



Challenges and Prospect of Achieving Health Care Insurance Coverage in Nigeria

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ABSTRACT

Over the years, the Universal health coverage (UHC) has gained prominence as a global health objective, and as such, there is consensus that the achievements of UHC depend on an efficient, equitable and sustainable healthcare system that can maximize health gains. Therefore, this paper aims to study the concept of Universal Health Coverage as well as examine the challenges of expanding health insurance coverage in Nigeria. It also researches into the possible prospects of expanding health insurance in Nigeria and how to implement and deliver patient-centered care.

Keywords: *Universal Health Coverage; Health insurance; Insurance Coverage*

Introduction

The right to an adequate standard of living for health and welfare is a human right recognized by all nations in the world, including Nigeria. The recognition is listed in Declaration of United Nation in 1948 on Human Right. In this scenario, Article 25 of the Universal Declaration of Human Rights of 1948 states that "everyone has the right to a standard of living that is adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control (WHO, 2012). Based on this, some countries take an initiative to develop social insurance, such as Universal Health Coverage = UHC (Beegle, de Weerd, and Dercon, 2008). In 2005, the World Health Assembly issued a call on member states for universal health coverage (UHC), with an aim of achieving affordable and accessible medical care for all citizens. United Nations (UN) member states endorsed UHC in a 2012 resolution (WHO, 2012) and adopted it as a Sustainable Development Goal (SDG) target in 2015. These global agreements conceptualize UHC as ensuring all people's access to the health services they need, with sufficient quality to be effective, while protecting against the financial risk (Preker, Lindner, Chernichovsky, and Schellekens, 2013). The Universal health coverage (UHC) has gained prominence as a global health objective, hence there is consensus that the achievements of UHC depend on an efficient, equitable and sustainable healthcare system that can maximize health gains. The consolidation of universal health coverage is directly related to multiple, complex factors internal and external to the health system, including economic, social, political, ethical and legal aspects. Therefore, the ability of health insurance programmes to contribute to such a system is determined by many factors, such as financial capacity (or bargaining power) of the funds, risk-sharing arrangements, provider payment mechanisms, management of consumer claims and cooperation across funds (Carrin, Waelkens & Criel, 2005). Universal health coverage has permeated the health discourse and is garnering worldwide attention. Despite that, it is an unusual target, for it has traditionally been regarded as a means for – and not a component of – better health outcomes. Millennium development goals (MDGs), the predecessor to SDGs, included health-related targets along the lines of reducing under-five mortality, maternal mortality, and halting the spread of HIV/AIDS, malaria, and other diseases. Inclusion of UHC in SDG3 has been taken with a pinch of salt, and doubts have been raised whether this undermines public health measures and health equity (Preker, Lindner, Chernichovsky, & Schellekens, 2013). Notwithstanding some practical issues, setting UHC as a SDG target has positive implications for health equity and overall health status.

A broad range of risk-pooling mechanisms or insurance schemes are increasingly being utilized across the developing world to increase access and reduce the financial burden of health (Dutta & Hongoro, 2013). The number of evaluations of such efforts is growing and while findings are mixed, the overall findings on impacts are encouraging. In theory, health insurance contribute to the achievement of UHC as it increases access and utilization by lowering the price of health care (Giedion, Alfonso, & Díaz, 2013). King, Gakidou, Imai, Lakin, Moore, Nall, C and Llamas (2009) examine the impact of the randomly assigned Mexican universal health insurance program Seguro Popular. The phased rollout of the program provides an experimental design for a study of a program aimed at reaching 50 million uninsured Mexicans. This study, however, shows Seguro Popular to have no significant impact on the use of medical services but it is important to note that the study is based on a time span of only 10 months (King et al. 2009). Galarraga Sosa-Rubi, Salinas-Rodriguez, and Sesma-Vazquez, (2010) found that in Seguro popular, there was a reduction of catastrophic health expenditures of 49 percent for the experimental evaluation database (the same used by King et al., but using a different method) and 54 percent for the whole country based on a DHS-like survey. In addition, the authors found a reduction of out-of-pocket health expenditures for most types of services (Trujillo, Portillo, & Vernon, 2005). There are few impact evaluations of health insurance in African countries and those that do exist demonstrate a weaker methodology. Smith and Sulzbach (2008) reported a correlation between health insurance and use of maternal health services but highlight that the inclusion of maternal health care in the benefits package of the insurance is key. In Jutting (2003), the author finds in a study of community-based health insurance in Senegal an increase in utilization of hospitalization services but a failure of the program to address the needs of the poorest of the poor (Galarraga, Sosa-Rubi, Salinas-Rodriguez, & Sesma-Vazquez, 2010). The impact of health insurance scheme in Africa continent have been documented, it is however noteworthy to assert that in Nigeria,

health insurance coverage has remained a mere dream due to certain limitations. In some situations, community-based health insurance (CBHI) is promoted as a mechanism to fund health services and provide financial protection for people working in the informal sector (Giedion, Alfonso & Díaz, 2007). But limitations exist to expand population, health service benefit and cost coverage because of its voluntary enrollment and weaknesses to offer a broad range of health service benefits and effective financial protection due to low contribution rates, irregular payments and frequent drop-outs this therefore calls for an evaluation on the prospects and challenges to expanding health insurance in Nigeria in order to attest to the benefits outlined in other countries. This paper therefore addresses the challenges and prospect of achieving health care insurance coverage in Nigeria.

The objectives of the paper

- i. Explain the concept of Health insurance coverage
- ii. Examine the challenges of expanding health insurance coverage in Nigeria
- iii. Assess the prospect of expanding health insurance coverage in Nigeria

The Concept of Health Insurance Coverage

The definition of Health insurance coverage cannot be adequately address without first examining the definition of universal health insurance coverage. The term “Universal Coverage”, or “Universal Health Coverage” originally came from WHO. It was further developed from a jargon “health for all”. Currently, the term “universal coverage” is widely used in social security, especially health insurance (Yip, & Hsiao, 2008). Universal Health Coverage (UHC) has been defined as providing access to needed health services without incurring financial hardships for the whole population, and is receiving renewed attention at both global and national levels. In other words, Universal Health Coverage is a system where each person in a community is able to access healthcare without suffering financial hardship (WHO, 2012). WHO clearly defines universal coverage as an access for community to get comprehensive healthcare with reasonable price and without suffering financial hardship through protection against catastrophic health expenditure (WHO, 2012). According Gustafsson-Wright, Tanović, & van der Gaag, (2013) the definition of WHO, entails access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship (WHO, 2005). The World Health Report 2010 explains the concept of UHC into three dimensions: 1) how many percent of people insured; 2) how complete the service insured, and 3) how big the proportion of direct budget borne by people. In short, universal coverage includes: universal participant coverage, access of equal healthcare, the cost proportion of public (out of pocket) which is getting fewer (Ekman, 2014). Healthcare implementation includes: prevention, promotion, medication, rehabilitation, and palliative care.

The concept of UHC predominates in government social security strategies in almost all LMICs (FCGH, 2012). It represents three related objectives: equity in access to health services, high quality of services (health promotion, prevention, curative services, rehabilitation, and palliative services) and financially affordable health care. In the era of the envisaged post-Millennium Development Goals framework, the increasing prevalence of chronic non-communicable diseases (NCDs) (Wang & Pielemeier, 2012) is becoming a major challenge not only in industrialized societies but also in LMICs (UN Report, 2013, Bloom et al. 2011, WHO World health statistics, 2013). The organizations supporting UHC include the World Health Organization (WHO), the World Bank, and the United States Agency for International Development (USAID), the Inter-American Development Bank, the Bill and Melinda Gates and the Rockefeller Foundations, among others (Giedion, Alfonso, & Díaz, 2013). Health insurance is a social instrument to ensure a person to get the benefits of healthcare and protection to fill health basic needs without considering economic condition when the person needs healthcare. Health insurance is considered as an option to raise and pool revenues, as well as provide some degree of financial protection in several African countries (Sibomana & Reveillon, 2015). Although it has some potential, especially when health insurance coverage and contribution is compulsory by law, several policy issues are raised and discussed in recent years. Therefore, with health insurance, people can reduce the risk of bearing the cost from their own pocket when they get illness, with the unpredictable cost and sometimes needs high amount of funding (Sachs, 2012). The concept of UHC does not

imply a particular health system organization and can include both national health systems (or a National Health Insurance model) which are state funded and government managed, and systems of Social Health Insurance (SHI) which are generally designed for the working population and financed by payroll taxes collected from employers and employees (Knaul, 2012). This model is most beneficial to countries that have a large enrollee base and efficient supervision and administration of funds. A third model of risk pooling and prepayment is Community-based Health Insurance (CBHI) often referred to as health insurance for the informal sector or micro-health insurance. CBHI's share three common characteristics: they include not-for-profit prepayment plans, community empowerment, and voluntary membership (Ghislandi, Manachotphong, & Perego, 2013). Many Sub-Saharan African and Asian countries use the CBHI model because their risk-pooling and saving schemes create a natural platform for the program (Makaka, Breen, & Binagwaho, 2012). Such models are smaller in scale and by definition do not aim to achieve coverage of the majority of the population. In view of the potential benefits associated with health insurance scheme, some African countries have shown a great success with health insurance and expanded insurance coverage using non-contributory revenues such as value added tax, state subsidy for contribution payment and public budget transfers to overcome the above-mentioned challenges. Currently, compulsory health insurance is practiced in Algeria, Gabon, Ghana, Kenya, Mali, Rwanda, Tanzania and Togo. Almost all health insurance schemes in these countries receive public subsidies or budget transfers. Mandatory insurance is discussed over many years in Benin, Swaziland, Uganda and Zambia, but policy consensus and decisions are still not reached yet. Ethiopia passed a decree on compulsory health insurance, but its implementation had lengthy delays mainly because of administrative capacity to implement the decree. Other private and CBHI options are also practiced in the region, but their scale is low except Rwanda that made health insurance coverage mandatory by law since 2015. The law strengthened communities to form the base of the bottom-up pillar of the health system with strong involvement and budget support of central and local governments. This makes the Rwandan health insurance system highly subsidized to cover more people, provide quality health service benefits and strengthen financial protection. To promote inclusive health insurance, the federal government through the National Health Insurance Scheme in 2008 started a rural community-based social health insurance program (CBSHIP). This was intended to help achieve universal healthcare coverage (UHC) by 2015, with at least about 70 million people to be reached. Unlike individual health insurance which focuses on the coverage of the individual (with or without a dependent) community health insurance focuses on a group of individuals and provides health coverage in a uniform manner, with each member having equal access to the benefits. It often cost less as each member is expected to share the risk of payment. It is considered as pro-poor scheme as it ensures that greater number of Nigerians including the rural poor have access to quality health care.

The Purpose of Universal Health Insurance Coverage

Universal health coverage is defined by access to the promotion of key interventions, prevention, treatment and rehabilitation for all, at an affordable cost, in the pursuit of achieving equity in access (Giedion, Alfonso, & Díaz, 2013). Therefore, the goal of universal health coverage is to ensure that all people have the health care they need, without financial restrictions. This definition is aligned with the values and principles established by the concepts of Health for All and Primary Health Care). Universal Health Coverage is based on the foundations agreed in the Constitution of the World Health Organization, in 1948, which declared health as a fundamental right of every human being, as well as the agenda established in Alma Ata in 1978. Universal Health Coverage has a direct impact on people's health as access to services is a crucial component for sustainable development and poverty reduction, and a key element for reducing social inequities.

There are two motivations related to commitment of implementing universal health insurance coverage. First, each individual has a right of health. Second, poor health has negative externality from an individual to community, or from poor countries to the rich countries. Therefore, public has an obligation to make sure that poor people get access to health coverage by exulting system that will enable the less privilege have access to quality and affordable health.

In the beginning, health assurance concept was not implemented to ensure all people, but current development proves that the social insurance concept in a country becomes a reliable concept. Universal health insurance coverage aims at ensuring an access for all people who needs healthcare without considering economic status or age. The principle is called social equity. It is a life philosophy of all people around the world. Universal health insurance coverage functions as redistribution of right and obligation between a group of people: rich-poor, healthy-sick, old-young, low risk-high risk, as a realization of human civilization (Wagstaff, Lindelow, Junc, Ling, & Juncheng, 2007). A country which has achieved universal health insurance coverage focuses on three problems, such as: who is covered, for what service they are covered, and in what level the financing contribution? People who wants to improve the health service access is always debated whether they have filled the requirements and what is the reason. Other components are what kind of healthcare insured, inpatient or outpatient, and expensive or cheap care. Also, financing resource are funded through public levies, privat contribution, or payment when they get the healthcare. Therefore, the purpose of Universal health insurance coverage is to make sure that everyone gets health service (it could be prevention, promotion, medication, rehabilitation, and palliative) without financial catastrophic risk or poverty, now and in the future (Wagstaff, & Lindelow, 2008)

Challenges of Expanding Health Insurance Coverage in Nigeria

The constraints to achieving UHC in Nigeria are numerous and complex. Factors limiting Nigeria's health outcomes are both demand and supply-side including inadequate financing, weak governance and enforcement, inadequate infrastructure and poor service quality, weak governance and enforcement, household poverty and insufficient risk pooling.

Inadequate Government Financing for Health

There are four main sources of public funding for the public (nonfederal) health sector: state governments, local governments, direct allocations from the federal government, and private individuals and organizations, including nongovernmental organizations and international donors in some states. The federal government and some state governments have increased funding to public health care (PHC) over the past decade, with a dramatic increase between 2005 and 2007 where the percent increase in health sector allocations jumped from 31.4 percent to 86.2 percent. Nonetheless, Nigeria spends a mere 5.3 percent of its GDP, or \$139 (PPP) per capita on health care. This is extremely low, in particular when compared to other African countries such as Burkina Faso (6.7 percent) and the Democratic Republic of Congo (7.9 percent), which have considerably lower GDP per capita. The government contributes only 36.7 percent of the country's total spending on health. The absence of institutionalized National Health Accounts (NHA), however, contributes to the challenge of reassessing health spending in the country. Finally, low levels of external health financing reflect an unwillingness to invest in the country. Just 9.2 percent of spending is donor funded, which is very low compared to, for example, Ghana with 16.9 percent, which has a comparable GDP per capita (Wagstaff, & Lindelow, 2008).

Weak Governance and Enforcement

The existing legislative structure for budget allocations to social sectors as well as weak governance and institutions leads to inefficient spending and lack of trust in the system. State governments in Nigeria have substantial autonomy and exercise considerable authority over the allocation and utilization of their resources. This arrangement constrains the leverage that the federal government has over state and local governments in terms of getting them to invest in the health sector. Therefore, top-down approaches continue to fail to produce improvements in access, financial protection and health indicator (Dutta & Hongoro, 2013). In addition, the public system lacks transparency and enforcement, making it subject to corruption and lending inadequate medical and administrative capacity to produce services efficiently and of adequate quality. A weak institutional framework leads to high uncertainty and risk and thereby lowers the level of trust which reduces the willingness of individuals to invest. As a consequence, the willingness to prepay for health care remains low (Dutta & Hongoro, 2013).

Inadequate Health Infrastructure and Poor Service Quality

Low government spending combined with weak institutions and lack of enforcement lead to inadequate health infrastructure and poor service quality. Due to the unwillingness to invest in health or prepay for health care, predictable revenue flow is unavailable for health providers to improve the supply chain leaving much of the country's health infrastructure in a dismal state. Many health facilities lack access to clean water and a reliable supply of electricity, face shortages of medical equipment, and are missing necessary medications or blood to treat their patients thereby limiting the patronage of universal health insurance scheme (Carrin, 2003). In addition, there is a deficiency in qualified health professionals in particular in poor communities. Large disparities exist between urban and rural areas and between states due to the variation in remuneration packages for health professionals across states and between federal and state level, health professionals gravitate to better paying federal facilities and states. Private providers mainly operate in urban settings where income levels are the highest. This situation results in a lack of qualified and competent health professionals for individuals who live in poor rural areas that tend to bear a greater disease burden (Carrin, 2003).

Poverty Constraints, Insufficient Risk Pooling and Burden on Private Individuals

Nearly two-thirds of Nigerian's live below the poverty line; eighty percent work in the informal sector. As the national health system mostly covers the formally employed only 3 percent of the population is covered by the NHIS. Private prepaid schemes are unreachable for the poor as premiums are unaffordable. With the overburdened public system unable to deliver, people have no option but to pay for health care out-of-pocket. By default, the private health sector has grown rapidly over the past decades and now provides over 65 percent of health care services (Hendriks, Wit, Akande, Kramer, Osagbemi, Tanović, & Gustafsson-Wright 2013). Beyond the inability to pay for existing expensive health insurance schemes, it is common in poverty stricken environments, that decision-making take place in a much shorter time horizon, with people refraining from saving, investing and buying health insurance. The willingness to prepay for health care is low in an environment of low trust in which people are unsure of benefits from a product or service in the future against a payment today (Hendriks, et al, 2013). In Nigeria, prepaid spending or risk-pooling only encompasses 3.1 percent of all private health spending. The remaining private spending consists of out-of-pocket payments. This makes the development of risk pools difficult and creates an environment that is not conducive to private investment. In short prepayment is low because people do not trust the system and because the quality of the services is low, while a lack of a steady revenue stream discourages providers from investing.

Increase Alignment

The magnitude and impact on health care expenditures due to elevated health care utilization and higher resources spent on the number of interventions required clearly represent a major challenge for healthcare systems (Kuo et al. 2013; Starfield et al. 2011). The treatment of NCDs, such as diabetes or cardio-vascular diseases often requires long-term, if not life-long care. Thus, providing life-long access to drugs, medical services etc. is necessary and challenging, especially if coverage is to be steadily expanded. The objective of UHC for NCDs cannot be achieved where national health systems are weak. Health workforce shortages, interrupted provision of essential drugs and other supplies, financial barriers to care, ineffective governance structures and poor planning, insufficient health information, and inappropriate models for service delivery make the provision of services for NCDs difficult (Samb et al. 2011). In many countries the provision of even essential health care insurance coverage cannot be assured. Multiple vertical programs are often focused on just a few specific acute conditions (often infectious diseases) and are mainly linked to the current aid agenda. In the light of changes in demand (NCDs, treatment adherence pattern) and supply (poorly coordinated services and financial burden for governments).

Prospect of Universal Health Insurance Coverage

Strategies to attain UHC are becoming more challenging due to increasing prevalence of NCDs at all ages coupled with the rate at which the population is ageing. Worldwide the number of people aged 65 and above is projected to grow from 524 million in 2010 to about 1.5 billion in 2050, with the largest rates of increase in LMICs (UN World Population Ageing, 2013). In addition, a forecast of the population structure in a number of LMICs shows that chronic diseases of women, e.g. breast and cervical cancer, will be extremely prevalent. Thus, financial support for women will be crucial as elderly women are frequently poorer than men of the same age (UN World Population Ageing, 2013). The difficulty in ensuring concurrent equity, quality and financial sustainability under the umbrella of universal coverage comes not only from an epidemiological shift, but also from the dual burden of diseases (communicable and NCDs) and multi-morbidity on top of a continuous struggle with high neonatal and maternal mortality hence for an effective Universal health insurance coverage, an alternative model is (public-private partnership community-based health insurance model (PPP-CBHI)) is often advocated. This model has the potential to contribute to the achievement of UHC by addressing many of the constraints of Universal Health Insurance. The PPP-CBHI model is based on three main pillars:

1. Building on existing local public and private institutions and informal networks;
2. Leveraging existing capital; and
3. Empowering local clients and communities.

Building on Existing Local Public and Private Institutions and Informal Networks

In developed countries, public institutions facilitate economic exchange in society by reducing risk and moral hazard. Public and social goods like health care, water, sanitation and education are effectively organized by the state through public or semi-public institutions. However, in low and middle-income countries like Nigeria the limited functioning of the state and its institutions hampers economic development and the rendering of public goods and services. Informal institutions often take the place of public institutions and transactions within those institutions are commonly enforced by social pressure and other social norms (Kutzin, Yip & Cashin, 2016). Interventions therefore, that build on existing local and often informal institutions for which there may be greater trust, are more likely to succeed (Kutzin, Yip, Cashin, 2016). This can be achieved by, for example, leveraging social capital of communities and their local leaders, and their existing ties with private providers. In this model, groups such as microcredit members, farmers, or market women are targeted to build on the existing social capital present in the group (Kutzin, Yip, Cashin, 2016). Also, contributing to the strengthening of formal institutions (e.g. quality standards/accreditation, investment funds for social infrastructure), through involvement of the private sector in the delivery of essential public, semi-public and social goods, is a logical step.

Leveraging Existing Capital

In many developing countries, the private sector is an important provider of health care, including for its poor who pay for these private services largely out-of-pocket. Increasingly, many of the facilitating functions for health care—information, quality certification, technology support, human resources—are also provided by the private sector. This makes the private sector an important partner to reach the primary beneficiaries, namely, low-income groups, and facilitate systemic change in a bottom-up approach. Harnessing the out-of-pocket expenditures into prepaid systems rather than crowding them out with public health funding is another important element of this model. Another important element is the leveraging of donor funding to mobilize private capital (Leive & Xu, 2008).

Empowering Clients and Local Communities

Ownership by and empowerment of clients and the communities they belong to is of crucial importance for the approach to succeed. A client-oriented approach requires knowledge about what clients want and need and what

they can afford and are willing to (pre) pay. It implies the importance of delivering good quality care to the clients/patients, which requires building a strong health care supply chain: without good quality supply the willingness to prepay is likely to be low.

Consumer theory

Consumer theory assumes that if consumers are perfectly informed, they maximize their utility as a function of consuming various goods, given relative prices, their income and preferences. Changes in prices and income influence how much of different goods rational consumers will buy (Begg et al. 2000). Health insurance is expected to be a normal good with a positive income elasticity of demand, implying that the poor are less likely to insure. A price increase of a substitute for insurance – such as user fees – is expected to raise the insurance demand, as is a decrease in insurance premium. However, due to uncertainty about the unknown future health, insurance choice is not made based on utility alone but on consumers' expectation about factors such as their health status (Cameron et al. 1988).

Conclusions

The call for UHC - health systems providing both access to health services and financial protection -challenges the global donor community and governments to make efforts toward achieving this goal in the near future. Nigeria is making efforts to achieve UHC, nevertheless, a mere 3 percent of the population is currently covered by the country's national health insurance and government spending on health represents only 5.3 percent of GDP therefore the solution to achieving UHC may be in risk sharing through private community health plans and private delivery. A public-private partnership community-based health insurance (PPP-CBHI) model could be a stepping stone towards achieving universal health coverage, both in Nigeria and elsewhere.

Recommendations

- i. In order to achieve effective access and financial protection, the government must begin by making a more serious commitment to spend on health.
- ii. There should be an increase private partnership in universal health insurance scheme
- iii. The government at all levels develop policy and enforce such policies that will reduce the financial burden of health care system on it's by ensuring adequate contributing scheme.

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