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THE NATIONAL HEALTH INSURANCE SCHEME IN NIGERIA: ISSUES AND CHALLENGES

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Abstract

The Nigerian government has formulated initiatives and plans to facilitate and strengthen the delivery of effective, efficient, quality and affordable health services to Nigerians part of which was the launching of the National Health Insurance Scheme (NHIS) in 2005. In this paper, the objectives of the scheme vis–a-vis the overall contributions to health care delivery in Nigeria were examined. The inherent flaws, problems and challenges of the scheme are also discussed. The paper concludes that the NHIS could be a monumental health security project if vigorously pursued with sincerity of purpose. Certain suggestions that may have direct impact on the success of the scheme were recommended.

Keywords: Health; Health Care; Health Insurance Scheme; Democratization; Development.

Introduction

Social Health Insurance Scheme (SHI) is seen as a framework for providing responsive, dynamic and functional health delivery system. There is strong evidence to suggest that the SHIs have been successfully implemented in Europe and Latin America. In Germany, for instance, the SHI has been in existence for more than a century. Governments in low and middle income countries of Thailand (Khoman, 1997; Tangcharoensathien et al 1999), Vietnam (Ensor, 1999), Indonesia and Philippines (Tan, 1998) as well as Kazakhstan (Ensor, 1999) have also adopted SHI as a means of improving accessibility to health care system. Generally, the SHI is supposed to be a health finance mechanism that could provide government with a stable and prompt flow of funds into the health sector usually through pooled

contributions. It may include pooled contributions from the public sector employees and their employers; self-employed persons; and contributions made on behalf of the poor persons by the government (Health Insurance Affairs, 2008).

In line with the global trends, the National Health Insurance Scheme (NHIS) was launched in Nigeria in 2005 with a view to solving some of the challenges faced by the modern healthcare services. It was opined that the scheme would solve the lingering problems and challenges that have tormented health care services over the years particularly the problems associated with accessibility (Ibiwoye & Adeleke, 2007) as well as inadequate funding in health sector. While it is crystal clear that the scheme is still young, an important question to ask is: to what extent has the NHIS improved accessibility to quality healthcare services in Nigeria? It is against this backdrop that this paper examines the conditions that informed the adoption and establishment of the NHIS in Nigeria. The objectives of the NHIS vis–a-vis its overall contributions to healthcare delivery are also examined. The inherent flaws, problems and challenges of the scheme are also discussed. Apart from the introductory part, the paper is divided into four sections. In the first section, the poor state of healthcare delivery system in Nigeria that necessitated the introduction of the scheme was discussed. The emergence of the NHIS was discussed in the second section vis-à-vis its objectives and purposes. The problems and challenges of the NHIS were highlighted in the third section of the paper. The last section concludes the paper by proffering measures capable of improving the activities of the NHIS.

The State of Health Care Services in Nigeria

One of the primary and statutory responsibilities of the government is to provide some form of social security and protection to the citizenry. Perhaps, one of the most paramount of the social security is health security. Hence, from time immemorial, governments all over the world, be it capitalist or socialist oriented government, have actively involved in health care service delivery and have consistently participated in transforming the health care systems with a view to achieving quality, efficiency, professionalism and democratic legitimation through performance management and state-sponsored policies and machineries (Kuhlmann et al. 2009). This, however, does not rule out or downplay the pivotal role of service users and professional groups in shaping the nature, future and dynamics of the public health care system (Kuhlmann et al. 2009). Even in countries where the principles of capitalism are dominant like the United States of America

(USA) and Germany, governments still play active role in terms of implementation of health policies capable of boosting the quality of health care services and protecting citizens' right to health.

The government of Nigeria is a signatory to local and international health treaties and legislations. The government of Nigeria "recognises the right to health and has committed itself to its protection by assuming obligations under international treaties and domestic legislations mandating specific conduct with respect to the health of individuals within its jurisdiction" (Nnamuchi, 2008, p.1). The Nigerian political system has been structured to reflect a Federal system arrangement where government machineries and responsibilities are constitutionally shared among the Federal, State and Local Government authorities. Each of these tiers of government is politically autonomous especially in terms of financing and managing health services under its jurisdiction (Nigeria Health Watch, 2010). More than 50% of the public health expenditure occurs at the state levels, 15.23% and 33% occur at Local Government and Federal levels respectively (Bello, 2006).

Correspondingly, the provision of health care services operates at three levels of care: the primary, the secondary and the tertiary health facilities (Ayeni, 2002; Federal Ministry of Health (FMoH), 2004a; Asuzu, 2004). These facilities provide overlapping health services. The primary health facilities are supposed to treat and manage minor health problems like domestic accidents and are usually under the management of the Local Government Authority. Where health matter becomes complicated and difficult to handle at the primary health facilities, they are supposed to be referred to secondary health facilities under the management of the State Governments which might include General and Specialist Hospitals. Tertiary health facilities are the apex health care delivery system in Nigeria. Apart from treating, and managing complicated health problems and handling surgical operations, they also serve as training ground for prospective medical doctors. They include Teaching Hospitals and Federal Medical Centres. These are managed by the Federal Government (see Ayeni, 2002; FMOH, 2004a). However, most Nigerians who seek treatment at these facilities do not often follow this procedural treatment, i.e. from primary to secondary and tertiary health institutions. In many occasions, tertiary health facilities are flooded with minor health problems that could be handled at the primary health facilities (Akande, 2004). A recent survey shows that there are 59 Teaching Hospitals and Federal Medical Centres across Nigeria; 37 states' ministries of health including Abuja; 774 Local Government

Departments of Health; 3, 303 General Hospitals; and 20, 278 Primary Health Centres and Health Posts (Omoruan et al. 2009).

The on-going democratisation process which began in 1999 inherited from the military junta a dysfunctional health care system; health system characterised by severe lack of skills and exacerbated by the 'brain-drain' syndrome, shortages of drugs and inadequate health infrastructures. According to Nnamuchi (2008), prior to the economic crisis of the mid-1980s, health service delivery in Nigeria witnessed a robust growth as services were virtually rendered free of charge at public hospitals except in rural areas where such services were apparently insufficient but visible. He attributed the improved state of health care at that time to government's commitment and foreign assistance from international donour agencies. However, things began to fall apart in the health sector after the mid 1980s. Many factors were attributed to the downward trends in the health sector. They included reduction in revenue from oil exports, swelling external debts burden as well as rapid population growth rate (Shaw & Griffin, 1995). The over all effect of these was a rapid decline in the quality, responsiveness and effectiveness of publicly provided healthcare services (Shaw & Griffin, 1995).

For almost a decade, the Nigerian Gross Domestic Product (GDP) has continued to grow. Unfortunately, this has had little impact on the Nigerian health sector. In Sub-Saharan Africa (SSA), Nigeria has one of the lowest health practitioners-to-patient ratios with 0.3 physicians per 1,000 persons, 1.7 hospital beds per 1,000 persons, as well as 1.7 nurses, 0.02 dentists, 0.05 pharmacists, 0.91 community health workers, 1.696 nurse midwives per 1,000 persons (Ogbolu, 2007; WHO, 2006). The majority of the Nigeria population has no adequate access to modern health care services with serious impact on infant and mortality rates. Out of the 101,041 communities in Nigeria, studies have shown that only 14.3% (14,474 communities) have access to some form of modern health care facility (Orubuloye & Ajakaiye, 2002). A recent report shows that the national average of the percentage of mothers receiving antenatal care is about 60% in Nigeria out of which only 37% deliver in health care facilities managed by qualified professionals (UNDP, 2009). The health inequality between rural and urban population is worse. This has been confirmed by Kupari's (2005) study in Ibadan where it was found that urban women received antenatal care three times more than their rural counterparts.

Nigeria has one of the worst health indicators in the world; as one of the countries with the highest infant and maternal mortality rate. While Nigeria constitutes only 1% of the world's population, she accounts for a whopping 10% of the world's maternal and under five mortality. More than 50 000 Nigerian women die from pregnancy related complications every year with another 250,000 newborn babies (FMoH and NPHCDA, 2009). Reports have indicated that rural infants, infants of uneducated mothers, and infants in the poorest households continue to have higher mortality risks than more advantaged infants (WHO, 2006). All these could explain why the Nigerian health care system performance was ranked 187th position among the 191 Member States of the World Health Organisation in 2000 (FMoH, 2004b; Nigeria Vision 2020 Programme, 2009). Table 1 below indicates that Nigeria has one of the lowest development reports in Africa.

Table 1: Development Reports in Selected African Countries

Country	HDI Rank	Expectation of Life	Under5 Mortality Rate '04	Maternal Mortality Ratio
Ghana	136	56.7	112	540
Cameroon	144	45.3	149	730
Togo	147	54.2	140	570
Kenya	152	47.0	120	1000
Nigeria	159	43.3	197	800
Benin	163	53.8	152	850
Ivory Coast	164	46.0	194	690
Chad	171	43.6	200	1100
Sierra Leone	176	40.6	283	2000
Niger	177	44.3	259	1600

Source: Adetokunbo (2006, p.12).

One of the contributing factors to the poor state of health care services in Nigeria is poor financing. Despite being the 2nd largest economy in Africa and the 6th Oil Producing Country in the world, health care financing in Nigeria remains one of the lowest in Africa. It is lower than Kenya, Senegal and South Africa. In 2003, government's contribution to health sector as a percentage of GDP stood at 1.3%, a decline from 2.2% in 2000 (Nnamuchi, 2008) compared to 8.7% in South Africa, 4.9% in Kenya and 5.1% in Senegal (Scheil-Adlung et al. 2006, p.3). This is also contrasts sharply the 15% of national budget recommended by the African Heads of States in Abuja in 2001 (African Union, 2009). The resultant effect of this scenario is that health services are funded through out-of-pocket (OOP)

payments which amount to 63% of the total health care expenditure in Nigeria (McIntyre & Green, n.d). Based on these challenges, it became crystal clear that the Nigerian health care sector needed an urgent solution to avert any further devastating and catastrophic consequences, hence, the need for establishment of the NHIS.

The Emergence of the NHIS

Some studies about alternative funding mechanisms for health sector have been centred on government funded national health services and social health insurance (Danish Ministry of Foreign Affairs, 2007). The 2008 report of the World Health Organisation (WHO) has advocated for a universal coverage under the principles of the SHI as a means of improving health care services particularly in developing countries (Health Insurance Affairs, 2008). In the same vein, it has been suggested that to tackle the problems of poor quality of services and insufficient funding embedded in the health sector in Nigeria, an alternative but autonomous health funding mechanism would be required to provide additional finance that would sustain the health care demands of a growing population and improve standards of care (Health Insurance Report, 2005). This development has brought SHI into the mainstream of health care policy in Nigeria which was originally conceived to provide resources that would allow cross subsidisation in the health sector such that the healthy pay for the sick, the young pay for the old and the rich pay for the poor (Health Insurance Report, 2005). However, it became obvious that this kind of socialist movement or social system could not thrive in countries where the formal sector is relatively small like Nigeria, and where the government may not be financially buoyant to pay for the contributions of the most vulnerable groups in the society (i.e. the old, children and the destitute persons) (Health Insurance Report, 2005). Yet, health care reform was imperative considering the inherent health challenges in Nigeria (Asuzu, 2004). The idea to reform the health sector was contained in the National Economic Empowerment and Development Strategy (NEEDS) of the government:

> The goal of the health sector's component of the NEEDS is to improve the health status of Nigerians as a significant co-factor in the country's poverty reduction strategy. The initiative will involve the undertaking of a comprehensive health sector reform largely aimed at strengthening the national health system, and enhancing the delivery of effective, efficient, quality and affordable health services to Nigerians (National Planning Commission, 2004, p.103).

Perhaps, consequent upon this resolution, the National Health Insurance Scheme was launched in 2005 with the following objectives:

- Ensure that every Nigerian has access to good health care services;
- Protect families from the financial hardship of huge medical bills;
- Ensure equitable distribution of health care costs among different income groups;
- Maintain high standards of health care delivery services within the scheme;
- Ensure efficiency in health care services;
- Improve and harness private sector participation in the provision of health care services;
- Ensure adequate distribution of health facilities within the Federation; and
- Ensure the availability of funds to the health sector for improved services (Ajumobi & Chiejina, 2010).

NHIS performs the following roles:

- Registration of HMOs and Providers;
- Setting of standards;
- Ensure compliance with standards;
- Mobilisation and sensitisation of all stakeholders;
- Defining the minimum benefit package;
- Drawing up contracts between stakeholders;
- Training, monitoring and evaluation (Awosika, 2005).

The main source of NHIS funds are contributory premiums from employees of the Federal Government of Nigeria. This is known as the Formal Sector Social Health Insurance. An employee contributes 5% of salary which is matched by 10% paid by the employer. Other conceived insurance programmes which are yet to be implemented are the Under-5 Children Social Health Insurance programme, Permanently Disabled Persons Social Health Insurance Programme, the Prison Inmates Social Health Insurance and the Rural Community Social Health Insurance Programme.

The National Health Insurance Scheme collaborates with the Health Maintenance Organisations (HMOs) in the provision of health care services. The NHIS purchases healthcare services on behalf of enrollees and their dependants from healthcare providers both in the public and the private sectors using health insurance companies and Health Maintenance Organisations (HMOs) as third-party administrators (Health Insurance Affairs, 2008). In return, the HMOs pay a combination of capitation payment and fee for service reimbursement to health care providers (HCPs) (DFID, 2002, pp.15-16). Other roles performed by the HMOs include:

- Register employers/employees;
- Collect contributions of employers and employees;
- Register providers;
- Ensure qualitative and cost effective health care services to contributors through Health Care Providers (HCPs);
- Ensure proper adherence to referral procedures;
- Render returns to NHIS;
- Maintain ethical marketing strategies;
- Ensure effective quality assurance systems;
- Ensure smooth change of provider within the stipulated period;
- Organise risk management enlightenment for parties involved; and
- Health promotion and education (Awosika, 2005).

Health services provided under the scheme shall include:

- Preventive health services - immunisation, family planning, ante- and post-natal care, Ambulatory and in-patient care services;
- Diagnostic treatments;
- Provision of drugs; and
- Limited dental and optical services.

There is an evidence to suggest that the scheme has been well received by Nigerians. NHIS is believed by the majority of Nigerians of capable of improving health care delivery to the people provided it is properly

implemented ([redacted]si & Awe, 2009a, 2009b). Reports have shown that there are no fewer t[redacted] seven million Nigerians that are currently registered under the NHIS (Th[redacted]erian Tribune, 2009, p.10). Indeed, the NHIS has brought some changes [redacted] the system of health care financing in Nigeria. Yet, certain challenges an[redacted]oblems have consistently bedeviled the NHIS. Some of these are enum[redacted]ed below:

Challenging Issues in NHIS

In 2002, the DFID Health and Population Department organised a workshop in London to sensitise policy makers in SSA countries on not only the strengths of the SHI but also the problems and challenges facing the scheme in developing countries including how to deal with the issues of chronic diseases like HIV/AIDS under the scheme. Among countries in attendance were Ghana, Nigeria, Kenya, South Africa, Tanzania, Malawi and Uganda. The workshop identified and highlighted some of the imminent bottlenecks and challenges that face public health insurance scheme in developing countries. They include: the challenges of raising additional revenue beyond employees' contributions; the challenges of universal coverage including the extension of the health care to the poor in the informal sector and rural areas; the challenges to cost containment and efficiency; and the challenges of health care package and responsibility for public health services. Beyond these, there are also the challenges of cultural compatibility. In other words, there are views in some quarters that the scheme does not recognise the African culture where dependants of an enrollee are very much likely to be more than four covered by the scheme.

According to DFID (2002), one of the major challenges of the SHI in SSA is the small size of the formal sector. The formal sector is so small that to generate the needed finance to sponsor the SHI to achieve a universal coverage becomes highly cumbersome. For instance, formal sector accounts for less than 10% of the total population in Nigeria (Health Insurance Report, 2005). As a result, there might be the need for additional programmes under the scheme to raise finances to enable the government achieve universal coverage for over 150 million Nigerians. Also related to this problem is the difficulty in increasing revenue from the informal sector of the economy considering the lackadaisical attitude towards insurance services in Nigeria A recent study by Yusuf et al. (2009) found that attitude towards insurance services among Nigerians is generally appalling. This was attributed to varying socio-cultural and economic factors.

Furthermore, so far, the beneficiaries of the NHIS are limited to employees of the Federal Government and large bureaucratic organisations like the banking sector. Employees of the State Governments, small private

businesses, those in the informal sectors of the economy and the rural populace are currently not covered under the scheme. In fact, the implementation of the NHIS is currently contrary to its mandate. Instead of closing the gap between the rich and the poor, the implementation of the scheme as it stands today seems to have widened the gap between the rich and poor. These categories of Nigerians, who are the majority, would have to continue to pay for health care services out of their pockets until they are recognised under the scheme. This means it is not clear if the universal health coverage promised by the scheme by 2015 would be achieved. This has been considered as a major set-back in government's efforts to improving access to modern health care services through the NHIS. The Executive Secretary of the scheme has therefore acknowledged the need for acceleration of efforts aimed at the engagement of the States and the Local governments for the purpose of covering them in the scheme (see Ajumobi & Chiejina, 2010).

Other problems bedeviling the NHIS include the problems of delay in registration and issuance of identity cards to new employees and their dependants and payment of capitation and fee-for-service by the HMOs to health care providers. Movement within the three tiers of health care is yet to be clearly spelt out and executed. These issues were echoed by the committee of Chief Executives of Federal Tertiary Hospitals in a communique issued at the end of the 58th quarterly meeting held at the University of Benin Teaching Hospital, in July, 2007. The committee concluded that there was the need for upward review of the capitation to institutions as well as the need to streamline the movement of patients within the three tiers of the health care system (i.e. the primary, secondary and tertiary health institutions) in order to improve access to health care services.

Finally, there have been reported cases of political and financial maneuvering between healthcare providers and the HMOs (Health Insurance Affairs, 2008) and various representatives of health team such as the community pharmacists and medical doctors (Chikwe, 2008). In 2008, barely three years after the launching of the NHIS, private health providers in Port Harcourt, through their professional body instructed members to desist from participating in the Managed care programmes of the HMOs. The managed care programmes is the "systems for organising doctors, hospitals and other providers into groups to enhance the quality of health care services" (Awosika, 2005, p.43). The emerging face-off between the stakeholders in Port Harcourt and some other parts of the country has been attributed to the high handedness' of the HMOs which, include the setting of arbitrary tariffs, inconsistency in the payment of capitation as well as communication

barriers between health providers and the HMOs coupled with 'weak regulatory capacity' of the NHIS (Health Insurance Affairs, 2008).

Conclusion

This paper has examined the most burning issues surrounding the NHIS in Nigeria. It is argued that the poor state of the Nigerian health sector which has inadvertently crippled activities in the sector necessitated the adoption of the NHIS in 2005. However, the implementation of the scheme has been engulfed by numerous administrative and logistical problems and challenges that make quite a number of Nigerians sceptical about the future of the programme and the possibility of achieving its mandate. For instance, less than 10% of the total population of Nigeria is genuinely covered under the scheme. Besides, there are infrastructural challenges that need to be addressed by the government in order to improve the quality of health care services in the country. In other words, the development and improvement of the infrastructural and social amenities such as electricity, information and communication technology (ICT) is germane to the successful implementation of the NHIS in Nigeria. Power generation and distribution have to be taken very seriously and non-politicised. At the moment, the electricity body in Nigeria, the Power Holding Company of Nigeria (PHCN) supplies only about 3000 megawatts of electricity to a population of about 160 million people. It is evident that a significant number of health institutions in Nigeria have limited access to internet connections to facilitate treatment, learning, research, record keeping and service delivery. Private-public sectors partnership is vital for attaining the best health possible (Ratzan et. al. 2000). The private health insurance scheme needs to be revitalised to improve competition and quality of health care services in the Nigerian health sector. Lastly, there is the need for a decentralisation of authority to provide speedy services to enrollees under the NHIS.

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