INTRODUCING SOCIAL HEALTH
INSURANCE TO SOLVE PROBLEMS OF
POOR HEALTH SECTOR FINANCING IN
NIGERIA

BY

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MASTERS OF ARTS IN HEALTH MANAGEMENT,
PLANNING AND POLICY

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**DECLARATION**

This dissertation is submitted in partial fulfilment of the requirements for award of the Masters of Arts in Health Management, Planning and Policy. The examiners cannot, however, be held responsible for views expressed, nor the factual accuracy of the contents.

Signed………………………………………………………………

PROGRAM DIRECTOR

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The University of Leeds
Declaration of Academic Integrity
I have read the University Regulations on Cheating and Plagiarism, and state that this piece of work is my own and does not contain any unacknowledged work from any other source.

Signed……………………… Date………………………………..

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**FORMAT**

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DEDICATION

I dedicate this work to God almighty, to whom all Glory shall always be.

And

To the memory of my late brother, O’ Tito, whom I loved so much but lost.
ACKNOWLEDGEMENT

I owe the completion of this work to my supervisor, Prof Andrew Green; who encouraged, advised and directed me.

Thanks to my personal tutor, Dr. Ricky Kaliecharan; my course director, Dr. Mayeh Omar; My course administrator, Terry Nicholson for every wonderful assistance and encouragement.

Special thanks to my mother and father Chief and Mrs. Arodiogbu: Linus (senior) and Maria, and to all my siblings: Cecilia, Chris, Joe, Jude – Regis, Humphrey, Angela, Antonia and Rose – Mary.

Thanks to My Mentor: Professor Frank Akpuaka and to all my friends.

Thanks to all my wonderful colleagues and friends I met at Nuffield for their pieces of advice.
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<tr>
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<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
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<tr>
<td>CBHF</td>
<td>Community – based health finance scheme</td>
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<tr>
<td>DFID</td>
<td>Directorate for international development</td>
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<td>FCT</td>
<td>Federal capital territory</td>
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<td>FMOH</td>
<td>Federal ministry of health</td>
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<td>FRN</td>
<td>Federal republic of Nigeria</td>
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<td>G.P</td>
<td>General practitioner</td>
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<td>GDP</td>
<td>Gross development product</td>
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<td>GNP</td>
<td>Gross national product</td>
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<td>HIV</td>
<td>Human immune virus</td>
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<td>HMIS</td>
<td>Health management information system</td>
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<td>HMO</td>
<td>Health maintenance organisation</td>
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<td>ILO</td>
<td>International labour organisation</td>
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<td>IMF</td>
<td>International monitory fund</td>
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<td>MDG</td>
<td>Millennium development goal</td>
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<tr>
<td>MIS</td>
<td>Management information system</td>
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<td>MOH</td>
<td>Ministry of health</td>
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<td>NAFDAC</td>
<td>National association of food drug administration and control</td>
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<td>NCH</td>
<td>National council on health</td>
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<tr>
<td>NEEDS</td>
<td>National Economic Empowerment and Development Strategy</td>
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<td>NGO</td>
<td>Non – governmental organisation</td>
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<td>NHA</td>
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<td>National primary health care development agency</td>
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<td>OECD</td>
<td>Organisation for economic development</td>
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<td>OPEC</td>
<td>Organisation of oil exporting countries</td>
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<td>PHC</td>
<td>Primary health care</td>
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<td>PPP</td>
<td>Purchasing power parity</td>
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<td>RAP</td>
<td>Resource allocation and purchasing</td>
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<td>SHI</td>
<td>Social health insurance</td>
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<tr>
<td>SWOT</td>
<td>Strengths, weaknesses, opportunities and Threats</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>U.S.</td>
<td>United States of America</td>
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<td>UF</td>
<td>User fee</td>
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<td>UNDP</td>
<td>United Nations development program</td>
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<td>UNECA</td>
<td>United Nations Economic commission of Africa</td>
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<tr>
<td>VAT</td>
<td>Value added tax</td>
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<td>WB</td>
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EXECUTIVE SUMMARY

Social Health Insurance (SHI) policy was enacted in Nigeria in 1999. Implementation was delayed till June 6, 2005, due to scepticisms whether SHI could solve the problem of inadequate health sector financing in Nigeria.

The present scenario is that while 74.6% of funding for the health sector comes from private sources 25.4% is from government. 90% of private funding is paid for by direct user fee. The inadequate funding of the health sector could hence be blamed on poor government funding of the health sector through tax revenue from crude oil which is only 3.40 per capita, and inefficiency of user fee to mobilise fund from private sources.

SHI is new to most countries of Sub-Saharan Africa, and the few countries like Tanzania that have implemented the policy, User fee still remain dominant. This has limited review of the experience of SHI to countries in Europe and Asia that have long experience with SHI. The review shows that SHI may improve resource mobilisation for the health sector, while ensuring access to health care through equity.

This dissertation analysed the health care situation in Nigeria especially the level of financing. A SWOT analysis was conducted to highlight the various issues that will enhance or endanger implementation and sustainability of SHI program in Nigeria.

The analysis of the Nigerian situation and the global experience with SHI formed background information in making a review of the Nigerian SHI policy. The review tends to analyse the following key components of the policy:

- Legal framework;
- Coverage/ access to health care services;
- Pooling revenues and sharing risks/ resource mobilisation;
- Revenue collection mechanisms/ efficiency;
- Resource allocation and purchasing (RAP) arrangement/ equity;
- Organisational structures and Management attributes.

Recommendations were drawn which focused on issues bordering on Benefit, Quality, Provider arrangement, Premium and financing, and Monitoring mechanisms of the program, while other recommendations was on strategies on improving health sector financing in Nigeria through SHI.
CHAPTER ONE

STUDY OVERVIEW

1.1. INTRODUCTION

This chapter gives an overview of the dissertation, the methodology of the research, scope, limitation, justification for the study and plan of dissemination. It concludes with an outline of the study according to chapters.

1.2. HEALTH SECTOR FINANCING IN NIGERIA

To sustain various government health policies and strategies, an adequate financing mechanism becomes imperative (Ansa, 2005). This has been grossly inadequate, due to poor attention given to the health sector in the past. Recent ideas on health as an investment good rather than a consumer good has increased attention to the health sector and hence increased attention to health sector financing (ILO, 2000).

This has led to wide spread consultation at various levels to policy issue of defining the best level and option for health care financing in Nigeria. In collaboration with the World Bank, ILO, UNDP, the federal ministry of health, Nigeria (FMOH), in 1994 introduced a formal sector National Health Insurance Scheme (NHIS), at a meeting of the National Council on Health (FRN/FMOH, 2000).

Resource generation through formal sector NHIS was poor because the scheme did not cover the majority of the population; hence failed to solve the problem of poor access to quality health care.

Its failure to cover no more than 60 % of the population employed in the informal sector and 55 % of the population that lived in the rural areas (FRN/National Planning Commission, 2000); meant that the aim of replacing user fee (UF) by the National health insurance (NHI) was not realised.

Community efforts in face of inequity in health care financing and access to quality care, led to various initiatives by communities and Non- Governmental Organisations in forming various community-Based health Finance Schemes (CBHF).

Since 1994 till date, while public financing of the health sector through tax remains low at 25.60 %, the remaining 74.40 % are from the private financing. The private sector pays by varying degree or mix of direct user fee, personal health insurance and CBHF (FRN/FMOH, 2000). This has yet worsened the difficulty for planners who, not only have very limited resources to plan for tremendous health needs (Green, 1999); but are also faced with problems of co- coordinating resource generation (Schieber and Maeda, 1999).
In 1999, the Government of Nigeria signed a bill introducing SHI as a mean of financing health services in Nigeria: National health insurance scheme Degree No. 35 of 1999 (Laws of the federation of Nigeria, 1999).

Inauguration of SHI on June 6, 2005, is hoped to achieve a wider coverage for the informal sector, by providing re-insurance cover for the CBHF through health maintenance organisations (HMO) (FRN/NHIS, 2000).

SHI is to act as substitute for government financing of health services from taxation, 90 % of which come from sale of crude oil (World Bank, 2000).

1.3 DEFINITION OF KEY CONCEPTS

“Health Insurance is a pre-payment plan providing services or cash indemnities for medical care needed in times of illness or disability” (Online encyclopaedia, 2003). From the above, National Health Insurance could be seen as a prepayment health scheme established by the government of a country, on a national scale, that gives members access to health care services in times of need.

Social health insurance is a social (Solidarity – based) health insurance that relates contribution to income (Donaldson and Gerald, 1993).

The main difference between NHI and SHI being that while a country has one National Health Insurance, multiple Social health Insurance Schemes may exist, according to the various social cohesive groups or categorisation stipulated in the country’s health insurance law.

According to Vineberg (2002), Community Based health Financing is a health plan organised and managed by members of a community as a reciprocal means of paying for the health care needs of members in times of illness. The significant difference of Community Based health Finance Schemes from other health insurance programs being that it is developed and managed by the members of the community in accordance to their needs and not by government set regulations.

1.4. AIM AND OBJECTIVES OF STUDY

1.4.1 Aim

The aim of this dissertation is to review the policy of Nigerian SHI and to develop recommendations that will improve health sector financing through effective implementation of SHI.

1.4.2. Specific objectives

1. To give an overview of health Sector financing in Nigeria, and outline problems affecting adequate financing of the health sector and implementation of social health insurance.

2. To review various countries’ experience with SHI.
3. To analyse key components of the Nigerian SHI policy.

4. To make recommendations to stakeholders on improving health sector financing through effective implementation of SHI.

1.5. METHODOLOGY

Information will be sourced from the following:

1.5.1. Primary sources

This will include discussions (formal and informal) with care users and providers, hospital administrators and policy makers, dissertation supervisor, lecturers and colleagues who have worked in related fields. This will also include information gathered from conferences and workshops by author.

1.5.2. Secondary sources

Secondary information is sourced from:

- Policy documents from the Federal ministry of health, Nigeria.
- Annual reports and press release from National health insurance board, Nigeria.
- Consultancy report from Nigeria on Health insurance.
- Research documents and publications on SHI from different countries.

Peer review Journals on health policy and planning, health economics, health and population.

The webpage of: World Bank, World health organisation, organisation for economic development and Nigerian: Country website was consulted.

Search engines used were: Google.com, MSN Search, Yahoo search, Social science information gateway (SOSIG).

Data bases used were: Medline, Pubmed, Web of Science (WOS), Zetoc.

1.5.3. Keywords

The key words used for the search were: Health sector financing, social health insurance, Health maintenance organisations, Community - Based health financing, developing countries, Nigeria, Health insurance, Inclusions. Search using different combinations yielded a total of 9,742 materials.

The author restricted himself to the use of 108 materials based on relevance to topic, authors and what is known about them, date of publication, countries under review, authenticity of source of material, the ideas conveyed in the articles and how well they are supported by evidences. After reading through, the author chooses some materials with opposing arguments to be able to make a critical analysis, from which rational conclusions were made.
1.6. JUSTIFICATION FOR RESEARCH

Social health insurance policy was signed into law in Nigeria in 1999. Opposition by different stakeholders like the labour union, practicing doctors and the general population, led to the program being abandoned (Oshiomole, 2005).

On 28th November, 2004, the scheme was resurrected, but further opposition by the labour union shifted the original take off date from 1st January, 2005 to 6th June, 2005 (FRN/NHIS, 2005). Opposition to the Scheme was based on lack of trust by the populace about government’s intention in establishing the Scheme. This fear is based on the fact that Nigerians have had bad experience with the insurance industry, heightened by poor management of existing Schemes by government officials and fraud (DFID, 2004).

Inauguration of SHI in Nigeria on June 6th, 2005 (Nigeriafirst, 2005) has not eradicated the doubt in Nigerians, whether social health insurance will proffer solution to the long endured poor health sector financing and improve access through equity, to quality health services.

Appraisal from different quarters has applauded the Nigerian SHI policy (Ansa, 2005). A more holistic and rationalistic analysis is still needed to review key components of the policy in relation to the goals of the health sector, especially its provision for the poor and compromised groups. There is also need to investigate the possibilities of improving health sector financing in Nigeria through SHI.

1.7. STUDY LIMITATION

The major constraint to this study is that SHI is yet to be implemented in most developing countries especially in Sub-Saharan Africa. Hence the experience is not well reported, restricting the author for detailed experience to countries in Europe and Asia.

Poorly developed health management information systems (HMIS) in Nigeria posed a great limitation to verification of data and restrict accuracy of information.

Most of the secondary data available are up to two years old and might not be exact representation.

Most of the data on SHI in Nigeria are unpublished and/or undated.

1.8. STUDY OUTPUT

The study will generate recommendation for effective implementation of SHI and improvement of financing of the health sector in Nigeria. It will also act as a guide for future planning, monitoring and evaluation of the program and for other countries trying to adopt SHI program.
1.9. STAKEHOLDERS

The stakeholders will be the federal and state health insurance boards, ministry of health (MOH), Non-Governmental organisations (NGO), and health systems administrators, hospital managers, health care providers, Labour organisation, the World Bank and World health organisation (WHO).

1.10. PLANS FOR DISSEMINATION

Recommendations from this research will be presented to all stakeholders for implementation. It will be available for reference in future researches by scholars.

Experience from this study will be discussed in different fora both formal and informal. It will be used as educational material in Community mobilisation and education in Nigeria.

1.10. STRUCTURE OF DISSERTATION

Chapter one gives an overview of the dissertation. Chapter two looks at the health system in Nigeria: a description of the health status of Nigeria is made; it describes the organisational structure of health system and health system financing. An analysis of the problems of the health system is also made. The history of development of SHI in Nigeria and a SWOT analysis on the program are also conducted.

Chapter three reviews the experience of other countries with SHI. Chapter four analyses key components of the Nigerian NHI policy. In chapter five, the author sets to make recommendations for improving health sector financing in Nigeria through effective implementation of SHI.

1.11. CONCLUSION

Chapter one has given an overview of the study. In chapter two, the problems of the Nigerian health sector financing will be discussed. The introduction of SHI in Nigeria will also be analysed.
CHAPTER TWO

HEALTH SECTOR FINANCING IN NIGERIA

2.1. INTRODUCTION

Chapter two looks at the health system, the organisational structure of health system financing and health status of Nigeria. The development of the Nigerian SHI will be discussed and a SWOT analysis conducted. Problems associated with effective implementation of the program are also analysed.

2.2. THE NIGERIAN CONTEXT

Out of the total population of 135.6 million people in Nigeria, 44.1% are aged between 0 -14years while 53.3% are between 15-65 yrs and only 2.6% are above 65 years old (FRN/National Population Commissions, 2003). This may suggest that Nigeria has a growing population.

The male: female ratio is 48 %: 52%. 55% of this population live in the rural areas while 45% live in the urban areas (FRN/National Population Commissions, 2003). Despite the larger population that live in the rural areas, social services including health services are lacking in these rural areas (Dare, Undated).

In spite of a well structured health system, development of the Primary health care (PHC) has not improved the health experience of the population, especially those in the rural areas.

Nigeria’s health expenditure of 4.7% GDP becomes increasingly inadequate in the face of the rising population and high disease burden.

2.3. THE HEALTH SYSTEM IN NIGERIA.

The issues discussed here are the health goal, key health policies and the structural framework of the ministry of health.

2.3.1. The health goal

The goal of the National health policy is: To establish a responsive and effective health system based on primary health care (PHC), for the attainment of improved health status for all Nigerians (FRN/National Primary Health Care Development Agency, 2004).

2.3.2. Key health policies

Nigerian health policy framework is derived from the National health policy, the draft National health plan, the National vision 2010 report and President Obasanjo’s health priority statements (DFID, 2000).
Nigeria is undergoing health sector reforms, whose vision is to improve the health status of all Nigerians and to attain a level of health delivery that would enable all Nigerians to live a socially and economically productive life (DFID, 2000).

Improved funding of the health sector is a key issue in the health sector reforms (See Appendix I).

2.3.3. **Structural framework**

Health care in Nigeria is administered through three tiers: primary, secondary and tertiary levels (numbers as shown on key to figure 1). The primary level is run by the local government, the secondary by the state, while the tertiary is run by the federal government (FRN/FMOH, 2000). There are contributions and interplay at different levels by private hospitals, NGOs, traditional and faith healers.

Administration of the health sector is through guidelines by the cabinet made up of members of National Advisory Council on health. Nigeria practices devolution (DFID, 2004).

The administrative framework of the health sector is from the cabinet to federal ministry of health, down to the state ministry, then to the local governments and the political wards; as shown in figure 1.

![Figure 1: Structure of Nigerian health system. Source from: FRN/FMOH, (2004).](image)

Unfortunately, there is no defined role by the federal government and local government on the delivery of primary health care, which leads to conflict of interest
and duplication of functions. According to Paulson, (2001), PHC which is supposed to be the base of health delivery in Nigeria is not able to clearly define its role, thereby creating a chaos in the health system.

2.4. PROBLEM STATEMENTS

Funding of the health sector in Nigeria has been grossly inadequate in the face of emerging health challenges and rapidly growing population.

2.5. BACKGROUND TO THE PROBLEM

Background to the problem of the poor health sector financing in Nigeria is identified by looking at the disease burden and health status of the country including risk factors against the background of the poor economic situation, with its inherent problems which make it difficult for resource mobilisation, allocation and management.

2.6. HEALTH INDICATORS

The Nigerian health status as shown in table1 has a high population and a rapid population growth rate. Life expectancy is low, where as disease control measures are not adequate. There are high risk factors, which pose present problems and future challenges to the health sector.

Table 1: Nigerian Health indicators (2003)

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>VALUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>135.6</td>
</tr>
<tr>
<td>Population growth rate (Annual %)</td>
<td>2.1</td>
</tr>
<tr>
<td>Life Expectancy at birth, total/years</td>
<td>45.3</td>
</tr>
<tr>
<td>Infant mortality rate (Per 1,000 live birth)</td>
<td>100.0</td>
</tr>
<tr>
<td>Under-5 mortality rate(Per 1,000 live birth)</td>
<td>198.0</td>
</tr>
<tr>
<td>DISEASE CONTROL</td>
<td></td>
</tr>
<tr>
<td>Access to Improved water source (% Population)</td>
<td>60%</td>
</tr>
<tr>
<td>Access to improved sanitation(% Population)</td>
<td>30%</td>
</tr>
<tr>
<td>Success rate of treated Tuberculosis(Registered cases)</td>
<td>70%</td>
</tr>
<tr>
<td>DOT detection rate (% of estimated cases)</td>
<td>18%</td>
</tr>
<tr>
<td>NUTRITION</td>
<td></td>
</tr>
<tr>
<td>Population undernourished(% population)</td>
<td>9%</td>
</tr>
<tr>
<td>REPRODUCTIVE HEALTH</td>
<td></td>
</tr>
<tr>
<td>Fertility rate</td>
<td>5.6%</td>
</tr>
<tr>
<td>Adolescent fertility rate (Per 1000)</td>
<td>122.0</td>
</tr>
<tr>
<td>Pregnancy related mortality rate (Per 10, 000)</td>
<td>800.0</td>
</tr>
<tr>
<td>Rate of contraceptive use (women aged 15-45 years)</td>
<td>13.0%</td>
</tr>
<tr>
<td>Unattended pregnancy (%)</td>
<td>17%</td>
</tr>
<tr>
<td>Birth attended by skilled staff (%)</td>
<td>35%</td>
</tr>
<tr>
<td>RISK FACTORS AND FUTURE CHALLENGES</td>
<td></td>
</tr>
<tr>
<td>Prevalence of Tuberculosis (Per 100,000 people)</td>
<td>293</td>
</tr>
<tr>
<td>Prevalence of HIV (People aged 15 – 49 years)</td>
<td>5.4%</td>
</tr>
<tr>
<td>Incidence of Diabetes (Population aged 20-79 years)</td>
<td>0.4%</td>
</tr>
</tbody>
</table>

2.7. HEALTH FACILITIES AND USE

Health facilities are inadequate in Nigeria (Yohesor, 2004). This includes health centres, personnel and medical equipment. This inadequacy is worse in rural areas. In Nigeria, there is an average of one doctor to 30,000 people and 2 hospital beds to 1,000 people. 70% of health services are provided by private and 30% by public means (FRN/FMOH, 2004). The state of existing facilities is often poor due to lack of maintenance.

Cultural belief and religious dogma is an important factor to the success of any health program and interventions. Success or failure depends on acceptance by religious leaders because Nigerians are very religious people (Author’s experience).

According to FRN/NAFDAC (2003) over 70% of drugs dispensed in Nigeria are sub-standard, leading to high morbidity and mortality and low health outcome, which bear a drastic consequence on the efficiency and quality of care. This resulted from poor system of purchasing and dispensing of drugs in the health systems, inefficiency of the regulatory body (NAFDAC), corruption and illiteracy.

2.8. EFFECT OF HEALTH BURDEN ON FINANCE

The cumulative effect of the entire scenario discussed calls for increase funding for the health sector which may not be guaranteed, considering the poverty level of the country and the economic recession on both the Public and private sectors.

2.9. HEALTH CARE FINANCING IN NIGERIA

Health services are funded in Nigeria as shown in Figure 2. It shows the flow of funds between the individuals, companies, government and external donors which sum up the country’s total health resources.
2.9.1. Nigerian health expenditure.

Nigeria’s total health expenditure (% of GDP in 2002) is 4.7% (WDR, 2005). This is very low, raising questions about the revenue allocation formulary of Nigeria.

Table 2 shows health expenditure of Nigeria by sector. While 25.6% of the total health expenditure is by public, 74.4% is by private. Government health spending has remained USD 3.40 per capita for ten years despite a fast growing population; which is inadequate. It also shows that out of pocket payment remains the major means of payment for health services in Nigeria.
Table 2: Selected National health accounts indicators of Nigeria (2002).

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per capita GDP in international dollars.</td>
<td>924</td>
</tr>
<tr>
<td><strong>Total health expenditure</strong></td>
<td></td>
</tr>
<tr>
<td>Total expenditure on health as % of GDP</td>
<td>4.7</td>
</tr>
<tr>
<td>Per capita total expenditure on health at average exchange rate(US$)</td>
<td>19</td>
</tr>
<tr>
<td>Per capita total expenditure on health in international dollars.</td>
<td>43</td>
</tr>
<tr>
<td><strong>Public health expenditure</strong></td>
<td></td>
</tr>
<tr>
<td>General Government expenditure on health as % of total expenditure on health</td>
<td>26.5</td>
</tr>
<tr>
<td>General Government expenditure on health as % of total general government expenditure</td>
<td>3.3</td>
</tr>
<tr>
<td>Per capita government expenditure on health at average exchange rate(US$)</td>
<td>5</td>
</tr>
<tr>
<td>Per capita government expenditure on health in international dollars</td>
<td>11</td>
</tr>
<tr>
<td><strong>Sources of public health expenditure</strong></td>
<td></td>
</tr>
<tr>
<td>Social security expenditure on health as % of general government expenditure on health</td>
<td>1.0</td>
</tr>
<tr>
<td>External resources for health as % of total expenditure on health</td>
<td>6.1</td>
</tr>
<tr>
<td><strong>Private health expenditure</strong></td>
<td></td>
</tr>
<tr>
<td>Private expenditure on health as % of total expenditure on health</td>
<td>74.4%</td>
</tr>
<tr>
<td><strong>Sources of private health expenditure</strong></td>
<td></td>
</tr>
<tr>
<td>Prepaid plans as % of private expenditure on health</td>
<td>6.7</td>
</tr>
<tr>
<td>Out-of-pocket expenditure on health as % of private expenditure on health</td>
<td>90.4</td>
</tr>
</tbody>
</table>


2.9.2. **Sources of funding for the health sector**

Health services in Nigeria are funded from both the public and private sources.

2.9.2.1. **Public and Quasi-Public**

This accounts for 26.5% of total health expenditure. This is revenue generated from general taxation and sales tax revenue like value added tax (VAT). The major source of the revenue is from taxation from sales of crude oil, which accounts for 90% of total revenue generation in the country (FRN/NPC, 2002).

2.9.2.2. **Private sources**

Private sources account for 74.4% of health care financing in Nigeria (WDR, 2005). This include direct employer financing and private out of pocket, which accounts for 6.1% (WDI, 2005). Private health insurance is just developing in Nigeria, with only about 0.3% of the population covered (Ogunbekun, 2004).

2.10. **Problems of resource generation / mobilisation**

Resource generation for the health sector is inadequate due to various reasons ranging from increasing poverty in the country and poor allocation of resources by government.

With external debt rising to 75.1% (% of GDP), Nigeria is ranked among the 20 poorest countries of the world (WDR, 2005). This is a cause for concern, as the substantial economic progress and social advancement that has been taking place in Nigeria in
the past 30 years is poorly reflected in its economy.

According to table 3; comparing Nigeria to global situation, Nigeria ranks high in population where as its ranking in every economic indicator like GNP is low. This shows that poverty is high in the country.

Table 3: Economic Indicators in Nigeria (Compared to Global situations)

<table>
<thead>
<tr>
<th>Indicators</th>
<th>World</th>
<th>Nigeria</th>
<th>Nigeria world ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population(Millions)</td>
<td>5,975(Million)</td>
<td>135.6(Million)</td>
<td>10</td>
</tr>
<tr>
<td>GNP(Billions of $)</td>
<td>29,232</td>
<td>37</td>
<td>54</td>
</tr>
<tr>
<td>Per capita GNP($)</td>
<td>4,890</td>
<td>319</td>
<td>179</td>
</tr>
<tr>
<td>Purchasing Power Parity GNP(Billions of $)</td>
<td>38,804</td>
<td>92</td>
<td>49</td>
</tr>
<tr>
<td>Purchasing power parity GNP per capita($)</td>
<td>6490</td>
<td>744</td>
<td>193</td>
</tr>
<tr>
<td>Human development Index</td>
<td>0.716</td>
<td>0.455</td>
<td>151</td>
</tr>
<tr>
<td>Gender-related development index</td>
<td>0.706</td>
<td>0.433</td>
<td>123</td>
</tr>
</tbody>
</table>

Adapted from: UNECA, (2002); WHO (2002).

2.10.1. Urban–rural poverty

Poverty remains very pronounced in Nigeria, worse in the rural areas due to lack of employment and poor development of human capital. Poor distribution of social amenities like pipe borne water and electricity has also led to poor industrial growth in these areas.

Increased emphasis of crude oil as the major source of income for Nigeria has reduced encouragement for Agriculture, which is the major means of income for the rural population.

Figure 3, shows poverty distribution by sectors: rural and Urban. It can be noted that the overall poverty of the country is more reflective of the rural population, as the curve for both has similar rise between 1980 and 1996.
2.10.2. **Inability of patients to pay for health services**

The economic recession in the early 80s and 90s led to a fall in GNP and purchasing power parity (PPP), high unemployment rate and triple digit inflation. This has led to high poverty level in Nigeria. According to WDR, (2005) 70.2% of the Nigerian population live below the poverty line of $1.00 per day.

This makes it difficult for the populace to pay for their health needs, leading to poor mobilisation of funds from the private sector.

2.10.3. **Poor government funding of the health sector**

Government expenditure on health is USD 3.40 per capita as opposed to the WDR recommendation of USD 34 per capita (WDI, 2005).

According to WDR, (2005), Nigeria’s external debt in 2003 is USD 35 billion. In effect, Nigeria spends many funds on debt servicing, thereby reducing spending on health. Secondly, part of pre-conditions for funding by international organisations like IMF/ World Bank, is a reduction in public sector expenditure (Soludo, 2004).

Economic recession led to low or negative growth rate in Nigeria due to introduction of Structural adjustment program (SAP) in 1987, mandated by IMF. This led to devaluation, a fall in PPP and inflation which raised cost of health goods and services (FRN/National planning Commissions, 2002).

Though global economic recession has affected revenue generation for most developing countries, for Nigeria, it is difficult to understand the down turn of its economy, despite huge crude oil sales on various occasions its OPEC quota has been increased due to incessant crises at the Golf region.

2.10.4. **Lack of foreign aid**

With introduction of primary health care in 1987, Nigeria attracted donors. This made the health sector to embark on health systems development activities (DFID, 2001).
This aid was not sustained. The withdrawal of donor activities coincided with the economic recession of the 80s.

A second issue, according to Wolfowitz, (2005), is that some African countries (Nigeria) are denied foreign aid incentives due to their inability to meet pre-conditions for aid assistance, which include improvement of public sector management and reduction in corruption.

2.10.5. Equity in financing

One of the major problems with health systems financing in Nigeria is inequity. Despite variation in people’s income, payment for health services in Nigeria is based on consumption and not ability to pay. This led to exclusion for the poor and inadequate mobilisation from the rich that can afford to pay more.

2.11. RESOURCE ALLOCATION

In spite of the severe global economic recession, Nigeria's inability to finance her health sector is due to poor allocation formulary of economic resources among public sectors (World Bank, 2005). This is due to: poor priority setting in budgeting, embezzlement, and perverse incentives.

2.12. RESOURCE MANAGEMENT

The limited resources available to the health sector are poorly managed, complicating the issue of inadequate financing. Poor management skills results from lack of skilled health finance managers as a result of high labour migration, low staff capacity due to low incentives and lack of on the job training (Martinez and Martineau, 2002). There is also no new recruitment of skilled health systems managers to replace the old ones.

A crucial issue in the management of health care resources is corruption in the public sector, lack of accountability and clear sense of responsibility. According to Yohesor, (2004), Nigeria is ranked as the second most corrupt country in the world.

2.12.1. Health Management Information systems (HMIS)

Despite the rapid growth trend in information technology and government funds disbursed to put it in place, Nigerian health system is yet to develop an adequate HMIS. This makes it difficult to monitor and evaluate health programs to enhance planning and Co-ordination of the health system and programs.

2.13. HISTORY OF DEVELOPMENT OF THE NIGERIAN NHIS

The above problems analysed have led Nigerian Government to introduce measures to improve funding of the health sector through insurance mechanisms, which have passed through stages of a formal sector NHI to the implementation of SHI.
2.13.1 Formal sector NHIS

NHIS was first conceptualised in Nigeria in 1960 but was staled by legislation and political instability till 1984, when the National Council on Health (NCH) set up a committee to advice government on the need for its implementation. A positive response by this committee led to the setting up of NHI reviews committee in 1985 (FRN/FMOH, 2001).

Based on recommendations of the reviews committee, Government set up a consultative committee on NHIS, also in 1985. The consultative committee’s report, submitted in 1988 encouraged Government to set up the Scheme (FRN/NHIS, 2001).

At a meeting of NCH in 1989, Government of Nigeria approved the NHI. An agreement was signed subsequently by Government with UNDP and ILO in 1991 for planning and implementation (FRN/NHIS, 2001). Studies carried out involved Actuarial analysis, computerisation requirements, financial procedures, management information system (MIS), guidelines and draft laws of NHIS (FRN/FMOH, 2001).

In 1993, FMOH presented a memorandum to the Federal Executive Council (FEC) for immediate implementation of NHIS. In 1995, the National health summit endorsed the document for immediate implementation. National health insurance was implemented in Nigeria in 1995 (FRN/NHIS, 2001).

2.13.2. Implementation and problems of the formal sector NHIS

NHIS collected premium and purchased health services for formal sector employees (NHIS, 2001). This represented less than 40% of the population, leaving out over 60% employed in the informal sector, especially over 52% in the rural areas. In effect, despite introduction of the NHIS, over 90% of health services in Nigeria remained paid for through direct user fee (Ichoku, 2005).

The problem of exclusion of the informal sector led the emergence of some CBHF schemes from peoples’ effort to create a safety net for their local communities.

2.14. COMMUNITY BASED HEALTH FINANCE SCHEMES (CBHF)

Some CBHF targeted members of local trade associations like taxi drivers’ association, market women association examples: Lawanson Health Plan (LHP) in Lagos (Initiative, 2004) and Ariaria traders’ health scheme of Aba (Yohesor, 2004). Others focused on members of a particular community, like the Country women association of Nigeria (COWAN) (Ogunbekun, 2004); and the Ndo-nwanne health scheme of Enugu (Koeman, 2003).

According to Anyaehie and Nwobodo, (2004), CBHFs are funded through premium which vary among schemes; from N1, 200 ($14) per month for COWAN to N1, 000 Ndo- Nwanne health scheme. Different schemes also have some flexible premium collection mechanisms.
2.14.2. Benefit packages of CBHF

While all CBHF schemes have improved access to health services and re-distribution of health care as objective, various health benefits are found based on their peculiar characters (See appendix IV).

2.14.3. Problems faced by CBHF

CBHF are faced with a number of problems which include:

- The small size of contributions is usually inadequate, due to high inflation rates, for financing the basic health needs of most low income families. Again the size of the schemes is too small to enjoy economies of scale.
- In most CBHF, there is no mechanism in place for assessing the quality of care rendered by health care providers and efficiency may be compromised.
- Reimbursements in the absence of negotiated fee schedules may also be difficult to determine.
- Sustainability becomes one of the greatest challenges faced by the CBHF. Poor legal founding by the CBHF may lead to collapse in event of unforeseen mishap on key members of board of directors; or financial insolvency.

2.14.4. Re-packaging of the NHIS to include the informal sector

At the 42nd meeting of NCH in 1997, approval was given for the ‘repackaging’ of the NHIS to ensure full private sector participation, by providing re-insurance coverage to the CBHF and HMOs to form SHI (FRN/NHIS, 2001).

SHI was launched on 15th October, 1997 while the enabling law establishing the Scheme, Degree 35 of 1999 (Now act 35 of 1999) was signed in May 1999. Implementation was delayed till June 6th, 2005 (FRN/NHIS, 2005).

‘Repackaging’ the NHIS to include the informal sector was a good idea, but chances that the weaknesses in the formal sector scheme could drag down community efforts at CBHF remain high.

Another doubt on the possibility of SHI to improve financing of the health sector in Nigeria may also arise based on problems of poor implementation.

2.15. DESCRIPTION OF NIGERIAN SHI

The Nigerian National Health Insurance (NHI) is a single or National health insurance scheme has different categories (formal, informal and the exemption) groups. It utilises the services of HMOs as health managers, for collecting revenues and distributing health services.

Some CBHF have increased the scope of their operation to register as HMOs, others have been mopped up by HMOs that operate in their community.
Contributions to the Scheme are made by members as premium through the HMOs, according to their different categories. The HMOs also provide service to members through health care providers register to the Scheme. Members are entitled to obtain health benefits from any health provider irrespective of location on provision of an adequate identification. All resources collected by the HMOs are pooled together to the NHIS, who regulates activities of the HMOs and disburses compensation to health providers through the HMOs.

The NHIS have offices in the 36 states of the federation. It also has Zonal offices in the six geo-political zones of the federation and a national office in the FCT, Abuja (NHIS, Undated).

NHIS is managed by a Governing Council, which ensures the effective implementation of the policy and procedures of the Scheme. Member of the Governing Council are to be appointed by the president, on the recommendation of the Minister of health. The council are to be headed by a chairman and a secretary.

2.16. PROBLEMS ASSOCIATED WITH IMPLEMENTATION OF SHI IN NIGERIA.

Implementation of SHI in Nigeria may face the following problems:

- The large informal sector and the diversity in economic status make it difficult for SHI in Nigeria to determine premium equitably.

- Determination of groups to be included in the exemption schemes and how to implement the exemption packages without encouraging free-riders might be difficult without compromising access to health care.

- HMOs may be reluctant to operate in the rural areas where premium may be difficult but will prefer the urban areas where they will not only enjoy ease of premium collection but a boom in enrolment due to population density. This may hinder access to the rural areas.

- It may also be difficult to determine method of compensation of physicians according to their various classifications and disbursement of the compensation without giving rise to moral hazard and fraud.

- Difficulty in determining line of services to cover by the scheme will be a cause of constant threat.

- SHI implementation may have problems in setting up regulatory mechanisms and enforcing them to be able to check quality and reduce problems of moral hazards, adverse selection and free- rider effect.

- Sustainability may become a problem if revenue generation through premium is not adequate to pay for expenditure.

- Efficient allocation of resources to cover health needs of members may be difficult to attain.
• The organisational structure of the Nigerian SHI may make decision making too bureaucratic if measures are not taken to enhance representation to the local level

2.16. SWOT ANALYSIS OF SHI IN NIGERIA

There discusses the inherent strengths, weaknesses, opportunities and threats (SWOT) of the Nigerian SHI.

2.16.1. **Strengths**

• The Government of Nigeria is implementing a National economic empowerment and development strategy (NEEDS), Health sector reforms, NEPAD, which emphasise improvement in health sector financing (Obasanjo, 2005).

• Allocation of resources by Nigeria to SHI is consistent with the UN recommendation for the achievement of the Millennium Development Goals (MDGs) for health, which Nigeria is trying to attain (Asare, 2005).

• Government is committed to the success of the Scheme, and has made adequate provision for its success both in legislation and planning by giving it technical support from the MOH, and National planning commission and by creating SHI board (NHIS, 1999). Further prove of government’s commitment is the setting aside of N26 billion ($150 Million) in the 2005 budget as its share of contribution to the successful take off of the Scheme (Asare, 2005).

• The Nigerian SHI integrates the formal and informal sector to increase coverage, which may increase net resource generation from the informal sector.

• The formal sector NHIS has already provided structures and personnel for easy implementation of the Scheme.

2.16.2. **Weaknesses**

• The organisational structure of providing insurance coverage to the informal sector through HMOs may escalate cost resulting from handling and administration.

• Low literacy level among the populace may make it difficult for them to understand the essence of SHI, the premium payment method and benefit packages. This may reduce community participation and ownership and may lead to moral hazard.

• Undeveloped health management information system may make it difficult to collect and store information about patients, leading to moral hazard and adverse selection. It may also affect financial planning and budget tracking, leading to poor management of the Scheme. Information on distribution of
health services may also be difficult to assess, making it difficult to monitor and evaluate the program.

2.16.3. **Opportunities**

- SHI is increasingly recognised as an instrument for financing health services in developing countries (Jutting, 2001).

- There is an existing NHI Scheme and various CBHF Schemes which creates an existing structure for easy implementation of the program.

- Tax based supplementary funding by the Government acts as support for the program on the short term. This fund may be used to develop facilities in the long term (FRN/FMOH, 2001).

- Development Partners and agencies like the World Bank and ILO are providing technical support and research resources for smooth implementation of the program.

2.16.4. **Threats**

- Nigerians have had bad experiences with the insurance industry and may be reluctant in enrolling in the programme.

- SHI involves huge sums of money and needs absolute transparency both in managing funds and in awarding contracts, which may not be guaranteed both in the public or private sectors in Nigeria and may discourage enrolment in the program.

- SHI requires huge financial input for implementation. Government has already spent over N100 Billion on the scheme, which is not well reflected by the level of operation in implementation (Yohesor, 2004).

- Recent high incidence of chromic diseases with high morbidity like HIV/AIDS and TB may place high financial burden on the scheme, which may affect financial sustainability.

- Free-rider effects may result from the informal sectors that are not educated about the activities of the scheme.

- Insolvency of the scheme could occur if there is hindrance to flow of funds due to poor economic situation in the country.

- Nigeria is noted for sudden change in Government and abandonment of policy. Such occurrence may hinder sustainability of the scheme, as subsequent government may not identify with the program and decrease funding to it.
2.18. CONCLUSION

Chapter two has discussed the health system and health system financing in Nigeria. The problems of poor health sector financing were also analysed. This led to the history of development of health insurance: from NHIS and CBHF to SHI. A SWOT analysis was also done. The next chapter will look at other countries’ experience with SHI.
CHAPTER THREE

GLOBAL EXPERIENCE OF SOCIAL HEALTH INSURANCE

3.1. INTRODUCTION

Having looked at the situation of health sector financing in Nigeria and the introduction of social health insurance in chapter two, this chapter will review the experience of other countries with SHI.

3.2. THE CONCEPT OF SOCIAL HEALTH INSURANCE

Government in various part of the world find it difficult to pay the total cost of health services for its citizens through tax, hence need to subsidize Government health spending.

SHI may be the best mechanism of funding from private means to subsidise Government spending, because a social or Solidarity means of paying for health services may allow cross-subsidisation of the poor by the rich and the sick by the healthy (Anyaehie and Nwobodo, 2004).

3.3. HISTORY OF SHI

SHI has a history spanning over a century, and for every country, it is associated with existing health problems and inability of economic resources available to pay for health services (Donaldson and Gerald, 1993).

Difficulty in paying for health services in Japan led to the formation of Jyorei, where members make contributions for health services from agricultural proceeds (Ogawa, et al.; 2003). Likewise, economic recession after the First World War made it difficult for Germans to pay for health services (Aaron, 2005).

SHI policy for every country goes through the same stages of need identification, planning, logistics, implementation, policy reforms and policy amendment as shown in figure 5.
3.3.1 **Origin of SHI**

Germany was the first country to adopt SHI. The German chancellor Prince Otto von Bismarck received approval for a compulsory sickness-insurance law in 1883, which was financed by state subsidy (Aaron, 2005).

SHI has its root in the mutual aid societies called *Jyorei* that started in Japan in 1835 (Ogawa *et al*.; 2003), but health insurance law was enacted in Japan in 1922 (Ministry of Health and Welfare Japan, 2000).

3.3.2 **Some countries with SHI laws by region**

Europe: Germany, France, Switzerland, Netherlands and Hungary.

Asia: Japan, Taiwan, Korea, Philippines and India.

Latin America: Mexico, Argentina and Brazil.

Africa: Tanzania, Kenya and Nigeria. It is being formulated in Zimbabwe, Uganda and Ghana.

Despite existence of SHI policy, implementation has not been possible for most developing countries due to huge resources and technical capacity required. Indian SHI suffers from poor coverage and inadequate funding (Ramesh and Dileep, 2000). The Philippine SHI scheme has made tremendous success (Quimbo, 2001). The fact that both countries share similar economic and socio-cultural characteristics shows that while resource and technical capacity are important prerequisite to successful implementation of SHI other issues like political priorities of a country also play vital roles.
3.4. HOW SHI OPERATES

SHI operates in the following ways:

3.4.1. Prospective Financing through Premium

SHI is a prospective financing; that is: funds are collected in advance in the form of premium, without knowing when or for whom they will be needed (Normand and Weber, 1994).

3.4.2. Compulsory coverage

The Bismarck model is a classical model of SHI: characterised by compulsory universal coverage within the framework of social security, and financed by employer and individual contributions (Pfaff, 1990). This characteristic distinguishes it from private health insurance that is voluntary. Tanzania and Germany practice a compulsory scheme, but the experience of SHI is recent in Tanzania (Humba, 2005).

According Pfaff and Nagal, (1994) illustration of the Bismarck – model: Insurance, Patients, providers, sickness funds and Government in SHI, funds and services flow in the same pattern as in figure 4, irrespective of whether it is a single or multiple fund SHI Scheme.

![Figure 4: The Bismarck-Model of SHI](source)

3.4.2. SHI funds (Single or multiple funds)

Contributions to SHI are made to one or several SHI Funds. These funds are separated from government, but are established by law according to the country’s SHI policy (Yohesor, 2004). The funds purchase health services for insured households.
3.4.2.1. Single fund

Here, contributions are made to a single fund. Single fund ensures that all citizens receive the same range and standard of care, since they pay to the same funds (Pfaff, 1990). As a bulk purchaser, administrative cost is lowered and it enjoys economies of scale. Single fund is practiced in Taiwan (Liu and Lee, 1998); France (Green and Irvine, 2002) and Tanzania (Humba, 2005).

3.4.2.2. Multiple funds

In this, many funds exist, leading to competition for members which may lead to reduction in price and improvement in quality of care. It could be argued that multiple funds may increase administrative cost. ‘Multiple funds’ is practiced in Japan (Ministry of health and Welfare Japan, 2000) and Germany (Schneider, 1994).

3.4.3. Model of service provision

Health care providers are either owned by the Scheme or are public or private facilities contracted to the Scheme. Services provided to members of the funds may be free at point of use as in Taiwan (Liu and Lee, 1998). Household pay some proportion of the cost (co-payment) in Germany (Pfaff, 1994). In France, patients pay at point of service and later receive reimbursement from the funds (Green and Irvine, 2002).

3.5. RATIONALE FOR INTRODUCING SHI

Different countries have different reasons for introducing SHI as in Table 4.

Table 4: Countries and Policy objectives

<table>
<thead>
<tr>
<th>Policy Objectives</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>To formalise cost sharing in the informal sector</td>
<td>Tanzania, Nigeria, Switzerland, India</td>
</tr>
<tr>
<td>To increase revenue to the health sector</td>
<td>Tanzania, Nigeria, Kenya, South Africa,</td>
</tr>
<tr>
<td></td>
<td>Uganda, India</td>
</tr>
<tr>
<td>To improve access to quality health care</td>
<td>Tanzania, Nigeria, Kenya, Philippines,</td>
</tr>
<tr>
<td></td>
<td>Korea, Germany, France, Korea, India</td>
</tr>
<tr>
<td>To improve risk sharing</td>
<td>Malawi, Kenya, Tanzania</td>
</tr>
<tr>
<td>To improve equity in revenue collection</td>
<td>Malawi, Nigeria, Kenya, South Africa,</td>
</tr>
<tr>
<td></td>
<td>Philippine, Korea, Taiwan</td>
</tr>
<tr>
<td>To improve efficiency of revenue collection</td>
<td>Nigeria, Philippines, Switzerland.</td>
</tr>
<tr>
<td>To improve quality of care</td>
<td>Taiwan, Korea, France, Switzerland,</td>
</tr>
<tr>
<td></td>
<td>India, Tanzania</td>
</tr>
</tbody>
</table>

3.6. SPECIFIC CHARACTERISTICS IN SOME SCHEMES.

Different countries have different types of scheme, depending on their objective, context, health and political agenda. In Taiwan, NHI is government owned and managed. It is compulsory for everyone resident in Taiwan for up to four months and there is penalty for failure to enrol (Liu and Lee, 1998); where as in France, the insurers are non government, Non–profit agencies. Premium is paid jointly by employers and employees as percentage of income. Patients pay fees at time of use of medical service and claims back 75 -80% later from insurer (Green and Irvine, 2002). Appendix III gives further examples.

The amount of benefits, conditions of eligibility vary widely between schemes, in accordance with these features which also determine the effects of the Scheme on the health system of any country.

3.7. EFFECTS OF SHI

SHI affects the members, the providers and the insurance Scheme, as illustrated in figure 6: there is an increased demand for health services with SHI. The provider enjoys increased utilisation of health services, increased supply of services and improved quality of care. Members of the scheme enjoy increased financial protection, increased labour productivity, improved health status and increased income. The insurance Scheme enjoys increased membership enrolment, increased resource mobilisation, which causes decreased administrative cost per contract and increased risk pooling; leading to decrease in premium.

Figure 6: Demand and supply diagram after the introduction of SHI; showing Process and effects.

3.7.1. Effect on members

As shown in table 5, SHI may improve access to health services for members (Cheng, 2004). It leads to an increase in number of health personnel (Doctors and nurses), increase in facilities and equipment and hence quality of care.
Table 5: Delivery system at a glance

<table>
<thead>
<tr>
<th></th>
<th>CT per 1 million</th>
<th>MRI per 1 million</th>
<th>Expenditure on drugs/total exp.</th>
<th>Acute care beds per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Japan</td>
<td>63.7</td>
<td>92.6</td>
<td>12.5</td>
<td>35.3</td>
</tr>
<tr>
<td>Korea</td>
<td>12.2</td>
<td>30.9</td>
<td>1.4</td>
<td>7.9</td>
</tr>
<tr>
<td>Taiwan</td>
<td>7.77</td>
<td>20.6</td>
<td>1</td>
<td>5.02</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ave. length of hospital stay</th>
<th>Physician/1000 Population</th>
<th>Nurse/1000 Population</th>
<th>Utilisation (no. visits/person/year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Japan</td>
<td>47.9</td>
<td>37.5</td>
<td>1.7</td>
</tr>
<tr>
<td>Korea</td>
<td>13</td>
<td>13</td>
<td>1.0</td>
</tr>
<tr>
<td>Taiwan</td>
<td>-</td>
<td>8.76</td>
<td>0.99</td>
</tr>
</tbody>
</table>


Table 5 shows a decrease in the average length of hospital stay and increased utilisation of health services measured by number of visits per person per year. In effect, SHI may reduce the prevailing condition of underutilisation of health facilities in developing countries (Muller, et al., 1996).

SHI saves members from difficult situations of searching for credit or selling assets in the event of ill health by creating a safety net for the poor, which protect them from vulnerability to health shock (Morrison, 2002).

Since there is no delay in seeking care, members recover more quickly and hence reduce labour loss due to ill health. This enables stability in income of the household (Jutting, 2003).

More specific effects of SHI on members are noted in the following benefits:

3.7.2.1. **Improved access to health care services**

There has been remarkable increase in access to health services with introduction of SHI in many countries, due to different measures put in place to achieve this.

Taiwan increased coverage from 59.4% in 1994 to 93.4% in 1996 (PRoC/DoH/HK, 1996). Strategies applied were increase in number of health facilities and contracting private hospitals to provide care (Liu and Lee, 1998).

According to Causon (2001), Philippines NHIP enrols the marginalised and less privileged population, as poverty is a major deterrent to access to health services in Philippines. According to Ramesh, (1999), lack of adequate exemption packages is the major cause of poor coverage in India.

For most developing countries of sub-Saharan Africa like Tanzania, Kenya, Mali, Senegal and Ghana, SHI may only improve access to care if health facilities and
personnel are increased and if the poor are enrolled in the Scheme, since widespread poverty in these countries may deter people from enrolling (Jutting, 2003).

3.7.2.2. Quality of care

Quality in health service delivery has been achieved in Philippines where it is mandatory for medical professionals and health institutions to secure accreditation to get reimbursement for services provided (Jutting, 2003). In Tanzania, health providers were accredited, but as good as it was in improving quality, it led to fraud, as health providers offered incentives to inspectors for accreditation (Newbrander, 1999). The experience of Tanzania may be applicable to most African countries like Nigeria.

In Korea there is no form of accreditation, no comprehensive information on clinical quality of health, and in effect the benefit of improving quality through SHI has not been realised (Jutting, 2003).

Quality of care is assured in the Taiwan BNHI as patients have right to choose among contracted facilities thus creating competition among care givers (Liu and Lee, 1998).

3.7.2.3. Equity of finance

Different Schemes have aimed at improving equity in financing health services; through differences in ways of calculating premium, and by creating exemption packages for the vulnerable groups.

- **Cost sharing:** Equity in finance may be achieved, when part of the premium is paid by the employer and the rest by the employees (Jutting, 2004). In Taiwan, there is also co-payment for certain services like dental care, considered as luxury (PRoC/DoH/HK, 1997). In Korea, cost-sharing is unrelated to ability to pay, and the Korean scheme is criticised for inequity (Jutting, 2003).

- **Premium:** Equity may be achieved by making premium income related. According to Green and Irvine, (2002), and Humba, (2005), this strategy is applied in France and Tanzania. In France, patient pay full fee on service, only to be reimbursed 75% to 80% later by the Insurer (Green and Irvine, 2002). This could affect access to care if adequate exemption package is not created for the poor.

- **Exemptions for the poor** In Germany exemption packages is through the sickness fund, which is mandatory for people earning less than DM 5,400 Pa., students and the unemployed while highly paid people purchase their health insurance cover from private insurers (PNHP Student home page, 2005). This is criticised that it makes the poor young people pay the health cost of the rich old.

3.7.2.4. Equity of care

Equity of care is addressed by various schemes through distribution of health facilities and personnel to amend for geographical area disparity.
In Philippines, Tanzania and India the mal-distribution of health facilities across regions creates inequity. This may be peculiar to Schemes in developing countries. For the individual patients, service delivery is according to health need in most equitable schemes like France.

3.7.2.5. Efficiency

Efficiency of the health system may be improved through SHI; but the combination of SHI and UF makes that difficult to realise in many countries like Tanzania, India and Kenya, due to difficulty in controlling the cost of health services.

Financial efficiency has led to surpluses in Taiwan. According to Liu and Lee, (1998), if efficiency is sustained, surplus funds could be saved as reserved funds to finance expenditure in years of deficits or to finance some services to reduce funding from the private sector. Such financial efficiency is however not obtainable in countries with low coverage like Tanzania and India.

Increase in funding, facilities and personnel contributed to reduced waiting time in France. This is an advantage over tax-based British NHS, criticised for long waiting time (Donelan et al., 1999).

3.7.3. Effect on provider/health system

SHI causes a rise in national health index (NHI), which ultimately leads to a rise in National health expenditure (NHE). According to Jutting (2003), SHI makes it easier for people to pay for health services, leading to increased resource mobilisation for the health system. This is due to various flexible premium collection mechanisms in some Schemes. Principally, the concept of SHI (section 3.2) enhances mobilisation of resources.

Figure 7 shows a growth in GDP and health expenditure per member of SHI in Germany, with a relative rise in income between 1996 and 2003.

Figure 7: The impact of SHI on health expenditure in Germany

28
From above it could be deduced that there has been a rise in health expenditure in Germany between 1996 and 2003, but this may also be as a result of a rise in GDP since there is also a rise in income.

Figure 8 shows that SHI contributed over 56.7% of the total health spending of Germany in 2003.

This shows that SHI may be responsible for the rise in NHE. Further evidence that a rise in NHE could be attributed to SHI may be deduced by looking at the change in NHE, as percentage of GDP.

This is important to prove that the growth in NHE is not due to other factors like population growth and growth of overall economy.

As shown in table 6, while there was a percentage rise in both the GDP and the NHE between 1991 and 2001, the change in NHE as percent of GDP (NHE/GDP in %) shows a progressive rise from 4.9% to 6.2 %. This suggests that the rise in NHE is due to impact of SHI on improving resource mobilisation for the health sector.

Increase in NHE is more attributable to SHI in countries where it is the dominant means of paying for health services but in countries like Tanzania and India, low coverage makes it difficult to determine percentage change in health expenditure attributable to SHI.


<table>
<thead>
<tr>
<th>Year</th>
<th>NHE/GDP (%)</th>
<th>NHE(% Change)</th>
<th>GDP(% Change )</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991-1992</td>
<td>4.9%</td>
<td>7.8%</td>
<td>2.6%</td>
</tr>
<tr>
<td>1992-1993</td>
<td>5.0%</td>
<td>3.8%</td>
<td>0.8%</td>
</tr>
<tr>
<td>1993-1994</td>
<td>5.3%</td>
<td>5.7%</td>
<td>1.2%</td>
</tr>
<tr>
<td>1994-1995</td>
<td>5.4%</td>
<td>4.7%</td>
<td>1.4%</td>
</tr>
<tr>
<td>1995-1996</td>
<td>5.6%</td>
<td>5.6%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Period</td>
<td>% GDP</td>
<td>% NNP</td>
<td>% NNP</td>
</tr>
<tr>
<td>--------------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>1996-1997</td>
<td>5.6%</td>
<td>2.1%</td>
<td>2.1%</td>
</tr>
<tr>
<td>1997-1998</td>
<td>5.8%</td>
<td>2.4%</td>
<td>-1.2%</td>
</tr>
<tr>
<td>1998-1999</td>
<td>6.1%</td>
<td>3.7%</td>
<td>-1.4%</td>
</tr>
<tr>
<td>1999-2000</td>
<td>5.9%</td>
<td>-1.6%</td>
<td>0.8%</td>
</tr>
<tr>
<td>2000-2001</td>
<td>6.2%</td>
<td>3.0%</td>
<td>-1.1%</td>
</tr>
</tbody>
</table>


3.7.4. Effect on the insurance scheme

SHI leads to increase in resource generation and improvement on health service delivery, which encourages increased participation. This enables the scheme to utilise ‘economies of scale’, leading to reduction of administrative cost per member and ultimately to reduction in premium (McGuire, et al.; 1989). This encourages a rise in participation.

3.8. PROBLEMS FACED BY SHI SCHEMES

SHI schemes may face the following problems:

3.8.1. Revenue mobilisation from the informal sector

A major problem of implementation of a sustainable SHI Scheme in most countries is difficulty in mobilising resources from the informal sector employees. This difficulty arise due to inability of the Scheme to determine the income and hence premium for people employed in the informal sector. Also, premium collection mechanism from informal sector may be difficult especially in countries with no adequate means of identification of its citizens. This is a problem in implementation of SHI in Tanzania (Humba, 2005) and India (Ramesh, 1999).

While Taiwan categorises its member to ameliorate this (Liu and Lee, 1998) Korea uses fixed premium rate for informal sector employees (Jutting, 2003) which is criticised for inequity. The use of HMOs with good information based about members has been able to minimised problems of determining premium and collecting contribution from members in Switzerland (Peneger and Etter, 1997).

3.8.2. Moral hazard

“Moral hazard” involves overuse of the insurance services provided, caused both by demand and the supply sides. Illiteracy, especially by people of the informal sector leads to information deficits on how health insurance systems work and health services needed in specific situations. This leads to moral hazard in SHI schemes.

Health service providers, being interested in ensuring patient satisfaction and obtaining income may encourage increase in the uptake of health services. According to Jutting and Tine (2001), insurance organizations have to limit cost increases that are caused by their members’ lack of information by community mobilisation and education (Jutting and Tine, 2001).
Health insurance organizations should define benefits package and its limitations clearly and negotiate prices with health service providers.

3.8.2.1. Moral hazard by providers

Countries with multiple funds, especially for funds with large and heterogeneous customer base, difficulty in estimating exact services required by clients due to information deficit leads to moral hazard (Dror and Jacquire, 1995).

If insurers are unable to restrict their service packages to rarely occurring health risks that create high costs and inflexible demand, moral hazard may arise (Hechter, 1988).

A single fund with adequate information about patient may be able to limit this.

Health providers either over treat patients to make more money if compensation is based on patient bill, or spend less time in medical consultation with patients to increase the number of patients if compensation is based on capitation. It is a major problem in Taiwan (Liu and Lee, 1998). A good regulatory mechanism combining capitation and choice of care provider has been effective in controlling this moral hazard in France (Green and Irvine, 2002).

3.8.2.3. Moral hazard from Patients

SHI schemes suffer from waste resulting from patient over-use of services, due to illiteracy and lack of clear information about SHI (Jutting, 2003). Co-payment checks moral hazard from patients in some health needs but there are cases of abuse that do not require co-payment (Liu and Lee, 1998). Access to health care may be compromised by co-payment.

3.8.3. Free rider dilemma

Free riders are people who want to benefit from the distribution of health risks and payments made by others, but are unwilling to show reciprocity by paying for services required by others. They are liable to join just before a disease develops and leave after they have recovered.

This results from health insurance organizations’ lack of sufficient information about its members’ health risk. To reduce this, Philippines and Taiwan introduced measures for clients to only be entitled to benefit after six months of registering with a fund.

Health insurance organizations may incorporate a waiting period as a “penalty” for late renewal of membership (Bethesda, 1998).

Free rider behaviour also occurs when membership card is used by third parties. To prevent this, effective identity controls for members are needed. For family memberships, photos are needed for each individual member of the family. Free-riders could also be checked if ill members are required to collect a certificate from the health insurance organization before they can claim health services (Atim, 1998A). This may be dangerous if exception is not made for emergency care.

3.8.4. Adverse selection

Adverse selection occurs when people with average health cost higher than expected sign up in an insurance plan.
Adverse selection is eliminated from the BNHI of Taiwan since everyone belongs to the single fund (Liu and Lee, 1998). It is a big problem to the multiple insurance schemes in India (Ramesh and Dileep, 2000).

3.8.5. Explosion and underestimation of costs

This could result from either the demand or supply side: members desiring to get value for premium paid may obtain treatment more frequently than necessary. On the other hand, health service providers may prolong members' treatments or indirectly make extra charges, as reimbursement is guaranteed by the insurance fund (Jutting and Tine, 2001).

Exploding costs can be kept under control in various ways: Running costs can be reduced through direct ownership of hospitals by insurance funds, self-management and by using voluntary staff if appropriate. Treatment prices can be negotiated and agreed with the suppliers. The benefit packages can be restricted to components for which demand is relatively inflexible and insurance benefits can be restricted to only a few basic health risks. Co-payment is widely applied in Germany, Korea and Philippines (Yohosor, 2004).

Taiwan BNHI on the other hand could have been said to have over estimated, as surpluses has been recorded in 1996, but reserve was saved to finance deficit in the future (Liu and Lee, 1998). Cost explosion indicates inefficiency in planning and budgeting, may also be associated with fraud in developing countries.

3.8.6. Cultural problems

Cultural hindrances arise with the concept of illness and risk. If illness is seen culturally by community as a random thing that can happen to any one, people will pay premium more readily than in a community that see illness as punishment for behaviour by magic power(Jutting, 2003). Cultural perception of ill health is identified as a hindrance to health insurance in India (Ramesh and Dileep, 2000).

In Senegal, Mali and Tanzania, the perception of saving for one’s eventual health cost is seen as ‘wishing oneself the disease’. This cultural believe hinders enrolment in health insurance programs (Jutting, 2003).

3.8.7. Political problems

Political consideration is responsible for inability of many countries to enact and implement SHI. This has hindered the development of SHI policy in South Africa (Doherty, et al., 2000) and many other African countries.

3.8.8. Social factor

Diverse ethnic, religious and cultural bearing reduce solidarity and people’s willingness to pay premium due to lack of homogenous, close link population necessary to build mutual trust (Jutting, 2003). Social factor is a problem in India (Ramesh and Dileep, 2000) and South Africa (Doherty, et al., 2000)
3.8.9. **Poverty**

Slow or negative economic growth weakens the ability of self-employed people to pay contribution (Jutting, 2003). Direct user fee remains popular in these countries as people find it difficult to pay Premium. Poor economy affected the spread of SHI coverage to the informal sector in India (Ramesh, 1999). It reduces spread to rural areas in Tanzania (Humba, 2005).

Wide spread poverty has also hindered implementation and sustainability of SHI in developing countries like Senegal, Rwanda and Mali (Jutting, 2003). Tanzania introduced phases in coverage to ameliorate that (Humba, 2005). Despite its poor economy, SHI has done well in Philippines (Quimbo, 2001).

According to Jutting, (2004), poverty makes it unlikely for people to pay premium to access health services at later days. Social exclusion may persist even if barriers to access are reduced for part of the population. Exemption mechanisms for the poorest or sliding scale for premium that might be remedy are not easy to implement.

3.9. CONCLUSION

The experience of various countries with SHI has been reviewed, which shall form a background to a review of the SHI policy in Nigeria in chapter four.
4.1. INTRODUCTION

Chapter three analysed other countries’ experiences with SHI. Chapter four will analyse the Nigerian SHI policy. The analysis will be based on a framework of setting criteria and using set criteria to analyse policy contents with examples drawn from other countries’ experiences discussed in chapter three.

4.2. THE POLICY OF SHI IN NIGERIA

The policy of SHI in Nigeria resulted from the 1997 re-packaging of the NHIS (see section 2.14.4). According to FRN/NHIS, (2001), the strategy was to strengthen the NHIS by creating a single funds insurance scheme, using the existing framework of the NHIS and improving participation by extending coverage to informal sector through HMOs.

The HMOs in turn are registered under the Nigerian NHIS, which is a central government health insurance body that regulates them (See section 1.3 for definitions). This relationship is governed by some contractual agreements (see section 4.5.4) under the NHI act.

4.3.1. Aim and objective of Nigerian SHI

This section will look at the aim and objectives of the Nigerian SHI policy using the following criteria: Relevance to problems, attainability and availability of resource for implementation.

The aim of SHI in Nigeria is to: provide an alternative and sustainable funding for the health sector, relocate responsibility for healthcare management from public sector exclusiveness to the community and ultimately, the individual; for more local ownership and management of health services (Nigeriafirst.org.2003).

According to FRN/NHIS, (1999), the objectives include:

• To ensure that every Nigerian has access to good healthcare services;
• To protect families from the financial hardship of huge medical bills;
• To limit the rise in the cost of healthcare services;
• To ensure equitable distribution of healthcare costs among different income groups.
• To maintain high standards of healthcare delivery services;
4.3.4. **Review of aim and objectives**

The problem of inadequate health sector financing stated in section 2.4 and subsequent analysis in sections 2.5 and 2.9 are similar to global experience of health sector financing that necessitated countries reviewed in section 3.3 to adopt SHI.

The aim of Nigerian SHI seems very comprehensive. On the other hand, it may be considered too ambitious and difficult to achieve.

The objectives raise issues like equitable distribution of health services within the country. This is not easily attainable, considering the present urban – rural diversity and the characteristic variation in health facilities and social infrastructure (section 2.9.4). Hence, it might take a complete social restructuring, not just SHI to achieve the aim and objectives.

The aim of improving health sector financing through SHI has been successful in countries reviewed in section 3.7.3. If SHI is well implemented in Nigeria it could improve financing of health sector. This might be difficult in Nigeria if strategies are not in place to enhance planning and management of resources.

4.5. REVIEW OF KEY COMPONENTS OF NIGERIAN SHI POLICY

Key components of the Nigerian SHI policy shall be reviewed using criteria adapted from Preker, (2004).

Key policy components considered are:
- Legal framework/Regulatory mechanisms;
- Access to health care/ Coverage;
- Equity in finance/ revenue collection mechanisms;
- Pooling revenues and sharing risks/equity in finance;
- Resource allocation and purchasing (RAP) arrangement;
- Organisational structures and management attributes.

4.5.1. **Legal framework**

The criteria for review of legal framework include: Legal acceptability, Political acceptability, Protection of parties involved, Ease of implementation, Specificity and Regulatory mechanisms.
4.5.1.1. Policy contents on legal framework

The legal framework establishing the Social health insurance in Nigeria was contained in the National health insurance Decree No. 35 of 1999, Laws of the federal republic of Nigeria (FRN/NHIS, 1999). This decree established the National health insurance in Nigeria as a legal corporate body/name (FRN/NHIS, 1999).

The development of this policy went through stages of planning, legislation and implementation (section 2.13.1) as in figure 5(Chapter 3). The peculiar characteristic of Nigerian SHI policy is the use of HMOs, which created need for various contractual agreements in the policy to protect every party involved and provides some regulatory mechanisms for the scheme.

4.5.1.2. Regulatory mechanisms through contractual agreements.

- **Contractual agreements with NHIS.** NHIS is regulated by a legal framework. It registers and provides implementation guidelines for HMOs, care providers and consumers (FRN/NHIS, Undated).

- **Contractual agreement with HMOs.** Each hospital may contract with one or more HMOs. A Contract with HMO is negotiated between the two parties and is to be mutually beneficial. Whilst the providers cannot directly access the funds in the Scheme, the HMO cannot directly provide services to the consumers (NHIS, Undated).

- **Contractual agreement service providers.** Health providers are registered with the Scheme in compliance with set standards, to provide services to contributors with reasonable care, skill and attention. They are required to register with one or more HMOs; through whom they receive payment for services provided.

- **Contractual agreement with care users.** Every resident of Nigeria is expected to be registered with either the formal or informal scheme accordingly, and comply with necessary regulations (NHIS, 1999).

4.5.1.3. Analysis of legal framework/Regulatory mechanisms

The Nigerian SHI policy has been duly signed into law, making it a legal body dating from 1999(see section 2.14.4). Though the SHI policy was enacted by a military government, it was passed through legislation which established it as an act before inauguration (NHIS, 2005). This has accorded it legal and political acceptability.

The Nigerian SHI is a ‘single fund’ like France and Tanzania (See section 3.4.2.). The essence of the single fund will enhance easy implementation and co-ordination of the scheme through the HMOs, and easy planning for distribution of health services. It also reduces moral hazard (see section 3.8.2.) On the other hand, implementation of a single fund in Nigeria may be difficult considering the size and population of the country.
These contractual agreements contained in the policy create protection for the HMOs as the negotiator between the providers and the consumer. While guaranteeing the provider payment for services provided, it guarantees the consumer services for premium paid, hence organising the flow of funds and services in the health sector. The use of HMO has been successful in Switzerland (Peneger and Etter, 1997) and Japan (Ogawa, et al; 2003); and studies on Senegal and Tanzania according to Jutting, (2003), shows positive attributes which could infer HMOs as ideal for implementing SHI in Nigeria.

As part of condition for each of the contractual agreements is based on set standards, quality of services could be regulated (see section 3.8.2.2). Various clauses in the maintenance of the contractual agreements could also regulate moral hazard, free rider and adverse selections which are identified as major problems to SHI schemes (section 3.8).

4.5.2. Coverage/ Access to health services

Criteria used to review coverage/Access to health services include: Provision for vulnerable groups, Coverage for the rural areas, Distribution of health facilities and personnel among geographical areas.

4.5.2.1. Policy content on coverage/ Access to health services

To improve access to health care for all Nigerians, SHI covers various segments of the population. It is expected to have 60% coverage within the first year of operation; 40% of which are from the formal and 20% from the informal sector.

Participants are categorised into the following to achieve greater coverage and improve access to health services:

- **Formal Sector SHI**: This program covers employees of the formal sector i.e. the public sector and organisations with ten (10) or more employees;

- **Urban self-employed SHI**: This covers groups of individuals who are engaged in common economic activities (taxi drivers, traders, welders etc) and are members of socially cohesive groups of 500 people or more;

- **Rural Community SHI**: This programme covers cohesive groups of households or individuals (i.e. communities);

- **Programme for Children under - five years of age**: This covers children of participants in the urban self employed and rural community SHI, who are under the age of five years;

- **Permanently disabled Persons SHI**: This covers disabled persons living in settlement camps, who are not able to engage in any economically productive activity due to their disability.
4.5.2.2. Review of coverage/ access to health services

The method of dividing the schemes into categories was successful in achieving coverage and improving access in various countries. Though the Japanese and German schemes have broad categorisations into formal and informal schemes, Nigeria with its peculiar variegated population class, categorisation is expected to be a viable design that may guarantee coverage to larger population diversity and creating exemption packages for the vulnerable groups.

It is claimed that: In Nigerian SHI there is something for everyone (Nigeriafirst.org, 2003). This is hoped to be achieved by improving access to health services for every segment of the population. This may not realisable since there is no exemption package/category for the elderly, the poor and the unemployed, as the case of France and Philippine. Poor coverage as in the case of India and Tanzania may result (See section 3.7.2.1).

For the exemption groups there is no provision for their transportation to the health care centre, this may hinder access due to geographical disparity.

The restriction of the disabled scheme to disabled living in settlement camps could be seen as a means of full denial of access because over 80% of disabled in Nigeria live with their families due to poor social perception of settlement camps (Yohesor, 2004).

Unfortunately, the policy has not made priority issues on the development of health infrastructures to the rural areas and also provision of incentives to health personnel to practice in the rural areas and for HMOs to base activities in the rural areas. So, access to care under the Scheme has not fully addressed the problems of geographical disparities.

4.5.3. Revenue/premium collection mechanism.

Criteria used to review revenue collection mechanism include: Level of prepayment compared to out of pocket spending, Degree of progressivity of contribution, Subsidies for the poor, Effect on economy and the population.

4.5.3.1. Policy content on revenue/premium collection mechanism

Premium collection is divided into two: Formal and informal sectors.

- **Formal sector contribution.** According to FRN/NHIS, (1999), Contribution is income related, which represents 15% of employee’s basic salary. The payment of premium is shared, with employer contributing 10%, while 5% is deducted from employee’s salary.

- **Informal sector contribution.** The urban self employed and the rural community health schemes are classified under the Informal sector. Members make flat rate contributions of N120 to N150 ($1.50) monthly as premium to the HMOs who collect premium and provide managerial functions for contributors and the SHI Scheme (FRN/NHIS, 2001).
4.5.3.2. Review of the Revenue/premium collection mechanism

A major criticism of the scheme is that the 5% deduction which amounts to N375 for lowest income earner (N7, 500 per month minimum wage) is higher than most household expenditure on health from ‘out of pocket’. For a high income earner, 5% deduction may be as high as N13, 000($100) (Yohesor, 2004). Whilst SHI is aimed to subsidise the health cost of the low income earner by the high, the low income earners argue that they already pay higher than they would spend to purchase their health care needs out of pocket.

Arguably, SHI may lead to increased net mobilisation of revenue for the health sector as seen in case of increase in health expenditure of Japan and Germany (section 3.7.3), which could be used to improve the state of health facilities. This revenue may spill over to other social or health related services like environmental sanitation. Efficient management of this resource may also lead to a situation where some services will no longer need funding from the private sector, leading to a fall in health spending, as in Taiwan and France (see section 3.7.2.5).

Using HMOs for Premium collection from the informal sector has been efficient in Japan, Germany and Switzerland. Studies by Jutting, (2001) reveal its effectiveness in the CBHF in Mali, Ghana, Senegal and Kenya. It is expected to be effective in Nigeria. On the other hand the Nigerian local population see HMOs as ‘tax collectors’; who make big business from the premium collected from the poor, without adding value to health services, and may be discouraged from enrolling if that notion is not corrected (Author’s experience).

4.5.4. Pooling revenues and sharing risks/ Efficiency

Criteria used to review pooling revenue and sharing risk include: Percentage of population enrolled in a given time, How much was generated, Redistribution from rich to poor, health to sick, and gainfully employed to inactive and urban to rural and Ability to reduce overall health spending in the future.

4.5.4.1. Policy contents on pooling revenues and sharing risks/efficiency

Out of the 135.6 million people in Nigeria, ten million contributors are expected to enrol in the program in the first year of implementation with about fifty million beneficiaries; with emphasis on the rural population and people employed in the informal sector. SHI is expected to generate N 125 billion (USD 1billion) for the health sector within the first three years of implementation (Ojuolape, Unpublished).

4.5.4.2. Review of pooling revenue and sharing risk

The estimated contributors of ten million (about 7% of the population) and the generation of N125 billion (USD 1 billion) seem encouraging. Efficiency in health sector financing has been noted with SHI in countries reviewed in section 3.7.2.5, where it is also related to coverage as countries with good coverage like Taiwan and France attain efficiency while less efficiency is reported of India and Tanzania due to poor coverage.
If expected fund mobilisation is realised in the Nigerian SHI, it may enhance financing of exemption packages for the poor. Also, some of the money may spill over to some other social services. It is also expected that with overall efficiency of the scheme over time, some services might not need further funding from the private sector hence subsidising health cost and reducing premium as the case of Taiwan (section 3.7.2.5).

As good as this may seem, it has not given good percentage coverage especially to the rural population. Means of mobilising participants across different economic class and different regions were not outlined. If corruption is not addressed, these funds may end up in private pockets.

4.5.5. Resource allocation.

Criteria used to review resource allocation/equity include: Provision for development of infrastructure, Provision for the rural areas, Provision for places with high population density and disease burden.

4.5.5.1. Policy contents on resource allocation.

The scheme is to purchase health care services for eligible beneficiaries to any of the categories, and their dependants; either in the primary health care facility, secondary or tertiary level of care. A good referral system shall be set up essentially for cost efficiency and effective management of patients (FRN/NHIS, 2001).

4.5.5.2. Review of resource allocation.

The policy makes to correct poor resource allocation identified in health sector financing in Nigeria (see section 2.11) and made provision for the improvement of a referral system. Unfortunately cost effective measures like priority to PHC services such as nutrition education, pre-natal care counselling remain poorly attended (see table 1). This may lead to a physician dependent health system, criticised for cost and inefficiency.

The policy did not specify percentage of premium to be earmark for maintenance of health infrastructures, and allocation to improve services to the rural areas and places with high population and disease burden identified as major problem to health sector financing in Nigeria. Efficient resource allocation system is evidenced in Taiwan, Japan and Korea (see table 5), is a prerequisite for SHI to improve the health experience of the people.

4.5.6. Range of services covered by the scheme/ equity of care

Criteria used to review range of services/equity of care include: What to buy, from whom to buy, at what price and how to pay, Economic viability, Feasibility, Equity.
4.5.6.1. Policy content on range of services / equity of care.

According to FRN/NHIS (1999), contributors to the scheme are entitled to the following health services under the Scheme:

- Defined elements of curative care;
- Prescribed drugs and diagnostic test;
- 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 in a standard ward during a stated duration of stay for physical disorders;
- Eye examination and care, excluding test and the ad provision of spectacles; and
- A range of prosthesis and dental care as defined.

4.5.6.2. Review of range of services covered by the scheme/equity of care.

The services provided by the scheme cover quite a large range of health needs. The distribution of the services also serves equity of care as identified in some countries’ experience (see section 3.7.2.4).

Unfortunately, mental health services which has been of great focus to most health systems are left out.

The means of purchasing services from both public and private health care centres was efficient in France, but might lead to moral hazard in Nigeria due to high illiteracy level. It may enhance private / public mix, since 70% health care services in Nigeria are provided by private facilities (section 2.7).

4.5.7 Organisational structures and management attributes

Criteria used to review organisational structure include: Organisational forms, Compliance with political structure, Incentive regime; Means of selection and Managerial skills.

These shall be used to analyse Policy contents on organisational structure and management attributes outlined in section 2.15(description of Nigerian SHI).

4.5.6.1. Review of the organisational structure and management attributes

The central structure from the state to the zones to the federal level becomes important in managing a single fund scheme. This is in line with organisational structure of the Nigerian MoH (see section 2.3.3). This is important for uniformity in decision making, pooling and allocation of resources, monitoring and evaluation. On the other hand, the long organisational structure may lead to bureaucracy in decision making and implementation, rise in administrative cost and room for corruption if not monitored and may also compromise efficiency.
Management level through the council lacks justification in method of choosing members since appointment is by the president. This may lead to the scheme being managed by politicians, with limited knowledge of health sector financing, particularly SHI.

4.7 CONCLUSION

The Policy component of SHI has been reviewed. In the next chapter, recommendations will be made based on findings in all the earlier chapters.
CHAPTER FIVE

RECOMMENDATIONS AND CONCLUSION

5.1. INTRODUCTION

Based on every issue discussed on SHI, recommendations will be made based on strategies to provide good benefit packages for the people, sustainability of the program and improve financing of the health sector in Nigeria.

5.2. RECOMMENDATIONS SPECIFIC TO SUSTAINABLE IMPLEMENTATION OF SHI

The following are set of recommendation will enhance sustainable implementation of SHI in Nigeria.

5.2.1. Benefit packages

Adequate benefit packages should be provided, which may include:

5.2.1.1. Access to care.

Exemption packages should be re-designed to include the poor and vulnerable groups. This should include the unemployed, the elderly and all permanently disabled persons and for all obstetric care. The exemption package should also include providing the exemption groups with means of transportation to health facilities. NHIS should introduce subsidy for rural based HMOs. Government should increase health infrastructure in rural areas and incentives created for all health professionals practicing in the rural.

5.2.1.2. Premium and financing.

A flexible premium collection mechanism should be introduced for the informal sector schemes, such as collecting premium from farmers during harvest. There should be co-payment system for specialist care and cosmetic surgery.

An efficient financing system should be put in place which is able to invest resources in long term capital goals so that services could become self funded in future.

5.2.3. Provider arrangement.

Capitation method should be used to compensate Physicians. This should be combined by a pre-determined billing system.
While preserving solidarity, competition should be encouraged among HMOs, by introducing open enrolment to any HMO and encouraging more than one HMO to operate in the same locality, and patients should have choice of provider.

Population based disease management program for chronic diseases and high risk program for sicknesses with complications and co-morbidity should be established and funded separately from the funds by government through tax, donation and foreign aid; to reduce excess burden on the Scheme.

Adequate referral system should be enforced by making sure that visit to specialist care must be on referral from the G.P, except on emergency.

5.2.4. Regulatory arrangements.

Necessary regulating mechanisms need to be put in place

5.2.4.1. Strengthening quality of health care services.

SHI on its own does not improve quality; quality improvement measures should be put in place.

Accreditation should be introduced and strictly adhered to before registering care givers and providers. Certification of health care personnel employed by contracted providers should be regularly conducted with appropriate registration board; example Nigerian Medical Council for doctors.

Activities of related regulating bodies like National Agency for Food and Drug Administration and Control (NAFDAC) and Standard organisation of Nigeria (SON) should be enhanced by the government, to ensure that fake and sub-substandard products are not used in health facilities.

5.2.4.2. Regulating abuse

Identity cards should be carried by patients to health facilities, and there should be proper identification of patients with photo, address and category of insurance.

5.3. RECOMENDATIONS FOR IMPROVEMENT OF HEALTH SECTOR FINANCING THROUGH SHI.

The following recommendations will improve health sector financing in Nigeria through effective implementation of SHI.

Community mobilisation and ownership: Respectable village leaders should be used in presenting the program to the local communities, and maybe elected to the board of directors of HMOs; as people will identify with the program considering the calibre of leaders involved.

Religious acceptability: Time should be taken to explain the program to religious leaders, to understand and preach the ideals; as their support means success and nobody will be identified with the program if religious leaders declare it evil.
**Political acceptability:** SHI program should be in line with agenda like MDG, to remain politically acceptable even in the face of changing government. Intersectoral collaboration should be encouraged to link the SHI program to other health related issues.

**Policy makers** should review the differential allocation among sectors and adopt their fiscal policy in order to adjust the financial allocations so that more funds will be allocated to health sector.

As a LDC, **Government and NGOs** should negotiate external assistance for the program, which will enhance expansion of membership and coverage to the poor.

**Government** should increase attention to social development on education, environmental sanitation, family planning and PHC by increasing funding to these areas.

**Research into Policy and Practice:** To enhance stakeholders’ ability to develop appropriate policies and strategies for scale up of the SHI, there is need for NHIS to develop periodic summary reports showing geographical and temporal variations of socio-economic and health status. This can be achieved by information on allocation and impact of resources.

**Eradicating corruption:** Government should show commitment to eradicating corruption, strengthening accountability, putting monitoring measures in place. Honest and credible people should be employed to manage the scheme. Government should define and implement punishment for corrupt practices in the scheme, and announce publicly any official involved. Making public witness of penalty melted on corrupt officials will serve as deterrent to others.

**Health Management Information System** should be developed with databases that are relevant to health Sector financing and specifically SHI. This should be linked to the database of the Ministry of health for relevant collaboration with other sectors. Relevant software packages for planning, budgeting and budget tracking should be installed.

5.3. **RESOURCES REQUIRED FOR IMPLEMENTATION OF RECOMMENDATIONS**

To effectively implement the above recommendations, large sums of money and personnel are required. This may be difficult to attain and hence make some of the recommendation seem infeasible. Considering the size of the country and its population density against the background of available financial, human and material resources like health facilities, a nation - wide program like the SHI will cost the government up to N300 Billion(USD 250 million) to implement. This money may not be easily available, hence affecting feasibility. A set of strategies will enhance effective implementation.
5.4. STRATEGIES FOR IMPLEMENTATION

The main strategy for implementation of the recommendation is that Government on the short term should increase level of resources in finance to the health sector; through general revenues and earmarked funds from tax on sales of crude oil, tobacco and alcohol to enable the scheme finance most of its capital projects. This could serve as a short term measure for ten years, as it is consistent with government health plan, noting the fact that SHI in any country of the world does not serve as sole means of funding the health sector, but a subsidy to government health spending.

Foreign and international collaborators should provide technical support to reduce cost on personnel and also to build local capacity.

A major feasibility to the recommendations is that most of them do not require financial input but improvement on the management of available resources which could be achieved.

5.5. CONCLUSION.

This dissertation has objectives of reviewing the Nigerian SHI policy and make recommendations to stakeholders. An analysis of prevailing health and economic situation in Nigeria were made, followed by a review of other countries experience with SHI.

On this background, key components of the Nigerian SHI policy were analysed.

Recommendations were made for dissemination to stakeholders based on all the issues discussed.
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<table>
<thead>
<tr>
<th>Item</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>To expand and strengthen primary health care services throughout the country.</td>
</tr>
<tr>
<td>2</td>
<td>To eradicate, eliminate and control childhood and other vaccine preventable diseases through adequate routine immunisation activities.</td>
</tr>
<tr>
<td>3</td>
<td>To integrate and strengthen all disease control efforts and health promotion Activities into health care at primary care level.</td>
</tr>
<tr>
<td>4</td>
<td>To address the demographic problems through the provision of family and Reproductive health services including the necessary services to reduce the incidence of STD and HIV infections.</td>
</tr>
<tr>
<td>5</td>
<td>To reduce environmental and occupational health related morbidity and Mortality.</td>
</tr>
<tr>
<td>6</td>
<td>To rapidly resuscitate and improve the services of secondary health care to serve as an effective referral for PHC.</td>
</tr>
<tr>
<td>7</td>
<td>To improve investigative, diagnostic and treatment capability of tertiary health facilities to serve as an effective apex referral system to all health facilities in the country.</td>
</tr>
<tr>
<td>8</td>
<td>To ensure the attainment of the goals and objectives of the National Drug Policy (NDP), this focuses on self-reliance in essential drugs, vaccines and biological through local manufacture and an effective drug administration and control system.</td>
</tr>
<tr>
<td>9</td>
<td>To ensure the attainment of the goals and objectives of the National Drug Policy (NDP), this focuses on self-reliance in essential drugs, vaccines and biological through local manufacture and an effective drug administration and control system.</td>
</tr>
<tr>
<td>10</td>
<td>To ensure that the support given by donors, NGOs and UN agencies is provided within the framework of the national health policy and plans.</td>
</tr>
<tr>
<td>11</td>
<td>To broaden financing options to expand and improve access to affordable and adequate health care to a majority of Nigerians.</td>
</tr>
<tr>
<td>12</td>
<td>To strengthen policy formulation, general management, financial management, and planning capacity of the Federal Ministry of Health and parastatals.</td>
</tr>
<tr>
<td>13</td>
<td>To strengthen the capacity to develop, implement, monitor and evaluate evidence-based national health policy, planning, programmes and activities.</td>
</tr>
</tbody>
</table>

Source: FMOH, (2000)
Appendix II: Stages in development of National health insurance.

A. History of NHI of Taiwan

<table>
<thead>
<tr>
<th>Year</th>
<th>Scheme</th>
<th>Coverage Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1950</td>
<td>Labour Insurance (40.12% of the population)</td>
<td></td>
</tr>
<tr>
<td>1958</td>
<td>Government Employee Insurance (8.06%)</td>
<td></td>
</tr>
<tr>
<td>1990</td>
<td>Low-income Household Insurance (.055%)</td>
<td></td>
</tr>
<tr>
<td>1995</td>
<td>The total population covered by these separate insurance schemes was 56.94%</td>
<td></td>
</tr>
</tbody>
</table>

Phases in the establishment of Taiwan’s NHI

<table>
<thead>
<tr>
<th>Phase</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1986-1993</td>
<td>Planning</td>
</tr>
<tr>
<td>1993-1994</td>
<td>Legislation</td>
</tr>
<tr>
<td>March 1, 1995</td>
<td>Implementation(expansion added 41% of the population to NHI)</td>
</tr>
</tbody>
</table>

2003 | NHI Covers 97% of the population


B. History of the National health insurance of Japan

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1922</td>
<td>Japan’s first health insurance Law enacted.</td>
</tr>
<tr>
<td>1958</td>
<td>Overall amendment of the National health insurance law. (Promotion of universal coverage and 50% benefit coverage as the benefit for the insured)</td>
</tr>
<tr>
<td>1961</td>
<td>Universal medical care insurance was achieved.</td>
</tr>
<tr>
<td>1973</td>
<td>Amendment of the Welfare Law for the Elderly, over 70 years of age (so the “free of charge” medical care for the elderly.)</td>
</tr>
<tr>
<td>1982</td>
<td>The health and medical service Law for the elderly was enacted.</td>
</tr>
<tr>
<td>2000</td>
<td>Long term insurance program was implemented.</td>
</tr>
<tr>
<td>2003</td>
<td>The age criteria were increased to 75 years for the elderly insurance.</td>
</tr>
</tbody>
</table>

Source: Ministry of health, labour and welfare, Japan (2004)
### Appendix III: Peculiar features in some country’s shi

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>PECULIAR FEATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philippines</td>
<td>SHI was purely a government sponsored system; divided into three categories: Medicare I; for formal sector and Medicare II; for the informal sector; and the risk coverage scheme as an exemption package. While Medicare II is administered by the provincial government, Medicare I and the risk coverage scheme are managed by the central government (Batista, 2000).</td>
</tr>
<tr>
<td>Germany</td>
<td>SHI is not government run. It is administered by national and regional self-governing associations of payers and providers called <em>Landers</em>. Government only specifies national health policies. Government does not subsidise the NHI; but has a statutory NHI for everyone earning less than a periodically revised income ceiling (U.S Library of congress, Undated).</td>
</tr>
<tr>
<td>Korea</td>
<td>SHI implementation followed a pluralistic approach which created health Insurance fragmentation across multi-quasi public insurance societies. Inefficient finance structure and inequity in economic burden resulted, since government did not exert regulatory control over contributions by members (Cauchon, 2002).</td>
</tr>
<tr>
<td>Taiwan</td>
<td>NHI is compulsory for everyone resident in Taiwan for up to four months and there is penalty for failure to enrol (Liu and Lee, 1998).</td>
</tr>
<tr>
<td>France</td>
<td>The insurers are non government, Non -profit agencies. Premium is paid jointly by employers and employees as percentage of income. Patients pay fees at time of use of medical service and claims back 75 -80% later from insurer (Green and Irvine, 2002).</td>
</tr>
<tr>
<td>Japan</td>
<td>There are two funds: the workers insurance and the community insurance. The workers insurance is either managed by the government or HMOs, while the community fund is managed by the municipality or HMOs (Ogawa et al; 2003).</td>
</tr>
<tr>
<td>Tanzania</td>
<td>Administration of the NHIF is by an autonomous board of director that only report to the health minister. The practice of fee for service in Tanzania NHIF has problems of high administrative control (Humba, 2005).</td>
</tr>
</tbody>
</table>
Appendix IV: Benefits of CBHF, organisations and strategies.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Outstanding Organisation</th>
<th>Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to health care</td>
<td>Lawanson health Plan</td>
<td>Improved health facilities through five member hospitals</td>
</tr>
<tr>
<td>Efficiency and sustainability</td>
<td>Association of reproductive family health</td>
<td>Diversification of revenue base through expansion of service to include loans and basic health services</td>
</tr>
<tr>
<td>Equity</td>
<td>‘Ariaria traders’ health scheme.</td>
<td>Categorisation of members into apprentice’ and masters groups , which makes premium income related</td>
</tr>
<tr>
<td>Community participation and quality</td>
<td>‘Ndo- nwanne’ health scheme.</td>
<td>Members are from same community. Members visit hospitalised colleagues and access quality of care receive; claims are also monitored</td>
</tr>
</tbody>
</table>

POOLED RESOURCES, DISTRIBUTED RISK.

Substitute Govt., health expenditure, increase health revenue, spread risk

Improved health facilities, motivated health staff

Access to healthcare according to need

Improved national health status

Improved equitable health system

Improved national economy

Introduces:

NIGERIA

APPENDIX V: SHI, NIGERIA ACCESS THROUGH EQUITY

SOURCE: AUTHOR, (2005)