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NIGERIAN HEALTH INSURANCE: AN EVALUATION OF GOHEALTH SCHEME IN YAMALTU DEBA LOCAL GOVERNMENT AREA, GOMBE STATE, NIGERIA

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Abstract
This research on Nigerian Health Insurance: An evaluation of GoHealth Scheme in Yamaltu Deba Local Government Area, Gombe State, Nigeria, used area of coverage and beneficiary satisfaction as the specific objectives on GoHealth. The study makes use of survey research design that allows for the use of questionnaires to elicit data from the respondents, the population consist of the entire inhabitants of Yamaltu Deba Local Government Area of Gombe State. The estimated Population of 186,732 persons was used where 400 persons were selected using Taro Yamane formulae to represent the entire population. Multiple regression was used for the analysis. The study found a significant effect on area of coverage and beneficiary satisfaction on GoHealth Scheme. The study further recommends that GoHealth Scheme should be expanded since it has created an avenue where employed and unemployed individuals can access healthcare services at little or no cost even when they are not making contributions as the government bear the cost incurred by the poor and vulnerable especially for those officially registered in a government certified unemployment register. Several Nigerians are not fully enlightened in thecomponents and structure of the NHIS, the same applies to GoHealth. The researcher recommends a massive and far-reaching enlightenment campaign to educate the populace on the scheme, the benefits there in and the rights of enrollees.

Key words: Evaluation, National Health Insurance Scheme, GoHealth

Introduction

Nigeria is among a few African countries that promulgated a National Health Insurance (NHI) law. Before the advent of the National Health Insurance Scheme (NHIS), health service to government officials, their dependents and students were supposed to be free, while the general populace was expected to Pay Out of Pocket (POP) for health service received at all level of the healthcare system. The operation of NHIS was obstructed following the Nigerian civil war. In 1984, the Nigerian Health Council resuscitated the scheme and a committee was set up to look at the National Health Insurance. And in 1988, the then Minister of Health commissioned Emma-Eronmi led committee that submitted her report which was approved by the federal Executive Council in 1989 (Agba *et al*, 2010). Consultants from International labour Organisation (ILO), and United Nation Development Programme (UNDP) carried out feasibility studies and come up with the cost implication, draft legislature and guidelines for the scheme. In 1993, the Federal government directed the Federal Ministry of Health to start the scheme in the country (Agba *et al*, 2010). In 1999, the scheme was modified to cover more people via Decree No 35 of May 10, 1999 which was promulgated by the then head of state, Gen. Abdulsalami Abubakar. The decree became operational in 2004 following several flagged off; first by the wife of the then President, Mrs Stella Obasanjo on the 18th February, 2003 in Ijah, a rural community in Niger state, North Central Nigeria. Since the Rural Community Social Health Insurance and Under-5 children Health Programme of the NHIS scheme were flagged up by the First Lady, other flagged offs were carried out in Aba, Abia State South East Zone, among others (Onyedibe, Goyit & Nnadi, 2012). The NHIS when launched in 2005 was built on the framework that it will cover both the formal and informal sector of the economy. This brought about the NHI guideline that appointed the professional

as providers in the scheme; registration of and classification of hospitals; registration of pharmacies; registration of health maintenance organisation; among others (NHIS, 2005).

Nguyen (2011) stated that to ensure effective scheme, principal-agent relationship was established among the actors- NHIS, HMOs, employees and providers. While the NHIS and beneficiaries are the principals, HMOs and providers serve as the agents in the scheme arrangement (Eric *et al,* 2013). However, the scheme so started could only cover the formal sector of the economy against its initial intention. The formal sector includes the federal, state and other taxable establishments. But the scheme initially covers only the federal government employees, although some private establishments like banks also have their private health insurance arrangement.

The emergence of state contributory health schemes became necessary when the NHIA could not cover more than 5% of Nigeria, which means Universal Health Coverage could not thrive. Gombe State Contributory Healthcare Management Agency; GoHealth is the State-Owned social health programme managed by the Gombe State Contributory Healthcare Management Agency. The Gombe State Contributory Healthcare Management Agency is established by part II section 4 of the Gombe State Contributory Healthcare Agency Law, 2019 signed by His Excellency, Governor Muhammadu Inuwa Yahaya on 30th December, 2019. The Agency has the mandate to ensure to the attainment of Universal Health Coverage through a credible and sustainable mechanism for pooling of resources to finance healthcare services, and improve access to quality healthcare provision with financial risk protection. The Agency is regulated by a Governing Board which consists of major stakeholders such as the NLC, TUC, CSOs, among others.
Objectives: To ensure that all residents of the State have access to effective, quality and affordable health care services

1. To Protect families from the financial hardship of huge medical bills
2. To Limit the inflationary effects of the rise in the cost of healthcare services
3. To ensure equitable distribution of health care costs across different income groups
4. To ensure the provision of high standard of health care delivery to the beneficiaries
5. To improve and harness private sector participation in the provision of health care services
6. To ensure adequate distribution of health facilities under the scheme within the State

Statement of the Problem

In most developing countries, Nigeria in particular there is a clear lack of universal coverage of health care and little equity. Access to healthcare is severely limited in Nigeria, Otuyemi, (2001). Inabilities of the consumers to pay for the services as well as the healthcare provision that is far from being equitable have been identified among other factors to impose the limitation, Sanusi, et al (2009). Financing of public health services in Nigeria has been through government subvention funded mainly from earnings from petroleum exports and user fees for patients. Decline in funding for healthcare commenced after the mid 1980's following a drastic reduction in revenue from oil exports, mounting external debts burden, structural adjustment programme and rapid population growth rate, Shaw et al (1995). The result as in most other developing countries was a rapid decline in the quality and effectiveness of publicly provided healthcare services, Shaw, et al (1995).Funding of healthcare in Nigeria has not only affected the quality of healthcare services but led to impoverishedhealth standard of the populace. Gana (2010), identified these funding challenges as low level of public (government) spending, high burden of healthcare costs on individuals and households (70% of all expenditure); thus ranking Nigeria as the country with the second highest level of out-of-pocket spending on health financing in the world.

More worrisome is the fact that the Nigerian System allows private healthcare providers to partake as majorstakeholders despite the establishment of the NHIS. Theextent of coverage of the NHIS is such that artisans, farmers, sole proprietors of businesses, street vendors, traders and the unemployed are not yet accounted for. Even within the formal sector, not all government and corporate organisation employees are enrolled within thescheme. Our public and private hospitals therefore are still operating on a fee for

service basis for the majority of its clients. Besides that, long queues are still usual sites while the issue of unavailability of required servicesis rearing its ugly head in NHIS approved hospitals. In addition, there is still weak and ineffective referral systems' resulting in overburdened secondary and tertiary health facilities. Furthermore, education of the teaming populace on the pros and cons and the need to participate in the NHIS is also a challenge yet to be surmounted. In view of the aforementioned, this study seeks to assess the extent of coverage of the GoHealth scheme and the degree to which the enrollees are satisfied with the Scheme in Yamaltu Deba Local Government, Gombe State Nigerian

Many studies were conducted on national health insurance scheme on local government health care such as Okpe, Luximon and Jamda (2022) assessed the impact of National Health Insurance Scheme on the health care needs of workers in Federal Medical Centre Makurdi, Benue State Nigeria. Pillah (2022) studied national health Insurance Scheme (NHIS) as a health care policy that was launched by the Federal Government of Nigeria in 2005 for better healthcare delivery to the public. Christina et al (2014) assessed the socio-demographic variables on the demand for health insurance in Lagos State. Onyedibe, Goyit and Nnadi (2012) examined national health Insurance Scheme (NHIS) as a health care scheme established by the Federal Government of Nigeria. This research studied area of coverage and beneficiaries satisfaction of the scheme.

i. What is extent of the coverage of GoHealth scheme in Yamaltu Deba Local Government, Gombe State?
ii. To what extent has beneficiaries satisfiedwith the GoHealth scheme?

Objective of the Study

The main purpose of this study is to evaluate the performance of the GoHealth scheme in Yamaltu Deba Local Government, Gombe State while the specific objectives include:

i. To determine the extent of coverage of GoHealth scheme in Yamaltu Deba Local Government, Gombe State
ii. To determine the extent to which beneficiaries are satisfiedwith the GoHealth scheme.

Literature Review

Concept of Health Insurance

The term health insurance is commonly described as any programme that helps pay for medical expenses, whether through privately purchased insurance, social insurance or a social welfare program funded by the government. Synonyms for this usage include "health coverage", "health care coverage" and "health benefits" (Elwyn, Edwards, Kinnersley&Grol, 2000). Health Insurance is insurance that covers the whole or a part of the risk of a person incurring medical expenses. By estimating the overall risk of health care and health system expenses, among a targeted group, an insurer can develop a routine finance structure, such as a monthly premium or payroll tax, to ensure that money is available to pay for the health care benefits specified in the insurance agreement. Health Insurance scheme started in Germany in 1887 as a way of financing health care, followed by Austria 1897, Norway 1902 and United Kingdom 1910. By 1930, Health insurance scheme had been well established and recognized in all European countries (Okezie, 2001). It is also common to all developed countries, but the mechanism of obtaining insurance differs from country to country (Cutler and Zeckhauser, 2000). The benefit is administered by a central organization such as a government agency, private business, or not-for-profit entity.

Concept of Social Health Insurance

Social Health Insurance (SHI) is a system of financing health care through government regulations. It is a form of mandatory insurance scheme (normally on a national scale). It provides a pool of funds to cover the cost of health care and it also has a social equity function which eliminates barriers to obtaining health care services. In SHI, every citizen is required to make contributions. Government may contribute on behalf of the poorest and the unemployed; employers also usually contribute on behalf of their employees (Carrin,

2005). Social health insurance pools, both the health risks of its members on the one hand, and the contributions of enterprises, households and government, on the other. Contributions of households and enterprises are usually based on income, whereas, government contributions are mostly financed from general taxes (Carrin, 2002).

Concept of National Health Insurance

National health insurance (NHI) – sometimes called statutory health insurance (SHI) – is a legally enforced scheme of health insurance that insures a national population against the costs of health care. It may be administered by the public sector, the private sector, or a combination of both. Funding mechanisms vary with the particular program and country. National or statutory health insurance does not equate to government-run or government-financed health care, but is usually established by national legislation. In some countries, such as Australia's Medicare system or the UK's National Health Service, contributions to the system are made via general taxation and therefore are not optional even though use of the health scheme it finances is (Obembe, 2007). In practice, of course, most people paying for NHI will join the insurance scheme. Where the NHI scheme involves a choice of multiple insurance funds, the rates of contributions may vary and the person has to choose which insurance fund to belong to (Carrin and James, 2005, Hennock, 2007).

GoHealth Scheme

GoHealth is the State-Owned social health programme managed by the Gombe State Contributory Healthcare Management Agency. The Gombe State Contributory Healthcare Management Agency is established by part II section 4 of the Gombe State Contributory Healthcare Agency Law, 2019 signed by His Excellency, Governor Muhammadu Inuwa Yahaya on 30th December, 2019. The Agency has the mandate to ensure to the attainment of Universal Health Coverage through a credible and sustainable mechanism for pooling of resources to finance healthcare services, and improve access to quality healthcare provision with financial risk protection. The Agency is regulated by a Governing Board which consists of major stakeholders such as the NLC, TUC, CSOs, among others. GoHealth, (2022)

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l. Departments

(a) Office of the Executive Secretary (b) Operations, Standard & Quality Assurances Department (c) Admin and Finance (d) Planning Research & Statistics Department (e) ICT, IEC & Marketing Department

Operations, Standard & Quality Assurances Department: Coordinate operational activities, Design of Operations (Formal Sector, Informal Sector, Health Equity Operations etc.), Oversee enrolment of all beneficiaries (formal, informal, TISHIP, Vulnerable groups) into the scheme in collaboration with other stakeholders, Coordination of operations, Program supervision, Periodic review of Operations, operations of the scheme and Develop Panel lists for HCPs It also Manages the Communication and sensitization of enrollees about the Scheme, Approve Secondary and Tertiary care, Coordinate activities of the Agency's Contact Centre, Conduct Utilization Reviews, Adjudication and verifications of claims – monitors TPA claims adjudication for the informal and formal sector and adjudicates claims from PHCs participating in BHCPF, Develop quality assurance (QA) guidelines and Define standards according to national guidelines and protocols It also Inspection, accreditation, selection and contracting of Healthcare providers and Third Party Administrators for the Scheme, Ensure compliance to the guidelines, Enforces compliance to

operational guideline, rules and protocols, Ensure Continuous Quality Assurance (hospital/medical audits, reviews and inspection/assessment, etc.), Reports to the Executive Secretary. GoHealth, (2022).

Empirical Framework

Okpe, Luximon and Jamda (2022) assessed the impact of National Health Insurance Scheme on the health care needs of workers in Federal Medical Centre Makurdi, Benue State Nigeria. The data for the study were collected through questionnaires and in-depth interviews. Questionnaires were administered on a sample of 341 respondents. Data analysis was quantitative and qualitative in nature. The specific objectives of the study were to examine the level of awareness about NHIS among the staff of FMC; assess the National Health Insurance healthcare services available in FMC Makurdi; examine the health care needs of the staff of FMC Makurdi; examine the impact of NHIS on health needs of workers in FMC Makurdi; assess the challenges of implementing NHIS in FMC Makurdi and suggest ways of minimising the implementation challenges of NHIS in FMC Makurdi. The analysed results show that, though all the staff of FMC, Makurdi were registered members of the National Health Insurance Scheme, many of them lacked adequate awareness on key issues about the Scheme, Federal Medical Centre Makurdi offers several healthcare services under the NHIS, even though the NHIS was overwhelmingly accepted by staff of FMC Makurdi as having a positive impact on staff of the FMC such as reducing the financial hardship of their medical bills, affordable services and greater access to medical care, the scheme is not perfect. The study therefore, recommends among other that there is need for aggressive awareness programme of the scheme in order to reveal its benefits to all Nigeria citizens.

Adeyemi and Olayiwola (2021) examined how health insurance offers financial risk protection and provides opportunity for smoothened medical expenditures over time. However, existing facts show that less than 4% of the Nigerian households are covered by health insurance scheme. This causes weak ability to smoothen consumption over time during illness for most of the Nigerians. This study investigates the impact of health insurance on non-medical consumption in Ekiti State, Nigeria using a propensity score matching estimator model. The study found that the average out-of –pocket health expenditures were N5,395.14 and N 9,123.05 within four weeks for lower households in the control group when compared to the treated group. Also, health insurance affords the insured households the opportunity to smoothen non-medical consumption during illness. It allows the insured households to consume necessary non-medical goods in the instance of sickness of any family member. Hence, health insurance provides the capacity to pay for non-medical consumption during illness.

Pillah (2022) studied national health Insurance Scheme (NHIS) as a health care policy that was launched by the Federal Government of Nigeria in 2005 for better healthcare delivery to the public. The policy aims at increasing effective healthcare coverage of the Nigerian population. The objective of this study is to evaluate the National Health Insurance Policy in Nigeria from inception to date with a view to determining the effectiveness of the policy. Specifically, the study observes the performance and challenges of the policy. It was observed that, though the implementation of the policy receives appreciable momentum and efforts by the NHIS implementation agency, there is still a wide gap in terms of public participation and effectiveness. Public participation in the scheme since inception in the country to date is below 10% of the Nigeria's population. The study identified delay in payment to health facilities by Health Maintenance Organizations (HMOs), inadequate public awareness, public apathy, poor management, rural exclusion, lack of standard facilities, Inadequate medical personnel and poor services as some of the banes of the scheme. Recommendations offered for addressing these barriers include public awareness campaign, personnel training and rural inclusion and focus on best practices and quality assurance. The scope of the study covers Nigeria Health Insurance Scheme (NHIS) with specific regards to its performance and challenges between from 2004 to 2021. The study used a descriptive qualitative analysis methodology. Data were obtained from secondary sources including publications, journals, relevant literature and internet sources.

Christina (2014) assessed the socio-demographic variables on the demand for health insurance in Lagos State. For this purpose, the researchers have been able to examine selected socio-economic and demographic variables and their effects on health insurance accessibility and desire of individual households. The

explanatory research design was employed. A convenience sampling technique was adopted. Data was gathered from individual households within Alimosho and Ojo Local Government Areas of Lagos State through the use of an interviewed schedule. The sample consisted of 212 respondents made up of individual households within the sample areas. Data collected was analyzed using multiple regression technique. The study was able to establish some level of contributory linkage between selected socio-demographic variables and demand for health insurance. The findings show that while education and income both appeared to have significant effect, gender and age both have positive contributory effect. The study therefore recommends that health insurance providers should endeavor to education the larger society of the significance of health insurance products to human existence. Secondly, a robust strategic health insurance outlines should be designed to incorporate the vulnerable ones in the society to ensure equality and fairness in the provision of National Health Insurance Scheme. Lastly, Health Maintenance Organizations should endeavor to implement flexible payment plans for participants in order to improve participation of more individuals.
Onyedibe, Goyit and Nnadi (2012) examined national health Insurance Scheme (NHIS) as a health care scheme established by the Federal Government of Nigeria in 2005 for better healthcare delivery to its populace. The objective of this study was to determine the proportion of Nigerian adults enrolled in the scheme, their satisfaction with the quality and availability of services within the scheme and the factors responsible for the dismal health indices in the country despite the scheme. Questionnaires were administered randomly to 200 adult respondents in Jos metropolis. The findings show that only 24% of adults were enrolled in the scheme. Notably, 82% of enrolled respondents were aware of NHIS and prefer it to the fee for service system. There was some level of dissatisfaction in the scheme (26% of enrollees). Sources of dissatisfaction included poor registration services, poor referral system, delays in receiving required services and unavailability or non coverage of some required services. It was statistically determined by the Chi Square tool of analysis that there was a direct relationship between the percentage of enrollees and the poor health indices of the populace. We strongly recommend modification of existing policies to enable enrollment of the self employed and unemployed as well as improved coverage and quality of services within the scheme.

Theoretical framework

The paper adopted Dissonance Theory by Cardozzo, (1965). The Dissonance Theory suggests that a person who expected a high-value product and received a low-value product would recognize the disparity and experience a cognitive dissonance (Cardozzo, 1965). That is, the disconfirmed expectations create a state of dissonance or a psychological discomfort (Yi, 1990). According to this theory, the existence of dissonance produces pressures for its reduction, which could be achieved by adjusting the perceived disparity. This theory holds that "post exposure ratings are primarily a function of the expectation level because the task of recognizing disconfirmation is believed to be psychologically uncomfortable. Thus consumers are posited to perceptually distort expectation-discrepant performance so as to coincide with their prior expectation level" (Oliver, 1977, p. 480). For instance, if a disparity exists between product expectations and product performance, consumers may have a psychological tension and try to reduce it by changing their perception of the product (Yi, 1990). Cardozzo argues that consumers may raise their evaluations of those products when the cost of that product to the individual is high. For example, suppose that a customer goes into a restaurant, which she or he expects it to be good, and is confronted with an unappetizing meal. The consumer, who had driven a long distance and paid a high price for the meal, in order to reduce the dissonance, might say that the food was not really as bad as it appeared or she likes overcooked meal, etc. The researchers pursued this approach implicitly assume that consumers would generally find that product performance deviated in some respect from their expectations or effort expenditures and that some cognitive repositioning would be required (Oliver, 1980).
This theory has not gained much support from researchers, partly because it is not clear whether consumers would engage in such discrepancy adjustments as the model predicts in every consumption situation. In his criticism of the Dissonance theory, Oliver (1977), for instance, argues that "Generally, it is agreed that satisfaction results from a comparison between X, one's expectation, and Y, product performance. Thus, it is the magnitude and direction of this difference, which affects one's post-decision affect level. X

serves only to provide the comparative baseline. Moreover, consumers are under no particular pressure to resolve the X-Y difference. In fact, satisfaction/dissatisfaction is thought to arise from recognition and acknowledgement of dissonance". If the Dissonance Theory holds true, then companies should strive to raise expectations substantially above the product performance in order to obtain a higher product evaluation (Yi, 1990). However, the validity of this assumption is questionable. Raising expectations substantially above the product performance and failing to meet these expectations may backfire, as small discrepancies may be largely discounted while large discrepancies may result in a very negative evaluation. This suggestion fails to take into account the concept of "tolerance level". The tolerance level suggests that purchasers are willing to accept a range of performance around a point estimate as long as the range could be reasonably expected. When perceptions of a brand performance, which are close to the norm (initial expectation), are within the latitude of acceptable performance, and then it may be assimilated toward the norm (Woodruff et al 1983). That is, perceived performance within some interval around a performance norm is likely to be considered equivalent to the norm. However, when the distance from this norm is great enough, that is perceived performance is outside the acceptable zone, then brand performance will be perceived as different from the norm, which, in contrast to this model's assumption, will cause dissatisfaction not a high product evaluation. The Dissonance Theory fails as a complete explanation of consumer satisfaction; however, it contributes to the understanding of the fact that expectations are not static in that they may change during a consumption experience. For instance, the importance attached to pre-holiday expectations may change during the holiday and a new set of expectations may be formed as a result of experiences during the holiday. This implies that as customers progress from one encounter to the next, say from hotel's reception to the room or the restaurant, their expectations about the room may be modified due to the performance of the previous encounter (Danaher & Arweiler, 1996). Dissonance Theory postulates a relationship between service quality, client satisfaction and client personality. The theory contends that client personality mediates the dependent variable. To assess the current GoHealth quality health services, the paper adopted the service quality dimensions of Dissonance Theory of Cardozzo, (1965). The framework illustrates the following basic sequence: GoHealth quality health services lead to client satisfaction and client personality is a moderator.

Smith, Humphreys, Jones, (2009) found that fairly perceived quality services may also result in high satisfaction for those civil servants who may not necessarily seek the health care under GoHealth. Such civil servants may view convenience, prompt attention and availability of services as more important variables affecting overall qualitative health services of GoHealth.

Research Methodology

This study makes use of survey research design that allows for the use of questionnaires to elicit data from the respondents. For this study, the population is the entire inhabitants of Yamaltu Deba Local Government Area of Gombe State. The estimated Population of Yamaltu Deba Local Government Area is 186,732 persons. However, since it is not feasible to reach the entire population, a sample size of (400 respondents) was selected to represent the entire population using Yamane formula. For this study, primary data came from persons who are adults above the age of eighteen (18). Questionnaire was used as the means of collecting data. Thus, the study was structured questionnaire administered to respondents as the principal method of data collection. Questionnaire was chosen as the suitable instrument for data collection considering the fact that it is costeffective, ensures uniformity, avoids ambiguity, avoids errors, saves time and has a relatively high degree of standardization. Data was analyzed using descriptive and inferential statistics.

$$n = \frac{N}{1 + N(e)^2}$$

Where:

n = sample size

N = population
1 = constant
e = level of significance 0.05
Therefore: the sample size for academic staff is calculated below:

$$n = \frac{186732}{1 + 186732(0.05)^2}$$

$$n = \frac{186732}{1 + 186732 \times 0.0025}$$

$$n = 400$$

Model Specification

This research study was modelled on multiple regression.

$Y = \beta + \beta_1 X_1 + \beta_2 X_2 + e$

Where

Y= National Health Insurance
e = error term
B_o= Constant term
B_x = Coefficient to be estimated
X_1 = extend of coverage
X_2= beneficiary satisfaction
b_1-b_2 = Regression Coefficient

Data Presentation and Analysis

This study was conducted to examine the Nigerian health insurance scheme in Yamaltu Deba local government area Gombe state. The data were analyzed using inferential statistics (regression) to test the hypotheses. Four hundred (400) copies of questionnaire were administered and used in the analysis. The results were presented in tables and discussed according to the research hypothesis.

Hypotheses: Nigerian health insurance area coverage and beneficiary satisfaction has no significant effect on GoHealth scheme in Yamaltu Deba Local Government, Gombe State.

Multiple Regression Analysis on the effects of extend of coverage, beneficiary satisfaction

Parameter	*Estimate*	*Standard Error*	*T Statistic*	*P-Value*
Constant	4.4157	1.5426	1.8785	0.042
extend of coverage	0.17598	0.2118	0.5883	0.038
beneficiary satisfaction	0.23948	0.1330	0.5712	0.019

$Y = \beta + \beta_1 X_1 + \beta_2 X_2 + e$
R-squared = 0.69 percent
R-squared (adjusted for d.f.) = 0.43 percent
Standard Error of Est. = 1.1405
Mean absolute error = 0.76154
Durbin-Watson statistic = 1.24850 (P=0.0138)
Lag 1 residual autocorrelation = 0.21031

The table above shows Nigerian health insurance area coverage and beneficiary satisfaction on GoHealth scheme in Yamaltu Deba Local Government, Gombe State. The result revealed a significant effect of area coverage, beneficiary satisfaction on GoHealth scheme. Since the p values 0.042, 0.038, 0.019) are less than the alpha (0.05) value ($p<\alpha$) the null hypothesis is rejected at 0.05 level of significance. Meaning there was a significant effect of area coverage, beneficiary satisfaction on GoHealth scheme. The R-Squared statistic

indicates that the model as fitted explains 0.69% of the variability in the variables used. The adjusted R-squared statistic, which is more suitable for comparing models with different numbers of independent variables, is 0.43%. The standard error of the estimate shows the standard deviation of the residuals to be 1.1405. The mean absolute error (MAE) of 0.76154 is the average value of the residuals.

Discussion of the findings

Ho_1 found a significant effect of area coverage on GoHealth scheme which is in line with Pillah (2022) studied national health Insurance Scheme (NHIS) as a health care policy that was launched by the Federal Government of Nigeria in 2005 for better healthcare delivery to the public and Okpe, Luximon and Jamda (2022) assessed the impact of National Health Insurance Scheme on the health care needs of workers in Federal Medical Centre Makurdi, Benue State Nigeria.

Ho_2 found a significant effect of beneficiary satisfaction on GoHealth scheme, which aligned with the study conducted by Onyedibe, Goyit and Nnadi (2012) examined national health Insurance Scheme (NHIS) as a health care scheme established by the Federal Government of Nigeria in 2005 for better healthcare delivery to its populace and Christina (2014) assessed the socio-demographic variables on the demand for health insurance in Lagos State.

Conclusion

Based on the findings, it can be concluded that the people in Yamaltu Deba Local Government Area of Gombe State benefited from the GoHealth. The non- coverage by the insurance scheme of some of the services required by enrollees is a policy issue which can only be dealt with at the level of policy formulation. Suffice to note that some enrollees will not mind increasing their contributions into the scheme in as much as these services would be covered in the benefit package.

Recommendation

The study therefore recommended that:

a. Expansion of the scheme where employed individuals and the immediate as well as unemployed individuals can also access healthcare services at little or no cost even when they are not making contributions. The government can bear the cost incurred by the poor and vulnerable especially for those officially registered in a government certified unemployment register. Several Nigerians are not fully enlightened in thecomponents and structure of the NHIS, the same applies to GoHealth. The researcher recommends a massive and far-reaching enlightenment campaign to educate the populace on the scheme, the benefits there in and the rights of enrollees.
b. Health Maintenance Organizations andhealthcare providers must realize that enrollees have the right to choose who their service providers are and can change to another when not satisfied with services rendered. Therefore, it is recommended that every provider strive to provide the best of services and the monitoring and regulating agencies should step up their monitoring and evaluation antennae in order to curb the menace of dissatisfaction which is fast becoming common place process of implementing the scheme.

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