Enhancing Political Will for Universal Health Coverage in Nigeria

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ABSTRACT

Universal health coverage aims to increase equity in access to quality health care services and to reduce financial risk due to health care costs. It is a key component of international health agenda and has been a subject of worldwide debate. Despite differing views on its scope and pathways to reach it, there is a global consensus that all countries should work toward universal health coverage. The goal remains distant for many African countries, including Nigeria. This is mostly due to lack of political will and commitment among political actors and policymakers. Evidence from countries such as Ghana, Chile, Mexico, China, Thailand, Turkey, Rwanda, Vietnam and Indonesia, which have introduced at least some form of universal health coverage scheme, shows that political will and commitment are key to the adoption of new laws and regulations for reforming coverage. For Nigeria to improve people's health, reduce poverty and achieve prosperity, universal health coverage must be vigorously pursued at all levels. Political will and commitment to these goals must be expressed in legal mandates and be translated into policies that ensure increased public health care financing for the benefit of all Nigerians. Nigeria, as part of a global system, cannot afford to lag behind in striving for this overarching health goal.

INTRODUCTION

Universal health coverage (UHC) arose as a visionary initiative by global health care leaders to address the challenges faced by many countries in providing increased access to quality health care services without creating financial hardship. It has been viewed from different perspectives.[1] According to the 2005 World Health Assembly resolution, UHC is "access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost thereby achieving equity in access."[2] In 2010, WHO referred to UHC as a basic principle according to which everyone, regardless of ability to pay, has access to quality health care services without suffering financial hardship as a consequence.[3] UHC has also been defined as "necessary health care of good quality,"[4] while some scholars define it as providing all citizens with "adequate health care, regardless of their employment status or any other factors."[5] In summary, UHC aims to increase equity in access to quality health care services and reduce associated financial risk.

UHC takes into account some foundational principles such as health as a human right and equity in health. Recognizing health as a human right entails that everyone has the right to the highest attainable standard of physical and mental health,[6] while equity in health implies the absence of unnecessary, avoidable, unfair and unjust differences in health across population subgroups, whether defined socially, economically, demographically or geographically.[7,8] There is some controversy on how to measure countries' progress towards UHC, and The World Health Report 2010 proposed nine indicators for this purpose.[3] In 2014, WHO and the World Bank proposed a framework for monitoring advances towards UHC focused on indicators and targets for service coverage including promotion, prevention, treatment, rehabilitation and palliation—with financial protection for all.[9] In 2016, Wagstaff proposed a UHC progress metric with two components in service coverage: prevention and treatment, and financial protection against impoverishment and catastrophic health care spending. He used nationally representative household survey data to adjust population averages to capture inequalities between the poor and better off, allowing nonlinear trade-offs between and within the two dimensions of the UHC indexes.[10] Population coverage of essential health services and financial protection against catastrophic health payments are considered important measures of progress toward UHC.

HEALTH IN NIGERIA

Nigeria is the most populous country in Africa, with a population of 182.2 million. Bordering Benin to the west, Chad and Cameroon to the East and Niger to the North, it is an oil-rich country with many natural resources and a GDP of $481.1 billion,[11] but high levels of inequality between rich and poor and between urban and rural areas. Nigeria, like many African countries, has yet to achieve UHC. Table 1 shows health indicators and health data for Nigeria and four African countries that have initiated varying health financing reforms aimed at achieving UHC: Ghana, South Africa, Rwanda and Tanzania.[12,13] According to 2015 data, compared to those four countries Nigeria displays a worse life expectancy at birth, as well as neonatal, infant, maternal and under-five mortality, although three of the four have lower per capita gross domestic product (GDP) and gross national income (GNI: GDP minus income earned by foreign nationals, plus income earned by nationals abroad) than Nigeria. In Nigeria, public health expenditure is less than 4% of GDP and total tax revenue is barely 1.6% of GDP; the lowest in this group of countries for both indicators.

Despite the World Health Assembly's 2005 resolution on UHC and health financing[2] and support for UHC in 2012 by both the UN[14] and Ministers of Health and Finance in Africa,[15] Nigeria still is far behind in moving toward UHC, according to progress metrics proposed by Wagstaff.[10] According to WHO, countries such as Mexico, Thailand, Saudi Arabia, Oman, Costa Rica, Colombia, Cuba and Estonia already have "some form of" UHC while countries such as Rwanda, Ghana, China, Chile, Indonesia, Singapore and Tunisia have gradually made important strides toward it.[16,17]

PROSPECTS FOR UHC IN NIGERIA

Political will and commitment are important in making headway toward UHC and must be expressed as a legal mandate and translated into policies that ensure increased public financing for health care for the benefit of all Nigerians. In my opinion, Nigerian political actors and policymakers lack the political will and commitment to make UHC a reality. Ghana, Chile, Mexico, China, Thailand, Turkey, Rwanda, Vietnam and Indonesia all adopted laws and regulations as steps toward implementing UHC reforms.[18,19] Nigeria can learn from these experiences by providing a legal framework for UHC and health financing reforms.

Table 1: Health indicators for Nigeria and four other African countries

Indicator	Nigeria	Ghana	South Africa	Rwanda	Tanzania
Human Development Index	0.514	0.579	0.666	0.483	0.521
Life expectancy at birth (years)	53	61.4	57.4	64.2	65.0
GNI per capita	5,341	3,852	12,112	1,458	2,411
Population living on <$1.25 a day (%)	62.0	28.6	9.4	63.0	43.5
Physicians per 10,000 population	4.1	1.0	7.8	0.6	0.1
Nurses and midwives per 10,000 population	16.1	9.3	51.1	6.9	4.4
Public health expenditure as a % of GDP	3.9	5.4	8.9	11.1	7.3
Infant mortality per 1000 live births	74.3	52.3	32.8	37.1	36.4
Under-5 mortality per 1000 live births	117.4	78.4	43.9	52.0	51.8
Maternal mortality per 100,000 live births	560	380	140	320	410
HIV prevalence (%)	3.2	1.3	19.1	2.9	5.0
Death due to malaria per 100,000 population	106.6	67.0	2.2	33.2	50.5
Death due to tuberculosis per 100,000 population	16.0	6.9	59.0	10.0	13.0
Total tax revenue as % of GDP	1.6	14.9	26.5	13.4	16.1
GDP per capita (2011 PPP)	5,423	3,864	12,106	1,426	1,718

Source: World Health Statistics 2015[12] and Human Development Report 2015[13]
GDP: gross domestic product
GNI: gross national income
PPP: at purchasing power parity exchange rate

According to the Nigeria Poverty Profile Report, about 70% of the Nigerian population lived in poverty in 2010.[20] WHO reported that in 2015, general government expenditure on health was 33.2% of total health expenditure and private expenditure 66.8%.[12] Alarmingly, out-of-pocket expenditure remains the major financial source for Nigeria's health system, representing 95.5% of private health expenditure (or 63.8% of total), according to World Health Statistics 2015.[12] In 2010, WHO proposed targets for four indicators of progress toward UHC (Nigerian value in parentheses after each): total health expenditure 4%–5% of GDP (3.9%); out-of-pocket spending not exceeding 30%–40% of total health expenditure (72%); providing coverage through prepayment and risk pooling schemes to over 90% of the population (<10%); and close to 100% population coverage in social assistance and safety net programs (3.4%).[3,12,13,21–23] Nigeria falls short of these four target indicators and is unlikely to achieve UHC, unless there is a reduction in reliance on out-of-pocket payments. Some attempts were made to explore social health insurance and private health insurance with the establishment of the National Health Insurance Scheme (NHIS) under Act 35 of 1999 and its eventual launch in 2005 (delayed by political instability), as well as establishment of health maintenance organizations, but these did not translate into increased population health coverage.

A 2013 study suggested that <5% of the Nigerian population is covered by NHIS, mainly government employees.[22] Most Nigerian states do not yet provide health insurance coverage to those in the formal sector of the economy covered by NHIS a decade since its inception.[23] A similar study in 2015 found <1% of the Nigerian population covered by private health insurance, which is voluntary[23] rather than legally mandated.[24] The law establishing NHIS does not mandate private companies to provide health insurance to their workers; not surprisingly, few do so. What's more most people in the informal economy have no health insurance coverage.

Another obstacle to UHC is inefficient use of resources. Health spending has not translated into improved health status and better population health outcomes.[12,13] However, in Rwanda, a community-based health insurance scheme (CBHI) has proven to be a viable model for moving closer to UHC.[25] While Nigeria's NHIS contains provisions for CBHI for poor communities (Community Based Social Health Insurance Programme, or CBSHI, part of the Informal Sector Social Health Insurance Programme), it has not provided financial protection for the vast majority of people in rural areas and the informal sector; I concur with other authors that it is due to poor leadership and lack of governance.[26] In fact, one study shows that the CBHI in Nigeria has been associated with poor coverage, poor health care service delivery, high rates of attrition, high levels of poverty in rural areas, poor uptake, low awareness, lack of information, low client participation, lack of trust, lack of incentives for management teams, inadequate financial support, and issues concerning sustainability of subsidies paid by program managers.[27] Once again, greater political will and commitment on the part of government is important to increase health investments, engender strong engagement, scale up CBHI across the country, provide the necessary leadership, improve governance, encourage community support, promote acceptance, build trust, and thus overcome most of the aforementioned shortcomings.

The right to health is a key component of UHC. The Nigerian constitution does not establish a fundamental right to health,[28] which could help explain the lack of political will and commitment to UHC among Nigerian policymakers and political actors. Furthermore, health systems in low- and middle-income countries, including Nigeria, are weak,[29] and there is evidence that UHC cannot be accomplished in weak health systems.[30] Weak health systems have hindered achievement of the Millennium Development Goals, the success of disease-specific interventions, improvement in population health and health outcomes.[31]

Health indicators displayed in Table 2 show that Nigeria falls short of the African continental average for health service delivery, health financing and health system organization. There are large health and health-related inequalities between the poor and the better-off in Nigeria. Most households and indi-

Table 2: Key Nigerian health system indicators in comparison with African average

Health Indicators	National Value	Africa Continent Average
Health Service delivery		
Unmet need for family planning (%) (2007–2013)	19	24
Contraception prevalence (%) (2007–2013)	15	28
Antenatal care coverage for ≥1 visit (%) (2007–2014)	61	77
Antenatal care coverage for ≥4 visits (%) (2007–2014)	51	48
Births attended by skilled health personnel (%)(2007–2014)	35	51
Births by caesarean section (%) (2007–2014)	2	4
Neonates protected at birth against neonatal tetanus (%) (2013)	60	75
Measles immunization coverage among children aged 1 year (%) (2013)	59	74
DTP3 immunization coverage children aged 1 year (%) (2013) (2013)	58	75
HepB3 immunization coverage among children aged 1 year (%) (2013)	63	76
Health financing		
Total expenditure on health, % of GDP	4	6
Public expenditure on health, % of GDP	3.9	3
Public expenditure on health, % of total health expenditure	25	51
Private expenditure on health, % of total health expenditure	75	49
Donor funding, % of total health expenditure	7	24
Out-of-pocket expenditure, % of total health expenditure	72	32
Private health insurance expenditure, % of total health expenditure	2	4
Per capita total health expenditure (US$)	217	274
Per capita public health expenditure (US$)	55	164
Organization of health system		
Physicians per 10,000 population (2007–2013)	4.1	2.7
Nursing and midwifery personnel per 10,000 population (2007–2013)	16.1	12.4
Dentist per 10,000 population (2007–2013)	0.2	0.5
Pharmacist per 10,000 population (2007–2013)	1.1	0.8
Psychiatrist per 10,000 population (2014)	<0.05	<0.05
Hospitals per 100,000 population (2013)	No data	0.8

Source: World Health Statistics 2015[12] and WHO 2016[32] GDP: gross domestic product

viduals do not get the health care services they need, regardless of their ability to pay.[12,32] Table 3 shows health and access disparities by sex, sector (rural vs. urban), education and region in Nigeria. States in the South East, South West and South South regions of Nigeria have better health outcomes than states in the North Central, North West and North East regions.[12,33] Furthermore, public and private health facilities demand upfront payment before a patient is treated even in an emergency. All these contribute to a substantial financial burden of out-of-pocket payment for health care among individuals and households; some 23% of Nigerian households experience catastrophic health expenditures (>10% of nonfood expenditure).[34]

THE WAY FORWARD

For Nigeria to improve people's health, reduce poverty and achieve prosperity, UHC must be vigorously pursued at all levels. Although the World Health Report 2010 acknowledged that there is no single path to UHC,[3] Many high- and middle-income countries have taken advantage of the benefits of UHC, and Nigeria, as part of a global system, cannot spare any efforts towards this overarching health goal. Inadequate health financing by political actors and policy makers is a major obstacle to UHC. Furthermore, health funding has not been judiciously utilized over decades, leading to concerns about efficiency in resource use, which impedes progress toward UHC.[35] Both developed and developing countries face challenges in financing their health systems,[36] but governments at all levels need to increase domestic tax revenue, a potential financial source proven to be key to achieving UHC.[37] Domestic financial support for UHC is crucial to its sustainability, both for countries that have achieved it and countries that are striving to move closer to it. Adequate government spending on health from domestic sources is an important indicator of a government's commitment to the health of its people.[38]

Political actors and policy makers need to take steps toward UHC in Nigeria as a major Sustainable Development Goal. Legislation is needed to make governments at all levels responsible for the health of the population. Health must be seen as a fundamental right by political actors and decision makers if Nigeria is to comply with the 2001 Abuja Declaration (in which African countries pledged to allocate 15% of their budgets to improving health),[39] not to mention make good on the National Health Act's promise to ensure Nigerians' right to access to health services.[40] NHIS should be expanded to cover people in both the formal and informal sectors by making health insurance compulsory. The present health financing system in Nigeria contributes to increasing poverty by impoverishing people with out-of-pocket payments; hence, Nigeria needs a deliberate health financing policy to protect the poor. Such a policy should provide an appropriate mix of financing mechanisms with <10% out-of-pocket payment. Lack of political will and commitment helps explain why the NHIS is made optional for states to adopt. Because NHIS is not mandated by law, most state governments have not adopted it, leaving the majority of state employees uninsured.

CBHI has played a key role in moving Rwanda and Ghana closer to UHC.[25,41,42] To make similar progress, the Nigerian government should scale up CBHI throughout the country to provide financial risk protection to rural residents (over 60% of the population) and the informal sector in Nigeria, providing leadership and governance by NHIS management and decision

Table 3: Health and access disparities in Nigeria

Health data	Sex		Sector		Education		Region					
	M	F	Rural	Urban	None	Secondary or higher	NC	NE	NW	SE	SS	SW
Contraception prevalence (modern methods) (%)	ND	ND	6	17	2	20						ND
Antenatal care ≥4 visits (%)	n/a	ND	38	74	28	80						ND
Births attended by skilled health personnel (%)	n/a	ND	23	67	12	76						ND
DTP3 immunization coverage, children aged 1 year (%)	40	37	25	62	12	74						ND
Stunting, children aged <5 years (%)	39	35	43	26	50	21						ND
Under-5 mortality rate per 1000 live births	150	136	167	100	178	85	100	160	185	131	91	90
Median age at first delivery for all women	n/a	ND	ND	ND	ND	ND	20.6	18.8	17.9	23.7	21.8	22.7
Current contraception prevalence (%)	ND	ND	9	27	3	66	16	3	4	29	28	38
Births in health facility (%)	n/a	ND	21.9	61.7	ND	ND	45.7	19.5	11.5	78.1	50.1	75
Postnatal checkup ≤2 days of birth (%)	n/a	ND	29	59.1	ND	ND	47.6	31.8	17.0	60.9	60.3	72.7
Problems accessing health care, women aged 15–49 years	n/a	ND	61.7	41.7	ND	ND	56.0	58.1	55.4	64.0	54.0	34.5
Population access to ITN (%)	ND	ND	39	31	ND	ND	37	43	33	42	33	33

Source: World Health Statistics 2015[12] and Nigeria Demographic and Health Survey 2013[33]
ITN: insecticide-treated mosquito net n/a: not applicable NC: North Central ND: no data NE: North East
NW: North West SE: South East SS: South South SW: South West

makers. Compulsory enrolment of members of rural communities under CBHI will reduce out-of-pocket payments for health care services to the barest minimum. Governments at all levels have to ensure strong involvement in the program by subsidizing premiums for poor rural dwellers and delivering quality health care services, as well as enlisting community support in order to increase uptake, reduce attrition, and increase awareness and coverage.

CONCLUSION

UHC is the provision of access to quality health care services without creating financial hardship. There is a growing consensus worldwide that health is a basic human right, hence a legal framework for UHC should be instituted in Nigeria. Enhanced political will and commitment among Nigerian political actors and policymakers are critical to making UHC a core objective of the country's Sustainable Development Goals.

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