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Analysis of Nigeria Health Insurance Scheme: Lessons from China, Germany and United Kingdom

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Abstract : *The primary objective of this study is to identify different health financing models as it operates in select countries- China, Germany and United Kingdom, taking into consideration the role of government; period of operation before universal or near universal coverage, and how scheme objectives were achieved. Lessons obtained were used to form an evidence- based decision aimed at improving the overall scale-up of Nigeria's Health Insurance scheme.*
Therefore, this research engaged a comparative study of health insurance as it operates in China, Germany and United Kingdom. The careful analysis of advantages and challenges indicated that, to ensure a scale up or near universal coverage of Nigeria Health Insurance, the government and policy makers need to increase subsidies, improve on health care infrastructure, ensure an active regular monitoring and evaluation of the system, alongside making participation compulsory for all citizens.
Keywords – *Health Catastrophe, Health Financing, Health Insurance, Universal Health Coverage, China, Germany, Nigeria, United Kingdom*

I. INTRODUCTION

The Nigeria Health Insurance program came into existence under Act 35 of 1999 constitution. Although enacted in 1999, it actually began its operation in 2003, covering initially only the Federal Civil Servants or Public workers by a compulsory participation, where access to healthcare was secured by a pool of contributions from both employees and employers, with the creation of a health scheme to serve the Nation, referred to as National Health Insurance Scheme (NHIS) a government parastatal directly tasked with the regulation and management of pooled contributions, alongside managing other stakeholders involved in the scheme. This is achieved by the National Health Insurance Council (NHIC) a board under the NHIS, which ensures the accreditation of Stakeholders such as; Health maintenance organizations (HMOs), health care providers (HCP), and registration of subscribers.

Over the years, the NHIS had expanded its scope and currently operates the following schemes; formal sector health insurance programme, informal sector health insurance programme and vulnerable health insurance programme. Their healthcare coverage include outpatient care, prescription drugs, pharmaceutical and diagnostic tests as provided in National Essential drug list or the Diagnostic Test lists. It also coves maternity care for four (4) live births, preventive care inclusive of immunization, health education, family planning, antenatal and post-natal care. It also covers specialist's consultation fees, hospitalization not more than cumulative 15days per year, eye examinations excluding spectacles and contact lenses. It covers a range of prostheses, preventive dental care and pain relief.

The NHIS tends to manage pooled funds using capitation on approved healthcare facilities. It also uses fee-for-service for secondary healthcare facilities in line with NHIS predetermined referral rate. Health maintenance organizations are paid administrative fees to ensure quality and provide codes for secondary care. (1)

II. LITERATURE REVIEW

Nigeria as a country operates a democratic system of governance, with power shared amongst the three tiers of government- Federal, States and Local governments. The provision of healthcare is also decentralized in like manner, with responsibility shared between the federal, states and local governments. The participation in the National health scheme is mandatory for some sectors and voluntary for others. This particular structure is sometimes considered as a major setback for the universal coverage of the scheme, (2, 3) even after operating for over a decade; it still has only about 3% of the population covered by formal sector and less than 1% in the informal sector. (4). The government over the years introduced some policies to support the health system.

These include the National Health Policy (NHP) with principal focus of increasing the healthcare finance options by the strengthening of sectors to ensure increased prepayment for healthcare. (5) The National Health Finance policy(NHFP) was also introduced to enhance equity, efficient and accountability, by focusing on measures to reduce out-of-pocket expenses (6)

The 2010-2015 National strategic health development plan (NSHDP) focused on a dual approach of improving health status, at same time strengthening National Health Scheme by ensuring increased funds allocation to the sector (7) While the National Health Bill (NHB) focused on measures to increase Primary Healthcare (8) States and local governments need to actively participate in structure and enforcement process (9). The participation of states especially in the formal sector health insurance scheme is below twenty percent, accounting for five participating states from a pool of 36states of the Federation. This poor participation by states is attributed to undefined state roles in the scheme, a lack of explicit accountability and financial reports on activities of NHIS since it began operation. (10)

Another setback for the uptake of NHIS can be due to the Nation's poor healthcare services, poorly equipped government hospitals due to lack of government funding, and pressure on available government health facilities. (11) These factors discourage participants from enrolling in the scheme, especially when they prefer to obtain health services from equipped centres not registered under the scheme. Some healthcare facilities have opted out of the NHIS, largely due to very low capitation fee schedule by HMOs, which do not measure up to the present day economic status, this may be due to the predetermined time frame set by HMOs for capitation reviews, which makes capitation unrealistic in the face of rising health cost. Other reasons affecting health facilities participations include slow payments and at times nonpayment of capitation by HMOs (12)

This study is significant and timely, because despite the years of Nigeria health insurance operation, there still exist a larger proportion of uncovered population, and the scheme is also faced with implementation challenges. It is hoped that the lessons from diverse health finance systems under observation would assist in solving some major implementation problems faced in the system.

III. RESEARCH METHODOLOGY

This study engaged a qualitative research approach, by the extensive review of literatures in scientific research articles, books and reports from World Bank, World Health Organization (WHO), National government policy and reports amongst other sources on the implementation of Health Insurance in China, Germany and United Kingdom. Secondary data was collected from Organization for economic cooperation and development (OECD) health database, statistics from the European Union (EU) and Individual countries' information systems.There was a careful and systematic selection of relevant literatures as it relates with the research questions, using appropriate search terms in the following search engines; Pubmed, Econlit, Google Scholar and Embase available studies providing descriptions of each health insurance scheme were used to provide comparative health and economic data for China, Germany and United Kingdom. The following search terms were used Universal Health, Health Insurance, Health Financing, Universal Health Coverage (UHC), Health Catastrophe, in combination with China, Germany, United Kingdom and Nigeria.

In this study the following criteria was used for countries selection- type of health financing scheme, population coverage and role of government in ensuring scheme success. Germany being the first country to adopt a National social health insurance model, the United Kingdom also the first country to adopt a general taxation model for financing the health system, and China a leading developing country with success in attaining near Universal coverage formed a rich source for a comparative study in this research. The three select countries represent major forms of Health insurance financing, such as National social health Insurance as it operates in Germany, the National Health Scheme based on general taxation as it operates in United Kingdom and a combination of Social health insurance and out of pocket (OOP) as it operates in China. These models would be reviewed and their success is hoped to assist policy makers in the scale up of Nigeria's existing Health Insurance.

Germany has its social health protection guaranteed by compulsory Social Health Insurance, depending on participation in the labour market and solidarity contributions by workers and employers in proportion to wages. (13) and currently covering 89% of the population. In the United Kingdom, the National Health Service (NHS), created in 1948, with universal access based on citizenship and tax-based financing, guarantees free coverage to the entire population, using a traditionally single and centralized structure. However, the NHS-Uk was decentralized in 2004 to the four countries of the United Kingdom, and the current NHS of England, Scotland, Wales, and Northern Ireland display some characteristics (14)Therefore the case focus of this study would be NHS-England.

China has experienced a rapid progression towards Universal 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. And there is an observed reduction in impoverishment and out-of-pocket payments as a proportion of total expenditures on health. (15)

In Germany, the decision-making process is shared among corporate organizations with public functions, the Federal government, and the 16 States. Health sector regulation is traditionally of the meso-corporatist type, according to which the government delegates regulation of a given sector of society to the stakeholders immediately involved in that activity. Federal legislation defines the structural conditions, while the competencies for their materialization are delegated to the stakeholders, namely representative organizations of the Sickness Funds, and providers, especially the Associations of Accredited Physicians (KVen) and the Joint Federal Commission of Sickness Funds, Physicians, and Hospitals (G-BA) (16)

In England, the NHS was traditionally regulated by the Department of Health, which both financed the system and regulated resource allocation and delivery. Beginning with the establishment of the internal market in the 1990s, a series of independent agencies with specific regulatory functions were created and successively restructured, featuring the National Institute for Health and Care Excellence (NICE), Monitor, and Care Quality Commission (CQC) (17) (18) (19)

China is renowned for its large population, faced with the challenge of health inequity had 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. (20) 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. (21)

China when compared with other fast growing economic countries (BRICS) and was said to have devoted the largest resources to health; this was probably facilitated by its rapid economic growth. (22)These reasons made me choose these countries as my case study, in order to draw lessons from success, while serving as a potential model for Nigeria.

IV. RESEARCH LIMITATIONS

Some limitations that I encountered in the course of this research includes, possible unintentional omission of key events as it relates to China, Germany, and United Kingdom by the literature search, no access to primary sources as materials used represent other scholar's impression of the scheme and finally the inability on my part, to use possible rich literatures written in Chinese or German languages due to poor translation to English.

V. RESULTS

Countries tend to pattern their healthcare system based on what they consider workable for them, hence healthcare systems seem to differ from country to country but the general observation is that they seem to follow same trend overtime. In this study focus is on four major healthcare financing systems, namely; Beveridge Model, Bismarck Model, National Health Insurance Model, and Out-of-Pocket model.

VI. ROLE OF GOVERNMENT

The role of government is a major determinant of any country's healthcare system. The central government in China is absolutely responsible for the country's health administration, legislation and policy making. The guiding principle states that all citizens are entitled to receive basic healthcare services. China health authority ensures healthcare organization and delivery, alongside the supervision of service givers. There is limited flexibility in regards to provincial health policies. (23)

In England, legislation and policy making is the joint responsibility of the State secretary for Health, Parliament and Health sector department. The Secretary of State has the legal duty as stated in the Health Act (2006) to promote a comprehensive health service, provide services free of charge, except areas with charges already. The NHS constitution contains the Rights for all eligible under the scheme. Department of Health in England has the oversight function overall health system, but NHS England, which is a separate public entity, see to the day-to-day running of the NHS. Other functions includes management of NHS budget, clinical commissioning groups (CCGs) and seeks compliance to the annual mandate objectives, efficiency and health goals by the Secretary of State for Health. The local government authorities, manages budgets for public health, and are required to set up "Health and Well-being Boards" to reduce disparities and improve co-ordination of local services. (24)

In Germany, permanent residents and citizens are mandated to participate in the insurance scheme. This can be accessed from a pool of contributions into a central fund, called sickness fund, managed by competing private health insurance companies, usually not-for profit. Majority of the university hospitals are state owned, with municipalities involved in public health activities, and own almost half of hospital beds. Unlike China and

England, the government at different levels does not participate in the management of funds or healthcare service delivery. Self –governing groups such as sickness funds and healthcare providers associations are tasked with a large degree of regulation. These put together, constitute the Federal Joint Committee (FJC) (25)

VII. HEALTH FINANCING AND COVERAGECHINA

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. (26).

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. In 2013, 274.2million people had this form of coverage.

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 299million 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 802million in 2013, representing a coverage rate of 98.7%.

Percentage 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% 0f the population since 2011 (27). 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. Presently, this sector lacks statistics to show the level of private insurance population coverage, but the government encourages its market development (23)

ENGLAND

The publicly financed healthcare is majorly funded from taxes, and payroll tax accounts for a small proportion. Funds from copayments, individuals who subscribe as private users of NHS and other minor sources account for some NHS income. In 2013, 8.8% of the UK gross domestic product was spent on healthcare, and NHS accounts for 83.3% of the public expenditure (28). Population coverage is universal, as it is automatic for residents. Non –European, visitors or illegal immigrants may access free treatment on emergency. (29)

Whereas, in UK, Private Health Insurance accounts for about 10.9% of the population (30), it makes access to care convenient and quicker . (24)

GERMANY

The Publicly Financed Health Insurance has a universal coverage for all legal residents. The sickness fund is an accumulation of compulsory contributions in relation to an individual's income, not exceeding a particular percentage. In 2013, total health expenditure was 11.5% of gross domestic product, 73% was publicly financed with Social Health Insurance spending accounting for 58 % (31).The SHI accounts for a mandatory coverage of all employed citizens alongside other groups such as pensioners, whose earnings are less than EUR 54,900 (USD 69,760) per year as of 2015, with a free of charge coverage for their non earning dependents. Whereas, individuals with gross wages higher than the threshold, previously SHI-insured and self employed can willingly maintain their public insurance scheme or can decide to purchase private health insurance, which also covers civil servants whose healthcare costs are partly refunded by their employer. 86% of the population is covered by the SHI and 11% covered through PHI, the remaining proportion of the population within the exempt are covered under special programs. The German SHI does not cover visitors but illegal immigrants access care under social security.

Private Health Insurance provides coverage for the exempt SHI groups such as self employed and civil servants whose employer partially reimburses healthcare expense, together with those who had opted out of the SHI. PHI made up of private insurances companies, had 42 companies registered in 2015, 24 of which were for-profit. This substitutive private health insurance had covered 8.8million people in 2014. The system appears attractive to young people with high income, promising wider coverage at less deduction. (25)

VIII. CONCLUSION

COMPARES BETWEEN BISMARCK, BEVERIDGE, NATIONAL HEALTH INSURANCE AND OUT-OF-POCKET MODELS.

The above four models of health insurance would be discussed in compares by considering the following factors;

IX.

X. SCHEME FINANCING

This considers the mode of funds generation to ensure the sustainability of the system. The Bismarck model is majorly funded by a pool of contributions usually from employers and employee to make up a sickness fund, from which access to healthcare is guaranteed. The Beveridge on the other hand, employs a general taxation system, from which healthcare is paid. The National Health Insurance model has a combination of both Bismarck and Beveridge, hence funding is on one part from taxation and also from contributions from employers and employees, a pool of the taxed and contributed monies, ensures the funding of the scheme. Meanwhile the Out-of-pocket model as seen in some countries do not enjoy the aforementioned pool of funds, instead payment for healthcare is at the instant of access by the one in need, hence this model is said to favor only the rich and puts the poor at risk of financial catastrophe. (32)

XI. HEALTH SERVICE PAYMENT

The Bismarck model engages a multiple payer system, where the sickness fund is managed by a group of insurance companies, who are tasked with the payment of providers for healthcare services. The Beveridge engages a single payer system, which is the government responsible for payments. The National Health Insurance Model organizes payment using a government controlled insurance program. Whereas, Out-of-pocket Model pays for health services directly by individuals in need, before access. (32)

XII. DOCTORS AND HOSPITALS

Under the Bismarck Model, Doctors and Hospitals tend to be private owned, which is not the case in the Beveridge, which has most of the hospitals government owned and doctors employed also by the government. It also has operating in this model a few private hospitals and doctors, also paid by the government. The National Health Insurance has a mix of both public and private sector providers, also the case in Out-of-pocket Model, which for several reasons peculiar to the country either due to poverty or poor organization is not able to establish any form of health insurance. (32)

XIII. COST CONTROL

Bismarck tends to control rising cost of healthcare by employing strict government regulations. This is easily achieved in the Beveridge model, due to the government being the sole payer is able to maintain low cost per capital., Just like the Beveridge, the National Health Insurance Model, has the government controlled health insurance program as its single payer, this enhances the power of price negotiation on the part of government, subsequently controlling cost by placing limits on health services to be paid for. Meanwhile, the Out-of-pocket model is market driven. (32) Nigeria like Germany operates a Social Health Insurance Scheme, which unlike the statutory scheme in Germany that demands compulsory participation, it is compulsory only for the formal employed and voluntary for others.

Subsequently, China, Germany and United Kingdom have attained universal or near universal coverage compared with Nigeria, which has only approximately 4% of its population covered and has it's a larger proportion of the population at risk of financial hardship or catastrophe.

Furthermore, China, Germany and United Kingdom 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 the three countries played a major role in the scale up of health insurance. In the case of the United Kingdom, it was a compulsory taxation by government, Germany also made its social health contribution statutorily compulsory for citizens, whereas in China, it was not necessarily by mandate, but the near universal coverage was attained by the Central government subsidizing cost for individuals and local governments(33)

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

and policy makers may need to toll the path of a compulsory social health insurance scheme for all citizens like Germany, or take the path of China with increasing subsidies to enhance participation by other government sectors and individuals.

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