Improving Pharmacy Services within National Health Insurance Scheme for better performance

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ABSTRACT

Background: Following many attempts at implementing policy strategy on health insurance since 1960, NHIS was eventually launched in 2005. It has a mandate for universal health coverage for Nigeria. The important roles of pharmacies are discernible in NHIS statutory objectives, though the NHIS operation is largely to the exclusion of Pharmacists Council of Nigeria (PCN)-licensed pharmacies.

Objectives: This review was carried out to create an awareness about the exclusion of pharmacists and the pharmacy profession in NHIS operations, and to recommend practical solutions.

Method: We conducted a review of relevant literature on health financing and provider payment mechanisms, in addition to NHIS and PCN documents relevant to NHIS operations.

Results: The healthcare financing function of strategic purchasing, and the closely related provider payment mechanisms are well defined in NHIS documents. NHIS adopts global capitation among other provider payment mechanisms, to control costs. The implementation is evolving and could benefit from periodic evaluation of NHIS payment methods. Other identified implementation gaps include the exclusion of pharmacies as legal entities and other health professionals.

Conclusion: The adoption of global capitation, and the consequent exclusion of some healthcare providers, can be seen to be detrimental to NHIS' overall performance, and enrolees' satisfaction. For improved performance, recommendations include - re-designing NHIS provider payment system by contextualising lessons from countries like the Kyrgyz Republic; harnessing the expertise of all health professionals including licensed pharmacies; Also, PCN needs to craft professional development strategy to hone pharmacists' prerequisite skills for providing pharmaceutical care which Nigerians direly need.

Key words: NHIS, Provider payment mechanism; Health Financing; pharmaceutical services

Améliorer les services de pharmacie au sein du régime national d'assurance maladie pour de meilleurs résultats

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RÉSUMÉ

Contexte : Après de nombreuses tentatives de mise en œuvre d'une stratégie politique sur l'assurance maladie depuis 1960, le NHIS a finalement été lancé en 2005. Il a pour mandat d'assurer une couverture sanitaire universelle au Nigeria. Les rôles importants des pharmacies sont perceptibles dans les objectifs statutaires du NHIS, bien que le fonctionnement du NHIS exclue largement les pharmacies autorisées par le Conseil des pharmaciens du Nigéria (PCN).

Objectifs : L'article vise à contribuer à la sensibilisation sur l'exclusion des pharmacies dans les opérations du NHIS, et à recommander des solutions pratiques.

Méthodes : L'article examine la littérature pertinente sur le financement de la santé et les mécanismes de paiement des prestataires, ainsi que les documents du NHIS et du PCN relatifs aux opérations du NHIS.

Résultats : La fonction de financement des soins de santé de l'achat stratégique, et les mécanismes de paiement des prestataires qui y sont étroitement liés sont bien définis dans les documents du NHIS. Le NHIS adopte la capitation globale parmi d'autres mécanismes de paiement des prestataires, afin de contrôler les coûts. La mise en œuvre évolue et pourrait bénéficier d'une évaluation périodique des méthodes de paiement du NHIS. Les autres lacunes identifiées dans la mise en œuvre comprennent l'exclusion des pharmacies en tant que personnes morales et des autres professionnels de la santé.

Conclusion : L'adoption de la capitation globale, et l'exclusion conséquente de certains prestataires de soins de santé, peuvent être considérés comme préjudiciables à la performance globale du NHIS et à la satisfaction des personnes inscrites. Pour améliorer les performances, les recommandations comprennent - la refonte du système de paiement des prestataires du NHIS en mettant en contexte les leçons de pays comme la République du Kirghizistan ; exploiter l'expertise de tous les professionnels de la santé, y compris les pharmacies autorisées. En outre, Le PCN doit élaborer une stratégie de développement professionnel afin d'affiner les compétences préalables des pharmaciens pour fournir des soins pharmaceutiques dont les Nigérians ont cruellement besoin.

Mots clés : NHIS, mécanisme de paiement des prestataires ; financement de la santé ; services pharmaceutiques

INTRODUCTION

Similar to most low- and medium-income countries (LMICs), Nigeria is confronted with health financing challenges, notably, low and retrogressive healthcare financing parameters. Nigeria has a long history of policy efforts to achieve healthcare coverage for its population. The need for strategies to improve healthcare funding during the economic recession of the 1980s reawakened the proposal for national health insurance targeting UHC in Nigeria.[1]

After many attempts at implementing policy strategy on health insurance since 1960, NHIS was established in 1999 and eventually launched in 2005. It has a mandate for universal health coverage for Nigeria. NHIS operations are fraught with some issues detrimental to its utmost performance. For instance, despite the fact that important roles of the pharmacy profession are readily discernible in NHIS statutory objectives, the NHIS operation is largely to the exclusion of PCN-licensed and NHIS-accredited pharmacies. This article aims to contribute to creating awareness of the exclusion and to recommend measures toward the inclusion of pharmacies.

METHODS

The article reviewed relevant literature on health financing and provider payment mechanisms, and NHIS documents relevant to NHIS operations. The current situation is analysed, operational gaps identified, lessons from international experience discussed, and recommendations presented.

RESULTS

Healthcare financing and universal health coverage

Globally, health care expenditures have risen from 3% of world GDP in 1948 to 7.9% in 1997.[2] However, back home, the health financing statistics are yet to improve; for instance, in 2017, Nigerian total health expenditure (THE) 73.935 USD was a low 3.8% of gross domestic product (GDP), the former was largely skewed towards out-of-pocket (OOP) - 77.22% of THE. OOP per capita stood hugely at - 57.088USD.[3]

This increasing spending worldwide has prompted nations to embark on search for sustainable health financing arrangements to ensure equitable financial access to care. Subsequently, global attention has converged on the need for countries to achieve universal health coverage (UHC). UHC aims to guarantee that all persons are able to equitably access needed and effective healthcare (promotive, preventive, curative and rehabilitative health interventions) without facing financial ruin.[4]

In the attempt to realise UHC, several low- and middle-income countries are developing more sustainable revenue sources, expanding pooling arrangements and employing more efficient and sustainable value-based purchasing strategies.[1]

Insurance systems

Social Health insurance (SHI), as a social security system, guarantees the provision of needed health services to persons on the payment of token contributions at regular intervals. SHI is strong in providing stable source of revenue, a visible flow of funds into the health sector, and in combining risks pooling with mutual support.[5] Greater fairness in financing is only achievable through risk pooling - whereby the healthy subsidize the sick, the rich subsidize the poor, and the young subsidize the old.[2] Consequently, many countries have introduced SHI as a part of social security package for their citizens.

National Health Insurance Scheme

National Health Insurance Scheme is a body set up by Decree 35, of 1999 (now Act 35 CAP N42 LFN 2004) operating as Public Private Partnership and directed at providing accessible, affordable, and qualitative healthcare for all Nigerians.[6] Although established in 1999, NHIS was formally launched in 2005. The Scheme is designed to facilitate fair financing of health care costs through pooling and judicious utilisation of financial risk protection and cost-burden sharing for people, against high cost of health care through institution of pre-paid mechanism.[7]

NHIS objectives

The ten objectives of the scheme as captured in the NHIS Act 6 are as follow

i. ensure that every Nigerian has access to good h ealth care services;
ii. protect families from the financial hardship of huge medical bills;
iii. limit the rise in the cost of health care services;
iv. ensure equitable distribution of health care costs among different income groups;
v. ensure efficiency in health care services;
vi. maintain high standards of health care delivery services within the scheme;
vii. improve and harness private sector participation

in the provision of health care services;
viii. ensure adequate distribution of health facilities within the Federation;
ix. ensure equitable patronage of all levels of health care;
x. ensure the availability of funds to the health sector for improved service

Purchasing function and operations of NHIS

The purpose of health financing is to make funding available, as well as to set the right financial incentives for providers, to ensure that all individuals have access to effective public health and personal health care. To ensure that individuals have access to health services, three interrelated functions of health system financing are crucial: revenue collection, pooling of resources, and purchasing of interventions.[2]

All these three functions are among the many functions of National Health Insurance Scheme (NHIS). Setting performance standards and regulations as contained in NHIS Operational Guidelines, and ensuring compliance by Health Maintenance Organisations (HMOs) and Health Care Facilities (HCFs) are among the others. Only purchasing as a health financing function is briefly described below.

Purchasing is the process by which pooled funds are paid to providers in order to deliver a specified set of health interventions. Purchasing can be performed passively or strategically. Passive purchasing implies following a predetermined budget or simply paying bills when presented.[2]

Strategic purchasing involves a continuous search for the best ways to maximize health system performance by deciding which interventions should be purchased, how, and from whom. This implies actively choosing interventions in order to achieve the best performance, both for individuals and the population as a whole, by means of selective contracting and incentive regimes.

For effective strategic purchasing, negative or positive incentives should be in place to encourage providers to supply only the services that are required, at a high level of quality.[2] Closely related to purchasing function is design of appropriate provider payment system as discussed under 'Gaps' below.

NHIS programme and benefit package

NHIS programmes are designed targeting the various sectors of the population namely, the formal, and informal sectors, and the vulnerable groups. These programmes are the public service, organised private sector, community-based, tertiary institutions' and prison inmates' programmes. A non-contributory intervention is the defunct joint NHIS-Millennium Development Goal (MDG) Maternal and Child Health (MCH) project. The Basic Healthcare Provision Fund (BHPF) is the new programme targeting the vulnerable groups.

The benefit package of the flagship formal sector programme is comprehensive, cutting across the three levels of healthcare delivery, excluding few conditions not ordinarily feasible under insurance principles. The packages for the other programmes are defined at the guided discretion of respective stakeholders; with due consideration to local context, disease prevalence and package cost.

The NHIS Operational Guidelines stipulate the minimum required standards for operations of providers including pharmacies. The services that make up the benefit package are provided by private and by public facilities. Providers, including pharmacies, for the three levels of healthcare were duly accredited prior to commencement in 2005. Subsequently, participating providers are periodically re-accredited to ensure the continuous delivery of qualitative health services.

The packages include the range of medications for the stated conditions. The NHIS Drug Price List derives from the Nigerian National Essential Drug Lists, with some additions outside of the list as deemed necessary. To contain costs, and engender rational drug use, and in line with Nigerian Drug Policy, NHIS implements the Generic Drug policy. Additionally, the drugs for inclusion must be registered by the National Agency for Food and Drug Administration and Control (NAFDAC).

NHIS Guideline is also supplemented by other periodically revised policy documents notably NHIS Fees for Professional Service. The NHIS drug list of 2016 has 516 products in 887 dosage forms. Prescribers are not expected to prescribe outside of it. Similarly, pharmacy providers are not under any obligation to fill prescriptions for drugs not on the list. Nevertheless, a pharmacist may, in agreement with the prescriber, initiate substitution where necessary. Furthermore, pharmacies are under obligation to source every prescribed drug on the list, and make available to enrolled patients as appropriate. It is, therefore, an offence eligible for sanction, to deny

enrollees prescribed listed medication, or to charge fee for any listed drugs or consumable.

Provider payment mechanism

A provider payment system consists of one or more payment methods and all supporting systems, such as contracting and reporting mechanisms, information systems, and financial management systems.[8] Payment methods generate powerful incentives that affect providers' behaviours in rendering health services. Incentives - economic signals that can direct healthcare providers towards self-interested behaviours. These behaviours can lead to beneficial or un-intended effects. A payment mechanism can encourage irrational use of pharmaceuticals (unintended effect), while another can promote a reduction in the average length of stay in hospitals (beneficial effect).[9]

Depending on the nature of these incentives, the market and institutional contexts in which they exist, payment mechanisms may induce movement toward or away from improved efficiency, equity, consumer satisfaction, and or health status.[10] Nevertheless, provider payment systems can be designed to create economic signals that lead providers to self-interested behaviour, which is in the interest of the purchaser, and the patients.[11]

Mixed system of different methods provides trade-offs to offset the disadvantages of individual complimentary methods, are therefore superior.[10] The abridged descriptions of common methods are presented in Table 1.

The desirability of a specific system depends on the economic, social, and institutional contexts. Consequently, low-income countries are encouraged to avoid complex payment systems requiring higher levels of institutional development. For general understanding of the rationale for adoption key advantages and disadvantages of some of the commonly-used payment mechanisms are presented in Table 2. These advantages and disadvantages are often used as incentives or disincentives for desired provider behaviours, especially with respect to cost containment and quality assurance.[10] This principle possibly informed the policy decision to adopt a mixed system of (global) capitation, FFS and per diem as the NHIS payment mechanism for quality delivery at optimum costs.[12]

Table 1: NHIS provider payment system

Method	Description	Services
Capitation (Global)	Prospective payment irrespective of utilization of services by enrolees. Per-capita-per-month payment to primary healthcare facilities through HMO	For defined primary care services, laboratory investigations, and drugs
Fee-for-service	Retrospective payment for secondary facilities (community pharmacies and diagnostic laboratories); Pharmacies submit claims for filled primary care prescriptions to the referring Primary Facility for direct payment	Primary providers refer prescriptions to pharmacies
Fee-for-service	For secondary and tertiary consultations, investigations, drugs etc. in specialist facilities paid through HMOs.	Secondary care prescriptions are implicitly expected to be filled by secondary and tertiary hospital pharmacies, but not community pharmacies.
Per diem	Per-day payment for bed space during hospitalization Primary providers pay per diem for emergency cases Providing facilities submit claims to referring Primary Facility Primary facility pays for 15 days for bed space for orthopaedics HMO pays for the remaining 27 days	For occupied bed space by the referred patient up to a maximum of 15 cumulative days. HMO pays per diem for bed space for the remaining cumulative 6 days per year, and 27 days for orthopaedics and other special cases.
Co-payment (applicable to contributory programmes)	10% payment made by enrolees to accredited pharmacy providers at the point of service. Enrolees pay 10% of the total cost of medications.	drugs dispensed per prescription in accordance with the NHIS drug price list
Co-insurance.	50% payment made by the enrolees for treatments/ investigations covered under partial exclusion list while the HMO pays the balance.	treatments/ investigations covered under partial exclusion list

Table 2: Advantages and disadvantages of provider payment methods

Payment Method	Key Advantages	Key Disadvantages	Measures to Minimize Disadvantages
Line Item Budget	Permits stringent central control, desirable for weak local management - Fund holder expenses can be forecasted.	No efficiency incentives - Provider may ration services provision· - fixed resource use may impede efficiency and quality of service	Monitoring performance for efficient use of resources, though at extra costs.
Global Budget	Purchaser expenses can be forecasted, - Low administrative costs - Facilitates efficient use of resources across levels	No incentives for efficiency in service production. Provider may ration service provision·	Monitoring performance for efficient use of resources, though at extra costs. - Define and give performance-based Bonuses (global budget linked to performance,)
Capitation	Purchaser expenses can be predicted. Promotes provider efficiency due to stronger controls on the price and volume of services. No risk of supplier-induced demand Minimal administrative Costs	Provider bankruptcy a possible outcome from financial risks. - To minimize risks provider may resorts to registering only low-risk enrolees. - Provider may provide poor quality care, or may under-provide if the rates are too low	- Adjusting capitations to reflect the underlying risks of enrolled population. Ensure compliance with contracts for qualitative and quantitative services
Fee for Service	Potential to increase services Satisfaction among enrolees perceiving more and/or expensive treatments as good quality health care	Strong incentives for supplier-induced demand, leading to oversupply of services and pharmaceuticals - Fund holder expenses cannot be predicted - Increased volume of utilization, leading to costs escalation - High cost of administration due to claims processing	Standard Treatment Guidelines and Price Schedules in place to make expenses fairly predictable, and reduce costs by defining realistic ceilings for expenditures Cost control by regularly revising and enforcing price schedules
Case-Based	Strong incentives to operate efficiently	Expenses for fund holder difficult to forecast. - High administrative costs (but less than fee-for-service) - Provider has incentives forcream-skimming low-risks - Gaming by swapping cases - Difficult to delineate cases in practice	- Define detailed case-mix category system - Better used in a mixed payment system
Per-diem (simplest of case-based)	- Reduces inputs per hospital day towards efficient operation - Easy and quick to calculate and implement	- Incentives for supplier-induced demand for admissions, and to extend the length of stay - Escalating health expenditure	- Effective monitoring system required - Adjusting to higher payment rates for short hospital-stay days may check abuse

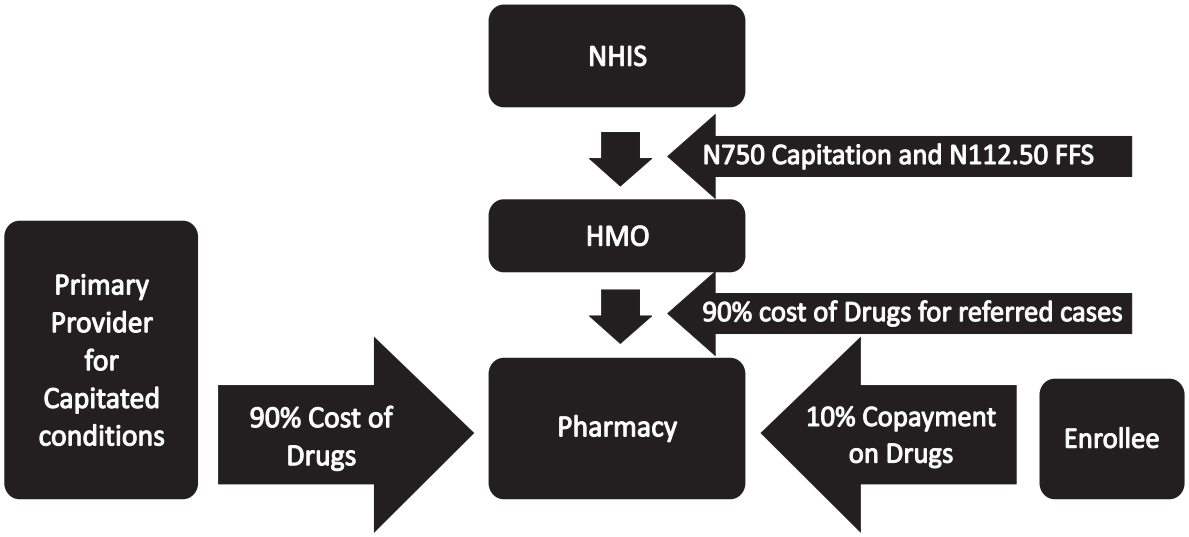

Figure 1: Pharmacy-related flow of funds in NHIS.

DISCUSSION

Gaps in NHIS operations with regards to pharmacy professional practice.

It is evident that in all the ten statutory objectives of NHIS, pharmacy practice and professionals have direct critical contributions to make towards the effective performance of the Scheme. The overall objective of NHIS is to ensure that its enrollees access equitable qualitative health care services. To achieve this objective, the pivotal position of drug manufacturing, management and its rational use, and consequent critical roles of pharmacies and pharmacists are evident. It is noteworthy that in any society, general perception of qualitative healthcare services mainly revolves around availability of efficacious drugs.

Furthermore, the performance of any healthcare delivery system, and specifically the viability and sustainability of any social health insurance Programme depend on the satisfaction of contributing enrollees. Limited participation or outright exclusion of any health professional is bound to create a void and with consequent denial of access to the full range of expertise that add up to the effectiveness of any healthcare delivery system. On the whole the patients or enrolees are worse off for it.

Fee-for-service (FFS) or capitation payment for drugs

Questions have often been asked in the past, why pharmacists are not paid capitation directly or why the Fee-for-Service (FFS) had to be routed through primary care facilities in the name of global capitation.

Furthermore, it is on record that the Pharmaceutical Society of Nigeria (PSN) announced its opposition to the payment method of FFS, and its aversion to the answerability of pharmacists to primary care providers for payments for drugs dispensed to enrolees. The payment system, the society reportedly claims, threatens the sustainability of the Scheme.[13] This development has led to withdrawal/exclusion of pharmacy professionals.

From the reviewed literature, capitation method cannot be justified for drugs. Most health insurance and provider payment literature situate drugs within the FFS, rather than the capitation mechanism.[14,11,9] Quinn,[15] in his exposition on eight basic payment methods, cited drugs only under FFS, and among the few similar items as medical equipment and supplies. It is evident that it could be counter-productive economically to pay capitation, in which the pharmacist would have to bear added financial risks. Financial risk gradually shifts from being primarily on providers when payment is per time period to being primarily on payers when payment is FFS.[15]

Pharmacists need to be educated on the concept of, and international best practices in provider payment mechanisms. The feasibility or otherwise of capitation method for drugs needs to be appreciated. FFS mechanism is the most feasible and commonly acceptable method for drugs. However, the position is reversible with emergence of new body of evidence to the contrary.

NHIS global capitation and engagement of unlicensed hospital pharmacies.

Global capitation has the advantage of cost containment, an incentive for fund managers such as NHIS. The adoption of global capitation as a payment mechanism, in which fees for consultation, laboratory tests, and drugs for primary care are bundled, and paid to primary provider hospitals, has inadvertently compromised the participation of independent medical laboratories and community pharmacies.

Most NHIS-accredited primary providers have in-house 'pharmacies' that are not registered by PCN, and therefore unfit for NHIS accreditation. The registration and accreditation are veritable tools to ensure compliance with quality and overall performance standards, and accountability to the system. As at 2019, only 210 hospital pharmacies nationwide were registered by PCN.[16] These capitation fundholding primary providers are saddled with purchasing responsibility for primary health care including drugs and medical laboratory examinations.[10] Experience has shown that pharmacy services end up being provided by the capitation holding primary care providers themselves, rather than referring prescriptions out to be filled as appropriate. Majority of these facilities are least prepared, unqualified, and unlicensed to provide pharmacy services. Consequently, enrollees are denied the specialized expertise of pharmacies, which contributes to the incessant outcry of enrollees for the denied or limited access to NHIS-listed drugs. The professional lapses manifest in enrollees being made to pay out-of-pocket for drugs, for which providers or HMOs have been paid by NHIS. This scenario is counterproductive, and constitutes a minus for NHIS performance; especially as a key objective of NHIS is to protect enrollees from the burden of out-of-pocket payment, which could be catastrophic and impoverishing.

The approach of incorporating drug financing into per capita PHC payment systems reportedly works well in Kyrgyz Republic, in Central Asia. Since 2001, it started the outpatient drug reimbursement systems linked to the per capita PHC payment system. The former is used to reimburse drugs purchased by the patients themselves through the pharmacy network.[17] In this arrangement, actively involved pharmacies are paid by reimbursement for drugs, with the financial risk residing with the purchaser. A relevant success story was reported in Kazakhstan.

Box1: additional drug package (ADP) in the Kyrgyz Republic.

"The Mandatory Health Insurance Fund (MHIF) contracts with private pharmacies to provide the additional drug package (ADP) medicines. The pharmacies must accept the MHIF conditions, including the reference price and co-payment amount. Individuals receive prescriptions from their PHC provider, they then choose their pharmacy, and make the co-payment. The pharmacy invoices the MHIF for prescriptions filled at the reference prices.

The ADP emphasizes patient responsibility through the co-payment and choice, by allowing individuals to purchase covered medicines from any participating pharmacy and to choose the drug within the prescribed class of medicine. It also encourages generic medicines, because the subsidy is a percentage of the reference price of the dispensed medicine. If a patient chose a higher-priced branded drug, he paid a higher co-payment. So, the choice of the patient is preserved by allowing generic substitution, but the MHIF aims to encourage an overall shift to less expensive drugs, so that overall access to necessary medicines can rise further."

There are lessons for NHIS in the implementation of outpatient drug reimbursement linked to per capita PHC payment systems in the Kyrgyz Republic and Kazakhstan. The participation of pharmacies is succinctly captured in Box[1]. The adaptation of the approach for the active participation of PCN - registered and NHIS-accredited hospital and community pharmacies in the operations of the renewed NHIS is a possible strategy for NHIS

Improving drug availability and cost-effectiveness for NHIS enrollees - contract manufacturing.

NHIS objective iii (above) is to "limit the rise in the cost of health care services". Nigerian Pharmaceutical Manufacturing Industry has an important role in making genuine drugs available at optimum costs for NHIS to achieve the cost containment objective. To ensure sustained availability of drugs, public subsidy for drug production may not be an option as publicly subsidized production of consumables, pharmaceuticals and medical equipment reportedly leads to low quality, lack of innovation, outmoded technology, inefficient production modalities and distribution delays.[2]

A worthwhile strategy is contract manufacturing of essential drugs purposely for NHIS operations. The

strategy should be pursued to its logical conclusion, with the Association of Industrial Pharmacists of Nigeria playing the active Co-Driver role and providing the technical direction.

Pharmacies urban - rural distribution imbalances.
It is well documented, that providers tend to concentrate in urban areas.[2] Almost all countries have some urban/rural imbalances among their human resources, and face problems in meeting the needs of specific groups in services provision. The groups include the poor, rural or urban ghetto dwellers. Nigeria is not an exception to this imbalance, which has implication for health insurance coverage for the large informal rural population of over 60%.

The PCN would need to revisit a past policy aiming to increase presence of pharmacies in under-served rural areas, to augment the limited public hospitals. The policy was for urban pharmacies to be allowed to open branches in rural settings, with some element of registration waivers as inducement.

Professional training on pharmaceutical care by PCN
Pharmaceutical care is a new professional area. It is defined as the responsible provision of drug-related care for the purpose of achieving definite outcomes that improve and/or maintain a patient's quality of life. It is patient-centred and outcome-oriented pharmacy practice that requires the pharmacist to work together with the patient and other healthcare providers to promote health, prevent disease, and initiate, assess, monitor, and modify medication use to assure the safety and effectiveness of drug therapy regimens.[18] Consequently, it is critical for pharmacists to be trained in pharmaceutical care to acquire the requisite knowledge and skills, and to gain the needed confidence to deliver the care. The PCN has an important role in designing a training module for pharmaceutical care and incorporating same in its regular Mandatory Continuing Professional Development programmes.

CONCLUSION

The adoption of global capitation, and the consequent exclusion of some healthcare providers, can be seen to be detrimental to NHIS' overall performance, and enrolees' satisfaction. Of grave concern are the near obliteration of the distinct roles and expertise of licenced pharmacies, and the plight of enrolees in being largely denied their drug benefits. The consequences include avoidable financial burdens for enrolees, and the corresponding NHIS objective not being realised. For improved NHIS performance, possible strategies would include - re-designing NHIS provider payment system by contextualising lessons from countries like the Kyrgyz Republic; harnessing the expertise of all health professionals including licensed pharmacies; also, PCN needs to craft professional development strategy to hone pharmacists' prerequisite skills for providing pharmaceutical care which Nigerians direly need.

The comprehensiveness of NHIS benefit packages with a wide spectrum of medications, has implications for the growth and development of Nigerian pharmacy practice, and pharmaceutical industry in many ways. The prospect for gainful employment of pharmacists to reduce unemployment rate is noteworthy. Opportunity also exists for pharmacists to engage with the enrolees across the different sectors and groups as they provide pharmaceutical care, for more visibility and relevance of pharmacists within the polity. Another benefit is the operational research opportunity to generate qualitative and quantitative evidence on drug consumption, and ultimately for research and development for Nigerian local active ingredients. Emergence of a strong vibrant pharmaceutical manufacturing sector, towards pharmaceutical self-reliance, drug security, manpower development and economic growth are possible overall outcomes.

Overall, for their satisfaction and improved health, Nigerian enrolees like their counterparts elsewhere, deserve an all-inclusive patient-centred pharmaceutical care, and protection from financial burden of drugs in NHIS.

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