Challenges Nigeria Faces with Health Insurance

Challenges Nigeria Faces in Implementing the National Health Insurance Scheme (NHIS)

By

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This thesis or project has been accepted on behalf of the department Public Policy and Administration by their supervisory committee

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Dedication

This work is dedicated to God Almighty who made it possible for me to go through this program successfully. I give him all the glory. To my daughter Uririoghene Toni Onosu, for her love and patience, I give my unfailing love.
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I want to acknowledge my husband, Mr. Emuobosan Onosu, who has been the source of inspiration. Words cannot express how grateful I am for all the sacrifices you have made on my behalf. Your prayers and care sustained me thus far. I would also want to thank my brothers, Dr. T.E. Okagbare, Prof. G.O. Okagbare, and Mr. Pius Edobor, who supported me in writing and inspired me to strive towards my goals.

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Abstract

National health insurance is health insurance that insures a national population for the costs of healthcare that is usually enforced by law. The Nigeria National Health Insurance Scheme is a law set up under Act 35 of 1999 and was established in 2005 by the Federal Government of Nigeria, operating as a Public-Private Partnership and directed at providing accessible, affordable, and quality healthcare for all Nigerians. The purpose of this study was to identify the challenges Nigeria is facing in the implementation of the NHIS and to offer recommendations.

The research methods used for this study were non-experimental qualitative method using content analysis and quantitative research method using a descriptive trend analysis. Data were gathered from existing and published materials that were available on the internet. The limitations of this study include inadequate information and limited time frame. The major challenges identified during the study include: the rapidly growing population, coverage to only one sector of the population, lack of awareness of the scheme, distrust, shortage of human resources, and lack of funds to implement the scheme. Based on these challenges, four recommendations were made.

The four recommendations include Government should introduce stringent birth control; Government should develop public strategic plan for reaching the enrollment target; Increase the supply of human resources and ensure transparency and accountability among enrollees, NHIS operators and state.
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CHAPTER ONE

Introduction

Insurance is a contract of indemnity that involves pooling of resources from a large number of people or organizations (Lloyd Insurance, 2014). A business that provides insurance agrees to take a risk on behalf of a company or individual in exchange for a fee. It does this by providing the business or individual concerned with an insurance contract, sometimes called a ‘policy.’ This policy may cover a person or business for many of the costs they have to meet as a result of a risk occurring and provides the policyholder with some security should the worst happen. There are various types of insurance such as automobile, life, fire, burglary, and health insurance. This research is concerned with the health insurance.

Health Insurance can be defined as a system of advance financing of health expenditures through contributions, premiums, or taxes paid into a common pool to pay for all or part of the health services specified by a policy or plan (NHIS Operational Guideline, 2012). Akwukwuma and Igodan (2012), also defined health insurance as the ability to get health services when required without having to pay fully at the time of need because payment has been made by a fixed regular contribution by the insured or employer or both. In addition, this involves risk sharing by contributors, thus individuals have the ability to get health services when required without having to pay fully, those with higher resources subsidize those with less, and those with low incidence of illness subsidize those who require care more frequently.

The fundamental objective of health insurance is to improve the health of a population and to provide financial protection against the unforeseen costs of ill-health. Central to achieving
these goals is the idea of risk pooling, where the risk of having to pay for health care is spread across the entire pool of members instead of being borne solely on the individual. Therefore, the larger the degree of risk pooling in a health financing system, the smaller the financial consequences of individual health risks, and the easier it is to increase access to health care and achieve universal coverage (Deloitte, 2012).

Health Insurance Models

According to Wallace (2013), at the national level there are four basic health financing models in the world: Beveridge, Bismarck, National Health Insurance, and out-of-pocket:

The Beveridge Model

The Beveridge model is a public financed health insurance approach that was developed by Sir William (Belveridge Kovner & Knickman 2011). In this system, healthcare is provided and financed by the government through tax payments. It provides universal coverage and no healthcare bills. It is a single payer system. Most hospitals and clinics are owned by the government; most doctors are government employees, but there are also private doctors that collect their fee from the government. The system tends to have a low costs per capital, because the government is directly involved in the payments of bills and also dictates doctors treatments methods and what they can charge. It has model can be seen in Britain, Spain, New Zealand, and Scandinavia. This model has become the British National Health Service (NHS).

The Bismarck Model

This model also known as the social insurance model is the oldest health care system that was introduced 1883 by German Chancellor Otto von Bismarck. This model uses an insurance
system known as the Sick Fund which is usually financed cooperatively by employers and employees through payroll deduction. It uses private payers and providers to deliver health care. In this model, a fee are set, and tightly regulates several hundred private and non-profit insurance plans to make sure everyone gets universal health coverage. Doctors and hospitals are mostly private in Bismarck countries. For instance, Japan, which is a Bismarck country, has more private hospital, than the US. Government has more cost control in the Bismarck model than the Beveridge model because of its multi-payer system. This system is also found in Germany, France, Belgium, Switzerland, and Netherlands and to a degree in Latin America (Reid, 2009).

The National Health Insurance (NHI)

Reid described it as the system that has the elements of Beveridge and Bismarck. It uses private care providers, but payment comes from government-run, non-profit insurance plans that citizens pay into monthly. In this model, health care is financed by the government and delivered by the private sector. It uses its superior marketing power to negotiate lower prices. The NHI also limits covered procedures to those that meet efficiency guidelines. This universal insurance tends to be cheaper; this is as a result of no financial motive to deny claims and no profit. It is also simple when it comes to administration because there is no need for marketing, since the government takes care of everything. The NHI plan also controls cost by limiting the medical services they will pay for or by making patients wait to be treated. NHI covers the entire health population, thereby, achieving universal coverage. The NHI system is found in Canada, Australia, Taiwan, and South Korea.

The Out-of-Pocket Model
This model refers to as pay-as-you-go. Health care is financed by patient and delivered by private and government hospitals. Countries under this model have their citizens’ pay for medical care costs from their own pocket if they can afford it. The implication is, in such countries only the rich get medical care while the others look for alternative methods to survive. According Reid (2009),”this model is found in Africa, e.g. Nigeria, Indian, China, and South America” Currently Nigeria pay as you go model is been transformed into the National Health Insurance Model (NHIS).

Nigeria features 36 states and its Federal Capital Territory, Abuja. Nigeria at present has an estimated population of 177 million which is the largest population of Blacks in any nation in the world (http://emmyboy.tripod.com/sitebuildercontent/Nigeria_files/).

Nigeria grapple with a lot of medical issues from malaria that has been a major killer, a major cause of infant mortality, and other illness due to lack of access to adequate medical services. In order to improve this situation, the Federal Government of Nigeria introduced the National Health Insurance Scheme (NHIS) in 1999.

Nigeria National Health Insurance Plan

Nigerian operates the Bismarck Model, where employers, employees or both contribute money to a Health Management Organization (HMO) (NHIS Operational Guideline, 2012).

The model comes with its advantages which include comprehensive and uniform benefits package. Government does not have to bear the cost of medical care, and universal coverage is possible in the long term. Countries under this model enforce compulsory contributions where the young healthy citizens tend to pay more.
Problem Statement

Good healthcare is vital to any person, people, organization or the nation at large. It is for this reason health is considered as wealth. This is also the reason why the three tiers of government in Nigeria is concerned with the provision of health care for her people. Despite the introduction of NHIS, the healthcare system has not improved considerably. The low level of awareness of the scheme could be a major challenge in the implementation of the scheme.

Purpose of the Study

The main purpose of this research work is to explore the challenges in the implementation of NHIS in developing country like Nigeria and to offer recommendations that may be helpful in the successful implementation of the scheme in Nigeria. To achieve this, the following objectives are set for this study:

- To identify the challenges of the recently introduced NHIS in Nigeria
- To access the operation of the NHIS in Nigeria
Chapter 2

Literature Review

The goal of this study is to identify the challenges Nigeria faces in implementing the NHIS. The research question for this study: What challenges does Nigeria face in implementing the NHIS? With this question in mind, the literature review will cover various aspects of the NHIS including, national health insurance in other parts of the world, problems of national health insurance in other parts of the world NHIS’s history in Nigeria, its importance, objectives, benefits, how it operates in Nigeria, the types of health insurance in Nigeria, healthcare delivery laws in Nigeria, goals and implementation of the scheme, illnesses covered by the scheme, why the scheme is difficult to adopt, and theory regarding policy implementation.

National Health Insurance in other Part of the World

The World Health Organization defines health as a state of complete physical, mental, and social well-being and not just the absence of disease (WHO, 2000). This definition seems abnormal in the Nigerian context.

The insurance industry sees Nigerians as easily manipulated targets within the industry because they lack representation and government support. The dream of every country is to provide its citizens with affordable and accessible health care. In South Africa for example, there is no national public health insurance scheme, but they can brag of better health indices than Nigeria. South Africa has private health insurance schemes that are affordable, well organized, and function effectively (Gana, 2010). A look at the national health insurance in other parts of the world may enlighten the reader about other countries’ success in implementing this program.
and allow for learning opportunities based on this success. The United Kingdom has National Health Service (NHS) which is a public funded healthcare system for all residents of the UK. Premiums are not collected, patients do not have to pay their medical bills, and costs are not prepaid from a pool. It is not an insurance system, but it does achieve the main objective of health insurance: sharing the financial risk arising from sickness where the population is covered directly from general taxation. The United States, on the other hand, relies on private insurance which was the main source of health coverage for most Americans before the Patient Protection Affordable Act was introduced.

France operates a unity level, incorporating both public and private schemes. The French health is generally known as offering the best, or one of the best, services of public health care in the world. In overall, it is a system that works, provides universal coverage, and is a system that is strongly defended by virtually everyone in France. World Health Organizations (WHO) ranked France as number one country with the best national health insurance (WHO, 2000). France practice what is called complementary private insurance. This means that people with chronic illness get 100% reimbursement, having their co-charges waved (Gana, 2010).

Canada comprises of both public and private scheme like France. Most health insurance schemes in Canada are administered at the level of provinces under Canadian Act that require all citizens to have free access to healthcare. 65% of Canadians have supplementary private health insurance (Gana, 2010). A good number of them received it from their employer. Canada has a universal health care system that's paid for through income taxes and sales tax. All Canadians are covered, and they can see any doctor they want anywhere in the country with no copays or deductibles (Varney 2009). In Australia, there is functional public health insurance alongside
with private schemes. Public health insurance scheme provides free universal access to hospital and subsidized out – of –hospital medical treatment. Public health system is financed by 1% levy on all tax payers and an extra 1% on high income earners as well as General Avenue. Private health insurers are both for profit and nonprofit organizations (Onyedibe et al 2009).

German sick fund is a health insurance scheme paid for by employers and employees and managed by nonprofit organizations. It is known for its efficient management, adequate investment, and private base provider. In Germany it is mandatory for citizen to have health insurance.

Ghana National Health Service (NHS) is fully financed from state revenue. It provides services to all her citizen without cost and also protected poor people from financial shocks. In Ghana there is no out of pocket fee at point of service unlike in Nigeria where majority are operating in the fee for service kind of payment. The Nigeria system allows private healthcare providers as major stockholders despite the establishment of the NHIS. The extent of coverage of the NHIS is such that farmers, street vendors, entrepreneurs and the unemployed are yet to be covered by the scheme. Majority of the employees in the former sector and co-operate organizations are yet to enroll in the scheme. Private and public hospitals are still operating on fee for service for the majority of their clients (Gana, 2010).

Problems of National Health Insurance in other countries

Despite the NHIS achievements in other developing countries, they are still faced with challenges. For the sake of this study, the research will focus on the problems NHIS is facing in Ghana, Canada, and France.
According to Garrido & Owusua (2013) Ghana’s National Health insurance scheme was established in 2003 to replace the cash and carry and system of paying for healthcare services at the point of service. Since the implementation of the scheme, the country has enjoyed free universal coverage with quality access to health care. Despite these great achievements, Ghana is still faced with the problems of claims payments, benefit packages, and cost of drugs challenging the healthcare service providers. The healthcare providers attributed some of the challenges they face in respect to claims as delays in reimbursement, lack of software, and format for processing claims, as well reduction in number of claims submitted. Another challenge Ghana NHS is facing is the drug prescription to NHS beneficiaries. The exclusions of some drugs on drug list, lack of awareness about the drugs list, and the fact the price of drugs are fixed and but they are rising. According to Garrido & Owusua (2013), the NHS is facing both operational and environmental challenges. Operational challenges are problems that have to deal with the renewal of membership cards, inadequate staff, logistics, monitoring of health providers, untimely released of funds and reimbursement, inadequate and noncompliance with gatekeeper system. The environment challenges on the other hand, high poverty and illiteracy levels among the population, inadequate health facilities, politicization of the scheme, and bad road networks. Quality of medical services deteriorated and the urban population benefitted more from the system than the left out rural.

Though, the NHS does not involve the out pocket payments at the point of service, the system could not be sustained due to inadequate resources and budgetary constraints.

France NHI, despite the achievement of universal coverage under NHI, there are still outstanding disparities in the geographic distribution of health resources and inequalities of
health outcomes by social class. Another problem with the NHI is that there is a newly perceived problem of uneven quality in the distribution of health services. According Rodwin (2003), in 1997, a trustworthy consumer publication issued a list of hospitals delivering low-quality, even dangerous care before this consumer awareness, there was a growing recognition that one aspect of quality problems, particularly with regard to chronic diseases and older persons, is the lack of coordination and case management services for patients. Although, compared with the United States, France appears to have controlled its health care expenditures, within Europe; France is still among the higher spenders. Level of health service use is high in France but prices per unit are low. This has result to physician’s strikes and demonstrations between physician associations and their negotiating partners—the NHI funds and the state. Physician’s salaries are very poor compare to other countries. As result of this, French physician refuse to accept assignment. Like health insurance schemes everywhere, the French state health insurance program has difficulty making ends meet, and relies increasingly on top-ups from the general budget of the state. An ageing population and the explosion of health care costs due to increasing expectations and the development of expensive new processes and medicines have put enormous strains on the system. The rates of reimbursement have been reduced in recent years, and some contributions increased. People complain of the cost, but at the same time very few voices are ever heard in France calling for a reduction in the services provided.

The National Health Insurance Scheme in Nigeria

The National Health Insurance Scheme is a body set up under Act 35 of 1999 by the federal Government of Nigeria, operating as Public Private Partnership and directed at providing accessible, affordable, and quality healthcare for all Nigerians (DR. Abdulrahman Sambo, 2012).
Act 35 of 1999, which established The National Health Insurance Scheme, empowers the scheme to determine the overall policies of the scheme, including the financial and operative procedures of the scheme; ensures the effective implementation of the policies and procedures of the scheme; assesses the research, consultancy, and training programs relative to the scheme; arranges for the financial and medical audit of the scheme; sets guidelines for effective co-operation with other organizations to promote the objectives of the scheme; ensures public awareness about the scheme; coordinates manpower training under the scheme; and carries out other such activities as are necessary and expedient for the purpose of achieving the objectives of the scheme as set out in this Act (NHIS Operational Guideline, 2012). This Act is not functioning optimally and this study seeks to identify why.

History of National Health insurance in Nigeria

According to Adesina (2009), the first attempt at adopting a health insurance system in Nigeria started in 1962, during the First Republic. This attempt began when the Federal Government invited Dr Halevi, through the International Labor Organization (ILO), to look into starting a health insurance system in Lagos. At that time, the then Minister for Health, Dr Majekodunmi, also presented the first bill to the congress. But due to the Nigerian civil war years, the issue was abandoned though re-visited by the health council in 1984 when a committee was commissioned to study the National Health Insurance (Adesina, 2009). In 1988, Professor Olikoye Ransome-Kuti commissioned the National Committee on Establishment of the NHIS; the committee was chaired by Emma-Eronmi. In 1989, Eronmi’s committee’s report was submitted and approved by the Federal Executive Council. The United Nations Development Program (UNDP) and International Labor Organization (ILO) consultants conducted their own
studies in Nigeria to provide costing, draft legislation, and implementation guidelines for establishing the NHIS in 1992 (Adesina, 2009). In 1993 the Federal Executive Council, that had given its consent in 1989, directed the Federal Ministry of Health in 1993 to start the scheme. In 1999, the enabling decree - Decree 35 - was promulgated on May 10, 1999. Six years after, the formal sector of the social health insurance scheme was officially launched on the 6th of June 2005 by Olusegun Obasanjo, the then president of the Federal Republic of Nigeria, but commencement of services to enrollees started in September 2005. The National Health Insurance Scheme (NHIS) was established to improve the health of all Nigerians at an affordable cost. Today, the scheme has covered all the Federal Ministries, Parastatals, Agencies, the Nigerian Police, Armed Forces, and also the private sector (Adesina, 2009).

The National Health Insurance Scheme in Nigeria was designed to be driven through the operation of Health Maintenance Organizations (HMOs). These may be Private or Public Companies, or for-profit and non-profit registered entities with the aim of ensuring the provision of quality and cost effective health care services to contributors under the scheme. Presently, over 4 million identity cards have been issued, 62 HMOs have been accredited and registered and also, 5,949 Healthcare Providers, 24 Banks, 5 Insurance Companies, and 3 Insurance Brokers have also been accredited and registered for the scheme. Among the 36 states in Nigeria, Benue, Rivers, Bauchi, and Enugu have indicated interest and adopted the program, suggesting the existence of limitations to adoption which need to be identified and addressed. Only a small percentage of the population is covered by health insurance and this is mainly through the formal sector’s social health insurance program (FSSHIP) of the NHIS.
Types of NHIS in Nigeria

According to NHIS Operational Guidelines (2012), there are three types of health insurance in Nigeria.

1) Private: - Health insurance that is risk based. This is through employer-owned on-site health facilities or through contracts with outside providers. Individuals with private health insurance (volunteers, and the privately employed) are catered for by agencies. Individuals with private health insurance are devoid of risk sharing, and these benefits are not as of rights but rather depend on the contract drafted between the service provider and the consumer. The measure given by the individual or the employer is the same measure of service received. Benefits are not uniform; contribution payable is based strictly on the needs of the individual i.e. the higher the health needs of the contributor, the higher the payment.

2) Social: - This is a system of health insurance that is financed by compulsory contributions which are mandated by the law. Payment is irrespective of needs and is usually based on employment and income. It is a form of payroll tax sharing between employers and employees earmarked to pay for health care; it is based on solidarity. Resources are pooled together among the larger population, and it enhances the security of each individual in the group.

3) Community Sponsored Insurance: - This community based program normally operates in rural areas and is mostly localized. It is coordinated and organized by cooperative societies, unions, and non-governmental organizations.

Importance of NHIS

According to Chubike,(2013), the World Health Organization (WHO) in 2005, ranked Nigeria at 197th out of 200 nations. Life expectancy was put at 48 years for males and 50 years
for females. On the other hand, healthy life expectancy for both sexes was put at 42 years. Nigeria only ranked higher than five countries: Sierra Leone, Afghanistan, Zimbabwe, Zambia and Lesotho. The WHO report further stated that Nigeria accounts for 10 percent of global the maternal mortality figure with 59,000 women dying annually during pregnancy and child birth. It adds that for every maternal death, 30 others suffer long term disabilities while 40 percent (about 800,000) of the global obstetric fistulas (tearing) occur in Nigeria. The frightening report described the health situation in the country as being so deplorable because only 39 percent of births are delivered by skilled health professionals. It also stated that the risk of a woman dying from child birth is 1 in 18 in Nigeria compared to 1 in 61 for all developing countries, and 1 in 800 in developed countries also only 23 percent of children (12-23 months) receive full a course of immunization against childhood killer diseases.

However, reducing infant and maternal mortality rates is part of the Millennium Development Goals (MDG) which the Nigerian government is committed to. It targets a reduction of the mortality of children under the age of five by two-thirds between 2000 and 2015, that is, from 207 in 2000 to 67 by 2015. In the same manner, MDG also targets a 75 percent decline in maternal mortality rate by 2015, that is, from 704 in 2000 to about 176 in 2015. It is, therefore, obvious that unless there is a quick intervention, Nigeria will get to 2015 without a change in its health status (Obalum & Fiberesima, 2011). That is where the National Health Insurance Scheme (NHIS) comes in. The NHIS represents a very promising sustainable healthcare financing strategy. The agency can work progressively towards achieving universal health insurance coverage for all Nigerians. Looking at the general poor state of the nation’s health services and the excessive dependence and pressure on Government owned health facilities with the deteriorating funding of healthcare in the face of rising costs, the Scheme is
designed to facilitate fair financing of health care costs. This will be achieved through pooling and judicious utilization of financial risk protection and cost-burden sharing for people, through institution of prepaid mechanism, prior to patients falling ill. This is in addition to providing regulatory oversight function, with respect to the Health Maintenance Organizations (HMOs) and Health Care Providers (HCPs).

In Nigeria, the health sector is principally financed by the government. The government is faced with various challenges– a stagnant mono-cultural economy that depends on crude oil as a single export commodity, rapid population growth, political instability, and high rate of unemployment. For these reasons, the government cannot afford to commit enough money to the health sector which is now faced with the consequence of underfunding, decreased efficiency, decreased quality/quantity of service, diminished confidence in public sector health facilities, and poor maintenance of equipment. The rising cost of healthcare services and the inability of the government health facilities to cope with the people’s demands made it necessary to establish the National Health Insurance Scheme in Nigeria. Healthcare costs are often unaffordable to individuals if they have to pay the full cost of treatment as it occurs.

Objectives of the scheme

The objectives of the scheme is to ensure that every Nigerian has access to quality healthcare services, protect families from the financial hardship of huge medical bills, limit the rise in the cost of healthcare services, ensure equitable distribution of healthcare costs among different income groups, maintain high standards of healthcare delivery services within the scheme, ensure efficiency in healthcare services, improve and connect private sector participation in the provision of healthcare services, ensure adequate distribution of health
facilities within the Federation, ensure equitable patronage of all levels of healthcare, and ensure the availability of funds to the health sector for improved services (NHIS Operational Guideline, 2012).

Benefits of the scheme

According to Onyedibe et al. (2009) Some of the benefits derived from participation in the scheme are outpatient and inpatient care, pharmaceutical care as in NHIS essential drug list, Ancillary Services such as (X-Ray), Laboratory tests, maternal care for up to four life births, preventive care such as immunization, health education, family planning, ante-natal post and natal care (that is limited to 15 days in a year), vision test and spectacles, preventive dental care and rehabilitation services. Beneficiaries of the scheme do not need cash to access treatment when required except for the 10% copayment for the cost of drugs. The issue of converting assets to cash especially in medical disasters can be avoided.

Those not covered by the scheme

According to (Onyedibe et al., 2009) there are certain healthcare services that are not covered by the scheme. Those not covered by the scheme are either total or partial healthcare services like radiologic investigation, computerized tomography, epidemics, cosmetic surgeries, CT scans, MRI’s, open heart surgeries, neurosurgeries, and family planning supplies which are completely excluded from the scheme. Also excluded from the scheme are injuries that arise from sports, riots, natural disasters, earthquake, or war. The healthcare services that are partially excluded from the scheme are usually referred to as social importance healthcare services. These services are usually expensive. Some of the examples of social health services are Myomectomy,
prostatectomy, and orthopedic repairs; hormonal assays, laparoscopies, Pap smears, makers, and other form of investigations are partially not included in the scheme. They are partial in the sense that HMO’s pay 25% while the employer pays 75% of the healthcare cost (Onyedibe et al., 2009).

National Health Insurance Laws in Nigeria

The provision of health care delivery services in Nigeria is the responsibility of the three tiers of government namely the Federal, the States, and the Local Governments. The inability of the three tiers of government to provide minimum, qualitative and affordable health care services in Nigeria led to the enactment of the National Health Insurance Scheme Act. This Act seeks to provide health care benefits to persons, their spouses and not more than four (4) biological children under the age of 18 years old. In order to sustain, the NHIS made some laws that will help the governments achieve their goals. They implemented five laws:

1. All NHIS contribution is required to be paid into the account of the health insured-Chosen Health Maintenance Organization (HMO).

2. All participant of the scheme must be registered by the NHIS governing council

3. All complaints regarding violations of any provisions of the NHIS ACT are required to be referred for judicial decision. And must be be in writing and delivered within sixty (60) days from the date when the event giving rise to the complaint arose. An extension of time may, however, be granted if the Arbitration Board is satisfied that the complainant was justifiably unable to submit the complaint within sixty (60) days of the occurrence of the complained event.

4. Any registered person who fails to pay any NHIS contribution into the account of any
NHIS organization within the time specified or who deducts NHIS contributions from an employee’s wages and withholds such NHIS deductions, commits an offence which on conviction, in the case of a first offender, attracts a fine of N100,000 (naira) or 50 percent of the amount involved, together with accrued interest. This fine could be with or without imprisonment for a term not exceeding two (2) years or less than one (1) year; or, to both the fine and the term of imprisonment. For repeat offenders, the above monetary penalties and term of imprisonment are required to be doubled when the repeat offender is convicted.

5 All health care providers, medical centers, institutions, or professional, are statutorily required to have a professional indemnity cover from an insurance company approved by the NHIS Governing Council.

How the scheme operates in Nigeria

According to the NHIS Operational Guideline, 2012, there are five major stakeholders in the scheme:

(a) Employer

(b) Employee, (c) Primary Care Providers - Primary and Secondary

(d) Health Maintenance Organizations - Operators of the scheme

(e) Government Agency (NHIS) - Regulator of the scheme.

For participation in the scheme, contributors will first register with an NHIS approved HMO and, thereafter, register with a primary health care provider of their choice from an approved list of providers registered by their HMO. Contributor and their dependents are issued
ID cards on registration. In the event of sickness, they present to their chosen Primary Care Provider (PCP) with their ID card.

Contributors have the right to change their PCP after a minimum of six months if they are not satisfied with the services there. A contribution made by the insured person entitles his or her spouse and four children under the age of 18 years to full health benefits. However, students in school up to the age of 25 years qualify as dependents. Extra contribution will be required for additional dependents.

Contributions to be made by formal sector employees for health benefits under the scheme will be 15% of wages, the payment of which will be by both the employee and the employer. The employee pays 5% while the employer pays the remaining 10%.

Why the Scheme is Difficult to Adopt

According to Onoka, Onwujekwe, Uzochukwu and Ezumah, about six years after NHIS was established only 4% of the population (mainly federal government employees), were covered by health insurance, and this was mainly through the Formal Sector Social Health Insurance program (FSSHIP) of the NHIS. In addition, only three out of thirty-six states in Nigeria had adopted the program. The states not adopting the scheme is result of the unclear role the states needs to play in the program. The states are interested in the (FSSHIP) of the NHIS but vague accountability systems and the absence of financial reports of activities carried out for the FSSHIP create distrust and affected their interest in adopting the scheme. The decision for adoption has also been affect by the feasibility of executing the policy design with regard to employer and employee contributions. Despite general agreements about the adequacy of the
benefits package, discontent about capitation rates and an unrevised drug list created apathy towards adoption amongst health care providers.

Theory Regarding Policy Implementation

According to Aminu & Onomisi (2014), implementation literally means executing, accomplishing, fulfilling, producing, or completing a given task. Policy Implementation is the stage of policy-making between the establishment of a policy and the consequences of the policy for the people whom it affects. Implementation involves translating the goals and objectives of a policy into an operating, ongoing program.

The current thinking in the major discussions on NHIS implementation and the burden of how the scheme will be fully implemented is geared towards Agenda Setting Theory.

Agenda-Setting Theory

According to Kingdon (1995), agenda setting is the first stage in the policy process. The policy agenda is the list of issues or problems to which government officials, or those who make policy decisions (including the voting public), pay serious attention. Moving an idea onto or higher up on that agenda involves three processes: problems, proposals, and politics.

Applying Kingdon’s Theory to Ways to Improve Nigeria’s Healthcare

Nigeria’s government and the citizens decided to introduce the NHIS with the aim of providing quality, affordable, and accessible healthcare to all Nigerians. Fundamentally, Nigerian government’s way to improve the healthcare system is based on the notion of policy idea- Universal health coverage – recognized as an “idea whose time has come” requires that it
appears on the policy agenda. Therefore, the way to improve healthcare in Nigeria is investing in the three elements of Kingdon’s theory. It attempts to inform thinking about the problems that quality healthcare for all Nigeria regarding implementation can be addressed by investing in research and communications to frame them. It invests in the proposal by supporting the development of policy solutions that fit the problem, with leadership and engagement efforts to build support for those solutions. It invests in politics by engaging influential constituencies to bring Nigeria’s healthcare problems and solutions to the fore. NHIS grantees and their partners could be actors in the new policy process helping to drive and shape these elements in the next policy round. See diagram (Figure 1)

<table>
<thead>
<tr>
<th>Ways</th>
<th>Outcomes</th>
<th>Kingdon process stream</th>
</tr>
</thead>
<tbody>
<tr>
<td>leaders &amp; engagement to improve quality of healthcare</td>
<td>Leaders approved, new ideals embraced policy development happens collaborately</td>
<td>problem identified, awareness grown on the urgent need to improve the quality of care</td>
</tr>
<tr>
<td>research make case quality for quality healthcare NHIS Policy</td>
<td>Research highlights the benefits of NHIS program and policy</td>
<td>Policy proposal, policy is informed by research and evidence</td>
</tr>
<tr>
<td>support from government, communities, individual contribution</td>
<td>healthcare accessibility increases and public demand for good health insurance</td>
<td>policy favourable, public and political support reaches a tipping point</td>
</tr>
</tbody>
</table>

Source: Harvard family research, 2007
Chapter 3

Methods

The purpose of this study is to learn about the challenges Nigeria faces in implementing the National Health Insurance Scheme, (NHIS), with the objective of coming up with recommendations that might help to improve the scheme. The research question that is guiding this study is: what challenges does Nigeria face in implementing the NHIS? This chapter describes the methodology that will be used in this study and is divided into the following sections: research design, sample frame, sample size, data collection, data analysis, IRB process, and the limitations of this study as well as confidentiality.

Research Design

The research design for this study were a non-experimental qualitative method using content analysis known as Hermeneutics and a quantitative research method using descriptive trend analysis. Hermeneutics is the art of interpretation (Gadamer1960/1989) and that has been used throughout history, from religion to academia, to interpret text and bring meaning. Gadamer (1996) offered that hermeneutics is a theoretical attitude towards the practices of interpretation and to the way experience in text are interpreted. Textual materials are the data for this study.

Sample Frame and Sample Size
The sample frame in this study covers the following aspects of the NHIS: benefits, importance, objectives, NHIS in other part of the world, history of NHIS in Nigeria, and how the scheme operates in Nigeria as studied through textual materials.

The sample size will be determined by available articles from Nigerian newspapers that discussed challenges in the implementation of the NHIS and what can be done to improve the scheme. In addition, journal articles of research conducted on NHIS that focus on the implementation of the NHIS in Nigeria will be used to determine whether the scheme is working or not.

Data Collection Methods

Information used in this study was mainly secondary data obtained from 30 articles on NHIS from notable Nigerian Newspapers, bulletins of NHIS, Journal articles, as well as general information on NHIS on the internet. The variables considered in this study were Nigerian Population, birthrate, death rate, infant mortality rate, life expectancy at birth, fertility rate, health spending as percentage of GDP, health spending, and maternal mortality rate. The data used for this study were for the years 2005, when the scheme was introduced, and 2014 baseline. This is to determine the changes of the health statistics of Nigerians.

Data Analysis

Conclusions were derived from analyzing various articles and reviews on NHIS scheme using the Hermeneutic method, which is content analysis. Hermeneutics is the art of interpreting and deriving meaningful conclusions from texts (Schwandt, 2001). The trends from selected variables were analyzed using simple statistical tools such as graphs and tables. Trend analysis is
a statistical method performed to evaluate theorized linear and nonlinear relationships between two quantitative variables- 2005 baseline data and 2014 data. It is generally used in situations when data has been collected over time or at different levels (Bautista, 2013). Content analysis is a qualitative research method that uses a set of procedures to make valid interpretation from the text. Content analysis is significant for research because it categorizes textual material, reducing it to more relevant data (Steve, 2001). Content analysis is divided into two, conceptual and rational but for this study rational content analysis will be used.

Limitations of the Study

The major limitation in this study is inadequate information, time constraints, and social desirable responses. The researcher relied on published articles for information which were based on people’s opinion. Though the freedom of information has been into law in Nigeria, public office holders are not expected to talk to the press without prior approval from the superiors. Upon approval, the content of the information must be scrutinized by the superior, who determine which information to disclose and the ones to withhold. Any information perceived to have negative impact on the ministry and the government of the day will not be disclosed because of political reasons. This is one of the reasons why information that could further enhance this research work could not be obtained

IRB Process

I have received approval by the CSU Bakersfield Institutional Review Board to conduct this research, which did not involve any human subjects. A copy of the approval from the Institutional Review Board communication is included in this research study.
Chapter 4

Findings

As a result of the high out pocket spending, limited insurance coverage, and lack of access to healthcare in Nigeria, the government has had to introduced the NHIS. The purpose of this section is to understand and analyze research found on what are the challenges Nigeria is facing in implementing the NHIS. These results will be analyzed from two aspects. The first is to interpret the health indices using trend analysis, which is the quantitative part of this research, while the second is content analysis which is the qualitative. Textual material analyzed included over 25 websites. To find literature about challenges Nigeria is facing in implementing the NHIS, individual searches were made using several combinations of the following terminology: Health insurance, National health insurance, and access to health care, problems, quality, and more.

Table 1 shows the trend analysis of Nigeria’s health indices using 2005 and 2014 has the base line. The variables selected for the study were Population, Birth rate, Death rate, Infant mortality rate, NHIS enrollees, Health spending, Health spending as percentage of GDP, Life expectancy at birth, and Fertility rate of Nigeria.

Table 1 shows that there was a significant increase in Nigeria’s population between the initiation of the NHIS in 2005 and 2014, which depicted a 38% increase in population. Similarly, there was also an increase of 9.63% in life expectancy at birth. The number of NHIS enrollees
also increased by 87.5%. The health spending also increased by 73.3%. This table also shows a 8.14% decrease in Birth rate and 15% decrease in Birth rate. There was a 25% decrease in Infant mortality, 24% decrease in maternal mortality rate, 7.9% decrease in fertility rate, and 9.1% decrease in Health spending as percentage of GDP.

Table 1: Nigeria Health Indices between 2005 and 2014

<table>
<thead>
<tr>
<th>Variables</th>
<th>2005</th>
<th>2014</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>128,772,000</td>
<td>177,155,754</td>
<td>38</td>
</tr>
<tr>
<td>Birth rate per 1000</td>
<td>41.4</td>
<td>38.03</td>
<td>-8.14</td>
</tr>
<tr>
<td>Death rate per 1000</td>
<td>16.0</td>
<td>13.16</td>
<td>-15</td>
</tr>
<tr>
<td>NHIS enrollees</td>
<td>4,000,000</td>
<td>7,500,000</td>
<td>87.5</td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>98.8/1000</td>
<td>74.09/1000</td>
<td>-25</td>
</tr>
<tr>
<td>Life expectancy at birth</td>
<td>48.0</td>
<td>52.62 years</td>
<td>9.63</td>
</tr>
<tr>
<td>Maternal mortality rate</td>
<td>740/100,000</td>
<td>560/100,000</td>
<td>-24</td>
</tr>
<tr>
<td>Fertility rate</td>
<td>5.7</td>
<td>5.25 children born</td>
<td>-7.9</td>
</tr>
<tr>
<td>Health spending</td>
<td>54.44 usd</td>
<td>94.34 (2012)</td>
<td>73.3</td>
</tr>
<tr>
<td>Health spending as percentage GDP</td>
<td>6.6</td>
<td>6.0 (2012)</td>
<td>-9.1</td>
</tr>
</tbody>
</table>

Table 2: Comparative health indices of Chile, Cuba, South Africa, Ghana, France and Nigeria for 2014

<table>
<thead>
<tr>
<th>Countries</th>
<th>Chile</th>
<th>Cuba</th>
<th>South Africa</th>
<th>France</th>
<th>Ghana</th>
<th>Nigeria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death rate</td>
<td>5.93/1000</td>
<td>7.64/1000</td>
<td>17.23/1000</td>
<td>9.06/10000</td>
<td>7.3/1000</td>
<td>13.16/1000</td>
</tr>
<tr>
<td>Birth rate</td>
<td>13.97/1000</td>
<td>9.9/1000</td>
<td>12.49/1000</td>
<td>12.49/1000</td>
<td>31.4/1000</td>
<td>38.03/1000</td>
</tr>
<tr>
<td>Life expectancy at Birth</td>
<td>75.42 years</td>
<td>78.22 years</td>
<td>49.41 years</td>
<td>81.66 years</td>
<td>65.75 years</td>
<td>52.62 years</td>
</tr>
<tr>
<td>Population</td>
<td>17,363,894</td>
<td>11,047,251</td>
<td>62,259,012</td>
<td>25,758,108</td>
<td>177,155,754</td>
<td></td>
</tr>
<tr>
<td>Maternal mortality rate</td>
<td>25/100,000</td>
<td>73/100,000</td>
<td>300/100,000</td>
<td>8/100,000</td>
<td>350/100,000</td>
<td>560/100,000</td>
</tr>
<tr>
<td>Health expenditure percentage GDP</td>
<td>7.5%</td>
<td>10%</td>
<td>8.5%</td>
<td>11.6%</td>
<td>4.8%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Infant mortality Rate</td>
<td>7.02/1000</td>
<td>4.7/1000</td>
<td>42.67/1000</td>
<td>3.31/1000</td>
<td>38.52/1000</td>
<td>74.09/1000</td>
</tr>
</tbody>
</table>
Table 2 shows the comparative health indices of five countries compared to that of Nigeria for 2014. Nigeria has the second highest death rate when compared to Chile, Cuba, South Africa, Ghana, and France. Nigeria has the highest birth rate among the counties studied. Nigeria also has the lowest life expectancy at birth, while France has the highest life expectancy at birth of 81.66 years. France has the lowest infant mortality rate, of 3.31/1000 as compared to Nigeria, 74.09%. This comparative analysis was necessary for the researcher to be able know the health indices of these countries and a draw conclusion about whether Nigeria is actually facing challenges in the implementation of the NHIS.

Table 3 shows the overall findings of the quantitative trend analysis for 2005 and 2014. This is to determine the impact the NHIS has made over this period of time.

Table 3: Overview of Findings of Quantitative Trend Analysis for 2005/2014

<table>
<thead>
<tr>
<th>Research Questions</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are the challenges Nigeria is facing in implementing the NHIS?</td>
<td>38% increase in population</td>
</tr>
<tr>
<td></td>
<td>• 15% decrease in death rate</td>
</tr>
<tr>
<td></td>
<td>• 8.4% decrease in Birth rate</td>
</tr>
<tr>
<td></td>
<td>• 87.5% increase in NHIS enrollees</td>
</tr>
<tr>
<td></td>
<td>• 25% decrease infant mortality rate</td>
</tr>
<tr>
<td></td>
<td>• 9.63% of increase in life expectancy at birth</td>
</tr>
<tr>
<td></td>
<td>• 24% decrease in maternal mortality rate</td>
</tr>
<tr>
<td></td>
<td>• 73.3% increase in Health spending</td>
</tr>
<tr>
<td></td>
<td>• 9.1% decrease in health spending as percentage GDP</td>
</tr>
</tbody>
</table>
As a result of the content analysis based on the research question (what are the challenges Nigeria is facing in implementing the NHIS?), the researcher has found five major challenges (see Table 4).

Table 4: Overview of Findings Using Content Analysis Methodology

<table>
<thead>
<tr>
<th>Research Questions</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are the challenges Nigeria is facing in implementing the NHIS?</td>
<td>• Large and Rapidly Growing Population</td>
</tr>
<tr>
<td></td>
<td>• Informal sectors are not covered</td>
</tr>
<tr>
<td></td>
<td>• Shortage of Human Resource</td>
</tr>
<tr>
<td></td>
<td>• Distrust between government levels</td>
</tr>
<tr>
<td></td>
<td>• The scheme has not met the coverage mandate</td>
</tr>
</tbody>
</table>

In spite of the achievement the scheme has made so far, based on improvement of the health status of Nigeria, the NHIS is still facing some challenges which are discussed.

Large and Rapidly Growing Population

The population of Nigeria currently is about 177,155,754, which is 2.48% of the world population (UN, 2014). This presents an enormous challenge to the NHIS as Nigeria is currently the sixth most populous country in the world, and the presidential set mandate of 30% coverage
by 2015 (Adekoya, 2014), as required by the NHIS, means providing healthcare coverage for 50 million people. To put this into perspective, 30% coverage of the entire population of Nigeria is twice the population of Ghana, which at present provides 45% health coverage of its entire population, which stands at 25,758,108 (Businessday, 2014). For the NHIS to provide this level of coverage, Nigeria has to address several issues, which includes the financial cost of coverage of 50 million of people, the provision of medical facilities, inadequate training of health workers, lack of other social infrastructure, and the multi-cultural nature of Nigeria with its many ethnic nationalities. All of these issues are complicated by the size of Nigeria’s population. This research reveals that in Nigeria, the average number of children per family is four, (Rosenthal, 2012) and although this is not a law some Nigerians are already implementing it. However, this reduction in family size does not appear to help the situation.

The figures in Table 1 show that in 2005, prior to when the NHIS was introduced, the population was 128,772,000 and has risen to 177,155,754 by 2014. This implies that NHIS has made some contribution to Nigerians having access to quality healthcare. This increase could be the result of the 15% decrease in death rate and 25% decrease in infant mortality (Table 3). However, considering the population of Nigeria and the number of NHIS enrollees after nine years of operation, the scheme is facing some challenges. NHIS enrollees increased from 4 million in 2005 to 7.5million in 2014 (Table 1), but this figure of 7.5million is about 4% of the population of Nigeria which is far cry from the presidential mandate of 30% by 2015.

Informal Sector Not Covered

The informal sectors in Nigeria are generally viewed as another sector outside the normal organized formal sector that provides employment and living through engaging in varieties of
activities such as street trading, private entrepreneurs, hawking, local manufacturing, and more. These sector enterprises are usually unprotected by law. The sector is characterized by low income families, self-employment, little capital, low level organization with no access to formal credit, and low productivity (Ademola & Anyankora, 2012).

This research revealed that 70% of Nigeria’s population belongs to the informal sector (Obi, 2014). Ogundipe (2009) reported that the low level of participation in the National Health Insurance Scheme (NHIS) in the country has been attributed to poor awareness among Nigerians. Majority of the poor health indices we have in the country today come from the rural areas. Unless the government carries the scheme to the rural areas, the indices will continue to be poor. For instance, the maternal mortality rate and infant mortality rate are still very high in Nigeria compared to other countries, like Chile, France, Ghana, Cuba, and South Africa (Table 2). This research also revealed that the NHIS has not lived up to its challenge, as average Nigerians in the informal sector, still remain ignorant of its existence and are persistently longing for government to decrease the healthcare cost. This researcher feels that even though many Nigeria in the informal sectors remain unaware of the NHIS, the NHIS is not making much effort to create awareness in the informal sectors knowing fully well that that is where 70% of the population is. Nigeria’s promise to cover 30% of Nigerians by 2015 without covering the informal sector is unachievable. The number of NHIS enrollees at present is 7.5 million (Table 1) and the scheme looks at covering about 50 million people. This has posed a big challenge on the scheme; in order for NHIS to cover the informal sector, more funds will be needed to employ more personnel that will help to get the information about scheme to the informal sector. Informal sector not being covered by the scheme can be linked to low awareness level of the scheme, which could be as a result of the literacy and poverty levels of those in the informal sector. Not
every Nigerian has access to social media where they can get information because of the poverty level. Also some of the people in the informal sector cannot read and write. This makes it difficult to embrace the scheme. Statistics shows that 61.3% is the literacy level of the population of Nigeria for 2014, and the population below the poverty line, as of 2004, in the rural area was 63.8% (www.ruralpovertyportal.org).

Shortage of Human Resources in Healthcare

Inadequate human resources in healthcare have made it difficult for Nigeria to implement the NHIS. For example, there is an inadequate supply of doctors, nurses, and general practitioners (GP), and, as a result, many Nigerians are not able to access physicians and this has made it difficult for NHIS to provide accessible and quality healthcare to Nigerians (Baba & Omotera, 2012). There is one doctor to every 6,400 patients in Nigeria. This is too large a patient to doctor rate as compared to the World Health Organization (WHO) standard of one doctor to every 600 patients and is a grave threat to the physical and mental wellbeing of the country’s population (Chiejina, 2013). Since the beginning of the Medical and Dental Council of Nigeria (MDCN), when there was 65,000 registered medical doctors, this has dropped to 25,000 in 2013, meaning that only 25000 medical doctors are practicing in Nigeria (Enabule, 2013). With these figures, it will be difficult for the NHIS to carry out its operation. Literature reveals that one of the reasons why there is a shortage of medical doctors in the country is, because of the massive migration of medical professionals in search of greener pastures abroad. Not only that, in Nigeria there this disproportionate concentration of medical personnel in the urban areas. Most Nigerian doctors and nurses find the remote areas unattractive, despite the huge disease burden in the rural areas. While poor geographical distribution of health care
professionals also contributes to this dearth of manpower, the poor doctor-patient ratio of 1:6400 in Nigeria as against the World Health Organization (WHO) standard of 1:600 remains a huge challenge, as medical schools in the country graduate between 2,500 and 4,000 new doctors annually (Businessday, 2013). According to Osahon Enabule, National president of the Nigerian Medical Association (NMA), the reason why Nigeria medical doctors are going abroad is because of the poor human resources plan and structures, unsatisfactory working conditions, poor remuneration, and few professional development opportunities (Businessday, 2013). Inadequate infrastructure and remuneration packages, a significant number of physicians, nurses and other medical professionals have lured away Nigerian doctors to developed countries in search of fulfillment and lucrative positions. Most of these doctors are presently working in the United States, Britain, South Africa, and other neighboring African countries where medical personnel are treated better. When comparing the ratio of doctors to patients in Nigeria to Cuba, it is clear that Nigeria is actually facing challenges in terms of shortage human resources personnel in implementing the NHIS. Cuba has a ratio of 1:125 doctors (Businessday, 2013). This could be a reason why Cuba health indices are good. The research suggest that human resource shortage in health institutions in Nigeria has put undue pressure and stress on the available staff, making it difficult for the NHIS to cope (Businessday, 2013). This shortage is more pronounced at the primary and secondary levels of healthcare and creates disruptive behavior and disharmony amongst health care workers. In addition, urban areas have become more attractive to health care professionals for their comparative social, cultural, and professional advantages. These areas offer more opportunities for career and educational advancement as well as better employment prospects. This is not an advantage for the scheme.
Distrust between Governmental Levels

The concept of health families is still strange to many Nigerian and people are distrustful of insurance in general. The literature revealed that most people are not used to the concept that once you have paid for health insurance you cannot get a refund if you don’t use it (Sambo, 2013). Some Nigerians believe that NHIS is another way of extorting money from them. Some Nigerians refused to adopt the scheme because of their religion: others complained about accountability and transparency of the NHIS activities. The results suggested there were over 200 different ethnic Nationalities that make up Nigeria. This by itself possesses a unique challenge to adequately providing health care coverage to all Nigerian at an affordable cost (Baba& Omotara, 2012). Depending on each of these different ethnic nationalities, different communities within Nigeria hold different views on health care. Some Nigerians still attribute health problems to witches, demons, and other mythical beliefs, even when good health care facilities are available, affordable, and accessible. Some Nigerians prefer seeking treatment from untrained herbalists’ unorthodox health care institutions, thus making it difficult for such groups to adopt the NHIS even though they are aware of the scheme and the group can afford it.

Accountability and transparency are other reason why people do not have trust in the NHIS. The literature suggests that some states in Nigeria refused to adopt the scheme. States are interested in the formal sector social health insurance program (FSSHIP) of the NHIS, but vague accountability systems and the absence of financial reports of activities carried out for the FSSHIP creates distrust and affected state’s interest in adoption of the scheme. The decision for adoption has also been affected by the feasibility of executing the policy design with regards to employer and employee contributions. Despite general agreements about the adequacy of the
benefit package, discontent about capitation rates and an unrevised drug list created apathy towards adoption amongst health care providers. (Onoka, Onwujekwe, Uzochukwu & Ezumah, 2012). Some Nigerians also refused to adopt the scheme because of its non-coverage of deadly diseases like cancer and kidney ailments. Also, there has being corruption by medical directors who own hospitals and clinics that are collecting money from Health Maintenance Organizations (HMOs) without providing qualitative medical care to enrollee’s issues related to capitation payment where hospital tell enrollees that their HMO paid a certain amount for their medical care in a month so for that their treatment is limited.

The scheme has not met the mandate coverage

The goal of NHIS is to cover 40% of Nigeria’s population in the scheme by 2015, (Thomas, 2014) even though the President, Dr Goodluck Jonathan gave the scheme a mandate of 30% coverage (Adekoya, 2014). Presently, the NHIS has only be able to achieve enrollment of 7.5 million, which only represents 4% of the total population of Nigeria, and the NHIS only achieved this level of enrollment after being in existence for 9 years which makes it highly unlikely that without overcoming significant enrollment drive challenge, the NHIS cannot achieve its goals. This researcher does not see how the scheme can achieve this with the figure they have at present. The researcher wants to believe that the NHIS is yet to make much impact on Nigeria healthcare. An author, (Dada 2012) confirmed this statement by saying that “it is not likely that much has changed in the lives of Nigerians masses,” in his report in Thisday newspaper (September 12th, 2012), he stated that since the establishment of NHIS five years ago the majority of Nigerians are still paying out of their pocket to access health care services in the country. The people for whom the scheme was designed to benefit mostly have been kept
absolutely in the background, except for only those who have social – economic advantages. The major objectives of the NHIS, as mentioned in Chapter 2 of this study, was to make sure that they provide easy access to healthcare for all Nigerians at an affordable cost through various payment systems. The question now is how possible can this be? From the results in Table 3, looking at the health indices of Nigeria and comparing it to other countries, the chances of achieving universal coverage is slim. For instance, Ghana, one of the West Africa countries, established an NHIS in 2003 (Garrido& Owusua, 2013). The NHIS in Ghana had been able to cover over 45% of its citizens despite their challenges (Businessday, 2014). Ghana has a population of 25,758,108 (table 2). Despite the fact that Ghana is small in size, they have better health indices than Nigeria. For instance, Ghana has a death rate of 7.3 /1000 (Table 2) compared to 13.16/1000 for Nigeria. Also the life expectancy at birth of Ghanaian’s is 65.75 years (Table 2) compared to 52.62 years for Nigerians. With this figure it is clear that Nigeria has not been able to fully implement the NHIS. Although, from the trend analysis of Nigerian health indices in table 3, the scheme has made improvement, when compared to other countries who have achieved Universal health coverage through NHIS, one can see that Nigeria is facing challenges in implementing the NHIS.

Multiple articles within the 30 reviewed, revealed that many Nigerians are lamenting that the scheme is not working. Thisday newspaper (September, 2012) reported an incident that happened in Nigeria, where one Mrs. Grace Eriaku was lamenting about the NHIS. According to her, ”we don’t know what the government is doing about the NHIS, they make so much noise about the scheme, but we have not seen the benefit of the scheme, if other people have been benefitting, I have not, it is difficult and disheartening.” Steve (September 12th, 2014) wrote that Eriaku is not the only person with this experience; there were several other Nigerians with
similar problems. Sambo, (2014) claimed that one of the challenges faced was the difficulty of determining the income of the people in the informal sectors. The results indicated that the scheme is also faced with delay in enrolling eligible Nigerians.

Though the results show that in 2005, prior to the initiation of the scheme, maternal mortality rate was reduced from 740/100,000 to 560/100,000, in 2014, nine years after the scheme was initiated. Nigeria, however, still has the highest rate of maternal mortality rate when compare to Ghana, Chile, France, and South Africa. This tells the researcher that the NHIS is not meeting healthcare needs of Nigerians. The high out-pocket spending in Nigeria is another challenge Nigerian healthcare sector is facing. This problem needs to be addressed for the scheme to be fully implemented.

The summary of the above study indicates that Nigeria has made some improvement in health with the implementation of the NHIS, but Nigeria is facing challenges in implementing the scheme. Almost all the articles studied, reported at least one, if not more, negative claim about the scheme. The complaints were mainly on coverage, access affordability, effectiveness, inadequate infrastructures and quality of services. The major challenges based on the outcome of this study of why the scheme had not been able to achieve universal coverage are: rapidly growing population, NHIS not been able to cover the informal sector, lack of awareness of the scheme, distrust, shortage of human resources, the scheme not meeting its set mandate, and the high out of pocket spending of healthcare expenditures.
Chapter 5

Conclusions and Recommendations

In Nigeria, the provision of quality, accessible, and affordable healthcare remains an important issue, and there is no doubt that Nigeria’s health indices are poor. The country still has one of the highest maternal mortality rates, death rates and infant mortality rates in the world. Government budgetary allocations at both federal and state levels to fund healthcare are inadequate; health insurance remains the only alternative source for funding healthcare in Nigeria. The introduction of the NHIS was the best thing that happened to the Nigerian healthcare system, but the scheme is facing serious challenges in spite of the achievements to date. The National Health Insurance Scheme is supposed to provide quality, accessible, affordable, equitable, and efficient healthcare and also assure a significant reduction in out of pocket spending. But from the result of this study, Nigeria’s NHIS has not been able to achieve this since its implementation. The purpose of this research was to determine the challenges Nigeria faces in implementing the NHIS. There are challenges identified in the implementation of the NHIS: Large and rapidly growing population, shortage of human resources in healthcare, NHIS not being able to cover the informal sector, distrust between governmental levels, the scheme has not met the coverage mandate, high out- of- pocket health spending, and lack of funds to implement the scheme. (Table4).
Recommendations

The following recommendations are made on the basis of the findings of this study with regard to the challenges identified:

Recommendation #1: Government should introduce stringent birth control

The large population places huge demand on infrastructure and human resources. This could be addressed by government introducing stringent family planning programs targeting family size reduction through the use of contraceptives and other child spacing methods. Also, awareness campaigns concerning birth control should be intensified especially, in the rural areas. Another way to control the population of Nigeria is to increase the literacy level in order to aware of the concept of family planning. Birth control may help to improve coverage in the long run by lowering the population that require health coverage, this will increase access to quality healthcare.

Recommendation #2: Government should Develop Public Strategic Plan for Reaching the Enrollment target.

The Nigerian Government should strive to raise the awareness levels of the need to subscribe to health insurance to the people in the informal sectors. The government and stakeholder who are involved in NHIS should initiate rigorous campaign to inform those in the informal sectors the need and benefit of the scheme. All of this could be done through the media, churches, committees, marketplaces, and governmental and non-governmental organizations. Also, establishing more community programs like the Community Based Social Health Insurance Scheme may enable the scheme to achieve its goals. NHIS can also offer potential
enrollees incentives to motivate them to sign up for the scheme. To achieve the presidential coverage, health financing and finance that come from the government has to be increased, this increase will progressively reduce the out of pocket payments for healthcare. NHIS should endeavor to expand its coverage by incorporating the informal sector. This might reduce the financial burden on the government and the enrollees at the same time improve Nigeria’s health indices as more Nigerians will have access to effective and affordable health care.

Recommendation # 3: Increase the Supply of Human Resources

Shortage of human resources in the healthcare industry should be addressed by expanding training programs of specialists, physicians, nurses and other health workers while putting in place incentives such as competitive remuneration and conducive working environment to discourage brain drain abroad amongst them. The government should also offer incentives to medical doctors and nurses in the rural areas to attract them to work in the rural primary health hospitals and health centers.

Recommendation # 4: Ensure Transparency, and Accountability among Enrollees, NHIS Operators and State

In order to engender trust between health care and ensure the provision of qualitative healthcare services to enrollees, NHIS operators or managers should ensure that capitation due to providers are paid promptly each month. Also enrollees’ distrust and dissatisfaction of the scheme can be reduced by allowing enrollees to make decision as to which healthcare provider they want to use. This will give them the flexibility of changing their healthcare providers if they
are not satisfied with the services they are getting as they would like to be sure they are getting the quality healthcare services they are paying for.

Managers of the scheme need to improve the transparency and accountability systems in the current program to earn the trust of other stakeholders. The NHIS Council needs to commence the annual publication of its reports of its activities and its audited account. Such information should be made available to the State.
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Appendices
Appendix A: shows the Death rate as of 2005 when the Scheme was initiated was 16/1000 and as of 2014 the death rate has declined to 13.6/1000, a decrease of 15% between 2005 and 2014. The Birth rate between 2005 and 2014 was 41.4/1000 and 38.08/1000 respectively.

Appendix A: Trend analysis for 2005/2014 Birth and Death rate per 1000
Appendix B is a graph showing the population of Nigeria. Between the initiation of the NHIS in 2005 and 2014 there was an increase in population of 483,837,540 which represents a 38% increase in population.

Figure Appendix B Nigeria Population
Appendix C above shows that there was a significant increase in the number of NHIS enrollees. As at 2005 when NHIS was introduced, the scheme recorded 4,000,000 enrollees but this has increased to 7,500,000, in 2014 which represents a 87.5% increase in the number of enrollees.
Appendix D shows the infant mortality rate in Nigeria. In 2005, the infant mortality rate was 98.8/1000 but this has decreased to 74.09/1000 in 2014 which represents a 25% decrease in infant mortality rate.

Appendix D: 2005 and 2014 Infant Mortality Rate
Appendix E shows life expectancy at birth in Nigeria. The life expectancy at birth of 2005 was lowered than that of 2014. In 2005 it was 48 years, but this has increased to 52.62 years. This shows that there was a significant increase in life expectancy at birth (9.63%).

Appendix E: 2005 and 2014 life expectancy

![Chart showing life expectancy at birth in Nigeria for 2005 and 2014. In 2005, life expectancy was 48 years, while in 2014, it increased to 52.62 years. The increase is significant at 9.63%.](chart.png)
The graph (Appendix F) shows the fertility rate. In 2005, prior to the implementation of the NHIS, the fertility rate was 5.7 but this has decreased to 5.25 which represents a 7.9% decreased in fertility rate.

Appendix F: 2005 and 2014 Fertility rate
(Appendix G) shows the maternal mortality rate in Nigeria. In 2005, prior to the implementation of the NHIS, the maternal mortality rate was 740/100000 but this has decreased to 560/100000 in 2014 and represent a 24% decreased in maternal mortality rate.

Appendix G: Maternal Mortality Rate

Maternal Mortality Rate 2005 and 2014
The graph above (Appendix H) shows the trend analysis of the health spending in Nigeria between 2005 and 2014. In 2005 when the NHIS was introduced, the health spending was 54.44 USD but this has increased to 94.34 USD which represent a 73.3% increase in health spending.

Appendix I: Trend analysis of 2005 and 2012 health spending
(Appendix I) shows the health spending as percentage of GDP for 2005 and 2012. There was no data for 2014. In 2005 health spending as percentage of GDP was 6.6% but this decreased to 6.0% which indicate a 9.1% decreased in health spending by Nigeria

Appendix I: 2005 and 2012 Trend Analysis of Health Spending as Percentage GDP
Institutional Review Board for Human Subjects Research

Date: 15 October 2014

To: Francisca Onosu, PPA Student

cc: B. J. Moore, Public Policy & Administration
    Paul Newberry, IRB Chair

From: Steve Suter, Research Ethics Review Coordinator

Subject: Protocol 14-98: Not Human Subjects Research

Thank you for bringing your protocol, “Challenges Nigeria Faces in Implementing National Health Insurance Scheme”, to the attention of the IRB/HSR. On the form, “Is My Project Human Subjects Research?”, received on October 15th, 2014, you indicated the following:

I want to interview, survey, systematically observe, or collect other data from human subjects, for example, students in the educational setting. NO

I want to access data about specific persons that have already been collected by others [such as test scores or demographic information]. Those data can be linked to specific persons [regardless of whether I will link data and persons in my research or reveal anyone’s identities]. NO

Given this, your proposed project will not constitute human subjects research. Therefore, it does not fall within the purview of the CSUB IRB/HSR. Good luck with your project.

If you have any questions, or there are any changes that might bring these activities within the purview of the IRB/HSR, please notify me immediately at 654-2373. Thank you.

Steve Suter, University Research Ethics Review Coordinator