

## RE-ASSESSING THE COLLABORATION IMPLEMENTATION STRATEGIES AND ADMINISTRATION OF NATIONAL HEALTH INSURANCE SCHEME (NHIS) ON *END-USERS* IN NIGERIA

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### **ABSTRACT**

*The study examined the role of National Health Insurance Scheme (NHIS) to average Nigerian to have a reliable, accessible and affordable healthcare delivery system and the performance of health sector through healthcare accessibility towards equitable, affordable, cost effective, and cost-efficient to the Nigerian populace. It is the duty of the government to provide the citizenry with accessible, affordable, qualitative, efficient and effective healthcare system. It explores documentary evidences about NHIS performance, the political situation, socio-development and psychological imponderances of the leaders and the masses in the unfolding scenario of Nigeria. The use of the internet, journal, thesis, archival materials, and the vast expanse of the literature assisted in the source of information. The paper found evidences of pervasive tendencies for fleece behaviours despite strong provisions that actually facilitated a good number of statutory, legal and administrative instruments to ensure health administration is free for everybody in the country at large. The paper concluded, among others, that NHIS has not cut across all the Federal and State University Teaching Hospital as reflected in the low level of participation in Nigeria.*

**Keywords:** *Accessible; Administration; Affordable; Equitable; Finance; Health Care; Implementation; NHIS; Strategies*

### **INTRODUCTION**

The Healthcare financing continues to stir debate around the world. Many low and middle income countries especially, keep exploring different ways of financing their health system. This is due to the fact that their health systems are chronically underfunded (Philip and Alexander, 2012). Users' fees were initially introduced at the point of service delivery in some countries in order to generate revenue for the running of their health system. In some context, the

introduction of users' fees led to improvement in the quality of health services. However, the overwhelming evidence suggest that users' fees 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. These problems and other issues have propelled debate to look for other alternative to health care financing modalities through which health care service delivery can be delivered to the people with ease (Philip and Alexander, 2012).

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. SHI is seen as helping to pool health risk, prevent health related impoverishment and improvement in efficiency and quality of healthcare service for the poor and helps mobilise revenue for providers. Nonetheless, the implementation of SHI programmes are challenged in term of high administrative cost, lack of managerial skills, problem of cost containment and ensuring national coverage. Due to these, there are still few example of SHI scheme operating at large in developing countries.

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. Then, provision of free health services has hitherto been major political campaign issue. However, in a state where this was implemented, the health facilities were mostly merely consulting clinic as drugs and supplies were constantly out of stock and there were gross infrastructure decay and/or inadequacies. The result is always very devastating with indicators like high infant and childhood mortality rates, high maternal mortality rate and a considerably short average life expectancy.

As Akinkugbe (1996) remarked, “Nigerian hospitals have been reduced to mere consulting clinics without drugs, dressing material, water and equipment” (cited in Omoleke, 2010). Lekki (2001) argued that, the option of insurance coverage is not yet popular in Nigeria. This also contributes to the inadequate healthcare funding as the common pool of resources needed to solve health problem is non-existent. The search for a comprehensive cost effective healthcare plan began in the 60’s at the inception of self government in Nigeria. Public health insurance was first considered as administrative policy in 1962 by the Halevi Committee and acquired legal teeth through the Lagos health bill. This was despite the opposition by the then Nigerian Medical Association (NMA) (Ejimokun, 2012).

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, Professor Olikoye Ransome-kuti 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 guide lines 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 (Agba *et al*, 2010).

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 (NIHS, 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. Till date, over 4million identity cards have been issued. So far 62 HMOs have been accredited and registered and more application is being processed. Presently, 5,949 Healthcare providers, 24 Banks, 5 Insurance Companies and 3 Insurance Brokers have also been accredited and registered (NHIS website).

#### **STATEMENT OF THE PROBLEM**

Nigeria's health system is ranked 187th of 191 World Health Organisation (WHO) member states (WHO, 2000). Professor Azuzu (2008) remarked that, Nigeria Health service performance has not changed much since year 2000 ranking. He cites several statistics to highlight the inadequacies in Nigeria's Primary Health Care system. Annual budget allocation to health have been persistently below 5% except for the year 1998-1999 and 2002-2003 when they were at or just above the level. Infant mortality rate have been deteriorating from 85% in 1990, 93 in 1991 to 100 in 2003, (NDHS, 2003). And in 2007, the Federal ministry of Health reported 110 deaths per 1000 live births. Maternal mortality ratio are estimated at 1100 per 100,000 live births in WHO's world health statistics 2008.

Azuzu 2008, identified causes as some are rooted in the country's colonial past, while others stem from a lack of political will and poor policy making that failed to divide responsibilities effectively between federal, state, and local government and resulted in PHC services lacking staffs and funds. Aside the above global concern by WHO, the problematic of this study derives from the lacuna in the literature concerning the paucity of empirical work in the area of NHIS.

Studies have shown that scholars have worked in area of NHIS especially on effect of health insurance on the demand for healthcare, healthcare funding system, assessment of client's satisfaction, but the administration of NHIS program in Obafemi Awolowo University Health Centre has not witnessed empirical survey, hence this study.

### **NHIS IN NIGERIA**

The Nigeria NHIS is a Social Health Insurance Programme (SHIP) which continues the principle of socialism (being one's brother's keeper) with that of insurance (pooling of risks and resources). The NHIS is a body corporate established under Act 35 of 1999 by the Federal Government of Nigeria to improve the health status of all Nigerian at an affordable cost (NHIS, 2005). The NHIS Act is a statutory authority for the scheme benefit programs. It sets the general rules and guidelines for the operation of the scheme (NHIS, 2005). Thus, the hope of the average Nigerian to have a reliable accessible and affordable healthcare delivery system has brightened.

It is modelled after the practices in developed countries where responsibility for quality health care delivery is shared. The NHIS, at full implementation, will spread health benefit across the primary, secondary, and tertiary spectra. Due to poor participation in the scheme, the NHIS started active registration of beneficiaries in 2005 (NHIS, 2005). All Federal Civil Servants were registered. They are meant to enjoy free Health care services for two years. There was also active registration of the Armed Forces and other uniform Federal workers. The participation this set of enrollee is free. The NHIS was packaged in such a manner to mobilise resources in a suitable manner for the provision of accessible, quality health care for all irrespective of status.

Part I Section 2 of the NHIS Act established a Governing Council charged with the responsibility of managing the scheme. The council consists of the following members:

- a) the chairman, who shall be appointed by the Head of State or President, Commander-In-Chief of the Armed Forces on the recommendation of the Minister of Health;
- b) one person to represent the Federal Ministry of Health;
- c) one person to represent the Federal Ministry of Finance;

- d) one person to represent the Office of Establishment and Management Service in the Office of the Secretary to the Government of the Federation;
- e) one person to represent the Nigerian Employers Consultation Association (NECA);
- f) one person to represent the Nigerian Labour Congress (NLC);
- g) one person to represent the registered health maintenance organisation;
- h) one person to represent the private the private health care provider
- i) two person to represent public interest; and
- j) the Executive Secretary of the scheme who shall also be the Secretary to the council.

Member of the council are expected to be men of proven integrity, and possessors of relevant high education and knowledge.

### **STRUCTURE OF THE NHIS**

The very design of the organisational structure of the NHIS is in itself a control measure aimed at ensuring an efficient, effective and economical scheme. The NHIS is constituted of the following bodies:

- i. The Council
- ii. State Licensure boards
- iii. State health insurance offices
- iv. Standard committee and inspectorate systems
- v. Health Maintenance Organisations (HMOs)
- vi. Health insurance companies (Public and Private)
- vii. Arbitration boards
- viii. Malpractices insurance scheme
- ix. Banks and banking systems and
- x. Tribunal (NHIS, 2005 and Oyedibe *et al*, 2012).

Funding will be by contribution of 5% of enrollees' basic salary while the employer contributes 10% of enrollees' basic salary to the scheme monthly (NHIS, 2005 and Oyedibe *et al*, 2012). The insured shall choose his primary health care provider who is associated with the HMOs. The primary health care guideline of the standard committee made up of statutory professional

registration boards. The state license board approves premises for practice by the health care provider. Liability insurance companies (public and private) will provide professional indemnity cover (malpractices insurance) for health care providers. The role of the arbitration board will be to handle conflicts between the above relationships (Oyedibe, *et al*, 2012).

### **OBJECTIVES OF THE NHIS**

The general purpose of NHIS is to ensure the provision of health insurance “which shall entitle insured persons and their dependents the benefit of prescribed good quality and cost effective health services” (NHIS Act 35 of 1999, Part 1(Section 1)). While the specific objectives of NHIS include:

- i. ensure that every Nigeria has access to good health care services
- ii. protect families from the financial hardship of huge medical bills
- iii. limit the rise in the cost of health care services
- iv. ensure equitable distribution of health care costs among different income groups
- v. maintain high standard of health care delivery services within the scheme
- vi. ensure efficiency in health care services
- vii. improve and harness private sector participation in the provision of health care services
- viii. ensure adequate distribution of health facilities within the Federation.
- ix. ensure equitable patronage of all level of health care
- x. ensure the availability of funds to the health sector for improved services (NIHS Act 35 of 1999, Part II, Section 5).

### **FUNCTIONS OF THE NHIS**

In accordance with Part II (6) of NHIS Act 35 of 1999, the scheme shall be responsible for:

- a) registering health maintenance organisation and health care providers under the scheme;
- b) issuing appropriate guidelines to maintain the viability of the scheme;
- c) approving format of contracts proposed by the health maintenance organisation for all health care providers;
- d) determining, after negotiation, capitation and other payments due to health care providers, by the health maintenance organisations;

- e) advising the relevant bodies on inter-relationship of the scheme with other social security services;
- f) the research and statistics of matters relating to the scheme;
- g) advising on the continuous improvements of quality of services provided under the scheme through guideline issued by the standard committee established under section 45 of this Act;
- h) determine the remuneration and allowance of all staff of the scheme;
- i) exchanging information and data with the National Health Management Information System (NHMIS), Nigerian Social Insurance Trust Fund (NSITF), the Federal Office of Statistics (FOS), the Central Bank of Nigeria (CBN), banks and other financial institutions, the Federal Inland Revenue Service (FIRS), the State Internal Revenue Service (SIBR) and other bodies; and
- j) doing such other things as are necessary or expedient for the purpose of achieving the objectives of the scheme under this Act.

### **HEALTH SECTOR REFORM IN NIGERIA**

Health sector reform is defined as the fundamental change in policy, regulation, financing, provision of health services, re-organisation, management and institutional arrangements, which led by government and design to provide the performance of the health system to attain a better health status for the population (Regional Committee, WHO African Region, 1999) as quoted in (Obansa and Orimisan, 2013).

The goals of reform are to make healthcare accessible and, therefore, equitable, affordable, cost effective, and cost-efficient. It is the duty of the government to provide the citizenry with accessible, affordable, qualitative, efficient and effective healthcare system. Against this background, the Nigerian government has adopted various national health policies and reforms (Obansa and Orimisan, 2013). World Bank, (1994) asserted that, health policy reforms are specifically designed to facilitate the achievement of stated health programme goals and objectives. They are meant to help in strengthening the element of the enabling environment of stated health programmes achieve their objectives in term of coverage, equity, efficiency and effectiveness. These include: safe water and sanitation, food security and nutrition, health care,



especially primary healthcare, education especially that of women, purchasing power, decent housing, family planning, cultural consideration (Obansa and Orimisan, 2013).

There are different strategies for reform; these include decentralisation and centralisation, substitution policies, redefinition of function of hospitals and primary care centres, creation of new roles for professionals, improved management, cost-containment and orientation. No matter the strategy adopted, the aim of a reform is to provide healthcare that is oriented towards outcomes, based on evidence, and focused on effectiveness and efficiency. It is to increase availability and accessibility of services, client/patient satisfaction, and quality of care (Obansa and Orimisan, 2013).

Aregbeyen (2001) and Olaniyan (2005) opined that, the health sector in Nigeria has witnessed several policy and institutional reforms, particularly since the enunciation of the National Health Policy (NHP), a strategy to achieve health for all Nigerians in 1988. This development has, in essence, been a vindication of government's readiness to demonstrate its real commitment to the attainment of the desired goals of a level of health that would enable all Nigerians to achieve socially and economically productive lives (Obansa and Orimisan, 2013). The response of FMOH to the unacceptable health conditions in Nigeria through increased commitment and willingness was undertaken to achieve a comprehensive health sector reform. A new reform commenced in 2003 within the context of the National Economic Empowerment and Development Strategy (NEEDS), MDGs and NEPAD. The National Health Policy which was revised in 2004 created the reform environment whilst the health sector reform programme 2004 established the framework including goals, target and priorities that should guide the action and work of the FMOH and, to some extent, those of State Ministry of Health (SMoH) and health development partners over a four-year period (2004-2007). The document describes the direction for strategic reforms and investment in key areas of the national health system (FMOH, 2004).

Obansa and Orimisan (2013) stated that, in 2004, the Federal Government launched the National Economic Empowerment and Development Strategy (NEEDS), in it the government promised to "improve the health status of Nigerian as a significant co-factor in the country's health sector

reform aimed at strengthening the national health system and enhancing the delivery of effective, efficient, quality and affordable health services to Nigerians”. The federal government explained that the reform was aimed at raising life expectancy in Nigeria to 65years and reducing infant mortality to 50 per 1,000 births. The Policy thrust includes:

- 1) to improve Government performance of its stewardship role of policy formulation, health legislation, regulation, resource mobilisation, coordination, monitoring and evaluation.
- 2) to strengthen the National Health System and improve its management.
- 3) to improve the availability and management of Health resources (financial, human, infrastructure, etc.).
- 4) to reduce the disease burden attributable to poverty disease and health problem including malaria, tuberculosis, HIV/AIDS and reproductive ill health.
- 5) to improve the populations’ physical and financial access to quality health service through the:
  - i. establishment and institutionalisation of a system for quality assurance.
  - ii. Registration and regulation of traditional and alternative health care providers.
  - iii. Establishment of a system that will regulate the location, practice and quality of human and material resources in both public and private health facilities and strengthen regulatory mechanism, including professional codes of conduct.
- 6) to increase consumer’s awareness of their health right and obligations, and
- 7) to foster effective collaboration and partnership with all health actors (Obansa and Orimisan, 2013).

The expected results from these policy thrust was equally outlined with plans of Action. There have been some achievement but other challenges still remain. Improving access to healthcare services and infrastructure, especially for the poor is vigorously with focus and sincere commitment from the Presidency and its implementers. The key challenges are the effective revitalization of PHC and getting the health bill, which defines the role of the different levels of government passed by the relevant bodies into law.

### **THE ORIGIN OF HEALTH CARE FINANCING IN NIGERIA**

Health care financing in Nigeria and other developing countries is characterized by gross under-funding. The Nigerian Government spends less than 2 percent of the Gross National Product on

Health which, in most cases, translates to an average of a few dollars per person per year (Makanjuola, 1996; Olayemi, 2003; and Olaiya and Ejimokun, 2011).

Another feature of our Health Care Financing is that most of our public spending on health is for curative purposes which consume a lot of resources and leaves preventive and promotive health largely not catered to, unfortunately, the services are available to a small proportion of the community (Makanjuola, 1996 and Olayemi, 2003). The private expenditure on health in Nigeria is often quite large but, mainly channeled towards curative Health and it is often unevaluated with regards to the proportion of total national expenditure on Health (Olayemi, 2003; Alausa et al, 1996; and Olaiya and Ejimokun, 2011).

The last feature of Nigeria's Health Care Financing is that donor agencies often spend their monies on vertical programs which at times may not meet the immediate priorities of the community (Olaiya and Ejimokun, 2011). This always leads to social acceptance problems for such programs.

In Nigeria, Orthodox Health Services (OHS) originated from the medical service established for the colonial army towards the end of the 19<sup>th</sup> century (Makanjuola, 1996). When the colonial army was integrated into the colonial government, orthodox medicare was extended to the Local civil Servants and their relations free of charge (Makanjuola, 1996). Later, civil populations who lived near the administrative officers also enjoyed free health services with less than 2 percent of the Gross National Product on health which, in most cases, translates to an average of a few dollars per person per year (Makanjuola, 1996). The services were then largely curative. One of the first Government Health Institutions was built in Lagos. It later became the Lagos General Hospital in 1893 (Makanjuola, 1996; and Olaiya and Ejimokun, 2011).

Various religious and private organizations also established hospitals, dispensaries and maternity centers in different parts of the country. They started by offering services on humanitarian grounds. The first General Hospital (private) was established by a catholic priest (Rev. Fr. Coguard) in Abeokuta in 1859 (Makanjuola, 1996).

Until 1975, Health Care System in Nigeria was dominated largely by provision of hospital based curative services in a few urban areas where the colonial and civil administrators and army personnel lived (Makanjuola, 1996). Remote rural areas inhabited by a majority of the populace were left to be cared for by local traditional medical practitioners and herbalists. This is typical for most countries in the developing world, especially those who went through colonial rule (Alausa and Osibogu, 1996; Makanjuola, 1996; Olaiya and Ejimokun, 2011).

As from 1975, government started focusing attention on promotive and preventive health care delivery ((Alausa and Osibogun, 1996). By 1988, the Nigerian government formally accepted and promulgated a National Health Policy based on Primary Health Care strategy for achieving health for all (Alausa and Osibogun,1996). The adoption of Primary Health Care was based on the fact that most health problems can be tackled at the Primary Health Care level ((Alausa and Osibogun, 1996). Communicable diseases, unsanitary environment, poor personal hygiene, and malnutrition were found to be the main health problems. Other causes of mortality included pregnancy related conditions, sickle cell disease, road traffic accidents, cardiovascular disease and more recently HIV/AIDS and various malignancies (FMH, 1996 and Ekpo, 1996).

Health care financing section of the 1998 document on National Health Policy can be summarized as follows: Government should review allocations to health in relation to the requirements of other sectors; government should lay emphasis on promotive and preventive health services; users are to pay for curative services while government will subsidize preventive services; private individuals and organizations are encouraged to establish or finance health care services and finally the cost benefit analysis of various health programs should be done to determine the feasibility of the program. Primary health care funding, encouraged by the National Health Policy, includes out of pocket payments (user charges), employer payment, and health insurance, voluntary organizations like Red Cross/Crescent and community social support strategies (Olaiya and Ejimokun, 2011).

The dilemma, even after the policy inauguration is that Government has not been able to adequately finance health care. Yet, government cannot leave Health Care Financing to private

initiatives because equity and quality cannot be adequately addressed by private entrepreneurs. Governments in Nigeria have a lot of health facilities scattered all over the country (rural and urban) without materials and manpower. This is typical of most developing countries (Makanjuola, 1996 and Alausa et al, 1996).

### **HEALTH CARE FUNDING IN NIGERIA**

Health care funding system in Nigeria is predominantly from general taxation by the government which is never sufficient for the provision of good health care service delivery in the country. This fund is made up predominantly of revenue accruing to government from oil sector in form of Oil Royalties and fees, and crude oil sales paid into Federation Account. This Federation Account is shared between the Federal, State and Local Governments on an agreed percentage and criteria thus; Federal Government 52.8%, State Government 26.6% and Local Government 20.6%. Both the state government 26.6% and the local government 20.6% are paid into state-local government joint account in which the Governor of a state is the signatory (Vanguard, 2012).

Okorosobo, (1998) stated that, the economic problem of over dependence on oil revenue, reduced export earnings leading to balance of trade problems , corruption, devaluation of the naira, debt burden in Nigeria and poor management of available resources, have reduced funds allocated to health care sector (Ejimokun, 2012). Even with this limited fund available to the health sector, the population increase is not curbed and this to a large extent exerts much pressure on the meagre funds for the health sector (Ejimokun, 2012).

The table below shows the recurrent expenditure on health and also expressed in percentage of total Federal Government recurrent expenditure between 1999 and 2013.

From the table, it will be noticed that Federal Government recurrent expenditure to health sector has been consistently low range from 3% to 5%, it only above 6% in 2011. However, this figure are insignificant when compared with the WHO recommended value of 10%.

**Table 2.1 Federal Government Recurrent Expenditure on Health Sector from 1999-2016**

<b>YEAR</b>	<b>AMOUNT(#'Billion)</b>	<b>% of TOTAL</b>	<b>TOTAL</b>
1999	16.6	3.0	449.7
2000	15.2	3.29	461.6
2001	24.5	4.23	579.3
2002	40.6	5.83	696.8
2003	33.3	3.38	984.3
2004	34.2	3.08	1,110.6
2005	55.7	4.22	1,321.2
2006	62.3	4.48	1,390.1
2007	81.9	5.15	1,589.3
2008	98.2	4.64	2,117.4
2009	90.2	4.24	2,128.0
2010	99.1	3.19	3,109.4
2011	231.8	6.99	3,314.4
2012	197.9	5.95	3,325.2
2013	180.0	4.88	3,689.1
2014	195.98	5.72	3,426.94
2015	257.75	6.73	3,831.98

*Source: Extracted from CBN 2016 Statistical Bulletin (Section B, Public Finance Statistics)*

The Alma-Ata declaration of 1978 recommended that Primary Health Care (PHC) be community oriented. The Federal Government of Nigeria (FGN) adopted the recommendation and consequently transferred PHC funding to the Local Government Areas (LGA). This further led to inadequate funding of the health sector due to lack of fiscal autonomy in our federal system of government. There has been a call for fiscal federalism, especially during the National Confab held in 2012 and a situation that is believed will improve the situation.

Second Schedule Part II of 1999 Constitution of the Federal Republic of Nigeria, put health on the concurrent legislative list, which means that each level of government has some responsibilities to play in the area of health. Section 7, Fourth Schedule assign to the local government the provision and maintenance of Primary Health Care with support from the other tiers of government.

Nigeria operate a mixed economy therefore, private providers of health care have role to play in health care service delivery. The federal government role is mostly limited to coordinating the

affairs of the University Teaching Hospital (tertiary health care system) and federal medical centres while the state government manage the various general hospitals (secondary health care system) and the local government focuses on dispensaries and health centres (primary health care) which are regulated by the federal government (Onotai and Nwankwo, 2012).

The truth about health care funding in Nigeria is that, apart from the public sector, no one knows exactly how much that goes into the health sector from other source (Ejimokun, 2012). Even, funding from different state government depends on the financial capability and political set up of that state; therefore, health sector may be financed adequately better in some state than others. The situation in Africa is not very different with Nigeria. This is also true for other developing countries of South America and Asia where the underlying logic is the same.

The UK has a famous National Health Service (NHS). It is a splendid example of a health care system that is funded mainly through general taxation. This system of funding is often referred to as the “Beveridge System” which is also considered as a public insurance system (Onotai & Nwankwo, 2012). France has a well established social health insurance system called the “Bismarckian System” of health care financing as it was first introduced by Bismarck in Germany in 1883 (Onotai & Nwankwo, 2012).

However, private health insurance is a significant source of funding in the United States of America (USA). This type of funding is called the “market system”. Health care is seen to be like other commodities, the government has a limited role and private provision (often for profit) predominates. This makes public involvement in finance and regulation to be substantial probable (Onotai & Nwankwo, 2012). In South Africa, health care is financed through a combination of mechanisms. Allocation from the government comes from general taxation, private medical scheme are well developed and out-of-pocket payments account for a considerable amount of total health care financing similar to what is obtainable in Nigeria (Onotai & Nwankwo, 2012).

#### **AWARENESS, PERCEPTION AND PARTICIPATION OF NIGERIANS IN THE NHIS**

The awareness of Nigerians on the NHIS was very low (15%) as in year 2000 from the research conducted among Civil servants in Sokoto State (Aliyu, 2000; and Olaiya and Ejimokun, 2011).

However, with the launching of the NHIS by the Federal Government of Nigeria in June 2005 and the subsequent full payment of Federal Civil Servants' contributions by the federal government from 2005 to 2006, the awareness became high. This was observed by Katibi, Akande and Akande, (2003) in a research on the awareness and attitude of medical practitioners in Ilorin towards the NHIS.

The awareness by State Civil Servants and the general public is not available as their packages in the NHIS are yet to commence despite the launching by the then Nigeria's First Lady, Stella Obasanjo, of the Rural Health Insurance Scheme. Data on the perception of Nigerians on the NHIS are not available yet. However, the willingness to participate by medical practitioners and civil servants is high, 66.1% and 84.1%, respectively (Aliyu, 2000; Kabiti et al, 2003; and Olaiya and Ejimokun, 2011). The WHO has presented a model to appropriately mix the financing as well as provision of services that will ensure that all vulnerable members of the society are protected with respect to health services of adequate quality (Alausa and Osibogun, 1996; and Olaiya and Ejimokun, 2011).

### **THE GUIDELINES**

The scheme comes in an attractive package of six components. Contributors can access healthcare needs from approved public and private health service providers (Aliyu, 2000 and Kabiti et al, 2003). Health Management Organizations (HMOs) are limited liability companies licensed by the NHIS to facilitate the provision of health care benefits to contributors in the formal sector social health insurance programme (NHIS, 2005; Akande, 2005; and Olaiya and Ejimokun, 2011). The HMOs interface between eligible contributors including voluntary contributors and the health care providers. For any organization to be licensed as HMO by the NHIS, it must be indemnified by NHIS approved insurance companies to the tune of #100 million and also maintain a bank balance of same amount from which the NHIS could mobilize funds to pay outstanding claims in the case of default (NHIS, 2005).

The Health Care Providers are licensed Government or Private Health Care Practitioners or facilities registered with the scheme for the provision of prescribed health benefits to



contributors and their dependants (NHIS, 2005). Health Care Providers (HCP) can either be Primary, Secondary or Tertiary. The Health Care Providers are required to take malpractice insurance (professional indemnity) with NHIS approved insurance companies (NHIS, 2005).

The Formal Sector, Social Health Insurance Programme incorporates workers in the public and organized private sectors. It is mandatory for any organization having ten or more employees. Contributors pay 5% of their basic salaries while their employers pay 10% to the common pool and this entitles a contributor, a spouse and four children to health benefits (NHIS, 2005). The Urban Self-Employed Social Health Insurance Programme is designed for self-employed individuals, urban dwellers in the informal sectors, and other members of socially cohesive groups who will make flat rate contributions regularly in order to derive health benefits as mutually determined by members based on their needs while each contributor can be identified with a NHIS participants' card by the health care provider (NHIS, 2005).

The Rural Community Social Health Insurance Programme is packaged for rural dwellers that constitute well over 50% of Nigeria's population. The rural dwellers also form social cohesive groups and make regular (monthly) contributions depending on the health package chosen by participants. The affairs of the user group are managed by a board of trustees elected by them (NHIS, 2005).

The Under - Five Children Programme as well as the Permanently Disabled Persons Social Health Insurance Programme will be under the direct management of the NHIS (NHIS, 2005). This package is free to ensure greater care. It is in consonance with the provisions of the National Health Policy of mandatory free and accessible health care benefits covering the major causes of childhood morbidity and mortality (Akande, 2005; and Olaiya and Ejimokun, 2011). The Prisons' Inmates Social Health Insurance Programme is also under the direct management of the NHIS. Their contributions will be fully paid by the Government.

The scheme has provisions against abuse. Participants who default in their payments are excluded from enjoying the benefits until they pay what they owe and a month's subscription in advance (Kabiti et al, 2003 and Akande, 2005). There is an arbitration board that handles all

complaints from participants. Stakeholders are at liberty to terminate their agreement by giving six months notice in writing from the day of receipt of notice (Kabiti et al, 2003 and Akande, 2005).

### **LIKELY CONSTRAINTS**

One of the constraints to the proper implementation of the scheme is lack of public confidence. People are skeptical about the scheme due to the failure of similar contributory scheme in the past such as the housing scheme (Kabiti et al, 2003 and Akande, 2005). Other constraints are poor data management and collusion between health care providers and the participants to cheat. The determination and collection of the correct premiums to be paid by participants outside the formal sector is also a constraint. This problem is not peculiar to Nigeria alone; it is also true in developed countries (Olayemi, 2003; Iekki, 2001; and Olaiya and Ejimokun, 2011).

Prompt payment of health care providers by HMOs and the HMOs by government and employers are also constraints to the health insurance scheme. Valuable time is wasted trying to collect these monies. Usurpation of responsibilities of Secondary Care Providers (Pharmacies, Laboratories, Radiography centers) by the primary care provider (hospitals, nursing homes, and primary health care centers) is also a constraint. It has been observed that the primary care providers also dispense drugs to the patients even when their pharmacies are not registered as Secondary Care Providers. They also offer laboratory and radiography services even when they are not registered for such (Olaiya and Ejimokun, 2011).

### **LIKELY IMPACTS ON HEALTH CARE DELIVERY**

The likely impacts of the NHIS on Nigeria's health care delivery include elimination of financial barriers to health care due to the contributory scheme; reduction of economic incentives for both excessive and insufficient care; and discouragement of administrative interference and expense. It will also improve the distribution of health facilities. The rural dwellers will benefit from this as the emphasis on funding of health facilities will no longer be concentrated in the urban areas. It will control cost by curtailing bureaucracy and also foster health planning. The resources available from the common pool will enable policy makers to make long term health plans.

## **CONCLUSION**

The coming into operation of the National Health Insurance Scheme, NHIS, will usher in a new era of improved health care service delivery in the country. In addition, it will provide alternative and sustainable funding of the health sector, relocate responsibility for health care management from public sector exclusiveness to the community and ultimately, the individual. However, wider coverage of the scheme and other steps has to be taken to address the anxieties of the respondents observed in this study. While it took the Dutch and the Germans one hundred and one hundred and fifty years respectively to achieve universal coverage (Dike, 2007), Nigeria should achieve the same feat in lesser number of years as we are not the pioneers of the scheme. With better funding, the sliding quality of physical infrastructure in the health sector will be addressed and Nigerians will have a greater control in the management of their health care. This is one of the policy thrust of the Health Sector Reform (HSR). It is not practicable for any country to rely exclusively on one source of funds for her health care needs. Reliance on a variety of sources has a stabilizing effect on the economy and allows for a better adaptation to the divers economic and cultural conditions of the country.

The World Health Organization maintains that the need for multiple financing mechanisms is to maximize the potential role of each source while ensuring that each has the intended effect on the overall achievement of health policy goals (Mbanefoh, 1998). Three out of eight Millennium Development Goals, MDG, of reducing child mortality, improving maternal health and combating HIV/AIDS, malaria and other diseases by the year 2015 can only be attained with adequate health care funding. National Health Insurance Scheme remains critical to adequate and affordable access to healthcare service delivery for members of staff of EKSUTH.

## **RECOMMENDATIONS**

In view of the findings of this study, the following recommendations are made:

- a) Development of electronic fund transfer system for the payment of Health Care Provider by Health Management Organizations and HMDs by NHIS to reduce delay in payment and wastage in man-hours there from.

- b) NHIS should be clear about their own task and always review their strategies to accommodate emerging issues and challenges as regards their operations. This will be reflected in administrative decisions that favors holistic rather than incidental, narrow approach to problems.
- c) NHIS must learn to cope with resource management and consumer demands as well as issues of effectiveness, efficiency and quality of care through better monitored output because it depends to a large extent, for its success, on the proper functioning of other services operating within its ranks.
- d) To control cost, a health insurance scheme must include limits beyond which expenses are borne by the insured. The complete removal of this for the armed forces and other uniform personnel should be revisited to avoid provider -induced demand.
- e) Despite the efforts of the orthodox healthcare system, traditional practitioners play a major role in the provision of health care especially in the rural areas. These traditional practitioners use herbs or fetishes or both to cure diseases. Some people believe that some diseases have spiritual undertone and can only be cured by mystical powers which are possessed by traditional practitioners. The practices of these fetish priests should be standardized and incorporated into the NHIS.
- f) The initial participants' base of 239,732 is inadequate. The States and Local Governments should be encouraged to undertake the funding of the scheme for their members of staff for the first two years just like the Federal Government. The efforts of the Cross River state government in this aspect is commendable.

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