Abstract: It is time worn to state that health is wealth. Yet this assertion is no less true and significant today as it was yesterday. Indeed, a healthy nation is contingent on healthy citizenry (1st NDP). This perhaps explains why no nation had ever attempted to go to sleep while its 'health house' is on fire. In fact, the health of a nation defines its potentials and actual deeds. The continual featuring of health in all the national development plans so far made, underscores the importance of the health of this nation's citizens to our social planners. Be that as it may available evidence shows a vacuum between rhetorics and action. While no two analysts agree on the modalities of making health care delivery services accessible to all (Steiner, 1966; Navarro, 1976; Titmus, 1966; Field, 1960). This paper is an attempt to contribute to this debate. Essentially, it warns that unless we re-order our priorities and achieve social justice in the health sector first, we may never be in a comfortable position to discuss the issue of integration less alone meaningful progress in the third republic; come 1992, when the present military government hands over power to a democratically elected government. Here lies the thrust.

INTRODUCTION

In his summation of the development of formal welfare scheme in Nigeria, Sanda (1987) observed that health care in the period 1870 to 1910 was largely in the hands of the Missionaries even though the state coped with the health needs of the British soldiers through the Military hospitals in Zungeru, Lokoja and Zaria. The first world war period saw the establishment of bush hospital especially around the war zones, while the depression of 1930s and the discontent among the ex-service men and the nationalist agitations all combined to direct the attention of the colonial government to the society's welfare needs. It was in this context the laws of 1940 were made to cope with the labour and children welfare needs, the 1945 ordinances were directed at solving the problems of disabled soldiers and the 1948 law designed to enforce the obligations of families to under 14 children. By the same token, workmen's compensation ordinance of 1941, 1945 and 1959 laws of the Federal republic of Nigeria all tried to protect workers on matters of contract, injuries at work compensation, forced labour, employment of young persons, wages, maternity leave and so forth. He then concluded by saying that the welfare structure that emerged became a combination of the
traditional pre-colonial heritages with equal dependence upon the efforts of the voluntary organisations and government as well as the extreme regionalization before the advent of the military. It goes without saying that the various Nigerian governments since independence have been aware of the ‘welfare–plight’ of Nigerians (1st–4th NDP). Be that as it may, the extent to which precepts have been substituted for action remains largely questionable. Aside the fact of official default in pursuing the orthodox approach to health care delivery services with all its curative emphasis, despite epidemiological reports which amply demonstrate that the bulk of the prevailing diseases in the tropics are preventable, reports concerning the state of disrepair to which Nigerian health services have continued to be taken lightly by the government of the day, while coup leaders now use such abysmal state of health as excuses for taking over power. This is further exacerbated by a number of factors, among which are the recent increase in brain drain which appears to have hit the health sector hardest, the fact of a steady rise in population and most of all. The WHO's call for health for all by the year 2000 (WHO 1978).

It is right to acknowledge that the Nigerian government is aware of this situation and have made a proposal for a health insurance scheme. However, the proposal as it stands now, will not actualise social justice in health distribution as it is tailored to cater for only the government 6 million work force and their 30 million dependants (The Guardian, Oct. 1, 1989). What this means is that the injustices of not catering for the remaining 94 million will continue to be perpetrated. Besides, with a ceiling of 12,000 patients currently proposed and an average of 32 patients per day; to be attended by an unassisted doctor, the entire package seems a panic measure designed to stem the tide of brain drain, by putting more money in the way of the medical doctor rather than improve the well being of the community. Besides, if patients are to be wholly responsible for consultation and drug fees, the question one would like to ask is whether the ‘old and stale wine’ has not managed to find its way into ‘new wine skin’. It is with a deep sense of correcting this unjust situation that we are proposing a partially free and comprehensive package with universal coverage.

**NATIONAL HEALTH INSURANCE SCHEME: A PROPOSAL**

Epidemiological studies have made it possible for us to predict the incidences of diseases in human populations. In taking advantage of this, various countries like Canada, Britain, Denmark, Zimbabwe and a host of others have designed and implemented various forms of insurance schemes, not the least, health; for their people. It is our firm belief that Nigeria can do likewise.

Health insurance scheme, like all other social policies is designed to act not only as checks in times of need, but also to conserve, protect and improve human responses (Friedlander, 1968; Rein, 1970). For clarity, we shall discuss it under the following 3 headings, namely: Scope, Finance and Method of provision.

**Scope**

The issue of what scope or range of people within a population should be covered by health policy is a fundamental one, with its consequences real. In addressing this issue, various countries have adopted various styles. For example, in Britain, a series of social
schemes existed until the Beveridge proposal of 1946 that led to the national health insurance scheme they have today. The same can be said for Canada, Denmark, New Zealand and a host of others. Today however, most of these countries run a centralized insurance scheme. The truth in the statement that the well-being of a nation is dependent on the state of health of its inhabitants suggests that we guarantee a minimum amount of health to every Nigerian. It is in the light of this that we postulate a compulsory, comprehensive and partially free insurance scheme with a universal coverage for this nation.

FINANCE

The issue of how to finance insurance scheme is no less complex (Steiner, 1966). Again in going about it, countries have always found it convenient to classify the population into employers of labour, employees, the self employed and dependants. We subscribe to this but would insist on the following modalities.

**EMPLOYERS:** A proportion of the total profits of all registered companies and those of unregistered employers of labour be taxed. All newly established firms should however be given three years tax-relief period to enable them stabilize. The payment should be made at the beginning or end of every financial year.

**EMPLOYEES:** All workers should be taxed to support the scheme. Such deductions should be graded and should take the form of pay-as-you-earn.

**SELF EMPLOYED:** All self employed people should be asked to pay a stipulated annual flat-rate to support the scheme. Like the employers, all newly self-employed people should be given a period of three years to stabilize. Besides, such rates should not be beyond the affordable reach of this category and should not be too low to make others feel cheated.

**DEPENDANTS:** As the name implies, this category has no means of livelihood. At least not as yet, and so cannot be taxed. All these payments should be subsidized by the Federal government which like the employer should reserve a percentage of the total revenue accruing from the sales of all natural resources of this nation to support the scheme. This can be further supported by the Federal, state and local governments by donating a part of their internally generated revenue to further fund the scheme.

**PENSIONERS:** By the same token, all pensioners are to pay a part of their earned income as contributions to the scheme. Again, we recommend that such contributions should be graded. This way, the scheme can be successfully financed, with the ‘never-sick’ carrying the ‘ever-sick’.

METHOD OF PROVISION

The fact that the bulk of the prevailing diseases in the tropics are preventable is no longer in doubt. If anything, epidemiological researches have made it abundantly clear. It is therefore to be expected that any proposal for health should take into account this salient fact. We are therefore proposing a two-headed prong: namely, preventive and curative measures.

**PREVENTIVE MEASURES:** Here the Federal Ministry of Health is to purchase drugs and are expected to organise periodic inoculations against the various contingencies of diseases as it currently done under the expanded programme on immunization. It should devote a part
of its budget to setting up schools for training public health educators and other paramedical staff, who will in turn facilitate the implementation of its programmes.

Since more than a tenuous relation exists between cultural practices and the occurrence of certain diseases in some areas (Meck, 1971; Oke, 1982), it will be the duty of such public educators to identify this relations and to point out why such people should invest in health by discontinuing such practices. If this preventive measure is sufficiently carried out, it should lessen the cases of ill-health for curative attention.

**CURATIVE:** There are diverse methods of operating insurance schemes, as there are countries. However, such method as may exist in a country, is usually dictated by the historical background, the needs, resources available and the acceptibility of the common use of such resources. Nigeria is currently into the era of privatization. However, the herculean nature of the task of maintaining a comprehensive health insurance policy with universal coverage goes beyond that of utilizing a private firm (Brieland, 1980). It is in recognition of this that we recommend reliance on existing structures.

We propose that all government health structures in all three levels of government be made the live-wire of this programme. The assignment of the Federal as well as the state governments should be limited to supervisory role. In this, the Federal Ministry should take precedence over the state, which should be seen as an organ for carrying out its directions in the various localities.

All structures are to be regarded as existing in the local government where they are located, and steps should be taken to see that all local governments have at least a 200–500 bed space hospital, that is adequately staffed. We suggest that the bulk of the cases should be handled on out-patient basis. More so when preventive dosage will be a part of the focus. The actual running of the hospitals should be left in the hands of the governing councils or management committees whose duty it should be to oversee and determine the budget of each of such hospitals. Such persons as will be appointed should compose of staff of the Federal or state ministry of health, in addition to limited members of staff of the hospitals and those of the public.

This should be followed by a direct call by the Federal Ministry of Health to its organs in states, to register and maintain a record of people in their localities. Such registration should be comprehensive enough to show the demographic attributes of the people. More importantly, it should show their ages, occupation and addresses. The duplicate of such records should be sent to the Federal Ministry of Health which ideally should maintain a central bank data unit on all localities.

Knowing the number of people by their social characteristics will further lend hand to ascertaining the number of persons who fall into the categories of people to the levied and the number of dependents. This will facilitate planning. By the same token, a list of all doctors who are interested in participating in the scheme should also be kept. All doctors already working for the various governments can either continue to work and receive their usual salaries or can withdraw their appointments and take-up contract like all other private doctors interested in the scheme. Based on the list collected, both the doctors and patients should be divided on local government basis. After this, doctors should be given the list of people they are to be ministering to. Such doctors should however have the powers of referral or even to consult other doctors in cases that need specialized treatment. This should be at no extra cost to the patient.
Again, the number of doctors to patient ratio should be determined by the size and bed-space of their hospital. Doctors will be expected to be paid on item for service basis. This principle should apply whether the service is that of a general practitioner, dentist, ophthalmologist or surgeon. However, services by specialist should attract better pay than those of general practitioners. Another way to go about this is to utilize only specialists and remunerate commensurately. The advantage of item for service payment is that it will not only make practice in this setting lucrative, but also stem the tide of brain drain. Such payments and ceiling will be pegged by the governing council at the Federal Ministry of Health, so that a uniform fee is adopted by all local government councils. All those who are working for the effectiveness of this scheme, be they doctors, paramedical staff, monitoring unit, or part-part governing council, should be remunerated from funds generated for the scheme. For effective monitoring of operation and prevention of false claims, it is expected that only the health centres or hospitals to be cited at the local government headquarters should be utilized for this scheme.

Patients may be allowed to change their doctors, but the right should be minimised as it can be abused, and used only at discretion, as where lack of confidence is established, or where a consenting note is issued by his/her personal doctor. In addition, such a person should give four weeks notice giving reasons and preferences. All patients are expected to show proof of eligibility. Only those who pay should be entertained. People out of their stations can utilize any hospital of their choice on the production of an up-to-date proof of subscription. What this means is that doctors may be allowed to treat patients outside their lists, but this should not be more than a predetermined number and such cases should be reconciled with his personal doctor in the locality.

Consultation with doctors for all patients should be free, but patients should be made to pay 75 per cent the cost of prescribed drugs. Hospitalised patients should pay 33.33 per cent hospital bill and 25 per cent the cost of diagnostic tests and in cases where patients foot all the bills, receipts should be submitted to the audit department of the hospital concerned, for reimbursement.

In order not to strangulate patients, government should produce and/or import most of the drugs. This will help to keep the lid on the gain-margins made by pharmaceutical companies and hence reduce costs of health at the end of the day. Since doctors will form the corner stone of this scheme, the least the supervisory body can do to guarantee fair play is for it to set up in all the states in Nigeria, committee of insurance doctors to discipline erring doctors or to refer the matter to the Nigeria Medical Association, which duty it is to exercise this role. Finally, all this should be given the necessary legal backing.

DISCUSSION

The range of people to be covered by any National Health Insurance Scheme is something that all nations intending to establish such program must grapple with. Generally, the scope of any national insurance scheme is limited by a number of factors, foremost of which is the nature of the scheme. For example, is it private or public? Under private insurance, you have self-help, which in the beginning of the insurance industry, involves a group of people pooling resources together against the contingencies of diseases, ravages of fire and other forms of natural disaster. Private insurance could also involve the individual taking out
insurance policy on whatever contingency he wants to and lastly it could mean employers or unions making private arrangement to cater for the welfare of their employees or members. One common strand that runs through all such arrangements is that it covers only those who take them out or on whose behalf they are taken.

Private arrangement constitutes the principal form of insurance in Denmark, France and Japan. It is also the practice in most of the states in the United States, which in addition to Switzerland remains the only two industrialized countries without resident compulsory insurance (Enc. Britannica, 1987).

The other method of making provision for health insurance scheme involves the public or government. The government of any nation can take steps to provide a range of social security measures like housing, sanitation, transport, pension, old age, medicare and so on. Coverage under public tutelage is limited by the aim of establishing the programme and the resource available to the state. The latter is further predicated upon the magnitude and general perception of the wealth. For example, a nation where all are agreed that no man can be self sufficient in the face of the unpredictable forms or dimensions of life’s hazards, and does have the resources, are more likely to impress it on their government to make social security measures a matter of priority.

Consequently, several countries have adopted modes, ranging from limited coverage of the population to full coverage. For example, 100 per cent coverage exists in the U.K. and in Cuba. Eighty per cent in Argentina, Brazil and Costa Rica. Fifty per cent coverage exists in Uruguay, Mexico and Panama; while more than 25 per cent exists in Bolivia and Venezuela whereas, others and in particular, African countries have less than 10 per cent (Enc. Brit., 1987).

Differing approaches to coverage also exists. For example New Zealand extended medical coverage to all residents in a number of stages. Beginning with free in-patient treatment in 1939, through out-patient treatment and free pharmaceutical to part payment of general practitioners in 1941. Further steps were taken later on. And while India Government extends full coverage only to states that can maintain them, Korea extended health insurance only to her urban employed citizens (Enc. Brit., 1987). Korean example is akin to the one currently proposed by the Federal Government of Nigeria, where only the government six million work force and their thirty million dependants are to be covered. The injustices of this proposal is seen when this computed sum of 36 million is removed from the current estimated population of 130 million (Sanda, 1986). This has far reaching consequences for health services in the rural areas where at least 90 million Nigerians live and where less than 10 per cent government establishments are located (1st-4th NDP) and for the realization of WHO’s call for health for all by the year 2000 (WHO, 1978). This perpetuated social injustice as seen in the concentration of social amenities in the urban area to the neglect of the rural population, who in part provide the bulk of the nation's wealth, is also noticable in Kenya, Zimbabwe, South Africa, Ethiopia and a host of other African states (Dixon, 1987). A further consequence of the above imbalance in the allocation of resources between the rural and urban sectors, is that the greater part of the health vote is spent in the urban area. Sadder still is the fact that available records show that the latter is not without a share of its injustice as most of the supposed urban vote end up under such ambiguous labels like 'hospital programmes' which are completely devoid of all services, be it preventive, palliative or curative (3rd NDP).
In our opinion, what is needed is a comprehensive preventive and curative man-centred national health insurance scheme, that will promote the health of everyman, not as found in one occupational group or social class, but man as devoid of all social taxonomic concepts and deserving a baseline guarantee by the society against the contingencies of diseases and other hazards of life that can debar him from living a fuller life.

Social insurance schemes anywhere found are usually financed from contributions, derived from the government, employers and employees. What makes the difference among countries is the proportion in which these services are utilized. Chambers’ Enc. (1973) reported that when compared to Britain, which has universal coverage, the national scheme and pension schemes in West Germany, France, and Italy, are characterised by their high contribution and benefit rates and the smaller percentage contribution of the state. Whereas, in the unemployment riddled Western Europe of the 1970s, the trend in Denmark, Ireland, Italy, The United Kingdom, Portugal and The Netherlands, was that of shifting costs away from employers unto taxes. By the same token, Enc. Brit. (1987) reported that no cost falls on the limited schemes in operation in places like Burundi and Ethiopia, and on the wider scheme in Malaysia, Philippines and Singapore. Whereas, contributions play a very small role in Austria, Czechoslovakia, Denmark, New Zealand and the USSR, where the bulk of costs is covered by taxation. National health insurance scheme in the UK is generally financed 50 per cent from taxes and 50 per cent from contributions.

What we have established is that all societies are dynamic and at all times try to make social security measures as relevant and amenable as possible to the prevailing circumstances and needs of their people.

Aside all the above listed sources of funds for sponsoring national insurance schemes, assistance by agencies also play a vital role in this exercise. In fact such programmes as those of the needy, aged, survivors and so forth, are supplemented with assistance payments in Austria, Czechoslovakia, France, West Germany, The Netherlands, United Kingdom and the US. Yet the US and Switzerland, can be lumped together in another extreme as archtype countries where tripartite financing as defined above is not practised. In fact, in the United States, such schemes are resisted by various organised bodies like the American Medical Association which argue that it is unwise to socialize medical practice in a free enterprise oriented country (Soc. sc. enc., 1968, Erinosho, 1981).

All systems sponsoring national insurance schemes are faced by problems of actuarial principles. They have to entertain such questions as to whether to make benefits related to prior earnings or whether needs should not take precedence. While this issue cannot be completely resolved, countries have adopted differing measures which themselves have influenced the state of health in such nations. For example, the United States adopted the earning-related benefit, whereas the United Kingdom in addition to adopting similar measure has introduced a floor to ensure that the common man is guaranteed some subsistance level or minimum standard of living.

Benefits under the scheme we are proposing are essentially medical and of service. Not cash. We are contented to allow existing firms handle company injury as dictated by existing union laws. What we are concerned with in this work, is laying a foundation for the take-off of a national health insurance scheme with a universal coverage.

Experience has shown that contributions to national health insurance schemes and other forms of social security designs, are strictly taxes on earned incomes. In our proposals, we
stated that the Federal Government, state, local, employers, employees and pensioners are to bear the brunt of financing the scheme in Nigeria. This is different from the practice of asking the employers and employees to carry the greater part of the burden if what the government is proposing comes through.

The advantage of asking the various arms of the government to contribute is obvious. Nigeria lacks accurate census figure. The last estimate was 130 million. If we remove government 6 million work force and 30 million dependants, we shall a staggering sum of 94 million uncartered for. Therefore, it would help to adopt a method that will involve everybody.

The Federal Government like the state and local government councils, is to donate a certain percentage of all their internally generated revenue and should in addition, give a part of the proceeds from the sale of all natural resources of this country. This is the only way the wealth can be held commonly.

In addition to the practice of taxing the employer and employees as individuals, we proposed that both be taxed accordingly and for the company to be taxed as a corporate body. The benefit of giving tax relief to newly established companies is seen in the fact that not many large corporations exist in Nigeria, and while many are still out of jobs, making employers pay part of the insurance for each employee, may be good in the short run but might prove regressive in the long run as it will probably lead to utilizing short cuts to contribution liability like giving jobs out on contract for a money wage, introducing overtime or even retrenchment. A phenomenon that will further worsen the already soared labour market. As for the argument that it is socially unjust to tax the employers as well as the profit of their corporation, we feel it is the least they can do to keep the system going. In any case, reports exist to show that employers' contributions are not always paid at the expense of profit (Enc. Brit., 1987). Besides Romanysyn (1971) has argued that all welfare programme does is to maintain the discipline of work and in real term ensures that somebody will be around to do the dirty job and by so doing, prevent people from probing into the more fundamental question of the causes of dependency. And while such thoughts are also inherent in the work of Filgerald (1977), De Schweinitz is of the opinion that the question of inequality would not have arisen if all it takes is the ability to contribute to society. This reason also underlay and serves to highlight the sharp difference in our proposal as against existing ones where governments set up special funds to run insurance schemes rather than contribute from its main revenue as we advocated.

We also proposed that a proportion of all pensioners' allowance be taxed to support the scheme. The tax should be graded and should take the form of pay as you go. It is common knowledge that the aged in all societies spend more on health than workers. Again, in a situation where we are proposing a universal coverage, it is only right to include all beneficiaries with known sources of income. Steiner (1971), has also made this call.

Enc. Brit. (1987) lists three modes of provision of health insurance benefits, namely; direct, indirect and reimbursement. Under direct service approach, the government or sponsoring body owns the facilities which include hospitals and clinics. It also pays for the supply of drugs and remunerates all staff. As the name implies, this is a direct contrast of the second method which entails the funding body making contract with people who provide and get remunerated accordingly. Whereas patients foot the entire bills and later submit them for claims in the third category.
A comparative study will show a preponderance with any of these methods. Reimbursement for example is largely used in France and to some extent in Australia and Sweden. The indirect method is heavily utilized for all services in such countries as Belgium, West Germany, Luxembourg and The Netherlands. Whereas the direct mode is employed in The UK, Scandinavia, Greece, Spain, Portugal and a host of others.

At a glance, this forms represent a tendency towards regidity. Habit has however shown the contrary. Indeed countries use a combination of these at any point in time, with the emphasis on any particular method dictated by the global configuration, the socio-economic and political order of the day. For example, aside employing the direct method, the national insurance scheme in Britain utilizes indirect contract for general practitioner, community pharmacist, opticians and most dentists. The same phenomenon is said to be at work in Greece, Italy and most Latin American countries (Enc. Brit., 1987). This observation can be made for our proposal which utilizes the direct method in the main but also insists on the third category where patients end up footing the bills.

In writing this paper, we made a number of assumptions:

1. That since men live in an organized community, the society owes it as a duty to provide a basic social security measure especially in the light of the contingencies of diseases and other forms of hazards the individual is ill-equipped to grapple with.

2. Inherent in the above is the assumption that health is an inalienable right of all citizens and should remain so if human societies are to make meaningful progress.

3. Bearing in mind the concept of social justice, we have implicitly argued that the wealth of Nigeria belongs to all Nigerians and should be maximally used for the benefit of all if we are to develop.

4. That when once we identify health as an active ingredient of development, the advocacy that it be accessible, compulsory and comprehensive is not too difficult to follow.

5. That to undermine these assertions is to support arbitrary and continuous duplicated health policies, to undermine the very health of the uninsured 94 million Nigerians with each of them automatically turned into a melancholic agent of development, to threaten the survival and well-being of the nation as well as render the principles of integration and meaningful progress in the third republic redundant.

The days of the much celebrated Daniel Defoe's hero—Robbinson Crusoe has come to an end in most countries of the world (Crampton, 1972; Smelser, 1966; Titmus, 1966). Today, men are no longer thought to be masters of their fates who must, following the principles of social Darwinism which pervaded western societies of the 19th century, engage in stiff competition for existence and reap the full consequences for his action or inaction. Indeed, it would appear that the definition of society which emphasis interaction has made increasingly impact on the leaders of men. Whether this phenomenon has its roots in the discovering of the fact that poverty has a direct relation with the social institutions that determine the allocation of personal and social resources needed for existence and competing for positions and power as Romanyszyn (1976) has hypothesized, or the benevolence act of a mover-unmoved, suffice to say that developing nations are aware of this and are atuning themselves more to the well-being of their peoples. Sadly however, a great gap still exists between precepts and deeds in most of these countries. The problems of implementing a national health insurance scheme are diversified, and range from the presence of resources, manpower to planning. We strongly believe that Nigeria has the resources to set up such a scheme if
properly managed. Tawney (1966) must have had Nigeria in mind when he argued:

Health... is a purchasable commodity, of which a community can possess, within limits as much as it cares to pay for. It can turn its resources in one direction and 50,000 of its members will live who would otherwise have died. It can turn them in another and 50,000 will die who would otherwise have lived.

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