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EFFECT OF NATIONAL HEALTH INSURANCE PROGRAMME ON HEALTH CARE DELIVERY IN NASARAWA STATE, NIGERIA

Muhammed, Abdullahi

Department of Public Administration Nasarawa State University, Keffi

Aliegba, Becky

Department of Public Administration Nasarawa State University, Keffi

Ibrahim, Musa Abdulrahman

Department of Public Administration Nasarawa State University, Keffi

Abstract

The objective of National Health Insurance Scheme is to provide affordability, qualitative and referral service to the enrollees. Due to some challenges such as inadequate facilities and limited resources facing some of the primary and secondary health care providers, they hardly entertain certain health conditions and in some cases referral service are required. It is on these bases, the study examined the effects of National Health Insurance Programme on Health care services delivery in Nasarawa State. The study adopted survey research design. The primary data was obtained through the administration of questionnaires. A sample of 400 was taken the total enrollees in Nasarawa State using Taro Yamane statistical formula. Multiple regression analysis was used to test the hypotheses. The social contract theory propounded by Thomas Hobbes (1656) was adopted as theoretical framework. Finding from the study also revealed that, implementation of the National Health Insurance programme has led to affordable health care services among the enrollees in Nasarawa State. The programme has minimized out of pocket expenses in most primary health care service providers in Nasarawa State. Finding also revealed that, National Health Insurance programme has not improved the qualitative health care services to the enrollees. The study recommended that among others; National Health Insurance Scheme (NHIS) should endeavor to provide enough facilities and resources in order to sustain the affordable scorecard recorded so far and improve in health care service delivery to the enrollees in Nasarawa State. The study concluded that, Implementation National health insurance programme have positive impact on affordable and referral health care services but has little impact on the quality health service delivered to enrollees in Nasarawa State.

Keywords: National Health, Insurance Programme, Healthcare, Delivery.

1. Introduction

Nigeria begun implementation of the NHIS as a policy objective to minimize out-of-pocket expenditure at the point of use of service (Wagstaff, 2010), thus reducing the financial barrier to health service utilization. The healthcare services under the scheme are provided by primary, secondary and tertiary healthcare facilities. The primary healthcare facilities are the point of first contact between individuals and healthcare facilities. They are the gatekeepers of the scheme and they provide preventive, curative and rehabilitative services when operating at optimum capacity.

The secondary healthcare facilities provide

specialized services and attend to patients referred to them from the primary healthcare facilities through the Health Management Organizations (HMOs). However, under situations of emergency, secondary healthcare facilities can attend to patients without necessarily informing the HMO. The tertiary healthcare facilities provide highly specialized services upon referrals from the secondary healthcare facilities through the HMOs. Employees from the public sector or private sector with staff strength of 10 or more persons are expected to enroll in the programme. The contribution of the employees to the programme depends on the earning of the employees. In Federal Government agencies, the employer pays 3.25 per cent while the employee pays 1.75 per cent, representing five per cent of the

employees consolidated salary. For agencies in other tiers of government as well as in the organized private sector, the employer pays 10 per cent while the employee pays five per cent, representing 15 per cent of the employee's salary. While the employer may decide to pay the entire 15 per cent for the employee, the employee may also make extra contributions in order to improve on the package of benefit available to them. The implementation of the scheme saw the registration of over 73 % of the Federal Government workers and their dependent into the scheme by 2019 (NHIS, 2019).

The mode of operation of the formal sector social health insurance programme is such that the health services of employees in the formal sector are financed from the funds pooled by the employer and the employees. In the formal sector social health insurance programme, specific responsibilities are expected from the healthcare facility, Health Maintenance Organization and the National Health Insurance Scheme. The healthcare facility must be accredited with the NHIS and must abide by the operational guidelines of the NHIS. The healthcare facility is expected to provide the services agreed with the NHIS in the benefit package and ensure enrollees satisfaction. The responsiveness of healthcare services to people's expectations is a target of health insurance schemes which impacts health system goals. Responsiveness is included in patient satisfaction and quality of care.

Statement of the Problem

Following Nigeria's independence in 1960, there have been several attempts to improve healthcare delivery (Asuzu, 2004). Successive Nigerian government has adopted different National Development Plans (NDP) to help address development challenges in the country at different periods (Iheanacho, 2014). The Nigeria health system was initially publicly financed with it attendant problems. The National Health Financing Policy and Strategy of Nigeria recommend that there should be a split between funding and purchasing and the powers for both should not reside in the same agency. It also recommends that there should be a split between purchasing and provision and the powers for these functions should not reside

in same agency. Hence, HMOs exist within the insurance scheme to help drive the purchaser-provider split and promote efficiency and sustainability that are not commonly found in the public sector. HMOs purchase care at the primary, secondary and tertiary levels of healthcare. The referral system through the HMOs starts from the primary to secondary and then to the tertiary care. The system is integrated in such a way that NHIS supervises and monitors all the activities that go on in the social health insurance scheme.

The main objective of the study is to examine the effect of National Health Insurance on healthcare service delivery in Nasarawa and Niger State. While the specific objectives are;

- i. To ascertain whether National Health Insurance Programme has provide affordable health care services to enrollees in Nasarawa State.
- ii. To find out whether National Health Insurance Programme has provide qualitative health care services to enrollees in Nasarawa State.
- iii. To determine whether National Health Insurance Programme has provide adequate referral health care services to enrollees in Nasarawa State..

The following hypotheses were formulated to guide the study;

- i. There is no significance relationship between National Health Insurance Programme and provision of affordable health care services to enrollees in Nasarawa State.
- ii. There is no significance relationship between National Health Insurance Programme and the provision of qualitative health care services to enrollees in Nasarawa State
- iii. There is no significance relationship between National Health Insurance Programme and provision of adequate referral health care services to enrollees in Nasarawa State.

1. Literature Review

2.1 Conceptual Issues

National Health Insurance

James (2003) defined the National Health Insurance Scheme as a social health insurance programme designed by the Federal Government of Nigeria to complement sources of financing the health sector and to improve access to healthcare by the majority of Nigerians. It is a form of social health insurance which pays for healthcare services through contributions to a health fund. Contributions, which are usually from both employers and employees, are based on payroll and ability to pay while access to services is based on need. The fundamental rationale for health insurance is risk sharing.

Healthcare Service Delivery

World Health Organization (WHO) defines Healthcare Service Delivery as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity". Basically healthcare implies the provision of condition for normal mental and physical development, functioning of the individual or group. It includes health protection measures, health promotion and disease prevention measures, thus encompassing curative and preventive medicine in its entire ramification (Smith & Dusansky, 2005).

National Health Insurance Programme and Accessibility to Healthcare Services

The need for healthcare varies in space and so the organization of provision necessarily has a spatial component. Neither population totals nor population characteristics such as age, sex, occupation is uniform in space. In a like manner, the physical environment varies in characteristics from place to place and this invariably has implication for the pattern of demand for healthcare. The spatial dimension is also important in utilization behavior since accessibility is a major determinant of the use of healthcare service (Okafor, 2007).

2.2 Empirical Review

Christmal and Kizito (2020) assessed the

implementation of the National Health Insurance Scheme (NHIS) in Ghana: Lessons for South Africa and Low- and Middle-Income Countries. The study relied on secondary method with a scoping review conducted using the Joanna Briggs Institute's System for the Unified Management, Assessment and Review of Information (SUMARI) and Mendeley reference manager to manage the review process. Journal articles published on the NHIS in Ghana from January 2003 to December 2018 were searched from Science Direct, Pub Med, Scopus, CINAHL, and Medline using the keywords: Ghana, Health, and Insurance. The result from the study revealed that, the implementation of the NHIS has provided access to healthcare for the Ghanaian population, especially to poor and vulnerable. Despite the successful implementation of the NHIS in Ghana, the scheme is challenged with poor coverage; poor quality of care; corruption and ineffective governance; poor stakeholder participation; lack of clarity on concepts in the policy; intense political influence; and poor financing.

Philip and Alexander (2012) examined the national health insurance scheme: perceptions and experiences of healthcare providers and clients in two districts of Ghana. The study took place in Data was collected through exit survey with 200 insured and uninsured clients, 15 in-depth interviews with healthcare providers and health insurance managers, and 8 focus group discussions with insured and uninsured community members. The result of the study shows that, the NHIS promoted access for insured and mobilized revenue for healthcare providers. Both insured and uninsured were satisfied with care (survey finding). However, increased utilization of healthcare services by the insured leading to increased workloads for providers influenced their behavior towards the insured. Most of the insured perceived and experienced long waiting times, verbal abuse, not being physically examined and discrimination in favor of the affluent and uninsured. The insured attributed their experience to the fact that they were not making immediate payments for services. A core challenge of the NHIS was a delay in reimbursement which affected the operations of health facilities and hence influenced providers' behavior as well. Providers preferred clients who would make instant

payments for healthcare services. Few of the uninsured were utilizing health facilities and visit only in critical conditions. This is due to the increased cost of healthcare services under the NHIS.

In the explanations of Fiedler (2003), access to healthcare services is considered as the link between the healthcare system and the population it serves; the volume and type of services, whether or not the service can be reached, the client's perceptions of the relative worth of the service and acceptability of services provided, all influence access and the utilization of services. In line with the postulates of the central place theory, healthcare facilities in Nigeria constitute a hierarchical system which is reflected in space by the geographical arrangements of service outlets in which a particular area tend to have numerous primary health facilities, much fewer secondary facilities and very few tertiary facilities if at all. Consequently, the findings of studies conducted by Okafor (2007) on the petroleum - producing region of Nigeria (the Niger Delta) revealed that inaccessibility of the available healthcare facilities in the region has obviously affected the utilization of healthcare services by a vast proportion of the beneficiaries who still depend on traditional medical care and self-medication.

Onoka, Hanson, and Hanefeld (2015) examined towards universal coverage: a policy analysis of the development of the National Health Insurance Scheme in Nigeria. The study relied on secondary method using document reviews, in-depth interviews, and use of a stakeholder analysis approach. The study revealed that, the inclusion of Health Maintenance Organizations (HMOs) as financing organizations for national health insurance at the expense of sub-national (state) government mechanisms increased credibility of policy implementation but resulted in loss of support from states. The most successful period of the policy process occurred when a new minister of health (strongly supported by the president that displayed interest in UHC) provided leadership through the Federal Ministry of Health (FMOH), and effectively managed stakeholders' interests and galvanized their support to advance the policy. Later, the National Health Insurance Scheme (the federal government's implementing/regulatory agency) assumed this leadership role but has been unable

to extend coverage in a significant way. Nigeria's experience shows that where political leaders are interested in a UHC-related proposal, the strong political leadership they provide considerably enhances the pace of the policy process. However, public officials should carefully guide policymaking processes that involve private sector actors, to ensure that strategies that compromise the chance of achieving UHC are not introduced. In contexts where authority is shared between federal and state governments, securing federal level commitment does not guarantee that a national health insurance proposal has become a 'national' proposal. States need to be provided with an active role in the process and governance structure. Finally, the article underscores the utility of retrospective stakeholder analysis in understanding the reasons for changes in stakeholder positions over time, which is useful to guide future policy processes.

A study conducted by Inyang and Bassey (2018) on National Health Insurance Scheme in Nigeria: Impact on healthcare delivery system in Nigeria. The study investigated and examines the impact of National Health Insurance Scheme (NHIS) on the healthcare delivery system in Nigeria. The study further examines the main objectives of the NHIS to find out the proportion of Nigerians covered by the scheme in Nigeria. In addition, the study examines the level of people's awareness of the scheme. The study also investigates and examines the level of funding and contribution to the scheme, through government fiscal policy. Finding from the study reveals that, the impact of the scheme was slow and low due to inadequate funding, poor awareness creation.

Another study conducted by Aryeetey, Nonvignon, Amissah, Aikins (2016) on the effect of the National Health Insurance Scheme (NHIS) on health service delivery in mission facilities in Ghana. The study examines the implementation of a National Health Insurance Scheme (NHIS) to minimize out-of-pocket expenditure at the point of use of service. The study conceptualised the effect of NHIS on facilities using service delivery indicators such as outpatient and inpatient turn out, estimation of general service readiness, revenue and expenditure, claims processing and availability of essential medicines. The data were collected from 38 mission facilities, grouped into the

three ecological zones; southern, middle and northern. Structured questionnaires and exit interviews were used to collect data for the periods 2003 and 2010. The data was analysed in SPSS and MS Excel.

Finding from the study shows that, implementation of the scheme was accompanied by increased access and use of healthcare services. Evidence suggests most health facilities are faced with management challenges in the delivery of services. The study aimed to assess the effect of the introduction of the NHIS on health service delivery in mission health facilities in Ghana. The study shows that, there were significant increases in outpatient and inpatient attendance, revenue, expenditure and improved access to medicines. Generally, facilities reported increased readiness to deliver services. However, challenging issues around high rates of non-reimbursement of NHIS claims due to errors in claims processing, lack of feedback regarding errors, and lack of clarity on claims reporting procedures were reported.

Another study conducted by Tanimola, Adekunle and Oluwole (2011) compared the pattern of utilization of the staff clinic two years before and after the commencement of NHIS at the University of Ilorin Teaching Hospital. The National Health Insurance Scheme (NHIS) was launched in Nigeria June, 2005 to covers public civil servants in Federal Establishments was the focus of the study. Descriptive cross-sectional study was carried out using records of patients seen at staff clinic, Unilorin Teaching Hospital, Ilorin two years before and after the commencement of National Health Insurance Scheme. Information obtained from the hospital records was entered into the Epi-Info software of the computer. Finding from the study reveals that, a total of 29,422 patients were seen in the period under review. Mean attendance per month before and after the commencement of National Health Insurance Scheme was 357 and 870 respectively. Communicable diseases accounted for 71% of cases seen before and 66.4% of cases seen after commencement. While for non-communicable diseases hypertension was most prevalent accounting for 11% and 14% of all cases before and after NHIS respectively. There was a statistically significant difference ($p=0.0003645$) in patients seen after the commencement of National

Health Insurance Scheme as more staff compared to their dependents attended the staff clinic.

Another study conducted by Garba and Ejembi (2015) on The role of National Health Insurance Scheme on structural development of health facilities in Zaria, Kaduna State, North Western Nigeria. This study was undertaken to assess and compare the funding patterns, and infrastructural and manpower development in health facilities in Zaria, Kaduna State, following the introduction of the NHIS. This study was comparative cross-sectional in design. Using stratified sampling technique one public and two private health facilities were selected from 16 secondary health facilities (5 public, 11 private) accredited by the NHIS. Retrospective analysis of data collected from their records on the pattern of funding, the levels of hospital infrastructure, and manpower in the facilities was carried out before and after the introduction of the NHIS. The Results of the study demonstrated an almost three-fold increase in financial resources availability to the health facilities following enrolment into the NHIS, with the private facilities having a higher increase (300%) than the publicly owned facility (261%). Funds from the scheme, now constituting up to 36% of the total revenue, accounted for almost half (47%) of the increase. The facilities also witnessed improvement in physical infrastructure, staff strength, and diagnostic capability with variable statistical significance.

Koli, Obembe, Osungbade, Adeniji, Adewole (2017) carryout their study in Oyo state and only focused on Self-referral patterns among federal civil servants in Oyo state. They found that, the desire for quality service and competent staff was common reasons for presenting to higher levels of care.

From the above reviewed, none of the study was reported carryout in Nasarawa and Niger state and secondly, none the study was carryout from 2011 – 2019. This present study seeks to bridge these gaps. The above studies were however, approached in a qualitative manner. Hence, the need for this quantitative exploration to add to understanding Healthcare service delivery using National Health Insurance Scheme as references is required to the fill the research gap.

2.3 Theoretical Framework

Social Contract Theory

The social contract theory propounded by Hobbes (1656), the choice of the theory is informed by its adequacy in explaining the origin of nature, and operation of any government in carryout responsibility to the citizen.

Hobbes (1588 – 1679) made emphasis of a state of nature describing it as poor, nasty, brutish and short, because, in it, there are certain features associated with human conditions, such that equality of need, scarcity, essential equality of human power, and limited altruism. The state of nature lacks fundamental social amenities for satisfying of human needs, due to poor social cooperation to produce these basic amenities and that for man to avoid this state of nature, there must be a guarantee that people will not harm one another and thus, the concept of social contract. The theory is built upon the premise that the basis of a legitimate legal power is in the idea of contract. In an organized society, contract had been formed between the citizens and the sovereign power (Government). As a result of such contract, power to act and regulate is vested in government which is represented by an individual or groups of individuals, these representations are trustees of the societies whether elected or selected commonly through periodic elections.

The concept of social contract, if well established, create an avenue that increases benefits between the parties to the contract in areas such as political, moral values and socio-economic, that bring lasting peace to societal existences. In other words, social contract has a strong temporal dimension such as the willingness of people to work together in maintaining the contract is strongly influenced by how they view the future. Usually citizens may see little worthy in cooperation with their rulers, if they doubt their sincerity of such contract which was entered for societal development purpose to do with social security, stability and economic development and growth without discrimination.

Basic assumption of social contract theory

- i. Often develop in times of political and social upheaval
- ii. Designed to provide a rational justification for at least a minimal set of moral principles
- iii. Sought to demonstrate that as rational self-interested beings
- iv. There are rules that we should follow, even if they are not to our immediate advantage.
- v. If people always pursue their interests, they will end up with less desirable results than if they sacrificed immediate advantages for cooperative mutual gains.
- vi. Even with rules, they still have to be enforced
- vii. Government has the police powers for enforcement
- viii. The powers must be limited, so that the government itself doesn't act indiscriminately.
- ix. Violating the rules leads to legitimate punishment for breaking the contract

Social contracts are not inclusive of all. As Waller states, "If you can't join in the contract, and you can't live up to the demands of the contract, then you aren't part of the moral community" (Waller, 2016). For, Nussbaum, (2009), this is a big problem because people with lifelong impairments are excluded: "The failure to deal adequately with the needs of citizens with impairments and disabilities is a serious flaw in modern theories that conceive of basic political principles as the result of a contract for mutual advantage. The flaw goes deep, affecting their adequacy as accounts of human justice more generally" (Nussbaum, 2009:98). Further, social contracts exclude those in different societies and countries and they exclude animals all to which we therefore have no contractual and thus no moral obligations.

It is important not to dismiss social contract theory altogether just because one might view Hobbes's conclusions as flawed. John Rawls does not fully share Hobbes's speculation about the state of nature being a cruel place, yet he advocates for social contracts which promote "justice as fairness" (Waller,

2016). Rawls arrives at moral principles via the social contract e.g., justice, equality, non-discrimination, respect which are not unlike morality asserted by liberal deontological theorists such as Kant.

Social contract theory is relevance to the provision of healthcare service from two sides: The demand and supply sides. Both sides of the theory however, agreed that healthcare insurance schemes are the social contact that is bind by the government, employer and employees established as incentives and motivation to encourage workers to increase their productivity or performance. The demand side of the theory posits that employees demand for effective healthcare facilities for better service delivery. Yet another benefit is an insurance cover of sorts against risks that incapacitated.

3. Method and Materials

The study adopted survey design research which set out to assess NHIS in line with its policy on healthcare service delivery to the enrollee. Survey used questionnaires to generate data in order to analyse the research proposition. It was adopted because the data generated is more or less unbiased and can be expressed in numerical terms for easy understanding. It is also relevant to this study because, it assist the researcher to explore the relationship between independent (National Health Insurance Scheme) and dependent variable (Healthcare Service Delivery). Analysis of existing data on the other hand will obtain data from the past researchers and official records relevant to the study. Analysis of existing data was employed because it has prospects of authenticity as it is free from respondents' ignorance, unwillingness to cooperate, bias and dishonesty. It also seeks to fill the gap left by the survey design.

3.1 Population, Sample and Sampling Techniques

The target population of this study is the principal enrolees. The choice of enrolees as a target Population is based on the fact that, they are the main beneficiary of this programme and the aim is to assess the effect of the National Health Insurance

Programme on the quality of healthcare service. Primary and secondary health facilities are located in each local government area. At the time of the study, Nasarawa State has 85,215 enrollees in the NHIS consisting of principals and dependants as identified by the NHIS regulatory agency. In Nigeria, the NHIS specified that "contributions made by an insured-person (principal enrollee) entitle him, his spouse and four biological children under the age of 18 years to a defined health benefit-package". Any health facilities in the state rendered health services to enrollees are accredited by National Health Insurance Scheme in Nigeria.

Simple Sampling Techniques will be used, selected representative from the target population. The sample will be adopted because each individual will be chosen entirely by chance and each member of the population has an equal chance of being included in the sample.

The total enrollees for the total of 78 accredited health facilities stood at 180056. The sample size was determined using Taro Yamane statistical formula:

$$n = \frac{n}{1 + N(e)^2}$$

Where n=sample size
N=total population size
1 is constant

e = the assume error margin or tolerable error which is taken as 5% (0.05)

$$n = \frac{n}{1 + N(e)^2} = \frac{85,215}{1 + 85,215(0.05)^2} = \frac{85,215}{213}$$

= 400 (sample size) Nasarawa State

Two method of data collection will be used in this study; primary and secondary. Primary method was

source using the instruments of questionnaire. Questionnaires were structure in closed-ended questions.

The questions were structured using five (5) Likert Scale (Strongly Agree, Agree Undecided, Disagree and Strongly Disagree).

Desk officers at the Primary Healthcare Providers and the management of Health Maintenance Office Staff (HMO) will be interview to ascertain the effectiveness of the implementation of the scheme. Secondary data was obtained from documented materials under the following: Text books were sourced from Department of public administration library, faculty of administration library and e-library online. Academic Journals articles like Journal of National Health Policy; Journal of Public Policy Implementation were sourced from Nasarawa State University library, department of political science, public administration library, faculty of administration library and internet.

Official documents like the quarterly progress report of the NHIS activities in Nasarawa and Niger State, nominal roll of staff, open registry on the Numbers of enrollees and the patronage, National Policy on National Health Insurance Scheme policy implementation guideline, annual report publication by NHIS, NHIS hand book. Conference materials/articles like paper presented at National Council on Health, conference reports on National Health Insurance, symposium and sensitization workshop paper on National Health Insurance programme.

The data was analyzed using the multiple regression analysis statistical techniques. The analysis was done using independent variable (National Health Insurance Programme) and Health Care Service Delivery in as the dependent variable.

4. Results and Discussion

Model Summary^b

Model	R	R ²	R2 Adjusted	Std. Error of the Estimate	Durbin-Watson
1	.90	.82	.82	.47984	.06

- Predictors: (Constant), affordable service, qualitative services and referral services.
- Dependent Variable: HealthCare Service delivery in Nasarawa State.

ANOVA^a

Model	Sum of Squared	DF	Mean Squared	F	Sig.
1Regression	582.11		182.19	314.97	.000
Residual	61.64	39	.23		
Total	572.62	39			

- Dependent Variable: Dependent Variable: HealthCare Service delivery in Nasarawa State
- Predictors: (Constant), affordable service, qualitative services and referral services.

The result shows that affordable service, qualitative services and referral services predicted the health care delivery in a joint manner ($F(5, 392) = 2.542$; R^2

$= 0.230$; $P < 0.05$) is significant to the implementation of National Health Insurance Programme in Nasarawa State.

Coefficients^a

Model	Unstandardized Coefficients		Standardized Coefficients	T	Sig.
	B	Std. Error	Beta		
(Constant)	.77	.16		7.09	.00
Affordable Service	.83	.19	.78	9.25	.00
Qualitative Services	-.13	.13	-.27	0.75	.61
Referral Services	.03	.07	.44	6.66	.02

The result of the table above shows that ($\beta = 0.782$; $t = 9.254$; $p = 0.000$) We reject the null hypothesis which stated that, there is no significance relationship between National Health Insurance Programme and provision of affordable health care services to enrollees in Nasarawa State. This means that implementation of National Health Insurance programme have provided affordability of health care service to the enrollees in Nasarawa State. Affordability of service has contributed to effective health care delivery among the enrollees in Nasarawa State.

The result of the table above shows that ($\beta = -.271$; $t = 0.750$; $p = 0.613$) We accept the null hypothesis which stated that, there is no significance relationship between National Health Insurance Programme and the provision of qualitative health care services to enrollees in Nasarawa State. This means that implementation of National Health Insurance programme have improved qualitative health care service among the enrollees in Nasarawa State. National Health Insurance Scheme has not contributed to Qualitative health care service delivery among the enrollees in Nasarawa State.

The result of the table above shows that ($\beta = 0.445$; $t = 6.660$; $p = 0.028$). The study reject the null hypothesis which stated that, there is no significance relationship between National Health Insurance Programme and provision of adequate referral health care services to enrollees in Nasarawa State. This means that implementation of National Health Insurance programme have provided adequate referral health care service to the enrollees in Nasarawa State. This revealed that referral service of the National Health Insurance Scheme has contributed to effective health care delivery among the enrollees in Nasarawa State

4.1 Discussion of Major Findings

Finding from the study also revealed that, implementation of the National Health Insurance programme has led to affordable health care services among the enrollees in Nasarawa State. This is because NHIS scheme has minimized out of pocket expenses in most primary health care service

providers. This finding goes contrary to the study conducted by Inyang & Bassey (2018) on National Health Insurance Scheme in Nigeria. The Finding revealed that, the impact of the scheme was slow and low due to inadequate funding, poor awareness creation. The therefore concludes by calling for the attention of stakeholders for a review of health policy to address the inadequacies if Nigeria intends to keep pace with Universal Health Coverage (UHC) of the world Health Organization (WHO).

Finding from the study further revealed that implementation of the National Health Insurance Policy did not improve the qualitative health care services among the enrollees in Nasarawa State.

This finding is in line with the study conducted Aryeetey, Nonivignon, Amissah, Aikins (2016) which revealed that, the implementation of a National Health Insurance Scheme (NHIS) have minimize out-of-pocket expenditure at the point of use of service but did not provide qualitative health to workers in Ghana due to inadequate funding.

Finding from the study revealed that, National Health Insurance Programme have provided adequate referral service and improved health care services among enrollees in Nasarawa State. This finding is in line with the study conducted by Aryeetey, Nonivignon, Amissah, Aikins (2016) which examined the effect of the National Health Insurance Scheme (NHIS) on health service delivery in mission facilities in Ghana. The finding from the study also revealed that, implementation of the scheme was accompanied by increased access and use of health care services in Ghana.

5. Conclusion and Recommendations

Implementation National health insurance scheme tested and found effective programme for providing and adequate referral service to the enrollees in Nasarawa State. The programme makes health care service affordable among the enrollees in Nasarawa State. The programme has also reduced the medical bill of enrollees in Nasarawa State because it charges only 10% of the total charges on any health service provided. Increasing operational pool funds usually made available and the upfront capitation payments

retained at health centres made it affordable for enrollees to access affordable service. The study concluded that, Implementation National health insurance programme have positive impact on affordable and referral health care services but has little impact on the quality health service delivered to enrollees in Nasarawa State.

- i. National Health Insurance Scheme (NHIS) should endeavor to provide enough facilities and resources in order to sustained the affordable scorecard recorded so far and improve in health care service delivery to the enrollees in Nasarawa State
- ii. There should be a substantial increase of government annual budget directed to the scheme in order to make health care service more affordable to the health care services among enrollees.
- iii. Ministry of health and National Health Insurance Scheme should ensure that all healthcare providers provide quality health care to the enrollees in order to justify the confidence reposed on them.

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