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Universal Health Coverage – Is Leaving No One Behind in Nigeria a Pipe Dream?

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Abstract Nigeria is widely recognized as contributing a major proportion of the global burden of diseases. The majority of her population reside in the rural areas and belong to the informal workforce that is largely untouched by government's National Health Insurance Scheme, leaving universal health coverage for Nigeria's citizens a dream still far from realization. Nigeria's health sector is thus plagued with myriad inequities and inefficiencies, leaving many individuals and families impoverished by catastrophic health expenditures out of their pockets. A well-thought-out strategy for the implementation of universal health coverage utilizing increased government expenditure, strengthened legislation, innovative financing mechanisms, recruitment, training and support of community health workers, community-based financing schemes, and private sector engagement is therefore necessary.

Keywords: *universal health coverage, healthcare financing, national health insurance scheme, prepayment, Nigeria*

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1. Introduction

A large number of the world's 1.3 billion people who survive on very low incomes still have little or no access to effective, affordable medications and interventions due to weak healthcare financing systems [1]. In 2005, members of the World Health Organization (WHO) member states adopted resolution encouraging countries to develop healthcare financing systems aimed at providing Universal Health Coverage (UHC) [1]. UHC ensures access to appropriate promotive, preventive, curative, rehabilitative and palliative services at affordable cost, without exposing the user to financial difficulty [2]. It has been projected that when a household spends more than 40% of their disposable income after basic food expenses on basic health services, such expenditures could push them below the poverty line, resulting in impoverishment [1].

In some cases, families manage to bear these expenses using coping strategies such as the sale of assets, borrowing and reduced household food consumption; all of which have negative impacts on the health and wellbeing of the family. These strategies end up perpetuating the cycle of poverty, keeping families indebted even long after recovery from the illness [3]. The World Health Organization (WHO's) advocacy for UHC is therefore aimed at protecting the poorest families from the devastating financial implications of paying out-of-pocket (OOP) for health services.

UHC therefore not only provides financial risk protection, but emphasizes the extent of population and health service coverage [1]. The strategy to combat this financial inaccessibility is therefore a system of organized prepayment, where funds are equitably pooled in readiness for a time of need [1]. The design and speed of the nature of prepayment would however depend on various socio-economic and political factors [4,5].

2. The Nigerian Health System and Health Financing Policy

Nigeria with a total population of 174 million, and a gross domestic product (GDP) of 522 million dollars spent an average of 6.8% as General Government Health Expenditure (GGHE) as a percentage of General Government Expenditure (GGE) between 2010 and 2014 [6]. Similarly, eternal resources for health as a percentage of Total Health Expenditure (THE), made up a mere 6.2%; while OOP expenses have been consistently constituted 96% of THE over the last 5 years [6]. The Nigerian health sector is therefore poorly funded, and even the average GGHE in neighbouring Ghana, has averaged 11.2% over the last 5 years, with OOP spending on health accounting for only 27% of THE by the end of 2014 [6].

A combination of poor health sector funding, skewed health resource allocation favouring secondary and tertiary facilities have led to system inefficiencies and inequities of access and payment, especially for the rural poor [7]. A dearth of attractive remuneration options and incentives for health workers in the rural-based primary healthcare centres has contributed to this 'allocative inefficiency' which has resulted in the over-provision of healthcare services in urban and semi-urban areas, to the detriment of rural areas [7]. With an absence of social security for the most vulnerable groups, regressive taxation, poor planning

and allocation of public funding for health, corruption and a lack of systemic coordination across all three tiers of government [7], these health inequities run literally unchecked amongst the populace, leading to even greater poverty.

A major reason for lack of end-user confidence in Nigeria's National Health Insurance Scheme (NHIS) is restriction to the use of services by spending limits in addition to limited number of services due to inadequate funding. Currently, the scheme caters to only about 4% of the population, majority of whom are formal sector employees despite its launch over a decade ago [8].

A health financing policy directed at UHC must therefore focus on the following financing functions: revenue collection in sufficient quantities equitably and efficiently; pooling of contributions to ensure cost-sharing and financial accessibility; and lastly equitable purchasing or provision of appropriate efficient and effective health interventions [1].

Subsequently, Government must therefore demonstrate not only the political will necessary to drive UHC, but also show the capacity to exercise good stewardship. The inability of large sections of the populace to access health services, catastrophic health expenditure and impoverishment are strongly associated with the extent to which countries rely on OOP as a means of financing their health systems [1]. Conversely, how equitably and efficiently run the system will be, would depend on a combination of both legislation and systemic frameworks for revenue collection, contributions-pooling and the purchasing or provision of appropriate and effective health services [1].

3. Recommendations for Government

Government's commitment to the 2001 Abuja Declaration by the allocation of not less than 15% of the GGE to the health sector [9] would demonstrate political will and commitment to the 2014 Presidential Summit Declaration on UHC. In addition, great potential exists for strengthening primary healthcare through the Basic Healthcare Provision Fund (BHCPF) stipulated in the National Health Act [10].

Half of this fund would go to providing a basic package of services in primary Healthcare centres (PHCs) through the NHIS [10]. 45% of the fund would be disbursed by the NPHCDA for the provision of essential medicines, maintenance and equipping of PHC facilities, provision of transportation, and the human resource capacity strengthening through trainings and workshops [10].

The left-over 5% would be used by the Federal Ministry of Health (FMOH) to respond to any national emergencies and epidemics [10].

For sustainability, the fund would be primarily financed from annual grants from the Federal Government, and supplemented by international donor funds and innovative financing schemes. States and Local Governments would also be mandated to contribute not less than 25% respectively as counterpart funding for PHC projects [10]. Revenue generation using innovative financing schemes such as the taxation of goods which pose health risks to consumers, such as tobacco, alcohol and even fast foods; levies on mobile phone calls or purchases, dedicated taxes on airline tickets, foreign exchange transactions, [11,12] and luxury goods is another viable option.

Tackling the scarcity of skilled manpower in rural areas via the recruitment, training and support of rural-based community health workers (CHWs) through the NPHCDA is a possible solution to the unavailability of skilled manpower at the rural primary care level, and has been employed successfully in other African countries [13,14,15]. These CHWs must be fully integrated into the health sector, with training and support given for the diverse skills needed to function in these hard-to-reach areas where the majority of people in desperate need of care reside. Their standards of training, job description, career progression, monitoring and supervision must also be clearly spelt out for them to succeed.

As part of its stewardship role, the FMOH must regularly monitor the process of healthcare financing reform via the NHIS. By monitoring the number of beneficiaries/enrolees, frequency of utilization and cost of services, number of service providers, and quality assessments based on feedback from beneficiaries and staff, staff performance evaluations, and health indicators such as maternal, infant and child mortality; and prevalence rates of communicable and non-communicable diseases [16], the NHIS will be in a better position to ensure the delivery of sustainable, quality health care services to end-users.

Regarding legislation, by facilitating the process of amendment of the 1999 National Health Insurance Scheme Act 35, government can ensure legal backing for compulsory health insurance, thus paving the way for UHC [17]. In India, for example, it is constitutionally mandatory for formal insurance companies to serve the rural sector as a means of ensuring equitable access [18].

In addition, the engagement and encouragement of stakeholders such as State governments to initiate State Health Insurance Schemes under NHIS guidance opens up another avenue for increasing access for rural populations.

Private sector engagement by the focused and strategic use of Public-Private Partnerships (PPPs) can be enlisted to strengthen this process recognized to be a cost-effective system with enormous potentials for increased efficiency in the management and deployment of scarce resources for health care delivery. [19] These partnerships could be in the form of privately-run PHCs in partnership with government, especially in communities where these firms operate and do business; thereby enhancing community participation and engagement and reducing the cries of marginalization in agitated areas. While the implementation of PPPs in Nigeria may be difficult, the benefits can be maximized if contracts and agreements are clear and legally-backed *ab initio*, authorizing the health service providers to make their own decisions, and manage their operational budgets with limited political interference [20]. There must then be a clearly defined system for monitoring the process of service delivery, as this has been the recognized 'Achille's heel' or weakness of PPPs [20].

Currently, Community Based Financing (CBF) Schemes are based in very few communities, affecting less than 1% of the total population of Nigeria [21]; the design and

development of Community based health insurance (CBHI) or financing schemes targeted at often neglected semi-urban, rural and informal sectors is another mechanism with potential for a wider reach than conventional health insurance pre-payment schemes [1]. The impact of CBF schemes has been widely studied in various Nigerian states and reported to be a sustainable health financing mechanism with potentials for positive health and economic outcomes [22,23,24].

4. Conclusion

The aim of this paper is to highlight various strategies that can translate to the provision of UHC in Nigeria. A healthy population is a healthy and more productive workforce which in turn will boost the country's economic capacity in a background of favourable economic and capital market policies. UHC as recognized as far back as 1978 at the International Primary Health Care Conference in Alma-Ata, USSR is a clear path to the lowering of Nigeria's poor health indices which greatly contribute to the global burden of disease. This can only be achieved through primary essential health-care services that are made universally accessible to individuals and families through their full participation and at affordable cost, making sure to leave no one behind in keeping with the underlying principle of the global goals.

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Statement of Competing Interests

The author has no competing interests.

List of Abbreviations

BHCPF – Basic Healthcare Provision Fund
CBF – Community-based Financing
CBHI – Community-based Health Insurance
CHW – Community Health Worker
FMoH – Federal Ministry of Health
GDP – Gross Domestic Product
GGE – General Government Expenditure
GGHE – General Government Health Expenditure
NHIS – National Health Insurance Scheme
NPHCDA – National Primary Healthcare Development Agency
OOP – Out-of-pocket
PHC – Primary Healthcare Centre
PPP – Public-Private Partnership
THE – Total Health Expenditure
UHC – Universal Health Coverage
WHO – World Health Organization

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