

The National Health Insurance Scheme and Its Implication for Elderly Care in Nigeria

Eteng Ikpi Etobe (PhD)¹, Utibe Eteng Etobe²

¹Department of Sociology, University of Calabar, Calabar, Nigeria

²Department of Obstetrics & Gynaecology, University of Calabar Teaching Hospital, Calabar, Nigeria

Abstract: *The National Health Insurance Scheme (NHIS) is an attempt by the Nigerian federal government to adopt universal health coverage (UHC) for her citizens. The significance of this paper is to highlight lacunas in respect of aging programs and services in the National Health Insurance Scheme in Nigeria, with a view to suggesting areas of lapses in policy formulation and implementation for the elderly population. Currently, there are no overt programs and services for the elderly population in Nigeria because there has not yet been a policy for the care of seniors in Nigeria. This paper will as well make advocacy for the establishment of some facilities for the care of the elderly population in order to better the lot of this cadre of the Nigerian population.*

Keywords: NHIS, Elderly population, Elderly care.

1. Introduction / Definition of Concepts/ Significance of Paper

Nigeria, with an estimated population of about 168.8 million in 2012 and a population growth rate of 2.5 percent, is the most populous country in Africa and the 8th most populous country in the world. The country is structured into 36 component States and the Federal Capital Territory (FCT) from its original three regions structure at her independence in 1960 and twelve States structure at the wake of the civil war (1967-1970). It is divided into 774 Local Government Areas and six geo-political zones. Nigeria is a pluralistic society made up of more than 250 linguistic or ethnic nationalities which were amalgamated in 1914 by Fredrick Lugard. This highlights the potential challenges of managing such a heterogeneous country. Nigeria is ranked as one of the fastest growing economies in the world with a growth rate of 6.4 percent in 2007, and 7.6 percent in 2011. Nigeria's GDP per capita in PPP adjusted dollars is \$1,500 in 2011 and \$2,666 in 2012 (World Bank Report, 2013). According to World Bank Report (2013) one of the issues facing the country is balancing oil sector revenue and government spending. Over the last few years, the accrued oil revenue has not led to significant improvement in the welfare of the majority of the population. But with the global dwindling oil prices spanning from late 2013 till the close of 2014 which saw oil price fall below \$50, the provisioning of social services in Nigeria were abysmally executed during the period under review. About 112 million Nigerians (67% of the population) live below the poverty line with a life expectancy of 52years (males) and 58.6years (females) according to the 2012 World Bank estimates. Nigeria's health indicators have either stagnated or worsened during the past decade despite the federal government's efforts to improve healthcare delivery. Nigeria's life expectancy of 52.3years is below the African average of 56.05years, while child and maternal mortality rates are astounding. Annually, one million children die before the age of five due mostly to neonatal causes, malaria and pneumonia. Maternal mortality is 630 per 100,000 live births which is comparable to low-income countries such as Lesotho and Cameroon. An estimated 3.3 million Nigerians

are infected with HIV and access to prevention, care and treatment is minimal. Nigeria also continues to combat the double burden of both communicable and non-communicable diseases.

The National Health Insurance Scheme (NHIS) is an attempt by the Nigerian federal government to adopt universal health coverage (UHC) for her citizens. Dutta and Hongoro (2013) define UHC as ensured access to and use of high-quality health care services by all citizens and protection for all individuals from any catastrophic financial effect of ill-health. On their part, Gustafsson-Wright and Schellekens (2013) see UHC as referring to health systems providing both access to health services and financial protection which includes avoiding out-of-pocket payments that reduce the affordability of services and ideally some compensation for productivity loss due to illness. The 'elderly' as used in this paper refers to all persons of the population aged 65years and older in Nigeria. The significance of this paper is to highlight the absence or non-existence of aging programs and services in Nigeria, with a view to advocating changes in policy formulation and implementation of health programs and services so as to affect the elderly population. Currently, there are no overt programs and services for the elderly in Nigeria because there has not yet been a policy for the care of seniors in Nigeria. This paper will as well make advocacy for the establishment of such facilities in order to better the lot of the elderly population in Nigeria.

2. Literature Review

2.1 History of and rationale for NHIS in Nigeria

Nigeria has the highest out-of-pocket health spending and poorest health indicators in the world (Gustafsson-Wright & Schellekens, 2013) and this has been the propelling force for the Nigerian federal State to initiate the National Health Insurance Scheme. Its policy was drafted in 1997 and its legal framework signed into law in 1999 and launched for implementation on 16th June, 2005. It was designed with the aim at universal health coverage targeted at providing comprehensive health care at affordable costs to employees

of the formal sector, self employed, ruralites and indigent population of Nigerians (Onyedibe, Giyit & Nandi, 2012). The health situation in the country shows that only 39 percent of the population in 1990 and 44 percent in 2004 have access to improved sanitation. Also, in 1990-92 and 2002-04, 13 percent and 9 percent of Nigerians were undernourished respectively (UNDP, 2008). HIV prevalence in Nigeria in the age bracket 15 to 49 years was 3.9 percent in 2005 (UNAIDS, 2006). In an attempt to address the precarious and dismal situation in the health sector, and provide universal access to quality health care service in the country, various health policies by successive administrations were made including the establishment of primary, secondary and tertiary health care facilities across the length and breadth of the country. The perennial health challenges in Nigeria informed the decision by Gen. Abdulsalam Abubakar on May 10, 1999, to sign into law the National Health Insurance Scheme (NHIS) Decree Number 35 (NHIS Decree No. 35 of 1999); with the aim of providing universal access to quality healthcare to all Nigerians. NHIS became operational after it was officially launched by the Federal Government in 2005 (Kannegiesser, 2009).

2.2 NHIS Provisions for Elderly care in Nigeria

The provisions of the NHIS toward the health care needs of Nigerians is targeted at the formal sector of the population with emphasis on federal civil servants engaged in the Ministries, parastatals, agencies and extra-ministerial corporations. It provides for both outpatient and inpatient care for the insured, his/her spouse and four siblings under 18 years (Akande, Salaudeen & Babatunde, 2011). The general purpose of NHIS is to ensure the provision of health insurance "which shall entitle insured persons and their dependents the benefit of prescribed quality and cost effective health services" (NHIS Decree No. 35 of 1999, part 1:1). The specific objectives of NHIS include:

- 1) The universal provision of healthcare in Nigeria.
- 2) To control/reduce arbitrary increase in the cost of health care services in Nigeria.
- 3) To protect families from high cost of medical bills.
- 4) To ensure equality in the distribution of healthcare service cost across income groups.
- 5) To ensure high standard of healthcare delivery to beneficiaries of the scheme
- 6) To boost private sector participation in healthcare delivery in Nigeria.
- 7) To ensure adequate and equitable distribution of healthcare facilities within the country.
- 8) To ensure that, primary, secondary and tertiary healthcare providers are equitably patronized in the federation.
- 9) To maintain and ensure adequate flow of funds for the smooth running of the scheme and the health sector in general (NHIS Decree No. 35 of 1999, part II: 5; NHIS, 2009).

The provision of healthcare is a concurrent responsibility of the three tiers of government in Nigeria. The mixed economy practiced in the country gives room for private sector participation in medical care provision (Wikipedia, 2009).

NHIS is therefore operational through three broad categories of stakeholders-government, the private sector as well as other agencies appointed by government and international donor agencies. A breakdown of these stakeholders include government at all levels, employers (both public or private sectors), self employed, Rural Community Health Insurance Program agency, health maintenance organizations, board of trustees, health providers, commercial banks, NGOs, community leaders and the media (Executive Secretary NHIS, 2009). Government under the scheme provides not only standards and guidelines but ensures the enforcement of policies, monitoring of implementation and evaluation of programs and services for the smooth and effective running of the scheme. Apart from funding by government and donors or partnering organizations, employees under the scheme contribute 5 percent of their basic salaries and another 10% counterpart contribution by the employer toward the success of NHIS (Executive Secretary, NHIS, 2009). An overview of the provisions of NHIS shows that, virtually no provision is made for the healthcare needs and social security of the elderly population in Nigeria.

2.3 Inclusions versus Exclusions in NHIS:

Since the launch of NHIS in 2005 and its operations, it has been the major initiative to expand health insurance in Nigeria. Hospitalization as provided by NHIS is limited to 15 days. The extent of NHIS coverage this far is such that artisans, farmers, sole proprietors of businesses, street vendors and the unemployed are not captured (Onyedibe, Goyit & Nnadi, 2012). Again, certain health care services are not covered by NHIS and where some are covered, it is a partial coverage. For instance, some radiologic investigations and major surgeries e.g. magnetic resonance imaging (MRI), computerized tomography (CT) scan, laparoscopic or fluoroscopic examinations, mammography, hormonal assays, prostatectomy and myomectomy are given partial coverage while care for occupational or industrial injuries, cosmetic surgery, open heart surgery, neurosurgery, family planning and epidemic outbreaks are excluded from NHIS coverage. Also, injuries arising from natural disasters (earthquakes, landslides, tornadoes, hurricanes, etc.), social unrest/upheavals and terrorist attacks are excluded from its benefits package. Similarly, injuries from extreme sports activities such as car racing, boxing, wrestling, polo and other martial arts are not covered by NHIS. In addition, therapies accruing from drug abuse, addictions, sexual pervasiveness, organ transplant, surgical repairs of congenital abnormalities and purchases of spectacles are excluded. These exclusions of major illnesses and therapies show that, the NHIS is shallow and segregatory in its coverage. It does not give a holistic coverage thereby negating the philosophy of its establishment. It strongly allows for more out-of-pocket expenditure by insurers and preventing universal health coverage by citizens of the country.

2.4 Workability of NHIS

NHIS can be a major determinant of improved health outcomes for all citizens especially the poorest of the population who cannot afford the basic necessities of life. Since its launch in 2005 the scheme claims to have issued 5

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, 2007a&b&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&b&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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