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The National Health Insurance Scheme (NHIS) in Nigeria: Has the Policy Achieved its Intended Objectives?

Sunday A. Adebisi[1], Joyce M. Odiachi[2], Ngozi A. Chikere[3]

[1,2,3]Faculty of Management Sciences, Department of Business Administration, University of Lagos, Akoka, Yaba, Nigeria,
[1]E-mail: yommysun@gmail.com, [2]E-mail: sumanyina@yahoo.com, [3]E-mail: chikerengozi2008@yahoo.com

Abstract

Universal coverage of health is one of the goals of the United Nations and one which every African country, Nigeria inclusive strives to achieve. Referred to as NHIS, the study was motivated by a desire to review a policy with so much importance and set out to appraise the scheme's objectives and assess the level of achievement across sectors including the Small and Medium Scale enterprises popularly known as the SMEs. Research design using the cross sectional approach was employed along with the use of convenience and random sampling, a sample of employees (150) from ten Lagos resident health maintenance organisations (HMOs) with National accreditation were used. Data was collected with the aid of a structured questionnaire and the study relied on regression analysis to derive results. The results showed that the relationship between objectives of the NHIS were significant to the predictor variables (FWA=facility well assessed, RPS=restricted to public sector, ASN=adequate subscription and HAW=high awareness), thus accepting the alternative hypothesis. However, the relationship with the SMEs was only marginal. The study, based on its findings, concludes the scheme is yet to fully achieve its intended objectives and therefore recommend that the scheme's management put effort to expand the coverage across all sectors through enlightenment, improved assess to facilities whilst also collaborating with relevant stakeholders to assuage the people's needs with regards to good quality and affordable healthcare service.

Key words

Universal health coverage, National health insurance scheme, Health management organisation, Small and Medium Enterprises (SMEs)

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1. Introduction

One of so many countries within the West African province of the continent, Nigeria is a nation blessed with resources, arable land and people. With an estimated population in 2012 of about 166.2million citizens and in 2016 an assumed increased to about 178.5million people (World Population Review, 2019), with so much people and so much potential, it is a sharp contrast to see side by side, a life expectancy index of an average 54.5 years. Though unconfirmed, it is believed that various reasons such as poverty, low income, poor access to quality health care amongst others are underlying factors. These indices, makes it imperative that nations look at various means of improving the welfare of her citizenry and provide quality affordable healthcare. Health in the package of every human, is one of the important things to be considered, believing that where there is health, people have the capacity to explore and achieve great things.

The United Nations development goals consider the health of citizens an important issue in achieving the sustainable goals. Well-being is one indicator of good health and the rising emphasis on the promotion and enhancement of health is mainly due to highlights of such by the United Nations goals (Agyemang *et al.*, 2013). However, according to Murray and Lopez (2013) one developmental problematic issue facing countries in Africa is non accessibility to good service in part due to lack of employment as well as poverty. Therefore, developing nations around the world including Africa needs to put in place policies on health that will not only benefit the nation but its citizens as well at all levels. It has become imperative that countries aim towards a health coverage, universal in nature (UHC) and which guarantees citizens have access to the much required health service, one which is effective and devoid of frustrating handicap, financial or otherwise (Onoka *et al.*, 2015).

The World Health Organisation (WHO) has been making a global appeal to nations and encouraging them to embrace the Universal Health Coverage (UHC) by implementing a sustainable financial model which can last the test of time (Aregbesola & Khan, 2018). According to Aregbesola (2017), the UHC has as part of its aims, an equitable increase in health care access of good quality and reduction in the exposure to financial risk. Currently, the World health statistics report of 2018 noted that Nigeria has a cover index of 39% with respect to UHC service (World Health Statistics, 2018). The

third goal of the SDGs which is to ensure across all age groups, healthy lives and well-being is the major essence of the NHIS.

Insurance is a financial mechanism by which risks in whatever form, is transferred from one person to another, so as to lighten the financial burden which ordinarily would have been borne by the former. Health insurance is one of such mechanisms which is aimed at providing cover for the insured against any ill health as stated on the terms of agreement. It can be said to be one of those means by which people enjoy protection from expensive treatment when sick (Eyong, Agada, Asukwo & Chuku, 2016). This is a very important financing mechanism within the health sector and helps to advance access to good health care. It provides financial risk protection most especially for those in the low income bracket (Aregbesola and Khan, 2018).

Based on the forgoing, many African nations have taken the health care sector as priority as most of them have come up with health policies to ensure good health for their citizenry. In Nigeria, the NHIS, is the country's attempt to adopt and actualize the UHC for her citizenry (Etobe & Etobe, 2013). It was implemented hoping to give all Nigerians admittance to health care service that is affordable and of good quality irrespective of the class, ethnic belief or sector whether formal, self-employed, under five children or the rural community. However, as at the time of this research paper, to the knowledge of the researchers, none of these schemes successfully took off. As such, a fundamental question of this study is the extent this policy has achieved the stated objective and the level of coverage among citizens in Nigeria especially when considering that Nigeria came up with the health scheme in 2005, two years after Ghana. From 2005 to date, making 14 years of existence, the scheme has undergone various phases and challenges. It is therefore important to look into the scheme for better understanding of the way the scheme has worked, is working and can be improved upon.

1.1. Statement of Problem

Accessing good quality health care has been a bane in Nigeria to both the people and the government. Gustafsson-Wright and Schellekens (2013) noted that Nigeria had the uppermost out-of-pocket health outlay in contrast to health indicators which were the poorest in the world. Aside this, the health financing system is also faced with economic difficulties and deficiencies such as issues of corruption, a lack of awareness on the part of the people, low donor funding, limited insurance coverage, insufficient medical supplies, apathy of rural settlers to enroll, amongst others (Olakunde, 2012). In most developing countries, the various governments have sought solace in the health care schemes so as to be able to give affordable and subsidized health services to its citizens. The main essence of health insurance is to provide cover against financial cost of healthcare services.

However, with a plateau of problems with respect of non-participation of the informal sector (Odeyemi, 2014), poor fund management and negative debt profile of health maintenance organisations (HMOs), poor registration services, dissatisfaction (Nwabughiougu, 2017) amongst others, the scheme seems to be rolling on the wrong footing. It is worthy to note that for any country, one of its major assets is its citizens. The state of their health and the ease of accessibility to quality health care will strongly indicate the path to not only human, but economic development. This study thus sets out to appraise the NHIS objectives as stated in the Federal Ministry of Health (FMoH) guidelines, and review the extent to which they have been achieved. This has become necessary as there is a need within the developing nations of world, with emphasis on Africa, for context based theoretical contributions. It will also assist the government and organisations, understand what is working or not working and where if necessary, improvements are required. The study also intends to contribute in enriching existing literature which will be useful to both students and the academic community, using selected HMOs in Nigeria as the study population.

Research questions were raised and hypothesis formulated thus:

Ho_1: Objectives of the NHIS in Nigeria over the years, has not been met.

Ho_2: The Small and Medium scale enterprises (SMEs) have not benefited greatly from the NHIS in Nigeria.

2. Literature review

In pursuit of the UHC as being propagated by the WHO, Nigeria like most other nations, has strived for expansion of the health schemes being operated in their countries. The concept of UHC follows that of social insurance which has a long history of success in Germany, Japan, France and Belgium amongst others where stakeholders resolving globally that individuals have the desirable entree to health care, adopted the universal health care model (Adewole and Osungbade, 2016). UHC is explained to be an expectation from countries citizens that each and every one of them will be able to obtain and access healthcare, whether it be palliative, preventive, for rehabilitation purposes, or even curative, whenever it is required whilst not undergoing undue financial hardship (Amu *et al.*, 2018). Where a nation attains UHC, it succeeds in

promoting for its' citizens, the enjoyment derivable from the attainment of a high standard regarding health, a basic entitlement of all humans irrespective of creed (WHO, 1948; Amu, Dickson, Kumi-Kyereme & Darteh, 2018). The NHIS is a policy aimed at assisting the country achieves the SDG goal of universal health coverage. The efficiency and operational effectiveness has been a subject of interest to various scholars, organisations and governments with their infrastructural developments and processes differing across countries (Mohammed and Dong, 2012; Lawan *et al.*, 2012).

2.1. Theoretical Framework

2.1.1. System Theory

Okotoni (2010) in Dahida *et al.* (2019), describe a system as a sub-system joined together with the aim of achieving a common goal. The basic component of a system is that singular unit act which involves the attainment of a goal and is made up of four components namely input, processing, output and recycling. According to Apenda (2010), the social system is faced with two main issues: the production and allocation of resources which is scarce and the achievement of integration or social order. The NHIS scheme is a goal which the government aims to achieve through the provision of good healthcare. To effectively do this, in line with the system theory, the four components need to be present in terms of input such as funds, human resource, medical supplies and personnel is required; processing involving the mix of all inputs; the output being cost effective and affordable healthcare service, easy access, quality personnel and finally the recycling or evaluation of the NHIS scheme to determine its success.

2.2. Health

Health is defined by WHO as a complete state of all-round well-being whether physically, socially and mentally and not only an absence of disease or ailment (Callahan, 1973). On the other hand, Card (2017) whilst noting that there is no separation between good or poor health, posed a new definition, where he described health as a state of physical fitness and psychological comfort, going further to state that the mere absence of disease or disability does not sign off as a measurement of good health. Monitoring changes in health around the globe of various populations, is done using global health indicators which have been tested and confirmed. Health indicators are simple population characteristics which are quantifiable and often used by governments to guide health care policies. The ten (10) leading indicators are: access to services, preventive services, quality of environment, concern of injury, health of mother and infant, mental health, nutrition, dental hygiene, reproductive health and social determinants. Most developing countries focus on morbidity and mortality.

Healthcare meanwhile, is concerned with the prevention, the diagnosis and the handling of illness, injury and other cerebral or bodily impairments in humans. Health systems require huge financial commitments. Health care system has given sufficiently to people, the chance to utilize services in the system that they require whilst ensuring they are adequately protected from any adverse financial burden connected with reimbursing for the service assessed (Saksena *et al*., 2014). The concept of financial risk protection (FRP) is based on the absence or non-existence of risk relating to financial hardship. Costs of health payments across the globe pose a heavy burden financially on a lot of people. FRP endeavors to protect people from the drain of healthcare prices which sometimes leads to impoverishment.

The great importance which health plays in the life of a nation and the growth of its economy cannot be downplayed. Governments thus, attempt to design policies which are germane and help to guide, control and regulate the health sector. In most instances, the implementation of a health policy is a thoughtful action, for public health advancement of its people (Pever *et al*., 2016). Universal health care (UHC) seeks to provide financial risk protection, that is, the people being able to access quality health care without the immediate need to pay at the point of accessing. In Nigeria, the NHIS is the country's attempt to adopt and actualize the UHC for her citizenry (Etobe and Etobe, 2013).

2.3. NHIS Background

In 1998, in its bid to keep to its commitment to ensure that every citizen of the country has a well-balanced physical, cerebral and societal well-being, the government of the day, pressured by global interest groups, recurrent health problems in the country and the increasing population, took up reforms and passed a military decree inaugurating the National Health Insurance Scheme, NHIS Decree No. 35. However, along the line, it became evident that no stakeholder consensus had been held before it was passed. Thus in 1999, according to Eyong *et al.* (2016) to ensure that a good thing was not discarded due to irregularities, the NHIS was established properly under the Federal Government Act 35 of 1999 that all citizens of the country could assess affordable healthcare. Private operators (HMOs) into the scheme were also introduced as well as some other changes including the participation of state governments (Onoka *et al*., 2015). The governing council was installed in 2001 and by mid-2003, the government went into full drive requesting for full compliance by 2005. The NHIS scheme is currently being run as a pool of funds from its participants and pays a listed web of providers for precise services (Akande *et al*., 2011).

2.4. Benefits of the Scheme operating in Nigeria

The Federal Ministry of Health (FMoH) observes that, NHIS aims for equitable cost distribution across the different sector of the economy and various income groups with clear objectives:

(i) Assess to qualitative healthcare service

(ii) Protection of citizens from pecuniary hardship arising from huge bills

(iii) Help redistribute healthcare costs equitably across the various income bracket by reducing rise in cost of services

(iv) Efficient delivery of health services and maintain highest standards

(v) Co-ordinate and harness private sector involvement

(vi) Equitable distribution of health care facilities

(vii) Availability of funds

(viii) Service improvement and all levels patronage.

2.5. Coverage

The NHIS scheme provides cover to access free remedial attention for the named sponsor or customer and his family from an accepted health care provider. Contributions are earning related and in the proportion of 10% from the employer and 5% from the employee, calculated on the basic salary. To effectively cover everyone, in 2005, they started the formal sector social health insurance program (FSSHIP) to offer coverage to all public servants at both the federal and state levels and the military with a mandate that UHC be achieved by 2015. The scheme was then expanded introducing the informal sector social health insurance scheme (ISSHIP); community-based health insurance (CBHI) and the voluntary contributor's health insurance (Kannegiesser, 2009).

The state government employees' status unfortunately, was unclear and the states were given lee way to decide if to belong to the scheme or not (Onoka *et al.,* 2013), neither was the SMEs clearly defined. The current focus of the NHIS in Nigeria is on the formal sector as they have yet to succeed in fully capturing the informal sector and there is the need for expansion to this area as within the emerging markets like Nigeria, the informal sector population is quite enormous and most cannot afford the cost of quality healthcare either personally or through employment benefits (Aregbesola and Khan, 2018). The percentage coverage of the NHIS scheme lies at present at about 5% of the populace in the last 14 years of its existence and most of which is the formal sector (Odeyemi, 2014). This gives rise to the query of the NHIS as a failure in its quest for affordable healthcare across all groups within the population.

2.6. Empirical Review

Literature has differing focus on the content of the NHIS. Okolo *et al.* (2019) in a study of the challenges of the health care system in Enugu State, found that poor health care policy, lack of financial commitment and state government intervention are major challenges faced by the state's health care system. However, the study was concerned with Enugu State and cannot be generalized. Emmanuel (2017) using a qualitative study, analysed the responses of stakeholders on the participation of HMOs in the scheme and noted they played an important part. In a study on NHIS awareness, Olalekan (2017) observed that his study group exhibited a high level of awareness. Aregbesola and Khan (2018) investigated the coverage of the NHIS scheme among women of child bearing age using secondary data. The findings showed that the scheme did not cover 97.9% of the women and that certain factors such as age, education and employment status affected enrollment into the scheme, advising the need to focus on the informal sector.

In a study to examining the upgrade and challenges faced within Kano metropolis, by the NHIS scheme, Lawan, Iliyasu and Daro (2012) using a cross sectional survey, found that poor knowledge resided amongst a number of respondents of the scheme. The extent of awareness of the scheme amongst the formal sector was higher than other sectors of the economy, informal sector inclusive (Adewole *et al.,* 2016). In their study of health policy in a selected teaching hospital in Nigeria, Kingsley and Daniel (2018) found that employees are well trained but there is the need for government to allocate enough funds to enable the teaching hospitals operates effectively and efficiently as this will enhance performance and help meet the health sector objective. Ilochonwu and Adedigba (2017) looked at the level of consciousness of the scheme and patronage and found that while the awareness was a bit on the fair side, utilisation was quite low.

Employing literature review, Ayanleye (2013) appraised legally, the NHIS scheme and found that prevalent poverty, scarce number in providers, lack of adequate facilities had an effect on low success rate of the NHIS scheme. Pever *et al.* (2016) studied the extent to which the initiatives of the government has impacted the achievement of quality health care using

secondary data and found that policies be properly formulated, implemented and monitored to assist successive governments achieve the objectives. Raji *et al.* (2019) studied the NHIS employing doctrinal approach and found that the policy in Nigeria does not cover retired employees after serving their country. They went further to call for a review of the policy to cater for retirees. This was in tandem with Etobe and Etobe (2013) that highlighted non-existence of programs and services for Nigerian elderly both in and out of the NHIS and advocated for changes. Evaluating the proportion of Nigerian adults covered under the scheme, Onyedibe *et al.* (2012) came with the findings that only few were registered under the scheme and that there existed a certain degree of dissatisfaction.

During a study of the NHIS in Ghana and Nigeria, Odeyemi and Nixon (2013) found that Ghana had more favourable health indicator than Nigeria as well as the fact that financing and access to the scheme was lower in Nigeria than in Ghana. Amu *et al.* (2018) looked at the different level of health insurance across Kenya, Nigeria, Ghana and Tanzania, noting that Ghana had achieved the highest in terms of socio-economic factors while Nigeria had the lowest coverage. The study was of the view that Nigeria needed to improve on the expansion of the coverage if she is to meet the 2030 SDGs of the United Nations on health.

3. Methodology of research

The study employed a cross sectional research design based on the ability of the design to effectively interpret data as well as permit usage of questionnaire (Ogaboh *et al.,* 2010). The research was carried out within metropolis of Lagos considered as the commercial hub of Nigeria and is estimated to host about 2.1 million Nigerian citizens. The choice of Lagos state was due to its reference point as a state in the upper echelon in terms of availability of quality healthcare. The population in the study comprises all NHIS accredited HMOs in Nigeria. With the aid of a multi-staged sampling, the study at the first stage employed convenience sampling technique in the selection of ten (10) HMOs who are accredited for National coverage and officially resident in Lagos State, whilst selection of fifteen (15) personnel done in the second stage, from each study organisation was with the aid of a random sampling technique so equal chance is given to all. Copies of questionnaire were administered to a sample of 150 employees, with 107 returned and only 105 found adequate to be used. Deriving the questionnaire from the objectives of the NHIS scheme by the researchers, from the FMoH guidelines, a pilot study was conducted with no replacement whatsoever. The Cronbach alpha for all the instrument came above required level of 0.70 (Nunnally, 1978). Responses were measured on the basis of (5) strongly agree to (1) strongly disagree from a 5-point Likert scale. Multiple regression analysis was employed and the model specification stated thus:

$$y = b_0 + b_1x_1 + b_2x_2 + \dots b_nx_n + e \quad (1)$$

The model above will be utilized to test the hypothesis below:

H_{01}: OBN = f [FWA + RPS + ASN + HAW]

Where, OBN = objectives of the NHIS; FWA = facility well assessed; RPS = restricted to the public sector only;

ASN = adequate subscription to the NHIS and HAW = high awareness.

H_{02}: OBN = f [LPH + GB]; Where, OBN = objectives of the NHIS;

LPH = large pool and high patronage; GB = greatly benefited.

4. Results and discussions of findings

Results in Table 1 and 2 below respond from the regression analysis to *Hypothesis 1: Objectives of the NHIS in Nigeria has not been met*

Table 1. Anova

Model	R	R^2	Adjusted R^2	Durbin Watson	F	Sig
1	0.767	0.589	0.572	1.528	35.809	.000[b]

a.Predictor: (Constant), FWA = facility well assessed; RPS= restricted to public sector; ASN = adequate subscription to NHIS;

HAW = high awareness

b. Dependent variable: OBN = Objectives of the NHIS scheme

Table 2. Coefficients[a]

Model	Variation	Unstandardized Coefficient		Std. Coeffi Beta	T	Sig	VIF
		B	Std. Error				
1	Constant	1.236	0.192		6.423	0.000	
	FWA	0.211	0.043	.339	4.918	0.000	1.154
	RPS	0.328	0.039	.541	8.305	0.000	1.031
	ASN	0.157	0.042	.284	3.701	0.000	1.427
	HAW	-0.085	0.046	-.136	-1.866	.065	1.292

a. OBN = Objectives of the NHIS scheme.

Note: FWA = facility well assessed; RPS= restricted to public sector; ASN = adequate subscription to NHIS; HAW = high awareness

Table 1 above, explains the overall variance in the study with our $R^2 = 0.589$ implying that 58.9% of the variance in the study is accounted for by the predictor variables. Our R on the other hand, yields a result of 0.767 indicating an existence of a correlation between the variables. Table 2 gives us results of the individual contribution of the predictor variables to the objectives of the NHIS, with the B coefficients showing the original values and the Beta coefficients giving the standardized values. The combined anova results of the analysis indicates a significant relationship existing between the study variables ($R^2 = 0.589$; $F = 35.809$; $p < 0.05$) thus accepting the alternate hypothesis.

However, when viewed individually, the results in table 2 shows that RPS (restricted to the public sector) had the strongest relationship ($\beta = 0.541$, $p < 0.05$), confirming in line with Adewole, Dairo and Bolarinwa (2016) that the scheme was predominant within the formal sector. Closely followed by FWA (facility well assessed) with results ($\beta = 0.339$, $p < 0.05$), and ASN (adequate subscription) exhibiting a marginal relationship at ($\beta = 0.284$, $p < 0.05$) and aligning with the study of Onyedibe, Goyit and Nnadi (2012) who observed in their evaluation of the proportion of enrolled adults into the scheme, that only a few were registered, while there was also a certain level of dissatisfaction. Contrary however to the study of Olalekan (2017), the results of this study showed that HAW (high awareness) did not have a significant relationship with the NHIS objectives ($\beta = -0.136$, $p > 0.05$), though it was in agreement with Lawan, Ilyasu and Daso (2012) who noted that the scheme did not have the requisite exposure needed due to poor knowledge by a number of respondents.

Results in Table 3 and 4 below respond to *Hypothesis 2: The SMEs have not benefited greatly from the NHIS in Nigeria*

Table 3. Anova

Model	R	R^2	Adjusted R^2	Durbin Watson	F	Sig
1	0.608	0.370	0.357	1.421	29.930	.000[b]

a.Predictor: (Constant), LPH = large pool and high patronage; GB = greatly benefited

b.Dependent variable: OBN = Objectives of the NHIS scheme

Table 4. Coefficients[a]

Model	Variation	Unstandardized Coefficient		Std. Coeffi Beta	T	Sig	VIF
		B	Std. Error				
1	Constant	1.676	0.181		9.268	0.000	
	LPH	.365	.055	.556	6.615	0.000	1.133
	GB	.091	.061	.126	1.502	0.136	1.133

a.OBN = Objectives of the NHIS scheme (OBN).

Note: LPH = large pool and high patronage; GB = greatly benefited.

Results reflected in table 3 above, gives us $R^2 = 0.370$ implying that 37% of the variance in the dependent variable is linked to the independent variable. R= 0.608 implies there exists a correlation between both variables. The VIF = 1.133 indicating that there exists multi-collinearity. The anova results combined indicates a significant relationship with ($R^2 = 0.370$; $F = 29.930$; $p < 0.05$), thereby accepting the alternate hypothesis as well. Table 4 on the other hand, in responding to the hypothesis, show individual reactions of LPH and GB to OBN. While the overall results indicates a significant relationship between the predictor (LPH, GB) and dependent variable (OBN) with a probability value less than 0.05, when viewed individually, the standardized beta coefficient values show that LPH had a more significant relationship ($\beta = 0.556$, $T = 6.615$, $p < 0.05$) aligning fully with Agyemang, Adu-Gyamfi and Afrakoma (2013) who espoused the need to maintain a large client base in order to ensure a sustainable scheme. The results of the study with respect to the benefits derived from

the scheme by the SMEs, showed that GB (greatly benefited) is a weaker predictor and not statistically significant at (β = 0.126, T = 1.502, p > 0.05).

5. Conclusions

Policies in health care by any government, is a conscious decision to promote public health of nation's citizens using well financed and organised provision of health care amenities and preparation of the health care personnel (Pever *et al*., 2016). This study appraised the NHIS scheme to confirm the achievement or otherwise of the objectives earlier highlighted in the course of the study. The study results accepted the alternative hypothesis thus suggesting is adequate attention is given to the scheme. While funding is a key factor, it is one thing for the government to provide funds for the scheme; however, it is pertinent to note that this is not the only prohibitive issue in the scheme. Each of the objectives of the NHIS is important and the achievement key to the success of the scheme. Access to the centers, transportation, and availability of medical personnel amongst other factors need also be considered.

The significant weight of health to economic growth and the life of a nation cannot be overemphasized as well as the citizens. The informal sector in Nigeria, of which the SMEs belong, has grown extensively over the years making it obvious that they are a group that cannot be ignored as they constitute a group that has the potential to impact the economy positively. It is a common parlance in Nigeria, that health is wealth, thus, where there is no health scheme in place for these essential group, there is the potential for a high percentage of people with poor health, which could translate to low productivity and in turn a failing economy. It thus is imperative, the NHIS extends its coverage to other groups outside the formal sector such as the SMEs, increase its awareness efforts and improve accessibility. Quite important as any country that has a fit population, will groom a healthy workforce, that transposes into an economy strong in output. It is worthy to note that it is an achievable feat for a successful NHIS, once there is a collective decision to pursue its success. Based on the outcomes of the study, it is recommended that there should be continuous orientation program be embarked upon to create improved awareness and understanding of the scheme both within the educated and uneducated populace as this will help expand patronage; access to the facilities should be made more convenient and affordable as it will help increase the number of enrollees and impact the scheme positively as this is currently a challenge; expanded coverage beyond the formal sector, encompass other sectors, the SMEs and others through proper enlightenment to the benefits of the scheme of both individuals and organisations. This will help ensure that the SMEs and informal sector have the much needed healthcare coverage; extension to the hinterlands for the low-income populace. Reintroduction of the mobile health scheme earlier jettisoned, to help penetration. The current concentration within the urban areas is detrimental to the growth of the scheme; there should be reforms of the National Health Insurance Act of 1999 to align with the current realities as well as the objectives of the scheme so as to ensure full achievement and success of the scheme; and delivery system should be revamped to include an effective NHIS through rigorous enforcement and implementation of the objectives of the scheme so as to meet the desired aim of providing affordable and assessable healthcare services to all citizens.

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