

National Health Insurance Scheme (NHIS) and Employees' Access to Healthcare Services In Borno State, Nigeria

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Abstract: There are many policies and programmes introduced by Government to improve healthcare services in Nigeria which Borno State is not exclusive One of these policies and programmes is National Health Insurance (NHIS) introduced in 1962. It is in view of this that this study assesses National Health Insurance Scheme (NHIS) and Employees' Access to healthcare Services in Borno State. The findings of this research revealed that Employees working in the Urban areas don't have full access to the scheme while those working in the Rural Areas have no access to the scheme at all. The study concludes that more medical equipment and personnel should be available and accessible and well as proper awareness about the scheme. The Study recommends amongst others that Stakeholders should embark on awareness, facilities should be provided in Hospitals and Clinics, personnel should be properly trained, government should provide adequate fund, fight corruption to avoid embezzlements and to have equal distributions.

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I. BACKGROUND OF THE STUDY

National Health Insurance NHIS was first introduced in Nigeria in 1962, during the First Republic (Johnson & Stoskopt, 2009). The scheme then was compulsory for public service workers. The operation of NHIS was obstructed following the Nigerian civil war. In 1984, the Nigerian Health Council resuscitated the scheme and a committee was set up to look at the National Health Insurance.

'Health Insurance is a social security system that guarantees the provision of needed health services to beneficiaries on the payment of token contributions at regular intervals'.

The National Health Insurance Scheme (NHIS) is a corporate body established under Act 35 of 1999 by the Federal Government of Nigeria to improve the health of all Nigerians at an affordable cost. The NHIS Act is the statutory authority for the State Schemes benefits programmes as well sets the general rules and guidelines for the operation of the Scheme.

In 1988, the then Minister of Health Professor Olikoye Ransome Kuti commissioned Emma-Eronmi led committee that submitted her report which was approved by the Federal Executive Council in 1989. Consultants from International Labour Organization (ILO), and United Nations Development Programme (UNDP) carried out feasibility studies and come up with the cost implication, draft legislature and guide lines for the scheme. In 1993, the Federal Government directed the Federal Ministry of Health to start the scheme in the country (Adesina, 2009). In 1999, the scheme was modified to cover more people via Decree No.35 of May 10, 1999 which was promulgated by the then head of state, Gen. Abdulsalami Abubakar (Adesina, 2009; NHIS Decree No. 35 of 1999). The decree became operational in 2004 following several flagged off; first by the wife of the then president, Mrs Stella Obasanjo on the 18th of February 2003 in Ijah a rural community in Niger State, North Central Nigeria. Since then it continues in other part of the country.

1.1 Statement of Problems

The National Government established Health Insurance Scheme (NHIS) with the aims of ensuring equitable distribution of health care service to the beneficiaries in all the state of the Federation., The general poor state of our health care services and excessive pressure on government in regards to health services, inadequate participation of private sectors and other health related problems informed Federal Government to enact policy on the Scheme.

The Health Care Services in Borno State is constraint with the following:

Poor Service delivery

Poor funding.

Poor health indices
Inequitable distribution of health care resources between urban and rural areas
Stewardship role of government – Ineffective.
Limited access to quality healthcare.
Inadequate participation of private sector
Discrimination in patronizing levels of healthcare services among others.

1.2 Objective of the Study

The general objective of the study is to assess the effectiveness, success and the failure of the scheme. The Institutional framework for NHIS in Borno State with the view to providing recommendation in achieving good health care services in the State. While the specific objectives include:

To examine the policy thrust of the scheme.
To identify the reasons for the establishment of the scheme.
To access the major stakeholders in the scheme.
To examine the institutional framework for its implementation.
To identify the areas of its failure/ Causes of the Failure
To examine Inequitable distribution of health care resources between urban and rural areas
Challenges
To provide solution and recommendation

II. LITERATURE REVIEW

Health population and indeed workforce are indispensable tools for rapid socio-economic and sustainable development The World over. Omoruan, Bamidele and Philips (2009) *'National Health Insurance Scheme is a social security system that guarantees the provision of needed health services to beneficiaries on the payment of token contributions at regular intervals'*.

Despite this indisputable fact, In Nigeria like most African countries, the provision of quality, accessible and affordable healthcare remains serious problem (WHO, 2007: Oba 2008). This is because the health sector is perennially faced with gross shortage of personnel (WHO, 2007a), inadequate and outdated medical equipment (Yohesor, 2004; Johnson & Stoskopt, 2009), poor funding (WHO, 2007a&b), policies inconsistency. Other factors that impede quality health care delivery in Nigeria inability of the consumer to pay for healthcare services (Sanusi & Awe, 2009).

Health Insurance Scheme is the health social security which guaranteeing persons access to good healthcare services (Physical and financial) and protect families from the financial hardship of huge medical bills (Bamidele and Philips 2009).

2.1 Policy thrust on National Health Insurance Scheme (NHIS)

The National Health Insurance Schemes (NHIS) has the following policy thrust:

Goal: To improve Health Status of Nigerians by providing financial protection and guaranteeing patients' satisfaction and insure equitable distribution of health care service for all.

Vision: To be the foremost institution giving the best tertiary healthcare and comprehensive support as far as to the grassroots level (of healthcare delivery) in the Country and also to Achieve solidarity through involvement of the society in funding and administering quality health care services for all citizens in a way to achieve a comprehensive social development, economic progress and political stability towards building a prosperous nation.

Mission: To provide prompt, courteous, effective and affordable healthcare service that accommodates the patients' culture using highly skilled and motivated staff with modern equipment. The optimum environment conducive for health manpower training and research shall be provided.

2.2 Reasons for the Establishment of NHIS

The following are the reasons for the establishment of NHIS
The general poor status of our health care delivery.
Inadequate participation of private sector in health services.
Excessive pressure on Government Health Services.
Inadequate distribution of Health facilities in the Country.
To improve physical and financial access to health care services.

2.3 Stakeholders in the National Health Insurance Scheme

Government

Government, through the National Health Insurance Scheme, sets standards and guidelines, while protecting the rights and enforcing the obligations of all stakeholders.

Employees: These are the contributors in the Formal Sector Social Health Insurance Programme. Their contributions (5% of basic salary), paid regularly in advance will guarantee them and their dependants good quality healthcare whenever they fall ill.

Employers: These are public or private sector organizations employing ten (10) or more persons, for whom they are required to pay contributions (i.e., 10% of an employee's basic salary). In the Formal Sector Social Health Insurance Programme, employers are guaranteed good quality health care for their workers at cheaper rates and a resultant increase in productivity. In addition, employers with in-house health facilities will run them cheaper and make them earn income by registering them as Providers under the Scheme.

Other Contributors: Contributors making small, affordable regular payments in the Urban Self-employed and Rural Community Social Health Insurance Programmes are guaranteed access to quality healthcare whenever they fall ill.

Health Maintenance Organisations: These are limited liability companies which may be formed by private or public establishments or individuals for the sole purpose of participating in the Scheme. They are registered by the Scheme to facilitate the provision of health care benefits to contributors in the Formal Sector Social Health Insurance Programme. Their functions include the following:-

Receive/collect contributions from eligible employers and employees

Collection of contributions from voluntary contributors

Payment of Health Care Providers for services rendered

Maintenance of quality assurance in the delivery of healthcare benefits in the Formal Sector Social Health Insurance Programme.

Board of Trustees (BOTs)

Participants in the Urban Self-employed and the Rural Community Social Health Insurance Programmes, through their elected Boards of Trustees, plan, run and manage their own health care, thereby engendering a sense of ownership and true community participation.

Healthcare Providers

A Health Care Provider as provided for in the NHIS Act, is a licensed government or private health care practitioner or facility, registered by the Scheme for the provision of prescribed health benefits to contributors and their dependants. Health Care Providers can either be Primary, Secondary, or Tertiary.

Primary Health Care Providers

Primary Health Care Providers will serve as the first contact within the health care system, and they include:

Private clinics/hospitals;

Primary Health Care Centres;

Nursing and Maternity homes; and

Out-patient departments of General Hospitals, Out-patient departments of the Armed Forces, the Police and other uniformed services, University Medical Centres and Federal Staff Clinics

Secondary and Tertiary Health Care Providers (Fee-for-service providers)

These include:

General hospitals (Out-patient and in-patient care for medical, surgical, paediatric, obstetric gynaecological patients, etc)

Specialist hospitals

Pharmacies

Laboratories

Dental Clinics

Physiotherapy clinics

Radiography etc.

Other Stakeholders

International Organizations and Collaborating Partners

Their role includes the provision of technical and financial support to ensure the successful implementation of the Scheme, especially among the urban self-employed, rural communities, permanently disabled persons, and children under- five tertiary institutions and voluntary contributors.

Non-Governmental Organizations (NGOs)

These organizations will assist in the areas of sensitization and mass mobilization to ensure adequate participation.

Community Leaders

They will assist in community mobilization and coordination.

The Media

The media will assist in sensitization, assist health providers to disseminate knowledge of the Scheme and guarantee mass participation.

Banks

Banks' responsibilities under the Scheme include:

- a) Take custody of all the funds accruing to the Health Maintenance Organizations (HMOs) affiliated to it;
- b) Ensure the safety of all funds for the operation of the programme.
- c) Provide on request, by the NHIS, information on the accounts of an HMO with the knowledge of the HMO.
- d) Forward monthly statement of accounts of the Health Maintenance Organizations (HMOs) on authorization by the HMOs to the NHIS.

Insurance Companies

Insurance companies are to provide cover (malpractice and indemnity insurance) for Health Maintenance Organizations Health Maintenance Organizations (HMOs) in the scheme.

Insurance Brokers

To coordinate and ensure that Health Maintenance Organizations (HMOs) and healthcare providers take up indemnity insurance cover. NHIS accredited Insurance Brokers will monitor and ensure compliance by accredited HMOs, healthcare providers and the insurance companies.

Professional bodies

Professional bodies will assist in sensitization and mobilization of health professionals, as well guarantee their participation.

2.4 Theoretical Framework

Social Health Theory

In this work we attempt to provide an outline of a theory of care transition. We argue for a view that sees health care in Borno State being transformed from a system characterized by medical dominance to one characterized by managed consumerism in an ageing society. The argument involves a number of conceptual distinctions that we hope will provide a better understanding of current change, not only in the Borno State Health Service (NHS), but in the international arena as well. Given the historical and cultural peculiarities of health care systems, some of the processes discussed will be specific to the NHS, but our belief is that the dynamics at work have applicability across a wide range of health services. We hope that the distinctions we make will be at least as valuable as Goffman's cold beer.

The study proceeds in three stages. In the first part we outline briefly the key drivers of change: demographic transition, epidemiologic transition and the rising social and economic pressures on health care systems. Secondly, we outline the main dimensions of care transition and some of the conceptual distinctions they contain. These refer to evidence and arguments about the end of medical dominance, the changing role of the professions, the changing social relations of health care and the place of the patient as consumer. We then consider the balance between rhetoric (empty talk) and reality in the formulation of change, especially in key ideas currently being promoted in policy circles. The study concludes by offering a critical reflection on the development of a theory of care transition in the future.

a) Transitions in professional autonomy

Alongside the reduction, if not elimination, of medical dominance, several other major changes in health care have been occurring in recent years. The first of these flows from the above discussion. One of the major developments noted by McKinlay and Marceau LD (2002) is that of the growth of 'medical pluralism', that is, the rise in numbers and importance of 'non physician clinicians' (Cooper and Stoflet, 2004). A range of occupations have been developing their educational and professional credentials, and making moves to undertake health care tasks that traditionally have been the sole province of doctors. In the NHS, for example, it has been estimated that there are approximately 387,000 full-time equivalent (FTE) nurses, including about 250,000 in England (Buchan, J. 2004). In many areas of practice, both in hospitals and in the community, patients visiting clinics may now see a nurse rather than a doctor, and activities such as prescribing (albeit in restricted areas) are being devolved.

b) Transitions in the social relations of health care

In recent years, the position of the medical profession, the state and the patient have undergone significant change. Such change involves a major shift in the social relations of health care. A number of different processes fall under this dimension of transition.

The first we should note is the widespread use of the language of 'partnership'. Promulgated widely by government ministers in the early years of the Blair administration, from 1997 onwards, partnership became the watchword for new relationships between the private and public sectors in financing large-scale projects such as hospital building. But its use was not confined to this arena alone. The idea that patients and their doctors (or other professional carers) should engage in partnership was seen to have relevance across a wide range of health care activities, especially in the management of long-term conditions.

Harry Cayton, then head of Public and Patient Involvement at the Department of Health (DoH), gave renewed expression to the familiar economic concept of the 'co-production of health', by likening it to the construction of furniture bought at stores such as IKEA. In a paper called the 'Flat Pack Patient' (2006), Cayton argued that in the future patients would not simply receive treatment as a finished product, but 'co produce' it with their professional careers.

This more active view of the patient included another key ingredient – shared decision- making. The relation between professional and patient here is one of mutual understanding, rather than paternalistic guidance. The time of treating patients as passive individuals was seen to be at an end; in the words of one commentator on the subject, 'patients have grown up and there's no going back' (Coulter, 1999). In fact Coulter has gone on to review developments in shared decision-making in the context of the English NHS, and has found a mixed picture. Continued resistance by doctors is matched by reluctance on the part of at least some patients. Despite the stricture on doctors that they should 'never make choices for patients' (Coulter, 2005, p. 95), but instead 'play the role of navigator', Coulter also notes that patients continue to value doctors' views and opinions and that these are 'likely to be the dominant influence on patients' decisions'. It may be that age plays a key role here, as patients in later life, as with those in their early years, are often not the main decision maker; a third party (career, mother) is often involved (Gabe *et al.*, 2004). In any event, older people may not want to make decisions against the best advice of their doctors, and though this is consistent with shared decision-making it paints a picture that is less challenging to medical authority.

2.2 Findings of Failure of the Scheme/Causes of failure

One of the major fall-outs of President Umaru Yar'Adua's prolonged absence from the country and his seeming "incarceration" in a Saudi Hospital has been the protest that if the Nigerian health care system were developed and well managed, the President not to talk of ordinary citizens would not have cause to travel abroad for medical treatment. Meaning: if President Yar'Adua had been in a Nigerian hospital receiving treatment, the noise about his health would have been less strident. But unfortunately, Nigeria runs a healthcare system that is worse than what they have in Haiti where tragedy has currently assumed its original human form. Based on these NHIS has failed. This is the simple fact.

When the NHIS was introduced by the Obasanjo government, the expectation was that it would help to improve access to healthcare for the majority of Nigerians, particularly persons in the public service and the private sector. In typical Nigerian style, the scheme began to die slowly a-burning. Many Nigerians depend on out of pocket spending for healthcare. With widespread poverty in the land, this creates special difficulties; unable to spare an extra Naira on healthcare, many Nigerians patronise quacks, or they make compromises with their health with tragic consequences. Even the educated, acting out of ignorance or expediency make uninformed choices. The NHIS as conceived was meant to bridge an existing gap and widen opportunities for access to qualitative healthcare with strong private sector participation, and with government defining policy and framework.

Nobody had any illusions that a national health insurance scheme would solve all of Nigeria's problems, surely a strong primary healthcare system would still be required to care for the usually marginalised segments of the population. But through insurance a sizeable and strategic segment of the population would have been captured. In the United States, health care reform remains a major issue, but despite the controversies, the national health insurance scheme works. The British NHS is also so attractive that many Nigerians travel regularly to take advantage of it, even when they are not resident in the United Kingdom. Britain has been running a health insurance system since 1911; Germany since 1883.

As ever, the Nigerian system needed to be strengthened. In 2005, when the NHIS was officially launched, the then President Olusegun Obasanjo had uttered the following words: "with the start of the National Health Insurance Scheme, (NHIS), we see a future of opportunity to improve our health indicator which is related to our poverty index. The scheme will never go the way of other government programmes. The scheme will prove to Nigerians, our administration is serious and sincere about the reform agendas." Yet nothing has been proved. The poverty index has risen, and so have the country's poor health indicators. Initially, Nigeria's NHIS had faced problems arising from what was defined as "global capitation"; in layman's terms that came across as rivalry among several professionals and service providers within the health sector but it was all the more about how to share revenue.

Nevertheless, this was the least of the problems. Managing a health care system for results and actual difference requires leadership, careful management, and capacity building. As at 2005, average expenditure on healthcare as measured through GDP was 4.6; Federal Government average expenditure on health was about 1.5 %. Very poor you would say, but state and local governments fared worse. And yet ensuring the well-being of all Nigerians is part of government's constitutional mandate. Not doing so is a violation of the rule of law. Nigerian governments have voted for the latter, indeed the failure of the NHIS is a comment on the failure of governance.

In the advertorial under review, the management of the NHIS claims inter alia, that Health Maintenance Organizations (HMOs) have not lived up to expectations, they have not made "sufficient progress" and that further re-accreditation of HMOs will be necessary. It is not impossible that certain Health Maintenance Organizations (HMOs) have not been so efficient. The irony though is that Health Maintenance Organizations (HMOs) have long been in the business of health insurance in the private sector before the same policy was formally adopted. What happened to the pool of knowledge that had been acquired? The NHIS advertorial does not tell the full story, but it also does in a way through the caveat that it provides rather conclusively. According to the NHIS, "the suspension shall not affect the following categories of providers: i. Providers in states folding into the Community Health Insurance Programmes for the Maternal and Child Health Project. ii. Providers in states folding into the NHIS Formal Sector Programme where additional facilities would be required." Our straight interpretation is that the big problem with Nigeria's NHIS is the ambition of the Federal Body to seize control of it. This does not serve the purpose of efficiency rather it satisfies the urge of a cabal for power and profit. The NHIS in its concluding paragraphs uses the phrase "fold into", that is, the states folding into the NHIS formal sector programme. We are confronted here, therefore, with the original problem with Nigerian federalism. We run an over-centralised state. The centre would rather dictate what happens in other parts of Nigeria in scandalous breach of the law!

III. CONCLUSION

The NHIS is a social security system put in place by the Federal Government to provide universal access to health care service in Nigeria. The scheme covers civil servants, the armed forces, the police, the organized private sector, students in tertiary institutions, self employed, vulnerable persons, the unemployed among others. More than four years after the scheme became operational in Nigeria, inadequate and outdated medical equipment, perennial shortage of medical personnel, lack of awareness and poor funding is jointly affecting the potency of NHIS in Borno State and the nation in general.

IV. RECOMMENDATIONS

On the strength of this study finding, the following recommendations were made:

Government and other stakeholders should gear up the awareness campaign in all the senatorial districts in Borno State. The print media, television and radio stations should be mobilized to air NHIS programmes in the state. Village heads, chiefs and religious leaders should also help in the propagation of programme in Borno State and the nation in general.

Hospitals, clinics and health care centres providing health service for NHIS beneficiaries should be properly equipped. Since private clinics and labs are involved in the scheme, government should also provide counterpart funding to ensure that these establishments are properly equipped.

Adequate and well trained medical personnel's should be employed to man the various hospitals, clinics, labs and health care centres where NHIS is providing health services to its beneficiaries. In-service

training should be organized to boost the knowledge of the existing staff in the health sector. Private hospitals/clinics participating in the scheme should be mandated by government to ensure that proper and adequate personnel's are employed and trained.

Government should increase funding to NHIS in particular and the health sector in general. Government agencies responsible for fighting corruption should peruse the activities of NHIS to ensure that corruption do not limit and weakened the scheme like other programmes in the country.

Government should put measures in place to ensure that all civil servants have equal opportunity to NHIS services and that adequate medical personnel and equipment should be provided to ensure effective service delivery.

We recommend a review of the NHIS and a decentralisation of the health insurance system in law and operation. The role of government should be restricted to regulation and monitoring and no more.

Finally, the provision of quality, accessible and affordable health care to all Nigerians would remain a mirage if these problems that weaken the potency of the scheme are not properly addressed. We therefore suggest that the recommendations made therein be strictly followed.

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