# Administrative Challenges of the National Health Insurance Scheme in Nigeria

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***Abstract***
*The study empirically examined the challenges health administrators encounter in the usage of the National Health insurance scheme and the possible ways of handling those challenges. A descriptive study design was employed using key informant interview approach. Nine (9) respondents were handpicked for the study. The study revealed that administrators experience great challenges ranging from: inadequate implementation policies, low level of awareness ineffective mode of payment etc. To this end, the study recommends that mass sensitization should be encouraged, strict administrative and regulatory oversight be harnessed, increase in usage of information and communication technology. These issues the stakeholders need to address in order to ensure reduced challenges to boost healthcare provision to the beneficiaries.*

***Keywords:*** *Administrative challenges, health insurance, health coverage, care providers.*

## INTRODUCTION

Health insurance is an important mechanism to preventing financial hardship in the process of accessing health care. Since the launch of Nigeria's National Health Insurance Scheme (NHIS) in 2005, only 5% of Nigerians have health insurance and 70% still finance their healthcare through Out-Of-Pocket (OOP) expenditure. Understanding the contextualized perspectives of stakeholders involved in NHIS is critical to advancing and implementing necessary reforms for expanding health insurance coverage at national and sub-national levels in Nigeria. In improving access to quality healthcare services, the World Health Assembly in 2005 has increasingly called for countries to prioritize universal health coverage (UHC). This remains a viable means of providing appropriate promoter, preventive, curative, and rehabilitative services at an affordable cost for all Thus, globally stakeholders have laid much emphasis on funding mechanisms of health systems. Aside the tax-based (Beveridge model) method of health financing, the social health insurance (SHI) (Bismark model) which has its root in Germany in the nineteenth century is one of many approaches used to address the challenges related to providing access to health care services for the poor segments of the population Saltman (2004). However, other different models of health financing exist such as the Medical Savings Account – (self – reliant/funding) in Singapore Busoi (2010) and the Affordable Care Act (Obama Care) USA, Community Based Insurance, and Private Health Insurance. Healthcare financing plays a critical role in the strengthening of a nation's health

system which necessitates the implementation of sustainable health financing structures and monitoring of progress towards achieving UHC WHO 2011.

A health insurance scheme has been defined as an arrangement in which contributions are made by or on behalf of individuals or groups (members) to purchasing institution (a fund) which is responsible for purchasing covered services from providers on behalf of the members of the scheme, Kutzin (1997). A social health insurance scheme involves contributions based on means and utilization based on need. It holds strong potential to improve financial protection and enhance utilization among enrolled populations. This underscores the importance of health insurance as an alternative health financing mechanism capable of mitigating the detrimental effects of user fees, and as a promising means for achieving universal healthcare coverage Spaan et al (2012).

## HISTORY OF NHIS

The history of NHIS could be traced back to 1962. However, the scheme became operational in 2005 as a tripartite public-private arrangement among three main stakeholder operators; the NHIS, the HMOs and health care providers. The other stakeholder are the enrollees under the scheme NHIS 2012. The primary aim is to ensure UHC that could enable improved access to health services and thus, a better population health outcome. It had the goal to achieve UHC within a period of 10 years from its inception (2005–2015). While the NHIS shapes the health insurance policy by accrediting the HMOs that operate within the health insurance space, it also accredits health care facilities to provide the benefit packages to registered enrollees. The HMOs are in charge of purchasing health care services on behalf of the Scheme for registered enrollees. The scheme has different programmes for different population groups in the country such as the formal and informal Sector Social Health Insurance Programme NHIS report 2005, NHIS report 2012. NHIS is a pro-poor policy with the potential to promote access to needed quality health care among Nigerian populace and reduce the rate of uninsured as was reported in the ACA in America Obama (2016). However, opinion is polarized among stakeholders on the efficacy of the scheme in addressing the health situation and poor health outcomes in the country Agba (2010).

Thus, there is a growing need to correct the persistent poor coverage by assessing the design and administrative challenges of the scheme. This will provide an objective assessment of the situation for policy actors.

## MATERIAL AND METHOD

The study was a descriptive case study design that employed qualitative methods using key informant interview (KII) with expert actors in the health insurance space in University of Calabar Teaching Hospital, Calabar, Cross River State, Nigeria. Nine KII were carried out among purposively selected health insurance stakeholders, consisting of 5 males and 4 females between the ages of 30 and 60 years, a mean age of 43.9 years who are major stakeholders in the NHIS department of the establishment whose organization had been operating in the health insurance industry and providing services to enrollees for more than 3 years. The average length of the interview was 45 min Interviews were tape-recorded with permission and informed consent obtained from stakeholders, and also, side notes were taken. The interviews were conducted in English Language as the official language of communication. The Health Care Provider (HCPs) was the most patronized and has a large enrollee base. The state coordinating office of the NHIS is located at Atekong by Marian, Calabar.

## RESULTS AND DISCUSSION

Administrative challenges such as inadequate implementation policies poses a higher degree of threat to the beneficiaries , low level of awareness, low interest (in the scheme), superstitious beliefs, inefficient mode of payment, drug stock-out, weak administrative and supervisory capacity. The scheme is believed to have provided more coverage for the formal sector, its voluntary nature and lack of legal framework at the sub-national levels were seen as the overarching policy challenge. Only NHIS staff currently makes required financial co-contribution into the scheme, as all other federal employees are being paid for by the (federal) government. The study found that NHIS is skewed towards the formal sector raising huge concerns about equity and financial risk protection for those outside the sector. Despite the introduction of Social Health Insurance (SHI) in Nigeria over a decade ago, a greater percentage of health services are paid for through direct user fees Onwujekwe (2010). Besides the payment made by voluntary contributors, most federal employees who are covered under the scheme do not co-contribute to the scheme. This is at variance with payment arrangement between employees and employers as stipulated in the NHIS guideline NHIS report 2012. This provides federal civil servants with more access to health services than employees in the state and the local government service as well as the self-employed Agba (2010). An exception was made as regards the employees of the National Health Insurance Scheme who have started co-contributing to the scheme in line with the guideline and sustainability model.

Although, majority of the stakeholders believe the capitation is adequate to purchase basic minimum care packages for the enrollees, opposing views came from health care providers who strongly believe that the capitation does not reflect the economic realities of the day hence, it should be reviewed for an increase. The provider-payment system found in this study viz.; capitation and fee-for-service are equivalent to that being practiced in Ghana's NHIS, and although there were complaints by providers on the system according to the study, amount of money was not mentioned unlike that of this study Amo et al (2015). A key finding was that enrollees are no longer assigned to HMOs as was the usual practice before. Likewise, there is freedom of enrollees to choose their providers as this could have been influenced by the quality of care and services rendered, incentives, location among others. This could lead to lopsidedness with some HCPs having large enrollees base as was found out by a study in Ibadan city where it was observed that more than half of current enrollees are concentrated between just three providers out of the 132 accredited providers Adewole (2016). Although stakeholders perceived this to be of advantage in terms of improving competition and quality assurance among the service providers, however, this may equally make other providers with fewer enrollee base feel shortchanged. The importance of health providers as 'street-level bureaucrats' whose engagement with patients and the policymaking process can influence policy implementation have been demonstrated in several studies, hence ignoring provider concerns may create an implementation gap especially in the area of consumer quality care Gilson (2001), (Kamu ,2015), (Walker, 2004).

There exist a number of measures put in place to ensure the quality of services by the stakeholders. This must have contributed to the high satisfaction of enrollees towards the scheme as reported by Osungbade et al (2014). This notwithstanding, other dissatisfying issues especially the delay in processing authorization code by Health Management Organization (HMO) when enrollees are to be referred to secondary or tertiary health facility continue to plague the scheme and negatively impact satisfaction Owunmi (2013).Previous studies have shown that social health insurance have facilitated access to health care and also have reduced out-of-pocket expenses among members. However, low level of population coverage is common Ogaboh (2010), Onoka et al (2013), Saraki (2010). Social health insurance schemes in other sub-Saharan African countries such as Ghana, Senegal and

Rwanda have been reported to perform better Chuma (2013), Ministry of Health report 2008, Adeyemi (2014). The poor achievement of the scheme in this regard in Nigeria unlike in Ghana has been attributed to many factors including the type of political institution and structure Nigeria operates Adewole (2015). Furthermore, Carrin and James Carrin et al (2005) reported the numbers of years of transition it took countries like Austria (79), Belgium (118), Costa Rica (20), Germany (127), Israel (84), Japan (36), Republic of Korea (26) and Luxembourg (72) to reach universal health coverage via social health insurance. However, previous studies have predicted more steady transitions to universal coverage, with coverage levels at 60–80% in just 9 years after implementation Carrin et al (2005). With the present post implementation population coverage of Nigeria at 5% in 15 years, it may take Nigeria about 180 years to implement universal coverage to the same level as those of Ghana, and Rwanda to extend coverage to the self-employed and those on low income levels. Several challenges serving as major constraints to the successful implementation of the scheme were highlighted making the attainment of universal coverage in Nigeria a far-reaching dream. Some of the challenges are not new and have been reported by previous studies Thomas et al (2011). Furthermore, the major lacuna in the Act establishing the NHIS which made it voluntary persists. It creates a loophole for major players and potential enrollees to exploit as compared with what obtains in Ghana, Rwanda, and Tanzania where the SHI is mandatory Chuma(2013).

Stakeholders' opinion on how to improve, scale-up and sustainably implement the scheme as found in this study was in line with recommendations of researchers over the years to achieve global best practices with consideration to our local context Iloh et al (2013). However, the issue remains how these recommendations are adopted and translated into practice.

According to Cassells (1995), actors' interests and power imbalance among them usually results in conflicts especially when it has to do with resources allocation American Heritage report (2000). This was the case of NHIS where most states resisted the adoption of the scheme, attributing it to lack of transparency since they were not allowed in the governance role Onoka et al (2015) Hence the need for reform as this will fast track better implementation of the scheme at both the state and local level thereby reducing the levels of poverty and catastrophic health spends. The findings revealed that not all stakeholders were aware of the reform about the decentralization of the NHIS to the state level in terms of state supported health insurance scheme (SSHIS). However, the favorable disposition of all stakeholders to the reform is highly commendable, especially considering that reforms involving policies for social health insurance may result in conflicts because the outcome may favor or disfavor various interest groups Carrin (2005). The important success factors and strategies for improving coverage among the informal sector as suggested by the stakeholders especially making the scheme mandatory, increasing awareness and encouraging those in the informal sector to form groups/associations and buy-into the community based health insurance may enhance the success of the reform. "Although, people may be willing to pay, however, because the majority of them in this environment are poor Chuma (2013), the capacity to pay the premium, especially on regular basis could be weak. This inadvertently affects a successful and sustainable implementation of the scheme. As there is no data bank of the population outside of the formal sector in Nigeria similar to the situation in the majority of the developing countries especially in the sub-Saharan African countries, this study recommend that efficient platforms to enroll the informal sector be designed. Promoting sub-national schemes such as community based health insurance schemes and the currently approved state supported health insurance program Adewole (2019) in Nigeria will be of assistance as they are closer to the people than the national scheme (NHIS). The community-based schemes could be re-insured to enhance a more financially viable and

stable schemes Layton (2016). Also, subsidies with full fee exemption for the most poor and a sliding –scale premiums Mills (2002), for other categories of the poor should be introduced. Again, poor attitude or low level of interest stems from many factors such as negative superstitious belief about prepayment schemes, and low level of trust in government health interventions Jegede (2007). This study recommends genuine efforts to build the trust of the people in government policies. This can be achieved through implementation of beneficial social policies in communities and making efforts not to breach agreements on the part of the government. Negative perception of the people about prepayment schemes could be addressed through intensive and sustained health education and advocacy to the communities of potential beneficiaries Arin (2013).

## RECOMMENDATIONS AND CONCLUSION

National Health Insurance Scheme administration in Nigeria is not effective and efficient enough. The coverage is skewed and inequitable, especially among the informal sector. Most of the Federal workers do not co-contribute to the scheme in line with the NHIS guideline raising concerns about sustainability and equity. The scheme still faces daunting challenges especially poor awareness about benefit packages among potential beneficiaries, voluntary nature of the scheme, poor service delivery by HCPs, and delay in issuance of authorization code by the HMOs, inefficient mode of payment, and weak administrative capacity of the regulatory body. In addition are wide spread poverty and lack of database for the informal sector, low interest of the people in the scheme, superstitious or religious believes, low adoption rate of reform at the sub-national level, bureaucracy among others.

Amending the NHIS Act, mass sensitization, capacity building for actors, increase use of ICT, organization of the informal sector, strict administrative and regulatory oversight has been suggested as ways to improve the effective implementation of the scheme. The various reforms of the scheme at the state level were wholly supported. Hence, there is a need for all stakeholders to work harmoniously to address these challenges. Also, sustained political will is required from policy actors and leaders to back various reforms put in place to attain the milestone of UHC by 2030.

Sub-national governments should create legal frameworks establishing compulsory health insurance schemes at the subnational levels with effective and efficient platforms to get the informal sector enrolled in the scheme as desired.

Awareness and education should also be raised to enlighten Health Care Providers and Staff in University of Calabar Teaching Hospital. Stakeholders need to address these gaps as well as poverty.

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