National Health Insurance Scheme (NHIS) and Employees' Access to Healthcare Services in Cross River State, Nigeria

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***Abstract*-Accessibility to healthcare and at affordable cost constitutes a high profile challenge in Nigerian. While government supported universal access to health care through social policy such as National Health Insurance Scheme (NHIS), opinion is polarized among Nigerians on the efficacy of the scheme in addressing the health situation in the country. This study therefore set to investigate the potency of NHIS and employees' access to quality and affordable healthcare in Cross River State, Nigeria. Findings revealed that federal civil servants have more access to NHIS than employees in the state and local government service as well as the self employed. The study also revealed that inadequate personnel and equipment affects the potency of NHIS in Cross River State. The study recommended among others that government should put measures in place to ensure that all civil servants have equal opportunity to NHIS services and that adequate medical personnel and equipment should be provided to ensure effective service delivery.**

I. INTRODUCTION

Healthy population and indeed work force are indispensable tools for rapid socio-economic and sustainable development the world over. Despite this indisputable fact, in Nigeria like most African countries, the provision of quality, accessible and affordable healthcare remains a serious problem (WHO, 2007a; Oba, 2008; Omoruan, Bamidele & Philips, 2009). This is because the health sector is perennially faced with gross shortage of personnel (WHO, 2007a), inadequate and outdated medical equipment (Yohesor, 2004; Johnson & Stoskopf, 2009), poor funding (WHO, 2007a&b), policies inconsistence (Omoruan, Bamidele & Philips, 2009) and corruption (Oba, 2008). Evidence shows that, only 4.6 percent of both public and private Gross Domestic Product (GDP) in 2004 was committed to the sector (WHO, 2007a,b&c). Other factors that impede quality health care delivery in Nigeria include inability of the consumer to pay for healthcare services (Sanusi & Awe, 2009), gender bias due to religious or culture beliefs (NCBI, 2009) and inequality in the distribution of healthcare facilities between urban and rural areas (Omoruan, Bamidele & Philips, 2009).Sequel to the aforementioned, the country is continually ranked low in healthcare delivery by international organizations. In 2000 for instance, WHO report on healthcare delivery ranked Nigeria 187 out of 191 countries (Wikipedia, 2009); eight years later, Human Development Report 2007/2008, ranked the country 158 out of 177. In 2005 only 48 and 35 percents of the children within the ages of zero-to-one year old were fully immunized against tuberculosis and measles respectively. Between 1998 and 2005, 28 percent of the children within the ages of 5 years who suffered from diarrhea received adequate treatment. Between 1997 and 2005 only 35 percent of births in Nigeria were attended by skilled health personnel. Furthermore, between 2000 and 2004, only 28 percent of Nigerians in every 100,000 persons had access to physicians (UNICEF, 2006; World Bank, 2007; UNDP, 2008). While the situation in the health sector persists, Nigeria continually loses her professional to other countries. It was reported in 1986 that more than 1,500 health professionals left Nigeria to other countries. In 1996, UNDP report revealed that 21,000 medical personnel were practicing in the United States of America and UK, while there was gross shortage of these personnel in the Nigerian health sector (Akingbade, 2006). The health situation in the country shows that only 39 percent in 1990 and 44 percent of Nigerians in 2004 have access to improved sanitation. In 1990/92 and 2002/04, 13 percent and 9 percent of Nigerians were undernourished respectively (UNDP, 2008). HIV prevalence in Nigeria within the ages of 15 to 49 years was 3.9 percent in 2005 (UNAIS, 2006). In an attempt to address the precarious and dismal situation in the health sector, and to provide universal access to quality health care service in the country, various health policies by successive administration were made including the establishment of primary health care centres, general and tertiary hospitals. The perennial health problem informed the decision of Gen. Abdulsalami Abubakar on May 10, 1999, to sign into law the National Health Insurance Scheme (NHIS) Decree Number 35 (NHIS Decree No. 35 of 1999); with the aim of providing universal access to quality healthcare to all Nigerians. NHIS became operational after it was officially launched by the Federal Government in 2005 (Kannegiesser, 2009).More than four years of NHIS existence in Nigeria, opinion is polarized among Nigerians on the efficacy of the scheme in addressing the health problem in the country, because of disheartening reports in the continual health situation. For instance, World Bank (2008) survey on the scheme shows that only one million people in Nigeria or 0.8

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percent of the population are covered by NHIS, while many persons have to pay for medical care out of their pockets or do without healthcare. The report further reveals that many low-income persons would not benefit from NHIS for at least another 10 years. The purpose of this study therefore, is to empirically examine the impact of NHIS in Cross River State. Specifically, the study would investigate NHIS and workers access to the scheme in the State.

II. STUDY AREA

This study was carried out in Cross River State, Nigeria. The Sate lies between latitude $5^0$32' and $4^0$27' North and longitude $7^0$50' and $2^0$20' East. It is bordered on the North by Benue State, on the East by Cameroon Republic, on the West by Ebonyi and Abia States, on the South-West by Akwa Ibom State. Occupying an area of 23,74.425 square kilometres, Cross River State is one of the largest states in the Niger Delta Region of Nigeria. The state is made up of three senatorial districts; the state is further divided into eighteen local government areas for administrative convenience, viz: Abi, Akamkpa, Akpabuyo, Bakassi, Bekwarra, Biase, Boki, Calabar Municipality, Calabar South, Etung, Ikom, Obanliku, Obubra, Obudu, Odukpani, Ogoja, Yala and Yakurr.The people of Cross River State are of the Bantu stock who migrated from central Africa. The Efiks, Efuts, Quas, Ejaghams, Ekios occupy the South Senatorial District of the state. Bahumono, Yakurr, Agbo, Boki, Mbembe, Nkim, Olulumo, Ofutop, Abanajum, and Nselle occupy Central Senatorial District, while Yala, Bekwarra, Bette, Utugwang, Mbube, Ekajuk, and Uhelle are of the Northern Senatorial District of the State. Despite the dialectic difference, the people of Cross River State have striking similarities in their mode of dressing, music, drumming and dancing which are indications of common descent.Cross River State people primarily engage in farming, trading and fishing. The state is endowed with natural resources like forestry, rivers solid minerals etc. The state is a home to private and government establishments. Consequently, it work force includes federal, state and local government staff. Others are workers in the private sector and the self employed; the study sample respondents from these categories of workers in Cross River State.

III. HISTORICAL BACKGROUND OF NHIS IN NIGERIA

NHIS was first introduced in Nigeria in 1962, during the First Republic (Johnson & Stoskopt, 2009). The scheme then was compulsory for public service workers. The operation of NHIS was obstructed following the Nigerian civil war. In 1984, the Nigerian Health Council resuscitated the scheme and a committee was set up to look at the National Health Insurance. And in 1988, the then Minister of Health Professor Olikoye Ransome Kuti commissioned Emma-Eronmi led committee that submitted her report which was approved by the Federal Executive Council in 1989. Consultants from International Labour Organization (ILO), and United Nations Development Programme (UNDP) carried out feasibility studies and come up with the cost implication, draft legislature and guide lines for the scheme. In 1993, the Federal Government directed the Federal Ministry of Health to start the scheme in the country (Adesina, 2009).In 1999, the scheme was modified to cover more people via Decree No.35 of May 10, 1999 which was promulgated by the then head of state, Gen. Abdulsalami Abubakar (Adesina, 2009; NHIS Decree No. 35 of 1999). The decree became operational in 2004 following several flagged off; first by the wife of the then president, Mrs Stella Obasanjo on the 18th of February 2003 in Ijah a rural community in Niger State, North Central Nigeria. Since the Rural Community Social Health Insurance and the Under-5 children Health Programmes of the NHIS scheme were flagged up by the First Lady, other flagged offs were carried out in Aba, Abia State South East Zone among others (Office of Public Communications, 2006). As in September 2009, 25 states of the Federation agreed to partner with NHIS. These include- Akwa Ibom, Rivers, Edo, Taraba, Adamawa, Kaduna, Zamfara, Kebbi, Sokoto, Katsina, Nassarawa, Anambra, Jigawa, Imo and Kogi States. Others include Bauchi, Ogun and Cross River States; these states are at various stages of implementation of the scheme (NHIS, 2009).

IV. NHIS: OBJECTIVES AND STAKE HOLDERS

The general purpose of NHIS is to ensure the provision of health insurance "which shall entitle insured persons and their dependents the benefit of prescribed good quality and cost effective health services" (NHIS Decree No. 35 of 1999, part 1:1). While the specific objectives of NHIS include:

1) The universal provision of healthcare in Nigeria.
2) To control/reduce arbitrary increase in the cost of health care services in Nigeria.
3) To protect families from high cost of medical bills.
4) To ensure equality in the distribution of healthcare service cost across income groups.
5) To ensure high standard of healthcare delivery to beneficiaries of the scheme
6) To boost private sector participation in healthcare delivery in Nigeria.
7) To ensure adequate and equitable distribution of healthcare facilities within the country.
8) To ensure that, primary, secondary and tertiary healthcare providers are equitably patronized in the federation.
9) To maintain and ensure 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 provision of healthcare is a concurrent responsibility of the three ties of government in Nigeria. The mixed economy practiced in the country also gives room for private sector participation in medical care provision (Wikipedia, 2009). NHIS is therefore a mixed bag of two broad categories of stakeholders-government and the private sector. A breakdown of these stake holders 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 employees' basic salary to NHIS (Executive Secretary, NHIS, 2009).

V. PAST AND PRESENT CHALLENGES OF NHIS IN NIGERIA

There are a number of challenges facing the actualization of NHIS in Nigeria. Funding remain a major problem to the scheme, the percentage of government allocation to health sector has always been about 2% to 3.5% of the national budget. In 1996 2.55 of the total national budget was spent on health, 2.99% in 1998, 1.95% in 1999, 2.5% in 2000 and a marginal increase to 3.5% in 2004 (WHO, 2007ab&c). Consequently, per capita public spending for health in the country is less than US$5; which is far below the US$34 recommended by WHO for low-income nations (WHO, 2007a&c). While the Nigeria per capita health expenditure dwindles, South Africa per capita health expenditure is US$22 in 2001 (The Vanguard Editorial, 2005).NHIS is also impeded by obsolete and inadequate medical equipment. The country suffers from perennial shortage of modern medical equipment such as X-rays, computerized testing equipment and sophisticated scanners (Johnson & Stoskopt, 2009). And where these equipments are available repair/services are always a problem. According to Oba (2009), this situation is not unconnected with corruption. Money meant to boost the health sector ends up in private pockets; example is the 300 million naira scam involving the Minister of health and his assistants in 2008.Lack of adequate personnel in the health sector is another impediment to the scheme. The country for instance had 19 physicians per 100,000 people between 1990 and 1999 (The Vanguard Editorial, 2005). In 2003 there were 34,923 physicians in Nigeria, that is 0.28 physician per 1000 persons and 127,580 nurses (1.03 nurses per 1000 persons) as compared to 730,801 physician (2.5 per 1000 population) in 2000 in the United States of America; and 2,669,603 nurses (9.37 per 1000 persons). Migration of health personnel to USA, UK etc is jointly responsible for the personnel situation in the health sector. For instance in 2005, there were 2,393 Nigerian doctors practicing in the US and 1,529 in the UK. Attributing factor includes poor remuneration, limited postgraduate medical programmes and poor condition of service in Nigeria (WHO, 2007a). According to World Bank Development Indicators (2005), the personnel situation in the health sector influenced birth attendance in Nigeria. For instance between1997 and 2005 only 35% of births were attended by skilled health personnel in the country.Cultural and religious practices also impact on the effectiveness of NHIS in Nigeria. Sexual inequality still exists and encouraged by some religious/cultural sects in the country because of lack of awareness; women are discriminated against and have limited access to social services such as education and healthcare (NCBI, 2009). Other challenge includes inequality in the distribution of healthcare facilities between urban and rural areas and policies inconsistency (Omoruan, Bamidele & Philips, 2009). Furthermore, poverty and the inability to pre-pay are significant challenge to NHIS. According to Schelleken (2009) "people are not willing to pre-pay; and because people do not pre-pay there is no risk pool. And because there is no risk pool, there is no supply side."

VI. METHODOLOGY

Survey design was adopted in this study, it was opted for because the design uncovered, interpret and integrate data, as well as point to their implication in interrelationships (Cohen & Manion, 1986). It allows for random sampling and the use of questionnaires. It is also used to study people attitude, feelings and opinions (Babbie, 1985). Purposive technique was used in selecting 1200 respondents from among four categories employees in Cross River State, Nigeria. These groups of workers are – federal, state, local government staff and the self-employed.With the aid of purposive technique, 300 respondents (150 from rural and 150 from urban area) were selected from each of the four categories of employees. That is a total of 600 respondents were purposively selected from urban areas and another 600 from rural communities. The distribution of respondents across the 3 senatorial districts shows that four hundred respondents were selected from Northern Senatorial Districts; another 400 each from the South and Central senatorial Districts respectively making a total of 1200 respondents.The study elicited data from respondents via structure questionnaire. The questionnaire was self administered and was divided into two sections. Section A, was the demographic variables of respondents. Section B accorded the study the needed topical data on National Health Insurance Scheme (NHIS) and employees' access to healthcare services in Cross River State, Nigeria. As depicted in Table 1, items in the four point Likert scale questionnaire with positive response were ranked 4, 3, 2, 1, with 4 standing for strongly agree (SA), 3 for agree (A), 2 for disagree (D), 1 for strongly disagree (SD). On the other hand, items that shows dislike were ranked from 1 to 4, with 4 standing for strongly disagree (SD), 3 for disagree (D) 2 for agree (A) and 1 for strongly agree (SA).

Table 1: Coding of Variables

Response Option	Positive	Negative
SA	4	1
A	3	2
D	2	3
SD	1	4

Where
SA = Strongly Agree
A = Agree
D = Disagree
SD = Strongly Disagree.

Descriptive and inferential statistics were employed in the analysis of data collected from respondents. We first analyzed the socio-demographic distributions of respondents in percentage for each variable and then a comparative analysis was made to ascertain the impact of NHIS on each category of workers' access to healthcare. A comparative analysis was also made to ascertain the effect of the scheme on rural and urban workers access to quality healthcare.

VII. RESULTS

The socio-demographic data of respondents is presented in table 2. As depicted in table 2, majority of the respondents were between the ages of 36-40 years (N = 331, 27.6 %). Those within the ages of 31-35 were 22.0 percent (N=264). While respondents within the ages of 51-55 years were 2.9 percent (N=35). Majority of the participants were male (N=659, 54.9%). Female respondents were 45.1 percent (N=541). More than 57 percent of the respondents were married, 17.4 percent were separated, 8 percent were single

Table 2: Socio-demographic Data of Respondents

Variable	Frequency	Percentage (%)
1. Age		
20 – 25	60	5.0
26 – 30	161	13.4
31 – 35	264	22.0
36 – 40	331	27.6
41 – 45	237	19.8
46 – 50	75	6.3
51 – 55	35	2.9
56 and above	37	3.1
Total	1200	100%
2. Gender		
Male	659	54.9
Female	541	45.1
Total	1005	100
3. Marital status		
Married	694	57.8
Separated	209	17.4
Widow	114	9.5
Widower	87	7.3
Single	96	8.0
Total	1200	100%
4. Residential area		
Urban	600	50
Rural	600	50
Total	1200	100%
5.Category of employees		
Federal civil servants	300	25.0
State civil servants	300	25.0
Local govemment staff	300	25.0
Self employed	300	25.0
Total	1200	100%

Source: Field Work 2010.

The distribution of respondents as depicted in table 2 also revealed that equal proportion of participant live in urban and rural areas (N=600, 50%). The study further revealed that a large proportion of the beneficiaries were civil servants (N=900, 75%). Their distribution shows that federal civil servants were 25.0 percent. State and local government staffs were 25.0 and 25.0 percent respectively. Self employed participants accounted for only 25 percent (N=300).The result presented in the upper part of table 3 shows the size, mean and standard deviation of the three groups of respondents on their access to NHIS in Cross River State, Nigeria. The actual result of ANOVA is presented in the lower part of table 3. This shows a calculated f-ratio of 4.671 which is higher than critical F-ratio of 3.00 at .05 level of significance with 2 and 1197 degree of freedom. This implies that respondent's access to NHIS was influenced by the senatorial district they reside. It reveals that, participants in Southern Senatorial District have more access to NHIS than those in Central and Northern Senatorial Districts.

Table 3: Results on one-way ANOVA of Respondents Access to NHIS in the Three Senatorial Districts

Group	N	$\bar{X}$	SD		
Central Senatorial District	400	2.5550	.95617		
Northern Senatorial District	400	2.6425	1.06655		
Southern Senatorial District	400	2.7650	.89822		
Total	1200	2.6542	.97913		
Source of variance	Sum of square	Df square	Mean square	F-ratio	Sign
Between groups	8.902	2	4.623		
Within groups	1140.578	1197	.953	4.671	.010
Total	1149.479	1199			

*Significant at .05 level, critical F = 3.00; N = 1200

Table 4: T-test Comparism of Respondents Access to NHIS Urban and Rural Areas

Group	N	$\bar{X}$	SD	Df	t-cal
Urban	600	2.8467	.93699		
				1198	6.943
Rural	600	2.4617	.98326		

Significant at p>.05, critical t=1.968, df = 1198

Table 4 shows that the value of t-cal (6.943) is greater than t-table (1.968), that is t-cal > t-table at 0.05 level of significance. Suggesting that, there is significant difference between urban and rural dwellers access to NHIS in the three senatorial districts of Cross River State.

Table 5; Analysis of Variance of Employees Access to NHIS among employees in Federal, State, Local Government and the Self Employed

Group	N	$\bar{X}$	SD		
Federal Civil Servant	300	3.2267	.70018		
State Civil Servant	300	2.5867	.84352		
Local Government Staff	300	2.6767	.82120		
Self Employed	300	2.1267	1.16410		
Source of variance	Sum of squares	Df	Mean square	F – ratio	Sign.
Between groups	183.323	3	61.108		
Within groups	966.157	1196	808	75.645	.000

* Significant at .05 level, critical F=3.00; N=1200

There is discrepancy among civil servants in regard to their access to NHIS. The result presented in the upper part of table 5 shows the size, mean and standard deviation of the four groups of respondents (Federal, States and Local Government Staff as well as the self employed) on their access to NHIS. The lower part of table 5 shows the ANOVA, which revealed that the calculated F-ratio of 75.645 is higher than the critical F-ratio of 3.00 at .05 level

of significance with 3 and 1196 degree of freedom. The implication is that federal civil servants (N=300, X = 3.2267) have more access to NHIS than the state employees, local government staff and the self employed in Cross River State.

Table 6: Independent T-test of Availability of Medical Equipment and Effectiveness of NHIS

Availability	N	X	SD	Df	t-cal
Adequate Equipment	694	2.3127	.98264		
				1198	2.102
Inadequate Equipment	506	2.4447	1.18818		

Significant at.05 level, critical t=1.968, df = 1198

Result of the analysis in table 6 shows that the calculated t-value of 2.102 is greater than the critical t-value of 1.968 at .05 level of significant with 1198 degree of freedom. This means that health centers and hospitals that are well equipped have a significant impact on NHIS service delivery.

Table 7: Independent T-test of the Availability of Medical Personnel and the Effectiveness of NHIS

Availability	N	X	SD	Df	t-cal
Adequate Personnel	655	3.1481	.84107		
				1174	6.009
Inadequate Personnel	521	2.8484	.86048		

Significant at.05 level, critical t=1.968, df = 1174

Result of analysis in table 7 shows that the calculated t-value of 6.009 is greater than the critical t-value of 1.968 at .05 level of significance with 1174 degree of freedom. This means that hospitals or health centers with adequate personnel affect NHIS service delivery positively vis-a-vis.

VIII. DISCUSSION OF FINDINGS

Quality health care delivery constitutes a high profile challenge in Cross River State, Nigeria. The drive by government to ensure universal access to healthcare and at low cost through NHIS is proving even difficult. The study demonstrated that there is discrepancy among employees in their access to the NHIS. Specifically the study revealed that federal civil servants have more access to the scheme in Cross River State than state government and local government staff. This may be attributed to Cross River State Government late acceptance of the scheme. According to NHIS (2009), it was only in September, 2009 that 25 states including Cross River, Akwa Ibom, Rivers States among others agreed to partner with NHIS. Awareness, among federal civil servants in different ministries, parastatals, departments and agencies where NHIS was accepted and implemented could constitute a major factor why workers at federal level have more access to NHIS facilities than state and local government staff and the self employed. The discrepancy among employees in their access to NHIS could also be attributing to funds. The cost implication of agreeing to partner with NHIS by state governments and private firms might have delayed the introduction of the scheme in Cross River State. According to WHO (2007 a&b), the provision of quality, accessible and affordable healthcare remains a serious problem because of inadequate funding and lack of government commitment to the provision of health care policies that covers all citizens.Respondents acknowledge that workers in Southern Senatorial District of Cross River State have more access to NHIS than those in the North and Central Senatorial Districts. The reasons could be tied to awareness level in each of the senatorial districts. The Nigerian Television Authority (NTA) station, the Cross River Broadcasting Corporation (CRBC) Radio and Television Stations are all located in Southern Senatorial District. The only state government television station in Central Senatorial District is epileptic in its operation. The distribution of newspapers in the Northern and Central Senatorial Districts of the state is also poor. NHIS programme awareness in the Northern and Central Senatorial Districts of Cross River State is therefore affected negatively by the near absent of information dissemination agencies or bodies.The study also revealed that workers access to NHIS in rural and urban areas recorded significant difference. That is federal civil servants, who are in rural areas had less access to NHIS as against their urban colleagues with high access to the scheme. Similarly, there is discrepancy among colleagues in the state and local government service who work in rural and urban areas. State government staffs in rural and urban areas have unequal access to NHIS. In the same vein, there is significant difference between local government workers in rural and urban areas in their access to NHIS. This could be attributed to the inequality in the distribution of healthcare facilities between rural and urban areas.

According to Omoruan, Bannidele and Philips (2009), the distribution of health care facilities between rural and urban areas constitution a high profile challenge to NHIS in Nigeria.More so, the study revealed that self employed in rural and urban areas recorded significant difference in their access to NHIS. This shows that, there is discrepancy between the level of programme awareness in rural and urban areas. This finding contrast with the observation of NHIS (2006) that, the self employed in urban and rural areas stand a great chance of benefiting from NHIS through Rural Community Social Health Insurance Programme (RCSHIP). Respondents across the three senatorial districts in Cross River State, acknowledged that inadequate and obsolete equipment affects the efficacy of the NHIS in the state. This finding corroborate Yohesor (2004), Johnson and Stoskopf (2009), Omoruan, Bamidele and Philips (2009) and Oba (2009), who observes that NHIS in Nigeria, as in other part of Africa is impeded by obsolete and inadequate medical equipment. This implies that workers and the self employed who have access to the NHIS could not get the best treatment because of lack of adequate medical facilities.The dearth and inadequate medical facilities in Nigerian hospitals is attributed to poor funding of the health sector by government. According to WHO (2007 a,b&c), poor funding of the health sector constitute a major challenge facing the actualization of NHIS in Nigeria. WHO (2007 a&b) observed that the percentage of government allocation to the health sector has always been about 2% and 3.5% of the annual budget. This allocation is very marginal to cater for the operation or implementation cost of NHIS in the country.Corruption could also be responsible for the near absent of medical facilities in Nigeria hospitals. According to Agba, Ikoh, Ushie and Agba (2008), bureaucratic corruption is responsible for government inability to effectively provide social services and reduce poverty in Nigeria. Corruption undermines and weakens vital institutions of development including that of health. Agba, Ushie, Ushie, Antigha and Agba (2009) observed that corruption is responsible for the continual ranking of Nigeria by United Nations Development Programmes (UNDP) as one of the countries with health crisis, high mortality, food insecurity and poor nutrition. Lack of adequate medical personnel in hospitals and clinics is another impediment to the effective implementation of NHIS in Cross River State. Participants both (civil servants and self employed) acknowledge that, though they have access to NHIS, they do not receive the best because of lack of adequate personnel. The situation is even worst in rural areas where medical consultants hardly reside because of poor condition of service. This finding is consistent with WBDI (2005) and WHO (2007[a]), who observed that lack of adequate medical personnel's in clinics, primary care centres, general and tertiary hospitals is limiting the effectiveness of NHIS in Nigeria.According to WHO (2007a), the exodus of medial personnel from Nigeria to the United States of America and the United Kingdom is jointly responsible for the personnel situation in the health sector. WHO (2007a) observe that in 2005, there were 2,393 Nigeria doctors practicing in the US and 1,529 in the UK. Vanguard Editorial (2005) observed that the movement of medical personnel outside the country is detrimental to the health sector; since Nigeria is still managing with 0.28 physicians per 1000 persons and 1.03 nurses per 1000 persons. Under this condition the realization of NHIS objectives in Nigeria becomes an uphill task. It is therefore not surprising that government workers and the self employed who have access to NHIS in Cross River State are not getting the very best of treatment because of inadequate medical personnel. The movement of medical staff outside the country according to WHO (2007) is not unconnected with poor remuneration, limited post graduate medical programmes and poor condition of service in Nigeria.

IX. Recommendations

On the strength of this study finding, the following recommendations were made:

1) Government and other stakeholders should gear up the awareness campaign in all the senatorial districts in Cross River State. The print media, television and radio stations should be mobilized to air NHIS programmes in the state. Village heads, chiefs and religious leaders should also help in the propagation of programme in Cross River State and the nation in general.
2) Hospitals, clinics and health care centres providing health service for NHIS beneficiaries should be properly equipped. Since private clinics and labs are involved in the scheme, government should also provide counterpart funding to ensure that these establishments are properly equipped.
3) Adequate and well trained medical personnel's should be employed to manned the various hospitals, clinics, labs and health care centres where NHIS is providing health services to its beneficiaries. In-service training should be organized to boost the knowledge of the existing staff in the health sector. Private hospitals/clinics participating in the scheme should be mandated by government to ensure that proper and adequate personnel's are employed and trained.
4) Government should increase funding to NHIS in particular and the health sector in general.
5) Government agencies responsible for fighting corruption should peruse the activities of NHIS to ensure that corruption do not limit and weakened the scheme like other programmes in the country.

X. Conclusion

The NHIS is a social security system put in place by the federal government to provide universal access to health care service in Nigeria. The scheme covers civil servants, the armed forces, the police, the organized private sector, students in tertiary institutions, self employed, vulnerable persons, the unemployed among others. More than four years after the scheme became operational in Nigeria, inadequate and outdate medical equipment, perennial shortage of medical personnel, lack of awareness and poor funding is jointly affecting the potency of NHIS in Cross

River State and the nation in general. The provision of quality, accessible and affordable health care to all Nigerians would remain a mirage if these problems that weaken the potency of the scheme are not properly addressed. We therefore suggest that the recommendations made therein be strictly followed.

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