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Full Length Research Paper

An evaluation of the national health insurance scheme (NHIS) in Jos, a north-central Nigerian city

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National health Insurance Scheme (NHIS) is a health care scheme established by the Federal Government of Nigeria in 2005 for better healthcare delivery to its populace. The objective of this study was to determine the proportion of Nigerian adults enrolled in the scheme, their satisfaction with the quality and availability of services within the scheme and the factors responsible for the dismal health indices in the country despite the scheme. Questionnaires were administered randomly to 200 adult respondents in Jos metropolis. The findings show that only 24% of adults were enrolled in the scheme. Notably, 82% of enrolled respondents were aware of NHIS and prefer it to the fee for service system. There was some level of dissatisfaction in the scheme (26% of enrollees). Sources of dissatisfaction included poor registration services, poor referral system, delays in receiving required services and unavailability or non coverage of some required services. It was statistically determined by the Chi Square tool of analysis that there was a direct relationship between the percentage of enrollees and the poor health indices of the populace. We strongly recommend modification of existing policies to enable enrollment of the self employed and unemployed as well as improved coverage and quality of services within the scheme.

Key words: Evaluation, National Health Insurance Scheme, Jos.

INTRODUCTION

Several approaches abound in financing healthcare. These range from fees for service to private insurance, general taxation, social insurance, community financing, loans and grants. In Nigeria, combinations of all these in different proportions have been practiced for decades. The most basic form of health care financing is that of fees for service, where a fee is charged to cover all or part of the cost of the service provided. In many low and middle income countries a fixed fee for service, known as a user charge, is used by government health facilities, both as a means of raising revenue and as a means of discouraging what may be viewed as 'unnecessary demand'. This form of health care financing has a number of disadvantages. The direct payment of fees for service is regressive in that it causes the greatest hardship for the poor, and may cause major difficulties in payment for waged labourers, who are unpaid during sickness (Goodman, 1993).

The rising cost of health care services as well as the inability of the government health facilities to cope with the people's demand necessitated the establishment of National Health Insurance Scheme (NHIS). The start of the NHIS dates back to 1962 when the need for health insurance in the provision of health care to Nigerians was first recognized (Akande and Bello, 2002; Katibi and Akande, 2003). It was fully approved by the Federal Government in 1997, signed into law in 1999 and launched officially on the 6th June 2005. The Scheme is designed to provide comprehensive health care delivery at affordable costs, covering employees of the formal sector, self employed, as well as rural communities, the poor and the vulnerable groups.

The Nigerian health sector has largely been based on

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a fee for service system with government funds supplementing in capital project financing. External loans and grants in form of technical assistance and free drugs especially for preventive services are common in Nigeria. The Global fund for HIV/AIDS, Malaria and Tuberculosis is one of such initiatives. Immunization campaigns are also supported by donor agencies. So far, the common man is yet to get the best of healthcare in Nigeria. The fee for service system takes so much from his pockets and leaves him unprepared for most medical expenses.

As a result of the possibility of very high and unpredictable medical costs, many users of the fee for service system arrange cover through private insurance schemes, where the risk of illness is pooled among the insured group. Private insurance schemes attempt to spread the risk of illness over all insurees and as such discriminate less against the sick than pure fee based systems (Green, 2007). Social insurance schemes on the other hand widen the base of private schemes with payments tied to wage levels. Contributions to the scheme are made by employees, employers, and in some cases the state. This system is identical for all enrolees, and the premiums are based on income rather than health status with collection systems for contributions organized within industrialized setting (Abel-Smith, 1992). In some countries social insurance systems have been the forerunners of national health systems through either national insurance or tax.

The Nigerian government instituted a social health insurance system in 2005 to bring succour to the plight of its citizens through the National Health Insurance Scheme (NHIS). Health insurance involves the application of insurance principles to cover cost of defined medical benefit packages. It involves risk sharing between those who will need the benefits and those who will not. It also involves spreading the burden of cost of healthcare services to the insured over time so that the insured can access services anytime without paying.

There is dearth of literature on the effect of various health financing options for low and middle income countries (Ekman, 2007; Mills, Rasheed, Tollman, 2006). More so enrolment in insurance has been found to result in altered behavior, such as utilizing unnecessary medical care, a concept known as 'moral hazard' (Sulzbach, Garshong, Owusu-Banahene, 2005). Statistics form a workshop on NHIS-MDG/MCH project by NHIS between 6th -10th June, 2011 reveals that the number of enrolees registered and processed by some states in Nigeria as at March, 2011 are: Bayelsa-184,685, Gombe-161,847, Niger-162,408, Imo-90,597, Oyo-158,152, Sokoto-161,738, Katsina-80,272, Jigawa-105,739, Bauchi-158,144, Yobe-102,556, Cross River-59,910. Furthermore, evidences from countries that have institutionalized national health insurance programme indicate positive impact on the health care system (Sanusi and Awe, 2009; Collins, White, Kriss 2007). In a study in Baltimore USA, health insurance was found to lead to an increase in non urgent utilization of health facilities(Speck, Peyrot, Hsaw, 2003).Similarly in Taiwan, the utilization of most prenatal and intrapartum care services increased after commencement of NHIS(Li-Mei, Shi, Chung-Yi, 2001). Also in a related study about public insurance in North Carolina, USA, it was reported that publicly insured children were more likely to have emergency department visit than un-insured children (Luo, Liu, Frush, Hey, 2003). Same trend was also noticed in Minnesota, USA (Kane, Keckhafer, Flood, Bershadsky, Siadaty, 2002). Also in Jordan, insurance was found to have a positive effect on the utilization of curative care and significantly increased the number of visits per illness episode. (Sanusi and Awe, 2009).

Generally, insurance is found to increase the intensity of utilization and reduce out of pocket spending (Ekman ,2007). However in Nigeria, since the NHIS was established; not much has been carried out to investigate utilization and access to quality health care as a result of the introduction of the Scheme (Ibiwoye and Adeleke, 2008). In Ghana, the utilization of health facilities under insurance cover revealed that Malaria, Respiratory problems and Diarrhea were the commonest illnesses (Sulzbach, Garshong and Owusu-Banahene, 2005). In a survey in Oyo State, Nigeria, among health care consumers, 15.8% of respondents were dependants while 84.2% were workers (primary beneficiaries) (Sanusi and Awe, 2009). Pattern of utilization of general practitioners under universal health insurance in Canada indicated that females made more visits than males (Segovia, 1999).

Research Problem

Nigeria's health system is ranked 187th of 191 World Health Organisation (WHO) member states (WHO, 2000), with an infant mortality rate ranging from 500 per 100,000 in the South West geo- political zone to 800 per 100,000 infants in the North East Zone; Prenatal mortality rate of 48 per 1000 and child mortality rate of 205 per 1000. This means that over 20% of Nigerian children would not survive beyond childhood (UNICEF, 2006). More recent figures (Partnership for Maternal, Newborn and Child Health, 2008) show the North East geo-political zone attaining a mortality rate of 1700 per 100,000 births.

In most developing countries, Nigeria in particular there is a clear lack of universal coverage of health care and little equity. Access to healthcare is severely limited in Nigeria, Otuyemi, (2001). Inabilities of the consumers to pay for the services as well as the healthcare provision that is far from being equitable have been identified among other factors to impose the limitation, Sanusi, et al (2009). Financing of public health services in Nigeria has been through government subvention funded mainly from earnings from petroleum exports and

user fees for patients. Decline in funding for healthcare commenced after the mid 1980's following a drastic reduction in revenue from oil exports, mounting external debts burden, structural adjustment programme and rapid population growth rate, Shaw et al (1995). The result as in most other developing countries was a rapid decline in the quality and effectiveness of publicly provided healthcare services, Shaw, et al (1995). Funding of healthcare in Nigeria has not only affected the quality of healthcare services but led to impoverished health standard of the populace. Gana (2010), identified these funding challenges as low level of public (government) spending, high burden of healthcare costs on individuals and households (70% of all expenditure); thus ranking Nigeria as the country with the second highest level of out-of-pocket spending on health financing in the world.

More worrisome is the fact that the Nigerian System allows private healthcare providers as major stakeholders despite the establishment of the NHIS. The extent of coverage of the NHIS is such that artisans, farmers, sole proprietors of businesses, street vendors, traders and the unemployed are not yet accounted for. Even within the formal sector, not all government and corporate organisation employees are enrolled within the scheme. Our public and private hospitals therefore are still operating on a fee for service basis for the majority of its clients. Besides that, long queues are still usual sites while the issue of unavailability of required services is rearing its ugly head in NHIS approved hospitals. In addition, there is still weak and ineffective referral systems' resulting in over burdened secondary and tertiary health facilities. Furthermore, education of the teaming populace on the pros and cons and the need to participate in the NHIS is also a challenge yet to be surmounted. In view of the aforementioned, this study seeks to assess the extent of coverage of the scheme and the degree to which the enrolees are satisfied with the Scheme in Jos.

Research Questions

i. What proportion of people in Jos is benefiting from the scheme?
ii. What proportion of the beneficiaries is satisfied with the scheme?

Objective of the Study

The main purpose of this study is to evaluate the performance of the NHIS within Jos metropolis while the specific objectives include:

i.To determine the percentage of enrolees that have benefited from NHIS

ii. To determine the level of satisfaction with NHIS.

Research Hypotheses

Hypothesis I

Ho: The enrolees have not significantly benefited from NHIS in Jos.

Hypothesis II

Ho: A significant percentage of the enrolees are not satisfied with NHIS in Jos.

Scope of the Study

The primary area of focus for this study will be the communities within Jos metropolis. This will include the working populace who are adults above the age of eighteen (18) years in Jos North, Jos South and Jos East Local Government Areas (LGA's) of Plateau State who have enrolled into the scheme. The period under study is 2005 to 2010. The choice of this period coincides with the start of NHIS in the country.

Significance of the Study

It is hoped that this study will serve as an available reference source and will help other researchers in this field; thus contributing to the existing literature. Moreover, the study will help government and managers of the scheme in policy formulation and administration for better service delivery and improvements in the scheme.

LITERATURE REVIEW

Concept of National Health Insurance Scheme (NHIS)

National Health Insurance Scheme is a form of formal sector social health insurance programme. It is a social health security system in which the health care of an employee is paid for by both the employer and employee. This is achieved by monthly deductions of 5% of basic salary from an employee and another 10% of basic salary paid by the employee's employer which is then pooled together and used for all enrolees. In social health insurance there is cross subsidisation where the healthy subsidize for the ill, the young subsidize for the old and the higher income group subsidises for the lower income group. Therefore, social health insurance is a social security system that guarantees the provision of a

benefit package of health care services paid from funds created by pooling the contributions of participants.

Global Perspective of Social Health Insurance

According to the (WHO 2000) health is a state of complete physical, mental and social well being and not just the absence of disease or infirmity. This definition looks like an aberration in Nigeria and if we go strictly by it, no

Nigerian can be said to be a healthy client for the insurance industry. Every country strives to provide for its citizens affordable and accessible healthcare. In South Africa for instance, there is no nationally operated public health insurance scheme. Yet, they can boast of better health indices than Nigeria. They have private health insurance schemes that are affordable, well developed and functioning effectively and efficiently (Gana, 2010). A look at the healthcare systems of some key countries can only enlighten us more.

In the United Kingdom (UK), there is the National Health Scheme (NHS) which is a publicly funded healthcare system for all residents of the UK. No premiums are collected, costs are not charged at the patient level and costs are not prepaid from a pool. It is actually not an insurance system but it does achieve the main aim of insurance which is to spread financial risk arising from ill health directly from general taxation. The United States health care system on the ether hand relies heavily on private health insurance, which is the main source of coverage for most Americans.

In Canada, public and private schemes exist; most health insurance schemes in Canada are administered at the level of provinces under the Canadian Health Act, which requires all people to have free access to healthcare. About 65% of Canadians have some form of supplementary private health insurance; many of them receive it through their employers. (Gana, 2010)

France operates a solidarity system. It has both public and private schemes. The peculiarity of the French system is that; the more ill a person becomes, the less the person pays. This means that for people with serious or chronic illness, the insurance system reimburses them 100% of expenses, and waives co-payment charges. Complementary private health insurance is also available. (Gana, 2010)

In Australia functional public health insurance exists alongside private schemes. The public health system (Medicare) ensures free universal access to hospital treatment and subsidised out-of-hospital medical treatment. Medicare is funded by 1% levy on all taxpayers, an extra 1% levy on high income earners as well as general government revenue. Some private health insurers are for profit while some non profit health insurance organisations are also operational

The sickness fund of Germany is a health insurance scheme paid for by employers and employees and managed by not-for-profit organisations. It is characterised by private provider base, efficient management, adequate investment and effective control of provider and purchaser behaviour. In Chile, public and private schemes exist, but like in most countries of Latin America, patients are migrating from public to private schemes (Korte 1992).

The Nigerian System allows private healthcare providers as major stakeholders despite the establishment of the NHIS. The extent of coverage of the NHIS is such that artisans, farmers, sole proprietors of businesses, street vendors, traders and the unemployed are not yet accounted for. Even within the formal sector, not all government and corporate organisation employees are enrolled within the scheme. Our public and private hospitals therefore are still operating on a fee for service basis for the majority of its clients Gana (2010).

Structure of the NHIS

The very design of the organizational structure of the NHIS is in itself a control measure aimed at ensuring an efficient, effective and economical scheme. The NHIS is constituted of the following bodies: (i) The council (ii) State licensure boards (iii) State health insurance offices (iv) Standards committee and inspectorate systems (v) Health maintenance organizations (vi) Health insurance companies (public and private) (vii) Arbitration boards (viii) Malpractice insurance schemes (ix) Banks and banking systems and (x) Tribunals. Funding will be by contribution of 5% of enrolees' basic salary while the employer contributes 10% of enrolees' basic salary to the scheme monthly. (NHIS, 2005). The insured shall choose his primary health care provider who is associated with the HMO's. The primary health care provider is to be registered by the NHIS according to the guidelines of the standards committee made up of statutory professional registration boards. The state licensure boards approve premises for practice by the health care provider.

Liability insurance companies (public and private) will provide professional indemnity cover (malpractice insurance) for health care providers. The role of the arbitration boards will be to handle conflicts between the above relationships.

Benefits of NHIS

Benefits of the scheme include outpatient care, pharmaceutical care as in NHIS essential drug list, diagnostic tests as in NHIS diagnostic test list, maternal care for up to four (4) life births; preventive care (immunization, health education, antenatal and postnatal care), hospital care (limited to 15 days in a year and admission in the general ward), eye care and preventive dental care. (Obadofin, 2006) Beneficiaries do not need

cash to access treatment when required except the 10% co-payment for the cost of drugs. Thus the usual practice of converting assets to cash especially in catastrophic illnesses can be avoided. In fact, the ministry of health asserts that the benefit package in the NHIS is the most comprehensive in the world.

Exclusions of NHIS

The NHIS package has certain healthcare services that are not covered in the scheme. These exclusions are either total or partial. Total exclusions healthcare services such as occupational or industrial injuries, radiologic investigations like computerized tomography (CT) scan, magnetic resonance imaging (MRI), epidemics, cosmetics surgeries, open heart surgeries, neurosurgeries, and family planning commodities are totally excluded from the NHIS. Injuries arising from natural disasters, earthquakes, landslides, conflicts, social unrests, riots and

wars are not included in the benefit package. Similarly, injuries arising from extreme sports such as car racing, polo, boxing and wrestling are also not covered by the NHIS. Epidemics and therapies accruing from drug abuse and addiction, transplant and surgical repairs of congenital anomalies and purchase of spectacles are also excluded (Obadofin, 2006).

Partial exclusions also exist. Generally, conditions of sizable prevalence, social importance and high cost are partially covered by the scheme. Terms of the partial coverage are such that the HMO pays 25% while the employer or employee pays 75% of the cost of the healthcare service. This applies to surgeries like prostatectomy, myomectomy and orthopedic repairs. In the case of high technological investigations in life saving emergencies; the HMO pays 10% while others pay 90% of the total cost of the service. Investigations like CT scan and MRI are included here. Other investigations like mammography, Pap smear, tumour markers, hormonal assays, laparoscopic or fluoroscopic tests, radio opaque studies and barium studies are also covered in this way. (Obadofin, 2006)

Challenges of Service Delivery

In 2005, the NHIS published guidelines for standard treatment of patients by healthcare providers. This was as a result of the concerns the management of the scheme had on the effects of unwarranted overuse of the system and on the solvency and sustainability of the scheme. Overuse would arise from improper provider behaviours through overprescribing, over treatment, undue generation of patients' visitation and unnecessary use in technology in order to attract more income. Under these guidelines, monitoring and evaluation is carried out jointly by the NHIS and the HMO's (NHIS, 2005).

Despite the published protocol, most of these practices are common place in our health institutions. In addition, long queues are still usual sites while the issue of unavailability of required services has started rearing its ugly head in NHIS approved hospitals. In addition, there is still weak and ineffective referral systems' resulting in over burdened secondary and tertiary health facilities. Furthermore, education of the teaming populace on the pros and cons and the need to participate in the NHIS is also a challenge yet to be surmounted.

Moreover, available financing risk protection under the NHIS is very limited in coverage and scope. Several very important and hitherto expensive healthcare services are excluded from the scheme, while common ailments that can be treated easily and very affordable are financed by the scheme.

METHODOLOGY

For this study, the population is the entire inhabitants of Jos city. Jos metropolis is comprised of three LGA's with a total population of 821,618 persons distributed thus: Jos North (429,300), Jos South (306,716) and Jos East (85,602) (www.plateaustategov.ng). However, since it is not feasible to reach the entire population of 821,618, a sample size has to be determined.

The minimum sample size has been calculated using the following formula (Araoye, 2004)

$N = Z^2Pq / D^2$; N = minimum sample size required; Z = standard normal deviation set at 1.96 which corresponds to the 95% confidence level; P = expected prevalence rate (%) = 15%; q= 1-p. (1 - 0.15 = 0.85); d= degree of accuracy desired set at 0.05.

$N = \frac{1.96^2 \times 0.15 \times 0.85}{0.05} = \frac{3.842 \times 0.15 \times 0.85}{0.0025} = 195.94$

Therefore, approximately 200 respondents will be sampled in this study. The approach will be to sample 20 persons in each of 10 different locations within the three LGA's of Jos Metropolis.

Method of Data Collection

For this study, primary data came from persons who are adults above the age of eighteen (18). Questionnaire was used as the means of collecting data. Thus, the study was structured questionnaire administered to respondents as the principal method of data collection.

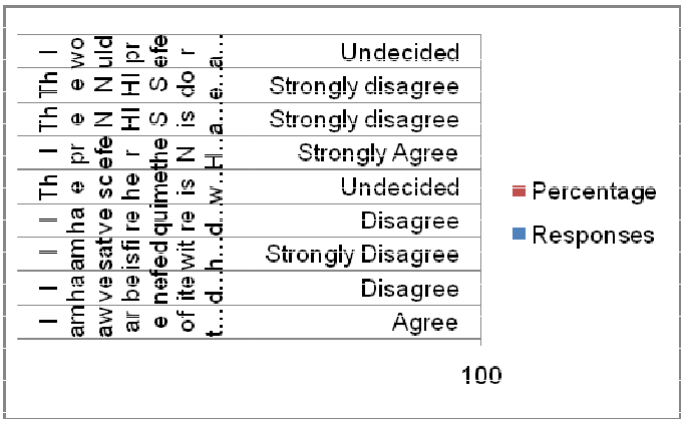
Questionnaire was chosen as the suitable instrument for data collection considering the fact that it is cost effective, ensures uniformity, avoids ambiguity, avoids errors, saves time and has a relatively high degree of standardization.

Method of Data Analysis

In this study, Chi square will be used as a tool to analyze

Summary of responses to questionnaire statements

Statement	Options	Responses	Percentage
1. I am aware of the NHIS	**Agree**	116	58%
2. I have benefited from the NHIS	**Disagree**	60	30%
3. I am satisfied with the services I have received in the NHIS	**Strongly Disagree**	123	61.5%
4. I have required a service in the past that is not covered in the NHIS	**Disagree**	72	26%
5. The scheme is worth the contributions I and my employers are making.	**Undecided**	104	52%
6. I prefer the NHIS to the fee for service system	**Strongly Agree**	82	41%
7. The NHIS is a waste of time and money	**Strongly disagree**	72	36%
8. The NHIS does not provide better healthcare services	**Strongly disagree**	72	36%
9. I would prefer an increase in my contributions from 5% to 7.5% or 10% to allow inclusion of other excluded services	**Undecided**	88	44%



the data.

Formula: $X^2 = \sum(fo-fe)^2/fe$

Where ∑= summation; Fo= observed; Fe= expected

The degree of freedom can be calculated using the formula

df= (r-1)(c-1) Where r = number of rows; c = number of column

DATA ANALYSIS AND RESULTS

The table and the diagram above reveal that 116(58%) agreed that they are aware of the NHIS, 60(30%) disagreed that they have benefited from NHIS. 68(34%) of the respondents strongly agreed that they are satisfied with the services they have received in the NHIS, 72(36%) disagreed that they have required service in the past that is not covered in the NHIS.

104(52%) were undecided as to whether the scheme is worth the contributions they and their employers are making or not, 82(41%) strongly agreed that they prefer NHIS to the fee for service system, 72(36%) strongly disagreed that the NHIS is a waste of time and money. Finally, 88(44%) of the respondents did not decide if they would prefer an increase in my contributions from 5% to 7.5% or 10% to allow inclusion of other excluded services.

Tests of Hypotheses

Hypothesis I

DOF = (R – 1) (C – 1); Level of significance = 5% (0.05)
DOF= (4 - 1) (5 – 1), DOF= (3)(4) = 12
Calculated Value = 24.1 Critical Value = 21.03
Where: X^2 = Chi square, Fo = Observed frequency
Fe = Expected frequency, ∑ = Summation

Ho: Ho: The enrolees have not significantly benefited from NHIS in Jos.

Options	Responses					
	Strongly Agree	**Agree**	**Indifferent**	**Disagree**	**Strongly Disagree**	**Total**
A	13(13.95)	11(13.73)	8(5.63)	5(4.73)	8(6.98)	**45**
B	35(24.80)	22(24.4)	10(10.00)	5(8.4)	8(12.4)	**80**
C	4(8.99)	8(8.85)	2(3.63)	63.05	9(4.50)	**29**
D	10(14.26)	20(14.03)	5(5.75)	5(4.83)	6(7.13)	**46**
Total	**62**	**61**	**25**	**21**	**31**	**200**

Ho: A significant percentage of the enrolees are not satisfied with NHIS in Jos.

Options	Responses					
	Very Satisfied	**Satisfied**	**Indifferent**	**Not Satisfied**	**Not Very Satisfied**	**Total**
A	13(13.95)	11(13.73)	8(5.63)	5(4.73)	8(6.98)	**45**
B	35(24.80)	22(24.4)	10(10.00)	5(8.4)	8(12.4)	**80**
C	4(8.99)	8(8.85)	2(3.63)	6(3.05)	9(4.50)	**29**
D	10(14.26)	20(14.03)	5(5.75)	5(4.83)	6(7.13)	**46**
Total	**62**	**61**	**25**	**21**	**31**	**200**

DOF = Degree of freedom

Decision Rule

Reject H_0, if the calculated chi-square is greater than the tabulated chi-square. Since the x^2 calculated value 24.1 is greater than the x^2 tabulated value of 21.03, reject H_0 and accept H_A (alternative hypothesis) which states that the enrolees have significantly benefited from NHIS in Jos.

Hypothesis II

DOF = (R – 1) (C – 1); Level of significance = 5% (0.05); DOF= (4 - 1) (5 – 1), DOF= (3)(4) = 12 Calculated Value = 24.1 Critical Value = 21.03; Where: X^2 = Chi square,
Fo = Observed frequency
Fe = Expected frequency, $\sum$ = Summation; DOF = Degree of freedom

Decision Rule

Reject H_0, if the calculated chi-square is greater than the tabulated chi-square. Since the x^2 calculated value 24.1 is greater than the x^2 tabulated value of 21.03, reject H_0 and accept H_A (alternative hypothesis) which states that a significant percentage of the enrolees are satisfied with NHIS in Jos.

SUMMARY OF FINDINGS

The findings in this study show that only 24% of adults are enrolled in the scheme most of whom are government employees between the ages of 18 and 40 years. 58% of respondents were aware of the existence of the scheme and 61.5% have benefitted from the scheme. Of the 24% enrolled in the scheme, 61.5% were satisfied while 26% expressed dissatisfaction with the services received in the scheme. Notably, 41% of respondents preferred the NHIS to the fee for service system while 54% preferred the NHIS to private insurance schemes. Only 14% preferred private insurance or the fee for service to the NHIS. Another 44% would prefer an increase in their contributions from 5% to 7.5% or 10% to allow inclusion of other services excluded in the benefit package. Yet another 52% opines that the the contribution for NHIS is a worthwhile venture.

CONCLUSION

Based on the findings, it can be concluded that the level of enrolment into the NHIS is still very poor which inevitably contributes to the poor health status of Nigerians and the dismal health indices recorded in our health institutions. The level of dissatisfaction in the scheme is also a cause for concern that requires immediate attention from both the HMO's and the healthcare providers. Sources of dissatisfaction included poor registration services, poor referral system, delays in receiving required services and unavailability of required service. The non coverage by the insurance scheme of some of the services required by enrolees is a policy issue which can only be dealt with at the level of policy formulation. Suffice to note that some enrolees (44%) will not mind increasing their contributions into the scheme in as much as these services would be covered in the benefit package.

RECOMMENDATIONS

The following recommendations are made:

(i) Removal of all bottlenecks encountered in the registration process in order to fast track registration of new and existing employees into the scheme

(ii) Making policy statements to enable enrolment of self employed individuals and the immediate

(iii) Creating an avenue where unemployed individuals can also access healthcare services at little or no cost even when they are not making contributions. The government can bear the cost incurred by the unemployed especially for those officially registered in a government certified unemployment register.

(iv) Compulsory enrolment into the scheme should be enforced for all working Nigerians starting with those working in government organizations. This will improve our dismal health indices as most Nigerians will then have access to better healthcare services without the encumbrance of large out of pocket expenses.

(v) The researcher recommends that employers who are not willing to enrol their employees should be prosecuted.

(vi) Health Maintenance Organizations and healthcare providers must realize that enrolees have the right to choose who their service providers are and can change to another when not satisfied with services rendered. Therefore, it is recommended that every provider strive to provide the best of services and the monitoring agencies should step up their monitoring antennae in order to curb the menace of dissatisfaction which is fast becoming common place in the scheme.

(vii) Several Nigerians are not fully enlightened in the components and structure of the NHIS. The researcher recommends a massive and far reaching enlightenment campaign to educate the populace on the scheme, the benefits there in and the rights of an enrolee.

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