



HEALTH SYSTEM

**POLITICAL ECONOMY OF UNIVERSAL HEALTH COVERAGE**

POLITICAL SYSTEM



ECONOMIC SYSTEM



POLITICAL ECONOMY OF UNIVERSAL HEALTH COVERAGE.

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## Introduction

In comparison to the concept of organized health care which had been in operation since the 1880s, the term “Universal Health Coverage” is relatively new. In 1883, Germany became the first country to start a compulsory sickness insurance program for workers only. Later, Austria, Hungary, Norway, Britain, Russia and the Netherlands followed suit creating healthcare programs up until 1912<sup>1</sup>. But, at this point, it was not truly a universal system because rural residents were not covered. Following World War II, universal health care systems began to be set up around the world. On July 5, 1948, the United Kingdom launched its universal National Health Service and became one of the basic models emulated worldwide.<sup>2</sup>

In 2012 the UN General Assembly implemented a resolution that underlined the need for governments to ‘urgently and significantly scale up efforts to accelerate the transition towards universal access to affordable and quality health-care services. In 2014, Universal Health Coverage Day was established to mark the anniversary of the UN General Assembly resolution<sup>3</sup>.

A lot has been written pointing to the fact that the expansion of health care is a political process and one often bound up with the growth of social welfare. A country’s progression towards UHC is characteristically political because it requires a coming together of political opportunities, available financial resources and the mobilization of strong political will<sup>4</sup>.

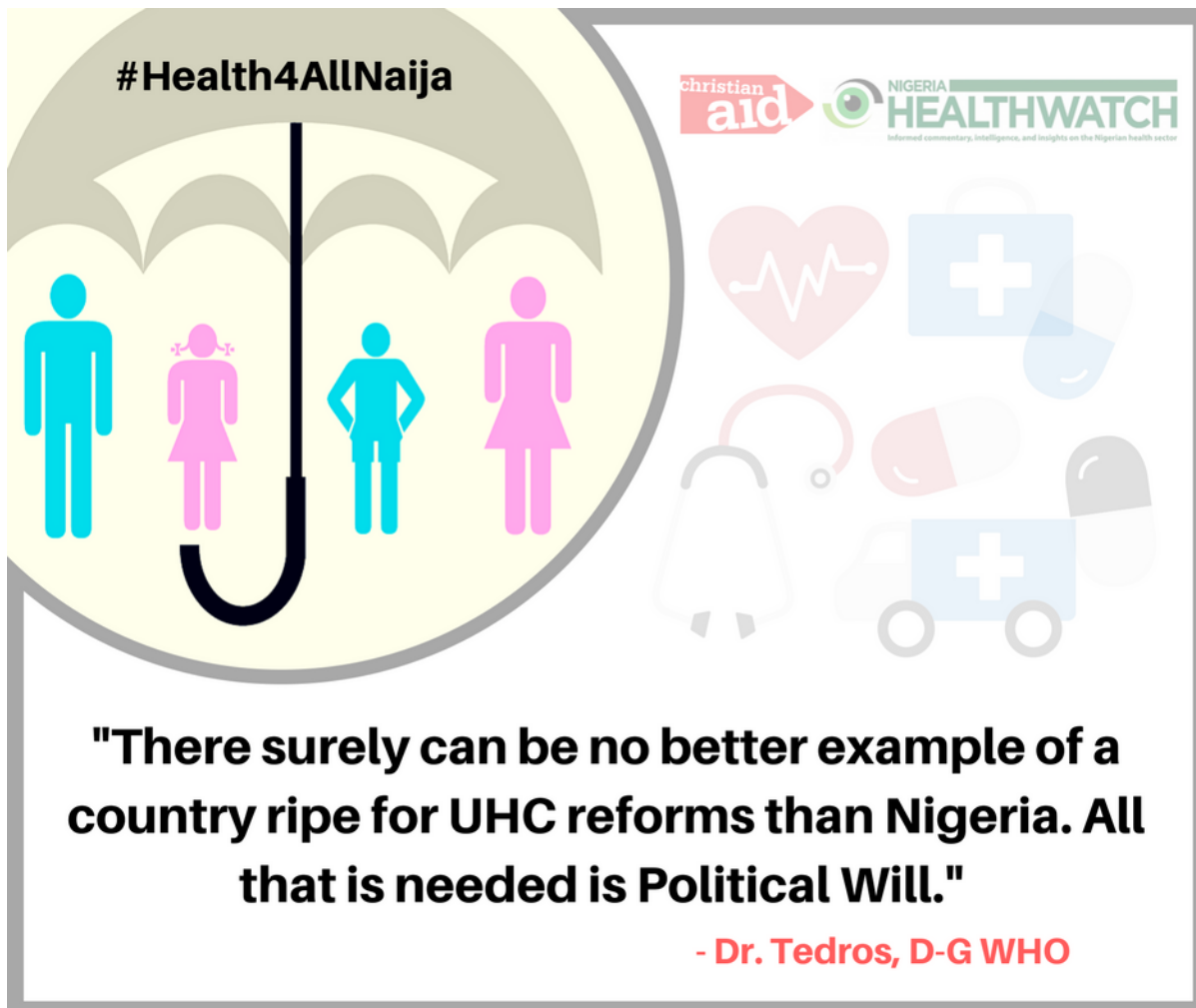
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<sup>1</sup>Historical Foundation of Universal HealthCare. Available at <http://www.healthcarereformmagazine.com/economics/historical-foundation-of-universal-healthcare/>. (Accessed on September 27, 2017)

<sup>2</sup>Universal Health Care: Lessons from The British Experience. Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447686/> (Accessed on September 27,2017)

<sup>3</sup>Political settlements and pathways to universal health coverage. Available at <https://www.odi.org/sites/odi.org.uk/files/resource-documents/10382.pdf> (Accessed on September 28, 2017)

<sup>4</sup>Universal Health Coverage: A Quest for All Countries But under Threat in Some. Available at <http://www.sciencedirect.com/science/article/pii/S1098301512041526> (Accessed on 28 September 2017)



**#Health4AllNaija**

**"There surely can be no better example of a country ripe for UHC reforms than Nigeria. All that is needed is Political Will."**

**- Dr. Tedros, D-G WHO**

All the top 51 countries with very high human development, according to the Human Development Index<sup>5</sup>, except the US, have made this transition because their governments have responded to the demand of most of the population to switch to a publicly financed health system and now, attention is turning to middle income countries (especially democracies) that have the fiscal capacity to finance a health system for everyone<sup>6</sup>.

Country	Population	GDP	Per Capita Health Exp.	UHC Status
Norway	5.137 million	\$498.3 billion	\$6,081	Yes
Australia	23.46 million	\$1.46 trillion	\$4,207	Yes
Switzerland	8.189 million	\$702.7 billion	\$6,787	Yes

<sup>5</sup>Human Development Index 2016. Available at [http://www.nationsonline.org/oneworld/human\\_development.htm](http://www.nationsonline.org/oneworld/human_development.htm) (Accessed on October 4, 2017)

<sup>6</sup>Universal Health Coverage is a potential Vote Winner. Available at <https://www.chathamhouse.org/expert/comment/universal-health-coverage-potent-vote-winner> (Accessed on 27 September 2017)

Germany	80.98 million	\$3.879 trillion	\$5,119	Yes
Denmark	5.643 million	\$352.3 billion	\$4,857	Yes
France	66.33 million	\$2.849 trillion	\$4,367	Yes
Netherlands	16.87 million	\$879.6 billion	\$5,277	Yes
United Kingdom	64.61 million	\$2.999 trillion	\$3,971	Yes
Canada	35.54 million	\$1.793 trillion	\$4,492	Yes
United States	318.6 million	\$17.39 trillion	\$9,024	No

### What is Universal Health Coverage?

Universal Health Coverage (UHC) is defined as access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access. UHC is a critical component of sustainable development and poverty reduction, and a key element of any effort to reduce social inequities. For UHC to be effective, there must be an efficient health system that provides the entire population with access to good quality services, health workers, medicines, etc. It needs a financing system to protect people from financial hardship and impoverishment from health care costs. While the path to UHC is specific to each country, the World Bank Group's aim is to support countries to build healthier, more equitable societies, as well as to improve their fiscal performance and country competitiveness<sup>7</sup>. Access to health services ensures healthier people; while financial risk protection prevents people from being pushed into poverty. Universal health coverage is a critical component of sustainable development and poverty reduction, and a key element to reducing social inequities<sup>8</sup>. UHC is the mark of a government's commitment to improve the welfare of all its people.

It is important to note that Universal Health Coverage does not require a universally applicable package of health care services that must be covered. Access to health care in the U.K. means something very different from access to health care in Ghana or Nigeria. The services needed vary from one location to another because the causes of ill-health also vary. All governments should decide what health services are most needed, and how to make sure they are universally available, affordable, efficient, and of good quality.

Universal Health Coverage is a political choice and a smart imperative. The vision and courage required has already been demonstrated by some, and the result will be a safer

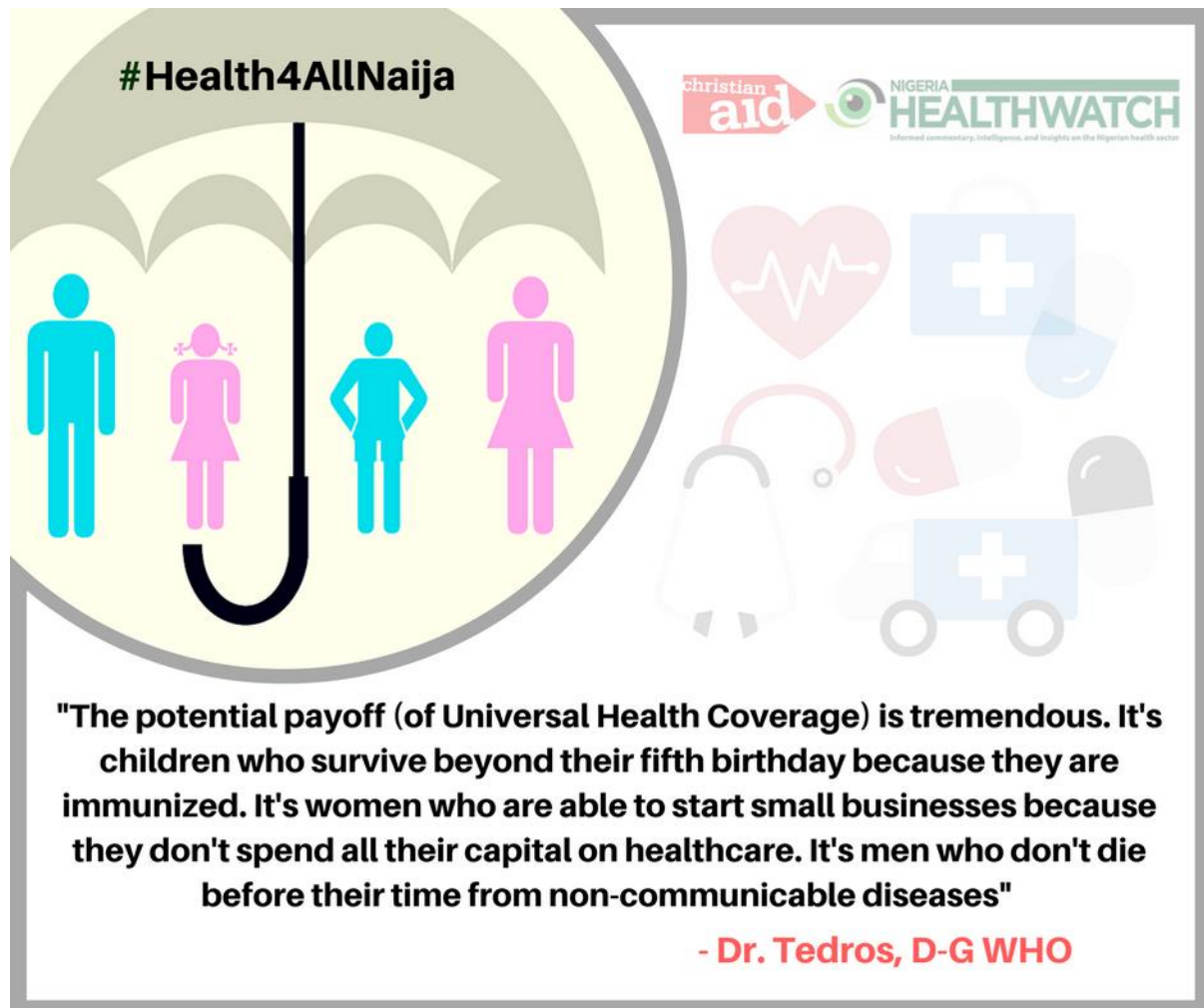
<sup>7</sup>UNIVERSAL HEALTH COVERAGE. Available at <http://www.worldbank.org/en/topic/universalhealthcoverage> (Accessed on October 4, 2017)

<sup>8</sup>Sustainable health financing, universal coverage and social health insurance. Available at [http://www.who.int/health\\_financing/documents/cov-wharesolution5833/en/](http://www.who.int/health_financing/documents/cov-wharesolution5833/en/) (Accessed on September 27, 2017)

and healthier world. Political leaders in Africa and around the world must agree that the path of inaction is one that cannot be taken<sup>9</sup>.

### Factors that Influence the Implementation of UHC

From well-defined benefit packages to improvements of health services provision, there is not a one-size-fits-all model for reaching universal health coverage but studies have shown that people living longer, children celebrating more birthdays and fewer families falling into poverty due to illness, are just a few of the outstanding results from countries increasingly adopting universal healthcare coverage in recent years.



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**"The potential payoff (of Universal Health Coverage) is tremendous. It's children who survive beyond their fifth birthday because they are immunized. It's women who are able to start small businesses because they don't spend all their capital on healthcare. It's men who don't die before their time from non-communicable diseases"**

**- Dr. Tedros, D-G WHO**

The road that any country takes towards UHC depends on its own history and distinctiveness. Nevertheless, the principles of UHC provide a robust guide when it comes to key technical and policy issues.

For UHC to be implemented, a country must have:

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<sup>9</sup>Universal Health Coverage and the Road to Equality. Available at [https://www.huffingtonpost.com/entry/universal-health-coverage-and-the-road-to-equality\\_us\\_59d3b2e1e4b02508a0a07a30](https://www.huffingtonpost.com/entry/universal-health-coverage-and-the-road-to-equality_us_59d3b2e1e4b02508a0a07a30) (Accessed on October 5, 2017)

1. A strong, efficient, well-run health system that meets priority health needs through people-centred integrated care.
2. An affordable system for financing health services so people do not suffer financial hardship when using them.
3. Essential medicines and technologies to diagnose and treat medical problems.
4. A sufficient capacity of well-trained, motivated health workers to provide the services to meet patients' needs based on the best available evidence.
5. Actions to address social determinants of health such as education, living conditions and household income which affect people's health and their access to services<sup>10</sup>.

### **Political Economy and how it Influences UHC**

While technical knowledge is important to run an effective UHC programme, the international community has increasingly come to recognise that technical solutions to development problems will have little practical effect if they are not also attuned to political economy concerns<sup>11</sup>. Researchers have only recently begun to apply political economy frameworks to global health issues. Nevertheless, there are signs of a growing appreciation of the importance of political economy issues to health coverage among theorists and key international organisations. For example, although WHO tends to avoid entanglement in its members' domestic politics, it has acknowledged that progress towards UHC is at least in part political: 'All countries can do more to raise funds for health or to diversify their sources of funding, to reduce the reliance on direct payments by promoting prepayment and pooling, and to use funds more efficiently and equitably, provided the political will exists'<sup>12</sup>.

The move towards UHC demands both technical knowledge and practical political strategies that are tailored to the national political economy setting. Individuals advocating for UHC are more likely to find success if existing institutions are supportive of their efforts, if the wider political and cultural context is conducive to redistribution for health and if it is possible, to take advantage of windows of opportunity<sup>13</sup>. The elevation of health reform on to the national political agenda depends on the preferences of governments for health improvement as opposed to other activities<sup>14</sup>.

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<sup>10</sup>Questions and Answers on Universal Health Coverage. Available at [http://www.who.int/healthsystems/topics/financing/uhc\\_qa/en/](http://www.who.int/healthsystems/topics/financing/uhc_qa/en/) (Accessed on September 27, 2017)

<sup>11</sup>The Politics of Universal Health Coverage in Low- and Middle-Income Countries: A Framework for Evaluation and Action. Available at <https://www.ncbi.nlm.nih.gov/pubmed/26195606> (Accessed on 28 September 2017)

<sup>12</sup>HEALTH SYSTEMS FINANCING The path to universal coverage. Available at [http://www.who.int/whr/2010/10\\_summary\\_en.pdf](http://www.who.int/whr/2010/10_summary_en.pdf) (Accessed on 28 September 2017)

<sup>13</sup>The political economy of universal health coverage. Available on <http://www.pacifichealthsummit.org/downloads/UHC/the%20political%20economy%20of%20uhc.PDF> (Accessed on 28 September 2017)

<sup>14</sup>Report from Bellagio: Advancing Political Economy of Global Health to Understand and Influence the Drivers of Universal Health Coverage. Available at <http://www.tandfonline.com/doi/full/10.4161/23288604.2014.991221> (Accessed on September 28, 2017)

## UHC Globally with Case Study of China and The United Kingdom

### China

Studies have shown that UHC reforms are often implemented on the heels of a political, economic or social crisis. Financial crises were the motivation for UHC reform in Indonesia, Thailand and Turkey; for France and Japan the reconstruction efforts post-World War II started off the reforms<sup>15</sup>. In China, the process of health reform began amidst the extreme poverty that existed some 30 years ago.

From the early 1950s to the early 1980s, the Chinese health care system made enormous improvements in health and health care. These achievements were largely due to improvements in the delivery of public health and primary care. Unfortunately, China was not able to continue this extraordinary trajectory after embarking on economic reform in 1978 because Chinese patients had increasing difficulty accessing affordable health care of reasonable quality<sup>16</sup>.

Eventually, this situation resulted in the advent of the widespread popular 1990s lament: “kanbingnan, kanbinggui,” or “insurmountable access barrier to health care, insurmountably high health costs”<sup>17</sup>. Both the phrase itself and the sentiment behind it soon gained wide recognition, appearing on television, in the print press and on internet social networks. Eventually, the intensity of the public outcry gained serious political attention but it was not backed by action. In April 2009, the Chinese central government announced the reform policy, with the goal to establish a universal, basic health-care system which will provide safe, efficient, and affordable basic health care services for all Chinese residents by 2020. In 2011, China, despite being a developing country with a population of 1.4 billion, achieved 95 per cent health insurance coverage<sup>18</sup>. Becoming the first large, middle-income nation with a population over 100 million that has attained effective universal coverage for more than primary care<sup>19</sup>.

### LESSONS LEARNED

China made significant progress in moving toward UHC by installing 3 major social health insurance schemes that covered more than 95% of the population now, utilization of health services and financial protection. The establishment of three different social health insurance schemes whose funds are pooled at the county or

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<sup>15</sup>Moving towards universal health coverage: lessons from 11 country studies. Available at <http://pubdocs.worldbank.org/en/279581440430453331/Moving-toward-universal-health-coverage-11-country-case-studies-Lancet-August-20-2015.pdf> (Accessed on September 27 2017)

<sup>16</sup>Universal Health Coverage The Case of China. Available at [http://www.unrisd.org/80256B3C005BCCF9/\(httpAuxPages\)/E15A4915BFDBEE8AC1257D9E0033BACE/\\$file/Hsiao%20et%20al.pdf](http://www.unrisd.org/80256B3C005BCCF9/(httpAuxPages)/E15A4915BFDBEE8AC1257D9E0033BACE/$file/Hsiao%20et%20al.pdf) (Accessed on September 27 2017)

<sup>17</sup>Ibid

<sup>18</sup>Early appraisal of China's huge and complex health-care reforms. Available at [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(11\)61880-1/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)61880-1/fulltext). (Accessed on September 27, 2017)

<sup>19</sup>Universal Health Coverage The Case of China. Available at [http://www.unrisd.org/80256B3C005BCCF9/\(httpAuxPages\)/E15A4915BFDBEE8AC1257D9E0033BACE/\\$file/Hsiao%20et%20al.pdf](http://www.unrisd.org/80256B3C005BCCF9/(httpAuxPages)/E15A4915BFDBEE8AC1257D9E0033BACE/$file/Hsiao%20et%20al.pdf) (Accessed on September 27 2017)

municipal level led to a de facto of more than 300 different health insurance plans with better benefit packages for the urban employees.

The Chinese government provided 85% of the premiums of the New Cooperative Medical Insurance for rural residents and 60% of the premiums of the Urban Resident Basic Medical Insurance.

## **WEAKNESSES**

- While in name China has achieved universal health coverage in recent years, benefits remain low; quality and extent of care and coverage vary widely.
- The existence of multiple schemes, complicated by massive migration, has resulted in weak portability of Social Health Insurance (SHI), creating barriers to access.
- Contingent on local conditions and financing capacity, benefit packages vary considerably across schemes, leading to systematic inequity

## **CHALLENGES**

- The country has a large health care demand gap due to an ageing population.
- Out-of-pocket cost is the most pressing issue, especially in rural areas.
- Many individuals are enrolled in multiple schemes, which causes inefficient use of government subsidies

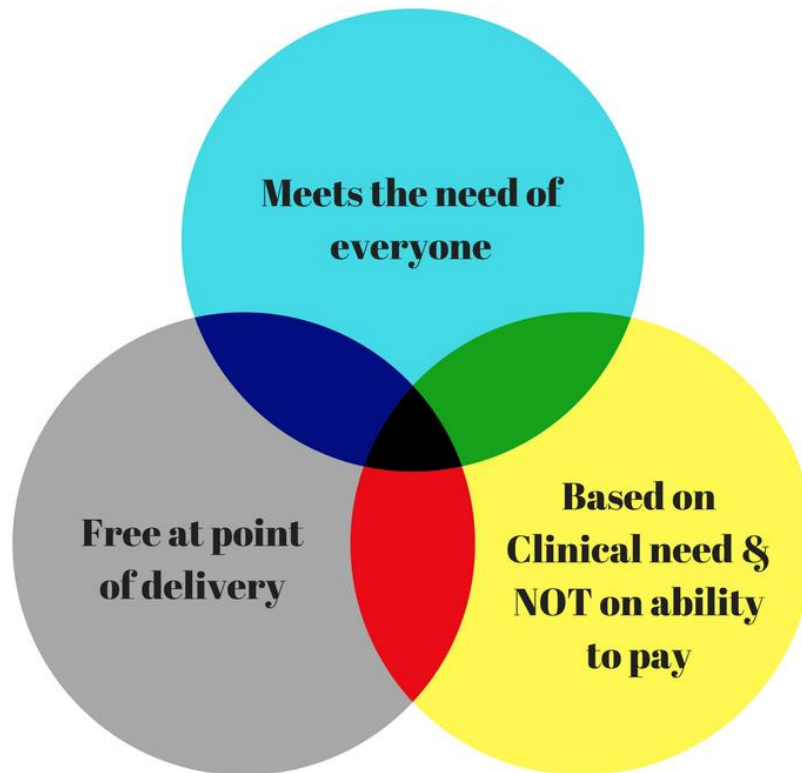
## **The United Kingdom**

At inception in 1948 the British National Health Service (NHS) was regarded as highly distinctive, with its features of Universal Health Coverage (UHC), comprehensive provision and services free at the point of use<sup>20</sup>. The NHS was born out of a long-held British ideal that good healthcare should be available to all, regardless of wealth. At its launch by Aneurin Bevan on 5 July 1948 it had at its heart three core principles: That it meets the needs of everyone, that it be free at the point of delivery, and that it be based on clinical need, not ability to pay<sup>21</sup>.

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<sup>20</sup>The British National Health Service 1948–2008: A Review of the Historiography. Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2639094/> (Accessed on 29 September 2017)

<sup>21</sup>National Health Service. Available at [https://en.wikipedia.org/wiki/National\\_Health\\_Service](https://en.wikipedia.org/wiki/National_Health_Service) (Accessed on September 29, 2017)



### **Core Principles of the United Kingdom's National Health Service at Inception**

The British NHS has made several good decisions that are transferable to other systems: Health care should be “free at the point of service,” a founding principle of the NHS; Fund health care from income taxes; establish a strong primary care base for a health care system; and reduce inequalities in historic funding that usually favor the affluent.

#### **LESSONS LEARNED**

The United Kingdom has made the most progress in developing provision of primary care, and this is one factor that explains why it is able to deliver universal and comprehensive health care for a much lower level of spending than the United States.

The model of the NHS, centrally funded out of taxation and thus politically directed, was quite different from that of other health systems reorganised after the war.

#### **WEAKNESSES**

NHS access is controlled by medical priority rather, leading to waiting lists for both consultations and surgery, up to months long,

The NHS measures medical need in terms of quality-adjusted life years (QALYs), a method of quantifying the benefit of medical intervention. It is argued that this method of allocating healthcare means some patients must lose out in order for others to gain, and that QALY is a crude method of making life and death decisions.

## CHALLENGES

- Aging population
- High cost of advanced technology and its impact on tight budgets
- Increased incidence of serious and expensive to treat diseases (cancer, HIV/AIDS)

## UHC in southeast Asia with case study of Thailand and Malaysia

### Thailand

In 2000, about one-quarter of people in Thailand were uninsured, and many other people had policies that granted incomplete protection. As a result, the country was in a healthcare crisis. About 20%<sup>22</sup> of the poorest Thai homes fell into poverty from out-of-pocket healthcare spending. In 2002 when Thailand was still a lower-middle income country, it became one of the few developing countries in the world to have successfully implemented Universal Health Coverage (UHC).

At first, Thailand had 5 different health insurance schemes. Health Insurance was fragmented, duplicated and the cover was inadequate. The government then adopted the Progressive Approach<sup>23</sup> which entailed strategic governmental reforms, integrating the benefit packages, provider payments and level of public budget subsidies, integration of all schemes into a single health insurance fund, while maintaining the institutional identities of the different schemes. They faced several challenges, one of which was in generating and building the citizen's trust to enrol in the UCH scheme and to demonstrate their dedication towards UCH of all Thais. To mitigate this, the government provided subsidies for the vulnerable population and that increased our enrolment rates. The journey to UHC was neither easy nor straightforward. UHC in Thailand is a product of the convergence of political will, civil society mobilization and technical know-how.

### LESSONS LEARNED

- Thailand's path towards universal coverage was influenced by politics, finances and health systems development.
- The success factors included strong political commitment, long-term investment in health infrastructure and human resources (particularly in rural and remote areas).
- Thailand has proved to the global community that 'universal health coverage' can be achieved even with a low GDP per capita.

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<sup>22</sup>What Thailand Can Teach the World About Universal Health Care. Available at <https://www.theguardian.com/health-revolution/2016/may/24/thailand-universal-healthcare-ucs-patients-government-political>. (Accessed on October 1, 2017)

<sup>23</sup>Achieving Universal Health Coverage in Thailand: What Lessons can Nigeria Learn. Available at <https://www.hsdf.org.ng/achieving-universal-health-coverage-thailand-lessons-can-nigeria-learn> (Accessed on October 1, 2017)

## WEAKNESSES

- Redirection of funds to primary care left many hospitals with large deficits.
- Staff need to be redeployed to primary care units, which are still underdeveloped.
- Confidence in primary care needs building, and the scheme may have to be modified to permit more choice and raise more funding

## CHALLENGES

- Harmonization of the three public insurance schemes has been slow, due to a lack of political will.
- Identifying new sources of funding and reducing non-essential outpatient elements within the benefit package.
- Ensuring a just system of financial contribution, as well as reducing geographic and social disparities in the access to essential services.

## Malaysia

Malaysia has been reported to have achieved UHC in 1980s when per capita income was \$3,700<sup>24</sup>. It attained Universal Health Coverage for comprehensive primary health services through the expansion of direct public provision, particularly in rural areas<sup>25</sup>. Additionally, Malaysia has been able to achieve levels of health status comparable to high-income countries with relatively lower health expenditures, spending about 4–5% of gross domestic product (GDP) on health, compared to an average of 11.6% in high-income countries. Such success has been attributed to the government's targeted expansion of rural primary care and effective intervention programs in high priority areas, especially, maternal and child health<sup>26</sup>. The country offers health coverage financed through general taxation to the entire population.

The public health system in Malaysia does not target specific populations as the Ministry of Health has been mandated to serve everyone. All Malaysians receive the same health care services, which are highly subsidized by the government. The poor and elderly have additional discounts. It is largely agreed that the Malaysian health system provides remarkable equity, access, and coverage through its comprehensive primary health care system<sup>27</sup>.

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<sup>24</sup>Achieving Universal Health Coverage: Learning from Chile, Japan, Malaysia and Sweden. Available at <http://www.r4d.org/resources/achieving-universal-health-coverage-learning-chile-japan-malaysia-sweden/> (Accessed on October 1, 2017)

<sup>25</sup>Malaysia: Approaches to covering poor, vulnerable, and informal populations to achieve universal health coverage. Available at [file:///C:/Users/NHWonlinemedia/Downloads/2015\\_ILN\\_Pop\\_Cov\\_Country\\_Profile\\_-\\_Malaysia\\_FINAL.pdf](file:///C:/Users/NHWonlinemedia/Downloads/2015_ILN_Pop_Cov_Country_Profile_-_Malaysia_FINAL.pdf) (Accessed on October 1, 2017)

<sup>26</sup>Chasm in primary care provision in a universal health system: Findings from a nationally representative survey of health facilities in Malaysia. Available at <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0172229> (Accessed on October 1, 2017)

<sup>27</sup>Malaysia: Approaches to covering poor, vulnerable, and informal populations to achieve universal health coverage. Available at [file:///C:/Users/NHWonlinemedia/Downloads/2015\\_ILN\\_Pop\\_Cov\\_Country\\_Profile\\_-\\_Malaysia\\_FINAL.pdf](file:///C:/Users/NHWonlinemedia/Downloads/2015_ILN_Pop_Cov_Country_Profile_-_Malaysia_FINAL.pdf) (Accessed on October 1, 2017)

## LESSONS LEARNED

- Malaysia has developed an extensive network of health services to its population mainly funded tax-based system.
- Malaysia has achieved UHC on at least two out of 3 dimensions: population coverage and service coverage.

## WEAKNESSES

- In Malaysia, outmigration of public health workers particularly specialist doctors remains an issue.
- While Malaysia has fared credibly in terms of curative care, there is a critical need to allocate more financing capacity to expand preventive care, in better managing escalating healthcare costs associated with the shifting of disease burden towards chronic non-communicable diseases

## CHALLENGES

- High OOP expenditure
- Raised health care cost and increasing prevalence of NCDs are major threats to sustainability of current health system

## UHC in Africa with case study of: Rwanda and Ghana

### Rwanda

In September 2012, Rwanda was recognized as one of the nine countries in Africa and Asia making significant progress towards achieving universal healthcare. The 1994 genocide in Rwanda crippled the healthcare system alongside the economy. However, it has since built one of the best healthcare systems in the region.

The Rwandan health insurance is run through a system called Mutuelles de Santé, a community-based health insurance scheme<sup>28</sup>, in which residents of a particular area pay premiums into a local health fund, and can draw from it when in need of medical care. Premiums are paid according to a sliding scale, with the poorest members of society entitled to use the service for free, while the wealthiest pay the highest premiums and are charged for treatment<sup>29</sup>.

The nation's turnaround from the devastation it experienced was the product of strong health leadership, a commitment to accountability and evidence-based practice, and highly focused attention on scaling up essential health tools and services<sup>30</sup>.

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<sup>28</sup>Towards Universal Health Coverage: An Evaluation of Rwanda Mutuelles in Its First Eight Years. Available at <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0039282#s1> (Accessed on October 1, 2017)

<sup>29</sup>Healthcare in Rwanda. Available at [https://en.wikipedia.org/wiki/Healthcare\\_in\\_Rwanda](https://en.wikipedia.org/wiki/Healthcare_in_Rwanda) (Accessed on October 1, 2017)

<sup>30</sup>Achieving a "Grand Convergence" in Global Health by 2035: Rwanda Shows the Way. Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4629710/> (Accessed on October 1, 2017)

## LESSONS LEARNED

- Rwanda's experience suggests that community-based health insurance schemes can be effective tools for achieving universal health coverage even in the poorest settings.
- The fast expansion of the Mutuelles program and high rates of enrolment suggests a strong societal consensus in equal opportunity for everybody to access health care with financial protection.
- The government played a crucial role through increased financial investment in the health sector, successful legislation of the entitlement of basic care for uninsured population, and an intensive nationwide campaign.

## WEAKNESSES

- Mutuelles enrolees in the poorest quintile still had significantly lower rates of utilization and higher rates of experiencing catastrophic health spending than Mutuelles enrolees in higher quintiles.
- The right to essential health care is a new concept in Rwanda; patients do not know their right with regards to healthcare; Generally, patients do not claim when some issues are not solved by health providers.
- No access to certain treatments; No access to private health providers

## CHALLENGES

- The Rwandan experience reveals that the path towards universal health coverage is not simple. While its population coverage is impressive, the quality of the healthcare provided can be limited.
- The healthcare package covered by the CBHI is incomplete. For instance, mental illness is not covered.
- Compulsory enrolment came at a price. It has created a strong pressure on the bureaucracy to maintain high membership.

## Ghana

Before the National Health Insurance Scheme (NHIS) in Ghana was conceived by former president John Kufuor, health care delivery was a cash and carry system. The health need of an individual was only attended to after initial payment for the service was made. Upon becoming president, former president Kufuor replaced it with the insurance scheme that ensured that treatment was provided first before payment for Ghanaian citizens. In 2003, the scheme was passed into law. Like many countries in the world, Ghana's health insurance was fashioned out to meet specific needs of Ghanaian citizens<sup>31</sup>.

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<sup>31</sup>National Health Insurance Scheme(Ghana). Available at [https://en.wikipedia.org/wiki/National\\_Health\\_Insurance\\_Scheme\\_\(Ghana\)](https://en.wikipedia.org/wiki/National_Health_Insurance_Scheme_(Ghana)) (Accessed on October 1, 2017)

The health insurance model in Ghana is the only one in sub-Saharan Africa that aims to provide a standardized, almost comprehensive and portable package of health benefits to all residents, delivered by accredited public and private providers who are reimbursed from a single national fund with no fees at the point of service, and that collects 90 percent of its revenues from dedicated taxes<sup>32</sup>.

Studies have shown that NHIS enrollees use health services more than non-enrollees overall and are more likely to use formal care services. Results of financial risk protection have been positive. This is one of the goals of the NHIS. Health system analysis showed that insured patients paid less out of pocket than the uninsured.

The Ghana case holds myriad lessons for other countries striving to increase access to affordable health care, on concerns such as national level financing and risk pooling, the merging of centralized authority with decentralized administration, and the purchasing of health service from public and private providers<sup>33</sup>.

## **LESSONS LEARNED**

- Made significant progress in providing financial risk protection for residents in Ghana over the past decade.
- Improved health-seeking behaviour of a significant proportion of the population evidenced by substantial increase in membership and utilization of health care services.
- Increased financial flows for health service delivery, however, there has been a retrogression in the last few years.

## **WEAKNESSES**

Ghana has a well-developed health system, but it faces critical bottlenecks. Policies and plans are in place, and innovative reforms are under way. However, in some cases:

- Standards have not been established; in others, implementation is weak and variable along geographical lines.
- Quantity and access have increased, quality of care remains problematic.
- Capital investment maintenance on a recurring basis is also inadequate.

## **CHALLENGES**

- Financial sustainability, lack of cost containment, slow growth, equity in membership coverage, quality of care.
- Enrolment in the NHIS has stagnated at about 40 % of the population, after rising rapidly in the early years of its establishment, the “Universal” in UHC and Ghana’s National Health Insurance Scheme: policy and implementation

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<sup>32</sup>Building on Community-based Health Insurance to Expand National Coverage: The Case of Ghana. Available at <file:///C:/Users/NHWonlinemedia/Downloads/Building-on-Community-based-Health-Insurance-to-Expand-National-Coverage-The-Case-of-Ghana.pdf> (Accessed on October 1, 2017)

<sup>33</sup>Ibid

## Nigeria

Nigeria, is a federal republic in West Africa, bordering Benin in the west, Chad and Cameroon in the east, and Niger in the north. It comprises 36 states and the Federal Capital Territory, where the capital, Abuja is located. With approximately 186 million inhabitants, Nigeria is the most populous country in Africa and the seventh most populous country in the world. The official language is English<sup>34</sup>.

In 2015, Nigeria was the world's 20th largest economy, worth more than \$500 billion and \$1 trillion in terms of nominal GDP and purchasing power parity respectively. It overtook South Africa to become Africa's largest economy in 2014. It has been identified as a regional power on the African continent, a middle power in international affairs, and has also been identified as an emerging global power<sup>35</sup>.

On the 31<sup>st</sup> of October 2014, Nigeria's National Health Act 2014 (NHA 2014) was signed into law. First proposed in 2004, the development and enactment of a legal framework for health in Nigeria took close to a decade. With this development, Nigeria after over 50 years as an independent country, now has a National Health Act 2014 (NHA) which provides a legal framework for the regulation, development, and management of a National Health System and set standards for rendering health services in Nigeria and for related matters<sup>36</sup>.

The Act was enacted for providing healthcare insurance to vulnerable people in the society. It was also set to achieve Universal Health Coverage and meet the Millennium Development Goal (MDGs) target. The Act provides that there would be improved funding of health care services at the grass root so that people don't have to travel far to access medical services. Through this Act states can also participate in improving health centres through a counterpart fund that would enable them benefit from the consolidated funds<sup>37</sup>.

## History of UHC in Nigeria

Nigeria's first attempt at building a healthcare system was made in 1962<sup>38</sup>. The then federal minister of health, Dr. M. A. Majekodunmi, presented a bill in parliament for its enactment in Lagos but it was rejected. In 1988, the then health minister commissioned a committee that recommended the template for the present day National health insurance scheme (NHIS). The law was signed in May 1999 but became operational in 2005. After the law became operational, a presidential mandate by President Jonathan

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<sup>34</sup> Nigeria. Available at <https://en.wikipedia.org/wiki/Nigeria>. (Accessed on December 18, 2017)

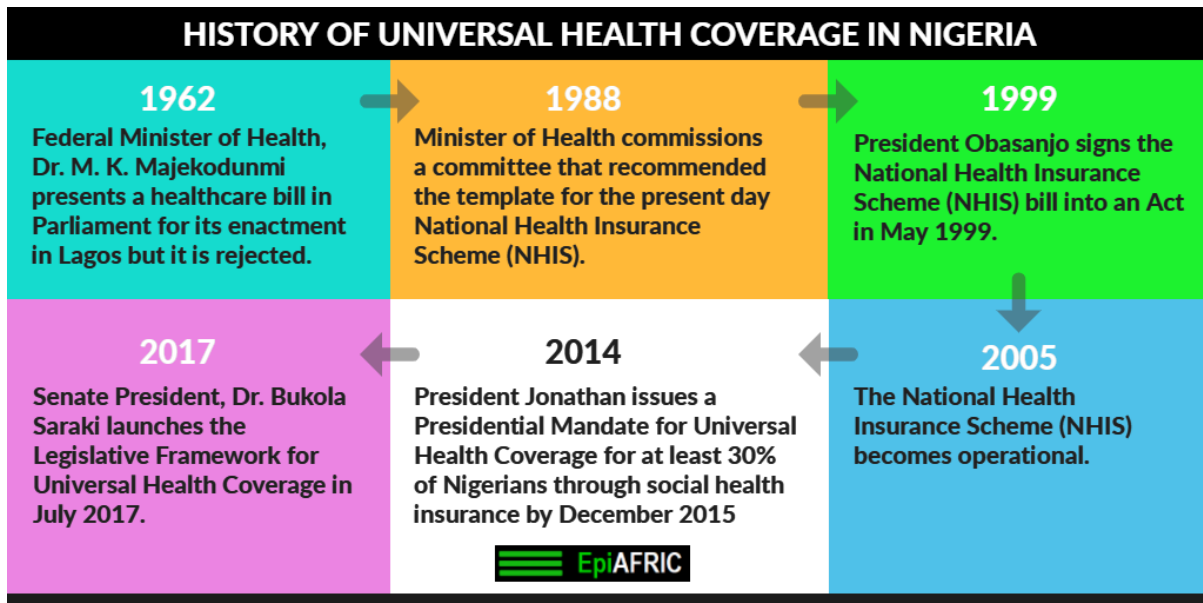
<sup>35</sup> Ibid

<sup>36</sup> Nigeria's National Health Act: An assessment of health professionals' knowledge and perception. Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5036296/>. (Accessed on December 18, 2017)

<sup>37</sup> FG TO FULLY IMPLEMENT THE NATIONAL HEALTH ACT IN 2017 – MINISTER OF HEALTH. Available at <https://nigeria.savethechildren.net/news/fg-fully-implement-national-health-act-2017-%E2%80%93-minister-health>. (Accessed on December 18, 2017)

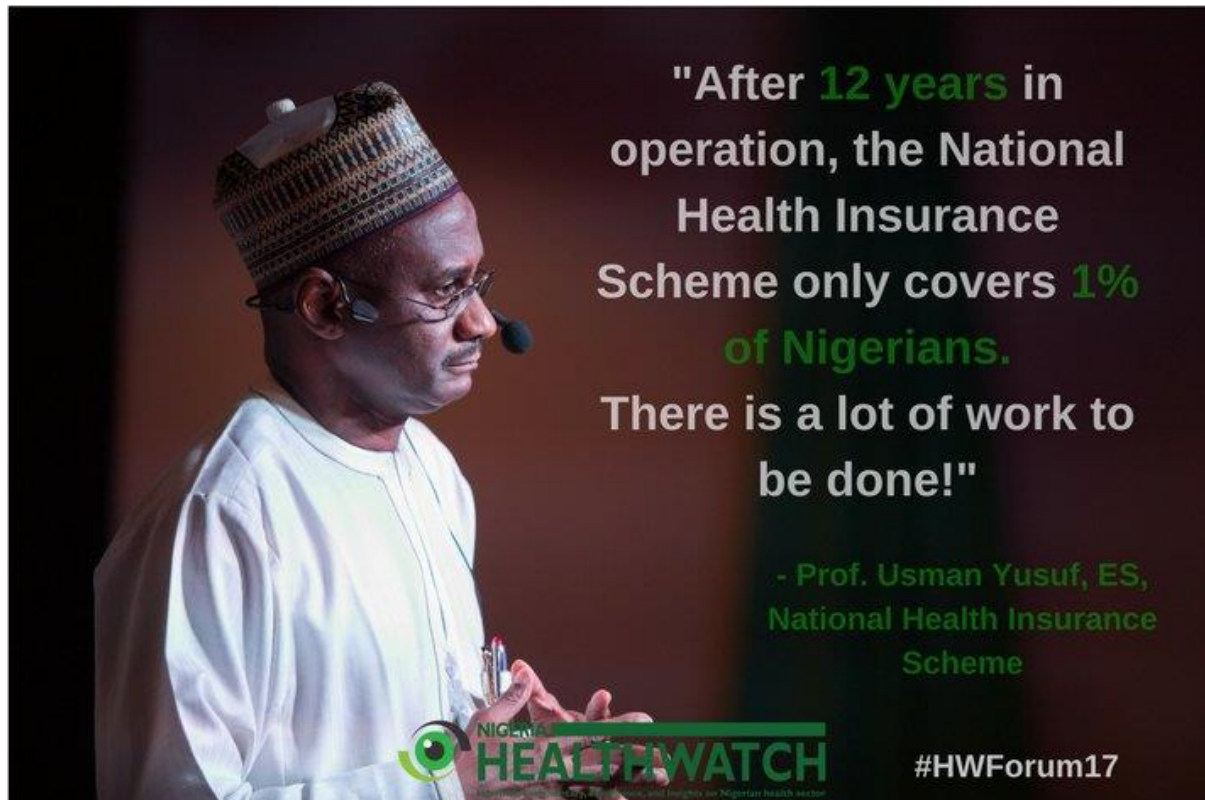
<sup>38</sup> UNIVERSAL HEALTH COVERAGE: Sustainable Health Financing in Nigeria Through Health Insurance. Available at <https://www.medicalworldnigeria.com/2015/03/universal-health-coverage-sustainable-health-financing-in-nigeria-through-health-insurance#.WdKaYWhSy01> (Accessed on October 1, 2017)

was given to ensure a universal coverage of all Nigerians by 2015 through the social health insurance<sup>39</sup>.



The National Health Insurance Scheme (NHIS) is designed to facilitate fair financing of health care costs through risk pooling and cost-sharing arrangements for individuals. Since its launch in 2005, the same year Ghana launched its own, while the Ghana scheme has covered well over 50 per cent of its population, the Nigeria NHIS, according to Prof. Usman Yusuf ES, National Health Insurance Scheme, only covers 1% of Nigerians leaving a huge portion of the citizens, especially the poor, to pay for healthcare from their pockets.

<sup>39</sup>History of Health Insurance in Nigeria. Available at <http://www.ehealthinsurance.com.ng/history-of-health-insurance-in-nigeria/> (Accessed on October 1, 2017)



## Problems of UHC in Nigeria

The issues hindering Nigeria from achieving UHC are abundant and intricate. The factors that contribute to the poor state of the National health services are both demand and supply-side and these include:

**Inadequate financing:** The Abuja Declaration, signed in 2001 by all member countries of the African Union, including Nigeria, who was the host, recommended that for the continent to be at par with other nations of the world in terms of healthcare provision, 15 per cent of their annual budget, at the least, be allocated to the health sector<sup>40</sup>. But 17 years after, Nigeria has been unable to implement this commitment. Currently, the health budget in Nigeria is at 4.17 per cent of the annual budget and this is extremely low<sup>41</sup>.

**Weak governance and enforcement:** State governments in Nigeria have substantial autonomy and exercise considerable authority over the allocation and utilization of their resources. This arrangement constrains the leverage that the federal government has over state and local governments in terms of getting them to invest in the health sector. Therefore, top-down approaches continue to fail to produce improvements in access, financial protection and health indicators. In addition, the public system lacks transparency and enforcement, making it subject to corruption and lending inadequate

<sup>40</sup> Nigeria's Grossly Inadequate 2017 Health Budget. Available at <https://www.thisdaylive.com/index.php/2017/02/09/nigerias-grossly-inadequate-2017-health-budget/>. (Accessed on January 8, 2018)

<sup>41</sup> Nigeria's Poor Implementation of Health Pledges. Available at <https://www.thisdaylive.com/index.php/2017/10/12/nigerias-poor-implementation-of-health-pledges/>. (Accessed on January 8, 2018)

medical and administrative capacity to produce services efficiently and of adequate quality. A weak institutional framework leads to high uncertainty and risk and thereby low levels of trust which reduces the willingness of individuals to invest. As a consequence, the willingness to prepay for health care remains low.

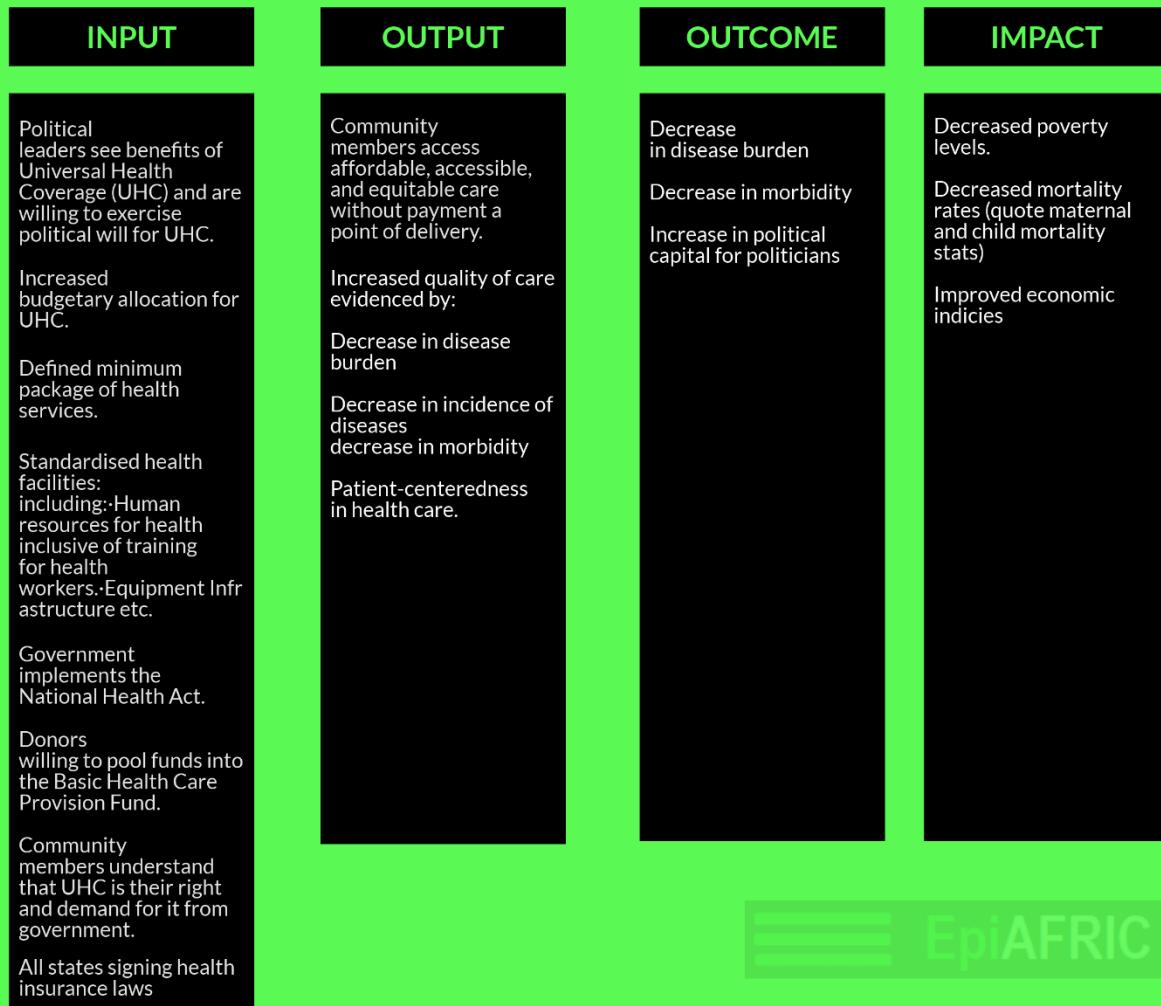
**Inadequate infrastructure and poor service quality:** Low government spending combined with weak institutions and lack of enforcement lead to inadequate health infrastructure and poor service quality. Many health facilities lack access to clean water and a reliable supply of electricity, face shortages of medical equipment, and are missing necessary medications or blood to treat their patients. In addition, there is a deficiency in qualified health professionals in particular in poor communities. Large disparities exist between urban and rural areas and between states due to the variation in remuneration packages for health professionals across states and between federal and state level, health professionals gravitate to better paying federal facilities and states. Private providers mainly operate in urban settings where income levels are the highest. This situation results in a lack of qualified and competent health professionals for individuals who live in poor rural areas that tend to bear a greater disease burden

**Household poverty and insufficient risk pooling:** The health financing system is mainly based on out-of-pocket user-fees; payments are made at the point of service. In a country where nearly two-thirds live below the poverty line, this is a huge burden. The willingness to prepay for health care is low in an environment of low trust in which people are unsure of benefits from a product or service in the future against a payment today. In Nigeria, prepaid spending or risk-pooling only encompasses 3.1 percent of all private health spending. The remaining private spending consists of out-of-pocket payments. This makes the development of risk pools difficult and creates an environment that is not conducive to private investment. The high share of out-of-pocket expenses is the most expensive, least efficient and least inclusive financing channel. It weighs heavily on household budgets and forces many into poverty due to unpredictable catastrophic health expenditure<sup>42</sup>.

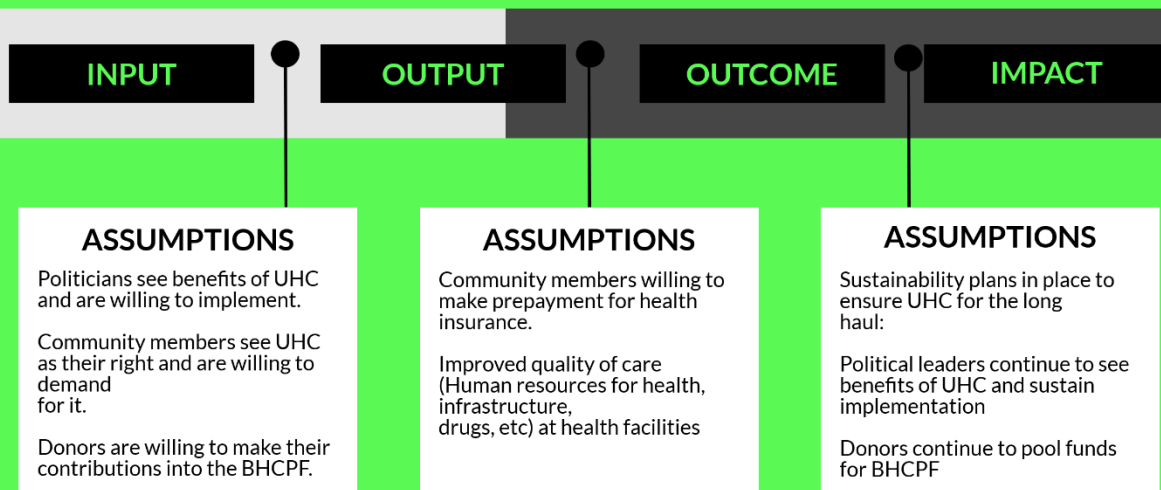
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<sup>42</sup> Achieving universal health coverage in Nigeria one state at a time. Available at <https://www.brookings.edu/wp-content/uploads/2016/06/Achieving-Universal-Health-Coverage-in-Nigeria.pdf> (Accessed on October 1, 2017)

## THEORY OF CHANGE - POLITICAL ECONOMY OF UNIVERSAL HEALTH COVERAGE



EpiAFRIC



### How the Nigerian Political Economy Influences UHC Implementation

Last year, in Nigeria, only four percent (N499.3 billion) of the N12.2 trillion total budgets of the two tiers of government was spent on public health. And this year, less

than five percent of the N13.5 trillion combined budgets of the federal and state governments will be spent on public health<sup>43</sup>. The two absolute foundations a country needs to implement UHC are genuine political commitment by the head of state and public financing<sup>44</sup>. Although Nigeria now has the domestic financial resources to reach UHC, it does not allocate enough funds for health interventions.

In Nigeria, different policies have been established which when applied will influence the implementation of UHC. An example is the Basic Health Care Provision Fund (BHC PF) which was provided in the 2014 National Health Act. This requires that 1% of the consolidated revenue fund is provided for to be invested in expansion and upgrade of health facilities, research and human capital development to address key communicable diseases. Without these investments, the economy will continue to lose billions of Naira through Nigerians that travel abroad to access medical services, while the poor continue to die from treatable and preventable diseases<sup>45</sup>.

UHC is not achievable without a reform in the health financing system. 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<sup>46</sup>. For Nigeria to improve its citizen's health, reduce poverty and achieve prosperity and achieve universal health coverage, political will must be expressed and be translated into policies that ensure increased public health care financing for the benefit of all Nigerians.

### **State Health Insurance Laws**

The slow growth of the NHIS prompted the Health in Africa Initiative of the International Finance Corporation of the World Bank Group to conduct a study on the NHIS where it identified some constraints affecting the expansion of the coverage. Issues identified include the voluntary nature of participation of the scheme, the lack of buy-in by state governments, the lack of a robust ICT platform to implement the scheme, and the lack of clarity on the regulatory functions of NHIS, for instance, its implementation of a public sponsored scheme. Following the acceptance of the report by the management of the NHIS in 2013 the agency went on to implement some of the recommendations which included the recognition of state governments to set up their State Supported Health Insurance Schemes (SSHIS)<sup>47</sup>. The development of SSHIS will allow the participation of private players to deliver care to a population that are normally left out and will increase consumer choice and even incentivise the movement of providers to areas not normally covered<sup>48</sup>. If policy makers wish to expand insurance coverage for the children, unemployed and elderly and improve affordability of health care for workers in the

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<sup>43</sup>FG, states spend 4.3% of N13.5tr budgets on health. Available at <https://www.dailytrust.com.ng/news/general/fg-states-spend-4-3-of-n13-5tr-budgets-on-health/182040.html> (Accessed on October 1, 2017)

<sup>44</sup>Interview with Robert Yates on the political economy of Universal Health Coverage. Available at <https://www.youngleadersforhealth.org/single-post/2017/05/26/Interview-with-Robert-Yates-on-the-political-economy-of-Universal-Health-Coverage> (Accessed on October 1, 2017)

<sup>45</sup>Dear President Buhari, honour the 2001 Abuja declaration and deliver a genuinely Pro-Poor 2016 Budget. Available at <http://nigeriahealthwatch.com/dear-president-buhari-honour-the-2001-abuja-declaration-and-deliver-a-genuinely-pro-poor-2016-budget/> (Accessed on October 1, 2017)

<sup>46</sup>Enhancing Political Will for Universal Health Coverage in Nigeria. Available at [file:///C:/Users/NHWonlinemedia/Downloads/mr\\_578.pdf](file:///C:/Users/NHWonlinemedia/Downloads/mr_578.pdf) (Accessed on October 1, 2017)

<sup>47</sup>Achieving Mandatory Health Insurance Coverage. Available at <https://www.thisdaylive.com/index.php/2017/09/21/achieving-mandatory-health-insurance-coverage/>. (Accessed on January 8, 2018)

<sup>48</sup>Ibid

informal sector, the most effective and far-reaching approach would be comprehensive, state initiated health insurance reform.

States can now have their own health insurance schemes and the NHIS is working with state governments to establish these insurance schemes. As a result, 14 states: Lagos, Oyo, Ekiti, Delta, Bayelsa, Cross River, Akwa Ibom, Kwara, Abia, Adamawa, Kano, Anambra, Sokoto, and Enugu<sup>49</sup> have passed health insurance bills into law. And because instituting a system of UHC for Nigeria will require a flexible architecture to deal with inequities in health outcomes, regional and sociocultural diversity and health care needs of populations in different locations, the bills are tailored to meet the respective needs of their communities. These states are yet to implement these laws.

Implementing State Health Insurance Schemes will make a strong political commitment to equitable and sustainable financing mechanism. As it will encourage state governments to provide and sustain financial access to quality services in communities within the state.

On the 6<sup>th</sup> of July 2017, Nigeria Health Watch in partnership with Christian Aid Nigeria convened an experience sharing meeting to deepen the conversation around state health insurance laws. The main purpose of the Experience Sharing Meeting was to create an opportunity for stakeholders within the health insurance space to share experiences. Seven States shared their experiences of health insurance laws. Three had already signed their laws, three were in the process of signing their laws while one was about to begin.

### **The Legislative Network for Universal Health Coverage**

The president of the Senate of Nigeria, Bukola Saraki, recently launched the National Assembly Legislative Network for Universal Health Coverage. It will work to guarantee health coverage for all citizens.

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<sup>49</sup> Advocates for health at the Nigeria Universal Health Coverage Day Walk in Abuja. Photo credit: Nigeria Health Watch Universal Health Coverage and the role of “marketers” for health in Nigeria. Available at <http://nigeriahealthwatch.com/universal-health-coverage-and-the-role-of-marketers-for-health-in-nigeria/>. (Accessed on January 8, 2018)



The network is the first of its kind anywhere in the world and seeks to bring together legislators from the thirty-six states of the Federation – Speakers of the State Houses of Assembly, House Clerks, Chairs of Health and Appropriation – for learning, knowledge and experience sharing on a wide variety of health issues as they relate to the legislature. Some of its objectives are:

- To achieve improved appropriation to the health sector by deepening the knowledge of lawmakers on economic, social, health and political benefits of improved funding towards UHC.
- To ensure prompt and adequate release of allocated funds by working with lawmakers to hold relevant central budget agencies accountable for fund releases.
- To ensure the timely passage of relevant high-quality health laws, especially the legal framework of State Supported Health Insurance Schemes (SSHIS).

During the launch, the senate president gave a guarantee that if the 2018 budget was brought to him with the 1% CFR, he would pass it.

Nigeria Senate President "Bring the 2018 budget with the 1% CFR allocation to PHC and I guarantee that we will pass it" 👍👍👍



## On-Going Universal Health Coverage Advocacy

Since the enactment of the National Health Act in 2014, there have been several advocacy efforts targeted at ensuring that there is motion in the right direction that will provide the revolution needed in and through the NHIS to progress towards Universal Health Coverage.

In August 2017, Christian Aid began the implementation of a one-year project, titled, 'Closing the Gap to Sustainable Health Care Access in Nigeria'. This project is designed to identify the current status of health insurance and identify the problems or challenges delaying the take-off of health insurance in the selected states. It will also identify the states' health policy direction which will, help among others, to establish the states' leadership commitment to health insurance.

To accelerate health financing reforms in pursuit of universal health coverage, the Federal Ministry of Health (FMoH), in collaboration with the West African Health Organization (WAHO), established a National Network of Advocacy Champions for Adequate Health Financing to contribute to better health financing. The Network will use strategic and targeted advocacy action at relevant points in the budget development process to hold Federal and State governments accountable for their financial resolutions, specifically for health. The WAHO is providing the Network with an initial US\$50,000 to begin operations.

In August 2017, Partnership for Advocacy in Child and Family Health (PACFaH) in partnership with Premium Times Centre for Investigative Journalism (PTCIJ) the Project for Advocacy in Child and Family Health, and the Project Pink Blu had a two day National Health Dialogue where stakeholders in the Health and Development sectors came together to discuss the Challenges and Prospects of Universal Health Coverage in Nigeria.

In September 2017, the Wellbeing Foundation Africa (WBFA), the continent's leading maternal and child health charity, attended the 72nd United Nations General Assembly (UNGA), in New York, where the Foundation's team continued their mission to increase investments in health infrastructure, while imploring national governments, the private sector and NGOs to commit to universal health coverage (UHC). Throughout the UNGA week, the organisation took on the task of urging partners to invest in health infrastructure and to commit to Universal Health Coverage at a range of high-level, ensuring that relevant stakeholders are effectively engaged.

The Centre for Social Justice (CSJ) dragged the Federal Government to court over alleged violation of health laws in the country. The suit was for the enforcement of the provisions of the National Health Act (section 11 (2) (a) on the Basic Health Care Provision Fund. It listed, President Muhammadu Buhari, the Senate, the House of Representatives, the Minister of Finance and the Attorney-General of the Federation (AGF) and Minister of Justice as defendants. The plaintiffs are seeking among others a Declaration that the Defendants are under a statutory duty to give effect to Section 11(2) (a) of the National Health Act of 2014; Declaration that the 1st Defendant's continued refusal to execute, implement, and give effect to Section 11 (2) (a) of the National Health Act of 2014 constitutes a flagrant violation of Section 5 (1) (b) of the

Constitution of the Federal Republic of Nigeria; and Declaration that the 4th Defendant is under a public duty to ensure that provisions are made in the Annual Federal Budgets for the Federal Government's annual statutory grant of not less than one percent (1%) of its Consolidated Revenue Fund to the Basic Health Care Provision Fund established by the National Health Act of 2014<sup>50</sup>.

## Conclusions

Access to affordable and quality health care is a human right and should be made available to all everyone. Universal Health Coverage is a critical component of sustainable development and poverty reduction, and a key element of any effort to reduce social inequities. It doesn't require a one size fits all approach, countries that have achieved UHC have tailored the laws to fit their individual needs. Using Ghana and Rwanda as an example, evidence has shown that Universal Health Coverage is possible in Low and Middle-Income Countries and can be achieved in Africa. 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.

Globally, there is a growing appreciation of the importance of political economy. The World Health Organisation (WHO) has acknowledged that progress towards UHC is in part political and if countries possess the political will, the necessary economic reforms can be carried out to make UHC possible.

Nigeria is performing extremely badly when it comes to health. For Nigeria to improve people's health, reduce poverty and achieve prosperity, UHC must be pursued at all levels

Nigeria has the economic means to implement UHC but lacks the necessary political commitment. 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 achieving this health goal.

## Recommendations

For Nigeria to improve people's health, reduce poverty and achieve prosperity, UHC must be vigorously pursued at all levels. Government at all tiers should affirm, through policies and legislation, that the achievement of UHC in Nigeria is a priority.

Government should establish a Universal Health Coverage fund with inventive funding sources. For Nigeria to fulfil the 2001 Abuja Declaration, where African countries pledged to allocate 15% of their budgets to improving health, health must be seen as a

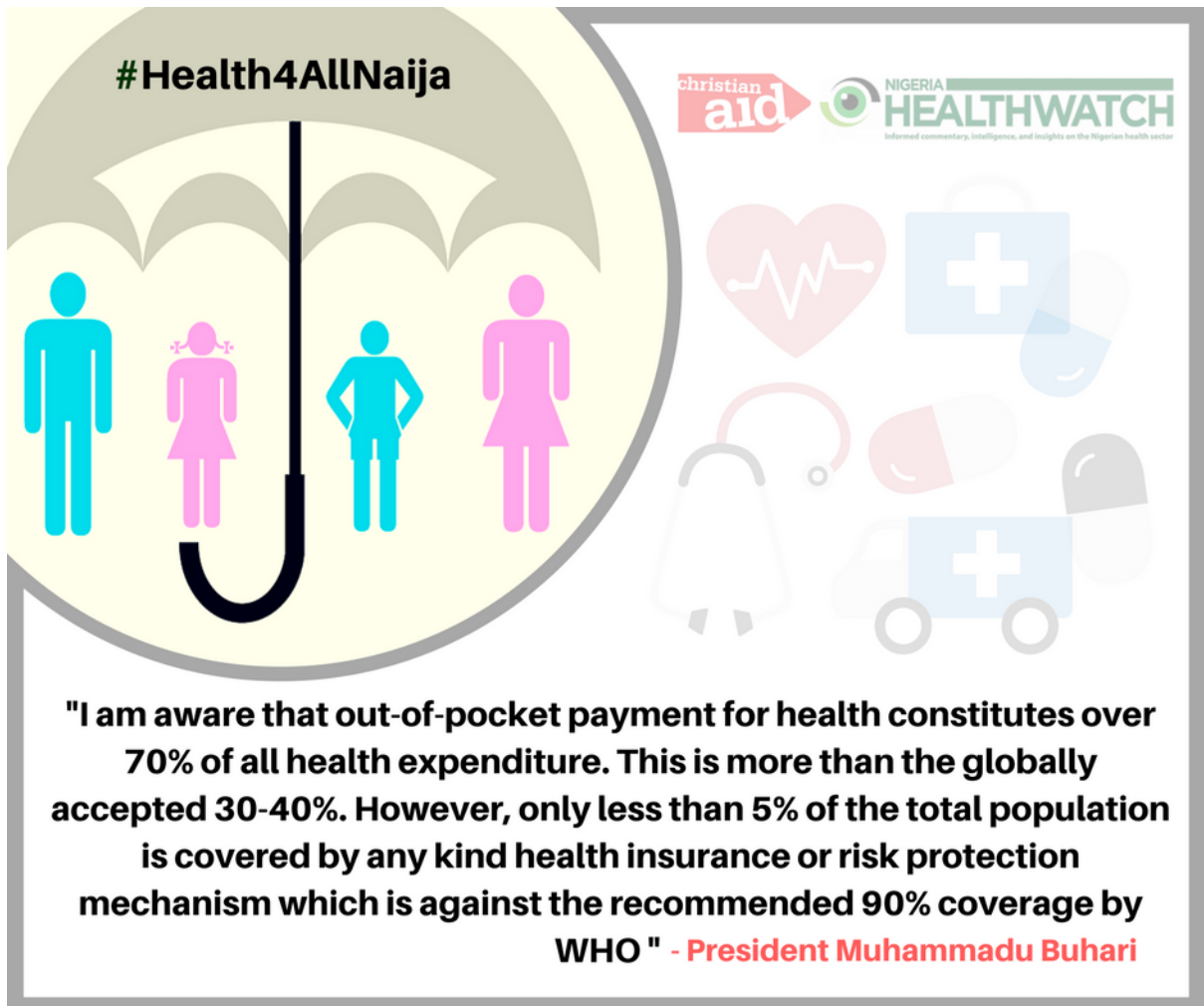
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<sup>50</sup> Violation Of Health Laws: CSJ Sue FG, NASS. Available at <http://www.dnlpartners.com/violation-health-laws-csj-sue-fg-nass/>. (Accessed on January 08, 2018)

fundamental right by political actors and decision makers. The government must make good on the National Health Act's promise to ensure Nigerians' right to access to health services by implementing the Basic Health Provision Fund. NHIS should be expanded to cover people in both the formal and informal sectors by making health insurance compulsory. Nigeria needs a deliberate health financing policy to protect the poor and protect them from out-of-pocket payments for health their health needs.

For States that plan to establish Health Insurance Schemes:

1. To ensure quality care, States should bring health facilities to standard. This includes having the right equipment, commodities, buildings and human resources. When schemes become functional, the facilities (supply) can then keep up with the health needs of the people (demand).
2. State Health Insurance Scheme is not another way to generate revenue. Instead, the programs and activities of the Scheme should have the health of the people at its core (patient-centred care).
3. Due to cultural and religious reasons, some States are not comfortable having the word "Insurance" in the names of their schemes. States should always consider such contextual factors to ensure community ownership of their schemes.
4. To ensure sustainability, States should involve community members from the start and all through the process. Let them be drivers of the process. "Politicians come and go but strong communities remain".
5. Over the years, individuals have made contributions for pensions, health insurance etc but have not benefited from what they paid for. As a result, communities are distrustful of government. States must consider this and make efforts to build trust. People should be convinced that Health Insurance Scheme is not another avenue to defraud them.



**#Health4AllNaija**

**christian aid** **NIGERIA HEALTHWATCH**  
Informed commentary, intelligence, and insights on the Nigerian health sector

**"I am aware that out-of-pocket payment for health constitutes over 70% of all health expenditure. This is more than the globally accepted 30-40%. However, only less than 5% of the total population is covered by any kind health insurance or risk protection mechanism which is against the recommended 90% coverage by WHO " - President Muhammadu Buhari**