NATIONAL HEALTH INSURANCE SCHEME AND SUSTAINABLE HEALTH CARE DELIVERY SYSTEM IN DELTA STATE (2010 – 2015)

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Abstract
The National health insurance scheme was established for all employees of government including informal sector employees in Nigeria. The NHIS like other social security measures is expected to help make healthcare accessible and affordable to the people of Delta State as well as improved funding and essential upgrading of facilities in the health sector if well managed and implemented. Against this backdrop the study focused on national health insurance scheme and sustainable health care delivery system in Delta State within the period under review. Data for the study were drawn from direct observation, media commentaries and authentic secondary sources. Data were analyzed through qualitative review of literature on the subject matter. Results indicated that inadequate funding among other factors posed a big challenge to the full implementation of the national health insurance scheme and sustainable health care delivery system in Delta State within the period under review. The study recommended among others that the NHIS should expand the participation of the public facilities, help decrease administrative costs, and set a framework for infrastructural development with a continuous supervision mechanism.

Keywords: National Health Insurance Scheme; Sustainable; Service Delivery; Delta State; Nigeria

Introduction

Healthy population and indeed work force are indispensable tools for rapid socio-economic and sustainable development all over the world. Despite this indisputable fact, in Nigeria the provision of quality, accessible and affordable healthcare remains a serious problem (WHO, 2007, Omonian, Bamidele, and Philips, 2009). This is because the health sector is perennially faced with gross shortage of personnel, inadequate and outdated medical equipment, poor funding and policies inconsistence. Evidence shows that, only 4-6 percent of both public and private Gross Domestic Product (GDP) in 2004 was committed to the sector (WHO, 2007). Among other factors that impede quality health care delivery in Nigeria include; inability of the consumer to pay for healthcare services and inequality in the distribution of healthcare facilities between urban and rural areas (Omoruan, Bamidele, and Philips, 2009). Sequel to the aforementioned, the country is continually ranked low in healthcare delivery by World Health Organizations. It is therefore, obvious that unless there is a quick intervention, Nigeria will get to 2025 without a change in her health status. This is where the idea of establishing a governmental body to address health care problems that will provide equitable access to healthcare delivery in Nigeria called the National Health Insurance Scheme (NHIS) in 1999.

Before establishing NHIS in 1999, health systems in Delta State operateda Pay-As-You-Go scheme and payments were based on the nature of services rendered to patients. The health systems in Delta State were plagued by many problem among which was poor funding due to inadequate budgetary allocations. For instance shortage of budgetary allocation released to Delta State health sector, resulted into loss of skilled health professionals, low level of healthy life expectancy and high maternal and child mortality rate. Since the establishment of NHIS programmes in 1999 in Nigeria, there was low level of people's awareness, funding and contribution to the scheme in Delta State because it existed among the public sector workers in the formal sector which covered about 3% of the population (4.1 million) only (Akpovi, 2002, Sanusi & Awe, 2009).

Delta State in its effort to review the state's health policy to ensure access to the use of high quality health care services by Deltans was the first in the country to pass laws establishing SSHIS to implement a mandatory health insurance scheme

in 2015 with plans to capture informal sector as soon as possible. This was aimed at addressing the associated health problems.

The National health Insurance scheme was established for all employees of the Federal Public Service, Federal Capital Territory, States and the private sectors (including informal sector employees) in Nigeria. The major operator under the scheme is the Health maintenance Organization (HMO) which makes payments for services rendered to the enrollee to the health care provider. Being a contributory scheme, employees are to contribute minimum 10% of basic salary while the employers are to contribute 5% basic salary to enjoy health care benefits. This study therefore aims at examining the impact of National Health Insurance Scheme (NHIS) on healthcare delivery system in Delta State.

The Problem

The health services in Delta State are judged to be unsatisfactory and inadequate in meeting the needs and demand of the people as reflected by the low state of health of the population. The falling standard of the health care system are poor service delivery, poor funding, poor health indices, limited access to quality health care, inadequate participation of private sector among others. The usual pattern of health care financing in Delta State, even with all the political will and socio-economic stability may take decades and billions of naira to make the public health institution functional, viable and effective.

The introduction of the National Health Insurance Scheme in Nigeria most especially Delta State is hoped among other things to help reduce or totally eliminate the "misery" in the health sector and help in improving healthcare facilities. The NHIS like other social security measures is expected to help make healthcare accessible and affordable to the people of Delta State as well as improved funding and essential upgrading of facilities in the health sector if well managed and implemented. But over ten years on, not much is known about it, its' mode of operations and benefits are not known to those who are even aware of the programme. It is against this backdrop that this study poses the following questions: What is the level of enrolment into NHIS in relation to funding and indicators of a sustainable health care delivery in Delta State? And, what are the major challenges of NHIS and a sustainable health care delivery in Delta State?

The general objective of the study is to examine the impact of National Health Insurance Scheme (NHIS) on health care delivery in Delta State. Specifically, the study sought to examine the level of enrolment into NHIS in relation to funding and indicators of a sustainable health care delivery in Delta State and identify the major challenges of NHIS and a sustainable health care delivery in Delta State.

Methodology

The study used qualitative descriptive approach, utilizing robust data from official documents and evidence from official documents and relevant agencies. Data collected from the mentioned sources were presented in tables and figures and descriptively analyzed.

Literature Review

The following related literature was reviewed in this study in order to have better understanding of the issues under our investigation**;**

National Health Insurance Scheme (NHIS)

Insurance is an undertaking that involved the regular payment of a token in order to safeguard against loss, sickness or death. According to Burke (1976), an insurance contract is an agreement between two or more parties which is enforceable in law. Awosika (1998) said health insurance is a social security system that guarantees the provision of needed health services to the persons on the payment of token contributed at regular interval.

Health Insurance is a financial mechanism that spreads the cost of medical care over as large portion of the group risk as possible. It is a form of savings set aside to cover relatively predictable contingencies facing individuals or households (Kutzin, 1995). It is a means of removing all part of the economic barrier to health and medical care services. Its purpose is to equalize the distribution of the burden of Medicare among individuals and families (Sarokin, 1975). It also assures that providers will be paid for services rendered. It protects all or part of the citizens from inability to acquire health care because of financial barriers. The National Health Insurance Scheme (NHIS) is a social health insurance scheme (Utman, 1995) and it is the national pooling of contributors from income of eligible persons to provide standard healthcare services to them and their dependants (Edozien, 1997).

According to the National Health Insurance handbook, (1999) it is a social security system that guarantees the provisions of needed health services to person on the payments of token premium at regular interval. Akande (2000) said that the history or government participation in health care dates back to colonial era when the few existing health facilities were maintained for the use and care of the colonial masters and the few civil servants who were Nigerians. Health Care as at then was free partially for all the recipients, being wholly subsided by the government. But as the level of education, awareness and of course population increased, the health demand increased and government had no choice than to restrict herself to the provision of the capital and human facilities for health on a "cash and carry" basis to the demanders of health care.

The National Health Insurance Scheme is a body corporate established under Act 35 of 1999 by the Federal Government of Nigeria to improve the health of all Nigerians at an affordable cost. The NHIS Act is the statutory authority for the scheme's benefit programmes as well sets the general rules and guidelines for the operations of the scheme.

According to Achime and Oyaide (2010) since the National Health Insurance Scheme is income related, it is expected to help in the redistribution of income from people who can afford the payment to those who cannot afford the cost of quality health care services within the economy, which is "rich pay for the poor" the healthy pay for the sick". The number of Nigerians who could not afford good health care is increasing. Health care must be accessible to all Nigerians.

Benefit Packages under NHIS

Health Insurance is basically, a social security system that guarantees the provision of needed health services to persons on the payment of token contributions at regular intervals, this is in tandem with the United Nations (UN) Sustainable Development Goals (SDGs) of ensuring healthy lives and promote well- being for all at all ages. The following among others are the benefits Nigerians stand to get from the NHIS packages

i. Outpatient care (including necessary consumables): Treatment that does not require an overnight stay in the hospital or medical facility, including necessary drugs, injection, drip etc.

ii. Prescribed drugs, pharmaceutical care and Diagnostic tests as contained in the NHIS Essential drugs list and Diagnostic Test Lists.
iii. Diagnostic tests as contained in the NHIS diagnostic test list.
iv. Antenatal care.
v. Maternity care for up to four (4) lives births for every insured contributor/ couple in the formal sector program. Additional care is also available if any stillbirth occurs.

Considering these benefits accruing to individuals who are part of the National Health Insurance Scheme (NHIS), the programme works when an employer registers himself and his employees with the scheme. Thereafter, the employer affiliates himself with NHIS approved Health Maintenance Organization (HMO) that will thereafter provide the employee/contributors with list of NHIS accelerated and approved health care providers (public and private) to choose from. The employee registers him/herself and dependants with such provider of his/her choice. There is extra dependant form also to be completed (optional) for those who have more than the stipulated number of wives or children and for those who want to add their parents or relatives, and this is done at an additional fee different from the 5% contribution of the employee (NHIS Act, 2009). There is a place for alternative provider for those whose families are outside their state of posting. So there are the opportunities of choosing say a provider (primary) in the state where you work and if your family is in say Abeokuta, you can choose a provider (alternative) for them in Abeokuta (Achime and Oyaide2010).

Upon registration, the employee/contributor and his/her dependants are issued with NHIS certified identity card with a Personal Identification Number (PIN). In the event of falling ill, the employee/contributor and or his/her dependants present the identity care to his/her chosen primary health care provider for treatment. The enrollee will be able to access care after a waiting period of thirty (30) days, this will enable the completion of all administration processes (NHIS Act, 2009).

Enrollee/contributors has the right and privileges to change his/her choice of primary provider after a minimum of six (6) months, if he/she is not satisfied with the services provided (NHIS Act, 2009). The Health Maintenance Organization (HMO) makes payments for services rendered to the enrollee to the health care

provider. An enrolment may however be asked to make a token payment called co-payment at the point of service (where applicable), usually at the pharmacy. This co-payment of 10% is only on total cost of drugs presented and it's a mechanism to check abuse of the system (NHIS Act, 2009).
In his opinion, Akande (2000) stated that the benefits in National Health Insurance Scheme could be accessed to the contributions of 15% of basic salary and earnings related where the employee pays 10% while the employee contributes 5% basic salary to enjoy health care benefits. However, the contributions made by and for an insured person entitle him or herself a spouse and four (4) biological children who must be below age of (18) eighteen to health care benefits as contained in NHIS benefits package. More dependants or a child above the age of eighteen could be covered on the payment of additional contributions by the principal beneficiary.

Cases that require specialized attention are referred following the laid down guidelines from primary to secondary and tertiary levels. Referral can be vertical or lateral. A patient may be referred from a primary to a secondary/ tertiary service facility or from a secondary to a tertiary service facility due to need for specialized investigations, for medical/ surgical reasons or other services diagnostic, physiotherapy etc. approval by the HMOs is necessary, except in emergencies and notification of such should be served within 48hrs. Referrals are made to the nearest specialist as contained in the list of NHIS accredited facilities in the area (NHIS Act, 2009).

Health Care Financing in Nigeria
A wide range of systems is used for financing personal health care, whereas public health services are normally financed by government and provided through government mandated system. Access to personal health care also depends on various mechanisms with varying degrees of financial involvement in government, social and private insurance scheme e.g. (NHIS), foreign donors, non-governmental organizations and individuals.

Akpovi (2002) asserted that the pattern of the public and private financing of health care in Nigeria is politically inadequate and economically inefficient to meet the goal of national policy on primary health care. Although the private sub sector of health care delivery is active and substantial in Nigeria but such private

spending had little or no impact on the low cost services for health care within the country. The underlying reality in Nigeria's health care problem is the decreasing availability of public funds of the federal, state and local government. Spending is highly dependent on federal assistance; the down turn in the world's oil market after 1984 seriously reviewed the resources available for public spending on health sector. Health care managers are often faced with various options in generating financial resources for effective management of health sector. The problem accompanying the options and choices for funding health sector is also likely to have implications for different approaches, however, the appropriate methods of financing of the health sector is complicated since the mechanism are numerous, their operations are often complex and their effects multiple.

It is obvious that government alone cannot afford the cost of providing the required resources without some assistance. It became clear that the major problem the health sector faces is one of pervasive under funding and insufficiency of financial resources to provide pertinent health care. This problem of resources efficiency is exasperated by confuting pressures which health care managers have to contend with. On the other hand, financial difficulties arising from the budget deficit and debt problem of government indicate the need for reduced expenditure on the health sector.

Achime and Oyaide (2010) opined that the present economic down turn in the country has increased the constraint of the Federal Government in funding Primary Health Care Services. Consequently, local governments and communities have been urged to increase their efforts in exploring other sources of funding and to make efficient use of the meager available funds. Although, the World Health Organization (WHO) (2000) recommends that at least 5% of a nation's budget be set aside for health, this has not been practicable in Nigeria.

With the NHIS set up as the health insurance with the enrollees willing to test new financing option and demand health insurance, that is, they become registered member of NHIS. Not everyone will fall sick, but a certain proportion may fall ill during the time (note their premium is paid for) and how to access and get health care at the health care provider level.

It is worth noting here that the positive experience with the NHIS in terms of immediate access to care and benefits for their health will create trust for the scheme and will convince people in other sector to join the scheme, while existing enrollees prolong their membership especially in CBHI. The provision of healthcare is a concurrent responsibility of the three tiers of government in Nigeria. The mixed economy practiced in the country also gives room for private sector participation in medical care provision.

NHIS is therefore a mixed bag of two broad categories of stakeholders-government and the private sector. A breakdown of these stakeholders include government at all levels, employers (in the public or private sector organization, self-employed and Rural Community Health Insurance Programme, health maintenance organizations, board of trustees, health providers (including primary, secondary or tertiary healthcare providers), international organizations (including donors and collaborating partners), commercial banks, NGOs, community leaders and the media (Executive Secretary NHIS, 2009). Government under the scheme provides not only standards and guidelines but ensure the enforcement of the same for the smooth and effective running of the programme. Apart from funding by government and donors or partnering organizations, employees under the scheme contribute 5 percent of their basic salary while the employer 10 percent of their basic salary to NHIS (Executive Secretary, NHIS, 2009).

Theoretical Framework

The theoretical framework for this study is Development theory propounded by Higgins (1977). In line with developmental strategies of the state through rich sustainable Health plan to ensure stable Healthcare for the teaming population, Development is associated to any efforts of the government and other well organized bodies or institutions in order to increase the standard of human welfare, while anything that undermines Health and welfare is anti-development. And this will damage people's relationships, productivity, determination of the equality of life, destruction of traditional cultural values, increase inequalities, lead to poverty, unemployment and hunger/starvation (Higgins 1977:117-8). Seers (1979) sees development as very holistic improvement in all endeavour through available sectors so that the effects will undoubtedly be noticed in all aspects of human life; political, economic, social, cultural, international, etc just like Gundre

(1967) in his capitalism and underdevelopment in Latin America. Political, healthcare sustainability and economic development seeks system stability and system integration. (Okoli 2003:33).

The theory posits the use of policies to strengthen the healthcare delivery of a nation by allowing for competiveness to ensure higher returns through productivity. All category in our population must be economically mobilized and empowered to make needful input to the national development. It is the right of people to enjoy good standard of living through sound healthcare provision so laws of the state should champion that course for national development. It also shows that is the responsibility of states to run a Health system that ensures welfare of its people to world standard.

Findings and Discussion

Level of Enrolment into NHIS in relation to funding and Indicators of a Sustainable Health care Delivery in Delta State.

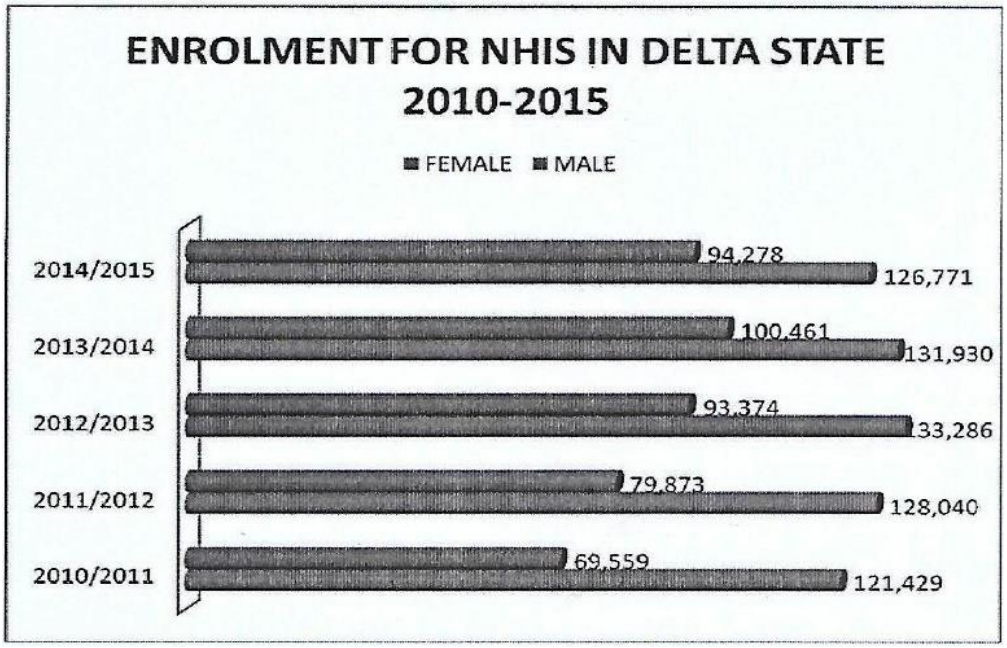
The sustainability and viability of a country's economic and social growth depend largely on vibrant healthcare sector of the nation, hence National Health Insurance Scheme (NHIS). The Delta State vision 2020 has a chapter on Human Development of which education and healthcare are key components. The vision of the health sector, as articulated in the plan, is high quality, accessible and affordable health care delivery for all Deltans, while the mission is to provide standard and adequate facilities, infrastructure and human resources to achieve the highest quality of healthcare that is globally competitive. While Nigeria's National Health Insurance Scheme (NHIS) has been made optional for its citizens, statistics have shown that 12 years after the establishment of the scheme, the impact of NHIS is still placed at 25%.

Table 1: Enrolment for NHIS in Delta State, 2010 — 2015

S/N	Year	Male	Female	Total
1	2010/2011	121,429	69,559	190,988
2	2011/2012	128,040	79,873	207,913
3	2012/2013	133,286	93,374	226,660
4	2013/2014	131,930	100,461	232,391
5	2014/2015	126,771	194,278	321,049
	GRAND TOTAL	641,456	537,545	1,179,001

Source: *Adapted from the Delta State Development Performance Assessment Report, 2010-2015*

Figure 1: Enrolment for NHIS in Delta State, 2010-2015



Source: *Delta State Development Performance Assessment Report, 2010-2015*

Figure 1 reveals the Delta State slow growth enrolment into National Health Insurance Scheme between 2010 and early 2015. The assessment revealed that contribution to the health insurance scheme was unpopular and facing resistance from civil servants in Delta state.

Consequently, there was no pre-payment arrangement being implemented. The Professional Associations however worked with the State Ministry of Health SMoH to mount a campaign to educate the general public about the merits of the fund pooling arrangement that allows sharing of financial risks due to health expenditure.

In 2015, Delta state being the first state in the country to have passed laws establishing SSHIS to implement a mandatory health insurance scheme, garnering over 321,049 registered enrollees within few months of new administration, a result that has shown that right health insurance models can achieve results. The scheme commenced services in 63 secondary healthcare facilities for pregnant women and children under-five years with the transition of free maternal and child health programme into the state before the end of December, 2015 through partnership, especially in healthcare service disadvantaged areas, adding that as at mid-year, it had a total 26,905 pregnant women and 44,445 children under five years who have been registered and were receiving treatment budgeted and paid for by the government.

About 100 Primary Healthcare Centres (PHC) spread across the state have been considered appropriate to commence provision of service under the scheme in August 2017 and a quality of service improvement programmes has been initiated to achieve 100 PHCs through partnerships, especially in healthcare disadvantaged areas.

The public sector workers in the formal sector group have signed up to be included in the scheme with the commencement of deduction of 1.75 percent of their consolidated salary, while the government will contribute an equivalent 1.75 % on their behalf, and so far, over 49,000 public sector workers have been enrolled in the scheme.

The next plan is to capture the informal sector that is the okada riders, market women and so on. The aim is to have a large number, because it has to be a pool, and health insurance coverage works better with numbers. The premium of N7,000 was adopted after consideration and review of the actual analysis report with focus on the affordability of the average family to ensure no one is left behind.

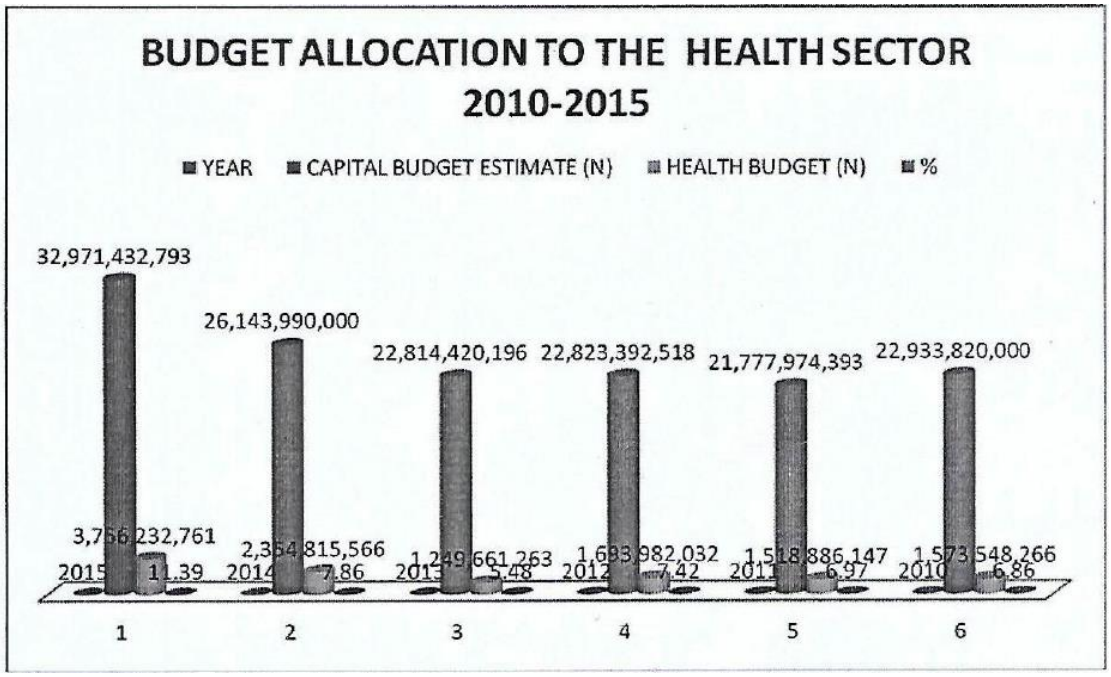
In order to have a well expanded health insurance coverage, the Delta stage government under Senator Dr. Ifeanyi Okowa first determined key household demography and health seeking behavior of Deltans to guide her planning. They determined the current household spending on health, insurance coverage needs willingness to pay for health insurance by Deltans.

Table 2: Budget allocation to the health sector, 2010-2015

Year	Capital Budget Estimate (N)	Health Budget	%
2010	22,933,820,000	1,573,548,266	6.86
2011	21,777,974,393	1,518,886,147	6.97
2012	22,823,392,518	1,693,982,032	7.42
2013	22,814,420,196	1,249,661,263	5.48
2014	26,143,990,000	2,354,815,566	7.86
2015	32,971,432,793	3,756,232,761	11.39

Source: *Delta State Development Performance Assessment Report, 2010-2015*

Figure 2: Budget allocation to the Health Sector, 2010-2015



Source: *Delta State Development Performance Assessment Report, 2010-2015*

They also estimated the proportion of Delta State residents in the lowest socio-economic quintiles and availability and capacity of health delivery facilities in Delta State to deliver proposed health insurance services.

The current Delta State administration of Gov. Okowa, established a law that 0.55% of the consolidated revenue of the state goes direct into health insurance, such that it won't only exist at the mercy of subsequent governors. In order to reduce administrative costs, the State deployed competent staff from the civil service who are already on payroll of the government and trained to work in the commission as against engaging health workers that becomes expensive to manage.

Table 3: Health Indicators for Delta State, Nigeria, 2010 - 2015

Year	Birth rate	Death rate	Infant mortality Rate	Maternal Mortality Rate	HIV Prevalence	TB Prevalence
2010	22,023	1497	48	456	254 (3.4)	28
2011	22986	1497	68	430	299 (2.9)	30
2012	19,289	1368	37	410	132 (2.5)	34
2013	25,057	1409	102	290	201 (2.6)	59
2014	27,149	1560	54.5	270	228 (2.9)	69
2015	30,162	1002	14	130	100 (2.0)	12
Total	146,666	8333	323.5	1910	1364	232

Source: *Delta State Development Performance Assessment Report, 2010-2015*

Birth rate

In the analysis of the data above, it shows that the proportion of births attended by skilled birth attendants were 22,023 in 2010 representing 15%, 22986 in 2011, representing 64%, 19,289 in 2012 representing 13%, 25,057 in 2013 representing 17%, 27149 in 2014 representing 19 % and, 30,162 in 2015 representing 21% respectively. In 2015 there was an increase in birth rates which was attributed to improved antenatal care coverage of four or more clinic visits under NHIS. There was also deployment of midwives to improve the quality of healthcare in the state.

Death rate

In 2010 and 2011, the death rate was 1497 which represents 18%. The rate reduced to 1368 in 2012 and increased to 1368 in 2012. The death rate increased to 1409 in 2013. Again, in 2014 the death rate was 1560 and extremely declined to 1002 in 2015 which stand for about 12% of death rate. It was observed that between 2010–2014, the estimated figures of death rate with all the indices on the high side are unfavourable. This might be attributed to low funding, poor infrastructure with consequent adverse effect on health status of the state. The figure in 2015 showed

the state of provision of infrastructural facilities, increased funding and high enrolment into NHIS with improved health gains as indicated in table 3 above.

Infant Mortality Rate

Infant mortality rate which increased from 48/1,000 live births in 2010 to 68/1,000 live births in 2011, reduced to 37/1,000 live births in 2012. Infant mortality rates stood at 102/1000 live births in 2013, 54.4/1,000 live births in 2014 and 14/1,000 live births in 2015. The table 3 shows that reduction in the mortality rate in 2015 was achieved as a result of the proportion of births that were attended to by skilled birth attendants under NHIS programme. There were routine immunization and special campaigns for measles and polio immunization. Before 2010, all these services were provided under a cost recovery at the primary, secondary and tertiary levels. But by 2015, the Delta State Government launched free Under-5 Healthcare Scheme under NHIS, which provided diagnostic and treatment services to children under age five.

Maternal Mortality Rate

Maternal mortality rate has progressively declined in the years under review (2010-2015), falling from 456/100,000 live births in 2010 to 430/100,000 live births in 2011.The maternal mortality rate was 410/100,000 in 2012 and 290/100,000 live births in 2013.In 2014 the rate further reduced to 270/100,000 live births. In 2015, 130/100,000 live births was achieved through the Delta State government's effort to equitable access to quality health care services. In a bid to promote safe motherhood and reduce maternal deaths, family planning, antenatal delivery, postnatal and emergency Obstetrics services were delivered under the State Health Insurance Scheme. The Nurses were trained on Live Saving Skills (LSS) and Doctors on Elongated Life Saving Skills (ELSS). There was improved preventive, diagnostic and treatment service utilization.

HIV Prevalence

As seen in Table 3, for each of the years shown the HIV prevalence was 3.4 percent in 2010, declining to 2.9 percent in 2011. The prevalence was 2.5 percent in 2012 and slightly increased to 2.6 percent in 2013. Again, in 2014 the HIV zero-prevalence rate was 2.9 percent declining to 2.0 percent in 2015. It was observed that in 2015 there was a significant decrease in the number of people with HIV. This is attributed to the scaling up of Anti-Retroviral Services (ART) which

targeted eliminating mother to child transmission of HIV by 2015 under National Health Insurance Scheme (NHIS). This was achieved with the support of the Institute of Human Virology (IHVN) undertaking HIV counselling and testing, and building the capacity of health workers under the scheme.

Tuberculosis Rate

There was steady increase in sputum smear positive rates of 28/100,000 population in 2010, 30/100,000 population in 2011 and 34/100,000 in 2012 and 59/100,000, 69/100,000 in 2013 and 2014 respectively. In 2015, there was reduction in the prevalence of deaths from TB infections 12/100,000 by more than 50 percent compared to the figure of 2010. The state empowered people with TB and communities through partnership, advocacy, communication and social mobilization and fostering community participation in TB care and prevention and health promotion through the state National Health Insurance scheme.

Major Challenges of the NHIS and a Sustainable Health Care Delivery in Delta State

There is no doubt that the health insurance scheme in Nigeria since its inception, has to a large extent positively affected the lives of its enrollees among which include reduction in the rising cost of health care among the participants, the restoration of confidence in primary and secondary levels of health care, etc. Besides, the Delta State Development Performance Assessment Report, the major challenges militating against the timely achievement of Health insurance outcomes in Delta State are as follows:

Poor Remuneration of Doctors and Health Professionals: In Delta State, Doctors and other health professionals are severely underpaid. Nonpayment of salaries and other benefits lead to nonchalant attitudes of health workers to the patients. Routine strikes disrupt the delivery of health services and lower the overall quality of healthcare. During the period of strike patients resorts to traditional medicine or quacks and roadside drug vendors because they are unable to get an appointment with a professional doctor.

Inadequate community involvement and participation: NHIS Delta State has really done a lot in the areas of awareness and orientation. They have used various channels in efforts to improve penetration, they have also carried out advocacy visits and provided supports to individuals, there is however an existing channels

that have not been harnessed properly, this is more grass root oriented and strong community participation which has health service ownership and sustainability uncertain. The community needs to know that their health insurance program is not just one of those government hand-out programs.

Problem of distribution and provision of medical facilities: Over 90% of the disease burdens are in the rural areas, with a corresponding less than 10 per cent of the facilities (Delta State Health Development Plan, 2010). Moreover, many of the health human resources are based in the urban areas and are not ready to move to the rural area to work. This is due to the dearth of infrastructures such as schools for the children, potable water, and electricity, among others.

Treatment coverage: There is big gap in the services that are covered under NHIS. NHIS cannot handle major illness like big surgeries, treatment of HIV, cancer etc. to a large extent, there is a high level of dissatisfaction among the enrollees because with a major illness, NHIS cannot handle it. At the end of the day, patients will end up in treating only ailments like malaria and typhoid.

Non-availability of quality drugs: This is one of the major challenges and limitation in the effectiveness of NHIS in Delta State. Drugs at health facilities were generally regarded as an essential aspect of quality service delivery. Access to drugs motivates people to seek health care and to enroll and remain in the NHIS. Lack of drug makes health insurance less attractive.

Non- reimbursement of health providers claims: The health providers complained that delays in claiming reimbursement negatively affected their cash flow and supplies and this led to low stock levels in the hospitals (Agbola, 2000). These delays made providers refuse to offer services to some insured clients. Other challenges affecting NHIS and sustainable health care delivery in Delta State were the stigmatization of people living with HIV & AIDS which prevents them from disclosing their zero-status and accessing needed drugs and services (Awosika, 1998).

Conclusion

Nigerians desire and deserve easy access to qualitative health care, however, this desire has not been met by Nigerian government, consequently, the health situation of the people of this country has remained unstable due to the onslaught of infectious diseases and poverty. Having delved extensively into the research,

we make bold to conclude that the implementation of the recommendations of this study will improve the National Health Insurance Scheme effectiveness in Delta state which will provide quality services to the clients.

Recommendations

Based on the findings of this study, the following recommendations are made:

i. Law establishing the NHIS should be made compulsory, and mandatory in order to ensure access to basic healthcare services to all residents of Delta State at an affordable cost.

ii. There is the need to digitalize and create systems that make bureaucracy minimal and give technology solution that makes the process seamless e.g. Premium can be paid with a POS, ATM and Online.

iii. The scheme should expand the participation of the public facilities, help decrease administrative costs, and set a framework for infrastructural development with a continuous supervision mechanism.

iv. The Office of the Special Adviser to the Governor of Delta State on Project Monitoring should provide and mandate a focal person for monitoring health insurance scheme, its implementation using elaborated M & E result framework. There should also be periodic assessment of achievement and progress towards MDG and reporting of cooperation of all stakeholders.

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