Healthcare Delivery Targets and the National Health Insurance Scheme Limitations in Nigeria

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Abstract

Health reforms that target universal coverage have intensified in Nigeria since the dawn of the 21st century, and the National Health Insurance Scheme, in particular, has been hailed as the panacea for, and appropriate framework in achieving the desired health for all by 2015. Few weeks after the target goal however, the reality is bleak and the task of reaching the goal more daunting than ever. A historical analysis of health care delivery in Nigeria is made and explanations for the difficulties in meeting health targets are discussed, pointing to weak governance, economic challenges, and socio-cultural contexts as important interacting factors slowing down the process. The paper concludes by outlining some important emerging possibilities for strengthening the health system, including the liberalization of the health sector, enhancing public-private partnership, and suggestions for improving the national health insurance scheme by recognizing key socio-cultural factors for inclusion in achieving health targets.

Keywords: Health insurance; private health care; user-fee; public-private partnership; health policy; universal health coverage; Nigeria

Introduction

Nigeria's significant socio-economic progress in the first two decades after independence in 1960 came to an abrupt halt with coups and counter coups that established the military in power for sixteen consecutive years, from 1984 to 1999, eroding the gains made in the preceding years. Governance during this period was not only predatory, but social institutions and public services were neglected with the health and education sectors being the most conspicuously affected. Tertiary institutions and medical research centres that were the hub for producing quality medical professionals became shadow of their former selves, while health centres were bereft of doctors, nurses, and consumables reducing hospitals and other health centres to mere consultation rooms "where people go to die" (Alubo, 1994). This deplorable state left much to be desired by the turn of the century. For example, life expectancy dropped from 56 years in 1978 to 48 years in 1998 while healthy life expectancy (HALE), which is the adjusted life expectancy for healthy life without disability, and an objective measure of survival, dropped to 42 years (Dogo-Mohammed, 2009).

Analysis showed that the low HALE ranking of Nigeria was due to high neonatal, infant, under-five and maternal mortality (WHO, 2005). This dismal performance, in the context of high revenue from crude oil and the promise of improved standard of living, precipitated an urgent need to arrest the situation leading to health care reforms in the country, and as its cornerstone, the establishment of the national health insurance scheme (NHIS) via Decree 35 of 1999 with a mandate of providing quality health for all Nigerians by the year 2015. Current data on health care provision however, indicate a very slow pace of universal coverage, and barely two months to the target year the prognosis for achieving the goal is not positive. Recent remarks by the minister of health and other senior health officials are indicative of the challenges government faces in achieving its set goal for universal health by 2015 (NDHS, 2013). Also, Akinseinde (2014) has noted that the scheme has not grown beyond 4% coverage of the Nigerian population after its establishment fifteen years ago.

In consonance with this elusive optimism, the United Nations Population Fund forecasted that Nigeria's ability in achieving the Millennium Goal, especially with regards to Goal 5, is unattainable due, primarily, to the slow rate of decline of maternal mortality, which has only reduced from 1,100 per 100,000 in 1990 to 840 in 2008 (UNPF, 2011). This paper discusses explanations for the slow pace of health care delivery by pointing to weak political structures in the country in relation to health services; the structural adjustment programme that nested health reforms; and the socio-cultural context in which the reforms operate. The paper draws heavily from relevant literature on health care reforms as well as from Nigeria's health policy.

1. Health care delivery in Nigeria: the collapse of a promise

After Nigeria's independence in 1960, there was a determination among the emerging endogenous political class to improve the quality of life of citizens and at the centre of that understanding was the need to continue with colonial policies, which accentuated, among other things, a formal adoption of orthodox medicine and the expansion of colonial health structures in urban and rural communities for effective health care delivery (Alubo, 1985). This ideological orientation represented government's overarching health programme and was driven by massive training of doctors and nurses both within and outside the country with the aim of developing indigenous capacity for western health care provisioning. Besides training, government also imported hospital equipment and set up bureaucratic structures for the management and delivery of health care for all citizens in rural areas and urban centres. The agenda was universal medical coverage. This commitment underpinned post-independence health policy with a primary accent for the provision of modern medicine to the bulk of the populace by establishing health centres with free medical consultation and unhindered access to free supply of drugs or at heavily subsidized rates (Lambo, 1991).

Also, at state and federal levels, secondary and tertiary health centres were built and equipped as a tangible goal for investing public funds. At the same time, attention was given to the training of nurses, midwives, and doctors for the primary purpose of staffing the health centres which government had set up and eager to develop (Erinosho, 1993).This welfare scheme, although desirable by government, was initially sluggish in gaining popularity among citizens due to their reluctance to abandon traditional forms of health care. Government had to resort to enlightenment campaigns to persuade local folks in patronizing modern medicine and the newly established health centres. The unwillingness of the public to patronize western medicine was due to the total variance of traditional and western concepts of illness/disease and the pathways to restoring good health. While western trained medical doctors operated within the germs theory in explaining the causative factors of diseases and illness, indigenous explanatory models incorporated the basic assumptions of the germs theory as well as traditional beliefs in supernatural and preternatural forces in explaining and interpreting health matters, which ultimately influenced health seeking behaviour.

The desire to embrace a completely new and diametrically opposed health system became problematic and government had to face the onerous task of educating and enlightening rural folks on the benefits of modern medicine, which, by government conviction, promises a superior quality of life. The ideological conviction of nationalists that the state is the coordinating instrument for facilitating development and solving social problems influenced massive investment in health facilities, personnel and consumables and the overt encouragement of the public to patronize government largesse. Consequently, the first two decades after independence witnessed the relative functioning of public health centres in terms of the provision of essential drugs and access to qualified medical officers with the public beginning to respond positively to the new development.

Financial subventions from government, both at the federal and state levels, met the operational expenses of the health ministry and were also regular even if not always sufficient due to competing demands from other sectors of the new economy (Aragbeyen, 1988). This, however, did not deter the growth of the health sector, which had begun commanding public confidence, especially in urban centres, as an important source of health care. But the growth in this sector as well as the people's confidence was not to last for long; by the mid-1980s the spiralling economic crisis that was beginning to build up at the twilight of the Second Republic in the late 1970s, put a halt in the development process. The consequence of the economic downturn was the mass exodus of highly qualified doctors and nurses from the country to North America, Europe and other African countries where up-to-date working facilities and better conditions of service were available.

The last straw that finally dealt the destructive blow was the retrenchment exercise initiated by the military governments starting from the Buhari regime in 1984, and reaching a climax in 1987, during the Babangida's administration, as part of a general reform agenda in the public sector that was crafted in the spirit of the IMF/World Bank Structural Adjustment Programme (SAP) (WHO, 2005; UNDP, 2006; Olukoshi, 1993). Fiscal constraints, due to increase in foreign debt, as well as pressure on government to sustain the financing of public services, impacted adversely on Nigeria's capacity of providing subsidized health services to the public. The economic hardship that followed SAP's implementation and the social crisis associated with it led to the inability of the state to fulfil its primary obligation as a developmental instrument particularly in the health sector. High mortality became rife reflecting the virtual collapse of the state as a result of the military junta's abdication of governance and the engineering of a quasi-civilian regime that enthroned a political ruling cabal that had only a parochial interest of self-aggrandizement through looting of the public treasury.

The political crisis that heralded the overthrow of the civilian administration on the eve of 1984, leading to counter coups and long military dictatorship and pseudo-democratic rule, became one of the most significant disturbances that obstructed developmental process in the country. Consequent upon this political dislocation was the weakening of state apparatus while developmental goals became blurred. The lack lustre of government in defining comprehensive national development plans and articulating its vision, reflected in anachronistic policies that reversed the gains that accrued to the nation in the period preceding the 1983 coup. In addition to this, the institutionalization of corruption by the military meant that the state was later perceived as not having "the moral fibre as well as the technical rationality to deliver health care to all its citizens" (Hyden, 1999). Government parastatals and public infrastructure became moribund.

The collapse of the state leading to infrastructural decay was characterized by neglect of the health sector such that procurement of drugs and other consumables were no longer the prerogative of government, while power supply became irregular and health facilities were not expanded and/or maintained (FMoH, 1986). The political impasse, which also led to the crisis in public health, acted as a fillip for the emergence and/or expansion of private health services underpinned by capitalist philosophy of hegemonic neo-liberalism that is market oriented as against the welfare approach adopted by the nationalist government. This shift in paradigm accelerated the growth and expansion of private health care provision in terms of its proliferation and the ambivalence of its services to the public (see Alubo, 2001 and Ogunbekun, et al, 1999).

One thing is sure however, the emergence and expansion of the private health system did not only signal the formal arrival of a highly stratified health structure in Nigeria, but it also challenged the universal character of the state as a problem-solving entity. This development forced the working poor to either make do with the deplorable public health system that were provided by government or seek other emerging popular alternatives including traditional healing practices, which had been neglected by successive governments and had become unpopular at least in urban centres. On the other hand, the precarious circumstance opened new opportunities for social advancement while it simultaneously provided the elitist class with the highest quality of health care through its patronage of private health providers and where this was not available resulted in the patronage of health services outside the country (Gureje and Lasebikan, 2004; Gureje, 2005). The virtual collapse of the state consequently led to a vacuum in the health system that eventually encouraged quacks to take over the sale of fake and sub-standard drugs in urban and semi-urban centres and the concomitant rise in mortality rates (Alubo, 1994).

The group that suffered the most in the crisis, however, was the rural poor who were in the process of embracing modern health care as a result of government enlightenment campaign efforts but were cut off track with the economic and political crises. As health posts were abandoned in rural areas by government and the progressive lack of drugs and qualified doctors that followed the economic crisis aroused rural folks' suspicions of government and the health system it once promoted. Consequent upon this disappointment was the reverting of rural folks to traditional health systems and varying traditional healing practices including the increasing patronage of religious healing centres. However, because most traditional health practitioners had stopped practicing due to poor patronage and, in some cases, the demise of highly skilled traditional professionals, quackery in this sector also flourished exacerbating mortality rates in rural and peri-urban areas. The amorphous health care system resulting in high mortality due to the dismal performance of government precipitated the need to address the enormous challenges in the health sector and restoring hope of equity in health care, access to quality health services and universal coverage.

2. Improving health care services: government efforts since 1999

2.1 *Health governance and financing*

When the country returned to a democratic rule on May 29, 1999, the public health system was completely dysfunctional and fragmented into varying forms. These ranged from public health centres that were still under the ambit of government; unregulated private health services; licensed and unlicensed chemist shop owners who procure and dispense drugs to the public; a plethora of traditional health practices; and religious healing homes among other forms of health care delivery. The public health sector, constitutive of the federal, state, and local government health departments, was also fragmented operating with meagre resources and poor coordination from the federal ministry of health. The system was heavily over burdened with infrastructural decay, poor condition of service, and low morale among the few staff who managed to stay behind. The situation was more deplorable in rural areas due to the complete abandonment of community health posts built in the 1970s in consonance with the primary health care initiative that targeted rural communities for the provision of basic health services.

Thus, by the turn of the century, only few health posts were available in rural communities and heavily concentrated public and private health facilities in urban centres. By 2002, 70% of all health care expenditure was on urban health even though 70% of health needs were in rural communities. The distribution of health facilities and personnel has not improved since then and there is no visible attempt by succeeding democratic governments in correcting the anomaly even though over 70% of those who are in dire need of health services still reside in rural areas (McKenzie et al, 2014). In a bid to reduce maternal mortality, there is a need for the government of the day to revamp all the rural posts and expand existing facilities to accommodate the increase in population since the 1980s. Current health policies must ensure that there is an appropriate scheme to encourage health workers including doctors and nurses to provide services in underserved areas. Inter-sectoral relations need strengthening to provide complimentary social amenities in rural communities to open up rural areas and encourage private health services. In doing so, however, effective organizational structure needs to be put in place to regulate activities of the private sector in preventing the sale of fake and sub-standard drugs.

Further to the vertical fragmented health system and skewed distribution of health facilities, was also the poor coordination of the private sector by the Ministry of Health in all tiers of government. Private health providers had unfettered freedom in importing drugs, and whether by act of omission or commission, but mostly due to corruption, fake or sub-standard drugs were being sold to the public (Alubo, 1994) leading to the overhauling of NAFDAC and the appointment, in 2004, of Dora Akunyili, a vigorous and uncompromising university professor of pharmacology with a personal passion to get rid of fake and adulterated drugs from the public and checking the excesses of the private health sector. But sadly, little has been done to improve the situation. The threat to the life of the NAFDAC boss, and her subsequent redeployment to the ministry of information in 2006 are indicative of the fact that private health care has become firmly rooted in the country with important power brokers behind some of its obnoxious dealings. Surveys conducted indicate that the private sector now contributes about 50% of health care delivery in the country but with very minimal presence in rural areas (Health survey, 2013). Despite sharp practices that are associated with the private sector, government still needs its support as it is obvious that government alone cannot provide health services for all members of the society as it once ambitiously planned. What needs to be done is for effective coordination of the sector to check its excesses by being firm and transparent in its dealings. The argument made by Alubo (2001) is in line with the challenges that are associated with private health provision but the potentials of the sector also need to be fully appreciated even if not as optimistically presented by Ogunbeku *et al* (1999).

2.2 The national health insurance scheme and health for all

The re-launching of the NHIS in 2002 by the Obasanjo administration was more focused and broad in scope than the 1999 decree that established the scheme and has as its key objectives: (1) ensuring unhindered accessibility of citizens to quality health service; (2) protecting families from financial hardship of huge medical bills; (3) limiting the rise in the cost of health care services; (4) ensuring the equitable distribution of health care costs among different income groups; (5) maintaining high standard of health care delivery services; (6) ensuring efficiency in health care services; (7) ensuring the equitable distribution of healthcare facilities; (8) providing funds to the health sector for improved services; and (9) ensuring equitable patronage of all levels of health care (NHIS, 2007).

The overall goal of the scheme was to improve the quality of life of citizens. The primary functions of the scheme include registering of health maintenance organizations (HMOs) and health care providers (HCPs), issuing appropriate guidelines towards maintaining the scheme's viability, and determining, after negotiation, capitation and other payments due to health care provision by HMOs.

In its operation, an employer with a minimum of ten employees may pay contributions under the scheme calculated as 10% from the employer and 5% from employees' basic salary and lodged with any HMO of their choice for quality treatment. Consideration for capitation payment in respect of each person registered, and liability to pay the specified contributions are required under the scheme. The scope of the scheme in terms of health services is restricted to consultation, prescription and supply of drugs, diagnostic tests; consultation with defined range of specialists, hospital care in a public or private ward for a specified period of admission for physical or mental disorders, a range of prosthesis and dental care as defined, and eye examination and care but excluding spectacles. Finally, simple preventive measures including immunization, family planning, antenatal and postnatal cares form an integral part of the scheme.

Expected advantages of the scheme include ensuring that patients in need of a physician or requires any form of health service would have relatively easy access within a reasonable distance with effective referral system. In addition, the scheme is to protect Nigerian families from the financial hardship of huge medical bills that are usually associated with 'out-of-pocket' system of health care provision thereby limiting the rise in the cost of health care services and ensuring availability of funds in the health sector for constant supply of quality consumables at cheaper price. The above will help in maintaining high standards of health care delivery services and ensuring the equitable distribution of health care cost among different income groups. Harnessing private participation in the health sector, government encourages public-private partnership to achieve its goals by reaching out to all segments of the population and the patronage of health services at all levels of health care with the NHIS serving as the coordinating structure for the safeguard of citizens' health.

Although user fee for health has a long history in Nigeria, the idea of paying in advance for health services in the form of insurance is certainly novel and thus needs careful planning and implementation in achieving the desired goal for universal health coverage. User fee is widely acceptable to Nigerians because of their identification with such a mechanism from their own socio-cultural transactions and for their immediate response to health matters. Health insurance on the other hand, although has its theoretical and practical benefits (Bituro, 1999; Akin, *et al*, 1987; Kannan, *et al*, 1991; Mwabu *et al*, 2002), is still a foreign idea and practice in Nigeria and demands careful planning and execution.

2.3 Human resources and health care coverage

One of the significant gains of the first two decades after independence was the production of skilled personnel in the health sector so that between 1960 and 1980 the number of registered medical doctors increased from 1, 250 to 16, 480, with a concomitant increase of doctor – population ratio from 21 per 100,000 to 62 per 100,000. Similarly, during the same period, the number of registered nurses and midwives increased fourfold from 14, 000 to 66,000. With the downturn of the economy however, and the resultant exodus of doctors and other health personnel, the country witnessed a significant drop in the number of doctors and nurses, which also reduced the ratio of health personnel to the population drastically. By 2010 the estimated number of medical doctors in the country had shrunk to 55, 376 translating to 40 physicians to 100,000 citizens and less than 1 dentistry personnel to 10,000 people with a total population of 3,781 (WHO, 2011). This situation is primarily caused by the decline in government expenditure on the health sector.

For example, general government expenditure on health was 6.4% of total government expenditure while the total expenditure on health was 5.2% of gross domestic product (WHO, 2011). What all this leads to is that total health coverage has not significantly improved with the various reforms initiated by the government, so that between 1990 and 2010 immunization coverage among children less than one year old dropped from 54% to 41% for measles and from 56% to 42% for DTP3 respectively. Similarly, antenatal care coverage dropped from 58% in year 2000 to 45% in 2010 (WHO, 2011).

3. NHIS and the challenges of attaining universal care

3.1 Key advantages of the NHIS

Significant advantages accruing to the NHIS especially in advancing security and equity due to advance payment that secures treatment even in the face of cash constrain during emergencies, which may occur in unexpected circumstances, are key to achieving universal health coverage. The scheme also ensures that the working class in both public and organized private sector with low income earnings is guaranteed quality health services at all times including periods of the month when most families are on tight budget, which may compromise rational decision in utilizing health services when urgent need arises. Thus the scheme insures contributory families against unexpected eventuality that would otherwise have dire consequences. Furthermore, families do not bear the full brunt of their medical bill because their contributions are distributive among co-contributors thereby reducing the burden of each participant but at the same time providing health services that would otherwise have been impossible if members had operated individually. It also promotes equity because the sick benefit from premiums of contributors who rarely fall ill.

This collective pool becomes the hallmark of the NHIS and the singular most important reason for its great promise for universal health care delivery. What needs special attention in this regard is balancing those expensive ailments associated with the rich versus the constant ill health of the poor (Wang'ombe, 1997). In all, the NHIS is, theoretically, a veritable and promising programme for health equity. While these positive factors have their benefits, scholars have noted some important consequences resulting from introducing various shades of medical insurance schemes in African countries. For example, in evaluating community insurance in Kenya, major setbacks associated with the scheme were observed with the cost of medical treatment increasing by 100% - 500%, leading to a reduction in utilizing government hospitals by 40% - 50% with the poor constituting majority of those who stopped patronizing formal health centres (Mwabu et al, 2002). Similarly, studies have highlighted the drawbacks associated with user-fees in other parts of Africa including poor patronage of health centres, especially among the poor, leading to inequity, while efficiency and sustainability are usually not guaranteed (Maiga*et al*, 2003; Quaye, 2004).

3.2 NHIS and the socio-cultural context

In Nigeria, the socio-cultural context in which the national health insurance scheme operates is crucial to its success. First, the scheme recognizes a family unit of a man, his spouse(s) and four of his children without recourse to indigenous family system. The logic of polygynous formation in Nigeria and the recognition of children outside wedlock negate the framework of one-man-one-wife-four-children equation on which the NHIS operates. In addition, the extended family structure that is pervasive in both urban and rural areas automatically excludes significant others in the family who legitimately depend on the breadwinner for their livelihood and well-being. While elements of modernization is certainly common in the country as a whole it is by no means universal and some cultural forms and pattern still exist and constitute a significant part of social relations in Nigeria.

At a conceptual level, the gender and social relations in Nigeria are not only complex but are also dynamic in their form infusing into them cultural, religious and exogenous trajectories. One of such is polygynous practice, which is common in most communities and sustained by cultural dictates and religious endorsement (such as Islam in the northern part of the country and African traditional religions in the south). The most current data on polygynous union in Nigeria, for example, indicate that 26% of women between ages 15 – 19 have one or more co-wives; while 53.7% of women aged 45 to 49 have one or more women as co-wives contesting for equal resources (NPC &ICF, 2009).

Furthermore, women's participation in decision-making is low with over 55% of men solely responsible in taking critical decisions regarding their wives' health (NPC &ICF, 2009: 275). Such practice only means that women's place is disadvantageous and circuited in negotiating their rights including those that pertain to health matters. The patriarchal structure of the Nigerian society also means that boys are better educated and therefore better empowered in accessing resources while their female counterparts depend mostly on them as fathers, brothers, or husbands for their survival. The practice of girl-child marriage also means that as more women outlive their aged husbands, women-headed households with marginal resources are common thereby limiting their participation in the scheme.

Consequently, by virtue of their social position in the society, a significant number of Nigerians are excluded automatically from the scheme because rarely do households or families in the country are composed of the evolved nuclear family on which the government designed the health insurance framework.

Further to the above, the traditional African concept of the family, which dominates rural thinking and practice, is not only at variance with western perspective and practice, but it also differs in its form and expectation. The scheme's recognition of the Nigerian family structure as constituting a man, his spouse(s) and four children means excluding one's parents, in-laws, and other members of the "extended family" as well as domestic helpers who are all regarded as part of the family and dependent on the breadwinner(s). The extended family concept as enunciated in its definition is mostly practiced in Nigeria's rural areas and, to a lesser extent, in urban centres. For the average Nigerian, partrilocal or martrilocal residency means that all members living in that homestead are family members without recourse to differentiating between "nuclear members" and those constituting "extended members". In such arrangement, the head of the family, who is either a man or a woman, takes responsibility for every family member without distinction as specified in the scheme.

The structure of the typical Nigerian family, except for acculturated families in urban centres, consists of more than the officially recognized one-man-one-woman-four-children composition but includes other members of the family who depend on the breadwinner for their survival and well-being. Recognizing only the core (nuclear) members in a family means excluding other members and thus, the danger of such policy lies in endorsing western values and ways of life that are totally at variance with local practices. The technical exclusion of a subset of the population by virtue of its unique relationship with other members of the society further buttresses folks' suspicion of government and why they will be less cooperative even when government is sincere. In this circumstance, rather than exacerbate the tension that characterizes the relationship between government and its people, it is instructive for health policy-makers to expand the scope of the scheme by recognizing and accommodating traditional forms of relationships and incorporating household members that breadwinners are capable and willing to support. Furthermore, promoting gender equity in health care provision must also recognize the peculiar position of women both in urban and rural areas and policies must be appropriately designed to address health inequities derived from such social arrangement.

3.3 NHIS and the private sector

The operational requirement that mandates employers with minimum staff of ten, to officially declare the financial viability of their organization before and after registration, serves as an important impediment for recruiting members into the scheme. The poor performance of the economy and the harsh condition in which businesses operate, have continuously discouraged entrepreneurs from registering their staff with the NHIS (Akinseinde, 2014) due to the financial commitment foisted on them against the need to maximize profit. Since employees do not want deductions made at source for this purpose, it means cooperating with their employers to circumvent the scheme. Since most companies are struggling to stay afloat, extraneous financial demand in the guise of medical insurance continues to face resistance from small and medium entrepreneurs.

Besides the economic consideration among employees, is the role culture and religious beliefs play in everyday life of the people. Paying in advance for an unwanted ailment that has not taken place is not only alien to the cultural dictates of most Nigerians, but more importantly, it negates their beliefs in the efficacy of prayers and other paraphernalia that go with healing and prevention of diseases and ailments. It is generally upheld among Nigerians, and especially so among the low-income group, that paying in advance for something negative is courting that phenomenon and encouraging it to come to pass. It is such idea that forbids the average Nigerian from patronizing life insurance coverage based on the belief that insuring one's life may open the door for the evil machination of malevolent spirits, which may lead to an untimely death. The very idea that one is paying for illness in advance also means, especially among Christians, a lack of faith, which compromises the belief that God is capable of protecting the believer from illness and diseases.

3.4 NHIS and infrastructural development

Prior to the launching of the NHIS in Nigeria and especially in the 1970s and 1980s, the federal government had established health posts and community health centres in most parts of the country to cater for the primary health care (PHC) programme and the immunization project targeted at children below five in both urban and rural areas of the country (Jegede, 1994).

However, the slow decline of activities and poor partnership with foreign donors led to the gradual disintegration of the structures (Ogunkelu, 2002). The lack of adequate structure on ground means that underserved populations are excluded from benefitting from the scheme. Although the scheme was in the drawing board for several years no adequate arrangement was made in practical terms to prepare the NHIS for a soft landing. The skewed distribution of health facilities and qualified health personnel become the most conspicuous deficiency in implementing the NHIS. In rural areas where health needs are in dire need, functional health posts and health centres are inversely proportional to health facilities in urban centres; so that over three-quarters of registered health centres are in urban and semi-urban centres.

Consequently, the poor referral systems in rural communities exclude people living in these underserved communities and forcing them to fend for themselves without critical government support (Lanre-Abass, 2008). In communities with some semblance of health posts, the scheme has not taken into account the economic hardship of the people who are incapable of paying their premiums and therefore are excluded from the scheme. This issue is important when we take into account that urban areas have a much higher proportion of people in the fourth and highest quintiles of 30% and 47% respectively with rural areas having higher proportion of the population in the lowest and second quintiles of 27% and 29% respectively (NDHS, 2009). What government needs to do in this regard is to subsidize the premium for this category of people for them to benefit from the scheme, although identifying the poor is a major contending issue that needs careful planning and execution (Mwabu *et al*, 2002).

Closely related to the above is the shortage of health personnel in bringing the scheme to fruition. The lingering crisis in the health sector prior to the NHIS, characterized by acute shortage of health workers and health facilities at the primary level (Manuwa-Olumide, 2009; Gupta *et al*, 2004; and Ogundeji, 2002), buttressed the dismal state of health care provision in Nigeria prior to the launch of the scheme. The situation however has not changed significantly in the post NHIS period with a 30% distribution of health facilities in rural areas and 70% in urban centres. As discussed above, the dwindling economic fortunes of the country in the mid-1980s due to the plunge in crude oil prices and the resultant introduction of the structural adjustment programme, led to the mass exodus of health workers, including physicians and nurses, outside the country. This development, coupled with the adjustment framework, became the platform on which so-called cost sharing/cost recovery policies were introduced from the late 1980s onwards. These policies, which taken with the deterioration in the public health system, have acted as a disincentive for continued popular access to and patronage of public health institutions (FMoH, 1986). These crises that characterized the health sector were not sufficiently addressed and resolved before the new and ambitious health insurance policy was decreed into existence.

4. Conclusion

Universal health care provisioning in a transitory and heterogeneous society such as Nigeria is daunting due to weak governance, sharp practices in the private health sector and incongruous health policies and programmes. Success in universal coverage will involve strengthening governance and engaging in dynamic public-private partnership as well as mobilizing grassroots participation. Government laissez-faire approach to health policies, characterized by whole-sale adoption of foreign health structure and poor supervision at all tiers of health delivery are determinants for the slow pace of meeting health targets. While the national health scheme has contributed to some improvement in health care in the short-term, it has compromised health equity and accessibility among underserved and disadvantaged groups who constitute the bulk of the Nigerian population. Understanding socio-cultural contexts of health care delivery is important and has significant benefits. Local contexts can explain why health reforms have not matched expected outcomes, or why huge financial commitment and key health programmes have recorded marginal results or unintended outcomes.

It also promises opportunities to modify health policies and programmes to effectively mobilize rural folks, such as recognizing family structures, indigenous beliefs, and social relations, or using existing traditional health practices such as user-fee to reach out to a much wider spread of the population. Ignoring local contexts in designing health policies and treating health systems from a Eurocentric perspective inhibit grassroots participation, which is critical for developing a sustainable health system and progressing towards universal coverage. Failures of government in reaching health targets have consistently demonstrated the weaknesses inherent in the top-bottom approach of health policies, and as 2016 approaches, it is expedient that other critical factors are recognized in the formulation of policies and in designing programmes.

The conclusion to be drawn from the above analysis is simple: as advanced and implemented by the Federal Government of Nigeria, the NHIS, in principle has great potentials in providing health services for its citizens, but in its present form the scheme's contents lack some critical components in achieving its universal goal. Based on the discussion above, emergent opportunities and limitations tend to generate relevant lessons for designing a more holistic and practical health policy and programmes in the context of achieving universal coverage. The implications include strengthening primary, secondary, and tertiary health referral systems through effective governance; promoting and strengthening public-private partnership for health care delivery; and paying more attention to local contexts by policy makers, planners and implementers.

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