

Social Health Insurance and Sustainable Healthcare Reform in Nigeria

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ABSTRACT The Nigeria's poor health status has attracted global concern. The Health system has no doubt contributed to this, though Nigeria's healthcare system is geared towards ensuring availability and accessibility of healthcare by Nigerians yet the nation healthcare remains a major concern. Reform in the healthcare entails purposeful changes and planning in the system. It has however become increasingly clear that the reform in the country is to contribute meaningfully to the nation's healthcare system and to be felt by the majority of the population. This paper therefore, examines Nigerian healthcare system, and the ongoing reforms in the health sector. Information will be sourced from the primary and secondary data, the paper then concludes with key considerations for sustainable reforms in Nigeria.

INTRODUCTION

Every government in Nigeria holds the view that a healthy population is essential for rapid socio-economic development of the country hence healthcare is on the concurrent list in the Nigerian constitution and its allocation comes next to education and defence in the national budget. Out of the total population of 135.6million people in Nigeria 55% live in the rural area while 45% live in the urban areas (National Population Commission 2003). Despite the large population, social services including healthcare services are inadequate coupled with several challenges facing the system. Various reform programmes have been put forward and government has expressed its determination to pursue a bold reform of the system. This paper begins with a brief review of the challenges of Nigerian healthcare system as a way of identifying the weaknesses that need to be tackled. Emphasis is also on the ongoing reform efforts to deal with perceived problems. The paper concludes with considerations that are crucial in having a sustainable healthcare reform in Nigeria.

METHODOLOGY

We used a qualitative approach to conduct this research, a qualitative technique commonly employed in social sciences inquiry. This method involves employing in-depth interviews with 30 respondents centrally involved with health reforms

at both the policy formulation and implementation levels. Using a snowball sampling technique we interviewed senior officials in the national ministries of health; national legislator; national planning commission members; state health officials; representatives of civil society organizations and private organizations working on health insurance. While there were some common questions asked each interviewee, including his or her assessment of the state of health insurance scheme we did not employ a uniform survey instrument since each interviewee had unique knowledge about the health insurance scheme in the country instead, we asked open-ended questions in an exploratory way to elicit that unique knowledge.

In addition to the interviews, we reviewed multiple documents, including demographic and health and other surveys, government policy document, health reports, published research on health insurance in Nigeria.

NIGERIA HEALTHCARE SYSTEM

Healthcare in Nigeria is administered through three tiers: The primary level is run by the local government, the secondary by the state, while the tertiary is run by the federal government (FMOH 2005). There are contributions and interplay at different levels by private hospitals, NGOs and traditional medicine. Administration of the health sector is through guidelines by the cabinet made up of members of National Advisory Council on health. The administrative- framework

of the health sector is from the cabinet to the federal ministry of health; down to the state ministry, then to the local governments and the political wards, as shown in figure 1.

In spite of a well structured health system, development of the Primary Health Care (PHC) has not improved the health experience of the population especially those in the rural area: The health sector's contribution to the national development remains a serious issue. However, the challenges of the sector are discussed below.

Poor Health Budgets

The Nigerian health sector's contribution to the national economy remains poorly defined. Health spending as a proportion of federal government expenditures shrank from an average 3.5% in the early 1970s to less than 2% in the 1980s and 1990s (FMOH 1988). Nigeria was ranked a dismal 187th position among the 191

United Nation member state in the year 2000. In the same year the country spent 4 dollars per capital on health compared to the 14 dollars which was the global minimum recommendation by World Health Organization for developing countries. (WHO 2000). Nigeria's total health expenditure in 2002 is 4.7% (WDR 2005). This is very low, raising questions about the revenue allocation formular of Nigeria.

Cost Recovery

Another challenge of Nigeria healthcare system is the gradual abortion of free medical services through the introduction of cost recovery mechanisms in all health institutions and at all level of health delivery, (Ogunbekun 1999). The resource generation for the health sector is inadequate due to various reasons varying from increasing poverty in the country, poor allocation of resources by government and out of pocket

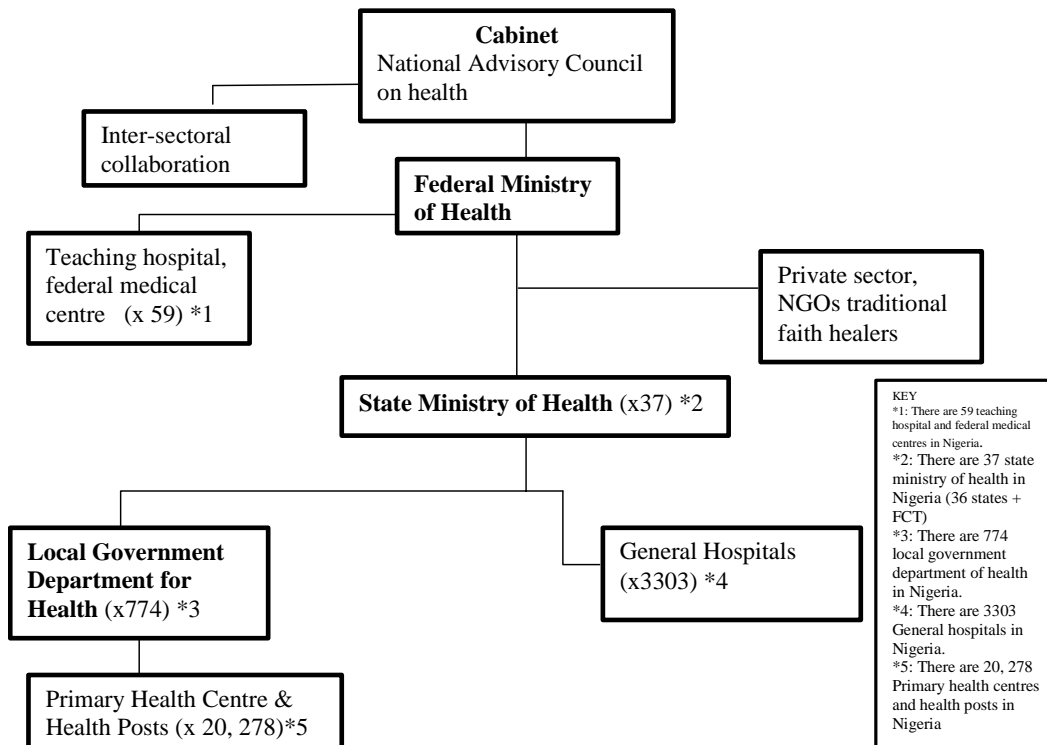


Fig. 1. Structure of Nigerian health system
 Source: FMOH (2004).

Table 1: Minimum fees for selected medical and dental services

	1992		1995		% increasing		Private as % of public (1995)
	Public	Private	Public	Private	Public	Private	
Registration	30	50	100	250	233	400	250
Outpatient consultation	30	50	50	200	67	300	400
Immunization	0	450	0	1350	0	200	1350
Antenatal care	1500	1000	5000	4500	233	350	90
Normal delivery	1000	1500	2000	4000	100	167	200
Room per day (open ward)	-	150	100	500		233	500
Simple tooth extraction	70	400	150	950	114	138	633
Simple amalgam filling	50	400	100	950	100	2233	233
Minor surgery	100	150	1500	3500	1400	2233	233
Major surgery	2000	2750	10000	20500	400	645	205

Source: Ministry of Health (1995)

services by healthcare providers. These make it difficult for the populace to pay for their health needs, leading to poor mobilization of funds from the private sector. The table 1 shows charges for healthcare services in the state hospital.

Quality of Care

Health facilities are inadequate in Nigeria (Yohesor, 2004). This includes health centres, personnel and medical equipment. This inadequacy is worse in rural areas. In Nigeria, there is an average of one doctor to 30,000 people and 2 hospital beds to 1,000 people. 70% of health services are provided by private and 30% by public means (FMOH, 2004). The state of existing facilities is often poor due to lack of maintenance.

According to NAFDAC (2003) over 70% of drugs dispensed in Nigeria are substandard, leading to high morbidity and mortality and low health outcome, which bear a drastic consequence on the efficiency and quality of care. This resulted from poor system of purchasing and dispensing of drugs in the health system.

Urban - Rural Poverty

Poverty remains very pronounced in Nigeria, worse in the rural areas due to lack of employment and poor development of human capital. This makes it difficult for the populace to pay for their health needs. Payment for health services is based on consumption and not ability to pay. This led to poor utilization and accessibility of healthcare services particularly in the rural areas of the country.

The brief review of the Nigerian healthcare system above revealed a number of weaknesses. First, the system is faced with financing difficulties

with a sharply reduced revenue growth and economic stagnation have brought to the fore the existing inefficiencies in the system just as dissatisfaction with quality of services is making an increase in contributions difficult. Second, the particular combination of the predominantly fee-for-services payment, a degree of competition in the market for services provision is likely to have resulted in the expansion of services volumes well beyond what might be necessary on clinical ground.

Reforms in Nigeria Health Care

Health care reform is the process of improving the performance of existing systems of assuming efficient and equitable responses to future changes. It has also been defined as sustainable, purposeful change aimed at improving the health sector (Berman 1995). Health sector reform as an inherently political process initiated by public or political action, motivated by dissatisfaction caused by the failure to deliver outcomes and implemented on a sector wide level. The underlying motivation is to address the problems of poor quality of care, inequalities and limited access to health, inefficiencies in the delivery of services, level of accountability and insufficient responsiveness to client needs.

As part of government effort to address the problems in the sector, the National Health Insurance Scheme (NHIS) was established. NHIS was first conceptualized in Nigeria in 1960 but was staled by legislation and political instability till 1984, when the National Council on Health (NCH) set up a committee to advice government on the need for its implementation. A positive response by this committee led to the setting up of NHI review committee in 1985 (FMOH 2001).

NHIS collected premium and purchased health services for formal sector employees (NHIS 2001). This represented less than 40% of the population, leaving out over 60% employed in the informal sector, especially over 52% in the rural areas. In effect, despite introduction of the NHIS, over 90% of health services in Nigeria remained paid for through direct user fee (Ichocku 2005).

The problem of exclusion of the informal sector led to the emergence of some Community Base Health Financing Schemes (CBHFs) from peoples' effort to create a safety net for their local communities. Some CBHF targeted members of local trade associations like taxi drivers' association, market women association for examples: *Lawanson Health Plan (LHP)* in Lagos (Initiative, 2004) and Ariaria traders' health scheme of Aba (Yohesor 2004). Others focused on members of a particular community, like the Country women association of Nigeria (COWAN) (Ogunbekun 2004); and the Ndo-nwanne health scheme of Enugu (Koeman 2003).

According to Anyaehie and Nwobodo, (2004); CBHFs are funded through premium which vary among schemes; from N1, 200 (\$14) per month for COWAN to N1, 000 Ndo – Nwanne health schemes. Different schemes also have some flexible premium collection mechanisms.

Problems Faced by CBHF

CBHF are faced with a number of problems which include:

- The small size of contributions is usually inadequate, due to high inflation rates, for financing the basic health needs of most low income families. Again, the size of the schemes is too small to enjoy economies of scale.
- In most CBHF, there is no mechanism in place for assessing the quality of care rendered by health care providers and efficiency may be compromised.
- Reimbursements in the absence of negotiated fee schedules may also be difficult to determine.
- Sustainability becomes one of the greatest challenges faced by the CBHF. Poor legal founding by the CBHF may lead to collapse in event of unforeseen mishap on key members of board of directors; or financial insolvency.

Re-packaging of the NHIS to Include the Informal Sector

At the 42nd meeting of NCH in 1997, approval was given for the 'repackaging' of the NHIS to ensure full private sector participation, by providing re-insurance coverage to the CBHF and Health Maintenance Organization (HMOs) to form Social Health Insurance (SHI) (NHIS 2001).

SHI was launched on 15th October, 1997, while the enabling law establishing the Scheme, Degree 35 of 1999 (Now act 35 of 1999) was signed in May 1999. Implementation was delayed till June 6th, 2005 (NHIS 2005).

'Repackaging' the NHIS to include the informal sector was a good idea, but chances that the weaknesses in the formal sector scheme could drag down community efforts at CBHF remain high.

Another doubt on the possibility of SHI to improve financing of the health sector in Nigeria may also arise based on problems of poor implementation.

DESCRIPTION OF NIGERIAN SHI

The Nigerian National Health Insurance (NHI) is a single or National health insurance scheme with different categories (formal, informal and the exemption) groups. It utilizes the services of Health Maintenance Organization (HMOs) as health managers, for collecting revenues and distributing health services.

Some CBHF have increased the scope of their operation to register as HMOs others have been mopped up by HMOs that operate in their community.

Contributions to the scheme are made by members as premium through the HMOs, according to their different categories. The HMOs also provide service to members through health care providers register to the scheme. Members are entitled to obtain health benefits from any health provider irrespective of location on provision of an adequate identification. All resources collected by the HMOs are pooled together to the NHIS, who regulates activities of the HMOs and disburses compensation to health providers through the HMOs.

The NHIS have offices in the 36 states of the federation. It also has Zonal offices in the six geo-political zones of the federation and a national

office in the FCT, Abuja. NHIS is managed by a Governing Council, which ensures the effective implementation of the policy and procedures of the Scheme. Member of the Governing Council are to be appointed by the president, on the recommendation of the Minister of health. The council is to be headed by a chairman and a secretary.

PROBLEMS ASSOCIATED WITH IMPLEMENTATION OF SOCIAL HEALTH INSURANCE (SHI) IN NIGERIA

Implementation of SHI in Nigeria may face the following problems:

- The large informal sector and the diversity in economic status make it difficult for SHI in Nigeria to determine premium equitably.
- Determination of groups to be included in the exemption schemes and how to implement the exemption packages without encouraging free –riders might be difficult without compromising access to health care.
- HMOs may be reluctant to operate in the rural areas where premium may be difficult but will prefer the urban areas where they will not only enjoy ease of premium collection but a boom in enrolment due to population density. This may hinder access to the rural areas.
- It may also be difficult to determine method of compensation of physicians according to their various classifications and disbursement of the compensation without giving rise to moral hazard and fraud.
- Difficulty in determining line of services to cover by the scheme will be a cause of constant threat.
- SHI implementation may have problems in setting up regulatory mechanisms and enforcing them to be able to check quality and reduce problems of moral hazards, adverse selection and free-rider effect.
- Sustainability may become a problem if revenue generation through premium is not adequate to pay for expenditure.
- Efficient allocation of resources to cover health needs of members may be difficult to attain.
- The organizational structure of the Nigerian SHI may make decision making too bureaucratic if measures are not taken to enhance representation to the local level.

CONSIDERATIONS FOR SUSTAINABLE HEALTHCARE REFORM

Having analyzed the challenges of Nigeria healthcare reforms the following points are crucial for sustainable healthcare in Nigeria.

Access to Care

Exemption packages should be re-designed to include the poor and vulnerable groups. This should include the unemployed, the elderly, disabled persons and for all obstetric care. The exemption package should also include providing the exemption groups with means of transportation to health facilities. Government should also increase health infrastructure in rural areas and incentives created for all health professionals practicing in the rural.

Premium and Financing

A flexible premium collection mechanism should be introduced for the informal sector schemes, such as collecting premium from farmers during harvest. There should be co-payment system for specialist care and cosmetic surgery.

An efficient financing system should be put in place which is able to invest resources in long term capital goals so that services could become self funded in future.

Provide Arrangement

Capitation method should be used to compensate Physicians. This should be combined by a pre-determined billing system. While preserving solidarity, competition should be encouraged among HMOs, by introducing open enrolment to any HMO and encouraging more than one HMO to operate in the same locality, and patients should have choice of provider.

Population based disease management program for chronic disease and high risk program for sicknesses with complications and comorbidity should be established and funded separately from the funds by government through tax, donation and foreign aid; to reduce excess burden on the scheme.

Adequate referral system should be enforced by making sure that visit to specialist care must be on referral from the General practitioners, except on emergency.

Strengthening Quality Care Services

Accreditation should be introduced and strictly adhered to before registered care givers and providers. Certification of health care personnel employed by contracted providers should be regularly conducted with appropriate registration board; example Nigerian Medical Council for doctors.

Activities of related regulating bodies like National Agency for Food and Drug Administration and Control (NAFDAC) and Standard organization of Nigeria (SON) should be enhanced by the government, to ensure that fake and sub-standard products are not used in health facilities.

Regulating Abuse

Identity cards should be carried by patients to health facilities, and there should be proper identification of patients with photo, address and category of insurance.

CONCLUSION

The major challenges of Nigeria healthcare system in the past has been largely the unplanned consequences of social policy. There have thus been little efforts of Nigerian government to improve and control health sector in terms of distributions of healthcare providers, quality of health services by various categories of providers and the cost of care. The promotion of health sector reform is highly welcome as a means to revitalize the nation healthcare system. A shift towards health insurance though necessary and welcome the care for the rural poor which constitute the majority of the population should be taken seriously. ICT technology would strengthen the reforms mechanisms for quality improvement and cost saving. Once these mechanisms are in place there would be better health care reform in Nigeria.

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