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The Challenges of Establishing Universal Health Coverage in Enugu State, South East Nigeria

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Abstract

Background:

Financial risk protection for healthcare is deficient in Enugu state, Southeast Nigeria and the worst affected are the rural dwellers and the poorest, thus creating both socioeconomic and geographic inequity in access and use of services. The study aimed at eliciting the level of awareness and use of pre-payment mechanisms, and more importantly, determining the economic and political factors that facilitate or constrain achievement of Universal Health Coverage in Enugu state, Southeast Nigeria.

Methods:

Study was conducted in two purposively chosen urban and rural local government areas(LGA) of Enugu state with mixed method study design. Cross-sectional household questionnaire survey was conducted on 802 sample size from the two LGAs and 12 key informants participated in In-depth interviews (IDIs). The quantitative data was analysed with STATA using descriptive statistics while the qualitative IDI data was organized into nodes and sub-nodes using Nvivo: political and economic factors, corruption, communication/Awareness, capacity development / Infrastructure, policy development, leadership and referral system. Later, findings were thematically analysed.

Results:

The survey results showed that 84% of the study sample have secondary school education and 83% are engaged in employment or petty business. About 56% are aware of prepayment mechanism for healthcare bills but only 10% of them have used prepayment mechanisms. Out of pocket payment (85%) is the main source of payment at health facilities.

Major political constraining factors to UHC revealed by the IDI include lack of political will backed with financial commitment from the political leaders, lack of legislative framework for UHC, lack of trust on the political leaders/government by the citizenry and inactive civil society organizations. Also, the poor fiscal space for health and the poverty level in the populace are big threats to sustainable UHC in Enugu state. Other economic challenges include corruption, poor health capacity development and poorly paid healthcare workers leading to poor quality of health care delivery. There is need for comprehensive health system development in the state to accommodate UHC.

Conclusions:

Establishment of sustainable UHC in Enugu state faces considerable political and economic challenges. There is need for increased government budgetary allocation for UHC to ensure coverage for the poor and vulnerable members. The lack of legislative framework for UHC could be resolved by legislative arm of the government. The government should invest in health system development to improve the quality of health care services to compliment the FRP component of UHC.

Keywords: Universal Health Coverage, Health Insurance, Financial Risk Protection
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1.0 Introduction / Background:

Universal Health Coverage (UHC) has been defined as having "access to all needed quality health services without financial hardship" (Saksena, Hsu and Evans, 2014; WHO, 2010). It consists of two concepts of making healthcare services available to people when they need it without the financial hardship of paying for the service at the point of receiving the service (financial risk protection) and availability of good quality health services (Saksena, Hsu and Evans, 2014; McIntyre and Mills, 2012 and Giedion, Alfonso and Díaz, 2013).

With respect to the availability and quality of the healthcare service, WHO (2013) emphasized that UHC includes the enjoyment of the highest attainable standard of health. In fact Saksena, Hsu and Evans (2014, p.3) stated that fundamental to UCH is the principle of "insurance value" of the health service being available, affordable and of good quality and most importantly, that "the use of the needed health services results in better

health". Nigeria and many other developing countries have a lot of work to do in that regard because evidence abound showing that the quality of healthcare delivery in these countries is poor (Chukwuneke, 2015; Olaposi, 2016; Vanguard Newspaper 12thJan. 2016; Ossai, Nwobi and Uzochukwu, 2015).

In considering the affordability of healthcare services, it should be noted that the financial cost for health service includes the direct cost of the service and the indirect cost of accessing the service. Even where the cost of the service has been made affordable or free, the cost of accessing the service (e.g. the cost and difficulties of transportation to the nearest health facility) could prevent some poor people from accessing the service. Bastagli (2013) reported Sinha et al.'s findings in India showing that Gujarat women enrolled in the Community based Health Insurance who live further away from the health facilities utilize healthcare service less than those who live closer to the health facilities, most likely because of the high cost of transportation. Other forms of indirect cost of accessing healthcare services include: time lost from work and lost income.

The financial risk protection (FRP) component of UHC targets the protection of healthcare service users from the effects of catastrophic expenditures and impoverishment of Out of Pocket (OOP) payments (Saksena, Hsu and Evans, 2014; McIntyre and Mills, 2012; Giedion, Alfonso and Díaz, 2013; Arin and Hongoro, 2013). A closely related concept with similar objectives to UHC / FRP is Social Protection. Social protection "includes any formal (and informal) initiative that aims to provide social assistance to particular vulnerable groups, social insurance against risks such as those associated with old age and the loss of employment as ..." (Bastagli, 2013, p. 5). The social insurance component of Social Protection is the basis of the FRP viz. "contribution-based and aims to mitigate risk for all social groups, including the poor, by pooling group resources (risk-pooling), ..." (Bastagli, 2013, p. 5). "Social health insurances aim to enable as many people as possible to enjoy good health by organising the funding of health care through payment according to means and providing access to health services according to need" (Doetinchem, Schramm and Schmidt, 2006, p. 32).

To achieve UHC entails that all members of the population should participate in one form of contribution-based health insurance or the other e.g. Community-based Health Insurance, formal sector Health Insurance, Private Health Insurance or tax financed health insurance. To be successful and sustainable, Social Insurance should be mandatory (Doetinchem, Schramm and Schmidt, 2006; WHO, 2014).

In African countries limited progress towards universal coverage has been made due to heavy reliance on out-of-pocket payments. Some countries such as Cameroon, Guinea, and Nigeria fund 70% or more of total health care expenditure through out-of-pocket payments (McIntyre and Mills 2012), in spite of its catastrophic expenditure and impoverishment effects. In Nigeria, the National Health Insurance Scheme (NHIS) was started in 1999 (NHIS, 2012) and for more than ten years, the national coverage was just about 5% (Onwujekwe, Hanson and Uzochukwu, 2012; McIntyre et al. 2013). In fact, in November 2018, the incumbent Executive Secretary of the National Health Insurance Scheme (NHIS), Prof. Usman Yusuf stated at a Press Conference that "In 13 years of NHIS, we've been able to cover only 3 million (out of 182 million) Nigerians" (Pulse News, 2018).

The NHIS developed several programmes to improve enrolment by several sectors/groups viz.

1. Formal Sector Social Health Insurance programmes (FSSHIP) for formal sector employees
2. Voluntary Contributors Social Health Insurance Scheme programme (VCSHIP)
3. Tertiary Institutions Social Health Insurance Scheme programme (TISHIP) for students in higher education institutions
4. Community Based Social Health Insurance Scheme (CBSHIP) programme, and
5. Vulnerable Group Social Health Insurance Scheme programme (VGSHIP).
6. In 2013, other programmes were introduced, such as Public Primary Pupils Social Health Insurance Programme (PPPSHIP) for primary school pupils, and
7. National Mobile Health Insurance Programme (NMHIP) for mobile phone users.

Of the programmes, only the FSSHIP and TISHIP were really implemented with minimal success. The low coverage level of the Nigerian NHIS to date shows that the national scheme face enormous challenges. Baba and Omotara (2012) identified some of the militating factors for development of the Nigerian NHIS to include fragmented health care delivery arrangement of the federal and state governments, weakened public health care service due to brain drain of health professionals to overseas, lack of resources and severe poverty of Nigerians. Other challenges that militate against the rapid expansion of the scheme include lack of awareness about the scheme, regressive contributions, insufficient stakeholder involvement and lack of trust in the scheme (Onwujekwe et al., 2009).More so, Odeyemi (2014) asserted that the lack of trust/confidence in the scheme is due to lack of awareness and information on the part of the citizens. In Nigeria there is lack of political will on the part of federal state, and local governments in expanding the NHIS coverage to civil servants (McIntyre et al., 2013 and Onoka et al., 2013).

UHC cannot be achieved by weak systems where more than 70% of healthcare financing come from out of pocket payments that impoverish poor households. Health systems research should be used to generate the needed evidence to achieve UHC. UHC ensures access to and use of quality healthcare services by all citizens

and protection from catastrophic financial effect of ill health (Arin and Hongoro, 2013). Achievement of UHC can be facilitated when political will and economic factors are put in proper perspective in the health system.

Other developing countries that introduced the NHIS recently had those challenges too. For example, in Ghana, Fusheini (2016) found the NHIS implementation challenges to include “poor leadership, corruption, lack of consensus, rapidity and politicisation of implementation, lack of participation, poor sense of direction, limited understanding and management of the political challenges”. In the case of Nigeria, it is not clear why the other programmes of the NHIS failed to take off, and the literature on that is scarce. However, suffice it to mention that like what Fusheini (2016) found in Ghana, there appears to have been poor leadership in the agency that manage the Nigerian NHIS. It appears the government lacked operational strategy and policy implementation on how to provide sufficient fund for the NHIS particularly the issue of providing financial support / subsidy for enrolment of the poor, vulnerable people and children in the schemes designed for them. The government’s support for the poor and vulnerable is very necessary for the success of UHC in Nigeria and Enugu state considering the level of poverty (52% of the population nationally and 10.3% for Enugu State) reported by the University of Oxford (2018). It is apparent that the lack of government subsidy for the poor in the society (who are mostly in the informal sector) has significantly contributed to the poor performance of the NHIS in expanding the coverage of the scheme in Nigeria.

A major challenge evident in the Nigerian NHIS arrangement which was discussed by Doetinchem, Schramm and Schmidt (2006) was the issue of centralization of administration and management of social insurance scheme. According to them, decentralization of resources and responsibilities helped to make NHIS organizations flexible and responsive in administrative management of the organization, dealing with stakeholders and negotiating remuneration packages with providers and patient groups. In the Nigerian NHIS, the NHIS – an agency of the Federal Ministry of Health – is highly centralized with zonal and state offices thereby excluding state governments in the management of the scheme. In addition, its flagship programme, the FSSHIP, designed for federal government civil servants excluded state government civil servants. This alienation of the state governments made it difficult for it to penetrate the state and local government areas in all the 36 states and improve the coverage particularly in the rural areas. Some state governments in Nigeria are therefore considering the option of establishing their own state government backed UHC.

This study aims to determine the level of awareness and use of Health Insurance in Enugu state and to ascertain constraining and facilitating factors to achieving UHC in the state. The long-term goal is to ensure that every household resident in Enugu state has financial risk protection in accessing quality health care services.

2.0 Methods:

2.1 Study area:

This study was conducted in Enugu state, one of the 36 states in the Federal Republic of Nigeria. The state has a population of about 3.3 million people (according to the 2006 census records), with about 59% of the population living in the rural areas. About 95% of the residents are of Igbo ethnic group (Makama, 2007 in Odinka et al, 2018). Up to 78% of employable adults in the state are self employed (Enugu state, 2004) in variety of businesses ranging from white collar jobs to blue collar jobs such as trading, livestock farming, transportation, building construction and other artisan roles (cite sources). The rural dwellers are mostly subsistence farmers, artisans and petty traders (Okoli and Cleary, 2011).

2.2. Study design

The study adopted a mixed method design involving cross sectional quantitative (questionnaire) and qualitative (in-depth interview) methods. The study was conducted in two purposively chosen urban and rural local government areas, Enugu North and Enugu East respectively. The questionnaire elicited data on the level and use of pre-payment mechanisms in the state, while in-depth interview was used to determine factors facilitating/constraining achieving universal financial risk protection in the state.

A sample size of 800 was determined using the formula for minimum sample size for estimating a population proportion when assuming random sampling from a large population: $n= P(1-P)Z^2/d^2$, where n = sample size, Z = Z statistic for a level of confidence, P=0.50 (anticipated proportion) and d=0.05 (precision) (Daniel, 1999). Initially, a sample size of 384 was achieved. In order to accommodate for non-response rate and ensure robust result we decided to increase the total sample size to 800. This is because the higher the sample-size the better the outcome. Ten questionnaires (five per LGA) were pre-tested in the two LGAs and outcome was used to update the final questionnaire before embarking on fieldwork. The questionnaire elicited data on the level of awareness and use of health insurance in the state.

Method of data analysis

The quantitative data from questionnaire was double entered in EPI-Info and analysed with STATA using descriptive and cross tabulation statistics. On the other hand, in-depth interview was used to ascertain factors

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constraining and/or facilitating universal health coverage in the state.

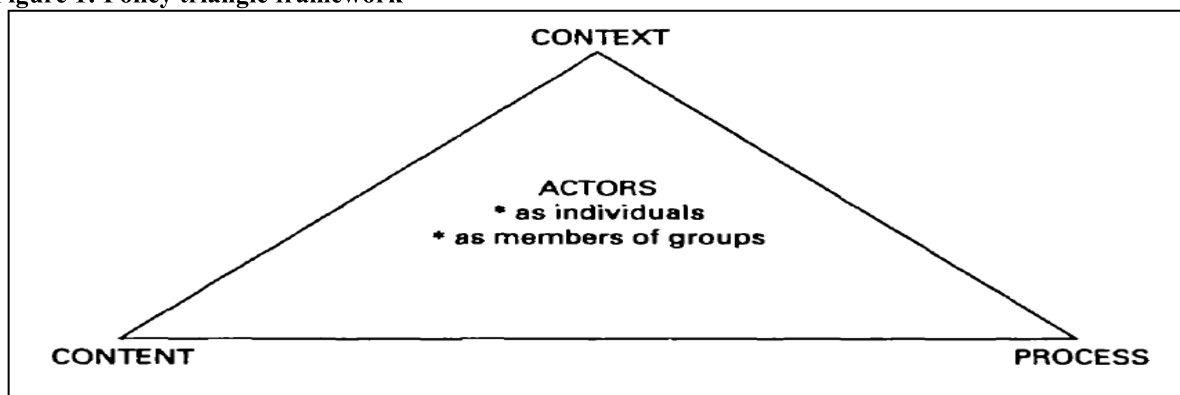
Document reviews of published and unpublished documents such as National Health Financing policy, the Enugu State Social Health Insurance Law, Enugu State Health Reform Act, etc were conducted using data abstraction form.

Twelve (12)in-depth interview (IDI) was conducted out of the 17 key informants purposively selected from Ministry of Health, State Health Board, State Primary Health Development Agency, cottage hospital, PHC, House of Assembly Committee on Health and NHIS desk officer. Question guide focused on prepayment mechanisms in the state, socio-economic and political challenges facing the implementation of universal health coverage in the state. All the IDIs were undertaken in May 2017 by four pairs of researchers from Health Administration and Management Research Group (HAMReG) and were tape recorded with the permission of the respondents.

All the recorded interviews were transcribed verbatim into MS-Word documents for analysis. Transcriptions were individually crosschecked with the original audio-recordings to ensure quality.

The interview transcriptions were coded into themes with NVivo 11 QSR. The themes include: existing prepayment mechanisms in the state, enabling economic and political factors, constraining economic and political factors, and actors in the state. Findings were interpreted and discussed using policy triangle framework consisting of Context, Process, Content and Actors (Walt and Gilson 1994) (Figure 1)

Figure 1: Policy triangle framework



Source: Walt and Gilson 1994

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3 Results

3.1 Quantitative Results

Table 1: Socio-economic and demographic characteristics of respondents

Variable	Frequency (%)
Gender	
Male	184 (22.9)
Female	618 (77.1)
Age	
Mean (SD)	38 (11.95)
Marital Status	
Married	643 (80.2)
Single	81 (10.1)
Divorced	75 (9.4)
Widowed	3 (0.4)
Highest education level	
No formal education	38 (4.7)
Primary school	94 (11.7)
Secondary school	396 (49.4)
Higher education (college, polytechnic, university)	272 (34)
Others	2 (0.2)
Occupation (major source of income)	
Employed in the public sector	95 (11.8)
employed in the private sector	105 (13.1)
Self-employed	295 (36.8)
Farmer	35 (4.4)
Petty trading	108 (13.5)
Housekeeping	29 (3.6)
Unemployed	61 (7.6)
Student (at school or university)	21 (2.6)
Pastor/Minister in Church	4 (0.5)
Retired	18 (2.2)
Artisans	27 (3.4)
Others	4 (0.5)

Table 1 shows the socio-economic and demographic characteristics of the respondents to the quantitative survey. Of the 802 respondents, 618 (77%) were females and the average age of the respondents was 38 years. Majority, 643(80%) of the respondents are married while nearly 75 (10%) of them are divorced. Most of the respondents (84%) are educated up to secondary school level while 665(83%) are gainfully employed (in the public and organized private sectors, self employment, farming, petty trading and as artisans).

Table 2: Level of awareness and sources of information about prepayment mechanism (health insurance)

	Frequency (%)
Knowledge of prepayment mechanism	
Yes	448 (55.9)
No	354 (44.1)
Source of information on prepayment	
Radio programme	189 (20.2)
Television	285 (30.4)
Relation/neighbour	145 (15.5)
Church	95 (10.1)
Hospital	137 (14.6)
Others	86 (9.2)

Table 2 shows level of awareness of the respondents about prepayment mechanisms. The result shows that over half of the respondents (56%) (448) claimed they have heard about prepayment mechanisms. The most common sources of information about pre-payment mechanisms are the television (30%; 285/802) and radio (20%; 189/802) and relation/neighbour (16%).

Table 3: Usage of Pre-payment mechanisms &Forms of payment for health Services at facility

	Frequency (%)
Used any pre-payment mechanism	
Yes	84 (10.5)
No	718 (89.5)
Total	**802 (100)**
Forms of payment for health Services at facility	
Out of pocket payment (OOP)	674 (84)
In kind payment	0 (0)
Exempted from payment	7 (.90)
Someone else paid	29 (3.6)
Not applicable	92 (11.5)
Total	**802 (100)**

Table 3 shows only 10.5% (84/802) stated that they have used prepayment mechanism to access health care. It shows that Out of Pocket payment (OOP) is by far the commonest form of payment for health services in Enugu State (84%) (674). It is worthy to note that less than 1% (7) of the respondents was exempted from payment

Table 4: Place of last treatment in the last one month

Variable	**Frequency (%)**
Place of treatment in the last one month	
Traditional healer (herbalist)	15 (2.9)
Chemist (patent medicine dealer)	285 (54.4)
Home treatment	8 (1.5)
Community health worker	25 (4.8)
Primary health centre	54 (10.3)
Public (general) hospital or clinic	133 (25.4)
Other	4 (0.7)
Total	**524 (100)**

Table 4 shows the places of treatment used by the patients within the month preceding the survey. A good majority of those who were ill sought for treatment at the local patent chemist dealer (54%) (285) followed by those who attended hospitals (general and private) 25% (133) and primary health centre (10%) (54).

3.2 Qualitative Results

The qualitative results included here are excerpts from the twelve key informant interviews (In-depth Interviews (IDI) conducted in this study. The findings are arranged under key thematic headings.

Two quotations that aptly summarize the challenges facing the achievement of UHC in Enugu State come from two key informants:

"What discouraged me personally was when I found out that the government wasn't ready to do anything ... yes, we are interested in universal health coverage, but we have not made any law in Enugu state to take care of anything. So, this means no commitment from their part, to promote universal health coverage. Can you tell me what the state government has done as per their financial commitment? I have not heard any" (HF13).

"As far as I'm concerned, the fundamental factor, in my own estimation is education. People are not aware that there is a programme where people's fund are pooled together and the less privileged can access healthcare without selling their clothes, without selling their land, so of paramount importance in my estimation is education, awareness and of course good management of the funds involved, technocrats, people who really know the sanctity of life should be placed into such positions so that funds can be well managed and not be diverted". (HF17)

Politics (including labour Union):

The political challenges pointed out by some of the key informants include the lack of political commitment and political will by the government in establishing and funding the UHC programme in Enugu State. A good number of the participants emphasized that political will is not just a manifesto, election promise or passing the bill to establish the UHC agency but providing the funding, logistics and manpower required to run the organization. One of the participants explained the lack of political commitment this way:

"Now, you know when people say political commitment, or political will, what does it translates to? It translates to funding meeting the obligation, the promised obligation of government. If a government promises X, it should provide X, if it promises Y, it should provide Y" (PM – MOH 9).

Illustrating the lack of government financial commitment further, PM – MOH 9 had this to say: *"Now, the national Health Act 2014 had included or includes a provision for 1% of the consolidated revenue fund of the*

federation for basic healthcare provision fund. Has it been translated into budgetary provision at the moment? No! At the level of the state here, the free maternal and child healthcare programme, the contribution role is 50% from the state, 50% from the local government. Has the state made this contribution? Absolutely no! Free maternal and child healthcare programme is being run with funds from the local government area only, at least since 2010. Does this show political commitment from the state leadership? No".

Others pointed out that the people, the citizenry, also need to show their own willingness and commitment for the UHC programme to work: *"It takes the political will of government because where there is a will, there is a way. If the government, even we, the citizenry, we the people, if we are committed to making the policy work; it will work"*(HF15).

"Legislation! Legislation, ... everything should go through process. Well, the governor can be willing, what about the legislators. The legislators can be willing, what about the citizenry? We are the people that are even playing the politics than the people that are ruling us. ..We too have a political will to say yes, this is what we want. That we want this and we want that; then push it to our legislators and they can push it to our governor"(HF 15).

This lack of political will among the citizenry was illustrated by another participant: *"There were failed attempts in the last administration to commence a formal sector health insurance package for civil servants. It was cut short because of actions of the labour union who were quite suspicious of government intentions. The fear of the labour union was that the government was going to play tricks; that they will not sustain it; and that the health facilities were not going to be functional, and that Public Private Partnership will be an issue. They will come in and sell t*he health facilities. So the labour union was afraid of government reliability on the matter" (PM-MOH 4).

Other political challenges adduced by the participants include:

- Public financial management: One of the threatening factors to the pool will be poor financial management system. This is likely to be the case if the UHC agency is retained in the Ministry of Health as a department or parastatal. It should rather be an independent public entity that is separate from the Ministry of Health but supervised by the Ministry.
- The role of Health Management Organisations in the running of the UHC scheme in Enugu state. They are seen as ripping off the NHIS scheme run by federal government.
- Clarity of roles – functional and contributory roles -of the different actors must be properly defined in the UHC Agency bill.
- *"The fact that we do not have a legislative framework for UHC Agency in Enugu State is already constraining the establishment of UHC in Enugu State"* (PM – MOH 09)
- *Local Civil Society Organizations (CSOs) are not active in playing their advocacy, monitoring and pressure group role well in making the government to live up to their responsibilities e.g. "In the ten years, we have run free MCH but we have not seen any CSO canvass for increased financial commitment by the government"* (PM – MOH 09).

Economic

Some of the economic factors affecting the establishment of UHC in Enugu State as discussed by the participants include:

1. The poor fiscal space i.e. the weak economic situation in the country and Enugu State constraining budgetary allocation for health. Enugu State is among the few states that receiving the least monthly allocation from the federation account.

- *"Thin fiscal space (Lack of sufficient funding) downward fluctuation of revenue coming from the federal government. Because the state government depends mostly on allocations from the federation account, the continuity of UHC may not be assured"* (PM – MOH 7).

2. Poverty of the people, unemployment and weak/low salary structure will make it difficult for people in the informal sector to pay health insurance contributions.

- *"There is no money; even salary is a problem. Like those of us in the local government, maybe you people are ok; you are working in a better place. Those of us in the local place, our salary is nothing to write home about and it is not even forthcoming as and when due. So I think the economic situation of the country will be a hindrance to its achievement"* (HF 14).
- *"The ordinary people; educate them and give them something to actually pay their premium, probably pay them their salary, improve the economy so that at least they can pay their premium"* (HF 15).

Other notable quotes highlighting the economic challenges include:

- *"If you come to some of the hospitals, they are decrepit; government cannot even resuscitate and renovate them, because of lack of funds. ... And if you come, like in some of our facilities where you don't have doctors; it is because of money. If government have enough money, I'm sure they will be obliged to supply all the facilities with doctors, nurses, this and that. If you go to certain hospitals, you*

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don't see X-rays; it's not because government doesn't want to install x-rays, ultrasound and the rest of them, it is because it is incapacitated financially" (PM SHB 11).

- *"Other things that we could do to address the issue of enhancing healthcare coverage are the payment of doctors and nurse and some paramedics. We have been having this issue of consolidated medical salary for doctors in the state and the nurses and some other paramedical have been angry about it"* (PM – MOH 10).

Corruption

Corrupt practices mentioned by the participants include misappropriation of budgetary allocations, embezzlement of fund by corrupt officials and collusion by government officials with suppliers resulting in payment for goods and services not supplied. Some of the participants' contributions on corruption include:

- *"initially there was 200 million naira (N200M) set aside by the past administration to kick start the project (UHC) but towards the end of that administration that money developed wings and disappeared so we are back to square one"* (PM – MOH 10).
- *"Yes, one of the political factors, not even only in Enugu state but in the entire country is sincerity of purpose, complete adherence to the budgetary provisions. So if we are sincere and can adhere to budgetary provisions and minimize corruption, because I can't say eliminating corruption but minimizing corruption is the greatest thing to do, we will. This is the area we are having problem. These things are in the budget they keep on repeating themselves every year they never implemented"*(PM-MoH10).
- *"Corruption is a major issue in healthcare delivery especially with respect with universal health coverage. --- because of corruption, resources that are meant for programme easily disappear and even when they are being utilized you will discover that not more than 10% to 30% of the resources meant for such programme are normally spent on that programme so corruption is major factor"* (PM-MoH10).
- *"There are so many ways Governor has been adopting to see whether they can block leakages. Because if you block leakages you can have enough money to do some of these things. We have been doing biometric capturing, we've been doing payroll scrutiny, we have adopted for three months to see whether we can pay people with cheque directly to check corruption and embezzlement"* (PM SHB 11).

Communication / Awareness

Some of the key informants stated that many people are not aware of health insurance (NHIS) and some people think they (particularly those in the informal sector) are not included in the programme. Some who have heard about it do not understand how it works, hence are sceptical to participate. All these point toward the difficulty in communicating government programmes. These are some of the statements made by some of the participants:

"It may not be funds alone. Coordination and creating awareness are needed. Thereis free maternal and child health in Enugu state, but so many in the communities could not access it, because they have not heard about it" (PM SHB 11).

"One thing that can help is to educate our people about how to go about it. Many people don't even know that they can access health insurance except civil servants. Many people don't know there is something like health insurance"(HF 15).

Capacity development / Logistics

Most of the key informants pointed out that provision of adequate and accessible health care facilities equipped and staffed to provide good quality health care service is necessary for the implementation of the UHC in Enugu State. The current state of our healthcare facilities in Enugu State will be a challenge for the realization of UHC and its sustainability. These are some of the things they pointed out:

"You also create ambient environment in the facilities. You should have the full compliment of workers who are going to drive the process… professionals". "So for you to be able to do this, you must first of all bring your facilities to optimal capacity both in infrastructure and in personnel"(PM SHB 11).

"We told them they should upgrade the hospitals because when you talk of universal financial risk protection, somebody has paid something. So, they (i.e. government) should upgrade facilities, employ more nurses, employ more doctors, bring in a lot of infrastructure, – ultrasound, x-ray and equip their labs. So if you don't have these things, you cannot put the cart before the horse" (PM-SHB11).

"In this facility, we are supposed to be the implementers but we don't have enough staff. Most of the people you see around are not properly trained ... Poor salary and in fact, lack of seats in some areas seems to be a challenge too. Some people don't have infrastructure. ... And there are some key staff now that I notice are lacking in almost all the facilities, like the compound cleaners" (HF 14).

"We don't even have electricity here; we don't have water either. We buy water from the vendors and apart from

that, the electricity bill is so high. We can't pay, so EEDC (electricity company) came and cut their light ... And we don't have a standby generator that we can fall back on if there is no electricity. So all these are the problems" (HF 14).
"Human resources is very important, -----there will be need for manpower such as medical personnel, health workers, ...There is need for increased manpower/personnel" (HF 17).

Policy Development
Regarding the UHC policy development, some of the participants wanted the policy to be relevant to the entire health system development in Enugu state as according to one of them *"prepayment mechanisms don't work in isolation; they work in a stronger health system. We need a stronger health system"*(PM-MoH9). The Policy content should be encompassing to include areas regarding health capacity development and infrastructure, quality of health care services and financing. Other participants advised on the need to avoid the pitfalls of the national NHIS policy development with respect to the top down approach that alienated the states in its affairs. Hence the need to involve all the stakeholders: Enugu state government, Local Government Area councils, community leaders, the public, healthcare providers and members of the health profession.
"The other reason why it (NHIS) failed was the top to bottom approach assumed by the NHIS where monies would have to be deducted from state civil servants salary source and then transferred directly to the coffers of NHIS, a federal agency; with the Enugu state executive organ feeling left out of the whole process" (PM - MOH 4).
"Some of us had a different opinion. We believed that the national health insurance as it is or as it were then, did not provide any form of accountability for the state. So if any state puts its money there, it is like just laying a conduit pipe to get the money out of the states" ..." We argued in favour of the state led mechanism" (PM – MOH 9).
"Avoid the use of third parties like the insurance companies and HMOs as the middle people. We mustn't use registered insurance companies – these HMOs. The Catholic communities did not use HMOs. They used the Dioceses. The same with the Anglican; they used the Dioceses. They have more reliance on the bishops and their clergies than the HMOs" (PM – MOH 4)

Leadership
Good leadership provided by the government, legislators and Ministry of Health is crucial in the establishment and implementation of the UHC programme in Enugu State. The participants pointed to the pivotal role of the Executive Governor of Enugu State:
"So, one political factor will be the leadership provided by the governor. So if the governor is in favour of universal financial risk protection, then you can be sure that it will survive the political terrain, but if he is against it, then, there is trouble" (PM – MOH 9).

Referral System
Another big challenge facing the implementation of UHC in Enugu State is the abuse of the referral system by primary& secondary health care service providers.
Other challenges to establishment of UHC in Enugu State mentioned by the participants include:
1. Provision of quality health service
2. Out of Stock (OS) Medicine and consumables (including surgical, physiotherapy, etc).
3. Lack of ICT infrastructure to counter corruption activities of clients, service providers and staff (of service providers, HMOs and the government).
4. Lack of access to health facilities – close to where people live, especially in the rural areas.

4 Discussion
The results show sample frame of highly literate respondents with 83% (668/802) of the sample having secondary or tertiary education. Only about a quarter (25%; 200/802) of the respondents were actually employed in the public civil service and organised private sector. Those working in the informal sector were 58% (467/802).Similar findings led Doetinchem, Schramm and Schmidt (2006, p. 36) to conclude that "Health insurances in poorer countries face the challenges of low contributive capacities and relatively few people being in formal employment". The high proportion of those in the informal sector reflects those who are excluded from the formal sector social health insurance programme and they are those who are mostly likely to rely on catastrophic and impoverishing OOP for their health care services. Furthermore, according to Bastagli (2013, p. 9), the "rural subsistence economy and informal sector, (as found in this study), are a challenge for taxation" when considering the funding options for health".

This study also showed the high level of those who claimed to be unaware of prepayment mechanisms (44%; 354/802) with 90% (718/802) of the sample not using any form of health insurance. The high level of

unawareness of prepayment mechanisms for healthcare services is significant when it is viewed against a highly literate and educated population as seen in this study sample. The importance of proper communication and creation of awareness about prepayment mechanisms amongst the populace cannot be overemphasised. In a study by Dienye, Brisibe and Eke (2011), quoted by Odeyemi (2014), they found that 97% of their study sample of surgical patients was unaware of their state government's insurance schemes. Other authors, Metiboba (2011) and Onwujekwe et al. (2010) found that lack of awareness is a challenge to participation in Community-based health insurance scheme in Nigeria.

The most common form of payment for health care services in our study was OOP (85%; 682/802). This is consistent with other studies and reports that confirm that OOP is biggest source of health care expenditure in developing & poor countries (Bastagli, 2006). In the comprehensive study of "Financing incidence analysis of household out-of-pocket spending for healthcare" in Nigeria, Onwujekwe et al. (2014) found that 98.8% of health care expenditures were made using OOP spending.

Another finding in this study worthy of note is the role of patient chemist vendors and Pharmacy shops in the Nigerian Health System. In this study more than half (54%; 285/802) of treatments for ill-health occurred at the patent chemist (and Pharmacy shops) and only 40% (212/802) attended health care facilities to seek treatment. Hence in trying to provide financial risk protection from healthcare expenditures or reduce OOP spending, it is necessary to consider ways of reducing visits to patent chemists and pharmacies by reducing Out of Stock syndrome in our hospitals and providing primary health care facilities closer to the people. Alternatively, pharmacies and patient chemists should be accredited to provide treatment to Social Health Insurance enrolees.

The following discussion on challenges of establishing UHC in Enugu state is based on the findings from the key informant interviews is structured in line with the Policy triangle framework (Wilson and Gill, 1994) stated above.

ACTOR CHALLENGES

As we know, the actors operate, administer, manage and oversee that all the other dimensions of the framework work together efficiently and effectively for successful implementation of the UHC programme. The study revealed a lot of challenges in the actors' roles for establishing UHC in Enugu state:

1. Lack of real political commitment on the part of Enugu State government in matching the political will with financial commitment. The Nigerian NHIS programme has been in operation since 2005 (Metiboba, 2011;Onwujekwe, Hanson and Uzochukwu, 2012, McIntyre et al., 2013), however, in spite of several attempts by Enugu State governments over the years, the Enugu State UHC programme has been stalled by lack of financial commitment to compliment the political commitment. Other studies by McIntyre et al., 2013 and Onoka et al., 2013) support this finding. Instances cited by participants in this study include the non payment of the counterpart funding for the free maternal and child health programme and the misappropriation of budgetary allocations for the UHC programme by previous state governors. Some of the key informant quotes in this regard include:

- *"initially there was 200 million Naira (N200M) set aside by the past administration to kick start the project (UHC) but towards the end of that administration that money developed wings and disappeared so we are back to square one"* (PM – MOH 10).
- *"At the level of the state here, for the free maternal and child healthcare programme, the contribution role is 50% from the state, 50% from the local government. Has the state made this contribution? Absolutely no! Free maternal and child healthcare programme is being run with funds from the local government areas only, at least since 2010. Does this show political commitment from the state leadership? No"* (PM – MOH 9)

This failure to match political will with financial commitment is a major challenge to the establishment and sustainability of UHC and has been reported by other researchers (Odeyemi, 2014, McIntyre et al., 2013 and Onoka et al., 2013). The poverty level in Enugu state of 10.5% in the University of Oxford (2018) study makes it necessary that the government to subsidize the UHC contributions (premiums) for this group of people. As has been stated by WHO and others, UHC cannot succeed without government contribution (Odeyemi, 2014; Bastagli, 2013 and Doetinchem, Schramm and Schmidt, 2006). The need for the government to support those who cannot make contributory payment is further discussed under Context (economic challenges) below.

2. Gaining ownership of the programme by the organised labour union and town unions (for CBHI).

According to Doetinchem, Schramm and Schmidt (2006), "It is generally not possible to introduce a social health insurance system without the broad support of the population and the political establishment". The labour unions and town unions constitute the voice of the people / health insurance beneficiaries. The people, through their labour unions, are the centre on which the whole UHC revolves as it is meant for the people and they also need to make it work by making regular payment into the scheme. Odeyemi (2014) in his review found that "the key to Rwanda's success in implementing CBHI appears to lie in a strong societal consensus over equality of access to health care" and that where the health insurance agency / government failed to engage beneficiary

participation, the UHC programme is bound to fail. This failure to engage the beneficiary (through their labour unions) led to the failure of the Enugu state formal sector social health insurance scheme in the recent past; one of the participants in this study stated that:

> *"there were failed attempts in the last administration to commence a formal sector health insurance package for civil servants; it was cut short because of actions of the labour union who were quite suspicious of government intentions. The fear of the labour union was the fact that the government was going to play tricks; that they will not sustain it; … They will come in and sell the health facilities. They were afraid of government reliability on the matter"* (PM-MOH 4).

3. The Citizenry: Looking at the citizenry, this study highlighted many challenges facing successful introduction of UHC. Some of these are: poverty and lack of knowledge about prepayment mechanism. The poor people are the ones most likely to need healthcare services and they are the ones most likely to avoid enrolling in a prepayment mechanism (health insurance) due to lack of money to pay insurance premiums. According to Bastagli (2013, p.4) "… the poorest typically continue to remain excluded by the pre-payments required for participation". Consequently, when the poor people fall sick, they are the ones most likely to suffer catastrophic healthcare costs and impoverishment.

4. Lack of sufficient expertise/capacity on the part of health care / Health Insurance providers in managing the UHC programme. The dearth of health insurance expertise amongst healthcare providers affects the establishment of UHC in many ways – both in providing quality healthcare services and in the administration of health insurance with accountability and the necessary transparency that are necessary for sustainability of the UHC. According to Doetinchem, Schramm and Schmidt (2006, p. 40), the quality of health services covered by a health insurance plays a decisive role in bringing about its acceptance among the population and a willingness of members to pay contributions in advance". Our finding regarding the impact of poor expertise in administration of health insurance under the UHC in Enugu State is supported by The International Bank for Reconstruction and Development/The World Bank (2007) finding that weak institutional capacity affects effective management of health.

Agyemang, Adu-Gyamfi and Afrakoma(2013) also identified lack of adequate human resources as one of the major challenges facing the NHIS in Cape Cost Metropolis in Ghana.

5. Lack of scrutiny and monitoring by active Civil Society Organizations (CSO). Our findings show CSOs can improve both enrolment in the NHIS by improving awareness of the scheme in Enugu State, putting pressure on the government to invest more money in the UHC, highlighting health quality issues by healthcare providers and being the mouth piece of the vulnerable group in demanding for free healthcare for this group.

"...the civil societies, the user representatives. First of all, the user representative should even be part of the governing bodies for these agencies, so that their voice will be on table and be heard. So, if the revenue is not coming, they should shout that it is not coming. If the money comes and it is being mismanaged, they should tell the world that it is being mismanaged" (PM – MOH 9)

CONTEXT CHALLENGES

The main contextual challenges identified in our study for establishment of UHC in Enugu state concern the present economic realities, corruption and the state of healthcare infrastructure in Enugu state.

1. Economic Realities: Almost all the participants alluded to the poor fiscal space constraining the Enugu State government in establishing and sustaining UHC in the state. The fact that Enugu State depends greatly on federal government monthly allocation for its revenues with very small Internally Generated Revenue (IGR) was identified as a major challenge. This gap in healthcare financing in the state affects the whole health economy including employment and payment of salaries of healthcare professionals, provision and maintenance of healthcare facilities for quality healthcare delivery and provision of subsidies for the poor for health insurance. This dire economic situation will make it difficult for the government to establish and sustain UHC in Enugu state. Many authors have identified the crucial importance of government financing for health and in particular UHC. Lu et al. (2012) attributed the success CBHI in Rwanda, partly to the crucial financial investment of the government in the health sector.

The prevailing economic hardship we are experiencing in Nigeria at the moment has impoverished the people due to rising unemployment, poor salary structure and poor market. One participant described this situation like this: *"There is no money; even salary is a problem. Like those of us in the local government, maybe you people are ok; you are working in a better place. Those of us in the local place, our salary is nothing to write home about and it is not even forthcoming as and when due. So I think the economic situation of the country will be a hindrance to its (UHC) achievement"* (HF 14)

The general poverty prevailing in the state will make it difficult for most people to pay their contributory health insurance premiums. This will necessitate the Enugu state government to provide extra funding to subsidize contributory premiums. This view is supported by other authors including Onwujekwe et al. (2009); Doetinchem, Schramm and Schmidt (2006); Odeyemi (2014); Arin and Hongoro (2013) and Bastagli

(2013).According to Bastagli (2013, p. 14) "...the obstacle to reaching the poorest generated by the prepayments required for participation may be overcome by regulating the cost of participation. This may be reduced or lifted by the institutions (health Insurance agencies) themselves or the public sector (government) would have to subsidise premiums".

Similarly, Doetinchem, Schramm and Schmidt (2006, p. 39) stated that "A social health insurance can only cover everyone, if either the state or the other members agree to pay contributions high enough to cross-subsidise the poor". Hence, in Enugu State, the success of UHC requires the government to ensure the poor are encouraged to participate in the social health insurance scheme by subsidizing their health insurance premium and providing social protection such as conditional cash transfers.

2. Corruption: According to one of our research participants, *"Yes, one of the political factors, not only in Enugu state but in the entire country is sincerity of purpose, complete adherence to the budgetary provisions. So if we are sincere and can adhere to budgetary provisions and minimize corruption, ... we will have less problem. This is the area we are having problem. They keep repeating things in the budget every year and they are never implemented"* (PM-MoH 10). According to Transparency International quoted in Kamorudeen and Bidemi (2012, p. 101), corruption in the health sector includes "bribery of health professionals, regulators and public officials; unethical research; diversion/ theft of medicines and medical supplies; fraudulent or overbilling for health services; absenteeism; informal payments; embezzlement; and corruption in health procurement". According to Agyemang, Adu-Gyamfi and Afrakoma (2013) and Fusheini (2016), corruption was equally common in the Ghanaian NHIS. Corruption can affect the success of UHC by reducing investment in the health sector, demoralizing workers, reducing the quality of health care service, reducing trust of both workers and clients in the health system and discouraging participation of people in the UHC scheme, etc.

CONTENT CHALLENGES

Looking at the content issues raised by the participants, it is evident that the establishment of the UHC in Enugu state has a long way to go towards realising this goal. As stated earlier, Saksena, Hsu and Evans (2014); McIntyre and Mills (2012); Giedion, Alfonso and Díaz (2013) and WHO (2013) made it clear that UHC includes the provision of good quality healthcare. It is evident from our research that the quality of health care delivery in Enugu state is poor and this is a big challenge to the establishment of UHC in Enugu state. Some of the quality issues highlighted by the participants include poor clinical staffing in health centres and hospitals, lack of diagnostic and therapeutic equipment, lack of drugs and lack of electricity for hospital services. In addition to the doctors, nurses and other clinical staff are poorly paid and demotivated to provide good care. McIntyre et al. (2013) made similar findings of poor quality of healthcare services in their study of seven low- and medium-income countries, with enrolees in countries such as India, Georgia and Nigeria not receiving the right care they needed. Likewise, Uzochukwu, Obinna and Ezumah (2014, p.7) documented testimonies of lamentations about the acute shortage of staff e.g. *"…… we have acute shortage of manpower. I am the only pharmacist working here for instance. I am the attendant, the dispenser, the youth corps member pharmacist etc. you can imagine that managing the whole district hospital, DHS service provision"* .

These content issues need to be comprehensively addressed in the policy content for establishment of UHC in Enugu state for it to succeed.

Other content areas highlighted by the participants include the organizational/stakeholder structure and financing structure for the UHC, clarity of roles (for healthcare providers and HMOs) and accountability framework for the UHC agency. These areas need to be clearly spelt out in the UHC bill to ensure the sustainability of the UHC in Enugu state and reduce corruption in the implementation of UHC. The UHC bill also needs to be very clear with the financing roles of the state and local governments, and the premiums to be paid by the enrolees and the financial support the government is providing for the poor and vulnerable members of the state. Our participants clearly spoke about the economic recession in the country, the paucity of salaries paid to civil servants and the need for this to be improved for these people to be able to pay their contributions for the UHC scheme.

Another important content area mentioned by the participants is the referral system in our health system. As stated by some of the participants and supported by other studies (Akande, 2004; Uzochukwu, Obinna and, Ezumah 2014, Oyedeji and Abimbola, 2014 and Ekwochi et al., 2015), the referral system in our health system is abused to the extent that cases that can conveniently be managed at the primary care level arrive at the tertiary level hospital as their first port of call. This overwhelms the tertiary level hospitals and increases the cost of treatment. For UHC to work well in Enugu State, the referral system should be implemented to support efficient and effective delivery of health care for the whole population.

PROCESS CHALLENGES

The process issues considered here include the legislative / political process for establishment of UHC, the stakeholder engagement process, importance of communication for engaging the stakeholders to support and

participate in the programme and the implementation process.

As pointed out by some of the participants, one of the major challenges to establishing UHC in Enugu state is the lack of enabling law establishing Enugu state UHC agency, even though considerable progress has been made as at August 2018. One of the key informants in this study put it like this: *"You need to have the legislative framework for such schemes. And as at now, none exist. So the fact that we do not have a legislative framework, it's already constraining such financial risk protection"* (PM -MOH 4)

However, as political office is a revolving door, the continuous change of political office holders, including the governor of Enugu state could be a challenge resulting in delay in passing the bill establishing UHC in Enugu state. It will be necessary for the UHC bill to lay the affirmative foundation for government to finance coverage for the poor and vulnerable groups in the state as well as assure the delivery of quality health care. In that regard, the bill should provide for sustainable funding of the UHC through mandatory participatory social contribution, taxation and other ring-fenced government funding sources (Bastagli, 2013 and Doetinchem, Schramm and Schmidt, 2006).Equally important is the legislation supporting reforming of the District health system in Enugu to support the delivery of quality health care to strengthen the health system in Enugu state (Uzochukwu, Obinna and Ezumah 2014; Wolvaardt, 2014).

As stated by one of our key informants, *"prepayment mechanisms do not work in isolation... they work in a stronger health system; we need stronger health systems"* (PM – MOH 9). This finding is supported by Aregbeshola (2017) findings. Hence, for UHC to succeed in Enugu state, the current health system in Enugu state needs to be reformed to support the implementation of UHC in the state.

An important area of the policy process as highlighted by McIntyre et al. (2013) is the implementation processes. Some of the challenges in the implementation processes highlighted in this study include the lack of communication with the public about the UHC, lack of awareness by the public and health care providers, the problem of corruption and absence of accountability within the government. For example, in respect of corruption, one of the participants stated this: *"Corruption is a major issue in healthcare delivery especially with respect with universal health coverage. --- because of corruption, resources that are meant for programmes easily disappear and even when they are being utilized you will discover that not more than 10% to 30% of the resources meant for such programme are normally spent on that programme, so corruption is major factor"*(PM-MoH10).Other authors also found corruption to be a major problem in the implementation of UHC (Aregbeshola, 2017; Fusheini, 2016 and Agyemang, Adu-Gyamfi and Afrakoma, 2011)).

Another implementation process challenge identified in this study is the role of HMOs in the implementation of UHC with some participants calling for the prohibition of HMO involvement in the process. This is not surprising as the Executive Secretary of NHIS accused the HMOs of "of collecting billions of naira from the NHIS but failing to pay hospitals as required, and, as a consequence, jeopardising the care that NHIS enrolees are entitled to" (Pulse News, 2018).

Conclusion

In this study we set out with the understanding of UHC to be synonymous with FRP and provision of good quality health care service to all the people. It is evident from the literature that contributory social insurance scheme that is universal, progressive and mandatory with adequate subsidy provisions for the poor and vulnerable groups in the society are the prerequisites for sustainable UHC in Enugu state and Nigerian in general. Using the Policy Triangle framework – Context, Process, Content and Actors – paradigm, we have studied the challenges facing the establishment of a sustainable UHC in Enugu state and found that there are challenges to this scheme in all the policy areas from policy development to the implementation. Some of these include:

1. The lack of political will supported with financial commitment by the political leadership in Enugu state.
2. There is no UHC bill to support the establishment of UHC in Enugu state and the legislative process goes round and round while people suffer from catastrophic and impoverishing OOP payments.
3. The scepticism by the citizenry and organized labour unions in the state to support the scheme due to mistrust of the government sincerity and probity.
4. Lack of expertise among the health administrators, health care providers and the HMOs in administering the UHC Insurance scheme in respect of provision of quality health care.
5. The harsh economic reality of poverty in Enugu state and Nigeria cannot be countenanced. Enugu state received one of the lowest shares of the Federal government fiscal allocation for state governments and the means for generating IGR in the state is limited. This will make it difficult for the state to provide sufficient funding to make UHC a reality in Enugu state.
6. Corruption in as a cankerworm in the Nigerian society and government exists in Enugu state as well. In its many forms, corruption could be the bane of running a sustainable UHC in Enugu state.
7. The poor state of the quality of health care services in Enugu state - from staffing, poor infrastructure and equipment to poor clinical practices, there is need to improve the health care system in Enugu state and Nigeria in general to a level that will assure good quality health care service provision before we can say we can provide

Universal Health Coverage in Enugu state and Nigeria in general.

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