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PRIMARY HEALTH CARE APPROACH TO ACHIEVING UNIVERSAL HEALTH COVERAGE IN NIGERIA: ARE EXTANT LEGAL AND POLICY REGIMES ADEQUATE?

Obiajulu Nnamuchi[*] and Maria Ilodigwe[**]

> *Universal health coverage should be based on strong, people-centred primary health care. Good health systems are rooted in the communities they serve. They focus not only on preventing and treating disease and illness, but also on helping to improve well-being and quality of life.*
>
> WHO (12 Dec 2021)

Abstract

The Declaration of Alma-Ata was quite categorical in projecting primary health care (PHC) as the key to attaining health for all or universal health coverage (UHC). PHC is not only the first level of interface between a patient and the health system, it is also the foundation of health systems and a crucial determinant of whether a health system is on a path to attaining UHC or otherwise. More recently, the World Health Assembly went a step further in not only affirming the link between PHC and UHC but also identifying a vital component of actualizing this goal, namely, social health insurance (SHI) system of health financing. In essence, to succeed in attaining UHC, countries must integrate PHC approach and SHI system into their national health architecture. This is critical given that for long, the capacity of PHC to deliver on its key mission, namely, improving efficiency in health care delivery, has been hampered by cost. Yet, cost challenges can be mitigated by adopting a SHI method of paying for health care. Nonetheless, whether extant legal and policy frameworks in Nigeria sufficiently address (if at all) this very crucial component of UHC is not at all clear – hence the significance of this paper.

Keywords: Primary health care, social health insurance, universal health coverage, access to health care, national health insurance scheme.

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1. Introduction and Preliminary Background

At the International Conference on Primary Health Care held in 1978, and which birthed the Declaration of Alma-Ata, the global community proclaimed quite categorically that not only is it the responsibility of governments to protect and promote the health of their people, the task can only be fulfilled by ensuring adequate health and provision of social measures.[1] Participating nations, including Nigeria, affirmed, as the goal of the international community in the coming decades, 'the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.'[2] The key to attaining this target was identified as primary health care (PHC). In other words, nations interested in achieving optimal health for the people in their jurisdictions must be prepared to devote necessary resources and attention to this level of health care. These commitments were subsequently affirmed and elaborated in the Declaration of Astana,[3] which was the outcome document produced at the Conference that marked 40 years since the Alma-Ata Declaration was adopted.[4] As to what a PHC approach to achieving UHC entails, the Declaration of Astana was unequivocal, that the vision is a PHC that is of 'high quality, safe, comprehensive, integrated, accessible, available and affordable for everyone' and 'provided with compassion, respect and dignity by health professionals who are well-trained, skilled, motivated and committed."[5] PHC is defined as "essential health care based on practical, scientifically sound and socially acceptable methods and technology' and which is 'universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.'[6]

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[1] Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978.

[2] Ibid, para V.

[3] Declaration of Astana, Global Conference on Primary Health Care, From Alma-Ata towards Universal Health Coverage and the Sustainable Development Goals, Astana, Kazakhstan, 25 and 26 October 2018.

[4] UNICEF, 'Astana Global Conference on Primary Health Care: A Renewed Commitment to Primary Health Care to Achieve Universal Health Coverage' <https://www.unicef.org/eca/stories/astana-global-conference-primary-health-care> accessed 30 May 2022.

[5] Declaration of Astana (n 3) Prmbl, para. 3.

[6] Declaration of Alma-Ata (n 1) para. VI.

Deducible from this definition are key components of PHC. Apart from being essential and constituting the basic tier of health care, the methods and technologies through which it is delivered must meet practical, scientific and social acceptability, and must be accessible to everyone in the community. Based on the idea that social inclusion is an essential element of the success of health systems, the participation of those whose health and wellbeing will be affected by the design, implementation and monitoring of the PHC must be integrated into the process. Social inclusion plays a significant role in acceptability, the degree of which depends on the extent to which individuals and households are allowed to participate in the process that would result in the introduction and subsequent operation of PHC in the community.

The last component is cost or affordability. It has two elements, namely, cost of introducing and operating PHC, which is borne primarily by the government and cost of accessing services, to be met by individuals and households. For countries desirous of attaining UHC, this last component needs to be taken seriously for although there may be several factors hindering access to health care, by far, the most significant is cost. This is particularly true in countries, most of them in the developing world, that rely on fee-for-service method of paying for health services.

Fee-for-service, also called out-of-pocket (OOP) cost or user fees, system of paying for health care means paying at the point of service, akin to purchasing ordinary commodities at a shop or market. A remarkable feature of cash payment for health care is absence of financial risk protection and a largely unresponsive health system. In such systems, all things being equal, health status is dependent on ability to pay, such that the affluent invariably enjoys better health outcomes than the poor. This explains why such systems are bemoaned as unfair and inequitable. It is a common phenomenon in emerging health systems, where although, in some cases, services at public health establishments are subsidized, OOP expenses coupled with unofficial charges render health care expensive for the common man.

Given the high number of Nigerians living in extreme poverty (on less than $1.90/day), 40 per cent of the population,[7] it is obvious that

[7] T Adeniji and Nwagba, 'Aid for Productivity: Innovating to Overcome Poverty in Africa through Enterprise' 10 <aid-for-productivity-digital-file-v7 (2).pdf> accessed 30 May 2022.

access to health care is a huge challenge in the country. True, there is a vibrant private health sector, with state-of-the-art technology and well-trained providers, but their services are unaffordable to the vast majority of the people. As a result, health care access remained a lingering problem for successive administrations in the country, at least since late 1970s. The situation took a dramatic turn in early 1980s, following the liberalization of the health sector as part of broader structural reforms to counteract worsening economic conditions in the country. The reforms led to the replacement of free and subsidized health care services with user fees as the bedrock of health care financing in the country, and with this development came a surge in the number of private health care establishments throughout the country. The consequence of this abrupt change was a precipitous decline in key heath indicators in the country, as only those with financial resources were able to keep up with rising cost of health services.

It was against this background (rising morbidities and mortalities in the country) that a decision was reached in 1984 by the National Council on Health, the highest policy-making body on health in Nigeria,[8] to seek a better way of financing the health system.[9] Following several meetings and consultations, it was decided that a social health insurance (SHI) system of funding the health system should be adopted. The result was the promulgation of the National Health Insurance Scheme (NHIS) Decree (now Act) 35 of 1999, which, for the first time, established a SHI system of financing health care in the country.[10] The NHIS, like all SHI systems, envisages a shared responsibility of paying for health care between the people and the government, the aim being to ensure that lack of funds does not pose a barrier to access to health care. Two legal regimes govern SHI in Nigeria, namely, the NHIS Act 1999 and NHIS Operational Guidelines, which were first issued in 2005 and revised in 2012. Nevertheless, whether these regimes, together with those on PHC, are sufficient to eventuate in UHC in Nigeria is not at all clear – hence the significance of this paper.

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[8] National Health Act, 2014 (Act No. 8 of 2014), s. 5 (NHA).

[9] For a robust discussion on the processes that resulted in the transition from user fees to a social health insurance system of paying for health care, see O Nnamuchi, 'The Nigerian Social Health Insurance System and the Challenges of Access to Health Care: An Antidote or a White Elephant?' (2009) 28 (1) Medicine and Law 126 – 129.

[10] National Health Insurance Scheme (NHIS) Act, Cap N42, Laws of the Federation of Nigeria (LFN) 2004.

Strikingly, the declining health indicators that compelled policymakers to seek new ways of sourcing funds for the health system are yet to be reversed. By all standards of measurement, the current state of health in Nigeria is appalling. Healthy life expectancy at birth in the country stands at 54.4 years, better than only 14 countries in Africa and lower than the regional mean of 56 years.[11] Even worse is maternal mortality rate (MMR). At 917 deaths per 100,000 live births, the MMR in Nigeria is better than just three countries in Africa.[12] The regional mean is 525.[13] The under-five mortality rate is equally atrocious, at 117 deaths per 1000 live births, the worst globally – a position it shares with Somalia, a war-torn failed state.[14] Nigeria shoulders the highest burden of malaria in the world. Latest data indicates that in 2020, 29 of the 85 countries that were malaria endemic accounted for about 96 per cent of malaria cases and deaths, with Nigeria having the highest number – at 26.8 per cent.[15] Four countries are responsible for more than half of all malaria deaths globally, the highest number (31.9 per cent) in Nigeria.[16] Malaria and the vast majority of the diseases and illnesses responsible for poor health outcomes in the country are amongst the common diseases treatable at the PHC level, making studies such as this, which is aimed at recalibrating the health system through the instrumentality of PHC and SHI, more urgent now than ever before.

Following this introductory background, Part II evaluates PHC system in Nigeria in the context of the relevant legal and policy regimes governing health care delivery at that level in the country. The purpose of the evaluation is to determine whether, as presently configured, sufficient focus has been placed on that tier of health care delivery as a vehicle to UHC. Along similar trajectory, the task of Part III is to determine whether the relevant frameworks on SHI in Nigeria are robust enough to advance the country toward UHC. The conclusion – Part IV – is that extant frameworks are adequate as building blocks of a UHC-bound health system, but the goal will not be realized in absence of

[11] WHO, *World Health Statistics 2021: Monitoring Health for the SDGs, Sustainable Development Goals* (Geneva: WHO, 2021) 20 82 – 88.
[12] Ibid.
[13] Ibid. 88.
[14] Ibid, 83 – 89.
[15] WHO, *World Malaria Report 2021* (Geneva: WHO, 2021) 25.
[16] Ibid.

incorporating the suggestions of the paper into the health architecture of the country.

2. Primary Health Care in Nigeria and Relevant Legal and Policy Frameworks

The principal concern of this section is whether extant legal and policy frameworks on PHC in Nigeria are sufficient to advance the country toward UHC. This question is critical, given that no nation has been able to achieve health for all without having in place a high performing PHC system.

2.1 Critical Preliminary Points

Prior to unpacking the central concern of this section, two preliminary points would need to be made. The first is that the declared intention of policymakers in Nigeria is to build the national health system on PHC. The National Health Policy, first published in 1988 and revised in 2004 and 2016 (the last being the current version), was very clear in declaring its overall objective to be to 'strengthen Nigeria's health system, particularly the [PHC] sub-system, to deliver effective, efficient, equitable, accessible, affordable, acceptable and comprehensive health care services to all Nigerians.'[17] To accentuate the importance of this particularization, the policy document proclaims PHC to be 'the bedrock'[18] and 'central focus'[19] of the national health system– in other words, the foundation of health care delivery in the country.

The second noteworthy point is that PHC is the first point of interaction of individuals and households with the health system; the first contact in a continuing health care process.[20] The lowest, albeit not the least of the three tiers of health care delivery system, the PHC is the point at which common presentations of diseases and illnesses are treated and referrals made, in appropriate cases, to secondary health care (SHC) or tertiary health care (THC) level, depending on the nature of the presentation. This is the reason PHC is referred to as the 'gate keeper' of the health system, in that by implementing appropriate referral system, PHC providers are able to ensure that less difficult cases are managed at this level, and only serious conditions are treated at the more specialized

[17] FMoH, 'National Health Policy 2016: Promoting the Health of Nigerians to Accelerate Socio-economic Development' XV (2016).
[18] Ibid, 27.
[19] Ibid, 45.
[20] Declaration of Alma-Ata (n 1) par. VI.

tiers of health care delivery. Restricting deserving cases to PHC centres, where cost of treatment is not exorbitant, means that higher charges that could have been accumulated had the same conditions been treated at SHC and THC levels, are saved.

Institutionalizing an appropriate referral regime promotes efficiency by ensuring that each tier of health care delivery system restricts itself to what it does best. In this way, health conditions are handled by the appropriate providers, thereby mediating the inefficiency and inequality that result from disproportionate reliance upon hospital and specialized care (termed 'hospital-centrism' by WHO) by many countries, including – quite paradoxically – developing ones.[21] The challenge presented by hospital-centrism is poor return on investment. In other words, the cost-benefit ratio is grossly negative.[22] More specifically, WHO faults hospital-centrist approach on the basis of unnecessary medicalization and pathogenesis as well as absence of preventive care and its adverse impact on human beings and social dimensions of health.[23] This is a challenge that should be taken seriously by policymakers, considering that the result of inaction would be depletion of resources that could have been channelled to PHC, which provides a more equitable as well as efficient and effective avenue for providing health services and improving the overall health of the population[24] – all of which are important components of UHC.

The Alma-Ata Declaration proclaims that PHC addresses the main health problems in the community, including promotive, preventive, curative and rehabilitative services,[25] the implication being that the amount of funds that would be saved by committing to the gate-keeping function of this level of health care delivery will be quite substantial. This is especially important to Nigeria given the nature of its disease burden. As affirmed by a former Minister of Health and chairman of the National Primary Health Care Development Agency (NPHCDA) in 1998, "80 to

[21] WHO, *The World Health Report 2008: Primary Health Care Now More Than Ever* (Geneva: WHO, 2008) 11.
[22] Ibid.
[23] Ibid.
[24] Ibid.
[25] Declaration of Alma-Ata (n1) par. VII (ii).

90 per cent of the health problems of our people can be tackled at the primary health care level."[26]

2.2 Principle or Pillars of Primary Health Care

Resource preservation is not the only advantage of PHC that is useful to attaining UHC. There are others that are not readily thought of as having cost implications but which, in the long run, ultimately result in savings to the health system. Numbering four, these are the pillars of PHC, what are required in terms of establishing a comprehensive health system based on PHC. As evident in the Declaration of Alma-Ata, these pillars are equity, social or underlying determinants of health, multisectoral or intersectoral collaboration and community participation.[27] Strikingly, these pillars are also elaborated in the National Health Policy.[28] These pillars or principles, which underlie both the Declaration and National Health Policy, are critical to building and sustaining a health system. Their integration into the two most important health policy documents on PHC in the country signals a great desire on the part of authorities to reap the dividends of building the health system on the basic level of health care delivery.

(i) Equity

The World Bank defines equity, the first of the four pillars, in terms of equality of opportunity and avoidance of deprivation in (health) outcomes.[29] The function of equity in a health system is to ameliorate prior and existing imbalances not only in access to health care and social health determinants but also in health outcomes. Although the task of equity is traditionally understood as being to protect poorer households from being 'disproportionately burdened with health expenses as compared to richer households,'[30] its tentacles are not so constricted. Imbedded within the walls of equity are goods and services that are necessary for maintaining the health and wellbeing of the poor and disadvantaged. Prioritization of their interests, so as to nullify extant inequality, placing them on the same pedestal as the rest of society, is a central mission of

[26] O Ransome-Kuti, 'Who Cares for the Health of Africans?: The Nigerian Case,' 6, International Lecture Series on Population Issues, The John D. and Catherine T. MacArthur Foundation, Kaduna, Nigeria, 19 March 1998.

[27] Declaration of Alma-Ata (n 1) para(s) II (equity), VII-3 (underlying health determinants) and VII-4 (multisectoral collaboration), VII-5 (community participation).

[28] National Health Policy 2016 (n 17) xiii – 66.

[29] World Bank, *World Development Report 2006: Equity and Development* (New York: The World Bank &Oxford University Press, 2005) XI, 76 – 80.

[30] United Nations Committee on Economic, Social and Cultural Rights, 'General Comment No. 14, The Right to the Highest Attainable Standard of Health (Twenty-second session, 2000)' para. 12(b), U.N. Doc. E/C.12/2000/4 (2000), reprinted in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.6 at 85 (2003).

equity and PHC. The National Health Policy seeks to address this by establishing "solid and evidence-based mechanisms and directions" that would "significantly improve the health status of all [Nigerians] to enable them lead fully healthy and fulfilling lives."[31] Improving the health status of everyone in the country would require mitigation or nullification of factors that make access to care a luxury for some but not others, placing everyone on the same path to the best attainable state of physical and mental health. It requires particularization of the concern of the less privileged throughout the chain of processes involved in health care delivery.

(ii) Underlying Health Determinants

The second principle, namely, underlying or social determinants of health[32] are the conditions in which human beings live and work. The WHO Commission on Social Determinants of Health adopts a cosmopolitan position,[33] defining the term as 'the structural determinants and conditions of daily life' including 'their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities' as well as 'their chances of leading a flourishing life.'[34] The significance of this principle is its emphasis on factors other than therapeutics that have impact upon human health. These factors, notes the U.N. Committee on Economic, Social and Cultural Rights (Committee on ESCR) in 2000,[35] include access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health, in addition to facilitating the participation of the population in all health-related decision-making at the community, national, and international levels.[36] As a recent WHO publication clarifies, '[w]hile medical care can prolong survival and improve prognosis after some serious diseases, more important for the health of the population as a whole are the social and economic

[31] National Health Policy 2016 (n 17) 78.
[32] Declaration of Alma-Ata (n 1) para. VII (3).
[33] WHO Commission on Social Determinants of Health, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health* (Geneva: WHO, 2008) 1.
[34] Ibid, 1.
[35] General Comment No. 14 (n 30) para. 11.
[36] Ibid.

conditions that make people ill and in need of medical care.'[37] In other words, whilst not discounting the importance of access to drugs, it is important to note that access alone is inadequate to maintain a healthy life. More is needed, and that is availability of socioeconomic conditions that are conducive to a healthy life. In fact, when critically scrutinized, access to medical care would be found to be an integral component of social determinants of health, as one of several elements that ensures good health.[38] The National Health Policy affirms the importance of social health determinants by reiterating the commitment in the Rio Political Declaration on Social Determinants of Health, namely, that governments will take appropriate action on the social determinants of health in order to create vibrant, inclusive, equitable, economically productive and healthy societies.[39] Nigeria not only participated in the WHO-sponsored World Conference on Social Determinants of Health, which took place in Rio de Janeiro, Brazil, and gave birth to the Declaration, it also endorsed the document.[40]

(iii) Intersectoral Collaboration

The third principle is intersectoral or multisectoral collaboration. It speaks to the involvement of and cooperation of multiple actors and sectors of the economy in addressing different components or factors that are required to sustain PHC. The Declaration of Alma-Ata was quite clear, emphasizing that in addition to the health sector, PHC involves all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors – all of whose efforts must be coordinated and directed toward the same goal.[41] This is a derivative of the concept of social health determinants and recognizes that the attainment of any human right or subset thereof such as PHC is not feasible through the sole effort of one sector alone; instead, a

[37] R Wilkinson and M Marmot, 'Introduction' in R Wilkinson & M Marmot (eds.), *Social Determinants of Health: The Solid Facts 7* (2nd ed, Copenhagen: WHO Regional Office for Europe, 2003).
[38] Ibid.
[39] National Health Policy 2016 (n 17) 2.
[40] WHO, 'World Conference on Social Determinants of Health, List of Delegates and Other Participants' 7 December 2011 <https://cdn.who.int/media/docs/default-source/documents/social-determinants-of-health/world-conference-on-sdh-lop.pdf?sfvrsn=588aa100_5> accessed 30 May 2022.
[41] Declaration of Alma-Ata (n 1) par. VII (4).

multisectoral collaborative approach is required. This collaborative approach is accorded recognition by the National Health Policy. A stated policy orientation of the Nigeria's health system is the establishment of multisectoral collaboration mechanisms to promote synergy and leverage capacity to address the social determinants of health.[42] Based on the premise that "many of the determinants of health outcomes are outside the health sector," the policy document urges greater effort in strengthening this collaboration.[43] Multisectoralism is not limited to just inter-ministry collaborative arrangements. Emphasized throughout the National Health Policy is engagement of civil society organizations and other stakeholders – to create a broad public/private partnership, which is crucial to unleashing the full benefit of multisectoral collaborative mechanism as a tool for achieving UHC.[44]

(iv) Participation

Participation, the fourth principle, involves social inclusion and ownership of PHC processes and ultimate outcomes. The type of participation envisaged by the Declaration of Alma-Ata centres on the planning, organization and implementation of PHC, both individually and collectively.[45] Although the National Health Policy seems to have clearly placed emphasis on "community ownership/participation" (and not also upon individuals), even declaring it as one as its ten policy thrusts,[46] the emphasis deserves no importance since the term 'community' is a conglomeration of individuals. Recognizing that the requisite knowledge and expertise for meaningful participation in the planning, organization, operation and control of PHC may not be readily available in the general population, the Declaration requires capacity building through such education as is necessary for productive participation of the communities.[47] Similar approach is envisioned in the National Health Policy as evident in the stipulation, as one of the goals of the health system, to strengthen and sustain active community participation and ownership in health planning, implementation, monitoring and evaluation.[48] None of these is possible in absence of adequate knowledge base on the operation of PHC.[49]

[42] National Health Policy 2016 (n 17) 43.
[43] Ibid, 25.
[44] See particularly, National Health Policy 2016 (n 17) 25, 56.
[45] Declaration of Alma-Ata (n 1) par. VII (5).
[46] National Health Policy 2016 (n 17) XV.
[47] Declaration of Alma-Ata (n 1) par. VII (5).
[48] National Health Policy 2016 (n 17) 56.
[49] FMoH, National Health Policy 2004, Chapter 4, 4:3 (stipulating that the health system shall 'develop, through appropriate education and information, the ability of communities to participate').

Effective participation is ensured by decentralization of the management of the local health system through the committee system of the National Health (NHA) 2014, the first comprehensive legal framework on health in Nigeria,[50] and National Health Policy such as ward development committees, village development committees, health facility management committees and so forth.[51] The mandate of these committees include, inter alia, monitoring of health services, community mobilization, and participation in programme implementation.[52] The community participation mandate builds on two of Bamako Initiative's major objectives, namely, to use PHC to improve health outcomes by requiring public participation in decision-making and decentralized implementation of programmes at the level of the local government health system.[53]The aim of the Initiative, which was a formal statement adopted by African Ministers of Health in 1987 at a conference of the health ministers of African countries jointly sponsored by UNICEF and WHO in Bamako, Mali, was to expand access to good quality PHC through more efficient use of resources. [54]

The idea of community participation as a principle of PHC approach to attaining UHC has crucial advantages. Aside from empowerment and democratization of the process, integrating the opinion of the people in decision-making ensures that not only are their needs met, but the needs are also operationalized in the desired manner, in a way that best advances their interests. Since members of the community are the primarily affected parties (end users), they have the greatest stake in the success of the process, including maximization of resources, and are, therefore, best suited to discuss the right mix of initiatives and strategies needed to achieve the best result.

2.3 Principles of Primary Health Care and Non-Implementation

Neglecting to implement or poorly implementing any of the four principles of PHC would attract a negative result, for instance, unwillingness to buy into the processes or the programme itself, thereby frustrating the actualization of UHC. And this raises a very interesting

[50] National Health Act (n 8) s. 1(2).
[51] National Health Policy 2016 (n 17) 46, 56.
[52] Ibid, 24.
[53] K Pangu, 'The Bamako Initiative' <https://apps.who.int/iris/bitstream/handle/10665/330655/WH-199> accessed 30 May 2022.
[54] Ibid.

concern. Bearing in mind that, at least in theory, serious commitment to the principles discussed in this section would result in institutionalizing a high performing PHC system in the country, the question becomes, would this institutionalization be sufficient in itself to result in UHC? Negative, the response must be. The explanation is simple. PHC is just one amongst three tiers at which health care is accessed in a health system. Despite the value of an effective delivery of services at the PHC level, as this section articulates, care must also be provided at the other levels, failing which the health system cannot be said to be high performing. Nevertheless, since the largest burden of diseases and illnesses (in the case of Nigeria, 80 – 90 per cent)[55] is tackled by way of PHC interventions, a more defensible statement is that an optimally functioning PHC, more than the other two tiers, places the country's health system on a more robust and sustainable trajectory toward UHC.

3. Social health Insurance System in Nigeria and Relevant Legal and Policy Frameworks

As previously indicated, the emergence of SHI in Nigeria is rooted in access difficulties of the late 1970s and early1980s.[56] Although multiple factors compelled the exodus from subsidized and free health care to user fees, the latter giving birth to SHI in the country, the most challenging are squandermania, kleptocracy and poverty – all of them serious contributors to the spike in cost of health care services. The surge in preventable morbidities and mortalities are some of the more visible manifestations of the impact of these social ills. Widespread poverty, which remains an intractable challenge even today,[57] resulted in denial of health care to a large proportion of the population, on account of inability to pay for required services. Consequently, the National Council on Health concluded, and rightly so, that unless reversed, this downward spiral would continue, worsening an already atrocious health landscape. This was the background to the emergence of SHI in the country, a product of wide consultation with stakeholders of different stripes and submissions by a vast array of relevant professional bodies. It was this broad-based support that led, as explained previously, to the establishment a SHI system in Nigeria via NHIS Act, 1999. Despite the urgency of the situation, however, implementation of the statute was delayed, owing to logistical

[55] Olikoye Ransome-Kuti, 'Who Cares for the Health of Africans?: The Nigerian Case,' International Lecture Series on Population Issues, The John D. and Catherine T. MacArthur Foundation, March 19, 1998, Kaduna, Nigeria, at 6.
[56] Nnamuchi (n 9) 128 (tracing the origin to the Health Insurance Bill which was introduced in the then National Parliament in Lagos in 1962).
[57] Adeniji and Nwagba (n 7).

difficulties, until 2005 when the first NHIS Operational Guidelines were published. A subsequent Guidelines issued in 2012 is currently in force.

(a) Social Health Insurance and the National Health Insurance Scheme

The NHIS is a SHI system, which is designed as a public-private partnership – that is, shared financial arrangement between the government and the people – and aimed at providing accessible, affordable and quality health care for all Nigerians. The NHIS Operational Guidelines 2012 defines a SHI as "system of health insurance that is financed by compulsory contributions which is mandated by law or by taxes and the system's provisions are specified by legal statute."[58] A distinguishing characteristic of SHI systems is that payment for coverage is not related to health risk (age or health history/status, for instance) but by ability to pay, and it is non-profit based. SHI is a form of health care financing that is based on risk pooling.[59] It pools not only the health risks of the population, it also pools resources; that is, the contributions of individuals, households, and other entities including businesses and the government.[60] It is from these contributions that funds are used to pay for members of the pool when illness strikes. SHI offers protection against financial and health burden that arises upon exposure to diseases and illnesses, and it is a relatively fair method of paying for health care.[61] Specific objectives of the NHIS Act are set out in section 5 and include:

(a) ensure that every Nigerian has access to good health care services;

(b) protect families from the financial hardship of huge medical bills;

(c) limit the rise in the cost of health care services;

(d) ensure equitable distribution of health care costs among different income groups;

(e) maintain high standard of health care delivery services within the Scheme;

(f) ensure efficiency in health care services;

(g) improve and harness private sector participation in the provision of health care services;

(h) ensure adequate distribution of health facilities within the Federation;

[58] FMoH, National Health Insurance Scheme, Operational Guidelines, revised in 2012, 15 (2012).
[59] WHO, 'Social Health Insurance: Report of a Regional Expert Group Meeting New Delhi, India, SEA-HSD-265' 13 – 15 March 2003, 1 (2003).
[60] Ibid.
[61] Ibid.

(i) ensure equitable patronage of all levels of health care; and,

(j) ensure the availability of funds to the health sector for improved services.

To appreciate the significance of these stipulations, they should be situated within the broader goal of expurgating barriers to access to health care in the country. First, they are to be understood in the context of the National Health Policy provisions on health financing, the goal of which is to '[e]nsure adequate and sustainable funding that will be efficiently and equitably used' in providing 'quality health services and ensuring financial risk protection in access to health services for all Nigerians, particularly the poor and most vulnerable'[62] Second, the stated vision of the National Health Policy is UHC for all Nigerians.[63] Its mission is to harness resources necessary for achievement of UHC as stipulated in the NHA[64] and Sustainable Development Goals (SDGs).[65] Reference to the SDGs is very important, for not only is one of them (SDG 3) exclusively devoted to health and health care, the rest of the SDGS, as shown in a recent paper,[66] are inseparable from health.

The third point to note is the impact or significance of the NHA to health governance in Nigeria. The statute charts the path for the national health system to follow in achieving UHC, namely, (a) it shall provide for persons living in Nigeria the best possible health services within the limits of available resources; and (b) protect, promote and fulfil the rights of the people of Nigeria to have access to health care services.[67] To have a right to health care means that regardless of socioeconomic status, everyone is entitled to access health services when needed.[68] The vernacular of "rights" is critical to the goal of health for all, in that it infuses force and urgency to the attainment of a basic human yearning, namely, access to health care. Right to health is the legal equivalent of UHC, the difference being that one is a legal term whilst the other is

[62] National Health Policy 2016 (n 17) 46.
[63] Ibid, 26.
[64] National Health Act (n 8) s. 1(1)(c) & (e).
[65] National Health Policy 2016 (n. 17) 26.
[66] O Nnamuchi, 'The Sustainable Development Goals (SDGs) and the Right to Health: Is there a Nexus?' (2020) 32 (2) Florida Journal of International Law 147 – 181.
[67] National Health Act (n 8) s. 1(1)(c) & (e).
[68] O Nnamuchi, 'Securing the Right to Health in Nigeria under the Framework of the National Health Act' (2018) 37 (3) Medicine and Law 477 – 532.

domiciled in health economics and health policy. Regardless of disciplinary cleavages, however, the goal is the same, as the objectives specified in section 5 of the NHIS Act amply demonstrate.

Responsibility for setting in motion the necessary strategies or measures to actualize these objectives is vested in the Scheme (the central implementing authority of the NHIS Act), including:

(a) registering health maintenance organisations and health care providers under. the Scheme;
(b) issuing appropriate guidelines to maintain the viability of the Scheme;
(c) approving format of contracts proposed by the health maintenance organisations for all health care providers;
(d) determining, after negotiation, capitation and other payments due to health care providers, by the health maintenance organisations;
(e) advising the relevant bodies on inter-relationship of the Scheme with other social security services;
(f) the research and statistics of matters relating to the Scheme;
(g) advising on the continuous improvement of quality of services provided under the Scheme through guidelines issued by the Standard Committee established under section 45 of this Act;
(h) determining the remuneration and allowances of all staff of the Scheme;
(i) exchanging information and data with the National Health Management Information System, Nigerian Social Insurance Trust Fund, the Federal Office of Statistics, the Central Bank of Nigeria, banks and other financial institutions, the Federal Inland Revenue Service, the State Internal Revenue Services and other relevant bodies; and,
(j) doing such other things as are necessary or expedient for the purpose of achieving the objectives of the Scheme under this [statute].

Viewed in light of the foregoing discussion on the obstacles regarding access to health care and the ameliorating qualities of SHI system of health financing, it becomes less difficult to understand the far-reaching powers vested in the authority charged with implementing SHI in the country and the underlying rationales. These powers or responsibilities are critical to realizing the objectives of the Scheme. While each of the duties are important, two clearly stand out as being directly related to setting in motion the process that would result in extending coverage to participants, namely, sections 6(b) and 6(j). The two provisions empower the implementing authority to issue guidelines that are needed to maintain the viability of the Scheme and to do all such other things as are necessary or expedient for the purpose of actualizing the objectives of the Scheme. It was on the basis of this authority that the Scheme issued "Operational Guidelines" (Guidelines) for implementation

of the programmes in 2005. However, owing to some deficiencies, some of which were explored in a 2009 paper,[69] the Guidelines were revised in 2012.[70] The revised framework contains elaborate provisions on the implementation of the Scheme, including the principal actors, programmes and the levels as well as types of participation, required contributions, applicable benefit packages, management of the programmes, health maintenance organizations (HMOs) and so forth.

(b) Coverage Programmes of the National Health Insurance Scheme

There are three avenues through which people can obtain coverage under the Scheme, namely, Formal Sector Social Health Insurance Programme, Informal Sector Social Health Insurance Programme and Vulnerable Group Social Health Insurance Programme. The Formal Sector Social Health Insurance Programme provides coverage to employees in the public sector (Federal, State and Local Governments), members of the Armed Forces, Police and other Uniformed Services as well as students of tertiary institutions. Also included are employees of organized private sector organizations, those employing ten or more persons.[71] The Informal Sector Social Health Insurance Programme, as its name implies, is designed for individuals and businesses operating in the informal sector of the economy. Those covered under this programme include individuals working in companies with 10 or less employees, artisans, voluntary participants, rural dwellers and others not receiving coverage under the Formal Sector or the Vulnerable Group Programmes.[72] There are two sub-programmes through which coverage can be obtained in the informal sector, namely, Voluntary Contributors Social Health Insurance Programme (VCSHIP) and Community Based Social Health Insurance Programme (CBSHIP).

The VCSHIP is a health insurance that is available to willing individuals and employers with less than ten employees.[73] Participation in VCSHIP is restricted to individuals who are not currently covered by any of the NHIS programmes and those who may have been unsatisfied with their health care services.[74] Included within this category are

[69] Nnamuchi (n 9) 151 – 163.
[70] Operational Guidelines (n 58)
[71] Ibid, s 1.1.0.
[72] Ibid, s 1.2.0.
[73] Ibid, s 1.1.6.1.
[74] Ibid, s 1.1.6.1.

interested individuals, families, employers of establishments with less than ten staff, and actively self-employed individuals as well as political office holders at the three tiers of governments and retirees not currently covered by any of the NHIS prepaid programmes.[75] Also eligible to obtain coverage under the VCSHIP are foreigners or persons with temporary residency status and Nigerians in Diaspora.[76] CBSHIP, on the other hand, is a health insurance plan for a cohesive group of households /individuals or occupation-based groups, formed on the basis of the ethics of mutual aid and the collective pooling of health risks, in which members take part in its management.[77] Participation is voluntary and open to all residents of the participating communities/occupation-based groups, including retirees.[78] To qualify for registration as a CBSHIP, at least 50 per cent (or a minimum of 1000 members) of a community or occupation-based group must be willing to participate.[79]

The third category, Vulnerable Group Social Health Insurance Programme, is an insurance plan that provides health care coverage to individuals who cannot engage in any meaningful economic activity due to their physical status, including age,[80] and mental status.[81] Eligibility for enrolment under this programme is restricted to physically challenged individuals, prison inmates and children less than five years old. Other eligible participants include refugees, victims of human trafficking, internally displaced persons and immigrants as well as pregnant women, orphans[82] and mentally challenged persons.[83]

(c) National Health Insurance Scheme and Key Challenges

The idea behind the foregoing discussion on SHI and NHIS is to show the existence of a structure in place that powerfully complements other efforts of the government in its desire to extend UHC to the population. Yet, it must be noted that although the law establishing NHIS was enacted more than two decades ago and implementation began in 2005, several challenges are obstructing the realization of the vision behind the

[75] Ibid, s 1.1.6.3.
[76] Ibid, s 1.1.6.3.
[77] Ibid, s 1.2.1.1.
[78] Ibid, s 1.2.1.2.
[79] Ibid, s 1.2.1.2.
[80] Ibid, s 1.3.1.
[81] Ibid, s 1.3.2.1.
[82] Ibid, s 1.3.1
[83] Ibid, s 1.3.2.1.

statutory regime.[84] Amongst these obstacles are widespread poverty, which makes enrolment difficult; poor mobilization campaign prior to unveiling of the scheme, as a result of which the vast majority of people are unaware of the existence of the scheme and benefits of participation; inequitable benefit packages; restriction of coverage to four biological children for participants in the formal sector; absence of coverage for cost of transportation to points of service; corruption; and, non-mandatory participation.[85] Whilst each of these challenges has a role to play in derailing the march to UHC in the country, the most critical is the last one – that is, having no law that makes participation in the various programmes of the scheme compulsory, a point to be revisited in the conclusion.

4. Conclusion: A Half-Hearted Approach to Universal Health Coverage or What?

This statement by WHO, describing UHC as 'access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost,'[86] is quite remarkable for many reasons. Implicit in the postulation are two very important components of UHC, namely, unfettered access to health services (equity in access to health care), and availability of access without subjecting users to financial hardship (financial risk protection).[87] The interplay between these two distinct elements in the context of the legal and policy frameworks governing PHC and SHI in Nigeria has been the primary concern of this paper. Focusing on PHC recognizes that whilst the higher tiers of care cannot be discounted in building the health architecture of any nation, it is the PHC that sets the overall tone and trajectory of the health system. As it goes, so does the entire structure, explaining why WHO has consistently urged maximum deployment of resources to that level of health care delivery.[88]

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[84] O Nnamuchi, et al., 'Successes and Failures of Social Health Insurance Schemes in Africa – Nigeria versus Ghana and Rwanda: A Comparative Analysis' (2019) 28(1) Annals of Health Law and Life Sciences 135 – 145.

[85] Nnamuchi (n 9) 151 – 163.

[86] WHO, 'Social Health Insurance Sustainable Health Financing, Universal Coverage and Social Health Insurance' Fifty-Eight World Health Assembly, A58/20, Provisional agenda item 13.16, 7 April 2005, Report by the Secretariat, para. 2 <http://apps.who.int/iris/bitstream/10665/20302/1/A58_20-en.pdf?ua=1> accessed 30 May 2022.

[87] WHO**,** *The World Health Report 2010: Health System Financing: The Path to Universal Coverage* **(**Geneva: WHO, 2010) X.

[88] World Health Report 2008 (n 21).

It is specifically for this reason that the position of PHC in any strategy aimed at achieving UHC must command supreme attention. The second component, paying for health services without exposing individuals or households to financial ruin, represents the other half of what is needed to put a nation solidly on a UHC map. So, how is Nigeria faring on these two fronts?

A carefully considered analysis of the legal and policy frameworks on PHC in Nigeria reveals a striking consistency with global standard and best practice, as contained in the WHO-sponsored Declarations of Alma-Ata[89] and Astana.[90] In the same vein, the enactment of the NHIS Act and Operational Guidelines was guided by one consideration, which was to provide coverage to everyone and protect them against health and financial risks. The various programmes of the NHIS, despite noted shortcomings, are directed at achieving UHC prerequisites. The NHA seeks to plug some of these shortcomings, particularly financial deficits, by doling out funds to PHC and other areas of need in the health system, including the NHIS.[91] Moreover, the NHA recognizes the importance of exempting the vulnerable from having to shoulder the cost of health care at public health establishment,[92] thus complementing the NHIS Act, which grants contribution-free participation to this demographic under the Vulnerable Group Social Health Insurance Scheme.[93]

Whilst these stipulations are certainly laudable, the reality on the ground suggests that additional measures are necessary. At just 5 per cent coverage rate,[94] it is obvious that the NHIS in Nigeria is grossly underperforming, especially when compared with similarly placed countries. Two African countries, namely, Ghana and Rwanda, introduced SHI at relatively the same time as Nigeria; yet, coverage rates

[89] Declaration of Alma-Ata (n1).
[90] Declaration of Astana (n3).
[91] National Health Act (n 8) s 11.
[92] Ibid. s. 3.
[93] Operational Guidelines (n 58) s.1.3.
[94] GO Alawode and DA Adewole, 'Assessment of the Design and Implementation Challenges of the National Health Insurance Scheme in Nigeria: A Qualitative Study among Sub-National Level Actors, Healthcare and Insurance Providers' (2021) 21(124) *BMC Public Health* <https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-020-10133-5> accessed 30 May 2022.

are significant higher in both countries, at 40[95] and 92[96] respectively. This suggests that the SHI in Nigeria needs retooling, specifically by responding to the challenges responsible for the country's underperformance versus other countries. Non-compulsory participation in the NHIS clearly stands out amongst the factors identified in the previous section, and for a very good reason too. There is no country that has been able to use SHI to significantly boost access to health care, even if yet to attain UHC, in which participation is not mandated. As affirmed by WHO, 'in the long run, participation will need to be compulsory if 100 [per cent] of the population is to be covered.'[97] Remarkably, the National Health Insurance Authority bill, which was signed into law on May 19, 2022, repealing the NHIS Act, makes health insurance mandatory throughout the country.[98] Although details are not yet available, it is hoped that this turning point could be the catalyst needed to reposition the country on a path to expanded access and UHC.

Furthermore, in addition to mandatory contribution to the NHIS, policymakers should also be cognizant of the fact that countries that have attained UHC are those with high public expenditure on health and low OOP spending. This can be evaluated in the context of the commitment by African governments in 2001 to allocate at least 15 per cent of their annual budget to health.[99] Available record indicates that in Nigeria, the domestic general government health expenditure (GGHE-D) as a percentage of general government expenditure (GGE) is 4.4 per cent,[100]

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[95] MA Ayanore and others., 'Health Insurance Coverage, Type of Payment for Health Insurance, and Reasons for not being Insured under the National Health Insurance Scheme in Ghana' (2019) 9 (39) *Health Economics Review* <https://healtheconomicsreview.biomedcentral.com/articles/10.1186/s13561-019-0255-5> (accessed 30 May 2022). The figure could be higher given that the latest survey was in 2014.

[96] Pacific Prime, 'Rwanda Health Insurance' <https://www.pacificprime.com/country/africa/rwanda-health-insurance/#:~:text=Rwanda%20healthcare%20system,most%20successful%20in%20the%20world> (accessed 30 May 2022)

[97] World Health Report 2010 (n 86) 89.

[98] N Adebowale, 'UPDATED: Buhari Signs Health Insurance Bill into Law' (Premium Times, 19 May 2022) <https://www.premiumtimesng.com/news/headlines/531087-updated-buhari-signs-health-insurance-bill-into-law.html> accessed 30 May 2022.

[99] Abuja Declaration on HIV/AIDS, Tuberculosis and other related Infectious Diseases, OAU/SPS/ABUJA/3, para. 26 <http://www.un.org/ga/aids/pdf/abuja_declaration.pdf> accessed 30 May 2022.

[100] WHO (n 11) 103.

which is considerably lower than many countries in Africa such as Kenya (8.5 per cent), Namibia (10.7 per cent), Madagascar (10.5 per cent), Malawi (9.8 per cent) and South Africa (13.2 per cent)[101] as well as the African mean budgetary allocation, which is 6.8 per cent.[102] Regarding OOP, Nigeria fares poorly as well. Measured in terms of population with household expenditures on health greater than 25 per cent of total household expenditure or income, 4.1 per cent of the population is affected, the third highest in Africa, after Benin and Sierra Leone,[103] and worse than the regional mean,1.8 per cent.[104] The reverse is the case in high performing health systems. A commonality amongst countries that have attained UHC is high government expenditure on health and low OOP spending by the citizenry. In Canada, government spending on health is 19.5 per cent of total spending,[105] whereas Germany and the United States recorded 20 and 22.5 per cent respectively.[106] OOP spending was also very low in these three countries. In none of them was the proportion of individuals with health expenditures that is greater than 25 per cent of total household expenditure or income) up to one per cent.[107] This is a remarkable achievement, one that compellingly commends itself to policymakers in Nigeria.

In the final analysis, an appropriate he summation must be that whilst on the right track, investment in the nation's PHC system and NHIS as well as an enabling environment in the nature of implementing legal and policy regimes should be seen for what they really are, as vital steps in the journey to UHC. They represent the foundation of a structure albeit with critical missing parts, which must receive urgent attention going forward otherwise previous efforts would smack of a half-hearted response to a very serious problem. This is certainly a situation that harbours nothing positive for the country or its health system.

[101] Ibid, 101 – 105.
[102] Ibid, 105.
[103] WHO, *World health Statistics 2020: Monitoring Health for the SDGs, Sustainable Development Goals* (Geneva: WHO, 2020) 51 – 55.
[104] Ibid, 57.
[105] WHO (n 11) 99.
[106] Ibid, 99 – 105.
[107] WHO (n104) 51 – 57.