as faith healing for various kinds of ailments, (Sofoluwe, 1996, Mume., 1996). In this study, male participants were more concerned about this than were the women groups that expressed more interest on having access to good quality health care.

Generally, African settings are patriarchal in nature, elderly men are regarded as custodians of cultural and religious values. Studies have shown that women are more likely to have better health seeking behaviour than were men, (Adamson *et al*., 2003, Morgan and Haar, 2008). The reason may not be unconnected with the natural need to seek for healthcare more than men especially during periods of pregnancies and child welfare visits to health facilities amongst others.

Efforts to identify a comfortable unifying locus between religion and cultural beliefs, (the two entities as a demand-side factor) on one hand and a well-designed prepayment system for healthcare (as a supply-side factor) on the other is a worthwhile venture that will promote acceptance and sustainability of the scheme especially among the informal sector of rural areas where religious and cultural beliefs tend to be more conservative, (Jütting, 2003). Fortunately, it has been shown that religion and religious organizations could play a vital role, providing the needed locus where religious beliefs and the reality of the inevitability of a need for a prepayment scheme for health are harmonized. There are evidences that prepayment scheme for health is accepted and is a method of financing health care even in many of the societies where religion and the nation-state are almost an inseparable entity, (Aji *et al*., 2013, Alkhamis *et al*., 2014, Davari *et al*., 2012, Rao *et al*., 2009). Therefore, if well managed religion is less likely to be a hindrance to a prepayment scheme for health but rather enhance its acceptance and expansion. In a study by Jutting in 2001, (Jutting, 2001) it reported a fairly good enrolment rate of members of a religious organization in a prepayment scheme for health in a rural setting in Senegal In a study by ARHAP in Zambia and Lesotho, religious organizations have been found to make invaluable contributions to the needed care and support for HIV/AIDS programmes. Such 'health promoting religious assets' (Onoka *et al*., 2013) could provide the resilient platform upon which health insurance schemes might be implemented in a sustainable manner.

Poverty is a major determinant in participating in a prepayment scheme in many developing countries, (Donfouet *et al*., 2011, Kimani *et al*., 2012). Likewise, inadequate human and material resources for healthcare could be a barrier to participation in a prepayment scheme for health. In Nigeria, the majority of the people are poor, earning less than a dollar per day and this is worse among those who live in the rural areas and in the informal sector of the population, (Kale, 2012, Omoruan *et al*., 2009). Among these people, income earnings are not consistent this might make it difficult to determine an appropriate premium for individuals in the group, (Carrin, 2002, Ezeoke *et al*., 2012, Onwujekwe *et al*., 2010). This situation could be worse in the rural areas where there is poor quality and quantity of healthcare personnel, physical health infrastructure and essential commodities such as drugs and medicaments as reported in this and previous studies (Omoruan *et al*., 2009). It is important that governments implement poverty reduction policies which could enhance an increment in earned income of individuals and families and thus make them more capable and willing to afford set premiums for prepayment schemes (Chuma *et al*., 2013); this will certainly reduce the proportion of those to be subsidized from public funds.

In one of the FGD sessions, a participant asserted thus; '……*but like the General Hospital in this place, when you go there, drugs will not be available, nothing would be available….when you go to the health centres, the staff are usually not there, they will stay for some few days in a week and disappear, for them to re-appear again the following week. As for me really, I cannot blame them, here in our village, there is no light, no water, health workers fetch water from the nearby stream for their use like we do, the doors and windows of the health centres are almost falling apart, mosquitoes are everywhere, so the health staff are suffering when they are here, and that's why they run back to town after spending some days every week'.* This statement accentuate the importance thatgovernment ensures that the health facilities are staffed with an adequate number and the right mix of health personnel, that healthcare facilities/infrastructures are made available in the rural areas, stocked with essential drugs and commodities and as well made more conducive a work environment, (Arin and Hongoro, 2013). It has been advocated that pro-poor financing mechanisms should be employed as means of solving the inequalities suffered by the poor (Onwujekwe and Uzochukwu, 2005). Other pro-poor strategies that could be considered are sliding scale payments based on assessment of the socio-economic status of the people. Administrative and managerial capacities to do this can be daunting in Nigeria like in any other developing countries (Mossialos and Dixon, 2002).

Majority of the participants in this study claimed never to have heard about the health insurance scheme. This finding is consistent with previous studies (Donfouet *et al*., 2011). Those who reported to have heard about it claimed to know little. Poor awareness creation of the scheme and for the few efforts made to do so, the awareness creation may not be appropriately executed to enable the masses especially the rural informal sector have a sense of been a stakeholder. This may result in nonchalant attitude towards the scheme as majority of the people in this category may feel alienated from government social programmes (Mathauer *et al*., 2008). Earlier studies in Nigeria; Olugbenga – Bello and Adebimpe (2010), Agba *et al*., (2010) Onwujekwe *et al*., (2010), Dienye *et al*., (2012) (Agba *et al*., 2010, Dienye *et al*., 2011, Olugbenga-Bello and Adebimpe, 2010) were in consisttent with this. Studies have shown that there is an association between awareness and participation in a health insurance scheme (Bhat and Jain, 2006, Kirigia *et al*., 2005). Thus, stakeholders must of necessity, promote the scheme by raising the level of awareness among potential beneficiaries.

Adopting an initiative is usually preceded by awareness and better knowledge facilitated by adequate information. Without adequate information to enrich potential beneficiaries' quest, implementing and sustaining beneficial social policies becomes a daunting task. Agba *et al*., (2010), (16), (Agba *et al*., 2010) in a study demonstrated that differentials in access to information about the scheme among federal public servants where health insurance is compulsory and implemented determines to a large extent the probability of eventual enrolment in the scheme; those who reside in rural areas with less information were less likely to enroll compared with their counterparts who reside in the urban settings with better information. Findings by Nyagero *et al*., (2012), (Nyagero *et al*., 2012) in a study in rural Kenya was similar.

Emphasis must be made to differentiate between a prepayment scheme for healthcare and other mutual financial contributions and sharing that exists amongst the people. In this study, statements such as the following were common 'what *happens to my contributions if I or any of my family members did not fall ill in a year, would the money or part of it be returned to me?* Matheur *et al*., (2008), (Mathauer *et al*., 2008) reported a similar finding in an earlier study in Kenya. In developed countries, the State and the market-based systems provide the necessary social security structures that protect individuals and families from and enables them cope with risks and losses including illnesses; these systems are almost non-existent in developing countries, (Jütting, 2000, Menon, 2006). However, in many developing countries, credit and savings associations do exists in communities. These make available, to some extent, the needed social security system by providing access to credit and loans to its members in solidarity and reciprocity manners, (Jütting, 2000). Among the Yorubas where this study was carried out, an age long traditional risk-sharing economic, and microfinance institution called *esusu* as well as variants of it exists like in many other African societies. Bascom in 1952 described the *esusu* in a study among the Yorubas as "a fund to which a group of individuals make fixed contributions of money at fixed intervals; the total amount contributed by the entire group is assigned to each of the members in rotation'' (Bascom, 1952). This enables individuals who ordinarily would not have been able to execute a project because of financial difficulties, the ability to do so.

The concept of mutual sharing of risks and funds through fund pooling as a mechanism of health insurance is new to the people. However, with the knowledge that it would considerably reduce or eliminate the tendency to financial hardship during illness, this could make health insurance scheme more acceptable. Furthermore, many African communities have well established solidarity mechanisms and communal support systems and structures which could be employed to explain the "principle of solidarity within the social health insurance mechanism'' (Mathauer *et al*., 2008). The possibility of social health insurance succeeding where there is an established system of mutual help was reported in previous studies (Jutting, 2001). Periodical comprehensive medical check-up, followed by the appropriate healthcare services could be adopted as a form of compensation to those who might feel 'cheated' for non-use of health insurance benefits for a considerable length of time because they had no need to use it.

Previous studies have shown that the attitude towards a prepayment scheme for healthcare was encouraging, (Dienye *et al*., 2011, Donfouet *et al*., 2011). Findings in this study were not an exemption. Having had the basic principles of a prepayment scheme explained to them, participants expressed willingness to participate. Despite this, concerns about fund management was raised. Lack of trust in fund management in an insurance scheme has been identified as a factor for non-acceptance of insurance schemes. Donfouet *et al*., (2011) (Donfouet *et al*., 2011) in a study in Cameroon and van Damme *et al*., (2004), (Damme *et al*., 2004) in Cambodia supported this. However, in a similar study by Matheurs *et al*., (2008), (Mathauer *et al*., 2008) in Kenya, lack of trust in fund management in health insurance schemes was not a factor. In Nigeria, expression of lack of trust was reported in a study by Katibi *et al*., (2003), (Katibi *et al*., 2003) in a study carried out on health insurance scheme among health workers. The findings of these studies support the suggestion that the degree of trust in government public policies could be a reflection of previous experiences. It is pertinent that stakeholders gain the needed trust of the scheme's potential beneficiaries.

In conclusion, this study shows that prepayment scheme for healthcare driven by the NHIS could succeed in Nigeria. Fundamental to the success of the scheme is robust awareness creation, that could engender better knowledge about it among potential beneficiaries as well as addressing appropriately the areas of concerns raised by the people are essential. Generally, the women groups showed less resistance to accepting the scheme than were their male counterparts. The reason for this may be related with women's better health seeking behaviour for obvious reasons. Female members of the society could serve as agents of publicity provided scheme's promises did not fall short of expectations.

The results will be more representative with a larger number of FGDs but for time and limited resources. Thus, it is recommended that similar studies be conducted in other parts of the country.

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