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National Health Insurance Scheme and Civil Servants' Satisfaction with Health Services in FCT, Abuja Nigeria

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Abstract
National health insurance scheme provides a platform for mobilizing revenue for health services and enhances universal health care in Nigeria. In addition, civil servants' satisfaction with health services under the scheme helps in identifying gaps and provides evidence toward strengthening the scheme. This study assessed enrollees' (civil servants) knowledge about the National Health Insurance Scheme (NHIS) and satisfaction with health services provided under the scheme. The paper attempted to highlight the importance of NHIS and the attitudes of civil servants towards the scheme in FCT, Abuja Nigeria especially during the ongoing war against covid-19 pandemic and other related diseases. The paper utilized mainly secondary sources through the review of relevant literatures. The paper found that civil servants in FCT, Abuja have sound understanding of the scheme, but the echelon of satisfaction with quality of health services available is not commendable. Therefore, the paper recommends that there is an urgent need to improve on all areas of quality of services to improve satisfaction with care among civil servants in the scheme.

Keywords: Health insurance scheme, FCT-Abuja, civil servants' knowledge, satisfaction, health services

Introduction

Social health insurance plays an increasingly important role in today's worlds. Recent news indicates that attention is being focused more and more on healthcare delivery (Olorunniwo, Maxwell & Godwin, 2006). The shifting of the health sector in developed countries from health care to health delivery is considered one of the most important long-term trended in the health organization today (Uwais, 2008). Over the past two decades, researchers have devoted considerable attention to studying quality health services as perceived by the patient. Due to their intangible natures, health insurance services are more difficult to evaluate than health organization, which typically can be inspected and evaluated for quality service delivery before seeking healthcare (Pollack, 2009). In the modern world, one of the first strategies and priorities of health sector is to achieved the satisfaction of patients (Nezhadhajaly Irani, 2008) and for successful health organizations offering high quality services is necessary (Ismail et al., 2006). Patient's satisfaction or dissatisfaction results from experiencing a service and comparing that experience with the kind of quality of health services that are expected (Oliver, 1980). In fact, researchers believe that high levels of quality and client satisfaction is necessary to maintain clients and patients' loyalty, especially in services delivery (Hossain and Leo, 2009).

Civil servants' satisfaction with services is a proxy of the quality of health care, and it measures the level of contentment with services received in a healthcare system (Newsome & Wright, 2019). Studies have shown that satisfaction is correlated with utilization and follow-up with health care interventions and compliance with prescribed treatment regimens (Dogo, 2007). Satisfaction with care could also enhance the tendency of care recipients to serve as agents of information dissemination and promote health intervention among potential beneficiaries of National Health Insurance Scheme (NHIS) (Aliyu, 2020). Thus, satisfaction could predict to some extent the sustainability of a health care programme of the NHIS.

There have been divergent views about the association between some socio-demographic factors and satisfaction. While some studies asserted that certain socio-demographic characteristics such as age, sex, marital status, and occupational status are not associated with satisfaction (Olamuyiwa & Adeniji, 2021), the majority believed that they influence it (Salawudeen, 2011). Type of occupation among other attributes is also inclusive (Adewole, Adeniji, Adegbrioye, Oluyinka & Ilori, 2020). Satisfaction with care has also been linked with the level of education and economic status (Adewole, Reid & Oni, 2022). In some separate studies conducted in developing and developed countries, findings have also attributed satisfaction with the type of health care facility where the care was received—public or private (Newsome & Wright, 2019). Onwujekwe Okereke, Onaka, Uzochukwu, Kirigia & Petu (2010), as well as Jolie and Robert (2009) in separate studies, affirmed that health literacy about the quality of care available, existence of multiple morbidities, and seeking information about the quality-of-care influence satisfaction. Opposing findings have been reported in other studies; while some reported a high level of satisfaction, some reported a low level (of satisfaction) with care (Shafiu, 2009; Sambo, 2009; Smith, Humphrey & Jones, 2009 and Odo & Ukawuilu, 2019).

In collaboration with accredited health insurers (the Health Maintenance Organizations—HMOs) and healthcare providers, in both the public and the private sectors, the National Health Insurance Scheme (NHIS) operates a social health insurance scheme in Nigeria (Sanusi & Awe, 2009). The main goal of the scheme is to minimize inequity of access to healthcare services and improve population health indices in the country (Okoro Ohagwu & Njoku, 2010). Statutorily, policy direction about the scheme is provided by the NHIS. The NHIS is also responsible for the accreditation of eligible HMOs and healthcare providers (Agba, 2010). There are three levels (e.g., the primary, secondary, and tertiary) of healthcare in Nigeria. Of these three levels, the secondary and the tertiary levels are eligible to provide care to enrollees under the scheme (Lecky, 2006 & Brwley, 2010). Although the secondary and the tertiary levels of healthcare serve as primary care providers, however, in addition, the tertiary level serves as a referral point for the secondary care level when necessary (Kabir, 2007 and Odo & Ukawuilu, 2019).

Current population coverage under the NHIS is less than 3% of the total population (Adinma, 2006 & Onwujeke et al 2009). The present population coverage and the rate of progress are unlike the experience in comparable schemes in related settings in Africa and Latin American countries (Christel, 2000 and Kumar, Kirkiing, Hass, Vinokuz, Tylor & Atikinson, 2010). Poor satisfaction with care has been cited as a factor of low uptake of health interventions (Jorge, Helga & Ahmed, 2001). This study aimed to assess the determinants of quality of care of enrollees in the NHIS in Nigeria. The outcome was satisfaction with health care services, which was used as a proxy for quality. Findings would be useful for strategic policies to improve enrollment in the NHIS and the achievement of universal health coverage.

Civil servants' satisfaction with public health care delivery, especially since the inception of NHIS in Nigeria, has not been widely studied. Several unpublished surveys revealed that the overall service utilization and satisfaction with public healthcare in Nigeria despite the commencement couple with the slow pace of implementation of NHIS since 2005 is considerably low and the possible contributing factors include poor knowledge and awareness of the NHIS operational modalities by the public, skeptism and lack mutual trust of the public on government policies/programmes with NHIS not an exception, cumbersome NHIS referral system, poor healthcare providers attitudes, conflicts among healthcare professionals as regards their roles in the scheme, fraud/corruption in the Health Maintenance Organisation(HMO) operation in the scheme etc (Awosika, 2005 & Dogo, 2007).

In an effort to cope with the spiralling cost of health care, the Nigerian National Healthcare Financing Policy (NHFP) (2006) articulates funding of health sector from budgetary sources, and recognizing additional avenues of revenue such as health insurance schemes and direct financing

by employers of labour. Thus, NHIS represents very promising sustainable healthcare service strategy, through which the government hopes to achieve more pliable, more creative and more aggressive feedback to the health organization in order to ensure every citizen has access to quality healthcare services (Uwais, 2008). The study intends to assess civil servants' satisfaction with health services under NHIS in National Assembly and Corporate Affairs Commission of FCT, Abuja in relation to healthcare providers and also to look at quality of health service in the perspectives of all the three key players of a health system, the level and pattern of utilization of outpatient care and clients' satisfaction with outpatient care under the NHIS in FCT, Abuja.

Conceptual Review

The following concepts were conceptualized

Concept of Health Insurance

Health insurance as a means of promoting universal health coverage has attracted considerable interest in the past (Cambell, 2007). Yet, the multi-dimensional nature of health insurance makes more studies on health insurance knowledge/awareness, perception, coverage, access and impact necessary. Many of the earlier studies have concentrated on developed economies where, the insurance system is well developed. Recently, however, we begin to see papers that address the use of health insurance as an option for financing and facilitating access to healthcare in developing economies. Notable among the recent researches is that of the Centre for Development Research (CDR, 2020) that examined the feasibility of health insurance scheme in rural areas in a number of developing countries including Senegal and Ghana in West Africa, Ethiopia in East Africa and Tanzania in Southern Africa.

Health insurance is based on the principles of social solidarity and mutual support which involve the transfer of resources from the relatively richer and healthier people to the relatively poor and sicker people. According to Crocco (2005), two types of social health insurance scheme can be distinguished; the primary benefit model where the healthcare benefit are financed by a specific health insurance contribution and the secondary benefit model where healthcare benefits are financed from general social security contributions which also cover other types of benefits.

The international labour organisation (ILO) classified social health insurance into three types:
i. Direct Social Health Insurance Scheme
ii. Reimbursement and
iii. Indirect Social Health Insurance Scheme

In Senegal, jutting (2010), using combined logit and log-linear models, found that members of the rural populace who participate in the insurance scheme have higher probability of using hospitalization services than non-members and pay substantially less when they need care, this reinforces the findings of Agba (2010) in a study conducted among the staff of Federal Polytechnic, Idah, Nigeria on the perceived impact of NHIS. In Uganda, Manje (2007) reported that provision of low-cost income workers enabled insurance premiums increased the sustainability of health financing. Instances where, health insurance seems to have worked in Nigeria is Anambra state community health systems and healthcare financing scheme (Onwujeke, Onoka & Uzochukwu (2009) and the Community based social health insurance scheme in Songa, Kwara state, being co-funded by the state government and a donor agency from Netherlands (Adewole, Adeniji, Adegbrioye, Oluyinka & Ilori, 2020).

Health Insurance is social security arrangement that guarantees the provision of the needed health care services to a person on the contribution of a token to provide financial protection to the participants. Health insurance is a mechanism for protecting families against the unexpected high costs of illness by sharing the risks of future costs among healthy and sick populations in the form of regular predictable payments. Three principal types have been identified, but in Africa,

studies have revealed four common models (Christel, 2000 and Blazenka, Vladiekiene; Xinxo, 2004 and Salawudeen, 2011). These include:
i. Social Health Insurance Scheme
ii. Private Health Insurance Scheme
iii. Employer Based Health Insurance
iv. Rural Community Based Health Insurance

In a study by Hall & Dorman (2000), six different forms of government health insurance were identified in sub-Saharan Africa. This study found that social health insurance was available in only seven out of twenty-three countries considered and private sector voluntary health insurance had a place in only five – Cote d'ivore, Ethiopia, Kenya, and Nigeria. Health insurance schemes in different countries usually differ in terms of the extent of coverage, benefit package, administration, health services delivery, provider payment and finance. In studying resource mobilization in five countries (South Africa, Ghana, Zambia, Zimbabwe & Botswana), Health and Human Resources Analysis for Africa (HHRAA)/Data for Decision Making (DDM) project (2019) found that health insurance was of increasing policy of interest as a method of raising resources and, potentially, improving the supply and provisions of health services. HHRAA/DDM research, however, indicated that only small percentages of the populations studied had any kind of health insurance and that insurance scheme currently do not contribute significant resources to total health care financing. Current health insurance scheme also tends to cover mainly the wealthier income groups or the formally employed, limiting the reach of such scheme into lower income or rural populations, similar to what is found in Nigeria.

The proponents of health insurance argue that people may be more willing to pay for health insurance rather than being heavily taxed or charged user fees, this was not collaborated by the findings of the study conducted by Onwuyekwe, Okereke, Onaka & Uzochukwu (2010) on willingness' to pay for Community Based Health Insurance (CBHI) in Anambra and Enugu states of Nigeria, where less than 40% of the respondents were willing to pay for CBHI membership.

Concept of National Health Insurance Scheme (NHIS)
Increasingly, a number of developing countries have increased the role of risk sharing mechanism in the delivery of healthcare. In most of these countries, the emphasis is on the introduction of various forms of "Social Health Insurance Scheme'' (Lecky, 2006).The NHIS for Nigeria is designed to be indirect social health insurance scheme with healthcare providers (public and private) to be contracted to give health care benefits to contributors (Dogo, 2007).Many of the earlier studies on NHIS in Nigeria have concentrated on health care providers or professionals, assessing their level of awareness on the operation of the scheme. Recently, however, we begin to see studies that address the client knowledge/awareness, utilization and satisfaction of NHIS, and moreover the impacts of health insurance intervention on assess and quality of health care in the country.

An overview of these researches reveals that the civil servants are the major stakeholders in the programme and are adequately aware of NHIS but have grossly inadequate knowledge of the basic principles of the operation of social health insurance scheme. Examining some of these works further can be illuminating in Kaduna, Salawudeen (2011) reported a low level of awareness and knowledge of NHIS among civil servants with generally high interest on NHIS. In a related work done by Sanusi et al in (2009) to assess the awareness level of NHIS among healthcare consumers in Oyo state, the report shows that 65% of the respondents are aware of NHIS. However, respondents who have been treated under the programme wanted the scheme to be discontinued.

Onwujekwe et al (2010), in a study examine differences in enrolment and utilization in two community- based health insurance schemes in the South eastern Nigeria, found that enrolment

was associated with enrollees perception of financial risk protection and quality of care, and the primary reasons for non-enrollment were inability to pay premiums, concurrent enrollment in government NHIS, and distance from an enrolled facility. The study further shows that the differential enrolment in the two programmes can be attributed to insufficient community involvement, lack of trust in the programmes, and the voluntary nature of the enrolment (Uwaais, 2008).

In the studies conducted on the attitude and satisfaction with NHIS health services among beneficiaries before the commencement of the scheme in 2005, Onuekwusi et al (2019) in Enugu and Sabitu et al. (2002) in Minna reported a very low proportion of the enrollees who are knowledgeable and positive perception on the various aspects of the operation of the scheme. In a related study done to assess the attitude and level of satisfaction opinion of enrollees in Jos towards NHIS, report is in line with findings of the studies of Enugu and Minna with high proportion of the respondents expressing willingness to participate in the scheme, Danladi C. (2003).

In 2009, four years after the commencement of the scheme, Okaro, Ohagwu & Njoku (2010) report on the assessment of awareness and perception of NHIS among radiographers in Southeast Nigeria, shows good attitudinal predisposition towards the scheme, despite their lack of adequate knowledge of the rudimentary principles of the operation of a social health insurance scheme.

Concept of Satisfaction

Satisfaction is defined as “pleasurable fulfillment” (Oliver, 1999). Patient satisfaction is an output, resulting from the patient’s perception or reaction comparison of expected performance with perceived actual performance and incurred cost (Aydin et al., 2005). Satisfaction is dependent on the ability of the provider to meet the patient’s norms and expectations. According to Morad, Hamidreza, Hamidreza & Sajjad, (2011), satisfaction is the experience evaluation of services given the expectations before seeking healthcare.

Several studies seem to conclude that satisfaction is an affective construct rather than a cognitive contract (Oliver, 1997; Olsen, 2002, Olorunniwo et al., 2006). Rust and Oliver (1994) further defined satisfaction as the "patient's fulfillment response," which is an evaluation as well as an emotion-based response to a service (Olorunniwo et al., 2006). Studies on patient and client satisfaction with services have traditionally measured the construct with single item measures (Bitner, 1990; Bolton and drew, 1991 b; Caruana et al., 2000; Sivadas and Baker-perwitt, 2000; Theodorakis et al., 2001; Imail et al., 2006). In this study, clients' satisfaction is measured by using one item that captured overall satisfaction of clients on the service offered by the health organizations. Commitment to client satisfaction is an on-going process. This is because no matter how good the services are, patients will continually expect better services (Ting, 2004).

Theoretical framework

The paper adopted Personality Satisfaction Theory. Personality Satisfaction Theory postulates a relationship between service quality, client satisfaction and client personality. The theory contends that client personality mediates the dependent variable. To assess the current NHIS quality health services, the paper adopted the service quality dimensions of Parasuraman et al. (1988). The framework illustrates the following basic sequence: NHIS quality health services lead to client satisfaction and client personality is a moderator. Previous studies provide evidence of relationship between quality services and client satisfaction (Ismail et al., 2006; Ueltschy et al., 2007; Pollack, 2008; Chaniotakis and Lymperopoulos, 2009). Smith et al. (2008) found that fairly perceived quality services may also result in high satisfaction for those civil servants who may not necessarily seek the health careunder NHIS. Such civil servants may view convenience, prompt attention and availability of services as more important variables affecting overall qualitative health services of NHIS. However, Sanusi et al. (2009) and Opere (2010) found that

attributes of NHIS health services quality are positively associated with civil servants' satisfaction (Ismail et al., 2006).

Civil Servant's Satisfaction with Health Services under NHIS

Civil servant satisfaction with healthcare has, in recent years gained widespread recognition as a measure of quality of care. This has originated meagrely because of the aspiration for prime involvement of the patient in healthcare process and partly because of the link demonstrated to exist between satisfaction and compliance in areas such as appointment keeping, intension to comply with recommended treatment and medication uses. Since quality healthcare result depends on patient satisfaction the latter has come to be seen as a justifiable health objective and therefore of quality care. Healthcare cannot be of distinguished quality except the patient is fully satisfied (Dave, 2003; Danladi, 2003&Araoye, 2004). Client satisfaction assessment is widely used to evaluate the quality and the effectiveness of various healthcare service deliveries. Different methods and instruments are used to measure consumer's satisfaction. Consumer satisfaction with healthcare services is associated with many contributing factors, among which are related to health providers and healthcare delivery process. The relationship between consumers' socio-demographic characteristics and their satisfaction with medical care is widely examined, such as age, ethnicity, gender, socioeconomic status, marital status and family size. For example, Adinma (2006) identify older consumers report greater satisfaction with mental healthcare services. Hall and Dorman (2010) conduct a meta-analysis of 221 studies, which examines the relation of consumers' socio- demographic characteristics to their satisfaction with medical care and conclude that greater satisfaction is significantly associated with greater age and less education and marginally significantly associated with being married and having higher social status. The average magnitudes of these relations are very small, with age being the strongest correlate of satisfaction. No overall relationship is found for ethnicity, gender, income or family size.

Doyle and Ware (2007), examined major dimensions of consumer satisfaction perceptions of accessibility, availability of medical personnel's, completeness of facilities, continuity of care, and doctor's conduct and found that physician conduct was the most important factor in the general satisfaction with healthcare. Instructions regarding medication and health education by healthcare providers were found to be associated with greater levels of satisfaction in healthcare in a study carried out by (Onwudiegwu, 2019). Consumer factors also have an influence on patient's satisfaction with the healthcare delivery. In a longitudinal study with 344 patients, Opere (2020), found that consumer's experience with healthcare was strongly associated with satisfaction and with intent to continue using the new medication.

In a related work done by Nketiah-Amponsah & Heimenz (2009) on the assessment of determinants of consumers satisfaction of health care in Ghana, shows that the satisfaction level with the health system is generally high (65%), while 11% were dissatisfied. In term of specific providers, subscribers of private healthcare are more satisfied than those who demanded care from other provider of services. Furthermore, distance, waiting time, level of education, communication, and cleanliness as well as the general attitude of the healthcare providers was found to be significant predictors of healthcare satisfaction.

In Uganda, Manje (2007) in a study to analyse client satisfaction with health insurance in Uganda, found that awareness/knowledge on the concept of risk pooling is very poor, perceptions have been influenced by previous negative experiences with insurance and health insurance providers have not been explicit enough on the benefits, terms and condition of their policies. Shafiu et al(2009), in a study conducted among staff of Ahmadu Bello University (ABU) Zaria to assess Client's satisfaction with the health insurance scheme in Nigeria, reported low satisfaction which is attributed with marital status especially in polygamy, adequate knowledge of health insurance, longer duration of enrolment and also being aware of money contribution for the scheme. Better

attitude of the providers towards clients, decreased waiting time in hospitals, and availability of hospital personnel at all times was also found to be significant predicator of satisfaction and would help in improving clients' satisfaction in terms of access and utilization of services.
Ibiwoye and Adeleke 2007), in their work a linear analysis of factors affecting the usage of Nigeria's NHIS, reported a considerable high usage of NHIS among civil servants. The study also revealed that occupation, income and other socio-economic factors affect the use of NHIS in Nigeria and these factors are mutually exclusive. Also, Ibiwoye and Adeleke (2009), in their study to assess the impact of the NHIS in promoting access to healthcare, identifies the ineffectiveness of the scheme and the need for all stake holders to engage in the active promotion of awareness on health insurance as option of healthcare provisioning. In a similar study by Agba (2010), to assess the perceived impact of NHIS among registered staff of Federal polytechnic Idah, Kogi State, also shows that although the scheme is ineffective it should not be discontinued because in a long run if properly managed its benefits will be tremendous on the workforce.

Smith et al (2009). in a study to measure the level of consumers' satisfaction on Health Maintenance Organization (HMO) found that methods of healthcare provider's payments also have an impact on consumer satisfaction, that is, consumer satisfaction with HMOs is negatively correlated with the proportion of healthcare providers' who are compensated on a capitation- fee basis and positively correlated with a fee-for- service incentive (Jatau, 2004).

Discussion

Nigeria's quest for qualitative healthcare delivery and universal health coverage since independence has been hampered by availability of quality health services which have led to series of health challenges and in recent times have consumed many lives. These challenges have regularly punctuated Nigeria's desire to nationhood by deep-seated health related problems (Lecky, 2006). In recent time, series of health challenges such as covid-19 pandemic, cholera, Lassa-fever, cancer diseases, diabetes, pneumonia, and hepatitis diseases have recently threatened life and human existence in the country. The recently most destructive and deadliest ever witnessed in Nigeria is the Lassa fever which has consumed many lives and continues to pose a distinct health threat to the health sector in the nation. Many lives were lost due to poor qualitative health services even with different health programmes provided by the governments. According to World Health Organization, an estimated life of ten thousand people died annually in Nigeria due poor health care system (WHO Report, 2019).

National Health Insurance Scheme (NHIS) was introduced in 2005 in Nigeria in response to the dwindling qualitative health services in the nation health sector, with the aim of improving the quality of health services, improving access with equity, and promoting utilization of health services by all participants. The first phase of implementation started seventeen years ago with the enrollment of formal sector employees. Greater acceptability and active participation in the scheme are essential if the desired goal of the scheme is to be achieved (Odo & Ukawuilulu, 2019).

To ensure continuous participation in the scheme, future planning efforts need to consider the clients satisfaction which, of course, is based on the knowledge and awareness of the enrollees. The level of awareness among enronllees was high but there was no correlation between awareness exhibited by majority of enronllees and their understanding of the working of the scheme, a trend exhibited by majority of enronllees in the different cadres. This supports the value of the beneficiaries' experience and its contribution to satisfaction. This is in agreement with the findings of Manje (2007) in Uganda who found that client's awareness/knowledge on the concepts of health insurance is very poor, a perception influenced by previous negative experience. Among other reasons that influenced the enrollees to choose the health care provider with adequate infrastructures, equipment, technical competence of the staff and proximity to

place of residence. This supported the fact that assessment of patient's expectation is one of the ways of learning about patients' needs.

With regards to overall satisfaction, most civil servants in FCT, Abuja were satisfied which supported the findings of Shafiu et al (2009) and contrary to baseline NHIS client utilization and satisfaction survey (2019) conducted three years ago which reported low satisfaction rate. This unacceptable level of client dissatisfaction may imply deterioration of quality of care being provided under the scheme coupled with poor knowledge of the operation of the scheme. Most of the civil servants who are beneficiary of the scheme expressed satisfaction with regards to the patience care they receive from their HCP under the NHIS. The enrolees would not want the scheme to be discontinued as reported by Okaro et al. (2010) which is in contrast to the finding of Sanusi et al (2009).

In summary, this paper found that the level of knowledge of NHIS clients and on the various aspects of NHIS activities is still poor many years after commencement, but there is very much improvement when compared to earlier findings of Onuekwusi (2010) in Enugu, Sabitu et al (2009) in Minna, Danladi (2010) in Jos, Sanusi et al (2009) in Ibadan and Shafiu et al (2009) and Salawudeen (2011) in Zaria. This might probably be due to the aggressive public enlightenment campaign in both print and electronic media and regular stakeholder's interactive forum embarked upon by the scheme (Odo et al. 2019). This shows that a lot still needs to be done to ensure that adequate and quality health-care services are received by NHIS enrollees. Expectedly, this will have a positive impact on patients' satisfaction with care, improve treatment outcomes, and ensure the general the realization of the underlying goals of the NHIS programme.

Similarly, this paper demonstrated that satisfaction with health service delivery was associated with prompt attention from the health care providers as more enronllees reported that they were satisfied with services. Generally, while efforts are being made to achieve universal health coverage, it is also critical to ensure that civil servants are satisfied with health services under NHIS. This can be realised by strengthening health-care providers as well as HMOs to provide quality healthcare to their clients (civil servants) under the scheme in achieving the objective of access to affordable health-care services (Adewole, 2010).

Most civil servants expressed satisfaction with quality of outpatient care provided in their centres, as related to such factors as health personnel behaviours, prompt attention, communication/information and medical equipment. This was supported by the findings of this study which revealed that majority of enrollees chose the hospital based on their previous experience and expectation. The service utilization under the scheme is still very low in terms of out-of-stock-drugs as reported by Adeoye et al (2007), some years ago; hence there is need for more aggressive sensitization and enlightenment of all the stakeholders about the operations of the NHIS. The referral for secondary care is very low, which call for urgent review of the NHIS referral protocol

Conclusion/Recommendations

The paper revealed that civil servants under NHIS have good attitudinal predisposition towards the scheme, despite their lack of adequate knowledge of the rudimentary principles of the operation of the scheme. This implies that if quality health services are made available to civil servants, the likelihood of their perception towards the scheme and consequent improved implementation will be high. This calls for a conscious delivery drive and intense quality services under the scheme. Also, the findings of the paper would be important to the scheme as it gives a clear picture of the feelings of the beneficiaries of the formal sector programme as well as insight into some remarkable achievements made by the healthcare providers as a result of regular improvement of the scheme, many years after commencement. Hence, the paper recommended that:

i. In order to consolidate the gains so far made in the scheme, there is need for the management of NHIS to embark on an intensive enlightenment and awareness campaign of all stakeholders' regular interactive forum and seminars/workshops.
ii. The management of the scheme should as a matter of urgency put in place an effective monitoring and evaluation programme in order to gauge the utilization of the scheme and fine tune its operations as well as dispel dissatisfaction by enrollees.
iii. There is urgent need for the management of NHIS to review their policy documents (operational guideline, benefit package etc) and update their website regularly for beneficiary to keep in touch with prevailing situation.
iv. There is the need for the Health Management Organization (HMO) of NHIS to establish a quality assurance committee in all the accredited centres and to incorporate the findings of this study to the minimum health package of the facilities.

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