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Contents

Peoples' perception of the implementation of NHIS and its impacts on the NHIS utilization among workers of the federal agencies in the Oyo State, Nigeria

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Abstract

The study investigated the People's perception of the implementation of NHIS and its impacts on the enrollees, among workers of the federal agencies in the Ibadan metropolis. It adopted a descriptive survey design. Two hundred and fifty enrollees across the federal agencies in the federal secretariat in Ibadan participated in the study. It examined the implementation of NHIS, utilization of NHIS, level of satisfaction with health care providers, the evaluation of the referral process from primary to secondary care services, distance of the health care facility, satisfaction with services at the secondary and tertiary health care levels. Data was analysed using frequency distribution, percentage and multiple regression analysis tested at 0.05 level of significance.

Results revealed that more than two-third (81%) of the respondents reported visiting NHIS accredited healthcare facility in the past two years. The patient's utilisation was high. However, nurses attitude, and waiting time were found to be the major causes of dissatisfaction. Quality service, enrollees satisfaction with services, location of the PHCs and management of the referral process have direct relationship and predicted increase in utilization rates. Independently, Service quality, enrollees' satisfaction with services, location of the PHCs were predictors NHIS utilization. Therefore, concerted efforts should be directed by all stakeholders towards the areas of patient dissatisfaction through better service delivery.

Keywords: National Health insurance Scheme, Utilisation, Health Maintenance Organisation, and Primary Care Providers

Introduction

In Nigeria, public health delivery system is very weak giving the constraints, on governments at the three-tier level towards funding and effective health care management. The resource allocation is insufficient and imbalanced between the various levels of government in the country. Thus, the quality of health service due to obsolete equipment in public healthcare facilities are very poor. The referral system is largely non-functional coupled with high influx of fake, substandard, adulterated and unregistered drugs in the country. The public are dissatisfied with the quality of health care services. This weak service delivery system is unable to deliver, the optimum package of quality healthcare, including routine immunization, emergency care, preventive and management of communicable and infection diseases especially malaria, tuberculosis and HIV/AIDS. Another area of concern is the poor integration of public and private health factors in the country. This has deprived the health system, the advantage of the experience and expertise which could be derived from modern facilities that could result from such relationship. Thus, to address these problems in the healthcare financing and access, many developing countries adopted the Health Insurance option, including Nigeria, yet substantial gaps exist between policies and their implementation in Nigeria.

The National Health Insurance Scheme (NHIS) which was established by Decree 35 of 1999, was signed into law on May 10 of that year. The objectives of the scheme include ensuring access to good health care without financial hardship to families and limiting the rise in cost of health care services; maintaining high standard of health care delivery services and improving and harnessing private sector participation in the provision of the health care services; promotion of equity in the distribution of health services and patronage of institutions at the different levels of health care delivery. Among its numerous functions are: registering Health Maintenance Organisation (HMOs); issuing appropriate guidelines to maintain the viability of the scheme; approving format of contracts proposed by the HMOs for all health care providers; determining, after negotiation, capitation and other payments due to health care providers, by the HMOs; advising the relevant bodies on inter-relationship of the scheme with other social security schemes; advising on the continuous improvement of quality of services provided

under the schemes through guidelines issued by the Standards' Committee established by its enabling law; and doing other things as are necessary or expedient for the purpose of achieving the objective of the scheme. Thus, it will be seen that based on the ascribed objectives and functions, the enabling law of the NHIS expects it to be a regulatory and supervisory agency of the operators involved in the service of health insurance provision and safeguarding the interest of consumers.

At present NHIS covers only 5% of the population and the conditions for NHIS are not favorable to success of achieving its national coverage by 2015, due to the low share of population in formal sector and the difficulty to collect taxes (Wakinen, 2007). As a result of the aforementioned, NHIS still face significant policy imbalance and a range of monitoring and implementation problems which make it difficult to achieve set goals and objectives of the NHIS. What can policy makers do to become more effective in solving monitoring and implementation problems? Both the causes and the solutions to the policy and implementation problems in the health insurance practice are complex. The problems seem to be rooted in political, economic, cultural (i.e. Endogenous) and health systems. The solution depends on numerous inputs-funds, education, data collection and tracking, lack of established Monitoring & Evaluation framework for analyzing the factors affecting the development and implementation of policies and strategies. Moreover, the importance of assessing progress towards the attainment of the NHIS mandate of universal coverage and/or health for all by the year 2015 cannot be overemphasized.

Therefore, to explore issues and barriers to be overcome in the implementation of a sound monitoring and evaluation standards in health insurance practice in Nigeria, with a view to providing policy makers, stakeholders and researchers with basis for right policy/best practices. Rational choice theory, or rational activity theory, is a theory for comprehension frequently explaining social and financial and also individual behaviour. The application of rational choice theory in the implementation of the health insurance scheme, health in general involves a lot of money and the financial resources at the disposal of the government is very limited plus the resources at the individual level

therefore the scheme was introduce in order to pool the resources together and use it to take care of those that actually need the service, it is assumed that those at the lower ladder of the economy are at the risk of developing ill-health condition, premium were being paid on monthly basis for any future eventuality which is far better, economical and more rational than out-of-pocket expenses the patients is expected to pay at the period of ill-health It is pertinent to evaluate the implementation of the NHIS operating functionally in the formal sector which no research have been able to examine before now. Thus, the purpose for this investigation was to do a critic evaluation of the implementation of NHIS program and in view of achieving it the following request will be answer.

1. Assess the level of utilization among the enrollees
2. Examine the level of satisfaction of patients with the services delivered by NHIS
3. Assess the perception of residency in relation to location of NHIS accredited health facility
4. Evaluate the enrollees' perception of the referral process under the NHIS.
5. Determine factors predicting the enrollees' utilization of the NHIS services.

The assessment of the perception of NHIS provided services can be used as one of the indicators of the effectiveness of the NHIS provided health care services. Findings from this study will help to identify service gaps and provide information for health policy decisions towards strengthening of the referral system and services under the National Health Insurance

Method

Research Design

The researcher adopted a cross sectional research design

Population and Sample

The study was conducted in four public organisations that utilised four healthcare providers in Oyo State, these hospitals are; University Health

Centre, Jaja Clinic, University of Ibadan, Idi-Ape Medical health Centre Agodi, Mooly health Centre, American Quarters Agodi, and Group Medical Centre, Mokola Ibadan. This was a hospital-based cross-sectional descriptive study carried out among NHIS patients attending the primary and secondary healthcare between April and September 2018. The hospitals are providing primary, and secondary care services, and attending to more than one thousand NHIS enrollees. A minimum sample size of 250 was derived from the Leslie Fisher formula for estimating sample size for descriptive studies, using 50% as the proportion of NHIS enrollees who were satisfied in a previous study. The inclusion criteria included adult NHIS patients aged 18 to 60 years, who have accessed care in the hospital not less than three different occasions and consented to participate in the study, while patients in need of urgent attention, children and patients' relatives were excluded from the study. Patients attending the General Outpatient Department were selected by systematic random sampling on the days questionnaires were administered with a sampling interval of two.

Instrumentation

A structured interviewer-administered questionnaire developed by the researchers, based on the complaints from NHIS patients was used for this study. The questionnaire contained information on basic socio-demographic variables. The questionnaire captures utilisation of NHIS Health Insurance Services (3 –items (0.73 alpha), referral process to secondary health care facilities (4 –items (0.77 alpha), and perception of the location and distance to health care facilities (5 –items (0.75 alpha). The Level of satisfaction with the Healthcare facilities (HCFs) was assessed using nine composite index which comprise of (i) Access to healthcare (ii) Waiting Time (iii) Patient-provider relationship (iv) Qualitative care and medication, (v) Availability of Doctors and Nurses during visit, and (vi) Family Coverage of the Scheme, as used by Mohammed (2011), Jadoo et al (2012) and Gup et al (2012). Each satisfaction item was scored in a five points Likert scale ordinal response (Strongly agree to Strongly agree). The scale has a reliability of 0.83 cronbach alpha and split-half reliability of 0.89 spearman brown co-efficient.

Data Collection

A pretested, structured, interviewer-administered questionnaire was adapted from the NHIS Questionnaire in 2012 was used for this study. The overall reliability of the pilot test was 0.74 cronbach alpha with test retest reliability of r=0.64. In the main study, patients completed the study questionnaires in the waiting room after providing written consent and prior to consultation. The questionnaires were distributed personally by the researcher who read and explained the purpose of the study to the respondents who responded to the questionnaire. The researcher and her assistants helped the uneducated respondents in interpreting the items and ticking their chosen responses. The copies of the questionnaire that were filled was utilized in the data analysis.

Method of data analysis

Data analysis was done using Frequency, percentages, and cross tabulations and multiple regression analysis were used as statistical tools. Ethical approval for the study was obtained from the Ethical Committee of Oyo State Ministry of Health, Ibadan. Participation was fully voluntary, confidentiality and anonymity assured, and written informed consent obtained from the participants.

RESULTS

Table 1: Socio-demographic characteristics of Enrollees of National Health Insurance Scheme.

Background Characteristics		Federal	State	
		n (%)	n (%)	Total (%)
Sex	Male	158 (63.3)	7 (2.2)	67.7
	Female	92 (36.8)	3 (0.7)	36.1
Age group	Under 18 years	24 (12.6)	2 (0.6)	23.6
	18-40 years	120(44.4)	3 (0.9)	35.7
	41-59 years	47 (22.4)	2 (0.6)	34.4
	60 years and over	33(10.0)	2 (0.6)	8.1
	61 and above	26(10.4)	1 (0.3)	1.3
Marital status	Married	163 (65.2)	2 (0.6)	22.5
	Single parent	49 (19.6)	0 (0.0)	3.1
	Separated	36(14.4)	4 (1.3)	72.1
	Others	2(0.8)	0 (0.0)	1.0
No. of Children	Nil	17(9.2)	0 (0.0)	20.0
	1-2	122 (48.8)	2 (0.6)	14.6
	3-4	28 (12.4)	0 (0.0)	20.8
	Above 4	80 (29.6)	3 (0.9)	24.9
Grade level	1-6	127(50.8)	3 (0.9)	13.4
	7-13	84 (33.6)	1 (0.3)	8.6
	14 and above	39 (15.6)	1 (0.3)	0.8
Number of dependents registered with NHIS	Nil	19 (7.6)	2 (0.6)	10.1
	Up to two	28 (11.2)	3 (0.9)	3.4
	Three to four	58 (23.2)	2 (0.6)	47.5
	Above four	145 (58)	5 (7.8)	50.3

The results in Table 1, reveals that larger proportions (63.3%) of the respondents were males while 36.8% were female. The age distribution

of the respondents, shows that 12.6%)of the respondents were under 18 years of age, (44.4%) were between 18-40years, (22.4%) were between the age range of 41-59years, (10%) were between the age group of 60 years and over, and (10.4%) of the respondents were between 61years and above. By marital status, majority(65.2%) were married, followed by Single parents (19.6%), separated (14.4%) and widows (0.8%).In respect to respondents number of children, the distribution range from no children (9.2%), 1 -2 children (48.8%), 3-4 children (12.4%) and 4 children and above(29.6%). The table also reveals the employment grade level of the respondents, (50.8%) were in 1 – 6 level, (33.6%) were in level 7 – 13 and (15.6%) were in level 14 and above. The table further reveals the number of dependents registered with NHIS, (7.6%) reported nil, 11.2%) reported up to two dependents, (23.2%) reported three to four dependents and larger proportion (58%) reported above four.

Table 2: Utilisation of NHIS Health Insurance Services

Visitation to NHIS accredited healthcare facility in the past two years			Yes 124 (81%)	No 76 (19%)	Total 250 (100%)
	Adequate	appropriate	inadequate	Needs improvement	Total
Perception of the services offered by benefit package of NHIS	128 (51.2%)	26 (10.4%)	83 (33.2%)	13 (5.2%)	250 (100%)
	Greatly enhance	Enhance	indifferent	Deter attendance	Greatly deter	Total
Influence of NHIS benefit package on attendance at the healthcare facilities	12 (4.8%)	46 (18.4%)	44 (17.6%)	137 (54.8%)	11 (4.4%)	250 (100%)

Table 2, more than two-third (81%) of the respondents reported visiting NHIS accredited healthcare facility in the past two years. Majority (51.2%) of the respondents reported adequacy of the services offered in the NHIS benefit package of 26(10.4%) reported appropriate, 83(33.2%) reported inadequate, 13(5.2%) reported the need for improvement about the services offered by benefit package of NHIS. The Table 2 reveals the benefit package of NHIS affect their attendance at the healthcare facilities, 12(4.4%) of the respondents reported that the NHIS package greatly enhance, 46(18.4%) enhance, 44(17.6%) indifferent, while large proportion 137(54.8%) of the respondents deter attendance and 11(4.4%) greatly deter at the NHIS clinics.

Table 3: Level of satisfaction with the Healthcare facilities (HCFs)

Items	Very unsatisfied	Unsatisfied	Neutral	Satisfied	Very satisfied
Services were readily available	25 (10%)	63 (25.2%)	72 (28.8%)	72 (28.8%)	18 (7.2%)
Services were convenient	15 (4.8%)	69 (28.8%)	80 (33.2%)	66 (25.2%)	20 (8%)
Nurses were friendly	140 (57.8%)	43 (15.4%)	44 (17.6%)	12 (4.8%)	11 (4.4%)
Doctors were friendly	10 (2.8%)	28 (11.2%)	60 (25.2%)	140 (53%)	12 (5.8%)
Waiting time was appropriate	135 (51%)	25 (8.8%)	40 (17.2%)	23 (12.2%)	27 (10.8%)
Time spent in Exam Room	24 (12.6%)	33 (10.2%)	120 (44.4%)	47 (22.4%)	26 (10.4%)

Time spent waiting for lab results	18 (7.2%)	44 (17.6%)	38 (15.2%)	115 (46%)	35 (14%)
Getting your problem resolved	66 (26.4%)	32 (10.4%)	65 (29.4%)	17 (8.6%)	70 (26.2%)
General quality of service received	22 (11.8%)	16 (6.4%)	20 (15.8%)	130 (46%)	62 (20%)

The Table 2 above shows that larger proportion that were satisfied with timely availability of services available (36%), services convenience (46%), doctors friendly attitude (58.8%), time spent waiting for lab results of (60%), time spent in exam room (32.8%) and overall quality of services received (66%). However, a larger percentage of the respondents were unsatisfied with the nurses unfriendly attitude (73.2%) the waiting time (59.8%) and the manner in which they get their problem resolved, (36.8%).

Table 3: The evaluation of referral process to secondary health care facilities

				Yes	No
Have you ever been referred to a secondary healthcare facility?				150 (55.2%)	100 (44.8%)
If Yes, how was the process of referral?		No	Cumber some	Easy	Denied approval
		100 (44.8%)	83 (35.2%)	106 (44.8%)	61 (22%)
Which procedure did you recently undergo at secondary or tertiary level(s) of care?	Lab investi gation	Surgical operation	Filling prescript ion	X-rays	others
	25 (10%)	63 (25.2%)	70 (26.8%)	74 (30.8%)	18 (7.2%)
Period to visit the facility you were referred to?		Less than 24hrs	24hrs-48hrs	Above 48hrs	Not served out
		6 (2.4%)	202 (80.8%)	37 (14.8%)	5 (2%)

Results displayed in Table 3, reveals that larger proportion 150(55.2%) of the respondents reported that they had been referred to a secondary healthcare facility while 100(44.8%) had not been referred to a secondary healthcare facility. The table above shows that 83(35.2%) of the respondents reported that the process of referral was cumbersome, while larger proportion 106(44.8%) reported that it was easy and 61(22%) reported that they denied them approval. 25(10%) of the respondents reported that they undergo lab investigation, 63(25.2%) reported surgical operation, 70(26.8%) reported filing prescription larger proportion 74(30.8%) reported x-rays and 18(7.2%) reported other procedures. Response time it took them to visit the facility they were referred, 6(2.4%) reported that less than 24hrs, large proportion 202(80.8%) reported 24hrs-48hrs, 37(14.8%) reported above 48hrs and 5(2%) not served out.

Table 4: Location and distance to health care facilities

	One time	Long	Too long	Frustrating
Length of wait period before seeing the specialist	102 (40.8%)	83 (33.2%)	49 (19.6%)	16(6.4%)
	Very far	Not very far	Within reasonable distance	Just okay
Distance of primary healthcare facility from residence	153 (61.2%)	43 (17.2%)	52 (20.8%)	20(.8%)
Distance of the nearest secondary/tertiary healthcare facility from residence	127 (50.8%)	26 (10.4%)	84 (33.6%)	13(5.2%)
			Yes	No
Distance of healthcare facilities from residence discouraging visits to seek medical attention.			158 (63.2%)	92 (36.8%)
Client or dependents been hospitalized?			113 (45.2%)	137 (54.8%)
Pay any fee for hospitalization?			131 (52.4%)	119 (47.6%)

Large proportion 102(40.8%) of the respondents reported that they waited one time before seeing the specialist, 83(33.2%) reported long, 49(19.6%) reported too long and 16(6.4%) reported frustrating. The table above shows that 153(61.2%) of the respondents reported that their primary healthcare facility is very far from their residence, 43(17.2%) reported not very far, 52(20.8%) reported within reasonable distance and 20(0.8%) reported just okay. Large proportion 158 (63.2%) of the respondents were aware that the distance of their healthcare facilities from their place of residence discouraging them from visiting them to

seek medical attention while 92(36.8%) were not aware, 113(45.2%) reported that they or their dependents have been hospitalized, majority 137(54.8%) reported that they or their dependents have not been hospitalized, 131(52.4%) of the respondents pay fee for hospitalization and 119(47.6%) did not pay any fee for hospitalization.

Factors predicting the enrollees' utilization of the NHIS services.
The role of the factors, of quality service, enrollees satisfaction with services, location of the PHCs and management of the referral process on utilisation level was tested using multiple regression analysis and the result displayed in Table 5. The provision of services was proxified as service quality, enrollees' satisfaction with services, and location of the PHCs and management of the referral process.

Table 5: multiple regression analysis showing the influence of Service quality, enrollees' satisfaction with services, location of the PHCs and management of the referral process on utilization of NHIS services

R = .812[a]

R^2= .659

Adj R^2= .654

S.E = .29

F= 142.28

Durbin Watson = 1.93

	Unstandardized Coefficients	Standardized Coefficients			
	B	Std. Error	Beta	t	Sig.
(Constant)	.571	.149		3.818	.000
Enrolees satisfaction	.011	.004	.099	2.838	.005
Location	.143	.006	.811	23.636	.000
Perceived service quality	.005	.002	.095	2.546	.007
Operational linkage mgt referral	.020	.019	.036	1.059	.290

Dependent Variable: UTILISATION OF NHIS SERVICES

The result from Table 5 shows that there is significant positive relationship between dependent variable (service utilization) and the independent variables of Service quality, enrollees satisfaction with services, location of the PHCs and management of the referral process (mr = .812, p <.05). Meaning that service quality increases the enrollees' utilization of NHIS services. The result also demonstrated that Service quality, enrollees satisfaction with services, location of the PHCs and management of the referral process have direct relationship and predicted increase in utilization rates (Adj R2 = .654, F (249) = 142.27, p<.01). The result demonstrated that every unit increase occur in the service quality, enrollees' satisfaction with services and location of the PHCs were associated with 65.4% of the change or increase unit increase in utilization rate of NHIS services. Independently, Service quality (β = 0.1, t(249)= 2.84,p< .01) enrollees satisfaction with services (β = 0.1, t(249)= 2.55, p< .01), location of the PHCs (β = 0.81, t(249)= 23.63,p< .01). The null hypothesis is thus rejected that NHIS service provision did not have direct influence on service quality and accept the alternate hypothesis that NHIS service provision have direct influence on enrollees' utilization of NHIS services.

Discussion

Results demonstrated that the larger proportions of the respondents were males. Majority were between 18-59years and were married. In respect to respondents number of children, majority had 1 -2 children (48.85%). About half of the respondents were junior works in grade six and below and one third were in level 7 – 13. The dependents registered with NHIS, were mostly more than four. This similar to findings from Yusuf et al al. (2018) who reported that the universal coverage was significantly associated with NHIS uptake among enrollees in their sample. More than two-third reported visiting NHIS accredited healthcare facility in the past two years. Their attendance was affected by benefit package of NHIS as it greatly deters their utilization. This finding is similar to the finding from Daramola et al. (2017, 2018) who demonstrated that there is a significant uptake of the NHIS insurance scheme. In the same trend Yusuf et al. (2018) also reported significant uptake of NHIS and utilization mostly for non-communicable diseases. Daramola et al. (2017, 2018) attributed these to the sustained enlightenment by the

NHIS/HMOs and health facilities provided by the institutions being a healthcare provider to NHIS patients and also having its staff registered as beneficiaries under the NHIS. The Scheme was demonstrated to relieve the workers, mostly those in the junior in terms of cost of health. Furthermore, Yusuf et al (2018) stated that NHIS was designed to provide minimum economic security for workers with regards to unfavourable losses resulting from accidental injury, sickness, old age and so on.

The findings also revealed that the respondents were majorly satisfied with timely availability of services available, services convenience, doctors' friendly attitude, time spent waiting for lab results of, time spent in exam room and overall quality of services received. This finding is similar to that of Daramola, Adeniran and Akande (2018) who found that more than half of the enrollees in Tertiary health facility in Abuja were satisfied with overall services of NHIS. Their respondents were highly satisfied mostly with doctors' consultation, laboratory services, hospital facilities, hospital services, reception/registration, waiting time and prescribed drugs. However, a larger percentage of the respondents were unsatisfied with the nurses' unfriendly attitude the waiting time and the manner in which they get their problem resolved. This finding is similar to that of Daramola, Adeniran and Akande (2018) who demonstrated that unavailability of prescribed drugs, long registration processes and waiting time were found to be the major causes of dissatisfaction among their study sample. The result demonstrated that service quality, enrollees' satisfaction with services and location of the PHCs were major predictors of utilization among enrollees. These findings are in agreement with Daramola et al. (2017, 2018) who demonstrated that quality of the service of NHIS insurance scheme was associated utilization. In the same trend Yusuf et al. (2018) also reported that family size, service quality and quality of referral process was significant associated uptake of NHIS and utilization (Daramola et al. (2019a; 2019b).

Conclusion

The design and implementation of National Health Insurance and reform are a popular phenomenon across the Globe. However, there is emerging evidence of lack of technical and political consensus on the viability of this mechanism. Often times, attention was not paid to the fact that the implementation of National health insurance is constrained by a country's economic, social and political context and the inherent technical limitations of health insurance. The main effect of making healthcare affordable and accessible to all especially in the public sector is the increase in productivity which has a direct effect on the output of the public workforce. Thus, an improvement is seen in the life of the individuals and in the economy in general. Also, of great importance is the involvement of private sector in creating more employment opportunities in the health sector as shown in the activities of HCFs and HMOs and other stakeholders.

The findings in this study shows that:

This study demonstrated that enrollees attendance was affected by benefit package of NHIS and greatly deter their utilization. The study findings also revealed that the respondents were majorly satisfied with timely availability of services available, services convenience, doctors' friendly attitude, time spent waiting for lab results of time spent in examination room and overall quality of services received. However, a larger percentage of the respondents were unsatisfied with the nurses' unfriendly attitude the waiting time and the manner in which they get their problem resolved. The result demonstrated that service quality, enrollees' satisfaction with services and location of the PHCs were major predictors of utilization among enrollees. The provision of quality, accessible and affordable health care to all Nigerians would remain a mirage if these problems that weaken the potency of the scheme are not properly addressed. We therefore suggest that the recommendations made therein be strictly followed.

Recommendations

Thereby recommend to the National Assembly as follows: Section (56) paragraph (1) of the propose bill which contain the establishment of the zonal office in each zones, all the zonal coordinators is each geopolitical

zones should be empowered to recruit of least lower cadres of staff and be financially independent to carry out little expenses within their domain.

All these observations will facilitate more community-based outreach programme to every Nigeria so that more people will be covered by the scheme, thereby meeting the 2015 millennium Development Goal (MDGs). On the strength of this study finding, the following recommendations were made: 1) Government and other stakeholders should gear up the awareness campaign in all the senatorial districts in Oyo state. The print media, television and radio stations should be mobilized to air NHIS programmes in the state. Village heads, chiefs and religious leaders should also help in the propagation of programme in Oyo state and the nation in general.

2) Hospitals, clinics and health care centres providing health service for NHIS beneficiaries should be properly equipped. Since private clinics and labs are involved in the scheme, government should also provide counterpart funding to ensure that these establishments are properly equipped.

3) Adequate and well-trained medical personnel should be employed to manned the various hospitals, clinics, labs and health care centres where NHIS is providing health services to its beneficiaries. In-service training should be organized to boost the knowledge of the existing staff in the health sector. Private hospitals/clinics participating in the scheme should be mandated by government to ensure that proper and adequate personnel are employed and trained.

4) Government should increase funding to NHIS in particular and the health sector in general.

5) Government agencies responsible for fighting corruption should peruse the activities of NHIS to ensure that corruption do not limit and weakened the scheme like other programmes in the country.

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