Global Journal of Political Science and Administration

Vol.6, No.5, pp.1-21, October 2018

Published by European Centre for Research Training and Development UK (www.eajournals.org)

HEALTHCARE DELIVERY AS PUBLIC GOOD: AN EVALUATION OF THE NHIS AS AN OPTION IN HEALTHCARE MANAGEMENT IN NIGERIA

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ABSTRACT: *The health of members of any society affects the overall efficiency and effectiveness of the entire society and as such should not be the sole responsibility of the individuals concerned. Currently, health insurance has dominated government efforts in providing healthcare to her citizens but the extent to which this option actually meets the needs of all segments of the society is questionable especially in predominantly poor societies where economic situations and poverty has fundamentally limited accessibility to healthcare based on contribution. This study explored the National Health Insurance Scheme in Nigeria (NHIS) with a view to examining how much it has achieved in providing health for ALL Nigerians since its inception over eighteen years ago. The study employed questionnaire and interview in its research to a sample size of 348 respondents in Enugu state. The findings show that the Scheme fell short of its objectives. The study recommended government direct budgetary allocation to healthcare services in general as a public good and not regard healthcare as the responsibility of the individual directly affected by health challenges. This is predicated on the fact that the health of any society is the basic social responsibility of government and should be publicly funded as public good.*

KEYWORDS: Healthcare, Public good, Health Insurance, National Health Insurance Scheme (NHIS)

INTRODUCTION

Many societies have taken the initiative both as individuals and governments to provide for and manage their healthcare needs. In some situations governments have supplemented such efforts to a more or less degree depending on the operational preferences and convenience. However, is has been strongly argued that the issue of healthcare delivery is primarily the responsibility of government since the maintenance of a healthy society is part of their welfare responsibility. This line of argument is premised on the fact that the efficiency and effectiveness of the socio-economic and political system at all levels of the society, the organized and unorganized private sectors, government institutions and agencies is directly or indirectly impacted on by the health status and functionality of those that run them.

Therefore the tendency to view public health as the exclusive responsibility of the direct beneficiaries has long been outdated. This is especially so since the capacity of individuals, especially in poor countries, to adequately cater for their health needs is highly limited due to high level of poverty and ignorance. The emergencies of crippling health challenges at short notices and the increasing cost of medical bills have necessitated the need for governments to take a second look at leaving healthcare services at the discretion of helpless individuals that form significant part of the society that substantially lack the capacity to mobilize the necessary

ISSN 2054-6335(Print), ISSN 2054-6343(Online)

funds at short notices, or even at long notices, to tackle them without seeking for help outside their personal resources. It is a truism that a good number of avoidable deaths and lingering diseases result from the inability of those facing such health challenges to mobilize adequate resources to access good healthcare services.

Again, if individuals are left on their own to grapple with health challenges that transcend their financial and material capacity, the aggregate health level and the operational capacity of the society will be significantly lowered. The resultant impaired productive capacity associated with health challenges is invariably transferred to the entire society in the form of low Gross Domestic Product (GDP). It is thus no longer the loss of fragmented individuals in the society but a collective loss. Consequently government, and the society at large, stand to gain by ensuring the wellbeing of her citizens by perceiving healthcare services as a public good which responsibility should not be left at the discretion and disposition of individual citizens since its overall outcome has sever implications for the ultimate performance of the entire society, good governance and socio-economic wellbeing of the society at large. Even where individuals contribute to healthcare maintenance either through health insurance schemes or direct financing, the government need to assume full ownership of that responsibility.

Statement of problem

The government have attempted to address the issue of healthcare service delivery through establishingand funding public hospitals and in addition made health insurance policies that address that need though public and private healthcare institutions. This paper examined how the option of health insurance has been deployed in addressing healthcare services in Nigeria under the National Health Insurance Scheme (NHIS). It sought to know whether this policy, and the operations of the Scheme has so far succeeded in addressing the enormous challenges of healthcare delivery in Nigeria.

Health Insurance according to Smith and Medalia (2015) refer to a means for financing a person's health care expenses whether through private health insurance or programs offered by the government. In recent times, the issue of health insurance in Nigeria has become prominent in view of the general poor state of the nation's healthcare services, the excessive dependence and pressure on government-provided health facilities, the dwindling funding of healthcare in the face of rising costs, and the need to enhance the integration of private health facilities in the nation's healthcare delivery system (National Health Insurance Scheme Handbook, 2006). In advancing the above view, McIntyre (2007) observed that the difficulty that low and middle-income countries have in providing for the health care needs of their populations remains a major problem that has increased the search for viable healthcare insurance financing option.

However, the health insurance option, unlike in general insurance where the majority contribute to the pool through the payment of premium but only a few draw from it in a given year, many policy holders use their insurance frequently since it provides "a comprehensive cover for everything from minor cuts and routine visits to organ replacement and accidents (Copland, 2013). This higher propensity for more people to draw from the financial pool in health insurance makes the policy relatively more expensive and thus more difficult to afford than other forms of insurance. Consequently, it limits healthcare services through health insurance to only those who have the opportunity and capacity to contribute to the scheme while those who do not contribute are left to their fate. Therefore in order to encourage wider participation in the benefits of healthcare services, governments' funding intervention to

ISSN 2054-6335(Print), ISSN 2054-6343(Online)

alleviate the financial challenges of those who cannot easily afford the cost of medical treatment becomes imperative.

However, apart from limiting the benefits of healthcare services under health insurance schemes to those who contribute to the scheme, the effort of the NHIS from inception has been focussed on the formal sectors, with particular reference to the public service. For now the burden of financing and enjoying healthcare under the Scheme is essentially a public sector issue. Again, the concentration of the Scheme's services essentially to public servants and organized private sectors significantly limits its impact on Nigeria population. This narrow coverage creates a false impression that the Scheme is doing well considering its current constituency. But since the Nigerian population constitutes more of people not employed in the public service, the vision of health for all citizens is still far from being realized.

Again, the distribution of healthcare facilities in Nigeria through which the NHIS render its services is for now skewed in favour of the urban centres with little or nothing in the rural areas. It is also a truism that alternatives to formal healthcare services such as patent medicine stores and alternative medicines are also concentrated in the urban areas where patronage is higher. This further leaves the rural areas with both the shortage of good medical care and close substitutes.

Unfortunately however, eighteen years after the establishment of the Scheme, not much has happened in the realization of her declared objectives of Accessibility to good health services; Cost reduction of healthcare services; Efficiency of healthcare service delivery; Protecting families from the financial hardship of huge medical bills; Limiting the rise in the cost of healthcare services; Equitable distribution of healthcare cost among different income groups; High standard of healthcare services delivery to Nigerians; Improvement and harnessing of private sector participation in the provision of healthcare services; Equitable distribution of health facilities within the Federation; Appropriate patronage of all levels of healthcare; and Availability of funds to the health sector for improved services. The attainment of these objectives to a significant level has remained an illusion as testified to by the number of Nigerians that are not yet benefiting from the scheme and those that patronize patent medicine stores, herbalist, quacks, or indulge in self medication for lack of needed access to good medical care. The failure of the Scheme to realize a significant part of any of its objectives after such a long time of its existence therefore raises questions as to how usefully it has impacted on healthcare services in Nigeria. It also call for a search for alternative ways of providing healthcare services that will reach the majority of Nigerians with a view to ensuring a healthy society and not just healthy civil servants.

Objectives of study

The purpose of this research is premised on the presumption by governments of developing nations like Nigeria that because healthcare services have been substantially addressed in developed nations of the world through health insurance schemes, it is equally possible to do the same in Nigeria. However there are other critical factors that made it possible to address healthcare in developed nations through health insurance schemes which do not exist in Nigeria and as such the same policy will not result in the same outcomes. First is the issue of level of income in developed economies that guarantees a minimum living wage which makes it possible for their citizens to have enough resources to enlist in such insurance schemes. Secondly, healthcare facilities are comparatively much more available in developed societies and consequently more accessible.

ISSN 2054-6335(Print), ISSN 2054-6343(Online)

On the other hand developing nations like Nigeria have an overwhelming majority of their population living very far below the poverty level and as such cannot afford to enrol in any form of health insurance scheme. They rely solely on government healthcare services if they must have anything decent. Again because of the nature of the nation's underdevelopment, the comparatively few available healthcare facilities are concentrated in the urban areas with little or nothing in the rural communities where the majority of people reside. Consequently, it is only government direct assumption of this responsibility that can assuage this shortfall meaningfully. The research aims at highlighting the need for governments of developing nations to review their policy position on healthcare delivery through health insurance in view of the overwhelming shortfall in other necessary conditionalities and infrastructure for its success as evidenced in developed nations.

The general objective of the study was to evaluate the performance of the National Health Insurance Scheme (NHIS) as an option in healthcare management in Nigeria with a view to understanding how realistically it has addressed the healthcare needs of ALL Nigerians as stipulated in the enabling Act. It is also intended here to examine a viable alternative of funding healthcare services directly as public good by government as their responsibility through budgetary allocation. Specifically, the study sought

1. To examine the impact of the National Health Insurance Scheme (NHIS) on healthcare delivery in Nigeria between 1999 and 2017
2. To examine the Challenges faced by the Scheme
3. To proposes an alternative approach for healthcare delivery as public good

LITERATURE REVIEW

The National Health Insurance Scheme (NHIS)

In order to address the challenges of healthcare delivery in Nigeria, the National Health Insurance Scheme (NHIS), a social security programme of the Federal Republic of Nigeria, was established by the National Assembly Act 35 of 1999 to fast-track health for ALL at affordable price. The major objectives of the NHIS are as summarily listed above under the statement of problems.

The purpose of the Scheme is to create the opportunity to gradually provide funds, through contributions, on regular but small instalments for handling health challenges if they eventually arise. These instalmental payments are usually a small percentage (5 percent) of the insured's basic monthly salary while the employer contributes 10 percent on his/her behalf where such a person is under paid employment (National Health Insurance Scheme Handbook, 2006). Under the health insurance scheme, these contributions are pooled together to finance healthcare services with minimum stress to the challenged when they arise, whether under normal circumstances or on emergencies. In the case of a health challenge, the insured person becomes entitled to medical care subject to the provisions of the specific healthcare programme he/she registered for.

However, participation in the Scheme has largely been limited to public servants while the rest of the public, especially the rural dwellers and the private sector is systematically excluded.

ISSN 2054-6335(Print), ISSN 2054-6343(Online)

Again, the distribution of healthcare facilities and good hospitals used by the NHIS in healthcare services are more readily available in favour of the urban centres leaving the rural areas without sufficient healthcare facilities to service their health needs.

The NHIS and healthcare financing

Part of the issues that is confronting the Scheme is the question of healthcare financing. From the enabling Act, the Scheme is to be financed through contributions from both governmental and non governmental sectors. But unfortunately, only the federal government has shown some level of commitment in this regard and what they contribute is primarily for their employees and some classified groups like children and pregnant women, which constitute a very minute percentage of the Nigerian population.

The essence of healthcare financing, according to the World Health Organization Report (WHO), is

> to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care (WHO, 2000).

The WHO advanced the argument further with the view that

> health financing systems should not only seek to raise sufficient funds for health, but should do so in a way that allows people to use needed services without the risk of severe financial hardship (World Health Organization, 2008: 2)

Unfortunately, the level of funding has so far not reflected the submission of the WHO and by extension the goal of healthcare financing.

Three main perspectives on healthcare financing were presented by the National Economic and Social Rights Initiative (2009). The first is that healthcare is the concern of the society as a whole and not an individual affair. This is predicated on the fact that the implication of health issues is not limited to the individual suffering such challenges, but is rather a collective challenge as the undesirable health condition of any individual ultimately rubs off on the larger society in one way or the other. Again, this school of thought see healthcare as a basic social responsibility of government and as such healthcare services fall into the category of public goods and as such should be provided and funded by government from public resources.

The second perspective view healthcare service from the individual perspective. They believe that individuals should decide what type and level of healthcare services they need and pay for it either through direct purchase or by pooling their resources together under an insurance scheme. Under this arrangement, healthcare services are only available to those who contribute to the pool and to the extent of their contribution.

The third view presents a midpoint between the proponents of healthcare as an exclusively public good provided by government and those who subscribe to it on private arrangements. It thus proposes a situation where both government contributions and involvement as well as individual contributions are required. It is not exclusively private and not exclusively public either.

ISSN 2054-6335(Print), ISSN 2054-6343(Online)

Healthcare as Public Good: The Implication for Healthcare management

Whereas the issue of healthcare financing may be perceived as a combination of both the private and public engagement, the National Economic and Social Rights Initiative (2009:1-4) contends that while it is often popularly believed that healthcare financing may be *realized as by-products of fragmented, market-based services*, the goal of a healthy society is actually at the roots of government responsibility. This places a duty on government to protect the health of all her citizens and deliver healthcare as public good. They therefore argue that,

> If we agree on the common goal of a healthy society, we need to create a robust and sustainable system of collective health care provision that guarantees that everyone can get the health care they need, regardless of their ability to pay.

This school of thought believes that healthcare services should be provided by government, through the public budget, as a core part of their social responsibility thereby making it equitably available to all members of society irrespective of their financial status. This is obviously opposed to the views of the proponents of healthcare insurance where the availability and level of service accessible to individuals ultimately depends on their ability to make the amount of contribution commensurate to what they need at a given time under a specified scheme.

Much as this stance of the Scheme does not preclude individuals from taking up health insurance that suits their fancies and peculiar needs, the argument for publicly provided healthcare emphasizes the necessity for a minimum healthcare service to be made available for those who may not be able to afford basic healthcare if the government do not take it up as a social responsibility.

They listed a number of points, in line with their proposition, which should guide healthcare delivery. They include the following:

1. The goal of a healthy society must take precedence over other factors and as such, the health care system should be financed in a way that guarantees and secures comprehensive health care for everyone.

2. How health care is financed must not lead to differences in how people receive healthcare, either with regard to access, quality, or outcomes. Financing mechanisms should produce a unified health care system and not give rise to different tiers of access or coverage.

3. Health care is a public good that should be publicly financed and administered with the burdens and benefits shared equitably by all. The government has a duty to guarantee everyone equal and easy access to healthcare as public goods and thus minimizes the disincentives to providing care that characterize the business model of private insurers.

4. At the point of access, health care services must be provided without any charges or fees. Health care funds should be collected independent of the actual use of care, to avoid creating a barrier to care.

Considering the above postulations by the National Economic and Social Rights Initiative (2009) it becomes obvious that only government financing of Health care services can provide

ISSN 2054-6335(Print), ISSN 2054-6343(Online)

equitable and non-discriminatory healthcare eservices through taxation and/or direct budgetary allocation.

The rationale for not leaving healthcare in the hands of those who have health challenges was supported by Smith and Witter (2004:1, 4), in their opinion that risk pooling is arguable on grounds of both equity and efficiency.

> While the equity arguments reflect the view that society does not consider it to be fair that individuals should assume all the risk associated with their health care expenditure needs, the efficiency arguments arise because pooling can lead to major improvements in population health, can increase productivity, and reduces uncertainty associated with health care expenditure.

Adding a voice to pooling of funds, McIntyre (2007:7),

> addresses the unpredictability of illness, particularly at the individual level; the inability of individuals to mobilize sufficient resources to cover unexpected health care costs; and, consequently, the need to spread health risks over as broad a population group and period of time as possible.

The justification for this line of thought is that it is unfair to allow individuals to totally bear the risk associated with the cost of their medical care. This is for the fact that individual health conditions have implications, not only for themselves, but also for the wider society. The implications of an individual's inability to function in the society due to health challenges is not limited to that individual alone, but have a wider implication for the society at large. The individual who is incapacitated to attend to his functions also affects other individuals and the society who depend on his functionality to carry on with their own endeavours. Thus, keeping such an individual functional is beneficial to the collectivity and as such it becomes a collective responsibility of the larger society to assist in ensuring the maintenance of his/her health.

The second part of the proposition is that if resources are pooled, it increases the capacity of the society to improve healthcare delivery system and thereby increase productivity of individual members of the society as well as reduce the uncertainties associated with health challenges and associated expenditure.

Among the five healthcare services financing mechanisms identified by Bennett and Gilson (2001), tax-based option seem very prominent because it is progressive in nature; the richer pay more while the poorer pay less tax from which healthcare services are provided. Again it is equally accessible to both the poor and the rich especially as it does not attract user fee at the point of accessing health care.

From the foregoing, only the government can manage such funding if all members of the society will benefit from a minimum healthcare service especially in a predominantly poor country like Nigeria. Any form of health insurance is naturally limited to those that contribute and the value of their contribution. This method ultimately excludes those who do not contribute either due to poverty or inaccessibility of the scheme to them. Government funding of healthcare as public good does not hinder those that prefer other higher healthcare attention from procuring them from other alternatives sources suitable to them.

It is arguable that funding healthcare services through tax revenue ensures more equity since the higher income earners pay more tax than the lower income earners. This arrangement thus

ISSN 2054-6335(Print), ISSN 2054-6343(Online)

transfers more health services at less cost to low income earners than they would otherwise have accessed if they paid directly through individual health schemes or direct purchase of healthcare services.

In the final analysis, where government perceives the financing of healthcare as necessary part of its social responsibility and provides it as a public good, the contributions of various segments of the society to healthcare financing will be perceived only as supportive and not primary as in the current disposition of the NHIS. Healthcare financing will thus be accommodated in public budgetary provision as a public good and whatever additional sources of income for financing healthcare that is available will be supplementary. This will ensure that sufficient funds are made available for adequate funding and development of the nation's healthcare services.

In other words, the perception of government's level of responsibility to healthcare delivery invariably determines its commitment to its funding. For now it appears as if government perceive it as a partial responsibility or have only a regulatory responsibility for the health sector. But government need to perceive it as her full social responsibility and make adequate budgetary provisions to accommodate cost of healthcare in her public spending.

Furthermore, Stabile and Thomson (2014:2) shared the view that nations across the OECD ensure universal access to health care for their citizens through national or regional risk pooling financed by mandatory income-related contributions (premiums). However they also noted that

> the evidence available on the relationship between financing and outcomes suggests that health systems financed through social insurance (as opposed to general tax revenues) tend to be more regressive (Stabile and Thomson, 2014:27).

This view on the retrogressive nature of social insurance is essentially borne out of the fact that the rich are likely to spend a lower percentage of their income on healthcare while the poor are more likely to spend a higher percentage of their income on the same heading. In order to ensure more equity in healthcare delivery, preference needs to be given for financing healthcare through taxation rather than health insurance.

However, the issue of how to guarantee wide coverage in healthcare delivery has remained a persistent question in healthcare financing. Emphasis has been on funding from enrolees and their employers with generally low government subsidy from budgetary allocation. The implication of this stance is that where the level of poverty is high, as in most African countries including Nigeria, contributions by enrolees and their employers are low. This is essentially because of the high level of unemployment, poor income level, and high population of dependent individuals. Where those engaged in formal public sector employment make their contributions of 5 percent, plus the 10 percent from their employers, it is still too low to support the scheme even for themselves how much more their other dependants. Currently, there is no strong means of mandatorily pooling funds from those not engaged in the public sector for the purposes of funding the Scheme thereby leaving it majorly optional. The obvious implication is lower patronage and consequent low coverage of the Scheme.

This study therefore attempts to persuade a view in favour of strong government budgetary allocation for healthcare services in ways and manner that will accommodate, not just those employed in the formal public sector and their immediate dependants, but the teeming army of the unemployed, the incapacitated, and the rural dwellers that constitute the higher percentage of the Nigerian population. Consequently, since the performance of the NHIS both in terms of

ISSN 2054-6335(Print), ISSN 2054-6343(Online)

its operations and development depends on the adequacy of its funding, the case for substantial and regular government budgetary allocations irrespective of contributions by enrolees and their employers is imperative.

METHODOLOGY

Instrumentation

The major instruments for collecting the data for this study were the questionnaire and interview. The questionnaire was a combination of structured and unstructured types meant to elicit responses in the areas that constitute the specific objectives of the study. One of the Questionnaires was administered to officials of the NHIS and healthcare providers in the Enugu urban while other types were administered to selected enrolees of the NHIS and members of the public.

Effort was made to ensure that only literate people who understood the information required in the questionnaire were enlisted as respondents. However, where responses from enrolees who could not read or write were necessary, research assistants interpreted and explained the questions to such respondents without any undue interference with what their opinions were. They were guided through their responses in a form of structured interview using the questionnaire as the format while research assistants filled in their responses to the questions.

Population and Sample of Study

The study involved a number of groups that included the officials of the NHIS, healthcare providers, beneficiaries of the NHIS, and members of the public. In order to accommodate every segment of these groups, the researcher adopted the Topman's formula for infinite population in determining the size of the sample to be used in the study since the population literally included the over 180 million Nigerians the Scheme was meant for.

The sample of three hundred and eighty four (384) for the study was thus arrived at using the formula as stated below.

n = Sample size

z = standard normal deviation

p = probability of success

q = probability of failure

e = error margin @ 5%

Where the values are:

p = .5

q = .5

z @ 5% = 1.96

e = .05

ISSN 2054-6335(Print), ISSN 2054-6343(Online)

Therefore:

$$n = \frac{z^2\,pq}{e^2} = \frac{1.96^{\,2}(.5 \text{ x } .5)}{.05^2} = \frac{1.96 \text{ x } 1.96 \text{ x } (0.25)}{.05 \text{ x } .05} = \frac{3.8416 \text{ x } 0.25}{0.0025} = \frac{0.9606}{0.0025} = 384.16$$

The sample size therefore is 384 respondents.

The sample for the study was randomly selected from the various categories to include officials of the NHIS in Enugu state, healthcare providers, enrolees of the NHIS and members of the public as shown in table 1 below. The sampling technique used in the study was stratified random techniques for all the four categories

Table 1

	Category	Sample	Percentage
1	NHIS Officials	34	9
2	Healthcare providers	20	5
3	NHIS Enrolees	150	39
4	Selected members of the public	180	47
	TOTAL	384	100

Sample Distribution table

Source: Research data 2018

RESULTS

Data presentation and discussion of findings in this paper was done in two phases. The first dealt with the issue of the perceived level of performance of the Scheme as an option in healthcare management in Nigeria. This was presented in line with the stated objectives of the Scheme. Individual and summary of the performance of the Scheme were presented in figures 1-4 below. These were accompanied with their discussions. Phase two discussed the challenges facing the Scheme in its attempt to pursuit its objectives. Most of the information included here emanated from both literature and interviews with purposively selected individuals. Finally, some recommendations were made based on the findings of the research.

The level of performance of the National Health Insurance Scheme (NHIS)

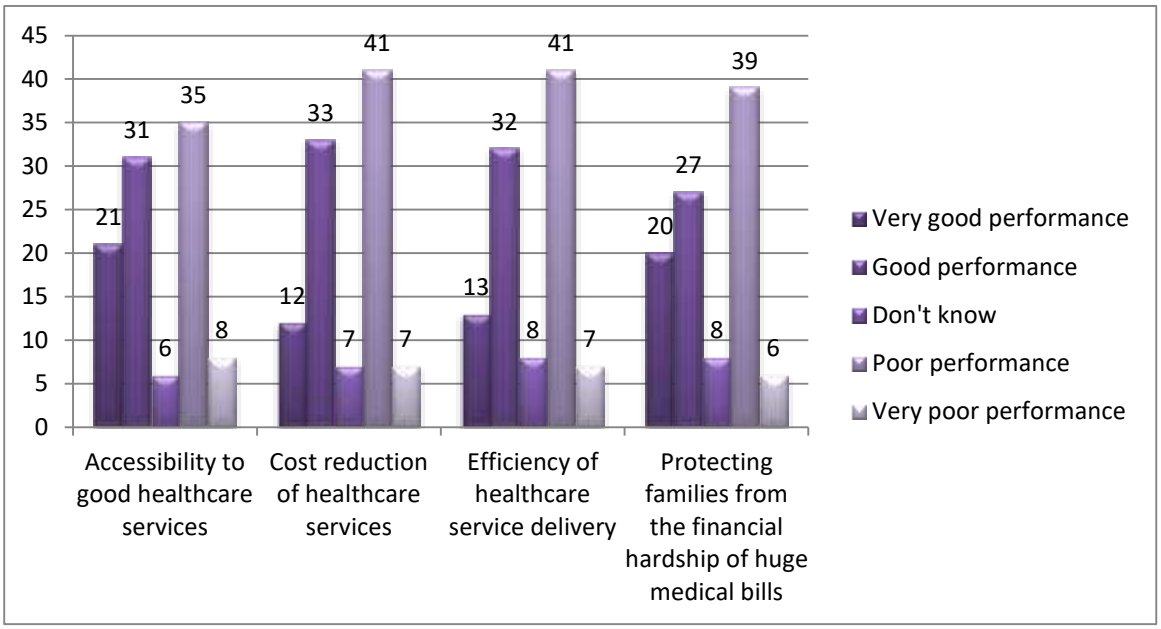
There was an attempt to evaluate the performance of the Scheme along the lines of their set objectives. The enabling Act 35 of 1999 that established the NHIS has the major objective of fast-tracking health for all Nigerians. This broad objective was split into eleven sub-goals which were listed as follows: Accessibility to good health services; Cost reduction of healthcare services; Efficiency of healthcare service delivery; Protecting families from the financial hardship of huge medical bills; Limiting the rise in the cost of healthcare services; Equitable distribution of healthcare cost among different income groups; High standard of healthcare services delivery to Nigerians; Improvement and harnessing of private sector participation in the provision of healthcare services; Equitable distribution of health facilities within the

ISSN 2054-6335(Print), ISSN 2054-6343(Online)

Federation; Appropriate patronage of all levels of healthcare; Availability of funds to the health sector for improved services.

The discussion of the findings in this regard is presented in the figures below in line with the different sub-goals shown in the bar charts.

Figure 1



(1) Accessibility to good health services; (2) Cost reduction of healthcare services; (3) Efficiency of healthcare service delivery; (4) Protecting families from the financial hardship of huge medical bills

Source: Research Data, 2017

From the responses obtained, the performance of the NHIS in the area of ***Accessibility to good healthcare services*** scored the highest positive value of 52 percent (21+31) and a negative rating of 43 percent (35+8). ***Cost reduction of healthcare services*** has a positive score of 45 percent (12+33) and 48 percent (41+7) negative score. ***Efficiency of healthcare service delivery*** has 45 percent (13+32) positive score and 48 percent (41+7) negative score. ***Protecting families from the financial hardship of huge medical bills*** has a positive score of 47 percent (20+27) as against a negative score of 45 percent (39+6).

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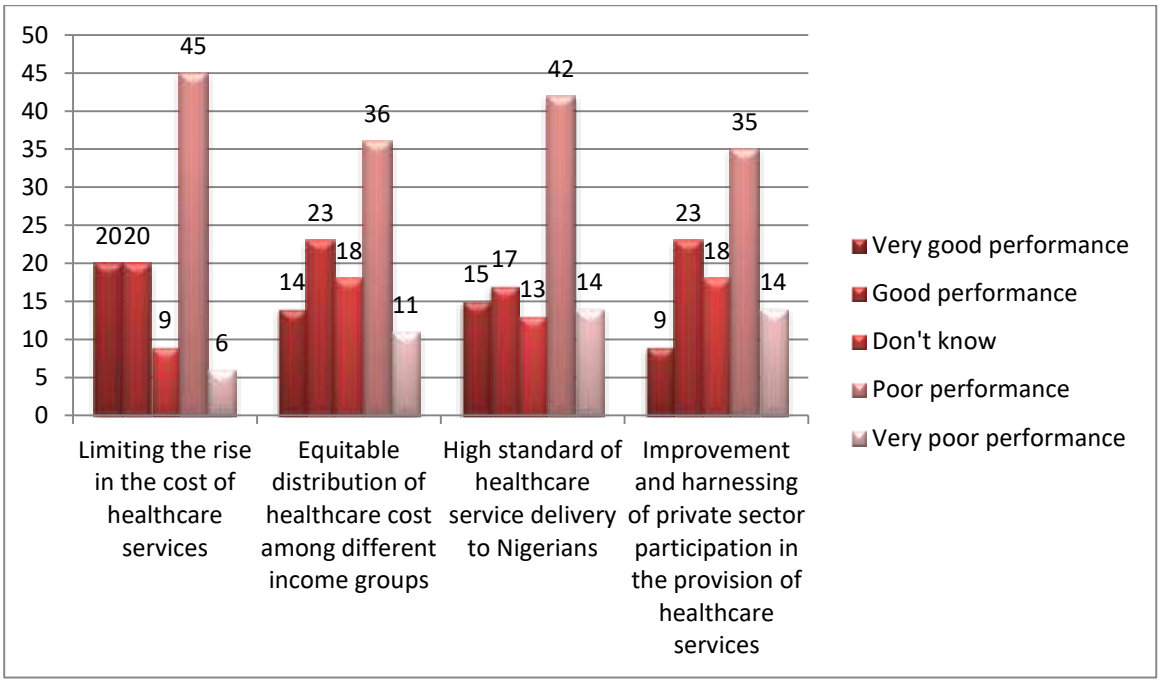
Figure 2



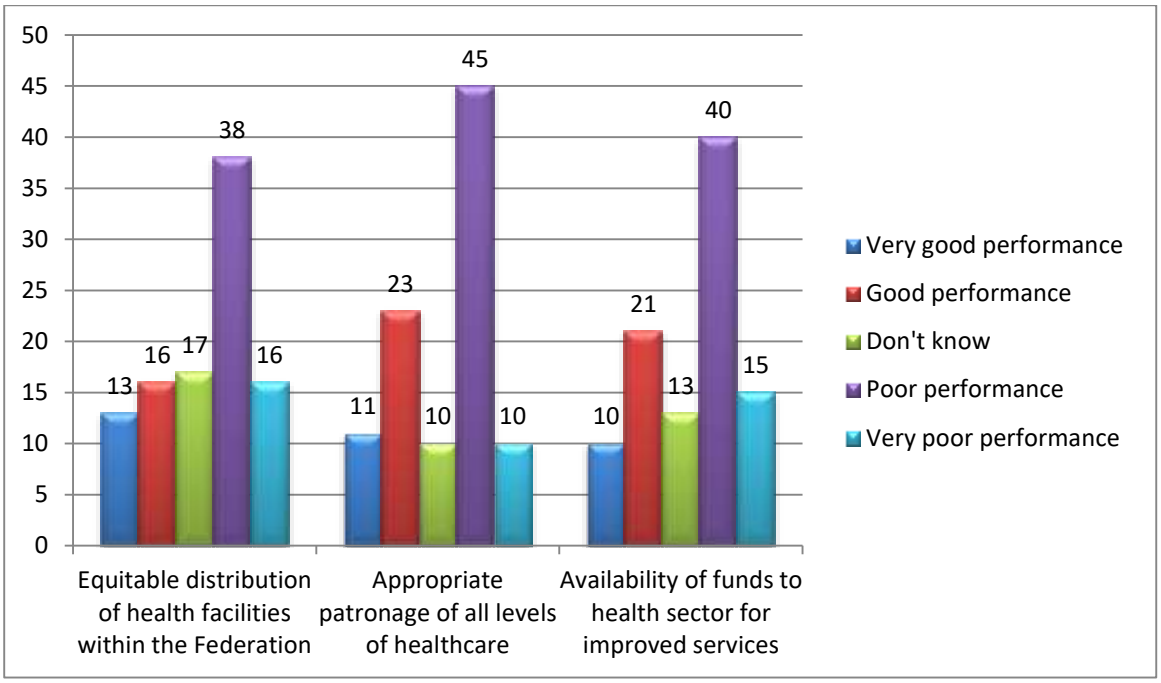
(5) Limiting the rise in the cost of healthcare services; (6) Equitable distribution of healthcare cost among different income groups; (7) High standard of healthcare services delivery to Nigerians; (8) Improvement and harnessing of private sector participation in the provision of healthcare services.

Source: Research data 2017

Limiting the rise in the cost of healthcare services has 40 percent (20+20) positive score and 51 percent negative score (45+6). ***Equitable distribution of healthcare cost among different income groups*** has 37 percent (14+23) positive score and 47 percent (36+11) negative score. ***High standard of healthcare services delivery to Nigerians*** has a positive score of 32 percent (15+17) and a negative score of 56 percent (42+14). ***Improvement and harnessing of private sector participation in the provision of healthcare services*** has a negative score of 32 percent (9+23) and 49 percent (35+14) negative score.

ISSN 2054-6335(Print), ISSN 2054-6343(Online)

Figure 3



(9) Equitable distribution of health facilities within the Federation; (10) Appropriate patronage of all levels of healthcare; (11) Availability of funds to the health sector for improved services.

Source: Research data 2017

Equitable distribution of health facilities within the Federation has a positive score of 29 percent (13+16) and a negative score of 54 percent (38+16). ***Appropriate patronage of all levels of healthcare*** has a positive score of 34 percent (11+23) as against a negative score of 55 percent (45+10). Finally, ***Availability of funds to the health sector for improved services*** scored 31 percent (10+21) positive with a negative score of 55 percent (40+15).

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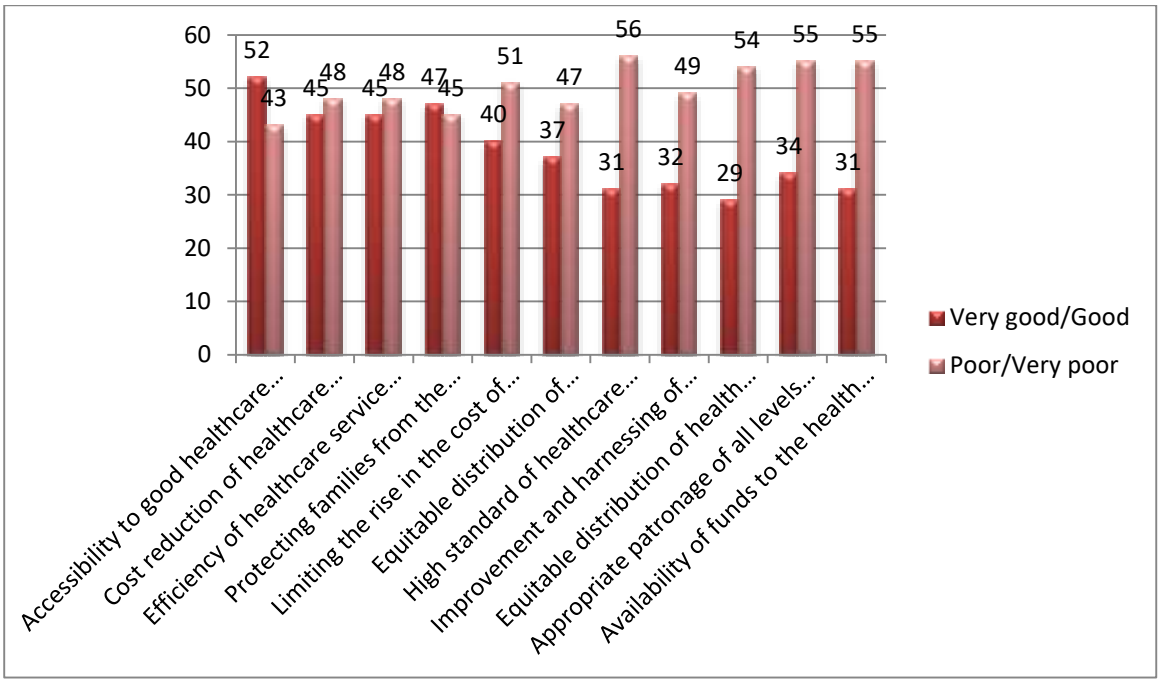
Figure 4



Summary of tables 1, 2 and 3

Source: Research data 2017

DISCUSSION

From the responses obtained, the performance of the NHIS in the area of *Accessibility to good healthcare services* scored the highest positive value of 52 percent and a negative rating of 43 percent. The scores for *Protecting families from the financial hardship of huge medical bills* also had a slightly higher positive score of 47 percent as against a negative score of 45 percent. Beyond the above two areas, the NHIS performance assessment are negative in all the other nine areas of their performance index.

Findings reveal that the performance of the Scheme may be divided into two major sides. The Scheme was deemed to have performed averagely in internal areas relating to services enjoyed by enrolees such as Accessibility to good health services and Protecting families from the financial hardship of huge medical bills. However, the performance of the Scheme was considered poor in external areas bordering on its responsibility to the larger society and its development strides such as Cost reduction of healthcare services; Efficiency of healthcare service delivery; Limiting the rise in the cost of healthcare services; Equitable distribution of healthcare cost among different income groups; High standard of healthcare services delivery to Nigerians; Improvement and harnessing of private sector participation in the provision of healthcare services; Equitable distribution of health facilities within the Federation; Appropriate patronage of all levels of healthcare; and Availability of funds to the health sector for improved services.

ISSN 2054-6335(Print), ISSN 2054-6343(Online)

It is safe to conclude that much as the Scheme have provided healthcare services to the enrolled public servants, the level of service provided has experienced serious challenges from the information volunteered by respondents. Worse still those outside the public sector have not been able to access healthcare services from the Scheme. In terms of the performance of the Scheme, one may safely conclude that it has not been felt in the larger society especially the unorganized private sector and the poor in the rural communities, and the Nigerian public at large.

The study attempted to review some of the major challenges confronting the NHIS which have made it difficult to attain its set objectives and which are capable of continuously crippling its operations into a distant future if not seriously addressed. They include issues bordering on funding, corruption, lack of sufficient government will and commitment, and other operational processes. Some of these challenges are briefly discussed below.

The challenge of funding the NHIS

The National Health Insurance Scheme Decree No 35 of 1999 (Section 11 of Part IV), Laws of the Federation of Nigeria made financial provision for the funding of healthcare delivery under the NHIS. These include such money as may be received from the Health Maintenance Organizations; money granted or received from the Federal, State and Local Governments; money granted or received from the organized private sector, international or donor organizations and non-Governmental organizations; and dividends and interests on investments and stocks. The thin spread of these donors without any definite budgetary commitment and responsibility by any of the above leaves the funding of the Scheme porous and to mere chance; a very poor treatment that a critical sector like the health sector do not deserve.

Unfortunately as should be envisaged from this arrangement, the level of funding available to the Scheme has remained grossly inadequate. According to *This Day* (2017) report on Nigeria's gross inadequate health sector budget for 2017 "while the United States of America will spend about $7m per prisoner in Guantanamo Bay in 2017, Nigeria will spend N1,688.00 on the health of each citizen in the same year. An unrealistic figure it (Nigeria) hoped would magically tackle the numerous health issues in the country". Again, the Executive Secretary of the NHIS, reported a budget proposal of N32b for 2017 operations of the Scheme to provide health insurance for 5 million Nigerians in the hinter-land. If this is broken down it will give a paltry sum of N6,400.00 for each person per year for healthcare services. This figure is grossly insufficient for even the 5 million Nigerians how much more daring the question of what happens to the remaining 175m Nigerians needing healthcare. According to the Executive Secretary (NHIS budgets N32b for 2017 operations, 2017), in 2016 N129m was budgeted while only N54m was released. Out of the amount released, N53m was spent across the six geographical zones on pregnant women and children below the age of 5 years, giving an average of about N7.57m per zone. What happened to the rest of the population that are neither pregnant nor under 5 years is anybody's guess.

Out of the internally generated revenue of N58.8m for 2016, the sum of N17.9m representing 25 percent was paid into the federation account. Only 4 million Nigerians out of 180 million were covered by the Scheme for 2016. The enabling NHIS Act stipulated that 1 percent of the nation's consolidated revenue should be allocated to Primary Health Development Agency and the NHIS, but this provision is very far from being realized (NHIS budgets N32bn for 2017 operations, 2017).

ISSN 2054-6335(Print), ISSN 2054-6343(Online)

Some pertinent questions that call for answers are whether Nigeria's top government officials, political office holders, members of the national and state assemblies dependent on the NHIS with this type of funding for their healthcare services both locally and abroad. Or do they have other arrangements outside the contributory health insurance scheme for their healthcare other than what they prescribe for the rest of the people under the NHIS? If they do it then means that they do not believe in the NHIS and consequently have budgetary and extra-budgetary provision for their health needs. Such provisions need to be extended to all other members of the society, some of who make more critical input to the Nigerian state than they do.

In their research on Health Care Financing in Nigeria, Eboh, Akpata, and Akintoye (2016) noted that poor governmental allocation of funds to the health sector has remained one of the major challenges facing the NHIS. This view was corroborated by Anyika (2014), Ejughemre (2014), Riman and Akpan (2012), Yunusa et al (2014), Eteng and Utibe, 2015) who saw funding as constituting the major challenge to healthcare delivery in Nigeria.

Leaving the funding of the Scheme to the contributions of the employers and employees relieves the government of her basic social responsibility of ensuring good health for the society by sitting on the fence. As observed by National Economic and Social Rights Initiative (2009), the various levels of government need to make adequate budgetary provisions for the health sector generally and the Scheme in particular. The implication of the current funding option majorly by employers and employees is that it highly limits the resources available to the Scheme for efficient and effective service delivery and further expansion. From research findings, a good number of prescribed drugs for enrolees are not available how much more setting out funds for future development. Financial constraints limit investment in infrastructural development, adequate equipment for healthcare points, and engagement of qualified personnel and organizations for the Scheme. This is especially so since the Scheme cannot grow beyond the level of funding available to it.

The Challenges of Corruption in the Scheme

Apart from very poor funding, the Scheme has had more than a fair share of corruption. The Punch Newspaper (2017) reported that the House Committee on Health of the National Assembly was investigating the "alleged rot in the implementation of the NHIS" and that the Executive Secretary was suspended over allegations of corruption. Of course the Executive secretary has been called back to office despite the hues and cries of the public and staff of the NHIS. The House Committee was also probing the role of Health Maintenance Organizations in the failure of the NHIS to deliver services."

Again, the Punch Newspaper (2017) also reported the discovery and removal of "23,000 ghost enrolees who have been enjoying the benefits of the NHIS which has brought a friction between the NHIS and Health Maintenance organizations in the country". The implication of this scenario is that the HMOs obviously make illicit gain from the enlistment of these ghost enrolees since they (HMOs) are paid for services not rendered. The Punch (2017) reported the petition bordering on alleged contract fraud of over N1b in the Scheme. According to the report "The Head of the Civil Service of the Federation has directed that the petition on 'monumental fraud, gross abuse of office and acts of nepotism' against the leadership of the Scheme be referred to your ministry for investigation and necessary action"

From the interview and the unstructured part of the questionnaire, some of the insinuations that pose serious challenge to the performance of the Scheme include accusations of diversion of

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funds and drugs meant for the Scheme. It was reported that while the small available funds are released to the Scheme, all such funds are not fully deployed for healthcare services under the Scheme. High level of corruption and fraud characterised the operations of the Scheme. There is a wide misappropriation of funds, dishonesty, greed and lack of transparency in the system. Some of the healthcare providers running the Scheme are selfish and do not consider the interest of enrolees in rendering healthcare services. They were rather more concerned with making their profits at the expense of their patients.

Lack of Government will and poor public policy drive

Part of the problem bedevilling the Scheme is bad governance and leadership coupled with the insensitivity of the federal government to the healthcare needs of the masses. The State government has also been unable to key in fully into the Scheme as a major stakeholder in developing and enhancing the operational capacity of the NHIS. There is insufficient budgetary allocation to the health sector to take care of those who cannot pay for medical care and finance the handling of critical ailments. Capitations sometimes do not come regularly to the Primary Healthcare Provider and as such affect healthcare delivery to enrolees.

Rewarding development stride in the Nigerian health sector will require purposeful governance that enunciates and drive well crafted public policies with determination. The NHIS is yet to see sufficient evidence of the demonstration of government's will and purposefulness in this regard. The Scheme is bedevilled with corruption, unhealthy scheming, and short-circuting of operational process that requires determined government supervision to contend with. But the weakness of government in handling these challenges has, over the years, pegged the functionality, growth and development of the Scheme. Inadequate government interest especially from other tiers of government other than the federal government has remained a prominent challenge to the Scheme.

Other challenges

While Osuchukwu *et al* (2013) identified other challenges facing the NHIS to include dearth of physicians, Anyika (2014) also argued that shortage of drugs, corruption, poor attitude of the health workers, obsolete and dilapidated health infrastructure also constitute major constraints on the operations and development of the health sector. Other challenges advanced by Omoruan, Bamidele and Philips (2009) include delays in the reimbursement of premium to the health facility owners. While (Agba, Ushie and Osuchukwu, 2010) argued that corruption and fund diversion have negatively affected the performance of the health sector, Sanusi and Awe (2009) pointed more to the prevalent obsolete and inadequate health facilities used by healthcare service providers. All these factors and more have contributed in one way or the other in grounding the effectiveness and efficiency of the NHIS is achieving its nation-wide objectives.

Other issues raised include the state of the society, the operation and system of the Scheme, the government, and the healthcare providers. On the part of the society, issues being experienced sometimes border on the level of poverty in the country. Respondents adduced that the rising unemployment and low income in Nigeria and the resultant high poverty rate makes it difficult for most persons that are not in the organized public sector to enrol in the Scheme. Even in some organized sectors like the Local government Authorities, poor salaries for the staff affect health insurance Scheme enrolment. Consequently, poor groups in the society were

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systematically excluded from the Scheme by reason of unaffordability and accessibility to the Scheme.

Furthermore, a lot of healthcare providers do not give complete medication to enrolees due to insufficient drugs in their hospitals. Enrolees are consequently compelled to use their money to buy the extra drugs they need after having made their contributions to the Scheme. Moreover, co-payment made by a contributor at the point of service is often very high. It is also expected that drug providers should cover all the basic drugs needed in the hospital as well as monitor how the drugs are distributed in the hospitals. But experience has not supported this expectation. At some other times, drugs meant for the Scheme are diverted to private clinics and other places thereby increasing the shortfall with the healthcare providers.

IMPLICATIONS TO RESEARCH AND PRACTICE

The implications of this paper to research and practice relate essentially to the need to approach any concept from the perspective of its context. Health insurance is a universally acceptable option in healthcare delivery the world over. However the temptation facing developing countries like Nigeria is the tendency to adopt such public policies that work in developed economies of the world without giving reasonable attention to the conditionalities that make such policies workable. The burden of comparative public administration is to examine the operations of public policies in the context of their interaction with their environment. For example, high rising building seen in developed nations are built without addressing the issues of power supply that will power the lifts and other accompanying facilities. Electoral policies are copied without giving due attentions to how to manage and control the underlying contextual ethnic, religious and class conflicts that influence it. The research points strongly at examining the operations of health insurance in the Nigerian context not withstanding its operations and successes recorded in more developed economies of the world from where Nigeria borrowed it.

Universally, health insurance puts some level of responsibility on the individual beneficiaries and helps them to take basic precaution like any other insurance policy. And rather than putting the entire burden on the government, it advocates a shared responsibility between beneficiaries and the government. This sounds quite acceptable in many quarters. However, when put in contextual perspective it becomes obvious that a concept that works in a developed economies of the world where basis income and means of livelihood is guaranteed, at least from government's welfare programmes, individuals have access to some sort of income from which they may be able to make contributions to health insurance. this may not quite work well in poorer nations of the world where people wallow in poverty without any basic support from the government by way of welfare support. Consequently, it is important to place any concept and policy in the context of its operational environment.

In practice, while successful administration in any state is based on the combination of efforts and sharing of responsibilities between the government and the governed, there are exceptions where this joint responsibility needs to be tilted in favour of one party to achieve an overall better result. Healthcare management is one of such areas where the insistence on affected individuals taking the responsibility may not turn out in the overall interest of the society at large. Much as one does not advocate a totally welfare approach to healthcare delivery, health insurance is best practicable where the economic circumstance of citizens can guarantee their contribution to health insurance. In that case, the government can rest assured that the citizens are capable of footing the full bill, or substantial part of the cost of their healthcare services.

ISSN 2054-6335(Print), ISSN 2054-6343(Online)

But where the predominant economic condition is abject, government will be doing itself, and the entire society, a lot of harm by limiting its operational capacity through the exposure of the greater percentage of their labour force to debilitating health challenges.

The major gap this study sought to fill is to proffer alternative to healthcare service delivery based essentially on contributory health insurance scheme with a predominant population of very poor citizenry who cannot afford the required contribution. This alternative is through direct budgetary allocation by different levels of government.

7.0 CONCLUSION

While some enrolees responded in favour of good performance of the Scheme because they are beneficiaries, it needs to be noted that the coverage of the Scheme has been very narrow and limited to the formal public sector. No attention has so far been given to the private sectors, individuals, and the rural communities that constitute the bulk of the Nigerian public. Consequently, much as the performance of the Scheme may be adjudged successful to some extent, the deception of this position is easily revealed when her performance is rated against its set objective of providing efficient, cost-effective and wide coverage of healthcare services to ALL Nigerians.

Consequently, the actual performance of the NHIS will be made more manifest when it is viewed in relation to the teeming population of Nigerians needing healthcare services. This is more appreciated in the views of the Guild of Medical Directors who revealed that "only 2 percent of Nigerians have enrolled in NHIS, and by comparison, Ghana, Kenya and Rwanda have achieved over 69 percent health insurance coverage enrolment (The Punch Newspaper, 2017). What happens to the remaining 98 percent is anybody's guess.

In conclusion, it is obvious that much as the NHIS has attempted to address healthcare management in Nigeria, their level of coverage and performance is still very far from being a viable option in healthcare management. In view of very limited funds generated through employee and government contributions, poor management of the Scheme, and other challenges advanced above, it is obvious that only full scale budgetary allocation can address the healthcare needs of the teeming Nigerian public. Health insurances only responds to the needs of those that contribute to the pool but has never successfully addressed those who are incapable of contributing to such insurance schemes but whose health is a necessary condition for the society to function effectively and efficiently.

Future Research

Following from the findings of the study, other areas that need further research with a view to ensuring and strengthening a healthier healthcare management include the following. Efforts need to be directed at examining how the development and operations of health insurance schemes should be substantially expanded to encompass all segments of the society especially in a predominantly poor countries of the world rather than focusing only on a segment of the formal public sector. Furthermore more rewarding options in handling corruption, fraud, misappropriation of funds, dishonesty, greed, diversion of drugs, and lack of transparency at all levels of governments that dissipate available funds should be sought. Finally opportunities need to be explored on how to accommodate public health financing in budgetary allocations of various levels of government especially in poor and developing nations.

ISSN 2054-6335(Print), ISSN 2054-6343(Online)

REFERENCES

Anyika, E. N. (2014). "Challenges of Implementing Sustainable Health Care Delivery in Nigeria under Environmental Uncertainty" *Journal of Hospital Administration*, 3(6):113-126.

Bennet, S., and Gilson, L. (2001). *Health Financing: Designing and Implementing Pro-poor Policies.* London, DFID Health Systems Resource Center.

Copland, K. P. (2013) "The Future of Healthcare Insurance: What's Ahead" in *Deloitte Review*, Issue 13, 118-121.

Eboh, A., Akpata, G. O., and Akintoye, A. E. (2016). "Health Care Financing in Nigeria: An Assessment of the National Health Insurance Scheme (NHIS)" in *European Journal of Business and Management* www.iiste.org ISSN 2222-1905 (Paper) ISSN 2222-2839 (Online) Vol.8, No.27, 2016

Ejughemre, U. J. (2014). "Accelerated Reforms in Healthcare Financing: the Need to Scale up Private Sector Participation in Nigeria" *International Journal of Health Policy Management*, (2)1:13-19

Eteng, I. E. & Utibe, E. E. (2015). "The National Health Insurance Scheme and its Implication for elderly Care in Nigeria" *International Journal of Science and Research*, (2)4:128-132.

Federal Government of Nigeria (1999) *National Health Insurance Scheme Decree, No 35 of 1999, Laws of the Federation of Nigeria* 10th May 1999

Federal Government of Nigeria (2006) *National Health Insurance Scheme Handbook*, Abuja, Government Press

McIntyre, D. (2007) "Health Financing, Learning from Experience: Healthcare financing in Low and Middle Income Countries" *Global Forum for Health Research June 2007*

McIntyre, D., Gilson, L., and Mutyambizi, V. (2005) *Promoting equitable health care financing in the African context: Current challenges and future prospects*. Harare: Regional Network for Equity in Health in Southern Africa (EQUINET).

National Economic and Social Rights Initiative (2009) "Human Rights Principles for Financing Health Care" *National Health Law Program (NHeLP)*, New York. Downloaded from http://www.healthlaw.org) on 26/02/2016

National Health Insurance Scheme (2006) *Handbook*, Abuja, Public Enlightenment and Mobilization Unit, NHIS

NHIS budgets N32bn for 2017 operations (2017). *Daily Trust* downloaded from https://www.dailytrust.com.ng

Nigeria's Grossly Inadequate 2017 Health Budget (2017) *This Day Newspapers* February 9, 2017. http://www.thisdaylive.com

Osuchukwu, N.C., Osonwa, K.O., Eko, J.E., Uwanede, C.C., Abeshi, S. E., & Offiong, D.A. (2013). "Evaluating the Impact of National Health Insurance Scheme on Health Care Consumers in Calabar Metropolis, Southern Nigeria" *International Journal of Learning and Development*, 3(4):30-45.

Riman, H. B. and Akpan, E. S. (2015). "Healthcare Financing and Health outcomes in Nigeria: A State Level Study using Multivariate Analysis" in *International Journal of Humanities and Social Science*, 2(15): 296-309.

Smith, J. C. and Medalia C. (2015) *Health Insurance Coverage in the United States: 2014*, Washington, DC, U.S. Government Printing Office.

Smith, P. C., and Witter, S. N. (2004) "Risk Pooling in Health Care Financing: The Implications for Health System Performance" *HNP Discussion Paper*, September,

ISSN 2054-6335(Print), ISSN 2054-6343(Online)

2004.The International Bank for Reconstruction and Development/ The World Bank Washington DC.

Stabile, M., and Thomson, S. (2014) "The Challenging Role of Government in Financing Health Care: An International Perspective." *Laboratoire Interdisciplinaire D'évaluation Des Politiques Publiques LIEPP Working Paper,* May 2014, Nº 26

Stoner, J. A. F., Freeman, R. E., Gilbert, D. R. (2006). *Management 6th edition*, New Delhi, Prentice Hall of India

The World Health Report. (2000). *Health Systems: Improving Performance.* World Health Organization, Geneva, 2000 [http://www.who.int/whr/2000].

World Health Organization (2005). *Sustainable health financing, Universal coverage and social health insurance*. Geneva 2005, (A58/33).

World Health Organization (2008). *Health Systems Financing: Toolkit on monitoring health systems strengthening* World Health Organization, Geneva, [http://www.who.int/2008]

Yunusa, U. Irinoye, O. Suberu, A. Garba, A.M. Timothy, G. Dalhatu, a. & Ahmed, S.(2014). "Trends and challenges of Public Healthcare Financing System in Nigeria: the Way Forward" *Journal of Economics and Finance,* 4(3):28-34.

ISSN 2054-6335(Print), ISSN 2054-6343(Online)