Investigating the Effectiveness of the Nigeria's National Health Insurance Scheme on the Health Care Delivery System

Tajudeen Olalekan Yusuf
Actuarial Science and Insurance,
University of Lagos, Akoka

&

Olukayode Olubumi Akinmola
Department of Clinical Pathology,
Lagos University Teaching Hospital (LUTH)

Abstract

The effect of National Health Insurance Scheme (NHIS) on quality of health care delivered to Nigerians remained largely untested till date especially in the area of level of awareness of health takers of the scheme, quality of health care delivered, cost implication, benefits and effectiveness of the entire scheme. This has necessitated this study to find out the effect of National Health Insurance Scheme (NHIS) on health care delivery in Nigeria using a Teaching Hospital in Lagos as a case study. A survey research was carried out involving 200 questionnaires, randomly distributed equally between the healthcare-givers and the patients - (100 each for both population of interest). Data obtained were subjected to correlational and regression analyses. The results indicated that there is significant relationship between National Health Insurance Scheme (NHIS) and the quality of health care delivered to the Nigerian citizenry. Furthermore, benefit derived and programme effectiveness had negative correlation on health care delivery of both patients and health givers. Meanwhile, the quality of health care delivered and cost implication of receiving treatment had a positive correlation with health care delivery. It was recommended that there is a need to create more awareness and education on the total package of the scheme. In addition, managers should improve the effectiveness of the programme through increase coverage of those hitherto-excluded in the scheme as quickly as possible.

Introduction

The beginning of the 21st century witnessed a renewed effort at health sector and health financing policy reforms in Nigeria. The National Health Insurance Scheme (NHIS), which commenced in 2005, is the most notable of these reforms. Despite these efforts, many Nigerians are yet to feel the impact and Nigeria is faced with the challenge of expanding the NHIS to cover the large and mainly poor informal sector (Adeyemo, 2005 and Eno, 2008).

Healthy population and indeed the work force are indispensable tools for rapid socio-economic and sustainable development the world over. Despite this indisputable fact, in Nigeria like most African countries, the provision of quality, accessible and affordable healthcare remains a serious problem (WHO, 2007a; Oba, 2008; Omoruan, Bamidele & Philips, 2009). This is because the health sector is perennially faced with gross shortage of personnel (WHO, 2007a), inadequate and outdated medical equipment (Yohesor, 2004; Johnson & Stoskopf, 2009), poor funding (WHO, 2007a&b), policies inconsistence (Omoruan, Bamidele & Philips, 2009) and corruption (Oba, 2008). Evidence shows that only

4.6 percent of both public and private Gross Domestic Product (GDP) in 2004 was committed to the sector (WHO, 2007a, b&c). Other factors that impede quality health care delivery in Nigeria include inability of the consumer to pay for healthcare services (Sanusi & Awe, 2009). There was gender bias due to religious or cultural beliefs (NCBI, 2009) and inequality in the distribution of healthcare facilities between urban and rural areas (Omoruan, Bamidele & Philips, 2009). On account of the aforementioned, the country is continually ranked low in healthcare delivery by international organisations.

In 2000 for instance, WHO report on healthcare delivery ranked Nigeria 187 out of 191 countries (Wikipedia, 2009). Eight years later, Human Development Report 2007/2008, ranked the country 158 out of 177. In 2005, only 48 and 35 percents of the children within the ages of zero-to-one-year-old were fully immunized against tuberculosis and measles respectively. Between 1998 and 2005, 28 percent of the children within the ages of 5 years who suffered from diarrhea received adequate treatment. Between 1997 and 2005, only 35 percent of births in Nigeria were attended by skilled health personnel. Furthermore, between 2000 and 2004, only 28 percent of Nigerians in every 100,000 persons had access to physicians (UNICEF, 2006; World Bank, 2007; UNDP, 2008). While the situation in the health sector persists, Nigeria continually loses her professionals to other countries. It was reported in 1986 that more than 1,500 health professionals left Nigeria to other countries. In 1996, UNDP report revealed that 21,000 medical personnel were practicing in the United States of America and UK, while there was gross shortage of these personnel in the Nigerian health sector (Akingbade, 2006).

The health situation in the country shows that only 39 percent in 1990 and 44 percent of Nigerians in 2004 had access to improved sanitation. In 1990/92 and 2002/04, 13 percent and 9 percent of Nigerians were undernourished respectively (UNDP, 2008). HIV prevalence in Nigeria within the ages of 15 to 49 years was 3.9 percent in 2005 (UNAIS, 2006). In an attempt to address the precarious and dismal situation in the health sector, and to provide universal access to quality health care service in the country, various health policies by successive administration were made including the establishment of primary health care centres, general and tertiary hospitals.

The perennial health problem informed the decision of Gen. Abdulsalami Abubakar on May 10, 1999, to sign into law the National Health Insurance Scheme (NHIS) Decree Number 35 (NHIS Decree No. 35 of 1999); with the aim of providing universal access to quality healthcare to all Nigerians. NHIS became operational after it was officially launched by the Federal Government in 2005 (Kannegiesser, 2009). More than four years of NHIS existence in Nigeria, opinion is divided among Nigerians on the efficacy of the scheme in addressing the health problem in the country, because of disheartening reports on the health situation in the country.

Meanwhile, drawing from the global perspective on health insurance scheme, WHO (2000) defines health as a state of complete physical, mental and social wellbeing and not just the absence of disease or infirmity. This definition looks like an aberration in Nigeria and if we go strictly by it, no Nigerian can be said to be a healthy client for the insurance industry. Every country strives to provide for its citizens affordable, qualitative and accessible healthcare. In South Africa for instance, there is no nationally operated public health insurance scheme. Yet, the country can boast of better health indices than Nigeria. The private health insurance schemes provided in the country are affordable, well developed and functioning effectively and efficiently (Gana, 2010).

The health system, like the rest of Nigerian public systems, is plagued by inadequate budgetary allocations, inefficiency and inequity in distributing available resources. And with rapid population growth, emergence of new diseases especially HIV/AIDS pandemic, and persistence of old diseases, the problem is further compounded (Abdulraheem, Olapipo & Amodu, 2012).

Data from the NHIS in 2011 shows 5% of the population are registered on the scheme (NHIS 2012b). Majority of those covered are in the employment of the federal and state governments and live in the urban areas (Lawan, Iliyasu, and Daso (2012). However, more than 60% of Nigerians belong to the informal sector and live in rural areas on less than $1 a day (as cited by UPI, 2012). Because they lack sufficient financial resources when faced with health challenges, they cannot afford good quality health care. Out-Of-Pocket (OOP) financing of health remains high at about 95.3% of the private expenditure on health (PvtHE) in 2010 (PvtHE as a percentage of Total Health Expenditure {THE} was 62.1% in 2010), and usually has a catastrophic effect on the poor. Many Nigerians have lost their lives due to their inability to meet this need (Lawan *et al*, 2012). NHIS is usually designed to significantly cater for the welfare of the citizens and especially the less privileged in the society (Kutzin, 2001). This, in essence, would guarantee access to care with financial risk protection. The scheme has been in operation since 2005 and the target date for achieving universal health coverage is 2015. The World Health Report (WHR) of 2010 has noted that countries that depend on OOP payments for health will be unable to achieve universal health coverage (WHO, 2010).

The question at this point is has the NHIS truly achieved the purpose of effective health care delivery among Nigerians? What has been the impact of the Scheme on health care delivery in the country? In order to provide answers to these interesting questions, we propose, as our objectives, the need to find out the impact of national health insurance scheme on effective health care delivery among Nigerians. Other specific objectives include determining the level of awareness and the quality of health care delivered to Nigerians. The attainment of these objectives would afford us the opportunity to make meaningful recommendations for policy and practice of the Scheme to interested stakeholders.

In line with the research focus, the following research hypotheses were verified:

$H_{01:}$ There is no significant relationship between the national health insurance scheme and effective health care delivery among Nigerians.

$H_{02:}$ There is no significant difference in the quality of health care delivered to Nigerians under the Platform of NHIS scheme and those who are not.

$H_{03:}$ There is no significant relationship between the cost implication and quality of the health care delivered to Nigerians under the coverage of this NHIS scheme.

To place the present study in proper perspective, the rest of the paper is structured as follows: Section 2 focuses on review of relevant literature. Section 3 dwells on the methods. Section 4 deals with results while section 5 discusses the findings and implications. Section 6 concludes with recommendations.

Literature Review

Theoretical Framework

Health insurance is common to all developed countries but the mechanism of obtaining insurance differs from country to country (Cutler and Zeckhauser, 2000). Social health insurance pools both the health risks of its members on the one hand, and the contributions of enterprises, households and government, on the other. Contributions of households and enterprises are usually based on income, whereas, government contributions are mostly financed from general taxes (Carrin, 2002). According to the Health Insurance Association of America (2014), health insurance is defined as "coverage that provides for the payments of benefits as a result of sickness or injury. It includes insurance for losses from accident, medical expense, disability, or accidental death and dismemberment" The term **health insurance** is commonly described as any program that helps pay for medical expenses, whether through privately purchased insurance, social insurance or a social welfare program funded by the government. Synonyms for this usage include "health coverage," "health care coverage" and "health benefits." (Elwyn, Edwards, Kinnersley, & Grol, 2000)

In a more technical sense, the term is used to describe any form of insurance that provides protection against the costs of medical services. This usage includes private insurance and social insurance programs such as Medicare, which pools resources and spreads the financial risk associated with major medical expenses across the entire population to protect everyone, as well as social welfare programs such as Medicaid and the State Children's Health Insurance Program, which provide assistance to people who cannot afford health coverage.

In addition to medical expense insurance, "health insurance" may also refer to insurance covering disability or long-term nursing or custodial care needs. Different health insurance provides different levels of financial protection and the scope of coverage can vary widely, with more than 40 percent of insured individuals reporting that their plans do not adequately meet their needs as of 2007.

On the other hand, Social Health Insurance (SHI) is a system of financing health care through government regulations. It is a form of mandatory insurance scheme (normally on a national scale). It provides a pool of funds to cover the cost of health care and it also has a social equity function which eliminates barriers to obtaining health care services. In SHI, every citizen is required to make contributions. Governments may contribute on behalf of the poorest and the unemployed; employers also usually contribute on behalf of their employees (Carrin, 2005).

Historical Background of NHIS in Nigeria
NHIS was first introduced in Nigeria in 1962, during the First Republic (Johnson & Stoskopt, 2009). The scheme then was compulsory for public service workers. The operation of NHIS was obstructed following the Nigerian civil war. In 1984, the Nigerian Health Council resuscitated the scheme and a committee was set up to look at the National Health Insurance. The then Minister of Health, Professor Olikoye Ransome Kuti, commissioned Emma-Eronmi led committee which submitted her report which was approved. Consultants from International Labour Organisation (ILO) and United Nations Development Programme (UNDP) carried out feasibility studies and came up with the cost implication, draft legislation and guidelines for the operation of the scheme.

In 1993, the Federal Government directed the Federal Ministry of Health to start the scheme in the country (Adesina, 2009). In 1999, the scheme was modified to cover more people via Decree No.35 of May 10, 1999 (Adesina, 2009; NHIS Decree No. 35 of 1999).
The scheme took-off in 2004 but did not become fully operational until 2005. As at September 2009, 25 states of the Federation agreed to partner with NHIS. These include- Akwa Ibom, Rivers, Edo, Taraba, Adamawa, Kaduna, Zamfara, Kebbi, Sokoto, Katsina, Nassarawa, Anambra, Jigawa, Imo and Kogi States. Others were Bauchi, Ogun and Cross River States. These states are at various stages of implementation of the scheme (NHIS, 2009).

National Health Insurance Scheme (NHIS) In Nigeria
The Nigerian NHIS is a Social Health Insurance Programme (SHIP) which combines the principles of Socialism (being one's brother's keeper, common good of all) with that of Insurance (pooling of Risks and resources) (Jutting, 2004). It is a body corporate with perpetual succession established under Act 35 of 1999 to provide Social Health Insurance (SHI) in Nigeria whereby the Health care services of the contributors are paid for from the pool of fund contributed by participants in the Scheme. The goal of NHIS- is to improve the health status of Nigerians as a significant co-factor in the national poverty eradication efforts. The mission of NHIS is to undertake a government led comprehensive Health Sector Reform aimed at strengthening the National public and private Health System to enable it deliver effective, efficient, qualitative and affordable Health Services.

The objectives of the scheme include to:
• ensure that every Nigerian has access to good health care services
• protect families from the financial hardship of huge medical bills
• limit the rise in the cost of healthcare services
• ensure equitable distribution of healthcare costs among different income groups
• ensure high standard of healthcare delivery to Nigerians
• ensure efficiency in healthcare services
• improve and harness private sector participation in the provision of healthcare services
• ensure equitable distribution of health facilities within the federation
• ensure appropriate patronage of levels of healthcare
• ensure the availability of funds to the health sector for improved services.

In order to ensure that every Nigerian has access to good health services the NHIS has developed various programmes to cover different segments of the society with joint financing from government and Public.

Health Financing In Nigeria
In Nigeria, successive governments realised the need to structure the funding of health care services as one of the ways to improve health care provision (Gilbert et al 2009). By 1999, the NHIS was established under decree no. 35 by the government and the first phase rolled out in 2005 (NHIS Decree 1999 & NHIS 2012b). The mandate of the scheme is "to provide easy access to qualitative, equitable and affordable healthcare via various pre-payment mechanisms" (NHIS Decree 1999). Ultimately, universal health coverage should be achieved by 2015 (NHIS Decree 1999). The large and mainly poor informal sector of the population remains largely excluded despite the existence of a roll-out operational guideline to achieve nation-wide enrolment (Lawan *et al*, 2012). There remains a challenge to extend the scheme to those who need it the most in Nigeria.

Methods
This health-institution-based study is cross sectional in design and aimed at collecting data on the effectiveness of the NHIS on health care delivery in Lagos-Nigeria. The institution is a tertiary teaching hospital situated in Lagos, the commercial capital city of Nigeria.

Sampling Procedure
The target population under study include health givers (registered doctors, nurses, nursing attendants etc) and health takers (patients that are registered under the scheme) of a teaching hospital in Lagos. The NHIS's register for patients in this hospital indicates 1000 registrants/enrolment. The number of licensed doctors, nurses and other health attendants was 1,825. For the purpose of this study, a sample size of 200 (made up of 100 patients and 100 health attendants) were randomly selected from the stratified population. In order to ensure a good representation of the entire population in the statistical sample, a stratified random sampling method was employed. Haber and Riechel (2005), describes a stratified sampling as a sampling technique that ensure good representation of a subgroups within a population based on their proportion in the particular population. The advantage of stratified sampling is that resulting sample will be distributed in the same way as the population in terms of the stratifying criterion. The major reason for adapting this method of sampling is because it provides a good representation of the entire targeted statistical population.

The questionnaire was divided into 3 sections: section A dwelt on demographics of the respondents; section B was to be filled only by patients while section C was to be filled by health givers. The patients section is meant to elicit information about patient's awareness of the scheme, including the level of their satisfaction with it. The health givers section is meant to assess the level of quality of the services incorporated into the NHIS and the level of its effectiveness and efficiency in meeting its goals.

Results
The larger percentage of the respondents falls within the age category 30-39years: 44% for patients, 72% for healthcare givers. In both instances, the percentage of males was more than females. Most of the respondents were married, 67% for patients and 66% for health givers. Most patients (51%) had HND/BSC/, while for the health givers, 91% had MSC/MBBS/PHD. Analysis also reveals only 4% of the patients and health givers earn above N250, 000. In terms of working experience, 70% of the health givers had 6-15years working experience and none of them had 26-35 years' experience. For patients, 8% had 25-35years working experience and 20% of them have 16-25 years' experience.

There was low negative significant relationship between health care delivery and benefits derived from the NHIS; r =.-288, N=100, P>0.05. NHIS Effectiveness had a negative correlation with other variables such as: health care delivery, benefits and exclusion of NHIS, level of awareness of NHIS at r values; -.142, -102,-203,-.224 and -0.52 respectively. In addition, correlation analysis shows that there was positive significant relationship between the level of awareness of NHIS and quality of health care delivered to patients under the coverage.

The relationship between the challenges of health care delivery and the quality of health care delivered from the view point of the health givers was also examined. Result shows a weak positive relationship between the variables at r=.104, N=100. Furthermore, the relationship between effectiveness of NHIS and quality of health care delivered to Nigerians and also shows there is a weak positive relationship between the variables.

Correlation Analysis
In order to verify the hypotheses, correlation analysis was carried out in the course of the data analysis between variables that makes up each construct. Correlation analysis establishes the relationship that exists among variables. The relationship between variables within NHIS construct was investigated using a Pearson product correlation coefficient. Preliminary analysis was carried out to ensure that there is no violation of the assumptions of normality, linearity and homoscedasticity.

Table 1 reveals the relationship between quality health care delivery, benefits and exclusion of NHIS; the level of awareness of the scheme and NHIS effectiveness was investigated using Pearson product moment correlation coefficients. Result shows that there is low negative significant relationship between quality health care delivery and benefits derived from the NHIS scheme, r =.-288, N=100, P>0.05. By extension, an increase in quality does not translate to increased benefit. Based on this finding, we reject the Null hypothesis 3, meaning there is a significant relationship between the benefit derived and quality of the health care delivered to Nigerians under the coverage of this NHIS scheme.

Furthermore, the relationship between effectiveness of NHIS and healthcare delivered to Nigerians under the coverage of this NHIS scheme was also investigated. Result shows that, effectiveness had a negative correlation with other variables such as: benefits, awareness, quality of health care delivery, and exclusion of NHIS, with r values; -.142,-102,-203,-.224and -0.52 respectively. This implies that the NHIS failed the effectiveness test among health takers. Ineffectiveness in the Scheme would also lead to low quality health care delivery. We therefore reject the null hypothesis1, that, there is a significant relationship between the National Health Insurance Scheme and effective health care delivery among Nigerians.

In a bid to investigate the relationship between the level of awareness of NHIS and quality of health care delivered to Nigerians under the platform, correlation analysis shows that there is a positive significant relationship between the level of awareness of NHIS and quality of health care delivered. This implies that the more people are aware of the NHIS scheme (benefits and its exclusions), the greater the quality of health care that would be delivered to the patients under the Scheme. Based on the outcome of this analysis, we therefore accept the Null hypothesis 2, that there is no significant difference in the level of awareness of NHIS and quality of health care delivered to Nigerians under the Platform of NHIS.

Table 1: Correlations (patients)

Scale	1	2	3	4	5	6
1. Healthcare	1	-.240**	.321**	.0.67	.146	.142
2 Benefit	-2.40**	1	.113	.003	.148	-.102
3. Awareness	.321**.	.113	1	.111	.122	-203*
4. Quality	0.67	.003	.111	1	0.41	-.224*
5. Exclusion	.146	.148	.122	.041	1	-0.52
6. Effectiveness	-.142	-102	-203*	-.224*	-0.52	1

*. * Correlation is significant at the 0.05 level (2-tailed)
*. Correlation is significant at the 0.05 level (1-tailed)

Table 2: Correlations (Health givers)

Scale	1	2	3
1. Healthcare	1	.104	0.04
2 Challenge	.104	1	0.063
3. Effectiveness	0.04.	0.063	1

. Correlation is significant at the 0.05 level (2-tailed)
*. Correlation is significant at the 0.05 level (1-tailed)

Table 2 investigates the relationship between the challenges of health care delivery and the effectiveness of the NHIS from the view point of the health-givers. Results shows that there is a weak positive correlation at r=.104, N=100. Correlation exists between the challenges encountered by health givers and the quality of health care delivered to the Nigerian citizen. This outcome shows that lots of challenges in the scheme will retard the quality of health care delivered. Furthermore, the relationship between the effectiveness of NHIS and quality of health care delivered to Nigerians also shows there is a weak positive relationship between the variables. This means that the effectiveness of the NHIS programme is poor. This further confirms the result obtained in table 4.25 that there is a significant relationship between the National Health Insurance Scheme and effective health care delivery among Nigerians

Regression Analysis
In addition to correlation analysis, multiple linear regression was used to explain in further details the relationship that existed between the independent variables and the dependents variables. By applying regression, the relative contribution of each independent variable in explaining variance in the criterion was determined. The essence of the regression analysis is to determine the level of contribution of each variable in explaining the variances in the examined variable. Preliminary analysis was carried out to ensure that there is no violation of the assumptions of multicollinearity, normality, linearity and homoscedasticity. The multicollinearity rule states that tolerance value should not be less than 0.1 and the variance inflation factor (VIF) should not be at least 10. Since these values were attained, there is no violation of the multicolineraity rule.

Table 3: Regression analysis (patients)
Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.460ª	.195	.141	2.938451

a. Predictors: (Constant), NHIS effectiveness, NHIS quality, NHIS benefit, Awareness of NHIS, NHIS exclusion

The R^2 value (also called the coefficient of determination), which is the proportion of variance in the dependent variable that can be explained by the independent variables (technically, is the proportion of variation accounted for by the regression model above and beyond the mean model). Table 4.27 shows that R^2 value is 0.195 and that our independent variables explain 19.5 % of the variability in dependent variable (Health care delivery).

Table 4   **Coefficients[a]**

Model		Unstandardized Coefficients		Standardized Coefficients			95% Confidence Interval for B	
		B	Std. Error	Beta	t	Sig.	Lower Bound	Upper Bound
1	(Constant)	11.309	2.659		4.253	.000	6.028	16.589
	Awareness of NHIS	.539	.171	.306	3.152	.002	.199	.878
	NHIS benefit	-.380	.126	-.286	-3.013	.003	-.630	-.129
	NHIS exclusion	-.045	.196	-.023	-.232	.817	-.434	.343
	NHIS quality	.204	.133	.145	1.527	.130	-.061	.469
	NHIS effectiveness	-.139	.201	-.068	-.691	.491	-.538	.260

   a. Dependent Variable: Healthcare of respondents

   Result from table 4 shows that the level of awareness of NHIS makes the highest contribution in explaining the variance in the dependent variable with a Beta value of .539, followed by the quality of service received by patients under the coverage of NHIS with a Beta value of .204. Meanwhile NHIS benefit, exclusion and effectiveness had beta values of -.380,-.045 and -.139 respectively. This implies that only the level of awareness and the quality of service delivered to patients under the coverage has a positive relationship with Health care delivery to patients under the coverage, while the benefits, exclusions and effectiveness have a negative relationship with healthcare delivery.

   It equally means that although quality health service is being delivered and people have some levels of awareness of the scheme, yet patients under the scheme are of the opinion that they have not truly benefited much from the scheme, neither are they aware of the exclusions within the scheme. Furthermore, in spite of the quality service rendered, respondents' belief the entire programme is in-effective. This further buttress the correlation result we got earlier. Therefore, we reject the null hypothesis1. As such, there is a significant relationship between the national health insurance scheme and effective health care delivery among Nigerians. We also reject null hypothesis3, meaning that there is significant relationship between the benefit derived and quality of the health care delivered to Nigerians under the coverage of this NHIS scheme.

Discussion and Managerial Implication of Findings
The outcome of this research has a number of important implications for patients under the coverage of NHIS, health givers, government and other stakeholders. For instance, in this study correlation analysis shows that there was positive significant relationship between the level of awareness of NHIS and quality of health care delivered to patients under the coverage. This result correlates with the findings of Agba (2010), who carried out a research among Registered Staff in Federal Polytechnic, Idah, Kogi State Nigeria on Perceived Impact of the National Health Insurance Schemes (NHIS). He found out that there is enough awareness of the scheme among registered members. This was reflected in the 100 percent of the respondents who indicated that they are aware of the existence of the scheme.

Also in his statement, "NHIS is not as elitist as people think because it is actually meant for the community, which is where 70% of the Nigeria population belongs". Based on the findings of this research, it is clear that most Nigerians are becoming much more aware of the programme compared to when it first started when there were misconceptions about the scheme.

Despite the level of awareness of the respondents, this research shows that most of them (70%/) are not aware of the exclusions in the scheme such as: occupational or industrial injuries, radiologic investigations like computerized tomography (CT) scan, magnetic resonance imaging (MRI), epidemics, cosmetics surgeries, open heart surgeries, neurosurgeries.

Meanwhile, 55% of respondents that were aware of the exclusions in the scheme still desire for some of the items on the NHIS exclusion list to be included. The possibility of this craving is in doubt according to Johnson & Stoskopt (2009). They opined that NHIS is impeded by obsolete and inadequate medical equipment and that the entire country suffers from perennial shortage of modern medical equipment such as X-rays, computerized testing equipment and sophisticated scanners e.t.c. This observation, correlates with the perception of the healthcare givers as discovered in the study, where unavailability of required services ranked highest as a component of ineffectiveness of the scheme among others.

The World Bank (2008) survey on the scheme shows that only one million people in Nigeria or 0.8 percent of the population are covered by NHIS, while many people have to pay for medical care out of their pockets or do without healthcare. The report further reveals that many low-income persons would not benefit from NHIS for at least another 10 years. This forecast by WHO correlates with the findings of this research. Result from this research shows that there was low negative significant relationship between health care delivery and benefits derived from the NHIS scheme. In other words, despite the supposed quality service offered to Nigerians under the coverage of the NHIS scheme, patients claim that they have not benefited much from the scheme even after nine years of its establishment.

In a recent development, an Infant mobile National Health Insurance Scheme (NHIS) was formulated by NHIS management, championed by MTN Nigeria in which subscribers will have access to standard and convenient health insurance cover on a pre-paid basis and could choose their Health Management Organisations (HMOs) and retainer hospitals, using their mobile phones for a range of pre-defined medical treatments as little as N250 weekly premium (N1, 000 monthly and N12, 000 yearly).

While government officials at several fora, have bandied the mandate to cover 30 percent of Nigerians (about 48 million) by 2015, this research exposes the under-utilisation of the mass media in the quest for effective healthcare delivery as reflected in the low percentage of awareness under media information.

In the hypotheses testing, NHIS effectiveness had a negative correlation with other variables such as: health care delivery, benefits and exclusion of NHIS, level of awareness of NHIS at r values; -.142,-102,-203,-.224and -0.52 respectively. Significant proportion of doctors and patient indicated that out –of –pocket means of financing health remains effective with about 49% of both respondents in support of the Social Health Insurance (NHIS), as a health financing scheme. This does not reflect ready acceptance of the scheme, giving the less than 50% approval from both respondents. All the result of the findings shows that the scheme is ineffective even after nine years of its establishment. Agba (2010), in his research on Perceived Impact of the National Health Insurance Schemes (NHIS) confirms that services rendered by health service providers in the scheme (NHIS) are poor.

This reflects the deteriorating state of health institutions in the country culminating in foreign medical tourism by the rich. This shows that policy cannot succeed or be effective without a good structure as proposed by observations from this study. There is need for

government to overhaul the entire health structure in Nigeria before any other health policy is proposed.

In addition to this, the health givers interviewed pointed out that challenges of health care delivery and the quality of health care delivered are negatively related. This implies that the scheme is presently hampered by some bottlenecks that inhibit the effectiveness of the scheme, with over 80% of them attesting to the fact that the programme is not achieving its set objectives. A significant proportion also pointed out that the entire policy is faulty. All these challenges put together, have not motivated the health givers to improve their activities. This observation correlates with Agba's (2010) findings, that the NHIS scheme did not improve health givers status, hence has not affected the quality of service they rendered. In essence, that the programme has no serious impact on the commitment and dedication to official duties.

From the on-going discussion, it means that, for a policy to be effective it must have a serious positive impact not only on the people at the receiving end but also change and influence the lives of the administrators.

Conclusion and Recommendations

Information on the NHIS scheme is still far from adequate. Consequently, the mass media, which is a medium of information dissemination, needs to be used to the fullest by policy makers championing the scheme.

The perceived non-availability of branded drugs, as observed by the patients, needs to be put in proper perspective. Proper education and enlightenment that expensive drugs do not, as a matter of necessity, mean that it is the best choice must be effectively communicated as patients believe that they are given cheap drugs.

The scheme also needs to be improved by expanding the scope of coverage to include hitherto excluded benefits.

Furthermore, guidelines for treatment should be re-structured such that health-givers can be flexible in administering treatment protocol.

The idea of using mobile means to access insurance by having a prepaid mechanism, though beneficial, could be made more flexible. This can be achieved through a seamless contribution by way of percentage deductions from recharge card loaded. This might require legislative backing.

References

Abdulraheem, I. S., Olapipo, A. R., & Amodu, M. O. (2012), Primary health care services in Nigeria: Critical issues and strategies for enhancing the use by the rural communities. *J Public Health Epidemiol*, *4*(1): 5-13.

Adesina, D. (2009). The National Health Insurance Scheme. Retrieved October 3, ~fromhttp://www.nigeriandoctor.Com/news.php?extend. 85D.

Adeyemo, D. O (2005), Local Government and Health Care Delivery in Nigeria: A Case Study, *Journal of Human Ecology*, Vol. 18(2): 149-160.

Agba, A. M. O., Ushie, E. M., Ushie, M. A., Bassey, A. O. & Agba, M. S. (2009). Human Development Trend in Nigeria: The Need for Concrete Implementation of the Seven Point Agenda. *Nigerian Journal of Social and Development Issues*, 4 (2): 12-24.

Agba M. S. (2010) Perceived Impact of the National Health Insurance Scheme among Registered Staff in Federal Polytechnic, Idah, Kogi State, Nigeria. *Studies in Sociology of Science* Vol. 1(1): 44-49.

Agba, A. M., Ogaboh; Ushie, E. M, and, Osuchukwu, N. (2010), National Health Insurance Scheme (NHIS) and Employees' Access to Healthcare Services in Cross River State, Nigeria. *Journal of human and Social Science* Vol. 10(7).

Akingbade, B. (2006). Meeting the Challenges of Human Capital Development in Nigeria – the Case for Reforms in Our Educational Policies and System. Being paper presented by CMO of MTN, at the Alumni convocation lecture, of the University of Nigeria, Nsukka.

Babbie, E. (1986). *The Practice of Social Research.* California: Wadsworth.

Carrin, G. (2002). Social health insurance in developing countries: a continuing challenge. *International social security review*, *55*(2): 57-69.

Cohen, A & Manion, L. (1980), Research *Methods in Education*. London: Croon Helm.

Health Insurance Association of America (2014) Health Insurance: Definition of terms. Available from: http://www.answers.com/topic/health-insurance. Retrieved August 26, 2014.

Cutler, D. M., & Zeckhauser, R. J. (2000). The anatomy of health insurance. *Handbook of health economics*, 1: 563-643.

Elwyn, G., Edwards, A., Kinnersley, P., & Grol, R. (2000), Shared decision making and the concept of equipoise: the competences of involving patients in healthcare choices. *British Journal of General Practice*, *50*(460): 892-899.

Eno, V. B. (2008). Governance Constraints and Health Care Delivery in Nigeria: The Case of Primary Health Care Services in Akwa Ibom State. *Journal of Public Administration and Management*, 15(2): 342-364.

Federal Ministry of Health (FMoH), 2007. HIV/STI biological and behavioural surveillance survey 2007. National AIDS/STI Control Programme and the Federal Ministry of Health, Abuja.

Gana, D. (2010). Roles of Health Care Provider in Health Insurance. An Article Presented at Nigeria Medical Association Annual Conference

Johnson, J. A. & Stoskopt, C. (2009). Comparative Health Systems: Global Perspectives. Online available at: http://books.google.com.ng/ books? Id=9vWpcQsfeJuc&pg=PA310.Retrieved October 3, 2013.

Johnson, J. A. & Stoskopt, C. (2009). Comparative Health Systems: Global Perspectives.OnlineAvailableat:http://books.google.com.ng/books?id=9vWpcQsfeJuc&pg=PA310.August 13, 2014.

Jütting, J.P. (2004). "Do community-based health insurance schemes improve poor people's access to health care? Evidence from rural Senegal", World *Development*, 32 (2), pp. 273-288.

Kannegiesser, L. (2009). Nation Health Insurance Scheme to Boost Generics Market in Nigeria. Online available at:http://www.frost.com/prod/ servlet/market-insighttop. pag?Src=RSS&docid=155485216. Retrieved on October 3, 2013.

Kutzin, J. (2001). A descriptive framework for country level analysis of health care financing arrangements. *Health Policy* 56:171-204.

National Health Insurance Scheme (1999). Online available at http://www.nigeria–law.org/NationalHealthInsuranceSchemeDegree.ht m. Retrieved on May 17, 2013.

NCBI (2009). Gender Bias in Access to Healthcare in Nigeria: A study of End-State Renal Disease. Online available. at:http://www.ncbi.nlm.nih gov/pubmed/18302871

NHIS (2009). NHIS – News: States Partners with NHIS. Online available at: http://www.nhis.gov.ng/index.php? Retrieved July, 17, 2013.

Oba, J. O. (2008). Nigeria: Yar'Adua and the Resuscitation of Health Sector. Online available at: http://allatrica.com/stories/200806021431.html. Retrieved October 22, 2013.

Ogunbekun, I., Ogunbekun, A., & Orobaton, N. (1999). Private health care in Nigeria: walking the tightrope. *Health policy and planning*, *14*(2), 174-181.

Okuma K, Iwakawa K, Turnidge JD, Grubb WB, Bell JM, O'Brien FG, (2002). Dissemination of new methicillin-resistant *Staphylococcus aureus* clones in the community. *Journal of Clinical Microbiology* 40:4289–94.

Olakunde, B. O. (2012). Public health care financing in Nigeria: Which way forward? *Annals of Nigerian Medicine*, *6*(1), 4.

Omoruan, A. I., Bamidele, A.P. & Phillips, O.F. (2009). Social Health Insurance and Sustainable Health Care Reform in Nigeria. *Ethno-Med*, 3 (2); 105-110.

Sanusi, R. A. & Awe, A. T. (2009). Perception of National Health Insurance Scheme (NHIS) by Health Care Consumers in Oyo State, Nigeria. *Pakistan Journal of Social Sciences,* 6 (1): 48-53.

Schellekens, O. (2009). In L. Akinola (Ed.), *A Model of Good Health. This Africa: A Global Perspective,* pp48-50.

The Vanguard Editorial (2005). National Health Insurance Scheme: A desideration. Online available at: http://nm.onlinenigeria.com /templates/? a=5836&2-7 Retrieved August 3, 2013.

Thomas O. (2014), "Nigerians can get Insurance worth #250", retrieved from the *Guardian Newspaper*, 21st July, 2014.

UNAIDS (2006). Correspondence on HIV Prevalence; May, 2006. Joint United Nations Programme on HIV/AIDS. Geneva: UNAIDS.

UNICEF (2006). Slated of the World's Children 2007. New York: UNICEF.

UNDP (2008). Human Development Report 2007/2008 on Fighting Climate Change: Human Solidarity in a Divided World. New York: Palgram Macmillan.

World Health Organisation. (2000). The World health report: 2000: Health systems: improving performance.

World Bank (2007). World Development Indicators. Washington D.C: World Bank. United Nations, Education Scientific and Cultural Organisation.

World Health Organisation (2007a). World Health Statistics 2007. Geneva: WHO.

World Health Organisation (2007b). Health Financing and Social Protection. Online available: http://www.whho.int/countries Retrieved March,9 2013.

World Health Organisation (2007c). WHO Country Cooperation: Federal Republic of Nigeria, 2002 – 2007.Geneva: WHO.

World Bank (2005). African Development Indicators 2005. Washington D. C. World Bank

World Bank (2007). World Development Indicators. Washington D.C: World Bank. United Nations, Education Scientific and Cultural   Organisation.

World Health Organisation. WHO Country Cooperation Strategy: Nigeria 2008-2013. Brazzaville: WHO Regional office for Africa; 2009.

Xu, A. Mendrek, M.S. Cohen, J. Monterosso, P. Rodriguez, S. Simon, (2005). Brain activity in cigarette smokers performing a working memory task: effects of smoking. *Biological Psychiatry,* 58, pp. 143–150.