

Chapter One

Introduction

1.1 Background to the Study

NHIS is a form of public enterprise, precisely a public corporation. The implementation of government policies through the setting up of public corporation is one of the ways governments renders direct and indirect service to the public¹. It is direct when government employees provide varied services to the public such as electricity, mortgage insurance, and mail delivery. It is indirect when government pays private contractors to provide goods and services to its citizens.

The Taraba State House of Assembly recently (December 2019) passed a bill for the establishment of (SHIS) State Health Insurance Scheme to cater for its teeming civil servants.

The public hearing of the bill generated a lot of issues, most especially about the Headship of the Scheme. The scheme needs a seasoned public administrator, for its effective take-off but there are already signs of political interference on who heads the scheme and composition of the board. This, in the long run will be counterproductive and lead to low efficiency/productivity.

Health issues are given primary consideration because they are central to life and living.

The conventional concept of insurance as a means of indemnity against a future occurrence of an uncertain event is relevant in the discourse of healthcare because it is a buffer for the section of the population that may have constant access to healthcare due to their socio-economic factors.

Healthy population and indeed work force are indispensable tools for rapid socio-economic and sustainable development². A nation that seeks to thrive needs to pay close attention to the wellbeing of its population and considers ways to resolve critical issues that could distract them from focusing on wealth generation via service provision. In all the G7 nations, healthcare is a large consumer of society's resources and seen in the huge budgetary provisions for healthcare³. The sustainable development goals 4, 5 and 6 focuses on reduction of child mortality rate, improvement of maternal health and combating HIV/AIDS, malaria and other diseases respectively. This indicates that health issues are among the key targets of improving social and economic conditions of world's poorest countries.

Poverty is keeping more and more people in poor health in Nigeria, just as poor health of an increasing number of Nigerians is retaining them in poverty. The nation is at a point where it needs to improve the health of its citizens, not only to break the vicious circle of ill-health, poverty and a low level of development, but to convert it to a virtuous circle of improved health status, improved well-being and sustainable development⁴.

Poverty indeed accounts for lack of access to medical care by less privileged population in Nigeria. Access to healthcare at an affordable cost constitutes a high profile challenge in Nigeria². In a situation where many are struggling to feed, the additional challenge of paying for cost of medical care is real. Although the economic condition of a nation directly affects factors as access to health care by its citizens, it should not be seen as a pre-requisite to meeting the needs of the people. In other words, pursuit of better health should not await improved economy; instead proactive actions taken on health will

inversely contribute to the economic growth⁵. Any country that intends to rise to the challenge of providing adequate health care for its citizens must select method(s) that are feasible and particularly suit its needs.

Reaching its population with adequate healthcare opportunities has been demonstrated by Nigeria via its health policies. At the centre of such effort is the desire to allow access to healthcare by every Nigerian irrespective of social status or other related reasons. Every government in Nigeria believes that a healthy population is essential for such, thus justifying its priority allocation in the national budget⁶. The National Health Insurance Scheme (NHIS) was established by the federal government of Nigeria so as to give average access to healthcare delivery in Nigeria. The conception of the idea of the scheme in Nigeria is traced to 1962 when the need for health for Nigerians arose⁷. Early as this was recognized, the scheme only gained full approval of the Federal Government in 1997, signed into law in 1999 and officially launched on 6th June, 2005 after the (2004) Act⁸.

Health insurance schemes are increasingly recognised as a tool to finance health care provision in developing countries and have the potential to increase utilisation and better protect people against (catastrophic) health expenses and address issues of equity⁹. Insurance schemes are often social plans that are hinged on arrangements with companies who agree to pay the costs in case of ill health. Health financing systems through general taxation or through the development of social health insurance are generally recognised to be powerful methods to achieve universal coverage with adequate financial protection for all against healthcare costs⁶. Health insurance is a way of paying for some or all of the costs of healthcare¹⁰. It protects insured persons from

footing high medical bills in the event of sickness. Most developed nations and many developing nations adopt health insurance as means of ensuring equitable access to affordable and quality health services by their citizens. The core roles of NHIS in health financing include mobilising revenue and pooling of resources for healthcare for effective sharing of health risk among enrollees¹¹. A common model uses the principle of collective risk taking in which case many contribute premiums over time to cover the cost for anyone who requires healthcare financing at a given time.

Health insurance involves the application of insurance principles to cover the cost of defined medical benefit packages. It involves risk sharing between those who will need the benefits and those who will not. It also involves spreading the burden of cost of healthcare services to the insured over time so that the insured can access services at any time without paying⁸.

This thus indicates a plan for the unforeseen eventuality through payment of premiums to a common pool. The scheme targets providing easy access to healthcare for all Nigerians at an affordable cost through various prepayment plans. Employees in public or private sector organisations employing ten (10) or more persons are required by law to participate in the scheme. The stakeholders of NHIS are individuals, groups, organisations, agencies and government who are directly or indirectly health care providers or consumers depending on their levels. Persons registered under the scheme contribute a certain percentage of his/her salary at a ratio of 10 and 5 employer employee respectively. The scheme operates through the Health Maintenance Organizations (HMOs), Health Care providers who in turn may either be a Primary Health Care Provider or a Fee for Service Health Care Provider¹².

The National Health Insurance Scheme Decree No. 35 outlines the objectives and functions of the scheme thus:

- i. Ensure that every Nigerian has access to good healthcare services;
- ii. Protect families from the financial hardship of huge medical bills;
- iii. Limit the rise in the cost of health care services;
- iv. Ensure equitable distribution of healthcare costs among different income groups;
- v. Maintain high standard of healthcare delivery services within the scheme;
- vi. Improve and harness private sector participation in the provision of healthcare services;
- vii. Ensure adequate distribution of health facilities within the Federation;
- viii. Ensure equitable patronage of all levels of healthcare; and
- ix. Ensure the availability of funds to the health sector for improved services¹.

The objective of the scheme thus reflects a direct desire to meet the healthcare needs of Nigerians, conscious of the fact that there is an existing imbalance in access to healthcare in terms of facilities, social status and economic strength.

The wealth of a nation is directly a product of the health status of its population. Economic development of individuals, families and the entire society is feasible only when persons are healthy. Healthcare delivery is an area of global concern primarily

because it is human-related. No wonder governments and organisations in the world over have invested and are still investing large resources into the provision of the necessities that will cater for the health needs of their population. Developing countries particularly are struggling with healthcare issues as a result of various factors and this has raised global concern¹³.

Many nations have populations that are immersed in acute lack of access to healthcare in terms of medicines, facilities and medical staff. In cases where such needs seem to be met in urban areas, those in rural areas still suffer deprivation in healthcare. The poverty level is high and is a major limiting factor. Public health in many parts of the world, especially developing countries, is a major issue of concern as over 14 million people are killed by infectious diseases each year and Africa is worst hit¹⁴.

These statistics indicates the prevalence of diseases in developing countries like Nigeria and in view of the necessity to create a level ground for all in terms of access to healthcare, a functional NHIS for all categories of Nigerians is necessary. As a panacea to combating extreme poverty, NHIS is highly necessary to reduce financial burden of illness¹². On the strides so far, within six years of the official flag off, the NHIS has given cover to 95% of federal government employees. Also, over 1.6 million pregnant women and children under age five were covered under the NHIS/MDG Maternal and Child Health (MCH) project in twelve states of the federation. While additional twelve states are currently being processed for the same project¹⁵.

In order to ensure uniform access to health insurance, citizens not in the employment of federal government needed to be co-opted into the scheme. This informed the expansion

of the scheme to involve Community Health Insurance and the Tertiary institutions health insurance scheme¹⁶. Community Based Health Insurance (CBHI) is a non-profit Social Health Insurance Programme for a cohesive group of households/individuals or occupation-based groups, formed on the basis of the ethics of mutual aid and the collective pooling of risks, in which members take part in its management¹⁷. This extension of coverage for all categories of Nigerians indicates determination on the part of the government¹⁵.

The Tertiary Students Social Health Insurance Programme has further resulted in providing financial protection and health care to more than two hundred and fifty thousand students in tertiary institutions in the country. The various private health plans for the organised private sector have been providing cover for those in the sector with their respective families. Other programmes at the verge of being rolled out include cover for National Youth Service Corps (NYSC) members, prison inmates and retiree.

The NHIS had, within its initial years, introduced direct Community Health Insurance in the six geopolitical zones in the country. The CBHI is intended for people living in rural areas who cannot get an employer-sponsored insurance¹⁸. The Voluntary Contributor of Social Health Insurance Programme is designed for those who are in informal employment (or firms with less than 10 staff) and who can afford to pay the required contribution of fifteen thousand naira per annum. This will give the contributor a health cover similar to the formal sector benefit package.

The Scheme is also working assiduously to address the vulnerable groups in society. These are those who do not have the formal financial ability to contribute to any pre-

payment plans. The creation of a vulnerable group fund will certainly be the solution to provision of cover to this group. The fund could be financed either directly by the three tiers of government through the proposed health bill¹⁸.

This is a pointer to the desire to create a practicable health financing system in Nigeria². Despite this, the fact remains that the plan is inundated by so many challenges¹⁹. Some of these are limited institutional capacity, corruption, unstable economic and political issues¹⁹. Similar problems are common in many sectors in Nigeria. Many government establishments run on limited funding due to negligence by the funding source or diversion of funds meant for such. Instability in political thrust and interest of leaders is also a challenge. When programmes or policies of a past government is discontinued by a current leader and new ones embarked upon, it amounts to waste of resources as well as slow development.

The effective implementation of health insurance in Nigeria is work in progress especially in the area of reaching the larger population. The former Minister of Health (Prof. Adewale) in April 2019 said that the NHIS in Nigeria has only been able to cover 4% of the population. The Nigerian Senate in April 2019 passed a bill to make NHIS compulsory for all Nigerians and they are to contribute two hundred naira monthly to access the facility. The problems of a large and multi-ethnic population like Nigeria are dynamic and require well designed approaches to meet growing needs and new challenges. Commitment is also a major factor on the part of government and its institutions to ensure successful implementation.

Access to healthcare at an affordable cost constitutes a high-profile challenge in Nigeria². In any case, pursuit of better health should not await improved economy; instead, proactive actions taken on health will inversely contribute to the economic growth⁵.

In order to offer fair access to healthcare delivery in Nigeria, the Federal Government of Nigeria set in motion the National Health Insurance Scheme (NHIS). Prior to its official launch in 2005, the health system in Nigeria was primarily operated on fee for services system where those requiring medical services pay directly from their pockets for such¹⁶. Additional ways that cushioned costs of health care included free drugs especially for preventive services through external loans and grants, and immunization campaigns supported by donor agencies⁸. On the whole, however, average Nigerians are yet to get the best of healthcare services that will have less effect on their income and savings.

The effective implementation of health insurance in Nigeria is work in progress especially in the area of reaching the larger population. As at 2019, the NHIS in Nigeria covers only 4% of the population. The Nigerian Senate in April 2019 passed a bill to make NHIS compulsory for all Nigerians and they are to contribute two hundred naira monthly to access the facility. Further advancement on this is the launch in November 2020 of Group, Individual and Family Social Health Insurance Programme (GIFSHIP).

1.2 Statement of the Problem

The lack of access to healthcare by many Nigerians indicates that more needs to be done to effectively cater for a growing population like Nigeria through realistic and functional mechanism of operation. Existing studies have shown that in the present circumstances, user charges are presently the major means of paying for health care. In this part of the country, out of pocket spending on medical care is still the practice.

Some challenges in the scheme's operations include; limited scope as the organised private sector has not been fully incorporated into the scheme, so also the vulnerable groups; delay in remittances from various establishment and agencies of government to the NHIS, which also lead inevitably to delays in remittances as well to HMO (Health Maintenance Organisation); accusation by NHIS that the HMO over bloats number of enrollee submitted; small family size covered; and polygamous homes not covered.

Thus, this study is filling the gap by assessing the challenges that are mitigating against the success of National Health Insurance Scheme in Taraba state, so as to identify them and suggest strategies to the various loopholes in the scheme within the state.

1.3 Aim and Objectives of the Study

The aim of the study is to assess to what extent has the National Health Insurance Scheme succeeded in Taraba state. The objectives are to:

1. assess the implementation of the National Health Insurance Scheme in Taraba State.
2. examine the successes and failures of the programme.

3. identify ways of meeting the challenges and improving the schemes' efficacy in Taraba State.

1.4 Research Questions

The following research questions will be answered by this study.

1. How is the National Health Insurance Scheme in Taraba State been implemented?
2. What are the successes and failures of the programme in Taraba State?
3. What are the ways in which the challenges of the programme can be met and improve the schemes' efficacy in the state?

1.5 Significance of the Study

The study is contributing in identifying grey areas in the proper implementation of the National Health Insurance Scheme to the target population, especially in Taraba State. It will assist the Federal Government in aligning the primary aim of the scheme to beneficiaries, thereby availing the populace with adequate health insurance services. This study will benefit Taraba State in identifying issues impeding the success of the scheme and thereby enlighten the citizens on its benefits. It will give the State Government a lead on where to go about the scheme which will avail the citizens improved health service. On the whole, there would be an economic growth resulting from decreased expenditure on healthcare services amongst the citizens. The research will broaden perspectives of medical health practitioners to provision of health services to patients. It will positively alter relationship with patients, particularly in the area of payment for health services. The study will contribute to information and knowledge

base in the area of public healthcare and research. It will contribute to the existing library of medicine related issues and provide relevant background information for further research.

1.6 Scope of the Study

This research is focused on the National Health Insurance Scheme in Taraba State, studying the overall aim of the scheme and how it has fared in Taraba State from its inception in 2005 to 2021.

The questionnaires targeted the adult population of both sexes residing or employed in public service with locations in Taraba State as their stations. In the coverage of the State, the three Senatorial Zones were each represented by a Local Government within the Zone. A total of one hundred and fifty (150) questionnaires were distributed evenly across the three Local Governments.

1.7 Limitation of the Study

The main limitation encountered during the course of the study is getting the exact facts and figures of those on the functionality list of NHIS in Taraba State, particularly as the assessment of the Scheme is a national programme ideally set to be operational in every state.

1.8 Operational Definition of Terms

This study engaged the frequent use of some terms, the key amongst which are defined thus:

Access: Opportunity to participate in the NHIS

Health Insurance: an insurance that covers the whole or part of the risk of a person incurring medical expenses, spreading the risk over several persons. It is also a pre-paid plan where the participants pay an established and stable regular amount

Healthcare Services: This include services that can be rendered to enhance health or the diagnosis and treatment of health conditions, and also recuperation of ailing people through formally structured institutions and personnel who provide services to respond to the needs and demands of the population within a defined regulatory and financial framework

Healthcare: It involves all activities that have the main purpose of promoting, restoring, maintenance or improvement of health by means of preventing, diagnosing, treatment or cure of illness, diseases, injuries and other psychological and physical impairment in individuals

Stakeholders: Individuals, groups, organisations agencies and government who are directly or indirectly healthcare providers or consumers

Endnotes

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Chapter Two

Literature Review

2.1 Conceptual Review

2.1.1 Health Insurance in Perspective

Healthcare holds a significant place in the quality of human capital. The increased expenditure in healthcare increases the productivity of human capital, thus making a positive contribution to economic growth¹. More attention was shifted to reducing the gaps in these critical areas as it became obvious that illness and illiteracy were often concentrated among poor people. From the 1950's to the 1970's, health and education expenditures were considered social investment by policy makers. In the health care financing system, public and private sectors are traditionally recognised. Nowadays, increased unemployment in developing countries diminished the coverage of social insurance. People not only lose their employment but also their social security services, so the demand to public health services increased. Some private insurance services were recently developed but only to cover high-income groups. In the recent times, quality of health services in private sectors increased while it tended to decrease in public services, so differences among private and public services increased and widen the gap between rich and poor in terms of access to health².

It is generally assumed from common knowledge that individuals who are healthier are able to work more effectively, in terms of physical and mental workload. Also, adults who were healthier as children will have acquired more human capital in the form of education, which is explained by the proximate effect of health on the level of income¹.

Simultaneously, the impact of individual income on health is also important. In both developed and developing societies, higher income can result in better health by facilitating access to better nutrition, preventative treatment, good sanitation, safe water, and affordable quality healthcare. In addition to the foregoing, health can also result into high income, by allowing individuals to work more, be more productive and earn higher income during the lifetime. Similarly, the impact of health on education is an important factor that plays a role in healthcare expenditure and economic performance. Children who enjoy good health can attend school regularly and have the potential of high learning ability and cognitive development¹. Also, if good health continues through adulthood, it will enable the population to recover the investments in education. Socio-economic realities however impede on several aspirations thus the need for solutions.

Health insurance methods were developed as a need to finance the health care cost specially due to its growth because technological and scientific advances. In developing countries, the health care systems have relied mainly on general revenues. Social insurance was developed, based on the social welfare concept and usually was associated to employment. In countries with a considerable development of social security services, the accessibility to health services improved specially for workers as well as the access to services of better quality. The concept of social welfare developed since 1930-40 especially in developed countries as a response to growing inequities, was later adopted by developing countries². The concept of health insurance cuts across countries and the method of implementation of the scheme derive from the particular needs of the country and the long term plans in terms of benefit for its citizens.

Health insurance is becoming an important supplementary instrument to health care financing in many countries. The earlier pattern, as in Bismarckian Germany or UK/NHS was Government-led, financed from general taxation and aimed at comprehensive cover. In recent decades, however, private voluntary health insurance has become a growing phenomenon in many countries. This is partly due to rising incomes and increasing dissatisfaction with publicly financed (and often publicly delivered) healthcare services³.

As a critical aspect of advancement in health care, health insurance schemes are gaining relevance in addressing financing health care in developing countries, particularly due to their potential to protect people against health expenses that may be unbearable. Studies have proposed that an annual improvement of one year in life expectancy increases economic growth by 4%^{4,5}. Health financing systems are sustained by general taxation or through the development of social health insurance. Health insurance has a way of paying for some or all of the costs of healthcare, protects insured persons from bearing expensive medical bills in the event of sickness. Most developed nations and many developing nations adopt health insurance as means of ensuring equitable access to affordable and quality health services by their citizens. Nigeria's NHIS therefore serves as the rallying point for mobilising revenue and pooling of resources for healthcare for effective sharing of health risk among enrollees. Collective risk taking is a common model where many contribute premiums over time to cover the cost for anyone who requires healthcare financing at a given time. Since 1990, health reform processes were developed especially in developing countries². Those reforms are principally oriented to improve efficiency of health services. Coordination and/or integration of

public health services and social security was promoted while in both improvement of efficiency is the principal goal. The relation between economic growth and development and health, education and other basic needs of people is well recognised and studied since the beginning of this century. Healthcare spending and the impact that it has on economic performance are important considerations in an economy². Some studies have shown that improvements in health can lead to an increase in Gross Domestic Product (GDP) and vice versa^{6,7}. A healthy population can reduce the expense on national healthcare and increase the potential for earnings.

Taking cognisance of these variations, examples from selected advanced and developing countries are considered in this discourse.

2.1.2 Healthcare

The concept of health is a balance between a person and the environment, the unity of soul and body, and the natural origin of disease, which was the backbone of the perception of health in ancient Greece. Similar concepts existed in ancient Indian and Chinese medicine. In the 5th century BC, health was defined as “harmonious functioning of the organs”, emphasising the physical dimension of health, the physical body and the overall functionality, accompanied by the feeling of comfort and absence of pain. Even today, this definition bears importance as a prerequisite for the overall health and wellness. A perfect human society could be achieved by harmonising the interests of the individual and the community, and the ideal of ancient Greek philosophy that says “a healthy mind in a healthy body” could be achieved if people established internal harmony and harmony with the physical and the social environment. Health has been connected with behaviour, which is essentially under the control of individuals⁸. Health

can also be explained in connection with the environmental factors and lifestyle. There was the concept of “positive health”, which depended on the primary human constitution (which is considered today as genetics), diet, and exercise. Proper diet and exercise were essential for health, and that seasons’ changes had a profound effect on the mind and body, resulting in different types of predominant diseases during the winter (respiratory tract diseases) and summer (digestive tract diseases)⁸. A lot might be said about the long standing philosophical discussion about body and soul, and in present society between body and mind, as an active dichotomy or as an integrated unity, which is important to know about in the current online environment.

In the middle Ages, health perception was strongly influenced by religion and the church. After Roman Empire fell apart, the church was left as an only important infrastructure providing care for the people and collecting the knowledge on remedies, for example, herbs grown in monastery gardens. The “forgotten” knowledge of antiquity was re-discovered during the Renaissance and re-framed up to the present. During the period of Industrial Revolution, health became an economic category, which was to allow good condition and working ability and reduce lost work days due to illness. Accordingly, the value of health was such as enabling economic profit. The health was intertwined with Darwinian understandings of strength and being the fittest, where meaning of life was tied to physical survival. Another health aspect considered the ability of the individual to adapt to the influences from the environment to the extent that the individual could tolerate and resist. When the adjustment is over, the disease occurs as a natural consequence. This approach first reflected only biological

mechanisms of adaptation, later adding on influences from the environment, which needed to be governed and modified⁸.

All modern concepts of health recognise health as more than the absence of disease, implying a maximum capacity of the individual for self-realisation and self-fulfilment. This should equilibrate the human inner forces and possibilities with the feeling of pleasure or dissatisfaction in their relations with the environment. Social medicine and public health approach to health advocate that they should not only observe the health of the individuals, but also the health of the groups and the community, as a result of the interaction of the individuals with the social environment⁸.

The holistic concept of health is contained in the expression of wholeness. Health is a relative state in which one is able to function well physically, mentally, socially, and spiritually to express the full range of one's unique potentialities within the environment in which one lives. Both health and illness are dynamic processes and each person is located on a graduated scale or continuous spectrum (continuum) ranging from wellness and optimal functioning in every aspect of life, at one end, to illness culminating in death, at the other⁸.

Establishing social welfare and facilitating, encouraging, and securing individual autonomy and dignity are key challenges in the contemporary times and society. The modern understanding of health became official when the World Health Organisation (WHO), at the time of its establishment in 1948, included the definition of health in its Constitution. The definition was proposed by a prominent scholar from Croatia in the field of social medicine and public health and one of the founders of the WHO. This

generally accepted definition states that health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity⁸. This definition promoted for the first time that, in addition to physical and mental health, social welfare is an integral component of the overall health, because health is closely linked to the social environment and living and working conditions⁸.

Respecting this definition as a global concept, many researchers and theorists subsequently advocated for adoption of working, practical, and operational definitions of health. In 1977, with the adoption of the WHO Global Strategy “Health for All by the Year 2000”, a pragmatic concept of health – the ability to conduct a socially and economically productive life – was accepted indirectly, which was an essential goal of this Strategy⁸.

To define health in operational and working terms was vital for creating policies and programs for maintaining and improving health, and it considerably managed to exceed the widely rooted notion that health simply means the absence of disease. The Ottawa Charter from the 1st International Conference on Health Promotion, held in Ottawa, Canada, in 1986, says that health is created in the context of everyday life and environment, where people live, love, work, and play. Thus, active and interactive understanding of health was introduced. The goal of health promotion is to combine the approach for addressing the social determinants with the resolution and commitment to motivate and encourage the individuals and the community for their active approach toward health and embracing healthy lifestyles⁸.

Within the last few decades, the WHO definition of health has been increasingly amended and supplemented by the fourth dimension – spiritual health¹⁵. Generally speaking, spiritual health involves a sense of fulfilment and satisfaction with lives, system of values, self-confidence and self-esteem, self-awareness and presence, peacefulness and tranquillity with dynamic emotional balance, both internal and toward the environment, morality and truthfulness, selflessness, positive emotions, compassion and willingness to help and support others, responsibility and contribution to the common good, and successful management of everyday life problems and demands as well as social stress⁸.

Research on individual perceptions regarding health and illness has been accumulating for some time, and it is becoming apparent that they have significant consequences on the person's health behaviour. It is found that gender and age influence people's perceptions of health as much as their background and environmental factors. Overall, lay people's perspective on health and illness should not be viewed as constructs on opposite ends of a single continuum, but rather as two distinct but overlapping constructs. Experiences of health are more intangible and elusive than experiences of illness, making the former much more challenging to study. Health could be taken for granted and not brought to people's attention before it is challenged in situations characterised mainly by the actual or threat of change, disease, or loss⁸.

People belonging to different backgrounds had different perceptions regarding determinants of health. Higher percentage of people agree that environment is the determinant of health, which is consistent with the scientific view of increased burden of diseases caused by environmental factors⁸.

The lay perspective on health appears to be characterised by three qualities: wholeness, pragmatism, and individualism. Wholeness is related to health as a holistic phenomenon. Health is an aspect interwoven with all other aspects of life, everyday life, working life, family life, and community life. Health is viewed as a resource and a total, personal, situation-specific phenomenon. Absence of disease is not enough – the life situation as a whole must be taken into consideration⁸. Family functioning and children's welfare is an important part of experiencing health as wholeness. To be able to live according to one's personal values is also an important issue. Pragmatism reflects the health as a relative phenomenon. Health is experienced and evaluated according to what people find reasonable to expect, given their age, medical conditions, and social situation. In this way, health is not necessarily freedom from disease or loss of functional abilities. Other positive values in life can compensate for different types of losses. Most people are realistic in their life-expectations. Furthermore, individualism relates to health as a highly personal phenomenon. The perception of health depends on who you are as a person. To be part of a society and to feel close to some other persons seems to be important to all. Furthermore, values are individual and, as every human being is unique, strategies for improving health must be personal⁸.

The plurality of health definitions reflects the variety of contexts in which health is elaborated. A concept 'home context' is the context in which the concept originates. It makes sense predominantly inside but not necessarily outside its home context. Conceptualising is a verbal act that sets out to identify and shape phenomena's border and content. The conceptualisation localises and attributes identity, content, or meaning. The definitions of health obviously reflect socially and culturally constructed and

tentative categories. The relation between an individual and society is implied in most concepts of health. In particular, in the digital environment, critical analysis of health concepts helps to understand better health policies and politics and their consequences. As they frequently represent societal powers rather than phenomenological differences, they are accordingly accepted, criticised, or even rejected⁸.

Today's society is a complex, high-cost, high-tech society where citizens constantly need to learn and update their knowledge and skills to be able to manage their own lives. As digital society is built on software that is constantly renewed or replaced by new software, navigation has become a new 'skill of hunting and gathering'. To appreciate concepts and conceptualisations, knowledge has become a key quality in digital society. The health concepts – particularly concepts used to explain, treat, heal or cope with disease – are words that are also used as search tools. A feature of digital society is that past and present categories and understandings are available at the same time, undermining the traditional western schooling system, where accumulation of past knowledge is understood and acknowledged as predecessor to present, updated knowledge⁸.

2.1.3 Healthcare Services

Health services refer to the patient care provided by medical professionals, healthcare personnel, and healthcare organisations. Health services consist of medical professionals, organisations, and ancillary healthcare workers who provide medical care to those in need. Health services serve patients, families, communities, and populations. They cover emergency, preventative, rehabilitative, long-term, hospital, diagnostic,

primary, palliative, and home care. These services are centred around making healthcare accessible, high quality, and patient-centred. Many different types of care and providers are necessary in order to offer successful health services⁹.

Types of Health Services

Health services cover many different types of medical issues. Many people think of primary care, outpatient care, and emergency care when they need an illness managed or are generally not feeling well¹⁶. However, there are more health services that are dedicated to certain illnesses or issues. These health services include:

- i. Mental health care
- ii. Dental care
- iii. Laboratory and diagnostic care
- iv. Substance abuse treatment
- v. Preventative care
- vi. Physical and occupational therapy
- vii. Nutritional support
- viii. Pharmaceutical care
- ix. Transportation
- x. Prenatal care⁹

Health services offer a range of options and can be collaborative. Not everyone will need each health service, while others will need several in order to have their healthcare needs met.

Types of Health Service Providers

There are many different types of health services providers, such as primary care providers, family practice and internal medicine physicians.

Both family practice and internal medicine physicians serve as primary care physicians. Both types of primary care physicians have attended four years of medical school, followed by a three-year residency. The focus of the residency is how these two are different.

Family practice physicians are also called family medicine physicians. The training for family practice physicians focuses on caring for the whole family. This includes children, also called paediatrics, and OB/GYN care, which is for girls and women.

Internal medicine training focuses only on adults and the conditions they face. Both types of physicians must take ongoing medical education courses throughout their careers.

Both family practice and internal medicine physicians provide a full range of primary care services, including:

- i. Treatment of a variety of illnesses and conditions
- ii. Conduct health screenings and comprehensive physical exams
- iii. Provide primary, wellness and preventative health care⁹.

They usually monitor and manage long-term illnesses and conditions like diabetes or high cholesterol. If they find a condition that needs follow-up care by a specialist,

primary care provider can help to connect with a specialty physician in order to get the care needed.

Obstetricians and gynaecologists, or OB/GYNs, are experts in the female reproductive system. Some women use their OB/GYN as their primary care provider. OB/GYNs are physicians trained to care for women during pregnancy and childbirth, as well as manage any disorders of the female reproductive system. Some OB/GYNs prefer to have a family practice or internal medicine physician follow patients for medical issues not related to the reproductive system⁹.

Like family practice and internal medicine physicians, OB/GYNs attend four years of medical school, followed by a three-year residency. Their residency training focuses on pregnancy, childbirth and the medical and surgical management of problems of the female reproductive system⁹.

Paediatricians are physicians trained to care for new-borns, infants, children and adolescents. They also attend four years of medical school followed by three years of residency training. They provide preventive care for healthy children and treat children who are injured or ill. They specialise in childhood diseases, growth and emotional health.

Medical Doctors, known as M.D.s, and Doctors of Osteopathy, or D.O.s, are physicians who are licensed to practice medicine. The main difference is in the type of four-year medical school they attend (medical or osteopathic). Following medical school, both obtain graduate medical education through internships and residencies. Like M.D.s,

D.O.s may choose to practice in any specialty area. Each must pass similar examinations for licensure and board-certification⁹.

Nurse Practitioners and Physician Assistants: Many primary care physicians also use Advanced Practice Providers, or APPs, to help take care of their patients. Advanced Practice Provider is a term used to describe nurse practitioners and physician assistants who are trained to care for patients under the supervision of a physician. They are licensed to provide primary care, as well as order diagnostic tests or prescribe many medications.

2.1.4 Health Insurance in Some Developed and Developing Countries

Overview of Health Insurance in Some Developed Countries

1. Health Insurance in the United Kingdom

Health care and health policy for England is the responsibility of the central government, whereas in Scotland, Wales and Northern Ireland it is the responsibility of the respective devolved governments. In each of the UK countries the NHS has its own distinct structure and organisation, but overall, and not dissimilarly to other health systems, healthcare comprises of two broad sections; one dealing with strategy, policy and management, and the other with actual medical/clinical care which is in turn divided into primary (community care, GPs, Dentists, Pharmacists, and others), secondary (hospital-based care accessed through GP referral) and tertiary care (specialist hospitals)¹⁰.

Health services in England are mostly free at the point of use. The NHS provides preventive medicine, primary care and hospital services to all those “ordinarily

resident”. Over 12% of the population is covered by voluntary health insurance schemes, known in the United Kingdom as private medical insurance (PMI), which mainly provides access to acute elective care in the private sector. Responsibility for publicly funded health care rests with the Secretary of State for Health, supported by the Department of Health. The Department operates at a regional level through ten (10) strategic health authorities (SHAs), which are responsible for ensuring the quality and performance of local health services within their geographic area.

Health care and health policy for England is the responsibility of the central government, whereas in Scotland, Wales and Northern Ireland it is the responsibility of the respective devolved governments. In each of the UK countries the NHS has its own distinct structure and organisation, but overall, and not dissimilarly to other health systems, healthcare comprises of two broad sections; one dealing with strategy, policy and management, and the other with actual medical/clinical care which is in turn divided into primary (community care, GPs, Dentists, Pharmacists etc.), secondary (hospital-based care accessed through GP referral) and tertiary care (specialist hospitals). Increasingly distinctions between the two broad sections are becoming less clear. Particularly over the last decade and guided by the “Shifting the Balance of Power: The Next Steps” (2002) and “Wanless” (2004) reports, gradual changes in the NHS have led to a greater shift towards local rather than central decision making, removal of barriers between primary and secondary care and stronger emphasis on patient choice¹¹. In 2008 the previous government reinforced this direction in its health strategy “NHS Next Stage Review: High Quality Care for All” (the Darzi Review), and

Health care and health policy for England is the responsibility of the central government, whereas in Scotland, Wales and Northern Ireland it is the responsibility of the respective devolved governments and responsibility for commissioning health services at the local level lies with one hundred and fifty one (151) primary care organisations, mainly primary care trusts (PCTs), each covering a geographically defined population¹⁸. Health services are mainly financed from public sources – primarily general taxation and national insurance contributions (NICs). Some care is funded privately through PMI, some user charges, cost sharing and direct payments for health care delivered by NHS and private providers. While the reform programme that developed since 1997 proved to be massive in its scope, some basic features of the English NHS, such as its taxation funding base, the predominantly public provision of services and division between purchasing (commissioning) and care delivery functions, remain unchanged. Nevertheless, in addition to the unprecedented level of financial resources allocated to the NHS since 2000, the most important reform measures included the introduction of the “payment by results” (PbR) hospital payment system; the expanded use of private sector provision; the introduction of more autonomous management of NHS hospitals through foundation trusts (FTs); the introduction of patient choice of hospital for elective care; new general practitioner (GP), consultant and dental services contracts; the establishment of the National Institute for Health and Clinical Excellence (NICE); and the establishment of the Care Quality Commission (CQC) to regulate providers and monitor quality of services¹¹.

2. Health Insurance in the United States of America

Health insurance inadequacies cut across all climes. Despite the spending on healthcare, the coverage for health insurance in the United States is inadequate¹². There are 45 million Americans with no health care coverage, and not surprisingly, lack of insurance is accounts for worse health outcomes¹³. Annually, about 18,000 young adults lose their lives due to lack of health insurance. Those without insurance are less likely than the insured to receive the professionally recommended standard of care for their chronic diseases, such as diabetes¹⁴. And if one has a serious health crisis while uninsured, one risks major debt or bankruptcy. Even the insured are inadequately covered. Employers and individuals who purchase coverage are unsatisfied with the exorbitant price of insurance premiums¹². To maintain competitive premiums, insurers are designing products that reduce the benefits they pay out by increasing the out-of-pocket portion that patients are required to pay for services received. Insured patients may have to pay cash for care until a designated amount is reached (the deductible)—which could be thousands of dollars. In addition, patients are often required to pay a dollar amount (co-payment) or a percentage of the charges (coinsurance) each time services are received. Insurers may also exclude specified services from coverage, such as maternity benefits or mental health services. Most insurance plans now use lists of contracted physicians and hospitals, and impose severe financial penalties for using health care providers that are not contracted. All of these measures reduce the value of insurance by shifting costs from the insurers to the patients who actually need care. Inadequate insurance coverage is making average-income Americans poorer. A recent study found that for 29% of individuals who had average or greater-than-average incomes and were continually

insured, medical bills had caused significant financial problems¹⁵. For those who were not continuously insured, the percentages were even higher. These financial barriers are impairing access to beneficial services. The United States insurance market is now dominated by insurance plans that provide neither adequate health security nor financial security.

There is a widespread belief that the high spending in the United States means that high quality care is being delivered to the majority, who can afford both comprehensive coverage and the attendant out-of-pocket expenses. But international comparisons of industrialised nations have shown that the United States is in the bottom quartile of population health indicators such as life expectancy and infant mortality¹⁵. And in regional comparisons within the United States, increased levels of spending have not produced a commensurate improvement in health care outcomes. In fact, a recent study found that in a state-by-state comparison, there is an inverse relationship between spending and quality outcomes—the more expenditure, the worse the quality¹⁶. In 2000, the World Health Organisation rated the United States first in its health expenditures per capita, but 37th in its overall health system performance, below most-industrialised nations¹⁷. The United States is clearly not receiving adequate value for its health care investment. Some contend that the poor performance of the United States system is due to the funding of health care in the private sector, and that all would be well if the government would just take over funding. But it is not quite that simple.

The greater part of health care in the United States—59%—is already funded by the tax system. On a per capita basis, the public, taxpayer-funded health care expenditures alone total more than the health care spending of every other nation's public and private

funding combined (with the exception of Switzerland, in which total spending per capita equals our public spending alone)¹⁸. How can the United States spend as much as it does and end up with such mediocre health care? Of the many reasons that exist, two are particularly important. The United States has a highly flawed system of funding health care and a flawed system of allocating its health care resources. In the United States, a multitude of private health plans cover the lucrative sector of society—low cost, healthy workers and their healthy families. But public programs must cover the higher costs of the elderly, individuals with permanent disabilities, and some low-income individuals. Since the uninsured are frequently unable to pay for the care they receive, the costs for their care are shifted to government programs or private plans, or to the charity of providers, even if unintended.

The costly administrative excesses of private health plans, especially when contrasted to government programs, have been well documented¹⁸. This fragmented system of funding care places an even greater administrative and financial burden on the providers of health care. Although the exact amount is disputed, most policy analysts agree that replacing this fragmented system of funding care with a single, universal, publicly administered insurance program could recover 200 billion dollars or more, which are currently being wasted sometimes on detrimental administrative services¹⁸. And what is wrong with the way that the United States allocates its resources? Many studies have confirmed that supporting a strong primary care base provides better outcomes at a lower cost¹⁹. But in the United States, specialised, high-technology care is heavily marketed and providers of that high-tech care are rewarded more generously than primary care professionals. Yet studies show that these greater expenditures result in no

additional benefit—and sometimes even in worse outcomes^{16,20}. Excessive resources are allocated to inappropriate expansion of high-tech facilities and to training an excessive number of specialists to provide high-tech services^{16,20}.

The response to these deficiencies in the United States health care system under the Clinton administration in the 1990s was attempt at introducing a comprehensive system of funding universal healthcare. The system would have used marketplace principles in a program of managed competition, but the idea was not acceptable due to its complications, and it was never even brought to a vote. Because of this miserable political failure, policymakers decided that any comprehensive approach should be avoided, and that reform must take place in incremental steps. To date, with the notable exception of the State Children's Health Insurance Program, the accomplishments of these incremental health reform measures have been unimpressive¹².

Over the past decade, the reform measures focused on managed care measures and, more recently, with consumer-directed measures that increase costs to patients by requiring greater out-of-pocket spending. But these measures are designed more to control costs than to increase coverage and access.

In the debate on universal coverage, three general concepts have been put forward:

- i. The expansion of the current system of public and private programs,
- ii. The establishment of a national health service with government ownership of the system, or

- iii. The replacement of all current funding with a single, publicly administered, publicly funded program of social insurance that does not alter the existing ownership status of the delivery system.

The greatest political support today is for incremental expansions of the current programs, which, theoretically, would eventually result in universal coverage. There are innumerable variations of this approach. Most would increase the affordability of insurance premiums for private group and individual plans by providing financial assistance through tax policies and by modifying the benefits and coverage of the plans. Some policy analysts recommend that employers be mandated to offer coverage to their employees. Others recommend that individuals be required to purchase their own coverage. Since some individuals would be left without coverage, a public program, such as the existing Medicaid program for low-income individuals, would be used to cover everyone else.

A couple of simulation studies indicated that these approaches could be effective in covering almost everyone, but they are the most expensive models of reform since they leave in place the administrative excesses of the fragmented system of funding care²¹. Also, to keep premiums affordable, these approaches may fall short on comprehensiveness of coverage and on the affordability of the out-of-pocket component, especially for those individuals with greater health care needs. In contrast, simulation of both the national health service and public social insurance models of reform have shown that they would provide truly comprehensive benefits for everyone, and that they are the least expensive models²¹. By integrating funding with the healthcare delivery system, both models are well suited for the introduction of an integrated information

technology system. Such a system would provide invaluable data to assist with decisions on resource allocation, enabling incentives to be established that would strengthen the primary care base. It would also improve capacity planning for high-tech and specialised services, thereby ensuring appropriate access without excessive queues²².

The political threshold for adopting a government-owned health service model in the United States is very high, since most citizens fear the spectre of “socialised medicine.” In contrast, the Medicare program, an insurance program for the retired and for those with long-term disabilities, is very popular. There is an increasing public perception that the US may need to accept a greater government role in health insurance if they are to adequately address the deteriorating status of its health care system. Scholars opine that correcting the flaws in Medicare and then using the program to cover everyone may be a concept that can gain political traction in the United States²².

The health insurance reforms brought about by the Affordable Care Act (ACA) have resulted in an estimated twenty million people obtaining insurance¹⁵. These coverage gains, according to the National Health Insurance Survey, contributed to a decline in the un-insurance rate from 16.0 percent (48.6 million people) in 2010 to 9.1 percent (28.4 million) by early 2016—the lowest recorded rate in the United States¹⁵. Health management experts opine that the US political process is currently dominated by those who are tended towards the market theorists and rather than the health policy scientists who plead for health care justice. The debate needs to focus on defining the best role for government in ensuring that people receive the best health care value. That debate needs to be guided by a thorough understanding and diligent application of sound health

policy science. The continuing deterioration of affordability, coverage, and quality in healthcare makes it imperative that United States policymakers broaden their reform efforts beyond the ineffectual tinkering of incrementalism. A universal, single-payer, publicly funded and publicly administered program of social insurance would ensure access to affordable, comprehensive, high-quality health care for all¹².

3. Health Insurance in Germany

The German healthcare system is financed by statutory and private health insurance. Germany has a reputation for having one of the best and most comprehensive health care systems in the world, providing its residents with health, sick pay and long-term nursing care insurance coverage. Approximately 90% of the population is a mandatory or a voluntary member of the public health scheme while the rest have private health insurance. What is obtained today has historical links to the Middle ages when Guilds and some companies assumed responsibility for financing medical and nursing care for their members and employees. Over the centuries, many forms of social safety net evolved and these were harmonized in the course of the 19th century.

One milestone was the world's first system of social insurance introduced in 1883 by the German chancellor at the time, Otto von Bismarck. It laid the foundations for the statutory health insurance system in Germany, which today covers most of the country's residents²³.

One has three options for health insurance while living in Germany if required to show proof of health insurance: the government-regulated public health insurance scheme (GKV), private health insurance from a German or international insurance company

(PKV) or a combination of GKV and supplemental PKV. One can opt for a full private health insurance plan if his/her income is above the threshold amount of 64,350 Euros gross salary (in 2021), if one is self-employed, not employed (a mini job does not count) or is over 55 years of age and not employed²⁴. Mandatory insurance Statutory health insurance (SHI) and private health insurance (PHI) were made mandatory on 1 April 2007, and as of 1 January 2009 everyone registered or usually resident in Germany is required to take out health insurance. Employees are required to make SHI contributions if their income is below a certain level (in 2020 the threshold was €5,212.50 per month). If their monthly income exceeds this level, employees can retain membership of the SHI on a voluntary basis or elect to take out private health insurance. Some groups are also exempt from mandatory contributions to the SHI regardless of their income level. They include civil servants and the self-employed, for example.

Both SHI and PHI are funded by contributions or premiums from their members. Whereas contributions to PHI depend on a person's health, the age at which they take out the insurance, their individual risk, the type of coverage and any excess, contributions to the SHI are based on a person's monthly income. With the SHI, all the insured receive the same level of services. Those who earn more pay higher contributions. This is what is meant by solidarity in the statutory health insurance system. The general contribution rate in the SHI is 14.6 percent of salary, of which the employer pays half²⁵. Each insurance fund can also charge an additional premium, which currently averages around one percent and of which the employer also pays half. People insured privately may also be subsidised by their employer or pension fund. In the SHI, in contrast to the PHI, coverage is extended at no extra cost to the children and

the spouse of the insured if they have little or no income. Health insurance contributions for those receiving unemployment or social security benefits are generally paid by the relevant benefits agency²⁵.

Payments are not made directly by those covered by SHI. Doctors, hospitals and pharmacies charge the cost of treatment and medicines directly to the health insurance funds. The insured are entitled to free treatment, apart from any individual extra charges defined by law.

The German health care system is financed on the principle of solidarity. This means that all those with statutory health insurance bear the costs for the treatment of individual members. Regardless of their income and therefore their health insurance contributions, everyone covered by SHI is entitled to medical care. In practice therefore, the healthy pay for the sick, the rich for the poor and singles for families. Another aspect of this solidarity is that those in work continue to receive their salary if they become ill. Employers pay them their full salary for the first six weeks. Anyone who is off work for longer receives an allowance of 70 percent of their gross pay from their health insurance fund²⁵.

Those covered by SHI receive medical treatment without direct payments for services. Doctors, hospitals and pharmacies charge the cost of treatment and medicines directly to the health insurance funds. The insured are entitled to free treatment, apart from any individual extra charges defined by law.

The complexity of the health system opens it up to conflicting interests, which have to be aligned with one another: patients want optimal treatment, doctors want modern

technology and the health insurance funds have to ensure that they can finance it all with the contributions they receive from the insured. On the matter of control, among the State, the market and the individuals involved, Germany has chosen the latter and applies the principle of self-administration.

The state therefore sets the structure for medical care and its responsibilities. It enacts legislation and regulations for this purpose. However, the workings of the system are organised and structured in detail and above all what medical treatments, operations, therapies and medicines are financed by the health insurance funds and those that are not are decided within the healthcare system. This self-administration of the healthcare system is carried out jointly by representatives of doctors, dentists, psychotherapists, hospitals, health insurance funds and the insured. Its supreme decision-making body is the Federal Joint Committee (G-BA). Representatives of patient organisations have the right to table motions in and take part in G-BA sessions. The G-BA defines in binding guidelines the healthcare services to which those covered by statutory health insurance are entitled, e.g. what treatments are covered by the statutory health insurance. As a rule, new medicines are covered²⁵.

One important element of the German health system is that the actors themselves decide which medical treatments are delivered by service providers at the expense of the community, that is, are financed by the statutory health insurance funds. In making their decisions, they are guided by the principle of cost-effectiveness. This means that treatment has to be sufficient, expedient and cost-effective; it may not go beyond what is necessary. Patients generally have to pay for any treatment going beyond this limit. With many available treatments, it goes without saying that they will be paid for by the

statutory health insurance: if someone has a heart attack, they will be treated by an emergency doctor immediately. And the statutory health insurance covers the bill. So too with sports – if someone twists their ankle, they show their health insurance card to the orthopaedic surgeon, are X-rayed and get their foot bandaged as necessary. But there are grey areas too. What if a patient with an orthopaedic injury wants to be treated by an osteopath rather than a physiotherapist? What if they do not want to take painkillers, but would rather have homoeopathic medicine? Then someone has to decide whether the health insurance fund will also pay for these treatments. This is the job of the Federal Joint Committee.

Overview of Health Insurance in Other Developing Countries

1. Health Insurance in India

India has made large strides towards Universal Health Coverage (UHC) with the launch of *Ayushman Bharat – Pradhan Mantri Arogya (AB-PMJAY)*. It is the largest fully government subsidized scheme in the world, covering nearly forty percent (40%) of India's population at the bottom of the pyramid. Nearly seventy percent (70%) of India's population is now estimated to be protected by some health insurance coverage including State Government schemes, social insurance schemes and private insurance²⁶.

In India, health insurance is a new concept except for the organised sector employees. Only about two percent (2%) of total health expenditure is funded by public/social health insurance while eighteen percent (18%) is funded by government budget²⁷. Over the last fifty (50) years, India has achieved a lot in terms of health improvement. But still India is way behind many fast developing countries such as China, Vietnam and Sri

Lanka in health indicators²⁸. In case of government funded health care system, the quality and access of services has always remained a major concern.

The commonest form of health insurance policies in India covers the expenses incurred on Hospitalisation, though a variety of products are now available which offer a range of health covers, depending on the need and choice of the insured. The health insurer usually provides either direct payment to hospital (cashless facility) or reimburses the expenses associated with illnesses and injuries or disburses a fixed benefit on occurrence of an illness²⁸. The type and amount of health care costs that will be covered by the health plan are specified in advance. Health insurance policies are available from a sum insured of Rs 5000 in micro-insurance policies to even a sum insured of Rs 50 lakhs or more in certain critical illness plans. Most insurers offer policies between 1 lakh to 5 lakh sums insured. As the room rents and other expenses payable by insurers are increasingly being linked to the sum insured opted for, it is advisable to take adequate cover from an early age, particularly because it may not be easy to increase the sum insured after a claim occurs. Also, while most non-life insurance companies offer health insurance policies for a duration of one year, there are policies that are issued for two, three, four- and five-years' duration also. Life insurance companies have plans which could extend even longer in the duration²⁸.

A Hospitalisation policy covers, fully or partly, the actual cost of the treatment for hospital admissions during the policy period. It is a wider form of coverage applicable for various hospitalisation expenses, including expenses before and after hospitalisation for some specified period. Such policies may be available on individual sum insured

basis, or on a family floater basis where the sum insured is shared across the family members.

Another type of product, the Hospital Daily Cash Benefit policy, provides a fixed daily sum insured for each day of hospitalisation. There may also be coverage for a higher daily benefit in case of ICU admissions or for specified illnesses or injuries. A Critical Illness benefit policy provides a fixed lump sum amount to the insured in case of diagnosis of a specified illness or on undergoing a specified procedure. This amount is helpful in mitigating various direct and indirect financial consequences of a critical illness. Usually, once this lump sum is paid, the plan ceases to remain in force. There are also other types of products, which offer lump sum payment on undergoing a specified surgery (Surgical Cash Benefit), and others catering to the needs of specified target audience like senior citizens.

Insurance companies have tie-up arrangements with several hospitals all over the country as part of their network. Under a health insurance policy offering cashless facility, a policyholder can take treatment in any of the network hospitals without having to pay the hospital bills as the payment is made to the hospital directly by the Third Party Administrator, on behalf of the insurance company. However, expenses beyond the limits or sub-limits allowed by the insurance policy or expenses not covered under the policy have to be settled by you directly with the hospital. Cashless facility, however, is not available if one takes treatment in a hospital that is not in the network²⁸.

Health experts have argued that most health insurance schemes and products in the Indian market are not designed for the missing middle. Private voluntary health

insurance is designed for high-income groups – it costs at least two to three times the affordable level for the missing middle. Affordable contributory products such as ESIC, and Government subsidised insurance including PMJAY are closed products. They are not available to the general population due to the risk of adverse selection²⁶. Just like several other schemes, relatively low health insurance coverage, and costlier provision of health services in the private sector drive India's high out-of-pocket expenditure (OOPE). Despite the decline in the past few years, India's OOPE as percent of current health spending is 63%, significantly above the average for lower-middle income countries, and amongst the highest in the world. High OOPE poses financial risk to individuals.

A very rapidly growing private health market has developed in India. This private sector bridges most of the gaps between what government offers and what people need. However, there is a growing number of various health care technologies and with corresponding price rise, thus making very expensive the cost of health care that cannot be accessed by a large segment of population. The government and people have turned to exploring alternate health financing options to contain problems arising from the challenges of private sector growth, increasing cost of care and changing epidemiological pattern of diseases²⁶.

2. Health Financing in Rwanda

At the end of the genocide in 1994, Rwanda has engaged in a national reconciliation process that aims to bring the country back to stability in the medium and long term with peace and economic growth for all²⁹. As a major vision for economic growth and poverty reduction, the country's national programmes are to be based on six

fundamental pillars, prominent among which are; comprehensive human resources development, encompassing education, health, and skills in information and communication technologies (ICT), aimed at the public sector, private sector and civil society (to be integrated with demographic, health and gender issues). The vision acknowledges the importance of education and health in the provision of an efficient and productive workforce. It also identifies demographic pressure as one of the major causes of the depletion of natural resources and subsequent poverty and hunger. To reverse this trend and to achieve improvement in the health status of the population, health policies are to target the poorest groups in order to improve access to quality health care at lower cost²⁹.

For Rwanda, the journey to move towards current UHC level was very short. Indeed, since 2000, Rwanda has developed the long-term strategy Vision 2020 whose health-goal is providing sufficient financial resources for universal access to quality health care to all Rwandan citizens at horizon 2020³⁰. To achieve this goal, Rwanda introduced “mutuelles de santé”, now named Community-Based Health Insurance (CBHI) since 1999/2000, which is now available to all non-insured citizens, especially of rural population and informal sector³¹. Therefore, the Rwanda CBHI is considered a vehicle for UHC and Universal Health Insurance (UHI) in Rwanda. Between 2009 and 2011/2012, Rwanda was not far from effective UHC^{31,32}. The dream of effective UHC in Rwanda became a reality. Rwanda is the most advanced country in Africa regarding UHC³³. Rwanda is among the leaders in the African region in terms of its total spending per capita. In an analysis from 2012, Rwanda was one of only four African countries to have met the targets of the Abuja Declaration (to allocate at least 15% of national

budgets to the health sector) and of the High-Level Taskforce on Innovative International Financing for Health Systems (to spend at least US\$44 per capita on health)³⁴. Government expenditure on health in 2013 was at 7% of GDP and 22 percent of general government expenditure (US\$41 per capita)^{33,34}.

The Out-Of-Pocket (OOP) payment rates as a share of total health expenditure (THE) have been falling from 25% in 2000 to 18% of THE in 2013 (US\$13 per capita). An impact evaluation of the CBHI scheme in Rwanda, using data from 2000 and 2006, found that households that were members of Mutuelles were significantly less likely to incur catastrophic health spending than uninsured households³⁰.

For Sub-Saharan Africa countries, including Rwanda, UHC remains an important challenge, with millions of households struggling with high percentage of Out-Of-Pocket (OOP) in total household expenditure for health services³². Since September 2012, Rwanda was recognised as one of the nine countries in Africa and Asia making significant progress to make universal healthcare systems possible. The five countries on intermediate - stage reform are Ghana, Indonesia, Philippines, Rwanda, Vietnam and the four on early-stage reform are India, Kenya, Mali and Nigeria³⁵. Until September 2012, the UHC built on CBHI had been observed nowhere in the world; the model of Rwanda UHC would be therefore the first of the kind³⁶.

3. Health Insurance in Kenya

Health financing policy has undergone several changes since Kenya gained independence in 1963. Health care was virtually free in the 1960s and 1970s, but a severe economic decline forced the government to initiate a cost-sharing programme for

health services and education in 1989 as part of the conditionality imposed by Structural Adjustment Programmes in return for loans from the World Bank and the International Monetary Fund. The new programme substantially expanded the modest fees that had been charged in government hospitals and health centres. Limited government resources led to deterioration in public health care services. Households turned to private clinics, pharmacies and traditional healers to obtain healthcare and private provision began to grow³⁷.

In Kenya, health insurance is low³⁸. A study in Viwandani slums, Nairobi based on the sample of 300 households to determine the health insurance coverage in the region found that only 43% of the households have insurance^{38,39}. A study to determine coverage for maternal and child in the country concluded that individuals are not getting effective health coverage from the existing cover⁴⁰. Kenya has experienced health crises in the past two decades and the public healthcare in the country is facing tremendous challenges as a result of corruption and inadequate budget³⁸. Kenya has a pluralistic health system, with the government, private actors and donors involved in the financing and provision of healthcare.

Since the late 1980s, the government has encouraged private investment in healthcare and there is now a large and diverse private health care delivery sector comprising for-profit and non-profit facilities. The growth of private provision has in turn created demand for private health insurance. Private health insurance cover is mainly purchased by higher-income employees in urban areas and only covered under 2% of the population in 2013. It is beyond the financial reach of most of the population in a country plagued by poverty and income inequality, where access to affordable health

care depends not just on the availability of funds but also on the availability of health workers and facilities. Until 2006, health insurers operated in an unregulated environment and there have been issues with fraud³⁷.

Besides using tax revenues and cost sharing, the Ministry of Health has continued to promote the National Hospital Insurance Fund (NHIF), with plans to turn it into a universal health insurance scheme. The NHIF established in 1966 but was repealed and replaced by the NHIF Act of 1998, which established the fund as an autonomous state corporation “to provide for a national contributory hospital insurance scheme for all residents”, replacing the then existing racial insurance schemes. Enrolment in the NHIF is mandatory for all formally employed workers and voluntary for the self-employed, unemployed and those working in the informal sector³⁷. The NHIF replaced earlier monthly flat rate contributions for those in formal employment with income-dependent contributions based on gross salary and the NHIF introduced coverage for outpatient benefits, thereby offering comprehensive medical cover. The NHIF-covered services can be accessed in the majority of accredited government facilities, mission healthcare providers and in some low-cost private health care providers across the country (together, over 400 facilities). No additional user charges are levied on these services. The NHIF cover also includes inpatient services in high-cost private hospitals, but patients using these facilities face user charges due to the high level of fees charged (the NHIF cover does not suffice)³⁷.

The promotion of affordable and equitable access to healthcare is a major challenge in Kenya. The government, development partners and the private sector all play significant roles in addressing this challenge. Private health insurance supplements publicly

financed coverage, but mainly focuses on households living in urban centres, where most quality health facilities are concentrated, exacerbating inequalities in access³⁷. There is need for aggressive poverty reduction strategies especially for dwellers of rural areas as well as awareness on the need for health insurance. The government also needs to ensure that there is adequate regulation in place to provide consumers with effective protection. Public policies used to be inadequate and poorly enforced, but current policy on insurance seems to be conducive to the expansion of private health insurance and to promoting government goals for the health sector. Care is needed, however, to ensure that the health insurance system is designed in a way that promotes equitable access to health care and does not undermine quality and accessibility for those who rely on publicly financed services³⁷.

4. A Brief of Ghana's Health Financing System

The National Health Insurance Scheme (NHIS) in Ghana was established by the National Health Insurance Act, 2003 (Act 650) and National Health Insurance Regulations, 2004 (L.I. 1809) with the view to improving financial access of Ghanaians, especially the poor and the vulnerable, to quality basic health care services and to limit out-of-pocket payments at the point of service delivery. The National Health Insurance law, mandated the establishment of District-wide mutual health insurance schemes (DMHIS) (henceforth called schemes). The Act mandates that all District schemes must charge a minimum premium of roughly US\$8 per adult for non-Social Security and National Insurance Trust (SSNIT) contributors to cover their premium. Those aged under 18, over 70, pensioners, pregnant women or deemed indigent (core poor) are exempted from premium payments⁴¹.

The Ghanaian NHIS, similar to many others, is designed with an in-built mechanism for equity in financial contributions with subscribers paying income-adjusted premiums. In practice, however, subscribers pay a flat rate because incomes are hard to assess. There is no cost-sharing beyond the premiums; members do not pay any co-payments or deductibles. All SSNIT contributors, most of whom are formal sector employees have their premiums collected at the central level via pay-roll deductions of 2.5% of SSNIT contributions which are proportional to income. However, they still have to pay a registration fee at a DMHIS office to receive a card in order to be enrolled and to access benefits⁴¹.

In order to provide the basic package of services, the NHIS covers both public and private health care providers at all levels of the health system, subject to their accreditation by the NHIA. All public and Christian Health Association of Ghana (CHAG) facilities (about 4000) have been given a provisional accreditation and 1551 private providers including (hospitals and clinics, maternity homes, pharmacies, licensed chemical shops and diagnostic facilities) have been accredited to provide service and to make the service more easily accessible to beneficiaries⁴². Claims are made by service providers and then submitted to the district schemes for payment using the Ghana-Diagnosis Related Group (G-DRG) rates for services and Fee-For-Service (FFS) for medicines⁴³.

There are an estimated 3,500 public, private, and faith-based health care facilities in Ghana. Fifty-seven percent of these facilities are public, 33 percent are private, and 7 percent are operated by the Christian Health Association of Ghana (CHAG)⁴². Health facilities include compounds, health centres, clinics, maternity homes, and seven types

of hospitals: district, municipal, metropolitan, regional, teaching, psychiatric and uncategorised. While all compounds and most health centres and district hospitals are public, most clinics, maternity homes, and uncategorised hospitals are private. One municipal hospital is CHAG-owned, and one teaching hospital is private; all other municipal, metropolitan, regional, and teaching hospitals are public facilities. The share of private facilities ranges from 5.4 percent in the Northern region to 74.9 percent in the Greater Accra region⁴⁴.

The National Health Insurance Authority (NHIA) mandates a pre-defined benefits package that covers 95% of the disease burden in Ghana. Services covered include outpatient consultations, essential drugs, inpatient care and shared accommodation, maternity care (normal and caesarean delivery), eye care, dental care and emergency care. The DMHIS contracts accredited providers (public, private and church-based) to deliver services to its members and reimburses them after submission of claims for services. This system separates the purchasing and provision functions across different stakeholders to increase transparency. Currently the NHIS reimburses providers based on the Ghana Diagnostic Related Groupings (G-DRGs) and fee-for-service (FFS) for medicines using a medicines tariff list⁴¹.

At the centralised level, the NHIS is regulated by the NHIA which also plays a key role in guiding management of the National Health Insurance Fund (NHIF). Revenues from the NHIF are used to provide a reinsurance mechanism for the District Mutual Health Insurance Schemes (DMHIS) and premiums for exempt groups⁴⁴. Prior to the establishment of the NHIS in 2003, Ghana has implemented most of the known healthcare financing mechanisms including general tax and donor funding, out-of-

pocket payments, community-based health insurance schemes. They assert however that, these approaches have not been successful in improving access to quality health care and reducing out-of-pocket expenditures⁴³.

5. Health Insurance Practice in South Africa

The effect of legislated Apartheid regime in South Africa is the margin in income abilities and this invariably reflects in the health sector. Since the first democratic elections in 1994, there has been considerable commitment to addressing these inequalities. However, progress has been limited: income inequalities have in fact been growing and inequalities within the health sector are increasingly related to class rather than race⁴⁵. Privatisation of health care financing and provision was actively promoted by the apartheid government during the 1980s, deregulating medical schemes in 1988. Following transition to a democratic government in 1994, there were concerted efforts to re-regulate medical schemes, but in spite of these reforms, medical schemes still reflect inequities in South African society. Only the wealthiest are able to afford medical scheme cover and they are often supported by their employers and by a substantial government subsidy through tax deductions for contributions. There have been ongoing debates about introducing some form of mandatory prepayment system to address inequities in the public-private health sector mix⁴⁵.

South Africa has a dual health system in which the majority of the population is covered by the public health care sector and 16% of the population with higher incomes is covered by voluntary private health insurance delivered through medical schemes⁴⁶.

There is no evidence that medical schemes have promoted efficiency and, in fact, their track record on technical and administrative efficiency has been dismal. Medical schemes are unable to control rapid increases in health care spending and non-health care spending grew particularly dramatically until placed under relentless scrutiny by the CMS. Although there are no accurate data on technical quality of care in the public and private sectors, there is undoubtedly a perception among South Africans that the private sector offers better quality of care than the public sector. There is no doubt that considerable additional financial resources have been drawn into the health system through the development of medical schemes. However, these resources only benefit the 16% of the population covered by medical schemes. Medical scheme members face considerable out-of-pocket payments due to cost sharing and coverage exclusions. Schemes have been unable to expand coverage to low-income workers who use private primary care providers on an out-of-pocket basis; indeed, coverage declined relatively dramatically as a percentage of the population, from about 17% of the population in the early 1990s to under 15% in 2003, and only began increasing again with the introduction of Government Employees Medical Scheme in 2006. Although government funding for the health sector has increased over the last decade, the task of rebuilding a deeply undermined public health system is enormous. South Africa is seriously considering pursuing a more integrated funding system to achieve universal coverage to address existing income and risk cross-subsidy problems⁴⁵. The desire to balance access to health insurance in ways that will ensure sustainability is at the centre of government policies on health-related issues.

6. Historical Background and Evolution of NHIS in Nigeria

The year 1962 saw the earliest introduction of NHIS in Nigeria, during the first Republic⁴¹. That was about the time a conscious realisation of the need for health needs of Nigerians came to the fore⁴⁷. Early as this was recognised, the bill failed to gain the full approval of Parliament in that year⁴⁸. The operation of NHIS was obstructed following the Nigerian civil war⁴⁹. It re-emerged in the 1980s, leading to the commissioning of a study on it by the National Council on Health. In 1988, the then Minister of Health, Professor Olikoye Ransome Kuti commissioned Emma-Eronmi led committee whose report was approved by the National Executive Council in 1989⁴⁹.

The Federal Government issued a directive to the Federal Ministry of Health to start NHIS in 1993 and the formal launching was performed in 1997 by Gen. Sani Abacha, the then military head of state^{48,50}.

In 1999, the scheme was modified to cover more people via decree No. 35 of May 10, 1999 which was promulgated by the then Head of State, Gen. Abdulsalami Abubakar⁵⁰. It was signed into law in 1999 and officially launched on 6th June, 2005^{51,52}. The scheme kicked off in earnest under the government of Chief Olusegun Obasanjo⁴⁸. As part of the efforts to strengthen the national health system, a National Health Policy (NHP) was adopted in 2006 to establish a realistic financing system capable of ensuring improved health status of Nigerians⁵³. Since then, various steps have been taken on repositioning the programme for greater results and needs response.

2.1.5 Infectious Disease Control

Measles and polio are examples of communicable diseases that have been brought under close control throughout the world. Smallpox, once a dreaded infectious disease of children, was officially declared eradicated in 1980. For other diseases, such as cholera and meningitis, there has been important growth in understanding that may contribute to their eventual control. Likewise, greater access to drug therapies and prevention awareness in the early 21st century contributed to a decline in new cases of AIDS (Acquired Immunodeficiency Syndrome) and a decline in deaths from AIDS, a disease that had first been detected in 1981⁵². Certain parasitic diseases spread as people brought about changes in their environment; the increase in schistosomiasis (infestation with blood fluke by means of snails as the intermediate hosts) in irrigation and human-made lake areas is an example. Research shed light on newly emerging mosquito-borne diseases, such as Zika fever and chikungunya fever, as well as on modes of transmission and means of preventing the spread of highly contagious diseases such as Ebola⁵².

2.1.6 Malnutrition

Knowledge and access to minimum diet requirements is a challenge in many local communities⁵⁴. Widespread malnutrition, particularly protein-calorie malnutrition in small children thus remains a problem. Protein-rich food supplements and more effective educational programs are aimed at combatting undernutrition and malnutrition in developing countries⁵⁴.

2.1.7 Family Health

The problems of rapidly growing populations have important consequences at both the family and the national level⁵⁵. Problems of maternal and child health, human reproduction, and human genetics are aspects of the greater problem of the health of the whole family as a single and fundamental social unit. Accordingly, family health, including family planning, is an important component of public health services⁵⁵.

2.1.8 Health Personnel

There is widespread recognition of inadequacies in both number and education of health personnel. The trend is toward coordinating the education of health personnel with the particular health service in which they will function. This trend requires close relationships between educational institutions and the agencies responsible for health services⁵⁶.

2.1.9 Comprehensive Community Health Services

The combination of curative and preventive services in comprehensive health organisational patterns plays an important role in community health. Health promotion, disease prevention, and the curing and rehabilitation of the illness are brought together into one network of integrated services that reaches to the community level⁵⁷.

2.1.10 National Health Planning

Complex decision making is involved in allocating limited health service resources to large numbers of people, a process that emphasizes the role of health planning and that

requires effective health service systems⁵⁸. A number of countries have established health planning units in the ministry of health or the national planning organization. An important aspect of national health planning is the close coordination between planning, budgeting, implementing and evaluating programs⁵⁸.

2.1.11 Health Issues in Developing and Developed Nations

Developing countries have sometimes been influenced in their approaches to health care problems by the developed countries that have had a role in their history⁵⁹. This obviously contributes to the current positions these countries find themselves in the issue of health. Some instances are the countries in Africa and Asia that were once British colonies reflect British patterns in their educational programs and health care systems with adaptations to local needs. Similar trends may be observed in countries influenced by France, the Netherlands, and Belgium.

Despite the fact that definite designs in health care structure can be found among some less-developed countries, there are also significant variations and gaps in the health resources and administration found in other less-developed countries. These variations and gaps are more prominent in developing versus developed regions because within the former are multifarious elements (socio-political flux) capable of obscuring and sometimes even totally disrupting the administration of health care. Countries with such unstable healthcare infrastructure often are dependent on aid from international organisations which of course are often subject to several internal challenges.

2.1.12 Patterns Shared among Developing Countries

Taking into consideration the variations from country to country, an administrative pattern that cuts across developing countries may be drawn thus: All health services, except for a small amount of private practice, are under a ministry of health, in which there are about five bureaus, or departments, hospital services, health services, education and training, personnel, and research and planning. Hospital and health services are distributed throughout the country. At the periphery of the system are dispensaries, or health outposts, often staffed by one or two persons with limited training. The dispensaries are often of limited effectiveness and are upgraded to full health centres when possible. Health centres and their activities are the foundation of the system. Health centres are usually staffed by auxiliaries who have 4 to 10 years of rudimentary education plus one to four years of technical training. The staff may include a midwife, an auxiliary nurse, a sanitarian, and a medical assistant. The assistants, trained in the diagnosis and treatment of sickness, refer to a physician the problems that are beyond their own proficiency. Together, these auxiliaries provide comprehensive care for a population of 10,000 to 25,000. Several health centres together with a district hospital serve a district of about 100,000 to 200,000 people. All health services are under the responsibility of the district medical officer, who, assisted by other professional and auxiliary personnel, integrates the health efforts into a comprehensive program⁵⁹.

Central importance is the distribution of responsibilities between auxiliaries and professionals. The auxiliaries, by handling the large number of relatively simple

problems, allow the professionals to look after only the more complex problems, to supervise and teach the auxiliaries, and to plan and manage the programs.

The district hospital is dependent on a regional hospital, to which patients with complex problems can be referred for more-specialised services. Administrative direction of both regional health services and regional hospital services can be combined at this level under a regional medical officer. The central administration of the ministry of health provides policies and guidance for an entire health service and, in some instances, also provides a central planning unit.

Problems of transportation and communication over great distances, shortages of staff and other resources, and inadequacies in staff preparation and motivation often lead to malfunctions in the system. Nonetheless, the public health services developed in African and Asian countries have generally provided a sound basis for future development within the framework of national development.

2.1.13 Disparities among Developing Countries

The organisation of public health services in Latin American countries differ substantially from those of Africa and Asia. These differences are an expression of the different historical backgrounds of the regions. The Latin American countries are generally more affluent than those of Asia and Africa. Private practice is more widespread, and private or voluntary agencies are more prominent. Health services are provided largely by local and national governments. Many Latin American countries also have systems of clinics and hospitals for workers financed by employers and workers. The distribution of health services, with health centres, hospitals, and

preventive services, is roughly similar to Africa and Asia⁶⁰. The Latin American countries, however, have used auxiliaries less than African and Asian countries. Latin America has pioneered in the development of health planning methods. Chile is reported to have one of the most-advanced approaches to health planning in the world.

An exception is Thailand which was never colonised and therefore has no historical influence favouring any particular pattern of health services. The Thai Ministry of Health has a well-developed system of hospitals and health centres across the country to serve both rural and urban people. In 2001, the country adopted a universal healthcare plan, supported in large part by government financing and supplemented by private funds. Within the public health services of Thailand, there are a number of separate divisions for instance, for tuberculosis, sexually transmitted diseases, and nutrition.

2.1.14 Health Problems and Obstacles

The difficulties of providing health services for the people of the developing countries involve a cluster of interrelated problems. These arise from the nature of the diseases and hazards to health, insufficient and mal-distributed resources, the design of health service systems, and the education of health personnel in those systems. Woven through the health programs of the less-developed countries and complicating them at both family and national levels are the pressures associated with rapidly growing populations⁵⁹.

There are differences in the kinds of diseases of different countries as well as their occurrence frequency and in the age groups involved. Life expectancy in some countries is less than half than that in others, principally because of high death rates among

small children in the less-developed countries. In Southeast Asia, for example, children under age five are between three and four times more likely to die than children of the same age group in the Americas. The infant (under one year of age) mortality rate in Africa is about six times that in Europe, and the death rate in children under age five (under-five mortality rate) is more than eight times greater⁵⁹.

The major triggers of sickness and death among small children in the developing countries are diarrhoea, respiratory infections, and malnutrition, many of which are closely related to culture, custom, and economic status. Malnutrition may result from food customs when taboos and simple oversight lead to deprivation of children. Gastroenteritis (inflammation of the lining of the stomach and intestines, usually with accompanying diarrhoea) and respiratory infections are often due to infectious organisms, some of which may be resistant to antimicrobial drugs. The interrelationships of these diseases increase the intricacy of treating them. Malnutrition is often the major problem. Aside the primary damage itself, particularly retardation of physical and mental development, it also opens the body up to other illnesses. A malnourished child develops gastroenteritis, inability to eat, further weakness, and then dehydration. The weakened child is susceptible to a lethal infection, such as pneumonia. Or, to complete the vicious circle, infection can affect protein metabolism in ways that contribute to malnutrition.

Another factor that contributes to this is family size. Malnutrition, with associated death and disability, occurs most often in children born into large and poorly spaced families. These are common in developing nations and in communities with low economic strength and sometimes culture driven⁶⁰. The resulting high death rate among small

children often reinforces the tendency of parents to have more children, with the belief that if some die, at least others will survive. People are not inclined to limit the size of their families until it is apparent that their children have a reasonable chance of survival. Thus, there is a fertility–mortality cycle in which high fertility, reflected in large numbers of small children crowded into a poor home, leads to high childhood mortality, which in turn encourages high fertility. This is the basis of the belief that population-control programs should include effective means of reducing unnecessary deaths among children.

Among limitations of resources, shortages of trained personnel are among the most important. Ratios of population to physicians, nurses, and beds provide an indication of the seriousness of these deficiencies and also of the great differences from country to country⁶⁰. Thus, the proportion of population to physicians in less-developed countries varies drastically.

Money is a crucial factor in healthcare: it determines how many health personnel can be trained, how many can be maintained in the field, and the resources that they will have to work with when they are there. Governmental expenditures on health care vary greatly from country to country.

In order to provide healthcare for its population, a country must have adequate resources in place to deal with urgent and complex problems, such as obstetric and surgical emergencies for which hospital care is essential. It is equally important that they actively reach into the communities and homes to find those who need care but do

not seek it and must discover the causes of such diseases as malnutrition and gastroenteritis.

2.1.15 Progress in Public Health in Developed Countries

Among the more-developed countries, the following trends are apparent.

1. Increasing Interest of National Governments

Formerly, governments were chiefly concerned with basic health problems, such as environmental sanitation, medical care of the poor, quarantine, and the control of communicable diseases. Gradually, many have extended their activities into the field of medical care services in the home, clinic, and hospital, so as to provide comprehensive health care for entire communities. Three factors have influenced this trend:

- i. increased costs of medical care,
- ii. increased appreciation of the economic loss to a country from sickness, and
- iii. heightened public interest in social services.

In many regions, health and social welfare are recognised as complementary, and social legislation tends to cover both, encouraging close cooperation between health and social welfare services⁶¹.

2. Changing Concepts of Preventable Disease

In the past, the term preventable disease referred to a circumscribed group of infectious diseases. The term has acquired a broader meaning, however, since many common non-infectious diseases are preventable as well. In the modern era, preventive health services

deal with a wide range of health hazards, such as malignant tumours, rheumatism, cardiovascular diseases, other chronic and degenerative diseases, and even accidents⁶¹.

3. Integration of Preventive and Medical Care Services

Medical care had its origin in the humanitarian motive of caring for the sick, while preventive health services sprang from the need to protect a healthy environment from epidemic diseases. They grew apart, but the trend became to integrate them within a comprehensive health service. Such an integration was the fundamental principle of public health in the Soviet Union, in which all local health services were centred in the district hospital under one administration. Today, in European countries and elsewhere, especially in rural areas, the two branches are brought together by the local medical practitioner⁶¹.

4. Provisions Directed Toward Better Mental Health

Mental health has a place in the preventive services. Improvements in arrangements for mental health include the provision of outpatient clinics and inpatient accommodations at general hospitals for early mental cases, an increase in child-guidance and marriage-guidance clinics, and schemes for the care of alcoholics and drug addicts. There have also been significant developments in the treatment of maladjusted members of society. Gains in understanding of psychoneuroses by general practitioners and the development of research facilities are also noteworthy⁶¹.

5. Growing Emphasis on Health Education

Many countries have expanded their commitment to health education, usually in cooperation with voluntary agencies. The most effective work is carried out at the local

level, especially in schools. The trend has been toward an expansion of health education as an essential preventive health service⁶¹.

6. The Bio-statistical, Epidemiological Approach

As it is obtainable in other sectors, a statistical service is essential in planning, administering, and evaluating health services. The interest of public authorities in medical care schemes has increased the importance of statistics on the incidence of diseases and other problems, as well as the epidemiology necessary to combat them. Both are vital in the planning, organisation, and evaluation of medical care schemes. Traditionally, the epidemiological method was used for infectious diseases, but it has been used increasingly for non-infectious diseases and the problems of medical care. This is very relevant to improved healthcare as it provides a guide for planning and execution of policies⁶¹.

7. Changes Resulting from an Aging Population

In more-affluent countries, an increase in older age groups bring about the need for public health facilities to provide special services for them. Healthcare of the elderly includes measures to prevent premature aging and chronic and degenerative diseases and to confront the psychological problems resulting from loneliness and inactivity. In the 21st century, the increasing prevalence of dementia in elderly populations posed significant challenges for public health. Geriatric clinics and assisted living facilities have been set up to meet these needs and to conduct research into the process of senescence⁶¹.

8. Concern Regarding the Quality of the Environment

A growing population requires an increase in industrial and commercial activities, which add to the volume of pollutants that threaten the atmosphere, rivers, lakes, and oceans and have destructive effects on natural ecology. These effects can cause declines in air and water quality and in species that are sources of foods and medicines, all of which can have consequences for human health. Many countries have taken steps toward the control of environmental deterioration, and means of international regulation have also been proposed and, in some instances, implemented⁶¹.

2.1.16 Progress in Public Health in Developing Countries

The typical characteristics of developing countries are deficit in socio-economic aspects. It is often enhanced by the challenges of mismanagement and outright corruption, most times with impunity. This has snowballed in many cases into poverty and increased cases of diseases in populations with little or no access to adequate healthcare services⁵⁹. In view of the large numbers of serious health problems facing people in developing countries and the limited resources for dealing with those problems, substantial progress also often comes with some degree of stagnation or even regression.

2.1.17 Meeting Nigeria's Health Care Needs Through Health Insurance

A core desire of any nation is to have a healthy population and productive workforce. However, access to quality and affordable health care will remain an illusion if majority of those in need of services and products cannot afford to pay for them. With many Nigerians struggling to live above poverty line, attention will be on buying food than

medicine or paying for health services. The deficiency in getting essential medicines in Africa is more severe than in other parts of the world^{62,63}. Even when medicines are available, they must be accessible in all dimensions – be found in both rural and urban areas of a country as well as being affordable to the poor⁶⁴.

Medical services are similarly not affordable by many Nigerians. Patients are left to bear all the financial burden of seeking for healthcare⁶⁵. On the whole, the economic status of an individual ultimately determines the level of service he/she will get. Visiting major health facilities and being attended to by specialists is ordinarily out of reach for many. It is therefore of primary importance to create an enabling environment where people can have fair rights to health care and one of such platforms is health insurance.

Given the general poor state of the nation's health services and the excessive dependence and pressure on Government provided facilities, with the dwindling funding of healthcare in the face of rising cost, the scheme is designed to facilitate fair financing of healthcare costs through pooling and judicious utilisation of financial risks protection and cost-burden sharing for people, against high cost of health care through institution of prepaid mechanism, prior to their falling ill⁶⁶.

National Health Insurance Scheme is thus a social health security system in which the health care of an employee is paid for by both the employer and employee⁵¹. It is a form of mandatory insurance scheme that usually adopts a national approach⁶⁷. This system guarantees the provision of healthcare services that are paid for by funds from pooled contributions of participants. It has a social function which eliminates barriers to

obtaining healthcare services in times of need especially by vulnerable groups^{66,68}. This enhances chances of access to everyone, irrespective of possible limiting factors.

Examples from countries that have established health insurance programmes shows positive impact on the healthcare system⁶⁹. In Africa, there are success stories from Rwanda, Kenya, Ghana and South Africa^{71,72}. Nigerian government has demonstrated a strong will to make the scheme functional and this, expectedly, should translate into positive impact in terms of a healthy population and vibrant economy.

2.1.18 The Operational Structure and Benefits of NHIS

The NHIS is constituted of The Council, State Licensure boards, State Health Insurance offices, Standards committee and inspectorate systems, Health Maintenance Organisations, health Insurance Companies (public and private), Arbitration boards, Malpractice Insurance Schemes, Banks and Banking systems and Tribunals⁵¹. In order to ensure coverage of different socio-economic groups in Nigeria, the NHIS has developed three major programmes: the formal sector, informal sector and vulnerable groups programmes⁵³. The planning of this structure indicates a commitment to ensure the efficacy of the scheme in Nigeria.

In the NHIS, an employer registers itself and its workers. Funding is by five percent (5%) contribution of enrolees' basic salary and ten percent (10%) contribution of enrolee's basic salary by employer to the scheme monthly⁴⁸. The employee thereafter enrolls him/herself with an NHIS approved Health Maintenance Organisation (HMO). The HMO will then provide the employees/contributors with a list of NHIS approved health care providers which could be private or public. The employee registers

him/herself and dependent(s) with the provider of his/her own choice^{48,72}. The coverage includes the enrollee, the spouse and up to four (4) biological children under the age of eighteen (18) and additional cost for extra dependents⁵³. An enrollee could change his/her primary health care provider if unsatisfied with the services after a minimum of six (6) months⁵³.

Contributions to the scheme are made by members as premium through the HMOs, according to their different categories. The HMOs also provide service to the members through health care providers register to the scheme. Members are entitled to obtain health benefits from any health provider irrespective of location on provision of an adequate identification. All resources collected by the HMOs are pooled together to the NHIS, who regulates the activities of the HMOs and disburses compensation to health providers through the HMOs⁵³.

This interplay of functions of the various organs of NHIS is expected to translate into a practically beneficial health care plan for Nigerians.

The informal sector is directed at the self-employed and rural community dwellers. The programme is based on a pilot conducted in twelve (12) communities. They make monthly contributions based on the benefit package set out by the local insurance group. These exist in some parts of the country but operate out of the purview of NHIS⁵³. The Vulnerable groups program is intended to be a subsidy programme to cater for pregnant women, children under five (5), the unemployed, orphans, prison inmates and permanently disabled. They are not expected to make contributions but are eligible for health benefits⁵³.

Currently, ninety-two (92) Health Maintenance Organisations (HMOs) licensed by NHIS facilitate the interface between the governmental organisations, the delivery system and eligible contributors⁵³. They manage the enrolment of individuals in the scheme, collect their payments, pay the health care providers and provide basic quality management of health insurance that covers formal employees^{51,53}. Liability insurance companies will provide indemnity to cover (malpractice insurance) for health care providers while arbitration boards will handle conflicts in relationships⁵¹.

The benefits package for workers in the formal sector precludes out-patient care, pharmaceutical care as in NHIS essential drugs list and diagnostic test list, maternity care for up to four (4) live births, preventive care (immunisation, health education, family planning, antenatal and post-natal care), hospital in-patient care in a standard ward for up to fifteen (15) cumulative days in a year, preventive eye and dental care^{53,73}. Beneficiaries do not require to pay cash for services outside the ten percent (10%) co-payment for the cost of drugs⁵¹. This ensures that lack of physical cash will not truncate access to health care. The benefit of the programme can be assessed based on the lives of people affected by it⁷⁴. The outcome of such health plans should be seen to translate into practical socio-economic benefit for the people.

2.1.19 Evaluations on the National Health Insurance Scheme

Quality healthcare provision has been argued to be a key factor in development of nations, healthcare is indeed part of the welfare system of modern industrial societies⁴⁷.

The National Health Insurance Scheme is a social health security system in which the health care of an employee is paid for by both the employer and employee. Health insurance is a factor to be considered in any nation's plan in order to reduce individual spending on healthcare⁵¹.

Insurance schemes are social plans that are based on plans with companies who consent to cover the financial burden in case of ill health. Health insurance is a system of paying for part or all of the costs of healthcare. It shields the insured persons from footing high medical bills in the event of sickness. Most developed nations and many developing nations implement health insurance as means of ensuring fair access to inexpensive and excellent health services by their citizens. Healthcare systems evolve over time as a result of historical factors under the influence of economic and social factors. In most cases, their effectiveness depends on reliable infrastructure and just procedures for access and concern for patient satisfaction⁷⁵. The foregoing thus justifies the reviews that occur from time to time to ensure maximum inclusion of beneficiaries.

The primary role of NHIS in health financing comprise mobilising revenue and pooling of resources for healthcare for effective sharing of health risk among enrollees⁴⁷. A typical model of health insurance adopts the standard of collective risk taking in which case many contribute premiums over time to cover the cost for anyone who requires healthcare financing at a given time. Health insurance involves the application of insurance principles to cover the cost of defined medical benefit packages. It involves risk sharing between those who will need the benefits and those who will not. It also involves spreading the burden of cost of healthcare services to the insured over time so that the insured can access services at any time without paying⁶⁶.

In this case, a comprehensive plan is made for contingency through payment of premiums to a common pool. The NHIS is focused towards placing good and affordable medical services within the reach of the common man using prepayment plans.

In order to reach out to parts of the population outside government employment, private sector organisations employing ten (10) or more persons are required by law to participate in the scheme. The stakeholders of NHIS are individuals, groups, organisations agencies and government who are directly or indirectly health care providers or consumers depending on their levels. Persons registered under the scheme contribute a certain percentage of his/her salary at a ratio of ten (10) and five (5) employer employee respectively. The scheme operates through the Health Maintenance Organisations (HMOs), Health Care providers who in turn may either be a Primary Health Care Provider or a Fee for Service Health Care Provider⁷⁴.

The economic status of a nation's population varies widely and some who are economically advantaged may afford to bear the cost of their medical care. However, the provision of level advantage base is the civic duty of a nation especially in areas such as the provision of adequate healthcare. In consideration of old age and other uncommon disease conditions, a standard ought to be set in terms of participation in insurance scheme. In this respect, health insurance should be mandatory and cover the entire nation⁶⁹. This means the enrolment for health insurance should not be an optional plan for every citizen. In this case, citizens in private businesses or even unemployed ought to have special plans that will accommodate them. The participants will have health coverage that is paid for by funds from pooled contributions of participants.

When health insurance is actively in use in a country, it creates a level playground for all, especially by vulnerable groups. No one is limited in terms of access to healthcare as a result of economic strength⁶⁶. In line with this, the chances of healthy living are open to everyone irrespective of possible limiting factors⁷⁴.

Health insurance is feasible in Nigeria as can be seen in successful implementation in many African countries⁶⁹. In Africa, there are success stories from Rwanda, Kenya, Ghana and South Africa^{71,76}. This is to avail healthcare to its citizens which is a major step towards a successful health insurance scheme.

Access to healthcare at an affordable cost constitutes a high-profile challenge in Nigeria. Nigeria is facing enormous challenges in terms of providing adequate healthcare to its population. Although so much policies and plans to address this key aspect is a nations' priority, the level of impact is yet to reach a point of commendation⁴⁹. The economy of Nigeria leaves many of its population living below poverty line. A number of people are struggling for survival, making the additional challenge of settling bills of healthcare an additional burden.

Nigeria has shown commitment to meeting the healthcare needs of its population as expressed in the initiative of National Health Insurance Scheme. Within six years of the official flag off, the NHIS has given cover to 95% of federal government employees. Also, over 1.6 million pregnant women and children under age five were covered under the NHIS/MDG Maternal and Child Health (MCH) project in twelve states of the federation. While additional twelve states are currently being processed for the same project⁵².

The alternative plan for those outside the employment of federal and state governments is the expansion of the scheme to involve Community Health Insurance and the Tertiary institutions health insurance scheme.

The Community Based Health Insurance (CBHI) is a non-profit Social Health Insurance Programme for a cohesive group of households/individuals or occupation-based groups, formed on the basis of the ethics of mutual aid and the collective pooling of risks, in which members take part in its management⁶⁶. This extension of coverage for all categories of Nigerians shows commitment of the government to reach every citizen.

The Tertiary Students Social Health Insurance Programme has further resulted in providing financial protection and healthcare to more than two hundred and fifty thousand (250,000) students in tertiary institutions in the country. The various private health plans for the organised private sector have been providing cover for those in the sector with their respective families. Other programmes at the verge of being rolled out include cover for NYSC members, prison inmates and retiree⁵².

The NHIS, had within its initial years, introduced direct Community Health Insurance in the six geopolitical zones in the country. The CBHI is targeted at people living in rural areas who cannot access an employer-sponsored insurance⁶⁷. The Voluntary Contributor of Social Health Insurance Programme is designed for those who are in informal employment (or firms with less than ten members of staff) and who can afford to pay the required contribution of fifteen thousand naira (₦15,000) per annum. This will give the contributor a health cover similar to the formal sector benefit package.

The Scheme is also working assiduously to address the vulnerable groups in society. These are those who do not have the formal financial ability to contribute to any pre-payment plans. The creation of a vulnerable group fund will certainly be the solution to provision of cover to this group. The fund could be financed either directly by the three tiers of government through the proposed health bill⁶⁷. This is an indication of a determination to make possible a functional financing system in Nigeria.

Although it is a laudable effort, the plan is not free of huge challenges. Limited institutional capacity, corruption, unstable economic and political issues are some of such challenges. Similar problems are not new in many sectors of the nation⁶⁷. A number of government establishments run on limited funding due to negligence by the funding source or diversion of dedicated funds. Instability in political thrust and interest of leaders is another factor. When programmes or policies of a past government is discontinued by a current leader and new ones embarked upon, it amounts to waste of resources and slows down development.

The implementation of health insurance in Nigeria is a progressive project particularly in terms of touching the lives of the larger population. With commitment and consistency, it is a realistic feat even if it takes time to materialise.

2.1.20 The Challenges of NHIS in Nigeria

One of the issues affecting Health in developing countries is the economic challenge they face. They lack monetary resources to fight common health problems and acquire

medicines^{51,73}. In comparison to economically established countries, even medicines, equipment and manpower that are considered available are still out of reach for many in developing countries because they are comparatively expensive.

Funding has been identified as a major challenge to the actualisation of NHIS in Nigeria⁶⁸. Nigeria's health expenditure is relatively low when compared to other African countries³⁰. There has been a decrease in health spending as a proportion of federal government expenditure from an average of 3.5% in the early 1970s to less than 2% in the 1980s and 1990s⁶⁸. This trend does not show sustainable improvement over the years. The total health expenditure (THE) as percentage of the gross domestic product (GDP) from 1998-2000 was less than 5%, which is below the THE/GDP ratio in other developing countries like Kenya (5.3%), Zambia (6.2%), Tanzania (6.8%), Malawi (7.2%) and South Africa (7.5%)⁶⁸.

Another impediment to the successful operation of the scheme is inadequate health facilities in Nigeria and obsolete equipment in the available health facilities^{41,49}. Maintenance of available equipment is itself poorly handled and corruption has been identified as a major setback^{49,72}. Diversion of public funds meant for specific use has been a common practice in Nigeria. Shortage of adequate personnel is also another challenge for the health sector and the efficacy of NHIS, especially as many are migrating to USA, UK etc. due to factors among which is poor remuneration⁴⁹. Inequality in the distribution of health care facilities between the urban and rural areas and inconsistent policies are among the setbacks of NHIS⁷⁷.

Another challenge of NHIS is the culture and religious belief of Nigerians. People with multiple wives and children are not captured by the NHIS. The dependency rate in this culture is very high.

A key criticism of the NHIS is the coverage rate when compared with the duration of the programme. Many Nigerians are unaccounted for by the scheme, as not all in the formal sector are enrolled⁵¹.

Right now, the scheme is only benefiting not up to five (5) million Nigerians who are mainly in the formal sector of the economy, such as the civil servants, the uniform people like the armed forces, the police, custom, immigration and other uniformed groups. The figure of the beneficiaries is very low compared to the total population of the country of about one hundred and sixty (160) million⁷⁸.

With the current population estimate of two hundred and twenty (220) million and with the challenges slowing down the speed of reaching out particularly to those in the informal sector, some HMOs have devised means of getting health services to the doorsteps of the people through Retail Health Insurance (RHI). Under this plan, people will be able to pay premium as low as fifty naira (₦50) per month⁷⁸.

It is argued that the optional requirement of enrolment is a factor in the low figures. Under Decree 35, (2004 Act), membership is not explicitly compulsory, which has created a challenge in phasing all groups that comprise the formal sector^{41,63}. Many in the informal sector are not enrolled.

A country ought to focus on multiple types of insurance in order to ensure a full coverage of its citizens. This is taking into consideration the fact that Nigeria's

population fall into varied category of income sources⁷⁸. Many are of the opinion that all structural modifications ought to be made and put at optimal level in order to achieve the set objectives of NHIS.

One major issue of HMO's in Nigeria might also be that it is like putting the cart before the horse. How can one talk of maintaining something that is below standard? Most of the healthcare provisions in the country require repair process. It is believed that after a repair process, one can talk of maintaining the standard. That is the holistic view behind the operation of Refundable Healthcare financing⁷⁹.

It is indeed crucial that healthcare facilities be fortified with the capacity to handle the potential increase in visits to such facilities and demands on them. On the relationship between HMO's and clients of NHIS, the major problem with HMO's is that many of the hospitals complain of non-payment of the bills of patients that they have treated for the HMO's. The clients complain that many diseases are not covered and they are given substandard drugs. Many of the clients still spend out of pocket to finance their health. Thus, what was meant to be solved, spending out of pocket is being encouraged⁵¹.

This co-relates with low information and understanding of the mechanism of the scheme. Most employees do not know how much they pay as premium and have no adequate information on their level of premium⁷⁴.

A commendable level of commitment to refining policies in the health sector to meet growing demands is evident in the health plan of Nigeria. There is a desire for dynamic response to changes and fresh challenges in the provision of adequate healthcare for Nigerians. It is usual for challenges to arise in the implementation of a national project

such as the NHIS that involves over two hundred and twenty (220) million Nigerians. However, the proactive measures taken to meet and overcome such are some of the marks of commitment on which the government of Nigeria will be scored.

2.2 Theoretical Framework

The research is hinged upon selected theories that border on administration, decision making and implementation of programmes and policies of public institutions. In all political and administrative systems, the decision-making theory is indispensable. Decision must be taken in articulating policies and programmes of government. The decisions must be rational and comprehensive to ensure that the policies of government have greater impact on the generality of the people. Policies must be people oriented and not a few imposing policies on the masses based on their whims and caprices. When the correct decisions are taken without bias, favouritism, nepotism, tribalism, religious bigotry or regionalism, there will be development in the society which invariably will reduce criminality, prostitution, ritualism, terrorism, insurgency etc.

The Policy of the National Health Insurance Scheme in Nigeria is a product of such process. A point of realisation for a need in response to certain demands occasioned by prevailing conditions accounts for decision making in all spheres of government or public operations. When the welfare of the common man is considered in every government decision, a relationship between the leaders and the led, reflects mutual appreciation.

2.2.1 The Theory of Decision Making: An Overview

All policies of government are end products of critical decision-making processes. This theory was propounded in 1947 and postulates on how rational individuals should behave under risk and uncertainty. It further proposes that decision making implies adopting and applying of rational choice for the management of private, business, or governmental organisations in an effective and efficient manner. It is the process of choosing a course of action among competing alternatives, thus the major players in administration are action and choice⁸⁰. Action is the implementation of policies and programmes of government. And implementation follows the choice of a policy.

Two groups are usually involved in the process of administrative organisation. The first group is made up of people who are physically responsible for realising its goals and objectives while the second group is made up of planners who decide how the goals and objectives will be met. The work of the first group is influenced by the second group. The influence involves conscious and unconscious selection of actions among possible ones. Therefore, if a particular course of action is selected, there are other courses of action which are left. In some cases, the selection process takes a rational form (that is, goal oriented) while in other cases, it is planned or designed. Consequently, in every administrative process, many alternative possible actions are often available for choice making by the administrator to choose from and it is what decision-making means⁸⁰.

Administrative actions are goal oriented because purpose is the major basis for determining what is to be done. Direction on what is to be done is shaped by the purpose it is intended to serve. Each decision involves the selection of final goals which are termed “value judgement” and those that border on implementation of the goal are “factual judgment”. The idea of purposiveness involves a hierarchy of decisions. Each

step downward in hierarchy is made up of an implementation of the goals set in the hierarchy consisting in an implementation of the goals or objectives. It is rational if it selects alternatives which are aimed at achieving previous selected goals⁸⁰.

Decision making is a matter of compromise in which case the selected option is the paramount solution that is available under the circumstances. Every organisation function within an environment which limits the alternatives that are available. The choices are often made from these alternatives. Decision making is a group activity which involves decisional processes. This necessitates a selection of inputs from members as well as establishing a regular procedure for arriving at choices and communicating such to members concerned. In typical organisational dynamics, decisions are reached following these steps:

- i. Specify functions, that outlines general scope and nature of duties
- ii. Allocate authority by determining who in the organisation is to have powers to make further decisions; and
- iii. Set such other limits to choice making that are necessary for coordinating the activities of members of the organisation⁸⁰.

The conditions under which decisions are made are certainty, risk and uncertainty.

Decision Making Under Conditions of Certainty

A condition of certainty exists when all the factors relating to the decision making are known. In this case, the alternatives available as well as their cost and benefit are known.

No chance elements exist in situations of certainty as all the sides of the coin are known

ahead of the decision making. In many cases, advance feasibility survey and analysis of cost time are made before the decision is finalised⁸⁰.

Decision making under these circumstances is however not as simple as it seems because a condition of perfect reality is elusive. So many intervening variables could impede the realisation of the conditions of certainty in the decision making process.

Decision Making Under Condition of Risk

Some decisions are made under conditions of risk in which case the alternatives are known but the outcome is not known. This is the typical condition in a case of a bet. Three or more alternatives are available and known but only one is the correct one. The choice must be made among the three and the outcome can only be determined at the end.

Most decisions are made under conditions of risk but administrators device methods to minimise the risk factors in the process. The techniques could be past experience, research and information management⁸⁰.

Decision Making Under Conditions of Uncertainty

In a condition of uncertainty, neither the alternatives nor the likely outcome is known. Decisions under conditions of uncertainty are complex and undependable. Such decisions occur in a case where no previous data exist from which antecedents could be drawn.

Decisions under conditions of uncertainty are made when new institutions are introduced and the organisation has no experience or existing knowledge of operations.

Models of decision making as observed are relevant to this discourse as it borders on the establishment of the National Health Insurance Scheme in Nigeria⁸⁰.

The Rational Comprehensive Model

This model is both rational and comprehensive because it attempts to achieve specific results and also examines available alternatives. This model consists of the following:

- i. The decision maker is confronted with a given problem that can be separated from other problems or at least considered meaningfully in comparison with them.
- ii. The goals, values or objectives that guide the decision-maker are clarified and ranked according to their importance.
- iii. The various alternatives for dealing with the problem are examined.
- iv. The consequences (cost and benefits), that would follow from the selection of each alternative are investigated.
- v. Each alternative and its attendant consequences can be compared with the other alternatives.
- vi. The decision-making will choose the alternative, and its consequences, that maximises the attainment of his goals, values and objectives⁸¹.

This model has been subjected to various criticisms. First, the ground of criticism is that the decision makers are not faced with concrete, clearly defined problems but rather they have to first identify problems on which they make decisions. A second criticism is that it is impossible for a decision maker to know all the available alternatives let alone

understand their consequences. The third is that decision makers are confronted with a situation of value conflict which makes it difficult to compare and weigh the alternatives. This is primarily based on the fact that personal values might be confused with public values.

Incremental Decision-Making Model

This model attempts to avoid the problems of rational comprehensive model thus features the following:

- i. The selection of the goals and objectives and the empirical analysis of the action needed to attend to them are closely intertwined rather than distinct from one another.
- ii. The decision-maker considers only some of the alternatives for dealing with a problem, and will differ only incrementally
- iii. For each alternative, only a limited number of important consequences are evaluated.
- iv. The problem confronting the decision-maker is continually redefined
- v. There is no single decision or right solution for a problem
- vi. Incremental decision making is essentially remedial and is geared more to the amelioration of present concrete social imperfection than the promotion of future social goals.

The criticisms on this model are that the decision made by incrementalist would reflect the interest of the most powerful and organised interest. Secondly, by focusing on short-

run solutions and seeking only limited variation in current policies, incrementalist will neglect basic social innovations⁸².

Mixed Scanning Model

Mixed Scanning Model of decision making is a combination of both rational comprehensive and incremental model. Instead of focusing on an expected outcome, the decision maker will focus on a broad angle.

The Administrator and Decision-Making

The administrator makes his decision on the basis of satisfying large number of people. Although most administrative decisions are not based on economic considerations, yet they are concerned with efficiency (i.e. achievement of goals with less cost).

The Administrative Man Model

- i. Recognises only a limited number of decisions
- ii. Propose only a limited number of alternatives
- iii. Be aware of only a few of the consequences of each alternatives
- iv. Formulate a simplified and limited model of the real situations
- v. Select the alternative which presents a satisfactory solution

The decision of an administrator is therefore not based strictly on economic consideration. He has certain interests which he will like to project or promote. His decisions are aimed at maximising these interests. Viewed from this perspective, the administrative man is acting politically. He plays politics in the process of decision

making without much regard for the process or the posts. He is interested in satisfying political interest⁸⁰.

Programmed Decision-Making

The features of programmed decision-making are as follows:

- i. Repetitive
- ii. Routine
- iii. A definite design to handle them
- iv. The search for alternative steps are minimal or non-existent
- v. Once problems are defined, its solution is either self-evident or at least reduced to a few alternatives which have proven successful over time.
- vi. Decision making is by precedent; the administrator simply applies a solution that has worked in same previous situations.

Programmed decisions include objectives, standards, procedures, methods, rule and politics.

a. Objectives: These are goals toward activity in which the organisation is directed. They serve as guides to administrators in the decision-making process.

b. Standards: Are criteria for comparison which every organisation uses as a guide to what is expected to be achieved. The daily activities of every individual in the organisation are directed towards meeting these standards. The standards are programmed decisions which cannot be distorted easily.

- c. Procedures: This is a series of sets established for the accomplishment of a task. Within each organisation there are jobs. Each job has a series of procedures that are used for performing the jobs.
- d. Methods: A method is one step of a procedure. Each procedure is therefore made up of various methods. A method is a programme decision.
- e. Rules: They are statements which tell a person what to do or what not to do. Each administrative organisation has its rules. They help to make room for judgement or discretion. Rules are thus programmed decisions which regulate the activities of those in the organisation as well as those having dealings with the organisation⁸⁰.

Non-programmed Decision-making

The features are outlined as follows:

- i. It is new
- ii. It is not structured
- iii. No earlier solutions exist for handling it
- iv. The problem requiring the solution is vague, ambiguous or complex
- v. The problem is so important that it deserves a custom-tailored treatment.

Non-programmed decision includes programmes, strategies and budget.

- a. Programmes: Are plans or designs for achieving an objective. A programme normally contains all the activities necessary for achieving the objective and

should clarify who should do what and when. Programmes are designed to solve problems and the nature of the problem determines the programme.

- b. Strategies: Are plans in reaction to or taking into consideration the action of others. Strategies are usually developed in areas such as finance, research, development, personnel and procurement.
- c. Budgets: These are non-programmed decision usually prepared for revenue, expenses and capital expenditure needs.

Techniques of Decision Making

Three of these are discussed.

Brainstorming: The technique of brainstorming has a philosophy behind it that is based on the premise that when people interact in an unrestrained setting, they will generate creative ideas. Each person's idea is likely to spark off creative idea in another, leading to a solution.

The steps employed in brainstorming are:

- i. A group of six to eight members is formed
- ii. The group is presented with a problem and asked to identify as many potential solutions as possible
- iii. It lasts between 30 minutes to one hour
- iv. Two days before a session, group members are given a page summary of problems they are to consider

- v. The summary includes the background information and examples of kinds of ideas desired.

The four rules of brainstorming are as follows:

- a. Criticism is prohibited. Judgment of ideas must be withheld until all ideas have been generated as criticism is believed to inhibit the free flow of ideas and group activity
- b. “Freewheeling” is welcome. The wider and further out the idea, the better. It is easier to tame down than think up ideas.
- c. Quantity wanted. The greater the number of ideas, the greater the likelihood of an outstanding solution.
- d. Combination and improvement are sought. In addition to contributing ideas of their own, members are encouraged to suggest how the ideas of others can be improved or how to merge ideas into another⁸³.

Synetics: The term is derived from a Greek word meaning “fitting together of diverse elements”. The idea behind the technique of synetics is to identify new alternatives by joining together different elements.

The steps in the technique of synetics are as follows:

- i. Group members are selected to represent a variety of backgrounds and training.
- ii. An experienced facilitator formulates the problem to be considered

- iii. Members respond by stating the problem as they understand it
- iv. Only after the nature of the problem is thoroughly reviewed and analysed do members suggest possible solutions.
- v. It is the facilitator's task to structure the problem and lead the discussion in such a way as to force members to deviate from their traditional ways of thinking.

Nominal Grouping: The technique of Nominal Grouping aims at utilising group thinking in the decision-making process. The five steps in the technique are as follows:

Step 1: Seven to ten individuals of varying backgrounds and training are brought together as a group and familiarised with a problem.

Step 2: Working silently alone, each group member is asked to prepare a list of ideas in respect to the problem.

Step 3: After a period of ten to fifteen minutes, members share their idea one at a time, in a round-robin manner. A facilitator records the ideas on a flip chart for all to see. The round-robin continues until all ideas are presented and recorded.

Step 4: A period of structured interaction follows in which members openly discuss and evaluate each recorded idea. At this point, the ideas may be rewarded, combined, deleted or added.

Step 5: Each group member votes by privately ranking the recorded idea in order of assessed importance. Following a brief discussion of the votes outcome, a final

secret ballot is considered. The group's preference is the authentic total of the ranked votes.

The Delphi Technique: Delphi was the site in Greece where the shrine to the prophetic god Apollo was located.

The steps in Delphi Technique are as follows:

- i. A panel of experts is formed to study a particular question
- ii. The experts do not meet in a group
- iii. The identity of panel members is kept secret so as to reduce the influence of psychological factors such as undue persuasion, the unwillingness to abandon publicly expressed opinion, and the bandwagon effect of majority opinion.
- iv. Panel members are asked to answer carefully designed questionnaire that seeks their opinion about future events
- v. Responses are collected
- vi. A coordinator operates a summary of members views
- vii. The summary is then fed back to the panel in the form of a second questionnaire
- viii. Members are asked to re-evaluate their earlier predictions and make a second forecast of the events being considered.

- ix. The round-robin procedure continues until a consensus exists, or when further rounds do not yield results different from the ones that proceeded.

Decision-making in varied fields is guided by a number of principles and techniques that will guide choices. The administrator is at the centre of this as decisions taken will go a long way in affecting the lives of people positively or otherwise. It is important to pay careful attention to policy design and monitor implementation in order to achieve optimal results. That explains the relevance of decision-making theory as clearly stated in the preamble of theoretical framework. When the right decisions, policies and programmes are articulated, it will have far reaching impact in terms of development of the nation⁸⁰.

The concept of health insurance cuts across countries and the method of implementation of the scheme derive from the particular needs of the country and the long-term plans in terms of benefit for its citizens. Health insurance is becoming an important supplementary instrument to health care financing in many countries and private voluntary health insurance has become a growing phenomenon in many countries.

In the demonstration of commitment to the desire to meet the needs of their citizens, many nations have taken definite steps to back their policies with relevant legislation so as to ensure uninterrupted provision of their healthcare plans. The conventional concept of insurance as a means of indemnity against a future occurrence of an uncertain event is relevant in the discourse of healthcare because it is a buffer for the section of the population that may have constant access to healthcare due to their socio-economic factors.

Healthy population and indeed work force are indispensable tools for rapid socio-economic and sustainable development. A nation that seeks to thrive requires giving close attention to the well-being of its population and considering ways to resolve critical issues that could distract them from focusing on wealth generation via service provision. In all the G7 nations, healthcare is a large consumer of society's resources and seen in the huge budgetary provisions for healthcare. The sustainable development goals 4, 5 and 6 focuses on reduction of child mortality rate, improvement of maternal health and combating HIV/AIDS, malaria and other diseases respectively. This indicates that health issues are among the key targets of improving social and economic conditions of world's poorest countries.

Poverty is keeping more and more people in poor health in Nigeria, just as poor health of an increasing number of Nigerians is retaining them in poverty. The nation is at a point where it needs to improve the health of its citizens not only to break the vicious circle of ill-health, poverty and a low level of development, but to convert it to a virtuous circle of improved health status, improved well-being and sustainable development.

Poverty indeed accounts for lack of access to medical care by less privileged population in Nigeria. Access to healthcare at an affordable cost constitutes a high-profile challenge in Nigeria. In a situation where many are struggling to feed, the additional challenge of paying for cost of medical care is real. Although the economic condition of a nation directly affects factors as access to health care by its citizens, it should not be seen as a pre-requisite to meeting the needs of the people. In other words, pursuit of better health should not await improved economy; instead, proactive actions taken on

health will inversely contribute to the economic growth. Any country that intends to rise to the challenge of providing adequate health care for its citizens must select method(s) that are feasible and particularly suit its needs.

Reaching its population with adequate health care opportunities has been demonstrated by Nigeria via its health policies. At the centre of such effort is the desire to allow access to healthcare by every Nigerian irrespective of social status or other related reasons. Every government in Nigeria believes that a healthy population is essential for such, thus justifying its priority allocation in the national budget. In order to offer fair access to healthcare delivery in Nigeria, the Federal Government of Nigeria set in motion the National Health Insurance Scheme (NHIS).

The conception of the idea of the scheme in Nigeria is traced to 1962 when the need for health for Nigerians arose. Early as this was recognised, the scheme only gained full approval of the Federal Government in 1997, signed into law in 1999 and officially launched on 6th June, 2005. Prior to this, the health system in Nigeria is primarily operated on fee for services system where those requiring medical services pay directly from their pockets for such. Additional ways that cushioned costs of health care included free drugs especially for preventive services through external loans and grants, and immunisation campaigns supported by donor agencies. On the whole, however, average Nigerians are yet to get the best of healthcare services that will have less effect on their income and savings.

Health insurance schemes are increasingly recognised as a tool to finance health care provision in developing countries and have the potential to increase utilisation and

better protect people against (catastrophic) health expenses and address issues of equity. Insurance schemes are often social plans that are hinged on arrangements with companies who agree to pay the costs in case of ill health. Health financing systems through general taxation or through the development of social health insurance are generally recognised to be powerful methods to achieve universal coverage with adequate financial protection for all against healthcare costs.

Health insurance is a way of paying for some or all of the costs of healthcare. It protects insured persons from footing high medical bills in the event of sickness. Most developed nations and many developing nations adopt health insurance as means of ensuring equitable access to affordable and quality health services by their citizens. The core roles of NHIS in health financing include mobilising revenue and pooling of resources for healthcare for effective sharing of health risk among enrollees. A common model uses the principle of collective risk taking in which case many contribute premiums over time to cover the cost for anyone who requires healthcare financing at a given time.

Health insurance involves the application of insurance principles to cover the cost of defined medical benefit packages. It involves risk sharing between those who will need the benefits and those who will not. It also involves spreading the burden of cost of healthcare services to the insured over time so that the insured can access services at any time without paying.

This thus indicates a plan for the unforeseen eventuality through payment of premiums to a common pool. The scheme targets providing easy access to healthcare for all

Nigerians at an affordable cost through various prepayment plans. Employees in public or private sector organisations employing ten (10) or more persons are required by law to participate in the scheme. The stakeholders of NHIS are individuals, groups, organisations, agencies and government who are directly or indirectly health care providers or consumers depending on their levels. Persons registered under the scheme contribute a certain percentage of his/her salary at a ratio of 10 and 5 employer employee respectively. The scheme operates through the Health Maintenance Organisations (HMOs), Health Care providers who in turn may either be a Primary Health Care Provider or a Fee for Service Health Care Provider.

The National Health Insurance Scheme Decree No. 35 (2004 Act) outlines the objectives and functions of the scheme thus:

- i. Ensure that every Nigerian has access to good healthcare services;
- ii. Protect families from the financial hardship of huge medical bills;
- iii. Limit the rise in the cost of health care services;
- iv. Ensure equitable distribution of healthcare costs among different income groups;
- v. Maintain high standard of healthcare delivery services within the scheme;
- vi. Improve and harness private sector participation in the provision of healthcare services;
- vii. Ensure adequate distribution of health facilities within the Federation;
- viii. Ensure equitable patronage of all levels of healthcare; and
- ix. Ensure the availability of funds to the health sector for improved services.

The objective of the scheme thus reflects a direct desire to meet the healthcare needs of Nigerians, conscious of the fact that there is an existing imbalance in access to healthcare in terms of facilities, social status and economic strength.

The wealth of a nation is directly a product of the health status of its population. Economic development of individuals, families and the entire society is feasible only when persons are healthy. Healthcare delivery is an area of global concern primarily because it is human-related. No wonder governments and organisations the world over have invested and are still investing large resources into the provision of the necessities that will cater for the health needs of their population. Developing countries particularly are struggling with healthcare issues as a result of various factors and this has raised global concern.

Many nations have populations that are immersed in acute lack of access to healthcare in terms of medicines, facilities and medical staff. In cases where such needs seem to be met in urban areas, those in rural areas still suffer deprivation in healthcare. The poverty level is high and is a major limiting factor. In many parts of the world, especially developing countries, is a major issue of concern as over fourteen (14) million people are killed by infectious diseases each year and Africa is worst hit⁷¹.

This statistic indicates the prevalence of diseases in developing countries like Nigeria and in view of the necessity to create a level ground for all in terms of access to healthcare, a functional NHIS for all categories of Nigerians is necessary.

2.2.2 Human Capital Theory

Human capital theory first came from the 18th century Scottish economist, Adam Smith, but was later argued that its biggest pioneer was an American economist, Greg Becker⁸⁷. It focuses on employers aiming at improving their workforce as well as their business. It constitutes two components which are health and education that promotes the welfare of both individual and the growth and development of the country at large⁸⁷. Given this, health has utility function which is subject to the decision of the individual to either spend or have improved health or not to spend to have ill –health. Therefore, the decision to spend on health as a component of human capital development is regarded empirically to contribute to the growth of per capita income of the individual which in turn promotes the economic growth of a Country. The WHO have identified the human capital development measuring on the basis of health care status and education as key determinants of economic growth^{83, 84, 87}.

According to human capital theory increases in a person's stock of health and knowledge or human capital raise his productivity in the market sector of the economy, where he produces money earnings and in the nonmarket or household sector, where he produces commodities that enter his utility function⁴⁹. To realise potential gains in productivity, individuals have an incentive to invest in formal schooling and on-the-job training. The costs of these investments include direct outlays on market goods and the opportunity cost of the time that must be withdrawn from competing uses. This framework was used to develop models that determine the optimal quantity of investment in human capital at any age^{49,86}. In addition, these models show how the optimal quantity varies over the life cycle of an individual and among individuals of the

same age. The model views health as a durable capital stock that yields an output of healthy time. Individuals inherit an initial amount of this stock that depreciates with age and can be increased by investment. The approach uses the household production function model of consumer behaviour to account for the gap between health as an output and medical care as one of many inputs into its production⁴⁹. This model draws a sharp distinction between fundamental objects of choice--called commodities--that enter the utility function and market goods and services.

2.3 Review of Empirical Studies

A study evaluated the performance and challenges of the National Health Insurance Scheme (NHIS) in Nigeria (2004 – 2021), and examined National Health Insurance Scheme (NHIS) as a health care policy that was launched by the Federal Government of Nigeria in 2005 for better healthcare delivery to the public. The policy aims at increasing effective healthcare coverage of the Nigerian population. The objective of this study is to evaluate the National Health Insurance Policy in Nigeria from inception to date with a view to determining the effectiveness of the policy. Specifically, the study observes the performance and challenges of the policy. It was observed that, though the implementation of the policy receives appreciable momentum and efforts by the NHIS implementation agency, there is still a wide gap in terms of public participation and effectiveness. Public participation in the scheme since inception in the country to date is below 10% of the Nigeria's population. This implied that the objective of achieving full coverage in the country is still very far from been achieved. The study identified delay in payment to health facilities by Health Maintenance Organizations (HMOs),

inadequate public awareness, public apathy, poor management, rural exclusion, lack of standard facilities, Inadequate medical personnel and poor services as some of the banes of the scheme. Recommendations offered for addressing these barriers include public awareness campaign, personnel training and rural inclusion and focus on best practices and quality assurance. The scope of the study covers Nigeria Health Insurance Scheme (NHIS) with specific regards to its performance and challenges between from 2004 to 2021. The study used a descriptive qualitative analysis methodology. Data were obtained from secondary sources including publications, journals, relevant literature and internet sources⁸⁶.

A study investigated NHIS-HMO enrolees' assessment of quality of illness treatment during visit to selected hospitals in South-West, Nigeria. The National Health Insurance Scheme (NHIS) and its implementation through the Health Maintenance Organisations (HMOs) is a representation of the Nigerian government attempt in ensuring quality health services are offered to all Nigerians. Yet, anecdotal evidences shows that quality of illness treatment rendered at hospitals is perceived to be low, very low or average among NHIS-HMO enrolees. Using simple random and convenient sampling technique across 9 healthcare facilities in 3 local government areas in Lagos, Nigeria, the study triangulated using survey method and In-Depth Interview (IDI) to elicit data from selected respondents. The results showed that while enrolees' were positive to statement pertaining to the medical consultant (doctor) mannerism, explanation and examination, significant numbers were not subjected to comprehensive tests and examinations were not promptly carried out. Health plans of enrolees were observed to have effect on the quality of service (treatment) accessed. IDI revealed that enrolees succumb to Out-of-

Pocket payments (OOP) at the Health Care Facilities (HCFs) for services considered higher in quality compared to the ones covered by the scheme. As such the study recommends that government should take appropriate measures including pro-active inspectorate division to ensure that accredited Health Care Providers (HCPs) deliver evidence-based services in ensuring the desired healthcare result is achieved⁸⁸.

The feasibility analysis of integrating community-based health insurance schemes into the national health insurance scheme in Uganda was assessed. Uganda has a draft National Health Insurance Bill for the establishment of a National Health Insurance Scheme (NHIS). The proposed health insurance scheme is to pool resources, where the rich will subsidise the treatment of the poor, the healthy will subsidize the treatment of the sick, and the young will subsidize the treatment of the elderly. However, there is still a lack of evidence on how the existing community-based health insurance schemes (CBHIS) can fit within the proposed national scheme. The study examined the feasibility of integrating the existing community-based health financing schemes into the proposed National Health Insurance Scheme. The study utilised a multiple-case study design involving mixed methods. The cases (i.e., units of analysis) were defined as the operations, functionality, and sustainability of the three typologies of community-based insurance schemes: provider-managed, community managed, and third party-managed. The study combined various data collection methods, including interviews, survey desk review of documents, observation, and archives. The CBHIS in Uganda are fragmented with limited coverage. Only 28 schemes existed, which covered a total of 155,057 beneficiaries with an average of 5,538 per scheme. The CBHIS existed in 33 out of 146 districts in Uganda. The average contribution per capita was estimated at

Uganda Shillings (UGX) 75,215 = equivalent to United States Dollar (USD) 20.3, accounting for 37% of the national total health expenditure per capita UGX 51.00 = at 2016 prices. Membership was open to everyone irrespective of socio-demographic status. The schemes had inadequate capacity for management, strategic planning, and finances and lacked reserves and reinsurance. The CBHIS structures included promoters, the scheme core, and the community grass-root structures. The results demonstrate the possibility and provide a pathway to integrating CBHIS into the proposed NHIS. The study, however recommends implementation in a phased manner including first providing technical assistance to the existing CBHIS at the district level to address the critical capacity gaps. This was followed by integrating all three elements of CBHIS structures. The last phase would then involve establishing a single fund for both the formal and informal sectors managed at the national level⁶⁶.

A study carried out a systematic review of patient satisfaction with the Nigerian National Health Insurance Scheme two decades since establishment and recommendations for improvement. To improve healthcare access and mitigate healthcare costs for its population, Nigeria established a National Health Insurance Scheme (NHIS) in 1999. The NHIS remains Nigeria's leading vehicle for achieving universal health coverage; nonetheless, questions remain regarding its quality and effectiveness. Studies on patient satisfaction have served as a useful strategy to further understand the patient experience and the efficacy of health systems. The study performed a systematic review of primary literature from 1999 to 2020 reporting on NHIS patient satisfaction in eight databases (including PubMed, Embase, and Africa-wide Information). This search returned 764 unique records of which 21 met criteria for

full data extraction. The 21 qualifying studies representing 11 of the 36 Nigerian states, were published from 2011 to 2020, and found moderate overall satisfaction with the NHIS (64%). Further, when disaggregated into specific domains, NHIS enrollees were most satisfied with provider attitudes (77%) and healthcare environments (70%), but less satisfied with laboratories (62%), billings (62%), pharmaceutical services (56%), wait times (55%), and referrals (51%). Importantly, time trends indicate satisfaction with the NHIS is increasing - although to differing degrees depending on the domain. The beneficiaries of the NHIS are moderately satisfied with the scheme. It was considered an improvement from being uninsured, but believe that the scheme can be considerably improved. The authors present two main recommendations: shorter wait times may increase patient satisfaction and can be a central focus in improving the overall scheme, and more research is needed across all 36 states to comprehensively understand patient satisfaction towards NHIS in anticipation of potential scheme expansion⁸⁸.

A study assessed the impact of the National Health Insurance Scheme (NHIS) on employee productivity. The study utilized data from the Federal College of Education (FCE, Yola) and American University of Nigeria (AUN) using a structured questionnaire. A sample of 200 respondents was drawn from the two institutions. Count data models were used to examine the effects of the benefits offered by NHIS on the productivity of workers. The findings from this study reveals that awareness and prevention campaign, drug quality, health treatment and dental care service reduce the probability of a worker falling sick and missing work days. The result shows 61% of workers who are insured have never missed work due to sickness in the last 12 months.

The study recommends that, the services offered by the NHIS should be more strengthened and sustained since they are found to be impacting much on workers. Thus, proper monitoring and supervision of the programme are important to ensure that the goal of the scheme is attained. Awareness and prevention campaigns should be conducted at regular intervals to bridge the information asymmetric among individuals. When workers are enlightened and informed about certain diseases, for example, diabetes, blood pressure, cancer, etc. They will be able to take both preventive and curative measures. Health treatment should also be improved at the various healthcare centres enrolled in NHIS scheme to ensure that there is efficiency and effectiveness in the treatment given to the beneficiaries⁴⁹.

A study investigated perception and participation of federal civil servants in Ibadan to National Health Insurance Scheme. The National Health Insurance Scheme 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. Presently, the enrolment level on the Scheme is majorly among those in the formal sector and user experiences have been different. This study seeks to determine the perception and participation of Civil Servants regarding the National Health Insurance Scheme in Ibadan. Methods: A descriptive cross-sectional study was conducted among 273 civil servants working at the Federal Secretariat, Ikolaba, between October and November 2015. An interviewer-administered questionnaire was used to collect information on socio-demographic characteristics, awareness, and membership of the NHIS, perception of NHIS, and health-seeking behaviour. Participation was defined as the number of civil servants registered or

enrolled under the scheme, in other words, members of the scheme. Information on perceptions was sought using a 3-point Likert scale. Descriptive statistics and chi-square tests were used for data analysis at a 5% level of significance. About 60.1% of the respondents were males. The average age was 39.7+9.1 years, with 85.0% of the respondents being married. The majority (65.2%) of the respondents were mid-level cadre workers, 17.62% were working as senior-level workers and the remaining 17.6% were low cadre workers. The majority (88.9%) completed tertiary education, while just 11.1% completed basic education. The mean household size was 2.5+0.6. Awareness of the National Health Insurance Scheme was very high (95.2%) with 83.5% enrolled under the scheme. About (50%) of the respondents joined the scheme because it is cheap and affordable. There was a significant association between awareness, level of education, knowledge of NHIS, and registration into the scheme by respondents. The majority of the respondents (87.3%) claimed that NHIS is a better means of settling healthcare costs than Out-of-pocket-payment. The majority of the respondents thought that health insurance is a viable programme. The perception of health insurance among civil servants was varied while participation was high. Relevant intervention should be introduced to remove bottlenecks to accessing and operating the scheme⁷⁴.

A study assessed the design and implementation challenges of the National Health Insurance Scheme in Nigeria: a qualitative study among sub-national level actors, healthcare and insurance providers. Health insurance is an important mechanism to prevent financial hardship in the process of accessing health care. Since the launch of Nigeria's National Health Insurance Scheme (NHIS) in 2005, only 5% of Nigerians have health insurance and 70% still finance their healthcare through Out-Of-Pocket

(OOP) expenditure. Understanding the contextualised perspectives of stakeholders involved in NHIS is critical to advancing and implementing necessary reforms for expanding health insurance coverage at national and sub-national levels in Nigeria. This study explored the perspectives of sub-national level actors/stakeholders on the design and implementation challenges of Nigeria's NHIS. A descriptive case study design was used in this research. Data were collected in Ibadan, Oyo State in 2016 from health insurance regulators, healthcare providers, and policymakers. Key informant interviews (KII) were conducted among purposively selected stakeholders to examine their perspectives on the design and implementation challenges of Nigeria's National Health Insurance Scheme. Data were analysed using inductive and deductive thematic approaches with the aid of NVIVO software package version 11. Implementation challenges identified include abject poverty, low level of awareness, low interest (in the scheme), superstitious beliefs, inefficient mode of payment, drug stock-out, weak administrative and supervisory capacity. The scheme is believed to have provided more coverage for the formal sector, its voluntary nature and lack of legal framework at the subnational levels were seen as the overarching policy challenge. Only NHIS staff currently make required financial co-contribution into the scheme, as all other federal employees are been paid for by the (federal) government. Sub-national governments should create legal frameworks establishing compulsory health insurance schemes at the subnational levels. Effective and efficient platforms to get the informal sector enrolled in the scheme is desirable. CBHI schemes and the currently approved state supported health insurance programmes may provide a more acceptable platform than NHIS especially among the rural informal sector. These other two should be promoted.

Awareness and education should also be raised to enlighten citizens. Stakeholders need to address these gaps as well as poverty⁵¹.

Patients Experiences in Accessing National Health Insurance Services in Nigeria was examined. Since the National Health Insurance Scheme (NHIS) commenced operations in 2005, the coverage has remained low. This has been attributed to poor service delivery, and numerous challenges experienced by citizens in accessing care at the provider level. This study identifies challenges faced by enrollees and their levels of satisfaction with the NHIS in Nigeria. This prospective qualitative study was conducted using enrollees of the NHIS. To elicit information from enrollees on topical issues which relate to service accessibility and satisfaction, Focused Group Discussions and interviews were employed. Data were analysed using NVivo Qualitative Data Analysis Software Version 11 and presented in the perspective of Health Management Organizations (HMOs) and healthcare providers' levels. Availability of prescribed drugs and poor referral system were major challenges encountered by enrollees in the process of accessing health services. Some of these challenges were occasioned by the non-remittance of funds to service providers at the due time. Hence, satisfaction among enrollees was also found to be low. The NHIS in Nigeria needs to strengthen its regulatory role by ensuring that HMOs comply fully with the operational guidelines and that HMOs in turn intensify their oversight and quality assurance responsibilities for healthcare providers⁶⁸.

A study looked at the factors affecting utilisation of the National Health Insurance Scheme by Federal Civil Servants in Rivers State, Nigeria. The National Health Insurance Scheme (NHIS) of Nigeria was established in 2005. This study assessed the

utilisation of health care and associated factors amongst the federal civil servants using the NHIS in Rivers state. This was a descriptive cross-sectional study using self-administered questionnaires. Data were collated and analysed using SPSS version 21.0. A Chi-square test was carried out. The level of Confidence was set at 95%, and the P-value $\leq .05$. Out of a total of 334 respondents, 280 (83.8%) were enrolled for NHIS, 203 (72.5%) utilized the services of the scheme. Most 181 (82.1%) of the respondents who utilized visited the facility at least once in the preceding year. Although, 123 (43.9%) of the respondents made payments at a point of access to health care services, overall, there was a reduction in out-of-pocket payment. Possession of NHIS card, the attitude of health workers, and patients' satisfaction were found to significantly affect utilisation $P \leq .05$. Regression analysis shows age and income to be a predictor of utilisation of the NHIS. Though utilisation is high, effort should be made to remove payment at the point of access and improving the harsh attitude of some of the health workers⁷¹.

A study assessed awareness of National Health Insurance Scheme activities and service utilisation among enrolled employees in government institutions in Nigeria. Adopting the survey research method, data was collected from 1200 samples employed in three federal Government Institutions in Calabar, Cross River State, Nigeria using a structured self-developed questionnaire. The samples were selected using the purposive and proportional sampling technique. Descriptive analysis was used to present result and linear regression was used to check the variable under study at 0.05 confidence level. The result from the descriptive analysis revealed that there was moderate knowledge (48 per cent) that there are drugs not on the NHIS drug list. Result also revealed minimal knowledge (30 per cent) that there is some treatment not on the NHIS

treatment List. Regression analysis revealed a moderate correlation (30 per cent) between awareness of NHIS activities and service utilisation ($F(1, 1112) = 16.472; p < .000$). The study concludes that there is moderate knowledge about the activities of the NHIS and this affects service utilisation and satisfaction. The study recommends among others that the operators of the National Health Insurance Scheme should include more drugs on the prescription list to address the health needs of participants. The scheme should be expanded to cover all medical cases of enrollees. The government and the agencies in charge of the health insurance scheme should carry out periodic assessments of clients' satisfaction with the scheme so as to make future policy decisions for better service delivery⁸⁹.

An Assessment of Socio-Economic Effect of National Health Insurance Scheme on Quality, Accessible and Affordable Healthcare in Nigeria was carried out. Accessible, affordable and quality healthcare remain one of the daunting challenges bedeviling most health systems globally especially the sub-Saharan Africa countries including Nigeria. This has pushed government of most countries to increase the allocation of revenue to the sector in order to create health systems that meet the needs of the masses. This no doubt has occasioned more public health spending annually with little or no desired expected health outcome. To afford quality healthcare, health seekers indulged more in out-of-pocket spending which unreasonably impacts on the households' income thereby impoverishing low-income earners. As social security measure, governments of most countries introduced health insurance schemes that shared in part of health financing of individuals to ensuring accessible, affordable, quality and universal health coverage for all.

In spite of the scheme, the three health needs viz; accessibility, affordability, and quality healthcare still remain inadequate. The rationale behind this study is to explore the extent to which national health insurance scheme (NHIS) of Nigeria has impacted on the health system through promotion of accessible, affordable and quality healthcare in Nigeria. To actualise the objective of the study, descriptive statistical technique using frequency, percentage, graph and chi-square test were utilised. The study concluded based on responses of the respondents that national health insurance scheme (NHIS) had significantly impacted on the health needs of the populace by promoting accessibility to healthcare, making it easy for the health seekers through the financing of health needs and promoting good health in Nigeria. On the contrary, the study discovered that majority of the populace in the informal sector are not adequately captured in the health insurance scheme therefore recommend the inclusion of informal sectors comprising of both private and self-employed into the scheme to achieving universal health coverage in Nigeria⁷⁴.

A study carried out a comparative assessment of the knowledge, enrolment and factors affecting the utilisation of National Health Insurance Scheme among women attending antenatal care in a secondary and tertiary health facility in Benin City, Nigeria. Health insurance is a risk-pooling prepayment of healthcare cost and this study assessed the knowledge, enrolment and factors affecting the utilisation of the National Health Insurance Scheme by women attending Antenatal Care in Benin City, Nigeria. A comparative cross-sectional study conducted among 604 pregnant women attending antenatal care in Central Hospital Benin and University of Benin Teaching Hospital in Benin City, Nigeria. Respondents were selected through a multistage sampling

technique and data collected using self-administered semi-structured questionnaires, analysed using IBM SPSS version 22.0 with level of significance set at $p < 0.05$. Thirty one (9.8%) respondents attending antenatal care in the secondary healthcare centre were enrolled in the National Health Insurance Scheme compared to 21 (15.8%) respondents in the tertiary healthcare centre. For 191 (66.8%) respondents in secondary health centre, poor knowledge was responsible for non-enrolment in the Scheme compared to 67(59.8%) in the tertiary health centre ($p = 0.191$). While inadequate funds were the hindrance to enrolment into health insurance, the absence of drugs/equipment was the major challenge to the utilisation of health insurance services ($p = 0.869$). Although awareness of National Health Insurance Scheme among the respondents was high, knowledge was poor. Enrolment into the scheme was almost two times higher among respondents in tertiary healthcare facility compared to the secondary healthcare facility. The absence of drugs, cost of registration and poor quality of services were major barriers to utilisation of the National Health Insurance Scheme services⁹⁰.

A study evaluated National Health Insurance Scheme (NHIS) enrolees' satisfaction with the medical care provided in Tertiary Hospital in North Central Nigeria. The National Health Insurance Scheme (NHIS) was designed to provide good and affordable healthcare to all Nigerians. The scheme has additional responsibility to maintain continuous quality assurance. This is the first attempt to evaluate patient satisfaction of NHIS enrolees in the study site in 15 years. The study determined the enrolees' satisfaction with NHIS services, it also assessed the patient and operational factors associated with satisfaction. Using a cross sectional study, we recruited 306 NHIS enrolees from five outpatient clinics of the study institution and assessed their level of

satisfaction in six domains, namely: General Satisfaction, Technical Quality, Interpersonal Manner, Communication, Financial Aspects, Time Spent with Doctor, Accessibility and Convenience, using the Patient Satisfaction Questionnaire - Short Form (PSQ-18). We analysed the data using the SPSS version 21. A P-value of < 0.05 was considered as statistically significant. General Satisfaction with services was 50.25%. Satisfaction from the six domains ranged from 53.55% to 81.25%. The highest level of satisfaction was from Communication (81.25%) and the lowest was from the Financial Aspects (53.55%). Enrolees who were new, male or non-staff of the health institution had higher satisfaction levels. HMO type was associated with satisfaction level, while enrolee age, referral status, occupation, level of education, marital status and number of children had no association with satisfaction. The study found an average General Satisfaction level. The finding that NHIS enrolees were least satisfied with Accessibility and Financial Aspects of their care is of concern because protecting enrolees from financial burden and ensuring accessibility to good healthcare are the core mandates of NHIS⁹¹.

A study carried out an assessment of service quality and clients' dissatisfaction of National Health Insurance Scheme. Health Insurance Scheme (NHIS), a medical package to start with a fraction of Nigerians at its inception, with the expectation of optimal services to all in the long. The Nigerian government established National run. However, there are complaints and dissatisfaction of enrolees of the scheme. This study determined factors responsible for enrolees' dissatisfaction of services in a general hospital within the federal capital territory, Abuja. Three hundred enrolees of National Health Insurance Scheme at the Kubwa general hospital were enrolled. Semi structured

questionnaires were used to obtain information on socio-demography, education, enrollee status, perception of the scheme and factors responsible for enrollees' dissatisfaction. SPSS version 22 was used to analyse Data using percentage. Majority (66.3%) of the respondents were between 35 and 54years while 28.5% were below 35years and 11.8% (32) were above 54years with the male to female ratio was 1.03:1. Sixty percent (179) of the respondents had a minimum of tertiary education with just 1.8% having primary education. Most (69.9% and 79.6%) respondents were principal enrollees and public servants respectively. Seventy percent of the respondents have been enrolled in NHIS for more than 3years and had a good perspective of the scheme. However, 30% of the respondents were not satisfied with NHIS services with 8.6% and 15.4% describing the services as substandard and below expectations respectively. Half (50.7%) of the respondents would consider an alternative to NHIS suggesting their dissatisfaction. The major factors responsible for dissatisfaction were billing system, long waiting hours and staff attitude accounting for 46.9%, 59.4% and 7.8% respectively. This study revealed that the level of clients' dissatisfaction with NHIS services is high despite their acceptance of the scheme with the major areas of concern being the billing system, waiting time and staff attitude. Therefore, it is necessary for the providers to look more into these areas as targets for service delivery improvement⁹².

Enrolees' awareness and attitudes toward the provision and utilization of NHIS services at a federal healthcare facility in Niger State, Nigeria was assessed. Awareness and acceptability of health insurance services by enrolees is critical for improved utilization and access to health care in order to achieve desired objectives. Hence, assessing enrolees' level of awareness and attitude towards the National Health Insurance Scheme

(NHIS) services in Nigeria is necessary for understanding their acceptability and extent of utilisation to inform policy for improved performance. This study aimed to assess the knowledge, attitude and utilisation of the NHIS services by the employees of a federal healthcare facility in Niger State, North Central Nigeria. A descriptive cross-sectional survey of 308 employees of the Federal Medical Centre (FMC) Bida, who are enrolled in the NHIS as federal staff, was undertaken. A semi-structured questionnaire was developed to collect relevant information on the knowledge and attitudes of the employees towards the scheme, while facility records were reviewed to obtain information on available packages and utilisation rates. Data was collected and analysed using SPSS 23.0. All the respondents (100%) indicated some level of awareness about the NHIS but less than 50% had adequate knowledge regarding the guiding principles. A greater percentage of (81.5%) revealed positive perceptions towards the scheme. However, this did not reflect in the level of utilisation of NHIS services as only 22.8% of the respondents appeared to have utilised the services on a regular basis. Key challenges experienced by respondents while accessing care include out-of-stock syndrome for most medications, lack of quality medications and services, as well as high incidence of out-of-pocket payments. Findings suggest poor utilisation of the NHIS services among enrolees in the facility informed mostly by their inadequate knowledge of the scheme, in addition to challenges encountered in the course of receiving care, such as poor availability of medicines, high OOP payments among others. There is need for enhanced education of the employees regarding NHIS services and improved provision of basic services to enhance efficiency of the scheme⁹³.

A study sought to explore the implementation of the NHIS in Ghana and the lessons South Africa and other low- and middle-income countries can learn from such a process. South Africa is having difficulties in rolling out the National Health Insurance (NHI) policy. There are ongoing arguments on whether the NHI will provide access to quality and equitable healthcare it is intended to and whether South Africa is ready to implement the policy. Many stakeholders believe the country needs more preparation if the policy will be successful. Ghana, on the other hand, has successfully implemented the National Health Insurance Scheme (NHIS) for over 15 years. A scoping review was conducted using the Joanna Briggs Institute's System for the Unified Management, Assessment and Review of Information (SUMARI) and Mendeley reference manager to manage the review process. Journal articles published on the NHIS in Ghana from January 2003 to December 2018 were searched from Science Direct, PubMed, Scopus, CINAHL, and Medline using the keywords: Ghana, Health, and Insurance. The implementation of the NHIS has provided access to healthcare for the Ghanaian population, especially to poor and vulnerable. Despite the successful implementation of the NHIS in Ghana, the scheme is challenged with poor coverage; poor quality of care; corruption and ineffective governance; poor stakeholder participation; lack of clarity on concepts in the policy; intense political influence; and poor financing. The marked inequity in the South African health system makes the implementation of the NHI inevitable. The challenges experienced in the implementation of the NHIS in Ghana are not new to the South African healthcare system. South Africa must learn from the experiences of Ghana, a context that shares common socio-cultural and economic factors and disease burden, in order to successfully implement the NHI⁴³.

A study aimed to find if the National Health Insurance Scheme (NHIS) in Ghana is achieving universal health coverage (UHC) or not. The study gives the trajectories of health policies in Ghana and their implications on long term health financing. NHIS in Ghana was implemented in 2004, with the aim of increasing subscribers' access to health care services and reduce financial barriers to health care. On equity access to healthcare, it addresses two core concerns which are enrolling particular groups (persons exempted from annual premium payments) and achieving UHC for all citizens and persons with legal residence. It utilises a multifactor approach to the conceptualization of UHC. The study used qualitative methods. In doing so, the study engaged participants in in-depth interviews, focus group discussions and direct observations of participants in their natural settings, like hospitals, clinics, offices and homes, with purposive and snowball techniques. This data triangulation approach aims to increase the reliability and validity of findings. The empirical evidence shows NHIS performed relatively well in enrolling more exempt groups (particular groups) than enrolling all persons in Ghana (UHC). The biggest challenge for the implementation of NHIS from the perspectives of health insurance officials is inadequate funding. The health insurance beneficiaries complained of delays during registrations and renewals. They also complained of poor attitude of some health insurance officials and health workers at facilities. Both health insurance officials and beneficiaries emphasised the need for increased public education and for implementers to adopt a friendly attitude towards clients. To move towards achieving UHC, there is a need to redesign the policy, to move it from current voluntary contributions, to adopt a broad tax-based approach to cover all citizens and persons with legal residence in Ghana. Also, to adopt a flexible

premium payment system (specifically ‘payments by installation’ or ‘part payments’) and widen the scope of exempt groups as a way of enrolling more into the NHIS⁴⁴.

A study investigated 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, journals, textbooks relevant to the study, 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; centralisation of the process for obtaining authorisation 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. The study recommends that the coverage of NHIS should be expanded to include all ailments; NHIS Pharmacies in UATH should be equipped with drugs to prevent enrollees from buying prescribed drugs from private outlets at exorbitant prices; process for obtaining authorisation code and service forms in UATH should be decentralised; there should be public enlightenment campaign by government on opportunities for quality and

affordable healthcare service that are provided by government through the National Health Insurance Scheme⁹⁴.

Enrolees Assessment of Health Maintenance Organisations (HMOS) in the Implementation of National Health Insurance Scheme (NHIS) in Abuja, Nigeria was studied. The abysmal performance of the healthcare sector in Nigeria led to the introduction of National Health Insurance Scheme (NHIS) in 2005 with the hope of increasing the performance of the healthcare delivery system in the Country. The pro-poor Scheme aimed at increasing coverage as well as affordability of healthcare services in Nigeria. As an Insurance Scheme, designed with Health Maintenance Organisations as intermediary, enrolees have disparate levels of satisfaction with the role of the HMOs. This study examines the perception of enrolees on the role of HMOs in the implementation of NHIS scheme in three tertiary medical institutions—University of Abuja Teaching Hospital (UATH); National Hospital (NH), Abuja; and Federal Medical Centre (FMC) Abuja. Anchored on Systems Theory, this survey study used self-administered structured questionnaire to elicit information from enrolees of the Scheme in the Tertiary Health Institutions in Abuja. The study found that the enrolees were not satisfied with the role of the HMOs in the implementation of the Scheme due to the problems of infidelity in the remittance of premium by employers; difficulty in generating authentication codes; no-show weekends; lack of skilled personnel; nonchalant attitudes of hospital staff; and ineffective means of communication. The study hence, recommends employers should remit to HMOs their employees' premium; HMOs should decentralise their structure to have representatives in tertiary health institutions and that the staff of the affected hospital. The NHIS have a duty to prevail

on the HMOs to act according to the objectives of the Scheme which is to create healthcare satisfaction among Nigerians⁹⁵.

A study assessed the National Health Insurance Scheme (NHIS) in Nigeria and if the policy achieved its intended objectives. Universal coverage of health is one of the goals of the United Nations and one which every African country, Nigeria inclusive strives to achieve. Referred to as NHIS, the study was motivated by a desire to review a policy with so much importance and set out to appraise the scheme's objectives and assess the level of achievement across sectors including the Small and Medium Scale enterprises popularly known as the SMEs. Research design using the cross sectional approach was employed along with the use of convenience and random sampling, a sample of employees (150) from ten Lagos resident health maintenance organisations (HMOs) with National accreditation were used. Data was collected with the aid of a structured questionnaire and the study relied on regression analysis to derive results. The results showed that the relationship between objectives of the NHIS were significant to the predictor variables (FWA=facility well assessed, RPS=restricted to public sector, ASN=adequate subscription and HAW=high awareness), thus accepting the alternative hypothesis. However, the relationship with the SMEs was only marginal. The study, based on its findings, concludes the scheme is yet to fully achieve its intended objectives and therefore recommend that the scheme's management put effort to expand the coverage across all sectors through enlightenment, improved access to facilities whilst also collaborating with relevant stakeholders to assuage the people's needs with regards to good quality and affordable healthcare service⁵⁰.

A study assessed implementation of national health insurance policy in Nigeria. Affordable and inclusive system of health care delivery for the citizens is a requirement for any nation that desires rapid socio-economic development. It is in realization of this that the 1999 constitution of Nigeria (as amended) under the chapter on Fundamental Objectives and Directive Principles of State Policy, Section 17, Sub-Section 3(d) declared that; “the state shall direct its policy towards ensuring that there are adequate medical and health facilities for all persons”. Pursuant to this constitutional provision coupled with the quest to extend the range of healthcare delivery, the National Health Insurance Scheme (NHIS) was established. NHIS is a social security system established by Decree 35, of 1999 (now Act 35) and became operational after it was officially launched by the Federal Government in 2005. The objective of the scheme is to ensure Universal Healthcare Coverage (UHC) for all Nigerians by the year 2015; especially poor and vulnerable Nigerians. To this end, the paper seeks to examine the implementation of the scheme in Nigeria. The methodology adopted is the content analysis and the studies are anchored on the elite theory as framework of analysis. The paper observed that there are challenges that stand between the scheme and the realization of its objective among which are, inadequate funding and inadequate awareness. It recommends among others that, the need to diversify sources of funding the scheme by creating a Special Tax Fund. This will ensure sustainability in the funding of the scheme; while public awareness of the existence of the scheme especially among rural people is intensified⁹⁶.

A study evaluated the effect of public health financing on National Health Insurance Scheme (NHIS) policy in Nigeria. Multistage (clustered and incident) sampling

technique was employed to select the sample size of 399 respondents in Ogbomoso North Local Government Area. Primary data for the study were collected using structured questionnaire. Variables included income, education, settlement of patients' bills, patient patronage, occupation, religion, and years of registration. Correlation analysis was used to analyse the effect of NHIS adoption on standard of living at 0.05 level of significance. The results showed that income had significant effect on NHIS adoption ($R^2 = 0.624$, $F\text{-ratio} = 15.344$; $p = 0.001$). Furthermore, NHIS adoption had significant effect on standard of living ($r = 0.6$; $p = 0.001$). This study concluded that NHIS adoption had significant effect on standard of living. This study recommended that improvement in the standard of living of citizen should be ensured thereby making more individuals benefit from NHIS⁶⁷.

A study examined knowledge and utilisation of National Health Insurance Scheme among adult patients attending a tertiary health facility in Lagos State, South-Western Nigeria. Despite the creation of the National Health Insurance Scheme (NHIS) by the Nigerian government, most Nigerians are not covered by the scheme. The aim of this study was to assess the knowledge and utilisation of NHIS among adult patients who attended a tertiary health facility in Lagos state, South-Western Nigeria. A descriptive cross-sectional study of 487 respondents recruited using a multi-stage sampling method. Data were collected using pretested semi-structured self-administered questionnaires, and analysis was done using Microsoft Excel 2007 and EPI Info 7 statistical software. Level of significance was set at $p < 0.05$. Ethical approval was obtained from the Health Research Ethics Committee Lagos State university teaching Hospital. A total of 487 of the 500 self-administered questionnaires were retrieved and analysed, giving a response

rate of 97.4%. The study showed that 80.7% of the respondents had poor knowledge of NHIS, only 12.3% of the respondents had registered with the NHIS, and 43.8% of respondents who had not registered with NHIS claimed they do not know where to register. There was a statistically significant association between age and utilisation ($p = 0.0007$), marital status and utilisation of NHIS ($p = 0.016$), employment status and utilisation of NHIS ($p = 0.001$). Most (96%) of those who have utilised NHIS were satisfied with NHIS services. Majority of the respondents had poor knowledge of NHIS and also majority of those who had registered were satisfied with the scheme. There should be increased awareness campaigns so that all Nigerians can benefit from the scheme⁹⁷.

A study examined factors that influence enrolment and retention in Ghana's National Health Insurance Scheme. The government of Ghana introduced the National Health Insurance Scheme (NHIS) in 2004 with the goal of achieving universal coverage within 5 years. Evidence, however, shows that expanding NHIS coverage and especially retaining members have remained a challenge. A multilevel perspective was employed as a conceptual framework and methodological tool to examine why enrolment and retention in the NHIS remains low. A household survey was conducted after 20 months educational and promotional activities aimed at improving enrolment and retention rates in 15 communities in the Central and Eastern Regions (ERs) of Ghana. Observation, in-depth interviews and informal conversations were used to collect qualitative data. Forty key informants (community members, health providers and district health insurance schemes' [DHISs] staff) purposely selected from two case study communities in the Central Region (CR) were interviewed. Several community members, health providers

and DHISs' staff were also engaged in informal conversations in the other five communities in the region. Also, four staff of the Ministry of Health (MoH), Ghana Health Service (GHS) and National Health Insurance Authority (NHIA) were engaged in in-depth interviews. Descriptive statistics was used to analyse quantitative data. Qualitative data was analysed using thematic content analysis. The results show that factors that influence enrolment and retention in the NHIS are multi-dimensional and cut across all stakeholders. People enrolled and renewed their membership because of NHIS' benefits and health providers' positive behaviour. Barriers to enrolment and retention included: poverty, traditional risk-sharing arrangements influence people to enrol or renew their membership only when they need healthcare, dissatisfaction about health providers' behaviour and service delivery challenges. Given the multi-dimensional nature of barriers to enrolment and retention, we suggest that the NHIA should engage DHISs, health providers and other stakeholders to develop and implement intervention activities to eliminate corruption, shortage of drugs in health facilities and enforce the compulsory enrolment stated in the NHIS policy to move the scheme towards universal coverage⁹⁸.

Assessment of satisfaction and utilisation of health-care services by National Health Insurance Scheme enrolees at Aminu Kano Teaching Hospital, Kano, Nigeria was examined. The National Health Insurance Scheme (NHIS) aims at universal health coverage through access to high-quality health-care to all enrolees. To achieve this goal, it is necessary to incorporate feedbacks from periodic patient-surveys into service improvement plans. This study therefore, assessed satisfaction and utilization of health-care services by enrolees of a Nigerian tertiary hospital. This was a cross-sectional

study of 399 respondents randomly selected from enrollees attending the NHIS-clinic of Aminu Kano Teaching Hospital, Kano. Using an interviewer administered questionnaire, it assessed their socio-demographics, medical history, number of and reason for clinic visits, satisfaction with- access to care, patient-provider relationships and hospital facilities/environment. Respondents' mean age was 38.3 ± 9.2 years and females accounted for 55.9% of respondents. Most respondents were satisfied with the ease of accessing care, waiting-time and hospital facilities/environment respectively. Most respondents were satisfied with their relationship with physicians, nurses, laboratory staff, pharmacists, record officers and other hospital-staff respectively. Overall, 80.5% of respondents were satisfied with the hospital's services. All respondents had visited the clinic at least once in the preceding 12-weeks. Although 49.1% visited for non-communicable diseases, more respondents who were for antenatal-care (followed by non-communicable and communicable diseases) had had ≥ 2 clinic visits. This study observed a high utilisation of and overall satisfaction with the hospital's services; however, there is a need for service improvement plans to address the challenges of patient access to care and waiting-time⁴⁸.

A study assessed patient satisfaction with services accessed under the National Health Insurance Scheme at a tertiary health facility in FCT Abuja, Nigeria. Evaluation of patients' satisfaction is increasingly gaining importance as one of the main tools for the assessment of the quality of healthcare delivery and its impact from the patients' perspective. A cross-sectional study was conducted among NHIS patients attending the General Outpatient Department at the National Hospital FCT Abuja, Nigeria between April and September 2017. Data was collected from 388 patients selected by systematic

random sampling; using pretested, anonymous, self-administered, structured questionnaires, with each satisfaction area scored on a five-point Likert scale ordinal response. Evaluation was done from the typical complaints received from NHIS enrolees such as: hospital reception and patient registration process, waiting time, doctors' consultations, laboratory services, availability of prescribed drugs and hospital facilities. Data analysis was done using IBM SPSS Statistics 20.0. The overall average satisfaction score was 58.1%. The satisfaction score with various aspects of services were: doctors' consultation (69.9%), laboratory services (66.5%), hospital facilities (62.2%), hospital services (60.4%), reception/registration (59.8%), waiting time (59%) and prescribed drugs (54.2%). The patient's overall satisfaction was good. However, unavailability of prescribed drugs, long registration processes and waiting time were found to be the major causes of dissatisfaction. Therefore, concerted efforts should be directed by all stakeholders towards the areas of patient⁹⁹.

A study examined enrolees' knowledge about the National Health Insurance Scheme (NHIS) and satisfaction with health services provided under the scheme. Social health insurance scheme provides a platform for mobilising revenue for health and enhances universal health-care coverage. In addition, knowledge about patients' satisfaction with health care under the scheme will help in identifying gaps and provides evidence toward strengthening the scheme. The study was a descriptive cross-sectional survey conducted among the NHIS enrolees accessing health-care services in the University College Hospital, Ibadan. A total of 373 individuals were consecutively recruited for the study, and a semi-structured, pretested interviewer-administered questionnaire was used to obtain information from respondents. Descriptive statistics was used to present results,

and Chi-square test was used to test for the association between categorical variables. The level of significance was set at $P < 0.05$. The mean age was 42.5 ± 10.0 years. Of the respondents, 209 (56.0%) were male and 359 (96.2%) were married. About two-thirds, 227 (60.9%), had good knowledge about the NHIS. Majority of the respondents 303 (81.2%) reported paying for some of the costs of service (drugs, laboratory tests, consultation fees, and X-ray) through out-of-pocket and of these, 218 (71.9%) reported that such payments were occasional. Overall, slightly more than half, 197 (52.8%), of the respondents were satisfied with service delivery under the scheme. Female respondents were significantly more satisfied with health-care services ($\chi^2 = 3.894, P = 0.048$). There was good knowledge of NHIS, but the level of satisfaction with service delivery was not outstandingly appreciable. There is an urgent need to improve on all areas of quality of service to improve satisfaction with care among enrollees in the scheme¹⁰⁰.

A study investigated how patient satisfaction is impacted by NHIS service in a teaching hospital in Nigeria. Healthcare delivery in the present day involves not just treating the patient but also paying attention to the overall satisfaction the patient derives while obtaining the service. This has made satisfaction in healthcare services a top priority for both healthcare professionals and patients. However, the costs of healthcare services continue to be key sources of hardship for many households, hence the introduction of the National Health Insurance Scheme (NHIS) service in Nigeria to lessen the financial burden of accessing healthcare. The population consists of all enrollees of NHIS at the University of Benin Teaching Hospital (UBTH). Copies of the questionnaire used for the study were administered to NHIS enrollees seeking medical care in three

departments of the hospital, namely: General out-patient, Maternity, and Dental. Out of the 200 questionnaires administered, 182 (General out-patient department – 79, Maternity department – 52, and Dental – 51) were found usable. To access the patients in the aforementioned departments of UBTH, convenience sampling, a form of non-probability sampling method, was applied. The method was chosen because it allows for simple access to and contact with target respondents. Multiple regression analysis was used to establish the statistical significance and relationship between patient satisfaction and NHIS services, such as accessibility, empathy, reliability, tangibility, responsiveness, and waiting time. The study found that accessibility, reliability, and waiting time have a significant impact on patient satisfaction with NHIS services. The study recommends that a more efficient and sustainable model should be designed and implemented in hospitals to minimise waiting time by engaging more health professionals and experts, as well as re-engineering the existing patient flow should be incorporated into the model. The study concludes that empirically investigating the quality of NHIS services and patient satisfaction in healthcare is important in several ways. First, it increases our understanding of service quality and patient satisfaction in particular, as well as service marketing in general, thereby laying the groundwork for future research. Secondly, the management of healthcare organisations will be able to spot any unsatisfactory service elements, which will serve as the basis for designing effective strategies to raise service quality in the healthcare industry¹⁰¹.

A study investigated health insurance in private and public health facilities in Southwestern Nigeria and what determines clients' satisfaction with quality of service. Insured-persons have complained about poor quality of services rendered by health care

providers, which has consequently affected their satisfaction with care received. The objectives of this study aimed to identify the determinants of satisfaction and compare the level of clients' satisfaction with quality of care received in both public and private health care facilities, in Oyo-State, Nigeria. This was a cross sectional study, comparative in design. A total number of 300 clients were recruited from selected public and private health facilities in Oyo-state, using a multistage sampling technique. Data were analysed using IBM SPSS version 24, and the level of significance was set at $p\text{-value} < 0.05$. The mean age of the respondents in private and public health facilities was 39.9 ± 10.0 years and 42.4 ± 10.1 years respectively. About 74% and 41.3% of the enrolees in the public and private health facilities respectively were dissatisfied with waiting time before receiving care with a statically significant difference of $p=0.002$. Majority of the respondents (82.7%) in the public health facilities and only 42.7% of those using private health care facilities were satisfied with the quality of drugs given to them at their respective pharmacies. This finding was statistically significantly different with $p=0.001$. Overall level of satisfaction with quality of care was 60% and 40% among enrolees using public and private health facilities respectively. There was a statistically significance difference ($p=0.028$) between the overall level of satisfaction and the type of health facility used by the clients. The determinants of clients' satisfaction with quality of care in both private and public health facilities in this study were mainly socio-demographic characteristics; age ($p=0.007$), level of education ($p=0.046$) and occupation ($p=0.004$), the waiting time experience and the type of facility where services were accessed. Clients attending public health facilities were more satisfied with care received under NHIS, compared with those using private health

facilities. Efforts should be made to reduce waiting time and improve quality of drugs in the public and private facilities respectively¹⁰².

A study assessed and compared clients' satisfaction between National Health Insurance Scheme (NHIS) insured and un-insured patients attending Aminu Kano Teaching Hospital. Periodic patients' satisfaction surveys provide feedback to hospital management and staff regarding the quality of services rendered. A cross-sectional design, using a mixed method of data collection was used to assess the levels of satisfaction of 149 NHIS-insured and 150 un-insured patients selected by systematic sampling. Using structured interviewer-administered questionnaires and focused group discussions (FGD), patient satisfaction was assessed and analysed using SPSS statistical software, with p-value set at 0.05. The two study arms were not statistically different in all the socio-demographic characteristics assessed ($P > 0.05$). Eight aspects of care were significantly different between the two study groups at bi-variate level. However, on multivariable logistic regression, only two factors remained independent predictors of difference between the two groups: 'overall time spent in the hospital' (aOR; 95% CI: 0.41; 0.23, 0.69) and 'satisfaction with last visit out of pocket expenditure' (aOR; 95% CI: 0.40; 0.21, 0.83). 'Duration of NHIS registration', 'time taken to hospital' and 'last visit out of pocket expenditure' were found to be determinants of satisfaction. The FGDs revealed improvements in services upon getting insured, with the main areas of dissatisfaction being; waiting time, appointment intervals, missing laboratory results and costs. Patients generally expressed high levels of satisfaction with the different aspects of care provided in the hospital, with the insured patients having higher levels of

satisfaction in nearly all domains. Improved NHIS coverage could markedly improve patients' access and satisfaction with services¹⁰³.

A study sought to assess client satisfaction with healthcare delivery under the National Health Insurance Scheme (NHIS) at a tertiary facility in Ghana. Client satisfaction is the direct effect of service delivery and, in essence, the basis for quality improvement in any industry. In health financing, it is a significant determinant of clients' enrolment in an insurance scheme. A cross-sectional study was conducted among patients attending the outpatient department of the Komfo Anokye Teaching Hospital. Data were collected using structured questionnaires. Questionnaires were administered to 300 purposively selected patients, stratified based on their insurance status. Data obtained were then analysed using mean score ranking and an independent sample t-test. Results. The client satisfaction variable with a high level of satisfaction was observed for physical environment. The least rated construct was responsiveness. A statistically significant difference in the means between the insured and uninsured was observed for two of the five constructs, namely, communication and service availability. This study advocates for prioritization of measures and policy initiatives aimed at improving responsiveness in healthcare delivery, as the least rated construct. It further draws health providers' attention to modesty in communication regardless of socioeconomic or insurance status¹⁰⁴.

A study assessed client's satisfaction with National Health Insurance Scheme service delivery system in Nigeria. National Health Insurance Scheme (NHIS) provides a platform for mobilising revenue for health and enhances universal health care coverage. In addition, knowledge about clients' satisfaction with health care under the scheme will

help in identifying gaps and provide evidence toward strengthening the scheme in achieving effective and efficient service delivery. This paper aims at assessing the level of enrollee satisfaction with service delivery under NHIS in Nigeria. To achieve this objective, the researcher adopted content analysis as its methodology. Using the system theory, the study concludes that the level of enrollee satisfaction with the scheme is low. The study recommends that there is a need to improve in all the areas in terms of quality of service so as to have a high level of satisfaction with care among enrollees. Also, the NHIS in Nigeria needs to strengthen its regulatory role by ensuring that HMOs comply fully with the operational guidelines and that HMOs in turn intensify their oversight and quality assurance responsibilities for health care providers¹⁰⁵.

A study examined the administration of National Health Insurance Scheme (NHIS) using public administration, Obafemi Awolowo University Health Centre (OAUHC) as a case study. The study identified various objectives of NHIS, effects of NHIS on the provision of health care services, implementation strategies for NHIS at the health centre as well as challenges confronting the scheme. The study utilised primary and secondary data. Primary data were sourced through set of validated questionnaires which were administered on NHIS clients (students and staff members) together with health workers and oral interview for Doctors and NHIS official in Obafemi Awolowo University Health Centre (OAUHC). The secondary source of data included published materials. Charts, frequency tables, percentages, Chi-Square, ANOVA and T-Test Analysis were used with the aid of Statistical Packages for Social Science (SPSS). The result showed that NHIS controls and reduces the cost burden of healthcare services (78.7%), NHIS reduces extortion by private health service providers (67%), NHIS

provide reliable and affordable health care delivery at the OAU health centre (77%), NHIS cut across all levels of healthcare whether preventive, curative and consultative (70%) and NHIS will, and has, reduced extortion by private healthcare service providers on the citizenry (67.4%) are various effects of NHIS in Obafemi Awolowo University Health Centre. The findings also revealed that 70.6%, 71.9%, 78.7%, 83.7% and 73.3% of the respondents agreed that funding of the scheme, scheme not made compulsory by Federal Government, Health centre not fully equipped, lack of adequate personnel and lack of adequate publicity among students and staff of OAU are challenges facing the proper implementation of NHIS in OAUHC respectively. The study concluded that introduction of NHIS has ensured equitable distribution of effective healthcare among different income groups¹⁰⁶.

2.4 Conceptual Framework

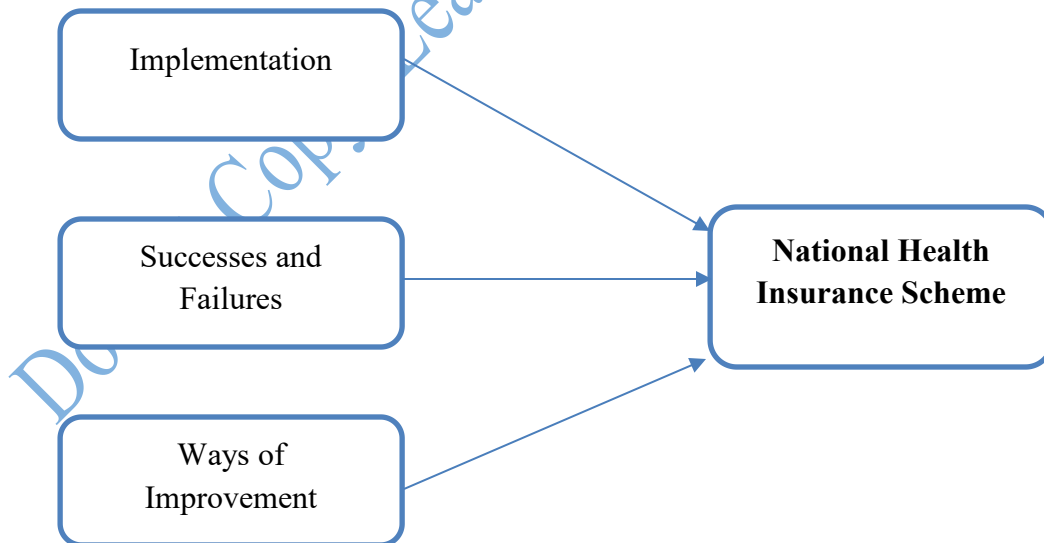


Figure 2.1: Assessment of National Health Insurance Scheme in Taraba State

Source: Researcher's Fieldwork 2022

2.5 Summary of Gap in Literature Reviewed

This chapter comprises of existing literature which are similar to the present research work. As outlined in the review of empirical studies, this research has shown that several authors have studied and addressed the financial performance of listed insurance companies in Nigeria generally. For example, different studies have been carried out to assess perception and participation, factors, design, satisfaction, formulation and implementation challenges of National Health Insurance Scheme in Nigeria^{51,75}. Also, various studies such as; performance and challenges of the National Health Insurance Scheme (NHIS) in Nigeria; NHIS-HMO enrollees' assessment of quality of illness treatment during visit to selected hospitals in South-West, Nigeria were reviewed. Similarly, studies that carried out systematic review of patient satisfaction with the Nigerian National Health Insurance Scheme, assessment of the impact of the National Health Insurance Scheme (NHIS) on employee productivity, perception and participation of federal civil servants to National Health Insurance Scheme, experiences in accessing National Health Insurance Services in Nigeria, feasibility analysis of integrating community-based health insurance schemes into the national health insurance scheme, the design and implementation challenges of the National Health Insurance Scheme in Nigeria, factors affecting utilisation of the National Health Insurance Scheme by Federal Civil Servants, awareness of National Health Insurance Scheme activities and service utilization among enrolled employees in government institutions in Nigeria, were all reviewed.

These studies are similar to the present study but this study tend to also focus on the successes and failures of National Health Insurance Scheme and improvement of the

programme, particularly in Taraba state. Furthermore, a study carried out on National Health Insurance Scheme (NHIS) enrollees' satisfaction with the medical care provided in Tertiary Hospital in North Central Nigeria determined the enrollees' satisfaction with NHIS services, service quality and clients' dissatisfaction of National Health Insurance Scheme, it also assessed the patient and operational factors associated with satisfaction⁹⁰. This study, therefore, tend to fill the gap of case study by using specifically Taraba State from the North Central States.

The study adopts systematic investigation process and empirical data to fill the gap of methodology which is not used in other previous studies.

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Chapter Three

Methodology

Before collecting data for a study, a plan should be established and documented that explains exactly how the data will be obtained; Unforeseen complications are not unusual, so often a pilot study (or a practice run) is conducted before the real data collection takes place, to see if the planned procedure is practical and optimal. This plan is a draft protocol (a procedure documenting the details of the design and implementation of studies, and for data collection).

A pilot study allows the researcher to:

- Determine the feasibility of the data collection protocol.
- Identify unforeseen challenges.
- Obtain data that might help with sample size calculations.
- Potentially save time and money.

3.1 Research Design

The study adopted both qualitative and quantitative research design using a systematic investigation process and empirical data on the subject of study. The research centred on assessment of NHIS in Taraba State with the aim of investigating its coverage in Taraba State as well as its impact. The study adopted the use of questionnaire for data collection. The responses contributed to the result and conclusions that were reached.

3.2 Population of the Study

Taraba State is located in the North East Geo-Political Zone of Nigeria and its capital town is Jalingo. The State was created out of the former Gongola State on 27th August 1991. It derives its name from the Taraba River. Taraba State is bounded in the West by Plateau State and Benue states and on the eastern border by the Republic of Cameroon. The State has sixteen local governments, which include Ardo Kola, Bali, Donga, Gashaka, Gassol, Ibi, Jalinga, Karim Lamido, Kurmi, Lau, Sardauna, Takum, Ussa, Wukari, Yoro, Zing and as well as two Special Development Areas – Yangtu and Ngada. From the final result of the 1991 population census, Taraba State is populated by 1,946,156 people (1999 projected). With an estimated land area of about 61,368.8sq. km., the state has a population density of 24.6 persons/sq. km. Diverse ethnic groups are found in Taraba State and they speak varied languages. Some of these are Jenjo, Jibu, Jukun, Kuteb, Kaka, Karinjo, Kona, Lo, Mambilla, Mumuye, Ndola, Panso, Tigun, Tiv and Yandang.

The target population for this study is limited to public servants in Taraba State who are beneficiaries of the NHIS. In order to access reliable and balanced data, the respondents include military and para-military personnel on the scheme as well as health workers who are on the scheme. This afforded an expansive view of the scheme's coverage in the State.

3.3 Sample and Sampling Technique

The purposive sampling which is a probability sampling method was utilised in the selection of respondents. The copies of questionnaire were distributed among the adult

population of both sexes employed in public service with locations in Taraba State as their stations. Consideration was given to respondents in the employment of the federal Government of Nigeria as its establishments were pilot areas in the scheme's implementation which many states of the federation are keying into.

In the coverage of the state, the three senatorial zones were represented each with a local government within the zone. Jalingo, Gashaka and Wukari Local Governments represented the Northern, Central and Southern Zones respectively. Jalingo, being the State capital hosts the state offices of many federal establishments thus it is an ideal location for sampling. A military barracks is located within Gashaka Local Government as well as other MDA's of the Federal Government. Wukari hosts at least two Federal Institutions (Federal University and Nigerian Correctional Services) apart from the Police and Nigeria Security and Civil Defence Corps (NSCDC). A total of 150 people were purposefully and randomly selected to meet with the criteria of the study sample. Also, a total number of 150 copies of questionnaire was distributed across the three Local Governments.

One key to obtaining accurate estimates about the population is to ensure that the sample studied is representative of the population of interest (that is, to ensure the study is externally valid).

The study made use of multiple formats of questionnaire consisting of fifteen (15) open-ended and closed-ended questions. These were used to get samples of data on NHIS benefits, acceptance and coverage in Taraba State. These were made up of one hundred and fifty questionnaires distributed across profession, age and educational attainment of

respondents residing in Taraba State. This afforded the varied sampling of information obtained from the participants. Out of these, 130 were returned and analysed.

3.4 Description of Research Instrument

In order to enhance proper and adequate collection of information, random sampling technique was used in the course of this study. Various beneficiaries of NHIS from different sectors of the public, military and para-military were randomly picked.

Two (2) principal techniques; observation and surveys were used in accessing relevant data of the subject of the study. These techniques consisted of 150 copies of questionnaire that were distributed to evaluate participant's knowledge, perceptions and suggestions. These questionnaires were distributed to various categories of people and after completion, collected and collated.

The research instrument used was a well modified structured four-point likert questionnaire composed of four sections – “A” “B” “C” and “D”; consisting of the demographic variables of respondents, respondents' knowledge and views about National Health Insurance Scheme in Taraba state, respondents' views on the performance of NHIS in Taraba state, and respondents were requested to suggest ways of improving and sustaining the scheme in Taraba state. Data was collected using the administered questionnaire and observation. Nonetheless, 8 persons were recruited and subsequently trained as research assistants to facilitate this process.

Respondents selected questions by simply ticking or writing comments where necessary. The researcher also applied the knowledge gathered from observation and participation in the operation of the scheme in Taraba state.

3.5 Validity of Research Instrument

The instruments used in the study area are standard research instruments and procedures. Questionnaires are universally valid testing instruments in research. These were fully utilised.

3.6 Reliability of Research Instrument

The information gathered were reliable as the questionnaires were designed in a simple form that was understandable by average literate persons who could read and write. The questions were clear and void of ambiguities. The responses were therefore based on clear understanding of the questions.

The methods of data analysis included quantitative and qualitative approaches. The data was collated and classified by a simple sorting process. The results are presented in simple cross-tabulation. The tables indicate the percentage of responses based on the number of respondents' answers on each question. The percentage of frequency of answers guides the results of the closed-ended questions. The open-ended questions were analysed based on qualitative analysis of the respondents' views. A content analysis of responses or comments identified the popular views of the participants on the subject under review.

3.7 Administration of Research Instrument and Methods of Data Collection

The principal techniques used accessed relevant data of the subject of the study. These techniques consist of 150 questionnaires which were distributed to evaluate participants' knowledge, perception and suggestions. The questionnaires were distributed to respondents in the three Local Governments viz: Jalingo, Gashaka and Wukari. These were subsequently collected after they were filled by the respondents, collated and analysed.

3.8 Method of Data Analysis

The methods of data analysis included quantitative and qualitative approaches. The data was collated and classified by simple sorting process. The results are presented in simple cross tabulation. The tables indicate the percentage of responses based on the number of respondents' answers on each question. The percentage of the frequency of answers guides the results of the close-ended questions. The open-ended questions were analysed based on qualitative analysis of the respondents' views.

Endnote

OnlineNigeria.com. *People, Population and Settlement*. 2014.

Do Not Copy, Lead City University, Nigeria

Chapter Four

Results and Discussion of Findings

This chapter focuses on the research questions and answers to them through the data collected from the field. These include data gathered from questionnaires that were distributed to the employees on the NHIS scheme in Taraba state.

4.1 Demographic Data Analysis

Descriptive Statistics

Out of the 150 questionnaires administered to various respondents viz health workers, military (soldiers) and para-military (NSCDC) and public servants, 130 were returned.

Data analysed using tables, percentage and charts are presented below.

Table 4.1.1: Analysis of Respondents by Sex

Sex	Respondents	Percentage (%)
Male	70	53.8
Female	60	46.2
Total	130	100

Source: Field survey, 2021

From Table 4.1.1 above, the number of males that responded to the questions were 70, representing 53.8% while females were 60 in number, translating to 46.2%. In the sex of the respondents, a fair balance was achieved in terms of responses. Healthcare needs are common to both gender as participation in the scheme is equally beneficial to both. Though males are heads of families and have primary stake in the health of family members, females are the direct caregiver managers of the home. The competitive

percentage of the female respondents with that of the males is thus not unusual as seen in the table above.

Table 4.1.2: Analysis of Respondents by Age

Age	Respondents	Percentage (%)
25-34 Years	18	13.8
35-44 Years	24	18.5
45-54 Years	41	31.5
55 Years and above	47	36.2
Total	130	100

Source: Field survey, 2021

From Table 4.1.2 above, the age of the respondents varied widely. 18 respondents were between the ages of 24-34 years, representing 13.8%, 24 respondents fall within the age range of 35-44 years, representing 18.5%. 41 respondents are within the age range of 45-54, representing 31.5% while 47 respondents were 55 years and above, representing 36.2%. The higher percentages of respondents that are 45 years and above (31.5% and 36.2%) provides a basis for the perception of family persons (measured by advanced age) as most persons interested in the Scheme. The burden of care giving for families is more challenging than that of a single person whose healthcare bills will proportionately be less. Additionally, there is increase in the need for healthcare with advancing age thus the need to access better and affordable healthcare services by older persons.

Table 4.1.3: Analysis of Respondents by Marital Status

Marital Status	Respondents	Percentage (%)
Single	7	5.4
Married	102	78.4
Widowed	16	12.3
Divorced	5	3.9
Total	130	100

Source: Field survey, 2021

From the information in Table 4.1.3 above, 5.4% of the respondents are single while 78.4 are married. 12.3% are widowed and 3.9 are divorced. The high percentage of 78.4 of married persons indicates the interest in catering for the healthcare needs of families as compared to single persons. It therefore translates that family persons are tended towards providing quality healthcare at an affordable cost for themselves and members of their families.

Table 4.1.4: Analysis of Respondents by Qualification

Qualification Status	Respondents	Percentage (%)
MA/MSc/MPA	4	3.0
BSc/BA/HND	51	39.0
OND/NCE	76	58.0
Total	130	100

Source: Field survey, 2021

In Table 4.1.4 above, 3.0% of the respondents hold higher degrees (MA/MSc/MPA), 39% are holders of BSc/BA/HND while 58% are OND/NCE holders. The higher

percentages of the respondents are learned and thus understand the benefits of the programme. Expectedly, their responses are fairly informed. The basic educational qualifications for engagement in public service in Nigeria are accommodated in the bracket. This is ideal as the target population for the study is necessarily those in public service as it is the only platform upon which the NHIS enrollees can access it currently in Taraba State.

Table 4.1.5: Distribution of Respondents by Occupation

Occupation	Respondents	Percentage (%)
Public servants	60	46.15
Soldiers	25	19.23
Civil Defence	15	11.53
Health workers	40	30.76
Total	130	100

Source: Field survey, 2021

Table 4.1.5 above shows the distribution of respondents by occupation. 60 respondents were public servants representing 46.15%. 25 respondents were soldiers, representing 19.23%. 15 respondents were Civil Defence Corps representing 11.53%. 40 respondents were health workers representing 30.76% made up of Doctors, Nurses, Pharmacists, Laboratory Scientists and others. Currently, the National Health Insurance Scheme is limited to the public service and institutions of the Government of Nigeria. The responses are therefore appropriate. Health workers could be said to understand the advantages of insurance cover more than others considering their involvement in the process of operation. This correspondingly increases their enrolment on the NHIS.

4.2 Presentation of Research Questions

4.2.1 Research Question One: Assessment of the Implementation of the NHIS in Taraba State

Table 4.2.1.1: The Level of Awareness in Taraba State

Are you aware of the NHIS?	Respondents	Percentage (%)
Yes	90	69.2
No	40	30.8
Total	130	100

Source: Field survey, 2021

The Table above shows the disparity in the level of awareness of NHIS amongst respondents. 90 respondents are aware representing 69.23% while 40 are not aware representing 30.8%. The responses indicate that the awareness of National Health Insurance Scheme is high in Taraba State. The result indicates that much has been done in terms of publicity about the operation of the scheme through various information outlets. This is a key factor in determining the level of enrolment in the scheme by the target beneficiaries. The awareness of the scheme, its method of operation and the advantages to potential beneficiaries is necessary for the success.

The level of awareness also aids the survey because the respondents' awareness of the NHIS will determine further responses from them. This again increases the reliability level of the information gathered from the survey.

Table 4.2.1.2: Respondents Source of Information about NHIS in Taraba State

Source	Respondents	Percentage (%)
Radio	80	61.54
TV	10	07.69
Friends/Colleagues	25	19.23
Newspapers	15	11.54
Hospitals	5	03.85
Total	130	100

Source: Field, survey, 2021

From the Table above, 61.54% are aware of NHIS through the radio while 19.23% through information from friends, 11.54% through newspapers (especially health workers), 07.65% through TV advertorials and 03.85% from hospital bill boards.

From the statistics of the responses, radio draws a high percentage as the source through which respondents learned about the National Health Insurance Scheme. Indeed, radio is a common information source available to the common man and the cost of operation and maintenance is low and affordable by most people. Most often, batteries are the major components that operate radios and the person has access to varieties of stations as well as large flow of information in the location he/she is. Another factor is the extensive coverage of radio signal even to remote locations, placing the rural resident on the same advantage with those in urban areas most times. The choice of language is available to the owner of a radio set who does not require formal education to listen and understand what goes on.

This is quite in contrast with Television where the cost of acquiring a set alone is daunting for the economically disadvantaged persons. Operating a TV also requires a higher financial input in terms of paying electricity bills or maintaining a generating set. In any case, the owner of a TV set is limited by either the erratic power supply pattern or few hours provided by the fuel in the generating set which in any case will not run most of the day. The hours of operation of the TV stations as in the case of Taraba State is limited to six or seven hours and only two of such local stations are in operation. The signal of the two TV stations is also limited in terms of coverage thus available to a limited number of the population resident in and around the capital or towns in which functional booster stations are located. Other alternative stations available to the TV owner on satellite may need to be paid for through monthly subscription, increasing the operational cost of the gadget. Ultimately, one requires to be at a particular location at a given time to be able to get information from a news broadcast or other programmes, whereas on radio, one could be on transit or involved in other activities and listening at the same time. These are likely factors that limit the choice of TV as source of information about NHIS.

The low response in newspapers as source of information could be adduced to the financial implication of accessing information through this source as well as literacy requirement. Many persons who cannot read will certainly not opt for newspapers as source of information. Another factor is the limited locations where such newspapers will reach around the State.

The low percentage of respondents who answered hospitals as source of information on NHIS could be analysed in a number of ways. First, hospitals may consider themselves

as agents' operation rather than of publicity about the scheme. Thus, patients requiring services are given such but little or no efforts is made at informing them about NHIS. Secondly, in the current State of NHIS operation in the State where it is only limited to persons in the public service, availing the information to others who are not going to be beneficiaries at that time may be of no use. It thus means that a beneficiary who is already an enrollee is informed of NHIS through other sources before getting to the hospital for NHIS related services.

Table 4.2.1.3: Respondents Who are Participating in the NHIS

Are you participating in the NHIS?	Respondents	Percentage (%)
Yes	40	30.7
No	90	69.3
Total	130	100

Source: Field survey, 2021

In the Table above, only 30.7% of respondents are currently participating in the National Health Insurance Scheme while 69.3% are not participating. The large percentage of non-participation in the NHIS points to the fact that the low participation is not due to lack of information but other factors. Earlier responses have indicated a large percentage of awareness about the NHIS in Taraba State. This relatively low response with regards to enrolment in the scheme could thus be interpreted to be an issue of choice based on wide ranges of perception of individuals in the population surveyed.

Table 4.2.1.4: Respondents Duration on the NHIS

How long have you been on the NHIS?	Respondents	Percentage (%)
1-3 Years	95	73.08
4-6 years	30	23.0
6 years and above	5	03.85
Total	130	100

Source: Field survey, 2021

The above Table indicates that 73.08% of the respondents have been on the NHIS for at least three years, 23.0% for at least 6 years while 03.85% have been on the scheme for over 6 years. The low percentage in response of those who have participated in the NHIS since its commencement indicates that Taraba State, as is the case in many others did not record early participation in the programme in its early years. However, a rise in the percentage is noticeable in the later period. That is the likely time range that the impact of the NHIS started to be felt in Taraba State. The recent years (1-3 years) reflects 73.08% indicating an increase of participants in the recent years. This could be as a result of increased awareness on one hand and improved service delivery compared to the period of inception.

Table 4.2.1.5: Benefit of the NHIS Scheme to Respondents

As an enrollee, how have you benefited from the Scheme?	Respondents	Percentage (%)
Reduced cost of treatment	41	31.6
Improved medical care	25	19.2
All of the above	22	16.9
None of the above	42	32.3
Total	130	100

Source: Field survey, 2021

Table above shows the benefits of NHIS to the respondents. 41 respondents answered reduced cost of treatment, representing 31.6% while 25 respondents answered improved medical care representing 19.2%. 22 respondents answered both improved medical care and reduced cost of treatment, representing 16.9%. 42 respondents however answered none of the above, representing 32.3%. The responses indicate a fairly balanced benefit history to the enrollees who attested to reduced cost of treatment as well as improved medical care. A third of the respondents have not benefited in the NHIS either way.

4.2.2 Research Question Two: Successes and Failures of the NHIS in Taraba State

Table 4.2.2.1: Respondents' Assessment of NHIS Services in Taraba State

What is your assessment of NHIS in Taraba State?	Respondents	Percentage (%)
Poor	100	76.92
Fair	25	19.23
Good	5	3.85
Very Good	-	-
Total	130	100

Source: Field survey, 2021

Table above indicates that 100 of the respondents representing 76.92% rated the NHIS in Taraba State as poor while 25 respondents representing 19.23% rated it as fair. 5 respondents, representing a meagre 3.85% rated the scheme as good. The low rating given by the high percentage of respondents is a direct interpretation of the impact of NHIS in Taraba State. Since most of the population of the State are yet to enrol and benefit from NHIS, the rating for its efficacy is unlikely to be high.

Table 4.2.2.2: Respondents' Views on NHIS Meeting its Objectives in Taraba State

Are the objectives of NHIS being met in Taraba State?	Respondents	Percentage (%)
Yes	15	11.54
No	90	69.23
Not sure	25	19.23
Total	130	100

Source: Field survey 2021

Table above shows that, 15 respondents, representing 11.54% believe the objectives of NHIS is being met in Taraba State while 90 respondents, representing 69.23% believe it is in the negative. 25 respondents, representing 19.23% are not sure. In the responses here, a higher percentage of the respondents opine that NHIS objectives are not being met in Taraba State. This again is a reflection of the low benefit level among the respondents. The percentage that responded positively are likely the few number that are currently on the scheme and have benefited from its operation.

Table 4.2.2.3: Respondents Views on Factors that Impede the Successful Operation of the Scheme in Taraba State

Factors militating against	Respondents	Percentage (%)
a. Inaccessibility to most parts of the State	20	15.38
b. Low standard of health facilities	4	3.08
c. Poor health facilities	4	3.08
d. Understaffing	10	7.69
e. Mismanagement and corruption	10	7.69
f. Feasibility of the scheme	10	7.69
g. Non/poor implementation of past government schemes	10	7.69
h. Source of funding	10	7.69
i. Institutional weakness	5	3.85
j. Religious/cultural beliefs	47	36.15
Total	130	100%

Source: Field survey, 2021

In Table above, the respondents' views about factors that impede the successful operation of the scheme shows a major pull towards religious/cultural beliefs (36.15%).

The respondents are of the view that the religious inclination of people or their culture is factors that hamper the success of the scheme in Taraba State. 15.38% of the respondents are of the view that inaccessibility to most parts of the State is the impeding factor. These are followed by understaffing, mismanagement and corruption, feasibility

of the scheme, non/poor implementation of past government schemes and source of funding ranging at 7%. Institutional weakness ranked 3.85% while low standard of health facilities and poor health facilities trailed at 3.08%.

4.2.3 Research Question Three: Ways of Meeting the Challenges and Improve the Scheme Efficacy in Taraba State

Table 4.2.3.1 Meeting Challenges and Improve the Efficacy of NHIS

Meeting the challenges and improve the Efficacy of the scheme	Respondents	Percentage (%)
a. Full participation of all relevant sectors	10	7.69
b. Equip and upgrade health facilities	14	10.77
c. Creation of access roads to rural areas	9	6.93
d. Enlightenment programs in various languages	20	15.38
e. Increase in the number of family members to enrol	10	7.69
f. Proper institutional framework	10	7.69
g. Maintaining high standard and professionalism	10	7.69
h. Fight against corruption and mismanagement	47	36.15
Total	130	100%

Source: Field survey, 2021

In the table above, the various suggestions on how to face the challenges and improve the efficacy of the scheme show that to fight against corruption and mismanagement

comes first with 47 respondents (36.15%) and enlightenment programs in various languages rating next (15.38%). The respondents are of the view that the level of corruption is very high within the system of the scheme and also that the people are not well enlightened.

4.3 Presentation of Data Analysis

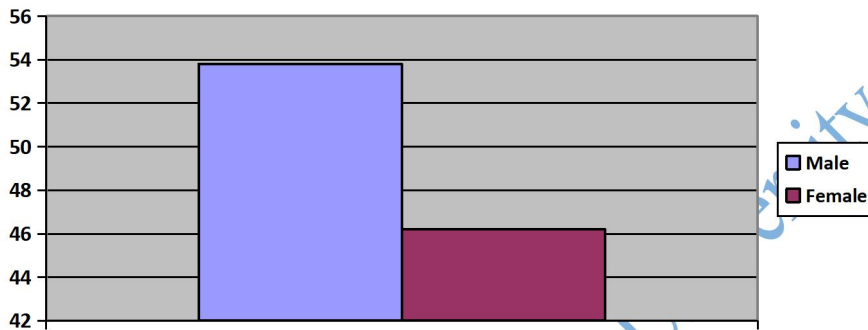


Fig. 4.3.1 Researcher's Fieldwork 2022

The corresponding values on the X axis indicates the percentage of response with regards to sex of respondents. The male respondents constitute 53.8% in the total number that participated in the survey while the female constitute 46.2%.

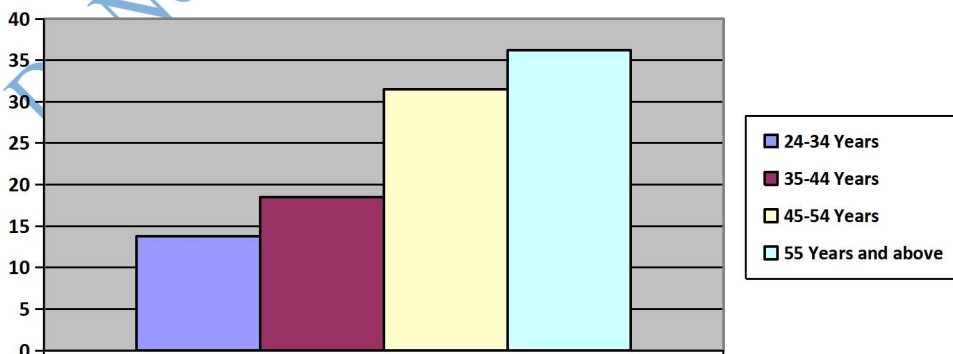


Fig. 4.3.2 Researcher's Fieldwork 2022

The corresponding values on the X axis indicates the percentage of response with regards to the age of respondents. The respondents aged between 25-34 years constitute 13.8% in the total number that participated in the survey while those aged between 35-44 years constitute 18.5%. Respondents aged between 45-54 years constitute 31.5% while those 55 years and above are 36.2%.

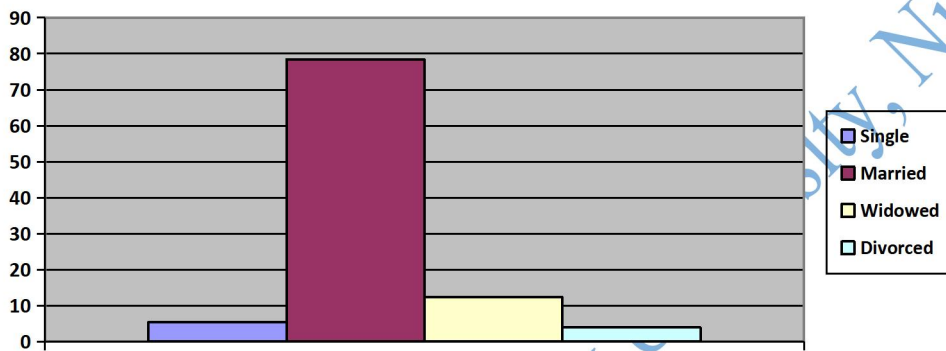


Fig. 4.3.3 Researcher's Fieldwork 2022

The corresponding values on the X axis indicates the percentage of response with regards to the marital status of the respondents. The respondents that are single constitute 5.4% in the total number that participated in the survey while those who are married represent 78.4%. Respondents who are widowed constitute 12.3% while those divorced are 3.9%.

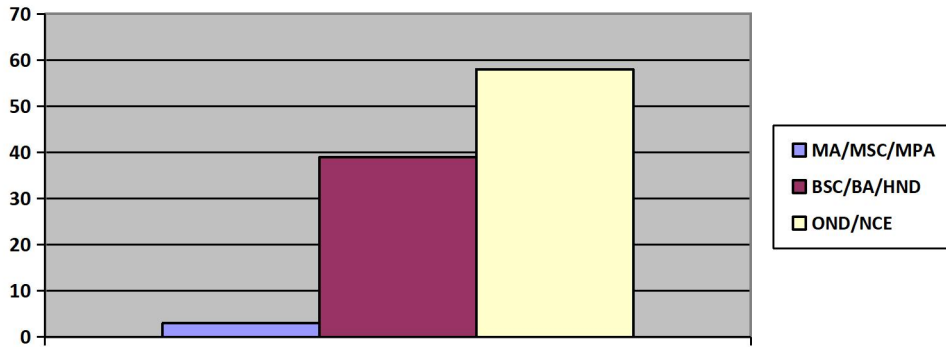


Fig. 4.3.4 Researcher's Fieldwork 2022

The corresponding values on the X axis indicates the percentage of response with regards to the qualification of the respondents. The respondents that hold MA/MS/MPA degrees constitute 3.0% in the total number of survey participants while those who hold BSC/BA/HND certificates constitute 39.0%. Those whose level of education fall in the range of OND/NCE make up 58.0%.

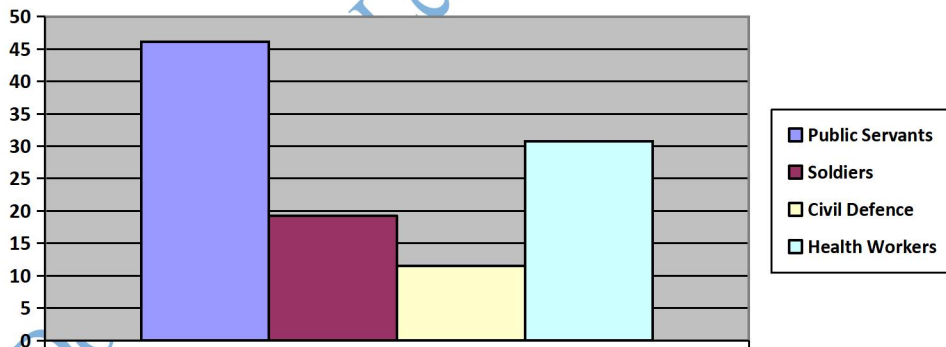


Fig. 4.3.5 Researcher's Fieldwork 2022

In the chart above, the corresponding values on the X axis indicates the percentage of the respondents by occupation. The respondents that are Public Servants make up 46.15% in the total number of survey participants while Soldiers constitute 19.23%.

Members of the Civil Defence Corps were 11.53% while Health workers comprise 30.76%.

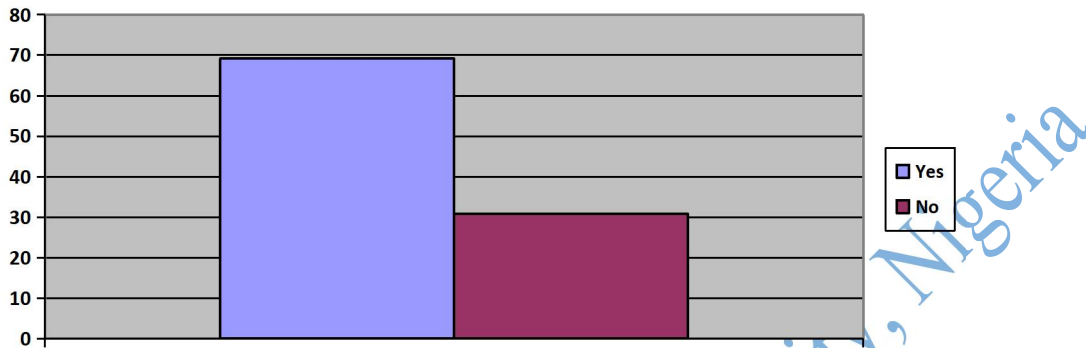


Fig. 4.3.6 Researcher's Fieldwork 2022

In the chart above, the corresponding values on the X axis indicates the percentage of the respondents' awareness of the NHIS. The respondents that are aware represent 69.2 % while those not aware are 30.8%. This indicates that the level of awareness is high even if the participation level is low. Other factors are thus responsible for low enrolment rather than lack of awareness.

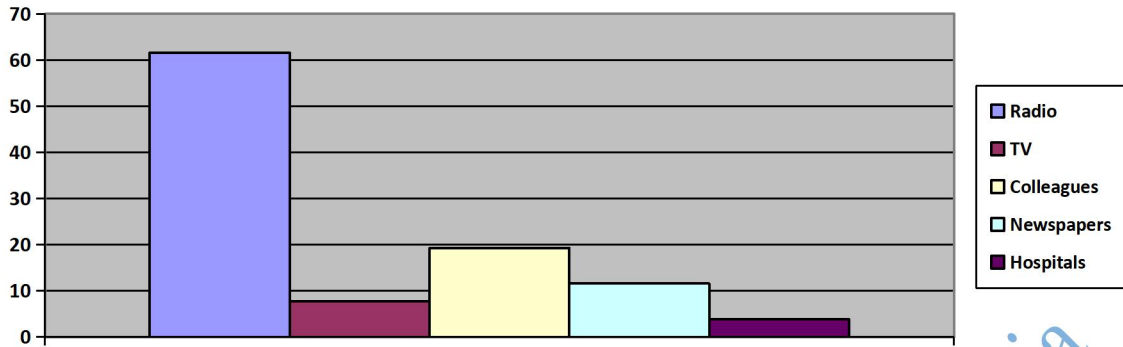


Fig. 4.3.7 Researcher's Fieldwork 2022

In the chart above, the corresponding values on the X axis indicates the percentage of the respondents by the source of their awareness of the NHIS scheme. The respondents that got information via radio form 61.54%, TV 7.69%, colleagues 19.23%, Newspapers 11.54% while hospitals 3.85%. Radio seems to be accessible to a greater part of the population by virtue of the responses. It could thus be a viable media outlet for dissemination of information and constant orientation for enrollees and prospective enrollees in the NHIS.

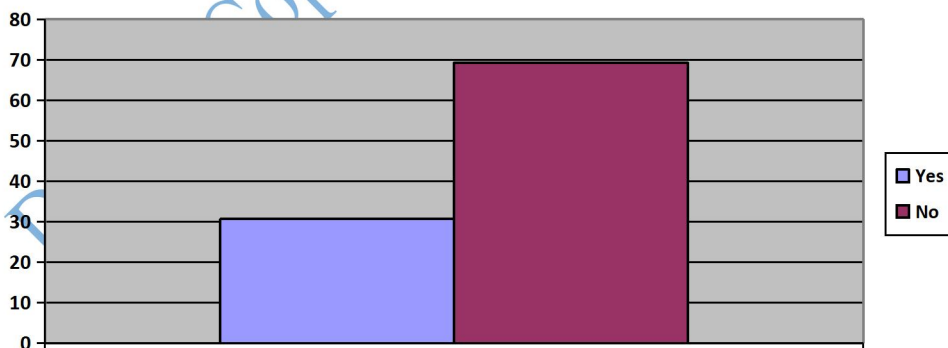


Fig. 4.3.8 Researcher's Fieldwork 2022

In the chart above, the corresponding values on the X axis indicates the percentage of the respondents who are participating in the Scheme. 30.7% of respondents are currently participating in the National Health Insurance Scheme while 69.3% are not participating.

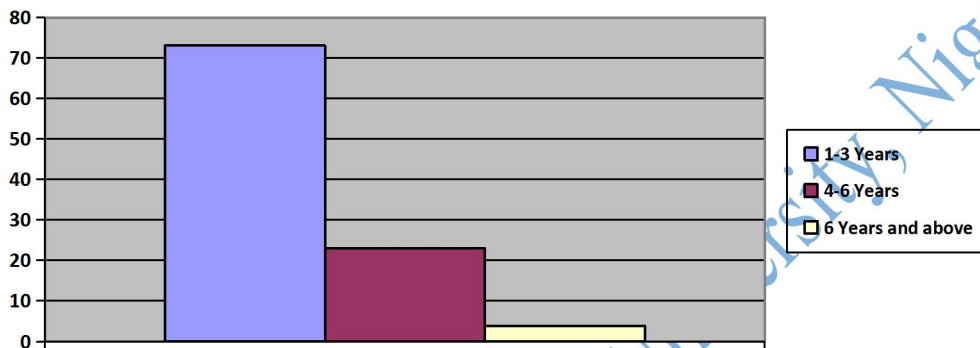


Fig. 4.3.9 Researcher's Fieldwork 2022

The above chart indicates that 73.08% of the respondents have been on the NHIS for at least three years, 23.0% for at least 6 years while 03.85% have been on the scheme for over 6 years. The low percentage in response of those who have participated in the NHIS since its commencement indicates that Taraba State, as is the case in many others did not record early participation in the programme in its early years. However, a rise in the percentage is noticeable in the later period. That is the likely time range that the impact of the NHIS started to be felt in Taraba State. The recent years (1-3 years) reflects 73.08% indicating an increase of participants in the recent years. This could be as a result of increased awareness on one hand and improved service delivery compared to the period of inception.

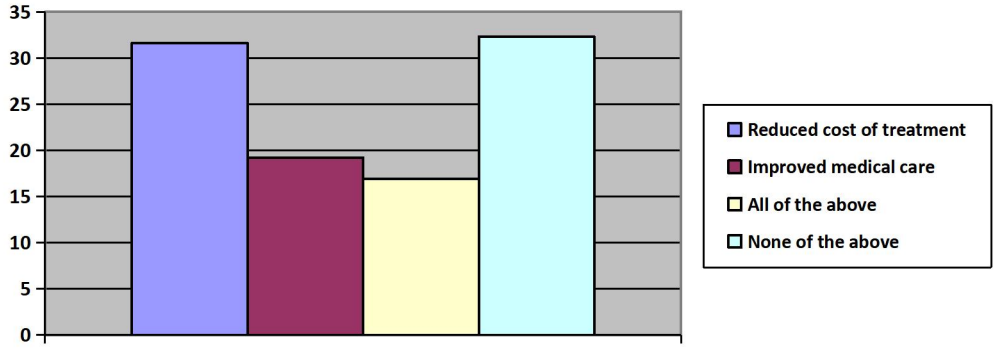


Fig. 4.3.10 Researcher’s Fieldwork 2022

The chart above shows the corresponding X axis, the benefits of NHIS to the respondents. 41 respondents answered reduced cost of treatment, representing 31.6% while 25 respondents answered improved medical care representing 19.2%. 22 respondents answered both improved medical care and reduced cost of treatment, representing 16.9%. 42 respondents however answered none of the above, representing 32.3%.

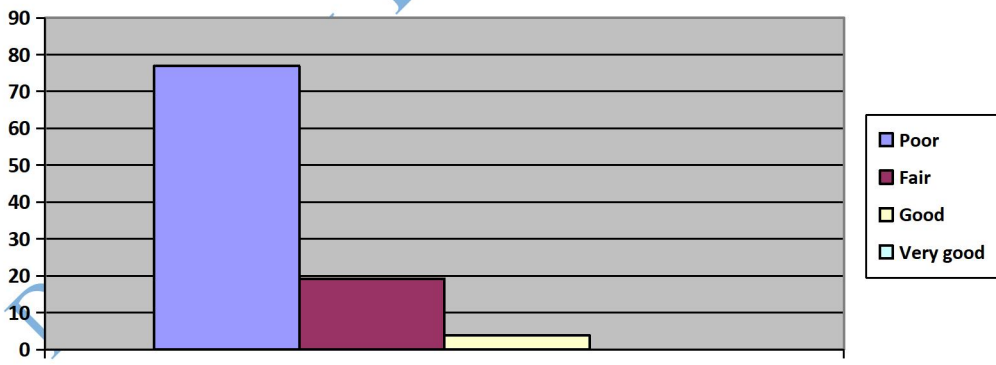


Fig. 4.3.11 Researcher’s Fieldwork 2022

In the chart above, the corresponding X axis indicates that 76.92% rated the NHIS in Taraba State as poor while 19.23% rated it as fair. 3.85% rated the scheme as good. The

low rating given by the high percentage of respondents is a direct interpretation of the impact of NHIS in Taraba State. Since most of the population of the State are yet to enrol and benefit from NHIS, the rating for its efficacy is unlikely to be high.

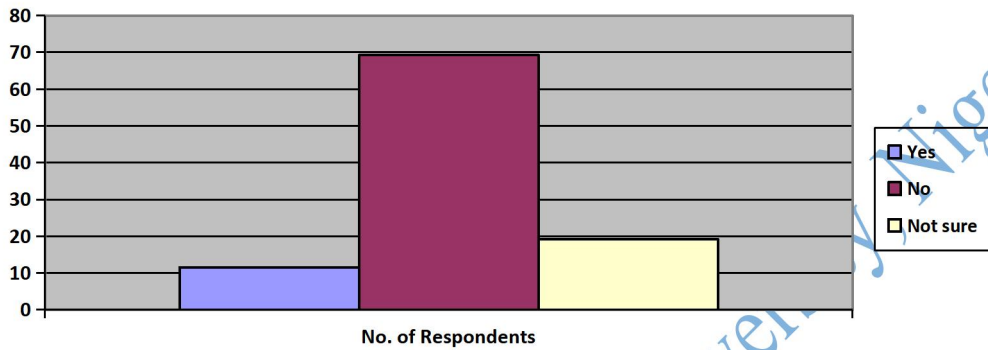


Fig. 4.3.12 Researcher's Fieldwork 2022

The chart above shows that, 15 respondents, representing 11.54% believe the objectives of NHIS is being met in Taraba State while 90 respondents, representing 69.23% believe it is in the negative. 25 respondents, representing 19.23% are not sure. In the responses here, a higher percentage of the respondents opine that NHIS objectives are not being met in Taraba State. This again is evidence of the low benefit level among the respondents. The percentage that responded positively are likely the few number that are currently on the scheme and have benefited from its operation.

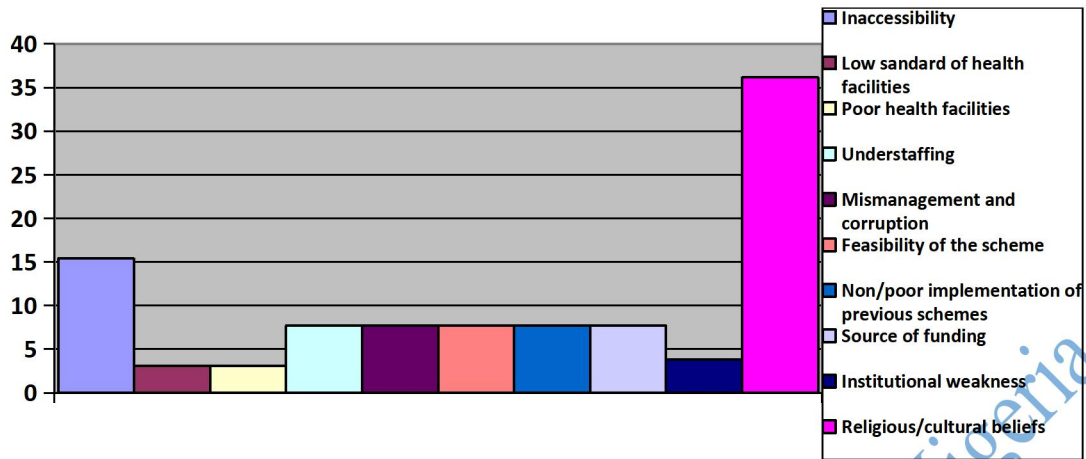


Fig. 4.3.13 Researcher's Fieldwork 2022

In the chart above, the respondents' views about factors that impede the successful operation of the scheme shows a major pull towards religious/cultural beliefs (36.15%). The respondents are of the view that the religious inclination of people or their culture is factors that hamper the success of the scheme in Taraba State. 15.38% of the respondents are of the view that inaccessibility to most parts of the State is the impeding factor. These are followed by understaffing, mismanagement and corruption, feasibility of the scheme, non/poor implementation of past government schemes and source of funding ranging at 7%. Institutional weakness ranked 3.85% while low standard of health facilities and poor health facilities trailed at 3.08%.

4.4 Discussion of Findings

The importance of NHIS to Nigeria viz Taraba State cannot be over emphasised. During this study, to determine the factors militating against a successful NHIS in Taraba State, lack of adequate information about the scheme among people in most rural settings was identified as a major factor. Other threats such as inaccessibility to most parts of the

state, religious/cultural beliefs, poor facilities and corruption were also identified. It was also observed rightly that achieving the objectives of good health outcome, equity, patients and providers' satisfaction are very challenging¹. In Taraba State, the workability of the scheme is seriously daunted and constrained by the fact that the scheme requires that a man, one wife and four children only be registered. What about the polygamist with more than four children? What becomes of the local farmers with no access to health in rural settings?

After analysis, the study carried out in Taraba, some factors were found to be serious impediments to the success of the scheme in Taraba State²

- i. Religious and cultural beliefs: This factor inhibits the people from going along with government policies such as the NHIS. The limiting factor of the number of persons to be registered for the scheme works to the disadvantage of people with multiple wives and many children. They thus dismiss the idea of the scheme once they discover these limiting factors.
- ii. High level of illiteracy among the citizens: In the course of the study, it was observed that large sections of the population in Taraba State are not literate, especially in the rural areas. This factor limits perception and tends to restrict one to a linear line of thought making it difficult to accept new ideas.
- iii. Poor implementation of past government programmes: Antecedents often have effects on the current plans and policies. Participants in the scheme are not confident that this plan will sail through successfully, considering past experiences with similar programmes. This leads to reservations and lack of

commitment to the scheme with fears of losing out in terms of resources committed.

iv. Mismanagement and corruption in the health sector: The trend of corruption that is common in many sectors of the nation also exists in the health sector. Diversion of funds or outright embezzlement is a major setback for the likely success of the scheme.

v. Understaffing: Necessary staff to implement the scheme especially in the rural communities where majority of the citizens reside is a daunting task. There seems to always be shortage of health staff to man facilities. This is especially the case in rural areas where large communities are dependent upon a single facility, yet staff are often lacking.

vi. Poor state of health facilities, lack of maintenance and advancing medical technology: The state of many health facilities around the country are in deplorable states due to negligence or poor management. Many of such facilities will not be able to meet the needs of the scheme if they lack the essential requirements of a health facility.

vii. Poor level of publicity about the scheme: The publicity about the scheme will require to be stepped up in order to furnish the populace with correct information. This will disabuse their minds from preconceived ideas about the scheme which may discourage them from desiring to enrol.

viii. Lack/absence of public opinion in the planning and implementation of the scheme: The public ought to be engaged in the planning and execution of the

scheme so as to sample varied opinions. If the approach is bottom to top, the input of participants will expand the horizon of the government and enhance the scheme².

The findings further show that the impact of National Health Insurance Scheme in Taraba State is poor, about 3.85%; the functional state of National Health Insurance Scheme in Taraba State is poor, about 23.08%; and the implementation of National Health Insurance Scheme in Taraba State is poor, about 11.54%.

The above findings may lead to a low level of insurance by the citizens except these issues are addressed.

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Endnotes

1. I. J. Okafor & H. S. Umar. *Assessment of the Implementation of National Health Insurance Policy in Nigeria*. **The International Journal of Humanities & Social Studies**, 7(6), 2019, 91-96.
2. S. A. Adebisi, J. M. Odiachi & N. A. Chikere, *The National Health Insurance Scheme (NHIS) in Nigeria: Has the Policy Achieved its Intended Objectives?* **Academic Journal of Economic Studies**, 5(3), 2019, 97-104.

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Chapter Five

Conclusion

This chapter is the concluding chapter of the study which deals with the summary, conclusion and recommendations of the study.

5.1 Summary of Findings

The findings of the study are outlined thus:

- i. Inability of government to carry the citizens along. The people are not in tune with government plans and intentions to improve the lives of the people. When this happens, people consider such government policies as the National Health Insurance Scheme as a means to enriching some individuals at the expense of the masses.
- ii. Adequate planning has not been prioritised in order to have enrollees derive utmost benefits from the NHIS. Though the intention to improve on health services of its citizens is clear, more needs to be done in terms of ensuring the objective is fully realised. The current “scheme” by the planners does not fully focus on how the Nigerian people viz Tarabans, government, businesses perceive and conduct their business life. It was formulated mainly on professional paradigm and theory that are foreign to the country’s culture, religious beliefs and socio-economic realities.
- iii. Access to healthcare has been a challenge in certain situations that border on the funding arrangement that was not fully inclusive. The policies that increasingly withdrew citizen-friendly medical services at all levels in order

to raise government revenue did not set the conditions for a sustainable scheme.

- iv. The challenge of poor accountability and mismanagement of funds as common in other sectors of the country's polity. Average masses ideology on government initiatives is tainted with suspicion of agents of government saddled with management of public resources. There is thus distrust by the masses based on past experiences of mismanagement and collaborative corruption.

5.2 Conclusion

The NHIS is a prepaid health insurance scheme. It is a scheme adopted by Nigeria with a view to achieve the goal of adequate, affordable and available health for its citizens. Introduced in 1962 during the first Republic, the NHIS in Nigeria, has undergone modifications. This action was however to meet with challenges as the bill failed to gain the full approval of Parliament in that year. The operation of NHIS was obstructed following the Nigerian civil war and re-emerged in the 1980s. Based on committee report that was approved by the National Executive Council in 1989, the Federal Government issued a directive to the Federal Ministry of Health to start NHIS in 1993 and the formal launching was performed in 1997. In 1999, the scheme was modified to cover more people via decree No. 35 of May 10, 1999 which was promulgated by the then Head of State, Gen. Abdulsalami Abubakar. It was signed into law in 1999 and officially launched on 6th June, 2005. The scheme kicked off in earnest under the government of Chief Olusegun Obasanjo. As part of efforts to strengthen the national

health system, a National Health Policy (NHP) was adopted in 2006 to establish a realistic financing system capable of ensuring improved health status of Nigerians.

Plans to achieve health for all citizens have been changing from one government to another and have remained a mirage. Various strategies have been initiated and tested, hoping for optimum efficacy in this very important sector. On the whole, factors such as poor medical facilities, shortage of medical personnel, lack of awareness, and poor funding have been identified as key challenges to many health plans. Such challenges keep rearing their heads in many ways, posing as encumbrances to the laudable objectives targeted towards Nigerians. The intention of the government to improve or change the method of providing health services to its citizens is laudable, but any valid and meaningful plan must assume and reflect socio-economic realities. The current “scheme” by the planners is not meaningful and valid to address the socio-economic situation of the country. It does not focus on how the Nigerian people viz Tarabans, government, businesses perceive and conduct their business life. It was formulated mainly on professional paradigm and theory that are foreign to the country’s culture, religious beliefs and socio-economic realities.

The government ought to be ready to adopt dynamic approaches to meeting the challenges that crop up at the various stage of their attempt.

5.3 Recommendations

Following enumeration of the existing constraints of a viable implementation of NHIS in Taraba State, these recommendations are advanced for improving the functionality of the scheme.

- i. Full participation of all relevant sectors: An active orientation to keep enrollees informed of all benefits and operational terms of the scheme is necessary. All sectors must play their part in ensuring the success of the programme. This is especially important where finances in many cases delay the operation of a project as a result of negligence or sabotage. Also, the stakeholders in the efficient running of the scheme should act as at when due.
- ii. Government should equip and upgrade health facilities: Attention should be given to upgrading health facilities to acceptable standards so that they can be able to meet growing healthcare challenges.
- iii. Government should create access roads to rural settings: Parts of the State that are rural and inaccessible due to bad terrain should be given attention. If the roads to those rural settings are accessible, movement of people as well as healthcare wares will be easy. It will encourage more participation in the scheme by health facilities in the rural settings as well.
- iv. Adequate and proper enlightenment programme in various languages should be put in place: Adequate enlightenment will encourage participation in the scheme. Considering the low level of literacy, consideration should be given to creating awareness in multiple languages that are spoken by the people. Also, alternative awareness methods should be employed using radio drama and other programmes.
- v. Increase the number of spouse(s) and children to be enrolled in the scheme: Consideration ought to be given to families who have more than the stipulated

number of spouses or children. This will accommodate them into the scheme. This will call for modification of any insurance plan Nigerians must have copied in order to suit local circumstances.

- vi. Proper institutional framework should be put in place: A proper and active monitoring system should be put in place to ensure smooth running of the programme. This will ensure that anyone in the line of operation play his/her part for maximal results.
- vii. Maintaining high standard and professionalism: This is especially important in order to keep the confidence of enrolees in the system of healthcare. They will be satisfied that they are receiving adequate care commensurate with their expectations.
- viii. Corruption and mismanagement to be reviewed: The approach to handling cases of mismanagement in Nigeria ought to be reviewed to deter others with such perception. Currently, culprits are handled with kid gloves and since no serious repercussion arises from such acts, others follow suit.

5.4 Contributions to Knowledge

The NHIS program is a very good scheme if it reaches the targeted audience and it is implemented properly as it has been in some developed countries. The proper implementation should not only be in Taraba state but also in all other states of the country. Thus, the study had been able to examine the shortcomings and challenges facing the scheme in Taraba state and suggested measures that can help in overcoming

these challenges. Also, the study has contributed to knowledge by establishing that “PAN NIGERIAN” approach is really needed to solve the various problems bedeviling the country, especially on the issue of study.

5.5 Suggestions for Further Research

The NHIS programme in the whole country can be assessed bearing in mind whether it is more successful in other states of the country or not. Also, the assessment of previous health programmes and why they did not succeed in comparison to the NHIS to prevent its collapse too. These are areas that can be further researched on.

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Appendix

Letter of Introduction (Questionnaire Respondents)

Department of Politics and International Relations,
Faculty of Management and Social Sciences
Lead City University, Ibadan
Ibadan.

Dear Respondent,

INTRODUCTION LETTER

The questionnaire is from a Ph.D. student of Public Administration in the above named institution carrying out a research on the topic, “Assessment of the National Health Insurance Scheme in Taraba”.

Your cooperation is highly needed to respond to each question for the success of this study. Be rest assured that the information collected from you will be used with utmost confidentiality for research purposes only.

Thanks for your cooperation.

Yours faithfully,

Shanka Buba Otuemhobe

Appendix II: Questionnaire

SECTION A: PERSONAL DATA OF RESPONDENTS

1. Sex: Male Female
2. Age: 25-34 years 35-44 years 45-54 years
55 years and above
3. Marital status: Married Single Widow Widower Divorced
4. Educational background: MA/MSC/MPA BSC/BA/HND
OND/NCE WAEC/GCE
5. Occupation: Pharmacist Doctor Civil servant
Military/Paramilitary others Specify _____

SECTION B: RESPONDENT'S KNOWLEDGE AND VIEWS ABOUT NATIONAL HEALTH INSURANCE SCHEME

6. Are you aware of the NHIS? Yes No
7. Are you participating in the NHIS? Yes No
8. What is your source of information about NHIS? Radio TV
Friends/Colleagues Newspapers Hospitals Others
(Specify) _____
9. How long have you been on the NHIS scheme? 1-3 years 4-6 years

6 years and above []

10. As an enrollee, how have you benefited from the scheme?

a. Reduced cost of treatment/drugs []

b. Improved medical care []

c. All of the above []

d. None of the above []

SECTION C: PERFORMANCE OF NHIS IN TARABA STATE

11. How would you assess the services of NHIS in Taraba state? Poor [] Fair []

Good [] Very good [] Excellent []

12. In your opinion, do you think the objective of the NHIS being met in Taraba State? Yes [] No [] Not sure []

13. Corruption undermines the efficiency of NHIS Scheme. Strongly agree []
Strongly disagree [] disagree []

14. Unavailability of drugs is responsible for the out of pocket payment by NHIS enrollees. Strongly agree [] Strongly disagree [] disagree []

15. In your opinion, what are the challenges of NHIS in Taraba State?

i.

.....

.....

ii.

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.....

iii.

.....

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iv.

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v.

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Appendix III

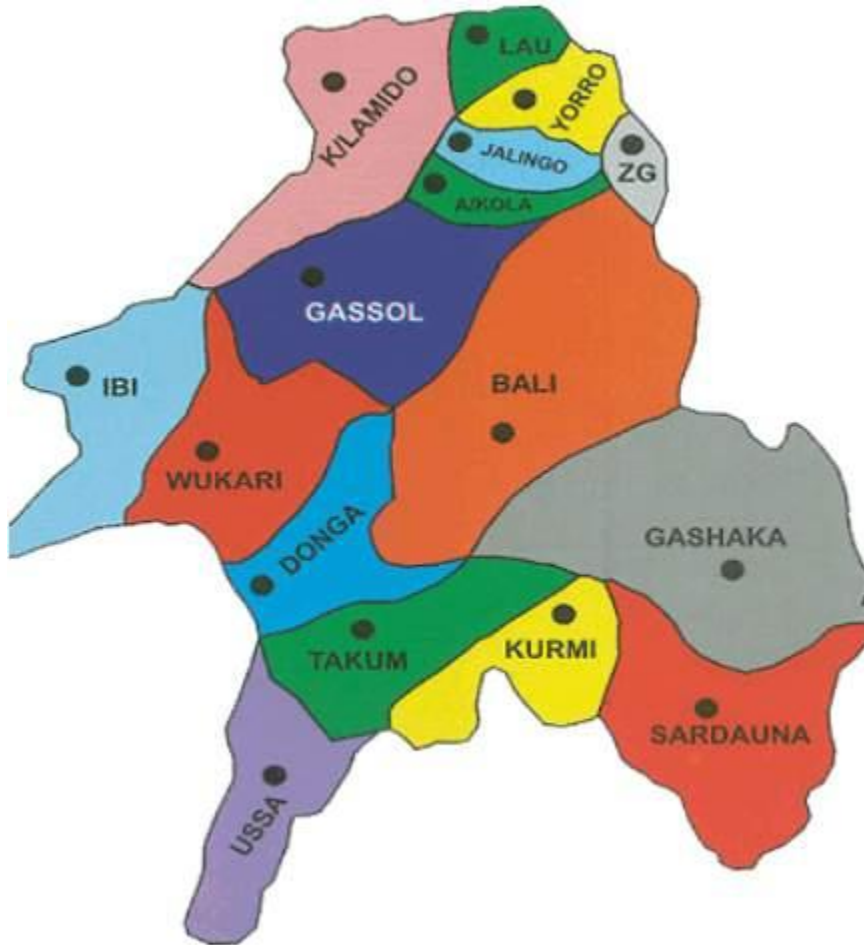
Map of Nigeria showing Taraba State



Source: Steve Dew Jones (www.google.com)

Appendix IV

Map of Taraba State showing LGAs



Source: Nigeria gallerie (www.google.com)

Bio-data

A. Personal Data

Full Name: Shanka Buba OTUEMHOBE
E-mail: bubashanka@yahoo.com
Phone No: +2348028879078
Date and Place of Birth: September 26, 1965/ Lagos
Nationality: Nigerian
Name and Address of Next of Kin: Mrs Otuemhobe, P.O BOX 90, Jalingo,
Taraba State.

B. Educational Background with Dates

Educational Institutions Attended with Dates and Qualifications

- Ph.D. Public Administration – Lead University, Ibadan (in view)
- MPA - National Open University of Nigeria 2016
- MBA - Peeble Hill University 2015
- DA - University of Ibadan 2007
- MBCHB - O.A.U, Ile-Ife, Osun State 1993
- S.S.C.E – Gaskiya College Lagos/ King College, Lagos 1984

C. Work Experience with Dates

- Murtala Mohammed Specialist Hospital Kano 1994
House Officer
- Gembu General Hospital, Mambilla Plateau 1995
Medical Officer (NYSC)
- Gembu General Hospital, Mambilla Plateau 1996-1998

- Medical Officer
- Gembu General Hospital, Mambilla Plateau 1998-1999
Senior Medical Officer i/c of Pediatric Unit
 - General Hospital Warwar, Mambilla Plateau 2000
Acting Principal Medical Officer
 - General Hospital Bali 2000
Acting Principal Medical Officer
 - Cottage Hospital Ibi 2000
Principal Medical Officer
 - Gembu General Hospital, Mambilla Plateau 2000 – 2001
Acting Principal Medical Officer
 - Specialist Hospital Jalingo 2001- 2003
Senior Medical Officer
 - Specialist Hospital Jalingo 2003- 2004
Principal Medical Officer
 - Abubakar Barde Memorial Hospital Yorro 2004 – 2006
Principal Medical Officer
 - Specialist Hospital Jalingo 2007-2011
Principal Medical Officer
 - Specialist Hospital Jalingo 2011
Chief Medical Officer
 - Specialist Hospital Jalingo 2011-2019
Head of Department (Anesthesia)

D. Awards and Fellowships

N/A

E. Membership of Academic and Professional Bodies

- i. Nigeria Medical Association
- ii. Nigeria Society of Anesthesia

F. Publications

- Shanka B. Otuemhobe & Adebola A. Alade. *Resource Management and Staff Productivity in Nigeria: Focus on Tertiary Institutions of Learning*. **African Scholar Journal of Humanities and Social Science – AJHSS**, Vol. 23, Issue 6, 2021. Pg. 321-339
- Shanka B. Otuemhobe & Adebola A. Alade. *Strategic for Curbing Indiscipline in Public Organizations in Nigeria: A Theoretical View*. **International Journal of Social Science Research and Anthropology**. Vol. 7, Issue 6, 2021. Pg. 1-28

G. Major Conferences Attended with Dates

- Conference on Human Resource Management – Matter Arising April 2023
- Safety on the Roads
The Role of Vehicle Inspection Officers May 2022
- Useful Guide to Effectively Leadership March 2022
- Health Worker in headship of Teaching Hospital – Matter Arising March 2022
- Basic Business Training June 2020
- Health Care Waste Management Training Nov. 2018
- The Menace of Substance Abuse in the Country Dec. 2017
- Expanded Life Saving Skills for Physicians March 2005
- Clinical of Ultrasonography July 2005
- Training on the New Strategies for Malaria Control Sept. 2005
- Tuberculosis Diagnosis and Management Workshop Feb. 2003
- Workshop on Clinical Management of HIV/AIDS Sept. 2003
- Workshop on Management of STIs Nov. 2002
- Workshop on Post-Abortal Care July 2001

H. Referees

Dr. Bello Olumuyiwa

Chief Lecturer,

College of Agriculture,

Jalingo, Taraba State.

08036332235

Dr. Adeola Richard

Chief Lecturer,

College of Agriculture,

Jalingo, Taraba State.

08034385123

Dr. Kyantirimam Ukwen

Senior Lecturer

Taraba State University, Jalingo

08069650675

Signature

Date

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The University Compliance Certification

This is to verify that the thesis written by Shanka Buba OTUEMHOBE with matriculation number LCU/PG/001165, in the Department of Politics & International Relations, Faculty of Management and Social Sciences, Lead City University, Ibadan, Oyo State, is in full compliance with the approved University format and style.

Signature

Date

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