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Barriers to Enrolment into Health Insurance Schemes in Nigeria: the case of Niger State Contributory Health Insurance Scheme

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Abstract

Niger State government has keyed into the health insurance program of the federal government since 2019, with the establishment of the Niger State Health Insurance Scheme. Although the scheme has beautiful mission for the formal and the informal sector workers as well as the students in tertiary institutions and the vulnerable groups, it is yet to enjoy reasonable patronage. Studies on barriers to enrolment into health insurance were mostly conducted in matured health insurance settings, where barriers to enrolment do with operational concerns. It is not clear whether operational concerns may affect enrolment in Niger State where the health insurance scheme is at the take-off stage. Using qualitative research design to explore the enrolment barriers, this study has drawn a sample of 22 respondents across the major tribes, religions, enrolment category and senatorial zones of the state. Four enrolment officers were also part of the respondents. An in-depth interview was conducted on the respondent and the results were analysed in themes. The findings of the study showed that lack of trust in anything government is the major barrier to enrolment among the public sector workers due to their prior experiences of failed schemes run by government. However, inadequate sensitization about the requirements, procedures for enrolment, cost and benefits of the scheme were the barriers to enrolment among the informal and the private sector workers. The enrolment of the vulnerable groups is undermined by the lack of social register from where the list of the qualified people would be extracted. In addition, the lack of National Identification Number, which is the pre-requisite for enrolment, deters enrolment of the vulnerable groups. The problem of insecurity in the state also affects outreach and enrolment. Necessary suggestions are given to the government.

Keywords: Health Insurance, Enrolment, Barrier

JEL Classification: G22, I11, I18

1. Introduction

Health insurance has become a veritable tool for accessing healthcare, particularly in low income countries like Nigeria. It acts as a safety net, saving individuals and their families from unforeseeable medical expenses (Alhassan, *et al.* 2016). The scheme operates by pooling resources through the collection of monthly premium from the enrollees by the

insurer (insurance company) and settles the medical bills of the enrollees based on their chosen enrolment plans. Health insurance therefore ensures equity in access to health (Ezeoke, *et al.* 2012). It also safeguards individuals and their families against incurring catastrophic health expenditure, where individuals have to sell their assets, borrow or beg to settle healthcare cost (Cleopatra & Eunice, 2018).

Nigeria signed the National Health Insurance Scheme (NHIS) law in 1999 and became operational in 2005 (Metiboba, 2011). However, enrolment into the scheme was disappointing, with less than 3% of the total Nigerian population being enrolled (Odeyemi, 2014). Thus, out-of-pocket health expenditure continues to dominate healthcare payments in Nigeria with its attendant catastrophic nature. In fact the study of Sambo, *et al.* (2013) in North Western Nigeria showed that a quarter of all families in the study area had difficulties settling their medical bills.

Similarly, the Niger state government had in 2019 signed a law that established the Niger State Contributory Health Scheme (NCHS). The scheme aims at increasing access to quality health for the residents of Niger State. It targets four categories of people, which are the formal sector workers such as those employed in the public and private sectors; the informal sector workers; students in tertiary institutions as well as the poor and the venerable groups. Despite its beautiful mission, less than 1% each for the formal and informal sector enrolment targets was achieved by the scheme while a meagre 4% of the targeted enrolment for the vulnerable groups was recorded (NiCare, 2024). Therefore, there is the need to find out the barriers to enrolment into the NCHS.

Studies that investigated the determinants of decision to enroll into health insurance schemes are often quantitative and tend to apply econometric modelling (Jamilatu, 2015; Jehu-Appiah *et al.* 2012). Econometric modelling is restricted to a number of variables; therefore it is insufficient to explain barriers to enrolment into health insurance schemes (De Allegri *et al.,* 2006). Although there are studies that applied qualitative or mixed methodological designs, mostly of the studies were not conducted on new insurance firms and were conducted in different contexts (Mussa *et al.,* 2021; Dror *et al.,* 2016; Alhassan *et al.,* 2016; Jehu-Appiah *et al.,* 2011; Zhang & Wang, 2008; De Allegri *et al.,* 2006). Consequently, this study applies qualitative research design to investigate the barriers to enrolment into the NCHS.

2. Review of the Literature

Studies on the barriers and determinants of enrolment into health insurance schemes have reported mixed result across different contexts. For instance, the benefits derivable from health insurance scheme, the price of the scheme, convenience with regards to accessibility to the health provider, peer influence and the attitude of the health provider were reported as the key determinants of enrolment in Ghana (Jehu-Appiah, Aryeetey *et al.,* 2012). Similarly, poor quality care was reported by Alhasssan *et al* (2016) as the barrier to enrolment in Ghana. In the middle and low income countries, Dror *et al*. (2016) found that inappropriate insurance package, cultural belief, affordability and distance to health facility affect enrolment. Other factors reported to have affected enrolment were poor policy and stringent rules (Dror *et al*, 2016). The lack of knowledge about the potential benefits of the scheme

was also reported to be a hindrance to enrolment in Nigeria while the experiences of long queues by the existing enrollees affect new enrolment in Ghana (Odeyemi & Nixon, 2013).

Enrolment into health insurance has also been linked to poverty and household background characteristics. The cost of insurance premium for instance was reported to have effect on enrolment in Ethiopia in addition to the household size, age, gender marital status, experience of illness and income (Mussa, *et al.*, 2021). Contrarily, Dao (2020) viewed that the decision to enroll in health insurance scheme in Vietnam is shaped by the peoples' level of anticipation of the unforeseen future events. He argued that the claim that people lack money to pay premium as a barrier to enrolment is not true because people have many future plans with their cash and the decision to allocate such cash to other future needs might overshadow the need to enroll into insurance since ailment is unforeseen, therefore might be unanticipated and considered unnecessary. There is also a strand of evidence which points to social exclusion as the barrier to enrolment into health insurance (Parmar *et al.*, 2014). Social exclusion is the denial for full access to certain rights, opportunities and resources to certain group of individuals. The study found that in West Africa, ethnic minority, women and older people in rural areas are less likely to be enrolled due to social exclusion.

Furthermore, the study of Jehu-Appiah, Aryeetey *et al.* (2011) in Ghana noted four categories of factors that affect enrolment into health insurance scheme, which include the predisposing, enabling, need and social factors. The predisposing factors comprises of age, gender, education, occupation, family size, marital status, peer pressure and health belief, while the enabling factors include income, and place of residence. The need and social factors comprise of health status and health perception respectively. In similar vein, sick people and more affluent ones were reported to be more likely to enroll into health insurance scheme in China, which point to the existence of adverse selection in the health insurance industry (Zhang & Wang, 2008).

The aforementioned literature has itemized a number of factors that determine enrolment into health insurance from both developed and developing countries. However, this study is paramount in order to investigate the specific factors standing as barriers to enrolment within the Niger state context.

3. Methodology

This study applied a qualitative research design. A total number of 22 in depth interviews were conducted with respondents. In depth interview was considered more appropriate than the focus group discussions because the decision to enroll is in the hands of individuals. In order to explore variations across locations, occupation and gender, individuals were selected based on stratified purposive sampling design (Patton, 1990). Household heads were interviewed because household resource allocation decision is championed by the household heads (De Allegri *et al*, 2006). The respondents are of two categories. The first category comprises of the staff of Niger State Healthcare Agency—NiCare, who provide information about the barriers to enrolment of the vulnerable groups. The second category of respondents are the yet to be enrolled residents of Niger State who are to explain their reasons for non-enrolment. Figure 1 shows the sampling design.

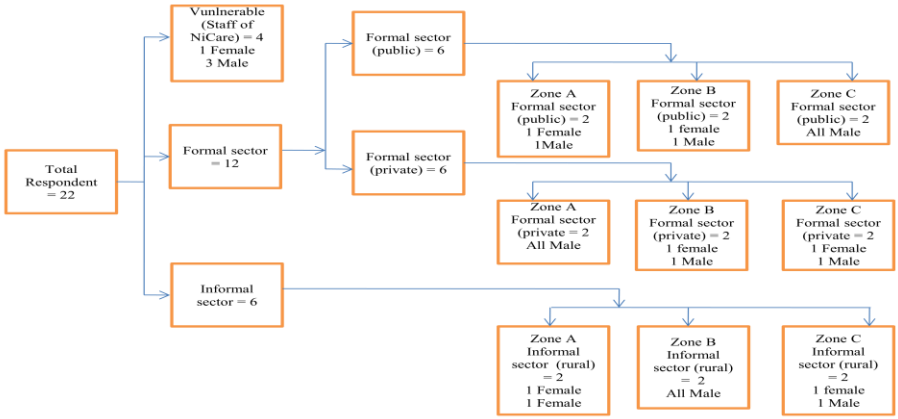

Figure 1: Sampling Design

Figure 1 shows that a total number of 22 respondents were selected and interviewed. In order to avoid compounding issues of enrolment and that of awareness, only those who are aware of the insurance scheme were interviewed and 12 of the non-Nicare staff were sampled from the urban centres while 6 respondents from the rural areas. The sample cut across different religious groups and ethnicity in order to determine whether religion or ethnicity maters in to the enrolment. The interviews were conducted in the language that the respondent understands, recorded and later translated and transcribed. The translation was done by the native of each of the three dominant languages in the state—Hausa, Gwari and Nupe.

Four of the 22 total respondents were staff of NiCare who answered questions regarding the enrolment of the vulnerable groups. Since these groups are enrolled for free, barriers to their enrolment may best be understood by the enrolment officers. Twelve out of the 22 respondents were selected from the formal sector workers, which comprise of 6 respondents from the private and 6 from the public sector workers. Two respondents each was selected from Zones A, B and C from among both the public sector private sector workers. Six samples were also selected from the informal sector workers, with each of the Zones A, B and C having 2 respondents. Across all the category of respondents, there were 2 female respondents for each of the three Zones of the state. The interviewed result were sorted manually and arranged theme-by-theme for thematic analysis.

4. Results

Demographic Characteristics of the Respondents

Table 1 provides the demographic characteristics of the respondents. It shows that 14 of the respondents were male while 8 were female. With the exclusion of the four respondents who are the staff of NiCare, twelve of the respondents were from urban setting while six were from the rural areas.

Also, three, six and nine respondents were Hausa, Gwari and Nupe by tribe respectively. Muslims dominate the responses with fourteen respondents while Christians were only four. There were five, ten and three responses from monogamous, polygamous and those not in any marriage respectively. The educational level of the respondents was of four categories, with one respondent not having any formal education, two respondents attended primary school, five attended school to secondary level while ten respondents to tertiary level.

Table 1: Demographic Characteristics of the Respondent

Number of Male	14
Number of Female	8
Residency	
Urban	12
Rural	6
Ethnicity	
Hausa	3
Gwari	6
Nupe	9
Religion	
Islam	14
Christianity	4
Marital Status	
Monogamous	5
Polygamous	10
Not in Marriage	3
Educational Level	
No formal Edu.	1
Primary Level	2
Secondary Level	5
Tertiary Level	10

Source: Author's Compilation

Interview Results

The findings of the interview are arranged in themes, capturing the major responses of each group of respondents. For the public sector workers, most of them reported the issue of trust as the key barrier to their enrolment. Most of them have experienced breach of trust and disappointments from similar schemes initiated by government in the past. Therefore, their labour unions frown at the current scheme and ordered their members to wait until concrete agreement is reached between the union and the government on the issue of security of their members' contributions and the quality of the scheme's services before their members could enrol. Most of the public sector workers are therefore waiting for directives for enrolment from their organisations, which is contingent upon the agreement reach between government and their labour unions. Some of the views of the public sector workers are:

> *".....I cannot enrol directly, my employer has to do it for me.....and I know for civil servants over the years one of the challenges that militate against enrolling is lack of consistency, fairness, security of funds and the benefits that you are going to*

enjoy from the scheme. For federal we have seen that is seamless, but for the state it has not been easy because of the previous contributions that people have experienced. You contribute and the services are not there, your funds are not secured..... " (Male, public sector worker)

"...I am not yet enrolled why because I have not been formally informed of the enrolment exercise through my office and as an individual I do not think that I should come over and do so individually with or without the consent of my office" (Male, public sector worker).

"....the scheme is very nice. Those who are working under federal government you go to standard clinic whatever the bill they incur they receive it under National Health Insurance Scheme—NHIS. We are planning to enrol but since as an individual you cannot enrol we are waiting for the labour union and the state government to agree so that we get go ahead" (Male, public sector worker)

"I am a very ardent lover of contributory health insurance scheme, but as an employer of Niger state, I am waiting for my employer to enlist me, but they said the Nigerian labour congress—NLC, said no to the government. So anytime NLC and the government resolve, I am ready to enrol (Male, public sector worker).

"..the reason why I did not enrol is that I am waiting for my employer to give directive on how to go about it" (Male, rural, private sector worker).

"...I am yet to enrol because agreement is yet to be reached between Niger State government and labour" (Female, public sector worker).

"....I think the reason why we don't enrol is that the scheme has problem with the labor. The policies behind that and the deductions are not clear with the labor that is why the labor did not allow any body to enrol" (Male, public sector worker)

".....I am aware of the scheme, but I am waiting for my employer to enrol me" (Male, informal sector work

On the other hand, workers in the private and informal sector reported the issue of poor sensitization and being enrolled in other similar scheme as their reasons for not enrolling in the NCHS. In fact most of them reported not having knowledge and awareness about how to enrol, benefits of the enrolment and its requirement as their barrier to enrolment. The views of some of them are:

".....there is no sensitization if not most of these organisations could have enrol. There is need for sensitization through media outfits" (Male, private sector worker)

".....basically we are unaware of what the scheme is all about at the local government level. So we know nothing about NCHS" (Female, private sector worker).

"...I have not enrolled because I do not know the procedures for enrolment and the premium" (Female, private sector worker).

"..I am aware of the scheme but I do not know the procedures for enrolment (Female, informal sector worker).

"..I need more sensitisation (Female, informal sector worker).

"....I am aware of the scheme, but nothing has been done to capture many of us into the scheme, the organisation itself needs to create awareness (Male private sector worker).

"....to my understanding, there is lack of sensitisation the information did not get to the workers.....there should be more sensitization....i could remember I ones worked with Niger state, general hospital Minna and I could see how health insurance scheme was going on..." (Male, private sector worker)

"....I am fully aware of the scheme, but I am yet to be enrolled. I don't know the procedures" (Female, informal sector worker)

"....my reason for not enrolling into the scheme for now is that I need more enlightment....." (Male, informal sector worker)

".....we in private sector are already into another contributory health insurance scheme. That is the reason why we did not enroll" (Male, private sector worker)

The barriers to enrolment of the vulnerable groups as reported by the staff of NiCare are the difficulty in identifying the group themselves as the updated register of such groups is not readily available. Secondly, most of the targeted groups lack the necessary requirements for enrolment, such as the National Identification Number—NIN. Thirdly, the problem of insecurity in the state has made some areas difficult to reach. This report is the view of all the respondents as reported below:

".....the challenges we face in enrolling the vulnerable groups into the scheme is that most of them do not have NIN number. So even if the beneficiaries are identified most of them would say they do not have NIN especially the children who are part of the vulnerable groups " (Female, NiCare staff)

" the major challenge that we face for enrolling vulnerable groups into the NCHS is that the vulnerable list itself, how do we get eligible people to enroll into the system? Now the list that we use is the social register that is generated by World Health Organisation —WHO, through youth empowerment and social support operation — YESO. Those list need to be revalidated and we do not have enough resources to do that and because a lot of people also want to be part of the list, how do we authenticate who are the venerable group? This is part of the challenge. And also Niger state has a very wide land mass with hard to rich communities. These also require a lot of resources and the resources are not that available. So these are the major challenge that we face for enrolling vulnerable group into the scheme " (Male, a staff of NiCare)

".....part of my response to your question on the barrier to enrolment of the vulnerable group into NCHS is the lack of mode of identification—NIN despite governments' efforts to sensitise the public and also make them obtain NIN, a lot of people in our rural areas don't have this NIN and NIN is one of our requirements for registration. So even though the enrolment for this group is free, if one does not have NIN he cannot be registered. Another barrier is the low level of literacy, even

though enrolment is free some people do not know the advantage of it, so they do not turnout.....” (Male, Nicare staff)

Discussion of Findings

Studies on barriers to enrolment in health insurance schemes often examine the cases of older insurance firms and were mostly conducted in relatively developed health insurance industrial settings. For instance, while the experiences of long queues by the existing enrollees affect new enrolment in Ghana, the lack of knowledge about the potential benefits of the health insurance scheme was a barrier to enrolment in Nigeria (Odeyemi & Nixon, 2013). Therefore, the findings of this study show that the barriers to enrolment into NCHS were more of take-off issues than the sustainability concerns. The views of most of the respondents were centred on acceptability or trust on the scheme, matters of sensitization and enrolment requirements.

Most of the respondents working with the public sector reported that their organisations have not given them the go-ahead to enroll and the go-ahead is subject to the agreements reached between their labour union (Nigerian Labour Congress—NLC) and the Niger State government. This portrays the absence of trust in anything government. The NLC acts to protect workers because of the previous experiences they suffered with similar schemes where workers were made to save but could neither enjoy the services of the then schemes, nor recoup their savings. Therefore absence of trust is identified as one of the barriers to enrolment in the scheme. Similar result was obtained by Alhassan *et al*, (2016), as well as Odeyemi and Nixon (2013) from their study in Ghana and Nigeria. Their result implicated absence of trust as the reason for low enrolment into health insurance

For most of the respondents in the informal sector, lack of awareness about the procedures for enrolment; the benefits derivable from the scheme and the costs were reported as the barriers to their enrolment. Therefore, poor sensitization is another barrier to enrolment into the scheme. This finding corroborates that of Odeyemi and Nixon (2013) in Nigeria and is in tandem with findings of Jehu-Appiah et al (2012) who reported perceived benefits, the price of the scheme, convenience with regards to accessibility to the health provider, and peer influence as the determinants of enrolment in Ghana. It thus shows that health insurance industry in Nigeria is still at its introductory stage and requires serious sensitization to gain public acceptance.

On the other hand, few respondents from the private sector reported being enrolled in other health insurance schemes as the reason for their non-enrolment in the NCHS. Availability of rival schemes therefore affects enrolment into the NCHS. The enrolment of the vulnerable groups is challenged by the absence of updated social register and national identification number (NIN) which are the requirements to identify and enroll the group members. Another problem that affect enrolment generally as reported by the NiCare staff is the problem of insecurity, which make some areas difficult to reach thereby affecting enrolment.

5. Conclusion and Recommendations

There is the need for clear commitment, sincerity and trust for the NCHS to command public confidence. Absence of trust is the major hindrance to enrolment in NCHS. The

management of NiCare must also embark on massive sensitisation to enlighten the public about the procedures, requirements, benefits and cost of enrolling into NCHS. It is therefore suggested that heavy initial advertisement investment be made. It is also pertinent to state that the NiCare has to design its identification model for the vulnerable groups based on the latest statistics to help them identify and enroll the qualified group members. The agency should also be made to operate using market principles, where they have to match revenue with costs and customers be allowed to voluntarily and individually enroll such that the quality of service delivery guides enrolment, not government directives.

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