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Health Care Financing in Nigeria: An Assessment of the National Health Insurance Scheme (NHIS)

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Abstract
How a nation finances its health care delivery system could be a clear parameter in assessing the premium placed on its people's health. As a critical developmental component like food, shelter and clothing, the health sector requires adequate funding. However, the funding of health care system varies across different countries. In the case of Nigeria, the financing of the health care delivery system is majorly through tax revenue, out-of-pocket payment or user fees, donor funding and social health insurance. The federal government introduced the National Health Insurance Scheme (NHIS) because it considered funding health so demanding due to dwindling economy, perennial shortage of qualified and competent health personnel, shortage of drugs and other health infrastructures. More importantly, the introduction of the scheme was to guarantee good and qualitative access to efficient health care services such that it could reduce catastrophic household out-of-pocket health expenditure. Since its inception and resuscitation, several states across the country have keyed into it. However, actual implementation of the scheme by these states appeared not to have commenced fully. While this paper identified the various major sources of health care financing in Nigeria, its focal point was on the NHIS. Consequently, a framework for explaining the impact of the scheme within the context of Nigeria was designed through a triangulation of Structural Functionalist and Rational Choice Theories. The major findings about NHIS from the cross-sectionalized review of the empirical studies conducted across Nigeria revealed among others that the level of awareness of the scheme among the target population in some states was high while a couple of states recorded low-level knowledge of the scheme. In addition, the introduction of the scheme has tremendously scaled up the patronage and utilization of health facilities and reduction in out-of-pocket expenditure for health services rendered. This paper therefore recommended among others that the government in collaboration with relevant partners should intensify optimal awareness and education on the scheme to all Nigerians. It also suggested increased funding for the scheme through budgetary allocation to the health sector.
Keywords: Health care financing, National Health Insurance Scheme; and Impact

1.1 Introduction

Research on health as a critical component of national development has continued to receive adequate attention in both extant and current literature. This is not unconnected with the fact that investment in human capital through health could bring about economic growth and development. Health boosts worker effectiveness and the productivity of an individual via increase in physical and mental capacities, which are necessary for economic growth and development (Imoughele & Ismaila, 2013; Owumi & Sakiru, 2013; Yunusa, Irinoye, Suberu, Garba, Timothy, Dalhatu & Ahmed; 2014). As important as this social good (health) is, access to it as an integral part of the overall health system has been fraught with some difficulties in terms of financing and cost of billing for the services received. Consequently, like many public services, it is not equally accessible to all people (Joseph & Phillips, 1984), and so, limited physical access to basic health care continues to be a major impediment to achieving the goal of health care for all. In the light of the foregoing, governments all over the world consciously attempt through policy formulation and implementation to bring health care services closer to people across economic divides and different social strata. This is basically to reduce the constraint of finance in accessing health services. While attempting to identify some sources of health care financing in Nigeria, the core concern of this paper however, is to explore theoretically and empirically the nature and the structure of the National Health Insurance Scheme (NHIS) in Nigeria; its level of awareness among the targeted populations, the scheme's effect on health care services utilization and the way forward.

1.2 Health Care Financing

Healthcare financing can be defined as the mobilization of funds for healthcare services (Oyefabi, Aliyu & Idris, 2014). In other words, it is the provision of money, funds or resources to the activities designed by government to maintain people's health. These activities encompass the provision of medical and related services geared toward maintaining good health, especially in the aspect of disease prevention and curative treatment. The concept of health care financing succinctly deals with the quantity and quality of resources a country expends on health care. This is proportionate to the country's total national income. The amount of resources earmarked for health care in a country is said to be a reflection of health value placement vis-à-vis other categories of goods

and services. It has been opined that the nature of health care financing defines the structure and the behaviour of different stakeholders and quality of health outcomes (Metiboba, 2012).

The pattern of health financing is therefore intricately connected and indivisibly linked to the provisioning of health services (Rao, Salvaraju, Nagpal & Sakthivel, 2009 & Riman & Akpan, 2012). The duo, Riman & Akpan argued that the definition of health care financing cannot be narrowly conceived and confined to raising enough resources to fund health care needs of people alone, but also entails the questions of affordability and equitable access to health care services by them, including guaranteed financial risk protection. In consonance, Metiboba (2012) contended that when it comes to analyzing health care financing, it is fraught with some nuances since some types of health care services are skewed towards benefitting groups and the community collectively. Worth mentioning here are vaccination against certain communicable diseases, control of malaria and environmental sanitation. Other issues that make analysis of health care financing problematic are public expenditures on food, clothing, shelter and education. The mutually reinforcing trajectory of relationships that exist between the aforementioned survival needs also makes health care financing analysis a difficult one.

One of the intricate issues and nuances associated with the analysis of health care financing is the identification of health care expenditure given the demarcation between preventive and curative health care services. The proposed integration of traditional medicine practitioners into the mainstream formal health sector will further pose a challenge to the analysis of health care financing as argued by Metiboba (2012).

1.2.1 Sources of Health Care Financing in Nigeria

There are various sources of healthcare financing existing across the world, including Nigeria. These sources include, but not limited to tax-based public sector health financing, household out-of-pocket health expenditure, the private sector (donor funding),community-based health expenditure, and social health insurances. External financing of health care includes grants and loans from donor agencies like the World Bank, the World Health Organization (WHO), Funds and Foundations among others (Dutta & Charles, 2013, Mladovsky & Mossialos, 2008; Metiboba, 2012; Riman & Akpan, 2012; Yunusa et al, 2014; Obansa & Orimisan, 2013; Jegede, 2002).

i. **Tax-based Public Sector Health Financing:** this source of health care financing is derived from proceeds of tax-based revenue of government across all levels and sectors. At the federal level, the pool of taxes entails crude oil and gas export proceeds, petroleum profit tax, royalties and the component proceeds of domestic crude oil sales/other oil revenues, companies' income tax, customs and exercise duties, Value-Added Tax (VAT), tax on petroleum products, education tax among others (Obansa & Orimisan, 2013; Yunusa *et al*, 2014; Onotai & Nwankwo, 2012). Financing of the healthcare by the government is largely a function of its revenue base. In essence, there is a strong positive relationship between the proportions of tax-based health spending and the progressivity of total health expenditure. Savedoff (2004) posited that one of the foremost advantages of tax revenue is the pooling of health risks across a large contributing population.

Another implication of raising funds through taxes is that contributions are usually spread over a larger share of the population than might otherwise be the case. Although in many countries, some employers and employees are not captured in the tax net due to some informal work arrangements thereby concentrating health insurance on formal sector workers, through other revenues that affect almost everyone, such as VAT, sales taxes, and import duties, including the scope for mobilizing resources which may be larger for Tax-Based Systems (TBS). It is also noted that countries with more progressive tax systems such as USA, Switzerland, Netherlands and Germany rely less heavily on general tax revenues to finance health expenditure; though political trade-off may be involved. The way some countries use tax revenues is such that some rely heavily on general income tax to fund their healthcare system while others depend solely on regional or local taxes as a source of funding for health (Savedoff, 2004).

ii. **Household Out-Of-Pocket (OOP) Health Expenditure:** this is also referred to as user-charges. The health facility owners impose some charges on individuals for healthcare services up-take. OOP health expenditure could be incurred directly by a patient to a health service provider without reimbursement. This covers on-the-spot payment for health care services received. The scope of individual health user-fees could be an admixture of drug costs, medical material costs, entrance fees, and consultation fees (Yunusa et al, 2014). Out-of-pocket payment, otherwise known as private health expenditures accounted for more than 90% cost in accessing health in Nigeria. Consequent upon this, it was noted that over-reliance on the ability to pay through OOP has the potency of reducing health care up-take. This can exacerbate the already inequitable access to quality care (Riman & Akpan, 2012; Uzochukwu & Uju, 2012; Onwujekwe, Uzochukwu, & Onoka, 2011; Ahmed & Mesbah, 2015). OOP expenses also comprise user-fees in public health facilities and any other private payments to healthcare providers for medicals and other treatment received.

Oyefabi, Aliyu & Idris (2014) further noted that significant number of people footed their health bills based on user-charges. Similarly, healthcare financing across the less developed and developing countries is still characterized by OOP health expenditure. Given the resonating poverty situation in Nigeria, health care spending on some debilitating illnesses can be catastrophic. It is catastrophic if OOP exceeds the household income or its capacity to pay for healthcare services received. In other words, if the large proportion of the household budget

goes into health expenditure thereby leaving little to meet other basic health components like food, shelter, education, hygiene, etc. In terms of measurement criteria, catastrophic health expenditure can be determined when OOP healthcare expenditures exceed a pre-specified fraction of the household total expenditure. That is, OOP healthcare expenditures exceeding 40% of non-subsistence expenditure. Catastrophic health expenditure for any household may further push it into poverty (Ahmed & Mesbah, 2015).

In extreme situation, the implication of a very high level of OOP health spending is that a significant proportion of the poor may be driven into squalor after paying for health care. A chronic ill-health situation that afflicts the breadwinner of the family may completely impoverish it especially those who sell their labour on daily basis to fend for their families. Even the non-poor may be impoverished by large random out-of-pocket payments arising from unpredictable ill health (Uzochukwu & Uju, 2012). In like manner, Abayomi (2012) argued that OOP health expenditure is a major barrier to seeking orthodox healthcare services. Out-Of-Pocket health spending can negatively affect people's health seeking behaviour. Its negative consequences can be analyzed in two ways: (i) how many people are impoverished by out-of-pocket spending. (ii) What is the percentage earmarked by households for health expenses? Medical impoverishment and catastrophic health expenditures are the likely outcome of over-reliance on OOP health spending. Incidence of catastrophic health expenditure is said to be generally greater in the rural areas compared to the urban areas. Similarly, the socio-economic status of a household is coterminous with its monthly catastrophic total household health spending with the poorest having the highest incidence of catastrophic expenditures (Onwujekwe, Uzochukwu, & Onoka, 2011). Other issues associated with OOP health expenditure include gender, age, income level, family size, nature of illness, healthcare services utilization among others (Apere & Karimo, 2014).

iii. **Private Sector (Donor Funding):** In view of the enormous demand for the funding of healthcare, government alone cannot shoulder the responsibility of good and quality health care provisioning given the dwindling economy culminating in an abysmally poor budgetary allocation to health sector. Therefore, it has become imperative to engage the private sector in financing of healthcare in Nigeria (Ejughemre, 2014). Private sector health financing include donor funding as well as Public-Private Partnership (PPP). Some of the health donors are UNICEF, the World Bank, WHO, UNDP UNAIDS, etc. The international community's contributions to global health come in various forms, namely: financial assistance (loans and grants), commodities (drugs, medical equipment), technical expertise, training, study tours and fellowship, research funding among others. It is on record that government donations and concession loans that include at least a 25% non-reimbursement component are referred to as official development assistance, and they serve as the major source of external financing for the health sector in the developing world (Ravishankar, Gubbins, Cooley, Leach-Kemon, Michaud, Jamison, & Murray, 2009). Lending for health and nutrition averaged USD 825 million a year over the first decade of 2000s (Ravishankar et al, 2009). Examples of some health-oriented donor agencies are United States (USAID), United Kingdom (DFID), Switzerland (SDC), Austria (ADA), France (AFD), Netherlands (DGIS), etc. Besides these major funds from the aforementioned agencies and countries, global public-private partnerships that tend to focus on specific diseases or health conditions have proliferated. Some of these foundations include GAVI Alliance, the Global Fund, the Medicines for Malaria Venture, and the Partnership for Maternal Newborn and Child Health, etc.

It has also been noted that the benefits of engaging the private sector to expand the financing of health systems cannot be underrated. This is in tandem with the growing recognition of the importance of strong health systems, which provide a promising prospect that systematically include the private sector as a vibrant component of Nigeria's health system strengthening strategy. Although**,** there have been efforts tailored towards increasing public funding to health sector in Nigeria as statutory allocation to health will not address the burgeoning health needs for about 170 million people (Ejughemre, 2013). However, private sector health financing is not without its challenges. One of the persistent challenges is duplication of financing efforts by the donor agencies and foundations coupled with lack of global coordination among donor agencies in sending health care aids to the developing countries.

iv. **Community-Based Health Financing (CBHF):** this is also referred to as Community-Based Health Insurance (CBHI). It is designed to provide financial protection from the cost of seeking health care. It has three main components, namely: prepayment for health services by community members, community control, and voluntary membership (Mladoysky, & Mossialos, 2008). Community-based health funds have existed for centuries. The earliest ones were largely financed by local religious organizations such as churches and synagogues. Community health financing scheme comes in various forms such as direct subsidy to individuals, cooperative healthcare, community-based third party insurance, provider sponsored insurance, and producer or consumer cooperative, personal services fees, drug sales, community and individual labour among others (Hsiao, 2001; Metiboba, 2012). A good example of CBHI in Nigeria is Hygeia Community Health Plan (HCHP) to be run in Lagos and Kwara states respectively under the auspices of an international health Non-government Organization (NGO) (Odeyemi, 2014).

It has been noted that CBHI is plagued with myriads of problems, namely: (1) small size of

contributions has been usually inadequate due to high inflation rates, for financing the basic health needs of most low income families. Again, the size of the schemes is too small to enjoy economies of scale. (2) Lack of mechanism in CBHF for assessing the quality of care offered by health care providers which may undermine efficiency.
(3) Reimbursements in the absence of negotiated fee schedules may also be difficult to determine. (4) Sustainability is a very potent challenge faced by the CBHF. (5) Poor legal framework by the CBHF may lead to collapse in event of unforeseen mishap on key members of board of directors; or financial insolvency (Omoruan, Bamidele & Phillips, 2009)

1.2.2 National Health Insurance Scheme (NHIS): What is known today as the National Health Insurance Scheme (NHIS) was first introduced in Nigeria in 1962 under the leadership of the then minister of health, Dr. Moses Majekodunmi (Agba, Ushie & Osuchukwu, 2010).The scheme then was compulsory for public service workers. Unfortunately, its full operation was later truncated following the escalation of the Nigerian civil war. After several years of comatose, the Buhari- led military regime in 1984 resuscitated the scheme and a committee was set up with a mandate to review it. Consequent upon this in 1988, the then Minister of Health, Professor Olikoye Ransome Kuti commissioned the Emma-Eronmi committee whose report was approved by the Federal Executive Council in 1989 (Agba *et al*, 2010)

Similarly, the International Labour Organization (ILO) and the United Nations Development Programme (UNDP) carried out feasibility studies and came up with the cost implication, draft legislature and guidelines for the scheme. In 1993, the Federal Government directed the Federal Ministry of Health to start the scheme in the country (Adesina, 2009). The scheme was modified to cover more people via Decree No.35 of 10th May 1999, which was promulgated by the then head of state, Gen. Abdulsalami Abubakar. The decree later became operational in 2004 following several flag offs; first by the wife of the then president, Mrs. Stella Obasanjo on the 18th of February 2003 in Ijah, a community in Niger State, North-Central Nigeria. Since the Rural Community Social Health Insurance and the Under-5 children Health Programmes of the NHIS scheme were kick-started by the First Lady, similar flag offs were carried out in Aba, Abia State in the South-East Zone among others. As at September 2009, 25 states of the Federation had bought into the scheme. These included Akwa Ibom, Rivers, Edo, Taraba, Adamawa, Kaduna, Zamfara, Kebbi, Sokoto, Katsina, Nassarawa, Anambra, Jigawa, Imo and Kogi States. Others are Bauchi, Ogun and Cross River States. However, these states are at various stages of implementation of the scheme (Adefolaju, 2014).

1.2.3. NHIS: Objectives and Stakeholders

According to the NHIS Decree No. 35 of 1999, part 1:1, the general purpose of the scheme is to ensure the provision of health insurance that shall entitle insured persons and their dependents the benefit of prescribed good quality and cost-effective health services. While the specific objectives as noted by some authors (Adefolaju, 2014, Owumi, Omorogbe & Raphael, 2013, Eteng & Utibe, 2015) entail:

i. The universal provision of healthcare in Nigeria.
ii. To control/reduce arbitrary increase in the cost of health care services in the country.
iii. To protect families from high cost of medical bills.
iv. To ensure equality in the distribution of health care service costs across income level distribution.
v. To ensure high standard and quality of health care delivery to beneficiaries of the scheme.
vi. To boost private sector participation in health care delivery in Nigeria.
vii. To ensure adequate and equitable distribution of health care facilities within the country.
viii. To ensure equitable patronage of primary, secondary and tertiary health care facilities in the federation.
ix. To maintain and ensure adequate flow of funds for the smooth running of the scheme and the health sector in general.

1.2.4 NHIS Vision

The vision of the NHIS is to build a virile, dynamic and responsive National Health Insurance Scheme that is totally committed to securing universal coverage and access to adequate and affordable health care in order to improve the health status of Nigerians, especially for those participating in the various programmes/products of the scheme (Adefolaju, 2014; Akande, Salaudeen & Babatunde, 2011).

1.2.5 NHIS Mission

The scheme provides regulatory oversight to the Health Maintenance Organizations (HMOs) and participating health providers. It is also driven by the mission of facilitating fair-financing of health care costs through pooling and judicious utilization of financial resources aimed at providing financial risk protection and cost burden-sharing for people against high cost of healthcare, through various prepayment programmes/ products prior to their falling ill (Michael, 2010).

1.2.6 NHIS' Areas of Coverage, Operational Scope and Programmes

At the commencement of the scheme, it only covered formal sector employees, representing less than 40% of the population. Preponderantly, about 60% in the informal sector was not reached (Omoruan et al, 2009). The problem of the exclusion of the informal sector later led to the scheme's expansion and inclusion of Community-

Based Health Insurance (CBHI) in 1997. At the 42nd meeting of the National Council on Health (NCH), an approval was given for the re-packaging of the NHIS to include and ensure full private sector participation by providing re-insurance coverage to CBHF and Health Maintenance Organization (HMOs) to form Social Health Insurance (SHI) (Omoruan *et al*, 2009, Doetinchem, Carrin & Evans, 2010). The scope of NHIS is principally concerned with the contributions paid to cover health care benefits for the employees, a spouse and four (4) biological children below the age of eighteen (18) years; more dependents or a child above the age of 18 years is covered on the payment of additional contributions by the principal beneficiary as determined by the scheme. Even though principals are entitled to register four (4) biological children each, a spouse or a child cannot be registered twice. In terms of access to good and qualitative health care services, the scheme has developed various programmes to include different socio-demographic segments of the country. These entail the following (Aminu, 2015):

1. Formal Sector Health Insurance Programmes

a- public sector (Federal, States and Local governments)

b- organized private sector health insurance programme

c- Armed forces, police and other uniformed services, students of tertiary institutions social health insurance programmes.

2. Informal Sector Social Health Insurance Programmes

a- Community-based social health insurance programmes (Odeyemi, 2014).

b- Voluntary contributors social health insurance programmes

3. Vulnerable Group Social Health Insurance Programmes

a- Physically challenged persons

b- Prisons inmates

c- Children under-five years

d- Refugees, victims of human trafficking, Internally Displaced Persons (IDPs) and immigrants social health insurance programmes

e- Pregnant women.

1.2.7 Major Stakeholders in NHIS and their statutory functions

According to Onyedibe,Goyit & Nnadi, 2012, the stakeholders of the scheme and their functions include:

i. **Government:** it majorly sets standards and guidelines by way of protecting and enforcing the obligations and privileges of all stakeholders.

ii. **Employees:** they are the contributors or enrollees who make contributions regularly in the form of premium for the health care services rendered to them and their accredited dependents.

iii. **Employers:** either they are publicly or privately owned organizations expected to make contributions (10% of a worker's basic salary) towards the scheme. However, employers with in-house health facilities can run them efficiently by registering them as service providers under the scheme.

iv. **Health Maintenance Organizations (HMOs):** they are private limited liability companies or organizations registered by NHIS to facilitate the provision of health care services to the enrollees or the scheme beneficiaries. Their main functions include collection of premiums or contributions from the enrollees; payment of health care services rendered to the beneficiaries, quality control assurance of health care services offered (Owumi, Adeoti & Taiwo, 2013).

v. **Health Providers:** they are basically the health care service providers like hospitals, clinics, etc. A health care provider in the NHIS act is a licensed government or private health facility recognized by the scheme as competent in providing health benefits to contributors and their dependents. Health care providers can be primary, secondary or tertiary, depending on their organizations, forms and services.

1.2.8 Potential Benefits of the NHIS

As an omnibus scheme, the NHIS is inherently beneficial to the willing participants and stakeholders in the following ways as opined by Onyedibe et al (2012): outpatient care, pharmaceutical care through the provision of drugs in the scheme's essential drug list, listed diagnostic tests, preventive healthcare services like immunization, antenatal and postnatal care, hospital care (15 days hospitalization by the scheme) and so forth. Obafidon (2006) noted that the NHIS is so important that beneficiaries do not need cash to access treatment when required except the 10% co-payment for the cost of drugs. This can invariably reduce the catastrophic effects of household health expenditure. Socio-economically, there is no doubt that the scheme has latently generated employment and investment opportunities through the activities of HMOs and health facility managers (Adefolaju, 2014). Premised on the above, the federal ministry of health asserted that the benefit package of the NHIS was the most comprehensive in the world (Onyedibe *et al*, 2012).

1.2.9 The Limitations of the Operational Scope of the NHIS

The robustness of the scheme notwithstanding, the following limitations according to Onyedibe *et al* (2012) and Eteng & Utibe (2015) have been noted: some important services not covered include occupational or industrial injuries, radiologic investigations like Computerized Tomography (CT) scan, Magnetic Resonance Imaging

(MRI), epidemics, cosmetic surgeries, open heart surgeries, neurosurgeries and family planning services (Onyedibe *et al*, 2012). However, other services that are partially covered are laparoscopic or fluoroscopic examinations, hormonal assays, prostratectomy and myomectomy. Some of the population segments that have been systemically excluded are the artisans, farmers, sole proprietors of businesses, street vendors and the unemployed.

On a critical note, it is argued that the NHIS negated its own philosophy of universal coverage and accessibility by excluding such vital aspects of illnesses like injuries arising from sports, therapies like drug abuse, drug addiction, sexual pervasion, organ transplant, medical repair of congenital abnormalities and procurement of spectacles (Eteng & Utibe, 2015). Given the shallow and the segregatory coverage of the scheme to the exclusions of major life-threatening illnesses and therapies mentioned above, catastrophic OOP health expenditure may continue to confront people in Nigeria.

1.3 Framework for Explaining NHIS

Explanations of the NHIS can be triangulated within the framework of two different but complementary theories, namely: Rational choice and Structural-functionalist theories. The basic principles of Rational Choice Theory (RCT) are grounded in neoclassical economics, sustained by the ideals of utilitarianism and game theory (Marshall 1998; Ritzer 2008; Haralambos & Holborn; 2008). An American social theorist, George Homans, pioneered RCT by grounding its explanations in behavioural psychology and economics sociology using the "cost-benefit" approach.

RCT takes actors as the central focus of explanations. Individuals are seen as actors endowed with capacity to take rational action. Rational action itself involves a systematic assessment of the various means of attaining goal and the selection of the most appropriate means of doing so (Haralambos & Holborn, 2008). At the heart of the theory is individual self-interest. That is, actors have ends or goals toward which their actions are tailored. Actors are also viewed as having preferences (or values, utilities). The concern of RCT however, is not with these preferences, or their sources. The fundamental issue is how to galvanize action to achieve objectives that are in tandem with an actor's preference hierarchy (Voss & Abraham, 2000). In this argument lies the central question of how actors co-ordinate their behaviour for the allocation of resources in a group or society. To this end, neoclassical economists emphasize the role of markets based on an assumption that supply and demand of rational actors with complete information yields an efficient allocation of goods. The medium of exchange within this model is money, which is used by the actors to value the goods exchanged on the market. The social pre-condition means that individuals are not isolated in a world of anonymous markets but viewed as social actors.

While RCT emphasizes actor's purposes or intentions, it necessarily acknowledges at least two major constraints on action, namely: the scarcity of resources coupled with the idea of opportunity costs, and that emanating from social institutions. Actors have different resources (e.g., money) as well as differential access to them. For those having much resources, achievement of ends is relatively easy, while those with few may find it hard to attain their ends (Ritzer, 2008). The challenge of managing limited resources to achieve an actor's end calls for the application of the principle of opportunity cost which emphasizes the importance of alternative forgone. The second constraining factor on individual's action is social institutions. As Friedman and Hechter pointed out and reiterated, an individual typically will…

> *find his or her actions checked from birth to death by familial and school rules; laws and ordinances; firm policies; churches, synagogues and mosques; and hospital and funeral parlors. By restricting the feasible set of courses of action available to individuals, en-foreseeable rules of the game-including norms, laws, agendas, and voting rules-systematically affect social outcomes* (Friedman and Hechter, 1988: 202)

This implies that there are trajectories of activities, processes and variables that determine outcomes of individual action in a bid to achieve some ends. These trajectories underscore some unintended consequences accompanying individual action. The institutional constraints provide both positive and negative sanctions that serve to boost certain actions and discourage others.

As an omnibus scheme, the various stakeholders and actors play indispensable role to fast-track healthcare service delivery, namely: HMOs, the governments (federal, state and local levels), the managers of health care facilities, contributing employers, enrollee beneficiaries and their dependents. It is assumed that these stakeholders and actors are rationally driven by different, but mutually reinforcing goals. While the ultimate concern of the government may be to increase good and qualitative access to health services for the citizens, the HMOs' interest is profit making. Similarly, employers of labour and managers of health care facilities participate in the scheme in order to elicit increased productivity from their workers, which could translate into profit along the line. The health facility managers are not left out in terms of getting returns on their investment for services rendered.

The actions of these stakeholders are therefore targeted at achieving their self-laden respective goals. These actors also have preference "hierarchy of needs" that requires allocation of resources guided by the principle of prudence. The actors operate with the foreknowledge of the NHIS' operational guidelines, terms and conditions. This is in tandem with the principle of rationality posited by RCT. The principal medium of exchange is money, while health care service is the "priced commodity". Since the potential enrollees have their competing needs, it is therefore incumbent on them to rationalize how the household income is to be spent vis-à-vis access to health care services. The question now is how can the various stakeholders function co-operatively to achieve their mutually reinforcing respective goals and at the same time meeting the healthcare needs of the targeted Nigerian beneficiaries? The explanatory answer to the preceding question can be triangulated using structural-functionalist theory.

Structural functionalism as loosely explained refers to the large-scale social structures and institutions of society, their interrelationships, and their constraining influence on actors (Ritzer, 2008). Historically, some founding fathers of sociology like Herbert Spencer, Auguste Comte and Emile Durkheim, laid the classical foundation of structural-functionalism. Talcott Parsons later refined it to reflect his work titled "the social system" in 1951 (Scott & Marshall, 2005). As a theoretical perspective in sociology, functionalism holds a view of society as a social system that is made up of different parts, which are interdependent and interrelated (Igbo, 2003). These component parts of society, which include the family, school, government, law; economy, etc. perform various functions positively toward the maintenance, stability and survival of the social system.

From the organismic analogy, the functionalists equate the human society with the human or biological organism that has a structure comprising organs, systems and capillaries, which must function for the maintenance and survival of the whole organism. To understand the structure of the organism (man), the respective component parts and their interconnected functions must be examined. The foregoing forms the basis of Parsons' concept of Adaptation, Goal maintenance, Integration and Latency function (AGIL). AGIL is an elaborate model of systems and sub-systems. It implies that for any society to survive, each system must meet the aforementioned four (4) functional prerequisites namely: Adaptation (adjustment to the physical environment); Goal attainment (a means of organizing resources to achieve societal goal and obtain gratification), Integration (forms of internal coordination and ways of dealing with differences), and Latency or pattern maintenance (means of achieving comparative stability). The point of emphasis here is how social equilibrium can be achieved and maintained between and among the various elements or institutions of a social system and sub-systems.

Parsons further opined that among these different structures and institutions such as economic, social, educational, political, religious, health, etc. institutions, any dysfunctionality in a structure could equally affect others that are intricately connected to it because of its mutually re-inforcing interdependence on others. For example, bad governance and political leadership can mar effective health care delivery system through corruption and misappropriation of funds.

Practically, the NHIS has some components and institutional stakeholders that must work harmoniously to achieve efficient and effective health care delivery to the target enrollees. Some of these stakeholders repeatedly mentioned include the government, employers, employees or enrollees, HMOs, health care facility owners or managers, etc. Among its statutory functions, the government through the scheme sets standards and guidelines for all the stakeholders to observe. The employers (public or private sector) must pay some amounts as premiums to the HMOs who in turn remit to managers or owners of health care facilities for treating registered enrollees. This chain of activities between and among these stakeholders must be kept intact and unbroken if the entire scheme is to achieve sustainable result. The interdependence of these various institutions and agencies in the scheme underscores the practical engagement of structural-functionalism. Since government alone could not fund effective and efficient health care system, hence the introduction of the NHIS, all the concerned stakeholders are expected to work cooperatively as it is in tandem with the principle of functionalism.

1.4 Impact of NHIS in Nigeria

Since the renascence of the NHIS in the country, several empirical studies have been conducted to "impact-assess" the scheme. From this motley of studies, records have shown that about 6 million Nigerians have so far enjoyed the scheme (Agba *et al*, 2010 & Adefolaju, 2014). On these accounts, majority of the enrollees were in the public sector utilizing the scheme with most of them located in the federal civil service (Adefolaju, 2014). Also, diverse aspects of the NHIS have equally been studied, ranging from people's level of awareness of the scheme, actual enrollment rate into it, satisfaction with the scheme, to its effect on healthcare services utilization in the country (Njoku, Ohagwu & Okaro, 2010; Akande, Salaudeen & Bababtunde, 2011; Osuchukwu, Osonwa, Eko, Uwanede, Abeshi & Offiong, 2013; Ndie,2013; Nwani, 2015; Eteng & Utibe, 2015; Onyedibe *et al*, 2013; Adewole, Dairo & Bolarinwa, 2016;).

While some states experienced high level of awareness of the scheme where it is currently being run

(Osuchukwu et al, 2013; Adewole et al, 2016, Nwani, 2005 & Njoku et al, 2010), some of them recorded low level knowledge of the scheme (Ndie,2013 & Akinwale, shonuga, & Olusanya; 2014). There is no doubt however; that the scheme has had some multi-faceted effects on the entire healthcare system and the people's health-seeking behaviour in the states where it is practised.

Significantly, the introduction of the scheme has prompted an unprecedented increase in the utilization of health facilities in some states (Osuchukwu *et al*, 2013 & Akande *et al*, 2011). Not only has the scheme caused the increase in utilization of health services, it has also led to the reduction of OOP health expenditure culminating in enrollee satisfaction with services offered (Osuchukwu *et al*, 2013). Economically, the introduction of the scheme has led to the "mushrooming" of several HMOs, which in turn generates employment and investment opportunities for the country. Despite the fact that some state governments have keyed into the scheme, access to quality health care delivery still remains a high profile challenge. It has been noted that there is a discrepancy among employees in their access to the NHIS. This was noted with federal civil servants having more access to the scheme than their counterparts do in the state civil service (Agba, Ushie & Osuchukwu, 2010). Consequent upon this, the implementation of the scheme is not without its challenges as they are examined below.

1.5 The Implementation of the NHIS and its Challenges in Nigeria

Fundamentally, the NHIS is a policy component programme of the entire healthcare delivery system in Nigeria. Therefore, the resonating problems confronting the country's healthcare system over the years are likely to affect the scheme's implementation and sustainability. These problems among others include poor governmental allocation of funds to the health sector (Anyika, 2014, Ejughemre, 2014, Riman & Akpan, 2012, Yunusa *et al*, 2014, Orubuloye & Oni, 1996, Aiyegbusi,& Adegbite, 2008, Eteng & Utibe, 2015), inadequate supply of physicians accentuated by brain-drain syndrome in the health sector (Osuchukwu et al, 2013, Eteng & Utibe, 2015), poor distribution of health facilities or urban-biased establishment of health facilities (Jegede, 2002), shortage of drugs, corruption, attitude of the health workers, obsolete and dilapidated health infrastructure (Anyika, 2014).

Generally, the interplay of the above mentioned problems plaguing the country's health sector have some constraining effects on the implementation and sustainability of the scheme. Though not insurmountable, noticeable specific areas of challenge facing the holistic implementation of the scheme according to Omoruan, Bamidele and Philips (2009) are:

1. Delay in the reimbursement of premium to the health facility owners coupled with corruption and fund diversion (Agba, Ushie & Osuchukwu, 2010).
2. Obsolete and inadequate health facilities used by healthcare service providers (Sanusi & Awe, 2009).
3. The challenge of large informal sector and the diversity in economic status coupled with the problem of determining equitable premium, how to determine groups to be included in the exemption scheme and the modalities of implementing exemption packages without constraining access to health services. Some HMOs may be reluctant to operate in the rural areas where premium may be difficult, but may prefer the city centres in order to leverage on both the ease of premium collection and large-scale enrollment into the scheme.
4. Sustainability of the scheme may become problematic if revenue accruing through premium is not adequate to pay for the running expenditure.
5. Dearth of medical personnel to implement the scheme. It was documented that at a time, the country had 19 physicians per 100,000 people between 1990 and 1999. While in 2003, there were 34,923 physicians in Nigeria; giving a doctor-patient ratio of 0.28 per 1000 patients as compared to what is obtainable in the western countries (Eteng & Utibe, 2015; Akande, Salaudeen & Bababtunde, 2011).
6. Inequality in the distribution of health facilities between urban and rural areas coupled with policy inconsistency (Omoruan, Bamidele & Philips, 2009).
7. Poverty and inability to pre-pay for healthcare services up-take through the scheme.
8. Lack of health programme synergy between the federal, state and local governments in implementing the scheme.
9. Lack of centralized patient information system for the healthcare centres in Nigeria to facilitate efficient healthcare delivery. In other words, patients' data kept by the NHIS are scattered among various HMOs (Akinwale, shonuga, & Olusanya, 2014).

Awareness level of the scheme in the country is still relatively low (Ndie, 2013; Osuchukwu *et al*, 2013)

1.6. Concluding Remarks and Recommendations

Several sources of healthcare financing abound to be leveraged on, such as tax-based public sector health financing, household out-of-pocket health expenditure, the private sector (donor funding) and social health insurances. The all-inclusive one is the social health insurance. It has the capacity and potency of reducing catastrophic health expenditure and exists either as community-based health or as social health insurances. The

focus of this paper *ab initio* is on the assessment of the NHIS and its multi-dimensional impact across the country. On this premise, the researcher concludes that the introduction of the scheme is a positive welcome development that has the capacity and potency to boost preventive, promotive and curative components of health care delivery. It can facilitate rapid access to quality health care services by the indigent, the poor, the marginalized and the socially excluded if the scheme is holistically implemented thereby achieving the Millennium Development Goals 4 and 5 respectively. In terms of employment and investment opportunities, the scheme has the generating capacity to absorb the army of unemployed graduates in the country. This can be made possible through the operations and activities of the HMOs and increased patronage to health facilities as the case may be. Therefore, governments at all levels should be encouraged and persuaded actively to embrace the scheme with a view to bringing quality health care closer to people.

The following recommendations are offered among others as a way forward to restructure the NHIS:

1. that the government in collaboration with relevant partners should intensify optimal awareness and education on the scheme to all Nigerians to trigger increase in the number of enrollees.
2. government should scale up funding to the scheme in particular and the health sector in general to meet the 15 % baseline allocation being suggested globally.
3. the scheme should further be repositioned to focus on quality improvement of health services to meet the satisfaction level of enrollees.
4. the current NHIS policy should be restructured to gain a wider coverage and ensures equity in accessing health services especially among the poor, indigent and marginalized populace.
5. there should be establishment of functional structures of arbitration to engage the scheme management constantly, health care providers and enrollees in order to minimize mistrust and improve uptake and service delivery.

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