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THE NATIONAL HEALTH INSURANCE AUTHORITY OF NIGERIA AND IMPLICATIONS FOR UNIVERSAL HEALTH COVERAGE

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ABSTRACT

Background: **The National Health Insurance Scheme (NHIS) of Nigeria was established in the year 2005. The overall objective of the scheme was to enhance access to quality healthcare for all and minimize catastrophic health expenditures. However, since inception, the population coverage has been less than ten percent of the total. Very recently, the National Health Insurance Authority (NHIA) of Nigeria was enacted, which concomitantly repealed the NHIS Act. This article examined the design of the NHIA and other factors outside of the scheme but in the health system of Nigeria, in comparison to similar schemes in other settings. Finally, the newly implemented NHIA and the gaps it seeks to fill were examined.**

Methods: **Relevant literature extracted from databases such as PubMed, Google Scholar, and the ordinary Google website was reviewed. Findings from these sources were triangulated and used to write the manuscript.**

Results: **Compared with social health insurance schemes in other settings, the current population coverage under the NHIA of Nigeria is poor. Some of the factors that contributed to the poor performance of the NHIA were the features of the design of the scheme, which run contrary to the design of the majority of social health insurance schemes in other countries. In addition to this, the primary healthcare level that is most widespread in many countries and that was made use of as service providers in other social health insurance schemes was not made use of under the NHIA. In addition to these, and unlike in other settings, membership in the NHIA has been on a voluntary basis until very recently, when it was made mandatory.**

Conclusion and recommendations: **Presently, population coverage under the NHIA is very poor. The informal sector, especially in rural settings, is mostly at a disadvantage. This is unlike in the majority of other countries, which encourage population coverage across both the formal and informal sectors. Stakeholders in the health insurance industry are encouraged to make the scheme mandatory and enforce it. The PHC facilities should also be engaged as service providers under the NHIA.**

Keywords: National health insurance authority, Primary healthcare, Universal health coverage, Health maintenance organization.

INTRODUCTION

In Nigeria, the NHIA of 2022 was signed into law to repeal the NHIS Act of 1999. The NHIS was the social health insurance scheme (SHIS) through which the country had planned to achieve universal health coverage (UHC). The core objective of the NHIS was to facilitate equitable access to healthcare in Nigeria. However, participation in the NHIS is voluntary; financial contribution to the scheme comes only from the employer (mainly the federal government for its employees); that is, enrollees do not contribute the expected counterpart fund. [1] The NHIS partners with other actors in both the public and private sectors, such as health care providers and health maintenance organizations (HMOs), in its operations. The HMOs were the only third-party administrators and intermediaries to facilitate claims between the insurer and the insured. This also includes the administration of claims, the collection of premiums, enrollment, and other administrative activities.[2]

While the NHIS provides policy direction and licenses the HMOs and health care providers, the HMOs purchase health care services from the NHIS-accredited health care providers. Of the three levels (primary, secondary, and tertiary), only the primary level of care was not licensed to provide care under the scheme. The two accredited levels of providers serve as primary care providers (first contact facilities). The tertiary level of care is also designated as a referral level of care for the secondary level of care. Thus, patients could be

referred from the secondary healthcare facilities to the tertiary-level facilities.[1]

Even though there are variants of SHIS in different countries, what is common to the majority of SHIS is the fact that enrollees pay wage-based, non-risk-rated contributions on a regular basis. In addition, there is the presence of the insurer, who, on behalf of the scheme, purchases and pays for health care services rendered by providers to enrollees. In addition, enrollment in the scheme is compulsory for individuals. The employer contributes a fixed percentage of the total fee for each individual employee in its workforce.[3] Globally, membership in a SHIS is made mandatory for the majority of the whole population except for individuals on high incomes in some countries, such as Germany and the Netherlands, who are allowed to buy private health insurance policies.[3,4] However, under the Act that established it, membership in the NHIS is voluntary.[1] This is unconnected with the political structure and the constitution of Nigeria, which, as it exists in the USA, is a federal, presidential system of government whereby the sub-national levels of government have some degree of autonomy regarding policies in certain sectors, including the health system.[5] Thus, when the national government introduced SHIS, the majority of the enrollees were formal sector employees (of the national government). However, the states and the local (sub-national level) governments did not accept the idea to participate,[6] while the informal sector was largely left out of the scheme for a lack of an efficient platform to enroll and collect premiums from that population group. This is a common challenge in other developing countries.[4] In addition, the Nigeria Labour Congress, the national labour union of the formal sector employees, refused its members to pay the counterpart contribution of the premium from the inception of the scheme until the present time.[1] Consequently, funding for the scheme comes from only one source: the national government. Thus, the scheme in Nigeria did not meet all the criteria of a viable SHIS, and therefore, in reality, the scheme is a quasi-form of social health insurance, which is one of the reasons it has performed poorly. This article examined the design of the NHIS and other factors in the health system of Nigeria in comparison to similar schemes in other settings. Finally, the newly implemented NHIA was examined. Conclusions and recommendations were made.

METHODS

The study employed a desk review of published literature and documents on the NHIS. Databases searched included PubMed, Google Scholar, and General Google. The NHIA, NHIS, enrollees, payment, and out-of-pocket were the search themes. The search was refined to narrow down to words like voluntary, universal health coverage, and primary healthcare. The search also included the websites of the NHIS/NHIA, an agency of the Federal Government of Nigeria. The eligibility criteria for document inclusion were a description of payment mechanisms for healthcare services received. The concept of a social health insurance scheme is hinged on some fundamental principles, such as premium contributions by beneficiaries, mandatory enrolment in a scheme, and the use of the lowest level of care and often the most widely distributed healthcare facilities in the health system of any country. One of the search findings is that there is a paucity of literature on the newly signed NHIA. Thus, the majority of the literature was on the NHIS. This manuscript was written using articles obtained from desk reviews; thus, it did not require ethical approval.

RESULTS

Findings revealed that, mostly, prepayment mechanisms in different countries all over the world were able to attain universal health coverage (UHC) over different periods of time. The designs of schemes in these countries that aided or served as barriers to population coverage were discovered. It also shows some other contextual factors that assisted the attainment of UHC in these countries. Unlike in the schemes of other countries, the premium contribution in the NHIA is only made by the employers; the expected counterpart contribution by the employees who are the beneficiaries of the scheme has never been implemented. Also, while membership in the schemes of other countries was mandatory or compulsory, it has always been voluntary under the NHIA until very recently. In addition to these, and unlike the practice in other countries, and despite its widespread location and use in most countries, including Nigeria, the PHC facilities are not engaged as service providers under the NHIA. Using the NHIA as a reference scheme, these findings in different countries in Africa, Asia, Europe, and Latin America were discussed, conclusions drawn, and appropriate recommendations made.

DISCUSSION

Challenges with the Nigeria NHIS and the implications for universal health coverage

Findings in this work have shown that the NHIA by design (until very recently) is a quasi-form of the design of known social health insurance schemes world-wide. This has contributed mostly to its poor performance, manifested in its low population coverage. A previous study on the NHIA of Nigeria found that the scheme incurs enormous financial losses as a result of the non-contribution of premiums by enrollees to the scheme; thus, the only source of revenue for the scheme comes

from the national government and for the formal sector workers only, and this arrangement has been referred to as a highly subsidized scheme for a privileged few. [7] The implication is that an ineffective fund, risk pooling, and weak social health insurance have a low capacity for a more comprehensive benefits package. A limited benefit package also correlates with paying out-of-pocket for many other services that are not covered. This may reverse the little gain realized from the scheme. In the majority of the countries that have achieved near or total universal coverage, the lowest levels of care in the health system are engaged to provide services to enrollees. In Nigeria, the lowest level of care that serves as the first point of entry into the health system for individuals is primary health care (PHC). The PHC has been adopted as the framework to implement healthcare programmes in Nigeria. The primary level of care consists of facilities such as health centres, clinics, health posts, and dispensaries. By design, the primary level of care provides preventive, curative, promotive, and pre-referral care to the population. Unlike the secondary and tertiary level facilities, the health facilities at the PHC level have widespread distribution throughout the country, and by government design, there should be one PHC facility per ward to ensure easy accessibility to people in both the urban and rural areas.[8,9] The impact of the contributions of the PHC system is evidenced in countries that have made good progress towards the attainment of UHC. What is common to these countries is a responsive and effective PHC system coupled with stakeholders' support at the community level. A typical example in Africa is Rwanda and Ghana.[4]

Similar reports were made about Brazil and some other Latin American countries. A properly implemented and managed PHC system will ensure the attainment of UHC, described as a mechanism to ensure equity of access to quality health and devoid of catastrophic expenditure that could put individuals and families into poverty. The PHC system has the potential to reduce inequity in access to care, thereby addressing poor population health outcomes. In a systematic review conducted on the workings of health system reforms in some selected Latin American countries, it was shown that, without an effective and efficient PHC system, the health-related component of the Sustainable Development Goals and UHC would be difficult to achieve.[10] Despite a widespread distribution in both urban and rural areas of Nigeria, it is noteworthy that PHC facilities are not accredited to provide health services to enrollees under the NHIS. Non-utilization of PHC facilities has been attributed to the generally poor infrastructure of these facilities; previous studies have reported dilapidated buildings, poor equipment, a lack of drugs, and other consumables. In many instances, especially at the PHC facilities, the health manpower is usually inadequate in number and skill mix and is usually poorly motivated. The management of services in these facilities, including opening hours and waiting times, is usually very poor and serves as a disincentive for consumers' patronage.[11] The situation of PHC facilities in Nigeria is in contrast to what happens in countries such as Ghana, Rwanda, and Brazil,[10] where encouraging population coverage under the respective SHIS has been reported. Achieving UHC is unlikely amid unfavourable situations such as a non-mandatory social health insurance scheme, refusal to pay a premium by current beneficiaries of the scheme, and the non-use of widespread PHC facilities for service provision.

At the current rate of population coverage, the NHIA of Nigeria will require more than seven centuries to achieve total population coverage, assuming the population remains static. This is comparable to the attainment of UHC in some countries such as Germany (127 years), Belgium (118 years), the Republic of Korea (26 years), Costa Rica (20 years),[12] and the encouraging reports from Rwanda.[4] Reports from some other countries suggest a more ambitious period of less than a decade post-implementation to achieve UHC. However, global experience from different countries suggests the possibility of 60–80% population coverage in nine years post-implementation.[12]

The NHIA, which was newly signed into law, is an entity that seeks to address the gaps that characterize the former SHIS, the NHIS. Unlike the NHIS, under the NHIA, enrollment is mandatory for all. The widely spread PHC facilities have been approved to provide services to enrollees. Also, the base of fund and enrollment management has been increased to accommodate more TPAs, thus breaking the monopoly and abuse of privilege, especially with regard to fund management leveled against the HMOs.[13,14] However, a setback in the prospect of a wider financial base for the NHIA is the subsequent removal of the telecom tax that was initially included in the NHIA package. [14] Also, the NHIA has not addressed how it plans to implement a cost-efficient platform for fund collection among those who are in the informal sector and whose data banks are not readily available, contrary to those in the formal sector. Presently, studies on the newly enacted NHIA are scant; thus, the majority of the literature that was reviewed was articles on the NHIS. However, the available information from the studies on the NHIS was used as a proxy for the NHIA. To some extent, this is a limitation of this study.

CONCLUSIONS AND RECOMMENDATION

This review posits that the social health insurance scheme in Nigeria as it existed through the NHIS, whereby the majority of the enrollees from the formal sector of the country do not pay counterpart premiums, in addition to other cardinal deficiencies such as non-mandatory participation in the scheme and non-engagement of the PHC facilities to provide healthcare services to enrollees in the scheme, as aforementioned, is unlikely to be sustainable. To reposition the SHIS in Nigeria for improved performance, stakeholders in the health insurance industry of Nigeria must attend to these deficiencies; most importantly, enrolment in the scheme must be made mandatory. This will require legal backing to make it effective. The mandatory nature of the scheme will result in wider and faster population coverage. It will also translate to a wider financial base for the scheme, a concomitant more robust benefits package, and a reduction in the OOP.

In like manner, ensuring enrollees pay the premium would enhance the wider revenue base of the scheme and enhance the achievement of the benefits aforementioned. Above all, it is important to actively engage the PHC facilities as healthcare service providers for enrollees in the scheme. This could be done by upgrading the PHC facility infrastructure and making drugs and other consumables available. Functional, round-the-clock PHC facilities are an effective marketing strategy to enhance enrollment in a social health insurance scheme. The opposite is a recipe for a scheme to fail. [15] Addressing the challenges above will enhance the likelihood of an efficient and sustainable social health insurance scheme in Nigeria. Similar schemes in other settings may derive useful lessons from this. It is encouraging that the provisions made in the newly enacted NHIA Act have addressed the majority of these gaps. However, the financial base of the scheme needs to be improved. The mandatory clause as provided in the NHIA should be implemented.

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