A COMPARATIVE ANALYSIS OF NATIONAL HEALTH INSURANCE SCHEME (NHIS) AND NATIONAL HEALTH INSURANCE AUTHORITY (NHIA) ON UNIVERSAL HEALTH COVERAGE (UHC) IN NIGERIA

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Health Insurance, Enrollees, Service Delivery, UHC and Health Service Providers

ABSTRACT

Background: NHIS was established for the purpose of attaining Universal Health Coverage (UHC) in Nigeria. However, the agency has less than 5% enrolment in 20 years. In effort towards bridging the above gap, NHIA was set up in 2022 as replacement for NHIS. Hence, the need to conduct a study to ascertain what makes NHIA different from NHIS. This is the gap that this paper intends to bridge.
Objective: The objective of this paper is to examine the extent to which NHIA has guaranteed UHC in comparison with NHIS.
Methods: The paper adopted a qualitative technique of data collection with the use of textual content analysis of documents obtained from concerned agencies.
Results: The findings of the paper reveal that both NHIS and NHIA have not been able to guarantee UHC due to insufficient manpower, inadequate equipment, non-availability of essential drugs, lack of protection for vulnerable groups and poor service delivery.
Conclusion: The study concludes that the inability of NHIA to make a noticeable different in its performance is due to lack of effective monitoring and regular enforcement of guidelines.
Key Contributions to Knowledge: The study contributed to knowledge through a comparative analysis of the performance of NHIS and NHIA.
Recommendations: The study recommends for proper supervision and regulation of health care service providers by NHIA in order to enforce compliance with relevant laws. Also, the challenges of poor funding, corruption, poor serviced delivery, protection of vulnerable groups, lack of sufficient drugs and facilities should be tracked by NHIA.

Introduction

The idea of attaining Universal Health Coverage became necessary at the end of World War II in order for Nations of the world to take care of injured citizens fairly and equitably. Similar, Universal health coverage was contained in World Health Organisation (WHO) Constitution of 1948. The constitution emphasized the attainment of highest health standard for all (WHO; 2010 Rodin & De Ferranti; 2012).

Subsequently, the Alma-Ata Declaration (1978) has a target of health care for all by the year 2000. Thereafter, the World Health Organization (WHO) in 2005 at its 58th assembly re-echoed that nations should introduce health insurance scheme for citizens (Rodin & De Ferranti; 2012). Moreover, United Nations (2012) directed countries of the world to adopt Universal Health Coverage for all as immediate priority. This finally culminated in making UHC as the 3rd of 8th goals of the Sustainable Development Goals in 2015 (Savedoff, & Alwang, 2015)

A review of existing literature reveals that the practice of health insurance has been very successful in developed countries of the world (Mokoena & Naidoo, 2024; Tangcharoensathien, Witthayapipopsakul, Panichkriangkrai, Patcharanarumol & Mills, 2018. For instance, the introduction of Statutory Health Insurance (SHI) in Germany recoded 90% coverage of the country's population (Busse and Blumel (2014), Japan practices Universal Health Insurance (UHI) that covers the whole population (Ikegami and Anderson, 2012). United Kingdom established the National Health Service (NHS) that provides inclusive health care services to all citizens. The scheme is financed through public tax system and provides free medical services to the citizens (Appleby & Harrison, 2013). In the case of Taiwan, National Health Insurance (NHI) was compulsorily introduced to all citizens. The scheme is financed through flexible payment plans with varieties of options (Cheng and Chiang, 2013). Similarly, South Korea puts in place National Health Insurance (NHI) that renders variety of health care services to all citizens (Kwon and Lee, 2014).

The success stories recorded by the countries practicing health insurance as presented above made Nigeria as a nation to introduce the National Health Insurance Scheme (NHIS) in May 1999 under the NHIS Act 35 with the aim of achieving Universal Health Coverage (UHC) for all categories of citizens by 2015 (Health Maintenance Organizations (HMOs), 2023, Stephen, 2023). Meanwhile, the activities of the organization commenced fully by 2005. The scheme has contributed immensely in the provision of affordable and accessible health care services to formal sector since public servant are to pay 10% of service cost only. However, it has not guaranteed national health coverage since citizens from the informal sectors are paying N15,000 annually (NHIS, 2020). In view of the above, only 5% of Nigerian Citizens have access to NHIS healthcare services. Similarly, 70% population in Nigeria are responsible for paying for medical bills out-of-pocket in both public and private hospitals 15 years after the implementation of Scheme (NHIS, 2020).

The low coverage of NHIS is due to lack of adequate awareness, obsolete equipment, inadequate personnel and unstable nature of health care professionals (Eze and Adeloye, 2024). For instance, it was reported that the number of doctors in Nigeria were 39,912 and 44,021 in 2017 and 2018 respectively. However, the number of doctors reduced abysmally to 24,640 in 2019 (NBS, 2021). Efforts toward addressing the challenges confronting the effective implementation of NHIS led to the introduction National Health Insurance Authority (NHIA) by the administration of President Muhammadu Buhari on 19th May, 2022. Unlike the previous programme that was referred to as "scheme", the use of "Authority" for the new agency is to command, superintend, support, control, incorporate health insurance scheme and enhance private sector participation in order to attain Universal Health Coverage (UHC) target. The intended steps towards the attainment of UHC according to NHIA Act are to make health insurance compulsory for all citizens, reinforce health funding mechanisms, facilitate improve revenue generation and incorporate 83 million vulnerable groups into the scheme (NESG, 2024).

NHIA made provision for State social health insurance agencies to oversee the use of health facilities, regulate the activities of Health Maintenance Organizations (HMOs), Mutual Health Associations and Third-Party Administrators and address complaints brought against health care providers by enrollees. The enabling Act equally empowers private health insurance to handle auxiliary remunerations

(top-up) under the supervision of NHIA ((NESG, 2024). The results obtained from existing literature reveal that some of the deficiencies identified in the implementation of NHIS were addressed by NHIA. For instance, access to healthcare services was made mandatory to all categories of enrollees both in the formal and informal sectors. Similarly, NHIA was empowered to invest funds for future use without tax on such investment. In efforts towards ensuring prudent management of resources, the state health agencies were empowered to handle financial matters and handle complaints from enrollees which were hitherto the responsibility of HMOs (Salami, 2023). However, challenges such as low government funding of healthcare services, low coverage of healthcare provision and low enforcement of the provisions of NHIA Act are yet be addressed (Michael, Adekunle, Aderonke, Oladapo, and Makanjuola, 2022).

Conversely, a study conducted by Akinlolu and Olufemi (2023) reveal that NHIA has enhanced wide coverage for vulnerable and physically challenged people, reduced health inequalities between enrollees from formal and informal sectors and improved access to health services. The inability of scholars to come up with common opinions on the comparison between the performances of NHIS and NHIA constitute a research gap in literature. Therefore, this study aims to carry out a comparative analysis of NHIS) and (NHIA) on the attainment of Universal Health coverage with emphases on the rate of enrolment, nature of health services, funding and population coverage.

Conceptual Clarification

The need for clear understanding of the concepts below became imperative in order to familiarize readers with the central ideas of behind the conduct of this study:

a. Health Insurance

Insurance refers to an arrangement whereby advance payments for the purpose of addressing or managing expected future risks. Therefore, health insurance is a situation whereby contributions are made periodically by the insured to insurance company for the purpose of having access to medical care at a reduced cost in future. According to Rosen and Gayer (2014), health insurance is a formal agreement that requires the insured to pay a premium to an insurer in return for lesser medical cost when the need arises. In other words, health insurance is a cover for the insured to alleviate unforeseen medical expenses in future. Similarly, Odeyemi (2021) conceived health insurance as a written agreement that requires insurer to make regular payment for the purpose of paying medical bills. Equally, Onoka (2020) views health insurance as monetary obligations regarding risk-sharing in order to protect beneficiary from making out-of-pocket payment for medical services. The above view was corroborated by Njoku and Adekeye (2014) by asserting that Health insurance is a plan put in place in order to upset the cost of medical bills to be injured in future. For the purpose of this study, health insurance refers to a contract between the insured and insurance company that mandates the insured to make regular payment within a specified period of time for the purpose of having access to medical treatment in future at lesser cost.

b. Health Care Services

Health care services refer to all activities aimed at ensuring total wholeness and wellbeing of patients physically, emotionally and mentally by health care providers through the use of curative, preventive and therapeutic methods. They are range of services rendered by health workers (Doctors, Dentists, Pharmacists, Nurses, Gynaecologists, Surgeon among others) to care, nurture, restore, revive, renew and manage individuals who are sick, wounded or those who require pre-emptive attention. Clinical, surgical, radiological, administrative, diagnostic, therapeutic, preventive, laboratory and supportive services are carried by health care professionals towards ensuring the wholeness of patients. According to World Health Organisation (WHO; 2007), health care activities are conducted by institutions whose responsibilities are to take care of human health. In the same vein, Pereira (2010) conceives health care services as an organised system of team of professionals working in synergy to address health needs of patients. For the purpose of this study, health care services refer to the activities carried out by health workers or health care providers for the purpose of ensuring the total wellbeing of patients.

c. Universal Health Coverage (UHC)

Universal health coverage is one in which all citizens in a given country, nation or region have

access to affordable medical services. In the opinion of According to Okpanchi (2024), universal health care coverage refers to is situation whereby residents in a particular society have access to medical service when the need arises at lesser cost. By implications, universal health coverage is a system put in place to ensure unrestricted access to medical services for all categories of patients including the vulnerable and destitute people in the society without financial burden. Universal Health Coverage aims to enhance population coverage, accessibility to health care services and financial protection,

Similarly, Universal Health Coverage is a situation whereby all categories of patients have access to quality essential, defensive, therapeutic and curative medical services at affordable rate (WHO, 2010). In other words, citizens should be offered the opportunities to receive quality medical treatment without out-of-pocket expenses. Conversely, Uchenna (2019), opines that Universal Health Coverage (UHC) refers to monetary hazard security, fairness, and excellent service delivery to enrolees from both formal and informal sectors of the economy.

d. Formal and Informal Sector Enrollees

Formal sector enrollees are employees from organised businesses or government services with regular income and payroll deductions. premium is often deducted from the emoluments of such employees against health-related expenses at a future date. Enrollees usually access healthcare services from registered healthcare providers with the HMOs managing their healthcare needs (Adesokun, Osemene, Ilori & Ihekoronye, 2020).

Informal Sector Enrollees of NHIS on other hand refers to persons who work in unorganised or unofficial or small-scale businesses. These categories of individuals usually lack formal employment contract, regular income or social security benefits. Such enrolees often engaged in activities such as buying and selling, artisan, cottage industry and private teaching with irregular income and shifting hours. They are vulnerable to occupational hazards due to poor condition of service and lack of protective measures (Aregheshola & Khan, 2022).

Research Methodology

This study adopted a qualitative and documentary method of of data collection with the use of textual content analysis of documents obtained from the Nigerian Medical Association (NMA), World Health Organisation (WHO), NHIS, NHIA, HMOs, health reports, circulars, and empirical studies. Document obtained through the above sources are critically analyzed comparatively on issue regarding the performance of NHIS and NHIA in the quest towards the attainment of Universal Health Coverage (UHC) for Nigeria.

Theoretical Framework

This study adopted the Anderson healthcare utilization model as a theoretic underpinning since it focuses on creating enabling environment wider coverage of health care insurance scheme. The theory is also known as Andersen's Behavioural Model was developed by Ronald Andersen. The model provides a theoretical structure to analyze and explain factors that influence access and the decision of persons to use or not to use existing health care services. First, the predisposing factors that influence individuals' chances of using healthcare services based on the consideration of demographics, age, race, social structure and health beliefs. Second, the enabling factors refers to the availability or none availability of resources that enhance or prevent the use of healthcare services. Third, the need factors refer to the perceived needs for the use of healthcare services which can be influenced by status and symptom (Andersen, 1968: Andersen & Newman, 1973).

The above theory is applicable to this paper since the predisposing, enabling and need factors play major roles in the enhancement or prevention of enrollees into National Health Insurance Scheme (NHIS) and National Health Insurance Authority (NHIA). For instance, demographic factors such as age, race, social structure and belief systems are responsible for wide disparities between the number of enrolees from the formal and informal sector of the economy. Secondly, the none availability of drugs and required heath facilities in NHIS accredited hospitals are largely responsible for low enrolment rates individuals from both formal and informal sector of the economy. Above all, high taste for efficient health care services made most patients of high status and

critical ailments not covered by health insurance to fly abroad for medical treatment from out-of-pocket expenses.

Comparative Analysis between NHIS and NHIA on Matters Regarding the Enhancement of Wider Coverage of Health Care Services in Nigeria

The challenges confronting the effective implementation of National Health Insurance Scheme (NHIS) are largely responsible for its replacement with National Health Insurance Authority (NAIA) in 2022. For instance, only 5% of Nigerian Citizens have access to NHIS health care services while 70% are responsible for paying for medical bills from Out-Of- Pocket expenses 15 years after the implementation of Scheme (NHIS, 2020). The creation of the NHIA was part of efforts to reform and strengthen the health insurance system with the aim of attaining Universal Health Coverage (UHC). Therefore, the aim of this study is to determine the extent to which NHIA has ameliorated the challenges hindering wider coverage of National Health Insurance Scheme in Nigeria as discussed below:

(a) Enrolment Rate

The results obtained from empirical studies (Eze & Nweze, 2018; Ibrahim & Mairiga; 2014 and Onwujekwe & Uzochukwu; 2010) reveal that NHIS succeeded in high enrolment of government workers who belong to the formal sector of the economy. However, the vulnerable groups such as the elderly, destitute, disabled and physically challenged people, self-employed, private sector workers, unemployed, retirees, sick and displaced individuals in the society are paying for medical services Out-Of-Pocket expenses. For instance, high level of poverty level among the above vulnerable people in the society made it difficult for them to pay the N15,000 enrolment fees. However, the introduction NHIA led to improved enrollment by the vulnerable groups in the society. For instance, an empirical study conducted by Bamigboye & Igbokwe (2022) reveal that NHIA has encouraged increase enrollment in both the formal and informal sectors of Nigeria's economy. Similarly, efforts were made towards reaching under privileged people in the society such low-income earners and physically challenged through innovative financing mechanisms and government incentives.

The remover of Health Maintenance Organizations (HMO) that acts as middlemen from the administration of funds and procurement of health facilities has enhanced the effectiveness of NHIA in regulating, implementing and payment of the Basic Health Care Provision Fund (BHCPF). This has gone a long way towards increasing access to essential healthcare services by vulnerable people such as low-income earners, pregnant women, and children under the age of five. The establishment of BHCPF has ensured the allocation of funds for the expansion of primary healthcare services through the collaboration of NHIA with State governments in the setting of administration of Primary Healthcare Centers in rural areas (Ogunbiyi & Onwujekwe (2022).

(b) Nature of Health Services

The nature of service delivery by NHIS is a contributory factor to the enrolment rate by vulnerable groups. For instance, the activities of HMOs and health care providers are largely responsible for delay in payment to health care facilities, difficulties in generating authentication codes, infidelity in remittance of premium, insufficient skills, referral system, lack of drugs, ineffective means of communication and nonchalant attitudes (Pillah, 2023). However, the introduction of NHIA has led to marginal improvement in the quality of healthcare services to enrollees by regulating and accrediting healthcare providers, ensuring that qualified facilities participate in the scheme and increasing the number of facilities that meet quality standards (Ogbuabor & Onwujekwe, 2022). Meanwhile, the rate of enrolment by vulnerable group has not significantly improved despites the numerous innovations introduced by NHIA in the area of service delivery system. As at 11th December, 2024 the NHIA reported 19.2 million registered enrollees out of which 2.4 million vulnerable Nigerians were sponsored under the Basic Healthcare Provision Fund (BHPF) (Aregbeshola, 2024). This is a far cry from millions of informal sector individuals who are yet to be enrolled into the scheme.

(c) Funding

Funding has been a major challenge to the effective implementation of National Health Insurance Scheme (NHIS) in Nigeria. For instance, the highest budgetary allocation to the health sector in Nigeria from 2014-2021 is 7.23% (N33.38 billion out of N4.695 trillion). This figure

is a far cry from the 15% annual budgetary allocation recommended by World Health Organization (WHO) and Abuja Declaration (2001) (Aregegbeshola and Khen, 2024 & Budget Report, 2014-2021). In the same vein, Salami (2014) found that the NHIS has not received adequate government support in terms of funding and policy commitment. This lack of political will to fully implement the scheme and expand its coverage, particularly for marginalized groups, has led to slow progress in achieving its goals. Also, Akinlolu & Olufemi (2015) identified corruption, inefficiency, and poor governance as significant barriers to the success of the NHIS. The mismanagement of funds, delayed payments to service providers, and embezzlement of health insurance funds have affected the overall efficiency and integrity of the scheme.

Similarly, Onwujekwe & Uzochukwu (2010) noted that while the NHIS has been partially successful in improving access to healthcare, financial constraints and irregularities in the payment of premiums and reimbursements to service providers remain a major obstacle. These financial gaps affect the quality and availability of services under the scheme. Likewise, delayed payment of premium by employers and HMOs has resulted into high reliance on Out-Of-Pocket payments which are not sustainable. By implications, the low enrolment and premium payment from the informal enrollees has limited the schemes revenue profile.

Efforts towards addressing the challenges confronting the funding of NHIS led to the introduction of NHIA. Report obtained from existing literature reveal that NHIA introduced the Basic Healthcare Provision Fund (BHCPF) to supplement the existing funding sources in order to encourage higher enrolment rates by participants from the informal sector of the Nigeria's economy. NHIA equally introduced measures towards cutting down wasteful spending and improving efficiency of fund utilization through the replacement of Health Maintenance Organizations (HMOs) with the State Health Insurance Schemes (Salami, 2023 & Pillah, 2023).

Likewise, NHIA has fostered collaboration with the private sector, especially in terms of health insurance provision, innovative delivery models, and public-private partnerships (PPP). These collaborations have helped expand the scheme's reach and improve service delivery in underserved areas (Oke, & Adeyemi, 2022). However, the sustainability of private sector participation is quite challenging due to limited capacity in data sharing and management system.

d. Population Coverage

According to Eze & Nweze (2018) NHIS has seen a gradual increase in enrollment, particularly among formal sector workers. However, the informal sector workers (who make up a large percentage of the population) are largely excluded. The informal sector's lack of stable income and the lack of structured employment relationships make it difficult to include them in the scheme. informal sector workers still face challenges like a lack of trust in the system, poor awareness of the scheme, and the absence of a structured mechanism to ensure their participation.

Ibrahim & Mairiga (2014) found that a significant portion of the Nigerian population, especially in rural areas, is unaware of the existence of the NHIS and its benefits. This lack of awareness has contributed to low enrollment and poor participation rates, hindering the scheme's impact. In the same vein, Dada & Okafor (2016) highlighted that many Nigerians, particularly those in rural areas, have limited knowledge about the procedures for enrolling in the NHIS. This lack of education and awareness negatively affects participation and leads to misconceptions about the scheme's effectiveness.

Meanwhile, the NHIA has developed and implemented awareness campaigns that focus on the benefits of health insurance, educating citizens about the importance of enrolling in the scheme. This has resulted in an increase in the number of enrollees, especially from the informal sector, which has traditionally been underinsured (Oke, & Adeyemi, 2022). Under the leadership of the NHIA, Nigeria has made efforts to ensure that vulnerable groups such as children, pregnant women, and people living with disabilities are provided for under health insurance schemes. This ensures that even the most marginalized populations have access to healthcare. The NHIA has implemented policies to expand coverage for vulnerable populations, including pregnant women, children, and people living with disabilities. These efforts have helped reduce health disparities and ensure that more people, regardless of their socio-economic status, have access to essential health services

(Akinlolu & Olufemi, 2023). However, the larger number of individuals from the informal sector of the economy and those from rural areas are still excluded from the NHIA initiatives

e. Service Delivery

One of the major goals of the NHIS is to reduce the financial burden of healthcare on Nigerians by shifting the responsibility for healthcare financing from individuals to a more organized pooling of funds. Ogunlayi & Akinwale (2016). found that the effectiveness of the NHIS is often hindered by poor healthcare infrastructure, particularly in rural and underserved areas. Limited access to accredited healthcare providers, lack of necessary medical equipment, and poor healthcare facility conditions further decrease the quality of care under the scheme.

Likewise, empirical studies reveal that by pooling premiums from employees, the NHIS has helped healthcare providers maintain a more predictable and stable revenue stream. This financial model has allowed healthcare institutions to invest in better facilities and improve the quality of care they offer to insured individuals (Akinyele, 2012). However, Oke and Adeyemi (2017) noted that while healthcare providers under the NHIS may be accredited, they are often faced with problems such as overcrowding, outdated equipment, and insufficient staff. This impacts the quality of care, reducing the overall effectiveness of the scheme.

Meanwhile, NHIA focuses on patient-centered care has led to improved patient satisfaction with enrollees reporting better access to healthcare services and more responsive care. The NHIA Act makes health insurance mandatory for all residents of Nigeria with the introduction of the vulnerable group fund and implementation of the Basic Health Care Provision Fund through the established State Health Insurance Schemes. Unlike the NHIS which is a Scheme, the NHIA is an Authority and has an expanded function to regulate, promote, manage and integrate all health insurance schemes and practices in Nigeria (Salami, 2023 & Pillah, 2023).

Conclusion

This paper is comparative analysis of the performances of National Health Insurance Scheme (NHIS) and National Health Insurance Authority on matters regarding the enhancement of wider coverage of health care services. The outcome of the study reveals that NHIS only has enrolment rate of 5% of Nigerian population for 15 years in existence due to lack of adequate health professionals, insufficient drugs, and high cost of medication, corruption, exclusion of vulnerable groups, lack effective financial administration, transparency and accountability.

The inability of NHIS to meet its targets at the expiration date in 2015 led to the introduction of National Health Insurance Authority (NHIA) Act in 2022. The National Health Insurance Authority came with laudable initiative and various numbers of specific objectives. These include easy access to affordable and qualitative healthcare service for Nigerians' enrollees, protection of families from financial hardship from huge medical bills, ensuring equitable distribution of healthcare costs among different income groups, as well as ensuring efficiency and effectiveness of healthcare service for all enrollees.

Implementation of the programme has to some extent provided many vulnerable and indigent Nigerians easy access to healthcare services. However, for NHIA to fulfil its mandate, concerted efforts must be made by both policy makers, all the stakeholders, and appropriate authorities to review urgently and regularly certain factors that limit its implementation, including inadequate funding, inadequate institutionalization of total quality management, inadequate sensitization of authorization codes, inadequate health personnel, unavailability listed drugs or out-of-stock syndrome in NHIA pharmacies, total exclusion of treatment of critical ailments or sickness from the NHIA, delay and long waiting time to access healthcare. The low level of public enlightenment (awareness) has created an impression that the NHIA is accessible only for those working in the formal sectors.

On the general note, the NHIA is a cost-saving authority for medical expenses on enrollees' easy access to affordable and qualitative healthcare that has been encouraging and worth replicating in both formal and informal sectors globally. Despites the numerous achievements recorded by NHIA as presented above challenges such as the exclusion of treatment of certain ailments or sickness, issues of delay and long waiting time to access healthcare; delay or inadequate sensitization of authorization codes

by HMOs, lack of adequate public enlightenment about NHIA healthcare service, and inadequate institutionalization of total quality management of healthcare facilities are confronting the scheme.

Recommendations

The following recommendations are considered invaluable for NHIA to attainment of goal of Universal Health Coverage by 2030:

i. NHIA should introduce more innovative measures aimed at sensitizing and facilitating the enrolment of more individuals from the informal and vulnerable sector of the society. For instance, measures such as mandatory health insurance, innovative and flexible financial mechanism to improve funding, expand coverage for vulnerable and indigent individuals in the society, and improve the benefit package.

ii. NHIA should increase public enlightenment (awareness) about the opportunities for affordable and qualitative healthcare via social media, print and broadcast media, and collaboration between the leaders of dominant religious (Christian and Islam) as well as traditional leaders so as to sensitize the citizens in rural areas and villages.

iii. None availability of drugs in most NHIA pharmacies serve as additional burden to enrolees through purchase of drugs at exorbitant rates in unaccredited pharmacies. Therefore, NHIA should ensure adequate availability of drugs at affordable rate in all accredited pharmacies for both inpatients and inpatients to encourage the enrolment of indigent and vulnerable individuals in the society. This will equally go a long way in reducing out-of-pocket expenses.

iv. NHIA should review the exclusion treatment of critical ailments or sicknesses such as cancer, diabetes, kidney diseases, tuberculosis, surgery, paediatric-congenital abnormalities, HIV and AIDs from the list of treatments that health insurance cover. This will further encourage the enrolment of informal and vulnerable people in the society into the scheme.

v. There should be increased transparency in the operations of NHIA and healthcare providers. Therefore, toll-free lines should be provided by NHIA as a means of communication and engagement with enrollees in order to obtain feedback from them on the quality-of-service delivery and issues that require urgent attention.

vi. NHIA should effectively monitor and supervise the operation of health care providers in order to ensure effective compliance with the provisions of National Health Insurance Authority Act. This can only be possible through the creation of enrolees-NHIA forum for the purpose of feedback and quality assurance.

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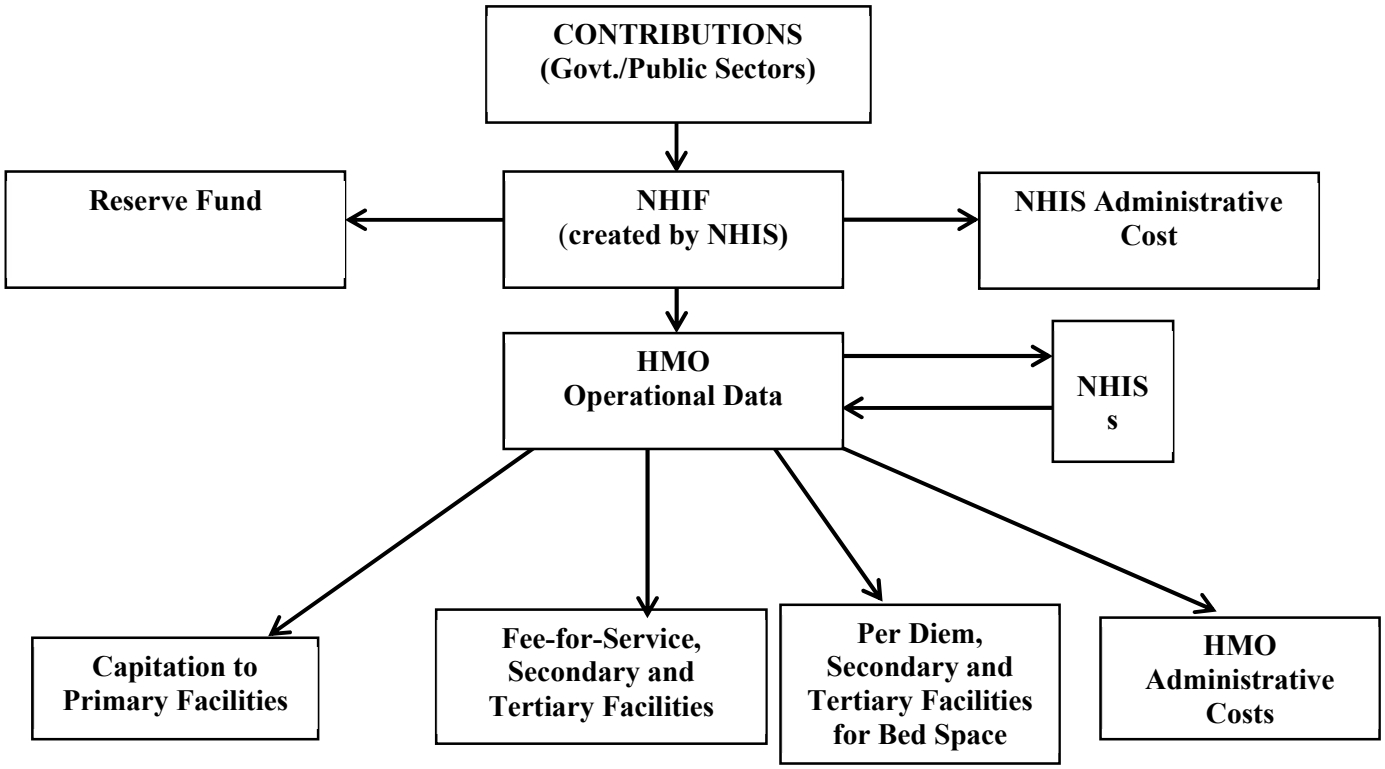
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Appendix

FIGURE 1: Flow of Funds

Transfer of Funds from NHIS to HMO (Formal Sector)



Source: NHIA – Operational Guideline, 2022.