INTERNATIONAL JOURNAL OF RESEARCH AND INNOVATION IN SOCIAL SCIENCE (IJRISS)
ISSN No. 2454-6186 | DOI: 10.47772/IJRISS |Volume VII Issue VIII August 2023

Healthcare Providers and Access to Quality Services Under the National Health Insurance Authority in Kano State, Nigeria

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DOI: https://dx.doi.org/10.47772/IJRISS.2023.7890

Received: 18 July 2023; Revised: 07 August 2023; Accepted: 19 August 2023; Published: 17 September 2023

ABSTRACT

Lack of effective operational facilities and manpower among healthcare facilities has also been attributed to poor operational practices, mismanagement of the government's health care funds, increased health care spending, and a negative impact on patient health outcomes. Like health maintenance organizations (HMOs), healthcare facilities are providers of National Health Insurance Authority (NHIA) for enrollees in the states. However, the roles of these facilities in implementation of social health insurance under the national health insurance Authority of Nigeria are not very well defined in terms of providing health care services as either providers or as well as purchasers. This qualitative, single case study was to explore the roles of these healthcare facilities as regards their impacts in contributing to implementation of the national social health insurance scheme in Kano state, Nigeria. A dominant qualitative design was employed in the study of health maintenance organizations officers using Key stakeholders' interview. Copious notes and transcribed interviews were analyzed. NVIVO version 12 with verbatim transcription was used for thematic analysis of qualitative data. Thus, analysis of the general outcomes showed a significant association between health facilities and quality of services provided. Conversely, findings support that, NHIA providers who attain accreditations and appropriate approvals were short of providing efficient and effective services and maximize their performances in terms of patient's outcome in ensuring achieving universal health coverage.

Keywords: Health maintenance organization officers, National Health Insurance Authority, providers

INTRODUCTION

National Health Insurance Authority (NHIA) is one of the health financing options adopted by Nigeria for improved healthcare access especially to the low income earners. One of the key operators of the scheme is the health care providers, thus their uptake of the scheme is fundamental to the survival of the scheme [1].

The National Health Insurance Authority (NHIA) formerly known as the National health insurance scheme (NHIS) is a corporate body established under NHIA ACT 2022 by the Federal Government of Nigeria to improve the health of all Nigerians at an affordable cost. It is a pre-payment plan where participants pay a fixed regular amount. The amount/funds are pooled, allowing the Health Maintenance Organizations (HMOs) to pay for those needing medical attention via the approved health facilities. It is primarily a risk pooling arrangement associated with the need to use and pay for health services rather than to be fully borne by the individual [2].

While developed countries such as the United States have long histories of hospital accreditation, Nigeria as well as other low- and middle-income countries (LMICs) only started accrediting healthcare providers more

recently as part of efforts to achieve Universal Health Coverage (UHC) [3]. Accreditation tied to pre-determined standards of quality is therefore particularly attractive to countries that aim to achieve UHC through Social Health Insurance, as well as improving their overall health system, allowing government insurers to "purchase for quality" [4]. However, while accreditation does seem to have an effect on quality, these effects are uneven across different areas of care and it is unclear if improvements made to meet accreditation standards ultimately result in improved health outcomes [5].

The Nigerian healthcare industry is facing challenges associated with outbound medical tourism, deteriorating medical infrastructure, low government budget allocation, and poor compensation and subsequent emigration of skilled healthcare workers. Nigeria has one of the fastest growing populations globally with 5.5 live births per woman and a population growth rate of 3.2% annually. It is estimated to reach 400 million people by 2050, becoming the world's third most populous country. The federal government allocated 5% of its budget to health in 2021, compared to the 15% it pledged as part of the 2001 Abuja Declaration [6].

However, in Nigeria, the growing effort by government to provide effective ways of accessing quality and affordable healthcare coverage to attain universal health coverage has been contentious. The cost of health care delivery in Nigeria is high and this poses a serious challenge to the country's health care delivery system [7]. The inefficient management of the health care funds overtime was observed as key contributor to the rising cost of healthcare services. About 3.9 percent of Nigeria's GDP is invested in the health sector, considerably below the average spending on healthcare among OECD countries [8]. In 2019, on average, health care made up six percent of Nigerian household spending, with higher figures in rural areas than in urban zones [9]. Also, on average, about 4% of households are estimated to spend more than half of their total household expenditures on health care and 12% of them are estimated to spend more than a quarter expenditure [10].

With the government lacking the funds to implement its health sector plans, the private sector is emerging as the indispensable player to improve Nigeria's healthcare capacities. The federal and state governments are using the public-private partnership (PPP) model to attract private sector participation in health projects. For example, Lagos state is building a 120-150 hospital bed Medical Park (MediPark) through a PPP to offer a full spectrum of high-tech, cutting-edge specialist medical and diagnostic services. Most private clinics cannot afford new equipment and therefore employ used equipment and most Nigerian hospitals still store patient records manually using traditional paper methods [6].

To address these challenges, the Nigerian government launched a new health policy in 2017. A strategic analysis of the health financing aspect of this policy shows the need for improve funding for health care at all levels of government and thus equitable access to health services by all Nigerians even though there was no demonstrable clarity on how this will be achieved. Furthermore, Successive governments seem to lack the political will to address these shortfalls. Also, critical gaps exist in the country's health laws, making it difficult to implement the strategies proposed in the new policy [11]

Health care systems structure in Nigeria historically was been designed around hierarchical perspectives. These methods rely on bureaucratic operating structure for control, efficiency and stability instead of those that encourage and support innovation, measured risk taking and most importantly change. Apart from these, there has been no emphasis on the traditional healthcare type(s) and a huge vacuum has been created that further entrenched inequality between the haves and have not and between the rural and urban settlements. This dichotomy brought to the fore, the challenges in the healthcare system and other associated services [12]. This is seen with the national health insurances scheme which is more tilted towards the formal sector as against those in the informal sector.

Furthermore, the total expenditure in health amounts to 4.6% GDP. However, financial managerial

competency, besides inadequate funding, remains a major problem. The situation is worse in the states and local government, where even less is allocated to health [13]. This reflects the value the government places on health and it is the most significant challenge faced in achieving UHC by Nigeria [14].

Thus, this study however seeks to assess the impact of accredited healthcare facilities as well as the quality of service they provide under the national health insurance Authority in Kano state, Nigeria. Nonetheless, the study tends to bring to fore the capacity or otherwise of NHIA accredited providers with respect to providing effective and efficient healthcare services as it impacts on access to universal health coverage. The implications of this study are that, the findings may help accredited providers explore strategies to reduce costs and improve efficiencies, quality, and access to care.

MATERIALS AND METHODS

A qualitative study approach method was employed· Data analysis which consists of in-depth interviews with selected Health maintenance organization (HMO) officers who are accredited partner of the social health insurance scheme was carried out.as parts of the HMOs that were approached for the study. The Interviews covered experiences of HMO official's working with hospitals, the opportunities and challenges they faced both with accredited providers and enrolling members. Transcripts were coded in Atlas.ti using an open coding approach and analyzed thematically. Measures were undertaken across the rounds of sampling, data collection, and analysis to increase the validity and reliability of the study. These steps are detailed in each of the relevant sections of the study methods.

Study Area

Source: Map of Kano state: researchgate.net

Kano state is located in North Western region of Nigeria. The city of Kano serves as the state capital and notably the commercial nerve centre of northern Nigeria. According to the federal Republic of Nigeria official gazette 2009, the national population census provisional results of 2006 indicated that the population of kano state was estimated to be about 9.4 million people and was considered the most populous state in the country [15] though unofficial sources have now ranked it second to Lagos state in terms of population growth from the last census. The state comprises of forty-four Local Government areas councils and shares borders with neighboring Jigawa, Bauchi, Katsina and Kaduna states. An estimated 1,346 health facilities

are said to be located in the State according to the Kano state wide rapid health facilities assessment [16]. More than 90% of the inhabitants are from the Hausa-Fulani stock, while Yoruba and Igbo tribes also form a sizeable portion.

Inclusion/Exclusion criteria

Participants are adult HMO representatives and have served in that capacity for their respective organizations for at least 3 years in the state.

Sample population

The selected hospitals were included in the sample to provide a point of comparison against which the study could better determine the effects of their interventions in the scheme. A purposeful sampling strategy [17] that represented providers with a mix of experiences of the scheme were sampled. Purposefully selecting participants who meet criteria strengthens the credibility and validity of a study [18]. Four HMO employees who had varying number of years of service and have served in that capacity were selected. The participants were suitable for this study based on leadership responsibility for the oversight, development, administration, operational strategies and policies and procedures as regards the impact of services provided by their respective organizations with hospitals under the NHIA scheme. The representation of this selected ones ensured that the study met the generalizability and transparency criterial.

Sampling Technique: Multi-stage sampling technique approach was carried out.

Stage 1: Some health facilities were sampled.

Stage 2: Proportional technique used to determine the of health facilities for the study.

Stage3: Systematic random technique and semi-structured interview to select HMO

officers.

Data collection

Also, face-to-face, semi-structured interviews, personal observations data collection methods which was part of reviewing vital records via key indicators (KI) for the purpose of this study was used. During exit interview rounds, permission was obtained to approach HMO representatives for screening. Participants who both met the screening criteria and agreed to an interview were consented and interviewed in an area that was relatively private. In both rounds of data collection, participants were asked a series of questions related to their experience of the NHIA scheme and services of health facilities as well as and operation of their organization as most relevant to this study.

All interviews were recorded using audio recorder in the manner the respondents were most comfortable and the interview conducted in English. An inductive thematic approach, coding and analysis was used and data transcribed and then translated simultaneously. Equally, back-checking of the interviews, including ensuring translation accuracy was carried out to ensured that any inaccuracies in data collection due to incorrect or incomplete translation would be negligible at most [19]. Accordingly, collection of reliable, pertinent data was critical to the soundness or validity of the study's outcome and if repeated can generate the same research findings [20].

Data Analysis

Data evaluated were recorded. NVIVO version 12 with verbatim transcription was then used for thematic

analysis of qualitative data especially for the Key Indicator Interview [21]. This was to to assist in coding and analyzing the transcribed interviews. The participants were labeled as Respondent HMO 1 through Respondent 4. The average interview time was approximately 30 minutes. In addition, key notes were recorded and participant observation as data collection methods was ensured. [22] held the view that, these methods were commonly used in qualitative studies and assisted the researcher in achieving triangulation. Triangulation however provided the opportunity to demonstrate variation in the information delivered a means of cross-checking the information's consistency, and mitigated researcher bias in the study [23, 24].

The reliability of this research for qualitative data collection was based on neutrality that generates consistent results and outcome to ensured conformability of all data collected and analysis of actual interpretation of participants' views [25].

Ethical Approval

Ethical clearance was obtained from the Health Research and Ethics Committee (HREC) of the State Ministry of Health, Kano State. This was done in accordance with adherence to all ethical framework that protect participants in a study. This was done via entrenching ethical action and respecting the participant's views. The frameworks were obtaining informed consents, autonomy, voluntariness that guarantee adequate privacy, anonymity and confidentiality that provided the participants the level of assurance, such that data collected did not breach any accepted ethical practices and codes of conduct.

RESULTS

Four stakeholders representing the health maintenance organizations were interviewed,

What constitute the HMOs choice of hospital for various enrolees

Most of the respondents mentioned hospitals accredited by NHIA, period of time taken after accreditation, approach taking by the hospitals, making proposal to the hospitals by the HMOs and quality of services provided were some of the criteria used to choose hospitals for enrolees. Others mentioned environment, trust of the healthcare providers i.e., doctors, Nurses etc. specific need or choices of the enrolees to a hospital, availability of equipment e.g., Laboratories, theatres etc. some of the captured responses are:

Respondent HMO 1	added *"what we looked at is, whether those hospitals are accredited by NHIS. (The name has now changed to the National Health Insurance Authority-NHIA Also, we go ourselves to these hospitals and get them on board or the hospitals look for us as partners."*
Respondent HMO 2	. stated in addition that *"we look at the quality of service at the hospitals and it has to meet specific standard before any of hospital is registered by us and also if accepted by our enrolees".*
Respondent HMO 3	*Posited that, "the criteria we use for selecting hospitals is based on quality and standard of service and the enrolees or client's choice, i.e., if they want a particular hospital, we go ahead and register them".*
Respondent HMO 4	*"First, is for us to be sure the hospital is registered with the NHIA and meet quality assurance to make sure that hospitals can provide qualitative healthcare services".*

Strategies put in place to improve patient's access to adequate health care service

The responses were, the introduction of e-health system for registrations, payments of capitations, change of facilities and also the use of telemedicine to reach out to doctors and physical facilities visits. Also,

negotiating tariffs to be affordable to the clients, reducing the time and duration to access healthcare services. Additional responses were:

Respondent HMO 1	stated *"One of our strategies is that, we try to improve services via automation of our operations, such that, service delivery can be done through e-health model, such as, online payment, registering and change of facilities when required''*
Respondent HMO 2.	stated that. ''we *have telemedicine platform where our clients can use a dedicated number to get across to doctors when they don't have to go to see a doctor physically via all hospitals across thirty states including and Federal Capital Territory Abuja".*
Respondent HMO 3.	*"On our own and not in collaboration with the NHIA, we have a leasing arrangement with all the hospitals under our management in which we provide them software device that we developed to prevent perpetuation of fraud that will affect service delivery".*
Respondent HMO 4.	States *"what we actually do as a private profit- run organisation is that, we look at ways of improving cost management by ensuring that we have good access to the health facilities and negotiate tariffs plans that we can afford via our "codes to access care".*

Rating the level of success of organizations in terms of meeting contractual obligation of customers

Varied responds in terms of the level of success of operational obligations to enrolees were elicited from the respondents as criteria of meeting HMOs contractual obligations of their customers. Some of the captured responses were;

Respondent HMO 1	*"Well, I can rate the success to be like 60-70% based on our agreed benefit package".*
Respondent HMO 2	*stated that, "our rating is about 80%, because at any point in time our enrolees access care and there has been no reason for an enrolee not to access same based on their contractual agreement with the hospitals".*
Respondent HMO 3.	Explained *"we have a call data processing platform made available to all the hospitals under our management which receives complains of enrolees to ensure clients satisfactory."*
Respondent HMO 4.	Stated that, *"I can rate ourselves 99.9% based on what we have been doing for over 5 years.*

Enrolee's perceptions with the level of services provided to them in term of prompt paying of capitation

Some of the respondents were of the view that, they don't have problem with the payment of capitations to their providers because it's a prepaid scheme to avoid disruption of clients' services. Some of the captured responses were:

Respondent HMO 1	stated, *"For capitation, we meet 98% of our obligations. As such, our organization has no problem as a prepaid scheme. We do not stop enrolee from accessing care because of only capitation fee. There is also fee for secondary and tertiary care services."*
Respondent HMO 2.	Noted "*some enrolees do not seem to understand the different between the service providers and the purchasers. Often times, they always consider the HMOs to be at fault, but in many cases, it lies with the healthcare provider, even at that, we guide them on how to access care and receive feedbacks".*
Respondent HMO 3.	*"we don't have problem with payment of capitation because we meet our provider's obligations. We are one of those HMOs that even pay capitation in advance".*

Respondent HMO 4.	*"We don't have problems with payment of capitation because the moment the federal government sent to us the capitations, we pay our providers, and we do not owe".*

Enrolees complains in terms of the hospitals chosen for them.

It was unanimous with the respondents that they do not choose hospital for clients but the enrolees choose facilities themselves from list of health facilities provided. Customers complaints about delays in accessing care, getting authorizations for secondary or tertiary services, arrogances on the part of front desk officers, out of stock of quality medicines and inadequate diagnostic equipment. Other responses were:

Respondent HMO 1	*stated that, "most of the times the enrolees choose the facilities by themselves, so the complaints we get from client's ranges from delay especially when they request for authorization for secondary or tertiary services from the hospital, arrogances of front desk officers and also out of stock of drugs".*
Respondent HMO 2	*"Most of them choose the facilities by themselves. The issue of quality drugs is a major problem enrolee normally complained about, and which attributed to cutting cost by dispensing cheap drugs and presumably of low quality by hospitals".*
Respondent HMO 3	*"As for us, we do not choose hospitals for our enrolees, rather they select hospitals by themselves. Other complains varies from out of stock of drugs, times wastage etc.".*
Respondent HMO 4	*Stated "sometimes we receive very few complaints about the facilities from the enrolees. Some of these complaints, if I can remember, are mostly about unavailability of drugs and diagnostic equipment".*

How services provided are improved upon for the patients in hospitals

Physical visits, administration of questionnaires and conducting quality assurance checks are some of the steps or strategies posited by the HMOs. Further responses were:

Respondent HMO 1	*"We do periodic quality assurance by visiting every hospital to ensure compliance and addresses our enrolee's concerns with the facilities.*
Respondent HMO 2	*"What we do at the end of our sensitization, we give out questionnaires to our enrolees and we use that questionnaire to make amendments regularly on our services".*
Respondent HMO 3	*"For the enrolees, I regard them as my own family, I work from 8.00am to 5.00pm but most of the time I attend to my enrolees even if it is 3.00am. I also take regular visit to the hospitals to ascertain compliance".*
Respondent HMO 4	*"Yes, when we have complaints, we try to clarify or verify those claims and if verified with evidences, then, we notify the hospital of such complains".*

Justification of the level of services and care provided to enrolees by hospital where they are enrolled

Most of the respondent were of the view that, they document issues between the clients and health facilities, take unscheduled visits to health facilities and ask clients about the quality of services provided to them and also sensitizations workshops. Further responses elicited were:

Respondent HMO 1	*added that, "we justify services provided to enrolees via periodic documentations and visits, and when bills or fees for services are sent to us, we verify such claims before payments are made".*

Respondent HMO 2& 3	*Also stated, "as part of control mechanisms in our organizations, we undertake quality assurance assessment of facilities to ascertain the level of compliance of the enrolees regarding the services provided to them and report same to NHIA for proper investigation ".*
Respondent HMO 4	*"For now, we can say, we work with our providers in harmony".*

How introduction of accountability impacted the organization's competitive advantage in the HMO industry, and measures taken or implemented to address these challenges

The respondents posited amongst other things like, conducting reviews and meetings, preventing problem, getting feedbacks from the enrolees and abiding by the rules and regulations in meeting contractual agreements. Others include, installation monitoring devices for accountability in their offices.

Respondent HMO 1	*added that ''structures are designed to checkmate such challenges by undertaking daily, weekly and monthly reviews and have meetings to help identify impending problems and address them promptly".*
Respondent HMO 2	Stated, *"We tried to make ourselves accountable by meeting client's obligations based on our contractual agreement with enrolees"*
Respondent HMO 3	*Stated, "as far as our organisation is concern and one of the major HMO in the country, we don't compromise on quality. We look at what our competitors are doing, and improve on them and we also provide cooperate social responsibility"*
Respondent HMO 4	***.....*** *Stated that "though the operations are hectic, the challenges are adequately addressed in terms of payment of staff salaries, paying the providers and addressing operational logistics promptly, as part of our internal control mechanism".*

DISCUSSION

The role of accredited providers with the national healthcare insurance Authority was to achieve optimal standards of quality and to maintain these standards through regular re-accreditation in particular, which was seen as an important aspect of achieving UHC as well. It was to ensure provision of quality healthcare delivery to enrollees of the scheme across both the federal, state and private run healthcare facilities in Kano state, Nigeria. However, as demonstrated from the study above, ensuring access to these quality services by providers was much challenging. Issues such as lack of funds, patient lack of understanding of the system due to inadequate orientation by health facilities, inadequate infrastructure and manpower affects both cost of care and patients' abilities to obtain satisfactory services.

The challenges of adequate human and technical resources, strategic decision making processes, assessments and adopting a holistic approach to patient's management care are key internal strategies for the success in improving operational efficiencies, reducing health care costs, and improving the quality of care of health facilities to the enrollees whose health care they managed.

However, the complexity of a health care delivery system relies heavily on human and technical resources to operate [26]. As evident from the data obtained in the study, it was suggestive of the fact that, HMOs over time have devised means to mitigate smooth healthcare delivery to their clients resulting from the inability of most hospitals to provide basic items to ensure quality services to clients. As pointed out by one of the participant, the NHIA accreditation enabled them to asses these parameters with health facilities as criterial to engaging their services.

This is in line with observation by [26], who noted that, complexity of a health care delivery system relies heavily on human and technical resources to operate. On the level of services provided as regards prompt paying of capitation by HMOs, which is their primary purpose of providing financial protection for enrollees, it was observed from the respondents that, prompt capitations are usually made to the health facilities they managed.

The data outlined above implies that, capitation may not be the problem as regards hospital meeting their obligations of enrollees under their care, however, in reality we found that, some providers struggled to understand and implement a system of financial risk pooling within their own facilities, oftentimes, charging HMOs high tariff with less than average services provided was a common occurrences in these facilities simply because, NHIA officials do not appear to monitor these practices regularly. As pointed out by [27] in their analysis of India's push toward UHC, money is necessary, but not sufficient for health system improvement. This is particularly true where capitations are remitted to hospitals by HMOs but there are no accountability mechanisms in place to ensure clients obtained good services. Accordingly, [28] have argued that, in order to achieve UHC, finances must not only be adequate, but must be managed correctly with attention paid to creating efficiencies in the system; an argument often used to support capitation.

Though it was observed that, capitation posed some unique challenges for providers. It was also evident from the study that, some providers had difficulty understanding the guiding principles of capitation and attainment of universal health coverage. Rather than looking at capitation as an essential tool in enhancing effective service delivery, some providers instead saw these regular huge sum of payments as means to increase their profitability. One HMO official noted that, inadequate funding from the NHIA was a common complaint, but that fraud was also a major concern from the provider's side. It could be deduced from the study that, providers sometimes tried to submit claims multiple times in order to get more money, or that they did not understand why certain claims were rejected by HMOs, but rather felt they were being short changed by the NHIA. This was also similar to finding in Ghana as reported by [19].

Similarly, delays in registration process, liberty in making choice of health facility by the enrollees, poor referral system for some secondary and tertiary services, unavailability of required drugs and quality of drugs supplied, poor infrastructures, delays in obtaining required services were also some of the shortfalls in most healthcare facilities enumerated. In some cases, providers also prescribed low quality drugs for enrollees, issue prescriptions for them to buy drugs outside the facilities. These could be corroborated with similar study conducted in Kwara state, Nigeria as reported by [29]. This was also reported in Ghana where patients were asked to pay for drugs which were said to be out of stock in these facilities [30]. The most commonly cited cause for allowing enrollees to wait for long times before accessing services such as consultation were also observed as impediments. Also, clients often spent considerable amount of time to go through the process of collecting cards and in some circumstances, having to wait for longer time for registration when such facilities experiences internet connectivity issues.

RECOMMENDATIONS

In view of study, these recommendations would seek to provide insights to some of needed impetus to bring about effective and efficient running of the national health insurance Authority for Nigerians.

1. In line with the Abuja declaration, there is a need for the government to demonstrate political commitment toward UHC by increasing budgetary allocation to healthcare. That is, government must strengthen its health laws to, among other things, increase capacity of health insurance companies and provide adequate funding for the healthcare system.
2. Considering the threats of health insecurity, there is urgent need for the NHIA to provide

specific project design to enhance effective resource allocation to provide for tertiary services coverage to purchasers of the scheme.

3. The NHIA should consider building a more monitoring and accountability mechanisms for healthcare facilities serving as providers of the scheme in order to reduce potential drift in financial prudency.
4. Both the NHIA and HMOs should ensure that, health facilities maintain the level of quality required to receive financing in accordance with tariffs for services rendered.
5. In the context of strategic planning, it is suggested that, government should not only set clear guidelines, but put strong systems in place to monitor provider's performance and curb corruption in the scheme.

CONCLUSION

The study point to several major barriers for accessing effective quality of services provided by accredited health facilities under the NHIA scheme in Kano state, Nigeria. This has inevitably translated to challenges for patients trying to access quality health services from accredited providers. Notably among such, was systemic management on the part of the providers. However, it was not uncommon for respondent to point out that, registration procedure was burdensome due to manpower and technical shortfalls resulting in long waiting time, unavailability of quality drugs, poor referral and unavailability of some secondary and tertiary services in most accredited facilities.

However, despite the perceived challenges of remittance of capitations by HMOs, lack of clarity around unsubstantiated financial claims by providers for service provided to clients was increasingly critical to the sustainability of the scheme. Providers often times faced challenges understanding capitation, which also resulted in providers charging high tariffs unnecessarily and offering clients reduced services.

LIMITATION OF THE STUDY

1. Enrollee's views were not sampled in the qualitative evaluation and as such, had no way to verifythese claims from the perspective of the patients. Lack of feedback from them was observed to have limit the scope of the study.
2. Data analyzed were drawn from specific HMOs which did not give a realistic and generalized viewsof other HMOs across the entire state.
3. Also, since all data was reported by the HMO representatives, the study did not review theprovider's views regarding the challenges with the NHIA schemes.
4. Regulatory/statutory guidelines that influence internal controls differ from one health facility to the other and this might influence operational standards, hence the outcome of the study.
5. The HMO representatives have different perspectives to the study and since each strategy and operations differ from one HMO to another, some level of caution in divulging specific information's were observed.

FUTURE RESEARCH

1. Further study is required to expand research to healthcare purchasers, such as HMOs and state contributory healthcare management agencies as regard the level of their financial engagement with providers. This would provide an insight to another aspect of the healthcare continuum of the scheme.
2. Replicate the study in other states of Nigeria as patient population, and health facilities controls mechanisms may differ from state to state.
3. NHIA to broaden the scope of the study to include employees with non-managerial roles in healthcare facilities who are directly involved in the scheme. This would help future researcher to determine

whether there are similarities or otherwise between the management leaders' perspective and those of the non-management workforce.

ACKNOWLEDGMENTS

I do acknowledge all the respondents' HMOs officers who participated in this study.

Conflicts of Interest: The authors declare no conflicts of interest.

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