million identity cards, covering about 3 percent of the population. (Gustafsson-Wright & Schellekens, 2013). Under the National Health Insurance Act 2008, the NHIS started a rural community-based social health insurance program (RCSHIP) in 2010. The majority of the enrollees, however, are individuals working in the formal sector and the community scheme still leaves large gaps among the poor and informally employed. Several proposals are currently in the pipeline to expand the reach of NHIS. One such proposal is to make registration mandatory for federal government employees. Earlier in 2013, the creation of a "health fund" targeting an earmarked "health tax" of 2 percent on the value of luxury goods was proposed. This fund would be used for the health insurance of specified groups of Nigerian citizens, including: children under five, physically challenged or disabled individuals, senior citizens above 65, prison inmates, pregnant women requiring maternity care, and indigent persons. (Gustafsson-Wright & Schellekens, 2013; Akande, Salaudeen & Babatunde, 2011; Onyedibe, Goyit & Nnadi, 2012; Agba, Ushie & Osuchukwu, 2010). At a broader level, the National Health Bill which was first proposed in 2006 to improve Nigeria's poor healthcare administration, by allocating at least 2 percent of the federal government's revenue to the health sector is still not signed into law. However, as of mid-2012, NHIS still covered only about 3 percent of the population (5 million individuals). Currently, NHIS programs exist that target the formal and self-employed sectors, with mixed success. The formal-sector program operates as a social health insurance scheme. Although the NHIS launched a rural community-based social health insurance program to cover more Nigerians, its uptake has been slow.

2.5 Challenges of NHIS in Nigeria

There are a number of challenges facing the actualization of NHIS in Nigeria. Funding remains a critical issue to the scheme. The percentage of government allocation to the health sector has always been abysmally low, about 2% to 3.5% of the national budget. For example, in 1996, only 2.55% of the total national budget was spent on health; 2.99% in 1998; 1.95% in 1999; 2.5% in 2000 and a marginal increase to 3.5% in 2004 (WHO, 2007ab&c). Consequently, per capita public spending for health in the country is less than US$5; which is far below the US$34 recommended by WHO for low-income nations (WHO, 2007a&c). While the Nigerian per capita health expenditure dwindles, the South African per capita health expenditure for example is US$22 in 2001 (The Vanguard Editorial, 2005). NHIS is also impeded by obsolete and inadequate medical equipment used by health services providers. The country suffers from perennial shortage of modern medical equipment such as radiologic and radiographic testing equipment and diagnostic scanners (Johnson & Stoskopt, 2009). And where these equipments are available, their repairs/servicing are always a problem. According to Oba (2009), this situation is not unconnected with corruption. Money meant to boost the health sector ends up in private pockets. An example is the 300 million naira scam involving the Minister of health and his assistants in 2008. Again, lack of adequate personnel in the healthcare sector is another impediment to the scheme. The country for instance had 19 physicians per 100,000 people between 1990 and 1999 (The Vanguard Editorial, 2005). In 2003, there were 34,923 physicians in Nigeria, giving a doctor-patient ratio of 0.28 physician per 1000 patients and 127,580 nurses or 1.03 nurses per 1000 patients as compared to 730,801 physicians or 2.5 per 1000 population in 2000 in the United States of America; and 2,669,603 nurses or 9.37 per 1000 patients. Out-migration of health personnel to the US, UK, Europe and other western/eastern countries is significantly responsible for the personnel situation in the health sector in Nigeria. For instance, in 2005 alone, there were 2,393 Nigerian doctors practicing in the US and 1,529 in the UK. Attributing factors include poor remunerations, limited postgraduate medical programs and poor conditions of service in Nigeria (WHO, 2007a). According to the World Bank Development Indicators (2005), the personnel situation in the healthcare sector influenced birth attendance in Nigeria. For instance, between 1997 and 2005 only 35% of births were attended to, by skilled health personnel in the country. Also, cultural and religious practices impact on the effectiveness of NHIS in Nigeria. Sexual inequality still exists and is encouraged by some religious/cultural sects in the country. Because of lack of awareness, women are being discriminated against and have limited access to social services such as education and healthcare (NCBI, 2009). Other challenges include inequality in the distribution of healthcare facilities between urban and rural areas and policies inconsistency (Omoruan, Bamidele & Philips, 2009). Furthermore, poverty and the inability to pre-pay for healthcare in Nigeria are significant challenges to the success of NHIS. According to Schellekens (2009) "people are not willing to pre-pay; and because people do not pre-pay there is no risk pool. And because there is no risk pool, there is no supply side." The NHIS's role in Nigeria is somewhat diluted. It manages subsidy programs for certain population groups (not the elderly population), who pay 100 percent of their premiums, and negotiates with HMOs for their service provisioning, while it delivers oversight and regulation functions for the system. Therefore, NHIS functions may require some streamlining, as recommended in the Ministerial Expert Committee Report in Nigeria (MEC, 2003). Some of the recommendations in this regard made by the Ministerial Expert Committee were adopted for creating appropriate institutions for the different tasks in a large system of social health insurance, such as the National Health Insurance Council to govern NHIS (MEC, 2003; JLN, 2012). Another striking challenge to the success of NHIS is the epileptic and sometimes lack of electricity in most parts of Nigeria which hampers the smooth operation of NHIS. Take for instance, a physician is carrying out a major operation on a patient and there is power disruption. This will threaten the success of that surgical procedure and endanger the life of the patient.

In addition to the above challenges, State governments in Nigeria have still not played a significant role in expanding health insurance (Asoka, 2012). The division of roles between the central government ministries, state governments, local government agencies, and the actual insurers is lacking the luster for the effective and efficient service delivery by NHIS. Finally, the commodification of health services could mar the objectives of NHIS. This is because healthcare providers see their services as economic commodity which they sell at a bargained and exorbitant

cost to those who could afford it. This negates one of the objectives of NHIS aimed at giving UHC to all Nigerians.

2.6 NHIS: Implication for Elderly care in Nigeria

Having examined the policy and legal provisions of NHIS in Nigeria, and analyzed its operations since its launch in 2005, one can succinctly agree that, it does not contain any provision for the care of the elderly in Nigeria. Although the average life expectancy of Nigerians is 52.3years (males) and 58.6years (females), with improved medical services and technology, more Nigerians are aging progressively. Before now, people aged 55years are said to be old in Nigeria, but nowadays when retirement of academic staff in the tertiary institutions has been increased to 70years, more Nigerians are celebrating their eightieth and ninetieth birthdays. Outmigration has made Nigerians in diasporas to age better than their counterparts down home, so that some of them clock 80years and are still strong and agile. One of the reasons most Nigerians are still residing overseas is the lack of facilities for the care of the aged. Whereas in US and most western countries, care of seniors is receiving primal attention by governments, private sector, charitable and nongovernmental organizations in terms of provision of health services, long-term care, assisted living and hospice care. This is palliating and a succor to the elders who cash on these facilities to age well and graciously. Dutta & Hongoro (2013) assert that UHC which NHIS is set to achieve can be a major determinant of improved health outcomes (and longevity) for all citizens especially the poorest poor. It is on this verge that NHIS policy and operations need overhauling and reassessment to incorporate the elderly population. The program should be evaluated periodically and monitored technically in order to appraise its gains and losses, strengthen its positive areas and possibly redesign its objectives toward achieving UHC in Nigeria. This view is supported by Gustafsson-Wright & Schellekens (2013) when they observe that, health insurance contribute to the achievement of UHC because it increases access and utilization of health services by lowering the price of healthcare.

3. Conclusion and Recommendations

From reviewed literature on health insurance administration and its benefits to healthcare recipients across the globe, it can be deduced that NHIS can increase the utilization of healthcare services especially to elders and among the rural population of Nigeria. Health insurance is expected to provide a financial protection since it addresses the financial risk of falling ill and eliminates out-of-pocket expenditures that usually accompany illness. The high share of out-of-pocket expenses experienced by patients is the most expensive, least efficient and least inclusive financing channel which weighs heavily on household budgets. In China, Wagstaff et al (2007) found out that, the rural health insurance scheme increased utilization of both outpatient and inpatient care by 20-30%. In sum, NHIS evaluation and overhaul to include care of the elderly will make it more inclusive, integrative and holistic in service provisioning and healthcare goal attainment in its administration. This is the goal of the World Health Organization which UHC seeks to address. Based on the above discussed issues on Nigeria's NHIS, the following recommendations are made:

1) An overhaul of NHIS policy should be made to incorporate care of the elderly in Nigeria.
2) Adequate funding of the program should be intensified for its smooth running and operations.
3) Bureaucratic bottlenecks should be removed and eliminated to allow for pragmatic service delivery to clients in need of healthcare.
4) Healthcare should not be seen as an economic commodity that is sold to the highest bidder, but should be seen as a fundamental right to be provided and protected by government.
5) Transparency and accountability should be implanted in the system to prevent and/or eliminate corrupt practices by administrators and providers of healthcare services.
6) Regular periodic monitoring, evaluation and re-planning of NHIS should be invoked.
7) There should be overt purposive commitment by governments at all levels who should as well provide oversight function in the running of NHIS in Nigeria.

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