Achieving universal health coverage in Nigeria: The National Health Insurance Scheme as a tool

Eno Ekaete Usoroh

Nigeria

48th International Course in Health Development

September 19, 2011 – September 7, 2012

KIT (Royal Tropical Institute)

Development Policy & Practice/

Vrije Universiteit Amsterdam

Achieving universal health coverage in Nigeria: The National Health Insurance Scheme as a tool

A thesis submitted in partial fulfilment of the requirement for the degree of Master of Public Health

By

Eno Ekaete Usoroh

Nigeria

Declaration:

Where other people's work has been used (either from a printed source, internet or any other source) this has been carefully acknowledged and referenced in accordance with departmental requirements.

The thesis "**Achieving universal health coverage in Nigeria: The National Health Insurance Scheme as a tool**" is my own work.

Signature:-

48th International Course in Health Development (ICHD)
September 19, 2011 - September 7, 2012
KIT (Royal Tropical Institute)/ Vrije Universiteit Amsterdam,
Amsterdam, The Netherlands

September 2012

Organised by:

KIT (Royal Tropical Institute), Development Policy & Practice
Amsterdam, The Netherlands

In co-operation with:

Vrije Universiteit Amsterdam/Free University of Amsterdam (VU)
Amsterdam, The Netherlands

Table of contents

List of figures, tables and boxes v

List of figures v

List of tables v

List of boxes v

List of abbreviations and acronyms vi

Glossary of terms viii

Acknowledgement x

Abstract xi

Introduction xii

Chapter 1: Background Information on Nigeria 1

1.1 Geographical profile 1

1.2 Demographic profile 1

1.3 Socio-economic situation 1

1.4 Health and epidemiological profile 2

1.5 Overview of the health system 2

1.6 Overview of the national expenditure on health 3

Chapter 2: Problem statement, justification, objectives, methodology and limitations 5

2.1 Problem statement 5

2.2 Justification 5

2.3 Objectives 6

2.3.1 General objective 6

2.3.2 Specific objectives 6
2.4 Methods 7
2.4.1 Study design 7
2.4.2 Search strategy 7
2.4.3 Key words 7
2.4.4 Introduction of the conceptual framework 8
2.4.5 Description of the conceptual framework 9
2.5 Limitations of the study 11
Chapter 3: Study results and findings 12
3.1 What is universal health coverage? 12
3.1.1 Revenue collection 13
3.1.2 Revenue pooling 15
3.1.3 Purchasing/provision of services 17
3.2 Health financing history of Nigeria 18
3.2.1 Health financing in colonial and pre-independence era: 19
3.2.2 Health financing from 1960 to 1988: 19
3.2.3 Health financing beyond1988: 19
3.3 Health sector and health financing policy reforms in Nigeria 21
3.3.1 Health Sector Reform Policy Programme (HSRPP) 22
3.3.2 National Strategic Health Development Plan (NSHDP 2010-2015): 22
3.3.3 National Health Bill (2011) and the National Primary Healthcare Development Fund (NPHDF): 23

3.4 The National Health Insurance Scheme (NHIS) in Nigeria 24

3.4.1 Operational guide-line and current implementation................ 24

3.4.2 Assessment of the NHIS using the health financing performance indicators 26

3.5 Comparisons - Ghana and South Africa health insurance schemes 29

3.5.1 Ghana 29

3.5.2 South Africa 29

Chapter 4: Discussion.. 32

4.1 Governance 32

4.2 Health financing functions 32

4.2.1 Revenue collection 32

4.2.2 Revenue pooling 34

4.2.3 Purchasing/provision of services 34

4.3 Challenges - The NHIS institutional design and organization 35

4.3.1 Sufficient, equitable and efficient revenue collection................. 35

4.3.2 Financial accessibility.. 36

4.3.3 Efficiency and equity in purchasing/provision of services 36

Chapter 5: Conclusions and recommendations................................ 37

5.1 Conclusions 37

5.2 Recommendations 38

References... 41

Annexes 50

Annex 1: Geographical map of Nigeria showing 36 states, Abuja (Federal Capital Territory) and boundaries 51

Annex 2: Nigeria - Critical health and population indices 52

Annex 3: Analysis of the 2012 proposed general government expenditure 53

Annex 4: NHIS establishing decree no. 35 of 2999 55

Annex 5: NHIS Benefit package and exclusions................................ 59

List of figures, tables and boxes

List of figures

Figure 1 : Nigeria 2012 – Analysis of general government expenditure (GGE) 4

Figure 2: Three ways of moving towards universal health coverage 9

Figure 3: Basic components of the framework to guide health financing system reform. 10

Figure 4: Figure 4: Health financing functions. 18

List of tables

Table 1: Changes in consumption of alcohol following an increased excise tax (to at least 40% of the retail price) 15

Table 2: Nigeria – Selected ratio indicators for National Expenditure for Health (NEH), 1995 – 2010....21

Table 3: NHIS programmes and segmentation of the Nigerian population 24

Table 4: 3 Country comparisons – Selected ratio indicators for National Expenditure for Health (NEH), 2001 – 2005 31

List of boxes

Box 1: National Primary Healthcare Development Fund allocation 23

List of abbreviations and acronyms

AIDS	Acquired Immune Deficiency Syndrome
CBHI	Community-Based Health Insurance
CD	Communicable Diseases
FFS	Fee-For-Service
FMOH	Federal Ministry of Health
FMOI	Federal Ministry of Information
GDP	Gross Domestic Product
GGE	General Government Expenditure
GGHE	General Government Expenditure on Health
HFA	Health For All
HIV	Human Immunodeficiency Virus
HMOs	Health Maintenance Organizations
HSRPP	Health Sector Reform Policy Programme
LGA	Local Government Area
LGDH	Local Government Department of Health
MCH	Maternal & Child Health
MDG	Millennium Development Goals
NBS	National Bureau of Statistics
NCD	Non-Communicable Diseases
NCH	National Council on Health
NDHS	Nigerian Demographic Health Survey
NEEDS	National Economic Empowerment and Development Strategy
NHA	National Health Accounts

NHB	National Health Bill
NHIS	National Health Insurance Scheme (or The Scheme)
NHP	National Health Policy
NHS	National Health Service
NLC	Nigerian Labor Congress
NPC	National Population Commission
NUFFIC	Netherlands Organisation for International Co-operation in Higher Education
OECD	Organisation for Economic Co-operation and Development
OOP	Out-of-Pocket expenditure
PPM	Provider Payment Methods
PPP	Public Private Partnership
PPS	Provider Payment System
PvtHE	Private Expenditure on Health
RAP	Resource Allocation or Purchasing
SHI	Social Health insurance
SMOH	State Ministry of Health
TB	Tuberculosis
THE	Total Expenditure on Health
TISHIP	Tertiary Institutions Social Health Insurance Programme
VAT	Value Added Tax
WHO	World Health Organization

Glossary of terms

Capitation: "A payment method in which all providers in the payment system are paid, in advance, a predetermined fixed rate to provide a defined set of services for each individual enrolled with the provider for a fixed period" (Langenbrunner, 2009).

Enrollee: "In health insurance, an eligible person who is enrolled in a health plan or a member's qualifying dependent" (Segen, 2002).

Fee-For-Service: An agreed payment per service rendered to an enrollee by a health care provider (as opposed to per person capitation) (IMSA NHI, 2009).

Financial catastrophe: High out-of-pocket payments for health services in the presence of low household financial capacity and an absence of prepayment mechanisms lead to financial catastrophe. This high expenditure for health care result in households or individuals reducing or becoming unable to pay for necessities like food, clothing and even education of children (Xu et al, 2005).

Fiscal space: Heller's broad definition of fiscal space is "the availability of budgetary room that allows a government to provide resources for a desired purpose without any prejudice to the sustainability of a government's financial position. Usually, the idea is that in creating fiscal space, additional resources can be made available for some form of meritorious government spending" (Heller, 2005).

General Government Expenditure: The total amount expended by a government is the general government expenditure. It is a reflection of the total expenditure that the government needs to finance from revenues generated such as taxes, economic income and borrowed funds. Current government expenditure including purchasing goods and services, wage bill, national defense, security, health etc. is all included here (OECD, 2009 & World Bank, 2012).

General Government Expenditure on Health: This is "the sum of outlays by government entities to purchase health care services and goods. It comprises the outlays on health by all levels of government, social security agencies, and direct expenditure by parastatals and public firms. Besides domestic funds, it also includes external resources (mainly as grants passing through the government or loans channelled through the national budget)" (WHO, 2012).

Gross Domestic Product (per capita): "Gross domestic product per capita, is gross domestic product divided by the mid-year population. GDP is the sum of gross value of all resident producers in the economy plus any product taxes and minus any subsidies not included in the value of products. It is calculated without making deductions for depreciation of fabricated assets or for depletion and degradation of natural resources" (World Bank, 2012).

Health Maintenance Organisation: A corporate organization that facilitates the provision of preventive and other health care services to a defined group of enrollees, usually financed by pre-paid employer-employee insurance premium payments. Care is provided by participating health providers and all parties are bound by agreements (Jonas, 2005).

Per diem: A method of reimbursing a health provider based on a fixed rate per day rather than on actual charges. It is usually uniform irrespective of degree of care (Kongstvedt, 2002).

Private Expenditure on Health: "Private health expenditure includes direct household (out-of-pocket) payments, private insurance, charitable donations, and direct service payments by private corporations" (World Bank, 2012).

Provider Payment Methods / Provider Payment System: the mechanisms used to transfer payments for services rendered from the purchaser or a proxy to the health care provider are provider payment methods. A broader term is "the provider payment methods combined with all supporting systems, such as contracting, accountability mechanisms that accompany the payment method, and management information systems. Provider payment systems accomplish far more than simply the transfer of funds to cover the costs of services" (Langenbrunner, 2009).

Public Private Partnership: "A public private partnership (P3) is a legally-binding contract between government and the private sector for the provision of assets and the delivery of services that allocates responsibilities and business risks among the various partners. The goal is to combine the best capabilities of the public and private sectors for mutual benefit" (Partnerships British Columbia, 2003).

Total Expenditure on Health: "This is the sum of public and private health expenditure and covers the provision of health services (preventive and curative), family planning services, nutrition activities and emergency aid designated for health. It does not include provision of water and sanitation" (World Bank, 2012).

Acknowledgement

I wish to thank everyone who has contributed to the production of this body of knowledge, especially as I cannot name you all. I thank especially the Netherlands government for the fellowship offered to me by her agency (NUFFIC) to undertake this 12 months master's programme in public health. This period has been life-changing for me and marks a water-shed in my medical career.

I thank the federal government of my country, Nigeria for the launch of our National Health Insurance Scheme in 2005. That year witnessed a shift in my public health career and served to create jobs and a new career path for young professionals like myself in health policy, management and finance.

My sincere gratitude goes to my thesis advisor and back-stopper for their relentless efforts and patience with me. They have been instrumental in my ability to turn straw into gold; in producing my first academic book. I wish to thank the entire faculty and especially the KIT course coordinators – Zwanikken P, Gerretsen B, Kane S, van den Berg Y, Maldonado F, de Groot S, Molenaar M and Sahebdin R, for all their support (both academic and social) throughout the rigorous academic year. Many thanks also to the ICHD 2011-12 cohort for making the KIT experience a unique one!

Special thanks go to all my tutors both internal and external, especially those who lectured us in health economics, policy and finance. Most memorable are Prof. Ok Pannenborg, Ms. Maria-Pia Waelkens, Dr Nimnath Withanachchi and Dr Jurien Toonen, who shared his vast knowledge of health insurance with me.

My families, both here and at home have been most supportive and I can only thank them profusely for believing in me. Thank you Dolly Afun-Ogidan, Dr Rakiya Usman & family, The Inangas, The Ibeaghas, The Folamis, Pastor Abarshie & Jesus House Redeemed Church, Amsterdam. To The Usorohs, Udoenohs, my parents - Prof. & Mrs Ukoyen, my siblings - Adia, Curtis, Una, Osoro, Otu, Glory, Essien, Adaeze & Emem; thank you for your love and prayers. To my three favorite "boys": beloved sons Ini-Abasi & Itoro-Obong, and darling husband Aniekan-Abasi; I love you very much and will be home soon. Thank you for your patience.

Finally I wish to thank my Almighty Father, Redeemer and King for causing the lines to fall unto me in pleasant places. I return all the glory back to You. I am eternally grateful for this once in a life-time opportunity to get my master's degree. It has been a long time coming. Thank You Jesus.

Abstract

Introduction: The start of the 21st century witnessed a renewed effort at health sector and health financing policy reforms in Nigeria. The National Health Insurance Scheme (NHIS), which commenced in 2005, is the most notable of these reforms. Despite these efforts, many Nigerians are yet to feel the impact and Nigeria is faced with the challenge of expanding the NHIS to cover the large and mainly poor informal sector.

Methods: Literature review

Findings: Nigeria is far from achieving universal health coverage seven years after the NHIS commenced. The scheme is yet to extend significant coverage to the larger and mainly poor informal sector. It is voluntary for Nigerians and estimated coverage is 5% in 2011. No concerted efforts have been made to raise and allocate funding for the informal sector SHI programmes and out-of-pocket payments for health is high.

Conclusions: Nigeria's slow progress towards achieving universal health coverage is mainly due to lack of good governance, inadequate funding for the health system, poor stakeholder participation, and challenges of human and infrastructural capacity.

Recommendations: Review the NHIS Decree making the scheme mandatory, and increase government stewardship of health financing policy reform implementation. Make transparency and accountability the watch-word in tackling innovative revenue generation and allocation of funds to the health sector and NHIS. Ensure community and stakeholders' participation to grow the scheme. Build capacity across the health system.

Keywords: Nigeria, national health insurance scheme, social health insurance, universal health coverage and health financing.

Word count: 11,288

Introduction

The National Health Insurance Scheme (NHIS) in Nigeria where I have functioned as a health services/ quality assurance manager is an emerging sector in the health system. For the past six years before enrolling for the ICHD, I worked as a pioneer staff of one of the Health Maintenance Organisations (HMO), the private sector partners in implementing the scheme. In Nigeria, successive governments realized the need to structure the funding of health care services as one of the ways to improve health care provision (Gilbert et al 2009). By 1999, the NHIS was established under decree no. 35 by the government and the first phase rolled out in 2005 (NHIS Decree 1999 & NHIS 2012b). The mandate of the scheme is "to provide easy access to qualitative, equitable and affordable healthcare via various pre-payment mechanisms" (NHIS Decree 1999). Ultimately, universal health coverage should be achieved by 2015 (NHIS Decree 1999). Notably, seven years after its establishment, mainly the formal sector social health insurance scheme has commenced (Lawan et al, 2012). The large and mainly poor informal sector of the population remains largely excluded despite the existence of a roll-out operational guideline to achieve nation-wide enrolment (Lawan et al, 2012).There remains a challenge to extend the scheme to those who need it the most in Nigeria.

Insurance is a tool for healthcare financing that comes in different models. These different models are in use by many countries to fund healthcare. Evidence shows that insurance is a useful and sustainable means for financing the structure and delivery of healthcare world-wide. (Gottret et al, 2008 & Okma et al, 2010). This thesis is a literature review that aims to describe the evolution of health financing policies for funding basic health services across all social levels in Nigeria. In addition, I will critically analyse the operational guide-line, and current implementation, and assess the performance of the NHIS in establishing a nation-wide programme. Comparison of successfully implemented health insurance schemes in similar middle income countries will also be made and policy implementation analyzed. The analysis and discussion will be structured around the World Health Organization (WHO) **O**rganizational **AS**sesment for **I**mproving and **S**trengthening (**OASIS**) health financing conceptual framework (Carrin et al, 2008; Mathauer & Carrin, 2010). Based on my findings, I will make recommendations to the government and key stakeholders to make appropriate changes and strengthen existing strategies.

Chapter 1: Background Information on Nigeria

1.1 Geographical profile

Nigeria is a country in West Africa, officially known as the Federal Republic of Nigeria. She consists of the Federal Capital Territory (FCT) in the city of Abuja, 36 states comprising 774 local government areas (LGA) and is divided into 6 geo-political zones administratively. Covering a total area of 923,768 sq km, she is the 32nd largest country in the world and the 14th largest in Africa. The climate is humid sub-tropical with wet and dry seasons. She is bound in the north by Niger Republic, the south by the Atlantic Ocean, the east by Republic of Cameroon and in the west by Benin Republic (FMOI, 2012). (see **Annex 1** for map).

1.2 Demographic profile

Nigeria is famous for her population size projected to be 168 million as at October 2011 according to the chairman of National Population Commission (NPC) (Oyedele, 2011). She has the largest population on the African continent, 7th largest worldwide and is also the largest homogenous nation of dark-skinned people (Wikipedia, 2012). According to the National Demographic Health Survey of 2008, the sex divide of Nigeria's population indicates a marginal male: female dominance of 51%:49%. She has a predominantly young population with the median age estimated at 19.4 years (NDHS, 2008. See **Annex 2** for critical population indices).

1.3 Socio-economic situation

Nigeria's natural resources include but are not limited to petroleum resources, tin, iron ore, coal, lead, zinc, hydropower and arable land. Successive governments have remained focused on the petroleum industry which accounts for 99% of foreign exchange income and about 80% of budgetary income (U.S Dept. of state, 2012). With a gross domestic product (GDP) corrected for purchasing power parity of $235 billion, Nigeria ranks 30th out of 192 countries on the GDP table. Petroleum wealth contributes about 39% of the GDP, with significant input from electricity, mining of other mineral resources, agriculture and banking (World Bank, 2012b). Interestingly, the highest GDP per capita was $2380 in 2010, averaging 11% worldwide. Despite her petroleum wealth, widespread corruption and poor resource management ensures that about 61% of Nigerians exist on less than $1 a day according to NBS, 2010 (as cited by UPI, 2012). Nigeria is ranked 156th out of 187 countries on the human development index (HDI) with a value of 0.459 (UNDP, 2012). She is classified as a middle income country (World Bank, 2012b).

1.4 Health and epidemiological profile

Nigeria is presently facing an epidemiological transition with the increasing emergence of non-communicable diseases (NCD) while communicable diseases (CD) remain the major causes of morbidity and mortality (WHO, 2010b). Annually, the Nigerian health sector grapples with some CDs of major public health concern. They include diarrheal diseases, malaria, respiratory tract infections, human immunodeficiency virus/acquired immune-deficiency syndrome (HIV/AIDS), tuberculosis (TB), cerebro-spinal meningitis, cholera, measles and (WHO, 2009)**.** NCDs like cardiovascular conditions, diabetes mellitus and cancer are beginning to increase the burden of disease in the country as the disease prevalence and mortality resulting from them continues to rise (WHO, 2009 & 2010b). Considerable morbidity and mortality is attributed to road traffic accidents annually and they also cause some public health concern (Chidoka, 2011). The populous country has poor health indices, some of the poorest in the world (See **Annex 2** for critical health indices).

1.5 Overview of the health system

The Minister of health heads the National Council on Health (NCH) which coordinates the activities of the federal and state ministries (FMOH/SMOH), and health agencies including the NHIS. Health care is delivered by public and private sector providers who are regulated by the ministries, and local government departments of health (LGDH). Broadly, the providers use modern and traditional (including faith-healing) methods of health care delivery (FMOH, 2004). Public hospitals include federal government administered tertiary hospitals which are mainly university teaching hospitals, federal medical centres and other specialist hospitals (e.g. orthopaedics hospitals, neuropsychiatry hospitals and national hospital). Others are state-owned general hospitals, government owned staff hospitals and clinics, LGA health centres and village health posts (FMOH, 2007). International non-governmental organizations also partner with the public sector in delivering some vertical health services like TB control, malaria control and HIV/AIDS programmes (JCIE, 2009).

The private health sector has evolved into a serious player in healthcare services delivery, especially in urban areas. They are generally split into for-profit and not-for-profit organizations and can be found in all major cities and towns nationwide. They vary widely in structure and include traditional healers, patent medicine vendors, retail pharmacies, maternity homes, company clinics, sole or group owned private general and specialist hospitals, local non-governmental hospitals, and faith-based organization general and specialist hospitals (Ogunbekun et al, 1999). About two thirds (2/3) of the population are rural dwellers and there is a wide disparity in access to basic amenities and priority health services between rural and urban populations.

The health system, like the rest of Nigerian public systems is plagued by inadequate budgetary allocations, inefficiency and inequity in distributing available resources, rapid population growth, emergence of new diseases especially HIV/AIDS pandemic, and persistence of old diseases (Abdulraheem et al, 2012). The rural dwellers also account for the bulk of the informal sector group. This informal sector is largely poor and has a higher risk of suffering impoverishment as a result of catastrophic expenditures for health. The Nigerian public health system fails to adequately provide good health services and those who need it the most are usually unable to pay for what is available (Lawan et al, 2012).

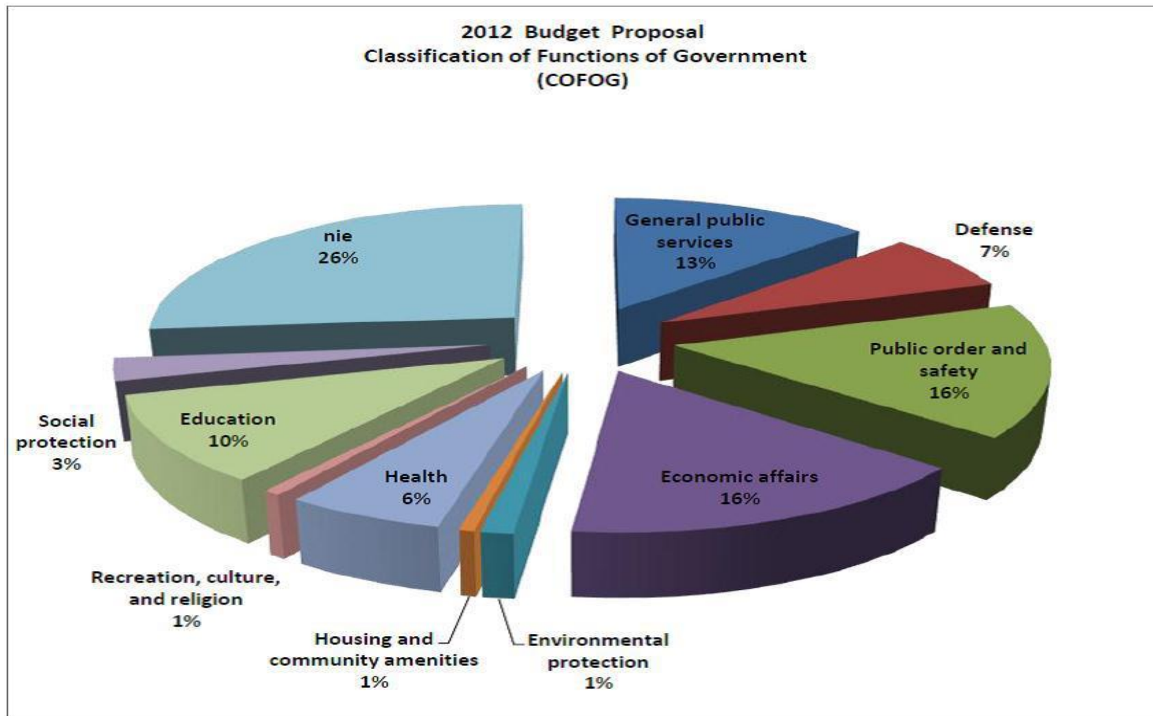
1.6 Overview of the national expenditure on health

An overarching issue preventing quality health care delivery in Nigeria is the inadequate general government expenditure on health (GGHE) as a percentage of the government general expenditure (GGE) (WHO, 2012b). Proposed GGHE as a percentage of the GGE is 6% for 2012 - **see Figure 1**. A proposed 26% of the budget not identified elsewhere (NIE) includes a hefty 12% for servicing of debts (see **Annex 3** for analysis of the 2012 proposed GGE).

This is not in keeping with the agreement of the African Union's (AU) Abuja Declaration of 2001 (appropriating 15% of the government's budget for health) which ironically held in Nigeria (African Union, 2001). In absolute figures, the Nigerian government's total expenditure on health (THE) has risen from $4.3 billion in 2003 to $10.5 billion in 2009; however as a percentage of the GDP, it actually fell from 7.5% in 2003 to 5.8% in 2009 THE as a percentage of the GDP fell further to 5.1% in 2010. In that year, the government contribution was 37.9% as GGHE, while private expenditure on health (PvtHE) as a percentage of THE was 62.1%. OOP expenditure on health was high at 95.3% of the PvtHE (WHO, 2012b). Clearly the people contribute more than half of THE and bear the brunt of health financing in Nigeria.

The fall-out of a non-focused approach to health-care financing in Nigeria is the continual struggle of more than 60% of Nigerians to pay health care bills and the country's health indices continue to plummet. Existing health financing options for Nigerians are fragmented, comprising of pockets of private and community health insurance schemes and the NHIS's social health insurance programme for the formal sector. These schemes are plagued by poor penetration, low acceptance and narrow benefit packages (Lawan et al, 2012).

Figure 1 : Nigeria 2012 – Analysis of proposed general government expenditure (GGE)



Source: Budget Office, the Presidency, Nigeria. 2012

Chapter 2: Problem statement, justification, objectives, methodology and limitations

2.1 Problem statement

Data from the NHIS in 2011 shows 5% of the population are registered on the scheme (NHIS 2012b). Majority of those covered are in the employment of the federal and state governments and live in the urban areas (Lawan et al, 2012). More than 60% of Nigerians belong to the informal sector and live in rural areas on less than $1 a day (as cited by UPI, 2012). They cannot afford good quality health care, yet have limited financial access when faced with health challenges. OOP financing of health, remains high at 95.3% of the PvtHE in 2010 (PvtHE as a percentage of THE was 62.1% in 2010), and usually has a catastrophic effect on the poor. Many Nigerians have lost their lives due to their inability to meet this need (Lawan et al, 2012). NHIS are usually designed to significantly cater for the welfare of the citizens and especially the less privileged in the society (Kutzin, 2001). The scheme has been in operation since 2005 and the target date for achieving universal health coverage is 2015. The World Health Report (WHR) of 2010 has noted that countries that depend on OOP payments for health will be unable to achieve universal health coverage (WHO, 2010).

2.2 Justification

The NHIS in Nigeria like in other middle income countries has the potential to be a successful health financing model. In a nation of roughly 168 million people, available data shows that the scheme only provides cover for about 7 million people (NHIS, 2012b). In Nigeria, there is a past trend of ineffective implementation of government schemes. This has informed a general negative perception and attitude among the people towards such schemes regarding their success, effectiveness, and sustainability. The AU Abuja declaration of 2001 recommended a budgetary allocation of at least 15% of the GGE to improve the health sector. This agreement has not been met by the Nigerian government and the proposed GGHE for 2012 is 6 % (Presidency Nig, 2012). Good governance has been lacking in implementing health sector and other social schemes, and funding the health system.

Research carried out in other developing countries shows that four out of five cases of bankruptcy are due to mounting or catastrophic health care bills (Gottret et al, 2008). High costs of medical care, especially when hospitalization is needed, are a burden that can tip individuals and their families into financial catastrophe (Xu et al, 2005). This is a situation that many similar socially and economically constructed countries like China, Taiwan, Chile, Brazil, South-Africa and near-by Ghana are taking concrete steps to eliminate through a well-structured healthcare financing system (Gottret et al, 2008 & Okma et al, 2010).

Nigeria, like these countries recognises health and access to health care as a fundamental human right and this must be translated into efficient and effective implementation of the NHIS. Fortunately, the NHIS has been launched with an operational guideline that clearly segments the population and outlines the implementation of the scheme for the different sectors. This is in keeping with the 2015 target for overall country development of the Millennium Development Goals (MDG) agreed to by all UN member states. MDG 4, 5 and 6 are directly linked to improved health care delivery and health systems (Presidency, 2010). Additionally, the scheme has been structured as a Public-Private Partnership (PPP) (PBC,2003). The private sector in Nigeria is generally viewed favourably with visible success stories in oil and gas, telecommunications and banking. With three years to 2015, less than 10% of the population are benefitting from the scheme. It is unlikely the target of 2015 will be met but Nigeria should still aim to attain universal health coverage. This thesis is a critical analysis of Nigeria's health financing policies and the NHIS implementation in order to make recommendations to the government and key stakeholders. Achieving universal health coverage with the NHIS as a tool will ultimately improve the health situation of Nigerians.

2.3 Objectives

2.3.1 General objective

To describe Nigeria's history of health financing policies for funding basic health services across all social levels; critically analyse the functioning of the NHIS and assess its performance, and compare alternative and complimentary health insurance policy implementation from two similar countries in order to make recommendations to achieve universal health coverage for Nigerians using the NHIS as a tool.

2.3.2 Specific objectives

1. To describe the evolution of health financing policies for funding basic health services across all social levels in Nigeria;
2. To critically analyse the operational guide-line and current implementation, and assess the performance of the NHIS;
3. To compare health insurance schemes of two similar middle income countries (in Africa) in order to identify alternative and complimentary policy implementation;
4. To make recommendations to the government and key stakeholders for achieving universal health coverage using the NHIS as a tool.

2.4 Methods

2.4.1 Study design

This thesis is a descriptive study based on literature review. It examined available data on the evolution of health financing policies for funding basic health services across all social levels in Nigeria. Data on the establishment and current implementation of the health insurance scheme in Nigeria and other middle income countries (Ghana and South Africa focused on for comparative analyses) were searched and analysed. Previous studies and reviews on health insurance schemes and achieving universal health coverage were studied in-depth**.** I also explored different policies and solutions proffered by various stakeholders. I used the **OASIS** approach developed by the World Health Organization's (WHO) department of health systems financing as a framework to assess the performance of the NHIS. Additionally, it guides my presentation of a critical discussion on an efficient and effective way to achieve universal health coverage within the context of the Nigerian health system.

2.4.2 Search strategy

The NHIS Website, Scopus, World Bank and World Health Organisation (WHO) database, Pub Med and Google Scholar were all accessed to review published literature. Royal Tropical Institute (KIT) and Vrije university libraries were also utilized for easy access to published works and other sources of information. I made use of unpublished works including country reports and guidelines where available. Expert opinion of authorities on health insurance was also sought and incorporated. Inclusion criteria were English language, studies from Nigeria and other middle income countries. Journal articles with only abstracts available were excluded due to the limitation of the incomplete information contained. Limitation of data collection was based on saturation of the data collected.

2.4.3 Key words

Various combinations of the following key words were used as a search strategy for literature for the review. Nigeria, national health insurance scheme, social health insurance, universal health insurance, universal health coverage/universal coverage, community-based health insurance, private health insurance, formal sector, informal sector, health financing, out-of-pocket expenditure for health, millennium development goals, basic health services, basic health package and middle income countries.

2.4.4 Introduction of the conceptual framework

The conceptual framework I used for my discussion is focused on an implementation guideline developed by the WHO's department of health systems financing. It is the **OASIS** approach: **O**rganizational **AS**sesment for **I**mproving and **S**trengthening health financing and is complementary to the WHR 2010 on health systems financing (WHO,2010). The approach is applicable to all countries and will provide practical guidelines for identifying appropriate country strategies for a health financing system in order to achieve the set goals. These options should be structured to enhance health financing performance and eventually position the health system to achieve and maintain universal health coverage (Carrin et al, 2008; Mathauer & Carrin, 2010). The concept is presently a front-burner topic in on-going discussions about health insurance, and the WHR 2010 "Health systems financing: the path to universal coverage" focuses on it (WHO 2010).

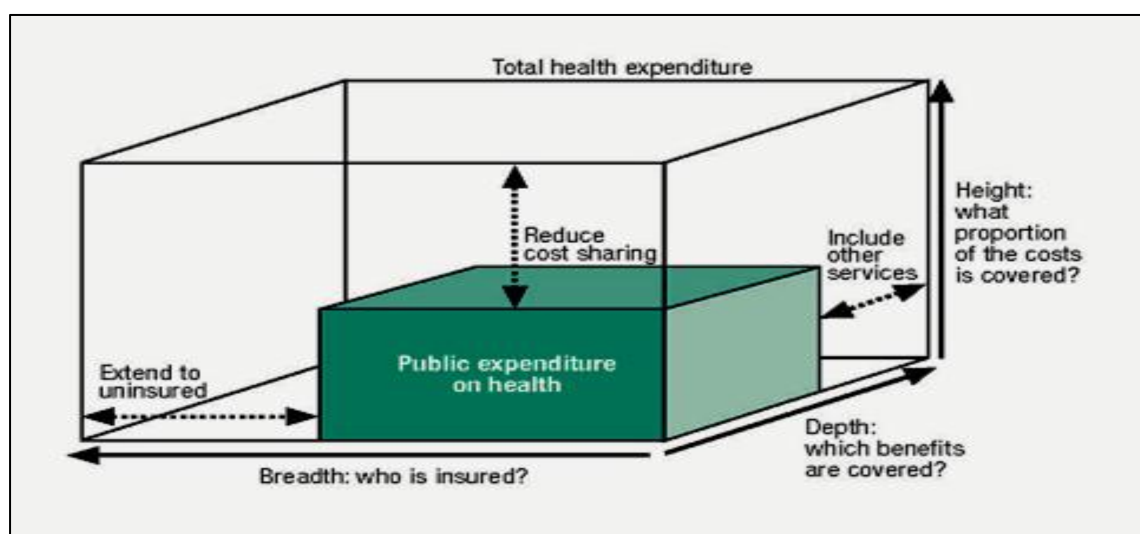
The Nigerian government has used several techniques in the past to finance health care delivery and achieve health for all (HFA), or universal health coverage with little success (Asoka, 2011). In 2005 its latest effort, the NHIS was launched and implementation is on-going (NHIS, 2012a). An NHIS that aims to achieve universal health coverage can only do so within the context of the Nigerian health system. Any reforms and policies therefore must be tailored to be sustainable within the constraints that abound in the system. Nigeria has diverse social, economic and political problems that affect all aspects of our national institutions and it is important to consider them on the pathway to universal health coverage (Asoka, 2011). In order to achieve universal health coverage, the following three health financing functions must be in full operation. These three dimensions illustrated in **Figure 2** describe the three financing functions as follows:

Height: What proportion of the costs is covered? This is a function of the revenue collection and entails sufficient quantities of financial contribution collected in an efficient and equitable manner.

Breadth: Who is insured? Revenue pooling determines the extent of the population covered, providing financial accessibility for all those to be covered from the collected funds such that the cost of accessing health services is shared by all. Individuals no longer have to make OOP payment for health care when they fall ill.

Depth: Which benefits are covered? This is the function of purchasing/provision of healthcare services. Efficient and effective health interventions are purchased using the pooled funds in the most equitable ways. This includes matching services to providers, and employing cost-containment strategies while using an appropriate mix of provider payment systems (PPS).

Figure 2: Three ways of moving towards universal health coverage



Source: World Health Report 2010; "Health system financing: a path to universal coverage" (WHO) 2010

2.4.5 Description of the conceptual framework

OASIS reviews and assesses the three health financing functions of collection, pooling, purchasing/provision. Attention is also paid to stewardship function in health systems and the approach is characterized by its focus on institutional design and organizational practice of health financing. The formal rules which include legal and regulatory provisions that relate to health financing are the institutional design. Organizational practices encompass implementation and compliance with these rules by all stakeholders in the health financing system. The whole process of health financing reforms includes development and enforcement of appropriate legislation, ensuring capacity in accountancy, actuarial analysis, banking and information management. It also includes community participation, health provider participation (both public and private sector), as well as monitoring and evaluating the process.

The specific goals of the **OASIS** approach are to:

- Review a health financing system and describe its weaknesses and strengths;
- Use health financing performance indicators to assess the performance of a health financing system and specific schemes. The 9 generic performance indicators are:

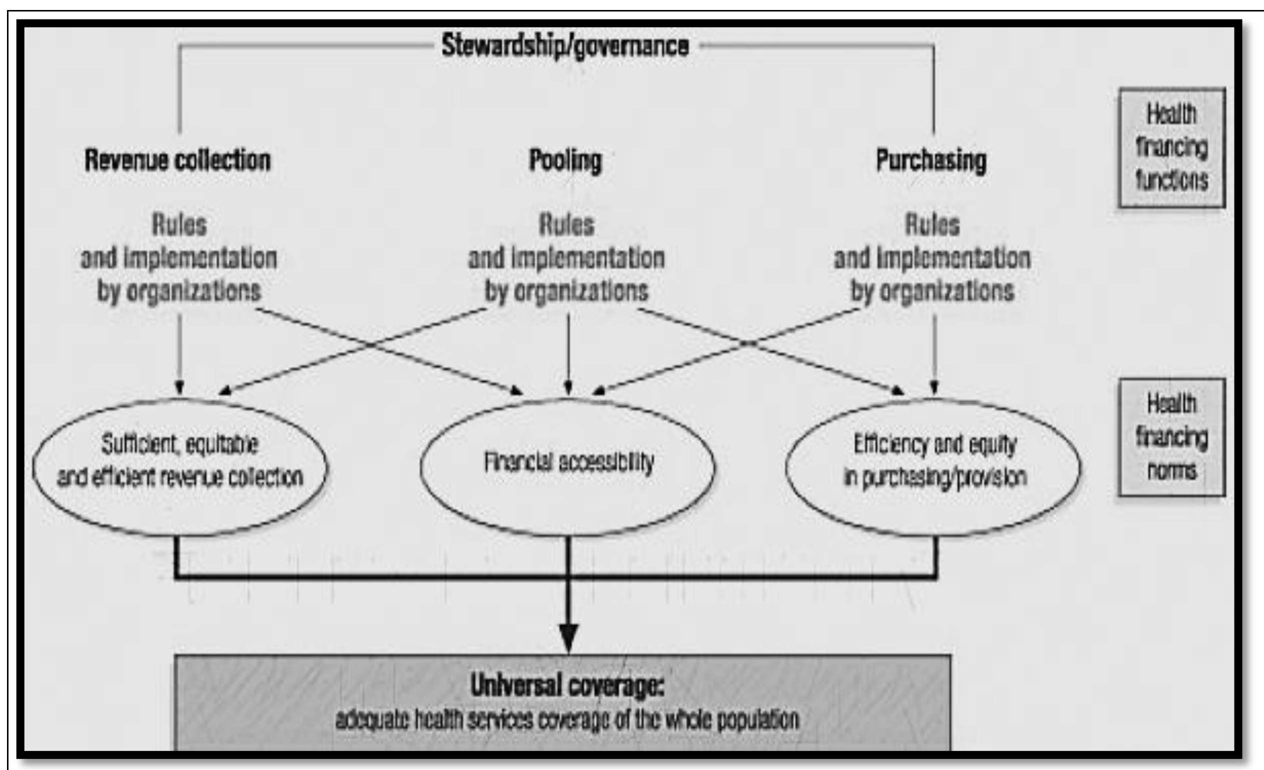
i. Level of funding;
ii. Level of population coverage;
iii. Level of equity in health financing;
iv. Level of pooling across the health financing system;
v. Degree of financial risk protection;
vi. Level of operational efficiency;

vii. Degree of cost-effectiveness and equity considerations in benefit package definition;
viii. Level of equity in delivery of a given benefit package at a given level of quality standards;
ix. Level of administration efficiency.

- Obtain a clear picture of the reasons for poor or good performance by identifying bottlenecks in institutional design and operational practice;
- Inform policy and develop options to improve and make appropriate changes where necessary in institutional design and organizational practices.

The **OASIS** approach will be used to analyze the performance of the NHIS in providing basic health services for Nigerians. As shown in **Figure 3** below, governance and its stewardship role are vital in steering the interaction of the 3 health financing functions and norms to achieve universal health coverage. It will serve as a framework for making recommendations on the path to increasing health financing performance and achieving universal health coverage using the NHIS as a tool.

Figure 3: Basic components of the framework to guide health financing system reform.



Source: Universal coverage of health services: tailoring its implementation. Bulletin of the WHO, no. 11. Nov 2008

2.5 Limitations of the study

The NHIS is a new scheme in Nigeria and there is limited literature evaluating its performance. Official information about utilization of services offered by the scheme is not available and figures from the different health providers and HMOs are not easy to harmonise. The data on population covered by the NHIS is also not current. The literature review carried out for this thesis is based on secondary data from unpublished literature, published papers and reports. Therefore, any errors that occurred in the primary data collection process, analysis and interpretation may have affected the reliability and validity of my work.

Chapter 3: Study results and findings

3.1 What is universal health coverage?

In advocating for the attainment of universal health coverage, it is important to define the concept and outline the means to attaining it. The Director-General of the WHO strongly recommends universal health coverage (or universal coverage) to all countries of the world. She encourages countries to aim for universal coverage which is a feasible and admirable goal for all nations. She stated in her preface to the 2010 world health report that "All countries, at all stages of development, can take immediate steps to move towards universal coverage and maintain their achievements" (WHO 2010). Universal coverage describes the organisation of health care systems that provide a specific benefit package to all members of a defined society. The aim of such organisation is financial access to necessary health services, and provision of financial risk protection in order to improve the health outcomes of the population (WHO 2010). Health care needs are infinite; certainly universal coverage does not imply coverage of all health services for everybody. The health benefit package must be defined and is determined by the three dimensions of health financing functions (Carrin et al, 2008):

i. How much of the cost is covered (revenue collection).

ii. Who is covered (revenue pooling).

iii. What services are covered (purchasing/provision of services).

Both rich and poor countries recognise the importance of robust policy and implementation guidelines for financing health care. Due to the global economic melt-down, countries must increasingly look for ways to improve efficiency in health financing as a matter of urgency as health care costs continue to rise, and new and more expensive treatments become available (Kutzin, 2001). In Nigeria, a changing epidemiologic profile with the double burden of increasing non-communicable diseases and persisting communicable diseases increases this sense of urgency (WHO, 2010b). Universal coverage as a form of health care delivery has been achieved in various forms across the world (Gottret et al, 2008). Germany has the oldest universal health system in the world, courtesy of Otto von Bismarck's social legislation in the 19th century. The Health Insurance bill was passed in 1883 and the programme was established to provide compulsory national insurance against sickness for the majority of the German workforce. In the United Kingdom, the National Insurance Act of 1911 paved the nation's path to provision of universal health care. This initial scheme which covered most employed persons and their dependants gave way to the National Health Service (NHS) in 1948 and extended financial protection for health care to all legal residents (Gottret et al, 2008).

Many other countries also carried out deliberate health care reform processes in the years after the 2nd world war in their bid to implement universal systems of healthcare (Gottret et al, 2008). Everyone has the right to the highest attainable standard of health and this is recognised in the Universal Declaration of Human Rights (UN, 2012) and the constitution of WHO (WHO, 2012c). Stewardship and good governance are necessary to establish sufficient, equitable and efficient revenue collection, pooling of funds to ensure financial accessibility, and efficiency and equity in purchasing/provision of services (Ogbimi, 2007). The development of health financing policies that guide the functions of collection, pooling and purchasing cannot be separated from the context of a government's available fiscal space (Tandon & Cashin, 2010). Sustainability of such policies can only be guaranteed within the context of a government's budgetary ability to provide earmarked resources for health without compromising its financial position (Heller, 2005). Achieving universal coverage may be a long-term goal, yet requires a well-defined strategy which must be outlined from the onset (WHO, 2010).

3.1.1 Revenue collection

Revenue collection for health insurance schemes can come from three major sources.

Government budgetary allocation for health: The African Union (AU) in its 2001 Abuja Declaration recommended that all member states appropriate 15% of the annual budget for health (African Union, 2001). An agreement like this is a useful strategy to adopt as many times, governments give relatively low priority to health when allocating their budget. Liberia (16.6%) and the United Republic of Tanzania (18.4%) are exemplary among the AU member states (WHO, 2011). Nigeria has gone from 12.5% (2003) and 8.6% (2005) to 6% in 2012 (WHO, 2012b). Governments can increase their budgetary allocation by improving efficiency in collection of revenue. Countries with more formalized economies and tax administration; where a good number of individuals and businesses pay taxes, have an increased revenue-raising capacity (Gottret et al, 2008).

As much as 32% of their GDP is raised from government revenues in high-income countries. Middle-income countries like Nigeria raise about 23% of the GDP this way, while low-income countries raise about 18%. This limits the ability of middle to low income countries to finance public services (Gottret et al, 2008). The Nigerian government however, is over-dependent on revenue from petroleum resources, making her a mono-economy nation (World Bank, 2012b). Efficient collection of pre-paid health insurance contributions further increases the ability of governments to collect and earmark funds for health (Gottret et al, 2008).

These contributions can take the form of pay-roll deductions from the formal sector (already in use by the Nigerian formal sector social health insurance scheme), voluntary contributions or premium pre-payment from the informal sector (NHIS, 2012B).

Innovative financing for health: Though raising overall general government revenues will translate into more money for health, new means of raising direct funds for health are also needed. In September 2008, the Taskforce on Innovative International Financing for Health Systems was set up and focused on financial innovations for health system strengthening in order to attain the MDGs in 49 low income countries. The title of the taskforce report "More money for health, and more health for the money" is in keeping with their agreed definition of innovative financing. This includes mechanisms designed to raise funds in excess of conventional means as well as mechanisms that improve how these funds are used (Le Gargasson, 2010).

The mechanism includes increased taxes on foreign exchange transactions, air tickets, and tobacco. The so-called excise, value-added (VAT) or "sin taxes" already exist in many countries on products like alcohol and tobacco (products that pose risks to health). Some countries plan to extend taxes to include unhealthy foods such as sweets, sugary drinks and foods high in salt and trans-fats. Evidence shows that as these taxes increase, consumption level of these products fall. Further possibilities for innovative fund-raising for health include solidarity levies on a range of products and services (Stenberg, 2010). Feasible examples are mobile phone call tariffs, diaspora bonds, luxury taxes on high-end products and possessions, and taxing specific profitable sectors of the economy. **Table 1** shows the estimated increase in income generation for countries after an increase in excise tax on alcohol.

Table 1: Increase in revenue generation following an increased excise tax on alcohol (to at least 40% of the retail price)

Country categorization	No. of countries	Estimated excise tax revenue ($ million)	
		Current rate	*If increased to at least 40% of the retail price*
By alcohol consumption level			
Low (<5 litres per capita)	13	8%	15%
Mid (5-10 litres per capita)	10	5%	16%
High (> 10 litres per capita)	19	6%	22%
By income level			
Low income	12	4%	11%
Middle income	12	9%	19%
High income	18	6%	23%
All countries	42	6%	18%

Source: Adapted from Centre for science: Alcohol Excise Taxes in Maryland: A Case for an Increase 2004

Development aid for health: A good deal of the recent increases in development aid for health have been focused on Africa, especially as funding for vertical programmes for specific diseases. Over $10 billion was released in 2003 as aid. MDG 4, 5 and 6 are directly linked to improved health care delivery and health systems and there is a renewed commitment of the European Union and Group of Eight nations to assist lower income nations to meet the MDGs generally (Gottret, 2006). As of 2010, external sources of funds as a percentage of THE for Nigeria is less than 10% (WHO, 2012b).

3.1.2 Revenue pooling

Sufficient revenue collection for health financing is very important, but this is not enough to achieve universal coverage. The earmarked resources must be efficiently and effectively pooled and allocated to purchasing of services. Pre-payment is critical in this wise, so also is the sustainability of the risk pooling. Pre-payment allows the establishment of health insurance whereby the beneficiaries pay a predetermined amount (or have the amount paid on their behalf) and are protected against future unpredicted health care expenses. This pre-payment also serves as a means to utilize more efficiently the high levels of OPP for health common in middle income countries like Nigeria (Gottret, 2008). Four means are available to ensure effective risk pooling for more efficient and equitable purchasing of health services and each has its merits and de-merits.

Governments have adopted one method or a mix of the four, and based on equity, efficiency, sustainability, cost and feasibility of administration. Where more than one method is adopted, equity and efficiency are improved by avoidance of duplication of efforts and unnecessary fragmentation (Gottret, 2008). The revenue pooling mechanisms are as follows (Gottret, 2006):

National Health Service (NHS): This a state-funded system administered through the ministry of health or national health services. Universal coverage is compulsory and the service is nationally owned and funded via a general government revenue-based system. This system is very popular and is adopted by 106 of the 191 WHO member states, the United Kingdom being the foremost. This approach has substantial benefits for a government with a robust revenue base, adequate public sector managerial capacity, and positive acceptability of the governments' services by the public. However, problems of administrative capacity of the government ministry or health service, accountability, corruption, underfunding, and allocative inefficiency are common with this method, especially in low to middle income countries.

Social Health Insurance (SHI): This is compulsory universal or employment group-targeted insurance system financed by employee-employer payroll deductions. It is a social security programme which is designed to pool funds into several not-for-profit insurance funds or a single pool of funds which may be centrally administered. An equity fund from the government can also be created to supplement contributions for those not formally employed. Over 60 high to middle-income countries use this method including the old Dutch Ziekenfonds, Colombia, Philippines (recently) and most famously, Germany. It is a useful method for funding the health system where there is a large payroll contribution to protect purchasing of health care services, and efficiency can be improved through competition in purchasing services. The drawbacks of this method are the need for a large enrollee base as well as efficient supervision and administration of the funds. Only 27 of the 60 countries have achieved universal coverage (Rijneveld, 2006).

Voluntary or Private Health Insurance: Private funding can also increase funds for health financing through voluntary contributions. Employers or individuals can purchase health insurance services from private or public owners of healthcare services or use middle fund managers (e.g HMOs). The contributions are not usually income related or tax based. Voluntary contributions are generally useful to supplement other types of public insurance as individuals in low to middle income countries lack purchasing power. Also it requires complex regulatory structures and a well-developed financial market which may not always be present. In the Netherlands, voluntary private health insurance makes up the primary source of coverage of health costs in the new health insurance system (Rijneveld, 2006 & Van der Gaag, 2007).

Community-based Health Insurance (CBHI): This form of risk pooling has existed for a long time in many countries. It basically involves not-for-profit prepaid revenue collection with community control and voluntary membership. Other names for CBHI include micro-insurance, mutual health organizations, rural health insurance and community heath funds (Rijneveld, 2006). The usually smaller CBHI schemes have been used as building blocks in many countries with NHS, SHI or universal private voluntary insurance schemes. Since 2003, the Philippines government has involved CBHI to develop a national health insurance system. In many Sub-Saharan African and Asian countries, traditional risk-pooling and savings schemes form a natural platform for CBHI. In 2001, the WHO commission on Macroeconomics and Health issued a report that supports the use of CBHI. The key recommendation is that "OOP expenditures by poor communities should increasingly be channeled into community financing schemes to help cover the costs of community based health delivery" (Bennett, 2004). The beauty of such schemes is the fact that affiliation is community-based (geographic, religious, ethnic, vocational etc.), members often share common values and it serves to cater for those who would otherwise be excluded (Rijneveld, 2006). Ghana, Tanzania, India and Bangladesh are countries with robust CBHI schemes. Significant differences exist in implementing the four revenue pooling mechanisms though none is better or worse. Governments and health policy makers determine what best suits the country-specific institutional, cultural and economic norms and practices (Bennett, 2004 & Rijneveld, 2006).

3.1.3 Purchasing/provision of services

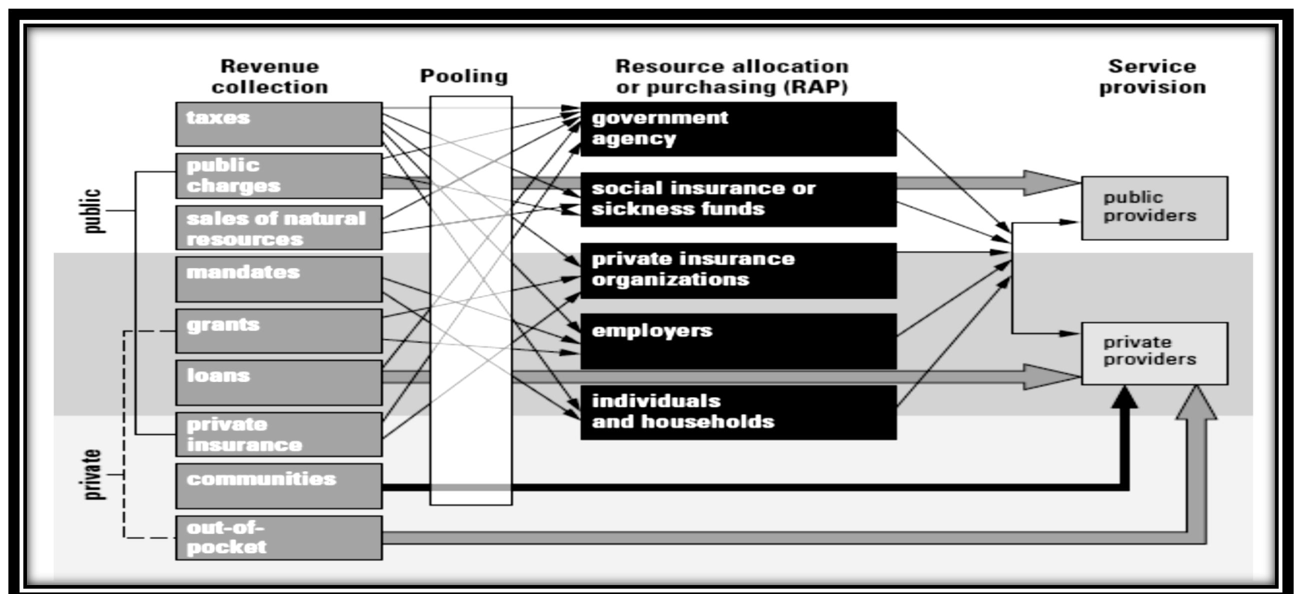
This third health financing function is of great importance for access to services, costing, quality and beneficiary satisfaction. It determines what services to purchase, from whom, for whom, at what cost and how to pay. Health services from public or private providers can be paid for using different pre- and post-paid PPM (Langenbrunner, 2009). Countries can use any combination of the RAP arrangements. There is no one-size fits all recommendations for countries on best RAP approaches. Technical and allocative efficiency gains made from adequate resource allocation or purchasing (RAP) further increase the pool of funds by providing better value for money and ensuring long-term financial sustainability of the scheme (Gottret, 2006). **Figure 4** demonstrates the interaction of the 3 health financing functions. There are various RAP arrangements which include the following.

Integration of purchasing and provision: Publicly owned facilities provide services for the NHS and are paid directly by the government from general revenues and sometimes insurance contributions.

Purchaser-provider split: Public and private facilities are paid directly by a separate health fund manager or government authority for purchased services on behalf of the beneficiary population.

Direct payments: Individuals pay the providers directly at point-of-service in various forms e.g. user fees, co-payments, administrative charges etc.

Figure 4: Figure 4: Health financing functions.



Source: Schieber & Maeda. "A curmudgeon's guide to financing Health in developing countries" 1997

3.2 Health financing history of Nigeria

The WHO has described the health system in terms of six building blocks which include: financing, service delivery, health workforce, governance, medicines and information (WHO, 2007). The Nigerian health system is decentralized by devolution into the federal, state and local government levels. Health care providers use modern or traditional (including faith healing) methods of health care delivery. Nigerians seek care from these providers, a-times doing so concurrently (WHO, 2010b). For clarity, this section will focus on the health financing history of modern health service delivery. Adequate health care has been recognised as a right and not a privilege, and ideally should be provided for Nigerians by the government based on need and not the ability to pay. Historically, health financing options for Nigerians has been fragmented and several attempts at health financing policy reforms have been made over the years. These reforms culminated in the formal launch of the NHIS in 2005.

The scheme commenced with the formal sector SHI programme, and informal sector programmes are yet to fully commence. The NHIS will be discussed in a separate section (NHIS, 2012b).

3.2.1 Health financing in colonial and pre-independence era:

The 1st Nigerian colonial development plan in 1946 regionalized the health system and lasted into the 1950s (Asuzu, 2005 & Orubuloye, 1996). Most public hospitals provided cost-free care for civil servants and their dependants while parallel church-owned hospitals provided care for the most needy in this period.

3.2.2 Health financing from 1960 to 1988:

Immediately post-independence in 1960, the 2nd and 3rd national development plans (by the 1970s) focused on building and expanding modern health facilities. No defined policy framework designated responsibilities including resource generation, development of human resources for health and service delivery between the 3 levels of government. Cost-free, tax-based care continued for all Nigerians under 18 years, civil servants and their dependants with subsidized services for the rest of the population till 1984 (Asuzu, 2005 & Orubuloye, 1996). Continuing attempts at improvement include the UN sponsored Bamako initiative of 1987 (Hardon, 1990), and introduction of the drug-revolving fund in 1988 (Uzochukwu, 2005). These 2 schemes achieved little success and government allocation of resources to the health sector dwindled in this period, ranging between USD 42-62 cents per capita or 1.6 – 1.9% of the GGE Orubuloye, 1996). This led to a rise in the general cost of health care and a decline in the quality of care offered by public hospitals. The private sector responded with a proliferation of hospitals and clinics and their charges were mostly exorbitant and out of reach of the poor and low income earners (Abdulraheem, 2012).

3.2.3 Health financing beyond1988:

Health for all (HFA) by the year 2000 was declared at Alma Ata in 1978 by WHO member states, and the Nigerian government began making concerted efforts to achieve this by 1988 (Asuzu, 2005 & Orubuloye, 1996). Attaining the goal of HFA was anchored on improving primary health delivery. The NCH was established and it developed a National Health Policy (NHP) which made resource allocation a major focus. The NHP led to the adoption of a National Health Accounts (NHA) framework which is an internationally accepted tool for analysing health financing at various levels of governance and capturing a nation's expenditure on health. The framework is useful for improving health system performance by supporting stewardship and the decision-making process with the financing structure of the health sector. Even when health services are provided free at the point of service to the general population, there is always a cost attached to it which is borne by someone, somewhere.

In order for NHAs to be useful for health financing policy making, countries must utilize accurate, complete and consistent data in producing it. International standards and definitions should be adhered to in order for the NHAs to be useful for comparison with other countries (Soyibo, 2005 & Soyibo, 2009). In 2001 the AU Abuja Declaration recommended that member countries allocate 15% of the GGE to health. In 2012, GGHE as a percentage of GGE is 6% and Nigeria is yet to live up to the declaration. In 2009, the global average of the GGHE as a percentage of THE was 40.8%, the highest being 99.9% and the lowest 8.2%. With a below average rate of 35.1%, Nigeria was 141 out of the 163 countries ranked (WHO, 2012). Prepared annually, NHAs provide information on health care financing, how much is allocated to purchasing goods and services, who is providing the services, and who is paying for the services (see **Table 2** below).

The table also illustrates that since 1995, Nigerians have been responsible for a major portion of household costs of healthcare. An average 70% of PvtHE makes up a percentage of THE, over 90% OOP being a percentage of PvtHE, and no form of social security exists. Every year approximately 25 million households or 100 million individuals worldwide are pushed into poverty due to mounting healthcare bills (Soyibo, 2009). Other research from developing countries including Nigeria show that four out of five cases of bankruptcy are due to meeting the cost of ill-health (Usoroh, 2012). Another devastating effect is that these people also sink further into poverty due to ill-health as they eventually decide not to seek health care due to lack of financial access. WHO suggests to countries that after meeting house-holds basic needs, income available after health expenditure should be greater than or equal to 60% to avoid financial catastrophe (Xu et al, 2005).

Table 2: Nigeria – Selected ratio indicators for National Expenditure for Health (NEH), 1995 – 2010

Selected ratio indicators for NEH	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08	'09	'10
GGHE as a % of GGE	7.1	7.1	7.1	7.1	5.4	4.2	3.2	3.1	5.1	7.8	6.4	7.1	9.2	7.7	5.9	4.4
Social security as a % of GGHE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
THE as a % of GDP	4.4	4.5	4.6	5.6	5.4	4.6	5.2	3.9	6.5	7.0	6.6	5.7	6.0	5.7	6.1	5.1
GGHE as a % of THE	25.6	20.8	23.5	26.1	29.1	33.5	31.4	25.6	22.4	32.7	29.2	34.0	39.6	41.2	35.1	37.9
External sources as a % of THE	0.5	0.2	0.3	13.1	13.8	16.2	5.6	6.1	4.2	4.5	3.7	2.8	3.6	4.3	5.1	9.2
PvtHE as a % of THE	74.4	79.2	76.5	73.9	70.9	66.5	68.6	74.4	77.6	67.3	70.8	66.0	60.4	58.8	64.9	62.1
Private insurance as a % of PvtHE	3.0	2.8	2.8	2.4	3.4	5.1	6.5	6.7	3.1	3.4	3.1	3.1	3.1	3.1	3.1	3.1
OOP as a % of PvtHE	94.4	94.6	94.6	95.0	94.8	92.7	91.4	90.4	96.2	95.3	95.8	95.6	95.5	95.4	95.6	95.3

Source: World Health Organization, 2012b

3.3 Health sector and health financing policy reforms in Nigeria

The preceding paragraphs demonstrate that the Nigerian health system has been chronically underfunded since independence. The health system competes with other social service systems like power, education, transportation, security, the environment and servicing of external debts. Public financing of healthcare in Nigeria has faced several challenges including lack of political will, corruption, poor institutional capacity, lack of data on health status and utilization. Other challenges include unstable political and economic climates (Soyibo, 2005 & Soyibo, 2009). The beginning of the 21st century witnessed several renewed attempts of successive governments at health sector and health financing policy reforms.

3.3.1 Health Sector Reform Policy Programme (HSRPP):

The federal government in 2004 committed to a sustained process of health system strengthening, focusing on policies, regulation, improved financing, re-organization of management and institutional arrangements. The framework was encapsulated in the new economic empowerment and development strategy (NEEDS). The HSRPP include goals, targets and priorities to guide the activities of the FMOH between 2004 and 2007 (FMOH, 2004). The action points of the programme were:

- ✓ Improving the stewardship role of government;
- ✓ Strengthening the national health system and its management;
- ✓ Reducing the burden of disease;
- ✓ Improving the availability of health resources and their management;
- ✓ Improving access to quality health services;
- ✓ Improving consumers' awareness and community involvement;
- ✓ Promoting effective partnership, collaboration and coordination.

Measurable results of the HSRPP were expected by the end of 2007. Of importance was the development of policy documents to guide and sustain the reforms into the future. The key results pertaining to health financing reforms were:

- ✓ **A 5-Year strategic plan** of action developed by departments of FMOH, SMOH, LGDH and other federal health institutions.

- ✓ The NHP reviewed, updated and harmonized into a **National Health Bill** that described the re-defined national health system and the functions of each level of government.

3.3.2 National Strategic Health Development Plan (NSHDP 2010-2015):

The renewed effort to reform the Nigerian health system birthed a 5 year National Strategic Health Development Plan (NSHDP) 2010-2015 with 8 strategic priority areas. It was developed as the health component of the government's poverty reduction policy (Nigeria Vision 20:20, 2010). The areas are (NSHDP, 2010):

- ✓ Leadership and governance for health
- ✓ Financing for health
- ✓ Health service delivery
- ✓ Human resources for health
- ✓ National health management information system (HMIS)
- ✓ Partnerships for health
- ✓ Community participation and ownership
- ✓ Research

3.3.3 National Health Bill (2011) and the National Primary Healthcare Development Fund (NPHDF):

Financing for healthcare delivery is a key focus of the 2011 National Health Bill (NHB). The NHB is "an act to provide a framework for the regulation, development and management of a national health system and set standards for rendering health services in the Federation, and other matters connected therewith" (NHB 2011). It proposes a radical shift in health financing in Nigeria through the establishment of a fund – National Primary Healthcare Development Fund (NPHDF). This fund (separate from the budgetary allocation for health) will be financed from the federal government (with an amount not less than 2% of the consolidated fund of the federation); international donor partners; and funds from any other innovative sources. The fund is intended to boost delivery of primary health care and its proposed allocation is found in **Box 1.**

Box 1: National Primary Healthcare Development Fund allocation

50% - Provision of a basic package of health services to all citizens in Primary health care facilities through the NHIS

25% - Provision of essential drugs for Primary healthcare services

15% - Provision and maintenance of facilities, equipment and transport for Primary healthcare

10% - Development of Human Resources for Primary healthcare services

Source: Nigeria National Health Bill 2011

The NHB passed in 2011 by the executive arm of government lists a fully functional National Health Insurance Scheme (NHIS) as one of its provisions and is the key resource platform for funding the NPHDF. Implementation of the NHB has been stalled as the current president failed to assent to it within the legally stipulated time. According to Shokunbi in 2012, a major reason cited for this is the lack of political will to raise the funds required to establish the NPHDF. This means the NHB has to be re-presented by the executive arm of government for another attempt to have it ratified and passed into law. This also means that the establishment and funding of the NPHDF has been placed on hold (Shokunbi, 2012).

3.4 The National Health Insurance Scheme (NHIS) in Nigeria

Despite all the short-comings in health sector and health financing reforms, the NHIS received a push and was launched in 2005.

3.4.1 Operational guide-line and current implementation

Operational guide-line: In order to ensure that every Nigerian has access to health care services, the Nigerian government deemed it necessary to commence a NHIS. The NHIS was established under decree no. 35 of 1999 (see **Annex 4**). The NHIS is designed as a SHI programme; its aim is to provide easy access to healthcare for all Nigerians at an affordable cost through various pre-payment systems. The strategy of the NHIS segments the entire population into formal and informal sectors, vulnerable groups and others. The scheme is expected to provide financial access to good quality health care via multiple programmes. The scheme is a PPP and the NHIS accredits privately owned HMOs to operate nationally and also regionally (in the 6 geo-political zones). The NHIS also accredits a mix of public and private health care providers to provide health care at primary, secondary and tertiary levels. Enrollees are free to choose any accredited primary provider as first contact for obtaining care. Secondary and tertiary levels of care are only accessed via referrals from the primary level (NHIS decree no. 35 of 1999). There are presently 62 accredited national and regional HMOs and 5,949 accredited providers (public and private) (NHIS, 2012a). The HMOs deal directly with the health care providers as fund and quality assurance managers for enrollees; the government regulates all activities of the scheme. The NHIS programmes aimed at different segments of the society are summarized below in **Table 2.**

Table 3: NHIS programmes and segmentation of the Nigerian population

Formal Sector	Public sector (Federal, State and Local Government) social health insurance scheme
	Armed forces, police and other uniformed services social health insurance scheme
	Organized private sector social health insurance scheme
	Students of Tertiary institutions social health insurance programme (TISHIP) and voluntary participants social health insurance scheme
Informal sector	Rural community social health insurance scheme (RCSHIS)
	Urban self-employed social health insurance scheme (USEHIS)
Vulnerable groups	Permanently disabled persons and the aged social health insurance scheme
	Children under 5 years health insurance scheme (CUFHIS)
	Pregnant women and orphans social health insurance scheme
	Prison inmates social health insurance scheme
Others	Diaspora family and friends social health insurance scheme
	International Travel Health Insurance
	Retirees and the unemployed social health insurance scheme

Source: NHIS Operational Guidelines May 2005

Current implementation: In 2005, the NHIS was officially flagged off with the formal sector programme which aims to provide SHI coverage to all workers in the civil service (public sector, armed forces, police and other uniformed services) and the organized private sector. The states (except Bauchi, Rivers and Cross-Rivers) however did not immediately embrace the scheme (Asoka, 2011). The formal sector SHI scheme being implemented is funded by pay-roll deductions, and the NHIS is currently responsible for collection of funds. The payroll deductions are proportional and theoretically comprise employer = 10% of basic salary; employee = 5% of basic salary. Notably, at the roll-out stage, the government waived the initial 5% which was to be contributed by the employee, and the NHIS commenced the programme with the 10% of basic salary provided by the federal government i.e the employer (NHIS, 2012a). Till date, this is how the scheme is being funded due to widespread resistance from the National Labour Congress (NLC) to have the 5% employee contribution deducted for the scheme, citing widespread poor salaries and non-inclusion in decision-making (Asoka, 2011).

In addition, the joint NHIS/MGD- maternal and child health (MCH) project was piloted in phases over 3 years (2008 – 2010) in 12 states. It is being expanded nationwide to provide care for pregnant women and children under 5 years (CU5) only up till 2015 and is presently funded by the MDG debt relief funds. Beyond 2015, the state governments are required to incorporate the project into state funded SHI programmes (Briscombe & McGreevey, 2010). Other methods of revenue collection are yet to be designed to fund the scheme for the informal sector, vulnerable and other groups.

In 2011, blueprints for the Tertiary Institutions Social Health Insurance Programme (TISHIP) and voluntary participants SHI schemes were launched to complete commencement of the formal sector programmes. The target populations are students of higher schools, the urban self-employed sector and any interested individuals, including those in the formal sector contributing on behalf of their dependants in the informal sector. Some tertiary institutions have commenced the TISHIP but the voluntary participants' scheme has not progressed beyond the blueprint phase (NHIS, 2012a). Some states have initiated donor and state-funded community health insurance pilot schemes (Uzochukwu et al, 2009). In addition, fractions of the organized private sector subscribe for direct premium-based voluntary private health insurance schemes with the HMOs (Asoka, 2011).

3.4.2 Assessment of the NHIS using the health financing performance indicators -:

Level of funding: The current formal sector SHI is presently being funded by 10% employer contributions of the basic salary of all federal and some state government workers (NHIS, 2012a). The NHIS/MGD-maternal and child health (MCH) project is funded by the MDG debt relief funds. Beyond 2015, the state governments are required to incorporate the project into state funded SHI programmes (Briscombe & McGreevey, 2010). The legislation establishing the NHIS does not make the scheme mandatory for all Nigerians thus hampering capacity to fund it. Nigeria is yet to explore other possibilities for innovative fund-raising including VAT and "sin-taxes'', solidarity levies on mobile phone call tariffs (over 90 million Nigerians own and use mobile phones), raising diaspora bonds (from our large diaspora population), and taxing specific profitable sectors of the economy like banking and oil and gas (Juttung, 2009)

Level of population coverage: Seven years after commencement, the scheme is estimated to cover 5% (roughly 7 million) of Nigerians, mostly in the formal sector. The Nigerian formal sector is said to make up roughly 30% of population. Asides the formal sector enrollees of the scheme, the MCH project is being expanded beyond 12 states in partnership with the MDG office as well as some state funded community health insurance schemes. Fractions of the organized private sector also subscribe for direct premium-based voluntary private health insurance schemes with the HMOs (Asoka, 2011 & Lawan, 2012).

Degree of financial risk protection: The current implementation of the NHIS in Nigeria offers financial protection only to those currently enrolled. However, the pre-payment ratio in the NHIS is below the recommended 70% and above (Mathauer & Carrin 2010). PvtHE as a percentage of THE remains high (62.1% in 2010) with over 90% of this made as OOP (NSHDP, 2010). This pattern of health spending contributes to widespread catastrophic spending among the poor and large informal sector (Onoka et al, 2010).

Level of equity in health financing: Majority of Nigerians - roughly 60% - are poor and exist on less than $1/day. They make up the large informal sector and vulnerable groups and are presently largely excluded from the current implementation of the NHIS. For the formal sector SHI, payroll deductions are made proportionally (15% of basic salary). Employer pays 10% on behalf of the employee (enrollee) who pays 5% (NHIS, 2012a). According to Executive secretary of NHIS, the 5% deductions are yet to commence due to resistance from the NLC (Asoka, 2011). Proportional contributions favour the higher earners as one pays less, the more one earns.

Level of pooling across the health financing system: The level of pooling across the health financing system offers services mainly to the formal sector in the employment of the federal government. Presently, the 10% of basic salary payroll deductions are centrally pooled into a health insurance fund domiciled with the headquarters of the NHIS. Funds are released every 2 months to the HMOs who subsequently purchase services from healthcare providers on behalf of the enrollees (NHIS, 2012a).

Level of operational efficiency: Presently, the NHIS is regulated centrally by the national headquarters with support from 6 regional offices in the 6 geo-political zones of the country. They oversee the activities of the HMOs and healthcare providers who deliver the services. There is a high degree of centralization of functions at the headquarters and regional offices have little powers to effect any major changes. There is inefficient HMIS within the health system and the NHIS has reported that communication and information sharing within the scheme is hampered. Quality of the scheme is assured by regular clinical audits and other activities of the HMOs who relate directly with the health care providers on a daily basis (NHIS, 2006).

Degree of cost-effectiveness and equity in benefit package definition: (see **Annex 5** for Benefit package and exclusions) The current benefit package (BP) offered enrollees of the NHIS was actuarially determined by the NHIS and covers health promotion activities, preventive services, family planning, curative emergency, out- and in-patient care, as well as basic dental and eye care. There is a plan in place to expand the benefit package as the revenue pooling becomes more effective with an increased number of enrollees. The benefit package is also the same across board no matter the socio-economic status of the enrollee. The BP exempts coverage for conditions covered by vertical programmes like HIV/AIDS (PEPFAR), TB and Leprosy (National TB and Leprosy control programme). However, opportunistic infections occasioned by these diseases are covered. Other exemptions include treatment of cancers, cosmetic procedures, treatment at the instance of the enrollee, kidney failure, major organ transplants and infertility(NHIS, 2012a).

Level of equity in delivering the benefit package: The HMOs are the fund and quality assurance managers of the scheme(NHIS, 2012a). They facilitate payments for the delivery of the BP to the enrollees by various Provider Payment Methods (PPM) (Langenbrunner, 2009 & NHIS, 2005). NHIS enrollees register with accredited primary level providers of their choice who serves as a gatekeeper to obtaining healthcare.

The enrollees are given identity cards, and every month, patient panels/photo cards are prepared by the HMOs and sent to the providers along with a fixed capitation payments of $3.8 (=N=550) per enrollee (NHIS, 2012a). This capitation is a pre-paid PPM and purchases an agreed global list of primary level services (Langenbrunner, 2009). Once an enrollee requires care at the secondary or tertiary level, the provider seeks and obtains an authorization from the responsible HMO based on evidence of the need, to refer the patient. Secondary and tertiary providers submit claims after completion of treatment, or on a monthly basis to the HMOs for claims verification and payment. Their services are post-paid by a fixed fee-for-service (FFS) tariff and per diem for hospital admission. A mandatory 10% co-payment for all drugs dispensed at the secondary or tertiary level of care applies to all enrollees (NHIS, 2012a).

For the NHIS/MDG-MCH project, monthly capitation is $3.6 (=N=500) per enrollee per month while the FFS is determined per case according to a fixed FFS tariff guide. HMOs administer claims submitted by providers and there is a uniform tariff guide for all the NHIS programmes. FFS claims submitted in the agreed format and within the stipulated 30 days following treatment are also expected to be vetted and settled within another 30 days. This allows time for claims verifications and any clinical audit into the evidence base behind treatments offered (NHIS, 2012a) Funds are expected to be released to HMOs every two months in advance by the central NHIS. HMOs in turn are expected to pre-pay monthly capitation by the 15th of each month for the following month. FFS claims are to be settled within 30 days of receipt. This is not the usual case. Fund release is not timely largely due to corruption and lack of transparency and administrative efficiency within the NHIS and HMO administrative structures. Many Health providers also lack the administrative capacity for proper fund management and often do not provide sufficient data or timely claims for requests for post-paid FFS (Usoroh, 2012)

Level of administrative efficiency: Revenue pooling for the NHIS is centrally carried out by the NHIS headquarters (NHIS, 2012a). The formal sector SHI covers each enrollee, and where applicable one spouse and 4 biological children under the age of 18years. Two percent of the pooled fund is used by HMOs to administer the scheme while 1% is ear-marked as a reserve NHIS stabilization fund. The actual administrative cost based on 10% contribution is put at an average of 12.3% of the total expenditure from figures available between October to December 2009 (NHIS 2009). The total fund provided for the lifespan of the NHIS/MDG-MCH is $33 million and 10% is retained as administrative cost by NHIS (Briscombe & McGreevey, 2010). There is presently no specific rule or plan in place to integrate the MDG-MCH project into an NHIS programme (NHIS, 2009b).

3.5 Comparisons - Ghana and South Africa health insurance schemes

Several African countries like Ghana, South Africa, Rwanda and Zimbabwe have all introduced some form of health insurance. A comparative analysis of the health financing functions of the health insurance schemes in Ghana and South Africa is made here to draw from the strengths and successes due to the similarities these countries share with Nigeria. **Table 4** below summarizes the national expenditure for health between 2001-2005 for Ghana, South Africa and Nigeria.

3.5.1 Ghana

Revenue collection: The Ghanaian NHIS is financed through payment of individual premiums by the formal sector, while the informal sector is funded via a 2.5% National Health Insurance levy which is a proportion of the existing 12.5% VAT. The funds raised from the levy contributed significantly to increasing enrolment of the population from 7% in 2005 to about 50% in 2008.

Revenue pooling: Membership of the Ghanaian NHIS is compulsory by law. Compulsory pay-roll deductions are made from the formal sector beneficiaries and pooled into a National Health Insurance Fund (NHIF). The deductions are made as a proportion (2.5%) of the salaries while members of the informal sector all pay a token flat rate as administrative fee. The bulk of contributions for the informal sector come from the National Health Insurance levy.

Purchasing/provision of services: Services are purchased via a single SHI for the formal sector and multiple mutual health insurance funds for the informal sector. The benefit package is delivered via public and private health providers and comprises of both in and out-patient care that cover the top 10 diseases. Provider payment is via fee-for-service (post-paid) only. The mutual health insurance schemes are domiciled in the various districts, and identity card production is localized. This allows for administrative efficiency in card production and running the schemes (Akazili, 2010).

3.5.2 South Africa

Revenue collection: Though South Africa does not operate a NHIS; health service provision is designed with universal coverage as the end goal. Health services in South Africa are funded from three main sources:

- ✓ General tax funds – money collected by government such as through income tax, value-added tax (VAT), and other taxes.

- ✓ Out-of-pocket payments – payments made by a patient directly to a health care provider (e.g. paying fees to a public hospital; payments by medical scheme members when the medical scheme does not pay the full bill; payments by someone who is not covered by a medical scheme when using a private provider such as a GP or a pharmacy).
- ✓ Contributions to medical schemes – monthly payments by individuals and their employers who belong to a medical scheme.

Revenue pooling: Everyone contributes to health care financing in one form or another. In 2005/06, general tax accounted for about 40%, medical scheme contributions for 45% and out-of-pocket payments for about 14% of total health care funds. South Africa has what can be described as a very progressive health care financing system – higher income groups contribute about three times more of their income to funding health care than lower income groups (most of this in the form of medical scheme contributions). Tax funding, and particularly medical scheme contributions, follow this pattern. On the other hand, out-of-pocket payments are regressive (the poor contribute a higher percentage of their income in this form of funding than the rich.

Purchasing/provision of services: Tax revenue is used for funding health services that benefit all South Africans. This includes about 68% of the population who access all services only from the public sector and a further 16% who receive subsidies for specialist and inpatient care. This later group make OOP payments to private healthcare providers for primary care. Health services funded by medical schemes benefit a further 15% of the population. Universal coverage is yet to be achieved as cross-subsidisation is not possible. There is a fragmentation between funding in the public and private health sectors and the medical schemes market. Still, the per capita health spending is more than adequate (the highest total per capita health care spending level in Africa) and the majority have access to a basic level of care (Akazili and Ataguba, 2010).

Table 4: 3 Country comparisons – Selected ratio indicators for National Expenditure for Health (NEH), 2001 – 2005

Selected ratio indicators for NEH (Ghana)	**2001**	**2002**	**2003**	**2004**	**2005**
GGHE as a % of GGE	8.7	9.3	9	6.9	6.9
Social security as a % of GGHE	n/a	n/a	n/a	n/a	n/a
THE as a % of GDP	7.1	6.5	6.2	6.2	6.2
GGHE as a % of THE	40	37.2	41.5	37.4	34.1
External sources as a % of THE	13.9	15.8	30.8	32.2	26
PvtHE as a % of THE	60	62.8	58.5	62.6	65.9
Private insurance as a % of THE	6.2	6.2	6.1	6.2	6.2
OOP as a % of PvtHE	79.4	79.1	78.2	78.7	79.1
Selected ratio indicators for NEH (South Africa)	**2001**	**2002**	**2003**	**2004**	**2005**
GGHE as a % of GGE	10.4	10.1	9.6	9.6	9.9
Social security as a % of GGHE	3.1	3.8	4.4	4.3	4.1
THE as a % of GDP	8.4	8.3	8.4	8.5	8.7
GGHE as a % of THE	41.2	40.6	40.1	40.6	41.7
External sources as a % of THE	0.2	0.4	0.3	0.5	0.5
PvtHE as a % of THE	58.8	59.4	59.9	59.4	58.3
Private insurance as a % of THE	76.7	77.7	77.3	77.3	77.3
OOP as a % of PvtHE	17.8	16.8	17.4	17.4	17.4
Selected ratio indicators for NEH (Nigeria)	**2001**	**2002**	**2003**	**2004**	**2005**
GGHE as a % of GGE	3.2	3.1	5.1	7.8	6.4
Social security as a % of GGHE	0	0	0	0	0
THE as a % of GDP	5.2	3.9	6.5	7.0	6.6
GGHE as a % of THE	31.4	25.6	22.4	32.7	29.2
External sources as a % of THE	5.6	6.1	4.2	4.5	3.7
PvtHE as a % of THE	68.6	74.4	77.6	67.3	70.8
Private insurance as a % of THE	6.5	6.7	3.1	3.4	3.1
OOP as a % of PvtHE	91.4	90.4	96.2	95.3	95.8

Source: World Development Indicators, African countries at a glance. WB 2006

Chapter 4: Discussion

The discussion of my study findings is in relation to the components of the conceptual framework introduced in **Chapter 2**. It will build upon the role of good governance in achieving universal health coverage. The 3 health financing functions will be discussed based on the 9 generic health financing performance indicators. Finally the challenges affecting the NHIS institutional design and organization will be discussed with examples of good practices from the 2 African comparisons highlighted.

4.1 Governance

Nigeria is the most populous country in Africa, her population currently put at 168 million. Such a large number of people have vast economic, health, and political influence on the West Africa sub-region, the entire continent and the world. The federal government of Nigeria needs to become more proactive in safe-guarding the health care needs and outcomes of all Nigerians, and speed up the implementation process of the NHIS in order to achieve this. The NHIS is a PPP with the government acting as overseer and regulator of the scheme. Enough has not been done in terms of provision of good governance or stewardship to ensure the success of scheme. The legislation backing the scheme does not make it mandatory for all Nigerians to subscribe to, unlike the Ghanaian NHIS which is mandatory for all.

Since the scheme was launched in 2005 with the formal sector SHI, the organized private sector as a part of the formal sector, as well as government workers at the level of the states and local governments have been slow in logging on to the scheme. The NLC have cited none inclusion in stakeholders' analysis before the scheme was launched as the reason for their resistance to it. This is a failure of stewardship by the government. There is generally a low level of awareness about the scheme and lack of a sense of ownership of the scheme by all the sectors to be included as set out in the operational guidelines. This remains a duty of the government to urgently correct the general apathy about the scheme among Nigerians. Also transparency must be shown by the government in dealing with the NLC especially concerning payroll deductions and utilization.

4.2 Health financing functions

4.2.1 Revenue collection

Level of funding: The level of funding for the scheme is functioning far below the expected capacity. This is because the payroll deduction of 15% basic salary has not been attained; and majority of the formal sector (federal, state, local government and organized private sector) are yet to subscribe to the scheme.

Tax-based health financing is not being practiced in Nigeria unlike the Ghanaian and South African models. The potential for geometrically increasing government revenues from tax, and therefore allocation to health in a populous country like Nigeria is yet to be seriously explored. Middle income countries like Nigeria can focus on innovative methods of ensuring a greater flow of funds into the health sector. The excise, VAT or "sin taxes" already existing in many countries like Ghana on products like alcohol and tobacco (products that pose risks to health) can be extended to include unhealthy foods such as sweets, sugary drinks and foods high in salt and trans-fats. The government of Nigeria will need to implement the methods that best suits our economy and can enjoy political support.

Increased development aid grants (which are not repaid) as well as debt relief enables countries to increase their resources and therefore fiscal space for increased budgetary allocations to health and other sectors (Heller, 2005). Debt relief gains have already been useful to the Nigerian health system in funding the NHIS/MDG-MCH project. Thus, government should increase lobbies for more debt relief, reduce external borrowing (12% budgeted to service debts) and improve capacity for better management of aid grants.

Level of population covered: The total number of Nigerians currently being covered by a form of health insurance is 7 million, about 5% of the population. These are mainly formal sector enrollees. The informal sector and vulnerable groups who need insurance the most are largely excluded. Seven years after the launch of the NHIS, the scheme is under-performing.

Equity in health financing: A well laid out operational guideline has neatly segmented the population. Asides the clearly defined pay-roll deductions to fund the formal sector SHI, no mechanism exists to fund the scheme for the large informal sector and vulnerable groups. This sector are most prone to financial catastrophe as a result of health care costs (Xu et al, 2005). In South Africa, about 68% of the population are covered by tax-funded (40%) primary health services. These are mainly those with little ability to pay. A further 16% of the population receive subsidies for health services. The large informal sector in Nigeria will be best served by this type of arrangement.

4.2.2 Revenue pooling

Pooling of funds and degree of financial risk protection: The large informal sector in Nigeria cannot pool revenue via payroll deductions. This sector will benefit from CBHI programmes. Preferably, their pooled health accounts (from various means of innovative financing, government equity funds, donor contributions and flat rate contributions) should be domiciled within the community and a certain percentage remitted to NHIS headquarters to cater for administration and collation of data. This will ensure that the spirit of community participation in the CBHI is preserved.

Level of operational efficiency: The HMOs, which are all private sector companies, have generally developed a fair level of operational efficiency with offices nationwide that are decentralized and carry out the activities of each region speedily. The NHIS needs to learn from the operational style of the HMOs and also decentralize her activities accordingly.

4.2.3 Purchasing/provision of services

Cost-effectiveness and equity considerations in benefit package definition: The BP should be provided by efficient, equitable and sustainable means. Sustainability of the BP was the premise for limiting it at the onset of the scheme, so as not to rapidly deplete the small pool of funds for the formal sector SHI. In terms of equity, the BP addresses the common diseases as well as the needs of some vulnerable groups (pregnant women and CU5). A major gap in the BP is the exclusion of provision of mental health services (at the primary level), and geriatric services.

Equity and quality assurance in benefit package delivery: Various PPM are utilized within the scheme including capitation, per diems and FFS(Langenbrunner, 2009). A 10% co-payment for all drugs dispensed at secondary and tertiary levels of care is also in operation. There is a balance between the PPMs being deployed by the NHIS.

Level of administration efficiency: The NHIS has been plagued with delays in producing identity cards from the onset. Mainly due to her centralized design, whereby only the headquarters produces the cards (NHIS 2012a). Also the administrative cost of 12.3% for the formal sector programme is above the NHA recommended level for middle income countries like Nigeria (less than 8%) (NHIS 2009). As the scheme grows, administrative efficiency must be ensured. Providers under the scheme also complain of inadequacies in the provider payment systems (PPS) (Langenbrunner, 2009). The general theme is that fees paid are insufficient for providers, especially those with smaller pools of enrollees to cover their costs. This questions the actuarial methods used by the NHIS in costing the BP for the scheme.

The NHIS/MDG-MCH project is administered in parallel with the formal sector SHI and this amount to an administrative inefficiency as the same HMOs and health providers facilitate and provide these services.

4.3 Challenges - The NHIS institutional design and organization

Since the late 1990s, the federal government of Nigeria has undertaken some major health sector and health financing policy reforms. The NHIS is the most recent and significant. Given that previous mechanisms for health care financing have failed to meet desired goals, the option of health insurance is a promising alternative. Through risk pooling and transferring unforeseeable healthcare costs to fixed premiums, there is the possibility of improving poor people's financial access to healthcare that is of an acceptable quality. The implementation of the NHIS is not without challenges. I will highlight below the major ones in order to make recommendations that will address them.

4.3.1 Sufficient, equitable and efficient revenue collection

A critical challenge facing the scheme is the fact that the establishing legislation does not make it mandatory for all Nigerians. The centralized administration of the NHIS makes it difficult for the states and local government to be willing to take up the scheme for their employees. The states are required to make their employer contributions to the national scheme and not a localized fund manager within the state. Majority of the states (33 of 36) have thus refused to join the NHIS and are exploring ways to float localized insurance schemes. The commencement of the scheme with the formal sector excludes the poor and informally employed. The focus should be on overall population coverage by multiple schemes, building up adequate reserves, community participation and ownership. For most people living in poor rural or urban slums in Nigeria, ill health still represents a permanent threat to their ability to generate income and continues to impoverish them. Apart from the direct cost for treatment and drugs, indirect costs such as loss of productive man-hours, and transport still have to be borne by the households.

The formal sector pay-roll deduction for the SHI is proportional in design thus the higher one earns the less one actually pays (expected total deduction is a flat rate of 15% of the basic salary). Since the 5% employee contribution has not yet commenced, this limits the funds available to provide services for the SHI and no review towards the planned BP expansion has been possible. The existing 10% co-payment for drugs not covered by capitation is not equitable for the lowest income group who have already contributed a larger proportion of their salaries. Asides the debt-relief funds used to fund the NHIS/MDG-MCH no other funds have been ear-marked to contribute to the NHIS health fund to commence SHI or CBHI for the informal sector and vulnerable groups. Countries have used excise and VAT on foreign exchange transactions, air tickets, and "sin taxes" to increase their revenue.

Other possibilities for innovative fund-raising include solidarity levies on mobile phone call tariffs (over 90 million Nigerians own and use mobile phones), raising diaspora bonds (from our large diaspora population), and taxing specific profitable sectors of the economy like banking, oil and gas (Juttung, 2009 & Uzor, 2009). This is unlike the health financing plans of Ghana and South Africa which relies on ear-marked funds from taxes (Akazili, 2010; Akazili and Ataguba, 2010).

4.3.2 Financial accessibility

The NHIS remains handicapped in providing financial access to essential health care services to majority of Nigerians. The proportional pre-payment method of pay-roll deductions for the formal sector places an undue pressure on the lowest earners. There is no plan for innovative fund-raising to establish a subsidy fund for the informal sector or exempt the most vulnerable groups outside of the MDG project. The informal sector still remains largely excluded. The stewardship role of the government in ensuring health financing policy implementation over the years has been lacking. Useful policy documents and plans like the NSHDP, the NHB, and the NPHDF have been left to stagnate with nothing done to implement them.

Only recently, the TISHIP and Voluntary contributors' scheme was launched by the NHIS in 2011 to complete the formal sector flag-off. Uptake of these programmes remains slow and financial accessibility low. As long as there is no legislation to make the NHIS mandatory for all, ensuring financial accessibility will remain a big challenge for the scheme.

4.3.3 Efficiency and equity in purchasing/provision of services

Since the commencement of the scheme, the NHIS has been plagued with inefficiency in identity card production. Till date not all registered enrollees have received their identity cards. This often results in refusal of care at the point of service, and is quite distressing to the enrollees. Resolving identification issues involves exhaustive phone calls and entreaties by the HMOs to the providers to offer care and is an avenue for impersonation and fraud against the scheme. The PPS of the NHIS is also not efficient. Capacity building across board for the NHIS, HMO and health provider staff on the operations of the NHIS has generally been lacking from the inception of the scheme. This is reflected in the various instances of inefficiency being witnessed. This in turn affects timely and efficient service delivery to the enrollees. Furthermore, as long as the large and poor informal sector of Nigerians remains excluded from the NHIS the scheme cannot be said to be equitable or efficient in purchasing/provision of services as this group are most in need of health care.

Chapter 5: Conclusions and recommendations

5.1 Conclusions

Nigeria has a poor health financing history, and till date Nigerians still bear the majority cost of health care provision. Since the beginning of the 21st century, there have been some efforts to improve efficiency in utilization of existing funds for healthcare provision. This has birthed the NHIS and other useful health financing policies. However, the government is yet to strengthen its commitment to implementing these policies. The current implementation of the NHIS in Nigeria is not geared towards achieving universal health coverage. Notably is the absence of institutional innovations to make the scheme a viable tool for financing health and provision of financial protection for the poor (and those able to pay). Deficiencies in the institutional norms and organisation of the scheme preclude this. Though the scheme is in tune with government's poverty reduction policies and strategies as risk sharing for health is critical in alleviating poverty, financial risk protection is absent for those who need it the most.

In a developing economy like Nigeria, resources for health care are scarce and the largely poor population bears most of the burden for providing this care. GGHE as a percentage of the GGE is inadequate to strengthen and sustain the health system. Since the 2001 AU Abuja declaration, Nigeria has not succeeded in increasing annual budgetary allocation for health to 15%. Innovative ways to raise revenue for the government and increase her fiscal space are not being explored. Nigeria exists almost as a mono-economy dependent on her petroleum resources. Not enough is being done to explore other ways to increase government's income.

The relationship between the federal, state and local arms of governance, especially within the health system is very important for the sustainability of a NHIS. The decentralization of functions notwithstanding, policies and mechanisms to ensure accountability and uniformity of policy implementations are necessary for a seamless rolling out of all the programmes of the NHIS. Close collaboration with stakeholders, especially in the NLC and community involvement in the implementation of the various programmes of the scheme is vital for its success. In addition, capacity building of all major players in the implementation and sustenance of our scheme must be a focal point, even within the context of infrastructural gaps and failings in our society. This will ensure an acceptable quality of health care is delivered by the scheme. The current proportional payroll deduction system for the formal sector is inequitable. Health providers claim the current PPM is inadequate in covering the running costs of most of them. These are gaps in equity and efficiency in funding and running the scheme. It is necessary to engage continuously with all groups of health providers who are the front-end in service delivery as acceptable PPM are a bed-rock for success in any NHIS.

Identity card production for enrollees is also inadequate. The HMIS backbone necessary to coordinate a nationwide scheme like this is not sufficiently in place. A strong HMIS will allow decentralization of NHIS activities and increase the decision space of the 6 regional offices. Definitely, challenges will exist for such a scheme which is a clear break from the traditional ways we have had of financing health care. The NHIS is an experiment we must tailor to suit the Nigerian context. We should not lose sight of setting time-bound targets, and monitoring and evaluating of efforts in order to learn from mistakes, accumulate best practices and improve. The need remains for innovative funding for the NHIS and ear-marking these resources in providing financial access to health care services for the people. Changes must be actively carried out to improve the efficiency of healthcare funding for the scheme to succeed.

5.2 Recommendations

Despite the current economic and social climate of Nigeria, the NHIS remains a potential tool for provision of affordable and acceptable quality of health care for the larger Nigerian population. These recommendations are suggested to ensure the effective and efficient implementation of the NHIS in order to achieve universal coverage and improve the health outcomes of all Nigerians.

Federal Government:

1. Stewardship efforts to establish an enabling environment for successful implementation of the NHIS is the sole preserve of good governance. An urgent review of the NHIS Decree is necessary to make the scheme mandatory for all Nigerians like it is in Ghana. Enforcing the implementation of this beneficial initiative for all will prevent the current NHIS from becoming a failed government scheme. The government must be accountable to all Nigerians in ensuring the NHIS works in order to improve our health outcomes.

2. The government needs to increase the annual budgetary allocation to health to the recommended 15% as agreed by the 2001 AU Abuja declaration (which we hosted). Innovative financing mechanisms to improve government's revenue generation should be explored extensively. These efforts can increase a tax-based pool of funds for health as practiced in South Africa and Ghana.

3. There is a need for Mr President to give the final assent needed for the NHB to become a law that will bind all players in implementation of the NHIS and establishment of the NPHDF. This fund and the development of innovative ways to fund the NHIS for the large and mostly poor informal sector will go a long way to improve efficiency and equity of the scheme in providing financial access and risk protection for all Nigerians.

4. The goal of achieving universal health coverage by 2015 or beyond is also largely dependent on optimum stakeholder involvement and participation. Vigorous and sustained efforts are necessary to ensure the widespread acceptance of the scheme and backing of key stakeholders including the state, local government authorities, communities, NLC, private sector, ministries, departments and agencies (MDA). This participation is crucial to establishing and sustaining for example mobile phone tariffs, HMIS development, and build capacity across board. The banking sector (for ease of payment platforms), donor partners and agencies, and different health care provider groups must all be involved optimally. Community participation and sense of ownership should be cultivated via media campaigns in all the major languages of the 6 geo-political zones. This will foster acceptability of the scheme and a willingness to participate.

Stakeholders (NHIS, HMOs, Healthcare providers):

1. The proportional contribution rule for the formal sector programme should be revised by the NHIS in order to introduce a progressive rule like is practiced in Ghana. This will ensure contributions are made based on ability to pay, i.e the more one earns, the more one pays. This will increase the solidarity and equity within the SHI.

2. The NHIS should determine actuarially how much contribution is needed to fund the informal sector and vulnerable groups' programmes. A formula should be arrived at to determine who can qualify for total exemption from contributing to the scheme, and what the rate of contributions will be for those who are able to. An agenda should be clearly set for administering the insurance programmes for the different sectors in order to reduce administrative inefficiencies and fragmentation of revenue and risk pooling. Transparency must be a watchword in planning for funding of the informal sector programmes.

3. Capacity needs to be built across board for all key players within the NHIS. The health care system needs to be strengthened even within the context of an infrastructural challenged country as ours. Continuing professional development programmes should be uniformly constructed and deployed across all cadres of health workers and levels of the health system (federal, state and local). The capacity of the NHIS to interpret policies, implement and regulate the scheme at all levels of the health system is very important.

Another key area for building capacity is within the HMOs as the ability to adequately manage the health funds disbursed to them in conjunction with the health care providers, resolve conflicts, carry out clinical audits while assuring an acceptable standard of care must not be under-estimated.

4. The NHIS needs an urgent overhaul of her HMIS. Database creation and timely identity card production is very important to reduce impersonation and fraud in purchase/provision of services. This will also improve efficiency in information sharing and coordination of implementation of the scheme across the 6 geo-political zones.

5. Everyone involved in any way with the scheme must be aware of their rights and what to expect within the scheme. Rules for implementing the scheme must be adhered to and penalties should exist and be enforced for any erring participant. Claims management and PPS should be reviewed and improved transparently. Realistic and time-bound targets should also be set to monitor and evaluate the progress of the scheme. This will help us to accumulate best practices that will ensure that this latest effort in health financing is a success for Nigeria.

References

Abdulraheem, I. S., Olapipo, A. R. and Amodu M. O. (2012) Primary health care services in Nigeria: critical issues and strategies for enhancing the use by the rural communities. Journal of Public Health and Epidemiology Vol. 4(1), pp. 5-13, January 2012 Available from: http://www.academicjournals.org/JPHE. DOI: 10.5897/JPHE11.133 ISSN 2141-2316.

African Union (2001) Abuja declaration on HIV/AIDS, Tuberculosis and other related infectious diseases. (Apr 2001) African summit on HIV/AIDS, Tuberculosis and other related infectious diseases. OAU/SPS/Abuja/3. Abuja, Nigeria.

Akazili, J. (2010) Who pays for health care in Ghana? Strategies for health insurance for equity in less developed countries. SHIELD Information Sheet. [online] Available from: http://web.uct.ac.za/depts/heu//SHIELD/reports/SHIELD_Ghana_WhoPays%20forHealthCare.pdf [Accessed 22nd March 2012]

Akazili, J and Ataguba, J.E. (2010). Health care financing in South Africa: moving towards universal coverage. Continuing medical education. Vol.28 no.2 [online] Available from: http://www.ajol.info/index.php/cme/article/view/55239/43707 [Accessed 22nd March 2012]

Asoka, T. (2011) Ensuring financial access to primary health care: the experience and challenges of the National Health Insurance Scheme in Nigeria. Paper presentation, National consultation on primary health care financing and National Primary Health Care Development Agency (NPHCDA) Nigeria [Online]. Available from: www.carenet.info/files/Ensuring_Financial_Access_to_PHC.doc [Accessed on 10 th August 2012].

Asuzu, M.C. (2005) The necessity for a health system reform in Nigeria. Journal of Community Medicine & Primary Health Care. 16 (1) 1-3. [Online]. Available from: http://www.ajol.info/index.php/jcmphc/article/viewFile/32398/6066 [Accessed on 10 th August 2012].

Bennett, S. (2004) The role of community-based health insurance within the health care financing system: a framework for analysis. Health policy and planning; 19(3): 147-158. Oxford University Press. DOI: 10.1093/heapol/czh018

Briscombe, B. and McGreevey, W. (2010) The cost and benefits of a maternal and child health project in Nigeria. Futures group, health policy initiative. Task order 1.Washington, USA.

Carrin, G., Mathauer, I., Xu, K and Evans, D. (2008) Universal coverage of health services: tailoring its implementation. Bulletin of the World Health Organization, 2008; Vol. 86:857–863. DOI: 10.2471/BLT.07.049387

Center for Science (2004) Alcohol excise taxes in Maryland: A case for an increase in the public interest. Alcohol Policies Project. Washington, DC, USA. [Online]. Available from: http://cspinet.org/booze/taxguide/0403Maryland.pdf [Accessed on 10 th August 2012].

Chidoka, O. (2011) Nigerian roads second-worst globally. 3rd annual road safety corps lecture, Abuja Nigeria. 2011 [Online]. Available at: http://www.frscinsight.com/?p=9843 [Accessed on 2nd May 2012].

Federal Ministry of Health (2004) Health sector reform programme Strategic thrusts with a logical framework and a plan of action, 2004 – 2007. Abuja, Nigeria [Online] Available from: http://www.herfon.org/docs/Nigeria_HealthSectorReformProgramme_2004_2007.pdf [Accessed on 10 th August 2012].

Federal Ministry of Health, Nigeria (2007) Integrated maternal, newborn and child health strategy, Federal Ministry of Health, Abuja, Nigeria. ISBN:978-978-084-870-5.

Federal Ministry of Health, Nigeria (2004) Revised national health policy, Federal government of Nigeria.

Federal Ministry of Information, Nigeria (2012) About Nigeria [Online]. Available from: http://fmi.gov.ng/about-nigeria/history-people/ [Accessed on 10 th August 2012].

Gilbert, K., Fleisher, L., Kariisa, E., Arur, A., Sanjana, P., Paina, L. (USAID), Dare, L., Abubakar, A., Baba, S., Ubok-Udom,E. and Unom, S. (2009) Nigeria Health System Assessment 2008. Federal Ministry of Health, Nigeria and Health Systems 20/20, Abt Associates Incorporated. Maryland, USA. Available from: http://www.healthsystems2020.org/content/resource/detail/2326/ [Accessed on 10 th August 2012].

Gottret, P., Schieber, G. J., and Waters, H.R. (2008) Good practices in health financing: lessons from reforms in low and middle-income countries The International Bank for Reconstruction and Development / The World Bank. Washington. DOI: /10.1596/978-0-8213-7511-2

Gottret, P. and Schieber, G. J. (2006) Health financing revisited. International Bank for Reconstruction and Development / The World Bank. Washington. DOI: 10.1596/978-0-8213-6585-4

Hardon, A. (1990) Ten best readings in the Bamako Initiative. Health Policy Plan. **5** (2): 186–189. DOI:10.1093/heapol/5.2.186.

Heller, P. S. (2005) Understanding fiscal space. IMF policy discussion paper. PDP/05/04. Washington. International Monetary Fund. Available from: http://www.imf.org/external/pubs/ft/pdp/2005/pdp04.pdf [Accessed on 14th August 2012].

Innovative Medicines South Africa (2009) IMSA National Health Insurance Glossary vF4 27 October 2009. Available from: http://www.imsa.org.za/national-health-insurance/policy-briefs/ [Accessed on 10 th May 2012].

Japan Center for International Exchange (2009) Global action for health system strengthening: policy recommendations to the G8. JCIE/USA, Japan [Online]. Available from: www.jcie.org/researchpdfs/takemi/full.pdf [Accessed on 14 th August 2012].

Jonas (2005) Mosby's dictionary of complementary and alternative medicine. (c) 2005, Elsevier [Online]. Available from: http://medical-dictionary.thefreedictionary.com/health+maintenance+organization [Accessed on 14 th August 2012].

Juttung, J. (2009) Innovations in health insurance: community-based models. Innovations in insuring the poor; 2020 vision for food, agriculture, and the environment. International Food Policy Research Institute. Focus 17; Brief 11

Kutzin, J. (2001) A descriptive framework for country-level analysis of health care financing arrangements, Health Policy, (56), pp. 171-204

Kongstvedt, P.R (2002) Managed care: what it is and how it works, 2nd ed. Gaithersburg, MD: Aspen Publishers; 2002:329.

Langenbrunner, J.C., Cashin,C., and O'Dougherty, S. (2009) Designing and implementing health care provider payment systems : how-to manuals. The International Bank for Reconstruction and Development / The World Bank. Washington. DOI: 10.1596/978-0-8213-7815-1

Lawan , U.M, Iliyasu, Z. and Daso, A.M (2012) Challenges to the scale-up of the Nigerian National Health Insurance Scheme: public knowledge and opinions in urban Kano, Nigeria. Ann Trop Med Public Health [Online] Available from: http://www.atmph.org/text.asp?2012/5/1/34/92878 [Accessed on 14 th August 2012].

Le Gargasson, J. and Bernard Salomé, B. (2010) The role of innovative financing mechanisms for health. World Health Report (2010) Background Paper, No12

Mathauer, I. and Carrin, G. (2010) The role of institutional design and organizational practice for health financing performance and universal coverage. Department of Health Systems Financing Discussion Paper Series Number 5, 2010. Also published in Health Policy. DOI 10.1016/j.healthpol.2010.09.013

National Health Bill (2011). Nigeria [Online] Available from: http://www.herfon.org/docs/Harmonised-NATIONAL-HEALTH-BILL-2011%20doc.pdf [Accessed 22nd March 2012]

National Health Insurance Scheme decree (1999) National Health Insurance Scheme Decree No. 35 of 19999, Laws of the Federation of Nigeria [Online] Available at: http://www.nigeria-law.org/National%20Health%20Insurance%20Scheme%20Decree.htm [Accessed on 14 th August 2012].

National Health Insurance Scheme (2012a) Operational guidelines [Online] Available at: http://www.nhis.gov.ng/index.php?option=com_content&view=article&id=92&Itemid=77 [Accessed on 14th August 2012].

National Health Insurance Scheme website (2012b) Welcome note from executive secretary [Online] Available at: http://www.nhis.gov.ng/index.php?option=com_content&view=article&id=47:welcome-note-from-executive-secretary&catid=34:home [Accessed on 14th August 2012].

National Strategic Health Development Plan 2010 – 2015 (NSHDP 2010-2015) Ministry of Health, Nigeria.

Nigeria Vision 20: 2020 (2009). Economic transformation blueprint. Accentur – National Planning Commission' Nigeria [online] Available from: http://www.npc.gov.ng/vault/files/ntwginductionpresentationfinal.pdf [Accessed 22nd March 2012]

Ogbimi, R.I. (2007) Stewardship: a conceptual imperative for managerial effectiveness in the Nigerian health system. Annals of Ibadan Postgraduate Medicine. Vol 5, no.2 (2007) ISSN: 1597-1627

Ogunbekun, I., Ogunbekun, A. and Orobataon, N. (1999) Private health care in Nigeria: walking the tightrope. Health Policy Plan. (1999) 14 (2):174-181.

Okma, K.G.H., Cheng, T. , Chinitz, D. , Crivelli, L. , Lim, M. , Maarse, H. and Labra, M. (2010) 'Six countries, six health reform models? Health care reform in Chile, Israel, Singapore, Switzerland, Taiwan and The Netherlands', Journal of Comparative Policy Analysis: Research and Practice, 12: 1, 75 — 113. DOI: 10.1080/13876980903076237

Onoka, C. (2010) NHIS in Nigeria: an analysis of constraints and enabling factors to adoption. The Alliance for Health policy and systems research [Online]. Available from: http://www.who.int/alliance-hpsr/projects/uninigeria_ufc/en/index.html [Accessed on 10th August 2012]

Organisation for Economic Co-operation and Development (2009), National accounts at a glance 2009, OECD Publishing. DOI: 10.1787/9789264067981-en

Orubuloye, I.O and Oni, J.B. (1996) Health transition research in Nigeria in the era of the Structural Adjustment Programme Health Transition Review, Supplement to Volume 6, 1996, 301-324

Oyedele, D. (2011) Nigeria's population now 168m, hits 221m in 2020. This Day live [Online]. Available from: http://www.thisdaylive.com/articles/nigerias-population-now-168m-hits-221m-in-2020/101436/ [Accessed on 14 th August 2012].

Partnerships British Columbia (2003) An introduction to public private partnerships [Online]. Available from: http://www.partnershipsbc.ca/pdf/An%20Introduction%20to%20P3%20-June03.pdf [Accessed on 14 th August 2012].

Presidency, Nigeria (2012) Analysis of proposed general government expenditure (GGE), Budget Office.

Presidency, Nigeria (2010) Millenium Development Goals report, MDG Office [Online]. Available from:http://www.ng.undp.org/mdgs/Final-MDG-report-2010.pdf. [Accessed on 14th August 2012].

Rijneveld, W. (2006) User fees or community based health insuranc. Woord en daad Research project no.:91.92.001. Program Basic Needs. [Online] Available from: http://www.search4dev.nl/document/210005 [Accessed on 14 th August 2012].

Schieber, G. and Maeda, A. (1997) A curmudgeon's guide to financing Health in developing countries. In G. Schieber, ed., Innovations in health care financing." Discussion Paper 365,World Bank, Washington, USA.

Segen, J.C (2002) Concise dictionary of modern medicine, 2nd ed. The McGraw-Hill Companies, Incorporated [Online]. Available from: http://medical-dictionary.thefreedictionary.com/enrollee [Accessed on 14 th August 2012].

Stenberg, K., Elovainio, R., Chisholm, D., Fuhr, D., Perucic, A., Rekve, D. and Yurekli, A. (2010) Responding to the challenge of resource mobilization - Mechanisms for raising additional domestic resources for health World Health Report (2010) Background Paper, No 13

Shokunbi, I.N (2012) When health bill becomes law. Daily Independent [Online] Available from: http://dailyindependentnig.com/2012/07/when-health-bill-becomes-law/ [Accessed on 14 th August 2012].

Soyibo, A. (2005) National Health Accounts of Nigeria, 1998-2002. NHA Estimation Group, Director Health Policy Training and Research Programme, Department of Economics University of Ibadan Nigeria. Final report submitted to WHO, Geneva.

Soyibo, A., Olaniyan, O. and Lawanson, A.O. (2009) National Health Accounts of Nigeria, 2003-2005. Vol 1: Main report submitted to FMOH, Nigeria

Tandon, A., and Cashin, C. (2010) Assessing public expenditure on health from a fiscal space perspective. Health, Nutrition and Population (HNP) Discussion Paper. The International Bank for Reconstruction and Development / The World Bank. Washington. Available from: http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/AssesingPublicExpenditureFiscalSpace.pdf [Accessed on 14th August 2012].

Usoroh, E. (2012) Establishing a National Health Insurance Scheme (NHIS): what steps should Nigeria take to avoid another white elephant scheme? Policy brief assignment, Health policy & finance, KIT, The Netherlands.

United Nations (2012) The universal declaration of human rights [Online]. Available from: http://www.un.org/en/documents/udhr/ [Accessed on 14 th August 2012].

United Nations Development Programme (2012) Nigeria country profile: Human Development Indicators [Online]. Available from: http://www.state.gov/r/pa/ei/bgn/2836.htm [Accessed on 14 th August 2012].

United States Department of State (2012) Bureau of African affairs, background note: Nigeria [Online]. Available from: http://www.state.gov/r/pa/ei/bgn/2836.htm [Accessed on 14 th August 2012].

United Press International (2012) World news: 100million Nigerians live on less than $1 a day. United Press International, Incoporated [Online]. Available from: http://www.upi.com/Top_News/World-News/2012/02/14/100M-Nigerians-live-on-less-than-1-a-day/UPI-64191329228901/ [Accessed on 14 th August 2012].

Uzochukwu, B. and Onwujekwe, O. (2005) Healthcare reform involving the introduction of user fees: influence on health workers' behavior in southeast Nigeria. Health policy, 2005 Dec; 75(1): 1-8, Amsterdam, The Netherlands.

Uzochukwu, B., Onwujekwe, O., Soludo, E., Nkoli, E., Obikeze, E.N and Onoka, C.A (2009) Community based health insurance scheme in Anambra State, Nigeria: an analysis of policy development, implementation and equity effects. Consortium for Research on Equitable Health Systems. Health Policy Research Group, University of Nigeria, Nigeria.

Uzor, B. (2012) Nigeria to become dominant in Africa's mobile payment market. Business day [Online]. Available from: http://www.businessdayonline.com/NG/index.php/news/76-hot-topic/31507--nigeria-to-become-dominant-in-africas-mobile-payment-market [Accessed 22 March 2012]

Van der Gaag, J. (2007) Health care for the world's poorest: is voluntary (private) health insurance an option? 2020 Focus brief on the World's poor and hungry people [Online]. Available from: http://www.ifpri.org/sites/default/files/publications/beijingbrief_vandergaag.pdf [Accessed on 14 th August 2012].

Wikipedia (2012) The free encyclopaedia. Map of Nigeria [Online]. Available from: http://en.wikipedia.org/wiki/Nigeria [Accessed on 14 th August 2012].

World Bank (2012) World Development Indicators, The World Bank [Online] Available from: http://data.worldbank.org/indicator [Accessed on 14 th August 2012].

World Bank (2012b) World Development Indicators, Data by country: Nigeria. The World Bank [Online] Available from: http://data.worldbank.org/country/nigeria [Accessed on 14 th August 2012].

World Health Organization (2009) Country profile of environmental burden of disease. Public Health and the Environment, 2009. World Health Organization, Geneva.

World Health Organization (2007) Everybody business : strengthening health systems to improve health outcomes : WHO's framework for action. 1. Delivery of health care - trends. 2. Health systems plans. 3. Outcome assessment (health care). 4. Health policy. World Health Organization. ISBN 978 92 4 159607 7

World Health Organization (2010b) Global status report on non-communicable diseases 2010 1. Chronic disease - prevention and control. 2. Chronic disease - epidemiology. 3. Chronic disease - mortality. 4. Cost of illness. 5. Delivery of health care. World Health Organization, Geneva. ISBN 978 92 4 068645 8 (PDF)

World Health Organization (2012c) WHO Constitution. World Health Organization, Geneva. [Online] Available from: http://www.who.int/governance/eb/who_constitution_en.pdf [Accessed on 14 th August 2012].

World Health Organization (2010) World Health Report, Health systems financing: the path to universal coverage. World Health Organization. Geneva.

World Health Organization (2011) The Abuja declaration: ten years on. World Health Organization, Geneva. Available from: http://www.who.int/healthsystems/publications/Abuja10.pdf [Accessed on 14 th August 2012].

World Health Organization (2012) World health statistics 2012. World Health Organization, Geneva. Available from: http://www.who.int/healthinfo/EN_WHS2012_Full.pdf [Accessed on 14 th August 2012].

World Health Organization (2012b) Nigeria - National Expenditure on Health. World Health Organization, Geneva.

Xu, K., Evans, D.B., Carrin, G. and Ana Mylena Aguilar-Rivera, A.M. (2005) Designing health financing systems to reduce catastrophic health expenditure. Technical briefs for policy-makers. No.2. 2005. World Health Organization. Geneva. Available from: http://www.who.int/health_financing/documents/pb_e_05_2-cata_sys.pdf [Accessed on August 10 2012].

Annexes

Annex 1: Geographical map of Nigeria showing 36 states, Abuja (Federal Capital Territory) and boundaries

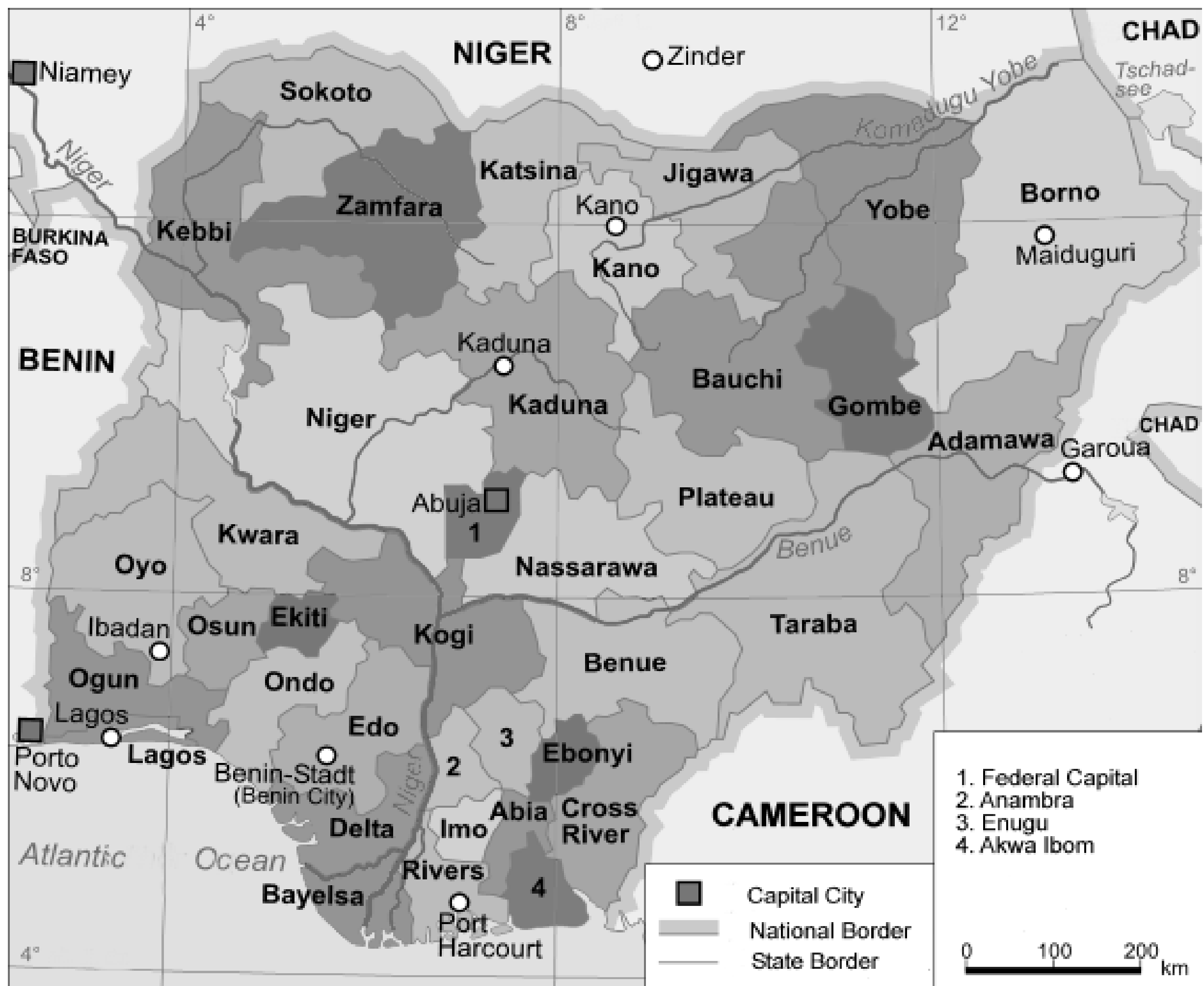
Annex 2: Nigeria - Critical health and population indices

Annex 3: Analysis of the 2012 proposed general government expenditure

Annex 4: NHIS establishing decree no. 35 of 1999

Annex 5: NHIS Benefit package and exclusions

Annex 1: Geographical map of Nigeria showing 36 states, Abuja (Federal Capital Territory) and boundaries



Source: Wikipedia, The free encyclopaedia. Map of Nigeria 2012

Annex 2: Nigeria - Critical health and population indices

S/N	Health/Population index	Value for Nigeria
1.	Human Development Index	156 of 187 countries (0.459)
2.	Male: Female Population distribution	51%:49%
3.	0-14 years age group as a % of population	40.9% (Male 32,476,681 / Female 31,064,539)
4.	15-64 years age group as a % of population	55.9% (Male 44,296,228 / Female 42,534,542)
5.	Access to improved water sources	56% of population
6.	Availability of improved toilet facilities	27% of population
7.	Proportion of population without education	Female – 40%; Male – 28%
8.	Growth rate	3.2%
9.	Infant mortality rate	91.5/1000 Live births
10.	Life expectancy at birth	51.9 years
11.	Children under 5 mortality rate	138/1000 Live births (Regional average 127/1000 Live births)
12.	Maternal mortality ratio	840 deaths/100,000 Live births (Regional average 620/100,000 Live births)

Sources: NDHS 2008/ NPC Fact Sheet 2011 / UNDP Human Development Index report, 2011

Annex 3: Analysis of the 2012 proposed general government expenditure

Federal Government of Nigeria
Classification of Functions of Government (COFOG)

Naira (millions) Ministries, Departments & Agencies (MDAs)	Personnel =N=	Overhead =N=	*Total Recurrent* =N=	Capital =N=	Total Allocation =N=
General public services	**368,877**	**75,211**	**448,780**	**171,881**	**621,761**
Presidency	13,293	14,502	27,796	15,800	43,596
Office of the Secretary to the Govt. of the Federation (SGF)	37,580	9,461	47,042	23,550	70,592
Ministry of Youth Development	63,140	8,136	71,276	4,800	76,076
Ministry of Women Affairs	923	861	1,785	2,400	4,185
Office of Auditor General of the Federation	1,594	1,092	2,687	600	3,287
Independent Corrupt Practices & Related Offences Commision	2,937	1,082	4,020	200	4,220
Ministry of Federal Capital Territory	-	-	-	45,572	45,572
Ministry of Foreign Affairs	18,798	23,988	42,786	7,400	50,186
Ministry of Finance	4,892	6,006	10,898	2,500	13,398
Office of the Head of Service of the Federation	5,067	2,641	7,708	5,060	12,768
Nat. Salaries, Income & Wages Commission	522	188	709	300	1,009
National Planning Commission	4,678	1,315	5,992	1,500	7,492
Ministry of Niger Delta	918	1,805	2,723	57,000	59,723
Ministry of Special Duties	164	201	365	100	465
National Population Commission	7,030	460	7,490	2,100	9,590
Code of Conduct Bureau	1,092	422	1,514	1,100	2,614
Public Complaints Commission	2,178	460	2,638	100	2,738
Revenue Mobilization Fiscal & Allocation Commission	1,577	686	2,263	600	2,863
Code of Conduct Tribunal	226	181	406	600	1,006
Federal Civil Service Commission	690	675	1,364	400	1,764
Federal Character Commission	1,827	459	2,286	100	2,386
Fiscal Responsibility Commission	255	337	592	100	692
National Human Right Commission	495	253	748	100	848
National Assembly	-	-	150,000	-	150,000
Niger-Delta Development Commission	-	-	54,692	-	54,692
	-	-	-	-	-
Defense	**252,659**	**39,024**	**291,683**	**34,671**	**326,354**
Defence/MOD/Army/Airforce/ Navy	252,659	39,024	291,683	34,671	326,354
	-	-	-	-	-
Public order and safety	**482,736**	**41,663**	**674,398**	**85,966**	**760,364**
Ministry of Justice	14,905	6,825	21,730	600	22,330
National Judicial Council	-	-	85,000	-	85,000
Police Service Commission	470	400	870	1,600	2,470
Police Formation & Command	290,714	8,104	298,818	9,040	307,858
Ministry of Police Affairs	3,127	483	3,609	2,500	6,109
Ministry of Interior	136,117	13,615	149,733	7,600	157,333
National Security Advisor	47,401	12,236	59,638	64,626	124,264
Police Reforms (share of FGN)	-	-	15,000	-	15,000
INEC	-	-	40,000	-	40,000
	-	-	-	-	-
Economic affairs	**180,213**	**47,208**	**187,421**	**567,394**	**754,815**
Ministry of Agriculture	30,186	3,789	33,975	45,010	78,985
Ministry of Works	7,014	24,586	31,600	149,200	180,800
Ministry of Trade & Investment	8,494	2,825	11,319	2,200	13,519
Ministry of Information	15,874	4,105	19,979	4,100	24,079
Ministry of Communications Technology	9,762	803	10,565	7,740	18,305
Ministry of Labour & Productivity	5,554	2,795	8,349	2,503	10,852
Ministry of Transportation	6,731	1,094	7,825	47,000	54,825
Ministry of Power	1,986	1,130	3,117	70,300	73,417
Nelmco	-	-	-	18,000	18,000
MYTO	-	-	-	50,000	50,000
Bulk Trader	-	-	-	20,000	20,000
PHCN	-	-	-	87,000	87,000
Ministry of Mines & Steel Devt.	10,149	1,827	11,977	3,000	14,977
Ministry of Petroleum Resources	49,060	2,265	51,324	8,341	59,665
Ministry of Aviation	4,649	1,678	6,326	42,901	49,227
Infrastructural Concessionary & Regulatory Commission	754	311	1,065	100	1,165
	-	-	-	-	-

Environmental protection	**17,404**	**4,889**	**22,293**	**36,804**	**59,097**
Ministry of Environment	10,535	3,155	13,690	6,404	20,094
Ministry of Water Resources	6,869	1,734	8,603	30,400	39,003
	-	-	-	-	-
	-	-	-	-	-
Housing and community amenities	**5,804**	**450**	**6,254**	**20,240**	**26,494**
Ministry of Lands & Housing	5,804	450	6,254	20,240	26,494
	-	-	-	-	-
Health	**216,893**	**8,867**	**225,761**	**57,011**	**282,772**
Ministry of Health	216,893	8,867	225,761	57,011	282,772
	-	-	-	-	-
Recreation, culture, and religion	**15,209**	**11,531**	**26,740**	**4,650**	**31,390**
National Sports Commission	1,583	6,887	8,470	1,400	9,870
Ministry of Culture , Tourism & NOA	13,626	4,644	18,271	3,250	21,521

Naira (millions) Ministries, Departments & Agencies (MDAs)	Personnel	Overhead	*Total Recurrent*	Capital	Total Allocation
	-	-	-	-	-
Education	**334,322**	**31,755**	**434,315**	**64,908**	**499,223**
Ministry of Education	317,899	27,193	345,091	55,057	400,148
Universal Basic Education	-	-	68,237	-	68,237
Ministry of Science & Technology	16,423	4,563	20,986	9,852	30,837
	-	-	-	-	-
Social protection	**0**	**0**	**129,626**	**0**	**129,626**
Conditional Grants and Safety Nets (MDG)	-	-	45,450	-	45,450
Presidential Amnesty Program	-	-	74,176	-	74,176
National Job Creation Scheme	-	-	10,000	-	10,000
	-	-	-	-	-
Not identified elsewhere (nie)	**0**	**0**	**971,051**	**286,152**	**1,257,204**
Debt Service	-	-	559,580	-	559,580
Other CRF charges	-	-	411,471	-	411,471
Capital Supplementation			-	286,152	286,152
Totals	**1,655,116**	**260,600**	**3,429,323**	**1,319,778**	**4,749,101**

COFOG	=N= (million)	US$ (million)	%
General public services	621,761	4,011	13.09%
Defense	326,354	2,106	6.87%
Public order and safety	760,364	4,906	16.01%
Economic affairs	754,815	4,870	15.89%
Environmental protection	59,097	381	1.24%
Housing and community amenities	26,494	171	0.56%
Health	282,772	1,824	5.95%
Recreation, culture, and religion	31,390	203	0.66%
Education	499,223	3,221	10.51%
Social protection	129,626	836	2.73%
nie	1,257,204	8,111	26.47%
Totals	**4,749,101**	**30,639**	**100.00%**

Source: Nigeria - Budget Office, the Presidency 2012

Annex 4: NHIS establishing decree no. 35 of 2999

National Health Insurance Scheme Decree
No 35 of 1999
Laws of the Federation of Nigeria

Arrangement of Sections

Part I
Establishment Of The National Health Insurance Scheme, Etc.

1. Establishment of the National Health Insurance Scheme.
2. Establishment of the Governing Council.
3. Tenure of office.
4. Cessation of membership.

Part II
Objectives, Functions And Powers Of The Scheme

5. Objectives of the Scheme.
6. Functions of the Scheme.
7. Functions of the Council.

The Federal Military Government Hereby Decrees As Follows

Part I
Establishment, etc. of the National Health Insurance Scheme

1. (1) There is hereby established a scheme to be known as the National Health Insurance Scheme (in this Decree referred to as "the Scheme") for the purpose of providing health insurance which shall entitle insured persons and their dependants the benefit of prescribed good quality and cost effective health services as set out in this Decree.

(2) The Scheme -

(a) shall be a body corporate with perpetual succession and a common seal; and

(b) may sue and be sued in its corporate name.

2. (1) There is hereby established for the management of the Scheme, a Governing Council (in this Decree referred to as "the Council") which shall, subject to this Decree, have general control of the Scheme.

(2) The Council shall consist of the following members -

(a) the Chairman, who shall be appointed by the Head of State, Commander-in-Chief of the Armed Forces, on the recommendation of the Minister of Health;

(b) one person to represent the Federal Ministry of Health;

(c) one person to represent the Federal Ministry of Finance;

(d) one person to represent the Office of Establishment and Management Services in the Office of the Secretary to the Government of the Federation;

(e) one person to represent the Nigerian Employers Consultative Association;

(f) one person to represent the Nigeria Labour Congress;

(g) one person to represent the registered health maintenance organisations;

(g) one person to represent the private health care providers;

(h) two persons to represent public interest; and

(i) the Executive Secretary of the Scheme who shall also be the Secretary to the Council.

(3) The Chairman shall be appointed from the private sector be a person of relevant high education, knowledge and integrity.

(4) The other members of the Council shall -

(a) be persons of proven integrity; and

(b) be appointed by the Head of State, Commander-in-Chief of the Armed Forces, on the recommendation of the Minister.

(5) The supplementary provisions set out in the Schedule to this Decree shall have effect with respect to the proceedings of the Council and the other matters contained therein.

3. (1) A member of the Council, other than an *ex-officio* member, shall hold office for a term of 4 years in the first instance and may be reappointed for a further term of 4 years and no more.

(2) The members of the Council shall be paid such remunerations and allowances as the Federal Government may, from time to time, determine for the Chairmen and members of statutory boards generally.

(3) A member of the Council, other than an ex-officio member, may resign his appointment by notice, in writing under his hand, addressed through the Minister, to the Head of State, Commander-in-Chief of the Armed Forces, which resignation shall take effect only on acknowledgement by the Head of State, Commander-in-Chief of the Armed Forces.

4. (l) A member of the Council shall cease to hold office

(a) he becomes of unsound mind; or

(b) he becomes bankrupt or makes a compromise with his creditors; or

(c) he is convicted of a felony or of any offence involving dishonesty; or

(d) he is guilty of serious misconduct in relation to his duties.

(2) A member of the Council may be removed from office by the Head of State, Commander-in-Chief of the Armed Forces, on the recommendation of the Minister if he is satisfied that it is not in the interest of the Scheme or the interest of the public that the member should continue in office.

(3) Where a vacancy occurs in the membership of the Council, it shall be filled by the appointment of a successor to hold office for the remainder of the term of office of his predecessor, so however, that the successor shall represent the same interest and shall be appointed by the Head of State, Commander-in-Chief of the Armed Forces.

Part II
Objectives, Functions and Powers of the Scheme

5. The objectives of the Scheme shall be to -

(a) ensure that every Nigerian has access to good health care services;

(b) protect families from the financial hardship of huge medical bills;

(c) limit the rise in the cost of health care services; (d) ensure equitable distribution of health care costs among different income groups;

(d) maintain high standard of health care delivery services within the Scheme;.

(f) ensure efficiency in health care services;

(g improve and harness private sector participation in the provision of health care services;

(h) ensure adequate distribution of health facilities within the Federation;

(i) ensure equitable patronage of all levels of health care;

(j) ensure the availability of funds to the health sector for improved services.

6. The Scheme shall be responsible for -

(a) registering health maintenance organisations and health care providers under. the Scheme;

(b) issuing appropriate guidelines to maintain the viability of the Scheme;

(c) approving format of contracts proposed by the health maintenance organisations for all health care providers;

(d) determining, after negotiation, capitation and other payments due to health care providers, by the health maintenance organisations;

(e) advising the relevant bodies on inter-relationship of the Scheme with other social security services;

(f) the research and statistics of matters relating to the Scheme;

(g) advising on the continuous improvement of quality of services provided under the Scheme through guidelines issued by the Standard Committee established under section 45 of this Decree;

(h) determining the remuneration and allowances of all staff of the Scheme;

(i) exchanging information and data with the National Health Management Information System, Nigerian Social Insurance Trust Fund, the Federal Office of Statistics, the Central Bank of Nigeria, banks and other financial institutions, the Federal Inland Revenue Service, the State Internal Revenue Services and other relevant bodies;

(j) doing such other things as are necessary or expedient for the purpose of achieving the objectives of the Scheme under this Decree.

7. The Council shall have power to -

(a) manage the Scheme in accordance with the provisions of this Decree;

(b) determine the overall policies of the Scheme, including the financial and operative procedures of the Scheme;

(c) ensure the effective implementation of the policies and procedures of the Scheme;

(d) assess, from time to time, the research, consultancy and training programmes relative to the Scheme;

(e) arrange for the financial and medical audit of the Zonal Health Insurance Offices established under section 21 of this Decree;

(f) set guidelines for effective co-operation with other organisations to promote the objectives of the Scheme;

(g) co-ordinating quarterly returns from the Zonal Health Insurance Offices;

(h) ensuring public awareness about the Scheme;

(i) co-ordinating manpower training under the Scheme;

(j) carry out such other activities as are necessary and expedient for the purpose of achieving the objectives of the Scheme as set out in this Decree.

Source: Laws of the federation of Nigeria 1999

Annex 5: NHIS Benefit package and exclusions

Healthcare providers under the Scheme shall provide the following benefit package to the contributors:

1. Out-patient care, including necessary consumables;
2. Prescribed drugs, pharmaceutical care and diagnostic tests as contained in the NHIS Essential Drugs list and Diagnostic Test lists;
3. Maternity care for up to four(4) live births for every insured contributor/couple in the Formal Sector Programme;
4. Preventive care, including immunization, as it applies in the National Programme on Immunization, health education, family planning, antenatal and post-natal care;
5. Consultation with specialists, such as physicians, paediatricians, obstetricians, gynaecologists, general surgeons, orthopaedic surgeons, ENT surgeons, dental surgeons, radiologists, psychiatrists, ophthalmologists, physiotherapists, etc.;
6. Hospital care in a standard ward for a stay limited to cumulative 15 days per year. Thereafter, the beneficiary and/or the employer pays. The primary provider shall pay the secondary or tertiary provider per diem for bed space for a total 15 days cumulative per year on behalf of the enrollee as bed fee is covered by capitation.
7. Eye examination and care, excluding the provision of spectacles and contact lenses;
8. A range of prostheses (limited to artificial limbs produced in Nigeria); and;
9. Preventive dental care and pain relief (including consultation, dental health education, amalgam filling, and simple extraction).

Important:

- All Providers are expected to provide counselling as an integral part of quality care.
- **Hospitalization**: Enrollees in the NHIS are entitled to hospitalization in general wards only, with the exclusion of meals. The use of private wards and feeding will attract extra charges to the enrollee at the point of use.

Exclusions: The following conditions are totally or partially excluded from the benefits package of the NHIS.

Total Exclusions

1. Occupational/industrial injuries are excluded and would continue to be covered under the Workmen Compensation Act.
2. High technology investigations, except in life-threatening emergencies, e.g. C.T scan, MRI (*See* 'Partial Exclusions')
3. Injuries resulting from:
    - Natural disasters, e.g. earthquakes, landslides, etc (*force majuer*)
    - Conflicts, social unrest, riots, wars, etc**.**
    - Epidemics
4. Family planning commodities, including condoms
5. Injuries arising from extreme sports, e.g. car racing, horse racing, polo, mountaineering, boxing, wrestling, etc.
6. Drug abuse/addiction
7. Terminal illnesses, including **all Cancers**
8. **General Surgery:**
    - Transplant and cosmetic surgeries
    - High cost surgical procedure, including organ transplants, e.g. open-heart surgery, neurosurgery (except Borehole), laminectomy, etc
9. **Ophthalmology:** Provision of spectacles, contact lens, etc

10. **ENT:** Hearing aids and associated appliances
11. **Medicine:**
    - Management of CVA
    - Tuberculosis
    - Chronic renal failure
12. **Paediatrics:**
    - Congenital abnormalities involving major/extensive surgical repairs, e.g. separation of Siamese twins, omphalocoele, etc.
    - Chronic congenital defects, e.g. Hirschsprung disease, etc.

13. **Obstetrics & Gynaecology*:*** Infertility management
14. **Dental:**
    - Dentures, crowns, bridges, implants
    - Scaling and polishing
    - Maxillo-facial surgeries
    - Root-canal treatment

Partial Exclusions

Due to the sizeable prevalence, social importance and cost of the under listed surgical conditions, the HMO will pay **40%** of the cost of management while the remaining **60%** would be borne by the contributor/employer:

1. Prostatectomy
2. Myomectomy
3. Open Reduction

For life-saving emergency treatment requiring high technology investigations, and high-cost screening, the HMO will pay **10%** of the cost, and the remaining **90%** paid by the contributor/employer.

1. C.T scan, MRI.
2. Prostate Specific Antigen (PSA)
3. PAP smear
4. Mammogram
5. Tumour markers
6. Hormonal assays
7. Fluoroscopic dye studies
8. Radio-opaque studies (Barium Meal/Swallow, I.V.U., etc).

However, in observance of an existing contractual agreement between employer and employee, the employer may choose to undertake extra cover in addition to the above.

Benefit package at 15% contribution

The Scheme also makes allowance for a 15% benefit package in recognition of the fact that Government will eventually permit an enrollee to make an additional contribution of 5% which will give better coverage. The following will be included in the benefit package when the 15% contribution becomes operational (subject to review):

1. Prostatectomy (Full Coverage)
2. Open reductions (Full Coverage)
3. Life-saving emergencies requiring high technology investigations

Source: Nigeria - National Health Insurance Scheme, Operational Guidelines May 2005