

## Implementation Challenges of National Health Insurance Scheme (NHIS) on Access to Healthcare in Federal Capital Territory (FCT) Abuja, Nigeria

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### Abstract

*This study was focused on evaluating the effectiveness of the implementation of the National Health Insurance Scheme (NHIS) and how it has impacted enrollees' access to healthcare in Federal Capital Territory (FCT) Abuja. The objective was to examine how readily accessible the healthcare services provided through the NHIS are to employees in FCT, Abuja, Nigeria. The study was guided by the theory of access as postulated by Penchansky and Thomas in 1981. A survey design was adopted, while data were collected and discussed in a mixed manner. This was the use of a questionnaire to obtain quantitative data for the purpose of testing the study hypothesis and addressing the research objective. The purposeful sampling technique was adopted in this research, and a sample of 401 was used in the study while 12 qualitative interviews were conducted. Questionnaire and semi-structured interviews were used for data collection, while Z-statistics was used to test the hypothesis. The result from the qualitative analysis indicated that the healthcare services provided through NHIS are accessible to the enrollees. These were expressed using the themes of availability, approachability, and appropriateness. A flip side of the accessibility of healthcare by the employees shows through the qualitative analysis two themes: service depth and distance. This means that the available health care services are only on the surface, as human resources and facilities are in short supply; hence, there is a serious need for improvement of access to healthcare in FCT.*

**Keywords:** Healthcare, Access, Enrollees, Implementation.

### INTRODUCTION

In the twenty-first century, the value of a worker who is healthy in a private or public organization cannot be overemphasized. A healthy population creates a healthy nation and workforce, which is crucial for organizations to achieve their corporate goals. Increased physical and mental capacities, which are important for economic growth and development, promote worker effectiveness and individual output (Imoughele & Ismaila, 2013; Owumi & Sakiru, 2013; Yunusa et al., 2014). When health problems strike people during their productive years, however, the number of available workers falls, absenteeism rises, and output falls. This indicates that a healthy population, as well as a healthy workforce, are required for quick socioeconomic and long-term growth (WHO, 2000; Ogunjuyigbe & Laisu, 2010). Despite this, in developing countries like Nigeria, providing quality, accessible, and affordable healthcare, particularly for workers, remains a major challenge (WHO, 2007a; Oba, 2008; Omoruan, Bamidele, and Philips, 2009). This means that, like many other public services, healthcare is not equally accessible to all individuals (Joseph & Phillips, 1984). As a result, limited physical access to basic health care remains a major hindrance to realizing the aim of universal health care.

In Africa, countries like Ghana, Kenya, and South Africa have some of the best healthcare policies for workers (Olayinka, 2012). In Nigeria, successive governments have made concerted efforts to provide affordable, accessible, and quality healthcare delivery to Nigerians through their various health policies. In 2002, Nigeria signed up for Universal Health Coverage (UHC) for all its citizens, as declared by the WHO (Olawumi, 2015). UHC is a healthcare system that provides health care and financial protection to all citizens. The definition of UHC by the World Health Organization (WHO) encompasses three dimensions: firstly, equity in access to health care, i.e. to ensure that those who need health care services get them, not only those who can pay for them; secondly, qualitative and affordable services, which is good enough to improve the health of those receiving services; and thirdly financial risk protection i.e. universal coverage must bring the hope of better health insurance and protection from poverty for the people, especially the most vulnerable ones (WHO, 2013).

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The concept of UHC includes national health systems, or a National Health Insurance model, and systems of Social Health Insurance (SHI) which are generally designed for the working population and financed by payroll taxes collected from employers and employees (Olawumi, 2015).

In 2010, the WHO, in its World Health Report (WHR-2010), focused on financing initiatives for achieving universal coverage (World Health Report, 2010). These initiatives include more efficient management of resources and the adoption of better policies and practices, all geared towards improving prepayment and risk pooling. The challenges of this in a developing country like Nigeria are obvious: lack of access to affordable health care services, poor distribution of health care facilities, shortage of drugs, poor attitude of health workers, the enormous cost of health services, which is sometimes out of the reach of the poor, poor infrastructure, and poor health education strategy (Jegede, 2004). Above all, many Nigerians are living below the poverty line and cannot afford the minimum health requirements (World Bank, 1996). These concerns over the years engendered several health policies, including the introduction of the National Health Insurance Scheme (NHIS) in Nigeria in 2005 (Owumi, Omoreghe, & Raphael, 2013). It must be noted, however, that the idea of health insurance in Nigeria was first mooted in 1962 when the then Health Minister, Dr. Majekodumi, presented a bill on it to the parliament in Lagos. The bill did not pass through on the argument that the country did not have enough providers of quality health care services. The NHIS was then established by Decree 35 of 1999, now NHIS Act CAP N42 (LFN) 2004. Part 1, Sections 1(1) and 2(1-2) of this Act provide for the establishment and management of the scheme. It also provides for a Governing Council, which has general control of the scheme (NHIS, 2020, p. 1).

NHIS in Nigeria is modeled after the practice of health insurance in the United States of America and Britain (Ikechukwu and Chiejina, 2010). The general objective of NHIS in Nigeria is to ensure the provision of health insurance “which shall entitle insured persons and their dependents to the benefits of prescribed good quality and cost-effective services” (NHIS Decree No. 35 of 1999, Part 1:1). Specific objectives of the scheme in Nigeria include:

The universal provision of health care in Nigeria;

To control or reduce the arbitrary increase in the cost of health care services in Nigeria;

To protect families from the high cost of medical bills;

To ensure equality in the distribution of health care service costs across income groups;

To ensure high sector participation in healthcare delivery to beneficiaries of the scheme;

To boost private, equitable sector participation in health care delivery in Nigeria.

To ensure adequate and equitable distribution of healthcare facilities within the country.

To ensure that primary, secondary and tertiary health care providers are equitably patronized in the federation.

To maintain and ensure an adequate flow of funds for the smooth running of the scheme and the health sector in general (NHIS Decree No 35 of 1999, part II: 5 NHIS, 2009).

The Scheme was officially launched on 6<sup>th</sup> June 2005 by the then Obasanjo administration and has been operational since then. When it was launched as a pilot scheme, it started with the Formal Sector, which covers employees of the Federal, State, and Local Government, including the Armed Forces, Police, and other Uniformed Services. This sector also covers the Organized Private Sector, Group, Individual, and Family Contributors. However, at the time it started, attention was more on the Federal Civil Servants, especially in the Federal Capital Territory, which is the seat of power in Nigeria. The Federal civil service forms the basic institutional framework or machinery for the administration of the state in the seat of power in Nigeria. These administrative and service agencies that constitute the civil service system in the federation are categorized into ministries, departments, boards, commissions, and parastatals. Those who work in the federal civil service are employees of the federal government. They were the first beneficiaries of the NHIS since its inception in 2005. Therefore, this study is carried out on the federal ministries which comprise today a total of thirty ministries. However, through a purposive sampling technique, five of these ministries, namely; Ministries of Education,

Health, Labour and Productivity, Information and Environment, were selected. These Ministries were chosen because they were among the first few ministries that enrolled their employees with the NHIS when the scheme started in 2005. Although, more than ten years into the commencement of NHIS in Nigeria, studies have shown that opinion is still polarized among Nigerians on the efficacy of the scheme in addressing the health problems of workers in the country because of the disheartening report from previous studies (Mac-Leva and Akor 2016, Yusuf 2016, Popoola 2014, Agba 2010, Adeniyi and Onajole 2010, Eboh 2008).

### **Statement of the Problem**

The poor state of Nigeria's health sector is a major concern for Nigerians. This is the reason for the country's high index among countries with poor health delivery systems. Nigeria is one of the several major health-staff-exporting countries in Africa. As a result of inadequate infrastructure and poor compensation packages, a sizeable number of physicians, nurses, and other medical professionals are lured away to developed countries in search of fulfilling and lucrative positions.

However, critical to the delivery of efficient healthcare in Nigeria is the way the healthcare system is funded and how citizens pay to access healthcare services. Currently, healthcare in Nigeria is financed by a combination of government funding, out-of-pocket payments, donor funding, and health insurance.

Out-of-pocket payments for health constitute over 70 percent of total health expenditure in Nigeria. This is more than the globally recommended 30–40 percent. However, only less than 5 percent of the total population is covered by any kind of health insurance or risk protection mechanism, which is against the recommended 90 percent coverage by the World Health Organization.

The above assertion shows the challenges faced by Nigerians in order to access quality healthcare services. Despite this, the government allocation to the health sector has never been above 5.5 percent of the total annual budgets. (See *The Guardian*, May 28 2015; *Premium Times*, November 7, 2019, *Premium Times*, October 12, 2022 )

Given that the NHIS is set up to improve access to healthcare services and reduce the financial burden of out-of-pocket payments, especially for workers in the formal sector, the enrollee's access to healthcare has emerged as an increasingly important parameter in the assessment of the scheme. Against this background, the research raises the following question: How readily accessible are the healthcare services provided through the NHIS to employees in FCT

### **Objective of the Study**

The specific objective was to examine how readily accessible the healthcare services provided through the NHIS are to employees of FCT, Abuja, Nigeria.

### **Review of Some Conceptual Literature**

#### **Access to Healthcare**

Etymologically, the Canadian Oxford Dictionary (1998) defines access as a way of approaching, reaching or entering a place, as the right or opportunity to reach, use or visit. Within health care, access is always defined as access to a service, a provider or an institution, thus defined as the opportunity or ease with which consumers or communities are able to use appropriate services in proportion to their needs (Daniel, 1982 & Whitehead, 1992). Health care access is the ability to obtain healthcare services such as prevention, diagnosis, treatment, and management of diseases, illness, disorders, and other health-impacting conditions. For healthcare to be accessible it must be affordable and convenient (Mcking, et al, 2021). Access to health care means having the timely use of personal health services to achieve the best health outcomes. Facilitating access is concerned with helping people to command appropriate health care resources in order to preserve or improve their health. Access is a complex concept and at least four aspects require evaluation. Based on this perspective, Healthy People (2020) looked at Access to healthcare as consisting of four components:

**Coverage:** facilitates entry into the health care system. Uninsured people are less likely to receive medical care and more likely to have poor health status.

**Services:** Having a usual source of care is associated with adults receiving recommended screening and prevention services.

**Timeliness:** ability to provide health care when the need is recognized.

**Workforce:** capable, qualified, culturally competent providers.

Access has been conceptualized in numerous ways. While the term access is often used to describe factors or characteristics influencing the initial contact or use of services, opinions differ regarding aspects included within access and whether the emphasis should be put more on describing characteristics of the providers or the actual process of care (Frenk, 1992). Some authors view access more as an attribute of health services, noting the fact that services can be accessed or utilized by those requiring care, while most authors do recognize the influence of characteristics of users as well as characteristics of providers on access, many put more emphasis on characteristics of health care resources that influence the utilization of services, acting as a mediating factor between the ability to produce services and their consumption (Donabedian, 1973). Lastly, access to health care is also seen as the ability to receive health services for the prevention, detection, and treatment of disorders that affect health. For health care to be accessible, it must be affordable and able to protect and improve health

### **Challenges to Healthcare Access in Nigeria**

**Insufficient Healthcare Infrastructure:** Nigeria's healthcare system frequently falls short of meeting the demands of the Nigeria's sizable and fast growing population. There is a dearth of medical personnel, healthcare facilities, and necessary medical supplies in the nation. Many families do not have access to even the most basic healthcare services, especially those who live in rural areas.

**Affordability:** For many families in Nigeria, the expense of healthcare is a major obstacle. Even for small illnesses, medical costs can add up rapidly and become a financial hardship. Although Nigeria offers public healthcare facilities, some families choose to use more expensive private healthcare services because these facilities are frequently congested and may not offer the necessary level of care.

**Geographical differences:** Families living in remote areas may have to travel long distances to access medical care, which could cause delays in treatment. Healthcare facilities and services are generally better in urban areas than in rural regions, where healthcare is frequently limited. These disparities are evident in Nigeria

**Inadequate Health Insurance Coverage:** The availability and penetration of health insurance in Nigeria are limited, with a small percentage of the population having coverage. Families without health insurance are at a greater risk of facing financial hardships when medical emergencies arise.

**Quality of Care:** While there are skilled healthcare professionals in Nigeria, the overall quality of care can vary. In some cases, families may receive substandard care due to inadequate training, poorly equipped facilities, and a lack of accountability.

### **Theoretical Framework**

**The Theory of Access.** The introduction of the theory of access by Penchansky and Thomas was informed by the determinants of use as proposed by Andersen and other utilization theorists. They argue that, Access influences users of healthcare and the systems in three ways; the use of the service, consumer satisfaction and a system practice. (Anderson & Newman, 1973). Guided by this argument in 1981, Penchansky and Thomas posits that access is defined as the degree of fit between the consumer and the service, that is, the better the fit, the better the access. They conceptualized access into five specific dimensions to explain the five different dimensions of access to health care. These dimensions are affordability, availability, accessibility, accommodation, and acceptability (Penchansky & Thomas, 1981).

**Tenets of the Theory.** The proponents of this theory argued that the dimensions of access are independent yet interconnected and each is important to assess the achievement of access in healthcare delivery. They maintained that access is central to health services and that these dimensions (affordability, availability, accessibility, accommodation, and acceptability) cannot be separated from it (Penchansky & Thomas, 1981 in King, 2015).

Affordability is determined by how the healthcare provider's charges relate to the client's (patient's) ability and willingness to pay for services. They said that affordable services examine the direct costs for both the service provider and the consumer (Surman, 2016). Affordability reflects the economic capacity of people to spend on resources and services that they need for their health. It is not only affected by the price of healthcare but also by the reduced income due to ill health. The idea here is for healthcare to be cost-effective, meaning that the price individuals pay for their care should produce effective and wanted outcomes in health. Inability to pay for healthcare results in a lot of health inequalities. Poverty, social isolation, or indebtedness are examples of factors restricting the capacity of people to pay for needed care. Often free healthcare can limit the effectiveness of care because it can take a very long time to access specialists and consultants. Whereas, private healthcare, which is more costly may give better health outcomes. It is a complex balancing act.

Availability measures the extent to which the provider has the requisite resources, such as personnel and technology, to meet the needs of the client. An available service has sufficient services and resources to meet the volume and needs of the consumers and communities served. iv. Accommodation reflects the extent to which the provider's operation is organized in ways that meet the constraints and preferences of the client. Of greatest concern are hours of operation, how telephone communications are handled, and the client's ability to receive care without prior appointments (Penchansky, 2001). Availability and accommodation refer to healthcare services and those within it being reachable both physically and in a timely manner. Characteristics of facilities, urban contexts, individuals, providers and modes of provision affect availability and accommodation of healthcare. Access is restricted if there are not enough facilities or resources or if resources are not evenly distributed. Decentralized healthcare services allow more access as individuals do not have to travel far to access services. Ability to reach healthcare is facilitated by better transport systems, occupational flexibility and knowledge about healthcare services. This is where we witness inequalities between socioeconomic status as they may live far from services with limited ability to spend on travel or take time off work (Penchansky & Thomas, 1981).

Accessibility refers to geographic accessibility, which is determined by how easily the client can physically reach the provider's location. This is often used interchangeably with approachability. And Approachability denotes that people with health needs can actually identify forms of services, which will improve health, exist and can be reached. Services are responsible for making themselves known among various social and geographical population groups through transparency, providing information and outreach activities to make their services approachable to everyone who needs it. Complementary to this dimension is the notion of ability to perceive need for care which is crucial. Factors such as health literacy, knowledge and health beliefs determine ability to perceive need for care. Increasing individual's ability to perceive need for care and approachability of services will increase the desire for care, resulting in more people willing to approach healthcare services. We can use mental health services as an example to contextualize approachability. Within many social and geographical populations, such as universities, mental health services are not approachable for students who need it. There is limited outreach activities and funding for mental health counselling for students who are often a neglected population group, resulting in fewer students identifying these services and, hence, approaching them.

Finally, acceptability captures the extent to which the client is comfortable with the more immutable characteristics of the provider, and vice versa. These characteristics include the age, sex, social class, and ethnicity of the provider (and of the client), as well as the diagnosis and type of coverage of the client (Penchansky & Thomas, 1981 in King, 2015).

Overall, access to healthcare encompasses many interlinking factors. It can be argued that some of these dimensions are too simplified and should relate to access to healthcare. One should not have access to

healthcare based on their geographical location or organizational availability and affordability, but rather proper access to healthcare is when individuals can choose acceptable and effective services. Healthcare should be timely, cost-effective, culturally and socially acceptable and inclusive, and readily available as and when someone needs it.

### **Application Of The Theory To The Study**

The **Theory of Access** is apt to the study because looking at the main objective of establishing the National Health Insurance Scheme, it is set to ensure that every Nigerian has access to good healthcare services and is protected from the financial hardship of huge medical bills. This is in line with the Universal health coverage whose key features are avoiding out-of-pocket payments and the support for risk pooling, across time and across individuals. Having implemented the scheme for more than fifteen years now, the theory of Access, with its component dimensions of affordability, availability, accessibility, accommodation, and acceptability, are used as indicators to measure the effectiveness of the scheme in the Nigerian public sector in particular and healthcare delivery in Nigeria as a whole.

It is important to mention that according to the theory of access believes that affordability is determined by how the healthcare provider's charges relate to the client's (patient's) ability and willingness to pay for services. They said that affordable services examine the direct costs for both the service provided and the consumer (patient), however in the case of NHIS their charges are moderate thereby increasing clients' ability to pay because government officials or civil servants are expected to pay only 10% of the total bill. This makes this tenet to be very obtainable in Nigeria because poverty has been considered to be responsible for most deaths even among civil servants because they cannot afford the fee to good quality health care.

Another very important aspect of the theory is the consideration of the availability of the resources required by client. Availability measures the extent to which the provider has the requisite resources, such as personnel and technology, to meet the needs of the client. There are lots of deficiencies in these aspects in Nigeria. This is because some drugs that are covered by the NHIS are not readily available especially the more expensive ones. Therefore, the patients are directed to buy the drugs outside the hospital, only after the available drugs have been given to client. On the other hand, the numbers of medical personnel especially medical doctors are not sufficient to cater for the clients seeking their services. Some time patients are told to go home to return the next day because it couldn't get to their turn. On a more balance parlance effort should be made to increase the number of medical personnel's especially medical doctors. This can only be possible if the government can provide better working conditions for medical personnel's who are constantly traveling abroad for greener pasture because of the poor remuneration and working conditions here in Nigeria.

**Hypothesis:** The following Hypothesis is formulated to guide the discussion: Healthcare services provided through the NHIS are readily accessible to employees in FCT, Abuja, Nigeria.

### **METHODS AND MATERIALS**

In this study, a survey design was adopted. This is a systematic method of collecting data from a target population. It aims at collecting information from a sample of the population such that the results are representative of the population within a certain degree of error. A survey design was used because it provided the researcher with first-hand primary data that was collected, maintained, and analyzed. Although a descriptive survey (explanatory and exploratory) was used, a mixed-method approach was however adopted.

The population of this study comprised all the employees in five selected ministries in the FCT, Abuja. These are Ministries of Education, Health, Labour and Productivity, Information and Environment. The selected federal ministries have a staff strength of 51,579 employees.

In addition to the above, the researcher through a purposive sampling technique selected 12 senior employees, levels 14 and above, who are enrollees of the NHIS from the five selected ministries and interviewed them.

Purposive sampling technique was adopted in this research. Purposive sampling (also known as judgment, selective or subjective sampling) is a sampling technique in which researcher relies on his or her own judgment when choosing members of population to participate in the study.

The sample consists 5% of the population, which translates to 401 and it was considered as the sample size. The figure was arrived at based on the application of Taro Yamane sample size determined formula at 5% error margin.

The data used for the study were generated through primary and secondary sources. The primary data were collected through the administration of 401 questionnaires to the respondents as presented above. Also, primary data were gathered through structured interview method schedule that were used to investigate ideas, compare and corroborate responses as they pertain to the issues on the implementation of the NHIS in five selected federal ministries in the FCT. Participants in the interview were twelve (12) in number, levels 14 and above, drawn from the five selected ministries in the FCT. This combination of both primary and secondary sources permits the extraction of descriptive and narrative information concerning the issue of the implementation of the National Health Insurance Scheme in the five selected Federal ministries in Abuja. The triangulation also compensates the weakness of the other so as to have a realistic view of the issues under study.

Descriptive and inferential statistics were used in the analysis of the study data. The descriptive data were analyzed using simple percentage, while the inferential statistics was the use of Z-statistics to make a deductive reasoning to test the formulated hypotheses of the study with the aid of Statistics package for social sciences (SPSSv.27). The interviews were analyzed using thematic codes with the aid of Nvivo 12 pro.

## **FINDINGS**

**Hypothesis:** Healthcare services provided through the NHIS are readily accessible to employees in the selected federal ministries in Abuja.

Here, our objective was to investigate how readily accessible is the healthcare services provided through the NHIS to employees in the selected federal ministries in Abuja. The findings were based on the data collected from the field. Accordingly, we found that:

The waiting time is reasonably prompt.

There is a high level of satisfaction with the health care providers' attention and care extended to the employees at the point of health service utilization.

The number of healthcare providers in the hospitals where enrolees registered for NHIS are adequate.

Healthcare services and facilities provided for the NHIS enrolees in the five selected Federal ministries in Abuja are available but limited in supply.

Drugs prescribed for NHIS enrollees are inadequate in supply.

Some of the health services required by the employees in the five selected Federal ministries in Abuja are not covered by the NHIS.

The responses from the questionnaires, as shown in the table below and in the qualitative data, buttressed the above findings.

**Table 4.5: Accessibility of the healthcare services provided through the NHIS to employees in the five selected Federal ministries in Abuja.**

		SA	A	UD	D	SD
1.	To what extent do you agree that your enrolment in the scheme has improved your access to health care services?	172 61%	43 15%	23 8%	33 12%	11 4%
2.	To what extent do you agree that the waiting time to see a doctor is prompt?	90 32%	80 28%	25 9%	50 18%	37 13%
3.	To what extent do you agree that your health maintenance organization promptly pays for your healthcare services?	110 39%	80 28%	0	59 21%	33 12%
4.	To what extent would you say that the number of healthcare providers are adequate at the hospital where you registered with NHIS?	95 34%	85 30%	11 4%	51 18%	40 14%
5.	To what extent do you agree that you are satisfied with the courtesy of care of the health providers at the point of health service utilization?	170 60%	44 16%	20 7%	34 12%	14 5%

Source: Fieldwork, 2021

Table 4.4 shows that 172(61%) strongly agreed, 43(15%) agreed, 33(12%) disagreed and 11(4%) strongly disagreed that their enrolment in the scheme has improved their access to health care services. 90(32%) strongly agreed, 80(28%) agreed, 50(18%) disagreed and 37(13%) strongly disagreed that the waiting time to see a doctor is prompt. On whether the health maintenance organization promptly pays for their healthcare services, 110(39%) strongly agreed, 80(28%) agreed, 59(21%) disagreed, and 33(12%) strongly disagreed. Furthermore, 95(34%) strongly agreed, 85(30%) agreed, 11(4%) were undecided, 51(18%) disagreed, and 40(14%) strongly disagreed that the number of healthcare providers is adequate at the hospital where they registered with the NHIS. The last question on this hypothesis was whether they are satisfied with the courtesy of care of the health providers at the point of health service utilization, accordingly, 170(60%) strongly agreed, 44(16%) agreed, 34(12%) disagreed and 14(5%) strongly disagreed.

The qualitative data based on the interview conducted showed that the service is readily accessible as long as the prospective beneficiaries are employees who are registered with NHIS in any of the five selected federal ministries. The interviewees shared that they have access to the health care provided through the scheme. The findings show that there is a shared perception that the health care services are readily accessible for all the participants since they are all enrollees of the scheme. The shared experience aligns with health service gained to the overall expectation of the scheme even though there were calls for capturing other areas of health services not already captured in the scheme.

It is pertinent to state that availability measures the extent to which the provider has the requisite resources, such as personnel and technology, to meet the needs of the client. An available service has sufficient services and resources to meet the volume and needs of the consumers and communities served. By the explanation given above, the respondents have confirmed that the healthcare services seem to be available and accessible but only on the surface. They posited that healthcare is available and accessible, albeit, they expressed concern about the limited services that are covered by the scheme and the number of persons that a doctor has to attend to every day. This means that the available services are rather short in supply of the health need of the participants that are enrolled in the scheme. The interviewees expressed the desire for the scheme to be improved to accommodate the growing number of individuals and new infections and diseases.

*“The healthcare services provided to us who are NHIS enrollees are quite accessible, so I really appreciate them on that” (Participant 4).*

*“The scheme is open to anyone that subscribes to it, as it is a proportion of our pay and you get to choose the healthcare provider of your choice” (Participant 8).*

*“My HMO (health management organization) has been very cooperative, though I wish that the scheme would cover more areas not currently covered” (Participant 10).*



## Emerging Themes and Definition

The data revealed three themes that emerged from the analysis, and these themes explain the accessibility of healthcare services by the employees in the five selected Federal ministries in FCT, Abuja. The themes that emerged are availability, approachability, and appropriateness.

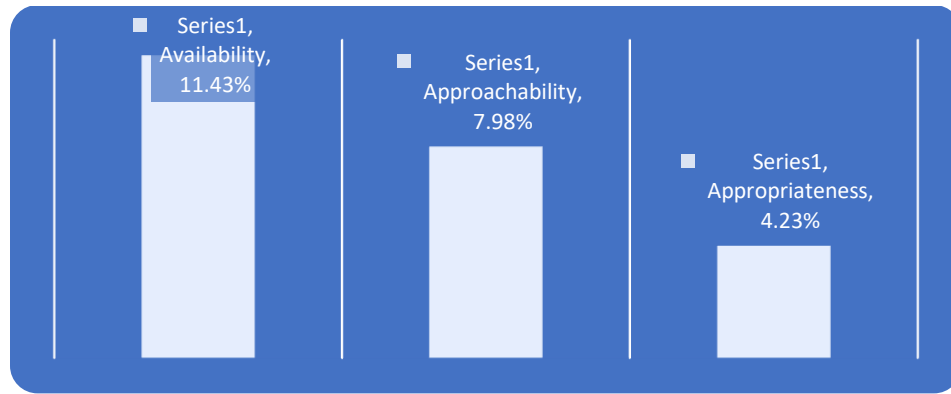


Figure 4.2: Thematic weight Output, Nvivo 12 pro

Source: Fieldwork, 2021

### Availability

This theme explains the interviewees' perspective on the provision of healthcare services through the NHIS. The theme was defined as the existence of selected basic healthcare services while also supporting the need for covering new services, not in the scheme. The availability theme explains the need for newer services not provided in the scheme, such as the provision of eyeglasses, tooth replacement, and dermatological services among others. The theme also suggests that there are available services but there is a need for the scheme to move further from the comprehensive services to advance services that would be useful to the enrollees. This means that the available services are rather short in supply of the health need of the participants that are enrolled in the scheme. The interviewees expressed the desire for the scheme to be improved to accommodate the growing number of individuals and new infections and diseases.

*"I would say the healthcare services are available physically but the manpower needs some improvement. The number of Doctors that attend to the patients who are under NHIS every day are very few, especially in the good hospitals in town....."* (Participant 9).

*"The services are available but the process is cumbersome. For example, you need to get a code before are attended to as a patient under NHIS"* (Participant 6).

*"The healthcare services are connected to most of the government hospitals, so one can still access them when in need. However, there is a need for improvement in terms of the number of hospitals present as compared to the patients and the kind of services they offer, even the number of doctors that are available....."* (Participant 1).

*"The services are available but then I need to travel far to access the services. Also, sometimes I spend a whole day because of the slow nature of the system. I think there is more they need to do to accommodate us"* (Participant 3).

*"I started benefiting from this scheme since the time I enrolled, but I would wish there are more services added from the ones not covered"* (Participant 8).

*"The scheme is very accessible .....it has helped me greatly"*(Participant 12).

*“It has been made very easy to access since its introduction, I consider myself lucky being a beneficiary” (Participant 7).*

### Approachability

Approachability refers to the reality that persons with health needs may recognize that some type of service exists, can be accessible, and has an influence on the individual’s health. Various socioeconomic or geographical demographic groups might become more or less aware of services. Transparency, awareness about existing care services, and outreach initiatives are all factors that might make services more or less accessible. In addition to this idea of service accessibility, the capacity of people to recognize the necessity of treatment is critical and is influenced by characteristics such as patient education, care practices, and perceptions about wellness and illness.

*“The coverage should be done in such a manner that it will allow people approach any healthcare for any ailment and not to be restricted to some selected ailment” (Participant 8).*

*“What counts is the extent that we can access support from the managers of the healthcare system so that those who do not have even the 10% will still get healthcare access.” (Participant 3).*

*“There is a need for changes that account for the renewal of the entire process so that new cases can be added and not leave it for too long on a certain type of healthcare issues that are basic and can be afforded by the enrollees” (Participant 9).*

### Appropriateness

This theme was defined as services being able to satisfy the expectations of the enrollees, which would yield increased benefits to them. The theme denotes the fit between services and clients’ needs, its timeliness, the amount of care spent in assessing health problems and determining the correct treatment, and the technical and interpersonal quality of the services provided. Access to optimal care ultimately requires the person to be fully engaged in care and this is seen as interacting with the nature of the service actually offered and provided.

*“There is need to ensure that the same services that people are able to handle on their own are not the same that the healthcare system is covering, it does not make sense ....” (Participant 11).*

*“The healthcare should be balanced so that it should be able to meet the healthcare need of enrollees in a locality” (Participant 8).*

**Test of Hypothesis** The hypothesis was intended to investigate how readily accessible is the healthcare services provided through the NHIS to employees in the five selected Federal ministries in Abuja. The parametric tool (Z-test) was applied; the result is shown in Table 4.5 below.

Level of significance ( $\alpha$ ) = 0.05

**Table 4.6: Z-Test statistics**

Variable	Test of = 2.50 vs 2.50; assumed sigma = 1.29					
	N	Mean	Std.	SE Mean	Z-stat.	Sig.(2-tailed)
Mean Response	4	2.452	0.361	0.823	1.630	0.003

Source: Researcher’s Computation, 2021.

**Decision Rule:** Reject the Hypothesis if the p-value < 0.05 otherwise accept.

The Z-test result in Table 4.5 shows a statistic value of 1.63 (in absolute terms) and an associated probability value of  $0.003 < 0.05$  indicating that healthcare services provided through NHIS are accessible to employees in the selected Federal ministries in Abuja. The researcher, therefore, upholds the hypothesis that the healthcare services provided through NHIS are readily accessible to employees in the five selected Federal ministries in Abuja.

## **DISCUSSION**

In hypothesis two, the study shows that the Z-test result shows a statistic value of 1.63 (in absolute terms) and an associated probability value of  $0.003 < 0.05$  indicating that healthcare services provided through NHIS are readily accessible to employees in the five selected Federal ministries in Abuja. The researcher, therefore, agrees with the hypothesis that the healthcare services provided through NHIS are readily accessible to employees in the five selected Federal ministries in Abuja. The result from the qualitative analysis equally validates the hypothesis and was expressed using the themes of availability, approachability, and appropriateness. Though, the result provided further ways through which the accessibility can be improved. This result is consistent with the study of Owumi, et al. (2013), and Agba et al. (2010), who also found that healthcare services provided through NHIS are highly accessible. It is also in agreement with the findings of Daramola, Maduka, Adeniran, and Akande (2017) and Mitiku and Geberetsadik (2019) that showed in their various studies that the majority of their respondents expressed a high level of satisfaction with laboratory services because it was quite accessible and timely especially when it comes to getting results. Similarly, the survey carried out by Ikechukwu et al (2019) revealed that enrollees have easy access to healthcare through the provision of 24 hours healthcare services in the various hospitals where the NHIS enrollees are registered. 87% of the enrollees sampled in the study agreed that healthcare providers offer 24 hours services in their facilities, while 100% of affirmative responses were recorded by the healthcare providers in the same study.

However, like the results from the interview and qualitative data demonstrated above, the healthcare services provided through the NHIS are available and accessible for the enrollees, although on the surface level. The secondary data also buttressed this; Daramola et al., (2019) corroborate the above in their study that non-provision of prescribed drugs was found to be one of the complaints from enrollees. This result is also consistent with the study of Agba (2010) and Kwanga, et al. (2016) who found that healthcare services are available in Nigeria but in limited quantity. Similar to this point is that of partial or complete exclusion. Exclusions of major illnesses and therapies like MRI, CT scan, cosmetic surgery, open-heart surgery, neurosurgery, organ transplant, dental care, and post-mortem examination, among others, are counter-productive to the establishment of the NHIS. (NHIS Operational guidelines (2012, 2009, 2005). These exclusions according to Eteng, et al. (2015, p.29) show that the NHIS is shallow and selective in its coverage. They, however, suggested that the availability can be improved upon through service depth and wide coverage. Similarly, according to Owoseye (2019), a serious gap exists in the health workforce in Nigeria. He argued that the statistics presented by the Medical and Dental Council of Nigeria (MDCN), a body responsible for the registration of medical practitioners in Nigeria, showed that as of December 2017, registered doctors still practicing were 39,912, while registered dental practitioners stood at 2,901. However, as of February 2019, a total of 91,079 Nigerian medical and dental practitioners have been registered so far. This technically means that Nigeria has a doctor/patient ratio of 1:5000 against the WHO recommendation of one doctor to 600 patients (1:600) for adequate and quality health care delivery. With these statistics, Owoseye concluded that “Nigeria’s ratio of doctors to population is about eight times below the World Health Organization’s recommendation” (*Premium Times*, February 4, 2019).

Corroborating the above, the then Minister of Health, Prof Isaac Adewole said Nigeria has a shortage of 144,000 health workers. He went further to say, presently, the country boasts of 240,000 nurses and midwives, and by 2030 the country will be needing 149,852 doctors and 471,353 nurses and midwives because it is only 99,120 doctors and 333,494 nurses and midwives that will be available in the year 2030 (*The Nation Newspaper*, May 9, 2017). The shortage of specialist medical personnel is further compounded by the mass migration abroad of Nigerian-trained health professionals, due to poor conditions of service and worsening insecurity in

the country. According to Nwachukwu, (2021), a “House of Commons report in 2020 revealed that 8,241 Nigerians are currently working in various capacities in the National Health Service (NHS) in just England alone, and more are coming”. Based on the analysis and discussion above, it is clear that healthcare services and facilities provided for NHIS enrollees are accessible and available, but limited in supply.

## CONCLUSION

This study made an effort to discuss the underlying issues related to the operations of the NHIS by identifying the basic elements of her services that enrollees, i.e., employees of the federal government, complain about, namely access to the services provided by NHIS. The mixed-methods approach provided quite interesting findings for scholarship on health insurance in a developing economy context. The study found out that the healthcare services provided through NHIS are accessible to employees in the five selected federal ministries in Abuja. However, it is concluded that accessibility can be improved by covering other areas not already captured in the scheme, for example, the provision of eyeglasses, tooth replacement, etc.

Finally, the study revealed that although healthcare services are available to NHIS enrollees in the five selected federal ministries in Abuja, they can be enhanced by ensuring that the healthcare service's qualitative depth and distance of health coverage are not a challenge to the enrollees. The following suggestions will be beneficial for future research: This study was concerned with the efficacy of the implementation of NHIS on access to healthcare in selected ministries in the Federal Capital Territory, Abuja, Nigeria. The sample was drawn from the staff of five selected ministries in the public sector in Nigeria. Similar studies could be carried out among workers in NHIS Offices in other states of the federation and the informal sector. The aim will be to compare what those in the formal and informal sectors are saying about the NHIS.

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