

Enrollees Assessment of Health Maintenance Organizations (HMOs) in the Implementation of National Health Insurance Scheme (NHIS) in Abuja, Nigeria

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Abstract

The abysmal performance of the healthcare sector in Nigeria led to the introduction of the 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 Organizations as intermediary, enrollees have disparate levels of satisfaction with the role of the HMOs. This study examines the perception of enrollees 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 enrollees of the Scheme in the Tertiary Health Institutions in Abuja. The study found that the enrollees 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 decentralize their structure to have representatives in tertiary health institutions and that the staff of the affected hospital. The NHIS has a duty to prevail on the HMOs to act according to the objectives of the Scheme which is to create healthcare satisfaction among Nigerians.

Keywords: NHIS, HMOs, Enrollees, Satisfaction, Healthcare

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Background to the Study

Prepayment method for health care financing has been adopted as the most certain strategy to ensure universal coverage for health (Chuma, Mulupi & McIntyre, 2013). Most countries in the developed world have a prepayment scheme for health (Evans, 2002; Mossialos & Dixon, 2002a) and have been existing for a considerable period of time. However, majority of the people in the developing countries especially in Africa pay for health care through the out-of-pocket method. This exacerbates the high burden of chronic illnesses, disabilities and mortality which cumulates in sub-optimal productivity, low life expectancy and poor development compared with the developed world (Murray & Lopez, 2013, Murray et al., 2013). In recent times, many countries in Africa have embraced prepayment methods to finance health care services (Chuma et al., 2013).

In Nigeria, the National Health Insurance Scheme (NHIS) was established in 2005 with the aim 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 health care services; ensure equitable distribution of health care costs among different income groups; maintain high standards of health care delivery services within the Scheme; ensure efficiency in health care services; improve and harness private sector participation in the provision of health care services; ensure equitable distribution of health facilities within the Federation; ensure appropriate patronage of all levels of health care; and ensure the availability of funds to the health sector for improved services (NHIS, 2018). However, efforts of the agency to achieve these aims have been less than satisfactory owing to a number of factors. The resultant effect is that at present, the scheme has only coverage of about 4% of the general population (NHIS 2018). This scenario is attributed, among others, to the fact that enrolment into the health insurance scheme in Nigeria is presently voluntary unlike in neighbouring Ghana where it is mandatory and thus with better coverage in the latter (Odeyemi and Nixon, 2013). The major stakeholders in the health insurance industry in Nigeria are the state actors such as the federal government through the National Health Insurance Scheme, (NHIS), the States and the local governments, as well as the non-state actors such as the Health Maintenance Organizations (HMOs), health services providers (public and private), pharmaceutical industries, the Nigerian Medical Association (NMA) and the masses who are the potential beneficiaries.

The medium of interface for the masses is the HMOs with whom the beneficiaries maintain their medical records and accounts. To a large extent, whether the scheme is successful or not depends on the efficacy of the HMOs since they represent the interface platform of the scheme. Enrollees' perception of these organizations is a significant scorecard of the entire scheme. This paper focuses on the perception of the attitude of HMOs in the implementation of NHIS in Abuja specifically by the enrollees in three tertiary medical institutions- University of Abuja Teaching Hospital (UATH); National Hospital, Abuja; and Federal Medical Centre (FMC) Abuja. The assessment is bordering on enrollees perception of the effectiveness of HMOs towards the implementation of NHIS in these organizations.

Statement of Problem

The NHIS policy was designed to increase accessibility and affordability of healthcare services to vast majority of the Nigerian population. It was discovered, prior to the introduction of the Scheme that Out-of-Pocket (OOP) expenses of the masses were committed to ensuring healthy living and given the precarious economic conditions of these people, the OOP method may not be sustainable hence the scheme was a natural response to the problems of healthcare in Nigeria.

As an insurance scheme, NHIS was designed to be contributory as both the beneficiaries and their employers contribute to the pool of funds held in trust and used to defray accrued medical expenses of the beneficiaries by the HMOs. The operational effectiveness of these HMOs has been called to question as many of the enrollees experience disparate service support from their various HMOs. Enrollees have had to cope with late or non-response of the HMOs in cases of referrals and outright refusal to pay accrued financial backlog of medical cost of the enrollees resulting in disenchantment and in some cases withdrawal from the scheme by these frustrated enrollees. This study, therefore, evaluates enrollees' opinions on the effectiveness of the HMOs in the operations of NHIS in Nigeria with a special focus on tertiary health institutions in Abuja-University of Abuja Teaching Hospital (UATH); National Hospital, Abuja; and Federal Medical Centre (FMC) Abuja. The study tries to provide answers to the following questions;

- a. What are the enrollees' perceptions on the role of different HMOs in the operation of NHIS?
- b. What are the challenges of assessing NHIS as occasioned by the HMOs?

Objectives of the Study

The general objective of this study is to examine the perception of enrollees to NHIS in various HMOs on the performance of the scheme in University of Abuja Teaching Hospital (UATH); National Hospital, Abuja; and Federal Medical Centre (FMC) Abuja. The specific objectives are;

- i. To find out enrollees' perceptions on the role of different HMOs in the operation of NHIS;
- ii. To ascertain the challenges of assessing NHIS as occasioned by the HMOs.

Conceptual Issues

National Health Insurance Scheme

Nigeria has the highest out-of-pocket health spending and poorest health indicators in the world (Gustafsson-Wright & Schellekens, 2013) and this has been the propelling force for the Nigerian federal State to initiate the National Health Insurance Scheme. Its policy was drafted in 1997 and its legal framework signed into law in 1999 and launched for implementation on 16th June, 2005. It was designed with the aim at universal health coverage targeted at providing comprehensive health care at affordable costs to employees of the formal sector, self-employed, ruralites and indigent population of Nigerians (Onyedibe, Giyit & Nandi, 2012). The health situation in the country shows that only 39 per cent of the population in 1990 and 44 per cent in 2004 have access to improved

sanitation. Also, in 1990-92 and 2002-04, 13 per cent and 9 per cent of Nigerians were undernourished respectively (UNDP, 2008). HIV prevalence in Nigeria in the age bracket 15 to 49 years was 3.9 per cent in 2005 (UNAIDS, 2006). In an attempt to address the precarious and dismal situation in the health sector, and provide universal access to quality health care service in the country, various health policies by successive administrations were made including the establishment of primary, secondary and tertiary health care facilities across the length and breadth of the country. The perennial health challenges in Nigeria informed the decision by Gen. Abdulsalam 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).

The provisions of the NHIS toward the health care needs of Nigerians is targeted at the formal sector of the population with emphasis on federal civil servants engaged in the Ministries, parastatals, agencies and extra-ministerial corporations. It provides for both outpatient and inpatient care for the insured, his/her spouse and four siblings under 18years (Akande, Salaudeen & Babatunde, 2011). 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 quality and cost-effective health services” (NHIS Decree No. 35 of 1999, part 1:1). The specific objectives of NHIS include:

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

The provision of healthcare is a concurrent responsibility of the three tiers of government in Nigeria. The mixed economy practiced in the country gives room for private sector participation in medical care provision (Wikipedia, 2009).

NHIS is, therefore, operational through three broad categories of stakeholders-government, the private sector as well as other agencies appointed by the government and international donor agencies. A breakdown of these stakeholders includes government at all levels, employers (both public or private sectors), self-employed, Rural

Community Health Insurance Program agency, health maintenance organizations, board of trustees, health providers, commercial banks, NGOs, community leaders and the media (Executive Secretary NHIS, 2009). Government under the scheme provides not only standards and guidelines but ensures the enforcement of policies, monitoring of implementation and evaluation of programs and services for the smooth and effective running of the scheme. Apart from funding by government and donors or partnering organizations, employees under the scheme contribute 5 per cent of their basic salaries and another 10% counterpart contribution by the employer toward the success of NHIS (Executive Secretary, NHIS, 2009). An overview of the provisions of NHIS shows that virtually no provision is made for the healthcare needs and social security of the elderly population in Nigeria.

Inclusions versus Exclusions in NHIS

Since the launch of NHIS in 2005 and its operations, it has been the major initiative to expand health insurance in Nigeria. Hospitalization, as provided by NHIS, is limited to 15 days. The extent of NHIS coverage this far is such that artisans, farmers, sole proprietors of businesses, street vendors and the unemployed are not captured (Onyedibe, Goyit & Nnadi, 2012). Again, certain health care services are not covered by NHIS and where some are covered, it is a partial coverage. For instance, some radiologic investigations and major surgeries e.g. magnetic resonance imaging (MRI), computerized tomography (CT) scan, laparoscopic or fluoroscopic examinations, mammography, hormonal assays, prostatectomy and myomectomy are given partial coverage while care for occupational or industrial injuries, cosmetic surgery, open heart surgery, neurosurgery, family planning and epidemic outbreaks are excluded from NHIS coverage. Also, injuries arising from natural disasters (earthquakes, landslides, tornadoes, hurricanes, etc.), social unrest/upheavals and terrorist attacks are excluded from its benefits package. Similarly, injuries from extreme sports activities such as car racing, boxing, wrestling, polo and other martial arts are not covered by NHIS. In addition, therapies accruing from drug abuse, addictions, sexual pervasiveness, organ transplant, surgical repairs of congenital abnormalities and purchases of spectacles are excluded. These exclusions of major illnesses and therapies show that the NHIS is shallow and segregatory in its coverage. It does not give a holistic coverage thereby negating the philosophy of its establishment. It strongly allows for more out-of-pocket expenditure by insurers and preventing universal health coverage by citizens of the country.

Workability of NHIS

NHIS can be a major determinant of improved health outcomes for all citizens especially the poorest poor of the population who cannot afford the basic necessities of life. Since its launch in 2005, the scheme claims to have issued 5 million identity cards, covering about 3 per cent of the population. (Gustafsson-Wright & Schellekens, 2013). Under the National Health Insurance Act 2008, the NHIS started a rural community-based social health insurance program (RCSHIP) in 2010. The majority of the enrollees, however, are individuals working in the formal sector and the community scheme still leaves large gaps among the poor and informally employed. Several proposals are currently in the

pipeline to expand the reach of NHIS. One such proposal is to make registration mandatory for federal government employees. Earlier in 2013, the creation of a “health fund” targeting an earmarked “health tax” of 2 per cent on the value of luxury goods was proposed. This fund would be used for the health insurance of specified groups of Nigerian citizens, including: children under five, physically challenged or disabled individuals, senior citizens above 65, prison inmates, pregnant women requiring maternity care, and indigent persons. (Gustafsson-Wright & Schellekens, 2013; Akande, Salaudeen & Babatunde, 2011; Onyedibe, Goyit & Nnadi, 2012; Agba, Ushie & Osuchukwu, 2010). At a broader level, the National Health Bill which was first proposed in 2006 to improve Nigeria's poor healthcare administration, by allocating at least 2 per cent of the federal government's revenue to the health sector is still not signed into law. However, as of mid-2012, NHIS still covered only about 3 per cent of the population (5 million individuals). Currently, NHIS programs exist that target the formal and self-employed sectors, with mixed success. The formal-sector program operates as a social health insurance scheme. Although the NHIS launched a rural community-based social health insurance program to cover more Nigerians, its uptake has been slow.

Challenges of NHIS in Nigeria

There are a number of challenges facing the actualization of NHIS in Nigeria. Funding remains a critical issue to the scheme. The percentage of government allocation to the health sector has always been abysmally low, about 2% to 3.5% of the national budget. For example, in 1996, only 2.55% of the total national budget was spent on health; 2.99% in 1998; 1.95% in 1999; 2.5% in 2000 and a marginal increase to 3.5% in 2004 (WHO, 2007ab&c). Consequently, per capita public spending for health in the country is less than US\$5; which is far below the US\$34 recommended by WHO for low-income nations (WHO, 2007a & c). While the Nigerian per capita health expenditure dwindles, the South African per capita health expenditure, for example, is US\$22 in 2001 (The Vanguard Editorial, 2005). NHIS is also impeded by obsolete and inadequate medical equipment used by health services providers. The country suffers from perennial shortage of modern medical equipment such as radiologic and radiographic testing equipment and diagnostic scanners (Johnson & Stoskopt, 2009). And where these equipments are available, their repairs/servicing are always a problem. According to Oba (2009), this situation is not unconnected with corruption. Money meant to boost the health sector ends up in private pockets. An example is the 300 million naira scam involving the Minister of health and his assistants in 2008.

Again, lack of adequate personnel in the healthcare sector is another impediment to the scheme. The country, for instance, had 19 physicians per 100,000 people between 1990 and 1999 (The Vanguard Editorial, 2005). In 2003, there were 34,923 physicians in Nigeria, giving a doctor-patient ratio of 0.28 physician per 1000 patients and 127,580 nurses or 1.03 nurses per 1000 patients as compared to 730,801 physicians or 2.5 per 1000 population in 2000 in the United States of America; and 2,669,603 nurses or 9.37 per 1000 patients. Out-migration of health personnel to the US, UK, Europe and other western/eastern countries is significantly responsible for the personnel situation in the health sector in Nigeria. For

instance, in 2005 alone, there were 2,393 Nigerian doctors practicing in the US and 1,529 in the UK. Attributing factors include poor remunerations, limited postgraduate medical programs and poor conditions of service in Nigeria (WHO, 2007a).

According to the World Bank Development Indicators (2005), the personnel situation in the healthcare sector influenced birth attendance in Nigeria. For instance, between 1997 and 2005 only 35% of births were attended to, by skilled health personnel in the country. Also, cultural and religious practices impact on the effectiveness of NHIS in Nigeria. Sexual inequality still exists and is encouraged by some religious/cultural sects in the country. Because of lack of awareness, women are being discriminated against and have limited access to social services such as education and healthcare (NCBI, 2009). Other challenges include inequality in the distribution of healthcare facilities between urban and rural areas and policies inconsistency (Omoruan, & Philips, 2009). Furthermore, poverty and the inability to pre-pay for healthcare in Nigeria are significant challenges to the success of NHIS. According to Schellekens (2009) "people are not willing to pre-pay; and because people do not pre-pay there is no risk pool. And because there is no risk pool, there is no supply side." The NHIS's role in Nigeria is somewhat diluted. It manages subsidy programs for certain population groups (not the elderly population), who pay 100 per cent of their premiums, and negotiates with HMOs for their service provisioning, while it delivers oversight and regulation functions for the system. Therefore, NHIS functions may require some streamlining, as recommended in the Ministerial Expert Committee Report in Nigeria (MEC, 2003).

Some of the recommendations in this regard made by the Ministerial Expert Committee were adopted for creating appropriate institutions for the different tasks in a large system of social health insurance, such as the National Health Insurance Council to govern NHIS (MEC, 2003; JLN, 2012). Another striking challenge to the success of NHIS is the epileptic and sometimes lack of electricity in most parts of Nigeria which hampers the smooth operation of NHIS. Take for instance, a physician is carrying out a major operation on a patient and there is power disruption. This will threaten the success of that surgical procedure and endanger the life of the patient.

In addition to the above challenges, State governments in Nigeria have still not played a significant role in expanding health insurance (Asoka, 2012). The division of roles between the central government ministries, state governments, local government agencies, and the actual insurers is lacking the luster for the effective and efficient service delivery by NHIS. Finally, the commodification of health services could mar the objectives of NHIS. This is because healthcare providers see their services as economic commodity which they sell at a bargained and exorbitant cost to those who could afford it. This negates one of the objectives of NHIS aimed at giving UHC to all Nigerians.

Theoretical framework

System Theory

According to Okotoni (2010), a system is a collection of part or sub-system integrated to accomplish an overall goal. It involves inputs, process, outputs and outcomes to achieve a

specified goal. The idea of system theory came from the discovery of a collection of cells by a microbiologist in the person of Bertalanffy (1968) where he observed the coming together of cells to form a specialised unit to achieve a purpose. His idea was taken by other scholars who related it to different fields such as management, political science and public administration. A system comprises of four main units like inputs (raw materials, human resources, capital, government, formal and informal sector, medical experts, medicines) processing (interaction of inputs), output (affordable health care delivery services) and the recycling (evaluation of National Health Insurance Scheme) (Chuang & Inder, 2009). These four units come together in form of cells to produce results which are in turn utilised to better the system.

The Input phase is the cornerstone of achieving the policy thrust of the NHIS in any country. Any system whose Inputs are not sufficient to meet its outcomes is bound to have challenges. These Inputs work together in harmony through a transformation process that involves contributions from experts to bring forth achievements of specified purpose of the system. The concluding part of the theory is the recycling phase which allows an evaluation of the entire health delivery system in order for it to be fortified especially in the area of health insurance. This theory presents an understanding of the interaction of major stakeholders in the health care delivery services.

Methodology

This survey study generated information for analysis through the use of structured questionnaires from selected enrollees of NHIS in University of Abuja Teaching Hospital (UATH); National Hospital (NH), Abuja; and Federal Medical Centre (FMC) Abuja. The study conveniently chose a sample of 13 out of the 77 registered HMOs by the NHIS for evaluation. The 13 sampled HMOs are the top list HMOs in Abuja according to the statistics provided by the HCPs under review. These HMOs are; United Healthcare International Limited, Premium Health Limited, Integrated Healthcare Limited, Managed Healthcare Services Limited, Princeton Health Group, Maayoit Healthcare Limited, Defence Health Management Limited, Healthcare Security Limited, International Health Services Limited, Zenith Medicare Limited, Zuma Health Trust, Prepaid Medicare Services Limited, and Police Health maintenance Limited. The study proportionally chose 15 respondents each operating with respective HMOs, across the three health institutions in Abuja, 5 each from a particular institution. Therefore, 195 copies of the questionnaire were personally administered by the researcher to the respondents for data collection. Face to face interview was also used to elicit the opinion of the managers of these HMOs in order to balance the views of the respondents. Analyses were done using frequency of responses to infer conclusion.

Findings and Discussion

The data generated for the purpose of this study were organized to answer the research questions in section 1.2 of this report. The responses to the first questions were in line with the general assessment of the respondents on the efficacy of the HMOs. The responses were organized to show whether each HMO has been “Good” or “Poor” in the

performance as relates to the operations of the NHIS. The responses to the first research question are as follows;

Table 1: Enrollees Assessment of the HMOs in the Operation of NHIS

ENROLLEES ASSESSMENT OF THE HMOs IN THE OPERATION OF NHIS				
HMO/HCP	UATH	NH	FMC	DECISION
United Healthcare International Limited	Good/Poor(42/23)	Good/Poor (29/36)	Good/Poor (47/18)	(118/77)GOOD
Premium Health Limited	Good/Poor (50/15)	Good/Poor (39/26)	Good/Poor (43/22)	(132/63)GOOD
Integrated Healthcare Limited	Good/Poor (15/50)	Good/Poor (17/48)	Good/Poor (12/53)	(44/151)POOR
Managed Healthcare Services Limited	Good/Poor (20/45)	Good/Poor (32/33)	Good/Poor (27/38)	(79/116)POOR
Princeton Health Group	Good/Poor (16/49)	Good/Poor (28/37)	Good/Poor (23/42)	(67/128)POOR
Maayoit Healthcare Limited	Good/Poor (12/53)	Good/Poor (18/47)	Good/Poor (22/43)	(52/143)POOR
Defence Health Management Limited	Good/Poor (39/36)	Good/Poor (59/6)	Good/Poor (50/15)	(138/57)GOOD
Healthcare Security Limited	Good/Poor (42/23)	Good/Poor (45/20)	Good/Poor (40/25)	(127/68)GOOD
International Health Services Limited	Good/Poor (27/38)	Good/Poor (23/42)	Good/Poor (25/40)	(75/120)POOR
Zenith Medicare Limited	Good/Poor (18/47)	Good/Poor (23/42)	Good/Poor (20/45)	(61/134)POOR
Zuma Health Trust	Good/Poor (52/13)	Good/Poor (48/17)	Good/Poor (46/19)	(146/49)GOOD
Prepaid Medicare Services Limited	Good/Poor (28/37)	Good/Poor (31/34)	Good/Poor (26/39)	(85/110)POOR
Police Health maintenance Limited	Good/Poor (44/21)	Good/Poor (38/27)	Good/Poor (41/24)	(122/73)GOOD

Source: Tertiary Health Institutions, Abiya

Table 1 above shows the breakdown of responses from the enrollees to NHIS in the 13 listed HMOs in the three tertiary health institutions in Abuja. The result shows that, generally, the enrollees are not satisfied with the services provided by the HMOs as seven of them were rated as poor while only six of them are rated to be good. There is an observable consistency in the pattern of assessment by the enrollees as they unanimously rate as “Poor” seven of the thirteen HMOs across the three health institutions. It suffices to conclude that the operations of these HMOs have left so much to be desired.

Gleaning from the interviews with representatives of the HMOs under review, it was discovered that part of the reasons the enrollees might want to assess them poorly is because majority of their employers have failed to remit their contributions to the scheme and the HMOs duly discontinued coverage of the affected beneficiaries. The handlers of the HMOs believe that they are not to be blamed for the failure of the enrollees to access healthcare since they are often denied the premium from various employers.

In addition to the above, the study uncovered various problems plaguing the scheme as occasioned by the HMOs and they are as follows;

- I. Difficulty in generating Authentication Codes: majority of the patients in tertiary health institutions are on referral while having their different HCPs, there is need to obtain authentication codes which will enable them to shift the recipient of the payment of their medical expenses from their primary HCP to the tertiary institution. There is often delay running into hours and sometimes days before the representatives of HMOs will respond to the request of the patient through

- the tertiary institution. Sometimes the responses are negative due to misspelt names or interposition of characters of names, all of which, mostly, are no faults of the patient. As urgent as medical matters should be, this type of difficulty, is unhealthy to the success of the scheme.
- ii. No-Show Weekends: medical services are required every hour of the day and every day of the week. Majority of the HMOs operate from 8 am to 5 pm from Mondays to Fridays and do not operate during the weekends. This unavailability of financial succor to access medical services during the weekends poses great challenge to the success of the scheme.
 - iii. Inadequate skilled Manpower: this study found that some of the staff in the NHIS department of these tertiary health institutions lacks the necessary skills for the job. It was found that in some cases, there is only one person with the requisite skill and no matter how long the person is out of office, the job remains undone until (s)he is back.
 - iv. Nonchalant attitude of hospital staff: in addition to the problem of shortage of qualified personnel, the staffs available show lack of enthusiasm towards lifting the plights of the patients. Sometimes, sheer indifference to the consequences of misspelling patients' details, causes the delay in response.
 - v. Ineffective means of communication: this study found that there are challenges associated with the usual method of communication which is the usage email, SMS and voice call services. Sometimes patients are caught between abandoning the course of chasing affordable healthcare through NHIS and seeking unorthodox alternative as a result of the delay of network services or total blackout in response from the desks of the HMOs.

Conclusion and Recommendations

It is obvious that the provision of affordable and accessible healthcare services in Nigeria through the instrumentality of National Health Insurance Scheme (NHIS) is challenged. No doubt, the NHIS initiative is lofty by the achievement of its objectives is contingent upon the resolution of these various challenges. As a tool of implementation of the scheme, the HMOs have played important roles in the operation of NHIS however; they have hardly been placed under academic scrutiny. This study evaluated the opinions of the enrollees to the scheme as covered by the various HMOs and concludes that the role of the HMOs has been ineffective. The opinions sampled revealed that the activities of a few of the HMOs are good while the majority of them are poor. This was possible because of 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 that;

1. The employers should remit the NHIS premium of their staff to the HMOs.
2. HMOs should decentralize their structure to accommodate their representatives in the tertiary health institutions to ensure that the generation of authentication codes for patients on referral is made easy.

3. Training and retraining of hospital staff are very important in order to inculcate in them the necessary skills and competence required for the job.

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