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NATIONAL HEALTH INSURANCE SCHEME (NHIS) IMPLEMENTATION IN NIGERIA:

Issues, Challenges and Way Forward

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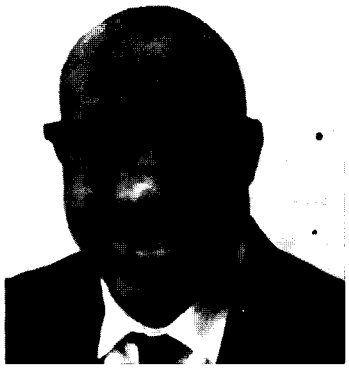

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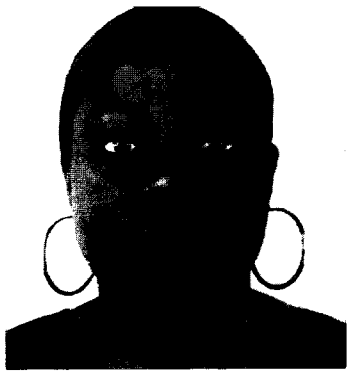


Halima U. Nagado (Mrs.)

Abstract

The paper discussed the National Health Insurance Scheme (NHIS) adopted by Nigeria for improved access to healthcare, especially to the low income earners. The objective of the study is to review developments In the implementation of the Nigerian NHIS and determine whether its achieving its objectives. Specifically, the study focused on key issues and challenges confronting the NHIS, with a bid to proffer appropriate recommendations towards sustainability, effectiveness and efficiency. The study adopted a descriptive qualitative analysis methodology and found limited coverage, religious and cultural limitations, in-extensive prescriptions, conflict of interests (NHIS and HMOs), low participants' coverage, issues of mistrust, total government financing limitation as well as low budget allocation compared to need, as major issues confronting the achievement of quality healthcare delivery from the Scheme. It proffered some recommendations which include: more private sector participation, governance right to HMOs on the Board of NHIS, creation of National Health Insurance Fund and commencement of contribution from participants.

JEL: I13
Key words: National Health Insurance Scheme (NHIS); Health care providers (HCPs); Health Maintenance Organizations (HMOs)

1.0 Introduction

Healthy citizenry is crucial to growth and development of any economy. As the age-long adage goes, "health is wealth," so it is that a country's health and wealth are inextricably linked. This assertion is underscored in the various growth theories that prominently feature labour as a key input of production. For instance, the Endogenous Growth Model emphasizes that an enhancement of a nation's human capital contribute significantly to its economic growth. Human capital concept recognizes that not only does the quality of labour matters, improvement of labour through education, training and health investments are equally important. The New Growth Theory also avers that people have control over their knowledge capital and argues that real gross domestic product (real GDP) per person will perpetually increase because of people's pursuit of profit. To the New Growth Theorists, innovations or technologies don't occur simply by random chance, but depends on a number of people seeking out these innovations and how hard they look for

[1] The enabling Decree 39 was promulgated in May 10, 1999 at the twilight of the Military Regime under General .A.A.Abubakar.

high. The weakened Public Health Care (PHC) system with low coverage of key interventions has resulted in the persistence of high disease burden. According to a national Health Policy Report, "life expectancy at birth has dropped over years from 53.8 years (females) and 52.6 (males) in 1991 to 48.2(females) and 46.8 (males) in 2000 and 41.3 in males and 41.8 in females by 2003 for reasons which include deterioration in both structure and organization of the healthcare system, lack of skilled personnel especially in the primary health care centers, lack of financial and geographic accessibility for the majority of the populace to the limited healthcare facilities.

The efforts to improve healthcare services and reduce health cost in Nigeria led to the establishment of the National Health Insurance Scheme (NHIS), which was formally launched in 2005, in a bid to improve accessibility. The establishment of NHIS as a group insurance plan provides an enhanced opportunity for inclusive growth, given that not Nigerians all have access to quality healthcare services. The scheme promises to play a prominent role in allowing all citizens to be included in the opportunity set for improving access and affordability to healthcare services, hence contributing to growth.

The objective of this study is to review the developments about the NHIS in Nigeria in order to gain insight into the implementation of the scheme and determine whether it is achieving its goal. Specifically, the study focuses on the key issues and challenges confronting the scheme, with a bid to proffer appropriate recommendations towards its sustainability, effectiveness and efficiency. The rest of the paper is structured as follows. Following this introduction, section two presents a theoretical and empirical review on health services provision and insurance. Section 3 presents some stylized facts on health sector in Nigeria, while section 4 discusses the overview of NHIS.. Section 5 highlights challenges and issues confronting the NHIS and also offers some policy recommendations.

2.0 Literature Review

2.1 Theoretical Review

The demand for health care is premised on several theories. The conventional theory, pioneered by Mark **Pauly, among others,** postulates that demand for health insurance is primarily driven by the desire to avoid risk, claiming that people purchase insurance because they prefer the certainty of paying a small premium to the risk of getting sick and paying a large medical bill. One advantage of health insurance obligation is that it allows the transfer of income from the pool of insurers who do not fall sick to finance the medical care of those who become ill.

Schoemaker (1982)'s expected utility theory of health insurance is one of the foremost decision-making theories that reflects on aversion and demand for income certainty. Due to uncertainty about the unknown future health, insurance choice is not made based on utility alone but on consumers' expectation about factors such as their health status. Schoemaker is however silent on the association between household socio-economic status and insurance enrolment. Theories on decision-making under uncertainty are often used to describe insurance enrolment (Cameron et al (1988)). Under the assumption that insurance is a normal good, with positive income elasticity of demand, the higher the income, the higher the tendency to key into a health insurance scheme.

Manning and Marquis (1989) avers that the choice of an economically optimal health insurance package involves a trade-off between the gains from reducing families' financial risks and the losses from inappropriate incentives for the purchase of more health care. They argued that, other things being equal, individuals are generally willing to pay more than an actuarially fair amount to reduce the risk of a

large financial loss caused by the possible future occurrence of illness and the resultant medical care expense. To Manning and Marquis, health insurance however affects the allocation of health care resources; the cost sharing decreases the out-of-pocket price paid by the patient and increases the amount of medical care demanded. This however underscores higher risk of moral hazard, given that consumers would not purchase this additional care if they had to pay its full cost, the extra services' value to consumers fall short of the social cost of producing that care.

John Nyman (2000) further posited that consumers demand for health insurance to obtain extra income when they become ill; in effect, insurance companies act to transfer income from those who are healthy to those who are ill. This additional income generates purchases of additional high-value care, often allowing sick persons to obtain lifesaving care that they could not otherwise afford. By implication, the theory suggests that health insurance is substantially more valuable to consumers and consumers prefer the risk of a large loss to incurring a smaller loss with certainty. Nyman posited that the central rationale for buying insurance is the individual's desire to obtain an income transfer from the risk pool when ill. One possibility is that the consumer seeks to smooth out consumption (or wealth) across time by sacrificing a little when healthy to be compensated in the event of injury or illness.

The nature of healthcare systems and how they are financed determine whether people can obtain needed healthcare and whether they suffer financial hardship at the instance of obtaining care (Carrins, Evans and Xu (2007). Likewise, Rao et al (2005) reiterated that the pattern of health financing is closely and indivisibly linked to the provisioning of services and help define the outer boundaries of the system's capabilities to achieve the overall goal of enhancing nation's economic development. Poverty literatures also show that socio-economic characteristics of economic agents can reveal the choice of whether or not to demand health insurance. Poor households are expected to become increasingly risk averse if they move closer to, or further below the poverty line (Wagstaff, 2000).

Nevertheless, due to uncertainty about the unknown future health, insurance choice is not made based on utility alone but on consumers' expectation about factors such as their health status. Thus, theories on decision-making under uncertainty are often used to describe insurance enrolment. On the contrary, poor households, who are more likely to have credit constraints in the future, may be more willing to sacrifice current income and insure in order to face less risk in the future (Morduch 1995).

Conversely, Wagstaff et al (2003) postulates that low income consumers could purchase health insurance. This is premised on the confidence that it can help reduce asset sales and additional debt, while increasing the quality and quantity of available healthcare costs when the need arises. The assumption here is that, typically, rise in medical expenses as a result of health issues leads to a decline in the contribution to household income and home production such as feeding and childcare.

Budget allocations to social services, including health were reduced by various African countries during the OPEC oil crisis of the 1970s. Economic circumstances in the 1980s led to even bigger problems, thereby forcing various African countries to seek for loans and grants from such financial institutions as the International Monetary Fund (IMF) and the World Bank. As a major funding conditionality, these governments were required to switch from their socialist-based development policies toward open-market reforms under the Structural Adjustment Programs (Mensah, 2006). Removal of government subsidies and

imposition of user-fees for social services such as education and health care became common requirements by the early 1990s (Mensah, 2008a). Out-of-pocket payment for health care services, which used to be the exception in the early post-independence years in Africa, became the rule (Mwabu, 2008; Vandemoortele et al., 1997).

2.2 Empirical Review

For convenience, the empirical review commences with Hanratty (2005) that compared the health outcomes for those that adopted the universal health insurance in 1962 against those that adopted same later in 1972 across Canadian Provinces. Findings indicated that there was a significant reduction in infant mortality rate of 4 per cent and a smaller reduction of 1.3 per cent in low birth weight in the former group. This outcome was attributed due to the government health insurance program.

In a study by Lichtenberg (2002), the effect of Medicare was examined by comparing the health and health care outcomes of people just below the age of 65, many of whom lack health insurance, to those of people just over 65, all of whom are covered by Medicare. More care and better health outcomes were attributed by both studies to the group with more insurance. Similarly, Finkelstein (2004) found that areas where Medicare caused the largest increase in health insurance coverage experienced faster increase in health care utilization.

With respect to the relationship between insurance status and health expenditures, mixed results are obtainable. (Oppong, 2001) found that out of pocket health financing yielded detrimental results; health indicators plummeted as health care became less accessible. A negative relationship between insurance coverage and health expenditures is also found in some studies (Jutting (2004) in Senegal; Jowett, et al (2004) in Vietnam; and Yip and Berman (2001) in Egypt). Yet other studies found that out-of-pocket spending remains the same or is even higher in the case of the insured when compared to the uninsured. Wagstaff et al (2007) explained this fact as a result of the institutional structure of health care in China, being that it favors increased utilization and substitution toward more expensive services and treatments.

Phillip et al (2012) examined the behavior of providers under the NHIS in Ghana by assessing the views of providers, insurance managers, insured and uninsured clients. The perceived opportunistic behavior of the insured by providers was responsible for the difference in the behavior of providers favoring the uninsured. Besides, the delay in reimbursement also accounted for providers' negative attitude towards the insured. The scheme was seen to be beneficial and led to an increase in the utilization of health care services for the insured and mobilized health resources for facilities. Survey findings indicated that insured and uninsured were satisfied with the provided care. However, most insured clients reported verbal abuse, long waiting times, not being physically examined and discrimination in favor of the uninsured and the cash customers. Providers also think that the insured were abusing their services by frequenting the facilities, and sometimes faking illness to collect drugs for their uninsured relatives. This had affected significantly the behavior of providers towards the insured.

Particularly underscored in Philip (2012) was the challenge relating to the delay in reimbursement. Managers and providers agreed that the National Health Insurance Authority (NHIA) had not reimbursed providers for almost six months. As a result, providers were not able to purchase drugs and non-drug supplies and hence were prescribing drugs for the insured especially, to purchase outside the facilities. The delay also affected providers' ability

to pay their casual employees who were not on government's payroll. This also influenced the behavior of providers where some of them preferred clients who would make instant payments for care

The contribution of National Health Insurance Scheme to healthcare delivery and the challenges against its sustainability in Ghana was assessed by Agyemang, et al (2013). Findings showed that the scheme has improved accessibility of health services to general public, especially the poor. The study however noted some of the challenges confronting the scheme to include delay in reimbursement, corruption, low level of awareness, weak institutional capacity and inadequate human resources.

Among the few studies on health insurance scheme in Nigeria is Sanusi and Awe (2009) that assesses the perception of the scheme and the prospect of its sustainability within the context of the socioeconomic characteristics of health service consumers and providers in Oyo State. While, several issues could be raised with respect to the methodology employed, such as the very small sample size and the bias tendency in the socioeconomic characteristic surveyed, findings could still be appreciated in terms of perception signal—majority of respondent wanted the programme discontinued because of the feelings of being cheated, especially by the subscribers with no dependents and those who believed that available drugs are insufficient. Also, some respondents were of the opinion that there was not much difference in healthcare service delivery, before and after the adoption of the scheme. The study recommended the need to intensify awareness campaign and expand coverage to reduce the burden of dependency on the few contributors.

Employing multivariate analytical tool, Riman and Akpan (2012) also assessed the demand for health service within the context of service accessibility, affordability and equity in financing. They also reviewed the patterns of health expenditure in Cross River State, including financial contribution of the public and private sectors, as well as other stakeholders. High levels of infant mortality and morbidity rate was associated with high incidence of out-of-pocket payment and wide disparity and inequality in income distribution. The study further highlights the disparity in spatial distribution of health facilities, concentrated at the urban areas leading to poor service delivery.

Mohammed et al (2014) conducted an in-depth performance evaluation of health insurance in Nigeria using four Optimal Resource Use (ORU) domains—provider payment mechanism (capitation and fee-for-service methods), benefit package, administrative efficiency and active monitoring mechanism. Applying logistic regression analysis, their findings concluded that fee-for-service payment method and claims review in the provider payment and active monitoring mechanisms, respectively, performed weakly, according to the perception of the providers. And, on the supply-side of health insurance, a shortfall on the supply-side could lead to a direct or indirect adverse effect on the demand side of the scheme.

The review of literatures on the NHIS in Nigeria indicates that the developments, trend and assessment of the role, impact and sustainability of the scheme are only just evolving. To this extent it is pertinent to continue to explore its understanding, with a bid to unravel the inherent complex issues relating to the scheme. The next section presents a brief overview of national health policy in Nigeria as well as some stylized facts.

3.0 Overview of the National Health Policies in Nigeria and Some Stylized Facts

Over the years, several national health policies have been put in place for the provision and maintenance of efficient healthcare delivery system in

Nigeria. The first National Health Policy was adopted in 1988, with the goal to bring about a comprehensive health care delivery system driven by primary health care that is extensive, preventive, protective, restorative, rehabilitative and affordable through a functional referral system. The policy was geared towards achieving health for all by the year 2000 and defined the roles and responsibilities of the three tiers of government, as well as Non-Governmental Organizations (NGOs) participating in health care services. The policy document stipulated that a comprehensive health care system should include maternal and child health care, as well as family planning services.

In 2004, the National Health Policy was reviewed to focus on National Health System and Management, National Health Care Resources, National Health Intervention and Service Delivery, National Health Information Systems, Partnership for Health Development, Health Research and Healthcare Laws. The revised policy was to enhance the implementation of the health component of the National Economic Empowerment and Development Strategy (NEEDS), New Partnership for African Development (NEPAD) and Millennium Development Goal (MDGs).

In 2014, a national health bill was passed, that is, The 2014 National Health Act, which established a basic health care provision fund to be financed from Federal Government Annual Grant of not less than one per cent of its consolidated revenue fund, as well as grants from international donor partners and any other source. Out of the fund, 50 per cent shall be used for the provision of primary health and secondary health care through the NHIS primary and secondary health care facilities through the National Health Insurance Scheme (NHIS); 20 per cent shall be used to provide essential drugs, vaccines and consumables for eligible primary health care facilities; 15 per cent shall be used for the provision and maintenance of facilities, equipment and transport for eligible primary healthcare facilities; 10 per cent shall be used for the development of Human Resources for Primary Health Care Delivery; 5 per cent for Emergency Medical Treatment. The fund is to be administered by a committee appointed by the National Council on Health.

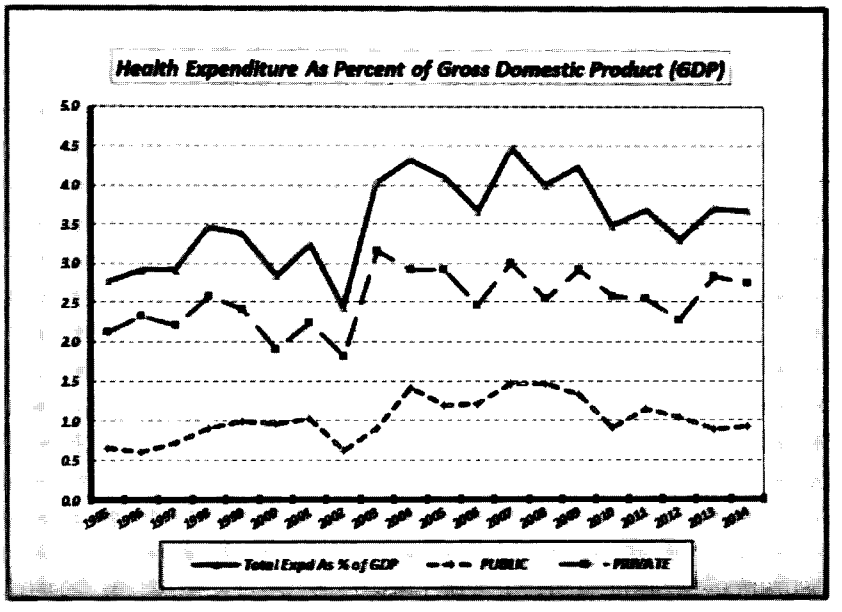
4.0 Stylized Facts

Figure 1 presents the total, private and public health expenditure as a percent of Gross Domestic Product (GDP) in Nigeria. As the figure illustrates, the total health expenditure as percentage of the GDP in Nigeria was 2.8 percent in 1995, and rose steadily to a local peak, at 3.5 percent in 1998, before exhibiting a downward trend until it reached the global trough in 2002. The following year in 2003, the total health expenditure increased substantially to 4.0 percent of GDP. Afterward, and through 2014, the highest value and global peak was 4.5 percent of the GDP in 2007, but with a downward trend that hovered around 3.5 percent of the GDP.

Private health expenditure as a percent of GDP was consistently higher and displayed more variations than public health expenditure as a percent of GDP. The lowest value for the private expenditure was 1.8 percent in 2002, while

highest value was in 2003. For the public expenditure, the lowest was 0.6 percent of the GDP in 1996, and while the highest was 1.5 percent in 2007 and 2008, respectively. Furthermore, except in 2000, when the private to public expenditure gap was 0.9 percent of the GDP widened the gap ranges from 1.1 to 2.2 percent of the GDP from 1995 to 2014. For the 20-year period under study, the private-public expenditure gap averaged 1.5 percent of the GDP.

Figure 1: Health Expenditure as a Percentage of GDP



Source: CBN Statistical Bulletin

Table 1 also presents how Nigeria ranks among other economies in 2014, with respect to Health sector spending patterns. As the table highlights, Nigeria ranks 162 among 187 countries, on the contribution of total health expenditure to the GDP at 3.7 percent. The ranking on the public health expenditure as percent of the GDP, at 0.9 percent, worsened to 182 out of 187. However, Nigeria recorded an improvement with respect to the private health expenditure as a percent of GDP, at 2.8 percent, attracting a ranking of 74 among 187 countries.

During the same period, at 25.1 percent, Nigeria ranked 173 out of 187, on public health expenditure as percent of total health expenditure. Similarly, it ranked 137 out of 187, on public health expenditure as percent of total government expenditure, at 8.2 percent. The narratives from this statistics demonstrate that, when compared to the rest of the world, less priority is placed on health sector in Nigeria.

TABLE 1: PUBLIC HEALTH EXPENDITURE RANKINGS	Percent	Ranking Among 187 Countries
Public Health Expenditure As Percent of GDP	0.9	182
Private Health Expenditure As Percent of GDP	2.8	74
Total Health Expenditure As Percent of GDP	3.7	162
Public Health Expenditure As Percent of Total Health Expenditure	25.1	173
Public Health Expenditure As Percent of Total Government Expenditure	8.2	137
Source:		

Further analysis of the public and private health expenditure in the period under study (1995 to 2014) revealed that the private expenditure component represents the greater share, at annual average of 71.5 percent. By the same token, public expenditure accounted for an average of 28.5 over the 20-year period. This implies that the public sector plays fewer roles in health care delivery (Figure 2). It is particularly interesting to

note that out-of-pocket spending as a proportion of the private health expenditure was consistently and substantially higher, averaging 95.0 percent over the period under study. Similarly, the proportion of out of pocket to the public health expenditure was 68.0 percent. This development reflects the people's response to the lack of, or inadequate health insurance and care services provision by the government. The implication is that people, either have no choice, or are willing to pay for the services on their own.

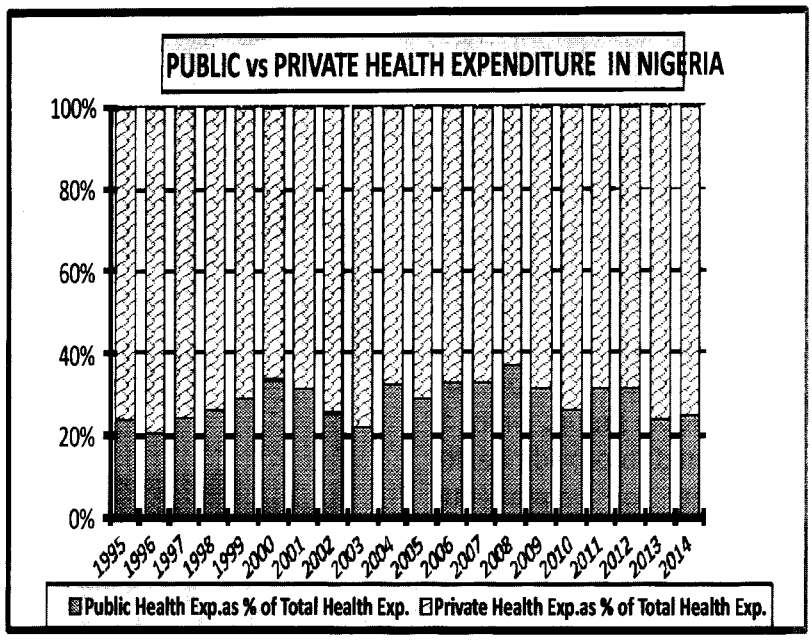


Figure 2: Public Vs Private Health Expenditure in Nigeria

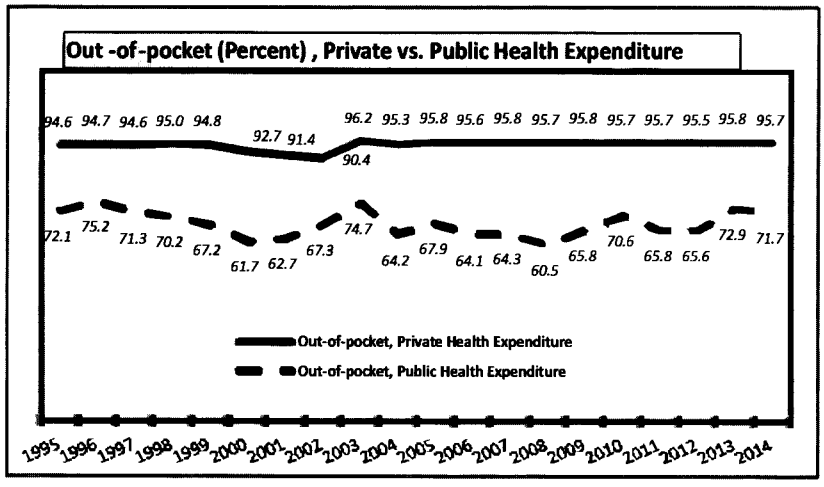


Figure 3: Out-of-Pocket, Private Vs Public Health Expenditure

4.1 National Health Insurance Scheme (NHIS) in Nigeria

The National Health Insurance Scheme (NHIS) was established under Decree Number 35 of 1999 Laws of the Federation of Nigeria. The objectives of the NHIS as articulated in the Decree are to:

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

The NHIS is structured into three sectors, comprising the formal, informal and vulnerable sectors. The formal sector has two categories, namely: the Formal Sector Social Health Insurance Programme (FSSHIP) and Voluntary Contributors Social Health Insurance Programme

(VCSHIP). The informal sector includes the Tertiary Institution Social Health Insurance Programme (TISHIP), Community Based Social Health Insurance Programme (CBSHIP) and Public Primary Pupil Social Health Insurance Programme (PPPSHIP). The third sector is for the vulnerable group, which is designed to provide health security for permanently disabled persons aged and children under five.

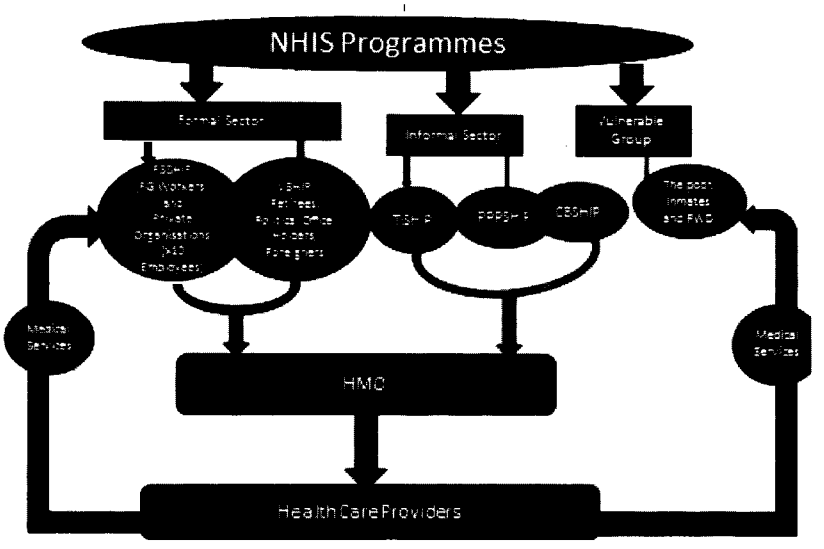


Figure 4: NHIS Programmes
Source: www.nhis.gov.ng/

4.2 FORMAL SECTOR

Under the Formal Sector Social Health Insurance Programme (FSSHIP), enrolment is mandatory and covers employees in the federal public service and organized private sectors with ten (10) or more employees Health care benefits includes: out-patient consultancy, prescribed drugs as contained in the NHIS essential drugs list, antenatal care, maternity care for up to four (4) live births for every insured person, post natal care, routine immunization as contained in the National Programme on Immunization (NPI), family planning consultations, mental disorders, eye examination and care excluding prescription glasses/spectacles and contact lenses, and dental care (limited to pain relief and treatment. Contributions are earnings-related and currently represent 15.0 per cent of basic salary. The employer pays 10 per cent and the employee, 5.0 per cent. Enrolment entitles the insured person, a spouse and four (4) children less than 18 years of age, to full health benefits. The contributions of two working spouses cover the spouses and four (4) children for each of them.

Enrollment under the Voluntary Contributor Social Health Insurance Programme VCSHIP is at the discretion of willing individuals or employers on behalf of employees in organizations with less than ten staff. This is a non-profit health insurance programme covering groups of individuals with common economic activities run by their members. Individuals who are members of socially cohesive groups, which are occupation-based, are free to join the Programme. The participants, based on their health needs, will choose the health care benefits. A prospective participant must be a member of an already existing Association. This Association, together with other associations, come together to form a user group. There must be a membership of at least 500 participants for each user group to ensure adequate pooling of resources. Contribution is at a flat monthly rate, depending on the health package chosen by members of the user group. Each contributor will be given an identity card with which he/she will obtain health care from the chosen health care provider (public or private).

4.3 INFORMAL HEALTH INSURANCE PROGRAMMES

The three programmes under the informal sector are Tertiary Institution Social Health Insurance Programme (TISHIP), Community Based Social Health Insurance Programme

(CBSHIP) and Public Primary Pupil Social Health Insurance Programme (PPPSHIP).

The TISHIP is designed for students in Tertiary Institutions, with the purpose to provide health insurance to Nigerian students who cannot benefit under other health insurance programmes. Through this mechanism, health care services are paid for from funds created by pooling of contribution of participating students and institutions. Membership is for students (full and part-time) of federal, state and private tertiary institutions. Institutions and students will contribute a determined rate at the point of payment of school fees. Participating institutions shall remit the contributions to the NHIS Fund at the beginning of each academic year. The NHIS will appoint a Health Maintenance Organization (HMO) registered and accredited by the Scheme for the purpose of health care management. The HMO shall be responsible for paying the provider for services rendered and shall also be responsible for maintaining quality assurance in the delivery of health care services under the programme. Students can be registered with accredited health centers of the Institutions, or any public or private accredited primary health care facilities of their choice

4.4 Community Based Social Health Insurance Programme (CBSHIP)

This is a non-profit health insurance programme for a cohesive group of households or individuals (i.e. a community) which is run by its members. Membership comprises individual and other members of the community, will choose the health care benefits. Prospective participant must be members of a community coming together to form a user group. There must be a membership of at least 500 participants for each to ensure adequate pooling of resources.

The contribution is in cash, paid as a flat monthly rate or at installments by participants and the contribution rate will depend on the health package chosen by members. A seven-member Board of Trustees, elected from among the members, i.e., Chairman, Secretary, Treasurer and four others, will manage the funds and run the user group formed. Each contributor will be given an identity card with which he/she will obtain health care from the chosen health care provider.

4.5 VUNERABLE SECTOR

There is also the Vulnerable Group Social Health Insurance Programme (VGSHIP), which is designed to provide health care services to the vulnerables, such as people with disability, senior citizens, children under five years of age, prison inmates, etc.

4.5.1 Voluntary Contributors Social Health Insurance Programme (VCSHIP)

This is a non-profit health insurance programme covering groups of individuals with common economic activities run by their members. Individuals who are members of socially cohesive groups, which are occupation-based, are free to join the Programme. The participants, based on their health needs, will choose the health care benefits. A prospective participant must be a member of an already existing Association. This Association, together with other associations, come together to form a user group. There must be a membership of at least 500 participants for each user group to ensure adequate pooling of resources.

Contribution is at a flat monthly rate. The contribution rate will depend on the health package chosen by members of the user group. Each contributor will be given an identity card with which he/she will obtain health care from the chosen health care provider (public or private).

4.5.2 The Vulnerable Group Social Health Insurance Programme (VGSHIP)

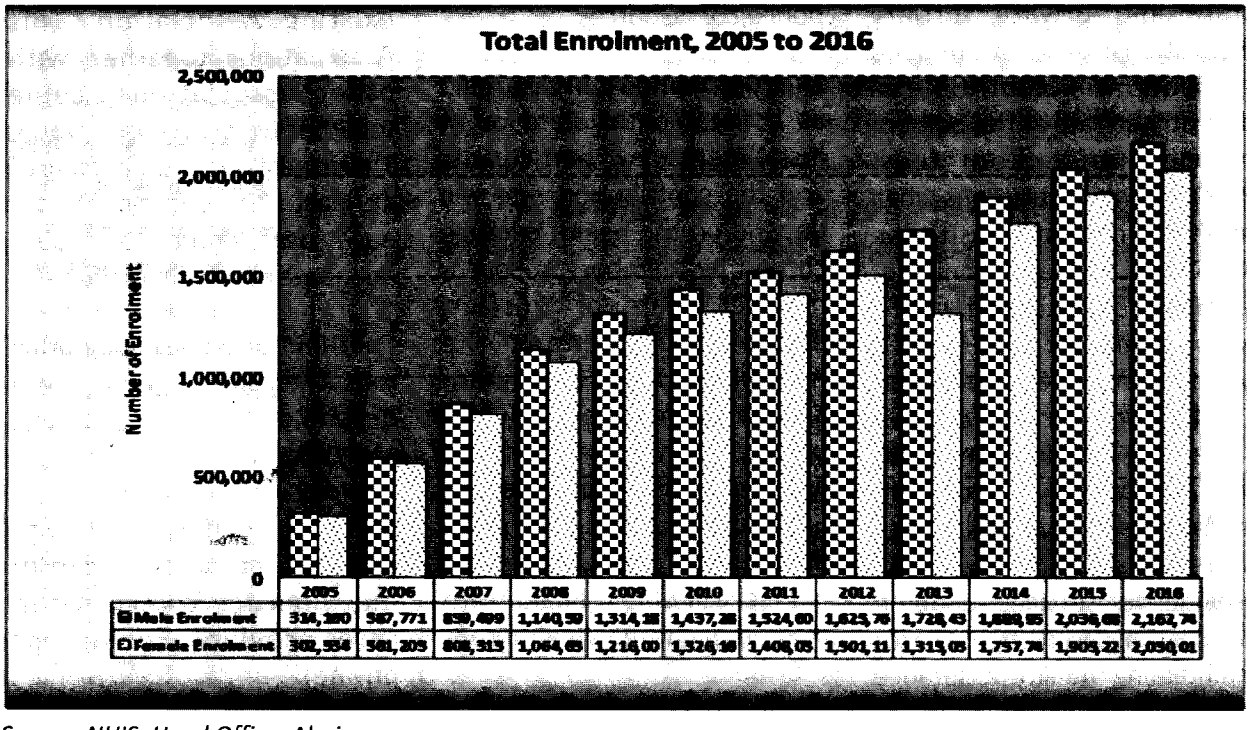
This is designed to provide health security for permanently disabled persons, aged and children under five. The health care benefits cover common illnesses. The beneficiary

Table 2: Selected Data on National health Insurance Scheme (NHIS)

SELECTED DATA ON NATIONAL HEALTH INSURANCE SCHEME (NHIS)												
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Total Enrolment	616,694	1,148,976	1,667,812	2,205,226	2,530,187	2,763,446	2,932,645	3,126,882	3,043,472	3,647,699	3,941,917	4,192,762
Total Male Enrolment	314,160	587,771	859,499	1,140,596	1,314,185	1,437,282	1,524,607	1,625,763	1,728,435	1,889,955	2,036,688	2,162,746
Total Female	302,534	561,205	808,313	1,064,630	1,216,002	1,326,164	1,408,038	1,501,119	1,315,037	1,757,744	1,905,229	2,030,016
Total Dependents Enrolment	437,434	814,053	1,174,683	1,553,859	1,779,417	1,939,152	2,057,298	2,192,035	2,336,821	2,565,545	2,784,074	2,973,732
No of HMO	8	31	27	26	29	28	70	61	76	77	79	62
No of HCPs	0	43	175	196	243	325	5,187	5,616	5,992	7,420	9,860	10,710
No of Subscribers & Dependents per HCP	-	45,652	16,243	19,179	17,735	14,470	962	947	898	837	682	669
No of Participating Private Sector	0	0	0	0	0	0	8	20	24	28	32	41
Total Private Sector Employees' Enrolment	0	0	0	0	0	0	0	158	440	1,481	2,337	2,952
No of States that Have Adopted NHIS	0	0	0	0	0	0	0	0	0	0	0	4

Source: NHIS, Head Office, Abuja

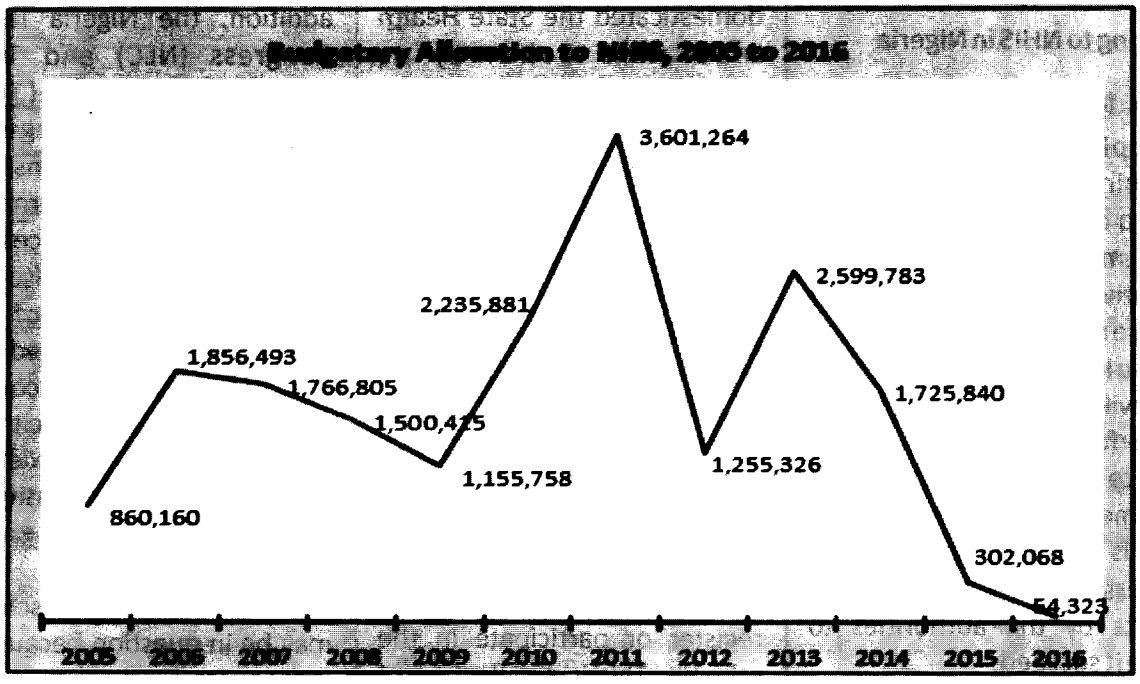
Figure 5: Total NHIS Enrolment



Source: NHIS, Head Office, Abuja

As illustrated in Figure 6, the pattern and trend in the budgetary allocation to the NHIS from 2005 to 2016. Allocation has been highly irregular and inconsistent over the years. From N860.16 million in 2005, it increased to N1856.49 million in 2006, and then declined steadily to N1155.7 million in 2009. Subsequently, budgetary allocation rose and reached its global peak, at N3601.25 million in 2011 before slumping back to N1255.32 million a year later. In 2013, allocation increased again to N2599.78, and since then has declined consistently through the years to a low N54.3 million in 2016. This irregular pattern has serious implication for the sustainability and credibility of the scheme in Nigeria.

Figure 6: Budgetary Allocation to NHIS, 2005 to 2016



Source: www.budgetoffice.gov.ng/

TABLE 3: ACTIVE HEALTHCARE PROVIDERS (HCPs) BY STATES, AS AT JUNE 2016

State	No of Primary HCP	Primary HCP As % of National	No of Secondary HCP	Secondary HCP As % of National
	66	1.8	124	1.8
	55	1.5	147	2.1
	51	1.4	101	1.4
	103	2.7	204	2.9
	58	1.5	42	0.6
	24	0.6	62	0.9
	88	2.3	152	2.2
	64	1.7	111	1.6
	90	2.4	119	1.7
	84	2.2	151	2.2
	19	0.5	40	0.6
	132	3.5	255	3.7
	27	0.7	64	0.9
	75	2.0	196	2.8
	264	7.0	658	9.4
	98	2.6	57	0.8
	73	1.9	146	2.1
	16	0.4	55	0.8
	157	4.2	412	5.9
	73	1.9	171	2.4
	48	1.3	84	1.2
	14	0.4	44	0.6
	49	1.3	100	1.4
	120	3.2	137	2.0
	865	23.0	1382	19.8
	56	1.5	84	1.2
	171	4.5	212	3.0
	134	3.6	156	2.2
	71	1.9	106	1.5
	52	1.4	90	1.3
	199	5.3	390	5.6
	78	2.1	164	2.3
	164	4.4	573	8.2
	55	1.5	59	0.8
	31	0.8	45	0.6
	22	0.6	50	0.7
	20	0.5	38	0.5
	3766	100	6981	100.00

5.0 Challenges and Issues relating to NHIS in Nigeria

As it is in Nigeria, NHIS still grapples with the usual teething challenges usually associated with the implementation of any new initiative. The scheme is not yet universally accepted or popular, and currently bedeviled with poor perception in performance and quality of service by the people that the scheme is meant to support. This is attributable to lack of understanding, despite the efforts by the authorities to make it succeed.

Another major challenge is concerned with the religious and cultural dimension that negatively affects the perception about health insurance. Culturally, some perceive that preparing for unforeseen unfortunate events is believed to be a self-fulfilling prophesy of an invitation to ill-luck or ill-health.

Also, there is a challenge of low enrollment and inclusion across the country. Membership is majorly limited to the Federal Government workers. The enabling act does not make subscription and participation mandatory for the private sector, unlike the Pension Act. In addition, it is usually difficult to identify the target population and how best to guarantee that the intervention reaches the targeted population in a timely and efficient manner.

Similarly, not all the states have domesticated the State Health Insurance Scheme, as stipulated in the NHIS Act. Only Kwara and Lagos states have done so, with Kwara having the Community Based State Health Insurance Programmes (CBSHIP). Lagos has recently enacted its own variation of NHIS law.

There are not enough health care providers (HCP), such as the medical practitioners (doctors, nurses and other paramedics professionals), who plausibly not willing to register or participate in the scheme. This is a reflection of the apathy toward the scheme, due to the shallow knowledge and understanding of the workings of insurance system. This is further compounded by poor and inadequate medical or other support infrastructure. The implementation of the scheme is also constrained by some institutional arrangements that allows for conflict of interest or responsibilities. There appears to be non-clarity of mandate between NHIS and HMO. For example, NHIS, which is a regulatory body, doubles as the implementer of the scheme. Similarly, the membership of the HMO, with a voting power, in the NHIS board that regulates HMO constitutes conflicts of interest. This creates the perception of weak regulatory effectiveness, abuse of rules and standard, inefficiency.
The Nigerian workforce has the concern that the benefit package is limited in scope. In addition, the Nigeria labour Congress (NLC) and Trade Union Congress (TUC) continued to be against employee payment, insisting that the Federal Government should bear the full cost of capitation. There is also the claim management of the scheme has been afflicted with mistrust, especially in a corrupt environment where citizens have developed the anxiety or suspicion and propensity of being cheated.

Sustainability of the scheme may be in question because of inadequate funding, especially with the low budget provisions in recent times. The scheme relies heavily on government appropriation, implying that dwindling government revenue could portend adverse implication for the implementation agenda of the scheme. The attendant insolvency tendency or signal could be a disincentive to participating HCP, fuel further unwillingness on the part of populace to register for the scheme.

Entwined with the above is the concern that all the NHIS fund is lumped and held in the Treasury Single Account (TSA) of the Federal Government. This could pose further problem given that the Fund is not a revenue generation and could not be an accrual to the government purse. The scheme has also experienced or confronted with "trust issue."

HMO had been recently involved with an incidence of breach of trust, regarding allegation of N90 scam or fraud. This development underpinned the endemic and systemic corruption ravaging all the sectors of the economy, propelling the negative perception and attitude against the effective implementation of NHIS.

5.1 Policy Recommendation/Way Forward

Health service delivery, being a public good, is understood to be a core responsibility of the government. To improve access, inclusion and quality delivery, the political will and commitment to universal healthcare service delivery is of utmost importance. Yet, the government alone cannot solve all the problems; there is the need to encourage full private sector participation and investment, as well as the coalition of other interests, such as Non-Governmental Organizations, Advocates and Foundations, among others.

The Authorities are urged to deepen an enhanced implementation process, especially with respect to the regulatory and oversight functions, as well as enabling the policy and institutional environment. Policy consideration is particularly underscored to facilitate the effective performance and utilization of the scheme to attain the desired objectives in a sustainable basis.

Steps should be taken to reposition the NHIS for optimal service delivery. The relationship with the labor union should be engendered to make stewardship credible and purposeful in a bid to address credibility issue.

The success of any insurance scheme is premised on the law of large numbers, hence to ensure sustainability, large memberships enrollment should be facilitated to create large pool of fund over a large population set. Similarly, to prevent fund misappropriation or related risk, it may be necessary to remove the NHIS fund from the Treasury Single Account (TSA), as being canvassed by the National Assembly and other stakeholders.

The negative perception and attitudinal cultural challenge relating to the lack of understanding of importance of insurance could be addressed by embarking on serious campaign, sensitization and education about NHIS. This will help in promoting positive perception and acceptance of the scheme, while reducing skepticism and poor expectation. By the same token, authorities are also urged to safeguard against corruption, be more transparent and engender trust, which is the backbone of insurance system.

Federal government authority is urged to encourage all states to domesticate the insurance scheme in their respective territories, and especially strengthen the community-based insurance. The necessary technical assistance and capacity development could also be provided for the states to assist in expediting the launching of the scheme.

Finally, it is critical to establish a National Health Insurance Fund (NHIF), independent of the NHIS to append credibility and engender transparency in the implementation of the scheme. Similarly, authorities are also urged to reconsider the implication of the HMO representation with a voting right on the board of the NHIS.

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