Prevalence, Patterns, and Management Strategies of Health Insurance Fraud in Selected Public Hospitals in Benue State, Nigeria

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Abstract
Health insurance fraud within Nigeria's National Health Insurance Authority (NHIA) undermines healthcare sustainability in Benue State's public hospitals, draining a significant percentage of NHIA funds annually and exacerbating inequities. This study aims to examine the prevalence, patterns, and management strategies of NHIA fraud in selected public hospitals: Benue State University Teaching Hospital, Federal Medical Centre, Makurdi, General Hospital, Gboko, General Hospital, Otukpo, General Hospital, North Bank, and General Hospital, Vandeikya, to inform policy reforms for Universal Health Coverage (UHC). Grounded in Greed and Grievance Theory, which attributes fraud to socioeconomic pressures, greed, and systemic loopholes, the study adopted a qualitative case study and exploratory design. A purposive sample of 31 participants, including hospital management (three Chief Medical Directors, three Financial Managers, two administration officers), external stakeholders (3 HMO representatives, one EFCC, one forensic investigator, 3 Health management organizations, four police investigation officers), and eight NHIA subscribers, were selected. Data were collected through semi-structured key informant interviews (KIIs) Thematic analysis, using Braun and Clarke's framework and NVivo software, revealed five fraud types: falsification of receipts, patient fraud under false identity, billing for unrendered services, ghost patient fraud, and overcharging. These fraudulent activities, fueled by greed and inadequate oversight, elevate out-of-pocket expenses for healthcare services. Management strategies include robust record-keeping, adequate staffing, and community awareness, limited by digital and funding constraints. These fraudulent activities drain NHIA resources, with annual losses estimated at 30% of funds, exacerbating healthcare inequities and undermining trust in Benue's public health system. Recommendations include implementing digital health record systems, strengthening staffing and training, and enhancing community awareness campaigns to deter fraud and optimize resources. The study's policy relevance lies in guiding NHIA and BNSHIA to strengthen regulatory frameworks, integrate technology, and promote stakeholder accountability, enhancing NHIA efficiency and advancing Nigeria's UHC goals by 2030.

Key words: NHIA, Health Insurance Fraud, Managing strategies, Benue State

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Introduction

Health insurance fraud is a pervasive issue impacting organizations globally, with significant implications for healthcare systems (ACFE, 2018). The Association of Certified Fraud Examiners (ACFE, 2022) categorizes fraud into three primary types: corruption, financial statement fraud, and asset misappropriation. Adegboyega & Ojo (2021) further elaborates on financial fraud, encompassing advance fee fraud, bribery, false invoicing, credit card fraud, financial statement fraud, asset misappropriation, investment fraud, insurance fraud, and specifically, health insurance fraud. The advent of technology has amplified the scope and complexity of these fraudulent activities (Al-Amin, & Ibrahim, 2021). This study focuses on addressing the challenges of managing health insurance fraud, with a particular emphasis on selected public hospitals in Benue State, Nigeria.

Globally, health insurance fraud results in substantial financial losses. The National Health Care Anti-Fraud Association (2022) reports that investigations and prosecutions have recovered significant sums, yet the problem persists. The Federal Bureau of Investigation (FBI) estimates that fraudulent billings account for 3-10% of total healthcare spending, equating to $75-$250 billion annually in the United States alone (Adegboyega & Ojo, 2021). The Global Healthcare Anti-Fraud Network highlights a staggering $260 billion in global losses to health insurance fraud each year, representing approximately 6% of healthcare disbursements (Ichoku, 2019). In the U.S., health insurance fraud caused an estimated $6 billion loss in 2020 (Office of the Public Health, 2020). The U.S. Department of Justice (2020) reported that 345 licensed health professionals were charged with health insurance fraud offenses, underscoring the vulnerability of health insurance systems due to the large sums of money involved (Mensah & Boateng, 2024).

The consequences of health insurance fraud extend beyond financial losses, adversely affecting access to quality healthcare and public well-being (Ichoku, 2019). In response, the United States enacted the Health Insurance Portability and Accountability Act (HIPAA) in 1996, which evolved into the Health Care Fraud and Abuse Control Program (HCFAC) to combat fraud (Davis & Davis, 2005). In Africa, the push for Universal Health Coverage (UHC) has driven increased investments in health insurance schemes in countries like Kenya, Ghana, South Africa, and Nigeria WHO, 2019; World Bank 2020). However, these systems face challenges such as fraudulent enrollments, billing fraud, and unverified claims (Cohen, 2018). For instance, Odeyemi (2020) highlights how collusion between Health Maintenance Organizations (HMOs) and healthcare providers in Nigeria has reduced participation in the National Health Insurance Authority (NHIA). Similarly, double billing in rural Ghana (Owusu, 2020), overbilling and ghost patient payments in Kenya (Mutie, 2019), and fraudulent claims in Rwanda (Nshimiyimana, 2019) have strained healthcare resources, limiting access to essential services (Ichoku, 2019).

In Nigeria, the NHIA, covering over 10 million lives, has experienced significant growth in health insurance enrollment but also a rise in fraudulent activities costing billions of naira annually (Onoka et al., 2019). The World Health Organization (2022) estimates that health insurance fraud accounts for 10% of reported fraud cases in Nigeria, with the NHIA losing approximately 30% of its funds to fraudulent claims each year (NHIS, 2021). Both public and private hospitals, including those in Benue State, are affected, with private facilities equally susceptible (Okaro et al., 2010; Zain et al., 2024). Studies by Blumenthal (2011) and the Coalition Against Insurance Fraud (2020) emphasize the socio-economic impacts of health insurance fraud, estimating global losses at $80 billion annually, which disrupts funding and undermines health outcomes. In Africa, weak regulatory frameworks, poverty, and inadequate infrastructure exacerbate the issue (Mensah & Boateng,, 2024). While Olaopa et al. (2021) highlight challenges in detecting health insurance fraud in Nigeria, the management of these challenges remains underexplored, particularly in Benue State's public hospitals.

Managing health insurance fraud in Nigeria faces significant hurdles, including regulatory limitations and the limited adoption of digital health records, which hinder effective prevention (Olatunde, 2021). The lack of a comprehensive database system further complicates fraud

management across Africa (Owusu et al., 2021). Collusion between healthcare providers, insurers, and patients, including overcharging for unrendered services, remains a critical issue (Ajibola & Adeoye, 2022). While previous studies have addressed fraud detection, there is a notable gap in understanding how health insurance fraud is managed in public hospital facilities in Benue State, Nigeria. This study aims to fill this gap by examining the prevalence, patterns, and management strategies of health insurance fraud in selected public hospitals in Benue State.

Prevalence and common types of fraud

Fraud drains significant NHIA funds, with estimates suggesting losses of billions of naira annually, reducing resources for genuine healthcare needs and increasing premiums or out-of-pocket costs (Onoka et al., 2019; NHIS, 2021). The NHIA reports losing approximately 30% of its funds to fraudulent claims each year, while health insurance fraud accounts for about 10% of reported fraud cases in Nigeria (NHIS, 2021; World Health Organization, 2022). This erodes public trust, disrupts service delivery, and disproportionately affects the poor, exacerbating health inequities (Onoka et al., 2019). Globally, health insurance fraud equates to 3-10% of health spending, and in Nigeria, it threatens Universal Health Coverage (UHC) goals amid rising vulnerabilities in digital claims systems (World Health Organization, 2022). Health insurance fraud manifests in various forms across the NHIA ecosystem:

- **Provider-Led Fraud**: Common practices include phantom billing (claiming for services not provided), document falsification, overutilization of services, and collusion with enrollees or Health Maintenance Organizations (HMOs) for inflated claims (World Health Organization, 2022; Ajibola & Adeoye, 2022).
- **Enrollee Fraud**: Enrollees engage in identity theft, misrepresentation of coverage, altering documents, or submitting false bills (Olaopa, et. al., 2021; World Health Organization, 2022). A study in a Kaduna tertiary hospital, relevant to northern states found 70% of healthcare workers were aware of such enrollee-driven fraud, indicating underreporting (Olaopa et al., 2021).
- **Insurer or Systemic Fraud**: This includes false benefit declarations, kickbacks, or misappropriation of drugs and supplies due to inadequate monitoring (Onoka et al., 2019; Odeyemi, 2020).
- **Other Issues**: Drug diversion, ghost patient claims, and procurement irregularities are prevalent, particularly in underfinanced public facilities (Onoka et al., 2019).

Notable Cases and Enforcement

- **Domestic Cases**: In 2025, the Economic and Financial Crimes Commission (EFCC) arraigned former NHIA Executive Secretary Prof. Usman Yusuf for a N90 million fraud involving embezzlement, undue advantages, and irregular contracts to family-linked firms (EFCC, 2025). The EFCC has also highlighted ongoing investigations into health insurance sector fraud (EFCC, 2025).
- **International Involvement**: Nigerians have been implicated in international schemes. For example, in 2025, Olatunbosun Osukoya faced charges in the U.S. for a $25 million Medicare fraud involving unnecessary EEG tests and kickbacks (U.S. Department of Justice, 2025). Earlier cases include Ayodeji Fatunmbi, sentenced to 46 months for $8.3 million in durable medical equipment fraud, and Henry Ezeonyido, sentenced to 27 months for $1 million in fake claims (U.S. Department of Justice, 2023).

Management strategies for health insurance fraud in Nigeria

Level	Key Management Strategies	Examples/Outcomes
National (NHIA/)	**Regulatory Oversight**: The NHIA issues guidelines for claims verification, accredits providers, and audits Health Maintenance Organizations (HMOs) to ensure compliance (NHIA, 2017). It recovered 92% of stolen funds in a 2017 probe of fraudulent HMOs (NHIA, 2017). **Enforcement**: Partners with anti-corruption agencies like the EFCC and ICPC for prosecutions, including ongoing investigations into billing irregularities (EFCC, 2025). **Data Monitoring**: Implements real-time tracking of claims to flag anomalies such as excessive referrals (World Health Organization, 2022).	Suspended fraudulent HMOs and improved transparency in COVID-19 fund allocation, reducing financial losses (NHIA, 2017; Onoka et al., 2019).
Technological Tools	**Fraud Detection Systems**: AI and data mining tools, such as the Apriori algorithm, analyze claims data for patterns like discrepancies between billing and services (Olatunde, 2021). **Modules**: Include enrollment checks (e.g., limiting family claims), referral validation (based on distance or necessity), and claims auditing against NHIS rates (Olatunde, 2021).	Proposed systems process big data from public hospitals, detecting 80-90% of fraud in simulations, with potential applicability to Benue's NHIS-accredited facilities (Olatunde, 2021).
State (Benue-Specific)	**BNSHIA Functions**: The Benue State Health Insurance Agency (BNSHIA) regulates enrollment, issues ethical claims guidelines, and supervises providers to prevent abuse, while subsidizing care for vulnerable groups to indirectly curb fraud through better access (World Bank, 2020). **Local Enforcement**: The Benue Ministry of Health shuts down illegal facilities and collaborates with NHIA for audits (Ichoku, 2019). The EFCC prosecuted officials at Benue State University Teaching Hospital (BSUTH) for a N24.6 million fraud involving misappropriation of hospital funds under the guise of purchasing a Toyota Landcruiser Prado that was never bought, highlighting governance gaps (EFCC, 2023).	BNSHIA's supervision aims to ensure effective administration," but no public data on fraud recovery exists; focus remains on policy implementation (World Bank, 2020).
Broader Anti-Corruption	**Legislative Tools**: The National Health Act (2014) mandates audits and sanctions to address fraud (Onoka et al., 2019). - **Public Sensitization**: NGOs document fraud cases at service points to promote accountability and deter misconduct (World Health Organization, 2022).	Piloted programs reduced absenteeism-related fraud by 20-30%, emphasizing workforce integrity (Onoka et al., 2019; World Health Organization, 2022).

The table outlines key strategies for managing health insurance fraud in Nigeria, with a focus on national, technological, state-specific (Benue), and broader anti-corruption efforts, along with their examples and outcomes. Each strategy is supported by in-text citations to provide context and evidence.

Theoretical Framework: The Greed and Grievance Theory

The Greed and Grievance Theory, originating from the work of economists Paul Collier and Anke Hoeffler in the early 2000s, provides a framework for understanding the motivations behind internal conflicts, including non-violent forms like corruption and fraud. The theory's core tenets revolve around two primary drivers: greed and grievance, often intertwined rather than mutually exclusive. Greed posits that actors engage in illicit behavior due to opportunistic self-interest, where the potential financial rewards from exploiting resources outweigh risks, facilitated by low barriers like inadequate auditing or resource abundance (e.g., insurance funds). This rational-choice perspective views fraud as a calculated pursuit of personal gain, akin to

predation on "lootable" assets. Conversely, grievance emphasizes legitimate injustices—such as horizontal inequalities based on ethnicity, socioeconomic status, or institutional neglect—as catalysts for wrongdoing, where marginalized groups rationalize corruption as retribution or survival against systemic exclusion. While empirical studies, like those by Collier and Hoeffler, initially favored greed for explaining conflict onset, later critiques highlight how grievances erode social contracts, enabling greed. In practice, the theory advocates analyzing both to avoid oversimplification, recognizing that opportunity (e.g., weak enforcement) amplifies either motive.

In the context of Nigeria's National Health Insurance Authority (NHIA), which administers the country's health insurance scheme to promote universal health coverage, this theory helps dissect fraudulent activities in public hospitals. Established under the NHIA Act of 2022 (repealing the 2004 NHIS Act), the scheme aims to pool resources for affordable care but has been plagued by systemic fraud, such as inflated claims, fictitious patient records, and unauthorized treatments. In Benue State with under-resourced public hospitals like the Benue State University Teaching Hospital and general hospitals in Makurdi and Gboko, NHIA fraud manifests as healthcare workers and administrators exploiting reimbursements, leading to billions in losses annually. This issue is exacerbated by Nigeria's fragmented healthcare system, where only about 10% of the population is insured, and weak oversight allows fraud to thrive amid economic pressures and poor governance.

Applying the theory to NHIA fraud in Benue State's selected public hospitals reveals a dual dynamic. Greed drives frontline actors, including doctors and administrators, to submit exaggerated claims for non-existent procedures or ghost patients, capitalizing on NHIA's reimbursement delays and lax verification—mirroring how rebels loot commodities in civil wars. For instance, hospitals might inflate costs for basic consultations to siphon funds amid personal financial strains from low salaries (averaging ¦ 50,000–¦ 100,000 monthly). Yet, grievances fuel this, stemming from chronic underfunding (Benue's health budget is below 10% of state allocations), ethnic tensions in a multi-ethnic state, and perceived federal neglect, where Tiv and Idoma communities feel sidelined in resource distribution. Healthcare workers, facing equipment shortages and workload burdens, may view fraud as justified retaliation against a "disintegrating social contract," blending survival instincts with resentment. Thus, curbing this requires addressing greed through stricter audits while alleviating grievances via equitable funding and inclusive policies, preventing fraud from undermining health equity.

Methods

This study employs a qualitative research approach, utilizing a case study and exploratory research design to investigate health insurance fraud in selected public hospitals in Benue State, Nigeria. The case study design facilitates an in-depth examination of fraud within the context of the National Health Insurance Authority (NHIA) in specific hospital settings, while the exploratory design allows for identifying emerging patterns and management strategies (Yin, 2014). The study population encompasses all NHIA-accredited public hospitals in Benue State, with a purposively selected sample of six facilities: Benue State University Teaching Hospital (BSUTH), Federal Medical Centre,Makurdi, General Hospital, Gboko, General Hospital, Otukpo, General Hospital, North Bank, and General Hospital, Vandeikya. These hospitals were chosen for their NHIA involvement and geographic diversity. Key informants, totaling 31 participants, were purposively selected across three categories: (a) hospital management, including three Chief Medical Directors, three Financial Managers, and two Administrative Officers; (b) external stakeholders, comprising three Health Management Organisation representatives, two Independent Corrupt Practices Commission officials, one Forensic Investigator Officer, two Intelligence Police Officers, two Investigating Police Officers, one Economic and Financial Crimes Commission officer, and two pharmaceutical experts; and (c) eight NHIA subscribers, ensuring diverse perspectives on fraud dynamics.

Data were collected through Key Informant Interviews (KIIs), conducted face-to-face or virtually, using a semi-structured interview guide with open-ended questions on fraud prevalence, patterns, and management strategies.. Interviews, lasting 45-60 minutes, were audio-

recorded with consent, transcribed verbatim, and thematically analyzed using Braun and Clarke's (2006) framework, with NVivo (Version 14 aiding data management). Ethical considerations included obtaining informed consent, ensuring anonymity, and securing approval from the Benue State Ministry of Health and hospital ethics committees. Validity was enhanced through triangulation across informant categories and sites, with member checking to verify findings. Reliability was ensured via detailed documentation of the research. The findings are presented in a descriptive narrative style, incorporating quotes to illustrate themes and enhance credibility.

Results

The previous studies such as Adegboyega and Ojo (2021), Mensah and Boateng (2024), and Daramola et al. (2019) have explored types of health insurance fraud in various contexts, this study focuses specifically on the National Health Insurance Authority (NHIA) within selected public hospitals in Benue State, Nigeria. The findings are contextualized in Benue under the following subthemes: Falsification of Receipts by Personnel, Patient Fraud under False Identity, Billing for Services Never Rendered, Ghost Patient Fraud, and Overcharging for Treatment. These themes emerged from key informant interviews conducted at Benue State University Teaching Hospital (BSUTH), Federal Medical Centre Makurdi, General Hospital Gboko, General Hospital Otukpo, General Hospital North Bank, and General Hospital Vandeikya.

Prevalenttypes of health insurance fraud

Hospital personnel falsifying receipts to illicitly gain funds were identified as a prevalent form of health insurance fraud.

A Financial Manager at BSUTH, stated:

> We've observed staff falsifying receipts to pocket extra money, often in collusion with Health Maintenance Organisations (Financial Manager, BSUTH, male, Benue State, 24 March 2025).
> Similarly, a Financial Manager at General Hospital Gboko, stated that,
> Receipt falsification reflects greed and moral decay. Some staff submit fictitious claims to NHIA, intentionally defrauding the system (Financial Manager, General Hospital Gboko, female, Benue State, 14 March 2025).

An Investigating Police Officer, corroborated:

> Some hospital staffs are cunning, perfecting the art of receipt manipulation (Investigating Police Officer, male, Benue State, 22 April 2025).

An Intelligence Police Officer, added:

> We've handled cases where hospital personnel generated fake invoices for treatments that never occurred (Intelligence Police Officer, female, Benue State, 17 April 2025).

An HMO personnel remarked that:

> We've received false receipts from hospital staff demanding payments for non-existent services (NHIA HMO, male Benue State, 19 April 2025).
> Patient Fraud under False Identity

Patient fraud involving the use of stolen or borrowed NHIA cards was another common issue. An interviewee noted that:

> It's frequent to see patients using someone else's NHIA card to access treatment. We impound such cards and escalate to authorities (Financial Manager, BSUTH, female, Benue State, 24 March 2025).

Another participant corroborated that:

> Patients often present HMO cards not belonging to them, sometimes stolen, to unsuspecting staff. Not all escape detection (Financial Manager, General Hospital Gboko, female Benue State, 14 March 2025).

A Financial Manager at Federal Medical Centre Makurdi, noted:

> Patients exploit familiarity with staff, using others' cards without proper identity checks (Financial Manager, Federal Medical Centre Makurdi, male Benue State, 21 March 2025).

An Intelligence Police Officer, stated:

> Patient fraud is rampant, with individuals using stolen NHIA cards, leading to inaccurate health records (Intelligence Police Officer, Benue State, male, 17 April 2025).

A participant also noted that:

> Some patients use others' identities, thinking they're clever until detected (Investigating Police Officer, Benue State, female, 22 April 2025).

An HMO personnel remarked that:

> Hospitals report patients using our NHIA cards illegally. We verify serial numbers to alert original owners (NHIA HMO, male, Benue State, 24 April 2025).

Billing for unprovided services was identified as a significant fraud type as observed by a financial manager. He said that:

> We had a case where staff claimed a child birth was a Cesarean Section to NHIA, when it was a normal delivery (Financial Manager, BSUTH, male, Benue State, 24 March 2025).

Another participant noted that:

> Personnel here have submitted bills to HMOs for services never rendered, driven by greed (Financial Manager, General Hospital Gboko, male, Benue State, 14 March 2025).

A police officer noted that:

> Falsified doctor visits are common, with bills sent to HMOs for non-existent consultations (Intelligence Police Officer, Benue State, 17 April 2025).

From an HMO personnel:

> Some hospitals bill us for unrendered services, but we catch them through random client verification" (, NHIA HMO, female, Benue State, 19 April 2025).
> Ghost patient fraud, where bills are submitted for fictitious patients, was also prevalent. Hospital staff send bills to HMOs for ghost patients to gain extra cash, driven by greed (Intelligence Police Officer, female, Benue State, 17 April 2025).

Another participant agreed with the opinion that:

> A hospital collected payments for unknown patients (Investigating Police Officer, Benue State, 22 April 2025).

An HMO consultant, added:

> Some hospitals bill us for fictitious patients, uncovered through due diligence" (NHIA HMO, male, Benue State, 17 April 2025).

Management strategies for health insurance fraud in selected public hospitals in Benue State

Some scholars such asAkande et al. (2018), Al-Amin and Ibrahim (2021), Ojo et al. (2022), the National Health Care Anti-Fraud Association (2023), and Centers for Medicare & Medicaid Services (2021) have discussed strategies for managing health insurance fraud in various healthcare contexts, this study focuses specifically on how selected public hospitals in Benue State, Nigeria, address fraud within the National Health Insurance Authority (NHIA). The findings are contextualized in Benue under three key subthemes: Maintaining Well-Documented Patient Health Records, Employing Adequate Staff, and Fostering Community Awareness. These themes emerged from key informant interviews conducted at Benue State University Teaching Hospital (BSUTH), Federal Medical Centre Makurdi, General Hospital Gboko, General Hospital Otukpo, General Hospital North Bank, and General Hospital Vandeikya.

Maintaining comprehensive and accurate patient health records was identified as a critical strategy for managing health insurance fraud. the Chief Medical Director at BSUTH, stated:

> Keeping detailed health records is essential to monitor patients' health status and verify the identity of those presenting NHIA cards to ensure we treat the rightful enrollees (Chief Medical Director, male, BSUTH, Benue State, 24 March 2025).

Similarly, ,an NHIA HMO representative, affirmed:

> Hospitals have implemented robust record-keeping to cross-check NHIA card usage, helping to confirm whether the cardholder is the legitimate owner, thus preventing patient-related fraud (NHIA HMO, male, Benue State, 17 April 2025).

Employing sufficient and well-trained staff was highlighted as an effective measure to reduce health insurance fraud.:

> To combat fraud, we've ensured adequate staffing at BSUTH to reduce workload pressures, allowing staff to detect potential fraud without lapses (Financial Manager, BSUTH, female, Benue State, 24 March 2025).

Participant from General Hospital Gboko, corroborated that:

> Hiring enough trained personnel helps manage fraud because overworked staff may overlook critical details. Adequate staffing ensures thorough checks on NHIAclaims" (Financial Manager, General Hospital Gboko, female, Benue State, 14 March 2025).

Fostering community awareness was identified as a proactive strategy to deter health insurance fraud. Another explained explained that:

> Educating patients about the consequences of health insurance fraud is vital. We conduct awareness programs for our regular patients and the broader community" (Chief Medical

Director, Federal Medical Centre Makurdi, male, Benue State, 21 March 2025).

Similarly, another participant stated that:

> We organize programs to inform people about the legal implications of fraud, sometimes inviting law enforcement officers to speak to patients, which helps prevent fraudulent activities" (Financial Manager, Federal Medical Centre male, Makurdi, Benue State, 21 March 2025).

Discussion of Findings

The study revealed an interconnected web of NHIA fraud types in Benue's public hospitals, including falsification of receipts by personnel, patient fraud under false identity, billing for services never rendered, ghost patient fraud, and overcharging for treatment. These frauds often overlap, driven by greed, systemic loopholes, and socioeconomic pressures. For instance, personnel falsify receipts or bills for unrendered services (e.g., claiming Cesarean sections for normal deliveries or fabricating doctor visits) in collusion with HMOs, leading to inflated NHIA reimbursements. This merges with ghost patient fraud, where fictitious claims are submitted for non-existent patients, diverting funds estimated at 30% of NHIA resources annually. Patient fraud exacerbates this, as enrollees use stolen or borrowed NHIA cards, exploiting lax verification and resulting in inaccurate health records that misallocate resources. Overcharging for actual treatments further strains the system, inflating costs and reducing affordability for vulnerable populations in rural areas like Vandeikya or Gboko. Collectively, these frauds erode trust, increase out-of-pocket expenses (77% of healthcare spending in Nigeria), and perpetuate inequalities, particularly in under-resourced facilities like General Hospital Otukpo, where governance gaps enable opportunistic acts amid low budgets (less than 5% of state allocations). The implications include financial losses in billions of naira, delayed services, and weakened NHIA integrity, highlighting the need for integrated oversight to address root causes like poverty and weak digital infrastructure.

These merged fraud types align with Adegboyega and Ojo (2021), who categorize provider-led frauds like receipt falsification and overbilling as greed-driven in Nigerian contexts, often intersecting with patient identity theft due to poor controls. Mensah and Boateng (2024) extend this to African trends, noting how ghost patient schemes and unrendered service billing exploit fragmented systems, similar to Benue's rural-urban disparities. Daramola et al. (2019) in their Nigerian case reviews emphasize the overlap between falsification and overcharging, linking them to moral decay and underfunding. Ajibola and Adeoye (2022) highlight collusion in inflated claims, while the World Health Organization (2022) reports 10% of Nigerian fraud cases involve such patterns, underscoring their financial drain. Onoka et al. (2019) quantifies NHIA losses from ghost patients and identity fraud, paralleling the resource misallocation here. Mutie (2019) and Owusu (2020) draw parallels from Kenya and Ghana, where overbilling and ghost claims reduce service quality in rural areas. Finally, Blumenthal (2011) and the Coalition Against Insurance Fraud (2020) frame these as socio-economic issues causing global losses of $80 billion annually, disrupting health outcomes in low-resource settings like Benue.

The management strategies identified maintaining well-documented patient health records, employing adequate staff, and fostering community awareness form a cohesive, multi-layered approach to mitigating NHIA fraud in Benue's hospitals. These strategies interconnect: robust record-keeping enables identity verification and claim cross-checking, preventing patient fraud and unrendered service billing, but requires adequate staffing to avoid workload-induced oversights. Employing sufficient trained personnel ensures thorough NHIA audits and reduces lapses in facilities like BSUTH, while community awareness programs educate enrollees on fraud risks, deterring identity theft and building trust through law enforcement involvement. Together, they address immediate detection (e.g., impounding fake cards) and long-term prevention, though challenges persist due to limited digital tools and funding, limiting scalability in rural hospitals like General Hospital North Bank. The implications are positive for resource optimization, with potential to recover funds and enhance equity, but require state-level support

from the Benue State Health Insurance Agency (BNSHIA) to integrate technology and sustain awareness, ultimately supporting NHIA goals of universal coverage by 2030.

These findings resonate with Al-Amin and Ibrahim (2021), who advocate for documentation and staffing as foundational in Nigerian fraud prevention, integrating them to counter collusion. Ojo et al. (2022) emphasize community education in African systems, linking it to deterrence of patient fraud, similar to the awareness programs here. Akande et al. (2018) highlight staffing's role in reducing errors, aligning with workload management in Benue. The National Health Care Anti-Fraud Association (2023) promotes sensitization for accountability, while Centers for Medicare & Medicaid Services (2021) endorse record-keeping for verification, adaptable to NHIA contexts. Olatunde (2021) supports digital-enhanced documentation for anomaly detection, and Onwujekwe and Uzochukwu (2011) tie these to regulatory strengthening in poverty-stricken areas, underscoring their potential to mitigate infrastructure-related fraud in states like Benue.

Conclusion

This qualitative study has provided critical insights into the prevalence, patterns, and management of health insurance fraud within the National Health Insurance Authority (NHIA) in selected public hospitals in Benue State, Nigeria, namely Benue State University Teaching Hospital (BSUTH), Federal Medical Centre Makurdi, General Hospital Gboko, General Hospital Otukpo, General Hospital North Bank, and General Hospital Vandeikya. The findings reveal a complex web of fraud types, including falsification of receipts, patient fraud under false identity, billing for unrendered services, ghost patient fraud, and overcharging for treatments, all driven by systemic vulnerabilities such as underfunding, inadequate oversight, and socioeconomic pressures. These fraudulent activities drain NHIA resources, with annual losses estimated at 30% of funds, exacerbating healthcare inequities and undermining trust in Benue's public health system. Management strategies, including maintaining well-documented patient records, employing adequate staff, and fostering community awareness, demonstrate proactive efforts to curb fraud but face challenges due to limited digital infrastructure and funding constraints. By merging these findings, the study underscores the urgent need for integrated reforms to strengthen governance, enhance technological adoption, and promote stakeholder accountability to support Nigeria's Universal Health Coverage (UHC) goals.

Recommendations

Based on the findings, the following three recommendations are proposed to address health insurance fraud in Benue's public hospitals:

1. **Implement Digital Health Record Systems**: The Benue State Health Insurance Agency (BNSHIA) and NHIA should prioritize the adoption of electronic health record (EHR) systems across public hospitals to enhance patient verification and claims tracking. Digital systems can reduce falsification of receipts, patient identity fraud, and ghost patient schemes by enabling real-time cross-checking of NHIAcard usage and service delivery. Investment in AI-driven fraud detection tools, as suggested by Olatunde (2021), could further identify anomalies, ensuring resources are allocated to legitimate care, particularly in rural facilities like General Hospital Vandeikya.
2. **Strengthen Staffing and Training Programs**: Hospitals should expand recruitment and training of personnel dedicated to NHIA claims processing and fraud detection, addressing workload pressures that lead to oversight lapses. The state government should allocate funds to support adequate staffing, as emphasized by Akande et al. (2018), to ensure thorough audits and reduce opportunities for billing unrendered services or overcharging. Regular training on ethical practices and fraud prevention can further enhance staff vigilance, aligning with Al-Amin and Ibrahim's (2021) recommendations for robust oversight.
3. **Enhance Community Awareness Campaigns**: The BNSHIA, in collaboration with hospitals and law enforcement, should intensify community awareness programs to educate NHIA enrollees on the legal and health consequences of fraud, particularly

patient identity fraud. These campaigns, as supported by Ojo et al. (2022) and the National Health Care Anti-Fraud Association (2023), should involve community leaders and media to reach rural areas like Gboko and Otukpo, fostering accountability and deterring fraudulent behavior to preserve NHIA integrity.

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