

National Health Insurance Scheme and Healthcare Administration in Nigeria: An Assessment

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Abstract: *The study “National Health Insurance Scheme and healthcare administration in Nigeria was undertaken to assess the outcome of the activities of National Health Insurance Scheme among employees who enrolled in the scheme. The study also aimed at assessing the level of healthcare services delivered to the enrollees of the scheme as well as the level of satisfaction derived by the enrollees from healthcare services provided by the scheme, and to determine the extent to which National Health Insurance Scheme (NHIS) has promoted equal access to healthcare facilities in the country. The study was anchored on Samuel Stouffer’s Relative Deprivation Theory of 1949. The study adopted a descriptive survey design. Findings from the study revealed that the level of healthcare services to the beneficiaries of National Health Insurance Scheme in Nigeria is low. It also revealed that a greater number of the enrollees are not satisfied with the quality of healthcare services provided by the scheme. The study also found out that NHIS has not promoted equal access to healthcare facilities among enrollees in the country. However, dissatisfaction was more with the amenities, referral system, awareness creation, coverage, negligence in the provision of services by the operators of the scheme, non-availability of required drugs, poor funding of the scheme, unequal distribution of healthcare services to the beneficiaries among other factors. The implication is that the scheme is yet to achieve the basic purpose of its establishment of ensuring universal provision of healthcare services to majority of Nigerians and to reduce out-of-pocket expenditure for healthcare services for Nigerians. The study therefore recommended that since funds are drawn for the purpose of reducing out-of-pocket expenditure, the scheme should be overhauled in order to identify and curtail funds diversion to increase the basic provision of healthcare goods and services. The study also recommended that an effective consumer protection authority should be established, not just for NHIS consumers but for all healthcare consumers in the country: to enable healthcare providers to know that they are actually dealing with irreplaceable lives and that the quality of healthcare should as well be borne in mind to prevent the consumption of sub-standard goods and services through the scheme.*

Keywords: NHIS, Healthcare services, Administration, Nigeria

1. Introduction

Government supports universal access to health care through social policies, such as National Health Insurance Scheme (NHIS), Subsidy Re-investment and Empowerment programmes (SURE-P), National Economic Empowerment and Development Strategies (NEEDS) etc. National Health Insurance scheme (NHIS) is 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 health care for the majority of Nigerians.

National health insurance scheme is a form of formal sector social insurance programme (Onyedibe, Goyit and Nnadi: 2012). It is a social health security system in which the health care of an employee is paid for by both the employer and the employee. This is achieved by monthly deduction of 5% of basic salary from an employee and another 10% of basic salary paid by the employee’s employer which is then pooled together and used for all enrollees. In social health insurance, there is gross subsidization where the healthy subsidize for the ill, the young subsidize for the old and the higher income groups subsidize for the lower income groups (Onyedibe et al, 2012). There are five major stakeholders in the scheme namely: Employer, Employee, Health Care Provider (Primary and Secondary), Health Maintenance Organization (HMO) and the government agency (NHIS). By this, the nature of health care for federal workers is under the control of new stakeholders (Adesina, 2009). For participation in the scheme, contributors will first register with NHIS approved HMO and thereafter register with a primary health care provider of their choice from an

approved list of providers registered by their HMO. The contributor and his/her dependents are issued ID card at registration. In the event of sickness, the ID card entitles the insured person, his/her spouse and four children under the age of eighteen (18) years to full health benefits.

Globally, National Health insurance is traced to Germany in 1883 when Emperor Otto Von Bismarck enacted a compulsory legislation on sickness fund for all German workers. This was followed by the creation of the “Accident Fund” in 1885 and the “Pension Fund” in 1891. In 1885, about 11% of the total populations of Germany were covered by more than 18 000 sickness funds (Ndie, 2013). At the beginning, payments primarily covered loss of income during sickness. In 1892, the first comprehensive regulations between health funds and health care providers were established. Health funds could decide whom to contract as a statutory health insurance physician (SHI-physician). In 1896 The Prussian medical fee schedule came into effect. From then on, other countries like Japan, Australia, Belgium, Nigeria etc keyed into the scheme.

In Nigeria, the concept of Social Health Insurance was first mooted in 1962 by the Halevi Committee, which passed the proposal through the Lagos Health Bill (Johnson and Sloskopt, 2009). The scheme then was compulsory for public servants. Unfortunately, the operation of NHIS was obstructed following outbreak of the Nigerian civil war (Agbe, 2010).

In 1984, forced by the need to source more funds for healthcare services, the National Council on Health headed by Admiral Patrick Koshoni, then Minister of Health,

inaugurated a committee, under the chairmanship of Prof. Diejomoah advised government on the desirability of Health Insurance in Nigeria and recommended its adoption.

In 1985, Dr. Emmanuel Nsan, the Minister of Health inaugurated a committee on National Health Review headed by Mr. L.Lijadu. The committee also reported that Health Insurance is viable in Nigeria (NHIS, 2005)

Later in 1985, Prof. Olikoye Ransome Kuti, the then Minister of Health, raised a consultative Committee on National Health Insurance Scheme. The committee was made of the Nigerian Labour Congress (NLC), Nigerian Employer Consultative Association (NECA), Nigerian Medical Association (NMA), Pharmaceutical Society of Nigeria (PSN), United Nations Development Programme (UNDP), Armed Forces Medical Directorate, National Planning Commission (NPC), Federal Ministry of Labour, and the Presidential Advisory Committee (PAC). Upon submission of their report another committee chaired by Dr. E. Umez-Eronin was set up to recommend an acceptable model for the implementation of a Social Health Insurance in Nigeria (NHIS,2005)

The National Council on Health at its 28th meeting set up another committee on National Health Insurance Scheme. After the submission of its report, the Federal Government approved the establishment of the National Health Insurance Scheme in 1989 (NHIS, 2005)

In 1991, the Federal Government signed an agreement with the UNDP and the International Labour Organization for the planning and the implementation of the scheme. Studies carried out involved enrollees analysis, computerization requirements, financial procedures, management information system, guidelines and draft law on the National Health Insurance Scheme. In 1993, the Federal Ministry of Health presented a memorandum to the Federal Executive Council (FEC) praying for immediate implementation of the National Health Insurance Scheme.

In 1995, the National Health Summit endorsed the need to set up the National Health Insurance Scheme as soon as possible. At its 42nd meeting, the National Council on Health (NCH) approved the repackaging of the NHIS to ensure full private sector participation. This model ensured the introduction of Health Maintenance Organizations (HMOs) as financial managers of the Scheme.

In 1999, the scheme was modified to cover more people through decree 35 of May 10, 1999, which was promulgated by the then head of state, Gen. Abdulsalami Abubakar (Adesina, 2009) cited in (Agba ,2010). The decree became operational in 2004 following the flag off by the wife of the then president Mrs. Stella Obasanjo on the 18th of February 2003 in Ijah, a rural community in Niger State, (North Central) Nigeria (Agba, 2010). Subsequent flagged offs were carried out in Aba, Abia state south east zone among others (office of public communication 2006, cited in Agba (2010). In September, 2009, 25 states of the federation agreed to partner with the scheme. These include Akwa Ibom, Rivers, Edo, Taraba, Adamawa, Kaduna, Zamfara, Kebbi, Sokoto, Katsina, Nassarawa, Anambra, Jigawa, Imo

and Kogi states. Others include Bauchi, Ogun and Cross Rivers states. (NHIS: 2009)

NHIS was established to ensure the provision of health insurance which shall entitle insured persons and their dependants the benefit of prescribed good quality and cost effective health services (NHIS decree No. 35 of 1999). It was also established to ensure: universal provision of health care in Nigeria, to control/reduce arbitrary increase in the cost of health care services, to protect families from high cost of medical bills, to ensure quality in the distribution of health care service cost among income groups, to ensure high standard of health care delivery to beneficiaries of the scheme, to boost private participation in health care delivery, to ensure adequate and equitable distribution of healthcare facilities within the country; to ensure that primary, secondary and tertiary healthcare providers are equitably patronized in the federation and to maintain and ensure adequate flow of fund for the smooth running of the scheme and the health sector in general (NHIS, Decree No.35 of 1999, NHIS 2009).

Many years after the commencement of NHIS in Nigeria, opinion is polarized among Nigerians on the efficacy of the scheme in addressing the health problems of workers in the country (Onwumi and Omorogbe, 2013). In 2008, Human Development report ranked the country 158 out of 177. In 2005 only 48 and 35 percent of children within the ages of zero to 1 year old were fully immunized against tuberculosis and measles respectively (HDI 2008). Between 1998 and 2005, 28 percent of the children within the ages of 5 years who suffer diarrhea received adequate treatment. Between 1997 and 2005 only 35 percent of births in Nigeria were attended by skilled health personnel. Again, between 2000 and 2004, only 28 percent of Nigerian in every 100,000 persons had access to physicians (UNICEF 2006, World Bank 2007; UNDP, 2008 in (Agba, 2010). Nigeria continually loses her professionals to other countries. UNDP report in 1996 revealed that 21,000 medical personnel's who are Nigerians were practicing in United States of America and UK, while there was gross shortage of these personnel in Nigerian health sector.

The health situation in the country shows that Human Immunodeficiency Virus (HIV) prevalence in Nigeria within the ages 15- 49 years was 3.9 percent in 2005 (UNAIDS, 2006). In attempt to address the precarious and dismal situation in the health sector, and to provide universal access to quality health care service in the country, various health policies by successive administrations were made including the establishment of primary Health Care centers, general and tertiary hospitals etc. The perennial health problem informed the decision of Gen. Abdulsalami Abubakar to sign into law on May 10, 1999, the National Health Insurance Scheme (NHIS) decree No. 33 with the aim of providing universal access to quality health care to all Nigerian. NHIS became operational after it was officially launched by the federal government in 2005 (Omonokpono, 2008). It is against this background that the researcher thought it wise to access the impact of NHIS among the employees in Nigeria

2. Statement of the Problem

10 years after the commencement of NHIS in Nigeria, opinion is polarized among Nigerians on the efficacy of the scheme in addressing the health problems of workers in the country. In Nigeria, like most African countries, the provision of qualitative, accessible and affordable healthcare still remains a serious problem (WHO, 2007, Oba 2008, Omoruan, Bamidele and Philip, 2009). This is because it seems that the health sector is perennially faced with gross shortage of personnel (WHO, 2007), policy inconsistency (Omoruan et al, 2009) inadequate and out-dated medical equipment, poor funding and corruption (Oba, 2008). Only 4.6 percent of both public and private Gross Domestic (GDP) product was committed to the sector in 2004 (WHO, 2007). Other factors that people assumed to impede quality health care delivery in Nigeria include inability of the consumers to pay for health care services (Sanusi and Awe, 2009) cited in Ogaboh (2010), gender bias, due to religious or cultural beliefs and inequality in the distribution of healthcare facilities between urban and rural areas (Omoruan et al 2009).

Nigeria's health system is ranked 187 of 191 by the World Health Organization (WHO) member states (WHO, 2000), with an infant mortality rate ranging from 500 per 100,000 in the south west geo-political zone to 800 per 100,000 infants in the North east zone; pre-natal mortality rate of 48 per 1000 and child mortality rate of 205 per 1000. (UNICEF, 2006). More recent figures according to partnership for maternal new born and child Health in 2008 show that the north east geo-political zone attained mortality rate of 1700 per 100,000 birth.

In Nigeria, there seems to be a clear lack of universal coverage care and little equity (Onyedibe, Givit and Nnadi 2012). It appears that access to health care is severely limited in Nigeria (Otuyemi, 2001). From people's comments, the inability of the consumers to pay for the services as well as the healthcare provision that is far from being equitable have been identified among other factors to impose the limitation (Sanusi, 2009). There are assumptions that the financing of public health services in Nigeria has been through government subvention funded mainly from the earnings from petroleum exports and user fees for patients. There seems to be a rapid decline in the quality and effectiveness of publicly provided healthcare services (Shaw, 1995). It is assumed that funding of healthcare in Nigeria has not only affected the quality of healthcare services but led to impoverished healthcare standard of the populace. Gana (2010) identified these funding challenges as low level of public (government) spending, high burden of health care costs on individuals and households (70% of all expenditure); thereby ranking Nigeria as a country with second highest level of out-of-pocket spending on health financing in the world.

More worrisome is the comment that the Nigerian System allows private healthcare providers as major stakeholders despite the establishment of the National Health Insurance Scheme (NHIS). It is also commented that the extend of coverage of the National Health Insurance Scheme (NHIS) is such that artisans, farmers, sole proprietors of business,

street vendors, traders and the unemployed are not yet accounted for. Even within the formal sector, not all government and corporate organization employees are enrolled within the scheme. Our public and private hospitals are still operating on fees for service for the majority of its clients (Nnadi, 2012). Besides, many enrollees still complain that long queues are still usual sites while the issue of unavailability of required services is rearing its ugly head in National Health Insurance Scheme (NHIS) approved hospitals. In addition, it is assumed that there is still weak and ineffective referral system resulting in over-burdened secondary and tertiary health facilities. Complaints are rife about drugs insufficiency, and situations where enrollees are made to consume sub-standard products which they would not have ordinarily consumed if they were to pay for full healthcare services they received without any subsidization.

Furthermore, it is observed that education of the teeming populace on the pros and cons and the need to participate in the NHIS is also a challenge yet to be surmounted. In view of the above problems, this study seeks to find out why people who enrolled in the scheme are not getting the adequate services they expect in spite of the huge amount of money pumped in to the scheme. However, to address the above problems, the following questions were posed to guide the study.

- 1) What is the level of health care delivery to the beneficiaries of the National Health Insurance Scheme in the Country?
- 2) What is the level of satisfaction of the beneficiaries from the scheme?
- 3) How does the scheme promote equal access to healthcare facilities in the country?

Objectives of the study

The broad objective of this study is to access the outcome of the performance performance of National Health Insurance Scheme (NHIS) in Nigeria.

The specific objectives are:

- 1) To determine the level of healthcare delivery to the beneficiaries of National Health Insurance Scheme .
- 2) To determined the level of satisfaction derived by the enrollees from the scheme in the hospital
- 3) To assess the extent to which the scheme has promoted access to health care delivery in the country.

Research Hypotheses

The following null hypotheses shall guide this study.

H₀₁: The quality of healthcare delivery to the beneficiaries of National Health Insurance Scheme is low.

H₀₂: The level of satisfaction derived from the operation of National Health Insurance Scheme (NHIS) is very low.

H₀₃: The scheme has not promoted equal access to health care facilities in the country.

3. Theoretical Framework

This research is situated within the ambit of the Relative Deprivation theory. Relative Deprivation theory was propounded by a sociologist, Samuel A Stouffer in 1949. The theory relates to the idea that feelings of deprivation are related to a desired point of reference. Feeling of deprivation

arises when desires become a legitimate expectation and those desires are blocked by society. Social Satisfaction is the opposite of relative deprivation.

The relative deprivation emphasized the lack of resources to sustain diet, lifestyle and amenities that an individual or group are accustomed to or that are widely approved or encouraged in the society to which they belong. Measuring relative deprivation allows an objective comparison between the situation of individual or group compared to the rest of society. It also emphasized individual experience or discontent when being deprived of something to which one believes one is entitled to. However, emphasizing the perspective of the individual makes objective measurement problematic.

The theory is used in social science to describe the feelings or measures of economic, political or social deprivation that are relative. It is extricably linked to social exclusion. It has important consequences for both behavior or attitudes, including feelings of stress, political attitude and participation in social action.

The Assumption of the deprivation theory is that people who are deprived of things deemed valuable in society, whether money, justice, status or privileges join social movement with the hope of redressing grievances. Improved conditions fuels human desires for even better conditions, and thus sparks revolution. It is important to look at relative deprivation based on the evaluation of what they think they should have compare to what they actually have. Relative deprivation is what people think they should have relative to what is given to them, or even compared with their own past and perceived future. Feeling of deprivation is relative as they come from a comparison of social norms that are not absolute but differ from time to time. It may be temporal, i.e., it can be experienced by people that experience expansion of right or wealth, followed by stagnation or reversal of those gains. Such conditions are also known as unfulfilled rising expectation. For instance, in political realm, the lack of the right to vote is more likely to be felt by people who had it once than by the people who never had the opportunity to vote.

The relevance of Relative deprivation theory to this study is predicated on the fact that National Health Insurance Scheme is a social policy geared toward reducing out of pocket expenditure for healthcare services and encourage a mechanism whereby the policy holders called the insured or the enrollees contributes into a common pool out of which the unfortunate is made fortunate at the occurrence of health deterioration. Disappointedly, the operators of the scheme, who are supposed to work in the public interest, putting into practice the policies and programmes of government as efficiently and effectively as possible, now act as self utility maximizers, motivated by such factors as salary, prerequisite of the office, public reputation, power patronage and the ease of managing the bureau enjoys the outcome of such policies to the detriment of the target group. These create a sense of discontentment on the part of the participants who were supposed to benefit from such policies.

Again, the realization that politician and managers of the scheme are driven by self interest is an extremely serious conclusion. The question that immediately comes to mind is "How far will they go"?. The answer to that is profound and extremely disturbing, for history shows that the wish to advance their own interest subjected thousands of citizens who are supposed to be the beneficiaries to abuse, torture, starvation, confinement and even death. From the above analysis, relative deprivation theory is relevant to the study.

4. Conceptual Clarification

The concept of health services

Yousuf, (2011) defined health services as a range of health benefits received by the beneficiary for a certain payment and with the use of certain goods. The service was defined as an activity provided by one party to another and it is considered a concrete basis not resulting in any property; Also, its production or submission may be linked to a tangible physical product (Al-Dmuur, (2008). The service also includes concrete benefits provided by the institution to its customers by a certain price (Al-Tarawneh, 2011).

Accordingly, the health service provided at the hospital does not depart from the content of this definition, whose core is intangible; however, it is possible to use different equipment to provide the service to the patient whose treatment might take either a short or a long time.

Health service is defined by many specialists as being the products offered by hospitals, clinics, health centers, clinics, and other agencies related to maintaining the physical and mental health of humans (Al_mussa9id, 2010). The quality of service is considered the most important area in the health services sector, which aims to improve the quality of health services that will benefit the health of beneficiaries as well as build confidence between the health sector and the beneficiaries and insure the rights and satisfaction of users of the health service; furthermore, commitment to the security standards and the security of beneficiaries is one of the most important criteria that focus on the adoption of the program of the quality of the health services. This care has been formed in the quality of the health service by specifying the dimensions of the quality of the health service which are considered the indicators to measure the quality of the health service.

5. Concept of Health Insurance

According to the (WHO 2000), health is a state of complete physical, mental and social well being and not just the absence of disease or infirmity. Resources pooling mechanism or pooling of resources refers to the accumulation of health assets on behalf of a population (O'brien, 2003). By pooling of resources, the financial and health risks are spread and distributed among the population. By pooling, the financial resources are no longer tied to a particular contributor. The essence of health insurance therefore is the pooling of funds and spreading the risk for illness and financing (O'brien, 2003). Health insurance as a means of promoting universal health coverage has attracted considerable interest in the past. Yet the multi-dimensional nature of health insurance makes more studies on health

insurance knowledge/awareness, perception, coverage, access and impact necessary (Collins Davis, Doty, 2009). Health insurance is a social security arrangement that guarantees the provision of the needed health care services to a person on the contribution of a token to provide financial protection to the participants. Health insurance is a mechanism for protecting families against the unexpected high cost of illness by sharing risks of future cost among healthy and sick populations in the form of regular predictable payments. In terms of benefits, health insurance was discovered to have two sides to its coin. Empirical studies suggested that workers in jobs with health insurance coverage had higher productivity and lower job turnover than workers without health insurance benefits (O'Brien (2003) Collins, Davis, Doty, Kriss and Holmgren, 2006). On the other hand, (Collins, White and Kriss, 2007) suggest that offering health insurance has very little or no effect on job turnover. However, it is generally believed that people without health insurance are more likely to be in worse health condition and have higher death rates than are people with insurance coverage because they are less likely to seek medical care.

Agba, (2010) defined health insurance as a contract between an insurance provider (e.g. an insurance company or a government) and an individual or his sponsor (e.g. an employer or a community organization). The contract can be renewable (e.g. annually, monthly) or lifelong in the case of private sector insurance, or be even mandatory for all citizens in the case of national health plans. It involves resource mobilization (generation and collection), pooling and allocation and purchasing. A health insurance scheme should provide quality, equitable, accessible, affordable and efficient care; it should assure a significant reduction in out of pocket expenditure and it should provide universal coverage. It should also provide a comprehensive good quality and cost effective health services to entitled and insured persons and their dependents in the formal sector, self employed, rural communities, poor and vulnerable groups the benefit prescribed (Agba, 2010).

According to the World Health Organization (WHO) in 2005, Nigeria was ranked 197th out of 2000 nations; life expectancy was put at 48 years for male and 50 years for female while healthy life expectancy (HALE) for both sexes was put at 42 years. Nigeria accounts for 10% of global maternal mortality with 59,000 women dying annually from pregnancy and child birth; only 39% are delivered by skilled health professionals. In order to provide equitable distribution of health, the NHIS was introduced in Nigeria. The need for the establishment of the scheme was informed by the general poor state of the nation's healthcare services, excessive dependence and pressure on the government's provision of health facilities, dwindling funding of health care in the face of rising cost, poor integration of private health facilities in the nation's healthcare delivery system and overwhelming dependence on out-of-pocket expenses to purchase health. Like any other insurance scheme, the premium for the NHIS is the amount charged by the insurance compared with the promise to pay for any eventual "covered medical treatment" for the designated "coverage". Consequently health insurance makes it possible to substitute a small but certain cost for a larger but

uncertain loss (chain) under an arrangement in which the healthy majority compensate for the risks and costs of the unfortunate ill minority. The NHIS currently represents 15% of one's basic salary. The employer is to pay 10% while the employee contributes 5% of his/her basic salary to enjoy healthcare benefits. The contribution made by the insured person entitles his/her spouse and four children under the age of 18 to full health benefits (FMH, 2005).

NHIS was designed to provide minimum economic security for workers with regard to enrollees' losses resulting from accidental injury, sickness, old age, unemployment and premature death of family wage earner. NHIS is made compulsory because the government based on past experiences predicted that some citizens cannot engage in the scheme and the government also has the duty to protect the general welfare of all citizens (Ibiwoye and Adedeke, 2007). It is also the government's belief that NHIS will help to break the vicious cycle of poverty in the country. It is also a form of social support for workers (Jutting, 2003).

National health insurance scheme is a form of formal sector social insurance programme (Onyedibe, Goyit and Nnadi, 2012). It is a social health security system in which the health care of an employee is paid for by both the employer and the employee. This is achieved by monthly deduction of 5% of basic salary from an employee and another 10% of basic salary paid by the employee's employer which is then pooled together and used for all enrollees. In social health insurance, there is Gross subsidization where the healthy subsidize for the ill, the young subsidize for the old and the higher income group subsidizes for the lower income group (Onyedibe et al, 2012). Therefore, social health insurance is a social security system that guarantees the provision of a benefit package of health care services paid from funds created by pooling the contributions of participants (Agba, 2010).

Obansa and Orimisan (2013) asserted that National Health Insurance Scheme (NHIS) is a cooperate body established under the act 35 of 1999 by the federal government of Nigerian to improve the health of all Nigerian at an affordable cost. At present the program covers only federal government employees. The contribution made by/for an insured person entitles him or herself, a spouse and four children under the age of 18 years to full health benefit. There are health maintenance organization that ensures that the affiliated providers provide health care services to the contributor who registers with or directly as the case may be. Health care providers under this programme are either paid by capitation or fee for services (Obansa et al, 2013).

Act 35 of 1999, National Health Insurance Scheme is a body corporate with perpetual succession established to provide social health insurance (HI) in Nigeria whereby the health care services of the contributors are paid for from the pool of fund contributed by participant in the scheme.

Aderoumu (2010) defines National health Insurance Scheme as a social health insurance programme (SHIP) which combines the principles of socialism (being one's brother's keeper) with that of insurance (pooling of risk and resources). The National Health Insurance Scheme in

Nigeria aimed to provide health insurance so that insured person and their dependents are able to have access to good quality and cost effective health care services (NHIS operation guideline, 2005).

As part of the effort to strengthen the NHIS in Nigeria, a national health policy (NHP) was adopted in 2006. It seeks to establish a realistic health financing system that has the capacity of meeting health system goal of improved health status of Nigerians, financial protection of citizens against cost of illness, fair financing of health services, and responsiveness to citizen expectations.

Benefits of NHIS

NHIS in Nigeria is modeled after the practice of health insurance in the United States of America and Britain (Ikechukwu and Chiejina, 2010 cited in Adindu 2010). The general objective of NHIS in Nigeria is to ensure the provision of health insurance “which shall entitle insured persons and their dependants to the benefits of prescribed good quality and cost effective services”(NHIS Decree No. 35 of 1999) While the specific objective of the scheme include:

- To ensure universal provision of health care in Nigeria.
- To control/reduce the arbitrary increase in the cost of health care services in Nigeria.
- To protect families from high cost of medical bills.
- To ensure equality in the distribution of health care service cost across income groups.
- To ensure high sector participation in healthcare delivery to beneficiaries of the scheme.
- To boost private equitable sector participation in health care delivery in Nigeria.
- To ensure adequate and equitable distribution of healthcare facilities within the country.
- To ensure that, primary, secondary and tertiary health care providers are equitably patronized in the federation.
- To maintain and ensure adequate flow of funds for the smooth running of the scheme and the health sector in general (NHIS Decree No 35 of 1999, part II: 5 NHIS, 2009).

The decree also state that the healthcare providers under the scheme shall provide the following benefits for the contributors and that the contributors to the scheme are expected to enjoy the following benefits under the scheme; Outpatient care, including necessary consumables; Prescribed drugs, pharmaceutical care and diagnostic tests as contained in the national essential drug list and diagnostic test lists; Maternity care for up to four live births for every insured contributor/couple in the formal sector program; Preventive care, including immunization, as it applied in the national program in Immunization, Health Education, Family planning, antenatal and postnatal care; Consultation with specialist, such as physicians, paediatricians, obstetricians, gynaecologists, general surgeons, orthopaedic surgeons, ENT Surgeons, dental surgeon radiologist, psychiatrist, ophthalmologists, physiotherapist etc; Hospital care in a standard ward for a stay limited to cumulative 15days per year. Thereafter the beneficiary and/or the employer pay. However the primary provider shall pay per

diem for bed space for a total 15 days cumulative per year; Optical examination and care, excluding the provision of spectacles and contact lenses; A range of prostheses (limited to artificial limbs produced in Nigeria) and Preventive dental care and pain relief (including consultation, dental health education, amalgam filing, and simple extraction) (Obadofin, 2006). Beneficiaries do not need cash to access treatment when required except the 10% co-payment for the cost of drugs. Thus, the usual practice of converting assets to cash especially in catastrophic illnesses can be avoided. In fact, the Ministry of Health asserts that the benefit package in the NHIS is the most comprehensive in the world.

6. Challenges of Service Delivery

In 2005, the NHIS published guidelines for standard treatment of patients by healthcare providers. This was as a result of the concerns the management of the scheme had on the effects of unwarranted overuse of the system and on the solvency and sustainability of the scheme. Overuse would arise from improper provider behaviours through over prescribing, over treatment, NHIS undue generation of patients' visitation and unnecessary use in technology in order to attract more income. Under these guidelines, monitoring and evaluation is carried out jointly by the NHIS and the HMO's (NHIS, 2005). Despite the published protocol, most of these practices are common place in our health institutions. In addition, long queues are still usual sites while the issue of unavailability of required services has started rearing its ugly head in NHIS approved hospitals (Onyedibe et al. 2009). In addition, there is still weak and ineffective referral systems' resulting in over burdened secondary and tertiary health facilities. Furthermore, education of the teaming populace on the pros and cons and the need to participate in the NHIS is also an insurmountable challenge. Moreover, Onyedibe, 2009) observed that available financing risk protection under the NHIS is very limited in coverage and scope. Several very important and hitherto expensive healthcare services are excluded from the scheme, while common ailments that can be treated easily and very affordable are financed by the scheme.

Africa's health care crisis has received renewed attention because of the greater awareness of the militating factors and a greater understanding of the link between health and economic development (Lowel et al, 2010).The major factors that affect the overall contribution of the health system to economic growth and development in Nigeria include inter alia; lack of consumer awareness and participation, inadequate laboratory facilities, lack of basic infrastructure and equipment, poor human resource management, poor remuneration and motivation, lack of fair and sustainable health care financing, Unequal and unjust economic and political relations between Nigeria and advanced countries, the neo-liberal economic policies of the Nigerian State, Pervasive Corruption, Very low government spending on health, High out-of-pocket expenditure on health, Absence of integrated system for disease prevention, surveillance and treatment (Obansa and Orimisan, 2013)

1) **Lack of consumer awareness and participation:** The majority of consumers are ignorant or unaware of available services and their rights regarding health service delivery mainly because of the absence of a bill

of rights for consumers (claim holders) and providers (duty bearers). The role of the family in preventing and managing illness is also underestimated or inadequately supported by government programmes. It is now well known that interventions should be implemented through the health system as well as at the household level. The capacity of families and communities should be developed to increase awareness for meaningful participation in their health care and that of their children.

- 2) **Inadequate laboratory facilities:** In many states of Nigeria, most of the laboratories in the primary and secondary health care centers require some infrastructural upgrading to provide a safe, secure and appropriate working environment. Some basic health centre laboratories are better equipped than those in comprehensive health centers and some secondary level hospitals, but equipment was often minimal. Most laboratory staff in secondary facilities were qualified as medical laboratory scientist or technicians, whereas most of those in primary health care facilities were qualified as science laboratory technicians. There is minimal quality control of laboratory test in secondary facilities and none in primary facilities because they lack appropriate professional supervision.
- 3) **Lack of basic infrastructure and equipment:** Basic life-saving commodities are in short supply in most low income health systems. This is, in part, a result of resource shortages, but, there are still problems even when substantial increase in funding are available, as in the case of Global Fund to fight AIDS, Tuberculosis and Malaria. Building effective and accountable national procurement and drug management systems is an increasing prominent component of the health system action agenda. The provision of health services relies on the availability of regular supplies of drugs and equipment, as well as appropriate infrastructure at the facility level. Facilities without safe water and electricity, with non-functioning equipments, and inadequate deliveries of drugs, diagnostic and other supplies are all too common in many states of the country. The Nigerian health system is characterized by inadequate and poorly maintained health facilities, particularly at the PHC level. Poor state of infrastructure such as buildings, equipments, materials, and supplies and inequitable distribution of available facilities is the norm in many places. In some communities, people have to travel over 5 km to access health care because sitting of structures is often based on political expediency rather than perceived need. The drug system is plagued with 'out-of-stock syndrome'. Fake, substandard, adulterated, and unaffordable drugs are prevalent across the country. Erratic supplies, non-availability of some basis essential and specialized drugs and other health supplies as a result of dependence on imported drugs are common. In addition to this, the drug distribution system is chaotic because of adherence to pharmaceutical regulations that need to be updated. Although very vital to provision of quality service, provision of drugs and vaccines alone cannot build systems nor ensure quality of care, but without the appropriate facilities and materials to do their job, health workers cannot function. Therefore, whenever

health systems cannot deliver, people turn elsewhere. This has contributed greatly to poor client satisfaction, which makes clients to turn to private sector and unqualified health workers. This poor drug supply system has also led to drug resistance, the resistance to anti-malaria drugs by the disease pathogens is clear example, (HERFON, 2006, Fmo H., 2004, Travis et al, 2004).

- 4) **Poor human resources and management:** Although human resources are no panacea for the poor health situation in any country, no health intervention can be successful without an effective workforce. Every country should, therefore, have a national workforce plan to build sustainable health systems to address national health needs. These plans should aim to provide access to every family to a motivated, skilled, and supported health worker. To optimize health system performance, workers should be recruited from, accountable to, and supported for work in their community where feasible. The 2003 and 2004 World Health Reports proposed improving rewards to health workers to improve productivity, along with deploying community health workers and engaging community in their health care. The 2004 report advocated using such approaches as contracting local government financing, empowering community, using vouchers, etc., to subsidize key health services for the poor. There is currently inadequate and inequitable distribution of health personnel at various levels in Nigeria, especially in the rural and hard-to-reach areas. The provider-client relationship is also poor, while poor incentives and compensation for health workers and structures are already worsening the brain drain syndrome and refusal of health workers to accept posting to rural areas.
- 5) **Poor remuneration and motivation:** Over the years, poor remuneration of health workers have had an adverse effect on their morale such that over 21,000 Nigerian doctors are practicing abroad, while there is an acute shortage of physicians in Nigeria. Health workers are paid salaries (about 75% lower than that of a doctor even in Eastern Europe) and they work in insecure areas and have heavy workloads, but lack the most basic resources, and have little chances of career advancement. Doctors complain of 'brain waste' and seek better opportunities for professional development in countries with better medical infrastructure. Nigeria is one of the several major health-staff-exporting countries in Africa. For example, 432 nurses legally migrated to work in Britain between April 2001 and March 2002, out of a total of about 2000 legally emigrating African nurses, a trend perceived by Nigeria's government as a threat to sustainable health care delivery (Lambo,2006).
- 6) **Lack of fair and sustainable health care financing:** Beyond the level of spending, the key questions concern how the health system is financed and what proportion of contributions comes from users themselves, either through out-of-pocket expenditure or through insurance payments. The WHO is promoting the principle that whatever system of financing a country adopts should not deter people from seeking and using services. In most cases, this will mean that payment at the point of service will need to be eliminated, or at least be related

to ability to pay. The financing system should also, as a minimum, protect people from catastrophic expenditure when they become ill, promote treatment according to need, and encourage providers to offer an effective mix of curative and preventive services.

- 7) **Pervasive Corruption:** Corruption has often manifested in Nigeria's health sector through the supply of fake drugs, substandard equipments, misdiagnosis of diseases, sharing of unallocated budget funds, inflation of contracts, diversion of drugs, treatment and appointments based on political patronage. Some examples abound: a consignment of vitamin A supplement by the Canadian government through its bilateral assistance to Nigeria was diverted in 2008 and it is now found in most itinerant chemist shops across the country (UNICEF, 2007). A former minister of health, Adenike Grange was sacked in 2008 for her complacency in the sharing of N300 million unallocated health sector fund. Corruption deprives the economy in general and the health sector in particular of vitally needed funds (Thisday, 2008). It has been estimated that Nigeria lost £225 billion to corruption over the period. Nigeria's Debt Management Office (DMO) has also indicated that the country wasted US\$300 billion during the period (World Bank, 2006, DMO, 2006). Given the pervasiveness of corruption in Nigeria's national life and its acknowledged consequences for development and good governance, the consequences of corruption for public and private health is a matter of major interest to health professionals and social scientists. Some observers of the pervasiveness of corruption in African countries have suggested that it should be treated as a disease that afflicts the African condition. While this has been rightly criticized for its racist undertones of the observation, there is, no doubt, that corruption is symptomatic of the level of anomie that characterizes a society which can be treated as a major problem of health sector growth and development.
- 8) **Very low governments spending on health:** According to Central Bank of Nigeria reports, federal government health spending increased from the equivalent of US\$141 million in 1998 to the equivalent of US\$228 million in 2003. Health spending as a proportion of total federal spending decline between 1998 and 2000, but increased in subsequent years, reaching 3.2% in 2003. Most federal health spending goes to teaching and specialized hospitals and federal medical centres. State spending on health is currently around 6.3% of total spending, estimated for 2003 at about US\$420 million or US\$3.50 per capita (Obansa, 2013). Like federal spending, state health spending is concentrated on the main area of state responsibility, secondary hospitals, and is also most likely on personnel. For 2003, the data available showed that spending on health was equivalent to US\$300 million or US\$2.45 per capita. Like other levels of government, most health spending by local governments is on personnel (World Bank CRS, Nigeria, 2005).
- 9) **High out-of-pocket expenditure on health:** This has further exacerbated the pauperization of the adverse economic condition of the poor. The 2004 Nigeria Living Standard Survey (NLSS) collected data on household health expenditures from a representative

sample of 19,159 households. The estimate from these data of average annual per capita out-of-pocket spending on health is Naira 2,999, equivalent to around US\$22.50. The survey data indicate that this out-of-pocket spending on health services accounts for 8.7% of total household expenditures. This health spending includes expenditure on outpatient care, transportation to health care facilities and medication. This is one of the largest shares of health expenditure out of total household expenditure in developing countries. Over the years, government resources dedicated to health are extremely low in Nigeria. According to World Health Organization (WHO; 2004), private health spending represents the largest proportion of total health expenditures in Nigeria. In 2004, private out-of-pocket health expenditure was equal to nearly 70% of total health expenditure in Nigeria. Prepaid plan represent around 5% of total health spending. Government health expenditures represent 30.4% of total health expenditure for the period.

- 10) **Absence of integrated system for disease prevention, surveillance and treatment:** This has manifested in the lack of targeted efforts at outreach, health promotion and disease prevention activities designed to reach the people where they are. This has resulted in low immunization coverage, pre-natal care and screening. Public health, where it exists, is in a passive mode, with little activity designed to motivate people to change their enrollees or to adopt attitudes and practices that reduce their risk to disease. The result is that many children are still not immunized, pregnant mothers do not receive the pre-natal care they need, older men and women do not have the regular screening they need for blood sugar and cholesterol, for breast and cervical cancer. When health professionals refer to low incidence rate for cancer in Africa, they forget that what is not screened for is not reported. Given the extremely low screening rates for cancer, diabetes, hypertension and other chronic and communicable diseases, no wonder the reported incidence and prevalence rate are low too.

7. Problems Associated with Implementation of Social Health Insurance (SHI) in Nigeria

Obansa and Oramisan established that the Implementation of SHI in Nigeria may face the following problems:

- The large informal sector and the diversity in economic status make it difficult for SHI in Nigeria to determine premium equitably.
- Determination of groups to be included in the exemption schemes and how to implement the exemption packages without encouraging free riders might be difficult without compromising access to health care.
- HMOs may be reluctant to operate in the rural areas where premium may be difficult but will prefer the urban areas where they will not only enjoy ease of premium collection but a boom in enrolment due to population density. This may hinder access to the rural areas.
- It may also be difficult to determine method of compensation of physicians according to their various

classifications and disbursement of the compensation without giving rise to moral hazard and fraud.

- Difficulty in determining line of services to cover by the scheme will be a cause of constant threat.
- SHI implementation may have problems in setting up regulatory mechanisms and enforcing them to be able to check quality and reduce problems of moral hazards, adverse selection and free-rider effect.
- Sustainability may become a problem if revenue generation through premium is not adequate to pay for expenditure.
- Efficient allocation of resources to cover health needs of members may be difficult to attain.
- The organizational structure of the Nigerian SHI may make decision making too bureaucratic if measures are not taken to enhance representation to the local level.

8. Conclusion

The major problem of the Nigerian healthcare system has been the unplanned consequences of social policy. There has been little effort on the part of Nigerian government to control and improve health sector in term of the distribution of healthcare services, quality of healthcare services by various categories of healthcare providers and the cost of care. The promotion of health sector reform is highly appreciated as a measure to revitalizing and improving the nation healthcare system. A movement of the health insurance to the rural areas which constitute the majority of the population should be given utmost priority by the government; as it will enable the rural poor, the unemployed and the less privileged to enjoy basic health insurance services as those in the federal government employ. It also discovered from the study that the unemployed are not covered in the scheme. This is in line with Gana (2010) who observed that only the public sector is covered by the scheme. This observation limits the scope and coverage of the scheme in the country. Again, the level of healthcare demand has not been significantly increased by the cost reduction which the scheme claims to make. From the literature, it was discovered that the services and drug provided by the NHIS should not be substandard but drug that are of high value in order to prevent moral hazard.

NHIS was established to tackle the various challenges facing the health sector in Nigeria, such as shortage of manpower, poor implementation of good programme, poor funding and lack of political will (Kumar, 2001) cited in Onotai et al ,2012). It was established to move the country toward achieving universal coverage of healthcare services in the country. It is observed that the unemployed citizens do not have access to healthcare services through the scheme which further widened the gap of health inequalities in the country. More so, the principal funding is from the government which is already associated with poor political drive and commitment. This means that the quality of healthcare services and people's level of satisfaction in some part of the country may continue to be low, if government do not embarked on drastic health reformation exercise that would extend the services of NHIS to the states and local government owned institutions, establishment as well as the informal sectors. Concentrating the scheme only in the

formal sector is still rudimentary as it is yet to achieve the aim of its establishment.

9. Recommendations

Based on the conclusion, the following recommendations are made

- 1) To promote access to healthcare, National Health Insurance Scheme should be re-designed to include the poor, and the vulnerable group. It should include the unemployed, the elderly and the disabled. This will reduce out-of-pocket for healthcare services and promote equal access to quality healthcare services in the country.
- 2) Government should increase health infrastructure in the rural areas and provide incentives for health practitioners / professionals practicing in the rural areas. This will extend the services of National Health Insurance Scheme to the rural populace that needed the service more.
- 3) A flexible premium collection mechanism should be introduced for the informal sector scheme, e.g collecting premium from farmers during harvest. There should be co-payment system in specialist care. An efficient financial system should be put in place which is able to invest resources in long term capital goals so that services could become self funded in the future.
- 4) Capitation method should be used to compensate physicians. This should be combined by a pre-determined billing system. While preserving solidarity, competition should be encouraged among Health Maintenance Organizations (HMO) and encourage more than one HMO to operate in the same locality and patients should have choice of providers.
- 5) Adequate referral system should be enforced in the scheme by making sure that visits to specialist care must be on referral from the general practitioners, except on emergencies
- 6) To strengthen quality care services, accreditation should be introduced and strictly adhered to before registered care givers and providers. Certification of healthcare personnel employed by contracted providers should be regularly conducted with appropriate registration board like the Nigerian Medical Association (NMA), Council for Doctors or other regulating agencies like NAFDAC, SON etc to ensure that fake and substandard drugs and other products are not used in NHIS approved health facilities.
- 7) There should be regulation of abuse. To do this, identity card should be carried by patients to the health facilities and there should be proper identification of patient with photo, address and categories of insurance.
- 8) Since funds are drawn for the purpose of reducing Out-Of-Pocket expenditure of participants, the scheme should be overhaul in order to identify and curtail funds diversion in order to increase the basic provision of healthcare goods and services
- 9) An effective Consumer Protection Authority or body should be established, not just for NHIS consumers but for all healthcare consumers in the country. This will make healthcare providers know that they are actually dealing with irreplaceable lives. Legal practitioners and health economist should be an integral part of this body.

- 10) Ways of checkmating the chances of moral hazard should be developed. This is a situation where a consumer consume goods and services which they will not ordinary consume if they were to pay the full cost for these goods and services. These checks should be done in such a way that the consumers are not out rightly denied what is legitimately theirs under the auspices of preventing unnecessary demand.
- 11) Effort should be made at capturing the informal sector, which constitutes the larger chunk of Nigerian poor, the real target of the scheme.
- 12) If the scheme is effective, satisfactory and attractive, it will automatically attracts its customers and keep them. Therefore, organizations should not make it compulsory to their staff members, those that do not feel satisfied could easily work away or have a protection agency to complain to. It will make NHIS sit up to it responsibility.

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