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Evaluation of the Implementation of National Health Insurance Scheme (Nhis) in Lagos State of Nigeria

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Abstract: This paper evaluates the implementation of the National Health Insurance Scheme [NHIS] in Nigeria. It looks at the provisions of the NHIS Act No.35 of 1999 and how far its provisions had been implemented by the Agency and other stakeholders. It discusses the objectives of the scheme and how far those objectives had been implemented, using Lagos State as the Study area. Two hundred copies of structured questionnaire were prepared and administered by the researcher. In-depth questions were drawn and focus groups, i.e. enrollees, health maintenance organizations, healthcare providers and some members of the Agency (NHIS), interviewed by using the questionnaire. Five hypotheses were tested using parametric statistical methods; linear regression analysis, correlation analysis and analysis of variance [ANOVA] and the results showed that many of the provisions of the Scheme had been implemented. However, further improvements need be made. These include, making concerted efforts to bring into the Scheme, the State and Local government employees, and other organizations from the private sector of Nigerian economy. The rural community programs must be vigorously pursued by the Agency (NHIS). If all the above mentioned groups are provided with the health care programs, the Agency will become more buoyant financially and it will also be self sustaining since the scheme obeys the law of large numbers.

Keywords: Implementation, NHIS, Evaluation, Employee Welfare.

BACKGROUND OF STUDY

Introduction

This paper is to preliminarily evaluate the success or failure of the Implementation of the National Health Insurance Scheme [NHIS] Act or Law (i.e. Decree No.35 of 1999) in Nigeria, [taking Lagos State as Case Study], eight years after its implementation (i.e. May 2005). The Decree, (which is now known as Act No. 35 of 1999), was promulgated during the military rule of General Abdulsalami Alhaji Abubakar in 1999.

This Decree No.35 was signed by the Military Head of State, General Abdulsalami Abubakar on May 10th 1999 as one of the Laws of the Federation of Nigeria.

The law was established to see that a Scheme ‘’for the purpose of providing health insurance which shall entitle insured persons and their dependants the benefit of prescribed good quality and cost effective health services as set out in the decree’’. NHIS Decree No.35, 1999, s (1).

This National Health Insurance Scheme, (NHIS) Decree, now known as Insurance Act No.35 of 1999 in Nigeria, was one of the steps taken by the military regime then to address the perennial health problem in Nigeria. The Scheme was meant to provide easily accessible and affordable healthcare to all Nigerians irrespective of their social, economic, religious and other considerations.

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Objectives of the Scheme:

There are nine stated objectives of the National Health Insurance Scheme. They include;

(a) To ensure that every Nigerian has access to good health care service.
(b) To protect families from the financial hardship of huge medical bills.
(c) To limit the rise in the cost of health care services;
(d) To ensure equitable distribution of health care costs among different income groups;
(e) To maintain high standard of health care delivery services within the Scheme;
(f) To ensure efficiency in the health care services;
(g) To improve and harness private sector participation in the provision of health care services;
(h) To ensure adequate distribution of health facilities within the Federation;
(i) To ensure equitable patronage of all levels of health care;
(j) To ensure availability of funds to the health sector for improved services.(NHIS Act No. 35 of 1999, part 2, section 5, NHIS, (2009), Ekundayo, O.A (2015, pp.41-42).

INSTITUTIONAL FRAMEWORK

In order for the above listed programs to be effective, the Scheme has put in place various technical and administrative methods. Administratively, NHIS has organized itself into the geo-political zones of Nigeria. Each zone has a Zonal Office and each Zone has State Office of NHIS. This arrangement is to make administration of the Scheme easy and effective. The technical method introduced by the Scheme is to appoint the Health Maintenance Organizations (HMOs) to ensure that they appoint the Health Care Providers (HCPs), who are medical professionals, to handle the healthcare service delivery to the Nigerian people. These Health Care Providers are either Public or Private Hospitals or Medical Centers and they are responsible for the treatment of the enrollees/ contributors to the NHIS Programs. Those HMOs and HCPs are further organized into Zones and States. Each of the Zone and State Offices has Zonal and State Health Office where coordination of the operations are made easier and more effective. In this arrangement, each State Office makes various monthly, quarterly and annual returns to the Zonal Office while the Zonal Office forwards the returns in its zone to the NHIS Headquarters in Abuja (NHIS, 2009).

In addition to the above mentioned process, the various programs of the NHIS are executed by different groups of people and professionals appointed by the authorities of NHIS. This arrangement is also to enable the administration of various segments of the Scheme to become easier, more efficient and effective. The above given framework has made it easy for the NHIS to evaluate its performance and make necessary improvements in order to realize the aims and objectives of the founding fathers of the scheme.

STATEMENT OF PROBLEM

After ten years of the establishment and commencement of National Health Insurance Scheme (NHIS), in Nigeria, many Nigerians have diversified opinions on the effectiveness and efficiency of the scheme in addressing the health needs and problems of the workers in particular and majority of Nigerians in general. Various authors have disheartening reports from previous studies, Agba, (2010), Eboh, (2008), Adeniyi, and Onajole, (2010).

Therefore, this study evaluates the levels of implementation of the NHIS' objectives as they

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affect the Nigerian workers in Lagos State. This is to uncover the influence of the scheme on the health status and the provision of healthcare services under the Scheme on the workers. Few studies on Nigerian NHIS had been carried out concerning workers' status and most of the studies were institutionally based. They mainly addressed workers' perception (Sanusi and Awe, Onuekwisi& Okpala, (2009), Jehu-Appiah, Aryeetey, Agypong, Spaan &Baltussen, (2010). Furthermore, the studies had neglected the workers' self- evaluation of the scheme as it relates to the objectives of NHIS forgetting the fact that the worker's health status is either positively or negatively influenced as assessed by the workers themselves, Owumi et al (2013). These workers contribute 5%of their basic salaries regularly in advance to the accredited Health Maintenance Organizations (HMOS) or NHIS. The workers' employers also add 10% of their basic salaries to sum up to 15% (NHIS, 2010). This 15% monthly contribution, in advance, of basic salary secures the workers and their dependants/ spouses and four biological children of below age 18years good healthcare services whenever they fall sick or ill, NHIS, (2009), Owumi et al (2013).

RESEARCH QUESTIONS

The following research questions go to the root of the investigation into the implementation of the NHIS' set objectives. The questions will guide this study in its investigation of the implementation exercise.

1. What is the level of awareness of the specific healthcare service objective available to the workers under NHIS?
2. How does the perceived benefit influence the health care standard or status of workers?
3. How do the workers or employers perceive the influence of NHIS on their health standard or status?
4. Are the effects of NHIS healthcare delivery services equally felt in all the local government areas of Lagos State?

RESEARCH HYPOTHESES

1. The level of awareness of specific healthcare service objectives available to workers is not quite satisfactory and below standard.
2. The benefitsand influence of NHIS on the workers' healthcare are not perceived as standard and high.
3. The healthcare service deliveries are not quite easily accessible and affordable to the workers.
4. The NHIS health facilities (both medical personnel and infrastructural) have no significant relationship with the workers' welfare.

RESEARCH OBJECTIVES

The objectives of this study are stated as follows;

1. To evaluate the level of effectiveness of NHIS on the health standards of the workers in Lagos State of Nigeria.
2. To identify the socio-economic characteristics of the workers.
3. To evaluate the level of awareness of the workers of the operational guidelines of the scheme.
4. To discuss the perceived benefits of the specific healthcare service and set objectives available in the NHIS in Lagos State.
5. To examine the various ways by which NHIS has made healthcare delivery

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services affordable and easily accessible to the Nigerian workers in Lagos State.

Significance Of The Study: This study will add to the body of knowledge on healthcare delivery and it will also assist the stakeholders of NHIS to know those areas of the implementation exercise of the Scheme that will require special or particular attention. It will further enable the workers to know their level of awareness of the benefit package and other provisions of the Scheme.

Scope Of Study: This study is designed to cover the workers in both the public and private sectors of economy in Lagos State of Nigeria.

Limitation Of The Study: There are perceived limitations in carrying out this research study in Lagos State. They include:

(a). Difficulty encountered in getting respondents to complete the copies of the questionnaire.

(b). financial difficulty in transportation and other expenses associated with the study.

c. Difficulty encountered in obtaining local literature on the topic.

LITERATURE REVIEW

In this evaluation, we will divide the objectives into three broad areas; viz.: quality, cost and efficiency.

The evaluation of National Health Insurance Scheme is very important for a number of reasons. Firstly, studies that have to do with welfare policies of which health care is part, have compared or have examined the reasons why a materially rich country does not have a comprehensive welfare policy. Secondly, the National Health Insurance Scheme Act No.35 of 1999 is a rare example in Nigeria's recent past, of any government whether military or civilian to establish since 1962 when it was first mentioned. The Federal Minister for Health then, Dr. Majekodunmi set up a Committee to look into the concept of Social Health Insurance. Osuorji (2010) cited in Ekundayo O.A (2015); 39). 'Further subsequent steps took place in 1984 when the Health Minister then, Admiral Patrick Koshoni set up another Committee headed by Professor Diejomoah to advise the Federal Government on the desirability or otherwise of the Scheme. Dr. Emmanuel Nsan who became the Health Minister in 1985 set up yet another Committee on National Health Review (FMOH, 2001). The Committee was headed by Mr. L. Lijadu. However, both 1984 and 1985 Committees recommended that the Scheme was desirable and viable. In 1985 also, another Committee was set up and it was headed by Dr. E. Umez-Eronini. This Committee recommended an acceptable model for implementation of a Social Health Insurance in Nigeria. Osuorji (2011) cited in Ekundayo, O.A (2015), 40).

The establishment of NHIS was approved by the Federal Government in 1989 after the report of the Committee set up at the 28th Meeting of the National Council on Health. The Federal Government signed an agreement with United Nations Development Program [UNDP] and International Labor Organization [ILO] for planning and implementation of the Scheme in 1991. The Federal Government presented memorandum to the Federal Executive Council [FEC] in 1993 pleading for immediate implementation of the Scheme. However, in 1995, the National Health Summit endorsed the need to set up the NHIS soonest. The Implementation Committee was thereafter set up and held its meeting in September 2001. Its report that recommended immediate take-off was submitted and the actual take-off of the NHIS took place in June, 2005. The enabling Act No. 35 was signed

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by the then military Head of State, Commander-in- Chief of the Nigerian Armed Forces, General Abdul salami Alhaji Abubakar in May, 1999 in Abuja.

The administration of the Scheme involves that the workers in both private and public sectors are expected to contribute 5% of their basic salaries to the Scheme while their employers will assist them to add 10% to each employee's contribution. The total contribution of an employee is 15% of the basic salary.This contribution covers a spouse, four biological children, under age 18years, to access the NHIS program at an approved health care provider.

Thirdly, the high cost of accessing the health care has been one of the reasons for the establishment of NHIS in Nigeria. Other reasons also include:-

1. General poor state of the National Health Services
2. Excessive dependence on and the pressure on public health facilities provided by the government,
3. Dwindling or poor funding of health care in the face of rising costs, lack of political will on the part of the government (Kumar, 2007), and
4. Poor integration of private health facilities in the nation's healthcare delivery system.

   Concerning how medical delivery services were administered then, Ojo, M. O(1997) said, ''in the second Republic in Nigeria [i.e. from 1962], medical delivery was achieved mainly through government – owned and funded hospitals, teaching hospitals, and the private medical practitioners.

   The establishment of government owned medical centers during the pre-NHIS period was politicized highly with little regards paid to economics of such move. The centers lacked essential infrastructures and equipments, medicament and motivated, dedicated, qualified and experienced personnel. Drugs were prescribed to the sick and they were expected to purchase the drugs from any of the pharmaceutical stores in the cities. The civil servants were corrupt, lacked probity, integrity and managerial competence. The private medical practitioners were extorting and exploiting Nigerians for the treatments given to the people. This inhuman act made the cost of treatment to be high. It is however pathetic that most Nigerians live below sustenance level and find it difficult to afford the prohibitive and ever increasing costs of good medical care. This scenario brought about a sharp increase in the number of partially sick persons in the country.

Taiye Adeleye (2010), in his paper presented at a one-day workshop for the uniformed civil servants which included the Federal Road Safety Corps [FRSC], and Civil Defence Corps on 31st August in Ibadan, Oyo State of Nigeria, highlighted the extent of poor health situations and health systems in Nigeria before the establishment of NHIS as follows:

i. Poor health: Nigeria's health status indicators were among the worst globally.
ii. Financial vulnerability: lack of financial risk protection.
iii. Social exclusion: high burden of disease among those that have the least financial means.
iv. Poor funding of health care at all levels of governance.
v. Weak, inefficient and ineffective national health system
vi. Unbalanced and inefficient resource allocation between the three tiers of

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government [i.e. Federal, State and Local Governments].

vii. Inequitable distribution of healthcare resources between urban and rural areas.

viii. Lack of confidence in the health care delivery services by the high class in the society.

ix. Lack of a functional referral system.

Therefore, evaluating the implementation of NHIS in Nigeria will shed light on how the funding mechanism may have impacted on the law.

The fourth reason for embarking on this evaluation concerns the provision of healthcare for the citizenry of any country which is very important. An American President, Harry Truman, as quoted by Hassan Wahab (2008) noted, 'healthy citizenry is the most important element in [America's] national strength', it is therefore necessary for America to 'develop a national health program which will furnish adequate public health services, and ample medical care facilities for all areas of the country and all groups of people'. However, sixty-one years after this pronouncement by that American President, United States of America is still not having an affordable and a comprehensive healthcare program for all its citizens.

Even though United States spent 16% of her GDP on healthcare services in 2007, [OECD Health Data, 2009], she alone among developed countries is not having a universal health care system. The recent Patient Protection and Affordable Care Act, provides for a nationwide health insurance exchange by 2014, but this is not universal in the way similar to other countries' practice. United States has publicly funded healthcare components such as Medicare, Medicaid, State Children's Health Insurance Program, and the Veterans Health Administration. These tax-financed programs that make the government the largest health insurer in the country cover 27.8% of the population. President Obama has made very bold efforts, in spite of stiff oppositions, to reform the US health system and I believe that effort won him the second term.

Two-thirds of urban hospitals in the U.S are non-profit hospitals, and the balance evenly divided between for-profit hospitals and public hospitals. The urban hospitals are associated with medical schools and they constitute the greatest percentage of non-federal hospitals. Health care in the U.S is generally provided by physicians in private practice and private hospitals. The survey shows that 59% of Americans receive health insurance from their employers through contributory schemes. ''The U.S Census Bureau estimated that 15.3% of the U.S population, or 45.7 million people were uninsured in 2007. However, U.S spent 15.2% of GDP on health care, or US$6,347 per capita in 2005 while she set 17.6% or US$8,086 per capita in 2009. Only 45% of these expenditures are from the government. It is worthy of note that the US Congress is currently considering many options for further reforming the US health care system.

The success of establishing Nigeria's NHIS could be construed as an attainment of a feat, especially when one considers the multifarious processes it underwent before the establishment. A materially rich country such as U.S has been unable to establish a unified health system, but a materially poor country like Nigeria has achieved. Though the Nigeria's civil war also has negative effect on period it took to achieve the declared objective of 1960 in Lagos, we thank God that the Scheme was finally established in 2005. The success of NHIS law would encourage other countries in the West African sub-region and the whole of Africa to pursue the establishment of their own schemes. This is very important especially when

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considering many health issues in the sub-region and the whole continent. These health issues include HIV/AIDS, malaria, guinea worms, tuberculosis, etc.

The establishment of National Health Insurance Scheme [NHIS] provides for administrative and technical sections.

The National Health Insurance Scheme developed various programs to cover different sections of the society in order to provide and ensure easy access to good health care services to every Nigerian. These programs include the following:-

(a). Formal Sector Social Health Insurance Program

(b). Urban Self- Employed Social Health Insurance Program

©. Rural Community Social Health Insurance Program

(d). Children Under-Five Social Health Insurance Program

(e). Permanently Disabled Persons Social Health Insurance Program

(f). Prison Inmates Social Health Insurance Program

(g). Tertiary Institutions and Voluntary Participants Social Health Insurance Program

(h). Armed Forces, Police and other Uniformed Services.

THEORETHICAL AND CONCEPTUAL FRAMEWORK

The Conceptual Framework

We cannot overemphasize the importance of good health standard. The reason is that good health is very essential to the preservation of human species and organized social life, (Zanden, 1996), Owumi et al (2013). Concerning Nigerian NHIS, Dogo Mohammed, (2010) said that NHIS was one of the fastest growing social organizations in the world. Nigeria recognized the need for health insurance since 1962. Many policies and health programs were designed and followed by the establishment of primary, secondary and tertiary health care centres, general and tertiary hospitals, (Agba, 2010) and Ekundayo, O.A (2015, pp.35-37). The Nigerian NHIS was modeled after the British and American health care systems, (Ikechukwu and Chiejina, (2010) as quoted by Owumi et al (2013). Its general objective was to ensure the provision of health insurance that would entitle all insured persons and their dependants to the prescribed good, qualitative and cost effective health services. (NHIS Decree (now Act) No. 35 of 1999, part 1, subsection 1). The specific objectives of NHIS are as stated above in this study.

THEORETICAL FRAMEWORK

Access Indicators' Theory

This theory explains the relationship between actual organization and availability of services as access indicators (Bodenheimer, I.S (1970), Freeborn, D.K and M.R. Greenlick (1973). It further emphasized that access meant that health services were made available whenever and wherever patients needed the services. The U.S Agricultural Department in its research on the problems of health services in the rural areas,concluded that ''rural and urban people do not have equal access to health services. Rural areas are deficient in professional medical personnel, physical health care facilities, and the ability to afford the financial costs of illness''.

Chen, M.K [as cited in Aday, L.A& Anderson, R (1974)] in his unpublished work, developed two descriptive indexes of the actual organization and availability of services as access indicators.

The first index has to do with the weighted sum of the appointment, waiting time, travel time, waiting room time and actual processing time for patients.

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The second index deals with the weighted sum of the difference between the ideal and the actual number of services, personnel and equipments in a given community.

Research Design: This research study is an investigative one [evaluation of the implementation of NHIS in Lagos State], therefore, a wider range of questions will be necessary to thoroughly probe into the depth of operations concerning the implementation of the Scheme and how the implementation has affected the people of Lagos State.

Well structured questionnaire and simple structured interview questions were used as primary data collection instruments. Two hundred and twenty (220) copies of the questionnaire were produced and administered by the researcher who also collected from the respondents two hundred copies for analysis after the results had been compiled.

The selection of the respondents was by simple random sampling technique.

Population Of Study, Sample Size, Sampling Technique And Research Instrument: The population of the study comprises of all workers and the general public in Lagos State. The sample of the study comprises of two hundred workers from various establishments and general public within Lagos State. They include workers from Lagos State civil service, private sector establishment workers, Federal Government workers, the students and the general public in Lagos State.The healthcare providers (HCPs) are the primary healthcare service providers and they attend to the health needs of the registered enrollees. The healthcare maintenance organizations (HMOs)are quality control and key-players in the implementation exercise of NHIS apart from the enrollees who are the receivers of the benefits. The HMOs serve as watch-dogs to the HCPs. They monitor the standards and control the quality of drugs and other operational activities of the Scheme. The Agency, NHIS has overall control of the Scheme.

Questions that related to the operations and implementation of the Scheme were asked the respondents to provide answers. The choice of questionnaire was considered appropriate because it afforded the various selected groups of respondents the opportunities to complete and carefully provide unbiased answers since all responses were treated with absolute confidentiality.

Meanwhile personal structured and scheduled interview is quite necessary in this type of research studyso that those aspects of the operation and implementation of NHIS which were not covered by the questionnaire could be taken care of.

Reliability and content validity tests were carried out before administering the questionnaire and the interview questions.

DATA PRESENTATION AND ANALYSIS

Methods of Data Analysis: Frequency distribution tables, pie charts, simple average, percentages and chi-square statistical tools were used in the analysis.

Three different parametric statistical techniques were used for the hypothesis testing. They were linear regression analysis, correlation analysis and analysis of Variance [ANOVA].

Regression Analysis was used to test hypotheses one and two, while Correlation Analysis was used to test hypotheses three and four. Analysis of Variance [ANOVA], was used to test hypothesis five. The SPSS Statistical Package was used in the parametric statistical techniques for the test of hypothesis.

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MAJOR FINDINDS

Table1: Age Distribution of Respondents

Lagos State	Age					Total
	Below 18 years	18-30 years	31-40 years	41-50 years	51 years & above	
Number	0	63	85	45	7	200
Row %	0.0	31.5	42.5	22.5	3.5	100.0
Column %	0.0	42.3	46.4	45.9	43.8	44.4

The age distribution of the respondents in this table shows that middle age people are more in Lagos State. People between age 31years and 50years provide 92.3% of the respondents. This result shows that majority of people in the study area are middle aged, agile and matured.

Table2: Sex Distribution of Respondents

Lagos State	Sex		Total
	Male	Female	
Number	106	94	200
Row %	53.0	47.0	44.4
Column %	45.1	43.7	44.4

Table2 shows that there are more males (106) than females (94) in the study area. The reason could be that many males are more involved in the white collar jobs than their female counterparts. Furthermore, males should be more interested in the health programs because they are expected to take care of their families in all aspects of life.

Table 3: Educational qualification of Respondents

Lagos State	Educational qualification				Total
	Primary school leaving certificate	WASCE	NCE/OND	HND/B.SC	
Number	11	25	67	97	200
Row %	5.5	12.5	33.5	48.5	100.0
Column %	73.3	41.7	54.5	38.5	44.4

The educational qualification's distribution shows that most of the people in the study area are well educated. Their qualifications range between NCE and BSC degrees and they sum up to 93% of the respondents. Definitely they are likely to understand the purpose of the study and will be able to answer the questions in the questionnaire almost correctly. The result obtained from them can be reliable.

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Table 4: Workforce of Respondents

Lagos State	Work force							Total
	Healthcare provider/health maintenance Organization	Federal civil service	State civil service	Students	Organized private sector with NHIS	organized private sector without NHIS	General public	
Number	3	49	0	17	24	54	53	200
Row %	1.5	24.5	0.0	8.5	12.0	27.0	26.5	100.0
Column %	100.0	47.1	0.0	34.0	100.0	40.3	84.1	44.4

Table 4 shows a result that indicates that (54) people from the organized private sector have not registered with NHIS while only (24) from the same sector had registered with the scheme. The other groups also need to be brought into the scheme so as to realize one of the objectives of the founding fathers of the scheme, i.e. to provide universal healthcare delivery services to all Nigerians.

Table 5: Marital Status of Respondents

Lagos State	Marital status				Total
	Single	Married	Divorced	Others	
Number	62	129	2	7	200
Row %	31.0	64.5	1.0	3.5	100.0
Column %	44.0	44.3	66.7	46.7	44.4

There are 129 married people in the study area and 62 singles. The implication of this result is that majority of the people (respondents) are regarded as being responsible because of their marital status. They are expected to be interested in NHIS for their good healthcare delivery services since the services are not expensive but affordable.

Table 6: Type of organization working with

Lagos State	Type of organization working with				Total
	Government	Private organization	Self employed	Others	
Number	52	68	40	30	190
Row %	27.4	35.8	21.1	15.8	100.0
Column %	29.9	45.9	67.8	60.0	44.1

Table 6 shows that only 52 respondents in this study area are civil servants while the remaining respondents (138), are either working with private establishments, self employed or students. The implication of this result is that NHIS still has a lot of work to do in order to get those groups enrolled into the scheme.

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Table 7: Number of employees in the organization

Lagos State	Number of employees in the organization				Total
	Less than 10	Above 10 but less than 50	Above 50 but less than 100	Above 100	
Number	23	24	53	52	152
Row %	15.1	15.8	34.9	34.2	100.0
Column %	50.0	26.7	57.6	34.2	40.0

In table 7, there are only 23 respondents from those organizations that have staff strength of less than 10 workers. Those establishments with staff strength of more than 10 and above 100 workers in this study area have staff strength of 129. This result further emphasizes the fact or the need for the NHIS to rise up to the challenges of getting more enrollees into the scheme

.

Table 8: Employees registered with NHIS in the organization

Lagos State	How many employees registered with NHIS in the organization				Total
	Below 10	Above 10 but less than 20	Above 20 but less than 50	50 and Above	
Number	25	37	32	35	129
Row %	19.4	28.7	24.8	27.1	100.0
Column %	31.3	59.7	38.1	31.3	38.2

The result in this table 8 further emphasizes the urgent need for the NHIS to be more pro-active in their drive to enroll more people into the scheme. There should be more awareness campaigns to further sensitize the Nigerian people. One can imagine what the result would have been in the rural areas when we have this type of result the former federal capital and the economic nerve center of Nigeria.

Table 9: Medical facilities are readily available at the NHIS centers

Medical facilities	Frequency	Percentage (%)
Strongly Agreed	56	28.0
Agreed	84	42.0
Strongly disagreed	11	5.6
Disagreed	14	7.1
Undecided	8	4.0
No response	27	13.3
Total	200	100

It can be inferred from the table that majority (70%) 0f the respondents agreed that NHIS made healthcare delivery services easily accessible and affordable to the Nigerian workers. this is because medical facilities such as laboratory tests, maternal and paediatric etc are easily available to patients.

Table 10: Qualified, skilled and experienced health personnel are in abundance

Abundance of Medical personnel	Frequency	Percentage (%)
Strongly Agreed	52	26.2
Agreed	66	33.1
Strongly disagreed	18	8.9
Disagreed	19	9.3
Undecided	17	8.4
No response	28	14.0
Total	200	100

The highest proportion (59.3%) of respondents affirmed that NHIS clinics always have qualified

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experienced and specialist medical personnel at all times.

Table 11: NHIS Medical personnel are always enough for effective operations

NHIS personnel	Frequency	Percentage (%)
Strongly Agreed	49	24.4
Agreed	53	26.7
Strongly disagreed	48	23.8
Disagreed	4	1.8
Undecided	17	8.7
No response	29	14.7
Total	200	100

Majority [51.1%] of respondents asserted that accessibility of NHIS will be easier if it is adequately funded.

Table 12: Adequate Funding of NHIS improves employee welfare

Funding	Frequency	Percentage (%)
Strongly Agreed	81	40.4
Agreed	70	34.9
Strongly disagreed	5	2.7
Disagreed	6	3.1
Undecided	8	4.2
No response	29	14.7
Total	200	100

The highest proportion [67.1%] of respondents believed that adequate funding of NHIS will have positive impact on the workers' welfare and improve their health conditions.

Table 13: NHIS healthcare delivery is not available at distance of 5 km away from patient's residence

NHIS healthcare	Frequency	Percentage (%)
Strongly Agreed	56	28.0
Agreed	61	30.4
Strongly disagreed	13	6.7
Disagreed	19	9.6
Undecided	18	9.1
No response	32	16.2
Total	200	100

58.4% of the respondents agreed categorically that NHIS healthcare delivery services are not available at a 5kilometer distance from the patient's home.

Table 14: NHIS provides alternative & sustainable funding for the health sector of Nigerian economy

NHIS	Frequency	Percentage (%)
Strongly Agreed	9	4.4
Agreed	106	53.1
Strongly disagreed	23	11.3
Disagreed	21	10.4
Undecided	12	6.2
No response	29	14.4
Total	200	100

While 57.5% of respondents believed that NHIS is a good alternative method of funding healthcare delivery services, 21.7% of the respondents disagreed with them. Others (20.6%) are either undecided or refused to participate in the exercise.

Table 15: Availability of health facilities has nothing to do with workers' welfare in Nigeria

Availability of healthcare and workers' welfare	Frequency	Percentage (%)
Strongly Agreed	12	5.8
Agreed	49	24.7
Strongly disagreed	60	30.2
Disagreed	44	21.8
Undecided	5	2.7
No response	30	14.9
Total	200	100

52% of the respondents believed that NHIS medical services have significant relationship with

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the worker's welfare while 30.5% of the group disagreed with the view. However, 17.6% of the respondents are either undecided or refused to participate.

Table 16: Enrollee always sees same set of medical personnel at the NHIS clinics

Enrollee	Frequency	Percentage (%)
Strongly Agreed	49	24.4
Agreed	56	28.2
Strongly disagreed	24	11.6
Disagreed	29	14.7
Undecided	12	6.0
No response	30	15.1
Total	200	100

The majority [52.6%] of the respondents asserted that NHIS clinics always have medical personnel on duty whenever the patients visit the clinics or NHIS controlled hospitals.

DISCUSSION OF SOME MAJOR FINDINGS

Table 17: The families are protected from financial hardship of huge medical bills**.**

One of the major factors that enhance complete acceptability of NHIS program is its affordability as the saying goes.

NHIS	Frequency	Percentage (%)
Strongly Agreed	36	17.8
Agreed	73	36.7
Strongly disagreed	29	14.7
Disagreed	24	11.8
Undecided	9	4.4
No response	29	14.7
Total	200	100

The table shows that (54.5%) of the respondents agreed that families are protected from financial hardship of huge medical bills while (26.5%) of the respondents disagreed with that view.In another study by Ekundayo, O.A (2015), it confirmed that NHIS usher in a new era of improved health care service delivery to Nigerians.

Table 18: The level of effectiveness of NHIS healthcare services on the Employees' Welfare of the Lagos State of Nigeria is high.

Shortage of doctors and nurses	Frequency	Percentage (%)
Strongly Agreed	71	35.6
Agreed	60	30.2
Strongly disagreed	13	6.7
Disagreed	14	7.1
Undecided	12	5.8
No response	29	14.7
Total	200	100

Majority of respondents (65.8%) agreed that NHIS healthcare delivery services are quite effective and the level of effectiveness is very high. 13.8% of the respondents disagreed with the statement, ''the level of effectiveness of NHIS healthcare delivery services is high'' while 20.5% of respondents did not respond and undecided. In a different study carried out by this author, it was discovered that 'about 90% of the NHIS disease burdens in urban areas receive provision and distribution of medical facilities'.

Table 19: NHIS healthcare providers do not receive their capitation promptly

NHIS healthcare providers	Frequency	Percentage (%)
Strongly Agreed	38	18.9
Agreed	48	24
Strongly disagreed	28	14.2
Disagreed	27	13.3
Undecided	30	14.9
No response	29	14.7
Total	200	100

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The table shows that (42.9%) of the respondents believed that the NHIS healthcare providers do not receive their capitation as and when due while (27.5%) disagreed. However, (29.6%) are either undecided or refused to participate.

Perceived benefits of specific healthcare services under NHIS

NHIS	Frequency	Percentage (%)
Free maternity care	36	18
Prescribed Drug supply	73	37
Consultation	29	15
Medical Treatment	20	10
Nursing care services	18	9
No response	24	12
Total	200	100

Perception of the workers as relates to their healthcare status

NHIS	Frequency	Percentage (%)
Excellent health status	73	36.7
Good	36	17.8
Fair	29	14.7
Poor	24	11.8
Very poor	9	4.4
Undecided	29	14.7
Total	200	100

DISCUSSION OF RESEARCH HYPOTHESES TESTING AND RESPONSE FROM THE FOCUS GROUPS

Hypotheses Testing

In this sub-section, five (5) formulated hypotheses were tested to establish relationship between Effectiveness of National Health Insurance Scheme and Employee Welfare in the Lagos State of Nigeria. It could be noted however, that three (3) different parametric statistical techniques were used. They are Linear Regression Analysis, Correlation Analysis and Analysis of Variance (ANOVA). The regression analysis was used to examine the first two hypotheses; Correlation analysis was used to test the hypotheses 3 and 4; while Analysis of Variance was used to examine hypothesis 5 which states that there is no difference in the effectiveness of NHIS in the study area.

Hypothesis one: (Ho_1): There is no significant relationship between accessibility to National Health Insurance Scheme (NHIS) and improvement in Employee Welfare in the Lagos State of Nigeria.

Regression Model 1

In this case, improvement in Employee Welfare variable is regressed on the explanatory variable of accessibility to National Health Insurance Scheme (NHIS) variable. The most general form for the model is:

$$Y = a + bx + e \ldots\ldots\ldots (1)$$

Where,

y = dependent variable (improvement in Employee Welfare)

a = constant

x = independent variable (accessibility to National Health Insurance Scheme)

b = the regression coefficient which determines the contribution of the independent variables

e = residual or stochastic error (which reveals the strength of b; if e is low, the amount of unexplained factors will be low and vice versa.

Regression Analysis of accessibility to National Health Insurance Scheme (NHIS) and improvement in Employee Welfare

Linear regression analysis was computed to determine the impact of accessibility to National Health Insurance Scheme (NHIS) on improvement

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in Employee Welfare in the study area. The dependent variable is, improvement in Employee Welfare, while the independent variable is, accessibility to National Health Insurance Scheme. It could be noted that the variables of improvement in Employee Welfare were regressed on variables of accessibility to National Health Insurance Scheme (independent variable). The results are contained in the following tables.

Table (a): Regression Model Summary

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.598[a]	.358	.396	1.008

a. Predictors: (Constant), Accessibility to NHIS

Source: Author's computation, (2015)

Table (b): Test of Statistical Significance of Regression Model

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	16.540	1	16.540	16.285	.000[a]
	Residual	384.940	379	1.016		
	Total	401.480	380			

a. Predictors: (Constant), Accessibility to NHIS

b. Dependent Variable: Employee Welfare Improvement

Source: Author's computation, (2015)

Table ©: Regression coefficient

Coefficients [a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.428	.101		14.102	.000
	Accessibility to NHIS	.169	.042	.203	4.035	.000

a. Dependent Variable: Employee Welfare Improvement

Source: Author's computation, (2015)

With F- value of 16.285 and P- value of 0.000 in table (b), it is observed that the relationship between accessibility to National Health Insurance Scheme (NHIS) and improvement in Employee Welfare is significant at $P<0.05$. Therefore, hypothesis one is hereby rejected. Moreover, with correlation coefficient (R) of 0.598 and coefficient of Multiple Determination (R^2) of 0.358, as shown

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in table (a), one observes that about 35% of impact of improvement in Employee Welfare may be attributed to a magnitude increase in accessibility to National Health Insurance Scheme. In other words, close to 36% of the variability in observed accessibility to National Health Insurance Scheme is explained by incidence of improvement in Employee Welfare in the study area. The remaining 64% as observed here may be due to other factors that informed improvement in Employee Welfare, like other emoluments in form of leave, training opportunities among others.

To determine the weight of the components of accessibility to National Health Insurance Scheme, reference is made to the regression coefficients as shown in table (c). Using the standardized beta coefficients, the constant "a" would disappear and the regression equation is of the form:

$$Y = a + bx$$

Becomes: Y (i.e. improvement in Employee Welfare) = 0.203x.

Hypothesis two: (Ho_2): There is no significant relationship between funding of National Health Insurance Scheme (NHIS) and improvement in Employee Welfare in the Lagos State of Nigeria.

Regression Model 2

In this case, improvement in Employee Welfare variable is regressed on the explanatory variable of funding of National Health Insurance Scheme (NHIS) variable. The most general form for the model is:

$$Y = a + bx + e \ldots\ldots\ldots\ldots (2)$$

Where,

y = dependent variable (improvement in Employee Welfare)

a = constant

x = independent variable (funding of National Health Insurance Scheme)

b = the regression coefficient which determines the contribution of the independent variable

e = residual or stochastic error (which reveals the strength of b; if e is low, the amount of unexplained factors will be low and vice versa.

Regression Analysis of funding of National Health Insurance Scheme (NHIS) and improvement in Employee Welfare

Linear regression analysis was computed to determine the impact of funding of National Health Insurance Scheme (NHIS) on improvement in Employee Welfare in the study area. The dependent variable is, improvement in Employee Welfare, while the independent variable is funding of National Health Insurance Scheme. It could be noted that the variable of improvement in Employee Welfare was regressed on variable of funding of National Health Insurance Scheme (independent variable). The results are contained in the following tables.

Table (a): Regression Model Summary

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.756[a]	.572	.035	7.954

a. Predictors: (Constant), Adequate funding of NHIS

Source: Author's computation, (2015)

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Table (b): Test of Statistical Significance of Regression Model

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	555.565	1	555.565	8.780	.003[a]
	Residual	13540.435	214	63.273		
	Total	14096.000	215			

a. Predictors: (Constant), Adequate funding of NHIS

b. Dependent Variable: Employee Welfare Improvement

Source: Author's computation, (2015)

Table (c): Regression coefficient

Coefficients [a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	34.694	.606		57.284	.000
	Adequate funding of NHIS	6.49E-007	.000	.199	2.963	.003

a. Dependent Variable: Employee Welfare Improvement

Source: Author's computation, (2015)

With F- value of 8.780 and P- value of 0.003 in table (b), it is observed that the relationship between funding of National Health Insurance Scheme (NHIS) and improvement in Employee Welfare is significant at P<0.05. Therefore, hypothesis two (2) is hereby rejected. Moreover, with correlation coefficient (R) of 0.756 and coefficient of Multiple Determination (R^2) of 0.572, as shown in table (a), one observes that about 57% of impact of improvement in Employee Welfare may be attributed to a magnitude increase in funding of National Health Insurance Scheme. In other words, close to 60% of the variability is observed in the funding of National Health Insurance Scheme and this is explained by incidence of improvement in Employee Welfare in the study area. The remaining 40% as observed here may be due to other factors that informed improvement in Employee Welfare, like other emoluments in form of leave, training opportunities among others.

To determine the weight of the components of funding of National Health Insurance Scheme, reference is made to the regression coefficients as shown in table ©. Using the standardized beta coefficients, the constant "a" would disappear and the regression equation is of the form:

$$Y = a + bx$$

Becomes:

Y (i.e. improvement in Employee Welfare) = 0.199x.

Hypothesis three: (Ho_3): There is no significant relationship between the abundance of Medical Personnel for the National Health Insurance Scheme (NHIS) and improvement in Employee Welfare in the Lagos State of Nigeria.

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Correlation Analysis of abundance of Medical Personnel for the National Health Insurance Scheme (NHIS) and improvement in Employee Welfare

In management science, as in many other academic disciplines, there is usually the need to investigate the effect of variation in one variable on another variable, and also to measure the magnitude of such variations. The quantitative index that measures the pattern of variation of one variable vis-à-vis the other and the level of association or relationship between them is called correlation coefficient. Correlation analysis is therefore a process of showing the strength of linear relationships between two variables.

Correlation coefficients range from -1.0 through 0.0 to +1.0. A correlation coefficient with a value of -1.0 means, that there is a perfect but negative correlation, between the variables that are being compared. The interpretation here is that as one variable is increasing, the other is decreasing linearly. A correlation value of 0.00 means there is no linear association at all between the variables, and variation in one does not influence the other, while a correlation coefficient of +1.0 means that there is a perfect and positive correlation between the variables, and as one variable is increasing, the other is also increasing linearly.

Correlation analysis was used in this sub-section of study to examine association between the abundance of Medical Personnel for the National Health Insurance Scheme (NHIS) and improvement in Employee Welfare in the Lagos State of Nigeria.

Correlation Analysis of abundance of Medical Personnel for the National Health Insurance Scheme (NHIS) and improvement in Employee Welfare

Correlations

		Abundance of Medical Personnel	Employee Welfare Improvement
Abundance of Medical Personnel	Pearson Correlation	1	.511*
	Sig. (2-tailed)		.030
	N	390	385
Employee Welfare Improvement	Pearson Correlation	.511*	1
	Sig. (2-tailed)	.030	
	N	385	388

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

Source: Author's computation, (2015)

The results of correlation analysis as shown in table 4.3 revealed Pearson correlation analyses (r) computed for abundance of Medical Personnel for the National Health Insurance Scheme (NHIS) and improvement in Employee Welfare to be 0.511. The implication of this is that there is high positive correlation between abundance of Medical Personnel for the National Health Insurance Scheme (NHIS) and improvement in Employee Welfare.

It can be deduced here that as variable of abundance of Medical Personnel for the National Health Insurance Scheme (NHIS) is increasing, improvement in Employee Welfare also continues to increase considerably. This finding has indeed established the abundance of Medical Personnel

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for the National Health Insurance Scheme as it promotes and enhances welfare of the employees.

The correlation analysis of abundance of Medical Personnel for the National Health Insurance Scheme (NHIS) and improvement in Employee Welfare is however found to be significant at P<0.05 confidence level (i.e. P<0.05 = 0.030).

It can however, be rightly said that there is significant correlation/relationship between abundance of Medical Personnel for the National Health Insurance Scheme (NHIS) and improvement in Employee Welfare. Therefore, the null hypothesis is rejected.

Hypothesis four: (Ho_4): There is no significant relationship between availability of infrastructural facilities for the National Health Insurance Scheme (NHIS) and improvement in Employee Welfare in the Lagos State of Nigeria.

Correlation Analysis of availability of infrastructural facilities for the National Health Insurance Scheme (NHIS) and improvement in Employee Welfare

Correlations

		Availability of Infrastructural Facilities	Employee Welfare Improvement
Availability of Infrastructural facilities	Pearson Correlation	1	.732**
	Sig. (2-tailed)		.010
	N	387	381
Employee Welfare Improvement	Pearson Correlation	.732**	1
	Sig. (2-tailed)	.010	
	N	381	386

**. Correlation is significant at the 0.01 level (2-tailed).

Source: Author's computation, (2015)

Table revealed the result of Pearson correlation analysis (r) of availability of infrastructural facilities for the National Health Insurance Scheme (NHIS) and improvement in Employee Welfare to be 0.732. This implies that there is very high positive correlation between availability of infrastructural facilities for the National Health Insurance Scheme (NHIS) and improvement in Employee Welfare.

It can be inferred that as the variable of availability of infrastructural facilities for the National Health Insurance Scheme (NHIS) is increasing, improvement in Employee Welfare also continues to increase significantly. This finding has truly established the availability of infrastructural facilities for the National Health Insurance Scheme as it stimulates and boosts welfare of the employees.

The correlation analysis of availability of infrastructural facilities for the National Health Insurance Scheme (NHIS) and improvement in Employee Welfare is however found to be significant at P<0.05 confidence level (i.e. P<0.05 = 0.010). It can however, be precisely said that there is significant relationship between availability of infrastructural facilities for the National Health Insurance Scheme (NHIS) and improvement in Employee Welfare. Therefore, the null hypothesis is rejected.

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Hypothesis five (Ho_5): There is no significant difference in the effectiveness of National Health Insurance Scheme (NHIS) across the Lagos State of Nigeria.

Analysis of Variance (ANOVA)

ANOVA is an inferential technique for comparing the means of two or more groups. It does so by analyzing the variances of the group data. Variance is a measure of variability used in describing variation of the values within a distribution, and also variation of one distribution compared with others (Adana, 1996). There are two types of variances for estimating the population variance in ANOVA. The first type talks about *variation of the values within a distribution*, while the second talks about *variation of one distribution compared with others*. In ANOVA, the first part (*variation of the values within a distribution*) is focusing on the spread of the values within the distribution of each group, and it is referred to as *variance within*. This is one kind of variance the ANOVA analyzes.

The second part (*variation of one distribution compared with others*) is talking about the variation in the means of the groups. This is referred to as *variance between*, and it is the second kind of variance. Therefore, we now define *variance within* as the variation of the values within each group; and *variance between* as the variation between the different groups means (Adana, 1996).

The technique of ANOVA thus provides the between and within estimates of the population and analyzes them, in order to see if the ratio of these two variances compare relative to the assertion of difference or similarity. From empirical rule, the ratios of the variances form the critical values in the F-Distribution. The null hypothesis in ANOVA is that all the means of the groups are similar while the alternate hypothesis states that at least one of the group means will not be similar.

$$Ho: m_1 = m_2 = m_3 = \ldots = \mu;$$
$$\text{i.e. } \sum (m_1 - \mu) = 0$$
$$H1: \sum (m_1 - \mu) \neq 0$$

Where (m_1 = group means; μ = population mean)

One-way Analysis of Variance

There are many classifications of ANOVA usually determined and defined by the number of factors. A one-way ANOVA analyzes one factor in many levels. A factor in an experiment is the concept that relates the different levels of the experimental treatment.

For this study, variable of Cities constitute factor (independent variable), while effectiveness of National Health Insurance Scheme (NHIS) is used as levels (dependents variable).

Analysis of Variance (ANOVA) of differences in the effectiveness of National Health Insurance Scheme (NHIS)

ANOVA

Effectivemnes of NHIS

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	18.674	5	3.735	2.470	.032
Within Groups	560.944	371	1.512		
Total	579.618	376			

Source: Author's computation, (2015)

The Analysis of Variance (ANOVA) result has revealed that with F-value of 2.470 and corresponding P-value of 0.032 (P<0.05), it is observed that there is statistical significant

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difference in the effectiveness of National Health Insurance Scheme (NHIS) across the Southwest States of Nigeria. This result establishes the fact that the level of effectiveness of National Health Insurance Scheme (NHIS) in the different local governments of Lagos State of Nigeria under review appears not to be the same. That is why one may observe that the level at which people embrace this health insurance scheme in different cities and states, is not at the same pace. Therefore, the null hypothesis which states that, there is no significant difference in the effectiveness of National Health Insurance Scheme (NHIS) across the local governments of Lagos State of Nigeria is hereby rejected.

Focus Group Discussion (FGD)

Focus Group Discussion (FGD) is defined as a collective conversation or group interview (Denzin and Lincoln, 1994). The group size varies from small (4 persons) to large (12 persons) and may or may not be guided by a facilitator. FGD is used to obtain in-depth information relating to concepts, perceptions and practices from group members (Morgan, 1998). This is not a question and answer time, but rather an opportunity to gain insight on the subject from the perspective of experts, practitioners and stakeholders in a purely interactive session.

Several researchers have used FGD successfully for the formulation of research questions, gaining greater insight on the subject and resolving unexpected issues encountered by questionnaire and interview methodologies (Balch and Mertens, 1999; Mbeng, 2009; Refsgaard and Magnussen, 2009).

For the purpose of this study, three FGD sessions were held with enrollees (6), healthcare providers (5) and NHIS officials (4). From the discussions, it found that the enrollees derived high level of satisfaction from the healthcare services delivered to them by the NHIS. However, they believed that NHIS could do better if such services have wider coverage.

On the capitation issue, NHIS attributed the delay to either the logistics of sending capitation to every accredited HCP quarterly together with the list of the newly registered enrollees. NHIS also confirmed that there had been increase in the capitation from N550 to N750 since year 2012.

The study showed that NHIS had worked hard to meet most of the objectives of the founding fathers of the Scheme. Majority of the respondents confirmed that the Scheme had done creditably well in the performance of its healthcare delivery services to the enrollees. They lauded the Scheme in providing abundance of qualified, experienced and skilled medical personnel, availability of infrastructural facilities, reducing huge medical bills and financial hardship of the families. The NHIS has effective quality control section that sees to proper implementation of the scheme's objectives by all its other agencies such as HMOS and HCPS that are the major or key players in the implementation exercise.

RECOMMENDATIONS FOR FUTURE DEVELOPMENT AND IMPROVEMENT OF THE SCHEME

However, in spite of the foregoing achievements of the Scheme, there are other sensitive areas that are crying for its attention. Such areas include:

i. The NHIS should intensify its efforts in concentrating on the rural community programs so as to enable the rural inhabitants enjoy the benefits offered by the Scheme. The rural area inhabitants are 55% while urban population of Nigeria is 45% [National Population Commission, (2003) as quoted by Omoruan et al (2009)].

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ii. More enrollees must be encouraged from the private sector of the Nigerian economy. The research study carried out by other authors as quoted by Eric Obikeze et al (2013), said that 'more than 95% of the population who needed financial risk protection against ill-health were yet to be covered'.This result onlyshows that about 5% of the Nigeria's workforce belongs to the Federal Government civil service.Furthermore, both the state and local governments in Nigeria have not been covered by the Scheme even though Commissioners for health of those states are members of the Nigerian National Council on Health. This action of bringing into the scheme those groups by NHIS will make the Agency to become financially buoyant and self sustaining since the Scheme is based on the law of large numbers.

iii. (a). NHIS should introduce biometric identity cards which will be issued instantly at the point of registration. This step or action will remove the delay being experienced presently by the enrollees from accessing their health care facilities. Presently, the newly registered enrollees have to wait for about three months before they can access their health care facilities.

(b). NHIS should also start to work on piloting electronic claims [E-claims] processing to reduce delay in the payment of capitation to the healthcare providers- [Ghana Daily Graphic, February 12, 2013].

(c). NHIS should establish a permanent and joint clinical and claims audit across the country all-year round to track isolated cases of connivance between the scheme and the providers [Ghana Daily Graphic, February12, 2013].

(d). Since the enrollees or subscribers' satisfaction is a key performance indicator, for NHIS, a subscriber's handbook that will give details of the benefit package, medicines and subscribers' rights and obligations should be compiled. This handbook should be made available to every enrollee at the point of registration and/or membership renewal.

(e).NHIS should introduce biometric identity cards which will be issued instantly at the point of registration. This step or action will remove the delay being experienced presently by the enrollees from accessing their health care facilities.

(f).To educate the public further on the operations of NHIS, a quarterly or biannual policy dialogue forum should be arranged on radio and television stations or networks [nationwide i.e. NTA and Radio Nigeria Stations] live to acquaint both the general public with the progress so far made and the plans for future developments of the Scheme.

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