

National Health Insurance Scheme Dispensing Outreach and Maintenance of Health Status In Oyo State

¹Owumi B.E. (phd), ²Adeoti, A. B., ³Patricia A. TAIWO

¹*Department Of Sociology, University Of Ibadan, Ibadan.*

²*Nhis Information Centre, Jaja Clinic, University Of Ibadan, Ibadan.*
Department Of Sociology, University Of Ibadan, Ibadan.

ABSTRACT: *This study examined the dispensing outreach programme of the National Health Insurance Scheme (NHIS) and its influence on the health status of users. It specifically examined the influence of the organizational structure of NHIS on the referral process in the utilization of health care services by clients, documented the satisfaction client' derived from NHIS service. It adopted a descriptive survey design through the use of qualitative and quantitative methods of data collection with four hundred and thirty-five enrollees. Sixteen In-depth interview was conducted with representatives of Health care International at Ibadan office. Data was analysed using the descriptive approach (method while qualitative data from the key informant interviews was content analyzed. Approximately 80% of the respondents preferred the NHIS services because it reduces the out-of-pocket expenses borne by the service users. Motivation for use of NHIS services stemmed from perceived services quality, drug availability, sophisticated pharmacy and the laboratory equipment. In terms of service expectation 57.1% of the respondents had their desires met as NHIS bore the bulk of health care cost, subsidized drugs and laboratory fees. Sixty percent of the studied population were thus satisfied with NHIS services though a reasonable proportion of 40% were dissatisfied with the way and manner their challenges were handled. Also, dissatisfying issues were associated with the delay in processing authorization code by Health Management Organization (HMO) when respondents were referred to secondary or tertiary health facility. The study recommended among others that government should improve on existing measures such as effective monitoring of the scheme implementation, facilitate the processing of authorization codes, ensure equity in access of all enrollees and the enforcement of adequate medical personnel and equipment for effective service delivery.*

Keyword, enrolles, health care, health status, health insurance, satisfaction

I. INTRODUCTION

In recent time there has been considerable interest in private sector participation in the health care delivery in Nigeria as a result of the challenges faced by the government in providing qualitative health care to the people. While the public sector is stills struggling with the backlog of unmet health needs for the control of infectious diseases, malnutrition, and other poverty-related diseases, it is continuously saddled with a growing threat of non-communicable diseases such as diabetes, high blood pressure and cancer (Ajayi, and Adebamowo 1999; Akinkungbe, 1992; Ezzati, Vander Hoorn, Lawes, Leach, James, 2005). Meanwhile, the private sector although largely unregulated, is growing and appears to be the main source of health care for majority of the population including the poor. (Ogungbekun, Ogungbekun, Orobato.1999). Hence, individual households had to spend a greater proportion of their disposable income on health services in the private sector with variable levels of quality. Soyibo. (2004).

From the foregoing, a partnership with the private sector, when properly structured and executed can lead to increasing the resources available to the health sector as well as expand the delivery of vital services to targeted populations and underserved area. This is in addition to making effective use of the private sector's expertise and comparative advantage in undertaking certain organizational functions such as marketing communications, enhancement of service quality and a potential to attract and retain better performing staff. In the past, government ministries of health paid little or no attention to the private sector; the approach to the private sector has rarely gone beyond enacting legislations and issuing regulations that were usually not enforced Soyibo, (2004) In the face of the constraints faced by the public sector, there is now a huge opportunity for engaging the private sector in a more constructive manner.

The introduction of the National Health Insurance Scheme (NHIS) and the adoption of Health Maintenance Organizations (HMOs) model have also brought in the private sector in the financing and managing of healthcare services at the level of first contact care (HMOs). In the same manner, big corporate

organizations such as MTN Nigerian Communications Commission, the British-American Tobacco Company of Nigeria (BATN) and some wealthy individuals notably, OtunbaSubomiBalogun and Chief Lulu Briggs have set up charitable foundations with specific remit of providing primary healthcare services for targeted populations (MTN Foundation, (Ugeh, 2003; SubomiBalogun 2007) and O.B. Lulu Briggs Foundation). Consequently, the range of active private sector participants in the health sector has been broadened to include private commercial companies, banks, insurance companies, and rich persons apart from individual practitioners and non-governmental organizations (NGOs).

At present, the private sector is involved in all aspects of health service delivery in Nigeria. This includes hospital-based services, ambulatory care, diagnostic centres, laboratories, retail pharmacies and ancillary services. As such, the use of privately provided services is prevalent among all socioeconomic groups. However, due to lack of both physical and financial access to health care services the poor tend to use private services more than the higher income groups. Patent medicine vendors (PMVs) provide most of this care. In a study of illness seeking behaviour for pre-school children in three rural local government areas (LGAs) in south – west Nigeria, it was found that 50% of parents has sought either first-line or subsequent care from PMVs compared with 13% at government facilities and 14% at private clinics (Salako, Brieger, Afolabi, 2001). A similar pattern was found from a review of treatment seeking for pre-school children with fever – 39% PMVs, 22% private clinics, and 29% government health facilities (Brieger, Sesay, Adesina, 2001). These findings clearly show that high utilization of private health services is not just a rural occurrence but urban residents have a wider choice of care. In both settings, the PMVs form the bulk of private medical provision and overall care options.

Access to health care is severely limited in Nigeria (Otuyemi, 2001). This may be due to inadequate facilities or inability of the consumer to pay for the services as well as the health care provision that is far from equitable. As far back as 1988, estimates from the Federal Ministry of Health and Social services show that not more than 35% of the population had access to modern health care services (Adeyemi and Petu, 1989; Falegan, 2008; Ngowu, Larson and Kim, 2008). Also, allocation to the health sector by the federal Government have always been quite low. For instance, between 2000 and 2004 an average of 3.52% of the entire budget of the government was spent on health (Adeyemi and Petu 1989, Falegan, 2008; NgowuLarson and Kim, 2008) leaving a noticeable shortfall of 1.46% of the of the World Health Organization (WHO) recommended standard. The Nigerian government is of the notion that a National Health Insurance scheme (NHIS) which is a health care help risk spreading mechanism is probably what is required to solve the problem of inequality in the provision of health care service (Ibiwoye and Adeleke, 2007). Thus the scheme was adopted to help spread the risks and minimize the cost of health care.

The growth of private health insurance has been limited by a myriad of factors, including the lack of public confidence in the insurance industry, limited technical capacity for underwriting this class of risk, poor knowledge of the nation's private medical care market, high prevalence of fraud on existing schemes, and the absence of reinsurance backup. In some instances, claims have grown much faster than premium incomes, threatening the viability of private health insurance schemes. This is largely the result of fee-for-service and the absence of effective cost-sharing formulae. Mechanisms for monitoring the quality of care rendered by providers and the market is not expected to witness significant growth in the foreseeable future. (www.jsi.com/intl/inspap.htm-ilk).

The introduction of National Health Insurance Scheme (NHIS) and its adoption of Health Maintenance Organizations (HMOs) model have also brought in the private sector in the financing and managing of health care services at the level of first contact care. It is against this background that the study attempts to investigate whether those registered under private sector of the NHIS scheme are satisfied with the health care services they received.

The study specifically seeks to examine the different practices that encouraged the use of NHIS services by the client, document the level of satisfaction derived by private employees under the NHIS scheme, document how organizational structure of NHIS influence the referral process in the use of services by private employees, elicit information about quality control procedure.

II. THEORETICAL FRAMEWORK

Political economy of Health

Political economy essentially an approach as well as realistic methodology with a holistic perspective to the analysis of societal development (Onimode, 1985; Aina, 1986; Ake, 1990; Alubo, 1995). Within this school of thought two basic variants are identifiable; the liberal, and the radical which comprises the world systems and the Marxist approaches. While the liberal school of thought stresses the role of market forces in the distribution and the allocation of resources, including those of health care, the radical school upholds production and relationship of production. For instance Marx insisted that the theory of value relates to the historically

specific (capitalist) method of resources in all societies, but goes on to add that the nature, purpose and modus operandi of these laws are shaped by social relation determined in turn by prevailing modes of a particular epochs (Onimode, 1990). In this purview Health care delivery system can be analyze within the frame work of a continuum that is characterized by two polar ends. At one end of the continuum is a system, which is grafted to laissez-faire, and at the other is one, that is shaped by a socialist or communist ideology. The economies of the countries of the world are either based on laissez-faire as in the case of the United State of America (USA) where market forces are allowed to hold sway. Health insurance scheme is left in the hand of private individuals, which is market oriented and driven towards profit maximization. On the other hand at the other end of the continuum are the socialist or communist ideologies, where the state plays a dominant role in socio-economic policies as in the case of China and Cuba. In between these two extreme are countries like Sweden and Nordic Countries and Nigeria inclusive which are neither strictly capitalist nor communist, but which accommodate strong elements of welfarism in public policy and governance. Health care delivery in these diverse contexts can be analyze against the backdrop of these clarifications. The capitalist or laissez-faire system of economy as it operate in America shape their health care system, the private health care practitioners were given so much power to decide on the health needs of the people. It was considerably funded and led to the introduction of medicare and Medicaid policies by the American congress which guaranteed coverage of health care delivery from birth to death.

Structural/Functionalist Theory

The early functionalists often drew an analogy between society and an organism such as the human body. They argued that an understanding of any organ in the body, such as the heart or lungs involves an understanding of its relationship to other organs and, in particular, its contribution towards the maintenance of the organism. In the same way, an understanding of any part of society requires an analysis of its relationship to other part and more importantly, its contribution to the maintenance of society. Continuing this analogy, functionalists argued that just as an organism has certain basic needs that must be satisfied if it is to survive, so society has basic needs that must be met if it is to continue to exist. Thus social institutions such as the family, health, law, religion among others are analysed as a part of the social system rather than as isolated units. In particular, they are understood with reference to the contribution they make to the system as a whole. (Haralambos and Holborn 2008)

The National Health Insurance Scheme (NHIS) comprise of different stakeholders organized to see to the actualization of the scheme. Each stakeholder in the light of Parson's structural functionalism, is 'subsystem' which work for the success of the general and specific objectives of the NHIS. These subsystems must be properly adapted to fit into the scheme (which in this case becomes its physical environment), also resources must be properly channeled by the 'subsystems' for the attainment of the objectives of the scheme (Goal attainment). Further more each of these stakeholders must be integrated through internal coordination, in order to achieve equilibrium in health care delivery. The stakeholders in NHIS programme include the government, Health Maintenance organizations (HMOs), health care providers (HCPs), the Enrollee, Employer and Board of Trustees (BOTs). Each of these parts performs their respective functions for the success of the whole, failure of which can affect others. The structural functionalists perspective provides a search light into understanding the role of the stakeholder (subsystems) in the success of the NHIS scheme. For instance what happens when the employer does not remit its part of the contribution or when there is lack of adequate supervision of the HMOs for prompt release of capitation to the health care providers' or when the health care providers are not effective in health care delivery to the affected patient/clients .

III. RESEARCH METHODOLOGY

The study was conducted in four private companies that insured their employees under the NHIS in Ibadan Oyo state, Nigeria. The private companies included: (1) American Christian Academy, Onireke, (2) Rom Oil and Mills, challenge, (3) New Age Beverages, behind Lead City University and (4) Siegweta Packaging Industry behind British American Tobacco Nigeria (BATN). The study combined both qualitative and quantitative research methods. It focused on the NHIS dispensing outreach and its implications for maintenance of health status in Oyo State. The quantitative relied on the use questionnaire, administered to 436 purposively selected employees of the four private companies, out of which 422 copies were retrieved and analyzed.

The table below shows the selection of respondents for the study from each of the company

Table 1

S/N	Private organizations selected	Population	Sample size
1	Christian American Academy Onireke, Ibadan	150	113
2	Siegweta packaging Industry, behind British American Tobacco Nig, Ibadan.	160	120
3.	Rom Oil and Mills, Challenge Ibadan.	150	113
4.	New Age Beverages, Behind Lead City University, Ibadan	120	90
	Total	580	436

The qualitative aspect of the study involved conducting 16 in-depth interviews (IDIs) with 4 selected interviewees each from the four private companies. Data analysis was carried out using descriptive analysis which included the use of frequency count and percentages as well as diagrammatic representations, while qualitative data were content analyzed.

FINDINGS

Socio- Demographic characteristics of respondents

As reflected in the table below, a larger proportion (63.3%) of the respondents are males. This probably so because of the expected role of the male gender to cater for the wife even in meeting her health needs hence women are more dependent of the male spouse even in relation to their health. Again, majority (75.8%) of the respondents fall within the age bracket of 18-40 years which represents the active ages of working population. Based on the respondent's marital status a large proportion of the respondents 64% are married, 35.8% are single.

Table 2. Socio-Demographic Characteristics of Respondents (N=422)

Variables	Category	Frequency	Percent
Sex	Male	267	63.3
	Female	155	36.7
Age	Under 18years	13	3.1
	19-40years	320	75.8
	41-45years	80	19.0
	46years and above	9	2.1
Marital status	Married	270	64.0
	Single	151	35.8
	Nil	241	57.1
Number of dependents	One to two	75	17.8
	Three to four	80	19.0
	Above five	26	6.2
Ethnic group	Yoruba	349	82.7
	Igbo	60	14.2
	Other	13	3.1
Religion	Islam	88	20.9
	Christianity	334	79.1
	Total	422	100.0

With reference to the number of beneficiary enrolled by the principal enrollees, a large proportion of the respondents (57.1%) did not register any dependants, 17.1% had registered 1 to 2 dependants, 19% registered 3 to 4 dependants while 6.2% had registered more than 4 dependants. Among the various ethnic groups we have in Nigeria. In terms of ethnic grouping, Yoruba were the larger majority among the respondents (82.7%); followed by the Igbo with 14.2% and other ethnic were 3.1%. Based on religion, a large majority of the respondents (79.1%) were Christians and while 20.9% were Muslims. NHIS started with government

workers but its spread to private organizations the number of the enrollees is increasing daily. The inclusion of the private organization maybe based on the fact that it is cheaper for the organizations to maintain and it gives them better opportunity to register and enjoy health services under the programme. By implication, if NHIS programme could cover all government and private establishment, a good proportion of the working population in Nigeria will have access to qualitative health care services. The scheme has undergone tremendous growth over the years such that it is now well entrenched in public sector and expanding in the private sector. Many of the HMOs have spent considerable years in the field. This was illustrated in the IDI conducted in the study. For the years of experience and challenges of the health care delivery respondent the HMO interviewed viewed that:

*Health care international has been in existence since 13 years ago, private NHIS has been their major business until 2005 when the Federal government started the implementation of the National health Insurance Scheme. It therefore means, health care international has been running private health insurance six year before the federal government launched the NHIS in 2005, **Health Care International** had their Head office at Abuja while Oyo State office is situated beside High Court of Justice, Ring Road, Ibadan.*

An enrollee interviewed stated that:

*As far as private NHIS is concerned, I can't say precisely when it started but when I joined the company **Rom Oil and Mills** four years ago, I met the scheme on ground, however information I gathered from other members of staff on ground said the company had a kind of retainership with a private hospital in Ibadan where the staffs and their dependants always received treatment when ill (IDI, **Human Resources Manager** June, 2012)*

Another enrollee interviewed stated that:

*Private NHIS Started in my company the same year the former sector started enjoying their own however, my company is not responsible for any medical attention since medical allowance are been paid along with the salary (IDI) **Admin officer, Siegweta**, June 2012).*

The member of the HMO organizations interviewed stated that:

*Health Care International, paid an unscheduled visit to most of these hospitals to see the attendance form of the enrollee, the **HMO** also demand for Grievance form which the enrollee must have filled in relation to their dissatisfaction with poor services in the hospital, the **HMO** also conduct forum for the enrollee in their working place, so that any complaints or comment can be adequately address, health care provider are also warn to keep on with the standard, anything short of that can be sanction, e.g. withdrawal of the accreditation through the NHIS bodies. There is no room for default, because premium or capitation will be paid first before they were allowed in the scheme. In our thirteen years in the service of health insurance with private institutions or organization, there was no single case. However, if it does happens, the services rendered by the health care provider will be stopped because this is basically capitalist idea, based on the cash for service likely to persistent.*

The above response reveals that the role and functions every Health Management Organization are usually being measure to ensure quality control and adequate service delivery which is worth the capitation being paid by the government

Practices that encourage persistent use of Health Care Provider services by the enrollees

On respondents' perceptions of the practices that encourage their use of Health Care Provider services, findings revealed that the large majority (80.1%) preferred the services because it reduces the out-of-pocket expenses borne by the service users and they can access health care without necessarily having money at hand, about 6% were motivated because the services quality have improved considerably and 14% preferred the NHIS service providers because drugs are always available at the pharmacy and the laboratory equipments were sophisticated compared to the health care services they procure on their own. More professional medical experts and paramedical were observed to be involved in the services. In Africa, out-of-pocket payments range from less than 10% to more than 80% government spending on health.

Assessing the respondent's reason for poor perception of satisfaction with the services of NHIS. For availability of service, the larger proportion (60.9%) gave reasons that the programme is a very laudable programme as it

improves the health conditions of the people; 11.4%, gave reasons that because they have access to health care without having money at hand, 15.9% preferred the scheme because the scheme allows them to choose an hospital very close to their house said because chronic diseases are not covered under the scheme. 7.7% did not feel the impact of contribution made of their financial contributions as it is deducted from their salary.

A large proportion of the respondents (57.1%) disliked the practice of HMO delay in processing of authorization code when referred to secondary or tertiary health facility, 17.8% reported cases of poor services from the health care providers, 19% were against the fact that chronic diseases are not covered under the scheme. The services in some hospital is still very poor despite premium been paid to health care provider on monthly or quarterly basis while 6.2% do not like the practice where stakeholders are beneficiary of the ruling party they said it is a way of asking their people to enjoy the National cake and misappropriate of fund.

Level of satisfaction among enrollees using the Health Care Provider services

In terms of whether NHIS Health Care Provider services have met the expectation of their burgeoning enrollees, a large proportion of the respondents (57.1%) believed that the scheme has really met their expectation in terms of services rendered. However, some significant percentage reports that their expectations remained largely unmet. About 17.1% gave reasons that the scheme has not really meet up to their expectation due to the fact that some of the private hospital engage in shady practices between the enrollees and primary health care providers. 19% experienced poor services in some hospital despite the premium paid to them (health care provider) on monthly or quarterly basis while 6.2% reported that the health care provider offered fake drugs to them in order to maximize profit.

Table 3. Enrollees' satisfaction with NHIS Health Care Provider services (%)

Service users' satisfaction	VERY UNSATISFIE D	UNSATISFIE D	NEUTRA L	SATISFIE D	VERY SATISFI ED
Services availability	7.8	11.4	15.9	60.9	4
Nurses relationship with patients	6.6	13.7	19.7	51.2	8.8
Doctors relationship with patients	7.3	10.9	17.8	17.8	14.5
Social worker efficiency	7.8	14.2	14.0	49.1	14.9
Waiting time	5.0	17.8	16.8	55.9	4.5
Time spent in consultations room	5.5	8.8	22.0	61.4	2.4
Getting problem resolved	6.9	24.9	31.3	30.6	6.4
General quality of service received	7.6	10.9	13.5	57.8	10.2
Time spent in laboratory investigation	8.1	14.2	14.9	53.6	9.2

(Field Survey, 2012)

For availability of service, a larger proportion of the respondents (64.9%) were satisfied. 60% were satisfied with the friendly attitude of the nurses. On the perceptions of the doctors' relationship with enrollees, only 32.3% were very satisfied with the doctors' ambience, showing a poor relationship between the doctors and the patients. 54.6% were satisfied with the efficiency of the social workers. 60.4% were satisfied with the waiting time believed the timing was appropriate. A large proportion of the respondents (61.4%) . only 40% were satisfied with the way and manner in which their problem were solved leaving a larger percentage not satisfied with the problem management among those attending the health care facilities. Looking at the general quality of service received by the respondents only 40% were very satisfied. Finally from the table, the larger percentages (61.7%) were satisfied with time spent in the laboratory for investigation.

The benefits derived from NHIS by respondents revealed that 26.1% benefitted non-payment of hospitalization bills, 55.2% received subsidized drugs below 90% of its original cost and 40.3% did not pay laboratory fees. The inclusion of the employees' organization maybe based on the fact it is cheaper for the organizations to maintain and it gives them better opportunity to register and enjoy health services under the programme. By implication, if NHIS programme could cover all government employees, a good proportion of the working population in Nigeria will have access to qualitative and quantitative health care services.

Perception of referral process in the use of NHIS Health Care Provider services.

Different opinions were rendered by the respondents concerning their opinion on what is responsible for difficulty experienced in service delivery. Some 7.6% said it was attitude of healthcare facilities withholding timely referral, others 14.5% viewed at it from the angle of failure on the side of HMOS to give approval. about 3.3% agreed on delayed payment of claim by HMOS. Describing some particular aspect of the service experienced by the respondents that stood out, some 9.5% agreed on the part of provision of employee and more

healthcare centers. Few agreed to maintenance of NHIS facilities and adequate drug injections. While a larger percentage 90% had no response on this matter. Based on the respondent's opinion on what would enhance the utilization of fee-for-service payment model, 13% suggested cooperation from all stake holders, 16.1% suggested appropriate record keeping and quick information and A large proportion of the respondents 70.9% gave no response on this matter. 8.8% believed by reducing the charges and the work load or employment of more health workers services, of healthcare can be improved. Some suggested proper and prompt motivation as tool to improving the services of the healthcare provider. Others 11.4% believed in provision of adequate healthcare facilities, while 54.7% suggested nothing. Also from the table, 47.8% disagreed to the facts there was a lot bottleneck in accessing healthcare under NHIS.

Enrollee's Perception of the regulatory bodies' management and quality control

Respondents' view of the stake holders handling of the scheme showed that 82.7% believed that the scheme is well handled by the government and other stakeholders that are involved. 14.2% expressed their opinion that the HMOs are not doing well, with respect to experience in the release of capitation or premium to the health care providers while 3.1% observed that some health care providers used most of the capitation or premium to procure furniture and vehicles instead of drugs and core materials.

Perception of quality control management among NHIS health care providers.

The necessity of quality control agents in ensuring healthcare delivery revealed that a larger proportion (85.3%) supported the idea of control agents in monitoring the health care providers and the HMOs. A larger proportion of the respondents (77.9%) agreed that most of the hospital accredited by NHIS does meet the criteria/standards in term of equipment and personnel. 60.4% of the respondents affirmed that NHIS can be sustained under the present political dispensation. However while expressing that health care services delivery is poor, a respondents suggest ways of improving services of health care providers, one of the enrollee interviewed stated that:

Frankly speaking, health care services is very poor, the health personnel need to be motivated so that they can improve their services. The premium needs to be increase, so that modern equipments such as laboratory machine can be purchased and genuine being stocked. (IDI, Human Resources Manager, Rom Oil Mills June, 2012).

The need to improve the financial support provided by the Government and other stake holders was further buttressed by other interviewee who said

.....more money should be going to health care provider for better services, also any erring officer should be sanction to serve as a deterrence ((IDI, Human Resources Manager June, 2012).

Another added to the issue of funding and support, the need to develop the skills of personnel by stating thus:

There are so many ways the services can be improved, such as more funding to the system, more qualified personnel, and quality control mechanism, any health care givers that did not doing well should be summarily dismiss from office New Age Beverage does not condone any act of laziness or lackadaisical attitude to work (IDI, Human Resources Manager June, 2012).

While final support was emphasized, another interviewee added on the need to build the capacity of staff by providing more fund to train and re-train personnel by saying:

.....all the health care provider needs to be improved, by way of organizing regular training and re-training for the personnel so that they can be abreast of latest development in medical care, then more funding will also help (IDI, Human Resources Manager June, 2012).

VI. DISCUSSION

Health care delivery constitutes a major challenge in Oyo state, Nigeria. The drive by government to ensure universal access to healthcare and at low cost through NHIS is a harden task. The study demonstrated that there is discrepancy among employees in their access to the NHIS. Specifically the study revealed that

employees in private organization are now enjoying greater access to the scheme despite the late acceptance of the scheme. About 80.1% preferred the Health Care Provider services because it reduces the out-of-pocket expenses to borne by the service users and they can access health care without necessarily having substantial money at hand. Motivation also stemmed from perceived services quality, drug availability, and sophisticated pharmacy and the laboratory equipments. The inclusion of the private organization maybe based on the fact that it is cheaper for the organizations to maintain and it gives them better opportunity to register and enjoy health services under the programme. Majorly the burden of health care cost on the respondents was reduced through where NHIS bearing cost of hospitalization, subsidized drugs and laboratory fees. By implication, if NHIS programme could cover all government and private establishment, a good proportion of the working population in Nigeria will have access to qualitative and quantitative health care services. The scheme has undergone tremendous growth over the years such that it is now well entrenched in public sector and expanding in the private sector. The discrepancy among employees in their access to NHIS could also be attributing to funds. According to WHO (2007 a & b), the provision of quality, accessible and affordable healthcare remains a serious problem because of inadequate funding and lack of government commitment to the provision of health care policies that covers all citizens. Respondents acknowledge that workers in private organizations have more access to NHIS than those in the in non participating industries. According to Omoruan, Bamidele and Philips (2009), the distribution of health care facilities between rural and urban areas constitution a high profile challenge to NHIS in Nigeria.

Respondents across the four organizations acknowledged that there is improvement in the equipment deployed by the health care provider. This finding corroborate Yohesor (2004), Johnson and Stoskopf (2009), Omoruan, Bamidele and Philips (2009) and Oba (2009), who observes that NHIS in Nigeria, as in other part of Africa is impeded by obsolete and inadequate medical equipment. This implies that workers and the self employed who have access to the NHIS could better treatment because organization which lack adequate medical facilities are often not accredited into the programme and their opportunity to refer to a tertiary health care facilities with adequate equipment under the scheme.60% of the respondents were satisfied with Health Care Provider services though a larger proportion were not satisfied with the way and manner in which their problem were solved leaving a larger percentage not satisfied with the problem management among those attending the health care facilities. . A large proportion of the respondents (57.1%) however disliked the practice of HMO delay in processing of authorization code when referred to secondary or tertiary health facility.57.1% believed that the scheme has really meet their expectation in terms of services rendered. However, some significant percentage reports that their expectations remained largely unmet due to the fact that some of the private hospitals engage in shady practices between the enrollees and primary health care providers. The dearth and inadequate medical facilities in Nigerian hospitals is attributed to poor funding of the health sector by government. According to WHO (2007 a,b&c), poor funding of the health sector constitute a major challenge facing the actualization of NHIS in Nigeria. WHO (2007 a&b) observed that the percentage of government allocation to the health sector has always been about 2% and 3.5% of the annual budget. This allocation is very marginal to cater for the operation or implementation cost of NHIS in the country. Corruption could also be responsible for the near absent of medical facilities in Nigeria hospitals. According to Agba, Ikoh, Ushie and Agba (2008), bureaucratic corruption is responsible for government inability to effectively provide social services and reduce poverty in Nigeria. Corruption undermines and weakens vital institutions of development including that of health. Agba, Ushie, Ushie, Antigha and Agba (2009) observed that corruption is responsible for the continual ranking of Nigeria by United Nations Development Programmes (UNDP) as one of the countries with health crisis, high mortality, food insecurity and poor nutrition.

Lack of adequate medical personnel in hospitals and clinics is another impediment to the effective implementation of NHIS in Oyo state .82.7% believed that the scheme is well handled by the government and other stakeholders that are involved. The necessity of quality control agents in ensuring healthcare delivery revealed that a larger proportion (85.3%) supported the idea of control agents in monitoring the health care providers and the HMOs. A larger proportion of the respondents (77.9%) agreed that most of the hospital accredited by NHIS does meet the criteria/standards in term of equipments and personnel. Some respondents during the interviewees expressed however that the HMOs are not doing well and some health care providers used most of the capitation or premium to procure furniture and vehicles diverting the necessary funds in to wrong ventures. 60.4% of the respondents affirmed that NHIS can be sustained under the present political dispensation. This finding is consistent with WBDI (2005) and WHO (2007a), if the programme is well sponsored in Nigeria it will achieving the gain recorded in countries like Ghana, and South Africa. It is therefore not surprising that government workers and the self employed who have access to NHIS in Oyo state are not getting the very best of treatment because of inadequate medical personnel. The movement of medical staff outside the country according to WHO (2007) is not unconnected with poor remuneration, limited post graduate medical programmes and poor condition of service in Nigeria.

V. CONCLUSION

The NHIS is a social security system put in place by the federal government to provide universal access to health care service in Nigeria. The scheme covers civil servants, the armed forces, the police, the organized private sector, students in tertiary institutions, self employed, vulnerable persons, the unemployed among others. Employees in the private organizations now have better access to Health Care Provider services supported by their organizations. The study also revealed that poor management and organizational inadequacies affects the effectiveness of the services offered by NHIS to the employees in the studied organizations. The study recommended among others that government should another streamline the measures in place to ensure that all employees in the private organizations have equal opportunity to NHIS services, including provision of adequate medical personnel and equipment to ensure effective service delivery. 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.

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:

RECOMMENDATIONS

- [1]. Following the findings from the study, 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's 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's 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.
 - 6) The Government and other stake holders should provide adequate modalities to ensured that authorization codes for referred patients are facilitated and

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