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An Epistle Of National Health Insurance Scheme And Workers' And Health Management Prescoping Federal Tertiary Institutions In Anambra State(2004 – 2018)

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Abstract :*This study examines the Epistle of National Health Insurance Scheme and Workers' and Health Management prescoping Federal Tertiary Institutions in Anambra State (2004 – 2018) . Since the policy and legal provisions of the National Health Insurance Scheme in Nigeria became operational in 2005, the Scheme had not been on track to meet its primary target of providing universal coverage for all Nigerians by 2014. The Data from the National Health Insurance Scheme in 2018 shows that only 5% of the population registered on the scheme. The subsequent objective of this study are; toaccess the level of implementation by NHIS and its benefits on employee health, evaluate the effectiveness of the NHIS on staff's financial burden and examine the effect of quality of services accessed under the NHIS on employee satisfaction. The theoretical frame work of this research study is hinged on the Structural/Functionalist Theory by Talcott Parsons (1975). The study adopted survey research design. The study made use of proportional allocation technique in selecting 366 senior and junior staff of the NnamdiAzikiwe University, Awka, Federal College of Education (Technical), Umunze, and Federal Polytechnic, Oko in Anambra. Data was collected using questionnaire structured in five point Likert scale, interview and personal observation. The data were analyzed using descriptive statistics: frequency, mean and standard deviation were used in analyzing the research question. The test of hypotheses was performed using Oneway Analysis of Variance (ANOVA). The result reveals that the NHIS implementation level has a significant benefit on employee health, the study also revealed that the services derived from the NHIS has no significant effectiveness on staff's financial burden and that there is no significant effect of quality of services accessed under the NHIS on employee satisfaction.Based on the findings the researcher recommends that it is necessary for the government to develop strategies that would make the operations of the scheme more effective, efficient and seamless in order to achieve the objectives of the scheme which among them is to reduce employee financial burden on healthcare services*.

Keywords: Financial Burden, Health Management, National Health Insurance Scheme, Workers.

Introduction

Its widely acknowledge that the performance of a national health system is largely determined by its financing mechanism. Hence, Abdulrahman and Olaosebikan (2017) noted the Federal Government through the NHIS is implementing a social health insurance programme and hopes to achieve a more flexible, more innovative and more competitive response to the health sector in order to ensure that every Nigeria has access to quality healthcare, that families are protected from the financial hardship of huge medical bills, ensure equitable distribution of healthcare costs among different income groups, improve and harness private sector participation in the provision off health services, equitable distribution of healthcare facilities within the federation, ensure availability of funds to the health sector for improved services.

National Health Insurance Scheme refers to a health insurance programme set up by the Federal government of Nigeria to provide equitable universal access to healthcare. All countries face challenges in expanding healthcare coverage. Many countries have committed themselves to achieving equity in healthcare coverage by including healthcare goals in human rights declarations, constitutions and health policy documents (Adewole, Dairo & Bolarinwa, 2016). According to Adewole *et al* (2016) expanding health insurance is a strategy that countries use to alleviate the adverse health outcomes of all citizens, especially the poorest. It is one of the methods that countries may consider to achieve universal health coverage. Universal health coverage implies ensured access to and use of high-quality healthcare services by all citizens, especially the poor, and protection for all individuals from the catastrophic financial effects of ill health.

Health Insurance, according to Ozuh (2010) is assuming the status of a global phenomenon. It was first introduced in Germany in 1883. Since then health insurance had continued to gain prominence in the other industrialized nations like France, United Kingdom and other nations. Developing countries also have joined in beaming their health search light on health insurance. According to Osuorji (2016) the overall national policy for Nationwide healthcare services was clearly stated in a 1954 Eastern Nigeria government report on policy for Medical and Health Services. This report stated that the aim was to provide health services for ALL.

Following Nigerian independence in 1960, efforts were made to develop a locally led health service by the Minister of Health in 1962 through a parliamentary bill for a Health Service Scheme in Lagos (Awosika 2005; FMOH 2008; NHIS 2013). Odeyemi and Nixon (2013) noted that the global economic downturn during the 1980s, a fall in oil prices and dwindling public

resources impacted negatively on health services in public health facilities in Nigeria. Because the Federal government 'could no longer afford to provide free healthcare for ALL, it opted to consider use of contributory mechanisms to complement other sources of healthcare funding for all Nigerians (Dogo-Mohammad 2007; Oyibo 2011). Two committees set up by two successive Ministers of Health, then recommended National Health Insurance as a desirable and feasible option for financing healthcare in Nigeria (Ndie, 2013). This set the stage for the development of a National Health Insurance policy. By the early 1990s, according to Ndie (2013), virtually all social infrastructures had deteriorated. One area of the economy that suffered greatly is the health sector. Government had responded to the infrastructural decay in all sectors of the economy by adopting a reform agenda embedded in the New Economic Empowerment and Development Strategy (NEEDS), (National Planning Commission, 2004). The health sector reform is part of the developmental strategy aimed at improving the standard of healthcare for all Nigerians. A veritable part of the health sector is the Health Insurance scheme which, as a health financing mechanism protects people against high cost of healthcare through a pre-payment method.

Nigeria, one of the few African countries to begin health insurance over the past years, seeks to achieve equitable universal healthcare coverage. Onwujekwe, (2013) maintained, that the rising cost of medical care in Nigeria coupled with underfunding of the healthcare sector by government, consequent upon the severe down-turn in the Nigerian economy in 1980s and 1990s resulted in the abysmally low patronage of the orthodox medical and other healthcare or health institutions. The World Bank (2008) reports that in the early 1990s the per capita health spending of Nigeria was not only low but was of low quality. The pitiable picture of Nigeria's health sector was revealed by the World Health Organization which noted that the country's overall health system performance in year 2000 was ranked 187th among the 191 member states of the organization (WHO, 2012) revealing low status of quality health care system in Nigeria.

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 to provide equitable distribution of health. The need for the implementation and establishment of the National Health Insurance (NHIS) Scheme was informed by the general poor state of the nation's healthcare services, excessive dependence and pressure on government's provision of health facilities, dwindling funding of healthcare in the face of rising cost, poor integration of private health facilities in the nation's healthcare delivery system and overwhelming dependence on out-of-pocket expenses to purchase health.

Bolanle, Wasiu and Gbeminiyi (2017) revealed that public health system in Nigeria, have failed to delivered adequate level of services, specially to the disadvantage groups. Firstly, access to quality public healthcare is limited, due to financial barriers such as availability and accessibility of health facilities. Secondly, public health worker's morale is poor, as salaries in public health sector are low in Nigeria, especially at state levels. As result of poor healthcare delivery system, the utilization of public health services is actually decreasing in some areas. Discontent with present situation is continually increasing among the general population; significant improvement is highly expected with the establishment of NHIS.

Quality accessibility to healthcare at affordable cost constitutes a high profile challenge in Nigeria (Agba, Ushie, Ushie, Bassey and Agba (2010). Universal Healthcare Coverage (UHC) has been difficult to achieve in many developing countries (Nigeria inclusive), with large populations remaining over-reliant on direct out-of-pocket expenses that include over-the-counter payments for medicines and fees for consultations and procedures (Odeyemi, 2014). Agba (2010) observes that access to quality health care by the poor results to long waiting of the patients during help-seeking for healthcare services and this tends to bore prospective users of NHIS rendering them unsatisfied. He noted that the scheme had not been able to meet the health needs of employee and consequent upon which are evidences of improper attention, expending substantial amount of money for procurement of drugs, etc. According to Agba (2010) All these have influence on family standard of living as money which could have been used to meet other needs are spent on healthcare expenses and this situation has rendered beneficially quite unsatisfied to the program.

The term 'satisfaction among beneficiaries of NHIS according to Okaro, Ohagwu and Njoku, (2016) is generally seen to be the broader concept and one that can be viewed at individual service encounter level or at more global level. Client evaluation is relative to knowledge of services, to expectations; to the help received from other services, to perceptions of the 'pleasantness' of the health worker (Wright, 2017). Unless such factors are taken into account, we can never be sure whether the high rate of staff satisfaction is related to factors of knowledge or limited expectations, than the actual helpfulness of the social contact. Staff satisfaction is a fundamental indicator of success in any form of service delivery and is therefore a key component of quality of healthcare.

Adeoye, Indabawa, Abdulsalam and Oboh (2015) revealed that Nigeria, like other developing countries, the quality of NHIS services and benefit recorded by employees was either very low or there was prevalence of substandard and unregistered health institutions. Adeoye *et al.,* (2015) the resultant effects of these were that at some point, our health institutions were not effective, the became shadow of themselves and consequently, reduced to poorly managed 'consulting clinic' which could hardly handle serious health problems. Quality of healthcare is best looked at in the perspective of the three key players of the health services, the client, the healthcare provider and the health manager. Most of the quality improvement initiatives as noted by Ele, Ogbonna, Ochei and Odili (2017) are provider centered, making it difficult to predict the patients' needs while few are patient centered neglecting the provider who is giving the care directly to the patients. Again in most instances studies about quality of

care were basically mere assessment of quality of care in various health institutions, while overlooking what actually constitute quality in the perspective of all the key players during service delivery.

Customers' satisfaction with healthcare has in recent years, gained widespread recognition as a measure of quality of care. Since high quality healthcare outcome is dependent on compliance which, in turn, is dependent on patient satisfaction, the latter has come to be seen as a legitimate healthcare goal and therefore of quality care. Hence care cannot be high quality unless the patient is satisfied. Increasing consumerism poses challenges for healthcare providers (HCPs), particularly for those in primary care. Quality improvement to meet patients' heightened demands for service excellence will require effective continuous measurement of patient perspectives. By systematically measuring patient satisfaction and perception of quality, medical practices can increase the effectiveness of primary care, improving patients' outcome and control cost.

Client satisfaction is regarded as one of the ultimate goals that all health system should strive for; it reflects the health system in client prospect. Yet public health care in developing countries have failed to achieve adequate level of services. In Anambra state for example, satisfaction for public health care is considerably low. To improve public participation and effectiveness of the undergoing health reform initiative in Anambra state, the underlying factors that contribute to consumer's satisfaction for public health services must be fully understood.

Research Questions

The following research questions will guide the study:

1. What is level of implementation by NHIS and its benefits on employee health?
2. How effective are the services derived from the NHIS on staff's financial burden?
3. What is the effect of quality of services accessed under the NHIS on employee satisfaction?

Level of Implementation by NHIS and its Benefits on Employee Health

In order to ensure that every Nigerian has access to good healthcare services, the Nigeria National Health Insurance scheme (NHIS) was structured to cover all groups in society. Thus, there is the formal sector health insurance programme; urban self-employed health insurance programme; rural community programme; the under five children insurance programme; the permanently disabled social health insurance programme; the prison inmates programme, and the international travel health insurance programme. National Health Insurance Scheme (NHIS) implementation in Nigeria started with compulsory enrolment of employees in the public sector (Falegan, 2018). Universal health coverage according to World Health Organization (2010) represents a sustainable development goal for health. This stems from the implicit truth that healthy populations mean higher labour productivity and higher returns to households from labour participation. According to the World Health Organization (2010), Universal Health Coverage (UHC) not only guarantees every citizen access to acceptable and quality healthcare, it also provides financial protection to them, thus cushioning them from the impoverishing effects of ill health and the costs thereof. Universal access to healthcare improves system's health outcomes, improves productivity and positively correlates with economic development.

Since its introduction in Nigeria in 2005, the National Health Insurance scheme (NHIS) has witnessed a substantial increase in coverage from less than 150,000 lives in 2005 to about 5 million (3% of the population) in 2010, the vast majority of beneficiaries being Federal Government employees and their dependents (NHIS Executive Secretary's Note, 2015; Mohammed, 2015) in the Formal Sector Social Health Insurance Programme (FSSHIP). To further improve coverage, the Informal Sector Social Health Insurance Programme (ISSHIP) (Community-based Social Health Insurance Programme (SHIP) and Voluntary contributors) and Vulnerable Group Social Health Insurance Programme (VGSHIP) were introduced. The number of players (Health Management Organisations (HMOs) and Health Care Providers (HCPs) in the Scheme had also expanded over the years. Despite these efforts, out-of-pocket payments (OOP) remain an important source of funding for healthcare, accounting for more than 90% of private expenditures on health (Soyibo, Olaniyan & Lawanson, 2009), placing a disproportionately huge financial burden on low income earners who often end up paying more due to delay in seeking prompt care (McIntyre, 2007). Endemic diseases such as malaria, typhoid, respiratory and diarrhea diseases are among the greatest contributors of the economic burden on both households and governments in Nigeria, accounting for over 90% of consultations under the National Health Insurance Scheme (NHIS) (Onwujekwe, 2005).

There has been a significant lag in the level of implementation and success of Social Health Insurance (SHI) at the Federal, State and Local Government levels in Nigeria. While Yobe state was among the first to implement Formal Sector Social Health Insurance Programme (FSSHIP) in 2005, other states like Anambra state started relatively later. Chikeleze (2007) found out that the level of awareness and/or success in Anambra state leaves much to be desired, as generality of the populace were reportedly unaware of such programme, and amongst those that were aware, majority of them were skeptical about its practicability and sustainability, while some others believed they are being short-changed of their hard-earned monthly stipends. Some others were duly registered but do not avail themselves of the services being rendered by the providers.

Conceptually, National Health Insurance scheme (NHIS) is a welcomed development in the Nigerian health sector given

its objective. However, its effectiveness in implementation, or otherwise, can only be determined by the extent to which it has achieved its objectives. Only federal public servants benefit now as only the public sector programmes have been implemented. On reduction of dependence on government for funding health services, Arum (2008) acknowledges that the scheme has reduced the burden on the government and improved the funding of health service through its contributory strategy. The 15 percent deduction from basic salaries of workers, which are remitted to the National Health Insurance scheme (NHIS) and the co-payment system, have all increased healthcare funding. The scheme however, had been rated low in the integration of private sector healthcare delivery system. According to Lambo (2006), most of the health service providers are government owned hospitals. Few private health institutions operate the scheme. While some have stopped the scheme so many others refuse to register additional clients. It is also observed that most of them lack the personnel and requisite facilities for operation of the scheme.

Ele *et al.,* (2016) stated that it is contemplated that the health care providers under the NHI scheme shall provide the following benefits for the beneficiaries. The beneficiaries to the scheme are expected to enjoy the following benefits under the scheme. The benefits package for the National Health Insurance Scheme for workers in the formal sector is pre-determined and includes: Out-patient care, including necessary consumables, Prescribed drugs, pharmaceutical care and diagnostic tests on the National Essential Drugs List and Diagnostic Test Lists, Maternity care for up to four live births for every insured contributor Preventive care including immunization, health education, family planning, antenatal and post-natal care Consultation with specialists referral, Hospital in-patient care in a standard ward for a 15 cumulative days per year, Eye examination and care, excluding the provision of spectacles and contact lenses, A range of prostheses (limited to artificial limbs produced in Nigeria), Preventive dental care and pain relief including consultation, dental health education, amalgam filling, and simple extraction (NHIS 2012).

Beyond offering universal coverage NHIS cuts the cost of healthcare services, promotes equity in health service utilization by maintaining equal standards, it ensures equity in the burden of funding through contributions from stakeholders alike (government, private sector and individuals) (Ministry of Health, Federal Republic of Nigeria, 2006). These benefits amongst others should encourage the utilization of the scheme. Adequate knowledge and awareness about a scheme such as the NHIS and its benefits are important for its sustainability. Moreover, adequate knowledge has been shown to be associated with membership of a health insurance scheme (Onuekwusi, 2018). However, the primary provider shall pay per diem for bed space for a total 15 days cumulative per year; optical examination and care, excluding the provision of spectacles and contact lenses; a range of prostheses (limited to artificial limbs produced in Nigeria) and Preventive dental care and pain relief (including consultation, dental health education, amalgam filing, and simple extraction). Nigeria which is comprised of 36 states and the Federal capital territory FCT as well as the 774 Local Government Area (LGAs) has a Federal structure that has shaped health delivery in Nigeria. There are also three tiers of government that are involved in health care delivery and organization. The provision of healthcare is a concurrent responsibility of the three tiers of government in Nigeria. All the three tiers of government are involved in the healthcare delivery organization, management, and financing.

Nevertheless, Soyibo (2009), states that most of the objectives of the National Health Insurance Scheme (NHIS) are far from being achieved few years after its take-off. For instance, not every Nigerian has access to good healthcare service under the scheme because of poverty, high cost of drugs and lack of healthcare facilities. Many are still facing financial hardship caused by huge medical bills. Only few hospitals provide high standard healthcare services. Furthermore, ensuring equitable distribution of healthcare services throughout the federation under the scheme is still far-fetched.

Currently, the implementations of the National Health Insurance Scheme (NHIS) have not been adequate in physical health facilities, personnel, administrative and logistics. The nation does not have enough healthcare providing institutions with adequate medical facilities and personnel for effective implementation of the scheme besides, the administration of the scheme has not been easy given the delays in processing documents of registered beneficiaries and remit contributions to the National Health Insurance scheme (NHIS), Health Management Organisations (HMOs) and Health Service Providers (HSPs) (Soyibo, 2009).

Furthermore, the informal sector is very difficult to organize for the scheme. Even private hospitals and clinics are becoming unwilling to embrace the scheme. Nevertheless, there seems to be prospects for the success of the scheme. As Ezeoke, Onwujekwe and Uzochukwu (2012), point out, the increasing political commitment or government support as well as international donor agency as support for the scheme indicate prospects for the scheme in Nigeria. Besides, many organized private sector enterprises are now bracing up for the scheme.

Current Implementation of the NHIS:

In 2005, the NHIS was officially flagged off with the formal sector programme which aims to provide Social Health Insurance (SHI) coverage to all workers in the civil service (public sector, armed forces, police and other uniformed services) and the organized private sector. The states (except Bauchi, Rivers and Cross-Rivers) however did not immediately embrace the scheme

(Asoka, 2011). The formal sector SHI scheme being implemented is funded by pay-roll deductions, and the NHIS is currently responsible for collection of funds. The payroll deductions are proportional and theoretically comprise employer = 10% of basic salary; employee = 5% of basic salary. Notably, at the roll-out stage, the government waived the initial 5% which was to be contributed by the employee, and the NHIS commenced the programme with the 10% of basic salary provided by the federal government i.e. the employer (NHIS, 2013). Till date, this is how the scheme is being funded due to widespread resistance from the Nigerian Labour Congress (NLC) to have the 5% employee contribution deducted for the scheme, citing widespread poor salaries and non-inclusion in decision-making (Asoka, 2011).

In addition, the joint NHIS/MDG-Millennium Development Goal, maternal and child health (MCH) project was piloted in phases over 3 years (2008 – 2010) in 12 states. It is being expanded nationwide to provide care for pregnant women and children less than 5 years (CU5) only up till 2015 and is presently funded by the MDG debt relief funds. Beyond 2015, the state governments are required to incorporate the project into state funded SHI programmes (Omagbemi *et al.,* 2020). Other methods of revenue collection are yet to be designed to fund the scheme for the informal sector, vulnerable and other groups.

In 2011, blueprints for the Tertiary Institutions Social Health Insurance Programme (TISHIP) and voluntary participants SHI schemes were launched to complete commencement of the formal sector programmes. The target populations are students of higher schools, the urban self-employed sector and any interested individuals, including those in the formal sector contributing on behalf of their dependents in the informal sector. Some tertiary institutions have commenced the TISHIP but the voluntary participants' scheme has not progressed beyond the blueprint phase (NHIS, 2013). Omagbemi *et al.,* (2020) revealed that some states have initiated donor and state-funded community health insurance pilot schemes. In addition, fractions of the organized private sector subscribe for direct premium-based voluntary private health insurance schemes with the HMOs.

The Effectiveness of the NHIS on Staff's Financial Burden

The increasing pressure to deliver effective and proper healthcare to the populace with the limited financial resources available had always been a source of concern for the government and health managers in Africa. The situation had led the government to explore alternative healthcare financing initiatives, including various types of health insurance schemes (World Health Organization, 2011). Bruno, Bart and Guy (2015) noted that many African countries, including Nigeria, decided to implement the National Health Insurance scheme (NHIS) to complement funding for the health sector, with a view to improve equity in health.

To ensure an effective scheme, a principal-agent relationship was established among the actors, National Health Insurance scheme (NHIS), Health Management Organisations (HMOs), Employers and Healthcare Providers (HCP) since 2005. While the National Health Insurance scheme (NHIS) and beneficiaries are the principals, Health Management Organisations (HMOs) and Healthcare Providers (HCP) serve as the agents in the scheme arrangement (Nguyen, 2011). 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 currently covers only the federal government employees, although some private establishments like banks also have their private health insurance arrangements (Onwujekwe, Uzochukwu, Obikeze, Okoronkwo, Ochonma, Onoka, Madubuko & Okoli, 2010).

The greatest expectation of employee about the NHIS is to reduce the burden of health care cost on households. Survey study by Ele *et al.,* (2017) has established that access and use of health care facilities have increased with NHIS membership. Ele *et al.*, (2017) revealed that the data shows that households registered with the NHIS shows that the benefit in terms of out-of-pocket (OOP) expenditures at health care facilities compared to those that are not registered. It has also revealed that less than 30% of persons who hold valid NHIS cards spend cash at health facilities. This is far less than the 90% of persons who are not registered with the scheme. Persons with NHIS valid cards may incur OOP because of two things: (i) illness that is not covered by the scheme (even though by regulation about 95% of all conditions are covered); (ii) an illness that may involve other medications that are not covered by the scheme. Despite these individual MHOs have operational challenges that tend to serve as barriers to beneficiaries to getting the needed assistance. Members of the scheme may also use facilities that are not accredited out of convenience.

The pointer however shows that more of the population who are in need of financial risk protection against ill health are yet to be covered. The scheme has potentials to give every employee of the federal government, his/her spouse and four children below the age of 18 years' access to health care. However, the kinds of health services beneficiaries receive depend on the inclusion and exclusion criteria. Those under the scheme are required to hold their identity cards and register with their choice providers. It is important to consider the level of information the beneficiaries have about the scheme and its potential benefits, as well as the effect of the inclusion-exclusion criteria on their overall health seeking behaviour.

Benefit Incidence Analysis (BIA) in health care considers who receives what benefit (in terms of socio-economic groups) from using health services (McIntyre & Ataguba, 2010), and it focuses only on publicly funded (health) services to access whether

or not public subsidies are pro-poor. A health insurance scheme that covers only what the poor can conveniently afford is not actually a good representation of risk protection against ill health no matter how impoverished the people may be. Benefit of a programme in terms of out of pocket spending can be translated based on how much people's lives could be affected by it (Mariko, 2013). In line with this, the National Health Insurance Scheme (NHIS) in Nigeria is expected to give benefits to the beneficiaries as well as encourage them to improve on their health seeking pattern. But the extent to which enrollees health finances have been affected due to the scheme has not been significant (Onwujekwe, 2010).

The greatest expectation of Nigerians about the NHIS is to reduce the burden of health care cost on households. Survey by IIiyasu, Abubakar and Abubakar (2016) has established that access and use of health care facilities have increased with NHIS membership. They show that households registered with the NHIS benefit in terms of out-of-pocket (OOP) expenditures at health care facilities compared to those that are not registered. They also revealed that less than 30% of persons who hold valid NHIS cards spend cash at health facilities. This is far less than the 90% of persons who are not registered with the scheme. Persons with NHIS valid cards may incur OOP because of two things: (i) illness that is not covered by the scheme (even though by regulation about 95% of all conditions are covered); (ii) an illness that may involve other medications that are not covered by the scheme. Despite these individual MHOs have operational challenges that tend to serve as barriers to beneficiaries to getting the needed assistance. Members of the scheme may also use facilities that are not accredited out of convenience.

The rationale for establishment of NHIS is very robust at reducing the burden of financing healthcare service. Despite this robust nature of NHIS, the health care demand is still very high. Another important observation from Nguyen, Yogesh and Hong (2015) in Ghana deals with the differences between the cost of treatment of diseases or ailment for households which are not NHIS subscribers and those that are NHIS subscribers, the cost of treatment for individuals under the NHIS was estimated to be GH¢20 while cost of treatment borne by individuals who are not insured was estimated at GH¢15. It is likely that people with valid NHIS card use high quality health care unlike those who do not belong to the scheme who may use low quality health care due to lower cost. However, it is important to caution against the possible abuse of the scheme and "overuse" of services, in order not to deplete the scheme's resources. The NHIS managers need to be encouraged to thoroughly review claims to avoid possible provider induced claims. Overall, the average cost of deliveries estimated from the survey is GH¢31 per delivery. However, responses from NHIS card holders, show that it costs the scheme nearly GH¢39.70 to take care of the cost of delivery per an individual, compared to GH¢27.32 by Non-NHIS card holders. This again raises concerns about possible over use and possible provider inducement. It is however important to observe that individuals without NHIS cards before the introduction of the exemption policy for maternal care were not using certain health services because of the cost involved.

The core roles of NHIS in health financing include raising of revenue and pooling of resources for health care so that health risk can be effectively shared among members on the NHIS (Akande *et al.*, 2011). This is one of the major indicators of a growing society as no society can be said to be genuinely growing unless the vital indicators of better living are evident. In support of the above assertion, Akhakpe (2014) stated that this will reduce the probability that households have to forgo other subsistence need for health care hence serving as safety net and not only that the financial barrier of accessing health services can be minimized. Since the introduction of NHIS during this last decade in many African countries, Olugbenga-Bello *et al.*, 2010; Shafiu *et al.*, 2013; Osiya, Ogaji and Onotai (2018) found out that there has been increase in utilization of health facilities and a reduction in Out-of-Pocket (OOP) expenditure. A research on evaluation of the effects of NHIS in Ghana revealed a doubling of utilization of health care facilities from 37% in 2004 (pre-NHIS era) to 70% in 2007 (post- NHIS era) and this was equally accompanied by a substantial reduction in Out-of-Pocket (OOP) expenditure for health care from 43,604cedis ($4.69) to 19,898cedis ($2.14) (USAID 2009). Similarly, Nguyen *et al.*, (2015) from their study on financial protection of NHIS underscores disparity between OOP expenditure by uninsured persons [29,843cedis ($3.21)] and insured persons [21,503 ($2.31)].

In Nigeria, before NHIS implementation an average of 357 patients were seen in the staff clinic of a tertiary institution monthly but after introduction of the scheme there was 150% increase in utilization (Akande *et al.*, 2011). Similar study in Nigeria by Adinma, Nwakoby and Adinma (2010) showed that there was significant utilization of maternal health services after implementation of health insurance scheme. In United States of America, Weller, Minkovitz and Anderson (2012) found that children with public insurance were significantly more likely than privately insured children to use 2 of the 4 medical services and 5 of the 7 health related services. Likewise in Taiwan, Agar, and Noemi (2016) revealed that the introduction of National Health Insurance Scheme reduced the disparity of patient utilization between the previously uninsured and insured older urban residents by 12.9 (22.0) percentage points.

Furthermore, various studies done in Nigeria reiterate patients' satisfaction with NHIS and its positive impact on financial burden. In Osun State of Nigeria, 39.1% and 2.9% of civil servant respectively "Agree" and "Strongly agree" that NHIS reduces the burden of medical bills (Olugbenga-Bello *et al*., 2010). Also in Zaria, a study revealed that 42.1% of client are "more satisfied" while 57.9% are "less satisfied" with NHIS (Shafiu *et al.*, 2013). In another study among dentists in Lagos, 76.6% admit the

scheme will improve access to oral health and 71.4% believed affordability of health services will equally increase with NHIS (Adewole, *et al.,* 2020). More so, Oyibo (2011) in his study on OOP payments for health services posited that majority of people have difficulties in accessing quality health care services as a result of financial hardship. This also reiterates the finding from a study carried out by Oladapo and Durojaiye (2015) in Sagamu, Nigeria where poor quality of emergency care for ruptured uterus was mainly due to financial constraint and for this reason the importance of NHIS on financial protection cannot be over-emphasized. However, studies by Akande *et al.,* 2011; Shafiu *et al.,* 2011; and Olugbenga-Bello *et al.,* (2010) also showed that the implementation of NHIS has some drawbacks. One of such drawbacks is that there have been reports on providers commonly soliciting informal payments by charging for services out of hours, asking patients to pay for drugs which are said not to be in stock or for drugs or services not covered by the scheme.

Oyibo (2011) on his study on out-of-pocket payment for health services: constraints and implications for government employees in Abakaliki, Ebonyi State had also reported unsatisfactory experiences of enrollees in the scheme; these include inadequate drug supplies, poor prescriptions of drugs, poor attitudinal disposition of some health workers, poor registration services, poor referral system and delays in receiving required services. Generally, evidence abounds that waiting time, attitude of health staff and type of health facility are predictors of users' satisfaction with health care services, including National Health Insurance scheme (Nabbuye-Sekandi, Makumbi, Kasangaki & Kizza 2011). All these combined could make the insured dissatisfied with the scheme and result in poor utilization of services rendered, seeking for healthcare in alternative places and consequent increase in out-of-pocket expenditures. The above reports depict a dysfunctional social health insurance scheme. These concerns might be partly responsible for the recent findings which showed that over 90% of healthcare services are paid for through direct user fees. For example, 69% of respondents in a study by Oyibo (2011) reportedly relied on out-of-pocket payment in order to pay for healthcare services at the time of seeking for medical treatment for themselves or their dependants; whereas 28.4% relied on a prepayment package National Health Insurance Scheme (NHIS) and 2.6% borrowed money. The high rate of out-of-pocket payment could have been responsible for alternative health seeking behaviours demonstrated by participants in the study; these include self-medication (47.7%), delayed seeking for health care (28.4%), patronage of herbalists (17.1%) and ignoring illness (6.8%). In view of the above, reversing this trend and scaling up universal healthcare coverage might require periodic assessment of enrollees' satisfaction as part of interventions aimed at improving optimal access and success of the scheme. The findings of such assessment would not only help sustain the interest of current and prospective enrollees but also useful for re-energizing the system by decision or policymakers.

The National Health Insurance Scheme (NHIS) was introduced in Nigeria as a means to improving access to healthcare services at affordable costs. However, Onoka, Onwujekwe, Uzochukwu and Ezumah (2013) stated that the demand for medical care is irregular and this is because it is either determined by illness or risk of death. Therefore, this creates a dire need for everyone to have access to basic medical care which should not be determined by an individual's socio-economic status. This is because the price of medical care, if high, can promote under-utilization of healthcare services and consequent sub-optimal health status (Onoka, *et al.,* 2013).

Despite the introduction of National Health Insurance Scheme (NHIS), current coverage is below 20% of the intended population (Lagomarsino, Garabrant, Adyas, Muga & Otoo, 2012). Furthermore, healthcare services are yet to be provided to those enrolled in the scheme effectively and efficiently. Result from a study done by Onyedibe, Goyit and Nnadi (2012), on evaluation of the National Health Insurance scheme (NHIS) in Jos Plateau State reveal that users have complained about how some healthcare providers charge extra fees for certain services as these are not covered under the benefit package.

The Effect of Quality of Services Accessed Under the NHIS on Employee Satisfaction

Consumer satisfaction with healthcare has, in recent years gained widespread recognition as a measure of quality of care. This has arisen partly because of the desire for greater involvement of the consumer in healthcare process and partly because of the link demonstrated to exist between satisfaction and compliance in areas such as appointment keeping, intension to comply with recommended treatment and medication use. Since quality clinical outcome is dependent on patient satisfaction the latter has come to be seen as a legitimate health care goal and therefore of quality care. Care cannot be of high quality unless the patient is satisfied.

Unsatisfactory experiences of enrollees in the National Health Insurance scheme (NHIS) are enormous and on the increase. In support Olugbenga-Bello & Adebimpe, (2010) asserted that the continued stagnating healthcare system in Nigeria is of great social, economic and health consequences to all including the work-force. According to Onyedibe (2012) It must be noted that lack of access to quality health care may result to poor health status, absenteeism at work, reduced productivity, financial drain/burden, and psychological problem as well as reduced national socioeconomic development in general. As a result, it is imperative to evolve a sustainable and equitable strategy that eliminates all barriers to healthcare service where policy makers and other

stakeholders in health institutions including health care providers and health maintenance organizations, must ensure proper implementation of quality and accessible National Health Insurance scheme (NHIS) services to health workers in Nigeria.

This bothers around the operations of NHIS and level of satisfaction of clients utilizing the NHIS services. Identified factors responsible for lack of satisfaction of NHIS services as revealed by Olalere (2017) includes shortage of drugs and out of stock syndrome, unavailability of blood and essential consumables, prolong waiting time which many refer to as waste of precious time, poor attitude of staff to work and unnecessary protocol. The significant correlation between needs, healthcare provisions and outcomes have led both researchers and practitioners to seek to evaluate healthcare through the intermediate outcome of patients' satisfaction (Nabbuye-Sekandi *et al.,* 2011; Osiya *et al.*; Olalere, 2017; Muhammed & Ibrahim, 2018. etc) in their findings argued that satisfaction with care will be directly related to the final outcome of that care and also that consumer satisfaction should be the ultimate objective of healthcare providers, just as it is that of other service providers. Therefore, satisfaction should be seen as an attitudinal response to value judgments that patients make about clinical encounter.

They reported that patient's satisfaction with the healthcare they receive is an important health outcome which should be given particular emphasis in current review of health service delivery. Nevertheless, Osiya *et al.,* (2018) revealed that the relationship between satisfaction and the quality of care received is a complex factor and is affected by patient, doctor and service factors. Studies by Nabbuye-Sekandi *et al.,* 2011; Osiya *et al.*; Olalere, 2017; Muhammed & Ibrahim, 2018. etc have speculated that patient expectation of the care they will receive has an important impact on satisfaction. Patients with inappropriately high expectations may be dissatisfied with optimal care, and those with inappropriately low expectations may be satisfied with deficient care. Furthermore, observed differences in satisfaction between people from different social classes, age, sex and cultural group or between different services and types of care may be confounded by match or mismatch between expectation and the service received.

Some scholars have made contributions on clients' satisfaction on health insurance. In particular reference to northern Nigeria, Mohammed, Sambo and Dong (2011) conducted a study in Ahmadu Bello University Zaria and found that 42% of the enrolled clients were satisfied with the services of the Health Insurance. The study also further revealed that, clients with more knowledge about the scheme and those that are aware of their financial contributions are more satisfied than those with low knowledge and those that are not aware of their financial contributions. They further highlighted the factors that significantly influenced satisfaction as; marital status, general knowledge of Health Insurance, and awareness of financial contributions. However, they claimed that other factors that slightly influenced satisfaction was; length of employment, salary income, hospital visits and length of duration of enrolment into health insurance. Abdulqadir (2012) equally discovered low level of satisfaction among NHIS enrollee. According to him 48.9% of the total respondents were satisfied with the services of the scheme. Onyedibe *et. al.,* (2012) equally arrived at same findings; they found the satisfaction of NHIS clients to be as low as 34%. According to them, poor registration system, poor referral system, and delay in receiving services were the factors that influenced dissatisfaction with the NHIS scheme. While contributing to the debate, Mohammed *et al* (2011) examined family coverage of NHIS as a proxy to clients' satisfaction of the scheme. They found that at the initial point, enrollees have viewed the NHIS as a favour. But later consistently express dissatisfaction over the term of coverage. This was so because the scheme covers only the primary insured persons, spouse and only four biological children that are less than Eighteen years in a setting where extended family is very common and welcomed practice. They further highlighted the dissatisfaction of clients as a result of exclusion of some members of their families. And they opined that, it will affect the willingness of some potential clients in participating in the insurance scheme. On the contrary, Gup, Ofoedu, Njoku, Odu, Ifedigbo and Iwuamanam (2012) find higher satisfaction with NHIS in their study. The client's satisfaction was 68.8% of the 400 respondents. The proxies used in the study as determinants of clients' satisfaction were; accessibility of the health facility, waiting time, patients-provider communication, patients-provider relationships, hospital bureaucracy and hospital environment. In the same line, Jadoo, Sharifa, Zafar and Ammar (2012) while contributing to the debate, conducted a cross sectional study in Istanbul, Turkey with the aim of determining the level of patients' satisfaction and the factors that influence the satisfaction. The study revealed 53.3% of the respondents were satisfied with the services of the National Health Insurance. The satisfaction was assessed using domains of; access to care, availability of resources, technical quality, overall satisfaction, continuity of care and humaneness of the personnel. The bivariate analysis of the variables indicated Eight (8) factors were significantly associated with the level of satisfaction. These factors were; age, gender, marital status, education, occupation, self-perceived health status, area of residency and type of household plan. Further analysis using Logistic regression indicated that the eight factors are also significant predictors to the level of satisfaction.

Reinforcing the argument, Akande, Salaudeen, Babatunde, Durowade, Agbana and Olomofe (2014) studied the clients' satisfaction on the on-going NHIS scheme for the University of Ilorin Teaching Hospital Staff. They found that among the junior staff 77.3% were satisfied with NHIS while only 22.7% were not satisfied, however among the senior staff 49.3% were satisfied and 50.7% were not satisfied. The main reason for dissatisfaction with the NHIS according to respondents include non-dispensing of expensive drugs (60.9%), non-availability of NHIS forms (24.5%), poor attitude of health workers (10.4%) and inadequate

coverage (4.2%). Akande *et. al.,* (2011) while contributing to the factors that influence the clients' satisfaction holds that "satisfaction with outpatient care under NHIS is largely determined by the knowledge of the rudimentary principles of the operation of the scheme". Additional contribution by Mohammed *et. al*., (2011) on the factors influencing clients' dissatisfaction with NHIS among staff of Ahmadu Bello University (A.B.U.) were non availability of drugs in the hospital and poor attitudes of health personnel.

Different methods and instruments are used to measure consumer's satisfaction. Consumer satisfaction with healthcare services is associated with many contributing factors, among which are related to health providers and healthcare delivery process. The relationship between consumers' socio-demographic characteristics and their satisfaction with medical care has been examined, such as age of ethnicity gender, socioeconomic status, marital status, and family size. For example, Linghui and Christopher (2017) identify older consumers report greater satisfaction with mental healthcare services. Hall and Dorman (2014) conduct a meta-analysis of 221 studies, which examines the relation of consumers' socio- demographic characteristics to their satisfaction with medical care and conclude that greater satisfaction is significantly associated with greater age and less education and marginally significantly associated with being married and having higher social status. The average magnitudes of these relations are very small, with age being the strongest correlate of satisfaction. No overall relationship is found for ethnicity, gender, income or family size.

Health Insurance is a social security that guarantees the provision of needed health services to persons on the payment of token contribution at regular intervals. Experts also conceptualized health insurance as insurance against the risk of incurring huge and unaffordable medical expenses among citizens of a nation. By assessing the overall risk of health care expenses among a targeted group. It is reported that employee's satisfaction with the healthcare they receive is an important health outcome which should be given particular emphasis in current review of health service delivery. Nevertheless, the relationship between satisfaction and the quality of care received is a complex factor and is affected by patient, doctor and service factors.

Analysis of Research Questions

What is the Level of Implementation by NHIS and its Benefits on Employee Health?

Mean ratings of respondents on level of implementation by NHIS and its benefits on employee health

S/N	ITEMS	NAU (n=220)		Dec.	OKO (n=86)		Dec.	UMUNZE (n=60)		Dec.
		$\bar{X}$	SD		$\bar{\chi}$	SD		$\bar{\chi}$	SD	
1	NHIS covers most types of health challenge of an employee.	3.34	1.295	A	3.26	1.365	A	3.55	1.320	A
2	Treatment received by an employee by NHIS staff is prompt and reliable	3.15	1.236	A	3.20	1.263	A	3.60	1.317	A
3	Drugs administered are of good quality and always available for an employee	2.24	1.081	D	2.26	.960	D	2.38	1.236	D
4	Laboratory tests are carried out as promptly on an employee as the need arises	2.04	1.231	D	3.12	1.409	A	3.27	1.351	A

Source: Authors field survey, 2019

(A= agree, D= disagree)

How Effective are the Services derived from the NHIS on Staff's Financial Burden?

Mean ratings of respondents on how effective are the services derived from the NHIS on Staff's Financial burden

S/N	ITEMS	NAU (n=220)		Dec.	OKO (n=86)		Dec.	UMUNZE (n=60)		Dec.
		$\bar{\chi}$	SD		$\bar{\chi}$	SD		$\bar{\chi}$	SD	
5	NHIS Reduces payment of hospital bills of an employee	2.32	1.224	D	2.28	1.113	D	2.50	1.214	D
6	The NHIS provides patient with all the services required	2.155	1.1835	D	2.40	1.120	D	2.32	1.242	D

	without out of pocket spending.									
7	Delays and extra spending are usually encountered in sourcing services from the NHIS	4.091	1.2279	A	3.29	1.300	A	3.30	1.357	A
8	Urgent attention and treatment is given to staffs, their spouse and at least 4 of their children who are less than 18years of age without extra expenses.	2.091	.9797	D	2.29	1.115	D	2.53	1.478	D

Source: Authors field survey, 2019
(A= agree, D= disagree)

What is the Effect of Quality of Services Accessed Under the NHIS on Employee Satisfaction
Mean ratings of respondents on effect of quality of services accessed under the NHIS on employee satisfaction

S/N	**ITEMS**	**NAU (n=220)**		**Dec.**	**OKO (n=86)**		**Dec.**	**UMUNZE (n=60)**		**Dec.**
		$\bar{X}$	**SD**		$\bar{\chi}$	**SD**		$\bar{\chi}$	**SD**	
9	The automatic access granted and quality services rendered by nurses, doctors, physicians etc. to employees by the NHIS create great satisfaction to employees.	2.450	1.3352	A	2.14	1.481	A	2.13	1.420	A
10	Amount paid by the NHIS commensurate with the services provided hence creates employees satisfaction	2.155	1.1601	D	2.24	1.157	D	2.40	1.238	D
11	Complains on lack of adequate time for comprehensive medical examination affects employees health and satisfaction on the scheme	2.245	1.0265	D	2.24	1.147	D	2.37	1.178	D

12	Employees perceived good health status due to quality of services rendered by NHIS made them satisfied with NHIS services.	3.300	1.3072	A	3.14	1.426	A	3.07	1.376	A

Source: Authors field survey, 2019
(A= agree, D= disagree)

Summary of Findings

In summary the study reveals that:

The National Health Insurance Scheme implementation level was initiated to cover every health challenge being encountered by enrollees. Thus, the National Health insurance scheme, incepted on 6th June 2005 is meant to improve health care services in Nigeria. The rationale include the general poor state of the nation's health care system, over - dependence on government for healthcare delivery, dwindling healthcare financing, rising cost of healthcare services and poor integration of healthcare institution of the nation's healthcare system.

The National Health Insurance scheme is not very ineffective. The goals of the NHIS include accessing good health care services for all Nigerians, ensuring equitable distribution of health care costs and facilities, high standard of healthcare services, availability of funds to the health sector and greater integration of private sector health institutions into the nation's healthcare system. Hence it was found that most of these stated services were not effectively covered.

The National Health Insurance Scheme is not easily accessible. Health providers appeared to be accessing health care services from their primary providers with their enrolled dependents in terms of registration and free consultations with physicians. The respondents were aware of some of the services accessible to them ranging from consultation with physicians, drug prescription, diagnostic tests, eye examination and care, prosthesis and maternity care. It was further observed from the respondents in the study area that the beneficiaries could not access those healthcare services.

Conclusion

The National Health Insurance Scheme, which was incepted against the background of the general poor state of the nation's healthcare system, is aimed at improving healthcare services and delivery in Nigeria by making good healthcare services accessible to all Nigerians. By being financed through government and workers contribution the scheme is intended to reduce the rising costs of healthcare services and make them affordable to the people. If effectively implementation the scheme will improve the utilization of private sector health personnel and facilities in the nation's health care system. There are many prospects for the success of the scheme despite its inherent weaknesses and challenges.

The introduction of NHIS has not been very effective in the study area. The view of respondents indicates that the levels of satisfaction derived from the National Health Insurance Scheme is minimal, thus, the services of NHIS have not improve enrollees' demand/access to qualitative health care services. Majority of respondents were not satisfied with the services received and felt that they had not benefitted maximally from the NHIS. Delays are usually encountered in sourcing services from the National Health Insurance Scheme. Inadequate attentions, poor facilities coupled with the presence of some unqualified staff in the premises of the providers, limitation and consequent denial of medicare to certain members of the enrolled families, amongst others were identified.

The provision of accessible quality and affordable health care to all Nigerians would remain a mirage if these problems that weaken the potency of the scheme are not properly addressed. If the scheme is effectively implemented the scheme will improve the utilization of both public and private sector health personnel and facilities in the nation's health care system. There are many prospects for the success of the scheme despite its inherent weaknesses and challenges.

Recommendations

From the findings of the study, the following recommendations are made:

1) The government should ensure adequate number of health personnel and facilities for the scheme. This can be achieved by getting more of the private sector health facilities into the scheme. Their under- utilized personnel and facilities can be put to maximum use under the NHIS. This will help covers most types of health challenge of an employee.
2) It is necessary for the government to develop strategies that would make the operations of the scheme more effective, efficient and seamless in order to achieve the objectives of the scheme which among them is to reduce employee financial burden on healthcare services.
3) There is need to focus on quality improvement by NHIS in order to increase access to enrolees with the services provided.

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