FINANCING HEALTH INSURANCE AND HEALTHCARE DELIVERY IN NIGERIA

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Abstract
The study examined the impact of financing National Health Insurance Scheme (NHIS) on healthcare delivery in Nigeria during the fourth republic. Descriptive survey research design was employed for the purpose of data collection analysis and interpretation. Similarly, secondary data were sourced from the repositories of Federal Ministry of Health, Teaching Hospitals, NHIS and Health Maintenance Organisations (HMOs). Out of a total of 2,708 questionnaire administered to enrollees and non- enrolees across the six geo-political zones of the federation, 2120 were completed and returned properly. Simple percentage and frequency distribution were used for the analysis of research questions. The findings of the study revealed that there has been low level of awareness about NHIS among respondents. Similarly, there is poor healthcare service delivery in public hospitals due to poor funding. The study recommends for increase budgetary allocation to the health sector and manpower strength of the scheme, institutionalization of financial transparency and accountability by managers of the scheme.

Key words: *National Health Insurance Scheme, Financing, Healthcare Delivery*

Introduction

In Nigeria, the major sources of healthcare financing include; (i) tax-based public sector that comprises Local, State and Federal Government (ii) the private sector (including the not-for-profit sector) financing which is done, directly or indirectly through health insurance of their employees (iii) households, through out-of-pocket expenditures, including user fees paid in public facilities; (iv) other insurance-social and community-based; and (v) external financing (through grants and loans) from donor organisation (Uzochukwu, Ughasoro, Etiaba, Okwuosa, Envuladu, Onwujekwe, 2015; Olakunde, 2012; Archibong, Ogana, Edet and Enamhe, 2023). However, there still exist disproportions in health system financing despites the health financing options so identified in Nigeria. For instance, Olaniyanand Lawanson (2010) observed that severe budgetary constraints and uneven distribution of resources among the urban and rural areas with the rural areas most affected by inequitable budgetary health expenditure allocation. Ichoku and Fonta (2006) had also noticed a catastrophic healthcare financing

in Nigeria which has led to further impoverishment of the poor. According to Ichoku and Fonta (2006), Nigeria's health financial arrangement has shifted from health provision by the government as a normal good towards a competitive market where a greater proportion of health services are provided by the ability to pay through out-of-pocket expenses (often referred to as user-fee). Furthermore, excessive reliance on the ability to pay through Out-Of-Pocket payment (OOP) reduces healthcare consumption, exacerbates the already inequitable access to quality care, and exposes households to the financial risk of expensive illness at a time when there are both affordable and effective health financing instruments to address such problems in low-income settings (O'Donnell, et al, 2005). Similarly, it could be argued that the system of healthcare financing in Nigeria is disproportionate, such that, it pushes the burden and risk of obtaining health services to the poor.

Funding of the healthcare sector in Nigeria is faced with enormous challenges that must be overcome if quality and effective healthcare services are to be made available to the people. The health of people in a country directly affects the development of the country. This is because according to the World Health Organization (WHO, 2005), 50% of economic growth differentials between developed and developing nations are attributable to ill health and low life expectancy. So for a country to be developed, it has to spend a high proportion of its Gross Domestic Product (GDP) on healthcare. It is in this view that the constitution of Nigeria in Ssection 17(3) (c) and (d) states that "the state shall direct its policy towards ensuring that the health, safety and welfare of all persons in employment are safeguarded and not endangered or abused and that the state shall direct its policy towards ensuring that there are adequate medical and health facilities for all persons." Having known that there is a positive relationship between health and economic growth, then for any economy to develop, it must commit sufficient expenditure to health to achieve desired levels of health status and economic development (Agbatogun andTaiwo, 2010). The government of Nigeria has come up with a lot of healthcare policies aimed at ensuring a better standard of living for its citizens. One of such policies is the establishment of the National Health Insurance Scheme (NHIS). The policy is projected at ensuring that every Nigerian has adequate healthcare delivery at a minimum cost. NHIS is a method of financing healthcare, which is based on a concept that aims at improving the health needs of the people especially the vulnerable groups.Efforts to establish a new social insurance programme in Nigeria were reinvigorated in Act No. 35 of 1999. This followed pressures traceable to 1962 through the 1980s and 90s. In 2005, the National Health Insurance Scheme was inaugurated (ISSA, 2006). In spite of huge government spending, coupled with bilateral and multilateral assistance in the health sector, access to healthcare has remained a problem. The health system is in shambles, policy somersault and reversals tend to have under-mined several reforms in the health sector over the years. Poor

human resources and policy management have led to unprecedented brain drain in the health sector as health professionals in search for better conditions of service abroad often vote with their feet in droves (FMoH, 2005). The Nigerian health system is in comatose, few hospitals with few drugs, inadequate and substandard technology and a lack of infrastructural support, including electricity, water and diagnostic laboratories resulting in misdiagnosis. Medical record keeping is rudimentary and diseases surveillance is very poor. Delivery of healthcare becomes a personal affair and dependent on the ability to pay for basic laboratory and physician services. These have exacerbated the disease burden (FMoH, 2004).

Healthcare financing is worse hit especially in the poor continent where healthcare faces a serious problem of acceptability with out-of-pocket expenditure accounting for over 70% of total private health expenditure is enough to dent the little progress made by the health system. Hence, the increasing out-of-pocket expenditure due to high disease burden on most poverty-stricken households has kept them in the vicious cycle of the poverty trap. Risk pooling in the form of private/commercial health insurance is often lopsided while the much-touted social insurance is limited to those in Federal government service (HERFON, 2006).Attempt to address the precarious and miserable situation in the health sector, and to provide universal access to quality healthcare service in the country, to provide universal access to quality healthcare to all Nigerians. The purpose of this study, therefore, is to empirically examine the impact assessment on the National Health Insurance Scheme (NHIS) in healthcare financing and delivery in Nigeria

Objectives

1. Assess the impact of financing National Health Insurance Scheme (NHIS) on Healthcare Delivery in Nigeria.

2. examine the impact of Healthcare Delivery on the health condition of Nigerians.

Conceptual Framework

Health Care Policy

Healthcare policy refers to what government chooses to do or not to do regarding the management and administration of private and public hospitals. In other words, healthcare policy means the document that contains the programmes, intended or unintended actions of government regarding the provision of healthcare delivery at a given period of time.According to World Health Organisation (2011), health policy refers to the decision, initiatives, agenda, plans and actions embarked upon in order to achieve established healthcare objectives in a given society. This means that health care

policy is the agenda, vision, future plans and mission of government on health related matters. However, Colombia University Mailman School of Public Health (2021) conceives health policy as the law, regulations, actions and decision implemented in efforts to towards ensuring wellness and the attainment of health care objective. By implication, this definition views health policy as immediate actions of government towards meeting specific health care goals. For the purpose of this study, health policy refers to an official document that contains the agenda, plans, initiatives, guidelines and intentions of government towards ensuring wellness and goods health for in individuals in a given society.

Health Insurance Policy

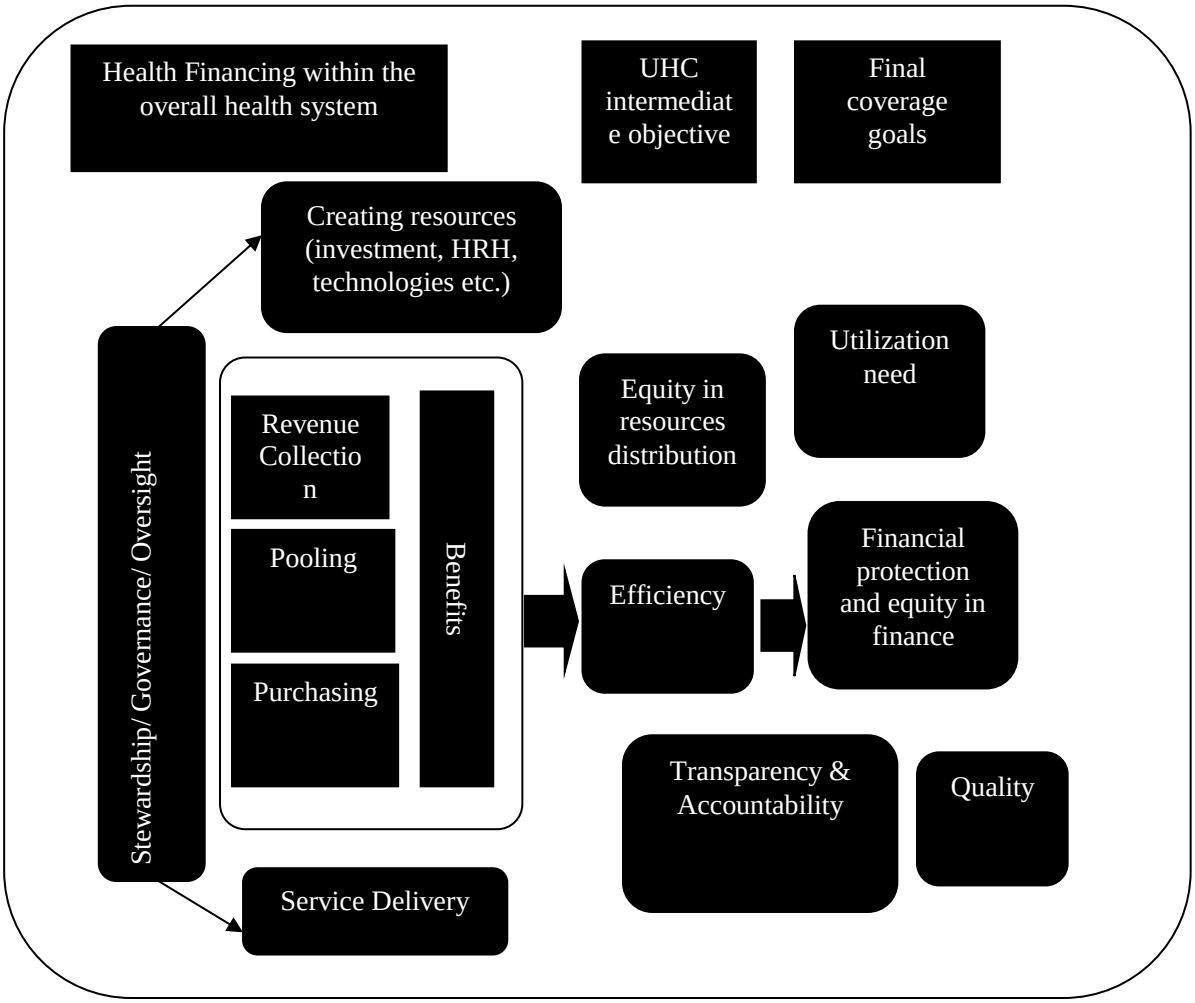
Health insurance policy on the other hand refers to plans put in place towards financing the cost inured as a result of future medical unforeseen circumstances such as accident, illness, death or impairment. In the opinions of Ahuja and Narang (2005), health insurance refers to the cost of medical bills and expenditure. It is an agreement between an insurer and insured where the insurer promises to provide specific insurance cover against a fixed amount of premium to be paid per annum. In the same vein, Akila (2013) opines that health insurance covers all or part of the risk of an individual inuring medical expenditure by spreading the risk over a large number of person (Das, 2018). For the purpose of this paper, health insurance refers to a contractual agreement between an insurer and insured for the purpose of handling unforeseen medical related issues in future. The insured pays a premium to insurance companies or insurer in order to receive payment for medical needs in future.

Healthcare Financing

Healthcare financing can be defined as the mobilization of funds for healthcare services (Oyefabi, Aliyu and Idris, 2014). In other words, it is the provision of money, funds or resources to the activities designed by the government to maintain people's health. These activities encompass the provision of medical and related services geared toward maintaining good health, especially in the aspect of disease prevention and curative treatment. The concept of healthcare financing succinctly deals with the quantity and quality of resources a country expends on healthcare. This is proportionate to the country's total national income. The amount of resources earmarked for healthcare in a country is said to be a reflection of health value placement vis-a-vis other categories of goods and services. It has been opined that the nature of healthcare financing defines the structure and the behaviour of different stakeholders and the quality of health outcomes (Metiboba: 2012).

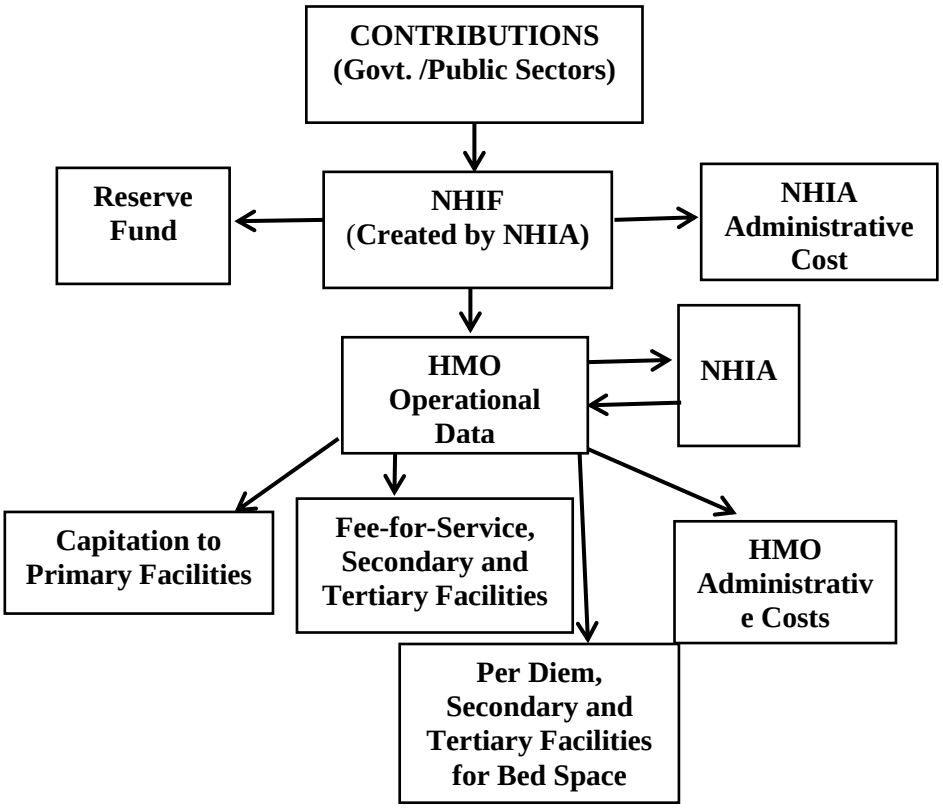
In the opinion of Uchenna (2019), the federal government of Nigeria signed into law the National Health Act. This law makes provision for the allocation of not less than 1% of the federal consolidated revenue fund to health and for it to be set aside specifically to finance the basic healthcare provision in Nigeria. This fund is called the Basic Health Care Provision Fund (BHCPF). The fund is equitably targeted at funding the basic healthcare needs of Nigerians at the primary care level in communities through the Health Care Development Agency (NPHCDA) and emergency gateway (now implemented by FMOH and NCDC).Though the fund (BHCPF) got its first appropriation in the 2018 fiscal year.

Figure. 1. Healthcare Financing



Source: WHO, 2017

Figure. 2: Transfer of Funds from NHIA to HMO (Formal Sector)



Source: NHIA – Operational Guideline, 2022.

Healthcare Delivery

Healthcare delivery refers to the procedures adopted for treatment of patients by public health organisations. It equally refers to service rendered to patients by medical practitioners, health workers and professions for the purpose of ensuring sound health and wellness in the society. This will go a long way in increasing the life expectancy and decreasing mortality in the society. Health care delivery is the method adopted for rendering medical services to patients. It focuses on improved quality treatment, reduced cost and meeting the expectations of patients. Similarly, the National Health Insurance Scheme (NHIS) in Nigeria was officially launched on 6th June, 2005 to ensure the provision of basic economic security to workers in case of health related challenges such as accidental injury, old age, sickness, diseases and ailments. The NHIS benefits and incentives are very incisive and widespread with regards to enrollees health related concerns such as consultation, drug infusion, consumables and some minor surgeries

(Eze, Iseolorunkanmi and Adeloye, 2024). However, Akwukwuma and Igodan (2012) observed that the level of corruption, lack of transparency, and accountability has negatively impacted the effectiveness of NHIS.Similarly, the provision of quality, accessible and affordable healthcare remains a serious challenge due to perennial shortage of personnel, inadequate and outdated medical equipment, poor funding and policy inconsistencies (Akwukwuma and Igodan 2012; WHO, 2007)

Theoretical Framework

This paper adopted the structural functionalism approach as a theoretical framework since NHIS was set up for the purpose of ensuring Universal Health Coverage in Nigeria. The theory examines the basis for the maintenance of order and stability in society and the relevant arrangements within the society, which maintain the said order and stability. In our formulation of a structural-functionalism framework, social processes and social mechanisms are intervening variables. A complete description of a social system would include, therefore, treatment of the social structures, and various functions of these structures; and of the social processes and mechanisms that must be in operation if structures are to satisfy certain functions (Holt, 1967). In other words Structural functionalism sees society as a complex system whose parts work together to promote solidarity and stability. In the 1970s, political scientists Gabriel Almond and Bingham Powell introduced a structural-functionalist approach to compare political systems. They argued that, in order to understand a political system, it is necessary to understand not only its institutions (or structures) but also their respective functions. They also insisted that these institutions, to be properly understood, must be placed in a meaningful and dynamic historical context.

The basic assumption of the structural-functionalist framework is that all systems have structures which can be identified, and those structures perform a specific set of tasks if they are to remain in existence and maintain their relevance to the system. According to Almond and Powell (1969), the functioning of any political system may also be viewed in terms of its capabilities, which is the way it performs as a unit in its environment. The concepts of regulative, extractive, distributive and responsive capability are employed as criteria to assess how a system is performing within its environment, how it is shaping its environment, and how it is being shaped by the environment as well.

Practically, the NHIS has some components and institutional stakeholders that must work harmoniously to achieve efficient and effective healthcare delivery to the target enrollees. Some of these stakeholders repeatedly mentioned include the government, employers, employees or enrollees, HMOs, healthcare facility owners or managers, etc. Among its statutory functions, the government through the scheme sets standards and

guidelines for all the stakeholders to observe. The employers (public or private sector) must pay some amounts as premiums to the HMOs who in turn remit to managers or owners of healthcare facilities for treating registered enrollees. (Scott and Marshall 2005)

Methodology

This study is a survey research. The survey approach included interviews and questionnaire administration. Also secondary data were be used. Considering the nature of the phenomenon under investigation, it was designed to collect relevant data from respondents who reside in the six (6) geopolitical zones through the use of questionnaire and oral interview. Because of the vast size of the country and the large population size, the study selected one (1) state from each geopolitical zone through convenience sampling techniques. Both enrolees and other health seekers formed our targeted population. Interviews were also conducted to elicit the opinion of respondents on the impact assessment on the National Health Insurance Scheme NHIS in the Healthcare Financing and Delivery in Nigeria. Those interviewed are major stakeholders whoare knowledgeable in the subject matter, they included staff of the NHIS, Hospital management and staff, HMOs, labour leaders and enrollees and non enrollees alike.

Population

The population of this study was drawn from six states (including FCT). These includes the total population of enrollees and non-enrollees in National Hospital Abuja, FCT (North Central); ABU Teaching Hospital, Kaduna State (North Central); AbubakarTafawaBalewa University Teaching Hospital, Bauchi State (North East); Lagos University Teaching Hospital, Lagos State (South West); University of Nigeria Teaching Hospital, Enugu State (South East) and Federal Medical Centre, Delta State (South-South). The total targeted population of these states which represents the enrollees and the non-enrollees in the entire geopolitical zones in Nigeria is 4,569,821, while the NHIS staff which represents the institutional population are 1,369. Therefore, the total targeted population was 4,571,190 as presented under the table below:

Table 1: Users and Non Users of NHIS

S/N	ZONE	STATE	HOSPITAL	NHIS ENROLEES	NON-NHIS ENROLEES	TOTAL
1.	North-Central	FCT Abuja	National Hospital Abuja	21,702	387,896	409,598
2.	North-West	Kaduna State	AhmaduBello University Teaching Hospital	19,290	1,764,248	1,783,538
3.	North-East	Bauchi State	AbubakarTafawaBalewa University Teaching Hospital	18,017	225,370	243,387
4.	South-West	Lagos State	Lagos University Teaching Hospital	9,017	1,440,000	1,449,017
5.	South-East	Enugu State	University of Nigeria Teaching Hospital, Enugu	16,870	427,401	444,271
6.	South-South	Delta State	Federal Medical Centre, Asaba	16,560	223,450	240,010
7.	**TOTAL**			**101,456**	**4,468,365**	**4,569,821**

SOURCE: NHIS 2017/Field Work (Number of NHIS users and non-users in the six states sampled across the six geo-political zones of Nigeria)

Table 2: Institutional Staff (NHIS Staff across Nigeria)

S/N	TOTAL NUMBER OF STAFF AND LOCATION	NUMBER
1.	Number of Head office Staff	518
2.	Number of Staff in the 7 Zonal Offices made up of (North Central, (Abuja) (SW II) Lagos, Enugu (SE), Ibadan (SWI), Benin (SS), Kaduna (NW), Maiduguri (NE)and Ilorin (NC)	177
3.	Number of staff in 36 States offices include the FCT	674
	Total	**1,369**

SOURCE: NHIS 2018

Table 3: Total Population of NHISEnrollees and Non Enrollees and Staff

S/N	TARGET POPULATION	NUMBER
1.	NHIS Enrollees	101,456
2.	Non-NHIS Enrollees	4,468,365
3.	NHIS Staff	1,369
4.	**Total**	4,571,190

Source: Nhis 2017/Field Work

Sample Size and Sampling Technique

The population sample of this work was derived using the Yamane formula and purposive sampling technique. The Yamane formula is thus: $n = N / (1 + Ne^2)$. Where N = population size, 1 = is constant and e = alpha level, i.e. e = 0.05.

Table 4: Sample Population and Questionnaire Distribution

S/N	Zone	Population of study Area	NHIS Enrollees	Non NHIS Enrollees	Sampled population
1.	North-Central: FCT Abuja	409,598	21,702	387,896	400
2.	North-West: Kaduna State	1,783,538	19,290	1,764,248	400
3.	North-East: Bauchi State	243,387	18,017	225,370	399
4.	South-West: Lagos State	1,449,017	9,017	1,440,000	400
5.	South-East: Enugu State	444,271	16,870	427,401	400
6.	South-South: Delta State	240,010	16,560	223,450	399
7.	NHIS	1,369			310
	TOTAL	**4,569,821**	**101,456**	**4,468,365**	2,708

Source: Survey Research, April 2018

Method of Data Analysis

The data collected through the primary source was analysed through the use of absolute frequency tables, and a statistical tool, 'Simple Percentage'. This method of data analysis was used to allow for a descriptive presentation of data collected in the study. The simple percentage method is derived through the calculation of frequency distribution of subject's opinions on the issues raised. These are presented in the contingency table.

The formula for computing the simple percentage is:

$$\frac{\text{Observed Frequency}}{\text{Total Frequency}} \times \frac{100}{1}$$

Table 5: Distribution of Questionnaire and Returns

S/N	Categories of Respondents	Sampled Population	Respondents NHIS Enrollees	Respondents NHIS Non-Enrollees	forms Returned by Enrollees	forms Returned by Non-Enrollees	% Returned
1	FCT	400	200	200	195	118	78.25
2	Kaduna	400	200	200	145	112	66.75
3	Bauchi	399	200	199	193	188	95.48
4	Lagos	400	200	200	135	105	60.0
5	Enugu	400	200	200	200	137	84.25
6	Delta	399	200	199	184	105	95.98
7	NHIS Staff	310			303		97.74
8	Total	2,708	1,200	1,198	2,120		**78**

Source: Fieldwork, 2018

Equal allocation of the sample was given to enrollees and non-enrollees to bring out the essence of the study. 78 percent of the questionnaire distributed was returned for analysis. 22% of not returned questionnaires did not affect the outcome of the work.

Data Presentation and Analysis

Table 6: Respondents opinion on how they rate the service of the NHIS Helpdesk of their Health Service Provider

Response	Frequency	Percentage %
Good	320	23.6%
Fair	810	59.8%
Poor	225	16.6%

Total	1355	100

Source: Survey Research, April, 2018

Data obtained from table 5.14 depicts that 23.6% respondents rated the NHIS helpdesk of the Health Service Provider as good, 59.8% respondents rated it as fair and the remaining 16.6% respondents rated it as poor. This means that NHIS helpdesk located in Health Service Provider are still rated by 16.6% as performing below expectation and therefore need to improve their service delivery to enrollees and the general public.

Table 7: Respondents opinion on waiting time before seeing the Doctor

Response	Enrollees	Percentage %	Non Enrollees	Percentage %
	Frequency		Frequency	
Less than 30 minutes	71	5.2%	423	55.3%
30 minutes to 1 hour	772	57.0%	202	26.4%
Above one hour	512	37.8%	140	18.3%
Total	1355	100	765	100

Source: Survey Research, April, 2018

In table 5.15, 5.2% respondents of the NHIS enrollees contend that they wait less than 30 minutes to see doctor while 55.3% respondents of non enrollees saw the doctor within the same period. Also, 57% respondents contend that it takes 30 minute to 1 hour to see doctor and get attended to. In the same manner 26.4% respondents of non enrollees spent the same time and the remaining 37.8% contend they wait for above 1 hour before they see a doctor or get attended to. Similarly, 18.3% respondents who are non enrollees spent same amount of time. This shows that majority of the non enrolee respondent's spent less time before seeing doctors. Further investigation proved that the hospital staff preferred health seekers who pays cash particularly in Government hospitals. This discriminating practices against the enrollees negates the objectives of setting up the Scheme. Further enquiry shows that the prevalence of out of pocket expense is still high as acceptance of health insurance is still low in Nigeria.

Table 8: Respondents opinion on how they rate the services of the Doctors/Pharmacists/Laboratory Technicians in their Healthcare Provider (Hospital)

Response	**Enrollees**	**Percentage %**	**Non Enrollees**	**Percentage %**
	Frequency		**Frequency**	
Excellent	347	25.61%	109	14.24%
Good	625	46.13%	332	43.39%
Fair	230	16.97%	201	26.27%
Poor	153	11.29%	103	13.46%
Total	**1355**	**100**	**765**	**100**

Source: Survey Research, April, 2018

In table 5.16, 25.61% respondents(enrollees) rate the services of doctors/pharmacists/laboratory technicians intheir Healthcare Provider as excellent; another 46.13% respondents assessed the services of the doctors in the facility and adjudged them to be good.16.97% respondents rate them fair, while the remaining 11.29% said that they were poor. Likewise14.24%, 43.39%, 26.27% and 13.46% respondents (non enrollees rate them excellent, good, fair and poor respectively. This means that an overwhelming majority of the respondents have confidence in the doctors/pharmacists/laboratory technologists as good in attending to them.

Table 9: Respondents opinion on how much they pay for prescribed drugs given by their Healthcare Providers (Hospital/Pharmacy) as part of the 10% drug cost

Response	**Frequency**	**Percentage %**
Full drug cost	204	15.1%
10% drug cost	1076	79.4%
Indifference	75	5.5%

Total	**1355**	**100**

Source: Survey Research, April, 2018

The data in the table 5.17 shows that 15.1% of the enrollees pay full for drugs to their Health Service Provider while the remaining 79.4% respondents pay only 10% of the cost of drug costs. In the same vein 5.5% respondents are indifferent. This means that majority of the enrollees enjoy the 10% drug cost.

Discussion of Findings

The data collected from questionnaire administration also shows that 73% of the respondents know about the role of National Health Insurance Scheme. This means a large majority of our respondents are aware of the role of NHIS. In term of rating the significance of NHIS, a substantial portion of the respondents (58%) are of the opinion that it is not significant. This means that the NHIS is performing below expectation thereby corroborating the assumption of this study. Also, an overwhelming 66% of the respondents agree that the NHIS regulate health insurance industry in Nigeria. This means that majority of the respondents are aware of the role of NHIS especially as it concerns regulating health insurance industry.

The questionnaire data also shows us in term of the NHIS contributing to healthcare delivery in their various states. Majorities of the respondents (58%) did not agree though around 40% of the respondents agree and strongly agree. This means lots of the respondents disagree, yet another substantial portion of them agree and strongly agree. In term of how significant the NHIS has contributed to healthcare delivery in Nigeria, 54% of the total respondents claimed it is not significant while 42% of them claimed it very significant and significant. This means that NHIS still need to do more in the area of making significant contribution to healthcare delivery in Nigeria.

The questionnaire data equally shows that an overwhelming majority of the respondents who are enrollees (50%) agreed that what they spend on premium in relation to their other financial commitment is low. This means that majority of the enrollees sampled agreed that what they spend on premium is low. About 79% of the enrollees are also of the opinion that their enrolment into the scheme improves their access to healthcare service. This shows that the scheme offers improved healthcare service to enrollees. This means the survey result clearly support and corroborate the assumptions of the study.

Furthermore, the result shows that an overwhelming majority of the enrollees want health insurance cover for all sicknesses and health insurance cover for all Nigerians. This means that an overwhelming majority of the people want health insurance offered

by the scheme to cover all Nigerians and all sickness. In fact this is what is expected of the scheme and what they should be doing or offering. In terms of challenges facing the National Health Insurance Scheme, health insurance and healthcare delivery in Nigeria, all the respondents chose inadequate staff, poor financial transparency, non-performing HMOs, poor coverage of non-civil servants and poor legislative oversight as the major challenges facing the scheme in Nigeria. This is in tandem with the argument of this thesis and corroborated our propositions.

From the study, it can be deduced that the effectiveness of healthcare financing in any society can never be overemphasized, more importantly, if it is a social insurance programme that tends to take care of the poor, vulnerable and physically challenged who cannot ordinarily afford the cost of healthcare service for themselves and their dependents. The establishment of the National Health Insurance Scheme was to make access to healthcare easy and affordable to all Nigerians especially poor, vulnerable and physically challenged through the healthcare financing system that will guaranty healthcare delivery.

Premised on this our finding indicates that the reasons for its establishment are germane and laudable as a better option for healthcare financing in terms of expectations it has not lived up to the vision and target of the formulators of the policy as implementation has been flawed in many areas. Majority of the enrollees believe that it takes a longer time before they can access care under the scheme. The helpdesk in the Health Service Providers, have not helped matters either.

Our findings equally indicated that while the majority of the respondents are aware of the existence of NHIS they opined that the scheme has not contributed significantly to healthcare delivery in Nigeria and are therefore performing below expectation. Our findings also indicated that many of our respondents want the scheme to cover all Nigerians and all sickness. Our findings are that presently the scheme is encumbered by inadequate staffs, poor financial transparency, greedy HMOs, poor coverage of non-civil servants and poor legislative oversight; these findings are in tandem with the argument of this thesis and corroborated our propositions.

The issue of universal health insurance has become a global initiative designed to address the problem of poor and inadequate access to health and inadequate finance to pay healthcare service. The imperative of a healthy population can never be overemphasized especially concerning their contribution to growth and development. Hence the important role the National Health Insurance Scheme plays in healthcare delivery in Nigeria.

The expectation of the people that formulated the health insurance scheme policy and

drafted the bill that was eventually passed into law was to establish an agency of government that provide easy access to quality healthcare for all Nigerians regardless of their status and by implication achieve universal health coverage for all Nigerians. This was supposed to be the guiding principle of the National Health Insurance Scheme that was established for that reason. But unfortunately, the scheme has performed far below expectation in the area of coverage and service delivery. As at the moment, only a little over 3 million people have been enrolled in a country with a population of over 180 million people. Even the 3 million people enrolled, most of them are federal public servants with a little from the organized public sector and less than 1% of the informal sector, that need the services. This means that in the area of coverage, the scheme still has a lot of work to be done. Also important is the fact that the scheme made it compulsory for public servants at the federal level with no concession for the self-employed, private sector employed, unemployed, vulnerable and physically challenged. This is the main reason why the overwhelming majorities of the people enrolled are public servants.

Also, the provision for Health Maintenance Organizations (HMOs) in the National Health Insurance Act is dubious and parasitic to the scheme, Nigerians and even the government. The role of the HMOs according to the Act is to collect premiums from the scheme and pay to the Healthcare Providers (HPs). The role of the Health Maintenance Organizations is similar to that of a middleman. Since they (HMOs) do not bear the risk and only the government bears the risk for enrollees.it is also important that excess premium accrues only to the government so that they can use it to improve our health infrastructure and/or cater for health insurance of poor, vulnerable and physically challenged. The parasitic and greedy role of HMOs need to stop, their role can equally be performed by the NHIS like in other countries for example Ghana NHIS have eliminated HMOs. This will save the scheme lots of money and afford the Scheme the opportunity to carry out other developmental projects including the employment of more people into the Scheme.

Conclusion

The imperative of health insurance to the development of the healthcare sector in any economy especially developing ones cannot be overemphasized. The introduction of the National Health Insurance Scheme no doubt has increased access to healthcare delivery by a substantially large portion of low-income earners among public servants in Nigeria. The impact has remained massive for those who have enrolled in the scheme.

The Sscheme was established with the sole intention of providing easy access and affordable healthcare services to all Nigerians especially the poor, vulnerable and physically challenged who cannot easily afford the high cost of healthcare service as at

when due and increase Nigeria efforts at achieving universal health coverage. The scheme since creation has made some impact on the lives and health of some Nigerians especially the federal public servants. Unfortunately, an overwhelming majority of those enrolled into the scheme are public servants and organized private sector employed with little from self-employed, unemployed, pensioners, senior citizens and the rest. This has made the scheme selective and a program for some selected group of people instead of been for all Nigerians.

This research work found out that there are lots to be accomplished as far as health insurance is concerned in Nigeria. The meagre 3 million-plus that have been enrolled so far in a population of over 180 million people is a far cry from reality. This means that there is an enormous task before the National Health Insurance Scheme, Ministry of Health and federal/state government regarding providing health insurance for all Nigerians especially the poor, vulnerable and physically challenged. The Scheme has offered succour to some Nigerians through the health insurance and healthcare support they have provided in federal owned health institutions and facilities across the country. The middle and lower cadre public servants have benefited immensely from the scheme and especially their dependants who are their wives (1) and children (not more than 4). The comfort and financial assurance the scheme has offered enrollees especially who earn small amounts and who ordinarily would not be able to afford the high cost of healthcare is satisfactory. Despite the little success the scheme has achieved, its inability to meet the mandate spelt out in the Act and the expectations of Nigerians is caused by a myriad of challenges facing it. The challenges facing the scheme range from inadequate staffs, inadequate funding, greedy/parasitic HMOs, poor coverage of non- public servants, poor legislative oversights, poor financial accountability and transparency.

The scheme has huge potential to offer all Nigerians with health insurance cover with proper and holistic tackling of the challenges facing the scheme and the right government support especially as regard the enrolment of those in the informal sector which includes, the poor, vulnerable and physically challenged. A healthy nation is no doubt imperative to national growth and development.

Recommendations

In line with findings of the research work and field survey conducted through the administration of questionnaires and the interviews, the study hereby makes the following recommendations:

i. There is a need to increase the manpower strength of the scheme to enable it

perform the expected role. This will address the issue of inadequate staff and poor outreach across the 36 states of the federation. It will also allow the scheme to reduce the time enrollees wait to obtain their ID cards, get register, increase monitoring and supervisory strength of the scheme especially as it concern HMOs and HCPs monitoring and supervision. In other words, this should be matched with a deliberate capacity-building policy of training and retraining to equip the staff members with the necessary skills to deliver on their mandate.

ii. There is a need to increase financial transparency and accountability at the National Health Insurance Scheme. This will go a long way in the enhancement of affordable and effective health care delivery. This is due to the huge resources under the scheme's control through premiums payment of enrollees. This will close all avenues for financial leakages and embezzlement. It will also save money for developmental purposes like rehabilitating our decaying health infrastructures and thus improve and increase healthcare delivery in the country.

iii. The National Assembly needs to increase their legislative oversight of the National Health Insurance Scheme, Health Maintenance Organizations and Health Service Providers. This will keep them abreast of all situations at these organizations and help them know the best way to review the Act and help ensure financial transparency and judicious use of all funds.

iv. Annual budgetary allocation to the Health Sector should be increased to 15% in line with the recommendations of World Health Organization (WHO). This will go a long way in ensuring adequate provision of required facilities, recruitment of more health care professionals and procurement of sufficient drugs in NHIS accredited Hospitals.

References

Agbatogun, K.K. and Taiwo, A. S. (2010) "Determinants of Health expenditure in Nigeria", Journal of research in National development. P.6-7

Ahuja, R., &Narang, A. (2005). Emerging Trends in Health Insurance for Low-Income Groups. Economic and Political Weekly. Vol. 40, No. 38, pp. 4151- 4157.

Akila, M. (2013). Penetration of Health Insurance Sector in Indian Market. Opinion: International Journal of Management, 3 (1)

Akwukwuma V, Igodan C. (2012): A framework of a web-based database system for national health insurance scheme. Asian J Inf Technol.; 11:7–13. [Google Scholar]

Almond, G. A., & Powell, G. (1969). Comparative politics: A developmental approach, Boston: LittleBrown.

Archibong E.P, Ogana J.F, Edet A.F and Enamhe D.C (2023). Health Care Financing and Services Utilization in Cross River State, Nigeria. Global Journal of Social Sciences, 22, 9-24

Columbia University Mailman School of Public Health (2021) Public Health Policy: Definition, Example and more, New York, USA

Das, M. (2018) Perception of Customers Regarding Health Insurance Benefit of Public Sector Insurance Companies: A Case Study of Karimganj District of Assam. International Journal of Humanities and Social Science Studies, 4 (4), 158-172

Eze OI, Iseolorunkanmi A, Adeloye D. (2024); The National Health Insurance Scheme (NHIS) in Nigeria: current issues and implementation challenges. *Journal of Global Health Economics and Policy*. 4:e2024002. doi:10.52872/001c.120197

MoH(2005) "Achieving Health- Related Millennium Development Goals in Nigeria: A report of the Presidential Committee on Achieving Millennium Development Goals in Nigeria" (August) –Executive Summary. P20 -21.

Ichoku, H.E and Fonta, W.M (2006) "The Distributional Impact of Healthcare Financing in Nigeria: A Case Study of Enugu State". PMMA Working Paper No. 17:3-22 p 73

Metiboba, S. (2012).Contemporary Issues in Health Sociology (A revised and enlarged edition): Owerri, BanterMultimedia Network

MoH (2004) "Health sector reform programme: Strategic Thrust with logical framework and plan of action 2004–2007". p 15 -16

NHIA (2022). "Organizational Content of National Health Insurance Authority''

NHIS, *National Health Insurance Scheme Act (2004), Laws of the Federation*.

NHIS Act (2004) *National Health Insurance Scheme Act, Laws of the Federation. Abuja:* Federal Government of Nigeria

O'Donnell O, van Doorslaer E, Rannan-Eliya RP, Somanathan A, Adhikari SR, Akkazieva B, *et al.*"Who pays for health care in Asia" J Health Econ 2008; p. 27:460-75.

Olakunde O, B (2012). Public health care financing in Nigeria: Which way forward?.

Annals of Nigerian Medicine, 6 (1), 4

Olaniyan, O and A. Lawanson(2010). "Health Expenditure and Health Status in Northern and Southern Nigeria": A Comparative Analysis Using NHA Framework. Paper presented at the 2010 CSAE conference held at St Catherine College, University of Oxford, Oxford, UK. Available online at www.csae.ox.ac.uk/conferences/2010-EDiA/.../451-Lawanson. p.55

Oyefabi, AO.Aliyu, AA. andIdris, A.(2014). "Sources of Healthcare Financing among Patients at the AhmaduBello University Teaching Hospital, Zaria, Nigeria". *Journal of Medicine in the Tropics*, 16(1):27-31.

Scott J, Marshall G, editors. A Dictionary of Sociology. 3rd ed. Oxford: Oxford University Press; 2005. [Google Scholar]

Uzochukwu, B S C'; Ughasoro, M D; Etiaba, E; Okwuosa, C; Envuladu, E; Onwujekwe, O E (2015). Health care financing in Nigeria Implications for achieving universal health Coverage. *Nigerian Journal of Clinical Practice, 18 (4), 437-444*

World Health Organization (WHO). World Health Statistics. 2007.

World Health Organization (WHO). *Health Policy*, accessed 22 March 2011. (Archived 5 February 2011)

WHO (1984) "Report of the working group on the integration of Traditional Medicine in Primary healthcare. Geneva": World Health Organization Regina Office for West Pacific. P.8

WHO (2005). "Country health system fact sheet, Nigeria". Geneva: World Health Organization. P 19

World Bank (2008). World Bank–Administered Groba Launches Prepaid Health Insurance Scheme in Lagos, Nigeria". Online available at *http://go.worldbank.org/DH7lw5RJQO RetrievedOctober32018.P.73-82*

World Health Organization (2007a).*WHO Country Cooperation: Federal Republic of Nigeria, 2002-2007.*Geneva: WHO. P 15 -20

Yohersor A. Social Health Insurance Scheme that Works: Recommendation to NHIS. Abuja: V.C Publishers. 2004.