

THE NEW NATIONAL HEALTH INSURANCE SCHEME: A LEGAL IMPETUS FOR ACCESS TO QUALITATIVE HEALTH CARE IN NIGERIA

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Abstract

Chapter II of the Nigerian Constitution 1999 sets out the Fundamental Objectives and Directive Principles of State Policy. These are lofty ideals which succeeding governments ought to aspire to bring into reality. One of such desired goals is the right of each citizen regardless of sex, social standing, ethnic group, religious or political affiliation, to have prompt and proper medical attention. The dwindling fortunes of the average Nigerian family occasioned largely by the ailing economy, has made many people to opt for the services of quacks or unqualified medical personnel. This paper x-rays the fundamental provisions of the new National Health Insurance Scheme and the possible areas where the system will encounter difficulties. It also proffers recommendations to showcase how the system can work in a hitch free manner to provide an enduring and improved health care delivery system in Nigeria.

Key Words: Contributions, Referrals, Pre-action notice, Fraud, Beneficiaries

Introduction

At the very centre of any organization of human beings is the innate desire to obtain maximum satisfaction 'of the individuals within the larger group. These desires are Human Rights referred to by Eze (1984) as "those demands or claims which individuals or groups make on society some of which are protected by law and have become part of *lex lata* while others remain aspirations to be attained in the future" These rights are classified into

- (a) Civil and Political rights e.g. right to fair hearing.
- (b) Economic, Social and Cultural rights e.g. right to basic education.
- (c) Group rights e.g. right to development.

Human rights are enshrined in the Nigerian Constitution 1999. Chapter IV deals with civil and political rights. They are inalienable rights that cannot be derogated from except in certain circumstances such as situations reasonably justifiable in a democratic State or to preserve the rights of others. Chapter II deals with the Fundamental Objectives and Directive Principles of State Policy. These provisions are merely a guide for successive Nigerian Governments, democratic or otherwise, as to the path to be toed towards building a nation to be proud of.

However, they are non-justiceable and cannot be enforced in law courts. Their enjoyment by citizens is tied to the apron strings of political will and economic advancement. Free health care is clearly a Chapter II provision in 1999 Nigeria constitution. Access to good health care for all has always been one of the goals of Nigerian regimes but the attainment of this noble objective was fraught with many debilitating factors.

They include inter alia:

(1) **Legal Provisions**

Constitutional and other statutory provisions on health care delivery before now had not attained the quality of justiciability. Today, the new National Health Insurance Act has upgraded the right to health to

one capable of enforcement in court.

(2). **Economic and Political Problems**

The oil boom of the 1970's elicited a regrettable neglect of other viable sectors of the economy. The economy subsequently regressed and corrupt political leaders and military interventions in government over the years did not help matters.

These factors impacted negatively on the health sector. The average Nigerian found it increasingly difficult to obtain adequate health services. Cases abound of impoverished citizens soliciting for financial support from the public to pay for medical procedures ranging from the extraction of tumors to multiple birth deliveries.

The quest for cheaper services has created a large and uninformed market for quacks and unqualified traditional Medicare practitioners who set up shops and offer concoctions akin to the mythical *elixir* of life as they are keenly advertised as the cure for almost all diseases. Only the highly placed could afford quality health care and wealthy Nigerians usually travel abroad for medical attention. The lure of better conditions of work available in developed economies resulted in the unprecedented migration of the best medical personnel from Nigeria.

The progressive decay in public health institutions also inspired the establishment of numerous private medical centres or clinics, which, without external or governmental regulation, were managed like any other business-to make maximum profit. Hence, it was common for critically ailing or fatally wounded persons to be turned away at emergency rooms unless they could provide deposits in a fee-for-service business model. Sometimes, the discharge of fully recovered patients was stalled if they were unable to pay their bills. Quite a number of them absconded. Others who managed to clear their debts thronged the streets as destitute and beggars because of strained finances in the family. Needless to say, precious lives were lost due to these practices, prompting experts and layman alike to consider the viability of a health insurance system in Nigeria.

Basic Insurance

Insurance can be defined as the equitable transfer of risk of a potential loss from one entity to another in exchange for a premium and duty of care. It is contained in a written contract known as a "policy". Madu and Chukwuma (2002) define insurance as a contract that arises between an insurer and an assured whereby the former undertakes to provide against a risk apprehended by the assured. The essential features of ordinary contracts (i.e. offer, acceptance, consideration and consensus ad idem) also apply to insurance. The payment of premium is a condition precedent to assumption of liability by insurers.

It is a contract *uberimae fidei* and all parties must act in good faith by disclosing all material facts for a proper evaluation of risks. It is a contract of indemnity where the insured will recover his actual loss. However, there must be an insurable interest or relationship between the insured and the subject matter of insurance. It is important to note the principle of subrogation, which entitles an insurer who has paid under an indemnity policy to sue in the name of the insured.

The insurance industry in Nigeria consists of about 103 insurance companies, 5 reinsurance companies and 350 insurance brokers (Intercontinental Bank, 2006). Insurance businesses transacted in Nigeria are fire, marine/aviation, life, accident, burglary and professional indemnity. Insurance is compulsory under the Section 40 (1) of the Workmen's Compensation Act 1990 And Section 3(1) of The Motor Vehicle (Third Party) Insurance and Act 1990.

Presently, the insurance industry is undergoing recapitalization. The National Insurance Commission (NAICOM) stipulated a minimum capital base of Two billion, Three billion, Five billion and Ten billion Naira for life, general, composite and re-insurance businesses respectively. Unfortunately, the process is not enjoying the sort of public interest experienced by the banking sector during its consolidation programme that ended on 31st December 2004. Apathy towards insurance stocks on the floor of the Nigerian Stock Exchange has made insurance companies consider the merger option. 17 groups comprising over 45 insurance companies have applied to NAICOM for endorsement of their merger proposal (Ugwuadu, 2006). Observers are of the opinion that only 30 companies may remain post consolidation (Alabadan, 2006).

Historical Development of Health Insurance in Nigeria

Health Insurance is a protection, which provides benefits for covered sickness or injury (Unicinsurance, 2006). It is a policy that will pay specific sums for medical expenses or treatment of the beneficiary. The term is generally used to describe a form of insurance that pays for medical expenses (Wikipedia, 2007). In other jurisdictions like Canada, it is known as “Medicare” wherein people have access to basic health services as well as supplementary or private insurance to cover non-basic medical procedures. The Canadian Supreme Court in **CHAULLI V. QUEBEC** [2005] 1 SCR 791, 2005 SCC 35 held that the Province's prohibition of private insurance for health care already insured by the Provincial Plan could constitute an infringement of the right to life. Britain's National Health Service (NHS) is reputed to be the world's largest health care service.

The growth of private health insurance in Nigeria has been limited by a myriad of factors including lack of public confidence in the insurance industry, limited technical capacity for underwriting this claim of risk, poor knowledge of the nation's private Medicare market and the absence of re-insurance back-up (Ogunbekun, 1997).

The National Health Insurance Scheme (hereinafter referred to as NHIS) is social health insurance programme designed by the Federal Government to complement sources of financing the health sector and help improve access to health care for majority of Nigerians. The idea of NHIS was first conceptualized in Nigeria by the Halevi Committee in 1962, which made the proposal through the Lagos Health Bill. Unfortunately, this initiative was not supported. In 1984, the National Council on Health Committee Chaired by Prof. Diejomoah advised the government on the need for health Insurance.

In 1985, Dr. Emmanuel Esan (the then minister of Health) set up a committee on National Health Review headed by Mr. L. Lijadu whose studies revealed that health insurance could work in Nigeria. Later in that year, Prof Olikoye Ransome-Kuti (former Minister of Health) raised a Consultative Committee on NHIS made up of stakeholders like the Nigerian Labour Congress (NLC) and the Nigerian Medical Association (NMA). On their recommendation, another committee piloted by Dr. E. Umez- Eronini was set up and charged with the responsibility of developing an acceptable model for implementation of the scheme. Their blue print was approved by the Federal Government in 1989.

In 1999, the Federal Government signed an agreement with the United Nations Development Programme (UNDP) and the International Labour Organization (ILO) for planning and implementation of the Scheme. Finally, the draft law on NHIS was signed into law on 10 May 1999 by General Abulsalami Abubakar as Decree (Now Act) 35 of 1999. The NHIS Operational Guidelines were published in May 2005. The NHIS was launched at the International Conference Centre, Abuja on June 6, 2005. This event is seen by many as a true dividend of democracy (Ogundipe, 2006). The scheme was flagged off at Ijah-a rural community in Niger State by the then first lady - late Mrs. Stella Obasanjo.

Major Provisions of the Act

(A) The Council

Section 1 sets out the purpose of the scheme as providing health insurance which will entitle persons and their dependants with the benefits of prescribed good, quality and cost effective health services. **Section 5** enumerates the objectives of the scheme as including the following:

- To ensure good health care services for every Nigerian.
- Protect families from the financial hardship of huge medical bills.
- Limit rise in the cost of health care services
- Ensure equitable distribution of health care cost among different Income groups.
- Maintain high standard of health care delivery services.
- Improve and harness private sector participation in the provision of health care services.
- Ensure adequate distribution of health care facilities in the federation.
- Ensure equitable patronage of all levels of health care providers.
- Ensure availability of funds to the health sector for improved services.

The Scheme shall be responsible for the registration of Health Care Providers, issuance of guidelines, conducting research and statistics plus general advice on the continuous improvement of quality services. Under **Section 2**, the Act established a Governing Council with powers to implement the Scheme, create public awareness, organize training programmes and arrange for the financial and medical audit of Zonal Health Insurance Offices. Interestingly, **Section 1 (4)** empowers the Scheme to invest in securities at the Nigerian Stock Exchange. Obviously, the Act seeks to obviate the phenomenon of idle funds, which are susceptible to misappropriation. To buttress this point, such investments by the Scheme are exempt from tax payment (**Section 15**)

(B) Contributions

Per **Section 16 (1)**, employers of more than 10 persons and their employees may pay contributions under the scheme at rates determined periodically by the Council. **Section 50** defines an employee as any person who is ordinarily resident in Nigeria and is employed under the service of the Federal, State or Local Government or under contract of services or an apprenticeship with an employer whether the contract is expressed, implied, oral or in writing.

It appears from the above definition that the employee must be resident in Nigeria to qualify for indemnity irrespective of his nationality or place of origin. However, foreigners as well as Nigerians outside the Nigerian territory may opt for the voluntary contribution to obtain an adequate cover for their health needs when they are in the country. To ensure adequate coverage, the Scheme has the following programmes:

- (1) Formal Sector Social Health Insurance Programme
- (2) Urban Self-employed Social Health Insurance Programme
- (3) Rural Community Social Health Insurance Programme
- (4) Children Under 5 Social Health Insurance Programme
- (5) Permanently Disabled Person Social Health Insurance Programme
- (6) Tertiary Institutions and Voluntary Participants Social Health Insurance Programme
- (7) Armed Forces, Police and Other Uniformed Services
- (8) Diaspora Family and Friends Programme
- (9) International Travel Health Insurance Programme.

This takes care of persons outside formal employment such as farmers and commercial motorcyclists. Under the Scheme, employees will contribute 5% of their basic salary while the employer will pay 10%. Contributions will be deducted from wages without reducing allowances or remuneration. Application form is available online at www.nhisinfo.org with fields requiring data like name, age, blood group, telephone number, address, medical history of significance (e.g. sickle cell, allergies, hypertension, epilepsy, diabetes etc); name of one spouse and four biological children below 18 yrs of age; primary providers data; alternative provider; signature, thumbprint and passport photograph. Identity cards will be issued by the Scheme at a cost, embossed with the Health Maintenance Organization's code.

What about a Contributor with more than the stipulated number/categories of dependants such as aged parents? The NHIS operational Guideline 2005 allows him/her to make additional payments to be qualified for cover.

(C) Health Care Providers

By Section 18, Health Care Providers registered under the scheme shall, in consideration of capitation payment in respect of each insured person registered with it provide

- ❖ Curative care
- ❖ Prescribed drugs and diagnostic tests
- ❖ Maternity care for up to 4 live births
- ❖ Preventive care (i.e. immunization, family, planning, ante/post natal care)
- ❖ Consultation with specialists

- ❖ Hospital care in a public or private hospital in a standard ward for 15 cumulative days a year for physical or mental disorders
- ❖ Eye examination and care excluding test and spectacles
- ❖ Range of prosthesis and dental care.

Enjoyment of some benefits is excluded under the Scheme. For instance, there is no cover under the scheme for hi-tech investigations like C. T scan except in life threatening situations; injuries resulting from natural disasters or conflicts, epidemics, terminal illnesses, transplants and cosmetic surgery. Facility and personnel requirements are spelt out in the Guidelines for all levels of Service Providers including fire fighting equipment, waste disposal and refrigerators. Minimum requirements are stipulated for theatre/labour rooms such as resuscitation equipment (Oxygen) and adequate lighting. A Standards Committee was set up to ensure the maintenance of quality services by Health Care Providers across the board through effective scrutiny of their academic qualifications, possession of current license to practice and appropriate facilities for service delivery. A Health Care Provider must possess professional Indemnity cover or a malpractice insurance cover from an insurance company approved by the Council.

Health Care Professionals include General and Specialist Medical practitioners, Pharmacists, Nurses/midwives, Laboratory Scientists, Radiographers, Physiotherapists, Dental Surgeons and Community Health Workers. Health Care Providers are classified into three.

1. Primary Health Care Providers or gatekeepers who have first contact with contributors and other beneficiaries under the scheme.
2. Secondary Health Care Providers who provide services on referrals from Primary Health Care Providers
3. Tertiary Health Care Providers that render services on referrals from the primary and secondary levels.

Referrals

Patients may be referred to a Specialist approved by a Health Maintenance Organization where necessary except in emergencies. This process involves establishing a referral line with a clinical basis, accompanied by a referral letter containing medical details. The referred case must be sent back by a Specialist after treatment with a Medical Report and instructions for follow-up treatment.

D. Health Maintenance Organizations

Section 19 provides for the registration of private and public Health Maintenance Organizations responsible for

- Collection of contributions
- Payment of capitation fees for services rendered by Health Care Providers
- Establishing a Quality Assurance System

There shall be Zonal Health Insurance offices in the country for maintaining a comprehensive register of Health Care Providers, inspection of facilities and collection of statistics on consultations and admissions to hospitals.

A Health Maintenance Organization shall be incorporated in Nigeria and obtain a Certificate of Accreditation under the Scheme at a fee of One Hundred Thousand Naria (N100,000). This registration may be cancelled if the Organization engages in fraudulent activity. Organizations that voluntarily wish to exit the scheme may do so at the expiration of a Three month written notice to the Scheme.

DIAGRAM: THE NHIS MACHINERY

Contributions are routed through health maintenance organization as capitation fees to health care providers who provide services at different development using referral system approved by health maintenance organization.

E. Legal Proceedings

In the event of displeasure with services rendered by an Organization or a Health Care Provider or a violation of the provisions of the Act, an aggrieved party may make a written complaint within sixty (60) days from the date of action giving rise to the complaint to the State Health Insurance Arbitration Board (**Section 26**). The Board if satisfied that the Complainant was justifiably unable to make the complaint within the stipulated period may extend this time.

The prevailing legal terrain in Nigeria encourages the use of Alternative Dispute Resolution (ADR) processes to settle matters timeously and inexpensively. But where these efforts fail, the parties may approach the Court for redress. Part VII of the Act deals extensively with offences and penal sanctions. Natural and corporate persons may be held liable on conviction to a fine of One Hundred Thousand or Two Hundred Thousand Naira (N100, 000. or N200, 000) imprisonment for two (2) years or both for failure to pay deducted contribution into the account of an Organization. In the case of a firm, any officer or persons purporting to so act at the time of commission of the offence is deemed to have committed the offence unless he proves that the act took place without his knowledge or connivance. This shifts the evidentiary burden of proof to the accused to prove matters especially within his knowledge.

The Attorney General of a State or a Legal Officer in the Ministry of Justice is the proper person to prosecute offenders at the High Court (**Section 30 and 31**). Criminal action may be instituted without prejudice to any other civil remedy under the Scheme. It is apposite to note **Section 34** which provides that a suit can not lie against a member of the council unless it is commenced:

- (a) Within three (3) months next after the act, neglect or default
- (b) In case of a continuing damage or injury, within six (6) months next after the ceasing thereof.

In addition, the Plaintiff will serve a Notice of Intention to commence suit in one month. The satisfaction of this condition of this pre-action notice is imperative or else a plaintiff runs the risk of having his suit struck off for being premature. Service of notices, summons or other documents shall be sent by registered post to the Executive Secretary at the principal office of the Scheme (**Section 35**). Any execution of judgment, attachment or process shall lie against the scheme after **three (3) months notice of intention** to so execute /attach (**Section 36**). Members of the Council or employees under the Scheme shall be liable to a fine of N20, 000 (Twenty thousand naira) or imprisonment not exceeding 2 (two) years or both for disclosure of confidential information or it is used for private gain (**section 38**). This provision is essential to safeguard sensitive medical and payment history of patients and the principle of confidentiality in the medical profession.

Towards Ensuring Access to Qualitative Health Care For All In Nigeria

The NHIS, as desirable as it may be at this point in our national existence, will definitely be confronted with some teething problems such as:

1. Adequate Enrolment under the Scheme:

To inject *animus* into the legal draftsman's work, there must be registered Contributors, Health Care Providers and Health Maintenance Organizations playing specific roles. As at March 2006, there was a total number of 5174 Health Care Providers under the Scheme with South West Zone having the highest number of 1420; South- South 901, North West 731, North Central 641, South East 530, North East 383 and Federal Capital Territory Abuja, 50. A mere 642, 478 beneficiaries were registered (Ogundipe, 2006). Currently there are 26 accredited Health Maintenance Organizations in Nigeria and only one exists in Imo State.

It can be deduced that the Scheme is still being viewed with skepticism by the public. Other reform

programmes of Obasanjo-led administration seem to have fared better. For instance, the Pension Reform scheme generated N60billion in the public sector by August 2006 and the effect of this can be seen in the scramble for blue chip stocks and their attendant capital appreciation (Financial Standard News, 2006).

Efforts to ensure enrolment by contributors must be stepped up if the system will be self-sustaining. This can be done through better sensitization especially of the non-formal sector to get the large pool of persons outside formal employment to participate.

2. Private Sector Participation in Provision of Facilities

Modern government has shifted emphasis to private sector - driven economy. The enrolment of the organized private sector in the provision of quality Medicare is necessary in Nigeria as existing structures are now operating below capacity. The NHIS has created a new investment window yet to be explored. It will be a wise decision to cash in on the gaping need for more primary health care facilities in rural communities as long as a workable referral line is established with other levels of providers although the profit motive must never undermine the humanitarian nature of medical duties. Incentives must be on ground to encourage investment in the health sector and the importation of much needed state-of-the-art equipment.

3. Expensive, Fake and Substandard Drugs

The National Agency for Food and Drugs Administration and Control (NAFDAC) has made giant strides to combat the menace of substandard drugs in the market. However, some of them still escape the monitoring system. The scheme must be strictly compliant with regulatory provisions to make it fool proof. Where drugs are available, they are usually not affordable. Development of local alternatives must be done by investing funds under the scheme in research efforts and in the growing Nigeria pharmaceutical industry. Handsome returns are not in doubt especially as Nigerian drug companies are slowly gaining respect in the international market.

4. Scope of Beneficiaries Under the Scheme

When the scheme becomes fully operational, the definition of persons eligible for the insurance cover may need to be expanded. While the present writer appreciates the need to cut the size of the average Nigerian family, the existence of already large ones must be kept in mind. Besides, the extended family system which still holds breadwinners in a vice grip cannot be wished away as more often than not, family resources are channeled in that direction.

On the frequently asked questions (FAQs), portal of the NHIS website should make a statement to the effect that relatives of single or unmarried persons cannot benefit under the scheme. This exclusion is unfortunate as there should be no discrimination based on marital status or other requirement in government policies. A system should be devised to enable single people take full benefit of their contribution under the scheme.

5. Insurance Fraud

Insurance fraud occurs when someone knowingly lies to obtain some advantage to which he is not otherwise entitled under the scheme. Fraud is a looming danger, casting a sinister shadow on the scheme. The attention of the criminal mind may move to health insurance in the face of clamp down in other areas by the Economic and Financial Crimes Commission (EFCC). Insurance fraud in other countries takes various forms like inflated/false billing, embezzlement of funds, unlawful solicitations/referrals (where patients are recruited to undergo procedures whether performed or not) and identity theft, the latter being the technique expected to be easily adopted in Nigeria. Others are misrepresenting facts on insurance application and "staging accidents".

More safeguards than are contained in the Act are necessary to forestall a take over of the scheme by fraudsters. The collaboration of EFCC and related agencies is surely needed coupled with the need to train NHIS staff on maintaining a safe database.

6. Incorporation of Traditional Medicine

NHIS ought to be truly "Nigerian" to gain wide acceptance. Many Nigerians have absolute confidence in traditional medicine and in some remote areas, orthodox medicine is unavailable. Thus,

traditional medicine should be incorporated into the scheme to play a complementary role. This will only be feasible after traditional medicine is standardized to prevent abuses. Traditional medicine practice is a source of income for many local practitioners. Its incorporation under the scheme will engender its unprecedented development and acceptance in wider circles as is the case with Chinese Local remedies. The government recently approved the Nigerian Traditional Medicine Policy and a Bill is in contemplation to establish a Traditional Medical Council focusing on herbal medicines, bone setting, psychiatry, birth attendance and fostering partnership with orthodox medicine (Lohor, 2006).

7. Full Involvement of The Insurance Sector

A recapitalized Insurance industry should take a strategic position in the NHIS. Granted the sector hitherto has not been doing well but this may be traced to an underdeveloped insurance culture in Nigeria. Most of the health insurance business should be undertaken by them as the professionals to give the sector a boost. This will also ensure competition and diversification of services in the industry. Insurance companies may also indirectly participate by investing in Health Maintenance Organizations.

Conclusion

A major index of development is the ability of an economy to create and sustain methods by which all persons within it will have access to good health care services. The NHIS which is long overdue in Nigeria, is basking in her rising profile after the ignoble years of military dictatorship. The system has good prospects but success will only be attained by sheer determination and a wealth of ideas to combat any difficulty that may be encountered in the years to come.

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