

## Repositioning Health Insurance in Nigeria: Prospects and Challenges

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### Abstract

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The quest to provide efficient and effective health care delivery system has always prompted the Nigerian government to review its health policies. One of such policies is the establishment of a health insurance scheme- a framework for the provision of affordable and efficient health care system- in the country. This was in the wake of an abysmal performance in the health sector manifesting in severe shortage of qualified personnel, drugs and other health infrastructures as a result of a dwindling economy. It became apparent that government alone could no longer fund the health system, hence a recourse to alternative funding mechanisms, leading to the emergence of a health insurance scheme in the country. The scheme was designed to solve some of the lingering challenges bedevilling the health sector especially the issue of inadequate funding which had limited access to quality health care services. This paper examines the health insurance scheme in Nigeria and recommends its further reform with a view to meeting its set objectives of providing qualitative and accessible health care delivery system.

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**Keywords:** Health, Insurance, Funding, Challenges, Nigeria.

### 1. Introduction

At independence in 1960, Nigeria, like most other developing countries adopted various measures aimed at fulfilling high standards of living for her citizens. Many development plans were formulated and implemented up till the early 1980s.

However, the desired objectives of these measures were not realised optimally due to the instability in the national polity.

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The intermittent incursions of the military into governance ensured the perversion of the people's desire to live a good life. The period thus witnessed economic mismanagement and authoritarian governance (Ajakaiye, Taiwo and Chete, 2002). The mismanagement meant abject poverty and low economic status of the citizenry leading to the emasculation of the majority of the people and thus widening the gap between the rich and the poor. Under the Human Development Index (HDI) of the United Nations Development Programme (UNDP), Nigeria has consistently ranked as one of the least in the measurement of quality of life of the people. By the early 1990s, according to Agbakoba (1996), virtually all the social infrastructures had deteriorated. One area of the economy that suffered greatly is the health sector.

The World Bank (1999) reports that in the early 1990s the per capita health spending of Nigeria was not only low but was of low quality. Health expenditure of US\$9 per person by Nigeria was much lower than in some other African countries such as Ghana (US\$14) and Kenya (US\$16). The net effect of this was that in 1990, infant mortality was 11.4 per cent in Nigeria compared to 7.4 per cent in Ghana and 5.7 per cent in Kenya. Thousands of Nigerian children were malnourished, and in the absence of adequate immunisation, were prey to the killer diseases, that is, measles, polio, whooping cough and diphtheria (Ehusani, 1996). The pitiable picture of Nigeria's health sector was revealed by the World Health Organisation which noted that the country's overall health system performance in year 2000 was ranked 187<sup>th</sup> among the 191 member state of the organisation (WHO, 2001). The consequence of this was high infant under-five and maternal mortality and the prevalence of diseases, many of which were of epidemic proportions. Malnutrition, iodine deficiency, stunting and low birth weight prevailed. Life expectancy fell to 48 years and the dream of health-for-all by the year 2000 became a mirage.

The situation in the sector was so critical that to Dr Agan, the Chief Medical Director, University of Calabar Teaching Hospital, Calabar, who noted that health care delivery in Nigeria was dead (Vanguard, May, 17, 2012). Nigeria parades one of the lowest health practitioner-to-patient ratio in Sub-Saharan Africa: 0.3 Physicians per 1000 persons, 1.7 hospital beds per 1000 persons, 1.7 Nurses, 0.02 Dentists, 0.05 Pharmacists, 0.91 Community Health Workers and 1.7 Midwives, per 1000 persons respectively (WHO,2006; Ogbolu 2007).

Interestingly, many of these skilled personnel have migrated to Europe, America and the Middle-East to practice and thereby constituting a brain drain costing much money and also a supply gap in the country (Kelland, 2012).

The state of Nigeria health services as currently organised, especially, show major defects which include, (Akindutire, 2008):

- a. Inadequate coverage: Many Nigerians still have no access to modern health care services. Rural communities and the urban poor are also not well served;
- b. The orientation of the services is inappropriate with the disproportionately high investment on curative services to the detriment of preventive services;
- c. The management of the services often shows major weakness resulting in waste and inefficient targets and goals;
- d. The lack of basic statistics is a major constraint at all stages of planning, monitoring and evaluation of health services;
- e. The financial resources allocated to the health services, especially to some priority areas, are inadequate to permit them to function effectively; and
- f. The basic infrastructure and logistic supports are often defective owing to inadequate maintenance of buildings, medical equipment and vehicles, unreliable supply of water and electricity, and the poor management of drugs, vaccines and supplies system.

Government has responded to the infrastructural decay in all sectors of the economy by adopting a reform agenda embedded in the New Economic Empowerment and Development Strategy (NEEDS), (National Planning Commission, 2004). The health sector reform is part of the development strategy aimed at improving the standard of health care for all Nigerians. A veritable part of the health sector is the health insurance scheme which, as a health financing mechanism protects people against high cost of health care through a pre-payment method. It is against this backdrop that this paper appraises the health insurance scheme instituted by the Nigerian government in line with its policy objectives.

## **1. The Concept of Health Insurance**

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. It is designed to pay the costs associated with health care by paying the bills and therefore to protect people 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.

It 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 (Nigerian Tribune, 24, May, 2010). It involves 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. It 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. This means that payment is not proportional to the risk of illness of individual beneficiaries.

Many advantages accrue from participation in social health insurance. According to Nielson (2009), they include:

- broadening the sources of health care financing;
- reducing the dependence and pressure on government budget;
- increasing the financial resources and ensuring stable source of revenue for healthcare;
- ensuring visible flow of funds to the sector;
- assisting in establishing patients' rights as customers;
- combines risk pooling with actual support by allocating services according to need and distributing financial burden according to ability to pay;
- solves equity and affordability problem in providing and financing health services; and,
- improves and harnesses private sector participation in the provision of health services.

Social health insurance schemes also enable experts to reasonably predict the healthcare cost of a large group. By lowering the personal costs of services, health insurance schemes induce individuals to seek health maintenance services more regularly than they otherwise would thereby preventing potentially serious illness.

## **2. Evolution of Health Insurance Scheme in Nigeria**

The scheme is government's response to the decay in the health care system in Nigeria. This manifests in government's acknowledgement of the poor state of the health care delivery system (FGN, 2000). According to Dogo-Muhammed (2007), all these have a combined effect on the health care delivery system leading to the inability to "deliver the optimum package of quality health care, including routine immunisation, emergency care, preventive and management of communicable and infectious diseases, especially malaria, tuberculosis and HIV/AIDS" .

This ultimately led to expression of dissatisfaction in the quality of health care services by the public. The poor state of the health sector prompted the Federal government to initiate an all-embracing reform policy presented as “a broad-based purposeful and sustainable fundamental change in the function, structure and performance of health system in order to deliver efficient, qualitative, affordable, effective and equitable health care services to the populace and ultimately improve the health status of the people” (FMOH, 2005). The main thrust of the health policy therefore, is to provide a fundamental shift of government’s perception of health, mode of delivering the services and the roles and responsibilities of each tier of government in providing better health care for Nigerians.

The health insurance scheme, as a health financing mechanism is located within the context of the health reform. The National Health Insurance Scheme (NHIS) was established under the National Assembly Act No. 35, 1999, by the Federal Government of Nigeria to improve the health status of Nigerians at an affordable cost. It must be noted that the idea of health insurance in Nigeria was first mooted in 1962 when the then Minister of Health, Dr Majekodunmi, presented a bill on it to the Parliament in Lagos. The bill did not pass through on the argument that the country did not have enough providers of quality health care services (Ana, 2010). However in 1988, the then Minister of Health, Professor Olikoye Ransome-Kuti set up a committee on the establishment of a health insurance scheme, the outcome of which was eventually approved by the Federal Executive Council in 1989 which directed the Federal Ministry of Health to start the scheme in 1993 (Adesina, 2009).

In establishing the scheme, government adduced the following reasons:

- The state of the nation’s health care services was generally poor;
- There was excessive dependence on government-provided health facilities;
- There was too much pressure on government-owned health care facilities;
- There was dwindling funding of health care in the face of rising costs;
- There was poor integration of private health facilities in the nation’s health care delivery system (NHIS, 2011).

Consequently, the following objectives were set for the scheme to achieve:

- To ensure that every Nigerian has access to good health care services;
- To protect families from the financial hardship of huge medical bills;
- To limit the rise in the cost of health care services;
- To ensure equitable distribution of health care costs among different income groups;
- To ensure high standards of health care services delivery to Nigerians;
- To ensure efficiency in health care services;
- To improve and harness private sector participation in the provision of health care services;
- To ensure appropriate patronage of all levels of health care; and
- To ensure the availability of funds to the health sector for improved services (NHIS, 2011).

The scheme has fully and effectively taken off, starting with the formal sector of the economy which is a social health security system in which the health care of workers in the formal sector of the economy is paid for from funds crated by pooling the contributions of both the employees and employers. As defined by the enabling law, the formal sector comprises:

- a. Public Sector;
- b. Organised private sector;
- c. Armed Forces, Police and Allied Services;
- d. Students of Tertiary Institutions; and
- e. Voluntary contributions.

### **3. Operational Framework of NHIS**

#### **3.1 Membership/Registration**

It is mandatory for organisations in both the public and private sectors employing up to ten (10) people to participate in the scheme. An employer is expected to register itself and its employees with the scheme. Thereafter the employer will affiliate itself with an NHIS approved Healthcare Maintenance Organisation (HMO), which is a limited liability company established for the sole purpose of participating in the scheme. The HMOs function thus:

- Receive/collect contributions from eligible employers and employees;
- Collect contributions from voluntary contributors;
- Pay health care providers for services rendered; and
- Maintain quality assurance in the programme.

### 3.2. Contributions and Scope of Coverage

Contributions are earnings-related. The employer pays 10 per cent while the employee pays 5 per cent, representing 15 per cent of the employee's basic salary. However, the employer may decide to pay the entire contribution. Furthermore, an employer, in accordance with existing contractual agreement between employers and employees, may undertake extra contributions for additional cover to the benefit package. The contributions paid cover health care benefits for the employee, a spouse and four biological children below the age of 18 years. More dependants or a child above the age of 18 years would be covered on the payment of additional contributions from the principal beneficiary. Under this programme, a beneficiary is entitled to out-patient care, pharmaceutical care, diagnosis tests, maternity care for up to four (4) live births, preventive care, among several others. According to the records of the NHIS, over 6 million Nigerians in the public sector are currently accessing the programme. They are mostly workers in the Federal public service and those of two states –Bauchi and Cross River (Nigerian Tribune, 6, September, 2010, P.17; The Guardian, 5, September, 2012. P.28).

### 4.3 Rights of Enrolees

All participants in the scheme enjoy certain rights which are as follows:

- Right to register and access medical care listed in the benefit package;
- Right to change provider after six months of the receipt of an identity card, if not satisfied;
- Right to access care in any NHIS accredited provider in the country on emergency;
- Right to know the names of the drugs given to the beneficiary;
- Right to request and know the total cost of drugs (10 per cent);
- Access to genuine and efficacious drugs;

- Right to identify the speciality of treating personnel, and
- Right to complain about poor services from health care providers.

#### 4. Prospects and Challenges of Health Insurance

Nigerians desire and deserve easy access to qualitative health care. However this desire has not been met by the Nigerian government. Consequently, the health situation of the people of this country has remained unstable due to the onslaught of infectious diseases and poverty. According to Stephensen (1997), the mortality rate is very high with the majority of deaths arising from infectious diseases and complications of pregnancy and child-birth. Nigeria's health care system has been described as below average and plagued with huge challenges in spite of increasing public health expenditures. Yet government's per capita expenditure on health is less than US\$5 –far below the US\$34 per capita recommended by the World Health Organisation (WHO), for developing countries (African Peer Review Commission (APRM) 2008).

It is in response to this low level availability and accessibility to quality health care services by Nigerians that series of reform policies were recently initiated and implemented in the health sector. One of such reforms is the introduction of the health insurance scheme to enhance access to health care. According to its guiding principles, the scheme is to provide access to health care to all citizens irrespective of socio-economic class, age, status and other considerations. The scheme is expected to be funded through monthly contributions from employers and employees from both private and public sectors.

There is no doubt that the health insurance scheme in Nigeria since its inception, has to a large extent positively affected the lives of its enrolees. According to Dr Dogo-Mohammed, the Chief Executive Secretary of the agency, some of the achievements of the programme are:

- a. It has reduced the rising cost of health care among the participants;
- b. It has led to the fair distribution of contributions for health;
- c. It has ensured that socio-economic groupings do not constitute a barrier to somebody to access health care where he wants; and
- d. It has restored confidence in primary and secondary levels of health care.

Many participants in the scheme have equally corroborated the above stated achievements. For example, Mr Bolanta, the then Commissioner of Police for Oyo State has acknowledged the good performance of the scheme. He notes that “the hassle experienced by policemen in the command in accessing qualitative medical care had largely been removed with the introduction of the scheme”. He further added that his officers and their dependants now had unfettered access to medical services without worrying about the bills (Nigerian Tribune, 3, December, 2010). It is therefore appropriate to state that the scheme has the potentials to transform health care delivery in the country. However the scheme is beset with a lot of challenges which constitute obstacles to the attainment of its laudable objectives. Most of the challenges of the scheme are located within the wider health sector of the economy. APRM (2008) identifies the challenges in the health sector to include:

- ❖ Poor implementation of programmes,
- ❖ Poor health facilities and lack of infrastructures such as good road network, water and electricity supply,
- ❖ Rural / Urban and class differential in access to quality health care, the poor and rural population are less likely to access quality health care than the rich and urban dwellers, and
- ❖ Traditional and religious belief precluding many Nigerians from taking advantage of health service delivery. Apart from the above stated challenges facing the health sector in general, the NHIS specifically has the following as challenges/obstacles to its activities;
- ❖ 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 and those of only two out of thirty-six (36) states at present,
- ❖ 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. According to him, they cite examples of previous schemes that failed and which made workers to lose their investments. Such schemes are the National Providence Fund (NPF) and the National Housing Scheme. Efforts by the Governor Oni's administration in Ekiti State, for instance, to ensure the enrollment of public servants in the State into the scheme was rebuffed by the labour unions who insisted that government should be responsible for the full payment,
- ❖ 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.

## 5. Conclusion and Recommendations

The key challenge for Nigeria's Health Sector is to achieve the targets of the Millennium Development Goals (MDGs) and they include:

- Reducing maternal mortality by three-quarters by 2015;
- Halting by 2015 and reversing the incidence of malaria and other major diseases;
- Reducing the under-five mortality rate by two-thirds by 2015; and
- Halting by 2015 and reversing the spread of HIV/AIDS. (NPC,2004).

It is obvious that Nigeria's health care system is very much challenged and constrained in providing quality health care to all her citizens, most especially the unemployed and the poor. Contrary to its stated objectives, the NHIS coverage is still very limited and exclusive, as only the health needs (partial) of Nigerians in the formal sector are covered at present. Thus the vast majority of Nigerians who are either unemployed or earn their living in the informal sector are not included.

The objective of government in providing for the health care needs of the people is lauded. Yet its attainment is contingent upon the resolution of the challenges as listed above. The resolution of the challenges is located in the establishment and operations of the health insurance scheme which was inaugurated in 2005. The objectives of the scheme are also commendable and achievable. However it is also challenged in many fronts, with the possibility of diminishing its successful implementation. To address these challenges it is imperative that the following steps are taken:

- ❖ Intensify public awareness. More intensive public intensive awareness programmes should be created to enlighten the people and relevant groups on the positive values of the scheme. The attributes of the scheme should be well publicised by translating it into the major Nigerian languages to enable the people to understand and appreciate its values and objectives.
- ❖ Diversify source of funding. It should be noted that pay-roll contributions by employers and employees are not the only way possible to fund the provision of health for the people. People's health care can also be insured through special tax contributions. For example, a health trust can be created to bridge subsidy gaps. Such a fund can be derived from incomes that accrue from petroleum products and customs duties, etc. This will remove the problem of funding on the part of government and affordability by would-be participants, which for now deny majority of the populace universal access to health care. However until this is attained, governments should increase its funding of the scheme in order to provide qualitative health services to the poor and fast-track the attainment of universal health in the country.
- ❖ Increased coverage. The scheme should be expanded to ensure that basic health needs of all citizens, irrespective of their social class and status are met. There is therefore the need for a legislation to make the scheme compulsory for all Nigerians. In furtherance of this, a community health insurance scheme should be put in place for implementation by all the three tiers of government- Federal, State and Local governments, as well as Non-governmental organizations (NGOs) and Community-based organizations (CBOs).

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