Social Health Insurance in Nigeria: Rethinking the Approach for Effective Health Care Delivery

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Introduction

The success story of Social Health Insurance (SHI) in developed countries such as Germany, Japan, and the Republic of Korea, among others, hit developing countries by the turn of the century, and thus, the World Health Organization (WHO), one of the leading advocates for SHI, encouraged developing countries to establish SHI as a financing option for health care.

The WHO describes SHI as a strategy for funds mobilisation, risk pooling and access to equitable health care (WHO 2005). In the same way, the World Bank and other international agencies endorse SHI as a policy instrument to facilitate desirable health sector reforms in developing countries (McGregor 2014; Word Bank 1989; 1993; Hsiao and Shaw 2007). SHI became an alternative option in low-and-middle-income countries (LMICs) due to the continued rise in health care expenditure and difficulty in funding it (WHO 2010). SHI has thus been explored as a strategy that could provide more revenue and ensure a flow of funds into the health sector by a combination of risk pooling and mutual support (Talampas 2014; Dutta and Hongoro 2013).

The Nigeria model of SHI, called the National Health Insurance Scheme (NHIS), was instituted with the mandate to ensure access to health care, protection from financial hardship and establishment of universal coverage. However, since its inception, expanding population coverage remains a challenge. Why is NHIS failing in its mandate? This question is increasingly important not only because NHIS is waning in terms of population coverage, but also because many LMICs are facing similar challenges (Talampas 2014; Barnighausen and Sauerborn 2002). This study attempts to address this issue by exploring the design and performance of NHIS vis-à-vis three selected countries, Germany, Thailand and Rwanda, based on their different institutional arrangements for funding, delivering and meeting Universal Healthcare Coverage (UHC). The study is organised as follows: a brief overview of the historical development of NHIS, strategies adopted to achieve universal coverage, the challenges that stem from the strategies, and lessons learned from the studied countries.

Historical development of Nigeria's health care financing

This period covers the early 1960s, when the country gained independence, to the early 1980s prior to the implementation of neoliberal structural adjustment policies (SAPs) in the country. The Nigerian government in the pre-reforms era provided 'free' health care services including curative and preventive care for its citizens through general taxation. Funds realised primarily from agricultural produce was used to finance socio-economic and infrastructural development. Health care was readily available at public hospitals and clinics at no charge (Adesina 2007a). In this regard, financial barriers to health care access were avoided as social spending on health was seen as social investment to enhance economic growth and development because the idea was predicated on nationalist beliefs in the social and economic nexus. Universal provision of social services was primarily the responsibility of the government; health and other basic social services like education were seen as issues of social welfare rather than consumable goods; and thus health expenditure as a percentage of Federal Government expenditure was on an average 3.5 per cent in the 1970s (Heidhues and Obare 2011; World Bank 1980). Within this period, social services were seen as a complement to economic growth and thus were given priority (Adesina 2007b; Obono 2007). Adesina further argues that, similar to education, 'social spending on health was part of the wider objectives of defeating the triad of ignorance, poverty and disease in the immediate post-independence era of most African states' (Adesina 2008: 6). The country had four

vigorous National Development Plans for health care in the pre-reform era primarily predicated on revolutionary transformation of the country's inherited colonial health care system. These include the first National Development Plan (1962–1968), the second National Development Plan (1970–1975), the third National Development Plan (1976–1980) and the fourth National Development Plan (1981–1985) (Scott-Emuakpor 2010: 3). The nationalists recognised the need for workforce training and development of indigenous skills in health care services and thus the number of medical doctors and other health professionals increased steadily from independence. The total population per medical doctor declined drastically from 73,710 to 15,740 between 1960 and 1975, infant and under-five mortality per 1,000 live births also declined from 50 in 1970 to 22 in 1979 (World Bank 1980).

However, given the low economic growth rate and limited fiscal space of the 1980s, the international financial institutions, led by the World Bank and International Monetary Fund (IMF), introduced SAPs as the prerequisite for structural adjustment loans for sub-Saharan African countries (Adesina 2007b; Obono 2007). The conditions of the loans included minimal government intervention in the economy, private participation and the introduction of User Fees for government facilities, with the claim that there would be more funds in the system through private participation, which in turn would subsequently be used to improve the quality of and increase access to health care (World Bank 1993).

On the contrary, these neoliberal policies reversed health care financing from the government to individuals and households. For instance, private health expenditure in Nigeria between 2000 and 2006 accounted for 66.5 per cent and 70.3 per cent, while government expenditure accounted for 33.5 per cent and 29.7 per cent respectively. In the same period, further analysis of private health expenditure shows that OOP payments accounted for 92.7 per cent and 90.4 per cent respectively (WHO 2009). The abrupt changes in Nigerian health care financing from the government to the individual denied the vast majority of the Nigerian population access to basic health care services. For instance, evidence reveals that in 1999 the Maternal Mortality Ratio (MMR) and Infant Mortality Ratio (IMR) were 1,200 deaths per 100,000 live births and 114.70 deaths per 1,000 live births respectively (WHO 2000). In response to the criticism and failure of User Fees to attain their set objectives, the promoters shifted to a more flexible and gradual approach to budget cuts hereby increasing the role of governments in providing the necessary supports for health care, education and other social services. Thus, in the early 1990s, a new call for 'adjustment with human face' took the centre stage, which implies paying more attention to social services and the role of government in the process. The failure of User Fees resulted in reconsidering the approach and thus risk pooling via prepayment and mutual support mechanisms was considered an alternative strategy to finance health care (WHO 2010; Save the Children 2008).

The NHIS was instituted in 1999, though became operational in 2005 with a wide range of programmes/plans such as the Formal Sector Social Health Insurance Programme, Voluntary Individual Social Health Insurance Programme, Community-Based Health Insurance Programme, and Vulnerable Group Social Insurance Programme, among others (NHIS 2012). However, the population covered by the Formal Sector Programme was insignificant; and thus, the Community-Based Programme was initiated in 2008 to fast-track population coverage. Despite the introduction of the Community-Based Programme, it added no meaningful contribution to the expansion of health coverage, and coverage remains stuck at about 3 per cent of the Nigerian population (Odeyemi and Nixon 2013).

Methods of achieving UHC

There are two main options to universal coverage via SHI: full population coverage and targeting a limited group(s) at the beginning, with the aim of expanding coverage gradually to the rest of the population. The latter could be operated in two ways: first, starting coverage with formal-sector workers (a 'top-down' approach), and gradually expanding inclusion to informal-sector workers; second, initial coverage of small and informal-sector workers (a 'bottom-up' approach), then gradually including employees in the formal sector (Gustafsson-Wright and Schellekens 2013). Literature has shown that countries such as Germany, Japan and Austria, which adopted the second option, that is, the 'bottom-up' approach, moved faster in achieving universal coverage than countries such as Nigeria, Ghana and Vietnam, which started with the first option, that is, the 'top-down' approach (Nicholson, Yates, Warburton et al. 2015; Hsiao and Shaw 2004; Barnighausen and Sauerborn 2002).

Challenges to achieving universal coverage in Nigeria

A number of challenges that hinder the achievement of universal coverage in Nigeria have been identified: (i) difficulty in expanding coverage to informal-sector workers and the rural populations; (ii) lack of mutual and social solidarity among the beneficiaries of health insurance programmes/plans; (iii) inadequate resource mobilisation; and (iv) proliferation of fund pools.

Lessons from selected countries

Germany

Germany is globally considered to be the source of the SHI model of health insurance. Since the end of the seventeenth century, a number of relief funds were developed in different regions of Germany, including relief funds for journeymen, artisans and other people who could not fit into other existing funds. Statutory sickness funds evolved out of the relief funds, animated by the principles of solidarity, community self-help and social justice (Carrin and James 2004; Barnighausen and Sauerborn 2002). It is worth mentioning that the German health care system developed incrementally. For instance, in the pre-Bismarckian statutory health insurance system, laws were instituted as follows: first, rules and regulations detailing how sickness funds could be organised, including provisions for contribution, benefit packages, entry conditions and the management of the funds. Second, the character of the laws gradually changed from liberal to obligatory. In 1843, the Common Law of Trade allowed Municipal Authorities to recognise compulsory contribution to the existing voluntary funds. By 1849, local governments were permitted to make insurance compulsory for particular groups of employees, and in 1854, all uninsured people were compelled to create insurance funds for mutual support. Third, in the same year, 1854, compulsory insurance moved from regional to supraregional levels, and for the first time one professional group in the entire region of Germany – the miners – was required to join one of the numerous miners' regional funds (Barnighausen and Sauerborn 2002). Thus, the three incremental phases in the development of Germany's health insurance system paved the way for the achievement of universal coverage.

Thailand

Prior to the universal coverage programme in Thailand, a wide range of plans existed, including universal coverage for the poor, workmen's compensation funds, and low-income scheme, among others (Talampas 2014). In 2001, the existing funds were merged into four schemes for the entire Thai population. These include: (i) the Medical Welfare Scheme (MWS), which provides coverage for the poor and vulnerable, including the elderly, children, secondary school students, the disabled and war veterans, among others; (ii) the Health Card Scheme (HCS), for non-poor households who were not eligible for the MWS; (iii) the Civil Servants Medical Benefits Scheme (CSMBS) for retired civil servants and their dependants; (iv) the Social Security Scheme (SSS) for employees of organisations with more than ten workers but not for their dependants. However, MWS and HCS were later merged to form the Universal Coverage Scheme (UCS) (Talampas 2014; Dutta and Hongoro 2013). The consolidation of the existing funds into three major funds was a major reform in Thailand. It has been estimated that 85 per cent of Thai population were covered in 2002 because of the merger (Dutta and Hongoro 2013).

Rwanda

Rwanda has been recognised as one of the countries in Africa and Asia that has made significant progress in achieving a UHC system since 2012. The country's dramatic reform of its health care system began in 1999, and by 2000, the country was committed to universal coverage. Mutuelles de santé (Mutuelles), a Community-Based Health Insurance Scheme (CBHIS) established by the Government of Rwanda, remains the main component of the national strategic plan for universal health coverage (Rwanda Ministry of Health 2010). Although other social health insurance programmes, such as the Military Medical Scheme and La Rwandaise d'Assurance Maladie, were available, they cover a very small proportion of Rwanda's population. The CBHIS took central stage in Rwanda's strategic health plan to achieving universal coverage, with the majority of the population (90 per cent) enrolling in it (Nyandekwe, Nzayirambaho and Kakoma 2014). According to Nyandekwe, Nzayirambaho and Kakoma (2014), a considerable number of factors underscore Rwanda's commitment to the attainment of UHC. These include, among others, first a long-term strategy, Vision 2020, with strategic social protection through universal access to health care promulgated in the year 2000. Second, Rwanda's Politique Nationale de Développement des Mutuelles, promulgated in 2004. Third, Law No: 62/2007 of 30 December 2007, declared in March 2008, which

states categorically that all Rwandan residents must be affiliated to a health insurance scheme that provides quality health care (Rwanda Ministry of Health 2010).

Lessons learned

A number of lessons were learned from the three countries studied. These included the amalgamation of existing health insurance plans into smaller and manageable numbers. For example, in Thailand, a considerable number of existing schemes were merged into three, which cover different population segments of the country, yielding population coverage of 85 per cent. In the same way, in Rwanda, a large number of CBHISs were harmonised into two categories and the two categories cover about 90 per cent of the entire population. Second, in all three cases, there was strong government commitment. For instance, a range of legal frameworks were passed to support the universal coverage agenda, including mandatory health insurance, and strong financial commitment to universal access through tax revenue. Third, all three adopted a 'bottom-up' approach, establishing insurance first for low-income informal workers and rural dwellers and then graduating to high-income formal workers. This method increased the pace of achieving universal coverage in the three studied countries.

Conclusions

The 'top-down' approach adopted by Nigeria's NHIS was fraught with pitfalls. However, the success story of UHC in Germany, Thailand and Rwanda was predicated on a 'bottom-up' approach. In addition, evidence from the selected countries explored shows strong government commitment, by making health insurance mandatory and supporting the scheme with tax revenue, especially for the poor. The lessons from the three countries studied could contribute to the debate on expanding coverage in Nigeria. By adopting mandatory coverage for the entire population, coalescing existing programmes/plans, equalising risk between the programmes/plans and allocating tax revenue, Nigeria could provide basic health care for all.

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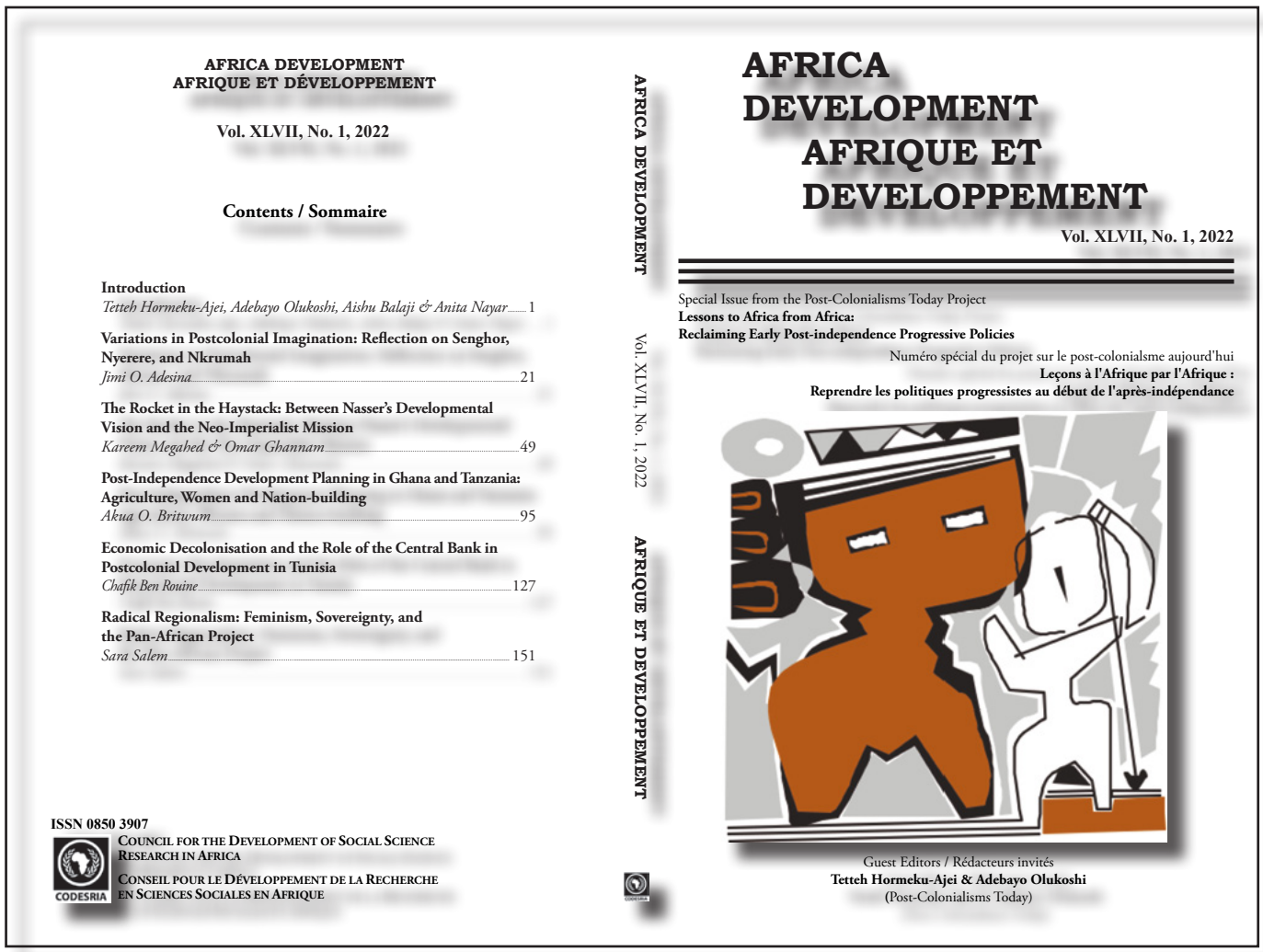

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