NATIONAL HEALTH INSURANCE SCHEME AND SUSTAINABLE DEVELOPMENT IN NIGERIA: A CRITICAL APPRAISAL

Okafor, **Nneka Ihuoma & Anigbogu, Kingsley C.**
nekkycampbell@yahoo.com; jkseven2003@yahoo.com
Department of Sociology/Anthropology
Nnamdi Azikiwe University, Awka, Anambra State, Nigeria

Abstract
Nigeria's health insurance progrmme is geared towards ensuring availability and accessibility of healthcare services to all the citizens. Unfortunately many people in Nigeria do not enjoy robust health today. Nigeria's healthcare sector is bedeviled by several infectious disease outbreaks year after year resulting in the death of many. Five areas that particularly affect the people's health have been identified as: reproductive health/maternal mortality, poverty, hunger, the burden of several communicable infectious diseases outbreaks (HIV/AIDS, TB, malaria) and non-communicable diseases. These health challenges threaten the people's well-being and productivity. Many reforms which entail purposeful changes and planning have however been introduced yet it has become increasingly clear that these reforms have not contributed significantly in improving the nation's healthcare and thus have not been of meaningful benefit. This scenario has in no small measure hampered sustainable Socio-Economic development in Nigeria. To address this problem, this paper anchors on Social Exclusion theory, which emphasizes lack of inclusive participation in health and social activities as its core element and strongly argues that the failure of the Nigerian nation to provide certain individuals and groups with those rights and benefits normally available to its member is responsible for the failure of health policies and programmes in the country. The paper therefore recommends that spending more on primary health care, organizing enlightenment campaigns on health programs/reforms, empowering citizens through education, zero tolerance for corruption, and inclusive health care provisioning will help usher sustainable development in Nigeria.

Key Words: **Healthcare, Health Insurance, Health Sector Reform and Sustainable Development**

Introduction

The background to the establishment of National Health Insurance Scheme (NHIS) in Nigeria is sequel to the general poor state of health services and health infrastructure across the nation. Indeed, the health system was in total decay as inadequate manpower, problems of quackery, brain drain, poor attitude to work of health workers, inadequate equipments, high cost of healthcare services, fake and substandard drugs, and poor health information system was high. There was also dwindling funds for healthcare in the face of rising cost of provision of healthcare services. Over - dependence on Government to finance health facilities, and inability of government healthcare institutions to cope with people's demand were other challenges. Against the above background, the option of National Health Insurance Scheme (NHIS) was adopted to give easy access to health at an affordable cost to the populace (Ibiwoye and Adeleke, 2008).

The history of NHIS in Nigeria dates back to 1962 when the need for health insurance was first recognized. It was fully approved by the Federal Government of Nigeria in 1997, signed into law in Act 35 of 1999. It was thereafter officially launched on 6th June 2005 while

commencement of services to enrollees started in September 2005. Over 4 million Identity Cards have been issued, 62 health maintenance organizations (HMOs) have been accredited and registered, 5,949 Healthcare Providers, 24 Banks, 5 Insurance Companies and 3 Insurance Brokers have also been accredited to provide better healthcare services upon payment of token contributions at regular intervals (Akande and Bello, 2002; Katibi and Akande, 2003; Ibiwoye and Adeleke, 2008). The NHIS structure is constituted of the following bodies: The council, State licensure boards, State health insurance offices, Standards committee and inspectorate systems, Health maintenance organizations, Health insurance companies (public and private), Arbitration boards, Malpractice insurance schemes, Banks and banking systems.

The NHIS motto is '**easy access to healthcare for all**'. The scheme is designed to facilitate fair financing of healthcare costs through institution of prepaid mechanism, pooling and judicious utilization of funds, financial risk protection and cost-burden sharing for people. This is against high cost of healthcare in addition to the provision of regulatory oversight on Health Maintenance Organizations (HMOs) and Health Care Providers (HCPs), prior to their falling ill (Mills, Rasheed, Tollman, 2006; Ekman, 2007).

The ultimate objective of NHIS is to ensure that every Nigerian have access to good healthcare services through a number of programmes, ensure efficiency in healthcare services, equitable distribution of healthcare cost among different income groups, equitable distribution of healthcare facilities within the federation, appropriate patronage of all levels of healthcare, and availability of funds to the health sectors for improved services, protect families from the financial hardship of huge medical bills, promote and harness private sector participation in the provision of healthcare services, limit the rise in the cost of healthcare services, maintain high standards of healthcare delivery within the scheme, through intermittent training or updated training where workers knowledge, skills and expertise are updated. However, the extent to which the NHIS has been able to achieve this is still very much in doubt.

Before the establishment of NHIS in Nigeria, the World Health Organization (WHO), in 2007, ranked Nigeria 197th out of 200 nations with poor healthcare policies. Life expectancy in Nigeria was put at 48 years for males and 50 years for females, while Healthy Life Expectancy (HALE) for both sexes was put at 42years. In HALE estimation, Nigeria only ranked higher than five countries namely Sierra Leone, Afghanistan, Zimbabwe, Zambia and Lesotho in the whole world. The WHO report further stressed that Nigeria accounts for 10% of global maternal mortality figure, with 59,000 women dying annually from pregnancy and child birth. It adds that for every maternal death, 30 others suffer long term disabilities while 40 per cent (about 800,000) of global obstetric fistulas occur in Nigeria. The frightening report described the health situation in Nigeria as being so deplorable because only 39 per cent of births are delivered by skilled health professionals. It also emphasized that the risk of a woman dying from child birth in Nigeria is 1 in 18 compared to 1 in 61 for all developing countries and 1 in 800 in developed countries. The report added that only 23 per cent of children (12- 23months) receive full course of immunization against childhood killer diseases. Considering the age bracket of the child bearing women being between 18 – 45yrs, we can conclude that it is the work force of the nation that is dying, thus a decline in productivity and development (WHO, 2007).

Reducing child and maternal mortality rates are part of the Millennium Development Goals (MDG) which the Nigerian government is committed to. It targets a reduction of the mortality of children under the age of five by two-thirds between 2000 and 2015, that is, from 207 in 2000 to 67 by 2015. In the same vein, MDG also targets a 75% decline in maternal mortality

rate by 2015, that is, from 704 in 2000 to about 176 in 2015. It is therefore, obvious that unless there is a quick intervention, Nigeria will get to 2015 without a change in her health status, without achieving the MDG goals and without achieving sustainable healthcare which is definitely a pathway to sustainable development at large. As the focus now is on sustainable healthcare services, the NHIS represents a very promising sustainable healthcare financing strategy which can work progressively towards achieving universal health insurance coverage for all Nigerians. Again, as the cost of healthcare increases, it has become increasingly important for people to obtain health insurance to maintain access to affordable, assessable, preventive, curative, rehabilitative, promotional and emergency health care. It is therefore, against the backdrop of the foregoing problems that this paper is situated.

Conceptual Issues

Sustainable development is a term originally conceived by the 1987 United Nations World Commission on Environment and Development (the "Brundtland Commission"), as "development that meets the needs of the present without compromising the ability of future generations to meet their own needs" (UNCED, 1987:43). Following the Brundtland Commission and its report "Our Common Future", that took place in 1992 the UN Conference on Environment and Development (UNCED), the Rio Declaration on Environment and Development emerged. Agenda 21 – a global programme of action on sustainable development, and a number of specific global conventions were conceived. Principle I of the Rio Declaration on Environment and Development states that "Human beings are at the centre of concerns for sustainable development. They are entitled to a healthy and productive life in harmony with nature" (Rio Summit 1992). Chapter 6 of Agenda 21 takes this principle further, stressing the need to protect and promote human health, with emphasis on meeting primary health care needs, particularly in rural areas; control of communicable diseases; protecting vulnerable groups; meeting the urban health challenge, and reducing health risks from environmental pollution and hazards. Thus, underlying the concept of sustainable development is the increasing recognition that the goals of sustainable development cannot be achieved when there is a high prevalence of debilitating illnesses (for example diseases of poverty), and the health of the population cannot be maintained without ecologically sustainable development (UNCED, 1987:43).

Within the Brundtland Report, the concept ″development", as distinguished from "growth" focuses on getting "better" rather than getting "bigger". The idea was to have a "qualitative concept incorporating ideas about improvement and progress in the cultural, social and economic dimensions" (Abrahamson 1997:31).

> *"... sustainable development is a process of change in which the exploitation of resources, the direction of investments, the orientation of technological development and institutional change are all in harmony and enhance both current and future potential to meet human needs and aspirations" (*(UNCED, 1987:*46).*

According to the definition given by Brundtland Report (1987), the term sustainable development is usually understood as "intergenerational" equity which would be impossible to achieve in the absence of present-day social equity, if the economic activities of some groups of people continue to jeopardize the well-being of people belonging to other groups or living in other parts of the world. Imagine, for example, that emissions of greenhouse gases, generated mainly by highly industrialized countries, lead to global warming and flooding of certain low-lying islands—resulting in the displacement and impoverishment of entire island nations. Or consider the situation when higher profits of pharmaceutical companies are earned at the cost of millions of poor people being unable to afford medications needed for treating their life-threatening diseases.

According to the more operational (practice-oriented) definition used by the World Bank, sustainable development is "a process of managing a portfolio of assets to preserve and enhance the opportunities people face". The assets that this definition refers to include not just traditionally accounted physical capital, but also natural and human capital. To be sustainable, development must provide for all these assets to grow over time—or at least not to decrease (Last, 2001).

Sustainable development includes economic, environmental, and social sustainability, which can be achieved by rationally managing physical, natural, and human capital. Thus, sustainable development could probably be otherwise called "equitable and balanced," meaning that, in order for development to continue indefinitely, it should balance the interests of different groups of people, within the same generation and among generations, and do so simultaneously in three major interrelated areas–economic, social, and environmental. Therefore, sustainable development is about equity, equality of opportunities for well-being, as well as about comprehensiveness of objectives. Obviously, balancing so many diverse objectives of development (economic objective: growth efficiency & stability; social objective: full employment, equity, security, education, health, participation & cultural identity; environmental objective: healthy environment for human, rational use of renewable natural resources & conservation of nonrenewable natural resources) is an important criteria for any nation on the road to sustainable development. Thus, to ensure that future generations inherit the necessary conditions to provide for their own welfare, our present day values must be educated enough to reflect their interests as well (McMichael, 2001).

Recent literature on sustainable development observed that the most critical problem of sustainable development—in each country as well as globally—is eradicating extreme poverty (Last, 2001; McMichael, 2001; Chasek, Pamela, 2008).). That is because poverty is not only an evil in itself. It also stands in the way of achieving most other goals of development, from clean environment to personal freedom. Another, closely related, global problem is establishing and preserving peace in all regions and all countries. War, as well as poverty, is inherently destructive of all economic as well as social and environmental goals of development. In the final analysis sustainable development is about long-term conditions for humanity's multidimensional well-being. To understand what the concept of sustainability means for the work within the network, we have to look on the characteristics of this paradigm. Two main characteristics are (Abrahamson 1997:31):

> "Sustainable development is *people-centered* in that it aims to improve the quality of human life and it is *conservation-based* in that it is conditioned by the need to respect nature's ability to provide resources and life-support services. In this perspective, sustainable development means *improving the quality of human life while living within the carrying capacity of supporting ecosystems*."
>
> "Sustainable development is a *normative concept* that embodies standards of judgment and behaviour to be respected as the human community 'the society' seeks to satisfy its needs of survival and well-being".

Theoretical Framework

This paper is anchored on Social Exclusion framework developed in France during the 1960s and 1970s by René Lenoir as an umbrella term describing individuals with problems unprotected by then current social insurance principles. This included the disabled, elderly, substance abusers and single parents. Social Exclusion was viewed as a failure of key state institutions at maintaining positive relationships between society and some individuals (Bhalla

and Lapeyre 1997: 413-433). In the 1980's, the term evolved to include more general types of social disadvantages created or exacerbated by rapid and dramatic economic change, rising social inequity, retraction of the welfare state and increasing segregation that threaten to breakdown relationships between society and some individuals (Silver 1995; Mohan 2002). Social exclusion emphasizes on lack of participation in social activities as the core characteristic and the failure of society to provide certain individuals and groups with those rights and benefits normally available to its members, such as employment, adequate housing, health care, education and training, etc.

The basis for adopting this theoretical thrust is that despite considerable investment in Nigeria's health sector over the years to ensure actualization of the right to health and universal coverage to all, available evidence suggests that health services throughout Nigeria are delivered through a weak health care system characterized by inequitable distribution of resources, poor coverage with high impact cost-effective interventions and negative attitude of health care providers among others. A whopping 70.8% of Nigerians still live below the poverty line, on less than $1/day, (Pogge, 2007) and therefore cannot afford the high cost of health care. This means that millions are left without any form of coverage on the healthcare insurance/policy.

Modalities of operation in NHIS:

- **Public Sector programmes:** This is the first stage or approach targeted at the Federal Civil Servants, Public Servants and those in well established companies. In this programme, the employers and the employees are expected to register with NHIS. During registration, the employee is expected to register himself, the spouse if married with a minimum of four children. The employee is also given a list of all healthcare service providers that are registered with NHIS from where he shall choose his primary healthcare provider who is associated with the HMO's that will help respond to his family/dependents and his own health needs. Some of these service providers are usually selected by the employee based on ease of accessibility and on the quality of service or care rendered. After registration, 5% of employee's basic salary is usually deducted monthly at source and remitted to NHIS while the employer pays 10% of the employee's basic salary which entitles him, his spouse and four children access to medicare from any approved selected service provider (NHIS, 2005). Technically, the 5% is called subscription or monthly premium and that is how the scheme raises funds. An NHIS card is usually issued to the employer after registration to enable him and his family members' access to the service provider. On arrival to the service provider, the first point of contact is the NHIS desk where the officer checks the status of the client through the use of internet to ascertain if the subscription is still valid and if payment is up-to-date. Once this check has been carried out, the employee is expected to go ahead and receive health services from the provider. After receiving medical attention, bills covering all expenses are prepared and forwarded to the employer who pays 10% of the bill while the rest is taken care of by the scheme. Usually when NHIS providers are used, they are often upgraded by government in terms of standby power, structures, infrastructures, equipments, manpower/officials, training of manpower, internet connectivity etc. Therefore, because of this upgrading from government there is always a lot of politics involved. Health institutions now lobby to be used as a service provider. However, since the inception of NHIS, so many workers within the Federal establishment have not fully accessed NHIS services; it is still a far cry. According to Erinosho (2006:49), public sector healthcare facilities in Nigeria are on the verge of collapse due to the dearth of resources, bureaucratization of medical practice, disrepair of facilities and equipment, low morale and job dissatisfaction among staff. In other

words the objectives and functions of NHIS have hardly attained any height as healthcare delivery continues to be limited; not equitable and does not meet the needs of the majority of Nigerian people. This is indicative of the high infant mortality rate, poor maternal care, very low life expectancy rate among others.

- **NHIS Program for students:** This is a new Programme approved and launched by the Federal Government early 2012 especially for students' in tertiary institutions. This was put up because the formal sector programme recognized only children under the age of 18 years. Children above 18 years could not enjoy the insurance contracted by their parents, hence the plan by the agency to introduce the scheme for higher/ tertiary institution students. Through this programme an estimated 48 million Nigerians would come on the scheme. Under the program, students' above 18 years and who are not employed are supposed to access healthcare services through the scheme. It is very new and still not very much in use in most tertiary institutions. Here, the student is expected to pay some amount into the scheme while the school management pays the balance to cover for a section. This is how the scheme generates or raises funds for its running. After this payment once the student falls ill he/she is expected to go to the health provider which is usually located inside the institution's medical center to receive medical attention.

- **Retiree Programme:** This program is very much similar to the public sector programme and retirees are expected to continue to make monthly subscription from his/her limited pension fund to be able to access healthcare services through the scheme.

- **Safety Net Programme:** This is a programme targeted at the vulnerable. It is for Nigerians, who are indigent, handicapped, physically challenged or incarcerated and as a result may not afford care. Thus, because this category of people may not be able to afford services through subscription, NHIS has undertaken to build a pool of fund through which they can provide health services to this category of vulnerable Nigerians. In this regard, the NHIS is planning a national health bill that would generate some funds for the scheme.

Health and Sustainable Development

According to Abrahamson (1997), development is the qualitative transformation of a whole society, a shift to new ways of thinking, and, correspondingly, to new relations and new methods of production. Moreover, a transformation qualifies as development only if it benefits most people—improves their quality of life and gives them more control over their destinies. This comprehensive process of change has to involve most of the population and cannot be imposed from outside the country or from above—for example, by means of unpopular government policy or by means of foreign aid. It is important to understand that all of the Millennium Development Goals are closely interconnected, so that achieving one of them can be expected to contribute to achieving the others. For example, reducing the share of people living in extreme poverty from about 30 percent of the developing world's population to about 15 percent would certainly help to deal with the health and education challenges, but achieving health and education goals would also contribute to the fight against poverty. It can also be shown that providing for environmental sustainability, although it may initially require some additional spending, will ultimately more than pay for itself in terms of better health, longer lives, and more natural resources available for poverty reduction. Unfortunately, failure to achieve some of these goals can also preclude the achievement of many or all of the others.

Particularly devastating can be the effects of an unchecked HIV/AIDS epidemic, which, by killing adults in their most productive years, exposes millions to extreme deprivation (Abrahamson, 1997:30-35).

'Health' and 'sustainable development' thus has an ethical or moral dimension, as well. Health, in this context, is not merely the absence of disease or infirmity, but is a complete state of physical, mental and social well-being – and, we might add, environmental well-being (Abrahamson, 1997). It is also a positive concept, emphasizing social and personal resources as well as physical capabilities. Viewed thus, population health becomes more than either a causal input or an incidental consequence of economic development. It becomes a central criterion. The purpose of "development", presumably, is to improve the conditions and enjoyment of life for human societies (and to do so in a way that entails sharing those benefits equitably). Thus, if development path is not conducive to sustained improvements in health, then it is not "sustainable development" (Abrahamson, 1997).

'Health' and 'sustainable development' are complex entities, in which the whole is greater than, and often different from, the sum of the parts. The relationships between effects and causes may be indirect, circular, and difficult to unravel. They may be synergistic or antagonistic, and they may vary with the geographic, political, economic and cultural setting. Good health usually facilitates development, and development often promotes improved health. However while improved health may be a prerequisite for development, some behavioural determinants of health, such as attitudes towards the environment, and people's lifestyles and consumption patterns, can impede the sustainability of the development process in the longer-term. Equally, development which is economically desirable e.g. in agriculture and industry, may have harmful consequences for health and the environment. For development to be sustainable, all three dimensions need to be addressed in a balanced and integrated way, with due regard given to meeting both present as well as future needs. The environmental, social and economic dimensions should thus be seen as mutually enforcing, interdependent entities of sustainability. In this context, health provides an important unifying theme in relation to the three pillars of sustainable development (von Schirnding and Mulholland, 2001).

Therefore, in order for development to be sustainable, it has to be comprehensive—it has to successfully balance economic goals with social and environmental. "Development" is really much more than simply economic growth. The understanding of development can differ among countries and even among individuals, but it usually goes far beyond the objective of increased average income to include things like health, education, safe environment, equity and much more. Hence, development is a comprehensive process involving economic as well as social and environmental changes.

According to the Human Development Report (1996), published by the United Nations Development Program, "human development is the end, economic growth a means". It is true that economic growth, by increasing a nation's total wealth, also enhances its potential for reducing poverty and solving other social problems. But history offers a number of examples where economic growth was not followed by similar progress in human development. Instead growth was achieved at the cost of greater inequality, higher unemployment, weakened democracy, loss of cultural identity, or overconsumption of generations. This kind of growth is inevitably unsustainable, that is, it cannot continue along the same lines for long.

If development occurs in unsustainable ways, population health gains may accompany improving economic conditions in the short term, but the health gains might not be sustainable in the long term. Thus, time scales matter with sustainable development and health. Social factors such as political instability, violent armed conflicts, discrimination, disasters, both human-induced and natural, environmental change which include climate change, depletion of the ozone layer, reduction of biodiversity, degradation of ecosystems and the spread of persistent organic pollutants, globalization, effects of urbanization like pollution, noise, crowding, inadequate water and sanitation, improper waste disposal, chemical contamination, poisonings and physical hazards, inequalities and inequities (within, and across, generations) are all inimical to health, and to sustainable development (von Schirnding and Mulholland, 2001).

The National Health Insurance Programme and Sustainable Development: An Appraisal

According to the (WHO 2000) health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity. In Nigeria, the extent of coverage of the NHIS is such that artisans, farmers, sole proprietors of businesses, street vendors, traders and the unemployed are not yet accounted for. Even within the formal sector, not all government and corporate organization employees are enrolled within the scheme. Public and private hospitals therefore are still operating on a fee for service basis for the majority of its clients (Gana, 2010). Besides that, long queues are still usual sights, while the issue of unavailability of required services continues to rear its ugly head in NHIS approved hospitals. In addition, there is still weak and ineffective referral systems' resulting in over burdened secondary and tertiary health facilities. Education of the teaming populace on the pros and cons and the need to participate in the NHIS is also a challenge yet to be surmounted.

Generally, insurance is found to increase the intensity of utilization and reduce out of pocket spending (Ekman, 2007). However, enrolment in insurance has been found to result in altered behavior, such as utilizing unnecessary medical care, a concept known as 'moral hazard' (Sulzbach, Garshong, Owusu-Banahene, 2005). Statistics from a workshop on NHIS-MDG/MCH project by NHIS between 6th -10th June, 2011 reveals that the number of enrollees registered and processed by some states in Nigeria as at March, 2011 are: Bayelsa- 184,685, Gombe-161,847, Niger-162,408, Imo-90,597, Oyo-158,152, Sokoto-161,738, Katsina-80,272, Jigawa- 105,739, Bauchi-158,144, Yobe-102,556, Cross River- 59,910.
Evidences from countries that have institutionalized national health insurance program indicate positive impact on the health care system (Collins, White, Kriss, 2007; Sanusi and Awe, 2009). In a study in Baltimore USA, health insurance was found to lead to an increase in non urgent utilization of health facilities (Speck, Peyrot, Hsaw, 2003). Also in a related study about public insurance in North Carolina, USA, it was reported that publicly insured children were more likely to have emergency department visit than un-insured children (Luo, Liu, Frush, Hey, 2003). Same trend was also noticed in Minnesota, USA (Kane, Keckhafer, Flood, Bershadsky, Siadaty, 2002). Pattern of utilization of general practitioners under universal health insurance in Canada indicated that females made more visits than males (Segovia, 1999). Also in Jordan, insurance was found to have a positive effect on the utilization of curative care and significantly increased the number of visits per illness episode (Sanusi and Awe, 2009). Similarly in Taiwan, the utilization of most prenatal and intra-partum care services increased after commencement of NHIS (Li-Mei, Shi, Chung-Yi, 2001). In Ghana, the utilization of health facilities under insurance cover revealed that malaria, respiratory problems and diarrhea were the commonest illnesses (Sulzbach, Garshong and Owusu-Banahene, 2005).

Despite the published protocol, most of these practices are common place in our health institutions. More disturbing is the fact that the Nigerian System allows private healthcare providers as major stakeholders despite the establishment of the NHIS. The aforementioned issues raised have led to the following challenges:

1. The issue of funding has been a major challenge to the programme. Financing of public health services in Nigeria has been through government subvention funded mainly from earnings from petroleum exports and user fees of patients. Decline in funding for healthcare commenced after the mid 1980's following a drastic reduction in revenue from oil exports, mounting external debts burden, structural adjustment programme and rapid population growth rate (Abel-Smith B, 1992). The result as in most developing countries was a rapid decline in the quality and effectiveness of publicly provided healthcare services (Abel-Smith B, 1992). Funding of healthcare in Nigeria has not only affected the quality of healthcare services but led to impoverished health standard of the populace. Gana (2010), identified these funding challenges as low level of public (government) spending, high burden of healthcare costs on individuals and households (70% of all expenditure), thus ranking Nigeria as the country with the second highest level of out-of-pocket spending on health financing in the world. For instance in 2007, NHIS was practically broke because the subvention that was budgeted for the scheme was not released and even when it was released, it was late. Again the programme reliance on monthly subscription for funding is not really helpful in achieving the NHIS objectives. Therefore it is necessary that the scheme should source for other means of fund rather than depending solely on subscription and government subventions.
2. Unavailability of facilities like hospitals and medical centers to all while those who have are ill-equipped for a smooth take-off of the program in the rural areas.
3. The issue of lack of public enlightenment, education and awareness about the pros and cons of the scheme created for the public that are expected to utilize the scheme and the need to participate in the NHIS is also a challenge yet to be surmounted.
4. Issue of corruption on the part of government officials who divert subvention allocated for the running of the scheme and mismanagement of funds raised through registration and subscription by NHIS officials.
5. Available financing risk protection under the NHIS is very limited in coverage and scope. Several very important and hitherto expensive healthcare services are excluded from the scheme, while common ailments that can be treated easily and very affordable are financed by the scheme.
6. The scheme is rather too slow in pursuing their objectives, in all, the program has not really moved forward as expected.
7. The program has been accused of favoritism and bias in the selection of health service providers. Transparency is not assured.
8. Long queues are still usual sights while the issue of unavailability of required services is always rearing its ugly head in NHIS approved hospitals.
9. There is still weak and ineffective referral systems' resulting in over burdened secondary and tertiary health facilities.
10. The sector has witnessed several years of neglect, decay of infrastructure, poor funding and inappropriate human resources management coupled with colossal depletion of trained personnel (brain drain).
11. Inadequate supervision of the operation and management of the Healthcare centers by the appropriate agency from the ministry of health.

Ways to Move NHIS in Nigeria Forward

The NHIS which was established to reduce our mortality rate has failed the purpose it was set up to achieve because those saddled with the responsibility of running the scheme have either lost their visions or are playing to the gallery to entertain their spectators who are beneficiaries of failed systems. NHIS has not been able to fulfill its promise of making health services available and assessable to all, it is only skeletal in most places. At best, it is seen as a program for only the Federal public servant. More so, people may have lost confidence in the scheme and have no reason to trust it any more. In most developing countries, Nigeria in particular, there is a clear lack of universal coverage of healthcare and little equity. Access to healthcare is severely limited in Nigeria (Akande T, Salaudeen A and Babatunde O, 2011). Inabilities of the consumers to pay for the services as well as the healthcare provision that is far from being equitable have been identified among other factors to impose the limitation (Sanusi, et al, 2009). But then if and when things are put in their proper perspectives, the present situation of NHIS might be redeemable on one hand, while on the other hand, the NHIS need the support and cooperation of Nigerians to cover all Nigerians. Ways to improve NHIS abound, the list is endless but the under listed has been suggested;

1. Government should truthfully fund and release approved funds allocated to the scheme as and when due.
2. Several Nigerians are not fully enlightened in the components and structure of the NHIS. There is therefore the need for a massive and far reaching public enlightenment and awareness campaign to educate the populace about the scheme, the benefits there in and the rights of an enrollee.
3. Multinationals, corporate bodies and individuals should support the NHIS by truthfully funding it without hidden agendas or personal interests.
4. Public and private sector partnership should be solicited and enlisted into the scheme.
5. All forms of biases and favoritism in the selection of health service providers should be discouraged. There should be clearly stated guidelines for the selection of healthcare service providers.
6. There should be accountability and transparency in managing funds so that lukewarm attitude of people towards the service would be eradicated.
7. There should be zero tolerance for all forms of corrupt practices and misappropriation of funds in the scheme. All forms of corruption within the administration of the scheme should be eliminated.
8. Removal of all bottlenecks encountered in the registration process in order to fast track registration of new and existing employees into the scheme
9. Compulsory enrolment into the scheme should be enforced for all working Nigerians starting with those working in government organizations. This will improve our dismal health indices as most Nigerians will then have access to better healthcare services without the encumbrance of large out of pocket expenses.
10. Employers who are not willing to enroll their employees should be prosecuted.
11. Making policy statements to enable enrolment of self employed individuals and the immediate family members.
12. Creating an avenue where unemployed individuals and special needs groups can also access healthcare services at little or no cost even when they are not making contributions. The government can bear the cost incurred by the unemployed especially for those officially registered in a government certified unemployment register.
13. Health Maintenance Organizations and healthcare providers must realize that enrollees have the right to choose who their service providers are and can change to another when not satisfied with services rendered. Therefore, it is recommended that every provider strive to provide the best of services and the monitoring agencies should step up their

monitoring antennae in order to curb the menace of dissatisfaction which is fast becoming common place in the scheme.

Conclusion

As this work has demonstrated that the relationship between the operations of health insurance programme and sustainable development in Nigeria is both complex and elusive. Attempts to improve on Nigeria's healthcare delivery system has been a mirage of sort, not because there had not been policies, but because of poor implementation which may be as a result of government's deliberate actions to realize selfish interest or ideals. Strategies that can lead to improvements in both health and the environment, while contributing to economic development are not pursued vigorously. Policy implementations in Nigeria are buried in some kind of huge crater comparable to the settled caldera i.e. a large depression from the erupted volcano, whose only evidences are revealed in the after-billows and smouldering smoke. This despicable attitude reflects in the misleading actions of people who carry out instructions that are primarily meant to take Nigeria nowhere by those who appoint them. This has become some kind of culture and almost a definition of our social-cultural lifestyle, in fact, a national identity. Instead of genuine purposes giving birth to visions, Nigeria has been caught up in the reverse, actions reflecting our mindsets.

References

Abel-Smith, B. (1992). Health insurance in developing countries: Lessons from experience. *Health Policy and Planning*. 7 (3), 215-226

.

Abrahamson, K. V. (1997). Paradigms of sustainability. *In* S. Sörlin, ed. *The road towards sustainability*: A historical perspective, A sustainable Baltic Region, The Baltic University programme, Uppsalla University.

Akande, T. M & O. Bello. (2002). National Health Insurance Scheme in Nig. *Medilor J*. 7(1)

Akande, T; A. Salaudeen & O. Babatunde (2011). The effects of National Health Insurance Scheme on utilization of health services at University of Ilorin Teaching Hospital staff clinic, Ilorin, Nig. *Health Sci J*. Vol 5 (2).

Bhalla, A.& Lapeyre, F. (1997) "Social exclusion: Towards an Analytical and Operational Framework," *Development and Change*, 28 (3), 413-433

Chasek, Pamela, (2008). "Sustainable Development in the 21st Century." In Michael Snarr and D. Neil Snarr (eds.), *Introducing Global Issues*, fourth edition. Boulder: Lynne Rienner.

Collins, S. R; C. White and J. L. Kriss (2007). Whither employer based health insurance? The current and future role of United States Companies in the provision and financing of health insurance. *The Commonwealth Fund Publication* Number 1059. 2007. Available at www.commonwealthfund.org.

Ekman, B. (2007). The impact of health insurance on outpatient utilization and expenditure: evidence from one middle-income country using national household survey data. Health Research Policy Systems

Erinosho, O. A. (2006). *Health Sociology*. Ogun: Bulwak Consult.

Gana, D. (2010). Roles of the Healthcare Provider in Health Insurance. An article presented at Nigerian Medical Association Annual Conference, 2010

Human Development Report (1996). Published for the United Nations Development Programme (UNDP) New York Oxford: Oxford University Press.

Ibiwoye, A. & I. A. Adeleke. (2008). Does Nationaln Health Insurance Promote Access to Quality Health Care? Evidence from Nigeria. *The Geneva Papers* 2008 33(2): 219-233.

Kane, R. L; G. Keckhafer; S. Flood; B. Bershadsky & M. S. Siadaty. (2002). The effect of Evercare on Hospital use. J Am Geriatr Soc 2002 51(10): 1427-34.

Katibi, I. A; A. A. Akande & T. M. Akande. (2003). Awareness and attitude of Medical practitioners in Ilorin towards National Health Insurance Scheme. *Nig. Medical Practitioner Vol43* No.2.

Korte R et al (1992) Paying for health sector, a review and annotated bibliography of the literature in developing countries. *EPC Publication No.12*. London School of Hygiene and Tropical Medicine, London

Last, J. (2001). *Health and Sustainable Development: Definitions, Principles and Concepts* (draft working paper prepared as input for the WHO meeting on "Making Health Central to Sustainable Development", Oslo, Norway 29 November – 1 December 2001.

Li-Mei, C; W. W. Shi & L. Chung-Yi. (2001). The impact of National Health Insurance on the utilization of health care services by pregnant women: The Case in Taiwan. *Maternal and Child Health Journal* 5(1) 35-42.

Luo, X; G. Liu; K. Frush & L. A. Hey. (2003). Children's health insurance status and emergency department utilization in the United States. *Pediatrics 112*(2): 314 9.

McMichael, A.J. (2001). *Contribution to WHO Concept Paper: Health and Sustainable Development* (draft working paper prepared as input for the WHO meeting on "Making Health Central to Sustainable Development", Oslo, Norway 29 November – 1 December 2001.

Mills, A; Rasheed, F; Tollman, S. (2006). Strengthening Health Systems. In *Disease Priorities In Developing Countries, 2nd ed* by Jamison, D. T; J. G. Breman; A. R. Measham; G. Alleyne; M. Clacson and D. B. Evans et al. Washington DC: Oxford University Press and The World Bank. Chapter 3
.

Mohan, J. (2002) "Geographies of welfare and social exclusion: 5 Dimensions, consequences and methods," *Progress in Human Geography*, 26 (1), 65-75.

NHIS (2005) Standard treatment guidelines and referral protocol for primary health care providers.

Obadofin, M. O. (2006). NHIS – An Overview. A paper presented at an NHIS awareness seminar in Jos University Teaching Hospital.

Obiajulu Nnamuchi, (2008). "Transparency and accountability are critical to actualization of all human rights, including the right to health" (2008) 14 (1) *Journal of African Law 12 – 18.*

Pogge, Thomas. (2007). "Severe Poverty as a Human Rights Violation" in Thomas Pogge, ed., *Freedom from Poverty as a Human Right: Who Owes What to the Very Poor.* New York: Oxford University Press.

Sanusi, R. A & A. T. Awe. (2009). An Assessment of awareness level of National Health Insurance Scheme among Health Care Consumers in Oyo State, Nigeria. *The Soc Sci J.* vol. 4(2).

Segovia, J; A. C. Edwards; N. Li & R. F. Batlett. (1999). Patterns of utilization of general practitioners under Universal Health Insurance. *Abstr Book Assoc Health Serv Res Meet.* 223.

Silver, H. (1995) "Reconceptualizing social disadvantage: Three paradigms of social exclusion," in G. Rodgers, C. Gore and J. B. Figueiredo (eds.) *Social Exclusion: Rhetoric, Reality, Responses*, Geneva, Switzerland: International Labour Organization, 57-80.

Speck, S. K; M. Peyrot & C. W. Hsaw. (2003). Insurance coverage and health care consumers' use of emergency departments: has managed care made a difference? J Hosp Mark Public Relations 15(1): 3-18.

Sulzbach, S; Garshong, B; Owusu-Banahene, G. (2005). Evaluating the effect of the National Health Insurance Act in Ghana: Baseline Report: United States Agency for International Development.

United Nations Conference on Environment and Development (UNCED). (1992) http://www.un.org/geninfo/bp/enviro.html; and E. A. Parson and P. M. Haas, "A Summary of the Major Documents Signed at the Earth Summit and the Global Forum," *Environment*, October, 12–18.

United Nations (1987). Brundtland Report of the World Commission on Environment and Development (UNWCED) "*Our Common Future*".

von Schirnding, Y. and Mulholland, C. (2001). *Health and Sustainable Development*: *Key Health Trends.* Thematic review of Chapter 6, Agenda 21. Prepared by (WHO) as input to the report of the UN Secretary-General - Prepcom 1, CSD 10; 30 April-2 May 2001.

World Commission on Environment and Development (WCED) **(**1987**).** *Our Common Future* New York: Oxford University Press.

World Health Organization (2000). Round table discussion on inefficiency and wastage in the health sector. WHO, Geneva. Plateau state website.www.plateaustategov.ng

World Health Organization (2007). *World health report 2007:* A safer future. global public health security in the 21st century. Geneva.