POLAC MANAGEMENT REVIEW (PMR)
DEPARTMENT OF MANAGEMENT SCIENCE
NIGERIA POLICE ACADEMY, WUDIL-KANO

ASSESSMENT OF THE IMPLEMENTATION OF THE NATIONAL HEALTH INSURANCE SCHEME (NHIS) IN FEDERAL MEDICAL CENTER BIDA, NIGER STATE, NIGERIA

Rahamat Mililicent Yakubu Department of Public Administration, Nasarawa State University, Keffi

Odonye Dauda Yusuf Department of Public Administration, Nasarawa State University, Keffi

Abstract

The study reviewed the implementation of National Health Insurance Scheme (NHIS) in Federal Medical Centre, Bida, Niger State adopted by Nigeria for improved access to healthcare services, especially to the low income earners. The objective of the study is to review developments in the implementation of the Nigerian NHIS in Federal Medical Centre, Bida, Niger State and determine whether it's achieving its objectives. Specifically, the study focused on key issues and challenges confronting the NHIS, with a bid to proffer appropriate recommendations towards sustainability, effectiveness and efficiency. The study adopted a descriptive qualitative analysis methodology. The main instrument for eliciting the primary data is the survey questionnaire which was complimented by secondary sources. After data collection, presentation and analysis, the study found limited coverage, religious and cultural limitations, in-extensive prescriptions, conflict of interests (NHIS and HMOs), low participants' coverage, issues of mistrust, total government financing limitation as well as low budget allocation compared to need, as major issues confronting the achievement of quality healthcare delivery from the Scheme. It proffered some recommendations which include: more private sector participation, governance right to HMOs on the Board of NHIS, creation of Notional Health Insurance Fund and commencement of contribution from participants.

Key Words: Health, Insurance, Scheme, Healthcare, Medical and Service

1. Introduction

To enable individuals, have access to needed health care, globally, stakeholders resolved to move towards universal health coverage (UHC) at an affordable cost (Murray, 2013). This is not unconnected with the poor health indices most prevalent in low income countries, and is worst in the sub-Saharan Africa (Murray and Lasino, 2012). Apart from general taxfunded method of financing healthcare, social health insurance has been acclaimed as the next best form of achieving UHC after general tax funding system (Mossaic, 2005). The concept of social health insurance (SHI) to fund health care started in Germany about hundred years ago (Carrin, 2002). France, Netherlands, Switzerland, Sweden and other European countries adopted SHI thereafter. In these countries, SHI is coupled with other prepayment methods of funding health care such as the private health insurance and general tax fund (Mossaic, 2005).

In Africa, a few countries have shown promising SHI schemes. Ghana, South Africa, Rwanda and Kenya are typical examples (Odeyenu, 2014). However, there still remain more challenges to implementing successful and sustainable prepayment schemes for health care in these countries, as the case is in almost all of the African countries. Some of these challenges are the absence of factors that could facilitate the implementation of a sustainable SHI scheme. Major factors include individual and household financial capability to pay prescribed premiums, adequate technical and administrative skills to manage a SHI scheme and a largely formal sector setting (Carrin, 2002). Collecting premiums for prepayment schemes in an efficient way as a result of the predominantly

large informal sector population is still a daunting task for stakeholders in African countries (Chuma, 2013).

One of the cardinal features of a SHI scheme is that the contribution (premium) is made by the insured either solely or with a part contribution from the employer. SHI schemes unlike the general-tax funded health care, is more transparent, more acceptable to the public and almost free from political manipulations. However, the most important of these could be the place of the 'voice' of the contributors to the SHI scheme. Generally, contributors could be more vocal and demand better services, or partner with other stakeholders to facilitate its development and sustainability. These peculiar attributes of SHI schemes could stimulate universal health coverage (Mossaic, 2001; Carrin, 2002). There are three dimensions of UHC: (a) direct costs; what proportion of costs is covered: (b) services; which services are covered and (c) population; who is covered? The extent to which the challenges peculiar to each of these dimensions is addressed, will determine the extent and the speed of achieving UHC (Chuma, 2013).

Awareness of insurance schemes and UHC through prepayment schemes, such as a SHI is low, with an attendant gross inequity in health care utilization (Federal Ministry of Health, 2015). A high level of awareness among the potential beneficiaries, better understanding of the basic concepts and of the benefit package of a SHI is essential to ensure acceptance of a scheme and thus, facilitate UHC. A study by Arin and Hongoro (2013) has shown that persistent and aggressive advocacy at the national and the sub-national levels is essential to engender a sense of ownership of the scheme among potential beneficiaries. Studies have shown that well above half of a population could be enrolled into a prepayment scheme within the space of a decade of its commencement, if the design and implementation of the scheme is tailored to address the peculiar challenges (Carrin & Adelhanardt, 2015). Thus, it is important to examine the challenges associated with the three dimensions of UHC with regards to the scheme in Nigeria. This will be of assistance in proffering the way forward for the scheme to achieving its objectives.

It should however be noted that healthy citizenry is crucial to growth and development of any economy. As the age-long adage goes, "health is wealth," so it is that a country's health and wealth are inextricably linked. This assertion is underscored in the various growth theories that prominently feature labour as a key input of production. For instance, the Endogenous Growth Model emphasizes that an enhancement of a nation's Human capital contributes significantly to its economic growth. Human capital concept recognizes that not only does the quality of labour matters, improvement of labour through education, training and health investments are equally important.

This study seeks to review the implementation of the National Health Insurance Scheme in Federal Medical Center, Bida, Niger State in order to gain insight into the implementation of the scheme and determine whether it is achieving its goal. Specifically, the study focuses on the key issues and challenges confronting the scheme, with a bid to proffer appropriate recommendations towards its sustainability, effectiveness and efficiency.

The health-care system of Nigeria like in most other developing countries is bedeviled with several problems. These problems include inadequate funding, poor cost-recovery efforts, poor quality services, inequality in health care provision, inequities and widespread inefficiency in the system. The public hospitals appear to be the hardest hit. Consequently, there has been increasing demand by the populace and policy makers for more equitable and efficient means of financing and delivering health care services.

The need to promote health insurance in Nigeria was due to the inefficiency and inequity in our health care system. This led the National Health Summit conveyed in 1995 to zero in on health insurance as our vehicle to the promised land of health for all.

Arising from these inadequacies in the health sector, the National Health Insurance Scheme was launched in May 2005, from which time it became operational. It

contained three major programmes which are; Formal Sector Social Health Insurance Program, Informal Sector Social Health Insurance Program under which was Community Based Social Health Insurance Program; and Vulnerable Groups Social Health Insurance Program which contained Physically Challenged Persons Health Insurance Program, Prison Inmates Social Health Insurance Program, Children Under Five Social Health Insurance Program (CUFSHIP), Refugees, Victims of Human Trafficking, Internally Displaced Persons and Immigrants Social Health Insurance Program.

Three years after its inception, the NHIS has not effectively taken off and operated as initially conceived. This is as a result of challenges facing the scheme. First, the scheme is still limited to the public sector and has not been extended to the private sector due to apparent lack of political will and commitment. The scheme suffers from restricted coverage.

Second, there is continuous delay in remittance from the federal government establishment to the NHIS council, lacks adequate facilities and personnel to cover the nation sufficiently, many of the Health Service Providers (HSPs) are withdrawing from the scheme and some functional ones are refusing to register new clients or public servants and Finally, inadequate logistic support or support facilities from the government and donor-agencies affects the scheme adversely. Furthermore, adequate publicity or enlightenment has not been given to the people on the scheme.

This current study is interested in assessing the implementation of National Health Insurance Scheme (NHIS) in Federal Medical Center Bida, Niger State, in order to address and answer the question:

2. Literature Review and Theoretical Framework

2.1 Conceptual Issues

Concept of Health

The Constitution of the World Health Organization defined health "as a state of complete physical, mental and social well-being." The writers of the Constitution were clearly aware of the tendency of seeing health as a state dependent on the presence or absence of diseases: so they added to that definition that an individual, if he is to be considered healthy, should not suffer from any disease …. "and not merely the absence of disease or infirmity" (WHO, 2020)

Concept of Health Insurance

Health insurance stands for a pooling of health risks, in order for the participants to get benefits due to the uncertainty underlying ill-health occurrence and payments for treating such ill- health. This is because the need for health-care is often highly unpredictable and very costly for the individual although it is predictable for groups. Insurance can be used to spread the burden of payment (Adekola, 2015).

National Health Insurance Scheme (NHIS)

Generally, social insurance is a compulsory insurance scheme designed to provide a minimal socio-economic security for affected individual especially low - income earners. According to Teriba (2005) it is a mandatory insurance scheme whose objective is to provide a minimum standard of living. It provides an answer to the question of dependency in our society and on the government for certain services social insurance embraces large group of individual and the cost is sometime distributed among participants in the scheme and, sometimes, among all and sundry.

This obtains essentially in advanced countries of the west where there is effective system of social security; In accordance with the principles, whenever the income of a family is inadequate to meet their health need payments are made to them form public funds bring their health condition to a minimum level considered acceptable vis- a vis current standard.

A health insurance scheme can be defined as an arrangement in which contributions are made by or on behalf of individuals or groups (members) to purchasing institution (a fund) which is responsible for purchasing covered services from providers on behalf of the members of the scheme, Kultzin (2012). A social health insurance scheme involves contributions

based on means and utilization based on need. It holds strong potential to improve financial protection and enhance utilisation among enrolled populations. This underscores the importance of health insurance as an alternative health financing mechanism capable of mitigating the detrimental effects of user fees, and as a promising means for achieving universal healthcare coverage, Span et, al (2012). The aim is to reduce out of pocket payment in all forms as this payment method reduces equity of access to health care especially among the poor (Ezeoke, 2014).

Overview of the National Health Policies in Nigeria

Over the years, several national health policies have been put in place for the provision and maintenance of efficient healthcare delivery system in Nigeria. The first National Health Policy was adopted in 1988, with the goal to bring about a comprehensive health care delivery system driven by primary health care that is extensive, preventive, protective, restorative, rehabilitative and affordable through a functional referral system. The policy was geared towards achieving health for all by the year 2000 and defined the roles and responsibilities of the three tiers of government, as well as Non-Governmental Organizations (NGOs) participating in health care services. The policy document stipulated that a comprehensive health care system should include maternal and child health care, as well as family planning services.

In 2004, the National Health Policy was reviewed to focus on National Health System and Management, National Health Care Resources, National Health lntervention and Service Delivery, National Health Information Systems, Partnership for Health Development, Health Research and Healthcare Laws. The revised policy was to enhance the implementation of the health component of the National Economic Empowerment and Development Strategy (NEEDS), New Partnership for African Development (NEPAD) and Millennium Development Goal (MDGs).

In 2014, a national health bill was passed, that is, the 2014 National Health Act, which established a basic health care provision fund to be financed from Federal Government Annual Grant of not less than one per cent of its consolidated revenue fund, as well as grants from international donor partners and any other source. Out of the fund, 50 per cent shall be used for the provision of primary health and secondary health care through the NHIS primary and secondary health care facilities through the National Health Insurance Scheme (NHIS); 20 per cent shall be used to provide essential drugs, vaccines and consumables for eligible primary health care facilities; 15 per cent shall be used for the provision and maintenance of facilities, equipment and transport for eligible primary healthcare facilities; 10 per cent shall be used for the development of Human Resources for Primary Health Care Delivery;5 per cent for Emergency Medical Treatment. The fund is to be administered by a committee appointed by the National Council on Health.

The history of NHIS could be traced back to 1962. However, the scheme became operational in 2005 as a tripartite public-private arrangement among three main stakeholder operators; the NHIS, the HMOs and health care providers. The other stakeholders are the enrolees under the scheme (NHIS, 2012b). The primary aim is to ensure UHC that could enable improved access to health services and thus, a better population health outcome. It had the goal to achieve UHC within a period of 10 years from its inception (2005–2015). While the NHIS shapes the health insurance policy by accrediting the HMOs that operate within the health insurance space, it also accredits health care facilities to provide the benefit packages to registered enrollees. The HMOs are in charge of purchasing health care services on behalf of the Scheme for registered enrollees. The scheme has different programmes for different population groups in the country such as the formal and informal Sector Social Health Insurance Programme (NHIS 2012). NHIS is a pro-poor policy with the potential to promote access to needed quality health care among Nigerian populace and reduce the rate of uninsured as was reported in the ACA in America, Obama (2016) However, opinion is polarized among stakeholders on the efficacy of the scheme in addressing the health situation and poor health outcomes in the country Agba, (2010) Thus,

there is a growing need to correct the persistent poor coverage by assessing the design and implementation challenges of the scheme. This will provide an objective assessment of the situation for policy actors.

2.2. Empirical Review

Okpanachi and Vambe (2020) examined the extent to which the National Health Insurance Scheme (NHIS) has improved access to quality and affordable healthcare service among enrollees in University of Abuja Teaching Hospital, Gwagwalada. The study used both primary and secondary data. Secondary data was obtained from non–confidential records of NHIS enrollees at University of Abuja Teaching Hospital Gwagwalada, NHIS Bulletin etc. Primary data was generated through 5-point Likert scale questionnaire which were administered to enrollees of NHIS in University of Abuja Teaching Hospital (UATH) Gwagwalada. Analysis of findings revealed that NHIS has significantly increased access to quality and affordable healthcare service among enrollees in UATH Gwagwalada. It was discovered that access to quality and affordable healthcare service through NHIS is constrained by limited coverage of ailments by the scheme; non availability of some prescribed drugs in NHIS pharmacies; centralization of the process for obtaining authorization code and service forms by patients; lack of awareness by the populace of the opportunities for quality and affordable healthcare service provided by government through the NHIS.

With respect to the relationship between insurance status and health expenditures, mixed results are obtainable. (Oppong, 2001) found that out of pocket health financing yielded detrimental results; health indicators plummeted as health care became less accessible. A negative relationship between insurance coverage and health expenditures is also found in some studies (Jutting (2004) in Senegal; Jowett, et al (2004) in Vietnam; and Yip and Berman (2001) in Egypt). Yet other studies found that out-of-pocket spending remains the same or is even higher in the case of the insured when compared to the uninsured. Wagstaff et al (2007) explained this fact as a result of the institutional structure of health care in China, being that it favors increased utilization and substitution toward more expensive services and treatments.

Phillip et al (2012) examined the behavior of providers under the NHIS in Ghana by assessing the views of providers, insurance managers, insured and uninsured clients. The perceived opportunistic behavior of the insured by providers was responsible for the difference in the behavior of providers favoring the uninsured. Besides, the delay in reimbursement also accounted for providers' negative attitude towards the insured. The scheme was seen to be beneficial and led to an increase in the utilization of health care services for the insured and mobilized health resources for facilities. Survey findings indicated that insured and uninsured were satisfied with the provided ca re. However, most insured clients reported verbal abuse, long waiting times, not being physically examined and discrimination in favor of the uninsured and the cash customers. Providers also think that the insured were abusing their services by frequenting the facilities, and sometimes faking illness to collect drugs for their uninsured relatives. This had affected significantly the behavior of providers towards the insured.

Particularly underscored in Philip (2012) was the challenge relating to the delay in reimbursement. Managers and providers agreed that the National Health lnsurance Authority (NHIA) had not reimbursed providers for almost six months. As a result, providers were not able to purchase drugs and non-drug supplies and hence were prescribing drugs for the insured especially, to purchase outside the facilities. The delay also affected providers' ability to pay their casual employees who were not on government's payroll. This also influenced the behavior of providers where some of them preferred clients who would make instant payments for care.

Sanusi and Awe (2009) assesses the perception of the scheme and the prospect of its sustainability within the context of the socioeconomic characteristics of health service consumers and providers in Oyo State. While, several issues could be raised with respect to the methodology employed, such as the very small sample

size and the bias tendency in the socioeconomic characteristic surveyed, findings could still be a appreciated in term of perception signal-majority of respondent wanted the programme discontinued because of the feelings of being cheated, especially by the subscribers with no dependents and those who believed that available drugs are insufficient. Also, some respondents were of the opinion that there was not much difference in healthcare service delivery, before and after the adoption of the scheme. The study recommended the need to intensify awareness campaign and expand coverage to reduce the burden of dependency on the few contributors.

Emmanuel and Obima (2019) evaluate the impact of National Health Insurance Scheme (NHIS) on the health status of civil servants in Abuja. The specific objectives of the study were to: assess civil servants' awareness level of the scheme, determine the benefits of the specific healthcare services available under the scheme and evaluate the impact of the scheme on the civil servants' health status. The study adopted survey design which involved the combination of quantitative and qualitative data collection. Data were collected from 396 respondents using questionnaire which was complemented by in-depth interview among ten respondents in National Assembly and Corporate Affairs Commission, Abuja. The questionnaires were analyzed using simple percentages, while the in-depth interview was analyzed using content analysis. The findings revealed a high level of awareness of the scheme among the civil servants. Also it was found that the health status of the civil servants has improved through medical treatment following the usage of the NHIS healthcare services. The findings equally revealed that NHIS has impacted positively on the health status of civil servants in Abuja. The study concludes that NHIS has great impact on the health status of civil servants in Abuja. It is recommended that the Government should further equip the scheme to provide quality healthcare services to the civil servants in Abuja and other parts Nigeria

Agunobi (2018) examines how the National Health Insurance Scheme is managed. This is against the background of the need to highlight its strengths and identify sources of its shortcomings. Data were then collected from both primary and secondary sources. The main instrument used in collecting the data is questionnaire. The data were then presented in tables as frequency distribution. The techniques of frequency and percentage were applied in analysing the data. The following are the major findings of the study: The NHIS was introduced against the background of poor state of the national healthcare system. The scheme aims at giving all Nigerians access to good healthcare services, ensure equitable distribution of healthcare costs and facilities and high standard of Healthcare services. The scheme is funded through joint contributions by government and workers. The NHIS regulates the scheme while the managers are the HMOS. Clinical and laboratory services are provided by HSPs.

2.3. Theoretical Framework

The demand for health care is premised on several theories. However, the conventional theory, pioneered by Mark Pauly (1989) was adopted for this study as a guiding framework. The conventional theory among others, postulates that demand for health insurance is primarily driven by the desire to avoid risk, claiming that people purchase insurance because they prefer the certainty of paying a small premium to the risk of getting sick and paying a large medical bill. One advantage of health insurance obligation is that it allows the transfer of income from the pool of insurers who do not fall sick to finance the medical care of those who become ill.

Nyman (2000) further posited that consumers demand for health insurance to obtain extra income when they become ill; in effect, insurance companies act to transfer income from those who are healthy to those who are ill. This additional income generates purchases of additional high-value care, often allowing sick persons to obtain lifesaving care that they could not otherwise afford. By implication, the theory suggests that health insurance is substantially more valuable to consumers and consumers prefer the risk of a large loss to incurring a smaller loss with certainty. Nyman posited that the central rationale for

buying insurance is the individual's desire to obtain an income transfer from the risk pool when ill. One possibility is that the consumer seeks to smooth out consumption (or wealth) across time by sacrificing a little when healthy to be compensated in the event of injury or illness.

The nature of healthcare systems and how they are financed determine whether people can obtain needed healthcare and whether they suffer financial hardship at the instance of obtaining care (Carrins, Evans and Xu (2007). Likewise, Rao et al (2005) reiterated that the pattern of health financing is closely and indivisibly linked to the provisioning of services and help define the outer boundaries of the system's capabilities to achieve the overall goal of enhancing nation's economic development. Poverty literatures also show that socioeconomic characteristics of economic agents can reveal the choice of whether or not to demand health insurance. Poor households are expected to become increasingly risk averse if they move closer to, or further below the poverty line (Wagstaff, 2000).

Nevertheless, due to uncertainty about the unknown future health, insurance choice is not made based on utility alone but on consumers' expectation about factors such as their health status. Thus, theories on decision-making under uncertainty are often used to describe insurance enrolment. On the contrary, poor households, who are more likely to have credit constraints in the future, may be more willing to sacrifice current income and insure in order to face less risk in the future (Morduch, 1995).

Budget allocations to social services, including health were reduced by various African countries during the OPEC oil crisis of the 1970s. Economic circumstances in the 1980s led to even bigger problems, thereby forcing various African countries to seek for loans and grants from such financial institutions as the lnternational Monetary Fund (lMF) and the World Bank. As a major funding conditionality, these governments were required to switch from their socialistbased development policies toward open-market reforms under the Structural Adjustment Programs (Mensah, 2006). Removal of government subsidies and imposition of user-fees for social services such as education and health care became common requirements by the early 1990s (Mensah, 2008a). Out-of-pocket payment for health care services, which used to be the exception in the early postindependence years in Africa, became the rule (Mwabu, 2008; Vandemoortele et al., 9971.

It is on the basis of the above premise that this study is situated in order to assess the implementation of the NHIS in Federal Medical Centre, Bida, Niger State.

3. Methodology

In this study, descriptive survey research design was adopted. The choice of this design was based on the fact that the entire population cannot be covered, therefore, sample representative was used in this study. Therefore, this study was a descriptive survey conducted among enrolees of FSSHIP (predominantly federal government employees), health care providers and administrators (staff of NHIS, Staff of Federal Medical Centre, Bida, Health Maintenance Organizations (HMOs) and Niger State Ministry of Health) in Niger state.

The population of this study comprises of the staff of the Federal Medical Centre, Bida Niger State, who deliver such service like the doctors, laboratory officers, pharmacist and nurses which are 372 Doctors, 98 Pharmacist, 94 Laboratory Scientist, 618 Nurse, 151 Admin officer and 657 enrollees who are direct beneficiaries of NHIS totally 3353 (FMCB/NHIS Records, 2024).

In selecting the sample size Taro Yamane (1964) formula was used, thus;

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

Where n = sample size

N = total population size

1 is constant

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

$$n = \frac{N}{1 + N(e)^2} \qquad \frac{3353}{1+3353(0.05)^2}$$

$$9.38 = 357$$

In this study, both primary and secondary sources of data were utilised. The primary data was obtained through questionnaire, interview, focus group discussion and observation both in eliciting responses from the selected respondents. While the secondary data was obtained from official documents (i.e. official files), articles and publications of local, national and international research institutes; and other relevant materials were utilized.

The technique of data analysis used was the simple frequency conversion of responses to percentages (i.e. the use of simple percentage method). In addition, Statistical Package for Social Sciences (SPSS) version 22 was used to test for significant relationship between the variables of the study. Descriptive and quantitative techniques such as mean, standard deviation and variance were also employed in the analysis of the study data.

4. Results and Discussion

Out of the total number of questionnaires distributed, 96 were completed and returned giving an overall response rate of 96%. 64 out of 68 questionnaires which were completed and returned by enrolees, while all 32 questionnaires distributed to health care providers and administrators were completed and returned. Majority of enrolees were males (77%, 49/64), of age group 30-39 years (68%, 43/64) and with a family size of 5 or more (78%, 50/64). Majority earned monthly income of N50,000 and above (68%, 43/64), and attained bachelor degree and above (70%, 45/64). Slightly more than half (58%, 37/64) of the respondents lived in urban locations. Table 4.1 below presents the details of the information.

Table 1: Socio-demographic Characteristics of Enrolees

Variable	Frequency	Percentage
Age (years)		
20-29	6	9
30-39	43	68
40-49	13	20
50 and above	2	3
Gender		
Male	49	77
Female	15	23
Family Size		
Single	6	9
1-4	8	13
5-9	30	47
10 and above	20	31
Monthly Income (Naira)		
Below 20000	8	12
30000-40000	13	20
5000 and above	43	68
Residential Location		
Urban	37	58
Rural	27	42
Education Level		
Less than Bachelor Degree	19	30
Bachelor Degree and above	45	70

Source: Field Work, 2024

We characterized enrolees according to their level of utilization, benefit and satisfaction with health care services provided under the NHIS.

Table 2: Enrolees level of utilization, benefit and satisfaction with health care services under NHIS

Variable	Frequency	Percentage
Duration since enrolment		
Less than one year	26	41
One year and above	38	59
Place of care		
Private health facility	13	20
Public health facility	51	80
Common services received		
Malaria treatment	42	66
Typhoid treatment	10	16
Hypertension	3	4
Treatment requiring surgery	1	2
Others	8	12
Enrolees' opinion sought prior to enrolment		
Yes	37	58
No	27	42
Enrolees' opinion on how beneficial NHIS has been to them		
Beneficial	60	94
Not Beneficial	4	6
Extent to which enrolees benefited		
Extremely	10	16
Minimally	3	4
Extremely	10	16
Don't know	1	2
Level of satisfaction with services		
Satisfied	40	62
Dissatisfied	24	38
Enrolees opinion on adequacy of facilities/equipment		
Adequate	33	52
Inadequate	31	48

Source: Field Work, 2024

Table 2 above shows that majority of respondents had been enrolled in the scheme for at least one year (59%, 38/64), received care at public facilities (80%, 51/64) commonly for malaria treatment (66%, 42/64), and were satisfied with the services (62%, 40/64). A clear majority (94%) of respondents believed that the NHIS has been beneficial to them, and that they had benefitted maximally from the scheme (78%, 50/64) (TABLE 2).

Table 3: Respondents' Perceived Changes in their Health Status and Health Care System in Niger state since Inception of NHIS

Variable	Frequency	Percentage
Impact on enrolees' health status		
Fair	4	6
Good	10	16
Very Good	50	78

Don't know	0	0
Improvement in enrolees' health status and access to health care		
Yes	60	94
No	4	6
Don't know	0	0
Enrolees' opinion on improvement in health care system		
Improve	40	62
Not Improved	24	38
Don't know	0	0
NHIS is best option to provide health care		
Yes	40	62
No	24	38
Alternatives to NHIS		
Traditional Healers	2	3
Primary Health Care	15	13
Mobile Health Care Services	8	13
Privatization of Health Care Services	4	6
Free Health Care Services	35	55

Source: Field Work, 2024

We examined enrolees' perception of changes in their health status and the overall health care system since the inception of NHIS as compared to the pre-implementation period. Results in Table 3 above showed that more than three quarter (78%, 50/64) of the enrolees felt that the NHIS has had a very good impact on their health status, and had clearly improved their access to health care (94%, 60/64). Majority (62%, 40/64) perceived that the health care system in Niger state had improved since inception of NHIS and that it was the best option to provide health care services in Niger state. About 23% (15/65) of respondents felt that primary health care was a viable alternative to NHIS.

Table 4: Respondents' Characteristics and Perception of the NHIS

Variable	Frequency	Percentage
Location of respondent's organization (n=15)		
Rural	3	20
Urban	12	80
Duration of work experience with NHIS		
0-11 months	12	38
12 months and above	20	62
Perception on funding of NHIS		
Inadequate	4	13
Adequate	20	63
Don't know	8	24
Perception on adequacy of manpower		
Adequate	20	63
Inadequate	10	31
Don't know	2	6
Perception on adequacy of equipment/facilities		
Adequate	13	41

Inadequate	18	56
Don't know	1	3
NHIS has increased demand/access to health care		
Yes	24	75
No	8	25
How respondent's organization has been coping with increased demand for health care		
Recruiting more health manpower	4	13
Building capacity of existing manpower	26	81
Provision of essential drugs	2	6
Average number of patients attended to weekly under NHIS		
1-19	5	16
20-29	6	19
30-39	8	25
40-49	2	6
50 and above	11	34

Source: Field Work, 2024

Results from Table 4 above revealed that majority (80%, 12/15) of organizations where health care providers and administrators in this sample belonged were located in urban areas. Majority (62%, 20/32) of the respondents had work experience with NHIS of 12 months or more and perceived that NHIS funding as well as manpower was adequate. Three quarters of the respondents believed that NHIS has increased demand/access to health care by all age groups, for which their organizations have only been able to cope through increased capacity building of existing manpower (81%, 26/32).

Table 5: Respondents' perceived Changes in their Health Status and Health Care System in Niger State since inception of NHIS

Variable	Frequency	Percentage
Opinion on current health care system		
Fair	5	16
Good	20	62
Very good	5	16
Don't know	2	6
Opinion on how NHIS has impacted health care indices		
Positively	24	75
Negatively	0	0
Don't know	8	25

Source: Field Work, 2024

As revealed in Table 5 above where we compared to pre-NHIS implementation period to the NHIS period, majority (62%, 20/32) of the health care providers and administrators in this sample believed that the current health care system was good, and that the NHIS has positively impacted (75%, 24/32) the health care indices in Niger state.

Table 6: Respondents' Opinion on the Challenges with NHIS and how it can be Improved

Variable	Enrolees (n=64)		Health care providers and administrators (n=32)	
	Frequency	Percentage	Frequency	Percentage
Problems Affecting NHIS				

Lack of sustainable funding	5	8	1	3
Inadequate facilities and equipment	13	20	5	16
Poor quality health care services	3	5	0	0
Lack of adequate manpower	6	9	3	9
Poor logistics services	3	5	1	3
Poor public awareness	2	3	1	3
Poor supervision and monitoring	5	8	5	16
Poor referral system	1	2		
Restricted number of family beneficiaries	3	5	2	6
Not all government workers are registered	10	16	2	6
Restricted ailments for treatment	6	9	5	16
Lack of stakeholders in NHIS eg NGOs	1	2	0	0
Mismanagement of funds	2	3	5	16
Deduction of salaries when not treated	2	3	0	0
Neglect of primary health care	0	0	2	6
Don't know	2	3	0	0
Suggested ways to improve NHIS				
Provision of adequate equipment and facilities	10	16	4	13
Proper monitoring and supervision	6	9	5	16
No restriction to ailments	2	3	0	0
Regular consultation with care	3	5	0	0
Regular funding	5	8	5	16
Provision of quality health services	8	13	0	0
No limitation to family size	1	2	3	9
Free medical care	7	11	5	16
Adequate health manpower	8	13	2	6
Create awareness about the scheme	2	3	1	3
Register all categories of civil servants	6	9	4	13
Provision of logistics services	2	3	1	3
Effective and efficient funds management	2	3	0	0
Good referral system	2	3	1	3
Involvement of health stakeholders	0	0	1	3

Source: Field Work, 2024

We sought respondents' opinion regarding the major problems affecting the NHIS and suggestions on how it could be improved in Niger State. The results as show in Table 6 above revealed that enrolees, health care providers and administrators believed that inadequate facilities and equipment was one of the major problems affecting the NHIS in Niger state. Additionally, respondents believed that poor supervision and monitoring, restriction of ailments eligible for treatment under the scheme, mismanagement of funds and systematic exclusion of some government workers and inadequate manpower were the other major challenges facing the successful implementation of NHIS in Niger state. They suggested solutions such as provision of adequate equipment and facilities, proper monitoring and supervision, regular funding, adequate health manpower, registration of all categories of civil servants, free medical care, improvement in quality of health care services, and where possible, free health care services.

Discussion of Findings

Like statistics on health indicators, data on NHIS coverage and success indicators in Niger State are not readily available and often incomplete. Studies on

impact of NHIS in Nigeria are hardly available in literature, suggesting a certain bias in reporting on health insurance schemes, possibly driven by national government, donor or research priorities, data availability and difficulty in publishing negative impact results. Similar to the findings among health care providers and administrators in the current study (75%), a study conducted among dentists in Lagos, Nigeria revealed that respondents believed NHIS would expand access to dental health services (Agba, 2010). We report a significantly higher proportion of enrolees in the current study who believed that they had benefitted from the introduction of NHIS compared to a meagre 0.3% reported in a similar study conducted among civil servants in Osun state, Nigeria (Adekola, 2015). Similar to the findings of a previous study among government employees in Abakaliki, South-east Nigeria (Agunobi, 2018), enrolees in the current study believed that the introduction of NHIS has improved their access to qualitative health care services, compared to those relying on out-of-pocket payments.

The issue of sustainable health financing remains on the top burner as a major impediment towards achieving universal health care coverage. A flurry of literature evidence suggests that health care financing options that reduce or eliminate out-of-pocket expenditures at the time of seeking health care have better potentials of reducing exclusions, inequities and delays in seeking prompt health care (Adeyemi, 2013), (Mohammed, 2017), (Ezeoke, 2012). It is instructive to note that pre-payment through the FSSHIP does not totally exclude, but rather minimizes out-of pocket expenses on health care. This is because certain health care services (e.g. transplants and cosmetic surgeries, family planning commodities, IVF, post-mortem examination etc) are not covered under the scheme and users would have to pay for such services when required. However, the negative effects of these payments on access to health care were significantly lower among the insured than uninsured (Onwajekore, 2015).

Beyond the adequacy of funding through risk pooling from employers and employees' earning-related monthly deductions and contributions to NHIS as reported by majority of health care providers and administrators in the current study, the issue of mismanagement of funds has become a very pertinent impediment against successful achievement of the NHIS objectives. Health care providers have reported delays in payment of their capitation or fee-for-service rendered by the HMOs. This, in addition to weak regulatory framework (Aderounmu, 2013) and poor monitoring and supervision identified by participants in this study may stand to reverse the gains made with NHIS if urgent steps to curb this trend are not taken.

Majority of enrolees in the current study reported being satisfied with the services received under the NHIS. This finding, although similar to findings of one Kenyan study, (Emmanuel and Obima, 2019) contrasts with the findings of a similar study conducted in Zaria, Nigeria where only about 42% of enrolees reported being satisfied with the services they received (Agunobi, 2018). Client satisfaction remains a fundamental determinant of service utilization (Uzodimma, 2017) (Ogbonna, 2016) and perceived benefits of the care received. It is therefore not surprising that majority of enrolees in the current study reported very good impact of the NHIS on their health status. Relatedly, satisfaction breeds confidence and trust in the health care system, which majority of respondents in our study perceived to have improved with the introduction of NHIS.

Although majority of the health care providers and administrators in our sample believed that the introduction of NHIS has positively impacted the health care indices of Niger state, it is difficult to reliably verify these claims in the absence of comprehensive statistical reference data. Although there was slight improvement in the health indicators as reported in 2008 Nigeria Demographic and Health Survey (NDHS) (Shagaya, 2015), it was difficult to determine the extent to which introduction of NHIS had contributed to these gains, especially as only a handful of federal government employees were currently participating in the FSSHIP in Niger state as at the time of this study. Indeed, further deterioration in health care services owing to significant destruction

of the health infrastructure by the Boko Haram insurgency (Anetoh et al, 2017) would have further worsened the situation in Niger State.

5. Conclusion and Recommendations

Based on the findings of this study, a conclusion could be made that the introduction of NHIS in Federal Medical Centre, Bida, Niger State has improved enrolees' demand/access to qualitative health care services. Majority of enrolees were satisfied with the services received and felt that they had benefitted maximally from the NHIS, evidenced by improvement in their health status and the overall health care system in Niger state. The funding was adequate and was being paid monthly, the level of supervision and monitoring was found to be grossly inadequate, poor facilities coupled with the presence of some unqualified staff in the premises of the providers, limitation and consequent denial of Medicare to certain members of the enrolled families, lack of public awareness of the scheme, excessive concentration of the providers in urban areas and undue emphasis on curative rather than preventive medicine amongst others were identified.

On the basis of the findings from this study, it was imperative to make the following recommendations:

i. Health care delivery in Niger State should be given more attention and more funds allocated to the health sector considering the implication of health on the workforce and the economy.
ii. Each Centre under the NHIS services should create a publicity department to educate the beneficiaries on health services and the activities of the NHIS.
iii. The NHIS act was made by the military and may have omitted some important aspects, thus the act should be reviewed to make it more inclusive, and effective to be in line with the current realities.
iv. The NHIS should be made mandatory for all tiers of government employees/employers i.e. federal, states and local governments.
v. The act should be reviewed to allow the informal employment and private sectors' workers to benefit.

References

Adefolaju T. (2014). *Repositioning Health Insurance in Nigeria: Prospects and Challenges; International Journal of health Sciences; Vol.2;* No.2; June, 2014. American Research Institute for Policy Development; Retrieved from www.ijhsnet.com

Adekola A. (2015). *Health Insurance in Nigeria; Medical World Nigeria.* Retrieved from*https://www.medicalworldnigeria.com*

Aderounmu, A.O. (2013). *National Health Insurance in Nigeria.* Retrieved from https://nanopdf.com>download>nation

Agba, M.S. (2010). *Perceived Impact of the National Health Insurance Scheme (NHIS) Among Registered Staff in Federal Polytechnic, Idah, Kogi State, Nigeria; Studies in Sociology of Science; Vol.I;* No.I, 2010. Retrieved from www.cscanada.net

Agunobi, O.C. (2008). *Management of national Health Insurance Scheme (NHIS) in Nigeria; (MSc. thesis, University of Nigeria, Enugu Campus,).* Retrieved from www.unn.edu.ng>files>images

Alabama Department of Insurance (n.d.). *Health Insurance Frequently Asked Questions.* Retrieved from www.aldoi.gov>Consumers>HealthFAQ

Anetoh, M.U., Jibuaku, C.H., Nduka, O.S., Uzodimma, S.U. (2017). *Knowledge and Implementation of Tertiary Institutions Social health Insurance Programmes (TISHIP) in Nigeria: A Case Study of Nnamdi Azikiwe University, Awka; Pan African Medical Journal,* doi:10.11604/pamj.2017.28171.11379.Retrieved from*www.panafrican-med-journal.com/content/article/28/171/full*

Anyika, E.N. (2014). *Challenges of Implementing Sustainable Health Care Delivery Under Environmental Uncertainties; Journal of Hospital Administration; Vol.3,*No.6;

dio.org/10.5430/jha.v3n6p113.Retrieved from*www.sciedu.ca/jha*

Arin, D. (2013). Hongoro C. Scaling up national health insurance in Nigeria: Learning from case studies of India, Colombia, and Thailand. Futures Group, Health Policy Project, Washington, DC.

Berman Peter (1995). *Health Sector Reform: Making Health Development Sustainable; Health Policy; Vol. 32,* Issue 1-3, April-June 1995, pp.13-28.doi.org/10.1016/0168-8510(95)00726-9. Retrieved from https://www.sciencedirect.com/science/article/pii/0168851095007269

Calidoni-Lundberg F (2006): *Evaluation: Definitions, Methods and Models; An ITPS framework;* Swedish Institute for Growth Policy studies. Retrieved from https://www.tillvaxtanalys.se>download

Cassels A (1995): *Health Sector Reform: Key Issues in Less Developed Countries; Journal of International Development; Vol.7,* Issue 3, pp.329-347. Retrieved from https://doi.org/10.1002/jid.3380070303

*Chukwura, C. E, (2015): Utilization of National Health Insurance Scheme (NHIS) Among Healthcare Providers Working at University of Nigeria Teaching Hospital, Ituku-Ozalla, Enugu;(Msc. Dissertation, University of Nigeria, Enugu Campus).*www.repository.unn.edu.ng>handle>discover

CIA World Factbook (2004): *Nigeria. History of Modern Medical Services;* Retrieved from http://www.photius.com/countries/nigeria/society/nigeria_society_

Carrin, G. (2002). Social health insurance in developing countries: A continuing challenge. Int. Social Security Rev.

Carrin, G. & Adelhardt, M. (20015). Health financing reform in Kenya-- Assessing the social health insurance proposal. S African Med.

Chuma, J. (2013). Providing financial protection and funding health service benefits for the informal sector: Evidence from sub-Saharan Africa. London, UK: KEMRI—Wellcome Trust Research Programme, University of Cape Town.

Distant Library (2015): Tertiary Institutions Social Health Insurance Programme (TISHIP). Retrieved from https://www.distantlibraryng.blogspot.com

Eboh A, Akpata, G.O. &Akintoye, A.E. (2016): *Health Care Financing in Nigeria: An Assessment of the National Health Insurance Scheme (NHIS); European Journal of Business and Management; Vol.8,* No.27. Retrieved from www.jiste.org.

Ele, G.N., Ochu U, Odili, V.U., Okechukwu, R.C. &Ogbonna B.O. (2016): *Evaluation of the Benefits, Quality of Service and Challenges to the Nigerian National Health Insurance Scheme Among Enrollees in a Tertiary Teaching Hospital in Southeast Nigeria; Journal of Advances in Medical and Pharmaceutical Sciences; 9(3): 1-11;* No. JAMPS.28320. www.sciencedomain.org.

Emuakpor, A.S. (2010): *The Evolution of Health Care System in Nigeria: Which Way Forward in the Twenty-first Century; Nigerian Medical Journal; Vol. 51,* Issue 2, pp:53-65. Retrieved from http://www.nigeriamedj.com/text.asp?2010/51/2/53/70997

Etobe, E.I. &Etobe, U.E. (2015): *The National Health Insurance Scheme and its Implication for Elderly Care in Nigeria; International Journal of Science and Research; Vol.4; Issue 2; February,2015.* Retrieved from *https://www.ijsr.net>archive>SUB15619*

Fatusi, A.O.(n.d.): *Health Sector Reform in Nigeria and the Potential for Poverty Reduction;* Retrieved from*www.studylib.net>doc>health-sector-reform*

Federal Ministry of Health (FMoH) (2016). National Strategic Health Development Plan (NHSDP) 2010-2015. FMoHAbuja, Nigeria. Available:http://www.health.gov.ng/doc/NSHDP.pdf (Accessed 12 June 2022)

George, T.O. (2008): *Women and the Globalization Movement: An Appraisal of Local and Foreign Health Policies in Nigeria; African*

Journals Online; The Ife Centre for Psychological Studies; Ile-Ife. Retrieved from https://www.ajol.info>gab>article>view

Grace, E.N., Brian, O.O., Oche, M.O., Odili, U.V. (2017). *Assessment of National Health Insurance Scheme's (NHIS) Effectiveness in a Tertiary Teaching Hospital in Southeast Nigeria; Journal of Advances in Medical and Pharmaceutical Sciences; Vol.13(3) No. JAMPS.32767*. Retrieved from www.sciencedomain.org

Gopalan, S.S. (2012). Addressing women's non-maternal healthcare financing in developing countries: What can we learn from the experiences of rural Indian women. PloS one.

Health Sector Reforms (n.d.). *Public Service Reform in Nigeria.* Retrieved from www.psr.nigeriagovernance.org>docs>doc

History of Health Insurance in Nigeria (n.d.).Retrieved from http://www.ehealthinsurance.com.ng/.

Ibiwoye A (2007). *The Impact of health Care Provisionin Developing Countries; Ghana Journal of Development Studies; Vol.4*, No.21, pp.49-58. Retrieved from http://dx.doi.org/10.4314/gjds.v4i2.35060

Jacobs R. & Goddard M. (2000). *Social Health Insurance Systems in European Countries; The role of the Insurer in the Health Care System: A Comparative Study of Four European Countries;* The University of York Centre for Health Economics, York

Kajang, D.R. (2004): *Organization and Management of Health Services in Nigeria: 1960-2004;* (Doctoral Dissertation, St. Clements University), September. Retrieved from http://docplayer.net

Kittoe, J.D. &Asiedu-Addo, S.K. (2017) *Exploring Fraud and Abuse in National Health Insurance Scheme (NHIS) Using Data Mining Technique as a Statistical Model; African Journal of educational Studies in Mathematics and Sciences, Vol.13, 2017. Retrieved from https://www.ajol.info>article>view*

Lane J-Erik (1962) *The Concept of Implementation.* Retrieved from https://books.google.com>books>about

Liechtenstein Medical Insurance (2017). Pacific Prime. Retrieved from https://www.pacificprime.com

Moffit K (n.d.) *Structural-Functional Theory: Definition, Examples and Quiz.* Retrieved from *http://study.com>academy*

Muanya C. (2016, August 21): *NHIS: Poor Implementation Threatens Health Care; The Guardian,* Retrieved fromhttps://t.guardian.ng/saturday-magazine.

Murray, C. J. (2013). Measuring the global burden of disease. N Engl J Med. 2013; 369(5):448-57.

Murray, C. J. & Lozano, R. (2012). Disabilityadjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990– 2010: A systematic analysis for the Global Burden of Disease Study 2010. Lancet.

Mossialos, E. & Dixon, A. (2002). Funding health care: An introduction. in Mossialos E, Dixon A, Figueras J, Kutzin J, editors. Funding health care: Options for Europe. Buckingham. Philadelphia: Oxford University Press.

National Health Insurance (March, 2009). *A Brief History of Reform Efforts in the U.S.* Retrieved from https://kaiserfamilyfoundation.files.wordpress.com.

National Health Insurance Scheme (April, 2014). *Operational Guidelines for the Implementation of the Tertiary Institutions Social Health Insurance Programmeme.*Retrieved from https://www.nhis.gov.ng>files>repository.

National Institute of Research Network [NIRN] (n.d.). *What is Implementation?* Retrieved from http://nirn.fmhi.usf.edu/resources/publications/Monograph/pdf/01.pdf

Oberman K, Muller P, Muller H, Burkhard S &Glasinski B (Ed) (2016): *German Health Care System: A Concise Overview;* Der Ratgeberverlag. Retrieved from https://www.researchgate.net>publication

Obiechina, G.O. &Ekenedo, G.O. (2013). *Factors Affecting the Utilization of University Health Services in a Tertiary Institution in South-*

West Nigeria; Nigerian Journal of Clinical Practice, vol.16(4), 454-7. Retrieved from https://www.researchgate.net>publication

Olakunde, B.O. (2012): *Public Health Care Financing in Nigeria: Which Way Forward?* http://www.anmjournal.com/article.

Onoka C.A., Kara H &Hanefeld J. (2015): *Towards Universal Coverage: A Policy Analysis of the Development of the National Health Insurance Scheme in Nigeria;* London School of Hygiene and Tropical Medicine; doi: 10.1093/heapol/czu116. Oxford University Press. Retrieved from https://www.ncbi.nlm.nih.gov>pubmed

Onotai, L.O. &Nwankwo, N.C. (2012): *A Review of the Nigerian Health Care Funding System and How it Compares to that of South Africa, Europe and America; Journal of Medicine and Medical Sciences; Vol.3(4);* April 2012 http://www.interesjournals.org/JMMS.

Odeyemi, I.A. (2014). Community-based health insurance programmes and the national health insurance scheme of Nigeria: Challenges to uptake and integration. Int. J Equity Health.

Roizen M. (n.d.) (2012). *What are the Origins of Health Insurance.* Retrieved from https://www.sharecare.com>health

Saka, M.J., Saka, A.O., Isiaka, S.B., Agbana,B.E. & Bako, I.A. (2012). *Health Related Policy Reforms in Nigeria:- Empirical Analysis From 2001 to 2010; The Past, Trend and Future Directions for Sustainable health Financing and Development; International Journal of academic Research in Business and social Sciences; Vol.2,*No.3; www.hrmars.com/journals

Shafiu M, Souares A, Bermejo, J.L., Sauerborn R & Dong H (2014): *Performance Evaluation of a Health Insurance in Nigeria Using Optimal Resource Use: Health Care Providers Perspective; doi:10.1186/1472-6963-14-127; BMC Health* Services Research. Retrieved from http://bmchealthservres.biomedcentral.com

Shagaya, Y.J. (2015) *Assessment of Student's Satisfaction and Quality of Patient Care under the Nigerian Tertiary Institutions Social Health Insurance Programmes (TISHIP). European Journal of Business and Management, Vol.7,* No.6, 2015. Retrieved from www.iiste.org

Subedi, D.P. (1937): *Structural Functional Perspective in Sociology(Conflict Theory Alternatives)* Retrieved from https://subedi.orgfree.com>docs>Structural_Functionalism

Shiffman, R.N, Michel G, Essaihi A. &Thornquist E. (2004). *Bridging the Guideline Implementation Gap: A Systematic Document-Centered Approach to Guideline Implementation; Journal of the American Medical Informatics Association,* 2004, 11(5):418-25. Retrieved from http://www.ncbi.nlm.gov>pubmed

Salaria N (2012). *Meaning of the Term Descriptive Survey Research Method; International Journal of Transformation in Business; Vol.1, Issue,* No. 6, April-June. Retrieved from http://www.ijtbm.com/

Tech Target (n.d.). *What is Implementation?* Retrieved from http://searchcrm.techtarget.com/sDefinitions/o,290660,sid11_gci851347.00.hml

The History of Health Insurance in the United States (2007). Retrieved from http://www.neurosurgical.com

Umar.I, Oche, M.O. & Umar, A.S. (2011). *Patients Waiting Time in a Tertiary Health Institution in Northern Nigeria; Journal of Public Health and Epidemiology, Vol.3(2),* pp76-82. Retrieved from http://www.academigjournals.org/jphe,