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The Imperative of National Health Insurance Scheme (NHIS) In Achieving Universal Health Coverage (UHC) In Nigeria

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Abstract The thrust of this study was to examine the pivotal role of National health Insurance Scheme (NHIS) in achieving universal health coverage (UHC). This was aimed at examining how the National Health insurance scheme can be used as a mechanism to achieve universal health care coverage in Nigeria and how the insurance scheme can mitigate the financial risk of the citizens in accessing quality health care. A review of existing literature and documents from WHO, NBS, etc overwhelmingly prove that revenue pooling from Social insurance scheme and tax are the appropriate sources of health care funding that can speed up the drive to attain UHC. Though between these two sources, Social insurance scheme prove to be sufficed in Nigeria due to the dwindling tax revenue of Government in recent times couple with corrupt practices by revenue officials. However, findings from this study indicate that despite the potential of the scheme in ensuring universal health coverage, the degree of NHIS coverage in Nigeria is very insignificance and unimpressive. It shows that the scheme is mainly implemented for employees under federal government while the other tiers of government and organized private sector are reluctant to sign up their employees because the law establishing the scheme did not make registration compulsory. Poor implementation of the scheme has excluded the poor masses from the health care system because they cannot afford out of pocket health expenditure. The management of the scheme is also bedeviled with inefficiency and poor remittances to HCP which inadvertently affect health outcome of enrollees. The paper recommend amendment of the Act establishing the scheme to ensure registration is compulsory to all organized sector while government should increase funding to extend the scheme to the vulnerable groups who are worst hit by the financial risk of out of pocket health expenditure.

Keywords: Universal Health coverage, Health Financing, Social Insurance Scheme.

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I. INTRODUCTION

Every nation in the world relies heavily on its available human resources for its economic development and technological advancement. Thus, every society requires a healthy population to guarantee its productive capacities. Ensuring good health of citizens is also critical in improving life expectancy, minimizing incidence of epidemics and other debilitating health conditions. A key pillar, in which this can be achieved, is financing of the health care system to ensure that citizens irrespective of their social status (especially income level) have access to health services without financial risk.

In the 1980s user fees was introduced to fund the health sector in African and other developing countries due to inadequate funding. However, evidences have shown that user fees or out of pocket health expenditure have been an ineffective, inefficient, and inequitable financing mechanism. They are ineffective at raising substantial funds (Yates, 2009). The inefficiency of user fees is attributable to high administration costs and a failure of fees to redirect patients to cost-effective services. According to Pearson (2004) user fees proved inequitable because poor and vulnerable people have been affected most—both in terms of their reduced use of services and through being impoverished by the effects of high catastrophic health expenditures. For example, in Nigeria out- of- pocket (OOP) as a percentage of the total health expenditure (THE) remains high at 72.2% as at 2015 (World Bank, 2018, Uzochukwu et al 2015). According to Thisday Newspaper (27, December, 2017) this is the highest on the continent and one of the highest in the world. Even poorer countries in sub-Saharan Africa like Kenya (26 per cent), Gabon (22 per cent), among others is doing better. Research also shows that countries afflicted with conflict and post-conflict like South Sudan (54 per cent) and Sierra Leone (61 per cent) are still better than Nigeria. This pattern of health spending contributes to widespread catastrophic spending among the poor and large informal sector. Besides the direct costs of health care, people who are impoverished face other economic barriers, such as high transport costs, and the opportunity cost of being away from work. The

combination of these indirect costs and user fees has often effectively excluded poor people from the formal health-care system.

It is in recognition of these that the global community has been advocating for a Universal Health Coverage, which is a system that provides healthcare and financial protection to all citizens of a particular country. It is organised around providing a specified package of benefits to all members of a society with the end goal of providing financial risk protection, improved access to health services, and improved health outcomes. This position was in 2005 acknowledged and for the first time explicitly endorsed by the World Health Assembly (WHA) as the goal of sustainable health care system (UNGA, 2010). Based on this resolution, WHO defined UHC as *"access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access"* (WHO 2012.).

However, evidence shows that insurance is a useful and sustainable means for financing the structure and delivery of healthcare world-wide. (Gottret et al, 2008 & Okma et al, 2010). As a tool for healthcare financing, Insurance comes in different models. These different models are in use by many countries to fund healthcare. For instance in America the Obama administration introduced Affordable Care Act of 2010 which makes health care more affordable for everyone by lowering costs for those who can't afford them.

In Nigeria, successive governments realized the need to structure the funding of health care services as one of the ways to improve health care provision (Gilbert et al 2009). Knowing that the nation can hardly afford quality healthcare with the annual meager allocation to the health sector that hovers between four and five per cent. By 1999, the NHIS was established under decree No. 35 by the government and the first phase rolled out in 2005 (NHIS Decree 1999 & NHIS 2012b). The mandate of the scheme is "to provide easy access to qualitative, equitable and affordable healthcare via various pre-payment mechanisms" (NHIS Decree 1999). The Decree projected that "ultimately, universal health coverage should be achieved by 2015" (NHIS Decree 1999).

The scheme intended to reduce the Financial catastrophe of the citizens by ensuring that health services are available at all times and reduce the high out-of-pocket payments for health services in the presence of low household financial capacity and an absence of prepayment mechanisms. The NHIS was launched with an operational guideline that clearly segments the population and outlines the implementation of the scheme for the different sectors. This was in keeping with the aim of attaining UHC and MDGs 2015 target for overall country's development.

However, despite the NHIS being formally launched in 2005, over a decade after, affordable good quality health care to many is still elusive in Nigeria, because of their limited financial access and the burden of out of pocket health expenditure when faced with health challenges.

In view of these problems bedeviling the health sector in Nigeria, this paper therefore seeks to examine how the National Health insurance scheme can be used as a mechanism to achieve universal health care coverage in Nigeria and how the insurance scheme can mitigate the financial risk of the citizens in accessing quality health care.

II. CONCEPTUAL CLARIFICATION

The Concept of Universal Health Coverage (UHC)

According to Abiiro and Allegri(2015) in the existing literature, different conceptual terminology, such as universal health care , universal health care coverage , universal health system, universal health coverage, or simply universal coverage, have been used to refer to basically the same concept.

Stuckler et al. (2010) noted that "universal health care" is often used to describe health care reforms in high income countries while "universal health coverage" is associated with health system reforms within low- and middle-income countries (LMICs). Given that the poor, marginalized and most vulnerable populations mostly reside in LMICs.

However, the operationalization of the concept of UHC has been polemic, to some scholars they argued UHC in terms of universal population coverage, others sees in terms of universal financial protection, and others in terms of universal access to quality health care, anchored on the basis of health care as an international legal obligation grounded in international human rights laws.

Clearly there are three dimensions to the understanding of the concept of UHC; First, as a humanitarian social concept, UHC aims at achieving universal population coverage by enrolling all residents into health-related social security systems and securing equitable entitlements to the benefits from the health system for all (Oxfam, 2012). Secondly, from the perspective of health economics, UHC is viewed as a means of protection against the economic consequences of ill health (Palmer et al,2004 and Xu et al 2003). A guaranteed financial protection requires the implementation of a health care financing mechanism that does not require direct (substantial) out-of-pocket (OOP) payments, official or informal, such as user fees, co-payments and deductibles, for health care at the point of use As a health economics concept, UHC guarantees financial protection by providing a shield against the catastrophic and impoverishing consequences of out-of-pocket

expenditure, through the implementation of pooled prepaid financing systems. Thirdly, as a legal concept, UHC implies the existence of a legal framework that mandates national governments to provide health care to all residents while compelling the international community to support poor nations in implementing this right as a public health concept, UHC has attracted several controversies regarding which services should be covered: comprehensive services vs. minimum basic package, and priority disease-specific interventions vs. primary health care.(Barcener,2014)

Howbeit, the intent for instance of WHA as captured in the definition of UHC and for the purpose of this paper the concept implies the three dimensions of UHC which are;

i. How much of the cost is covered (revenue collection).

ii. Who is covered (revenue pooling).

iii. What services are covered (purchasing/provision of services).

Again, health care needs are infinite; certainly universal coverage does not imply coverage of all health services for everybody. According to (Carrin et al, 2008), health benefit package is defined and determined by the three dimensions of health financing functions.

Health Care Financing

Healthcare financing can be defined as the mobilization of funds for healthcare services (Oyefabi, Aliyu & Idris, 2014). In other words, it is the provision of money, funds or resources to the activities designed by government to maintain people's health. These activities encompass the provision of medical and related services geared toward maintaining good health, especially in the aspect of disease prevention and curative treatment.

The concept of health care financing succinctly deals with the quantity and quality of resources a country expends on health care. This is proportionate to the country's total national income. The amount of resources earmarked for health care in a country is said to be a reflection of health value placement vis-à-vis other categories of goods and services. Metiboba, (2012) opined that the nature of health care financing defines the structure and the behaviour of different stakeholders and quality of health outcomes. The pattern of health financing is therefore intricately connected and indivisibly linked to the provisioning of health services (Riman & Akpan, 2012).

The duo, Riman and Akpan argued that the definition of health care financing cannot be narrowly conceived and confined to raising enough resources to fund health care needs of people alone, but also entails the questions of affordability and equitable access to health care services by them, including guaranteed financial risk protection.

In consonance, Metiboba (2012) contended that when it comes to analyzing health care financing, it is fraught with some nuances since some types of health care services are skewed towards benefitting groups and the community collectively. Worth mentioning here are vaccination against certain communicable diseases, control of malaria and environmental sanitation. Other issues that make analysis of health care financing problematic are public expenditures on food, clothing, shelter and education. The mutually reinforcing trajectory of relationships that exist between the aforementioned survival needs also makes health care financing analysis a difficult one.

One of the intricate issues and nuances associated with the analysis of health care financing is the identification of health care expenditure given the demarcation between preventive and curative health care services. The proposed integration of traditional medicine practitioners into the mainstream formal health sector will further pose a challenge to the analysis of health care financing as argued by Metiboba (2012).

Financing healthcare services has continued to provoke discourse among low and middle income countries around the world given the fact that their health system has continued to claim more attention and fund (Philip and Alexander, 2012).

III. METHODOLOGY

Data for this study was collected from existing literature relating to health care financing and management. Reports from National Bureau of Statistics,(NBS),WHO, Federal Government annual budgets and publication by experts in the field of health management were reviewed as the sources of exposing the health care expenditure pattern in Nigeria and the imperative of NHIS financing health care in Nigeria towards attainment of UHC. Data were also sourced from NHIS reports and website. Grey literatures like: thesis, projects etc were also review to gain insight into the financing of the health sector in Nigeria. Data obtained from these sources were content analysed. This was aimed at giving the readers a better and concise understanding of the concept

1. NHIS SCHEME IN NIGERIA

In Nigeria the NHIS was officially launched in 2005 as an integrated scheme to cater for the health needs of all segment of the society as follows:

Formal sector	Public sector (Federal, State and Local Government) social health insurance scheme
	Armed forces, police and other uniformed services social health insurance scheme
	Organized private sector social health insurance scheme
	Students of Tertiary institutions social health insurance programme (TISHIP) and voluntary participants social health insurance scheme
Informal sector	Rural community social health insurance scheme (RCSHIS)
	Urban self-employed social health insurance scheme (USEHIS)
Vulnerable groups	Permanently disabled persons and the aged social health insurance scheme
	Children under 5 years health insurance scheme (CUFHIS)
	Pregnant women and orphans social health insurance scheme
	Prison inmates social health insurance scheme
Others	Diaspora family and friends social health insurance scheme
	International Travel Health Insurance
	Retirees and the unemployed social health insurance scheme

Source: *NHIS Operational Guidelines May 2005*

The scheme is a PPP and the NHIS accredits privately owned HMOs to operate nationally and also regionally (in the 6 geo-political zones). The NHIS also accredits a mix of public and private health care providers to provide health care at primary, secondary and tertiary levels. Enrollees are free to choose any accredited primary provider as first contact for obtaining care. Secondary and tertiary levels of care are only accessed via referrals from the primary level (NHIS decree no. 35 of 1999). There are presently 60 accredited national and regional HMOs and about 5,949 accredited providers (public and private) (NHIS, 2012a). The HMOs deal directly with the health care providers as fund and quality assurance managers for enrollees; the government regulates all activities of the scheme.

Population Coverage of the Scheme

Currently, only the formal sector programme has been implemented and this covers the following;

i. Public sector employees which includes civil servant at all level

ii. Organizations with more than 10 employees, and

iii. Armed forces, police and other uniformed services (Arum, 2006:18):

The current formal sector is presently being funded by employer 10% and employee 5% contributions of the basic salary of all federal and some state government workers (NHIS, 2012a).

IV. POTENTIALS OF THE SCHEME IN ACHIEVING UHC

Health insurance is a social security mechanism that guarantees the provision of needed health services to persons on the payment of some amount at regular intervals. Given the resonating poverty situation in Nigeria, health care spending on some debilitating illnesses can be catastrophic. Therefore the NHIS is the best way to pay the costs associated with health care. This method of payment will protect the poor against high cost of health care by making payment in advance of falling ill. The scheme therefore protects people from financial hardships occasioned by large or unexpected medical bills.

The scheme also saves money on the short run and protects the poor from medical conditions that can lead to greater loss of money on the long run. According to the NHIS operational guidelines, the Federal, State, Local, Governments, Development Partners and Civil Society Organizations will pay contributions in advance into the vulnerable Group Fund to provide health services for the vulnerable in the society who are not economically active. Such groups include; aged, infants' pregnant women, physically challenged and even prison inmates. This will ensure that this group who are usually excluded from the health system due to lack of financial power are given due attention and integrated into the health care system.

NHIS encourages the pooling of resources from persons of different illness-risk profiles and the cost of the risk of illness among those who are ill and those who are healthy, are shared. This helps reduce financial burden on the sick. The pooling of resources will also provide health care providers with additional resources to upgrade physical infrastructures and consumables in their facilities.

In a nutshell the scheme has three main characteristics- prepayment, resource pooling and cost-burden sharing. Pre-payments under the scheme are fixed either as a proportion of the pay-roll, or as flat rates contributed by the participants. Resources pooling in the sense that contributions from large subscribers provides adequate funds to provide services on demand. And cost burden sharing implies that payment is not proportional to the risk of illness of individual beneficiaries, every cost of services is burn by all the subscribers.

V. CHALLENGES IN THE IMPLEMENTATION OF THE SCHEME

Despite the enormous benefits the scheme portends, sadly, over a decade after commencement, the scheme is estimated to cover paltry 5% (roughly 7 million) of Nigerians, mostly in the formal sector. An insignificant fractions of the organized private sector also subscribe for direct premium-based voluntary private health insurance schemes with the HMOs (Lawan, 2012). The scheme has presently covered those in civil service, the armed forces, paramilitary forces and other employees of the federal government. The states have showed disinterest in enrolling its work force into the scheme. This is predominantly because there is no legal framework making the scheme compulsory for state government employees and employers of the formal and informal sectors. Thus one significant breakthrough towards coverage increase will be to make enrollment into the scheme compulsory for everyone.

The scheme is designed to maintain a high standard in the delivery of care. But the experience of enrollees point at poor service delivery with long waiting time, use of substandard drugs and poor attitude of healthcare providers. These have festered because of poor supervision and weak regulation. The poor health outcome witnessed by NHIS enrollees is also attributed to collusion between agents of the regulatory body, the health care providers and health maintenance organizations.

Other Impediment to the success of NHIS in ensuring UHC

***Corruption*:** As revealed in a study cited by Aregbesola (2018), the management of NHIS funds for health care had been fraught with corruption and a lack of transparency and accountability. Despite the disbursement of N411 billion to HMOs by the NHIS since 2005, HMOs were indebted to HCPs across Nigeria to the tune of N2.276 billion, and NHIS enrollees continue to be at the receiving end of this massive corruption with lack of improvements in their health status. Enrollees who together with their employers make these financial contributions are unsatisfied with the services they receive, and in fact most NHIS enrollees complain that they are treated badly at hospitals by health workers because of the indebtedness of HMOs to hospitals.

***Inadequate legislation*:** The law that set up the scheme appears inadequate especially as it makes participation in it optional, thereby restricting participation. This could account for the participation of only federal civil servants, those of only few out of thirty-six (36) states at present and few organized private sector.

Practice of federalism: Nigeria operates a federal, as well as a three – tier system of government. This means that each of the tiers- Federal, State and Local government – is relatively autonomous of each other and therefore can take independent decisions within their domain. Hence the apparent reluctance of the state and local governments to buy into the scheme,

***Problem of distribution and provision of medical facilities*:** Over 90 per cent of the disease burdens are in the rural areas, with a corresponding less than 10 per cent of the facilities. Moreover many of the health human resources are based in the urban areas and are not ready to move to the rural area to work. This is due to the dearth of infrastructures such as schools for the children, potable water, and electricity, among others.

***Lack of public awareness*:** Some people do not want to know or buy into the scheme because they are dogmatic. Some people question its contributory nature, believing that it is the responsibility of government to take care of the health needs of its citizens.

Labour resistance: Labour organizations across the country are fiercely opposed to the scheme. Ana (2010), reports that in Cross River State, labour unions refused participation for fear of failure of the scheme.

Inadequate funding: It is apparent that government resources are limited. In the case of Nigeria, the revenue is dwindling, due to many factors, in the face of competing demands from various sectors of the economy. Funding the health insurance scheme by government alone is a daunting challenge.

VI. CONCLUSION

The clamor for Universal health coverage is predicated on the fact that many household in middle and low income countries (MLIC) spend a huge chunk of their income to access health care, thereby exposing them to the risk of providing other basic needs of life.

From the international community standpoint and other key stakeholders, the overwhelming evidence suggest that users ' fees or OOP constitute a strong barrier to the utilization of health care services, as well as preventing adherence to long term treatment among poor and vulnerable groups.

But, prepayment and risk pooling through Social Health Insurance (SHI) and taxation are found to provide protection against some of the undesirable effects of users' fees. The international community is therefore paying more attention to SHI as one of the promising financing mechanism for providing coverage to population against high health care service cost.

Moreso, in Nigeria given the monoculture nature of the economy and the plummeting price of crude oil the best option for sustainable health care financing is through the social insurance scheme.

Unfortunately, many years after the scheme was introduced in Nigeria the degree of coverage remains unimpressive as greater health expenditure in Nigeria still reflect out of pocket expenditure which according to *WHO* is the major cause of catastrophic and impoverish health expenditure.

As currently implemented, the NHIS has totally excluded the rural poor and others who are not employed in the formal sector or organized private sector but constitute more than 70% of the national population from protection against financial risk occasioned by OOP.

VII. RECOMMENDATIONS

In view of the daunting challenges bedeviling the implementation of NHIS in Nigeria and the poor funding of health care which has made the achievement of UHC bleak, the following recommendation is suffice to make progress in UHC attainment through NHIS:

1. Most paramount in achieving wide population coverage of NHIS and other insurance scheme is to recalibrate the legal framework which established it and make it compulsory for all employers and tiers of government to adopt an insurance scheme that will protect the employees and vulnerable groups in the society against the financial risk of health expenditure. Also a larger pool of contribution will guarantee more funds to provide services.
2. In addition, timely remittances to the health care providers (HCP) should be priorities by Health management organizations (HMOs), this will ensure certainty and quality health outcome for enrollees because part of the reason for poor services to enrollees by HCPs is the uncertainties of repayment by HMOs.
3. Proper monitoring and supervision of HMOs and HCPs is very important to ensure that proper services are provided to the enrollees.
4. Government must step-up the level of funding the scheme to ensure that other aspect of the scheme is implemented to cover especially the vulnerable groups whose main source of funding still lies on OOP. Successful addition of this group with government funding can substantially increase the coverage of the scheme and UHC.
5. To encourage providers to setup in underserved rural areas, the capitation paid to private providers domiciled in rural areas should be set higher than those in urban areas. In addition, the government may also apply tax breaks for them. The government will need to apply appropriate and sufficient incentives to retain public sector health workers in rural areas.

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