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HEALTH INSURANCE SCHEME (NHIS) IN NIGERIA: AN EMPIRICAL SURVEY

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ABSTRACT
The 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 questionnaire 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 NHISwill, 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 groups.
***Key words**: Insurance Scheme, Health insurance, Health Administration*

Introduction

Financing healthcare services has continued to provoke discourse among low and middle income countries around the world given the fact that their health system has continued to claim more attention and fund (Philip and Alexander, 2012). Users' fees were initially introduced at the point of service delivery in some countries in order to generate revenue for the running of their health system. In some context, the introduction of users' fees led to improvement in the quality of health services while the same dovetailed into reduction in healthcare service delivery. However, the overwhelming evidence suggest that users' fees constitute a strong barrier to the utilization of health care services, as well as preventing adherence to long term treatment low income people. These problems and other issues have propelled debate to look for other alternative to healthcare financing modalities through which health care service delivery can be delivered to the people with ease (Philip and Alexander, 2012).

Prepayment and risk pooling through Social Health Insurance (SHI) and taxation are found to provide protection against some of the undesirable effects of users' fees. The international community is therefore paying more attention to SHI as one of the substitute financing mechanism for protecting the vulnerable proportion of the population against high healthcare service cost. SHI is seen as helping to pool health risk, prevent health related impoverishment and improvement in efficiency and quality of healthcare service for the poor and helps mobilise revenue for providers.

Nigeria is among a few African countries that promulgated a National Health Insurance (NHI) law. Before the advent of the National Health Insurance Scheme (NHIS), health service to government officials, their dependents and students were supposed to be free, while the general populace was expected to Pay Out of Pocket (POP) for health service received at all level of the healthcare system.

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. And in 1988, the then Minister of Health commissioned Emma-Eronmi led committee that submitted her report which was approved by the federal Executive Council in 1989 (Agba *et al*, 2010). Consultants from International labour Organisation (ILO), and United Nation Development Programme (UNDP) carried out feasibility studies

and come up with the cost implication, draft legislature and guidelines for the scheme. In 1993, the Federal government directed the Federal Ministry of Health to start the scheme in the country (Agba *et al*, 2010).

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. The decree became operational in 2004 following several flagged off; first by the wife of the then President, Mrs Stella Obasanjo on the 18th February, 2003 in Ijah, a rural community in Niger state, North Central Nigeria. Since the Rural Community Social Health Insurance and Under-5 children Health Programme of the NHIS scheme were flagged up by the First Lady, other flagged offs were carried out in Aba, Abia State South East Zone, among others (Agba *et al*, 2010).

The NHIS when launched in 2005 was built on the framework that it will cover both the formal and informal sector of the economy. This brought about the NHI guideline that appointed the professional as providers in the scheme; registration of and classification of hospitals; registration of pharmacies; registration of health maintenance organisation; among others (NHIS, 2005).

Nguyen (2011) stated that to ensure effective scheme, principal-agent relationship was established among the actors- NHIS, HMOs, employees and providers. While the NHIS and beneficiaries are the principals, HMOs and providers serve as the agents in the scheme arrangement (Eric *et al,* 2013). However, the scheme so started could only cover the formal sector of the economy against its initial intention. The formal sector includes the federal, state and other taxable establishments. But the scheme initially covers only the federal government employees, although some private establishment like banks also have their private health insurance arrangement.

As at September 2009, 25 states of the federation had agreed to partner NHIS. These include; Akwa-Ibom, Rivers, Edo, Taraba, Adamawa, Kaduna, Zamfara, Kebbi, Sokoto, Kastina, Nasarawa, Anambra, Jigawa, Imo and Kogi states. Others include Bauchi, Ogun, Oyo and Cross-River states; these states are at various stages of implementation of the scheme (Agba *et al* 2010). Oyedibe *et al* (2012) remarked that, statistic from a workshop on NHIS-MDG/MCH project by NHIS held between 6th-10th June, 2011 reveals that the number of enrolees registered and processed by some state in Nigeria as at March, 2011 are: Bayelsa-

184,685, Gombe-161,847, Niger-162,408, Imo-90,597, Oyo-158,152, Sokoto-161,847, Kastina-80,272, Jigawa-105,739, Bauchi-158,144, Yobe-102,556 and Cross-River-59,910.

Till date, over 4million identity cards have been issued. So far 62 HMOs have been accredited and registered and more application is being processed. Presently, 5,949 Healthcare providers, 24 Banks, 5 Insurance Companies and 3 Insurance Brokers have also been accredited and registered (www.NHIS.org).

Problem Area for Research

Nigeria's health system is ranked 187th of 191 (WHO, 2000). Azuzu (2008) remarked that, Nigeria Health service performance has not changed much since year 2000 ranking. He cites several statistics to highlights the inadequacies in Nigeria's Primary Health Care system. Annual budget allocation to health have been persistently below 5% except for the year 1998-1999 and 2002-2003 when they were at or just above the level. Infant mortality rate have been deteriorating from 85% in 1990, 93 in 1991 to 100 in 2003, (NDHS, 2003). And in 2007, the Federal ministry of Health reported 110 deaths per 1000 live births. Maternal mortality ratio are estimated at 1100 per 100,000 live births in WHO's world health statistics (2008).

Azuzu 2008, identified causes as some are rooted in the country's colonial past, while others stem from a lack of political will and poor policy making that failed to divide responsibilities effectively between federal, state, and local government and resulted in PHC services lacking staffs and funds.

Aside the above global and local concern, the problem of this study is derived from the lacuna in the literature concerning the paucity of empirical work in the area of appraisal of NHIS' administration in OAUTHC. Studies have shown that scholars have worked in area of NHIS especially on effect of health insurance on the demand for healthcare, healthcare funding system, assessment of client's satisfaction, but the administration of NHIS program in Obafemi Awolowo University Health Centre has not done empirical survey, hence this study. Thus, emanating from the foregoing are the various research objectives upon which the remaining aspects of this study is based. They are to: *assess the implementation strategies for the NHIS programme in Obafemi Awolowo University Health Centre; analyze the effect of NHIS on the provision of health service at the health centre of OAU and examine the challenges confronting the scheme in OAUHC;*

Generalised Appraisal of NHIS in Nigeria

The Nigeria NHIS is a Social Health Insurance Programme (SHIP) which continues the principle of socialism (being brother's keeper) with that of insurance (pooling of risks and resources). The NHIS is a body corporate established under Act 35 of 1999 by the Federal Government of Nigeria to improve the health status of all Nigerian at an affordable cost (NHIS, 2005). The NHIS Act is a statutory authority for the scheme benefit programs. It sets the general rules and guidelines for the operation of the scheme (NHIS, 2005). Thus, the hope of the average Nigerian to have a reliable, accessible and affordable healthcare delivery system became brighter. It is modelled after the practices in developed countries where responsibility for quality healthcare is shared. The NHIS, at full implementation, will spread health benefit across the primary, secondary, and tertiary fields. Due to poor participation in the scheme, the NHIS started active registration of beneficiaries in 2005 (NHIS, 2005). All Federal Civil Servants were registered. They are meant to enjoy free Health care services for two years. There was also active registration of the Armed Forces and other uniform Federal workers. The NHIS was packaged in such a manner to mobilise resources in a suitable manner for the provision of accessible, quality health care for all irrespective of status.

Part I Section 2 of the NHIS Act established a Governing Council charged with the responsibility of managing the scheme. The council consists of the following members;

a) the chairman, who shall be appointed by the Head of State or President, Commander-In-Chief of the Armed Forces on the recommendation of the Minister of Health;
b) one person to represent the Federal Ministry of Health;
c) one person to represent the Federal Ministry of Finance;
d) one person to represent the Office of Establishment and Management Service in the Office of the Secretary to the Government of the Federation;
e) one person to represent the Nigerian Employers' Consultation Association (NECA);
f) one person to represent the Nigerian Labour Congress (NLC);
g) one person to represent the registered health maintenance organisation;
h) one person to represent the private the private health care provider
i) two person to represent public interest and
j) the Executive Secretary of the scheme who shall also be the Secretary to the council

The very design of the organisational structure of the NHIS is in itself a control measure aimed at ensuring an efficient, effective and economical scheme. The NHIS is constituted of the following bodies;

i. The Council
ii. State Licensure Boards
iii. State health insurance offices
iv. Standard committee and inspectorate systems
v. Health Maintenance Organisations (HMOs)
vi. Health insurance companies (Public and Private)
vii. Arbitration Boards
viii. Malpractices insurance scheme
ix. Banks and banking systems and
x. Tribunal (NHIS, 2005 and Oyedibe *et al*, 2012).

Funding will be by contribution of 5% of enrolee's basic salary while the employer contributes 10% of enrolee's basic salary to the scheme monthly (NHIS, 2005 and Oyedibe *et al*, 2012). The insured shall choose his primary health care provider who is associated with the HMOs. The primary health care guideline of the standard committee made up of statutory professional registration boards. The state license board approves premises for practice by the healthcare provider. Liability insurance companies (public and private) will provide professional indemnity cover (malpractices insurance) for health care providers. The role of the arbitration board will be to handle conflicts between the above relationships (Oyedibe *et al*, 2012).

Objectives of the NHIS

The general purpose of NHIS is to ensure the provision of health insurance "which shall entitle insured persons and their dependents the benefit of prescribed good quality and cost effective health services" (NHIS Act 35 of 1999, Part 1(Section 1)). While the specific objectives of NHIS include;

i. ensure that every Nigeria has access to good health care 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 health care costs among different income groups
v. maintain high standard of health care delivery services within the scheme
vi. ensure efficiency in health care services
vii. improve and harness private sector participation in the provision of health care services
viii. ensure adequate distribution of health facilities within the Federation.
ix. ensure equitable patronage of all level of health care
x. ensure the availability of funds to the health sector for improved services (NIHS Act 35 of 1999, Part ll, Section 5).

Functions of the NHIS

In accordance with Part ll (6) of NHIS Act 35 of 1999, the scheme shall be responsible for-

a) registering health maintenance organisation and health care providers under the scheme;
b) issuing appropriate guidelines to maintain the viability of the scheme;
c) approving format of contracts proposed by the health maintenance organisation for all health care providers;
d) determining, after negotiation, capitation and other payments due to health care providers, by the health maintenance organisations;
e) advising the relevant bodies on inter-relationship of the scheme with other social security services;
f) the research and statistics of matters relating to the scheme;
g) advising on the continuous improvements of quality of services provided under the scheme through guideline issued by the standard committee established under section 45 of this Act;
h) determine the remuneration and allowance of all staff of the scheme;
i) exchanging information and data with the National Health Management Information System (NHMIS), Nigerian Social Insurance Trust Fund (NSITF), the Federal Office of Statistics (FOS), the Central Bank of Nigeria (CBN), banks and other financial institutions, the Federal Inland Revenue Service (FIRS), the State Internal Revenue Service (SIBR) and other bodies;
j) doing such other things as are necessary or expedient for the purpose of achieving the objectives of the scheme under this Act.

Brief X-ray of Health Care Funding in Nigeria

Health care funding system in Nigeria is predominantly from general taxation by the government which is never sufficient for the provision of good healthcare service delivery in the country. This fund is made up predominantly of revenue accruing to government from oil sector inform of Oil Royalties and fees, and crude oil sales paid into Federation Account.

The table below shows the recurrent expenditure on health and also expressed in percentage of total Federal Government recurrent expenditure between 1999 and 2013.

From the table, it will be noticed that Federal Government's recurrent expenditure to health sector has been consistently low range from 3% to 5%, it was only above 6% in 2011. However, this figure is insignificant when compared with the WHO recommended value of 10%.

Table 2.1 Federal Government Recurrent Expenditure on Health Sector from 1999-2013

YEAR	AMOUNT(#'Billion)	% of TOTAL	TOTAL
1999	16.6	3.0	449.7
2000	15.2	3.29	461.6
2001	24.5	4.23	579.3
2002	40.6	5.83	696.8
2003	33.3	3.38	984.3
2004	34.2	3.08	1,110.6
2005	55.7	4.22	1,321.2
2006	62.3	4.48	1,390.1
2007	81.9	5.15	1,589.3
2008	98.2	4.64	2,117.4
2009	90.2	4.24	2,128.0
2010	99.1	3.19	3,109.4
2011	231.8	6.99	3,314.4
2012	197.9	5.95	3,325.2
2013	180.0	4.88	3689.1

Source: Extracted from CBN 2013 Statistical Bulletin (Section B, Public Finance Statistics)

The Alma-Ata declaration of 1978 recommended that Primary Health Care (PHC) be community oriented. The Federal Government of Nigeria (FGN) adopted the recommendation and consequently transferred PHC funding to the Local Government Areas (LGA). This further led to inadequate funding of the health sector due to lack of fiscal autonomy in our federal system of government. There has been a call for fiscal federalism,

especially during the just concluded National Confab; a situation that is believed will improve the situation.

Basic System of Medical Care: A Universal Survey

Three basic systems of medical care exist in the world today- Public Assurance, Health Insurance and National Health Service (Ejimokun, 2012). The first is dominant in 108 countries constituting 49% of the world's population. The countries are located in Asia, Africa (including Nigeria) and South America (Ejimokun, 2012). In these countries, all health care services are available through a public assurance system for the poor. These are government hospitals and health centres financed by general taxation.The Health insurance is dominant in 23 countries (18% of the world's population) (Ejimokun, 2012). These (industrialized) countries are located in Western Europe and North America, Austria, New Zealand, Japan, and Israel. In most of them, a blend of governmental and non- governmental insurance exists. In some, however, (Canada, Denmark, Finland, Iceland, Norway and New Zealand), the entire population is covered by Governmental Medical Care insurance.

National Health Service is dominant in 14 counties constituting 33% of the world's population (Ejimokun, 2012). These include nine nations in Europe, four in Asia and Cuba. All these countries are either industrialized or undergoing rapid industrialization while the National Health Service covers the entire population. Financing is almost always through general governmental funds. Services are provided by salaried doctors and other health personnel who work in Government Hospitals and Health Centres spread all over the country (rural and urban) in the spirit of true equitable distribution (Ejimokun, 2012). Practically, all services are included and provided free ofcharge. Administration is unified by health departments. Regional integration of facilities, which is almost impossible to realize under health insurance program, is one of the most important achievement of National Health Service (Ejimokun, 2012).

Other outstanding sets of health Insurance systems were revealed by Ernst Spaan *et al* (2012) viz:

> National or social health insurance (SHI) which is based on individuals' mandatory enrolment. Several low- and middle-income countries, including the Philippines, Thailand and Viet Nam, are establishing SHI. Voluntary insurance mechanisms include private health insurance (PHI), which is implemented on a large scale in

> countries like Brazil, Chile, Namibia and South Africa and community-based health insurance (CBHI), now available in countries like the Democratic Republic of the Congo, Ghana, Rwanda and Senegal.

In Asian countries, the demand for PHI is speedily on the increase. For instance, in China, 30% of the urban people currently possess some kind of PHI while almost 20% are planning to buy the same in the nearest future. A major determinant is the economic factor according to Dreschler and Jutting (2007). It was revealed that people with income up to 4500 renminbi record close to 27% penetration into PHI while close to 50% of the affluents have enrolled. The enrolment looks attractive but it must be noted that the market is still immature and non-sophisticated. This is to the extent that consumer usually claim that they are not aware of the scope of condition covered in the insurance. Hence, it is imperative that consumer be properly educated on the nitty-gritty of the scheme. This scheme is not in existence in Nigeria up to the time that PharmAccess, a Dutch government-backed, Non-profit organisation skeletally introduced a similar package for the farmers in certain states in Nigeria (Gary, 2010). This is a fantastic effort which is capable of extending health care facilities to nongovernment workers and farmer at large with a bid to meeting up with the millennium development goals (Ben-Chendo *et al* 2014).

Since the implementation of National Health Insurance System, about 5 million Nigerians can readily access care through the NHIS. The NHIS benefits package is very comprehensive, covering virtually all the medical needs of enrollees- from consultation to drugs, consumables and major and minor surgeries. Studies have found that income and occupation impact usage of NHIS services; a large percentage—about 67%—of civil servants and professionals make use of NHIS services. Thus, like most Asian countries, income appears a major determining factor.

DATA PRESENTATION AND ANALYSIS

Response Rate

Two hundred and fifty five (255) copies of questionnaire were administered on chosen respondents. However, out of the two hundred and fifty five (255) questionnaire administered on the sampled population, two hundred and twenty one (221) copies of questionnaire representing 87.0% of the total questionnaire distributed were returned and accurately filled,

and found usable for analysis. In the case of Students, One hundred and seventy five (175) copies of questionnaire were administered and One hundred and forty eight (148) copies of questionnaire were returned accurately filled, this amounted to 85.0% response rate. Sixty three (63) copies of questionnaire were administered to OAU staff and Fifty eight (58) copies of questionnaire amounted to 87.0% were returned accurately filled and Seventeen (17) copies of questionnaire were administered to OAUHC staff, in which Fifteen (15) copies of questionnaire amounted to 88.0% response rate were returned accurately filled.

Assessing the implementation strategies for NHIS in the Obafemi Awolowo University Health Centre (OAUHC) (Objective 1).

The tables below assess the implementation strategies of National Health Insurance Scheme (NHIS) in Obafemi Awolowo University Health Centre, Ile Ife, Osun State.

Table 4.14: HMO's maintain quality assurance in the delivery of healthcare benefit under the scheme.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	4	1.8	28.6	28.6
	Agree	8	3.6	57.1	85.7
	Undecided	1	.5	7.1	92.9
	Disagree	1	.5	7.1	100.0
	Total	14	6.3	100.0	
Missing	Value	207	93.7		
Total		221	100.0		

Source: Field Survey, December, 2014.

Table 4.14 above shows the analysis that HMOs maintain quality assurance in the delivery of health care benefits under the scheme. The result shows that 5.4% of the respondents agreed that HMOs maintain quality assurance in the delivery of health care benefit under the scheme, while 0.5% of the respondents disagreed with the statement and 0.5% were undecided on the statement. There is a missing value of 93.7% of the study population; this represents students and non-health centre staff who are not eligible to answer this question and one health centre respondents who failed to answer this question

Table 4.15: The Involvement of Health Insurance Companies (HIC) in the scheme is necessary

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	5	2.3	35.7	35.7
	Agree	5	2.3	35.7	71.4
	Undecided	1	.5	7.1	78.6
	Disagree	3	1.4	21.4	100.0
	Total	14	6.3	100.0	
Missing	Value	207	93.7		
Total		221	100.0		

Source: Field Survey, December, 2014.

The table 4.15 above shows the analysis on the necessity of the involvement of Health Insurance Companies in the NHIS Scheme. It shows that 4.6% of the respondents agreed that involvement of Health Insurance Companies in the Scheme is necessary, while 1.4% of the respondents disagreed with the statement and 0.5% of the respondent neither agree nor disagree with the statement. There is also a missing value of 93.7% of the total respondents representing students and non-health centre staff and health centre staff that failed to respond to the question.

Table 4.17: Healthcare provider should provide and maintain standard facilities

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	11	5.0	73.3	73.3
	Agree	2	.9	13.3	86.7
	Undecided	2	.9	13.3	100.0
	Total	15	6.8	100.0	
Missing	Value	206	93.2		
Total		221	100.0		

Source: Field Survey, December, 2014.

Table 4.17 above shows the analysis of whether the health care provider should provide and maintain standard facilities in their establishment. The result shows that 5.9% of the total respondents agreed that Health care provider should provide and maintain standard facilities

in their establishment, while 0.9% of the respondents are undecided and there is missing value of 93.2% of the study population.

Table 4.18: One Sample Statistical Analysis of implementation strategies for NHIS in Obafemi Awolowo University Health Centre (OAUHC).

Variables	N	Mean	Std. Deviation	Std. Error Mean
HMO maintain quality assurance in the delivery of healthcare benefit under d scheme	14	1.93	.829	.221
Healthcare provider should provide and maintain standard facilities	15	1.40	.737	.190

Source: Field Survey, December, 2014.

Table 4.18 above shows the One Sample Statistical Analysis on implementation strategies for NHIS in Obafemi Awolowo University, Ile Ife, Osun State. The table shows that the average response number is 15, average Mean is 1.67, average Standard Deviation is 0.783 and average standard Error Mean is 0.206.

Table 4.19: T-Test Analysis of the implementation strategies for NHIS in Obafemi Awolowo University Health Centre (OAUHC)

	Test Value = 0					
					95% Confidence Interval of the Difference	
Variables	T	Df	Sig. (2-tailed)	Mean Difference	Lower	Upper
HMO maintain quality assurance in the delivery of healthcare benefit under the scheme	8.707	13	.000	1.929	1.45	2.41
Healthcare provider should provide and maintain standard facilities	7.359	14	.000	1.400	.99	1.81

Source: Field Survey, December, 2014.

Table 4.19 above shows the T-Test Analysis of the implementation strategies for NHIS in Obafemi Awolowo University Health Centre (OAUHC), Ile Ife, Osun State. The T-test table shows the result of the tested hypothesis, arriving at the result that averagely, Degree of freedom is 14, Significant (2-tailed) value is 0, Mean Difference is 1.665 and Confidence

Interval at 95% is 1.22 and 2.11 lower and upper respectively. The average T-test value is 8.033.

Since the calculated T-test value is 8.033 is greater than tabulated value, which is 1.76, therefore it is concluded that there is significant in implementation strategies for NHIS in Obafemi Awolowo University Health Centre, Ile Ife, Osun State. Hence, null hypothesis is rejected. Therefore, the result affirms that there is significant in the "Implementation strategies for NHIS in Obafemi Awolowo University Health Centre, Ile Ife, Osun State".

4.2.4 The Effects of National Health Insurance Scheme (NHIS) on the Provision of Health Service at Obafemi Awolowo University Health Centre (OAUHC) (Objective 2)

There are many ways in which National Health Insurance Scheme (NHIS) can have effects on the health care service at Obafemi Awolowo University Health Centre (OAUHC). The tables below examine the various effects of National Health Insurance Scheme (NHIS) on the provision of health care service in Obafemi Awolowo University Health Centre, Ile Ife, Osun State.

Table 4.20: NHIS has made healthcare service more efficient

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	46	20.8	20.8	20.8
	Agree	134	60.6	60.6	81.4
	Undecided	19	8.6	8.6	90.0
	Disagree	20	9.0	9.0	99.1
	Strongly Disagree	2	.9	.9	100.0
	Total	221	100.0	100.0	

Source: Field Survey, December, 2014.

The table 4.20 above shows the effect of National Health Insurance Scheme on Healthcare service in Obafemi Awolowo University Health Centre (OAUHC). The result shows that 81.4% of the total respondents agreed that NHIS has made healthcare service more efficient at the health centre, while 9.9% of the total respondents disagreed with the statement and 8.6 of the total respondents were undecided on the statement.

Table 4.21: NHIS increase utilization of healthservice at OAUHC

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	52	23.5	23.5	23.5
	Agree	114	51.6	51.6	75.1
	Undecided	38	17.2	17.2	92.3
	Disagree	16	7.2	7.2	99.5
	Strongly Disagree	1	.5	.5	100.0
	Total	221	100.0	100.0	

Source: Field Survey, December, 2014.

Table 4.21 above shows the analysis of whether National Health Insurance Scheme has led to an increase in the utilization of health services at staff and students clinic of OAU health centre. The result shows that 75.1% of the total respondents agreed that NHIS has led to an increase in the utilization of health service at staff and students clinics of OAU health centre, while 7.9% of the total respondents disagree with the statement and 17.2% were undecided about the statement.

Table 4.22: NHIS cut across all level of healthcare(Curative, Preventive or Consultative)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	78	35.3	35.3	35.3
	Agree	76	34.4	34.4	69.7
	Undecided	42	19.0	19.0	88.7
	Disagree	21	9.5	9.5	98.2
	Strongly Disagree	4	1.8	1.8	100.0
	Total	221	100.0	100.0	

Source: Field Survey, December, 2014.

Table 4.22 above shows the analysis of whether NHIS cut across all levels of healthcare whether curative, preventive or consultative. It shows that 69.7% of the total respondents agree that NHIS cut across all levels of healthcare whether curative, preventive or consultative, while 11.3% of the total respondents disagree with the statement and 19.5% of the total respondents were undecided on the statement.

Table 4.23: NHIS provide reliable and affordable healthcare delivery at Health Centre

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	62	28.1	28.2	28.2
	Agree	108	48.9	49.1	77.3
	Undecided	22	10.0	10.0	87.3
	Disagree	28	12.7	12.7	100.0
	Total	220	99.5	100.0	
Missing	Value	1	.5		
Total		221	100.0		

Source: Field Survey, December, 2014.

Table 4.23 above shows the analysis if NHIS provide reliable and affordable healthcare delivery system at the health centre. The result shows that 77% of the total respondents agreed that NHIS provide reliable and affordable healthcare delivery system at the health centre, while 12.7% of the total respondents disagreed with the statement and 10.0% of the total respondents were undecided. There is a missing value of 0.5% of the total respondents.

Table 4.24: NHIS can be adjudged better than previous healthcare delivery service

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	48	21.7	22.0	22.0
	Agree	118	53.4	54.1	76.1
	Undecided	31	14.0	14.2	90.4
	Disagree	21	9.5	9.6	100.0
	Total	218	98.6	100.0	
Missing	Value	3	1.4		
Total		221	100.0		

Source: Field Survey, December, 2014.

Table 4.24 above shows the analysis of opinion whether NHIS can be adjudged better than previous health care delivery service. The result shows that 75.1% of the respondents agreed that NHIS can be adjudged better than previous health care delivery service, while 9.5% of the respondents disagree with the statement and 14.0% of the total respondents were undecided. There is a missing value of 1.4% of the total respondents.

Table 4.25: NHIS will, and has, reduced extortion by private healthcare service providers on the citizenry

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	36	16.3	16.4	16.4
	Agree	113	51.1	51.4	67.7
	Undecided	39	17.6	17.7	85.5
	Disagree	27	12.2	12.3	97.7
	Strongly Disagree	5	2.3	2.3	100.0
	Total	220	99.5	100.0	
Missing	Value	1	.5		
Total		221	100.0		

Source: Field Survey, December, 2014.

Table 4.25 above shows the analysis of whether NHIS will, and has, reduced extortion by private healthcare service provider on the citizenry. The result shows that 67.4% agreed that NHIS will, and has, reduced extortion by private healthcare service providers on the citizenry, while 14.5% of the respondents disagree with the statement and 17.6% of the total respondents were undecided on the statement. There is a missing value of 0.5% of the study population.

Table 4.26: Chi-Square Tests Analysis of the Effects of National Health Insurance Scheme (NHIS) on the Provision of Health Service at OAUHC

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	27.782[a]	12	.006
Likelihood Ratio	26.362	12	.010
Linear-by-Linear Association	11.812	1	.001
N of Valid Cases	218		

. 8 cells (40.0%) have expected count less than 5. The minimum expected count is .10.

Source: Field Survey, December, 2014.

Table 4.26 above shows the Chi-Square Test Analysis of second objective. It examines the Effects of National Health Insurance Scheme (NHIS) on the provision of health service at Obafemi Awolowo University Health Centre (OAUHC). The Chi-Square Test table shows the result of the tested hypothesis, where we arrived at Pearson Chi-Square Value being 27.782 with a Degree of Freedom of 12 and Asymptotic Significant (2 sided) value is 0.006. The Likelihood ratio value is 26.362 with Asymptotic Sig. Value of 0.010, Linear-by-Linear Association Value being 11.812 with Asymptotic Sig. Value of 0.001 and Number of Valid Cases is 218.

Since the calculated Pearson Chi-Square value 27.782 is greater than tabulated value, which is 21.026, therefore it is concluded that there is significant effect of National Health Insurance Scheme (NHIS) on the provision of Health Service at Obafemi Awolowo University Health Centre (OAUHC). Hence, the null hypothesis is rejected. Therefore, the finding affirms that there is a significant "Effect of NHIS on the provision of Health service at Obafemi Awolowo University Health Centre (OAUHC)".

4.2.5 Challenges Confronting National Health Insurance Scheme (NHIS) in Obafemi Awolowo University Health Centre (OAUHC) (Objective 3).

There are many challenges confronting the implementation and administration of National Health Insurance Scheme (NHIS) in Obafemi Awolowo University Health Centre (OAUHC), Ile Ife, Osun State. Tables below are used to examine various challenges militating against successful administration of National Health Insurance Scheme (NHIS) in Obafemi Awolowo University Health Centre (OAUHC), Ile Ife, Osun State.

Table 4.27: Funding remains a major problem of the scheme

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	52	23.5	23.5	23.5
	Agree	104	47.1	47.1	70.6
	Undecided	40	18.1	18.1	88.7
	Disagree	18	8.1	8.1	96.8
	Strongly Disagree	7	3.2	3.2	100.0
	Total	221	100.0	100.0	

Source: Field Survey, December, 2014.

Table 4.27 above shows the analysis of the problem of funding as one of challenges confronting NHIS in Obafemi Awolowo University Health Centre (OAUHC). The result shows that 70.6% of the respondents agreed that funding remains a major problem of the scheme, while 11.3% of the total respondents disagree with the statement and 18.1% of the total respondents were undecided on the statement.

Table 4.28: The Scheme is not made compulsory by FG and is a challenge to its effectiveness

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	42	19.0	19.1	19.1
	Agree	117	52.9	53.2	72.3
	Undecided	36	16.3	16.4	88.6
	Disagree	22	10.0	10.0	98.6
	Strongly Disagree	3	1.4	1.4	100.0
	Total	220	99.5	100.0	
Missing	Value	1	.5		
Total		221	100.0		

Source: Field Survey, December, 2014.

Table 4.28 shows that 71.9% of the total respondents agreed that the fact that the scheme (NHIS), although a government policy, is not made compulsory by the Federal Government is a challenge to its effectiveness, while 11.4% of the total respondents disagree with the statement and 16.3% of the total respondents were undecided on the statement. There is a missing value of 0.5% of the study population.

Table 4.29: The Healthcentre is not fully equipped with facilities such as expensive drugs, X-rays Computerised testing equipment, etc and when available, repair/servicing are always a problem

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	67	30.3	30.3	30.3
	Agree	107	48.4	48.4	78.7
	Undecided	25	11.3	11.3	90.0
	Disagree	12	5.4	5.4	95.5
	Strongly Disagree	10	4.5	4.5	100.0
	Total	221	100.0	100.0	

Source: Field Survey, December, 2014.

Table 4.29 above shows that 78.7% of the total respondents agreed that the health centre is not fully equipped with facilities such as X-rays, computerised testing equipment and sophisticated scanner etc and when this equipment are available repair/servicing are always a problem, while 9.9% of the total respondents disagree with the statement and 11.3% of the total respondents neither agree nor disagree with the statement.

Table 4.30: There is lack of adequate personnel compared to population of patients attended to in OAUHC

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	89	40.3	40.3	40.3
	Agree	96	43.4	43.4	83.7
	Undecided	19	8.6	8.6	92.3
	Disagree	15	6.8	6.8	99.1
	Strongly Disagree	2	.9	.9	100.0
	Total	221	100.0	100.0	

Source: Field Survey, December, 2014.

Table 4.30 above shows the analysis of the fact that there is lack of adequate personnel compared to the population of patients attended to in OAUHC. It shows that 83.7% of the total respondents agreed that there is lack of adequate personnel compared to the population of patients attended to in OAUHC, while 7.7% of the respondents disagree with the statement and 8.6% of the total respondents were undecided with the statement.

Table 4.31: There is Lack of publicity among students and staff of OAU

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	92	41.6	41.6	41.6
	Agree	70	31.7	31.7	73.3
	Undecided	24	10.9	10.9	84.2
	Disagree	20	9.0	9.0	93.2
	Strongly Disagree	15	6.8	6.8	100.0
	Total	221	100.0	100.0	

Source: Field Survey, December, 2014.

Table 4.31 above is use to analysis whether there is also lack of publicity among the students and staff of Obafemi Awolowo University. The result shows that 73.3% of the total respondents agreed that there is lack of publicity among the students and staff of Obafemi Awolowo University, while 15.8% of the total respondents disagree with the statement and 10.9% of the total respondents neither agree not disagree.

Table 4.32: ANOVA Analysis of the Challenges Confronting NHIS in OAUHC

Variables		Sum of Squares	Df	Mean Square	F	Sig.
Healthcentre is not fully equipped with facilities	Between Groups	41.722	4	10.430	12.008	.000
	Within Groups	187.626	216	.869		
	Total	229.348	220			
There is lack of adequate personnel compared to patient population	Between Groups	37.822	4	9.455	14.288	.000
	Within Groups	142.948	216	.662		
	Total	180.769	220			

Source: Field Survey, December, 2014.

Table 4.32 above shows the analysis of the third objective i.e. assessing the challenges confronting National Health Insurance Scheme (NHIS) in Obafemi Awolowo University Health Centre (OAUHC). The Analysis of Variance table shows the result of the tested hypothesis, arriving at the result that averagely, Sum of Squares Between Groups is 39.772 and Sum of Squares Within Groups being 165.287 with Degree of freedom of 4 and 216 respectively. The significant value is 0.000, the average Mean Square being, Between Groups is 9.943 and Within Groups is 0.766, therefore F- value is 13.148.

Since the calculated F value 13.148 is greater than tabulated value, which is 5.63, therefore it is concluded that there are challenges confronting National Health Insurance Scheme (NHIS) in Obafemi Awolowo University Health Centre (OAUHC). Hence, null hypothesis is

rejected. Therefore, the findings affirm that there is a "Challenge confronting National Health Insurance Scheme (NHIS) in Obafemi Awolowo University Health Centre (OAUHC)".

4.2.6 Interview Analysis

Question 1: In what way is NHIS Scheme beneficiary to participants?

Medical Doctors in the Health Centre stated that, as a healthcare provider under NHIS, the scheme has enabled OAU community to have access to adequate healthcare at affordable cost. It was explained that before the introduction of the scheme, healthcare service was usually on payment out of pocket by the patient which led many into self-treatment when there is no money.

A Pharmacist stated that, National Health Insurance Scheme has helped patients to have prescribed drugs free of charge and those one not available in the store will be bought outside.

In the NHIS Unit, Head of Departments are of the opinion that the scheme provides a platform for adequate health care at affordable cost which cannot be provided by a private healthcare provider at that cost.

Question 2: What are the shortcomings you have observed in the implementation of the scheme?

Medical Doctors are of the opinion that the scheme has increased the workload on the health centre staff, since it now include students of Obafemi Awolowo University. This is made more apparent by inadequate personnel in the health centre compared with the present population of the patients.

A Pharmaceutical Doctor was of the opinion that, people viewed the scheme as national cake, therefore collect drug indiscriminately without considering the attitude as being a waste of resources. He also contemplated on the lack of personnel as a result of increased in the population of patient being attended to in the health centre.

A Head of Department in the NHIS Unit stated that one of the challenges he has observed in the health centre is the problem of delay. Patients are delayed too long before being attended to, and without considering those that may be in pain. Another expert, who represented another Head of Department, opined that there is lack of publicity among the clients. Even though, there is a compulsory payment for the students, the fact that it was not separately paid from their school fees, did not enable fresh student to be aware of the scheme, even many returning students were victims of the same circumstance. This is line with scholars' findings on challenges militating against the success of Health Insurances in other climes such as Asia, Latin America and some African Countries. Musgrove (2007) and Addae-Koranke (2013) alluded to the fact that the challenge is summarily viz: 'people do not always get the health needs the desire'. In their assertions, various factors were identified as underlining reasons for this lacuna. The issue of funding is given the topmost priority in their articles

Question 3: What improvements are needed to be carried out for the scheme to be effective?

Medical Doctors were of the opinion that the scheme has increased the number of those who patronise the centre and that there is need to employ more hands and train those on ground.

Pharmaceutical Doctors opined that identification of enrolee through data record needs to be put in place to ensure more successful implementation of the scheme. They stated that if the enrolees have computerised data record in the health centre, it will assist in the identification of staff and quick response from their ends would be ensured.

A Head of Department in NHIS Unit stated that students' bodies such as Students' Union, Departmental Association need to educate their members especially fresh students about the objectives and importance of the scheme, through liaising with Health Maintenance Organisation (HMO) for a brief discussion at the orientation programme.

Conclusion

The result showed that NHIS controlled and reduced the cost burden of healthcare services. It reduced extortion by private health service providers, it provided reliable and affordable health care delivery at the OAU health centre and it cut across all levels of healthcare such as preventive, curative and consultative. The findings also revealed that the enrolment for the scheme should be made compulsory by Federal Government. Also, that some problems militated against the success of the scheme at the Health centre. Some of the identified problems included shortage of equipment, lack of adequate personnel and lack of adequate publicity among staff of OAU.

The study concluded that introduction of NHIS has ensured equitable distribution of effective healthcare among different income groups in the university.

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