IOSR Journal Of Humanities And Social Science (IOSR-JHSS)
Volume 24, Issue 4, Ser. 10 (April. 2019) 57-69
e-ISSN: 2279-0837, p-ISSN: 2279-0845.
www.iosrjournals.org

Awareness of and Access to National Health Insurance Scheme in Nigeria and Ghana

Oni, Michael Abiodun, Busayo Olayinka, Ntiwunka, G. U. and Ogu, M. I[1]
Corresponding Author: *Oni, Michael Abiodun*

National Health Insurance schemes are mechanisms through which governments of various countries ensure that citizens have access to affordable and quality health-care services. In spite of establishment of NHIS in Ghana in 2003 and Nigeria in 2005, health care delivery had been experiencing several challenges, as majority of citizens of both countries do not have access to quality health-care services. The study examined the level of awareness and access to NHIS services by the citizens of both countries. Survey design was adopted. The population of the study was 4,786,990 enrollees of NHIS in both countries. Sample size of 400 was determined using Taro Yamane formula. Respondents were selected from and three regions in Ghana (Ashanti, Brong-Ahafo, and Greater Accra regions) and five states in Nigeria (Lagos, Abuja, Edo, Imo and Ogun States). Questionnaire was the instrument of data collection and data were analyzed using descriptive and inferential statistics. The study concluded that the level of awareness and access to NHIS had a significant relationship with service delivery in both Ghana and Nigeria.

Keywords: Access, Awareness, Health-care services, NHIS, service delivery

---

Date of Submission: 16-04-2019 Date of acceptance: 01-05-2019

I. INTRODUCTION

Universal Health Coverage (UHC) is a strategic aspect of the post-2015 Millennium Development Goals (MDGs), aimed at reducing individual and household health spending that is a major cause of poverty in many countries. As Margaret Chan, Director-General of the WHO, explained, UHC is the single most powerful concept that public health has to offer ... a powerful equalizer that abolishes distinctions between the rich and the poor, the privileged and the marginalized, the young and the old, ethnic groups, and women and men (Chan 2012).

According to WHO (2013), is an idea targeted at ensuring that all people have access to promotive, preventive, curative and rehabilitative health services of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services. Since it became a priority programme of the WHO, it has become a major focus of health reform programmes globally. It is particularly relevant to health reforms in sub-Saharan Africa where health statistics present an ugly picture, particularly in terms of economic and physical access as well as equity, two major issues that drive and sustain poverty.

National Health insurance Scheme (NHIS) is a social security mechanism that guarantees the provision of needed health services to persons on the payment of some amount at regular intervals. It is designed to pay the costs associated with health care by paying the bills and therefore to protect people against high cost of health care by making payment in advance of falling ill. The scheme therefore protects people from financial hardships occasioned by large or unexpected medical bills. It saves money on the short run and protects the poor from medical conditions that can lead to greater loss of money on the long run (*Nigerian Tribune*, 24, May, 2010).

It involves pooling of resources from persons of different illness-risk profiles and the cost of the risk of illness among those who are ill and those who are healthy, are shared. It has three main characteristics-prepayment, resource pooling and cost-burden sharing. Pre-payments under the scheme are fixed either as a proportion of the pay-roll, or as flat rates contributed by the participants. This means that payment is not proportional to the risk of illness of individual beneficiaries (Adefolaju, 2014). Many advantages accrue from participation in social health insurance. According to Nielson (2012), they include broadening the sources of

[1] The authors are of the Department of Political Science and Public Administration, Veronica Adeleke School of Social Sciences, Babcock University, Ilishan-Remo, Ogun State, Nigeria. They can be reached through: olaoluby@gmail.com.

health care financing; reducing the dependence and pressure on government budget; increasing the financial resources and ensuring stable source of revenue for healthcare; ensuring visible flow of funds to the sector; assisting in establishing patients' rights as customers; combines risk pooling with actual support by allocating services according to need and distributing financial burden according to ability to pay; solves equity and affordability problem in providing and financing health services; and, improves and harnesses private sector participation in the provision of health services.

Administration is the process of getting things done through the coordination and management of other people. The ability to deploy labour power in achieving organisational goals determines the success of what is intended to be attained. Therefore, administration involves every effort deployed at maximizing the human potentials within an organization towards the actualization of its stated objectives. The importance of administration to all aspect of human endeavour cannot be questioned given the valuable roles of policy formulation and implementation which is adjudged the hallmark of organisational success. Though administrative efficiency or inefficiency constitute the bulwark of actualization of objectives that midwife the formation, establishment and inauguration of every policy framework within government, private or individual phase of human establishment (Adamolekun, 2011).

However, the determination of who gets what, when and how basically falls within the purview of administrative and policy operation especially when structured to meet the overall goal of service delivery (Lasswell, 2010). Therefore, the provoking thought of the National Health Insurance Scheme (NHIS) framework falls within the authoritative allocation of the content of the policy that birth the scheme and what place enhanced administration hold for quality service delivery to the beneficiary and also, the need for policy and institutional reforms that will propel the speedy realization of the total health service for the citizens. The nature of administration of any policy to a very large extent determines what and how effective, impactful such policy will affect and achieve it intended result. This fact has informed the level of successes that have been achieved across developed countries where people centred policies are formulated and implemented.

The importance of quality and healthy life of the masses was constructively underscored by Soyinka who averse that "good health is one of the most important basic needs of mankind and is indispensable in social and economic development of a nation" (Soyinka, 2011).Therefore, in meeting the health need of the people one important issues is administrative questions which constitute a major challenge in the implementation of organisations policy. This is because the success or failure of administration to a very large extent determines the direction of organisational objective which is a functional driver for policy analysis and institutional reforms which of great consequence in measuring the end product of governmental drives towards impacting the lives of its citizens.

National Health Insurance Scheme(NHIS) is a framework established by National policy to guarantee financing of affordable and quality health care services such as adequate drug supply, good services provisions, adequate financing/ funding, adequate personnel to carry out the services, adequate supply of modern equipment's and good administration for the citizens of Ghana and Nigeria. However, despite the lofty objectives it has been observed that there are still many challenges ranging from inadequate drugs supply, poor funding/financing, shortage of modern equipment, policies inconsistences, shortage of personnel, poor service provisions, lack of refresher training for the personnel, Corruption and most fundamentally poor implementation. Ghana and Nigeria have had varying degrees of success in policy implementation, adoption and domestication of the NHIS as transferred from Countries such as USA, UK, France, Canada, China where success had been recorded. In most developing countries (including Nigeria and Ghana) poor state of the nation`s healthcare system reinforces poverty and squalor to further deteriorate living condition (Nwosu, 2012). The study therefore, examined the level of awareness of and access to National Health Insurance Scheme in Nigeria and Ghana.

Over the years, health of humans has been conceptualized in diverse ways. Health of humans does not merely connote the absence of ailments and disease ,but its sum total which also encompasses the proper physical, mental and social functioning of humans. Health is also influenced by socio-economic, cultural, environmental as well as hereditary factors (Wilson: 2012, WHO: 2016, Deliege, 2014). The attainment of healthy well-being by individuals, and the community at large, is therefore, a social concern because a society can function properly only when majority of its members are healthy enough to perform the tasks that sustains human society

II. LITERATURE REVIEW

National Health Insurance Schemes

The World Health Organization (WHO) argues that a health system is more than a pyramid of publicly-owned personal healthcare delivery facilities or structures, but also consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health (WHO 2017). Health system goals generally include improvement of health and health equity in ways that are responsive, financially sustainable

and optimally efficient; they must also avoid wastage of resources. However, in order to attain these goals, a health system must also achieve the intermediate goals of ensuring greater access, effective coverage, quality and safety of healthcare services for the majority of the people (WHO 2017).

People enjoy different levels of economic, social and physical access to healthcare needs. It is reasonable, therefore, to establish systems that can allow individual members of a group to access healthcare when they need it without paying astronomical costs, which they may not be able to afford unless they sacrifice other needs that may also be pressing. Social health insurance, Kutzin (2016) submits, that NHIS is 'a way to pay for health care and to ensure access to services by providing a mechanism for sharing the risk of incurring medical expenditures among different individuals'.

Kutzin emphasizes the strategic importance of financial protection as well as the ability, willingness and access to use health services, as prerequisites for social health insurance. He argues that since public policy objectives in the health sector include improving health status, equity, efficiency, acceptability (to providers and users) and sustainability, expanded coverage of health insurance may be a means to achieve progress towards these objectives (Kutzin 2016).

National Health insurance Scheme (NHIS) is a social security mechanism that guarantees the provision of needed health services to persons on the payment of some amount at regular intervals. It is designed to pay the costs associated with health care by paying the bills and therefore to protect people against high cost of health care by making payment in advance of falling ill. The scheme therefore protects people from financial hardships occasioned by large or unexpected medical bills. It saves money on the short run and protects the poor from medical conditions that can lead to greater loss of money on the long run (*Nigerian Tribune*, 24, May, 2010).

It involves pooling of resources from persons of different illness-risk profiles and the cost of the risk of illness among those who are ill and those who are healthy, are shared. It has three main characteristics-prepayment, resource pooling and cost-burden sharing. Pre-payments under the scheme are fixed either as a proportion of the pay-roll, or as flat rates contributed by the participants. This means that payment is not proportional to the risk of illness of individual beneficiaries (Adefolaju, 2014).

Many advantages accrue from participation in social health insurance. According to Nielson (2012), they include "broadening the sources of health care financing; reducing the dependence and pressure on government budget; increasing the financial resources and ensuring stable source of revenue for healthcare; ensuring visible flow of funds to the sector; assisting in establishing patients' rights as customers; combines risk pooling with actual support by allocating services according to need and distributing financial burden according to ability to pay; solves equity and affordability problem in providing and financing health services; and, improves and harnesses private sector participation in the provision of health services".

Ever since Emperor Otto Von Bismarck of Germany enacted the mandatory legislation on the "sickness funds" for working Germans in 1883, different models of health insurance have continued to evolve worldwide albeit with the same general insurance principles. In the developed world, insurance in one form or the other is a veritable and sustainable tool for financing healthcare (Ndie, 2013).

Health Service Delivery

The core function of the health sector across the world is to make available quality health services to the patient as at when required. This core responsibility determines to a large extent the wellbeing of the patient and also shapes its perception about the sector. In any health system, good health services are those that deliver effective, safe, good-quality personal and non-personal care to those that need it, when needed, with minimum waste. Services – be they prevention, treatment or rehabilitation – may be delivered in the home, the community, the workplace or in health facilities (WHO, 2017).

Although there are no universal models for good service delivery, there are some well-established requirements. Effective provision requires trained staff working with the right medicines and equipment, and with adequate financing. Success also requires an organizational environment that provides the right incentives to providers and users. The service delivery building block is concerned with how inputs and services are organized and managed, to ensure access, quality, safety and continuity of care across health conditions, across different locations and over time (WHO and Health Matrices Network, 2017).

Sufficient funding and efficacious technology may be necessary conditions for achieving health gains, but experience in many countries confirms that they are not sufficient. Effective and efficient service delivery is the point at which the potential of the health system to improve lives meets the opportunity to realize health gains. Health service–delivery performance means access and use by those in need; adequate quality of care to produce health benefits; efficient use of scarce resources; and organizations that can learn, adapt, and improve for the future. All too often, potential benefits are not realized because service delivery underperforms (Berman, Pallas, Smith, Curry and Bradley; 2011).

According to World Health Organization (WHO), (2010), Service provision or delivery is an immediate output of the inputs into the health system, such as the health workforce, procurement and supplies, and financing. Increased inputs should lead to improved service delivery and enhanced access to services. Furthermore, WHO, (2010), stated that ensuring availability of health services that meet a minimum quality standard and securing access to them are key functions of a health system.

Berman, Pallas, Smith, Curry and Bradley; (2011), at the level of health service delivery organizations, relevant dimensions of access include physical, financial, linguistic, and information access; service availability/allocation; and non-discriminatory service provision (equitable treatment regardless of age, gender, race, ethnicity, religion, and class). Sample measures of access include geographic distance to a facility, availability of transport to a facility, hours of operation of a facility, absenteeism of health care workers from a facility, affordability of services, availability of culturally and linguistically appropriate services.

This involves the basic physical and social amenities as well as services that are needed to ensure effective health services delivery. According to Agency for Healthcare Research and Quality, (2014), the components are not necessarily health care aims/attributes in themselves, but are a means to those aims since they are elements of the health care system that better enable the provision of quality care... health systems infrastructure are of interest to the extent that they improve effectiveness, safety, timeliness, patient-centeredness, access, or efficiency.

Also important in the delivery of quality services in the health sector is the availability of good physical structure, wherever, health services are delivered, must be designed specifically for that purpose with all the facilities (lighting, adequate space, water supply system, etc.) put in place to achieve the goal of provision of health care needs of the public in a sustainable manner (Ibama, 2017). According to Health and Care Infrastructure Research and Innovation Centre, (2011), most healthcare systems, have insufficient knowledge to optimize interacting variables such as lighting, heating, ventilation, optimal room size, layout, location and access, infection control and energy efficiency. Furthermore, some facilities are out of date, some are inappropriate, some are unused or underused.

In furtherance to the above, Ibama, (2017) also notes that:

One cardinal principle of health care delivery system is accessibility of services to the public in need. It is only when available health care services are utilized by those in need and in the required magnitude that we can consider such health care system as being effective. Effective health care delivery is not easily achievable in the midst of poor road network and transportation system which had been known and classified as the cause of second delay in accessing health care, therefore good road network and transportation system is needed prominently in making health care services accessible to the public to promote productivity.

Appropriate legislation is needed in promoting effective health services delivery through ensuring that basic infrastructure and adequate budgetary allocation are provided for health care services as well as role definition of all cadres of the health team to avoid role conflict as do observed. In Nigeria, the signing into law of the National Health Bill on 9th December, 2014, intended to providing framework for the regulation, development, and management of a national health system is a welcome development. The National Health Act creates a Basic Health Care Provision Fund to ensure Nigerians have access to basic healthcare services as a strategy to universal health coverage.

However, what is more important is the sincere implementation of the law as enshrined therein to ensure effective health service delivery. In all of these, what is quite obvious is that, inadequacies in health system infrastructure may limit access and contribute to poor quality of care and outcomes, particularly among vulnerable population groups that include racial and ethnic minority groups and people residing in areas with health professional shortages (Agency for Healthcare Research and Quality, 2014).

III. THEORETICAL FRAMEWORK

System Theory/Model

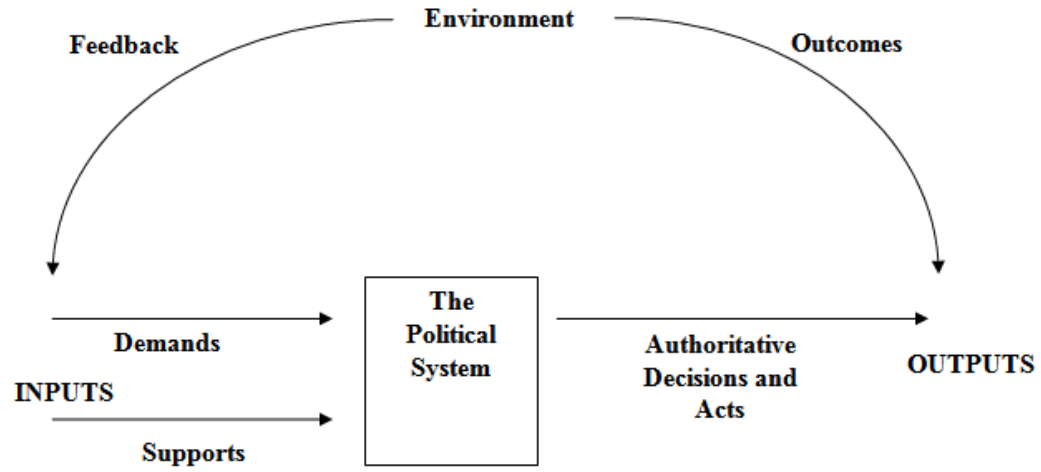
Karl Luwid Von Bertalanffy (1901-1972) a biologist. He opines that in social science, general systems concepts were applicable, most especially theories that had found their way into the field of sociology from a modern system approach that included the concept of system, of feedback, information and communication (Bertalanffy, 1969).

Borrowing from the above, David Easton used the system theory to explain issues that involves political, administrative and public policy discourses. Easton is usually credited with the task of domesticating the general system approach in the field. He describes political system as the system of interaction in any society through which binding or authoritative decisions are made and implemented (Ogundiwin, 2015).

He considers the political system as existing within an environment of other systems- physical, biological, social, psychological, to mention a few, which affects it and are in turn affected by the political system- through continuous transaction and exchanges. According to Easton, the political system or policy framework functions by getting inputs from it environment. Inputs are events in the environment which evoke

response from it. The inputs could be demands that values be allocated in a particular way or they could be supports, that is, expressions of approval for particular decisions. The inputs from the environment undergo a *conversion process* within the political system and come out as *outputs.* Which are usually authoritative decisions such as government policies, judicial decisions, acts of parliament, etc., promulgated by the authorities. Those authoritative outputs usually affect the environment as *outcomes* and in turn excite some form of feedback, that is changes in the intensity and volume of demands and support from the environment.

Table 2.1 David Easton's System Model of Analysis



Various constituent units which are fundamental in the determination of the applicability and relevance of a policy. Policies within the public domain are meant to address the need of the people and the only means for arriving at the extent to which it has addressed its underlying objectives.

According to Ogundiwin (2015), for a system to be regarded as a system it must have the following attributes:

A system must have objects the parts, elements, or variables within the system. These may be physical or abstract or both, depending on the nature of the system. It should be noted that political scientist is more concerned with an abstract construct to represent what goes on in real world for purposes of analysis. A system consists of attributes the qualities or properties of the system and its object. A system has internal relationships among its objects. Systems exist in an environment. A system, then, is a set of things that affect one another within an environment and form a large pattern that is different from any other parts.(P.172)

The system model explains in concrete terms the level of interaction between the basic machinery of the state which is centred on policy formulations and implementation and by extension informs policy appraisal, reforms within institutions and policy frameworks.

Though the model has being criticised for being too abstract and too isolated from concrete reality in its explanation of interactions between the components of the state but it concisely laid the path in the determination of the extent impact of policy formulated by government on the satisfaction of the need of masses which is measured through the feedback mechanism that enables the agents of government to take informed decisions especially as regards what is to be done to improve the general goods of the people (Ogundiwin, 2015).

The combination of the decision making theory and system theory help establish the imperatives of improved administrative procedures in confronting the needless lapses bedevilling the operations of NHIS in Nigeria and Ghana especially as regards the actualization of the overall objectives and goals that necessitated the establishment of the scheme in the respective countries involved.

Also of material consequence is the relevance of administrative decisions that will cater first amongst other things for the health of the masses that is contained in the NHIS policy framework and most consequentially, the operations of all actors and stakeholders within the framework of standard practices that is required for delivery quality health care services for the masses and also ascertain the workings of the registered services providers which must operate within acceptable systems for the satisfaction of the beneficiaries.

In this respects the system theory helps explain the imperatives of inputs and outputs from the (government and Ministry of Health's), the registered health providers and the feedbacks obtained from the beneficiaries which is needed to measure the extent of success achieved by the stakeholders working for the success of the scheme.

Finally, the services rendered within the scope of the scheme on the masses are by extension measured through the feedback obtained from the beneficiaries of the scheme. This feedback is used to determine to a large extent the extent to which the operators have been able to deliver the objectives of the policy and to determine periodically the need for reforms of policy, personnel or institutions which is the basis of this research. It is therefore important to underscore the fact that, though with a relative level of success, the scheme has not been able to deliver on its stated goals which is evident in various research conducted.

Methodology

The study adopted survey research design. By this method, the researcher used both structured questionnaire and interview guide to obtain data from a sample of population in order to make generalization on the purpose of the study. The survey research design was used to solicit information from the respondents. The main independent variable in this research is the administration of National Health Insurance Scheme. The population of the study was 4,786,990 (see Table 4.1). These are individuals and health facilities registered under NHIS in Nigeria and Ghana. This study selected five states in Nigeria (Lagos, Abuja, Edo, Imo and Ogun States) and three regions in Ghana (Ashanti, Brong-Ahafo, and Greater Accra regions) the justification for the Ghana is that those three regions are one of the largest regions in Ghana. Taro Yamane was used to determine the sample size of 400. Questionnaire and interview guide were the instruments for data collection. Descriptive and inferential statistics were employed in the analysis of data.

IV. RESULTS AND DISCUSSION

Table 5.2: Awareness of and Access to NHIS Services in Ghana and Nigeria

S/N	Statements	Country	SA F(%)	A F(%)	D F(%)	SD F(%)	U F(%)	Mean	SD
1	National Health Insurance Scheme (NHIS) is well known by beneficiaries	Nigeria (N=169)	89 (52.7)	58 (34.3)	10 (5.9)	3 (1.8)	9 (5.3)	4.27	1.03
		Ghana (N=209)	91 (43.9)	92 (44.0)	13 (6.2)	3 (1.4)	10 (4.8)	4.20	.97
2	I am aware of the operations and services provided by the NHIS	Nigeria (N=169)	47 (27.8)	81 (47.9)	30 (17.8)	8 (4.7)	3 (1.8)	3.95	.90
		Ghana (N=209)	57 (27.3)	101 (48.3)	36 (17.2)	10 (4.8)	5 (2.4)	3.93	.92
3	I am a registered member of National Health Insurance Scheme (NHIS)	Nigeria (N=169)	57 (33.7)	62 (36.7)	35 (20.7)	7 (4.1)	8 (4.7)	3.90	.07
		Ghana (N=209)	70 (33.5)	76 (36.4)	43 (20.6)	8 (3.8)	12 (5.7)	3.88	1.10
4	My level of awareness and access to the services of the scheme has been satisfactory.	Nigeria (N=169)	19 (11.2)	81 (47.9)	38 (22.5)	26 (15.4)	5 (2.3)	3.49	.98
		Ghana (N=209)	42 (20.1)	60 (28.7)	60 (28.7)	34 (16.3)	13 (6.2)	3.40	1.16
5	The scheme has good working relations with media houses and they inform you about the operations of the scheme in your state and country	Nigeria (N=169)	23 (13.6)	50 (29.6)	47 (27.8)	35 (20.7)	14 (8.3)	3.20	1.16
		Ghana (N=209)	34 (16.3)	89 (42.6)	61 (29.2)	10 (4.8)	15 (7.2)	3.56	1.05
6	Beneficiaries are satisfied with the services rendered by the scheme.	Nigeria (N=169)	31 (18.3)	55 (32.5)	52 (30.8)	21 (12.4)	17 (5.9)	3.45	1.11
		Ghana (N=209)	40 (19.1)	63 (30.1)	50 (23.9)	35 (16.7)	21 (10)	3.32	1.24
	Mean and SD							**3.69**	**.63**

Source: Field Survey, 2018.
(N=378) Cut-off point=3.5

As indicated in Table 5.2, the weighted mean for the awareness and access to NHIS services was 3.69 with a standard deviation of 0.62. The results indicate that on average, the level of awareness of and access to NHIS services was high. On the average most of the respondents agreed that National Health Insurance Scheme (NHIS) is well known to beneficiaries in Nigeria (X=4.27, SD=1.03) and Ghana (X=4.20, SD=0.97). They were also aware of the operations and services provided by the NHIS in Nigeria (X=3.95, SD=.90) and Ghana

(X=3.93, SD=.92). The result revealed that, on the average majority are registered members of National Health Insurance Scheme (NHIS) in Nigeria (X=3.90, SD=.07) and (Ghana X=3.94, SD=.911) and in both Nigeria X=3.49, SD=.98) and Ghana (X=3.40, SD=.911) the respondents level of awareness and access to the services of the scheme has not been satisfactory as the average value indicated that they mostly disagreed. While the average value of Nigeria (X=3.20, SD=1.16) revealed that most of the respondents in Nigeria are of the opinion that the scheme has not informed them about the operations of the scheme in their state and country, however, in Ghana (X=3.56, SD= 1.05) many reported that the scheme has good working relations with media houses and they inform them about the operations of the scheme in their state. Most of the beneficiaries in both countries, Nigeria ((X=3.45, SD=1.11) and Ghana (X=3.32, SD=1.24), were reported not to be satisfied with the services rendered by the scheme. This is indicates that majority of individuals in both countries were highly aware of and had access to National Health Insurance Scheme in their respective, country, especially in Ghana.

The first research question sought to examine thelevel of awareness of and access to National Health Insurance Scheme in Nigeria and Ghana. An analysis of descriptive statistics was utilized to assess mean score of 3.69 with a standard deviation of 0.62 which indicated that the level of awareness of and access to NHIS services was high. This is not surprising considering the fact a whole lot has been put in place in the last few years. According to WHO (2015), Ghana is one of the few countries in sub-Saharan Africa spending a relatively high percentage of its Gross Domestic Product (GDP) on health. In a similar study by Okaro, Ohangwu and Njoku (2010) where all the radiographers in South Eastern Nigeria were sampled, the result indicated that there was a high level of awareness of the existence of NHIS in Nigeria among the Radiographers. Although, respondents indicated high level of awareness and access, the problems of access to healthcare services has proved a daunting challenge to the people on the one hand and by extension the government which has question its ability to meet the various needs to the masses. This challenge is associated with how and what people feel about the operations of policies meant to aid implementation of NHIS.

Hypothesis One: There is significant relationship between awareness of and access to NHIS and implementation in Nigeria and Ghana. This was tested using Pearson Product Moment Correlation Analysis the result is displayed on Table 4.8.

Table 4.8: Pearson Product Moment Correlation Analysis of awareness of and access to NHIS and implementation in Nigeria and Ghana

Variables	N	Mean	S.D	R	Sig.	Remark
Awareness and Access to NHIS	378	3.6909	.62931	.302*	.000	Significant
Implementation of NHIS	378	3.7011	.83677			

Source: Field Survey, 2018.

*Correlation is significant at 0.01 level (2-tailed)

As shown in Table 5.8, there is a significant positive relationship between awareness of and access to NHIS and implementation in Nigeria and Ghana. Thus, the higher the level of awareness of and access to NHIS, the higher the implementation of NHIS (r =.302, $p < .05$). Therefore the hypothesis that there is no significant relationship between awareness of and access to NHIS and implementation in Nigeria and Ghana is rejected.

Hypothesis one examined the relationship between awareness of and access to NHIS and implementation in Nigeria and Ghana. This was tested using Pearson Product Moment Correlation Analysis. The result showed that there is a significant positive relationship between awareness of and access to NHIS and implementation in Nigeria and Ghana. Thus, the higher the level of awareness of and access to NHIS, the higher the implementation of NHIS. In a study by Alderman, (2011) and Lavy and Germain (1994), the utilisation of healthcare was found to be sensitive to quality of care such that households limit their demand when services are of poor quality and others bypass low quality health facilities in search of high quality ones (Klemick, Leonard, &Masatu,, 2010). The interpretation that implementation dependens on the level of awareness and access to NHIS influences the extent of enrolment. Thus, in earlier work done by Onuewkusi and Okpala (2013) to access workers awareness of NHIS among Nigerian Healthcare professionals, it was reported that one year after the launching of the NHIS, Nigeria Health care professionals who are major stakeholders in the programme have grossly inadequate knowledge of the rudimentary principle of the operation of a social health insurance scheme, making implementation challenging.

V. CONCLUSION AND RECOMMENDATIONS

This study provided empirical evidence on administration of NHIS in Nigeria and Ghana and its implication for implementation and institutional reforms. It was revealed that awareness of and access to NHIS was significantly related to NHIS implementation and NHIS policy and legislation is related to operation and service delivery of the scheme.

National Health Insurance Scheme (NHIS) should be made accessible in Nigeria to all citizens instead of the present situation where it is only for the federal civil servants that are covered by the scheme.The National government of the two countries need to increase the level of finding of the health sector to entrance the delivery of services covered by NHIS to include major surgical operations. The governments of both countries should work on review of the legislation establishing the NHIS to make it more effective.

REFERENCES

[1]. Anifowose, R. &Enemuo, F. (2015).*Element of Politics.*Lagos: Sam Iroanusi Publications.

[2]. Ann, L., &Miloud, K. (2011).*Role of the private sector in the provision for immunization services in low and middle-income countries*. Oxford: Oxford University Press.

[3]. Ansah, E. K., Narh-Bana, S., Asiamah, S., Dzordzordzi, V., Biantey K, & Dickson, K. (2011). Effect of removing direct payment for health care on utilization and health outcomes in Ghanaian children: A randomized controlled trial. *PLoS Medicine, 6*(1), 1–11.

[4]. Asante, A. D., Zwi, Anthony B. & Maria T. (2011). Getting by on credit: how District Health Managers in Ghana cope with the Untimely Release of Funds. *BMC Health Services.*

[5]. Assensoh, A. B. & Wahab, H. (2011). A Historical-cum-political overview of Ghana's National Health Insurance Law. *African and Asian Studies*, 7 (18), 289–306.

[6]. Atinga, R. A., Abekah-Nkrumah, G. & Domfeh, K. A. (2011) Managing healthcare quality in Ghana: A necessity of patient satisfaction. *International Journal of Health Care Quality Assurance*; *24* (1), 548-563.

[7]. Awosika, L. (2015). Health insurance and managed care in Nigeria. *Annals of Ibadan Postgraduate Medicene. 3*(2), 23-43.

[8]. Azuh, D. (2017). Corruption and Other Challenges Facing Health Care Delivery at the Grassroots Level in Nigeria.*State and Society: An Interdisciplinary Journal of the Nigerian Sociological Society, 2*(1), 56-67.

[9]. Babbie, E. (2011). *Survey Research Methods* (2nded.). Belmont, California: Wadsworth Thomson Learning.

[10]. Babbie, E. (2011). *The basics of Social Research* (4nded.). Belmont, California: Wadsworth Thomson Learning.

[11]. Bergevaern, L.E., Mellomvik, F. & Olson, O. (2011). Institutionalization of municipal accounting - a comparative study between Sweden and Norway. In Brunsson, N. and J.P Olsen, J. P. (eds). Organizing Organizations (pp. 279- 302). Bergen: Fagbokforlaget.

[12]. Blichner, L.C. and Sangolt, L. (2011). The concept of subsidiarity and the debate on European cooperation: pitfalls and possibilities. In Brunsson, N. and Olsen, J. P. (eds). Organizing Organizations (pp. 107-32). Bergen: Fagbokforlaget.

[13]. Bohm, A. (2013). Theoretical Coding: Text Analysis in Ground Theory. In U. Flick, E. Kardoff & I. Steinke (Eds.) *A Companion to Qualitative Research.* London: SAGE Publications.

[14]. Boyce, C. & Neale, P. (2016).*Conducting In-depth Interviews: A guide for designing and conducting in-depth interviews for evaluation inputs.* Pathfinder International.

[15]. Bruce, E., Narh-Bana, S. & Agyepong, I. (2014): Community satisfaction, equity in coverage and implications for sustainability of the Dangme West Health Insurance Scheme Project No. 2001/GD/08 technical report series No. 9. 2008. Ghanaian Dutch Collaboration for Health Research and Development: Accra.

[16]. Brugiavini, A. & Pace, N. (2016). Extending Health Insurance in Ghana: Effects of the National Health Insurance Scheme on Maternity Care. *Health Economics Review,6* (7), 1–10

[17]. Brunsson, N. and Jacobsson, B. (eds) (2013). A World of Standards. Oxford: Oxford University Press.

[18]. Brunsson, N. and Olsen, J.P. (2013). The Reforming Organization. Bergen: Fagbokforlaget

[19]. Carrin, G. & James, C. (2012). Reaching universal coverage via social health insurance: Key design features in the transition period. Health financing policy issue paper. WHO.

[20]. Christensen, T. & Laegreid, P. (2011a). Administrative reform policy: the case of Norway, *International Review of Administrative Sciences, 64* (4), 457-75.

[21]. Christensen, T. & Laegreid, P. (2011b). Public administration in a democratic context - a review of Norwegian research. In Brunsson, N. and Olsen, J. P. (eds). *Organizing Organizations* (147-170). Bergen: Fagbokforlaget.

[22]. Churchill, C. (2016). *What is Insurance for the poor*? In C. Churchill (ed.), Protecting the Poor, A Micro Insurance Compendium. International Labor Organisation: Geneva.
[23]. Creswell, J. (2012). *Research Design: Qualitative, Quantitative and Mixed Methods Approaches* (2nd ed.). Thousand Oaks, CA: SAGE Publications.
[24]. Criel, B. & Waelkens, M. P (2012). Declining Subscriptions to the Maliando Mutual Health Organization in Guinea-Conakry (West Africa): What is going wrong? *Soc Sci Med*; *57*(1), 1205–19.
[25]. Czarniawska, B. & Jorges, B. (2015). Winds of organizational change: How ideas translate into objects and actions. Brunsson, N. and Olsen, J. P. (eds). Organizing Organizations (197- 236). Bergen: Fagbokforlaget.
[26]. D'souza, S. C. & Sequeira, A. H. (2012). Measuring the customer-perceived service quality in health care organization: A case study. *Journal of Health Management*; *14*(1), 27–41.
[27]. Deliege, D. (2014). Indicators of physical, mental and social well-being. *World Health Organization Quarterly, 36* (¾), 349-393.
[28]. Dong, H., De-Allegri, M., Gnawali, D., Souares, A. & Sauerborn R (2013). Drop-out analysis of community-based insurance membership at Nouna, Burkina Faso. *Health Policy*, *92*, 174–9.
[29]. Dror, D. M., & Preker A. S (2012). Social Reinsurance: A new approach to sustainable community health financing, (Washington), World Bank & ILO, 2002, xvii+518.
[30]. Durairaj, V., D'Almeida, S., & Kirigia, J. (2010). Obstacles in the process of establishing sustainable national health insurance scheme: Insights from Ghana, technical briefs for policy-makers, department of health systems financing and health financing policy, WHO/HSS/HSF/PB/10.01.
[31]. Ejembi, H. O. & Bandipo, B. A. (2016). *he Impact of Nigeria Structural Adjustment Programme (SAP) in Health Care System*, at the conference of SAP and future of Nigeria, organized by CSER/ABU Zaria, March 28-30th.
[32]. Fadeji, O. (2013). Goals of Nigeria's health Policy. *Medical Journal. 16*(3), 89-102.
[33]. Federal Ministry of Health Abuja FMH (2017).The National Health Policy and Strategy to Achieve Health for all. FMH, Abuja.
[34]. Federal Government of Nigeria (2017). The Nigeria Demographic and Health Survey (NDHS) (Federal Office of Statistics, Abuja –Nigeria).
[35]. Federal Ministry of Health, Nigeria. (1996). National Health Policy and Strategy to Achieve Health for all Nigerians. Federal Ministry of Health. Revised National Health Policy. 2004. Abuja, Nigeria.
[36]. FMH (2017). Operational Guideline of National Health Insurance Scheme.FMH Abuja.
[37]. Fusheini, D., Marnoch G, & Grey, A. M. (2012).The implementation of the national health insurance programme in ghana–an institutional approach. Paper presented at the 62nd Political Studies Association Annual International Conference in Defence of Politics.
[38]. Ghana Community-based Health Planning and Services- CHPS (2016). Provision of Health Care Delivery Coverage, http://ghanachps.org/?page_id=15 (accessed 16 June 2018).
[39]. Ghanaian Chronicle: Ghana: Region Records 1,761 New Cases of TB in 2007, 29 April 2008 (published on allAfrica.com) http://allafrica.com/stories/200804291067.html (accessed 20th March, 2018).
[40]. Ghanaian Chronicle: Ghana; Corruption Rife in Health Sector- GII Report 2 February 2006 (published by Transparency International) www.transparency.org/content/download/4912/28857/file/Ghanaian_Chronicle_06-02-02.pdf (accessed 20th March, 2018).
[41]. Glaser W.A (2011) "Doctors and Politics" *American Journal of Sociology*, Vol. 66, (Nov. 1960).
[42]. Government of Ghana, (2013). Draft National Health Insurance Act 650 Review Policy, Accra.
[43]. Gronroos, C. A (2012) Service Quality Model and its Marketing Implications. *Eur J Mark*; *18*(4), 36–64.
[44]. Harold, D. L. (2014) Politics: Who Gets What, When and How. *American Political Science Review*, 309 (6), 1174-1176.
[45]. Havey, S. (2011). Strategies for conducting elite interviews. *Sage Journal, 11*(4), 431-441.
[46]. Health Research Unit (HRU) (2016). Report on the perception and demand for mutual health insurance in the Kassena-Nankana district of Northern Ghana. Retrieved from http://www.hru-ghs.org/Newsletter.pdf
[47]. Health Research Unit. (2012). *Treatment default among adult tb patients registered at the Effia - Nkwanta Regional Hospital*: What are the contributing factors? Retrieved from http://www.hru-ghs.org/Newsletter.pdf
[48]. Heidenheimer, A.J., (2015). *Comparative Public Policy: The politics of social choice in Europe and America.* The Macmillan Press Ltd: London.
[49]. Hepnet, K. (2017). Health economics and policy network in Africa: The Implementation of the National Health Insurance Scheme (NHIS) Ghana: Experience Sharing.
[50]. HERFON, (2016). *Nigeria health review, health reform foundation of Nigeria*, Kenbim press Ltd: Ibadan. 10-12.
[51]. Holloway, W. & Jefferson, T. (2011).*Doing qualitative research differently.* London: SAGE Publications.

[52]. Ibiwoye, A. & Adeleke, A. A. (2017).The impact of health insurance on healthcare provision in developing countries. *Ghananian J. Development Stud.4* (21) 49-58
[53]. IRIN – Integrated Regional Information Network: Ghana: Quality healthcare still a dream, 21 September 2006 http://www.irinnews.org/Report.aspx?ReportId=61148 (accessed 20th March, 2018).
[54]. Irinoye, A. I. (2014). Optimal management of health care organizations. Ibadan: Spectrum Books.
[55]. Israel, G. (2012). *Determining Sample Size.* Fact Sheet PEOD-6, IFAS, University of Florida: Gainesville.
[56]. Jaro, I. M. and Ibrahim, A.A (2012). The accessibility problems of primary healthcare to rural people in Jigawa State, Nigeria. *Global Advanced Research Journal of SocSci*, *1*(4): 072-076.
[57]. Jehu-Appiah, C., Aryeetey, G., Agyepong, I., Spaan, E., & Baltussen, R. (2012). Household perceptions and their implications for enrolment in the national health insurance scheme in Ghana. *Health Policy Plan*, *27*(3), 222–233.
[58]. Johnson, J.A. & Stoskopf, C. (2016). *Comparative health systems: Global perspectives*. Massachusetts: Jones and Bartlett Publishers.
[59]. Jutting, J. (2013). Health insurance for the poor –determinants of participation in Community Based Health Insurance Scheme in Rural Areas, Elsevier Ltd Paris
[60]. Kajang, D. R. (2011). The Impact of changing health policy on Nigerian workers. (A Case Study of Kaduna Metropolis) Unpublished M.Sc Thesis, Department of Sociology, A.B.U. Zaria, Nigeria.
[61]. Katibi, L.A. Akande, A.A. & Akande, T. M. (2013). Awareness and attitude of medical practitioners in Ilorin towards national health insurance scheme. *Nigerian Medical Practitioner,* Vol. 43, 2, 33-35
[62]. Klein, R. (2014). Policy problems and policy perceptions in National Health Service. *Policy and Politics, 2(3), 86-9.*
[63]. Klemick, H., Leonard, K. L. & Masatu, M. C. (2017). Defining access to health care: Evidence on the importance of quality and distance in Rural Tanzania. *Am J Agric Econ*, 91(2): 347–358.
[64]. Kutzin, J. (2015). Health insurance for the formal sectors in Africa. Geneva: World Health Organization.
[65]. Langwick, S. (2016).*Geographies of Medicine: Interrogating the Boundaries between "Traditional and Modern" Medicine in Colonial Tanganyika in Borders and Healers: Brokering Therapeutic Resources in Southeast Africa*. West Bloomington: Indiana University Press
[66]. Lavy, V. & Germain, J. M. (2011). Quality and cost in health care choice in developing countries. Living Standards Measurement Study (LSMS) working paper No. LSM 105. Washington DC: The World Bank.
[67]. Lavy, V., & Quigley, J. M. (2015). *On the economics of medical care: The choice of quality and intensity of medical care in Ghana*. Washington DC, London: The World Bank, Sage; 627–685.
[68]. Loewenson, R., & Whiteside, A. (2012). Social and economic issues of HIV/AIDS in Sothern Africa, Harare. Zimbabwe: SAfAIDS.
[69]. Luiten, A. (2015). *Improving Survey Field Work with Paradata.* Hague: Statistics Netherlands.
[70]. March, J.G. and Olsen, J.P, (2013). The institutional dynamics of international political orders. *International Organization, 52*(4): 943-969.
[71]. March, J.G. and Olsen, J.P. (2015). Ambiguity and choice in organizations. Bergen: Universitetsforlaget.
[72]. March, J.G. & Olsen, J.P. (2013). The New Institutionalism: organizational factors in political life, American Political Science Review, 78 (5): 734-49.
[73]. March, J.G. & Olsen, J.P. (2016). *Rediscovering Institutions: The Organizational Basis of Politics*. New York: Free Press.
[74]. Marshall, G. N., Hays, R. D., Mazel, R. (2016). Health status and satisfaction with health care: results from the medical outcomes study. *J Consult ClinPsychol,64* (1), 380–390.
[75]. Mba, T. (2012). Primary Health Care Service and Millennium Development Goals" (A policy paperpresented to National Planning Committee).
[76]. Ministry of Health (2016).Common Management Arrangements (CMA II). Accra, Ghana: Ministry of Health.
[77]. Ministry of Health (2017).The Ghana Health Sector 2008 Progamme of Work. Accra, Ghana: Ministry of Health.
[78]. Ministry of Health (2012). Half Year Report, January to June 2012. Accra-Ghana: Ministry of Health.
[79]. Ministry of Health, 2011. Draft Report-Ghana Annual Independent Health Sector Review.
[80]. Mossialos, E., A. Dixon, J. Figuera & Kutzin, J. (2012). Funding healthcare options for Europe. Buckingham: Open University Press.
[81]. National Bureau of Statistics. Poverty Profile for Nigeria.2015, Abuja.
[82]. NHIS (2014). National Health Insurance Scheme. *Retrieved fromhttp://www.nhis.goving.*
[83]. NHIS (2017). National Health Insurance Scheme. *Retrieved fromhttp://www.nhis.goving.*

[84]. National Health Insurance Authority (2013). Annual Report. Retrieved from http://www.nhis.gov.gh/files/annualreport2011.pdf
[85]. National Health Insurance Scheme (NHIS) (2012). National Health Insurance Scheme handbook. Abuja: Government Press.
[86]. National Health Insurance Scheme Decree No. 35 of 1999. Online available *at http://www.nigeria–law.org/NationalHealthInsuranceSchemeDegree.ht m.* Retrieved on March 23, 2018.
[87]. NCBI (2014).*Gender Bias in Access to Healthcare in Nigeria: A study of End- State Renal Disease*. Online available at: *http://www.ncbi.nlm.nih.gov/pubmed/18302871?dopt=Abstractplus* Retrieved March, 23, 2018.
[88]. Ndie, E. C. (2013). Evaluation of National Health Insurance Scheme (NHIS) awareness by civil servants in Enugu and Abakaliki. *International journal of Medicine and Medical Science, 5*(7), 356-358.
[89]. Nnamuchi O. (2016). The Nigerian social health insurance system and the challenges of access to health care: An antidote or a white elephant? *Medicine and Law*, 28:125–166.
[90]. Noah, A. (2012). Lagos State Commissioner for Health report. The Guardian, 27 October, 2013.
[91]. Nwatu, R. (2014). *Making the health system Effective*. Medical Journal. Jan.
[92]. Nwosu, A.B.C (2015). Healthcare financing in Nigeria; 2000-2003. *Medical Journal, 21*(3), 1-12.
[93]. Nyonator, F. & Kutzin, J. (2016). Health for some? The Effects of user fees in Volta region of Ghana. Health Policy and Planning, 14(4): 329-341.
[94]. Oba, J. O. (2013). Nigeria: Yar'Adua and the Resuscitation of Health Sector. Online available at: *http://allatrica.com/stories/200806021431.html*. Retrieved March, 23, 2018.
[95]. Obansa, S. A. J. & Orimisan, A. (2013). Health care financing in nigeria: prospects and challenges. *Mediterranean Journal of Social Sciences*, *4* (1), 221-236.
[96]. Obasanjo, 0 (2015). The NHIS (A policy Paper presented to the National Executive Council on Mar. 15.
[97]. Ogunbekun, O. & Ogunyemi, A. (2011). Private health care in nigeria, walking a tightrope. *Health Policy Planning*, 1(1), 174-181.
[98]. Ogundiwin, A. O. (2015). Selected theories and their application to political science research in Nwachukwu, J. N., Ogundiwin, A. O. and Nwaobia, A. N (ed.) *Anthology of Theories and their Application in Social and Management Sciences.* Lagos: JAMIRO PRESS LINK.
[99]. Ohalete, C. A. (2013). *Management of National Health Insurance Scheme (NHIS) in Nigeria*, Issues, problems and prospects. a research project presented to the department of management, faculty of business administration, University of Nigeria, Enugu Campus.
[100]. Okaro, A. O., Ohagwu, C. C. & Njoku, J. (2010). Awareness andperception of National Health Insurance Scheme (NHIS) among radiographers in South East Nigeria. *American Journal of Scientific Research*, 8, 18-25.
[101]. Olaiya, T. A. & Ejimokun, B. P. (2011). Appraising the effects of National Health Insurance Scheme (NHIS) on End-Users in Nigeria. *International Journal of African Culture and Ideas.11*(1&2), 62 –90.
[102]. Olakunde, O. B. (2012). Public health care financing in Nigeria: Which way forward? Ann Nigerian Med (Internet).2012; 6: 4-10. Available from: http://www.anmjournal.com/text.asp?2012/6/1/4/100199.
[103]. Olanrewoju, T. (2013).NHIS of what Benefits to Nigerian Masses. Tribune, January 24 2013.
[104]. Omoran, A. I., Bamidele, A.P. & Phillips, O.F. (2011). Social Health Insurance and Sustainable Health care Reform in Nigeria. *Ethno-Med*, 3 (2); 105-110.
[105]. Onuekwusi, N. &Okpala C.O. (2016).Awareness and Perception of National Health Insurance Scheme (NHIS) among Nigerian Health Care Professionals. *Journal of College of Medicine, 3(2), 97-99.*
[106]. Opaluwah, S.(2016)Health Care Delivery in Nigeria and the Imperative of Change. https://pointblanknews.com/pbn/articles-opinions/healthcare-delivery-system-nigeria-imperatives-change/
[107]. Otuyemi, O. D. (2011). Orthordontic in Nigeria: Journey so far and Challenges ahead. *Journal of Orthordontic*, 28(1), 90-92.
[108]. Oyewo, A. T. (2017). *The Application of Presidential System into Nigeria Local Government.*Jator Publishing Co: Ibadan.
[109]. Porter, M. (2014).Cluster and the new Economics of Competitions.*Harvard Business Review.* Nov-Dec.
[110]. Public Agenda: Ghana: NHIS Reeling Under Sanitation-Related Diseases, 1 September 2008 (published on allAfrica.com) http://allafrica.com/stories/200809011434.html (accessed 20th March, 2018).
[111]. Ransome - Kuti, O. (2012). Imperatives of an inefficient healthcare services delivery. *Community Medicine.* 6 No 2.
[112]. Ray, A. (2012). *The methods of sampling and purposive sampling.* Munich: GRIN Vertag. *Research*, 6(.105), 17 .

[113]. Robyn, P. J., Barnighausen, T., Souares, A., Savadog, G., Bicaba, B., & Sie, A.(2013). Does enrolment status in community-based insurance lead to poorer quality of care? Evidence from Burkina Faso. *Int Journal Equity Health*; *12* (2), 31–44.
[114]. Runki, B. (2014), *Public Administration Concept and Theories.*New Delhi: Sterling Publishers Private Limited.
[115]. Sahlin-Andersson, K. (2012). *The social construction of projects. A case study of organizing of an extraordinary building project - the Stockholm Globe Arena*, in Brunsson, N. and Olsen, J. P. (eds), Organizing Organizations (pp. 89-106). Bergen: Fagbokforlaget.
[116]. Sahn, D. E. , Younger, S. D. & Genicot G. (2013). The demand for health care services in rural Tanzania. *Oxf Bull Econ Stat*; 65(2): 241–26.
[117]. Saltman, R., Richard S, Busse R, & Figuares, J.(2014). Social health insurance system in Western Europe, World Health organization.
[118]. Sani, M. (2016). Integrating federal health resources at the local level: A case study of the development of the national primary health care delivery system. M.P.A Field Report; Obafemi Awolowo University, Ile-Ife.
[119]. Sanusi R. A & Awe, A. T (2011). An assessment of awareness level of national health insurance scheme consumers in Oyo state Nigeria. *The Medwell J. 4* (2), 143-148
[120]. Sanusi, R. A. & Awe, A. T. (2015).Perception of National Health Insurance Scheme (NHIS) by Health Care Consumers in Oyo State, Nigeria. *Pakistan Journal of Social Sciences,6* (1), 48-53.
[121]. Schellekens, O. (2014). In L. Akinola (Ed.), A Model of Good Health. *This Africa: A Global Perspective, March,2009*.pp.48-50.
[122]. Scott, E. A. (2010). *The evolution of health care systems in Nigeria: Which way forward in the twenty-first century*? *Niger Med J. 2010; 51: 53-65.* Available from: http://www.nigeriamedj.com/text.asp?2010/51/2/53/70997 (25 June, 2018 date last accessed).
[123]. Shehu, U. (2016). Health Policies in Nigeria. An overview. *Nigeria Journal of health Planning and Management.* 12(2), 4-6.
[124]. Sofaer S, Firminger K. (2005) Patient perceptions of the quality of health services. *Annu Rev Public Health; 26*: 513–539.
[125]. Spaan, E., Mathijssen, J., Tromp, N., McBain, F., Have, A. T., & Baltussen, R. (2012). The impact of health insurance in Africa and Asia: A systematic review. *Bull World Health Org*; *90*, 685–692.
[126]. Strasser S, Ahorony, L., & Greenberger, D. (2013). The patient satisfaction process: moving towards a comprehensive model. *Med Care Res Rev*, 50, 219–248.
[127]. Stupak, R., Gilman, S. & Hartzer. C. (2016), *UnderstandingPolitical Science- the Arena of Power*.New York: Alfred Knopf.
[128]. Sven, O. H. (2011). Decision Theory, a brief introduction", in *Royal Institute of Technology (KTH) Stockholm.*
[129]. Synder, et al (2013). The decision makingaprroach to the study of international politics, in James N. R. (ed), *International Politics and Foreign Policy. A Reader in Research and Theory.*New York: Free Press.
[130]. Teriba, J (2015).The NHIS so far. *Vanguard Newspaper*. July 26. Pg.29
[131]. Terris, M. (2012). The three world systems of medical care: trends and prospects. *World Health Forum. 1:1&2, 1980; 78-86.*
[132]. The Research Savvy Practitioner (2013). Key informant interviews (KII). *Research Review, 3(1),* 117-143.
[133]. The Vanguard Editorial (2015). National Health Insurance Scheme: A desideration. Online available at:*http://nm.onlinenigeria.com/templates/?a=5836&2-7* Retrieved March 23, 2018.
[134]. The World Bank, (1994). Better health in Africa: Experience and lessons learned. Washington, DC.
[135]. Thoenig, J. C. (2011) Institutional theories and public institutions: New agendas and appropriate. In Peters, B. G. and poerre, J. (eds). The Handbook of Public Administration (pp 185-101). California: Sage.
[136]. Townsend, R. (2014) Risk and insurance in village India. *Econometrica, 62*(3), 539-91.
[137]. Ugbaja, C.O (2011). Alternative method of healthcare financing. *Community Medicine. Oct - Dec. Vol.1, 19-30.*
[138]. United Nations Development Programme (UNDP). Human development indices.*2007/2008 Human Development Report.* New York, UNDP.
[139]. Universal Declaration of Human Rights (UDHR) Article 25 s.1 (2015).
[140]. Van den Boom, G .J .M., Nsowah-Nuamah, N. N. N. & Overbosch, G. B. (2014). Healthcare provision and self-medication in Ghana. Retrieved from http://web.archive.org/web.
[141]. Van den Boom, G.J.M; Nsowah-Nuamah, N.N. N. & Overbosch, G. B. (2011*). Curative health care utilization in Ghana: A multinomial analysis of equitable access opportunities,undated*. http://www.agricta.org/partners/sadaoc/Francais/N%B052.pdf (accessed 20th March, 2018).

[142]. Varian, H. (2014). *Microeconomic Analysis*. New York: W.W. Norton and Co.
[143]. VOA – Voice of America: Ghanaian Health Official Laments Slow Progress in Providing Universal Health Care, 28 February 2007. http://www.voanews.com/english/archive/2007-02/2007-02-28-voa28.cfm (accessed 20th March, 2018).
[144]. Wagstaff, A. (2012). Social health insurance re-examined. *Health Economics*; 2009; 19: 503-517.
[145]. Walia, R. (2015). A Saga of qualitative research. *Social Crimonol 3(124),* 1-3. Doi: 10.4172/2375-4435.1000124.
[146]. WHO (2014). Alma Ata 1978: *Report on the international conference on primary health Care* WHO Geneva.
[147]. WHO, (2011). *Regional overview of social health insurance in South-East Asia WHO/AFRO* Strategic Health Research Plan (1999-2003) for the WHO Africa Region. WHO/Regional Committee for Africa Resolution AFR/RC48/R/4. Harare.
[148]. WHO. (2016). Sustainable health financing, universal coverage, and social health insurance. In: 58th World Health Assembly. Agenda Item 13.16 Edition. Geneva.
[149]. Wilson, R. (2015) *Sociology of Health: An Introduction.* Random House: New York.
[150]. Witter, S., Adjei, S., Armar-Klemesu, M., & Graham, W. (2010). Providing free maternal health care: Ten lessons from an evaluation of the national delivery exemption policy in Ghana.*Global Health Action*,2(10),1–13
[151]. World Bank (2012). *African development indicators 2005.*Washington D. C. World Bank
[152]. World Bank (2010a).*World development Indicators.* Washington D.C.: World Bank. United Nations, Education Scientific and Cultural Organization.
[153]. World Bank, CRS (2012). Country status report for Nigeria.
[154]. World Bank (2010a) Improving primary health care delivery in Nigeria: Evidence from four States. World Bank.
[155]. World Health Organization (2015). Everybody's business. strengthening health systems to improve health outcomes. WHO's framework for action Geneva, World Health Organization.
[156]. World Health Organization (2015a). *World health statistics 2007.* Geneva: WHO.
[157]. World Health Organization (2015b). Health financing and social protection. Online available: *http://www.whho.int/countries* Retrieved March 23, 2018.
[158]. World Health Organization (2015c)*WHO country cooperation: Federal Republic of Nigeria, 2002-2007*Geneva:WHO.
[159]. World Health Organization (2018). *Mortality Rate in Nigeria. Geneva:* World Health Organization.
[160]. World Health Organization (2015). The world health report 1995: Bridging the gaps. Geneva: WHO, 1995.
[161]. World Health Organization (2016). Universal health coverage (UHC) WHO fact sheet 2016. Available from: http://www.who.int/mediacentre/ factsheets/fs395/en.
[162]. Yohersor, A. (2014). *Social health insurance scheme that works: Recommendation to NHIS.* Abuja: V.C Publishers.

IOSR Journal Of Humanities And Social Science (IOSR-JHSS) is UGC approved Journal with Sl. No. 5070, Journal no. 49323.

Oni, Michael Abiodun. " Awareness of and Access to National Health Insurance Scheme in Nigeria and Ghana." IOSR Journal of Humanities and Social Science (IOSR-JHSS). vol. 24 no. 04, 2019, pp. 57-69.