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LEGAL FRAMEWORK FOR NATIONAL HEALTH INSURANCE IN NIGERIA AND GHANA: A COMPARATIVE ANALYSIS

By

Kehinde Anifalaje, *B.L, LL.M**

Abstract

A comparative analysis is made of the legal framework for National Health Insurance in Nigeria and Ghana from the prism of organisational structure, coverage, financing mechanism and benefit package with a view to determining the relevance and adequacy of the Nigerian archetype of health insurance in providing qualitative healthcare services to the citizenry. Our major conclusion is that unlike the Ghanaian health insurance scheme which has extended coverage to quite a large number of the population, health insurance is still a mirage to a larger percentage of the Nigerian citizenry especially the vulnerable groups because of the identified limitations in terms of coverage, financing and benefit package of the National Health Insurance Scheme. Requisite reform proposals to address these lacunae within the context of the general health care system are offered in order that the health insurance law in Nigeria may be sufficiently strengthened to make it internationally competitive, fulfill the yearnings and aspirations of the average Nigerian for qualitative healthcare services and to enhance the overall productivity of the nation. The article concludes with a call for effective integration of the primary health care system as a foundation for having a truly universal health insurance scheme in Nigeria.

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Introduction

In Africa, quite a large number of people have little or no access to the basic health care services[1] despite the fact that people in this Sub-Region are recorded to face a heavy and wide-ranging burden of diseases, which negatively impacts on social and economic development and shortens their life expectancy. Although some countries in the Region have embarked on series of health sector reforms to improve on their health service delivery, health systems in many of these African countries are still weak and not fully functional due largely to inadequate financial and human resources.[2] In order to address these basic problems, few countries including Nigeria and Ghana have further taken the bold initiative in their health sector reform drive to make healthcare accessible and affordable to all by institutionalising National Health Insurance Schemes (NHIS). These National Health Insurance Schemes are peculiar in their funding mechanisms because they are based on the social insurance system with the general objective to insure the whole population for the cost of healthcare.[3] The essential feature of the

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1. Health care is one of the two rubrics of the right to health care, the other being the underlying or social determinants of health. See General comment No. 14: "The Right to the Highest Attainable Standards of Health" UN Economic and Social Council, 22nd Session, 11 August 2000. UN doc. E/C.12/2000/4, at paras 4 and 13. *http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En.* Visited 12/15/2013 at 2 pm. Although the two branches are interrelated and of equal significance, the main focus of this article is on the first component - the health care.
2. See WHO *Bulletin of World Health Organisation*, Vol 91, October 2013, 106. *http//whqlibdoc.who.int/afro/2006/9290231033_rev_eng.pdf.* Visited 10/28/2013 at 3 pm.
3. Germany has the oldest social health insurance programme dating back to 1883 when Chancellor Otto Von Bismarck introduced the mandatory state-supervised sickness insurance scheme by the Sickness Insurance Law of that year to replace the existing voluntary structures See K Romer (ed) ***Facts About Germany***, Federal Republic of Germany, Lexicon Institute Berteshman, 1979, p. 240. The other approach to National Health Insurance is the one that adopts the tax-financed system such as is available under the National Health Service Act 1946 of the United Kingdom as well as in Canada whereby health care services are provided on a universal basis to all citizens as well as legal residents within a given country with virtually all the financial responsibilities assumed by the

National Health Insurance (NHI) is solidarity, which basically involves the pooling of risks among members. As such, individuals are required to contribute towards the best interest of the whole society generally through its structure of income re-distribution with a view to reducing social inequalities and inequity. Within the category of persons covered, re-distribution of income does take place between the healthy and the sick, the active and inactive, persons who are employed and those who are unemployed and to some extent between persons earning a high or moderate wage and lower-paid workers.[4] Solidarity thus ensures that healthcare services are made available to those who need it most and not just those who can afford it. In this sense, solidarity in the health sector is sometimes presented as "operationalising social justice"[5] Indeed, it has been aptly stated that health is of special moral importance and has priority over other social goods because of its contribution to the range of opportunities available to individuals and that if the society has social obligations to protect individual opportunity, promoting and restoring health is one component of fulfilling these obligations.[6] The basic goals of a NHI have *inter alia* been identified to include ensuring access to medical care by all persons, eliminating the financial hardship of medical bills and limiting the rise in healthcare cost.[7] Other supplementary goals

state from the general tax revenue. See H. Leeson ***Constitutional Jurisdiction Over Health and Health Care Services in Canada,*** Canada, Commission on the Future of Health Care in Canada, 2002, p. 5.

4. See Section 5 of the National Health Insurance Act, 1995, No. 7875 (Philippines) for example which provides *inter alia* that the programme shall serve as the means for the healthy to help pay for the care of the sick and for those who can afford medical care to subsidize those who cannot.
5. Houtepen, R and Meulen, R, "New Types of Solidarity in the European Welfare State" in Special Issue: Solidarity in Health Care, ***Health Care Analysis*** Vol. 8 No 4, 2000, p. 334 .
6. See N. Daniels ***Just Health Care,*** Cambridge, Cambridge University Press, 1985, passim.. See also N. Daniels ***Just Health: Meeting Health Needs Fairly,*** New York. Cambridge University Press, 2008, passim.
7. K Davis, ***National Health Insurance; Benefits, Costs and Consequences***, Washington, D. C., The Brookings Institution, 1975, p. 3. See also Carrin, G

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include equitable financing method, easy understanding and administration as well as acceptability to providers of medical services and to the public.[8] In addition to these laudable goals, NHI has other advantages which *inter alia* include its seemingly private nature in the funding and delivery of health care services, its self-regulating nature as well as stability in organisational and financial terms.[9]

In Nigeria, the vigorous clamours by notable pressure groups[10] for a National Health Insurance Scheme were eventually heeded by the Nigerian policy makers in 1999 with the promulgation of the National Health Insurance Scheme (NHIS) Decree, (now Act) 1999.[11] Hitherto, on attainment of independence in 1960, health care financing began with a tax-funded system that provided free health care services to all. However, with the global slump in oil prices in the 1980s which greatly affected the government's major source of income, coupled with the Structural Adjustment Programmes introduced in 1986 with the resultant impact on the budgetary allocation to the health sector, several cost-recovery mechanisms such as user charges and Drug Revolving Funds were introduced.[12] Consequently, access to health care services was, by and large, limited to citizens who could afford to pay for the needed services. Therefore, apart from being considered as an escape route from the dwindling government resources at that time, the

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and James, C. "Social Health Insurance: Key Factors Affecting the Transition Towards Universal Coverage." ***International Social Security Review*** Vol. 58 No. 1, 2005, p.1.

8. Davis, *ibid.*
9. Id. at 4.
10. Consideration for the introduction of a NHIS actually started in Nigeria in the 1960s during the First Republic and reached a climax in the 1980s with unrelenting campaigns of social groups especially the Nigeria Medical Association which clamoured for its introduction See *Daily Times,* 28 June 1982 p. 2; *National Concord* 23 July 1984, p. 5.
11. No 35 of 1999. The Decree was promulgated by the Military Administration as the NHIS Decree, 1999. The title has however since changed in the subsequent Civilian Administration to NHIS Act, 1999 by the Adaptation Law (Re-designation of Decree, etc.) Order, 1980.
12. See *The Guardian,* 10 May 2009, p. 76.

NHIS Decree was promulgated with the lofty aims of *inter alia* addressing the inequities inherent in the user charges system, providing the much-needed health-care services for the citizenry and stemming its rising costs.[13] It was also thought of as a means of effectively integrating private health facilities in the nation's healthcare delivery system in form of partnership between the public and private sectors. The Scheme was first launched in October 1997, while its enabling law, the NHIS Decree which established the NHIS was promulgated in 1999. The Decree was however dormant for almost six years until the Scheme was eventually re-launched on June 6, 2005 by the civilian government and became fully operational.

Similarly, in Ghana, the tax-funded system of health care financing that provided free public health care services to all was adopted after independence. In the 1980s however, user-fee for public health services popularly known as the "cash and carry" system was also introduced to supplement limited health financing resources on the one hand and to discourage unnecessary use of services on the other. The resultant effect of this was the dramatic decline in the utilisation of health care services such that out-patient visits to hospitals were said to drop from 4.6 million to 1.6 million in 1985, when charges were first increased dramatically.[14] However in the 1990's, in the bid to reduce household out-of-pocket expenditure, a few community-based health insurance schemes, also known as mutual health organisations, initiated by non-governmental organisations, were introduced as an alternative to the "cash and carry" system. The schemes however suffered serious limitations in that they were merely targeted to specific areas, failed to address key social insurance issues, and were not supported by government. Thus, by 2003, such community schemes could provide coverage for just about 1 per cent of the country's 19 million population,

13. See *Daily Sketch*, 20 June 1984, p. 16.
14. See USAID. ***An Evaluation of the Effects of the National Health Insurance Scheme in Ghana***, *www.healthsystems2020.org/.../2361_file_Ghana NHIS Evaluation Tech Report_FBN11.Pdf*. Visited 11/30/2013 at 2 pm.

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leaving many Ghanaians vulnerable in the event of catastrophic illness. As such, the system of user fees remained the predominant means of health care financing with the result that many people who could not afford to pay the requisite fees for health care delivery opted for self-medication and other cost-saving behaviours and practices.[15] Therefore, in an attempt to increase access and improve the quality of basic health care services, the National Health Insurance Act was enacted in August 2003, establishing the National Health Insurance Scheme. In line with the basic goal of a NHI, the policy objective of the Act seeks to ensure that within the first five years of operation, every resident of Ghana would belong to a health insurance scheme that adequately covers him or her against the need to pay out-of-pocket at the point of service use in order to obtain access to a defined package of acceptable health services. The Ghanaian National Health Insurance Act, though passed in 2003 became effective in 2005, the same year the Nigerian law also became fully operational.

It is the aim of this paper to analyse the Nigerian National Health Insurance Scheme (NHIS) Act, 1999[16] from the perspective of its organisational structure, coverage, financing mechanism and benefit packages vis-a-vis the Ghanaian National Health Insurance Act, (Act 650, 2003) with a view to determining its relevance, value and adequacy in raising the standard of health care delivery in Nigeria. The paper will examine the defects in the Nigerian enabling law and proffer requisite reform proposals. A description of the National Health Insurance Laws of these two countries will be our first focus, and this we now turn to.

15. See Blanchet, N.J, Fink, G and Osei-Akoto "The Effect of Ghana's National Health Insurance Scheme on Health Care Utilisation" ***Ghana Medical Journal,*** Vol.46 No. 2, 2012, pp 76-84. *http://www.ncbi.nlm. nih. gov/pmc/articles/PMC3426378/* Visited 30/11/2013 at 2 pm. See also, Hassan, W "Universal Healthcare Coverage: Assessing the Implementation of Ghana's National Health Insurance Scheme Law", *www.indiana.edu/-workshop /seminars/papers/wahab_mc paper08.pdf.* Visited 10/13/2013 at 2 pm.

16. No. 35 of 1999.

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Regulation of National Health Insurance in Nigeria and Ghana

(a) *Organisation*

The Nigerian NHIS Act in section 1 thereof establishes the National Health Insurance Scheme[17] (hereinafter referred to as the Scheme) for the purpose of providing health insurance which shall entitle insured persons and their dependants to the benefit of prescribed good quality and cost-effective health services as set out in the Act. In line with the basic goals of any viable health insurance scheme, the general objectives of the Scheme as copiously spelt out under section 5 of the Act include, ensuring that every Nigerian has access to good health care services; protecting families from the financial hardship of huge medical bills; limiting the rise in the cost of health care services; ensuring equitable distribution of health care costs among different income groups; maintaining high standard of health care delivery service within the Scheme; ensuring efficiency in health care services; improving and harnessing private sector participation in the provision of healthcare services; ensuring adequate distribution of health facilities within the Federation; ensuring equitable patronage of all levels of health care and ensuring the availability of funds to the health sector for improved services. Furthermore, the general functions and powers of the Scheme as provided under section 6 of the Act are to register health maintenance organizations (HMOs) and health care providers (HCPs) under the Scheme and issue appropriate guidelines to maintain the viability of the Scheme. The general management of the Scheme is vested in the governing council (hereinafter referred to as the council) established under section 2 of the Act, whilst the general functions and powers of the council, which are quite comprehensive for purposes of ensuring the effective implementation of the policy directives of the Scheme, are stated

17. By Section 1(2) of the NHIS Act, the Scheme shall be a body corporate with perpetual succession, a common seal and may sue and be sued in its corporate name.

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under section 7 of the Act to include *inter alia* managing the Scheme in accordance with the provisions of the Act; determining the overall policies of the Scheme, including its financial operative procedures; ensuring the effective implementation of the policies and procedures of the Scheme; and carrying out such other activities as are necessary and expedient for the purpose of achieving the objectives of the Scheme as set out in the Act. Apart from the general power given to the Minister of Health under section 47 of the Act to give to the council directives of a general nature with respect to any of its functions, all the financial activities of the Scheme are also subject to the scrutiny and approval of the Minister to avoid any loss or diminution of the Fund. Furthermore, in order to ensure that the Scheme is responsive to prevailing socio-economic realities in the country, the council is required under section 9 of the Act to appoint for the Scheme, a licensed actuary on such terms and conditions of service as the council may, from time to time, determine to review the Scheme and evaluate it actuarially, including the rates of contributions payable under the Scheme and make appropriate recommendations upon which the council is to act accordingly as it considers appropriate. Also, to ensure a wide coverage of the target population and for effective management and co-ordination of the activities of the Scheme across the country, section 21 of the Act empowers the council to divide the country into such number of zones as it may, from time to time determine, and establish in each zone, a zonal health insurance office (hereinafter referred to as zonal office). Thus, a zonal office so established is to be responsible under section 22 of the Act for inter alia determining the areas in which there are sufficient services for the Scheme to operate; strategic planning for the successful implementation of the Scheme and undertaking programmes for phasing in the Scheme. Other subsidiary bodies saddled with the management of the Scheme at their respective levels to ensure the smooth operation, as well as, the success of the Scheme include, health care providers (HCPs) registered under section 18 of the Act; health maintenance organisations

(HMOs) registered under section 19 of the Act; the standards committee charged with the responsibility for recommending to the Scheme guidelines for the maintenance of quality assurance among registered HMOs and HCPs,[18] and an Arbitration Board charged with the responsibility of considering complaints made by any aggrieved party concerning the violation of any of the provisions of the Act or against any agent of the Scheme or any HMO or HCP[19].

In Ghana, the National Health Insurance Act, (Act 650, 2003) was also enacted with the primary objectives of *inter alia* providing a policy and regulatory framework for health insurance that will enable the nation achieve the goal of equitable access to healthcare for all residents in relation to need rather than socio-economic or socio-cultural status. The Act in its section 1 establishes the National Health Insurance Authority (NHIA) whose object as stated in section 2 thereof is to secure the implementation of a national health insurance policy that ensures access to basic healthcare services to all residents. In furtherance of its statutory objective, the NHIA is vested with wide ranging powers under section 2 of the Act to register, licence, regulate and supervise the operations of health insurance schemes; grant accreditation to healthcare providers and monitor their performance; ensure that healthcare services rendered to beneficiaries of schemes by accredited healthcare providers are of good quality; determine in consultation with licensed district mutual health insurance schemes, contributions that should be made by their members; make proposals to the minister for the formulation of policies on health insurance; devise a mechanism for ensuring that the basic healthcare needs of indigents are adequately provided for; provide a mechanism for resolving complaints by schemes, members of schemes and healthcare providers; manage the Health Insurance Fund as well as to perform any other function conferred on it under the Act or that

18. See Section 46 of the NHIS Act.
19. See Section 26 of the NHIS Act.

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are ancillary to the object of the council. The governing body of the Authority is, however, the National Health Insurance Council (hereinafter referred to as the Council) established under section 3 of the Act. In the performance of its functions, the Council is empowered under section 7 of the Act to appoint committees composed of members of the Council or non-members or both and assign to the committees any of its functions.

Another important organ in the organisational structure of the health insurance scheme is the health complaints committee established under section 8 of the Act, which is responsible for hearing and resolving complaints that may be submitted to the council by members of health insurance schemes, the schemes and healthcare providers. And in order to ensure quick response to and settlement of complaints, the health complaints committee is decentralised and established in every district office of the NHIA. The Minister of Health is generally empowered under section 10 of the Act to give to the council directives of a general nature on matters of policy which must be complied with by the council. In order to fulfil the objective of ensuring access to basic health care services for all Ghanaians, the Act establishes three types of health insurance schemes, namely, the district mutual health insurance scheme under section 29 which is to be located in every district in the country; the private commercial health insurance scheme under section 39 which may be operated by a body corporate registered as a limited liability company under the Companies Act, 1973 (Act 179); and private mutual health insurance scheme under section 46 of the Act, which may be formed by any group of persons resident in the country. Another important body in the regulation of the health insurance is the healthcare providers who are required to be approved and accredited by the NHIA to provide services to members of the various health insurance schemes.

(b) Coverage

By section 16(1) of the Nigeria NHIS Act, the Nigerian Scheme covers any employment in which the employer has a minimum of

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ten employees in his employment. This basically implies that coverage is, in principle, restricted to employees in the services of the Federal, States and Local Governments, as well as, private sector organisations having at least a minimum of ten employees. Also covered by the Scheme are members of the Armed Forces, the Nigeria Police Force, Nigeria Customs Service and the Nigeria Immigration Service. The Act in its section 17(3) however, gives allowance for those not ordinarily covered by the Scheme to register as voluntary contributors.

In Ghana, the National Health Insurance Act, 2003 requires all Ghanaians to join any of the three legally-recognised health insurance schemes viz- the community-based district mutual health insurance schemes, the private commercial health insurance schemes and the private mutual health insurance schemes to obtain health care services.[20] The objective of universal coverage is however being achieved more through the establishment of the district mutual health insurance scheme in every geographical area of a district assembly for the residents of the country.[21] Thus, under section 31 of the 2003 Act, a person resident in Ghana other than a member of the Armed Forces and the Police Force, is required to seek membership of the scheme in the relevant district for the purpose of accessing health care benefits available under the Act. However, in order to ensure that the scheme fulfils its objective of improving access to health care for all irrespective of economic or social status, all formal sector employees are compulsorily enrolled under the Scheme whilst coverage under the Act is also mandatory for children under 18 years of age, adults over 70 years and the indigents.

(c) Financing

In Nigeria, the bulk of the health care funding under the Act is from the wage-related contributions shared between the employers and their employees depending on the type of health

20. See Section 11 of the Ghana Health Insurance Act, Act 650, 2003.
21. See Section 29 of the National Health Insurance Act, 2003 (Ghana).

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care services they may require. Section 17 of the NHIS Act provides that an employer may, together with his employees, register under the Scheme and pay wage-related contributions at such rate, and in such manner as may be determined from time to time by the Council through designated HMOs into a Fund established under section 11 of the Act for that purpose. Such contributions ordinarily cover health care benefits for the employee, a spouse and four biological children below the age of 18 years. More dependants of such employee or a child above 18 years are covered on the payment of additional contributions from the principal beneficiary.[22] In line with best global practices, contributions of security personnel such as members of the Armed Forces, the Nigeria Police Force, Nigeria Customs Service, Nigeria Immigration Service and such other Federal uniformed service as the minister may by Order in the Gazette specify, are to be paid by the Federal Government.[23] Other sources of revenue to the Scheme as listed under section 11 of the Act include money as may be granted or received from either the Federal, State or Local Government; the organised private sector; international or donor organisations and non-governmental organisations; dividends and interests on investments and stocks; and all other money which may, from time to time, accrue to the Scheme. A measure of tax relief is given by the government to employers and employees in respect of their respective contributions by virtue of section 40 of the Act which deems such contributions as part of tax deductible expenses in the computation of tax payable by such an employer or an employee as the case may be. Similarly, under section 15 of the NHIS Act, general tax exemption is given to the Scheme in respect of any income accruing from investments made by the Council for the Scheme.

In Ghana, funding for the health insurance scheme is derivable from a combination of wage-related contributions,

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22. See the NHIS Operational Guidelines, <http://*www.NHIS.gov.ng*. Visited 6/20/2012 at 3 pm.
23. See Section 44 of the NHIS Act, 1999.

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contributions from the Social Security and National Insurance Trust, imposition of health insurance levy under section 86 of the Act and other funds such as investment returns or donations. The National Health Insurance Regulations, 2004 provides for a range of premiums to be charged according to a person's income or wealth, ranging from 7.2 GhC for the "very poor" to 48 GhC for the "very rich". However, each District Mutual Health Insurance Scheme (DMHIS) is given the latitude to decide on the premium amount and has the option of graduating amounts according to income level. It has however been established that many DMHISs have moved to charging a constant premium to all, typically in the GhC 8 – 10 range, which is set at a minimum of 72,000 cedis (approximately US$5) per person.[24] Nevertheless, for effective implementation of the programme and to ensure that opportunity is provided to all Ghanaians to have equal access to the functional structures of health insurance, the Act has, in addition to the required contributions to be made by members, established the National Health Insurance Fund under section 78 thereof to subsidise the cost of provision of health care services to members of the DMHISs, reinsure DMHISs by payment of any deficit between contribution of members and the claims made by health care providers as well as make provision for the required funds to cover the basic health care needs of indigents resident within the various districts and who have been identified and registered on the basis of a means test prescribed for determining their

24. See Blanchet, Fink and Osei-Akoto "The Effect of Ghana's National Health Insurance Scheme on Health Care Utilisation" (n. 15) p. 13. For instance, in the Nkoranza district, all non-exempt community members pay a flat premium rate of 80,000 cedis. There is no gradation by income nor any differences for SSNIT contributors. The lack of differentiation is said to be premised on the argument that the wealthier community members do not accept that they should pay higher rates since they invariably pay for their poorer relations. The registration fees are however charged at 20,000 cedis and 30,000 cedis for existing members and new members respectively. See USAID, ***An Evaluation of the Effects of the National Health Insurance Scheme in Ghana.*** (n. 14), p. 12.

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eligibility.[25] To this end, 2.5 per cent of the 17.5 per cent Social Security National Insurance Trust contributions paid by formal sector employees are automatically diverted to support the NHIS. Accordingly, formal sector employees, their dependants, as well as, pensioners under the Social Security Pension Scheme, all children under 18 years of age, whose parents are enrolled in a DMHIS are exempted from paying premiums. Also, in order to ensure equitable enrolment of all segments of the population, people over age 70 and the "core poor", defined as being unemployed with no visible source of income, no fixed residence and not living with someone employed and with a fixed residence are entitled to healthcare coverage free of charge.[26] The community itself identifies and determines those who are qualified to be exempted and the decision to exempt such a person is usually taken at the Annual General Meeting of the Scheme.[27] Furthermore, in order to reduce the maternal mortality rate in terms of access to formal health care services, pregnant women have, since July 2008 been exempted from paying premiums. As at the end of 2008, about 70 per cent of the National Health Insurance Scheme members were said to be in the exempt category.[28]

According to available statistics, the percentage of government's total funding to the health care system in Ghana amounts to about 68 per cent of the health budget comprising 45 per cent from the regular budget and 23 per cent from the National Health Insurance Fund, which is largely tax-base. Moreover, Health Fund and Era-Marked Funds account for 13 per cent each; Internally-Generated Revenue from Out-of-Pocket

25. See Section 33 and 38 of the National Health Insurance Act, 2003 (Ghana).
26. See Part II, sections 56 and 58 of the Legislative Instrument (LI) 1809 (2004) (Ghana). All enrollees, including SSNIT contributors are required to pay nominal registration fees to cover the cost of issuance of identification cards. Some DMHISs also require the indigents to pay registration as well.
27. See USAID, ***An Evaluation of the Effects of the National Health Insurance Scheme in Ghana***, (n. 14) p. 15.
28. *Ibid.*

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payment to facilities, 3 per cent and HIPC inflows, 3 per cent.[29] The sales taxes, Value Added Tax and levies under section 86 of the Act fund the health care services of most of those who are exempted. In this regard, the social health insurance scheme has served not only as an indispensable part of the broader structure of social security but also a veritable means of income support. Indeed, studies have shown that the age-based exemptions, such as those for children under 18 and the elderly over 70 have really worked well in improving access to health care.

(d) Benefit Package

Generally, in consonance with Article 13 of the Medical Care and Sickness Benefits Convention, 1969, No. 130, a basic package of healthcare benefits is defined under section 18 of the Nigerian NHIS Act to include defined elements of curative care; prescribed drugs and diagnostic tests; maternity care for up to four live births for every insured person; preventive care, including immunisation, family planning, ante-natal and post-natal care; consultation with defined range of specialists; hospital care in a public or private hospital; eye examination and care excluding test and actual provision of spectacles and a range of prosthesis and dental care as defined. Enrollees are given the freedom to consult any HCP of their choice to access the available health care services provided that such HCP is registered by the Scheme under section 18 of the Act. Such HCP is also required under section 45 of the Act to take a professional indemnity cover from an insurance company approved by the Council. Thus, the entry point for all enrollees is the HCP who may then refer patients to specialists if the need arises. Remuneration of HCPs is by capitation payment in respect of each insured person registered with each of them, as well as, by

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29. *See* WHO "WHO *Country Cooperation Strategy; Ghana,* 2008-2011" *http://www.who.int/countryfocus/cooperation_strategy/ccs_gha_en.pdf* Visited 2/18/2013 at 3 pm.

payment of approved fees for services[30] rendered following appropriate referrals or prescriptions sent to them.

In order to achieve the laudable objectives of the Scheme and to ensure efficient and effective service delivery, the Act has adopted a market-driven structure by employing the services of Health Maintenance Organizations (HMOs) who are private and public insurers registered under section 19 of the Act. As health managers, they are charged under section 20 of the Act with the responsibility of collecting contributions from enrollees and distributing health services; contracting only with the HCPs approved by the Council for the purpose of rendering health care services under the Act; the payment of capitation fees for services rendered by registered HCP under the Scheme; rendering to the Scheme returns on their activities as may be required by the Council; ensuring that contributions are kept in accordance with guidelines issued by the Council and in banks approved by the council and establishing a quality assurance system to ensure that qualitative care is given by every HCP.

Similarly, under section 64 of the Ghanaian National Health Insurance Act 2003, a licensed scheme is required to provide to its members the minimum health care benefits that the Minister may, on the advice of the Council by Legislative Instrument prescribe. To this end, the Legislative Instrument 1809, 2004 has prescribed the minimum health care benefits to include *inter alia* general and specialist consultations, requested investigations such as ultrasound, laboratory investigations, prescriptions, medications, cervical and breast cancer treatment, surgical operations, eye care services, oral health services, maternity care, confirmatory HIV/AIDS test, psychiatry care, generic medicines and emergency care. The benefit package is thus quite

30. Section 50 of the NHIS Act defines capitation payment as payment to a HCP in respect of services to be provided by him to an insured person registered by the HCP whether the insured person uses the service or not while "Fee for Service" is defined as payment made directly for completed healthcare service, not included in the capitation fees, and paid to healthcare providers or professionals following appropriate referrals or prescriptions sent to them by HCPs under the Scheme.

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comprehensive and curative with the expectation that about 95 percent of most diseases in Ghana shall be covered under the National Health Insurance Act. In contrast to the benefit package of the Nigerian Health Insurance Scheme, certain public health services which are considered to be of benefit to the public, such as family planning and immunisation, were excluded from the benefit package on the assumption that such services would continue to be provided for free at public health services. Also, some services deemed either unnecessary or too expensive, such as cosmetic surgery, assisted reproduction, organ transplantation and private inpatient accommodation, are excluded from coverage. The Act is not selective in respect of public health facilities that could participate in the Scheme as all such public health facilities are automatically accredited to participate whilst the National Health Insurance Scheme, in addition, contracts with a wide network of private service providers to serve the beneficiaries. As a means of controlling cost, the service providers are remunerated on a fee-for-service system for services rendered such as inpatient and outpatient care and for drugs prescribed to NHIS beneficiaries. Defined benefits are provided on a uniform basis to all and access to care is a function of a person's health needs rather than his or her ability to pay. Similarly, no discrimination in terms of payment of different rates for health care services according to age, occupation or previous health status is allowed.

Basic Contrasting Features

A review of the coverage and financing mechanisms of health care services in Ghana reveals that the common assumptions that SHI systems are work-related insurance with no intention of population-wide coverage and that SHI countries rely predominantly on wage-related contributions to fund their health care systems is no longer tenable. First, it would be observed from the foregoing descriptive analysis of the health insurance schemes of the two countries that, unlike what obtains in Nigeria where the NHIS is basically employment-related with the option

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of voluntary participation given to other segments of the population, a central and remarkable feature of the National Health Insurance in Ghana is solidarity in terms of population coverage and funding. It is noteworthy that one of the determinants of a population's health is access to qualitative health care services. Accessibility in this context connotes not only non-discrimination in whatever form in accessing health facilities but also physical accessibility in terms of making health facilities within safe physical reach for all sections of the population, especially the vulnerable and marginalised groups including women, children, older persons and persons with disabilities; economic accessibility and information accessibility.[31] Thus, while the Ghanaian health insurance law has given due recognition to the non-working segments of the society as well as the aged, the poor and the most vulnerable in the society and has thus been able to achieve a near universal coverage of the population, the Nigerian NHIS Act does not make any explicit provision for the poor, the aged and other vulnerable groups with limited means who are mostly in need of assistance and have continued to experience diminished health and reduction in their productive capacity. As such, the proportion of the citizenry presently covered by the Nigerian health insurance scheme is still abysmally low. Although one of the objectives of the Scheme implicit in the title and explicit in section 5 of the Act is universal access to good health care services which connotes equal or equitable access to needed care, there are however certain provisions of the Act which are contradictory of this laudable objective and have regrettably rendered the Scheme an illusion to many Nigerians. For instance, the provisions of sections 16 and 17 of the Act clearly indicate that the Scheme is basically employment-related and discretionary. The formal sector which the Scheme covers represents only about 20 to 25 per cent of the

31. See General Comment No 14. "The Right to the Highest Attainable Standards of Health" UN Economic and Social Council, 22nd Session, 11 August 2000. UN doc. E/C.12/2000/4, at paras 4 and 13. *http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En.* Visited 12/15/2013 at 2 pm.

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Nigerian population.[32] It is therefore not surprising that several years after the Scheme has been formally launched, coverage has only been limited majorly to employees in the formal sector of the economy especially federal civil servants, who can make monthly contributions from their salaries.

Indeed, most state governments are yet to embrace the Scheme. Participation under the Scheme for those in the organised private sector has also been limited to those who are in such employment where the employer has at least ten workers in his employment and such participation is left to the discretion of the employer. It is certainly not in the best interest of employees whose employers neither have a better alternative to the NHIS nor any form of health insurance package whatsoever, to have left the decision to participate in the Scheme to the whims and caprices of the employers. An indifferent employer, who does not value the importance of the Scheme, may decline participation even where his employees desire otherwise thereby reducing the opportunity such employees would have had to access quality health care services at little or no cost when the need arises. Disease and disability, it has been argued, impair normal functioning and restricts the range of opportunities open to individuals. The central function of health care therefore, is, to maintain normal functioning thereby contributing to the protection of an individual's fair share of the normal range of opportunities reasonable people would choose in a given society. Specifically, by keeping people close to normal functioning, health care preserves the ability of the citizenry to contribute meaningfully to the political, social and economic life of their society.[33] It is common knowledge that in many developing

32. According to the Executive Secretary of the Council, as at August 2010, only 5.3 million Nigerians or about 3.73% of the population comprising mainly federal government employees and their families is so far benefiting from the Scheme. See *The Guardian*, 22 August 2010, p. 50.

33. See N Daniels "*Justice, Health and Health Care*", *www.hsph.harvard.edu/benchmark/ndaniels/pdf/justice_health.pdf*. Visited 11/23/ 2013 at 2 pm.

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countries such as Nigeria, most people would not readily subscribe to the medical care required to assist them in enjoying longer and fuller lives. There is also no gainsaying the fact that access to qualitative health care services in Nigeria is either limited or non-existent basically due to the scourging effect of poverty especially in the rural areas, coupled with inadequate health care facilities, shortage of health care professionals, high level of illiteracy and poor transportation system. There is therefore the need for a viable, non-discriminatory and broad-based health insurance scheme that would guarantee access to qualitative health care services for all as it is being done in some other African countries such as Ghana.

Moreover, contrary to what obtains in the NHIS of Ghana, certain benefits obtainable under the Nigerian NHIS are linked to the levels of contribution of each enrollee under the wage-indexed structure as would be observed for instance, in Section 48 (1) (j) of the Act, which *inter alia* provides that the Scheme may issue guidelines for "the nature and amount of benefits to be provided under the Scheme, the circumstances and the manner in which the benefit shall be provided." A health insurance scheme founded on the egalitarian theory of distributive justice which component principle entails that social and economic inequalities are to be arranged so that they are both to the greatest benefit of the least advantaged and open to all under conditions of fair equality of opportunity[34] must, necessarily promote equality, fairness and opportunity. Justice implies equal treatment of equals under comparable circumstances. In this context, justice means not only equality in the formal access to health care services in terms of ensuring that payment for health care services is based on the principle of equity, but also equal chances to benefit from the available package of healthcare regardless of social or economic background.[35] Solidarity in schemes such as this therefore, ought

34. See J Rawls *A Theory of Justice,* Cambridge MA, .Oxford University, 1973, p. 302.

35. See Breyer, F. "Health Care Rationing and Distributive Justice", *www.mm-journal.de/download/o28_breyer.pdf.* Visited 12/20//2013 at 11 am.

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to promote mutual aid and co-operation between the low-income and high-income earners. But, the degree of solidarity within the Nigerian health insurance scheme is reduced since healthcare service is not based on actuarial risks but rather on affordability. It is the usual practice for purposes of getting registered with any of the HMOs, to require the prospective enrollee to choose from the various categories of services ranging from the best to the average, which premiums differ from one to another. Given this scenario, enrollee's choice is automatically dependent on his/her level of income.[36] The disparity in accessing benefits is definitely not in consonance with the equitable principle which a Scheme such as this is expected to advance and it is also not an equitable method of financing as enunciated in section 5(d) of the Act which provides that the Scheme shall ensure equitable distribution of health care costs among different income groups.

A corollary to the central issue of solidarity is the commitment as well as political will on the part of the Ghanaian government not only to provide accessible and qualitative health care services at affordable price to the citizenry but also to take pro-active policy measures to overcome the challenges confronting the health sector. In Nigeria, one of the major problems confronting the health sector is the poor stewardship role of the government manifesting inter alia in inadequate and inefficient financing, inadequate political commitment, especially at lower levels, lack of communication between various actors, lack of transparency and poor accountability, which have all contributed to the lack of strategic direction and an inefficient and ineffective health care delivery system.[37] Stewardship, according to the World Health Organisation is referred to as "function of a government responsible for the welfare of the population, and concerned about the trust and legitimacy with which its activities

36. See *The Punch,* 1 February 2008, p. 13.

37. See ***The National Strategic Health Development Plan Framework (2009 - 2015). NCH ADOPTED,*** July 2009, *www.internationalhealthpartnership .net/.../Nigeria/Nigeria%20National&.* Visited 12/20 2013 at 10 am.

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are viewed by the citizenry."[38] Thus, the concept of stewardship role of government in health means the way in which governments mobilise and spend revenues and make regulations and policies that deal with the issue of accountability and transparency in the health system with specific regard to matters such as oversight, financing, promotion of the health of the people, etc.[39] In this context, especially, on issue of funding for the Nigerian Scheme, the source of finance for the Scheme is limited majorly to contributions from enrollees.

There is no provision in the NHIS Act requiring government to provide any form of financial support for the Scheme as has been seen in similar scheme in Ghana where a combination of the two financing systems (the tax-financed system and the social insurance system) has been employed simultaneously in parallel directions in funding healthcare systems. Undoubtedly, the amount of public health expenditure has serious implications on the quantity and quality of health care services within a country. From the available statistics, whilst total health expenditure for 2011 in Ghana was 4.8 per cent and Nigeria's was 5.3 per cent, public health expenditure in Ghana accounted for 56.1 per cent while Nigeria's was just 36.7 per cent for the same period.[40] Indeed, whilst the Ghanaian government has been able to meet the recommended 15 per cent budgetary allocation prescribed by World Health Organisation (WHO) and affirmed by the 2001 Abuja Declaration of African Heads of State, the budgetary provision for health in Nigeria has, over the years, always been far less than the 15 per cent of the national budget. Consequently, whilst private out-of-pocket health expenditure in Ghana has significantly reduced from 80 per cent to 66.3 per cent of total spending as at 2011, out-of-pocket expenditure in Nigeria still

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38. See WHO, ***World Health Report 2000: Health Systems – Improving Performance***. WHO, 2000.
39. See ***The National Strategic Health Development Plan Framework (2009 – 2015*** (n. 37)..
40. See World Bank. 2013. ***World Development Indicators (WDI),*** *http://databank.worldbank.org/topic/health* Visited 12 /12/2013 at 10 am.

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remains as high as 95.4 per cent for the same period.[41] There is no doubt that private out-of-pocket expenditure is regressive as it proportionally affects the poorest in the society, forces many into poverty due to unpredictable catastrophic health expenditure and therefore challenges the basic tenets of equity embedded in health care systems.

With the high level and devastating effect of poverty in the country which is impacting adversely on the nation's health indicators,[42] it behoves government at all levels to make concerted efforts at reducing the burden of health expenditure on the poor households through appropriate funding. Indeed, the legitimacy of any national health system depends on how best it serves the interest of the poorest and most vulnerable people, for which improvements in their health status is central towards the realisation of poverty reduction goals. In general, the Ghanaian government has demonstrated commendable stewardship in terms of making access and financing more equitable such as by giving necessary subsidies to support the programme, thereby ensuring better access and generally improving the health of the citizenry. Although it is admitted that improvements in health outcomes is

41. *Ibid.*
42. Poverty incidence in the country has varied but remained high over the past decade. In 2004, about 70 % of Nigerians or two-thirds of the Nigerian people are said to be living below international poverty benchmark of US $1 a day, living in absolute poverty with not even the barest essentials to support minimally decent human life. At the then level of the country's population of 126.2 million, this translated into about 89 million people living in abject poverty thereby making Nigeria a nation with the highest concentration of people living in extreme poverty. See National Planning Commission ***National Economic Empowerment and Development Strategy,*** Abuja, National Population Commission, 2004, p. *xii.* Currently, about 40 per cent of Nigerians are classified by the National Bureau of Statistics as "extremely poor" having less than a threshold per capita expenditure per year. See National Bureau of Statistics, ***Harmonized Nigeria Living Standard Survey (HNLSS) 2009/2010,*** Abuja, National Bureau of Statistics, 2010. Available statistics also shows that Nigeria occupies 153rd position out of the 187 countries in the Human Development Index Report for 2013. See UNDP. **2013. *Human Development Report,*** http://www.hdrstats.undp.org/images/explanations/ NGA,pdf. Visited 12/13/2013 at 2 pm.

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not determinable solely by access to health care services as other socially-controllable factors such as environment and life style as well as human biology affect the levels of population health, there is however no gainsaying the fact that improved access to health care has contributed significantly to the sustained and more favourable health indicators Ghana has recorded over the years. For instance, as at 2000, the health system of Nigeria and Ghana were in a deplorable state. Life expectancy in Nigeria at the time was 48 years for males and 49 years for females whilst the corresponding figure for Ghana was 58 and 59 years respectively.

Infant mortality rate as well as under-five mortality rate per 1,000 live births was 116 and 186 for Nigeria whist Ghana's was 64 and 99 respectively.[43] Also vaccine-preventable diseases and infectious diseases exacted their toll on the health survival of the citizenry of both countries, remaining the leading causes of morbidity and mortality. However, as at 2011, life expectancy in Nigeria has increased to 52 years whilst Ghana's has also increased to 61. Also, in Nigeria, maternal mortality rate for 2010 was put at 630/100,000 live births; infant mortality rate and under-five mortality rate for 2012 were put at 78/1,000 live births and 124/1,000 live births respectively. The corresponding figures for Ghana for these years were maternal mortality rate - 350/100,000 live births, infant mortality rate and under-five mortality rate were 49/1,000 live births and 72/1,000 live births respectively.[44] The percentage of one-year-olds fully immunized against measles for 2012 was put at 42 per cent for Nigeria and 88 per cent for Ghana. The incidence of tuberculosis was put at 108/100,000 people for Nigeria and 72/100,000 for Ghana whilst the total percentage of population suffering from HIV was put at 3.1 for Nigeria and 1.4 for Ghana.[45]

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43. See UNDP. 2013. ***Human Development Report***, *Ibid.*
44. Id. See also WHO ***"WHO Country Cooperation Strategy; Federal Republic of Nigeria, 2008 – 2013"*** p. 4, *www.who.int/countryfocus/cooperation _strategy/ccs_nga_en.pdf* Visited 6/17/2012 at 10 a.m. WHO "***WHO Country Cooperation Strategy; Ghana,* 2008-2011**, (n 29) p. 3 and p. 5..
45. World Bank 2013, **WDI**, (n. 40). See also WHO "**WHO** ***Country Cooperation Strategy; Federal Republic of Nigeria, 2008 – 2013"*** *Ibid.*

Also, no wild polio cases were detected in Ghana from 2003 - 2007[46] unlike the situation in Nigeria where the country is still reported to be the most entrenched reservoirs of wild polio virus in the World and having the World's second-lowest rate of immunisation coverage.[47] Nevertheless, both countries are still being confronted with heavy burden of major diseases, although it is lower in Ghana. For instance, Nigeria is said to be suffering from a double burden of both communicable and non-communicable diseases (NCDs) with high levels of epidemic outbreaks and periodic occurrence of man-made and natural disasters and rising incidence of NCDs.[48] Similarly, it has been reported that the prevalence of (NCDs) such as diabetes mellitus, hypertension and other cardiovascular diseases is also on the increase in Ghana as it is estimated that NCDs currently constitute over 20 per cent of all cases of out-patient attendance.[49] Some other challenges facing the Ghana National Health System include morbidity and mortality in children, high levels of communicable and pregnancy - related conditions and poor reproductive health which need to be further addressed by the government to further improve on the overall health system of the country. In this wise, the concerted efforts of government at confronting and overcoming some of these challenges which are evident in the number of policy decisions that have so far been taken are commendable. For instance, The maternal care introduced in 2008 into the range of services covered by the National Health Insurance Act is provided free of charge to basically address socio-cultural beliefs and practices which discourage institutional delivery. The Ministry of Health has also

46. ***WHO* "WHO *Country Cooperation Strategy; Ghana,* 2008-2011**, (n. 29) p. 6
47. See ***Global Polio Eradication Initiative > Infected Countries> Nigeria.***, *www.polioeradication.org/infectedcountries/Nigeria.aspx* Visited 11/30/2013 at 7 p.m.
48. WHO "***WHO Country Cooperation Strategy; Federal Republic of Nigeria, 2008 – 2013"*** (n 44) 4.
49. WHO "**WHO** *Country Cooperation Strategy; Ghana,* 2008-2011", (n 29) p. 4.

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declared maternal mortality a national emergency and has made Millennium Development Goal 5 a national priority.[50] These sterling attributes and pro-active measures are surely worthy of emulation by Nigerian policy makers.

Undoubtedly, the quality of life is almost meaningless without sound health and the health of a nation is inextricably linked to its wealth. In a country where a vast majority of the citizenry is denied access to qualitative healthcare, quality of life is impaired and the productive capacity of the nation is adversely affected. It is therefore imperative for the Nigerian policymakers to urgently address the foregoing identified gaps in the NHIS Act with a view to promoting sound health among the citizenry, enhancing the socio-economic development of the nation as well as its Gross Domestic Product. The following reforms are therefore proposed to realise the objectives and enhance the operations of the Nigerian National Health Insurance Scheme.

Proposals for the Reform of the Nigerian NHIS Act

The first critical problem that needs to be addressed is improving access to health care services. Access to health care services should not be made the exclusive preserve of employees in the formal sector of the economy. Universal coverage in the true sense without regard to socio-economic, cultural, employment or family status ought to be vigorously pursued. Meeting the health care needs of the vulnerable groups in the society such as the aged, the disabled, the unemployed, and the indigent must be accorded a top priority. Although the Scheme has introduced a number of innovative Schemes such as the Tertiary Institutions Social Health Insurance Scheme to extend insurance coverage to students in select nation's tertiary institutions and has also partnered with the Office of the Millennium Development Goals (MDGs) in its efforts towards reducing maternal and child mortality rate by extending health insurance coverage to pregnant women and children under age five in select States of the

50. *Ibid* p. 7.

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Federation,[51] the proportion of those covered under these schemes is infinitesimal when one considers the number of students in the remaining higher institutions not yet covered as well as the number of pregnant women and under-five children in the remaining thirty states of the Federation and the Federal Capital Territory of Abuja. The management of the NHIS needs to expedite action in the perfection of its other operational framework for extending its activities to other segments of the population outside the formal sector.[52] It is equally pertinent to note that a health insurance scheme that would rely heavily on pay roll is not particularly appropriate to achieve the presidential target of universal coverage by 2015 and to meet the Millennium Development Goals in the health sector[53] because of the factor of

51. Under the Maternal Child Health Programme (MCHP), the NHIS with funds from the MDGs Office had enlisted over 300,000 vulnerable women and children in six states of the Federation with poorest health indices in its pilot project. It was sometime disclosed by the Senior Special Assistant to the President on MDGs, Hajiya Amina Ibrahim that over N5 billion has been earmarked for the implementation of the debt-relief funded NHIS maternal and child projects in these states, namely, Gombe for the North East, Sokoto for the North West, ,Niger for the North Central, Imo for the South East, Bayelsa for the South South and Oyo for the South West See *The Guardian*, 19 November 2009, p. 15.
52. The NHIS has disclosed that it has developed other programmes to cover some other segments of the society. These are the Urban Self-Employed Social Health Insurance Programme; the Rural Community Social Health Insurance Scheme; Permanently Disabled Persons Social Health Insurance Programme; Prison Inmates Social Health Insurance Scheme and the Armed Forces, Police and other Uniformed Services Social Health Insurance Programme. <http://*www.NHIS.gov.ng*> Visited 3/7/2012 at 4 p.m. A few Community-Based Health Insurance Programmes have actually taken off, such as the Shonga Community Health Insurance Scheme in Kwara State wherein members contribute two thousand naira per annum to access health care services for the year. See *The Guardian*, 12 January 2009, p. 3. However, there is a lot of disparity in financing and benefit package from one scheme to the other. The benefit packages are also not fully comprehensive with implication for access to care for excluded conditions by some members. As such, their impact on the overall health care services is still minimal.
53. Four Millennium Development Goals (MDGs) that are directly related to health are to eradicate extreme poverty and hunger in the world; reduce child mortality; improve maternal health and combat HIV/AIDS, malaria and other

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the present level of the nation's economic development, the factor of social strata and the existing contrast between the metropolis and the rural hinterland. Due consideration also has to be given to the fact that more than seventy per cent of the Nigerian population are in the informal sector of the economy and to the crucial factor of high level of illiteracy in the country which may pose some associated problems of administrative difficulties in registering prospective enrollees, assessing income and collecting contributions.

A multi-pronged drive therefore, could be adopted in addressing the problem of access to healthcare services. First, it is proposed that the NHIS Act in its present form should be made to cover everyone in the formal sector, both public and the organised private sector, and without any exception on a compulsory basis. As it is presently, the Scheme is to continue to be financed by contributions from both the employees and employers. Secondly, another scheme comparable to what is being practised in the Ghanaian National Health Insurance Act, 2003 through the DMHISs should be adopted to respond to the priority needs of the informal segment of the population. This second-tier scheme for the informal sector would be open to all residents within the geographical zone of each ward and their dependants who would be required to make such contributions as may be determined by such schemes. However, it is expedient that a flexible financing mechanism be incorporated into the schemes such that members are given the option of making either a monthly or an annual contribution depending on the nature of their source of income. Farmers, for instance, may be given the opportunity of paying their own contributions annually especially, during harvest.

Thirdly, vulnerable members of the community such as the aged, the disabled and indigents resident within the community who have been identified through a means test by the Scheme are to be covered by these ward-based community health insurance

diseases. See WHO, "*WHO Country Cooperation Strategy; Federal Republic of Nigeria, 2008 – 2013*" (n 44) p. 3.

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schemes and are to be provided with necessary healthcare services without their own personal contributions but through subsidy from the Government as it is practised in Ghana.[54] For this purpose, every ward-based community health insurance scheme is to be provided with sufficient budgetary allocation that would substantially subsidize the cost of health care delivery to these vulnerable groups as well as any deficit between contributions of members and the claims made by health care providers. A minimal point of service charge is however necessary for artful dodgers who though may have the means, may not be willing to contribute. Each community should also be involved fully in the decision-making process concerning the scope as well as the management of the Scheme in order to build up the confidence of the people in the Scheme and to have an enduring and sustainable health insurance system. In core rural areas however, it is desirable that a special scheme separate from the proposed community health insurance scheme, which would provide free qualitative health care services to residents in these areas be also introduced. A method of reimbursement such as establishment of fee schedules for physicians and attractive benefit packages for paramedical personnel as well as provision of adequate health infrastructure may be necessary to serve as incentives for the creation and optimal utilisation of medical resources in these core rural areas.

Furthermore, the disparity in the type of health care services that can be provided to enrollees under the NHIS Scheme on grounds of one's ability or inability to pay for same ought to be removed. Accessing any form of health care services under the Scheme should be based on need rather than on ability to pay. And in order to have a more uniform utilisation of health care services for people with comparable health problems among the high and low-income groups, it might be expedient that an equitable method be devised for financing the Scheme in a way that would relate contributions to income in a systematic way that

54. See Sections 33 and 38 of the National Health Insurance Act 2003 (Ghana).

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the burden does not fall disproportionately on low-income earners and families. By this, lower-income persons would make minimal contributions and would not at the same time be put at any disadvantage in accessing health care services. To this end, it is imperative that Government provides subsidies that would equalize funding for all members and ensure uniform comprehensive benefit package for all contributors. Also, in a situation where husband and wife are eligible to participate under the Scheme, contributions of such couple should be calculated in proportion to their respective income while their children are insured with the spouse having a higher income. It would however be necessary to establish a monitoring mechanism within the system to be operationalised through a contract with HCPs that would safeguard against over-utilisation or under-utilisation of services, unnecessary diagnostic and therapeutic procedures and interventions as well as inappropriate referral practices.

Given the poverty level in the country, it is essential for government at all levels to increase their funding to the health sector in order to provide the necessary safety measure for the poor and the vulnerable members of the society. In this wise, government should ensure that at least 15 per cent of the total annual budget as recommended by the Abuja Declaration is committed to the health sector. In addition, it is important that the NHIS takes pro-active measures that would ensure its financial sustainability through diversification of its revenue base by investing in long-term capital goals. Government could also take a cue from the practice in Ghana where national health insurance levy is charged on every goods and services made or provided in Ghana as well as on every importation of goods and the supply of an imported service in order to generate funds to finance the health care services to the vulnerable groups. It is not in the best interest of the Scheme to rely too heavily on payroll for contributions in view of the high level of unemployment in the country and the decreasing number of people in paid employments. It is however important that Nigeria learns from the experience of Ghana to ensure that such earmarked taxes are

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used and targeted effectively to ensure equity in coverage and especially to ensure that the defined exempted groups are well covered for necessary health care services. The experience in Ghana has indicated that despite the earmarked resources, sufficient progress has not yet been made in the coverage of the indigent and inequities in coverage still persists. For example, it is said that, as at 2008, only 20 per cent of individuals in the lowest socio-economic quintile have been registered compared with 64 per cent in the highest quintile.[55] Nigeria should take necessary pro-active measures to forestall such happenings. Moreover, the benefit package of the NHIS Act ought to be expanded to include diseases such as breast and cervical cancers, renal failures, diabetes and hypertension that have recently become pandemic in the society and have continued to constitute a great threat to the survival of many people. This is equally important to avoid problems of acceptability especially among the formal sector employees when coverage under the Scheme is eventually made compulsory for all within the sector.

In addition, the Scheme ought to embark not only on aggressive advocacy to encourage more states and local governments to embrace the Scheme but also massive awareness and enlightenment campaigns in line with the general power given to the governing council under section 7(h) of the Act to sensitize the entire citizenry about the tremendous benefits to be derived from participating in the Scheme as enunciated under section 5 of the Act.

Conclusion

In all, the Nigerian policymakers have apparently displayed considerable interest in meeting the basic goals of a national health insurance programme especially in terms of making healthcare services accessible and affordable to all as would be gathered from some of the laudable provisions of the NHIS Act. It is however lamentable that the NHIS Act is equally fraught

55. WHO "***WHO Country Cooperation Strategy; Ghana,* 2008-2011** (n 29) p. 8.

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with a number of inadequacies which are clearly antithesis of government's outward display of commitment and which are not only undermining its basic objectives especially in terms of access but are also endangering its international competitiveness. One is hopeful that if the reform proposals could be taken into due consideration and implemented, Nigeria will witness a significant improvement in her health performance indicators. Nevertheless, in addition to the foregoing reform proposals, it is to be emphasised that there is need for government to strengthen the Primary Health Care (PHC) system as enunciated in the Declaration of Alma-Ata.[56] It is common knowledge that the PHC system which forms the nucleus and the bedrock of the health care system of any nation and by which the Nigerian government could have reduced the exclusion and social disparities in the NHIS coverage is in a prostate.[57] PHC has been defined as "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through

56. See WHO and UNICEF, ***Primary Health Care Report of the International Conference of Primary Health Care***, Alma-Ata, USSR, 6-12 September, 1978. WHO, Geneva, 1978. *http://whqlibdoc.who.int/publications* Visited 12/17/2013 at 3 p.m.

57. In Thailand for example, the success of the Universal Coverage Scheme and the improvement of the health outcomes are based on a strong commitment to PHC as the entry point for every Thai citizen seeking health services. See A Dutta and C Hangoro, ***Scaling Up National Health Insurance in Nigeria: Lessons from Case Studies of India, Columbia and Thailand.*** 2013, Futures Group. Health Policy Projects, p.38 *http://www.healthpolicyproject.com/pubs/96 NigeriainsuranceFinal.pdf.* Visited 12/28/2013 at 2 p.m. Similarly, in Finland, the Primary Health Care Act, 1972 effected a fundamental re-organization to promote Primary Health Care. The Act shifted the emphasis in health care policy towards non-institutional medical care and health care and also sought to guarantee universal and equal health care services in various parts of the country and for various population groups. See H Niemela and K Salminen, ***Social Security in Finland.*** <*.http://www.193.209.217.5/in/Internet/liite.nsf/NET/1905041457/OOEK/&File/social % 20 security in Finland. Pdf*>, Visited 6/12/2009 at 5 p.m.

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their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self determination."[58] It is an approach to health that would readily enhance the health of the citizenry to enable them to lead a socially and economically productive life in the spirit of social justice. The essential features of a strong system led by primary care therefore are: accessibility (with no out-of-pocket payments); a person (not disease) focus over time; universality; a broad range of services in primary care and co-ordination when people do have to receive health care services elsewhere.[59]

Although a number of policy initiatives have been taken in line with the Declaration of Alma-Ata starting with the PHC - focused health policy which was adopted for the country in 1988 with the latest review in 2004; the Ward Minimum Health Care Package (WMHCP) ratified by the National Council on Health as a minimum PHC standard in 2007, and the Nigeria's Global Alliance for Vaccine and Immunisation (GAVI) Health System Strengthening proposal which was approved in early 2008; the absence of any law to provide any clearly-defined roles and responsibilities for the various tiers of government concerning health services provision has however, been a major clog in the wheel of progress of most of these programmes. The National Health Policy for example, has merely ascribed responsibility for primary health care to Local Governments whilst secondary and tertiary health care are ascribed to the State and Federal Government respectively. The absence of any such law has not only led to duplication of efforts in some areas but has also diminished the effective utilisation of the PHC such that, the impact which the programme has so far had on the general

58. See WHO and UNICEF, ***Primary Health Care Report of the International Conference of Primary Health Care***, (n 55).

59. See S Rawaf, J De Maeseneer, and B Starfield ***From Alma-Ata to Almaty: A New Start for Primary Health Care***. *http:www.jhsph.edu/research/centers-and-institutes/Johns-hopkins-primary-care-policy-center/* Publications PDFs/E73.pdf. Visited 11/14/2013 at 12 p.m.

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performance of the health system has been very minimal indeed. Furthermore, mismanagement, underfunding and lack of capacity at the local government level have generally contributed to the general poor state of the PHC system across the country with the result that most health services can only be accessed at secondary and tertiary levels that are concentrated in urban areas, thus limiting access to rural population.[60] Furthermore, due actualisation of the universal health in Nigeria requires the availability of functioning public health and health care facilities that are scientifically and medically appropriate and of good quality.[61] This demands the availability of skilled medical personnel, scientifically approved and unexpired drugs and hospital equipments, safe and potable water and adequate sanitation. However, the primary and secondary health care systems in Nigeria are, at present, at the verge of total collapse thereby forcing many people to depend on the tertiary health institutions.[62]

According to a survey made by WHO, malaria accounts for 24% of deaths among children while pneumonia accounts for 20%, diarrhoea 16%, measles 6% and HIV/AIDS 5% with underlying malnutrition contributing to about 60% of the deaths.[63] These deaths could have been prevented or reduced substantially with the availability of adequately equipped PHC facilities across the country. Indeed, with an effective PHC system, most of the health problems such as malaria and vaccine-preventable diseases would be adequately addressed through the provision of promotive and preventive care[64] services at the

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60. See WHO, "***WHO Country Cooperation Strategy; Federal Republic of Nigeria, 2008 – 2013***"(n 44) p. 4.
61. See **General comment no 14**, (n 1).
62. See also, *The Punch* 2 January 2013, p. 46 wherein the Chief Medical Director of University of Ilorin Teaching Hospital revealed that primary and secondary health care have almost collapsed completely in Nigeria and that only few States have functional General Hospitals in terms of personnel and equipment.
63. WHO. 2009. ***WHO, Country Cooperation Strategy; Federal Republic of Nigeria, 2008 – 2013,*** (n 44) p 5.
64. Preventive Care activities have been defined as activities which may improve health by reducing the probability of an illness or an accident or that reduce the

community level. Regrettably, it has also been reported in the said WHO survey that at present, less than 15% of wards across the country have at least one fully functioning PHC facility. Furthermore, health expenditure in Nigeria currently, is said to be mostly on curative services almost to the total neglect of preventive and other services which are potentially cost-saving.[65] More emphasis therefore ought to be placed on activities geared towards the promotion of public health and preventive care as these are vital to reducing the need and spending for curative health care services. There is therefore the urgent need to resuscitate and strengthen the PHC system to serve as a fulcrum to having a truly universal health insurance system as well as to effectively and efficiently provide the essential minimum primary health care services to the people. Moreover, it ought to be emphasised that supplementary programmes to overcome specific barriers to medical care in peculiar situations such as transportation assistance for hinterland residents and residents of sparsely-populated areas are very essential. In the same vein, co-ordination of medical and other services affecting health such as sound nutrition, better sanitation, improved water supplies, better housing and environmental protection, health related data collection, surveillance and outcome monitoring[66] should be

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seriousness of an illness or an injury given the occurrence of an unhealthy state. See Ghez, G.R and Grossman, M "Preventive Care for Children and National Health Insurance." in MV Pauly (ed) ***National Health Insurance: What Now, What Later, What Never?,*** Washington, D.C., American Enterprise Institute for Public Policy Research, 1980, p. 138.

65. For instance, between 2003 and 2005, health expenditure of curative care was said to average 74.10 per cent of the total health expenditure while cost-reducing health services like public health preventive care and others like training and research averaged just 12.72 per cent and 11.50 per cent of the total health expenditure respectively during the same period. See A Soyibo, OI Olaniyan and A Lawanson "National Health Accounts of Nigeria, 2003 - 2005, Vol. 1:Main Report. Submitted to the Federal Ministry of Health, Abuja, *http://www.who.int/nha/country/nga/nigeria_nha_2003-2005_reportpdf.* Visited 11/22//2013 at 3 p.m.

66. Some health problems in Nigeria are attributable to poor nutrition and unhygienic environment which have manifested in the incidences of such diseases as Kwashiorkor and marasmus, malaria, cholera and guinea worm.

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adequately addressed as they are all key factors towards promoting good health and reducing the burden of preventable and treatable diseases that are confronting us as a nation.

Undoubtedly, if Nigeria could effectively manage her resources and fight the menace of corruption with the sincerity of purpose it deserves, there would be enough resources at government's disposal to effectively and efficiently discharge its obligations to all as far as health care services are concerned irrespective of socio-economic status. In the meantime, it is important to reiterate the fact that government at all levels, including the Federal, State and Local Governments must endeavour to be more financially committed to the health sector to the abiding benefit of all. Such investment in human resources is not only a moral imperative to promoting the cause of social justice and alleviating the sufferings of the citizens but is also *sine qua non* to improving the quality of life of the citizenry, securing the future for all and to the rapid socio-economic growth and the overall productivity of the nation.

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