

A COMPARATIVE ANALYSIS OF THE NATIONAL HEALTH INSURANCE SCHEME IN NIGERIA AND CHINA

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ABSTRACT

This paper attempts a comparative analysis of the National Health Insurance Policies as obtained in Nigeria and China. The paper is basically qualitative in nature which employed the use of library-based documentation analysis. The paper examined the basic components of the policy objectives of the National Health Insurance Schemes in both countries and found that the Nigerian policy document is defective because there was no provision for universal health coverage as the insurance policy is only compulsory for the formal sector. The study identified that the National Health Insurance Scheme in Nigeria has been faced by a myriad of socio-economic and institutional challenges such as poverty, obsolete health facilities, delay in reimbursement of insurance premium to participating health facilities, selective nature of medical cases covered by the scheme and lack of government commitment largely due to the corrupt nature of the public service. Comparatively, the Chinese Health Insurance Policy is comprehensive and all inclusive and has achieved nearly universal health coverage for its population. Statistics indicates that over 95% of the population has been covered by the scheme due to the health sector reforms and government commitment to funding by contributing about 5.6% of its total GDP to the sector. The study recommends that Nigeria should take a cue from Chinas' Health Policy as a lesson for progress in her quest to achieve universal health coverage for all.

Key Words: *Policy, Insurance, Health coverage and Health Financing.*

INTRODUCTION

There is generally a growing global concern about health care services in terms of delivery, affordability and accessibility. This concern has been due to poor health indices that are most prevalent in low income countries most especially Sub-Saharan Africa. The need for health insurance to fund health care became imperative with the realization that not all individuals can afford the cash and carry system of health care delivery.

In Nigeria, health indices have indicated that the health condition is very poor in both rural and urban centers which have resulted in high mortality rate and a general poor health standard precipitated by high cost of medical treatment and lack of access to quality medical care. Consequently, it became paramount on the government to introduce a policy that will ameliorate the worsening situation thereby delivering quality health services to the teeming population. It was in line with this that the National Health Insurance Scheme (NHIS) was introduced as a

policy instrument to replace the existing system of health financing that is not suitable for a low-income population.

This paper is premised on a comparative analysis of the health insurance policy in Nigeria and China with a view to examining the objectives of the scheme, the financing models, the scope of coverage as well as the achievements and challenges.

Background to National Health Insurance Scheme (NHIS) in Nigeria

In order to improve access to quality healthcare services and health status of the Nigerian citizen, the National Health Insurance Scheme (NHIS) was established by decree NO 35 of 1999 by the then military administration of General Abdulsalam Abubakar. This is given the general poor state of the nation's health services and the excessive dependence and pressure on government health facilities with the dwindling funding of healthcare in the face of rising cost. The scheme is designed to facilitate fair financing of healthcare cost, through pooling and judicious utilization of financial risk protection and cost burden sharing for the people, against high cost of health care through prepaid mechanism.

The full operation of the scheme was launched in 2003 under President Olusegun Obasanjo's administration with the initial coverage of only federal civil servants or public servants, where access to health care was secured by a pool of contributions from both employees and employers. With advances in implementation, the scheme has expanded its scope of coverage to include formal sector health insurance program, informal sector health insurance program and vulnerable health insurance program.

Their health care coverage includes outpatient care, prescription drugs, pharmaceutical and diagnostic test. It also covers maternity care for four live births, preventive care inclusive of immunization, health education, family planning, ante natal and post natal care. It also covers specialist consultation fees, hospitalization of not more than 15 cumulative days per year, eye examination excluding spectacles and contact lenses.

In his analysis of the National Health Insurance Scheme (NHIS), Agbor (2007) outlined so many factors that are responsible for the emergence of the scheme in Nigeria. These include:

- i. Poor state of the nations' health services
- ii. Excessive dependence and pressure on government provided health facilities
- iii. The rising cost of health care services
- iv. Inadequate participation of private health services and inappropriate distribution of health facilities in the country
- v. The cash and carry system which allows for everybody to bear the cost of medical care was not within the means of most Nigerians.

It was based on these factors that specific programs were designed in order to ensure that an effective coverage for the populace. These programs are the formal sector health insurance program for the federal civil servants, urban self employed social health insurance program, rural community social health insurance program, children under five social health insurance program which also covers pregnant women, permanently disabled social health insurance program, prison inmates social health insurance program, tertiary institutions and voluntary participants social health insurance program and the armed forces, police and other uniform services insurance program (NHIS 2005). It is however worthy of note that only the formal sector program is functional.

Objectives of the Scheme

The policy document of the National health Insurance Scheme (2005) outlined ten (10) objectives to be pursued by the scheme, these are stated as follows:

- a. Ensure that every Nigerian citizen has access to good health
- b. Protect families from the financial hardships of huge bills
- c. Limit the rise in cost of healthcare services
- d. Ensure equitable distribution of healthcare cost among different income groups
- e. Maintain high standard of healthcare delivery service within the scheme
- f. Ensure efficiency in healthcare services
- g. Improve and harness private sector participation in the provision of health care services
- h. Ensure adequate distribution of health facilities within the nation
- i. Ensure equitable patronage of all levels of health care
- j. Ensure the availability of funds to the health sector for improved services.

Scope of Coverage and Financing of the NHIS

The scheme covers a range of healthcare benefits based on participants' contribution. Specifically, the employee, his spouse and four biological children are entitled to healthcare coverage under the operational guidelines of the scheme. If the principal beneficiary wishes to introduce additional dependent for coverage, he must pay extra money to capture the dependent. The cost of participation is borne by both the employer and employee. The employer pays 10% while the employee pays 5% making a total of 15% of the employee's basic salary. (NHIS 1999)

The Implementation of the NHIS and its Challenges in Nigeria

Fundamentally, the NHIS is a policy component program 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 according to Ayika (2014) includes poor governmental allocation of funds to the health sector, inadequate supply of physicians accentuated by brain-drain syndrome in the health sector, poor distribution of health facilities or urban-biased establishment of health facilities, shortage of drugs, corruption, attitude of the health workers, obsolete and dilapidated health infrastructure. Similarly, Agbor (2007) have observed that the implementation of the scheme in Nigeria have been marred by myriads of socio economic and institutional challenges. The socio-economic challenges constitute a minimal percentage of the problems and are those arising from inability of the individuals to engage in health care insurance especially due to their low income caused by poverty. However, the institutional challenges constitute a chunk of the problems which ranges from government recklessness, lack of publicity, insufficiently well-equipped service providers, selective acceptance of medical cases due limited coverage of cases covered by the scheme as well as over politicization of serious matters in Nigeria.

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:

- i. Delay in the reimbursement of premium to the health facility owners coupled with corruption and fund diversion
- ii. Obsolete and inadequate health facilities used by healthcare service providers
- iii. 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 centers in order to leverage on both the ease of premium collection and large-scale enrollment into the scheme.
- iv. Sustainability of the scheme may become problematic if revenue accruing through premium is not adequate to pay for the running expenditure.
- v. 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)
- vi. Inequality in the distribution of health facilities between urban and rural areas coupled with policy inconsistency
- vii. Poverty and inability to pre-pay for healthcare services up-take through the scheme.
- viii. Lack of health program synergy between the federal, state and local governments in implementing the scheme.
- ix. Lack of centralized patient information system for the healthcare centers 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).

Impact of NHIS in Nigeria

Since the takeoff of the NHIS in the country in 2004, several empirical studies have been conducted to assess the scheme. From this motley of studies, records have shown that about 6 million Nigerians have so far enjoyed the scheme (Agba, 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.

While some states experienced high level of awareness of the scheme where it is currently being run, 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 behavior in the states where it is practiced.

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 (Osuchukwu, et al, 2013)

The Chinese Health Insurance Policy

China has experienced a rapid progression towards Universal health coverage especially with increased service coverage. This has reduced the risk of financial hardship of catastrophe since almost all its population is either covered by its urban or rural health insurance schemes. According to Zhang X (2015), there is an observed reduction in impoverishment and out-of-pocket payments as a proportion of total expenditures on health in China.

The World Health Organization (WHO) has observed that China, renowned for its large population is faced with the challenge of health inequity and had to undergo a reform in 2009, aimed at setting up an affordable, equitable and efficient healthcare system that would be readily accessible for its entire people. This in principle forms the major purpose of universal health coverage as defined by the World Health Organization. Before the 2009 reform, the rural and urban health schemes had begun some form of expansion in 2003 and 2007 respectively. The introduction of the reform further strengthened the systems coverage, laying emphasis on primary care, restructuring of public hospitals, removal of mark-ups on drugs and improved delivery of public health initiatives. (Meng Q. and Xu L. 2014)

In their assessment of progress towards universal health coverage in the BRICS, Marten R. and Travasso C. (2014), found that China have devoted a large share of its resources to the health sector amounting to about 5.6% of the country’s total GDP largely due to its rapid economic growth. This has surpassed the contribution of any other country in the BRICS.

These obvious developments constitute reasons for choosing China in this comparative analysis in order to draw lessons from success, while serving as a potential model for Nigeria.

Objectives of Chinas’ Health Insurance policy

The health sector reform in China is aimed at ensuring a robust health insurance scheme to achieve universal health coverage for its teeming population. The reform is predicated on achieving five key objectives as explained here under.

- i. **Medical Insurance.** Chinas’ Health Insurance Policy consist of three health Insurance Schemes, the Urban Employees Basic Medical Insurance (UEBMI) covering city dwellers who are employed, the Urban Resident Basic Medical Insurance (URBMI) covering retirees and students in cities and the New Cooperative Medical Scheme (NCMS) covering rural residents. According to the National Health and Family Planning Commissions’ statistical year book (2017), these three schemes covers more than 95% of the Chinese population, nearly complimenting the government stated goal of covering 100% of the population by 2020. The government had advanced a goal to reduce out of pocket spending which recent statistics indicates that this has reduced drastically from 34% to less than 20% in a period of 6 months in 2016 (ibid). According to Zhang (2017),

the Gradual Improvement of Basic Insurance Scheme, which is a sub component of the Medical Insurance Scheme, has had positive impact with the rise of overall reimbursement level in the past few years. For example, the URBMI have reduced copayments for outpatient services from 80% to 50% and from 65% to 50% in Kunming and Shaoxing respectively. Similarly, the Critical Disease Insurance which is another sub component with the intent to provide additional protection against catastrophic diseases for the most vulnerable groups comprising of individuals as insured under the NCMS and URBMI is a major milestone in achieving universal health care. The government has set up funding and operational models for this top up insurance that provide secondary reimbursement for all parts out patients' out of pocket spending over the standard basic medical insurance reimbursement ceiling.

- ii. Drug Supply Security. The Essential Drug List (EDL) was set up to define minimum number of molecules needed to cure the broadest spectrum of disease at lower possible cost. This was because China had no systems to manage the cost, availability and quality of drugs, nor did it have any policy in place to cover tendering supply and distribution.
- iii. Medical Service Provision. Public institutions underlie Chinas' health care system. Available data indicates that 90% of the in patients' cases were treated in public system in the first 6 months of 2017 (NHFPC 2018). The public health system is organized by levels, with class III hospitals representing large maximum care providers and academic medical centers often with over 1000 beds boasting Chinas' best medical talent.
- iv. Public Health Service. In a desire to provide more equal access to quality healthcare, the government has invested massively in rural provider infrastructure. The current five-year plan has received investment of five billion dollars (\$5bn) in improving health infrastructure, upgrading medical talent, implementing population health programs such as increasing the examination rate of common disease among rural women to deepen the impact of rural health reform. (Zhang, 2013)
- v. Operating Environment. To build a sustainable, cost effective and high-quality public hospital system with four core elements viz.
 - a. Funding mechanism. Increasing government subsidies and medical service charges as the main source of funding and reducing dependence on drug sales.
 - b. Cost Control. Capping budgets and establishing payer provider relationships with cost control mechanisms.
 - c. Management Transformation: setting clear KPIs for service quality and operational efficiency.
 - d. Improvement in Resource Balance: reallocating resources from large hospitals in big cities to grass root institutions such as community health centers.

Health Financing and Coverage in China

China health Insurance is financed and also publicly provided by the local governments. This is achieved mainly through either of its health insurance models. In 2013, China spent approximately 5.6% of its gross domestic product on healthcare, 30% of which was by local government, 36% was funded by the formal, private and social health schemes (NHFP 2014).

Urban employment – based basic Insurance (UEBIS) was introduced in 1998. It involves a mandatory participation of employees in urban areas with funding from a pool of employees and

employer payroll taxes. This system has minimal government funding and does not cover employee's unemployed family members. The office of social security and human resources is responsible for its administration, while it is managed by the local authorities. According to the National Health and Family Planning Center, 274.2 million people had enrolled under this form of coverage as at 2013. The Urban Resident Basic Insurance (URBI) was introduced in 2009. It involves a voluntary participation at the household level covering self-employed persons, school students, children and the aged. The office of social security and human resources is responsible for its administration and managed by the local authorities. It enjoys government financing and covered 299 million people in 2013. The New Cooperative Medical Scheme was introduced in 2003. Participation is voluntary at household level and it is mainly government financed. It is under the administration of National health and family planning commission, managed by local authorities with rural population coverage of 802 million in 2013, representing a coverage rate of 98.7%. Percentage of Government financing varies with developments. In more developed areas, government subsidies are provided, whereas central government in less developed provinces provide largest share of subsidies. Publicly financed health insurance coverage is near universal-exceeding 95% of the population since 2011 (Jiang C. 2015). A same coverage benefit as citizens applies to the few foreign permanent residents, while visitors and illegal immigrants are not covered. For profit, companies operate the private health insurance. This is purchased primarily by higher-income individual or employers for workers because it holds promises of wider healthcare benefit package especially including care for some rather expensive health services not covered in the public scheme.

Conclusion

The objective components of health insurance policies of Nigeria and China differ greatly in terms of composition. Chinas' health policy was able to state clearly how its policy objectives could be achieved. This is obvious especially when an analysis of the 'medical insurance' component is brought to bear which comprises of three major schemes, the Urban Employees Basic Medical Insurance (UEBMI) covering city dwellers who are employed, the Urban Resident Basic Medical Insurance (URBMI) covering retirees and students in cities and the New Cooperative Medical Scheme (NCMS) covering rural residents. While the number one objective of the National Health Insurance Scheme (NHIS) was to 'ensure that every citizen have access to good healthcare', the operational guidelines does not provide for compulsory access to health care insurance for the teaming population. This alone jeopardizes the achievement of other objectives since the policy is not aimed at providing healthcare for all but a few individuals.

Nigeria like China operates a Social Health Insurance Scheme, which unlike the statutory scheme in China that demands compulsory participation, it is compulsory only for the formal employed and voluntary for others.

Subsequently, China have attained universal or near universal coverage of over 95% of its total population compared with Nigeria, which has only approximately 4% of its population covered with 3% in the formal sector and only 1% in the informal sector, which puts a larger proportion of the population at risk of financial hardship or catastrophe.

Furthermore, China, have invested in Health infrastructure in terms of healthcare providers and healthcare facilities, with increased subsidies for healthcare, thereby improving access and reducing disparity. This is a major lesson for Nigeria, where the health sector is faced with

reduced funds, poor and under equipped healthcare facilities, coupled with fewer healthcare personnel in ratio to the population, making access and quality care an uphill task.

Finally, it can be observed that government of China played a major role in the scale up of health insurance. China was able to achieve this through the universal coverage which was attained by the Central government subsidizing cost for individuals and local governments. Given the above summation, I would recommend that Nigeria government increase the investment funds for the health sector especially towards healthcare infrastructure to ensure easy access and reduce disparity. Also introduce and implement strict monitoring and evaluating measures of all scheme sectors to avoid fraudulent practices by stakeholders. Finally, to ensure universal coverage or scale-up, the government should ensure that the health insurance policy covers a considerable percentage of the population. This is because Nigeria is still far from achieving universal health coverage due to its poor economic background characterized by high rate of unemployment which consequently translates into individuals' inability to take any insurance cover.

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