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Healthcare Delivery and the Limits of the National Health Insurance Scheme in Nigeria

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Abstract

Health reforms that target universal coverage have intensified in Nigeria since the dawn of the twenty-first century, and the National Health Insurance Scheme (NHIS), in particular, has been hailed as the panacea and appropriate framework for achieving the desired health for all by 2015. A few months to the target goal however, the reality is bleak and the task of reaching the goal more daunting than ever. This article provides a historical analysis of healthcare delivery in Nigeria Explanations for the difficulties in meeting health targets are discussed, pointing to weak governance, economic challenges, and socio-cultural contexts as important interacting factors slowing down the process. The aricle concludes by outlining some important emerging possibilities for strengthening the health system, including the liberalization of the health sector, enhancing public-private partnership, and suggestions for improving the National Health Insurance Scheme by recognizing key socio-cultural factors for inclusion in achieving health targets.

Key Words: Health insurance; private healthcare; user fee; public-private partnership; health policy; universal health coverage; Nigeria

Résumé

Les réformes de la santé visant la couverture universelle d'ici à 2015 se sont intensifiées au Nigéria depuis l'aube du XXIe siècle, et le système national d'assurance maladie, en particulier, a été salué comme la panacée et le cadre approprié pour atteindre l'objectif fixé. Cependant, à quelques mois du terme, la réalité est sombre et l'atteinte de cet objectif est une tâche plus redoutable que jamais. Le présent article vise à faire l'analyse historique de la prestation de services de soins de santé au Nigéria et des difficultés rencontrées dans l'atteinte des objectifs sanitaires, en soulignant la faiblesse de la gouvernance, les défis économiques et les contextes socioculturels comme facteurs interactifs importants ralentissant le processus. En conclusion, l'article met en exergue certaines nouvelles possibilités importantes pour le renforcement du système de santé, notamment la libéralisation du secteur de la santé, le renforcement du

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partenariat public-privé, et fait des suggestions pour améliorer le système national d'assurance maladie tout en reconnaissant la nécessité de tenir compte des facteurs socio-culturels pour l'atteinte des cibles.

Mots clés : assurance maladie, services de soins de santé privés, frais pour les usagers, partenariat public-privé, politique de santé, couverture sanitaire universelle, Nigeria.

Introduction

Nigeria's significant socio-economic progress in the first two decades after independence in 1960 came to an abrupt halt with coups and counter coups that established the military in power for sixteen consecutive years, from 1984 to 1999, eroding the gains made in the preceding years. Governance during this period was not only predatory, but social institutions and public services were neglected with the health and education sectors being the most conspicuously affected. Tertiary institutions and medical research centres that were the hub for producing quality medical professionals became a shadow of their former selves while health centres were bereft of doctors, nurses, and consumables, reducing hospitals and other health centres to mere consultation rooms 'where people go to die' (Alubo 1994). This deplorable state left much to be desired by the turn of the century. For example, life expectancy dropped from 56 years in 1978 to 48 years in 1998 while healthy life expectancy (HALE), which is the adjusted life expectancy for a healthy life without a disability, and an objective measure of survival, dropped to 42 years (Dogo-Mohammed 2009). Analysis showed that the low HALE ranking of Nigeria was due to high neonatal, infant, under-five and maternal mortality (WHO 2005). This dismal performance, in the context of high revenue from crude oil and the promise of an improved standard of living, precipitated an urgent need to arrest the situation leading to healthcare reforms in the country, and as its cornerstone, the establishment of the national health insurance scheme (NHIS) via Decree 35 of 1999 with a mandate of providing quality healthcare for all Nigerians by the year 2015. Current data on healthcare provision, however, indicate a very slow pace of universal coverage, and barely two months before the target year the prognosis for achieving the goal is not positive. Recent remarks by the Minister of Health and other senior health officials are indicative of the challenges government faces in achieving its set goal for universal healthcare by 2015 (NDHS 2013). Also, Akinseinde (2014) has noted that the scheme has not grown beyond 4 per cent coverage of the Nigerian population since its establishment fifteen years ago. In consonance with this elusive optimism, the United Nations Population Fund forecasted that Nigeria's ability to achieve the Millennium Goal, especially with regards to Goal 5, is unattainable due primarily to the slow rate of decline of maternal mortality, which has only

reduced from 1,100 per 100,000 in 1990 to 840 in 2008 (UNPF 2011). This article discusses explanations for the slow pace of healthcare delivery by pointing to weak political structures in the country in relation to health services; the structural adjustment programme that nested health reforms; and the socio-cultural context in which the reforms operate. The article draws heavily from relevant literature on healthcare reforms as well as from Nigeria's health policy.

Healthcare Delivery in Nigeria: The Collapse of a Promise

After Nigeria's independence in 1960, there was a determination among the emerging endogenous political class to improve the quality of life of citizens and at the centre of that understanding was the need to continue with colonial policies, which accentuated among other things, a formal adoption of orthodox medicine and the expansion of colonial health structures in urban and rural communities for effective healthcare delivery (Alubo 1985). This ideological orientation represented government's overarching health programme and was driven by massive training of doctors and nurses both within and outside the country with the aim of developing an indigenous capacity for western healthcare provisioning. Besides training, government also imported hospital equipment and set up bureaucratic structures for the management and delivery of healthcare for all citizens in rural areas and urban centres. The agenda was universal medical coverage. This commitment underpinned post-independence health policy with a primary accent on the provision of modern medicine to the bulk of the populace by establishing health centres with free medical consultations and unhindered access to a free supply of drugs or at heavily subsidized rates (Lambo 1991). Also, at state and federal levels, secondary and tertiary health centres were built and equipped as a tangible goal for investing public funds. At the same time, attention was given to the training of nurses, midwives, and doctors for the primary purpose of staffing the health centres which government had set up and was eager to develop (Erinosho 1993).

This welfare scheme, although desirable by government, was initially sluggish in gaining popularity among citizens due to their reluctance to abandon traditional forms of healthcare. Government had to resort to enlightenment campaigns to persuade local people to try modern medicine and the newly established health centres. The unwillingness of the public to patronize western medicine was due to the total variance between traditional and western concepts of illness/disease and the pathways to restoring good health. While western-trained medical doctors operated within the germs theory in explaining the causative factors of diseases and illness, indigenous explanatory models incorporated the basic assumptions of the germs theory

as well as traditional beliefs in supernatural and preternatural forces in explaining and interpreting health matters, which ultimately influenced health-seeking behaviour. The desire to embrace a completely new and diametrically-opposed health system became problematic and government had to face the onerous task of educating and enlightening rural folks on the benefits of modern medicine, which, by government conviction, promises a superior quality of life.

The ideological conviction of nationalists that the state is the coordinating instrument for facilitating development and solving social problems influenced massive investment in health facilities, personnel and consumables and the overt encouragement of the public to patronize government largesse. Consequently, the first two decades after independence witnessed the relative functioning of public health centres in terms of the provision of essential drugs and access to qualified medical officers with the public beginning to respond positively to the new development. Financial subventions from government, both at the federal and state levels, met the operational expenses of the health ministry and were also regular even if not always sufficient due to competing demands from other sectors of the new economy (Aregbeyen 1988). This, however, did not deter the growth of the health sector, which had begun commanding public confidence, especially in urban centres, as an important source of healthcare. But the growth in this sector, as well as the people's confidence was not to last for long; by the mid-1980s the spiralling economic crisis that was beginning to build up at the twilight of the Second Republic in the late 1970s put a halt to the development process.

The consequence of the economic downturn was the mass exodus of highly qualified doctors and nurses from the country to North America, Europe and other African countries where up-to-date working facilities and better conditions of service were available. The last straw that finally dealt the destructive blow was the retrenchment exercise initiated by the military governments starting from the Buhari regime in 1984, and reaching a climax in 1987 as part of a general reform agenda in the public sector that was crafted in the spirit of the IMF/World Bank Structural Adjustment Programme (SAP) (WHO 2005; UNDP 2006; Olukoshi 1993). Fiscal constraints, due to the increase in foreign debt, as well as pressure on the government to sustain the financing of public services, impacted adversely on Nigeria's capacity to provide subsidized health services to the public. The economic hardship that followed SAP's implementation and the social crisis associated with it led to the inability of the state to fulfill its primary obligation as a developmental instrument particularly in the health sector. High mortality became rife reflecting the virtual collapse of the state as a result of the military junta's

abdication of governance and the engineering of a quasi-civilian regime that enthroned a political ruling cabal that had only a parochial interest of self-aggrandizement through looting of the public treasury.

The political crisis that heralded the overthrow of the civilian administration on the eve of 1984, leading to counter-coups and a long military dictatorship and pseudo-democratic rule, became one of the most significant disturbances that obstructed developmental process in the country. Consequent upon this political dislocation was the weakening of state apparatus while developmental goals became blurred. The lacklustre of government in defining comprehensive national development plans and articulating its vision, was reflected in anachronistic policies that reversed the gains that accrued to the nation in the period preceding the 1983 coup d'état. In addition to this, the institutionalization of corruption by the military meant that the state was later perceived as not having 'the moral fibre as well as the technical rationality to deliver healthcare to all its citizens' (Hyden 1999). Government parastatals and public infrastructure became moribund. The collapse of the state leading to infrastructural decay was characterized by a neglect of the health sector such that procurement of drugs and other consumables were no longer the prerogative of government, while power supply became irregular and health facilities were not expanded and/or maintained (FMoH 1986). The political impasse, which also led to the crisis in public health, acted as a fillip for the emergence and/or expansion of private health services underpinned by a neo liberal philosophy that is market-oriented as against the welfare approach adopted by the nationalist government. This shift in paradigm accelerated the growth and expansion of private healthcare provision in terms of its proliferation and the ambivalence of its services to the public (see Alubo 2001 and Ogunbekun *et al.* 1999).

One thing that is sure, however, is that the emergence and expansion of the private health system did not only signal the formal arrival of a highly stratified health structure in Nigeria, but it also challenged the universal character of the state as a problem-solving entity. This development forced the working poor to either make do with the deplorable public health system or seek other emerging popular alternatives including traditional healing practices, which had been neglected by successive governments and had become unpopular at least in urban centres. On the other hand, the precarious circumstances opened up new opportunities for social advancement while it simultaneously provided the elite class with the highest quality of healthcare through its patronage of private health providers and where this was not available it resulted in the patronage of health services outside the country (Gureje and Lasebikan 2004; Gureje 2005). The virtual collapse of the state consequently led to a vacuum in the health system that eventually encouraged

quacks to take over the sale of fake and sub-standard drugs in urban and semi-urban centres and the concomitant rise in mortality rates (Alubo 1994).

The group that suffered the most in the crisis however, was the rural poor who were in the process of embracing modern healthcare as a result of government enlightenment campaign efforts but were caught off track by the economic and political crisis. Health posts were abandoned in rural areas by the government and the progressive lack of drugs and qualified doctors that followed the economic crisis aroused rural people's suspicions of government and the health system it once promoted. Consequent upon this disappointment was the reverting of rural people to traditional health systems and varying traditional healing practices including the increasing patronage of religious healing centres. But because most traditional health practitioners had stopped practicing due to poor patronage and, in some cases, the demise of highly skilled traditional professionals, quackery in this sector also flourished exacerbating mortality rates in rural and peri-urban areas. The amorphous healthcare system resulting in high mortality due to the dismal performance of government precipitated the need to address the enormous challenges in the health sector and to restore any hope of equity in healthcare, access to quality health services and universal coverage.

Improving Healthcare Services: Government Efforts since 1999

Health Governance and Financing

When the country returned to a democratic rule on 29 May 1999, the public health system was completely dysfunctional and fragmented into varying forms. These ranged from public health centres that were still under the ambit of government; unregulated private health services; licensed and unlicensed chemist shop owners who procured and dispensed drugs to the public; a plethora of traditional health practices; and religious healing homes, among other forms of healthcare delivery. The public health sector, constitutive of the Federal, state, and local government health departments, was also fragmented operating with meagre resources and poor coordination from the federal Ministry of Health. The system was heavily over-burdened with infrastructural decay, poor conditions of service, and low morale among the few staff who managed to stay behind. The situation was more deplorable in rural areas due to the complete abandonment of community health posts built in the 1970s in consonance with the primary healthcare initiative that targeted rural communities for the provision of basic health services. Thus, by the turn of the century, only a few health posts were available in rural communities and public and private health facilities were heavily concentrated in urban centres. In 2002, 70 per cent of all healthcare expenditure was on

urban health even though 70 per cent of health needs are in rural communities. The distribution of health facilities and personnel has not improved and there has been no visible attempt by succeeding democratic governments to correct the anomaly even though over 70 per cent of those who are in dire need of health services are in rural areas (McKenzie *et al.* 2014). In a bid to reduce maternal mortality, there is a need for the government of the day to revamp all the rural posts and expand existing facilities to accommodate the increase in population since the 1980s. Current health policies must ensure that there is an appropriate scheme to encourage health workers including doctors and nurses to provide services in under-served areas. Inter-sectoral relations need strengthening to provide complementary social amenities in rural communities to open up rural areas and encourage private health services. In doing so however, an effective organizational structure needs to be put in place to regulate activities of the private sector in preventing the sale of fake and sub-standard drugs.

In addition to the vertically fragmented health system and skewed distribution of health facilities, was the poor coordination of the private sector by the Ministry of Health in all tiers of government. Private health providers had unfettered freedom to import drugs, and whether by act of omission or commission, but mostly due to corruption, fake or sub-standard drugs were being sold to the public (Alubo 1994) leading to the overhauling of the National Agency for Food and Drug Administration and Control (NAFDAC) and the appointment, in 2004, of Dora Akuyili, a vigorous and uncompromising university professor of pharmacology with a personal passion to get rid of fake and adulterated drugs from the public and to check the excesses of the private health sector. But sadly, little has been done to improve the situation. The threat to the life of the NAFDAC boss, and her subsequent redeployment to the Ministry of Information in 2006 were indicative of the fact that private healthcare has become firmly rooted in the country with important power brokers behind some of its obnoxious dealings. Surveys conducted indicate that the private sector now contributes about 50 per cent of healthcare delivery in the country but with very minimal presence in rural areas (Health Survey 2013). Despite sharp practices that are associated with the private sector, government still needs its support as it is obvious that government alone cannot provide health services for all members of the society as it once ambitiously planned. What needs to be done is for effective coordination of the sector to check its excesses by being firm and transparent in its dealings. The argument made by Alubo (2001) is in line with the challenges that are associated with private health provision but the potentials of the sector also need to be fully appreciated even if not as optimistically presented by Ogunbeku *et al.* (1999).

The National Health Insurance Scheme and Health for All

The re-launching of the NHIS in 2002 by the Obasanjo administration was more focused and broad in scope than the 1999 decree that established the scheme and has as its key objectives: (1) ensuring unhindered accessibility of citizens to a quality health service; (2) protecting families from the financial hardship of huge medical bills; (3) limiting the rise in the cost of healthcare services; (4) ensuring the equitable distribution of healthcare costs among different income groups; (5) maintaining a high standard of healthcare delivery services; (6) ensuring efficiency in healthcare services; (7) ensuring the equitable distribution of healthcare facilities; (8) providing funds to the health sector for improved services; and (9) ensuring equitable patronage of all levels of healthcare (NHIS 2007). The overall goal of the scheme was to improve the quality of life of citizens. The primary functions of the scheme include registering of health maintenance organizations (HMOs) and healthcare providers (HCPs), issuing appropriate guidelines towards maintaining the scheme's viability and determining, after negotiation, the capitation and other payments due to healthcare provision by HMOs.

In its operation, an employer with a minimum of ten employees may pay contributions under the scheme calculated as 10 per cent from the employer and 5 per cent of the employees' basic salary and lodged with any HMO of their choice for quality treatment. Consideration for capitation payment in respect of each person registered, and liability to pay the specified contributions is required under the scheme. The scope of the scheme in terms of health services is restricted to consultation, prescription and supply of drugs, diagnostic tests; consultation with a defined range of specialists, hospital care in a public or private ward for a specified period of admission for physical or mental disorders, a range of prosthesis and dental care as defined and eye examination and care but excluding spectacles. Finally, simple preventive measures including immunization, family planning, antenatal and postnatal care form an integral part of the scheme.

The expected advantages of the scheme include ensuring that patients in need of a physician or requiring any form of health service would have relatively easy access within a reasonable distance with an effective referral system. In addition, the scheme is to protect Nigerian families from the financial hardship of huge medical bills that are usually associated with an 'out-of-pocket' system of healthcare provision, thereby limiting the rise in the cost of healthcare services and ensuring availability of funds in the health sector for a constant supply of quality consumables at a cheaper price. The above will help in maintaining high standards of healthcare delivery services and ensuring the equitable distribution of healthcare cost among different

income groups. Harnessing private participation in the health sector, government is encouraging public-private partnership to achieve its goals by reaching out to all segments of the population and the patronage of health services at all levels of healthcare with the NHIS serving as the coordinating structure for the safeguarding of citizens' health.

Although a user fee for health has a long history in Nigeria, the idea of paying in advance for health services in the form of insurance is certainly novel and thus needs careful planning and implementation in achieving the desired goal for universal health coverage. A user fee is widely acceptable to Nigerians because of their identification with such a mechanism from their own socio-cultural transactions and for their immediate response to health matters. Health insurance on the other hand, although it has its theoretical and practical benefits (Bituro 1999; Akin *et al.* 1987; Kannan *et al.* 1991; Mwabu *et al.* 2002), is still a foreign idea and practice in Nigeria and it demands careful planning and execution.

Human Resources and Healthcare Coverage

One of the significant gains of the first two decades after independence was the production of skilled personnel in the health sector so that between 1960 and 1980 the number of registered medical doctors increased from 1,250 to 16,480, with a concomitant increase of doctor-population ratio from 21 per 100,000 to 62 per 100,000. Similarly, during the same period, the number of registered nurses and midwives increased fourfold from 14,000 to 66,000. With the downturn of the economy however, and the resultant exodus of doctors and other health personnel, the country witnessed a significant drop in the number of doctors and nurses, which also drastically reduced the ratio of health personnel to the population. By 2010 the estimated number of medical doctors in the country had shrunk to 55,376, translating into 40 physicians to 100,000 citizens and less than 1 dentistry personnel to 10,000 people with a total population of 3,781 (WHO 2011). This situation is primarily caused by the decline in government expenditure on the health sector. For example, general government expenditure on health was 6.4 per cent of total government expenditure while the total expenditure on health was 5.2 per cent of gross domestic product (WHO 2011). What all this leads to is that total health coverage has not significantly improved with the various reforms initiated by the government, so that between 1990 and 2010 immunization coverage among children less than one-year-old dropped from 54 per cent to 41 per cent for measles and from 56 per cent to 42 per cent for DTP3 respectively. Similarly, antenatal care coverage dropped from 58 per cent in the year 2000 to 45 per cent in 2010 (WHO 2011).

NHIS and the Challenges of Attaining Universal Care

Key Advantages of the NHIS

Significant advantages accruing to the NHIS especially in advancing security and equity due to advance payment that secures treatment even in the face of cash constraints during emergencies, which may occur in unexpected circumstances, are key to achieving universal health coverage. The scheme also ensures that the working class in both the public and organized private sector with low-income earnings is guaranteed quality health services at all times including periods of the month when most families are on a tight budget, which may compromise rational decisions in utilizing health services when an urgent need arises. Thus, the scheme insures contributory families against unexpected eventualities that would otherwise have dire consequences. Furthermore, families do not bear the full brunt of their medical bill because their contributions are distributive among co-contributors, thereby lightening the burden of each participant but at the same time providing health services that would otherwise have been impossible if members had operated individually. It also promotes equity because the sick benefit from the premiums of contributors who rarely fall ill. This collective pool becomes the hallmark of the NHIS and the singular most important reason for its great promise for universal healthcare delivery. What needs special attention in this regard is balancing those expensive ailments associated with the rich versus the constant ill health of the poor (Wang'ombe 1997). In all, the NHIS is theoretically a veritable and promising programme for health equity.

While these positive factors have their benefits, scholars have noted some important consequences resulting from introducing various shades of medical insurance schemes in African countries. For example, in evaluating community insurance in Kenya, major setbacks associated with the scheme were observed with the cost of medical treatment increasing by 100 per cent-500 per cent, leading to a reduction in utilizing government hospitals by 40 per cent-50 per cent with the poor constituting the majority of those who stopped patronizing formal health centres (Mwabu *et al.* 2002). Similarly, studies have highlighted the drawbacks associated with user fees in other parts of Africa including poor patronage of health centres, especially among the poor, leading to inequity, while efficiency and sustainability are usually not guaranteed (Maiga *et al.* 2003; Quaye 2004).

NHIS and the Socio-cultural Context

In Nigeria, the socio-cultural context in which the national health insurance scheme operates is crucial to its success. First, the scheme recognizes the family unit of a man, his spouse(s) and four of his children without recourse to the indigenous family system. The logic of polygynous formation in

Nigeria and the recognition of children outside wedlock negate the framework of the one-man-one-wife-four-children equation on which the NHIS operates. In addition, the extended family structure that is pervasive in both urban and rural areas automatically excludes significant others in the family who legitimately depend on the breadwinner for their livelihood and well-being. While elements of modernization are certainly common in the country as a whole, it is by no means universal and some cultural forms and patterns still exist and constitute a significant part of social relations in Nigeria.

At a conceptual level, the gender and social relations in Nigeria are not only complex but are also dynamic in their form infusing into them cultural, religious and exogenous trajectories. One of such is polygynous practice, which is widely practiced in most communities and sustained by cultural dictates and religious endorsement (such as Islam in the northern part of the country and traditional African religions in the south). The most current data on polygynous unions in Nigeria, for example, indicate that 26 per cent of women between ages 15-19 have co-wives, while 53.7 per cent of women aged 45-49 have one or more women as co-wives contesting for equal resources (NPC & ICF 2009). Furthermore, women's participation in decision-making is low with over 55 per cent of men solely responsible for taking critical decisions regarding their wives' health (NPC & ICF 2009:275). Such a practice only means that women are disadvantaged and circuited in negotiating their rights including those that pertain to health matters. The patriarchal structure of the Nigerian society also means that boys are better educated and therefore better empowered in accessing resources while their female counterparts depend mostly on them as fathers, brothers, or husbands for their survival. The practice of girl-child marriage also means that as more women outlive their aged husbands, female-headed households with marginal resources are common thereby limiting their participation in the scheme. Consequently, by virtue of their social position in society, a significant number of Nigerians are excluded automatically from the scheme because households or families in the country are rarely composed of the evolved nuclear family on which the government designed the health insurance framework.

Further to the above, the traditional African concept of the family, which dominates rural thinking and practice, is not only at variance with western perspective and practice but it also differs in its form and expectation. The scheme's recognition of the Nigerian family structure as constituting a man, his spouse(s) and four children means excluding one's parents, in-laws, and other members of the 'extended family' as well as domestic helpers who are all regarded as part of the family and dependent on the breadwinner(s). The extended family concept as enunciated in its definition is mostly practiced in

Nigeria's rural areas and, to a lesser extent, in urban centres. For the average Nigerian, partrilocal or martrilocal residency means that all members living in that homestead are family members without recourse to differentiating between 'nuclear members' and those constituting 'extended members'. In such arrangements, the head of the family, who is either a man or a woman, takes responsibility for every family member without distinction as specified in the scheme. The structure of the typical Nigerian family, except for acculturated families in urban centres, consists of more than the officially recognized one-man-one-woman-four-children composition but includes other members of the family who depend on the breadwinner for their survival and well-being. Recognizing only the core (nuclear) members in a family means excluding other members and thus, the danger of such policy lies in endorsing western values and ways of life that are totally at variance with local practices. The technical exclusion of a subset of the population by virtue of its unique relationship with other members of the society further buttresses people's suspicion of government and why they will be less cooperative even when government is sincere. In this circumstance, rather than exacerbate the tension that characterizes the relationship between government and its people, it is instructive for health policy-makers to expand the scope of the scheme by recognizing and accommodating traditional forms of relationships and incorporating household members that breadwinners are capable and willing to support. Furthermore, promoting gender equity in healthcare provision must also recognize the peculiar position of women both in urban and rural areas and policies must be appropriately designed to address health inequities derived from such social arrangements.

NHIS and the Private Sector

The operational requirement that mandates employers with a minimum staff of ten to officially declare the financial viability of their organization before and after registration, serves as an important impediment for recruiting members into the scheme. Both the poor performance of the economy and the harsh condition in which businesses operate have continuously discouraged entrepreneurs from registering their staff with the NHIS (Akinseinde 2014) due to the financial commitment foisted on them against the need to maximize profit. Since employees do not want deductions made at source for this purpose, it means cooperating with their employers to circumvent the scheme. Since most companies are struggling to stay afloat, extraneous financial demand in the guise of medical insurance continues to face resistance from small and medium-sized entrepreneurs.

In addition to the economic consideration among employees is the role that culture and religious beliefs play in everyday life of the people. Paying in

advance for an unwanted ailment that has not taken place is not only alien to the cultural dictates of most Nigerians but more broadlly, it negates their beliefs in the efficacy of prayers and other paraphernalia that go with healing and prevention of diseases and ailments. It is generally upheld among Nigerians, and especially so among the low-income group, that paying in advance for something negative is courting that phenomenon and encouraging it to come to pass. It is such an idea that forbids the average Nigerian from taking out life insurance cover based on the belief that insuring one's life may open the door for the evil machination of malevolent spirits, which may lead to an untimely death. The very idea that one is paying for illness in advance also means, especially among Christians, a lack of faith, which compromises the belief that God is capable of protecting the believer from illness and diseases.

NHIS and Infrastructural Development

Prior to the launching of the NHIS in Nigeria and especially in the 1970s and 1980s, the federal government had established health posts and community health centres in most parts of the country to cater for the primary healthcare (PHC) programme and the immunization project targeted at children below five in both urban and rural areas of the country (Jegede 1994). However, the slow decline of activities and poor partnership with foreign donors led to the gradual disintegration of the structures (Ogunkelu 2002). The lack of adequate structure on the ground means that underserved populations are excluded from benefitting from the scheme.

Although the scheme was on the drawing board for several years, no adequate arrangement was made in practical terms to prepare the NHIS for a soft landing. The skewed distribution of health facilities and qualified health personnel become the most conspicuous deficiency in implementing the NHIS. In rural areas where health needs are in dire need, functional health posts and health centres are inversely proportional to health facilities in urban centres, so that over three-quarters of registered health centres are in urban and semi-urban centres. Consequently, the poor referral systems in rural communities exclude people living in these underserved communities, forcing them to fend for themselves without critical government support (Lanre-Abass 2008). In communities with some semblance of health posts, the scheme has not taken into account the economic hardship of the people who are incapable of paying their premiums and, therefore, are excluded from the scheme. This issue is important when we take into account that urban areas have a much higher proportion of people in the fourth and highest quintiles of 30 per cent and 47 per cent respectively with rural areas having a higher proportion of the population in the lowest and second

quintiles of 27 per cent and 29 per cent respectively (NDHS 2009). What government needs to do in this regard is to subsidize the premium for this category of people for them to benefit from the scheme, although identifying the poor is a major contending issue that needs careful planning and execution (Mwabu *et al.* 2002).

Closely related to the above is the shortage of health personnel for bringing the scheme to fruition. The lingering crisis in the health sector prior to the NHIS, characterized by the acute shortage of health workers and health facilities at the primary level (Manuwa-Olumide 2009; Gupta *et al.* 2004; Ogundeji 2002), reinforced the dismal state of healthcare provision in Nigeria prior to the launch of the scheme. The situation, however, has not changed significantly in the post-NHIS period with a 30 per cent distribution of health facilities in rural areas and 70 per cent in urban centres. As discussed above, the dwindling economic fortunes of the country in the mid-1980s due to the plunge in crude oil prices and the resultant introduction of the structural adjustment programme led to the mass exodus of health workers, including physicians and nurses, out of the country. This development, coupled with the adjustment framework, became the platform on which so-called cost sharing/cost recovery policies were introduced from the late 1980s onwards. These policies which, taken with the deterioration in the public health system, have acted as a disincentive for continued popular access to and patronage of public health institutions (FMoH 1986). These crises that characterized the health sector were not sufficiently addressed and resolved before the new and ambitious health insurance policy was decreed into existence.

Conclusion

Universal healthcare provisioning in a transitory and heterogeneous society such as Nigeria is daunting due to weak governance, sharp practices in the private health sector and incongruous health policies and programmes. Success in universal coverage will involve strengthening governance and engaging in a dynamic public-private partnership as well as mobilizing grassroot participation. The government *laissez-faire* approach to health policies, characterized by the wholesale adoption of foreign health structure and poor supervision at all tiers of health delivery, are partly reponsible for the slow pace of meeting health targets. While the national health scheme has contributed to some improvement in healthcare in the short-term, it has compromised health equity and accessibility among underserved and disadvantaged groups who constitute the bulk of the Nigerian population.

Understanding socio-cultural contexts of healthcare delivery is important and has significant benefits. Local contexts can explain why health reforms

have not matched expected outcomes, or why huge financial commitment and key health programmes have recorded marginal results or unintended outcomes. It also promises opportunities to modify health policies and programmes to effectively mobilize rural folks, such as recognizing family structures, indigenous beliefs, and social relations, or using existing traditional health practices such as user fee to reach out to a much wider spread of the population. Ignoring local contexts in designing health policies and treating health systems from a Eurocentric perspective inhibits grassroot participation, which is critical for developing a sustainable health system and progressing towards universal coverage. Failures of government in reaching health targets have consistently demonstrated the weaknesses inherent in the top-bottom approach of health policies, and as 2015 approaches, it is expedient that other critical factors are recognized in the formulation of policies and in designing programmes.

The conclusion to be drawn from the above analysis is simple: as advanced and implemented by the Federal Government of Nigeria, the NHIS in principle has great potential for providing health services for its citizens, but in its present form the scheme's contents lack some critical components for achieving its universal goal. Based on the discussion above, the emergent opportunities and limitations tend to generate relevant lessons for designing a more holistic and practical health policy and programmes in the context of achieving universal coverage. The implications include strengthening primary, secondary, and tertiary health referral systems through effective governance; promoting and strengthening public-private partnerships for healthcare delivery; and paying more attention to local contexts by policy makers, planners and implementers.

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