

Inequalities in health: the role of health insurance in Nigeria

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Abstract

Health financing is a core necessity for sustainable healthcare delivery. Access inequalities due to financial restrictions in low-middle income countries, and in Africa especially, significantly affect disease rates and health statistics in these regions. This paper focuses on the role of a national health insurance cover as a funding medium in Nigeria, highlighting the theoretical premise of health insurance, its driving forces, key benefits and key limitations particular to the country under scrutiny. Emphasis is laid on its overall effect on the pressing public health issue of health inequality.

Background and aim

It is an indubitable fact that financing is a core necessity for sustainable health care delivery. The World Health Organization maintains that *health financing is fundamental to the ability of health systems to maintain and improve human welfare*.¹ Despite this, financial inclusion with regards to healthcare is relatively poor within sub-Saharan countries, Nigeria inclusive. Palmer *et al.*² describe how there is especially severe difficulty in low income countries to maintain an adequate and properly managed funding of their public health systems, laboring with few and inequitably distributed resources.

It is against this background that this paper, focusing on the role of a national health insurance cover as a funding medium in Nigeria, attempts to highlight the theoretical premise of health insurance as well as the driving forces, examine its key benefits as a form of financial inclusion in healthcare delivery, its key limitations in the country, as well as its overall effect on the pressing public health issue of health inequality. It is the hope that health inequality as influenced by access to healthcare through health insurance, which ordinarily seems to pale in comparison to the much more obvious public health issue of disease in the region but is in fact insidious and a major hindrance to the control of disease, will be emphasized.

Inequalities in health

Inequalities in health are far-reaching, from the point of provision to that of reception. It is not an injustice if good health is unattainable, though it would be unfortunate; however, the presence of health inequalities, where they are avoidable, is inequity.³ Qidwai *et al.*⁴ describe equity in health care as when *health resources are allocated and health care services are received according to need*. This is irrespective of social status or influence, instead concentrating on those with poor health status, greater disease burden and lesser resources.⁴ Equal healthcare access for everyone in need requires both economic and political input.⁴ The economic situation of any nation plays a key role in the financing of health in that country.⁵ Health funding in its many facets plays a central role in early detection of diseases. Screening programs, research grants, provision of adequate, updated infrastructure and access by citizens to these facilities are all necessary to a comprehensive health system of any country. Inadequate health financing is one of the major obstacles in the path of the eradication of disease in African countries.⁶

WHO deems health to be directly proportional to socioeconomic position.³ Other socioeconomic disadvantages affect health in general such as a lack of proper education, which invariably affects the ability to make judgment calls when it comes to health treatment, environmental factors, where the poorer people find themselves in squalid living and working environments which serve as a breeding ground for an assortment of disease vectors, not to mention the effect on mental health, as detailed by the Commission on Social Determinants of Health.⁷ For these reasons, it is understood that people who fall at the bottom of the socioeconomic gradient are far more susceptible to raking up health costs.

Healthcare access is widely perceived to be how far an individual has to travel to get to a health facility.⁸ However, although physical distance remains an important hindrance, access to healthcare transcends geographical factors as socio-economic and socio-cultural forces play determining roles on the distribution of healthcare within nations, as Mensah points out.⁸ Ibiwoye and Adeleke (2008) similarly outline that physical accessibility is but one aspect of the problem facing healthcare accessibility.⁹ They further suggest that the greatest impediment to healthcare accessibility in the country is the high prevalence of poverty, pointing out that cost can prevent individuals in need who live a stone-throw away from hospitals from accessing healthcare because they cannot afford it.⁹

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The situation in Nigeria

According to World Bank data, as at 2010, 62% of Nigerians lived on less than \$1.25 a day.¹⁰ In a country where the majority percentage of the people are classified as living under the global poverty level, the inability of people under a certain social stratus to access healthcare is worrisome and an obvious, important public health problem. Ichoku *et al.*¹¹ put this already worrying statistic into greater perspective by denoting that it costs \$10, on an average, to treat an episode of malaria, a very commonplace occurrence in the population. Health financing is an important bridge in closing inequality gaps within any economy, because, as Olakunde rightly states: *the first wealth of a nation is its health*.⁵ An effective, functional health insurance system is key to ensuring accessibility to health services across the population.¹²

These gaping inequalities in financial access to healthcare are a strong indication of the need to implement a working health insurance system as an effective intervention.¹² Evidence shows that health insurance in Nigeria has been extremely slow on the uptake. As far back as 1962, two years after independence, the concept of Social Health Insurance was passed as proposal through the Lagos Health Bill. Unfortunately, it was cut short for reasons undisclosed.¹³ Health funding in the post-independence days of Nigeria was largely done by the government in the form of free, universal health care mainly in public facilities.¹⁴ This came to an end when the government could not afford to provide free health care due to the 1980's global slump in oil prices, as oil export revenues were a major

source of financing.¹⁴ A 1985 committee set up by the Ministry of Health testified to the viability of health insurance in Nigeria, and plans were underway for the launching of the scheme by mid-1991.¹⁵ It was, however, not until 1999 – eight years after the proposed launch date – that the flagship body of health insurance in Nigeria, the National Health Insurance Scheme (NHIS) was signed into law,¹³ and was finally launched in 2005.¹⁶

The NHIS advocates insurance on different levels by different programs. Among them, there are the following ones.

Formal Sector Social Health Insurance Program: it covers employees from both the public sector and the organized private sector, and is compulsory for all organizations with employees who number 10 and above.¹³ This program follows the ideal of an equitable system, which is the increase of taxation for the richer population, with health services accessed by beneficiaries on a need basis, irrespective of their socioeconomic position.¹⁷ However, as majority of Nigerians are either self-employed, work for SMEs or are unemployed,¹⁶ this excludes the bulk of the population, and only seem to promote a different kind of inequity: availability of an equitable service to the select population of people employed in organizations with ten employees and above.

Rural Community Social Health Insurance Program: it covers associations of individuals who number at least 500 with common economic activities and it is run by the members. Premium is paid at a flat monthly rate depending on the choices of the participants, who are members of households who belong to the same community.¹³ However, a study shows that the problems of operational difficulties like low rates of enrolment, incompetent management, a lack of clear legislation regarding the policy, exaggerated expenses and insufficient measures for effective risk management continue to ground the scheme.¹⁸ Odeyemi confirms that it accounts for only a very small percentage of the total health expenditure.¹⁹

The NHIS lists among its objectives: *to ensure that every Nigerian has access to good health care services, to protect families from the financial hardship of huge medical bills, to limit the rise in the cost of health care services, to ensure equitable distribution of health care costs among different income groups, to ensure equitable distribution of health facilities within the Federation and, to ensure the availability of funds to the health sector for improved services.*¹³ Despite this, the evidence shows that these objectives are yet to be actualized. As Odeyemi and Nixon explain,¹⁴ the chief aim of the insurance scheme is to reduce the dependency on out-of-pocket payments as they largely affect the poorer population and therefore are a manifestation of inequity within the health-care system. However, Onwujekwe *et al.*¹⁶

assert that so far, the NHIS provides cover for only federal government workers, who make up less than 5% of the population of Nigeria while the sum coverage of the other insurance agencies such as private health insurance and community-based health insurance is less than 1% of the population. Following this, it can be deduced that only a paltry 6% of the entire population are covered one way or the other. If the numbers are to be gone by, 94% of the population are paying for health services out-of-pocket (OOP). This can only mean that the majority of the poor, who cannot afford to pay for health services out-of-pocket, are not under any form of insurance cover, which in turn explains the high mortality rate of an easily preventable and treatable disease such as malaria.²⁰

Furthermore, a study carried out by Odeyemi and Nixon in 2013,¹⁴ comparing the NHIS structure in Nigeria with that of Ghana noted that that though both countries are similarly lower middle-income countries and though both had their respective NHS launched at around the same time, Ghana reported a sharp decline in out-of-pocket expenditure since the introduction of their NHIS in 2004 from 80% to 66%. Nigeria, on the other hand, saw high OOP expenditure levels persist at 93-95% from 2000 to 2010.¹⁴ Despite the involvement of numerous agencies in health funding and provision of services at different levels of government – the federal government, state ministries of health, local government provision of primary health care and even private organizations (profit and non-profit),¹¹ Amaghionyeodiwe maintains that the access to health services by populations remains very low.²¹ This shows that there has been very little impact of the NHIS on reducing finance-related health inequality in the country. The private health insurance (PHI) provisions available in the country operate on the basis of flat-rate packages *i.e.* how much each individual pays as their annual insurance premium determines the extent of the cover.¹³ This is regressive, as it has an adverse effect on equity.¹⁴ Macha *et al.*¹⁷ describe progressive health care financing as a situation where the richer part of the population pay more of a proportion of their income for health care taxation than the poorer part, and the vice versa applies. In a study by Carapinha *et al.*,²² there emerged apparent evidence that wealthier individuals from urban communities are the predominant patrons of PHI organizations. There is also to be considered the allegation by Ichoku *et al.*¹¹ that some private insurance companies provide hospital services themselves in order to maximize profit at the expense of their patrons.

The disproportion between societies and the resulting social hierarchy ensures the unequal distribution of power, prestige and social as

well as economic resources, which subsequently powerfully affects the distribution of health in the society, as well as health itself.³ There is a great disparity in the level of health-care services available to people at both ends of the socioeconomic spectrum in Nigeria, the root-cause of which being the chasm between the social strata of the elite and the common man, according to Ichoku *et al.*¹¹ This is further exacerbated by the fact that these elite, among whom are the vast majority of the politicians and lawmakers who are in the position to influence change the health sector, prefer to seek health services in countries where the healthcare system is far more developed, leaving the sector in its current dilapidated state.¹¹ They go on to allege that in addition to medical pilgrimage by these elite, they use their political powers and public funds which are meant for national issues such as health reforms to allocate substantial benefits, allowances of all types, from risk to medical. This, as well as the presence of special *federal clinics* for the use of government officials only, are some of the underlying reasons why the uptake of health insurance in the country remains stalled.¹¹

Quality healthcare in Nigeria comes at a high financial cost, and the poor, who are the majority,¹⁰ can hardly afford it. Between the meager scope of coverage of the NHIS and the inequitable charging policy of private insurance schemes, the poorer percentage of the population (which is in the majority) find themselves either excluded from or unable to afford any type of insurance cover. Onwujekwe *et al.*²³ outline that even the lowest of bills can seem devastating to financially constrained individuals, which may discourage them from obtaining the required care as they cannot afford hospital charges. Lack of education in addition to inability to afford professional health services spurs the population at the bottom of the socioeconomic gradient to seek alternative methods. The proliferation of visits by individuals to traditional healers is observed,²⁴ as well as to spiritual healers, which in turn has the ripple effect of increasing illness through misdiagnosis, improper treatment and fake medicine.

A study carried out in Malawi showed that due to inaccessibility to healthcare and lack of knowledge, epileptic patients turned to traditional healers where they were subjected to invasive but ineffective treatment procedures.²⁵ In the long run, there is greater detriment to their health and general well-being. Because of the cost of health services, it is far easier for majority of the population consider themselves to be healthy unless they're at death's door. Mental wellbeing, for example, is not considered generally considered by the population to be a pressing health issue, and most times, illnesses of both the mind and the

body are allowed to fester as they are not believed to warrant the cost of scientific treatment. Ayorinde *et al.*²⁶ mention that 70% of mental treatment is delivered by either religious organizations or traditional healers, as people tend to believe that mental illness is triggered by supernatural forces.

Health is a fundamental human right. The United Nations identifies *the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.* (United Nations 1966). It is the responsibility of the government to facilitate the best conditions for all individuals to achieve good health.³

Ensuring a national, collective and all-inclusive national insurance system will be a huge leap in solving health inequalities between populations in Nigeria. According to a WHO report on health systems financing,²⁷ evidence emphasizes that that raising funds through compulsory prepayment provides the most efficient and equitable means of achieving universal coverage is through general taxation as a method of risk-pooling, so that the sick don't bear the entire burden of health expenditure. In Russia, there is an established system of compulsory health insurance, where the predominant financing source is through general taxes, with salary taxation used as a complementary channel.²⁸ This model has proven to be extremely effective and would only work in Nigeria if the current challenges faced by the general tax system such as gross corruption, unaccountability and an absence of tax records are overcome.²⁹

It is evident that more effort should be put into emphasizing and enforcing health insurance as a mandatory health policy in Nigeria, as is done in countries like the UK and Russia. The African Union recommends the regular reviewing of health policies in order to ensure that they are in accordance with the government's current priorities, while advocating the declaration of necessary legislation to support health policies in order to ensure equitable, accessible and appropriate healthcare access for the population.⁶ The government has the pivotal role of passing the necessary legislation which allows universal cover irrespective of socioeconomic status.

Also, populations in the lower socio-economic strata, where the level of education is low, have little or no idea of the workings of health insurance as a concept. Odeyemi and Nixon maintain that the readiness to be part of the NHIS is at an encouraging level among the rural dwellers.¹⁴ They however point out that the scheme is crippled by the ignorance of the details and benefits it presents, and recommend that the government increase efforts in terms of creating awareness for the NHIS especially in remote areas.¹⁴

Even though evidence shows great health disparities between social classes within coun-

tries, the international focus remains largely on reducing the disparities between nations which are better and worse off.⁴ This only points to the fact that the task of lessening the gaps of inequality within countries falls on the indigenous government's ability to make and implement policies that benefit populations across all social groups, one of which is health insurance. Macha *et al.*¹⁷ advocate that to reduce out-of-pocket payments and thus break down financial barriers to access to healthcare among the poor, insurance coverage should be expanded exponentially.

Of course, health insurance is but one rung in the ladder of tackling health inequalities. Fox and Meier rightly stress that there is far more to be done in breaking the link between poverty and health than implementing programs which influence only one sector of the health system, and advocates a systemic intervention that focuses eradicating poverty through addressing all the underlying health determinants.³⁰ Nevertheless, in the words of the Director-General of the World Health Organization, Dr. Margaret Chan, in her address to the 65th World Health Assembly in Geneva in 2012: *Universal health coverage is the single most powerful concept that public health has to offer.*¹² Health insurance as an agent of financial inclusion is instrumental to the future success of the Nigerian public health system. The evidence shows that there is need for exponential increase in the effort to solidify the presence of health insurance in Nigeria, as it is a definite way forward in tackling health financing issues.

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