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Opinion Article

National Health Insurance Scheme: A highly subsidized health care program for a privileged few in Nigeria.

ABSTRACT: THE NATIONAL HEALTH INSURANCE SCHEME OF NIGERIA WAS ESTABLISHED OVER A DECADE AGO WITH THE AIM TO ACHIEVE UNIVERSAL HEALTH COVERAGE WITHIN TEN YEARS OF INCEPTION. CURRENTLY THE POPULATION COVERAGE IS LESS THAN 10%, BENEFICIARIES ARE MAJORLY THE FORMAL SECTOR EMPLOYEES. AN ASSESSMENT OF THE THREE DIMENSIONS OF UNIVERSAL HEALTH COVERAGE IN THE SOUTHWEST GEO-POLITICAL ZONE OF NIGERIA IS ESSENTIAL TO DETERMINE THE GAPS IN THESE AREAS. THESE WILL BE OF ASSISTANCE FOR POLICY MAKERS IN THE EFFORT TO EXPAND THE SCHEME. METHODS: DATA WAS SOURCES FROM THE INTERNET WITH THE USE OF SEARCH ENGINES SUCH AS GOOGLE. DATA WAS ALSO OBTAINED FROM THE SOUTHWEST ZONAL OFFICE OF THE NATIONAL HEALTH INSURANCE SCHEME OF NIGERIA, AS WELL AS FROM OFFICIAL DOCUMENTS OF THE FEDERAL MINISTRY OF HEALTH OF NIGERIA. DATA ANALYSIS WAS DONE MANUALLY WITH THE AID OF MS- EXCEL. RESULTS: POOR HEALTH INDICES EXEMPLIFIED BY LOW LIFE EXPECTANCY AT 54 YEARS, HIGH INFANT AND UNDER 5 MORTALITY RATES OF 88 AND 143 PER 1000 LIVE BIRTHS RESPECTIVELY. MATERNAL MORTALITY RATIO WAS 630 PER 100,000 LIVE BIRTHS. ESTIMATED PERCENTAGE OF ENROLLEES OF THE POPULATION WAS 1.7. AT AN ANNUAL GROWTH RATE OF 2.7%, THE ESTIMATED POPULATION OF THE SOUTHWEST ZONE IN 2016 IS OVER 35MILLION PEOPLE OF WHICH ONLY 1.7% WERE ENROLLEES UNDER THE SCHEME. 75% OR ABOVE OF ENROLLEES IN THE ZONE ARE REGISTERED WITH JUST OVER 10% OF ALL THE ACCREDITED HEALTH FACILITIES. FUNDING OF THE SCHEME WAS SOLELY LIMITED TO CONTRIBUTIONS FROM THE FEDERAL GOVERNMENT WHILE BENEFICIARIES CONTRIBUTION IS NIL WITH A RESULTANT SHORTFALL OF ABOUT ONE-THIRD OF THE EXPECTED TOTAL FUND. CURRENT POPULATION COVERAGE OF THE SCHEME IN THE SOUTHWEST ZONE IS POOR, DISTRIBUTION OF THE ENROLLEES ACROSS ACCREDITED HEALTH FACILITIES IS GROSSLY SKEWED, AND FUNDING OF THE SCHEME IS INADEQUATE. THESE FINDINGS HAVE NEGATIVE IMPLICATIONS ON EFFICIENCY IN SERVICE DELIVERY, EQUITABLE ACCESS TO QUALITY HEALTH CARE SERVICES. STAKEHOLDERS MUST ADDRESS THESE GAPS THAT UNIVERSAL HEALTH COVERAGE IS ACHIEVED.

Keywords: *National Health Insurance Scheme, labor unions, formal sector, health indices, UHC*

1. INTRODUCTION

To enable individuals have access to needed health care, globally, stakeholders resolved to move towards universal health coverage (UHC) at affordable cost. This is not unconnected with the poor health indices most prevalent in low income countries, and is worst in the sub-Saharan Africa especially [1, 2]. Apart from general tax-funded method of financing healthcare, social health insurance has been

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acclaimed as the next best form of achieving UHC after general tax funding system [3].The concept of Social health insurance (SHI) to fund health care started in Germany over a hundred years ago [4]. France, Netherlands, Switzerland, Sweden and other European countries adopted SHI thereafter. In these countries, SHI is coupled with other prepayment methods of funding health care such as the private health insurance and general tax-fund [3]. The much better health indices in these countries is largely attributed to prepayment methods, as opposed to out-of-pocket (OOP) payment system prevalent in majority of the low income countries. OOP payment fosters inequitable access to health care, delay or non-utilization of care, impoverishes individuals and households and contributes in no small way to the high morbidity and mortality as experienced in majority of the developing economies [5]. Among the low and middle income (LMICs) countries where OOP is more prevalent, Asian countries for example Thailand and South Korea, fare better than countries in Africa, especially those in the sub-Sahara region [6].

In Africa, few countries had shown promising SHI schemes. Ghana, South Africa, Rwanda and Kenya are typical examples [7]. However, there still remain more challenges to implementing successful and sustainable prepayment schemes for health in these countries as the case is in almost all of the African countries. Some of these challenges are the absence of factors that could facilitates the implementation of sustainable SHI scheme. Factors such as individual and household financial capabilities to pay prescribed premium, adequate technical and administrative skills to manage a SHI scheme and a largely formal sector setting are major [4]. Collecting premiums for prepayment schemes in an efficient way as a result of the predominantly large informal sector population is still a daunting task for stakeholders in African countries [6].

One of the cardinal features of a SHI scheme is that the contribution (premium) is made by the insuree either solely or with a part contribution from the employer while the employer pays the remaining. SHI schemes unlike the general-tax funded health care could be more transparent, more acceptable to the public and almost free from political manipulations, as opposed to a typical general tax-funded health care program. However, the biggest of these could be the place of the ‘voice’ of the contributors to SHI scheme. Generally, contributors could be more vocal to demand for better services and partner with other stakeholders to facilitate its development and sustainability. These peculiar attributes of SHI scheme

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could stimulate universal health coverage [3, 4]. There are three dimensions of UHC; Direct costs: what proportion of costs are covered, services: which services are covered and population: who is covered? The extent to which the challenges peculiar to each of these dimensions is addressed will determine the extent and the speed of achieving UHC [6].

Awareness of, and UHC through prepayment schemes such as a SHI is low, with an attendant gross inequity to health care utilization [8].A high level of awareness among the potential beneficiaries, better understanding of the basic concepts and of the benefit package of a SHI are essential to ensure acceptance of a Scheme and thus, facilitate UHC. A study by Arin and Hongoro (2010) has shown that persistent and aggressive advocacy at the national and the sub-national levels is essential to engender a sense of ownership of the scheme among potential beneficiaries [9]. Studies have shown that well above half of a population could be enrolled into a prepayment scheme within a space of a decade of its commencement [10]. If the design and implementation of the scheme is tailored to address the peculiar challenges. Thus, it is important to examine the challenges associated with the three dimensions of UHC with regards to the scheme in Nigeria. This will be of assistance in proffering the way forward for the scheme to achieving its objectives.

1.1 Nigeria; Geo-Political Description

Nigeria is a country in West Africa. It lies 5 degree North of the Equator and between 3 degree and 4 degree of the Greenwich Meridian. It is bordered on the South by the Bight of Benin and the Atlantic Ocean, on the North by the Republic of Niger and Chad, on the East by the Republic of Cameroon and on the West by the Republic of Benin. Nigeria has a land mass of 923,768 km square [8]. About a decade ago, Nigeria population stand at 140 million people, [11] and at an annual growth rate of 2.7% per annum, [12] current population estimate is 178 million people.

Although almost 70% of the population live on less than $2 a day, Nigeria has a GDP of $568.5 million, and is currently classified as a Lower middle income country. However, available health indices reflects a weak health system, whose performance is lower than other nations in the African Region that has a much less health care resources (see Table 1).

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Achieving previous United Nations health development agenda, Concepts and Goals has failed [13]. It is doubtful that the present health – related Goals will be met, if important issues are not appropriately addressed timely. Politically, Nigeria operates a Federal System of Government at three levels; the Federal, State and the Local Governments Areas (LGAs). There are 36 states and the FCT (federal capital territory). The FCT has the status of a state. The States and the FCT has a total of 774 Local Government Areas (LGAs) as the smallest administrative units in the entity. The 36 states and the FCT are re-grouped into 6 geo-political zones as shown in the table below. Of the six geo-political zones in Nigeria, the South West zone has one of the well-resourced health sector and best indices available in the country [8, 14].

Like the USA and France, Nigeria runs a federal/presidential system of government, where except in defense and economy, the sub-national governments (States and the LGAs) are autonomous and thus, possess legislative power to determine direction of other sectors. The health sector is one of these [15].

1.2 The National Health Insurance Scheme (NHIS); A Brief Background

As aforementioned, in order to improve access to quality health care services and health status of the citizens, the National Health Insurance Scheme was established in 1995. It became operational in 2005. The NHIS is a public-private-partnership between the NHIS, the Health Maintenance Organizations (HMOs) and health care providers (private and public). The overall objective is to secure universal health coverage and access to adequate and affordable health care, in order to improve the health status of the citizens. It had the mandate to achieve this (UHC) within a period of ten years from its inception (2005-2015). While the NHIS shapes the health insurance policy by licensing the HMOs that operates the health insurance business, it also accredits health care facilities to provide the benefit packages to registered enrollees. The HMOs has the responsibility of purchasing health care services on behalf of the Scheme for registered enrollees. Currently, there are 62 HMOs contracted by the NHIS to function under the Scheme. However, of these HMOs, just 5 has a total of 75% of the current enrollees. Under the present arrangement, an individual federal government worker is entitled to register a spouse and four children under the age of 18 years. Enrollees choose preferred health facility to receive care [16].

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To ensure an effective coverage of the populace, the Scheme has specific program for different segments of the society. These are the Formal Sector Health Insurance Program for the Federal Civil servants, Urban Self-employed Social Health Insurance Program, Rural Community Social Health Insurance Program, Children under Five Social Health Insurance Program (also covers pregnant women), Permanently Disabled Social Health Insurance Program, Prison Inmates Social Health Insurance Program, Tertiary Institutions and Voluntary Participants Social Health Insurance Program and the Armed Forces, Police and other Uniformed Services Insurance Program (captured under the Formal Sector Program). However, of all these Programs, only the Formal Sector Program is functional [17].

Of the 23,640 health care facilities available in the Country, only 7,300 representing 31% of the facilities were accredited by the NHIS to provide services to registered enrollees. Currently, 4.5million people representing 3% of Nigeria's population are covered under the Scheme. This percentage is mainly in the formal sector, the over 75% in the informal sector are largely not covered yet. Under the present arrangement, the employer contributes 10% of the basic salary of the insured while the remaining 5% is undertaken by the employee. Lately, this has been revised to 3.5% and 1.75% of the basic salary by employers and employees respectively. However in reality, this formula is not operational, as the Federal Government pay 750 naira per life insured on quarterly basis, while the insured has no financial contribution into the Scheme. Till date, the Act that established the Scheme makes it voluntary for individuals to enroll; thus, the existing trade unions in the Country, the Nigeria Labor Congress (NLC) and the Trade Union Congress (TUC) refused a buy- in into the Scheme. Although, the NHIS is responsible for accreditation of the HMOs and the HCPs, as well as request compliance with the rules of engagement by them (HMOs and HCPs), it does not have sufficient powers to enforce these, instead, the power to prosecute a stakeholder for contravening any provision of the Act is vested in the Legal Officer in the Ministry of Justice of the State. This arrangement undermines the role of the NHIS as an effective regulator of health insurance. Thus, complaints made by clients about the HCPs or the HMOs, or made by the HCPs about the HMOs or vice versa are hardly appropriately addressed [16]. Recently, there was a reform to devolve the insurance Scheme to the sub-national governments (States) to operate, using the template of the NHIS and with technical oversight from the NHIS. This approach, it is hoped will encourage a sense of ownership of the health insurance in the States and thus, expand the coverage.

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Very recently, the NHIS has devolved to the federating States to operate state-run social health insurance schemes with technical support from the NHIS [18].

Implementation and expanding health insurance schemes in developing economies characterized by very large informal sector population, poor funding and inefficient fund collection mechanisms can be very difficult. These factors among others excluded millions from having access to quality health care services in affected nations with resultant and persistent poor health indices and development [1, 2, 19]. To the best of our knowledge, studies that examines location-allocation of health insurance enrollees by facility and by principal enrollee as well as the gap in fund generated is rare in this environment. An assessment of the extent of universal coverage achieved by the Scheme in the South West geo-political zone is important to objectively assess the likely existing gaps. This could serve as a yardstick to gauge the Scheme's performance in other geo-political zones in Nigeria. It will also be of assistance in planning to improve the Scheme's performance.

2. MATERIAL AND METHODS

Search engines mainly Google was used to access secondary data from the World Bank website on health indices. Some of these indices were also obtained from the Strategic Review of Nigeria's National Health Insurance Scheme, a report of the Federal Ministry of Health on the NHIS. Nigeria population census figure was obtained from the (Nigeria) National Population Commission website. Data on the number of enrollees, accredited facilities and the distribution of these by State in the South West geo-political zone was obtained from the NHIS Southwest Zonal Office in Ibadan, Oyo State Nigeria. The available data were manually analyzed with the aid of the MS – Excel. Appropriate tables to align with the study objectives were generated.

3. RESULTS AND DISCUSSION

Table 1 shows some of the selected health indices in Nigeria. Low healthy life expectancy at birth and a high maternal mortality ratio. Current health expenditure per capital is $118 while OOP is 95.7%. Only 3.7% of the total GDP is allocated to health. Total fertility rate of 5.7 which is considered to be on the high side.

Table 1. Comparison of selected health indices of Nigeria and Africa

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Serial No	Health Indicator	Nigeria	African Average 2010
1.	Life expectancy at birth	54	54
2.	Maternal Mortality Ratio (per I00,000 live births)	630	480
3.	% 1 year olds immunized against measles	71	76
4.	Adolescent birth rates (per 1000)	123	117
5.	Infant Mortality Rate (per 1000 live births)	88	75
6.	Under 5 Mortality Rate (per 1000 live births)	143	119
7.	Prevalence of HIV (per 100,000) 2009	2104	2740
8.	Prevalence of TB (per 100,000)	199	332
9.	Fertility rate, total (births per woman)	5.5	4.8
10.	Health expenditure, public (% of total health expenditure)	25.1	-
11.	Health expenditure, total (% of GDP)	3.7	-

Source: Strategic Review of Nigeria's National Health Insurance Scheme

Table 2 below shows that the estimated population of the South West zone of Nigeria is using the current World Bank value of annual population growth rate of 2.7% per annum is 35,207,488 an increase in population growth of 27% (7,485,056.7) in the last ten years. At the current estimated population, the proportion of the enrollees to the total population is 1.7% (580,014/35,207,488), while the average number of dependents per principal enrollee is less than two individuals across the states and overall in the zone.

Table 2. Pattern of distribution of enrollees across South West Zonal states and NHIS accredited health facilities

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Serial No	State (A)	Principal (B)	Dependants (C)	Total NHIS accredited health facility in the State (D)	2006 Census Population Figure	% Population Increase, 2006 – 2016 (2.7% World Bank Annual Growth Rate)	Total Enrollees (B + C)	Average no of Enrollees per Principal (C/B)	Average enrollees per facility (C/D)
1.	Ekiti	13592	22555	27	2,398,957	3,046,675.4	36147	1.7	1339
2.	Lagos	93643	155312	578	9,113,605	11,574,278.4	248955	1.7	269
3.	Ogun	21978	40317	44	3,751,140	4,763,947.8	62295	1.8	916
4.	Ondo	18193	32926	63	3,460,877	4,395,313.8	51119	1.8	522
5.	Osun	22440	38244	49	3,416,959	4,339,537.9	60684	1.7	780
6.	Oyo	40926	79888	165	5,580,894	7,087,735.4	120814	1.9	484
Regional estimate		**210,772**	**369,242**	**926**	**27,722,432**	**35,207,488.7**	580,014 1.7% of 2016 estimated Southwest Region population	**1.8**	**718**

Table 3. Population distribution and growth pattern among zones in the last ten years

The analysis of the National Population distribution shows the South West geo-political zone as the second most populated after the North West zone, while the South East is the least (Table 3).

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Geo-Political Zones	**States**							**2006 Pop**	**Estimated 2016 Pop @2.7% growth rate per annum**
North West	Jigawa	Kaduna	Kano	Katsina	Kebbi	Sokoto	Zamfara	35,915,467	45,612,643.1
North East	Adamawa	Bauchi	Borno	Gombe	Taraba	Yobe		18,984,299	24,110,059.7
North Central	Benue	FCT Abuja	Kogi	Kwara	Nasarawa	Niger	Plateau	20,369,956	25,869,844.1
South West	Ekiti	Lagos	Ogun	Ondo	Osun	Oyo		27,722,432	35,207,488.6
South East	Abia	Anambra	Ebonyi	Enugu	Imo			16,395,555	20,822,354.9
South South	Akwa – Ibom	Bayelsa	Cross-River	Delta	Edo	Rivers		21,044,081	26,725,982.9
Total								**140,431,790**	**178,348,373.3**

In Table 4, the distribution of the total enrollees by accredited facilities in the Southwest geo-political zone indicates that at least three-quarter of the total enrollees across the states as well as overall in the zone were located in less than twenty per cent of the accredited facilities.

Table 4. Pattern of enrollees' distribution in NHIS accredited facilities across South West zone

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State	Total no of enrollees per State	Total no of NHIS accredited facilities per State	NHIS accredited facilities with ≥75% of registered enrollees
Ekiti	36,147	27	4 (14.8)
Lagos	248,955	578	75(12.9)
Ogun	62,295	44	7(15.9)
Ondo	51,119	63	9(14.3)
Osun	60,684	49	5(10.2)
Oyo	120,814	165	20(12.1)
Total	**580,014**	**926**	**120 (12.9)**

The Federal Government pays a sum of seven hundred and fifty naira per life insured per quarter. For the lives insured in the SW geo-political zone, this amounts to 1,740,042,000 naira per annum. If the arrangement of 10%:5% contributory ratio between employer (Federal Government) and the employees (Federal Civil Servants) is operational, the contribution from the employees should be half of that from the Federal Government. As shown above, the monthly financial resources to the pool for the SW zone enrollees should be 2, 610,063,000 naira (equivalent of $13,091,600). Fig.1

Fig 1. Financial contribution/revenue generation base for the South West Geo-Political Zone

Total revenue generated per annum

= N750 x 580,014 x 4 times in a year for Southwest geo-political zone

= N1, 740,042,000 (10%)

= $8,727,700 actual ***revenue***

Expected revenue = N1, 740,042,000 (10% of basic salary) + N870, 021,000 (5% of basic salary)

= N2, 610,063,000

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= $13,091,600 ***expected/possible revenue***

($1 = N199.4) *Ref; Oanda currency converter 1st May 2016*

4.0 Discussion

As shown in Table 1, the poor health indices exemplified by low life expectancy, high maternal mortality ratio, high infant and under 5 mortality rates among others, to some extent are a reflection of poor investment in the health system. This is shown by the very low health expenditure as a percentage of GDP as well as low public spending on health [12].Poor investment or inadequate investment in the health system impacts negatively on the system including physical infrastructure, diagnostic equipment, hospital consumables and logistics systems. Health human resources welfare and development are likely to be affected; Poor and irregular remuneration of health care personnel might lead to emigration of these individuals a phenomenon referred to as 'brain-drain' with untold adverse consequences on the delivery of health care services to those who need to access health care services. Other reasons that can be alluded to this poor health indices is the out-of-pocket (OOP) method of financing health care by the majority of the people. OOP method of health care financing is highly regressive and promotes inequality of access to needed health care services. It results in delay of utilization of health care, and or not utilizing it at all [5].Spread of treatable infectious diseases to otherwise non-infected people, development of chronic illnesses, disability and mortality are the usual outcomes [1, 2].In an environment where TFR is quite high, to meet up with the challenges of population increase, stakeholders must devise means of efficiently expanding the scheme to those who are not yet covered.

Of the current estimated population of the South West zone, less than 2% are enrollees in the NHIS. Considering the fact that the SW geo-political zone is one of the two best zones (the other one is the South East zone) in terms of some parameters such as access to and utilization of health services and thus a much better health indices, [8] it speaks volumes of the state of the same parameters in other zones that are less endowed. If less than two percent are under a prepayment scheme such as the NHIS, more than 98% of the SW citizens are without doubt paying for health care services through the OOP payment system. This scenario is in conformity with the present World Bank figure of the size of the population using OOP as a method of paying for health care services in Nigeria [12].

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Estimated length of time required to achieve universal coverage differs from clime to clime based on specific and individual country-contextual factors. While it has taken many of the European countries a century to achieve this, it is advocated that an average of half of a century would be needed for aspiring countries to do so. However, a number of Asian countries have achieved UHC in less than 50 years. It has been advocated that enrolling families instead of individual workers could facilitate the achievement of UHC faster than the individual worker enrolment approach [4]. Presently, family enrolment approach is the practice in majority of the African countries, including Nigeria [16]. Studies have shown that on average, it would require a decade to achieve a population coverage of between 60% – 90 % [10]. It is noteworthy that Ghana and Nigeria commenced SHI schemes the same year, 2005. Though, it fell short of the predicted mark, Ghana had covered about two-thirds of its total population within a decade of its existence, comprising both the formal and the informal sectors, and in both the urban as well as the rural areas[20]. This is a lot better compared with Nigeria where the population coverage presently stand at between 4%-6% and limited to the formal sector workers[16].The present coverage figure has also shown a gross under- achievement of the NHIS. Whereas, the NHIS set an ambitious goal of achieving UHC within a period of ten years of its establishment, till date it has not been able to achieve one-tenth of that in more than a decade of its establishment. This is in contrast to Ghana that has kept to expectations in terms of the extent of coverage [7, 10].

In this study, analysis shows that an average principal enrollee takes responsibility to pay for the costs of health care of less than two dependents. This is despite the fact that the Total Fertility Rate (TFR) in Nigeria is above five. This is an encouraging evidence to demonstrate the effectiveness of prepayment schemes in risk and cost sharing especially when large numbers of people are involved in such schemes. Cost and risk sharing are tools to ensure that as many as possible number of people are enrolled in prepayment schemes for health, have better access to and thus, reduce inequity of access to needed health care. This can be used to market the concept of prepayment schemes to potential beneficiaries as well as decision makers at all levels and especially opposition voices like the labor unions.

One of the means of achieving universal coverage is by increasing the revenue base of a prepayment scheme. Making health insurance mandatory for all will increase the revenue base much more than when it is voluntary. This is evident in countries that have achieved universal coverage in developed economies

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of Europe, and in many of the Asian countries [3]. It is also the case in countries like Rwanda and Ghana. Increasing revenue base through innovative funding mechanisms as it is presently done in countries like Gabon, Ghana and Zambia are examples that could be explored [6]. Of the three dimensions of universal coverage, sufficient revenue generation in an efficient manner is important. Presently, the only source of fund into the pool of the NHIS is from the employer (Federal Government). Whereas the employee is expected to contribute, the labor unions have strongly opposed this since inception of the Scheme [16, 21]. As a result, the financial losses amounts to half of the revenue generated solely through Employer's contribution on periodic basis. Despite the refusal to make financial contribution to the Scheme, the federal civil servants continue to enjoy the benefits. This worsens the existing inequity of access to health care services. The scenario amounts to gross inequality as those who are enrolled have easier access to health care services making use of the public fund, at the expense of the general populace who for some reasons are yet to be enrolled. This class of people are majorly in the informal workforce and vulnerable groups whose income are usually poor and irregular. Also, it is common that the design of many available prepayment schemes for health are unfavorable to their financial capacity. They are thus left with no alternative than OOP system and other regressive methods of financing health care, resulting in catastrophic health expenditures, poverty and poor health outcomes [19, 22, 23]. One of the ways to do this is through persistent advocacy consultation with the relevant stakeholders, [9] especially the labor unions and the politicians. Objective evidences of the benefits of the Scheme such as risk and cost sharing mechanisms as has been demonstrated in this study (Table 2) could be used sell the Scheme to them. The importance of having a healthy workforce for development should be emphasized.

In a recent report, it was stated that above three – quarters of the enrollees were registered with only 8.1% (5/62) of all accredited HMOs working on the Scheme [16]. In like manner, three – quarter or more of the enrollees registered with less than one-fifth of the accredited health care facilities in the SW geo-political zone. Similar pattern exists in all the states in the Zone. It is not better at the national level as less than one-third of all accredited health care facilities are currently providing services to the enrollees. Skewed distribution of the enrollees across accredited facilities have implications on access to care, efficiency of service delivery and the quality of care rendered. For any reason such as proximity or perceived quality of care,[24-26] some health care facilities could be over-patronized while the opposite is

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the case for some others. In the facilities that are heavily patronized and despite adequate financial coverage, access to quality health care may be seriously compromised as the benefit package may not be delivered even if it is available [27]. Overburdened facilities may become grossly inefficient in service delivery resulting in long waiting hours for clients 28]. As it is not unlikely that many enrollees come from far distance, traveling to access health care services in faraway facilities could have negative impact on health outcomes for individuals [26, 29]. It could also result in delay seeking care or not seeking care at all [5, 24]. For individuals travelling a considerable distance, transportation costs could result in high indirect cost of seeking care thus an unfavorable cost-benefit ratio [26].

5. CONCLUSION

Politically or at the best in policy statement, there is a social health insurance scheme in Nigeria. However, and at the best technically, what currently exists is a pseudo-social health insurance scheme, a program that subsidizes costs of health care for a privileged few. To establish a genuine SHI scheme that could achieve UHC, the government and other stakeholders need to work on the three dimensions of a UHC. Increasing the revenue base by making the scheme compulsory is a step in the right direction. Transitioning to a mandatory status will require an appropriate amendment in the Act that established the present scheme. Involving the present and the potential beneficiaries to achieve a buy-in is important. The recent approval by the National Council on Health to devolve the Scheme to the federating entities as States Supported Health Insurance Program (SSHIP) is a welcome development.

Consent

Data used was obtained by official permission of the National Health Insurance Southwest Zonal Office

Ethical approval

Permission obtained from the Southwest NHIS Zonal office

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